

PSYCHOTHERAPIES FOR TRAUMA AND SUBSTANCE ABUSE IN WOMEN

Review and Policy Implications

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Women are subject to high rates of interpersonal violence. One frequent co-occurring issue is substance abuse, which may arise posttrauma as a way to cope. In this article, psychosocial therapies for co-occurring trauma and substance abuse are reviewed. Description of empirically studied models is provided, as well as results of the empirical studies. Overall, this area of work suggests positive growth in the availability of new models but very limited empirical work thus far for all but one model. Directions for the future include the need for greater study of treatments in this area, as well as the need to address issues beyond specific models (e.g., workforce issues, access to care, and changing the culture of treatment systems). Policy implications are also offered.

Key words: *trauma; substance abuse; co-occurring disorders; treatment; psychotherapy; posttraumatic stress disorder; substance use disorder; chemical dependency; alcoholism*

IT IS WELL ESTABLISHED THAT WOMEN ARE SUBJECT TO HIGH RATES OF INTERPERSONAL VIOLENCE of all kinds (see elsewhere in this special issue). Such violence has enormous impact on their emotional and physical well-being and may spur the development of substance abuse. Indeed, when substance abuse develops, it typically follows after the onset of PTSD, a pattern that may reflect self-medication of trauma symptoms (Najavits, Weiss & Shaw, 1997).

As one woman said, "My whole life went downhill. I was abused, and used alcohol to

escape the pain. I became horrible to myself and everyone around me. I honestly didn't care what happened anymore." Directionality also occurs the other way, however (substance abusers are at higher risk for trauma of all kinds). And for some, both trauma and substance abuse arose at the same time, often in unhealthy family systems (Najavits, 2002a). Substance abuse is a growing concern for females as it has increased in the past several decades. Indeed, in the 1990s, girls caught up with boys in age of first use (Najavits, 2002b; National Center on Addiction and Substance Abuse at Columbia University,

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KEY POINTS OF THE RESEARCH REVIEW

- Many models have been developed but there is limited empirical work.
- Treatment shows positive impact.
- Models have important similarities and differences.
- Specificity for women is unclear.
- Specificity for interpersonal violence is unclear.
- There is a need to look beyond models (e.g., to address workforce issues, increased funding for services, and changing the culture of treatment systems).

2006). This stems in part from decreased stigma for female substance use, as well as greater access to substances. Particular subgroups of women are especially vulnerable to substance abuse, including rural women, women with disabilities, lesbian women, professional women, women in the helping professions, adolescent girls, and others (Najavits, 2002b).

Epidemiology data indicate that women have double the risk for posttraumatic stress disorder (PTSD) as men (10% vs. 5% U.S. lifetime rates) and that women's PTSD often results from interpersonal violence in childhood and/or adulthood (Kessler et al., 1994). Women's rate of substance use disorder (SUD) is also high at 18% (lifetime), though this is still much lower than men's rate of 35% (Kessler et al., 2004). In terms of comorbidity among women who develop PTSD at some point in their lives, 28% of these women develop alcohol use disorder and 27% develop drug use disorder (Kessler et al., 1995). PTSD and SUD are thus significant problems for women, both independently and as comorbid conditions.

In the field of interpersonal violence, there has historically been an understandable hesitation to diagnose mental disorders in women who suffered interpersonal violence, as it could be perceived as "blaming the victim." However, disorders such as PTSD and substance abuse make sense as responses to violence and can be successfully treated if they are accurately diagnosed. Moreover, in the past several decades treatments of these disorders have become more empathic, with less confrontation and judgment (Najavits, in press).

Treatment of co-occurring trauma and substance abuse has grown over the past decade, although much remains to be done. This article will address the following:

- (a) Models for co-occurring trauma and substance abuse and their empirical base
- (b) General themes
- (c) Policy implications and future directions.

This article is targeted toward clinicians, researchers, program administrators, and policy makers.

Because most of the therapies thus far were designed for use across various trauma types, including interpersonal violence, the term *trauma* will be used in this article. However, it is noteworthy that in most samples for the empirical studies on these therapies, interpersonal violence was the primary trauma type. The term *substance abuse* is also used throughout for simplicity rather than the formal diagnostic phase, *substance use disorder*.

MODELS

Each model in this section has at least one published study. Most of the study samples included women who had experienced interpersonal violence (except for two models, for which trauma type was not reported: collaborative care; and substance dependence-PTSD therapy). Some of the models were designed specifically for trauma and substance abuse, whereas others were designed for just one or the other domain, but were studied in a sample with both. Models are classified into treatment and prevention.

Treatment Models

Seeking Safety. Seeking Safety (Najavits, 2002a) is a present-focused coping skills model designed to address trauma and substance abuse at the same time. It targets four domains: cognitive, behavioral, interpersonal, and case management. In all twenty-five topics are offered, although the clinician can use as few or as many as desired, as all topics are independent of the others. Topics include *honesty*,

asking for help, compassion, healthy relationships, taking good care of yourself, creating meaning, integrating the split self, healing from anger, and detaching from emotional pain (grounding). Seeking Safety was designed for a high level of flexibility (all types of trauma and substance abuse, group or individual modality, all types of clinicians and settings, and both genders). It is the most empirically studied model for the dual diagnosis, with consistent positive findings in across numerous studies including four randomized controlled trials, a multisite trial, a controlled trial, and eight pilot studies (for a review see Najavits, 2007). Most of the studies thus far have been on women or girls, and in those samples the vast majority of participants had a history of interpersonal violence (typically sexual and/or physical abuse in childhood). Overall results across the various studies indicate consistently positive outcomes on PTSD, substance abuse, and various other areas (such as HIV risk behaviors, social functioning, suicidality, cognitions related to PTSD/substance abuse); consistent superiority to treatment as usual (TAU); comparability to a gold standard treatment (relapse prevention); and high satisfaction by clients and clinicians. At this point, it is the only model for trauma and substance abuse that meets criteria as an effective treatment (Chambless & Hollon, 1998; Najavits, in press; Najavits et al., in press). Studies have addressed diverse samples, including women in community treatment, adolescent girls, homeless women veterans, women in prison, and various ethnic and racial subgroups. Dissemination materials include a Web site, training videos, and foreign-language translations (Spanish, French, German, Dutch, Swedish). See www.seekingsafety.org for further information and updates on research.

Concurrent treatment of PTSD and cocaine dependence. This model (Brady et al., 2001; Back et al., 2001) combines existing manualized treatments that had shown efficacy for PTSD and SUD separately in prior trials (exposure therapy for PTSD, relapse prevention for substance abuse, and coping skills). It is a 16-week individual therapy. There is one study on the model, an uncontrolled pilot study, which found

that those who remained in treatment showed reductions in PTSD, substance abuse, and depression. The sample was primarily women with a history of interpersonal violence. The study suggests that some patients with PTSD and substance abuse can benefit from PTSD exposure treatment. However, questions remain regarding treatment retention and paying patients to attend sessions.

Trauma recovery and empowerment model (TREM). This present-focused group therapy model by Harris and colleagues (1998) was originally designed for women abuse survivors with severe mental disorders. It offers 40 sessions in individual addressing cognitive restructuring, psychoeducation, skill building, survivor empowerment, and peer support. There is one study on the model, a post hoc analysis of one site (Toussaint, VanDeMark, Bornemann, & Graeber, 2007) from a multisite trial on women with co-occurring disorders and violence (Cocozza et al., 2005). For that project, TREM was modified to 24 sessions and a trauma workbook by Copeland and Harris was added for orientation prior to starting TREM (2000). Toussaint et al. studied women in residential substance abuse treatment, all with histories of interpersonal violence comparing TREM plus workbook to TAU. The former evidenced better outcomes on trauma-related symptoms; both conditions improved in substance use symptoms with no difference between them.

Substance dependence-PTSD therapy. This model by Triffleman, Carroll, and Kellogg (1999) offered 40 sessions in individual modality to addresses PTSD and substance abuse. It is a phase-based approach using existing models for each disorder (such as *in vivo* PTSD exposure and coping skills training). One study has been published on the model (Triffleman, 2000). Substance dependence-PTSD therapy (SDPT) was compared to 12-step facilitation (TSF) in a sample with at least current partial PTSD and lifetime substance abuse. Although females comprised 50% of the sample, their rate of interpersonal violence was not reported. Only one difference between the two treatments

was found (more sessions of SDPT were attended than TSF among those who attended at least three sessions). As no other differences were found, the researchers thus combined the data, making it difficult to draw conclusions about SDTP (SDTP did not outperform TSF on PTSD or substance abuse, nor are results reported separately for SDTP).

Prevention Models

Collaborative Care This prevention model by Zatsick et al. (2004) was designed for medically injured trauma survivors at risk for developing PTSD and alcohol use disorder. The model combines various existing treatments, including motivational interviewing, cognitive-behavioral therapy (CBT), case management, and psychopharmacology. The specific amount and type of treatments varies based on clients' presentation. In one study that included both women and men, CC was compared with TAU in a sample that was approximately one third female. Rate of interpersonal violence in the sample was not reported. Results indicated that those in CC were less likely to have PTSD and SUD than TAU at one year. However, the study had various methodological limitations (e.g., no mention of blind evaluators nor adherence ratings, and lack of full randomization). The rate of interpersonal violence in the sample was not reported.

Video intervention. Resnick et al. (2005) developed a 17-min video for women rape survivors to prevent the development of PTSD and related symptoms, including substance abuse. It is shown prior to the forensic medical exam that occurs immediately postassault. The video has two components: The first is to reduce anxiety about the forensic medical exam; the second is psychoeducation to normalize reactions to the rape and to instill healthy coping in the weeks and months ahead. In a randomized, controlled trial of women who did or did not receive the video, that is, those who did receive the video showed lower likelihood of marijuana abuse 6 weeks postrape (Acierno et al., 2003), and for those with a prior rape history, lower PTSD, and depression symptoms

(Resnick et al., 2007). However, among those without a prior rape history, higher PTSD and anxiety symptoms were found at 6 weeks postrape, raising the question of whether the video should be shown to those without a prior rape history (as well as the need to explore other aspects of this finding).

Other Models

Several other models are not reviewed here for a variety of reasons. Transcend (Donovan, Padin-Rivera, & Kowaliw, 2001) was designed and tested on men only. Acceptance and commitment therapy was not designed to treat both trauma and substance abuse, and has only a single case study on a client with these (Batten & Hayes, 2005). Others models have no published study thus far: *Creating Change: A Past-Focused Treatment Manual for PTSD and Substance Abuse* (Najavits, in press); "Behavioral Treatment of the PTSD-Substance Abuser" (Abueg & Fairbank, 1991); an inpatient model by Bollerud (1990); *Treating Addicted Survivors of Trauma* (Evans & Sullivan, 1995); a group therapy for PTSD and alcohol abuse by Meisler, 1999; *Double Bind* (Trotter, 1992); and TAMAR (trauma, addiction, mental health, and recovery) trauma treatment group model. Several other integrated models were part of a multisite study (Cocozza et al., 2004) but results were aggregated across models so it is not possible to determine the outcomes of each separately: *Addiction and Trauma Recovery Integration Model* (Miller & Guidry, 2001) at one site; *Triad* (Clark & Fearday, 2003) at one site; *Seeking Safety* at four sites, and *TREM* at three sites. Finally, two other models were developed primarily for trauma survivors, and they provide some attention to substance abuse as well: *Beyond Trauma* (Covington, 2003), which was specifically designed for women, and *Trauma Adaptive Recovery Group Education and Therapy* (Ford, Kasimer, MacDonald, & Savill, 2000); however, both await a published outcome study.

Various other models have been broadly applied to women in various settings and have a strong empirical record, but either do not explicitly address trauma (e.g., *Dialectical*

Behavior Therapy by Linehan, 1993) or have not been studied or designed for comorbid substance abuse patients (e.g., *Eye Movement Desensitization and Reprocessing* by Shapiro, 1995).

General Themes

Several broad themes can be summarized at this point.

Many models have been developed but there is limited empirical work. The past decade has seen the growth of new models that may be relevant for women who experienced interpersonal violence and substance abuse. This is a positive development that bodes well for improving services. At this point, however, only one model is established as effective (*Seeking Safety* by Najavits, 2002a). All other models have either one study or none, and no randomized controlled trials. There have also been no trials as yet that compare between models. Beyond outcome trials, more work is also needed to study the processes of training clinicians, dissemination of models, cost-benefit analyses, preferences for particular models, and mechanisms of action of models (aspects that account for change). No study has thus far compared outcomes based on trauma type (e.g., interpersonal violence vs. other types). The next decade will likely see more on these topics to help improve services as well as policy decisions.

Treatment shows positive impact. Thus far, treatments for trauma and substance abuse have consistently evidenced positive outcomes. Moreover, they consistently outperformed TAU in the few studies that have evaluated that. One major study also concluded that they are cost-effective relative to TAU (Domino, Morrissey, Nadlicki-Patterson, & Chung, 2005). Research indicates that a wide range of clients can benefit from the models and that a variety of clinicians can conduct them (see also Coccozza et al., 2005). These are important conclusions when considering earlier assumptions that treating trauma in the context of substance abuse would lead to negative impact or could only be conducted by clinician with advanced degrees (Najavits, 2002a).

Models have important similarities and differences. Future work would also benefit from a greater understanding of how models may be similar or different and what aspects are actually important to promote change. Some considerations are as follows:

- To what extent does the client benefit from focusing on the present (coping skills and psychoeducation) versus focusing on the past (telling the story of past trauma and substance abuse)?
- To what extent are the models unique? In an era of proliferation of approaches, it would be helpful to obtain a greater understanding of how much the models are actually different versus largely repeating similar strategies and content.
- To what extent is it helpful to combine models?
- Which clients may benefit from particular models versus other clients (characteristics based on trauma and/or substance abuse history, sociodemographics, etc.)?
- How do clinician factors interact with models? For example, are some clinicians more able to implement particular models? What models or features of models do clinicians most like?

Specificity for women is unclear. It is heartening that much of the empirical work on the models either addresses women or includes them within their samples. However, there is virtually no research as yet to address whether gender-specific treatment is needed or whether outcome results vary by gender. It could be argued that women need gender-sensitive models, given the differences between women and men in their trauma and substance abuse patterns and their particular recovery needs. However, this remains an open question. For example, the psychotherapy field rarely shows differences between carefully crafted manualized models (e.g., Benish, Imel & Wampold, 2007). The famous saying by Luborsky et al. still holds, quoting from Alice in Wonderland—"All have won and all must have prizes." Moreover, major multisite trials typically fail to show differences based on gender, even when a trial is specifically designed to find such differences (e.g., Project MATCH Research Group, 1997). The bottom line, however, that the treatment outcome literature that addresses trauma and substance abuse has not yet included a comparison by gender. The only exception is Triffleman et al. (2000), who found

no gender differences at end-of-treatment nor followup; however that study had a small sample ($n = 19$) and only a post-hoc gender analysis.

Specificity for interpersonal violence is unclear. It is not yet clear whether models need to prioritize interpersonal violence as a particular type of trauma, or whether general trauma models can be applied to any trauma type. The latter appears to be the case thus far, as most of the models developed thus far were developed for all trauma types. However, interpersonal violence was certainly the predominant type of trauma in all studies thus far; hence, this remains an open question.

There is a need to look beyond models. The broad question of how to improve treatment for women affected by interpersonal violence requires looking beyond just therapy models. Three key areas are as follows:

1. *Workforce issues:* There are numerous workforce issues that are largely independent of models. Due to resource limitation, the most severe patients are often subject to the least trained and least experienced clinicians (Gustafson, 1991). Some women in treatment programs report harassing or insensitive clinicians who do not understand either interpersonal violence, substance abuse, or both. Clinicians' own history of interpersonal violence and/or substance abuse may also play a role, although this likely may go in both directions (it can increase empathy and ability to work with clients; or, if not healed, may impair the clinician). Clinicians are known to vary in their outcomes with clients, apart from therapy models (Najavits, 1994), and training of clinicians is known to have very limited impact overall. Thus, many issues remain in how to create a workforce that is sensitive and skilled in working with women who experienced interpersonal violence.

2. *A need for increased funding for services:* Even when both skilled clinicians and effective treatment models are present (the ideal scenario), many patients have limited access due to insurance and other financial issues. For example, it is reported that "92% of the women in need of alcohol or drug problems do not receive it" (p. vii, CASA, 2006). The majority of people with PTSD, both female and male, do not receive PTSD treatment (Jacobsen, Southwick, & Kosten, 2001). Some women need long-term services, yet systems are often overburdened and unable to provide these. Access to care is particularly challenging for women with comorbid PTSD and substance abuse, as systems remain split and clients are known to be rejected from either mental health or substance abuse if they are too severe in one or the other domain (Najavits, 2002a). Basic efforts to screen all clients for both disorders also remains a need.

3. *Efforts to change the culture of treatment systems:* There is a need for greater understanding, models, and empirical study on how to change the culture of treatment systems. The recent work on developing trauma-informed services (Fallot & Harris, 2001) is one of the most relevant to women who suffered interpersonal violence. It is a major innovation designed to help all staff in all clinical settings become aware of the impact of trauma—what it is, how it "shows up" in clients' behavior, and how to respond to it with compassion. Trauma can become a lens to better understand the patient and promote more effective interactions with them. A comparable culture shift in the substance abuse field is the focus on support over confrontation (Miller & Rollnick, 1991). The classic culture of addiction treatment for much of the 20th century followed a highly confrontational, rigid approach that was designed to break down the denial of addiction. There was "one right way" to recover, and patients who resisted any part of it were typically harshly confronted and ejected from treatment if unwilling to go along. In some settings, methods veered toward the abusive, with exercises designed to humble the client, such as having to wear a dunce cap. More recent movements in the substance abuse field are designed to build empathy and support, based on research showing these to be more helpful than confrontation (Miller, Benefield, & Tonigan, 1993). A related development is the broadening of possible ways of working on substance abuse (harm reduction and controlled-use models rather than solely abstinence models). In sum, in both the trauma and substance abuse fields, there has been a growing attempt to shift cultures to provide a more compassionate approach by staff.

POLICY IMPLICATIONS

Treatment of women who have suffered interpersonal violence and substance abuse is a major public health concern. There is a need to provide more services, to improve the quality of services, to obtain more empirical work on models of treatment, and to educate all clinical staff who interact with these women. Change requires a multilevel approach that emphasizes a dynamic of mutual dialogue that is respectful of women's own power, rather than solely being subject to others' decisions for them—in sum, encouraging an empowerment perspective. The following policy changes are needed:

- Increase standards for selecting and monitoring clinicians who work with women
- Elicit women's own views on what treatment methods and clinicians are most helpful to them
- Require an evidence base rather than perpetuating treatment and training methods that have no clear validity

- Explore ways to increase services to improve access to care (including initiatives for peer support, paraprofessionals, self-help and other low-cost methods)
- Improve the culture of treatment, in addition to just increasing the use of specific models (e.g.,

trauma-informed services, supportive rather than confrontational approaches for substance abuse)

- Implement routine screening for both PTSD and substance abuse.

IMPLICATIONS FOR POLICY, PRACTICE, AND RESEARCH

- For women, interpersonal violence is common; moreover, it is highly associated with disorders such as PTSD and substance abuse.
- Historically, there has been an understandable hesitation to diagnose mental disorders in women who suffered interpersonal violence. However, disorders such as PTSD and substance abuse make sense as responses to violence, and can be successfully treated if accurately diagnosed.
- Routine screening for PTSD and substance abuse is important.
- The past decade has seen the emergence of several models developed or tested for co-occurring PTSD and substance abuse.
- One model, Seeking Safety, is established as effective based on scientific evidence; others have either one or no studies, and thus further empirical study is needed.
- Two models are designed to prevent PTSD and substance abuse (collaborative care and a video intervention).
- Most of the research on treatment models has been conducted on samples of women who experienced interpersonal trauma.
- Overall, positive outcomes have been found with these specialized models; moreover, a wide range of clients have been shown to benefit, a wide range of clinicians are able to conduct them; and, according to

one major study on the topic, they appear to be cost-effective.

- Research on treatment for co-occurring PTSD and substance abuse is at an early stage. Future research should include comparison of models to each other, how to effectively train clinicians, cost-benefit analyses, preferences for particular models, and mechanisms of action. Also, no study has compared outcomes based on gender or trauma type (e.g., interpersonal violence vs. other types).
- The content of the treatment models should be studied more. It is unclear how much they overlap, what components are important, and whether it is beneficial to combine them.
- Increase standards for selecting and monitoring clinicians who work with women.
- Elicit women's own views on what treatment methods and clinicians are most helpful to them.
- Require an evidence base rather than perpetuating treatment and training methods that have no clear validity.
- Explore ways to improve access to care (including peer support, paraprofessionals, self-help and other low-cost methods).
- Improve the culture of treatment (e.g., trauma-informed services, and supportive rather than confrontational approaches for substance abuse).

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