ESTSS expert recommendations for the psychological treatment of PTSD with comorbid substance use disorder (SUD)

Introduction

PTSD and substance use disorder (SUD) frequently co-occur, and PTSD-SUD comorbidity presents many clinical challenges for treating clinicians. Individuals with PTSD-SUD present with a more severe clinical profile than either disorder alone, tend to have poorer functioning and wellbeing, and poorer treatment outcomes. Clinicians view this comorbidity to be substantially more difficult to treat than the two disorders in the absence of comorbidity. Most recent guidelines (e.g., American Psychological Association, 2017[1]; ISTSS 2018[2]; NICE 2018[3]) have not included scoping questions to address issues of comorbidity, and there are no widely accepted guidelines about how to manage and treat such individuals.

In view of these challenges an expert recommendation committee was established to develop recommendations for the psychological treatment of this comorbidity, with the support of ESTSS, in 2020. This document presents these recommendations and describes the process and methodology used to develop them.

Expert recommendation development process

The committee recognised from the outset that the research literature which might inform the recommendations is still developing and is somewhat limited. Recommendations were developed through two stage process which was circulated to ESTSS members for consultation prior to commencement.

1) Systematic review

The committee developed a number of scoping questions which it sought to address through a systematic review and meta-analyses of available evidence from randomised controlled trials (RCTs). Scoping questions were based on a PICO format (Population, Intervention, Comparator, Outcome) and framed in terms of three overarching questions, which were addressed through several sub-questions, to enable consideration of more specific treatment approaches. From a knowledge of the literature the types of interventions most widely evaluated in the literature were thought to be present focused treatments (also known as

coping based/ non-trauma focused treatments), trauma focused treatments and integrated cognitive restructuring-based interventions (without imaginal and in vivo exposure). The committee also judged that the most usual control comparator in studies evaluating these types of interventions would be treatment for SUD only.

Scoping questions

1. For individuals with PTSD and comorbid SUD, do psychological treatments for PTSD only or PTSD and SUD when compared to treatment as usual for SUD only result in a clinically important reduction of PTSD and SUD symptoms, reduced presence of disorder in terms of diagnostic status, decreased drop-out or difference in reported adverse effects? Example comparisons:
    a. Are present focused treatments (also known as coping based/ non-trauma focused treatments) plus treatment as usual for SUD more effective than treatment as usual for SUD only?
    b. Are trauma focused treatments plus treatment as usual for SUD more effective than treatment as usual for SUD only?
    c. Are integrated cognitive restructuring-based interventions (without imaginal and in vivo exposure) for PTSD and SUD plus treatment as usual for SUD more effective than treatment as usual for SUD?

2. For individuals with PTSD and comorbid SUD, do psychological treatments for PTSD and SUD when compared to other psychological treatments for PTSD and SUD (head-to-head comparisons), result in a clinically important reduction of PTSD and SUD symptoms, reduced presence of disorder, decreased drop-out or difference in reported adverse effects? Example comparisons:
    a. Are trauma focused treatments more effective than present focused treatments?
    b. Are trauma focused treatments more effective than integrated cognitive restructuring-based interventions (without imaginal and in vivo exposure)?
    c. Are integrated cognitive restructuring-based interventions (without imaginal and in vivo exposure) more effective than present focused treatments?

3. When compared to sequential treatments do integrated treatments offered by one therapist OR simultaneous treatments for PTSD and SUD offered by different

therapists result in a clinically important reduction of PTSD and SUD symptoms, reduced presence of disorder, decreased drop-out or difference in reported adverse effects?

These scoping questions were addressed by updating a previous Cochrane review of psychological interventions for this population[4]. An updated comprehensive search was undertaken in order to identify relevant RCTs published between 1st January 2015 and 13th September 2021.

Inclusion criteria were:

- RCT or cluster randomised trial, including cross-over design
- Studies evaluating one or more psychological intervention aimed at treating PTSD and/ or SUD.
- Eligible comparator interventions: treatment as usual, SUD treatment only, wait list or other psychological intervention comparison condition.
- Participants met formal diagnosis for PTSD using a structured clinical interview according to ICD or DSM, OR subthreshold PTSD using predefined subthreshold criteria, which include re-experiencing symptoms. A minimum of 60% of participants were required to meet full PTSD diagnosis.
- All participants met formal diagnosis for SUD using a structured clinical interview.
- The study included PTSD and/ or SUD outcomes using validated measures
- Studies published in English.

There was no minimum sample size. No restriction based on age. Unpublished studies were eligible for inclusion. Interventions for adults and children were analysed and presented separately. Studies primarily aimed at evaluating PTSD and nicotine dependence were not included. Studies included in in the Cochrane Review[4] and studies excluded on the basis of PTSD diagnostic status were rechecked to ensure that their eligibility status had not changed. Primary outcomes of interest were PTSD severity (giving primacy to clinician administer outcomes), SUD severity (giving primacy to clinician administer outcomes, followed by biological markers, followed by self-report measures) and leaving treatment prematurely (as defined by the study). Other outcomes of interest were PTSD diagnosis, SUD diagnosis and adverse effects.

The search identified 2219 potential new studies, which were assessed against the inclusion criteria agreed by the committee. After screening and full reads of potentially eligible papers 13 new studies were identified, alongside the 14 studies previously identified in the previous Cochrane Review[4], making 27 studies in total. A full description of the systematic review, meta-analytic findings and identified studies can be found here[5].

Developing recommendations.

The committee agreed that treatment recommendations would be based on the strength of findings from meta-analyses, and the quality of these findings based on the GRADE approach. The committee developed criteria for considering the clinical importance of findings based on a threshold effect size ≥ 0.4 for PTSD severity and 0.3 for SUD severity for interventions compared against a SUD only/ treatment as usual comparator, and 0.2 for head-to-head comparisons, but decided to take a cautious approach to interpreting the outcomes of analyses, in recognition of the fact that there is no consensus in the literature about such criteria in the PTSD/ SUD population.

During final deliberations, two further methodologically rigorous systematic reviews relevant to the recommendations were published[6,7], the second of which was based on patient level data from 36 studies of psychological and pharmacological interventions. Given the direct relevance of these reviews it was decided to incorporate their findings studies into the recommendations.

Stage 2. The committee recognised that many of the problems and dilemmas faced in the clinical assessment and treatment of this population were unlikely to be adequately addressed from systematic review findings. To complement the recommendations based on systematic review, the committee therefore decided to seek to collate guidance, good practice and consensus recommendations made in trusted, authoritative, methodologically rigorous treatment guidelines and expert guidance publications published in English. These recommendations were reviewed by the committee members prior to inclusion.

The following publications meeting this description were identified by the committee and checked:

- American Psychological Association PTSD Guidelines, 2017[1]
- Australian PTSD Guidelines, 2020[8]
- Effective Treatments for PTSD: Practice Guidelines from ISTSS, 2020[10]

- International Society for Traumatic Stress Studies PTSD Guidelines, 2018[2]
- UK NICE PTSD Guidelines 2018[3]
- USA Department of Veteran's Affairs/ Department of Defense PTSD Guidelines, 2023[9]
- World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines[11]
- World Health Organisation PTSD Guidelines, 2013[12]

RECOMMENDATIONS

Assessment

1. Individuals with suspected PTSD require a thorough assessment which should include relevant history, including trauma history, exploration of PTSD feature and related disorders using appropriate assessment instruments (such as the Clinician Administered PTSD Scale for DSM-5 (CAPS-5)), general psychiatric status, physical health, marital and family situation, social and occupational functioning, quality of life, strengths and resilience, previous treatment and the patients response to this[3,8,10].
2. Clinicians assessing and treating individuals with PTSD, should recognise that SUD and other comorbidities are common and should routinely assess for them, using appropriate assessment instruments (such as the Alcohol Use Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST)), during the evaluation and treatment for PTSD[8,9].
3. Current and past alcohol and drug use patterns for individuals with PTSD or reported trauma histories should be assessed routinely to identify possible substance misuse or dependency[5].
4. Current and past alcohol and drug use patterns for individuals with significant trauma histories or PTSD should be assessed routinely to identify substance misuse or dependency[9].
5. Clinicians should seek to understand the development of PTSD symptoms and drug and alcohol usage over time both pre- and post-traumatic event so that they can fully understand the relationship between traumatic events, symptom development, and maintaining factors to formulate a treatment plan appropriate to the individual's needs[10].
6. Any associated risks such as suicidal intent, serious self-harming, and potential threat to others should be assessed and addressed in treatment planning. High-risk concerns where a person is in imminent danger of harm to themselves, or others should normally be the priority for intervention[10].
7. Assessing clinicians should note both the presence and severity of SUD and other comorbidities in their assessments and consider their implications in the treatment plan[8].
8. When PTSD- SUD comorbidity is indicated health care providers should consider whether treatment can be safely and effectively delivered in primary care or a general

mental health setting, or whether referral to a specialist service is required[9]. Factors that might influence decisions about where treatment should take place include the availability of appropriate clinical expertise to deliver the required intervention effectively within the provider service, as well as broader case management and risk management need.

9. Assessment and monitoring should continue throughout treatment and if the individual is not making adequate progress, the clinician should revisit the treatment plan and consider reassessment and reformulation[8,10].

Treatment planning

10. Clinicians should develop a collaborative care treatment strategy to address comorbid health concerns, such as SUD, simultaneously with PTSD symptoms[9].
11. Information on PTSD and strategies to deal with PTSD symptoms should be provided to individuals with SUD who are seeking to reduce their drug or alcohol use, as PTSD symptoms may worsen during substance use treatment due to acute withdrawal or loss of substance use as a coping mechanism[8]. Addressing PTSD early in treatment may help to optimize long-term outcomes[10]. Clinicians should also consider providing such information to family or loved ones, as well as the individual with their consent, in order to strengthen social support.
12. Evidence suggests that drug and alcohol misuse should be dealt with from the start of treatment, alongside interventions which aim to promote understanding and initial behavioural management of an individual's PTSD symptoms. This approach recognises that frequent alcohol and drug usage often functions as a form of self-medication which the individual has used to address their PTSD symptoms[8].
13. The presence of co-occurring disorders such as SUD should not prevent or exclude individuals from receiving established evidence-based/ guideline recommended treatments for PTSD and individuals should not be excluded from treatment solely on the basis of comorbid drug or alcohol misuse[3,9, 10]. Readiness to engage in evidence-based treatment should be evaluated on an individual basis[10].
14. For people with PTSD and co-occurring alcohol or drug misuse, the treating clinician/ team should help the individual manage any circumstances which provide a barrier to them engaging with trauma focused therapies. Common barriers include difficulties

with travel, treatment related costs, perceived service stigma, motivational issues, and fears about potential negative effects of treatment[3].

15. For those with complex needs, a case management approach is often required to plan and coordinate a response to primary needs[10]. Common case management issues might include housing problems, health related and medical needs, involvement with the criminal justice system and management of acute serious risks.
16. Some individuals may require a period of time to focus on developing a trusting therapeutic relationship with a clinician, service or team in order to facilitate engagement in evidence-based treatment[10].
17. Psychoeducation, adapted to the individual's level of understanding, and motivational interventions are often an important part of the engagement process[10].
18. There is evidence that the majority of patients with PTSD-SUD comorbidity prefer integrated treatment[10].
19. There is some evidence showing the benefits of combined or integrated substance misuse and PTSD treatment for adults on PTSD and SUD symptoms[5,8]. Sequential models of treatment have not been widely tested. Further studies investigating the differential effects of sequential vs integrated or combined treatments are needed[5,6,7].
20. Current evidence for adults is that those receiving combined and integrated treatment make similar progress to those receiving SUD only based interventions in reducing drug use[5,6,7].
21. Current evidence for adults is that trauma-focused psychological intervention based on prolonged exposure, combined with treatment for SUD is the most effective treatment for PTSD symptoms. Average treatment gains are smaller than they are for individuals without SUD comorbidity and there is a higher level of treatment drop-out[5,7].
22. The benefits of trauma focused psychological therapy for individuals with AUD, in terms of reduction in PTSD severity and alcohol misuse appear to be stronger when trauma focused therapy is delivered in combination with alcohol targeted pharmacotherapy[7].
23. For adults there is weaker evidence of PTSD symptom improvement from integrated cognitive behavioural therapy, also with a higher level of drop-out than typical seen for individuals without SUD comorbidity[5].
24. Current evidence for adults is that present focused therapies such as Seeking Safety are not more effective than SUD only treatments at improving PTSD symptoms[5,7].

However, there is evidence that present focused treatment and treatment for SUD only demonstrate small to medium improvements in PTSD and SUD symptoms. In the absence of access to trauma focused psychological intervention these interventions may therefore be of benefit to some individuals with PTSD-SUD comorbidity[,6,7].

25. The current evidence base is not yet sufficiently developed to make treatment recommendations for children and young people[5].
26. Integrated and combined trauma focused treatment is usually characterised by a brief period of psychoeducational and symptom-focussed cognitive behavioural interventions for both disorders prior to the introduction of trauma-focused interventions[8]. Normally this would take up to three or six sessions, depending on need. The provision of psychoeducation should not unnecessarily delay trauma-focused treatment when the individual is ready to engage in this.
27. Patients presenting with co-occurring PTSD-SUD should be offered integrated treatment or evidence-based treatment for PTSD without waiting for abstinence. However, the trauma focused component of treatment should not commence until the individual demonstrates the capacity to manage treatment related distress without recourse to prolonged, therapy interfering substance misuse[8]. Decisions about readiness to begin trauma focused intervention should be undertaken collaboratively and some planning for the management of cravings related to exposure related reminders should be undertaken before the onset of trauma processing.
28. For individuals with complex presentations and needs it may be necessary to increase the duration or number of therapy sessions according to the individual's needs[3].
29. There is emerging evidence from one study that incentivisation with shopping vouchers may reduce drop-out from trauma-focused CBT based intervention[5].
30. Therapists should work with the individual to plan any ongoing support they will need after the end of treatment (e.g., residual PTSD symptoms, continuing substance misuse other mental health difficulties, relapse prevention)[3].

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