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## Group Cognitive-Behavioral Therapy for Women With PTSD and Substance Use Disorder

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**Abstract**—*This paper describes a model of group cognitive-behavioral therapy (CBT) for women with posttraumatic stress disorder (PTSD) and substance use disorder (SUD). The need for specialized treatment derives from the high incidence of these comorbid disorders among women as well as from their particular clinical presentation and treatment needs. The treatment educates patients about the two disorders, promotes self-control skills to manage overwhelming affects, teaches functional behaviors that may have deteriorated as a result of the disorders, and provides relapse prevention training. The program draws on educational principles to make it accessible for this population: visual aids, education for the patient role, teaching for generalization, emphasis on structured treatment, testing of acquired knowledge of CBT, affectively engaging themes and materials, and memory enhancement devices.*

**Keywords**—cognitive-behavioral; substance abuse; PTSD; posttraumatic stress disorder; psychotherapy.

SUBSTANCE USE DISORDERS (SUD) and posttraumatic stress disorder (PTSD) co-occur at a relatively high rate, often portending a more severe course than would occur with either disorder alone (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Brown, Recupero, & Stout, 1995; Miller, Downs, & Testa, 1993; Najavits et al., 1995). Estimates of substance abuse or dependence in PTSD patients range from 16% to 80% (Breslau & Davis, 1987), depending on the clinical population surveyed. In a general population study of young urban adults, the rate of substance use disorders was 43% among those diagnosed with PTSD, compared to

25% for those without PTSD (Breslau, David, Andreski, & Peterson, 1991). A study of 363 opioid addicts found that 31% had histories of childhood trauma; this subgroup showed more impaired psychological, medical, employment, family and social functioning than opioid addicts without histories of childhood trauma (Rounsaville, Weissman, Wilber, & Kleber, 1982). While these data are suggestive of a strong comorbidity between the two disorders, the methodological limitations of the various studies must also be considered. For example, the study by Breslau and Davis (1987) used *DSM-III* diagnoses and studied only a male Vietnam veteran inpatient sample. The study by Breslau et al. (1991) used the Diagnostic Interview Schedule with a sample of middle class members of a health maintenance organization. The sample of the Rounsaville et al. (1982) study was mostly male.

The relationship between the two disorders is complex. For example, the presence of either disorder alone can increase the risk of developing the other dis-

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order. A recent report (Cottler, Compton, Mager, Spitznagel, & Janca, 1992) from the St. Louis Epidemiological Catchment Area Study showed that substance users had a higher likelihood of traumatic events compared to non-users, and that the substance use typically preceded the PTSD. In addition, certain drugs (cocaine and opioids) showed a higher association with trauma and the diagnosis of PTSD than did other drugs such as marijuana. Even a family history of substance use problems is a significant risk factor for exposure to traumatic events (Breslau et al., 1991). Conversely, the presence of trauma has also been associated with the development of SUD (O'Donohue & Elliott, 1992; Rounsaville et al., 1982); this has been termed the "traumatogenicity" theory of substance use disorders (Berk, Black, Locastro, & Wickis, 1989). The relationship between the two disorders also appears to be more enduring than, for example, other Axis I disorders (such as mood or anxiety syndromes) in which attaining abstinence from substances is strongly associated with a reduction in psychiatric symptoms (Brown & Schuckit, 1988). In addition, PTSD and SUD have consistently been found to be comorbid regardless of the nature of the trauma (Keane & Wolfe, 1990).

Thus far, the vast majority of work on this dually diagnosed population has focused on male combat veterans whose SUD developed or worsened after exposure to the traumas of war. Research on females with the two disorders has been minimal, despite the fact that both Breslau et al. (1991) and Kessler et al. (1994) found that women were twice as likely as men to have PTSD. Moreover, it has become increasingly clear that male combat patients and female trauma victims (typically exposed to physical or sexual assault) may represent different subtypes of PTSD (Herman, 1992; O'Donohue & Elliott, 1992). Women trauma survivors are described as having different fears from combat veterans and more self-blame, suicide attempts, sexual dysfunction, and revictimization (O'Donohue & Elliott, 1992). In a major epidemiological study, Cottler et al. (1992) found that for people with SUD, combat events were the least likely traumatic events, whereas physical assaults were the most likely. After all other variables were controlled, female gender and use of cocaine or opioids predicted a diagnosis of PTSD (among subjects exposed to traumatic events) while age, race, depression and antisocial personality disorder did not (Cottler et al., 1992). In another recent study (Miller et al., 1993), 70% of a sample of 98 women in treatment for alcoholism reported childhood sexual abuse; these patients had significantly higher rates of such abuse than women in the same treatment setting without alcohol problems and women in a household sample. In general, women are at relatively high risk for trauma, with lifetime estimates of sexual assault at 25% to 50% in community samples, and a childhood

history of sexual abuse in approximately 50% of female inpatients (Foy, 1992). Females are at higher risk for child sexual abuse, rape, and spouse battering than are males (Foy, 1992; O'Donohue & Elliott, 1992).

In recent years, there has been an increasing literature on the treatment of patients with SUD and co-existing psychiatric illness. Most authors have suggested the importance of addressing both disorders and their interaction (Meyer, 1986; Mirin & Weiss, 1991). However, there has been relatively little empirical research that has specifically addressed the treatment of women with co-existing SUD/PTSD.

The use of cognitive-behavioral therapy (CBT) for comorbid SUD/PTSD is suggested for several reasons. First, in both SUD and PTSD, and certainly in their combination, patients are often reported to be overwhelmed by negative affects such as extreme guilt, anxiety, shame, self-blame, depression, suicidal feelings, and dissociation (Beck, Wright, Newman, & Liese, 1993; Chu, 1991; Herman, 1992). CBT is often used to teach the patient to self-manage affects, either as an end in itself or so that exploration using more psychodynamic, exploratory therapies can proceed without the patient's regression. CBT self-control strategies such as impulse control programs, reattribution, grounding, problem solving, cognitive restructuring, anger management, and cue exposure are commonly used with both disorders (Beck et al., 1993; Foa, Steketee, & Rothbaum, 1989; Mackay, Donovan, & Marlatt, 1991; Marlatt & Gordon, 1985). Second, CBT teaches functional behaviors that may never have developed or may have deteriorated due to drug use and the sequelae of trauma. These include relationship skills (assertiveness, negotiation, asking for help, active listening); problem solving; self-nurturing techniques (such as coping self-talk, positive self-statements); and adaptive lifestyle activities (such as daily activity planning, relaxation training). Third, CBT offers explicit training in relapse prevention. Since patients with substance use disorders commonly have high relapse rates, such training is essential. Relapse prevention techniques are also directly modifiable for other Axis I disorders (Hollon & Najavits, 1988) and are likely to be relevant to PTSD (e.g., the need to prevent relapse to dissociative symptoms and self-harm behaviors). Specific techniques, for example, include the development of a hierarchy of situations that trigger relapse and in vivo behavioral exercises to rehearse coping strategies. Thus far, there has been extremely limited empirical testing of CBT for PTSD populations (Solomon, Gerrity, & Muff, 1992).

The use of a group format could be quite useful for SUD/PTSD patients, given the importance of social support for these disorders (Herman, 1992). Treatment of both SUD and PTSD requires significant attention to validation of experience, shame reduction, and nor-

malization because of strong feelings of self-blame that often accompany the disorders (Beck et al., 1993; Herman, 1992). Also, group treatment can reach larger segments of the population due to its lower cost, and is a standard modality of inpatient and outpatient psychosocial treatments. Group treatment is also a well-established modality for cognitive-behavioral intervention and has been empirically shown to be effective when compared with individual CBT treatment (Najavits & Garber, 1989).

The development of a CBT treatment manual specifically for female patients with SUD/PTSD has not yet occurred. However, there is some evidence for the efficacy of CBT for SUD (Hollon & Najavits, 1988; Woody, McLellan, Luborsky, & O'Brien, 1990). Indeed, "relapse prevention," which derives from CBT, has a relatively long-standing tradition within SUD treatment programs (Beck et al., 1993; Mackay et al., 1991). The use of CBT with PTSD patients has been documented for inpatient females (Orzack, Shnidman, & Maynard, 1992) and for the successful treatment of women with histories of rape or childhood trauma (Foa et al., 1989; Richards & Rose, 1991; Steketee & Foa, 1987). CBT has also been found helpful with male combat populations diagnosed with conjoint SUD/PTSD (Perconte & Griger, 1991). Currently, several treatment manuals exist for CBT, including recent manuals for the individual treatment of cocaine use disorder (Beck et al., 1993) and for PTSD (Foy, 1992). However, no CBT manuals address group therapy for women with PTSD and SUD.

In planning a group cognitive-behavioral treatment for this population, a strong effort is needed to make CBT accessible and engaging. SUD/PTSD patients typically represent a more impaired, treatment-resistant group than SUD-only or PTSD-only patients (Brady et al., 1994). Their clinical presentation, especially early in treatment and while actively using substances, is marked by poor concentration, dissociation, and impulsiveness, which may limit the impact of any traditional verbal therapy. To make CBT most effective for them, several strategies from the educational and cognitive literatures are helpful, all of which have been empirically validated by prior research. These include *visual aids* (e.g., the use of illustrations, concept-mapping, and charts); *role preparation* (specific instruction on the patient role, such as ensuring confidentiality and behaving appropriately in group); *teaching for generalization* (i.e., promoting the use of CBT techniques outside of therapy sessions through extensive rehearsal, feedback on patients' use of techniques, explicit training in how and when to use strategies, varying the format and level of difficulty of the materials, and frequent review); *emphasis on structured treatment* (providing a syllabus outlining the course of treatment sessions, targeting a focal idea for each ses-

sion to which other concepts are subordinated, providing explicit learning objectives at the start of each session); *testing of acquired knowledge of CBT* (a brief written test at each session, the use of quotations and inspiring descriptions of others with SUD/PTSD who have recovered); and *memory enhancement devices* (the use of simple language rather than jargon, mnemonic devices, written summaries of main points at each session, and an audiotape for each session to review main ideas) (Najavits & Garber, 1989). Patients are encouraged whenever possible to teach the skills learned in group to others (e.g., a spouse who may help implement use of the strategy) and, at times, to lead the group briefly in a skill they have mastered.

The treatment, which is described below, derives from a therapy development research project sponsored by the National Institute on Drug Abuse and is currently in use as both a clinical intervention and a pilot research program at the Alcohol and Drug Abuse Program of McLean Hospital.

### DESIGN OF THE TREATMENT PROGRAM

The content of the treatment program draws upon the traditions of four literatures: cognitive-behavioral therapy of substance use disorders (Beck et al., 1993; Carroll, Rounsaville, & Keller, 1991; Marlatt & Gordon, 1986), posttraumatic stress disorder treatment (Davis & Bass, 1988; Chu, 1988; Herman, 1992; van der Kolk, 1987), women's treatment (Jordan, Stiver, & Surrey, 1991; Lerner, 1988), and educational research (Najavits & Garber, 1989). The program is designed to help patients attain abstinence from substances and decrease overt symptomatology of PTSD. It seeks to educate patients about each disorder and their interaction, and to increase patients' daily life structure, coping skills, management of affects, and self-care. It is not intended to promote exploration of trauma histories or to rely on insight or group processes beyond basic support and validation. As such, the program fits what has typically been recommended as "early treatment" or "first stage" therapy for PTSD and for SUD. For example, Herman's (1992) model of a "stage one" recovery group for trauma survivors is defined by a focus on safety and self-care as the primary therapeutic tasks, a present-time orientation, homogeneous membership (all have the same primary diagnoses), low tolerance for conflict within the group, an open-ended format, didactic intent, and moderate level of cohesion among members. In Kaufman's (Kaufman, 1989; Kaufman & Reoux, 1988) depiction of stages of treatment for substance use disorders, the first stage focuses on "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 co-existing psychiatric illness; cognitive-behavioral methods are emphasized over exploration, interpretation, or insight. It is presumed that CBT will help the patient gain control over acute symptoms of PTSD and SUD, thus allowing her to make better use of other treatments that may be undermined by such symptoms as continued substance use, self-harm behaviors, and the severe dissociation that sometimes accompanies PTSD. The CBT model is designed to complement therapeutic interventions of other theoretical orientations that the patient either currently attends, or plans to attend (e.g., psychodynamic psychotherapy, 12-step self-help groups, family therapy).

The treatment is considered appropriate for women who are diagnosed with current SUD and PTSD, ages 18 to 65. For patient selection, PTSD is defined by either the *DSM-IV* or the "Disorders of extreme stress not otherwise specified" (DESNOS) categories; the latter targets syndromes that developed from childhood trauma (Herman, 1992). The treatment is believed most appropriate for patients with a history of childhood trauma, or severe, violent, or repetitive abuse, as this is the sample on whom the treatment was developed and those who represent the majority of women with concurrent PTSD and SUD seen in clinical settings (Brown, Recupero, & Stout, 1995; Fullilove et al., 1993; Najavits et al., 1995). With regard to SUD, all patients must meet *DSM-IV* criteria for a substance use disorder. In addition, the patient must have actively used substances in the month prior to treatment to ensure a sample that is at the same stage of treatment. Exclusion criteria are psychosis, organic mental disorder, and mental retardation. Patients are encouraged to attend concurrent treatments during their participation, including self-help groups such as Alcoholics Anonymous and Rational Recovery, psychotherapy, pharmacotherapy, family therapy, case management, and job counseling; they may have previously attended such treatments in the past as well.

Therapists are assumed to have at least one year of experience in the treatment of trauma survivors, a basic understanding of CBT (e.g., prior reading in CBT and several cases conducted in this modality), and a professional degree in an area that included training in psychopathology (e.g., LICSW, PhD, MD, MA in counseling). A strong emphasis is placed on supervising the therapist to maintain compassion for patients, to set limits as needed, to review patients' twice-weekly urine testing results, and to keep patients engaged in the treatment (Najavits & Weiss, 1994a; 1994b).

The treatment totals 24 sessions, meeting twice per week for 3 months; all sessions are 1½ hours. The group size ranges from a minimum of 3 to a maximum of 10 patients. It is recommended that the group be run in a modified-closed format, such that once the

group has begun, new patients are only allowed to join up through session 12, since early sessions provide a foundation that is drawn upon in later sessions. However, since each session has its own independent content, an open format could be used. Once a patient has joined the group, she would only be excluded if her participation is found to be destructive to other members of the group (e.g., selling drugs to group members), or if she misses three sessions in a row without calling the therapist.

### Structure of Sessions

Each session is structured as follows: 1) "Check in" (5 minutes per patient): each patient states how many times since the last session she has used substances, what positive coping methods she has attempted, and how she is doing overall; 2) "Group tally": A tally of the group's average level of attendance, abstinence, and homework completion is calculated and posted on the board by the group leader to promote group cohesion and accountability; 3) "Quotation of the day": A brief, inspiring quotation is read aloud and posted on the board; 4) "Agenda": The leader identifies the learning goals for the session; 5) "Experiential learning": The session topic is taught, discussed, and rehearsed; 6) "Homework review": Review of the previous session's homework (last 15 minutes of the session); 7) "Closure": Final points are made, and new homework is assigned.

At each session, patients are offered reading materials to borrow (self-help books relevant to PTSD and SUD on topics such as anger management, communication skills, cognitive restructuring, substance abuse, trauma, and parenting skills). Resource lists of local treatments and self-help groups are also made available. The therapist remains after each session for brief contact with any patient who requests it, and is available by telephone at other times as needed. Patients are encouraged to call each other outside of sessions for support and review of session material, to the extent they choose.

### Content of Sessions

The content of each week's session is structured to provide both a theme relevant to both SUD and PTSD and a specific CBT skill to learn. At each session, a written handout summarizes the main session points. The treatment is comprised of 5 units: an individual pre-group interview with each patient, an individual HIV risk counseling session, introduction (2 sessions), behavioral skills (7 sessions), cognitive skills (6 sessions), relationship skills (6 sessions), and review/termination (3 sessions).



*Session 5. Self-Care Versus Self-Neglect: Developing an "Action Plan".* A 20-item checklist is provided at the beginning of the session, with each item identifying an area of self-neglect (e.g., "Do you get regular medical, dental, and gynecological check-ups?" "Do you try to avoid dangerous neighborhoods?"). Discussion focuses on why women with PTSD and SUD tend to have low levels of self-care, and to identify a specific "action plan" each group member is willing to do by the next session (make a dental appointment, eat three meals a day, etc.).

*Session 6. "When the Telephone Weighs a Thousand Pounds": Learning to Ask for Help.* Patients are taught that PTSD and SUD may predispose them to stay isolated when in trouble rather than asking for help. The concept of adaptation to unhealthy environments is discussed, such as learning to keep quiet around an abuser or trying to put up a false front around a family that was uncaring. In the group, the message is conveyed that reaching out for help is necessary for recovery. Patients role-play how they would ask for help when particular problems arise such as drug cravings, flashbacks, or inability to sleep. Patients are asked to write down a list of telephone numbers they can call on an index card.

*Session 7. Fighting Triggers of SUD and PTSD.* Patients are guided to identify "triggers" in each disorder (e.g., seeing a drug dealer may set off cravings; hearing a child cry may set off a flashback). They are also taught how to fight triggers (e.g., distraction, avoiding triggering situations, calling someone for help, and thinking out the consequences of one's actions); and to notice how one's strength increases each time a trigger is successfully resisted. Patients discuss how to recognize triggers, what triggers they find most difficult, and how they will manage them.

*Session 8. Managing Ambivalence: Putting Actions First.* Ambivalence is conceptualized as a central problem for both SUD and PTSD, particularly with regard to giving up substances and certain PTSD sequelae such as self-cutting. Patients are guided to express their ambivalence by an "advantages/disadvantages" sheet (Marlatt & Gordon, 1985). Discussion focuses on the importance of acting in constructive ways despite one's ambivalence; and on the idea that recovery from PTSD is based on recovery from SUD.

*Session 9. Review of Behavioral Unit: The "Life Stresses Box".* As a review of the behavioral unit, a box is presented in which a variety of difficult situations are written on slips of paper (such as "You see your dealer walking toward you on the street," "You are having a flashback, and you want a drink to relax"). Each patient is asked to randomly choose a situation, to read

it aloud, and to describe to the group how she would constructively handle it. The group provides feedback and suggests additional alternatives. The leader writes the strategies on poster-board to hang on the wall for later sessions as a visual reminder.

### **Rethinking Unit (6 sessions)**

This unit provides education and practice in cognitive restructuring, with particular attention to maladaptive thoughts associated with PTSD and SUD (i.e., "victim thinking" and "user thinking") and the integration of previously learned behavioral techniques with the new cognitive techniques.

*Session 10. Twisted Thinking: Distortions that Increase PTSD and SUD Symptoms.* In this session, the "rethinking model" is introduced by way of a table of thought distortions associated with PTSD and SUD. The term "rethinking" is used in place of "cognitive restructuring" as a way to reduce jargon and improve accessibility of the material. The list of distortions includes some from Burns (1980) (e.g., all-or-none thinking, focusing on the negatives) and others that may be particular to PTSD and SUD (Najavits, 1994) (e.g., confusing needs and wants, the illusion of escape, "beating yourself up," the pink cloud). Patients are asked to rate the degree to which each thought distortion is a problem for her and to give examples. The basic CBT idea that thoughts can affect feelings and behavior (Beck et al., 1979) is also discussed. Patients are given a simplified version of the Daily Record of Dysfunctional Thoughts (Beck et al., 1993), which helps them to identify an upsetting event, their associated thoughts, and relevant distortions.

*Session 11. Methods of Rethinking.* A list of rethinking methods is provided, based on the work of Beck et al. (1993) and Burns (1990). Each patient reads one of the methods and gives examples to the group. The concept of empirical hypothesis testing is emphasized: that rethinking does not mean "positive thinking" but rather testing out one's beliefs by evaluating evidence (Beck et al., 1993).

*Session 12. Getting Out of "User Thinking" and "Victim Thinking": Practicing Rethinking for PTSD and SUD.* Patients are taught to integrate various concepts from the past two sessions using the full Dysfunctional Thought Record, or DTR. Thoughts related to PTSD (which we call "victim thinking") and thoughts related to SUD (which we call "user thinking") are emphasized. A group exercise is conducted to demonstrate how to complete the full DTR, using patients' examples.

*Session 13. More Practice in Rethinking.* This session provides additional practice in rethinking, using pa-

tients' PTSD- and SUD-related thoughts. They are asked to focus on thoughts that are particularly difficult for them to rethink and to use the group for help and feedback.

*Session 14. Advanced Rethinking: The Main Thoughts that Lead to PTSD and SUD.* More practice is provided, but this time patients are split into subgroups. The leader gives each subgroup a thought typical of women with PTSD and SUD (e.g., "My life is ruined already; why bother trying?") and asks them to fill out a DTR as a group. After finishing, their responses are compared.

*Session 15. Review of Rethinking Unit: Distortions and Methods to Get Out of Them.* To review the material, patients are asked to respond to a series of questions to test their knowledge of and ability to apply the rethinking tools. For example, the leader asks, "What is an example of 'all-or-none thinking?'" and "If you were thinking 'I'll never find a job,' what would be one method to rethink that thought?"

### **Relationships Unit (6 sessions)**

A separate unit on relationships and communication skills is provided, due to the importance women place on relationships (Jordan et al., 1991) and the significant issues of betrayal and mistrust that arise for many women with PTSD (Herman, 1992). In addition, it is emphasized that recovery from both PTSD and SUD requires letting go of destructive relationships and building a supportive network.

*Session 16. Self-Protection in Relationships.* Qualities of constructive and destructive relationships are described and patients are asked to evaluate their circle of relationships for these patterns. Specific strategies are suggested to reduce drug-related friendships and abusive relationships. Discussion focuses on concepts of boundaries, "co-dependency," being "addicted to pain," and how women with trauma histories tend to be revictimized unless they learn to identify and seek safe relationships.

*Session 17. When a "No" to Others Is a "Yes" for the Self: Practicing Refusal Skills.* Patients rehearse how to say "no" to dangerous social situations (e.g., being offered drugs or alcohol, being pressured into unwanted sexual contact). Patients then discuss when they can openly acknowledge their history (e.g., SUD and PTSD) and when it is not in their best interest to do so. Finally, the group explores how a history of PTSD and SUD may predispose them to overcompliance.

*Session 18. Communication Problems of Women with PTSD and SUD.* Patients are directed to identify neg-

ative communication patterns they may be using, such as dishonesty about substance use, sarcasm, hiding one's reactions, and not listening to others (Burns, 1990; McKay, Davis, & Fanning, 1983). These patterns are discussed in the context of early adaptation that has outlived its usefulness. Several key strategies for more effective communication are described (e.g., directness, reflective listening) and posted on the board.

*Session 19. Rebuilding Trust: Practicing Effective Communication.* This session provides more opportunity to replace destructive with constructive communication. Patients are asked for examples of relationship problems and guided in rehearsal of more effective communication, using the techniques taught in the previous three sessions.

*Session 20. Healthy Relationship Thinking.* Patients are led to contrast thoughts associated with healthy relationships (e.g., "Finding a solution to a conflict is better than blame," "Honesty is essential to a good relationship") versus thoughts associated with immature relationships (e.g., "The other person should change for me," "If things go wrong with someone, it's all my fault."). Patients are asked to complete the Dysfunctional Thought Record after identifying negative relationship thoughts.

*Session 21. Review of Relationship Unit: Role Plays.* Patients are given examples of difficult relationship problems and asked how they would respond to them. For example, "Your ex-husband criticizes how you are raising your children," "Your daughter refuses to follow your agreed-upon curfew," "A friend has told a secret that you had confided in her."

### **Review and Termination (3 sessions)**

The final sessions focus on processing the ending of the group, ways to replace the support the group has provided, and cues by which to assess one's progress in recovery from both PTSD and SUD.

*Session 22. Red and Green Flags: How to Know Whether You're Doing OK.* In this session, specific cues are identified to help patients become more aware of when they are progressing or deteriorating in their recovery. For example, isolation may be a danger sign, whereas staying in contact with drug-free friends would be a positive sign. Also, a discussion of the course of recovery is offered to emphasize some of the main stages that can be expected.

*Sessions 23 and 24. Review and Termination.* In the last two sessions termination is processed, with particular attention to other supports that will be needed to make up for the loss of the group treatment. Each

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patient's continuing care plan is reviewed with the group. Also, patients are asked to review the main concepts and skills learned in previous sessions through questions related to each session (e.g., "What are some of the main symptoms of PTSD and SUD?", "What is grounding and when is it used?").

### Examples of Homework Assignments

Homework is designed to maximally engage patients on an affective level, to stimulate their curiosity and self-understanding, and to generalize skills to patients' day-to-day life. Examples include the following:

*Session 3. Teach the Person You Are Closest to How to Do Grounding.* Practice grounding together, and make a plan for this person to continue to help you with it as needed.

*Session 19. Write Out the Dialogue from a Conversation that Went Badly.* Then, rewrite the dialogue showing how you could have responded better.

*Session 17. Write Out How You Would Handle the Following Situation.* Your boyfriend/husband still uses drugs. You've told him that you don't want to use. He lights up a joint and says, "You're being too sensitive about this. You can take a hit and it won't kill you." What would you say?

*Session 23.* Read the following quotation: "What can be imagined can be achieved" (T. Peavey). Now, write out a description of your life as a person who is able to manage her PTSD symptoms and is substance-free. What would your day-to-day life be like? How would you relate to others? How would you manage everyday frustrations and disappointments? If you want, give this person a name that you like so that you can be sure to remember her when times get tough.

### Examples of Session Quotations

Much like the popular books of "daily meditations," patients report that quotations can be inspiring and helpful. Examples include:

*Session 9.* "There's no situation so bad that you can't make it worse by the way you handle it." (G. DuWors)

*Session 12.* "Our life is what our thoughts make it." (Aurelius)

*Session 17.* "When one door closes, another opens; but we often look so long and so regretfully upon the closed door that we do not see the one which has opened for us." (A.G. Bell)

## SUMMARY

This treatment is the first known psychotherapy for comorbid PTSD and SUD to undergo empirical evaluation. It has been designed to address the unique clinical needs of women with these disorders, with particular attention to the following main features:

- The treatment is cognitive-behavioral, consistent with the literature on both disorders that suggests that patients who are early in their recovery from PTSD and SUD require a strong focus on coping skills to gain control over their symptoms. The treatment is present-focused, homogeneous in membership, closely monitors substance use, promotes abstinence from all substances, and encourages mutual support among members.
  - While the treatment is modeled on existing CBT therapies (Beck et al., 1993; Carroll et al., 1991; Marlatt & Gordon, 1985), it also adds new components believed to be central for this population, including a 6-session unit on relationships to reduce reenactment of damaging relationships; and themes such as "safety and self-protection," "self-neglect," "user thinking and victim thinking," and "reaching out for help."
  - The treatment program is believed to be innovative in its use of educational devices to promote rapid and sustained learning of the material. These devices include a check-in at each session in which patients report constructive coping that they have recently attempted; written summaries of the main points of each session for patients' further review; posting the main concepts and strategies on the board; conducting several review sessions to reinforce material; posting the group's abstinence, attendance, and homework completion rates at each session; and the use of affectively engaging quotations and homework assignments.
  - Each of the patients' two disorders is used as leverage to motivate them to gain control over the other: substance abuse stalls emotional development and prevents full recovery from PTSD, and lack of control over PTSD symptoms may perpetuate reliance on substances. Patients are continually guided to focus on both disorders and their interaction and they are instructed about stages of recovery, with the notion that more insight-oriented therapeutic work can only occur once they have attained abstinence and some control over PTSD symptoms.
- Research is currently underway to evaluate the treatment program in terms of reducing PTSD and SUD symptoms, patient retention, identifying the most helpful treatment components, studying patients' knowledge acquisition and actual use of the strategies taught, and the potential for training other therapists to conduct the treatment. In addition, future research will



be needed to address the generalizability of this treatment model. That is, are there particular subsets of women with PTSD and SUD who may benefit most or least from the program (e.g., based on age of onset of each of the disorders, severity of the disorders, patients' access to other concurrent treatments, or patients' previous treatment histories)? The optimal duration and timing of the treatment, and appropriate aftercare must also be identified.

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