
7

SEEKING SAFETY:
AN EVIDENCE-BASED MODEL FOR SUBSTANCE ABUSE AND TRAUMA/PTSD

LISA M. NAJAVITS
Harvard Medical School
Boston, Massachusetts

INTRODUCTION

When I was twelve I had my first drink, and I knew immediately this was my answer. I felt relaxed for the first time in my life. I became an instant alcoholic.

Nate had been abused by both parents as far back as he can remember, with relentless physical, sexual, and emotional abuse. By the time he was in junior high school he had a history of repeated fights, and was abusing alcohol. In adulthood he was dependent on heroin and marijuana. He sometimes lived in the woods, homeless. He had several serious suicide attempts, cycled through jail sentences and treatment programs, and was labeled antisocial. Until his mid-40s no one had identified his posttraumatic stress disorder (PTSD).

There are innumerable client stories, many different types of trauma, substance use, and paths of survival. However, it is clear that PTSD and substance use disorder (SUD) are closely linked for many. Trauma—defined by the DSM-IV (American Psychiatric Association, 1994) as the experience, threat, or witnessing of physical harm—comprises a variety of experiences. These include combat, childhood physical or sexual abuse, serious car accident, life-threatening illness, natural disasters such as hurricane or tornado, and manmade disasters such as terrorist attack and chemical spill. Most people in the United States experience one or more traumas during their lifetime, with rates at 60 percent for men and 50 percent for women (Kessler et al., 1995). Yet, remarkably, most
people who suffer a trauma do not go on to develop PTSD. For the approximately 20 to 30 percent of people who develop PTSD after trauma (Adsehead, 2000), their symptoms cluster into three categories: (1) reexperiencing (e.g., flashbacks and nightmares); (2) avoidance (e.g., detached feelings and a wish to avoid talking about the trauma); and (3) arousal (e.g., anger, sleep problems, and exaggerated startle response). Persistence of these symptoms for more than one month and marked decline in functioning are also required for the diagnosis.

In the United States, among men who develop PTSD, 52 percent develop alcohol use disorder and 35 percent develop drug use disorder; among women, the rates are 28 percent and 27 percent (Kessler et al., 1995; see also Breslau, Davis & Schultz, 2003; Chilcoat & Breslau, 1998; Coster et al., 1992). In clinical settings, the rates of co-occurring PTSD and SUD are even higher (Najavits et al., 1997). Moreover, various subgroups have particularly high rates of PTSD and SUD, such as adolescents, veterans, prisoners, gay/lesbian/transgendered/bisexual, the homeless, rescue workers such as firefighters and police, victims of domestic violence, and prostitutes (Najavits, 2006).

The clinical needs of this population are urgent and serious. Research consistently shows that those with the dual diagnosis of PTSD and SUD, compared to those with either disorder alone, have worse treatment outcomes; more positive views of substances; more Axis I and II disorders; increased legal and medical problems, HIV risk, self harm, and suicidality; lower work and social functioning; and increased rates of future trauma (Brady, Killean, Saladin, Dansky & Becker, 1994; Cohen & Hien, 2006; Hien, Nunes, Levin & Fraser, 2000; Najavits, Gastfriend et al., 1998; Ouimet, Finney & Moos, 1999).

Historically, treatment of the dual diagnosis has been marked by a separation that only lately has begun to improve. A culture of “other” predominated, in which mental health clinicians typically believed they could not treat SUD, and many SUD clinicians believed they could not treat PTSD (Najavits, 2002c; Read et al., 2002). There is now growing awareness that a no-wrong-door approach is most likely to be helpful (Clark, 2002). Clients need attention to both disorders regardless of how they enter the treatment system. Split systems, in which a client who uses substances is turned away from mental health treatment until abstinent, or the client with mental health problems is rejected from SUD treatment until stabilized, are believed less effective than integrated or simultaneous treatment (K. T. Brady, 2001; Ouimet & Brown, 2002). Yet older messages abound, such as “Just get clean and sober first,” “Go to Alcoholics Anonymous or I won’t treat you,” or “You’re defocusing from your addiction if you talk about the past.” Clinicians in many settings fail to assess for trauma, PTSD, and SUD. Indeed, under-diagnosis or misdiagnosis of both PTSD and SUD remain common (Davidson, 2001; Najavits, 2004a), and most SUD clients are neither assessed for PTSD nor given treatment for it (P. J. Brown et al., 1998; Dansky et al., 1997; Hyer et al., 1991; Najavits, 2004a). Clients also tend to minimize both SUD and PTSD, sometimes out of shame, guilt, or denial.
develop PTSD. For the approximately 14% of individuals who develop PTSD after trauma (Adashe, 2000), with (1) reexperiencing (e.g., flashbacks, nightmares, intrusive thoughts) and (2) avoidance (e.g., sleep problems, anxiogenic symptoms for more than one month) are the hallmark symptoms required for the diagnosis.

Developing PTSD, 52% of patients meet criteria for substance use disorder; among women, the rates are even higher (Najavits et al., 2006). In clinical practice, PTSD and SUD are even higher (Najavits et al., 2006). PTSD patients have particularly high rates of PTSD and SUD symptoms in firefighters and police, victims of PTSD, and SUD, compared to treatment outcomes; more positive disorders; increased legal and medical utilization; lower work and social function. Brady, Killeen, Saladin, Dansky & D'Onofrio, 2000; Finney & Moos, 1999).

PTSD has been marked by a separation of “other” predominate, believed they could not treat SUD, and not treat PTSD (Najavits, 2002c). Readiness to seek treatment and believe in this approach is a necessary step. Yet, older messages abound, such as “An anonymous or I won’t treat you if you talk about the past.” Clinicians, PTSD, and SUD. Indeed, underdiagnosis of SUD remains common (Davidson et al., 2003), and the need for more comprehensive assessment of PTSD and SUD is essential. Najavits et al., 1997; Hyer et al., 2002d, to minimize both SUD and PTSD.

A major effort over the past few years has been the development of integrated therapies for PTSD and SUD. It is now widely recommended to work on both disorders from the start of treatment (K. T. Brady, 2001; Najavits et al., 1996; Ouimette & Brown, 2002). Clients also prefer to include treatment of PTSD in their SUD treatment (P. J. Brown et al., 1998; Najavits et al., 2004). Moreover, research indicates that integrated treatment models for PTSD and SUD show positive outcomes. Treating PTSD and SUD at the same time helps clients with addiction recovery, rather than derailing them from abstinence (e.g., K. Brady et al., 2001; Donovan et al., 2001; Hien et al., 2004; Najavits et al., 1998, 2005; Triffleman et al., 2000; Zlotnick et al., 2003).

PTSD treatment offers a depth that many SUD clients and clinicians find helpful. It honors what clients have lived through, encourages self-awareness, and may increase motivation and reduce relapse. It can reassure clients to learn that they may have used substances to cope with overwhelming emotional pain, and that this is a common pattern. Such understanding can move them beyond the revolving door of just more treatment, into different treatment. Rather than cycling back to 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, 2002).

OVERVIEW OF TREATMENT

Seeking Safety (Najavits, 2002c) was developed beginning in the early 1990s to help meet the needs of those dually diagnosed with PTSD and SUD. It was the first empirically studied treatment for the dual diagnosis (Najavits et al., 1998), and remains the most empirically studied model thus far (Najavits, in press). Seeking Safety is present-focused and specifically designed for early recovery. Its central goal is to help clients attain safety from both PTSD and SUD. The treatment is available as a book (Najavits, 2002c), providing clinician guidelines and client handouts. It was designed for group and individual format, males and females, a variety of settings (e.g., outpatient, inpatient residential), and the full range of substance use disorders and types of trauma. Seeking Safety has also been used in practice with a wide variety of clients (e.g., those with just PTSD or SUD but not both, those with a history of one or the other, and those with other disorders). It has been studied with both adults and adolescents. Seeking Safety offers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. However, one does not have to use all 25 topics.

The term “substance abuse” is sometimes used, as in the title to this chapter, as it is more common. But the model was designed for the full range of substance use disorders, from abuse to dependence.
but rather can use as few or as many as time allows. In general, the treatment was designed for a high level of flexibility—topics can be done in any order, clients can join at any point, and a wide variety of counselors can conduct it (e.g., paraprofessionals and professionals).

The treatment was first described in a paper (Najavits et al., 1996), but evolved considerably after that: from an initial focus on women to both genders; from group format to individual as well; and from outpatient to a broader array of settings. The model was developed beginning in the early 1990s under National Institute on Drug Abuse grants. Clinical and training experiences led to various versions of the manual, with the final published version in 2002. In this chapter, the treatment is described in more detail, its empirical results are reviewed, implementation and assessment considerations are offered, and it is compared to relapse prevention.

KEY ELEMENTS

SAFETY

The title of the treatment—Seeking Safety—expresses its central idea: When a person has both active substance abuse and PTSD, the most urgent clinical need is to establish safety. “Safety” is an umbrella term that signifies various elements: safety from substances; safety from dangerous relationships (including domestic violence and drug-using friends); and safety from extreme symptoms, such as dissociation and self-harm. Many of these self-destructive behaviors reenact trauma—having been harmed through trauma, clients are now harming themselves. “Seeking safety” refers to helping clients free themselves from such negative behaviors and, in so doing, to move toward freeing themselves from trauma at a deep emotional level.

Throughout the treatment, safety is addressed over and over. For example, there is the topic Safety, a list of over 80 Safe Coping Skills, a Safe Coping Sheet to explore recent unsafe incidents, a Safety Plan to identify stages of danger, a Safety Contract, and a report of unsafe behaviors at each session’s check-in. The idea is that, no matter what happens, clients can learn to cope in safe ways—without substances and other destructive behavior.

The treatment thus fits what has been described as first-stage therapy for both PTSD and SUD. Experts within both fields have independently described an extremely similar first stage of treatment, titled safety or stabilization, that prioritizes psychoeducation, coping skills, and reducing the most destructive symptoms (Herman, 1992; Kaufman & Reoux, 1988). Later stages, again quite similar for the two disorders, are conceptualized as mourning (facing one’s past by exploring the impact of trauma and substance abuse) and reconnection (attaining a healthy engagement with the world through work and relationships) (Herman, 1992). The first stage, safety, is an enormous therapeutic task for some clients, and thus the Seeking Safety model addresses only that stage.
A VARIETY OF TOPICS

The treatment provides 25 topics to help clients attain safety (see Table 7.1 for a description of each topic). The clinician can choose as few or as many topics as fits the treatment context, depending on length of stay, client need, and clinician preferences. Similarly, each topic can be done in one session or extended over several sessions. Each topic addresses both trauma/PTSD and SUD. Topics are evenly divided among cognitive, behavioral, and interpersonal domains, with a clinician guide and extensive 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, the four combination topics are Introduction to Treatment/Case Management; Safety, The Life Choices Game (Review); and Termination.

PRESENT FOCUS

Seeking Safety was created as a present-focused model, given repeated concerns in the literature that SUD clients may worsen if guided to explore past trauma (e.g., telling the trauma story). Such past-focused PTSD treatment is a major treatment intervention for PTSD and goes by names such as exposure therapy (e.g., Foa & Rothbaum, 1998), eye movement desensitization and reprocessing (Shapiro, 1995), and mourning (Herman, 1992). Research shows that both present- and past-focused PTSD models work, and they achieve equivalent outcomes (Najavits, in press). Thus, the clinician and client have considerable choice and may elect to do both types of treatment (perhaps in sequence or simultaneously), or may choose just present- or just past-focused therapy (Coffey et al., 2002; Najavits et al., 2005). In general, it is recommended that the clinician carefully evaluate whether the substance abuse client needs a period of stable abstinence and functionality before beginning past focused PTSD treatment, and to consider whether it is even needed or desired by the client (Chu, 1988; Keane, 1995; Ruzeck et al., 1998; Solomon et al., 1992). The special consideration for SUD clients is based on concerns that they may not yet have adequate coping skills to control their impulses. Clients may use substances more, relapse (if already abstinent), or increase dangerous behaviors such as self-harm or suicidality (Keane, 1995; Ruzeck et al., 1998; Solomon et al., 1992). 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 SUD recovery; others may want to talk about the past but may underestimate the impact of uncovering intense emotions and disturbing memories.
TABLE 7.1: Resources on Seeking Safety

Book
Najavits, L. M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford. Published as a book in English and Spanish. The book includes all materials needed to conduct the treatment (clinician guide and client handouts). Both the English and Spanish versions of the book can be ordered at www.seekingsafety.org (section Order); the English version can also be ordered from any online or local bookstore (e.g., amazon.com).

Web Site
The web site www.seekingsafety.org has freely downloadable materials (articles, information on training, etc.). The web site includes sections such as:
• About Seeking Safety
• Studies (results of each study of Seeking Safety completed thus far)
• Training (calendar of trainings and information on how to set up a training)
• Articles (downloadable articles on Seeking Safety, PTSD/substance abuse, and other topics)
• Assessment (the Seeking Safety Adherence Scale, and links to other measures)
• Sample Seeking Safety topics
• How to refer clients to local Seeking Safety treatment

Videos
A set of training videos on Seeking Safety are available (from www.seekingsafety.org, section Order). The videos were developed under a grant from the National Institute on Drug Abuse. They are:
• A two-hour training video by Lisa Najavits
• A one-hour example of a Seeking Safety session led by Lisa Najavits with real clients
• A one-hour adherence session with real clients (to learn how to use the Seeking Safety Adherence Scale for supervision or research purposes)
• A demonstration of teaching grounding technique
• One client's story of PTSD and substance abuse

Translation into Spanish
A Spanish translation of Seeking Safety is available (from www.seekingsafety.org, section Store). It was designed for Spanish speakers from North, South, and Central America.

Poster
A professionally produced poster of Safe Coping Skills is also available (from www.seekingsafety.org, section Order). It was developed to help remind clients of safe coping throughout the treatment.

Training
Training and consultation on Seeking Safety has been available since the mid-1990s. The web site www.seekingsafety.org (section Training) provides a training calendar of all upcoming trainings, their location, and contact information for registration. Also, information is provided on how to book a training or consultation.

Adherence Scale
The Seeking Safety adherence scale is freely downloadable (from www.seekingsafety.org, section Assessment). The scale can be used for research and/or supervision to quantify how much a clinician is conducting Seeking Safety per the manual. It offers three sections: format, content, and process, all of which are rated for both adherence and helpfulness.

Implementation Articles
Several articles expand on how to implement Seeking Safety and are freely downloadable (from www.seekingsafety.org, section Articles).

Contact
For further information on Seeking Safety, contact Lisa M. Najavits by e-mail (info@seekingsafety.org), phone (617-731-1501), or mail (12 Colbourne Crescent, Brookline, MA 02445). See also www.seekingsafety.org.
Thus, Seeking Safety focuses on trauma and PTSD directly—but only in the present. Its goal is an empathic approach that names the trauma experience, validates its connection to substance use, provides psychoeducation, and offers specific safe coping skills to manage the often overwhelming emotions of this dual diagnosis. It was designed to help explore the link between them, but without delving into details about the past that might destabilize them. If a client brings up details of trauma during a Seeking Safety session, the clinician is taught to empathically validate the importance of such material, but to remind the client that the treatment is present-focused, that description of trauma details may be overly upsetting for the client (and others if it is a group therapy), and to gently refocus the client on the present and how to cope with whatever is coming up. However, at any point in the treatment clients can share in a brief phrase the type of trauma they experienced (such as child sexual abuse, rape, combat) if they so choose.

INTEGRATED TREATMENT

Seeking Safety was designed to continually attend to both PTSD and SUD. Both are treated at the same time by the same clinician. This integrated model contrasts with a sequential model in which the client is treated for one disorder, then the other; a parallel model, in which the client receives treatment for both but by different treaters; or a single-model, in which the client receives only one type of treatment (Weiss & Najavits, 1997). Integration is, ultimately, an intrapsychic goal for clients as well as a systems goal: to “own” both disorders, to recognize the links between them, and to understand how one disorder triggers the other. The treatment helps clients discover connections between the two disorders in their lives—in what order they arose and why, how each affects healing from the other, and their origins in other life problems (such as poverty). Integration also occurs at the intervention level. Each safe coping skill in Seeking Safety can be applied to both PTSD and SUD. For example, Asking for Help can apply to PTSD (e.g., calling a friend when feeling upset) and to SUD (e.g., asking a partner to stop offering drugs).

A FOCUS ON IDEALS

It is difficult to imagine two mental disorders that each individually, and especially in combination, lead to such demoralization and loss of ideals. In PTSD this loss of ideals has been written about as “shattered assumptions” (Janoff-Bulman, 1992) and the “search for meaning” (Frankl, 1963). With substance abuse there is also a loss of ideals—life narrows and, in its severe form, the person “hits bottom.” Seeking Safety explicitly strives to restore ideals. The title of each topic is framed as an ideal 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 irrespon-
sibility and impulsivity. Taking Good Care of Yourself is a solution for bodily self-neglect. 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 clients can summon the motivation for the incredibly hard work of recovery from the two disorders.

STRUCTURE

The multiple needs, impulsivity, and intense affect of PTSD/SUD clients can lead to detailed sessions if the clinician does not create clear structure. The session structure is described in Table 7.2. It includes a check-in, quotation (for

<table>
<thead>
<tr>
<th>Table 7.2: Seeking Safety Treatment Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Introduction to Treatment/Case management</td>
</tr>
<tr>
<td>This topic covers: (a) Introduction to the treatment; (b) Getting to know the client; and (c) Assessment of case management needs.</td>
</tr>
<tr>
<td>(2) Safety (combination)</td>
</tr>
<tr>
<td>Safety is described as the first stage of healing from both PTSD and substance abuse, and the key focus of the treatment. A list of over 80 Safe Coping Skills is provided and clients explore what safety means to them.</td>
</tr>
<tr>
<td>(3) PTSD: Taking Back Your Power (cognitive)</td>
</tr>
<tr>
<td>Four handouts are offered: (a) &quot;What is PTSD?&quot;; (b) &quot;The Link Between PTSD and Substance Abuse&quot;; (c) &quot;Using Compassion to Take Back Your Power&quot;; and (d) &quot;Long-Term PTSD Problems.&quot; The goal is to provide information as well as a compassionate understanding of the disorder.</td>
</tr>
<tr>
<td>(4) Detaching from Emotional Pain: Grounding (behavioral)</td>
</tr>
<tr>
<td>A powerful strategy, grounding is offered to help clients detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world, away from negative feelings.</td>
</tr>
<tr>
<td>(5) When Substances Control You (cognitive)</td>
</tr>
<tr>
<td>Eight handouts are provided, which can be combined or used separately: (a) &quot;Do You Have a Substance Abuse Problem?&quot;; (b) &quot;How Substance Abuse Prevents Healing From PTSD&quot;; (c) &quot;Choose a Way to Give Up Substances&quot;; (d) &quot;Climbing Mount Recovery,&quot; an imaginative exercise to prepare for giving up substances; (e) &quot;Mixed Feelings&quot;; (f) &quot;Self-Understanding of Substance Use&quot;; (g) &quot;Self-Help Groups&quot;; and (h) &quot;Substance Abuse and PTSD: Common Questions.&quot;</td>
</tr>
<tr>
<td>(6) Asking for Help (interpersonal)</td>
</tr>
<tr>
<td>Both PTSD and substance abuse lead to problems in asking for help. This topic encourages clients to become aware of their need for help and provides guidance on how to obtain it.</td>
</tr>
<tr>
<td>(7) Taking Good Care of Yourself (behavioral)</td>
</tr>
<tr>
<td>Clients explore how well they take care of themselves using a questionnaire listing specific behaviors (e.g., &quot;Do you get regular medical check-ups?&quot;). They are asked to take immediate action to improve at least one self-care problem.</td>
</tr>
</tbody>
</table>
TABLE 7.2: (Continued)

(8) **Compassion** *(cognitive)*
This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of “beating oneself up,” a common tendency for people with PTSD and substance abuse. Clients are taught that only a loving stance toward the self produces lasting change.

(9) **Red and Green Flags** *(behavioral)*
Clients explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of “red and green flags” (signs of danger and safety). A Safety Plan is developed to identify what to do in situations of mild, moderate, and severe relapse danger.

(10) **Honesty** *(interpersonal)*
Clients discuss the role of honesty in recovery and role-play specific situations. Related issues include: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn’t accept honesty?

(11) **Recovery Thinking** *(cognitive)*
Thoughts associated with PTSD and substance abuse are contrasted with healthier “recovery thinking.” Clients are guided to change their thinking using rethinking tools such as List Your Options, Create a New Story, Make a Decision, and Imagine. The power of rethinking is demonstrated through think-aloud exercises.

(12) **Integrating the Split Self** *(cognitive)*
Splitting is identified as a major psychic defense in both PTSD and substance abuse. Clients are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these.

(13) **Commitment** *(behavioral)*
The concept of keeping promises, both to self and others, is explored. Clients are offered creative strategies for keeping commitments, as well as the opportunity to identify feelings that can get in the way.

(14) **Creating Meaning** *(cognitive)*
Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as Deprivation Reasoning, Actions Speak Louder Than Words, and Time Warp. Meanings that are harmful versus healing in recovery are contrasted.

(15) **Community Resources** *(interpersonal)*
A lengthy list of national nonprofit resources is offered to aid clients’ recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help clients take a consumer approach in evaluating treatments.

(16) **Setting Boundaries in Relationships** *(interpersonal)*
Boundary problems are described as either too much closeness (difficulty saying “no” in relationships) or too much distance (difficulty saying “yes” in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided.

(17) **Discovery** *(cognitive)*
Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called “staying stuck”). Discovery is a way to stay open to experience and new knowledge, using strategies such as Ask Others, Try It and See, Predict, and Act “As If.” Suggestions for coping with negative feedback are provided.

(continues)
TABLE 7.2:  (Continued)

(18) **Getting Others to Support Your Recovery (interpersonal)**
Clients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as a letter that they can give to others to promote understanding of PTSD and substance abuse. A safe family member or friend can be invited to attend the session.

(19) **Coping with Triggers (behavioral)**
Clients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change who you are with, what you are doing, and where you are (similar to “change people, places, and things” in AA).

(20) **Respecting Your Time (behavioral)**
Time is explored as a major resource in recovery. Clients may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues such as: Do they use their time well? Is recovery their highest priority? Balancing structure versus spontaneity, work versus play, and time alone versus in relationships are also addressed.

(21) **Healthy Relationships** (interpersonal)
Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief “Bad relationships are all I can get” is contrasted with the healthy belief “Creating good relationships is a skill to learn.” Clients are guided to notice how PTSD and substance abuse can lead to unhealthy relationships.

(22) **Self-Nurturing (behavioral)**
Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other “cheap thrills”). Clients are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse.

(23) **Healing from Anger (interpersonal)**
Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered.

(24) **The Life Choices Game (combination)**
As part of termination, clients are invited to play a game as a way to review the material covered in the treatment. Clients pull from a box slips of paper that list challenging life events (e.g., “You find out your partner is having an affair”). They respond with how they would cope, using game rules that focus on constructive coping.

(25) **Termination**
Clients express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. An optional Termination Letter can be read aloud to clients to validate the work they have done.

**Note:** Each topic represents a “safe coping skill” relevant to both PTSD and SUD. Domains (cognitive, behavioral, interpersonal, or a combination) are listed in parentheses. Topics can be done in any order, and one can use as few or as many topics as fits the treatment context. A topic can be done over one session or more.
emotional engagement), handouts, and check-out. The structure is designed to model good use of time, appropriate containment, and setting goals and sticking to them. For clients with PTSD and SUD, who are often impulsive and overwhelmed, the predictable session structure helps them know what to expect. It offers, in its process, a mirror of the focus and careful planning that are needed for recovery from the disorders. Most of the session is devoted to the topic selected for the session (see Table 7.1), relating it to current and specific problems in clients’ lives. Priority is on any unsafe behavior the client reported during the check-in.

FLEXIBILITY

Seeking Safety was developed to be broadly applicable in a wide variety of settings. It has been conducted in a variety of formats, including group and individual; open and closed groups; sessions of varying lengths (50 minutes, 1 hour, 90 minutes, and two hours); sessions of varying pacing (weekly, twice weekly, and daily); singly and co-led; outpatient, inpatient, and residential; integrated with other treatments or as a stand-alone therapy; and single-gender or mixed-gender. Each topic in Seeking Safety is independent of the others and can be conducted as a single session or over multiple sessions, depending on the client’s length of stay and needs. There are no particular coping skills or topics clients must master, but rather they are offered a wide variety from which to choose. 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. Some programs have conducted all 25 topics, others created two blocks of 12 sessions each; and others have allowed clients to cycle through the entire treatment multiple times. In some programs, there is not enough time to do all topics and so just a few are selected. Topics can be conducted in any order, with the order selected by clients, clinicians, or both. Extensive handouts are available, from which they can choose those that are most relevant.

The treatment is flexible to allow clients’ most important concerns to be kept primary, to allow adaptation to a variety of settings, to respect clinicians’ judgments, and to encourage clinicians to remain inspired and interested in the work. These concerns are believed paramount for a population such as this, where the risks of client dropout and clinician burnout are high (Najavits, 2001). Moreover, they were designed to adapt to the managed care era, in which many clients will have limited access to treatment. The therapy is also designed to be integrated with other treatments. Although it can be conducted as a stand-alone intervention, the severity of clients’ needs usually suggests that they be in several treatments at the same time (e.g., 12-step groups, pharmacotherapy, individual therapy, group therapy). The model also includes an intensive case management component to help engage clients in additional treatments. Finally, as noted earlier, Seeking Safety has been implemented with a wide variety of clients, and typically PTSD and SUD diagnoses are not required.
EASE OF USE

The model was designed to be user-friendly. For each topic, the book provides:

- A brief Summary
- A Clinician Orientation, which provides background about the topic, clinical strategies for conducting the session, and discussion of countertransference issues
- A Quotation that is read aloud at the start of each session to emotionally engage clients; for example, the quotation for the topic PTSD: Taking Back Your Power is from Jesse Jackson, the African-American political leader: “You are not responsible for being down, but you are responsible for getting up” (Marlatt & Gordon, 1985, p. 15)
- A set of Client Handouts, which summarize the main points of the topic
- A segment on Tough Cases, to highlight treatment challenges; for example, when conducting a session on the topic Safety, a client may say “I don’t want to stay safe. I want to die.” The clinician is encouraged to rehearse possible responses to such statements.

Background chapters on the dual diagnosis and how to conduct the treatment are also provided. A variety of resources to support use of the manual have also been developed, including videos, articles that can be downloaded, and a poster of the Safe Coping Skills (see the resources section at the end of this chapter).

SIMPLE, ENGAGING LANGUAGE

The goal was to write the manual in simple, emotionally compelling language. It provides a respectful tone that honors clients’ courage in fighting the disorders, and teaches new ways of coping that convey empathy for their experience. Words such as “safety,” “respect,” “honor,” and “healing” are used. Scientific jargon and polysyllabic words are avoided. Because the concepts are stated simply, the model also has been implemented with clients who cannot read. For such clients, the clinician summarizes the material briefly or encourages other clients to read small segments out loud.

REHEARSAL OF SKILLS

Each Seeking Safety topic represents a new coping skill, and thus strong emphasis is placed on rehearsal of the skills during the session. A variety of methods can be used, depending on client and clinician preferences:

- Do a walk-through. Clients identify a situation in which the safe coping skill might help, then describe how they would use it. For example, in the topic
 Asking for Help: “If you felt like using, whom could you call? What would you say?”

- In-session experiential exercise. The clinician guides clients through an experience rather than simply talking about it. For example, the skill of grounding is demonstrated in a 10-minute exercise during the session.
- Role-play. The client tries out a new way of relating to another person by practicing out loud. This is one of the most popular methods for interpersonal topics.
- Identify role models. Clients think of someone who already knows the skill and explore what that person does. For the topic Commitment: “Do you know anyone who follows through on promises?”
- Say aloud. Clients practice a new style of self-talk out loud. For example, on the topic Compassion, “When you got fired from your job this week, how could you talk to yourself compassionately?”
- Process perceived obstacles. Clients anticipate what might happen if they try to implement the skill. For example, in Setting Boundaries in Relationships, “What might your partner say if you requested safe sex?”
- Involve safe family/friends. Clients are encouraged to enlist help from safe people, as in the topic, Getting Others to Support Your Recovery.
- Replay the scene. Clients identify something that went wrong and then go through it again as if they could relive it: for example, “What would you do differently this time?” A Safe Coping Sheet is designed for this process or it can be done more informally.
- Discussion questions. For every topic, ideas to generate discussion are offered.
- Make a tape. Create an audiotape for clients to use outside of sessions as a way to literally “change old tapes.” For the topic Compassion, for example, kind, encouraging statements can be recorded.
- Review key points. Clients summarize the main points of the handout that are meaningful to them.
- Question/Answer. The clinician asks questions about the topic. For example, “Does anyone know what the letters ‘PTSD’ stand for?”

**COMMITMENTS**

To reinforce rehearsal of skills, at the end of each session clients are asked to select a commitment to try before the next session. Commitments are very much like cognitive behavioral homework, but the language is changed to emphasize that clients are making a promise—to themselves, to the clinician, and, in group treatment, to the group—to promote their recovery by taking at least one action step to move forward. Also, commitments do not have to be written, as clinical experience with this population suggests that some clients do not like written assignments. Examples of commitments include “Ask your partner not to offer you any more cocaine,” “Read a book on parenting,” and “Write a supportive
letter to the young side of you that feels scared.” Ideas for commitments are offered at the end of each handout, but clinicians are encouraged to customize them to best fit each client (see also Najavits, 2005).

ATTENTION TO CLINICIAN PROCESSES

Due to the challenges of working with this population, special emphasis is placed on the clinician role, such as countertransference, self-care, and secondary traumatization. (The latter refers to clinicians developing PTSD-like symptoms when exposed to traumatized clients.) Additional clinician processes in Seeking Safety include trying the treatment’s coping skills in one’s own life, compassion for clients’ experience, giving clients control whenever possible (empowerment), heroically doing anything possible within professional bounds to help the client get better, listening to clients’ behavior more than their words, and obtaining feedback from clients. The reverse of such positive clinician processes are negative processes such as harsh confrontation; sadism; neglect; power struggles; inability to hold clients accountable; becoming victim to clients’ abusiveness; and, in group treatment, allowing a client to be scapegoated. As Herman (1992) suggested, clinicians who treat traumatized clients may unwittingly repeat the classic trauma roles of victim, perpetrator, rescuer, or bystander.

Attention is also directed to the paradox of countertransference in PTSD and substance abuse. That is, each disorder appears to evoke opposite countertransference reactions. PTSD tends to evoke identification with clients’ vulnerability, which, if taken too far, can lead to excessive support at the expense of growth. Substance abuse may evoke anxiety about the client’s substance use, which, if extreme, can become harsh judgment and control (e.g., “I won’t treat you if you keep using”). The goal is thus to integrate support and accountability. Clinicians are encouraged to help clients seek explanations, but not excuses, for their unsafe behavior.

EMPIRICAL RESULTS

Seeking Safety is the most studied treatment thus far for the dual diagnosis, with eleven completed outcome studies: outpatient women using group modality (Najavits et al., 1998); women in prison, in group modality (Zlotnick et al., 2003); women in a community mental health setting, in group format (Holdcraft & Comtois, 2002); low-income urban women, in individual format (D. A. Hien et al., 2004); adolescent girls, in individual format (Najavits et al., 2006); men and women veterans, in group format (Cook et al., 2006); homeless women veterans in group and/or individual format (Desai & Rosenheck, 2006); women with co-occurring disorders in group format (Morrissey et al., 2005); outpatient men traumatized as children, in individual format (Najavits et al., 2005); women veterans, in group format (Weller, 2005); and women in outpatient treatment
scared.” Ideas for commitments are nicians are encouraged to customize its, 2005).

CIAN PROCESSES

this population, special emphasis is transference, self-care, and secondary ans developing PTSD-like symptoms tional clinician processes in Seeking g skills in one’s own life, compassion of whenever possible (empowerment), professional bounds to help the client rere than their words, and obtaining positive clinician processes are nega- sadism; neglect; power struggles; ming victim to clients’ abusiveness; o be scapegoated. As Herman (1992) d clients may unwittingly repeat the rescuer, or bystander.

of countertransference in PTSD and ars to evoke opposite countertransfertification with clients’ vulnerability, ve support at the expense of growth. the client’s substance use, which, if control (e.g., “I won’t treat you if you support and accountability. Clinicians tions, but not excuses, for their unsafe

RESULTS

tment thus far for the dual diagnosis, ngroup modalities (Zlotnick et al., 2003); ting, in group format (Holdcraft & n, in individual format (D. A. Hien d format (Najavits et al., 2006); men (2006); homeless women vet- sai & Rosenheck, 2006); women with orrissey et al., 2005); outpatient men at (Najavits et al., 2005); women vet- and women in outpatient treatment

(McNelis-Domingos, 2004). Seven studies were pilots (Cook et al., 2006; Hold- craft & Comtois, 2002; McNelis-Domingos, 2004; Najavits et al., 1998, 2005; Weller, 2005; Zlotnick et al., 2003), and four were controlled trials (Desai & Rosenheck, 2006; D. A. Hien et al., 2004; Morrissey et al., 2005; Najavits et al., 2006). Two were multisite trials (Desai & Rosenheck, 2006; Morrissey et al., 2005). In all the studies, the clients were severe. That is, they had symptoms of the disorders for many years, in most cases were substance dependent, had multiple traumas (often in childhood), and typically had additional co-occurring Axis I and/or Axis II disorders. Three of the studies are omitted from the summary that follows. Two were not designed to evaluate Seeking Safety per se, but rather included that as one model among several, and did not report differences among models (Holdcraft & Comtois, 2002; Morrissey et al., 2005). One study was an unpublished master’s thesis (McNelis-Domingos, 2004). Nonetheless, all three of those trials showed high acceptability and satisfaction with Seeking Safety and positive outcomes on a variety of measures.

All eight studies reviewed here evidenced positive outcomes. Seven of the eight studies reported on substance use, and six of these found improvements in that domain (D. A. Hien et al., 2004; Najavits et al., 1998, 2005, 2006; Weller, 2005; Zlotnick et al., 2003). All eight studies assessed PTSD and/or trauma-related symptoms and found improvements in those areas. Improvements were also found in various other areas, including social adjustment, general psychiatric symptoms, suicidal plans and thoughts, problem solving, sense of meaning, depression, and quality of life. Treatment satisfaction and attendance were reported to be high in all eight studies. Four studies had follow-ups after treatment ended and showed that some key gains were maintained (D. A. Hien et al., 2004; Najavits et al., 1998, 2005, 2006; Zlotnick et al., 2003).

In all three controlled trials, Seeking Safety outperformed treatment-as-usual (Desai & Rosenheck, 2006; D. A. Hien et al., 2004; Najavits et al., 2006). All three allowed clients in the Seeking Safety condition to obtain unlimited amounts of treatment-as-usual in addition to Seeking Safety, and thus essentially evaluated the impact of (1) Seeking Safety plus treatment-as-usual versus (2) treatment-as-usual alone (a challenging test as clients had so much additional treatment other than Seeking Safety). In the study by Hien et al. (2004), both Seeking Safety and Relapse Prevention (an additional arm of the study) showed positive effects with no significant difference between them, and both outperformed treatment-as-usual, which was a nonrandomized control. In Najavits, Gallop et al. (2006), Seeking Safety outperformed treatment-as-usual for adolescent outpatient girls. In the Desai et al. (2006) multisite study of homeless women veterans, Seeking Safety outperformed a nonrandomized treatment-as-usual comparison condition. That study is notable for having used case managers rather than clinicians to conduct Seeking Safety. Finally, it can also be noted that one of the pilot studies (Najavits et al., 2005) combined Seeking Safety with Exposure-Therapy-Revised (ETR), an adaptation for substance abuse clients of Foa and Rothbaum’s Exposure Therapy for PTSD (Foa & Rothbaum, 1998). Clients were given a choice
over the number of sessions of each type and chose an average of 21 Seeking Safety sessions and nine sessions of ETR.

In sum, Seeking Safety has shown consistent evidence of high acceptability among diverse clients and clinicians, positive outcomes on a variety of measures, superiority to treatment-as-usual, comparability to a gold standard treatment (relapse prevention), and efficacy in populations typically considered challenging (e.g., the homeless, prisoners, adolescents, public sector clients, and veterans). Nonetheless, empirical work on the model is at an early stage, with a need for more randomized controlled trials, evaluation of mechanisms of action, and studies of clinician training. For a continuously updated list of studies, visit www.seekingsafety.org (section Outcomes).

IMPLEMENTATION ISSUES

CLIENT AND CLINICIAN SELECTION

In selecting clients the goal is to be as inclusive as possible, with a plan to monitor clients over time to determine whether it is helpful to them. As noted earlier, most of the empirical studies on Seeking Safety were conducted on clients formally and currently diagnosed with both disorders, but in clinical practice the range has been much broader. It has included clients with a history of trauma and/or SUD, 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 preference. Given the powerlessness in both PTSD and substance abuse, empowerment is key. It appears best to describe the treatment and then give clients a choice in whether to participate. Letting them explore the treatment by attending a few sessions, without obligation to continue, is another helpful process.

Thus far, there do not appear to be any particular readiness characteristics or contraindications that are easily identified. As the treatment is designed for safety, coping, and stabilization, it is not likely to destabilize clients and thus has been implemented quite broadly. Similarly, clients do not need to attain stabilization before starting; it was designed for use from the beginning of treatment. For clients with addictive or impulsive behavior in addition to substance abuse (e.g., binge-eating, self-mutilation, gambling), clients are encouraged to apply the safe coping skills in Seeking Safety to those behaviors, while also referring them to specialized treatment for such problems as part of the case management component. Clients are not discontinued from the treatment unless they evidence a direct threat to staff or other clients (e.g., assault, selling drugs). An open-door policy prevails; they are welcome back at any time, a position advocated in early recovery (Herman, 1992).

The key criteria for selecting clinicians to conduct Seeking Safety are positive attitudes toward this dual diagnosis population, willingness to try a treatment manual, strong empathy, a willingness to cross-train (e.g., for mental health
and chose an average of 21 Seeking Safety were conducted on clients with disorders, but in clinical practice the clients with a history of trauma, mental illness, clients with just other disorders (e.g., eating disorders). It appears best to give clients a choice in whether to participate. The treatment is designed for clients to stabilize clients thereby stabilizing the beginning of treatment. For in addition to substance abuse (e.g., eating disorders), Seeking Safety is an open-door model, a position advocated in early days. Seeking Safety are positive in their willingness to try a treatment cross-train (e.g., for mental health clinicians to learn about substance abuse), and the ability to hold clients accountable and work with aggression (Najavits, 2000). In early use of Seeking Safety, various professional characteristics were sought, such as a mental health degree and particular types of training (CBT, substance abuse). It became clear over time that far more important than any such credentials are the more subtle criteria mentioned earlier (Najavits, 2000). Clinicians who enjoy these clients, often perceiving the work as a mission or calling, bring at least a level of commitment that no degree per se can provide. Similarly, clinicians who are open to the value of a treatment manual, viewing it as a resource to help improve the quality of the work, can make the best use of the material. As there are no strict criteria for selecting clinicians, the treatment can be implemented across the full range of clinicians, regardless of degree or training. 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 is comparable to relapse prevention models, and thus does not exceed the training, licensure, or ethical limits of substance abuse counselors or paraprofessionals. 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, it is also important that if a clinician does not have any prior background in trauma, PTSD, substance abuse, or CBT, some learning and/or supervision on these should be sought. Additional suggestions for selecting a Seeking Safety clinician are described in a protocol that can be downloaded from www.seekingsafety.org (section Training). Briefly, it suggests a try-out to determine whether the potential clinician might be a good match. The potential clinician conducts one or more audio-taped sessions using Seeking Safety with a real client, and the sessions are rated by the client as well as evaluated on the Seeking Safety adherence scale. Once hired, methods for training and implementation are described in the manual as well as related articles (Najavits, 2000; 2004b). A study exploring clinicians' views on treating these dual diagnosis clients may also be relevant (Najavits, 2002a).

Training methods for the treatment (Najavits, 2000; 2004b) emphasize these various process issues as well as observation of the clinician in action (e.g., taped sessions) and intensive training experiences (e.g., watching videotapes of good vs. poor sessions, peer supervision, role plays, knowledge tests, identifying key themes, and think-aloud modeling).

ADAPTATION

Because of the high degree of flexibility inherent the model, Seeking Safety can be adapted without going outside of its intended use. Thus, it is not only possible but desirable to customize the treatment for particular subgroups (gender, type of trauma, race, ethnicity, age, etc.). A useful framework is to think of...
adaptations inside the model versus outside the model. The former are recommended whereas the latter are not unless they are carefully evaluated and deemed necessary. Adaptations inside the model include using examples from clients’ experience, covering the material over as many sessions as needed, creating a pace and length of sessions based on the treatment context, using creative devices (such as drawings), and allowing clients to make use of strategies and materials they find helpful, and letting go of those that they do not find helpful. Adaptations outside of the model include changing the session structure in a way that detracts from the intent of the model (e.g., spending the entire session discussing the quotation), and a priori narrowing the range of materials given to clients (e.g., presuming clients will not like certain topics and thus deleting them).

In general, two suggestions are paramount. First, try the model as planned when starting out, and collect feedback directly from clients. Two forms are included in the manual for this purpose: the End of Session Questionnaire and the End of Treatment Questionnaire. If clients suggest changes, make adaptations based on that. Second, make adaptations if needed due to unusual treatment contexts. For example, one day program group had 30 clients and thus it was impossible to conduct a check-in and check-out on each person. The group leader decided to focus solely on the handouts. Other programs with large groups decided to ask just a single check-in and check-out question.

Several adaptations within the model highlight the creativity that dedicated clinicians bring to their work. For example, one day program created a "grounding table" in the back of the treatment room with various small objects and soothing materials. If clients became upset during a session, they were encouraged to use the grounding table to help calm down, while the group continued. In another program, each of the safe coping skills was written on a heart-shaped cut-out and posted on the wall. Some clinicians have developed experiential exercises as well. A recent article (V. B. Brown et al., in press) describes adaptations of Seeking Safety in three community programs, with a summary of feedback and satisfaction by both clients and clinicians.

DIVERSITY (ETHNICITY, RACE, GENDER)

Before the manual was published, Seeking Safety was conducted with diverse clients, including two heavily minority samples (D. Hien et al.; Zlotnick et al., 2003), women and men, and clients with various trauma histories (e.g., child abuse, crime victimization, and combat). The examples and language in the book were written to reflect these experiences, and to mention sexism, racism, poverty, and both female and male issues. Thus far, the treatment has obtained high client satisfaction ratings in these subgroups (see, for example, Brown et al., in press; and Zlotnick et al., 2003). Rates of diversity in published trials include 77 percent minority in Hien et al. (2004), 65 percent minority in Desai and Rosenheck (2006), 35 percent minority in Zlotnick et al. (2003), and 21 percent minority in Najavits et al. (2006). However, clinicians working with particular populations
may benefit from adding more examples from their lives, cultural elements relevant to them, and addressing their particular context and burdens. In treating men, for example, exploring how certain traumas violate the masculine role may be helpful (e.g., weakness and vulnerability). In treating Latinos, one can use the Spanish-language version of Seeking Safety (see www.seekingsafety.org, section Order, and provide cultural context (e.g., concepts such as familismo and marihunismo and acculturation stress).

**GROUP MODALITY**

Seeking Safety can be conducted in individual or group modality, and the format is the same. Groups can be open or closed format, and singly or co-led. Some issues to consider when conducting the treatment in group format are as follows. First, choose the name of the group carefully. One program called their group Trauma Group and few clients wanted to attend. When they renamed it Seeking Safety Group the attendance improved. 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. A more upbeat title is reassuring. Thus, it can be Safety Group, Seeking Safety, or Coping Skills Group for example. Second, the number of group members should be planned carefully. Remembering that the check-in allows up to five minutes per client (but usually goes quicker), a one-hour group could easily accommodate five to seven clients. For longer sessions, more clients can be added. As noted earlier, very large groups may need to curtail or delete the check-in and check-out. 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" 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, 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 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 triggering), and only when clients agreed to join a mixed-gender group. The clinicians, too, typically have been the same gender as the clients, although it has also been conducted with mixed gender combinations. Finally, if clients miss a session, they can be given the handouts to keep up with the group. If a client plans to join an open group once it has begun, it is suggested that the topic PTSD: Taking Back Your Power be first reviewed individually, to increase the client's awareness of trauma and PTSD. However, some clients join a Seeking Safety group but do not have trauma, PTSD and/or SUD, so this too is flexible.
ASSESSMENT

A recent book chapter offers practical considerations in assessing SUD and PTSD (Najavits, 2004a). It includes a list of domains within each disorder to consider for assessment, and websites for free assessment measures (see also www.seekingsafety.org, section Assessment, for links to key sites). Specific issues discussed in the book chapter include the therapeutic benefit of accurate assessment; the importance of routine assessment of trauma and PTSD at the start of treatment (not delaying these due to clients’ substance use or withdrawal); the use of brief screenings; limiting collection of trauma information early in treatment to avoid triggering the client; and the need to delay assessment if the client is intoxicated. Also discussed are issues of diagnostic overlap between the two disorders, misconceptions of SUD criteria, age-appropriate measures, secondary gain in PTSD and SUD, common misdiagnoses, memory issues, countertransference by assessors, and the needs of clinical versus research instruments.

CLINICAL CASE ILLUSTRATION

As an example of how Seeking Safety has been used by one client, the following case material is offered. It was an unsolicited e-mail sent to the author and is reprinted here unchanged and with her permission. It illustrates several typical themes, which will be highlighted at the end of this section.

I came upon your Seeking Safety treatment program while in a Women’s PTSD program. The program used a variety of different modalities for treatment and Seeking Safety was a portion of it. Unfortunately, I had only been in the PTSD program 10 days when I tried a non-safe coping skill, abusing over-the-counter sleep-aids, to try and overcome the pain of facing my trauma and was asked to leave the program. Being asked to leave the program for resorting back to some of the behaviors that got me in there was difficult. I wasn’t using as much, and was learning to admit I had a problem, and to me it seemed like I was being punished for finally asking for help. I almost let that send me into a tail-spin, but I chose to help myself if they weren’t willing to help me. I bought the Seeking Safety book and I read it as though I were going to treat a patient, only that patient was me. I admit it is difficult, and potentially dangerous, to treat oneself but it seemed I was the only one who hadn’t given up on me so what choice did I have. I “meet” with myself 2-3x a week and I sit in front of a mirror and conduct sessions with my self. I check in, I review “commitments,” I discuss a chapter or portion of a chapter with myself and I check-out. After “session,” I write in my journal patient notes. I wish I had a treatment provider willing to help me sometimes, but doing it myself is better than nothing. As this is your program, I wanted to share what my experiences so far have been:

1. It is a lot easier to provide encouragement and support to someone else, than it is to provide encouragement and support to oneself. I would never put down someone else, or judge their progress when they are really putting forth the effort. Myself, that is a different story. I have struggled a long time with negative self-talk. Since I began treating myself as a patient, I see how hard I’m working and I see how far I’ve come. I’m really proud of me! I’ve not used substances or self-harming behaviors in 30 days. I would be
RECOGNITION

c onsiderations in assessing SUD and of domains within each disorder to r free assessment measures (see also nt, for links to key sites). Specific de the therapeutic benefit of accurateessment of trauma and PTSD at the clients' substance use or withdrawal); c tion of trauma information early in d the need to delay assessment if the uses of diagnostic overlap between the criteria, age-appropriate measures, m on misdiagnoses, memory issues, e needs of clinical versus research

ILLUSTRATION

has been used by one client, the fol unsolicited e-mail sent to the auth her permission. It illustrates several at the end of this section.

ram while in a Women's PTSD program. ies for treatment and Seeking Safety was in the PTSD program 10 days when I counter sleep-aids; to try and overcome leave the program. Being asked to leave haviors that got me in there was difficult. nit I had a problem, and to me it seemed r help. I almost let that send me into a 'willing to help me, I bought the Seeking sing to treat a patient, only that patient dangerous, to treat oneself but it seemed to what choice did I have. I “meet” with 'error and conduct sessions with myself, a chapter or portion of a chapter with in my journal patient notes. I wish I had imes, but doing it myself is better than share what my experiences so far have t and support to someone else, than it is if I would never put down someone else, using forth the effort. Myself, that is a negative self-talk. Since I began treating ; and I see how far I’ve come, I’m really creme behaviors in 50 days. I would be

at 90 days, but I had a tough experience 50 days ago and I used. I almost gave up on myself because I’d let myself down, but I wouldn’t have given up on a patient and I didn’t give up on me. I learned from the experience and I moved on.

2. It feels strange to carry on a conversation with myself, but I am so much more aware of where I am since I’ve started this. I realize how often I say “I can’t . . .” and I realize how distorted my view of myself is. I believe being more aware has helped me be more honest with myself. It has also made me realize how much I can gain from others. I never saw how much I push people away until I stopped having someone there to push away. I wish I could get back into that PTSD program because I could use someone else’s insight, but so far they say “no.”

3. I took the list of safe coping skills and I put each one on an index card. I carry those cards with me most of the time because when things get tough, I want to use what works and using drugs does help in the moment and that’s my first thought. Now I have all these skills to try and sometimes the first card has a skill that doesn’t help me enough, but the second or the third or the fourth or whatever eventually works. If I make it through the whole pile, I might see using as the only option but I can’t see that happening. I also add new skills as they come and my pile gets bigger and I get farther from believing that unsafe behaviors are the only way to make it through the moment.

I could share so much more, but I think you get my point. I just really wanted to say “Thank you” because your book has helped me to help me at least until I can get someone else to help me too.

This client's account helps bring out several themes that can occur in treatment with this population. First, her experience of being rejected by a mental health treatment program for using a substance still remains quite common. Second, she perceived that she had no other treatment options and had to do the best she could on her own. She was remarkably resilient in attempting to conduct Seeking Safety with herself. Clearly, this is not the optimal strategy, as she herself notes. But it provides a poignant example of the dilemmas that clients sometimes face. Third, she very creatively came up with strategies to use the material, such as writing the safe coping skills on index cards and practicing self-talk in front of a mirror. Fourth and finally, her description offers a realistic portrayal of some of the ups and downs that can occur. Her ability to stay abstinent and to overcome a slip on her own are notable. In a follow-up e-mail, she conveyed that she was recently married and continues to try to enter a treatment program to further her recovery. She appears to have located a program that will admit her and is pursuing that.

RELATION TO RELAPSE PREVENTION

Seeking Safety and relapse prevention have both similarities and differences. These are worth outlining as an aid to training and implementation efforts. Many clinicians who are familiar with relapse prevention report that Seeking Safety feels like a comfortable fit for them because of the similarities between the two models. Yet because of Seeking Safety's intensive focus on trauma and PTSD, it usually also requires some new learning.
SIMILARITIES

Both Seeking Safety and relapse prevention are:

- Present focused
- Coping skills oriented
- Psychoeducational
- Low risk
- Manualized
- Structured
- Empirically supported
- Focused on skill rehearsal
- Designed for a wide range of clients (all types of substances, severity, genders, etc.)
- Designed for a wide range of staff (e.g., substance abuse counselors)
- Intended for all treatment contexts (outpatient, inpatient, group, individual, etc.)
- Early-stage treatment (for active users and early recovery)
- Similar in some topics (e.g., *Coping with Triggers*)

DIFFERENCES

Seeking Safety was designed for the dual diagnosis of PTSD and SUD. Thus in contrast to relapse prevention, Seeking Safety uniquely focuses on:

- Trauma and PTSD
- Safety as a core theme
- Humanistic language
- Case management
- Emotional engagement (e.g., use of quotations)
- Some different topics (e.g., Integrating the Split Self, Setting Boundaries in Relationships, Compassion)
- Ideals to restore hope
- Emergency situations
- Increased interpersonal emphasis
- Application to both mental health and substance abuse settings
- Emphasis on clinician processes (countertransference, self-care, secondary traumatization)
- Abstinence or harm reduction, depending on the client and setting
- High flexibility (topics can be done in any order; client can choose handouts, etc.)
- Empowerment

In identifying these similarities and differences, it is important to note that research is needed to address how the two modalities compare in outcome results.
TIES

- Types of substances, severity, genders,
- Substance abuse counselors
- Patient, inpatient, group, individual,
- Early recovery
- Triggers

TIES

diagnosis of PTSD and SUD. Thus

TIES

... Split Self, Setting Boundaries in

stance abuse settings

... Transference, self-care, secondary

on the client and setting

... Order; client can choose handouts,

... References, it is important to note that

dailies compare in outcome results.

For example, in the only study thus far directly comparing Seeking Safety and Relapse Prevention, both outperformed treatment-as-usual, yet did not differ from each other overall (D. A. Hien et al., 2004). This is in keeping with the general treatment outcome literature in which manual-based treatments are generally comparable to each other in outcome and superior to treatment-asusual (e.g., Najavits, in press). Thus, clinicians and clients can choose freely among different models. For example, in Seeking Safety, clients are encouraged to “try out” the treatment for a few sessions to see whether they like it. Some clients have been through a lot of substance abuse treatment and want a change. Other clients may want both models, and yet others may prefer just one or the other.

For a description of how Seeking Safety compares to other models (e.g., dialectical behavior therapy, cognitive behavioral therapy, exposure therapy, motivational enhancement therapy) see Najavits (2002).

CONCLUSIONS AND RECOMMENDATIONS

Integrated therapies for dual diagnosis have become prominent in the past decade to help clients better overcome SUD and co-occurring mental disorders. Seeking Safety is the most empirically supported model thus far for the dual diagnosis of PTSD and SUD. It has been described in detail in this chapter, including assessment and implementation considerations.

Despite advances in this area of work, there is a need for more research. Thus far, only a few randomized controlled therapy trials have been conducted, and no trials comparing integrated models versus other models (sequential or parallel) have been published. Studies of active mechanisms and how best to combine treatments have not yet occurred. There is also a need to evaluate methods for selecting and training clinicians to work with such high-severity clients. Clinically, assessment and treatment of PTSD in SUD settings is not yet widespread, and conversely, in mental health settings both PTSD and SUD may not be sufficiently addressed. Rigorous large-scale studies are rare, as are studies of long-term outcomes (one year or more). Given the often chronic course of both PTSD and SUD through the life span (e.g., Port, 2001), further support for clinical implementation and research are needed. In short, much more is unknown than known at this point. Learning from a variety of patients, clinicians, settings, and studies will be an evolving process. In closing, the quotation by Jacob (1997), from the Seeking Safety topic Discovery, is apt:

Progress . . . begins with the invention of a possible world . . . which is then compared by experimentation with the real world. And it is this constant dialogue between imagination and experiment that allows . . . an increasingly fine-grained conception of what is called reality.
TABLE 7.3: Conducting the Session

The session has four parts: check-in, quotation, relate the topic to clients’ lives, and check-out.

1) Check-In
The goal of the check-in is to find out how clients are doing (up to 5 minutes per client). Clients report on five questions: “Since the last session (a) How are you feeling?; (b) What good coping have you done?; (c) Describe your substance use and any other unsafe behavior; (d) Did you complete your Commitment?; and (e) Provide a Community Resource update.”

2) Quotation
The quotation is a brief device to help emotionally engage clients in the session (up to 2 minutes). A client reads the quotation out loud. The clinician asks, “What is the main point of the quotation?” and links it to the session topic.

3) Relate the Topic to Clients’ Lives
The clinician and/or client selects any one of the 25 treatment topics (listed in Table 7.1) that feels most relevant. This is the heart of the session, with the goal of meaningfully connecting the topic to clients’ experience (30–40 minutes). Clients look through the handout for a few minutes, which may be accompanied by the clinician summarizing key points (especially for clients who are cognitively impaired). Clients are asked what they most relate to in the material, and the rest of the time is devoted to addressing the topic in relation to specific and current examples from clients’ lives. As each topic represents a safe coping skill, intensive rehearsal of the skill is strongly emphasized.

4) Check-Out
The goal is to reinforce clients’ progress and give the clinician feedback (a few minutes per client). Clients answer two questions: (a) “Name one thing you got out of today’s session (and any problems with it)” and (b) “What is your new Commitment?”

AUTHOR NOTE

Adapted parts of this chapter were drawn from several previous publications on Seeking Safety (Najavits, 2002b; 2004c; 2006).

REFERENCES


the topic to clients’ lives, and check-out.

e doing (up to 5 minutes per client). Clients how are you feeling? (b) What good coping l any other unsafe behavior; (d) Did you inanity Resource update.”

e clients in the session (up to 2 minutes). asks, “What is the main point of the
treatment topics (listed in Table 7.1) that with the goal of meaningfully connecting the look through the handout for a few minutes, izing key points (especially for clients who y most relate to in the material, and the res ion to specific and current examples from skill, intensive rehearsal of the skill is
clinician feedback (a few minutes per thing you got out of today’s session (and com"


Evention to Specific Problem Areas

- Maintenance strategies in the treatment of avioral skills training for persons with co-substance abuse. Thesis submitted for the Connecticut State University, New Haven,


cognitive-behavioral therapy for women with substance Abuse Treatment 13:13–22.
