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POSTTRAUMATIC STRESS DISORDER AND SUBSTANCE USE DISORDER COMORBIDITY TREATMENT: PRINCIPLES AND PRACTICES IN REAL-WORLD SETTINGS

LISA M. NAJAVITS

In recent years, there has been increasing recognition of the need to adapt posttraumatic stress disorder (PTSD) treatment for clients with co-occurring substance use disorder (SUD). Typical challenges include how best to prioritize treatment components of PTSD and SUD, concerns about clients' potential for harm to self and others, intense emotions that are evoked in both clients and clinicians, lack of clarity on how to proceed with PTSD treatment if clients relapse on substances, case management issues (e.g., "split" treatment systems), and how to reduce substance use in the context of PTSD (Back, Dansky, Carroll, Foa, & Brady, 2009; Najavits, 2002a; Najavits, Norman, Kivlahan, & Kosten, 2010). Moreover, studies of clinicians have consistently shown that treating PTSD-SUD is perceived as more difficult and less gratifying than treating PTSD alone (Back et al., 2009; Najavits, 2002a; Najavits, Norman, et al., 2010). Clinicians in mental health settings, compared with those in substance abuse settings, report the greatest difficulty in treating the comorbidity (Najavits, 2002a; Najavits, Norman, et al., 2010).

This chapter has three goals: first, to explore the historical disconnection between PTSD and SUD treatment; second, to highlight how PTSD treatment differs in the context of SUD; and third, to describe how Seeking

Safety, an empirically supported therapy for PTSD–SUD comorbidity, fits into this framework. The focus is real-world clinical practice, with its complexity of diverse clients, clinicians, and settings. The task is to bridge academic rigor and the realities of care, where resources are often limited, clients present with numerous life problems, and clinicians struggle with how to cope with large caseloads and sometimes overwhelming needs.

THE HISTORICAL DISCONNECTION BETWEEN PTSD AND SUD TREATMENT

Until recently, PTSD treatment was not adapted for SUD. SUD was typically ignored and not assessed, or, if identified, SUD clients were referred out to address the SUD before entry into PTSD treatment (Back et al., 2006; Dansky, Roitzsch, Brady, & Saladin, 1997; Najavits, Weiss, & Shaw, 1997). The general rule was that clients needed to attain solid SUD recovery (i.e., protracted abstinence from substances), after which they would be stable enough to address the PTSD. It is crucial to recognize, however, that this strategy was not just a simplistic idea from a less enlightened era. It was a legitimate and careful principle based on the long-standing clinical observation that SUD clients, especially those in the severe spectrum, are vulnerable to increased substance use, harm to self or others, and decompensation when exposed too quickly to emotionally intense therapy.

For most of the 20th century, the predominant therapy models were psychoanalytic or psychodynamic and, when trauma was present, were designed to bring intense feelings to the surface through the exploration of trauma memories and narratives (Najavits, in press). Such therapies were the precursors to current-era PTSD therapies, and, by and large, focused on remembrance and mourning, the second stage of Judith Herman's (1992) three-stage model of trauma treatment. They have as their primary goal the "working through" of disturbing PTSD memories and emotions. In the current era, Stage 2 PTSD treatments, such as prolonged exposure, eye movement desensitization and reprocessing (EMDR), and cognitive processing therapy (CPT), have manuals, adherence scales, cognitive behavioral structures, and other modern accoutrements but at heart are highly similar in focus to these earlier treatments (Jackson, 1994; Najavits, in press). That is, their primary goal is to work through trauma memories and emotions, focusing intensively and repeatedly on the trauma narrative or variants thereof (e.g., in vivo reminders of it, body sensations related to it). Repeated clinical observation that severe SUD patients worsened in such treatments (Herman, 1992; Keane, 1995; Pitman et al., 1991; Solomon & Johnson, 2002) thus naturally and quite sensibly led to the notion that SUD recovery should precede PTSD treat-

ment. More recently, new treatments have been developed that allow for comorbid PTSD–SUD treatment in ways that help keep the focus on safety (Najavits, 2002b) or combine them with SUD models to balance the focus on each (Back, Waldrop, & Brady, 2001; Triffleman, Carroll, & Kellogg, 1999). The goal of such adaptations is to directly work on trauma and PTSD while also carefully attending to SUD and titrating the intensity so that comorbid clients can tolerate it without destabilizing.

It is helpful to remember that for much of the 20th century, SUD was generally not addressed in psychotherapy (Najavits & Weiss, 1994). The SUD patient was viewed as a poor candidate for psychotherapy, and Vaillant even suggested it might be “wasteful” and serve to increase denial (Dodes, 1988). Thus, until recently, SUD was addressed almost exclusively in ancillary systems outside of the mainstream of standard mental health treatment, such as 12-step self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous; therapeutic communities, such as Daytop, Syn-Anon, and Phoenix House; sober houses; and experimental therapeutic environments, such as the “narcotic farm” at Lexington, Kentucky (White, 1998). SUD and mental health treatment systems thus evolved largely independently and were (and to this day remain) split in their funding sources, culture, staffing, assessments, and therapies. In the past decade or so, however, there has been much interest in bridging these two worlds, with progress being made in comorbidity research, clinical innovation, and, to some extent, the reconciliation of these systems issues. Nonetheless, the mental health and SUD treatment worlds still retain significant differences and cultural legacies that endure and that help to inform the principles discussed here. There has been much productive development in the current era, but much remains to be done for the true integration of these quite different treatment worlds.

KEY PRINCIPLES IN THE TREATMENT OF CO-OCCURRING PTSD AND SUD

Several overarching principles help guide PTSD–SUD comorbidity treatment.

Recognize That Comorbidity Is the “Expectation, Not the Exception”

This memorable phrase (Minkoff, 2001) captures an essential truth that is increasingly recognized in the PTSD field: The majority of PTSD patients have one or more co-occurring psychiatric disorders (Brady, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). SUD is one of the most common such co-occurring disorders (Kessler et al., 1995) and is also the

second most common psychiatric disorder in the U.S. population (Kessler et al., 2005). This has major public health implications: Clients need to receive services for both PTSD and SUD when they are present, and clinicians need training in how to provide such services. Yet PTSD treatment outcome research has consistently excluded SUD patients (Bradley, Greene, Russ, Dutra, & Westen, 2005; Riggs & Foa, 2008), especially those with substance dependence and/or those with additional complexities (e.g., domestic violence, homelessness, suicidality). These are some of the most important clients to serve, because they typically have high rates of trauma and PTSD. In one study of patients with cocaine dependence, for example, participants had an average of 5.7 lifetime traumas (Najavits et al., 1998). Comorbidity also goes beyond PTSD and SUD. These clients (especially those in the severe spectrum), typically have additional co-occurring Axis I and II disorders (Najavits, Weiss, & Shaw, 1997); other co-occurring addictions, such as pathological gambling (Najavits, Meyer, Johnson, & Korn, 2010); and/or co-occurring medical diagnoses (Felitti et al., 1998). With an expectation of comorbidity, it thus becomes evident that clinicians, treatment programs, and policymakers need to routinely address comorbidity of all types. It may still be a legitimate and sometimes best option to refer the client to SUD programs or to provide additional specialty care if there is a high level of SUD or medical complexity, but it is essential to identify all co-occurring disorders and attend to them in some way. For a summary of screening and assessment resources for comorbid PTSD–SUD, see Najavits (2004a); for a summary of treatments, see Najavits (2009a) and Najavits, Kivlahan, and Kosten (2011).

Learn About SUD Treatment

Many mental health and PTSD clinicians have not been trained in SUD and believe they are ill-equipped to treat it. Nonetheless, almost all clinicians will see clients with SUD in their practices. Thus, it is helpful to learn key SUD treatment principles, such as the following.

Continuously monitor clients' level of substance use (type of substance, amount, and frequency). Do this at every session, and do not assume the client will bring it up. Minimization, denial, and secrecy are inherent in the illness of SUD, and thus the clinician must take an active approach to assess for substance use. Consider also standardized measures for SUD and, if at all possible, urinalysis and/or breathalyzer testing.

Do not hold a session with a client who is intoxicated. This principle includes both assessment and treatment sessions. This is standard operating practice for various reasons, including not reinforcing substance use, preventing escalation of intense emotions, and preventing potential harm to other clients and staff. Do, however, create procedures for how to handle an intoxicated

client, such as calling a cab or significant other to arrange to get the client home safely.

Learn SUD terminology. Central concepts include denial, enabling, withdrawal, tolerance, abuse versus dependence, slip versus relapse, abstinence versus recovery, 12 steps, sponsor, harm reduction, moderation management, controlled use (and safe limits on alcohol use), hitting bottom (Najavits, in press). Also, it is highly recommended to attend at least one 12-step open meeting as a visitor to see directly how the program works (especially if clients are routinely referred to such; Najavits, 2002b).

Make use of SUD treatment resources. The federal government website <http://www.health.org>, for example, provides extensive and free SUD monographs, protocols, resources, and treatment-related materials.

Respect the wisdom of the SUD treatment world. As noted earlier, SUD treatment represents a distinct culture with its own history and wisdom, which may seem foreign to mental health providers. SUD programs rely less on advanced credentials and educational background in their staff, have greater informality and self-disclosure, more focus on rules, less use of psychiatric medications, a less hierarchical power structure, fewer resources, greater openness about clinicians' own SUD recovery, and a much broader focus on transforming the "whole person" rather than just symptoms. SUD programs have typically treated the most severe and chronic SUD cases that mental health programs are often unwilling or unable to treat. An open-minded attitude toward SUD treatment principles and assumptions is essential.

Learn About Trauma and PTSD Treatment

This may seem self-evident for mental health clinicians. However, PTSD came late into the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) diagnostic system and even within mental health was often underassessed, undertreated, and undertrained relative to other diagnoses (van der Kolk, 1987). Thus, clinicians of all types can benefit from reviewing trauma and PTSD treatment principles. Some examples include the following.

Create trauma-informed care (TIC). TIC has become a cornerstone of quality treatment in all settings in recognition of the fact that trauma is so common in the population at large (Kessler et al., 1995) and has so much impact on clients' clinical presentation. Regardless of which treatment "door" clients enter, TIC principles apply, such as the need for routine screening of trauma and PTSD, a compassionate and empowering approach to interactions with clients, use of trauma-specific treatment models, and education on trauma and PTSD for all staff (Fallot & Harris, 2001).

Learn trauma and PTSD terminology. Central concepts include accurate definitions of trauma and PTSD, dissociation, simple versus complex PTSD,

secondary traumatization, reenactments, grounding, specific trauma types (e.g., military sexual trauma, childhood trauma), specific PTSD treatment models, and so on.

Adapt rules to be sensitive to trauma when possible. A residential client may feel safer with the lights on at night while sleeping, for example. However, trauma should not become an excuse that hinders growth. It is never an excuse for substance use, for example, even though it may help to explain it.

Respect the wisdom of the mental health treatment world. Just as respect is due to the SUD field, so, too, is it due to the mental health/PTSD field. Indeed, some major positive influences from mental health have led to changes in SUD treatment, such as a more supportive rather than confrontational style, appropriate use of psychiatric medications rather than dismissing them as "substances," trauma-informed care, a greater focus on establishing efficacy of models, more emphasis on manuals and adherence, and openness to various models beyond just 12-step.

Make use of PTSD treatment resources. See various federal government websites, for example, <http://www.ptsd.va.gov>, <http://www.samhsa.gov/nctic>, and <http://www.nctsn.org>.

Respect the Phases of Recovery Approach

A consistent clinical observation in both the PTSD literature and SUD literature is that recovery occurs in phases. In the PTSD field, Herman (1992) is often cited for her eloquent description of the treatment phases of *safety*, *remembrance and mourning*, and *reconnection*, which are labeled Stages 1, 2 and 3, respectively. Such phases were named by many different PTSD writers over the course of the 20th century (van der Kolk, 1987) and thus represent important clinical wisdom. Similarly, in the SUD field, a long-standing principle is that stabilization precedes more intensive work (Najavits, 2002b; Zweben, Clark, & Smith, 1994; Zweben & Yeary, 2006). It is thus important to recognize that most evidence-based therapies in the PTSD field were developed as Stage 2 models, primarily on less complex outpatient clients (e.g., ruling out clients with substance dependence, domestic violence, psychosis, bipolar disorder, homelessness, and suicidality). Such Stage 2 treatments have not yet been found to be evidence-based for PTSD-SUD generally and are not yet tested sufficiently on severe and complex substance-dependent clients, nor when conducted by SUD clinicians in SUD settings. Thus, until the evidence base for such models is sufficient to warrant their widespread dissemination for such complexities or are adapted for such complexities, the "first do no harm" approach is to address *safety* as Stage 1 before proceeding to *remembrance and mourning* as Stage 2. Addressing Stage 1 may simply be an assessment to establish readiness for Stage 2, or it may involve conduct-

ing a Stage 1 treatment first. Various writers have elaborated on PTSD–SUD clients' readiness for Stage 2 treatment or ways to address Stage 2 (Coffey, Dansky, & Brady, 2002; Coffey, Schumacher, Brimo, & Brady, 2005; Najavits, *in press*; Najavits, Schmitz, Gotthardt, & Weiss, 2005). An excellent PTSD–SUD case history example emphasizing the need for careful timing of Stage 2 is provided in Jaffee, Chu, and Woody (2009).

Furthermore, it is important to recognize that present-focused therapies are not “less useful than” past-focused models. Studies that have directly compared present- versus past-focused PTSD approaches have found both to produce positive outcomes, without significant differences between them (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Najavits *et al.*, 2008; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Schnurr *et al.*, 2003). One study did find a difference, but it was a very small effect size (Schnurr *et al.*, 2007). Thus, past-focused treatment is not the “real” or better treatment at this point. It is also noteworthy that clinicians have preferences for whether they like to conduct present- versus past-focused models, and clinicians in mental health actually endorse lower preference for these than do SUD clinicians (Najavits, 2006; see also Becker, Zayfert, & Anderson, 2004; Zayfert & Becker, 2000). More research is needed to better understand when and under what conditions present- and past-focused PTSD methods are needed and which clinicians may be best able to conduct them.

Take a Sophisticated View of Avoidance

A related principle is the reformulation of “avoidance” into terminology that is sensitive to SUD and other complexities. Avoidance is widely understood in Stage 2 PTSD therapies as an obstacle to recovery, and the clinician is taught to help move the client into facing the past. It makes sense that such models identify avoidance as something to be overcome. It is indeed a symptom cluster of PTSD (Criterion C, “persistent avoidance”; American Psychiatric Association, 1994), and Stage 2 models strive to heal PTSD by having clients directly face the past rather than avoid it. However, for complex SUD clients, avoidance may be the best and healthiest decision until they are ready to face the past in ways that will not be iatrogenic. Avoidance can thus be reframed as “right timing”—the client should engage in Stage 2 if and when the timing is right. As Rothschild (2004) stated, developing “trauma brakes” makes it possible for clients, often for the first time, to have control over their traumatic memories, rather than feeling controlled by them. This may mean when there is further stabilization or safety, when the client is in the right environment for the work, when the client has the right clinician, and/or when the client has adequate coping skills (Chu, 1988; Najavits, *in press*; Zweben & Yeary, 2006). Or it may mean never doing Stage

2 work, which is also a legitimate stance, or moving in and out of the work according to the client's ability to handle it (Najavits et al., 2005). According to Sterman (2006),

It is useful to visualize recovery of addicted survivors . . . as a perpetual staircase, rather than an uninterrupted line. . . . In other words, in treatment these [clients] frequently need "breaks" when their material is too overwhelming. This may take the form of . . . temporarily derailing sessions by producing "red herrings" (the client dangles an inviting topic before the clinician to get away from the overwhelming material). The clinician may acknowledge that the client is taking this break . . . [and] must show respect for the client's self-knowledge in taking this break. (p. 268)

Finally, it is worth noting that PTSD clinicians often refer to substance use per se as "avoidance" (a desire to escape painful feelings) rather than exploring the much broader functional purposes it may serve. Although avoidance is a common reason for substance use in the context of PTSD, substances may also serve the opposite purpose—as a way to access trauma-related feelings and memories ("Alcohol is the only way I could cry about what happened to me"; State of Connecticut Department of Mental Health & Addiction Services, 2000). It may also serve various other purposes related to PTSD (Norman, Inaba, Smith, & Brown, 2008) and, more broadly, various purposes that have no connection to PTSD, such as to celebrate, have fun, seek thrills, or fit in with peers. Thus, the goal is to listen closely to clients' reasons for using and keep an open mind.

Choose Among the Many Evidence-Based Models

One of the most enduring findings in the psychotherapy field is that manualized treatments generally have positive outcomes but do not show differences between them (Beutler, 1991; Luborsky, Singer, & Luborsky, 1976). This has also been found in more recent years in meta-analyses both within the PTSD field (Benish, Imel, & Wampold, 2008; Powers et al., 2010) and the SUD field (Imel, Wampold, Miller, & Fleming, 2008; Morgenstern & McKay, 2007). For example, prolonged exposure therapy for PTSD, one of the most widely disseminated models, works, but not more than other PTSD models (e.g., CPT, EMDR, cognitive therapy, and stress inoculation training; Powers et al., 2010). Yet clinicians do indicate clear preferences for some PTSD or SUD models over others (Barry et al., 2008; Becker, Zayfert, & Anderson, 2004; Cook, Biyanova, & Coyne, 2009; Fals-Stewart & Birchler, 2001; Najavits et al., 2011; Russell, 2008). Thus, being evidence based is a relevant consideration in choice of models, but not the only one. Other

important factors for models include cost (e.g., materials, training, supervision required to learn it), degree of flexibility, level of difficulty, which clinicians can do them (based on degree or training), how the models converge or conflict with existing practices, which clients can benefit from them, and their basic appeal (readability, format). In sum, models should ultimately be selected on the basis of goodness of fit with the clinician, the setting, the client population, the length of stay, and available resources. There is neither one right model nor one right path. This is parallel to SUD recovery, summarized as "many roads, one journey" (Fletcher, 2001; Kasl, 1992).

Set Policies Based on Strong SUD and PTSD-SUD Principles

Regardless of specific models or techniques, treatment policies should be based on a sophisticated understanding of PTSD-SUD comorbidity. These policies include the following.

Recognize that motivation to reduce substance use may be the result, not the start, of good treatment. It is common to hear of clinicians or programs that require clients to state a willingness to give up or reduce substance use. If a client is unwilling, this is seen as poor prognosis, and he or she may be referred out. Historically, this has occurred in both the mental health and SUD fields (e.g., waiting until the client "hits bottom"). Yet motivation is sometimes the result of good treatment rather than present at the start. Complex or chronic SUD clients may feel especially hopeless or incapable of decreasing their use. Thus, SUD therapies such as motivational interviewing and motivational enhancement therapy are designed to help increase motivation (Miller & Rollnick, 1991). Requiring it from the start selects for a narrower range of clients—those who are healthier or more willing to lie about their motives.

If possible, continue to treat clients even after substance slips and relapses. This will depend on the program because some may legitimately need to eject clients whose substance use causes harm to others or to the milieu. Yet SUD is known to be a chronic, relapsing disorder. Treating symptoms of the illness (e.g., slips) with judgment or removal from treatment slows clients' progress and misses important growth opportunities. The analogy is often drawn that one would not remove a client whose depressive symptoms became more severe.

Consider alternative models, such as harm reduction and controlled use, when appropriate. Some clients can succeed with these alternatives to substance abstinence. Careful use of alternative methods can help engage clients who otherwise might not engage.

Do not require clinicians to have a mental health degree to treat PTSD–SUD comorbidity, unless a specific therapy model requires this. Some models require much more careful selection and training of clinicians than others (Zweben & Yeary, 2006). See the next section, on Seeking Safety, for an example of a model that does not require any specific clinician background yet is very safe for PTSD–SUD. The content of the model, the level of possible negative impact, and the treatment developer's requirements all play a role in what clinician credentials are necessary. Some programs presume that a mental health degree is necessary to treat PTSD, but this is not accurate (Najavits, Meyer, et al., 2010).

Have clear policies on substance use. It can be frustrating for clients to learn that one peer is ejected from the treatment setting for substance use yet another is allowed to stay. Developing clear and consistent written policies can help build an open, positive atmosphere. Such policies may address, in addition to slips, topics such as how often urinalysis or breathalyzer testing will occur, if at all; contraband (no substances or substance-related paraphernalia in the treatment setting); and confidentiality, for example.

SEEKING SAFETY

In this section, Seeking Safety (Najavits, 2002b) is offered as a model that is consistent with the principles described in the foregoing sections. It was specifically developed for comorbid PTSD–SUD and, at this point, is the most evidence-based therapy for it (Najavits et al., 2008). It was designed specifically for the sort of highly complex, chronic, and multiply burdened clients and systems that are sometimes the last resort for treatment. There are no exclusionary criteria for its use in clinical settings (and it has even been used with PTSD–SUD clients who also had serious and persistent mental illness; Hills, Rugs, & Young, 2004). It is one of the lowest-cost models available (see <http://www.seekingsafety.org>). Furthermore, it does not require any specific type of clinician to conduct it. Indeed, it has been used successfully in a peer-led format (Welsh, Miller, Hamilton, Doherty, & Najavits, 2010), by case managers (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2009; Desai, Harpaz-Rotem, Rosenheck, & Najavits, 2008), and by domestic violence advocates (G. Grant, personal communication, May 2009). There are 24 completed outcome studies on the model. To download the outcome studies, a summary of the scientific evidence on the model, as well as information on the Seeking Safety adherence scale, training, and translations, see <http://www.seekingsafety.org>. It should also be noted that other models have been developed or used for PTSD–SUD (see, e.g., Najavits, 2009a; Najavits et al., 2011), and there is a continuing need for further research on Seeking Safety as well.

Overview

Seeking Safety was begun in the early 1990s. The manual was published in 2002, after a decade of development based on clinical experience, research, and clinician training. The title of the treatment—Seeking Safety—expresses its central idea: When a person has PTSD, SUD, or both, the most urgent clinical need is to establish safety. *Safety* is an umbrella term that signifies various elements: safety from substances; safety from dangerous relationships, including domestic violence and substance-using friends; and safety from extreme symptoms, such as suicidality and dissociation. Many of these destructive behaviors reenact trauma—having been harmed through trauma, clients are now harming themselves or others. The term *seeking safety* refers to helping clients free themselves from such negative behaviors and, in so doing, to move toward freeing themselves from trauma at a deep emotional level.

Seeking Safety is an evidence-based cognitive behavioral therapy that can be used from the start of treatment. It is a flexible, engaging intervention designed for both male and female clients, and individual or group formats. It can be used as a primary intervention or as an adjunct to other treatments, in any setting, for any treatment length, for any trauma type, and for any substance type. It was designed to explore the link between trauma and substance abuse but without delving into details of the past that could destabilize clients during early recovery. It is a present-focused, empathic approach that “owns” and names the trauma experience, validates the connection to substance use, provides psychoeducation, and offers safe coping skills to manage the often overwhelming impulses and emotions of these co-occurring disorders and strives to build hope. It is an integrated therapy that focuses equally on trauma and substance abuse, at the same time, from the start of treatment but in a manner that is designed to be as safe, supportive, and as containing as possible.

The concept of safety is designed to protect the clinician as well as the client. By helping clients move toward safety, clinicians are protecting themselves from treatment that could move too fast without a solid foundation. Increased substance use and harm to self or others are of particular concern with this vulnerable population. Thus, seeking safety is both the clients’ and clinicians’ goal. Over many years, feedback on the model indicates that its structured approach and compassionate tone make it practical and user-friendly for both the clinician and client. It has been successfully implemented with a wide range of populations, including both male and female clients, adolescents, military and veterans, homeless, domestic violence, criminal justice, racially and ethnically diverse clients, clients with cognitive or reading impairments (including mild traumatic brain injury), seriously and persistently mentally ill clients, multiple comorbidities, behavioral addictions such

as pathological gambling, subthreshold PTSD and/or SUD. It has also been implemented to treat personality disorders, active substance users, and clients in all levels of care (outpatient, residential, inpatient, community care, private practice, outreach). In an empirical study on the model conducted by community-based clinicians with 176 clients, Seeking Safety was found to be highly safe (Killeen et al., 2008).

Seeking Safety Topics

There are 25 topics, each representing a safe coping skill relevant to both trauma and substance abuse. The topics address different domains: cognitive, behavioral, interpersonal, case management, or a combination of these. The cognitive topics are *PTSD: Taking Back Your Power*, *Compassion*, *When Substances Control You*, *Creating Meaning*, *Discovery*, *Integrating the Split Self*, and *Recovery Thinking*. The behavioral topics are *Taking Good Care of Yourself*, *Commitment*, *Respecting Your Time*, *Coping With Triggers*, *Self-Nurturing*, *Red and Green Flags*, and *Detaching from Emotional Pain (Grounding)*. The interpersonal topics are *Honesty*, *Asking for Help*, *Setting Boundaries in Relationships*, *Getting Others to Support Your Recovery*, *Healthy Relationships*, *Healing from Anger*, and *Community Resources*. The case management topic is *Introduction/Case Management*. The combination topics are *Safety*, *Life Choices*, and *Termination*.

When implementing Seeking Safety, it is not necessary to conduct all 25 topics. Indeed, significant improvements have been found with clients who were offered fewer than half of the 25 topics (Ghee, Bolling, & Johnson, 2009; Hien, Campbell, Killeen, et al., 2010; Hien, Campbell, Ruglass, et al., 2010; Hien, Jiang, et al., 2010; Hien, Wells, et al., 2009). A clinician may conduct as many topics as time allows, and in any order. There is no right or wrong sequencing because each topic is independent of the others. Thus, Seeking Safety can be conducted in open-ended groups, and if clients miss any topics, they can return at any point, because each topic stands on its own. Topics can, moreover, be covered in one session or span across several sessions, depending on clients' needs. Some programs conduct segments of four, eight, or 12 topics; clients come to one segment and then decide whether they want to continue to the next segment. These considerations are especially important for substance abuse treatment, in which retaining clients is a challenge.

Session Format

Seeking Safety sessions are structured to emphasize a good use of time, appropriate containment, and setting and sticking to goals. For clients with

trauma and substance abuse, who are often impulsive and overwhelmed, the predictable session structure helps them know what to expect. It offers, in its process, a mirror of the focus and careful planning necessary for recovery.

Sessions are conducted with the following four parts: (a) *check-in*—brief questions to find out how clients are doing; (b) *quotation*—an inspirational quotation is read aloud, to emotionally engage clients in the session, (c) *handouts*—used to explore a new coping skill, and (d) *check-out*—brief questions to reinforce clients' progress and close the session on a positive note.

The session format keeps the treatment on track and uses time well. The same format is used for individual or group treatment, and clients consistently state that it helps them feel safe because they know what to expect. In group modality, it promotes boundaries and sharing of time, rather than letting any member dominate the session. At a deeper level, the structure promotes processes to counteract the impulsivity, chaos, and disorganization of PTSD and SUD (e.g., pacing, planning, organizing). For large groups of 20 to 40 clients, the format can be adapted such that the check-in and check-out can be reduced to just one or two questions, with only a few clients responding. However, if possible, a clinician should base the size of the group on how much time is available so that clients can go through the full check-in and check-out.

Client Selection

Although Seeking Safety was originally designed for co-occurring PTSD and SUD, it has been applied to a wider range of clients, such as those who could simply benefit from improved coping skills. In part, this is because many treatment programs focus less on formal diagnoses than on general treatments and most of the Seeking Safety topics are broad enough to apply to issues beyond trauma and substance use (e.g., *Asking for Help*, *Compassion*, *Honesty*, *Creating Meaning*, *Taking Good Care of Yourself*).

The outcome research on Seeking Safety has also broadened in scope over time. In early studies of the model, all clients met criteria for current PTSD and SUD, but later studies loosened these criteria to a wider range of clients and still found positive outcomes (e.g., Desai et al., 2008, 2009; Morrissey et al., 2005). Generally, too, research on Seeking Safety has had a far broader range of severity and complexity of clients than most treatment outcome studies in the PTSD field. In Seeking Safety studies, clients typically had chronic PTSD and SUD for years; had a history of multiple childhood-based trauma; often had substance dependence (the most severe form of SUD); frequently had additional co-occurring Axis I and/or Axis II disorders. Some studies included clients with suicidal ideation (e.g., Najavits et al., 2005).

In selecting clients for Seeking Safety, a clinician should be as inclusive as possible. Any client can start in Seeking Safety, and clients are only removed if they present a clear danger to others or are otherwise inappropriate for participation. Clients do not need to be stabilized before entering Seeking Safety, and it can be conducted at any stage of recovery from PTSD or SUD. For example, some clients may still be actively using substances, whereas others may have been abstinent for some period of time; they can learn from each other. Alternatively, some clinicians may prefer to create homogenous groups, such as "early recovery." Seeking Safety can also be conducted for just PTSD or just SUD (or subthreshold); simply instruct clients to ignore the terms *PTSD* or *substance abuse* in the handouts if these do not apply to them. The models' coping skills can apply to many life problems beyond PTSD and SUD. For example, *Asking for Help* may be relevant to finding a job or apartment, dieting, or resolving a relationship conflict.

Implementation

Safety is a broad concept, and part of the work is helping clients experience the feeling of safety in the treatment itself. The clinician is thus ideally like a "good parent" within professional bounds—ensuring that clients do not scapegoat each other, ensuring that time is being used well, calming clients who become too distressed, and maintaining a respectful stance. Clients are encouraged to focus primarily on their own recovery and to interact with each other using support and problem solving. Seeking Safety offers more than 80 "safe coping skills," with the idea that clients can choose what works for them and let go of any that are not helpful. This empowerment approach respects the fact that there is no one right way to cope—what works for one person may not work for another. As long as it is safe coping, it is good coping. Similarly, clinicians are encouraged to find their own style. The flexibility in the model honors clinicians' own styles and preferences when conducting the work. Some clinicians move faster, some slower. Some like to use worksheets, some do not. Some bring in humor, artistic exercises, or other personal touches. The model should feel like it brings out their best work, in any way that suit their personality.

When working with PTSD–SUD comorbidity, the clinician may need to emphasize trauma themes heavily. If clients have been identified as having SUD, they are typically referred to substance abuse treatment programs, where trauma themes may not be prominent. Thus, the clinician needs to raise trauma themes explicitly so that clients become more aware of them. In Seeking Safety, clients are guided to name their traumas, if they choose to, and to explore how these play a role in the present. Note, too, that although

Seeking Safety encourages the development of coping skills in the present, it does not encourage avoidance of the past. Clients are able to name their past traumas, discuss how those traumas continue to affect them, and develop improved coping skills in relation to trauma. Throughout, the clinician helps clients notice how they tried to cope, how successful it was, and how they can improve their coping. This may include trying many ways of rehearsing the Seeking Safety coping skills (e.g., role-plays, think-aloud exercises, in-session experiential exercises, processing perceived obstacles, "replaying" a scene that went awry, discussion questions). It may also include various options for reducing substance use, in keeping with current understanding about addiction, such as *abstinence* (clients give up all substances forever), *harm reduction* (decreasing use, usually with a goal of ultimate abstinence), or *controlled use* (decreasing use, with a goal of still being able to use in the future at safe levels), depending on the philosophy of the treatment program, clinician, and client needs.

Adaptation

Seeking Safety has been successfully adapted in many settings. The primary principle is to adapt within the model rather than outside the model, which means making use of the flexibility that is inherently part of Seeking Safety. Such adaptations include varying session length and pacing, and varying the number of sessions; using examples relevant to different types of clients; conducting topics and handouts in any order; using group or individual format; going as slow or fast as needed; adding in artwork, games, and other creative exercises; developing gender-, age-, ethnic-, or profession-specific exercises; and combining it with any other necessary treatments. Several publications provide further ideas on implementation of the model (Najavits, 2000, 2002a, 2004b, 2007, 2009b).

CONCLUSION

The PTSD-SUD comorbidity field has emerged as a major area of research, clinical innovation, and policy work. This has brought a greater understanding of clients' struggles to overcome these illnesses and engendered a healthy awareness of both the strengths and limits of current PTSD treatments. The field is young, and it is humbling to recognize that much work is still needed so that all clients with PTSD-SUD can receive high-quality services regardless of their entry point into different treatment systems. Much is also still needed to make treatment models as powerful as possible to promote healing, yet also relevant and flexible for widespread

use. It is often said that the greatest sign of wisdom is to know what we don't know. At this early stage, there is so very much more yet to be discovered on how best to treat PTSD-SUD comorbidity.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Back, S. E., Dansky, B. S., Carroll, K. M., Foa, E. B., & Brady, K. T. (2001). Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Description of procedures. *Journal of Substance Abuse Treatment*, 21, 35-45. doi:10.1016/S0740-5472(01)00181-7
- Back, S. E., Waldrop, A. E., & Brady, K. T. (2009). Treatment challenges associated with comorbid substance use and posttraumatic stress disorder: Clinicians' perspectives. *The American Journal on Addictions*, 18, 15-20. doi:10.1080/10550490802545141
- Back, S. E., Waldrop, A. E., Brady, K. T., & Hien, D. A. (2006). Evidence-based time-limited treatment of co-occurring substance-use disorders and civilian-related posttraumatic stress disorder. *Brief Treatment and Crisis Intervention*, 6, 283-294. doi:10.1093/brief-treatment/mhl013
- Barry, D. T., Fulgieri, M. D., Lavery, M. E., Chawarski, M. C., Najavits, L. M., Schottenfeld, R. S., & Pantalon, M. V. (2008). Research- and community-based clinicians' attitudes on treatment manuals. *The American Journal on Addictions*, 17, 145-148. doi:10.1080/10550490701860880
- Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, 42, 277-292. doi:10.1016/S0005-7967(03)00138-4
- Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review*, 28, 746-758. doi:10.1016/j.cpr.2007.10.005
- Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology*, 59, 226-232. doi:10.1037/0022-006X.59.2.226
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *The American Journal of Psychiatry*, 162, 214-227. doi:10.1176/appi.ajp.162.2.214
- Brady, K. T. (2001). Comorbid posttraumatic stress disorder and substance use disorders. *Psychiatric Annals*, 31, 313-319.
- Chu, J. A. (1988). Ten traps for therapists in the treatment of trauma survivors. *Dissociation: Progress in the Dissociative Disorders*, 1, 24-32.

- Coffey, S. F., Dansky, B. S., & Brady, K. T. (2002). Exposure-based, trauma-focused therapy for comorbid posttraumatic stress disorder-substance use disorder. In P. Ouimette & P. J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 209-226). Washington, DC: American Psychological Association.
- Coffey, S. F., Schumacher, J. A., Brimo, M. L., & Brady, K. T. (2005). Exposure therapy for substance abusers with PTSD: Translating research to practice. *Behavior Modification*, 29, 10-38. doi:10.1177/0145445504270855
- Cook, J. M., Biyanova, T., & Coyne, J. C. (2009). Comparative case study of diffusion of eye movement desensitization and reprocessing in two clinical settings: Empirically supported treatment status is not enough. *Professional Psychology: Research and Practice*, 40, 518-524. doi:10.1037/a0015144
- Dansky, B. S., Roitzsch, J. C., Brady, K. T., & Saladin, M. E. (1997). Posttraumatic stress disorder and substance abuse: Use of research in a clinical setting. *Journal of Traumatic Stress*, 10, 141-148. doi:10.1002/jts.2490100114
- Desai, R. A., Harpaz-Rotem, I., Najavits, L. M., & Rosenheck, R. A. (2009). Seeking Safety therapy: Clarification of results. *Psychiatric Services*, 60, 125.
- Desai, R. A., Harpaz-Rotem, I., Rosenheck, R. A., & Najavits, L. M. (2008). Effectiveness of treatment for homeless female veterans with psychiatric and substance abuse disorders: Impact of "Seeking Safety" on one-year clinical outcomes. *Psychiatric Services*, 59, 996-1003.
- Dodes, L. M. (1988). The psychology of combining dynamic psychotherapy and alcoholics anonymous. *Bulletin of the Menninger Clinic*, 52, 283-293.
- Fallot, R. D., & Harris, M. (2001). *Using trauma theory to design service systems. New directions for mental health services*. San Francisco, CA: Jossey-Bass.
- Fals-Stewart, W., & Birchler, G. (2001). A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment*, 20, 277-283. doi:10.1016/S0740-5472(01)00165-9
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14, 245-258. doi:10.1016/S0749-3797(98)00017-8
- Fletcher, A. (2001). *Sober for good: New solutions for drinking problems—advice from those who have succeeded*. Boston, MA: Houghton Mifflin.
- Ghee, A. C., Bolling, L. C., & Johnson, C. S. (2009). The efficacy of a condensed Seeking Safety intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse: Research, Treatment & Program Innovations for Victims, Survivors, & Offenders*, 18, 475-488. doi:10.1080/10538710903183287
- Herman, J. L. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Hien, D. A., Campbell, A. N., Killeen, T., Hu, M. C., Hansen, C., Jiang, H., . . . Nunes, E. V. (2010). The impact of trauma-focused group therapy upon HIV sexual risk

- behaviors in the NIDA Clinical Trials Network "Women and Trauma" multisite study. *AIDS and Behavior*, 14, 421–430. doi:10.1007/s10461-009-9573-7
- Hien, D. A., Campbell, A. N., Ruglass, L. M., Hu, M. C., & Killeen, T. (2010). The role of alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's Women and Trauma Study. *Drug and Alcohol Dependence*, 111, 114–119. doi:10.1016/j.drugalcdep.2010.04.011
- Hien, D. A., Jiang, H., Campbell, A. N., Hu, M. C., Miele, G. M., Cohen, L. R., . . . & Nunes, E. V. (2010). Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's Clinical Trials Network. *American Journal of Psychiatry*, 167, 95–101.
- Hien, D. A., Wells, E. A., Jiang, H., Suarez-Morales, L., Campbell, A. N., Cohen, L. R., . . . Nunes, E. V. (2009). Multisite randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. *Journal of Consulting and Clinical Psychology*, 77, 607–619. doi:10.1037/a0016227
- Hills, H. A., Rugs, D., & Young, M. S. (2004, June). *Diffusing research: Adopting a gender-sensitive intervention*. Paper presented at the Joint Conference of the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration on Complexities of Co-Occurring Conditions: Harnessing Services Research to Improve Care for Mental, Substance Use and Medical/Physical Disorders Conference, Washington, DC.
- Imel, Z. E., Wampold, B. E., Miller, S. D., & Fleming, R. R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors*, 22, 533–543. doi:10.1037/a0013171
- Jackson, S. W. (1994). Catharsis and abreaction in the history of psychological healing. *Psychiatric Clinics of North America*, 17, 471–491.
- Jaffee, W. B., Chu, J. A., & Woody, G. E. (2009). Trauma, dissociation, and substance dependence in an adolescent male. *Harvard Review of Psychiatry*, 17, 60–67. doi:10.1080/10673220902735660
- Kasl, C. (1992). *Many roads, one journey*. New York, NY: HarperPerennial.
- Keane, T. M. (1995). The role of exposure therapy in the psychological treatment of PTSD. *Clinical Quarterly (National Center for Posttraumatic Stress Disorder)*, 5, 3–6.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593–602 [Correction appeared in *Archives of General Psychiatry* (2005) 7, 709. Note: author Merikangas, K. R. added]. doi:10.1001/archpsyc.62.6.593
- Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Post-traumatic stress disorder in the National Comorbidity Survey [Correction appeared in *Archives of General Psychiatry* (2005) 7, 709. Note: Merikangas, K.

- R. added]. *Archives of General Psychiatry*, 52, 1048–1060. doi:10.1001/archpsyc.1995.03950240066012
- Killeen, T., Hien, D. A., Campbell, A., Brown, C., Hansen, C., Huiping, J., . . . Nunes, E. (2008). Adverse events in an integrated trauma-focused intervention for women in community substance abuse treatment. *Journal of Substance Abuse Treatment*, 35, 304–311. doi:10.1016/j.jsat.2007.12.001
- Luborsky, L., Singer, B., & Luborsky, L. (1976). Comparative studies of psychotherapies: Is it true that "everybody has won and all must have prizes"? *Proceedings of the Annual Meeting of the American Psychopathological Association*, 3–22.
- Marks, I., Lovell, K., Noshirvani, H., Livanou, M., & Thrasher, S. (1998). Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring: A controlled study. *Archives of General Psychiatry*, 55, 317–325. doi:10.1001/archpsyc.55.4.317
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
- Minkoff, K. (2001). *Behavioral Health Recovery Management Service planning guidelines: Co-occurring psychiatric and substance disorders*. Bloomington, IL: Behavioral Health Recovery Management.
- Morgenstern, J., & McKay, J. R. (2007). Rethinking the paradigms that inform behavioral treatment research for substance use disorders. *Addiction*, 102, 1377–1389. doi:10.1111/j.1360-0443.2007.01882.x
- Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, 56, 1213–1222. doi:10.1176/appi.ps.56.10.1213
- Najavits, L. M. (2000). Training clinicians in the Seeking Safety treatment for posttraumatic stress disorder and substance abuse. *Alcoholism Treatment Quarterly*, 18, 83–98. doi:10.1300/J020v18n03_08
- Najavits, L. M. (2002a). Clinicians' views on treating posttraumatic stress disorder and substance use disorder. *Journal of Substance Abuse Treatment*, 22, 79–85. doi:10.1016/S0740-5472(02)00219-2
- Najavits, L. M. (2002b). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford Press.
- Najavits, L. M. (2004a). Assessment of trauma, PTSD, and substance use disorder: A practical guide. In J. P. Wilson & T. M. Keane (Eds.), *Assessment of Psychological Trauma and PTSD* (pp. 466–491). New York, NY: Guilford Press.
- Najavits, L. M. (2004b). Treatment for posttraumatic stress disorder and substance abuse: Clinical guidelines for implementing the Seeking Safety therapy. *Alcoholism Treatment Quarterly*, 22, 43–62. doi:10.1300/J020v22n01_04
- Najavits, L. M. (2006). Present- versus past-focused therapy for PTSD/substance abuse: A study of clinician preferences. *Brief Treatment and Crisis Intervention*, 6, 248–254. doi:10.1093/brief-treatment/mhl005

- Najavits, L. M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In K. A. Witkiewitz & G. A. Marlatt (Eds.), *Therapist's guide to evidence-based relapse prevention: Practical resources for the mental health professional* (pp. 141–167). San Diego, CA: Elsevier. doi:10.1016/B978-012369429-4/50037-9
- Najavits, L. M. (2009a). Psychotherapies for trauma and substance abuse in women: Review and policy implications. *Trauma, Violence, and Abuse: A Review Journal*, 10, 290–298.
- Najavits, L. M. (2009b). Seeking Safety: An implementation guide. In A. R. D. Springer (Ed.), *The clinician's guide to evidence-based practice* (pp. 311–347). Hoboken, NJ: Wiley.
- Najavits, L. M. (in press). *Creating change: A past-focused model for PTSD and substance abuse*. New York, NY: Guilford Press.
- Najavits, L. M., Gastfriend, D. R., Barber, J. P., Reif, S., Muenz, L. R., Blaine, J., . . . Weiss, R. D. (1998). Cocaine dependence with and without posttraumatic stress disorder among subjects in the NIDA Collaborative Cocaine Treatment Study. *The American Journal of Psychiatry*, 155, 214–219.
- Najavits, L. M., Kivlahan, D., & Kosten, T. (2011). A national survey of clinicians' views of evidence-based therapies. *Addiction Research and Theory*, 19, 138–147.
- Najavits, L. M., Meyer, T., Johnson, K. M., & Korn D. (2010). Pathological gambling and posttraumatic stress disorder: A study of the co-morbidity versus each alone. *Journal of Gambling Studies* [published online]. doi:10.1007/s10899-010-9230-0. Retrieved from <http://www.seekingsafety.org/7-11-03%20arts/2010%20JOGS%20ptsd%20pg%20main%20pa.pdf>
- Najavits, L. M., Norman, S. B., Kivlahan, D., & Kosten, T. R. (2010). Improving PTSD/substance abuse treatment in the VA: A survey of providers. *The American Journal on Addictions*, 19, 257–263. doi:10.1111/j.1521-0391.2010.00039.x
- Najavits, L. M., Ryngala, D., Back, S. E., Bolton, E., Mueser, K. T., & Brady, K. T. (2008). Treatment for PTSD and comorbid disorders: A review of the literature. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 508–535). New York, NY: Guilford Press.
- Najavits, L. M., Schmitz, M., Gotthardt, S., & Weiss, R. D. (2005). Seeking Safety plus exposure therapy: An outcome study on dual diagnosis men. *Journal of Psychoactive Drugs*, 37, 425–435. doi:10.1080/02791072.2005.10399816
- Najavits, L. M., Schmitz, M., Johnson, K. M., Smith, C., North, T., Hamilton, N., . . . Wilkins, K. (2009). Seeking Safety therapy for men: Clinical and research experiences. In L. J. Katlin (Ed.), *Men and addictions: New research* (pp. 37–58). Hauppauge, NY: Nova Science.
- Najavits, L. M., & Weiss, R. D. (1994). The role of psychotherapy in the treatment of substance use disorders. *Harvard Review of Psychiatry*, 2, 84–96. doi:10.3109/10673229409017121

- Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *The American Journal on Addictions*, 6, 273-283.
- Norman, S. B., Inaba, R. K., Smith, T. L., & Brown, S. A. (2008). Development of the PTSD-alcohol expectancy questionnaire. *Addictive Behaviors*, 33, 841-847. doi:10.1016/j.addbeh.2008.01.003
- Pitman, R. K., Altman, B., Greenwald, E., Longpre, R. E., Macklin, M. L., Poiré, R. E., & Steketee, G. S. (1991). Psychiatric complications during flooding therapy for posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 52, 17-20.
- Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review*, 30, 635-641. doi:10.1016/j.cpr.2010.04.007
- Riggs, D. S., & Foa, E. B. (2008). Treatment for co-morbid posttraumatic stress disorder and substance use disorders. In S. H. Stewart & P. J. Conrod (Eds.), *Anxiety and substance use disorders: The vicious cycle of comorbidity* (pp. 119-138). New York, NY: Spring Science+Business Media.
- Rothschild, B. (2004, January/February). Applying the brakes. *Psychotherapy networker*. Retrieved from <http://home.webuniverse.net/babette/Brakes.html>
- Russell, M. C. (2008). Scientific resistance to research, training and utilization of eye movement desensitization and reprocessing (EMDR) therapy in treating post-war disorders. *Social Science & Medicine*, 67, 1737-1746. doi:10.1016/j.socscimed.2008.09.025
- Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, T., Chow, B. K., . . . Bernardy, N. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women. *JAMA*, 297, 820-830. doi:10.1001/jama.297.8.820
- Schnurr, P. P., Friedman, M. J., Foy, D. W., Shea, M. T., Hsieh, F. Y., Lavori, P. W., . . . Bernardy, N. C. (2003). Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: Results from a Department of Veterans Affairs Cooperative Study. *Archives of General Psychiatry*, 60, 481-489. doi:10.1001/archpsyc.60.5.481
- Solomon, S. D., & Johnson, D. M. (2002). Psychosocial treatment of posttraumatic stress disorder: A practice-friendly review of outcome research. *Journal of Clinical Psychology*, 58, 947-959. doi:10.1002/jclp.10069
- State of Connecticut Department of Mental Health & Addiction Services. (2000). *Trauma: No more secrets* [video]. Hartford, CT: Author.
- Stermann, C. (2006). Traumatized addicted women: Treatment issues. In B. Carruth (Ed.), *Psychological trauma and addiction treatment* (pp. 255-281). Binghamton, NY: Haworth Press.
- Triffleman, E., Carroll, K., & Kellögg, S. (1999). Substance dependence post-traumatic stress disorder therapy. An integrated cognitive-behavioral approach. *Journal of Substance Abuse Treatment*, 17, 3-14. doi:10.1016/S0740-5472(98)00067-1

- van der Kolk, B. A. (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.
- Welsh, T., Miller, N., Hamilton, N., Doherty, J., & Najavits, L. M. (2010, May). *Peer-led Seeking Safety pilot*. Presented at the Substance Abuse and Mental Health Services Administration conference, San Diego, CA.
- White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.
- Zayfert, C., & Becker, C. B. (2000). Implementation of empirically supported treatment for PTSD: Obstacles and innovations. *The Behavior Therapist*, 23, 161–168.
- Zweben, J. E., Clark, H. W., & Smith, D. E. (1994). Traumatic experiences and substance abuse: mapping the territory. *Journal of Psychoactive Drugs*, 26, 327–344.
- Zweben, J. E., & Yeary, J. (2006). EMDR in the treatment of addiction. *Journal of Chemical Dependency Treatment*, 8, 115–127. doi:10.1300/J034v08n02_06