Trauma and Substance Abuse: A Clinician's Guide to Treatment

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Substance use disorder (SUD) frequently co-occurs with posttraumatic stress disorder (PTSD) and trauma symptoms broadly. This comorbidity is clinically important, with research showing that it signifies a more difficult course of recovery and greater impairment than either disorder alone (Ouimette and Read 2013). The presence of SUD also impacts how PTSD is addressed in treatment. The whole is not the sum of its parts—addressing PTSD/SUD is not simply about applying treatments for each, but requires conceptualization of how each disorder affects the other and how to engage in successful strategies to address each without worsening the other. It is like a seesaw that needs careful balancing to prevent tipping too far to one side.

Too often, either the SUD or the PTSD is not addressed by clinicians. Patients still frequently hear messages from earlier eras:

- "Get your substance use under control; only then can we address your PTSD."
- "You must go to Alcoholics Anonymous or other 12-step groups."
- "Your PTSD is the root issue—if we just address that, your substance use will decrease too."
- "If you don't stop using substances, I will not treat you."
- "Your substance use means you are avoiding your PTSD."
- "You need to hit bottom."

As will be explored in this chapter, these old messages are generally not helpful to PTSD/SUD patients and can impede recovery. Splits between PTSD and SUD

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treatment are well known, and most clinicians never receive formal training in both. Patients have often been left to try to integrate what our field has not. Although PTSD and SUD may be viewed separately, they are strongly intertwined in the day-to-day experience of patients' lives.

This chapter offers a brief summary of models for PTSD/SUD, key findings from outcome research, practice principles, and future directions.

16.1 Various Models

Recent years have seen the emergence of new therapies to address PTSD/SUD and research evaluating them. Table 16.1 provides a list of models that were either developed specifically for PTSD/SUD or studied in that population. In addition, for inclusion the model had to use a manual, was for treatment not prevention, and had to have at least one study addressing both PTSD and SUD outcomes, and a controlled or randomized controlled trial (RCT) had to provide outcomes for the experimental treatment. Thus, Substance Dependence PTSD Therapy (Triffleman 2000) was excluded. Due to space limits, it is not possible to describe each model nor list all research citations pertaining to them. One primary empirical citation is listed per model from which more information can be obtained; and if the model has a website, that is listed too. The number of studies listed is per Najavits and Hien (2013) plus a subsequent literature search.

Table 16.1 PTSD/SUD behavioral studies

Model and primary empirical citation	Number of outcome studies
Seeking Safety (SS) (Najavits and Hien 2013)	22
Trauma Recovery and Empowerment Model (TREM) (Fallot et al. 2011)	3
Helping Women Recover followed by *Beyond Trauma* (HWR/BT) (Covington et al. 2008)	2
Integrated CBT for PTSD and SUD (ICBT) (McGovern et al. 2009)	2
Prolonged Exposure plus *BRENDA SUD counseling* (PE/BRENDA)	1
PE (Foa et al. 2013) BRENDA (Volpicelli et al. 2001)	
Concurrent Prolonged Exposure (COPE)[a] (Mills et al. 2012)	1
Structured Writing Therapy for PTSD plus *manual-based SUD group therapy* (SWT) (van Dam et al. 2013)	1
Integrated Therapy (Sannibale et al. 2013)	1
Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Frisman et al. 2008)	1
Creating Change (CC)[b]	1

[a]Prior version was Concurrent Treatment of PTSD and Cocaine Dependence (Brady et al. 2001)

[b]Prior version was Exposure Therapy-Revised (Najavits et al. 2005)

16.2 Major Findings

Several findings can be observed across the literature at this point, including some surprises. Even for clinicians who do not specialize in PTSD/SUD treatment, it is worth understanding the current state of the field. As it is said, every clinician has PTSD/SUD patients in their practice, whether they know it or not.

For details on the findings, see Najavits and Hien (2013), which is a comprehensive literature review on all outcome studies for PTSD/SUD. That review was written for clinicians as well as researchers and provides extensive descriptions of each study's methodology and results. Recent studies that emerged after that review are cited in Najavits (2013b); Hien et al. in press. Other reviews are available but are not comprehensive (e.g., Torchalla et al. 2012). Also more research is needed, given the methodology limitations of some studies (Najavits 2013b).

PTSD/SUD studies consistently show positive outcomes. In the 38 outcome studies conducted thus far, the pattern of results has consistently been positive. Improvements were found in PTSD, SUD, and other domains such as self-compassion, cognitions, coping skills, psychopathology, and functioning. Treatment satisfaction was strong in studies that addressed it. Early concerns that addressing PTSD in the context of SUD would worsen patients' state have not been borne out. But it is important to remember that all studies used new models specifically designed for PTSD/SUD or made major changes to classic PTSD therapies to make them tolerable and feasible for SUD samples.

All studies using a PTSD exposure (past-focused) approach combined it with a SUD coping skills (present-focused) approach—but none outperformed models that were present-focused alone. A major current discussion in the field is the relative merit of present- versus past-focused approaches to PTSD treatment. Broadly speaking, models that focus on exposure-based or other emotionally intense exploration of trauma memories are termed here *past-focused.* In contrast, *present-focused* models focus on coping skills and psychoeducation but do not explore trauma memories in detail (Najavits 2013a). Note that *trauma-focused* is often used to refer to exposure-based models. However, all present-focused PTSD models directly focus on trauma. The difference is how they approach it. Exposure-based models focus primarily on the past by exploring the intense trauma narrative and memories. Present-focused PTSD models explicitly omit detailed exploration of the past and instead offer psychoeducation and coping skills to help patients work on PTSD in the present (e.g., learn to identify and manage trauma symptoms; improve functioning; increase safety in their current actions, thinking, and behavior; and promote overall stabilization). Moreover, the term *non-trauma-focused treatment* for present-focused PTSD models is problematic; it is comparable to referring to women as "non-men" or children as "non-adults." Thus the terms *present- and past-focused* are used here.

The majority of PTSD/SUD studies thus far use present- rather than past- focused approaches. This is convergent with the widely endorsed stage-based approach to PTSD treatment in which present-focused stabilization occurs before moving into past-focused exposure (Cloitre et al. 2011; Herman 1992). This frame- work also helps explain why most of the PTSD literature has excluded SUD patients.

In recent years, there has been the healthy development of trying to evaluate whether past-focused approaches may be safely used with PTSD/SUD populations. Importantly, every study using a past-focused PTSD approach combined it with a present-focused SUD model. Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE; Mills et al. 2012) combines PTSD exposure therapy (Foa and Rothbaum 1998) with two CBT SUD models (Baker et al. 2003; Carroll 1998). The PE study (Foa et al. 2013) combined PE (Foa et al. 2007) with a motivational interviewing SUD model (Volpicelli et al. 2001). The Integrated Treatment Study (Sannibale et al. 2013) combined PTSD therapies (exposure and PTSD cognitive restructuring) with SUD treatment manuals from Project MATCH (Kadden et al. 1995) and Project COMBINE (Miller 2004). A study by van Dam et al. (2013) combined Structured Writing Therapy for PTSD (SWT; van Emmerik et al. 2008) with SUD group CBT (Emmelkamp and Vedel 2006). Creating Change uses a gentle approach to explore the past in relation to both PTSD and SUD, including preparation for the work, readiness evaluation, strong safety monitoring, and theme-based session topics (Najavits 2013a). In sum, no investigator has used any past-focused PTSD approach as-is with a SUD population.

Moreover, it is notable that all studies that included a past-focused component were delivered in individual modality rather than group and were almost always restricted to less complex samples than present-focused studies, in keeping with the PTSD-alone literature. "Less complex" means that patients were typically excluded if they had drug use disorders (rather than alcohol only), current domestic violence, homelessness, suicidality, violence, cognitive impairment, serious mental illness, and/or criminal justice involvement. In contrast, present-focused models were primarily group modality and accepted a much broader range of patients (Najavits and Hien 2013). (See below for more on this point.)

Many people believe that past-focused models are more powerful than present-focused models, perhaps because they are experienced as more emotionally intense. Yet all four RCTs that included past-focused PTSD treatment found null results (no difference) on either PTSD or SUD at the end of treatment compared to a control conditions that was present-focused only (Mills et al. 2012; Foa et al. 2013; Sannibale et al. 2013; van Dam et al. 2013) See Najavits 2013b for a summary. End of treatment is emphasized as that is the most rigorous time point for evaluating the impact of a model relative to a control. Both past- and present-focused models worked, but past-focused was not superior to present-focused, even on PTSD where it would be expected to if the "emotional intensity" hypothesis held. One explanation for the null results is that combining past-focused methods with present-focused diluted the past-focused work (Foa et al. 2013). Another explanation is that

past-focused models may be too intense for patients who are struggling with SUD, which is consistent with the dropout problem Hoge et al. (2014), in various past-focused studies (e.g., (Foa et al. 2013; Mills et al. 2012; Brady et al. 2001)). See also the recent meta-analysis by Gerger et al. (2013), which found that the PTSD treatment models they reviewed, which were predominantly past-focused, worked best with simpler rather than more complex patients, when compared to nonspecific therapies such as supportive therapy and relaxation training. A study sample was identified as complex if 80 % met at least two of four clinical criteria: (a) duration of symptoms lasting more than 6 months; (b) presence of multiple problems (e.g., comorbid mental disorders, being in an ongoing violent relationship; being a refugee); (c) presence of a complex psychological traumatization, that is, childhood, multiple, or intentional trauma; and (d) the presence of a formal PTSD diagnosis per the DSM.

Overall, with PTSD/SUD patients, greater emotional intensity in sessions does not equal better outcomes. Both present- and past-focused models may be helpful to patients, based on readiness of the patient and clinician, training, setting, and other contextual factors. Such findings are consistent with psychotherapy research broadly, which shows that manual-based models perform equally well, including those developed for PTSD and those developed for SUD (Imel et al. 2008; Benish et al. 2007; Powers et al. 2010). The bottom line is that clinicians have a lot of choice in which models to use.

The most evidence-based model at this point is Seeking Safety (SS). SS has been very widely implemented in treatment programs for PTSD/SUD (as well as for either alone and for subthreshold patients). It has been the subject of the majority of PTSD/SUD studies, including 13 pilots, 3 controlled studies, and 7 RCTs (Najavits and Hien, 2013; Hien et al. in press). It is also the model with the most number of studies by independent investigators, which are less subject to positive bias (Chambless and Hollon 1998). SS has had consistently positive outcomes and is the only model thus far to outperform a control on both PTSD and SUD (Najavits and Hien 2013). However, some *partial-dose* SS studies were more mixed. Partial-dose studies used just 24–48 % of the model, including the largest study of SS, the National Institute on Drug Abuse Clinical Trials Network. SS is currently the only model for PTSD/SUD listed as having strong research support by professional entities, such as the International Society for Traumatic Stress Studies and Divisions 12 and 50 of the American Psychological Association.

Most studies addressed complex PTSD/SUD populations. It is heartening that the majority of PTSD/SUD studies addressed a broad range of patients: those with substance dependence rather than just substance abuse, those with drug disorders rather than just alcohol, and often including those with issues such as homelessness, domestic violence, suicidality, violence, serious and persistent mental illness, criminal justice involvement, unemployment, multiple prior treatment episodes, and low education. Inclusions and exclusions varied by study, but generally there were low to moderate exclusions in contrast to the relatively high exclusions in the PTSD-alone literature. Among PTSD/SUD studies, those with past-focused models had the most exclusions, in keeping with the PTSD-alone literature from which they derived. Exceptions, however, were Mills et al. (2012), Najavits and Johnson (2014), and Najavits et al. (2005), all of which had a broader range of patients.

Most studies used lower-cost formats for delivery of treatment models. The PTSD/SUD literature primarily uses group rather than individual therapy, open rather than closed groups, frontline clinicians who were native to the setting rather than brought in from the outside, and clinicians who were less highly trained (e.g., without advanced degrees). Such features are common in SUD treatment settings, which is where most of the studies were conducted. Here too, past-focused models differed overall, being conducted in individual modality and generally by highly trained clinicians brought in from the outside.

It appears easier to change PTSD than SUD. In the literature thus far, when there were differences between conditions, they were more often on PTSD or other mental health variables and less often on SUD. This may indicate that in PTSD/SUD patients, PTSD and mental health issues may be easier to treat than SUD. That remains a question for future research but does fit clinicians' perceptions (Back et al. 2009). This pattern also fits the current view of PTSD as amenable to time-limited treatment, whereas SUD (severe SUD in particular) is conceptualized as a chronic relapsing disorder needing ongoing care (Arria and McLellan 2012).

16.3 Recommendations for Practice

1. *Attend to both PTSD and SUD if the patient has both*. This may seem simple but all too often is not done in practice. There are many reasons for it, including lack of sufficient training on PTSD and/or SUD in professional degree programs. The disorders are also known to evoke strong emotional reactions in clinicians and, for SUD in particular, stigma and negative attitudes (Imhof 1991; Pearlman and Saakvitne 1995). Clinicians may shy away from addressing them, may feel incompetent to manage them, or may simply not notice them. Yet just as a patient with cancer and diabetes needs help with both, so too the patient with PTSD and SUD needs help with both. The treatment plan will depend on many factors. Some clinicians may be the primary treater for both; others may treat one or the other or refer out for both. But the "no wrong door" principle still applies: address both in some fashion if present.
2. *The first step in helping is accurate assessment.* Accurately identify both PTSD and SUD, along with other diagnoses and problems that may be present. Use validated instruments rather than homegrown instruments or ad hoc questions. There are at this point many assessments that are easy to obtain, including screening tools, diagnostic interviews, and self-report measures of problem areas. See (Najavits 2004; Ouimette and Read 2013; Read et al. 2002).
3. *The second step in helping is working together with the patient to explore treatment options.* Collaboration is crucial. Ultimatums often drive the patient away and reinforce distrust of professionals. "My way or the highway" approaches are sometimes used with SUD patients out of frustration or a misguided view that harsh confrontation or "hitting bottom" is needed to overcome SUD denial. Yet research shows that a supportive stance is best when working with SUD (Miller et al. 1993; Miller and Rollnick 1991) as well as PTSD. Offer the patient

as many treatment options as possible and empower patients to try out as many as possible before they choose which fit best for them. A helpful strategy is to encourage them to attend up to three sessions of various treatments. According to research, the therapeutic alliance is established by about the third session (Garfield and Bergin 1994). If the alliance is weak at that point, have the patient try other approaches. Pushing patients to stay in treatments they do not like is counterproductive and can drive patients away for good. To learn about treatment resources for PTSD and SUD, search online and find manuals that address PTSD/SUD.

4. *Be compassionate*. Listen closely and convey empathy. PTSD/SUD patients have typically lived lives of extraordinary pain. They are often highly sensitive and feel enormous self-hatred. They are used to being misunderstood by their own families, communities, and, unfortunately, sometimes by clinicians. If they perceive you as aloof or judgmental, they will be less likely to open up. They may drop out of treatment. A caring professional stance is the basis of good treatment. However, remember that true compassion does not mean letting go of standards, making excuses, tolerating unacceptable behavior, or otherwise "enabling" patients. It is about being kind and caring when you enforce treatment expectations and boundaries.
5. *Recognize differences among PTSD/SUD patients*. They vary in many ways, including the presence or absence of co-occurring personality disorders, physical health problems, financial concerns, and legal issues. They also differ in strengths, such as ability to get along with others and level of intelligence. Each patient's kaleidoscope of features will impact treatment. PTSD/SUD patients are not a homogeneous population.
6. *Severity of PTSD and SUD is key, not order of onset.* Some clinicians erroneously believe that if the PTSD occurred first (which it does in most cases), then addressing PTSD is primary. Yet rather than order of onset of PTSD and SUD, it is the *severity* of each that most determines the treatment plan. By the time the patient is sitting in front of you with both disorders, which came first is much less important than what happens next. Both disorders will need attention. And severe disorders will need the most immediate and strong help. Severity refers to both level of symptoms and also negative consequences, such as which disorder gets them in the most trouble, causes the most harm, etc. Some patients are equally severe on both disorders; others are more severe on one or the other. Use validated instruments to assess the severity of each to help determine the plan.
7. *Directly monitor substance use.* Good SUD care requires the clinician to actively inquire about substance use at every visit. Ideally, this will be verified by urinalysis, breathalyzer, or other biological methods. Even if those are not possible, which may be the case in private practice settings, it is crucial to use a valid self-report instrument and to have a clear written contract on substance use. The contract targets the goal per substance, such as "No more than 1 drink a day, measured with a shot glass," "No substance use at all," or whatever other goal is established. Inquire about substance use at each session, including

amount and frequency; patients will often not bring it up directly. PTSD symptoms should also be assessed ongoing.

8. *Do not push past-focused treatments.* Patients are sometimes overly strongly pushed into past-focused models with statements such as "You're avoiding if you don't do it," "This is the only way to really recover," and "If you do this work, it will get to the root of your problems and you won't need substances anymore." Even if well intentioned, these are not accurate for most PTSD/SUD patients, especially those with severe SUD. As reviewed earlier, scientific evidence at this point indicates that past- and present-focused approaches work equally well for PTSD/SUD patients. Be direct with patients about the evidence base and let them choose what is right for them without pressure. Some are ready for past-focused work, want to do it, and can benefit. Others do not.
9. *Attend to behavioral addictions as well as SUD.* There is increasing focus on behavioral addictions such as excessive gambling, work, exercise, internet, pornography, sex, etc. (Najavits et al. 2014; Freimuth 2005). Most are not in DSM-5 yet still warrant attention. Ask patients explicitly about these and offer options for help as needed.
10. *Choose PTSD/SUD models based on realistic factors.* Both the clinician and patient need models that fit for them. Factors such as preference for individual versus group work, past treatment experiences, appeal of various treatments, insurance coverage, and other factors will play a role.
11. *Provide up-to-date information.* Strive to stay current. Even if well intentioned, inaccurate messages can do more harm than good. See the beginning of this chapter for examples of such messages. Read updated books on PTSD/ SUD. Reading on PTSD alone or SUD alone can be helpful but are not suffi- cient for the combination of PTSD/SUD combination. Get a broad understand- ing and seek training as needed.

16.4 Future Developments

Overall, as this review shows, various models have emerged to address the widespread suffering endured by PTSD/SUD patients. Such models have evidenced positive impact and can bring innovation and inspiration to clinical work. In the decades ahead, empirical efforts will, it is hoped, continue to expand understanding of how to best help these patients.

From a broader lens, it is also worth recognizing that no therapy model in and of itself is ever likely to quickly resolve what for many of these patients have been decades of abuse, neglect, violence, substance use, and associated problems, such as homelessness, criminal justice involvement, job problems, poverty, discrimination, and physical health problems. Many are multiply burdened (Brown et al. 1995), chronic in their PTSD and SUD, and come from generations of family who have also struggled with these issues. They often have few resources for care and receive treatment from some of the least trained clinical staff. They often end up in public health systems of care.

Thus it is worth considering options beyond therapy models per se and which may potentially boost the impact of models.

PTSD/SUD patients may need ongoing support rather than time-limited help. Some less severe patients may do well with a round of short-term treatment. But the clinical reality is that many cycle repeatedly through the revolving door of treatment. SUD in particular has been conceptualized as a disorder comparable to diabetes in needing long-term management rather than short-term models (Arria and McLellan 2012). This is reflected in the wisdom of 12-step approaches that provide free ongoing support to sustain abstinence from substances and which grew up as a grass-roots model by addicts themselves. For PTSD, there is as yet no widespread supportive resource of this type. Becoming creative about developing resources for chronic patients, beyond 12-step groups, may be an important public health goal. Some of the models identified in this article can perhaps be used in such ways.

The workforce treating these patients also needs support. Many clinicians have their own histories of trauma and addiction. They often handle large caseloads of complex patients without sufficient support or training. There is little research on how best to select and retain them and how to best support their work. Treatment models for PTSD/SUD are an important resource, but their professional needs go beyond models. Clinicians treating PTSD/SUD report notable gratification in the work but also significant stressors (Najavits et al. 2010).

Beyond the "horse race" of models, focus on cost, appeal, ease of implementation, and sustainability. Several decades of research indicate that well-constructed therapy models relevant to PTSD and SUD have positive impact but do not differ notably in their outcomes (Imel et al. 2008; Benish et al. 2007; Powers et al. 2010). However, they may differ in other important ways such as how much they cost, how easy they are to implement, and how sustainable they are. A model with slightly lower outcomes but greater strength in these factors may be an excellent choice. In the PTSD/SUD field, such factors have largely not yet been researched in relation to treatment models.

Case Example

To help highlight some of the themes in this chapter, the following case example is offered, using Seeking Safety as the treatment.

Implementation of Seeking Safety (SS). SS arose out of the need for a trauma intervention that could be used safely and effectively with substance abuse clients, most of whom have major trauma histories yet may not be able to tolerate emotionally intense past-focused PTSD therapies. SS is consistent with the stage-based approach to trauma recovery (Herman 1992), which is supported by PTSD experts (Cloitre et al. 2011). The first stage of work, *safety*, is present-focused, emphasizing stabilization and coping. SS focuses solely on this phase. Later work may include past-focused processing of trauma memories if needed.

SS provides education and coping skills for trauma survivors. It is optimistic, building hope through emphasis on ideals, humanistic language, inspiring

quotations, and concrete strategies. Originally designed for co-occurring trauma and substance abuse, it is now used for either or both. SS is highly flexible: for males, females, all trauma types, adults, adolescents, groups, individuals, and any counselor, setting, and duration. It has been implemented successfully with numerous vulnerable populations including people who are homeless, living with HIV, incarcerated, suicidal, and cognitively impaired. Each SS topic offers a coping skill to build resilience, such as *Asking for Help, Honesty, Coping with Triggers, Self-Nurturing,* and *Healing from Anger.*

The case. Jolene is a 45-year-old African-American female veteran who served in the army 20 years ago. She survived a brutal sexual assault by a military commander, resulting in mild traumatic brain injury (mTBI) and severe PTSD. The mTBI resolved eventually, but the PTSD was so severe that she was virtually housebound for 20 years, living off of her benefits, unable to work, and in contact only with her siblings (her parents having died some years ago). She developed severe alcohol use disorder and came in for therapy on the advice of her primary care physician, who identified liver problems from the alcohol. She had never told anyone about the sexual assault until the SS therapy. In SS, patients can share the nature of their traumas, but we do not go into a detailed narrative of it. "Headlines, not details" is the guiding principle. Jolene expressed relief that she could work on her PTSD in SS without having to revisit the painful trauma narrative. She continually blamed herself for the trauma, saying "If I had been a better soldier, I would have been able to defend myself." She had had outstanding success in her military career until the assault but after it was unable to function and was discharged. "It's as if I was two different people: the person before and the person after."

The treatment. Jolene was hesitant to come to therapy and canceled the first several appointments. I encouraged her to try just one session. I let her know that it would be up to her whether or not she wanted to continue—thus striving from this first phone contact to empower her to choose what was best for her. Empowerment is a core aspect of SS. The model conveys that there are many ways to cope safely, and patients can choose what works for them, even if it is different than what others choose. "Safety" is a rich concept in SS, referring to safety in relationships, thinking, and behavior, with no harm to self or others.

Jolene ultimately attended a full course of SS with weekly sessions over 6 months. She was highly intelligent and conscientious, with military-style, responsible behavior—showing up on time, reading the handouts ahead of time, and following through on most of her therapy commitments (the latter is the SS term for homework). But emotionally she was all over the place—tearful, lacking focus, obsessing about small details, not taking care of her health (poor diet, no exercise), and drinking every day unable to stop.

Our primary focus in the work was threefold. First, we focused on coping—what she could do each week to move forward in her life, in any way possible. For example, the week that we covered the topic *Taking Good Care of Yourself*, she could see that her isolation was not healthy. That week she thus chose to

attend an online AA meeting (an in-person meeting was not something she was willing to try). Another week we focused on *Setting Boundaries in Relationships*, and she was able to say no to her sister's request for money rather than giving into it as she had done too often in the past. Each session, we worked to relate the SS coping skills in meaningful yet also practical ways to her current struggles. Even small successes meant a lot to her—showing her that she was no longer stuck in the same old patterns but able to make new choices and to keep learning from them. SS, at its core, is all about learning—trying new strategies and adapting, refining, and changing them as needed to keep progressing. Such learning is both unique to each person yet also universal.

Our second major focus was reducing the alcohol use. Given the many years of daily drinking, her physician worked with her on the physiological aspects to prevent seizures that can occur with abrupt reduction of alcohol. In SS, I would gently bring up the alcohol either during the session, as part of our SS topic, weaving it in here and there to question, nudge, and guide her to see more clearly in its impact on her life and to explore alternative actions she could do when she had a craving to drink. I would ask questions such as, "Would you be willing to try drinking only every other day?" and we would explore that, always coming back to how the SS coping skills might help her to achieve that goal. Helping her see the linkages between her trauma and alcohol use was also a repeated theme. She said, "I can see it now much more clearly. I just wish I could have seen it 20 years ago." There was deep sadness with such statements, and her course of alcohol use had some ups and downs, but by the last third of the therapy, she had reduced her drinking by half and was moving toward abstinence.

Finally, our third major focus was bringing a compassionate approach to her self-hatred about her trauma. She had spent decades blaming and judging herself for not fighting off the attacker. We worked on SS topics such as *Compassion*, *Creating Meaning*, and *Integrating the Split Self* to help her respond to herself in kind ways when her inner critical voices arose. She was better able to get through her day with increased functionality as she learned to coach herself through her daily struggles rather than giving up. She was able to recognize too that there really had been no way for her to prevent the trauma—no matter how fine and strong a soldier she had been—and that her task now was to create a better future for herself rather than staying stuck in "beating herself up" about the past.

The case management component of SS also came into play, identifying referrals for any treatments that she would be willing to attend. She had limited social contact, often none in any given week, but was able to join a women-only therapy group and the online AA meetings. We also worked on referral to a nutrition consult to help with her poor diet.

She ended the SS therapy with greater hopefulness, even though there was still recovery work to do. "It has felt so healing to be able to start living more—to expand my world, to move forward."

16.5 Closing

The first generation of research on PTSD/SUD is impressive in attending to patients who were consistently excluded from most prior outcome research on PTSD. The development of new models tailored to this population has advanced the field, and at least one model thus far is established as evidence based (SS). However, there remains much to be done. There is a need for additional research to overcome methodology limitations of prior trials. Continued refinement of models is also needed. It is hoped that just as patients have often shown remarkable resilience, so too can this area of work continue to grow and expand.

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