California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE PRESENTATIONS

Presentation materials not included on this CD were unavailable at time of production.

California Department of Alcohol & Drug Programs

California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE ADDRESS

Dennis McCarty
Professor, Department of Public Health and Preventive Medicine, Oregon Health Sciences University

Day One: Wednesday, September 6, 2006
9:30 – 10:30 a.m.

California Department of Alcohol & Drug Programs

Reengineering Alcohol and Drug Treatment Systems: Why and How

Dennis McCarty, PhD

Oregon Health & Science University

September 6, 2006

Sacramento, CA

Robert F. Kennedy on Change

- Some men see things the way they are, and ask “Why?”
- I dream of things that never were and ask “Why not?”
  (Robert F. Kennedy paraphrasing George Bernard Shaw)

Overview

- Why Reengineer?
  - Changing expectations, environment, organizations
  - Opportunities for growth and new markets
- How to Reengineer?
  - Leadership and staff, customer involvement, rapid cycles
- Can Reengineering Improve Services?
  - Network for the Improvement of Addiction Treatment (NIATx)
- Convert challenge to opportunity
- Resources?

Why? The World is Changing: 2025 and Beyond www.7revs.org

- Population Growth: 3rd world growing; US aging
- Resource Management: food, water, energy shortages
- Technology Innovation: biotech, genomics, nanotech
- Knowledge: economics of knowledge; information access
- Economic Integration: globalization, new markets
- Conflict: economic and political instability
- Governance: blurring lines, changing models, corporate roles

Why?
Dissatisfied with Current Status

- Favorable outcomes can be improved
  - 40% to 60% continuous abstinence at 12 mo.
  - 15% to 30% have not resumed dependent use
- Comparable outcomes for chronic disease
  - Type 1 diabetes (60% adherence)
  - Hypertension and asthma (40% adherence)
- Low income patients have worse outcomes
  (McLellan, et al., 2000, JAMA, Vol 284, 1689 – 1695)
- Inefficiencies in repeated treatments
- Difficult patients provide more opportunity to improve

Why?
Changing Policy Environment

- Demands for More Accountability
  - Crossing the Quality Chasm
  - Systems of Care for Alcohol and Drug Disorders
- SAMHSA Reauthorization
  - Performance Partnership Grants
  - National Outcome Monitoring System
- State Initiatives
  - Substance Abuse and Crime Prevention Act

Crossing the Quality Chasm
(Institute of Medicine, 2001)

- Redesign health care to improve quality
  - Focus on chronic conditions
  - Use information technology to facilitate communication
  - Train the workforce to improve skills
  - Coordinate care across services and settings over time
  - Monitor clinical processes and patient outcomes daily

10 Rules for Health Care Redesign (IOM, 2001)

- Continuous healing relationships
- Responsive to patient needs & preferences
- Shared decisions
- Shared knowledge – access to records
- Care is based on best available science
- Priority on patient safety
- Transparency: no hidden details
- Anticipate patient needs
- Do not waste resources or patient time
- Clinical cooperation

Improving Health Care for Mental and Substance-Use Conditions (IOM, 2006)

- The Quality Chasm framework applies to mental health and substance use disorders
- High quality care is …
  - Safe, Effective, Patient-Centered,
  - Timely, Efficient and Equitable

IOM 2006 Recommendations (continued)

- Measurement
  - Continuous measurement improves processes & outcomes
- Coordination
  - Services and clinicians exchange patient information
- Electronic Records
  - Implement information standards & electronic records
- Workforce Development
  - Specify clinical competencies; require national standards
- Financing
  - Link funding to quality of care

Why?
Changing Organizations

- 13,454 specialty facilities (SAMHSA, N-SSATS, 2004)
  - 81% outpatient, 60% not-for-profit, 62% free-standing
  - Median caseload = 40 (38% have a caseload of 60 or greater)
  - 44% closed or acquired; 53% staff turnover rate
- "We have to grow or die!"
  - Arthur Schut, CEO, June 27, 2006
    Mid-Eastern Council on Chemical Abuse, Iowa City, IA

Why?
Opportunities

- Solve problems
  - Reduce expenses
  - Develop new markets and new services
  - Improve quality and outcomes
- Implement evidence-based practices
- New alliances and linkages
  - Primary care and mental health services
  - Criminal justice and child welfare systems
- Use new technology

How?

- Change is not self-executing
- Implementation requires purposeful activity and attention to
  - Organizational and staff selection
  - Staff training
  - Supervision, coaching and feedback
  - Administrative support and system interventions

  (Fixsen et al, 2005, *Implementation Research: A Synthesis of the Literature)*

  http://nirn.fmhi.usf.edu/resources/publications/Monograph

Jack Welch on Change (Former CEO at General Electric)

- "Change doesn't come from a slogan or a speech."
- "It happens because you put the right people in place to make it happen."
- "People first. Strategy and everything else next."

(Welch, J. with J. A. Byrne. 2001. *Jack: Straight from the Gut.* Warner Books: New York. p. 135.)

How?
Seize the Moment

- Efficacious and effective treatments are available for alcohol and drug dependence
  (Institute of Medicine, 1998. *Bridging the Gap Between Practice and Research*. Washington, DC: National Academy Press)

- Implement evidence-based practices
- A bias to action

Key Principles for Change

(Network for the Improvement of Addiction Treatment www.niatx.net)

- Understand and involve the customer
- Fix big problems: help the CEO sleep at night
  - Make the business case
- Pick a powerful change leader
- Pressure and ideas from outside the field
- Use rapid cycle testing

What is it like to be a patient?

Using Walk-Throughs to Understand the Customer

Between patient and help lies a canyon of burdensome paperwork and processes

- A chronic disease where timing is everything
- Business processes keep patients and staff apart
- Business processes often waste money
- **Processes CAN be improved!**

Between patient and caring lies a canyon of burdensome paperwork and processes

- First contact
- Intake and assessment
- Transition thru levels of care
- Paperwork
- Scheduling
- Engagement
- Social supports
- Outreach
- Maximizing revenue

Conduct a Walk-through

- Role play a “client” and “family member”
  - Call for an appointment: What happens?
  - Arrive for the appointment:
    - How are you greeted?
    - Were directions clear and accurate?
  - Complete an intake process:
    - How long does it take?
    - How redundant are the questions?
  - What did you learn? What will you change?

A New England Hospital Clinic

- Vice-president sought care as an opiate dependent woman
- Medical Director acted as her brother
- What they learned …
  - The brother was not allowed to participate
  - Hospital could not admit her without detoxification
  - Hospital could not provide opiate detox
- Changes were made; daily census increased

Leadership is key

- Address problems the CEO values and endorses
  - The CEO must be committed to the goals, processes and results
- Change leader must have access to resources and authority to make change
  - Has the CEO's home telephone and is willing to call day or night

Use Rapid Cycle Testing: Plan, Do, Study, Act – PDSA

- **Plan** the change
  - What needs to be improved? Why is it important?
  - Collect baseline data
- **Do** the plan – take action
  - Test the idea with one patient, for one week, etc.
- **Study** the results
  - Did the change work?
- **Act** on the results
  - Are modifications required?

Rapid Cycles …

- "…reduce staff resistance to change because they engage staff at a low level – the change is temporary and begins small."

  Arthur Schut, CEO, MECCA, Iowa City, IA, June 27, 2006

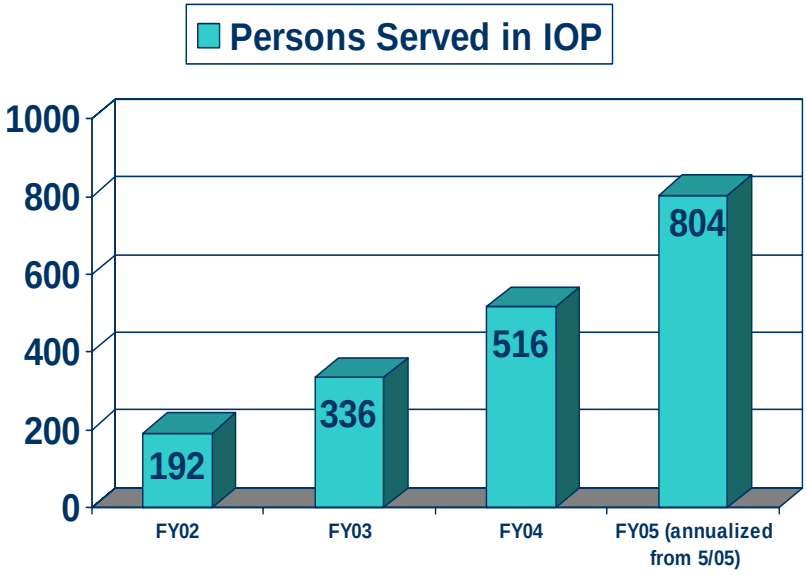
Acadia Hospital

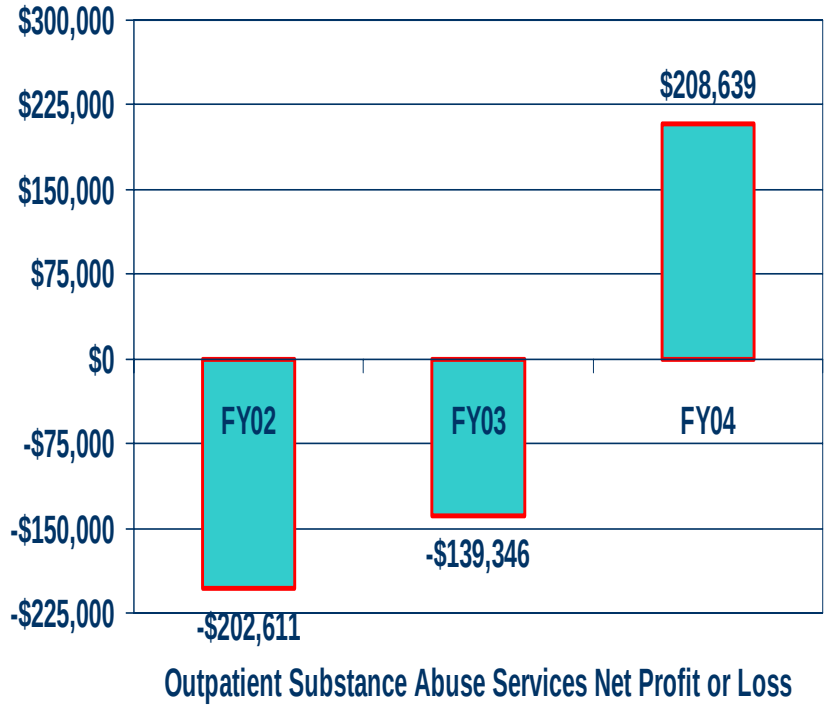
Changing a System of Care

Open Access to IOP

- Clients offered evaluation @ 7:30 the next morning.
- Evaluated clients start treatment @ 9:00 that day
- Mean days between 1st contact & screening dropped from 4.1 to 1.3
- Clients who stayed in treatment rose from 19% to 53%
- By March 2005 retention climbed to 67%

Project #1
Admissions and Revenues Increased



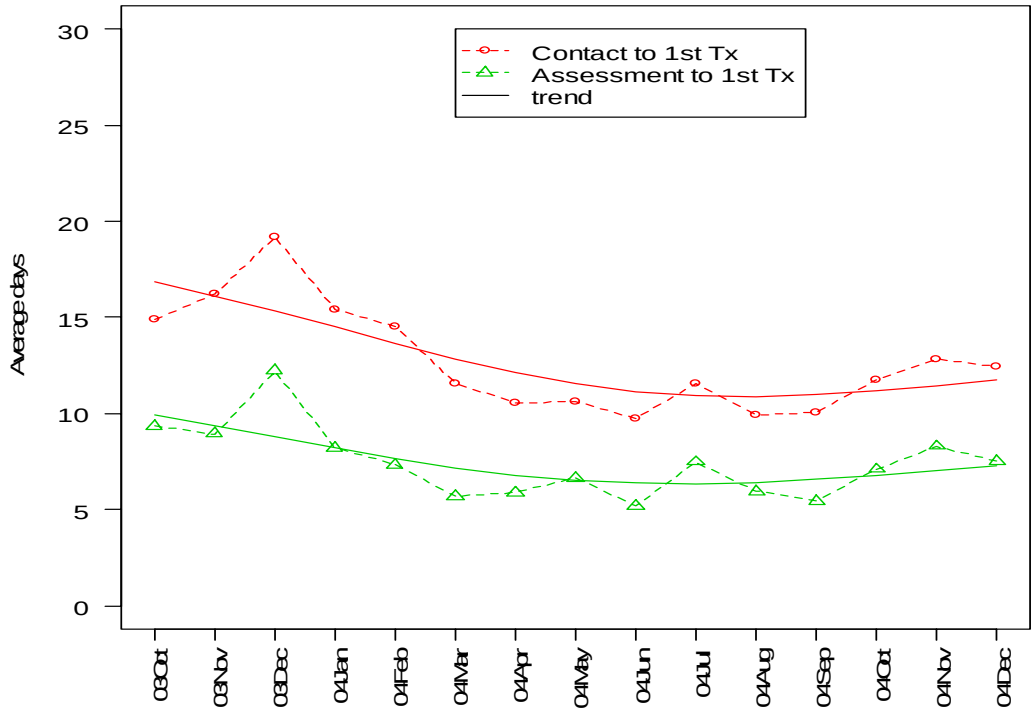


Lessons Learned: Acadia

- When program opened up, clients most needing Tx showed– and stayed
- Remove barriers and sicker clients come
- Treatment must change to accommodate their needs
- Improving access makes good clinical sense

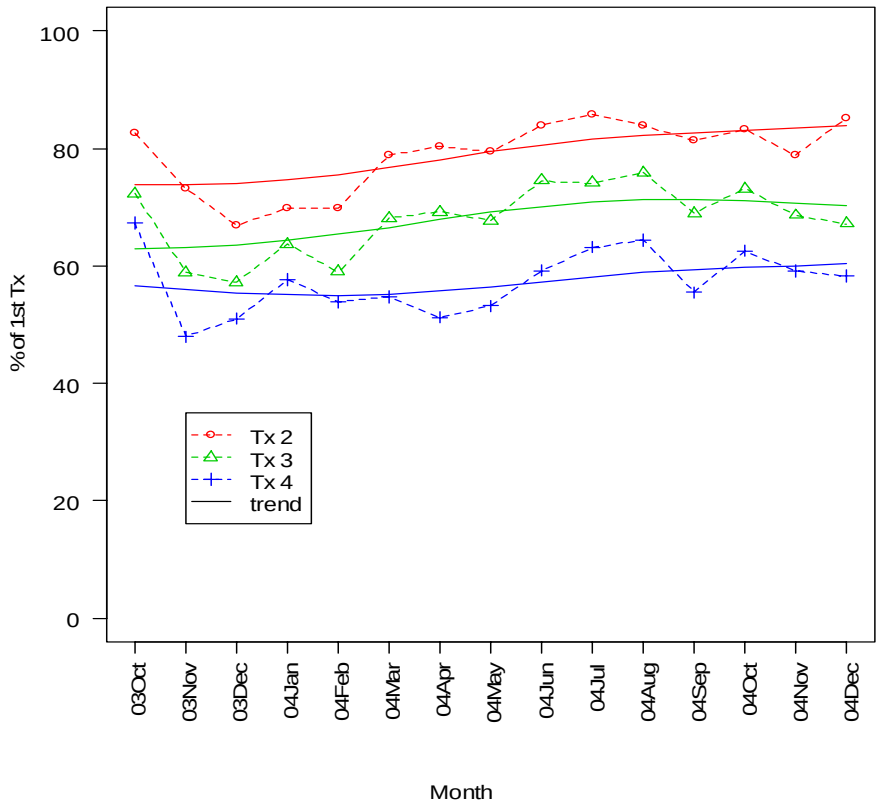
AND good business sense

NIATX National Results
Days to Treatment Declined 39%



Retention in Care Increased

(Session 1 to 2 = 18%; Session 1 to 3 = 17%; 1 to 4 = 11% ns)



Reengineering Opportunities

Converting Challenge to Opportunity

Challenge:
Focus on Quality Improvement

- Measure quality
- Improve quality

- Opportunities
  - Organization and system change
    - NIATx Model of rapid cycle improvement
  - Expand markets and reduce costs

Challenge: Linkages to Medical Care

- 3% of programs affiliated with health settings
- Opportunities?
  - Primary care improves treatment outcomes (Weisner et al, 2001)
  - Linking strategies?
  - Access to medications?

Challenge:
Performance Partnership Grants

- Identify performance measures
- Construct and implement data systems
- Opportunities?
  - Document patient impacts
  - Learn to manage with data

Challenge: Implement Evidence-Based Practices

- Screening and Brief Intervention
  - Identify new clients
  - Reduce burden on health care and criminal justice
- Psychosocial Interventions
  - CBT, MET, MI, Contingency Management
- Pharmacotherapy
  - Buprenorphine, naltrexone, acamprosate
- Wrap-around Services
- Aftercare and Recovery Management (National Quality Forum, 2005 for RWJ Foundation)

Challenge: Use Medications

- Vivitrol (injectable naltrexone) became available June 1, 2006
  - Injected every 30 days
  - Reductions in drinking days and amounts
- Challenges?
- Opportunities?

NIAAA Clinician Guidelines

- "All approved drugs have been shown to be effective adjuncts to the treatment of alcohol dependence.
- Thus, consider adding medication whenever you are treating someone with active alcohol dependence ..."

NIAAA NIH Government Publications. Helping Patients Who Drink Too Much: A Clinician's Guide. 2005 ed. Available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf.

Hazelden on Medications

(p. 3, Hazelden Voice, Winter 2002)

- "We are puzzled why some providers are so enthusiastic about medications, when we see, **for our patients**, that recovery is possible without them." (emphasis added)
- "Some medications … may prove to be mood altering"

Read and Reflect to Lead Re-engineering

Where do Ideas Come From?

- Reading
  - What do you read?
  - What should you read?
- Observing and Attending
  - What's new and creative?
  - Which conferences do you attend?
- Trying
  - What can you try?

Institute of Medicine Reports (available at www.nap.edu)

- *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, 2006
- *Crossing the Quality Chasm*, 2001
- *Bridging the Gap Between Practice and Research*, 1998
- *Broadening the Base of Alcoholism Treatment*, 1990
- *Treating Drug Problems*, 1990

NIAAA and NIDA Journals

- *Alcohol Research & Health*
  http://www.niaaa.nih.gov/Publications/AlcoholResearch/default.htm

- *Science and Practice Perspectives*
  http://www.drugabuse.gov/Perspectives/index.html

Business Books and Magazines

- Christensen, C.M. (2000). *The Innovator's Dilemma.* New York: HarperBusiness
  An analysis of the role of innovation in business success and failure

- *Fast Company*
  A monthly magazine on leadership and change
  http://www.fastcompany.com/homepage/index.html

Web Sites and Resources

- www.carnevaleassociates.com
  (policy analysis – former ONDCP deputy director)
- www.jointogether.org
  (advocacy & resources – daily e-newsletter)
- www.facesandvoicesofrecovery.org/main/index.php
  (advocacy group for people in recovery)
- www.niatx.net
  (Network for the Improvement of Addiction Treatment)
- www.ibr.tcu.edu
  (Institute of Behavioral Research – Dwayne Simpson)

Concluding Comments

Keep Focused on the Goal

- Persistent improvements in the quality and effectiveness of care

Many of My Friends Never Made It

Acknowledgements

- Preparation of this presentation was supported through awards from
  - Robert Wood Johnson Foundation: 46876 & 50165
  - The Center for Substance Abuse Treatment: SAMHSA SC-05-110
  - The National Institute on Drug Abuse: R01 DA018282
- The Network for the Improvement of Addiction Treatment provided data included in the presentation.

Acknowledgements (continued)

- Thanks to NIATx colleagues Victor Capoccia, Elaine Cassidy, Frances Cotter, Jay Ford, David Gustafson, Todd Molfenter, Betta Owens
- Special thanks to the NIATx Evaluation Team: Luke Bergmann, Eldon Edmundson, Marie Elwood, Carla Green, Kim Hoffman, Traci Rieckmann, Katie Riley, Marie Shea, and Jennifer Wisdom

California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE ADDRESS

David Mee-Lee
Psychiatrist, DML Training & Consulting

Day One: Wednesday, September 6, 2006
1:45 – 2:45 p.m.

California Department of Alcohol & Drug Programs

Recovery in Co-Occurring Disorders:
What Do You Really Mean and Walking the Talk about Recovery

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Voice mail: (916) 715-5856;
DAVMEELEE@aol.com www.DMLMD.com

September 6, 2006 Sacramento, CA

A. Recovery – Definitions and Attitudes

1. How do you answer a client who asks: "How long do I have to be here?"
2. Does "recovery" mean different things for substance use versus mental health problems?
3. What does treatment completion mean? What does finishing the program and graduation mean?

Recovery in Addiction

"Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse or substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health."
(White, W. & Kurtz, E. (2005). "The Varieties of Recovery Experience". Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at http//:www.glattc.org)

Recovery in Mental Health

"Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness"
(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

- A 2001 paper in *Psychiatric Services* summarized a conceptual model on recovery and referred to both internal conditions ("the attitudes, experiences and processes of change of individuals who are recovering") and external conditions ("the circumstances, events, policies and practices that may facilitate recovery").

Recovery – A Conceptual Model
Internal Conditions

- Hope – belief that recovery is possible; it lays the groundwork for healing to begin
- Healing – recovery is not synonymous with cure; active participation in self-help activities; locus of control is with consumer
- Empowerment – corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices
- Connection – recovery is a social process; a way of being in the company of others; to find a role to play in the world

Recovery – A Conceptual Model
External Conditions

- Human rights – reducing and eliminating stigma, discrimination against psychiatric disabilities; equal opportunities in education, employment, housing; access to needed resources

- Positive Culture of Healing – a culture of inclusion, caring, cooperation, dreaming, humility, empowerment, hope

- Recovery-oriented services – best practices of clinical care, peer and family support, work, community involvement to be implemented by consumers, clinicians, and community; services that facilitate individual recovery and personal outcomes; collaborative services; consumers for consumers

References:
Jacobson N, Greenley D (2001): "What Is Recovery? A Conceptual Model and Explication" Psychiatric Services. April 2001, Volume 52; No. 4:482-485. You can go to Google, type in Psychiatric Services journal and get to the April 2001 edition and download the paper.

Also, check out a commentary on that paper: Peyser H (2001): "What Is Recovery? A Commentary" Psychiatric Services. April 2001, Volume 52; No. 4:486-487.

B. Role of Illness Management in Recovery

1. **Era of Consumerism** (Kizer, KW (2001): "Establishing Health Care Performance Standards in an Era of Consumerism" JAMA 286:1213-1217)
   - US Health care system reengineering itself to address the need for quality improvement
   - It is being actively reshaped by the expectations of consumers
   - All stakeholders demand active collaboration with health care system

2. **Self-Management of Chronic Disease** (Bodenheimer T, Lorig K, Holman H, Grumbach K (2002): "Patient Self-management of Chronic Disease in Primary Care" JAMA 288:2469-2475)
   - Patients with chronic conditions make day-to-day decisions about their illnesses – self manage is inevitable
   - New chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education
   - Programs teaching self-management skills are more effective than information only patient education in improving clinical outcomes
   - Self-management education for chronic illness may soon become an integral part of high-quality primary care

3. **Illness Management and Recovery** (Mueser KT, Corrigan PW, Hilton DW et al (2002): "Illness Management and Recovery: A Review of the Research" Psychiatric Services 53:1272-1284; Drake RE, Essock SM, Shaner A et al (2001): "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness" Psychiatric Services 52:469-476; Carey KB, Carey MP, Maisto SA, Purnine DM (2002): "The Feasibility of Enhancing Psychiatric Outpatients' Readiness to Change Their Substance Use" Psychiatric Services 53: 602-608)

   - "Illness management is a broad set of strategies designed to help individuals with serious mental illness collaborate with professional, reduce their susceptibility to the illness, and cope effectively with their symptoms"

- Involves psychoeducation to improve people's knowledge of mental illness; behavioral tailoring to help people take medication as prescribed; relapse prevention to reduce symptom relapses and rehospitalizations; coping skills training to reduce severity and distress of persistent symptoms
- Comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; help clients acquire skills and supports to manage both illnesses and pursue functional goals; cultural sensitivity and competence
- Empowerment corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices (Mueser, Corrigan et al., 2002; Drake, Essock et al., 2001; Carey, Carey et al., 2002; Jacobson & Greenley, 2001).

4. **Evidence-Based Practices and Quality Improvement**: Guidelines for the redesign of health care were published in "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001) and "Improving the Quality of Health Care for Mental and Substance-Use Conditions" (2005) – both reports from the Institute of Medicine. Of the 10 rules originally published to guide the redesign of the health care system, at least 5 involve "patient-centered care":

- The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
- Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information
- The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
- The health system should anticipate patient needs, rather than simply reacting to events.

C. Compliance versus Adherence

Treatment or medication *compliance* is a term that has had long use in the health care field in general and the addiction and mental health sectors in particular. Webster's Dictionary defines "to comply" as "to act in accordance with another's wishes, or with rules and regulations." By contrast, it defines "adhere" as "to cling, cleave (to be steadfast, hold fast), to stick fast."

In this age of empowerment and collaborative service planning, it is not an appropriate role for a counselor or other professional to develop a plan with which a patient must comply. It isn't for the physician to prescribe the medication with which the patient must demonstrate medication compliance. "Stages of change" models and motivational enhancement therapies have been found to be effective in engaging patients and changing attitudes and behavior. Over the past 30 years, more than 2,000 research papers have been published on the concept of the therapeutic alliance. These findings emphasize the importance of developing the alliance with patients, especially in the early phases of treatment (CSAT, 2005; DiClemente, 2003; Horvath & Bedi, 2002; IOM, 2001, 2005; Miller, Duncan et al., 1997; Miller & Rollnick, 2002; Norcross, 2002).

D. **Inconsistencies in Attitudes and Practice**

Person's Attitudes and Behavior	Recovery Process in 12 Step Programs and other Recovery Groups	Traditional Addiction Treatment Attitudes and Practice
1. Ambivalent about abstinence and recovery	1. "Keep coming back" – do the research; you don't have to get the program; it will get you; stages of change and cognitive behavioral approach (SMART Recovery)	1. Client must agree to abstinence as a precondition of admission into treatment; or "come back when you are ready"
2. Reluctant to attend recovery meetings and groups	2. Outreach with 12-Step calls; offer to be a sponsor; assist with transportation; welcoming and "attraction not promotion"	2. Access to care is difficult; long waiting lists; recorded messages and complicated intake procedures
3. Shows up to a meeting after a few drinks	3. "Keep coming back" – "There but for the grace of God go I"; a good "remember when"	3. Leave and come back when you are sober. Sign a contract that you will not come to treatment if you have used
4. Feels will power will fix addiction and trouble accepting suggestions	4. "Powerlessness" and helping people understand the paradox of surrender and power; unmanageability and making amends	4. Counselors act as if powerful and able to confront and coerce recovery; work harder for recovery than client
5. Involves family and significant others in a web of pain and loss	5. "Detachment" – Al-Anon, Alateen; Naranon; help the family develop serenity and their personal recovery	5. Act as if we will stop addiction; work as hard as the family did to stop addiction; compassion fatigue and staff burnout

Person's Attitudes and Behavior	Physical and Mental Health Recovery Approach	Addiction Treatment Recovery Approach
1. Relapse or re-occurrence of signs and symptoms of disorder	1. Viewed as a poor outcome or crisis requiring a timely response; assessment and treatment plan change	1. Viewed as willful misconduct with exclusion from treatment that day and possible discharge from treatment. "Punitively discharge clients for becoming symptomatic" (W.White, 2005)
2. Psychosocial crisis; treatment adherence problems; acute exacerbation of the disorder	2. Discussed as lack of progress and a poor outcome requiring a change in treatment strategies e.g., individual, group, family therapy, pharmacotherapy, case management	2. Discussed as the need for "consequences", sanctions and possible discharge or transfer to another treatment team and setting
3. Persistent treatment adherence problems	3. Variety of proactive strategies – Assertive Community Treatment (ACT teams); Intensive Case Management (ICM); supported housing and employment; variety of "wet", "damp" and "dry" shelters; mental health crisis teams to enhance natural and community supports	3. Blacklist client from readmission to the facility; discharge and send notice of case closed; refer to extended residential and inpatient care away from the person's community with poor continuing care and reintegration into the community; invoke legal sanctions and remove from treatment
4. Severe and chronic illness	4. Utilize levels of care including acute hospitalization; day treatment; outpatient and community-based services; group and independent housing options. No fixed length of stay. Illness, disease and recovery management model.	4. Utilize predominantly fixed length of stay residential programs for those who can pay. Utilize predominantly low intensity outpatient services in the public sector. "Serial episodes of self-contained, unlinked interventions….Relegate post-treatment continuing care services to an afterthought" (W.White, 2005) Repeated episodes of acute care for detox; stabilization; discrete fixed program stay; "treatment completion"; "graduation"
5. Poor outcomes	5. Viewed as the need for more intensive case and care management and community outreach	5. Blame the client for denial and "stinking thinking"; non-compliance; stubbornness to take suggestions

E. **Terminology and its Effect on Practice** – Do you really believe in recovery and illness management?

1. "Negative consequences" – In addiction treatment clinicians often say that if a person uses while in treatment there needs to be "negative consequences". But if a person gets depressed again and cuts herself; or manic and spends a lot of money; or psychotic because of not taking medication, do we say there need to be "negative consequences"?
2. "Graduation" – Clients and counselors talk of "graduation" from the program. But when does a person graduate from diabetes treatment? Or from Bipolar Disorder treatment? Or from hypertension or asthma treatment?
3. "Complete the program" – Similarly, when does a person complete the depression program; or complete the Schizophrenic Disorder program? On what basis is the decision to discharge or transfer a person from successful treatment made? Is it based on a set time and/or number of sessions? Or do you focus on the level of function and the quality of the person's recovery?
4. "How long is your program?" or "How long do I have to stay?" – The same issue is raised here. Do we really believe we are managing long-term illnesses; or do we act more like there is a set of program expectations and monitoring compliance with rules and expectations.
5. "More willing to follow rules and compliant with treatment activities"; "Compliant participation in group" – These are examples of Progress Notes that focus on a client's doing time, not doing treatment. They do not speak of harnessing a client's positive efforts and energy. It promotes passive behavior to please others or to jump through certain hoops.
6. "Serious and persistent" – This phrase has no counterpart in general medicine care, which describes general illnesses with similar consequences as "severe' and "chronic" as opposed to "mild" and "acute." It is not common for example, to talk about "serious" cancers. The term "persistent" could connote a lack of belief in the ability to improve and recover. There is a less pejorative and clinically useful way to categorize individuals with mental illnesses that have chronic functional limitations. It might be to refer to them as having mild, moderate, or severe disability associated with a mental illness symptom or diagnosis, rather than to refer to them as the "seriously" mentally ill. ("Improving the Quality of Health Care for Mental and Substance-Use Conditions" pp. 86-87 Institute of Medicine. The National Academies Press, Washington, D.C. 2005)

LITERATURE REFERENCES AND RESOURCES

McLellan A.T., McKay J.R., Forman R., Cacciola J., Kemp J. (2005) Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction* 100:447-458. (http://www.tresearch.org/resources/pubs/ConcurrentRecoveryMonitoring.pdf)

McLellan AT, Lewis DC, O'Brien CP, Kleber HD (2000): "Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation." JAMA. 2000 Oct 4;284(13):1689-95.

Mueser KT, Noordsy DL, Drake RE, Fox L (2003): "Integrated Treatment for Dual Disorders – A Guide to Effective Practice" The Guilford Press, NY.

White, W. & Kurtz, E. (2006). "Recovery – Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches" Northeast Addiction Technology Transfer Center. Obtain copies from (866) 246-5344. Also www.ireta.org for PowerPoint slides

White, W (2005): "Recovery Management: What If We Really Believed that Addiction was a Chronic Disorder?" Great Lakes ATTC. www.glattc.org

RESOURCES FROM SAMHSA

1. Center for Substance Abuse Treatment. "**Substance Abuse Treatment for Persons With Co-Occurring Disorders"** Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005
(TIP 42 should be available online within the next couple of weeks. It will be posted to the Health Services/Technology Assessment Text (HSTAT) section of the National Library of Medicine Web site at the following: URL: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441)

2. **The Co-Occurring Center for Excellence (COCE)**
In September 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Co-Occurring Center for Excellence (COCE) with a vision of its becoming a leading national resource for the field of co-occurring mental health and substance use disorder treatment. The mission of COCE is threefold: (1) Receive, generate and transmit advances in substance abuse and mental health that address substance use and mental disorders at all levels of severity and that can be adapted to the unique needs of each client, (2) Guide enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems, and (3) Foster the infusion and adoption of prevention, treatment, and program innovations based on scientific evidence and consensus.

COCE consists of national and regional experts who serve to shape COCE's mission, guiding principles, and approach.
(For more information on the COCE, see: www.coce.samhsa.gov. You can contact the COCE at (301) 951-3369, or e-mail: coce@samhsa.hhs.gov.)

RESOURCE FOR ASSESSMENT INSTRUMENTS

A variety of proprietary assessment instruments for identifying substance use disorders, psychiatric diagnoses for adults and adolescents. To order: The Change Companies at 888-889-8866. www.changecompanies.net.

For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at evinceassessment@aol.com

RESOURCE FOR HOME STUDY AND ONLINE COURSE

"Dilemmas in Dual Diagnosis Assessment, Engagement and Treatment" By David Mee-Lee, M.D.
This home study or online course (with CEU's) is designed to improve practitioners' abilities to assess, engage, and treat people with co-occurring mental health and substance use problems. Practical strategies and methods are offered to help change interviewing methods, treatment planning and documentation, program components, range of services, and policies to better engage the dually diagnosed client.

Professional Psych Seminars, Inc. Agoura Hills, CA Toll-free phone: (877) 777-0668. Website: www.psychsem.com

FREE MONTHLY NEWSLETTER

"TIPS and TOPICS" – Three sections: Savvy, Skills and Soul and additional sections vary from month to month: Stump the Shrink; Success Stories and Shameless Selling. Sign up on www.DMLMD.com or here at the workshop.

California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE ADDRESS

WHAT'S DIFFERENT ABOUT WOMEN? CREATING GENDER-RESPONSIVE SERVICES

Stephanie S. Covington, Ph.D.
Co-Director, Center for Gender & Justice
Institute for Relational Development

Day Two: Thursday, September 7, 2006
9:30 - 10:15 a.m.

California Department of Alcohol & Drug Programs

What's Different about Women?

Creating Gender-Responsive Services

Stephanie S. Covington, Ph.D., L.C.S.W.
Center for Gender and Justice
Institute for Relational Development

"Reengineering the System"
ADP
Sacramento, CA
September 7, 2006

Definition: Gender-Responsiveness

Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls and that addresses and responds to their strengths and challenges.

(Covington and Bloom)

Guiding Principles for a Gender-Responsive Services

- **Gender**
- **Environment**
- **Relationships**
- **Women's Services**
- **Economic & Social Status**
- **Community**

Guiding Principles

- **Gender:** Acknowledge that gender makes a difference.
- **Environment:** Create an environment based on safety, respect, and dignity.

Guiding Principles (cont.)

- **Relationships:** Develop policies, practices, and programs that are relational and promote healthy connections to children, family, significant others, and the community.

- **Services:** Address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services.

Guiding Principles (cont.)

- **Socioeconomic status:** Provide women with opportunities to improve their socioeconomic conditions.
- **Community:** Establish a system of comprehensive and collaborative community services.

(Bloom,Owen,Covington 2003)

Who Are The Women?

- Pathways to crime:
  - Survival of abuse and poverty
  - Addiction
- Most are poor, undereducated, unskilled, single mothers, and disproportionately women of color.
- Between 1995 and 1996, female drug arrests increased by 95%, (male 55%).
- Nationwide, the number of women incarcerated for drug offenses rose by 888% from 1986 to 1996.

Male/Female Differences

- Employment histories
- Substance abuse problems
- Criminal involvement
- Psychological functioning
- Physical/sexual abuse history

(Messina, Burdon and Prendergast 2001)

Women's Issues: An International Perspective

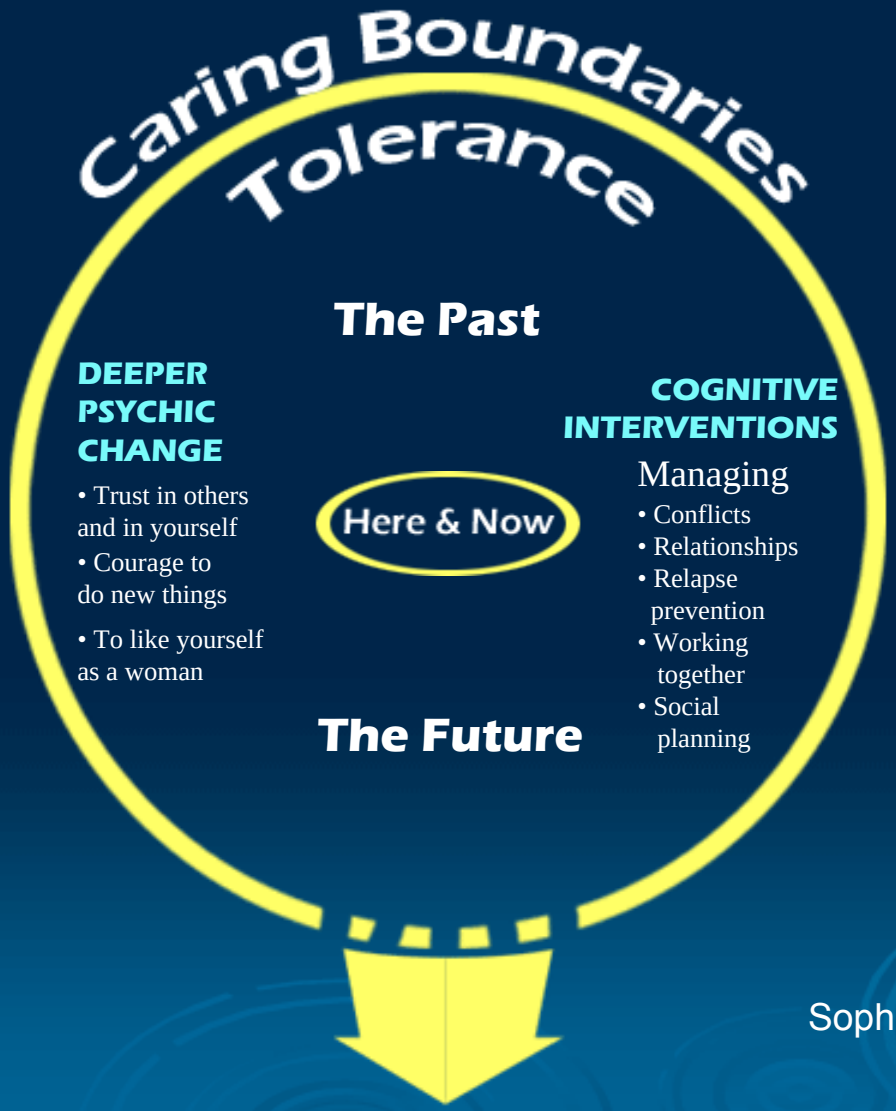
- **Shame and Stigma**
- **Physical and Sexual Abuse**
- **Relationship Issues**

  -fear of losing children
  -fear of losing partner
  -needing partner's permission

Women's Issues: An International Perspective

- **Treatment Issues**
  - lack of services for women
  - not understanding treatment
  - long waiting lists
  - lack of childcare services
- **Systematic Issues**
  - lack of financial resources
  - lack of clean/sober housing
  - poorly coordinated services

THE ATMOSPHERE OF THE INSTITUTION
THE SPIRIT OF THE "GOOD FAMILY"
ENVIRONMENTAL THERAPY



MEETING THE WOMAN WITH POSITIVE EXPECTATIONS

RESPECT

Sophia, Malmö, Sweden

Theoretical Foundation

The theories related to gender and substance abuse (and any other relevant treatment services) that create the framework of thought for program development. This is the knowledge base that creates the foundation upon which the program is developed.

Treatment Strategies

The approaches used in the program that create the therapeutic process. These are the ways in which theory is operationalized (how theory is applied).

Helping Women Recover:
A Comprehensive Integrated Approach

Theory of Addiction

- Holistic health model
- Chronic neglect of self in favor of something or someone else

Theory of Women's Psychological Development

- Relational Model (Stone Center)

Theory of Trauma

- Three Stage Model (Herman)
- Upward Spiral – A Transformational Model (Covington)

Voices: A Program of Self-discovery and Empowerment for Girls

Theory of Girls' Psychological Development

- Relational Model (Stone Center, Gilligan, Brown)

Theory of Attachment

- Ainsworth, Bowlby, Harlow, Stern

Theory of Trauma

- Three Stage Model (Herman)
- Transformational Spiral (Covington)

Theory of Resilience

- Biscoe, Wolin & Wolin

Theory of Addiction

- Holistic Health Model

Beyond Trauma: A Healing Journey for Women

Trauma Theory

Sandra Bloom
Mary Harvey
Judith Herman
Peter Levine
et al.

Integrates cognitive-behavioral, expressive arts, guided imagery and relational therapy.

Beyond Trauma Themes

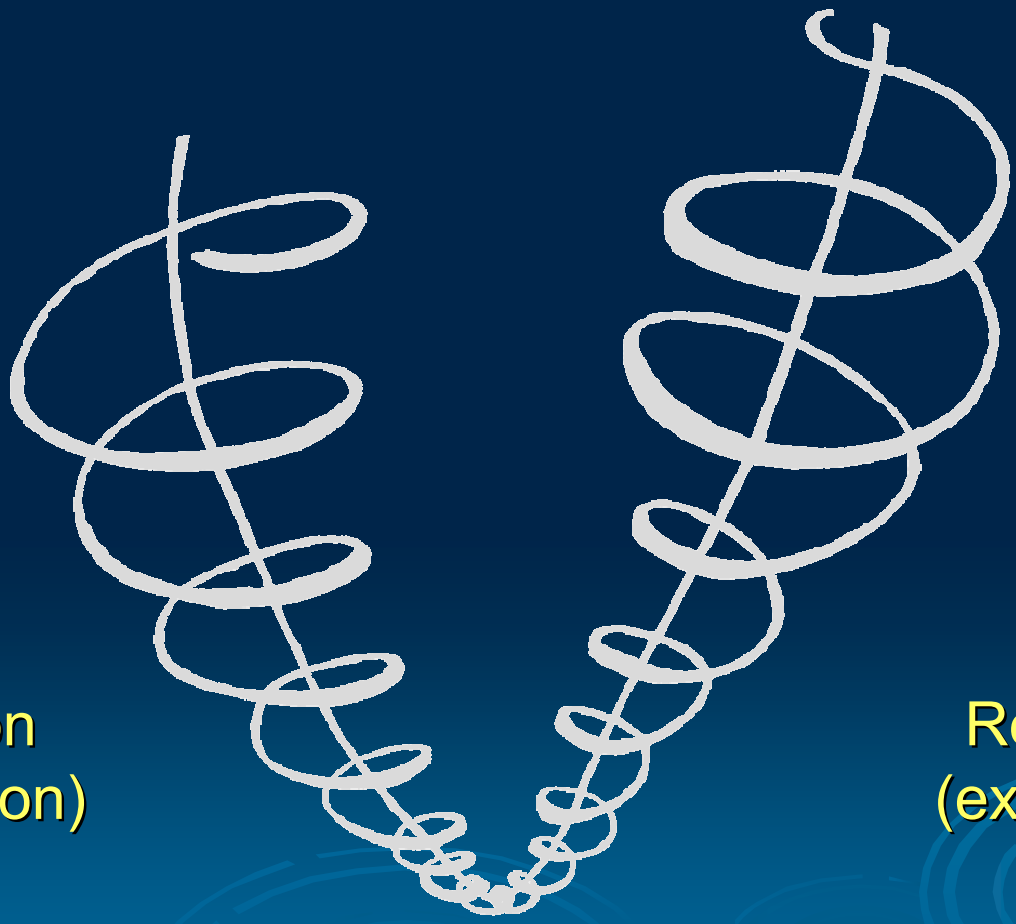
- Safety
- Empowerment
- Connection (Aloneness)
- Normal reactions (Shame)
- Mind-body connection
- Substance abuse
- Woman-centered
- Uses a variety of treatment strategies:
  psychoeducational, cognitive, relational, expressive

Addiction:
A Holistic Health Model

- **Physiological**
- **Emotional**
- **Social**
- **Spiritual**
- **Environmental**
- **Political**

Upward Spiral

Transformation



Addiction
(constriction)

Recovery
(expansion)

Relational Theory

Some women use drugs:

- To maintain a relationship
- To fill in the void of what's missing in a relationship
- To self-medicate the pain of abuse in relationships

(Covington & Surrey, 1997)

Trauma-informed Services

Trauma-informed services:

- Take the trauma into account.
- Avoid triggering trauma reactions and/or traumatizing the individual.
- Adjust the behavior of counselors, other staff and the organization to support the individual's coping capacity.
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain and benefit from the services.

(Harris & Fallot)

Definition of Trauma

The diagnostic manual used by mental health providers (DSM IV-TR) defines trauma as, “involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.”

“The person’s response to the event must involve intense fear, helplessness or horror (or in children, the response must involve disorganized or agitated behavior).”

Trauma & Abuse

- **Sexual abuse**
- **Physical abuse**
- **Emotional abuse**
- **Domestic violence**
- **Witnessing abuse/violence**
- **Self-inflicted violence**

Trauma & Abuse (cont.)

Stigmatization

Women and girls in criminal justice system

Women and girls of color

Women and girls in poverty

Lesbian, transgendered, bisexual

Women and girls with mental illness

Post-traumatic Stress Disorder

- Nightmares; Flashbacks
- Estrangement
- Numbing of General Responsiveness
- Insomnia
- Exaggerated Startle Response
- Hypervigilance

(DSM-IVTR)

Co-occurring Disorders

There is a high level of co-morbidity between post-traumatic stress disorder and:

- Depression
- Anxiety
- Panic disorder
- Phobic disorder
- Substance abuse
- Physical disorders

Source: “Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders Project: Covington & Bloom (2001)

Process of Trauma

TRAUMATIC EVENT
Overwhelms the Physical & Psychological Systems
Intense Fear, Helplessness or Horror

RESPONSE TO TRAUMA
Fight or Flight, Freeze, Altered State of Consciousness, Body Sensations, Numbing, Hyper-vigilance, Hyper-arousal

SENSITIZED NERVOUS SYSTEM
CHANGES IN BRAIN

CURRENT STRESS
Reminders of Trauma, Life Events, Lifestyle

PAINFUL EMOTIONAL STATE

RETREAT	SELF-DESTRUCTIVE ACTION	DESTRUCTIVE ACTION
ISOLATION DISSOCIATION DEPRESSION ANXIETY	SUBSTANCE ABUSE EATING DISORDER DELIBERATE SELF-HARM SUICIDAL ACTIONS	AGGRESSION VIOLENCE RAGES

Three Critical and Interrelated Issues

- Substance Abuse
- Mental Health
- Trauma

Addiction – Trauma – Mental Health Issues

Areas of Separation

- Training
- Treatment
- Categorical Funding

ACE Study
(Adverse Childhood Experiences)

- Recurrent and severe emotional abuse
- Recurrent and severe physical abuse
- Contact sexual abuse

Growing up in a household with:

- An alcoholic or drug-user
- A member being imprisoned
- A mentally ill, chronically depressed, or institutionalized member
- The mother being treated violently
- Both biological parents *not* being present

(N=17,000)

ACE Study
(Adverse Childhood Experiences)

Results

ACEs still have a profound effect 50 years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness.

- Smoking
- Alcoholism
- Injection of illegal drugs
- Obesity

(Felitti, V.J.: Origins of Addictive Behavior: Evidence from the ACE Study. 2003 Oct:52(8): 547-59. German. PMID: 14619682 (PubMed-indexed for MEDLINE).

Childhood Traumatic Events

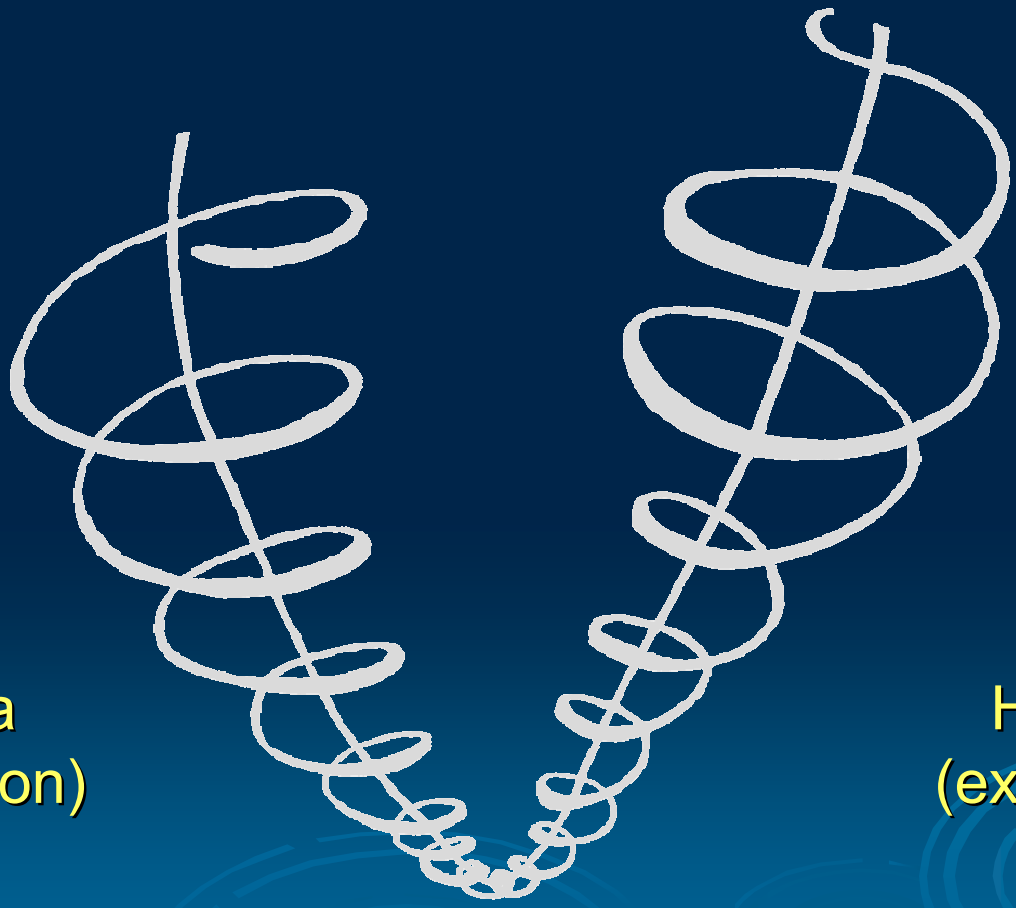
Largest Effect-Mental Health

- 980% increase in odds if exposure to 7 CTE's

(Messina & Grella, 2005)

Upward Spiral

Transformation



Trauma
(constriction)

Healing
(expansion)

Comprehensive Treatment for Women

Issues

Within the treatment program, counselors should address the following issues:

- The etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to onset of addiction)

Comprehensive Treatment for Women (cont.)

- Low self-esteem
- Race, ethnicity and cultural issues
- Gender discrimination and harassment
- Disability-related issues, where relevant
- Relationships with family and significant others
- Attachments to unhealthy interpersonal relationships

Comprehensive Treatment for Women (cont.)

- Interpersonal violence, including incest, rape, battering, and other abuse
- Eating disorders
- Sexuality, including sexual functioning and sexual orientation
- Parenting
- Grief related to the loss of alcohol or other drugs, children, family members, or partners

Comprehensive Treatment for Women (cont.)

- Work
- Appearance and overall health and hygiene
- Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources
- Life plan development
- Child care and child custody

Source: *Practical approaches in the treatment of women who abuse alcohol and other drugs. CSAT 1994.*

Key Issues for Women in Recovery

- **Self**
- **Relationships**
- **Sexuality**
- **Spirituality**

Source: Covington, S., (1994) *A Woman's Way Through the 12 Steps,* Hazelden

Points of Intervention

- **Cognitive**
- **Behavioral**
- **Affective**

From Treatment to Recovery

- Acute care model → chronic illness
- Many pathways to recovery
- Recovery is holistic
- Recovery is empowerment

Evidence-Based Programs

- Conceptually Sound and Internally Consistent
- Program Activities Related to Conceptualization
- Reasonably Well Implemented & Evaluated

Source: SAMSHA Model Programs website:
http://modelprograms.samhsa.gov/template.cfm?page=default

Promising

- Some positive outcomes

Source: SAMSHA Model Programs website:
http://modelprograms.samhsa.gov/template.cfm?page=default

Effective

- Consistently positive outcomes
- Strongly implemented & evaluated

Source: SAMSHA Model Programs website:
http://modelprograms.samhsa.gov/template.cfm?page=default

Model

- Availability for dissemination
- Technical assistance available from program developers

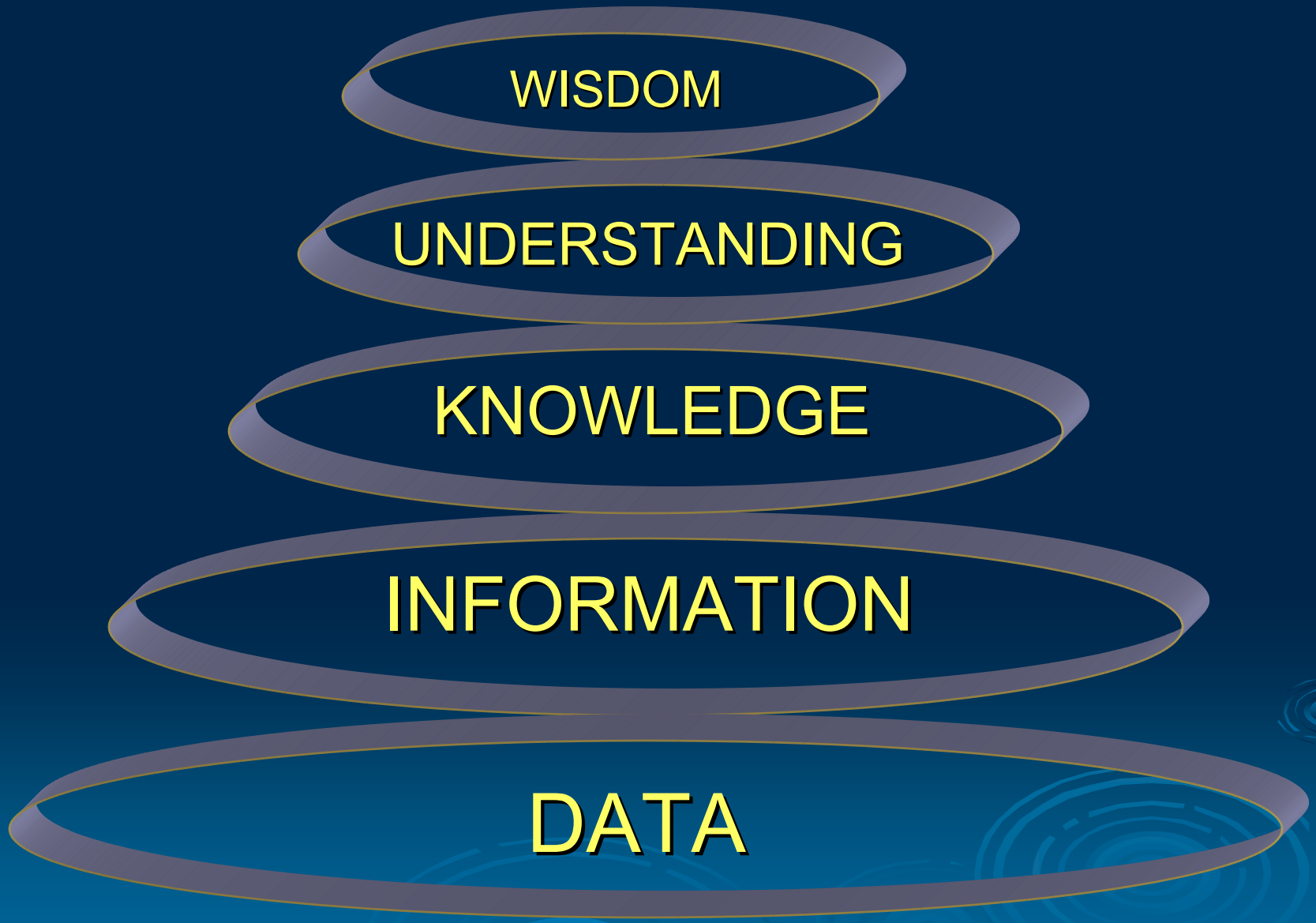
Source: SAMSHA Model Programs website:
http://modelprograms.samhsa.gov/template.cfm?page=default

Definition of Evidence-based

Evidence-based practice (EBP) is defined as the integration of the best available research and clinical expertise within the context of patient characteristics, culture, values, and preferences.

(APA Presidential Task Force, 2005)

HOLISTIC, SPIRITUAL, INTUITIVE, CREATIVE, RARE



SEPARABLE, LINEAR, MECHANISTIC, MEASURABLE, ABUNDANT

Women Healing

Working on multiple levels:

- Individual
- Political
- Spiritual

Helping Women Recover: A Program for Treating Addiction

Bibliography

Belknap, J. (1996). *The invisible women: Gender, crime, and justice.* Belmont, CA: Wadsworth.

Berg, I.K. & Miller, S.D. (1992). *Working with the problem drinker: A solution-focused approach.* W.W. Norton & Company.

Bloom B. & Covington S. (2001). Effective gender-responsive interventions in juvenile justice: Addressing the lives of delinquent girls. Paper presented at the 53rd Annual Meeting of the American Society of Criminology, Atlanta, Ga., November 2001.

Bloom B. & Covington S. (1998). Gender-specific programming for female offenders: What is it and why is it important? Presented at the 50th Annual Meeting of the American Society of Criminology, Washington, DC.

Bloom, B., Owen, B., & Covington, S. (2003). *Gender responsive strategies: Research, practice, and guiding principles for women offenders.* Washington, DC: National Institute of Corrections.

Briere, J., & Scott, C. (in press). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, CA: Sage Publications.

Brown, S. and Lewis V. (1999). *The alcoholic family in recovery.* New York: Guilford Press.

Brown, S. and Yalom, I. (Eds.). (1995). Treating *alcoholism*: *A volume in the Jossey-Bass library of current clinical technique*; San Francisco: Jossey-Bass.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery.* San Francisco*:* John Wiley & Sons.

CASA. (1998). *Behind bars: Substance abuse and America's prison population*. New York: National Center on Addiction and Substance Abuse at Columbia University.

Center for Substance Abuse Treatment (1999). *Substance abuse treatment for women offenders: Guide to promising practices*, TAP#23. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration.

Community Connections. (2001). *Men's trauma recovery and empowerment model (M-TREM): A clinician's guide for working with male survivors in groups.* Washington, DC: Community Connections, Inc.

Covington, S. (2004) Voices*: A program of self-discovery and empowerment for girls*. Carson City, NV: The Change Companies.

Covington, S. (2003). *Beyond trauma: A healing journey for women*. Center City, MN: Hazelden.

Covington, S. (2003) A woman's journey home: Challenges for female offenders. In J. Travis and M. Waul, eds., *Prisoners Once Removed.* Washington, D.C.: The Urban Institute.

Covington, S. (2002). Helping women recover: Creating gender-responsive treatment. In L. Straussner and S. Brown, eds., *Handbook of Women's Addictions Treatment.* San Francisco: Jossey-Bass.

Covington, S. (2002). *Women in recovery: Understanding addiction.* Carson City, NV: The Change Companies.

Covington, S. (2002). *Mujeres en recuperacion: Entendiendo la adiccion.* Carson City, NV: The Change Companies.

Covington, S. (2001). Creating gender-responsive programs: The next step for women's services. *Corrections Today*, February.

Covington, S. (2000). *Awakening your sexuality.* Center City, MN: Hazelden.

Covington, S. (1999).*Helping women recover: A program for treating addictions* and *Helping women recover: A program for treating substance abuse (a special edition for the criminal justice system).*San Francisco: Jossey-Bass.

Covington, S. (1998). Creating gender-specific treatment for substance-abusing women and girls in community correctional settings. Presented at the Annual Conference of the International Community Corrections Association, Arlington VA.

Covington, S. (1998). The relational theory of women's psychological development: Implications for the criminal justice system. In Ruth T. Zaplin ed. *Female crime & delinquency: Critical perspectives and effective interventions*, Aspen Books.

Covington, S. (1998). Women, addiction, and sexuality. In L. Straussner and E. Zelvin (Eds.). *Gender issues in addiction: Men and women in treatment,* Jason Aronson.

Covington, S. (1998).Women in prison: Approaches in the treatment of our most invisible population. *Women and Therapy Journal,* Haworth Press, Vol. 21, No.1, pp 141-155.

Covington, S. (1994). *A woman's way through the 12 Steps.* Center City, MN*:* Hazelden.

Covington, S. (1991). Sororities of helping and healing: Women and mutual help groups. In Paula Roth, (Ed.), *Alcohol and drugs are women's issues.* Scarecrow Press.

Covington, S. and Beckett, L. (1988). *Leaving the enchanted forest: The path from relationship addiction to intimacy.* HarperSanFrancisco.

Covington, S. and Bloom, B. (1999). Gender-responsive programming and evaluation for females in the criminal justice system: A shift from *what works?* to *what is the work?* Presented at the 51st Annual Meeting of the American Society of Criminology, Toronto, Ontario, Canada.

Covington, S. and Bloom, B. (2003). Gendered justice: Women in the criminal justice system. In B. Bloom, ed., *Gendered justice: addressing female offenders*. Durham, NC: Carolina Academic Press.

Covington S. and Kohen, J. Women, alcohol, & sexuality, *Advances in Alcohol & Substance Abuse,* Vol. 4, No. 1, Fall 1984.

Covington, S. and Surrey, J. (1997). The relational model of women's psychological development: Implications for substance abuse. In Sharon & Richard Wilsnack, (Eds.) *Gender and alcohol: Individual and social perspectives.* Rutgers University Press.

Creighton, A. & Kivel, P. (1998) *Young men's work.* Center City, MN: Hazelden.

Dolan, Y. (1991). *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors.* W.W. Norton.

Galbraith, S. (1998). *And so I began to listen to their stories.* New York: Policy Research, Inc.

Gerstein, D. Harwood, H., Suter, N. & Malloy, K. (1994). Evaluating recovery services: The California drug and alcohol treatment assessment (CALDATA). Sacramento: California Department of Alcohol and Drug Programs.

Gilligan, C. (1991). Women's psychological development: Implications for psychocounseling. In C. Gilligan, A. Rogers, & D. Tolman (Eds.), *Women, girls, and psychocounseling: Reframing resistance.* New York: Haworth.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Goodheart, C.D., Kazdin, A.E., & Sternberg, R.J. (Eds.) (2006). *Evidence-based psychotherapy: Where practice and research meet.* Washington, D.C.: American Psychological Association.

Herman, J. (1992). *Trauma and recovery.* HarperCollins.

Jersild, D. (2001). *Happy hours: Alcohol in a woman's life.* HarperCollins.

Kasl, C. (1991). *Many roads, one journey: Moving beyond the 12 steps,* NY: HarperCollins.

Kivel, P. (1992). *Men's work: How to stop the violence that tears our life apart.* Center City, MN: Hazelden.

Länne, Lotta. Sofia Behandlingshem. Malmö, Sweden, 011-46-40-34 5576.

Leshner, A. *(*1997*).* Drug abuse and addiction are biomedical problems. *Hospital Practice: A Special Report*, 2-4.

Linehan, M. (1993) *Cognitive-behavioral therapy for borderline personality disorder.* Guilford Press.

Linehan, M. (1993). *Skills training manual for treating borderline personality disorder.* Guilford Press.

Mattson, K. (1992). *A relapse prevention workbook for women*. Hazelden/Johnson Institute.

McCann, I.L., and Pearlman, L.A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation.* Brunner/Mazel.

Miller, W.R.. (1996) Motivational interviewing: research, practice and puzzles. *Addictive Behaviors,* 61 (6): 835-842.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services,* May 2001, 52(5), 597-599.

Naparstek, B. (2004). *Invisible heroes: Survivors of trauma and how they heal.* New York: Bantam Dell.

National Alcohol and Drug Information Clearinghouse, (800) 729-6686.

National Institute on Drug Abuse (1999). *Principles of drug addiction treatment: A research-based guide.* NIUH Publication No. 99-4180.

Nowinski, J. & Baker, S. (1998). *The twelve step facilitation handbook: A systematic approach to early recovery from alcoholism and addiction.* San Francisco: Jossey-Bass.

Petracek, L. (2004). *The anger workbook for women: How to keep your anger from undermining your self esteem, your emotional balance, and your relationships*. Oakland: New Harbinger Publications, Inc.

Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post treatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7-29.

Project MATCH Research Group (1997). Project MATCH secondary a priori hypotheses (Research Report). *Addiction, 92*, 1671-1698.

Sandmaier, M. (1992). *Invisible alcoholics.* TAB Books.

Sebold, A. (1999*). Lucky: A memoir.* New York: Schribner

Vincent, N. (2006). *Self-made man*. Penguin.

White, W., Boyle, M., and Loveland, D. (2002). Alcoholism/Addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20 (3/4) 107-130.

Wilsnack, S., and Beckman, L. (1984) *Alcohol problems in women: Antecedents, consequences, and intervention.* Guilford Press.

Work-in-Progress. Papers from the Stone Center. The Stone Center, Wellesley Centers for Women, 106 Central Street, Wellesley, MA 02481, (781) 283-2510. www.jbmti.org or www.wcwonline.org

Stephanie S. Covington, Ph.D.
Center for Gender and Justice
Institute for Relational Development
7946 Ivanhoe Ave., Ste. 201B
La Jolla, CA 92037
sc@stephaniecovington.com
www.stephaniecovington.com
www.centerforgenderandjustice.org

California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE ADDRESS

NUMBING THE PAIN: POST TRAUMATIC STRESS DISORDER AND SUBSTANCE ABUSE

Lisa Najavits
Associate Clinical Professor and Research Psychologist,
Harvard Medical School, McLean Hospital

Day Two: Thursday, September 7, 2006
1:45 – 2:15 p.m.

Asking for Help

SUMMARY

Each of the disorders—PTSD and substance abuse—leads to problems in asking for help. Today's topic encourages patients to become aware of their need for help, and provides guidance in how to do so effectively.

ORIENTATION

"It feels like the telephone weighs a thousand pounds."

"I lose whether I get help or not. If I get help, I feel guilty; if I don't, I feel humiliated and alone."

"How hard is it to ask for help? I think it's easier to give up cocaine than to ask for help."

"Everyone in my life has hurt me one way or another. I guess I'll have to try to trust. It's not easy—I can't take any more hurt."

For both PTSD and substance abuse, others' help is essential. It has been said, "The power of drugs equals the need for help. . . . They are as closely related as supply and demand in economics, as inseparable as pressure and volume in behavior of gasses. . . . The gun is pointed at my head: get help or die" (DuWors, 1992, pp. 97–99). Similarly, for severe PTSD it has been said that healing can take place only in the context of relationships (Herman, 1992).

There are good reasons why patients may find it hard to reach out for help. They may have had no one to trust while growing up; they may feel a need to keep up an image as someone "strong"; they may have learned that asking for help evokes punishment. For many patients with PTSD, sufficient help was not available at the time of the trauma, and they may

Ideas for a Commitment

Commit to one action that will move your life forward!
It can be anything you feel will help you, or you can try one of the ideas below.
Keeping your commitment is a way of respecting, honoring, and caring for yourself.

✦ Option 1: Write a list of people you can call when you are having problems (e.g., wanting to talk, feeling afraid, drug cravings, needing a ride, etc.). Include friends, family members, self-help sponsors, treaters, hotlines, drop-in centers, and anyone else you can think of (see example below).

List of people to call for help

1. My friend Martha: 466-4215 or 252-7655
2. My therapist (Dr. Klein): 855-1111 or can page at 855-1000
3. My AA sponsor (Barbara): 731-1502

✦ Option 2: Go for it! Fill out the Approach Sheet.

APPROACH SHEET–EXAMPLE

Fill in the first three parts now. Later, after you've approached the person, fill in the last part.

(1) Who will you talk to?

My friend Elizabeth.

(2) What will you say?

"Please help me not drink at the party tonight–you can help by not offering me any alcohol and checking in with me at times during the party to see if I'm okay."

(3) What do you predict will happen?

She won't want to help me. She'll think I'm pathetic.

(4) What did happen in reality?

I called Elizabeth. She was very willing to watch out for me at the party, and also gave me the phone number for a good AA group in town. She didn't convey any judgment or negative views of me.

feel unable to seek help now when it is more available to them. Substance use may have come to seem like the only "help" they could get. Some patients may have sought help from systems that failed them, such as treatment systems ignorant about PTSD or substance abuse, or legal systems that may have punished them rather than providing treatment. For a description of one patient's dilemmas in asking for help, see "A Patient's Story: Why It's Hard to Ask for Help" at the end of this topic.

Today's topic provides explicit instruction in how to reach out more often, and more effectively, toward others. This skill can literally save lives in times of need. Because there are many people in patients' lives who truly cannot or will not provide help, a key theme is learning to move on to others who can, even if only to treaters. See also the topic *Setting Boundaries in Relationships* for more on getting patients to say "yes" to help from others.

Countertransference Issues

Some therapists, particularly if they grew up in a supportive environment, underestimate patients' obstacles in seeking help. They may believe that the problem is mostly in patients' perceptions rather than in reality, and they may be unaware of some real dangers in reaching out for help. See "Suggestions" (below) for more on this issue.

SESSION FORMAT

1. ***Check-in*** *(up to 5 minutes per patient)*. See Chapter 2.
2. ***Quotation*** *(briefly)*. See page 170. Link the quotation to the session—for example, "Today we'll focus on asking for help. That may feel like a big risk for some people—but it is incredibly important to learn to take that risk and reach out."
3. ***Relate the topic to patients' lives*** *(in-depth, most of session)*.
   a. *Ask patients to look through the handouts*:

      Handout 1: Asking for Help
      Handout 2: Approach Sheet

   b. *Help patients relate the skill to current and specific problems in their lives.* See "Session Content" (below) and Chapter 2 for suggestions.
4. ***Check-out*** *(briefly)*. See Chapter 2.

SESSION CONTENT

Goals

- ☐ Discuss effective ways to ask for help.
- ☐ Rehearse how to ask for help.
- ☐ Explore patients' experiences in asking for help.

Ways to Relate the Material to Patients' Lives

★ ***Role plays.*** The best situations to role-play are current, real-life situations that patients raise. Also, patients can choose upcoming events that provide an opportunity to reach out for help. If a patient has had any unsafe behavior since the last session (substance use, starting a physical fight, self-cutting, unprotected sex, suicide attempt), it is strongly recommended that this be the top priority in rehearsing the skill. For example, you might say, "Role-play the last time you used a substance. Whom could you have called? What could you have said?" Other role-play ideas include "Tell your therapist you don't feel safe," "Call a friend when you are feeling lonely," "Ask someone to go with you to a self-help meeting," "Ask your partner to help you review the material in this treatment," or "Call someone if you feel like hurting yourself or someone else."

★ ***Work on the Approach Sheet (Handout 2).*** Help patients identify a current situation that would benefit from asking for help, and process how to go about it. The goal is to get patients out of the assumptions "in their heads" and into finding out "what's real." Thus, guide them to fill out the first three boxes of Handout 2, the blank Approach Sheet (what help they need help, whom they can ask, and what they predict will happen). Then, before the next session, they can try actually asking for the help specified and observe whether their prediction was accurate (filling out the fourth box in the sheet).

To help create a success experience, make sure that patients are truly trying something new and not just going through the motions; try to set up a situation with the most likelihood of success (e.g., asking someone safe); explicitly discuss how to prepare if a request for help doesn't go well; explore practical and emotional obstacles to following through on the assignment; and, when patients come to the next session, process what happened. If it didn't go well, the idea is to help patients learn something constructive from the experience (e.g., "I'm able to take a risk," or "Now I know I need to find other people to ask help from"). Also, find out *how* they asked for help, and give honest feedback and instructions on more effective ways.

★ ***Discussion***

- "What do you most want help with?"
- "Why is asking for help such a crucial coping skill?"
- "Was there a time recently when you needed to call someone for help, but didn't?"
- "Is it harder to ask for help with your PTSD, your substance abuse, or both equally?"
- "Why might PTSD and substance abuse make it hard for you to ask for help?"
- "What happens when you do not ask for help?"
- "Are there any successes you've had in asking for help? What made those possible?"
- "Do you think you can learn to ask for more help?"
- "How can you cope if the other person refuses to help?"
- "If you feel an impulse toward a destructive behavior, do you know whom you would call and what you would say?"
- "Why would asking for help make you more *independent* in the long run?"
- "Can you 'coach' the other person in advance on what you want him or her to say?"

Suggestions

✦ ***You may want to introduce the topic with a simple, forceful statement:*** "I am going to tell you one of the greatest secrets of recovery you will ever hear. This is like a law of physics and as solid as the ground we walk on: You need help from others to recover." Allow patients to respond to this, and praise any positive examples they provide of asking for help.

✦ ***Out-loud rehearsal is typically most effective.*** Having patients rehearse how they would ask for help tends to be more engaging than a general discussion. Thus role plays and the Approach Sheet generally work best.

✦ ***Note that some patients have no one safe to ask help from.*** This is a very real situation for some people. In this case, the goal becomes practicing asking help from treaters (e.g., a hotline, an AA member or sponsor, a therapist). It is usually less helpful to "debate" with patients whether particular friends or family members really would be there for them—patients' instincts may be accurate, and the goal of the session is to have them locate help anywhere they can. Treaters are an excellent source for mastering the skill of asking for help, and over time, patients may then be able to move on to developing a safe support network of nontreaters. Patients can be encouraged even now to get involved in activities that will help them to build a support network (e.g., self-help groups, leisure activities, religious organizations). However, some patients are not yet capable of utilizing these, in which case treaters become the "fall-back" option. You may also want to offer patients resources from Handout 1 in the topic *Community Resources*, which provides many toll-free numbers for obtaining informational help. Here too, just practicing reaching out is the goal.

✦ ***Be sure to take very seriously that there may be valid reasons why asking for help is genuinely dangerous for some patients at this point.*** Sometimes patients have abusive partners who will hurt them if they seek help; at other times, emotional obstacles may be dangerous (e.g., "If I don't get the help I ask for, I become suicidal"), or treaters/treatment systems are unhelpful. The most important strategy is usually to empathize with patients' fears and to redirect them to safe options. For example, a patient can plan on asking for help just before or during a therapy session (such as making a call in the therapist's office) to be able to process how it went. It is not helpful, in contrast, to respond with simplistic "cheerleading" such as "Just keep trying with your partner," or "You can do it!"

✦ ***Encourage patients to instruct people in their lives about the kind of help they need.*** For example, one concern patients raise is that if they ask for help before using a substance, the other person will try to talk them out of it. Try to have patients rehearse explicitly in advance what they want the other person to say—for example, "I cannot stop you from using, but I am worried about you," or "I will just listen to anything you want to say." See the topic *Getting Others to Support Your Recovery* for more on this.

✦ ***It may be safest to start with concrete, physical help rather than emotional help.*** For example, asking a friend for a ride to a self-help meeting may be easier than asking for advice on a complex emotional problem. The goal is to take a step, however small, toward reaching out to others in a time of need. Adjusting the level of difficulty of the task (not too hard, not too easy) is key. Also, patients should select someone who truly has the potential to help, not a

"hopeless case," such as a family member who has abused them or a friend who has refused to help in the past.

✦ ***Any time is better than no time.*** Sometimes patients believe that they can only ask for help before using (or other such events) and once they've begun a self-destructive act it is too late to reach out. Process ways to ask for help at any point in the sequence, as in this example:

Before: "Call someone when you have a drug craving, before you use."
During: "If you're at a bar, go to the pay phone and call your sponsor."
After: "Call a friend the next day to discuss what happened."

✦ ***Identify ways to cope with rejection before it happens.*** Rehearse how patients might handle it if a person refuses a request for help. Cognitive strategies may be especially helpful, such as explanations that are not self-blaming: "I guess the person I asked just isn't as generous as I had thought," "I can learn from this and try again later with someone else," "I need to give myself credit for trying, even if it didn't work out as I had hoped."

✦ ***Persistence matters.*** Patients should not give up easily. Offer suggestions, such as "You may have to ask twice for someone to 'hear' you," or "If one person can't help you, try another person immediately."

✦ ***Patients may be afraid of becoming too dependent if they ask for help.*** It is often a surprise that in fact it makes them more *independent* in the long run. Learning to recognize and prioritize one's needs, knowing how to put a request for help into words, tolerating the vulnerability of such a request—all of these empower patients and increase strength and self-esteem. Asking for help means that one is not afraid of people and can join with others safely.

✦ ***Notice how patients ask for help, particularly in the role plays.*** You may need to give honest feedback and instructions on more effective ways to ask for help. For example, one patient said, "I told my partner that she was totally unhelpful and that she had to start helping me from now on." This person needed guidance in softening the approach.

✦ ***Some patients may not understand the quotation.*** You may want to emphasize that it suggests the importance of taking risks in life. Not taking risks, though it may feel "self-protective," can keep one alone and isolated. Reaching out for help is an important risk to take.

Tough Cases

* "I'm always helping others, but no one helps me."
* "I can ask for help in role plays, but not in real life."
* "I don't have anyone in my life to ask help from."
* "Whenever I ask for help, I get rejected."
* "I can't ask for help when I feel like using—I don't want to be talked out of it."
* "I'm calling you from a pay phone and I need help right now; I'm going to kill myself."
* "My family does not want me to get help from anyone except them."
* "When I was growing up, I was beaten if I asked for help."
* "As a Latino in this society, I can only ask for help from other Latinos."

A PATIENT'S STORY: WHY IT'S HARD TO ASK FOR HELP

"My trauma started around the time I was about 5 or so. Always around nighttime, when the lights went out, it was a scary time. Bad things happened in the dark. I would pretend to be asleep but that didn't matter. If I closed my eyes, it would go away. But that wasn't true. I would hold onto my doll for comfort. Sometimes I would hold on so tight I thought her head would pop off.

"So why didn't I ask for help? If only I went for help, I could have stopped the whole thing. But I didn't. I did nothing; I let it all happen. Was I stupid? Or maybe I liked it? Please give me the answers—I don't have them. I feel dirty, always feeling dirty. Growing up, and even now when I think about it, it was always my fault. I didn't stop any of it. Even after the rape at 11 years old, I still didn't tell anyone. Even as an adult, I let it go on in my marriage. An adult! I should have stopped it then. But I didn't. I'm just a little girl crying for help but not doing anything about it.

"Well, yes, my trauma did happen as a little girl. That's just it—a little *girl. This man was very powerful. There was no way I could stop this person who was terrifying me. No, I am not stupid, and I did not enjoy it. It sickens me when I think about it. I couldn't go for help because then my sisters would have been hurt. I was helpless. He was my father, a very powerful figure in my life. I may not have gotten help then, but I'm getting help now. It's never too late to ask for help. I will get my life in order and stand on my own two feet. If I talked then, bad things would have happened. Well, no more. I will not be hurt any more in my life."*

"And the trouble is, if you don't risk anything, you risk even more."

—Erica Jong
(20th-century American writer)

From *Seeking Safety* by Lisa M. Najavits (2002).

Asking for Help

MAIN POINTS

★ It is very common to have difficulty asking for help if you have PTSD and substance abuse.

★ You must get help from others to recover. No one can do it alone.

★ In learning to ask for help, start "small": Practice on safe people, with simple requests.

★ Try to ask for help *before* a problem becomes overwhelming. But you can call any time—*before*, *during*, or *after* a hard time.

★ Prepare how you'll handle it if the person refuses your request for help.

★ In asking for help, you don't have to "spill" everything.

★ Asking for help makes you stronger and more *independent* in the long run.

★ Learning to ask for help may feel very awkward at first.

★ If there is no one in your life to ask help from, work on building a support network.

★ When asking for help, be gentle—no demands, threats, or insults.

★ Discover whether your fears are accurate: Compare your *prediction* to *reality*.

★ Carry in your wallet a list of phone numbers you can call.

Approach Sheet

★ *Fill in the first three parts now. Later, after you've approached the person, fill in the last part.*

(1) Who will you talk to?

(2) What will you say?

(3) What do you predict will happen?

(4) What did happen in reality?

★ *You may want to ask yourself:*

- What did you learn from trying this?
- Did you get what you wanted, or at least part of what you wanted?
- Is there anything you might do differently next time?
- How do you feel about your experience?
- How difficult was it?

Lisa M. Najavits, PhD / 2006

PTSD

a) **What is PTSD?**

- DSM-IV definition: After a trauma (the experience, threat, or witnessing of physical harm, e.g., rape, hurricane), the person has each of the following key symptoms for over a month, and they result in decreased ability to function (e.g., work, social life): intrusion (e.g., flashbacks, nightmares); avoidance (not wanting to talk about it or remember); arousal (e.g., insomnia, anger).
- Simple PTSD results from a single event in adulthood (DSM-IV symptoms); Complex PTSD results from multiple traumas, typically in childhood (broad symptoms, including personality problems)

b) **About PTSD**

- Rates: 10% for women, 5% for men (lifetime, US). Up to 1/3 of people exposed to trauma develop PTSD. Men have higher rates of trauma, but women have more childhood trauma, and are more likely than men to develop PTSD if exposed to trauma (Kessler et al., 1996)
- Treatment: if untreated, PTSD can last for decades; if treated, people do recover. Most effective treatments: cognitive-behavioral (i.e., coping skills training) and exposure (tell the trauma story).

Substance Abuse

a) **What is substance abuse?**

- "The compulsion to use despite negative consequences" (e.g., legal, physical, social, psychological). Note that neither amount of use nor physical dependence define substance abuse.
- DSM-IV term is "substance use disorder", with substance abuse a milder form, and substance dependence more severe.

b) **About substance abuse**

- Rates: 35% for men; 18% for women (lifetime, US) (Kessler et al., 1994)
- It is treatable disorder and a "no-fault" disorder (i.e., not a moral weakness)
- Two ways to give it up: "cold turkey" (give up all substances forever; abstinence model) or "warm turkey" (*harm reduction*, i.e., any reduction in use is positive step; *moderation management*, i.e., some people can use in a controlled fashion-- but only those not dependent on substances, and without co-occurring disorders)

The Link Between PTSD and Substance Abuse

a) **About PTSD and substance abuse**

- Rates: Of clients in substance abuse treatment, 12%-34% have current PTSD. For women, rates are 33%-59%.
- Gender: For women, typically a history of sexual or physical childhood trauma; for men, combat or crime
- Drug choice: No one drug of choice, but PTSD associated with severe drugs (cocaine, opioids); "self-medication" in 2/3 of cases (i.e., PTSD first, then substance abuse).

b) **Treatment issues**

- Other life problems are common: e.g., other Axis I disorders, personality disorders, interpersonal and medical problems, inpatient admissions, low compliance with aftercare, homelessness, domestic violence).
- PTSD does not go away with abstinence from substances; and, PTSD symptoms are widely reported to become worse with initial abstinence.
- Separate treatment systems (mental health versus substance abuse).
- Fragile treatment alliances and multiple crises are common.
- Treatments helpful for either disorder alone may be problematic if someone has both disorders (e.g., exposure, twelve-step groups, benzodiazepines). Also, some messages in substance abuse treatment may be problematic: "hitting bottom", "confrontation".

♥Attend religious services (if you like them)? YES___ NO___ N/A___
♥Other: _____ YES ___ NO ___

YOUR SCORE: (total # of "no's) _____

Notes on self-care:

Self-Care and PTSD. People with PTSD often need to learn to take good care of themselves. For example, if you think about suicide a lot, you may not feel that it's worthwhile to take good care of yourself and may need to make special efforts to do so. If you were abused as a child you got the message that your needs were not important. You may think, "If no one else cares about me, why should I?" Now is the time to start treating yourself with respect and dignity.

Self-Care and Substance Abuse. Excessive substance use is one of the most extreme forms of self-neglect because it directly harms your body. And, the more you abuse substances the more you are likely to neglect yourself in other ways too (e.g., poor diet, lack of sleep).

Try to do a little more self-care each day. No one is perfect in doing everything on the list at all times. However, the goal is to take care of the most urgent priorities first and to work on improving your self-care through daily efforts. "Progress, not perfection."

Najavits, LM (2002)

Creating Meaning in PTSD and Substance Abuse

MEANINGS THAT *HARM*	DEFINITION	EXAMPLES	**MEANINGS THAT *HEAL***
Deprivation Reasoning	Because you have suffered a lot, you deserve substances (or other destructive behavior).	*--I've had a hard time, so I'm entitled to get high.* *--If you went through what I did, you'd cut your arm too.*	**Live Well.** A happy, functional life will make up for your suffering far more than will hurting yourself. Focus on positive steps to make your life better.
I'm Crazy	You believe that you shouldn't feel the way you do	*--I must be crazy to be feeling this upset.* *--I shouldn't have this craving.*	**Honor Your Feelings.** You are not crazy. Your feelings make sense in light of what you have been through. You can get over them by talking about them and learning to cope.
Time Warp	It feels like a negative feeling will go on forever.	*--This craving won't stop.* *--If I were to cry, I would never stop.*	**Observe Real Time.** Take a clock and time how long it really lasts. Negative feelings will usually subside after a while; often they will go away sooner if you distract with activities.
Actions Speak Louder than Words	Show distress by actions, or people won't see the pain.	*--Scratches on my arml show what I feel* *--An overdose will show them.*	**Break Through the Silence.** Put feelings into words. Language is the most powerful communication for people to know you.
Beating Yourself Up	In your mind, you yell at yourself and put yourself down.	*--I'm a loser.* *--I'm a no-good piece of dirt.*	**Love—Not Hate--Creates Change.** Beating yourself up does not change your behavior. Care and understanding promote real change.
The Past is the Present	Because you were a victim in the past, you are a victim in the present.	*--I can't trust anyone.* *--I'm trapped.*	**Notice Your Power.** Stay in the present: I am an adult (no longer a child); I have choices (I am not trapped); I am getting help (I am not alone).

The Escape	An escape is needed (e.g., food, cutting) because feelings are too painful	*--I'll never get over this; I have to cut myself.* *--I can't stand cravings; I have to smoke a joint.*	**Keep Growing.** Emotional growth and learning are the only real escape from pain. You can learn to tolerate feelings and solve problems.
Ignoring Cues	If you don't notice a problem it will go away.	*--If I just ignore this toothache it will go away* *--I don't abuse substances.*	**Attend to Your Needs.** Listen to what you're hearing; notice what you're seeing; believe your gut feeling.
Dangerous Permission	You give yourself permission for self-destructive behavior.	*--Just one won't hurt.* *--I'll just buy a bottle of wine for a new recipe*	**Seek Safety.** Acknowledge your urges and feelings and then find a safe way to cope with them.
The Squeaky Wheel Gets the Grease	If you get better you will not get as much attention from people	*--If I do well, my therapist won't notice me.* *--No one will listen to me unless I'm in distress.*	**Get Attention from Success.** People love to pay attention to success. If you don't believe this, try doing better and notice how people respond to you.
It's All My Fault	Everything that goes wrong is due to you.	*--The trauma was my fault* *--If I have a disagreement with someone, it means I'm wrong.*	**Give Yourself a Break.** Don't carry the world on your shoulders. When you have conflicts with others, try taking a 50-50 approach (50% is their responsibility, 50% is yours).
I am My Trauma	Your trauma is your identity; it is more important than anything else	*--My life is pain.* *--I am what I have suffered..*	**Create a Broad Identity.** You are more than what you have suffered. Think of your different roles in life, your varied interests, your goals and hopes.

PTSD Checklist-Civilian Version

INSTRUCTIONS:

1) List here the trauma (stressful event) that is being rated: _____.

[Clinician: be sure to check that the trauma listed fits criterion A – see DSM-IV or DSM-IV-TR]

2) Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, and check off the box to indicate how much you have been bothered by that problem in the past month, in relation to the trauma you listed in "1" above.

		Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful experience?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5

11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94) END OF TEST

Citation: Weathers, Litz, Huska, & Keane; National Center for PTSD - Behavioral Science Division; This is a government document in the public domain.

The instructions have been adapted by Lisa Najavits to include the listing of the trauma, and to include the scoring below. For other information on the measure, go to www.ncptsd.org.

Before administering, remove scoring below!

----------Scoring for PCL-C----------

Scoring: any item endorsed at 3 or higher counts as a symptom. PTSD Criterion B: 2 or more from items 1-5; criterion C: 3 or more from items 6-12; criterion D: 2 or more from items 13-17.

----------Scoring for Trauma Symptom Checklist-40 (next page)----------

******Before scoring, read "important note" at bottom of next page******

Subscale composition and scoring for the TSC-40 The score for each subscale is the sum of the relevant items:

Dissociation: 7,14,16,25,31,38
Anxiety: 1,4,10,16,21,27,32,34,39
Depression: 2,3,9,15,19,20,26,33,37
SATI (Sexual Abuse Trauma Index): 5,7,13,21,25,29,31
Sleep Disturbance 2,8,13,19,22,28
Sexual Problems 5,9,11,17,23,29,35,40
TSC-40 total score: 1-40

Trauma Symptom Checklist-40

How often have you experienced each of the following in the last month? Please circle one number, 0 through 3.

	Never			Often
1. Headaches	0	1	2	3
2. Insomnia	0	1	2	3
3. Weight loss (without dieting)	0	1	2	3
4. Stomach problems	0	1	2	3
5. Sexual problems	0	1	2	3
6. Feeling isolated from others	0	1	2	3
7. "Flashbacks"(sudden, vivid, distracting memories)	0	1	2	3
8. Restless sleep	0	1	2	3
9. Low sex drive	0	1	2	3
10. Anxiety attacks	0	1	2	3
11. Sexual overactivity	0	1	2	3
12. Loneliness	0	1	2	3
13. Nightmares	0	1	2	3
14. "Spacing out" (going away in your mind)	0	1	2	3
15. Sadness	0	1	2	3
16. Dizziness	0	1	2	3
17. Not feeling satisfied with your sex life	0	1	2	3
18. Trouble controlling your temper	0	1	2	3
19. Waking up early in the morning	0	1	2	3
20. Uncontrollable crying	0	1	2	3
21. Fear of men	0	1	2	3
22. Not feeling rested in the morning	0	1	2	3
23. Having sex that you didn't enjoy	0	1	2	3
24. Trouble getting along with others	0	1	2	3
25. Memory problems	0	1	2	3
26. Desire to physically hurt yourself	0	1	2	3
27. Fear of women	0	1	2	3
28. Waking up in the middle of the night	0	1	2	3
29. Bad thoughts or feelings during sex	0	1	2	3
30. Passing out	0	1	2	3
31. Feeling that things are "unreal"	0	1	2	3
32. Unnecessary or over-frequent washing	0	1	2	3
33. Feelings of inferiority	0	1	2	3
34. Feeling tense all the time	0	1	2	3
35. Being confused about your sexual feelings	0	1	2	3
36. Desire to physically hurt others	0	1	2	3
37. Feelings of guilt	0	1	2	3
38. Feeling that you are not always in your body	0	1	2	3
39. Having trouble breathing	0	1	2	3
40. Sexual feelings when you shouldn't have them	0	1	2	3

Important note: this measure assesses trauma-related problems in several categories. According to John Briere, PhD "***The TSC-40 is a research instrument only***. **Use of this scale is limited to professional researchers**. It is not intended as, nor should it be used as, a self-test under any circumstances." For a more current version of the measure, which can be used for clinical purposes (and for which there is a fee), consider the Trauma Symptom Inventory; contact Psychological Assessment Resources, 800-331-8378. The TSC-40 is freely available to researchers. No additional permission is required for use or reproduction of this measure, although the following citation is needed: Briere, J. N., & Runtz, M. G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. Journal of Interpersonal Violence, 4, 151-163. For further information on the measure, go to www.johnbriere.com.

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

Helping people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the ***last 30 days***.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

_____	1.	I am happy.
_____	2.	I am preoccupied with more than one person I help.
_____	3.	I get satisfaction from being able to help people.
_____	4.	I feel connected to others.
_____	5.	I jump or am startled by unexpected sounds.
_____	6.	I feel invigorated after working with those I help.
_____	7.	I find it difficult to separate my personal life from my life as a helper.
_____	8.	I am losing sleep over traumatic experiences of a person I help.
_____	9.	I think that I might have been “infected” by the traumatic stress of those I help.
_____	10.	I feel trapped by my work as a helper.
_____	11.	Because of my helping, I have felt “on edge” about various things.
_____	12.	I like my work as a helper.
_____	13.	I feel depressed as a result of my work as a helper.
_____	14.	I feel as though I am experiencing the trauma of someone I have helped .
_____	15.	I have beliefs that sustain me.
_____	16.	I am pleased with how I am able to keep up with helping techniques and protocols.
_____	17.	I am the person I always wanted to be.
_____	18.	My work makes me feel satisfied.
_____	19.	Because of my work as a helper, I feel exhausted.
_____	20.	I have happy thoughts and feelings about those I help and how I could help them.
_____	21.	I feel overwhelmed by the amount of work or the size of my casework load I have to deal with.
_____	22.	I believe I can make a difference through my work.
_____	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____	24.	I am proud of what I can do to help.
_____	25.	As a result of my helping , I have intrusive, frightening thoughts.
_____	26.	I feel “bogged down” by the system.
_____	27.	I have thoughts that I am a “success” as a helper.
_____	28.	I can't recall important parts of my work with trauma victims.
_____	29.	I am a very sensitive person.
_____	30.	I am happy that I chose to do this work.

with teachers, replace *helper* with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring:
    a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
    b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
    c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

Treatment Innovations
12 Colbourne Crescent
Suite 2
Brookline, MA 02445 USA
617-731-1501
e-mail : info@seekingsafety.org

Seeking Safety

www.seekingsafety.org

Seeking Safety Clinical Resources ORDER FORM

Please note: **you can return this form by email or regular mail. Payment can be by check, credit card, or purchase order (purchase order for institutions only).**

	Each	No.	Total
(a) **Videos** [all VHS format]:			
Set of all 4 videos listed below (one each of videos #1, 2, 3, 4)	$ 250	X _____	= $ _____
Video #1 – *Seeking Safety* (2 hours)	$ 95	X _____	= $ _____
Video #2 – *Therapy Session: Asking for Help (*1 hour)	$ 65	X _____	= $ _____
Video #3 – *Adherence Rating Session: Healthy Relationships* (1 hour)	$ 60	X _____	= $ _____
Video #4 – *A Client's Story* (20 minutes) and *Example of Teaching Grounding to a Client* (16 minutes)	$ 50	X _____	= $ _____
(b) **Poster** of Safe Coping Skills with scenic background	$ 14	X _____	= $ _____
(c) **Books**: *Seeking Safety* (English language)	$ 40	X _____	= $ _____
En busca de la seguridad (Seeking Safety, Spanish language)	$ 48	X _____	= $ _____
A Woman's Addiction Workbook	$ 20	X _____	= $ _____

Sales tax for Massachusetts shipping addresses only (add 5%) $ _____
Discount (if ordering 10 or more of same title or set, subtract 10%) $ _____

Shipping and handling

For shipment to U.S. addresses:

VIDEOS: there are three shipping options for videos shipped to a U.S. address (check one)

☐ Media mail (takes up to 2 weeks, but usually within 5-7 days) $1.50 per video ($6 for 4 videos, etc.) $_____
☐ First class mail (takes 3-5 days) $2.25 per video ($9 for 4 videos, etc.) $_____
☐ Fedex or UPS [rate varies by zone; can only be done via ordering by credit card *or* if you provide your "bill to" Fedex account number here] _____

POSTER: there are two shipping options for the poster shipped to a U.S. address (check one)

☐ First class mail (takes 3-5 days) $2 per poster ($4 for 2 posters, etc.) $_____
☐ Fedex or UPS (overnight by next business day) [rate varies by zone; can only be done via ordering by credit card *or* if you provide your "bill to" Fedex account number here] _____

BOOKS: there are three shipping options for books shipped to a U.S. address (check one)

☐ Media mail (takes up to 2 weeks, but usually within 5-7 days) $3 for 1st book, $1.50 per additional book (same title*) $_____
☐ First class mail (takes 3-5 days) $5 for 1st book, $3 per additional book (same title*) $_____
☐ Fedex or UPS (overnight by next business day) [rate varies by zone; can only be done via ordering by credit card *or* if you provide your "bill to" Fedex account number here] _____

*Note: if ordering two books but different titles (e.g., 1 Seeking Safety book and 1 Woman's Addiction Workbook), the rate for media mail would be $3 per book, totaling $6 shipping; the rate for 1st class mail would be $5 per book totaling $10 shipping.

For shipment to Canadian addresses:

Canada: $3 (USD) per video $_____
Canada: $4 (USD) per poster $_____
Canada: $5 (USD) per book $_____
Note: if ordering from Canada, and payment is by check, an additional fee of $4 USD is charged (which the bank here charges to process any Canadian check). A credit card order does not incur this fee. Canada check charge (if applicable) $_____

For shipment to international addresses (other than Canada):

Email info@seekingsafety.org for rate (depends on country)

Total Cost (in US Funds) $ _____

Shipping address: *(please print)*

*Name _____

Organization _____

*Address _____

_____

*City _____ *State/ Province _____ *Zip / Postal Code _____

*Country _____ *Email Address _____ *Telephone Number _____

Return policy: Videos cannot be returned for refund; exchanges only if defective (within 45 days of shipping). The poster and books cannot be returned for refund. If any item arrives damaged, please mail it back and a replacement will be sent.
Privacy policy: Your information will never, ever be shared with anyone or sold to any list. It is only used to process your order.
Replacement policy: If you buy any video, and it later wears out or becomes unusable, it can be replaced for a fee of $20, plus shipping. Please email info@seekingsafety.org for instructions before you return it.

Method of payment:

☐ Check enclosed. Please make check payable to *Treatment Innovations*.
☐ Purchase Order (institutions only): attach PO to this form. Name and information for authorized contact person for PO:
Name: _____ Phone: _____ Email: _____
☐ Credit card: Mastercard or Visa. Please provide your credit card information below.

For Credit Card Orders only: Printed Name on the Card: _____ Circle one: Mastercard / Visa

Credit card# _____ Expiration Date _____ / _____

Is your credit card name/address exactly the same as the Shipping address information you provided above? Yes / No. If no, provide it here:

*Name _____

Organization _____

*Address _____ _____

*City _____ *State/ Province _____ *Zip / Postal Code _____

*Country _____ *Email Address _____

*Telephone Number _____

Please email this form to info@seekingsafety.org (as an attachment) or send it by regular mail to Treatment Innovations, 12 Colbourne Crescent, Brookline, MA 02445. If you would like a receipt, it will be sent via email; please check here: _____.

For more information, see www.seekingsafety.org or email info@seekingsafety.org

c) **Recommended treatment strategies**

- Treat both disorders at the same time, according to experts. Also, clients prefer this.
- Decide *how* to treat PTSD in context of active substance abuse. Options:

Type 1) Focus on present only (coping skills, psychoeducation, educate about symptoms) [safest approach, widely recommended]

Type 2) Focus on past only (tell the trauma story) [high risk; works for some clients]

Type 3) Focus on both present and past

d) **Diversity Issues**

- In the US, rates of PTSD do not differ by race (Kessler et al., 1995). Substance abuse: Hispanics and African-Americans have lower rates than Caucasians; Native Americans have higher rates than Caucasians (Kessler et al., 1995, 2005). Rates of abuse increase with acculturation. Some cultures have protective factors (religion, kinship).
- It is important to respect cultural differences and tailor treatment to be sensitive to historical prejudice. Also, terms such as "trauma," "PTSD," and "substance abuse" may be interpreted differently based on culture.

The *Seeking Safety* Treatment

a) **About *Seeking Safety***

✧ A present-focused therapy to help clients (male and female) attain safety from PTSD and substance abuse.

✧ 25 topics that can be conducted in any order:

- Interpersonal topics: Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources
- Cognitive topics: PTSD: Taking Back Your Power, Compassion, When Substances Control You, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking
- Behavioral topics: Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding)
- Other topics: Introduction/Case Management, Safety, Life Choices, Termination

✧ Designed for flexible use: can be conducted in group or individual format; for women, men, or mixed-gender; using all topics or fewer topics; in a variety of settings; and with a variety of providers.

b) **Key principles of *Seeking Safety***

ᘓ Safety as the goal for first-stage treatment (later stages are mourning and reconnection)

ᘓ Integrated treatment (treat both disorders at the same time)

ᘓ A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse

ᘓ Four content areas: cognitive, behavioral, interpersonal, case management

ᘓ Attention to therapist processes: balance praise and accountability; notice countertransference (sadism, scapegoating, victimization, giving up on clients); all-out effort; self-care

c) **Additional features**

∗ Trauma details not part of group therapy; in individual therapy, assess client's safety and monitor carefully (particularly if has history of severe trauma, or if client is actively using substances)

∗ Identify meanings of substance use in context of PTSD (e.g., substance use as revenge against abuser; reenactment of abuse toward self; to remember feelings or memories; to numb out feelings or memories; to live; to die)

∗ "Optimistic": focus on strengths and future

∗ Help clients obtain more treatment and attend to daily life problems (housing, AIDS, jobs)

∗ Harm reduction model

∗ 12-step groups encouraged, not required

∗ Give clients control whenever possible

∗ Make the treatment engaging: quotations, everyday language

∗ Emphasize core concepts (e.g., "You can get better")

d) **Evidence Base**

"Tough Cases" -- Rehearsing Difficult Client Scenarios

Below are examples of "tough cases" in the treatment of PTSD and substance abuse. They are organized by themes related to this dual diagnosis.

Trauma/PTSD:
* "I'll never recover from PTSD."
* "Reading about trauma makes me want to burn myself."
* "How can I give up substances when I still have such severe PTSD?"

Substance Abuse:
* "Using cocaine makes my PTSD better—I can't give it up."
* "It's my alter who drinks and she's not here now" (dissociative identity disordered client)
* "I definitely think I can do controlled drinking."
* "Do I have to get clean before working on my PTSD?"
* "In AA they said to me, 'You don't drink because you were molested as a child, you drink because you're an alcoholic.'

Self-Nurturing:
* "I just can't experience pleasure—nothing feels fun to me."
* "All of the people I know drink to have a good time."
* "Whenever I try to do something pleasurable I feel guilty."
* "My partner doesn't want me to go out of the house."

Safety:
* "I don't want to stay safe; I want to die."
* "Safe coping skills are a nice idea, but when I get triggered it's so fast that I don't even have time to think about what I'm doing."
* "I feel like I need mourn my trauma now, not wait until later."

Boundaries in Relationships:
* "I can't say 'no'. It makes me feel I'm being mean, like my abuser."
* "When I say 'no' to my partner I get hit."
* "I want to set a boundary with you-- stop telling me to get off substances! I'm not ready."
* "You tell me to reach out to others, but I feel safer alone."
* "My cousin keeps offering me crack no matter how much I say not to."

Honesty:
* "But it will hurt the other person if I'm honest."
* "I can be honest in the role-play, but in real life I could never do it."
* "I won't tell my doctor that I abuse alcohol."
* "Should I tell everyone at work that I'm an addict?"
* "Are you telling me I'm a liar?"
* "When I was growing up, I told my mother that my brother molested me and she said I was lying."

Creating Meaning:
* "My thoughts are bad, just like I'm bad."
* "But my negative thoughts really are true!"
* "Positive thinking never works for me."

Stressful Life Experiences Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewha t stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then	Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.		
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.		
	I have witnessed or experienced a serious accident or injury.		
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.		
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.		
	I have witnessed or experienced the death of my spouse or child.		
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).		
	I or a close friend or family member has been kidnapped or taken hostage.		
	I or a close friend or family member has been the victim of a terrorist attack or torture.		
	I have been involved in combat or a war or lived in a war affected area.		
	I have seen or handled dead bodies other than at a funeral.		
	I have felt responsible for the serious injury or death of another person.		
	I have witnessed or been attacked with a weapon other than in combat or family setting		
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury		
	As an adult, I was hit, choked or pushed hard enough to cause injury		
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.		
	As a child/teen I was forced to have unwanted sexual contact.		
	As an adult I was forced to have unwanted sexual contact.		
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact		
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____		

Positive outcomes have been found in the 11 completed studies on *Seeking Safety*. For a description of each study and the full article, go to www.seekingsafety.org (section "Research"). The studies are: outpatient women (Najavits et al., 1998); women in prison (Zlotnick et al., 2003); women in a community mental health setting (Holdcraft & Comtois, 2002); low-income urban women, in individual format (Hien et al., 2004); adolescent girls (Najavits et al., under review); men and women veterans (Cook et al., in press); homeless women veterans (Desai & Rosenheck, 2006), women with co-occurring disorders in group format (Morrissey et al., 2005), outpatient men traumatized as children (Najavits et al., 2005), women veterans (Weller), and women in outpatient treatment (Mcnelis-Domingos, 2004). Seven studies were pilots (Cook et al., in press; Holdcraft & Comtois, 2002; Mcnelis-Domingos, 2004; Najavits et al., 2005; Najavits et al., 1998; Weller, 2005; Zlotnick et al., 2003), and four were controlled trials (Desai & Rosenheck, 2006; Hien et al., 2004; Morrissey et al., 2005; Najavits et al., under review). Two were multisite trials (Desai & Rosenheck, 2006; Morrissey et al., 2005).

e) **Resources on *Seeking Safety*.** All below can be ordered from www.seekingsafety.org.

✧ **Book (English):** *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Provides clinician guide and all client handouts (section Seeking Safety). Can also be ordered from regular bookstores.

✧ **Book (Spanish):** Spanish language translation of the book (section Store).

✧ **Video training series:** four videos provide training on Seeking Safety (section Store). (1) *Seeking Safety* (two hour training video by Lisa Najavits); (2) *Asking for Help* (one-hour demonstration of a group session with real clients); (3) *A Client's Story* (26 minute unscripted life story by a male trauma survivor) and *Teaching Grounding* (16 minute example of the grounding script from Seeking Safety with a male client); (4) *Adherence Session* (one hour session that can be rated with the Seeking Safety Adherence Scale).

✧ **Poster:** poster of over 80 safe coping skills, 24x30, full-color, scenic background (section Store).

✧**Training:** training calendar and information on setting up a training (section Training).

✧ **Research articles:** all articles related to Seeking Safety can be downloaded free (section Research).

✧ **Adherence Scale:** can be downloaded free (section Measures).

✧ **Assessment tools:** can be downloaded free (section Measures).

Contact Information

Contact: Lisa Najavits, PhD, *Treatment Innovations*, 12 Colbourne Crescent, Suite 2, Brookline, MA 02478; 617-731-1501 [phone]; info@seekingsafety.org [email]; www.seekingsafety.org [web]

Resources on Substance Abuse and PTSD

a) **Substance abuse**	
National Clearinghouse for Alcohol and Drug Information	800-729-6686; www.health.org
National Drug Information, Treatment and Referral Hotline	800-662-HELP; http://csat.samsha.gov
Alcoholics Anonymous	800-637-6237
SMART Recovery (alternative to AA)	www.smartrecovery.org
National Institute on Drug Abuse (Info-Fax Service)	888-NIH-NIDA; www.nida.nih.gov
Addiction Technology Transfer Centers	www.nattc.org
Harm Reduction Coalition	212-213-6376; www.harmreduction.org
b) **Trauma / PTSD**	
International Society for Traumatic Stress Studies	708-480-9028; www.istss.org
International Society for the Study of Dissociation	847-480-9282; www.issd.org
PTSD Alliance	877-507-PTSD; www.ptsdalliance.org
National Centers for PTSD (extensive literature on PTSD)	802-296-5132; www.ncptsd.org
Sidran Foundation (trauma information, support)	410-825-8888; www.sidran.org
National Resource Center on Domestic Violence	800-537-2238; www.nrcdv.org
Many Voices (trauma survivors newsletter)	513-751-8020; www.manyvoicespress.com
Community screening for PTSD and other disorders	www.mentalhealthscreening.org

Educational Materials

Books on PTSD

1. Herman J. L. (1992). Trauma and Recovery. New York, Basic Books.
2. Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors. New York: WW Norton.
3. Foa E. B., Rothbaum, B. O. (1998). Treating the Trauma of Rape. New York: Guilford.
4. Resick, P.A., & Schnicke, M.K. (1993). Cognitive processing therapy for rape victims: A treatment manual. Newbury Park, CA: Sage Publications.
5. Schiraldi, G. R. (2000). The Post-Traumatic Stress Disorder Sourcebook. Los Angeles: Lowell House.

Books on Substance Abuse

1. Beck A. T., Wright J., et al. (1993). Cognitive Therapy of Substance Abuse. New York: Guilford.
2. Marlatt G., Gordon J. (1985). Relapse Prevention. New York: Guilford.
3. Fletcher, A. (2001). Sober for Good. Boston: Houghton Mifflin.
4. Najavits L. M. (2002). A Woman's Addiction Workbook. Oakland, CA: New Harbinger.
5. Miller, W. R., Zweben, A., et al. (1995). Motivational Enhancement Therapy Manual (Vol. 2). Rockville, MD: U.S. Department of Health and Human Services.

Books on PTSD and Substance Abuse

1. Najavits L. M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford. *Spanish version also available (www.seekingsafety.org;* section Store)
2. Evans K., Sullivan J. M. (1995). Treating Addicted Survivors of Trauma. New York: Guilford.
4. Ouimette, P. & Brown, P. (2002) Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders. Washington, DC: American Psychological Association Press.
5. Fallot, R.D. & Harris, M. (2001). Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services. San Francisco: Jossey-Bass.

Videos

a) Najavits, L.M. (2006). Video training series on Seeking Safety*; www.seekingsafety.org* (section Store).
b) Najavits, L.M., Abueg F, Brown PJ, et al. (1998). Nevada City, CA: Cavalcade [800-345-5530]. Trauma and substance abuse. Part I: Therapeutic approaches [*For professionals];* Part II: Special treatment issues [*For professionals];* Numbing the Pain: Substance abuse and psychological trauma [*For clients]*

Clinically-Relevant Articles

1. Golier, J.A., Yehuda, R. et al. (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. American J Psychiatry,160, 2018-24.
2. Brady, K.T., Dansky, B.S. et al. (2001). Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Preliminary findings. J Substance Abuse Treatment, 21, 47-54.
3. Donovan, B., Padin-Rivera, E. (2001). Transcend: Initial outcomes from a posttraumatic stress disorder / substance abuse treatment program. J Traumatic Stress, 14, 757-772.
4. Kessler, R.C., Sonnega, A., et al. (1995). Posttraumatic stress disorder in the national comorbidity survey. Archives of General Psychiatry, 52, 1048-1060. *[Provides rates]*
5. Najavits, L.M. (2004). Assessment of trauma, PTSD, and substance use disorder: A practical guide. In J. P. Wilson & T. M. Keane (Eds.), *Assessment of Psychological Trauma and PTSD* (pp. 466-491). New York: Guilford.
6. Najavits, L.M. (2000). Training clinicians to conduct the *Seeking Safety* treatment for PTSD and substance abuse. Alcoholism Treatment Quarterly, 18, 83-98.
7. Najavits, L.M. Treatment of posttraumatic stress disorder and substance abuse: Clinical guidelines for implementing *Seeking Safety* therapy. Alcoholism Treatment Quarterly, 2004; 22:43-62.
8. Najavits, L.M., Weiss, R.D. et al. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. American J on the Addictions, 6, 273-283.
9. Follette, VM & Ruzek, JI (2006). Cognitive-Behavioral Therapies for Trauma (pp. 226-255). New York: Guilford.
10. Triffleman, E., Carroll, K. et al. (1999). Substance dependence posttraumatic stress disorder therapy: An integrated cognitive-behavioral approach. J Substance Abuse Treatment, 17, 3-14.
11. Vogelmann-Sine, S., Sine, L., et al. (1998). EMDR: Chemical Dependency Treatment Manual. Unpublished manuscript, Honolulu, Hawaii.

Assessment of Mental Disorders

https://medical-outcomes.com/HTMLFiles/MINI/MINI.htm [MINI International Neuropsychiatric Disorder]-free

Pubmed (medical literature)

http://www.ncbi.nlm.nih.gov/entrez/

Safe Coping Skills (Part 1)

from "Seeking Safety: Cognitive- Behavioral Therapy for PTSD and Substance Abuse"
by Lisa M. Najavits, Ph.D.

1. Ask for help- Reach out to someone safe **2. Inspire yourself-** Carry something positive (e.g., poem), or negative (photo of friend who overdosed) **3. Leave a bad scene-** When things go wrong, get out **4. Persist-** Never, never, never, never, never, never, never, never, never give up **5. Honesty-** Secrets and lying are at the core of PTSD and substance abuse; honesty heals them **6. Cry-** Let yourself cry; it will not last forever **7. Choose self-respect-** Choose whatever will make you like yourself tomorrow **8. Take good care of your body-** Eat right, exercise, sleep, safe sex **9. List your options-** In any situation, you have choices **10. Create meaning-** Remind yourself what you are living for: your children? Love? Truth? Justice? God? **11. Do the best you can with what you have-** Make the most of available opportunities **12. Set a boundary-** Say "no" to protect yourself **13. Compassion-** Listen to yourself with respect and care **14. When in doubt, do what's hardest-** The most difficult path is invariably the right one **15. Talk yourself through it-** Self-talk helps in difficult times **16. Imagine-** Create a mental picture that helps you feel different (e.g., remember a safe place) **17. Notice the choice point-** In slow motion, notice the exact moment when you chose a substance **18. Pace yourself-** If overwhelmed, go slower; if stagnant, go faster **19. Stay safe-** Do whatever you need to do to put your safety above all **20. Seek understanding, not blame-** Listen to your behavior; blaming prevents growth **21. If one way doesn't work, try another-** As if in a maze, turn a corner and try a new path **22. Link PTSD and substance abuse-** Recognize substances as an attempt to self- medicate **23. Alone is better than a bad relationship-** If only treaters are safe for now, that's okay **24. Create a new story-** You are the author of your life: be the hero who overcomes adversity **25. Avoid avoidable suffering-** Prevent bad situations in advance **26. Ask others-** Ask others if your belief is accurate **27. Get organized-** You'll feel more in control with lists, "to do's" and a clean house **28. Watch for danger signs-** Face a problem before it becomes huge; notice red flags **29. Healing above all-** Focus on what matters **30. Try something, anything-** A good plan today is better than a perfect one tomorrow **31. Discovery-** Find out whether your assumption is true rather than staying "in your head" **32. Attend treatment-** AA, self-help, therapy, medications, groups- anything that keeps you going **33. Create a buffer-** Put something between you and danger (e.g., time, distance) **34. Say what you really think-** You'll feel closer to others (but only do this with safe people) **35. Listen to your needs-** No more neglect- really hear what you need **36. Move toward your opposite-** E.g., if you are too dependent, try being more independent **37. Replay the scene-** Review a negative event: what can you do differently next time? **38. Notice the cost-** What is the price of substance abuse in your life? **39. Structure your day-** A productive schedule keeps you on track and connected to the world **40. Set an action plan-** Be specific, set a deadline, and let others know about it **41. Protect yourself-** Put up a shield against destructive people, bad environments, and substances **42. Soothing talk-** Talk to yourself very gently (as if to a friend or small child)

With appreciation to the Allies Program (Sacramento, CA) for formatting this Safe Coping List.

Safe Coping Skills (Part 2)

from "Seeking Safety: Cognitive- Behavioral Therapy for PTSD and Substance Abuse"
by Lisa M. Najavits, Ph.D.

43. Think of the consequences- Really see the impact for tomorrow, next week, next year **44. Trust the process**- Just keep moving forward; the only way out is through **45. Work the material**- The more you practice and participate, the quicker the healing **46. Integrate the split self**- Accept all sides of yourself; they are there for a reason **47. Expect growth to feel uncomfortable**- If it feels awkward or difficult you're doing it right **48. Replace destructive activities**- Eat candy instead of getting high **49. Pretend you like yourself**- See how different the day feels **50. Focus on now**- Do what you can to make today better; don't get overwhelmed by the past or future **51. Praise yourself**- Notice what you did right; this is the most powerful method of growth **52. Observe repeating patterns**- Try to notice and understand your re-enactments **53. Self- nurture**- Do something that you enjoy (e.g., take a walk, see a movie) **54. Practice delay**- If you can't totally prevent a self-destructive act, at least delay it as long as possible **55. Let go of destructive relationships**- If it can't be fixed, detach **56. Take responsibility**- Take an active, not a passive approach **57.Set a deadline**- Make it happen by setting a date **58. Make a commitment**- Promise yourself to do what's right to help your recovery **59. Rethink**- Think in a way that helps you feel better **60. Detach from emotional pain (grounding)**- Distract, walk away, change the channel **61. Learn from experience**- Seek wisdom that can help you next time **62. Solve the problem**- Don't take it personally when things go wrong- try to just seek a solution **63. Use kinder language**- Make your language less harsh **64. Examine the evidence**- Evaluate both sides of the picture **65. Plan it out**- Take the time to think ahead-it's the opposite of impulsivity **66. Identify the belief**- For example, shoulds, deprivation reasoning **67. Reward yourself**- Find a healthy way to celebrate anything you do right **68. Create new "tapes"** Literally! Take a tape recorder and record a new way of thinking to play back **69. Find rules to live by**- Remember a phrase that works for you (e.g., "Stay real") **70. Setbacks are not failures**- A setback is just a setback, nothing more **71. Tolerate the feeling**- "No feeling is final", just get through it safely **72. Actions first and feelings will follow**- Don't wait until you feel motivated; just start now **73. Create positive addictions**- Sports, hobbies, AA… **74. When in doubt, don't**- If you suspect danger, stay away **75. Fight the trigger**- Take an active approach to protect yourself **76. Notice the source**- Before you accept criticism or advice, notice who's telling it to you **77. Make a decision**- If you're stuck, try choosing the best solution you can right now; don't wait **78. Do the right thing**- Do what you know will help you, even if you don't feel like it **79. Go to a meeting**- Feet first; just get there and let the rest happen **80. Protect your body from HIV**- This is truly a life-or-death issue **81. Prioritize healing**- Make healing your most urgent and important goal, above all else **82. Reach for community resources**- Lean on them! They can be a source of great support **83. Get others to support your recovery**- Tell people what you need **84. Notice what you can control**- List the aspects of your life you do control (e.g., job, friends…)

Lisa Najavits, PhD

Detaching From Emotional Pain (Grounding)

WHAT IS GROUNDING?

Grounding is a set of simple strategies to *detach from emotional pain* (for example, drug cravings, self-harm impulses, anger, sadness). Distraction works by **focusing outward on the external world**-- rather than inward toward the self. You can also think of it as "distraction," "centering," "a safe place," "looking outward," or "healthy detachment."

WHY DO GROUNDING?

When you are overwhelmed with emotional pain, you need a way to detach so that you can gain control over your feelings and stay safe. As long as you are grounding, you cannot possibly use substances or hurt yourself! Grounding "anchors" you to the present and to reality.

Many people with PTSD and substance abuse struggle with either feeling too much (overwhelming emotions and memories) or too little (numbing and dissociation). In grounding, you attain balance between the two-- conscious of reality and able to tolerate it.

Guidelines

- Grounding can be done any time, any place, anywhere and no one has to know.
- Use grounding when you are: faced with a trigger, having a flashback, dissociating, having a substance craving, or when your emotional pain goes above 6 (on a 0-10 scale). Grounding puts healthy distance between you and these negative feelings.
- Keep your eyes open, scan the room, and turn the light on to stay in touch with the present.
- Rate your mood before and after to test whether it worked. Before grounding, rate your level of emotional pain (0-10, where means "extreme pain"). Then re-rate it afterwards. Has it gone down?
- No talking about negative feelings or journal writing. You want to distract *away* from negative feelings, not get in touch with them.
- Stay neutral-- no judgments of "good" and "bad". For example, "The walls are blue; I dislike blue because it reminds me of depression." Simply say "The walls are blue" and move on.
- Focus on the present, not the past or future.
- Note that grounding is *not* the same as relaxation training. Grounding is much more active, focuses on distraction strategies, and is intended to help extreme negative feelings. It is believed to be more effective for PTSD than relaxation training.

WAYS TO GROUND

Mental Grounding

- Describe your environment in detail using all your senses. For example, "The walls are white, there are five pink chairs, there is a wooden bookshelf against the wall..." Describe objects, sounds, textures, colors, smells, shapes, numbers, and temperature. You can do this anywhere. For example, on the subway: "I'm on the subway. I'll see the river soon. Those are the windows. This is the bench. The metal bar is silver. The subway map has four colors..."
- Play a "categories" game with yourself. Try to think of "types of dogs", "jazz musicians", "states that begin with 'A'", "cars", "TV shows", "writers", "sports", "songs", "European cities."
- Do an age progression. If you have regressed to a younger age (e.g., 8 years old), you can slowly work your way back up (e.g., "I'm now 9"; "I'm now 10"; "I'm now 11"…) until you are back to your current age.
- Describe an everyday activity in great detail. For example, describe a meal that you cook (e.g., "First I peel the potatoes and cut them into quarters, then I boil the water, I make an herb marinade of oregano, basil, garlic, and olive oil…").
- Imagine. Use an image: *Glide along on skates away from your pain*; *change the TV channel to get to a better show*; think of *a wall as a buffer between you and your pain.*
- Say a *safety statement.* "My name is ____; I am safe right now. I am in the present, not the past. I am located in _____; the date is _____."
- Read something, saying each word to yourself. Or read each letter backwards so that you focus on the letters and not on the meaning of words.
- Use humor. Think of something funny to jolt yourself out of your mood.
- Count to 10 or say the alphabet, very s..l..o..w..l..y.
- Repeat a favorite saying to yourself over and over (e.g., the Serenity Prayer).

Physical Grounding

- Run cool or warm water over your hands.
- Grab tightly onto your chair as hard as you can.
- Touch various objects around you: a pen, keys, your clothing, the table, the walls. Notice textures, colors, materials, weight, temperature. Compare objects you touch: Is one colder? Lighter?
- Dig your heels into the floor-- literally "grounding" them! Notice the tension centered in your heels as you do this. Remind yourself that you are connected to the ground.
- Carry a *grounding object* in your pocket-- a small object (a small rock, clay, ring, piece of cloth or yarn) that you can touch whenever you feel triggered.
- Jump up and down.
- Notice your body: The weight of your body in the chair; wiggling your toes in your socks; the feel of your back against the chair. You are connected to the world.
- Stretch. Extend your fingers, arms or legs as far as you can; roll your head around.
- Walk slowly, noticing each footstep, saying "left","right" with each step.
- Eat something, describing the flavors in detail to yourself.
- Focus on your breathing, noticing each inhale and exhale. Repeat a pleasant word to yourself on each inhale (for example, a favorite color or a soothing word such as "safe," or "easy").

Soothing Grounding

- ❖ Say kind statements, as if you were talking to a small child. E.g., "You are a good person going through a hard time. You'll get through this."
- ❖ Think of favorites. Think of your favorite color, animal, season, food, time of day, TV show.
- ❖ Picture people you care about (e.g., your children; and look at photographs of them).
- ❖ Remember the words to an inspiring song, quotation, or poem that makes you feel better (e.g., the Serenity Prayer).
- ❖ Remember a safe place. Describe a place that you find very soothing (perhaps the beach or mountains, or a favorite room); focus on everything about that place-- the sounds, colors, shapes, objects, textures.
- ❖ Say a coping statement. "I can handle this", "This feeling will pass."
- ❖ Plan out a safe treat for yourself, such as a piece of candy, a nice dinner, or a warm bath.
- ❖ Think of things you are looking forward to in the next week, perhaps time with a friend or going to a movie.

WHAT IF GROUNDING DOES NOT WORK?

- Practice as often as possible, even when you don't "need" it, so that you'll know it by heart.
- Practice faster. Speeding up the pace gets you focused on the outside world quickly.
- Try grounding for a looooooonnnnngggg time (20-30 minutes). And, repeat, repeat, repeat.
- Try to notice whether you do better with "physical" or "mental" grounding.
- Create your own methods of grounding. Any method you make up may be worth much more than those you read here because it is *yours*.
- Start grounding early in a negative mood cycle. Start when the substance craving just starts or when you have just started having a flashback.

Taking Good Care of Yourself

Answer each question below "yes" or "no."; if a question does not apply, leave it blank.

DO YOU…

♥Associate only with safe people who do not abuse or hurt you? YES___ NO___
♥Have annual medical check-ups with a:
- •Doctor? YES___ NO ___
- •Dentist? YES___ NO ___
- •Eye doctor? YES ___NO ___
- •Gynecologist (women only)? YES ___ NO ___

♥Eat a healthful diet? (healthful foods and not under- or over-eating) YES ___ NO ___
♥Have safe sex? YES ___ NO ___
♥Travel in safe areas, avoiding risky situations (e.g., being alone in deserted areas)? YES ___ NO ___
♥Get enough sleep? YES ___ NO ___
♥Keep up with daily hygiene (clean clothes, showers, brushing teeth, etc.)? YES ___ NO ___
♥Get adequate exercise (not too much nor too little)? YES ___ NO ___
♥Take all medications as prescribed? YES __ NO___
♥Maintain your car so it is not in danger of breaking down? YES ___ NO ___
♥Avoid walking or jogging alone at night? YES___ NO ___
♥Spend within your financial means? YES___ NO ___
♥Pay your bills on time? YES___ NO ___
♥Know who to call if you are facing domestic violence? YES___ NO ___
♥Have safe housing? YES___ NO ___
♥Always drive substance-free? YES___ NO ___
♥Drive safely (within 5 miles of the speed limit)? YES___NO___
♥Refrain from bringing strangers home to your place? YES___ NO ___
♥Carry cash, ID, and a health insurance card in case of danger? YES___ NO ___
♥Currently have at least two drug-free friendships? YES ___ NO ___
♥Have health insurance? YES___ NO ___
♥Go to the doctor/dentist for problems that need medical attention? YES__NO__
♥Avoid hiking or biking alone in deserted areas? YES___ NO ___
♥Use drugs or alcohol in moderation or not at all? YES ___ NO ___
♥Not smoke cigarettes? YES ___ NO ___
♥Limit caffeine to fewer than 4 cups of coffee per day or 7 colas? YES ___ NO ___
♥Have at least one hour of free time to yourself per day? YES ___ NO ___
♥Do something pleasurable every day (e.g., go for a walk)? YES___ NO___
♥Have at least three recreational activities that you enjoy (e.g., sports, hobbies— but not substance use!) ? YES___ NO___
♥Take vitamins daily? YES___NO___
♥Have at least one person in your life that you can truly talk to (therapist, friend, sponsor, spouse)? YES___NO___
♥Use contraceptives as needed? YES___NO___
♥Have at least one social contact every week? YES___NO___
♥Attend treatment regularly (e.g., therapy, group, self-help groups)? YES___NO___
♥Have at least 10 hours per week of structured time? YES ___ NO ___
♥Have a daily schedule and "to do" list to help you stay organized? YES___NO___

California Conference on Alcohol and Other Drug Prevention, Treatment and Recovery 2006

KEYNOTE ADDRESS

ADDICTION AND THE HUMAN BRAIN

Pat Wolfe, EDD
Mind Matters, Inc.

Day Three: Friday, September 8, 2006
11:45 – 1:30 p.m.

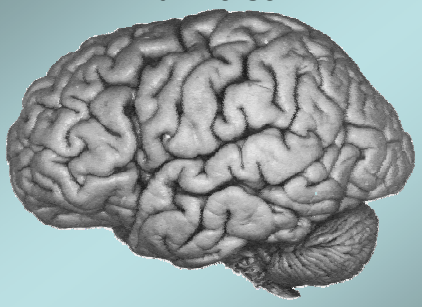
California Department of Alcohol & Drug Programs

The Brain and Addiction

Presented by Pat Wolfe, Ed.D.

ADP Conference
Sacramento
September 8, 2006

The brain, our 3-pound universe!

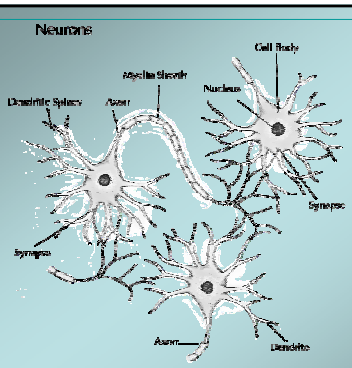


Neural Plasticity

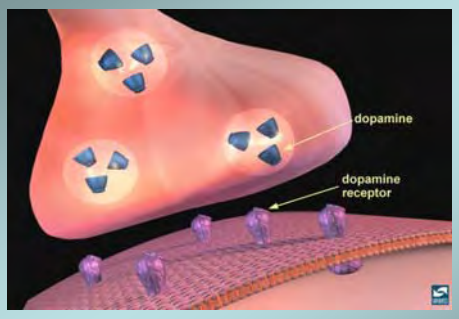
- The most amazing thing we've learned is that the brain is the only organ in the body that sculpts itself, positively or negatively, based on experience!
- In the case of addiction, every drug actually causes the brain to reorganize on a cellular level
- Some drugs literally destroy cells or functions of the brain

Addiction as a Brain Disease

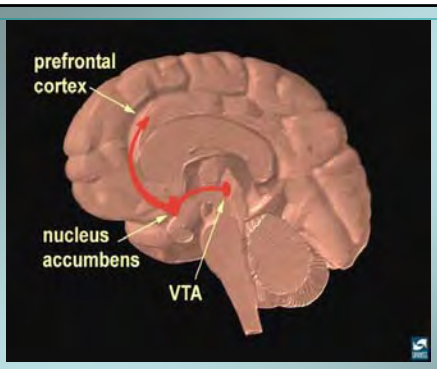
- While addiction begins with the voluntary behavior of taking drugs, most scientists - and the AMA - agree that addiction is a brain disease
- The substance-dependent brain is physiologically and chemically different from the normal brain
- The progression of the disease is complex, influenced by genetic and environmental factors



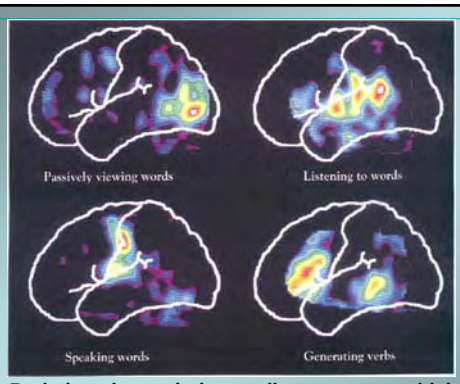
The brain is composed of over 100 billion brain cells (neurons) which communicate at junctures called synapses.



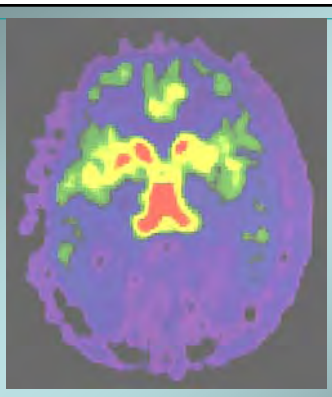
When a neuron is stimulated, it sends an electrical impulse to the synapse. This releases various types of chemicals (called neurotransmitters) which fit into receptor sites on the receiving neuron.



The brain has a reward circuit which is designed to increase the probability of survival. The neurons in this "pleasure center" release feel good neurotransmitters.



Brain imaging techniques allow us to see which areas of the brain control various functions.



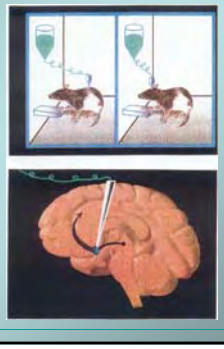
PET scan of the brain's opiate receptors

The Reward Circuit & Natural Opiates

- The brain uses its own natural opiates to reward behaviors that enhance survival. They are released by:
  - Food
  - Social Interactions
  - Sex
- Among these neurotransmitters are endorphins, noradrenalin, and dopamine

Early Animal Research

- In the 1950s, two scientists from Canada discovered that rats will keep pushing a lever to obtain cocaine to the exclusion of all other behavior

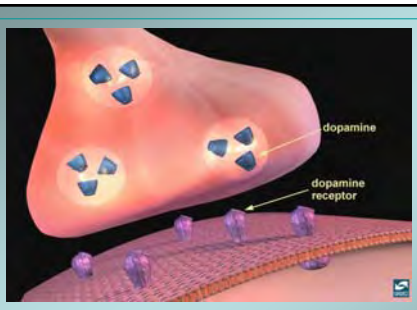


Drugs Hijack the Brain's Reward System

- How do non-natural opiates (drugs) produce effects in the brain when there are no receptor sites for them?
- Some drugs of abuse are so similar to neurotransmitters in their chemical composition that they fit into the receptor sites of the brain's own opiates

Dopamine – the Primary Molecule of Addiction

- Nearly all drugs of abuse cause the reward pathway to receive a flood of dopamine
- Initially dopamine produces euphoria and mediates reward and reinforcement
- But over time there are additional effects…

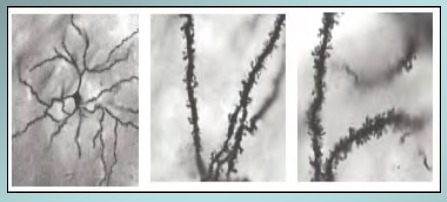


Cocaine blocks or occupies dopamine transporter sites and prevents dopamine from returning to the brain cells that release it. This allows high concentrations of dopamine to remain available in the brain longer than normal.

Tolerance

- When the brain is consistently subjected to artificially high levels of dopamine, the brain "downshifts" its internal supply
- If the extra dopamine supplied by drugs is missing, the addict feels much less pleasure, is often depressed and fatigued, and goes into withdrawal
- The only relief from these symptoms comes from using more and more of the drug

Sensitization



The first two micrographs show neuron branches of animals exposed to non-addictive drugs.

The micrograph on the right is from an animal addicted to cocaine. The neuron has developed additional spines on the branch making the neuron more sensitive to cocaine.

Dependence

- When the addict stops taking the drug, dramatic withdrawal symptoms appear
- Withdrawal from alcohol or heroin include gastrointestinal problems, shaking, cramps and difficulty breathing; withdrawal from crack cocaine and methamphetamine result in depression and sadness
- The addict has become dependent on the drug. The result is uncontrollable, compulsive craving for the drug

Genetic Factors

- Addiction is a complex interaction between what the drug is doing to the brain, and what the state of the brain was when you started using drugs
- People with a particular kind of severe, early-onset alcoholism are genetically predisposed to it
- New research has uncovered a genetic predisposition to how much one likes marijuana

Genes and Dopamine Levels

- Every brain is unique in its chemical composition. Some brains have more receptors for dopamine than others
- Studies are studying the D2 dopamine receptor levels in abusers vs. non-drug abusers
- Persons with low levels, appear to be more predisposed to addiction

Memory & Relapse

- When dopamine is released during drug use, the major memory structure in the brain (hippocampus) is activated
- This causes the memory of the event and the surrounding environment to be strengthened
- Years after drug abuse has ended, exposure to this (or a similar) environment can cause craving for the drug to return

Can Memory Be Blocked?

- A hormone called orexin appears to play a role in strengthening memories
- When given an orexin blocker, animals do not remember the environmental cues

Can the Addicted Brain Change Back?

- Because of neural plasticity, some change is always possible
- However, the recovery will depend on the amount of damage done to cells and cell circuits. Some of the changes may be irreversible
- It is important to focus on what drove the person to using drugs in the first place