



Posttraumatic Stress Disorder, Violence, and Substance Use

An article on co-occurring posttraumatic stress disorder (PTSD) and substance use disorders (SUD) is available online from Medscape, which offers continuing education credit, including continuing medical education (CME): **Johnson, S.D. (2008). Substance Use, Post-traumatic Stress Disorder and Violence. *Current Opinion in Psychiatry*, 21(3), 242-246.** Available online for registered users (free) at <http://www.medscape.com/viewarticle/573767>

The author reviews current research on the co-occurrence of PTSD and substance use/disorders and the role of violence as a mediating factor, paying particular attention to some of the problems with research and the limitations of our current knowledge. For example, she notes that while there are indications that the type of substance abused and the severity of a substance use disorder may affect PTSD symptoms and the ability of clinicians to diagnosis the disorder, few studies attempt to assess different types of substances and different levels of severity within their samples.

Another problem that makes it difficult to compare prevalence rates among various studies is the use of various differing measures of both SUD and PTSD. Johnson discusses some of the better screening and assessment instruments available for both researchers and clinicians, but notes the need for more research to identify and validate appropriate instruments for clients with these co-occurring disorders.

Johnson also discusses the current understanding about the best treatment approaches for these co-occurring disorders, noting that treatment may benefit from targeting specific substances of abuse as different substances can interact in unique ways with PTSD to trigger relapse (e.g., individuals with cocaine dependence are more likely to use during pleasant times than are those with alcohol dependence). Also, she points out that integrated treatment is a more efficient approach as well as an effective one, and that concerns that integrating treatment may jeopardize treatment effectiveness are not supported by the research.

Another significant issue in the review is the role of violence in understanding the interaction of PTSD and SUD. Johnson observes that the type of violence experienced may affect treatment outcome and needs to be taken into account in treatment planning. She again notes that research often fails to distinguish the type of trauma and how the level of violence involved in the trauma may affect the development of both the SUD and PTSD.

Another recent article looks at the relationship of exposure to violence and the use of treatment services for alcohol dependence: **Rothman, E.F., Cheng, D.M., Pedley, A., Samet, J.H., Palfai, T., Liebschutz, J.M., and Saitz, R. (2008). Interpersonal violence exposure and alcohol treatment utilization among medical inpatients with alcohol dependence. *Journal of Substance Abuse Treatment*, 34(4), 464-470.**

These authors evaluated histories of violence exposure for 238 individuals who were hospitalized inpatients at a large urban hospital and who were identified through a Screening and Brief Intervention program. A large percentage of the participants had been homeless (30.3 percent) at least one night in the past 3 months, and many were unemployed (68.1 percent). Participants were assessed for further treatment participation (detoxification, living in a halfway house, Employee Assistance Program counseling, self help groups, and/or other forms of substance abuse treatment) at 3 and 12 months after their initial hospitalization. They found that participants who reported a history of interpersonal violence (n=183) were 1.6 times more likely to participate in further treatment during the follow-up year. While the authors found that there were no significant differences between further treatment participation and the recency of the trauma when aggregating all subtypes of violence into one broad category, they found that those who had been raped (one of the specific categories of violence examined) within the past 3 months were significantly more likely to participate in further treatment than were those who had been raped prior to that time.

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COD Research

National Epidemiological Studies

Grant, B.F., Chou, S.P., Goldstein, R.B., Huang, B., Stinson, F.S., Saha, T. D., et al. (2008). Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder: Results From the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 69, 533–545.

The authors report on the prevalence and correlates of Borderline Personality Disorder using data from the second wave of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The authors found that 5.9 percent of their sample of 34,653 adults met criteria for a diagnosis of borderline personality disorder (BPD) during their lives. Interestingly, there were no significant differences in rates for men and women. Men who were Native American; adults who were separated, divorced, or widowed; people who were younger; and people with lower incomes and education levels were more likely to have a diagnosis of BPD. They also found that BPD, especially for women, was associated with high rates of both co-occurring mental and physical disability. However, after controlling for other disorders, BPD was not found to be significantly associated with substance use disorders. BPD did have a strong association with bipolar disorder, schizotypal personality disorder, and narcissistic personality disorder.

Hatzenbuehler, M.L., Keyes, K.M., Narrow, W.E., Grant, B.F., and Hasin, D.S. (2008). Racial/Ethnic Disparities in Service Utilization for Individuals With Co-Occurring Mental Health and Substance Use Disorders in the General Population: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 27, e1–e10.

The authors used data from the 2001–2002 NESARC survey to evaluate the relationship of race/ethnicity to service use for people with COD (N=4250, 653 of whom were African Americans). They found that African Americans with co-occurring mood/anxiety and substance use disorders were significantly less likely than Caucasians with those co-occurring disorders to receive services targeted primarily to treat their mood or anxiety disorders, about as likely to receive alcohol use disorder treatment, and more likely to receive services for drug use disorders. Regardless of the respondents' race/ethnicity, respondents were almost twice as likely to get services for their mood/anxiety disorders as for their substance use disorders.

Client Characteristics

Clingempeel, W.G., Britt, S.C., and Henggeler, S.W. (2008). Beyond Treatment Effects: Comorbid Psychopathologies and Long-Term Outcomes Among Substance-Abusing Delinquents. *American Journal of Orthopsychiatry*, 78:(1), 29-36.

The authors assessed co-occurring mental disorders among 80 youth who abused substances and were involved in the criminal justice system and then reassessed them on a number of measures 5 years later when they were in early adulthood. Those who had COD had significantly higher scores on measures of psychopathology, criminal behavior, and health problems at the 5-year reassessment. Those individuals who had both internalizing and externalizing disorders had more negative outcomes than those who had externalizing disorders only. Having a greater number of internalizing disorders was associated with higher internalizing and aggression scores, more criminality, and poorer physical health at follow-up. Having more externalizing disorders was associated with higher scores on measures of internalizing, delinquency, and criminality. For women but not men, having a greater number of internalizing disorders was associated with greater criminality and especially more aggressive crimes as young adults.

Hall, J.A., Vaughan-Sarrazin, M., Reedy, A.R., and Huber, D.L. (2008). Comprehensive case management for substance abuse clients who have mood or anxiety disorders. *Mental Health and Substance Use: dual diagnosis*, 1(2), 143-157.

The authors evaluated the use of a comprehensive case management program (the Iowa Case Management Project) developed to aid people in rural areas with a group of substance abuse treatment clients who had COD (N=518).

Participants attended either residential or intensive outpatient treatment programs and received either the case management intervention or standard treatment. While there were significant decreases in substance use for all participants following treatment, there were no significant differences in this regard between those who did and did not receive the intervention. Regardless of the intervention, participants who had COD had significantly poorer outcomes than did those without COD.

Manning, V., Strathdee, G., Best, D., Keaney, F., Bhui, K., and Gossop, M. (2008). Differences in mental health, substance use, and other problems among dual diagnosis patients attending psychiatric or substance misuse treatment services. *Mental Health and Substance Use: dual diagnosis*, 1(1), 54-63.

The authors evaluated differences in degree and type of disorder for 159 individuals with COD who were receiving different types of treatment services (namely community mental health services, inpatient psychiatric services, drug abuse treatment services, or alcohol abuse treatment services). They found that individuals with COD who were receiving inpatient psychiatric services had the most severe mental disorders, that those who received community mental health services had the lowest rates of alcohol use disorders, and that among all participants there were high rates of affective disorders and a high risk for suicide.

Infrastructure

Workforce Development and Training

Manley, D.S. (2008). Acceptability and applicability of Cue Exposure Therapy as a relapse prevention intervention for individuals who have substance misuse and mental health problems. *Mental Health and Substance Use: dual diagnosis*, 1(2), 172-184.

The author assessed the acceptability of Cue Exposure Therapy (CET) to a group of psychiatric professionals who received training in the intervention. Participants reported that they found CET an acceptable intervention for their clients with COD. Participants' confidence in the intervention and their ability to administer it was significantly increased by the training.

Services & Service Systems

Treatment Planning & Services

Brown, E.S., Garza, M., & Carmody, T.J. (2008). A Randomized, Double-Blind, Placebo-Controlled Add-On Trial of Quetiapine in Outpatients With Bipolar Disorder and Alcohol Use Disorders. *Journal of Clinical Psychiatry*, 69, 701-705.

The authors studied the use of quetiapine, an atypical antipsychotic also used to treat bipolar disorder, as a potential agent to reduce alcohol use and improve mood among individuals with co-occurring bipolar and alcohol use disorders (N=102 participants available for at least one assessment after the trial began). Participants were randomly assigned to receive either quetiapine or a placebo for 12 weeks. There were no significant differences for ratings of alcohol use or mania, but those who received quetiapine scored significantly lower on a measure of depression (the Hamilton Rating Scale for Depression). The size of the difference in depression scores was most apparent in the first 6 weeks of the trial, as those receiving the placebo showed larger decreases in depression scores after that period.

Grant, J.E., Kim, S.W., and Hartman, B.K. (2008). A Double-Blind, Placebo-Controlled Study of the Opiate Antagonist Naltrexone in the Treatment of Pathological Gambling Urges. *Journal of Clinical Psychiatry*, 69, 783-789.

The authors evaluated the use of naltrexone to help individuals with pathological gambling cope with urges to gamble. They carried out an 18-week study involving 77 participants, in which participants were randomly assigned to receive varying doses of naltrexone or a placebo. Individuals who received naltrexone had significantly greater reductions in their Pathological Gambling Adaptation of the Yale-Brown Obsessive Compulsive Scale scores, in urges to gamble, and in

actual gambling behaviors. Those receiving naltrexone also had significantly greater improvements in overall gambling severity and in psychosocial functioning. There were no significant differences in outcomes for people receiving different dosages of naltrexone, so that doses as small as 50 mg/day appeared to be as effective as larger doses.

Johnson, J.E. and Zlotnick, C. (2008). A pilot study of group interpersonal psychotherapy for depression in substance-abusing female prisoners. *Journal of Substance Abuse Treatment*, 34(4), 371-377.

The authors conducted a pilot study of an interpersonal therapy intervention for depression with a group of 26 incarcerated women who had one or more substance use disorders and major depression and/or dysthymic disorder. The intervention lasted for 8 weeks and by the end of that period 72 percent of the women no longer met criteria for any depressive disorder.

Moleiro, C. and Beutler, L. E. (2008). Change factors in depression and substance use treatment: A longitudinal integrative model. *Mental Health and Substance Use: dual diagnosis*, 1(1), 64-83.

The authors analyzed a model developed to evaluate the effect of treatment alliance and four different evidence-based principles for creating change as potential predictors of symptom reduction during and after treatment. They followed 190 individuals who completed one of five substance abuse treatment interventions (each lasting 20 sessions). They found that the model proposed fit well. Those participants who had high levels of subjective distress upon entering treatment had the best substance use outcomes when provided with affective-focused interventions. Also, matching clients according to their preferred coping style (i.e., externalizing or internalizing) with an appropriate treatment focus (either focused on symptom change or insight) made for a better treatment alliance.