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Seeking Safety: A New Cognitive-Behavioral Therapy for PTSD and Substance Abuse

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Over the past decade, an emerging body of work has documented a very strong association between PTSD and substance abuse. Indeed, most women and many men in substance abuse treatment have a history of trauma, and rates of current PTSD range from 12% to 59% (1-4). Among people with PTSD, rates of substance abuse are also high (5-7). Moreover, the disorders have consistently been found to co-occur across various types of traumas (8) and substances (9).

Historically, the connection between PTSD and substance abuse was first emphasized in VA settings with male combat veterans after the Vietnam War (8). Later, studies of civilian populations documented high rates, particularly among females who endured childhood physical and/or sexual abuse (2).

Aside from numbers, the suffering associated with this dual diagnosis is extraordinary, with multiple co-existing life problems, vulnerability to repeated trauma, and difficulties in treatment. Studies that have compared patients with PTSD and substance abuse to patients with substance abuse alone, for example, have consistently found the former more impaired, including more co-morbid Axis I disorders, particularly mood and anxiety disorders, Axis II disorders, medical problems, psychological symptoms, inpatient admissions, and interpersonal problems; and lower global level of functioning, compliance with after-care, and motivation for treatment (1, 9-12). Life problems are often very severe, including homelessness, HIV, domestic violence, and loss of custody of one's children (2, 3).

In 1993, I began developing a cognitive-behavioral therapy to address this dual diagnosis under a grant from the NIDA Behavioral Therapies Development Program. At that point, there had not been a single published treatment study on this population, nor any psychosocial treatment that had undergone empirical evaluation. Through repeated trial-and-error, the treatment Seeking Safety (13, 14) was developed while simultaneously testing its impact on a pilot sample of

women with PTSD and substance dependence. In developing the treatment, the major influences on my thinking were works by Herman (15), Marlatt and Gordon (16), Beck and colleagues (17), Miller (18), Frankl (19), as well as educational research (20).

The treatment is currently being empirically evaluated in samples from six populations: a Palo Alto VA sample of male combat veterans; homeless women; inner-city cocaine-addicted women; adolescent females; incarcerated women; and outpatient women. A description of the treatment, its initial empirical results, and an in-depth example of one session follow.

The title of the treatment...

"Seeking Safety" expresses its philosophy: when a person has both active substance abuse and PTSD, the most urgent clinical need is to establish safety.

TREATMENT OVERVIEW

Summary of the treatment. Seeking Safety is a 25-session treatment based on five key principles.

(I) Safety as the priority of this "first stage" treatment.

The title of the treatment, "Seeking Safety", expresses its basic philosophy. 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 re-

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enact trauma (particularly for victims of childhood abuse, who represent a large segment of people with this dual diagnosis (2)). The concept of first-stage treatment as stabilization and safety has been consistently recommended separately in both the PTSD (15) and substance abuse clinical literatures (21). Later stages of treatment include mourning (a.k.a. exposure therapy (22)) and reconnection (15). In Seeking Safety, safety is taught through a wide range of Safe Coping Skills, asking patients to become conscious of their decisions via a Safe Coping Sheet, setting a Safety Plan, and a report of unsafe behaviors at each session, for example.

II. Integrated treatment of PTSD and substance abuse.

Seeking Safety is designed to treat PTSD and substance abuse at the same time. An integrated model is consistently recommended by clinicians and researchers as more likely to succeed, more sensitive to patient needs, and more cost-effective (9, 10, 12, 23-25). Indeed, a recent survey of patients with this dual diagnosis found that they also prefer simultaneous treatment of both disorders (26). Currently many treatment systems for substance abuse and mental health remain separate, which often leaves the patient to integrate treatment for themselves. One of my patients reported that she had to lie to get into a PTSD treatment program because it did not admit active substance abusers. Indeed, most settings do not treat the two disorders simultaneously (23, 24).

It is important to note, however, that "integration" in Seeking Safety means attention to both disorders in the present. It does not mean asking the patient to talk in detail about the past, which in the stage conceptualization described above, would be "second stage" treatment. Despite the known efficacy of exposure therapy for PTSD (27), numerous experts have recommended that for substance abusers, such work not begin until they have achieved a period of stable abstinence and functionality (25, 28, 29). The concern is that if patients are overwhelmed by painful feelings about the past, this could trigger substance abuse as a misguided attempt to cope. In Seeking Safety, integrated treatment thus means helping patients learn about the two disorders and why they so frequently co-occur; teaching safe coping skills to decrease current symptoms of both PTSD and substance abuse; repeatedly exploring the relationship between the two disorders in the present (e.g., using crack last week to cope with PTSD flashbacks); and helping patients understand that healing from each disorder requires attention to both disorders.

III. A focus on ideals.

It is difficult to imagine two mental disorders that each individually, and especially in combination, lead to such demoralization and loss of ideals. Thus, this treatment seeks to instill countervailing humanistic themes to restore patients' feelings of potential for a better future. The title of each session is framed as a positive ideal, one that is the opposite of some

pathological characteristic of PTSD and substance abuse. Thus, for example, the session Honesty combats denial, lying, and the "false self". The session Commitment is the opposite of irresponsibility and impulsivity. The session Taking Good Care of Yourself is a solution for the bodily self-neglect of PTSD and substance abuse. The language throughout the treatment emphasizes values such as "respect", "care", "integration", and "healing". By aiming for what can be, the hope is that patients can summon the motivation for the incredibly hard work of recovery from both disorders.

IV. Four content areas: cognitive, behavioral, interpersonal, and case management.

While originally designed as a cognitive-behavioral intervention (a theoretical orientation that appears well-suited for first-stage stabilization treatment), the treatment was eventually expanded to include equally strong attention to interpersonal and case management issues. Interpersonal sessions now comprise a third of the sessions 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 PTSD most commonly arises from traumas inflicted by others, both for women and men (6). Whether childhood physical or sexual abuse, combat, or crime victimization, all have an interpersonal valence that raises issues such as whether to trust others, confusion over what can be expected in relationships, and the need to avoid reenactments of abusive power (15) both as victims and 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, manage interpersonal conflict. The case management component of the treatment was added to help patients obtain necessary help with life problems such as housing, job counseling, HIV testing, domestic violence, childcare, and other typical difficulties.

V. Attention to therapist processes

Research shows that for substance abuse patients in particular (and psychotherapy in general), the effectiveness of treatment is determined as much or more by the therapist as by any particular theoretical orientation or patient characteristics (30). With this dual diagnosis population, who are often considered "difficult", "severe", or "extreme" (9), it is a major challenge to provide effective therapy.

Therapist processes emphasized in Seeking Safety include: building an alliance, compassion for patients' experience; attempting to use the various coping skills in one's own life (not asking the patient to do things that one cannot do oneself); giving patients control whenever possible (as personal control was typically taken away as part of trauma and lost to substance abuse); 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 how they really feel about the treatment. The flip side of such positive therapist processes are countertransference issues that can detract from effective treatment. Indeed, the more severe the patient, the more likely that countertransference may get in the way of the work (31). This includes: harsh confrontation in which the therapist insists on her/his own point of view, sadism, inability to hold patients accountable due to misguided sympathy, becoming "victim" to the patient's abusiveness, power struggles, and, in group treatment, allowing a patient to be scapegoated.

Session topics and format

Examples of session topics are: *Honesty; Asking for Help; Compassion; Taking Good Care of Yourself; Creating Meaning; Setting Boundaries in Relationships; Commitment; Healthy Relationships; Detaching From Emotional Pain (Grounding); Getting Others to Support Your Recovery; Integrating the Split Self; Self-Nurturing; Protecting Yourself From HIV; and PTSD: Taking Back Your Power*. The treatment has been conducted in a variety of formats thus far, including group and individual, open and closed group, 50 and 90-minute sessions, singly and co-led, and outpatient and residential. Its empirical testing, however, was a closed group meeting twice weekly for 12 weeks with 1.5 hour sessions by a single leader.

A typical session

The session begins with a check-in comprised of five questions: Since the last session, "*How are you feeling?*", "*What good coping have you done?*", "*Describe your substance use and any other unsafe behavior*", "*Did you complete your Commitment?*", and "*Case management update*". (See below for a description of Commitments). Next, an inspiring quotation is read aloud; for example, in the session on PTSD the quotation is from Jesse Jackson, "You are not responsible for being down, but you are responsible for getting up." Most of the session is then devoted to the topic of the session, with emphasis on relating the material to current and specific problems patients are experiencing. Strategies to achieve this include role-plays, experiential exercises, discussion, and the use of a Safe Coping Sheet that guides patients to contrast their "old way" of coping with a "new way" that is safe. Throughout the treatment, patients are encouraged to identify ways that they can cope safely with any life situations that arise. They can draw from a list of over 80 Safe Coping Skills and are encouraged to discover which ones work for them. Two essential process themes are giving the patient control whenever possible (to counteract the inherent loss of control associated with both trauma and substance abuse): the promotion of honesty (to counteract the secrecy and lying typically characteristic of both trauma and substance abuse) and the balanced provision of patient praise (positive reinforcement) and holding patients' accountable (pushing patients to adhere to high standards of behavior to move their lives forward). To close the session, a check-out is conducted in which patients are asked to "*Name one thing you got out of today's session*" (an educational device to reinforce learning as well as give the therapist feedback), and "*Name one Commitment you will complete before the next session*". A Commitment is a between-session assignment that can be any positive, specific step to

move forward in one's life (e.g., "*Try calling a hotline to ask for support when you are feeling overwhelmed one time this week*"). Patients can also select from a variety of written options if they choose (e.g., "*Imagine that you are being interviewed for a TV documentary about what helped you to survive so far... What would you say?*").

Examples of session topics are:

Honesty; Asking for Help;

Compassion;

Taking Good Care of Yourself;

Creating Meaning;

***Setting Boundaries in Relationships;
and Integrating the Split Self.***

Empirical results

Thus far, one published study reports results for the Seeking Safety treatment (32). It was conducted in a group format, enrolling a total of 27 women of which 17 (63%) completed the minimum-dose of six sessions. All patients met current DSM-IV criteria for both PTSD and substance dependence. In addition, 65% of patients met criteria for one or more personality disorders. It is important to note that most of the patients in the study had a history of early and repetitive childhood physical and/or sexual abuse, which as later became clear from research reports, represents the majority of women with this dual diagnosis (2). Results were obtained on the 17 patients who met the minimum dose of six sessions as the intent of this initial study was to assess the impact of the treatment on them. Patients attended an average of 67% of available sessions. Based on assessments at pre-treatment, during treatment, post-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 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.

Example of a session sheet

To provide a feel for the treatment, an excerpt from a session sheet is provided below. In each session, the therapist is provided with a Therapist Guide that offers background on the topic, goals, strategies on how to conduct the session, clinical notes, and "tough cases" that may come up. Patients are provided with a session sheet that summarizes the main points in the session and offers ideas for Commitments. The session "Creating Meaning" is designed to help patients explore assumptions that are common among patients who have the

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dual diagnosis of PTSD and substance abuse. Examples of some of these beliefs (13) are presented in Table 1.

Future work. Despite the initial promise of Seeking Safety, it is clearly in an early stage of development. Future research, some of which is currently underway, includes the need to study the treatment in randomized controlled trials, to compare and/or combine it with existing treatments for PTSD (e.g., exposure) and substance abuse (e.g., relapse prevention), and to study its generalizability to a wide range of patients, clinicians, and settings.

Table 1. Excerpt from session sheet on Creating Meaning.

MEANINGS THAT <i>HARM</i>	EXAMPLES	MEANINGS THAT <i>HEAL</i>
Deprivation Reasoning. Because you have suffered a lot, you need substances (or other self-destructive behavior).	-- <i>I've had a hard time, so I'm entitled to get high.</i> -- <i>If you went through what I did, you'd do your arm too.</i>	Live Well. A happy, functional life will make up for your suffering far more than will hurting yourself. Focus on positive steps to make your life better.
I'm Crazy. You believe that you shouldn't feel the way you do	-- <i>I shouldn't want to get high.</i> -- <i>I must be crazy to be feeling this upset.</i>	Honor Your Feelings. You are not crazy. Your feelings make sense in light of what you have been through. You can get over them by talking about them and learning to cope with them.
Time Warp. Your sense of time is distorted, believing that a negative feeling will go on forever.	-- <i>This craving won't stop.</i> -- <i>If I were to cry, I would never stop.</i>	Observe Real Time. Take a clock and time how long it really lasts. Negative feelings will usually subside after a while; often they will go away sooner if you distract with activities.
Beating Yourself Up. In your mind, you yell at yourself and put yourself down.	-- <i>I'm a bad person.</i> -- <i>My family was right: I'm worthless.</i>	Love--Not Hate--Creates Change. Beating yourself up may echo what others in the past have yelled at you. But it does not change your behavior; in fact, it makes you <u>less</u> likely to change. Care and understanding promote real change.

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