

Promising Integrated Treatment Model to Help Veterans with Co-Occurring PTSD and Substance Use Disorders

By Robb Hicks, MD

Since the terrorist attacks of September 11, 2001, an estimated 2.5 million United States servicemembers have been deployed to support operations in Afghanistan and Iraq. Many of these brave men and women have endured multiple tours of duty with extended periods of exposure to combat-related stress and other traumatic events. While the majority of servicemembers are able to successfully readjust to civilian life, one in five (18.5%) troops returning from Operations Enduring Freedom and Iraqi Freedom are diagnosed with post-traumatic stress disorder (PTSD), also known as Post-Traumatic Stress (PTS), Combat Stress or Combat Operational Stress (Tanielian & Jaycox, 2008).

The National Institute of Mental Health (NIMH) defines PTSD as “the body’s normal reaction to direct or indirect exposure to a terrifying event or ordeal, in which grave physical harm occurred, or was threatened, to oneself or a loved one.” Different from physical wounds, PTSD remains invisible to other servicemembers, their relatives and society at large; yet, it has debilitating effects. Some of the symptoms, which may not appear until months after the exposure to stress, include difficulty concentrating, trouble sleeping, constantly feeling on alert, feeling numb, feeling irritable and avoiding people and places that are stressful (NIMH, n.d.).

Along with traumatic brain injuries, PTSD is oftentimes considered a “signature wound” of war that will last a lifetime. The Department of Veteran Affairs estimates one in three veterans seeking treatment for substance use disorder (SUD) also has PTSD (National Center for PTSD, n.d.). Therefore, successful treatment of PTSD/SUD is likely to have a significant public health effect on society (Ouimete, Read, Wade, & Tirone, 2010).

Experts Theorize About the Origins of PTSD/SUD

Although researchers and medical professionals are unable to identify a single explanation as to why a patient will develop comorbid PTSD/SUD, four hypotheses have been proposed. The first theory is PTSD leads to SUD. From a developmental standpoint, traumatic stress occurring in childhood would challenge maturing self-regulatory skills on both the neurobiological and behavioral levels. Patients would then be predisposed for later SUD due either to a lack of coping skills, or to the inability to manage emotions and feelings.

The second theory, the high-risk hypothesis, is based upon the reality that people with SUD tend to engage in more risky behaviors. This increases the likelihood of experiencing traumatic events, and thereby increases the probability of developing PTSD. The third theory, the susceptibility hypothesis, proposes individuals with SUD have some as-yet-undefined higher psychological and biological vulnerability to the effects of trauma exposure. This proposed susceptibility increases the probability of developing PTSD. The fourth theory proposes PTSD and SUD are related by a third variable, such as disconstraint, when it occurs in the presence of deficits in coping skills.

The addition of a SUD to PTSD also has been found to severely worsen the symptoms of this anxiety disorder. For instance, PTSD may create insomnia and/or sleep disturbances. A patient may then “self-medicate” him/herself with alcohol and/or drugs, hoping to improve their quality of sleep. PTSD makes patients feel “on edge,” and SUD can amplify these feelings. Patients also may use drugs and/or drink alcohol to temporarily distract themselves from their problems, when in actuality drugs and alcohol make it more difficult to concentrate on tasks (Schäfer & Najavits, 2007).

While the symptoms of these conditions appear differently in every patient, it is believed the most effective treatments must be collaborative, multifold and developed soon if we are to successfully treat the growing prevalence of patients struggling with these unrelenting disorders.

Progressions in Treatment Methods Improve Patient Care

Practitioners, mental health and substance abuse professionals, and military leaders utilize a host of treatment programs to assist veterans with PTSD/SUD, including but not limited to: Individual or group cognitive behavioral therapy (CBT); Cognitive Processing Therapy (CPT); Prolonged Exposure (PE); behavioral couples therapy with a spouse or family member; and medications to help a patient manage their PTSD/SUD symptoms. Evidence indicates most patients will show signs of improvement when concurrently provided treatment to address both disorders (National Center for PTSD, n.d.).

As recently as 10 years ago the majority of PTSD/SUD patients received sequential treatment, which required an individual to first complete a substance abuse program, and maintain a certain period of abstinence, before beginning treatment for another disorder like PTSD. A critical drawback to this method was one condition was left unaddressed while the other was being treated. In fact, sequential treatment has been shown to lead to higher relapse rates among patients with PTSD/SUD than those found in the general SUD population (Coffey, Schumacher, Brimo, & Brady, 2005). Concurrent treatments, on the other hand, involve two individual programs simultaneously treating a patient with both conditions, but in separate settings and by different clinicians (Minnesota Center for Mental Health, 2013). Although more successful, this method does raise valid concerns regarding reliability and consistency of treatment administration.

Seeking Safety Adopted by the National Center for PTSD and Spreads to Thousands of Hospitals and Clinics Worldwide

Within the past few years, integrated treatment options have yielded promising outcomes for patients with co-occurring conditions when they are provided by an individual clinician through a single intervention. As of 2010, the National Center for PTSD categorized *Seeking Safety*, a manual-based cognitive behavioral therapy program developed by Lisa Najavits in 1992, as the only truly-integrated treatment for PTSD/SUDs

(National Center for PTSD, 2010). Women who participated in clinical trials reported significantly improved substance use and trauma-related symptoms (Najavits, Weiss, Shaw, & Muenz, 1998). Generally speaking, integrated treatments have demonstrated higher levels of patient retention and overall greater symptom improvements for both conditions (Dass-Brailsford & Myrick, 2010).

Seeking Safety is considered by some to be the most promising and widely-adopted integrated treatment model. It is now being used in over 3,000 hospitals, treatment facilities and clinics in the United States and 11 other countries (Substance Abuse and Mental Health Administration, 2012). The drawback to this treatment model is its lack of a trauma-focused component; therefore, it is recommended that it be combined with additional treatment programs to ensure all problematic behaviors decrease (SAMHSA, 2012).

Veterans with PTSD/SUDs are specialized patients who may require a treatment program tailored to their individual circumstances and unique nature of combat and military culture. Clinical trials offer guidance to treatment, but clinicians ultimately must decide on the most effective approach for their specific patient's given needs and variables.

Call to Action: Overcoming Access Gaps in Mental Health Care is a Key Component in Veterans' Reintegration

The current state of national mental health is one of optimism, with undertones of urgency. Leaders of the Department of Defense, Veteran Affairs, and both the medical and research communities hope to develop advanced tools and treatment methods to effectively and efficiently care for veterans with cognitive conditions such as PTSD/SUDs. The findings of a RAND survey in 2008 indicated only half (53%) of returning troops with PTSD symptoms actually sought treatment from a professional (SAMHSA, 2012). The lack of willingness to seek help is presumed to be due to concerns about confidentiality and/or fear of losing the trust of family members, potential employers and colleagues. Furthermore, returning servicemembers may not seek treatment due to longer wait times for appointments, particularly in facilities resourced primarily to meet the needs of older veterans (SAMHSA, 2012).

Better projections of the amount and types of demands among newer returnees are needed to ensure Veteran Affairs' offices are appropriately staffed and equipped with the resources needed to care for its patients. More specialized inpatient, residential, and outpatient programs specifically for veterans with new onset, severe or complex diagnosis of PTSD/SUD also are needed. Nonetheless, we all can support veterans and their families in the reintegration process by increasing public awareness and communal support of these unseen wounds. All of these changes are a part of the National Research Action Plan (NRAP) proposed by the White House in August 2013 intending to honor the brave men and women who have selflessly sacrificed their lives to protect and defend our freedoms (U.S. Department of Defense, 2013).

REFERENCES

- Coffey, S., Schumacher, J., Brimo, M., & Brady, K. (2005). Exposure therapy for substance abusers with PTSD: Translating research to practice. *Behavior Modification*, 29 (10): 10–33.
- Dass-Brailsford, P. & Myrick, A. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, & Abuse*, 11 (4), 202–212.
- Minnesota Center for Mental Health. (2013, February). Treatments Models for Co-Occurring PTSD and SUD. Practice Brief. Retrieved from mcmh.umn.edu/system/resources/.../MCMHPracticeBrief1_web.pdf.
- Najavits, L., Weiss, R., Shaw, S., & Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress*, 11, 437–456.

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1. One in _____ troops returning from Operations Enduring Freedom and Iraqi Freedom are diagnosed with PTSD, Combat Stress, or Combat Operational Stress.
2. Which of the following is a symptom of PTSD?
3. The Department of Veteran Affairs estimates one in _____ veterans seeking treatment for substance use disorder also has PTSD.
4. Which of the following describes the "high-risk hypothesis"?
5. Which of the following describes the "susceptibility hypothesis"?
6. The addition of a substance use disorder to PTSD has been found to _____ the symptoms of this anxiety disorder.
7. Which of the following treatment options are utilized with PTSD?
8. _____ has been shown to lead to higher relapse rates among patients with PTSD and SUD than those found in the general SUD population.
9. Which of the following methods of treatment involves two individual programs simultaneously treating a patient with both conditions, but in separate settings and by different clinicians?
10. Veterans' lack of willingness to seek help is presumed to be due to concerns about confidentiality and/or fear of losing the trust of family members, potential employers, and colleagues.

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National Center for PTSD. (n.d.). PTSD and Substance Abuse in Veterans. Retrieved from http://www.ptsd.va.gov/public/problems/problems_ptsd_substance_abuse_veterans.asp. Accessed on February 15, 2014.

National Center for PTSD. (2010). Towards integrated treatments for PTSD and substance use disorders. *PTSD Research Quarterly*, 21 (2): Retrieved from <http://www.humana-military.com/library/pdf/integrated-treatments-ptsd-substance-use.pdf>.

National Institute of Mental Health. (n.d.) What is Post-Traumatic Stress Disorder (PTSD)? Retrieved from <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>.

Ouimette, P., Read, J. P., Wade, M., & Tirone, V. (2010). Modeling associations between posttraumatic stress symptoms and substance use. *Addictive Behaviors*, 35: 64–67.

Schäfer, I. & Najavits, L. (2007). Clinical challenges in the treatment of patients with Posttraumatic Stress Disorder and substance abuse. *Current Opinion Psychiatry*, 20(60): 614–618. Retrieved from <http://www.medscape.com/viewarticle/564893>.

Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Practices. (2012). Seeking Safety. Retrieved from <http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139>.

Tanielian T. & Jaycox L. H., eds. (2008) *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 492. Retrieved from http://www.rand.org/pubs/research_briefs/RB9336/index1.html.

U.S. Department of Defense. (2013) National Research Action Plan: Responding to the executive order improving access to mental health services for veterans, service members and military families. Retrieved from http://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf.



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