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Seeking Safety and the 12-Step Social Model of Recovery: An Integrated Treatment Approach

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ABSTRACT

A comparison study examined the effects on coping styles that occur when an evidence-based treatment, Seeking Safety (SS), is added to an established 12-step social model of recovery. While involved in a 12-step program, 52 participants volunteered to engage in 8 sessions of SS group therapy to determine how participation impacted self-reported use of adaptive and maladaptive coping styles. Overall, findings support the hypothesized enhancements with significant improvement noted in 15 of the 17 coping styles assessed. The current study provides foundational data on the benefits of incorporating evidence-based treatment with the 12-step model.

KEYWORDS

Addiction; coping skills; seeking safety; substance abuse; trauma; 12 steps

The co-occurrence of substance use disorders (SUD) and posttraumatic stress disorder (PTSD) is frequently observed in treatment settings. The self-medication hypothesis suggests that the diagnostic comorbidity exists due in part to individual attempts to personally administer treatment to alleviate symptoms of mental distress or psychological trauma (Khantizian, 1997). Although substance abuse can provide temporary relief, prolonged use exacerbates trauma-related symptoms (i.e., intrusive re-experiencing, avoidance of reminders of the trauma, and hyperarousal and hypervigilance) in the long-term (e.g., Bryan et al., 2016). Yet, the appeal of being able to promptly reduce one's psychological suffering and the negative reinforcement associated with withdrawals contribute to the reliance of substance abuse as a form of maladaptive coping with psychological symptoms. Comorbidity increases one's risk for problematic outcomes, such as poorer mental health treatment results or increased risk for attempting suicide (e.g., Najavits, Weiss, & Shaw, 1999; Root, 1989). Thus, an integrative treatment approach that addresses the relationship between the two diagnoses can serve to reduce relapse rates (Dass-Bailford, & Myrick, 2010; Jos, Cooper-Sadlo, & Stillwell, 2013).

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The 12 steps

Alcoholics Anonymous (AA) is one of the most popular therapeutic approaches in the United States because it is free, widely available, and emphasizes abstinence from substances within a sober community (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008). This social model of recovery has expanded beyond alcohol to include treatment of a variety of addictive substances and behaviors (e.g., Narcotics Anonymous, Gamblers Anonymous, and Dual Recovery Anonymous). Across 12-step offerings, the defining emphasis is on peer support within a safe environment.

Working the 12-steps is the primary feature of this social model approach (AA, 2002; see the appendix). However, mere compliance with behaviorally completing each step has been found to be not enough; spiritual internalization of the steps with the use of a sponsor seems to be necessary for individuals in recovery to achieve abstinence (Greenfield & Tonigan, 2012).

The use of AA principles within structured treatment programs has demonstrated enhanced client functioning across numerous domains including overall health status, self-esteem, positive affect, reduced symptoms of anxiety and depression, prolonged involvement in AA/NA, relationships, improved safe sex practices, as well as abstinence 6 months following treatment completion (e.g., Banerjee, Howard, Mansheim, & Beattie, 2007; Polcin et al., 2002; Zemore & Kaskutas, 2008; Wilcox, Pearson, & Tonigan, 2015). Furthermore, individuals involved in both peer helping and the 12-steps showed greater engagement in treatment possibly due to an ability to share experiences about recovery and provide emotional support to one another (Zemore et al., 2008).

Despite the widespread use of 12-step models, the research on its effectiveness is sparse. The anonymity of the approach is appealing to many within the community but make it difficult for researchers to study the components that contribute to recovery. Moreover, there is well-known laymen knowledge about variability across sponsors, locations, and meetings, as well as interpretation and application of the 12-steps. Even though the 12-step model is a popular treatment approach, mental health providers are often unfamiliar with the methodology (Magill et al., 2016). It is possible that the unknown and uncontrolled aspects of the social model of recovery persuade mental health professionals to favor evidence-based treatments.

Seeking safety

Within the field of psychology, there has been growing emphasis for clinicians to use interventions derived from evidence-based treatments. One of the most well-known integrated treatment programs for the dual diagnosis of trauma and substance abuse is Seeking Safety (SS), a manualized treatment that provides "a present-focused therapy to help people attain safety" (SS, n.d.).

The wealth of literature that supports SS has "found positive outcomes; in the controlled and/or randomized controlled trials, SS typically outperformed the comparison condition; treatment satisfaction was high in all studies" (Najavits, 2011). The treatment has demonstrated efficacy with both males and females in

a range of treatment settings, such as inpatient, outpatient, residential, correctional facilities, and mental health settings (e.g., Najavits, 2002; Zlotnick, Najavits, Rohsenhow, & Johnson, 2003). Furthermore, it has been shown to be effective in both individual and group treatment formats (Najavits, 2002) with the ability to be modified based upon the needs of specific clients and settings (Brown et al., 2007).

Research supports the use of SS with individuals experiencing comorbid substance use and trauma diagnoses. The literature cited for SS has demonstrated the effectiveness of the treatment being applied to males and females in a variety of treatment settings. However, no research was located that tested the effectiveness of SS within a social model that employed a 12-step program. Because of the flexibility of SS, it is reasonable to assume that both treatment models can be integrated and contribute to favorable client outcomes.

Hypotheses

The purpose of this study was to determine if adding an evidence-based treatment, SS, to an established social model of recovery contributed to an increase in adaptive coping styles as well as a decrease in maladaptive coping styles. Consistent with the literature discussed above, it is expected that SS would lead to enhanced use of healthy coping skills and thus potentially provide the secondary benefit of improved ability to manage trauma-related symptoms.

Method

Participant population

An expense-free facility in Louisville, Kentucky offers abstinence-based residential substance use treatment to around 240 women and 350 men, over the age of 18, between two campuses. The facility's treatment programming is based upon the 12-step social model of recovery. Participants were residents at the facility and were recruited through self-referrals as well as referrals from facility staff members.

To be eligible, participants needed to have experienced at least one traumatic event in their lifetime and satisfy *DSM-5* Criteria A (exposure to a traumatic stressor). Participants were not required to meet full criteria for a PTSD diagnosis to be considered for inclusion. In addition, inclusion criteria required that participants were (a) over the age of 18, (b) met criteria for substance dependence in the past, (c) had at least 30 days remaining at the facility, and (d) capable of giving informed consent.

Individuals were excluded from data collection if they had a significant risk of suicidal/homicidal intent or behavior, psychosis, refused to complete pre- and post-treatment measures, and if there was reason to believe they were not able to complete the 4-week treatment (e.g., finished program before completion of SS group).

Materials

After obtaining informed consent, participants completed a demographic questionnaire that was created with relevant information regarding the social model at the

site. To be accepted into the treatment program, each individual had to meet criteria for dependence in the past. Because all participants met criteria for dependence, measures were not used to confirm each individual's history of substance abuse. Rather, information was gathered about sobriety date and substance of choice.

To assess the history of traumatic experiences at intake, each individual was administered the Stressful Life Events Screening Questionnaire—Revised (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998), which assessed lifetime exposure to traumatic events. The SLESQ is a 13-item self-report measure that evaluates 11 specific and two general categories of events, such as physical and sexual abuse, witness to another person being killed or assaulted, and a life-threatening accident. For each event endorsed, respondents indicated specific items related to the event, such as time, frequency, and duration. The SLESQ had been shown to have good test-retest reliability, adequate convergent validity, and good discriminative validity between Criterion A and non-Criterion A events (Goodman et al., 1998). Furthermore, the SLESQ had been found to be an appropriate measure for individuals from different cultural groups due in part to the understandable wording of items (Green, Chung, Daroowalla, Kaltman, & DeBenedictis, 2006).

The SLESQ consists of the following items: (a) Have you ever had a life-threatening illness? (b) Were you ever in a life-threatening accident? (c) Was physical force or a weapon ever used against you in a robbery or mugging? (d) Has an immediate family member, romantic partner or very close friend died because of accident, homicide, or suicide? (e) At any time, has anyone (parent, other family member, romantic partner stranger, or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated? (f) Other than the experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you have sex against your wishes? (g) When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you? (h) As an adult, have you ever been kicked, beaten, slapped around, or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else? (i) Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you that you were no good? (j) Other than the experiences already covered, has anyone ever threatened you with a knife or gun? (k) Have you ever been presented when another person was killed? Seriously injured? Sexually or physically assaulted? (l) Have you ever been in any other situations where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)? (m) Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported?

To measure changes in coping skills among respondents, the COPE Inventory was administered pre- and posttreatment (Carver, Scheier, & Weintraub, 1989). The COPE Inventory is a 60-item assessment that measures two overall coping styles and 15 different subscales of coping among respondents. Some of the various coping

reactions have been known to be generally adaptive while others are known to be problematic.

The adaptive coping styles assessed were positive reinterpretation and growth (finding the silver lining); use of instrumental social support (getting advice or physical help); active coping (mobilizing resources to deal with stressor); religious coping (praying and/or seeking spiritual guidance); humor (finding comfort through lighthearted jokes); use of emotional social support (seeking trusted others for emotional comfort); acceptance (acknowledging stressors and limitations); planning (mapping out solutions to correct feelings or stressor); suppression of competing activities (dealing with one task at a time); and restraint coping (inhibiting actions until appropriate time). In addition, the following maladaptive coping styles were assessed: behavioral disengagement (physically detaching from goals); mental disengagement (cognitively giving up on goals); focus on venting of emotions (complaining excessively about the stressor); denial (inability to accept or admit difficulties); and substance use (using drugs or alcohol).

Procedures

The study design was approved by the Institutional Review Board at an APA accredited university in Louisville, Kentucky. Procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for inclusion in the study.

Participant recruitment involved asking for volunteers at a community-wide meeting at the facility. Of the volunteers, participants were chosen based upon random selection and information from staff members to ensure individuals met inclusion criteria.

The treatment group consisted of a closed-group format where topics from SS were implemented in each meeting. Group size ranged from 5 to 10 individuals, depending upon number of self-referrals that met inclusion criteria. Participants in the treatment group received 2-hr group therapy sessions, twice a week, over the course of 4 weeks. The 4-week format was used to meet the needs of the facility, which desired a group model and a brief treatment that did not delay completion of the 12-step program. Each group therapy session covered one topic and the final session used two topics from the SS manual for a total of nine topic areas. The following topics were used: introduction to treatment/case management, safety, PTSD: taking back your power, coping with triggers, recovery thinking, setting boundaries in relationships, self-nurturing, the life choices game, and termination. All sessions used the structure described in the SS manual with four steps: check-in, quotation, relating the material to the client's lives, and check-out. Handouts for each topic and the end-of-session questionnaire were used, as described by the SS manual.

Treatment was delivered through the use of five clinical psychology doctoral students (including the author, Lange-Altman), who all possessed a Master's of Arts degree, from a local doctoral training program. Two clinicians were paired

to co-lead each treatment group. To address the potential of extraneous variables from differing clinicians, the psychologists were paired differently for each treatment group. Prior to implementation of the research study, each clinician received training in SS by the primary author, Lange-Altman, and obtained educational training from the facility about the 12-step program. Clinical adherence to the SS treatment program was assessed through supervision and the use of the Seeking Safety Adherence Scale–Brief Version (Najavits, Liese, & Heath, 2007). Ongoing supervision was provided throughout treatment delivery to monitor intervention fidelity and clinical competence.

Upon completion of group therapy, all participants were provided a debriefing form, which included information regarding therapeutic resources and contact information for the primary investigator if participants wanted further information regarding the study. Participants were also asked to volunteer written feedback about their experience participating in the Seeking Safety groups.

Results

Descriptive data

Participants in the current study include 30 women and 22 men across two facilities. Individuals volunteered for participation in the study. The sample was largely Caucasian (75%) between the ages of 26–35. Most individuals endorsed voluntarily pursuing treatment for substance use as well as a history of previous involvement in treatment programs. Substance of choice varied with heroin and alcohol being the most identified. Participants had an average age of onset for substance abuse at 15.86 years. The length of substance use varied widely between 1.16 and 50 years. With the majority of participants at the 4^{th} step of the 12-step program, the average length of sobriety for the sample was 187.12 days.

Traumatic experiences

Notably, every individual who completed the survey endorsed at least one of the 13 questions regarding types of traumatic experiences. Refer to Table 1 for information regarding frequency of endorsement.

Seeking safety

Individuals in the treatment SS group received 2-hr group therapy sessions, twice a week, over the course of 4 weeks. Data was collected on the first group meeting (premeasure) as well as the last group meeting (postmeasure). Group attendance ranged from 5 to 8 sessions ($M = 7.31$, $SD = 0.98$). As presented in Table 2, results of a paired sample t-test demonstrated that individuals who participated in SS had a statistically significant increase in adaptive coping ($M = .48$, $SD = .51$), $t(51) = -6.80$, $p < .001$, as well as a statistically significant decrease in Maladaptive coping ($M = .57$, $SD = .53$), $t = (50) = 7.67$, $p < .001$.

Table 1. Trauma history of sample ($n = 52$).

Item number endorsed	*n*	%
1. Life-threatening illness	5	9.6
2. Life-threatening accident	22	42.3
3. Physical force in robbery/mugging	18	34.6
4. Relative/partner/friend death	30	57.7
5. Physical force sexual contact	16	30.8
6. Touched private parts against wishes	22	42.3
7. As a child, physical harm	16	30.8
8. As an adult, physical harm	33	63.5
9. Other person ridiculed	34	65.4
10. Threatened with knife/gun	27	51.9
11. Present other killed/injured/assaulted	17	32.7
12. Other serious injury/life in danger	11	21.2
13. Horrifying situation/felt helpless	13	25.0
Same incident in multiple questions	10	19.2

Note. Item numbers reflect questions from the Stressful Life Events Screening Questionnaire. Items abbreviated in table. The full item questions can be located in the *Materials* section.

Results from further evaluation of the 15 subscales are also presented in Table 2. Findings indicate the experimental group demonstrated a statistically significant increase in 9 of the 10 adaptive coping styles. Specifically, individuals did not report using humor as a method of adaptive coping. For the statistically significant changes in adaptive coping, effect sizes ranged from medium ($d = 0.41$) to large ($d = 0.98$). Moreover, individuals reported a decrease in 4 of the 5 maladaptive coping styles with no decrease in the focus on venting of emotions. For the statistically significant changes in maladaptive coping, effect sizes ranged from medium ($d = 0.46$) to large ($d = 1.10$).

As a whole, the sample demonstrated marked improvement in the use of the majority of adaptive coping styles as well as a marked decrease in the use of maladaptive coping styles. However, there were no changes in humor or focus on venting of emotions.

Table 2. Degree of change in coping styles ($n = 52$).

Coping style	Cohen's d	*p*value
Adaptive	0.94	.000
Positive reinterpretation and growth	0.81	.000
Instrumental social support	0.88	.000
Active coping	0.71	.000
Religious coping	0.78	.000
Humor	− 0.01	.934
Emotional support system	0.78	.000
Acceptance	0.41	.004
Planning	0.98	.000
Suppress competing activities	0.44	.003
Restraint	0.56	.000
Maladaptive	1.07	.000
Behavioral disengagement	0.77	.000
Mental disengagement	0.46	.002
Focus on venting of emotions	− 0.17	.218
Denial	0.65	.000
Substance use	1.10	.000

Note. Findings represent change (pre- to post-measure) in males and females who participated in Seeking Safety.
* $p < .05$.

Table 3. Degree of change in coping styles by gender.

	Males ($n = 22$)		Females ($n = 30$)	
Coping style	Cohen's *d*	*p* value	Cohen's *d*	*p* value
Adaptive	0.98	.000	0.94	.000
Positive Reinterpretation and growth	0.80	.001	0.80	.000
Instrumental social support	0.92	.000	0.85	.000
Active coping	0.82	.001	0.67	.001
Religious coping	0.93	.000	0.70	.001
Humor	− 0.21	.326	0.10	.587
Emotional support system	1.03	.000	0.64	.002
Acceptance	0.12	.568	0.60	.003
Planning	0.87	.001	1.07	.000
Suppress competing activities	0.15	.486	0.64	.001
Restraint	0.73	.003	0.47	.015
Maladaptive	1.10	.000	1.04	.000
Behavioral disengagement	0.75	.002	0.78	.000
Mental disengagement	0.64	.007	0.31	.097
Focus on venting of emotions	0.21	.332	− 0.48	.014
Denial	0.63	.008	0.66	.001
Substance use	0.96	.000	1.20	.000

Note. Significance level set at $p < .05$.

Comparison of males and females in the experimental group

Because treatment occurred across two campuses, further statistical analyses were conducted to determine if there were differences in coping styles based upon gender. As demonstrated in Table 3, both males and females ($M = 0.40$, $SD = 0.41$; $M = 0.60$, $SD = 0.55$; respectively) reported a statistically significant increase in the use of adaptive coping, $t(51) = 6.80$, $p = .000$, and a decrease in maladaptive coping styles, $t(50) = 7.67$, $p = .000$. For males, there was an increase in seven of the adaptive subscales and a decrease in four of the maladaptive subscales. The effect sizes ranged from small ($d = 0.12$) to large ($d = 1.10$). Of interest, males reported a decrease in the use of humor to cope but not to a statistically significant degree. Also, there were no significant changes in the use of acceptance, suppression of competing activities, as well as focus on venting of emotions.

Conversely, females endorsed significant increases in nine adaptive and decreases in three maladaptive coping styles. Effect sizes ranged from medium ($d = 0.31$) to large ($d = 1.20$). Notably, there was an increase in use of focus on venting of emotions, which is a maladaptive coping style. In other words, females demonstrated more complaining about a stressor at the conclusion of the SS groups then when it began. There were no significant changes in humor and mental disengagement.

Subjective data

Individuals were asked to volunteer feedback regarding the impact of participation in the SS group while engaged in the 12-step model of recovery. Exploration of themes revealed overwhelmingly positive reactions to participation in the group. Numerous individuals commented on the structure of the sessions and enjoyed the small class size. Moreover, many stated that the group size helped to facilitate a safe environment that encouraged emotional release, acknowledging personal change,

and building stronger bonds with peers. Responses highlighted views that the leaders were professional, compassionate, and provided information in an interesting manner, which helped many to overcome a prior fear of therapy. Subjective data consistently included expressions of appreciation for the incorporation of variables from the social model of recovery into another form of therapy. The perceived benefits gained from the class included an increase in knowledge of coping skills, confidence in using healthy coping skills, as well as an enhanced ability to express thoughts and feelings. Notably, there were no negative responses provided when participants were asked to volunteer feedback.

Discussion

The purpose of the study was to determine if adding eight sessions of an evidence-based treatment, SS, to an established social model of recovery contributed to increased use of adaptive coping styles as well as a decrease in maladaptive coping styles. Individuals who volunteered to participate in SS demonstrated a commitment to the treatment through high rates of session attendance. Moreover, individuals who missed sessions frequently provided advanced notice and explanations for the absence. Some reasons given for missing sessions were illness, stepwork with sponsor, previous requirements for the treatment facility, General Education Diploma class, complications due to serious physical illness (i.e., AIDS), court, hospital, and funeral attendance.

Overall, the hypotheses were supported in that there was a substantial degree of change in coping styles since the start of the group; the sample endorsed enhanced use of adaptive coping skills and a decrease in maladaptive coping skills after participation in SS. In summary, both genders reported a sizeable improvement in adaptive coping and a drastic reduction in maladaptive coping.

A closer look at the factors that comprise adaptive coping demonstrated that participants had significant improvements on nine out of ten coping styles. Therefore, the sample reported substantial improvement in being able to find the silver lining, seek advice or physical help from others, mobilize resources, pray and seek spiritual guidance, seek trusted others for emotional comfort, acknowledge difficulties, identify solutions, deal with one stressor at a time, and wait to act until the right time. However, both genders demonstrated no increase or decrease in finding comfort through jokes. The lack of significant change in this adaptive coping skill may be due to the reality surrounding sobriety and having to confront one's past misdeeds through stepwork, which are often serious in nature.

The components of maladaptive coping revealed improvement in four out of five styles. Participants reported a considerable decrease in: physically and cognitively detaching from goals, inability to accept or admit difficulties, as well as using drugs or alcohol. Notably, results also showed that female participants worsened on one maladaptive coping skill. Specifically, females engaged more in complaining excessively about the stressor at the end of treatment. Research has shown that venting of emotions can lead one to feel better in the short-term because an individual can feel

connected to others during the process (Parlamis, 2012). However, long-term, individuals who engage more in venting of emotions often tend to do so because they are unsuccessful in emotion regulation (Gross, 2002). The increase in use of this maladaptive coping style among females may be a representation of an unsuccessful attempt to regulate one's emotions through connecting with other peers.

The authors propose that 12-step involvement addressed the shortcomings of the evidence-based treatment, SS, contributing to the observed changes in coping skills among the sample. For instance, studies have demonstrated that the 12 steps focus on the role of spirituality and religiosity in recovery (Dermatis & Galanter, 2016; Temme & Kopak, 2016), which is deemed as an adaptive coping style and not specifically addressed in SS. Moreover, the 12-step program provides access to a social support system largely comprised of individuals striving for abstinence, which has been shown to be beneficial for recovery (Stevens, Jason, Ram, & Light, 2015). Based upon the core principles (see the appendix), it is promising to suggest that the 12 steps contributed partly to improvements reported in coping styles (e.g., use of instrumental social support, religious coping, use of emotional social support, denial). Thus, having a sense of community with a common goal may have partly contributed to the improvements observed in coping styles.

Taken as a whole, significant improvement was observed in 15 of the 17 coping styles assessed. Although there was minor variability based on gender, participants who engaged in eight sessions of SS endorsed enhancing adaptive coping and decreasing maladaptive coping. Support for these findings was further confirmed through written feedback about the experience of participating in SS while engaged in the 12-step model. Subjective data revealed that participants experienced benefit from the group beyond measures of coping styles (e.g., connectedness, improved mood). Because of methodological constraints, it is impossible to identify for certain the impact 12-step involvement had on changes in coping skills. However, it is proposed that the mechanisms of 12-step programming fulfill some of the drawbacks of SS.

Limitations of the study

One limitation of the study was that there was no control group, which would have allowed for data to be gained regarding degree of change attributable to the 12 steps and/or SS. Because of the acute needs and transient nature of the population at the homeless facility, there were numerous obstacles in data collection for a control group. The lack of a control group for this study does hinder certainty in the results. Despite this methodological flaw, it is still believed that the results are promising for exploring the potential benefits of combining coping skills treatment with the 12 steps.

Another limitation of the study is that participants were not randomly assigned into treatment modalities. Random assignment into treatment modalities would have allowed for more confident causal claims about the role of each modality in coping skill changes. Moreover, the sample was comprised of individuals who

volunteered to participate in additional treatment. Therefore, the data may reflect those who were already motivated for change.

The population's general mistrust towards outsiders was another limitation. Twelve-step programs center on anonymity and participants expressed concern about confidentiality of data. The primary researcher addressed individual concerns and provided further explanation of confidentiality in research. However, it is unclear how concerns over anonymity influenced the make up of the sample.

Future research

Future research still needs to be conducted to determine the degree of change that is attributable to each treatment modality when SS and the 12 steps are integrated. Future research could use a random control trial that gathers data on individuals solely receiving treatment from the 12-step social model versus those who receive both forms of treatment (i.e., SS and 12 steps).

Another suggestion for future research may involve the use of 12–step facilitation therapy, an evidence-based treatment for substance abuse that is administered by mental health professional. The use of another manualized treatment would help to standardize the research process; however, it may negate the potential benefit of peer support and prevents assessment of the social model of recovery.

It would also be beneficial to conduct a longitudinal study on benefits gained to determine if SS combined with the social model contributes to longer periods of sobriety or improved mental health symptoms over time. Moreover, future research should also continue to explore the ways in which evidence-based therapeutic services can be effectively combined with social models of recovery.

Conclusion

To the authors' knowledge, this is the first study of its kind to incorporate the principles of the 12-step model with SS, an evidence based treatment. The study provides promising information that supports the integration of SS, an evidence-based treatment, with the social model of recovery. Research indicates "treating a patient in psychotherapy who is also working in the AA program without a good understanding of AA can result in the two approaches working at cross-purposes, diminishing the effectiveness of both interventions" (Knack, 2009, p. 86). Therefore, it is important for therapists to fully understand the 12-step model to effectively integrate the treatment models.

The 12 steps are a widely used approach to recovery that is expense-free as well as accommodating to many schedules and circumstances. Although there is much flexibility in delivery, the central tenet is rooted in adherence to steps directed toward complete abstinence. The lack of consistency in how the steps are implemented can create variability on attention and inclusion of mental health symptoms, especially trauma reactions. The shortcomings of the 12 steps can arguably be filled with the incorporation of an evidence-based treatment, such as SS. Although SS may not be

as widely available as 12-step meetings, it is appealing to those who have difficulty with the concept of a "higher power" and for those who prefer treatment to be delivered by mental health professionals. Moreover, the manualized approach provides a structure for addressing the dual diagnosis through emphasizing safety and coping skill attainment. SS prioritizes safety, flexibility to individual needs, and coping skills, which has repeatedly been demonstrated through research to be beneficial to those with comorbid substance abuse and trauma-related symptoms. Thus, it is worthwhile to continue investigating the potential impact that integration of SS and the 12 steps can have on an often difficult population to treat.

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Appendix

The twelve steps of Alcoholics Anonymous

1. We admitted we are powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over the care of God *as we understood Him*.

4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects in character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.