

Najavits, L. M. (2006) Seeking Safety. In V. Follette & J. Ruzek (Eds). Cognitive-behavioral therapies for trauma (2 ed., pp. 228-257). New York: Guilford Press.

CHAPTER TEN

Seeking Safety

Therapy for Posttraumatic Stress Disorder and Substance Use Disorder

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“I just felt so ugly, hateful and evil. I hated myself. There was nothing good in me. I didn’t know I was someone. I would always look down. But when I drank, it made me feel confident, secure and happy. It made me feel all the things I was not.” (quoted in Stamm, 2002)

This client put into words what many live day to day: the use of substances to escape the emotional pain of trauma. Having suffered childhood physical and sexual abuse by multiple family members, the client began using substances at a young age. Despite attending self-help groups such as Alcoholics Anonymous (AA) and numerous treatment programs, she was unable to stop. Eventually she found a therapist who helped her explore the connection between her trauma and her substance use disorder (SUD). She views therapy as her foundation and has achieved 8 years of sobriety (Stamm, 2002).

There are many different client stories, types of trauma, substances, and treatment methods. However, research over the past decade has established the basic and important point that trauma and SUD frequently co-occur. For example, posttraumatic stress disorder (PTSD), the psychiatric disorder most directly related to trauma, is highly associated with SUD (for reviews, see Brady, 2001; Jacobsen, Southwick, & Kosten, 2001; Najavits, Weiss, & Shaw, 1997; Ouimette & Brown, 2002; Ruzek, Polusny, & Abueg, 1998; Triffleman, 1998). In community samples, men with PTSD have a 51.9% lifetime rate of alcohol use disorder, and 34.5% have drug use disorder; the respective rates for women are 27.9% and 26.9% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In treatment settings, the rates are higher. For example, 33–59% of women in substance abuse treatment have current PTSD, and 55–99% report

one or more lifetime traumas (Najavits et al., 1997). Among males the most common traumas associated with SUD are combat and crime victimization, whereas among females they are childhood physical and sexual abuse (Najavits et al., 1997). Large-scale traumatic disasters such as the 9/11 attacks, the Oklahoma City bombing, and Hurricane Hugo, are also associated with increased substance use (Clark, 2002; North et al., 1999). Substances are also used by trauma perpetrators, who may be under the influence at the time of assault or sedate the victim through use of a substance (Bureau of Justice, 1992). Various subgroups tend to have especially high rates of trauma and SUD, including women, veterans, the homeless, adolescents, prisoners, gays and lesbians, rescue workers such as firefighters and police, prostitutes, and victims of domestic violence (Davis & Wood, 1999; North et al., 2002; Smith, North, & Spitznagel, 1993; Substance Abuse and Mental Health Services Administration, 2001; Tarter & Kirisci, 1999; Teplin, Abram, & McClelland, 1996).

The clinical needs of this population are serious and urgent. A variety of studies indicates that those with the dual diagnosis of PTSD and SUD have worse outcomes than those with either disorder alone; higher rates of subsequent trauma; and greater impairment, including other Axis I and Axis II disorders, self-harm and suicidality, medical and legal problems, HIV risk, and lower work functioning (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Hien, Nunes, Levin, & Fraser, 2000; Najavits et al., 1998a; Najavits et al., 1997; Najavits, Weiss, & Shaw, 1999b; Ouimette, Finney, & Moos, 1999). Abuse of substances itself is often construed as a reenactment of trauma. Substance use may represent harm to the body that symbolizes familiar traumatic experiences; living the role of the marginalized; or not caring about oneself after violation by others (Najavits, 2002d; Teusch, 2001). Notably, one of the major predictors of both trauma and SUD is a family history of these—the repeated generational cycles of this seemingly inexorable combination (Kendler, Davis, & Kessler, 1997; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998).

Treatment of the dual diagnosis has historically been marked by a separation that only lately has begun to improve. A culture of “other” predominated in which many mental health clinicians believed that they could not adequately assess or treat SUD, and many SUD clinicians believed that they could not assess or treat PTSD (Najavits, 2002d; Najavits, Weiss, & Liese, 1996; Read, Bollinger, & Sharansky, 2002). There is now increasing awareness that a no-wrong-door approach is likely to be the most helpful (Clark, 2002). Regardless of how they enter treatment, clients need attention to both disorders. Split systems, wherein a client who uses substances is rejected from mental health treatment until abstinent, or the client with mental health problems is rejected from SUD treatment until stabilized, are believed less effective than concurrent or integrated treatment (Brady, 2001; Ouimette & Brown, 2002). Yet older messages abound, such as “Just get clean and sober first,” “Go to Alcoholics Anonymous or I won’t treat you,”

or "You're defocusing from your addiction if you talk about the past." Clinicians in a variety of settings may fail to assess routinely for trauma, PTSD and SUD. Indeed, underdiagnosis or misdiagnosis of both PTSD and SUD are common (Davidson, 2001; Najavits, 2004b), and *most* SUD clients are neither assessed for PTSD nor given treatment for it (Brown, Stout, & Gannon-Rowley, 1998; Dansky, Roitzsch, Brady, & Saladin, 1997; Hyer, Leach, Boudewyns, & Davis, 1991; Najavits, Sullivan, Schmitz, Weiss, & Lee, 2004). Clients too tend to minimize both SUD and PTSD. Shame, guilt, denial, and lying are more common in these disorders than in many other psychiatric conditions. A client may say, "I drink alone so no one will see how much I'm using," or "I shouldn't feel bad about the trauma; I'm just being weak." In treatment, some clinicians may take too harsh a stance, such as threat of termination if the client relapses on substances. Newer approaches to SUD, including harm reduction (reinforcing any decrease in use rather than requiring full abstinence) and emphasis on choices and support (rather than confrontation) may be unfamiliar (Fletcher, 2001; Marlatt, Tucker, Donovan, & Vuchinich, 1997). Yet these modifications of standard treatment may be especially helpful for clients with dual diagnosis, in general, and those with PTSD, specifically, who often suffer from demoralization and hopelessness (Marlatt et al., 1997; Najavits, 2002d). The 12-step approach of AA, one of the mainstays of addiction recovery, has been helpful for many (Fletcher, 2001). However, for PTSD clients, abstinence may be more difficult, and such methods may not work as well (Ruzek et al., 1998; Solomon, Gerrity, & Muff, 1992). PTSD symptoms may worsen with abstinence, for example, leading the client back to a cycle of using substances to cope with overwhelming emotion (Brady et al., 1994; Kofoed, Friedman, & Peck, 1993).

A major clinical effort of the past several years has been the development of integrated therapies for PTSD and SUD. Working on both disorders at the same time from the start of treatment is now widely encouraged (Brady, 2001; Najavits et al., 1996; Ouimette & Brown, 2002). Clients too report a clear preference to include treatment of PTSD in SUD treatment (Brown et al., 1998; Najavits et al., 2004). Most of all, evidence thus far indicates that integrated approaches to PTSD and SUD result in positive outcomes in both domains as well as related areas. Contrary to older views, treating PTSD and SUD simultaneously appears to help clients with addiction recovery, rather than derailing them from attaining abstinence (Brady, Dansky, Back, Foa, & Carroll, 2001; Donovan, Padin-Rivera, & Kowaliv, 2001; Hien, Cohen, Litt, Miele, & Capstick, 2004; Najavits, Schmitz, Gotthardt, & Weiss, in press-a; Najavits, Weiss, Shaw, & Muenz, 1998b; Triffleman, 2000; Zlotnick, Najavits, & Rohsenow, 2003).

Treatment for trauma offers a depth to SUD treatment that many clients and clinicians find helpful. It honors what clients have lived through, encourages empathy and self-understanding, and may increase motivation for abstinence. It can be reassuring for clients to realize that they may have used substances to cope with overwhelming emotional pain, and to recognize that this pattern is common. Such understanding can move them beyond the revolving

door of just more treatment, into different treatment. Rather than cycling back through standard treatment, the client can go down a new path. One client said, "I was relieved to find I had something with a name. I thought it was just me—I'm crazy. But I can deal with this now. Now I can put down the cocaine and work on what's behind it" (Najavits, 2002e, p. 81).

Integrated models that have been empirically studied (i.e., one or more published outcome trials) are Seeking Safety (Najavits, 2002d); Concurrent Treatment of PTSD and Cocaine Dependence (Back, Dansky, Carroll, Foa, & Brady, 2001; Brady et al., 2001); Substance Dependence PTSD Therapy, later relabeled Assisted Recovery from Trauma and Substances (ARTS, Triffleman, 2000; Triffleman, Carroll, & Kellogg, 1999); and Transcend (Donovan et al., 2001). Other models include the Addictions and Trauma Recovery Integrated Model (Miller & Guidry, 2001); Helping Women Recover (Covington, 1999; Covington, 2000); Trauma Adaptive Recovery Group Education and Therapy (Ford, Kasimer, MacDonald, & Savill, 2000); Trauma-Relevant Relapse Prevention Training (Abueg & Fairbank, 1991; Abueg et al., 1994); Treating Addicted Survivors of Trauma (Evans & Sullivan, 1995); Double Bind (Trotter, 1992); an unnamed group model (Meisler, 1999); and an inpatient model (Bollerud, 1990). The various models differ in their emphases. Some focus more on the present and others more on the past, some address both disorders throughout the therapy, whereas others attend more to one than the other at different times, some are fully manualized, with handouts and published materials, whereas others are briefer or not yet published. Models for PTSD alone or SUD alone also abound but are beyond the scope of this chapter.

DESCRIPTION OF SEEKING SAFETY

In this chapter the Seeking Safety model is described; it is the most studied treatment, thus far, for clients with PTSD and SUD (see the section, Empirical Results). It has also been implemented broadly with clients who do not necessarily meet diagnostic criteria for these disorders, such as those with trauma-related symptoms but not formal PTSD. The complete treatment manual is provided in book form (Najavits, 2002d), and the website www.seekingsafety.org provides materials that can be freely downloaded, including sample topics, a description of each empirical study, upcoming trainings, assessment tools, and journal articles (such as how to train clinicians in the model [Najavits, 2000] and implementation strategies [Najavits, 2004a]). Prior descriptions of the model are provided in book chapters and articles (Najavits, 2002b, 2002c; Najavits et al., 1996).

Overview

The title of the treatment, Seeking Safety, expresses a central idea: When a person has both active substance abuse and PTSD, the most urgent clinical

need is to establish safety. "Safety" is an umbrella term that signifies various elements: safety from substances, safety from dangerous relationships (including domestic violence and drug-using friends), and safety from extreme symptoms, such as dissociation and self-harm. Many of these self-destructive behaviors reenact trauma—having been harmed through trauma, clients now harm themselves. "Seeking safety" refers to helping clients free themselves from such negative behaviors and, in so doing, to move toward freeing themselves from trauma at a deep emotional level.

Seeking Safety is an integrated treatment for SUD and trauma/PTSD that can be used from early recovery onward. It was designed to help explore the link between SUD and trauma/PTSD, but without delving into details about the past that may destabilize clients during early recovery. Its goal is a present-focused, empathic approach that helps clients "own" and name the trauma experience, validates the connection to substance use, provides psychoeducation, and offers specific "safe coping skills" to manage the often overwhelming impulses and emotions of this dual diagnosis. The model focuses equally on both disorders, at the same time, from the start of treatment, but in a way that is designed to be as safe, supportive, and containing as possible.

The treatment provides 25 topics to help clients attain safety. Topics are evenly divided among cognitive, behavioral, and interpersonal domains, with a clinician guide and extensive client handouts. Each topic addresses both trauma/PTSD and SUD.

The seven interpersonal topics are:

- Asking for Help
- Honesty
- Setting Boundaries in Relationships
- Healthy Relationships
- Community Resources
- Healing from Anger
- Getting Others to Support Your Recovery

The seven behavioral topics are:

- Detaching from Emotional Pain: Grounding
- Taking Good Care of Yourself
- Red and Green Flags
- Commitment
- Coping with Triggers
- Respecting Your Time
- Self-Nurturing

The seven cognitive topics are:

- PTSD: Taking Back Your Power
- Compassion
- When Substances Control You

- Recovery Thinking
- Integrating the Split Self
- Creating Meaning
- Discovery

The four combination topics are:

- Introduction to Treatment/Case Management
- Safety
- The Life Choices Game (review)
- Termination

See Table 10.1 for a brief description of all topics. The treatment manual provides a summary for each topic, a therapist orientation with background and clinical strategies for conducting the session, a quotation to read aloud at the start of each session to engage clients emotionally, client handouts, and examples of “tough cases” that the therapist can rehearse to prepare for the topic. Background chapters on the dual diagnosis and how to conduct the treatment are also provided.

The topics are written in simple language and designed to be emotionally compelling, with a respectful tone that honors clients’ courage in fighting the disorders. The topics address new ways of coping and convey the idea that no matter what happens, clients can learn to cope in safe ways—without substance use or other destructive behavior. Special emphasis is placed on the clinician’s role, such as countertransference and self-care, as this dual-diagnosis population is considered difficult to treat.

The treatment was developed to be broadly applicable in a wide variety of settings. It has been used for clients with formal diagnoses of both PTSD and SUD, those with one disorder but not the other, and those who do not meet diagnostic criteria (e.g., a trauma history but no PTSD, and/or a SUD history that is not current). For simplicity, the terms PTSD and SUD are used below, although clients do not have to meet formal criteria for these disorders. Topics can be conducted in any order, with the order selected by clients, clinicians, or both. Extensive handouts are available from which clients and clinicians can select those that are most relevant. Each topic is independent of the others and can be conducted as a single session or over multiple sessions, depending on the client’s length of stay. Suggestions for how to select the order of topics are provided in the manual.

Session Structure

The session structure includes a check-in, a quotation (to emotionally engage clients), handouts, and a check-out (see Table 10.2). The structure is designed to model good use of time, appropriate containment, and achievement of goals. For clients with SUD and PTSD, who are often impulsive and

TABLE 10.1. Seeking Safety Topics

1. Introduction to Treatment/Case Management
This topic covers (a) introduction to the treatment, (b) getting to know the client, and (c) assessment of case management needs.
2. Safety (*combination*)
Safety is described as the first stage of healing from both PTSD and substance abuse, and the key focus of the treatment. A list of over 80 Safe Coping Skills is provided and clients explore what safety means to them.
3. PTSD: Taking Back Your Power (*cognitive*)
Four handouts are offered: (a) What is PTSD?; (b) The Link between PTSD and Substance Abuse; (c) Using Compassion to Take Back Your Power; and (d) Long-Term PTSD Problems. The goal is to provide information as well as a compassionate understanding of the disorder.
4. Detaching from Emotional Pain: Grounding (*behavioral*)
A powerful strategy, "grounding," is offered to help clients detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world, away from negative feelings.
5. When Substances Control You (*cognitive*)
Eight handouts are provided, which can be combined or used separately: (a) Do You Have a Substance Abuse Problem? (b) How Substance Abuse Prevents Healing from PTSD; (c) Choose a Way to Give Up Substances; (d) Climbing Mount Recovery, an imaginative exercise to prepare for giving up substances; (e) Mixed Feelings; (f) Self-Understanding of Substance Use; (g) Self-Help Groups; and (h) Substance Abuse and PTSD: Common Questions.
6. Asking for Help (*interpersonal*)
Both PTSD and substance abuse lead to problems in asking for help. This topic encourages clients to become aware of their need for help and provides guidance on how to obtain it.
7. Taking Good Care of Yourself (*behavioral*)
Clients explore how well they take care of themselves using a questionnaire that lists specific behaviors (e.g., "Do you get regular medical checkups?"). They are asked to take immediate action to improve at least one self-care problem.
8. Compassion (*cognitive*)
This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of "beating oneself up," a common tendency for people with PTSD and substance abuse. Clients are taught that only a loving stance toward the self produces lasting change.

Note. Each topic represents a *safe coping skill* relevant to both SUD and trauma/PTSD, and can be conducted over one or more sessions. After the first topic, the rest can be conducted in any order based on clinician and client preference. Domains are listed in parentheses (cognitive, behavioral, interpersonal, or a combination).

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9. Red and Green Flags (behavioral)

Clients explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of "red and green flags" (signs of danger and safety). A Safety Plan is developed to identify what to do in situations of mild, moderate, and severe relapse danger.

10. Honesty (*interpersonal*)

Clients discuss the role of honesty in recovery and role-play specific situations. Related issues include: What is the cost of dishonesty? When is it safe to be honest? What if the other person does not accept honesty?

11. Recovery Thinking (*cognitive*)

Thoughts associated with PTSD and substance abuse are contrasted with healthier recovery thinking. Clients are guided to change their thinking using rethinking tools such as List Your Options, Create a New Story, Make a Decision, and Imagine. The power of rethinking is demonstrated through think-aloud exercises.

12. Integrating the Split Self (*cognitive*)

Splitting is identified as a major psychic defense in both PTSD and substance abuse. Clients are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these.

13. Commitment (*behavioral*)

The concept of keeping promises, both to self and others, is explored. Clients are offered creative strategies for keeping commitments, as well as the opportunity to identify feelings that can get in the way.

14. Creating Meaning (*cognitive*)

Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as Deprivation Reasoning, Actions Speak Louder Than Words, and Time Warp. Meanings that are harmful versus healing in recovery are contrasted.

15. Community Resources (*interpersonal*)

A lengthy list of national nonprofit resources is offered to aid clients' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help clients take a consumer approach in evaluating treatments.

16. Setting Boundaries in Relationships (*interpersonal*)

Boundary problems are described either in terms of too much closeness (difficulty saying no in relationships) or too much distance (difficulty saying yes in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided.

17. Discovery (*cognitive*)

Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called "staying stuck"). Discovery is a way to stay open to experience and new knowledge, using strategies such as Ask Others, Try It and See, Predict, and Act As If. Suggestions for coping with negative feedback are provided.

TABLE 10.1. *cont.*

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18. Getting Others to Support Your Recovery (*interpersonal*)
Clients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as is a letter that they can give to others to promote understanding of PTSD and substance abuse. A safe family member or friend can be invited to attend the session.
19. Coping with Triggers (*behavioral*)
Clients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change *who* you are with, *what* you are doing, and *where* you are (similar to AA's "change people, places, and things").
20. Respecting Your Time (*behavioral*)
Time is explored as a major resource in recovery. Clients may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues, such as the following: Do they use their time well? Is recovery their highest priority? Also addressed is how to balance structure versus spontaneity; work versus play; and time alone versus time in relationships.
21. Healthy Relationships (*interpersonal*)
Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief, "Bad relationships are all I can get," is contrasted with the healthy belief, "Creating good relationships is a skill I can learn." Clients are guided to notice how PTSD and substance abuse can lead to unhealthy relationships.
22. Self-Nurturing (*behavioral*)
Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other "cheap thrills"). Clients are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse.
23. Healing from Anger (*interpersonal*)
Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (when acted out against self or others). Guidelines for working with both types of anger are offered.
24. The Life Choices Game (*combination*)
As part of termination, clients are invited to play a game as a way to review the material covered in the treatment. Clients pull from a box slips of paper that list challenging life events (e.g., "You find out your partner is having an affair"). They respond with how they would cope, using game rules that focus on constructive coping.
25. Termination
Clients express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. An optional termination letter can be read aloud to clients to validate the work they have done.
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overwhelmed, the predictable session structure helps them know what to expect. It offers, in its process, a mirror of the focus and careful planning that are needed for recovery from the disorders. Most of the session is devoted to the topic selected for the session (per Table 10.1), relating it to current and specific problems in clients' lives. Priority is on any unsafe behavior the client reported during the check-in. The tone of the treatment, when conducted well, feels like deep therapy rather than just psychoeducation or school. There is strong emphasis on rehearsal of the skills during sessions, using any of a number of methods (e.g., role play, experiential exercises, think-alouds, discussion, question-answer, replaying a scene of poor coping, and processing obstacles). There are no particular coping skills or topics clients must master; rather, they are offered a wide variety from which to choose. The goal is to "go where the action is"—to use the materials in a way that adapts to the client, the clinician, and the program.

TABLE 10.2. Session Format

1. Check-In

The goal of the check-in is to find out how clients are doing (up to 5 minutes per patient). Clients report on five questions: Since the last session (a) How are you feeling? (b) What good coping have you done? (c) Any substance use or other unsafe behavior; (d) Did you complete your commitment? and (e) Community Resource update.

2. Quotation

The quotation is a brief device to help emotionally engage clients in the session (up to 2 minutes). A client reads the quotation out loud. The clinician asks, "What is the main point of the quotation?" and links it to the topic of the session.

3. Relate the Topic to Clients' Lives

The clinician and/or client select any of the 25 treatment topics (see Table 10.1) that feels most relevant. This is the heart of the session, with the goal of meaningfully connecting the topic to clients' experience (30–40 minutes). Clients look through the handout for a few minutes, which may be accompanied by the clinician summarizing key points (especially for clients who are cognitively impaired). Clients are asked what they most relate to in the material, and the rest of the time is devoted to addressing the topic in relation to specific and current examples from clients' lives. As each topic represents a safe coping skill, intensive rehearsal of the skill is strongly emphasized.

4. Check-Out

The goal is to reinforce clients' progress and give the clinician feedback (a few minutes per client). Clients answer two questions: (a) Name one thing you got out of today's session (and any problems with the session); (b) What is your new commitment?; and (c) What community resource will you call?

At the end of each session clients are asked to select a commitment to try before the next session. Commitments are very much like cognitive-behavioral therapy (CBT) homework, but the language is changed to emphasize that clients are making a promise—to themselves, to the therapist, and, in group treatment, to the group—to promote their recovery by taking at least one action step forward. Commitments do not have to be written, because clinical experience with this population suggests that some clients do not like written assignments. Examples of commitments include “Ask your partner not to offer you any more cocaine,” “Read a book on parenting,” and “Write a supportive letter to the young side of you that feels scared.” Ideas for commitments are offered at the end of each handout, but therapists are encouraged to customize them to best fit each client (see also Najavits, 2005).

The treatment is thus both highly structured yet also extremely flexible—characteristics that may be particularly important when working with severe populations. The multiple needs, impulsivity, and intense affect of such populations can lead to derailed sessions if the clinician does not impose clear structure. Yet the treatment is also highly flexible to allow clients’ most important concerns to be kept primary, to allow adaptation to a variety of settings, to respect clinicians’ clinical judgment, and to encourage clinicians to remain inspired and interested in the work. These considerations are believed to be paramount when working with a population such as this, where the risks of client dropout and clinician burnout are high (Najavits, 2001). Moreover, the model was designed to adapt to the managed care era, in which many clients have limited access to treatment. Thus the treatment can be extremely short-term (e.g., one or a few sessions, such as on a brief inpatient stay), or can be extended to long-term treatment. The therapy is also designed to be integrated with other treatments. Although it can be conducted as a stand-alone intervention, the severity of clients’ needs usually suggests that they be in several treatments at the same time (e.g., 12-step groups, pharmacotherapy, individual therapy, group therapy). Thus, not only was the treatment designed to be used in conjunction with other treatments, but it also includes an intensive case management component to help engage clients in other treatments.

Seeking Safety has been conducted in a variety of formats, including group and individual; open and closed groups; sessions of varying lengths (50 minutes, 1 hour, 90 minutes, and 2 hours); sessions of varying pacing (weekly, twice weekly, and daily); singly and co-led; outpatient, inpatient, and residential; integrated with other treatments or as a stand-alone therapy; and single gender or mixed gender. Some programs have covered all 25 topics, others created two blocks of 12 sessions each, and others allowed clients to cycle through the entire treatment multiple times. In some programs particular topics were added to ongoing treatments (e.g., Healing from Anger was added to an existing anger management group), or only selected topics were covered. In general, however, it is recommended to first try conducting the treatment as planned, in terms of both the topics and the session format, before adapting it. Empirical studies of the treatment thus far, however,

were conducted under constrained conditions to evaluate gains within the typical limits of managed care treatment. The treatments were time-limited (typically twice per week for 3 months), with one session per topic. A recent article (Brown et al., 2005) describes adaptations of Seeking Safety in three community programs, with a summary of satisfaction and feedback from both clients and clinicians.

The treatment was first described in an early paper (Najavits et al., 1996), although it evolved considerably after that: from a focus on women to both genders, from group modality to individual as well, and from outpatient to diverse settings. The therapy was developed over 10 years, beginning in the early 1990s, under grants from the National Institute on Drug Abuse. An iterative process was used, such that clinical experience with this dual-diagnosis population led to various versions of the manual over time, with the final version published in 2002. The treatment also drew on educational innovation and research (i.e., how to convey concepts in a way clients can understand). In the rest of this chapter, the treatment is described in more detail, and implementation and assessment considerations are offered.

KEY PRINCIPLES

Seeking Safety is based on five principles.¹

Safety as the Priority of This First-Stage Treatment

The treatment fits what has been described as first-stage therapy for both PTSD and SUD. Experts within both fields have independently described an extremely similar first stage of treatment, termed "safety" or "stabilization," that prioritizes psychoeducation, coping skills, and reducing the most destructive symptoms (Herman, 1992; Kaufman & Reoux, 1988). Later stages, again quite similar for the two disorders, are conceptualized as "mourning" (facing one's past by exploring the impact of trauma and substance abuse) and "reconnection" (attaining a healthy engagement with the world through work and relationships), to use the language of Herman (Herman, 1992). The first stage, safety, is an enormous therapeutic task for some clients, and thus the Seeking Safety treatment addresses only that stage. Throughout the treatment, safety is addressed over and over, including the use of the topic Safety; a list of safe coping skills; a Safe Coping Sheet to explore recent unsafe incidents; a Safety Plan to identify stages of danger and how to address them; a Safety Contract; and a report of unsafe behaviors at each session's check-in. The concepts of safety and first-stage treat-

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ment are designed to protect the clinician as well as the client. By helping clients move toward safety, clinicians are protecting themselves from the sequelae of treatment that could move too fast without a solid foundation, resulting in vicarious traumatization, medicolegal liability, and/or dangerous transference dilemmas (Chu, 1988; Pearlman & Saakvitne, 1995). In particular, eliciting trauma memories too early in treatment when safety has not been established may have harmful consequences (Chu, 1988; Ruzek et al., 1998). Increased substance use and suicidality are of particular concern in this vulnerable dual-diagnosis population. Thus, seeking safety is, hopefully, both the client's and the clinician's goal.

Note that although clients do not delve into the past in the Seeking Safety model, the treatment can be combined with trauma-processing methods such as exposure therapy (Foa & Rothbaum, 1998), eye movement desensitization and reprocessing (Shapiro, 1995), and other models of trauma exploration. One pilot study on men, for example, combined Seeking Safety with a revised version of Exposure Therapy (Najavits et al., in press-a). At this stage, however, there has been little research on which SUD clients are best suited for trauma exploration and at what point in treatment. Indeed, within the mental health field, in general, it remains unclear whether all PTSD clients need to engage in trauma exposure therapy, whether some may benefit from both present- and past-focused PTSD treatment (and, if so, whether to combine the two treatments sequentially or concurrently), whether some may need just one or just the other type of treatment, and how to decide. Thus far, studies that directly compared present-focused versus past-focused PTSD approaches have found both to produce positive outcomes, without significant differences between them (e.g., Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Schnurr et al., 2003). In teaching clinicians about a present-focused treatment such as Seeking Safety, it is important for these issues to be raised. It is sometimes a surprise that treatment of PTSD does not necessarily have to involve exploration of trauma memories. Many assume that present-focused PTSD treatment is always a precursor to eventually doing the "real" treatment of trauma exposure. But more research is needed both in SUD and other samples to better understand when and under what conditions present- and past-focused PTSD methods are needed. See Coffey et al. (Coffey, Dansky, & Brady, 2002; Coffey, Schumacher, Brimo, & Brady, 2005) and Najavits et al. (Najavits et al., in press-a) for more on this issue.

Integrated Treatment of PTSD and Substance Abuse

Seeking Safety is designed to continually integrate attention to both disorders; that is, both are treated at the same time by the same clinician. This *integrated* model contrasts with a *sequential* model, in which the client is treated for one disorder, then the other; a *parallel* model, in which the client receives treatment for both disorders but by different treaters; or a *single* model, in which the client receives only one type of treatment (Weiss &

Najavits, 1997). An integrated model is consistently recommended as the treatment of choice for this dual diagnosis population (Abueg & Fairbank, 1991; Brady et al., 1994; Brown, Recupero, & Stout, 1995; Evans & Sullivan, 1995; Kofoed et al., 1993; Najavits et al., 1996; Ruzek et al., 1998). Furthermore, a survey of clients with this dual diagnosis found that clients also preferred simultaneous treatment of both disorders (Brown et al., 1998).

In practice, however, the two disorders are not usually treated simultaneously. Indeed, it is still the norm for clients to be told that they need to become abstinent from substances before working on PTSD—a mandate that does not work for many clients. In many settings clinical staff are reluctant to even assess for the other disorder; and clients' own shame and secrecy about trauma and substance abuse can further reinforce treatment splits (Brown et al., 1995). Integration is thus, ultimately, an intrapsychic goal for clients as well as a systems goal: to "own" both disorders, to recognize their interrelationship, and to fall prey less often to the vulnerability of each disorder triggering the other. Seeking Safety provides opportunities for clients to discover connections in their lives between the two disorders: in what order the disorders arose and why, how each affects healing from the other, and the origins of both disorders in other life problems (e.g., poverty). The clinician, too, is guided to use each disorder as leverage to help clients overcome the other disorder, because clients often have stronger motivation initially to work on one rather than the other. Finally, integration also occurs at the intervention level. Each safe coping skill in the treatment can be applied to both PTSD and substance abuse. For example, setting boundaries in relationships can apply to PTSD (e.g., leaving an abusive relationship) and to substance abuse (e.g., asking a friend to stop offering drugs). In sum, Seeking Safety was designed to attend equally strongly to both disorders. It was not originally a SUD treatment that later added a focus on PTSD, nor vice versa. Also, it directly targets improvements in both domains, although more empirical work is needed to evaluate whether, in fact, the treatment consistently has equal impact on both.

A Focus on Ideals

It is difficult to imagine two mental disorders that each individually, and especially in combination, lead to such demoralization and loss of ideals. This loss of ideals in PTSD has been written about, for example, in work on "shattered assumptions" (Janoff-Bulman, 1992) and the "search for meaning" (Frankl, 1963). Some research has found that trauma survivors who are able to create positive meanings from their suffering fare better than those who do not (Janoff-Bulman, 1997). There is also a loss of ideals in substance abuse—life narrows in focus, and, in its severe form, the person "hits bottom." It is notable that the primary treatment for substance abuse for most of this century, AA, is the only treatment for a mental disorder that has a heavily spiritual component. The AA goal of living a life of moral integrity is an antidote to the deterioration of ideals inherent in substance abuse.

Seeking Safety explicitly seeks to restore ideals that have been lost. The title of each topic is framed as a positive ideal, one that is the opposite of some pathological characteristic of PTSD and substance abuse. For example, the topic Honesty combats denial, lying, and the false self. Commitment is the opposite of irresponsibility and impulsivity. Taking Good Care of Yourself is a solution for bodily self-neglect. Throughout, the language of the treatment emphasizes values such as respect, care, integration, protection, and healing. By aiming for what can be, the hope is that clients can summon the motivation for the incredibly hard work of recovery from two difficult disorders.

Four Content Areas: Cognitive, Behavioral, Interpersonal, and Case Management

CBT is the basis for this treatment, because it so directly meets the needs of first-stage treatment through its high degree of structure, focus on problem solving in the present, educational emphasis, and time-limited framework. Moreover, in outcome studies CBT has been found to be one of the most promising approaches for the treatment of each of the disorders (PTSD and substance abuse) when treated separately (Najavits et al., 1996). The cognitive domain of Seeking Safety addresses beliefs and meanings associated with PTSD and SUD and explores how to rethink these in an adaptive way. The behavioral domain addresses how to take concrete actions in one's life, such as taking good care of one's body. The interpersonal domain is an area of special need because most PTSD arises from trauma inflicted by others (e.g., in contrast to natural disasters or accidents; Kessler et al., 1995). Whether the trauma involved childhood physical or sexual abuse, combat, or crime victimization, all have an interpersonal valence that may evoke distrust of others, confusion over what can be expected in relationships, and concern over reenactments of abusive power (Herman, 1992). Similarly, substance abuse is often associated with relationships. It is typically initiated in interaction with others and is frequently used to cope with interpersonal conflicts and anxiety in social situations (Marlatt & Gordon, 1985). The case management component arose because data in the first Seeking Safety pilot study showed that many clients were engaged in few treatment services (Najavits, Dierberger, & Weiss, 1999a). Most participants required significant assistance getting the care they needed, such as psychopharmacology, job counseling, and housing. Thus, case management (termed "community resources") is heavily emphasized, based on the idea that psychological interventions can work only if clients have an adequate treatment base.

Attention to Clinician Processes

Research shows that for substance abuse clients, in particular (and psychotherapy, in general), the effectiveness of treatment is determined as much

or more by the clinician as by any particular theoretical orientation or client characteristics (Najavits, Crits-Christoph, & Dierberger, 2003; Najavits & Weiss, 1994). With dual-diagnosis clients, who are often considered difficult, severe, or extreme (Kofoed et al., 1993), providing effective therapy is a major challenge. Moreover, in conducting workshops for clinicians and listening to hundreds of therapy tapes using the model, it has become clear that some of the most frequent dilemmas that emerge are about process: for example, how to calm agitated clients and how to confront clients who have lied about substance abuse. Clinician processes emphasized in Seeking Safety include compassion for clients' experience, using the treatment's coping skills in one's own life (not asking the client to do things that one cannot do oneself), giving clients control whenever possible (because loss of control is inherent in trauma and substance abuse), modeling what it means to try hard by meeting the client more than halfway (e.g., heroically doing anything possible within professional bounds to help the client get better), "listening" to clients' behavior more than their words, learning to give both positive and negative feedback, and obtaining feedback from clients about their reactions to the treatment. The flip side of such positive clinician processes is negative countertransference, including harsh confrontation, sadism, inability to hold clients accountable because of misguided sympathy, becoming victim to clients' abusiveness; power struggles; and, in group treatment, allowing a client to be scapegoated. As Herman (1992) suggested, clinicians may unwittingly repeat the trauma roles of victim, perpetrator, or bystander. Attention is also directed to what I call the "paradox of countertransference" in PTSD and substance abuse; that is, each disorder appears to evoke opposite countertransference reactions that are difficult for clinicians to balance. PTSD tends to evoke identification with clients' vulnerability, which, if taken too far, may lead to excessive support at the expense of growth. Substance abuse tends to evoke anxiety about the client's substance use, which, if extreme, can become harsh judgment and control (e.g., "I won't treat you if you keep using"). The goal is thus for the clinician to integrate support and accountability, which are viewed as the two central processes in the treatment. Clinicians are encouraged to help clients seek explanations, but not excuses, for their unsafe behavior.

Training methods for the treatment (Najavits, 2000, 2004a) emphasize these various process issues as well as observation of the clinician in action (e.g., taped sessions) and intensive training experiences (e.g., watching videotapes of good vs. poor sessions; peer supervision, role plays, knowledge tests; identifying key themes; and think-aloud modeling). For every topic in the manual, "tough case" clinical scenarios are provided that also emphasize challenging statements clients may say. For example, when covering the topic Safety, the client may say, "I don't want to stay safe; I want to die." The clinician is encouraged to rehearse possible responses to such statements.

WHAT IS NOT PART OF THE TREATMENT

There are two main areas that this treatment explicitly omits, particularly when it is offered in group format: exploration of past trauma, and interpretive psychodynamic work.

Exploration of past trauma is, in and of itself, a major treatment intervention for PTSD. As noted above, it is conceptualized as the second stage of treatment, after the client has attained a foundation of safety (Herman, 1992; Kaufman & Reoux, 1988). A variety of PTSD treatment methods have as their central goal the evocation of traumatic memories as a means to process them. These include mourning (Herman, 1992), exposure therapy (e.g., Foa & Rothbaum, 1998), and eye movement desensitization and reprocessing (Shapiro, 1995). By directly processing trauma memories, they no longer hold such emotional power over the client.

Despite the known importance and efficacy of such treatments for PTSD (e.g., Marks et al., 1998), various experts have recommended the delay of such work for substance abusers until they have achieved a period of stable functioning and abstinence (Chu, 1988; Keane, 1995; Ruzek et al., 1998; Solomon et al., 1992). Until then, trauma processing may be too emotionally upsetting for clients who do not yet have adequate coping skills to control their impulses. Concerns repeatedly expressed in the literature are increased substance use, relapse (if already abstinent), or an increase in dangerous behaviors such as self-harm or suicidality (Keane, 1995; Ruzek et al., 1998; Solomon et al., 1992). Opening up the "Pandora's box" of trauma memories may destabilize clients when they are most in need of stabilization. Clients themselves may not feel ready for trauma processing early in SUD recovery; others may want to talk about the past but may underestimate the intense emotions and new disturbing memories.

Thus far, only a few studies of clients with PTSD and substance abuse have used exploration of past trauma as a key intervention. In one study (Brady et al., 2001) results indicated that the 39% of their sample who was able to complete at least 10 of the 16 sessions showed positive outcomes in PTSD symptoms and cocaine use (as well as other symptoms), which were maintained at the 6-month follow-up. However, most clients were noncompleters; and the researchers excluded clients with suicidal ideation, and thus likely selected a less impaired sample. In a study that combined Seeking Safety plus Exposure Therapy-Revised (Najavits et al., in press-a), positive outcomes were found in various domains, including psychiatric and substance abuse symptoms. However, a large number of modifications to standard exposure therapy was created, the treatment was conducted individually, and various "safety parameters" were put in place to maximize clients' ability to safely tolerate the work. For a description of the safety parameters and elaboration of how Seeking Safety was combined with exposure, see Najavits et al. (in press-a) and also Chapter 2 of the Seeking Safety manual (Najavits, 2002d). Finally, another study (Triffleman, Wong, Monnette, &

Bostrum, 2002) also reported positive outcomes for exposure therapy in opioid-dependent clients.

Thus, until further research explores the use of exposure techniques with this dual-diagnosis population, it is not included as part of Seeking Safety. Also, Seeking Safety was initially tested in a time-limited group format, which did not appear to be an appropriate context in which to conduct exposure methods for victims of repeated early trauma, who represent a large number of clients with this dual diagnosis (Najavits et al., 1997). Even the mention of trauma experiences has been found to trigger other clients, and in a short-term group treatment format, there may be insufficient ability to process the material fully. If a client brings up details of trauma during a Seeking Safety session, the clinician empathically validates the importance of such material but reminds the client that the treatment is present-focused and that description of trauma details may be overly upsetting for him or her (and to others, if it is a group therapy). The clinician gently refocuses the client on the present and how to cope with whatever is coming up. However, at any point in the treatment, clients can share in a brief phrase the type of trauma they experienced (such as child sexual abuse, rape, combat) if they choose to, which can help them feel understood and bond with others in a group without being overly destabilized.

Interpretive psychodynamic work is also specifically avoided in Seeking Safety. There is little, if any, transference-based exploration of the client's relationship with the clinician or, in group treatment, of members with each other. There is also no interpretation of intrapsychic motives or dynamic insights. Although these powerful interventions can be helpful in later stages of treatment, they are believed to be potentially too upsetting for clients at this stage. There is a lot of interaction and discussion in Seeking Safety, but the model primarily focuses on support, problem solving, and coping. The heavily confrontational style of some SUD group therapies is also avoided to maintain the safety of a trauma-focused treatment. Accountability, but not harsh confrontation, is emphasized.

CLIENT AND CLINICIAN SELECTION

In selecting clients, in general, the goal is to be as inclusive as possible, with a plan to monitor clients over time and evaluate whether the model appears helpful to them. As noted earlier, although most of the empirical studies on Seeking Safety were conducted on clients formally and currently diagnosed with both disorders, in clinical practice the range has been much broader. It has included clients with a history of trauma and/or SUD, clients with serious and persistent mental illness, clients with just one or the other disorder, and clients with other disorders (e.g., eating disorders). An important consideration is clients' own preference. Given the powerlessness inherent in both PTSD and SUD, empowerment is key. It appears best to describe the

treatment and then give clients a choice in whether to participate. Letting them explore the treatment by attending a few sessions, without obligation to continue, is another helpful process. Thus far, there do not appear to be any particular readiness characteristics or contraindications that are easily identified. Because the treatment is designed for safety, coping, and stabilization, it is not likely to destabilize clients and thus has been implemented quite broadly. Similarly, clients do not need to attain stabilization before starting; Seeking Safety was designed for use from the beginning of treatment. Clients who have addictive or impulsive behavior in addition to substance abuse (e.g., binge eating, self-mutilation, gambling) are encouraged to apply the safe coping skills taught in Seeking Safety to those behaviors, while also participating in specialized treatment for such problems as part of the case management component. Clients are not discontinued from the treatment unless they evidence a direct threat to staff or other clients (e.g., assault, selling drugs). An open-door policy prevails; clients are welcome back at any time—a position advocated in early recovery (Herman, 1992).

The key criteria for selecting clinicians to conduct Seeking Safety are positive attitudes toward clients with PTSD and SUD, a willingness to use a treatment manual, a high degree of empathy, a willingness to cross-train (i.e., for mental health clinicians to learn about substance abuse, and vice versa), and a strong ability to hold clients accountable and work with aggression (Najavits, 2000). In early use of Seeking Safety, various professional characteristics were sought, such as a mental health degree and particular types of training (e.g., CBT, substance abuse). It became clear over time that far more important than any such credentials were the more subtle criteria mentioned above (Najavits, 2000). Clinicians who genuinely enjoy these clients, often perceiving the work as a mission or calling, bring a level of commitment that no degree, per se, can provide. Similarly, clinicians who are open to the value of a treatment manual, viewing it as a resource to help improve the quality of the work, can make the best use of the material. Because there are no strict criteria for selecting clinicians (such as degree or training), the treatment may be widely applicable. Many substance abuse programs, for example, do not have staff with advanced degrees or formal CBT training. Because the treatment focuses on stabilization rather than trauma processing, it is comparable to relapse prevention models and thus does not appear to exceed the training, licensure, or ethical limits of substance abuse counselors. However, they are guided to refer clients out for specialized professional mental health treatment if clients' problems exceed the parameters of their work (e.g., dissociative identity disorder). Per the manual, it is also important that if a clinician does not have any prior background in trauma work, PTSD, substance abuse, or CBT, some training and/or supervision in these areas should be sought.

Additional suggestions for selecting a Seeking Safety clinician are described in a protocol that can be downloaded from www.seekingsafety.org

(see Clinician Selection). Briefly, it suggests a try-out to determine whether the clinician might be a good match. The clinician conducts one or more audiotaped sessions using Seeking Safety with a real client, and the sessions are rated by the client as well as evaluated on the Seeking Safety adherence scale. Methods for training and implementation are described in the manual as well as related articles (Najavits, 2000, 2004). A study exploring clinicians' views on treating these clients with dual diagnoses may also be relevant (Najavits, 2002a).

EMPIRICAL RESULTS

Seeking Safety is the most studied treatment thus far for the dual-diagnosis of PTSD and SUD, with seven completed outcome trials: outpatient women, in a group modality (Najavits et al., 1998b); women in prison, in group modality (Zlotnick et al., 2003); women in a community mental health setting, in group format and combined with other manual-based treatments (Holdcraft & Comtois, 2002); low-income urban women, in individual format (Hien et al., 2004); adolescent girls, in individual format (Najavits, Gallop, & Weiss, 2005); men and women veterans, in group format (Cook, Walser, Kane, Ruzek, & Woody, in press); and outpatient men traumatized as children, in individual format (Najavits et al., in press-a). In all of the studies the clients were severe. That is, they had the disorders for many years and the majority of cases involved substance dependence. Most clients had a history of multiple traumas, often in childhood, and typically had additional co-occurring Axis I and/or Axis II disorders.

Participants in all seven studies of Seeking Safety evidenced positive outcomes. In the six studies that reported on substance use, improvements were found in that domain. The six studies that assessed PTSD and/or trauma-related symptoms found improvements in those areas. Improvements were also found in various other areas, including social adjustment, general psychiatric symptoms, suicidal plans and thoughts, problem solving, sense of meaning, depression, and quality of life. Treatment satisfaction and attendance were reported to be high. Four studies had follow-ups after treatment ended and found that some key gains were maintained (Hien et al., 2004; Najavits et al., 2005; Najavits et al., in press-a; Najavits et al., 1996; Zlotnick et al., 2003). Five studies were pilots, and two were randomized controlled trials (Hien et al., 2004; Najavits et al., 2005). In the study by Hien et al., both Seeking Safety and relapse prevention treatments showed positive effects with no significant difference between them, and both outperformed a nonrandomized treatment-as-usual control (unspecified and unlimited treatment in the community). In Najavits et al. (2005), Seeking Safety outperformed treatment-as-usual for adolescent outpatient girls. It can also be noted that two studies combined Seeking Safety with other manual-based

therapies. The study of men (Najavits et al., in press-a) combined Seeking Safety with exposure therapy—revised (ETR), an adaptation for substance abuse clients of Foa and Rothbaum's exposure therapy for PTSD (Foa & Rothbaum, 1998). Clients were allowed to choose the number of sessions of each type and chose an average of 21 Seeking Safety sessions and 9 ETR sessions. The study of women in a community mental health center (Holdcraft & Comtois, 2002) combined Seeking Safety with Linehan's (1993) dialectical behavior therapy.

Future directions for empirical work on Seeking Safety include the need for more randomized controlled trials, more studies comparing the model to other manualized treatments (e.g., to PTSD treatment alone), exploration of mechanisms of action, evaluation of clinician selection and training, and further studies in community-based settings. A brief 12-session version is currently being evaluated in the National Institute on Drug Abuse Clinical Trials Network; Seeking Safety was also used by four sites in the Substance Abuse and Mental Health Services Administration study, Women, Co-Occurring Disorders and Violence (Cocozza et al., 2005).

ASSESSMENT

A recent book chapter describes, in detail, practical considerations in assessing SUD and PTSD (Najavits, 2004b). It includes a list of specific domains within each disorder to consider for assessment and provides websites from which free assessment measures for both disorders can be downloaded (see also www.seekingsafety.org, section Assessment, for links to key sites). Specific suggestions for assessment are provided, including the therapeutic benefit of clients' receiving information about each of their diagnoses; the importance of routinely assessing for both trauma and PTSD even in the context of clients' substance use or withdrawal; the use of brief screenings to address the resource limitations of many programs; the goal of collecting only minimal information on trauma early in treatment to avoid triggering the client; and the need to delay assessment if the client is intoxicated. Also discussed are issues of diagnostic overlap between the two disorders, misconceptions of SUD criteria, age-appropriate measures, secondary gain in PTSD and SUD, common misdiagnoses, memory issues, countertransference by assessors, and clinical versus research instruments.

Implementation²

Several key considerations in implementing the treatment are explored in this section. Additional implementation suggestions are provided elsewhere. These include (1) how to integrate trauma processing therapy with Seeking Safety (see Chapter 2 of the manual [Najavits, 2002d], and Najavits et al., in press-a); (2) emergency procedures (see Chapter 2 of the manual); (3) pro-

cess and training issues (see Chapter 2 of the manual and related articles by Najavits, 2000, 2004a); and (4) a detailed description of the Seeking Safety format (see Chapter 2 of the manual). See also Brown et al. (2005) for examples of how community programs adapted Seeking Safety.

Diversity (Ethnicity, Race, Gender)

Before the manual was published, Seeking Safety was conducted with diverse clients, including two studies with diverse racial/ethnic samples (Hien et al., 2000; Zlotnick et al., 2003), women and men, and clients with various trauma histories (e.g., child abuse, crime victimization, combat). The examples and language in the book were written to reflect these experiences and to mention sexism, racism, poverty, and both female and male issues. Thus far, the treatment has obtained high client satisfaction ratings in these subgroups. However, clinicians working with particular populations may benefit from adding more examples from their lives, including cultural elements relevant to them, and addressing their particular context and burdens. In treating men, for example, exploring how certain traumas violate the masculine role may be helpful (e.g., themes of "weakness" and vulnerability). In treating Latinos, using the Spanish-language version of Seeking Safety (see www.seekingsafety.org, the section Seeking Safety) and providing cultural context may be useful (e.g., acculturation stress and concepts such as *familismo* and *marianismo*). In treating gay, lesbian, bisexual and transgendered clients, homophobia concerns may be central. If clients cannot read written materials or have very low intelligence, summarizing the material briefly or having other clients read small sections out loud in group may help.

Group Modality

Several issues are notable when conducting the treatment in a group format. First, the name of the group can make a difference. One program initially called their group "Trauma Group," and few clients wanted to attend. When they renamed it "Seeking Safety Group," the attendance improved considerably. If the group title includes the term "trauma" or "PTSD," clients may fear that they will be asked to describe their traumas or will have to listen to others do so, and may not feel ready for that step. If it has a more upbeat title, they may feel more reassured. Thus the group might be called Safety Group, Seeking Safety, or Coping Skills, for example. Second, the number of group members should be planned carefully. Keeping in mind that the check-in allows up to 5 minutes per client (although it often goes more quickly) and that the average group is 1 hour in length, a group of five cli-

²This section is reprinted with minor edits from Najavits (2004a). Copyright by . Reprinted by permission.

ents is workable to allow up to 25 minutes of check-in. For longer sessions, such as 1.5 hours, more clients can be added. However, adaptability is important here too. One residential program, for example, decided to conduct very large groups with 30 clients and to make the treatment psychoeducational rather than therapy-oriented (thus leaving out the check-in and check-out), because clients already participated in small groups where they received more personal attention. Third, because Seeking Safety focuses on trauma, the tone of the group may be different from typical substance abuse groups. In the latter, confrontation may be accepted (e.g., a client may tell another that he or she is "in denial" or "being too self-pitying"). In the Seeking Safety model such statements would be seen as detracting from the emotional safety of the group. The clinician is asked to train clients to focus on their own recovery work and to interact primarily in supportive and problem-solving ways rather than confrontational ways. Fourth, single-gender groups are the most common way of implementing the treatment, because trauma is often sexual or physical in nature, and clients are likely to feel more comfortable with others of the same gender. However, Seeking Safety has been implemented with mixed-gender groups as well, but only when none of the clients had a major history as a perpetrator (which could be too triggering), and only when clients agreed to join a mixed-gender group. The clinicians, too, have typically been the same gender as the group, although it could be argued that having a group leader of the opposite gender can create positive new experiences that may be healing for trauma survivors (Chu, personal communication). Finally, as noted earlier, the treatment has shown positive outcomes both in open and closed group formats, and when both singly-led and co-led. If clients miss a session, they are offered the handouts, if desired, as a way to keep up with the group. If clients plan to join an open group once it has begun, it is suggested that they review the topic "PTSD: Taking Back Your Power" prior to attending their first session, to learn about trauma and PTSD.

Typical Difficulties

One of the most common difficulties is talking too much or lecturing clients. In keeping with the goal of deep-level learning, an 80/20 rule is suggested; that is, clients talk 80% of the session, and clinicians 20%. This ratio preserves the feeling that the session is more like therapy than school, and it promotes success by having the clinician listen closely enough to clients to help solve their problems in a realistic way. When the clinician does not listen sufficiently, interventions tend to be less effective and more simplistic. Clinicians are encouraged to use the treatment's coping skills in their own lives, to give them a personal understanding of how the skills may (or may not) work.

A second major difficulty is not following the structure of the treatment. Although Seeking Safety is highly adaptable and flexible, it nonetheless asks

clinicians to follow a structured format. This format was based on empirical testing conducted over many years with diverse populations. Even the wording of check-in questions, for example, was tested in different versions to identify ones that worked best. Thus clinicians are asked to start by using the structure as planned, only adapting it if clients provide negative feedback about it. In the projects that have used Seeking Safety thus far, clients have reported liking the structure and they learned it quickly with minimal instruction. Clinicians, however, particularly those who are not used to using a treatment manual, have needed more time and effort to adjust to it.

Finally, a third issue is staying "real." Because the treatment emphasizes validation, support, and empathy for clients' difficult trauma histories, clinicians sometimes overemphasize these processes at the expense of constructive feedback and setting limits. For example, when a client does a role play, clinicians sometimes offer only praise, rather than giving feedback on both strengths and weaknesses. Yet growth-oriented feedback is essential for clients to improve. Another example is owning anger, both seeing it in clients and in oneself. In the topic "Healing from Anger," it is suggested that clients' anger is inevitable in recovery from PTSD and substance abuse, and that it is a common countertransference reaction in clinicians as well. Yet in an attempt to be sympathetic, clinicians sometimes ignore or repress anger to a degree that is unhelpful. For example, a client may continually reject every suggestion offered, but the clinician keeps offering additional ideas to placate the client. It would be more helpful to process the dynamic of anger that typically underlies this help-rejecting client stance.

CONCLUSIONS AND RECOMMENDATIONS

Integrated therapies for dual diagnosis have become prominent in the past decade to help clients better overcome SUD and co-occurring mental disorders. A variety of integrated therapies has emerged for SUD and trauma/PTSD, with positive outcomes evidenced thus far in empirical trials. Seeking Safety is the most studied therapy to date for this particular dual diagnosis. It is described in detail in this chapter, including assessment and implementation considerations.

Despite advances in this area of work, there is a tremendous need for more research. Few randomized controlled therapy trials have been conducted, and no trials comparing integrated models versus other models have been published (e.g., sequential or parallel treatment). Studies of mechanisms of treatment have not yet occurred. Innovative methods for training clinicians to work with such clients who have severe and complex conditions also need research. Clinically, there remains significant concern that assessment and treatment of PTSD in SUD settings is not widespread, and similarly, in mental health settings both PTSD and SUD may not be adequately addressed. Rigorous and large-scale studies are relatively rare, as are studies

of long-term outcomes (1 year or more). Given the often chronic course of both PTSD and SUD through the lifespan (e.g., Port, 2001), more research and clinical help may be necessary than are reflected in the largely short-term outcome studies conducted thus far. If, how, and when to use trauma-processing models in SUD clients is a particular question in the literature, and more studies on this issue are needed. More generally, how best to combine treatments for this dual diagnosis has rarely been studied. Hopefully over time, further insights from both the clinical and research domains can help improve services for a population that is greatly in need.

ACKNOWLEDGMENTS

Preparation of this chapter was supported in part by grants K02DA00400 and R43DA018437 from the National Institute on Drug Abuse. Parts of this chapter were adapted from Najavits (2002c, 2004a). Copyright by The Guilford Press and the American Psychological Association Press. Adapted by permission.

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