FIFTH ANNUAL CONFERENCE

Friday, May 1, 2009

NEA BPD

YALE-NEW HAVEN PSYCHIATRIC HOSPITAL

NAMI Connecticut

Borderline Personality Disorder

and

Problems of Substance Use

May is Borderline Personality Disorder Awareness Month

H R 1005 Passed April 1, 2008

The Mary S. Harkness Auditorium

Sterling Hall of Medicine, Yale University School of Medicine

PROGRAM
Borderline Personality Disorder and Problems of Substance Use

FRIDAY

May 1, 2009

8:00 am Registration and Coffee

8:30 am *Welcome and Opening Remarks:*
Perry D. Hoffman, PhD
Seth R. Axelrod; PhD
Dwain C. Fehon, PsyD

- **Moderator for the day: Seth R. Axelrod, PhD**

8:45 am *BPD and Substance Use Disorders Comorbidity*..... Samuel A. Ball, PhD

9:45 am *Seeking Safety for PTSD and SUD*.....Lisa M. Najavits, PhD

10:45 am Break

11:00 am *Psychopharmacology of BPD and SUD* ... Elizabeth Ralevski, PhD

12:00 pm *Family and Consumer Perspectives* ...

12:30 pm Lunch

1:30 pm *What are empirically supported therapies for substance use disorders, where did we get them, and what do we do with them?*
...Kathleen M. Carroll, PhD

2:15 pm *DBT for BPD and Substance Use Disorders* ... M. Zachary Rosenthal, PhD

3:15 pm Break

3:30 pm *Dynamic Deconstructive Psychotherapy for BPD*....Robert Gregory, MD

4:30 pm *Panel Discussion: Developing and Disseminating BPD+SUD Treatments*
.....Drs. Carroll, Gregory, Najavits, Rosenthal. Moderated by Dr. Axelrod

5:00 pm Closing Remarks and Adjourn

Yale University

Department of Psychiatry
School of Medicine
425 George Street
New Haven, Connecticut 06455

May 1, 2009

It gives me such pleasure to welcome you to this fifth annual Yale BPD conference, ***Borderline Personality Disorder and Problems of Substance Use.*** Our conferences continue to be open to consumers, family members, mental health trainees, and helping professionals, and we have continued in our spirit of enhancing our understanding of these challenges through a partnership of consumers, family members, and professionals. Worthy of note, today's conference falls on the first day of the second annual **National Borderline Disorder Awareness Month** (United States House of Representatives 2008 Resolution 1005), and we will take a few moments of our day to thank Representative Rosa DeLauro for her vote to pass this resolution.

This year's conference is truly exciting in bringing together leading world experts in the development and implementation of novel treatments, particularly as they relate to trauma, borderline personality disorder, and substance use disorders, as well as individuals who have encountered these challenges first hand in their own life experience, or through the experience of their family member. Our conference will begin with an orientation to the challenges of co-occurring borderline personality disorder and substance use disorders, and then we will have a unique opportunity to learn about several novel approaches to treatment including those that address biological dysfunctions, trauma, and both cognitive behavioral and psychodynamic formulations. To help us in understanding the state of development of these therapies we will be oriented to science of treatment development and we will have the opportunity to address our presenters and hear them interact in a panel discussion at the end of the day.

Please join me in extending my deep appreciation to the various forms of generosity associated with making this conference possible, including our professional, family, and consumer speakers for volunteering their time for this cause; our conference volunteers for spending their day helping make the logistics of the conference possible; the numerous administrators and staff involved in our co-sponsoring organizations including the National Education Alliance for Borderline Personality Disorder, Yale-New Haven Psychiatric Hospital, the Yale University School of Medicine, and the Connecticut chapter of the National Alliance on Mental Illness, and our conference vendors. I'd particularly like to recognize Ms. Patricia Woodward of NEA-BPD for her interminable energy, effort, and vision of success in planning this conference, my conference co-Director, Dr. Perry Hoffman, and our conference coordinators, Lisa Maccarelli, Jacquelyn Smith, and Peggilee Wupperman, who made the tasks involved with planning this conference a true pleasure. In addition, and most importantly, I express my sincere appreciation to all of you who chose to join us today to expand your understanding of borderline personality disorder and problems of substance use, and even more so, for all of your efforts facing the challenges associated with these difficulties.

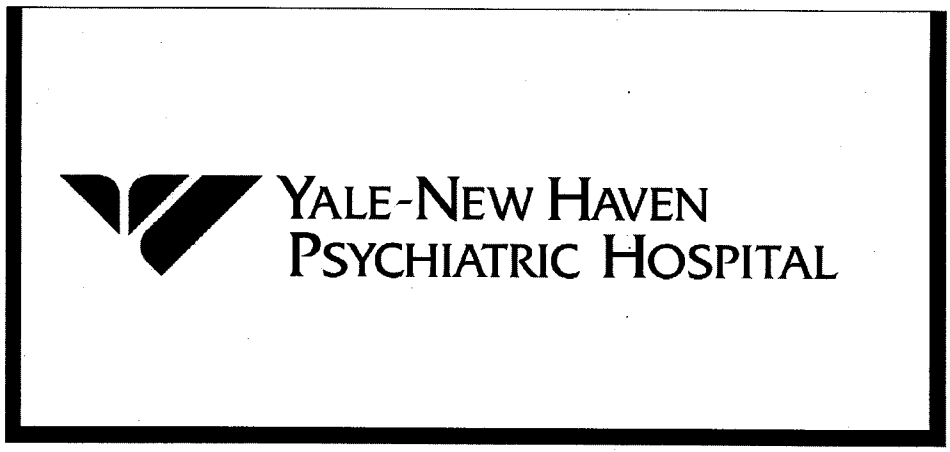
Most respectfully,

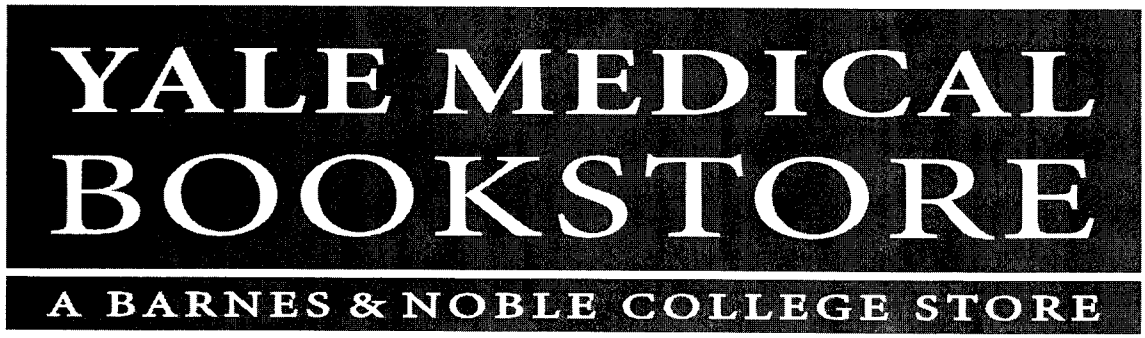
Seth Axelrod, PhD , Assistant Professor, Yale University, School of Medicine

ACKNOWLEDGEMENTS

The conference Course Directors and Coordinators thank all those who volunteered their time and energies to the planning of the events today. Especial thanks go to the Yale-New Haven Psychiatric Hospital for ongoing support and making the Trainee lunch a reality.

NAMI-CT has been most generous in supporting the conference and our thanks go to Kate Mattias, MPH, JD, Executive Director and Paloma B.Dee, Family Education Program Manager. Don Levy of the Yale Medical Bookstore returns to offer the BookFair. We welcome Silver Hill Hospital and Gunderson Residence, McLean Hospital personnel.





Gunderson Residence
of McLean Hospital

SILVER HILL HOSPITAL
RESTORING MENTAL HEALTH SINCE 1931

BPD AWARENESS MONTH

For ideas about activities to support BPD-AM, visit the NEA-BPD web site at www.borderlinepersonalitydisorder.com

Dear Senator/Congresswoman:

As your constituent and as someone who (has suffered from/who has watched a member of my family suffer from) borderline personality disorder, I urge you to work to raise the research budgets of the National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

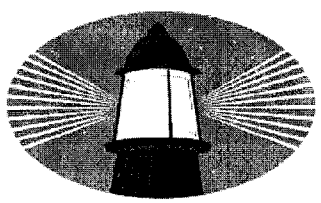
Increases in the NIH budget in the late 1990's generated a flood of advances in basic research that remain to be translated into advances in the treatment of psychiatric and addictive disorders. Further, the advances in basic research have created important new leads at the most basic levels of research that need to be followed to generate new treatments in upcoming decades.

At a time when increased funding for NIMH, NIDA, and NIAAA are needed to sustain the momentum of progress created over the past 10 years, these institutes face the first budget reductions in recent history.

The implications of these cuts could be devastating for me and those that I love. We are counting on the continued progress in treating borderline personality disorder and our best hope lies with NIMH, NIDA, and NIAAA. Please work to protect the budgets and the missions of these Institutes.

Sincerely,

Advance the Agenda
BPD Awareness Month Activities
Write letters of support
Logos Print materials
HR 1005
BPD Fact Sheet
Press Release



AWARENESS BRINGS HOPE

WELCOME

PERRY D. HOFFMAN, PHD

PRESIDENT, NEA-BPD

Perry D. Hoffman, Ph.D. is the President and a co-founder of the National Education Alliance for Borderline Personality Disorder (NEA-BPD). She has several grants from the National Institute of Mental Health with a focus on families who have a relative with borderline personality disorder. Dr. Hoffman is co-designer of the 12-week psycho-education course for families, *Family Connections,* which is available in many locations both in the United States as well as other countries. She is a co editor, with John G. Gunderson, MD, of the book *Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Family Member* and co editor of *Borderline Personality Disorder: Meeting the Challenges to Successful Treatment* currently in press. Dr. Hoffman, who is intensively trained in Dialectical Behavior Therapy (DBT), has been the director of several treatment programs in the New York area and now is in private practice in New York City and Westchester County, NY.

SETH R. AXELROD, PHD

ASSISTANT PROFESSOR OF PSYCHIATRY YALE UNIVERSITY SCHOOL OF MEDICINE

Dr. Axelrod is an assistant professor in the Department of Psychiatry at the Yale University School of Medicine and the team leader of the DBT and DBT for Substance Use Disorders (DBT-SUD) programs at the Yale-New Haven Hospital Intensive Outpatient Program. He received his PhD from the University of Kentucky, completed his internship; focused on DBT with the Connecticut Department of Mental Health and Addiction, and obtained postdoctoral training in personality disorders in the Department of Psychiatry at the Yale University School of Medicine. He founded the Connecticut DBT Network, which promotes DBT referrals and communication among DBT providers to support DBT Treatment in the State of Connecticut. Dr. Axelrod teaches and supervises mental health trainees and professionals in DBT and personality disorders, and provides consultation to schools and mental health agencies. He developed the annual Yale conference on Borderline Personality Disorder, and he is actively involved in research focusing on borderline personality disorder and DBT adaptations.

OPENING REMARKS

DWAIN C. FEHON, PSYD

ASSISTANT PROFESSOR OF PSYCHIATRY, YALE UNIVERSITY SCHOOL OF MEDICINE
CHIEF PSYCHOLOGIST, YALE NEW HAVEN PSYCHIATRIC HOSPITAL

Dr. Fehon has been Assistant Professor, Department of Psychiatry since 1993 and Chief Psychologist, Yale New Haven Psychiatric Hospital since 2001

As Assistant Professor within the Department of Psychiatry, Yale University School of Medicine, Dr. Fehon holds three distinct, yet overlapping titles: Chief Psychologist for Yale-New Haven Psychiatric Hospital, Co-Service Manager to the psychiatric hospital's adolescent services, and Coordinator/Developer of behavioral health services within Yale-New Haven Hospital. The daily clinical, administrative, and teaching and research activities are closely intertwined and involve aspects of each of his faculty roles.

Thus far, Dr. Fehon's research activity has focused on the examination of adolescent psychopathology referable to depression, suicidality, substance abuse, PTSD, violence exposure, and violence risk within acutely disturbed, high-risk, psychiatrically-hospitalized teenagers. He has authored or co-authored approximately 20 peer-reviewed publications, presented data at national conferences, and has been invited to serve as a peer reviewer for several psychiatry journals.

Currently, Dr. Fehon is in the process of implementing a new line of clinical-research projects to examine psychiatric, psychological, and psychosocial issues among medically ill populations within the Yale New Haven Transplant Center, Yale Cancer Center, and Yale Epilepsy program.

BORDERLINE PERSONALITY AND SUBSTANCE USE DISORDERS COMORBIDITY

SAMUEL A. BALL, PHD

PROFESSOR OF PSYCHIATRY
YALE UNIVERSITY SCHOOL OF MEDICINE

Bio

Samuel A. Ball, Ph.D. is a Professor of Psychiatry at the Yale University School of Medicine and Director of Research for The APT Foundation in New Haven, CT. He also coordinates psychology training in the Division of Substance Abuse, supervises and teaches psychology interns, and mentors and coaches junior faculty at Yale and other universities. His research focuses on the assessment and treatment implications of personality dimensions, personality disorders, and multidimensional subtypes in substance abuse. Dr. Ball is the developer of Dual Focus Schema Therapy that has shown promising results in several clinical trials with substance abuse patients who have co-occurring personality disorders.

Objective

1) Participants will learn about the high prevalence of borderline personality disorder (BPD) among substance use disorder patients and the high rates of SUD in patients diagnosed with BPD.
2) Participants will gain familiarity with the central role of two broad personality (and psychopathology) dimensions related to negative affect (and internalizing disorders) and behavioral disinhibition (and externalizing disorders) in both BPD and SUD.
3) Participants will learn about the prognostic significance of BPD-SUD co-occurrence with regard to symptom presentation, treatment response, and follow-up outcome.

GOALS OF PRESENTATION
3 Cs

- **Co-occurrence**
  (Prevalence and Models)
- **Complexity**
  (Heterogeneity and Subtyping)
- **Challenges**
  (Patients and Providers)

BORDERLINE PERSONALITY DISORDER (151 proof)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity (>=5):

1) frantic efforts to avoid real or imagined abandonment
2) unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3) identify disturbance, unstable self-image or sense of self
4) potentially self-damaging impulsivity in at least two areas (e.g., spending, sex, substance abuse, reckless driving, binge eating)
5) recurrent suicidal or self-mutilating behavior, gestures, or threats
6) affective instability due to marked reactivity of mood
7) chronic feelings of emptiness
8) inappropriate, intense anger or difficulty controlling anger
9) transient, stress-related paranoid ideation or severe dissociative symptoms

NATIONAL EPIDEMIOLOGIC SURVEY ON ALCOHOL and RELATED CONDITIONS *(NESARC; Grant et al, 2008)*

- High rates of Borderline Personality Disorder (BPD) in the community
- No significant differences in prevalence between women (6.2%) and men (5.6%)
- BPD associated with other Axis I and II disorders and significantly disability

PERSONALITY DISORDERS IN SUBSTANCE USE DISORDERS (SUD)

Depending on the study, **50-100%** of SUD patients have at least one personality disorder

- Opiates (median=79%)
- Cocaine (median=70%)
- Alcohol (median=44%)

Verheul, Ball, & van den Brink (1998)

PERSONALITY DISORDERS IN SUD PATIENTS

- Personality disordered drug abusers average 4 disorders (2 for alcohol)
- Borderline and Antisocial Personality Disorder are the most common (10-40%)
- Variability in prevalence related to drug used, setting, assessment method, diagnostic system

Verheul, Ball, & van den Brink (1998)

MEDIAN RATES of BPD in USD

• Substance	Alcohol		21%
	Drug		18%
	Opiates		7%
	Poly		22%
• Setting	Inpatient		22%
	Outpatient		13%
	Mixed	36%	
	Community	7%	

Verheul, Ball, & van den Brink (1998)

RATES OF SUD IN BPD PATIENTS

- 57% SUD: 49% alcohol; 38% drug diagnoses (Trull et al, 2000 review)
- 59% SUD: BPD patients 4.3 times as likely (as non-BPD) to have alcohol; 8.2 times as likely to have drug diagnoses (Skodol et al, 1999)
- BPD predicts diagnosis of (SUD) even when controlling for other psychiatric conditions

(Feske et al, 2006; Skodol et al, 1999)

WHY FOCUS ON THESE TWO CO-OCCURRING DISORDERS/

- Among BPD patients, the three most significant risk factors for serious suicide attempts are substance abuse, major depression, and prior attempts *(Black et al,.2004)*
- BPD persistence (non-remission) over a 6-year period more related to an unremitted SUD in comparison to mood, anxiety, or eating disorders *(Zanarini et al, 2004)*

COLLABORATIVE LONGITUDINAL PERSONALITY DISORDER STUDY (CLPS)

- BPD and SUD are independent, significant predictors of suicide attempts
- BPD impulsivity, affective instability, and identity disturbance symptoms most strongly associated with suicidal behaviors
- BPD patient had higher rates of new onset SUD over a 7-year follow-up

(Walter et al, 2009; Yen et al, 2003, 2004)

CONCEPTUAL MODELS FOR BPD-SUD ASSOCIATION

Vulnerability Models:

- Primary SUD:

  1) social learning; 2) behavioral learning;

  3) neuropharmacological
- Primary PD:

  1) behavioral disinhibition; 2) stress reduction;

  3) reward sensitivity

Common Process/Spectrum Models:

- **Common Factor (etiology):** 1) ASPD, BPD, SUD as impulsive spectrum disorders; 2) abuse/trauma history; 3) genetically-based impulsive-aggressive and negative affect traits

Independent/Interactive Models:

- **Pathoplasty (mutual influence)**: 1) drug use of SUD increases emptiness, suicidality, and unstable relationships of BPD; 2) affect dysregulation of BPD increases craving and desire to self-medicate

Lyons, Tyrer, Gunderson, & Tohen (1997); Verheul, Ball, & van den Brink (1998)

ARTIFACTUAL REASONS FOR BPD-SUD ASSOCIATION

- **Trait Overlap**: shared impulsivity (substance use) diagnostic criteria
- **Acute Substance Effects**: substance-induced changes in behavior
- **Treatment Effects**: Co-occurring disorders more likely to seek treatment
- **High Base Rates**: Co-occur because both common

Shea et al (2004)

GOALS OF PRESENTATION

3 Cs

- Co-occurrence (Prevalence and Models)
- **Complexity** (Heterogeneity and Subtyping)
- Challenges (Patients and Providers)

CRITERIA FORPERSONALITY DISORDER (APTS 52)

Borderlines | subs. tend to have all 4

- **A: enduring problems with cognition, affectivity, interpersonal functioning, or impulsivity (at least 2)**
- B: Inflexible and pervasive pattern across situations
- C: significant distress or social/occupational impairment
- D: early onset and persistent
- E: not accounted for by another mental disorder
- **F: not due to a substance or medical condition**

PERSONALITY ASSESSMENT PROBLEMS in Substance Abusers

- Differentiation of personality traits from acute states (intoxication, withdrawal)
- Differentiation of addiction-related behavior from Cluster B (Antisocial, Borderline) disorders
- Requires patients have:
  - *introspectiveness*
  - *cognitive competence*
  - *motivation to make dispositional attributions*
  - *acknowledge rather than deny or project*

Ball et al (2001); Ball (2004)

PERSONALITY DISORDER & SUD DIAGNOSTIC STUDY

- 370 inpatient and outpatient substance abusers
- Alcohol (25%); Cocaine (35%); Opiates (38%)
- Assessed upon entry into active phase of treatment
- Structured interviews with exclusion criteria
  - *21% (n=79) Borderline Personality Disorder*
- 56%Women; 55% Caucasian; 56% single
- Mean age 32.6; Mean education 12 years

Ball et al (1997, 2001); Rounsaville et al (1998)

UNTANGLING ADDICTION FROM PERSONALITY DISORDER

- Item-by-Item approach
  - before use or during sustained abstinence
  - pervasiveness, persistence, maladaptivity
- Obtaining non-substance related examples
- Not intoxicated or in acute withdrawal
- Time frame of at least past 2 years
- Use diagnostic interviews
- Differentiate from other Axis I

Rounsaville, Kranzler, Ball et al (1998)

PERSONALITY DISORDERS
Rates in Treated Substance Abusers

Disorder	*incl*	(*excl*)	Disorder	*incl*	(*excl*)
Paranoid	17%	(13%)	Narcissistic	14%	(10%)
Schizoid	4%	(4%)	Avoidant	20%	(18%)
Schizotypal	6%	(5%)	Dependent	12%	(8%)
Antisocial	46%	(27%)	Obsessive-	6%	(6%)
Borderline	**30%**	**(18%)**	Compulsive		
Histrionic	13%	(12%)			
			Any PD	**70%**	**(57%)**

Rounsaville, Kranzler, Ball et al (1998)

IMPORTANCE OF SUBTYPING BORDERLINE SUBSTANCE ABUSERS

- Heterogeneity of BPD patients
- Co-occurrence with other disorders
- Identify those in need of specialized intervention
- Substance-induced versus independent borderline symptoms less relevant
- Factor or cluster analysis of symptoms or related problems yields 2-5 different types
- Literature subtyping BPD based on symptom domains (psychotic vs. neurotic, suicidality/impulsivity, affective, abuse history)

BORDERLINE PERSONALITY DISORDER

Prototypic Case #1

- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, anger, physical fights)
- A pattern of unstable and intense relationships characterized by alternating between extremes of idealization and devaluation
- Transient, stress related paranoid ideation or severe dissociative symptoms
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

threatening
(DBT good approach)

BORDERLINE PERSONALITY DISORDER

Prototypic Case #2

- Frantic efforts to avoid real or imagined abandonment
- Chronic feelings of emptiness
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety lasting a few hours and only rarely more than a few days)
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

threatened!

BPD CORE PROBLEM DOMAINS

- Externalizing (ASPD, SUD) and Internalizing (Mood, Anxiety) Psychopathology *(Krueger)*
- Impulsive aggression and Affective instability *(Skodol)*
- Impulsivity/Disinhibition and Negative Affective/Emotional Dysregulation *(Trull)*
-

PERSONALITY and SUD
Negative Affect Correlates

- Treatment seeking and history
- Depression and Anxiety disorders
- Childhood abuse
- Suicide attempts
- Past psychiatric treatments
- Psychosocial problems
- Attention problems
- Personality disorder *(Ball, 2003, 2004)*

PERSONALITY and SUD
Impulsivity Correlates

Age of onset	HIV risk behaviors
Polydrug use	Psychiatric symptoms
Chronic, heavy use	Mood disorders
Conduct disorder, ASPD	Suicide attempts
Violence and arrests	Family history
Dependence severity	Early treatment drop-out

(Ball, 2003, 2004)

BPD as an INTERNALIZING and EXTERNALIZING DISORDER

- Meeting lifetime criteria for both a "disorder of affect" and a "disorder of impulse" is a more sensitive and specific predictor BPD in comparison to other PDs
- 75% of BPD inpatients exhibit this comorbidity pattern; 75% of non-borderline PDs do not
- BPD and SUD are most strongly related to emotional dysregulation, impulsivity, and childhood abuse

(Bornovalova et al, 2006, 2008; Trull et al, 2000; Zanarini et al, 1998)

BPD-SUD SUBTYPING

1. Axis II Comorbidity
2. Childhood Sexual Abuse
3. Mood Disorder
4. Suicidality

AXIS II COMORBIDITY

Over 90% of all BPD individuals currently in treatment have one or more additional Axis I or II disorders

(Gunderson, 2001; Trull et al, 2000; Widiger & Trull, 1993)

AXIS II COMORBIDITY

Cluster A ***("psychotic subtype")***

Paranoid, Schizoid, Schizotypal

Cluster B ***("disinhibition subtype")***

Antisocial, (Borderline), Histrionic, Narcissistic

Cluster C ***("neurotic subtype")***

Avoidant, Dependent, Obsessive-Compulsive

BPD DIAGNOSTIC SUBTYPING

BPD + Cluster A (35%) > BPD – Cluster A (65%)
BPD + other Cluster B (44%) > BPD – other Cluster B (56%)

No differences on clinical validation variables as a function of Clusters A or (non-BPD) B

BPD DIAGNOSTIC SUBTYPING

BPD + Cluster C (37%) > BPD – Cluster C (63%)

Lifetime rates of anxiety disorders

BPD DIAGNOSTIC SUBTYPING

BPD + Sexual abuse (44%) > BPD – Sexual abuse (56%)

History of physical abuse

BPD DIAGNOSTIC SUBTYPING

BPD + Mood (54%) > BPD – Mood (46%)

- ASI Psychiatric severity
- SCID Substance dependence severity
- CPI Sociopathy
- BSI symptoms: obsessive-compulsive, depression, anxiety, psychotic ideation, and global severity

BPD DIAGNOSTIC SUBTYPING

BPD + Suicide attempts (41%) > BPD – Suicide attempts (59%)

- ASI Alcohol severity
- Earlier age of onset of drug abuse
- CPI Sociopathy
- Unemployment
- Childhood physical and sexual abuse

BPD-SUD SUBTYPE SUMMARY

History of mood disorder and suicide attempts may provide better differentiation of BPD substance abusers and has clear treatment implications and focus for intervention

GOALS OF PRESENTATION

3 Cs

- Co-occurrence
  (Prevalence and Models)
- Complexity
  (Heterogeneity and Subtyping)
- **Challenges**
  (Patients and Providers)

BPD and ADDICTION-RELATED SEVERITY in SUD PATIENTS

- Substance dependence severity
- Polydrug abuse
- Past 30 day cocaine use
- ASI Drug, Family, and Psychological severity
- 12-month follow-up ASI Psychological and Employment severity

Rounsaville, Kranzler, Ball et al (1998)

BPD and PSYCHIATRIC SEVERITY in SUD PATIENTS

- Global psychiatric symptoms
- Lifetime and current mood, anxiety, and other personality disorders
- Lifetime physical and sexual abuse
- Lifetime and recent suicidal ideation and attempts
- Parental history of substance and psychiatric problems; family history of suicide attempts

Rounsaville, Kranzler, Ball et al (1998)

AUSTRALIAN TREATMENT OUTCOME STUDY

(Darke et al, 2005)

- BPD SUD associated with high injection-related health problems, overdose, crime, polydrug use, major depression, suicidality, psychological dysfunction
- BPD associated with more interrupted course of treatment (although total days equal to non-BPD)
- At 3-year follow-up, BPD not associated with worse substance use, but with higher levels of crime, injection-related health problems, overdose, major depression, and global mental health functioning

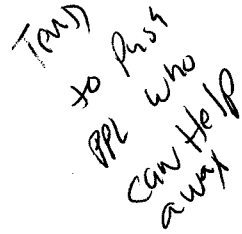
BPD TREATMENT OUTCOMES

- Associated with higher impairment
- More likely to drop-out early from inpatient and outpatient treatment
- Borderline Personality Disorder is more severe, but do just as well as non-BPD when provided psychiatrically enhanced inpatient

(Nace et al, 1983, 1986, 1993; Skodol et al, 1999)

PATIENT AND PROVIDER CHALLENGES FOR BPD-SUD

- **More sensitive to relapse triggers:**
  Negative Emotional States; Social Pressures; Craving; Interpersonal Conflict; Low Social Support
  (Kruedelbach et al, 1993; Verheul et al, 1998)
- Limited response to traditional or single focus addiction or mental health treatment
  (Ball, 2003; Thomas et al, 1999; Pettinati et al 1999)
- Struggle with alliance, compliance, and motivation
  (Verheul, van den Bosch, & Ball, 2005)



PATIENT AND PROVIDER CHALLENGES FOR BPD-SUD

- Social support necessary for recovery is diminished related to dysfunctional interpersonal relations:
  - 1) disagreeable, provocative, hostile, critical
  - 2) shifting avoidance/dependence and under-/overidealization
  - 3) maladaptive coping with schemas of abandonment and mistrust/abuse
- Impulsive, attention seeking, manipulative, or dangerous acting-out (self or other)
- Emotional volatility
- Trauma re-exposure

PATIENT CHALLENGES

- Getting competent help for two or more disorders
- Viewing therapist as someone who is available and caring rather than a worker in the system
- Lack of clinician knowledge and skills (or counter-therapeutic reactions) triggers maladaptive patient behaviors and increases poor outcome

PROVIDER CHALLENGES

- Level of effort and time needed to obtain compliance and collaboration necessary for treatment engagement, utilization, and retention
- Interpersonal, affective, and impulsive symptoms enacted within and outside of sessions
- Learning complex therapy models and obtaining skilled supervision and system support

MANUAL-GUIDED BPD PSYCHOTHERAPY MODELS

- Dialectical Behavior Therapy *(Linehan)*
  - DBT-S
- Transference-Focused Therapy *(Kernberg & Yeomans)*
- Mentalization Based Therapy *(Fonagy & Bateman)*
- Schema Therapy (Young)
  - Dual Focus Schema Therapy *(Ball & Young)*

BPD-SUD TREATMENT FOCI
Impulsivity and Affect

- Impulsive behaviors the only diagnostic criteria associated with number of lifetime suicide attempts (other than self destructiveness)
- Impulsivity predicts suicidality even when controlling for lifetime diagnosis of depression and SUD
- Recommend treatments focused on reducing impulsive behaviors (e.g., DBT, SUD treatment, medication)

(Brodsky et al, 1997)

BPD-SUD TREATMENT FOCI
Impulsivity and Affect

- **Very strong support** for DBT for BPD women with prominent self-harm, suicidality, affect dysregulation, and hospitalization risk
- **Very modest support** for DBT for BPD without suicidality or with prominent externalizing disorders (SUD, ASPD)

SUMMARY POINTS

- **Co-occurrence:**
  1) ¼ of SUDs have BPD; ½ of BPDs have SUD
  2) independent, but interactive disorders
  3) dual disorder risk factors for suicide

- **Complexity:**
  1) heterogeneity within; overlap between
  2) internalizing and externalizing disorders
  3) mood and suicide are valid subtypes

- **Challenges:**
  1) higher severity, impairment, abuse/trauma
  2) need for specialized, integrative intervention
  3) providing (receiving) effective treatments

Tammy Green - Elected Congress.

SEEKING SAFETY FOR PTSD AND SUD

LISA M. NAJAVITS, PHD

PROFESSOR OF PSYCHIATRY
BOSTON UNIVERSITY SCHOOL OF MEDICINE

Bio

Lisa M. Najavits, PhD is Professor of Psychiatry, Boston University School of Medicine; Lecturer, Harvard Medical School; clinical psychologist at the National Center for PTSD, Veterans Affairs Boston Healthcare System; and psychologist at McLean Hospital. She is author of the books Seeking Safety: A Treatment Manual for PTSD and Substance Abuse (2002) and A Woman's Addiction Workbook (New Harbinger Press; 2002), as well as over 125 professional publications. In 1997 she was recipient of the Chaim Danieli Young Professional Award of the International Society for Traumatic Stress Studies; in 1998 the Early Career Award of the Society for Psychotherapy Research; and in 2004 the Emerging Leadership Award of the American Psychological Association's Committee on Women. She is currently president-elect of the American Psychological Association Division on Addictions. She is past-president of the New England Society for Behavior Analysis and Therapy; and on the advisory boards of Psychotherapy Research, Psychology of Addictive Behaviors, and the Journal of Gambling Studies. Dr. Najavits has received a variety of National Institutes of Health research grants, including an independent scientist career award from the National Institute on Drug Abuse. She is a fellow of the American Psychological Association; board certified in behavioral therapy; a licensed psychologist in Massachusetts; a psychotherapy supervisor; and conducts a psychotherapy practice. She received her PhD in clinical psychology from Vanderbilt University (Nashville, Tennessee) and her bachelor's degree with honors from Columbia University (New York, New York). Her major clinical and research interests include: trauma, posttraumatic stress disorder; substance abuse; and psychotherapy outcome research.

Objective

1) To review scientific literature on rates and presentation of PTSD/substance abuse;
2) To increase empathy and understanding of PTSD/substance abuse;
3) To describe specific therapeutic strategies for this dual diagnosis;
4) To provide assessment and treatment resources.

Past lives abuse

PTSD usually occurs 1st (2/3)

impulsive (less) more coping

Lisa M. Najavits, PhD / 2008

PTSD

a) **What is PTSD?**

- DSM-IV definition: After a trauma (the experience, threat, or witnessing of physical harm, e.g.,c 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.

No one drug – had drugs common

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

key themes control & secrecy

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".

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:

PTSD addressed

Not at all, focus on present / focus on past

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***

- Safety as the goal for first-stage treatment (later stages are mourning and reconnection)
- Integrated treatment (treat both disorders at the same time)
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
- Four content areas: cognitive, behavioral, interpersonal, case management
- 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**

Seeking Safety is established as an evidence-based model. Positive outcomes have been found in the 15 completed studies on *Seeking Safety*. For a description of each study and the full article, go to www.seekingsafety.org (section "Outcomes"). The studies include: outpatient women (Najavits et al., 1998); women in prison (Zlotnick et al., 2003); women in a community mental health setting (Holdcraft & Comtois,

Seeking Safety.org

2002); low-income urban women, in individual format (Hien et al., 2004); adolescent girls (Najavits et al., 2006); men and women veterans (Cook et al., 2006); homeless women veterans (Desai & Rosenheck, 2006), women with co-occurring disorders in group format (Morrissey et al., 2005; Gatz et al., 2007), outpatient men traumatized as children (Najavits et al., 2005), women veterans (Weller, 2005), women in outpatient treatment (Mcnelis-Domingos, 2004), young African-American men (Hamilton et al., in preparation), and two dissemination studies (Hills et al., 2004; Brown et al., 2007). The studies include pilots, randomized controlled trials, controlled trials, multisite trials, and a dissemination study.

e) **Resources on *Seeking Safety*.** All below are available from www.seekingsafety.org.

- ✧ **Research articles:** all articles related to Seeking Safety can be freely downloaded (section Research).
- ✧ **Training:** training calendar and information on setting up a training (section Training).
- ✧ **Consultation:** on clinical implementation, research studies, evaluation projects (contact Lisa Najavits)
- ✧ **Adherence Scale:** can be freely downloaded (section Assessment).
- ✧ **Assessment tools:** can be freely downloaded (section Measures).

The resources below can be ordered from the website, section Order:

- ✧ **Book (English):** *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Provides clinician guide and all client handouts.
- ✧ **Translations (Spanish, French, German, Swedish)**
- ✧ **Video training series:** four videos provide training on Seeking Safety. (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 (in English or Spanish).
- ✧ **Card deck:** all of the safe coping skills and quotations on cards, with ideas for games.

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]

Would you like to be added to the Seeking Safety website to list that you conduct Seeking Safety? If so, please email Lisa basic information. *Example:* Boston, MA: Karen Smith, LICSW; group and individual Seeking Safety; private practice with sliding scale. 617-300-1234. Karensmith@netzero.com.

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
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
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
Department of Veterans Affairs	800-827-1000; www.va.gov
EMDR International Association	866-451-5200; www.emdria.org
Many Voices (trauma survivors newsletter)	513-751-8020; www.manyvoicespress.com
Community screening for PTSD and other disorders	www.mentalhealthscreening.org

always a way to cope Safely

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. 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. Obtain from www.health.org (free).

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)*
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. San Francisco: Jossey-Bass.

Videos

a) Najavits, L.M. (2006). Video training series on Seeking Safety; *www.seekingsafety.org* (section Order).
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. Bradley, R., Greene J., et al. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. American Journal of Psychiatry, 162, 214-227.
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. Vogelmann-Sine, S., Sine, L., et al. (1998). EMDR: Chemical Dependency Treatment Manual. Unpublished manuscript, Honolulu, Hawaii.
11. Cocozza JJ, Jackson EW, Hennigan K, Morrissey JP, Reed BG, Fallot R, Banks S. (2005). Outcomes for women with co-occurring disorders and trauma: program-level effects. J Substance Abuse Treatment 28: 109-19.
12. Najavits LM (2007). Psychosocial treatments for posttraumatic stress disorder. In P. E. Nathan & J. Gorman, A Guide to Treatments that Work (3rd ed.). Oxford Press: New York.
13. Najavits, LM, Schmitz, M, Johnson, KM, Smith, C, North, T et al. (in press). Seeking Safety therapy for men: Clinical and research experiences. In Men and Addictions. Nova Science Publishers, Hauppauge, NY.
14. Brown et al. (2007). Implementing an evidence-based practice: Seeking Safety group. Journal of Psychoactive Drugs, 39, 231-240.

Assessment of Mental Disorders: www.medical-outcomes.com [MINI International Neuropsychiatric Disorder]
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...)

25 Topics - Cognitive behavior Inter personal

Quote

Contact.

Chartbook.

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).

Topics are ideas to inspire

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 looooooonnnnnggggg 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___

♥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."

Key Question
How did you cope?

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 average scores below.

Compassion Satisfaction Scale. The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout Scale. The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 27 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Trauma/Compassion Fatigue Scale. The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

If you have any concerns, you should discuss them with a health care professional.

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12 Colbourne Crescent
Brookline, MA 02445 U.S.
617-731-1501 (phone)
617-701-1295 (fax)
orders@seekingsafety.org (email)

Seeking Safety

www.seekingsafety.org

✧ *Seeking Safety* Clinical Resources ORDER FORM ✧

	Each	Number	Total
✧ TRAINING VIDEOS ✧			
Item 1a: Set of all 4 videos listed below (one each of #1, 2, 3, 4)	$ 250	X ____	= $_____
Item 1b: Video #1 – *Seeking Safety* (2 hours)	$ 95	X ____	= $_____
Item 1c: Video #2 – *Therapy Session: Asking for Help* (1 hour)	$ 65	X ____	= $_____
Item 1d: Video #3 – *A Client's Story / Example of Grounding* (36 mins.)	$ 60	X ____	= $_____
Item 1e: Video #4 – *Adherence Session: Healthy Relationships* (1 hour)	$ 50	X ____	= $_____
***Select format: DVD__ *or* VHS ___(if not specified VHS will be sent)**			
If preferred, videos can be rented; see www.seekingsafety.org, section Order			
✧ POSTERS ✧			
Item 2a: Poster of Safe Coping Skills with scenic background (**English**)	$ 15	X ____	= $_____
Item 2b: Poster of Safe Coping Skills with scenic background (**Spanish**)*	$ 15	X ____	= $_____
✧ CARD DECK ✧			
Item 3: Card Deck of Safe Coping Skills (112 cards; can play as game)	$ 15	X ____	= $_____
✧ BOOKS ✧			
Item 4a: *Seeking Safety* (**English** language)	$ 45	X ____	= $_____
Item 4b: *A Woman's Addiction Workbook* (**English** language)	$ 22	X ____	= $_____
Item 4c: *Seeking Safety* (**Spanish** translation of entire book)	$ 50	X ____	= $_____
Item 4d: *Seeking Safety* (**French** translation of entire book)	$ 50	X ____	= $_____
Item 4e: *Seeking Safety* (**Swedish** translation of handouts only)	$ 40	X ____	= $_____
Item 4f: *Seeking Safety* (**German** translation) [available 11/08; email if interested]			

***** Please fill in shipping details below *****

Sales tax for Massachusetts shipping addresses only (add 5% or fax your tax exempt certificate) $_____
Discount (if ordering 10 or more of exact same item number, subtract 10%) $_____

Shipping and Handling

➢ **All orders are shipped within 6 business days (regardless of method below). Then, add additional time based on the method below.**
➢ **If ordering 50 items or more (any combination), take 10% off the shipping charge (see line at bottom of this page)**

For shipment to a U.S. ADDRESS (select one)

☐ *Media mail* (typically 12 days but may several weeks, especially for West Coast, and up to 6 weeks for Hawaii/Alaska) $_____
$4 first item, $1.50 each additional item. For example, 1 item=$4; 2 items=$5.50; 3 items=$7, etc.
Note: if you are ordering the full set of videos (or DVDs), count that as 1 item (not 4)
Please note that due to postal regulations, media mail cannot include anything other than the items (thus no packing slip)

☐ *Priority mail* (takes 2-3 days) $_____
$12 first item, $2 each additional item. For example, 1 item=$12; 2 items=$12; 3 items=$14, etc.

☐ Order can be shipped by *Fedex* if you provide your "bill to" account number here (sorry we cannot use UPS)
a) Provide your Fedex "bill to" account number: _____
b) Indicate how quickly you want it: _____Overnight or ___ 2nd day or ___ 3rd day
d) Add $3 handling at right $_____

For shipment to a CANADIAN ADDRESS:
1st class (this is the only available method)
For books: $10 first book, $2.50 each additional book. $_____
All other items: $6 first item, $2.50 each additional item. $_____
If ordering from Canada, and payment is by check, an additional fee of $4 USD is charged (which the bank here charges for any Canadian check). A credit card order does not incur this fee. Canada check charge (if applicable) $_____

For shipment to an INTERNATIONAL ADDRESS (other than Canada):
Books: $20 first book plus $2.50 each additional book. $_____
All other items: $10 first item, $2.50 each additional item. $_____

If shipping 50 items or more to 1 address, take 10% off the shipping charge: *subtract* $_____

TOTAL COST (in US Funds) $_____

Please note:
1. You can return this form by email, fax, or regular mail (see bottom of this page).
2. All orders are sent within 6 business days; posters ship separately in mailing tube. Please allow several weeks if you select "media mail."
3. All items are shipped with "delivery confirmation", which allows verification that the item was delivered.
4. If using a credit card, your statement will say "Treatment Innovations."
5. Institutions: for a completed W-9 and/or FEIN, download it from www.seekingsafety.org, click "Order", then "Information for Institutions". You will also find terms, and business and tax information (no tax charged if you have an address outside of Massachusetts or are tax exempt).
6. We do not routinely confirm that orders are received. If you want confirmation that your order arrived, please email us.
7. **If you would like a receipt, it will be sent via email; please check here: __.**

Return policy: Videos/DVDs cannot be returned for refund; exchanges only if defective (within 45 days of shipping). The poster, card deck, 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 orders@seekingsafety.org for instructions before you return it.

Shipping address (please print clearly as this will be your mailing label)

Name
Organization
Address
City / State / Zip
Country
Email
Phone

Method of Payment

Please choose one of the following 3 options:

☐ **(1) Check enclosed.** Please make check payable to *Treatment Innovations*.

☐ **(2) Purchase Order (institutions only)**: attach PO to this form. Name and information for authorized contact person for PO:

Name: _____ Phone: _____ Email: _____
Note: if a PO is paid from any foreign bank (Canada, etc.), a $4 check fee is added as the bank adds that to cash the check. Please initial here to indicate that you have included this on your form (can add it into shipping total on page 1 of this form) _____

☐ **(3) Credit card (only Mastercard or Visa are accepted).** Please provide your credit card information below.

For Credit Card Orders only: Printed Name on the Card: _____
Credit card# _____ Expiration Date _____ / _____
***Important*: Is your credit card name/address exactly the same as the shipping address provided above? Yes / No. If not, list it here:**
*Name _____
*Address _____
Organization _____
*City _____ *State/ Province _____ *Zip / Postal Code _____
*Country _____ *Email Address _____ *Telephone Number _____

Send this Form

Please either:

(1) email this form to orders@seekingsafety.org (paste it into the email or send as an attachment)

or

(2) fax it to 617-701-1295

or

(3) mail it to Treatment Innovations, 12 Colbourne Crescent, Brookline MA 02445

For more information, go to www.seekingsafety.org or email orders@seekingsafety.org. Thanks!

"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				somewhat 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:_____ _____		

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
10	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.	2	0
0	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.	0	0
	I have witnessed or experienced a serious accident or injury.		
0	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.	0	0
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.		
0	I have witnessed or experienced the death of my spouse or child.	0	0
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).		
0	I or a close friend or family member has been kidnapped or taken hostage.	0	0
0	I or a close friend or family member has been the victim of a terrorist attack or torture.	0	0
0	I have been involved in combat or a war or lived in a war affected area.	0	0
0	I have seen or handled dead bodies other than at a funeral.	0	0
10	I have felt responsible for the serious injury or death of another person.	10	10
0	I have witnessed or been attacked with a weapon other than in combat or family setting	0	0
0	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury	0	0
0	As an adult, I was hit, choked or pushed hard enough to cause injury	0	0
0	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.	0	0
0	As a child/teen I was forced to have unwanted sexual contact.	0	0
0	As an adult I was forced to have unwanted sexual contact.	0	0
0	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact	0	0
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____		

DIALECTICAL BEHAVIOR THERAPY FOR SUBSTANCE USE DISORDERS (DBT-SUD)

M. ZACHARY ROSENTHAL, PHD

ASSISTANT PROFESSOR
DUKE UNIVERSITY MEDICAL CENTER

Bio

M. Zachary Rosenthal, PhD is an Assistant Professor in the Duke University Medical Center Department of Psychiatry and Behavioral Sciences, and is Director of both the E.M.B. Brout Sensory Processing and Emotion Regulation Program (www.dukescience.org) and the Duke Cognitive Behavioral Research and Treatment Program (CBRTP). Dr. Rosenthal received his Ph.D. from University of Nevada, Reno, after completing an internship in medical psychology at Duke University Medical Center. Dr. Rosenthalâ€™s line of research has focused on characterizing problems with emotional functioning and emotion regulation in borderline personality disorder (BPD). Recently, his research has expanded to the development of novel computer-based interventions for treatment-resistant populations. He is the PI on a NIDA-funded project (R01-018311) developing a virtual reality-based cue exposure platform and cellular phone-based extinction reminder delivery system to augment treatment for substance abusers. This work has recently been featured on ABCâ„¢s *Good Morning America* as an example of cutting edge research using new technologies. In addition, he is the PI on a NIDA-funded study (R01-017372) evaluating the efficacy of Dialectical Behavior Therapy (DBT) for opioid dependent adults with BPD. He has published in scientific journals and book chapters, including, *Emotion*, *Journal of Abnormal Psychology*, *Clinical Psychology Review*, *Journal of Traumatic Stress*, and *Behavior Research and Therapy*. Clinically, Dr. Rosenthal is a licensed clinical psychologist in North Carolina who is trained in cognitive behavioral therapy (CBT) and is an expert in the treatment of BPD and other difficult-to-treat populations using dialectical behavior therapy (DBT). Dr. Rosenthal provides clinical supervision to Duke University clinical psychology graduate students, medical psychology interns, Psychiatry residents, and post-doctoral fellows. In addition, Dr. Rosenthal provides educational trainings to community mental health and substance abuse professionals through a partnership between Duke University and the North Carolina Evidence-Based Practices Center.

Objectives

1) Understand basic principles underlying Linehan's biosocial model of borderline personality disorder
2) Learn the rationale for adapting DBT to address substance use disorders
3) Identify how DBT has been modified to incorporate problems with substance use

Sodhwick / Satel 90

DBT and DBT-SUD: Context

- Development of standard DBT - 80's 90's
- Development of DBT-SUD - 90's Is it effective?

DBT-SUD? Really?

1. Up to 2/3 of individuals with BPD meet criteria for a SUD *(Dulit et al., 1990)*
2. Many with SUDs meet criteria for BPD
3. A diagnosis of BPD among opiate addicts treated with methadone predicts greater psychiatric problems and alcoholism following treatment *(Kosten, Kosten, & Rousaville, 1989)*

Why DBT-SUD?

Tendency to be overwhelmed • Rushed planned

- The two disorders share some core features (e.g., impulsivity; *Trull, 2001*)
- SUD amplifies problems for BPD individuals. For instance, the use of substances can erode the BPD patient's inhibitions, resulting in increased risk for self-harm, suicide, and other self-damaging behaviors
- It is not uncommon for therapists to feel overwhelmed, frustrated, or otherwise unmotivated when treating BPD/SUD patients.

BPD and SUD Patients are Difficult Customers

- Effective treatments are scarce
- Non-collaborative, non-compliant
- Often drop out of treatment
- Disliked by caregivers and by the public
- Associated with increased ~~morality~~ mortality

DBT-SUD: Standard DBT + Modifications Targeting Addiction

DBT Assumptions

- Difficult behaviors represent maladaptive solutions, not the problem.
- Engaging reluctant patients is a therapeutic task, not a pre-requisite for enrollment.
- Patients are doing the best they can.
- Patients need to do better and try harder to change.
- Patients want to have lives worth living
- When patients say their lives are unbearable, this is a valid statement.
- Patients may not have caused their problems, but they need to solve them.
- Patients need to demonstrate adaptive behaviors in all relevant contexts.
- Safety and security in therapy is not necessarily valued, in so far as it does not reflect the real world.
- Patients cannot fail in treatment.
- Therapists who conduct **DBT** need consultation.

Modes of Treatment in DBT-SUD

- Outpatient Individual Psychotherapy
- Outpatient Group Skills Training
- Telephone Consultation
- Therapists' Consultation Meeting
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy
  - Acute-Inpatient Psychiatric

DBT typically 1 yr Treatment weekly individual weekly group

Available as needed within one week

DBT-SUD: Outpatient Individual Psychotherapy

- Pre-treatment work and commitment
- Targeting substance use
- Attachment strategies

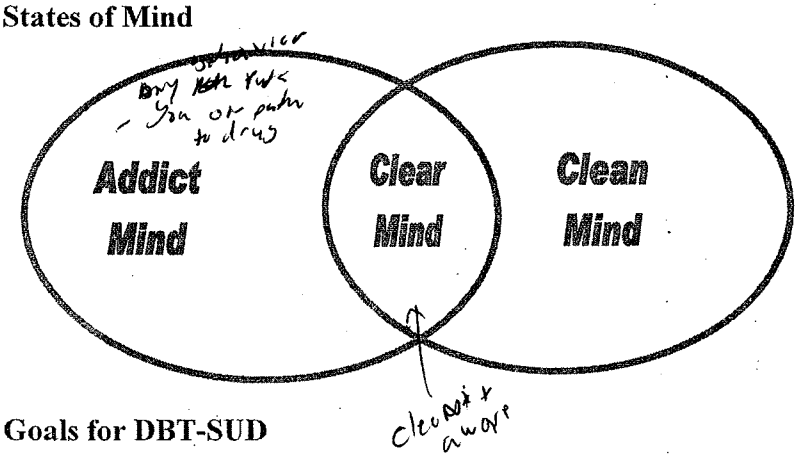
Pre-treatment Work and Commitment: Dialectical Abstinence

- Abstinence v. Harm Reduction?
- Expecting the best and planning for less than the best
- Olympic athletes must **believe** and **behave as though** they can **win every race**, even though they have lost before and will lose again

Pre-treatment Work and Commitment: Planning to Prevent Dropout

- Validation and goals/values
- Planning for when patients go missing
- Orienting to attachment strategies

Pre-treatment Work and Commitment: States of Mind



Goals for DBT-SUD

- Stop using drugs and parasuicidal behaviors
- Increase ability to self-regulate emotions
- Replace maladaptive behaviors with skillful behaviors
- Improve dysfunctional cognition: irrational beliefs, black and white thinking, unrealistic expectations of the world and of the self
- Validate patient to strengthen identity
- Teach how to live skillfully in the world as it is

Pre-treatment Work and Commitment:
Targeting substance use

- Placing substance use on the treatment hierarchy

  Goals:

  (1) Decrease Substance Abuse

  (2) Decrease Physical Discomfort

  (3) Decrease Urges, Cravings, & Temptations to Use Drugs

  (4) Decrease the Option to Use Drugs

  (5) Decrease Contact with Cues for Drug Use

  (6) Increase Community Reinforcement of "Clear Mind" Behaviors

do not expect/force linear approach

DBT Attachment Strategies

- Orient client to attachment problem
- Increase contact during initial trimester – several sessions per week first few months (ideally)
- Contact using voice mail
- Conduct therapy *in vivo* – go to home if necessary, appropriate, safe & ethical
- Shorten or lengthen therapy sessions
- Conduct supportive family and friends network meetings
- Treat therapists who are getting demoralized
- Phone to break avoidance
- Find clients when they are lost

DBT-SUD: Attachment Strategies

- Attachment strategies involve an emphasis on outreach efforts

- If a patient does not show up for a session, the therapist might call the patient, go out to the patient's home, or send the patient a card, balloons or flowers to encourage the patient to return to treatment

DBT-SUD: Outpatient Group Skills Training

- Structure
- Process
- Common problems and solutions

2 co-leaders if 1 co-leader's doesn't show, someone does to find them (call, etc)

DBT-SUD: Outpatient Group Skills Training

General Goals

Behaviors to Decrease

Confusion about self and identity, cognitive dysregulation

Decrease identity as "drug addict"

Interpersonal chaos

Decrease enmeshment in drug user culture

Labile emotions, moods

Decrease moods, physical pain and cravings associated with drug use

Impulsiveness

Decrease drug use and associated behavior

Behaviors to Increase

Core mindfulness skills

Increase mindfulness of self as drug free

Distress tolerance skills

Increase tolerance for [temporary] craving and physical distress

Emotion regulation skills

Increase control over mood states without resorting to drugs

Interpersonal effectiveness skills

Increase interpersonal reinforcement for drug free life

A Modified Guideline for Skills Training

Patients are not to tempt other group members to use drugs:

- Patients are not to come to sessions under the influence of drugs or alcohol.
- Patients under the influence of drugs or alcohol are to come to sessions acting and appearing clean and sober.
- Patients are not to discuss current or past drug use or other risky behaviors with other group members outside of sessions.
- Patients are not to sell each other drugs, give information about getting drugs, or take each other to drug use environments.

Skills Added to DBT for Substance Abusers

- Urge Surfing (Observing Skill)
- Alternate rebellion (find a way to rebel that does not harm you)
- Burning bridges: eliminate options to use drugs and eliminate access to drugs
- Avoid and eliminate cues, reminders of drug use

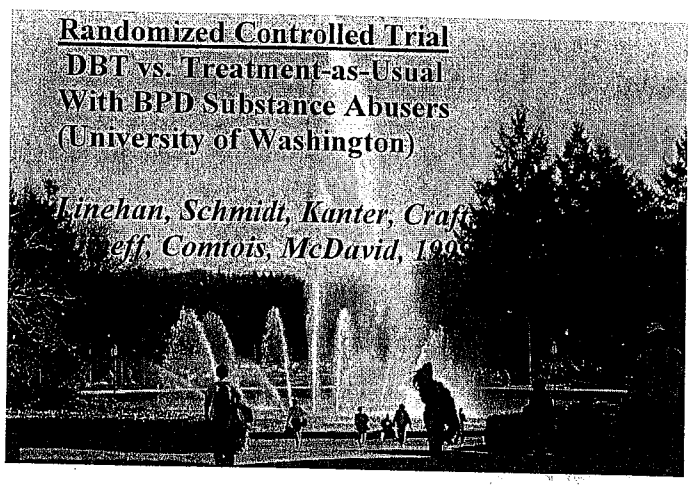
DBT-SUD: Telephone Consultation

- Training the phone as a tool for therapy
- Anticipating problems and planning with flexibility

DBT-SUD: Therapists' Consultation Meeting

- Ongoing education
- Balancing acceptance and change

Are Outcomes in DBT Superior to Treatment-as-Usual?



Design: RCT

Conditions: Dialectical Behavior Therapy (DBT)
Treatment-as-Usual (TAU)

Time Frame: 1 year treatment / 4 month follow-up

Assessments: Pre-treatment
4 month / 8 month /
12 month (post-treatment) / 16 month

Subjects: $n = 28$

- BPD
- SUD for opiates, cocaine, amphetamines, sedatives, hypnotics, or anxiolytics *or* Polysubstance Use Disorder
- Female
- Did not meet criteria for:
  - Schizophrenia or other Psychotic Disorder
  - Bipolar Disorder
  - Mental Retardation

Matching Variables

- Age
- Severity of Highest Drug Dependence
- Readiness to Change
- Global Adjustment (Axis V, *DSM-IV*)
-

DBT < TAU

Drug use

Drop out

DBT > TAU

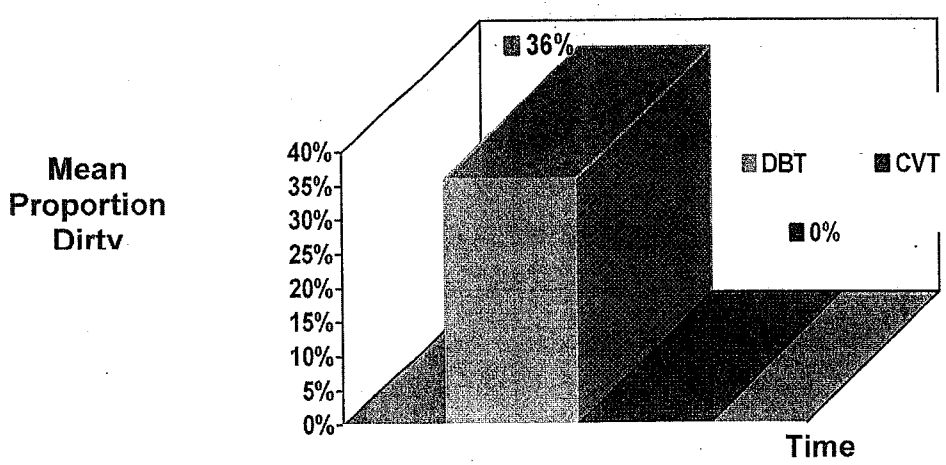
Global Adjustment (at 16-month)

Social Adjustment (at 16-month)

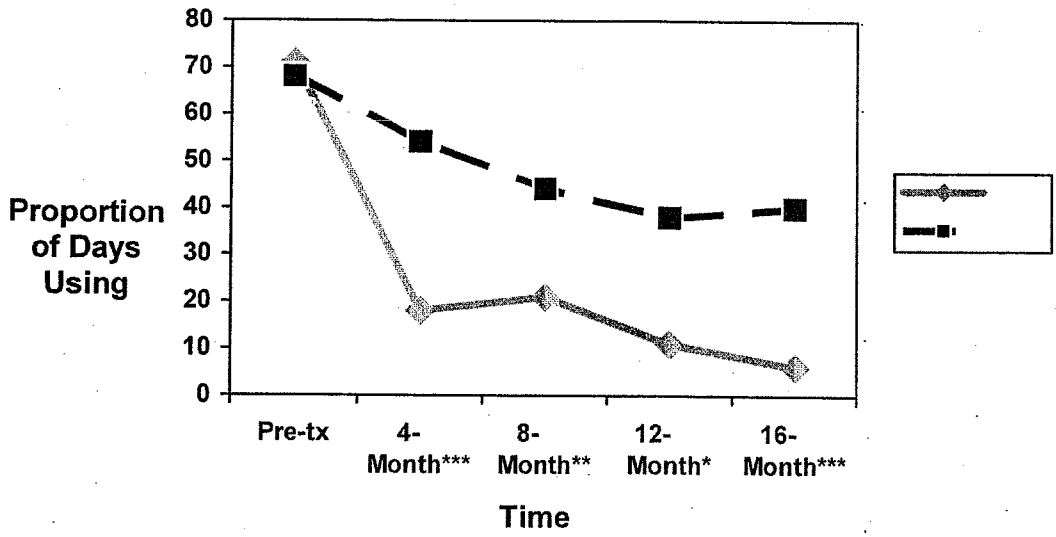
DBT gains continued at follow-up

CVS comprehensive validation Therapy

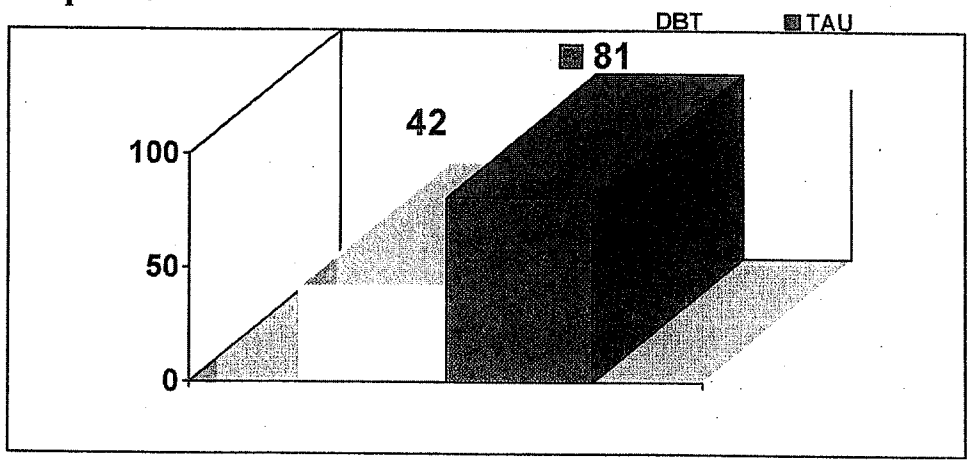
Proportion of Urinalyses *DIRTY* by Condition



Interviewer-Assessed Proportion of *DAYS USING* Drugs and Alcohol by Condition



Percent Treatment Drop-Outs



DBT vs. TAU: ns

Pre-treatment > 12-month

- Parasuicide Episodes
- Anger

Randomized Controlled Trial of DBT vs. Comprehensive Validation (1 Year) with BPD Heroin Addicts

University of Washington

Linehan, Dimeff, Comtois, McDavid, & Kivlahan

Subjects: $n = 23$

- BPD on SCID II and PDE
- Met criteria for Heroin Dependence
- 18-45 Years
- Female
- Did not meet criteria for:
  - Schizophrenia or other Psychotic Disorder
  - Bipolar Disorder
  - Mental Retardation

Matching Variables

- Age
- Cocaine Dependence
- Anti-Social Personality Disorder
- Global Assessment of Functioning (GAF)

Design: RCT

Conditions: Dialectical Behavior Therapy (DBT)
Comprehensive Validation Therapy (CVT)

Time Frame: 12 month treatment
4 month follow-up

Assessments: Pre-treatment
4 month
8 month
12 month (post)
16 month

Treatment Conditions

DBT

- Individual Therapy
- Group Skills Training
- Homework Review
- Phone Coaching
- Therapist Consult Meeting
- Drug-Replacement

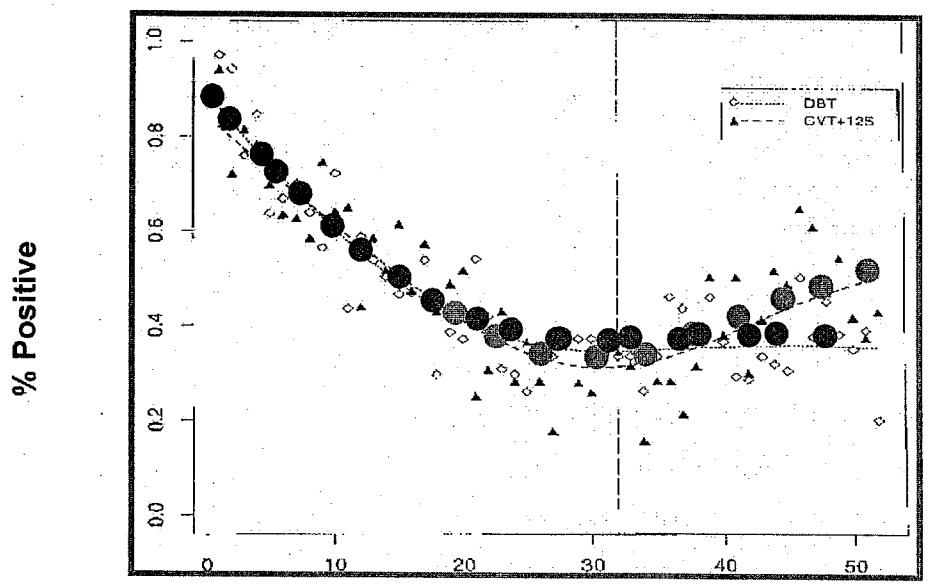
TAU

- Individual Therapy
- NA 12&12 Group
- NA 12&12 Sponsor
- Crisis Intervention
- Therapist Consult Meeting
- Drug-Replacement

Assessments

- Urinalysis (3 times weekly)
- Substance Abuse History Interview (SAHI)

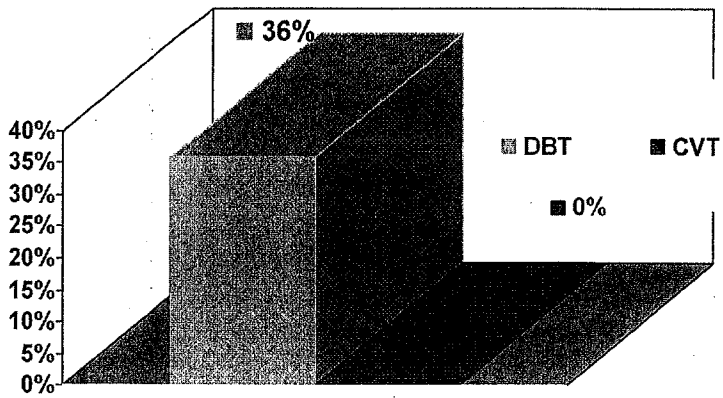
Opiate Use Across Year



Correlation of Urinalysis vs. Time-line Follow-back Self-Reports of Opiate Use

- Entire sample — $r = .53, p<.01$
- DBT — $r = .72, p< .02$
- CVT — $r = .02$

Percent Treatment Drop-Outs



DBT vs. CVT+12S: ns

Pre-treatment > 12-month

- Drug Use, Self-Report
- Brief Symptom Inventory
- Global Adjustment
- Social Adjustment

DBT-SUD?

- It is unclear whether standard drug counseling approaches common in the substance abuse treatment community are efficacious for these particular (BPD and SUD) difficult-to-treat patients

Ongoing Randomized Controlled Trial of DBT-SUD

University of Washington (PI: Linehan)

Duke University Medical Center (PI: Rosenthal)

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- Melissa Haidet
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Aims

- Examine whether DBT-SUD has different treatment outcomes compared to standard Individual and Group Drug Counseling (I/GDC) in a sample of adults 18-60 with Co-occurring BPD and Opioid Dependence

I/GDC as a Control

The I/GDC condition was included to control for the following major threats to internal validity:

1. Between-assessment history and maturation
2. Reactivity of assessments
3. Assessor drift
4. Regression to the mean
5. Participant factors associated with presenting for treatment at an academic research clinic
6. Selection bias
7. Opiate replacement with suboxone
8. Availability of treatment structure including individual and group drug counseling
9. Availability of psychotropic medication as needed (e.g., sleep)
10. Attention to crisis intervention when needed

Project Overview (Across sites)

- 1128 Telephone screens conducted
- 383 Interviews conducted
- 176 Accepted into study
- 125 Enrolled (DBT = 62; IGDC = 63)
- 67 Dropped (DBT = 30; IGDC = 37)

• BPDs w/ SuD less likely quickly ATTACH TO Therapist
↳ Develop ATTACHMENT STRATEGY

Project Overview (Across sites)

- 1 year of weekly individual and group treatment
- 1 year of suboxone
- Monthly visits with Study Psychopharmacologist
- Experienced therapists/supervisors with allegiance to each condition

Project Overview (Across sites)

- Urine tests given 3x weekly for 1 year
- Assessments given every 4 months for 2 years: e.g., ASI, TLFB, HIV risk behavior
- Pre and post-session data

Project Overview (Across sites)

- Results being analyzed and will be presented in November at ABCT in NYC
- However....a few thoughts....

• not Expecting any difference IN Retention

Dialectical Behavior Therapy for Substance Use Disorders (DBT-SUD)

M. Zachary Rosenthal, Ph.D.
Assistant Professor
Duke University Medical Center

NEA-BPD Yale Conference 4/30/09

DYNAMIC DECONSTRUCTIVE PSYCHOTHERAPY FOR BPD AND SUD

ROBERT J. GREGORY, MD

ASSOCIATE PROFESSOR OF PSYCHIATRY
SUNY UPSTATE MEDICAL UNIVERSITY

Bio

Dr. Robert Gregory is Associate Professor in the Department of Psychiatry at SUNY Upstate Medical University, where he currently serves as Director of their Syracuse Center for Psychotherapy. His educational background encompasses a B.S. in biology at Cornell University, an M.D. at SUNY Buffalo School of Medicine, and residency training in psychiatry at Harvard's Beth Israel Hospital. Dr. Gregory's clinical and research interests include borderline personality disorder, addictions, suicide prevention, and psychodynamic psychotherapy. He has authored numerous publications and presentations elaborating theoretical models and empirical research of borderline personality disorder and has been the recipient of nine separate awards for his teaching of medical students and psychiatry residents. Dr. Gregory has developed a manual-based psychodynamic treatment, labeled dynamic deconstructive psychotherapy, which particularly targets those patients who have co-occurring substance use disorders. He has recently completed a 12-month randomized controlled trial of this treatment method for patients with co-occurring borderline personality disorder and alcohol use disorders, which was published in the March issue of *Psychotherapy*. The results support its effectiveness in reducing self-harm, suicide attempts, problematic drinking behavior, and inpatient utilization.

Objectives

1) Participants will learn the latest neurobiological research on the links between aberrant processing of emotional experiences and the development of hyperarousal, which is frequently managed by overuse of substances
2) Participants will become familiar with principles and empirical research for dynamic deconstructive psychotherapy and how this treatment is hypothesized to dampen hyperarousal and restore functioning
3) Participants will learn how to implement some key treatment techniques

Dynamic Deconstructive Psychotherapy
Gregory & Remen (2008). Psychotherapy: Theory, Research, Practice, Training, 45, pp. 15-27

- Manual-based, weekly individual treatment
- Preset duration (12 months)
- Targets refractory BPD patients, e.g. dually diagnosed substance use or antisocial p.d.
- Remediates aberrant neurocognitive processing of emotional experiences

Altered Processing of Emotional Experiences

- Difficulty labeling their emotions *(Ebner-Premier 2007; Leible & Snell 2004; Levine 1997),* linked to distress *(Ebner-Premier 2008)* and activation of the amygdala *(Guru 1997)* fear/anxiety response
- Deficits in episodic memory, i.e. the ability to sequence emotional experiences into narratives *(Levy 2006, Westen 2006)* and produce over-general memories *(Startup 2001)*
- Simplistic, distorted & polarized misattributions of self and others *(Arntz & Veen 2001, Conklin & Westen 2005, King-Casas 2008)*

1. Difficulty labeling emotions
2. Over-general memories * ← Discuss w/ Dr. Gard
3. Distorted & polarized attributions

Pseudonarrative

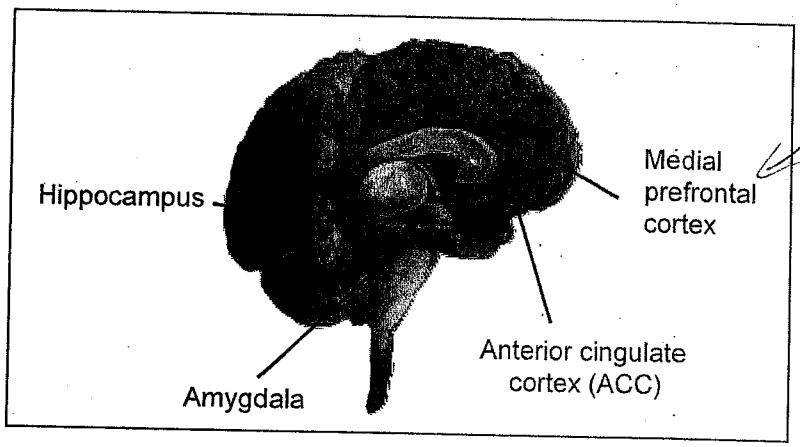
I know this sounds incredibly mean, but I get so sick of people coming to me for advice. When my friends are talking about what jerks their boyfriends are and how annoying their parents are, I keep thinking about killing myself because no one around me thinks I'm going through anything at all.

(2) selective memory
I take care of everyone else, no one takes care of me
Heroic victim.

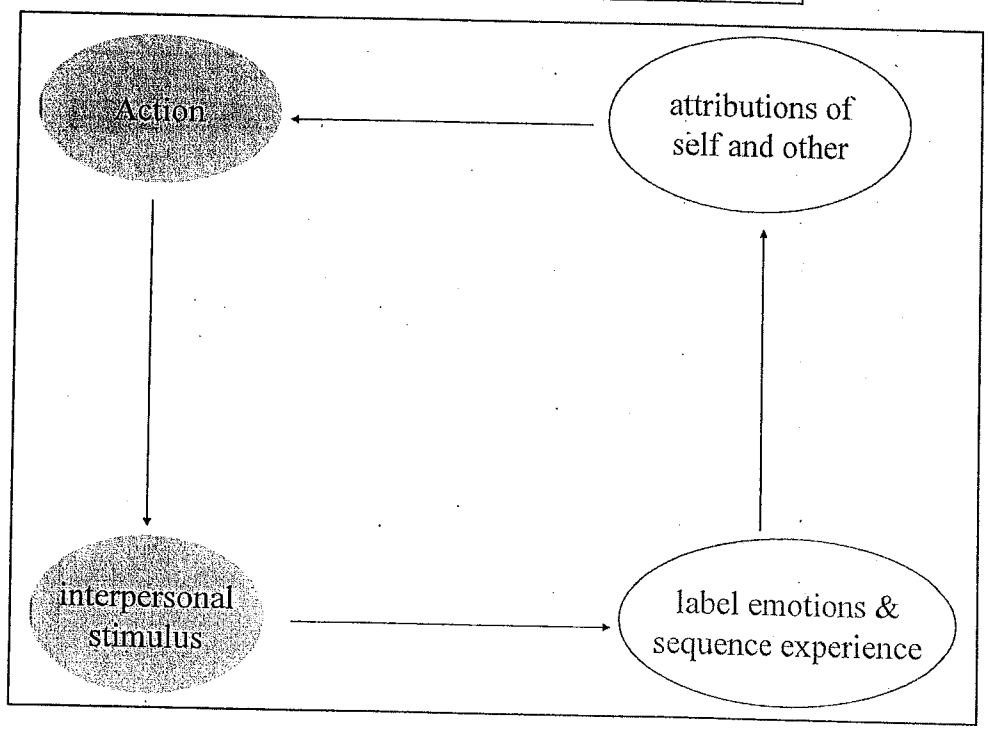
Functional Imaging Studies in BPD

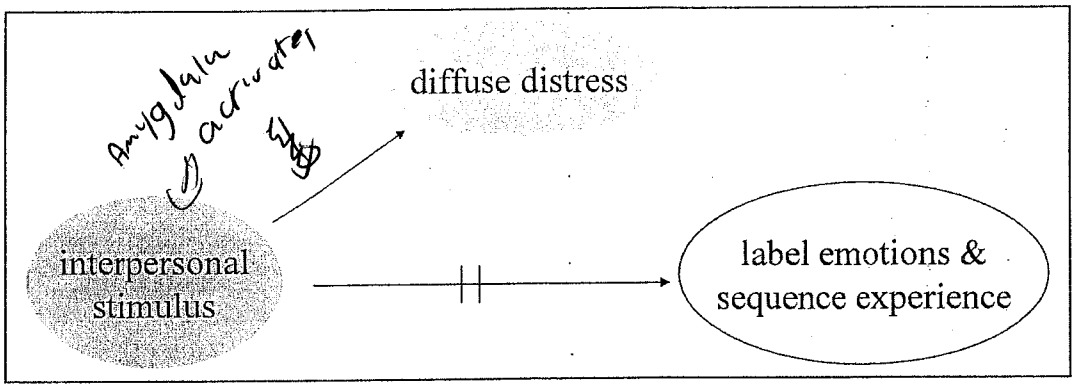
Responses to emotional stimuli:

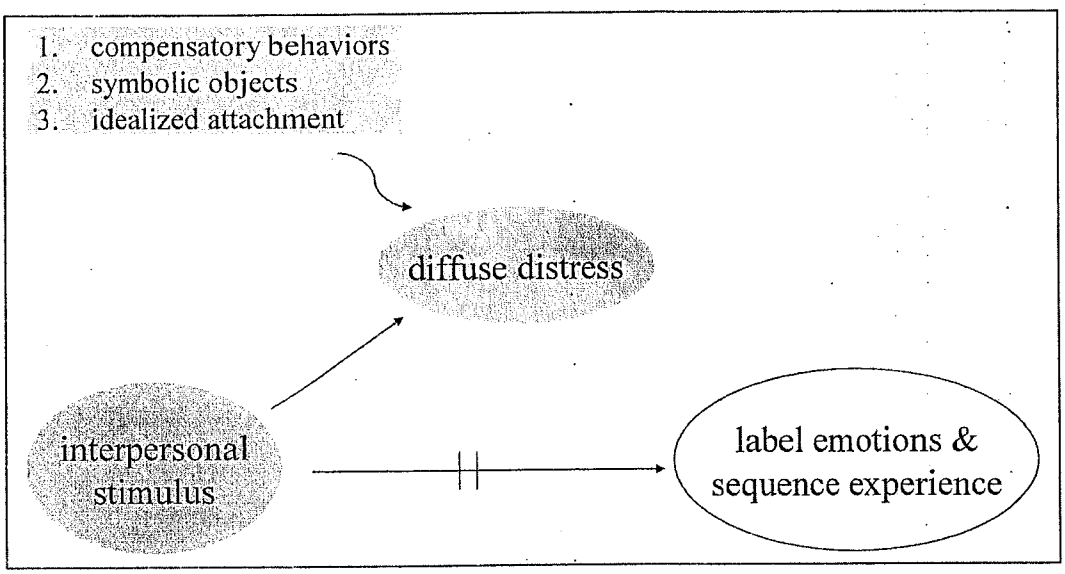
- **Amygdala** – increased activation in response to emotionally aversive pictures *(Donegan 2003, Herpetz 2001)*
- **Medial prefrontal cortex** – deactivation in response to trauma scripts *(Schmahl 2003)*, negative word cues *(Silbersweig 2007)*
- **Anterior cingulate** – deactivation in response to fearful faces *(Donegan 2003)*, trauma scripts *(Schmahl 2004)*, and negative word cues *(Silbersweig 2007)*

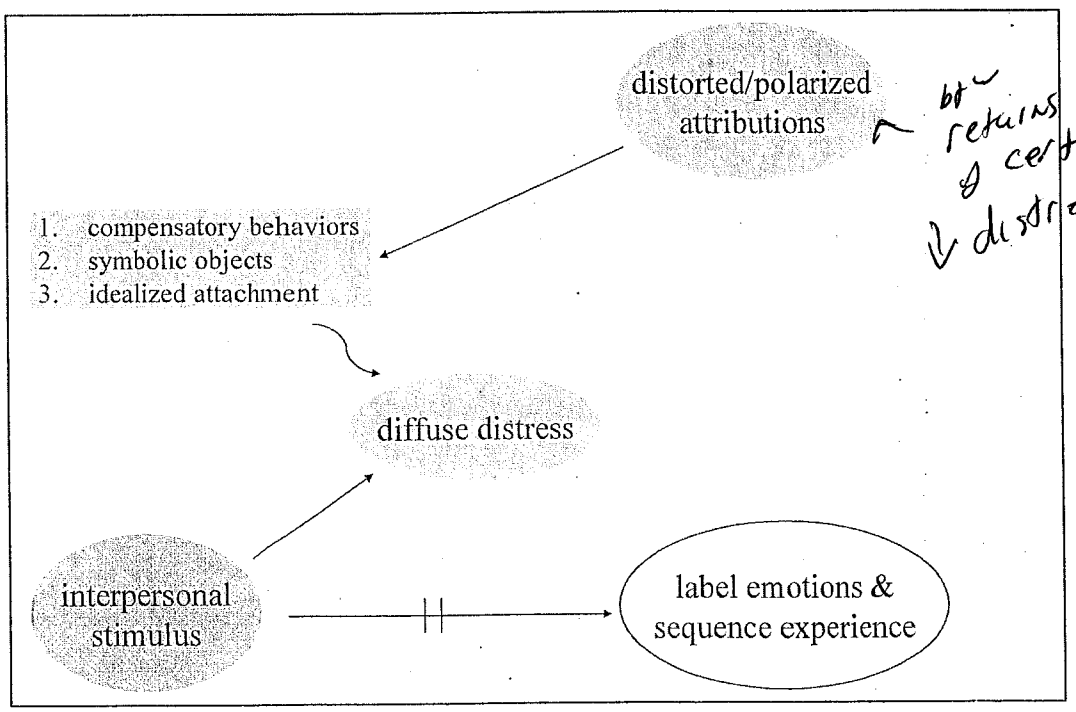


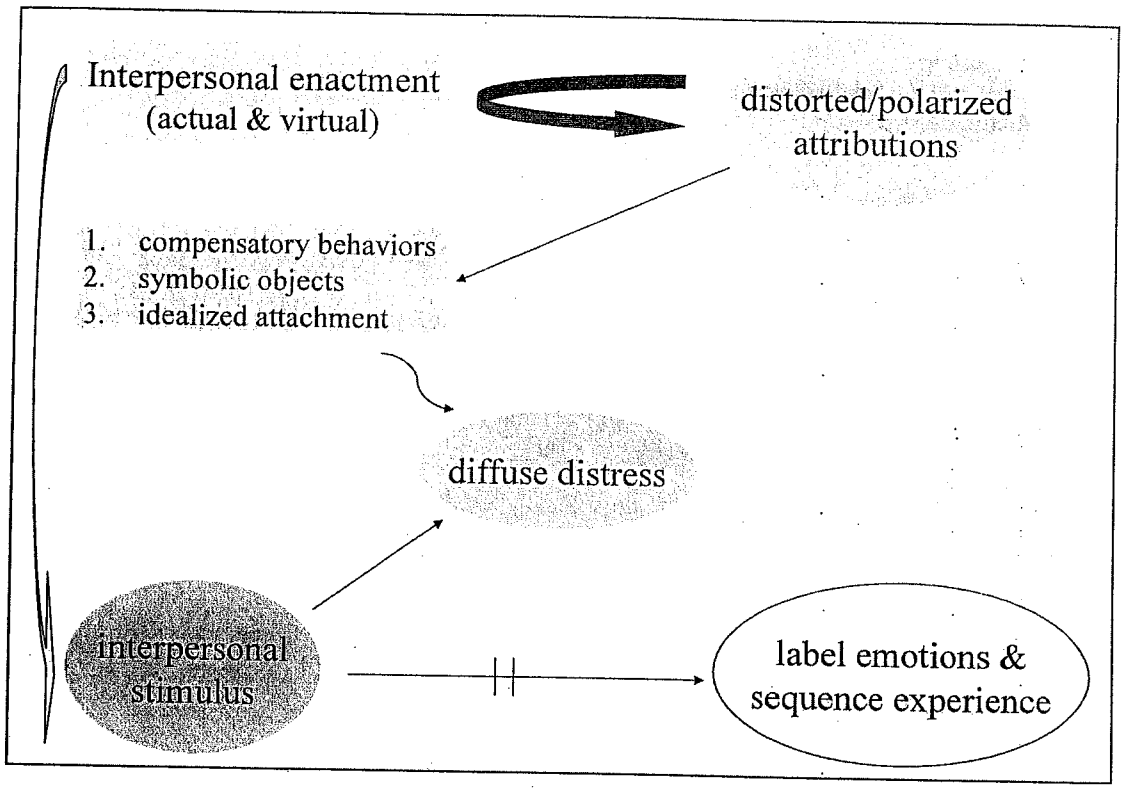
deactivated Int. ATTACHMENT & Semantic











Three neurocognitive functions targeted for remediation

1.	Association	Identify, label, acknowledge, and sequence emotional experiences
2.	Attribution	Make complex and integrated attributions of self and others
3.	Alterity Individuate	Make realistic attributions. and differentiate self from other

Neurocognitive Deficits and Substance Dependence

Association

- Difficulty recalling specific relapse episodes and the associated emotional responses

Attribution

- Polarized attitudes towards substance use
- Polarized agency regarding substance use

Alterity

- Patient-therapist control struggles

← Take all or no blame for action

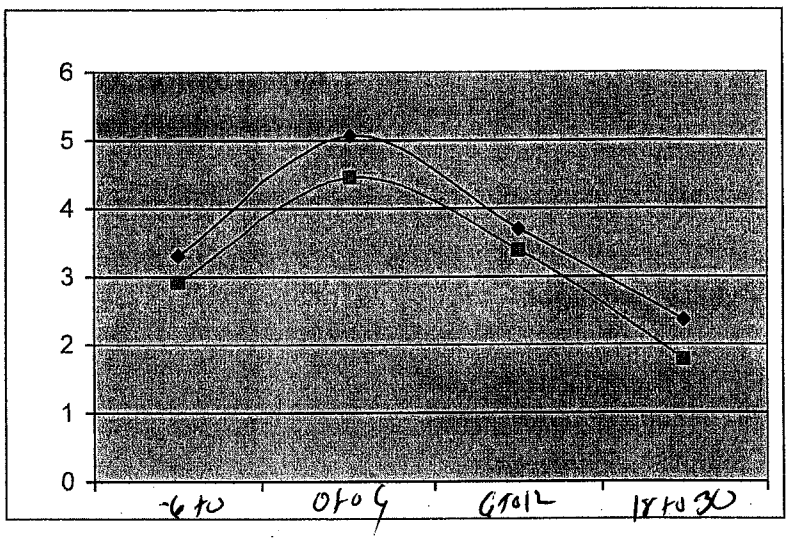
Taking all blame has always been my biggest weakness

DDP Research

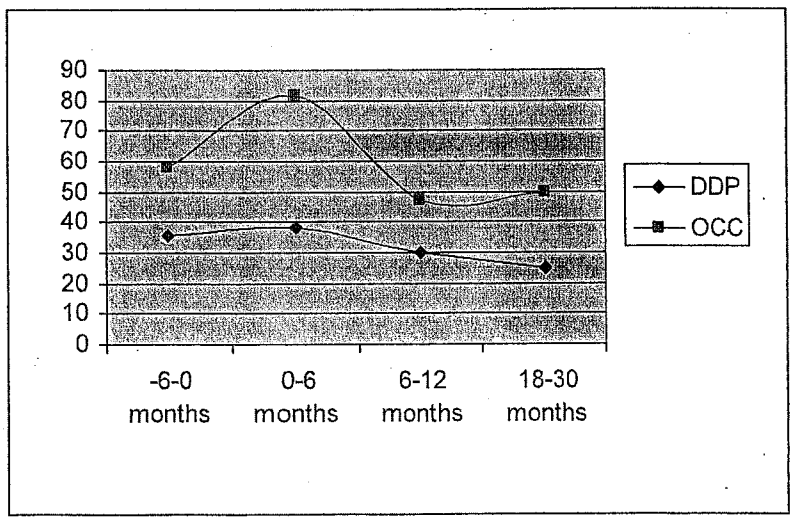
Gregory et al. (2008) Psychotherapy: Theory, Research, Practice, Training,45, pp. 28-41

- N=30, BPD and active alcohol abuse or dependence
- RCT of 12 months DDP vs. optimized community care + 18 months naturalistic f/u
- DDP therapists includes the P.I. (RG) and 5 PGY-III residents trained to competency
- Multiple comorbidities (antisocial PD – 43%, illicit drug use – 83%, bipolar disorder – 17%)

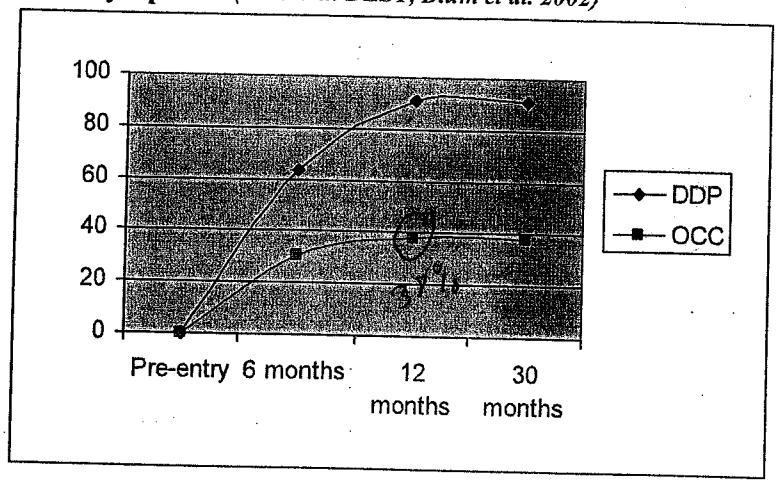
Individual Mental Health Contacts/Month



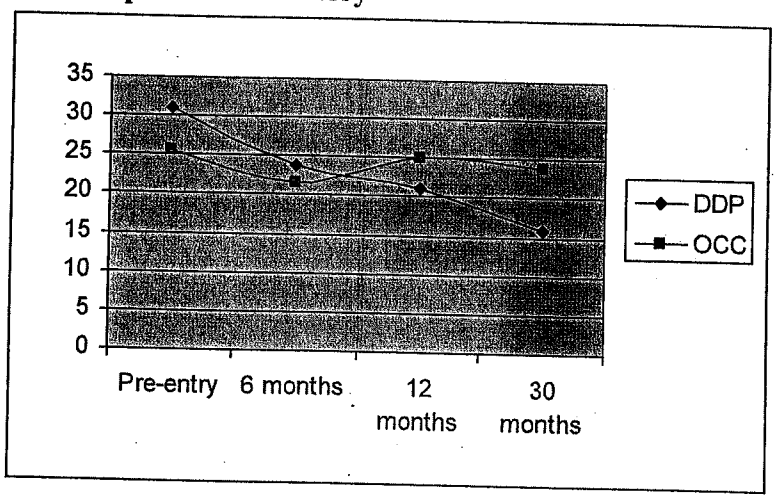
Proportion Receiving Group Therapy (combined paid and self-help)



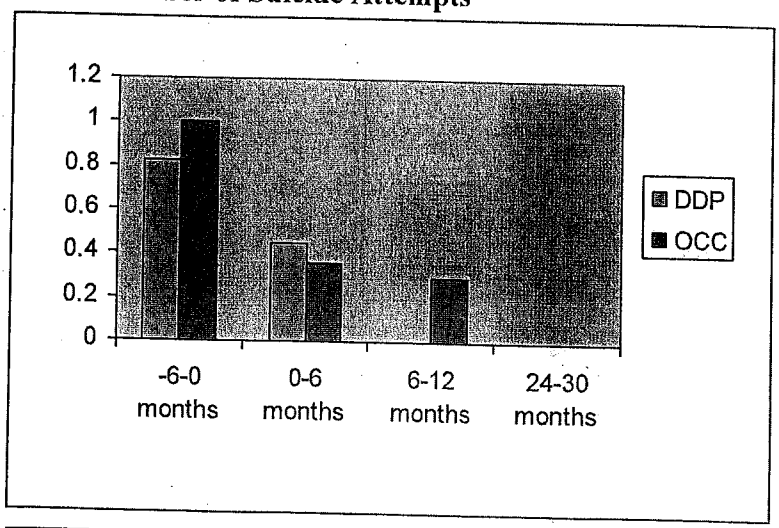
Proportion Achieving Clinically Meaningful Change in BPD Symptoms *(25% Δ in BEST, Blum et al. 2002)*



Beck Depression Inventory

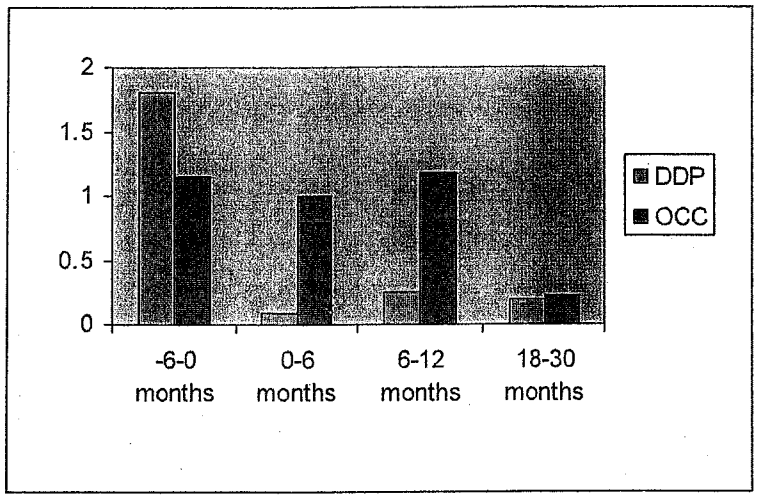


Mean Number of Suicide Attempts

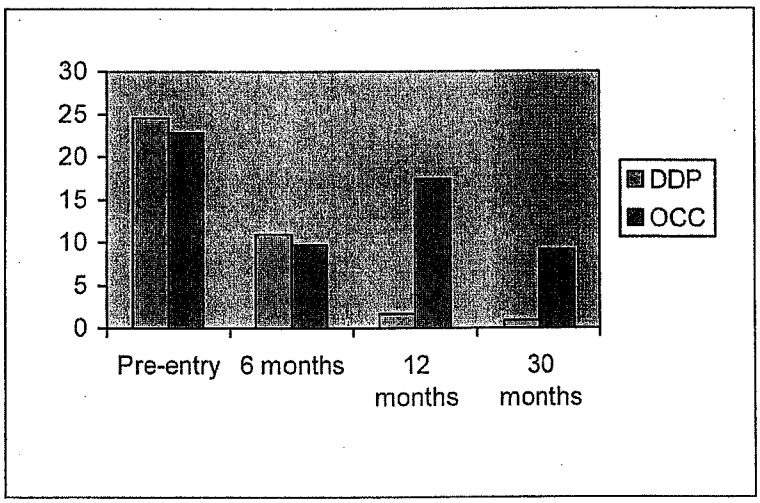


Inpatient Days Per Month

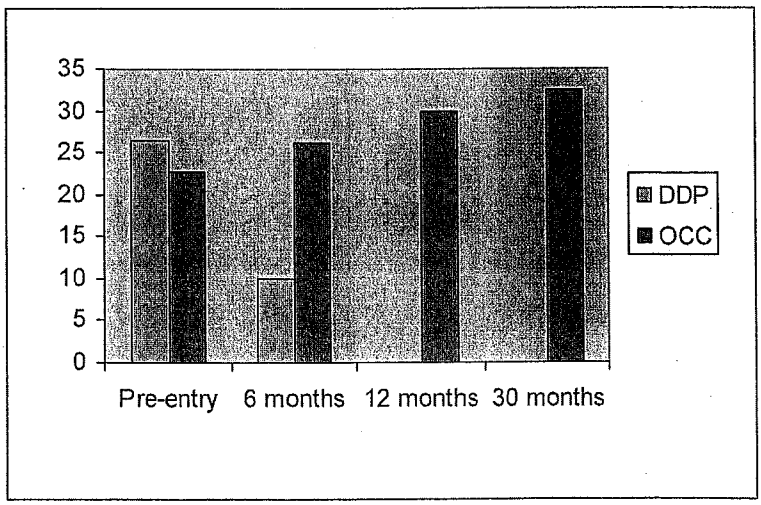
psychiatric and detox/rehab



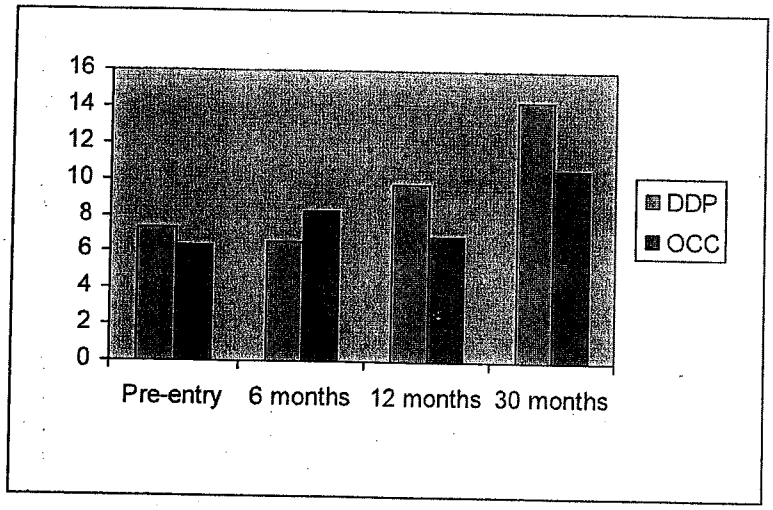
% Heavy Drinking Days



% Days Using Recreational Drugs



Paid Employment (Mean Days Per Month)



Adherence of Therapists to DDP
(Goldman & Gregory, Psychotherapy, in press)

- Video-recorded sessions of DDP
- Independent coding of average adherence = 71%
- Adherence strongly correlated with improvement in BPD symptoms ($\rho = 0.64$)

Conclusions From the Study

- DDP demonstrates broad effectiveness that continues after treatment ends for co-occurring BPD/Alcohol
- Partial support for remediation model
- May be effectively applied by trainees
- Very cost effective, i.e. better outcomes obtained with less treatment
- Limitations: single study, small N, interview-based drug use estimates

Practicing DDP:
Remediating Interventions

1. *Association*: Foster verbalization of recent interpersonal episodes into simple narratives and elaboration of the patient's emotions

2. *Attribution*: Explore alternative or opposing attributions towards self and other, while remaining generally non-directive and non-judgmental

3. *Alterity*: Provide novel experiences in the patient-therapist relationship that deconstruct distorted attributions and promote individuation & differentiation

Interventions

1. Association
2. Attribution
3. Alterity

Pseudonarrative

I know this sounds incredibly mean, but I get so sick of people coming to me for advice. When my friends are talking about what jerks their boyfriends are and how annoying their parents are, I keep thinking about killing myself because no one around me thinks I'm going through anything at all.

Interventions for Substance Use

Association

- Elaborate a narrative sequence for the relapse episode

Attribution

- Integrate positive vs negative aspects of substance use
- Integrate internal vs. external agency

Alterity

- Avoid control struggles
- Neither encourage nor discourage the behavior

www.upstate.edu/ddp

PSYCHOPHARMACOLOGY OF BPD AND SUD

ELIZABETH RALEVSKI, PHD

RESEARCH SCIENTIST / SCHOLAR
SUBSTANCE ABUSE PROGRAM,
VA CONNECTICUT HEALTHCARE SYSTEM

Bio

Elizabeth Ralevski, PhD is a Research Scientist at Yale University. She received her BA and completed her Ph.D. degree in Psychology at York University in Toronto, Canada in 1999. She finished her two-year post-doctoral training at McLean Hospital, Harvard Medical School in 2001. That same year she joined the faculty at Yale University.
Dr. Ralevski is pursuing research into various aspects of substance abuse, with a primary focused on alcoholism. Current research projects are focusing on treatment studies with novel psychopharmacological approaches to the treatment of individuals who are diagnosed with alcoholism and other psychiatric conditions including depression, post traumatic stress disorder, schizophrenia and borderline personality disorder. Her other research examines factors, such as stress, that may lead to the development and maintenance of alcoholism and other mental disorders.

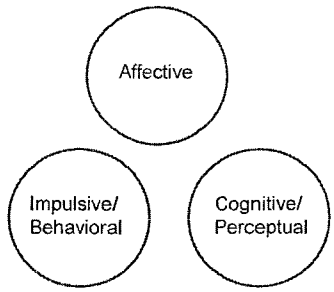
Objectives

1) Review the pathophysiology of BPD and the pathophysiology of SUD

2) Orient participants to current practice standards for treating BPD and for treating SUD

3) Introduce potential medication strategies for treating comorbid BPD and SUD

Borderline Personality Disorder



Comorbidity of BPD and SUD

- High rates of comorbidity with substance use disorders
- Alcohol use most frequently reported

Historical Perspective

- Fermented drinks date back thousands of years
- Beverages made from honey, dates, cereals, grapes and other fruits

- Ancient Egyptians had a Goddess of Wine
- Ancient Greeks had a God of Wine

Alcohol Use Today

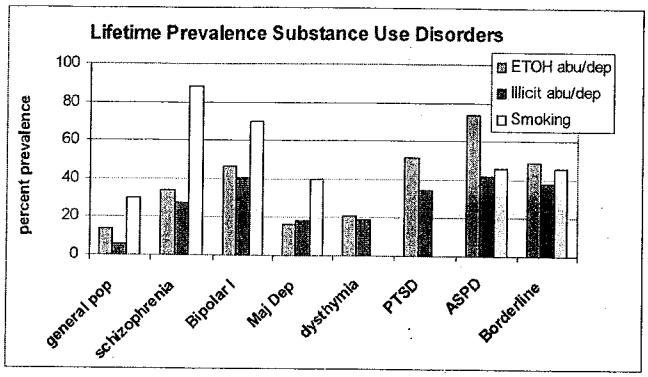
- Estimated that 90% of adults in US have sampled alcohol
- Estimated that 69% of adults use some alcohol regularly (i.e. non-abstainers)

From WHO Report on Alcohol, 2004

Comorbidity of BPD and AUD

- Substantial evidence supports comorbidity
- Data come from clinical samples and general population, using variety of methods including cross sectional designs, longitudinal research and prospective studies

Substance Use Disorders (SUDs) in Mental Illness



- *General pop, schizophrenia, bipolar, unipolar, dysthymia (ECA data early 1980's) Regier et al.(JAMA,1990)*
- *PTSD (NCS data early 1990's) Kessler et al. (Arch. Gen Psy,1995)*
- *Borderline (1980's –1990s), Trull et al. (Clin Psy Rev, 2000)*
- *All smoking data (1980 local outpt study), Hughes et al. (Am J Psy,1986)*

Causal Pathways

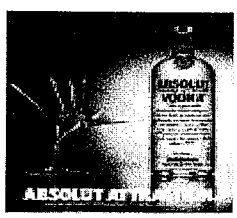
- Direct causal link – the existence of one leads to the development of the other
- Indirect causal link – the existence of one affects a third variable that in turn leads to the development of the second
- No causal link – presence of common factors may lead to the development of both disorders

Direct Causal Link

- **Alcohol abuse precedes Personality Disturbance**

■Character traits may be reinforced or maintained by alcohol

■Individuals part of social group will use alcohol and will develop behaviors that will be strengthened and maintained by the group

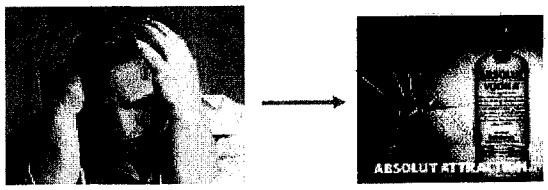


Direct Causal Link

- **Personality Disturbance precedes AUD**

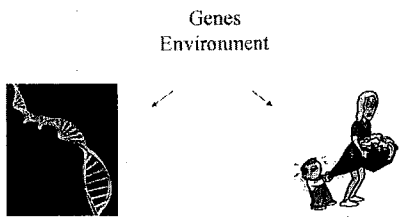
▪Individuals who tend to seek novel and exciting experiences may use alcohol for its rewarding properties

▪Individuals prone to stress use alcohol to reduce tension or to self medicate "self-medication hypothesis"



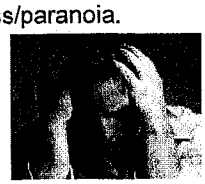
Common Factors

- Comorbidity can be explained by common underlying factor or common genetic/environmental variance



Self Medication" Hypothesis

- Use alcohol to deal with mood symptoms, anxiety, suspiciousness/paranoia.
- Use alcohol to treat side effects of medications used for mood symptoms, anxiety, suspiciousness/paranoia.



AUD and Affect

"I don't have feelings. Feelings are meaningless to me. I can say words like 'up' and 'down' but I really don't know the difference. It's a matter of space, the drugs fill in, they go into the space. With them I can predict what it will be like inside me, otherwise there is no control, like gun control".

Southwick & Satel, 1990

AUD and Affect

"Drinking makes me feel wanted and acceptable. When I don't drink I get real angry with different people. I smash things when I'm mad and it relieves me some; drinking does the same thing".

Southwick & Satel, 1990

AUD and Impulsivity-link to behaviors

Pt decided to curtail her promiscuous behavior "because of AIDS", and curb risk-taking behaviors "because I almost wrecked my car twice last week".

Alcohol is the "best way I have to deal with boredom now that I never leave the house".

Southwick & Satel, 1990

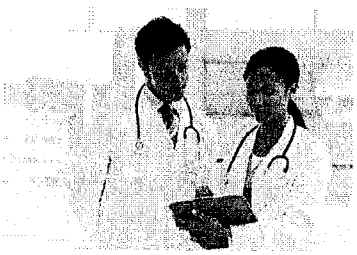
AUD and Cognitive-Perceptual

"Sometimes I feel afraid of people and I kind of keep my back to the wall. I just don't feel as afraid when I drink".

Alcohol may be taken to deal with medication side effects that result from neuroleptics or mood stabilizers.

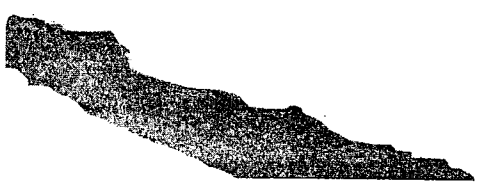
Southwick & Satel, 1990

Treatment



Medications

A very small piece of a bigger picture

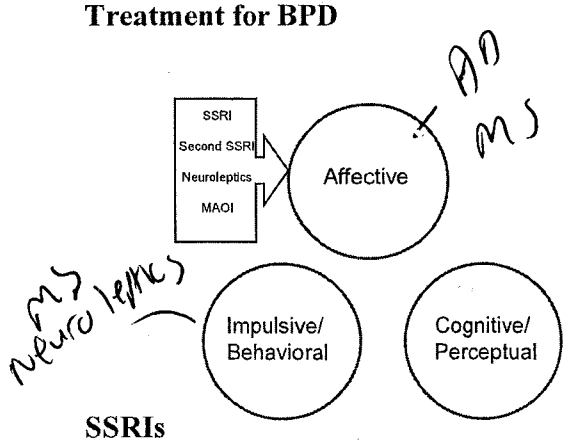


Medications for BPD

Different algorithms based on symptoms

- Affective Dysregulation symptoms
- Impulsive-Behavioral Dyscontrol symptoms
- Cognitive Perceptual symptoms

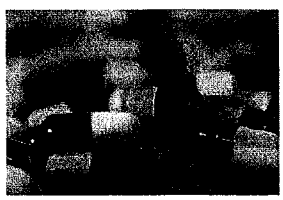
Treatment for BPD



SSRIs

- **Selective serotonin reuptake inhibitors** are a class of compounds typically used as antidepressants in the treatment of depression, anxiety, and some personality disorders.
- SSRIs increase the level of the neurotransmitter serotonin by inhibiting its reuptake.
- Increase the level of serotonin available to bind to the receptor.

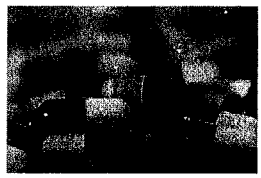
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)



Other Antidepressants (MAOIs)

- *Monoamine oxidase inhibitors* (MAOIs) may be used if other antidepressant medications are ineffective.
- MAOIs work by blocking the enzyme monoamine oxidase which breaks down the neurotransmitters dopamine, serotonin, and norepinephrine (noradrenaline).
- MAOIs can be as effective as tricyclic antidepressants, although they can have a higher incidence of dangerous side effects.
- Food restrictions

- Phenelzine (Nardil)
- Isocarboxazid (Marplan)
- Tranylcypromine (Parnate)
- Moclobemide (Aurorix, Manerix)
- Selegiline (Eldepryl, Emsam)

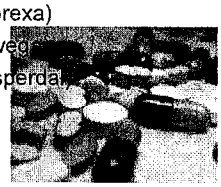


Neuroleptics

- The word *neuroleptic* is derived from Greek: "νεύρον" (nerves) and "λαμβάνω" (*take hold of*). Thus, the word means *taking hold of one's nerves*.
- This term reflects the drugs' ability to make movement more difficult and sluggish.
- There are typical and atypical neuroleptics. Both classes of medication tend to block receptors in the brain's dopamine pathways, but neuroleptic drugs encompass a wide range of receptor targets.

- Haloperidol (Haldol)
- Chlorpromazine (Thorazine)
- Fluphenazine (Prolixin)
- Perphenazine (Trilafon)

Clozapine (Clozaril)
Olanzapine (Zyprexa)
Paliperidone (Invega)
Risperidone (Risperdal)



Mood Stabilizers

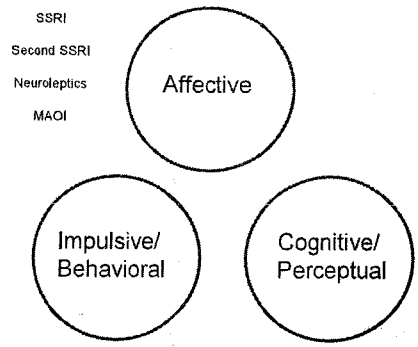
- This category of drugs encompasses medications with both antimanic and antidepressive actions.
- Anticonvulsant medications are often included in this category.
- Can encompass a wide range of receptor targets.

- Lithium Carbonate

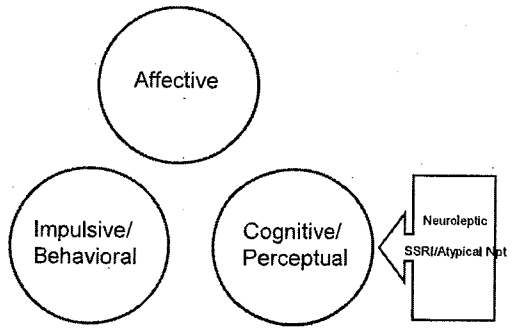
Anticonvulsants

- Valproic acid (Depakene), Divalproex sodium (Depakote)
- Lamotrigine (Lamictal)
- Carbamazepine (Tegretol)
- Gabapentin (Neurontin)
- Topiramate (Topamax)

Treatment for BPD



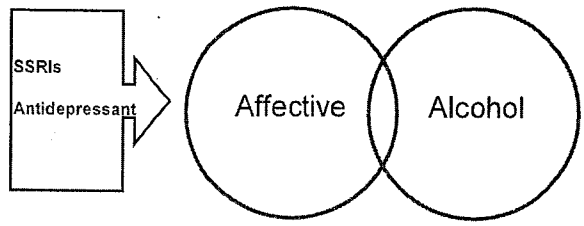
Treatment for BPD



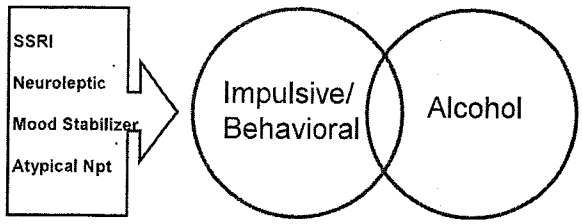
Considerations in patients with BPD and AUD

- Efficacy — Does it work
- Side effects
- Toxicity
  - Lithium
  - MAOIs
- Compliance

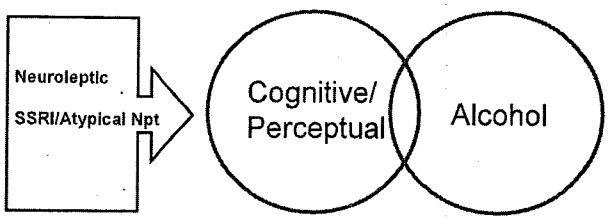
Treatment for Comorbid BPD and AUD



Treatment for Comorbid BPD and AUD



Treatment for Comorbid BPD and AUD



Medications for Alcoholism

Disulfiram (Antabuse)

in use for over 50 years

Naltrexone (Revia)

FDA Approved in 1994

Acamprosate (Campral)

FDA Approved in 2004

Disulfiram

- **Disulfiram** (Antabuse) interferes with the metabolism of alcohol.
- Drinking while taking disulfiram causes unpleasant symptoms.
- Those can include facial flushing, severe headaches, nausea, vomiting, increased blood pressure and increased heart rate.
- The idea is that the association of negative symptoms with drinking will deter people from drinking.
- Individuals who choose to start drinking stop taking the medication for a few days before consuming alcohol.

Naltrexone

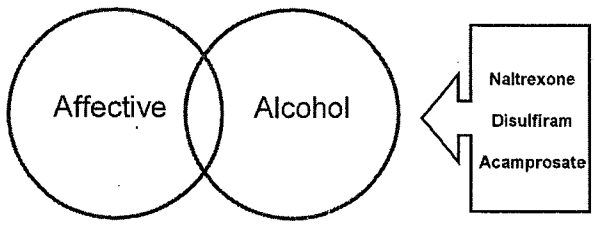
- Naltrexone is an opiate receptor antagonist – blocks opioid receptors.
- Used to reduce craving and alcohol relapse.
- Eliminates euphoria associated with alcohol.
- Makes alcohol less rewarding.
- Does not cause sickness if alcohol ingested.
- Has a relatively mild side effect profile.

influences mood?

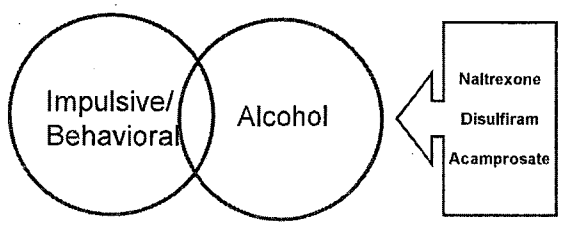
Acamprosate

- Thought to normalize alcohol-disrupted brain activity.
- Acts on the GABA and glutamate neurotransmitter systems.
- Best at maintaining abstinence.
- Not absorbed by the liver.
- Mild side effect profile.

Treatment for Comorbid BPD and AUD



Treatment for Comorbid BPD and AUD



For more information

http.//borderlinedisorders.com http.//www.alcoholics-anonymous.org

http.//www.niaaa.nih.gov

http.//www.nacoa.net

WHAT ARE EMPIRICALLY SUPPORTED THERAPIES FOR SUBSTANCE USE DISORDERS, WHERE DID WE GET THEM, AND WHAT DO WE DO WITH THEM?

KATHLEEN M. CARROLL, PHD

PROFESSOR OF PSYCHIATRY
YALE UNIVERSITY SCHOOL OF MEDICINE

Bio

Dr. Kathleen M. Carroll graduated summa cum laude from Duke University, received her Ph.D. in clinical psychology in 1988 from the University of Minnesota, and completed her pre-doctoral training at the Yale University School of Medicine's Division of Substance Abuse, where she was promoted to Professor in 2002. Since 1994 she has served as Scientific Director of the Center for Psychotherapy Development at Yale, NIDA's only Center devoted to behavioral therapies research, and since 1999 she has been Principal Investigator of the New England Node of the National Institute on Drug Abuse's Clinical Trials Network, one of the four founding centers funded in this national infrastructure. A Thompson Institute for Scientific Information Highly Cited Researcher, Dr. Carroll is the author of over 150 peer-reviewed publications as well as numerous chapters and books. Her research has focused on the development and evaluation of behavioral treatments and combinations of behavioral therapies and pharmacotherapies, with an emphasis on improving the quality and rigor of clinical efficacy research in the addictions. Dr. Carroll received a NIH MERIT (Method to Extend Research in Time) award in 2003 for her work on developing President of the American Psychological Association's Division 50 (Addictions) from 2002-2005 and received the Divisions' Distinguished Scientific Contributions to Education and Training Award in 2005.

Objective

1) Understand what empirically supported therapies are, as well as how they are developed and evaluated.
2) Identify some empirically supported therapies for substance use disorders
3) Recognize some of the challenges in transporting empirically validated therapies to clinical practice.

W(h)ither Empirically Supported Therapies?
OR
Now that we have them, what should we do with them?

Overview of presentation

A vision for the evaluation and dissemination of Empirically Supported Therapies (ESTs), emphasis on addictions

- Now that we have Empirically Supported Therapies, what should we do with them?
- Strengths and weaknesses of moving ESTs into clinical practice
- Questions/implications for training, clinical programs, and areas for research

Critical issues regarding dissemination of empirically supported therapies

- Effectiveness:
  - Do empirically supported therapies stand up in the real world?
- Training:
  - What do we actually know about training, what do we THINK we know, and what do we need to know about training?

Criteria for evaluating empirically supported therapies

At least two independent randomized clinical trials where:

- The treatment is compared to a well-defined control or comparison condition
- Patient groups defined using inclusion/exclusion criteria
- Treatment defined in manual or other method that can serve as a basis for training
- Treatment fidelity/quality monitored objectively
- Use of validated outcome assessments, assessors independent of treatment

Available ESTs vs. Clinical practice

- Community reinforcement approaches
- Contingency management approaches
- Behavioral marital therapy
- Motivational interviewing
- Multisystemic approaches, BSFT for adolescents
- Cognitive behavioral approaches
- Manualized Twelve Step Facilitation (individual)

Now that we have all these ESTs, what should we do with them?

- How should clinicians select among available therapies?
  - Meta-analyses of meta-analyses suggest few meaningful differences in outcomes between different ESTs.
  - Little support from large matching studies regarding what type of patient does well in what type of treatment
- What therapies should be disseminated?
- What clinicians should be trained in what therapies?

Little research on

- Are ESTs actually superior to clinical practice or 'clinicians' choice?
- Most trials done in 'community settings' replicate those found in controlled research settings, BUT
  - Few trials address whether adding ESTs to standard treatment improves outcomes

How should training be done?

- Massive deployment of armies of trainers in the 100+ available ESTs to all clinicians worldwide?

OR

- Careful consideration of issues such as:
  - Which of the ESTs are likely to foster the greatest improvements in practice?
  - How best to train clinicians and sustain effects of training?

What do clinicians need in order to implement ESTs *effectively*?

- Mastery of 140+ interventions impractical
- Most clinicians not in specialty clinics/ practices where the large number of ESTs might be manageable
- Clinician's work rarely directly monitored

- EST = Easily Sustainable Treatment

What are options for *training* programs?

- Lumping
  - Major categories (e.g., CBT, interpersonal, motivational, disease model)
  - Focus on a few change principles
  - Master specific ESTs by interest or specialty
  - This has resulted in few practitioners who actually practice ESTs
- Splitting
  - Require mastery of 1-2 EVTs?

What are options for *treatment* programs?

- Identification of a reasonable 'first line' therapy
  - Inexpensive, broadly applicable, empirical support
- More expensive, specialized approaches (e.g., Contingency Management) reserved for those who don't respond to first line treatment
  - Adaptive treatment strategies
- For specialty programs with experienced therapists, training in 3-4 change processes associated with ESTs may be practical

Caveats*

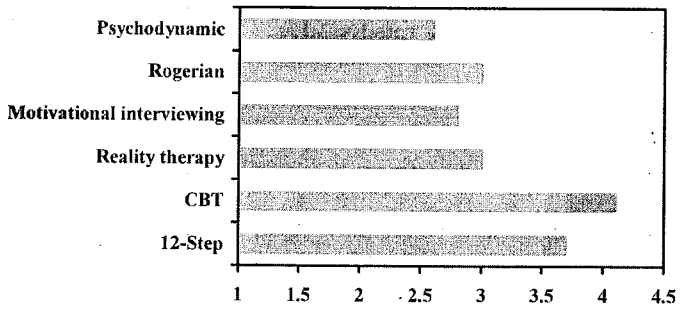
- These were *early* sessions only
- Most clients also had access to group and other program elements

But…

- Volunteers aware of being taped

- Highly reliable ratings, validated instruments used

CTN MET/MI studies:
Primary counseling orientations endorsed
***BEFORE* randomization and training**



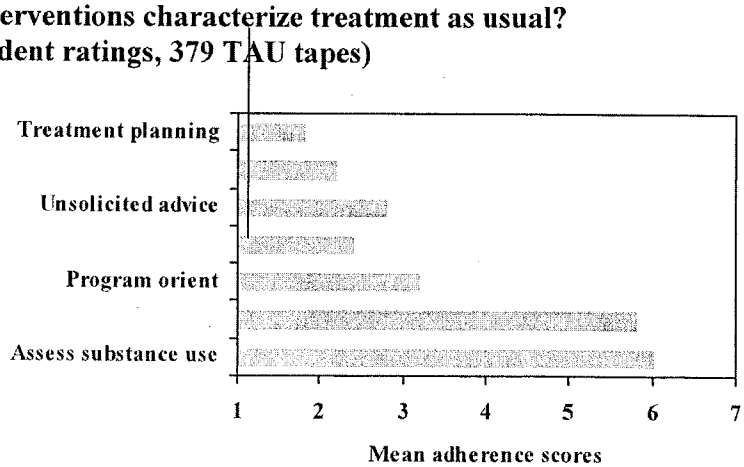
Sample YACS Item-Assessment

To what extent did the therapist assess the patient's substance use since the last session?

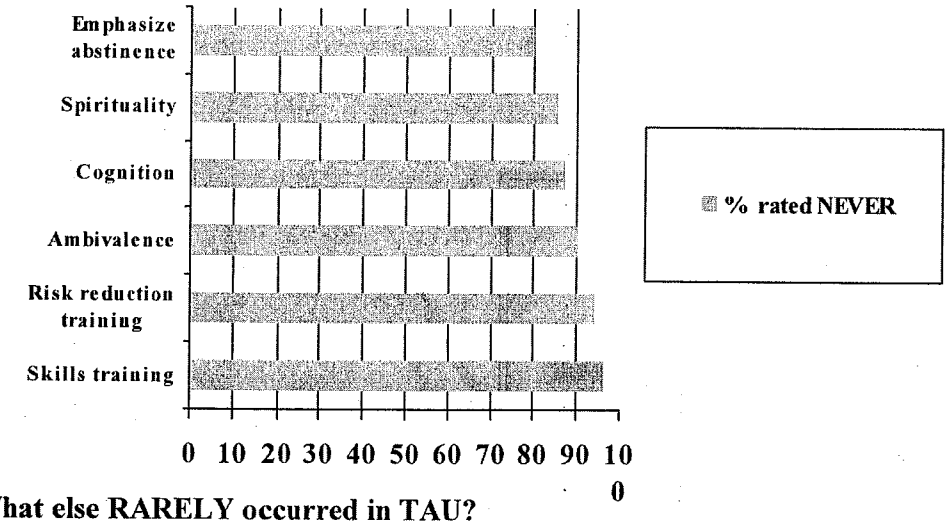
Quantity/adherence rating
1------2------3-------4-------5-------6-----7
Not at all A little Moderately A great deal Extremely

Quality/skill rating
1------2------3-------4-------5-------6-----7
Poor Fair Adequate Good Excellent

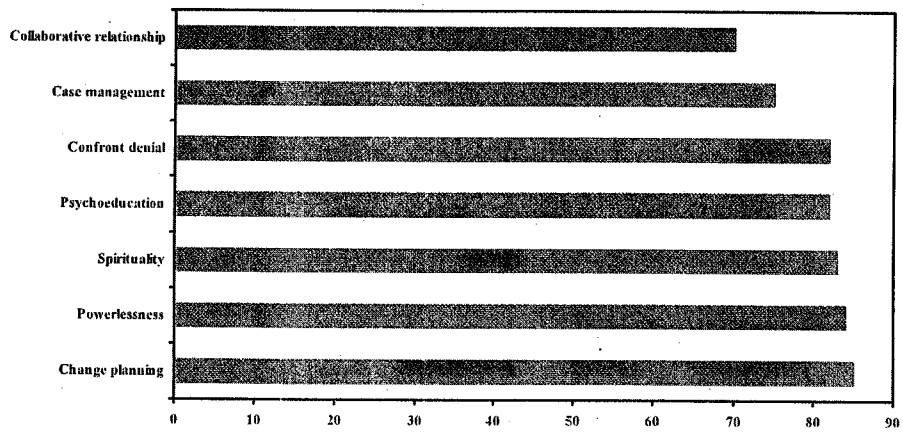
What interventions characterize treatment as usual?
(independent ratings, 379 TAU tapes)



What interventions NEVER occurred in TAU?



What else RARELY occurred in TAU?



Bottom line: Analysis of TAU tapes

- Most frequent: assessment of substance use and social support
- Extremely rare: interventions associated with ESTs
- Clinicians dramatically overestimate time spent on interventions
- High levels of discourse unrelated to presenting problems, 'chat'
- Training / supervision appears to reduce level of chat, improve outcome*
  - *Outcomes reasonably good, but small 'tweaks' with MI enhance outcome
- *Supervision, self monitoring may be key*

What do we *know* about training?

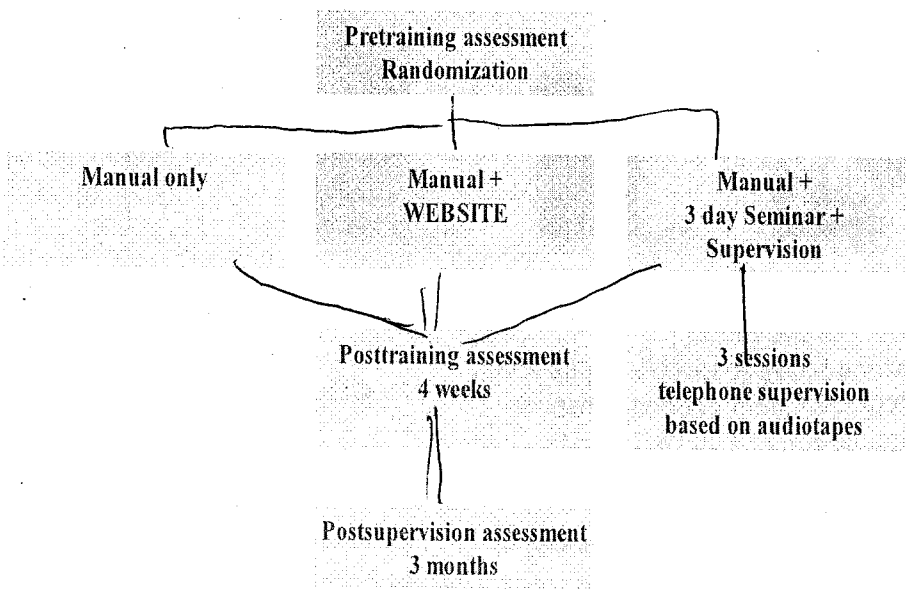
- Efficacy study models ***appear*** to be effective model of training ***selected*** therapists to use manualized therapies in clinical trials
- The model appears associated with relatively little variability in outcome across therapists, highly discriminable treatments implemented with good fidelity to manual guidelines
- BUT: Many elements accepted at face value and have not been systematically evaluated

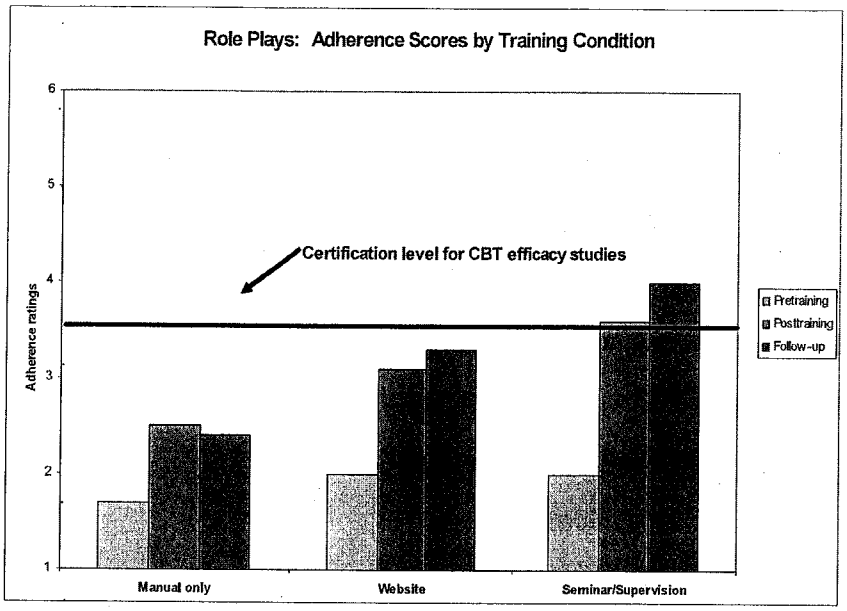
Dominant models of training in empirically supported therapies

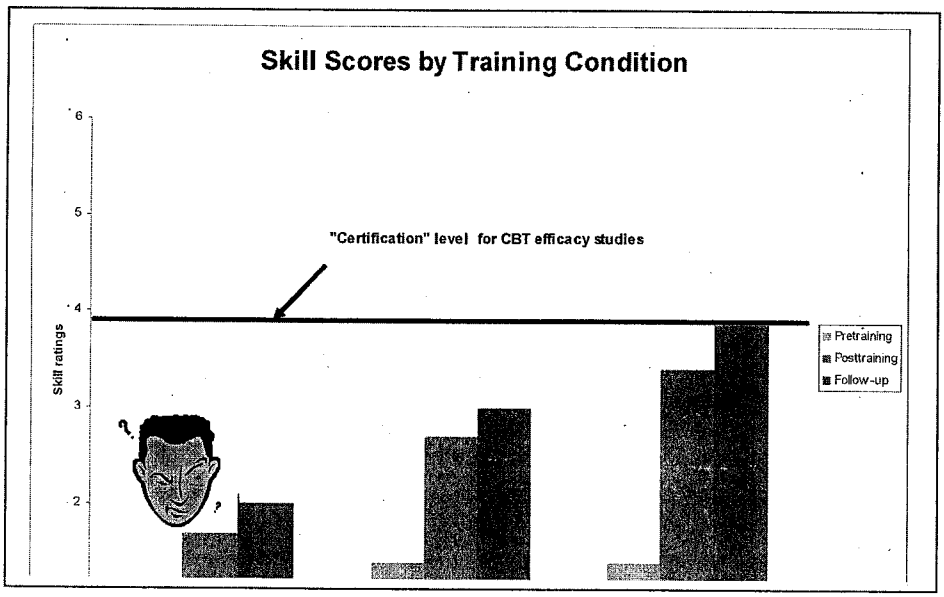
- On the job training
- Widespread distribution of manuals
- Brief workshops

How effective are they?

Design: CBT Dissemination trial







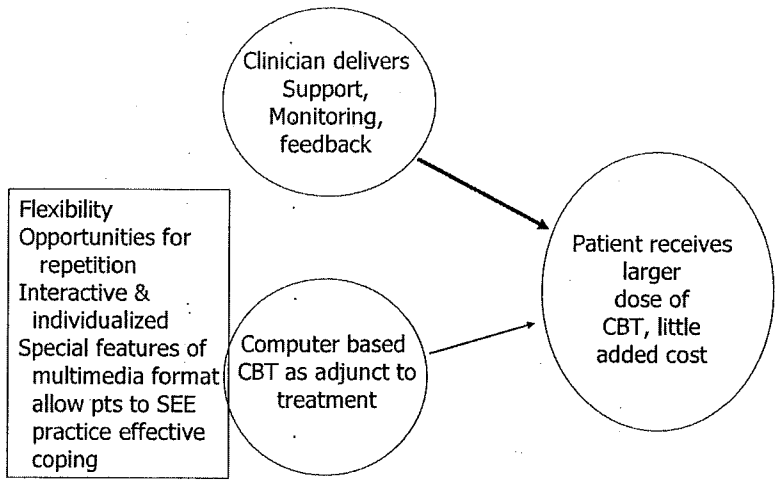
Implications: Training study

- Clinicians unlikely to be able to effectively implement CBT after reading a manual
- …or after attending a single workshop
- Supervision, feedback, coaching may be essential
- Promise of computer-assisted training

echo! Marsha

Sholomskas et al, 2005, JCCP

Computer-based delivery of CBT as adjunct



'CBT 4 CBT'
Computer Based Therapy/CBT

- 6 modules, 1 hour each, high flexibility
- Video examples of characters struggling
- Multimedia presentation of skills
- Repeat movie with character using skills to change 'ending'
- Interactive exercises, quizzes
- Multiple examples of

'homework'

Overview: Randomized clinical trial

- 8 week randomized clinical trial
- Outpatient community treatment program
- Standard treatment (weekly individual + group therapy) (TAU) vs. CBT4CBT + TAU
- CBT4CBT offered in up to 2 weekly sessions
- 6 month follow-up

- Option of fMRI studies

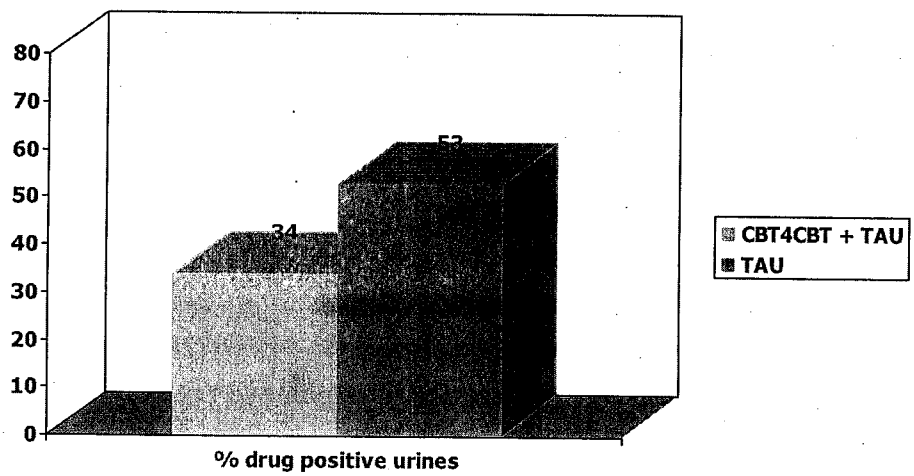
Carroll et al., Am J Psychiatry, 2008

Participants

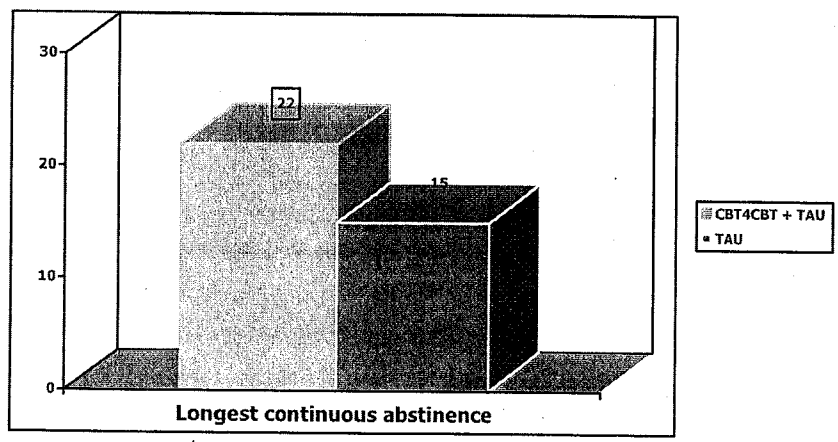
"All comers": few restriction on participation, only require some drug use in past 30 days

- 43% female
  - 45% African American, 12% Hispanic
- 23% employed
- 37% on probation/parole
- 59% primary cocaine problem, 18% alcohol, 16% opioids, 7% marijuana
- 79% users of more than one drug or alcohol

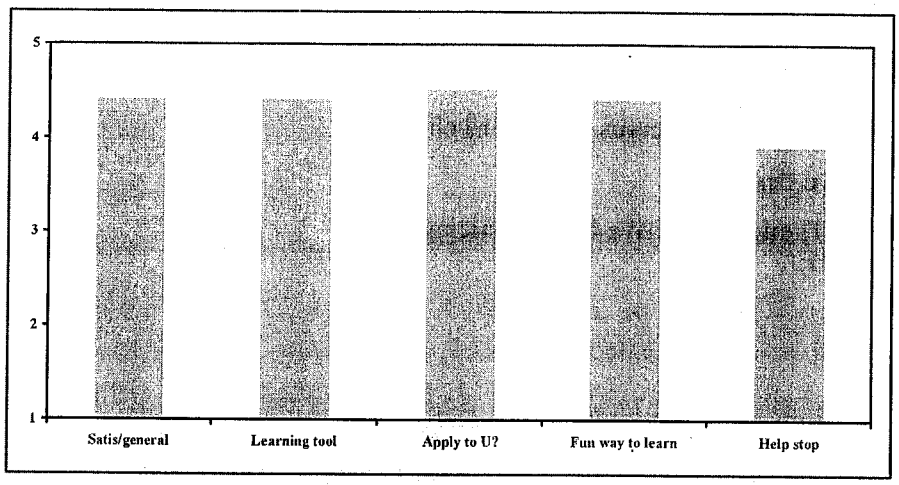
Primary outcomes, 8 weeks CBT+TAU versus TAU



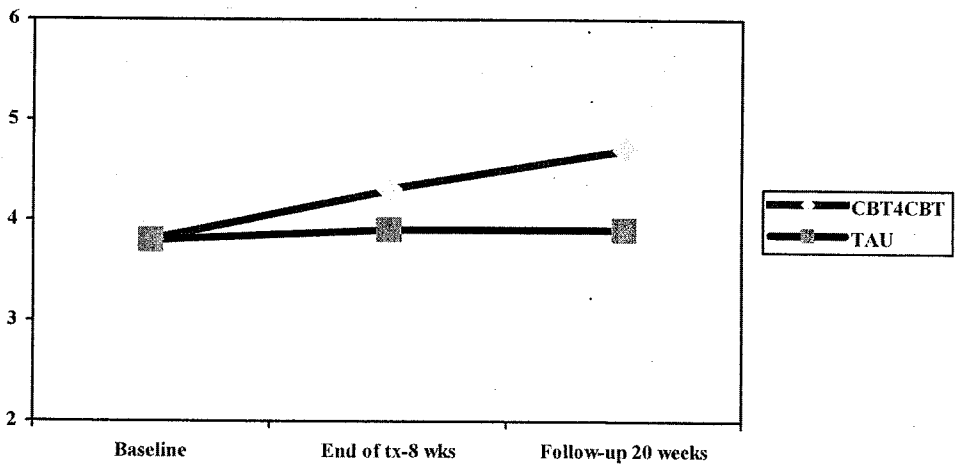
Primary outcome: Longest consecutive abstinence, in days, at 8 weeks by condition



Participants' satisfaction w/CBT4CBT

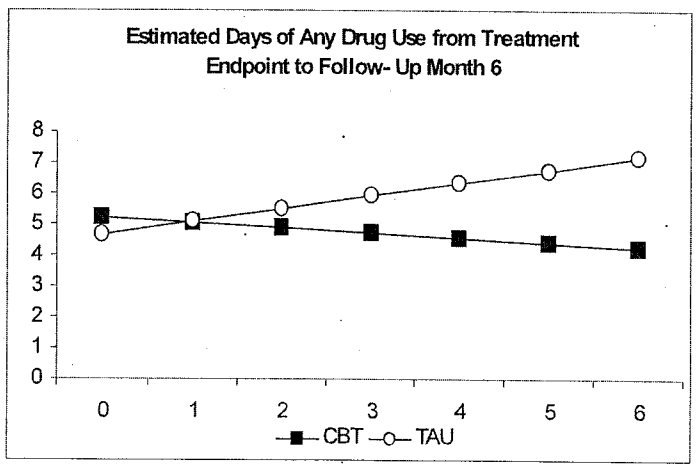


Skill level though 6 month follow-up: Quality of best response by condition



Durability of Effects: 6 month follow-up

Carroll et al., in press



W(h)ither ESTs: Key questions

- Efficacy
  - First line therapies versus 2nd or 3rd choice
  - Adaptive designs?
  - Are ESTs more effective than "clinician's choice"?

- Training
  - Limitations of current models
  - How much and what kind?
  - How sustainable
  - Role of supervision
  - Costs and benefits
  - Leveraging resources

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