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Seeking safety a treatment manual for ptsd and substance abuse ebook. Seeking safety a treatment manual for ptsd and substance abuse (the guilford substance abuse series). Seeking safety a treatment manual for ptsd and substance abuse pdf.

JIKI NKKKI, DKKKKI, DKKKKI, DKKKK. "This reference volume presents a cutting-edge approach to the treatment of patients who depend on drugs to soothe PTSD pain. In surprising details, the najavits show how the same therapist can treat both conditions simultaneously. His Kinder and The most delicate approach is a welcome change from traditional conflict interventions. The volume is enriched by its empathy and wisdom. All therapists trying to help these patients should have this book to guide them. "- Aaron T. Beck, MD, university professor of psychiatry, University of Pennsylvania "Fabulous! This processing manual provides practical procedures, clearly described for the treatment of an extremely difficult customer group. The organization of treatment is superb. From my perspective, the most important parts of a complete treatment are here - Attention To the safety of the customer, the targeting of the substance, use simultaneously with PTSD targeting, integrating ideals and values (I love quotes!). A core of cogn Behavioral interventions, a focus on interpersonal relationships and attention to the therapist's needs. Very impressive. Of course written by an experienced clinic. "- Marsha M. Linehan, PhD., Professor of Psychology of the University, University of Washington" Born of experience and energized by passion, this carefully crafted and caring treatment manual will guide doctors through the difficult waters of Substance Abuse and PTSD treatment. Security research will help clinicians decide what to do and how to do it well. As empirically guided treatment manuals begin to emerge in greater number and variable quality, the najavits maintain an essential and elegant balance between a glossy map of indications for treatment, on the one hand, and the complex dynamics of the clinical territory of the other. This is a very important job that I highly recommend for doctors of each strip. "- Howard J. Shaffer, PhD, CAS, director, dependency division, Harvard Medical School" The strength of this manual is its understanding. The book reveals the wide clinical experience of the author working with this population and his passionate ability to apply the basic principles of theCognitive-behavioral and interpersonal in ways that are concrete and practical fill a long date gap in the evaluation and treatment of PTSD and substance abuse. The completeness of the Najavits and its commitment to research in progress in this sector are illustrated by its inclusion of A A for patients and therapists who use the handbook to provide input on what worked and what didn't. Psychologists, psychiatrists, social workers and all doctors who conduct therapy with this population will benefit from having this handbook." æ Psychiatric Services Published on: 2002-11-01 " A very impressive volume describing the first treatment for this population which has published empirical validation.... Essentially, what Dr. Najavits provides is a full buffet of skill-based therapy topics with accompaniments. From the 26 topics presented, the therapist can then select which issues are most relevant to a particular client or group of clients....The presentations provided are clear, and generally user friendly for both physicians and clients. There is a fair amount of structure to treatment, but the author continually encourages doctors to customize treatment to their personal style and the constraints of a clinical situation (i.e., time, setting). She is very clear on what is a 'must' in treatment (and why) and what is a guideline. This gives the clinician the structure of a manual as well as the freedom to be a flexible and creative clinician....This treatment manual is an impressive contribution to both substance abuse and PTSD fields, as well as the target comorbid diagnostic arena. It is highly recommended for all doctors." Journal of Cognitive Psychotherapy Published on: 2003-09-01 "The Safety Research Manual is designed to be outpatient-friendly and provides a plethora of patient and therapist information and shipments. Each chapter is easily accessible, including a summary of the session's coping skills, a therapeutic orientation to the topic, ideas for preparing for the session, session content, and examples of hard cases. Also included in every chapter of coping skills are patient materials. These are thought out, adding key points, examples, alternatives and suggestions, and ideas for how to apply the material to everyday life. In the introduction of the protocol, there is a wealth of information on PTSD and substance abuse and a section on what is not part of the treatment (focused trauma work). Therapeutic processes are also addressed throughout the manual with a kind eye to the difficulty of helping people with this dual diagnosis recover. The research security manual is action-oriented, information- and detail-oriented and is also attentive to the emotional pain that brings people undergoing treatment. In short, Seeking Safety has scientific merit, clinical wisdom, provides an excellent philosophy and protocol for the 'time and resource physician' and patients like it!" Journal of Trauma Practice Published On: 2003-08-01 "Given the prevalence of patients with stress disorders (PTSD) and diagnosis of substance abuse and their complex interactions, this volume makes an important and timely contribution. On a huge gap in treatment resources. It provides physicians with an empirically based and well-developed treatment program that allows them to intervene in comorbid SUD and PTSD in an integrated manner....Try a breath of fresh air rising above the often contentious debate over whether cognitive behavioral therapy (CBT) psychodynamic interventions, or 12-step-oriented approaches are the best model Treatment... It is an innovative, flexible and practical program that is adaptable to a variety of treatment settings. Although this handbook is particularly useful for physicians, I highly recommend it as a resource for students and researchers looking to gain a better understanding of the treatment needs of individuals who have concurrent SUDs and PTSDs as well." Criminal Justice Review Published on: 2005-09-01 " This handbook provides a well researched treatment approach developed specifically for the difficult to treat but common double diagnosis of post-traumatic stress disorder and substance abuse. The author gives a lot of himself, his thoughts and past experiences in the preface, including reservations that are not easy answers....the book is a very useful tool, well organized and imaginative." Addiction Today Published: 2002-10-01 Lisa M. Najavits, PhD, is currently an adjunct professor at the University of Massachusetts Medical School and was previously a faculty member at Harvard Medical School for 25 years and Boston University School of Medicine and Veterans Affairs Boston Healthcare System for 12 years. He is the author of over 180 publications, including Seeking Safety: A Treatment Manual for PTSD and Substance Abuse (for mental health professionals) and Finding Your Best Self, Revised Edition: Recovery from Addiction, Trauma, or Both (for general readers). He is Director of Treatment Innovations, who conducts research and training related to mental health and addiction. Dr. Najavits serves on the advice of several journals, including the Journal of Traumatic Stress, Journal of Gambling Studies, Youth Double Diagnosis, and Psychological Trauma, and has received awards including the Betty Ford Award from the Association for Medical Education and Substance Abuse Research, the Emerging Leadership Award by the Committee for Women in Psychology of the American Psychological Association, the International Society for Prevention Prevention of the Professional Society He also served as president of the Society of Addition Psychology of the American Psychological Association. His main clinical and research interests include addiction, trauma, co-occupant disorders, community-based care, veteran mental health, the development of new models of counselling, and research into clinical trials. He has a privatePractice in Massachusetts. Happy1. Overview2. Conducting Treatment TopicsIntroduction to Treatment / Custody Managementsafetiptsd: Resume Your PowerDetaching from Emotional Pain (grounding) When Substances Control Elpaking Good Care of YourselfCompassioned and Green flagshonestyRecovery ThinkingNegaring the Split SelfCommitmentCreating Meaning Confinite Resourcsetting in Relationships Discover Your Recovery with Teathealthy Relationsself-NurtuingHealing Triggers from Angerlife Game Choices (Review) Termination A Handbook on Treatment for PTSD and Substance Abuse by Lisa M. Najavits Copyright A© 2002 The Guilford Press All Right Reserved. ISBN: 1-57 230-639-4 Overview Overview PSD and Substance Abuse PTSD and Substance Abuse: Patient Perspective "The more I use, the more I won't feel anything. The pain is so bad you just want to die. There is no other way. If you talk about it, it'll hurt too much. So, so, keep it a secret. No one will know". "When I was sober I was crazy, hiding under the bed." These patients have experienced what is beginning to be understood within the fields of mental health and substance abuse, which post-traumatic stress disorder (PTSD) and substance abuse co-occurs for a very high number of people, particularly women. Their stories also point to several major themes that are becoming increasingly recognized, based on clinical and scientific evidence. * The dual diagnosis of PTSD and substance abuse is surprisingly common. The rate of PTSD among patients in the treatment of substance abuse is 12%-34%. For women it is 30%-50%. Lifetime Trauma rates are even more common (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Langeland & Hartgers, 1998; Najavits, Weiss, & Shaw, 1997; Stewart, 1996; Stewart, Conrod, Pihl, & Dongier, 1999; Triffleman, 1998). * Becoming abstinent from substances does not develop PTSD. In fact, some PTSD symptoms worsen with withdrawal (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Kofoed, Friedman, & Peck, 1993; root, 1989). * Treatment outcomes for patients with PTSD and substance abuse are worse than for other dual-diagnosed patients and for patients with substance abuse alone (Ouimette, Ahrens, Moos, & Finney, 1998; Ouimette, Finney, & Moos, 1999). * People with PTSD and substance abuse tend to abuse "drug drugs" (cocaine and opiates); Prescription drugs, marijuana and alcohol are also common. Substance abuse is often seen as a "self-drug" to cope with the overwhelming emotional pain of PTSD (Wroclaw, Davis, Peterson, & Schultz, 1997; Chilcoat & Wroclaw, 1998; Cotler, Compton, Mager, Spitznagel, & Janca, 1992; Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995; Goldenberg et al., 1995; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Hien & Levin, 1994). * People with PTSD and abuse Substances are vulnerable to repeated trauma (Fuilove et al., 1993; Herman, 1992), and other than patient patients substance abuse alone (Dansky, Brady, & Saladin, 1998). * People with both disorders suffer from a variety of life problems that can complicate their clinical profile, including other DSM-IV disorders, interpersonal and medical problems, child abuse, custody battles, homelessness, HIV risk, and domestic violence (Brady, Dansky, Sonne, & Saladin, 1998; Brady et al., 1994; Brown & Wolfe, 1994; Dansky, Byrne, 1999, & Brady. * People with PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders (Najavits, Weiss, & Shaw, 1999b; Najavits et al., 1998c). * Among patients receiving substance abuse treatment, this double diagnosis is two to three times more common in women than in men (Brown & Wolfe, 1994; Najavits et al., 1998c). * Most women with this dual diagnosis have experienced physical and/or sexual abuse of childhood; men with both disorders have typically experienced victimization of war crime or trauma (Brady et al., 1998; Kessler et al., 1995; Najavits et al., 1998c). * PTSD and substance abuse were consistently found to be co-occur, regardless of the nature of the trauma or the type of substance used (Keanne & Wolfe, 1990; Kofoed et al., 1993). * A "cryic down" is common. For example, substance use may increase vulnerability to new trauma, which in turn may lead to more substance use (Fullilove et al., 1993). From a patient perspective, symptoms of PTSD are common triggers of substance use (Abueg & Fairbank, 1991; Brown, Recovery, & Stout, 1995), which in turn may increase symptoms of PTSD (Brown, Stout, & Cannon-Rowley, 1998; Kofoed et al., 1993; Kovach, 1986; Root, 1989). * Various subgroups have high rates of this dual diagnosis, including combat veterans, prisoners, victims of domestic violence, the homeless and adolescents (Bremner, Southwick, Darnell, & Charney, 1996; Clark & Kirisci, 1996; Dansky et al., 1999; Davis & Wood, 1999; Jordan, Schlenger, Fairbank, & Caddell, 1996; Kilpatrick et al., 2000; Ruze The link between PTSD and substance abuse appears to be long-lasting, rather than a simple artifact of substance use, withdrawal or overlap of DSM-IV criteria (Bolo, 1991; Kofoed et al., 1993). * Violent substance abusers use aggression at the time of assault in a high proportion of domestic abuse (50%) and rape (39%) (Bureau of Justice Statistics, 1992). PTSD and substance abuse: a therapist's perspective The other half of the clinical equation is the therapist's perspective. A social worker in the private practice said: "I used to hear that I would not go near substance abuse patients with a 10-foot pole - I would not treat them and I was judged enough. Mostly I didn't understand them. But when I realized that many have a history of trauma I started to more compassionate. I realized how often they self-medicate their pain." A psychiatrist on the substance abuse unit of a hospital said: "Where I work, patient patients They said to stop substances only once they are clean they can face trauma. They receive four groups of substance abuse a day, but no group for the DPPTS. Some of them feel disabled, as if their trauma had no importance. "Doctors may feel confused about treating these patients. For example. * A «The patient should talk about painful traumatic memories during treatment?" * A «I insist that the patient must become without substances before working on the DPPTS?" * "How can I contain a patient who becomes overwhelmed From the symptoms of PTSD? A * A. Should I interrupt treatment if the patient continues to use substances? "" Does psychotherapy work for this population?]? However, both doctors and researchers recommend an integrated model for the treatment of both disturbances at the same time, as more likely to success, cheaper and more sensitive to patient needs (Abueg & Fairbank, 1991; Bollerud, 1990; Brady et al., 1994; Brown et al., 1995; Brown, Stout, & Mueller, 1999; Evans & Sullivan, 1995; Full Love et al., 1993; Kofoed et al., 1993; Najavits, Weiss, & Liese, 1996c; Sullivan & Evans, 1994). Patients also prefer integrated treatment of these disorders (Brown et al., 1998). * Most patients with PTSD and substance abuse does not receive treatment focused on PTSD (Brown et al., 1998, 1999). * Many patients are never evaluated for both PTSD and substance abuse (Fullilove et al., 1993; Kofoed et al., 1993). It is common that patients report more treatments for substance abuse during which they have never received questions about trauma, they never informed of having met the diagnosis of PTSD and they never said that PTSD is a treatable disorder for the What specific treatments exist. Similarly, some mental health clinicians do not systematically evaluate the abuse of substances. * It can be difficult to predict the patient recovery course. Paradoxically, both abstinence and continued use of substances can improve or worsen PTSD symptoms, depending on the patient (Brown et al., 1998; Najavits, Shaw, & Weiss, 1996B). * The treatment can be effective, but it is often difficult and can be characterized by unstable alliances, multiple crises, irregular and recurrent frequency at the use of substances (Brady et al., 1994; Brown, Stout, & Mueller, 1996; Root, 1989; Triffleman, 1998). * Whether in culture in general and among doctors, patient opinions with substance and / or PTSD abuse can be quite negative. Counter-distribution reactions are common (Herman, 1992; Imhof, 1991; Hirsch, & Terenzi, 1983; Najavits et al., 1995). Patients are sometimes perceived as A «crazzià» A «lazy» or A «bad», both from others and alone. * The treatments that are effective for the PTSD or the abuse of substances separately may not be advisable when the two disorders occur together. For Treatments for PTSD such as benzodiazepines or exposure therapy may not be indicated if the patient is substance dependent, treatment for substance abuse such as 12-stage groups may not work when a patient has PTSD (Ruzek et al., 1998; Satel, Becker, & Dan, 1993; Solomon, Gerrity, & Muff, 1992). * Patients with this dual diagnosis may require intensive case management, which may go beyond the training of some clinicians and sometimes lead to a "burnout" (Najavits et al., 1996b). * The need for cross-training is common: cultures, assumptions, and treatments for substance abuse and PTSD can be very different, and most therapists do not have the same experience in both (Evans & Sullivan, 1995; Najavits, 2000; Najavits et al., 1996c). Substance abuse counselors are usually not trained to work on serious mental health problems, so PTSD can be ignored or misunderstood. Similarly, most mental health therapists are not trained to work on substance abuse. More information on the relationship between PTSD and substance abuse The key points above summarise a growing body of research that emerged mainly in the last decade and is still being validated. Although a full discussion of this work is beyond the scope of this book, additional materials are recommended at the end of the book (see entries marked with an asterisk in the list of references). In addition, the experience of a patient with PTSD and substance abuse is reported at the end of this chapter to illustrate the experience of this dual diagnosis. THIS TREATMENT This book describes a psychotherapeutic treatment for PTSD and substance abuse consisting of 25 topics. It is the first treatment for PTSD and substance abuse with published results (Najavits et al., 1997, 1998e). It offers a variety of features designed to be of maximum help to frontline doctors, where time is of the essence, the needs are great and the need for something to work is imperative. The creative contribution this treatment, hopefully, offers is the adaptation of Cognitive Behavioural Therapy (CBT) to this population. The aim was to shape a therapy that is more responsive to patients' needs by listening carefully to them in the context of treatment, reading available literature and conducting empirical research on therapy. The 25 treatment topics are equally divided between cognitive, behavioural and interpersonal domains, each of which addresses an ability to safely address both disorders. Each topic is designed to be independent of the others, allowing maximum flexibility for patients and therapists in choosing the order of topics. Treatment may be conducted on an individual or group basis, which have shown positive results so far in studies (Hien & Litt, 1999; Najavits, 1996, 1998; Zlotnick, 1999). It has also been applied in clinical contexts to a wide range of patients (e.g. women, men, adults, teenagers, prisoners, war veterans, war.Agency in patients, inpatients, suburban patients, minorities). Data so far do not indicate positive treatment satisfaction in several of these subpopulations, but results of the results have still been collected. (See Chapter 2 for more information on the use of treatment in different treatment settings.) Below, the principles of treatment are described, followed by additional key features, what is not part of the treatment, how it was developed, its empirical tests and how it differs from other treatments. Safety Research Principles This treatment is based on five central ideas: (1) safety as a priority of this first stage treatment; (2) integrated treatment of PTSD and substance abuse; (3) a focus on ideals; (4) four content areas: cognitive, behavioural, interpersonal and case management; and (5) focus on therapeutic processes. These five principles are described below, followed by additional treatment characteristics and a summary of what is not part of the treatment. Safety as the objective of this first stage processing The title of this book, in search of safety, expresses the basic philosophy of processing. That is, when a person has an abuse of active substances and PTSD, the most urgent clinical need is to establish safety. "SAFETY" is an umbrella term that means several things: stopping substance use, reducing suicide, minimizing exposure to HIV risk, letting go into dangerous relationships (such as peripheral abuse and drugs using "friends"), gaining control over extreme symptoms (such as "friends"), dissociation) and stop self-damaging behaviors (such as cutting). Many of these are self-destructive behaviours that re-traumatize, particularly for victims of child abuse, who represent a large segment of people with this dual diagnosis (najavits et al., 1997). Although the trauma may have occurred a long time ago, patients themselves in ways that repeat it, ignoring their needs and pain perpetuating the pain (although sometimes in an attempt to satisfy short-term impulses). These patients were typically abused and are now abused. This is not a coincidence, but rather represents a significant connection between their ailments. "The search for safety" refers to helping patients get rid of such negative behaviors and, by doing so, to move towards liberating themselves from trauma at a deep emotional level. Just as security breaches are the breach of life, the means to establish security are the improvement of life: learning to ask for help from safe people, using community resources, exploring "thought of recovery", taking care of one's own body, trying honesty and compassion, growing self-reducing activities and so on. These are the that this treatment tries to teach. The treatment then adapts to what has been described as the first phase therapy for each of the disorders. Experts within the PTSD and substance abuse camps have independently described a very similar first stage of treatment. Continue ... extracts from from from © 2002 by the guilford press. excluded from the permit. All rights reserved. no part of this extract can be reproduced or reprinted without permission in writing by the publisher. Excesses are provided by Dial-A-Book inc. exclusively for the personal viewers of this site. site.

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