



Editorial

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## Current Treatment Approaches for PTSD-Substance Use Disorder Comorbidity

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Recent years have seen a rise in the number of empirically supported treatments for Post Traumatic Stress Disorder (PTSD) [1]. One of the most effective treatments is prolonged exposure (PE), which involves *in vivo* and imaginal exposure to avoided cues and reminders related to a trauma in order to aid in emotionally processing memories of that traumatic event [2]. However, despite the effectiveness of treatments including PE, efforts to treat PTSD are often complicated by the presence of comorbidities; perhaps most commonly, comorbid substance use disorder (SUD) which affects nearly 50% of people with PTSD [3]. This prevalence is notable given that people with PTSD-SUD experience greater physical and psychosocial impairments compared to people with either disorder alone [4,5]. Given the prevalence and cost associated with PTSD-SUD, recent years have seen research attention turn to approaches that can effectively address this comorbidity. These approaches can best be described as either sequential (one disorder addressed prior to the other) or integrated (both disorders addressed concurrently).

Based largely on concerns that substance use would interfere with PTSD treatment; historically, interventions for people with PTSD-SUD have focused first on SUD symptoms and then on PTSD in a sequential manner. However, patients with comorbid PTSD-SUD have poorer short- and long-term SUD treatment outcomes than patients with SUD alone [6,7] and delaying treatment for PTSD has been found to result in greater SUD relapse rates in people with PTSD-SUD despite their greater use of costly addiction treatment services [8,9]. Collectively, findings such as these have led researchers to hypothesize that failure to address underlying psychopathology may hinder initial SUD therapy attempts.

More recent research has examined integrated interventions in which PTSD and SUD symptoms are addressed concurrently [10]. The potential benefits of concurrent treatment have been noted [11], and these interventions have shown promise. However, concurrent treatments have only been tested in small pilot studies [12], have produced relatively small improvements in symptoms [13], or have resulted in high drop-out rates [14]. Further, combining two interventions may overwhelm participants to an extent, resulting in less effective treatment than a single treatment [15], and implementing concurrent treatments for people with PTSD-SUD

is cited by clinicians as one of the most challenging approaches for treating this comorbidity [16].

One approach that has not been previously examined is to test the potential efficacy of sequential treatments in which PTSD symptoms are addressed prior to SUD. Despite aforementioned concerns, more recent research has demonstrated the efficacy of exposure therapies in reducing PTSD severity in PTSD-SUD patients [17,18]. Addressing psychiatric symptoms prior to addressing SUD may remove barriers to successful SUD implementation and increase the success of SUD treatment. In line with tension-reduction hypotheses, addressing PTSD first may remove the source of tension that is driving substance use. Despite the merits of a sequential approach that initially targets PTSD as well as the potential efficacy of incorporating PE as part of that treatment, virtually no research has attempted to test such a treatment. Given the limitations associated with each of the treatment approaches described above, and the public health impact of comorbid PTSD-SUD, research should explore the efficacy of sequential PTSD then SUD treatment for people with PTSD-SUD.

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