1. Substance Abuse, Posttraumatic Stress Disorder and Treatment

October 1, 2001—January 22, 2004

2003

Brown, P. J., J. P. Read, et al. (2003). Comorbid posttraumatic stress disorder and substance use disorders: Treatment outcomes and the role of coping. Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders. P. Ouimette and P. J. Brown, Washington, DC, US: American Psychological Association**:** 171-188.

In this chapter the authors describe a study that examines the prospective relationship between posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) among inpatients (aged 18-55 yrs) recently treated for substance abuse or dependence. To provide a context for this study, the authors survey the relevant prospective literature on SUD-PTSD comorbidity and review factors suggested by this literature on affect symptom presentation, treatment, and remission of these two disorders. Specifically, the authors discuss the role of gender and coping skills in the relationship between SUDs and PTSD. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Brune, M., C. Haasen, et al. (2003). "Treatment of drug addiction in traumatised refugees. A case report." Eur Addict Res **9**(3): 144-6.

The comorbidity of post-traumatic stress disorder (PTSD) and drug addiction is quite often overlooked in refugees. However, the simultaneous treatment of both disorders is of elemental importance for a positive outcome in addicted and traumatised refugees. Furthermore, mutual misinterpretations of habits, behaviours and reactions through negligence of the distinct sociocultural context of patient and clinician often leads to unfavourable developments. These observations are exemplified in this case report.

Forbes, D., M. Creamer, et al. (2003). "Comorbidity as a predictor of symptom change after treatment in combat-related posttraumatic stress disorder." Journal of Nervous & Mental Disease **Vol 191(2)**: 93-99.

Posttraumatic stress disorder (PTSD) is a difficult condition to treat, and existing studies show considerable variability in outcome. Investigations of factors that influence outcome have the potential to inform alternate treatment approaches to maximize benefits gained from interventions for the disorder. Because PTSD is commonly associated with comorbidity, it is important to investigate the influence of comorbidity on symptom change after treatment. This article examines pretreatment and 9-month follow-up data for 134 Australian Vietnam veterans (mean age of 50.30 yrs) who attended a treatment program for combat-related PTSD. A series of analyses were conducted to investigate the influence of the comorbid factors of anxiety, depression, anger, and alcohol use on PTSD symptom change after treatment. Analyses identified anger, alcohol, and depression as significant predictors of symptom change over time, independent of the effect of initial PTSD severity. Further analyses indicated that anger at intake was the most potent predictor of symptom change. Further investigations of anger as an influence on symptom change after treatment of combat-related PTSD is recommended. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Marshall, R. D. and E. J. Suh (2003). Contextualizing Trauma: Using Evidence-Based Treatments in a Multicultural Community After 9/11. Psychiatric Quarterly. **Vol 74(4):** 401-420.

The mental health community was caught unaware after 9/11 with respect to treatment of survivors of terrorist attacks. Because this form of trauma was quite rare in the U.S., few trauma specialists had extensive experience, or taught regularly on this subject. Since the primary objective of terrorism is the creation of demoralization, fear, and uncertainty in the general population, a focus on mental health from therapeutic and public health perspectives is critically important to successful resolution of the crisis. Surveys after 9/11 showed unequivocally that symptomatology related to the attacks were found in hundreds of thousands of people, most of whom were not escapees or the families of the deceased. Soon after 9/11, our center formed a collaboration with other academic sites in Manhattan to rapidly increase capacity for providing state-of-the-art training and treatment for trauma-related psychiatric problems. Our experience suggests that evidence-based treatments such as Prolonged Exposure Therapy have proven successful in treating 9/11-related PTSD. However, special clinical issues have arisen, such as the influence of culture on clinical presentation and treatment expectations in a multiethnic community... (PsycINFO Database Record (c) 2003 APA, all rights reserved)

McNally, R. J., R. A. Bryant, et al. (2003). Does early psychological intervention promote recovery from posttraumatic stress? Psychological Science in the Public Interest. **Vol 4(2):** 45-79.

In the wake of the terrorist attacks at the World Trade Center, more than 9,000 counselors went to New York City to offer aid to rescue workers, families, and direct victims of the violence of September 11, 2001. These mental health professionals assumed that many New Yorkers were at high risk for developing posttraumatic stress disorder (PTSD), and they hoped that their interventions would mitigate psychological distress and prevent the emergence of this syndrome. Typically developing in response to horrific, life-threatening events, such as combat, rape, and earthquakes, PTSD is characterized by reexperiencing symptoms (e.g., intrusive recollections of the trauma, nightmares), emotional numbing and avoidance of reminders of the trauma, and hyperarousal (e.g., exaggerated startle, difficulty sleeping). People vary widely in their vulnerability for developing PTSD in the wake of trauma. For example, higher cognitive ability and strong social support buffer people against PTSD, whereas a family or personal history of emotional disorder heightens risk, as does negative appraisal of one's stress reactions (e.g., as a sign of personal weakness) and dissociation during the trauma (e.g., feeling unreal or experiencing time slowing down). However, the vast majority of trauma... (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Najavits, L. M. (2003). Seeking safety: A new psychotherapy for posttraumatic stress disorder and substance use disorder. In Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders. P. Ouimette and P. J. Brown, Washington, DC, US: American Psychological Association**:** 147-169.

This chapter reviews Seeking Safety, a cognitive-behavioral based therapy for the dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder. The author provides (a) a description of Seeking Safety and how it was developed, (b) a comparison with existing treatments, (c) a review of outcome research on it, and (d) ideas for future directions. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Ouimette, P., R. H. Moos, et al. (2003). Substance use disorder-posttraumatic stress disorder comorbidity: A survey of treatments and proposed practice guidelines. Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders. P. Ouimette and P. J. Brown, Washington, DC, US: American Psychological Association**:** 91-110.

In this chapter the authors review empirical research on the treatment course of substance use disorder-posttraumatic stress disorder (SUD-PTSD) comorbidity. They highlight treatment implications in an attempt to profile the state of the art in treating this particular comorbidity. The findings show that comorbid PTSD is associated with poorer treatment outcomes following treatment for SUDs. On the basis of the empirical evidence reviewed in this chapter, the authors make recommendations for empirically based practice. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Ouimette, P., R. H. Moos, et al. (2003). "PTSD treatment and 5-year remission among patients with substance use and posttraumatic stress disorders." Journal of Consulting & Clinical Psychology **Vol 71(2)**: 410-414.

Given the high prevalence of comorbid substance use and posttraumatic stress disorders (SUD-PTSD), how to best treat these patients is a pressing concern for SUD providers. PTSD treatment may play an important role in patients' recovery. One hundred male SUD-PTSD patients who attended SUD treatment completed 1-, 2-, and 5-year follow-ups. Outpatient treatment information was gathered from Veterans Affairs databases. PTSD treatment and 12-Step group attendance in the 1st year predicted 5-year SUD remission. Patients who received PTSD treatment in the first 3 months following discharge and those who received treatment for a longer duration in Year 1 were more likely to be remitted in Year 5. The receipt of PTSD-focused treatment immediately after SUD treatment may enhance long-term remission. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Riggs, D. S., M. Rukstalis, et al. (2003). Demographic and social adjustment characteristics of patients with comorbid posttraumatic stress disorder and alcohol dependence: Potential pitfalls to PTSD treatment. Addictive Behaviors. **Vol 28(9):** 1717-1730.

The present study examined the demographic and social adjustment characteristics of a sample seeking treatment for comorbid posttraumatic stress disorder (PTSD) and alcohol dependence (AD). Using descriptive statistics, we compared the characteristics of this group to those of a sample seeking treatment for PTSD alone and to another sample seeking treatment for AD alone. Results indicated that compared to the PTSD alone and AD alone samples, a greater percentage of the comorbid sample was unemployed, with low income and living without the support of a spouse or intimate partner. Further, participants in the comorbid sample were less likely than those in the PTSD alone sample to have received more than a high school education, though the comorbid and AD samples were comparable on education level. These results are discussed with attention to how poor social adjustment may place comorbid AD-PTSD patients at greater risk for premature termination of therapy, particularly when that treatment is focused on alleviating PTSD symptoms. Suggestions are made to enhance retention of these difficult patients in treatment programs. (PsycINFO Database Record (c) 2004 APA, all rights reserved)

Ruzek, J. I. (2003). Concurrent posttraumatic stress disorder and substance use disorder among

veterans: Evidence and treatment issues. Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders. P. Ouimette and P. J. Brown, Washington, DC, US: American Psychological Association**:** 191-207.

This chapter reviews evidence and treatment issues in concurrent posttraumatic stress disorder (PTSD) and substance use disorder (SUD) among veterans. The author describes the literature related to the dual diagnosis in specific groups of veterans (Vietnam, World War II and Korea), identify clinical practices helpful in working with these veterans, and explore key challenges to the better integration of PTSD and SUD treatment. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Somer, E. (2003). Prediction of abstinence from heroin addiction by childhood trauma, dissociation, and extent of psychosocial treatment. Addiction Research & Theory. **Vol 11(5):** 339-348.

This study is an investigation of trauma and dissociation in 93 Israeli patients recovering from drug use disorder. The respondents showed more emotional, physical and sexual traumatization than consecutive admissions to an Israeli outpatient stress clinic, and their levels of dissociation were similar to those previously measured in Israeli patients diagnosed with Posttraumatic Stress Disorder and Acute Stress Disorder. It was posited that the level of trauma-related dissociation can make an independent contribution to explaining variance in recovery from a drug use disorder. The finding of structural equation analyses supported this model and suggests that childhood traumatization is related to the proclivity of chemically-dependent respondents to participate in psychosocial treatment and that duration of psychosocial treatment can positively predict duration of abstinence. Dissociation levels made an independent negative contribution to the prediction of abstinence. While our findings imply that tenacity in treatment could be a sustaining process associated with abstinence from drug use, they also suggest that without a thorough resolution of trauma-related dissociation, optimal treatment outcome is compromised. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Triffleman, E. (2003). Issues in implementing posttraumatic stress disorder treatment outcome research in community-based treatment programs. Drug abuse treatment through collaboration: Practice and research partnerships that work. J. L. Sorensen, R. A. Rawson and et al., Washington, DC, US: American Psychological Association**:** 227-247.

In this chapter, the author briefly provides information regarding the occurrence, significance, and clinical challenges associated with concurrent posttraumatic stress disorder and substance use disorders (PTSD-SUDS) and then describes an integrative, empirically based treatment: substance dependence PTSD therapy (SDPT). The author then examines issues generated by implementing PTSD-SUDS research across clinical settings both as a general and as a specialized case of the research-clinical interface. The author summarizes common stages of implementation, common problems of interest to clinical administration and researchers, and the unique challenges of implementing a PTSD-SUDS related research-treatment outcome study in a clinic that had not previously hosted treatment outcome studies. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Zatzick, D. (2003). Collaborative care for injured victims of individual and mass trauma: A health services research approach to developing early interventions. Terrorism and disaster:

Individual and community mental health interventions. R. J. Ursano, New York, NY, US: Cambridge University Press**:** 189-205.

This chapter summarizes the results of a pilot of collaborative care intervention that targeted the spectrum of posttraumatic behavioral and emotional disturbances of physically injured trauma survivors. The study explored the feasibility of delivering the intervention and assessing outcomes in surgical wards and outpatient settings. 34 patients (aged 14-65 yrs) recruited from a Level 1 trauma center were randomized: 16 Ss were assigned to the collaborative care intervention and 18 Ss to the usual care control. The main outcome variables assessed were posttraumatic stress disorder and depressive symptoms, at-risk drinking, and physical functioning. The collaborative care intervention significantly decreased posttraumatic stress disorder (PTSD) and depressive symptoms in the first month after trauma. While these improvements were not maintained at the final 4-month evaluation, the intervention appeared successful in both preventing the development of symptomatic distress consistent with a PTSD diagnosis and in reducing clinically significant distress in Ss with initial high symptom levels. There was no evidence that the intervention impacted posttraumatic functional limitations or patterns of alcohol consumption. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

2002

Coffey, S. F., M. E. Saladin, et al. (2002). "Trauma and substance cue reactivity in individuals with comorbid posttraumatic stress disorder and cocaine or alcohol dependence." Drug Alcohol Depend **65**(2): 115-27.

Although the high comorbidity of posttraumatic stress disorder (PTSD) and substance use disorders has been firmly established, no laboratory-based studies have been conducted to examine relationships between the two disorders. Using cue reactivity methodology, this study examined the impact of personalized trauma-image cues and in vivo drug cues on drug-related responding (e.g. craving) in individuals with PTSD and either crack cocaine (CD) or alcohol dependence (AD). CD and AD groups displayed reactivity to both trauma and drug cues when compared to neutral cues, including increased craving. However, the AD group was more reactive than the CD group to both classes of cues. The CD participants were more reactive to trauma-image cues if drug-related material was included in the image while the AD participants were reactive to the trauma cues regardless of drug-related content. It is hypothesized that PTSD-related negative emotion may play a relatively more important role in the maintenance of AD when compared to CD. Evidence that substance dependent individuals with PTSD report increased substance craving in response to trauma memories is offered as a potential contributing factor in the poorer substance abuse treatment outcomes previously documented in this comorbid population.

Cramer, M. A. (2002). "Under the influence of unconscious process: countertransference in the treatment of PTSD and substance abuse in women." Am J Psychother **56**(2): 194-210.

PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costly in the resulting traumatic reenactments experienced by patients whose attempts to escape the past keep them evermore tightly bound to it. Rather than "difficult

patients" a more dynamic and intersubjective conceptualization emphasizes the notion of a "difficult treatment dyad." Vicarious traumatization, unconscious affects about addiction, and pressures within the treatment surround conspire to pull the therapist out of connection with the patient at critical points, and toward sadistic abandonment or collusive indulgence. The concomitant desires to rescue and desert patients create forces for action in the therapist, precisely when what is needed most is the ability to tolerate and contain one's own and the patient's affective experience. The pull for action is also felt by treatment systems, eager for "action" that can be measured in "behavioral observables." Support for the therapist in the form of process supervision can assist the therapist to contain, identify, and acknowledge his/her affective responses evoked in treatment. The therapist is called upon to "grow one's own heart" through a confrontation with the undeveloped parts of self that are vulnerable to the dynamics of the treatment.

Felton, C. J. (2002). "Project Liberty: a public health response to New Yorkers' mental health needs arising from the World Trade Center terrorist attacks." J Urban Health **79**(3): 429-33.

The September 11th terrorist attacks had a dramatic impact on the mental health of millions of Americans. The impact was particularly severe in New York City and surrounding areas within commuting distance of the World Trade Center. With support from the federal government, state and local mental health authorities rapidly mounted a large-scale public health intervention aimed at ameliorating the traumatic stress experienced by residents of the disaster area. The resulting program, named Project Liberty, has provided free public educational and crisis counseling services to tens of thousands of New Yorkers in its initial months of operation. Individuals served vary widely in the severity of experienced trauma and associated traumatic reactions. Data from logs kept by Project Liberty workers suggest that individuals with the most severe reactions are being referred to longer-term mental health treatment services.

Hoge, C. W., D. T. Orman, et al. (2002). "Operation Solace: overview of the mental health intervention following the September 11, 2001 Pentagon attack." Mil Med **167**(9 Suppl): 44-7.

At the direction of the Army Surgeon General, the Army behavioral health consultants in psychiatry, psychology, and social work assembled in Washington, DC immediately after the September 11, 2001 attack to plan and implement a proactive behavioral health response to the Pentagon attack. The goal was to minimize the short- and long-term adverse behavioral health and related medical effects predicted to emerge based on past U.S. mass casualty scenarios. This article summarizes the goals, methods, and rationale used to develop the plan, as well as the key elements of the behavioral health intervention developed in response to the attack.

Jack, K. and S. Glied (2002). "The public costs of mental health response: lessons from the New York City post-9/11 needs assessment." J Urban Health **79**(3): 332-9.

There is evidence of increased rates of psychiatric disorder in New York City in the period following September 11th. Public mental health services need to develop plans to respond to these higher rates of disorder. This article describes what we know and do not know with respect to the costs of such response. We examine evidence on the demand for mental health services, the nature of services to be provided, the characteristics of providers, and the likely sources of payment for care in the context of the attacks of September 11th in New York City.

Miller, D. (2002). "Addictions and trauma recovery: an integrated approach." Psychiatr Q **73**(2): 157-70.

The co-occurrence of addiction with trauma-based mental health problems forms a toxic feedback loop, creating assessment and treatment challenges for consumers and their healthcare providers. Traditional separation of addiction and mental health treatment has contributed to a high level of recidivism among clients challenged by trauma and addiction problems. A new treatment model rooted in an understanding of trauma re-enactment, is described. ATRIUM integrates cognitive behavioral and relational treatment through an approach which stresses mind, body, and spiritual health.

Najavits, L. M. (2002). "Clinicians' views on treating posttraumatic stress disorder and substance use disorder." J Subst Abuse Treat **22**(2): 79-85.

The dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder (SUD) is reported to be both highly prevalent and highly challenging. In this study, 147 clinicians were surveyed on their degree of difficulty and gratification in working with each disorder (PTSD, SUD) and their combination; specific types of difficulties and gratifications; and personal and professional characteristics. The dual diagnosis was perceived as more difficult than either disorder alone; but, interestingly, gratification in the work was higher than its difficulty. Areas of greatest difficulty were clients' self-destructiveness, case management, and dependency; areas of greatest gratification were teaching new coping, developing expertise, and helping clients achieve abstinence. In general, difficulty and gratification appeared to be separate constructs, rather than simply opposites. Those finding the work most difficult were more likely to be in a mental health setting and to have no personal history of trauma. Clinical implications are discussed.

Najavits, Lisa. M. Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press, 2002, 401 pp., ISBN 1-57230-639-4.

This manual presents the first empirically studied, integrative treatment approach developed specifically for PTSD and substance abuse. For persons with this prevalent and difficult-to-treat dual diagnosis, the most urgent clinical need is to establish safety--to work toward discontinuing substance use, letting go of dangerous relationships, and gaining control over such extreme symptoms as dissociation and self-harm. The manual is divided into 25 specific units or topics, addressing a range of different cognitive, behavioral, and interpersonal domains. Each topic provides highly practical tools and techniques to engage patients in treatment; teach "safe coping skills" that apply to both disorders; and restore ideals that have been lost, including respect, care, protection, and healing. Structured yet flexible, topics can be conducted in any order and in a range of different formats and settings. The volume is designed for maximum ease of use with a large format and helpful reproducible handouts and forms.

van Minnen, A., A. Arntz, et al. (2002). "Prolonged exposure in patients with chronic PTSD: Predictors of treatment outcome and dropout." Behaviour Research & Therapy **Vol 40(4)**: 439-457.

Investigated predictors of treatment outcome and dropout in 2 samples (N=59 and 63) of posttraumatic stress disorder (PTSD) patients with mixed traumas treated using prolonged imaginal exposure. Possible predictors were analysed in both samples separately, in order to

replicate in one sample findings found in the other. The only stable finding across the two groups was that patients who showed more PTSD-symptoms at pre-treatment, showed more PTSD-symptoms at post-treatment and follow-up. Indications were found that benzodiazepine use was related to both treatment outcome and dropout, and alcohol use to dropout. Demographic variables, depression and general anxiety, personality, trauma characteristics, feelings of anger, guilt, and shame and nonspecific variables regarding therapy were not related to either treatment outcome or dropout, disconfirming generally held beliefs about these factors as contra-indications for exposure therapy. It is concluded that it is difficult to use pre-treatment variables as a powerful and reliable tool for predicting treatment outcome or dropout. Clinically seen, it is therefore argued that exclusion of PTSD-patients from prolonged exposure treatment on the basis of pre-treatment characteristics is not justified. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Wells, J. D., W. E. Egerton, et al. (2002). "The U.S. Army Center for Health Promotion and Preventive Medicine response to the Pentagon attack: A multipronged prevention-based approach." Military Medicine **Vol 167(Suppl9)**: 64-67.

Discusses the multipronged approach of personnel of the US Army Center for Health Promotion and Preventive Medicine (USACHPPM) to the September 11, 2001 terrorist attack on the Pentagon. The USACHPPM approach encompassed the areas of environmental science, behavioral health, occupational and preventive medicine, risk communication, epidemiology, and medical surveillance. In the early weeks and months following the attack the USACHPPM staff assisted the North Atlantic Regional Medical Command in providing direct health care to those with physical and mental health concerns and have developed, fielded, processed, and are analyzing the results of the Pentagon Post-Disaster Health Assessment (PPDHA). The PPDHA was a Web-based survey completed by 4,764 Pentagon employees. Considerable technical difficulties were encountered in accessing and completing the survey. Preliminary results show that 36 percent of respondents reported a worsening of prior health problems and/or new health problems, of which the majority were stress-related. 28 percent of respondents reported symptoms associated with high risk for at least 1 of the following: post-traumatic stress disorder, depression, depressive disorder, panic disorder or attacks, or alcohol abuse. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

2001

Back, S. E., B. S. Dansky, et al. (2001). "Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: description of procedures." J Subst Abuse Treat **21**(1): 35-45.

An estimated 30 percent to 50 percent of cocaine-dependent individuals meet criteria for lifetime PTSD. This comorbidity has detrimental effects on clinical presentation, and treatment course and outcome. Cocaine dependence is associated with increased rates of exposure to trauma, more severe symptoms, higher rates of treatment attrition and retraumatization, and greater vulnerability to PTSD when compared to other substance use disorders. These associations underscore the need for effective treatments that address issues particular to PTSD in a manner tolerable to cocaine-dependent individuals. This article describes a manualized psychotherapy developed specifically for individuals with PTSD and cocaine dependence. Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) provides coping skills

training, cognitive restructuring techniques, and relapse prevention strategies to reduce cocaine use. In-vivo and imaginal exposure therapy techniques are incorporated to reduce PTSD symptom severity. Primary treatment goals include psychoeducation specific to the interrelationship between PTSD and cocaine dependence, and clinically meaningful reductions in cocaine use and PTSD symptomatology. Secondary goals include a reduction in HIV high-risk behaviors and improved functioning in associated areas, such as anger and negative affect management.

Donovan, B., E. Padin-Rivera, et al. (2001). ""Transcend": initial outcomes from a posttraumatic stress disorder/substance abuse treatment program." J Trauma Stress **14**(4): 757-72.

This paper describes the development of a comprehensive treatment program for combat veterans diagnosed with posttraumatic stress disorder (PTSD) and substance abuse (SA). Outcome data are presented on 46 male patients who completed treatment between 1996 and 1998. The treatment approach, defined by a detailed manual, integrates elements of cognitive-behavioral skills training, constructivist theory approaches, SA relapse prevention strategies, and peer social support into a group-focused program. The Clinician-Administered PTSD Scale (CAPS) and the Addiction Severity Index (ASI) were used to assess treatment effectiveness at discharge and 6- and 12-month follow-up. Significant symptom changes revealed on CAPS and ASI scores at discharge and follow-up are analyzed. Discussion focuses on hypotheses regarding treatment effectiveness, study limitations, and suggestions for further research.

Hadzibajric, A., Z. Dvizac, et al. (2001). "[Comprehensive approach in treatment at the day care hospital department for alcoholism and other drug addictions in the Sarajevo Canton]." Med Arh **55**(3): 151-3.

In this paper, experiences in treatment of alcoholics with the symptoms of posttraumatic stress disorder are presented in the form of case review. During the five year post-war period /1996-2001/ 72.8 percent of total number of treated patients were treated for the first time, and 34.5 percent had the diagnosis of posttraumatic stress disorder beside the diagnosis of alcohol addiction. In the observed period, changes in symptoms of the patients-alcoholics that were caused by the war trauma were noticed. The authors present their own experiences in the application of new techniques and the approach to these patients that have been integrated in the overall treatment system. Principles such as active treatment and multidisciplinary team approach through networked group and individual treatment forms were pointed through this case review.

Harris, M. and R. D. Fallot (2001). "Designing trauma-informed addictions services." New Dir Ment Health Serv(89): 57-73.

Because addictive disorders are so common among women who have experienced prolonged sexual and physical abuse, it is especially important to design addictions services that meet the needs of the trauma survivor.

Zatzick, D. F., P. Roy-Byrne, et al. (2001). "Collaborative interventions for physically injured trauma survivors: A pilot randomized effectiveness trial." General Hospital Psychiatry **Vol**

23(3): 114-123.

Posttraumatic behavioral and emotional disturbances occur frequently among physically injured hospitalized trauma survivors. This investigation was a pilot randomized effectiveness trial of a 4-mo collaborative care intervention for injured motor vehicle crash and assault victims. As surgical inpatients, intervention subjects (Ss; N=16; mean age 35.3 yrs) were assigned to a trauma support specialist who provided counseling, consulted with surgical and primary care providers, and attempted postdischarge care coordination. Control Ss (N=18; mean age 32.5 yrs) received usual posttraumatic care. For all Ss, posttraumatic stress disorder (PTSD) and depressive symptoms, episodic alcohol intoxication, and functional limitations were evaluated during the hospitalization and 1 and 4 mo postinjury. Study logs and field notes revealed that over 75 percent of intervention activity occurred in the first month after the trauma. One-month post-trauma intervention Ss when compared to controls demonstrated statistically significant decreases in PTSD symptoms as well as a reduction in depressive symptoms. However, at the 4-mo assessment, intervention Ss evidenced no significant improvements in PTSD and depressive symptoms, episodic alcohol intoxication, or functional limitations.