

# TraumAddiction



## Treating Addicted Survivors of Trauma



Fall - Spring  
2020-2021

**J. Eric Gentry, PhD, LMHC**  
Board-Certified Expert in Traumatic Stress

# TRAUMADDICTION

## Treating Addicted Survivors of Trauma

**Hello.** I am excited to get to facilitate this course with you. In many ways, I have been preparing to teach this material since I started in the caregiving field in 1982. In 1988, I surrendered a long battle with addiction and began my journey of recovery. In 1990, I started in private practice. Shortly after getting clean I began developing florid symptoms of Posttraumatic Stress Disorder. I began outpatient psychotherapy for myself in 1992. My first day in therapy I told my therapist, “Charlie, I don’t deserve to be here. I work with people who have *real* trauma.” I have an ACE score of nine, yet I did not comprehend this as trauma.

As I began to work through the traumas of my past, using an abreactive treatment process, I became flooded with flashbacks and nightmares that significantly compromised my ability to function. Within a month of completing my credentialing as a Certified Addiction Counselor in 1993 and on a trip to Oakland to get certified in biofeedback, I relapsed in my recovery from addiction. It took 17 long months for me to start to put clean-time together again—even though I was attending 12-Step meetings fervently. In the Spring of 1995 after a fatal motor vehicle accident, from which I was resuscitated, I restarted my recovery in earnest. I have been clean since then. Staying clean meant I had to make some changes and one of those changes was ending my marriage.

Before I relapsed, I attended a Level I training in EMDR and began to progressively treat more and more trauma survivors in my private practice. I discovered that I had a gift for working with survivors and found it very rewarding. After my divorce in 1995, I started a year-long fellowship in Psychotraumatology at the WVU School of Medicine working with Louis Tinnin, MD. We started the very first intensive outpatient/partial hospitalization treatment program for trauma and dissociation that year and I grew immensely as a clinician. Following that fellowship in May of 1996, I had a couple friends drive me to Maine and I thru-hiked the Appalachian Trail Southbound. When I completed the Trail, I began my doctoral studies at Florida State University where I studied with Professor Charles Figley. He and I started the first Traumatology Institute there in 1997. In 2001, I took the institute to the University of South Florida where I co-directed the program with Michael Rank, PhD. When that institute disbanded I moved to Sarasota in 2004 to start a private practice. In 2009, with two other colleagues, we started the International Association of Trauma Professionals. And in 2017, I moved to Phoenix and purchased part ownership in the Arizona Trauma Institute where I live today

Since 1991, I have worked with hundreds of addicted survivors of trauma. I am grateful to Katie Evans and J. Michael Sullivan for writing *Treating the Addicted Survivor of Trauma* in 1995. They were the pioneers of this work and the first to advocate for treating both trauma and addiction simultaneously. It is upon their shoulders that I stand to bring this training to you in the hopes that no one else ever need die from the horrors of addiction or traumatic stress.

# Healing Trauma: Simple not Easy

I have treated people who suffer the effects of trauma for over 30 years. In the beginning, I was terrified as I sat across from these survivors who put their hope and trust in me to help them navigate through the dark tunnel of traumatic stress. I was afraid that I would not be able to help them, or worse, that I would cause them harm. As a result of this fear, I became a very cautious therapist. With my anxious and overly cautious approach, I can see clearly now how I was actually causing harm and thwarting treatment—although I would have vehemently argued this 20 years ago. My anxiety had its upside though, as it compelled me to accrue more and more training. By the mid-90s, I had become trained in every known treatment, the whole “alphabet soup” of protocols, which had shown efficacy and/or effectiveness in treating traumatic stress. These include: Eye Movement Desensitization and Reprocessing (EMDR I & II); Traumatic Incident Reduction (TIR), Neuro-Linguistic Programming (NLP), TRI-Method, CBT protocols (DTE, CPT, SIT, etc), Dialectical Behavioral Therapy (DBT), Gestalt, Psychodynamic methods, Structural & Strategic Treatment for Dissociative Disorders, Thought Field Therapy (TFT), Somatic Experiencing (SE), Emotional Freedom Techniques (EFT), Hypnotherapy, and Critical Incident Stress Management.

In 1995-96, I completed a fellowship in psychotraumatology at WVU’s School of Medicine, where I studied with Louis Tinnin, MD—a man Bessel van der Kolk has named the 20th Century’s Pierre Janet. Lou is a genius in working with traumatic stress. He turned Pierre Janet’s work of the 1880’s into a comprehensive treatment model for effectively treating trauma and dissociation. I was able to assist in some of the research that demonstrated the effectiveness of this treatment. Lou taught me two very important ingredients in successfully treating trauma: the value of narrative and a fearless approach of the client’s traumatic material.

After I completed this fellowship, I began my doctoral work at Florida State University where I studied under Charles Figley, PhD. Charles will probably become known by history as one of the most important people in the development of the field of Traumatology. His research in the late 1970s help lead to the diagnosis of PTSD being included in the DSM III. He was the first president of the International Society for Traumatic Stress Studies and was the first editor of the Journal of Traumatic Stress. It was an honor to have him as my major professor. In 1997, I assisted Charles in the development of the curricula for the Traumatology Institute at FSU and became one of the original faculty. In that first year, we won the UCEA award for the best continuing education program in the country. Since that time, as faculty and Associate Director of the Traumatology Institute at FSU, co-director the International Traumatology Institute at USF, and owner of Compassion Unlimited in Sarasota, I have trained nearly 100K professionals in some form of traumatic stress intervention.

In my doctoral coursework, I took the course that we all have to take—the one in which we learn to critically evaluate scientific writing. For my work in this particular course, I wanted to evaluate all the treatments for traumatic stress that had demonstrated effectiveness. In the process of doing this, I decided to ask the research question: “Are there any ingredients in

trauma treatment that are demonstrated to be important to all effective treatments?” After completing a qualitative analysis of the all Discussion sections of each of the articles I reviewed, I discovered that there was a resounding “yes” answer to this question. Integral to almost every effective treatment is the combination of some form of exposure to the traumatic material paired with relaxation.

After reviewing the work of Patricia Resick (1988, 1993), Charles Marmar (1989) and James Pennebaker (1989, 1997), and from my own experience of training with Lou, it became obvious to me that the type of exposure was very important. If we could help survivors construct *complete narratives* of their traumatic experiences while in a *relaxed state*, we could help them to accelerate healing of their traumatic stress symptoms. By facilitating this important narrative process, not only are we assisting them with confronting the traumatic material, we are also helping them to structure the intrusive sensory traumata into language. These previously mentioned researchers have been able to demonstrate that effective narrative construction has a powerful ameliorative effect upon the intrusive symptoms of trauma (i.e., flashbacks and nightmares). Virtually every treatment that demonstrated effectiveness with traumatic stress utilized some form of narrative (exposure) paired with some form of relaxation.

As I progressed in my understanding of central nervous system functioning and especially understanding the role of perceived threat and sympathetic dominance in the etiology of traumatic stress symptoms, I began to see ever more clearly the importance of relaxation. Integrating the work of Bob Scaer (2001; 2006) into my own research on relaxation, I began to see that as a person is able to develop and maintain parasympathetic dominance (i.e., relaxation), then symptoms abate. Through working with Emergency Medical Technicians, Neuro-Muscular Therapists, as well as several psychiatrists and neurologists, I stumbled onto the discovery of how 20-30 seconds of pelvic floor relaxation (e.g., psoas, sphincter, and pubio-coxyx , or Kegel, muscles) precipitates parasympathetic dominance. This simple relaxation strategy fortifies the individual with (a) comfort in their body; (b) total access to memory, language and neocortical functioning; and (c) the capacity for intentional living (more about this in the training). If and when a trauma survivor is able to keep their body relaxed, they no longer suffer symptoms.

For a while I thought and taught that these were the **only two** crucial ingredients to effective treatment of traumatic stress—narrative/exposure and relaxation (reciprocal inhibition). In 1999, Hubble, Duncan, and Miller released, in my opinion, the single most import text of the past decade—*The Heart & Soul of Change*. This book is chocked full of paradigm-shifting information. One of the most important truths to come from their huge meta-analytic study was what they learned about predictors of positive outcomes in psychotherapy. They found that the MOST important predictor of positive outcomes in our patient’s psychotherapy has nothing to do with the therapy itself—it is occurrences that happen outside of therapy that account for over 40% of positive outcomes. Then, of the 60% that we, as helpers, can influence we find that 30% is contingent upon the development and maintenance of a good therapeutic relationship. The remaining 30% is split equally between positive expectancy (which has also been called either “hope” or “placebo”) and techniques/models. There is a good argument that

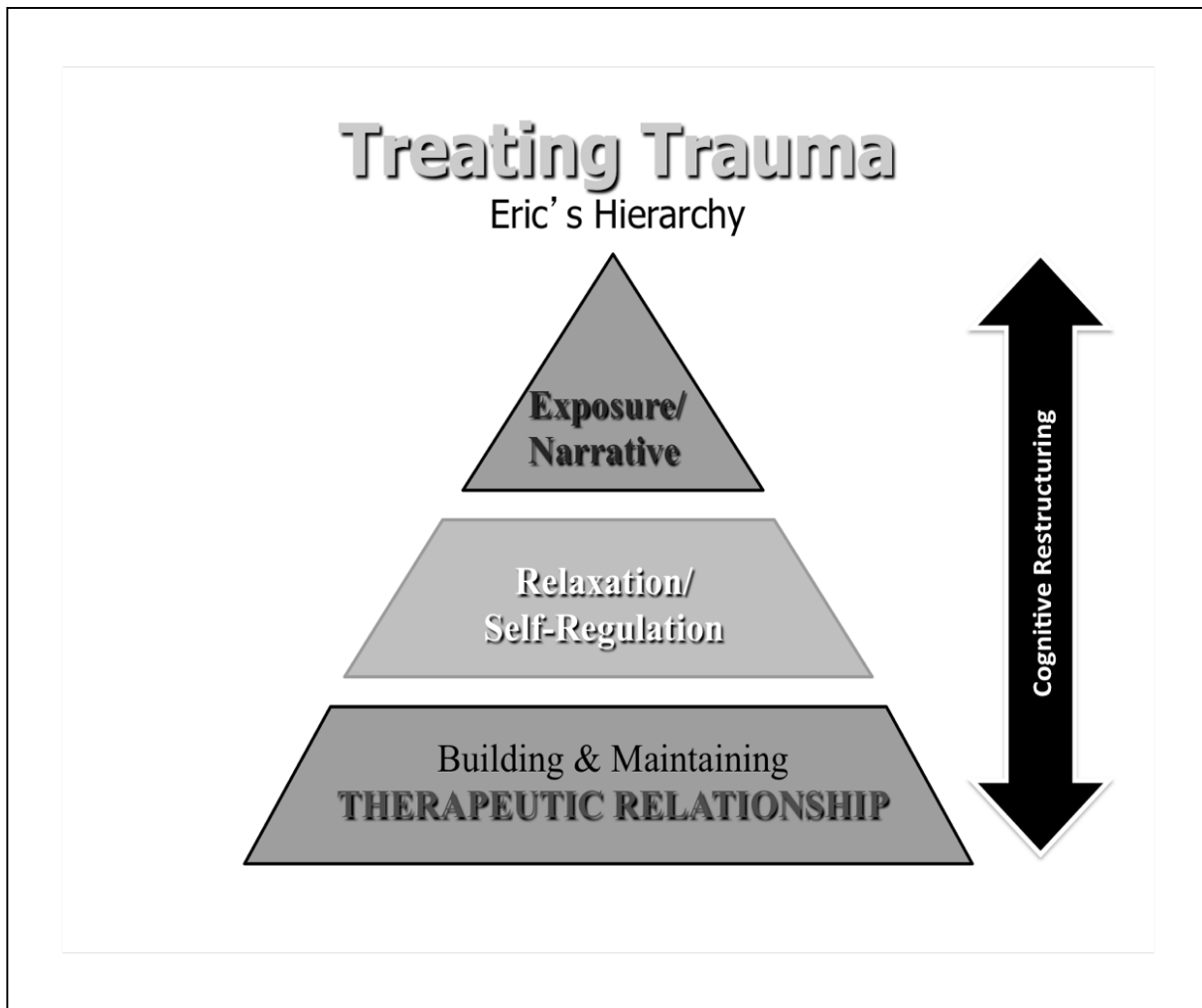
the process of developing expectancy/hope/ placebo is also a relational function. If this is so, then that means the degree to we can influence positive outcomes for our clients, 75% is contingent upon relational factors and 25% is contingent upon technical and/or philosophical factors. This data confirms what I, as a professional care provider for nearly three decades, have always intuited—people heal people! It is not EMDR, or CBT, or psychopharmacology that accounts for most of the magical transformation that happens in our office. It is the quality of the relationships that we build with our clients. All we have to do is confirm the gravity of this truth is to think back upon a time in our own lives when we navigated through emotional difficulty and we'll see that it was the support, care, and presence of another that we recall as the active ingredient in our own successful resolution of this problem.

After fully integrating the work of Hubble, Duncan & Miller, I started seeing that there were **three** “active ingredients” to successful resolution of traumatic stress symptoms— relationship, relaxation, and narratives. Without the relationship developed and maintained, I found that I was unable to successfully teach self-regulation or co- construct narratives with my trauma survivor clients. Since that time, I have treated thousands of people suffering the effects of traumatic stress. I have found that when we complete these three simple (not easy) therapeutic tasks, then my clients no longer meet diagnostic criteria for PTSD. And, unless they have some organic condition, when they complete these tasks they no longer meet diagnostic criteria for **any** Axis I or II condition.

Build and maintain a strong therapeutic relationship; teach survivors how to relax their bodies, especially in the context of a perceived threat; and help them construct complete chronological narratives of their traumatic experiences. The completion of these three tasks will heal traumatic stress. Three tasks = Trauma healed. Simple. Not easy but simple. Sometimes it takes years of work through countless sessions to complete these tasks. However, as a professional caregiver helping clients heal from traumatic stress, I am always working on one of these three tasks. I hope that I will be able to convince you, during today's session, of the value in this approach and why a clinician should avoid cognitive work with a trauma survivor. Either way, I suspect we're in for an exciting training.

**Biographical** J. Eric Gentry, PhD, LMHC is an internationally-recognized leader in the field of disaster and clinical traumatology. His doctorate is from Florida State University where he studied with Professor Charles Figley, one of the pioneers of traumatic stress. Dr. Gentry was one of the original faculty members of the Traumatology Institute and later became the co-director of the International Traumatology Institute at the University of South Florida. Dr. Gentry, along with Dr. Anna Baranowsky, is the co-author and co- owner of the Traumatology Institute Training Curriculum—17 courses in field and clinical traumatology leading to seven separate certifications. He has trained thousands of professionals and paraprofessionals worldwide in the treatment of traumatic stress. He has been a clinical member of several CISM teams and has provided assistance in many different disaster and critical incidents including Oklahoma City, New York City, and hurricanes in Florida. He was the developer of the Community Crisis Support Team, which began in Tampa, Florida and has become a model for

communities to integrate mental health services into their disaster response network. Dr. Gentry has published many research articles, book chapters, and periodicals in this maturing area of study. He is the co-author of *Trauma Practice: Tools for Stabilization and Recovery* published by Hogrefe and Huber in 2004 (2011; 2013) and *Forward-Facing Trauma Therapy* in 2016. He has a private clinical and consulting practice in Sarasota, FL and is adjunct faculty at many universities. Dr. Gentry draws equally from his scientific study and from his rich history of 35 years of professional care giving to balance this training with current, empirically-grounded information and experienced-based compassionate intervention skills. You will be challenged, inspired, and uplifted by Dr. Gentry and this unique day of training.



## Healing Trauma

Simple....not easy

# COURSE OUTLINE

## FOUNDATIONAL ISSUES IN ADDICTIONS-INFORMED PSYCHOTHERAPY

- ADDICTION VS. SUBSTANCE USE DISORDER VS. CHEMICAL DEPENDENCE
- NEUROBIOLOGY OF ADDICTION
- CAUSES OF ADDICTION (BIOPSYCHOSOCIAL)
- ATTACHMENT ISSUES

## TRAUMATIC STRESS

- WHAT CAUSES TRAUMA?
- SYMPTOMS OF PTS(D)

## EMPOWERMENT & RESILIENCE TREATMENT STRUCTURE: FOUR-STAGE BEHAVIORAL TREATMENT MODEL FOR CO-OCCURRING TRAUMATIC STRESS AND ADDICTION

1. PREPARATION & RELATIONSHIP
2. SKILLS DEVELOPMENT & COGNITIVE RESTRUCTURING
3. DESENSITIZATION & INTEGRATION
4. POSTTRAUMATIC GROWTH & RESILIENCE

## 1. PREPARATION & RELATIONSHIP

- Assessment
- Feedback Informed Tx

## 2. SKILLS DEVELOPMENT & COGNITIVE RESTRUCTURING

- Tools for Hope/ANS
- Self-Regulation
- Graphic Time-Line/Narrative
- Shame > Self-Compassion
- Additional Stabilization & Containment

## 3. DESENSITIZATION & INTEGRATION

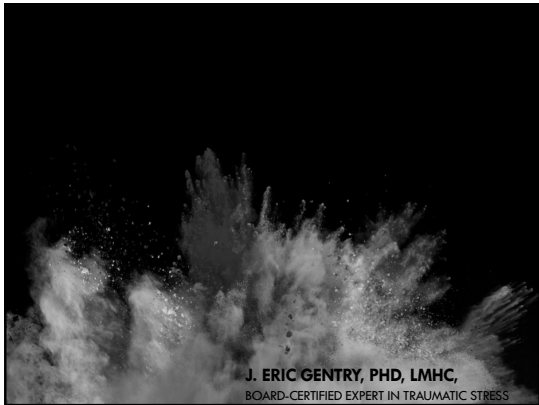
- In vivo Exposure
- Forward-Facing® Trauma Therapy
- Capacity-Building
- Imaginal Exposure (1+ year of recovery)

## 4. POSTTRAUMATIC GROWTH & RESILIENCE

- Elements of PTG
- Continuance of IVE/FFTT/Capacity-Building
- Reconnection
- Optimization

# OBJECTIVES

1. SUMMARIZE THE CAUSES OF SUBSTANCE USE DISORDERS & FACTORS THAT REINFORCE DRUG USE AS RELATED TO CASE CONCEPTUALIZATION.
2. EXPLAIN THE BASIC NEUROBIOLOGY OF ADDICTIVE CHEMICALS AND ITS TREATMENT IMPLICATIONS.
3. CONCEPTUALIZE TREATMENT THAT ADDRESSES **BOTH** TRAUMATIC STRESS AND ADDICTION CONCURRENTLY
4. DISCOVER THE "ACTIVE INGREDIENTS" FOR TRAUMA TREATMENT THAT WORK EQUALLY WELL WITH ADDICTIVE DISORDERS
5. DEVELOP SKILLS FOR ASSESSING TRAUMATIC STRESS & ADDICTION DISORDERS
6. COMPETENTLY IMPLEMENT FEEDBACK INFORMED THERAPY WITH TRAUMADDICTED CLIENTS FOLLOWING TRAINING TO DEVELOP, MAINTAIN & ENHANCE THERAPEUTIC RELATIONSHIP AND POSITIVE OUTCOMES
7. DISCOVER TECHNICAL AND RELATIONAL INTERVENTIONS FOR ENHANCING POSITIVE EXPECTANCY DURING TREATMENT
8. CONCEPTUALIZE IMPORTANCE OF TEACHING CLIENTS ABOUT ANS FUNCTIONS ESPECIALLY THREAT RESPONSE (TOOLS FOR HOPE)
9. IDENTIFY THE KEY COMPONENTS TO INTERRUPTING THREAT RESPONSE IN REAL-TIME ACTIVITIES (SELF-REGULATION)
10. DEVELOP SKILLS FOR AMELIORATING SHAME TOWARDS SELF-COMPASSION USING GRAPHIC TIME LINE INTERVENTION
11. SKILLS DEVELOPMENT FOR RELAXATION, GROUNDING & CONTAINMENT TO ASSIST WITH SAFETY & STABILIZATION
12. EMPLOY PRINCIPLES OF RECIPROCAL INHIBITION TO ENGAGE IN VIVO EXPOSURE TO LESSEN PTS(D) AND ADDICTION SX
13. LEARN FORWARD-FACING® TRAUMA THERAPY
14. LEARN AND IMPLEMENT INTO PRACTICE CAPACITY-BUILDING AS SKILLS DEVELOPMENT AND TRAUMA RESOLUTION
15. DISCOVER PRINCIPLES OF POSTTRAUMATIC GROWTH AND RESILIENCE FOR BOTH EARLY-STAGE SKILLSBUILDING LATER-STAGE OPTIMIZATION



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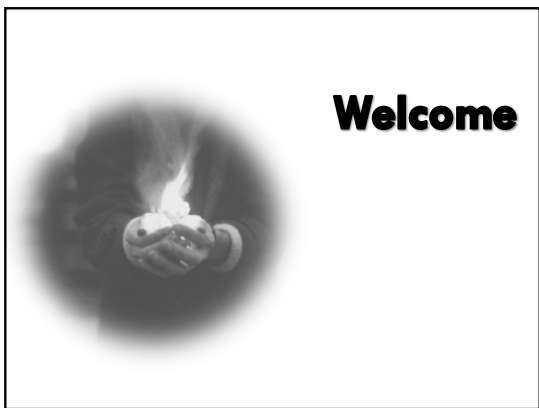
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**APA CEU STATEMENT**

*MATERIALS THAT ARE INCLUDED IN THIS COURSE MAY INCLUDE INTERVENTIONS AND MODALITIES THAT ARE BEYOND THE AUTHORIZED PRACTICE OF MENTAL HEALTH PROFESSIONALS. AS A LICENSED PROFESSIONAL, YOU ARE RESPONSIBLE FOR REVIEWING THE SCOPE OF PRACTICE, INCLUDING ACTIVITIES THAT ARE DEFINED IN LAW AS BEYOND THE BOUNDARIES OF PRACTICE IN ACCORDANCE WITH AND IN COMPLIANCE WITH YOUR PROFESSIONAL STANDARDS*

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### ERIC'S CEU STATEMENT

- 250+ CITATIONS FOR THIS COURSE
- BOARD-CERTIFIED EXPERT IN TRAUMATIC STRESS (2008)/CERTIFIED ADDICTIONS COUNSELOR (1993)
- 37 YEARS OF CLINICAL EXPERIENCE WITH TRAUMA AND ADDICTION
- 25 YEARS CLEAN (32 YEARS IN RECOVERY) – STILL REGULARLY ATTEND MEETINGS OF A 12-STEP FELLOWSHIP
- BALANCE OF SCIENCE AND LITERATURE-BASED INTERVENTIONS WITH PRACTICAL RELATIONAL-BASED DELIVERY

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### ERIC'S BIASES

- ANXIETY/STRESS IS A THREAT RESPONSE. IT IS THIS THREAT RESPONSE THAT PRODUCES ALL OUR CLIENT'S DISTRESS (UNLESS ORGANICITY). MUCH OF THIS COURSE IS ORGANIZED AROUND TEACHING CLINICIANS TO INTERRUPT THEIR OWN THREAT RESPONSES AND THEN TEACHING CLIENTS THE SAME. YOU CANNOT HAVE STRESS IN A RELAXED BODY
- EVIDENCE-BASED TREATMENTS **DO NOT** RESOLVE TRAUMA OR ADDICTION – THE **EFFECTIVE DELIVERY** OF THESE TREATMENTS BY RELATIONALLY & TECHNICALLY PROFICIENT PRACTITIONERS DO.
- ADDICTION IS A SOLUTION—ALBEIT WITH DIMINISHING EFFECTIVENESS—FOR SURVIVORS OF TRAUMA AND THEIR CHRONICALLY DYSREGULATED ANS...A SOLUTION THAT BECOMES THE PROBLEM. ALTHOUGH PROGRESSIVE, INCURABLE AND FATAL, IT CAN BE ARRESTED AND RECOVERY IS POSSIBLE
- TRAUMA ALMOST ALWAYS HAS CONCOMITANT ADDICTION COMPONENT AND ADDICTION ALMOST ALWAYS HAS A TRAUMATIC STRESS COMPONENT – THEY SHOULD BE TREATED SIMULTANEOUSLY

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### COURSE OUTLINE

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| <p><b>FOUNDATIONAL ISSUES IN ADDICTIONS-INFORMED PSYCHOTHERAPY</b></p> <ul style="list-style-type: none"> <li>• ADDICTION VS. SUBSTANCE USE DISORDER VS. CHEMICAL DEPENDENCE</li> <li>• NEUROBIOLOGY OF ADDICTION</li> <li>• CAUSES OF ADDICTION (BIOPSYCHOSOCIAL)</li> <li>• ATTACHMENT ISSUES</li> </ul> <p><b>TRAUMATIC STRESS</b></p> <ul style="list-style-type: none"> <li>• WHAT CAUSES TRAUMA?</li> <li>• SYMPTOMS OF PTSD</li> </ul> <p><b>EMPOWERMENT &amp; RESILIENCE TREATMENT</b></p> <p><b>STRUCTURE: FOUR-STAGE BEHAVIORAL TREATMENT MODEL FOR CO-OCCURRING TRAUMATIC STRESS AND ADDICTION</b></p> <ol style="list-style-type: none"> <li>1. PREPARATION &amp; RELATIONSHIP</li> <li>2. SKILLS DEVELOPMENT &amp; COGNITIVE RESTRUCTURING</li> <li>3. DESENSITIZATION &amp; INTEGRATION</li> <li>4. POSTTRAUMATIC GROWTH &amp; RESILIENCE</li> </ol> | <p><b>1. PREPARATION &amp; RELATIONSHIP</b></p> <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Feedback Informed Tx</li> </ul> <p><b>2. SKILLS DEVELOPMENT &amp; COGNITIVE RESTRUCTURING</b></p> <ul style="list-style-type: none"> <li>• Tools for Hope/ANS</li> <li>• Self-Regulation</li> <li>• Graphic Time-Line/Narrative</li> <li>• Shame &gt; Self-Compassion</li> <li>• Additional Stabilization &amp; Containment</li> </ul> <p><b>3. DESENSITIZATION &amp; INTEGRATION</b></p> <ul style="list-style-type: none"> <li>• In vivo Exposure</li> <li>• Forward-Facing® Trauma Therapy</li> <li>• Capacity-Building</li> <li>• Imaginal Exposure (1+ year of recovery)</li> </ul> <p><b>4. POSTTRAUMATIC GROWTH &amp; RESILIENCE</b></p> <ul style="list-style-type: none"> <li>• Elements of PTG</li> <li>• Continuance of IVE/FTT/Capacity-Building</li> <li>• Reconnection</li> </ul> |
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## OBJECTIVES

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15. DISCOVER PRINCIPLES OF POSTTRAUMATIC GROWTH AND RESILIENCE FOR BOTH EARLY-STAGE SKILLSBUILDING LATER-STAGE OPTIMIZATION.

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## RESOURCES

**Trauma Competency for the 21<sup>st</sup> Century**

www.aztrauma.org

[WWW.AZTRAUMA.ORG/GENTRY](http://WWW.AZTRAUMA.ORG/GENTRY)

PPT/VIDEOS/MANUAL

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## TRAUMADDICTION

- 35% TO 50% OF PEOPLE IN ADDICTION TREATMENT PROGRAMS HAVE A LIFETIME DIAGNOSIS OF POSTTRAUMATIC STRESS DISORDER (PTSD)
- 25% TO 42% HAVE A CURRENT DIAGNOSIS OF PTSD
- CO-OCCURRING PTSD AND SUBSTANCE USE DISORDERS ADD TO GREATER PROBLEM SEVERITY IN PSYCHIATRIC, MEDICAL, SOCIAL AND EMPLOYMENT FUNCTIONING
- PERSONS WITH PTSD RESPOND LESS FAVORABLY TO ROUTINE TREATMENTS, USE MORE TREATMENT SERVICES, ARE MORE LIKELY TO DROP OUT OF TREATMENT, AND ARE LESS LIKELY TO REMAIN IN CONTINUING CARE.
- HISTORICALLY, ADDICTION TREATMENT PROGRAMS DID NOT ADDRESS PTSD FOR FEAR OF STIMULATING OR EXACERBATING RE-EXPERIENCING SYMPTOMS (NIGHTMARES, FLASHBACKS, RE-LIVING TRAUMATIC EVENTS), AND RISK JEOPARDIZING EARLY AND UNSTABLE PERIODS OF ABSTINENCE (KILLEEN ET AL., 2008).

(Bask et al., 2000; Brody, Bask, & Coffey, 2004; P. J. Brown, Rucupero, & Stout, 1995; Cacciolo, Alterman, McKay, & Rutherford, 2001; Damsky et al., 1996; Jacobson, Southwick, & Keane, 2001; Mills, Lynskey, Teesson, Ross, & Darke, 2005; Quimette, Ahrens, Mason, & Finney, 1997; Traffon et al., 2006)

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## TRAUMATIC STRESS & ADDICTION

- ARE BOTH THE AFTEREFFECTS OF TRAUMA
- BOTH ARE CAUSED BY DYSREGULATION OF THE ANS (DYSAUTONOMIA)
- BOTH ARE DEBILITATING, MISUNDERSTOOD, PROGRESSIVE, AND FATAL
- ARE BOTH ARRESTED WITH THE INTERRUPTION OF THE THREAT RESPONSE/SELF-REGULATION & CONNECTION
- SHOULD BE TREATED CONCURRENTLY

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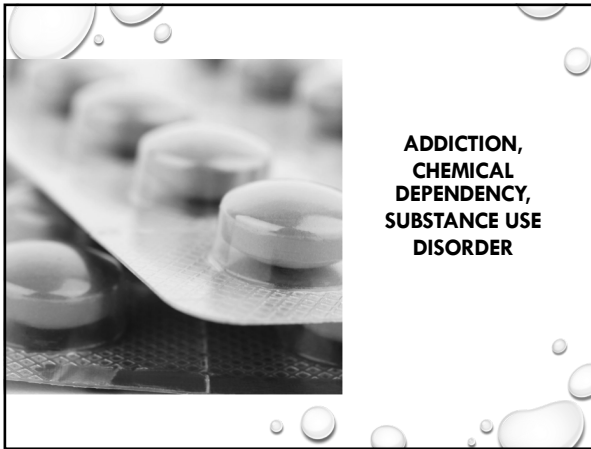
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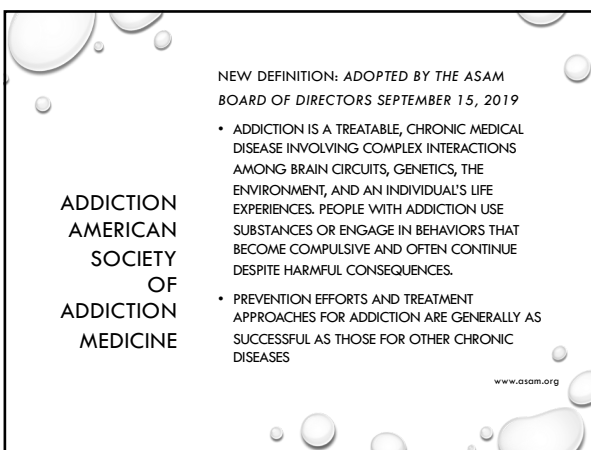
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**AMERICAN PSYCHOLOGICAL ASSOCIATION**

- **ADDICTION** IS A CHRONIC **DISORDER** WITH BIOLOGICAL, PSYCHOLOGICAL, SOCIAL AND ENVIRONMENTAL FACTORS INFLUENCING ITS DEVELOPMENT AND MAINTENANCE. ABOUT HALF THE RISK FOR ADDICTION IS GENETIC. GENES AFFECT THE DEGREE OF REWARD THAT INDIVIDUALS EXPERIENCE WHEN INITIALLY USING A SUBSTANCE (E.G., DRUGS) OR ENGAGING IN CERTAIN BEHAVIORS (E.G., GAMBLING), AS WELL AS THE WAY THE BODY PROCESSES ALCOHOL OR OTHER DRUGS. HEIGHTENED DESIRE TO RE-EXPERIENCE USE OF THE SUBSTANCE OR BEHAVIOR, POTENTIALLY INFLUENCED BY PSYCHOLOGICAL (E.G., STRESS, HISTORY OF TRAUMA), SOCIAL (E.G., FAMILY OR FRIENDS' USE OF A SUBSTANCE), AND ENVIRONMENTAL FACTORS (E.G., ACCESSIBILITY OF A SUBSTANCE, LOW COST) CAN LEAD TO REGULAR USE/EXPOSURE, WITH CHRONIC USE/EXPOSURE LEADING TO BRAIN CHANGES.
- THESE BRAIN CHANGES INCLUDE ALTERATIONS IN CORTICAL (PREFRONTAL CORTEX) AND SUB-CORTICAL (LIMBIC SYSTEM) REGIONS INVOLVING THE NEURO-CIRCUITRY OF REWARD, MOTIVATION, MEMORY, IMPULSE CONTROL AND JUDGMENT. THIS CAN LEAD TO DRAMATIC INCREASES IN CRAVINGS FOR A DRUG OR ACTIVITY, AS WELL AS IMPAIRMENTS IN THE ABILITY TO SUCCESSFULLY REGULATE THIS IMPULSE, DESPITE THE KNOWLEDGE AND EXPERIENCE OF MANY CONSEQUENCES RELATED TO THE ADDICTIVE BEHAVIOR.

ADAPTED FROM THE RECOVERY RESEARCH INSTITUTE, MASSACHUSETTS GENERAL HOSPITAL, HARVARD MEDICAL SCHOOL.  
[HTTPS://WWW.APA.ORG/TOPICS/ADDICTION/](https://www.apa.org/topics/addiction/)

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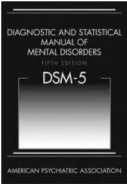
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**AMERICAN PSYCHIATRIC ASSOCIATION**



- **APA:** ADDICTION IS A COMPLEX CONDITION, A BRAIN DISEASE THAT IS MANIFESTED BY COMPULSIVE SUBSTANCE USE DESPITE HARMFUL CONSEQUENCE. PEOPLE WITH ADDICTION (SEVERE SUBSTANCE USE DISORDER) HAVE AN INTENSE FOCUS ON USING A CERTAIN SUBSTANCE(S), SUCH AS ALCOHOL OR DRUGS, TO THE POINT THAT IT TAKES OVER THEIR LIFE.
- **DSM 5 - SUBSTANCE-USE DISORDERS:** ARE PATTERNS OF SYMPTOMS RESULTING FROM THE USE OF A SUBSTANCE THAT YOU CONTINUE TO TAKE, DESPITE EXPERIENCING PROBLEMS AS A RESULT.
- **DSM 5 - SUBSTANCE-INDUCED DISORDERS,** INCLUDING INTOXICATION, WITHDRAWAL, AND OTHER SUBSTANCE/MEDICATION-INDUCED MENTAL DISORDERS, ARE DETAILED ALONGSIDE SUBSTANCE USE DISORDERS.

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**CHANGES SPECIFIC TO SUBSTANCE-RELATED AND ADDICTIVE DISORDERS**

-  combines the DSM-IV categories of substance abuse and substance dependence into a single disorder
-  now have 11 criteria for substance-related disorders
-  eliminated criteria of recurrent substance related legal issues
-  added criteria of "craving, or strong urge to use"
-  called substance-related and addictive disorders

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**SUBSTANCE INTOXICATION**

SUBSTANCE INTOXICATION, A GROUP OF SUBSTANCE-INDUCED DISORDERS, DETAILS THE SYMPTOMS THAT PEOPLE EXPERIENCE WHEN THEY ARE "HIGH" FROM DRUGS. DISORDERS OF SUBSTANCE INTOXICATION INCLUDE:

- MARIJUANA INTOXICATION
- COCAINE INTOXICATION
- METHAMPHETAMINE INTOXICATION (STIMULANTS)
- HEROIN INTOXICATION (OPIOIDS)
- ACID INTOXICATION (OTHER HALLUCINOGEN INTOXICATION OR "ACID TRIP")
- SUBSTANCE INTOXICATION DELIRIUM

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**CHANGES SPECIFIC TO SUBSTANCE-RELATED AND ADDICTIVE DISORDERS**

- substance-related disorders divided into two groups substance use disorders  
substance-induced disorders
- each disorder measured on a continuum from mild to severe
- addition of first behavioral disorder, "gambling disorder"

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**11 DIAGNOSTIC CRITERIA FOR SUD**

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

See page ...

DSM 5 - APA

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Criterion	DSM-IV substance dependence	DSM-5 substance use disorder
Tolerance	✓	✓
Withdrawal	✓	✓
Taken more/longer than intended	✓	✓
Desire/unsuccesful efforts to quit use	✓	✓
Great deal of time taken by activities involved in use	✓	✓
Use despite knowledge of problems associated with use	✓	✓
Important activities given up because of use	✓	✓
Recurrent use resulting in a failure to fulfill important role obligations		✓
Recurrent use resulting in physically hazardous behavior (e.g., driving)		✓
Continued use despite recurrent social problems associated with use		✓

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### SEVERITY OF SUD

- **TWO OR THREE (2 - 3)** SYMPTOMS INDICATE A **MILD** SUBSTANCE USE DISORDER
- **FOUR OR FIVE (4 – 5)** SYMPTOMS INDICATE A **MODERATE** SUBSTANCE USE DISORDER, AND
- **SIX (6+)** OR MORE SYMPTOMS INDICATE A **SEVERE** SUBSTANCE USE DISORDER.

**CLINICIANS CAN ALSO ADD**

- "IN **EARLY REMISSION**,"
- "IN **SUSTAINED REMISSION**,"
- "ON **MAINTENANCE THERAPY**," FOR CERTAIN SUBSTANCES AND
- "IN A **CONTROLLED ENVIRONMENT**."

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### ADDICTION VS. SUBSTANCE USE DISORDER

ADDICTION	SUBSTANCE ABUSE DISORDER
<ul style="list-style-type: none"> <li>• Pre-existing to use of substances—behavioral manifestations frequently emerge during development</li> <li>• Process and/or substance</li> <li>• Cannot stop behavior by act of will</li> <li>• Tolerance &amp; withdrawal</li> <li>• Dissociative experiences</li> <li>• Adaptive Competency</li> <li>• Obsession/Compulsion/Self-obsession</li> <li>• Self-administered analgesia</li> </ul>	<ul style="list-style-type: none"> <li>• Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMSHA, 2019)</li> <li>• DSM V Nomenclature</li> <li>• May or may not include addiction</li> <li>• Tolerance &amp; withdrawal</li> <li>• The compulsion to use despite negative consequences" (e.g., legal, physical, social, psychological). Note that neither amount of use nor physical dependence define substance abuse.</li> </ul>

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## SUBSTANCE USE DISORDER

### SUBSTANCE USE DISORDER

- SUBSTANCE USE DISORDER IN DSM-5 COMBINES THE DSM-IV CATEGORIES OF SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE INTO A SINGLE DISORDER MEASURED ON A CONTINUUM FROM MILD TO SEVERE. EACH SPECIFIC SUBSTANCE (OTHER THAN CAFFEINE, WHICH CANNOT BE DIAGNOSED AS A SUBSTANCE USE DISORDER) IS ADDRESSED AS A SEPARATE USE DISORDER (E.G., ALCOHOL USE DISORDER, STIMULANT USE DISORDER, ETC.), BUT NEARLY ALL SUBSTANCES ARE DIAGNOSED BASED ON THE SAME OVERARCHING CRITERIA. IN THIS OVERARCHING DISORDER, THE CRITERIA HAVE NOT ONLY BEEN COMBINED, BUT STRENGTHENED. WHEREAS A DIAGNOSIS OF SUBSTANCE ABUSE PREVIOUSLY REQUIRED ONLY ONE SYMPTOM, MILD SUBSTANCE USE DISORDER IN DSM-5 REQUIRES TWO TO THREE SYMPTOMS FROM A LIST OF 11. DRUG CRAVING WILL BE ADDED TO THE LIST, AND PROBLEMS WITH LAW ENFORCEMENT WILL BE ELIMINATED BECAUSE OF CULTURAL CONSIDERATIONS THAT MAKE THE CRITERIA DIFFICULT TO APPLY INTERNATIONALLY.
- IN DSM-IV, THE DISTINCTION BETWEEN ABUSE AND DEPENDENCE WAS BASED ON THE CONCEPT OF ABUSE AS A MILD OR EARLY PHASE AND DEPENDENCE AS THE MORE SEVERE MANIFESTATION. IN PRACTICE, THE ABUSE CRITERIA WERE SOMETIMES QUITE SEVERE. THE REVISED SUBSTANCE USE DISORDER, A SINGLE DIAGNOSIS, WILL BETTER MATCH THE SYMPTOMS THAT PATIENTS EXPERIENCE.
- ADDITIONALLY, THE DIAGNOSIS OF DEPENDENCE CAUSED MUCH CONFUSION. MOST PEOPLE LINK DEPENDENCE WITH "ADDICTION" WHEN IN FACT DEPENDENCE CAN BE A NORMAL BODY RESPONSE TO A SUBSTANCE.

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## ADDICTIVE DISORDERS

### ADDICTIVE DISORDERS

- THE CHAPTER ALSO INCLUDES GAMBLING DISORDER AS THE SOLE CONDITION IN A NEW CATEGORY ON BEHAVIORAL ADDICTIONS. DSM-IV LISTED PATHOLOGICAL GAMBLING BUT IN A DIFFERENT CHAPTER. THIS NEW TERM AND ITS LOCATION IN THE NEW MANUAL REFLECT RESEARCH FINDINGS THAT GAMBLING DISORDER IS SIMILAR TO SUBSTANCE-RELATED DISORDERS IN CLINICAL EXPRESSION, BRAIN ORIGIN, COMORBIDITY, PHYSIOLOGY, AND TREATMENT.
- RECOGNITION OF THESE COMMONALITIES WILL HELP PEOPLE WITH GAMBLING DISORDER GET THE TREATMENT AND SERVICES THEY NEED, AND OTHERS MAY BETTER UNDERSTAND THE CHALLENGES THAT INDIVIDUALS FACE IN OVERCOMING THIS DISORDER.
- WHILE GAMBLING DISORDER IS THE ONLY ADDICTIVE DISORDER INCLUDED IN DSM-5 AS A DIAGNOSABLE CONDITION, INTERNET GAMING DISORDER WILL BE INCLUDED IN SECTION III OF THE MANUAL. DISORDERS LISTED THERE REQUIRE FURTHER RESEARCH BEFORE THEIR CONSIDERATION AS FORMAL DISORDERS. THIS CONDITION IS INCLUDED TO REFLECT THE SCIENTIFIC LITERATURE ON PERSISTENT AND RECURRENT USE OF INTERNET GAMES, AND A PREOCCUPATION WITH THEM, CAN RESULT IN CLINICALLY SIGNIFICANT IMPAIRMENT OR DISTRESS. MUCH OF THIS LITERATURE COMES FROM STUDIES IN ASIAN COUNTRIES. THE CONDITION CRITERIA DO NOT INCLUDE GENERAL USE OF THE INTERNET, GAMBLING, OR SOCIAL MEDIA AT THIS TIME.

2013, American Psychiatric Association

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## NARCOTICS ANONYMOUS

AS ADDICTS, WE HAVE AN INCURABLE DISEASE CALLED ADDICTION. THE DISEASE IS CHRONIC, PROGRESSIVE AND FATAL. HOWEVER, IT IS A TREATABLE DISEASE. WE FEEL THAT EACH INDIVIDUAL HAS TO ANSWER THE QUESTION, "AM I AN ADDICT?" HOW WE GOT THE DISEASE IS OF NO IMMEDIATE IMPORTANCE TO US. WE ARE CONCERNED WITH RECOVERY.

• NARCOTICS ANONYMOUS FELLOWSHIP, NARCOTICS ANONYMOUS, LIBRE DIGITAL, KINDLE EDITION.



The physical aspect of our disease is the compulsive use of drugs: the inability to stop using once we have started. The mental aspect of our disease is the obsession, or overpowering desire to use, even when we are destroying our lives. The spiritual part of our disease is our total self-centeredness.

Narcotics Anonymous Fellowship, Narcotics Anonymous, Libre Digital, Kindle Edition.

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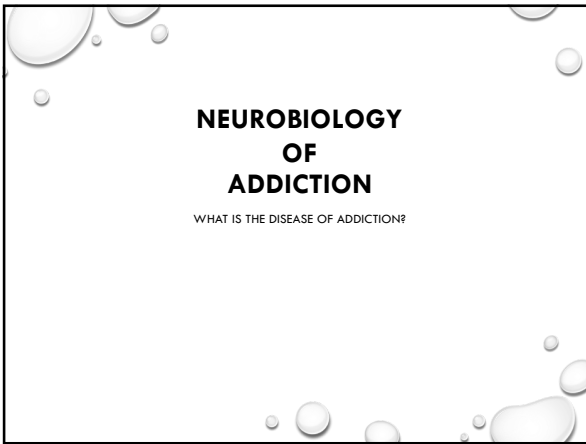
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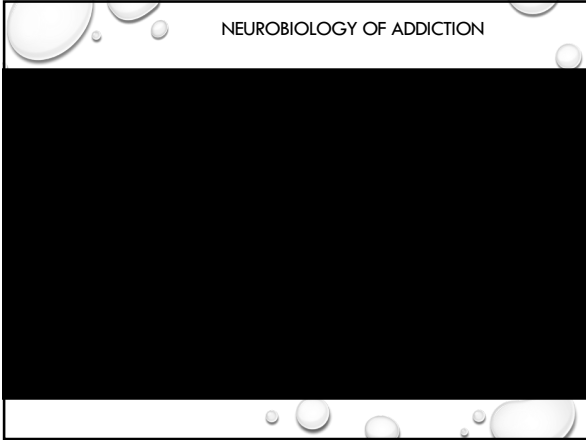
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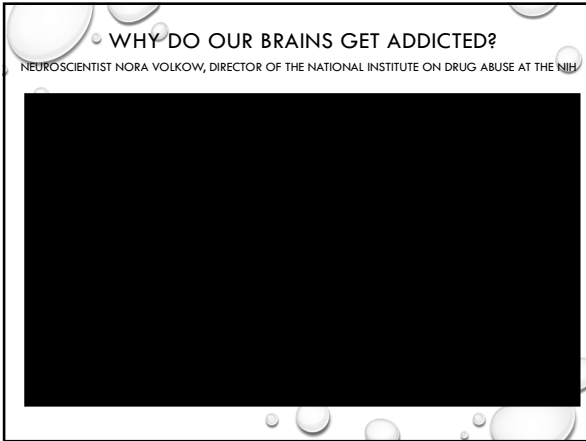
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**KEY FINDINGS\***

- WELL-SUPPORTED SCIENTIFIC EVIDENCE SHOWS THAT ADDICTION TO ALCOHOL OR DRUGS IS A CHRONIC BRAIN DISEASE THAT HAS POTENTIAL FOR RECURRENCE AND RECOVERY.
- WELL-SUPPORTED EVIDENCE SUGGESTS THAT THE ADDICTION PROCESS INVOLVES A THREE-STAGE CYCLE: BINGE/ INTOXICATION, WITHDRAWAL/NEGATIVE AFFECT, AND PREOCCUPATION/ANTICIPATION. THIS CYCLE BECOMES MORE SEVERE AS A PERSON CONTINUES SUBSTANCE USE AND AS IT PRODUCES DRAMATIC CHANGES IN BRAIN FUNCTION THAT REDUCE A PERSON'S ABILITY TO CONTROL HIS OR HER SUBSTANCE USE.
- WELL-SUPPORTED SCIENTIFIC EVIDENCE SHOWS THAT DISRUPTIONS IN THREE AREAS OF THE BRAIN ARE PARTICULARLY IMPORTANT IN THE ONSET, DEVELOPMENT, AND MAINTENANCE OF SUBSTANCE USE DISORDERS: THE BASAL GANGLIA, THE EXTENDED AMYGDALA, AND THE PREFRONTAL CORTEX. THESE DISRUPTIONS: (1) ENABLE SUBSTANCE-ASSOCIATED CUES TO TRIGGER SUBSTANCE SEEKING (I.E., THEY INCREASE INCENTIVE SALIENCE); (2) REDUCE SENSITIVITY OF BRAIN SYSTEMS INVOLVED IN THE EXPERIENCE OF PLEASURE OR REWARD, AND HEIGHTEN ACTIVATION OF BRAIN STRESS SYSTEMS; AND (3) REDUCE FUNCTIONING OF BRAIN EXECUTIVE CONTROL SYSTEMS, WHICH ARE INVOLVED IN THE ABILITY TO MAKE DECISIONS AND REGULATE ONE'S ACTIONS, EMOTIONS, AND IMPULSES.
- SUPPORTED SCIENTIFIC EVIDENCE SHOWS THAT THESE CHANGES IN THE BRAIN PERSIST LONG AFTER SUBSTANCE USE STOPS. IT IS NOT YET KNOWN HOW MUCH THESE CHANGES MAY BE REVERSED OR HOW LONG THAT PROCESS MAY TAKE.
- WELL-SUPPORTED SCIENTIFIC EVIDENCE SHOWS THAT ADOLESCENCE IS A CRITICAL "AT-RISK PERIOD" FOR SUBSTANCE USE AND ADDICTION. ALL ADDICTIVE DRUGS, INCLUDING ALCOHOL AND MARIJUANA, HAVE ESPECIALLY HARMFUL EFFECTS ON THE ADOLESCENT BRAIN, WHICH IS STILL UNDERGOING SIGNIFICANT DEVELOPMENT.

\* WELL-SUPPORTED: WHEN EVIDENCE IS DERIVED FROM MULTIPLE RIGOROUS HUMAN AND NONHUMAN STUDIES; SUPPORTED: WHEN EVIDENCE IS DERIVED FROM RIGOROUS BUT FEWER HUMAN AND NONHUMAN STUDIES.

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- SUBSTANCE USE DISORDERS RESULT FROM CHANGES IN THE BRAIN THAT CAN OCCUR WITH REPEATED USE OF ALCOHOL OR DRUGS. THE MOST SEVERE EXPRESSION OF THE DISORDER, ADDICTION, IS ASSOCIATED WITH CHANGES IN THE FUNCTION OF BRAIN CIRCUITS INVOLVED IN PLEASURE (THE REWARD SYSTEM), LEARNING, STRESS, DECISION MAKING, AND SELF-CONTROL.
- EVERY SUBSTANCE HAS SLIGHTLY DIFFERENT EFFECTS ON THE BRAIN, BUT ALL ADDICTIVE DRUGS, INCLUDING ALCOHOL, OPIOIDS, AND COCAINE, PRODUCE A PLEASURABLE SURGE OF THE NEUROTRANSMITTER DOPAMINE IN A REGION OF THE BRAIN CALLED THE BASAL GANGLIA; NEUROTRANSMITTERS ARE CHEMICALS THAT TRANSMIT MESSAGES BETWEEN NERVE CELLS.
- THIS AREA IS RESPONSIBLE FOR CONTROLLING REWARD AND OUR ABILITY TO LEARN BASED ON REWARDS

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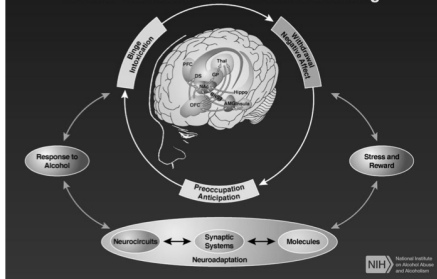
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**Conceptual Framework for Neurobiological Bases of the Transition to Excessive Drinking**



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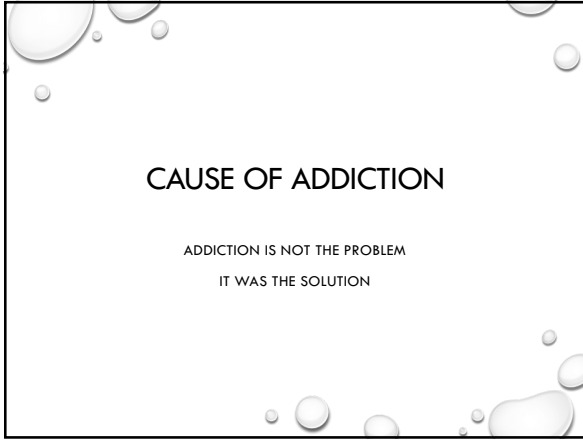
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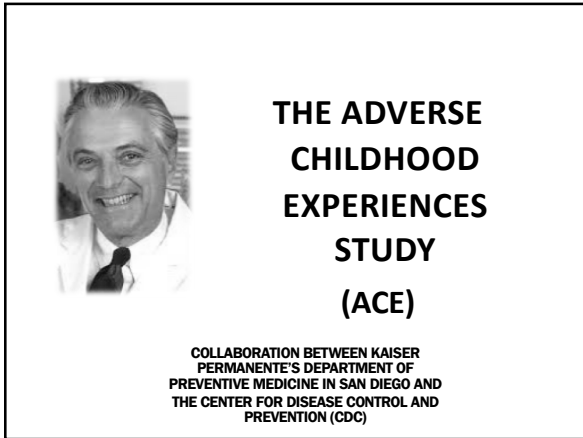
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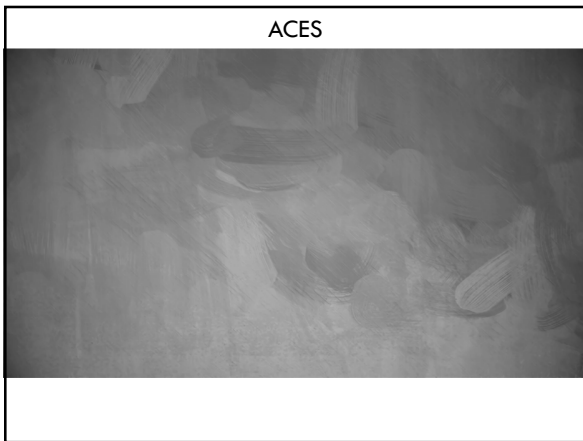
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**Finding Your ACE Score**

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household often or very often...  
Smear at you, insult you, put you down, or humiliate you?  
or  
Act in a way that made you afraid that you might be physically hurt?  
Yes No if yes enter 1
2. Did a parent or other adult in the household often or very often...  
Push, grab, slap, or throw something at you?  
or  
Ever hit you so hard that you had marks or were injured?  
Yes No if yes enter 1
3. Did an adult or person at least 5 years older than you ever...  
Touch or fondle you or have you touch their body in a sexual way?  
or  
Attempt or actually have oral, anal, or vaginal intercourse with you?  
Yes No if yes enter 1
4. Did you often or very often feel that...  
No one in your family loved you or thought you were important or special?  
or  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No if yes enter 1
5. Did you often or very often feel that...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
or  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No if yes enter 1
6. Were your parents ever separated or divorced?  
Yes No if yes enter 1
7. Was your mother or stepmother...  
Often or very often pushed, grabbed, slapped, or had something thrown at her?  
or  
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?  
or  
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?  
Yes No if yes enter 1
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No if yes enter 1
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes No if yes enter 1
10. Did a household member go to prison?  
Yes No if yes enter 1

Now add up your "Yes" answers: \_\_\_\_ This is your ACE Score.

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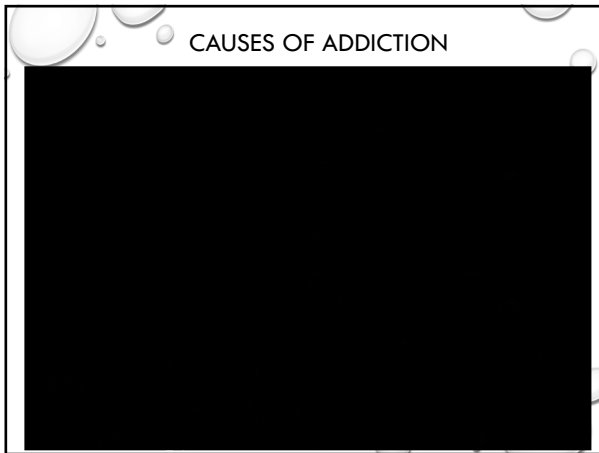
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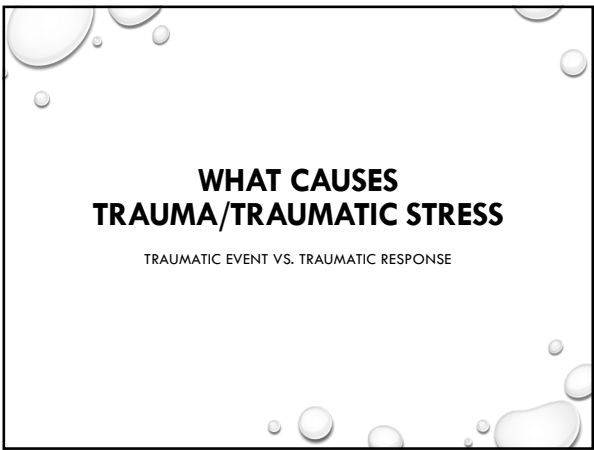
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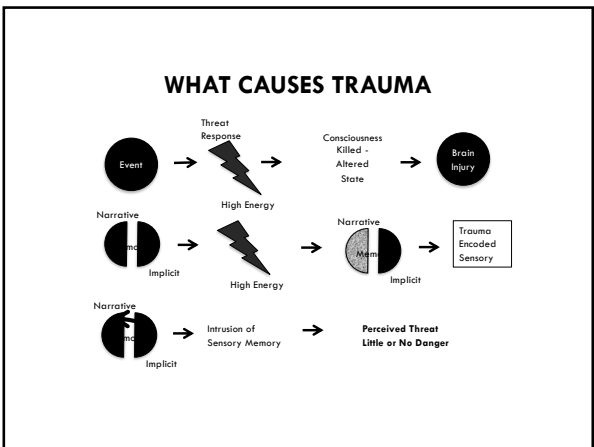
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## HEALING TRAUMA


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**Integration:**  
Sensory memory into Narrative  
(language)


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**Desensitization:**  
Reciprocal Inhibition  
Exposure + Relaxation

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## Reciprocal Inhibition

- JOSEPH WOLPE (1915-97)
- **CS (ANXIETY) + RELAXATION = EXTINGUISHED CR**
- ENGINE OF ALL EFFECTIVE PSYCHOTHERAPEUTIC TREATMENTS FOR ANXIETY/TRAUMA
- MOST TRAUMA SURVIVORS CONFRONT PERCEIVED THREATS WITH ANS AROUSAL (I.E., "BRUTE FORCE"). TREATMENT PROPER IS TEACHING THEM TO CONFRONT THESE PERCEIVED THREATS WITH ANS REGULATION (LEFT-HAND SIDE OF YERKES-DODSON)
- BOUDEWYN'S PROMULGATED THIS IDEA IN 1990. HE WAS, HOWEVER, INCONSISTENT WITH THE USE OF RELAXATION WITH EXPOSURE.




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## TOOLS FOR HOPE



AN OWNER'S MANUAL FOR THE ANS  
SELF-REGULATION  
CO-REGULATION  
RESILIENCE




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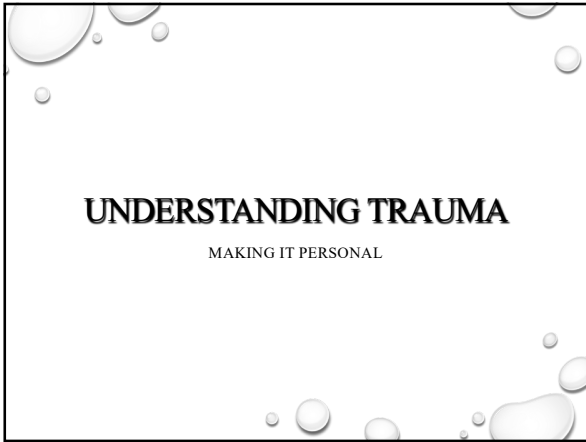
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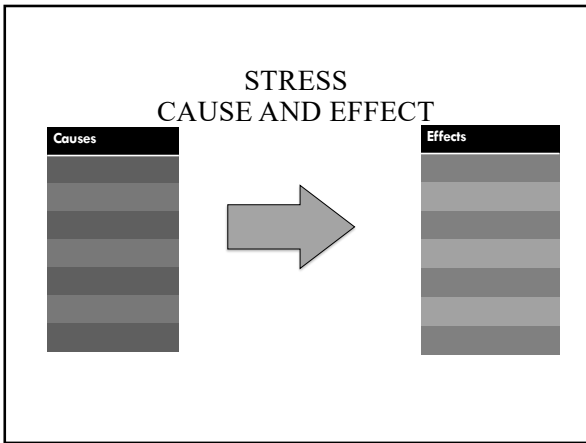
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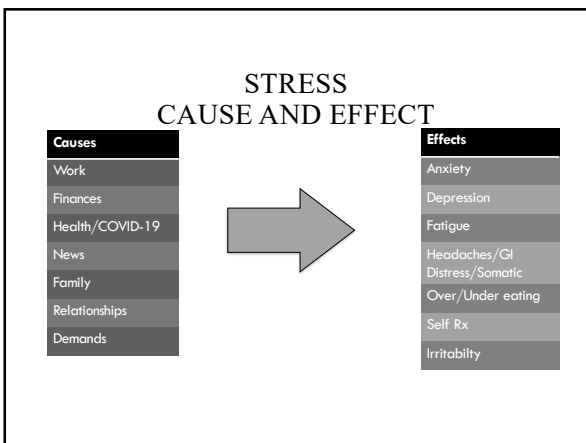
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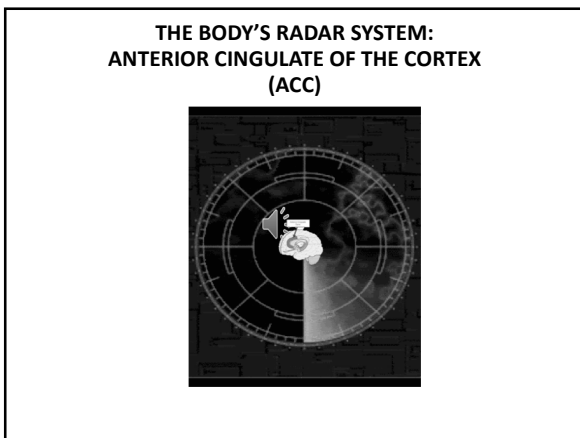
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# NEUROCEPTION

**DETECTING SAFETY IN THE ENVIRONMENT ESPECIALLY WHEN PERCEIVING THREAT**



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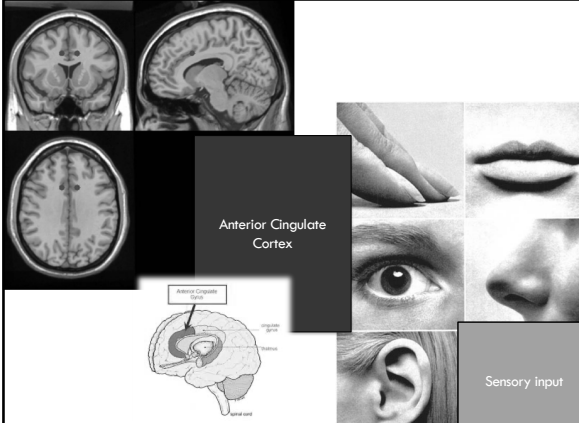
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Anterior Cingulate Cortex

Sensory input

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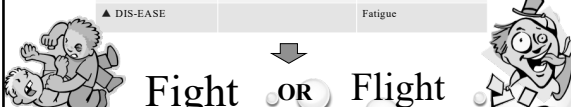
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## Perceived Threat

Physiological	Brain Mechanics	Other Effects
▲ Heart Rate	▲ Basal Ganglia & Thalamus Fx	▲ Obsession
▲ Breathing Rate	▼ Neo-cortical Fx	▲ Compulsion
▼ Breathing Volume	▼ Frontal Lobe activity	▼ Speed & Agility
Centralized Circulation	▼ Executive Fx ▼ Fine motor control ▼ Emotional regulation	
▲ Muscle Tension	▼ Temporal Lobe Activity	▼ Strength
	▼ Language (Wernicke's)	
	▼ Speech (Broca's)	
▲ Energy	▼ Anterior Cingulate	Constricted thoughts & behaviors
▲ DIS-EASE		Fatigue


Fight OR Flight

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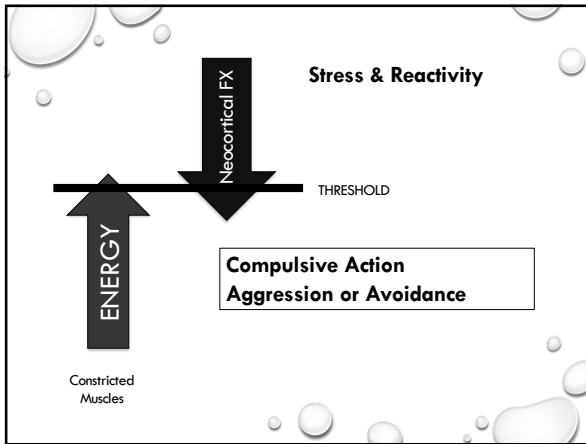
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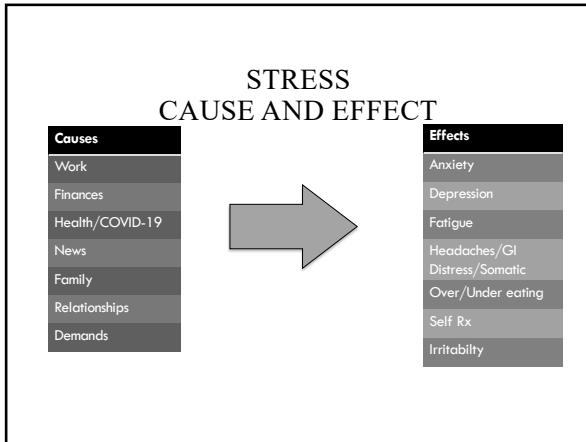
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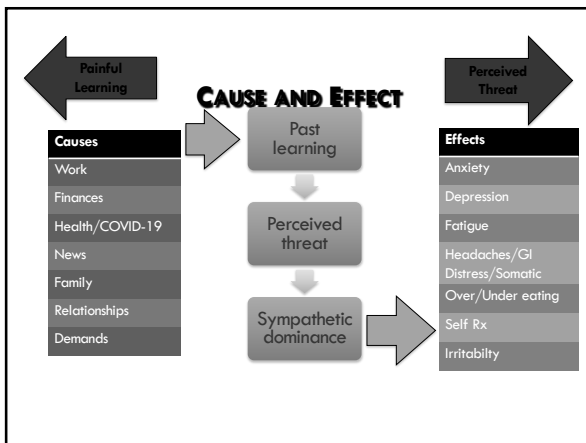
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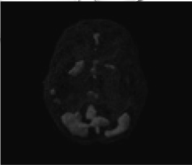
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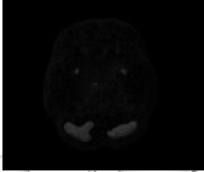


**High Anxiety**  
Increased basal ganglia activity

**Stress = Perception of Threat**

**Normal**  
Note the lessened activity of the basal ganglia

<http://www.smeronetics.com/lbp/enlay/ch2.php>



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**SELF-REGULATION**  
NEUROCEPTION - INTEROCEPTION  
&  
BALANCING THE ANS

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**NEUROCEPTION**

**DETECTING SAFETY IN THE ENVIRONMENT ESPECIALLY WHEN PERCEIVING THREAT**



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## INTEROCEPTION

You want to know what heals trauma? ... Interoception heals trauma  
- Bessel van der Kolk

- PRESENT "FELT SENSE" ON ONE'S OWN PHYSIOLOGICAL PROCESSES
- BECOMING SENSITIVE TO "FEEDBACK" FROM ONE'S BODY
- LOWERING THRESHOLD OF AWARENESS OF DYSREGULATION
- MONITORING RISING LEVELS OF ENERGY (SNS ACTIVATION) AND RECOGNIZING WHEN THERE IS THE NEED FOR CONSCIOUS AND INTENTIONAL INTERVENTION (I.E., RELEASING CONSTRICTED MUSCLES)

Interoception + Acute Relaxation x 100/day = No Stress

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58

## INTEROCEPTION



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59

Neuroception + Interoception +  
Acute Relaxation = Trauma Resolution



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60

**SKILLS  
SELF-REGULATION**



- BODY SCAN/"WET NOODLE"
- SOFT-PALATE
- PERIPHERAL VISION
- PELVIC FLOOR RELAXATION

61

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Who is squeezing the  
muscles in your body?



62

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TRAU                      ENTURY

**THE ACTIVE INGREDIENTS APPROACH**

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### What works?

AVAILABLE EVIDENCE DOCUMENTS THAT THE THERAPIST IS ONE OF THE MOST ROBUST PREDICTORS OF OUTCOME AMONG FACTORS STUDIED.

- **THERAPISTS (5%–9%)** IS LARGER THAN THE VARIABILITY OF TREATMENTS (0%–1%), THE **ALLIANCE (5%)**, AND THE SUPERIORITY OF AN EMPIRICALLY SUPPORTED TREATMENT TO A PLACEBO TREATMENT (0%–4%)

(DUNCAN ET AL., 2010; LUTZ ET AL., 2007; WAMPOLD, 2005).

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64

### Trauma Tx: Active Ingredients



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### ACTIVE INGREDIENTS APPROACH

- BENISH, IMEL & WAMPOLD (2008)
- GENTRY, 1999
- GENTRY, BARANOWSKY & RHOTON (2017)
- NATIONAL CENTER FOR PTSD/VA/DOD (2010; 2012; 2016)
- CLOITRE, COURTOIS, CHARUVASTRA, CARAPEZZA, STOLBACH, GREEN (2011)
- SCHNYDER, EHLERS, ELBERT, FOA, GERSONS, RESICK, ... CLOITRE (2015)
- MURRAY, ET AL., 2015

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66

## CHANGING THE PARADIGM

THE RELATIVE EFFICACY OF BONA FIDE PSYCHOTHERAPIES FOR TREATING POST-TRAUMATIC STRESS DISORDER:  
A META-ANALYSIS OF DIRECT COMPARISONS

BRONKHORST, VAN DER BRUG, & VAN DER KAM

**ABSTRACT**

PSYCHOTHERAPY HAS BEEN FOUND TO BE AN EFFECTIVE TREATMENT OF POST-TRAUMATIC STRESS DISORDER (PTSD), BUT METAANALYSES HAVE YIELDED INCONSISTENT RESULTS ON RELATIVE EFFICACY OF PSYCHOTHERAPIES IN THE TREATMENT OF PTSD. THE PRESENT META-ANALYSIS CONTROLLED FOR POTENTIAL CONFOUNDS IN PREVIOUS PTSD META-ANALYSES BY INCLUDING ONLY BONA FIDE PSYCHOTHERAPIES, AVOIDING CATEGORIZATION OF PSYCHOTHERAPY TREATMENTS, AND USING DIRECT COMPARISON STUDIES ONLY. THE PRIMARY ANALYSIS REVEALED THAT EFFECT SIZES WERE HOMOGENOUSLY DISTRIBUTED AROUND ZERO FOR MEASURES OF PTSD SYMPTOMOLOGY, AND FOR ALL MEASURES OF PSYCHOLOGICAL FUNCTIONING, INDICATING THAT THERE WERE NO DIFFERENCES BETWEEN PSYCHOTHERAPIES. ADDITIONALLY, THE UPPER BOUND OF THE TRUE EFFECT SIZE BETWEEN PTSD PSYCHOTHERAPIES WAS QUITE SMALL. THE RESULTS SUGGEST THAT DESPITE STRONG EVIDENCE OF PSYCHOTHERAPY EFFICACIOUSNESS VIS-À-VIS NO TREATMENT OR COMMON FACTOR CONTROLS, BONA FIDE PSYCHOTHERAPIES PRODUCE EQUIVALENT BENEFITS FOR PATIENTS WITH PTSD.

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## ACTIVE INGREDIENTS

<b>VA/DOD (2010)</b>	<b>ISTSS (2009)</b>	<b>PHOENIX PROJECT (AUS) (2013)</b>
<ul style="list-style-type: none"> <li>• PSYCHO-EDUCATION</li> <li>• EXPOSURE</li> <li>• ANXIETY MANAGEMENT</li> <li>• COGNITIVE RESTRUCTURING</li> </ul>	<ul style="list-style-type: none"> <li>• EMOTION REGULATION STRATEGIES</li> <li>• NARRATION OF TRAUMA MEMORY</li> <li>• COGNITIVE RESTRUCTURING</li> <li>• ANXIETY AND STRESS MANAGEMENT</li> <li>• INTERPERSONAL SKILLS.</li> </ul>	<ul style="list-style-type: none"> <li>• THERAPEUTIC ALLIANCE</li> <li>• PSYCHO-EDUCATION</li> <li>• EMOTIONAL REGULATION AND COPING SKILLS</li> <li>• SOME FORM OF EXPOSURE TO MEMORIES OF TRAUMATIC EXPERIENCES</li> <li>• COGNITIVE PROCESSING, RESTRUCTURING, AND/OR MEANING MAKING</li> <li>• TACKLING EMOTIONS</li> <li>• ALTERING MEMORY PROCESSES.</li> </ul>
MANAGEMENT OF POST-TRAUMATIC STRESS WORKING GROUP (2010)  <a href="http://www.ptsd.va.gov">WWW.PTSD.VA.GOV</a>	CLOITRE, ET AL. (2011)	<a href="http://phoenixaustralia.org/the-6-common-elements-of-evidence-based-therapies-for-ptsd/">HTTP://PHOENIXAUSTRALIA.ORG/THE-6-COMMON-ELEMENTS-OF-EVIDENCE-BASED-THERAPIES-FOR-PTSD/</a>

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## ACTIVE INGREDIENTS

<b>EU TSN (2015)</b> <ul style="list-style-type: none"> <li>• PSYCHOEDUCATION</li> <li>• EMOTIONAL REGULATION AND COPING SKILLS</li> <li>• IMAGINAL EXPOSURE</li> <li>• COGNITIVE PROCESSING &amp; RESTRUCTURING</li> <li>• MEANING MAKING</li> <li>• DEALING WITH EMOTIONS</li> <li>• RESOLVING MEMORY PROCESSES</li> </ul>	<b>COMMON ELEMENTS OF TRAUMA APPROACH (2015)</b> <b>JOHNS HOPKINS</b> <ul style="list-style-type: none"> <li>• RELAXATION</li> <li>• COGNITIVE COPING</li> <li>• EXPOSURE-TRAUMA MEMORIES</li> <li>• DTE (IN VIVO) EXPOSURE</li> <li>• COGNITIVE RESTRUCTURING</li> <li>• BEHAVIORAL ACTIVATION</li> <li>• PROBLEM SOLVING</li> </ul>
SCHYNDER, ET AL., 2015	MURRAY, ET AL., (2015)

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## HEALING TRAUMA: ACTIVE INGREDIENTS

(GENTRY, 1999; GENTRY, BARANOWSKY & RHOTON, 2017)

- THERAPEUTIC RELATIONSHIP
- RELAXATION/SELF-REGULATION
- EXPOSURE
- COGNITIVE RESTRUCTURING/  
PSYCHOEDUCATION

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### Trauma Competency: An Active Ingredients Approach to Treating Posttraumatic Stress Disorder

J. Eric Gentry, Anna B. Baranowsky, and Robert Rhoton

Recent analysis studies have indicated a common element among effective posttraumatic stress disorder treatments: cognitive restructuring and psychoeducation. In addition, and central to recovery, trauma-related relaxation and self-regulation, and exposure via narrative of traumatic experiences. The authors present a clinical treatment approach whereby these active ingredients are delivered through an active ingredients approach to trauma treatment. This article represents an attempt to identify critical competencies and baseline standards for the field of trauma counseling.

**Keywords:** posttraumatic stress disorder (PTSD), active ingredients, trauma competency

In the 25 years since posttraumatic stress disorder (PTSD) was recognized as a diagnosis (American Psychiatric Association, 1980), researchers and clinicians have explored its etiology and effective treatments for survivors of trauma. In 2018, a significant milestone was passed with the publication of the Department of Veterans Affairs (VA) and Department of Defense (DoD) treatment guidelines for PTSD (Department of Veterans Affairs & Department of Defense, 2018). These guidelines provide a comprehensive and evidence-based approach to PTSD treatment, which has far-reaching implications for practice and research. This article reviews the active ingredients approach to trauma treatment, which is a competency-based approach to trauma treatment that is grounded in evidence-based practice and trauma-informed care. It discusses the implications of this approach for practice and research, and provides a framework for understanding the active ingredients approach to trauma treatment.

**Identifying Effective Treatments for Trauma Survivors**

In 2018, the VA and DoD, using the professional consensus and empirical evidence approach, published the management of posttraumatic stress (Management of Post-Traumatic Stress Working Group, 2018). This guideline represents the most comprehensive and authoritative evidence-based clinical practice guideline for the management of PTSD. The guideline is grounded in the best available evidence, including the results of randomized controlled trials, meta-analyses, and expert consensus. The guideline identifies several key components of effective treatment, including exposure therapy, cognitive processing therapy (CPT), prolonged exposure therapy (PET), and trauma-focused cognitive behavioral therapy (TF-CBT). These components are identified as the active ingredients of effective treatment for PTSD. The guideline also identifies several key competencies for trauma counselors, including the ability to provide a safe and supportive environment, the ability to assess and manage risk, and the ability to collaborate with clients and other professionals. The guideline is a valuable resource for trauma counselors and other professionals who work with trauma survivors.

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Journal of Counseling & Development, 96(1), 31-37

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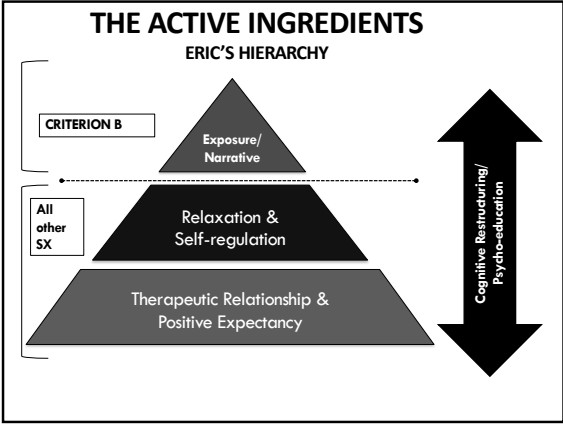
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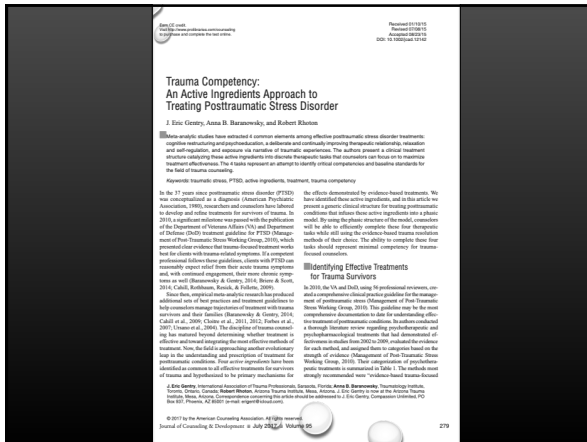
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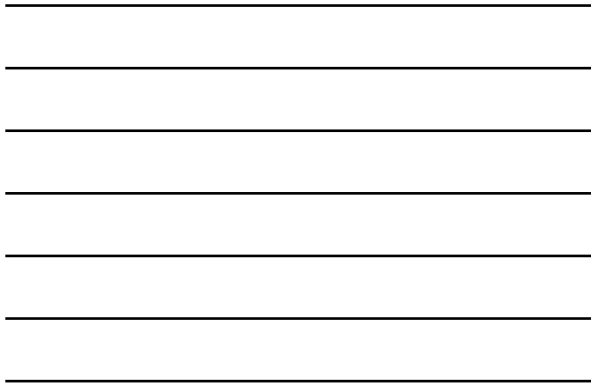
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**The Empowerment & Resilience Structure: An Active Ingredients Approach**

- I. PREPARATION & RELATIONSHIP
- II. PSYCHO-EDUCATION & SKILLS-BUILDING
- III. INTEGRATION & DESENSITIZATION
- IV. POST TRAUMATIC GROWTH & RESILIENCE

RHOTON & GENTRY, 2014; 2019

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**The Empowerment & Resilience Structure: An Active Ingredients Approach**

- I. PREPARATION & RELATIONSHIP
  - PRE-SESSION INTENTION – DELIBERATE PRACTICE
  - ASSESSMENT (INSTRUMENTS & INTERVIEW)
  - INFORMED CONSENT (DOCUMENT & PROCESS)
  - R-I-C-H
  - EXPECTANCY (HOPE) BUILDING
  - BEGIN COGNITIVE RESTRUCTURING (SURVIVAL = RESILIENCE)
  - LONGITUDINAL VS. CROSS-SECTIONAL VIEW
  - BEGIN FEEDBACK-INFORMED THERAPY (MILLER, 2008)
  - DOWNWARD-MOVING SCORES ON THE SRS > STAGE II

Unless Survivor needs Stabilization; then implement skills training

75





## The Empowerment & Resilience Structure: An Active Ingredients Approach

### II. COGNITIVE RESTRUCTURING & SKILLS-BUILDING

- TOOLS FOR HOPE (PERCEIVED THREAT + ANS)
- STRESS = PERCEIVED THREAT + DYSREGULATED ANS
- AM SAFE (NO PRESENT DANGER) VS. FEEL SAFE (SCARED)
- EXTERNAL CAUSE (STRESS) > INTERNAL CONTROL (SELF-REGULATION)
- SELF-REGULATION SKILLS-BUILDING
  - NEUROCEPTION + INTEROCEPTION + ACUTE RELAXATION
  - PRACTICE & COACHING BETWEEN SESSIONS
  - IN VIVO EXPOSURE / DTE
- GRAPHIC TIME LINE + NARRATIVE
- COGNITIVE RESTRUCTURING
  - WHAT DID IT TAKE TO SURVIVE?
  - NORMALIZE NEGATIVE SELF-REFERENCING BELIEFS
  - RESILIENCE

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## The Empowerment & Resilience Structure: An Active Ingredients Approach

### III. EXPOSURE

- IN-SESSION BRIEF (5-SECOND) IMAGINAL FIRST
- IN VIVO PRACTICE
  - PERCEIVED THREATS + SELF REGULATION
  - EXPLORE SUCCESS AND SHORTCOMINGS IN EARLY PART OF SESSIONS
- FORWARD-FACING® TRAUMA THERAPY [OPTIONAL]  
MID-SESSION ASSESSMENT (CRITERION B)
- IMAGINAL EXPOSURE METHODS (EBTS)
  - EMDR (PRIMARY)
  - HYPNOSIS (LESS AROUSAL)
  - NARRATIVE METHODS (CPT/PE) – LESS INDICATED
  - IFS OR DISSOCIATIVE TABLE FOR DISSOCIATION
  - SE OR SENSIMOTOR FOR SOMATIZATION
- MOURNING/GRIEF WORK

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## The Empowerment & Resilience Structure: An Active Ingredients Approach

### IV: POSTTRAUMATIC GROWTH & RESILIENCE

- MORE PRESENT & FUTURE FOCUSED
- OPTIMIZATION VS. SYMPTOM REDUCTION
- CONSOLIDATING GAINS
- REACTIVITY > INTENTIONALITY
- REPAIR MORAL WOUNDING
- RELATIONAL ENGAGEMENT
- CAM
- PTG PRINCIPLES
- FFFT
- TERMINATION VS. LIFE-LONG CONSULTANT

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**PREPARATION & RELAT**

**STAGE I**

Preparation  
Assessment  
Hope  
Relationship



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**POSITIVE EXPECTANCY/PLACEBO HOPE**

- POWERFUL PREDICTOR OF POSITIVE OUTCOMES IN MULTIPLE METANALYTIC STUDIES
- NECESSARY BUT INSUFFICIENT FOR CHANGE
- CATALYZING EXPECTANCY IMPROVES EFFICACY OF INTERVENTION
- INCREASES ENGAGEMENT
- INCREASED CONTINUATION
- HOW DO YOU GET HOPE INTO THE HOPELESS
  - TECHNICAL – MI
  - TRANSPERSONAL – FELT-SENSE BY CLIENT THAT HELPER BELIEVES IN THEM AND THEIR PATH OF HEALING. SURETY.

80

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**RESILIENCY**



*"THAT WHICH IS TO GIVE LIGHT  
MUST ENDURE BURNING"*

- VIKTOR  
FRANKL

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***Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.***

**- Viktor Frankl**

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In 2013, Feedback Informed Treatment (FIT)—that is, formally using measures of progress and the therapeutic alliance to guide care—was deemed an evidence-based practice by SAMHSA, and listed on the official **NREPP website**. It's one of those good ideas. **Research to date** shows that FIT as much as doubles the effectiveness of behavioral health services, while decreasing costs, deterioration and dropout rates.

**SCOTT D MILLER - FEEDBACK-INFORMED THERAPY**

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**FEEDBACK INFORMED THERAPY  
(MILLER, 2008)**

- EBT IN 2013.
- +25K DATA POINTS OF EFFECTIVENESS
- SCORES OF STUDIES; MULTIPLE RCTS
- ONE OF THE MOST EFFECTIVE MODALITIES AVAILABLE IN PSYCHOTHERAPY—MODEL OF TREATMENT IS MUCH LESS RELEVANT
- NEAR 2X EFFECTIVENESS BY IMPLEMENTING FIT WITH WELL-DESIGNED STUDIES

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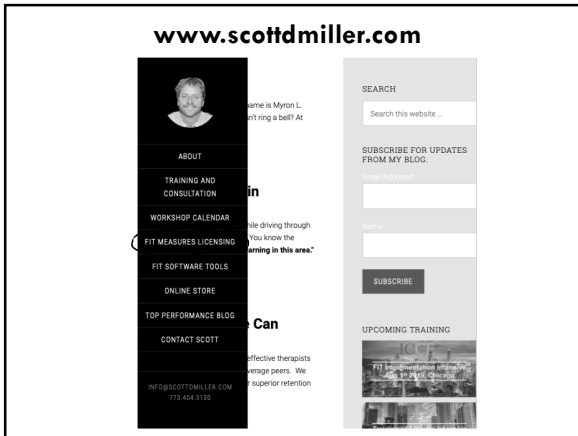
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**SUGGESTIONS FOR POSITIVE OUTCOMES**  
WWW.SCOTTMILLER.COM

- 1. COLLECT EMPIRICAL DATA EVALUATING THE QUALITY OF THE THERAPEUTIC PROCESS & RELATIONSHIP**
- 2. GENERATE HONEST FEEDBACK FROM CLIENT ON METHODS TO IMPROVE THERAPY (I.E. RELATIONAL)**
- 3. BE WILLING TO CHANGE TOWARD WHAT WORKS BEST FOR CLIENT— DEMONSTRATE THAT CHANGE**

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**Session Rating Scale (SRS V.3.0)**

Name \_\_\_\_\_ Age (Yrs) \_\_\_\_\_  
 ID# \_\_\_\_\_ Sex: M / F \_\_\_\_\_  
 Session # \_\_\_\_\_ Date \_\_\_\_\_

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

**Relationship**

I did not feel heard, understood, and respected. |-----| I felt heard, understood, and respected.

**Goals and Topics**

We did not work on or talk about what I wanted to work on and talk about. |-----| We worked on and talked about what I wanted to work on and talk about.

**Approach or Method**

The therapist's approach is not a good fit for me. |-----| The therapist's approach is a good fit for me.

**Overall**

There was something missing in the session today. |-----| Overall, today's session was right for me.

Institute for the Study of Therapeutic Change  
 www.talkingcure.com

© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson

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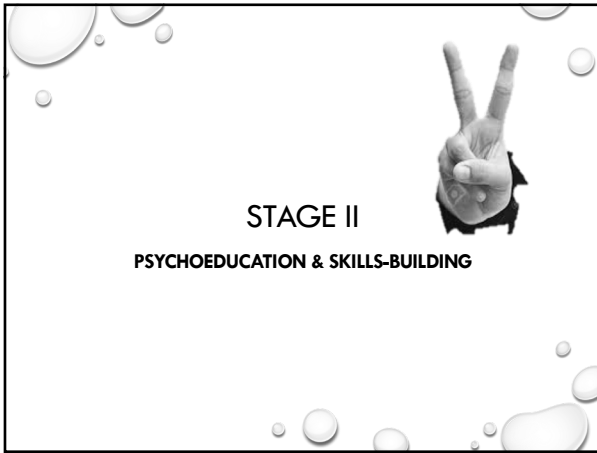
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**TRS - TRAUMA RECOVERY SCALE**

**PART II**  
 Place a mark on the line that best represents your experiences during the past week.

- I make it through the day without distressing recollections of past events. 0% ----- 100% of the time
- I sleep free from nightmares. 0% ----- 100% of the time
- I am able to stay in control when I think of difficult memories. 0% ----- 100% of the time
- I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events). 0% ----- 100% of the time
- I am safe. I feel safe. 0% ----- 100% of the time
- I have supportive relationships in my life. 0% ----- 100% of the time
- I feel that I can now safely feel a full range of emotions. 0% ----- 100% of the time
- I can allow things to happen in my surroundings without needing to control them. 0% ----- 100% of the time
- I am able to concentrate on thoughts of my choice. 0% ----- 100% of the time
- I have a sense of hope about the future. 0% ----- 100% of the time

AS - FS  Mean Score

Scoring Information: mean of the scores for which the health mark lies within the 0-100 range from 0% to 100% of the time. Interpretation: 100 - 90 (Self-aware individuals), 80 - 90 (Highly sensitive individuals), 70 - 80 (Moderately sensitive individuals), 60 - 70 (Slightly sensitive individuals), 50 - 60 (Slightly insensitive individuals), 40 - 50 (Moderately insensitive individuals), 30 - 40 (Highly insensitive individuals), 20 - 30 (Slightly insensitive individuals), 10 - 20 (Moderately insensitive individuals), 0 - 10 (Highly insensitive individuals).

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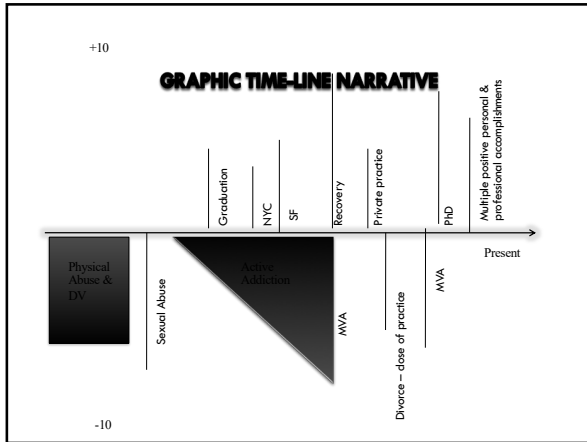
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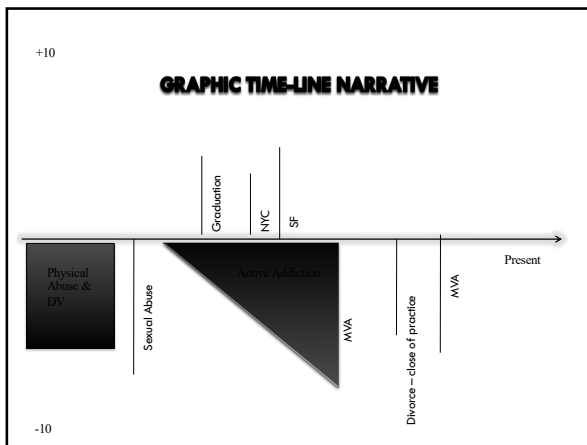
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### COGNITIVE RESTRUCTURING

- WHAT WOULD ANY REASONABLE RATIONAL HUMAN BEING COME TO BELIEVE ABOUT **THEMSELVES** (INTELLECTUALLY, EMOTIONALLY, SPIRITUALLY, PSYCHOLOGICALLY, PHYSICALLY, SOCIALLY, AND ACADEMICALLY) FROM HAVING THESE THINGS OCCUR IN THEIR LIFE?
- WHAT WOULD ANY REASONABLE RATIONAL HUMAN BEING COME TO BELIEVE ABOUT **IMPORTANT RELATIONSHIPS** (INTELLECTUALLY, EMOTIONALLY, SPIRITUALLY, PSYCHOLOGICALLY, PHYSICALLY AND SOCIALLY) FROM HAVING THESE THINGS OCCUR IN THEIR LIFE?
- WHAT WOULD ANY REASONABLE RATIONAL HUMAN BEING COME TO BELIEVE ABOUT **THE WORLD AT LARGE** FROM HAVING THESE THINGS OCCUR IN THEIR LIFE?

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## EARLY SESSIONS

- ACE – TRAUMA HISTORY
- TRS – TRAUMA HISTORY & TX PLANNING
- PCL – DIAGNOSIS
- BEGIN FEEDBACK INFORMED THERAPY (FIT)
- TOOLS FOR HOPE (PERCEIVED THREAT/ANS-SELF- REGULATION)
- PSYCHOEDUCATION (SHAME TO SELF-COMPASSION)
- GRAPHIC TIME LINE OF LIFE INCLUDING ALL SIGNIFICANT TRAUMATIC EXPERIENCES
- VERBAL NARRATIVE USING GTLAS MAP

BEGIN IN VIVO EXPOSURE WITH SELF-REGULATION

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## TRI-PHASIC MODEL

HERMAN, 1992

- **SAFETY** (STABILIZATION & SKILLS BUILDING)
- **REMEMBRANCE & MOURNING**
  - TRAUMA RESOLUTION
  - DESENSITIZATION & REPROCESSING
  - METABOLIZATION OF TRAUMA
- **RECONNECTION**
  - PRESENT & FUTURE



STANDARD of CARE

98

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## TRI-PHASIC MODEL

HERMAN, 1992

- **SAFETY** (STABILIZATION & SKILLS BUILDING)
- **REMEMBRANCE & MOURNING**
  - TRAUMA RESOLUTION
  - DESENSITIZATION & REPROCESSING
  - METABOLIZATION OF TRAUMA

Safe, Stable, and Skilled

BEFORE

Addressing Trauma  
Memories

STANDARD of CARE

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## WHAT IS NECESSARY?

GENTRY, 1998  
SIX EMPIRICAL MARKERS

ALL  
In  
Stage II

}

1. RESOLVE (REAL) DANGER
2. DISTINGUISH BETWEEN REAL VS. PERCEIVED THREAT
3. DEVELOP BATTERY OF REGULATION/RELAXATION, GROUNDING, AND CONTAINMENT SKILL
4. NON-ANXIOUS PRESENCE + GOOD PROGNOSIS

Only  
for  
Stage III

}

5. DEMONSTRATE ABILITY TO SELF-REGULATE & SELF-RESCUE WHILE ACCESSING TRAUMA MEMORY
6. CONTRACT (VERBAL) TO ADDRESS TRAUMATIC MATERIAL – TRANSFER OF INITIATIVE TO CT

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100

## ADDITIONAL SKILLS

- RELAXATION
  - PMR (SLEEP PROBLEMS)
  - ANCHORING
  - TAPPING (TFT)
- GROUNDING
  - 3-2-1 SENSORY
- CONTAINMENT
  - ENVELOPE METHOD

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## PROGRESSIVE RELAXATION

- START AT TOES
  - TIGHTEN FOR 5 SEC
  - RELEASE FOR 5 SEC
  - REPEAT
  - NOTICE DIFFERENCE
- EACH MUSCLE GROUP ALL THE WAY TO HEAD
- BACK DOWN TO TOES



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## ANCHORING - NLP

- DRAW PIX OF PLACE FROM HX OR IMAGINATION THAT IS SAFE & COMFORTABLE (5 MIN)
- "MAY I APPROACH YOU?"
- EXPERIMENT – FLASHBACKS OF "GOOD" STUFF
- ANCHOR (SQUEEZE) STONE WHILE TELLING STORY
- CARRY STONE FOR WEEK
  - SQUEEZE WHEN ANXIOUS
  - SQUEEZE WHEN COMFORTABLE
- REPORT NEXT WEEK

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## THOUGHT FIELD THERAPY (TFT) CALLAHAN



### WHAT IS THOUGHT FIELD THERAPY® (TFT)?

- THOUGHT FIELD THERAPY (TFT) IS A LITTLE-KNOWN, BUT HIGHLY EFFECTIVE, DRUG-FREE AND NON-INVASIVE WAY TO REDUCE OR ELIMINATE EVEN CHRONIC PAIN WITHOUT THE RISK OF MEDICATIONS.
- TFT WAS DISCOVERED AND DEVELOPED BY CALIFORNIA CLINICAL PSYCHOLOGIST, DR. ROGER CALLAHAN. **IT WORKS WITH NATURE'S HEALING SYSTEM COMBINING THE ACUPRESSURE MERIDIAN SYSTEM AND MODERN PSYCHOLOGY.**
- WHILE THERE IS INCREASING EVIDENCE AS TO ITS EFFECTIVENESS FOR TFT (EVEN MORE WITH EFT), ESPECIALLY WITH PAIN, WE ARE USING TFT HERE AS A SELF-HELP METHOD FOR ANXIETY REDUCTION – NOT A TREATMENT FOR TRAUMATIC STRESS!




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## Distressing Thought

	SUDs	SUDs
10		
9		
8		
7		
6		
5		
4		
3		
2		
1		
0		

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105

**THOUGHT FIELD THERAPY (TFT)**  
CALLAHAN (1985; 2000)

<p><b>1. TRAUMA MEMORY</b></p> <p><b>2. SUDS</b></p> <p><b>3. ALGORITHM (TRAUMA)</b></p> <ul style="list-style-type: none"> <li>• EYE BROW (8 - 12 TAPS)</li> <li>• UNDER EYE (8 - 12 TAPS)</li> <li>• UNDERARM (8 - 12 TAPS)</li> <li>• COLLARBONE (8 - 12 TAPS)</li> </ul> <p><b>4. 9 GAMUT</b></p> <ul style="list-style-type: none"> <li>• WHILE CONTINUOUSLY TAPPING 9-GAMUT SPOT...</li> </ul>	<ul style="list-style-type: none"> <li>• EYES OPEN</li> <li>• EYES CLOSED</li> <li>• EYES OPEN DOWN RIGHT</li> <li>• EYES OPEN DOWN LEFT</li> <li>• EYES CLOCKWISE</li> <li>• EYES COUNTERCLOCKWISE</li> <li>• HUM A TUNE</li> <li>• COUNT TO FIVE (ALOUD)</li> <li>• HUM A TUNE</li> </ul> <p><b>5. REPEAT # 3</b></p>
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106

**END-OF-SESSION/CONTAINMENT**

<p><u><b>END OF SESSION</b></u></p> <ul style="list-style-type: none"> <li>• DRAW FOR 2 MINUTES AN EXPRESSION OF WHAT IS HAPPENING INSIDE OF YOU</li> </ul>	<p><u><b>CONTAINING TRAUMA</b></u></p> <ul style="list-style-type: none"> <li>• DRAW FOR 1 MINUTE AN ABSTRACT SYMBOL OF THE MEMORY</li> </ul>
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- Have client place drawing in envelope
- Staple envelope closed
- Brief statement
  - Therapy happens here/life out there
  - I will keep this safe here (the pain and fear associated with it)
- Ask client at beginning of next session if they wish to work on the envelope material

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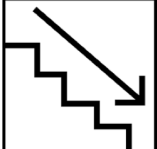
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107




ROCKTAPE



MELGISA





**CAPACITY-BUILDING**  
(RHOTON, 2015; 2019)

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108

**CAPACITY-BUILDING**  
(RHOTON, 2015; 2019)

- Resilience, Restructuring and Trauma Processing
- Oblique way of processing intrusive memories
- Strengths-based
- 1:1 or group
- Simple non-obreactive cognitive method for helping clients to put trauma behind them

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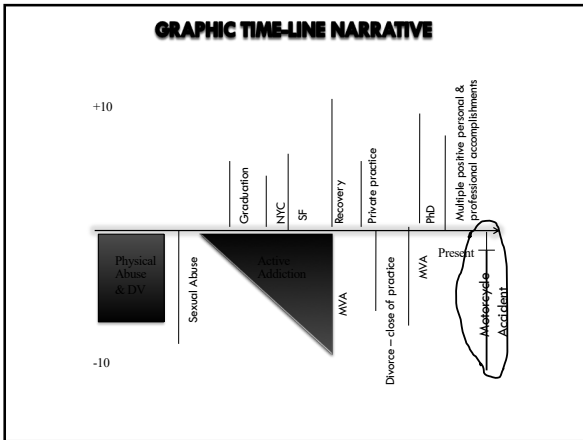
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110

**CAPACITY-BUILDING**  
(RHOTON, 2015; 2019)

Motorcycle Accident 5/17/17

SUDs = 8

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111

**CAPACITY-BUILDING**  
(RHOTON, 2015; 2019)



Motorcycle  
Accident  
1/1/19

SUDs = 2

112

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**CAPACITY-BUILDING**  
(RHOTON, 2015; 2019)

**Steps**

1. Medical Tx
2. Repair bike
3. Physical rehab
4. Riding again
5. Leaning
6. Leaning at speed (Relaxed body) x 100

Motorcycle  
Accident  
1/1/19

SUDs = 2

113

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**CAPACITY-BUILDING**  
EXERCISE

1. Draw Time-Line
2. Identify "Trauma" that *had* a SUDs of 7+
3. That now is < 3
4. Identify (Write Narrative)
  - a. The first thing you did that brought the SUDs down
  - b. Four to five more things you did that helped you get the SUDs down to < 3
5. Share this as a Story of Recovery in dyads or triads (5 min in triads / 7 min in dyads)
6. Discussion

SUDs Now

Event  
Date

SUDs then

114

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**STAGE III**  
**DESENSITIZATION & INTEGRATION**

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**The Empowerment & Resilience Structure:  
 An Active Ingredients Approach**

**III. INTEGRATION & DESENSITIZATION**

- **IN VIVO PRACTICE**
  - PERCEIVED THREATS + SELF REGULATION
  - EXPLORE SUCCESS AND SHORTCOMINGS IN EARLY PART OF SESSIONS
- **FORWARD-FACING® TRAUMA THERAPY**
- **CAPACITY-BUILDING**
  - **MID-SESSION ASSESSMENT (CRITERION B)**
- **IMAGINAL EXPOSURE METHODS (EBTS)**
  - **EMDR**
  - CPT/PE HYPNOSIS (LESS AROUSAL)
  - NARRATIVE METHODS
  - IFS OR DISSOCIATIVE TABLE FOR DISSOCIATION
  - SE OR SENSIMOTOR FOR SOMATIZATION
- **MOURNING/GRIEF WORK**

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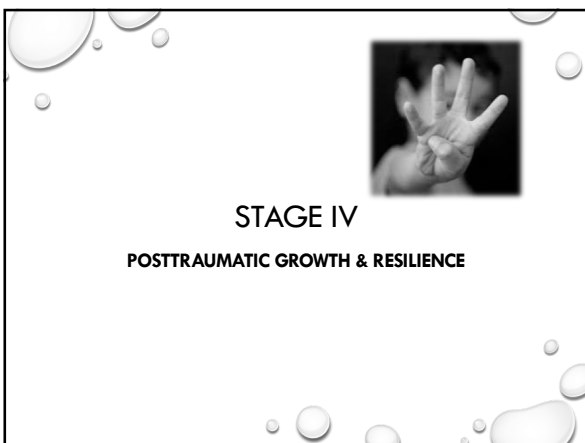
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**STAGE IV**  
**POSTTRAUMATIC GROWTH & RESILIENCE**

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## POSTTRAUMATIC GROWTH

**WHAT IS POSTTRAUMATIC GROWTH?**

➔

IT IS POSITIVE CHANGE EXPERIENCED AS A RESULT OF THE STRUGGLE WITH A MAJOR LIFE CRISIS OR A TRAUMATIC EVENT



The greatest souls are awakened out of suffering. The most impressive personalities endure many scars.

- Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455-471.
- Calhoun, L. G., & Tedeschi, R. G. (2013). *Posttraumatic growth in clinical practice*. New York: Brunner Routledge.

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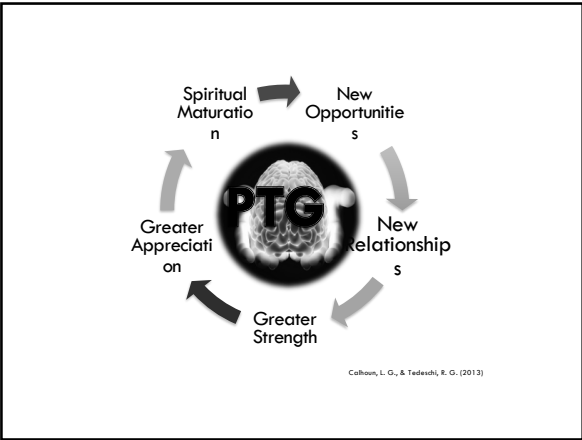
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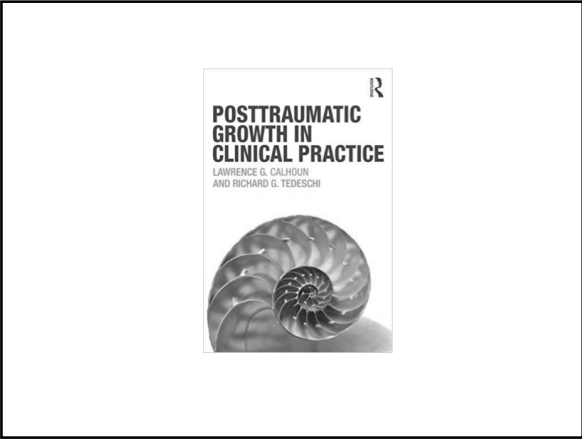
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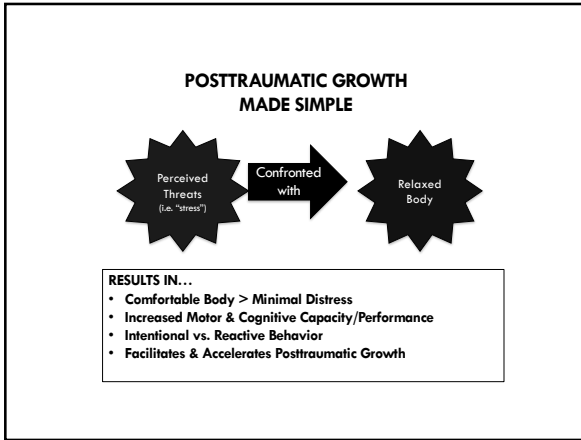
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121

**THE EMPOWERMENT & RESILIENCE STRUCTURE: AN ACTIVE  
INGREDIENTS APPROACH**

- I. PREPARATION & RELATIONSHIP**
- II. PSYCHOEDUCATION & SELF-  
REGULATION**
- III. INTEGRATION & DESENSITIZATION**
- IV. POST TRAUMATIC GROWTH &  
RESILIENCE**

RHOTON & GENTRY, 2014

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## Appendix I – Screening/Assessment Instruments

### STABLE RESOURCE TOOLKIT

#### CAGE-AID - Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

#### Clinical Utility

Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

#### Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

#### Psychometric Properties

The CAGE-AID exhibited<sup>1</sup>:

	<b>Sensitivity</b>	<b>Specificity</b>
One or more <b>Yes</b> responses	0.79	0.77
Two or more <b>Yes</b> responses	0.70	0.85

1. Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*. 1995;94(3) 135-140.

### CAGE-AID Questionnaire

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

*Permission for use granted by Richard Brown, MD.*



## Am I an Addict?

This is NA Fellowship-approved literature.

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Narcotics Anonymous World Services, Inc.  
All rights reserved.

*Only you can answer this question.*

This may not be an easy thing to do. All through our usage, we told ourselves, "I can handle it." Even if this was true in the beginning, it is not so now. The drugs handled us. We lived to use and used to live. Very simply, an addict is a person whose life is controlled by drugs.

Perhaps you admit you have a problem with drugs, but you don't consider yourself an addict. All of us have preconceived ideas about what an addict is. There is nothing shameful about being an addict once you begin to take positive action. If you can identify with our problems, you may be able to identify with our solution. The following questions were written by recovering addicts in Narcotics Anonymous. If you have doubts about whether or not you're an addict, take a few moments to read the questions below and answer them as honestly as you can.

1. Do you ever use alone? Yes  No
2. Have you ever substituted one drug for another, thinking that one particular drug was the problem? Yes  No
3. Have you ever manipulated or lied to a doctor to obtain prescription drugs? Yes  No
4. Have you ever stolen drugs or stolen to obtain drugs? Yes  No
5. Do you regularly use a drug when you wake up or when you go to bed? Yes  No
6. Have you ever taken one drug to overcome the effects of another? Yes  No
7. Do you avoid people or places that do not approve of you using drugs? Yes  No
8. Have you ever used a drug without knowing what it was or what it would do to you? Yes  No
9. Has your job or school performance ever suffered from the effects of your drug use? Yes  No
10. Have you ever been arrested as a result of using drugs? Yes  No
11. Have you ever lied about what or how much you use? Yes  No
12. Do you put the purchase of drugs ahead of your financial responsibilities? Yes  No
13. Have you ever tried to stop or control your using? Yes  No
14. Have you ever been in a jail, hospital, or drug rehabilitation center because of your using? Yes  No
15. Does using interfere with your sleeping or eating? Yes  No

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 16. Does the thought of running out of drugs terrify you?                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. Do you feel it is impossible for you to live without drugs?                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. Do you ever question your own sanity?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 19. Is your drug use making life at home unhappy?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. Have you ever thought you couldn't fit in or have a good time without drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 21. Have you ever felt defensive, guilty, or ashamed about your using?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 22. Do you think a lot about drugs?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 23. Have you had irrational or indefinable fears?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 24. Has using affected your sexual relationships?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 25. Have you ever taken drugs you didn't prefer?                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 26. Have you ever used drugs because of emotional pain or stress?                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 27. Have you ever overdosed on any drugs?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 28. Do you continue to use despite negative consequences?                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 29. Do you think you might have a drug problem?                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

"Am I an addict?" This is a question only you can answer. We found that we all answered different numbers of these questions "Yes." The actual number of "Yes" responses wasn't as important as how we felt inside and how addiction had affected our lives.

Some of these questions don't even mention drugs. This is because addiction is an insidious disease that affects all areas of our lives—even those areas which seem at first to have little to do with drugs. The different drugs we used were not as important as why we used them and what they did to us.

When we first read these questions, it was frightening for us to think we might be addicts. Some of us tried to dismiss these thoughts by saying:

"Oh, those questions don't make sense;"

Or,

"I'm different. I know I take drugs, but I'm not an addict. I have real emotional/family/job problems;"

Or,

"I'm just having a tough time getting it together right now;"

Or,

"I'll be able to stop when I find the right person/get the right job, etc."

If you are an addict, you must first admit that you have a problem with drugs before any progress can be made toward recovery. These questions, when honestly approached, may help to show you how using drugs has made your life unmanageable. Addiction is a disease which, without recovery, ends in jails, institutions, and death. Many of us came to Narcotics Anonymous because drugs had stopped doing what we needed them to do. Addiction takes our pride, self-esteem, family, loved ones, and even our desire to live. If you have not reached this point in your addiction, you don't have to. We have found that our own private hell was within us. If you want help, you can find it in the Fellowship of Narcotics Anonymous.

“We were searching for an answer when we reached out and found Narcotics Anonymous. We came to our first NA meeting in defeat and didn’t know what to expect. After sitting in a meeting, or several meetings, we began to feel that people cared and were willing to help. Although our minds told us that we would never make it, the people in the fellowship gave us hope by insisting that we could recover. [...] Surrounded by fellow addicts, we realized that we were not alone anymore. Recovery is what happens in our meetings. Our lives are at stake. We found that by putting recovery first, the program works. We faced three disturbing realizations:

1. We are powerless over addiction and our lives are unmanageable;
2. Although we are not responsible for our disease, we are responsible for our recovery;
3. We can no longer blame people, places, and things for our addiction. We must face our problems and our feelings.

The ultimate weapon for recovery is the recovering addict.”<sup>1</sup>

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<sup>1</sup> Basic Text, *Narcotics Anonymous*

Score: \_\_\_\_\_

# TRS

Name \_\_\_\_\_

## TRAUMA RECOVERY SCALE

### PART I

**Directions:** Please read the following list and check all that apply.

	<u>Type Of Traumatic Event</u>	<u>Number of Times</u>	<u>Dates/Age(s)</u>		
<input type="checkbox"/>	1. Childhood Sexual Abuse	_____	_____	_____	_____
<input type="checkbox"/>	2. Rape	_____	_____	_____	_____
<input type="checkbox"/>	3. Other Adult Sexual Assault/Abuse	_____	_____	_____	_____
<input type="checkbox"/>	4. Natural Disaster	_____	_____	_____	_____
<input type="checkbox"/>	5. Industrial Disaster	_____	_____	_____	_____
<input type="checkbox"/>	6. Motor Vehicle Accident	_____	_____	_____	_____
<input type="checkbox"/>	7. Combat Trauma	_____	_____	_____	_____
<input type="checkbox"/>	8. Physical Injury/Medical	_____	_____	_____	_____
<input type="checkbox"/>	9. Childhood Physical Abuse	_____	_____	_____	_____
<input type="checkbox"/>	10. Adult Physical Abuse	_____	_____	_____	_____
<input type="checkbox"/>	11. Victim Of Violent Crime	_____	_____	_____	_____
<input type="checkbox"/>	12. Captivity	_____	_____	_____	_____
<input type="checkbox"/>	13. Torture	_____	_____	_____	_____
<input type="checkbox"/>	14. Domestic Violence	_____	_____	_____	_____
<input type="checkbox"/>	15. Sexual Harassment	_____	_____	_____	_____
<input type="checkbox"/>	16. Threat of physical violence	_____	_____	_____	_____
<input type="checkbox"/>	17. Accidental physical injury	_____	_____	_____	_____
<input type="checkbox"/>	18. Humiliation	_____	_____	_____	_____
<input type="checkbox"/>	19. Property Loss	_____	_____	_____	_____
<input type="checkbox"/>	20. Death Of Loved One	_____	_____	_____	_____
<input type="checkbox"/>	21. Neglect	_____	_____	_____	_____
<input type="checkbox"/>	23. Witnessed Event (see below)	_____	_____	_____	_____
<input type="checkbox"/>	24. Other: _____	_____	_____	_____	_____
<input type="checkbox"/>	25. Other: _____	_____	_____	_____	_____

If you witnessed trauma and it has caused significant distress or problems in your life please identify the even(s) and people involved.

- Witnessed Event: \_\_\_\_\_
- Witnessed Event: \_\_\_\_\_
- Witnessed Event: \_\_\_\_\_
- Witnessed Event: \_\_\_\_\_
- Witnessed Event: \_\_\_\_\_
- Witnessed Event: \_\_\_\_\_
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- Witnessed Event: \_\_\_\_\_

Comments: \_\_\_\_\_

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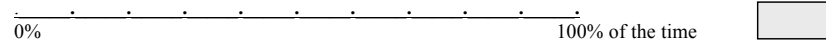
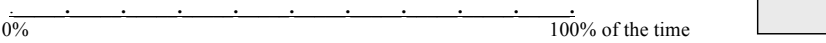
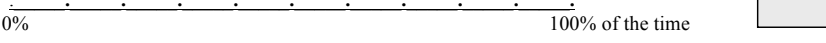
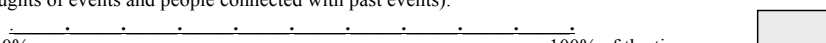
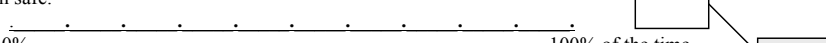
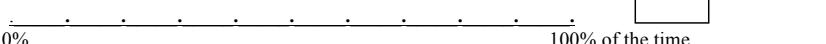
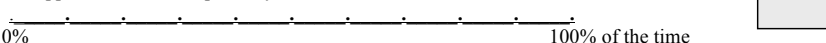
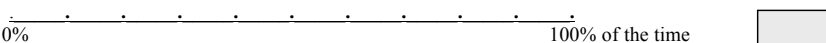
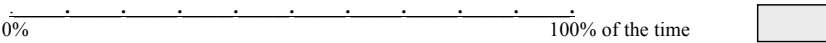
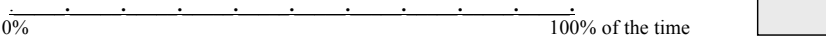
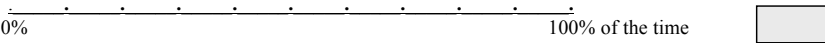
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# TRS TRAUMA RECOVERY SCALE

## PART II

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.  

2. I sleep free from nightmares.  

3. I am able to stay in control when I think of difficult memories.  

4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).  

5. I am safe.  
  
 I feel safe.  
  
 (Note: Two boxes are connected by lines to a larger box on the right, indicating a combined score for this item.)
6. I have supportive relationships in my life.  

7. I find that I can now safely feel a full range of emotions.  

8. I can allow things to happen in my surroundings without needing to control them.  

9. I am able to concentrate on thoughts of my choice.  

10. I have a sense of hope about the future.  


AS – FS

**Scoring Instructions:** record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

**Interpretation:** 100 – 95 (full recovery/subclinical); 86 - 94 (significant recovery/mild symptoms); 75 – 85 (some recovery/moderate symptoms); 74 (minimal recovery/severe); below 35 (probable traumatic regression)

Mean Score

### Finding Your ACE Score

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often or very often**...  
Swear at you, insult you, put you down, or humiliate you?  
**or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes No If yes enter 1 \_\_\_\_\_
2. Did a parent or other adult in the household **often or very often**...  
Push, grab, slap, or throw something at you?  
**or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes No If yes enter 1 \_\_\_\_\_
3. Did an adult or person at least 5 years older than you **ever**...  
Touch or fondle you or have you touch their body in a sexual way?  
**or**  
Attempt or actually have oral, anal, or vaginal intercourse with you?  
Yes No If yes enter 1 \_\_\_\_\_
4. Did you **often or very often** feel that ...  
No one in your family loved you or thought you were important or special?  
**or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No If yes enter 1 \_\_\_\_\_
5. Did you **often or very often** feel that ...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No If yes enter 1 \_\_\_\_\_
6. Were your parents **ever** separated or divorced?  
Yes No If yes enter 1 \_\_\_\_\_
7. Was your mother or stepmother:  
**Often or very often** pushed, grabbed, slapped, or had something thrown at her?  
**or**  
**Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?  
**or**  
**Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_

**Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score.**

092406RA4CR



## DSM-V AND SUBSTANCE RELATED DISORDERS

The DSM-V combined the DSM-IV categories of substance dependence (addiction marked by a pattern of compulsive use or loss of control) and substance abuse disorders (using in a manner that causes problems but does not have a pattern of compulsive use) into one broad category of substance related disorder.

### CLASSES:

The DSM-V recognizes substance related disorders resulting from the use of ten separate classes of drugs:

1. alcohol
2. caffeine
3. cannabis
4. hallucinogens (phencyclidine or similarly acting arylcyclohexylamines), other hallucinogens such as LSD
5. inhalants
6. opioids
7. sedatives
8. hypnotics
9. anxiolytics
10. stimulants (including amphetamine-type substances, cocaine, and other stimulants), tobacco, and
11. other or unknown substances.

Some major grouping of psychoactive substances are specifically identified. Use of other or unknown substances can also form the basis of a substance related or addictive disorder.

### GROUPS:

There are two groups of substance-related disorders: substance use disorders and substance-induced disorders.

**Substance use disorders** are patterns of symptoms resulting from use of a substance which the individual continues to take, despite experiencing problems as a result.

**Substance-induced disorders** include intoxication, withdrawal, substance induced mental disorders, including substance induced psychosis, substance induced bipolar and related disorders, substance induced depressive disorders, substance induced anxiety disorders, substance induced obsessive-compulsive and related disorders, substance induced sleep disorders, substance induced sexual dysfunctions, substance induced delirium and substance induced neurocognitive disorders.

**CRITERIA FOR SUBSTANCE USE DISORDER:**

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

The DSM-V allows clinicians to specify how severe the substance use disorder is, depending on how many symptoms are identified:

MILD: Two or three symptoms indicate a mild substance use disorder.

MODERATE: Four or five symptoms indicate a moderate substance use disorder.

SEVERE: Six or more symptoms indicate a severe substance use disorder.

Clinicians can also add “in early remission,” “in sustained remission,” “on maintenance therapy,” and “in a controlled environment.”

DSM-5 Substance Use Diagnosis Guide		DMC Approved Billable Codes	
SEVERITY LEVELS	SPECIFIERS		
<ul style="list-style-type: none"> <li>Mild = Presence of 2-3 DSM-5 criteria symptoms</li> <li>Moderate = Presence of 4-5 DSM-5 criteria symptoms</li> <li>Severe = Presence of 6 or more DSM-5 criteria symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Early Remission = 3 months to 1 year with no presence of DSM-5 criteria symptoms</li> <li>Sustained Remission = 1 year or more with no presence of DSM-5 criteria symptoms in controlled environment = if individual is in an environment where access to substances are restricted</li> </ul>		
SUBSTANCE	DSM-5 DIAGNOSIS LABEL	ICD-10 CODES	
<b>Alcohol</b> Example: beer, liquor	Alcohol Use Disorder, MILD	F10.10	
	Alcohol Use Disorder, MODERATE or SEVERE	F10.20	
	Alcohol Use Disorder, Mild in early or sustained REMISSION	F10.11	
	Alcohol Use Disorder, Moderate or Severe in early or sustained REMISSION	F10.21	
	Alcohol Intoxication with Use Disorder, MILD	F10.129	
	Alcohol Intoxication with Use Disorder, MODERATE or SEVERE	F10.229	
	Alcohol Intoxication without Use Disorder	F10.929	
	Alcohol Withdrawal without Perceptual Disturbances	F10.239	
	Opioid Use Disorder, MILD	F11.10	
	Opioid Use Disorder, MODERATE or SEVERE	F11.20	
<b>Opioid</b> Example: Heroin, Hydrocodone (Norco, Vicodin), Oxycodone (OxyContin, Percocet), Morphine, Hydromorphone (Dilaudid), Codeine (cough syrup), Meperidine (Demerol), Fentanyl, etc.	Opioid Use Disorder, Mild in early or sustained REMISSION	F11.11	
	Opioid Use Disorder, Moderate or Severe in early or sustained REMISSION	F11.21	
	Opioid Intoxication without Perceptual Disturbances with Use Disorder, MILD	F11.129	
	Opioid Intoxication without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE	F11.229	
	Opioid Intoxication without Perceptual Disturbances without Use Disorder	F11.929	
	Opioid Withdrawal	F11.23	
	<b>Cannabis</b> Example: Marijuana and marijuana-related products	Cannabis Use Disorder, MILD	F12.10
		Cannabis Use Disorder, MODERATE or SEVERE	F12.20
		Cannabis Use Disorder, Mild in early or sustained REMISSION	F12.11
		Cannabis Use Disorder, Moderate or Severe in early or sustained REMISSION	F12.21
Cannabis Intoxication without Perceptual Disturbances with Use Disorder, MILD		F12.129	
Cannabis Intoxication without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE		F12.229	
Cannabis Intoxication without Perceptual Disturbances without Use Disorder		F12.929	
Sedative, Hypnotic, or Anxiolytic Use Disorder, MILD		F13.10	
Sedative, Hypnotic, or Anxiolytic Use Disorder, MODERATE or SEVERE		F13.20	
<b>Sedative, Hypnotic, or Anxiolytic</b> Example: Benzodiazepines (Xanax [alprazolam], Ativan [lorazepam], Valium [diazepam], Klonopin [clonazepam]); Barbiturates (Pentobarbital, Secobarbital, etc.); Ambien [zolpidem], Lunesta [eszopiclone], Sonata [zaleplon], Imreest [zopiclone], Z-drugs, etc.		Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild in early or sustained REMISSION	F13.11
	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe in early or sustained REMISSION	F13.21	
	Sedative, Hypnotic, or Anxiolytic Intoxication with Use Disorder, MILD	F13.129	
	Sedative, Hypnotic, or Anxiolytic Intoxication with Use Disorder, MODERATE or SEVERE	F13.229	
	Sedative, Hypnotic, or Anxiolytic Intoxication without Use Disorder	F13.929	
	Sedative, Hypnotic, or Anxiolytic Withdrawal without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE	F13.239	
	<b>Cocaine</b> Example: Cocaine (coke, blow, snow, etc.)	Cocaine Use Disorder, MILD	F14.10
		Cocaine Use Disorder, MODERATE or SEVERE	F14.20
		Cocaine Use Disorder, Mild in early or sustained REMISSION	F14.11
		Cocaine Use Disorder, Moderate or Severe in early or sustained REMISSION	F14.21
Cocaine Intoxication, without Perceptual Disturbances with Use Disorder, MILD		F14.129	
Cocaine Intoxication, without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE		F14.229	
Cocaine Intoxication without Perceptual Disturbances without Use Disorder		F14.929	
Cocaine Withdrawal		F14.23	

<b>Amphetamine-Type Substance</b> Example: Methamphetamine (crystal meth, crank, speed, tweek, glass, etc.)	Amphetamine-Type Substance Use Disorder, MILD	F15.10
	Amphetamine-Type Substance Use Disorder, MODERATE or SEVERE	F15.20
	Amphetamine-Type Substance Use Disorder, Mild in early or sustained REMISSION	F15.11
	Amphetamine-Type Substance Use Disorder, Moderate or Severe in early or sustained REMISSION	F15.21
	Amphetamine-Type Substance Intoxication without Perceptual Disturbances with Use Disorder, MILD	F15.129
	Amphetamine-Type Substance Intoxication without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE	F15.229
	Amphetamine-Type Substance Intoxication without Perceptual Disturbances without Use Disorder	F15.929
	Amphetamine-Type Substance Withdrawal	F15.23
	Other or Unspecified Stimulant Use Disorder, MILD	F15.10
	Other or Unspecified Stimulant Use Disorder, MODERATE or SEVERE	F15.20
<b>Other or Unspecified Stimulant</b> Example: Ritalin (methylphenidate), Adderall (dextroamphetamine/amphetamine), Vyvanse (lisdexamfetamine), etc.	Other or Unspecified Stimulant Use Disorder, Mild in early or sustained REMISSION	F15.11
	Other or Unspecified Stimulant Use Disorder, Moderate or Severe in early or sustained REMISSION	F15.21
	Other Stimulant Intoxication without Perceptual Disturbances with Use Disorder, MILD	F15.129
	Other Stimulant Intoxication without Perceptual Disturbances with Use Disorder, MODERATE or SEVERE	F15.229
	Other Stimulant Intoxication without Perceptual Disturbances without Use Disorder	F15.929
	Other Stimulant Withdrawal	F15.23
	Phencyclidine (PCP) Use Disorder, MILD	F16.10
	Phencyclidine (PCP) Use Disorder, MODERATE or SEVERE	F16.20
	Phencyclidine (PCP) Use Disorder, Mild in early or sustained REMISSION	F16.11
	Phencyclidine (PCP) Use Disorder, Moderate or Severe in early or sustained REMISSION	F16.21
<b>Phencyclidine</b> Example: PCP (phencyclidine)	Phencyclidine (PCP) Intoxication with Use Disorder, MILD	F16.129
	Phencyclidine (PCP) Intoxication with Use Disorder, MODERATE or SEVERE	F16.229
	Phencyclidine (PCP) Intoxication without Use Disorder	F16.929
	Other Hallucinogen Use Disorder, MILD	F16.10
	Other Hallucinogen Use Disorder, MODERATE or SEVERE	F16.20
	Other Hallucinogen Use Disorder, Mild in early or sustained REMISSION	F16.11
	Other Hallucinogen Use Disorder, Moderate or Severe in early or sustained REMISSION	F16.21
	Other Hallucinogen Intoxication with Use Disorder, MILD	F16.129
	Other Hallucinogen Intoxication with Use Disorder, MODERATE or SEVERE	F16.229
	Other Hallucinogen Intoxication without Use Disorder	F16.929
<b>Other Hallucinogen</b> Example: LSD (acid), Ecstasy (MDMA), Ketamine, magic mushrooms (psilocybin), Peyote (Mescaline), etc.	Inhalant Use Disorder, MILD	F18.10
	Inhalant Use Disorder, MODERATE or SEVERE	F18.20
	Inhalant Use Disorder, Mild in early or sustained REMISSION	F18.11
	Inhalant Use Disorder, Moderate or Severe in early or sustained REMISSION	F18.21
	Inhalant Intoxication with Use Disorder, MILD	F18.129
	Inhalant Intoxication with Use Disorder, MODERATE or SEVERE	F18.229
	Inhalant Intoxication without Use Disorder	F18.929
	Other (or Unknown) Substance Use Disorder, MILD	F19.10
	Other (or Unknown) Substance Use Disorder, MODERATE or SEVERE	F19.20
	Other (or Unknown) Substance Use Disorder, Mild in early or sustained REMISSION	F19.11
Other (or Unknown) Substance Use Disorder, Moderate or Severe in early or sustained REMISSION	F19.21	
<b>Other (or Unknown) Substance</b> Example: Glues, spray cans, etc.	Other (or Unknown) Substance Intoxication with Use Disorder, MILD	F19.129
	Other (or Unknown) Substance Intoxication with Use Disorder, MODERATE or SEVERE	F19.229
	Other (or Unknown) Substance Intoxication without Use Disorder	F19.929
	Other (or Unknown) Substance Withdrawal	F19.239



**ALCOHOL & OTHER DRUG SERVICES**

**DIAGNOSIS REFERENCE GUIDE**

**A. Diagnostic Criteria for Substance Use Disorder**

See DSM-5 for criteria specific to the drugs identified as primary, secondary or tertiary.

P S T (P=Primary, S=Secondary, T=Tertiary)

- 1. Substance is often taken in larger amounts and/or over a longer period than the patient intended.
- 2. Persistent attempts or one or more unsuccessful efforts made to cut down or control substance use.
- 3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from effects.
- 4. Craving or strong desire or urge to use the substance
- 5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- 6. Continued substance use despite having persistent or recurrent social or interpersonal problem caused or exacerbated by the effects of the substance.
- 7. Important social, occupational or recreational activities given up or reduced because of substance use.
- 8. Recurrent substance use in situations in which it is physically hazardous.
- 9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- 10. Tolerance, as defined by either of the following:
  - a. Markedly increased amounts of the substance in order to achieve intoxication or desired effect; Which: \_\_\_\_\_
  - b. Markedly diminished effect with continued use of the same amount; Which: \_\_\_\_\_
- 11. Withdrawal, as manifested by either of the following:
  - a. The characteristic withdrawal syndrome for the substance; Which: \_\_\_\_\_
  - b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms; Which: \_\_\_\_\_

**Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Diagnostic Codes**

**Alcohol Use Disorder (ICD 10)**

- 305.00 (F10.10) Mild 2-3 symptoms present
- 303.90(F10.20) Moderate 4-5 symptoms present
- 303.90(F10.20) Severe 6+ symptoms present

**Phencyclidine Use Disorder**

- 305.90 (F16.10) Mild 2-3 symptoms present
- 304.60 (F16.20) Moderate 4-5 symptoms present
- 304.60 (F16.20) Severe 6+ symptoms present

**Inhalant Use Disorder:**

- 305.90 (F18.10) Mild 2-3 symptoms present
- 304.60 (F18.20) Moderate 4-5 symptoms present
- 304.60 (F18.20) Severe 6+ symptoms present



ALCOHOL & OTHER DRUG SERVICES

Stimulant Use Disorder

- Mild: Presence of 2-3 symptoms
- 305.70 (F15.10) Amphetamine-type substance
- 305.60 (F14.10) Cocaine
- 305.70 (F15.10) Other or unspecified stimulant

- Moderate: Presence of 4-5 symptoms
- 304.40 (F15.20) Amphetamine-type substance
- 304.20 (F14.20) Cocaine
- 304.40 (F15.10) Other or unspecified stimulant

- Severe: Presence of 6 or more symptoms
- 304.40 (F15.20) Amphetamine-type substance
- 304.20 (F14.20) Cocaine
- 304.40 (F15.10) Other or unspecified stimulant

Cannabis Use Disorder

- 305.20 (F12.10) Mild 2-3 symptoms present
304.30 (F12.20) Moderate 4-5 symptoms present
304.30 (F12.20) Severe 6+ symptoms present

Other Hallucinogen Use Disorder

- 305.30 Mild Presence of 2-3 symptoms
304.50 Moderate Presence of 4-5 symptoms
304.50 Severe Presence of 6 or more

Opioid Use Disorder

- 305.50 (F11.10) Mild 2-3 symptoms present
304.00 (F11.20) Moderate 4-5 symptoms present
304.00 (F11.20) Severe 6+ symptoms present

Sedative, Hypnotic, or Anxiolytic Use Disorder

- 305.40 (F13.10) Mild 2-3 symptoms present
304.10 (F13.20) Moderate 4-5 symptoms present
304.10 (F13.20) Severe 6+ symptoms present

Tobacco Use Disorder

- 305.10 (Z72.0) Mild 2-3 symptoms present
304.10 (F17.20) Moderate 4-5 symptoms present
304.10 (F17.20) Severe 6+ symptoms present

Additional Specifiers \_\_\_\_\_

Screening of substance use revealed insufficient symptoms to indicate abuse or addiction.

Name \_\_\_\_\_

Date \_\_\_\_\_

Diagnosis by \_\_\_\_\_

Credential \_\_\_\_\_

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