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Trauma-Informed Interventions for Women with Co-Occurring Substance Use & Mental Health Disorders


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Objectives


Participants will be able to discuss and critically appraise the following trauma-informed interventions for women with co-occurring SUDs and MH disorders:

- *Seeking Safety*®
- Eye-Movement Desensitization & Reprocessing (EMDR)
- Dialectical Behavioral Therapy (DBT)
- Emotional Freedom Technique (EFT)

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Shortcomings of Traditional 12-Step & CBT Models in Recovery

- Concepts built on historically male pathways in addiction and recovery
- Marginalized women with quite different pathways to addiction and recovery
- Failed to address co-occurring mental health problems
- Failed to account for childhood & adult traumas that increased vulnerability for relapse

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Recognition of Treatment Needs for Women with Co-Occurring Disorders

- Separate treatment settings that offer services tailored for women:
 - Dually treat SUDs, MH, **and trauma-related** problems on site
 - Job training / supported employment at living wage
 - Access to affordable childcare services
 - Access to safe, affordable housing
- Psychotherapies with better outcomes emphasize:
 - Emotion regulation
 - Functional assessment
 - Problem-solving
 - Affirmation, change and acceptance

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Trauma-Informed Evidence-Based Interventions for Women with Co-Occurring Disorders

- *Seeking Safety*®
- Eye-Movement Desensitization & Reprocessing (EMDR)
- Dialectical Behavioral Therapy (DBT)

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Seeking Safety®

- Lisa Najavits, MD
- 1993 NIDA – Behavioral Therapies Development Grant
- Time-limited group therapy using CBT approach
- Option to use in individual therapy format
- Designed for women with PTSD & substance abuse
- Integrated SA Tx, PTSD Tx, CBT, & Women’s Tx
- Evolved into a manualized CBT intervention using 6-24 sessions

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Seeking Safety® - Trial & Error "What Didn't Work"

- Conducting full models (8 consecutive sessions) of cognitive, behavioral, & interpersonal sessions.
- Topics framed in negative terms
- Assigning group partners
- Homework
- Providing most of written material to therapists (rather than patients)
- Patient goal setting at beginning of first session
- Writing autobiography of PTSD & substance abuse
- Linking every substance use incident to PTSD

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Seeking Safety® - Six Core Sessions

- Safety
- PTSD: Taking Back Your Power
- When Substances Control You
- Detaching from Emotional Pain (Grounding)
- Asking for Help
- Coping with Triggers*

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Seeking Safety® - Conducting the Session

- Check-In (5 minutes per patient)
 - Any unsafe incident
 - Patients identify "good coping"
 - Review patient's "commitment"
 - Brief feedback
- The Quotation
- Relate the Topic to Patients' Lives
 - Patients look through Handouts – choose 1 or 2 most relevant
 - Ask patients to relate material to current / specific problems
 - Optional "Safe Coping Sheet"
- The Check-Out

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Seeking Safety® Studies

- Initial pilot study (Najavits, 1998)
- Controlled trial against “treatment-as-usual” with group format (Najavits, 1996)
- Controlled trial comparing to relapse prevention therapy for inner-city women with substance abuse (using individual therapy format) (Hien, 1997)
- Pilot study in women’s prison using group format (Zlotnick, 1999)
- Over 20 studies support efficacy
- Listed as EBP (Chambless & Hollon, 1998)

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Seeking Safety® Website

- <http://www.seekingsafety.org/>
- Links to full text pdf’s of clinical outcome studies
- FAQ for general public
- Information for researchers
- Information for clinicians
- Training resources
- Treatment adherence measures

(1) CHECK-IN

The goal of the check-in is a brief update (up to 5 minutes per client), using the five check-in questions. The clinician makes only brief comments (e.g., praise or concern), and notes material to return to later in the session. In group, clinician promotes each client’s “space” without cross-talk from other group members.

For supervision. Pages in the manual to assist clinician: 33-35; 54-55.

Rating	ADHERENCE (quantity)	Rating	HELPFULNESS (quality)
NA	Check-in not required (e.g., case management session, or life/death emergency).	NA	Can't rate because appropriately not done in session
0 Not done	Did not conduct check-in, but should have	0 Harmful	Check-in punitive (e.g., “You were bad to use substances”), hurtful, or neglectful (e.g., ignores client’s suicidal feelings)
1 Done A little	Minimally complete (e.g., made attempt at check-in, but clearly lacking in some components or time limits; or intervened far too much or too little)	1 Ineffective	Uninvolved, listened but did not appear supportive or helpful; cut clients off abruptly rather than redirecting in a kind way
2 Done A lot	Mostly complete; did check-in with only minor flaws	2 Somewhat helpful	Attentive and basically good, but some flaws (e.g., overly rushed)
3	100% complete: all	3	Conveyed sincere interest and support in

(2) QUOTATION

Conducted after check-in; no more than two minutes on quotation; have client read quote out loud; ask "What is the main point?" and allow client to answer, clarify if patient does not understand; link to session topic.

For supervision. Pages in the manual to assist clinician: 35, 54-55.

Rating	ADHERENCE (quantity)	Rating	HELPFULNESS (quality)
NA	Quotation not applicable (e.g., more than one session on same topic).	NA	Can't rate because appropriately not done in session
0 Not done	Quotation not done, but should have been done	0 Harmful	Client made to feel stupid for not understanding quotation; or a harmful message conveyed about the quotation
1 Done A little	Too much or too little time on quotation, done at wrong time, or clinician alone identifying main point	1 Ineffective	Went through the motions, misunderstood the quotation, or told client what to think without letting client explore it

Nagyvits, LM (2003). Seeking Safety Adherence Scale. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

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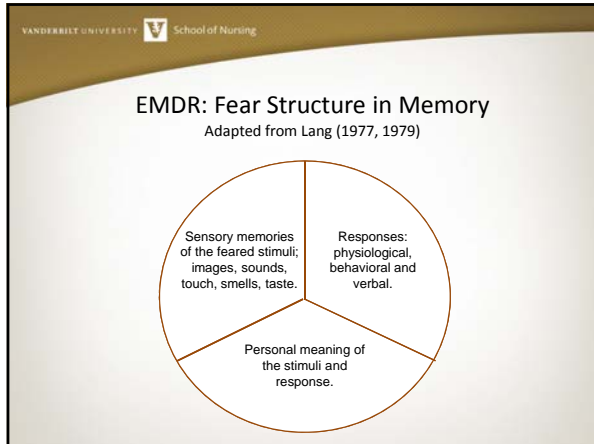
Seeking Safety[®]

<p>Strengths</p> <ul style="list-style-type: none"> • Manualized group or individual intervention • Workbook with handouts, quote, exercises for 24 topics • Modify for 1 to 24 sessions • Initially for SUDs & PTSD • Applications for co-occurring SUDs & MH DOs • Evidence-based practice • Website resources • Treatment adherence tool 	<p>Limitations</p> <ul style="list-style-type: none"> • Materials are copyright protected – purchase cost • Training costs for staff • Limitations of studies: <ul style="list-style-type: none"> – Low sample sizes – Few well-controlled – Variability of treatment fidelity – Variability of # of sessions
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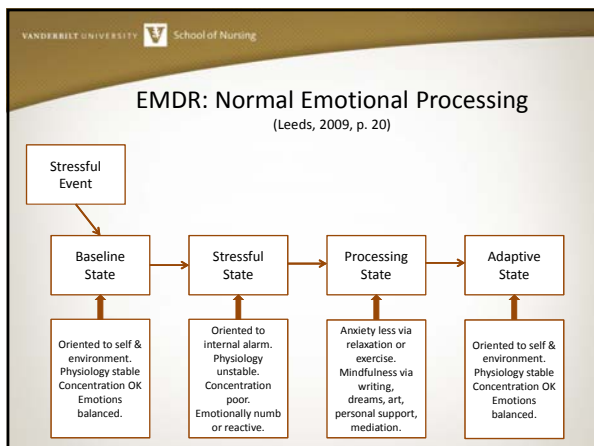
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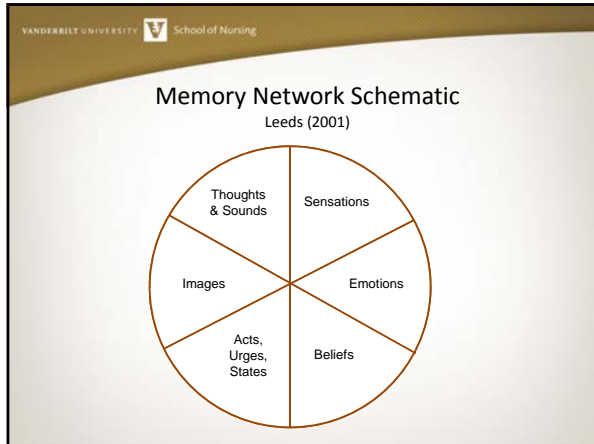
EMDR


- Francine Shapiro, PhD
- 1987 – Empirical observations
- EMDR evolved from:
 - a) A simple technique (eye movements)
 - b) An initial procedure (EMD)
 - c) A protocol (EMDR) for PTSD
 - d) An overall treatment approach
- EMDR's theoretical framework: Adaptive Information Processing model (Shapiro, 2001)



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- ### EMDR: Alternative Modes of Bilateral Stimulation
- During 1989-1992 modifications for patients with medical history of eye problems or blindness
 - Auditory tones (snapping fingers or using clickers)
 - Hand taps (vibrations)
 - Usually as effective as eye movements
 - Insufficient research / evidence to make definitive statement (Servan-Schreiber et al, 2006)






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Eight Phases of EMDR Treatment

Phase 1: History Taking	<ul style="list-style-type: none"> • Therapeutic alliance • Psychosocial & medical history • Develop treatment plan / case formulation • R/O exclusion criteria
Phase 2: Preparation	<ul style="list-style-type: none"> • Informed consent • Offer psycho-education • Practice self-control methods • Patient starts weekly log • Strengthen therapeutic alliance
Phase 3: Assessment	<ul style="list-style-type: none"> • Access primary aspects of target memory • Obtain baseline measures on SUD & VoC (Subjective Unit of Distress) (Validity of Cognition)

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Eight Phases of EMDR Treatment (cont'd)

Phase 4: Desensitization	<ul style="list-style-type: none"> • Reprocess the target experience to an adaptive resolution as indicated by a "0" SUD
Phase 5: Installation	<ul style="list-style-type: none"> • Continue reprocessing target with overt inclusion of preferred belief. • Fully integrate preferred belief into memory network as indicated by "7" VoC
Phase 6: Body Scan	<ul style="list-style-type: none"> • Verify any residual disturbance associated with the target until fully reprocessed. • Allow patient to reach higher levels of synthesis.

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Eight Phases of EMDR Treatment (cont'd)

Phase 7: Closure

- Ensure client stability and current orientation at the close of each reprocessing session.

Phase 8: Reassessment


- Verify whether all aspects of treatment plan are being addressed.

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EMDR Session

- <http://www.youtube.com/watch?v=bqbF1j5vwmA&feature=related>


Session of EMDR – illustrating key concepts

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EMDR Studies


Over 150 studies evaluating EMDR including:

- 6 meta-analyses
- 28 randomized clinical studies
- 18 randomized studies testing hypotheses re: EMDR effects
- 19 non-randomized studies
- 28 studies evaluating mechanism of information processing and procedures
- 16 studies evaluating mechanism of action
- 11 studies evaluating efficacy in combat veterans
- 15 neurobiological and psychological effects

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Practice Guidelines for PTSD

- **American Psychiatric Association (2004).** *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder.* Arlington, VA: American Psychiatric Association Practice Guidelines.
EMDR given the same status as CBT as an effective treatment for ameliorating symptoms of both acute and chronic PTSD.
- **Department of Veterans Affairs & Department of Defense (2004).** *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress.* Washington, DC.
http://www.oqp.med.va.gov/cpg/PTSD/PTSD_cpg/frameset.htm
EMDR was one of four therapies recommended and given the highest level of evidence.

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Practice Guidelines for PTSD (cont'd)


- **SAMHSA's National Registry of Evidence-based Programs and Practices (2011)**
<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=199>.
The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency of the US Department of Health and Human Services (HHS).

This national registry (NREPP) cites EMDR as evidence-based practice for treatment of PTSD, anxiety and depression symptoms. Their review of the evidence also indicated that EMDR leads to an improvement in mental health functioning.

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EMDR Websites

- <http://www.emdr.com/>
 - EMDR Institute, Inc.
 - FAQ for general public
 - Resources for researchers & clinicians
 - Training and certification resources
- <http://www.emdria.org/>
 - EMDR International Association
 - Resources for researchers & clinicians
 - Training and certification resources
- <http://www.emdrhap.org/home/index.php>
 - EMDR Humanitarian Assistance Programs

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EMDR

Strengths

- Time efficient individual therapy approach for PTSD
- Protocol for co-occurring SUD & trauma-related disorders
- Website resources
- Standardized training & certification for clinicians
- Evidence-based practice
- APA & VA/DoD Practice Guidelines for PTSD


Limitations

- Cannot be delivered as group intervention
- Training & certification costly
- Limited studies for co-occurring SUDs and MH disorders

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DBT

- Marsha Linehan, PhD
- 1993 – DBT evolved from efforts to treat patients with self-injurious behavior and borderline personal disorder (BPD).
- Integrated elements of dialectical philosophy (balancing *acceptance* and *change*-oriented strategies), cognitive and behavioral therapy, and Eastern mindfulness techniques.
- Soon used with other patients with impulse control / emotional dysregulation problems:
 - Females with BPD and SUD
 - Eating disorders
 - Elderly with depression & personality disorders

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DBT: Treatment Components

- Weekly individual therapy (1 hr/wk)
- Weekly group skills training (2 hrs/wk)
- Therapist consultation team meeting (1-2 hr/wk)
- Critical Elements of DBT:

<ul style="list-style-type: none"> – Five functions of treatment: <ol style="list-style-type: none"> 1) Enhancing capabilities 2) Generalizing capabilities 3) Improving motivation & reducing dysfunctional behaviors 4) Enhance / maintain therapist capabilities / motivation 5) Structuring the environment 	<ul style="list-style-type: none"> – Biopsychosocial therapy focusing on emotions – Dialectical philosophy – Acceptance and mindfulness
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DBT: Treatment Components

Enhancing Capabilities - Group Therapy sessions to build skills:

- Regulating emotions
- Paying attention to the experience of present moment
- Regulating attention (mindfulness skills)
- Effectively navigating interpersonal situations
- Tolerating distress and surviving crises


Generalizing Capabilities – Individual & Group sessions:

- Apply new skills in daily lives
- Homework assignments
- Individual therapist available by phone between sessions (coaching)

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DBT: Acronyms

• Mindfulness (Wise Mind)	• Interpersonal Effectiveness
• Distress Tolerance	(Objectiveness)
– ACCEPTS	– DEAR MAN
– Self soothe with 5 senses	(Relationship effectiveness)
– IMPROVE	– GIVE
• Emotion Regulation	(Self-respect)
– PLEASE	– FAST

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DBT: Studies

- Limited number of studies evaluating DBT – two specific to co-occurring SUD and BPD
- 8 randomized, clinical trails
- 1 non-randomized comparative study
- All demonstrated efficacy over treatment comparison or control group.

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DBT Websites

- DBT Self-help Website
- Handouts / learning resources
http://www.dbtselfhelp.com/html/linehan_dbt.html
- Behavior Tech, LLC: DBT Training & Research Resources
<http://behavioraltech.org/index.cfm?CFID=48270163&CFTOKEN=32790617>

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DBT

<p>Strengths</p> <ul style="list-style-type: none"> • Manualized CBT components of the skills • Initially for BPD, now apply to SUDs, Eating DOS, etc. • Clinicians frequently modify to suit setting • Website resources • Listed as EBP for BPD by Chambless & Hollon (1998) Chambless & Ollendick (2001) 	<p>Limitations</p> <ul style="list-style-type: none"> • Surprisingly few studies to support EBP • Training costs • Treatment costs: 1:1, group, & consultation weekly.
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Emotional Freedom Technique (EFT)

- Gary Craig
- Developed to treat anxiety and fear
- “Tapping of meridians”
- Energy field psychology
- EFT website: <http://www.eftuniverse.com/>

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EFT

Strengths	Limitations
<ul style="list-style-type: none">• Simple “tapping on meridians” easily transferred beyond therapist sessions.• Holds promise for low cost, self-help treatment approach to reduce emotional distress.	<ul style="list-style-type: none">• Few published studies• Review by Waite & Holder (2003) suggests treatment results are attributable to characteristics it shares with more traditional therapies.

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Summary

- Trauma-informed psychotherapies likely to have better outcomes emphasize:
 - Emotion regulation
 - Functional assessment
 - Problem-solving
 - Affirmation, change and acceptance
- Although “Seeking Safety”, DBT and EMDR are identified as evidence-based practice for treatment, the evidence is still relatively limited.
- EFT is an emerging “complementary” therapeutic approach that remains to demonstrate efficacy in randomly controlled trials.

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