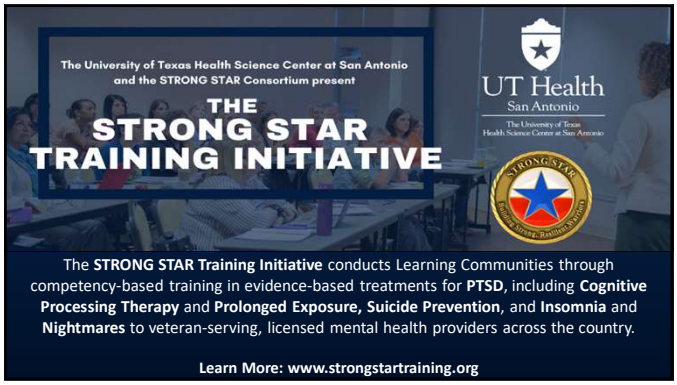
STRONG STAR TRAINING INITIATIVE

Integrating Substance Use Treatment Techniques into Evidence-Based Treatments for PTSD

Brooke Fina, LCSW, BCD
Associate Professor-Research, UT Health San Antonio
Director of Training, STRONG STAR Training Initiative

1



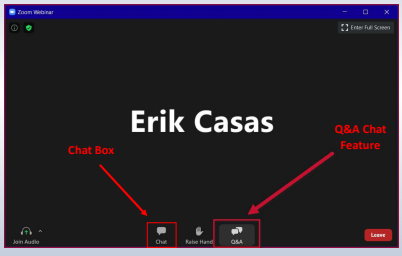
The **STRONG STAR Training Initiative** conducts Learning Communities through competency-based training in evidence-based treatments for **PTSD**, including **Cognitive Processing Therapy** and **Prolonged Exposure, Suicide Prevention**, and **Insomnia** and **Nightmares** to veteran-serving, licensed mental health providers across the country.

Learn More: www.strongstartraining.org

2

Housekeeping Rules

- Place questions in the "Q&A" chat feature – questions will be answered at the end of the presentation.
- Place technical issues in the chat box.



3

Continuing Education Credits

If attending this presentation live: CE evaluation link will be provided in chat box at end of the webinar and emailed to you.

If viewing this recorded presentation through the Provider Portal:

- ****Two passwords** will be shared during this recording****
- You will need ***both passwords*** in order to complete the CE evaluation and receive your CE certificate.
- To access the CE evaluation, click on the CE credit link provided in this webinar's description on the Provider Portal.

Your CE certificate will be emailed to the address you provide in the CE evaluation form.

PLEASE NOTE: The CE evaluation link and CE certificate are often blocked by government/VA email accounts. If applicable, please forward the link to your personal email address, and provide a personal email address on the CE evaluation in order to avoid a delay in receiving your certificate.

The University of Texas Health Science Center at San Antonio is approved by the American Psychological Association to sponsor continuing education for psychologists. The University of Texas Health Science Center at San Antonio maintains responsibility for this program and its content.

4

Integrating Substance Use Disorder Treatment Techniques into Evidence-Based Treatments for PTSD

Brooke Fina, LCSW, BCD

Associate Professor-Research, Division of Behavioral Medicine, Department of Psychiatry and Behavioral Sciences, School of Medicine University of Texas Health Science Center at San Antonio

Director of Training, STRONG STAR Training Initiative

5

Conflict of Interest Disclosure

The presenter(s) have no conflicts of interests to disclose.

6

Acknowledgements

- Sudie E. Back, Ph.D. Professor, Department of Psychiatry & Behavioral Sciences, Medical University of South Carolina (MUSC), Staff Psychologist, Ralph H. Johnson VA, Charleston, SC
- COPE Treatment Developer
- Offered training for SSTI PE providers December 2021
  - Brian Lozano, Ana Santa, PhD, Yanya Saraiya, PhD

Training materials today are based on COPE manual & COPE training

MUSC Medical University of South Carolina

7

Learning Objectives:

- Describe the relationship between PTSD and substance use disorders (SUD)
  - Science of PTSD & SUD & Treatment
- Understand the rationale for integrated psychosocial treatment approaches for PTSD/SUD
  - Support Conceptualization
- Describe cognitive-behavioral techniques for SUD integrated with PTSD treatment
  - With a PTSD treatment lens, how might you integrate SUD techniques

8

Myths

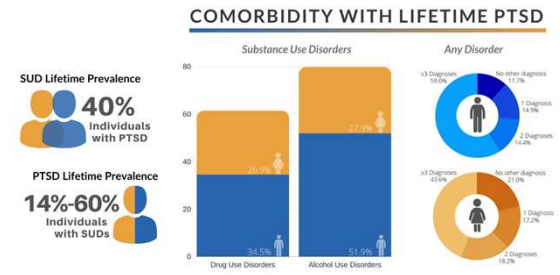
- If I ask about the trauma, they will relapse in their substance use (or get worse).
- Abstaining from substances is the only way to do PTSD treatment.
- Treatment won't help patients with co-occurring PTSD & SUD.

9

The Science of PTSD & SUD

10

How often do PTSD and SUDs Co-occur?



Source: https://istss.org/public-resources/friday-fast-facts/substance-use-and-traumatic-stress

11

PTSD & SUD in Veterans

More than 2 of 10 Veterans with PTSD also have SUD.

Among first-time users of VA healthcare from 2001-2010 (N=456,502), 63.0% with alcohol use disorder had comorbid PTSD (Seal et al., 2011).

Most Veterans (85%) indicate that their substance use increases when their PTSD symptoms get worse (Back et al., 2014)

As it relates to treatment, Veterans with PTSD and co-occurring poly-SUD, may experience greater SUD improvement but less improvement in PTSD symptoms during integrated treatment (Jeffirs et al., 2019)

12

PTSD & Opioid Use Disorder (OUD)

- Prescription opioids (e.g., hydrocodone, oxycodone) are the most commonly used drug, 2nd only to marijuana.
- High rates of trauma (e.g., 92-97%) and PTSD (33-54%) among patients with opioid use disorder (OUD) (Mills et al., 2005, 2006; Peirce et al., 2009).
- Among military service members, odds of having PTSD was 28 times higher in those with, vs. without, OUD (Dabbs et al., 2014).
- Concurrent trauma-focused treatment may be important in retention and overall outcomes (Meshberg-Cohen et al., 2019).

Source SSTI COPE Training

13

PTSD & SUD: Treatment outcomes

- Patients with PTSD & SUD have a more severe clinical profile, including suicidality, poorer well-being, psychosocial functioning. (Schäfer & Najavits, 2007; Back et al., 2000; Tate et al., 2007), making them harder to treat.
- When PTSD gets better, SUD gets better, but not the reverse (Hien et al., 2010; Back et al., 2006; Brown et al., 1998).
- EBTs for PTSD are well tolerated for PTSD/SUD patients and they show improvements (e.g., Kaysen 2014), but poorer outcomes (Back 2010).
- Impact of CPT on hazardous drinking: Treatment did not exacerbate hazardous drinking, and the hazardous drinking group showed significant reductions in drinking following PTSD treatment (Dondanville et al., 2019)

14

Sequential Model for Treatment

Historically, SUD Tx first then PTSD

Example:

- *SUD only treatment first (attain and maintain abstinence), then refer to PTSD treatment.*

Challenges:

- Can be difficult for some patients to achieve abstinence or reduce use, especially in the face of PTSD symptoms.
- Unknown about treatment engagement rates in this model.
- Longer time in treatment, higher costs for patient, greater burden on clinics and organizations.

Source SSTI COPE Training

15

Behavioral Health Integrated Treatments

Treatments that address PTSD and SUD together have been shown to improve PTSD symptoms without worsening SUD, & improving SUD (e.g., Back, 2010; Back et al., 2012; Brady et al., 2001).

Integrated treatments are more effective than treatment as usual (Roberts et al., 2015)

Examples:

- Seeking Safety (Najavits, 2006),
- Integrated Cognitive Behavioral Therapy (ICBT) (Capone et al., 2018; McGovern et al., 2009).
- Concurrent Treatment of PTSD and SUD using Prolonged Exposure (COPE)

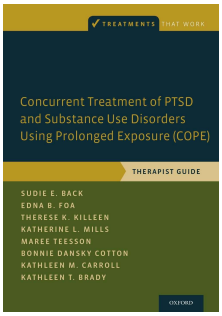
Source SSTI COPE Training

16

Integrated Model

- Cognitive-behavioral therapy that integrates evidence-based trauma-focused treatment for PTSD with evidence-based behavioral treatment for addiction.
- Delivered by 1 clinician during 1 treatment episode.
- Preferred model for patients (Back et al., 2014; Back et al., 2006; Brown, et al., 1998; Najavits, 2004).
- Recommended by VA/DOD and other clinical practice guidelines.

17



COPE

- COPE consists of 12, individual sessions, 90 minutes each, delivered weekly.
- Synthesis of two evidence-based treatments:
  1. Prolonged Exposure (PE) for PTSD (Foa)
  2. Cognitive Behavioral Therapy (CBT) for SUD (Carroll)
- Primary goals:
  - Psychoeducation regarding the functional relationship between PTSD and substance use.
  - Decrease PTSD symptoms via Prolonged Exposure.
  - Decrease substance use using cognitive behavioral techniques.

Back et al., 2014

18

COPE Studies to Date

Research to date includes **476 participants** in 4 RCTs, 2 open-label trials, and 2 case reports. Findings show COPE is safe, feasible, and results in significant reduction in PTSD and SUD.

Completed COPE Studies	
Brady et al., 2001	First open-label trial (cocaine and PTSD)
Mills et al., 2012	First RCT (polysubstance and PTSD, Australia)
Back et al., 2012	First OEF/OIF military Veteran (alcohol and PTSD)
Ruglass et al., 2017	RCT in civilians with sub-threshold or full PTSD (polysubstance)
Persson et al., 2017	Open-label trial of translated manual (women with alcohol and PTSD, Sweden)
Jaconis et al., 2017	First telehealth case (female Veteran with alcohol and MST)
Back et al., 2019	First RCT in military Veterans (mostly alcohol and PTSD)
Norman et al., 2019	First comparison of COPE vs. Seeking Safety (military Veterans with alcohol and PTSD)

19

Case Conceptualization

20

STRONG STAR TRAINING INITIATIVE

PASSWORD #1:

strong

21

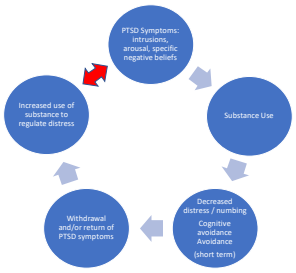
Functional Association Between PTSD & SUD

- Self-medication model: Substances are used to manage (avoid) PTSD symptoms such as emotional pain, intrusions, poor sleep, guilt or anxiety. (Khantzian, 1985, 1990, 1997; Reed, et al., 2007)
- High Risk model - Substances and/or high-risk contexts (e.g., drug-related crime) lead to trauma exposure and the development of PTSD. (Chilcoat & Breslau, 1998; Acierno, et al., 1999)
- Susceptibility model – Early stress exposure leading to PTSD makes people more vulnerable to develop SUD later on. (Kendler et al., 2000; Young-Wolff et al., 2011)
- Shared liability and mutual maintenance model – There are shared reinforcing relationships between traumatic stress and SUD that underlie and maintain both disorders (Norman et al., 2012; Lopez-Castro et al., 2015)

22

PTSD & SUD

Biopsychosocial Framework of Understanding SUD:
Addiction is not a "lack of will power" or moral failing.
Biopsychosocial framework helps understand there are numerous factors contribute to SUD.
Social determinants can result in inequities in SUD and affect risk and resilience.
SUD is a chronic but treatable medical condition that, at the brain level, involves dysregulation in neural circuits involved in reward, stress, and self-control that are "hijacked" by alcohol/drugs (Volkow, NIDA).



Source SSTI COPE Training

23

Talking to patients about integrated treatment

Discuss	Discuss substances as a way to avoid
Elicit	Elicit their experiences with substances as avoidance
Ask about	Ask about short term relief vs long term consequences
Offer	Offer treatment model: • Treat both PTSD & SUD • Manage trauma symptoms without substances • Recovery from both conditions • Long term relief

Back et al., 2014

24

Abstinence vs. Harm Reduction

Abstinence is one option

- Safest option (only way to avoid all negative consequences from use) so it's encouraged, but not required to receive care.
- Identified as a goal by older veterans, those with more severe SUD, and comorbid alcohol and drug use disorders.
- Consider severity of SUD, negative consequences (medical, legal, family/social), previous attempts to cut down, withdrawal symptom severity (seizures, hospitalizations), and family history density.

Harm reduction is another option

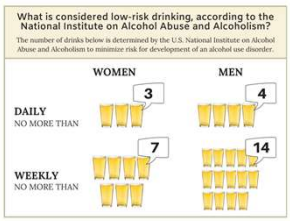
- Harm reduction refers to practices aimed at minimizing harmful effects of use.
- Identified as a goal by younger veterans (average of 12 yrs younger), OEF/OIF theatre, employed, and less severe SUD.
- Be specific about amount and frequency of reduction goals.
- Aim for having some DAYS with no use (therapy appt, practice assignments)
- Revisit goals throughout therapy.

Source SSTI COPE Training (Logan & Marlatt, 2014; Marlatt 1998; Lozano et al., 2015; 2021)

25

For alcohol, use National Institute on Alcohol Abuse and Alcoholism (NIAAA) Guidelines

- NIAAA has defined low-risk drinking limits:
- Low risk is not no risk
- May be difficult for some to stay in this limit, therefore abstinence being a better choice.



26

Integrated Treatment Techniques

27

SUD Assessment

- Ask **specific questions** about substance use (poly). Just like PTSD assessment, SUD avoidance associated with guilt and shame.
- PTSD Assessment + …
- SUDs Screening & Assessment measures:
  - Alcohol Use Disorder Identification Test (AUDIT; Babor et al; 2001)
  - CAGE, CAGE-AID (Cooney, et al., 1995)
  - Drug Abuse Test (DAST-10; Yudko et al., 2007)
  - Time Line Follow Back* (TLFB; Sobell & Sobell, 1992 to assess frequency and intensity of use)

*Used for screening, assessment and SUD symptom tracking DURING treatment

Back et al., 2014

28

Treatment Planning & Motivation

Explicit agreement to work on both. If lack of desire to reduce, motivational intervening or MET may be helpful to start with.

Monitor PTSD & SUD symptoms through treatment

Rationale for integration

Be patient and repeat important messages, rationale, and instructions as needed.

Back et al., 2014

29

SUD Integration with PE & CPT

COPE (Back et al., 2014)

Treatment of Integrated Posttraumatic Stress and Substance Use (TIPSS) (Vujanovic et al., 2018)

-- Comprised of 12, individual, 60-minute sessions

-- Clinical trial work developed (https://clinicaltrials.gov/ct2/show/NCT02461732)

30

Development of a Novel, Integrated Cognitive-Behavioral Therapy for Co-Occurring Posttraumatic Stress and Substance Use Disorders: A Pilot Randomized Clinical Trial

CPT + Cognitive Behavioral Therapy (CBT) for SUD (Carroll)

Vujanovic, A. A., Smith, L. J., Green, C. E., Lane, S. D., & Schmitz, J. M. (2018). Development of a novel, integrated cognitive-behavioral therapy for co-occurring posttraumatic stress and substance use disorders: A pilot randomized clinical trial. *Contemporary clinical trials*, *65*, 123–129. https://doi.org/10.1016/j.cct.2017.12.013

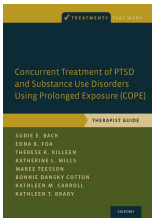
Summary of Session Content: TIPSS for PTSD/SUD

Session	Topics[a]
1	Introduction/Motivational Interviewing for PTSD/SUD Treatment Engagement
2	Psychoeducation on PTSD/SUD; Trauma- and Substance-Related Triggers
3	Values and Valued Action
4	Coping Skills for Managing PTSD and SUD Symptoms
5	Impact of Trauma and Substance Use on Beliefs about Self, Others, and World
6	Identification of Thoughts and Feelings about PTSD and SUD
7	Remembering the Trauma I
8	Remembering the Trauma II
9	Challenging Questions regarding PTSD and SUD
10	Problematic Thinking regarding PTSD and SUD
11	Themes: Trust, Safety, Power/Control, Esteem, Intimacy
12	Themes: Trust, Safety, Power/Control, Esteem, Intimacy / Graduation

31

COPE Session Overview

PTSD	SUD
1. Introduction: Psychoeducation, Therapy Contract and Goals, Breathing Retraining	
2. Common Reactions to Trauma	Awareness of Cravings
3. In Vivo Hierarchy	Managing Cravings
4. First Imaginal Exposure	Review Coping Skills
5. Imaginal Exposure continued	Planning for Emergencies
6. Imaginal Exposure continued	Awareness of High Risk Thoughts
7. Imaginal Exposure continued	Managing High Risk Thoughts
8. Imaginal Exposure continued	Refusal Skills
9. Imaginal Exposure continued	SUD: Seemingly Irrelevant Decisions
10. Imaginal Exposure continued	Awareness of Anger
11. Imaginal Exposure continued	Managing Anger
12. Review & Termination	



Back et al., 2014

32

Structure of integrating SUD Content

COPE & TIPSS provides a roadmap

- Introduce the concept in the treatment session
- Assign as integrated in homework
- Homework review & problem solving at next session

Session structure:

- Fully integrated content (60 minutes for CPT + SUD, 90 minutes for COPE)
- 2 sessions per week – one dedicated to PTSD and SUD each

33

Managing Cravings

Psychoeducation about time limited nature of cravings & normalize.
15 minutes.
Cravings become less frequent and less intense as you learn how to effectively manage them

Monitor substance craving esp. during practice (e.g., imaginal exposure or CPT worksheets).
Craving thermometer

Decision delay technique: Delay the decision to use for **30 minutes** and engage in healthy activities (e.g., call a friend, exercise, watch a movie, go to AA/NA meeting, go for a walk). Repeat delay.

Consider explicit long-term consequence of engaging.

Urge surfing – learn to experience craving differently.
- Breathing retraining

Back et al., 2014

34

Awareness & Managing High-Risk Thoughts

- *Escape*
- *Relaxation*
- *Nostalgia*
- *Testing Control*
- *Crisis*
- *Feeling Uncomfortable When Abstinent or Clean*
- *To-Hell-With-It*

ABC Model

Activating Event	Belief	Consequence
You run into an old using buddy.	*"Man, we sure did have some good times. I bet I could use just one. No one will ever know".*	*Feeling an intense craving and going to use.*

"Are my thoughts helping me achieve my goals? What can I do to change the situation? Or change my thoughts about the situation ."

Example alternative actions:
- *Leave the situation immediately.*
- *Distract yourself with a pleasant, healthy activity.*
- *Use the Decision Delay technique.*
- *Remind yourself of the positive benefits of not using.*

Back et al., 2014

35

Cognitive-Behavioral Chain

Trigger	Thoughts	Feelings	Behavior
Trauma memory	"I can't handle this, it's too painful."	Craving/Urge	Use

VS.

Trigger	Thoughts	Feelings	Behavior
Trauma memory	*"I can't handle this, it's too painful."*	Less or no craving/urge	Practice breathing

"These memories may be uncomfortable, but if I practice my breathing I can manage them. Using will only make it worse."

Source SSTI COPE Training

36

Refusal Skills

Psychoeducation

- Overt and covert pressures

Guidelines

- *Avoid high-risk alcohol/drug situations whenever possible.*
- *Not avoiding safe trauma-related triggers.*
- *Give a convincing "No" without hesitation.*
- *Change the subject to avoid long discussions.*
- *Suggest another activity.*
- *Avoid excuses (i.e., I'm on medication).*
- *Don't feel guilty.*
- *Request behavior change.*

Practice

- in session role play / writing out responses for specific situations for practice.

Back et al., 2014

37

Check in about Goals Midway

If the Patient's Substance Use Is Improving:	If Not Improving
• Highlight this fact and offer ample praise. • Ask about skills or techniques using in order to make this progress. Encourage continuing using them. • Where possible, link improvements in substance use to improvements in PTSD symptoms (e.g., "I noticed that as your substance use decreased you started sleeping better. Do you think those are related?"). • Determine if the patient wants to continue with those same substance abuse goals or revise them.	• Discuss this with the patient in an empathetic and nonjudgmental manner. • Inquire about the patient's perspective. Be sure that the original • Substance abuse goals established in session 1 were realistic. • If necessary, revise the goals to make them more realistic and achievable. • Ask the patient to help you identify obstacles that may be getting in the way of substance use improvements ("What do you think is currently going on that makes it difficult for you to reduce/stop your use?" "How can you handle these situations differently?").

Back et al., 2014

38

Final Reflections

- SUD is on a continuum. Research focusses on SUD. There are many patients using substances in a way that isn't helpful.
- SUD strategies may help with these patients too.
- If you see a SUD / PTSD population strong recommendation to receiving training in EBTs plus SUD (e.g., can use COPE).
- The science is clear that integrated treatment is the clinical standard.

39

STRONG STAR TRAINING INITIATIVE

PASSWORD #2:

star

40

Resources

- Back, S. E., & Killeen, T. K. (2014). Concurrent treatment of PTSD and substance use disorders using prolonged exposure(COPE): Therapist guide. Treatments That Work. DOI: https://doi.org/10.1093/med:psych/9780199334537.001.0001
- PTSD Research Quarterly: Behavioral Interventions for Comorbid PTSD and Substance Use Disorder by the National Center for PTSD for a detailed review of the state of the research on interventions for PTSD and substance use disorders (https://www.ptsd.va.gov/publications/rq_docs/V31N2.pdf)
- ISTSS Fast Fact Fridays & podcast https://istss.org/public-resources/friday-fast-facts/substance-use-and-traumatic-stress
- Posttraumatic Stress and Substance Use Disorders: A Comprehensive Clinical Handbook by Dr. Anka Vujanovic and Dr. Sudie Back
- McCauley, J. L., Killeen, T., Gros, D. F., Brady, K. T., & Back, S. E. (2012). Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment. *Clinical psychology : a publication of the Division of Clinical Psychology of the American Psychological Association*, *19*(3), 10.1111/cpsp.12006. https://doi.org/10.1111/cpsp.12006

41

References

Acierno, R., Resnick, H., Kilpatrick, D. G., Saunders, B., & Best, C. L. (1999). Risk factors for rape, physical assault, and posttraumatic stress disorder in women: examination of differential multivariate relationships. *Journal of anxiety disorders*, *13*(6), 541–563. https://doi.org/10.1016/s0887-6185(99)00030-4

Back, S. E., & Killeen, T. K. (2014). Concurrent treatment of PTSD and substance use disorders using prolonged exposure(COPE): Therapist guide. Treatments That Work. DOI: https://doi.org/10.1093/med:psych/9780199334537.001.0001

Chilcoat, H. D., & Breslau, N. (1998). Posttraumatic stress disorder and drug disorders: Testing causal pathways. Archives of General Psychiatry, 55(10), 913-91

Hien, D. A., Jiang, H., Campbell, A. N., Hu, M. C., Miele, G. M., Cohen, L. R., Brigham, G. S., Capstick, C., Kulaga, A., Robinson, J., Suarez Morales, L., & Nunes, E. V. (2010). Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's Clinical Trials Network. The American journal of psychiatry, 167(1), 95–101. https://doi.org/10.1176/appi.ajp.2009.09091261

Jeffirs, S. M., Jarnecke, A. M., Flanagan, J. C., Killeen, T. K., Laffey, T. F., & Back, S. E. (2019). Veterans with PTSD and comorbid substance use disorders: Does single versus poly-substance use disorder affect treatment outcomes?. Drug and alcohol dependence, 199, 70–75. https://doi.org/10.1016/j.drugalcdep.2019.04.001

Kaczkurkin, A. N., Asnaani, A., Alpert, E., & Foa, E. B. (2016). The impact of treatment condition and the lagged effects of PTSD symptom severity and alcohol use on changes in alcohol craving. *Behaviour research and therapy*, *79*, 7–14. https://doi.org/10.1016/j.brat.2016.02.001

Kendler, K. S., Bulik, C. M., Silberg, J., Hettema, J. M., Myers, J., & Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: an epidemiological and cotwin control analysis. Archives of general psychiatry, 57(10), 953-959.

42

References

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. Harvard Review of Psychiatry, 4(5), 231–244. https://doi.org/10.3109/10673229709030550

Lopez-Castro, T., Hu, M. C., Papini, S., Ruglass, L. M., & Hien, D. A. (2015). Pathways to change: Use trajectories following trauma-informed treatment of women with co-occurring post-traumatic stress disorder and substance use disorders. Drug and alcohol review, 34(3), 242–251. https://doi.org/10.1111/dar.12230 Pietrzak RH, Goldstein RB, Southwick SM, Grant BF. Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: Results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. Journal of Anxiety Disorders. 2011; 25:456–465.10.1016/j.janxdis.2010.11.010 [PubMed: 21168991

Meshberg-Cohen, S., Black, A. C., DeViva, J. C., Petrakis, I. L., & Rosen, M. I. (2019). Trauma treatment for veterans in buprenorphine maintenance treatment for opioid use disorder. *Addictive behaviors, 89*, 29–34. https://doi.org/10.1016/j.addbeh.2018.09.010

Mills KL, Teesson M, Ross J, Peters L. Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry. 2006;163(4):652–658. doi: 10.1176/appi.ajp.163.4.652. Najavits LM, Gallop RJ, Weiss RD. Seeking safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. Journal of Behavioral Health Services and Research. 2006;33:453–463. doi: 10.1007/s11414-006-9034-2 Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse and neglect: A systematic review and meta-analysis. Public Library of Science Medicine, 9(11), 1–31.*

Reed PL, Anthony JC, Breslau N. Incidence of drug problems in young adults exposed to trauma and posttraumatic stress disorder: do early life experiences and predispositions matter? Archives of General Psychiatry. 2007;64(12):143 1442. doi: http://dx.doi.org/10.1001/archpsyc.64.12.1435. Seal, K. H., Cohen, G., Waldrop, A., Cohen, B. E., Maguen, S., & Ren, L. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001-2010: Implications for screening, diagnosis and treatment. Drug and alcohol dependence, 116(1-3), 93–101. https://doi.org/10.1016/j.drugalcdep.2010.11.027

Vujanovic, A. A., Smith, L. J., Green, C. E., Lane, S. D., & Schmitz, J. M. (2018). Development of a novel, integrated cognitive-behavioral therapy for co-occurring posttraumatic stress and substance use disorders: A pilot randomized clinical trial. Contemporary clinical trials, 65, 123–129. https://doi.org/10.1016/j.cct.2017.12.013

Young-Wolff, K. C., Kendler, K. S., Ericson, M. L., & Prescott, C. A. (2011). Accounting for the association between childhood maltreatment and alcohol-use disorders in males: a twin study. Psychological medicine, 41(1), 59–70. https://doi.org/10.1017/S0033291710000425

43

Continuing Education Credits

If attending this presentation live: CE evaluation link will be provided in chat box at end of webinar and emailed to you tomorrow.

If viewing this recorded presentation through the Provider Portal:

- **Two passwords** will be shared during this recording**
- You will need ***both passwords*** in order to complete the CE evaluation and receive your CE certificate.
- To access the CE evaluation, click on the CE credit link provided in this webinar's description on the Provider Portal.

Your CE certificate will be emailed to the address you provide in the CE evaluation form.

PLEASE NOTE: The CE evaluation link and CE certificate are often blocked by government/VA email accounts. If applicable, please forward the link to your personal email address, and provide a personal email address on the CE evaluation in order to avoid a delay in receiving your certificate.

The University of Texas Health Science Center at San Antonio is approved by the American Psychological Association to sponsor continuing education for psychologists. The University of Texas Health Science Center at San Antonio maintains responsibility for this program and its content.

44

Q&A

- Please type your questions in the Q&A feature at the bottom of the screen.

45

Next Month's Webinar

- ***CPT: An Empowerment Approach to Treating PTSD in Sexual Assault Survivors***
- Presented by Tonya Edmond, Ph.D., interim co-dean of the Brown School, and co-director for the Center of Violence and Injury Prevention and faculty affiliate for the Center for Mental Health Services Research.
- **When**: Thursday, April 7 at 1pm CST/ 2pm EST

46