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Chapter 2

SEEKING SAFETY THERAPY FOR MEN: CLINICAL AND RESEARCH EXPERIENCES

**Lisa M. Najavits¹, Martha Schmitz², Kay M. Johnson³,
Cary Smith⁴, Terry North⁵, Nancy Hamilton⁶, Robyn Walser⁷,
Kevin Reeder⁸, Sonya Norman⁹ and Kendall Wilkins¹⁰**

1. Harvard Medical School / McLean Hospital, Boston MA, USA
2. San Francisco VA Medical Center, CA, USA
3. St. Luke's-Roosevelt Hospital,
Crime Victims Treatment Center, New York, NY, USA
4. Vet Centers, Readjustment Counseling Service,
Department of Veteran Affairs. Washington DC, USA
5. VA Omaha, NE, USA
6. Operation PAR, St. Petersburg, FL, USA
7. VA Palo Alto, CA, USA
8. Central Arkansas Veterans Healthcare System, AR, USA
9. VA San Diego Healthcare System and University of California, San Diego, CA, USA
10. San Diego State University and University of California, San Diego, CA, USA

ABSTRACT

This chapter highlights clinical and research experience on the use of Seeking Safety therapy with men clients. Seeking Safety is a present-focused, coping skills model that addresses trauma and/or substance abuse, from the start of treatment. Its major goal is to help clients increase safety in their lives. The model was designed for both genders, and all types of traumas and substances. We describe how it has been implemented in various settings with men including mental health and substance abuse programs, veterans' hospitals, correctional settings, and residential treatment. The authors represent a range of clinicians and researchers who have conducted the model with men for many years. We describe key themes, treatment strategies, and research studies on Seeking Safety with men.

INTRODUCTION

Seeking Safety is an evidence-based therapy for trauma and/or substance abuse (Najavits, 2002). The manual was designed for both genders, and thus includes examples from both men and women as well as gender-neutral language where appropriate. Because many of the studies on Seeking Safety were conducted on women, it is sometimes assumed that the model was intended for woman rather than men. This also derives from an early paper on the model (Najavits *et al.*, 1996), which focused on women in group treatment. However, by the time the model was finalized and published in book form, it explicitly targeted both genders and both group and individual modalities (Najavits, 2002). The idea was for the model to be as inclusive as possible—in addition to both genders, it is intended for use across trauma and substance abuse types; across modalities; across treatment settings (e.g., outpatient, inpatient, residential); and for any clinician within those settings who treats this population.

It is worth commenting on why so many studies of the model were on women (for a summary of research see Najavits, 2007). This was largely due to growing recognition of the importance of trauma and substance abuse in the lives of women. Earlier, both of these areas were largely understood as men's problems. Substance abuse has historically been much higher in men, and trauma was associated with men and combat (Najavits et al., 1996). Studies on women with trauma and substance abuse became an important area of work in the 1990's and early 2000s. There was increased recognition of traumas typical in women (child abuse, domestic violence); and greater focus on making substance abuse treatment more gender-sensitive. Thus, Seeking Safety studies addressed what was considered a new need: treatment for women with trauma and substance abuse.

The model is characterized by the following key features:

- Integrated treatment of trauma and substance abuse (although it can also be used for either alone);
- Early-stage treatment (can be used from the start of treatment, as it is designed for stabilization);
- Coping-skills oriented (to help increase safety from trauma and substance abuse)
- Present-focused (no exploration of trauma details, although it can be used in conjunction with any other treatment)
- Idealistic (to restore hope)
- Evidence-based (the only model thus far established as effective for the dual diagnosis of PTSD and substance use disorder; Najavits et al., in press)
- Designed to be engaging (use of quotations, humanistic language, creative exercises)
- Flexible (it offers 25 topics that are each independent of the others; the clinician can do as few or many topics as there is time for, for any treatment length)
- Clinician-sensitive (addressing countertransference, clinician self-care, and secondary traumatization)

A variety of male subgroups have been treated with the model including veterans, adolescents, men abused in childhood, and men in various settings (e.g., community treatment, criminal justice, substance abuse treatment, mental health treatment, inpatient, outpatient, residential, and private practice). Across these settings, a wide variety of traumas

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The experiences of the women in the study were used to validate and understand the themes, some helpful in the abuse of males; and So

This chapter is based on the following sources also highlight the

1. Clinical Experien

Lisa M. Najavits, PhD, is an associate professor at Boston University and a clinical psychologist in the Boston area in hospital and private practice. She has published on PTSD from child abuse and neglect, and research on it.

Martha Schmitz, J.D., is a professor at Boston and San Francisco, and as the lead practice, and as the lead (2005); worked with n provided supervision, Safety with various po homeless, drug court, a

Kay Johnson, LIC, based program in Har traumas; ran both grou programs; provided tra research projects invol also, conducted Seekin

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Terry North, PhD, is the director of the Omaha VA. Service Center, where he works with veterans who experienced trauma, from all war eras and mixed-gender.

Nancy Hamilton,
Substance Abuse Merit

and addictions have been addressed. The model has been conducted in group and individual format, and in single and mixed-gender format.

In this paper, we explore themes related to its use with males. We also summarize existing studies of Seeking Safety with men.

The experiences of men with trauma and/or substance abuse are deeply important to validate and understand. For anyone interested in reading more about male gender-based themes, some helpful books include Shay (1994) on combat PTSD; Lew (1988) on sexual abuse of males; and Sonkin (1998) on male child abuse of all types.

BASIS FOR THIS CHAPTER

This chapter is based on the following clinical and research experiences. These diverse sources also highlight the many ways in which men seek help for trauma and substance abuse.

I. Clinical Experience

Lisa M. Najavits, PhD. Nine years experience conducting Seeking Safety with men in the Boston area in hospital and community settings; primarily clients with severe addictions and PTSD from child abuse and neglect; also treatment of women using the model, and teaching and research on it.

Martha Schmitz, PhD. Six years experience conducting Seeking Safety with men in Boston and San Francisco, including veterans (Vietnam and Iraq/Afghanistan eras), in private practice, and as the lead clinician on a pilot study of Seeking Safety with men (Najavits et al., 2005); worked with men who experienced child abuse, combat, and other traumas; also provided supervision, consultation, and training for over five years on the use of Seeking Safety with various populations (prisoners, immigrants, survivors of gangs/street violence, homeless, drug court, and mental health and substance abuse treatment).

Kay Johnson, LICSW. Six years conducting Seeking Safety with men in a community-based program in Harlem, New York, most of whom had experienced multiple violent traumas; ran both group and individual modality Seeking Safety in residential and outpatient programs; provided training and ongoing supervision for community-based programs and research projects involving men in alternatives-to-incarceration and crime victims' programs; also, conducted Seeking Safety with women for ten years.

Cary Smith, LMSW. Nine years conducting Seeking Safety in Washington DC for with men combat veterans with dual diagnosis (various wars), in an outpatient community veterans clinic; both group and individual Seeking Safety.

Terry North, PhD. Eight years conducting Seeking Safety as Director of the PTSD Clinic at the Omaha VA. Seeking Safety was conducted in group or individual modality with veterans who experienced trauma in the military (combat, line of duty, and military sexual trauma, from all war eras); many had a dual diagnosis. Seeking Safety groups were single- and mixed-gender.

Nancy Hamilton, MPA, CAP, CCJAP. Three years as principal investigator on a Substance Abuse Mental Health Services Administration (SAMHSA) grant to provide

Seeking Safety and other services to young African-American men mandated to residential substance abuse treatment in St. Petersburg, Florida.

Robyn Walser, PhD. Seven years experience conducting Seeking Safety in inpatient and outpatient VA settings serving as clinician and supervisor of trainees learning Seeking Safety. Five years conducting training in use of Seeking Safety in VA facilities. Currently involved in randomized controlled trial investigating Seeking Safety in outpatient VA substance abuse clinic.

Kevin Reeder, PhD. Four years conducting Seeking Safety groups with men and women veterans in group format in both residential PTSD programs and outpatient mental health clinic settings at VAs in Kansas City, Missouri and Little Rock, Arkansas; also trained interns and colleagues to conduct Seeking Safety.

Sonya Norman, PhD. Three years' conducting Seeking Safety in San Diego with veterans from Iraq and Afghanistan and with dually diagnosed women in a community outpatient psychiatric clinic; also conducting research on Seeking Safety in both domestic violence and veterans' settings.

Kendall Wilkins, BA. Six months conducting Seeking Safety with dually diagnosed women in a community outpatient psychiatric clinic in San Diego; also part of research team evaluating Seeking Safety with new veterans (Iraq/Afghanistan) in the VA.

II. Research Experience

Four different investigator groups have conducted research on Seeking Safety with men. They are as follows and are described in more detail in the section Research later in the chapter:

- A qualitative evaluation study that addressed the feasibility of Seeking Safety with men veterans (Weaver, Trafton, Walser and Kimerling, 2007).
- A pilot study of five men with chronic, severe PTSD and substance dependence, based on childhood trauma (largely physical and sexual violence) (Najavits et al., 2005).
- A pilot evaluation of Seeking Safety with 76 young African-American males referred by drug courts into residential treatment (Hamilton, 2006).
- A pilot study of Seeking Safety with older veterans, primarily male (Cook et al., 2006).

CLINICAL THEMES

Several major themes emerged based on our clinical experiences conducting Seeking Safety with men. It is important to emphasize, however, that factors other than gender may play a role, such as trauma type and setting. Thus, where possible, we try to distinguish between these. Further, any of the patterns below can occur with women too, but appear more prominent with men, in our experience.

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Bonding in male ways (like warriors, teams). It has been emphasized in developmental psychology that males tend to bond in different ways than females. Part of this is the tendency to form teams, often represented by sports or war units going into battle. In the use of Seeking Safety with men veterans, for example, it has been observed that when it goes well, they "bond like a symbolic combat unit; they are supportive of each other, and connect almost like a fire team [a group on a military mission]. The recovery of these men is like a different version of combat; it's a real love for their comrades and they get to re-live it here. A lot of Seeking Safety groups directly express that notion of being combat veterans on a mission to recover." These sorts of bonds also have been observed in civilian men, and there has been a sense when doing Seeking Safety that there is less of the scapegoating and intense interpersonal dynamics that can occur with groups of women (particularly those severe in PTSD and substance abuse). One clinician commented that after a few weeks with the men, "it feels as if they almost don't even need me in there—in the beginning I'm doing a lot of the work and then toward the end, they're doing it." Women too, of course, bond in positive ways when doing Seeking Safety or other treatments, but the "feel" of the bond may be different.

Difficulty with feelings. Another theme observed in Seeking Safety and generally in the treatment of men is they have more difficulty with feelings. They may believe that it is not masculine to express feelings, especially vulnerable ones such as sadness, weakness, and shame. They may not even be aware of what they are feeling or may be prone to alexithymia. They may appear more guarded and hypervigilant than women initially; for some, "everything is a threat". Several Seeking Safety topics may help men address their feelings. The topic *Grounding* can increase awareness, for example. One clinician said, "Many experience feelings in an all-or-none way, from 'I don't feel angry' to exploding in anger. What has worked is to help them identify levels of feeling (what is a level 1, 4, 6, 8 and 10 on the 0-10 scale) and what triggers the feelings. Then they have used grounding successfully in anticipating situations where they will be triggered and in bringing themselves down if triggered suddenly. They become less surprised by their own feelings." Other Seeking Safety topics that emphasize feelings include *Healing from Anger*; *PTSD: Taking Back Your Power*; *Coping with Triggers*; and *Integrating the Split Self*. In the topic *When Substances Control You*, they also learn why they may have turned to addiction as a way to keep painful feelings at bay. Focusing on feelings may also be a way to engage them in the substance abuse work. One clinician said, "Clients have a lot of minimization and denial about substance use. Some would refuse to go to the substance abuse clinic. We have found that the PTSD piece really brings them in. The trauma piece engages them and then we are able to motivate them to do work on substance use."

Anger. Anger problems are also a common issue when conducting Seeking Safety with men. Sometimes the men are aware of their anger problems, barely able to keep a "lid" on it and feeling great remorse over anger outbursts. Other times, the anger feels so familiar that they are not even clear that it's a problem—they may need additional work just to motivate them to reduce anger. Anger may feel like part of their identity or like a power they do not want to give up. Topics in Seeking Safety that are especially relevant for anger issues are *Healing from Anger*, *Integrating the Split Self* (to observe their angry and non-angry sides), *Recovery Thinking* (to shift out of angry cognitions), *Case Management* (to refer the client to additional anger management treatment if needed). Anger problems may be especially visible in veterans, as the military trained them to channel anger into aggression for combat. They may need to unlearn such anger patterns once back in civilian life. Indeed, some older

veterans have commented that if there is one major Seeking Safety skill they wished they had learned when younger, it is *Healing from Anger*. Similar issues may apply to men in the community who have been involved in gangs, street violence, or domestic violence. For men who suffered child abuse, anger may be directed more toward themselves (self-harm, suicidality) than toward others.

Perpetration of violence. A small but important subset of men will raise issues of perpetration of violence. Some have revealed legal charges against them a few sessions into the therapy. Others have a history of perpetration and there remains a question of whether they will act on violent impulses again. One client told his individual Seeking Safety therapist that he felt protective of her and would assault anyone who hurt her. A common observation is that many of the men were not violent prior to trauma, and indeed appear to be quite unaware of their impulses until triggered or startled. They may appear overwhelmed or perplexed by their own behavior, and feel sadness and remorse when talking of perpetration incidents. If they have severe antisocial personality disorder, however, they may not show remorse. In Seeking Safety, clients are guided to view violence as unsafe both for others and themselves, and learn better coping skills to manage such thoughts and impulses.

Sexuality issues. Men have expressed a variety of concerns related to sexuality in the course of Seeking Safety. These include sexual addiction; pornography addiction; hooking up with strangers for unsafe sex; lack of condom use; having affairs; fears or ambivalence about being gay related to sexual abuse by a male; reenactments of sexual abuse (one client, when high on drugs, would torture himself with various objects sexually in repetition of what had occurred to him as a child); and sometimes a feeling of being used for sex. Most of these issues were reported for community-based men who were sexually abused as children or adolescents; indeed, veterans rarely focused on sexuality except for an occasional mention of pornography addiction. Women who had been sexually abused also expressed sexual problems during Seeking Safety, but these were typically about staying with partners who hurt them, anxiety or dissociation during sex, fear of engaging in sex, difficulty setting boundaries on sex, and lack of pleasure. As part of Seeking Safety with men, we have encouraged them to understand that sexuality problems may relate to trauma; this can help reduce their sense of shame. Also, several of us have found sexual-based addictions can improve with Seeking Safety by using the same principles as apply toward substance use. Psychoeducation about sexuality sometimes becomes part of the work, including having clients read about healthy male sexuality. Referral to a sex therapist may be part of case management for clients who need more intensive treatment.

Hard to engage in treatment / hard to end treatment. There is a paradox that males appear harder to engage in treatment initially but also appear not to want to end treatment once engaged. Strategies for initial engagement include letting the men sit in on a few sessions of Seeking Safety after which they can decide if they want to join; calling the treatment "training" rather than "treatment" (especially for men in military settings who may be resistant to the idea of treatment); and conducting the therapy in shorter blocks of 6 or 12 sessions. One program conducted an orientation group of a few key topics (*Safety; PTSD; Taking Back Your Power; Asking for Help*), conducted in lecture format, and then let the men decide whether to join the actual therapy. Also, it is strongly advised not to insist on any specific attendance requirement on the front end; and, if a client wants to leave, take a "no harm, no foul" approach by letting them end easily without judgment or blame.

Observations on men's modality. Some men want to teach them that saying go *Healthy Relationships, Cr* which men could return coping; this helped prev through Seeking Safety a

Isolation. The men w women do, and initially a task and limit their talking; withdrawn, needing to en to feel a strong positive problems, and can ultima life may have reinforced the enemy was dangerous the bunker," such as sitti client to buy an answerin her clients to interact wit identity outside of war e moving out of "stuck" be

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Observations on men's difficulty ending Seeking Safety have occurred primarily in group modality. Some men want to end a few days early to avoid having to say goodbye. It helps to teach them that saying goodbye is part of healthy relationships (e.g., using a topic such as *Healthy Relationships*, *Creating Meaning*, or *Honesty*). One program ran an alumni group in which men could return on a drop-in basis to check in and focus on their safe and unsafe coping; this helped prevent a feeling of an abrupt ending. Another program let men go through Seeking Safety a second time if desired.

Isolation. The men we have worked with appear to struggle more with isolation than the women do, and initially appear more quiet. With women it often takes effort to keep them on task and limit their talking if they "spill" too much. With men it is the opposite: overly quiet, withdrawn, needing to encourage them to open up more. In Seeking Safety, they often come to feel a strong positive bond with men who have similar trauma, addiction, and life problems, and can ultimately feel less alone. For veterans, it helps to identify how military life may have reinforced isolation (sharing feelings was discouraged; making "contact" with the enemy was dangerous). When they return to civilian life they may need to stop "hiding in the bunker," such as sitting alone in front of the TV for hours. One clinician encouraged a client to buy an answering machine to help him stay connected to others. Another prompted her clients to interact with various people, not just veterans, to help build commonality and identity outside of war experience. Some found the topic *Discovery* especially helpful for moving out of "stuck" beliefs and patterns.

Caretaking problems. This emerges in two ways. First, men may carry the societal role of caretakers for their family (financially and otherwise) and feel strong guilt and failure when they let their partner or children down due to addiction or trauma. They may feel "not man enough". Also some have experienced trauma related to their children. One man chose to go to prison instead of treatment and his child was killed by the abusive man who was then living with the child's mother. He felt unable to forgive himself, but was able to use *Grounding* and *Asking for Help* when triggered by this situation. Other men use Seeking Safety as a forum for planning how to first establish safety (e.g., sobriety and stability on medication) and then reconnecting with children or other important people in their lives. A second area of caretaking difficulty is self-care. Like the classic "guy who won't go to the doctor," many men we have worked with appear unable to take basic steps toward healthy living (nutrition, exercise, routine medical and dental care). These are especially pronounced in men with chronic addiction problems. The topic *Taking Good Care of Yourself* is especially relevant for such issues.

Issues with authority and control. Clients with trauma and substance abuse often present with problems of control, such as taking too little control of their lives (overly passive) or too much control (power struggles) (Najavits, 2002). The men we have worked with exhibit a wide range along this continuum. Some want the therapist or other authority figure to tell them what to do, showing difficulty making healthy decisions for themselves. Others resist influence, refusing to go to the hospital or additional treatment, rejecting therapeutic suggestions, and in some cases, struggling with authority figures or work settings (e.g., police, social services, or bosses). In Seeking Safety clients can benefit from hearing how other men handle such problems. They can also use the skill *Grounding* as an immediate way to calm down. One client, for example, reported that he was pulled over by a police officer while driving. His first instinct was to run, but he was able to use grounding to talk calmly with the officer and handle the situation without negative consequences. In one of the pilot

"Actions speak louder than words"; "Focusing on the negative"; and the "Uniqueness fallacy" (only combat veterans can understand). The cognitive topics can also help shift the clients out of all-or-none beliefs ("This is my last time to enter treatment"; "Nothing will help me with my disorders"; "I never feel like using.")

Self-hatred (feeling "like a monster"). Some men we have worked with feel that they are bad, which they sometimes describe as being "like a monster" or a "mean person". This is prominent in veterans who as part of military work had to kill or maim others, but also occurs among community-based men who perhaps fought in prison or gangs. Men and women traumatized as children tend to turn hatred against themselves (feeling like damaged goods, unworthy, or used). However, they too sometimes identify with the perpetrator and believe they are bad because they have scary thoughts or impulses to hurt others, even if they never act on them. In Seeking Safety, clients can explore the connection between trauma, addiction and such internal feelings. The topic *Compassion* is especially useful for this. As one VA clinician said, "A lot of guys don't understand compassion. We talk about how when you first go into the service, compassion is something you unlearn. You go to basic training, and then combat, and the only way to survive is to lose compassion for all others, even for yourself. Once you're home you have to relearn it. When we use Seeking Safety and the language of compassion, they can put it into context instead of seeing themselves as bad people. They can see themselves as courageous warriors again, but now toward healing and regaining intimacy and the love of their families. It gives them hope." Another clinician said, "They sometimes have a strong reaction to the topic *Compassion*-- difficulty understanding what compassion means, difficulty believing that changing harsh self-talk is an appropriate goal. It has become a powerful change tool when there is at least one group member who relates to the material and connects it to the way he was treated as a child and notices the benefits of changing self-talk. Once this happens, compassion often becomes a theme or identified way of coping during the check-in questions." The topic *Honesty* can also bring out a lot in this area-- helping clients explore more of what they feel inside. One clinician said, "Sometimes they may have an initial resistance to the topic of *Honesty*, feeling like they're being accused of lying, or having different definitions of what honesty is. But it is still a really good session, one of the best, because they work on it. We never know what we will get but it typically goes really well." Finally, the topic *Integrating the Split Self* was also identified as important. "They can look at the combat side and the caring side and the work they have to do to integrate those; the purpose of them; how the two sides interact. The guys get it. It's fantastic stuff to see that change."

Intimacy. Men with trauma and addiction often have difficulty with intimacy. They may engage in relationships without being fully present, or may enact relationship styles that alienate others. After everything they have endured others' concerns may seem trivial ("Oh come on-- is this a life or death issue? Why are you bothering me?"). They may find it hard to be open and genuine. One VA clinician said, "They have trouble going to the store for a pack of cigarettes--the wife thinks they're running around, but it really is just cigarettes. They do it so stealthily; everything is a big secret; because in the military that was an important way to stay alive." Some men have repeated superficial romantic relationships, unable to become close to anyone. "They've done such a good job keeping people away; they seem to be saying, 'I don't want to be known right now; if people knew me they wouldn't like me.'" In Seeking Safety, the concept of secrecy is explored in relation to trauma and addiction; this can help explain where such behavior originates. According to one clinician, "Clients said the

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Seeking Safety material felt 'personal, as if the writer was talking about me.' They found the material engaging and noted that they were sharing it with their spouses. This was viewed as positive and helpful, and offered one way of helping them become more known to people in their lives." Other emphasized the topic *Setting Boundaries in Relationships*: "That really takes off as a topic. We spend more time on that and provide extra materials on it because it really seems to be an important topic. The men really do get into it. They are pretty perplexed by the boundary issues but they are interested in sorting them out."

Multiple problem areas. Uniformly, all of the clinicians emphasized that the men they saw in Seeking Safety had numerous problem areas, beyond just trauma and addiction. They applied it as a general coping skills model and did not require clients to meet formal PTSD or substance use disorder criteria (consistent with prior implementation efforts (Najavits, 2004). The men presented with many different issues, including other Axis I and II disorders (e.g., eating disorders, pathological gambling, bipolar disorder, psychotic disorders); addictions not defined in the DSM-IV (e.g., sex or pornography); medical issues (especially those associated with substance abuse such as HIV and hepatitis C; but also diabetes, high blood pressure, and other health problems); suicidality; dissociative symptoms; poverty; discrimination; and homelessness. The *Case Management* and *Community Resources* topics in Seeking Safety guide clients toward needed treatments of all kinds. The topic *Commitment* teaches clients how to follow through on goals to help improve their lives.

RESEARCH

Four formal research efforts have evaluated the use of Seeking Safety with men; each is described below. All addressed samples of men who were typically severe and chronic in both trauma symptoms and substance abuse, along with numerous other life problems.

Qualitative study on use of Seeking Safety with men veterans. Weaver et al. (2007) report as follows. "In 2006, we conducted a 12-week pilot test of Seeking Safety with male veterans in methadone maintenance treatment at a Department of Veterans Affairs (VA) mental health clinic before the initiation of a five-year randomized controlled trial. We then conducted a semiformal focus group of volunteer participants to ask about general concerns, such as what we could improve, and specific concerns, such as whether the examples of sexual trauma were a problem. We also asked a male researcher and a male veteran who was also a counselor to review the protocol for gender-biased language. In addition, we consulted extensively with the therapist who ran the pilot therapy sessions and the therapist's clinical supervisor, the latter of whom has extensive experience training and supervising clinicians to conduct Seeking Safety.

Without exception, the consensus was that the protocol did not need substantive gender-related changes to work well with our population of male veterans with substance use disorders and PTSD. For instance, despite specific concerns, sexual trauma examples helped our participants who had a relevant history discuss this more 'taboo' form of trauma, perhaps for the first time. In contrast, those with primarily combat trauma readily brought the general concepts to bear on their experience. In our view, this phenomenon actually increased the need for sexual trauma examples, while decreasing the need for additional explicit combat examples. No protocol modification could have kept combat trauma from being a prominent

focus in our groups. Men with histories of exacerbated inequality in

Careful wording in Seeking Safety to avoid bias...[Thus] although men with histories of inequality with men made excellent examples of men who felt that this does not appear to allow for adaptation as a

Pilot study on men with PTSD and SUD. This study by Najavits et al. (2004) plus Exposure-Therapy modified for PTSD and current PTSD and SUD showed how much of each type of symptom improved. Improvements in drug use, dissociation, sexual trauma, thoughts related to safety, and high. The need for further research (425). Also notable was the need for exposure sessions; the need for which typically did; and

Pilot study on veterans with PTSD and SUD. Twenty-five outpatient veterans began participating in 12 sessions (had attended a minimum of 10 sessions). Twenty-five completers, 72% were included alcohol abuse dependence (33%; n=6) but were not receiving P

The veterans who showed improvements from pre-treatment PTSD symptoms decreased. Mean = 65.54, SD=8.80, p < .05, increased, as measured by the PTSD Symptom Scale (SD=20.82, very low; p < .05). Veterans reported increased safety. They also endorsed in Seeking Safety. Regarding substance use, confirmed by urine test results. They felt that when they felt difficulty employing a treatment made them feel safe. This uncontrolled pilot study followed up months after completion (91).

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with men; each is re and chronic in problems. t al. (2007) report with male veterans VA) mental health then conducted a erns, such as what of sexual trauma who was also a on, we consulted herapist's clinical ising clinicians to

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focus in our groups. Modifying the focus away from sexual trauma could actually have exacerbated inequality in our group and reinforced avoidance of sexual trauma issues.

Careful wording in the Seeking Safety protocol also appears to avoid appreciable gender bias...[Thus] although concerns that Seeking Safety would need significant adaptation for use with men made excellent clinical sense, the consensus of our experts and consumers indicates that this does not appear to be the case. The careful construction of the manual appears to allow for adaptation as a natural part of the group process" (pg. 1012).

Pilot study on men with PTSD (based on childhood trauma) and substance use disorder (SUD). This study by Najavits et al. (2005) evaluated "a novel combination: Seeking Safety plus Exposure-Therapy Revised...The latter is an adaptation of Foa's exposure therapy, modified for PTSD and SUD. In this small sample (n=5) outpatient pilot trial, patients with current PTSD and SUD were offered 30 sessions over five months, with the option to select how much of each type of treatment they preferred. Outcome results showed significant improvements in drug use; family/social functioning; trauma symptoms; anxiety; dissociation; sexuality; hostility; overall functioning; meaningfulness; and feelings and thoughts related to safety.... Treatment attendance, satisfaction, and alliance were extremely high. The need for further evaluation using more rigorous methodology is discussed" (pg. 425). Also notable was that the clients chose an average of 21 Seeking Safety sessions and 9 exposure sessions; the study did not rule out patients for active suicidality (unlike prior trials which typically did); and significant results were obtained despite the very small sample size.

Pilot study on veterans (72% men). Cook et al. (2006) report that, "...four Seeking Safety groups were initiated and completed at the Philadelphia VA Medical Center (PVAMC). Twenty-five outpatient veterans with clinician-diagnosed comorbid SUD-PTSD voluntarily began participating in the groups. Of those, 18 completed a series of 25 group treatment sessions (had attended at least 14 sessions and were still coming at the end of therapy). Of the completers, 72% were male...with a mean age of 50. Primary substance use disorders included alcohol abuse/dependence (78%; n=14), cocaine abuse (61%; n=11) and heroin dependence (33%; n=6). The majority were receiving services in the SUD treatment program but were not receiving PTSD care at the time.

The veterans who completed Seeking Safety evidenced statistically significant improvements from pre- to post-treatment in self-report PTSD symptoms and quality of life. PTSD symptoms decreased as measured by the PTSD Checklist-Military (Weathers et al.; pre M=65.54, SD=8.80, post M=51.15, SD=14.38, $t(12)=6.60$, $p<.001$). Quality of Life increased, as measured by the Quality of Life Inventory; Frisch et al., 1992; pre M=-15.43, SD=20.82, very low; post M=.29, SD=18.38, low; $t(6)=-2.46$, $p<.05$). Qualitatively, the veterans reported increased ability to identify and manage PTSD and substance use triggers. They also endorsed improvements in their communication and problem solving skills. Regarding substance use, the veterans did demonstrate continued abstinence from substances confirmed by urine testing. The veterans spoke of the "value of having their own manual to refer to when they felt distressed (i.e., experiencing triggers or cravings) or were having difficulty employing a particular coping skill. Finally, the veterans indicated that the treatment made them feel valued and hopeful for the first time in years. This was an uncontrolled pilot study and thus there was no control group, no followup on dropouts, and no followup months after completion to see if there were lasting effects of treatment." (pgs. 90-91).

Evaluation project on young African-American men. Hamilton (2006) conducted a SAMHSA project titled the African-American Center of Excellence (AACE). It served two Florida county drug courts, offering residential treatment at Operation PAR in Florida. All participants in AACE ($n=76$) were African-American males between the ages of 18 and 25, all with lifetime criminal justice involvement. During the six-month residential program, all clients completed all of the assigned modules of Seeking Safety.

Overall, clients were high severity with significant substance abuse and mental health problems. In the year prior, 55% had drug-related charges; 29% interpersonal crimes; and 24% property crimes. A total of 80% met current criteria for substance abuse or dependence (marijuana and cocaine were the most common), with the remaining 20% reporting substance use. Other current diagnoses included 20% ADHD, and 17% each for major depression, PTSD, and conduct disorder. Also, 12% had current suicidal or homicidal thoughts; 76% had been victimized during their lifetime (60% prior to age 19); and 20% had been homeless during their lifetime.

Results indicated a notable drop in substance use, based on self-report. At baseline, the mean days clients reported using substances was 25.3 days; at six months (the ending of the residential program) there was 100% abstinence from substances; at 12 months post-intake, the mean numerous of substance use days was 2 days (twelve-month follow-up $n=55$). Significant reductions were also found from baseline to six months on various scales: the Anxiety subscale of the SCL-90 ($p<.05$); all five subscales of the Cognitive Distortions Scale at $p<.05$ (self-criticism; self-blame; helplessness; hopelessness; and preoccupation with danger); and seven subscales of the Trauma Symptom Inventory at $p<.05$ (anxious arousal; depression; anger/irritability; intrusive experiences; dysfunctional behavior; impaired self-reference; and tension reduction behavior). No data are available for those measures at 12 months, however. Finally, the rate of self-reported unprotected sex decreased from 22% at baseline to 5.9% at 6-month followup, but returned to baseline levels at 12-month followup.

Several conclusions were drawn from this project. First, the implementation of Seeking Safety made significant progress with AACE clients and their understanding of trauma and its relationship with substance abuse. Based on anecdotal information, the use of Seeking Safety provided a structured and safe environment where clients were enabled to express and address their behaviors and emotions without fear of reprisal or judgment. Second, the findings from the AACE data seem to indicate that clients do very well while they are in the residential phase of treatment. However, when they enter the aftercare phase after the six months of residential treatment, recidivism begins to increase and treatment compliance begins to decrease. Thus, it is suggested that future efforts should target the post-residential phase more intensively.

Overall research conclusions. In sum, these research projects reveal high acceptability of the model among several subsets of men: veterans, men traumatized in childhood, and young African-American men referred by drug courts. Moreover, all three projects that reported on quantitative outcomes found statistically significant positive results on various domains. Yet research thus far is at an early stage, and no randomized controlled trial on Seeking Safety with men has been conducted. Future research is needed to verify and extend the positive results of existing studies.

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ADDITIONAL SUGGESTIONS FOR CONDUCTING SEEKING SAFETY WITH MEN

In the section *Clinical Themes* earlier in this chapter, various ideas were offered that may help when implementing Seeking Safety with men. The following are additional suggestions.

Use language and examples relevant to men. The Seeking Safety manual encourages language and examples relevant to any subpopulation, whether based on gender, ethnicity, age, setting, or other factors. Below are examples that may be helpful for men clients.

- “*Seeking Safety*” or “*Seeking Strength*”. For military settings, Najavits [2005] suggested the title *Seeking Strength* as soldiers cannot always seek safety-- they must pursue dangerous situations as part of their work. With other men, some clinicians use *Seeking Safety*; others use *Seeking Strength*. One program used *Strength Through Safety* (Stillson, personal communication, 2006).
- *Asking For Help*
 - Men seem to respond well to the idea of asking for help if it is described as a collaboration. Men actually help each other all the time with tasks and activities. They have the experiences of working together to achieve a common goal in battle, the work place, and sports. These examples help men to focus on the reciprocity rather than the vulnerability of asking for help.
- *Grounding*
 - When conducting the grounding exercise with men, incorporate a phrase about feeling “strong in your body, empowered, more focused.”
 - Highlight that there is a middle ground between hypervigilance and being completely vulnerable (especially for men in situations that may be currently dangerous, such as prison or the military). “Staying grounded will help you to make safer choices when you have to go back into battle or the prison yard.”
- *Compassion*
 - “Using compassionate self-talk is like being a good sports coach.”
 - “It’s found that Olympic athletes perform the best when coaches give them balanced feedback. A coach may say: ‘When you cleared the hurdle, you did well, but your right leg was a bit too low.’ This is more helpful than just praise or criticism.”
- *Safety/Safe Coping Skills*
 - In general, men seem to think in terms of degrees of safety (what is *safer*) rather than safe versus unsafe. When you think about this from the perspective of a trauma survivor, this seems more adaptive than a more all-or-nothing view.
 - Men seem to respond especially well to the following coping skills (in the topic *Safety*): take responsibility; leave a bad scene; notice the source; notice what you can control; solve the problem; examine the evidence; plan it out; find rules to live by; work the material; focus on now; rethink; notice the cost; set an action plan; notice the choice point; if one way doesn’t work, try another; get organized; list your options; when in doubt, do what’s hardest.
- *PTSD: Taking Back Your Power*

- Some men are so used to trauma that they view it as normal. Many are surprised to find their experiences qualify as traumatic events. Talking about “violence” may be helpful for some men to understand the word trauma.
- “Think of it as a purple heart winner getting ammunition to use in the real world.”
- One VA clinician said, “I even use Lisa’s preface which helps the guys see her as the warrior that she is and that she understands it’s about restoration of ideals and that kind of thing; it’s not about not being strong enough or that it’s for women.”
- Get them to visualize a young person they care about (son or daughter, etc) coming to them with a problem such as combat or abuse. Ask, “How would you respond to that person?” and then ask if they themselves are worthy of this same response.
- *Creating Meaning*
 - The term “beliefs” rather than “meanings” can be used.
- *Life Choices Game (Review)*
 - Have men create their own scenarios for this topic so relevant issues will emerge.

Know that men like the treatment format. Men have consistently reported that they like the Seeking Safety format. As one clinician said, “I can’t say enough about how important the session structure is. It is very comforting to them. Over and over they tell me: I know what I’m getting into; it’s not a horribly unknown situation, I know what I’m getting into.” Some men have also commented on liking the check-in question, “How are you feeling?” because they often are not asked this question.

Gently encourage homework (“commitments”). Those who do the commitments “take the work to a whole other level. It’s also one of the best ways of getting to know the clients.” But getting them to do commitments can be challenging. “A lot of them are ‘high school holdovers’—they don’t like the idea of homework.” It helps to remember that commitments are optional, not required, in Seeking Safety. Gentle encouragement is thus the best strategy. In groups, subtle peer pressure sometimes exerts an influence on those who are not doing commitments. One program made the commitments more formally part of the session by holding a 2 hour meeting, with a half-hour of that peer-led and set aside for completing commitments. The half hour can be added to the front or end of the clinician-led session. They also allowed clients to try a buddy system in which they paired up with another client to do the commitment during that half hour or outside of it.

Consider mixed-gender groups. Because Seeking Safety focuses on the present and coping skills, it can be done in mixed-gender format. Sometimes this is necessary in settings where there are only a few of one gender and they would otherwise not have access to group treatment. Suggestions include making sure the minority gender clients (whether male or female) know there will be many more of the other gender in the group, and that they can choose whether or not to join. Also, encourage them to try it for a few sessions to see if they feel comfortable, before they decide. One clinician spoke of the positive value of a mixed gender group: “A female veteran who had experienced military sexual trauma, was in our mostly male group. She got some excellent, very compassionate feedback and pointers

regarding boundary issues that this group experienced them all as predators--positive feedback from

Address men’s issues good supervision for men. She stated, “The clinicians who aren’t s The clinician is taken materials are for women or viewing it as a group who work with men, in word, other than safety we ask a different question women’s question!” Other are clinical dilemmas supervision, we discuss clients’ lives.”

Learn from the clients concerns about using topics.” “The case may do.” She said that in explanation and rationale and noted that they were recognized that the discussion important not to make to try the model as is ways of obtaining the chapter 2) and the Enc may even be humorous responses to the part of *Boundaries in Relationships*

Strive to respond how men will respond topic *Respecting Your* veterans may need to feel overwhelmed by treatment). Also who experienced the same than men with different gender: poverty, legal factors, and relationships

Adapt Seeking Safety model, such as the following

regarding boundary issues with males. Another female military sexual trauma victim reported that this group experience helped her develop a more balanced view of men--no longer seeing them all as predators-- because for the first time in her life she received emotional support and positive feedback from males."

Address men's issues as part of supervision. One clinician emphasized the importance of good supervision for clinicians who have concerns about conducting Seeking Safety with men. She stated, "The questions about the Seeking Safety materials seem to come more from clinicians who aren't sure how to respond to men, rather than the men rejecting the materials. The clinician is taken off guard by men's questions, and then buys into the idea that the materials are for women, rather than seeing the client's questions as stemming from curiosity or viewing it as a growth opportunity for the men. In my experience supervising clinicians who work with men, they occasionally bring up questions, such as: 'Can we use a different word, other than safety?' The men will just say: 'There's no way to feel safe in prison!' Can we ask a different question, other than 'How are you feeling?' The men think this is a women's question!" Or, "*Compassion* isn't for men -- it suggests taking a warm bath." These are clinical dilemmas for supervision, not a sign that the materials need to be adapted. In supervision, we discuss how to personalize the materials to use relevant examples from clients' lives."

Learn from the clients. One program director reported that her staff initially had a lot of concerns about using Seeking Safety with men. "It will be too long." "They won't like the topics." "The case management will not work." "The structure of the sessions will be hard to do." She said that in fact, the men clients "were open to the Seeking Safety treatment explanation and rationale. They agreed that the disorders should be treated simultaneously and noted that they were thankful that such a treatment had 'finally' been developed. They recognized that the disorders were interrelated." She said her staff eventually realized that it is important not to make up-front assumptions about what they will or will not like, but instead to try the model as is and obtain clients' feedback. In the Seeking Safety book, two main ways of obtaining their feedback are emphasized: the End of Session Questionnaire (in chapter 2) and the End of Treatment Questionnaire (in the final chapter). Occasionally there may even be humorous moments. One clinician said the men in her group had "interesting responses to the part about saying 'no' to continuing prostitution when doing the topic *Setting Boundaries in Relationships*."

Strive to respond to men's different needs. Recognize that there are many variations in how men will respond to the material. For example, VA clinicians have observed that the topic *Respecting Your Time* goes differently with older veterans than younger ones. Older veterans may need to increase activities in their available time whereas younger veterans may be overwhelmed by too many demands (trying to get a job, find a partner, raise children, attend treatment). Also, do not assume that all reactions are based on gender. Men and women who experienced the same type of trauma (such as early child abuse) may appear more alike than men with different trauma types. Also, many other factors may play a role beyond gender: poverty, legal problems, length of substance abuse, treatment setting, resiliency factors, and relationship with the clinician.

Adapt Seeking Safety to your setting. Clinicians reported different ways of conducting the model, such as the following:

- -An orientation group to present a few key Seeking Safety topics in psychoeducational format (allowing the clinician and clients to see if it feels like a good fit).
- -An alumni group conducted on a drop-in basis so that men can return for support as needed.
- -Letting clients go through Seeking Safety a second time, if desired.
- -Conducting the treatment in blocks (4, 6, 8, or 12 sessions).
- -Encouraging clients sit in on up to three sessions to see if they like it, before joining.
- -Adding additional materials as may be helpful (additional anger management tools; information on the biology of trauma and substance abuse, etc.).
- -Allowing a client to do individual Seeking Safety if the group modality does not work for him.
- -Bringing in treatment-relevant videos.
- -Adding creative exercises or games.

Rehearse the skills. Frequent rehearsal of the Seeking Safety skills helps clients use them when new situations arise. One clinician said, "The structure, coping skills format, and cohesiveness of the groups have helped many participants cope constructively with very difficult situations in the present as well as in the past. For example, the child of a combat veteran disclosed sexual abuse by a neighbor. Naturally this news put the veteran in fighting mode and he was struggling with intense rage and homicidal thoughts. The group gave him a safe place to process very charged emotions and his reports of effectively controlling his rage by using grounding and cognitive strategies was very reinforcing in demonstrating that these techniques can work well when one is motivated to apply them. Also, I believe the broad focus on a range of traumas offered by the materials helped the veteran respond in a very understanding, compassionate manner to his child's disclosure and emotional distress. Another veteran received some serious threats from a co-worker. He initially had thoughts of a pre-emptive strike, but the group helped him safely work through this (did some problem solving to help him identify reasonable steps he could take to feel safer and to consider the potential negative consequences of making a pre-emptive strike)."

If needed, shorten the check-in. Some programs that treat men have very limited resources, such as in prisons and community settings. Seeking Safety may therefore be conducted in large groups and it may be necessary to reduce the check-in to one or two questions (e.g., "What good coping have you done?" and "Any substance use or other unsafe behavior?"). If conducting the model with extremely large groups (20 or more), consider having just a few clients answer the questions (ask for volunteers, or have different clients answer at each session). One program modeled the check-in for clients so they could see that it was designed to be short.

CLINICAL EXAMPLES

Below are two types of clinical materials that may help illustrate the use of Seeking Safety with men: quotations from clients and clinicians; and two case examples.

I. Quotations

- An email from

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II. Case Examples

Case example #1.
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I. Quotations

- An email from a male clinician treating men at a veterans' center:

"Thank you for bringing your expertise to the men and women who served our country. Thank you also for making my practice here so overwhelmingly successful with such a hard to reach population of combat veterans. You've allowed me to reach the unreachable. It never ceases to amaze me how such a bunch of nice guys, with a high body count, 'get it', immediately. Your program gives them the recovery of intimacy and helps them to see the transcendent in the everyday intimacies of love, work, and play. As they recover through the epiphany of your treatment program I see them move from distrust to trust, from fear to faith, from self-enclosure to mutual disclosure. We old combat vets thank you for your knowledge that shows how it is never too late to recover the intimacy to change things, and inviting us to experience more epiphanies like this through your sessions focusing on the ideals lost in combat."

- A male Vietnam veteran: "I wish I would have learned these skills 30 years ago; it would have changed my life."
- A female clinician treating men in the community: "Seeking Safety provided a missing component on trauma that the 12-Step program did not address. I find Seeking Safety a valuable tool to address both issues and have seen enormous benefits in the lives of clients."

II. Case Examples

Case example #1. Joe is a 37 year-old Italian Catholic man who was molested during childhood by both his parish priest and by his swim coach. When Father Dominic started taking a special interest in him, such as inviting him to the movies or out to ice cream, he initially felt flattered. He grew up in a large family (one of 7 children), so was pleased to feel "special". The first molestation occurred on an outing for the altar boys. Afterwards, he tried to forget about it and to convince himself that he had "imagined the whole thing." After he was molested several more times, he told his parents. However, they never took action; in their traditional Catholic family, one never questioned the authority of a priest.

At age 14, Joe was also molested by his soccer coach. He had learned from his previous molestations that "spacing out" and just "getting it over with" was the best way to deal with these events. He started drinking and using marijuana in high school. Soon, it became a daily habit.

At age 20, Joe met and married his wife who was also a traditional Catholic. They had 4 children. He worked as a civil servant for the county. Although he "felt ok," he found that he could not attend or even pass by a Catholic church without having a panic attack. Eventually, he became more and more depressed. He and his wife were estranged, though they continued to live in the same house. He felt a tremendous void from the loss of his spirituality, as well as estrangement from his family of origin (who continued to actively participate in church events). His daily marijuana use began to impact his work. He found himself contemplating

suicide. One day, shortly before beginning the Seeking Safety treatment, he tried to hang himself.

Joe immediately felt comfortable with Seeking Safety and began carrying around the safe coping skills sheet. The connection between trauma and substance abuse made sense to him, and he felt motivated to stop his marijuana use. Later in the treatment, he was even able to confide in his father about his marijuana use. His father, a recovering alcoholic, strongly supported Joe in becoming substance-free.

The PTSD symptoms were another matter. As soon as Joe stopped smoking marijuana regularly, his flashbacks and nightmares increased with a vengeance. He and his wife began arguing more. She was concerned that treatment might be making him worse, rather than better. After an exposure therapy session, Joe became dissociative, and later, suicidal. He was hospitalized on the inpatient unit for several days. He stated that one of the interventions that "helped things turn around" for him was discussing the "Getting Others to Support Your Recovery" handout. The therapist had conducted the session with Joe and his wife on the inpatient unit.

Once he was discharged from the hospital, Joe made a firm commitment to practice the safe coping skills on a daily basis. He used grounding whenever his anxiety started to creep up. He practiced driving to his old neighborhood, past his childhood church, and using grounding. He noticed that over time, his anxiety started to decrease. Towards the end of treatment, he was able to attend his niece's baptism at a Catholic church, though "I had to practice grounding the whole time." As his anxiety decreased and his sleep began to improve, Joe started to believe that "I can get past the trauma." He and his wife also began couples therapy.

Case example #2. D is a tall, 50-something, Hispanic man. Upon meeting him, his gentleness and humor are quickly apparent. D has survived a lot. While growing up, he was sexually abused for many years by his uncle. He began using drugs (primarily heroin) at an early age and quickly became involved in the criminal justice system. He had many different sexual relationships with both men and women. His long-term partner committed suicide while in prison, and this was the beginning of D's road to recovery. He became suicidal and was hospitalized for several months, which allowed him to engage in treatment for the first time. He established sobriety. He began to receive regular medical evaluations; although he learned he was HIV positive he received treatment for it. Recently, however, the gains he made were threatened. During a sexual encounter, he contracted a sexually transmitted disease which worsened his medical conditions. He felt betrayed and this triggered a flooding of memories and feelings related to the sexual abuse. He felt like getting high again. After "spilling" his story to his primary care doctor, he agreed to a referral to receive help for the trauma and substance abuse problems.

Even though D's HIV-related problems make it difficult for him to remember appointments, he has worked to find ways to remember them and attends consistently. He readily engaged with the present-focused approach. He has embraced the overall goal of increasing safety in his life. He has started to use the skills he is learning, to address trauma-related symptoms as well as substance cravings. The grounding skill helped him to "detach from painful feelings and memories related to the sexual abuse" he experienced and he no longer "spills" his story to anyone who will listen to him. He uses grounding when he feels like using and has developed ways to reduce his access to substances. He has been able to maintain his recovery from substances. While going through the topic *Setting Boundaries in*

Relationships he role-played risk of losing his housing. manager to assist him with difficulty by directly setting *Healthy Relationships* and again "showed up at his door for the above situations, (we learned at an early age that protect himself more. He especially while learning (a group which he would like ended treatment. In reflection connection between the abuse stand up for myself and he find ways to calm myself down

This chapter highlights with men. However, much suggestions, but are aware from clinicians and clients important. The research is model with men; however Seeking Safety studies with more multisite trials); such studies. Finally, it is essential to include trauma and substance and subpopulations such as factors. Although we have influences may play an understanding of the intervention work.

Several general conclusions
Based on clinical and

- Both trauma and substance use are in control. Men are able to work on achieving

Relationships he role-played asking his niece to move out as her presence was putting him at risk of losing his housing. While learning *Asking for Help* he made a phone call to his case manager to assist him with his niece, but eventually was successful at overcoming his difficulty by directly setting limits with her until she moved out. He has been learning about *Healthy Relationships* and made the decision to set boundaries with an ex-boyfriend who again "showed up at his doorstep". He is starting to use *Compassion* when he blames himself for the above situations, (which trigger his wanting to use substances) and understands that he learned at an early age that he couldn't say "no", but now recognizes that he can learn to protect himself more. He is working to increase contact with supportive people in his life, especially while learning *Getting Others to Support Your Recovery*; he has also identified a group which he would like to attend to meet more people and receive support. D recently ended treatment. In reflecting on his treatment experience he says, "I never made the connection between the abuse I experienced and using substances. I didn't realize that I could stand up for myself and have better relationships. I didn't realize that I can ask for help and find ways to calm myself down without using substances. Thank you so much for this help."

FUTURE WORK

This chapter highlights clinical and research experiences on the use of Seeking Safety with men. However, much more remains to be done. We have shared our impressions and suggestions, but are aware that all of us have "taken" to the Seeking Safety model. Learning from clinicians and clients who do not like it or who decide not to adopt it would also be important. The research studies thus far provide consistent positive support on use of the model with men; however, they represent an early stage of scientific work. Further Seeking Safety studies with more rigorous designs are needed (randomized controlled trials and multisite trials); such studies have been conducted with women but not as yet on men. Finally, it is essential to remember that gender is one of many influences on clients; others include trauma and substance abuse type; clinician and setting; minority and cultural issues; and subpopulations such as veterans, homeless, criminal justice clients, adolescents; and other factors. Although we have tried to record our observations on men, we recognize that other influences may play an equal or more important role at times than gender. Greater understanding of the interplay between gender and these other factors is also needed in future work.

CONCLUSION

Several general conclusions can be highlighted.

Based on clinical and research experience thus far:

- Both trauma and substance abuse violate the traditional male role of being strong and in control. Men may have to fight these images to accept where they are and to be able to work on achieving genuine strength and control.

- It can be helpful to obtain books or other resources on the psychology of men, especially in relation to trauma and substance abuse.
- Seeking Safety was designed for both men and women, and works well with both genders.
- Seeking Safety has been successfully implemented with diverse men including veterans, men in the criminal justice system, men with histories of childhood abuse, men of various ethnic and racial categories, men of different ages including adolescence, different substance and trauma types, and different settings.
- Four formal research studies have evaluated Seeking Safety with men. All have found the materials highly acceptable as is, and in the three studies that obtained quantitative data, all evidenced significant pre- to post-treatment improvements on various outcomes.
- Early concerns that the material is too feminine have not been supported by either clinical experience or research.
- The overall response to Seeking Safety by men and their clinicians has been highly positive. Both the format and content are perceived as relevant. There are no particular topics or aspects that have thus far been found less useful with men than with women.
- Several typically male themes have been identified. Although these can occur in both genders, we have found them especially prominent with men. Awareness of these can guide implementation of Seeking Safety: (a) bonding in male ways (like warriors, teams); (b) difficulty with feelings; (c) anger; (d) perpetration; (e) sexuality issues; (f) hard to engage in treatment / hard to end treatment; (g) isolation; (h) caretaking problems; (i) issues with authority and control; (j) identity ("Who are you?"); (k) self-hatred (feeling "like a monster"); (l) intimacy; (m) multiple problem areas.
- Seeking Safety emphasizes flexibility, and thus can be adapted as needed (using examples relevant for client subgroups; changing the pacing or length of the treatment; adding in additional materials).
- Suggestions for using Seeking Safety with men include: (a) use language and examples relevant to men; (b) know that men like the treatment format; (c) gently encourage homework ("commitments"); (d) consider mixed-gender groups (e) address men's issues as part of supervision (e) learn from the clients; (f) strive to respond to men's different needs; (g) adapt Seeking Safety to your setting; (h) rehearse the skills; (i) if needed, shorten the check-in.
- Many important aspects of the work transcend gender-- for example, developing a recovery identity, reducing symptoms of trauma and substance abuse, and attaining safety.

Future Work

- Further research is needed, especially randomized controlled trials and multisite trials.
- Further clinical experience will also be helpful. Learning from clinicians and clients who do not like the model or decide not to adopt the model would also be useful.

- It will be important to explore cultural factors (e.g., trauma, cultural issues);
- More on men, and how Seeking Safety works with them.

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- It will be important to explore what facets actually relate to gender versus other factors (e.g., trauma and substance abuse type; clinician and setting; minority and cultural issues; and subpopulation).
- More on men, trauma, and addiction is needed, aside from any particular focus on Seeking Safety.

AUTHOR NOTE

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Author: Lyman J. Katlir

Chapter 3

RELATIONS OF IMPI MONETARY

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* Corresponding author: Ta
mail: taikitakahashi@
Sapporo, Japan.