

PTSD 101
Posttraumatic Stress Disorder and Substance Abuse:
Dual Diagnosis Overview & Treatment
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Slide 1: Posttraumatic Stress Disorder and Substance Abuse: Dual Diagnosis Overview and Treatment

Hello. I'm Dr. Robyn Walser with the National Center for PTSD and I'm going to be presenting on Post Traumatic Stress Disorder and Substance Abuse: Dual Diagnosis Overview and Treatment.

Slide 2: Goals of the Presentation

The goals of this presentation are to address the relationship between posttraumatic stress disorder and substance abuse disorders. I also want to talk about assessment of the two disorders. I want to look at the treatment environment and therapeutic relationship. And then finally, I'll present some recent treatments that address the dual diagnosis of PTSD and substance use.

Slide 3: Complex Relationship between PTSD and SUD

But first let's begin by talking about the complex relationship between PTSD and substance use disorders. First let me note that they tend to occur at a relatively high rate and estimates vary across populations. Some of the recent data that we have includes that the rate among patients in substance use treatment programs ranges from twelve to fifty-nine percent. The higher end usually tends to be women as they get diagnosed more frequently with this dual disorder. Fifty-eight percent of veterans in SUD programs have lifetime PTSD. And about seventy-three percent of male Vietnam veterans who met diagnostic criteria for PTSD also qualified for lifetime substance use disorders.

Slide 4: Complex Relationship between PTSD and SUD

It should also be noted that the odds of drug use disorders are about three times greater in individuals with versus without PTSD. And the presence of either disorder alone increases the risk for the development of the other. So if you have a trauma it's associated with the development of SUDs and people with PTSD and SUD disorders are vulnerable to repeated traumas.

Slide 5: Complex Relationship between PTSD and SUD

There is also evidence that PTSD and substance use disorders have an adverse impact on treatment outcome. It will be one thing that you'll want to think about and consider when you're treating individuals who have this dual diagnosis. Some of the treatments that I'm going to talk about later may help as you consider working with these individuals. It's also been found that

PTSD and SUD diagnosis is associated with more severe drug use. So individuals are often using things like cocaine and opiates and the struggle to get clean can be quite difficult.

Slide 6: Complex Relationship between PTSD and SUD

PTSD and substance use disorder patients also evidence significantly greater impairment in a number of areas. So they have other Axis I disorders such as depression, other anxiety disorders. These patients also have increased psychiatric symptoms and inpatient admissions. And they tend to have more interpersonal and medical problems. Individuals that I've worked with in the past often have multiple marital, family, and friendship problems. And I've also worked with individuals who have a variety of medical problems including chronic pain, fibromyalgia, and gastrointestinal disorders. These tend to complicate treatment. Much of the time these individuals are dealing with medical issues that can sometimes interfere with treatment progress. It's important to always assess for these issues and work with your primary care doctor. These patients also have decreased motivation for treatment, decreased compliance with after care. It's associated with maltreatment of children, custody battles, homelessness, and HIV risks. So as you can see many of these individuals have multiple problems.

Sometimes when an individual with this dual diagnosis walks through your door it can feel a little bit overwhelming. One of the treatments that I'm going to talk about a little later can help with addressing some of these multiple problems that show up when somebody has this dual diagnosis.

Slide 7: CBT-Derived Methods are Much Used in VHA/RCS PTSD Services

PTSD unlike other disorders may worsen in the early stages of abstinence creating a challenging treatment environment. When individuals with this dual diagnosis are getting clean and they're going through withdrawal symptoms they may begin to experience anxiety and other symptoms that are associated with PTSD and then want to begin taking the drug of choice again so that they can self-medicate the symptoms. In addition exposure therapy can trigger substance abuse relapse. And exposure therapy is one of the main treatments for PTSD and so it's one thing that you'll want to consider when you're introducing exposure therapy is.... is the person at risk for relapse and if so what kinds of relapse prevention interventions can you introduce?

I'd also like to take a few minutes and talk about aspects of twelve step groups that are difficult for some trauma patients. First let me talk about the issue of powerlessness. In the first step of twelve step groups you have to admit that you're powerless and many individuals who are struggling with PTSD have difficulty working with this particular notion. Often when they're coming to treatment they're wanting to regain power. They're wanting to find some sense of control in their world that feels out of control. So powerlessness can trigger PTSD symptoms or admitting that one is powerless. So one of the things that you can do as a treatment provider is talk with the individual that you're sending to the twelve step group about this particular issue. Let them know that they're admitting that they're powerless to the substance but not powerless to their lives. That is that they can regain power in their life by working on the powerlessness in the substance abuse area.

Another aspect of twelve step groups is working with a higher power. Many individuals who have PTSD are struggling with their notions of religion and God and may have difficulty working with this notion of a higher power. It maybe important to remind your client before

sending them to a twelve step group that the higher power can be anything that they choose. It can be nature. It can be the universe. It can be the group itself. It doesn't necessary have to be a God-like figure. It can be very helpful to the trauma survivor to work through issues of religion. It's also important to work with your patient on locating the appropriate group. If you've never attended a twelve step group it is a good idea to at least attend one so that you know what kinds of things happen in those groups. It may be surprising to you.

There are a variety of twelve step groups that are available and people can go to groups ranging from all women to gay and lesbian to open to closed. So it's important to help the person that you're working with find the group that suits them.

I can give an example. I once worked with a woman who had a trauma history and was also planning to attend NA. She and I picked an open group and met at the NA meeting. Much to our surprise the leaders of the group were gentlemen who were wearing leather jackets and also were carrying swords on the sides of their bodies. If you're an individual who has experienced a trauma and there is a male figure who's carrying a weapon this might feel threatening to you. I don't understand how the weapons were allowed at the group but it just goes to the point of the importance of knowing where you're sending your trauma survivor when you're involving them in twelve step groups.

Finally I'd like to address issues of forgiveness. Often within the AA community individuals are working on forgiveness of themselves and perhaps others. One of the things that can show up there is that some trauma survivors may immediately think that they need to forgive their perpetrator. You want to remind them that this is not the issue. That forgiveness is not necessary of their perpetrator and in fact they may not need to make any kind of reparations along those lines. It also can be important in terms of forgiveness of self. Some of our trauma survivors who have been in war have committed war crimes or war atrocities. It is often difficult to think about forgiving one's self under these conditions. One of the ways that I address this is to talk about forgiveness in terms of what it literally means. It means to give what went before. So here I talk with the patient about giving to themselves the thing that came before the trauma. So for instance you might have a combat veteran who's been in the Vietnam War. Think about who he was before he went to war, that nineteen year old boy who had ideals and probably didn't imagine himself having PTSD and a substance use disorder later in life. If he could think about what to give to him from this point in time what would that be? Usually you can talk about it in terms of kindness to self, caring for one's self, acceptance of one's self when you're picturing that nineteen year old who went to war. This way forgiveness is seen as more of an action rather than a feeling. I also talk with patients about how forgiveness isn't necessarily a feeling. Often people feel lighter or like they've had a sense of being lifted when they've forgiven someone or if they've forgiven themselves. But I remind them that these feelings can come and go and at times they will feel forgiving and at times they won't feel forgiving. However they can always act in a forgiving way. So if you focus on the action part of forgiveness that can help them stay focused on being compassionate towards themselves.

Finally I think it's important just to keep in contact with your patient about how the twelve step groups are going. Keep an open dialogue with your patient so you can see if they're being triggered, if the group is being accepting. Remind them that they may want to keep their trauma story in session with you and not necessarily say it in the group. You don't know what kinds of responses others might have to a difficult trauma story. So just keeping in touch with your patient about attending these groups can be very helpful and can guide you in how you work with the individual as they continue in their twelve step process.

Slide 8: Functional Associations between PTSD and SUD

I'd like to take a few moments and talk about the functional associations between PTSD and substance use disorders. One of the main thoughts about the functional associations between PTSD and substance use is that alcohol and drugs are abused in an attempt to control PTSD symptoms. That is individuals are self-medicating. They're trying to manage their symptoms by suppressing them through depressants or else they're trying to feel good by using stimulants.

A couple of other functional associations include PTSD arising from a trauma as a result of heightened physiological arousal due to repeated withdrawal. When withdrawing from substances you can experience a lot of arousal. If you also experience a trauma during this time PTSD could result. Additionally SUD may increase the risk of development of PTSD by increasing the likelihood of exposure to certain types of trauma. If you are living within the substance use world or culture you may be encountering situations that increase the likelihood that you'll be traumatized.

And finally a third variable maybe related to the development of both PTSD and substance use disorders following a trauma exposure. So for instance having poor coping skills maybe a third variable that leads to the development of this dual disorder.

Slide 9: Assessment

I'd like to take a few minutes and talk about assessment of this dual diagnosis. There are two major considerations in assessment. First there is timing and then there's measures and methods.

Slide 10: Assessment

Let's first talk about timing. One of the things that you'd like to do is make sure that when you're doing the assessment you're not doing it at a time when the person is actively using or withdrawing from a substance. The substance use can mask or minimize PTSD symptoms. Diagnosing PTSD should be avoided while in these acute stages of withdrawal so that you don't have an interference of the symptoms with what it is that you're trying to assess. For instance withdrawal symptoms can appear similar to PTSD symptoms. They can include things such as sleep loss, nightmares, and anxiety. And you just want to be sure that these are due to PTSD and not withdrawal.

Slide 11: Assessment

Secondly let's look at measures and methods. You also want to think about the types of interviews or assessments that you'll want to give the individual. There are a number of ways that you can do this. There are structured clinical interviews, which I'll just mention three here in a moment and also self-reports. These three structured clinical interviews include the structured clinical interviewer for DSM-IV or the SCID, the Clinician-Administered PTSD Scale or the CAPS, and the Addiction Severity Index or the ASI. The SCID can be used to assess both PTSD and substance abuse. It does have excellent psychometric properties that require a substantial amount of training. For substance use it can be used to diagnose abuse or dependence and it also allows you to specify mild, moderate, and severe. It is also fine for PTSD but lacks

the precision that the CAPS has. The CAPS assesses core and associated PTSD symptoms that are both current and occurring over a person's lifetime. It has been found to have excellent psychometric properties and is widely used. The ASI is not necessarily a diagnostic measure per se but is commonly used in clinical research settings to gather detailed information about substance use and its consequences.

I'll take just a moment and talk about self-report measures. These are both time efficient and effective in assessing trauma.

Slide 12: Self Report Assessment

So let's go ahead and talk about self-report measures. I'll list just a couple. For PTSD there's the PTSD checklist or the PCL, the Trauma History Questionnaire, and the PTSD Symptom Scale self-report. These are just a few that are available. There are others, but these are some of the main self-report assessments that are used. For substance use disorders there's the Michigan Alcohol Screening Test and the Drug Abuse Screening Test.

Let me just mention that the self-report measures are time efficient and effective in assessing trauma, however, the drug and alcohol screens are insufficient for a formal diagnosis. They are useful for screening and further testing, however. The self-report measures are easy to administer and can be used in a variety of settings.

Slide 13: Treatment Environment

Let's move onto the treatment environment. Most treatment programs treat either trauma or substance use but not both. It is recently opined that perhaps PTSD and trauma should be treated simultaneously. So it's one thing to consider. And as I talk about treatments a little bit later you'll see how individuals are beginning to look at this dual diagnosis as something that should be treated by the same clinician at the same time.

Another thing to consider is that treatments that are effective for PTSD may not be effective for substance use disorders and vice versa. So you want to be looking at treatments that can address both of these disorders.

Also if you look at the treatment programs or clinicians who are treating individuals they often do not have training in both of these areas. So substance use treaters often are only familiar with substance use or maybe slightly familiar with PTSD. And PTSD treaters are only slightly familiar with substance use treatment or incorporate it to some small degree. The cultures and assumptions can be quite different for each disorder and population. It is important for treaters to get cross-training, to know both about PTSD and substance use in order to provide the most effective treatment.

Slide 14: Treatment Environment

Other issues related to the in-treatment environment include that many clients may have intensive case management needs, which go beyond the training capability of some therapists. The thing that you may want to do is maintain close contact with your treatment team or social workers who can help you with case management needs. If you'll recall when I was talking about the complex relationship between PTSD and substance use there are a variety of things

that individuals who have this dual diagnosis maybe dealing with. And so you want to be helping them to manage a number of things in addition to their symptoms.

It can also be difficult to predict patient's course of recovery. Both abstinence and continued use can make symptoms better or worse. As the treater you'll want to be watchful to see what's happening with the individual that you're working with in their course of recovery. Also treatment can be effective but unstable. Often there are multiple crisis, erratic attendance and early relapse. So you want to be focusing on coping skills that can help individuals deal with these particular problems.

Slide 15: Treatment Environment Considerations

Other considerations include group therapy. Often group therapy requires social skills and some degree of comfort. What you may want to do is work with the individual first and then place them in group therapy in order to increase their comfort level or if it feels appropriate you can talk with your patient about how being in group therapy can increase their social skills, will help them shape and refine those things so they can better interact in their environment. Also group therapy can be difficult for sexual assault survivors because of the interpersonal nature of their trauma. They may find it harder to disclose. They may feel quite a bit of shame and responsibility about what has happened to them and so many feel great discomfort in the group setting. Be sure to assess for this with your individual before placing them in group therapy. Also with this population there is a greater need for a safe therapeutic environment. You want to be sure to minimize exposure to triggers to whatever degree you possibly can.

Slide 16: Treatment Environment Considerations

Intensity of treatment is also an issue. In the initial stages of treatment you may want to increase contact. And you also may want to increase environmental interventions. If possible you want to get the family involved. You want to see if you can increase contact with abstainers. You want to see if there is anybody at work who can support them in recovery. Be sure to get consent before you do this. You want to evaluate community resources and see what's available to your patient. You may want to consider residential treatment. And another clear issue that happens with people who have PTSD and substance use is that they often are not doing anything in terms of positive activity. When working with the veterans I often give them a schedule to fill out and what I learn much of the time is that they're not really doing anything during their week. They may have an individual appointment on Monday and a group therapy appointment on Thursday but during the rest of the week they're really not doing anything. So one of the things you'll want to be keen to as a therapist is to talk with them about what activities they've given up and see if they would like to reinstitute those activities. If they no longer want to do those kind of activities talk with them about other kinds of hobbies and activities that they can pick up so that they can increase positive activities in their life. You want to look at twelve step programs. You'll also want to create safety and reduce triggers. And as much as possible involve significant others.

Slide 17: The Therapeutic Relationship

I'd now like to talk about the therapeutic relationship. In the culture and among clinicians the views about substance use disorders in PTSD patients can be quite negative. For instance I've heard such quotes as "PTSD veterans are just out to get money" or "substance abusers can never be trusted." This can cause problems in the relationship if you're holding these negative views. It can interfere with your ability to work with the individual in a way that's most helpful to them. So one of the things that you'll want to do is assess yourself and see if you're holding these kinds of judgmental positions about the individual that you're working with. If you are, talk with other treaters about it or see if you can resolve it in some way so that it doesn't interfere with your treatment of the individual.

You also may want to consider countertransference reactions. Sometimes treaters can feel angry with individuals that they're working with who have substance use disorder. Some of the issues that arise are...you may have been working with the individual for quite some time. They've become clean. They're doing well and then they use again. If this happens a number of times therapists can become frustrated and maybe have anger with their clients. This too you'll want to talk about with other therapists and keep your anger in check if that's something that's happening for you. Anger is never useful in the treatment of this particular disorder.

In addition for PTSD sometimes people overpathologize. They see every behavior as pathological and can actually have quite negative impressions of an individual based on behavior that they're evaluating as part of the pathology. If you talk with treaters about how trauma and substance use can effect you behaviorally sometimes you can come to recognize that the behavior is functional for them in some way and it just needs to be shaped into something else. It's not always pathological. So you want to be careful not to overpathologize the behaviors of individuals who have this dual diagnosis.

Slide 18: The Therapeutic Relationship

Another consideration within the therapeutic relationship is less emphasis on confrontation and more tolerance of the problem. Many individuals who treat substance use disorders can use a harsh confrontational style. They can draw the line in a very specific way and say to their client things like "You need to get yourself together," "You need to stop doing this." And can really push on the client in a way that is very confrontational. The thing to consider when working with somebody who has trauma is that their trauma may have occurred under conditions of harsh confrontation and so the very intervention maybe triggering the individual thus causing problems within the therapeutic relationship and perhaps even affecting treatment. On the other side of that is misguided sympathy. There are treaters who feel that their patients have had too many traumas and really over sympathize with what's happening for them and they don't hold them responsible for doing homework or engaging in the responsible actions that are necessary for them to recover. So you want to think of this as harsh confrontation on one end of a continuum and misguided sympathy on the other end of the continuum and see if you can put yourself right in the middle using a soft confrontational style and holding the patient responsible for the different things that they need to do to promote recovery.

Another issue that shows up in the therapeutic relationship is insisting that the individual get clean first. I just want to comment that this does not always need to be a requirement. Individuals can benefit from therapy even if they continue to use. It's not to say that you want them to show up to the therapy session high or drunk. It's that you want to help them through

the process of getting sober and clean. And so the goal maybe sobriety but it doesn't, it isn't a necessary requirement for them to be in treatment. Usually before people start treatment they insist on the individual having no substances onboard. You might want to reconsider this and see how you can help the patient get clean across time as you work with them. I worked with a number of individuals who have this dual diagnosis and have been using in the process of therapy and have worked towards getting clean and sober in that process. You do want to have backup plans for the individual if they show up to the session drunk or high. So you want to have your plans in place should something like that happen. You also want to have any emergency plans in place should the individual overdose or have other complications related to the substance use. Again let me emphasize that you're working with the individual towards sobriety.

Another issue that can show up within the therapeutic relationship is that sometimes clinicians or treaters will have the idea that once an individual deals with their PTSD that their substance use disorder will go away. This is actually not the case and so you always want to be thinking about treating the two disorders and that just by addressing one doesn't mean that the other one will resolve itself.

Slide 19: The Therapeutic Relationship

Finally in terms of the therapeutic relationship I'd like to talk about the clinician's stance. You want to use both praise and accountability with your client. Often when the individual comes into treatment you're focusing on problems that they have and we don't often focus on the good things that they've done. And so one thing that you can do is ask your client what has gone well for them in the past week. Find out from them what good coping that they're doing and praise them for that so that they also are aware that not everything in their life is going poorly, that they are coping well in some areas. You do want to also hold them responsible so if they are failing in some areas you'll want to address that too. Use of both praise and accountability can be very effective in the relationship. As the clinician you also always want to be working on the alliance and maintaining compassion for the situation. If individuals who are in treatment are not maintaining their responsibilities or are relapsing sometimes it's difficult for the clinician to work on the alliance or maintain compassion.

One of the things that you'll want to keep in mind is that people do not want to be struggling with these two disorders. And so if you as the clinician can always have compassion for the situation and always be working on acceptance of the individual while addressing the problems this can help the therapeutic relationship.

You also want to give control whenever possible. Work with the client so that each of you are talking about what therapy is going to look like. Have them say what it is that they like to see happen. If you're heading a particular direction and the client doesn't like it be willing to shift. So help, let them have some control in what's happening. Often when you think about PTSD and substance use these are disorders of loss of control. So instituting control wherever possible can be helpful. As the clinician you also we want to model what it means to try hard and obtain feedback whenever possible. Ask the client how therapy is going.

Slide 20: Treatment of PTSD/SUD

I'd now like to spend time talking about treatment of this dual diagnosis. Practice guidelines exist for both PTSD and substance use disorders, however, there are currently no guidelines specific to the treatment of the comorbidity. There are some recommendations within the existing guidelines, however. For instance PTSD and substance use disorder individuals may benefit more from psychosocial rehabilitation as patients maybe more treatment resistant and maybe engaging in high risk behaviors. Another recommendation is that you'll want to screen PTSD patients for substance use disorders at intake and then again later if there is a failure to respond to treatment. And then you'll always want to refer to specialty care based on these recommendations.

Slide 21: Empirically Based PTSD/SUD Practice

There is information about empirically based PTSD and substance use disorder practice. These are as follows: Substance use disorder patients should be routinely screened for PTSD. You'll want to implement it in your substance use treatment programs. There is some quick screens that you can locate at the National Center for PTSD that are easy to implement and will take care of this particular issue. SUD and PTSD patients should be referred for concurrent treatment of the trauma. So you want to be addressing both disorders at the same time. SUD and PTSD patients should be referred also for concurrent self-help groups and family treatment when indicated. And finally providers should offer SUD and PTSD continuing outpatient mental health care.

Slide 22: Manual-Based Promising Treatments

Keeping the practice guidelines in mind and the empirically based practices in mind I'd now like to talk with you about some specific treatments. There are several manual-based promising treatments that are available. Three that I'm going to talk about are Seeking Safety, a treatment manual for PTSD and substance use, Transcend for combat-related substance use disorder and PTSD, and Substance Dependence PTSD therapy.

Let's first start with Seeking Safety.

Slide 23: Seeking Safety

Seeking safety was developed by Dr. Lisa Najavits. It's a protocol therapy that has gained some scientific support and research and publications are currently being generated. This protocol therapy contains twenty-five coping skills topics and for content areas. These are cognitive, behavioral, interpersonal, and case management. There's about seven to eight coping skills in each of the three areas of cognitive behavioral and interpersonal and case management is followed throughout the treatment. So you're constantly working on case management issues when you're using this particular protocol. The protocol is designed to be maximally helpful to clinicians. And Dr. Najavits defines safety as discontinuing substance abuse, decreasing suicidality, gaining control over extreme symptoms plus other things that make the individual safe and stabilize them as they embark on treatments. Of note there is a version of this treatment that's under development for use with OEF and OIF returning and active duty individuals. I just want to give you a couple of examples of the coping skills topics that are available in this protocol. These are asking for help, healthy relationships, community resources, anger

management, taking good care of yourself, and grounding. This gives you a brief idea of the types of coping skills that are covered in the manual.

Slide 24: Key Features of Seeking Safety

There are several other key features of the seeking safety manual. Seeking safety sees safety as the priority or the first stage of treatment. This is based on Judith Herman's model of recovery where safety and stabilization is the first priority. We then move onto the second stage wherein you address the trauma, work on trauma focus, and then finally you reconnect with the here and now and focus on current issues. This manual targets that first stage and is really focused on safety and stabilization. However I've used this manual in a number of areas and it's good both at first stage, second stage, and third stage in terms of teaching individuals coping skills. The other nice feature about seeking safety it's an integrating treatment. It addresses PTSD and substance use disorders simultaneously. Every session looks at those two disorders and teaches the individual how to work with them as they're looking at that particular coping skill. Another nice feature is that focuses on ideals. It holds that the client is capable of making changes, that there is a potential and hope for the individual and doesn't focus at all on pathologizing the individual. The manual pays attention to therapist's processes and includes information about how to deal with difficult patients and the treatment methods that are in the seeking safety are based on educational research to maximize learning on the patient's part.

Slide 25: Key Features of Seeking Safety

Some other key features of seeking safety include attention to language. Dr. Najavits designed the book so that it doesn't contain a lot of psychological terms that maybe difficult for the individual to comprehend or understand. She uses the word thinking instead of cognition and feeling instead of affect for instance. This makes it easier for the individual to work with the material that they're given.

Seeking safety also emphasizes practical solutions. So its focus is on helping the client do things that are within their grasp. In addition the material is easily related to the patient's lives. Sometimes with manual-based therapies therapists report that they can't always apply the particular session to what's happening for the client. This particular intervention doesn't seem to have that problem. In almost every case where I've been using this intervention I've been able to apply the coping skill that's being addressed to the problem that's being presented at that particular session. Given that you can relate the material to the patient's lives it has a nice clinical realism and feels applicable across the board. And finally it's interesting to the patients. Patients often report that they enjoy the manual, that they like what it has to say, and that it feels like it fits for them specifically.

Slide 26: Transcend

I'd now like to take the last few minutes of our time to talk about transcend for combat-related SUD and PTSD and substance dependence PTSD therapy. I know less about these therapies but I am going to take just a few minutes to describe them briefly.

Transcend was developed by Donovan, Padin-Rivera, and Kowaliw. It's an integrated treatment for patients with combat related SUD and PTSD and the first phase is twelve week partial hospitalization.

Slide 27: Transcend – Phase I

In that first phase of treatment there's a focus on decreasing PTSD symptoms, promoting an addiction free lifestyle. It includes behavioral skills training and exposure. The exposure is of the narrative trauma processing type. And the exposure emphasizes a meaning of the trauma, self-acceptance, and forgiveness. They also work on relapse prevention training and gaining peer social support.

Slide 28: Transcend – Phase II

Phase II of Transcend includes long term continuing care. Here individuals attend a weekly group for six months. And what they work on during that time is PTSD symptom management and relapse prevention. Just briefly in a pilot investigation PTSD symptoms decreased during first phase and remained stable at one year follow-up. I look forward to seeing more data about this particular intervention.

Slide 29: Substance Dependence PTSD Therapy

And finally I'd like to mention Substance Dependence PTSD therapy developed by Triffleman. This particular intervention was developed for patients with varied SUDs and traumas rather than focusing on combat or a particular trauma. It's a two-phase intensive format where the individual meets twice weekly for five months.

Slide 30: Substance Dependence PTSD Therapy

In Phase 1 of Substance Dependence PTSD therapy we are working to establish abstinence, educating the patient about the relationship between PTSD and SUD and you're also working on abstinence-oriented trauma-informed coping skills.

Slide 31: Substance Dependence PTSD Therapy

In the second phase of this therapy the client and the clinician are working on education about decreasing PTSD symptoms, stress inoculation is incorporated, and in-vivo exposure used to desensitize patients to trauma related stimuli is also conducted. Of note, a preliminary open trial supported the efficacy of this intervention. And again I'm looking forward to further data regarding this particular intervention and its effectiveness.

So to summarize when thinking about treating the individual who has this dual diagnosis you'll want to consider assessment. You'll want to consider practice guidelines and empirically-based practice information. And then finally, treating the dual diagnosis simultaneously. So looking at both the PTSD and substance use, being treated by the same clinician or within the same unit so that you're addressing each of these and the relationship between the two. In planning your treatment you'll want to keep in mind the manual-based promising treatments that

are available. Again this is Seeking Safety, Transcend, and Substance Dependence PTSD therapy. If you have any questions or comments please feel free to contact me at robyn.walser@va.gov. Finally, in the last few slides, I include references in case you're interested in looking up any of these materials. Thank you for your time.

Slide 32: References

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