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Seeking Safety

A Present-Focused Integrated Treatment for PTSD and Substance Use Disorders

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Introduction

Seeking Safety (Najavits, 2002) is a present-focused, cognitive-behavioral psychotherapy specifically designed to address both trauma/posttraumatic stress disorder (PTSD) and substance use disorders (SUD) using an integrated approach. The connection between trauma and substance use is introduced early in treatment, and both issues are addressed simultaneously throughout each module. *Safety* is defined as reduction in substance use and self-destructive behaviors, cultivation of healthy relationships, and self-protection from dangers associated with the two disorders (e.g., HIV risk and partner violence). Although Seeking Safety was not the first treatment developed for SUD clients with trauma histories (see, e.g., Evans & Sullivan, 1995; Miller & Guidry, 2001), it became the most widely adopted and most empirically studied.

Historically, substance abuse settings typically referred clients out for trauma treatment; however, without attention to the trauma in their lives, many clients could not achieve or sustain abstinence. Similarly, in mental health settings, a traumatized client with substance use issues was generally referred to addiction treatment (Meisler, 1999); trauma work began only after clients were abstinent from substances (Brown, Stout, & Gannon-Rowley, 1998; Ouimette, Brown, & Najavits, 1998). This approach led many frustrated clients to feel caught between systems and caused many to drop out of treatment.

This chapter will describe Seeking Safety and its clinical usefulness for working with clients with both PTSD and addiction, as a first stage of treatment and as a model that can effectively be integrated into a treatment program at any time during the recovery process. An overview of Seeking Safety, including a description of guiding principles and format, will be followed by a review of the empirical support for the model and a discussion of its clinical applications in group and individual treatment

across clinical settings. Suggestions for how clinicians might prepare to meet implementation challenges are described, as are ideas for potential supplemental materials.

Treatment Approach

Drawing from many clinical models and utilizing a psychoeducational framework, Seeking Safety focuses on the recognized need to establish safety in the process of recovering from the negative impact of both trauma and addiction. This premise derives from the influential work of Judith Herman (1992), who proposed three stages of recovery from trauma: (1) safety, (2) mourning and remembrance, and (3) reconnection. Herman underscored the importance of helping clients achieve a level of safety and stability early in treatment before working through memories of a traumatic past, drawing on over a hundred years of clinical description of trauma recovery. This stage-based approach has been endorsed by PTSD experts, as well (Cloitre, Petkova, Wang, & Lu, 2012).

The first stage of recovery, safety, is particularly relevant to trauma treatment with SUD clients, as these clients often present with profound deficits related to substance involvement, as well as other dangerous or self-destructive personal or interpersonal problems. Toward the goal of achieving safety, the Seeking Safety model accentuates the development and rehearsal of coping skills and offers a strong self-care message, focusing on healing language and encouraging clients to "take back their power" (Najavits, 2002, p. 110) in their recovery. In the client handout for the *Safety* topic, goals for this stage are

> to free yourself from substance abuse, stay alive, build healthy relationships, gain control over your feelings, learn to cope with day-to-day problems, protect yourself from destructive people and situations, not hurt yourself or others, increase your functioning, and attain stability.
>
> *(Najavits, 2002, p. 101)*

Seeking Safety approaches these goals in a present-focused format. It addresses the trauma in clients' lives by attending to the *impact of the trauma on clients' lives without delving into the narrative* of their experience. Clients can share aspects of their trauma in "headlines rather than details." For example, a client may indicate that she was raped without providing the detailed story of the rape. After they have achieved some stability through Seeking Safety, clients may elect to shift their focus to processing their traumatic experiences by participating in a past-focused treatment (e.g., cognitive processing therapy [CPT]; Resick & Schnicke, 1993), prolonged exposure (PE; Foa, & Rothbaum, 1998), or eye movement desensitization and reprocessing (EMDR; Shapiro, 2017). A new past-focused model, Creating Change (Najavits, 2014), is designed to follow Seeking Safety and to continue to address both trauma and addiction . Many clients experience significant symptom relief from Seeking Safety, however, and may not need or want to do past-focused work. Thus far, empirical evidence shows both past- and present-focused models are effective, thus empowering clients and clinicians to choose which treatment approach they prefer (Benish,

Imel, & Wampold, 2008; Bradley, Greene, Russ, Dultra, & Westen, 2005; Najavits, 2007; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010).

Seeking Safety is grounded in cognitive-behavioral therapy (CBT) principles. These include helping the client attend to underlying thoughts and assumptions in situations that contribute to the feelings and behaviors related to their problems. Like *Relapse Prevention* (Carroll, 1996; Marlatt & Gordon, 1985), a gold standard evidence-based practice for treating SUD, Seeking Safety applies CBT concepts to SUD but also to PTSD. It is an active, collaborative model, focusing on skills and strategies to anticipate and approach current challenges. Additional features of Seeking Safety include the use of educationally based strategies; use of simple, everyday language; efforts to relate material to clients' lives and experiences; and a strong emphasis on inspiring hope and on identifying practical solutions. Seeking Safety also offers a strength-based approach in that it focuses on clients' potential for growth and helps clients feel empowered to manage their PTSD and SUD symptoms by learning more adaptive coping skills (e.g., setting more appropriate boundaries in relationships, containing anger, thinking more constructively). The empowerment stance can be an antidote to the feelings of powerlessness clients have felt in the face of trauma and addiction.

Seeking Safety is appropriate for a wide range of clients who struggle with the consequences of a traumatic past and/or addiction. This chapter will mostly refer to PTSD and/or SUD for efficiency; however, it is not important for clients to meet full criteria for PTSD and/or SUD (e.g., Hien, Cohen, Miele, Litt, & Capstick, 2004). Clients with subthreshold levels of symptoms connect well with the topics, and even clients who do not struggle with both a trauma history and SUD find meaning in the materials. Seeking Safety has, as described below, been widely implemented for either population alone (trauma/PTSD or SUD). Clients who have experienced trauma but do not use substances problematically still find value in talking about the impact of their trauma on their sense of self, on their relationships and ability to set boundaries, and on managing distress, for example. Moreover, many clients identify other unsafe behaviors in their lives, and Seeking Safety provides the opportunity to address these issues (e.g., disordered eating, other addictions, risky sexual behaviors, problems managing money). Although designed as a "first-stage" treatment, clients can be at different places along their recovery from PTSD and SUD when working with Seeking Safety. The model can be useful at various stages of a client's recovery process as clients absorb different elements of the material as they change and grow. Even clients who return to topics over the course of treatment notice how they gather new insights upon revisiting the material.

Content

Seeking Safety comprises up to 25 topics covering four content areas addressing salient therapeutic issues for clients with co-occurring PTSD and SUD: cognitive, behavioral, interpersonal, and case management. (see Table 10.1). Each topic covers a different safe coping skill relevant to both trauma and addiction. Topics can be done in any order and can be conducted in one or more sessions. Throughout the treatment, basic education on SUD and PTSD and their interaction is presented. Topics

Table 10.1 Seeking Safety Treatment Topics and Domains (Cognitive, Behavioral, Interpersonal, or a Combination)

Session topic	*Domain(s)*
Introduction to Treatment/Case Management	Case Management
Safety	Combination
PTSD: Taking Back Your Power	Cognitive
Detaching From Emotional Pain (Grounding)	Behavioral
When Substances Control You	Cognitive
Asking for Help	Interpersonal
Taking Good Care of Yourself	Behavioral
Compassion	Cognitive
Red and Green Flags	Behavioral
Honesty	Interpersonal
Recovery Thinking	Cognitive
Integrating the Split Self	Cognitive
Commitment	Behavioral
Creating Meaning	Cognitive
Community Resources	Interpersonal
Setting Boundaries in Relationships	Interpersonal
Discovery	Cognitive
Getting Others to Support Your Recovery	Interpersonal
Coping With Triggers	Behavioral
Respecting Your Time	Behavioral
Healthy Relationships	Interpersonal
Self-Nurturing	Behavioral
Healing From Anger	Interpersonal
The Life Choices Game (Review)	Combination
Termination	

focus on increasing safety, practicing healthy coping, identifying unsafe situations and people, building positive relationships, and decreasing intense negative emotions. Typically, the first session is *Introduction to Treatment/Case Management.* The clinician introduces the approach to treatment, highlighting that the treatment will not ask clients to tell the story of their trauma. Beginning with this topic, Seeking Safety also emphasizes case management, which identifies client needs in 16 different areas, including 12-step groups, HIV testing, medication consultation, leisure activities, and so on. The model seeks to engage clients between sessions to obtain as much help as possible, both professional and nonprofessional, to support their recovery efforts.

Structure

Sessions follow a structure that creates consistency and safety in the therapeutic process: (1) *check-in*, including a brief comment about how the clients are feeling, what safe coping skills they have used, an update about any substance use or unsafe

behavior, and whether or not their between-session Commitment (described below) was completed; (2) *session quotation*, a brief point of inspiration to affectively engage participants and link to the session topic; (3) *relating the material to the client's life*, using *handouts* to facilitate discussion and rehearsal of the coping skill; and (4) *check-out*, including a specific between-session Commitment, either practicing a new skill or any other meaningful step a client would like to take prior to the next session.

The check-in allows the clinician to prioritize the most pressing safety issues (e.g., substance use and self-harm behavior) by tracking them from session to session and making them a focus of treatment. It also enables clinicians to reinforce good coping and progress on Commitments. Handouts in each session are used as an anchor to guide discussion of a specific topic and safe coping skill relevant to both trauma and addiction. Clients can return to written material between meetings or after termination to further explore the material. The check-out reinforces the day's topic by asking clients to "name one thing you got out of today's session." Clients are also given a chance to identify any problems with the session to allow them to voice dissatisfaction rather than potentially leave treatment over an unexpressed frustration.

Research Support

Seeking Safety evolved over a 10-year period starting with a grant from the National Institute on Drug Abuse (NIDA) in accordance with the NIDA stage model (Onken, Carroll, Shoham, & Riddle, 2014). Clinical experience and research studies informed revisions of the manual, resulting in the final published version in 2002. Since then, other integrated treatments for this population have been introduced. Seeking Safety, however, has undergone more empirical evaluation than other treatments currently available and is now a widely used treatment for PTSD and SUD.

Seeking Safety has been tested both by its developer, Dr. Lisa Najavits, and by various independent research groups over the past 15 years. The empirical database on the model has been generated through a variety of research designs, including randomized clinical trials (e.g., Hien et al., 2009; Hien et al., 2015; Najavits, Gallop, & Weiss, 2006; Weaver, Trafton, Waiser, & Kimerling, 2007), multisite studies (e.g., Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008; Hien et al., 2009; Morrissey et al., 2005), in-service demonstration research (e.g., Cocozza et al., 2005; Domino, Morrissey, Nadlicki-Patterson, & Chung, 2005; Morrissey et al., 2005), open trials (e.g., Holdcraft & Comtois, 2002; Najavits, Weiss, Shaw, & Muenz, 1998; Patitz, Anderson, & Najavits, 2015; Searcy & Lipps, 2012; Weller, 2005; Wolff, Frueh, Shi, & Schumann, 2012; Zlotnick, Najavits, Rohsenow, & Johnson, 2003), and small-scale pilot studies (e.g., Najavits et al., 2014).

The Seeking Safety model has been studied in a range of populations, including outpatient men and women (Najavits, Schmitz, Gotthardt, & Weiss, 2005; Najavits, Weiss, Shaw, & Muenz, 1998), inpatient men and women (Searcy & Lipps, 2012), incarcerated men and women (Barrett et al., 2015; 45Lynch, Heath, Mathews, & Cepeda, 2012; Wolff, Frueh, Shi, & Schumann, 2012; Zlotnick, Johnson, & Najavits, 2009; Zlotnick, Najavits, Rohsenow, & Johnson, 2003), female and male veterans (Boden et al., 2011; Cook, Walser, Kane, Ruzek, & Woody, 2006; Desai, Harpaz-Rotem,

Najavits, & Rosenheck, 2008, 2009; Fontana, Rosenheck, & Desai, 2010; Norman, Wilkins, Tapert, Lang, & Najavits, 2010; Weaver, Trafton, Walser, & Kimerling, 2007; Weller, 2005), low-income urban women (Cohen & Hien, 2006; Hien, Cohen, Miele, Litt, & Capstick, 2004), rural women (Patitz, Anderson, & Najavits, 2015), adolescent girls (Najavits, Gallop, & Weiss, 2006), women with physical disabilities (Anderson & Najavits, 2014), young African American men (Hamilton, 2006), men and women with PTSD and pathological gambling (Najavits et al., 2013), and international samples of men and women in Canada, France, and Germany (Daoust et al., 2012; Freyd-Harleaux & Stentz, 2014; Kaiser et al., 2015; Marsh et al., 2015).

Based upon the empirical findings to date, Seeking Safety is recognized on a number of national lists and registries. For example, the American Psychological Association (APA), Division 12 (Psychotherapy) lists Seeking Safety as a treatment for PTSD/SUD with "strong research support," and APA Division 50 (Society of Addiction Psychology) categorizes Seeking Safety as a treatment with "strong research support" for adults and "modest research support" for adolescents. The International Society for Traumatic Stress Studies designates Seeking Safety as Level A, the highest level of evidence for treatment. Seeking Safety is also included on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Practices, and it is listed on the California Evidence-Based Clearinghouse as supported by research evidence for adults and promising research evidence for adolescents.

This section will review the findings in order to provide a summary of the evidence base for the Seeking Safety treatment model and potential subgroups for which the treatment may be most effective. Overall, the treatment model has demonstrated benefits on the two primary outcomes for which it was designed: reduction of PTSD symptoms and reduction in SUD severity. The most rigorous studies have shown statistically significant reductions in PTSD symptoms when comparing the Seeking Safety treatment model, delivered in group or individual modalities, to a no-treatment or a low-level intervention group (e.g., Desai et al., 2008, 2009; Hien, Cohen, Miele, Litt, & Capstick, 2004; Hien et al., 2009). Studies have also shown similar reductions in substance use when comparing Seeking Safety to no-treatment or treatment-as-usual comparison groups (e.g., Boden et al., 2011; Hien et al., 2004). Studies have typically used an intervention dose of either partial (12 sessions or less) treatment or a full treatment (up to 25 weekly sessions) (Hien, Cohen, Miele, Litt, & Capstick, 2004).

The treatment has been studied primarily in community settings with community substance use treatment practitioners with substantial clinical experience who were subsequently trained in Seeking Safety and rated for fidelity, peer-led groups, and case managers with no prior therapy training (Desai et al., 2008, 2009). Groups by paraprofessionals without previous training have also been evaluated. A small pilot study ($N = 18$) of a peer-led Seeking Safety intervention, delivered solely by clients in a residential substance use setting, found positive outcomes and strong satisfaction (Najavits et al., 2014).

The largest randomized clinical trial of a group-delivered version of Seeking Safety was conducted in NIDA's Clinical Trials Network, Women and Trauma Study. The study compared Seeking Safety to an active control, Women's Health Education group

(WHE; Tross, 1998). The WHE addressed neither trauma nor addiction directly but provided health education on topics, including HIV, sexuality, the female body, and medical problems such as diabetes. Treatment was conducted in seven community-based SUD treatment programs across the United States. The study enrolled 353 women who met *DSM-IV* (APA, 2000) criteria for full or subthreshold PTSD. Trained clinicians from each program site conducted the group treatments twice weekly over a six-week period (12 sessions total for both treatments). Both treatments (Seeking Safety and WHE) were associated with large and clinically significant reductions in PTSD symptoms, which occurred rapidly during the acute intervention phase and were sustained over the one-year follow-up. Differences in PTSD outcomes between the treatments were small, but with interactive and trend effects favoring Seeking Safety, particularly in the subsample of participants who attended at least 50% of the treatment (i.e., 6 of the 12 sessions). There were no overall effects of treatment group on SUD outcomes, although importantly, close to half of the sample was abstinent from substances at baseline and remained so at outcome. Also, outcomes showed that lower PTSD scores during follow-up were associated with lower levels of self-reported and urine-confirmed substance use at posttreatment and over the one-year follow-up period (Hien, Jiang, et al., 2010). In secondary subgroup analyses, Seeking Safety, compared to WHE, reduced (1) PTSD severity and frequency among alcohol misusers defined as daily use in the past 30 days; (2) alcohol and cocaine severity among heavy drug users (13 or more days in the past 30 days) who improved in PTSD by 30% or more at each successive assessment point; (3) alcohol among 12-step members who attended 12-step groups regularly (19.5 days or more over past 30); and (4) stimulant use among heavy stimulant users (13 or more days in the past 30 days). In general, for more severe clients, Seeking Safety was superior to WHE, whereas for moderate or less severe clients, both treatments performed equally overall. Many of the analyses provide important indicators to guide treatment matching by client characteristics. Those who also attended 12-step programs benefited more from Seeking Safety in reducing drinking and drug use. Furthermore, Ruglass, Hien, Hu, and Campbell (2014) and Ruglass, Hien, Hu, Campbell, Caldiera, et al. (2014) found complex and nuanced differences across racial/ethnic groups that suggest the potential importance of identifying the race/ethnicity of providers and participants in order to match to treatment.

In a recent study of individuals ($N = 69$) with alcohol use disorders and PTSD (Hien et al., 2015), Seeking Safety, delivered in an individual 12-session format combined with the antidepressant sertraline or placebo, provided strong evidence for benefits of *Seeking Safety* on both PTSD and alcohol outcomes, showing clinically significant reductions that were sustained over one year posttreatment. Individuals who received sertraline versus placebo derived additional reduction in PTSD symptoms. For alcohol outcomes, Seeking Safety evidenced a significant reduction in heavy drinking days and increased abstinence rates (10% vs. 54%), with no additional benefit on alcohol use conferred by the addition of sertraline.

Given the accumulation of studies, there have been a series of reviews and small-scale meta-analyses (e.g., Gerger et al., 2014; Lenz, Henesy, & Callender, 2016; Najavits & Hien, 2013; Roberts, Roberts, Jones, & Bisson, 2015; Torchalla, Nosen, Rostam, & Allen, 2012; van Dam, Vedel, Ehring, & Emmelkamp, 2012) that have compared effect

sizes and impact of integrated "non-trauma-focused" therapies (those treatments that do not contain specific trauma processing elements but may include more general trauma-related psychoeducation and coping skills) (with Seeking Safety as the most widely tested in this category) to "trauma-focused" therapies (i.e., those treatments that include a trauma processing component, such as CPT or PE). These reviews and meta-analyses (conducted with studies published prior to 2013) vary greatly in rigor from more qualitative and descriptive examinations of predominantly noncontrolled trials with less diagnostic specificity (i.e., Torchalla et al., 2012) to more stringent requirements that studies meet stricter research design criteria to be included (e.g., Roberts, Roberts, Jones, & Bisson, 2015).

Across these reviews, little support for integrated "non-trauma-focused" models (Seeking Safety included in some of the studies) was identified, leading authors to suggest that there is very little evidence to support use of "non-trauma-focused" individual or group-based interventions. However, significant limitations of these reviews include small sample sizes paired with significant study heterogeneity (dosages of treatments were often unspecified, inclusion criteria varied greatly). One of the authors (Roberts, Roberts, Jones, & Bisson, 2015) noted, "The quality of evidence described in this review was assessed as being of low to very low quality and findings may be liable to change as further evidence is accumulated. The findings may, therefore, be best regarded as preliminary" (p. 34). Also important to note is that most of the studies of Seeking Safety that were examined in these reviews did not use the "full dose" of the therapy (i.e., 25 sessions) but rather were based on a "partial dose" of the therapy. Further, the reviews consistently did not consider the severity of clients in the trials. The majority of trauma-focused trials have excluded high-severity clients (e.g., exclusions such as suicidality, violence, domestic violence, current homelessness, incarceration). Also, there is an inherent confound in that trauma-focused trials are consistently provided in individual format whereas non-trauma-focused trials are often conducted in groups. In the most recent meta-analysis by Lenz et al. (2016), data on over 1,900 participants and 12 studies evidenced medium effect sizes for Seeking Safety on PTSD and modest effect sizes on SUD.

Najavits and Hien (2013) attempt to clarify the designation of "trauma-focused" versus "non-trauma-focused" treatments, suggesting that a more accurate designation of Seeking Safety and other treatments typically called non-trauma focused would be *"present-focused" trauma therapy* versus *"past-focused" trauma therapy*. This designation leaves room for truly non-trauma-focused therapies, like many of the comparison treatments such as relapse prevention or women's health education, to be accurately compared to those therapies that *do* include a component that directly addresses the symptoms of trauma and PTSD, with either present-focused (psychoeducational and coping skills) or past-focused (emotional processing of the past events) elements. Moreover, it states what a treatment *is* rather than what it is not.

Nonetheless, individual studies that have examined the evidence for this treatment model tested in both efficacy (controlled) and effectiveness (real-world) trials show benefits in the form of symptom reduction on PTSD and mental health outcomes, as well as on substance use symptoms. These findings have generally been stronger when examined with the full dose (25 sessions) versus partial dose (12 sessions or less)

and when compared to treatment as usual as opposed to an active intervention comparison group. This pattern is mirrored by the general literature on PTSD treatments, SUD treatments, and psychotherapy generally: Manualized models typically have been shown to be superior to treatment as usual but do not outperform each other (e.g., Benish et al., 2008; Bisson, Roberts, Andrew, Cooper, & Lewis, 2013).

The safety profile of Seeking Safety has been shown to be high; analyses of adverse events for clients receiving the program show no significant differences when compared to an active comparison treatment. There were also no differences in treatment attendance (Killeen et al., 2008). Also of relevance are findings that Seeking Safety had high ratings on therapeutic alliance measures. Similar to other studies of therapeutic alliance as a predictor of positive psychotherapy outcomes (i.e., Barber et al., 2009), higher therapeutic alliance in early sessions predicted lower PTSD severity posttreatment (e.g., Ruglass et al., 2012). Additionally, studies show that therapists and clients alike rate Seeking Safety as having high levels of treatment acceptability (e.g., Najavits & Anderson, 2015). These attributes have helped the model to be widely disseminated.

Future research on this model will help clarify important questions about subpopulations for which the treatment is most effective and mechanisms regarding how the treatment works. Specifically, studies that extend beyond basic symptoms to examine other realms of functioning such as quality of life, other mental health symptoms, and emotion regulation abilities will provide additional breadth to the literature. Studies are also needed to examine effects over more specific time frames (early versus over longer periods of time) and to assess for the most effective combinations of treatments (pharmacotherapy and other types of combination behavioral techniques), as these will be particularly relevant to further treatment development and clinical application.

Clinical Application

We offer some additional reflections about the application of Seeking Safety based on our extensive behavioral intervention research, clinical experience with the model, and collaboration with the developer, Dr. Lisa Najavits. We have implemented Seeking Safety for close to 20 years in various settings: 12-session individual interventions, 12-session groups in addiction treatment centers, 25-session individual interventions, and our research-to-practice initiative in the "real-world" setting of an outpatient psychiatry department. Seeking Safety served as part of the foundation of a specialty hospital-based program in New York City for women and men who were trauma survivors with SUD. The program had a clear integrative perspective from its inception and was thus specifically designed to simultaneously address the needs of clients in recovery from trauma and SUD. The following considerations are based on these experiences while also guided by a focus on fidelity to the model.

Flexibility

A highlight of Seeking Safety is its flexibility. The comprehensive approach to cognitive, behavioral, interpersonal, and case management objectives provides a framework to address many presenting issues, but there is no set order of sessions. In our experience,

following the sequence of initial sessions in the manual works well as a core set of topics: (1) Introduction to Treatment/Case Management, Safety; (2) PTSD: Taking Back Your Power; (3) Detaching From Emotional Pain (Grounding); and (4) When Substances Control You. Nevertheless, these and the rest of the topics can be decided upon collaboratively or based on clinical judgment to best suit therapeutic goals.

Each topic has multiple subsections or "handouts." This enables a client and clinician to further hone the session discussion according to the client's needs and allows movement between themes within each topic. Some topics focus on a singular handout. Others have as many as eight handouts. Clinicians are guided to provide the full set of handouts for each topic, although all or some of these handouts may be used for each topic. Clinicians are encouraged to ask clients what interests them in the handouts as a jumping-off point for discussion. If treatment is ongoing, there may be an option to spend multiple weeks on a given topic, giving clients more opportunity to absorb and connect to the material. In a time-limited framework, a clinician may have time for fewer topics and may choose to explore one topic per session. Clients may, of course, read through handouts on their own, and clinicians encourage this.

The model is designed to be implemented in individual or group format. Individual treatment, when possible, clearly allows the most flexibility as the client and clinician can decide how long to spend on a given topic and can choose which topics are most relevant and important for a client's presenting issues and goals. Individual treatment also provides clients a greater opportunity to relate the material to their lives, enabling them to speak more personally than some will feel comfortable doing in group.

There is also flexibility in how to focus the session. Importantly, while providing a substantial amount of material, Seeking Safety strives to have clients connect the material to their lives. To promote this, there are various options offered for discussion and skill rehearsal. A clinical goal is to balance depth and breadth. Depth is encouraged by helping clients invest in the material personally, to absorb and learn new concepts, to relate to and rehearse the coping skills in meaningful ways. It is in some ways less important for clients to be exposed to many topics than to connect to the material emotionally.

Clinicians also need to balance skills acquisition, understanding, and personal connection with sustaining momentum in the treatment. Introducing new topics keeps clients excited about the material. Of course, there is no need to cover all of the Seeking Safety modules, and clients may make gains from working on only a small subset of topics that are particularly relevant. In this way, Seeking Safety is adaptable to provide clients with useful components of the model regardless of the length of a given program or group.

Seeking Safety may be used as a stand-alone treatment or as a component in a larger treatment program. A client's level of distress, substance use, co-occurring disorders, and case management needs may support the use of Seeking Safety as part of a broader treatment plan. Clients who are good candidates for Seeking Safety because of their addiction and PTSD often have substantial needs, as discussed earlier. The built-in case management component recognizes this and encourages clients to connect to other supportive and clinical resources (e.g., self-help groups, medical care, financial assistance/entitlements, partner violence resources, parenting skill assistance).

Seeking Safety easily fits into larger treatment programs and settings where many services are available. Seeking Safety has been used in outpatient substance use programs, mental health settings, inpatient and partial hospitalization programs, criminal justice environments (jail, prison, drug courts), homelessness programs, primary care, peer support, and other settings that work to stabilize clients with PTSD and/or SUD. Having access to additional treatment and case management resources not only makes it easier for clients to develop the network of supports they need but also enables client and clinician to use Seeking Safety to focus on clinical issues. Nevertheless, it is always important for the Seeking Safety therapist to stay abreast of case management needs and encourage client follow-up.

Group Considerations

Seeking Safety is often conducted in group modality, which provides a welcome level of support and validation from other clients who have similar experiences. Group modality is also the most common modality in substance abuse treatment settings, and some clients prefer group to individual treatment. The power dynamics of past trauma can make it difficult for some clients to feel comfortable in individual treatment if they feel there is a power imbalance with the clinician. For these clients, group is more comfortable.

On the other hand, some clients may be reluctant to consider group initially due to mistrust that is also common among survivors of trauma. Secrecy about their traumatic experiences, substance use, or unsafe behaviors is often paramount in survivors' lives. Some clients report that entering into a group can feel like taking a big risk. They worry about sharing their stories: "I don't want anyone to know my business." They worry about being triggered by others' stories: "I can't listen to other people talk about their problems or what happened to them. I have enough of my own problems." Following an explanation of the rationale for treatment and preparation of the client to enter group, however, many clients are surprised by the power of connecting with others who are struggling with the same or similar issues. They may find others with experiences to which they can relate and with whom they can share the struggles they have often kept to themselves.

Seeking Safety provides a safe entrée into this kind of group experience. Through its structure, use of psychoeducational material, and present-focused emphasis, clients can explore the impact of trauma on their lives and the connection trauma has to their substance use. Clients do not have to worry about sharing or hearing details of trauma as past-focused trauma narratives are discouraged in this treatment. As described earlier, Seeking Safety is a first-stage trauma treatment and focuses on creating safety and stability. An important role of the clinician in Seeking Safety is to maintain the safety of the group experience by monitoring and containing potentially triggering material, keeping the discussion present focused, and emphasizing processes that encourage positive group interaction, including sharing time, staying respectful of other group members, and emphasizing two core processes in Seeking Safety: (1) praise (positive reinforcement) and (2) accountability (being honest about unsafe behaviors).

Treatment Settings

Substance Use Treatment Settings

Clients in SUD treatment settings sometimes struggle to recognize that their trauma is relevant to their recovery from addiction. This may have to do with attitudes that they encountered in addiction treatment over time that did not give credence to the importance of addressing how a traumatic past could contribute to problematic substance use and interfere with recovery. Clients may also feel unprepared to talk about violence in their lives. Some clients who are exposed to Seeking Safety, on the other hand, begin to understand the important connection between their SUD and PTSD and experience a huge sense of relief. It is meaningful to learn that there is logic to aspects of their lives that had previously made them feel "crazy, lazy or bad" (Najavits, 2002). Seeking Safety normalizes and validates their experiences.

In SUD treatment, Seeking Safety is compatible with the major approaches to substance reduction: (1) abstinence, which supports refraining from substances completely; (2) harm reduction, which provides flexibility in determining substance use goals and supports any direction toward safer substance use; and (3) controlled use, which supports the chance to set a goal of moderate use. Controlled use is consistent with a harm reduction approach. Seeking Safety has been widely used and studied among clients who are actively using substances, and it provides a strong emphasis on education and skills to help reduce or eliminate use. In the topic *When Substances Control You*, there are options to try the "quit all at once"/"cold turkey" model, "try an experiment"/"warm turkey" model, or "cut down gradually"/"harm reduction" model (Najavits, 2002, p. 153). Seeking Safety emphasizes that the treatment program philosophy, clinician, and client all contribute to the substance reduction approach taken when using Seeking Safety in a SUD treatment setting.

Based on the empirical literature (Najavits & Hien, 2013), however, many Seeking Safety clients have active, severe, and chronic substance use, and abstinence is often the chosen direction. Abstinence can be an important goal for clients with traumatic and complicated psychiatric histories and polysubstance use who are frequently unable to achieve or sustain reduced or controlled substance use (McCauley, Killeen, Gros, Brady, & Back, 2012). For clients who are already clean and sober, the handouts related to reducing substance use may not need to be covered; however, some clients who enter into Seeking Safety groups even after years of abstinence report that they still value the aspects of the material related to recovery from addiction.

Some confusion and tension can arise if individuals who are committed to abstinence are in the same Seeking Safety groups as individuals whose substance use goals are flexible. This has less to do with the model itself than the experience of being triggered in group by those who are still actively using. Clients who have committed to abstinence are not always comfortable with other clients who may be attempting to moderate, but not eliminate, their substance use. Training and supervision can help clinicians manage this friction.

Mental Health Settings

Seeking Safety can be a particularly useful addition to mental health settings, which are less likely to provide SUD treatment. This has been changing with increasing emphasis on No Wrong Door policies that promote the ability to address co-occurring substance use and mental health disorders regardless of where a client presents for treatment (Clark, Power, Le Fauve, & Lopez, 2008). Nevertheless, many mental health programs still have few offerings to address substance use. Seeking Safety provides a welcome way for mental health clinicians to integrate treatment for traumatic stress and SUD in their practice. Often, mental health practitioners lack substantial training in providing treatment for SUD. Although these clinicians may still need to augment their training in treating SUD, Seeking Safety is a structured, user-friendly approach to being able to discuss the addiction issues in the lives of traumatized clients.

Interestingly, participating in Seeking Safety in a mental health setting compels clients to consider the importance of addressing the role of substances in their lives in new ways. Unlike clients in addiction settings for whom addressing substance use is a more clear priority, clients in mental health settings may not be ready or motivated to reduce their substance use. Because it allows for harm reduction as an approach to reducing substance use, Seeking Safety can be used to work with clients at varying levels of readiness to change their substance use. Some clients are aware of their SUD and/or other unsafe behavior, but many are not. Seeking Safety can help clients become aware of and address unsafe behaviors as part of the work. In group therapy, other members often provide useful reinforcement for this, sharing their own experiences and providing feedback about behaviors that are unsafe. Unsafe behaviors include not just substance use but any addictive behavior (e.g., gambling, pornography, Internet, spending) or other dangerous activity (e.g., driving under the influence, hanging out with people who are violent, unsafe sex, self-harm such as cutting).

Integrating Seeking Safety Into Psychotherapy

Seeking Safety lends itself well to being integrated into ongoing psychotherapies of all types. A clinician may adopt topics to augment the treatment being conducted (e.g., anger management groups or interpersonal skills training) or to introduce an emphasis on PTSD and/or SUD. The handouts create a way for clients to stay with uncomfortable content that may be beset with shame, denial, or minimization. They provide a modulated approach, allowing clients to initially engage through education and gradually relating to the material at a more intimate level, with the clinician's guidance.

Some especially useful stand-alone topics include *Grounding* and the use of *Safe Coping Skills*. *Grounding* provides a set of concrete exercises to help clients manage emotional dysregulation, dissociation, or cravings for substances or other emotional pain. The exercises guide clients to turn away from their overwhelmed internal experience by focusing on the present and their surroundings and using other skills to detach from painful emotions.

Similarly, the *Safe Coping Skills* encourage clients to find alternative activities to the unsafe choices they may be making when experiencing cravings or feeling flooded by trauma memories. The list of more than 80 skills includes activities and motivational statements designed to help clients approach a situation more adaptively, for example, "Actions first, and feelings will follow," "Create positive addictions," and "Avoid avoidable suffering" (Najavits, 2002, pp. 103–108). Clients are taught that there is always a way to cope safely, without the use of substances or any behavior that harms self or others.

Challenges for Clinicians

Literacy

In certain clinical populations, it is reasonable to expect that clients will have educational limitations. Many individuals with complex PTSD, for example, have been exposed to multiple adverse childhood events, a known risk factor for limiting educational potential (Felitti et al., 1998). Chronic substance use, especially beginning at a young age, can also lead to cognitive impairment (see Allen, Goldstein, & Seaton, 1997; Rogers & Robbins, 2001, for reviews), which may impact a client's ability to absorb material in treatment (e.g., McCrady & Smith, 1986). Literacy or comprehension issues create a need for the Seeking Safety clinician to be attentive to the client's ability to absorb the written material. While very rich, the Seeking Safety material can feel complex for some clients, and clinicians will want to consider the most effective way to present a topic.

Seeking Safety accommodates client abilities by allowing various ways to explore handouts. Optimally, the client has an opportunity to read the material during the session and then explore relevant aspects with the therapist or group, using the material as a jumping-off point to discuss personal experiences as they relate to the topic. Alternative approaches include scanning the handouts, focusing on headers or highlighted items, or providing the handouts ahead of time for clients to read prior to the session. Clinicians may ask group members to volunteer to read excerpts aloud. Alternatively, clinicians may read the excerpts aloud or provide brief summaries. Moreover, even for clients who cannot read, Seeking Safety skills are straightforward, and clients can be engaged in discussion and rehearsal (e.g., "asking for help," "taking good care of yourself"). These options enable Seeking Safety to be used effectively with clients across a wide spectrum, including those with illiteracy, cognitive impairment, serious mental illness, and mild traumatic brain injury (Najavits & Anderson, 2015).

Handouts

Many clients are immediately drawn to the material and devour it, eager for more. They highlight sections and make notes and willingly take on the Commitment exercises at the end of each topic. For a Commitment, clients identify something specific to their own recovery or self-care that they can do before the next session. Some clients read and reread the material, often organizing their materials in binders

that they can keep and to which they can refer. Some clients express disbelief at how much the handouts seem to capture their experience. They value the skills they learn and feel grateful for the connections made between their PTSD and substance use (Brown et al., 2007).

Some clients, however, need more help engaging with the material. In the language of Seeking Safety, the clinician has leeway to "adapt within the model," remaining true to Seeking Safety while accommodating to client needs. This may include creating games or artwork related to the session. There is even a safe coping skills card deck developed by the author to help clients learn and reinforce skills and ideas from Seeking Safety. Clinicians are encouraged to use examples and language relevant to their clients' experience (e.g., for adolescents, focus on school, family, and dating). As noted above, if clients cannot or do not want to read the handouts, clinicians have options to approach the material. If language is an impediment, Seeking Safety is available in over 10 languages.

Comorbidity

Even though Seeking Safety focuses on PTSD and SUD, clients frequently present with multiple psychiatric diagnoses. The National Comorbidity Survey (Kessler et al., 1995) estimated that 80% of individuals with PTSD also meet criteria for at least one other psychiatric diagnosis, with 16% having one other diagnosis, 17% having two other diagnoses, and nearly 50% having three or more additional diagnoses. Most commonly, these diagnoses include affective disorders and other anxiety disorders (Kessler et al., 1995; Spinhoven, Penninx, van Hemert, de Rooij, & Elzinga, 2014). Clients with prolonged childhood trauma are also likely to have psychiatric problems such as dissociation, poor impulse control, and interpersonal deficits (see Hien, Litt, Cohen, Miele, & Campbell, 2009). Accordingly, the mental health presentation of these clients is typically complex and often severe. Clients with co-occurring SUD and PTSD also have a variety of physical health care needs, which are known consequences of trauma (Felitti et al., 1998).

The severity of this clinical presentation can pose challenges for the clinician. With its emphasis on safety and self-care, Seeking Safety is well suited to work with many of the issues facing these clients. Its focus on case management – helping clients to take advantage of local available treatments and support services – builds supports outside of sessions. In Seeking Safety, clients are encouraged to apply the coping skills to their current problems, not just focus on trauma and/or substance abuse. As described above, Seeking Safety has been successfully implemented in numerous vulnerable populations with high levels of other co-occurring difficulties such as HIV/AIDs, serious mental illness, gambling disorders, domestic violence, homelessness, and criminal justice involvement.

A high level of comorbidity can be especially challenging in group situations in which the therapist has to attend to the needs of many clients at once. For group work, having a Seeking Safety co-facilitator can also be helpful to manage a group with high clinical and service needs. Seeking Safety was designed to be implemented with only one group facilitator, recognizing that having a second clinician is not often

practical. Nevertheless, the benefit of having an additional facilitator, when possible, holds for any trauma group in which group members have severe clinical profiles and have the potential to be in distress or triggered. Should a group leader have to attend to a distressed client, for example, a second facilitator enables a group to continue with less interruption.

Group Admission

Seeking Safety was designed to be conducted in open or closed groups, as it is frequently impractical to hold closed groups, especially with a client population who often live chaotic, unpredictable lives. Moreover, treatment programs typically need to be able to add new members to treatment, not ask clients to wait weeks or even months for a group to finish a cycle and begin again. The topic, *Introduction to Treatment*, was designed to be conducted individually at any time with clients before they enter a Seeking Safety group or can be reviewed with a small cohort of a few clients who are about to start the larger group at the same time. The *Introduction to Treatment* topic also gives the clinician an opportunity to get to the know the client and his or her struggles, to develop the therapeutic alliance, and to flesh out some personal recovery and case management goals that will be pursued in the treatment. If clients are not familiar with the terms *trauma*, *PTSD*, or *substance abuse*, reviewing handouts on these topics prior to joining the group can be useful, as well.

Therapist Preparation

Seeking Safety provides a substantial amount of material to help therapists implement the treatment. Each topic includes a section that guides the therapist through the format, content, and goals for each topic and provides suggestions for discussion questions, how to relate the material to clients' lives, and other topic-specific ideas. Clinicians are also encouraged to engage in cross-training if they have knowledge gaps about substances or about trauma or need to boost clinical skills, such as role-playing or other CBT skills. Seeking Safety makes reading recommendations to clinicians to help enhance their expertise in these areas.

Seeking Safety encourages the discussion of how trauma and substance use or other unsafe behaviors are connected, yet some clinicians need guidance on how to keep a focus on trauma symptoms and experiences, in order to deepen the work. Some clients, especially SUD clients who are sometimes enculturated to focus on their SUD rather than trauma, will not explore trauma unless encouraged. Similarly, in mental health settings, clinicians may need help keeping the role of substances and unsafe behavior present in the discussion.

As noted, traumatic events are viewed through the lens of their impact on the client's current functioning. Although clinicians are attuned to PTSD, they also need to remain present-focused during the exploration of the handouts. Seeking Safety emphasizes attention to "current, specific and important" client issues rather than lengthy exploration of past events. The therapist material in Seeking Safety includes "tough case" examples for each topic, which can be helpful in anticipating challenging clinical situations and how to address them in this present-focused approach.

If clinicians have never implemented a structured treatment with handouts, it may take time to adjust. The check-in and check-out process, in particular, and the importance of staying connected to the handouts can be challenging for clinicians more accustomed to an open-ended, exploratory modality. Being able to maintain the structure is also particularly important in group. Group leaders help to create a safe and productive space for members by adhering to structure and boundaries. In a reasonable sized group (e.g., eight to ten clients), for example, it is critical that the therapist keep the group on track for a concise check-in and check-out, lest the group lose the time to delve into the handouts.

Seeking Safety emphasizes the need to balance support and accountability. Most clinicians are comfortable with providing support but may shy away from nudging clients to take steps outside of treatment. Seeking Safety encourages clients to be accountable for their recovery by asking them to identify something they can work on between sessions. As with similar exercises in other CBT treatments, clinicians need to be accountable for asking if the client has followed through with her or his Commitment during the subsequent check-in. There is demonstrated efficacy to this CBT treatment element, not specific to Seeking Safety; clients who engage in between-session assignments improve more quickly than those who do not follow through (Cronin, Lawrence, Taylor, Norton, & Kazantzis, 2015; Lebeau, Davies, Culver, & Craske, 2013). More broadly, the emphasis on holding clients accountable means having clear expectations (e.g., keeping the group safe for all members), praising what clients do well, and expressing concern about issues that clients need to work on. Along these lines, the clinician in Seeking Safety can give direct advice and feedback (e.g., "I'm concerned about your decision to get a job as a bartender – let's talk about whether that's safe to do.").

Collaboration is also an important clinical skill for Seeking Safety, drawing on many treatment approaches that value the interaction between client and clinician in establishing and pursuing treatment goals. Mental health counselors or substance use counselors who have been trained to be the "expert" in the therapeutic relationship sometimes find this to be a major shift. While not all counselors approach their work this way, many struggle to step away from an authoritative or confrontational position. Particularly in abstinence-based programs, traditional therapeutic communities, and mental health programs, clients have not always been given the opportunity to collaborate with clinicians about their treatment goals (see Hien et al., 2009), and some clinicians are less practiced in approaching treatment this way. Motivational interviewing (W. R. Miller & Rollnick, 2002) and motivational enhancement therapy (W. R. Miller, Zweben, DiClemente, & Rychtarik, 1992) are among treatment approaches that have evolved to help clinicians foster a collaborative relationship with their clients.

For trauma survivors who have often faced disbelieving or dismissing responses from others, validation in treatment is critical. Working with trauma survivors demands an empathic stance, and Seeking Safety supports a value of communicating empathy frequently and explicitly. Validating and supportive clinicians are better able to encourage and reinforce good coping. If clinicians are too directive in sessions, they may miss what is happening for clients emotionally and fail to attend to what is important to them. Clinicians are encouraged to offer supportive comments

throughout the session, including check-in and check-out. Clinicians need to genuinely convey these sentiments, providing emotional validation that does not sound like "cheerleading."

Because there are many Seeking Safety handouts, it can be tempting to slip into a mode of "teaching" the material in order to cover it all, but it is important to allow the direction of the sessions to flow from the clients' reactions to the material. Najavits emphasizes the value of adhering to an "80/20" guideline in which the therapist speaks only 20% of the time, allowing clients to speak the rest of the time about aspects of the topic that are important to them (Najavits, 2004). It is not necessary to review all of the topic material for each session, but it is important to encourage clients to identify and discuss ways to apply the new skills in their lives.

Many of these challenges can be addressed through clinician training and supervision. Although Seeking Safety does not require dedicated training and certification, clinicians often find it helpful to have some guidance as they utilize the model. The developer's organization, *Treatment Innovations*, offers consultation, training, and supervision, which can be tailored to the needs of clinicians and settings. Other experienced Seeking Safety providers can also provide training and identify and develop areas for further growth.

Although not specific to Seeking Safety, we have found it to be very helpful for clinicians to receive feedback based on audio or video recordings of sessions. Unlike supervision that is based on discussion of session process, supervision of the structure and content of manualized treatments is especially effective when audio or video sessions are available. Some clients are not comfortable with this, although many clients are willing to provide written informed consent once the parameters of the use and privacy of the recordings for supervisory purposes are made clear. Recorded sessions allow supervisors to commend clinicians on what they are doing well but also allow supervisors to detect areas of difficulty of which clinicians may be unaware. This may relate specifically to *Seeking Safety* or to a therapeutic approach that is potentially undermining to trauma survivors and important to discuss (Hien et al., 2009).

Clinicians have expressed high levels of satisfaction with using Seeking Safety (Brown et al., 2007). Seeking Safety provides a structured and rich means to begin to address the difficult co-occurring issues of traumatic stress and SUD. Furthermore, the treatment can be adopted by therapists with a range of training.

Suggested Supplemental Materials

Based on our many years of experience with Seeking Safety, we offer a few suggestions for supplemental materials that can be useful with this treatment. While we encourage adherence to the model, these are some select suggestions that we have found beneficial to enhance our implementation of Seeking Safety.

CBT Concepts

Some of our clients found it helpful to have an introduction to cognitive-behavioral concepts before engaging in the cognitive-focused segments of Seeking Safety. Before

topics such as *Recovery Thinking* and *Creating Meaning*, for example, we discuss the relationship between thoughts and feelings, as well as help clients begin to pay attention to their thoughts. Topics such as *PTSD: Taking Back Your Power* and *Compassion* compel clients to examine their self-talk as well, and it can be helpful to contextualize how thoughts and inner dialogue impact feelings and behaviors, especially if those behaviors are unsafe. We found that giving clients an understanding of how automatic patterns in thinking evolve and how distortions in thinking sometimes take hold was a useful prelude or accompaniment to some of the Seeking Safety topics.

Feelings Handouts

We supplemented the check-in with a feelings list and other handouts designed to help clients identify how they feel (e.g., the feelings wheel [Cloitre et al., 2006] or "How are you feeling today?" faces handout). The inability to identify and articulate their emotional state is a common experience for some individuals with PTSD and SUD, especially those with early life childhood trauma and substance use initiation. Children exposed to abuse and violence, particularly in the context of an invalidating environment, sometimes fail to learn how to accurately understand, identify, and believe their emotional experience (Krystal, 1978; van der Kolk, 1996). Some learn to shut down any upsetting affective reaction, including using substances excessively to achieve this (Khantzian, 1997). Carried into adulthood, these deficits suggest difficulty not only tolerating strong negative emotions but also even labeling them (Evren, Dalbudak, Cetin, Durkaya, & Evren, 2010; Zlotnick, Mattia, & Zimmerman, 2001). The check-in asks clients to note how they are feeling, but we have found that clients may need help identifying their emotions. Supplemental material on emotional awareness may also be useful (e.g., dialectical behavior therapy [DBT]: Linehan, 1993; Skills Training in Affective and Interpersonal Regulation with Prolonged Exposure [STAIR/PE]: Cloitre et al., 2006).

Conclusion

Seeking Safety offers a structured yet flexible treatment model to address SUD and the sequelae of trauma in an integrated, cognitive-behavioral, present-focused format. It has been studied in a wide range of populations and settings, and in rigorous research investigations, it has demonstrated efficacy in reducing PTSD symptoms and substance use. Seeking Safety is a useful and accessible treatment, well liked by clients and clinicians.

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