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Challenges in Developing a New Psychotherapy for a Complex Population

A Review of

Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): Therapist Guide
by Sudie E. Back, Edna B. Foa, Therese K. Killeen, Katherine L. Mills, Maree Teesson, Bonnie Dansky Cotton, Kathleen M. Carroll, and Kathleen T. Brady
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Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): Patient Workbook
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Reviewed by

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In the realm of psychotherapy, one of the most important developments of the past 30 years has been the growth of treatment manuals to specify models and to test them in outcome trials—which is widely known as *evidence-based practice*. This has revolutionized the field of psychotherapy from prior methods that used to rely too heavily on unspecified methods and unclear results. The growth of manuals has "pulled back the curtain" for all to see what is supposed to happen within the realm of treatment sessions. As manuals have proliferated, therapists now have a wide array of choices and there are now manuals for all sorts of mental health conditions.

The COPE therapist manual and patient workbook are ambitious in addressing a population that is numerous and also widely considered difficult to treat. Each disorder alone, posttraumatic stress disorder (PTSD) and substance use disorder (SUD), presents challenges for the therapist. When a patient has both disorders, those challenges increase (Ouimette & Read, 2014). Having both a mental health condition and a SUD is called *comorbidity* (or *co-occurring disorders*), and since the early 1990s there has been increasing attention to this important topic. The old approach, which prevailed for most of the 20th

century and which still prevails to some degree, was to first treat the SUD and only once the patient had that under control to then address the PTSD or other mental health conditions. "Get clean and sober first" was a common phrase. Mental health and SUD treatments, moreover, had separate systems of care, workforces, cultures, and funding streams. Yet, patient surveys show that patients are often more motivated to work on the PTSD than on the SUD and, most of all, that treating both at the same time by the same therapist—what is called *integrated treatment*—works (Najavits & Hien, 2013).

A Unique Challenge for PTSD/SUD Treatment: To Tell or Not to Tell the Trauma Narrative

For PTSD/SUD comorbidity, one of the major unique challenges is whether the patient should tell the trauma narrative, i.e., the detailed account of trauma—the gory details of what happened, how it felt, etc. Telling the narrative can be helpful for some as it helps them emotionally process it ("working through"), but it can also trigger others to use substances more as they now are staring into the dark abyss of painful trauma memories and emotions. Because of this potential for worsening, of which there are clear early reports (e.g., Pitman et al., 1991), patients with SUD and other clinical complexities were routinely excluded from PTSD psychotherapy outcome trials. Foa herself, the developer of prolonged exposure (PE) therapy and one of the authors of the COPE manual, stated over a decade ago that PE is not a first-line treatment if patients have co-occurring SUD (Najavits, 2013). Thus, when people refer to "gold standard" PTSD therapies such as PE, they are referring to a more narrow, easier-to-treat PTSD population that routinely excluded those with co-occurring SUD as well as associated complexities such as homelessness, domestic violence, suicidality, and violence.

With regard to PTSD/SUD patients, there are two opposite stances about having them tell the trauma narrative: present focused versus past focused. Present focused refers to explicitly omitting any detailed focus on telling the trauma narrative, which is considered too intense for many PTSD/SUD patients (especially those on the more severe and chronic end of the spectrum), and instead it focuses on coping skills and psychoeducation as its primary methods. In contrast, a past-focused approach encourages the patient to tell the trauma narrative in detail, typically using some version of PE as its base but modifying it for SUD patients to address the SUD as well. Thus far, the vast majority of evidence on PTSD/SUD models focuses on present-focused approaches, which also fit what is widely endorsed as the *consensus model* of PTSD treatment, in which the first stage is safety and stabilization, followed by past-focused processing of the trauma narrative, especially for complex patients (Cloitre et al., 2011).

The approach to PTSD in the COPE manual is past focused. It takes PE, an evidence-based PTSD model, and combines it with *relapse prevention* (RP), an evidence-based practice for SUD. COPE thus attempts integrated treatment of PTSD/SUD by interweaving two existing evidence-based models—PE and RP.

This combination can be considered a bold move in that it goes against the established history in the field. This is the first published treatment manual on the topic. The attempt is especially bold given some of the challenges of getting PE adopted even for simpler PTSD-alone patients who do not have comorbid SUD. There are known issues with dropout (Najavits, 2015), limited uptake by therapists (Zayfert et al., 2005), and cost in that it

requires substantial training, supervision, and an advanced degree in a mental health field (Karlin et al., 2010). The SUD culture is typically a low-resource clinical environment that lacks many of these features.

Is the Sum Greater Than or Equal to Its Parts?

The COPE manual also inherently asks a very interesting question—can you take two models, each of which is "evidence-based" for one disorder alone, and combine them in a way that works for the comorbid population? Will the combination be equal to, greater than, or less than its two original parts?

In theory, the approach should work. In practice, it is much more challenging. It speaks to the proverbial saying: "In theory, theory and practice are the same; in practice, they're not."

"Treatments That Work?"

The question of how well the approach works is also pivotal as this manual is published by Oxford University Press under the series title Treatments That Work, with an introduction by David Barlow, a leader in the field of evidence-based therapies in mental health.

It is thus puzzling, and indeed concerning, that nowhere is the evidence on COPE provided either in the therapist manual or the patient workbook. There are repeated strong statements about the evidence for PE and for RP, but how COPE itself has fared in clinical trials is not addressed.

To name just one example, on page 48 of the therapist manual, the therapist is instructed to tell the patient,

> The treatment we're using has been shown in numerous research studies in the United States, Sweden, and Australia to be very helpful in improving substance use disorders and PTSD. This treatment uses the most effective therapies to teach you how to manage memories about the trauma without using alcohol or drugs. . . .Importantly, you won't feel that you need to use alcohol or drugs to cope.

Such broad claims are listed without any citations to back them up. Moreover, to my knowledge the evidence for COPE is not so sanguine. Findings for COPE in the Mills et al. (2012) study, the only published study I was able to find, showed that COPE did not outperform treatment-as-usual at any point on SUD, depression, or anxiety, and for PTSD no difference at end of treatment. The only difference on PTSD occurred at 9 months, which was 6 months after the treatment was supposed to have ended. Attendance was an issue so they extended the treatment window for some patients out to 9 months (thus confounding length of treatment; Najavits, 2012). Indeed, thus far there have been four randomized controlled trials (RCTs) that have used an exposure-based treatment for PTSD/SUD patients, including the COPE study, and not one found better outcomes for the exposure therapy compared to a less intensive model such as treatment-as-usual or supportive therapy at the end of treatment (Najavits, 2013). Yet, the patient workbook (p. 119) states that "the best therapy available for helping people recover from PTSD is a cognitive-

behavioral therapy (CBT) program called prolonged exposure" with no mention of the actual results for these exposure RCTs in PTSD/SUD patients.

First, Do No Harm

The question of evidence base for COPE is all the more important given that PE requires substantial efforts by both patient and therapist. What if there are models that achieve the same results with less demand—financially, emotionally, and otherwise? Are there ethical obligations to explore that?

COPE is an individual modality therapy designed for 90-min sessions that "should only be applied by [therapists] with graduate training in psychology or psychiatry e.g., MD, PhD, MA, MSW, formal training in the delivery of CBT and PE, and adequate ongoing supervision" (with the latter not defined; p. 31). There needs to be some serious thought as to whether such an expensive model should be recommended without compelling evidence that it's worth the price.

The price also accrues to patients, who are asked not only to attend the sessions and tolerate revisiting painful trauma memories, but also to complete a high burden of homework between sessions. For example, the patient's homework for Session 1 includes: listening to a recording of the session at least once, practicing breathing retraining at least three times per day, reviewing a section of the patient workbook, reading two additional handouts, plus "if applicable" sharing three additional handouts with family or loved ones. Additional sessions have similar loads. The craving form in the patient workbook (p. 141) asks patients to "record any time you have a desire to use or think about using alcohol or drugs" as well as the intensity and what they did about it—quite unrealistic for many severe SUD patients.

Finally, patients are repeatedly given the message that only by revisiting painful material can they overcome it. Page 111 in the patient workbook states: "Don't avoid something because it is upsetting. To get over it, there is no way to the other side except through it." Yet, this point of view is not convergent with the existing literature, which evidences positive outcomes for both PTSD and SUD when staying in the present rather than exploring the trauma narrative (Najavits & Hien, 2013).

The question of iatrogenesis—clinical worsening—is also not sufficiently addressed. For example, Form 3 of the patient workbook (p. 118) has useful instructions for families to help support the patient but provides no advice for what to do if the patient worsens. Likewise, I could not find in the patient workbook instructions on what patients should do in the moment if the exposure homework makes them want to use substances more—should they still try it? And what steps will keep them safe if they indeed use a substance in relation to the homework? Iatrogenesis is a key topic as there is clear documentation that patients sometimes do worsen in a treatment such as PE which is so emotionally challenging (e.g., Morris, 2015). Throughout the therapist manual are statements that simply may not be true for some SUD patients even if they are true for PTSD-alone patients: "being distressed is not dangerous" and "memories are not dangerous" (p. 121). Especially for severe, chronic SUD patients, distress and memories can lead people to increased substance use and other unsafe behavior.

Realistic?

Another pivotal question for COPE is whether it is realistic for routine clinical implementation. The high level of clinician requirements were stated earlier. In addition, COPE excludes patients who don't want to cut down on their use of substances; who have strong urges to hurt self or others, who are engaged in serious self-injury, who are in current domestic violence; who don't have clear memories of the trauma; or who have current psychosis. The first criterion alone will exclude a large number of PTSD/SUD patients, as many feel unable to commit to reducing their use.

Further, the therapist manual states, "Patients should be able to demonstrate some level of clinically significant improvement in frequency and/or intensity in substance use over the course of the first three sessions, before the exposures begin" (p. 21). And, they go on to state that if patients can't achieve this, the focus should be just on SUD until they do achieve it—which effectively takes the treatment back to the era before integrated treatment, i.e., the patient first has to decrease substance use before working substantially on the PTSD. The requirement that patients must be substance free before, during, and after both imaginal and in vivo exposures (including listening to the session tape) is also likely to be achievable by only a limited proportion of patients.

What's Left Out

A final major concern is what is left out of the manual. Coverage of the existing literature is not adequate, and it often lacks citations. Nowhere is there a balanced, clear description of the various alternate models for PTSD/SUD, some of which have far more evidence at this point than COPE. For example, the manual cites only one of the various RCTs on Seeking Safety, the current preeminent evidence-based therapy for PTSD/SUD, and even covering that with broad brush that does not accurately summarize it (p. 18). Ultimately, there is an odd solipsistic quality to this manual as if it stands alone in the field, when in fact it is rather a latecomer to PTSD/SUD clinical innovation. There have been close to 40 outcome studies on PTSD/SUD and various models developed—yet the reader would not know that by reading this manual.

So, too, the reader is left without a broader sense of how COPE fits the broader history of the field, such as why the authors decided to go away from the classic position of the PTSD exposure literature, which consistently excluded SUD patients. Also, what parts of standard PE and RP manuals have been left out or changed? It would have been really interesting to hear more about the intellectual progression on these topics by the authors.

On a practical level, no rationale is provided for why the treatment is 12 sessions, especially given that the typical treatment course for these patients is far longer (Najavits & Hien, 2013). And, what should happen at Session 12 if the patient is not better? Session 12 of the patient workbook says, "You have made great strides and have come a long, long way in this treatment" (p. 110). But, what if that is not true? Similarly, there are instructions on acceptable levels of alcohol, but not drug, use. With growing legalization of marijuana and epidemic prescription misuse, this is a lost opportunity to provide therapists with guidance.

Important clinical issues at times lack detail. Page 24 states that if another disorder or problem is "primary," the therapist should address that first—but without explanation of how to decide what is primary. This is key as most PTSD/SUD patients arrive to treatment with multiple diagnoses and life problems. Page 38 encourages having the patient try abstinence "for a brief period"—how long is that? Page 50 tells therapists to "assess the need for medically supervised detoxification from substances" with no instructions on how to do that. Page 57 says "encourage them [patients] to call you between sessions" but nothing about what to do if they call intoxicated or suicidal. Such SUD-related issues are especially important as there is no requirement that therapists have any prior background or training in SUD.

And, on an almost humorous note, I couldn't figure out what "COPE" stands for. It doesn't appear to be an acronym for the model that is the book's main title ("concurrent treatment of PTSD and substance use disorders using prolonged exposure").

The Focus on Substance Abuse

Although it is good that the book addresses SUD after the decades in which PTSD has not been addressed by mental health therapists, the actual focus on SUD is at times problematic. The consistent view of SUD expressed in COPE is that substance use is "self medication" of PTSD symptoms. This is certainly true some of the time, but it does not address more nuanced clinical realities. For example, SUD can lead to PTSD and both use and withdrawal from substance use can lead to increase or decrease of PTSD symptoms. In general, although this treatment is identified as CBT, it is oddly convergent with the old psychodynamic view that if you treat the PTSD or other "underlying problem," the need for substance use will go away. But this is often not true. The Mills et al. study of COPE, for example, showed that nearly half of patients still had substance dependence after COPE.

At times there is confusing language for SUD terms. For example, there is no requirement for abstinence from substances, so stating on page 37 that "some of them may lapse and begin using" does not appear to make sense. Throughout, there is mention of "lapse" in similar fashion.

I also would have wanted to see deeper exploration of some of therapists' major challenges in working with SUD patients, such as persistent denial, family members encouraging them to use, glorification of SUD, and other major SUD phenomena that weigh heavily in the impulse to use and are not easily changed. There appeared to be too much reliance on simple strategies such as giving patients information about the need to reduce their substance use or well-known techniques such as doing pleasant activities.

Strengths

What I found most compelling was the clinically rich discussion of issues that can arise in PE including under-engagement, over-engagement, and subtypes of the latter. I can imagine that these points would be very helpful to the typical clinician who might implement COPE or PE generally.

The manual has various other strengths too, including its emphasis on assessment, a good therapeutic alliance (albeit not stating how to determine that), the need for a nonjudgmental stance toward SUD, attention to involving significant others (although no mention of what to do if the significant other *encourages* substance abuse), and mention of the need for a suicide assessment (p. 66).

Structure and Style

The overall structure of having a therapist manual and patient workbook is good, and it follows the tradition of various other treatment models. However, at times there was high degree of repetition both within and across each of the books that was disorienting. For example, page 145 is word-for-word what is on pages 132–133. Pages 124–127 in the patient workbook are identical to pages 26–29. Given all there is to address with this challenging population, better organization and use of space would have been helpful.

The tone is definitely written for a highly educated therapist audience. It would be challenging for the average SUD clinician to use as the SUD workforce generally has lower education and training. There are few case examples and few actual patient quotations, which adds to the overall academic feel of the manual.

Overall

The authors took the bold step of tackling a challenging and important topic though, in the end, the reach may have exceeded the grasp. The books, a therapist manual and patient workbook, describe how to use a past-focused PTSD model (prolonged exposure therapy) with SUD patients, augmented with relapse prevention which is a SUD model. But, if patients aren't able to reduce their substance use quickly, it then reverts to SUD-only treatment with the PTSD put off until later if at all, thus negating the notion of integrated care that is one of the major advances in comorbidity clinical innovation.

Given various concerns raised in this review, I would conclude that the manual offers a useful research protocol, but whether it is ready for adoption for wide clinical practice is unclear. The audience for this book are highly trained therapists and highly motivated PTSD/SUD patients who have the capacity to follow through on the many notable demands of the model. For that segment, albeit a narrow one, I can imagine this could be a helpful treatment. The field awaits, however, further empirical validation of the model and further elaboration of how to make use of it under real-world broader public-health oriented contexts.

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Footnotes

Disclosure of interests: Dr. Najavits is director of Treatment Innovations, which provides consultation, research, and materials related to psychotherapy including the Seeking Safety model, which she authored.