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Treatment of Posttraumatic Stress Disorder and Substance Abuse: Clinical Guidelines for Implementing *Seeking Safety* therapy

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Abstract:

This article describes clinical guidelines for implementing the *Seeking Safety* therapy for posttraumatic stress disorder (PTSD) and substance abuse. The rationale for the treatment, key features, empirical evidence, and implementation suggestions are offered. The latter include how to select clients and clinicians for the treatment, application to a variety of treatment formats, how to make the skills most useful to clients, typical difficulties of clinicians, diversity issues, group modality suggestions, and how to involve staff who are not directly conducting the treatment. A website, www.seekingsafety.org, provides additional information.

Treatment of Posttraumatic Stress Disorder and Substance Abuse: Clinical Guidelines for Implementing *Seeking Safety* therapy

A large number of clients in substance abuse[i] treatment have current posttraumatic stress disorder (PTSD), estimated at 33%-59% in women and12%-34% in men (Najavits, Weiss, & Shaw, 1997). The majority have a history of trauma and often multiple traumas, such as child abuse, rape, criminal assault, serious accidents, natural disasters, and combat. Yet traditional treatment has not attended to these issues. Most do not receive assessment or treatment of their PTSD (Brown, Stout, & Gannon-Rowley, 1998; Danksy, Roitzsch, Brady, & Saladin, 1997). Messages in substance abuse treatment such as "Don't work on the PTSD until you've been clean for a year", or "Substance abuse is the only problem you need to focus on", while well-intentioned, can be perceived as invalidating of clients' trauma history (Najavits, 2002c). The 12-step approach of Alcoholics Anonymous that dominated 20th century treatment of substance abuse has been very helpful for many (Fletcher, 2001). However, clients and clinicians report that when a client has PTSD, becoming abstinent is a bigger hurdle and such traditional methods may not work as well (Ruzek, Polusny, & Abueg, 1998; Solomon, Gerrity, & Muff, 1992). The tendency for PTSD memories and feelings to worsen with abstinence is a common phenomenon, for example (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Kofoed, Friedman, & Peck, 1993). Similarly, in the mental health field, messages such as "We can't treat you if you have a substance abuse problem", or more commonly, neglecting to even ask about it, have left clients without adequate attention to their substance abuse. Sadly, clients with this dual diagnosis have worse outcomes than those with either disorder alone (Ouimette, Brown, & Najavits, 1998; Ouimette, Finney, & Moos, 1999), and may internalize a sense of failure when they do not succeed in standard treatment programs that work for others. Feeling "crazy, lazy, or bad" is common-- a sense that something is terribly wrong with them without knowing why, as well as demoralization and self-blame (Najavits, 2002c). Families and treaters

at times may convey such messages as well: "That event happened 20 years ago-- move on already", or "You're just trying to avoid your addiction problem by talking about the past".

PTSD offers a framework that many clients and clinicians find helpful. Like a new lens that honors what clients have lived through, it encourages empathy and self-understanding, and may increase their motivation for abstinence. It can be reassuring to realize that they may have abused substances as an attempt to cope with overwhelming emotional pain, and to recognize how common this pattern is. This understanding can move them beyond the revolving door of just more treatment, into different treatment. Instead of cycling back through another round of standard treatment, it goes down a new path. As one client said, "I was relieved to find I had something with a name. I thought it was just me-- I'm crazy. But I can deal with this now...Now I can put down the cocaine and work on what's behind it" (Najavits, 2002d). Unlike some diagnostic labels, "PTSD" tends to be well-received. Indeed, clients express a clear preference to include treatment of PTSD in substance abuse treatment (Brown et al., 1998; Najavits, Sullivan, Schmitz, Weiss, & Lee, in press). Most of all, evidence thus far suggests that working on PTSD and substance abuse in an integrated fashion results in positive outcomes in both of these disorders, as well as related areas. Contrary to older views, studies show that treating both PTSD and substance abuse at the same time helps clients with their addiction recovery, rather than derailing them from attaining abstinence (Brady, Dansky, Back, Foa, & Caroll, 2001; Hien, Cohen, Litt, Miele, & Capstick, under review; Najavits, Schmitz, Gotthardt, & Weiss, under review; Najavits, Weiss, Shaw, & Muenz, 1998; Triffleman, 2000; Zlotnick, Najavits, & Rohsenow, in press).

However, one of the major misconceptions at this point is that PTSD treatment necessarily means "digging up" trauma memories-- telling the story of what happened, and processing the past. For someone with active substance abuse, there remain significant questions about when, how, and whether to do such trauma processing work. Such treatments go by many names, including exposure therapy (Foa & Rothbaum, 1998), eye movement

desensitization and reprocessing (Shapiro, 1995), mourning (Herman, 1992), the counting method (Ochberg, 1996), and cognitive processing therapy (Resick & Schnicke, 1993). Such treatments are an important clinical tool and have shown efficacy for PTSD alone (Foa, Keane, & Friedman, 2000). However, in the context of active addiction, they may be problematic. They may be too emotionally upsetting when clients do not yet have adequate coping skills to control their impulses. Concerns repeatedly expressed in the literature are that clients may use substances more, may relapse (if already abstinent), or may increase dangerous behaviors such as self-harm or suicidality (Ruzek et al., 1998; Solomon et al., 1992; Keane, 1995). Opening up the "Pandora's box" of trauma memories may destabilize clients when they are most in need of stabilization. Clients themselves may not feel ready for trauma processing early in substance abuse recovery. In a study of exposure therapy by Brady et al. (2001), for example, 61.5% did not complete the minimum dose of treatment. Interestingly, however, the 38.5% who were able to engage improved in both substance abuse and PTSD symptoms (although it should be noted that the study ruled out clients with suicidal ideation, thus likely selecting a less severe sample).

An alternative to trauma-processing models that delve into the past are cognitive-behavioral therapy (CBT) coping skills models that focus on the present. Such models provide psychoeducation, teach clients how to decrease symptoms when they flare up, and help them gain control over current life problems. The idea that early recovery treatment should focus on stabilization and safety has been consistently recommended separately in both the PTSD (Herman, 1992) and substance abuse literatures (Kaufman & Reoux, 1988). It is noteworthy that studies that have directly compared trauma-processing models with CBT models show them to be equally helpful (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998), although such comparison studies have not yet been conducted in substance abuse samples. In short, it is not yet clear which clients may benefit from either or both approaches. The field is young in its understanding of these complex issues.

The *Seeking Safety* therapy

Seeking Safety fits into the category of present-focused, coping skills approaches. It was developed as an integrated treatment for PTSD/substance abuse that can be used in early recovery from both disorders. It does not require the client to delve into the past, although it can be combined with trauma-processing methods. (Indeed, one study, under "Empirical Evidence" below, offers positive outcomes for this combination.)

Seeking Safety is described in a treatment manual that offers both a therapist guide and extensive client handouts (Najavits, 2002c). A recent book chapter also provides a summary (Najavits, 2002b). The *Seeking Safety* website www.seekingsafety.org provides sample topics, articles, and other materials that can be directly downloaded. The treatment was first described in a 1996 paper (Najavits, Weiss, & Liese, 1996), although the treatment evolved considerably since then: from an initial focus on women to both genders; from group modality to individual as well; and from outpatient to a variety of settings. The therapy was developed over a ten-year period beginning in the early 1990's under an initial grant from the National Institute on Drug Abuse. An iterative process was used, such that clinical experience with this dual diagnosis population was the basis for various versions of the manual over time, resulting in the final published version in 2002. Below, the treatment is described, empirical results are summarized, and implementation suggestions are offered.

Key Features of *Seeking Safety*

Core principles

The treatment is based on five central ideas:

(1) Safety as the priority of treatment. The title "Seeking Safety" expresses its basic philosophy: when a person has both substance abuse and PTSD, the most urgent clinical need is to establish safety. Safety is a broad term that includes discontinuing substance use, reducing suicidality and self-harm behavior, ending dangerous relationships (such as domestic abuse and drug using friends), and gaining control over symptoms of both disorders. In

Seeking Safety, safety is taught through *Safe Coping Skills*, a *Safe Coping Sheet*, a *Safety Plan*, and a report of safe and unsafe behaviors at each session, for example.

(2) Integrated treatment. Seeking Safety is designed to treat PTSD and substance abuse at the same time. An integrated model is recommended as more likely to succeed, more sensitive to client needs, and more cost-effective than sequential treatment of one disorder then the other (Abueg & Fairbank, 1991; Evans & Sullivan, 1995). In *Seeking Safety*, integrated treatment includes helping clients understand the two disorders and why they so frequently co-occur; teaching safe coping skills that apply to both; exploring the relationship between the two disorders in the present (e.g., using drugs to cope with trauma flashbacks); and teaching that healing from each disorder requires attention to both disorders.

(3) A focus on ideals. Both PTSD and substance abuse individually, and especially in combination, lead to demoralization and loss of ideals. Thus, *Seeking Safety* evokes humanistic themes to restore clients' feeling 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. For example, the topic *Honesty* combats denial, lying, and the “false self”. *Commitment* is the opposite of irresponsibility and impulsivity. The language throughout emphasizes values such as “respect”, “care”, “integration”, and “healing”. By aiming for what can be, the hope is to instill motivation for the hard work of recovery from both disorders.

(4) Four content areas: cognitive, behavioral, interpersonal, and case management. While *o*riginally designed as a cognitive-behavioral intervention (a theoretical orientation that appears well-suited for early recovery stabilization), the treatment was expanded to include interpersonal and case management domains. The interpersonal domain is an area of special need because PTSD most commonly arises from traumas inflicted by others, both for women and men (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Interpersonal issues include how to trust others, confusion over what can be expected in relationships, and the need to avoid reenactments of abusive power. Similarly, addiction is often perpetuated in relationships. The

case management component offers help obtaining referrals for problems such as housing, job counseling, HIV testing, domestic violence, and childcare.

(5) *Attention to clinician processes*. It can be a challenge to provide effective therapy to clients with this dual diagnosis, who are often considered "difficult." Clinician processes emphasized in *Seeking Safety* include compassion for clients' experience; using coping skills in one's own life; giving the client control whenever possible (to counteract the loss of control inherent in both trauma and addiction); meeting the client more than halfway (e.g., doing anything possible within professional bounds to help the client get better); and obtaining feedback about how clients view the treatment. A balance of praise and accountability are also suggested. The opposite of such positive therapist processes are negative processes such as harsh confrontation, sadism, difficulty holding clients accountable due to misguided sympathy, becoming "victim" to the client's abusiveness, and power struggles.

Twenty-five topics

Seeking Safety offers 25 treatment topics, each with a clinician guide and client handouts. The seven interpersonal topics are: *Asking for Help, Honesty, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Healing from Anger,* and *Getting Others to Support Your Recovery*. The seven behavioral topics are: *Detaching from Emotional Pain: Grounding, Taking Good Care of Yourself, Red and Green Flags, Commitment, Coping with Triggers, Respecting Your Time,* and *Self-Nurturing.* The seven cognitive topics are: *PTSD: Taking Back Your Power, Compassion, When Substances Control You, Recovery Thinking, Integrating the Split Self, Creating Meaning,* and *Discovery*. In addition, four combination topics are: *Introduction to Treatment / Case Management, Safety, The Life Choices Game (Review),* and *Termination.*

A balance of structure and flexibility

Seeking Safety has a structured session format, to make the best use of time available. The structure includes a check-in, quotation (to emotionally engage clients), handouts, and

check-out. The goal is to counteract the impulsivity and chaotic nature of both disorders with a process that emphasizes planning, pacing, and predictability. However, the treatment was also designed to be extremely flexible to adapt to clients' needs, clinicians' preferences, and a variety of treatment contexts. Thus, diverse topics and handouts are offered, from which clients and/or clinicians select the order of topics as well as which handouts to read. Each topic is independent of the others, to allow for clients to enter or leave treatment at different times, and for shorter or longer time frames. See the section Implementation below for a description of how the treatment has been conducted in different formats.

A treatment for women and men

The treatment was originally designed for women (Najavits et al., 1996), but later expanded to men. In two existing studies that included men, both evidenced high client satisfaction (Najavits, Schmitz et al., under review; Cook, Woody & Kane, under review). Feedback in clinical programs also shows high acceptability in both genders, as well as in the clinicians treating them (personal communications: V. Brown, C. Smith, B. Burchfield, J. Hallisey, L. Holdcraft, J. Harvey, J. Cook, C. Smith, T. North, R. Walser). The manual has examples using both women and men, and a variety of traumas (e.g., child abuse, crime victimization, combat).

Other features

Other features, described in the *Seeking Safety* treatment manual, include a focus on simple, human language and themes (i.e., accessible language that avoids jargon); treatment methods that are based on educational strategies to increase learning; a focus on potential; emphasis on practical solutions; and an urgent approach to time. The manual also describes how the treatment differs from existing treatments, such as dialectical behavior therapy, relapse prevention, and other comparable therapies.

Empirical Evidence

Seeking Safety was the first treatment for the dual diagnosis of PTSD/substance abuse with published outcome results, and at this point has been studied more than any other approach (Najavits, 2002b). Seven outcome studies have been completed thus far on a variety of samples, with all evidencing positive results: outpatient women using group modality (Najavits et al., 1998); women in prison, in group modality (Zlotnick et al., in press); low-income mostly minority women, in individual format (Hien et al., under review); adolescent girls, in individual format (Najavits, Gallop & Weiss, under review); outpatient men traumatized as children, in individual format (Najavits, Schmitz et al., under review); women in a community mental health setting, in group format (Holdcraft & Comtois, in press); and finally, men and women veterans, in group format (Cook et al., under review). In all six studies that reported on substance abuse, improvements were found in that domain (i.e., only Cook et al., under review, did not assess for it). Similarly, all six studies that included assessment of PTSD and/or trauma-related symptoms found improvements those areas (only Holdcraft & Comtois, in press, did not measure this domain as the sample were general dual diagnosis clients rather than PTSD specifically). Improvements were also found in a variety of other areas, such as general psychiatric symptoms, suicidal thoughts and plans, problem-solving ability, sense of meaning, social adjustment, quality of life, and depression. Treatment attendance and satisfaction were reported to be high. Four of the studies had follow-up periods after the treatment ended and showed maintenance of some key gains (Hien et al., under review; Najavits et al., 1998; Najavits, Gallop et al., under review; Zlotnick et al., in press). In all of the studies, the clients were severe, i.e., they had the disorders chronically for many years and in most cases were substance-dependent. The studies that addressed PTSD showed most having childhood and multiple traumatization, and typically additional co-occurring Axis I and Axis II disorders. Five of the studies were pilots, while two were randomized controlled trials (Hien et al., under review; Najavits, Gallop et al., under review). In the trial by Hien et al. (under review), *Seeking Safety* performed as well as *Relapse Prevention* treatment (considered a “gold standard treatment” in

the substance abuse field), and both *Seeking Safety* and *Relapse Prevention* significantly outperformed treatment-as-usual in the community (standard substance abuse and mental health treatment). In the Najavits, Gallop et al. study (under review), *Seeking Safety* outperformed treatment-as-usual in the community for outpatient adolescent girls.

Two of the studies combined *Seeking Safety* with other manual-based approaches. The study of men combined *Seeking Safety* with *Exposure-Therapy-Revised*, an adaptation of *Exposure Therapy* for PTSD specifically for substance abuse clients (Najavits, Schmitz et al., under review). Clients were able to decide how many *Seeking Safety* and how many exposure sessions they wanted, on a session-by-session basis; they chose an average of 21 *Seeking Safety* sessions and 9 exposure sessions (highlighting the importance, perhaps, of integrating the two types of models described in the section Background above). The study of women in a community mental health center (Holdcraft & Comtois, in press) combined *Seeking Safety* with Linehan's *Dialectical Behavior Therapy.*

Other studies of *Seeking Safety* are currently underway, with larger samples and control or comparison conditions. For a more detailed description of the completed studies, see the website www.seekingsafety.org (section Empirical Studies).

Implementation

Seeking Safety has been implemented in a variety of clinical programs in addition to the research studies described above. The following are some of the most frequently asked questions about how to conduct the treatment in diverse settings. One key feature of the treatment is its flexibility. It was designed to be adaptable to a wide variety of contexts, to meet the clinical reality that programs differ in their needs and structure. However, more research is needed to actually study these issues. At this point, the suggestions below are based on a blend of experience from the research studies and clinical implementation by programs. Note that additional, extensive implementation guidelines are described in detail in published materials, such as the book on *Seeking Safety* (Najavits, 2002c), and an article on training

therapists in the treatment (Najavits, 2000) that can be downloaded from the website www.seekingsafety.org.

Client selection

While the research studies were typically conducted on clients formally and currently diagnosed with both disorders, in clinical practice the range of clients has been much broader. It has included clients with a history of trauma and/or substance abuse, clients with serious and persistent mental illness, clients with just one or the other disorder, and clients with other disorders (e.g., eating disorders). An important consideration is clients' own wish to participate in the treatment. Given the powerlessness inherent in both PTSD and substance abuse, empowerment is key. It appears simplest and best to describe the treatment and then give clients a choice in whether to join. Allowing them to explore the treatment by attending just a few sessions, without obligation to continue, is another helpful method. In general, the idea is to be as inclusive as possible for entry into the treatment, with a plan to monitor clients over time and evaluate whether it appears helpful to them. Thus far, there do not appear to be any particular client readiness characteristics or contraindications that are easily identified. As the treatment is focused on safety, coping, and stabilization, it is not a treatment that is likely to destabilize clients and thus has been implemented quite broadly. Similarly, clients do not need to attain stabilization before beginning; it was designed for use from the start of treatment. If a client has addictive or impulsive behavior in addition to substance abuse (e.g., cutting, bingeing, gambling), clients are guided to apply the "safe coping skills" taught in *Seeking Safety* to those behaviors (while also being referred out to specialized treatment for such problems as part of the case management component).

Clinician selection

The most essential characteristics for selecting clinicians to conduct *Seeking Safety* are (1) their wish to work with this client population, and (2) their willingness to use a manual-based treatment. Originally, various criteria were sought, such as a mental health degree (e.g., PhD or

LICSW) and particular types of training (e.g., CBT, substance abuse). But what became clear over time was that far more important than any of these professional credentials were the more subtle, subjective criteria mentioned above (Najavits, 2000). Clinicians who genuinely enjoy working with these clients-- often perceiving their work as a "mission" or calling-- bring to the work a level of commitment that no degree per se can offer. Similarly, clinicians who are open to the value of a treatment manual, viewing it as a resource that can help improve the quality of the work, are able to make the best use of the material. Because there are no strict criteria for therapist selection (such as degree or training), the treatment may be widely applicable to a range of settings and clinicians. Many substance abuse programs, for example, do not have staff with advanced degrees or formal CBT training. Because the treatment focuses on stabilization rather than trauma processing, it does not appear to exceed the training, licensure, or ethical limits of substance abuse counselors. However, they are guided to refer out for specialized professional mental health treatment if clients exceed the parameters of their work (e.g., dissociative identity disorder). Per the manual (Najavits, 2002c), it is also suggested that if a clinician does not have any prior background in PTSD, substance abuse, or CBT, some training and/or supervision on these should be sought as needed.

Several additional suggestions can be offered for selecting a *Seeking Safety* clinician. These are described in a protocol that can be downloaded from the website www.seekingsafety.org (see the section Clinician Selection). Briefly, it involves a "try-out" to determine whether the potential clinician is a good match for the treatment. The potential clinician conducts one or two audiotaped sessions using the manual with a real client, with the sessions rated by the client as well as evaluated on the *Seeking Safety* adherence scale. Once hired, methods for training the clinician are described in an article (Najavits, 2000), as well as in the *Seeking Safety* manual. A recent study exploring clinicians' views on treating clients with this dual diagnosis might also be relevant (Najavits, 2002a). All articles can be downloaded from the website (see the section Articles).

Application to different formats

As mentioned earlier, the treatment was designed to be highly adaptable to different contexts. In research, it has shown positive results in both individual and group formats; in both women and men; in sessions of one hour and 1.5 hours; in outpatient, inpatient, and prison settings; in 50 and 90-minute sessions; in open and closed groups; and with singly and co-led groups (Cook et al., under review; Hien et al., under review; Holdcraft & Comtois, in press; Najavits, Gallop et al., under review; Najavits, Schmitz et al., under review; Najavits et al., 1998; Walser, 2002; Zlotnick et al., in press). The time frame in research thus far has typically been 25 sessions over three months (twice-weekly treatment), but clinically has also been implemented once weekly, three times per week, or a blend (e.g., twice weekly then once weekly). The length of treatment also varies: for example, a client on an inpatient unit may have time for only three sessions, and thus just one or a few topics might be covered. In a long-term residential program, each topic might be covered over two or three sessions, for a much longer time frame. Some programs have created two blocks of 12 sessions each; while others have allowed clients to cycle through the entire treatment multiple times (personal communications: V. Brown, S. Cadiz, N. Finkelstein, 9/24/02). As all of the *Seeking Safety* topics can be conducted in any order and independently of each other, clients do not have to be available for the full treatment, but can use whatever time is available to them. Clients can join or leave at any point, and if conducted in group modality, open groups are thus typically best for most settings. However, it is recommended that topic *1a Introduction / Case Management* be conducted as the first session to orient the client to the treatment. Also, if a client is joining an open group once it has already begun, it may also be important to conduct the topic *PTSD: Taking Back Your Power* prior to the client entering the group, so that s/he will be aware of what PTSD is. For group treatment, if clients miss a session, they are offered the handouts from it, if desired, as a way to keep up with the group. Suggestions for how to select the order of topics is provided in the manual (Najavits, 2002c). Clients are not discontinued from the treatment

unless they are a direct threat to other clients or staff (e.g., assaultive, selling drugs). Rather, an "open door" policy prevails: they are welcomed back at any time, a position advocated in early recovery (Herman, 1992). Similarly, there are no particular coping skills or topics clients must master, but rather they are offered a wide variety from which to choose what works for them. The goal is to "go where the action is"-- to use the materials in a way that adapts to the client, the clinician, and the program. With a complex dual diagnosis population such as this, a stance of flexibility appears key (Najavits, 2001).

Best methods for teaching the Seeking Safety *skills*

A natural tendency is for clients to discuss a skill at length. For example, the topic *Honesty* may generate insights and extensive discussion. This can be helpful, but to take the work to a higher level, it is suggested that *rehearsal* of the skill also occur. Thus, the clinician would role-play scenarios with clients that involve honesty and would apply honesty to specific situations that arose recently (e.g., "When you last felt like using cocaine, were you honest with anyone about that? Whom did you tell?"). For every skill, several ways of rehearsing are offered in the manual to promote generalization, i.e., actually using the skills in real life when they are most needed. Related to this is the importance of asking clients, "How did you try to cope?". By guiding clients to repeatedly notice how they did or did not cope well with recent situations, improved awareness and skills can develop. Relating the skills back to both target disorders, PTSD and substance abuse, is also helpful. Thus, the clinician might ask, "Why do you think it might be hard to be honest if you have a history of PTSD and substance abuse?" Helping clients notice the link between the disorders and their current skills deficits can aid recovery. Finally, exploring childhood messages can deepen the work. For example, "What messages did you learn, growing up, about honesty?" Note that this does not ask clients to reveal details of trauma, but it does ask them to see how childhood and family messages may have strongly impacted their development.

Typical difficulties

One of the most common clinician difficulties is talking too much or lecturing clients. In keeping with the goal of deep-level learning, an "80/20 rule" is suggested; that is, clients talk 80% of the session, and clinicians 20%. This preserves the session feeling like therapy rather than school, and promotes success by having the clinician listen closely enough to clients to help solve their problems in a realistic way. When the clinician does not listen sufficiently interventions tend to be less effective and more simplistic. Thus too, clinicians are encouraged to use the treatment's coping skills in their own lives, which gives a personal understanding of how the skills may or may not work.

A second major difficulty is not following the structure of the treatment. While *Seeking Safety* is highly adaptable and flexible, it nonetheless asks clinicians to follow a structured format. This format was based on empirical testing over many years in different populations. Even the wording of check-in questions, for example, was tested in different versions to identify ones that worked best. For example, the question "What is the main point of the quotation" focuses the client on understanding the idea in the quotation. Clinicians often change the wording to "What does the quote mean to you?" While this seems like a minor change, in fact it can lead clients to free-associate about the quotation, which results in a much longer and less effective use of it. Similarly, "What good coping have you done since the last session" was tried as "What *safe* coping…" and "What *positive* coping…", neither of which worked as well. Thus, clinicians are asked to start by conducting the structure as planned, and only adapt it if clients' provide negative feedback about it. In the projects thus far using *Seeking Safety, c*lients have reportedly liked the structure, and they learned it quickly with minimal instruction. Clinicians, however, particularly those who are not used to using a treatment manual, have needed more time and effort to adjust to it.

Finally, a third issue is staying "real". Because the treatment emphasizes validation, support, and empathy for clients' difficult trauma histories, clinicians sometimes over-do these, at the expense of growth, constructive feedback, awareness of anger, and limit-setting. For

example, when a client does a role-play, clinicians will sometimes offer just praise, rather than feedback on both strengths and weaknesses. Yet growth-oriented feedback is essential for clients to improve. Another example is owning anger-- both seeing it in clients and in oneself. In the topic *Healing from Anger* it is suggested that clients' anger is inevitable in recovery from PTSD and substance abuse, and that it is a common countertransference reaction in clinicians as well. Yet in an attempt to be sympathetic, clinicians sometimes ignore or repress anger to a degree that is unhelpful. For example, a client may continually reject every suggestion offered to her, yet the clinician keeps offering additional ideas to placate the client, rather than processing the dynamic of anger that typically underlies this "help-rejecting" client stance.

Diversity issues (e.g., gender, ethnicity, race)

Before *Seeking Safety* was published, it was conducted with a variety of clients, including two studies on largely minority samples (Hien et al., under review; Zlotnick et al., in press), both women and men, and clients with a variety of trauma histories (e.g., child abuse, combat, and crime victimization). The language and examples in the book were written to reflect these diverse experiences, and to include mention of racism, poverty, sexism, and both male and female names and examples. Moreover, the treatment has obtained high client satisfaction ratings in all of these subgroups. However, it is suggested that clinicians who work with a particular subgroup may benefit from adding in even more to make the treatment engaging to them by using examples from their lives, incorporating cultural elements relevant to them, and discussing their particular pressures and burdens. In the treatment of men, for example, a discussion of how trauma violates the traditional masculine role may be important (e.g., issues of "weakness" and vulnerability). In the treatment of Latinas, verbalizing the material in Spanish and providing cultural context may be helpful (e.g., acculturation stress, and concepts such as "familismo" and "marianismo"). In the treatment of gay, lesbian, bisexual or transgendered clients, discussion of homophobia may be central. If clients are illiterate,

summarizing the material for them briefly, or having literate clients read small sections out loud in group are methods that have been used.

Considerations for group treatment

Several issues are notable when conducting the treatment in group format. First, the name of the group can make a difference. One program initially called their group "Trauma Group" and few clients wanted to attend. When they renamed it "Seeking Safety Group" the attendance improved considerably. If the group title includes the term "trauma" or "PTSD", clients may fear that they will be asked to describe their traumas or will have to listen to others do so, and may not feel ready for that. If it has a more upbeat title, they feel more reassured. Thus, it can be called "Safety Group", "Seeking Safety", or "Coping Skills" for example. Second, the number of group members should be planned carefully. Keeping in mind that the check-in allows up to five minutes per client (although it often goes quicker) and that the average group is 1 hour in length, having five clients is workable as it allows up to 25 minutes of check-in. For longer sessions, such as 1.5 hours, more clients can be added. However, adaptability is important here too. One residential program, for example, decided to conduct very large groups with 30 clients and to make the treatment psychoeducation rather than therapy (thus leaving out the check-in and check-out), as clients already had other small groups where they received more personal attention. Third, because *Seeking Safety* focuses on trauma, the tone of the group may be different than typical substance abuse groups. In the latter, confrontation may be accepted (e.g., a client may tell another that she is "in denial", "not facing her addiction", or "being too self-pitying"). In *Seeking Safety* such statements would be seen as detracting from the emotional safety of the group. The clinician is asked to train clients to focus on their own recovery work, and to interact primarily in supportive and problem-solving ways rather than confrontational ways. Fourth, single-gender groups are the most common way of implementing the treatment, as much trauma was sexual or physical in nature and clients are likely to feel more comfortable with others of the same gender. However, *Seeking Safety* has been

implemented with mixed-gender groups as well, but only when none of the clients had a major history as perpetrators (which could be too triggering), and only when clients agreed to join a mixed-gender group. The clinicians too have typically been the same gender as the client, although it can be argued that having a leader of the opposite gender can create positive new experiences that may be healing for trauma survivors (Chu, personal communication). Finally, as noted earlier, the treatment has shown positive outcomes both in open and closed group formats, and both singly-led and co-led.

The importance of trauma information for all staff

Even for staff who are not actually conducting *Seeking Safety*, services can be enhanced by educating all staff on trauma and PTSD. This represents the goal of "trauma-informed" services (Fallot & Harris, 2001) or "dual diagnosis enhanced" services (American Society of Addiction Medicine, 2001; Minkoff, 2002). *Seeking Safety* can be used in two specific ways. First, some of the material can be used to educate personnel about trauma and PTSD so that their routine interactions with clients can be more empathic. Of most relevance are Chapter 1 of the manual, which describes the rationale for integrated treatment of the dual diagnosis, the topic *PTSD: Taking Back Your Power*, which identifies the signs of PTSD; and the topic *When Substances Control You*, which explores the link between trauma and substance abuse. Second, a few of the key skills can be taught to all staff who attend to clients while not necessarily treating them, such as night staff of an inpatient or residential program, and mental health aides. Some suggested key skills are *Detaching From Emotional Pain (Grounding)*, *Asking For Help,* and *Coping with Triggers.* Role-playing how to respond to clients who are agitated or dissociating may be important, as are modifying the treatment setting, within reason, to adapt to trauma survivors. For example, as one survivor writes, "Realize that the woman who keeps her light on all night is not treatment resistant because she will not turn out her light. She is terrified of the dark because that is when her father used to come into her room and rape her"

(Bjelajac, 2002). Thus letting her keep lights on may be a reasonable adaptation that is respectful of her.

Additional implementation suggestions are offered elsewhere. These include: (1) how to integrate trauma processing therapy with *Seeking Safety* (see chapter 2 of the manual, and the paper (Najavits, Schmitz et al., under review); (2) emergency procedures (see chapter 2 of the manual); (3) process issues (see chapter 2 of the manual and the article on training (Najavits, 2000); and (4) a detailed description of the *Seeking Safety* format (see chapter 2 of the manual).

Conclusion

Seeking Safety was designed to help clients and clinicians explore the link between trauma/PTSD and substance abuse, but without delving into extensive details about the past that may be de-stabilizing during early recovery. Its goal is to provide a present-focused, empathic approach that "owns" and names the trauma experience, helps validate the connection to substance abuse, and provides specific safe coping skills to manage the often-overwhelming emotions and impulses of this dual diagnosis. Implementation issues were the focus of this paper, including selection of clients and clinicians, typical difficulties, different formats, methods of teaching, diversity issues, group modality, and the importance of trauma information for all staff. Several studies of *Seeking Safety* have shown promising results, but more empirical research is needed. The hope is that over time, further insights from both the clinical and research domains can help improve services for a population greatly in need.

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[i] The term “substance abuse” is used throughout this paper as it is the most commonly used term; however, all of the material applies to “substance use disorders” (the DSM-IV term).