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Seeking Safety: A Treatment Manual for PTSD and Substance Abuse, Lisa M. Najavits
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1

Overview

PTSD AND SUBSTANCE ABUSE

PTSD and Substance Abuse: Patients' Perspective

"The more I use, the more I won't feel anything. The pain is so bad you just want to die. There is no other way out. If you talk about it, it will hurt too much. So instead, keep it a secret. No one will know."

"When I was sober I was crazy, hiding under the bed."

These patients have lived what is only beginning to be understood within the mental health and substance abuse fields—that posttraumatic stress disorder (PTSD) and substance abuse[1] co-occur for a very large number of people, particularly women. Their stories also point to several major themes that are becoming increasingly recognized, based on clinical and scientific evidence:

- The dual diagnosis of PTSD and substance abuse is surprisingly common. The rate of PTSD among patients in substance abuse treatment is 12%–34%; for women it is 30%–59%. Rates of lifetime trauma are even more common (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Langeland & Hartgers, 1998; Najavits, Weiss, & Shaw, 1997; Stewart, 1996; Stewart, Conrod, Pihl, & Dongier, 1999; Triffleman, 1998).
- Becoming abstinent from substances does not resolve PTSD; indeed, some PTSD symptoms become worse with abstinence (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Kofoed, Friedman, & Peck, 1993; Root, 1989).
- Treatment outcomes for patients with PTSD and substance abuse are worse than for

[1] This treatment was originally developed for patients with substance dependence, the most severe form of DSM-IV substance use disorders. However, the term "substance abuse" is used throughout the manual, as it is more commonly used in treatment settings.

other dual-diagnosis patients and for patients with substance abuse alone (Ouimette, Ahrens, Moos, & Finney, 1998; Ouimette, Finney, & Moos, 1999).

- People with PTSD and substance abuse tend to abuse "hard drugs" (cocaine and opiates); prescription medications, marijuana, and alcohol are also common. Substance abuse is often viewed as "self-medication" to cope with the overwhelming emotional pain of PTSD (Breslau, Davis, Peterson, & Schultz, 1997; Chilcoat & Breslau, 1998; Cottler, Compton, Mager, Spitznagel, & Janca, 1992; Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995; Goldenberg et al., 1995; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Hien & Levin, 1994).
- People with PTSD and substance abuse are vulnerable to repeated traumas (Fullilove et al., 1993; Herman, 1992), and more so than patients with substance abuse alone (Dansky, Brady, & Saladin, 1998).
- People with both disorders suffer a variety of life problems that may complicate their clinical profile, including other DSM-IV disorders, interpersonal and medical problems, maltreatment of their children, custody battles, homelessness, HIV risk, and domestic violence (Brady, Dansky, Sonne, & Saladin, 1998; Brady et al., 1994; Brown & Wolfe, 1994; Dansky, Byrne, & Brady, 1999; Najavits et al., 1998c).
- People with PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders (Najavits, Weiss, & Shaw, 1999b; Najavits et al., 1998c).
- Among patients in substance abuse treatment, this dual diagnosis is two to three times more common in women than in men[2] (Brown & Wolfe, 1994; Najavits et al., 1998c).
- Most women with this dual diagnosis experienced childhood physical and/or sexual abuse; men with both disorders typically experienced crime victimization or war trauma (Brady et al., 1998; Kessler et al., 1995; Najavits et al., 1998c).
- PTSD and substance abuse have consistently been found to co-occur, regardless of the nature of the trauma or the type of substance used (Keane & Wolfe, 1990; Kofoed et al., 1993).
- A "downward spiral" is common. For example, substance use may increase vulnerability to new traumas, which in turn can lead to more substance use (Fullilove et al., 1993). From patients' perspective, PTSD symptoms are common triggers of substance use (Abueg & Fairbank, 1991; Brown, Recupero, & Stout, 1995), which in turn can heighten PTSD symptoms (Brown, Stout, & Gannon-Rowley, 1998; Kofoed et al., 1993; Kovach, 1986; Root, 1989).
- Various subgroups have high rates of this dual diagnosis, including combat veterans, prisoners, victims of domestic violence, the homeless, and adolescents (Bremner, Southwick, Darnell, & Charney, 1996; Clark & Kirisci, 1996; Dansky et al., 1999; Davis & Wood, 1999; Jordan, Schlenger, Fairbank, & Caddell, 1996; Kilpatrick et al., 2000; Ruzek, Polusny, & Abueg, 1998).
- The connection between PTSD and substance abuse appears to be enduring, rather than simply an artifact of substance use, withdrawal, or overlapping DSM-IV criteria (Bolo, 1991; Kofoed et al., 1993).
- Perpetrators of violent assault use substances at the time of assault in a high percentage of domestic abuse (50%) and rape (39%) cases (Bureau of Justice Statistics, 1992).

[2] In Kessler and colleagues' (1995) major study of a community sample, however, rates for men were higher than for women.

PTSD and Substance Abuse: Therapists' Perspective

The other half of the clinical equation is the therapist's perspective. One social worker in private practice said,

> *"I used to feel that I wouldn't go near substance abuse patients with a 10-foot pole—I wouldn't treat them and was pretty judgmental of them. Mostly I didn't understand them. But when I became aware that many have a history of trauma I began to feel more compassionate. I realized how often they are self-medicating their pain."*

A psychiatrist on the substance abuse unit of a hospital said,

> *"Where I work, patients are told to get off of substances first—only once they are clean can they deal with the trauma. They get four substance abuse groups a day but no groups for PTSD. Some of them feel invalidated, as though their trauma doesn't matter."*

Clinicians may feel confusion over how to treat such patients. For example:

- "Should the patient talk about painful trauma memories during treatment?"
- "Do I insist the patient must become substance-free before we work on the PTSD?"
- "How can I contain a patient who becomes overwhelmed by PTSD symptoms?"
- "Should I discontinue treatment if the patient keeps using substances?"
- "Does psychotherapy for this population work?"
- "Should I insist that the patient go to Alcoholics Anonymous (AA)?"

Just as new knowledge has arisen about patients, new knowledge is also growing about treatment:

- Most clinical programs treat PTSD or substance abuse, but rarely both. Yet an integrated model—treating both disorders at the same time—is recommended by both clinicians and researchers as more likely to succeed, more cost-effective, and more sensitive to patient needs (Abueg & Fairbank, 1991; Bollerud, 1990; Brady et al., 1994; Brown et al., 1995; Brown, Stout, & Mueller, 1999; Evans & Sullivan, 1995; Fullilove et al., 1993; Kofoed et al., 1993; Najavits, Weiss, & Liese, 1996c; Sullivan & Evans, 1994). Patients too favor integrated treatment of these disorders (Brown et al., 1998).
- The majority of patients with PTSD and substance abuse do not receive PTSD-focused treatment (Brown et al., 1998, 1999).
- Many patients are never even assessed for both PTSD and substance abuse (Fullilove et al., 1993; Kofoed et al., 1993). It is common for patients to report multiple substance abuse treatments during which they were never asked about trauma, never informed that they met the diagnosis of PTSD, and never told that PTSD is a treatable disorder for which specific treatments exist. Similarly, some mental health clinicians do not routinely assess for substance abuse.
- It can be difficult to predict patients' course of recovery. Paradoxically, both abstinence

and continued use of substances may make PTSD symptoms either better or worse, depending on the patient (Brown et al., 1998; Najavits, Shaw, & Weiss, 1996b).

- Treatment can be effective, but is often difficult and may be marked by unstable treatment alliances, multiple crises, erratic attendance, and relapse to substance use (Brady et al., 1994; Brown, Stout, & Mueller, 1996; Root, 1989; Triffleman, 1998).
- Both in the culture at large and among clinicians, views of patients with substance abuse and/or PTSD may be quite negative. Countertransference reactions are common (Herman, 1992; Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983; Najavits et al., 1995). Patients are sometimes perceived as "crazy," "lazy," or "bad," both by others and by themselves.
- Treatments that are effective for PTSD or substance abuse separately may not be advisable when the two disorders occur together. For example, PTSD treatments such as benzodiazepines or exposure therapy may not be indicated if a patient is addicted to substances; substance abuse treatment such as twelve-step groups may not work when a patient has PTSD (Ruzek et al., 1998; Satel, Becker, & Dan, 1993; Solomon, Gerrity, & Muff, 1992).
- Patients with this dual diagnosis may have intensive case management needs, which may go beyond the training of some clinicians and sometimes lead to "burnout" (Najavits et al., 1996b).
- The need for cross-training is common: The cultures, assumptions, and treatments for substance abuse and PTSD can be quite different, and most therapists do not have equal expertise in both (Evans & Sullivan, 1995; Najavits, 2000; Najavits et al., 1996c). Substance abuse counselors are not typically trained to work on severe mental health problems, and thus PTSD may be ignored or misunderstood. Similarly, most mental health therapists are not trained to work on substance abuse.

More on the Relationship between PTSD and Substance Abuse

The key points above summarize a growing body of research that has emerged primarily over the past decade, and is still undergoing continued validation. Although a full discussion of this work is beyond the scope of this book, further materials are recommended at the end of this book (see the entries marked by an asterisk in the References list). In addition, one patient's experience of PTSD and substance abuse is provided at the end of this chapter to illustrate the experience of this dual diagnosis.

THIS TREATMENT

This book describes a psychotherapy treatment for PTSD and substance abuse comprised of 25 topics. It is the first treatment for PTSD and substance abuse with published outcome results (Najavits et al., 1997, 1998e). It offers a variety of features designed to be maximally helpful to clinicians on the front lines of treatment, where time is short, the demands are great, and the need for something that works is imperative.

The creative contribution that this treatment, it is hoped, provides is its adaptation of cognitive-behavioral therapy (CBT) to this population. The goal was to mold a therapy that

would best fit patients' needs by listening to them very closely in the context of treating them, reading available literature, and conducting empirical research on the treatment.

The treatment's 25 topics are evenly divided among cognitive, behavioral, and interpersonal domains, with each addressing a safe coping skill relevant to both disorders. Each topic is designed to be independent of the others, thus allowing maximum flexibility for patients and therapists to choose the order of topics.

The treatment can be conducted on either a group or an individual basis, both of which have evidenced positive outcomes thus far in studies (Hien & Litt, 1999; Najavits, 1996, 1998; Zlotnick, 1999). It has also been applied in clinical settings to a wide variety of patients (e.g., women, men, adults, adolescents, prisoners, war veterans, outpatients, inpatients, inner-city patients, suburban patients, minorities). Data thus far indicate positive satisfaction with the treatment in several of these subpopulations, but outcome results are still being collected. (See Chapter 2 for more on using the treatment in different treatment contexts.)

Below, the principles of the treatment are described, followed by additional key features, what is not part of the treatment, how it was developed, its empirical testing, and how it differs from other treatments.

PRINCIPLES OF *SEEKING SAFETY*

This treatment is based on five central ideas: (1) safety as the priority of this first-stage treatment; (2) integrated treatment of PTSD and substance abuse; (3) a focus on ideals; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to therapist processes. These five principles are described below, followed by additional features of the treatment and a summary of what is *not* part of the treatment.

Safety as the Goal of This First-Stage Treatment

The title of this book, *Seeking Safety*, expresses the basic philosophy of the treatment. That is, *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: discontinuing substance use, reducing suicidality, minimizing exposure to HIV risk, letting go of dangerous relationships (such as domestic abuse and drug-using "friends"), gaining control over extreme symptoms (such as dissociation), and stopping self-harm behaviors (such as cutting). Many of these are self-destructive behaviors that reenact trauma, particularly for victims of childhood abuse, who represent a large segment of people with this dual diagnosis (Najavits et al., 1997). Even though the trauma may have occurred long ago, patients treat themselves in ways that repeat it, ignoring their needs and perpetuating pain (albeit sometimes in the guise of trying to satisfy short-term impulses). These patients have typically been abused and are now abusing themselves; this is not coincidence, but rather represents a meaningful connection between their disorders. "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.

Just as violations of safety are life-destroying, the means of establishing safety are life-

enhancing: learning to ask for help from safe people, utilizing community resources, exploring "recovery thinking," taking good care of one's body, rehearsing honesty and compassion, increasing self-nurturing activities, and so on. It is these skills that this treatment attempts to teach.

The treatment thus fits what has been described as first-stage therapy for each of the disorders. Experts within the PTSD and substance abuse fields have independently described an extremely similar first stage of treatment. For example, within the PTSD domain, Herman's (1992) model of a first-stage recovery group is defined by a focus on safety and self-care as the primary therapeutic tasks, a present-time orientation, homogeneous membership (all patients have the same primary diagnoses), low tolerance for conflict within the group, an open-ended format, didactic intent, and a moderate level of cohesion among members. Likewise, for substance abuse, Kaufman and Reoux (Kaufman, 1989; Kaufman & Reoux, 1988) depicts the first stage of treatment as "achieving abstinence," including assessing the extent and impact of substance use, developing a plan for abstinence, reviewing the patient's recent drug use and craving at each session, and diagnosing and treating coexisting psychiatric illness. These suggestions are echoed by other writers as well (Brown, 1985; Carroll, Rounsaville, & Keller, 1991; Evans & Sullivan, 1995; Marlatt & Gordon, 1985; Sullivan & Evans, 1996). In the topic *Safety*, a more extensive description of the stages of healing from both PTSD and substance abuse is provided. To summarize here briefly, the three stages are as follows (using Herman's terms):

Stage 1: **Safety**
Stage 2: **Mourning**
Stage 3: **Reconnection**

This treatment addresses only Stage 1. The first stage, safety, is in and of itself an enormous therapeutic task for some patients. Thus, if patients remember nothing else from the treatment, the hope is that they will "take home" the idea of safety above all. It is addressed over and over in numerous ways, including the Safe Coping Sheet (see Chapter 2), the list of Safe Coping Skills (in the topic *Safety*), the Safety Plan (in the topic *Red and Green Flags*), the Safety Contract (in the topic *Healing from Anger*), and the report of unsafe behaviors at each session's check-in, for example.

The concepts of safety and first-stage treatment are designed to protect therapists as well as patients. By helping their patients move toward safety, therapists are protecting themselves from the sequelae of treatment that could move too fast without a solid foundation: worry over the patients' well-being, vicarious traumatization, medico-legal liability, and dangerous transference and countertransference dilemmas that may be evoked by inappropriate treatment (Chu, 1988; Pearlman & Saakvitne, 1995). Thus "seeking safety" is, it is hoped, both patients' and therapists' goal.

Integrated Treatment of PTSD and Substance Abuse

The treatment is designed to continually address both PTSD and substance abuse. That is, both disorders are treated at the same time by the same clinician. This integrated model con-

trasts with a sequential model in which the patient is treated for one disorder, followed by treatment of the other; a parallel model, in which the patient receives treatment for both but by different treaters; or a single model, in which the patient receives only one type of treatment (Weiss & Najavits, 1998).

An integrated model is consistently recommended as the treatment of choice for this dual diagnosis (Abueg & Fairbank, 1991; Bollerud, 1990; Brady et al., 1994; Brown et al., 1995; Evans & Sullivan, 1995; Fullilove et al., 1993; Kofoed et al., 1993). In practice, however, most settings do not treat the two disorders simultaneously (Abueg & Fairbank, 1991; Bollerud, 1990; Evans & Sullivan, 1995). If patients enter a PTSD or general psychiatric setting, they usually address only trauma issues. If they enter a substance abuse setting, they are usually encouraged to work only on the substance abuse (Abueg & Fairbank, 1991; Bollerud, 1990; Evans & Sullivan, 1995). Indeed, one patient reported that she had to lie about her substance abuse to enter a PTSD program because the program did not accept patients with substance abuse—a not uncommon policy. In many settings clinical staff may be reluctant to assess for the "other" disorder (Bollerud, 1990; Fullilove et al., 1993), sometimes because they are unsure how to treat it if it is discovered. Patients' own shame and secrecy about trauma and substance abuse can also reinforce treatment splits (Brown et al., 1995). Whereas dual-diagnosis treatment settings may, by design, attend to co-occurring disorders, they also tend to provide generic rather than specialized treatment by diagnosis. Yet the treatment needs of a patient with schizophrenia and substance abuse may be quite different from those of a patient with PTSD substance abuse, for example (Weiss, Najavits, & Mirin, 1998b).

Integration is 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 each disorder triggering the other. Thus the content of this 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 (such as poverty).

In addition, therapists are guided to use each disorder as leverage to help patients overcome the other disorder. Patients rarely emphasize each disorder equally. Some want to talk at length about PTSD and believe that their substance abuse is not really a problem. Others acknowledge substance abuse, but are afraid to address PTSD. The wish to deny aspects of one's experience is much more characteristic of these disorders than of many other Axis I disorders (e.g., major depression or generalized anxiety disorder). The shame and secrecy surrounding trauma and substance use, and fear of others' judgment, converge toward substantial disavowal. The denial can be intrapsychic, as in dissociative phenomena, or external, as in dishonesty about substance use. In any event, it requires deft therapeutic skill to continually help patients maintain focus on both disorders.

Integration of the treatment also occurs at the intervention level. Each topic 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 one's roommate to stop growing marijuana plants in the house). Integration is also created by fluid movement among the four target areas of the treatment—cognitive, behavioral, interpersonal, and case management. Weaving in and out of these areas helps patients recognize

the links among their thoughts, actions, and relationships, and between their internal experience and their functioning in the external world.

It is important to note that "integration" means attention to both disorders at the same time *in the present.* It is not asking patients to talk in detail about the past; indeed, that is specifically not part of this treatment (see the section below, "What Is Not Part of This Treatment"). Rather, it means helping patients learn what the two disorders are and why they co-occur; exploring their interrelationship in the present (e.g., using crack last week to cope with PTSD flashbacks); understanding the course of the disorders in recovery (e.g., with abstinence, PTSD may feel worse before it feels better); increasing compassion by viewing substance abuse as an attempt to cope with the pain of trauma; and teaching safe coping skills that apply to both. In short, patients are encouraged to see that healing from each disorder requires attention to both disorders. However, it does not mean telling patients, "You have to get clean first before you can deal with your PTSD," or "Once you deal with your PTSD your substance abuse will go away" (messages patients sometimes hear in treatment programs). Instead, the idea is to gain control over the notorious downward spiral in which each disorder sets off the other. Themes common to both disorders are highlighted as well, such as "secrecy" and "control" as hallmarks of both.

A Focus on Ideals

It is difficult to imagine two mental disorders that individually, and especially in combination, lead to such demoralization and loss of ideals. In the PTSD field, this loss of ideals has been written about, for example, in Janoff-Bulman's (1992) work on "shattered assumptions" and Frankl's (1963) work on the "search for meaning." As one patient said, "I feel as though everyone is born good but the world destroys that. I keep thinking, 'What is the meaning of being alive?' and I can't come up with an answer." Trauma can raise an existential dilemma: Having experienced suffering and evil, do survivors remain sunken at that level, continuing to trade in distrust, destruction, and isolation (toward both self and others)? Or do they rise above it and create a new dialogue of honesty, integrity, connection, and higher values? These contrasts recur as themes throughout various literatures on trauma, whether of Holocaust victims, war veterans, crime victims, or child abuse survivors (Frankl, 1963; Herman, 1992; Shay, 1994). 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). And many patients report feeling more upset about a loss of ideals, such as trust, than about particular external conditions, such as poverty or lack of a job.

With substance abuse, there is also a loss of ideals. Life has become narrowed in focus, and in its severe form one is living "at the bottom"—surrounded by people who cannot cope, pushing away reality, losing connections to normal life (job, home, relationships), lying about substance abuse, unable to face emotional pain. It is striking that the primary treatment for substance abuse for most of the 20th century, 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 this treatment 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 characteris-

tic of PTSD and substance abuse. For example, *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 the bodily self-neglect of PTSD and substance abuse. The quotation in each topic is an attempt to be inspiring, and the language throughout the treatment emphasizes values such as "respect," "care," "integration," "protection," and "healing." The hope is that, by aiming for what can be, patients will summon the motivation for the incredibly hard work of recovery. If they are being asked to give up substances, something better needs to be offered in their place.

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, "safety" treatment. Beck, Emery, and Greenberg (1985) have described several key features of CBT. It is present- and problem-oriented, to reduce current symptoms. It is brief, time-limited, and structured, with the goal of strong treatment gains over a short time frame. It is educational, with emphasis on rehearsal of new skills. It is directive and collaborative, guiding patients (much as a good parent would) while emphasizing patients' mature contribution to their own treatment. These processes provide, in the very format of the treatment, an antidote for the powerlessness and lack of control inherent in PTSD and substance abuse. CBT also teaches self-control strategies, to help patients acquire functional behaviors that may never have been developed or may have deteriorated due to substance abuse and PTSD (e.g., problem solving, cognitive control, relationship skills, self-care). Such coping skills are specifically recommended by experts on PTSD and substance abuse (Ouimette et al., 1999). CBT offers explicit training in relapse prevention, which is commonly used to prevent substance abuse relapses (Beck, Wright, Newman, & Liese, 1993; Carroll et al., 1991; Marlatt & Gordon, 1985) and is directly applicable to PTSD as well (Foy, 1992). Finally, according to research, CBT has been found to be one of the most promising approaches, independently, for PTSD (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Ruzek et al., 1998; Solomon et al., 1992) and substance abuse (Carroll et al., 1991; Maude-Griffin et al., 1998; Najavits & Weiss, 1994a).

In the behavioral topics, patients are encouraged to commit to action. The "behavioral bottom line" is taught: that it is not sufficient to talk about action, but real action, however small, is essential. At each session, patients make a commitment of one concrete step to promote healing (see Chapter 2). Therapists are encouraged to listen to patients' behavior more than their words to hear them most effectively (e.g., self-destructive behavior as a "cry for help"). With the Safe Coping Sheet, patients are guided to "own" their actions—that is, no matter what happens in their lives, they can learn to cope without substances.

The importance of cognition is addressed through standard cognitive therapy interventions, such as identification of beliefs and restructuring. In addition, patients are guided to explore the meaning of substances in the context of their PTSD (e.g., self-medication? compensation? slow suicide? revenge?). Cognitive distortions (Burns, 1980) are identified for PTSD and substance abuse (such as "Deprivation Reasoning," "Beating Yourself Up," and "Time Warp") and contrasted with healthier meaning systems (such as "Live Well," "Honor

Your Feelings," and "You Have Choices"). The topic *Compassion* is used as a means to connect cognition and emotion: to understand, at a deep level, the reasons behind one's actions rather than judging them. Thus PTSD does not mean "crazy" but rather overwhelming emotional pain; substance abuse does not mean "bad" but rather a misguided attempt to solve a problem. In short, the meanings patients create for their lives may vary widely. One may tell the sad story of someone who was destroyed by life; another may tell the uplifting story of someone who overcame adversity. The goal of the cognitive topics is thus to help patients shift their meaning systems toward self-respect and adaptation.

Originally, the treatment was solely cognitive and behavioral. The interpersonal and case management domains were added after it became apparent, from work with patients, that these were equally important. Interpersonal topics now constitute a 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 (in contrast to natural disasters or accidents, for example; Kessler et al., 1995). Whether the trauma was childhood physical or sexual abuse, combat, or crime victimization, all have an interpersonal valence that may evoke in the survivor distrust of others, confusion over what can be expected in relationships, and concern over reenactments of abusive power (Herman, 1992; Shay, 1994) both as victims and as perpetrators. Similarly, substance abuse is often precipitated and perpetuated by relationships. Many patients grew up in homes with substance-abusing family members, and substance use may be an attempt to gain acceptance by others (Miller, Downs, & Testa, 1993) and manage interpersonal conflict (Marlatt & Gordon, 1985). As Trotter (1992) has noted, patients with PTSD and substance abuse are often much more concerned with interpersonal issues than with issues of autonomy (e.g., work functioning), which may represent a later developmental step.

Thus the interpersonal topics of the treatment seek to help patients maximize the presence of supportive people and let go of destructive people. There is an option to invite significant others to a session to help support patients' recovery (in *Getting Others to Support Your Recovery*). Patients are encouraged to communicate honestly when it is safe to do so, but also to recognize that they can only change *themselves* at this point, and that trying to change others while in early recovery is not usually a productive focus. They are guided to explore parallels between their relationship with themselves and with others (e.g., it is common to have problems setting boundaries both internally within oneself and externally with others), and to notice extreme relationship dynamics that reevoke trauma (e.g., overcompliance, enmeshment) and substance abuse (e.g., "friends" who keep offering substances).

The case management component arose from data in the *Seeking Safety* pilot study that showed many patients' having received few treatment services prior to joining the program (Najavits et al., 1998e; Najavits, Dierberger, & Weiss, 1999a). This was the opposite of what had been expected, which was that they would be heavy utilizers of treatment. Some people with PTSD and substance abuse may indeed receive a lot of treatment, particularly if they are connected to a treatment system such as Department of Veterans Affairs (VA) services or inpatient hospitalization (e.g., Brown & Wolfe, 1994). In contrast, patients for our study were recruited via newspaper advertisements, which likely drew a different sample. Most required significant assistance in getting the care they needed (psychopharmacology, job counseling, housing, etc.). An extensive discussion of the rationale and methods for case management is

provided in the topic *Introduction to Treatment/Case Management*. In short, it is assumed that psychological interventions can work only if patients have an adequate treatment base.

Attention to Therapist Processes

Techniques per se are inert; they come alive in the person of the therapist. Indeed, research shows that for patients with substance abuse in particular, the effectiveness of treatment is determined as much or more by the therapist as by theoretical orientation or patient characteristics (Luborsky et al., 1986; McLellan, Woody, Luborsky, & Goehl, 1988; Najavits, Crits-Christoph, & Dierberger, 2000; Najavits & Weiss, 1994b). Even separating a treatment into content and process may be an artificial distinction (Strupp & Binder, 1984). The therapist represents the form the treatment takes and can magnify or diminish its impact. And the more severe the patients, the more negative therapist processes are likely (Imhof, 1991; Imhof et al., 1983).

Therapist processes emphasized in this treatment include building an alliance; having compassion for patients' experience; using the various coping skills in one's own life (i.e., 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); and obtaining feedback from patients about their genuine reactions to the treatment. The flip side of such positive therapist processes is negative countertransference, including harsh confrontation; sadism; inability to hold patients accountable, due to misguided sympathy; becoming victim to patients' abusiveness; power struggles; and, in group treatment, allowing a patient to be scapegoated. As Herman (1992) has suggested, therapists may unwittingly repeat the roles of trauma—victim, perpetrator, or bystander. Attention is also directed to what might be termed "the paradox of countertransference" in PTSD and substance abuse. That is, PTSD and substance abuse appear to evoke opposite countertransference reactions, and it is difficult for therapists to balance these. PTSD tends to evoke sympathy and identification with patients' vulnerability, which if taken too far may lead to excessive support and overindulgence rather than encouraging accountability and growth. Substance abuse tends to evoke concern and anxiety over patients' substance use, which, if extreme, becomes harsh judgment and confrontation. Therapists typically land too much on one or the other side of these opposites. Thus the goal is for the therapist to integrate praise and accountability, which are viewed as the two central processes in the treatment.

Therapist processes in this treatment are addressed through several features in each topic: a therapist "Orientation" that provides background about the topic and discussion of countertransference issues; a "Tough Cases" segment that presents typical treatment challenges for the therapist to rehearse; and an "End-of-Session Questionnaire" that obtains patient feedback about each session (see Chapter 2).

In addition, despite its highly structured approach, the treatment is designed to adapt flexibly to therapist preferences. For example, some therapists enjoy using CBT forms in sessions, while others dislike them; they are provided but always optional. Many topics have multiple subtopics from which to choose; and instead of a strict protocol, various ways to ad-

dress the material are suggested. There is no required order of topics, and there are a variety of formats in which to conduct the treatment (see Chapter 2). In short, respect for therapists' individual styles and support for their very difficult role are emphasized throughout.

Additional Features of the Treatment

In addition to the five main principles above, several additional features of the treatment can be described.

Use of educational research strategies. Several strategies are derived from educational research to maximize learning (Najavits & Garber, 1989), including contrast-set teaching (comparing extremes such as safe vs. unsafe coping, supportive vs. destructive people); role preparation (e.g., explicitly telling patients how to make the most of the treatment); teaching for generalization (e.g., asking patients to teach a new skill to a partner who can cue them to use it); structured treatment (e.g., each session follows a consistent format); affectively engaging themes and materials (e.g., the quotation for each topic), and memory enhancement devices (e.g., a list of Core Concepts of Treatment—see Chapter 2).

A focus on potential rather than pathology. To increase patients' (and therapists'!) hopefulness, the treatment emphasizes the present and future more than the past, and stresses patients' strengths more than their pathology. It is necessary to be aware of patients' deficits; however, in an early-stage treatment in which the goal is to help patients attain safe functioning, focusing on the past or pathology appears to demoralize patients. Thus the stance is to keep an optimistic frame, aim high (believing that patients truly can get better), and use praise rather than negative reinforcement to promote change. Specific techniques include having patients report good coping at each session's check-in, teaching compassion rather than self-blame, allowing patients to return to treatment no matter what (except in the case of physical danger), and delaying exploration of past trauma and interpretive psychodynamic work until later stages of treatment (see "What Is Not Part of This Treatment," below).

Attention to language. The treatment is designed to use simple, everyday words; to avoid jargon; to use humanistic rather than scientific terms; and, when possible, to convey patients' experience with quotations in their own words. For example, "rethinking" is used rather than "cognitive restructuring"; "commitment" rather than "homework"; "honesty" rather than "assertiveness"; and "emotional pain" rather than "psychiatric symptom." To focus on strengths rather than pathology, virtually every term that began as a negative was reframed after it became clear that negative language made patients feel worse about themselves. Thus the standard CBT phrase "cognitive distortions" was reworked as "creating meaning." Also, therapists are encouraged to allow patients to decide what language fits them. For example, some patients with PTSD prefer the term "healing" to "recovery" because they believe that no matter how well they become, trauma has changed them forever; thus PTSD is an existential issue rather than a "medical illness" that one "recovers" from. Finally, language is gender-neutral whenever possible, so that both women and men can relate to the material. Patient examples from both genders and from a variety of types of trauma are provided throughout.

Emphasis on practical solutions. The treatment attempts to provide materials that are highly practical in nature: lists of national resources; extensive handouts for each topic; the

broad list of Safe Coping Skills; specific in-session exercises to try (e.g., an actual script to rehearse grounding). The goal is that patients will never need to believe "There is nothing I can do." If one tool doesn't work, the idea is to use another.

Relating the material to patients' lives. With so much written material, it is a challenge to keep the treatment therapeutic rather than didactic or intellectual. Ways to do so include relating the material to current and specific problems in patients' lives; and, whenever possible, directly rehearsing skills both in and outside of the session so that patients, in the words of the famous educator John Dewey, "learn by doing" (Dewey, 1983).

Clinical realism. Although the material conveys how sessions will ideally go, there is also a great deal of attention to the realities of front-line clinical work. Thus "Clinical Warnings" are given for material that may be upsetting to some patients; "Suggestions" for each topic address issues that may emerge when using the treatment; "Tough Cases" are provided for each topic to present some challenging comments patients tend to make; a section on "What Didn't Work" when developing this treatment is provided at the end of Chapter 2. Moreover, there is emphasis throughout on understanding the limits of patients' lives and, when implementing strategies, avoiding simplistic solutions (such as "positive thinking" in the cognitive topics).

An urgent approach to time. The conjoint influences of managed care, the typically short retention in treatment of many patients with substance abuse (Crits-Christoph & Siqueland, 1996), and the severity of patients with this dual diagnosis lead to a sense of urgency in trying to help them quickly. Indeed, *Seeking Safety* was initially tested as a short-term (3-month) group treatment with a single therapist, to evaluate whether gains could be achieved within these limits (Najavits et al., 1998e). It can and, it is hoped, will be conducted over a longer time frame if the setting allows it, but for most patients, there is too little time and a great deal to accomplish. Thus sessions are highly focused to make the best use of time available, and time outside of sessions is utilized whenever possible to promote recovery (e.g., making case management calls during the session, completing commitments between sessions). One of the key skills the therapist needs to master is "redirection" to help keep the sessions goal-directed.

Making the treatment interesting to patients. Considerable attention has been devoted to making the treatment accessible and engaging with devices such as the Life Choices Game; recording therapeutic audiotapes in the session; providing self-exploration questions on patient handouts; the use of metaphors; and a quotation to start each topic. Such efforts may be particularly important for patients with PTSD and substance abuse, who represent a more impaired, treatment-resistant group than those with substance abuse alone (Brady et al., 1994; Najavits et al., 1996b, 1998c). Their clinical presentation, especially early in treatment, may be marked by poor concentration, dissociation, and impulsiveness, which can limit the impact of traditional verbal therapy. Several writers have commented on the need to "hook" these patients into treatment (Abueg & Fairbank, 1991; Jelinek & Williams, 1984; Kofoed et al., 1993). The high dropout rate from substance abuse treatment in general (Craig, 1985) warrants strong efforts to make treatment stick. CBT is sometimes perceived as mechanistic, superficial, and inattentive to feelings (Clark, 1995; Gluhoski, 1994), so it appears especially important to make treatment as creative as possible. Moreover, this utilizes a primary defense in PTSD—the use of fantasy—as a tool for recovery (Herman, 1992).

Substance abuse as a priority. Substance abuse treatment and mental health treatment have, for most of the 20th century, been two different cultures. Each has derived its own strategies from clinical experience with many patients over time. For therapists who are new to substance abuse treatment, there is often a steep learning curve. Some of the approaches to substance abuse in this treatment include making it a priority at each session; conveying that while the goal is to understand substance use incidents, there is never an excuse for using (i.e., it is always possible to cope in a better way); using urinalysis and breathalyzer testing; validating mixed feelings about giving up substances; recognizing that giving up substances will not feel good; understanding how substances "solve" particular PTSD and other problems in the short term (although they do not work in the long term); understanding the biological basis of addiction; recognizing denial and other defenses typical of substance abuse; setting abstinence as the goal, but harm reduction as a means to that end if needed; and strongly encouraging twelve-step self-help groups while never forcing patients to attend them.

What Is Not Part of This Treatment

There are two main areas that this treatment explicitly omits: exploration of past trauma and interpretive psychodynamic work. Exploration of past trauma is, in and of itself, a major intervention for PTSD in a variety of treatments, including mourning (Herman, 1992), exposure therapy (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. For example, in exposure therapy (Foa & Rothbaum, 1998), the patient describes the trauma in detail ("imaginal exposure"), perhaps audiotaping the trauma narrative and listening to it outside of sessions, as well as confronting feared reminders of trauma ("*in vivo* exposure," such as driving over a bridge where an assault occurred). As patients face these trauma triggers, they are flooded by overwhelming emotion—typically anxiety, sadness, or anger—that gradually dissipates with repeated exposure to them. It follows a classic behavioral model of exposure to feared stimuli. It is highly effective for PTSD (Foa & Rothbaum, 1998; Marks et al., 1998) in as few as nine sessions or in prolonged versions for more complex cases. The "mourning" phase described by Herman (1992) is similar, but draws on psychodynamic influences, emphasizing a review of the patient's life before the trauma, creation of meaning to understand what happened, emphasis on how trauma affected relationships, and trauma imagery.

There are several reasons why exploration of trauma memories is not part of *Seeking Safety*. Primarily, it is not yet known whether it is safe and effective for patients who are actively abusing substances. Numerous experts have recommended that for substance abusers, such work not begin 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. Moreover, *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 num-

ber of patients with this dual diagnosis (Najavits et al., 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 time to fully process the material.

It can be noted, however, that when *Seeking Safety* has been conducted as an individual therapy over a longer time frame, it has been combined with exposure therapy and, at least thus far, appears to be a highly compatible mix of treatments. A pilot study using this combination in a sample of men is described in "Empirical Results" later in this chapter (Najavits, Schmitz, Gotthardt, & Weiss, 2001), and initial guidelines for combining the treatments are described in the section "Treatment Guidelines" in Chapter 2. However, until further research explores the use of exposure techniques with a broad range of this dual-diagnosis population, it is not included as part of *Seeking Safety*.

Interpretive psychodynamic work is also specifically avoided in *Seeking Safety*. There is little, if any, processing of the patient's relationship with the therapist or, in group treatment, of members' relationships with each other. There is also no exploration of intrapsychic motives or dynamic insights. Although these powerful interventions are likely to be helpful in later stages of treatment, they are believed too advanced and potentially upsetting for patients at this stage. See the topic *Safety* for more on this issue.

HOW THE TREATMENT WAS DEVELOPED

This treatment was begun in 1993 under a grant from the National Institute on Drug Abuse (NIDA) Behavioral Therapies Development Program. The goal was to design the treatment and to conduct a pilot study to scientifically evaluate its impact on patients. The sample was to be all women, given their very high prevalence of this dual diagnosis and the format was to be time-limited group therapy (selected for cost-effectiveness). At that point, there had not been a single published treatment study on patients with PTSD and substance abuse, and existing treatment resources were either brief articles (Abueg & Fairbank, 1991; Bollerud, 1990), were not empirically evaluated (Abueg & Fairbank, 1991; Bollerud, 1990; Evans & Sullivan, 1995; Trotter, 1992), did not provide session materials (Abueg & Fairbank, 1991; Bollerud, 1990; Evans & Sullivan, 1995; Trotter, 1992), and/or were not cognitive-behavioral (Bollerud, 1990; Evans & Sullivan, 1995; Trotter, 1992).

The content of the treatment draws on the traditions of several literatures: substance abuse treatment (Beck et al., 1993; Carroll et al., 1991; Marlatt & Gordon, 1985; Miller, Zweben, DiClemente, & Rychtarik, 1995), PTSD treatment (Chu, 1988; Davis & Bass, 1988; Herman, 1992; van der Kolk, 1987), CBT (Beck, Rush, Shaw, & Emery, 1979), women's treatment (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Lerner, 1988), and educational research (Najavits & Garber, 1989).

The process of developing the therapy involved an enormous amount of trial and error over several studies: the initial pilot study, using a group format (Najavits et al., 1998e); a controlled trial against a "treatment-as-usual" control condition, using a group format (Najavits, 1996); a controlled trial comparing it to relapse prevention therapy for inner-city women with substance abuse, using an individual format (Hien, 1997); a pilot study in a women's prison using a group format (Zlotnick, 1999); and a pilot study with men in an individual format. It

was also used in three VA clinical settings, which provided input on male war veterans (C. Smith, personal communication, April 10, 2000; T. North, personal communication, October 12, 1999) and female war veterans (J. Ruzek, personal communication, September 15, 1998). On these projects, working closely with numerous therapists conducting the treatments was crucial in refining the manual and learning that what seemed to make sense on paper needed a great deal of work to get conveyed effectively to others. I conducted the first two treatment groups in the initial pilot study and thereafter supervised other therapists in running them, listened to tapes of many sessions, and worked closely with therapists to identify what did and did not work. Patients' response to various aspects of the treatment and their suggestions on what to change also provided important feedback. The manual was reviewed by several experts in the field as well.

Two related studies were conducted to provide additional input. The first was a survey of 50 CBT psychotherapists, asking them to report their reactions to treatment manuals, rate various components of manuals, identify favorite manuals, rate their opinions on controversies about manuals, and report how they use manuals (Najavits, Weiss, Shaw, & Dierberger, 2000). Second, a study was conducted comparing 30 women with PTSD and substance abuse to 30 women with substance abuse alone, on a battery of many different measures (Najavits et al., 1999b). The goal was to explore variables that might help to distinguish people who developed both disorders from those with just one (e.g., evaluating coexisting psychiatric problems, risk and protective factors during childhood, cognitive distortions, treatment history, and coping style).

There were several major changes to the treatment, based on this trial-and-error and information-gathering process. These are described here, as it may be helpful to elaborate what was tried but did not work in clinical settings.

- ***Conducting full modules (eight consecutive sessions) of cognitive, behavioral, and interpersonal sessions.*** Originally the treatment was conducted in blocks of cognitive, behavioral, and interpersonal sessions (eight each, with all sessions in predetermined order) in an attempt to have patients truly master each domain. Indeed, at one point a separately designed Safe Coping Sheet was used for each of these modules. However, this did not work well. Patients preferred the diversity of moving among domains rather than being "stuck" in one for several weeks, and they increased their learning by interweaving the domains rather than separating them. Thus, the current format allows patients and therapists to select any order for the treatment topics.
- ***Topics framed in negative terms.*** Topics were labeled, for example, *Cognitive Distortions* and *The Damaged Self*; these are now *Creating Meaning* and *PTSD: Taking Back Your Power.* Throughout the treatment, material that had been framed as pathology has been either deleted or reworked to offer a contrast with healthy coping (e.g., compassionate vs. harsh self-talk; the split vs. integrated self). This was found much more supportive and motivating for patients.
- ***Assigning group partners.*** Patients were assigned randomly to another person in the group treatment to keep a "buddy system" (someone to go to AA with, someone to call if they missed a session, someone to do the commitments with). Patients gave this treatment component a very low rating, and it seemed to create serious boundary problems.

- ***Homework.*** Originally, homework followed the standard cognitive therapy model: It was written, it was called "homework," and it was required. These are now all changed: It can be any concrete, defined assignment that moves a patient forward (see Chapter 2); it does not need to be written (many patients never liked school, and written homework reevoked failure experiences for them); it is called a "commitment"; and it is strongly encouraged but never required.
- ***Providing most of the written material to therapists rather than patients.*** Originally, the idea was to keep the handouts simple, one-page summaries with the bulk of information in the therapist guide. However, after experimentation, it appeared that patients greatly appreciated having a lot of written material to return to outside of sessions, and that this also alleviated the burden of therapists' having to convey a large amount of information.
- ***Patient goal setting at the beginning of treatment.*** Patients were asked to identify their goals for treatment at the first session—that is, "Write your personal goals for your life: what you would like to accomplish, what you would like to learn, how you would like to live." Although this has worked with other patients, it did not appear to work with this population. They tended not to have a vision of the future (indeed, this is a defining criterion of PTSD), had difficulty articulating goals, and then often felt bad for not being able to do so. They were able, however, to set very short-term goals (i.e., the commitments between sessions).
- ***Writing an autobiography of PTSD and substance abuse.*** It is a standard exercise in relapse prevention (Marlatt & Gordon, 1985) to write an autobiography of one's substance abuse. When asked to write their history of both PTSD and substance abuse, however, some patients felt extremely triggered and a few did not return to treatment. Indeed, writing about one's history of PTSD is a formal part of exposure therapy for PTSD and is now known to evoke extreme anxiety. It is thus unsafe as a routine part of this treatment, although if carefully planned, combining the two treatments—*Seeking Safety* and exposure—may be productive (Najavits et al., 2001).
- ***Linking every substance use incident to PTSD.*** A naive early stance was trying to identify each incident of substance use as reflective of PTSD. There are many reasons why people with the dual diagnosis use substances in addition to attempting to manage their PTSD (e.g., habit, being around people who are using, and biological factors).

EMPIRICAL RESULTS

This treatment has been empirically evaluated in four studies thus far: outpatient women, inner-city women, men, and women in prison (Hien, 1997; Najavits et al., 1998c, 2001; Zlotnick, 1999). It is currently being evaluated in several other studies as well: adolescent girls (Najavits, 1998), women veterans (Rosenheck, 1999), women in substance abuse treatment (Brown, Finkelstein, & Hutchins, 2000), outpatient women (Najavits, 1996), and women in residential treatment (Detrick, 2001). In some studies the treatment is conducted in a group format, while others use an individual format.

Results for the pilot study are described in detail in a journal article (Najavits et al., 1998c). Briefly summarized, a total of 27 women were enrolled in that project, of whom 17 (63%) completed the "minimum dose" of 6 sessions of the group psychotherapy. All patients

met current DSM-IV criteria for both PTSD and substance dependence on the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First, Spitzer, Gibbon, & Williams, 1994), and all had active substance use in the month prior to intake. (Note that substance dependence is the most severe form of substance use disorder.) In addition, 65% of patients met criteria for one or more personality disorders. Most patients in the study had a history of repetitive physical and/or sexual abuse in early childhood, which, as later became clear from emerging research reports, characterizes the majority of women with this dual diagnosis (Najavits et al., 1997). All women reported five or more lifetime traumas, with first trauma at an average age of 7 years. Ninety-four percent reported sexual abuse, 88% physical abuse, and 71% other criminal victimization. Rates of DSM-III-R substance dependence disorders were 41% drug dependence, 41% alcohol dependence, and 18% both. Breakdown by type of drug was 59% alcohol, 29% cannabis, 24% cocaine, 6% anxiolytics, 6% sedatives, and 6% nonprescription sleeping pills. The sample was 88% white and 12% black. Most were unemployed (59%), and most had children (59%).

A large data set was collected before, during, and after the treatment to study several key questions: How much did patients' PTSD and substance abuse symptoms change over time (as well as numerous other areas of functioning)? How satisfied were they with the treatment? What did they like and dislike about it? Why did some patients remain and others drop out?

Results were obtained on the 17 patients who met the minimum dose of 6 sessions, as the intent of the pilot study was to assess the impact of the treatment on them. Patients attended an average of 67% of available sessions. Based on assessments at pretreatment, during treatment, at end of treatment, and at 3-month follow-up, results showed significant improvements in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment. Patients' alliance and satisfaction with treatment were very high. Interestingly, the 17 patients who met the minimum dose of treatment were *more* impaired than dropouts on a wide variety of measures, yet were also more engaged in the treatment. All results are clearly tentative, however, due to the lack of a control group, multiple statistical comparisons, and the absence of assessment of dropouts.

In a pilot study on five outpatient men, a combination of *Seeking Safety* and exposure therapy for PTSD were combined in individual format (Najavits et al., 2001). Patients were offered a total of 30 sessions over 5 months, with the patient and therapist together deciding on the number of sessions of each treatment based on patients' needs and preferences. The average number was 21 *Seeking Safety* sessions and 9 exposure therapy sessions. All of the men had been traumatized as children (with an average age of first trauma at 8.8 years); all had had chronic PTSD and substance dependence for many years. Results showed significant improvements by the end of treatment in a wide variety of areas, including drug use, trauma symptoms, dissociation, anxiety, hostility, suicidal thoughts and plans, family/social functioning, global functioning, and sense of meaning. Treatment attendance, alliance, and satisfaction were all extremely high. The study is limited by the absence of a control condition, small sample, and lack of control over external treatments.

Two other studies provide initial results. In the study of women in prison (Zlotnick, 1999; C. Zlotnick, personal communication, November 8, 2001), the attendance rate for the treat-

ment was 83% of available sessions and every measure of client satisfaction was consistently high. Of the 17 women studied, 9 (52%) no longer met criteria for PTSD at the end of the 3-month treatment, as measured by the Clinician-Administered PTSD Scale (Weathers et al., 1993); at a follow-up 3 months later, 48% still no lnger met criteria for PTSD (7 of 15 women with follow-up data). Substance use could not be assessed while the women were in the controlled environment of prison, but a follow-up 3 months after release from prison indicated that 53% were not using. A study is currently under way (C. Zlotnick, personal communication, November 8, 2001) to evaluate whether providing additional *Seeking Safety* sessions after release from prison might be beneficial.

The study of inner-city women was a stage-II randomized clinical trial comparing *Seeking Safety*, relapse prevention treatment (RPT), and a nonrandomized "treatment-as-usual" (TAU) control group. In the TAU condition, patients receive whatever treatments they choose to obtain for themselves in the community. The treatment population all had active cocaine dependence and PTSD. In a preliminary analysis of the data on 83 women who completed at least 6 sessions of treatment, both *Seeking Safety* and RPT showed significantly more reduction in substance use severity and PTSD severity than did the TAU control at the end of the 3-month treatment. *Seeking Safety*, but not RPT, also showed significantly greater reduction in psychiatric severity than the TAU control at the end of treatment (Hien & Litt, 2000). Further analyses on both of these studies, including follow-up data after treatment ended, remain to be completed.

For further information about *Seeking Safety*, go to the website www.seekingsafety.org. It provides updates on new research, journal articles that can be downloaded, information on training therapists, and resources for conducting research on the treatment.

HOW *SEEKING SAFETY* DIFFERS FROM EXISTING TREATMENTS

Psychotherapy is currently in a period of proliferation in which many new treatments are emerging. Thus it is important to distinguish a new treatment from existing ones. Although this treatment draws on the traditions of many existing treatments (discussed above), it was developed to meet needs that did not appear to be addressed thus far. Broadly speaking, *Seeking Safety* differs from existing treatments in its combination of theory (i.e., safety as the target goal), its emphasis on humanistic themes (e.g., safety, compassion, honesty), 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 provision of detailed therapist and patient materials for each topic, and its attention to process issues. Several manualized and empirically studied treatments that would appear to be most closely related are described below, along with how this treatment differs from those. Moreover, all of the treatments below are highly relevant for patients with PTSD and substance abuse, and therapists are encouraged to read the treatment manuals for them. See the entries marked with an asterisk in the References list.

Cognitive-behavioral therapy (CBT). CBT is one of the most widely used, manualized, empirically studied treatments. It has been adapted in recent years for PTSD (see Ruzek et

al., 1998) and for substance abuse (Beck et al., 1993; Carroll et al., 1991). However, none of these 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 (see, e.g., Monti, Abrams, Kadden, & Cooney, 1989).

Dialectical behavior therapy (DBT). This treatment uses a coping skills approach and has recently been adapted for substance abuse (Linehan et al., 1999). However, it is designed for patients with borderline personality disorder and does not describe or address PTSD. Although some patients have both borderline personality disorder and PTSD, these are separate disorders (Herman, 1992; Linehan et al., 1999). Indeed, in the pilot study on *Seeking Safety*, only 29% of patients met criteria for borderline personality disorder; paranoid personality disorder was more prevalent at 47% (Najavits et al., 1998e). 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., short-term group treatment with one leader) that can be expanded to more intensive, lengthy, and individual formats if patients have access to more care. The format of DBT, the skills it teaches, and its language and level of abstraction are also different.

Exposure therapy for PTSD. This is a widely used, empirically based behavioral treatment for PTSD. Its main technique is exposure to trauma memories and triggers, which by design is not part of *Seeking Safety* (as discussed above under "What Is Not Part of This Treatment"), although it can be combined with it. Also, it is briefer (9–12 sessions) and does not address substance abuse, case management, or in-depth work on coping skills (although it sometimes utilizes some CBT interventions) (Foa & Rothbaum, 1998).

Motivational enhancement therapy. This treatment for substance abuse (Miller & Rollnick, 1991) seeks to engage and retain patients in treatment by focusing on positive interpersonal therapy processes (e.g., "roll with resistance," "express empathy," "avoid argumentation"). It is manualized and has shown positive results in empirical studies (Project MATCH Research Group, 1997; Miller & Rollnick, 1991). However, it does not rehearse coping skills, does not address dual diagnosis or PTSD in particular, and is not cognitive-behavioral.

Twelve-step treatment. While twelve-step treatments such as AA are highly compatible with this and many other psychotherapy treatments, they focus on substance abuse only (not PTSD); advocate an abstinence model only; are not designed to be led by professional treaters; and do not provide explicit rehearsal of coping skills. Some psychotherapy adaptations of twelve-step models (Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994) provide the latter two characteristics, however.

Treatments for PTSD and substance abuse. Several treatments have been developed for this dual diagnosis. In addition to *Seeking Safety*, three others have undergone pilot empirical testing: Dansky and colleagues' concurrent treatment of PTSD and cocaine dependence (Dansky, Back, Carroll, Foa, & Brady, 2000), Triffleman and colleagues' substance dependence PTSD therapy (Triffleman, Carroll, & Kellogg, 1999), and Donovan and colleagues' "Transcend" program (Donovan, Padin-Rivera, & Kowaliw, in press). The treatment by Dansky and colleagues (2000) is a 16-session model that adapts a combination of Foa's exposure therapy for PTSD (Foa & Rothbaum, 1998), relapse prevention techniques

(Carroll, 1998; Project MATCH Research Group, 1997), and psychoeducation about PTSD and cocaine dependence. It differs from *Seeking Safety* in its inclusion of exposure techniques, its shorter length, the range of substances being addressed (i.e., cocaine only), its format, and particular skills. Triffleman and colleagues' (1999) treatment differs from *Seeking Safety* in its inclusion of *in vivo* exposure for PTSD, its format, and particular skills. Donovan and colleagues' (2001) treatment is a 12-week program developed for veterans comprised of 10 hours a week of group treatment and mandatory attendance in a substance abuse rehabilitation program, as well as supplementary activities (e.g., volunteer community service) and a 6-week focus on skills development and on trauma processing, based on a combination of concepts derived from constructivist, existential, dynamic cognitive-behavioral and twelve-step theories. It differs from *Seeking Safety* in its design as an intensive partial-hospital program, its particular skills, and its focus on trauma processing. Finally, five other models have not yet been empirically tested or offer detailed treatment materials (e.g., session-by-session plans and patient handouts). These are books by Trotter (1992) and Evans and Sullivan (1995), both in the twelve-step tradition; an article by Abueg and Fairbank (1991) describing a behavioral model developed in a VA setting; Bollerud's (1990) article on an eclectic model for inpatient care; Meisler's (1999) book chapter on group treatment for PTSD and alcohol abuse; and a book by Miller and Guidry (2001).

ONE PATIENT'S EXPERIENCE OF PTSD AND SUBSTANCE ABUSE

It seems fitting to end this introductory chapter with a patient's own account of PTSD and substance abuse. For treaters new to this population, it may be helpful to see the disorder through a patient's eyes; and, for all clinicians, it is a reminder of the complexity of these cases. The excerpt below was written by a woman treated as part of the pilot study on this treatment. She gave permission for this to be reprinted, and all identifying information has been deleted.

> *"As far back as I can remember—I wasn't even walking or talking yet—and my oldest brother was physically hurting me. I was 3½ years old when I can remember the first sexual abuse by my brother. That was the first time I recalled feeling the paralyzing anxiety that I've suffered ever since. I was constantly abused by my brother physically, sexually, and emotionally from those early years to about 6 or 7 years old. During those years my mother was emotionally distant from me. I always felt she hated me. From both my mother and brother, I was often ridiculed and embarrassed. My father sexually abused me too. He suffered from a brain tumor when I was between the ages of 4 and 9. He was always in and out of hospitals during that time. Sometimes he would come home in a manic state or in a depression or very disoriented and confused. I recall him being very physically abusive towards my older brother. He confused and frightened me very much. During those years a neighbor forced me to have oral sex with him. And also my brother's friend would often beat me up. I constantly lived in fear. I felt that I was such a bad person and everything was my fault. I couldn't stand people even looking at me. My father died when I*

turned 9 years old. After he died I did not remember any of this. I blanked out my whole childhood and it wasn't until the last few years that the memories started to come back.

"I remember growing up always feeling people hated me and wanted to hurt me. I was always so nervous around other people. By the time I was 11 years old I started drinking. It made me less nervous and more sociable. By 12 years I was doing drugs. Downs, speed, acid, pot, and also drinking. Back then I tried them for curiosity reasons, plus I felt better—that's why I did the different drugs. My first boyfriend was 16 years old was when I was 12 years old. He was good friends with my older brother and had lived with us at times. The first time I experienced intercourse was right after I turned 13 years old and my boyfriend raped me. He tried to smother and choke me. It was an awful experience and there was no one I could tell. I also have two other brothers, one older and one younger, but they were not abusers. They didn't do anything to try to stop it, but I don't know how much they knew what was going on.

"By 14 I met another boyfriend who was 22 years old. He turned me on to heroin. We both got addicted. I went away to get off the heroin and he was in a bad fire. I was told that I was evil and could not see him again. After that my anxiety was really out of control. Between 15 and 17 I did a lot of downs and speed. I hated myself and just wanted to die. I was also raped at gunpoint by three men at 16 years old. By 17 I felt I went through every drug out there and yet knew that nothing was going to help me.

"At 17 my anxiety was so bad that I couldn't leave the house, and felt I couldn't go on. At this point I didn't think there were any options but to kill myself. I finally got up the courage to take 98 barbiturates. I survived the suicide attempt, but after that I went back to drinking and smoking pot. I mainly wanted the pot to help me sleep at night and the booze to control my anxiety. When I was about 23 I moved to the South, thinking that if only I get out of town everything would be all right. I proved that wrong. I got into an abusive relationship down there. Finally, I got such a bad beating it broke my jaw. I came back here, and kept drinking and smoking pot through my late 20s.

"Then I was introduced to AA. I went into a halfway house. After 3½ months, I left. I felt I could manage my life again. However it wasn't long before I went into another halfway house, only staying 6 weeks this time. I met someone else in my early 30s. We both did cocaine together. Another very abusive relationship—we stayed together till one night he almost killed me and I ended up in the hospital. I still went back to him, and although he didn't physically hurt me again, he emotionally abused me. I felt terrorized a lot of the time I was with him. When I was 35 we broke up for good. I am in therapy now. I began to realize the abusive pattern I was in. And now through therapy I am beginning to understand why my life was the way it was. I am now 38 and am taking Antabuse for a backup, so I won't drink during this very difficult time of dealing with my memories and anxiety. However, I am still smoking pot and hope that I can learn to feel in control of my dreams and my anxiety. I am proud that I have survived longer than my brother who abused me—he got addicted to heroin and cocaine since he was about 18 till the day he killed himself at 36."

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