

# **Toward Integrated, Trauma-Responsive Treatment of Substance Use Disorders and Trauma**



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# **The Co-Occurrence of PTSD and Substance Misuse**

# Co-occurrence of PTSD and Substance Misuse

**Co-occurring  
disorders are  
the rule  
rather than  
the exception.**

(SAMHSA, 2002)



Figure 1

## COMORBID DISORDERS ARE THE RULE, RATHER THAN THE EXCEPTION FOR PTSD

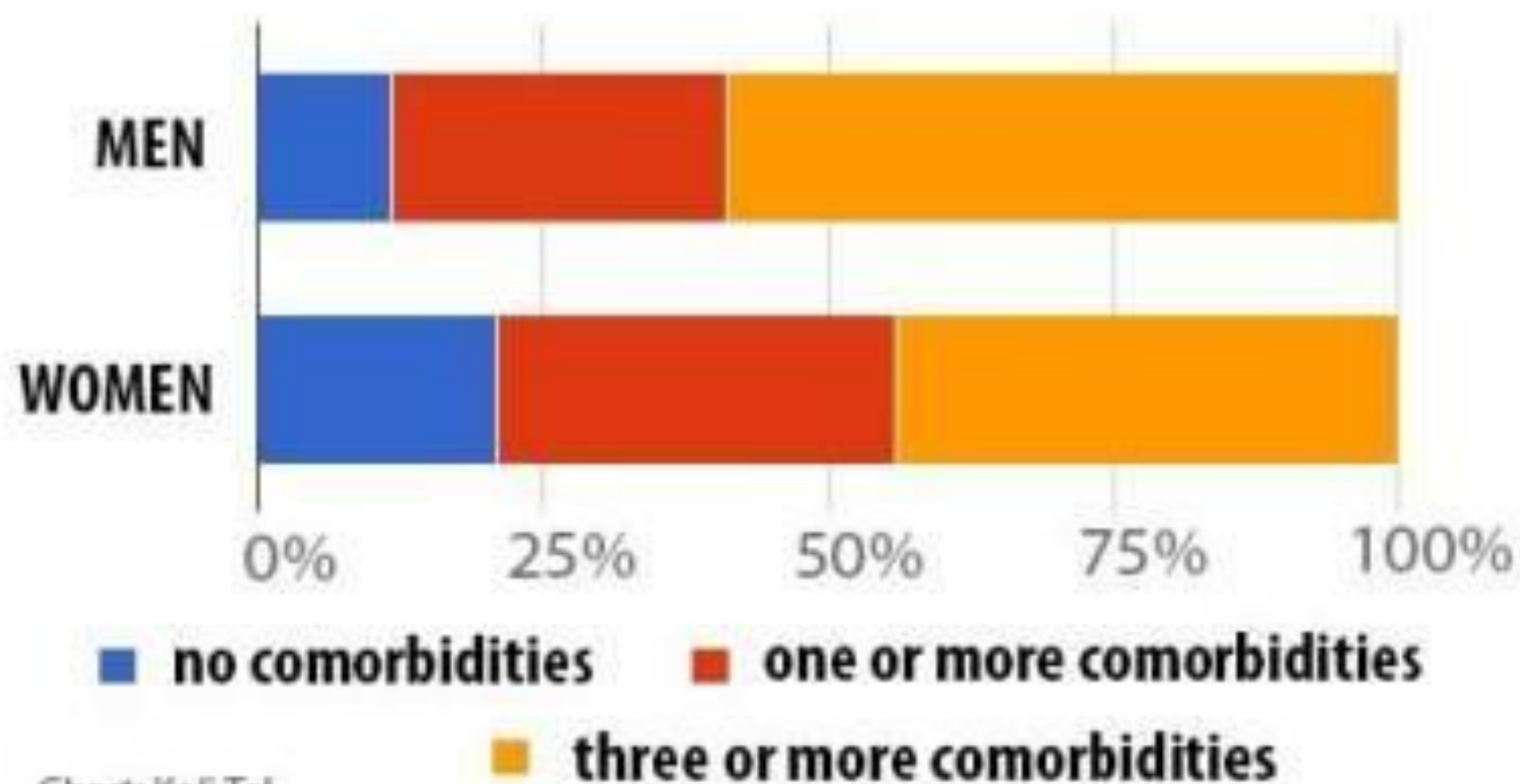


Chart: Kali Tal


# Co-occurrence of PTSD and Substance Misuse

## National Comorbidity Survey

Among those with PTSD:


	Male	Female
Alcohol Abuse/ Dependence	51.9%	27.9%
Drug Abuse/ Dependence	34.5%	26.9%

# Co-occurrence of PTSD and Substance Misuse



- PTSD and substance misuse co-occur at a high rate
  - 20-50% of people with PTSD also have SUDs (Boden et al., 2011; SAMHSA, 2007)
  - 40-60% of people with SUDs also have PTSD
- Among people with PTSD, 52% of men and 28% of women develop an Alcohol Use Disorder (Najavits, 2007)
- People with AUD have a 30% greater risk of having PTSD (Grant et al., 2015)
- People with Drug Use Disorders have a 50% greater risk of having PTSD (Grant et al., 2016)

# Co-occurrence of PTSD and Substance Abuse



- Substance use disorders are 3-4 times more prevalent in people with PTSD than those without PTSD (Khantzian & Albanese, 2008)
- The presence of either disorder alone increases the risk for the development of the other
- PTSD increases the risk of alcohol recurrence (Heffner et al., 2011) and substance recurrence (Norman et al., 2007)
- The combination results in poorer treatment outcomes (Ouimette et al., 2003; Sonne et al., 2003)



# PTSD and Alcohol Misuse



- Among people with PTSD, 52% of men and 28% of women develop an Alcohol Use Disorder (Najavits, 2007)
- In particular, adults who have experienced childhood traumas and those who are victims of assaultive violence are at risk of Alcohol Use Disorder (Fetzner et al., 2011)
- PTSD increases the risk of alcohol recurrence (Heffner et al., 2011)


# PTSD and Cannabis Misuse

- Some people with PTSD claim that marijuana is the only thing that helps their PTSD
- Some Veterans have lobbied Congress to allow the VA to prescribe “medical” marijuana
- There is no research evidence for this claim
  - The first study (Wilkinson et al, 2015) showed that marijuana *blocks* PTSD treatment



"Cannabis saved me when PTSD was just overwhelming me."

Sean Azzariti, 32 year old Iraq veteran became the first person to buy legal marijuana in Colorado when recreational stores opened Jan 1st



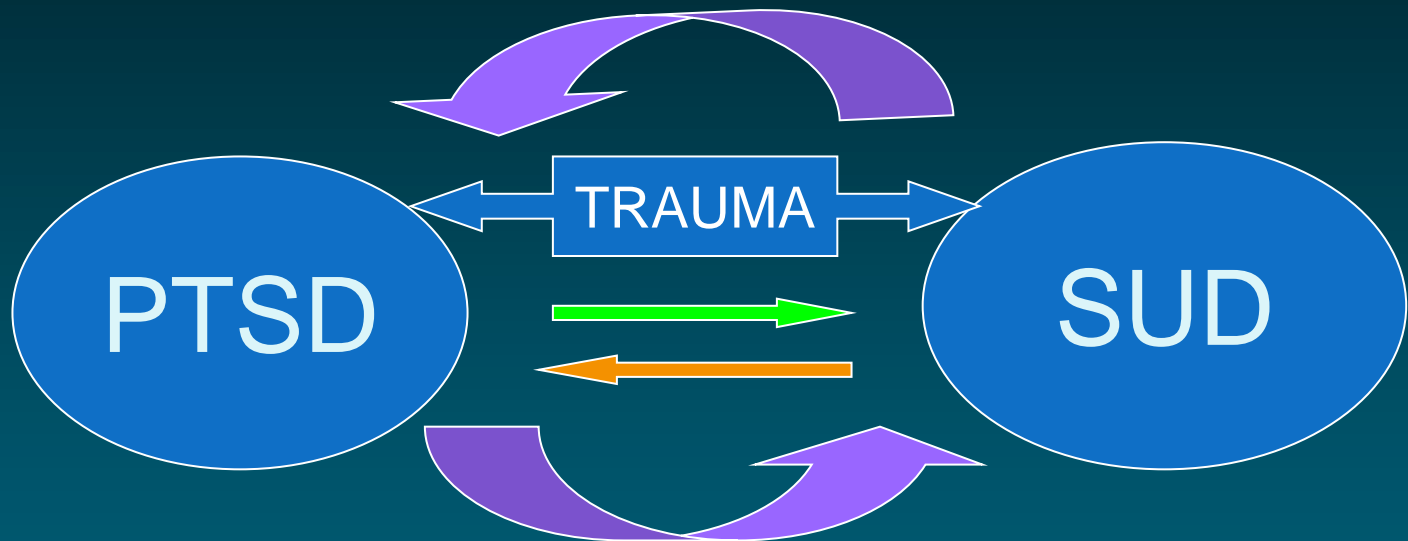
# **The Complicated Relationship between Substance Misuse and Trauma**

# Why Do PTSD and SUDS Co-occur So Frequently?

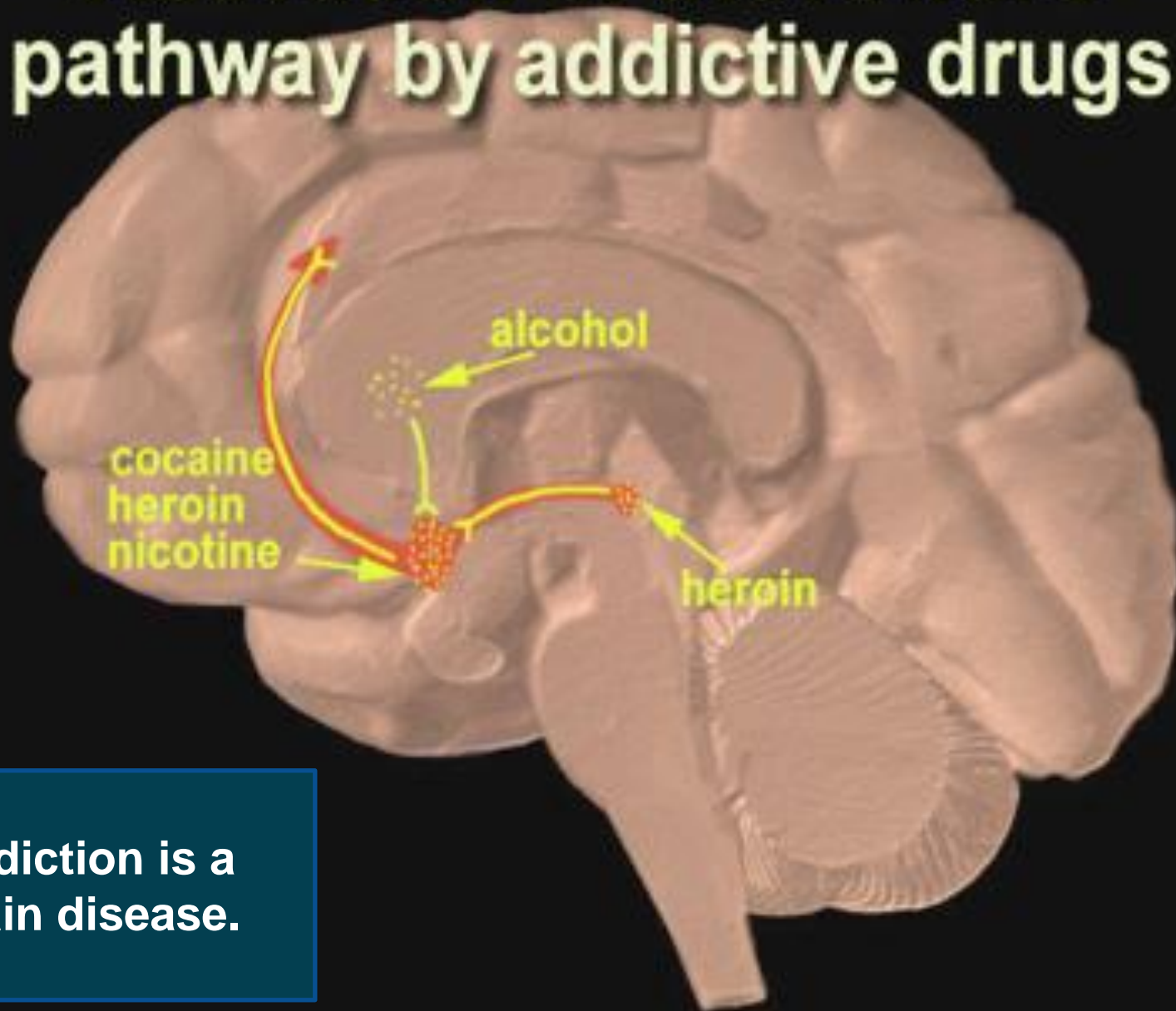


- People may have grown up in homes in which violence and substance abuse co-occurred
- People who use substances are at increased risk of developing PTSD
- People with PTSD use substances to cope with their distress
- Alcohol and drug use may increase a person's risk for developing PTSD
- There may be a shared genetic vulnerability to both PTSD and substance use following a trauma
- PTSD and substance misuse may be connected in a downward spiral

# Pathways Between Trauma-related Disorders and Substance Misuse

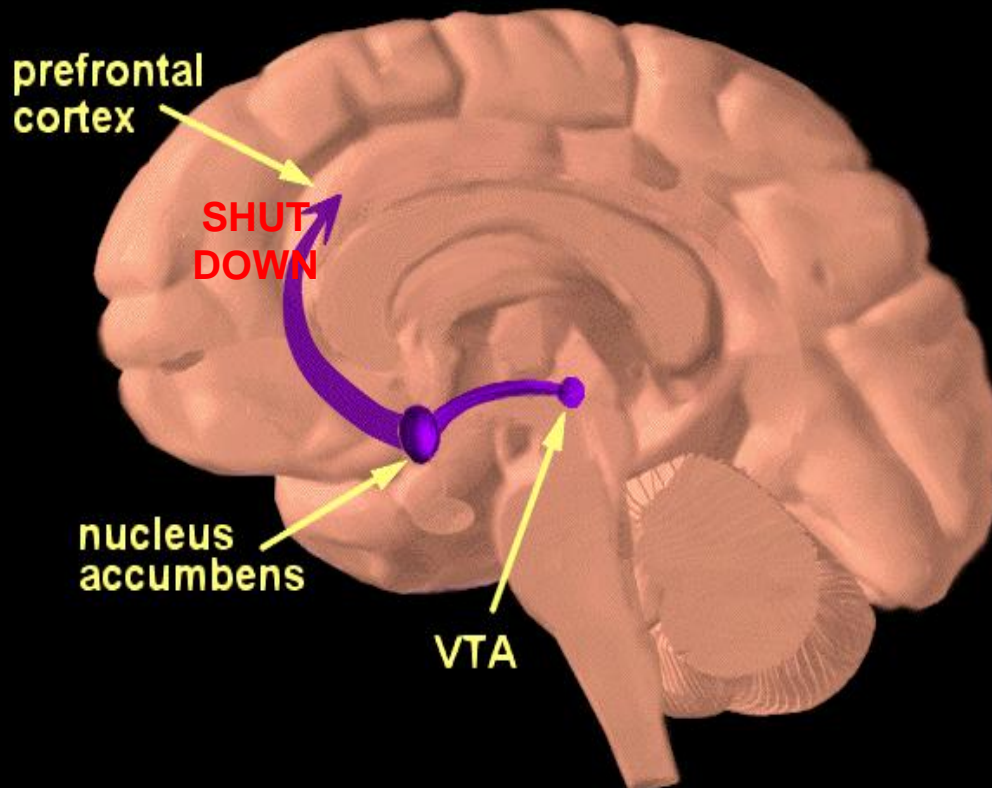


# Activation of the reward pathway by addictive drugs



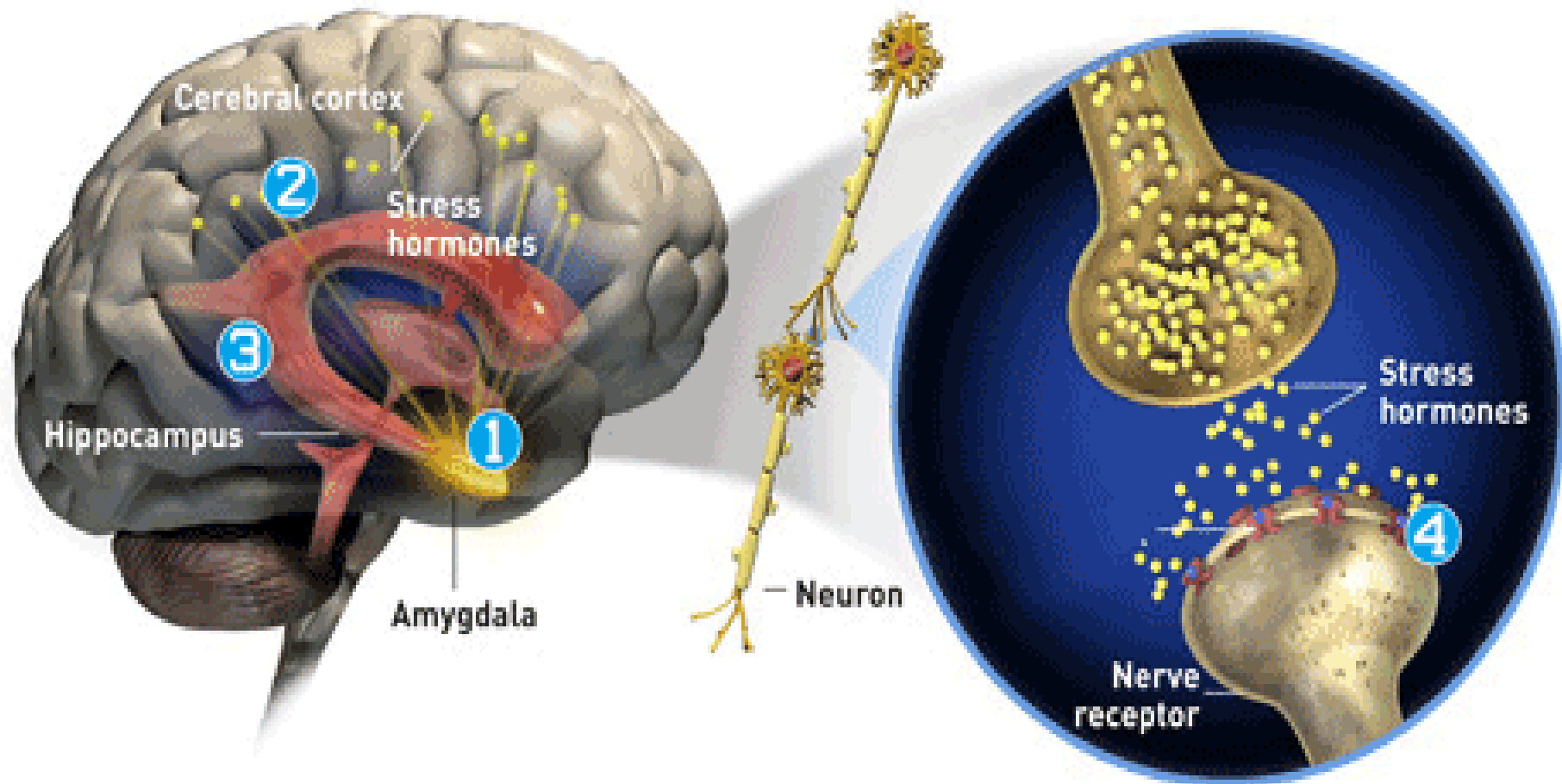
**Addiction is a  
brain disease.**

# The Brain's Reward System



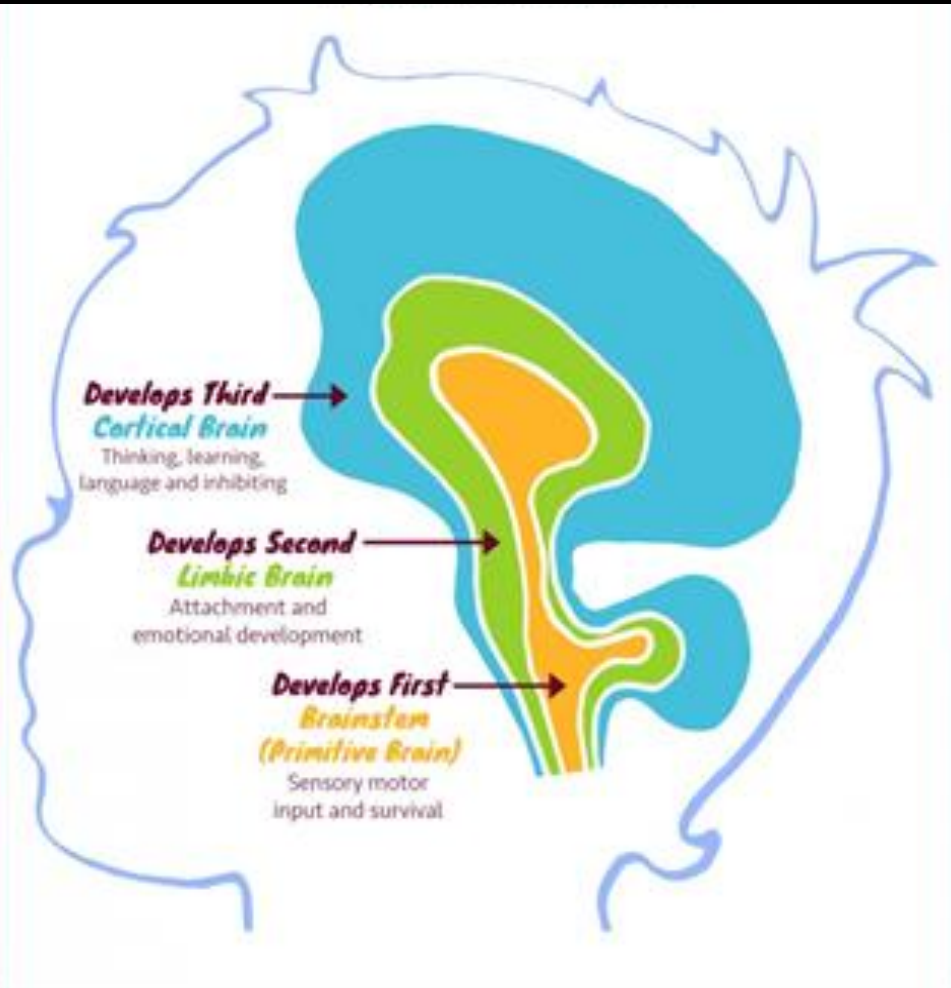
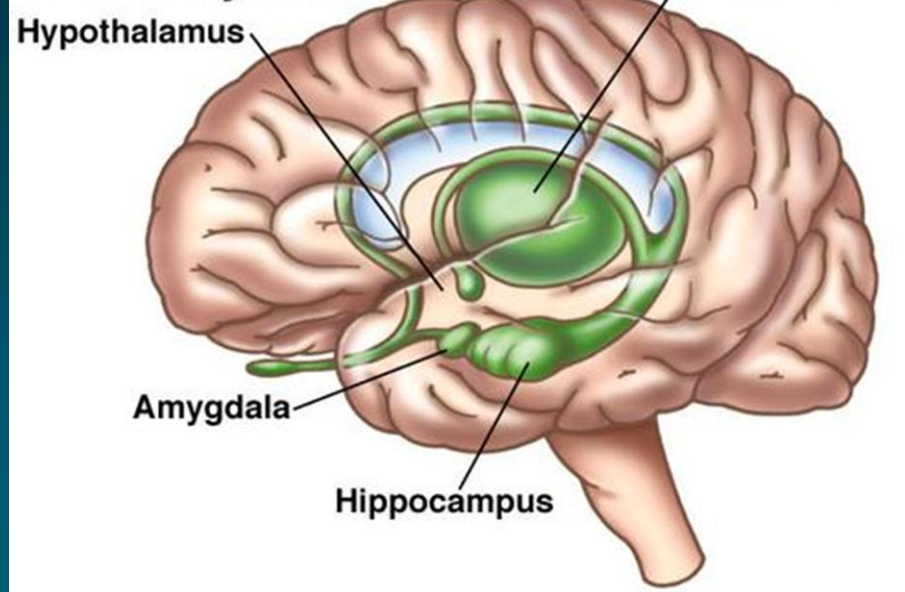
- At first, substances excite the release of dopamine
- Over time, tolerance develops, requiring more of the substance to release dopamine
- Eventually, substances are used to prevent withdrawal and just to keep going

# Traumatic Stress and the Brain



# Children's Brains Exposed to Trauma

## Limbic System



↑ Children's brains develop from the bottom up. ↑

# Trauma Changes the Brain



Non-traumatized



PTSD

# Co-Occurring PTSD and SUDs Make Each Other Worse



- Substance misuse exacerbates PTSD symptoms, including sleep disturbance, nightmares, rage, depression, avoidance, numbing of feelings, social isolation, irritability, hypervigilance, paranoia, and suicidal ideation
- People who drink or use drugs are at risk for being retraumatized through accidents, injuries, and sexual trauma

# The Truth about Self-Medication

- Only about 1/3 of people start misusing substances after their traumatic experience
- About 1/3 experience trauma and start misusing substances simultaneously
- About 1/3 misuse substances before they experience trauma



# Many Reasons Why People with PTSD Use Substances

- To numb their painful feelings (self-medication).
- To try to relax.
- To forget the past.
- To go to sleep.
- To prevent nightmares.
- To cope with physical pain.
- To stop dissociation and flashbacks.
- To feel some pleasure in life.
- To let out their anger.



# Many Reasons Why People with PTSD Use Substances



- Physical pain.
- Peer pressure.
- To socialize with other people and feel accepted.
- Family members drank or used drugs when they were growing up.
- It was common in the military.
- Boredom.
- To get through the day.
- To show people how bad they feel.
- “Slow suicide.”

“

Many women who have experienced violence and other forms of trauma use drugs to self-medicate, engage in sex for drugs and money to support their addictions, and may be coerced into unsafe sex by clients.

”

Erika Kates, 2015

# Five Patterns of the Relationship between PTSD and SUDs



1. Trauma/PTSD occurs first, then substance misuse (self-medication)
2. Substance misuse occurs first, then trauma/PTSD
3. PTSD and SUDs arise together from the same trauma
4. PTSD and SUDs arise separately
5. PTSD and SUDs make each other worse in downward spiral

# PTSD/SUD Patients Have Significantly More Problems

- 
- Other Axis I disorders
  - Increased psychiatric symptoms
  - Increased inpatient admissions
  - Interpersonal problems
  - Medical problems
  - Decreased motivation for treatment
  - Decreased compliance with aftercare
  - Divorce (Breslau et al., 2013)
  - Maltreatment of children
  - Custody battles
  - Unemployment (Henkel, 2011)
  - Academic dropout (Breslau et al., 2011)
  - Incarceration (Nowotny et al., 2014)
  - Homelessness (Palepu et al., 2013)
  - HIV risk (Seedat, 2012)

# What is Complex Trauma?

- The psychological effects of chronic, cumulative, and often different types of traumas
- Results from interpersonal victimization, multiple traumatic events, and/or traumatic exposure of prolonged duration
  - Sexual and physical abuse
  - Domestic violence
  - Ethnic cleansing
  - Prisoners of war
  - Torture
  - Being held hostage



# Complex PTSD Is Much More Than Simple PTSD

- Loss of a coherent sense of self
- Problems in self-regulation
- Tendency to be revictimized
- Other mental health disorders
- **Substance use disorders**
- Health problems
- Relationship problems
- Changes in systems of belief and meaning



# Complex Trauma in ICD 11\*

## PTSD

Re-experiencing

Avoidance

Hyperarousal

## Complex PTSD

Re-experiencing

Avoidance

Hyperarousal

Affect Dysregulation

Negative Self-Concept

Interpersonal Disturbances

\*Effective January 1, 2022

# People at Risk of Developing Complex Traumatic Stress Disorders

- Economically impoverished inner city minorities
- Incarcerated individuals
- Homeless persons
- Sexually and physically revictimized children or adults
- Victims of genocide or torture
- Developmentally, intellectually, or psychiatrically challenged persons
- Civilian workers and soldiers harassed on the job or in the ranks
- Emergency responders



# **The Rationale for Integrated Treatment**

# Why Should We Treat Co-Occurring Disorders Integratively?



- PTSD does not go away with abstinence; in fact, it may get *worse*, at least initially
- Improvement in PTSD symptoms does not bring about abstinence from substance use
- Even if substance misuse began as self-medication, it takes on a life of its own
- Separate treatment is usually uncoordinated and at worst countertherapeutic
- Integrated treatment leads to better outcomes

# Why Should We Treat Co-Occurring Disorders Integratively?



- Integrated treatment results in better attendance and retention (Amaro et al., 2007; Boden et al., 2011)
- Integrated treatment leads to better outcomes (Najavits, 2006)

# Ways That Substance Misuse Prevents Healing From PTSD



- It makes many PTSD symptoms worse
- It keeps a person from coping with their feelings
- It takes away a person's control
- It makes them hate themselves
- It is a way of neglecting themselves
- It isolates them

# The Importance of Integrated Treatment for PTSD and SUDs

- Treating one disorder without treating the other is ineffective
- Sequential treatment (usually SUD first) is ineffective
- Fully integrated treatment is optimal
- Simultaneous treatment is next best



# The Importance of Integrated Treatment for PTSD and SUDs



- Recent evidence on integrated and simultaneous treatment (Hien et al., 2010) suggests:
  - If PTSD symptoms decline, so do SUDs
  - If SUDs decline, PTSD symptoms do not
- Therefore, ***treating substance misuse without treating PTSD will fail***
  - This includes ASAP programs

# Why Don't We Treat PTSD and SUDs Integratively?



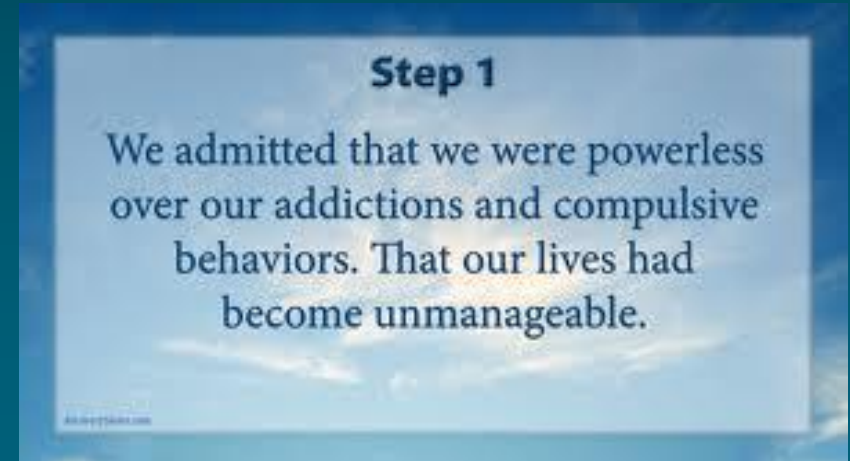
# Barriers to Integrated Treatment

- Most insurance does not pay for substance abuse treatment
- Separate payment streams
- Separate treatment systems
- Professional training biases
- Lack of dually trained clinicians




# PTSD and Substance Misuse Treatment

- PTSD symptoms may worsen in the early stages of abstinence
- Some aspects of 12-Step groups are difficult for some trauma patients
  - Powerlessness
  - Higher Power
  - Issues of forgiveness



# Trauma-Informed ≠ Evidence-Based Treatment



- Trauma-informed treatment means that trauma is taken into account when treating substance misuse
  - *Beyond Trauma: A Healing Journey for Women* by Stephanie Covington
- Evidence-based means that research has shown treatment to be effective
  - *Seeking Safety* by Lisa Najavits
- Evidence-based is better



# **Integrated Treatment of Trauma and Substance Misuse**

# Phases of Integrated Treatment



Phase I:  
Safety and  
Stabilization

Phase II:  
Remembrance  
and Mourning

Phase III:  
Reconnection

After Herman, 1992

# Stage I: Safety and Stabilization



- Alliance building
- Psychoeducation about multiple traumas
- Safety
- Stabilization
- Skills-building
  - Affective regulation
  - Cognitive
  - Interpersonal
- Self-care

# Stage I: Safety

- Safety plans
- Tension reduction activities (e.g., exercise)
- Harm reduction and elimination
  - **Substance misuse**
  - Self-harm and suicidal behaviors
  - Gambling
  - Driving
  - Fighting
  - Eating
  - Sex
  - Medication
  - Breaking laws



# Stage I: Stabilization

- Elimination of drug and alcohol misuse
- Health
- Housing
  - In a safe neighborhood
- Income
  - Employment
  - Financial skills (budgeting, banking)
- Transportation
- Setting and keeping a schedule



# Stage I: Skill-building



## Affect Regulation Skills

- Anger Management
- Relaxation (breathing, progressive muscle relaxation, Drop 3, etc.)
- Emotional literacy
- Distraction from intense emotion
- Self-soothing strategies
- Behavioral activation
- Changing facial expressions
- Self-talk
- Opposite emotion

# Stage I: Skill-building



## Cognitive Regulation Skills

- Grounding
- Thought-stopping
- Attending to one thing in the present moment
- Re-thinking
- Noticing choices
- Seeing the whole picture
- Problem-solving
- Examining the evidence

# Medication Treatment of Substance Use Disorders

- Alcohol:
  - Antabuse (Disulfiram)
  - Naltrexone
  - Acamprosate
- Opioids:
  - Methadone
  - Buprenorphine
  - Suboxone
  - Naltrexone



# Medical Treatment of PTSD and SUDs

- Medication for symptom management and co-morbid disorders
  - Antidepressants
  - Mood stabilizers
  - Anticonvulsants
  - Sleep aids, including Prazosin for nightmares
  - ~~Atypical antipsychotics~~ **No longer**
  - ~~Anxiolytics~~ **Not benzodiazepines**
- Only SSRIs (Prozac, Zoloft, and Paxil) are approved for treating PTSD
- There is no medication that specifically “cures” PTSD

# Psychological Treatment of Substance Use Disorders



## Evidence-Based Treatments:

- Motivational Interviewing
- Motivational Enhancement Therapy
- Cognitive-Behavioral Therapy (CBT)
- Contingency Management
- Behavioral Couples Therapy

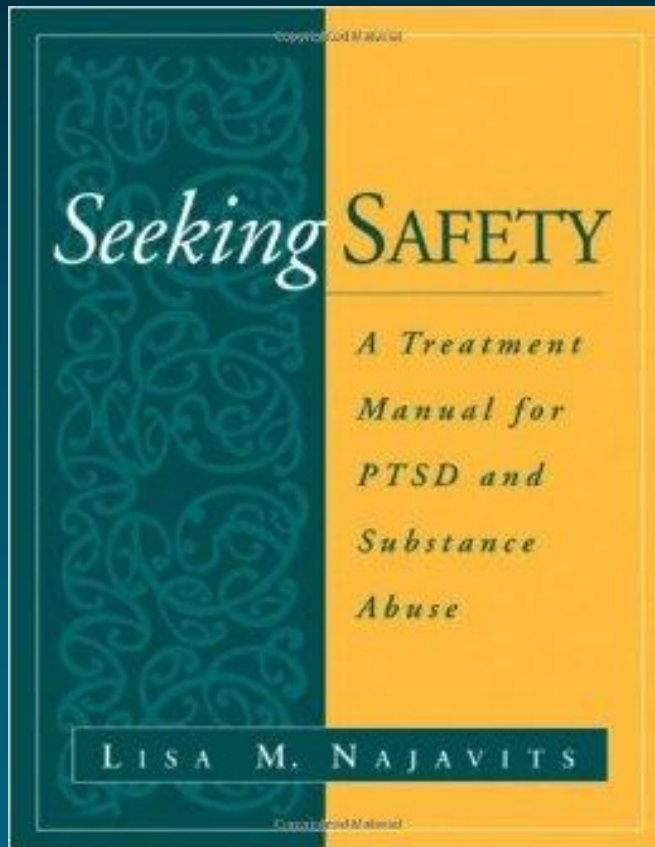
# Psychological Treatment of PTSD and SUDs



## Evidence-Based Psychotherapies for Integrated Phase I Treatment:

- Seeking Safety
- Dialectical Behavior Therapy (DBT)
- Therapies for specific problems
  - Imagery Rehearsal Therapy
  - Cognitive-Behavioral Therapy
  - EMDR resource building, safe place, etc.

# Seeking Safety



- 25 lessons on topics that overlap between PTSD and Substance Misuse
  - Safety Skills
  - Grounding
  - Anger
  - Boundaries
  - Self-care
  - Honesty
  - Compassion
- 84 Safe Coping Skills

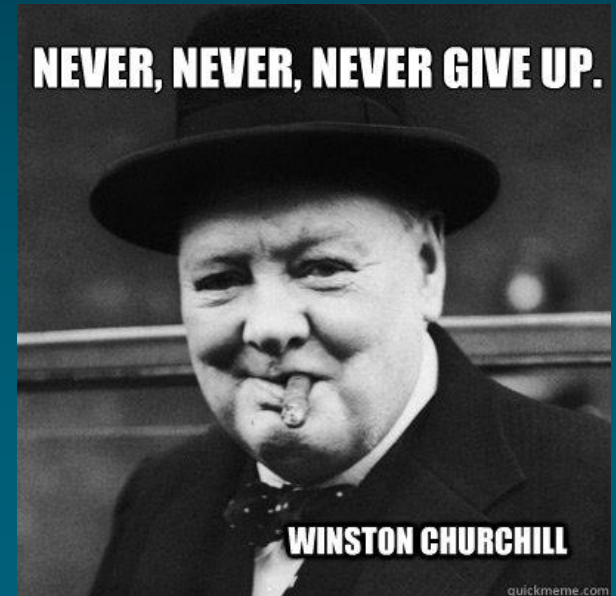
# Seeking Safety



- An integrated treatment in which both PTSD and SUDs are treated by the same clinician
- Weekly 90 minute sessions
- Sometimes taught in 12 sessions, but 25 is better
- Can be provided individually or in groups
- Typical group size is 8 members
- Combined psychoeducational and cognitive-behavioral treatment
- Can be provided by professionals or paraprofessionals

# Seeking Safety Format

- Check-in (3-5 minutes per person)
  - Used to elicit information to be discussed during the course of the session
- Quotation
- Topic of the day (50 minutes)
  - Mix in Safe Coping Skills
- Check out with commitment



# Seeking Safety Results



- 6 randomized controlled trials and 3 controlled studies
- Seeking Safety has shown positive results across all studies (Najavits & Hien, 2013)
- Populations include
  - Women outpatients, inpatients, Veterans, homeless women, rural women, and women in prison;
  - Men outpatients, inpatients, and Veterans;
  - Adolescent girls; and
  - Young African-American men.

# Other Advantages of Seeking Safety

- Tested on and effective with populations with complex problems not usually studied in treatment research
  - Domestic violence, homelessness, drug use disorders, low cognitive functioning, serious mental illness
- Present focus is as good as past focus (Marks et al., 1998; Najavits, 2007; Schnurr et al., 2007)
  - It's also less disturbing
- No history of adverse events (Killeen et al., 2008; Najavits, 2009)
- Treatment satisfaction is high (Najavits, 2009)
- Treatment retention is high

# How to Pit PTSD vs. Substance Misuse to Help Both

- Ask the client which is more important, to heal from PTSD or to keep using substances (to set up motivation)
- Have them list their PTSD symptoms
  - Write them in four boxes corresponding to the four areas of PTSD: re-experiencing, avoidance, negative thoughts and moods, and arousal
  - Then write those four area names at the top of each box
- Ask which box substance misuse fits into
- Then say, “So, if substance misuse is part of avoidance, and avoidance is part of PTSD, how are you going to get rid of your PTSD when substance misuse is practicing PTSD?”
- When they say they can’t, respond “Then let’s get to work on making your PTSD better.”
- Make sure to give them the piece of paper with the boxes



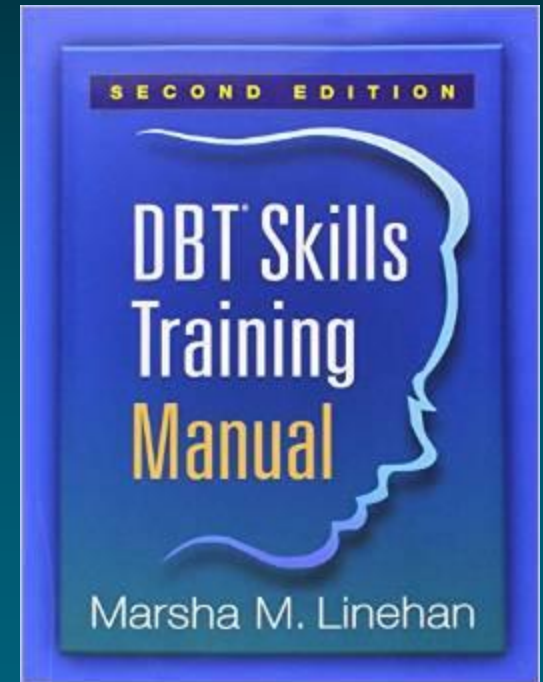
# Dialectical Behavior Therapy



- Combination of individual therapy and group DBT Skills Training
- Usually provided in teams with different therapists
- One therapist carries a beeper and takes emergency phone calls for coaching DBT skills
- DBT Skills Training group lasts one year, with each topic covered twice

# DBT Skills Training

- Four topics with multiple lessons
  - Mindfulness
  - Interpersonal Effectiveness
  - Distress Tolerance
  - Affect Regulation
- New manual provides suggested menus of different specific skills and exercises with different populations



# DBT Results



- 18 randomized controlled trials
- Results are all positive
- Populations include:
  - Women: with Borderline Personality Disorder (BPD) and suicidality, with BPD and substance dependence, with bulimia nervosa, with binge eating disorder, with opiate addiction and BPD, domestic violence victims, with childhood sexual abuse, and with trichotillomania;
  - Adults: with BPD, with personality disorders, with Bipolar Disorder, prisoners with intellectual disabilities, and prisoners with impulsivity;
  - Male prisoners; and
  - Adolescents: suicidal, female offenders, with self-injurious behavior, with eating disorders.

# Stage II: Remembrance and Mourning



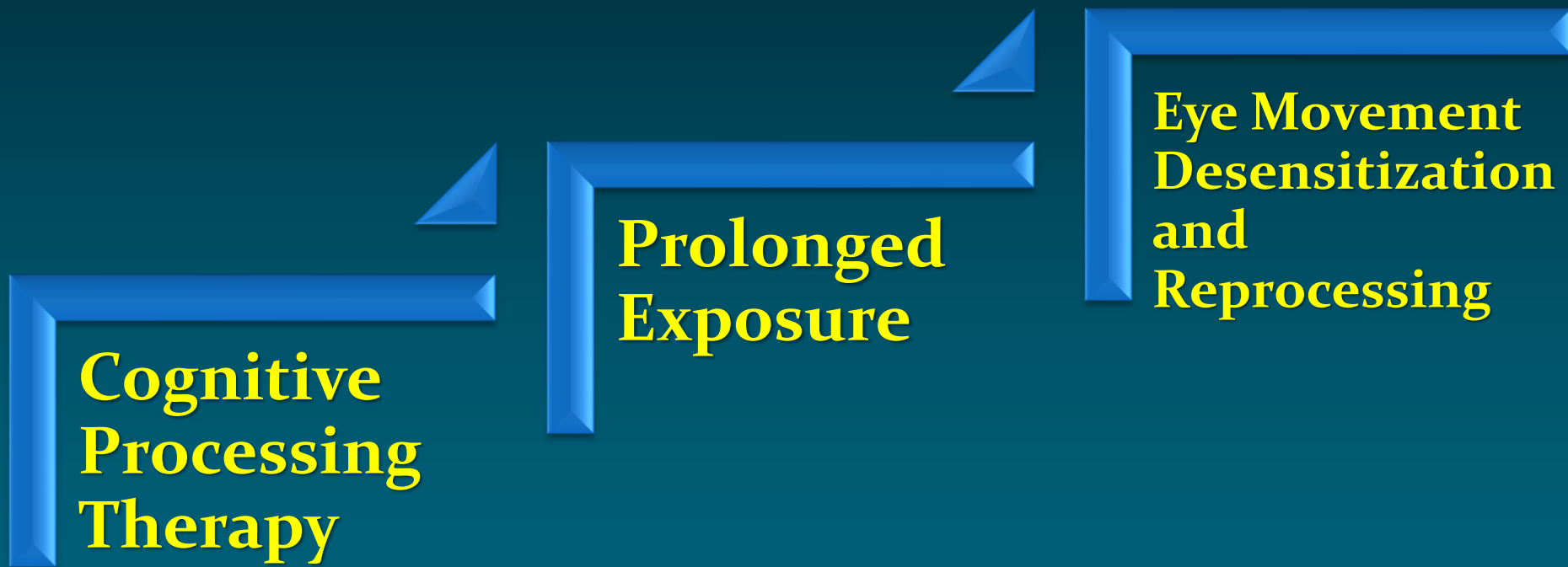
- Exposure and desensitization
- Processing
- Grieving
- Constructing a narrative
- Integration of the trauma

# When to Begin Stage II Treatment



- When safety and stability can be maintained
- When the client has sufficient skills to manage strong emotions that may emerge
- When substance misuse is in remission for 90 days
- Exceptions:
  - Occasional use
  - When a person can manage minimal use

# Evidence-Based Treatments for Stage II



# Cognitive Processing Therapy



- A cognitive intervention to change the way a traumatized person thinks
- 12 weekly sessions delivered in a structured, manualized protocol
  - Number of sessions can be expanded
- May or may not include a trauma narrative
- Can be delivered individually and/or in groups
- Homework worksheets between sessions

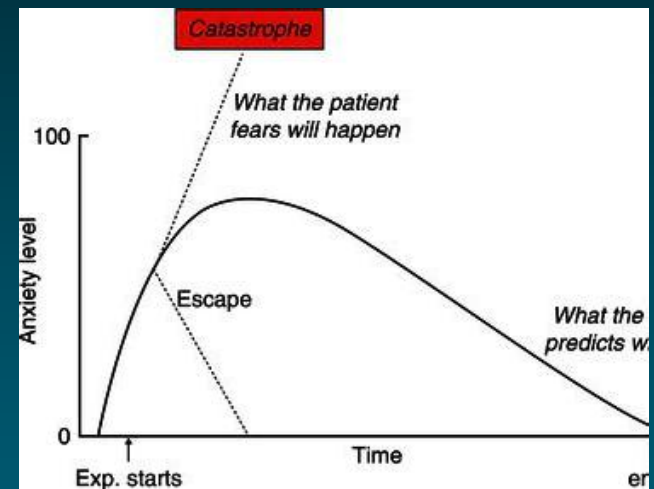
# Cognitive Processing Therapy



- Central techniques:
  - Identifies stuck points
  - Examines evidence for thoughts and beliefs
  - Challenges beliefs
- Changing the interpretation of the traumatic event changes the emotions resulting from the event
- CPT is an effective treatment for PTSD  
(Vickerman & Margolin, 2009; Ougrin, 2011; Jonas et al., 2013; Ehring et al., 2014)
- CPT can treat complex trauma (Resick et al., 2003; Galovski et al., 2013)

# Prolonged Exposure

- A behavioral intervention that repeatedly exposes patients to distressing stimuli in order to decrease their anxiety in response to those stimuli
- 10 weekly sessions
- First part involves *in vivo* exposure to places that increase anxiety (e.g., public places)
  - Uses an anxiety hierarchy



# Prolonged Exposure



- Second part involves writing and dictating a trauma narrative focusing on one traumatic experience
  - The patient listens to the narrative over and over for an hour each day
  - Repeated and prolonged exposure decreases their anxiety
- Prolonged Exposure is an effective treatment for PTSD (Vickerman & Margolin, 2009; Ougrin, 2011; Jonas et al., 2013; Ehring et al., 2014)
- There is no evidence that it successfully treats complex trauma

# Eye Movement Desensitization and Reprocessing



- Patient focuses on distressing image
  - States a belief that goes with it
  - Notices feelings that go with it
  - Identifies body sensations that go with it
- Therapist passes fingers back and forth, guiding the eyes
- As this occurs, the images, thoughts, feelings, and body sensations change
- Adaptive information processing results

# Eye Movement Desensitization and Reprocessing

- Auditory and tactile alternatives to eye movements using bilateral stimulation
- Additional exercises:
  - Safe Place
  - Lightstream
  - Resource-building
  - **Protocol for substance misuse**
  - Etc.



# Eye Movement Desensitization and Reprocessing Results

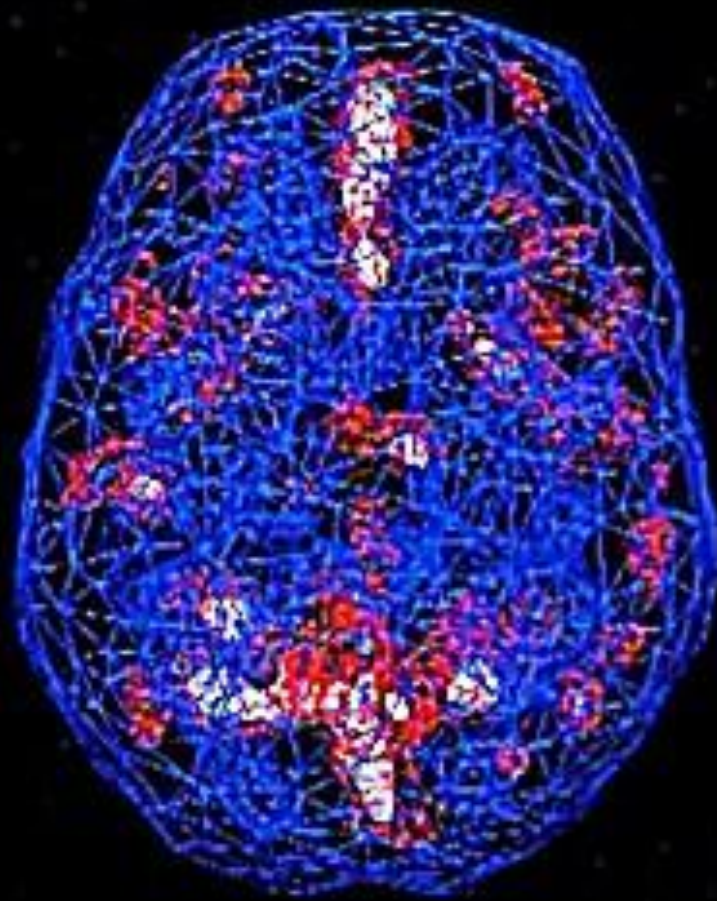


- EMDR works for both PTSD and Complex PTSD (Davidson & Parker, 2001; Foa et al., 2009; Maxfield & Hyer, 2002; Seidler & Wagner, 2006)
- EMDR **addresses substance misuse** (Vogelmann-Sine et al., 1998)
- EMDR uses the same mechanism for resolution (eye movements) that sleep does
  - EMDR also targets nightmares

# Trauma Changes the Brain

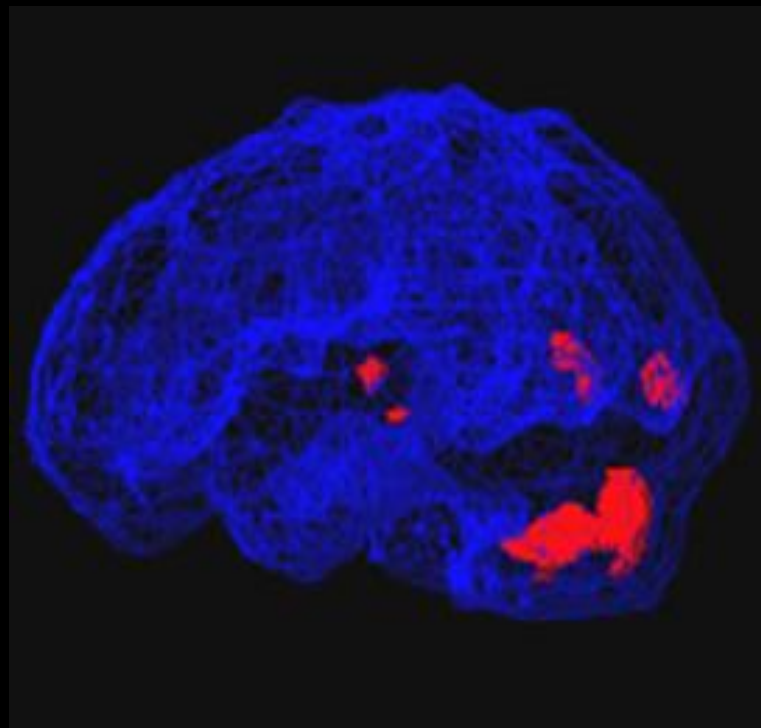
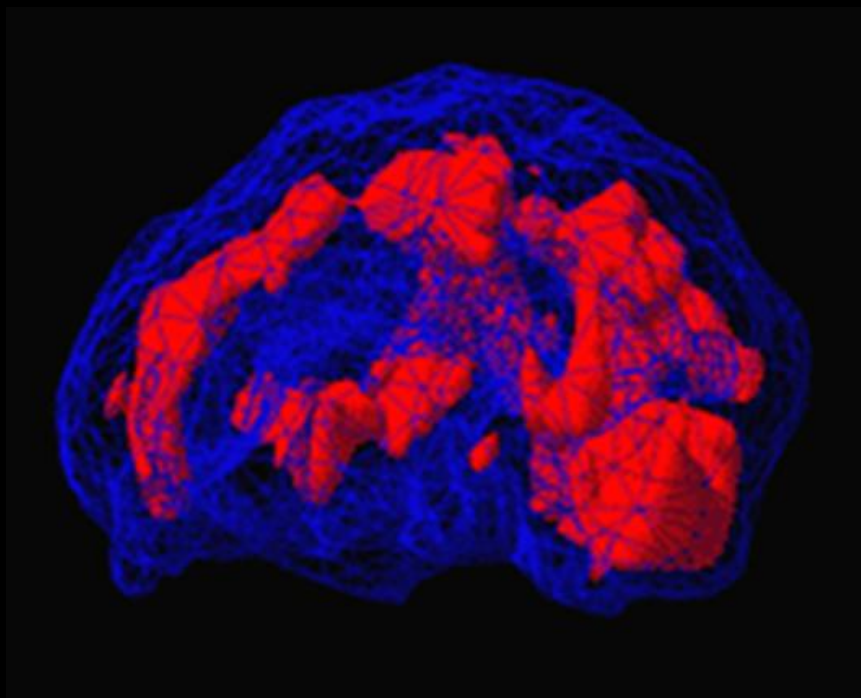


Non-traumatized



PTSD

# EMDR Changes the Brain



Brain scans of a woman with PTSD showing areas of overactivity in the brain in **red**, before and after four sessions of EMDR (photos by Daniel Amen)

# Evidence-Based Treatment of Trauma in Trauma-Responsive Courts

- Five year phasic study of adding trauma treatment to a 12-18 month **drug court program** in Washington State (Brown et al., 2015)
  - Added Seeking Safety (SS) for 150 participants with trauma histories
  - 112, or 75%, completed SS
  - All were offered EMDR, and 65 accepted (58%)
- Graduation rates differed:
  - Of the 65 that engaged in EMDR, **91%** successfully graduated from drug court
  - Of the 47 who did not, only **57%** graduated
- Recidivism rates differed:
  - 70 without trauma history who received Program as Usual had a **10%** recidivism rate
  - 65 who did SS + EMDR had a **12%** recidivism rate
  - 47 who did SS only had a **33%** recidivism rate

# Decision Pathways for Adult Trauma Treatment in a Trauma-Responsive Court



Brian L. Meyer, after Brown et al., 2015

# Stage III: Reconnection



- Gradually decrease isolation
- Re-establishing estranged relationships
- Developing trusting relationships
- Developing intimacy
- Developing sexual intimacy
- Parenting
- Community-based activities
- Spirituality

# Reconnection

- Giving back to the community
- Atonement/penance
- Acceptance
- Reclaiming
- Creativity
- Finding meaning
  - What are you living for?
- Re-finding joy
  - What makes you happy?
  - DBT list of pleasurable activities
- Post-traumatic growth



THE SEARCH  
FOR MEANING

# Reconnection

- There are no Evidence-Based Psychotherapies for Phase III trauma treatment
  - but couples and/or family therapy may be helpful





# Promising Treatments

# A Promising Treatment: STAIR Narrative Therapy



- Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy uses coping skills from Stress Inoculation Training and Dialectical Behavior Therapy (Cloitre et al., 2006)
- 8-10 sessions of skills building and 8 sessions of narrative therapy

# Promising Treatments: STAIR Narrative Therapy



## Narrative Therapy: developing an autobiography

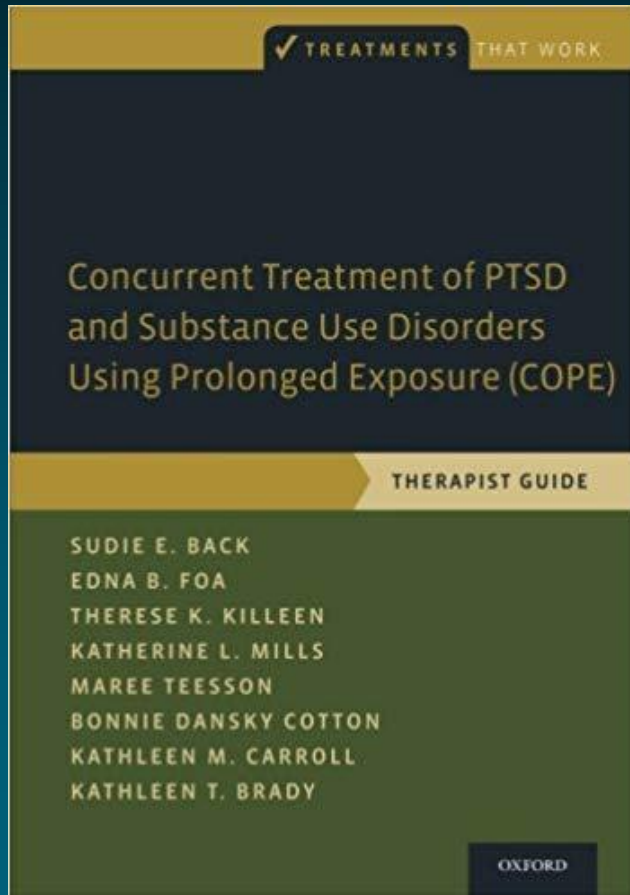
- Repeated narration to organize trauma memory and reduce fear
- Analyze meaning of event(s) to revise beliefs/schemas about self and others, integrate traumatic memories into a life history, and explore and resolve feelings other than fear
- Continue practice of STAIR skills

# A Promising Treatment: STAIR Narrative Therapy



- Four studies of STAIR Narrative Therapy (Cloitre et al., 2002; Levitt et al., 2007; Trappler & Newville, 2007; Cloitre et al., 2010) show:
  - Decreases in PTSD symptoms
  - Improvements in interpersonal problems
  - Improvements in emotion regulation
- Studies of women with child abuse histories, post 9/11 survivors, and inpatients with co-morbid PTSD and Schizoaffective Disorder
- Implemented in many VA facilities

# Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)



- COPE combines CBT for SUDs (Carroll, 1998; Kadden et al., 1992) and Prolonged Exposure (Foa et al., 2007)
- 12 90 minute sessions
- An integrated treatment in which both PTSD and SUD are treated by the same clinician

# COPE

- Education about the relationship between PTSD and SUD
- Education about common reactions to trauma
- Techniques to manage cravings and thoughts about using substances
- Coping skills to prevent recurrence



# COPE



- Breathing retraining
- Repeated in vivo exposures to safe situations
- Repeated imaginal exposure to the trauma memories

# COPE Session Structure



- Review current PTSD symptoms and any substance use since previous session
- Review homework
- 45-60 minutes of PTSD material
- 30 minutes on substance abuse
- Assign homework

# Research on COPE



- Several studies of COPE show mixed results
  - Exposure therapy does not increase substance use
  - One study found that integrated exposure therapy plus SUD treatment improves trauma symptoms but not substance misuse, depression, or anxiety compared to TAU (Mills et al., 2012)
  - A second found that Prolonged Exposure plus Naltrexone does not improve trauma symptoms more than treatment as usual (Foa et al., 2013)
  - A third found that COPE and Relapse Prevention Therapy decreased PTSD symptoms by a similar amount (Ruglass et al., 2017)



# Resources

# PTSD and SUDs



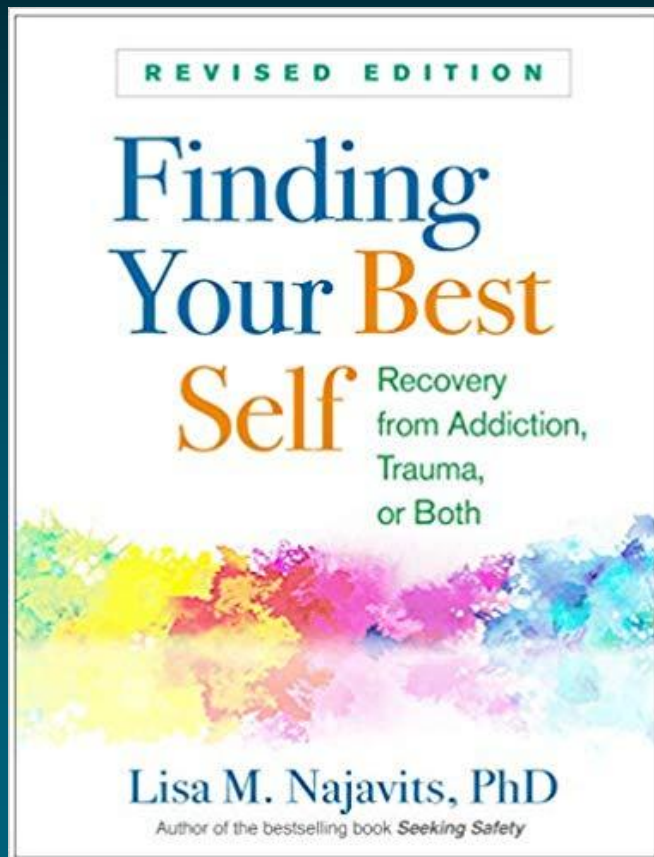
- PTSD 101 course about treating PTSD and SUDs:  
[www.ptsd.va.gov/professional/ptsd101/course-modules/SUD.asp](http://www.ptsd.va.gov/professional/ptsd101/course-modules/SUD.asp)
- Practice recommendations for treating co-occurring PTSD and SUDs:  
[www.ptsd.va.gov/professional/pages/handouts-pdf/SUD PTSD Practice Recommend.pdf](http://www.ptsd.va.gov/professional/pages/handouts-pdf/SUD_PTSD_Practice_Recommend.pdf)

# Resources



- *Trauma and Substance Abuse (2<sup>nd</sup> ed.)* by Page Ouimette and Jennifer Read
- *Treating Survivors of Childhood Abuse and Interpersonal Trauma: STAIR Narrative Therapy (2<sup>nd</sup> ed.)* by Marylene Cloitre, Lisa Cohen, Kile Ortigo, Christie Jackson, and Karestan Koenen

# Seeking Safety



- *Seeking Safety* (2002), Lisa Najavits
- *Finding Your Best Self* (2019), Lisa Najavits
- <http://www.treatment-innovations.org/seeking-safety.html>

# Dialectical Behavior Therapy



- *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993), Marsha Linehan
- *DBT Skills Training Manual, 2<sup>nd</sup> edition* (2014), Marsha Linehan
- *DBT Skills Training Handouts and Worksheets, 2<sup>nd</sup> edition* (2014), Marsha Linehan
- <http://www.behavioraltech.com>
- <http://www.linehaninstitute.org/>

# Prolonged Exposure



- *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide* (2007), Edna Foa, Elizabeth Hembree and Barbara Olaslov Rothbaum
- *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook* (2007), Barbara Rothbaum, Edna Foa and Elizabeth Hembree
- Free online course:  
<http://www.deploymentpsych.org/online-courses/pe>

# Cognitive Processing Therapy

- *Cognitive Processing Therapy for PTSD: A Comprehensive Manual* (2017), Patricia Resick, Candice Monson, and Kathleen Chard
- Free online courses:

<https://cpt.musc.edu>

<http://www.deploymentpsych.org/online-courses/cpt>



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# EMDR

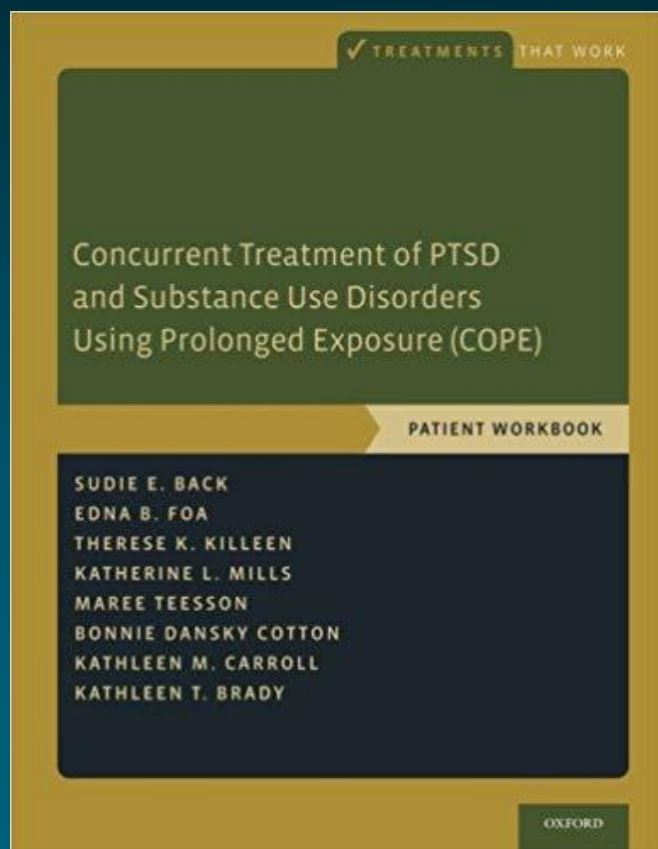
- *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures, 3rd ed. (2017), Francine Shapiro*
- *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy (2013), Francine Shapiro*
- [www.emdr.com](http://www.emdr.com)
- [www.emdria.org](http://www.emdria.org)
- [www.emdrhap.org](http://www.emdrhap.org)

# STAIR Narrative Therapy



- *Treating Survivors of Childhood Abuse and Interpersonal Trauma: STAIR Narrative Therapy*, 2<sup>nd</sup> ed. (2020), Marilene Cloitre, Lisa Cohen, Kile Ortigo, Christie Jackson, and Karestan Coenen
- Online at <http://www.stairnt.com/index.html>  
[http://www.ptsd.va.gov/professional/continuing\\_ed/STAIR online training.asp](http://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp)

# COPE



- *Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE), Therapist Guide (2015)*, Sudie Back et al.
- *Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE), Patient Workbook (2015)*, Sudie Back et al.



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