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13

CREATING CHANGE: A NEW PAST-FOCUSED MODEL FOR TRAUMA AND SUBSTANCE ABUSE

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It is well-established that recovery from trauma and addictions can benefit from a stage-based approach. From the earliest writings on trauma in the 19th century through the present era, stages of trauma recovery have repeatedly been identified, particularly for complex or comorbid clients (Courtois, 2004; Herman, 1992; van der Hart, Brown, & van der Kolk, 1989; van der Kolk, McFarlane, & Weisaeth, 1996). Indeed, it has been termed a *consensus model* in the field because of its importance as a theoretical framework for trauma recovery (Courtois, 2004; Leeds, 2006). This consensus is empirically supported by a recent survey of 50 posttraumatic stress disorder (PTSD) experts, in which 84% endorsed a sequenced, stage-based approach to PTSD treatment (Cloitre et al., 2011).

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STAGE-BASED FRAMEWORK

The stages, per Herman's terminology (1992), are safety (Stage 1), mourning and remembrance (Stage 2), and reconnection (Stage 3). Each represents a distinct type of therapeutic work and time perspective (Najavits, 1997). Safety (Stage 1) is present focused, encompassing coping skills and psychoeducation. Mourning and remembrance (Stage 2) is past focused, referring to processing of painful memories and related emotions. Past-focused models prominent in the current era include prolonged exposure therapy (PE), eye movement desensitization and reprocessing therapy (EMDR), narrative exposure therapy, and cognitive processing therapy (CPT). (See elsewhere in this volume for more on these types of models.)¹ Reconnection (Stage 3) is future focused, building a strong social and work life ahead. There may be overlap between these stages, and some clients may not need all three, but overall this stage-based approach is a helpful guide to the recovery endeavor. The addictions field too has similar stages, although addictions treatment tends to rely most heavily on present-focused approaches (Najavits, 2002b).

There is a growing literature on empirical studies of stage-based approaches. In the PTSD field, the overarching pattern is that both present- and past-focused models are effective, with neither superior to the other; similarly, past-focused models have positive results but do not outperform each other (Benish, Imel, & Wampold, 2008; Bradley, Greene, Russ, Dutra, & Westen, 2005; Najavits, 2007; Powers, Halpern, Ferenschak, Gillihan, & Foa). The substance use disorder (SUD) field does not distinguish present focused versus past focused, with most SUD treatment being present focused. However, comparison of SUD models also consistently shows a lack of difference between them (see, e.g., Carroll & Rounsaville, 2007; Imel, Wampold, Miller, & Fleming, 2008; Sellman, 2010). In general, these findings mirror the larger field in which several decades of behavioral therapies research indicates that manual-based models rarely outperform each other (Beutler, 1991; Garfield & Bergin, 1994; Torchalla, Nosen, Rostam, & Allen, 2012). In short, clinicians have many choices in which approaches they can use and can base their choices on many factors, including what treatments they have been trained to conduct, their preferences and those of their clients, length of treatment episode, setting, and cost.

¹Past-focused models are sometimes termed *trauma-focused*. However, that term is potentially confusing because present-focused treatments for PTSD also directly address trauma in their content. The terms *trauma processing* and *past-focused* are used in this chapter to refer to any model that predominantly guides clients to describe or explore trauma memories or cues with a goal of evoking and working through their associated intense feelings.

SEEKING SAFETY: A STAGE 1 INTEGRATED MODEL

Seeking Safety therapy (SS; Najavits, 2002b) was developed as a Stage 1, present-focused approach for co-occurring PTSD and SUD. It is an optimistic, cognitive behavior therapy (CBT) approach that provides psychoeducation and coping skills to help clients attain safety from PTSD, SUD, or both. Examples of SS topics include Safety, Asking for Help, Setting Boundaries in Relationships, Honesty, Detaching From Emotional Pain (Grounding), Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Integrating The Split Self, Recovery Thinking, Taking Good Care of Yourself, and Self-Nurturing. It builds hope through emphasis on ideals and a compassionate, humanistic approach. It was developed for use across all levels of care and settings (e.g., outpatient, inpatient, residential), all types of trauma and substances, both male and female patients, and group or individual modality. Topics can be conducted in any order, using as few or as many as are possible within clients' length of stay and by a wide variety of staff (no particular professional degree, training, or background is required, and it has even been conducted as a peer-led model).

SS has been researched in more than 22 outcome studies (including pilots and several controlled and randomized controlled trials [RCTs]), with consistent positive findings. See Najavits and Hien (2013) for a comprehensive literature review of PTSD–SUD outcome studies, including SS. Also, the website <http://www.seekingsafety.org> provides a full description of the model and its empirical studies. SS is established as an empirically supported treatment at the highest level per the International Society for Traumatic Stress Studies (Level A; Najavits et al., 2008) and also at the highest level for both PTSD and SUD per Division 12 (Psychotherapy) of the American Psychological Association (i.e., “strong research support”; <http://www.psychologicaltreatments.org>). It also has a rating of “supported by research evidence” in the California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org>). However, there is a need for additional RCTs on the model because many of the outcome studies have been pilots. The manual has been translated into seven languages, and tens of thousands of clinicians have been trained in the model, with more than 900 invited trainings conducted in the United States and internationally. SS has also been adopted in various government rollouts in states and counties.

From a public health standpoint, SS is one of the most easily implemented models, given its flexibility, low cost, feasibility with numerous vulnerable populations, and overall safety and efficacy (Killeen et al., 2008; Najavits, 2009). It is also notable for evidencing successful use in the challenging populations that have been consistently excluded or not as yet addressed with existing PTSD models such as PE, CPT, and EMDR—that is, clients who are highly unstable because of current substance dependence,

homelessness, domestic violence, suicidality, or additional co-occurring Axis I or Axis II disorders. Furthermore, although SS was originally designed for clients with both PTSD and SUD, it has been implemented more broadly with those who are subthreshold, have just one or the other disorder, or a history of them. It is also notable for being the lowest cost model for PTSD treatment available, not requiring the intensive, lengthy training and consultation and prerequisites required by other evidence-based PTSD models (see, e.g., Karlin et al., 2010; <http://www.emdrnetwork.org/choosing.html>).

CREATING CHANGE: A STAGE 2 INTEGRATED MODEL

A new manual, *Creating Change* (CC; Najavits, 2013), provides a natural “next step” after SS. Where SS offers a present-focused integrated model for PTSD–SUD recovery, CC offers a past-focused integrated model for PTSD–SUD. CC is designed to offer the same positive features of SS, including a warm, supportive tone, its format, its flexibility, and its applicability to the broadest possible range of PTSD–SUD populations, staff, and settings. Given both the appeal and efficacy of SS, a Stage 2 model such as CC that draws on the strengths of SS could provide a helpful new model.

However, with the various evidence-based Stage 2 (past-focused) treatments that already exist (see the first section of this chapter), a natural question is whether there is really a need for another model. CC was developed to address the following gaps in the field, which relate not solely to the need for effective models but also to the need for models that will be appealing to clinicians and clients and sensitive to public health considerations (e.g., cost, workforce capacity).

CC offers a past-focused, integrated PTSD–SUD approach that is feasible in SUD settings. As noted earlier, there are numerous past-focused models for PTSD. Although these models are evidence based for PTSD, they are not yet evidence based for PTSD–SUD (Najavits et al., 2008). Moreover, none were designed originally for SUD, and thus they lack potentially important topics (e.g., how PTSD and SUD are linked). Some have recently been applied to PTSD–SUD samples, but their origins as PTSD treatments make them challenging to apply in SUD settings, which generally do not have the workforce, resources, or typical (i.e., less complex) clientele for them. For example, most past-focused PTSD models assume individual modality, as well as a high level of clinician professional background, training, and supervision (with a resulting relatively high cost). Standards for training have been described for CPT and PE as part of a national rollout on these models in the Veterans Affairs (VA) system (Karlin et al., 2010). The rollouts were in part designed to address the

historically low uptake of those models in the absence of a formal rollout (Becker, Zayfert & Anderson, 2004; van Minnen, Hendriks, & Olff, 2010). CPT involves a required 3-day workshop plus 6 months of weekly 1-hour phone consultations; for PE it is a 4-day workshop plus weekly consultation for as long as needed on two cases (Karlin et al., 2010). Requirements for EMDR clinicians are also intensive and require an advanced degree (<http://www.emdrnetwork.org/choosing.html>). In contrast, community-based SUD settings provide most treatment in group modality, generally with a less educated workforce and fewer resources for training and supervisory time.

In addition, the existing outcome literature on all PTSD past-focused models has consistently excluded the types of high-complexity PTSD-SUD clients who are addressed in SS and CC. According to a meta-analysis by Bradley et al. (2005), 62% of PTSD outcome trials excluded clients with SUD; 46% were excluded for suicide risk and another 62% for unspecified "serious comorbidity" (separate from exclusions for psychosis and organic mental disorder). Only 42% of studies reported on Axis I comorbidity, and only 12% reported on Axis II comorbidity. In a recent chart review of PTSD and alcohol use disorder (AUD) among more than 500 VA clients seen in residential treatment and treated with CPT, only 2.6% met criteria for current alcohol dependence, and only 4.7% met criteria for current alcohol abuse (i.e., had AUD diagnoses that were neither past nor in remission). In the Monson et al. (2006) study of CPT for PTSD in VA, only 3% had a current SUD diagnosis. Of the studies in the Powers, Halpern, Ferenschak, Gillihan, and Foa (2010) meta-analysis of PE, all but one had exclusionary criteria for SUD, substance use, or both (van Minnen, Harned, Zoellner, & Mills, 2012). In the few PTSD trials in which SUD is included, it is almost always the less severe form (substance abuse) rather than the more severe form (substance dependence; Najavits et al., 2008). In the RCT by Foa, Riggs, and Hembree (2006) of PE in a substance-dependent sample, the authors focused only on alcohol dependence, excluded clients with cocaine or opioid disorder, required outpatient detoxification before starting the PE, and provided 27 to 36 hours of individually delivered PE per client (in addition to treatments the clients were receiving in the SUD setting). Furthermore, the PE was delivered by highly trained PTSD psychologists brought in from outside (with the SUD treatment by an experienced SUD provider in a nonintegrated fashion).

There is also a long history of identifying exposure-based PTSD therapies as not appropriate for SUD clients or, at best, recommending significant modifications to be useable with this population (Coffey, Dansky, & Brady, 2002; Coffey, Schumacher, Brimo, & Brady, 2005; Keane, 1995; Ruzek, Polusny, & Abueg, 1998; Solomon, Gerrity, & Muff, 1992; Vogelmann-Sine, Sine, Smyth, & Popky, 1998). Foa and colleagues (1999) called it a *second line* treatment for SUD clients (in Brady, Dansky, Back, Foa, & Carroll, 2001). Coffey et al.

(2002) stated that the PTSD–SUD clients most amenable for exposure therapy are those with

a history of just one trauma or multiple discrete traumas; relatively clear memories of the trauma; if multiple trauma occurred, the traumas did not occur before the age of 15; minor dissociation during exposure therapy techniques; ability to develop vivid images; intrusive memories, flashbacks, fear-avoidance, or hyperarousal being the most prominent trauma symptoms. (p. 144)

They also noted that a high level of anger and multiple traumas that result in a large in vivo hierarchy to address may make exposure problematic or inappropriate for PTSD–SUD clients. Challenges implementing exposure-based therapies even with non-SUD clients have been described as well (Ehlers et al., 1998; Pitman et al., 1991; Scott & Stradling, 1997; Tarrrier & Humphreys, 2000; Zayfert & Becker, 2000).

In terms of evidence-based SUD models, none thus far were designed to address PTSD (e.g., 12-step, contingency management, motivational enhancement therapy). In terms of PTSD–SUD models, which have been developed only in the recent past (Najavits et al., 2008), there is one that has a past-focused component: the COPE model, which is an adaptation of its precursor, Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD; Back, Dansky, Carroll, Foa, & Brady, 2001; Brady et al., 2001). COPE is a 19.5-hour model, delivered in individual format. An RCT found that COPE showed no advantage over treatment as usual at the end of treatment on any outcome (PTSD, SUD, depression, anxiety), although at follow-up it had an advantage on PTSD but not SUD, depression, or anxiety (Mills et al., 2012). The earlier model, CTPCD, was 24 hours of individual therapy (in 16 sessions) combining existing evidence-based present- and past-focused approaches within and across sessions. The present-focused methods were from CBT for substance abuse (see manuals by Carroll, 1998; Kadden et al., 1995; Monti, Abrams, Kadden, & Cooney, 1989). The past-focused method was PTSD exposure therapy from the manual by Foa and Rothbaum (1998). One uncontrolled pilot study on CTPCD was completed, with positive outcomes (Brady et al., 2001). This pilot study was impressive in being the first to evaluate a PTSD exposure therapy model with SUD clients (including both imaginal and in vivo exposure). However, its limitations included paying incentives to clients to attend sessions, its high dropout rate (Brady et al., 2001, p. 47), outcome analyses solely on treatment completers (just 38.5% of participants rather than all participants), variable dosage of CTPCD (from 9 to 27 hours), and its solely individual modality. The authors of the pilot study also excluded clients with suicidal or homicidal ideation. Suggestions to help make CTPCD easier to implement with SUD clients in community mental

health centers were described a few years later (Coffey et al., 2005) but have not yet been published in a manual. All other PTSD–SUD models thus far are present-focused approaches (Najavits, 2009; Najavits et al., 2008) or, in the case of Triffleman et al.'s substance dependence PTSD therapy (Triffleman, 2000; Triffleman, Carroll, & Kellogg, 1999), a quasi-past-focused model in that it used solely in vivo exposure (no imaginal exposure), with no superiority to 12-step facilitation in an RCT (Triffleman, 2000).

In sum, CC attempts to fill as yet unmet needs: It was specifically designed for SUD settings, taking into account the realities of the workforce, their complex clientele, the need for the group modality, and the resource limitations of these environments. It also appears to be more integrated in terms of past-focused PTSD–SUD content, guiding clients to process painful SUD memories as well as trauma memories and exploring in detail the life trajectory of both disorders in relation to each other. Other past-focused PTSD–SUD studies have typically used or brought highly trained PTSD specialist therapists into SUD settings (e.g., Berenz, Rowe, Schumacher, Stasiewicz, & Coffey, 2012; Foa et al., 2006), rather than using the standard SUD workforce. Moreover, those uses of PE appear to focus primarily on conducting PE exposure in the context of SUD treatment rather than building in SUD content as part of the exposure per se.

CC *emphasizes flexibility and choice*. It includes all the flexible elements that have aided the implementation of SS. It is designed for both genders, all types of trauma and substances, individual or group modality, and different settings. All topics are independent of the others; the clinician can thus move in any order and conduct as many topics as desired. They are called *topics* rather than *sessions* because the clinician may choose to implement some topics over multiple sessions or return to them again later in the therapy. The model can be conducted over a shorter or longer time (both in the session length and across the treatment course). Such flexibility allows for implementation across many settings and populations, which vary widely in length of stay, client severity, clients' or clinicians' need for pacing, and other factors.

Choice and empowerment are also central. By their very nature, both trauma and addiction represent a loss of control. Thus, a central goal is to help restore personal power. Clients are guided to evaluate their preference and readiness for past-focused work, and clinicians are also asked to explore whether CC fits their temperament and abilities. At each session (when conducted in individual format), the clinician and client can choose whether to focus the current session on the past or present (see the section Combining SS and CC later in the chapter). Choice also occurs in the use of handouts, letting clients move among them fluidly, spending time on aspects that resonate for them, and letting go of those that do not. Rather

than a one-size-fits-all approach, the materials are a plentiful resource from which they can creatively experiment, draw on, respond to, try out, and choose from. The focus on choice also serves the practical function of eliciting clients' buy-in to make attendance and successful outcome more likely. This may be especially important for past-focused PTSD treatments, which historically have struggled with issues of dropout (e.g., Brady et al., 2001; Hembree et al., 2003; Riggs, Rukstalis, Volpicelli, Kalmanson, & Foa, 2003; Schnurr et al., 2003; Zayfert & Becker, 2000). Yet although CC offers choices, it also provides guidance, such as how to deliver it as one topic per session (thus conducting it to mirror the research studies on CC, where it was done in 17 weekly sessions).

CC addresses broad social and historical contexts—beyond the individual. Many clients with PTSD–SUD feel abandoned or betrayed by society, whether by their family, authority figures who harmed them, or societal oppression or neglect related to class, race, or other subgroup issues. CC contextualizes PTSD and SUD beyond the individual, including social influences, culture, and institutional responses. Such wider circles play both positive and negative roles in the development of PTSD–SUD and in the recovery process. Clients can come to terms with the impact of these larger forces and decide which messages they want to “hold on to” going forward. For example, one topic is titled “The Larger Context” to address some of these themes. For the clinician, CC offers a historical overview of past-focused models going back to the 19th century (with precursors extending to ancient times). By providing these broad social and historical frameworks, the goal is to go beyond the primarily individual focus in the current mental health environment in which clients are often intaked as individuals, seen in individual therapy, and guided to view recovery as their personal task.

CC provides strong engagement strategies. Engagement is a priority in CC. Like SS, it seeks to convey a warm, compassionate tone rather than a technical one and offers extensive psychoeducational material, an inspirational quotation for each topic, handouts, creative exercises, and simple, humanistic language. Such strategies may help engage clients and clinicians more in past-focused work, given their persistent low uptake of such models (Coffey et al., 2005; Karlin et al. (2010); Zayfert & Becker, 2000).

CC details extensive safety parameters. Until recently, SUD clients were excluded from most past-focused PTSD treatments and research trials (as discussed earlier) because of legitimate clinical concerns about the risk for negative outcomes such as increased substance use, harm to self or others, treatment dropout, and impaired functioning (Keane, 1995; Pitman et al., 1991; Ruzek et al., 1998; Solomon et al., 1992). It is now known, however, that some SUD clients want to do past-focused treatments and can improve in them—clients who previously were considered unsuitable (Brady et al.,

2001; Coffey et al., 2005; Foa et al., 2006; Mills et al., 2008; Najavits, Schmitz, Gotthardt, & Weiss, 2005; Triffleman et al., 1999). Yet in all such studies, the past-focused treatment was modified or exclusionary criteria were used to select less severe clients. PTSD-SUD clients indeed are more vulnerable than those with PTSD alone: Research consistently finds them to have greater impairment and worse outcomes (even in non-past-focused treatments; Najavits et al., 1998, 2007; Ouimette & Brown, 2002; Riggs et al., 2003). The principle "first, do no harm" is key.

CC addresses safety parameters in detail, all the more because of its inclusion of a wider range of clients and clinicians than previous past-focused models:

1. In each session, a self-report scale can be used to assess functioning and recent unsafe behavior.
2. A written plan documents after-hours and emergency procedures.
3. The session checkout has an optional 3 to 5 minutes of grounding (calming strategies).
4. The client is provided with in-depth preparation about past-focused work.
5. A Readiness Questionnaire helps identify clients' fit for past-focused work; clinician and treatment setting readiness are also addressed.
6. The clinician is instructed on serious problems that may arise and how to handle them, such as rage, dissociation, and impulse to harm.
7. The homework, called *commitments*, is designed for stabilization (i.e., present rather than past focused) unless the clinician decides otherwise.
8. Therapeutic alliance is measured before moving into intense material.
9. Clients' functioning is emphasized throughout ("one foot in the past and one in the present").
10. An advance directive specifies clients' preferences for additional help if the need arises.
11. SS or other coping-skills approaches can be incorporated if desired.
12. The clinician is identified as the "gatekeeper," monitoring progress and adjusting treatment as needed, with client input.

For clinicians who are familiar with classic past-focused PTSD models, some of these strategies may appear to reinforce avoidance. However, the premise is that classic PTSD models need to be adapted for PTSD-SUD

because they were generally developed and tested on healthier clients—typically outpatients, often with adult-based trauma, and excluding co-occurring SUD and other complexities. The goal is thus to move beyond the extremes that have historically guided therapy of PTSD–SUD clients: Either none should do past-focused work (“they are too fragile”) or all should do it (“it’s helpful for everyone”). The clinician’s task is to balance these opposites, focusing on how, when, and whether to move in and out of the work with each client.

CC is sensitive to complexity. Given the consistent finding, as noted earlier, of PTSD–SUD clients being more impaired than PTSD-alone clients, CC assumes that a high level of complexity may be present. This can include various Axis I and Axis II disorders, life problems such as poverty and marginalization, and unsuccessful previous treatment. CC provides extensive guidance to help create a successful experience. For example, there is a review of overall principles of high-quality trauma and substance abuse treatment, ongoing metrics to monitor and pace the work, and emphasis on a strong therapeutic alliance. However, CC also seeks to expand beyond earlier limits on past-focused treatment for PTSD–SUD clients. Myths related to treatment are explored, such as the idea that SUD clients per se are not appropriate for it, that some lengthy period of abstinence is required before beginning, or that only clinicians with an advanced mental health degree can conduct it. Thus, complexities of all kinds are openly addressed.

CC addresses the clinician role in detail. A treatment manual is inert until brought to life by the clinician and client. A large body of research suggests, moreover, that clinician factors are more predictive of outcome than client factors or type of model per se (Najavits & Weiss, 1994). With regard to PTSD–SUD treatment in particular, there are also some surprising findings with regard to workforce issues. For example, although PTSD–SUD clients are perceived as more challenging to treat than those with PTSD or SUD alone, gratification in the work is consistently rated higher than difficulty with it (Back, Waldrop, & Brady, 2009; Najavits, 2002a; Najavits, Norman, Kivlahan, & Kosten, 2010). Moreover, the clinicians who rate PTSD–SUD as the most difficult or least gratifying to treat are those working in a mental health setting (compared with an SUD setting), with no personal history of trauma, with no personal history of SUD, with a PhD, with lower allegiance to a 12-step orientation, older clinicians, and those who find clinical work less stimulating (Najavits, 2002a). (See similar results in Back et al., 2009, who conducted a replication study, and Najavits et al., 2010, in a study of VA clinicians.) In a study addressing the relative appeal of present- versus past-focused models for PTSD–SUD treatment, there were similar findings (Najavits, 2006). Those who rated past-focused treatment for PTSD–SUD as more appealing (compared with less appealing) were those with a personal

history of trauma or SUD (or both), those who worked in an SUD setting (compared with a mental health setting), and those who rated themselves as less burned out. In general, present-focused treatments were perceived as more appealing than past focused, but both types were viewed as useful to do for PTSD–SUD and within their scope of practice.

In CC, there is strong emphasis on the clinician role to help guide the work in positive ways and also to address some of these workforce issues, which have roots in the historical—and to a notable degree, still current—separation of mental health versus SUD treatment systems. Helping providers in both settings become comfortable with and effective in treating PTSD–SUD is the goal. There is no specific type of clinician who can do CC, based on easy-to-measure characteristics such as years' experience, type of degree, or theoretical orientation. Instead, clinicians are asked to self-reflect on their interest in this type of work and their readiness for it. CC also directly addresses the possible impact of clinicians' own personal history of PTSD–SUD.

Key clinician themes in CC include the need to offer moral compassion toward trauma and addiction rather than neutrality, staying real, sustaining hope, being open to feedback, maintaining boundaries, self-care, honoring one's own history of trauma and/or addiction (if applicable), the clinician as gatekeeper for decisions about the treatment course, and self-reflection to evaluate one's goodness-of-fit with past-focused treatment. CC also addresses myths that clinicians may hold about PTSD–SUD treatment, such as "Clients just need to tell their story," "If clients want to talk about their past, they are ready," and "All clients need to do this work."

THE DEVELOPMENT OF CC

CC was developed on the basis of clinical experience, pilot research, and various literatures (e.g., history of medicine, SUD, PTSD, psychotherapy research, educational research). The first pilot study was conducted with men (Najavits et al., 2005) with CC at that point an early version called Exposure Therapy Revised (ETR). The study had clients with high severity and chronicity in both disorders, all with childhood-based PTSD and substance dependence. The study also had fewer exclusionary criteria than any previous exposure-based study of PTSD–SUD; for example, suicidal ideation was not an exclusionary criterion. ETR was a combination of SS and exposure, offering up to 30 sessions using the "interweaving" method described subsequently (see Combining SS and CC). It emphasized adaptations of exposure to make it relevant for comorbid SUD, such as enhanced safety parameters, and exploring both trauma and SUD memories. Results showed significant positive outcomes in numerous domains, including trauma and

SUD symptoms, as well as excellent treatment attendance and satisfaction (Najavits et al., 2005). Notably, clients were assessed at the start of treatment on their preference for present- versus past-focused methods. They rated present-focused methods as more appealing than past-focused ones before starting treatment but, by the end, had strong satisfaction with both types. They also reported that the exposure sessions helped equally with both their PTSD and SUD. The average number of SS sessions selected was 21 and exposure sessions nine, indicating a naturalistic titration of present-versus past-focused work.

The CC manual was written by December 2007. A second pilot study (Najavits & Johnson, 2013) used the CC manual in a community agency with men and women clients in individual format (and not combining it with SS). This pilot study showed significant improvements in various domains, as well as strong satisfaction and attendance. Other CC research is underway, including an RCT with men and women veterans comparing CC with SS. The model has also been implemented successfully in group format in three cohorts in a community substance abuse agency (R. Beardsley, personal communication, April 30, 2012). The CC manual (Najavits, 2013) will be published soon.

FORMAT

Like SS, CC has a structured format that aims to counteract the chaos, impulsivity, and instability of PTSD–SUD by evoking their opposites: planning, pacing, and consistency. The structure itself helps to promote a sense of safety. SS sessions are structured as follows.

1. Check-in: “How are you feeling?” “What good coping have you done?” “Any substance use or other unsafe behavior?” “Did you complete your commitment?” and “Community resource update”.
2. Quotation to emotionally engage clients in the session topic.
3. Handouts to read, discuss, and relate to clients’ lives through active rehearsal.
4. Checkout: “Name one thing you got out of today’s session (and any problems with the session)” and “What is your new commitment?”

The format of CC is identical to that of SS, except for two added elements. As part of the checkout, there is a 3- to 5-minute optional grounding exercise to help clients shift back to the present before leaving. *Grounding* is a method of calming described in detail in SS using physical, mental, and

soothing methods. The grounding also helps rehearse emotion regulation generally. The second added format element applies only to individual, not group, delivery of CC. It is an option at the start of the session to ask, "Today would you prefer to focus on your past (CC) or present (e.g., SS)?" This method was used in the original pilot of ETR (Najavits et al., 2005) and was perceived positively by study participants. Allowing the clinician and client to collaboratively decide whether to focus on the past or present promotes responsiveness to clients' ups and downs in recovery. If they choose a present focus at the session, they can do a topic from SS, relapse prevention, or any other present-focused model.

CONTENT

The CC manual provides several background chapters, including "Context," which offers background on PTSD-SUD and CC; "Conducting the Treatment," on how to implement the model; and "The Clinician" to elaborate the clinician role. Each CC treatment topic has a clinical focus, which is similar to SS but with a different emphasis: In SS, each topic represents a safe coping skill; in CC, each topic represents a processing theme. Examples of CC topics follow.

Explore Options

Clients are introduced to the idea of facing the past, of bringing "light and air" to emotional pain. They learn about differences between past- and present-focused models and how both may help in PTSD and SUD treatment. They are offered a vivid portrayal of past-focused work, with quotes from people who have lived it. Elements of the process are described, such as "grieving," "letting go," and "vulnerability." Education is provided on the difference between expressing feelings (venting, spilling, catharsis) versus processing feelings (working through, mourning, accommodation). The potential benefit of such work—visible and enduring change in clients' lives—is emphasized.

Choose a Path

A Readiness Questionnaire evaluates clients' strengths and obstacles that may help determine whether now is the right time for past-focused work. Clients' preferences for treatment are also explored (present or past focused, or both). If they are not ready for past-focused work, they are guided to honor that and identify what work is needed to prepare for it.

Encourage Along the Way

Clients naturally have doubts and questions throughout treatment. They are encouraged to identify concerns, such as “I thought ‘time heals all wounds,’” “I’m too far gone,” “If I start to cry, I’ll never stop,” “It’s easy—let’s just get on with it,” “If I recover, it means the trauma didn’t matter,” and “I just need to work on my substance abuse.” They are offered possible responses to these as well.

Listen to Your Body

Trauma and substance abuse are major physical experiences that have an impact not just on the body but also on the whole person—mind, feelings, and relationships. In this topic, clients are encouraged to become more aware of their body—how it helped them survive but also how it has held the experiences of trauma and substance abuse. They are guided to notice body memories related to trauma and SUD and themes such as physical health, body neglect versus self-care, body addictions, sexuality, and feeling safe in one’s body. Education is provided on how trauma and substance abuse affect the body and how to become more attuned to one’s body and its messages.

Respect Your Defenses

This topic explores how defenses can be healthy or unhealthy. Clients are encouraged to respect defenses as a way they survived but that may need to change going forward. Unhealthy defenses include splitting, isolation, regression, blaming, and secrets. Healthy defenses include humor, helping others, spirituality, and creative work. Defenses represent emotional patterns that go beyond symptoms of PTSD–SUD. For example, one client with PTSD–SUD becomes isolated, whereas another bullies others. Such styles often represent self-protection. Clients are not wrong for having the defenses, but they can now choose healthier responses.

Link Trauma and Addiction

The goal here is to explore the development of addictive behavior in relation to trauma. Exercises promote emotional expression rather than just intellectual awareness. One handout helps identify their addictions, including SUD and also behavioral addictions such as gambling, Internet use, exercise, work, sex, and spending. Other handouts encourage drawing a timeline

of trauma and addiction, identifying losses due to trauma and addiction, exploring family history of trauma and addiction, and becoming aware of how substances may have "solved" trauma problems.

Honor Your Survival

Clients identify traumas, losses, tragedies, painful events, stressors, and addictions. They are encouraged to respect their survival and to explore the emotional context that may have added to their pain, such as betrayal, isolation, humiliation, and not being believed. There is also discussion of the impact of such events, both positive (e.g., posttraumatic growth, altruism toward others who have suffered) and negative (e.g., psychological symptoms, identity problems, "addiction to pain").

Tell Your Story

In this topic, clients can reveal what happened, telling their narrative of trauma and addiction. They have many choices in methods, with the idea that there is no one right way. They can tell a small or large part first, the easiest or worst part, tell it in words or through writing or art, chronologically or out of order, focus on one event or many. The essential ingredient is to access emotions connected to their memories because this is central to healing. They are given strategies to access feelings, such as slow motion, shifting perspective, noticing their body, closing their eyes, and facing reminders. These strategies are drawn from various past-focused models.

Seeing Clearly

In both PTSD and SUD, more than many other disorders, there is a prominence of "knowing and not knowing," or varying levels of truth. It can take many forms that reflect a lack of complete awareness: fragmented memory, denial, minimization, blackouts, splitting, the "pink cloud," avoidance, the false self, memory phobia, and body memory, for example. It is part of PTSD and SUD to block the full brunt of reality, and part of therapy is to bring it to light, gently but persistently. Seeing clearly in this topic thus means facing painful truths. Truth is approached in a postmodern sense: It is a meaningful construction that clients build over time, rather than a simple accounting of facts. Seeing clearly can also be called *facing illusions*, *lifting the veil*, *owning it*, and *trusting truth*. Memory problems in PTSD and SUD are also explored (e.g., how trauma memory differs from normal memory, how substances can impair or evoke memories).

Recognize Relationship Patterns

PTSD and SUD can create major relationship disturbances, but relationships can also be a source of healing. This double-edged quality—relationships can drag clients down or raise them up—makes it a potent force in both illness and recovery. Clients explore how current relationship patterns have origins in the past. They identify lessons learned in relationships and learn to observe relationships in the broadest sense—not just with others but also with substances, food, possessions, money, nature, pets, and themselves (e.g., nurturing or depriving, kind or harsh).

WAYS TO COMBINE SS AND CC

SS and CC are “twins,” with the same format, compassionate tone, simple language, integrated approach to PTSD–SUD, flexibility, engagement of clients through exercises and handouts, and emphasis on the clinician role. They differ in that SS addresses the present, whereas CC focuses on the past. The two models can be used separately or combined as follows.

First One, Then the Other (Sequential)

In keeping with the stage-based framework of treatment (Herman, 1992), SS can be done first and CC second. This method has intuitive appeal. However, research indicates that the work does not always have to follow these stages. Some clients may benefit from a past-focused approach from the start of treatment (not needing present-focused therapy); others may benefit from just a present-focused approach (not needing past-focused therapy). Thus, a sequential approach is one way, but not the only way.

Back and Forth (Interweaving)

In this method, the clinician conducts both models, moving back and forth between them, session by session. This was the method in the precursor pilot study on CC (Najavits et al., 2005). At each session, after the check-in, the clinician and client decided whether to focus on an SS or CC topic. This was perceived as extremely helpful because it allowed pacing that was sensitive to how the client was doing week to week. It should be noted that this method of interweaving can be done in individual therapy but would not lend itself to the group modality because clients may have divergent needs and preferences.

Two Separate Treatments (Parallel)

In this method, clients attend both SS and CC at the same time. The two models can be conducted by the same or different clinicians, and each treatment can be an individual or group modality. Parts of each could also be combined, rather than conducting all of both. SS topics that may be especially helpful while conducting CC include Introduction/Case Management, Safety, Detaching from Emotional Pain (Grounding), Asking for Help, When Substances Control You, PTSD: Taking Back Your Power, and Healing From Anger. However, it is generally not a good idea to cover both an SS topic and a CC topic in the same session because there is not enough time to do justice to each.

FUTURE DIRECTIONS

The PTSD-SUD field is in an early stage, even with many positive developments over the past decade, as discussed in other chapters of this volume. CC is a new past-focused model that offers the potential to expand existing PTSD-SUD treatment options. CC follows SS, a present-focused PTSD-SUD model, drawing on its successful elements to create a companion model that can be used either alone or in combination with SS (as well as any other treatment models). Yet many questions remain: Which clients are most likely to benefit? What characteristics of clinicians and settings are optimal for successful outcomes? What training is necessary? Can readiness be quantified? What treatment topics are essential or optional? How do its outcomes compare to existing evidence-based models developed for PTSD alone or SUD alone? Can it be applied to as many populations as SS? There is also a need for empirical study of stage-based approaches to PTSD and SUD treatment generally.

It is said that recovery is a verb, not a noun. So, too, is treatment. It thus seems fitting to close with a client's own words. In the 2005 pilot study on CC, one client wrote the following as part of his feedback at the end of treatment:

The best aspect of this therapy was that I understood early on that I was the one who would have to take the supplied "tools" and apply them. It was difficult to go back into my mind and memory and revisit the multiple traumas, but the therapy taught me that, up until now, I was revisiting it with the mind of a ten year-old. The therapy taught me to see it with the mind of a 38-year-old. This completely changed my perception of the abuse, and I was freed of shame and responsibility. The work is arduous and painful, and it is only the desire to be well

that got me through it. Dealing with the past and substance abuse was not only fine, but it allowed the substance desire to be less powerful. Since it was the PTSD that drove the substance abuse, it makes perfect sense to address them simultaneously. I can't thank you enough. You saved my life.

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