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Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder and Substance Use Disorder

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In 1993 I began developing a cognitive-behavioral therapy (CBT) for the dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder (SUD), under a grant from the Behavioral Therapies Development Program of the National Institute on Drug Abuse. At that point, there were no published treatment outcome studies or any empirically studied psychosocial treatments for this population. Through trial and error, the Seeking Safety treatment manual (Najavits, 2002b) was developed while simultaneously its impact was tested on patients in a variety of settings. Seeking Safety is the first treatment for PTSD and substance abuse with published outcome results (Najavits, Weiss, Shaw, & Muenz, 1998). The goal was to mold a therapy that would best fit patients' needs, and to accomplish this by listening to patients very closely in the context of treating them, reading available literature, and conducting empirical research on the treatment.

Seeking Safety has shown positive outcomes in four studies thus far that tap a range of subpopulations with this dual diagnosis: women in prison, inner-city women, adult outpatient women, and adult outpatient men. Other studies are currently underway.

This chapter provides (a) a description of Seeking Safety and how it was developed, (b) a comparison with existing treatments, (c) a review of outcome research on it, and (d) ideas for future directions. An earlier article describing the treatment (Najavits, Weiss, & Liese, 1996) is now outdated, as the treatment has evolved considerably with empirical testing and implementation in various populations. For example, Seeking Safety was originally designed for women but has since been expanded to men. Although it was originally designed as a group treatment, it has been adapted for individual therapy as well. Treatment topics, format, and training have also changed considerably over time.

The term *substance abuse* is used throughout this chapter, as it is commonly used in clinical settings. However, Seeking Safety was designed to address both *substance abuse* (the less severe version of the disorder) and *substance dependence* (the most severe version), both of which are subsumed within the term *substance use disorder* in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 1994). Note that *substance dependence* is used for any studies that specifically target that syndrome.

Description of the Treatment

The Seeking Safety treatment comprises 25 topics that are approximately evenly divided among cognitive, behavioral, and interpersonal domains (see Exhibit 8.1 for a brief description of all topics). Each addresses a "safe coping skill" designed to help the

patient attain safety from both PTSD and substance abuse. The topics are designed to be written in simple language; to be as emotionally compelling as possible; to provide a respectful tone that honors patients' courage in fighting the disorders; and to teach new ways of coping that convey the idea that, no matter what happens, they can learn to cope in safe ways—without substances and other destructive behavior.

Key Principles

Seeking Safety is based on five principles.

1. Safety as the Priority of This First-Stage Treatment

The title of the treatment—"Seeking Safety"—expresses its 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 re-enact trauma—having been harmed through trauma, patients are now harming themselves. *Seeking safety* refers to helping patients free themselves from such negative behaviors and, in so doing, to move toward freeing themselves from trauma at a deep emotional level.

The treatment fits what has been described as *first-stage therapy* for each of the disorders. Experts within the PTSD and substance abuse fields (e.g., Herman, 1992; E. Kaufman & Reoux, 1988) have independently described an extremely similar first stage of treatment that prioritizes stabilizing the patient, teaching coping skills, and reducing the most destructive symptoms (Najavits, 2002b). Later stages, again quite similar for the two disorders, are *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 (1992). The first stage, safety, is an enormous therapeutic task for some patients, and thus the Seeking Safety treatment addresses only that stage. Throughout the treatment, safety is addressed over and over, including, 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 treatment are designed to protect the therapist as well as the patient. By helping patients move toward safety, therapists are protecting themselves from the sequelae of treatment that could move too fast without a solid foundation: vicarious traumatization, medico-legal liability, and 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, Polusny, & Abueg, 1998). Increased substance use and suicidality are of particular concern in this vulnerable dual-diagnosis population (Chu, 1988). Thus, seeking safety is, hopefully, both the patient's and the therapist's goal.

2. Integrated Treatment of PTSD and Substance Abuse

The treatment 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 patient is treated for one disorder, then the other; a *parallel* model, in which the patient receives treatment for both disorders, but by

different treaters; or a *single* model, in which the patient receives only one type of treatment (Weiss & Najavits, 1997). An integrated model is consistently recommended as the treatment of choice for this dual diagnosis (Abueg & Fairbank, 1991; Brady, Killeen, Saladin, Dansky, & Becker, 1994; Brown, Recupero, & Stout, 1995; Evans & Sullivan, 1995; Kofoed, Friedman, & Peck, 1993; Najavits et al., 1996; Ruzek et al., 1998). Indeed, a survey of patients with this dual diagnosis found that they also prefer simultaneous treatment of both disorders (Brown, Stout, & Gannon-Rowley, 1998). In practice, however, the two disorders are not usually treated simultaneously. Indeed, it is still the norm for patients to be told that they need to become abstinent from substances before working on PTSD, which does not work for many patients. In many settings clinical staff are reluctant to even assess for the other disorder; and patients' own shame and secrecy about trauma and substance abuse can further reinforce treatment splits (Brown, Recupero, et al., 1995). Integration is thus, ultimately, an intrapsychic goal for patients 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. Thus, the treatment provides opportunities for patients to discover connections between the two disorders in their lives: in what order they arose and why, how each affects healing from the other, and their origins in other life problems (e.g., poverty). The therapist, too, is guided to use each disorder as leverage to help patients overcome the other disorder, as patients often have initially stronger motivation 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).

3. *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. In PTSD this loss of ideals 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). With substance abuse there is also a loss of ideals—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, Alcoholics Anonymous (AA), is the only treatment for a mental disorder with 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.

Thus, 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 patients can summon the motivation for the incredibly hard work of recovery from two difficult disorders.

4. 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). Whereas originally the treatment was solely cognitive and behavioral, interpersonal and case management domains were added when the need for them became apparent in working with patients. Interpersonal topics now comprise one third of the topics, and case management is begun in the first session and addressed at every session throughout the treatment. 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, Sonnega, Bromet, Hughes, & Nelson, 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 re-enactments of abusive power (Herman, 1992). Substance abuse similarly 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 (e.g., Marlatt & Gordon, 1985). The case management component arose because data in the first Seeking Safety pilot study showed that many patients were engaged in few treatment services (Najavits, Dierberger, & Weiss, 1999). 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 on the basis of the idea that psychological interventions can work only if patients have an adequate treatment base.

5. Attention to Therapist Processes

Research shows that for substance abuse patients in particular (and psychotherapy in general), the effectiveness of treatment is determined as much or more by the therapist as by any particular theoretical orientation or patient characteristics (Najavits, Crits-Christoph, & Dierberger, 2000; Najavits & Weiss, 1994). With dual-diagnosis patients, 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 patients and how to confront a patient who has lied about substance abuse. Therapist processes emphasized in Seeking Safety include compassion for patients’ experience, using the treatment’s coping skills in one’s own life (not asking the patient to do things that one cannot do oneself), giving patients control whenever possible (as loss of control is inherent in trauma and substance abuse), modeling what it means to try hard by meeting the patient more than halfway (e.g., heroically doing anything possible within professional bounds to help the patient get better), listening to patients’ behavior more than their words, learning to give both positive and negative feedback, and obtaining feedback from patients about their reactions to the treatment. The flip side of such positive therapist processes is negative

countertransference, including harsh confrontation; sadism; inability to hold patients accountable because of misguided sympathy; becoming victim to patients' abusiveness; power struggles; and, in group treatment, allowing a patient to be scapegoated. As Herman (1992) suggested, therapists 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 therapists to balance. PTSD tends to evoke identification with patients' vulnerability, which, if taken too far, may lead to excessive support at the expense of growth. Substance abuse tends to evoke anxiety about the patient'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 therapist to integrate support and accountability, which are viewed as the two central processes in the treatment.

Training methods for the treatment (Najavits, 2000) emphasize these various process issues as well as observation of the therapist in action (e.g., taped sessions) and intensive training experiences (e.g., watching videotapes of good vs. poor sessions, rehearsal of "tough-case" scenarios, peer supervision, role plays, knowledge tests, identifying key themes, and think-aloud modeling).

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: (a) exploration of past trauma and (b) 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 patient has attained a foundation of safety (Herman, 1992; E. 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), eye movement desensitization reprocessing (Shapiro, 1995), the counting method (Ochberg, 1996), the rewind method (Muss, 1991), and thought field therapy (Figley, Bride, & Mazza, 1997). By directly processing trauma memories, they no longer hold such emotional power over the patient.

Despite the known importance of such treatments for PTSD (e.g., Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998), numerous experts have recommended that such work not begin for substance abusers until they have achieved a period of stable abstinence and functionality (Chu, 1988; Keane, 1995; Ruzek et al., 1998; Solomon, Gerrity, & Muff, 1992). The concern is that if patients are overwhelmed by painful memories from the past, their substance use could worsen in a misguided attempt to cope. Thus far, only two studies of patients with PTSD and substance abuse have used exploration of past trauma as a key intervention: a study by Brady and colleagues (Brady, Dansky, Back, Foa, & Carroll, 2001; see also chapter 7, this volume) and a study by Najavits and colleagues that combined Seeking Safety plus exposure therapy—revised (Najavits, Schmitz, Gotthardt, & Weiss, 2002; see also the section entitled Research on Seeking Safety). In the study by Brady and colleagues, results indicated that the 39% of their sample who were able to complete at least 10 of the 16 sessions

showed positive outcomes in PTSD and cocaine use (as well as other symptoms), which were maintained at 6-month follow-up. However, most patients were noncompleters, and they excluded patients with suicidal ideation, and thus likely selected a less impaired sample. In the study by Najavits and colleagues, positive outcomes were found in various domains, including psychiatric and substance abuse symptoms. However, a large number of modifications to standard exposure therapy were created, the treatment was conducted individually, and various “safety parameters” were put in place to maximize patients’ ability to safely tolerate the work.

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 patients with this dual diagnosis (Najavits, Weiss, & Shaw, 1997). Even small mention of trauma experiences has been found to trigger other patients, and in a short-term group treatment there may be insufficient ability to fully process the material.

Interpretive psychodynamic work is also specifically avoided in Seeking Safety. There is little, if any, exploration of the patient’s relationship with the therapist 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 too potentially upsetting for patients at this stage.

Treatment Format

For each of the 25 treatment topics, the following are provided in the Seeking Safety manual (Najavits, 2002b):<nl>

1. A brief *Summary*.
2. A *Therapist Orientation* that provides background about the topic, clinical strategies for conducting the session, and discussion of countertransference issues.
3. A *Quotation* that is read aloud at the start of each session to emotionally engage patients. For example, the quotation for the topic “PTSD: Taking Back Your Power” is from the political leader Jesse Jackson: “You are not responsible for being down, but you are responsible for getting up” (p. 11, Marlatt & Gordon, 1985).
4. A *Patient Handout* that summarizes the main points in the session and offers ideas for “commitments” (i.e., homework patients can do between sessions; see Exhibit 8.2 for an example of a patient handout).
5. A segment on *Tough Cases* of treatment challenges that the therapist can rehearse.

Additional materials include a background chapter on PTSD and substance abuse and an in-depth chapter on how to conduct the treatment (including emergency situations).

Topics can be conducted in any order, with the order selected by patients, therapists, or both. Many topics provide a variety of handouts, from which they can select those that are most relevant to cover. Moreover, each topic can be conducted as a single session or over multiple sessions, depending on the patient’s length of stay.

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 a population can lead to derailed sessions if the therapist does not impose clear structure. Yet the treatment is also highly flexible, which allows patients' most important concerns to be kept primary, to allow adaptation to a variety of settings, to respect therapists' clinical judgment, and to encourage therapists to remain inspired and interested in the work. These concerns are believed paramount for a population such as this, where the risks of patient dropout and therapist burnout are high (Najavits, 2001). Moreover, they were designed to adapt to the managed care era, in which many patients will have limited access to treatment. Thus, the treatment can be used for just one or a few sessions, 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 patients' 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 patients in them.

The treatment has been conducted in a variety of formats thus far, including group and individual; open and closed groups; 50- and 90-minute sessions; singly and co-led sessions; weekly and twice weekly; outpatient, inpatient, and residential; integrated with other treatments or as a stand-alone therapy; and single-gender or mixed-gender. The four empirical studies of the treatment conducted 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 three months), with one session per topic, and, in two of the studies, used a group modality.

Patient Selection

Although the treatment was formally tested on patients who met current diagnostic criteria for both PTSD and substance dependence, it has also been used clinically on patients who did not fully meet these criteria. This includes, for example, a patient struggling with PTSD who has a prior substance abuse history but no current use or, conversely, a patient who abuses substances and has a trauma history but not PTSD. Indeed, it appears helpful to guide patients to apply the treatment's coping skills to whatever problems are most important to them right now. The substance abuse material may be especially relevant for other impulse-control disorders such as binge eating, gambling, workaholism, and sex addiction.

Also notable is the wide range of clinicians who have used the treatment, including those with diverse specialties (addiction counseling, psychology, social work), primary foci (mental health, substance abuse), and orientations (psychodynamic, 12-step, cognitive-behavioral). It appears that far more important than any such characteristics are a high degree of empathy, a willingness to cross-train (i.e., for mental health clinicians to learn about substance abuse and vice versa), positive attitudes toward this patient population, and a strong ability to hold patients accountable and work with aggression (Najavits, 2000). Future research is needed to evaluate the benefit of the treatment based on particular patient and clinician characteristics.

Conducting the Session

Exhibit 8.3 summarizes the format of the session, which comprises four parts: (a) check-in, (b) quotation, (c) relate the topic to patients' lives, and (d) check-out. Optional additional elements are urinalysis testing (conducted prior to the session to assess recent drug use) and a feedback questionnaire for patients to rate the helpfulness of the session. The structure is designed to model how to make good use of time, how to "contain" appropriately, and how to set goals and stick to them. For patients with PTSD and substance abuse, who are often impulsive and overwhelmed, the predictable structure of the session helps them know what to expect. It offers, moreover, in its process, a mirror of the careful planning and focus that are needed for recovery from the disorders.

Most of the session is devoted to any 1 of the 25 topics described in Exhibit 8.1, with emphasis on relating it to current and specific problems in patients' lives. Priority is placed on attending to any unsafe behavior the patient reported during the check-in. Thus, the tone of the treatment, when conducted well, feels like deep therapy rather than simply psychoeducation or "school." Each topic represents a safe coping skill, and strong emphasis is placed on having patients try out the skill during the session, using any method the therapist prefers:

- *Do a "walk-through."* Ask patients to identify a situation in which the safe coping skill might help, then describe how they would use it. For example, in the topic "Asking for Help": "If you feel like cutting your arm, whom could you call? What would you say?"
- *In-session experiential exercise.* Some topics lend themselves to guiding patients through an experience rather than just talking about it. For example, the skill of grounding is demonstrated in a 10-minute exercise during the session.
- *Role play.* This is one of the most popular methods, particularly for interpersonal topics.
- *Identify role models.* Ask patients to try to think of someone who already knows the skill and explore what that person does. For the topic "Commitment," one can ask the patient "Do you know anyone who follows through on promises?"
- *Think aloud.* This is particularly useful for the cognitive sessions. Patients practice out loud a new way of talking to themselves. For example, on the topic "Compassion," one can ask "When you were fired from your job this week, how could you have talked to yourself compassionately?"
- *Process obstacles.* Ask patients to anticipate what might happen if they try to implement the skill. For example, in "Setting Boundaries in Relationships," one can ask the patient "What might your partner say if you requested safe sex?"
- *Involve safe family and friends.* Some topics encourage the patient to obtain help from safe people, such as "Getting Others to Support Your Recovery."
- *Replay the scene.* Ask patients to identify something that went wrong and then go through it again as if they could relive it ("What would you do differently this time?"). A Safe Coping Sheet was designed for this process, or it can be done more informally.
- *Discussion questions.* For each topic, ideas to generate discussion are offered.

- *Make a tape.* Create an audiotape for patients to use outside of sessions as a way to literally “change old tapes.” In the topic “Compassion,” for example, kind, encouraging statements can be recorded.
- *Review key points.* Ask patients to summarize the main points of the handout that are meaningful to them.
- *Question and Answer.* Ask patients questions to see what they do and do not know about the topic; for example, “Does anyone know what the letters ‘PTSD’ stand for?”

Throughout, patients are encouraged to identify ways that they can cope safely with any life situations that arise. They can draw from the list of more than 80 safe coping skills (which is posted on the wall and provided as a handout in the topic “Safety”), and are encouraged to discover which ones work for them. They can also fill out the Safe Coping Sheet, which guides them to contrast their old way of coping with a new way that is safe. This sheet was derived from forms used in CBT (e.g., Beck’s [1979] dysfunctional thought record) but is modified to be simpler and to have patients rate the safety of their old and new ways of coping. Patients are encouraged to seek explanations, but not excuses, for their unsafe behavior. The goal is to understand why they might be coping in poor ways (e.g., through substance use or self-harm) but to learn that no matter what happens in life, there is always a way to cope constructively rather than destructively.

At the end of each session patients are asked to select a commitment to try before the next session. Commitments are very much like CBT homework, but the language is changed to emphasize that patients 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. Also, commitments do not have to be written, as clinical experience with this population indicates that some patients do not like written assignments. Examples of commitments include “Ask your partner not to offer you any more cocaine,” “Read a book on parenting,” “Try calling a hotline,” and “Write a supportive letter to the young side of you that feels scared.” Ideas for commitments are offered at the end of each patient handout, but therapists are encouraged to customize them to best fit each patient. Therapists are also offered strategies for working with patients who repeatedly do not complete their commitments.

How the Treatment Was Developed

When beginning Seeking Safety in 1993, I selected a sample of women, given the high prevalence of this dual diagnosis in female substance abusers, and chose a format of time-limited group therapy for cost effectiveness. In addition to reading literature on PTSD and substance abuse, I drew from the traditions of several clinical areas: substance abuse treatment (Beck, Wright, Newman, & Liese, 1993; Carroll, Rounsaville, & Keller, 1991; Marlatt & Gordon, 1985; Miller, Zweben, DiClemente, & Rychtarik, 1995), PTSD treatment (Chu, 1988; Davis & Bass, 1988; Herman, 1992; Van der Kolk, 1987), CBT (Beck, 1979), women’s treatment (Jordan, Stiver, & Surrey, 1991; Lerner, 1988), and the field of education (Najavits & Garber, 1989).

The process of developing the therapy involved a large amount of trial and error over several studies (see the section Research on Seeking Safety) and a variety of clinical settings. On these projects, I conducted some of the treatment directly, supervised other

therapists in conducting it, listened to tapes of many sessions, and worked closely with therapists to identify what did and did not work. The manual was also reviewed by several experts in the field, and patients' response to various aspects of the treatment and their suggestions provided important feedback. Several related studies provided additional input, including a literature review on women with PTSD and substance abuse (Najavits et al., 1997), a descriptive study of women with PTSD and substance abuse (Najavits, Weiss, & Shaw, 1999), a study of cocaine-dependent patients with and without PTSD (Najavits, Gastfriend, et al., 1998), an assessment study (Najavits, Weiss, Reif, et al., 1998), a survey of therapists on their views of treatment manuals (Najavits, Weiss, Shaw, & Dierberger, 2000), and a survey of clinicians on their difficulties and gratifications in treating patients with this dual diagnosis (Najavits, 2002a).

How Is Seeking Safety Different From Existing Treatments?

Broadly speaking, Seeking Safety differs from existing treatments in its theory (i.e., safety as the target goal), its emphasis on humanistic themes (e.g., compassion, honesty, commitment), its attempt to make CBT accessible and interesting to patients who may be difficult to reach, its strong focus on case management, its format (e.g., the use of quotations), its detailed therapist and patient materials for each topic, and its attention to process issues. Several manual-based and empirically studied treatments that would appear to be most closely related are contrasted with Seeking Safety here.

CBT

CBT is one of the most widely used treatments. It has been adapted in recent years for PTSD (Ruzek et al., 1998) and for substance abuse (Beck et al., 1993; Carroll et al., 1991); however, none of these adaptations were designed for the combination of PTSD and substance abuse. In addition, the characteristics of Seeking Safety described above are not typically part of CBT. The same applies to two close cousins of CBT: relapse prevention (an offshoot of CBT developed for substance abuse) and coping skills training (e.g., Monti, Abrams, Kadden, & Cooney, 1989).

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) uses a coping skills approach and has recently been adapted for substance abuse (Linehan et al., 1999); however, it was designed for patients with borderline personality disorder and does not attempt to diagnose, describe, or treat PTSD. Although some patients have both borderline personality disorder and PTSD, they are separate disorders, with only a minority of patients having both (Herman, 1992; Linehan et al., 1999; Najavits, Weiss, Shaw, et al., 1998). DBT is also a much longer, more intensive treatment with a full year of treatment in both group and individual concurrent therapies totaling over 3 hours per week plus as-needed phone coaching (Linehan et al., 1999). Seeking Safety was designed as a lower cost treatment (e.g., originally tested as a short-term group treatment with one leader) with expansion to more intensive and lengthy formats if patients have access to more care. The format of DBT, many of the skills it teaches, and its language and level of abstraction are also different.

Motivational Enhancement Therapy

Motivational enhancement therapy for substance abuse (Miller & Rollnick, 1992) seeks to engage and retain patients in treatment by focusing on positive interpersonal therapy processes (e.g., “roll with resistance,” “express empathy,” “avoid argumentation”). However, it does not include rehearsal of coping skills, does not address dual diagnosis or PTSD in particular, and is not cognitive–behavioral.

Twelve-Step Treatment

Although 12-step treatments such as AA are highly compatible with Seeking Safety and many other psychotherapy treatments, they focus on substance abuse only (not PTSD), advocate an abstinence model only (i.e., they reject a harm-reduction approach), are not designed to be led by professional treaters, and do not provide explicit rehearsal of coping skills. Some psychotherapy adaptations of 12-step models (Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994) provide the last two characteristics, however.

Specific Treatments for PTSD

A variety of treatments have been designed specifically for PTSD (for a description, see Schiraldi, 2000). However, none of these have been designed for or evaluated in this dual-diagnosis population, except for exposure therapy, which is discussed in the next two sections.

Treatments for PTSD and Substance Abuse

Several treatments have been developed for patients with a dual diagnosis of PTSD and substance abuse. In addition to Seeking Safety, three others have undergone pilot empirical testing: (a) Concurrent Treatment of PTSD and Cocaine Dependence (Back, Dansky, Carroll, Foa, & Brady, 2001); Substance Dependence Posttraumatic Stress Disorder Therapy (Triffleman, Carroll, & Kellogg, 1999); and Transcend (Donovan, Padin-Rivera, & Kowaliw, 2001).

Back et al.’s (2001) treatment is a 16-session model that adapts a combination of Foa’s exposure therapy for PTSD (Foa & Rothbaum, 1998), relapse prevention (Carroll, 1998), and psychoeducation about PTSD and cocaine dependence. It differs from Seeking Safety in its inclusion of exposure techniques, shorter length, limited range of substances being addressed (i.e., cocaine only), format, and particular skills. Triffleman et al.’s (1999) treatment differs from Seeking Safety in its inclusion of in vivo exposure techniques for PTSD, format, and particular skills. Donovan et al.’s (2002) treatment is a 12-week program developed for veterans that comprises 10 hr/week of group treatment, mandatory attendance in a substance abuse rehabilitation program, and supplementary activities (e.g., volunteer community service). Six weeks focus on skills development, and 6 weeks on trauma processing, based on a combination of concepts derived from constructivist, existential, dynamic, cognitive–behavioral, and 12-step theories. It differs from Seeking Safety in its design as an intensive partial-hospital program, its skills, its target population (veterans), and its focus on trauma processing. Finally, five other models have been described but have not yet been empirically tested: books by Trotter (1992) and by Evans and Sullivan (1995), both in the 12-step tradition; a book by Miller and Guidry (2001); a chapter by Abueg and Fairbank (1991) that describes a behavioral model developed in a Veterans Administration setting; an article by Bollerud (1990) on

an eclectic model for inpatient care; and a chapter by Meisler (1999) on group treatment for PTSD and alcohol abuse.

Research on Seeking Safety

Four outcome studies on Seeking Safety have been completed. Each is briefly described here.

Women Outpatients

In this study (Najavits, Weiss, Shaw, et al., 1998), outcome results were reported for 17 female outpatients who completed group modality Seeking Safety treatment, with 25 sessions over 3 months. Completion of the treatment was defined as six or more sessions (met by 63% of the 27 who enrolled). All the women met criteria for current substance dependence and PTSD. All had experienced five or more lifetime traumas, with an average age of 7 at the time of the first trauma. Sixty-five percent of the sample had one or more co-occurring personality disorders. Forty-one percent had drug dependence, 41% had alcohol dependence, and 18% had both. Assessments were conducted at pretreatment, posttreatment, and 3-month follow up.

Results showed significant improvements in substance use (both alcohol and drug), 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. The only negative finding was a worsening of somatic symptoms (which may have been a function of substance withdrawal). Patients' treatment attendance (67% of available sessions), alliance, and satisfaction were also very strong. Treatment completers were more impaired than dropouts yet more engaged in the treatment. Overall, the data suggest that women with PTSD and substance abuse can be helped when provided with a treatment adapted to them. All results are clearly tentative, however, because of the lack of a control group, external treatments the patients may have engaged in, multiple comparisons, and the lack of assessment on dropouts.

Women in Prison

This was a study of 17 women in a minimum-security correctional setting using group modality Seeking Safety treatment, with 25 sessions over 3 months (Zlotnick, Najavits & Rohsenow, 2002). All participants met criteria for current PTSD and substance dependence, and all had histories of repeated physical abuse, sexual abuse, or both (with an average age of 8 at the first trauma). The most common drug of choice was cocaine. All of the women who were offered treatment began treatment.

The attendance rate was 83% of sessions, and measures of client satisfaction and alliance were high. Results showed that, of the 17 women, 9 (53%) no longer met criteria for PTSD at the end of the 3-month treatment; at a follow up 3 months later, 46% still no longer met criteria for PTSD. PTSD symptoms decreased significantly from pretreatment to posttreatment, and this was maintained at the 3-month follow up. During incarceration, random urinalysis showed that none of the women were using a

substance. A follow up 6 weeks after release from prison indicated that 29% were using an illegal substance, and at 3 months after release the rate was 35%. A significant decrease in drug and alcohol use and legal problems was found from pretreatment to both 6 weeks after release and 3 months after release. Recidivism rate (return to prison) was 33% at 3-month follow up, a rate typical of this population. The participants rated the treatments for PTSD and substance abuse as equally helpful.

Low-Income Urban Women

This study of 100 outpatient low-income urban women compared Seeking Safety in individual format to relapse prevention treatment (RPT) in a randomized controlled trial, with a “treatment-as-usual” nonrandomized control condition. Twenty-five sessions were conducted over a 3-month period, and all participants met current criteria for PTSD and SUD (Hien, Cohen, Litt, Miele, & Capstick, 2002). At the end of treatment, patients in both Seeking Safety and RPT had significant reductions in substance use frequency and intensity, PTSD symptoms, and psychiatric symptom severity, whereas participants in the treatment-as-usual comparison group did not show any significant changes. Improvements in PTSD severity were sustained at the 6-month follow-up point but not at 9 months for patients in both treatment groups. Although statistically significant improvements in substance use and psychiatric severity were not maintained for either of the treatments at the 6-month follow up, trends in the direction of lower substance use and psychiatric severity were found. Results of the study were interpreted to suggest that carefully conducted cognitive-behavioral interventions can substantially decrease current symptoms of both PTSD and SUD in a relatively brief period with an exceedingly hard-to-reach population.

Outpatient Men

This study of 5 outpatient men evaluated a combination of Seeking Safety plus Exposure Therapy-Revised, using individual treatment (Najavits, Schmitz, et al., 2002). They were offered 30 sessions over 5 months, with the option to select how much of each type of treatment they preferred on a session-by-session basis. All patients met criteria for current PTSD and substance dependence, with childhood trauma the basis of the PTSD. They had an average of 9.6 different types of trauma (all noncombat), with an average first trauma at 8 years of age. They reported an average of 22 days of drug problems in the prior month and 6 days of alcohol problems. The Exposure Therapy-Revised component was an adaptation of Foa and Rothbaum's (1998) exposure therapy, modified for PTSD and SUD. The modifications were designed to increase the acceptability and safety of exposure therapy in substance abuse patients by using a variety of “safety parameters.”

Outcome results showed significant improvements in drug use, family and social functioning, trauma symptoms, anxiety, dissociation, sexuality, hostility, overall functioning, meaningfulness, and feelings and thoughts related to safety. All 5 patients attended all 30 sessions, and they chose an average of 21 Seeking Safety sessions and 9 Exposure Therapy-Revised sessions. Treatment satisfaction and alliance were very high. The need for further evaluation using more rigorous methodology is discussed.

Current Studies

Other studies are currently underway, including a study of homeless female veterans at 10 Veterans Administration sites, a study of women in substance abuse treatment at four sites, a brief version of the treatment (12 sessions) in the Clinical Trials Network of the National Institute on Drug Abuse, a randomized controlled trial of women in prison, and a study of women in residential treatment.

Future Work

Several issues may be particularly interesting to address in future research:

- *How long should the Seeking Safety treatment be?* In research, patients' main critique of the treatment has been that it is too short. Therapists, too, have conveyed that they would prefer a longer length, with the possibility of conducting each topic over several sessions. Conversely, in many clinical settings, therapists report that they have far fewer than 25 sessions available per patient. Study designs could address this issue by offering different numbers of sessions and then evaluating the degree to which they impact outcomes.
- *What adjunctive treatments are most helpful in combination with Seeking Safety?* Exposure treatment has successfully been combined with Seeking Safety (Najavits et al, 2002). Also, data are currently being analyzed on the amount of 12-step self-help group participation by patients in the treatment. These and other future projects may help elucidate optimal combinations of treatments.
- *Does Seeking Safety provide differential benefit for particular types of symptoms?* Although the four studies thus far have shown a positive impact on various symptoms, it will be important over to determine whether the treatment differentially affects PTSD symptoms, substance abuse symptoms, and other key areas.
- *What are the treatment's active mechanisms?* For example, some topics may be much more helpful than others; or some domains (cognitive, behavioral, interpersonal, case management) may have different degrees of impact.
- *How can training boost the power of the treatment?* Training clinicians has proved to be an area ripe with questions (Najavits, 2000). How can training be more effective and more transportable to a variety of settings (especially when the weekly hour-long supervision typical of research studies is not available)? How can therapists be identified who are likely to be most effective with this population? What methods of training are most helpful?
- *What degree of benefit can be expected?* One of patients' most common questions is "Will I really get better?" Answering this in relation to Seeking Safety (or any other treatment) will require empirical data to determine how much and what types of improvement can be expected, over what timeframe, and under what conditions. The notion of what *recovery* means for either PTSD or substance abuse is complex, with some people believing full recovery is possible and others believing that adaptation to lifelong disorders is more realistic.

In short, a great deal is unknown at this point. Learning from a variety of patients, clinicians, settings, and studies will be an evolving process. In closing, a paraphrase of a quotation by Jacob (1997), from the topic "Discovery," is apt:

Progress...begins with the invention of a possible world...which is then compared by experimentation with the real world. And it is this constant dialogue between imagination and experiment that allows...an increasingly fine-grained conception of what is called reality.

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Exhibit 8.1

Seeking Safety Treatment Topics (and Domain)

1. Introduction to Treatment/Case Management	Covers (a) introduction to the treatment, (b) getting to know the patient, and (c) assessment of case management needs.
2. Safety (combination)	Safety is described as the first stage of healing from both posttraumatic stress disorder (PTSD) and substance abuse and is the key focus of the treatment. A list of more than 80 safe coping skills is provided, and patients 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, <i>grounding</i> , is offered to help patients 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 patients to become aware of their need for help and provides guidance on how to obtain it.
7. Taking Good Care of Yourself (behavioral)	Patients explore how well they take care of themselves using a questionnaire listing specific behaviors (e.g., "Do you get regular medical check-ups?"). 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. Patients are taught that only a loving stance toward the self produces lasting change.

<p>9. Red and Green Flags (behavioral)</p> <p>Patients 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.</p>
<p>10. Honesty (interpersonal)</p> <p>Patients discuss the role of honesty in recovery and role-play specific situations. Related issues include the following: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn't accept honesty?</p>
<p>11. Recovery Thinking (cognitive)</p> <p>Thoughts associated with PTSD and substance abuse are contrasted with healthier “recovery thinking.” Patients are guided to change their thinking using rethinking tools such as <i>List Your Options</i>, <i>Create a New Story</i>, <i>Make a Decision</i>, and <i>Imagine</i>. The power of rethinking is demonstrated through think-aloud exercises.</p>
<p>12. Integrating the Split Self (cognitive)</p> <p>Splitting is identified as a major psychic defense in both PTSD and substance abuse. Patients 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.</p>
<p>13. Commitment (behavioral)</p> <p>The concept of keeping promises, both to self and others, is explored. Patients are offered creative strategies for keeping commitments, as well as the opportunity to identify feelings that can get in the way.</p>
<p>14. Creating Meaning (cognitive)</p> <p>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 Waits for No One. Meanings that are harmful versus healing in recovery are contrasted.</p>
<p>15. Community Resources (interpersonal)</p> <p>A lengthy list of national nonprofit resources is offered to aid patients' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help patients take a consumer approach in evaluating treatments.</p>
<p>16. Setting Boundaries in Relationships (interpersonal)</p> <p>Boundary problems are described as either 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.</p>
<p>17. Discovery (cognitive)</p> <p>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.</p>
<p>18. Getting Others to Support Your Recovery (interpersonal)</p> <p>Patients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as 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.</p>
<p>19. Coping With Triggers (behavioral)</p> <p>Patients 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</p>

(similar to “change people, places, and things” in Alcoholics Anonymous).	
20. Respecting Your Time (behavioral)	Time is explored as a major resource in recovery. Patients 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? Balancing structure versus spontaneity; work versus play; time alone versus in relationships are also addressed.
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 to learn.” Patients 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”). Patients 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 (a danger when acted out against self or others). Guidelines for working with types of anger are offered.
24. The Life Choices Game (combination)	As part of termination, patients are invited to play a game as a way to review the material covered in the treatment. Patients 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	Patients 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 patients to validate the work they have done.

Note. Each topic represents a safe coping skill relevant to both PTSD and substance abuse. Domains (cognitive, behavioral, interpersonal, or a combination) are listed in parentheses.

Exhibit 8.2

Excerpt From a Patient Handout

Taking Good Care of Yourself

DO YOU...

- ♥Associate only with safe people who do not abuse or hurt you? YES ___ NO ___
- ♥Eat a healthful diet? (healthful foods and not under- or overeating) YES ___ NO ___
- ♥Have safe sex? YES ___ NO ___
- ♥Travel in safe areas (e.g., avoid being alone in deserted places)? YES ___ NO ___
- ♥Get enough sleep? YES ___ NO ___
- ♥Keep up with daily hygiene (e.g., clean clothes, showers, brushing teeth)? YES ___ NO ___
- ♥Get adequate exercise (not too much nor too little)? YES ___ NO ___
- ♥Take all medications as prescribed? YES ___ NO ___
- ♥Maintain your car so it is not in danger of breaking down? YES ___ NO ___
- ♥Avoid walking or jogging alone at night? YES ___ NO ___
- ♥Spend within your financial means? YES ___ NO ___
- ♥Have annual medical check-ups with each of the following: Doctor? Dentist? Eye doctor? Gynecologist (women only)? YES ___ NO ___
- ♥Know who to call if you are facing domestic violence? YES ___ NO ___
- ♥Have safe housing? YES ___ NO ___
- ♥Always drive substance-free? YES ___ NO ___
- ♥Refrain from bringing strangers home to your place? YES ___ NO ___
- ♥Carry cash, ID, and a health insurance card in case of danger? YES ___ NO ___
- ♥Currently have at least two drug-free friendships? YES ___ NO ___
- ♥Not smoke cigarettes? YES ___ NO ___
- ♥Have at least one hour of free time to yourself per day? YES ___ NO ___
- ♥Do something pleasurable every day (e.g., go for a walk)? YES ___ NO ___
- ♥Take vitamins daily? YES ___ NO ___
- ♥Have at least one person that you can truly talk to (therapist, friend, sponsor, spouse)? YES ___ NO ___
- ♥Use contraceptives as needed? YES ___ NO ___
- ♥Have at least one social contact every week? YES ___ NO ___
- ♥Attend treatment regularly (e.g., therapy, group, self-help groups)? YES ___ NO ___
- ♥Have at least 10 hours per week of structured time? YES ___ NO ___
- ♥Have a daily schedule and "to-do" list to help you stay organized? YES ___ NO ___
- ♥Attend religious services (if you like them)? YES ___ NO ___ N/A ___

YOUR SCORE: (total # of "no"s) _____

Notes on self-care:

Self-Care and PTSD. People with PTSD often need to learn to take good care of themselves. For example, if you were abused as a child you got the message that your

needs were not important. You may think, “If no one else cares about me, why should I?” Now is the time to start treating yourself with respect and dignity.

Self-Care and Substance Abuse. Substance abuse is one of the most extreme forms of self-neglect because it directly harms your body. And, the more you abuse substances the more you are likely to neglect yourself in other ways too (e.g., poor diet, lack of sleep).

Note. From *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (p. 179) by L. M. Najavits, 2002, New York: Guilford Press. Copyright 2002 by Guilford Press. Reprinted with permission.

Exhibit 8.3

Session Format

1. CHECK-IN

The goal of the check-in is to find out how patients are doing (up to 5 minutes per patient). Patients report on five questions: “Since the last session (a) How are you feeling? (b) What good coping have you done? (c) Describe your substance use and any 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 patients in the session (up to 2 minutes). A patient reads the quotation out loud. The therapist asks “What is the main idea in the quotation?” and links it to the topic of the session.

3. RELATE THE TOPIC TO PATIENTS’ LIVES

The therapist and/or patient select any of the 25 treatment topics (listed in Exhibit 8.1) that feels most relevant. This is the heart of the session, with the goal of meaningfully connecting the topic to patients' experience (30–40 minutes). Patients look through the handout for a few minutes, which may be accompanied by the therapist summarizing key points (especially for patients who are cognitively impaired). Patients 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 patients' 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 patients' progress and give the therapist feedback (a few minutes per patient). Patients answer two questions: (a) “Name one thing you got out of today's session (and any problems with it)” and (b) “What is your new commitment?”

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