Welcome, your facilitator will be:
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Cognitive Restructuring for PTSD: A Non-Exposure Trauma Treatment Option

Presented by Suzy Langevin, LICSW, LADC I and Andrea Wolloff, LMHC
Polling Question 1
How many individuals that you treat for substance use disorder also report experiencing trauma, and/or a diagnosis of PTSD?

A. Almost none  
B. Less than half  
C. About 50-50  
D. More than half  
E. Almost all
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10/14/2020

Trauma & PTSD

It is estimated that PTSD affects about 8% of the US population:
- 1:10 men, 2:10 women
- Not everyone who experiences a traumatic event will develop PTSD

Characterized by symptoms of:
- Avoidance
- Re-experiencing
- Hyperarousal
- Negative feelings

PTSD & SUD

Prevalence rates of trauma among individuals with an SUD vary in studies from half to nearly all:
- Range from 60-97%
- Often higher on clinical instruments than determined by clinical judgment

Potential neurobiological links that make individuals with SUD more likely to experience symptoms of PTSD:

Complicated relationship with trauma experienced in the commission of using substances:
- Assault and sexual assault while intoxicated
- Exchanging sex for drugs or money for drugs
- Family disruption/child removal due to neglect

Why doesn’t treatment always work?

“Gold standard” treatments include exposure:
- Prolonged Exposure
- Cognitive Processing Therapy
- Optional, but exposure element included in clinical trials
- EMDR

BUT… treatment drop out is incredibly common:
- As high as 95% in a number of prospective studies (vs RCTs used to establish best practice principles)
Barriers to Effective Trauma Treatment

- Exposure work is very challenging, and requires a big commitment on the part of the individual entering treatment
  - Normal life changes, like moves or job changes, can often disrupt progress
  - Avoidance is especially common with co-occurring SUD

- Exposure sessions are designed to be longer than your “typical” 50 min sessions
  - To be truly effective, may need to meet more frequently than once per week

- Exposure work is very challenging for clinicians, too!
  - Many of us avoid talking about trauma or “back off” when people experience distress talking about their traumatic experiences.
  - It's a lot to sit with hearing.

Polling Question 2

What's your current comfort level with addressing trauma & PTSD in treatment?

- A. Very uncomfortable
- B. Somewhat uncomfortable
- C. Neutral
- D. Somewhat comfortable
- E. Very comfortable

A Different Approach: Cognitive Restructuring

CR for PTSD focuses on the impact on CURRENT thoughts and feelings
- Present-based situations and difficulties
- Examines the relationship between the experience of trauma and the development of negative thoughts
Specifically designed for individuals with other co-morbid psychiatric conditions
Shown to be helpful for complex, ongoing trauma vs. discreet single incidents
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Treatment Structure

12 to 16 sessions of weekly individual therapy
• 1 to 1.5 hours per session
• Follows basic structure of a CBT session
Use of symptom assessments
Active use of treatment handouts each session
Primary focus on skill development
• Using CR in everyday life
• “Becoming your own therapist”

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Treatment Elements

Breathing Retraining
A breathing technique that helps individuals relearn breathing patterns to better manage anxiety

Psychoeducation
Information about trauma & PTSD and its effects

Cognitive Restructuring
A technique to critically examine thoughts and restructure thoughts to be more accurate and helpful

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Breathing Retraining

Often when people are anxious, they don’t breathe in a way that is helpful, often increasing physical sensations of anxiety
Teaching Breathing Retraining allows the individual to walk out of the first session with a new skill
Breathing can be calming and can be used in session when needed
Breathing can be used anywhere
Educate about the effects of breathing on anxiety

Provide instruction using the handout

Demonstrate the technique

Practice together

Debrief the use of the skill and troubleshoot any difficulty

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Polling Question 3

What strategies do you teach your clients for relaxation?

A. Specific breathing techniques
B. General deep/belly/diaphragmatic breathing
C. Progressive muscle relaxation
D. Guided meditations
E. Mindfulness strategies

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Choose a word that you find relaxing.

Take a normal breath in through your nose.

While you exhale, say your calming word very slowly. For example: c-a-a-a-l-m.

Pause before your next breath, counting to 4 if preferred.

Repeat for about 10 to 15 breaths.
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Psychoeducation

Goal: Individuals come to understand the symptoms they experience and know that they are not alone. There is a name to what is experienced. This also allows individuals to explore how trauma has impacted their life. Psychoeducation can serve as a motivator to participate in the treatment. Studies suggest that psychoeducation alone can reduce the experience of PTSD symptoms for some individuals.

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Psychoeducation

<table>
<thead>
<tr>
<th>Psychoeducation I: Common Reactions</th>
<th>Psychoeducation II: Associated Symptoms</th>
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</thead>
<tbody>
<tr>
<td>Re-experiencing</td>
<td>Distressing Feelings</td>
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<tr>
<td>Avoidance</td>
<td>Relationship Challenges</td>
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<tr>
<td>Overarousal/hyperawareness</td>
<td>Drug and Alcohol use and other behaviors</td>
</tr>
<tr>
<td>Negative thoughts</td>
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</tr>
</tbody>
</table>

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A note about avoidance...

Avoidance often impacts the person’s ability to come to treatment or to address PTSD directly in session:
- It is important for counselors to balance empathy regarding avoidance with education.
- It is not uncommon for there to be more cancellations when working with someone with PTSD.
- Substance use is a really great way to avoid! This may be even more pronounced with co-occurring PTSD and substance use.
- Framing use as avoidance may be a helpful psychoeducation intervention.
Cognitive Retructuring for PTSD: A Non-Exposure Trauma Treatment Option

The cornerstone skill taught in treatment

Gives individuals a framework to evaluate their own thoughts

First used to evaluate more “surface thoughts,” and over time, will be used to challenge and restructure core beliefs impacted by trauma

**The 5 Steps of CR**

1. **The Situation**
   - What was the situation that led to experiencing a negative emotion?

2. **The Feeling**
   - What negative feeling did you experience?

3. **The Thought**
   - What’s the thought that led to you feeling that way? Often feelings have similar thoughts that stand behind them over and over.

4. **The Evidence**
   - What’s the evidence that supports this thought? What’s the evidence that doesn’t support this thought?

5. **The Restructuring**
   - Taking the evidence on balance, what’s the more accurate and helpful way of looking at the situation? Does that cause you less distress?

Tracking of symptoms on validated measures is a part of the treatment

Gives individuals real-time feedback on the impact treatment is having on measurable outcomes

- **PTSD 5 Checklist (PCL)**
  - Can be used to make a diagnostic determination of PTSD
  - Looks at all domains of PTSD symptoms

- **Beck Depression Inventory (BDI)**
  - Tracks symptoms of depression often co-morbid with PTSD
  - Can substitute with another instrument, particularly if you need one in public domain, eg PHQ 9

Outcomes

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Outcomes: PTSD Checklist (PCL)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Pre PCL</th>
<th>Post PCL</th>
<th>PCL Diff</th>
<th>% Diff</th>
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</thead>
<tbody>
<tr>
<td>Total Cases</td>
<td>57.42</td>
<td>40.05</td>
<td>-17.37</td>
<td>30.3%</td>
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<tr>
<td>Reported Sexual Trauma</td>
<td>58.11</td>
<td>39.16</td>
<td>-18.95</td>
<td>32.6%</td>
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<tr>
<td>Reported Physical Trauma</td>
<td>62.08</td>
<td>47.41</td>
<td>-14.67</td>
<td>23.6%</td>
</tr>
<tr>
<td>Other Reported Trauma</td>
<td>54.61</td>
<td>38.48</td>
<td>-16.13</td>
<td>29.5%</td>
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</tbody>
</table>

Outcomes: Beck Depression Inventory (BDI)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Pre BDI</th>
<th>Post BDI</th>
<th>BDI Diff</th>
<th>% Diff</th>
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</thead>
<tbody>
<tr>
<td>Total Cases</td>
<td>34.62</td>
<td>22.90</td>
<td>-11.72</td>
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</tr>
<tr>
<td>Reported Sexual Trauma</td>
<td>32.95</td>
<td>20.06</td>
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<td>39.1%</td>
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<tr>
<td>Reported Physical Trauma</td>
<td>41.83</td>
<td>27.75</td>
<td>-14.08</td>
<td>33.7%</td>
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<tr>
<td>Other Reported Trauma</td>
<td>34.25</td>
<td>25.16</td>
<td>-9.09</td>
<td>26.5%</td>
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</tbody>
</table>

Case Study: Jane, 16

Jane is a 16 year old Caucasian female residing in an adolescent group home setting. Her "index trauma" was multiple sexual assaults that included being held against her will, after using drugs with her assailant. She had attempted to manage her symptoms by avoiding going to the area where she was assaulted, but eventually it got to the point where seeing the name of the city on a street sign caused a panic attack, and she knew she needed more help.

Pre-treatment
- PCL IV Score = 58 (Diagnostic for PTSD)
- BDI II Score = 11 (Moderate Depression)
- Thoughts: "I'm never going to be normal again."
- "I had never started using drugs in the first place, this wouldn't have happened to me, it's all my fault."

Post-treatment
- PCL IV Score = 24 (Below diagnostic threshold)
- BDI II Score = 2 (Minimal Depression)
- Thoughts: "I can make the rest of my life whatever I want it to be."
- "What's in my past doesn't define my future."

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Other Treatment Options

Cognitive Processing Therapy
- Promulgated by the Veterans Administration
- Mobile app resources in development

Seeking Safety
- Also non-exposure
- Modular based treatment appropriate for groups

References


National Center on PTSD. https://www.ptsd.va.gov/public/understanding_TX/booklet.pdf


Thank You! Any Questions?

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  By: Frederick Doroszewski, PhD, LMHC, MAC, CASAC

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By: Thomas Durham, PhD
Part Four: Stages of Clinical Supervision
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