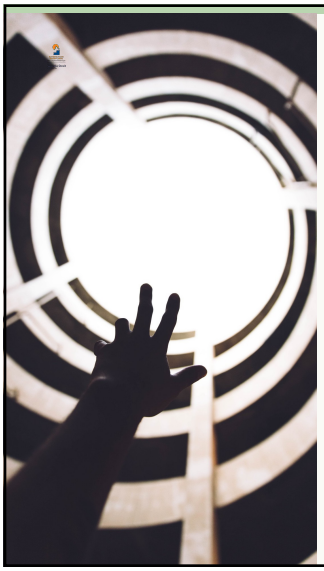


Practical Intervention Strategies to Help Adolescents and Adults who Struggle with Addictions

Dr. Carissa Muth, R.Psych (AB & BC)

Sunshine Coast Health Centre

Georgia Strait

Addictions

"Momentary freedom from the claims of the aging, confining, nagging, frightening flesh." William Burroughs, roin

- Excessive habits of everyday life
- Dynamic
- Multifaceted

Addiction Myths

True or False?

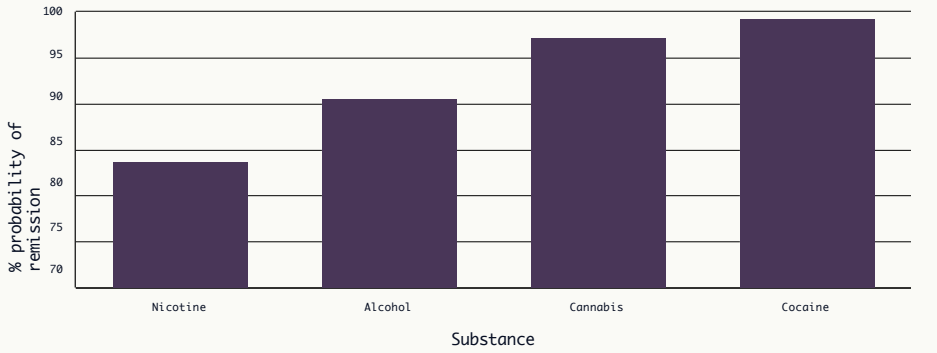
most people who get sober do with without professional help

TRUE !

83%

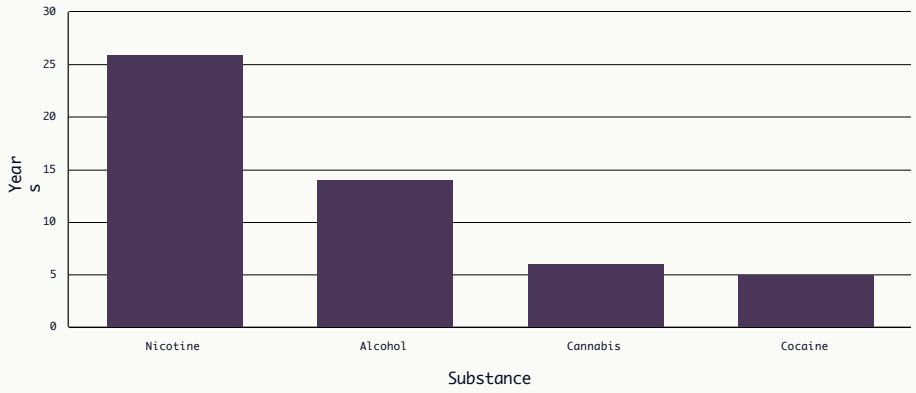
According to the NCS 2001-2003, 83% of people who were previously diagnosed with a substance use disorder achieved remission for at least a year. Most stopped using prior to age 30 and did not recieve any professional help.

Lifetime Cumulative Probability Estimate of Remission



2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

Years of use prior to remission in half of all cases



2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

Predictors of Remission

- **Income and other socio-economic factors and employment**
  For nicotine- income lower than $20K were less likely to remit than individuals with incomes $70K or more
- **CoMorbid psychiatric diagnosis**
  - No association for anxiety and mood disorders
  - Conduct disorder increased probability of remission from cannabis and cocaine and decreased for alcohol
  - A PD decreased probability of remission from alcohol or cannabis
- **Race or ethnicity**
  Discrimination and lower levels of social capital seen in communities of visible minorities decrease rates of remission
- **Age**
- **Health**
- **Gender**
  Women are more likely to remit and tend to experiences worse physical, mental, and social consquences from substasnce use

2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

True or False?

teens are more at risk for abusing substances

Adolescence

- ages 12-18
- Extended adolescence 18-24
- marked by unique developmental factors

  Necessary to move to next development phase. Allows for disconnection from parental connection in the establishment of individual identity and autonomy.

Characteristics of Psychological Development in Adolescence

Identity formation

Adolescents explore their sense of self and values, struggling with questions of 'who am I?'

Risk-taking behavior

Increased propensity for risky activities due to heightened sensation-seeking and impulsivity.

Peer influence

Strong desire for acceptance and belonging within peer groups can lead to risky behaviors.

Emotional instability

Mood swings and intense emotions are common as self-regulation skills develop.

Adolescence is a critical period of physical, cognitive, and psychosocial changes that shape identity and future behaviors.

Characteristics of Cognitive Development in Adolescence

higher order reasoning

During development there is increased ability to plan, problem solve and make decisions.

Cognitive flexibility and abstract thinking

Adolescents develop the ability to think more abstractly and consider multiple perspectives, which can influence their understanding of addiction and its consequences.

working memory

Encoding and maintenance performance stabilizes by late adolescence, but performance on more complex working memory tasks, such as those involving distraction or manipulation of stimuli in memory, have shown to continue to develop during adolescence.

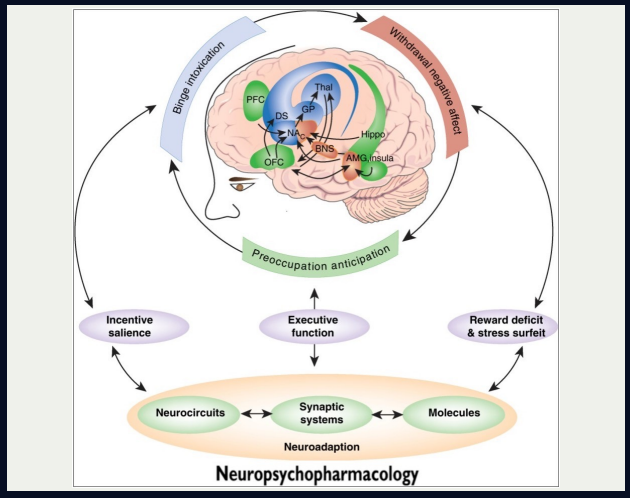
Understanding the cognitive and psychosocial changes during adolescence is crucial for developing effective intervention strategies to address and prevent addictions in this vulnerable population.

Erikson's Psychosocial Stages

Stage	Basic Conflict	Virtue	Description
Infancy (0-1 year)	Trust vs. mistrust	Hope	Trust (or mistrust) that basic needs, such as nourishment and affection will be met.
Early Childhood (1-3 years)	Autonomy vs. shame/doubt	Will	Develop a sense of independence in many tasks.
Play Age (3-6 years)	Initiative vs. guilt	Purpose	Take initiative on some activities - may develop guilt when unsuccessful or boundaries overstepped.
School Age (7-11 years)	Industry vs. inferiority	Competence	Develop self-confidence in abilities when competent, or sense of inferiority when not.
Adolescence (12-18 years)	Identity vs. confusion	Fidelity	Experiment with and develop identity and roles.
Early Adulthood (19-29 years)	Intimacy vs. isolation	Love	Establish intimacy and relationships with others.
Middle Age (30-64 years)	Generativity vs. stagnation	Care	Contribute to society and be part of a family.
Old age (65 onward)	Integrity vs. despair	Wisdom	Assess and make sense of life and meaning of contributions.

True or False?

Addictions are simply a choice



False!

The disease model of addictions has provided evidence of the impact of substances on the brain and the creation of the addiction cycle. Considering addictions as simply a choice undermines the impact on the brain.

Neuropsychopharmacology (2014) **39**, 254–262; doi:10.1038/npp.2013.261

Dopamine

- Increase extracellular dopamine concentrations in the limbic region
- Stimulants directly increase dopamine in synaptic space
- Other substances work directly or indirectly to modulate dopamine cell firing
- Increases motivation to seek substance

True or False?

once an addict, always an addict

Alcohol

- Central nervous system depressant
- Initial: Relief of anxiety, increased talkativeness, feelings of confidence and euphoria, and enhanced assertiveness
- Medical complications
- Skeletal fragility and damage to tissue such as brain, liver, and heart

- Alcohol is a neurotoxin
- Associated with atrophy of the cerebral cortex, reduced white matter volume, enlarged ventricles, and atrophy of subcortical structures
- Cognitive deficiencies with both white and grey matter abnormalities
- Frontal lobes, limbic system, and cerebellum particularly vulnerable to chronic alcohol abuse
- Alcoholic dementia
- Korsakoff's syndrome

Cannabis

- Acute effects: hallucinatory and reactive emotional states, some pleasant, some unpleasant and even terrifying; time disorientation; and recent-transient- memory loss
- Likely no permanent neurotoxic effects
- Impact on neurodevelopment: changes in adult brain circuits after heavy cannabis consumption during adolescence, leading to impaired emotional and cognitive performance and potentially representing a risk factor for developing schizophrenia

Cocaine

- Disrupts the functional integrity of the brain's reward centres
- Abnormal metabolism and hypoperfusion even after sustained abstinence- slowed mental processing, memory impairments, reduced mental flexibility

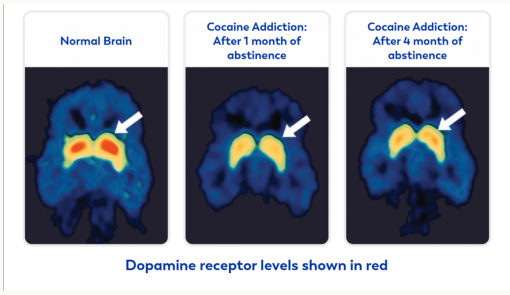
Opiates

Long- term uses can sustain permanent cognitive impairments- attention, concentration, various aspects of memory and learning, and visuospatial and visuomotor activities

Methamphetamine

- Paranoid psychotic episodes with vivid hallucinations, both auditory and visual, and vulnerability to psychotic relapses
- Damage to dopaminergic and serotonergic terminals
- Cognitive impairments- attention, memory, executive functions

Dopamine recovery



True or False?

everyone with an addiction has trauma

False!

Individuals directly exposed to potentially traumatic life events are more at risk (2.5 times more likely to have an addiction)

Co-occurrence of PTSD ~ 25-42%

Co-occurrence childhood sexual or physical abuse ~ 50%

Correlation NOT causation

Trauma and Stress-Related Disorders in DSM-5

Post-Traumatic Stress Disorder (PTSD)
Exposure to actual or threatened death, serious injury, or sexual violence, leading to intrusive symptoms, avoidance, negative alterations in cognition and mood, and heightened arousal.

Acute Stress Disorder
Temporary but severe anxiety, dissociative, and other symptoms occurring within one month after a traumatic event.

Adjustment Disorders
Emotional or behavioral symptoms in response to an identifiable stressor, occurring within three months of the stressor.

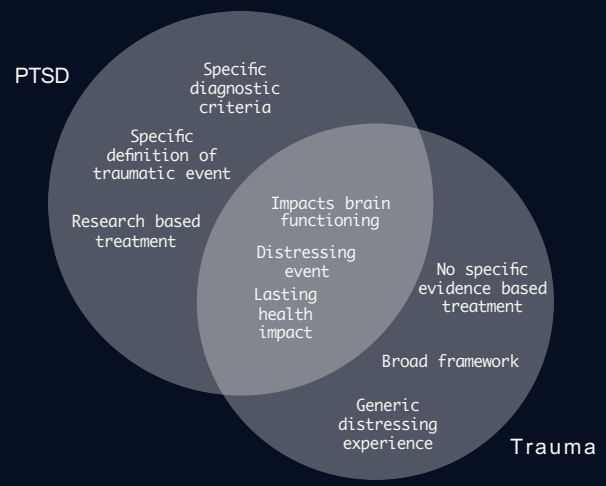
Reactive Attachment Disorder
Failure to form healthy attachments with caregivers in early childhood due to neglect or abuse.

Other Specified Trauma- and Stressor- related disorder
Symptoms do not meet criteria for other diagnosis in category but are due to a stressor. Provide specifics such as PTSD like symptoms

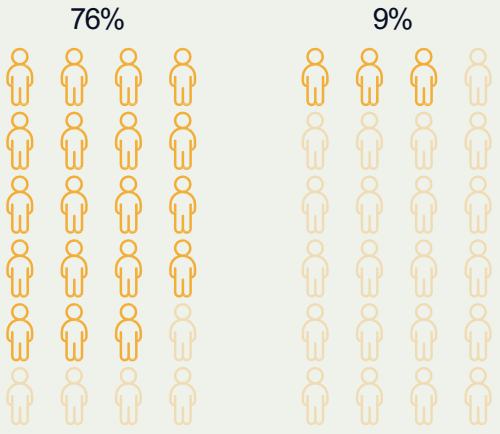
Unspecified trauma-and stressor-related disorder
Typically used in an emergency room when a proper diagnosis cannot be obtained

T(t)rauma

Trauma - exposure to a distressing or stressful event resulting in physiological, emotional and/or psychological changes



How prevalent is PTSD?



Source: Canadian Psychological Association

What is PTSD?

- **Severe psychological trauma**
  Exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence,
- **Persistent Reexperiencing**
  Recurrent and distressing recollections, flashbacks, or nightmares about the traumatic event. Can be dissociation, depersonalization or derealization
- **Avoidance**
  Efforts to avoid thoughts, feelings, people, places, or activities associated with the trauma.
- **Negative changes in thoughts and mood**
  Persistent negative beliefs about oneself, others, or the world, and disturbed emotional state.
- **Hyperarousal**
  Exaggerated startle response, irritability, difficulty concentrating, and sleep disturbances.

Cognitive behavioural Theory of PTSD

Learning theories

Fear condition of the traumatic event (i.e. memories) leads to flashbacks and reminders of the event make the memory reoccur

Maladaptive cognitive appraisals

Negative beliefs about themselves, the world, and the future, leading to distorted perceptions and exaggerated threat appraisals such as "I am worthless"

stress response theory

The traumatic event is compatible with current schemas causing the emergence of psychological defense mechanisms.

The cognitive model provides a framework for understanding how our thought processes and interpretations contribute to the development and maintenance of PTSD symptoms.

Information Processing Theories of PTSD

fear network

Coined by Peter Lang, fear networks contain the integration of emotions and cognitions which enable a survival response

Continual activation

Fear networks are continually active for those with PTSD leading to continual "survival mode."

Memory significance

Traumatic memories are unique from daily life causing fragmentation of the fear network and require reintegration

Information that is not processed properly, causes psychological harm

Theories of the Multiple Memory System of PTSD

multiple memory systems

More memory systems than episodic and function differently

Dual representation theory

Two parallel memory systems: contextual memory and sensory memory. Traumatic memories are encoded pathologically in which S-mem is enhanced and C-mem is weakened.

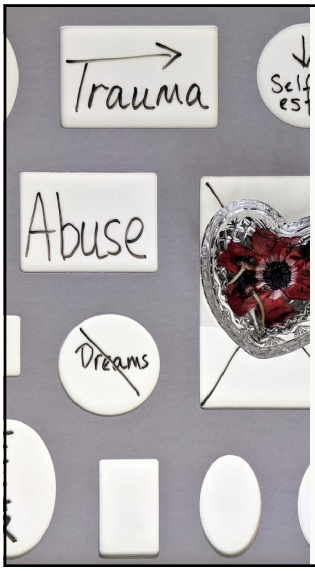
flashbacks

Partially processed sensory and perceptual information is stored in the S-mem hence why the retrieval of traumatic memory is visual and triggered by situational cues.

Disturbance in normal memory functioning causes ptsd symptoms

Brain and PTSD

Hippocampus and Memory	Amygdala and Fear Response	Prefrontal Cortex and Emotional Regulation
The hippocampus, a region crucial for memory formation and retrieval, can be affected by trauma. Individuals with PTSD may exhibit decreased hippocampal volume, which can impact their ability to process and store memories.	The amygdala, responsible for processing fear and emotional responses, may become hyperactive in individuals with PTSD. This can lead to heightened anxiety, hypervigilance, and an exaggerated startle response.	Trauma can impact the prefrontal cortex, which plays a role in emotional regulation, decision-making, and impulse control. Individuals with PTSD may have difficulty regulating their emotions and managing their behaviors.



What is CPTSD?

Considered a separate diagnosis by the World Health Organization and included in the ICD-11

Contains all the symptoms of PTSD with the unique symptomatology of disturbances of self-organization (DSO)

Currently not accepted by the American Psychiatric Association as a separate disorder from PTSD

Disturbances of Self- Self-Organization

Affect dysregulation

Impaired ability to regulate and/or tolerate negative emotional states

Negative self-concept

A person's overall perception and evaluation of themselves is critical

Disturbances in relationship

Difficulty navigating interpersonal relationships or demonstrating perspective taking

Characteristics

Repetitive trauma

Prolonged or repetitive events from which escape is difficult or impossible

Personality changes

- Inflexible and maladaptive features
- Hostile or mistrustful attitude toward the world
- Difficulty creating social bonds

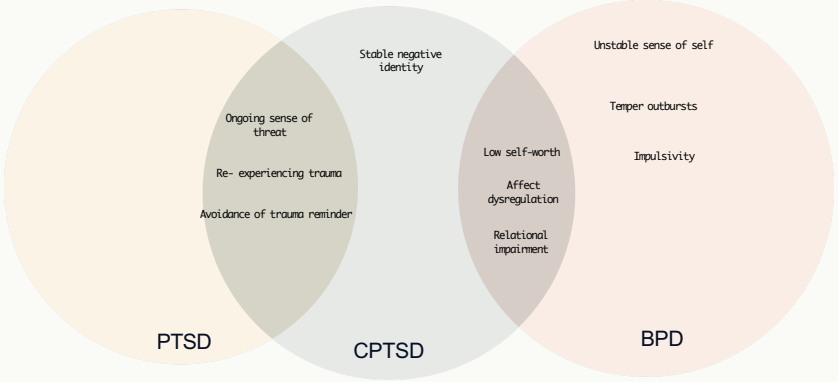
Include PTSD symptoms

- Re-experiencing in the present
- Avoidance
- Ongoing sense of threat

Developmental Impacts

CPTSD is not simply a more serious form of PTSD. Due to the prolonged nature inherent in the traumatic events, cognitive schemas and brain development is impacted in a unique way.

Differential Diagnosis



Childhood Development and Trauma

Early childhood experiences shape development

Traumatic events during formative years can have profound and lasting impacts on mental health and well-being.

schema development

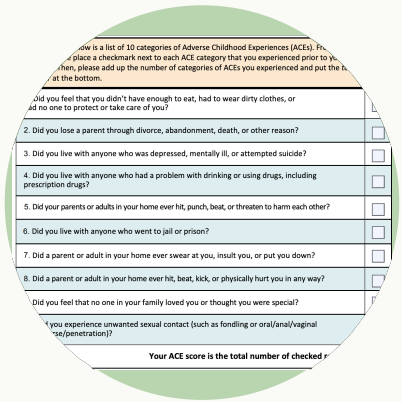
Early experiences shape how children form mental representations and conceptual frameworks.

low-grade inflammation

Childhood abuse was associated with low-grade inflammation. Chronic inflammation has been established as the overlying mechanism demonstrating how the immune system contributes to disease development.

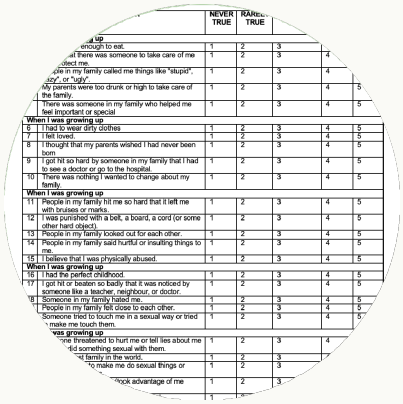
Understanding the implications of stress on childhood development is crucial for providing appropriate support and interventions.

Adverse Childhood Experiences Questionaire



- 10 question assessment of childhood experiences
- Connected to increased risk for poor health outcomes in adulthood
- Not a screening tool for trauma - opens a conversation about impacts of early childhood experiences
- Debated in research as a valid measuring tool
- ACEs are considered "common"
- 67% of sample population scored at least one, 20% scored above 3 (CDC 2021)

Childhood Trauma Questionaire



- 70 item likhert scale questionnaire (Short form -28 questions)
- Measures emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect.
- Peer reviewed evidence of validity and reliability
- Highly sensitive to identifying individuals with verified histories
- Published by Pearson

Lasting Impacts of Childhood Trauma

Poor Stress Reponse

Reduced ability to return to baseline physiological and psychological states after facing acute stress.

Executive dysfunction

Reduced ability to control and coordinate thoughts and behaviour caused by alterations in connectivity in the brain.

Maladaptive personality characteristics

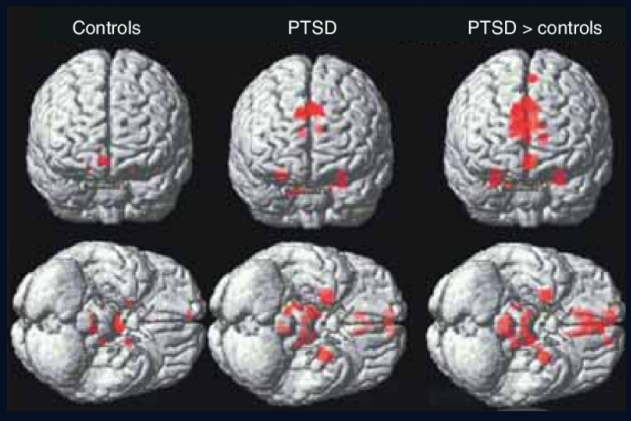
Higher risk for anxiety and depression as well as neuroticism and negative self-associations.

Brain alterations

Reduced medical prefrontal cortex volume and increased amygdala reactivity.

.

Childhood trauma can have profound and lasting impacts on brain structure, function, and emotional well-being, highlighting the importance of early intervention and support.



MRI: Functional magnetic resonance imaging; PTSD: Post-traumatic stress disorder
Reproduced from [57].

Role of Amygdala

"Attentional bias for trauma-specific reminders, for trauma-exposed participants, reflected by an increase in functional activity in visual, sensory, memory, and attention related area" (Nilsen et al., 2016)

True or False?

Addictions needs to be considered as a complex dynamic between various factors

True!

biological
- Addiction cycle
- Genetics
- Cascade model
- Impact of trauma and development

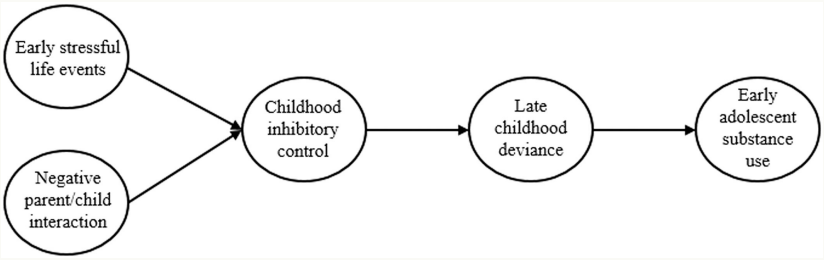
psychological
- Learned helplessness
- Attachment
- Emotional regulation
- Co-morbid psychiatric diagnoses
- Conditioned behaivior
- Self-efficacy

social
- Social learning theory
- Social dislocation
- Social disparity

spiritual (meaning)
- Motivation for sobriety
- Salutogenesis
- Feeling of being alive
- Self-awarness

Biological

Cascade Model

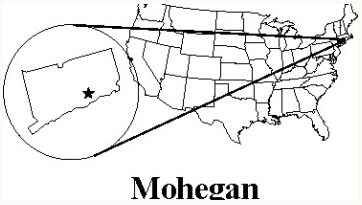


Attachment

- Early childhood experiences and insecure attachments – Interrelated risk factors for addictions
- Bowlby's internal working model
- Self- Medication theory of addictions
- "Significant positive association between insecure attachment (anxious and avoidant) and a more intensive and dysfunctional use of the internet and social media"

Social Learning Theory

Social Dislocation



Dislocation - lack of attachment, belonging, identity, meaning, [and] purpose

Social Disparity

- Poverty
- Lack of mental health resources
- Housing
- Increased stress

Psychological

Addiction and ADHD

- Etiology
- Genetic – 0.8 heritability estimate
- Environment- Risk factors smoking during pregnancy, premature birth, low birth weight
- Medications that inhibit the dopamine transporter increase synaptic dopamine levels and ameliorate the symptoms of ADHD
- Reduced volume prefrontal cortex
- Effects 8%-18% of children and adolescents
- 60% continue to show symptoms into adulthood (4.4%)

Addiction and ADHD

- When combined with SUD, severity of impairment increases
- More likely to move to another DOC after a period of sobriety
- Longer duration of having a substance use disorder and a slower remission rate
- Poor emotional regulation and rejection sensitive disphoria

Mood Disorders and Addiction

- Major Depressive Disorder most common – 15% to 50% lifetime prevalence rate
- MDD linked to worse outcomes in addiction treatment
- Bipolar Disorder - 1%-3%
- Largest strength of association between addiction and Bipolar, increase likelihood of addiction by four

Anxiety Disorders and Addiction

- High comorbid relationship between alcohol and anxiety
- Overlap of symptoms between disorders makes it difficult to know rates of prevalence

NESARC study – 50% of those with lifetime GAD had a lifetime comorbid SUD

Psychotic Disorders and Addiction

- Transient substance-induced psychotic symptoms are not uncommon
- One month of abstinence needed to make the diagnosis of a primary psychotic disorder
- 47% of persons with schizophrenia have a lifetime experience of SUD

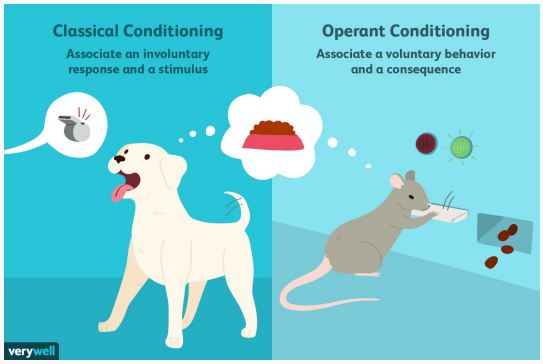
Personality Disorders and Addiction

- Usually experiences the PD as ego-syntonic and externalizes blame for their dysfunction
- Onset of PD typically late adolescence or early adulthood
- Treatment
- Structured environment with dual focus of PD and SUD
- Utilize integrated psychosocial treatments
- Integrated system of care
- Symptom-targeted pharmacotherapy
- Psychosocial interventions

PTSD and Addiction

- In civilian populations- SUD occurs in 21.6% to 43% of individual with PTSD
- Self-medication theory
- Treatment
- Cognitive Therapy
- Exposure therapy (CPT, PE, EMDR, NET)

Conditioned Response



Behavioral Economics

"Behavioral economic theory predicts that the primary contextual influences on drug use are both constraints on access to drugs and the availability and value of alternative substance-free sources of reinforcement"

- Correia et al., 2010

Learned Helplessness

- Patterns of thinking and behavior that are used to interpret
- Maximum neurons at 3 years old
- Pruning for efficiency
- Chronic stress causes excess pruning
- Self-protection and survival
- Narrative therapy and challenging schemas

Motivation

- Intrinsic motivation
- Flow
- External regulation
- Goal
- Value
- Possible Self
- Achievement striving
- Competence
- Opponent process
- Positive affect
- Introjection
- Personal control
- Relatedness

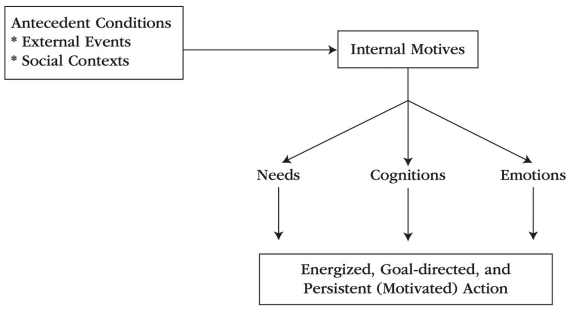


Figure 1.2 Three Categories of Internal Motives

Johnmarshall Reeve. Understanding Motivation and Emotion, 7th Edition (p. 3). Wiley. Kindle Edition.

Table 14.1 The Motivational Urge (Action Tendency) Associated with 17 Emotions

Individual Emotion	Motivational Urge or Action Tendency
Fear	Flee; protect oneself.
Anger	Overcome obstacles; right an illegitimate wrong.
Disgust	Reject; get rid of; get away from.
Contempt	Maintain the social hierarchy.
Sadness	Repair a loss or failure.
Joy	Continue one's goal striving; play; engage in social interaction.
Interest	Explore; seek; acquire new information; learn.
Pride (Authentic)	Acquire further skill; persist at challenging tasks.
Shame	Restore the self; protect the self.
Guilt	Make amends.
Embarrassment	Appease others; communicate blunder was unintended.
Envy (Benign)	Move up; improve one's position.
Gratitude	Act prosocially; grow the relationship.
Regret	Undo a poor decision or behavior.
Hope	Keep engaged in the pursuit of a desired goal.
Empathy	Act prosocially; help the other.
Compassion	Reduce suffering.

Johnmarshall Reeve. Understanding Motivation and Emotion, 7th Edition (p. 3). Wiley. Kindle Edition.

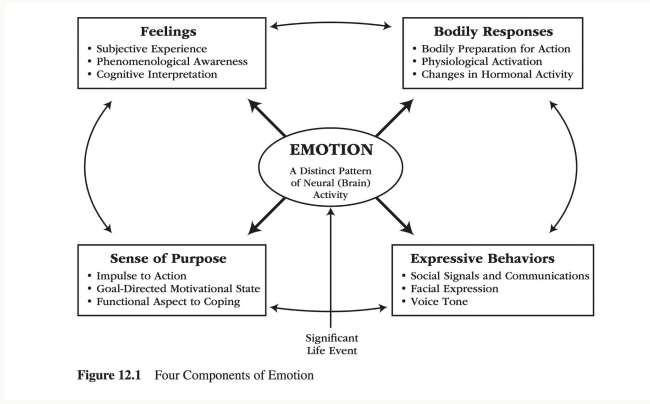


Figure 12.1 Four Components of Emotion

Johnmarshall Reeve. Understanding Motivation and Emotion, 7th Edition (p. 3). Wiley. Kindle Edition.

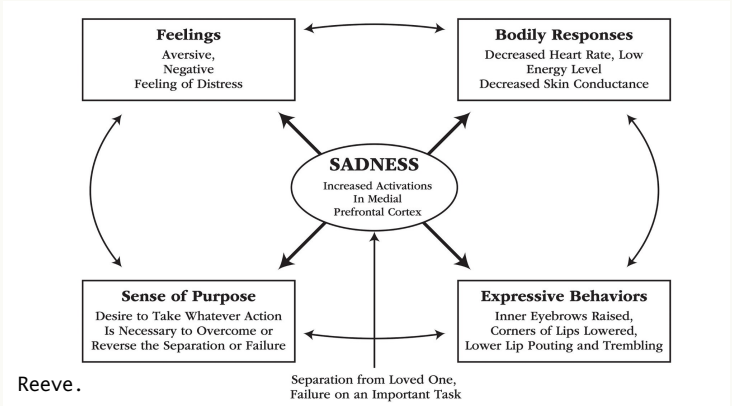


Figure 12.2 Four Components of Sadness

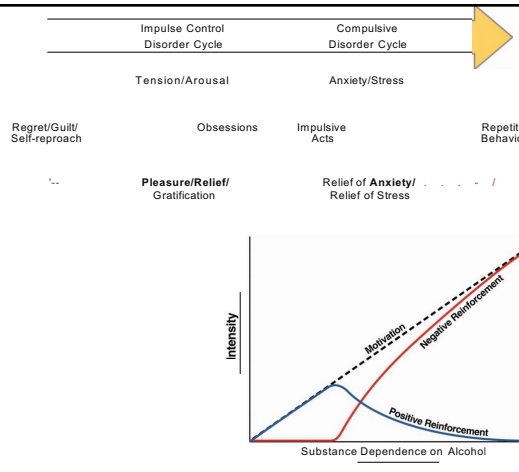
Johnmarshall Reeve. Understanding Motivation and Emotion, 7th Edition (p. 3). Wiley. Kindle Edition.

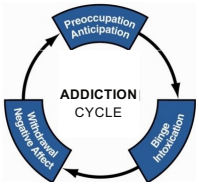
Emotional Intelligence

- Ability to identify and communicate emotional experiences
- Ability to connect specific mental experiences with situations and behaviors
- Ability to self-regulate negative emotional states
- Ability to monitor future behavior from prior feelings and emotions

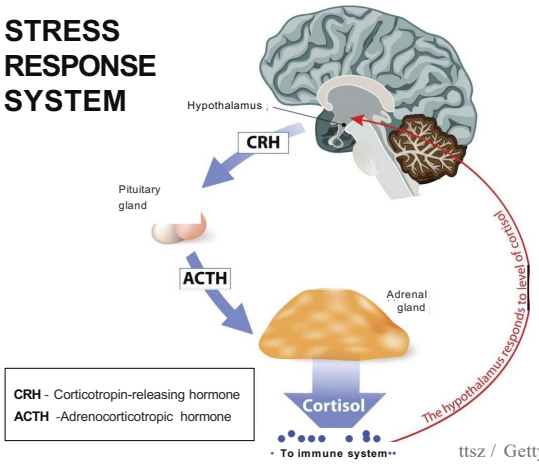
- Difficulty identifying feelings and distinguishing between these feelings and bodily sensations of emotional arousal
- Difficulty describing feelings
- Constricted imaginal processes
- Externally oriented cognitive style

- “Anything which causes an alteration of psychological homeostatic processes”
- Brain responses to chronic stress
- Stress management and learned behaviour





Kwako LE, Koob GF. Neuroclinical Framework for the Role of Stress in Addiction. *Chronic Stress.* 2017;1



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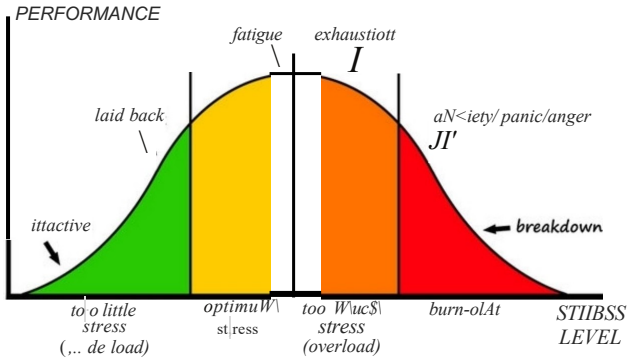


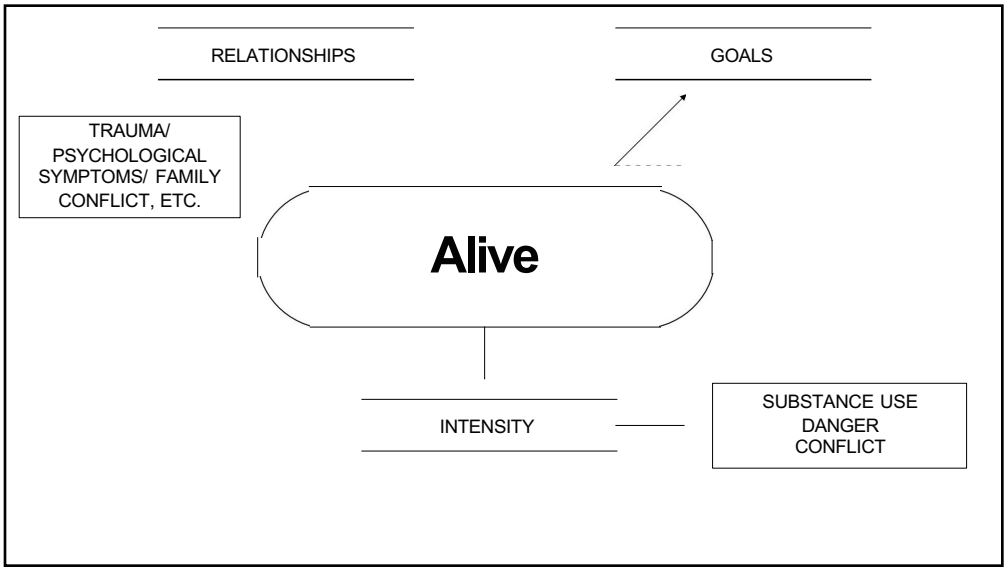
Meaning

Addiction as a Response

"Such widespread phenomena as depression, aggression and addiction are not understandable unless we recognize the existential vacuum underlying them."

"When a person can't find a deep sense of meaning, they distract themselves with pleasure."

– Viktor E. Frankl



Developing Meaning

- Acceptance of suffering
- Self- awareness
- Relationships
- Intrinsic goals

"If there is meaning in life at all, then there must be meaning in suffering."

-Viktor Frankl

"...the individual is defined only by his relationship to the world and to other individuals; he exists only by transcending himself, and his freedom can be achieved only through the freedom of others. He justifies his existence by a movement which, like freedom, springs from his heart but which leads outside of himself."

- Simone de Beauvoir, 1948, *The Ethics Of Ambiguity*, p. 156

"In order to live a meaningful life,humans need answers, i.e., a certain understanding of basic existential questions. These 'answers' do not have to be made completely explicit, as a lack of words does not necessarily indicate a lack of understanding, but one has to able to place oneself in the world and build a relatively stable identity. The founding of such an identity is only possible if one can tell a relatively coherent story about who one has been and who one intends to be."

"People have two basic concerns: One is to survive; one is to exist. The former only asks to go on living; the latter asks for meaning. The former concerns itself with how to live, the latter with why to live, the meaning of living.

- Xuefu Wang, 2019, The Symbol of the Iron House: From Survivalism to Existentialism. In *Existential Psychology East-West* (Vol. 2), p. 7.

"Personal meaning is defined as feelings of satisfaction and fulfillment that flow from the pursuit of worthwhile activities and life goals"

- Dr. Paul Wong

"The existential vacuum manifests itself mainly in a state of boredom. now we can understand Schopenhauer when he said that mankind was apparently doomed to vacillate eternally between the two extremes of distress and boredom. In actual fact, boredom is now causing, and certainly bringing to psychiatrists, more problems to solve than distress."

- Viktor Frankl

Assessment

Structured Interview

- Background
- Childhood- medical issues, traumatic events, relationship with family
- Education- primary and secondary school, social connections, academic performance, any difficulties
- Employment- patterns of length of employment
- Psychiatric history- medications, diagnosis, treatment
- Substance use history
- Current
- Psychological symptoms- MSE presentation

Mini- Mental Status Exam

https://cgatoolkit.ca/Uploads/ContentDocuments/MMSE.pdf

ADHD Screening Tools

- Wender Utah Rating Scale
- Conners Adult ADHD Rating Scale
- Adult ADHD Self- Report Scale version 1.1

PTSD Screening Tools

- PCL-5
- PC-PTSD-5

Depression Screening Tool

- Patient Health Questionnaire (PHQ-9)
- Beck's Depression Inventory (8D1-2)

Anxiety Screening Tool

- General Anxiety Disorder (GAD-7)
- Beck Anxiety Inventory (BAI)

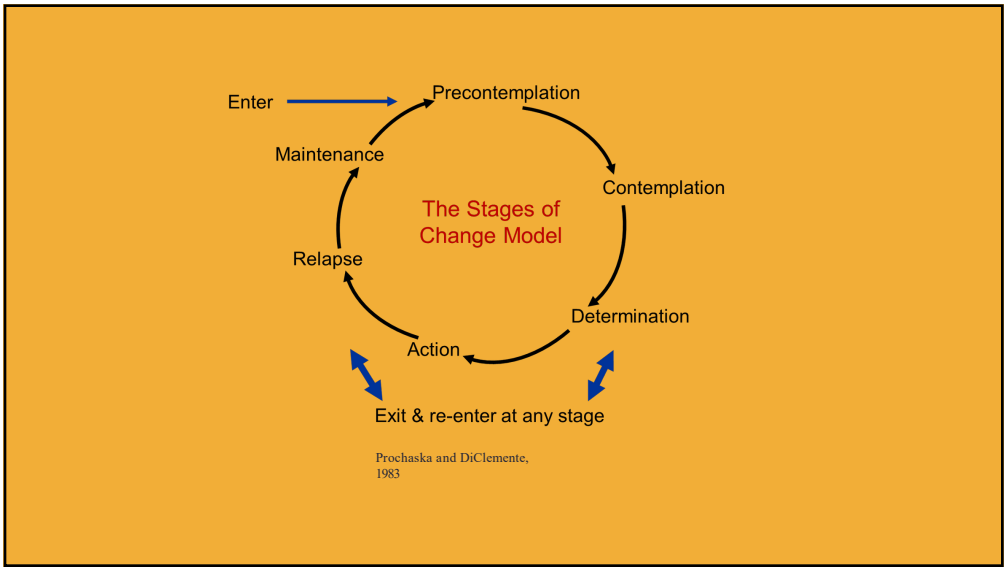
Psychometric Tools

- AUDIT
- CIWA
- SCID-5
- TAPS
- NIAAA (Youth)
- CRAFFT (Youth)

Key Factors

- Impact on daily life activities
- Contributing factors to compulsion to consume
- Attempts to stop

Treatment



Inpatient Treatment

- Concentrated therapeutic interventions
- Behavioral monitoring
- Interpersonal focus
- Interdisciplinary approach
- Multifaceted approach
- Time removed from substance to allow for biological stabilization
- Reduced exposure to stressors to reduce cravings

Post Inpatient Treatment Care

Behavioural Pattern

Stress Management

Difficult Relationships

Ongoing Care

Community support groups

Monitoring and testing

Cravings and Triggers

Awareness of self

Community Support Groups

SMART Recovery	Recovery Dharma	Alcoholics Anonymous

Working With Low Motivation

- Resistance
- Mapping effects of the issue
- What does the substance provide you?
- Discovering intrinsic motivation

Therapeutic Interventions

1. **Understanding**

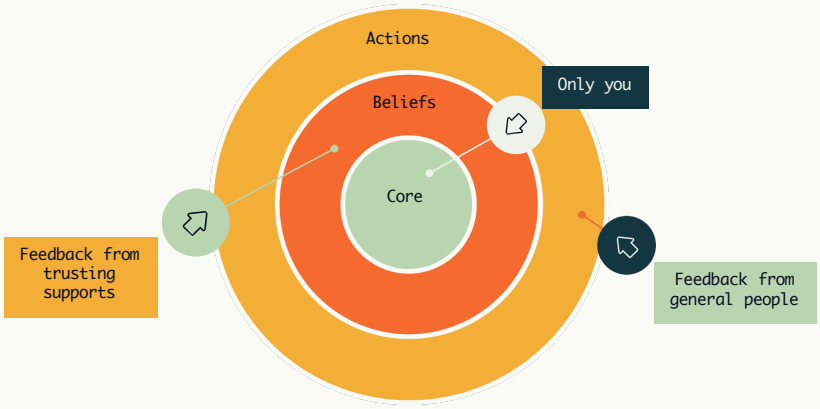
- What does the substance provide?
- How does the client understand their substance use?
- Identifying thought distortions Goal: understand the client's narrative, cognitive schemas, and relationship with their substance

Therapeutic Interventions

1. **Shifting**

- Creating alternative stories
- Challenging schemas
- CBT thought records
- Amplified reflection (Motivational interviewing)
- Reframing

Core, Beliefs and Actions



Therapeutic Interventions

1. **Developing a "New Normal"**

- What gets you out of bed in the morning?
- What do you want to live for?

Working with Families Impacted by Addictions

Family Systems

- Interdependent
- Healthy Dependence
- Myth of Codependence
- Family Disorder

Family Impact

Increased time in recovery

More beneficial than not

No cultural differences

Autonomy

Communication

Living System

Tools for Families

1 Most relapses happen r-2 weeks before substance is consumed

2 Act as a mirror

3 Compassion and empathy provide hope

4 Support, don't enable

5 Respect atitonomy

Boundaries

- Think about yourself first
- Aligh with your values
- Focus on relationship health
- Not about control

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Healthy **Communication**

- Be purposeful with non-verbals
- Remember the objectives of the conversation
- Use "I feel" statements
- Listen more than you talk
- Respond to feelings with empathy
- Stay caln1

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Barriers

Jcan't nlakc then, nlake good choices

They can't do it without me

I anl exhausted crying co fix it

I need a guarantee

If I do _____, then they will be safe

This is the way it has always been done

It is hopeless, they will never change

Solutions

Focus only on what you can control

Practice healthy boundaries - not enabling

ever do more than 50% of the work

Practice healthy self care

Respect your loved one's autonomy

Do vvhat is healthy, not what is con,fortable

You have an impact

Working with Families

Small changes ınalce a difference

Maintain boundaries

watch for maniptllation

Encourage healthy communication

Provide hope of impact

Don't enable

De-escalation

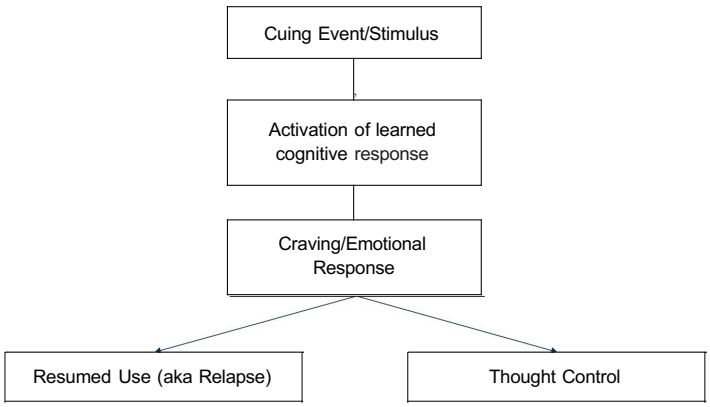
Focus on needs | Remember the objective | Deep breaths | Don't take it personally | Empathize

Biological

- Massage
- Healthy Touch
- Pharmaceutical interventions
- Time for stabilization

Choice Theory

- Encourage non-drug choices
- Take better advantage of current resources



Feedback-Informed Treatment

- Evidenced based approach to assess and adapt to client's feedback in real time in order to improve session outcomes
- Based on common factor model of psychotherapy

Common Factors

Catharsis

Trust

Positive relationship

Empathy

Therapeutic alliance

Feedback

Reframing

Reality testing

Lambert, 2013

Common Factors

1. Real relationship
2. Creation of expectations through explanation of disorder and the treatment involved
3. The enactment of health promoting actions

Wampold, 2015

Session Rating Scale

ame: _____ Age (Yrs): _____ Sex: M/F

Session#: _____ Date: _____

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

Relationship

I did not feel heard, understood, and respected. — 1----------I — 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. — 1----------I — 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. — 1----------I — The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. — I----------1 — Overall, today's session was right for me.

International Center for Clinical Excellence

Source: www.centerforclinicalexcellence.com

Outcome Rating Scale

Name: _____ Age (Yrs): _____ Sex: M/F

Session #: _____ Date: _____

Who is filling out this form? Please check one: Self _____ Other ____

If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Incliviclually
(Personal well-being)
|----------1

Interpersonaliy
(Family, close relationships)
|----------1

Socially
(Work, school, friendships)
1----------|

Overall
(General sense of well-being)
1----------|

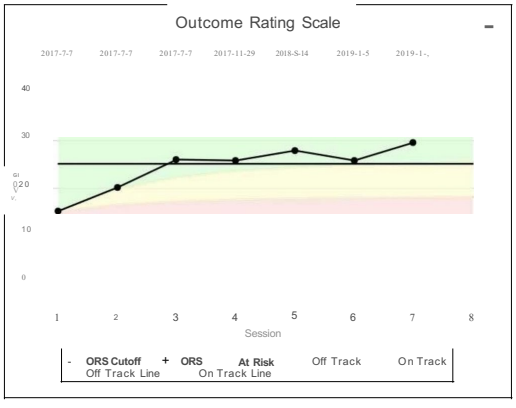
International Center tor Clinical Excellence

Source: www.centerforclinicalexcellence.com

Outcome Rating Scale

ORS Feedback: Outcome Rating Scale

Measure	Score
Individually	7.5 out or 10
Inrerpersonelly	7.4 out 0110
Socially	7.3 out or 10
Overall	7.3 out ol 10
Total Score	**29.5 out of 40**



PTSD Treatment Options

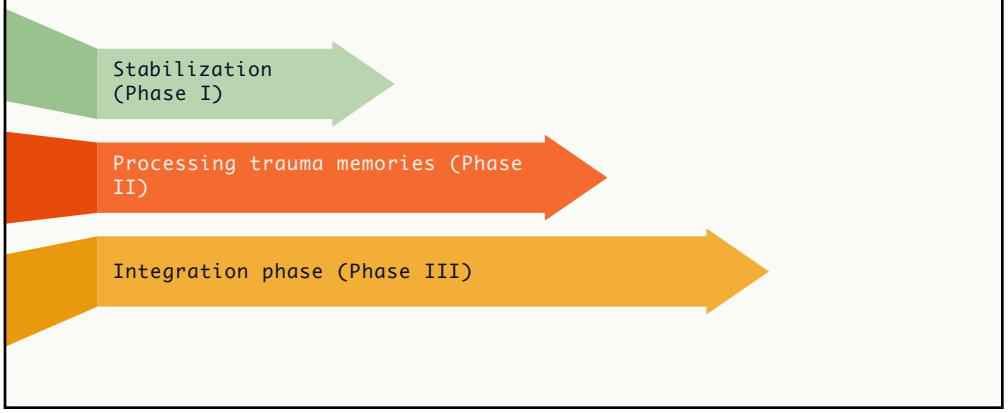
- **Cognitive Processing Therapy (CPT)**
  A trauma-focused cognitive behavioral therapy that helps individuals modify unhelpful beliefs related to their traumatic experience and develop more adaptive ways of coping.
- **Prolonged Exposure Therapy (PE)**
  A type of cognitive-behavioral therapy that gradually exposes individuals to memories and situations related to their trauma in a safe and controlled environment, with the goal of reducing fear and anxiety.
- **Eye Movement Desensitization and Reprocessing (EMDR)**
  Exposure and relaxation. Bilateral stimulation has been evidenced to be ineffective but treatment still beneficial
- **Medication Management**
  Various medications, such as selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs), can help alleviate symptoms of PTSD, such as anxiety, depression, and sleep disturbances.
- **Group Therapy**
  Participating in group therapy sessions with others who have experienced trauma can provide social support, validation, and opportunities to learn coping strategies.
- **Mindfulness-Based Interventions**
  Practices such as mindfulness meditation, yoga, and deep breathing exercises can help individuals develop greater awareness, acceptance, and regulation of their thoughts, feelings, and physical sensations related to PTSD.

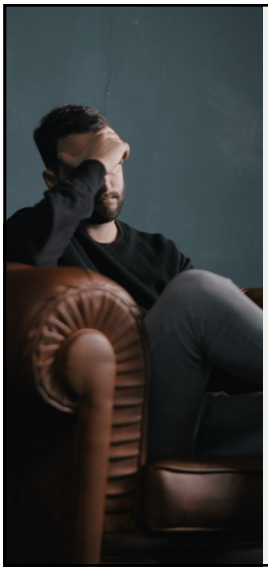
Posttraumatic Growth

- Move beyond happiness
- Suffering as needed for growth
- Resiliency
- Vulnerability and flourishing
- Transforming suffering to flourishing

Phased Treatment

Current Guidelines for CPTSD recommends phased treatment though this is debated





Phase I

- Aimed at ensuring the individual's safety by reducing self-regulation problems and improving distress tolerance and social competencies.
- Increased by in and therapeutic alliance for dropout prone clients
- DBT- PTSD

Phase II

- Prolonged exposure therapy
- EMDR
- CPT
- NET
- CT-PTSD

Phase III

- Consolidates treatment gains
- Adapt to current life circumstances

Emotional Regulation Skills

- Create emotionally safe environments
- Non-judgmental approach
- Teach skills
- Self-talk, taking a break, catharsis, breathing
- Normalize

Building Self-Awareness

Mindfulness

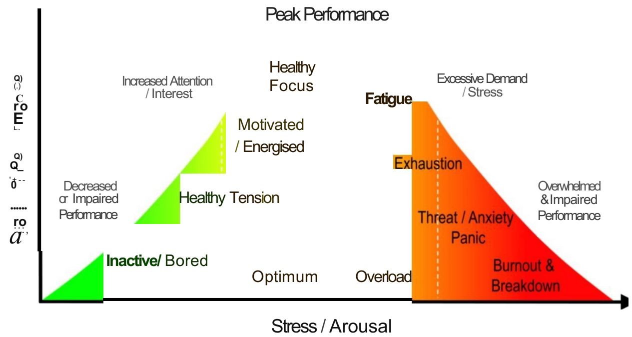
HANDOUTS

LABELING Ef ıı duNS

- Start by sitting comfortably, eyes either closed or partially open. Take a few deep breaths, or if you prefer, bring your attention to cbc sounds around you.
- Spend a few moments connecting with your anchor. When you arc taken away by an emotion, note what the emotion is. With an attitude of warmth and acceptance, label the emotion. For example, note, "worry, worry, worry." Don't obsess about gcccing the label exactly right. It doesn't need to be precise co be effective.
- See where you find chis emotion an your body. Allow yourself to simply' be with it.
- Notice the attitude you bring to this practice. Arc you yelling at yourself when you notice "anger, anger, anger"? Are you telling yourself chat you're a bad person for having this emotion? Sec if you can label with kindness, warmth, and acceptance.
- If the emotion becomes too intense aucl you start to gee overwhdmecl or lost in it, simply return to your anchor.
- There *is* no need to hold on to or analyze the emotion. Let it rise and fall away. No need to go into che history or story bch.ind the emotion either. Label it and let it go.
- Label the emotions with as much warmth and kindness as possible. If you feel that negative emotions don't deserve kindness, label chis as wdl. Be open to pleasant emotions and labd chem too.
- Continue to alternate between labding che emotions and grounding with your anchor. When you're ready, rake a few deep breaths, wiggle your fingers and toes, screech, and open yolu eyes if they have been closed. Try to continue to be aware of your emotional reactions as you move into your next activity.

Building Self-Awareness

Stress Curve



Thought Record Sheet - 7 column

Situation / Trigger	Feelings Emotions - (Rate 0-100%) Body sensations	Unhelpful Thoughts/ Images	Facts that [redacted] the unhelpful thought	Facts that provide evidence [redacted] thought	Alternative, more realistic and balanced perspective	Outcome Re-rate emotion
What happened? Where? When? Who with? How?	What emotion did I feel at that time? What else? How intense was it? What did I notice in my body? Where did I feel it?	What went through my mind? What disturbed me? What did those thoughts/images/memories mean to me, or say about me or the situation? What am I responding to? What 'button' is this pressing for me? What would be the worst thing about that, or that could happen?	What are the facts? What facts do I have that the unhelpful thoughts are totally true?	What facts do I have that the unhelpful thoughts are NOT totally true? Is it possible that this is opinion, rather than fact? What have others said about this?	STOPP! Take a breath. What would someone else say about this situation? What's the bigger picture? Is there another way of seeing it? What advice would I give someone else? Is my reaction in proportion to the actual event? Is this really as important as it seems?	What am I feeling now? (0-100%) What could I do differently? What would be more effective? Do what works! Act wisely. What will be most helpful for me or the situation? What will the consequences be?

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Group Therapy

- Cutting off
- Drawing out
- Deepening
-

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Resources

Presentation PDF

Family Videos

Family Resources

Thank you!

Questions?