

NAADAC
CR PTSD
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>> SAMSON TEKLEMARIAM: Hello everyone and welcome to today's webinar on Cognitive Restructuring for PTSD, a non-exposure trauma treatment option presented by Suzy Langevin even and Andrea Wolloff, it is great you can join us today at my name is Samson Teklemariam and I am the director of training and professional develop and for NAADAC, the Association for addiction professionals. I will be the organizer for the training experience, the permanent homepage for NAADAC webinars is www.naadac.org/webinars. Make sure to bookmark this webpage so you can stay up-to-date on the latest in addiction education. We are still working right now with CaptionAccess to secure a closed captioning live captioner, please check your most recent email or our Q&A in chat box the most updated information on closed captioning or we will have a transcript available after the live webinar.

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Our Goto Webinar control panel looks a little like the one you see here on my slide and you can use that orange arrow anytime to minimize or maximize the control panel. If you have any questions for the centers,-into the questions box at the Goto Webinar control panel and we will gather those questions and give them to the presenters had the designated Q&A the end of the webinar. Any questions we don't get to we will try to get this questions and answers to the website within a couple of weeks after the webinar. Lastly, under that tab you will see handouts and you can download the PDF file of the PowerPoint slides from that handouts tab and also a user friendliest instructional guide how to access the online CE quiz and immediately earn your CE certificate. Please make sure to use that CE instructions guide if this is your first time trying to get CEs from our webinar.

Let me introduce you to today's presenters, Andrea Wolloff, a private practice clinician and consultant and received her master's degree in counseling psychology from Assumption College, now Assumption University with further specialization in various applications of CBT, her specialties are PTSD and trauma and anxiety disorders. she uses evidence-based treatment models to treat PTSD including cognitive restructuring, prolonged exposure, and written exposure therapy. Andrea also delivers consultation and training in cognitive restriction for PTSD in this capacity Andrea provides training and direct supervision to clinicians for including providing fidelity assessments of audio recorded sessions for new CR collections in 2014 she led a team that was awarded the Association for behavioral health excellence and outcomes award for their strong outcomes in CR for PTSD preachy also co-authored a research poster for these outcomes at the ABC-TV conference in 2018 and also with this today is Suzy Langevin the director of training and professional development for Open Sky services in Worcester Massachusetts, she oversees the professional develop and programming for both employees of

open sky and the bridge training Institute which provides continuing education and consultation in evidence-based to a variety of mental health disciplines.

Suzy holds an MSW from Boston College and is licensed as a clinical social worker and substance use counselor, she is a member of MINT, the motivational interviewing networking of trainers and teaches MI and CBT interventions for mental health and substance use disorders and has been practicing cognitive behavioral therapy for clients since 2011 and was part of a group that received the associated behavioral health excellence and outcomes award for CR and PTSD practice in 2014, NAADAC is so delighted to provide this webinar presented by these accomplished presenters so Suzy whenever you are ready I will turn this over to you. Thank you, Samson.

Thank you to NAADAC for providing the space today for us to tell you about the CR for PTSD protocol and the benefits we've seen of the treatment both for individuals with serious mental illness in PTSD as well as individuals with substance use disorder and PTSD.

So, taking a look at what we are hoping you will get out of today, we want to make sure that we are describing the key components of the CR for PTSD treatments you get a good sense of what the treatment looks like overall. We want to talk a little bit about why eye movement desensitization and reprocessing treatment makes sense for treating co-occurring PTSD and substance use disorder. There's a number of different options that are out there for PTSD treatment and we want to provide some background on why CR in particular has been a successful intervention for the folks we've worked with these co-occurring conditions.

We also want to spend time getting to know the key counseling skills associated with the practice of CR, what are the core components that we used to introduce the practice, take people through the practice and get them to the point where they're able to take these skills and really be their own therapist and continue to benefit from the skills in treatment far beyond when they leave the therapy room.

So we are going to go ahead and look at our first poll question to get a sense of their audience out there, how many of the individuals that you treat for substance use disorder also report an experience of trauma or formal diagnosis of PTSD. So looking at these categories something about is it almost none, is it less than half, is it about half, more than half or almost all of the individuals you are treating for substance use disorder that have a co-occurring experience of trauma or diagnosis of PTSD.

>> SAMSON TEKLEMARIAM: Perfect, thank you Suzy, so everyone you will see -- already 50% if you have voted so we believe this open for about 30 seconds just as a reminder, if you have any questions for our presenters, after of course the interacting with the polling question, you can send in any and all of your questions into the questions box of the Goto Webinar control panel just as a brief update, we do not have live closed captions available for this webinar however a transcript will be available after this webinar on our website within about 48 hours. So about five more seconds with the polling question left on the screen, how

many individuals you treat for substance use disorder also experienced trauma or a diagnosis of PTSD, five answer options there. Perfectly think is so much everyone who voted, we will close the poll and share the results and I will turn this back over to your presenters.

>> SUZY LANGEVIN: So looking at this data, it is not surprising that the majority of us are tilted towards at least half or more individuals experiencing substance use disorder also report an expansive trauma or PTSD. This checks out with some of the other data that we know so let's go ahead and take a look at some of that data.

So, what we know about PTSD is that it is estimated that a formal diagnosis of PTSD affects about 8% of the US population, when we look at the overall ratio of men to women, about 1/10 men will experience PTSD and about 2/10 women will experience PTSD. It is important to note that not everyone that experiences a traumatic event will develop PTSD. Trauma is in some ways unfortunately in our society today especially given the advent of COVID 19 and everything people are dealing with for the last seven months, trauma is fairly prevalent in our society and I would say a lot of people are able to say that they've experienced trauma. As far as people who go on to then develop the actual clinical diagnosis of PTSD, we're looking at about 8% of the population. When we think about what PTSD is, if you want to go back to the DSM-V, we are looking at symptoms of avoidance so avoiding -- triggers that remind you of the trauma or places or things related to the trauma experience the symptoms and people feel they are reexperiencing the trauma event over and over again whether through to disturbing dreams, at the most extreme end people may experience dissociation where they feel like they are back in that traumatic episode. But there is a real range of experiences that people can feel after the experience of a trauma, hyperarousal or people feeling they constantly have to be on alert and edge and watching out for something to happen again. In the new to the DSM-V, negative feelings. And the co-occurring negative emotions around anxiety, depression, guilt, shame, that come along with the experience of PTSD.

When we get further into the slides you will see those negative emotions are really one of the core things that we are going to be looking to target with the CR for PTSD treatment.

When we look at PTSD and substance use disorder, there's a very high correlation between folks who have substance use disorder and who experience PTSD. When you look at the numbers in the studies over all you will see range from 60% of people with substance use disorder also experience trauma related symptoms to 97%. That 97% figure is more associated with women with a history of substance use disorder and their experience of trauma. Men, the prevalence rate tends to be closer to that 60%, somewhere around half. If you want my personal opinion from my practice, the number for women is accurate, the number for men is low. There are a lot of barriers to men in particular acknowledging some of their experiences as dramatic. And so there is a seeming underreported level of trauma under the population of men with substance use disorder. What is interesting is when we use standard clinical instruments like the PTSD checklist which we will talk about, we see higher levels of incidence of trauma and PTSD symptoms than we do if we are just looking at clinical judgment. So when we are just looking at taking a history or doing a psychosocial assessment, and then making a

determination of trauma that's impacted someone, we get a lower instance than if we use a clinical instrument that looks at those things, devoid of our clinical judgment. So that tells us something about how we are conditioned to think about trauma as clinicians. And where we are inclined to see it and treat it.

We know there are some potential neurobiological links that make individuals who experience substance use disorder more likely to experience symptoms of PTSD. We do not have a great understanding of it yet but when you control for a number of other factors, we find that when someone with substance use disorder has been through a traumatic experience, there is something about the neurobiology that makes it more likely they will go on to then develop symptoms of PTSD. As opposed to someone without substance use disorder goes through each medic experience, they may not be as likely to then develop those trauma related symptoms.

What we found in our practice is that many individuals who have substance use disorder have a real complicated relationship with trauma that they experience while they are using. We know that assault and sexual assault are incredibly common while people are intoxicated and there is a whole extra layer of guilt and shame builds onto those assaults when they happen while someone is under the influence. We know that particularly for women but also for men, there is often an exchange of sex for drugs or money for drugs. And that can be a complicated relationship and cloud people idea of what consensual sexual contact means. Which muddies the waters around, was this dramatic or not. We also know this population particularly women experience a high level of family disruption and child removal due to neglect that's predicated on the parent substance use, which has an influence of trauma on both the parent and child. So there is a really strong relationship to trauma and these endemic pieces of substance use disorder and it makes it a really complex all to unwind.

That is one of the reasons why CR could be so beneficial which we will talk about again in a bit. But by focusing on the present rather than trying to untangle the past, CR really lets us be present and future focused in a way that can provide this problem solving going forward without getting bogged down in what has happened in the past. I will now turn it over to Andrea to talk more about treatment options for PTSD.

>> ANDREA WOLLOFF: Thank you, Suzy. So there are -- one of the nice things about PTSD if there is a nice thing is that there are lots of evidence-based options for treatment for PTSD. So, what I am always telling individuals that I am treating is, you've got options here and if the treatment they are using is not working so well, there are other options and things we can try. So here is a few. And I want to talk about some of the barriers that come up with these treatments in particular are so the gold standard treatment for PTSD is prolonged exposure therapy. I don't even know how many studies at this point support the effectiveness of this treatment it if you're not familiar with it. It is really I will give a very simplified version of it but it is really about having the person recount the details of the traumatic experience in great detail in a very systematic way, session by session. They retell the story as if it is happening again.

I also have training in this treatment and I believe in it and it works well but there are challenges especially when looking at substance use disorders. Cognitive processing therapy and EMDR are also backed by research but there is an exposure element to both of those treatments as well. And so one of the challenges, big challenge for the treatments is the dropout rate is common, it is high and it can be as high as 95% and we have seen in some of the studies. So it's something to pay attention to and we'll talk later in the training is appointed as part of PTSD and how it also comes out with substance use.

I want to talk a little bit more about some of the barriers that come up with trauma treatment. One of the biggest is just readiness of the individual. So with exposure work it is challenging and it is about re-telling the event as if it is happening again and about facing triggers that cause a lot of anxiety. And so often people are feeling scared about that and aren't feeling ready to do that and I get people that say no. I am not talking about it, that is not what I want to do it sounds terrible. And so that is something that comes up frequently. The other part of that is there's a big commitment to it so not only are they retelling the story but we are recording that in session, part of the treatment is for them to listen to that session and the portion they are retelling the story every day. So not only do they need to commit time to the therapy session every week, but they are committing to daily practice and listening to the recording and doing other exposure works daily homework should be an hour to 1.5 hour commitment.

Other normal life changes that are coming up that we all have and get in the way of that with any type of exposure you want to make sure there's not a lot of disruption because the progress can slow way down if you are missing sessions or missing some of that important practice. And so avoidance comes up, it is a common challenge.

The time given with the homework, exposure sessions tend to be 90 minutes. It can be done in 60. I am treating people in 60 minutes but it is really for people who have a straightforward PTSD presentation and they're not other things going on. So it's hard in my opinion to make that happen in a 60 or 50 minute time block when looking at substance use. So people need to be putting in that level of time.

The other big barrier, I've trained a lot of conditions over the years and readiness to treat PTSD, it is a challenge -- it is scary work, you are hearing about difficult stories and with exposure work in particular, your hearing all the details of what happened to that person and it is hard to sit with. And so clinicians hearing the stories over and over, there's the risk of vicarious trauma.

So many of us, it is common to back off and back out of details about trauma because it feels uncomfortable and it is distressing. And that is just something that comes up. So I want to ask you guys this question. What is your current comfort level with addressing trauma and PTSD in your treatment?

>> SAMSON TEKLEMARIAM: Everyone can now see the poll, about 30% if you have voted. I will leave this up for about 20 more seconds or so- the question is what is your current comfort

level with addressing trauma in PTSD in treatment and you'll see five answer options and in case you missed our instructions you will see a questions box in the Goto Webinar control panel and you can click on that questions box anytime and type out a question for the presenters. any questions you have asked me will do our best to get to and any questions that we don't get to we will give the presenters and they will send it in a written document in about a week's time. A couple more seconds on the poll. Thank you so much everyone I will now close the poll and share the results. And I will turn this back over to your presenters, Andrea and Suzy.

>> ANDREA WOLLOFF: I think this is what we expected, people are somewhat comfortable at most, 40% there. I am glad to see that there are a number of you that are very comfortable and have that level of comfort with this topic. That is so important.

I want to give you introductory information on cognitive restructuring, there are challenges with exposure, great treatment but when we look at the population we want to look at, are there other options for people? Cognitive restructuring, this focuses on current thoughts and feelings related to trauma. So it is not about going back into the past and talking to the details about what happened, instead it is looking at that happened or a series of traumatic events that happen, how is it impacting you here and now today in your day to day life and let's work on that. As Suzy mentioned earlier, negative thoughts and feelings it a symptom set of PTSD and it's something that keeps it going. So this treatment targeting those negative thoughts and feelings helps people recover from PTSD and go on to not meet that diagnostic criteria anymore. So we focus on the present situations and challenges that are coming up and we look at the relationship between that experience of trauma and how that developed these negative thoughts. So, the CBT approach looks at we all have a belief system that is at our core and we are not always aware of it.

But would we go through trauma, it's something that really shakes our belief system at its core and shapes how we start looking at ourselves as people, others in the world around us. So this treatment is about helping people shift out of that belief system, where the person is kind of viewing the world through this lens of PTSD. The treatment itself was designed for individuals with comorbid psychiatric conditions. So the studies that were done to form this evidence base, you know, the individuals who received the treatment also

Had diagnoses of major depressive disorder and schizophrenia, borderline personality disorder and so that was one of the reasons we had chosen this model is because a lot of the people we served were not coming in with just PTSD, there were a lot of other things going on that need to be managed within the treatment. So it is shown to be helpful for complex ongoing trauma as well. And so the people we were treating were not coming in with one isolated traumatic event, they were coming in most often with repeated events often in childhood or adolescence to adulthood and we were seeing people that were also using substances.

So the treatment structure is very important. So, in order for the treatment to work based on what the evidence base shows, it is important to follow the protocol. So the treatment itself lasts for 12-16 weekly individual therapy sessions from personal experience, most people need

16. We have extended the treatment out to 20-22 sessions, depending on the person's needs. And for a variety of reasons. We have not found that it needed to extend out past that. The sessions happen in 60 minutes and we have 1.5 hours here occasionally that has come up when I have seen that come up, it is because there are other things going on. We have treated people with some intellectual disabilities and making modifications around that and other cognitive challenges, sometimes people have needed the 90 minutes. But for the most part this happens in a weekly hour session. And it follows the basic structure of a CBT session.

What I mean by that is each session we are setting an agenda. So, you and the individual in front of you know exactly what to expect in that hour, which by the way, especially for people who are expressing PTSD, they appreciate that because they are often coming in pretty anxious, and this way they know exactly what to expect. So we are setting that agenda, we are reviewing homework and practice from the last session because that's an important part of the treatment is what we are teaching in the therapy, we will be working collaboratively with the individual. To figure out how they will use that in real life so we make sure to check in on that.

And the bulk of the session is the material, depending on where we are in the treatment. At the end of the session we collaboratively set that homework assignment and ask for feedback on how the session went. So each session follows that structure and people appreciate that because you know exactly what is going to be discussed. In my experience, people who are expressing PTSD open ended sessions are very anxiety provoking because they do not know what to say or what will come up.

We also use symptom assessments. So, that is a part of the treatment. So, we are using the PTSD checklist, we are doing that every 3-4 sessions. Alongside of that we are using a depression measure. So the Beck Depression Inventory is what was used in the clinical trials. That is a fantastic measure to use. Or an alternative is the patient health questionnaire, or the PHQ nine. So it is important to track depression as well for those expressing depression. So we track the results and we share the results and that's part of the agenda for the session, that they are taking those assessments and I have had so many- I've had people that- cry about that they have these tears because they see how far they have come. So that is a very important part of the treatment.

The treatment itself has a handout and worksheet packet that goes along with it. And so, again, it allows some containment and structure within the treatment that again, people really appreciate. We also find as people write down answers and follow along in the worksheet, worksheets, it allows them to solidify the skills and then they take those out and documenting things and bring it back so we can kind of get a good sense.

Let's do a couple of minutes of breathing and get re-centered and get back to work. We always want to make sure we are getting back to work. The matter where you are you have to breathe. So if you are using the skill affect nobody knows you are doing that so again it is one of the reasons why it is my favorite. So there is a handout we use that we go through and walk

through the instructions. What you do with the person she will educate them-- you provide the detailed instructions using the handout, it is important to demonstrate it. I will demonstrate that in a moment. And then practice together. So it is so important that as you teach these things you are showing a genuine support for the strategies, you are sharing with them if you practice them on your own, just to show these are things that it is important for all of us and that you really act these kinds of strategies so we will then debrief the use of this skill and troubleshoot any difficulties. So how was that and what went on? You are distracted, let's talk that through and see if we can help you increase your focus.

So before I teach you guys the skill, I want to know, what strategies do you teach your clients for relaxation?

>> SAMSON TEKLEMARIAN: So this question has popped up on your screen, great questions, you are all sending us so far. Thank you so much for those questions everyone, continue to use the questions box read we have NAADAC staff standing by to answer questions about today's presentation. Any questions for the presenters will be saved for the end and have a live Q&A and about five more seconds to answer the polling questions you will see on your screen now. Perfect, thank you everyone we will go ahead and close this poll and share results in turn this back over to Andrea and Suzy.

>> ANDREA WOLLOFF: The beautiful thing about mindfulness is there are so many options. And we have general deep belly breathing, thank you for answering those questions.

You may like this strategy, it may not be a big stretch from what you are already using and you may already be using it. We will all take a minute or two to try this out on your own. Just to get a feel for it. Again, this is what you would be doing with an individual if you were teaching this, then you will practice it.

The first step is choosing a word you find relaxing. So the words we use in the treatment as examples are either the word calm, relaxed or peace. And I always say that if the words don't work for you, choose one you like. I have had people choose food items like pizza and cheese. Whatever works for you is fine. I will demonstrate using the word calm. So the next step is then to take a normal breath in through your nose. So it is not a deep breath, it is what you would consider to be a normal breath.

While you exhale you will say your calming word very slowly enjoyed out because this is where the relaxed section happens so by saying the word out loud it forces you to stretch it out and allows you to hear how long your exhale is. . I will demonstrate that in a moment but when we practice it, once people are getting used to it then I say that you can do it in your head because this is something you want to use anywhere. And most people do not want to walk through the grocery store chanting the word "calm". so we want to get some practicing it out loud and then it can be something you can do inside your head. Pause briefly before your next breath, if that feels comfortable. Some people like to count to four, but that is not my preference. I do a brief pause and go into my next breath but that's personal choice. And when we practice, we repeat

it for 10-15 breaths, which works out to about one minute.

I will demonstrate. And then we will all practice together for about a minute. So normal breath in, callllllmmmmmmmmmm. And then you repeat. Okay? and we do that for about a minute.

I will turn off my microphone for moment and keep track of about one minute. I want everybody to practice and then we will resume the presentation.

Don't practice when you are at your most stressed when you are alone and echoes for all the skills we are teaching today. If you ever tried something new and you are not at your best you tend to not do well so we usually work out a time of day the, where the person feels okay and that is when you should practice. When we practice it together we tend to keep our eyes closed or looked down and not stare at each other etc. like we would do in a mindfulness exercise. So I am going to move on.

>> SUZY LANGEVIN: Now we will talk about the psychoeducation. I love sharing information with people, that is one thing I love to do. But the other piece that is so powerful about the psychoeducation is that it helps people understand that what they are experiencing makes sense in the context of having been to trauma. Often I talk with people feel completely alone in their experience and they are broken or they feel something is wrong with them because they are having these experiences a feeling on edge all the time read or having these thoughts that they cannot control it when we put a name to these things it can be a powerful experience for people to understand they are not alone in this experience of a reaction to trauma. And it explores how trauma has impacted their life and get a sense of this being one piece of the story and how things are interconnected.

Psychoeducation can be a powerful motivator to participate in the treatment and once they can understand and name what they are experiencing, as PS TD. We now know we can do something about that. Help people manage their systems and increases people's buy-in to complete the rest of the treatment. And this compelling data suggesting that just the psychoeducation on its own can help reduce PSD symptoms for some individuals and I've seen this play out in people I have treated so as we do the assessments and go through the treatment, we tend to see after psychoeducation, a dip in people's PTSD assessments at that point in time. So that's one of the cool things about doing the assessments as you could fall in real-time the elements of the treatment helping people feel better.

Psychoeducation is broken down into two handouts in the curriculum. I would say this is usually two sessions begin sometimes take longer and be spread out over two sessions. The first is what we would call the diagnostic symptoms of PTSD, the reexperiencing, avoidance, over arousal and negative thoughts so what would be termed as the textbook symptoms of PTSD. The second cycle Ed session get set associated symptoms or problems people may experience as a result of PTSD. Distressing feelings having to do with the depression symptoms I spoke of earlier that have a really common occurrence with the experience of PTSD. Relationship challenges or the problems people experience in their relationship experiences as a result of

going through this trauma. And self-destructive behaviors.

Having the piece of the drug and alcohol use as part of the components of psychoeducation helps normalize the idea that drug and alcohol use can be for some folks every action to the experience they've had of trauma. We talked a little bit about avoidance earlier and I want to take a moment to highlight how prevalent avoidance is for individuals who experience co-occurring substance use disorder and PTSD. Avoidance often impacts the person's ability to come to treatment or directly address PTSD symptoms in the session.

It is important that we are able to balance for ourselves the empathy of understanding this is difficult for people to talk about along with the education of why avoidance is a symptom of PTSD. It is really not uncommon to have more cancellations in treatment when you're working with someone with PTSD. It is helpful as clinicians to remember that people are avoiding, and that is a part of what we are treating so when we can, given our settings and we do have people from a variety of different treatment settings but when it is possible to give a little more leeway for cancellations, and not have to stick to super strict cancellation policies that can be helpful.

One thing to keep in mind is substance use is a really great way -- have been using substance many people we have been working with have used substances to avoid guilt or shame for a very long time. It may be the most effective way they have been able to avoid those symptoms, like guilt and shame and anxiety, for very long time.

It does not mean it is not still a system. I noticed in my practice not to talk about substance use as in "coping strategy" but as a substance strategy and when we put it in that frame it provides the psychoeducation of what avoidance looks like and actually is. and that it is one more piece of the puzzle which we need to contextualize, and make a plan around going forward but it is not this discrete entity. We do not have substance use here on first base and PTSD and third base we want to integrate this in a holistic way.

It is helpful for people to get their brain around the idea that substance use can be avoidance, because you cannot avoid something forever but I always do people in treatment, avoidance is a fantastic strategy for dealing with PTSD until it is not. Until you hit that wall of the thing that you cannot avoid, and it blows up to the point where so much of your life is consumed by avoidance and you fail to do things you want to do.

When substance use becomes so big that it takes over your life and you cannot do other things you want to do because substance use is so prevalent, drawing the connection between those things helps people to understand the role substance use disorder plays, not only in their expensive trauma, but the proliferation of their PTSD experience and I know Andrea has that experience as well were people of Québec to the table after the psychoeducation and said, I hadn't about how my alcohol or marijuana use impacted my expensive trauma but I need to get a handle on that. I will pass it over to Andrea to talk about the core skill that we use in CR, the five steps.

>> ANDREA WOLLOFF: So, the five steps of cognitive restructuring is the core skills so we will use this over and over again through treatment so after psychoeducation happens it is usually around session 5, sometimes four that we introduce cognitive restriction and we do this by introducing the common styles of thinking. And we get into a number get into the five steps. We will use this to help people adjust their trauma. It is a nice way to structure out what is going on for the person and organize their thoughts. I've had a lot of conversations lately with people around all their thoughts are kind of all over the place what it is coming to the PTSD but when they are doing the five steps, they pull out what they need and it is a nice way to organize it. We start out with CR. Like I said with the breathing retraining, we start when we are less stressed out so we start with things that are distressing but not the most distressing things.

Just getting practice with the skill and getting comfortable with it and when the person is ready we start pulling in some of the trauma related material. And start restructuring those thoughts that are related to trauma. So I will teach you the five steps. As I am doing that with each step I will give an example of what that looks like. So by the end of the five steps you will see a five step example in its entirety. I do want to let you know before I go through this that even though this is not exposure based, we are still talking about upsetting things so there could be some things in the five steps that I share with you that could be upsetting but if that happens you what you need to do to take care of yourself if you need to step out for a minute return the vine down or whatever you need. You can do that. I want to let you know the five steps I am sharing is a composite of clients. So I will illustrate something that commonly comes up and we do the five steps related to PTSD and substance use.

When we teach this forgiving the person a worksheet, to page worksheet that goes through the five steps we want to identify a current situation that is upsetting Pete anything is fair game for the five steps it does not have to be trauma related, it can be anything distressing. It's not about digging into the past and sank five years ago I was in this terrible car accident. That is my situation. It is more about I was driving to the store and Monday and I had an intrusive memory of that car accident so it's keeping it in the present moment.

Once we get rolling with the five steps, the connection is there and it emerges.

The example that I will give you is this person said I was watching a movie and there was a rape scene. So it is a common thing that people bring up as something distressing. There is a trigger and it brings them right back to their trauma. So step two is identifying the negative feelings associated with that situation. Not the trauma, but the situation of I was watching movie and there was a rape scene. So on the handout it gives four sets of emotion. There is fear and anxiety, sadness and depression, guilt and shame and then anger, we try to keep it to the four because of things like frustration or misery tend to fall under one of those categories it oftentimes people circle multiple emotions on step two and one of the rules we have is okay, out of the three you circled which one feels the strongest. The reason we do that is because when we get to step three and looking at thoughts, shameful thought looked different than a fearful thought so we want to make it as, as straightforward as possible.

For the situation, the most upsetting feeling is guilt and shame. So it starts to get a little more complicated when we get to step three which is identifying thoughts. This is identifying, with this situation you're feeling guilt and shame. What are you saying to yourself about it or what is running through your head about it? As we get through the treatment there is a scale called the downward arrow technique and help the person start identifying beliefs. And we teach how to do that but when the person is doing the five steps, they are listing out all the thoughts that are coming up for the person. Everything running through their head buried so for this situation there are three thoughts, I could have done something to stop what happened to me. It is my fault this happened to me and it is my fault I was assaulted because I was drinking .

>> SUZY LANGEVIN: I want to jump in really quick to say that within the treatment handouts there is a helpful Hannah called the Guide to Thoughts and Feelings that draws connections between these categories and the common thoughts. The beginning of treatment sometimes people have difficulty teasing out the difference between a feeling and thought and that and out is useful in helping people understand what is feeling and a thought that underlines that in notice the common themes that these tend to be thoughts that motivate anger and these thoughts motivate guilt or shame page

>> ANDREA WOLLOFF: Thank you for mentioning that. That is a common occurrence. People often are really intoed with how they are feeling but don't know the thoughts or they just get confusing.

Before we even get to the five steps we do work on that helping people practice starting to identify what their thoughts are. So it is super common for people to have more than one thought going on and so what we do -- and in this case there are three thoughts. I will say out of these three thoughts which gets you? Which is the one that is most powerful that you notice quite a bit. So for this one it is, it is my fault I was assaulted because I was drinking. So you can see, the situation itself was a present focus situation it was watching moving feeling triggered. But that thought is a belief that has emerged, that trauma that happened that stuck for that person and we often see these shameful beliefs around believing what caused the trauma especially when referring to sexual assault.

Step four, once we identify the thought we are going to start to weigh evidence. We look at two sides of the evidence: what are the facts that support your thought. And what are the thoughts that do not support the thought?

It is important to teach rent facts. Usually I give the analogy of the court of law or science experiment. If you are sitting on a jury, what types of information are you going to be looking for as you hear testimony? You will be zeroing in on the facts, not emotions or opinions pretty district to pull the emotion out of it.

What we typically find his people easily can come up with things that support the way they are thinking. Of course they can. That is what they are zeroed in on.

It is so important to then be also able to see the other side and part of this is training the person to look at the full picture. And they have been viewing the world through this PTSD lens.

Let's start looking at what has been missing. And this is whereas counselors we need to do a lot of help getting them there. We ask a lot of questions without giving them evidence but what is called Socratic question so. You said that it is your fault, you were assaulted because you were drinking. If your friend said that you, what would you say to her? And usually they would say, well, I would never say it was her fault it okay, that is interesting. I wonder then why you are saying that about yourself that wonder if there is some evidence there. And so we ask a series of questions like that and using some of the guided discovery to come up with the evidence on their own. So I will share some evidence for this thought and evidence against Britt the thought was it is my fault I was assaulted because I was drinking. The persons evidence that supported it was I was drinking.

It is a fact, they were drinking. I did not do anything to stop it, meaning the assault, I was hanging out with him and I did flirt with him so the evidence against and this is with a lot of questioning from the therapist to get here, everyone else was drinking also and they did not get assaulted. My friend told me it was not my fault. If this it happened to her, I wouldn't say it is her fault. My friend was also flirting and we did not get assaulted for, I often flirt and it was harmless. I remember swatting it at him to get off me, and he knew I was drunk but he still did it and that suggestive thing bad about him predicting I went to a party to have fun with my friends, wasn't asked to be raped. People go to parties all the time and aren't planning to get raped there but they don't say, I am not going to drink because if I do I will get raped.

So again, this is what I see a lot of the time. There's a lot of this self-blame. But when you get into it and look at the other side with a lot of thought questioning and people say this is an example of evidence that happens later treatment versus the beginning and oftentimes we work on the same themes over and over again. So once you the evidence you review it and then there is step five the restructuring pizza looking at both sides you asked, based on this evidence is your thought that it was your fault you were assaulted because you were drinking, supported? Hopefully the person will say no it is not in for this person their new thought was the fault of the assault is always on the perpetrator, drinking was a choice I made and something I need to work on.

But it doesn't mean I deserve to be hurt or it was my fault. So we are looking for more balanced factual thoughts. I often get a lot of, when we are looking at substance use, taking responsibility for actions and wanting to change behavior around substance use, but not taking responsibility -- but moving that responsibility to worry belongs. It is not just gone because we do the five-step support of the practice is taking that new thought and saying it over and over again and writing it down, reading it every day, reviewing the other side of the evidence that does not support your thought, we need to retrain the brain to get it there and that is what is going to change belief systems.

So that is the five-steps we are going to look at outcomes.

>> SUZY LANGEVIN: As we mentioned from the beginning, one of the important elements of the treatment is tracking outcomes throughout the process. We give based on assessments at the beginning of treatment and every four sessions through the treatment where we repeat the steps to see how people are going through prodigious. For people to see the number go down, they get excited at the downward slope of their results and they see how this ability to change their thoughts is impacting their experience of symptoms.

It is helpful for us also to have that real-time feedback about what is making a difference for this person could I love drilling down into the assessment and taking a look at which symptoms that is the most prevalent for you particularly working with people with co-occurring substance use disorder like clockwork that avoidance is through the roof, and pointing that out highlights that element when we get to the psycho Ed and the role that substance use disorder plays in that avoidance symptoms set. So this rich information that comes out of the process. Outcomes can vary a little bit, one we use is called the PTSD checklist.

This is also a diagnostic tool for PTSD so you can tell from the beginning does this person meet diagnostic criteria for PTSD D. So those of you in insurance-based settings and needing to get diagnosis information early in treatment PCL is useful for that. There are multiple versions the most recent is PCL 5 which correlates to the most recent update to the DSM five around the symptoms of PTSD, so it includes the domain of negative thoughts and feelings which was not initially part of the PTSD diagnosis. And also a tracking mechanism for depression symptoms, the data we will look at from when we rolled out the treatment is based on the Beck Depression Inventory which is a great depression rating scale looking at different domains impacted by the depression. The challenge with this inventory is that it is not in the public domain page so need to pay for access to be able to use that assessment. If you are not able to come and we understand that is a limitation for many agencies and practitioners, you can substitute any other instrument that looks at depression symptoms over time paid we've shifted to during the PHQ9 in many cases because it is shorter, it is nine questions versus the 21 I believe on the Beck Depression Inventory, so if you are using with the shorter depression method can help save time but gives you some really good data and realistic pictures of what people are doing with depression symptoms along with their PTSD.

We are talking about the previous version of the PCL with the set of data. So when we initially started doing this treatment we were under the DSM four so still using the PCL 4. It has a different scaling mechanism and the numbers of different here than they would if we looked at the PCL 5. So if you do look at the PCL 5 and you compare the numbers here, that is why it looks off from what we would expect otherwise.

In terms of what we are looking at, we saw for the overall about 88 cases. A pretreatment PCL forum of 57.4 to enter post treatment score of 40.05. So a 30% reduction in symptoms reductions throughout the course of the treatment. When we break that down in separate categories get more information about how this is useful. When we look at people reporting

that sexual trauma was their index, we see a slightly greater difference in score pre- to post, about 32% reduction in scores, for every reported trauma even with the general population. One of the reasons this is so important is something we've seen in practice is that the most challenging and impactful extremes of trauma, far away is childhood sexual abuse. We have found for individuals who experience childhood sexual abuse it is something that so impacts the development of people's core beliefs that even if there's other trauma and things that happened much more recently for the person, we always get back to the childhood sexual trauma as the most impactful. So knowing this is particularly effective for that particular type of trauma is hopeful to understand the impacts of childhood sexual abuse work and how we can make an impact on that area. Another outcome we looked at was the Beck Depression Inventory. And when we look at the full number of cases we saw about a 34% reduction in people's experience of symptomatic depression pre- and post-treatment. We saw the greatest level of relief happening for people reported sexual trauma. So when we zero in on that particular population we see the depression symptoms in particular have a significant reduction as a result of engaging in the treatment.

I want to share with you be for example of the impact that CR for PSD treatment has. This is an individually treated a number of years ago and I share the identified example with her permission of what the treatment look like for her.

She was a 16-year-old Caucasian female, living in an adolescent group home and was receiving services from our state mental health agency. She identified her index trauma or the trauma that was most distressing and most contributing to her experience of PTSD symptoms as an experience she had where she was sexually assaulted multiple times while being held against her wheel she had used drugs with the person who assaulted her and was holding her. And because of that she held a strong belief that she was solely responsible for what happened to her because of her initial choice to use substances. She is the poster child in some ways for avoidance of the symptom set of PTSD because her strategy at that point had been, I am just never going to go back to the area where the assault happened and I will keep myself safe by just avoiding this place. That was her strategy. And it was effective for a time.

But extremes that drove her into treatment was that she was in the car and was driving and saw the name of the place she was assaulted on a street sign. And had a panic attack.

So we say avoidance works great until does not, avoidance worked well for her until she hit a trigger she could not avoid. She was going to have to drive by that street sign every day going to school so she had to engage in something to endure that experience without having the panic attack. That was the cure for her, to say I need to get this under control and I need to get into treatment and get help.

She scored 58 and met the criteria, hurt BDI score was 17 indicating mild depression, so it wasn't the overarching predominant symptoms that but was impacting her daily life but some of the thoughts she brought up at the start of treatment were on their way to be normal again - she thought she ruined her life at 15 by this experience happen interpret and her Keystone

thought that we had to work on in therapy, if I never started using drugs in the first place this would not have happened to me, it is all my fault. And that was her core belief that she carried into the room when we started meeting. Was this all happened because of my decision-making.

So once we got through treatment and I think for her, Andrea mentioned We average at about 16 sessions we were actually coming up against her transition home

When we think about treating PTSD CR is a wonderful option and we talked about exposure therapy which is another option but there are other options that also exist. So we want to touch on those people are aware of the full spectrum available.

Andrea mentioned cognitive processing therapy which is the particular trauma treatment promulgated by the VA. and they use this for folks who are combat veterans dealing with PTSD related to that. They are working through the VA to develop a mobile app for people to use CPT. Which I think is a cool develop. There is overlap.

We know this effectiveness in both elements of cognitive processing therapy and in the exposure work. So there's a lot of good information out there about that model also. Did you want to mention anything else?

>> ANDREA WOLLOFF: No. Just noting that it's a combination of restructuring with exposure.

>> SUZY LANGEVIN: The other treatment for this audience we want to mention and many are familiar with is seeking safety. And that is another non-exposure option. We use seeking safety at my agency primarily in group format. So that is our preferred group for dealing with co-appearing trauma and substance use and its modular base treatment really focused on developing skills and number of areas to help people manage the impact of trauma and substance abuse and what it's had on their life. It's a great option out there. Its applicability is a little different. I prefer it for a group model as opposed to individual therapy model but it can be used for both.

Here are some references including the book itself, Prevalence of Posttraumatic Stress Disorder among Patients with Substance Use Disorder is an important resource. And now we will open it up to Samson for Q&A.

>> SAMSON TEKLEMARIAM: Just demonstrating some telehealth techniques for anyone during to learn about telehealth as well. Make sure to have your cell phone Ut when speaking to your clients. Andrea and Suzy. Great presentation we have a ton of questions I will shift to the live Qian get as many questions out there as possible per the first one you may have actually just answered but I think a lot of people want to learn more about the treatment manual. They ask how do I get the treatment manual and where are the worksheets and had I find them and what are your favorite ones, we have 10 variations of handouts and manual related questions. So I thought I would ask that first on behalf of Megan, Laurel, Jonah, Drew and a few others asking.

>> ANDREA WOLLOFF: I would follow that reference Suzy noted, it's a textbook but it's an easy read and an engaging read. It provides narratives and what you say as the therapist. And at the back of the book and in the index are the handouts. With permission we created the handouts and type them out so we could pass them out. And you can get that book on Amazon.

>> SAMSON TEKLEMARIAM: And that was on the references page?

>> ANDREA WOLLOFF: Yes.

>> SAMSON TEKLEMARIAM: Carol asks, can you describe one of the homework assignments that would be given to client in between sessions?

>> ANDREA WOLLOFF: I would say at the end of the session, we worked on the five steps today, what do you think makes sense based on what we talked about, to do for homework week and so it might be practicing the new thought they created and saying that over and over again Pete hopefully it is also practicing at least one of the five steps through the week on their own they can bring back to therapy. I'm usually shooting for little bit more on that but baby steps. It is really based on the session you are in within the treatment protocol.

>> SAMSON TEKLEMARIAM: Thank you. David from Wisconsin asks, are these approaches also appropriate for complex and develop mental trauma? What considerations should we have for adapting?

>> SUZY LANGEVIN: Excellent question. As Andrea mentioned, when rolled out this treatment at our agency, we treated individuals, applying this approach to a variety of populations in the most important note I think we found as we rolled this out we need to break this information down into smaller pieces.

So, 16 session timelines was not something we adhered to quite as closely when working with folks with IDDD. We would spend more time on other steps in using adaptations to use an alternative form of cognitive restructuring as opposed to the five steps and some found it overwhelming to go through five separate areas and go through the worksheet whereas the other method was three boxes, really simple. We always try the five steps first because there's a wealth of information with the five steps but if it doesn't work we could go into the catch it, check it, change it program instead. I don't think we chased almost anybody with discrete single incident trauma with one sexual assault or one car accident or one house fire. Those were not the cases we were getting. We got folks with serious, long-term trauma that had occurred at all different points in their lifespan. And because the focus is on the present and the here and now, we do not have to spend as much time worrying about what each individual trauma did we worry about the impact the trauma has had on this person holistically, allowing us to address multiple traumas with this one treatment option by focusing on the thoughts in the here and now.

>> SAMSON TEKLEMARIAM:, Wonderful and thank you for that question, David read the next question comes from Jasmine. She asks, is there any research to support or discourage using bilateral stimulation while doing CR?

>> SUZY LANGEVIN: I don't think that has been looked at?

>> ANDREA WOLLOFF: I have not seen anything. But on so I don't think there is anything to say --

>> SAMSON TEKLEMARIAM: Cat asks for the PCL it looks like a civilian, there's a civilian assessment, is there a different one or a different one for service members, specifically for service members? Or is it the same?

>> ANDREA WOLLOFF: I am pretty sure they are the same.

>> SUZY LANGEVIN: Initially when you administer the PCL, there's an additional element called the "life events checklist" or the LEC and for service members I believe the LEC is more extensive around what they would've experienced in combat so it asks more questions related to that particular scenario. The questions on the PCL itself are related directly to the PTSD symptoms that so those are the same across the board but drilling down to the experience of combat can be helpful, and I believe that is the LEC is the component that is different for service members.

>> SAMSON TEKLEMARIAM: Okay. Erica from Hawaii asks, defined the people are more receptive to the breathing skills if they come in session one symptom or asymptomatic?

>> ANDREA WOLLOFF: I had the experience of both, I've had such a good express overall. Regardless of how people are coming in. People generally just being receptive to that strategy. I've had people come in that are experiencing some panic in the session and I will just jump right to that. We will do the skull together from the beginning. And that has helped in the session.

>> SAMSON TEKLEMARIAM: I will see if I can squeeze in two more. The next one is like us more about this environment. I gave a joke early about telehealth and me being on mute. So Lori asks, can this treatment be done virtually, Skype, or Zoom, and if so what do we need to remember when delivering the techniques virtually?

>> ANDREA WOLLOFF: I am actively using this model right now, telehealth only. And it is working. So part of it is navigating the handouts and sending them out ahead of time and if you are able to screen share, that can be helpful. So, I would prefer to be face to face with somebody doing this but I have been able to make it work. There's a few things you want to look at though with this treatment. In making the decision to move forward until health. are they in a safe place to do the treatment and what is their risk level? If it is high, we might want to look at figuring out how to help the person waits until you are able to be back in an office.

>> SAMSON TEKLEMARIAM: Does this work equally well for adults and adolescents or is there one group that responds better? I'm wondering, any other generational considerations are cultural adaptations that clinicians should make?

>> SUZY LANGEVIN: One of the things we decide and programmatically is that we would only use the treatment for people about age 15 and up. When you look at CBT strategies particularly ones like this -- core beliefs, we want to make sure they can develop a certain ability to work through those things and commit to following through with those things. When we have some buddy for whom CR is not necessarily an appropriate fit develop mentally, we might offer trauma focused CBT the gold standard treatment for kids and adolescents around trauma so we have other options. But for the most part, ages 15 and up is where we have used.

In terms of the difference between adolescents and adults, I've had success with both. I sure the case study of an individual at 16 but I have treated effectively those at 60. I think present date makes a difference. We're not asking people about something that happened 40 years ago, but something that happened maybe two days ago and it is accessible for a 16-year-old as a 60-year-old so the present focus seems to be the "secret sauce" of making CR work across a variety of age categories.

In terms of cultural considerations are adaptations we might need to make, I think the biggest thing that I have found is maintaining a sense of respectful curiosity about how people classify their own experiences. And we've on this life events checklist we use things that are commonly felt as traumatic. And we want to help people understand this may have impacted you I'm careful to use people's own label around what an experience is meant for them. Is it traumatic or just something that happened to you? Was it a learning experience, whatever that languages, because people's experience of what makes something traumatic is so culture bound to their own environment that we always just want to be respectful of understanding that just because something impacts a lot of people in a certain way does not mean it has impacted you that this impacted you.

>> SAMSON TEKLEMARIAM: Incredible presentation. Everyone, every NAADAC webinar has its own webpage that houses everything that you need to know about that particular webinar so immediately following this life event you will find the online CE quiz on the same website that you use to register for this website. And here's the schedule for our upcoming webinars, please tune in as you can, there are many interesting topics with great present is just like today.

The addiction professional guide to addressing medical marijuana use is for those dealing with marijuana use issues. Bookmark this webpage, NAADAC.org/cultural – humility – webinars we have eight awesome trainings that are free. Registration is open now paid and we've a lot more coming so stay tuned. As an additional resource

[End captions]