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Early Career Award Paper

Lisa Najavits received SPR's Early Career Award in 1998. We asked her to write about her program of research and to explain how she thinks about her work.

The Editors

HELPING "DIFFICULT" PATIENTS

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Psychotherapy research has advanced considerably since its beginnings in the 1950s, yet it still has limited impact on "difficult" populations. My program of research addresses this area through 2 main topics: improving therapist effectiveness, and psychotherapy for substance abuse. Key studies in these areas and their development over time are described, with particular emphasis on a new psychotherapy manual I have developed, *Seeking Safety*, for the dual diagnosis of substance abuse and posttraumatic stress disorder. Finally, several themes across the projects are identified, including combining humanistic content with scientific methods; emphasizing practical solutions; creating depth in psychotherapy; promoting patient needs over professional self-interest; and listening to therapists.

> Do you think it is easy to change?
> Alas, it is very hard to change and be different.
> It means passing through the waters of oblivion.
>
> *D. H. Lawrence* (*20th-century writer*), *from the poem "Change"*

What moves me most about psychotherapy is being part of people's struggle to become well, to face life, to wake up, to lose illusions. A great deal remains unknown about how this process occurs and how to help people create it. The quotation from Lawrence's "Change" suggests the inexplicable nature of deep change. Why do some people with seemingly identical backgrounds and diagnoses differ greatly in outcome? Why do some people with mental illness emerge resilient, whereas others remain permanently disabled? The quotation also underscores the concept that real change is extremely difficult.

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Psychotherapy has emerged over the past century, concurrent with advances in technology that have freed people from physical hard labor to a world in which information, service, and personal development are ascendant. Psychotherapy might rightly be seen as one of the great inventions of the 20th century. Yet it is still young, with psychotherapy research even younger, dating to the 1950s. Moreover, the paradox remains that despite the century's exceptional material progress, there does not appear to have been a decline in mental illness.[1]

As psychotherapy has developed, it has become increasingly broad in its range; types of treatments available; combinations of orientations, modalities, and time frames; response to various types of patients; and embrace of different professionals who practice it (Garfield & Bergin, 1994). It has become socially acceptable and, indeed, part of mainstream culture: in the media, in self-help books and movements, and as part of standard health care in treatment systems. Psychotherapy research too has progressed through what might be termed a first phase: demonstrating that psychotherapy works, identifying basic processes by which it works (e.g., alliance), testing key theoretical orientations (e.g., cognitive–behavioral, psychodynamic, experiential), and developing rigorous process and outcome methods by which to study therapies.

Having come of professional age when much of this work had been well underway for several decades, what has emerged as most interesting to me is the pursuit of psychotherapy for patients who are widely presumed to be difficult: patients who suffer multiple disorders and hard-to-treat disorders (e.g., substance abuse, complex posttraumatic stress disorder [PTSD], Axis II disorders); patients who represent underserved populations (e.g., adolescents, prisoners, minorities); patients who present serious challenges for the therapist (e.g., suicidality, domestic violence); and patients who repeatedly cycle through treatment systems. Indeed, research indicates that therapists define difficult patients across diagnostic categories (Colson et al., 1985). An important aim within this topic is the study of therapist differences and processes, because the more difficult the patient, the greater the need for outstanding clinicians.

It is important, however, to put the word "difficult" in quotation marks. "Difficult" seems to stand for our limited knowledge at this point rather than necessarily for any inherent qualities about patients. This represents an intriguing parallel process in which we are both the subject and object of change, in which we must change to effectively help others change. It is on this edge that psychotherapy research appears most interesting. As Kurt Lewin (1951, p. 86) said, "If you want to find out how something works, try changing it." It is where psychotherapy does not yet work well that so much can be gained. For "difficult" patients, the very best treatments and therapists are required.

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[1]Although statistics are not available for most disorders, research indicates the following: the rate of depression, based on community sampling, has not decreased from the earliest study in the mid-20th century until now; other investigators found increases in depression (Murphy, Laird, Monson, Sobol, & Leighton, 2000); the rate of suicide increased from 10.2 per 100,000 population in 1900 to 11.1 in 1997; the rate of homicide increased from 1.2 per 100,000 population in 1900 to 5.8 in 1999; consumption of alcohol more than doubled between 1900 and 1997, in gallons per adult per year, although the latter is not a mental illness per se (Caplow, Hicks, & Wattenberg, 2000). Finally, child abuse has increased (Emery & Laumann-Billings, 1998).

In this paper, my program of research is defined by two major topics: (a) improving therapist effectiveness and (b) psychotherapy for substance use disorders.[2] I describe the development of this work, followed by key themes and a summary.

Program of Research: Topic 1. Improving Therapist Effectiveness

My first topic, and one that I still strongly value, is the study of therapist effectiveness: good versus poor clinicians—identifying them, observing their characteristics, exploring their inner world, and finding methods of training that might draw on the wisdom of the best to improve the quality of the worst. In the colorful language of Ricks's (1974) early study on this topic, it is the comparison of "supershrinks" versus "subshrinks" or, in the language of the current managed care culture, provider profiling.

My interest in this area began well before any formal study of psychology. When I was 19 years old, my mother, with whom I had been very close, died suddenly of a heart attack. It was the first time I sought therapy. I was surprised to find that the therapist to whom I had been assigned at my college counseling service seemed strangely cold. She would never say hello when I greeted her and kept a blank-slate demeanor of what apparently had been a strong psychoanalytic training. It was an unhelpful therapy that made the bereavement feel more painful. Years later, after having been assaulted in a criminal attack in New York City, I was referred to a crime victim counselor who played rock music on her radio throughout our sessions, unwilling to turn it off. There was a private practice therapist who, at the initial session, asked far more detailed questions about my personal finances than about any other topic, apparently trying to "diagnose" whether I could afford an expensive treatment. Aside from such egregious incidents, much of what passed for therapy seemed remarkably lacking: excessive interpretations that felt forced and overintellectualized or a blandly supportive quality without much power or insight. In short, therapy seemed to hold such extraordinary potential—reaching toward the essential aspects of existence (purpose, suffering, growth)—but in real life seemed to fall flat. Luckily, I eventually found an excellent therapist, who was caring and intelligent. This range of therapists, from the worst to the best, showed me what was possible in therapy.

I believe that my experience is not all that different from what most patients tell me: that a large number of therapists are mildly helpful, a few are downright negative, and occasionally one can find someone genuinely life changing. Such findings are also reflected in the psychotherapy research literature, in which effects are overall rather modest; beset by substantial differences among clinicians; and indicate that, on average, patients leave treatment "prematurely" after six sessions (Garfield, 1994; Najavits & Strupp, 1994).

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[2]Technically the term "substance use disorder" includes both substance abuse (the less severe version of the disorder) and substance dependence (the most severe version) (*Diagnostic and Statistical Manual of Mental Disorders* [fourth edition; *DSM-IV;* American Psychiatric Association, 1994]). However, the term "substance abuse" will be used throughout this article because it is more commonly used in clinical settings. However, "substance dependence" will be used for any studies that specifically target that syndrome.

In graduate school I was fortunate to be able to study this topic directly, under the guidance of two outstanding mentors in psychotherapy research: Steve Hollon and Hans Strupp (each representing a different theoretical orientation, cognitive–behavioral and psychodynamic, respectively). My dissertation used the data set of Strupp's Vanderbilt II Study to determine whether the 16 therapists on the study differed in effectiveness and, if so, to explore descriptive characteristics of those who were more effective versus less effective. Effectiveness was defined by two variables: the ability to retain patients in treatment and to achieve positive outcomes, analyzed per therapist caseload on a wide battery of measures. Especially intriguing was the fact that all therapists were of the same theoretical orientation (psychodynamic), were experienced and highly trained (psychiatrists and doctoral psychologists), and had strong reputations in the community. Thus, one would not expect to find differences in their performance. Results showed, however, that they indeed differed and that such differences were not accounted for by patient variables at baseline (Najavits & Strupp, 1994). In exploring therapist characteristics (based on behavior in Sessions 3, 8, 16, and 22), the more effective therapists were found to display more positive behaviors (e.g., warmth, alliance), fewer negative behaviors (e.g., attacking, blaming), and, interestingly, more self-criticism of their therapeutic work. All therapists, however, showed some negative behavior. Therapists were differentiated almost entirely by relationship (nonspecific) variables rather than technical (specific) ones. Therapists, independent observers, and patients were able to identify therapists as either more effective or less effective, whereas supervisors were largely unable to distinguish them. Such findings validated what clinically seemed so apparent: Important differences among therapists existed, and, moreover, could be connected to in-session behaviors.

In later work surveying the literature on therapist differences in relation to substance abuse patients, findings were similar (Najavits & Weiss, 1994b; Najavits, Crits-Christoph, & Dierberger, 2000). Moreover, these literature reviews expanded my understanding, indicating that therapists had a greater impact than either theoretical orientation or patient baseline characteristics (e.g., diagnosis, severity of drug use, sociodemographic status).

Since then, most of my interest has turned to studying characteristics of therapists that might help to explain their differences in effectiveness. It appeared that exploring their inner world—emotions, beliefs, and metaphors—might be a productive area. Certainly, it was clear that the typical simple-to-measure descriptors of therapists in much psychotherapy research (e.g., orientation, training; years of experience; sociodemographics; and, in substance abuse, recovery status) had not accounted for therapist effects despite decades of studies of this sort (Beutler, Machado, & Neufeldt, 1994; Christensen & Jacobson, 1994; Faust & Zlotnick, 1995; Lambert & Bergin, 1994; McLellan, Woody, Luborsky, & Goehl, 1988). Three studies described later in this paper illustrate my attempt to explore these more subtle, internal therapist variables.

My first job after postdoctoral training was as project director of the Boston sites of the National Institute on Drug Abuse (NIDA) Collaborative Cocaine Treatment Study. The study represented the largest psychotherapy outcome trial on cocaine addiction ever conducted: a 7-year, five-site project comparing three theoretical orientations (cognitive–behavioral, psychodynamic, and 12 step), headed by Paul Crits-Christoph. On this project, I had the opportunity to develop a measure of therapists' emotional responses to patients, the Ratings of Emotional Attitudes to Clients by Treaters (REACT; Najavits & Colson, 1992). The study of therapist emotions was appealing because it was so central to clinical practice and theory (indeed, it seems to be the area with which clinicians struggle most), yet had received only a handful of

empirical studies. The dual-edge nature of emotion as both harmful to treatment, when too intense, and helpful to treatment, when used as a guide to patients' internal world, is also well known.

The REACT scale, adapted from Colson et al. (1986), is composed of 60 items, including both seemingly positive and negative feelings, based on a literature search on therapist emotions. The scale was rated by therapists for each patient after Sessions 2, 5, and 24, with a total of 52 therapists rating 140 patients. Several findings emerged. First, factor analysis of the measure appeared to meaningfully derive four factors, in order of explained variance: therapist in conflict with self (e.g., confused, doubting one's competence, overwhelmed by the patient's severity); therapist focused on own needs (e.g., bored, burned out, insufficiently paid); positive connection (e.g., enjoyment, empathy, liking), and therapist in conflict with the patient (e.g., power struggles, feeling manipulated). Second, therapist positive feelings were high early in treatment and stayed high throughout, but negative feelings, although initially low, increased significantly over time. Third, when compared by theoretical orientation, 12-step counselors had more positive emotions than did cognitive or supportive-expressive therapists. Finally, although therapists were offered the opportunity to endorse "can't say" for any item, this happened in less than one percent of the data.

These findings taught me that therapists appear able to rate their own reactions and are comfortable reporting negative feelings toward patients. The two largest factors (conflict with self and own needs) seemed particularly interesting, highlighting therapists' insecurity and their search for gratification when working with such a difficult patient population and perhaps suggesting the intensity of their self-focus while in sessions. Such internal struggles may not be visible when simply observing therapy tapes. Needless to say, however, this scale, as with the two that follow, must be related to objective benchmarks of treatment such as outcome to understand whether therapists' emotions are related to actual effectiveness and whether there is some optimal mix of positive and negative emotions. The need to refine methods for studying therapist emotions is also essential (Najavits, 2000a).

Next, I became interested in therapists' implicit theories (Najavits, 1997), that is, therapists' private assumptions or working model about how to conduct psychotherapy that is distinct from, but coexists with, formal theoretical orientations. It seemed intriguing to explore how formal (explicit) theories might interact with informal (implicit) theories, with the hypothesis that the combination of an explicit theory and an implicit theory might account for more variance than an explicit theory alone when studying psychotherapy. In psychotherapy research, the single most predominant way to define therapists was by their formal theoretical orientation (Lambert, 1989). Yet research showed theoretical orientation to be remarkably limited as a descriptor. Therapists of the same orientation have been found to differ widely in their processes and impact on patients (Luborsky et al., 1986; Najavits & Strupp, 1994), whereas conversely, therapists of different orientations have been found highly similar in their therapeutic style (e.g., Fiedler, 1951) and outcomes (Smith, Glass, & Miller, 1980). With most psychotherapists defining themselves as eclectic and the proliferation of more than 400 separate schools of therapy (Garfield & Bergin, 1994), the role of orientation is further undercut. There appear to be two responses to this dilemma. One is to try to inculcate allegiance to formal theoretical orientations more fully, such as by treatment manuals and adherence scales. The other, which I sought to pursue, is to try to understand better whether therapists' own theories might be as or even more important than their explicit theoretical orientation.

Examples of implicit theories might include personal strategies on what to do during sessions, such as Reik's (1956) emphasis on looking for elements of surprise in the patient's report or Kottler's (1986) statement on the importance of taking risks in therapy. It could include views about what processes are actually occurring during therapy (such as the idea that the patient changes the therapist as much as the therapist changes the patient; Kottler, 1986) and views about what not to do in therapy (the discovery, after years of being a therapist, that one should not try to mold a patient into an image of one's own life; Burton, 1972). It may also include assumptions that hinder treatment: "I must not push my clients too hard or else they'll dislike me," "I must mainly use techniques that I enjoy or that are easy whether or not helpful to patients" (Ellis, 1983). Implicit theories can also include personal axioms therapists tell themselves during sessions, views on what to do when particular problems arise and subjective criteria by which they measure their success. In my article, I drew on writings in clinical psychology as well as fields in which the construct of implicit theories is more established (e.g., personality psychology, educational psychology). The key topics included an exploration of implicit theories of therapy, how to measure them, and their implications for psychotherapy research (e.g., identifying expert therapists, improving training in manualized treatments, and understanding negative outcomes).

In addition to this concept paper, I've made several attempts to study therapists' implicit theories. For example, I conducted a study of therapists' metaphors for psychotherapy, trying to understand whether therapists' views of therapy might be encapsulated in ideas such as "therapy is art" or "therapy is science." Thirty practicing therapists rated 16 such metaphors for the therapy process in an anonymous survey (Najavits, 1993). Results indicated that the highest endorsement was obtained for therapy as "art," "teaching," and "healing"; that metaphors clustered into larger meaning systems; and that professional background characteristics did not explain therapist ratings. Interestingly too, therapists' rated their own metaphors more highly than those provided on the survey, reinforcing the notion that therapists' idiosyncratic understanding of therapy can help illuminate how they go about their work.

In another project, I sought to develop a measure of therapists' implicit theories that might potentially differentiate more and less effective therapists, thus bringing together the original interest in therapist effects with the concept of implicit theories. The measure, the Therapist Beliefs Inventory (TBI; Najavits, 1994), comprises 70 items that are designed to identify views of psychotherapy irrespective of theoretical orientation (e.g., "I like to think up new interventions in therapy," "Therapy for me feels like a calling or mission in life," "I must be willing to feel patients' emotional pain along with them," "It's okay to lie to patients at times"). Therapists rate the items on a scale ranging from 0% to 100%. The goal is to construct a measure that might accurately categorize clinicians, similar to a measure such as the Minnesota Multiphasic Personality Inventory, which has been able to identify patient categories through its assortment of statements. Indeed, categorization of therapists appears to be an important goal that has received scant attention. The *DSM-IV* (American Psychiatric Association, 1994) represents a sophisticated, empirically based categorization of patients, yet we have no typology of therapist categories. An early categorization of therapists as A and B faded over time after empirical results did not support it (Lambert, 1989). My categorization thus far includes the following hypothesized dimensions, which serve as the basis of the TBI scale: (a) supportive (e.g., kind, empathic) versus harsh (e.g., blaming, power struggles); (b) accepting of emotions (interested in and able to tolerate emotions) versus defended against emotions; (c) mission oriented (seeking rewards inherent in the work itself) versus job oriented (focus on

external rewards from the work); (d) high standards/high work ethic versus low standards/low work ethic (e.g., accountability, organization); (e) creative versus routine (e.g., whether the therapist sticks to a standard set of interventions or not); (f) self-confident versus self-doubting; (g) eclectic versus theory driven; (h) modulated boundaries versus boundary excesses (boundaries too loose or too tight); and (i) deep versus superficial. Whether these categories will hold remains, of course, to be studied. The scale was implemented on the NIDA Collaborative Cocaine Treatment Study, and results are currently being analyzed.

Finally, another project explored therapists' views of treatment manuals (Najavits, Weiss, Shaw, & Dierberger, 2000). A 56-item survey was constructed to obtain therapists' satisfaction with manuals, how many manuals they have read, listing of favorite manuals, opinions on controversies in the field (e.g., "Do they promote an oversimplified 'cookbook' approach to treatment?"), and components of the ideal manual. The survey was administered solely to cognitive–behavioral therapists (N = 47) to control for orientation. Findings indicated a very positive view of manuals, extensive use, and few concerns. Notably, however, they had low ratings for two hardline research-based views on manuals: they did not believe that having an empirical base for a manual is necessary before a manual is disseminated, and they did not endorse the idea that therapist uniformity is the goal of reading manuals. Clearly, such beliefs contrast with those of many psychotherapy outcome researchers and may be fertile ground to help elucidate the implementation of treatment manuals into real-world practice. Therapists also had preferences for particular features of manuals, with highest endorsement for practical advice and interventions. This helped inform my own development of a manual, described in the next section. A related manuscript currently in preparation explores therapists' views on implementing the four manualized therapies in the NIDA Collaborative Cocaine Treatment Study. The goal was to explore how quickly therapists became comfortable with the manualized treatments, whether they would use them in their own practice once the study ended, what sorts of changes they would make to the treatments, and reactions to conducting a manualized treatment on a psychotherapy trial.

Program of Research: Topic 2. Psychotherapy for Substance Abuse

The work on therapists provided a conceptual backdrop for my next area of work: developing a treatment for patients with the dual diagnosis of PTSD and substance abuse. My path to this topic was a series of steps equally guided by chance and defined purpose. At McLean Hospital, my postdoctoral year was clinically focused, and I still entertained the idea of a solely clinical career, because conducting psychotherapy had been my primary motivation. I approached John Gunderson to seek out a research component, however, wanting to continue to develop the research skills I had cultivated during graduate school. Gunderson was an expert on borderline personality disorder, a population I had enjoyed treating (always preferring intense patients). I joined a study he had been doing on long-term psychotherapy outcome of borderline patients and helped analyze its results (Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Gunderson, Waldinger, Sabo, & Najavits, 1993; Najavits & Gunderson, 1995). It provided a first foray into studying a difficult patient population in psychotherapy, integrating insights from clinical practice with data-based research. Toward the end of that year he connected me with Roger Weiss for the job as project director on the NIDA Collaborative Cocaine Treatment Study.

On the NIDA study, I became fascinated with psychotherapy for substance abuse patients. This was rather a surprise because I had not studied substance abuse in graduate school, had never treated a substance abuse patient in psychotherapy until then, and had no particular connection to it. If I had any prior impression, it was likely negative (an impression I have since realized is fairly typical in the mental health field): "They can't get better," "I don't understand that area of work," "Alcoholics Anonymous is the main treatment for that." Yet I came to see that substance abuse represents one of the most intriguing challenges for psychotherapy. It has the highest lifetime prevalence rate of any psychiatric disorder (Kessler et al., 1994); its cost (in health care, loss of productivity, and law enforcement) is greater than that of all other mental illnesses combined (Galanter, 1993); and it has continued to rise over the past decade (National Institute on Drug Abuse, 1998). It is one of the greatest public health problems in the United States, with impact on crime, physical health, and suicide risk and causing untold harm not just to addicts themselves, but to families and communities as well.

Although psychotherapy had largely neglected the area of substance abuse for most of the past century (Najavits & Weiss, 1994a), the past 15 years had seen exciting developments: an enormous expansion of outcome research, new psychotherapy treatments, and improved training. Where previously treatment was limited largely to 12-step or occasionally psychodynamic programs, new modalities with at least some empirical validation now included a wide variety of therapies such as relapse prevention, cue exposure, motivational enhancement, payment for clean urine samples, and network therapy (Najavits & Weiss, 1994a).

One of the most promising developments as I came into this area of work was the focus on dual diagnosis: the recognition that many substance abuse patients suffer other psychiatric disorders that impede their ability to give up substances (Weiss & Najavits, 1997). My mentor in substance abuse research, Roger Weiss, suggested that I write a grant and steered me toward developing a new psychotherapy for dual diagnosis. Dual diagnosis was his area of expertise, and NIDA had just initiated a Behavioral Therapies Development Program to fund investigators to develop new psychosocial treatments. He named some possible dual diagnoses to work on: depression and substance abuse, bipolar disorder and substance abuse, PTSD and substance abuse. I chose the latter, only a short time later consciously connecting it to my own experience with trauma (my mother and grandmother having survived the Holocaust, and myself having experienced a criminal assault). Most important, at that point there had not been any published treatment studies on patients with PTSD and substance abuse. The goal was thus to design the treatment and conduct a pilot outcome study to evaluate its impact on patients. I selected a sample of women, given their high prevalence of this dual diagnosis; and a time-limited group therapy format (selected for cost effectiveness, because many substance abuse patients lack the financial resources for individual therapy).

I worked on several projects to understand this population better. One was a literature review (Najavits, Weiss, & Shaw, 1997), in which it became clear that PTSD is one of the most common psychiatric diagnosis in substance abuse patients. Estimates indicate a 12% to 34% rate of current PTSD among mixed-gender patients in substance abuse treatment and, much higher, a rate of 33% to 59% among women. Trauma per se is extremely common, with 55% to 99% of women substance abuse patients having experienced a lifetime trauma, most typically childhood physical or sexual abuse; and for men, most typically combat or crime victimization. Treatment systems—mental health and substance abuse—are largely separate and often exclude

such patients until the co-occuring diagnosis remits. Patients thus must try to integrate what the systems have not and at times resort to lying to obtain the services they need (Najavits, in press). Clinically, patients with this dual diagnosis present significant treatment challenges. They tend to abuse the most dangerous substances (cocaine and opioids), become flooded with PTSD symptoms as they become abstinent (presumably because substances served to self-medicate the PTSD), and are vulnerable to repeated trauma. Treatments that may work well for either disorder separately may not work when a patient has both disorders. For example, some patients with PTSD are unable to tolerate 12-step groups such as Alcoholics Anonymous; benzodiazepines that may work for PTSD can easily become another substance of abuse; PTSD exposure therapy (exploration of traumatic memories) is widely believed too overwhelming for substance abuse patients (Keane, 1995; Solomon, Gerrity, & Muff, 1992); and highly confrontational substance abuse treatments may feel like a traumatic repetition for patients who have experienced emotional abuse. Patients with this dual diagnosis are reputed to have intense dynamics in treatment, evoking strong countertransference, dropping out of treatment, and having lives of crisis that test even the most dedicated clinicians. Indeed, PTSD and substance abuse are not the whole story: domestic violence, legal problems, medical problems, other co-occurring psychiatric disorders, and loss of custody of their children are common. PTSD and substance abuse are both described as difficult disorders (Othmer & Othmer, 1995), in part because they engender a high degree of resistance based on self-deception and self-protection (e.g., denial, concealing, and impaired access to memories).

Two empirical studies provided further background. In a study of patients on the NIDA Collaborative Cocaine Treatment Study (Najavits, Gastfriend, et al., 1998), patients with PTSD and cocaine dependence (n = 25) were compared to patients with cocaine dependence alone (n = 97) on current substance use, psychopathology, and sociodemographic characteristics. Patients with PTSD evidenced significantly higher rates of co-occurring Axis I and II disorders, interpersonal problems, medical problems, resistance to treatment, and psychopathology symptoms. The latter was the most consistent area of difference between the two groups and provided the best prediction of PTSD status in a logistic regression. However, the groups did not differ significantly in current substance use or sociodemographic characteristics. This study highlighted the intense clinical needs of patients with PTSD and substance abuse above and beyond just substance abuse treatment. It also indicated that substance use per se did not appear to be the most important factor in clinical presentation: Despite equivalent severity of current substance use, the dual-diagnosis patients showed markedly increased problems compared with those with cocaine dependence alone.

In a related project, 28 women with PTSD and substance dependence were compared with 29 women with PTSD alone to try to better understand why some women with PTSD turn to substances whereas others do not (Najavits, Weiss, & Shaw, 1999). Results showed, consistent with the previous study, that the dual-diagnosis group had a more severe clinical profile than the single-diagnosis group, including worse life conditions (e.g., physical appearance, opportunities in life), both as children and as adults; greater criminal behavior; a higher number of lifetime suicide attempts; a greater number having a sibling with a drug problem; and fewer outpatient psychiatric treatments. The only discrepant finding was a lower rate of major depression, which might be interpreted as self-medication in the dual-diagnosis group (i.e., substance use perhaps masking depressive symptoms that are normally high in PTSD patients). Most surprising, however, was that no significant differences were found between the two groups

in number or type of lifetime traumas, PTSD onset or severity, parental history of substance use; coping style, functioning level, psychiatric symptoms, or sociodemographic characteristics. It might have been expected that the dual-diagnosis group would have suffered, in particular, worse trauma and PTSD. Yet more important appeared to be risk and protective factors outside of diagnostic categories.

Aside from such statistics, one realizes in working with them what a tragic, degraded life they live. I cannot imagine two disorders that more clearly interact to create a loss of faith in life and in people. The myriad destructive behaviors they display—not just substance abuse and other addictions, but violence toward others, and self-harm such as suicidality and self-mutilation—speak to the degree of psychic escape they are trying to accomplish, yet which unwittingly leads to more enduring emotional pain. Successful therapy thus needs to counteract with the opposite of such destruction by establishing trust with others, discovering their power, gaining a sense of self-discipline, and facing the truth of what happened (both inflicted by the world, as in trauma, and inflicted by their own actions, as in substance abuse).

The opportunity to put on paper my own views of what therapy might look like—how best to treat such a difficult population, how to bring out the best in both treaters and patients—felt like the quintessential psychotherapy research project for me. I relished the opportunity to listen to patients, try out a variety of interventions, refine the treatment with successive patients, and assess outcomes. It has been both the most challenging project I have worked on and the most gratifying. In the next section, the treatment manual, *Seeking Safety* (Najavits, in press), is described in some detail, including a summary of empirical research on it.

Description of the *Seeking Safety* Therapy

The treatment addresses 25 topics, summarized in a manual. It is currently being tested in eight psychotherapy outcome trials, described later. The treatment topics are evenly divided among cognitive, behavioral, and interpersonal domains, with each topic addressing a "safe coping skill" relevant to both disorders. Examples of topics include honesty, integrating the split self, compassion, setting boundaries in relationships, taking good care of oneself, creating meaning, asking for help, recovery thinking, detaching from emotional pain, and coping with triggers. Throughout, patients are taught that, no matter what happens, they can learn to cope safely without substances or other destructive behavior.

Each topic consists of the following:

1. A therapist guide with background about the topic, discussion of countertransference issues, and a "tough cases" segment that presents typical treatment challenges.
2. A quotation to read aloud at the start of each session to affectively engage patients. For example, the quotation for the topic "PTSD: Taking Back Your Power" is from political leader Jesse Jackson: "You are not responsible for being down, but you are responsible for getting up" (cited in Marlatt & Gordon, 1985, p. 15).
3. Patient handouts, including ideas for "commitments" (i.e., homework) patients can do between sessions.

The treatment is highly structured yet also extremely flexible, characteristics that I believe may be particularly important when working with severe populations. The multiple needs and intense affect of such a population can lead to derailed sessions if the therapist does not impose clear structure. Yet the treatment is also highly flexible. Sessions can be held in any order; a variety of handouts are provided for each topic; and the therapy can be been conducted in many different formats (group or individual treatment; 50- or 90-min sessions; closed or open group; one leader or two; varied pacing of sessions; integrated with other treatments or as a stand-alone therapy). The flexibility is designed to keep patients' most important concerns primary, to allow adaptation to a variety of settings, and to encourage therapists to remain inspired and interested in the work. With difficult patients, the risks of dropout and therapist burnout are heightened. Moreover, the treatment was designed to adapt to the managed care era, in which many patients have limited access to treatment. Thus, the treatment can be used for just one or a few sessions or can be extended to long-term treatment.

The treatment is cognitive–behavioral, although with a strong degree of psychodynamic influence, reflecting my exposure to both modalities in graduate school and on internship. Indeed, I believe I have been unusually lucky in having experienced both orientations at these crucial stages of my career. For PTSD and substance abuse, each orientation offers a unique contribution: The psychodynamic gives voice to the "dark side" of the disorders such as unmodulated aggression and unconscious dynamics such as the repetition compulsion; the cognitive–behavioral contributes concrete skills and tasks to help move recovery forward. My undergraduate training in the humanities at Columbia University (as a history major, with minors in literature and education) is also reflected in the treatment: the use of inspirational quotations and humanistic themes and the attempt to write in simple, evocative language.

The treatment is based on five principles. First, safety is the priority of this early-stage treatment. The title of the manual, *Seeking Safety*, expresses its central idea. That is, when a person has both substance abuse and PTSD, the most urgent clinical need is to establish safety—from substances, dangerous relationships, and extreme symptoms such as dissociation and self-harm. Many of these self-destructive behaviors reenact trauma: having been hurt through trauma, patients are now hurting themselves. "Seeking safety" refers to helping patients free themselves from such negative behaviors, and, in so doing, free themselves from trauma at a deep emotional level. The treatment fits what has been described as first-stage therapy for each of the disorders. Experts within the PTSD and substance abuse fields have independently described an extremely similar first stage of treatment that prioritizes stabilizing the patient, teaching coping skills, and reducing the most destructive symptoms (Najavits, in press). Later stages, again quite similar for the two disorders, are mourning (facing one's past by exploring the impact of trauma and substance abuse), and reconnection (attaining a healthy engagement with the world via work and relationships; Herman, 1992). The first stage, safety, is in and of itself an enormous therapeutic task for some patients, and thus *Seeking Safety* addresses only that stage. By helping the patient move toward safety, therapists are also protecting themselves from the sequelae of treatment that could move too fast without a solid foundation: vicarious traumatization, medicolegal liability, and dangerous transference dilemmas (Chu, 1988; Pearlman & Saakvitne, 1995). Thus, seeking safety is, it is hoped, both the patient's and the therapist's goal.

Second, the treatment is designed to integrate attention to both PTSD and substance use disorder. That is, both are treated at the same time by the same clinician. An integrated model is consistently recommended as the treatment of choice for this dual diagnosis (Najavits, Weiss, & Liese, 1996). In practice, however, most settings do not treat the two disorders simultaneously. It is still common for patients to be told that they need to become abstinent from substances before working on PTSD, which does not work for many patients. Many clinical staff are reluctant to even assess for the other disorder; and patients' own shame and secrecy about trauma and substance abuse often further reinforce treatment splits (Brown, Recupero, & Stout, 1995). Integration is thus, ultimately, an intrapsychic goal for patients as well as a systems goal: to recognize both disorders, to explore their interrelationship, and to fall prey less often to the vulnerability of each disorder triggering the other. Finally, integration also occurs at the intervention level. Each safe coping skill can be applied to both PTSD and substance abuse. For example, setting boundaries in relationships can apply to PTSD (e.g., leaving an abusive relationship) and to substance abuse (e.g., asking a friend to stop offering drugs).

Third, there is a focus on ideals. Each disorder, and especially their combination, leads to tremendous demoralization and loss of ideals. In PTSD this loss of ideals has been written about, for example, in work on shattered assumptions (Janoff-Bulman, 1992) and the search for meaning (Frankl, 1963). With substance abuse there is also a loss of ideals: life has become narrowed in focus and in its severe form one "hits bottom." Thus, the treatment explicitly seeks to restore ideals that have been lost. Each topic is framed as a positive ideal, one that is the opposite of some pathological characteristic of PTSD and substance abuse. For example, the topic "honesty" combats denial, lying, and the false self. The topic "commitment" is the opposite of irresponsibility and impulsivity. Throughout, the language of the treatment emphasizes values such as respect, care, integration, protection, and healing. By aiming for what can be, the hope is that patients can summon the motivation for the incredibly hard work of recovery from both disorders.

Fourth, there are several content areas: cognitive, behavioral, interpersonal, and case management. Cognitive–behavioral therapy (CBT) is the basis for this treatment because it so directly meets the needs of first-stage, safety-oriented treatment. It offers a high degree of structure, focus on problem solving in the present, educational emphasis, and time-limited framework. Moreover, in outcome studies, CBT has been found to be one of the most promising approaches for the treatment of each of the disorders when treated separately (Najavits et al., 1996). Whereas the treatment was originally solely cognitive and behavioral, interpersonal and case management domains were added later. Interpersonal topics now comprise a third of the topics; and case management is begun in the first session and addressed at every session. 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, e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Similarly, substance abuse is often precipitated and perpetuated by relationships. The case management component arose from data in the pilot study on this treatment indicating that many patients had received few prior treatment services (Najavits, Dierberger, & Weiss, 1999; Najavits, Weiss, Shaw, & Muenz, 1998). Thus, case management is emphasized on the assumption that psychological interventions can work only if patients have an adequate treatment base.

Fifth, therapist processes are emphasized. Given my interest in therapist factors as well as clear research findings for the importance of therapist factors in substance abuse treatment (Najavits, Crits-Christoph, & Dierberger, et al., 2000; Najavits & Weiss,

1994b), therapist processes became a major component of the treatment. Therapist processes emphasized in *Seeking Safety* (Najavits, 2000b; Najavits, in press) include compassion for patients' experience; using the treatment's coping skills in one's own life (not asking the patient to do things that one cannot do oneself); giving patients control whenever possible (because loss of control is inherent in both trauma and substance abuse); heroically doing anything possible within professional bounds to help the patient get better; listening to patients' behavior more than their words; providing honest positive and negative feedback; and eliciting patients' views of 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) suggested, therapists may unwittingly repeat the roles of trauma as victim, perpetrator, or bystander. Throughout, the goal is for the therapist to integrate support and accountability, which are viewed as the two central processes in the treatment.

The pilot study (Najavits, Weiss, et al., 1998) funded by the original grant evaluated outcome results for the treatment when tested in group format for 17 outpatient women who met a minimum dose of treatment of six sessions, out of 27 women initially enrolled. All of the women met current substance dependence criteria and were active users when starting the study and had current PTSD (which resulted from repeated childhood physical or sexual abuse for virtually all patients). In addition, the sample is notable for a high rate (65%) of one or more coexisting personality disorders, most commonly paranoid personality disorder. Further description of the sample is provided in Najavits, Weiss, et al. (1998). Assessments were conducted pretreatment, during treatment, posttreatment, 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' treatment attendance (67% of available sessions), alliance, and satisfaction were also very strong. Patients who met the minimum dose of treatment were more impaired than dropouts and yet more engaged in the treatment. Overall, the data suggested that women with PTSD and substance use disorder can be helped when provided with a treatment adapted to them. However, methodological limitations of the study included the lack of a control condition, no assessment of dropouts, the presence of concurrent external treatments, and multiple statistical comparisons.

The treatment is currently being evaluated in eight funded outcome studies that target different subpopulations with this dual diagnosis and also take the scientific testing to its next stage, with control conditions and larger samples. These include a study of outpatient women (Najavits, 1996), women in prison (Zlotnick, 1999), inner-city women (Hien, 1997), adolescent girls (Najavits, 1998), men who experienced child abuse (Najavits, Brady, et al., 2000), homeless women veterans at seven Veterans Administration hospitals (R. Rosenheck, personal communication, 1999), inpatient women veterans (Ruzek & Wilser, 2000), and three treatment sites as part of a national multisite study on women, violence, and substance abuse (Hutchins, Finklestein, & Brown, 2000). In the studies of adolescent girls, inner-city women, and men the treatment is conducted in individual format; in all the others it is group format. Initial results on the study of inner-city women (Hien & Litt, 2000) indicate that the therapy showed significantly better outcomes than the treatment-as-usual control condition. In the other projects, data thus far indicate positive satisfaction with the treatment, although outcome results are still being collected.

In all of the projects, the main goals are to adapt the treatment to the subpopulations and to test outcomes. For example, one adaptation is to add a PTSD exposure therapy component. Exposure therapy helps patients work through the intense affect of trauma through discussion of specific memories and triggers. A colleague suggested some years ago that this might be a productive mix of treatments (B. Dansky, personal communication, 1997); currently it is being piloted in the studies of adolescents and of men.

Ancillary goals of the projects are to develop advanced therapist training materials (e.g., video-based training), and measures specific to the treatment (e.g., adherence). The studies are designed to address some key questions: Does the therapy provide differential benefit for particular types of symptoms? What adjunctive treatments are most helpful in combination with this therapy? What degree of benefit can be expected? How long should the treatment be? Descriptive studies of the PTSD-substance abuse samples are also under way.

Currently, the focus is solely to test the feasibility and outcome of the treatment. If it indeed shows positive outcome results, a later phase of work will be to undertake process studies to understand why. For example, some subset of skills taught in the treatment might be more powerful than others (the concept of active ingredients); some interventions may work better with particular patients than others; or therapists may be able to conduct parts of the therapy more easily than others. An initial attempt to explore process is represented by a treatment-specific measure, the Core Components of Treatment Scale (Najavits, 1995), in which patients rate, before and after treatment, their use of 42 safe coping skills in the treatment and 24 key ideas in the treatment. Analysis of this scale is currently under way to identify which skills and ideas patients endorse most highly and whether these change over the course of treatment.

Key Themes

Across the various projects are several overarching themes that represent what I find most meaningful in the work and which I hope to continue to pursue empirically. Each, moreover, is relevant to the treatment of difficult patients in particular.

Combining Humanistic Content With Scientific Method

The role of science is invaluable as a method: to study whether and how a treatment works. Indeed, the contribution of psychotherapy research is to bring scientific methods to the therapy endeavor. However, at times it appears that, because science is so useful as a method, there is an assumption that it must also comprise the content of treatment: thus the use of jargon rather than simple human language, the description of human suffering mostly as symptoms, and the view that therapies should be highly programmed. With difficult patients, such treatments may be less engaging than ones that draw on humanistic themes. Some techniques are clearly scientific (e.g., biofeedback), but much of what draws difficult patients to treatment is a chaotic mix of problems that tap humanistic issues. PTSD and substance abuse, for example, evoke essential questions about human nature: why people victimize each other, how to have faith in the future, the meaning of bad luck, whether life is worth living. These themes were explored for thousands of years in the humanities well before psychotherapy began. Indeed, most of my favorite works on psychotherapy

for difficult disorders draw from humanistic, broader streams, for example, Herman's *Trauma and Recovery* (1992), which explores a historical view of PTSD; Linehan's (1993) dialectical behavior therapy, which draws on Eastern spirituality for the treatment of borderline personality disorder; and Jamison's (1995) *An Unquiet Mind*, which integrates personal and professional experience in the treatment of bipolar disorder. In developing topics for the *Seeking Safety* treatment, I have tried to draw on universal themes conveyed in everyday language, with which patients and therapists could, it is hoped, easily connect (e.g., honesty, compassion, creating meaning, setting boundaries). Moreover, there is a goal of using language that is emotionally engaging rather than based in scientific jargon: emotional pain (rather than symptom); honesty (rather than assertiveness); rethinking (rather than cognitive restructuring); creating meaning (rather than cognitive distortion); commitment (rather than homework). Each session starts with an inspiring quotation to try to stir patients' motivation for the work. In short, the content of the treatment is strongly humanistic, yet rigorous scientific methods are used for studying its impact (Najavits, Weiss, et al., 1998), including the use of an adherence scale, standardized assessments, and quantified outcomes. The same holds for the development of several scales on therapies on which I have worked: for example, the study of therapist metaphors for therapy and the study of implicit theories, in which therapists' unique conceptualizations of therapy are juxtaposed against formal theories.

Practical Solutions

The more difficult the patient population, the greater is the need for psychotherapy to offer practical solutions in addition to emotional insight. Indeed, in psychotherapy for substance abuse, CBT and 12-step treatments are more widely recommended than interpersonal or dynamic treatments in early-phase recovery (Najavits, in press; Najavits & Weiss, 1994a). Concerns include how to get patients to attend treatment, enlisting family members to help monitor the patient (Galanter, 1993), and what to do when patients lose their housing or job. Most therapists do not enjoy these tasks and are not trained to do them, yet without this foundation patients are less able to make use of emotional and relational forms of change, which are higher order functions, for example, in Maslow's famous hierarchy (1970). In training therapists, I am struck by how often they seek psychological solutions when pragmatic ones have not yet been tried. For example, a patient has problems with her children; the therapist typically explores this at length but does not suggest sending the patient to Parents Anonymous, parenting skills classes, or even reading a book on parenting. With difficult patient populations, who may have limited financial resources for therapy, such practical solutions seem essential. Indeed, most people with mental disorders never obtain professional psychotherapy for their problems (Howard et al., 1996; Kessler et al., 1994), underscoring the public health need to continue to find cost-efficient solutions for getting help to those who need it. In psychotherapy research, it would thus seem important to measure therapists' use of such practical solutions, as well to promote research designs that take into account the use of them outside of the treatment under study. In *Seeking Safety*, I have tried to attend to these issues by developing an extensive module on case management and providing a lengthy list of nonprofit national organizations that patients and therapists can access for help on substance abuse, mental illness, parenting, medical problems, and so on. The use of bibliotherapy has also been explicitly addressed, both in *Seeking Safety* and in an empirical study on this topic (Najavits & Wolk, 1994).

Creating Depth in Therapy

One of the major challenges in psychotherapy is creating depth and intensity rather than simply support. Many therapists are adept at being kind and nurturing. Far fewer can confront patients in a compassionate way; give incisive feedback to promote growth; manage aggression; elicit the most hidden feelings and thoughts; and hold patients accountable to do their very best (P. Crits-Christoph, personal communication, 1998; Najavits, 2000b; Strupp & Binder, 1984). As Zinberg said regarding treating substance abuse patients, the goal is to "meet your patients where they're at and take them where they don't want to go" (H. Shaffer, personal communication, 1999). With difficult patients, therapists need to notice what the patient is not saying (rather than just what is being said), focus patients on the hard work of moving forward (not just venting feelings), develop concrete plans to protect patients from themselves, and help patients face the losses and wasted years that result from mental illness. Helping patients learn to cry when they have never been able to before is another example of depth work that is particularly central for PTSD patients. In training therapists to work with difficult patients, one of the single greatest problems appears to be therapists' wish to be liked by patients superseding the pursuit of depth. Many appear to hold the belief that if they talk to the patient in "real" ways, the patient will not return to treatment. They seem to confuse patients' vulnerability with the idea that patients must be shielded from honest truths. As Strupp noted some time ago, therapists' difficulty working with aggression and negative feedback is also particularly widespread (Strupp & Binder, 1984): Many therapists appear to want to keep direct conflict out of sessions and may ignore their own and patients' aggression rather than working with it as inherently part of the therapeutic task. In my work, I have tried to address the issue of depth in two ways. One is directly assessing it on measurement scales. On the TBI scale, depth is one of the hypothesized dimensions. In the adherence scale for *Seeking Safety* therapy, depth is addressed, for example, in an item that distinguishes warmth from compassion (the latter being a deeper level of work). Second, there is an attempt to create depth throughout the treatment, such as in the discussion of how to conduct cognitive restructuring without simply flipping negative beliefs into positive ones.

Promoting Patient Needs Above Professional Self-Interest

In both clinical work and psychotherapy research, there are times when professional self-interest appears to outweigh a focus on the ultimate goal of the work: helping patients. Thus, for example, in psychotherapy research, Mohr (1995) wrote about a strong resistance in the field to studying negative effects. As he stated after an extensive review of the literature, "Our field has tended to shy away from looking at negative outcome. It is seldom reported. . . . Yet is not our reluctance to examine failures . . . itself neurotic? . . . Certainly it cannot be too much to ask that we do what we ask of our patients—to examine our failings with an open mind and with a view toward change" (pp. 23–24). Another area that has evoked resistance in both the research and clinical communities is the finding over many studies that therapists' professional training does not appear to predict outcomes (Christensen & Jacobson, 1994; Faust & Zlotnick, 1995). Yet most credentialing bodies and outcome studies continue to require particular degrees automatically rather than identify empirical criteria that might better impact outcomes. Indeed, there appears to be a goal of protecting therapists' work from close scrutiny because the work represents

their livelihood and self-esteem. Except for the most scandalous cases, it is typically difficult to get rid of poor therapists. Degrees, licensure, and promotion are not typically based on empirical measures of actual performance with patients but rather on indirect and loosely related concerns, such as grades in academic work (e.g., for degrees), multiple-choice tests (e.g., for licensure), and ratings of financial productivity (e.g., in clinical settings). In general, therapist performance is rarely rigorously evaluated, both in the clinical world and in outcome studies (where most studies continue to aggregate across therapists, thus obviating scrutiny of therapist differences). It might be hoped that if psychotherapy research could provide accurate benchmarks to evaluate therapist performance, the result might be demonstrable improvements in training and supervision, and, if necessary, removal of consistently iatrogenic treaters. My interest in this area stems from my research findings on therapist differences in effectiveness as well as observation of clinical settings.

Listening to Therapists

Equally important as accountability (see section above) is trying to understand therapists' views of their work. Each requires a different perspective: the former an objective view of therapists, the latter an empathic one. Yet, historically, psychotherapy research has tended to ignore therapists, viewing them either as equivalent to each other or as "noise" in attempts to study interventions (Garfield, 1997; Kiesler, 1966; Najavits & Strupp, 1994). To paraphrase Clandinin (1986), research is of two types: research on what we know about therapists, and research on what therapists know. Listening closely to understand therapists' assumptions about therapy could potentially enrich our understanding of how to improve the quality of treatments. For example, it could help elucidate how manualized treatments are differentially implemented, how therapists sustain their emotional energy or burn out when working with difficult patients and how they learn and respond to training. Current realities of clinical practice, such as the erosion of therapists' roles and salaries with the advent of managed care, also need to be kept in mind. As Gustafson (1991) noted, the message to clinicians is typically "Do more and do it better." A survey of 231 substance abuse counselors found that 76% planned to leave their job within the next 5 years (Evans & Hohenshil, 1997). Support for their difficult work is crucial (Najavits, Crits-Christoph, & Dierberger, 2000). In research, it thus appears important to listen closely to therapists' experiences, refine treatments based on their needs (in addition to the ultimate concern for patients' needs), and help therapists understand how psychotherapy research might aid them. In my work, I have attempted to develop several measures to tap into therapists' inner world (e.g., the studies of therapists' emotions, beliefs, metaphors, and views of treatment manuals).

Summary

My initial interest in psychotherapy research was the study of therapist differences in effectiveness; that is, identifying good versus poor clinicians. With clear evidence for such differences through my own and others' work, the search for how to explain them became paramount and remains so. The legacy of much prior research had shown that popular, simple-to-measure therapist variables (e.g., formal theoretical orientation, years of experience, gender, training) largely did not account for therapist differences. Thus, my interest grew in trying to devise ways to tap into

therapists' inner world (e.g., their emotions, implicit theories, metaphors for the therapy process, and views of treatment manuals). Such exploration, it is hoped, can honor the complex nature of therapeutic work while also finding quantitative ways to measure it. Some of my work has been devoted to studying therapists who treat substance abuse patients in particular, with the idea that patients who are typically viewed as difficult to treat might evoke therapists' most intense and wide-ranging responses. The real story, however, is still ahead because much of the effort thus far has been "spade work" to develop measures, identify concepts, and refine research strategies. Relating these complex therapist attributes back to outcomes and validating an empirically based therapist typology—my current goals—might help to determine whether such work is fruitful in the long run. Ultimately, it seems that if we want to improve the quality of care that patients receive (particularly the care of the most vulnerable and most impaired patients), we will need exceptionally in-depth understanding of therapists. Although outcomes are a function of patients and treatments as well as therapists, research thus far indicates that, of these three, the therapist accounts for more outcome variance than the other two.

My second major area of work has been the development and testing of a new psychotherapy for a "difficult " population: patients with the dual diagnosis of PTSD and substance abuse. Drawing from my clinical practice with patients, literature review, research studies describing key characteristics of this population, supervising therapists on the treatment, and listening to hundreds of hours of treatment tapes, I have sought to identify a model of treatment that might closely target their needs. The treatment manual, *Seeking Safety*, addresses 25 topics designed to offset the self-destructiveness of this population with skills that can help them cope safely. The skills address humanistic themes (e.g., honesty, compassion, creating meaning, integrating the split self) within the context of cognitive, behavioral, interpersonal, and case management goals. Key features of the treatment include its attempt to integrate treatment of both disorders at the same time, the priority of safety as the preeminent goal in first-stage treatment for these disorders, a focus on ideals to restore hope, and strong attention to therapist processes. The latter feature, in particular, draws on my interest in therapist differences by highlighting dilemmas that therapists face when treating such patients. Adapting the treatment to subpopulations with this dual diagnosis and developing technology to improve its application (e.g., adherence and treatment-specific scales, training videos) are currently in progress. Although a pilot study has shown a variety of positive effects, current psychotherapy trials testing it against control conditions are essential for evaluating its outcome. Eight studies are currently in progress, including those of outpatient women, combat veterans, women in prison, inner-city women, adolescent girls, and men abused in childhood. If the treatment indeed shows positive outcomes, a later phase of work will be to explore its processes.

When I began in the field of psychotherapy, my primary motivation had been to help patients through clinical work. My intensive graduate and postgraduate training in psychotherapy research converted me into a researcher as well, because I came to value that research can potentially make a wider contribution than solely conducting clinical practice. Refining and testing treatments (and related issues, such as therapist factors) feel like the ultimate connection between insights derived from practice and the scientific testing of them to improve the quality of care. This fusion of clinical work and research is mirrored too in the range of educational experiences I have been privileged to acquire: undergraduate training in the humanities, graduate and internship training in both psychodynamic and cognitive–behavioral orien-

tations, and exposure to a number of outstanding mentors. In looking back at my work thus far and thinking about work I hope to do in the future, several key themes appear prominent: combining humanistic content of treatment with scientific methods, striving to create depth in psychotherapy, emphasizing practical solutions when possible, promoting patient needs over professional self-interest, and listening to therapists.

It is exciting to pursue psychotherapy research at a time when it already has an established legacy of knowledge and methods but also still holds much opportunity for new advances. "Difficult" populations–those for which treatments are as yet insufficient—represent this cusp between old and new and need the best help that psychotherapy and psychotherapy research can provide.

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Zusammenfassung
Die Therapieforschung hat seit ihren Anfängen in den fünfziger Jahren beträchtliche Fortschritte gemacht, dennoch ist ihre Bedeutung für "schwierige" Patientengruppen immer noch begrenzt. Mein Forschungsprogramm ist mit 2 Hauptthemen speziell auf diesen Bereich ausgerichtet: Verbesserung von Therapeuteneffektivität und Psychotherapie von Süchtigen. Wichtige Studien in diesen Bereichen werden, unter Berücksichtigung ihrer Entwicklung über die Zeit, berichtet mit dem besonderen Schwerpunkt auf einem neuen von mir für die Diagnosen Drogenmißbrauch und posttraumatische Stress-störungen entwickelten Psychotherapiemanual: Suche nach Sicherheit. Schließlich werden einige projektübergreifende Themen identifiziert, die eine Verbindung humanistischer Konzepte zu wissenschaftlichen Methoden beinhalten, die Betonung auf praktische Lösung legen, tiefergreifende psychotherapeutische Effekte hervorbringen, Patientenbedürfnisse über professionelles Selbstinteresse stellen, und die auf den Therapeuten gerichtete Bereitschaft, zuzuhören, betreffen.

Résumé
Malgré les progrès considérables de la recherche en psychotherapie depuis ses débuts dans les années cinquante, son impact sur des populations « difficiles » reste limité. Mon programme de recherche vise ce domaine par 2 sujets principaux : l'amélioration de l'efficacité des thérapeutes et la psychothérapie pour les cas d'abus de substances. Des études clés dans ces domaines ainsi que leur évolution dans le temps sont décrites, avec un accent particulier sur un nouveau manuel de psychotherapie que j'ai développé, *Chercher la Sécurité*, pour le double diagnostic d'abus de substances et d'état de stress post-traumatique. Pour finir, plusieurs sujets apparaissant à travers les projets sont identifiés, dont combiner un contenu humaniste avec des méthodes scientifiques; mettre l'accent sur des solutions pratiques; aller en profondeur en psychothérapie; promouvoir davantage les besoins des patients que les intérêts professionnels propres; et écouter les thérapeutes.

Resumen
Si bien la investigación en psicoterapia ha avanzado considerablemente desde sus comienzos en la década del '50, todavía tiene un impacto limitado en las poblaciones "difíciles". Mi programa de investigación aborda esta área a través de dos tópicos principales: el mejoramiento de la efectividad terapéutica y de la psicoterapia en casos de abuso de sustancias. Se describen estudios clave y sus desarrollos en estas áreas, con énfasis particular en un manual de psicoterapia desarrollado por mí, *Se Busca Seguridad*, para el doble diagnóstico de abuso de sustancias y de desorden por estrés postraumático. Finalmente, se encaran varios proyectos, entre ellos la combinación del contenido humanístico con los métodos científicos; el énfasis en soluciones prácticas; mayor profundidad en la psicoterapia; mayor atención a las necesidades del paciente por sobre el autointerés profesional; y la escucha a los terapeutas.

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