(2000) Alcoholism Treatment Quarterly, 18(3): 83-98

# Training Clinicians in the *Seeking Safety* Treatment Protocol for Posttraumatic Stress Disorder and Substance Abuse

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**ABSTRACT.** This paper provides suggestions for training clinicians in the *Seeking Safety* psychotherapy for patients with posttraumatic stress disorder and substance abuse. The treatment is a manual-based 25-session cognitive-behavioral therapy for integrated treatment of both disorders. Training guidelines include: procedures for clinician selection and training, supervisory principles, and typical problems. Emphasis is placed on procedures that allow observation of the clinician "in action" rather than through verbal report (e.g., taped sessions) and on intensive training experiences (e.g., watching videotapes of good versus poor sessions, rehearsal of "tough case" scenarios, peer supervision, identifying key themes, and think-aloud modeling). Supervisory principles include, for example: Encourage clinicians to use the coping skills in their own lives; Elicit patient feedback; and Listen to behavior more than words. These methods are "best guesses" based on experience with clinicians over several years; further empirical testing will be needed to determine which training strategies are most effective. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com>]*

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The study was supported by grants RO1 DA-08631 and K02 DA00400 from the National Institute on Drug Abuse, and R21 AA-12181 from the National Institute on Alcohol Abuse and Alcoholism.

## *INTRODUCTION*

### *Positive Views*

- My counselor saved my life.
- My doctor gave me answers I was looking for. I don't feel so crazy now.
- My therapist is like a cup of warm tea on a cold winter day.

### *Negative Views*

- After I see my therapist, I want to drink.
- My counselor would just get frustrated; he didn't seem to know what to do.
- My doctor accused me of abusing my daughter by drinking. I never went back.

Treating substance abuse patients can be extremely challenging. Treating dual diagnosis patients–who have a mental illness in addition to substance abuse–can add even more complexity. The quotations above are all direct statements from patients, and highlight both the lifesaving role the clinician can play at best and the damaging role the clinician can play at worst.

Indeed, research on substance abuse treatment over the past decade has shown that clinicians differ widely in their impact on outcomes, with some showing exceptional ability to help patients while others evidence no impact or, at worse, harmful impact (see reviews by Najavits & Weiss, 1994; Najavits, Crits-Christoph & Dierberger, in press). Indeed, in the majority of studies, therapists have had more of an impact on outcome than either patient characteristics or type of treatment. How to select and train clinicians for substance abuse treatment thus becomes an important issue, with real implications for the quality of care patients receive.

In this paper, the author will describe some principles that have arisen in the context of training clinicians to conduct a manual-based treatment for the dual diagnosis of posttraumatic stress disorder and substance abuse. The treatment, *Seeking Safety*, is a 25-session cognitive-behavior therapy specifically designed for this dual diagnosis. It has been under development since 1993 through funding by the National Institute on Drug Abuse, and is based on five key principles: (1) *Safety* as the priority of this "first stage" treatment; (2) *Integrated treatment* of PTSD and substance abuse at the same time; (3) A focus on *ideals*; (4) Four content areas; *cognitive, behavioral, interpersonal,* and *case management*; and (5) Attention to *therapist processes*. Each session is designed to address a coping skill relevant to both PTSD and substance abuse; sample topics are *Honesty, Asking for Help,*

*Setting Boundaries in Relationships, Taking Good Care of Yourself,* and *Recovery Thinking.* It is described in detail in Najavits (in press-a) and Najavits, Weiss and Liese (1996). It has shown promising outcome results in an initial pilot study (Najavits, Weiss, Shaw & Muenz, 1998), with significant improvements from pre- to post-treatment in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment. Patients' treatment attendance, alliance, and satisfaction were also very strong. Currently it is being tested in six controlled trials, in adult women, adolescent girls, poor/homeless women, incarcerated women, inner-city women, and male combat veterans.

The author has trained over a dozen clinicians to conduct the treatment as well as taught numerous workshops on it. Based on this experience, suggestions for training are described below, with clinical examples. Specifically, three topics will be covered: (1) procedures for clinician selection and training; (2) supervisory principles; and (3) typical problems. It should be noted, however, that these training principles are "best guesses" derived from experience but not yet empirically studied in any rigorous way (as is true of most psychotherapy training). To the degree possible, the description below addresses issues particular to this treatment program and patient population, although some are likely non-specific and applicable to others as well.

## *PROCEDURES FOR CLINICIAN SELECTION AND TRAINING*

In selecting and training clinicians to conduct *Seeking Safety* several procedures appear to be helpful. These are highly intensive procedures which, while developed in research studies, can translate to clinical settings as well.

*Clinicians are selected based on performance rather than professional background.* A large body of research has shown that the standard criteria for hiring clinicians is not borne out by the data. This is one of the most counter-intuitive and resisted issues in the mental health field: that clinicians' professional degree, training, and experience level (and within the substance abuse community, recovery status) do not produce differential outcomes overall (see review by Najavits et al., in press). Despite such findings, most clinical settings and research studies continue to utilize such criteria.

In hiring clinicians for *Seeking Safety,* the selection procedures are designed to evaluate actual performance instead. Thus, there are no cut-off criteria for how many years' experience the clinician needs to have had, training, degree, theoretical orientation, or substance abuse recovery status. Instead, a two-step initial process is used to see how the clinician does "in action" when treating patients. The same principle applies for the training and supervision procedures: rather than emphasizing the standard supervi-

sion method of verbal report by the clinician, sessions are taped and discussed and teaching methods emphasize "in action" strategies. This emphasis was an evolution over time, after an initial phase in which therapists who sounded "perfect" for the work based on their professional background were not necessarily the ones who did the best with the treatment, while some who did not match as well on paper in fact were better in action. Looking back, it makes sense that there are many factors that predict therapist performance. Indeed, it may well be the case that pre-existing therapist factors (such as how the clinician was raised, personality style, and life experiences) may have more impact on performance than professional background characteristics such as degree and training. The two-step procedure for therapist selection/training is as follows.

1. *Conduct two audiotaped sessions of the protocol before beginning training.* All clinicians applying to work on the study conduct two audiotaped sessions of the treatment with actual patients (a procedure used in Crits-Christoph et al., 1998). Even before formal training, just picking up the manual and trying it out with patients can help determine whether it will be a good match. Some clinicians do not like treatment protocols and it is better to find this out early on; and, perhaps the best way to do this is by direct experience rather than simply reading the manual or talking about it. Moreover, the patients are asked to fill out a confidential questionnaire after the session, which helps to determine patients' reactions to the therapist. If the tapes suggest moving forward to the next stage, the therapist and supervisor then have an initial supervisory session in which the tapes are discussed (strengths and weaknesses) to also "try out" whether they will be a good working team and whether the supervisor's suggestions for growth areas feel acceptable to the therapist.

2. *Conduct the full treatment at least once with a real patient.* The bulk of the training process involves having the clinician conduct each session of the treatment with a patient (who has both PTSD and substance abuse), or if group treatment, an entire group. All sessions are audiotaped and the therapist meets with the supervisor weekly to discuss the work. After each session, the patient fills out a brief (2-minute) feedback questionnaire rating how helpful the clinician, session topics, and handouts were. This initial trial run is extremely helpful in identifying how to translate what's on the pages of the manual to real-life work, and to be able to see the repeating themes that occur across the treatment.

3. *Intensive training strategies.* In addition to the above, a variety of intensive training strategies are used to try to further solidify the clinician's skill in conducting the treatment. The strategies emphasize training methods that go beyond standard-supervision verbal discussion of cases, aiming as much as possible for more direct methods of instruction. Not all of the

strategies are used with every clinician; the selection is adapted based on clinician preference, training needs, and feasibility.

*Rehearsing "tough cases."* A series of role-plays are conducted to rehearse how to manage challenging clinical situations that may arise with some patients. Table 1 provides examples of these for several sessions of the treatment.

*Watching videos of good and poor sessions of the treatment.* As all sessions of the treatment are videotaped when conducted for research, this provides an archive of sessions that clinicians can watch. Sessions, or clips from them, are identified to model "how to" and "how not to" conduct the treatment. It should be noted, however, that to use such videos for training requires formal permission from patients as part of the institution's procedures for obtaining informed consent for research participants. In studies, it is made clear to patients that the videotapes will be used for training future clinicians and that they can sit outside the range of the camera if they do not want to be seen. Many clinicians have reported that watching videos is the easiest way for them to absorb the treatment principles.

*Watching qualitative interviews of patients.* As part of conducting research on patients with PTSD and substance abuse, patients are offered the opportunity to volunteer to participate in a videotaped "qualitative interview" in which they discuss issues such as how they view their disorders, their perception of the link between the two disorders over time, their views on what is helpful and harmful in the treatment of the disorders, and other topics relevant to the dual diagnosis. These tapes are especially helpful for clinicians who have never worked before with this population of dual diagnosis patients, can speed up the learning process, and can increase clinicians' empathy for this patient population. The same informed-consent procedures are obtained for these videos as noted above.

*Identifying key themes across treatment.* To keep the big picture in mind, clinicians are asked, throughout the training, to notice key themes that are emphasized across sessions. By noticing key themes, clinicians can be helped to avoid one of the greatest dangers of manual-based treatment: sticking so closely to the session protocol that they "lose" the patient in the process. Clinicians are encouraged to make the treatment their own, to fit the protocol to their style, and to pursue any areas the patient believes are important. Thus, in any session where they want to pursue a topic that is not directly related to the session protocol, this is acceptable as long as it fits the larger key themes of the treatment in some way. Examples of key themes are:

- Safety (e.g., helping the patient act, think, or relate in ways that increase safety)
- Linking PTSD and substance abuse (e.g., helping the patient understand how the two disorders are related)

- Focusing on PTSD and substance abuse (e.g., in every session, the terms "PTSD" or "trauma" and "substance abuse" need to be mentioned and related to the session topic)
- Gaining control over intense affects (e.g., if the patient is overwhelmed by intense affect, such as anger or drug cravings, the goal is to bring the affect down to a moderate level as a way of learning to cope, in-vivo in the session)

*Think-aloud modeling.* If feasible, the supervisor co-leads a training case with the clinician (particularly for group treatment) to directly model session interventions. After the session, they can discuss what the supervisor was thinking and aiming for, how decisions were made during the session, and pros and cons of different strategies that were attempted. This can also be accomplished if both clinician and supervisor watch the same videotape of a previously recorded session conducted by the supervisor.

*Peer supervision.* Clinicians conducting the treatment are encouraged, but not required, to attend a peer supervision group for clinicians treating this dual diagnosis. The goal is to have a place to freely discuss issues that arise and to share in supporting each other. It is set up by the supervisor, but no supervisors are present.

*Background reading.* Clinicians are asked to read several books relevant to this population: *Trauma and Recovery* (Herman, 1992), which offers an excellent overview of PTSD; *Cognitive Therapy of Substance Abuse* (Beck, Wright, Newman & Liese, 1993), which applies cognitive therapy to substance abuse, and *Motivational Interviewing* (Miller & Rollnick, 1991), which teaches "good therapy process" skills for substance abuse treatment. (Indeed, I developed a brief mnemonic to help memorize the principles: "The good therapist READS the patient," i.e., roll with *r*esistance, express *e*mpathy, avoid *a*rgumentation, develop *d*iscrepancy, and promote *s*elf-efficacy.)

*Required AA/self-help exposure.* Clinicians are required to attend at least two Alcoholic Anonymous meetings or other similar self-help groups so that they can better understand how such meetings are helpful for patients.

*Knowledge test.* A multiple-choice test of important principles of the treatment is completed by each therapist after the initial training period.

*Listen to a tape for each supervision session.* Within a few days prior to supervision, it is helpful for both clinician and supervisor to listen to a session tape (with the clinician re-listening if the session was more than a few days ago). This allows for specific feedback and re-playing of sections of the tape to identify strengths or weaknesses. For group supervision, this is especially useful as clinicians get to hear each other conducting the sessions.

*Adherence/helpfulness ratings.* As is standard now in all rigorous psychotherapy outcome studies, the supervisor or an outside expert rates at least a sample of tapes for the clinician's adherence (how much the clinician fol-

lowed the protocol). In addition, ratings of *helpfulness* (how much patients appeared helped by the interventions) is rated as part of *Seeking Safety.* (A technical note: in most psychotherapy studies, clinicians are rated for *competence*, i.e., whether they conducted the intervention in an expert way, rather than *helpfulness*. In *Seeking Safety,* helpfulness is rated as it is believed to be more directly related to outcome; however, empirical results on this question are not yet available). Such ratings can also be used in clinical work that is not part of research studies, and it has been suggested (Carroll, Rounsaville & Nich, in press) that having clinicians rate their own adherence and compare it to supervisory ratings may also improve performance.

## *SUPERVISORY PRINCIPLES*

In addition to the specific training methods above, some general guidelines have emerged over time as particularly helpful in working with clinicians on *Seeking Safety* (see Table 1).

*Imagine a triangle of the patient, the treatment, and the clinician.* In conducting a protocol treatment, it is easy to lose the essential balance between these elements. If the *treatment* is over-emphasized, it can feel like "school" to the patient, or invalidate the patient's own concerns. For example, the patient brings up that she had unsafe sex over the weekend; the clinician selected the topic *Integrating the Split Self* for today's session and does not know how to relate it to the topic, so ignores the patient's unsafe behavior. If the therapist overemphasizes the *patient* at the expense of the treatment, the session takes on an unstructured, rambling quality, and the patient does not learn the new coping skills that the treatment is designed to address. A typical example of this is when the clinician is conducting the check-in (designed to be no more than five minutes per patient, with important issues getting additional attention later in the session). Many clinicians cannot maintain this limit and the check-in becomes the entire session with a scant attempt to work on the session topic in the last few minutes of the hour. Finally, if the *clinician* is overemphasized, it means clinicians are putting their needs above those of the patient or the treatment. For example, the clinician is having a hard day and does not feel like making the effort to look up a referral for the patient.

*Notice the paradox of countertransference in PTSD and substance abuse.* In the treatment of patients with PTSD and substance abuse, therapists tend to be either "too nice" or "too harsh." This appears to be a result of identifying more with either one disorder or the other. If they identify primarily with the PTSD, they tend to be very warm and supportive, sympathetic, and conscious of patients' fragility. At the extreme, however, they fail to hold the patient accountable in ways that promote growth. They are so "supportive" that

TABLE 1. Examples of "tough cases" used for training clinicians in *Seeking Safety.*

From the session on *Honesty* (interpersonal session)

- "But it will hurt the other person if I'm honest."
- "Whenever I'm honest with my husband he beats me up."
- "I can be honest in a role-play, but in real life I could never do it."
- "Are you telling me I'm a liar?"
- "When I was a child, I told my mother that my brother molested me and she said I was lying."
- "Should I tell everyone at work that I'm an addict?"
- "I can't tell my doctor that I abuse alcohol."

From the session on *Creating Meaning* (cognitive session)

- "My thoughts are bad, just like I'm bad."
- "Positive thinking never works for me."
- "I think my childhood was miserable, filled with abuse and pain. Are you saying I shouldn't view it that way?"
- "I tried rethinking the situation, but it didn't make me feel better."
- "Do you use rethinking yourself?"

From the session on *Self-Nurturing* (behavioral session)

- "I just can't experience pleasure–nothing feels good to me."
- "All of the people I know drink to have a good time."
- "Whenever I try to do something pleasurable I feel guilty."
- "I have three kids, a job, and take a class at night. I don't have any time for myself."
- "My partner doesn't want me to go out of the house."

mything the patient does is praised. For example, a patient says "I used ocaine this week" and the therapist says, "Well, that's okay; I'm sure you ried your best." Indeed, a danger is that patients may begin to escalate their nsafe behaviors to try to evoke a real response from the therapist.

If, alternatively, therapists identify primarily with the substance abuse, hey tend to emphasize patient responsibility and decision-making, holding hem accountable for their actions. At the extreme on this end, they may ecome too harshly confrontational and the patient may feel coerced or

misunderstood. For example, a patient says, "I'm not ready to give up substances" and the therapist says, "You're an addict; admit that, or you're not going to get better." For patients with PTSD, such harsh messages may re-enact an abusive past in which others took control at their expense. In short, the therapist, just like the patient, needs to learn to balance both disorders. Both support and accountability are essential to promote patients' growth.

*Master the format first, then the content.* It has been found easiest to first have the clinician work on becoming comfortable with the format. Issues such as keeping the check-in brief, remembering to do all parts of the session, and how to select what gets covered in the session require an initial learning curve. Unless these are mastered, it becomes difficult to focus clearly on the content.

*Encourage therapists' own style in conducting the treatment.* One of the most important areas of growth for the supervisor as well as the clinician is to allow a wide diversity of interpretation in implementing the treatment. With protocol treatments, there is sometimes a danger of being overly directive or judgmental about "what works." For it to become natural, clinicians need to feel that their own style can be valued and that the protocol will not become a strait-jacket that mars the gratification of conducting therapy. Here too, just as the *Seeking Safety* treatment tries to empower patients by having them select what works for them (and letting go of those that do not), so too the clinician is asked to "select what suits you" amid a variety of possible interventions. For example, some clinicians dislike role plays and filling out clinical forms, while others enjoy these.

*Identify cross-training needs.* It is rare for a clinician to have equivalent expertise in the treatment of both substance abuse and mental illness. With separate treatment systems and a longstanding historical split between the two areas, clinicians typically belong to either one culture or the other. In dual diagnosis work, there is a strong need for clinicians to learn "the other side" if they are to be effective. For the clinician whose primary expertise has been substance abuse treatment, typical training areas include: learning about mental health treatments for PTSD (e.g., exposure therapy, eye-movement desensitization retraining, critical incident stress debriefing, cognitive-behavioral therapy, and medications used for anxiety disorders); phases of recovery for PTSD (e.g., safety, mourning, and reconnection; Herman, 1992); assessment of trauma and PTSD; how to "deepen" the treatment by exploring the meaning of substance use in the context of PTSD (Najavits, in press); and how to evaluate outcome more broadly than for substance-abuse-alone treatment. For the clinician whose primary expertise has been mental health treatment, typical training areas include: basic education in types of substances abused, the psychobiology of addiction (e.g., withdrawal, tolerance),

the need for urinalysis and breathalyzer testing, assessment of substance use at each session, case management, the need to re-assess psychiatric symptoms after a period of abstinence, and self-help groups.

*Use a "triage" approach for deciding what to work on in each session.* Patients with PTSD and substance abuse typically have enormous needs and frequent crises and clinicians frequently report feeling overwhelmed. A simple guideline is to identify the patient's most unsafe behavior since the last session and work on that, in keeping with the treatment's priority on safety above all. Specific rehearsal of how to handle emergencies is also helpful.

*Aim for the light, but see the darkness.* Or, in mental health terms, strive for ideals but assess pathology as well. Related to the point above, clinicians need to notice what patients are doing poorly (unsafe coping). Because each topic is framed in terms of an ideal to strive for (e.g., Honesty, Compassion), clinicians sometimes fall into the trap of discussing the topic without ever assessing patients' pathology (e.g., in a session on Honesty, the clinician needs to identify when the patient last lied; in a session on Compassion, the clinician needs to assess the patient's self-hatred). When the clinician does not do this, the session is likely to lack depth. If the clinician comes from a personal background with little hardship, they may also be prone to the belief that "everything works out in the end" or other overly optimistic views. Emphasizing the very real life-and-death struggles patients go through–truly "getting" this at an emotional level–is necessary for working with this population.

*Encourage awareness of self-care and systems issues.* Much of what impacts therapy sessions is what happens outside of them. Clinician self-care is a known need when working with highly disturbed patients. By taking care of their emotions and life outside of treatment, clinicians are free to be more present and caring toward patients. Moreover, one of the most significant stresses in conducting work with this population are systems problems that clinicians cannot solve: managed care or other resource limits that create "revolving door" treatment, splits between mental health and substance abuse systems that prevent coordination of care, inadequate staffing, lack of upward career paths, and sometimes low pay and poor environments. As Gustafson (1991) has noted, the message to clinicians is often, "Do more and do it better." Empathizing with these very real constraints is essential, as is doing whatever the supervisor can to mitigate their impact (e.g., setting up free peer supervision).

*Relate process issues back to PTSD and substance abuse.* Clinicians tend to have the greatest difficulty with the therapy process. The questions they most frequently ask include: "How do I rein in a patient who is dominating the group?" "How do I de-escalate a patient who is upset?" "How should I manage a patient who is mad at another?" "Should I eject the patient from treatment?" These questions, far more than content about PTSD and sub-

stance abuse, predominate. While no simple answers can be given here, the supervisor can be guided both by general works on process with difficult patients (e.g., *Motivational Interviewing*), and also by helping the clinician connect these process issues back to PTSD and substance abuse. The nature of these disorders is often expressed in dynamics such as control, secrecy, intense affect, distrust, and acting out; by understanding the process issues in light of the disorders, solutions become clearer. For example, if a patient is dominating the group session and the clinician can see this as a striving to "be heard" because growing up he was repeatedly abused and never listened to, the intervention in the session might be very different than if the clinician conceptualizes the behavior as relating to antisocial personality disorder.

*Encourage clinicians to use the treatment skills in their own lives.* It is very difficult to effectively teach a coping skill that one has not mastered oneself. Clinicians are encouraged to practice the coping skills both in their own lives and in supervision, such as noticing their own belief systems and using "rethinking" (see also Beck et al., 1993; and Najavits, 1997 on the latter), being honest in supervision even when it is difficult, trying the skill of discovery (e.g., experimenting with unfamiliar treatment interventions), using grounding, etc.

*Listen to behavior more than words.* The nature of patients' defenses in both PTSD and substance abuse (e.g., splitting, re-enactments, denial) requires clinicians to use patients' behavior as their primary guide in assessing them. Patients may talk very genuinely about coping in safe ways, but the clinician will do best by "listening" to their behavior above all. If the patient is not showing up for treatment, gets a dirty urine, is practicing unsafe sex or any of the other myriad unsafe ways their symptoms get expressed, then the clinician needs to intervene at that level. Moreover, understanding patients' unsafe behaviors as an expression of emotional pain is usually the most empathic stance. Some clinicians, particularly early in working with this population, buy into patients' hopes and wishes more than their behavior and thus inadvertently slow down potential progress.

*Notice countertransference.* As in all therapies, noticing one's own reactions to the patient is crucial (see review by Najavits, in press-b). In addition to the "paradox of countertransference in PTSD and substance abuse" discussed above, some typical signs of problematic countertransference include:

- You don't enjoy working with the patient
- You find it hard to learn from the patient (who has much to teach you)
- You feel a strong need to control the patient
- You feel victimized
- You argue with the patient
- You don't care what happens
- The patient wants to work with someone else

*Elicit patients' feedback.* At the end of every session, patients are asked to complete a brief feedback form. In this and throughout the treatment, clinicians are encouraged to elicit patients' genuine reactions to the clinician and therapy. While it may be painful at times, clinicians need to really hear what patients are telling them and try to modify the treatment to adapt to it whenever possible. Some precepts that capture this include "going with the patient," "seeing the world through the patient's eyes," and "the customer is always right (at least to some degree)." There may be times when defending one's own view or interpreting the complaint in light of the patient's pathology is accurate, but it is most helpful as a first step to identify the element of truth in the feedback.

*Teach clinicians how to give direct, honest feedback to patients.* Therapists tend to have a far easier time establishing a positive alliance with patients than they do providing constructive feedback. Some have such a difficult time with the latter that the treatment devolves into sentimentality. "Sentimental therapists" are supportive at the cost of reality and growth; they protect the patient at the expense of helping them. They convey sympathy but appear to lack a deeper compassion for the patient. It can be useful to encourage the clinician to strive for *helping* the patient rather than being *liked* by the patient; and teaching the precept that "alliance is necessary but not sufficient." Role-playing how to convey constructive feedback can also be useful. For example, asking the patient to obtain urine testing for substance abuse, or talking with the patient about a urine that was positive for substances (after the patient denied using) are difficult for some clinicians. (Note that some clinicians who are not yet skilled at these difficult tasks may initially come across as overly harsh; it may take a while for them to create a balanced tone.)

## *TYPICAL PROBLEMS*

In Table 2, some of the most common problems in implementing the treatment are listed. Below, some are described in more detail, with suggested solutions, to illustrate the training process (see Table 2).

*Typical problem: The therapist is overly abstract and general.* Patients with PTSD and substance abuse often become overwhelmed with the struggles of recovery. They tend to get into hopeless and suicidal states, and their cognitive/emotional pattern can be one of generalization and abstractions. If the therapist becomes caught up in this sort of dialogue, it is usually not helpful.

> Example: Patient: "I want to give up. There's no point in living anymore."
> Clinician: "But you have so much to live for."

Patient: "I can't stand it; I just want to die."
Clinician: "You can get better; things can change."

Notice that this sort of abstract dialogue can go on endlessly without resolution. It can become a philosophical debate about the meaning of life, yet the patient never becomes convinced.

*Suggested solution: Stay focused on specific and current problems.*

Patient: "I want to give up. There's no point in living anymore."
Clinician: "Did something happen this week that makes you feel this way?"
Patient: "My mother was criticizing me a lot."
Clinician: "Let's talk about how you can respond to your mother's criticism . . ."

Notice that here the clinician tries to find out what happened very recently (in the past week) that triggered the patient's hopeless feelings. By finding out specifics, the clinician can now work with the patient on a specific problem that can be changed.

*Typical Problem: The clinician lectures the patient.* Particularly when using a manual-based treatment with a psychoeducational component (or other information to convey), clinicians often devolve to a "talking at the patient" style. Patients may feel lectured to and feel that their own needs are not being met.

*Example:* Clinician: "Today we're going to talk about the symptoms of PTSD. Take a look at the handout. The symptoms of PTSD are. . . ." [The clinician spends several minutes telling the patient what is on the handout, with the patient quietly listening; no dialogue is occurring.]

*Suggested solution: Turn statements into questions.*

Clinician: "Do you know what 'PTSD' is? Have you ever heard that term?"
Patient: "I was told I have it but I'm not sure what it is."
Clinician: "Take a look at this list on the handout–does any of this fit your experiences?"
Patient: "Yes, this point here about sleep problems, I've had that for a long time . . ."

Notice that here the patient and clinician are engaged in a dialogue, and information is conveyed in light of patients' own knowledge and experiences. The clinician primarily asks questions rather than making statements.

*Typical problem: The clinician does not know how to de-escalate an agitated patient.* Patients with PTSD and substance abuse can easily become

TABLE 2. Typical clinician problems in conducting *Seeking Safety.*

1. "Schoolish": lecturing the patient or staying too abstract.
2. Focusing on PTSD or substance abuse but not both.
3. Inability to de-escalate a patient who is overwhelmed by emotions.
4. Speaking in jargon rather than simple, human language (e.g., "cognition" versus "thinking," "negative affect" versus "emotional pain").
5. Not giving patients accurate, constructive feedback.
6. Not following the format for sessions.
7. Telling patients how they feel rather than asking them.
8. Losing sight of the "big picture" goals of treatment (e.g., reduce substance use).
9. Asking the patient to do things the clinician cannot do (e.g., "Please find yourself a detox," when the clinician does not know how to find one).
10. Giving patients answers rather than getting patients to generate answers.
11. Not "making up" for lack of background in PTSD or substance abuse.
12. No sense of time urgency (e.g., case management slow and vague).
13. Feeling either too much for the patient's pain (overwhelmed) or too little (numb).
14. Not recognizing the life/death nature of some of patients' problems.
15. Pessimism: not recognizing that patients can improve.
16. Protecting the needs of the clinician or staff over those of the patient.
17. Not hearing patients' goals and concerns.
18. Not using the coping skills in one's own life, but asking patients to.
19. Being defensive or not knowing how to apologize after making a mistake.
20. Wanting to avoid patients' negative feedback.
21. Letting patients ramble rather than re-focusing on important issues.
22. Being "too nice."
23. Being "too harsh."
24. Offering dynamic interpretations in early-stage recovery.

escalated. They may dissociate, become enraged, or cry; if any of these become too intense without the clinician helping the patient to de-escalate, the patient may feel out of control and may be more likely to engage in unsafe behavior such as substance use or self-harm.

*Example:* The patient describes a recent upsetting incident and in doing so becomes increasingly agitated. The clinician passively lets the patient keep talking, and the patient eventually leaves the session early because she is so upset.

*Suggested solution: Use empathy, empowerment, and grounding to de-escalate an agitated patient. Empathy* means soothing the patient by validating the emotional pain, e.g., "I can really hear you're upset," "I understand that you're angry." The clinician does not need to agree with the patient's views or explore them; but rather, just to provide soothing empathy to the patient. *Empowerment* means give the patient power and choice (e.g., "You can keep talking about this issue, but I'm worried that it's making you extremely upset. Do you want to continue talking about it?"). Another strategy is *grounding* (often used for PTSD but also helpful for substance abuse symptoms such as cravings). This involves working on a set of concrete sensory and cognitive exercises with the goal of helping patients focus away from their feelings, to distract and detach from emotional pain. For example, "Look around and notice all the colors in the room . . . Tell me how many chairs you see . . . Can you tell me the names of TV shows on Thursday nights?. . .", etc. It is described at length in Najavits (in press). Finally, in general, when trying to de-escalate a patient it is important not to explore any issues, query the patient, or defend one's own point of view; these can only be addressed once the patient is calmer.

## *SUMMARY*

This paper provides a guide to training clinicians in the *Seeking Safety* manual-based treatment for patients with posttraumatic stress disorder and substance abuse, a population that is typically considered "difficult to treat." Several topics were covered: the importance of highly skilled clinicians, procedures for clinician selection and training, supervisory principles, and typical problems. Emphasis was placed on selection and training procedures that allow observation of the clinician "in action" rather than through verbal report (e.g., taped sessions), intensive supervisory training procedures (e.g., watching videotape exemplars of good versus poor sessions and interviews with patients, rehearsal of "tough case" scenarios, providing peer supervision, identifying key themes, think-aloud modeling), and a wide array of supervisory principles (e.g., "Encourage clinicians to use the treatment skills in their own lives," "Elicit patient feedback," and "Relate process issues

back to PTSD and substance abuse"). It is noted that these methods are "best guesses" based on experience training clinicians over several years, but that further empirical testing will be essential to determine which training strategies are most effective.

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