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Investigating the Experience of Individuals with Comorbid Posttraumatic Stress Disorder and Substance Misuse Attending a Seeking Safety Group

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Conflict of Interest

The authors received no specific financial support in relation to this study. All authors were employed by an NHS trust during the completion of the study. The second author of this study was the facilitator of the Seeking Safety group described. They had no involvement in the interviewing or analysis of participant data. They did provide feedback on drafts of the manuscript.

Ethical Statements

All authors abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BPS.

Investigating the Experience of Individuals with Comorbid Posttraumatic Stress Disorder and Substance Misuse Attending a Seeking Safety Group

Purpose: There is no specific recommended treatment for the co-morbid presentation of Post-traumatic Stress Disorder and Substance Use Disorder in the United Kingdom (UK). Seeking Safety, a group-based treatment that targets symptoms of both disorder, has emerging evidence in the United States (US) however to date no UK based studies have explored service users' experience of attending Seeking Safety or evaluated its impact of the group on mental health symptomology or substance misuse.

Design/Methodology/Approach: A mixed method approach was used to evaluate the acceptability of Seeking Safety for a small sample (n=7) of adult users of a substance misuse service in the UK. Thematic Analysis was used to explore their experiences, derived from individual semi-structured interviews. We also calculated the number of participants who achieved reliable and/or clinically significant change in mental health symptomology and substance misuse from data routinely collected by the service.

Findings: Seven overarching themes emerged: (1) Strengthening the Foundations of the Self, (2) The Evocation and Management of Emotions, (3) Safety and Validation Provided Relationally, (4) Readiness and Commitment, (5) Content and Delivery, (6) Seeking Safety is Not an Island, and (7) Ending. Most participants with data available both before and after the group made reliable (3 out of 4) and clinically significant (2 out of 3) change for depression and anxiety symptomology, however this was less evident for PTSD symptomology with 2 out of 3 making reliable change and 1 out of 3 making clinically significant change.

Originality: To the authors' knowledge, this was the first study exploring the experiences of UK attendees of a Seeking Safety group.

Keywords: PTSD; Substance Misuse; Dual Diagnosis; Seeking Safety; Treatment; Service User Perspectives

Investigating the Experience of Individuals with Comorbid Posttraumatic Stress Disorder and Substance Misuse Attending a Seeking Safety Group

Post-traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) have significant costs at individual and societal levels (Fineberg et al., 2013; Pagotto et al., 2015). While effective psychological treatments have been developed for each in isolation (see Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017), when they co-occur, as is common (Kessler et al., 1995), a challenge for treatment emerges (Brown et al., 1995).

Theoretical Explanation of the Co-occurrence of PTSD and SUD

Three theories have conceptualised the co-occurrence of PTSD and SUD, namely (i) self-medication, whereby substances are used to alleviate PTSD symptoms (see Khantzian, 1997), (ii) substances exacerbating PTSD symptoms via impacting the central nervous system (see Smith & Randall, 2012, for overview) and (iii) the shared vulnerability model, which suggests shared common factors contribute to the development of both (Meyer, 1986). Once their co-occurrence is established, PTSD and SUD symptoms perpetuate one another (see Stewart, 1996).

Treatment

Traditionally, it was thought SUD must be treated first, with PTSD treatment beginning following a period of abstinence (Ouimette et al., 2003). However, if a SUD developed to cope with PTSD symptoms, delaying PTSD treatment may result in increased risk of SUD relapse (Brown et al., 1996). Indeed, PTSD symptoms have been reported as worse when abstinent (Kofoed et al., 1993). This may suggest that treating PTSD first could be a helpful approach.

Efficacious PTSD treatment using cognitive behavioural therapy (CBT) involves exposure to avoided aspects of trauma (Ehlers and Clark, 2000).. Exposure temporarily increases distress, which could result in further substance misuse (Simpson et al., 2012), impeding trauma processing and engagement in therapy (Bedard-Gilligan et al., 2018). Therefore, clinicians recognise the benefit of treating the two disorders in an integrated manner (National Institute for Clinical Excellence (NICE), 2005).

Seeking Safety

One integrated treatment with emerging evidence (See Najavits & Anderson (2015 for review) is *Seeking Safety* (SS; Najavits, 2002). SS is a present-focused stabilisation treatment with foundations in CBT for Substance Abuse (Beck et al., 1993) and PTSD (Herman, 1992). It incorporates psychoeducation on the links between trauma, substance use, and coping (Najavits, 2002) covering 25 interpersonal, cognitive, behavioural or “combination” (e.g. safety, and endings)

topics. It holds a number of key concepts at its core including (1) staying safe, (2) self-respect, (3) using coping skills to replace substance use, (4) making the future better than the present, (5) trust, (6) active self-care, (7) identifying safe people who can be helpful, (8) becoming substance free whilst healing from PTSD, (9) trying something different and (10) persistence in the face of adversity. Detailed discussions of past trauma are prohibited during the program (Najavitis, 2002).

Research in the US has provided evidence SS can improve PTSD and SUD symptoms in a variety of populations including military veterans (Boden et al., 201), victims of childhood sexual abuse (Ghee et al., 2009) and female prisoners (Lynch et al., 2012) amongst others, whilst a cost-benefit analysis has identified an 72% likelihood of SS providing benefit over cost in terms of the impact of SUDs and PTSD in economic terms (Washington State Institute for Public Policy, 2019). A meta-analysis of 12 between-group studies evaluating the effectiveness of SS found it yielded moderate effect sizes for reducing PTSD symptoms compared to both waitlist and alternative treatments. It yielded small effect sizes for reducing frequency of substance use compared to alternative treatments, while there were not enough studies with a waitlist control group to calculate an aggregate effect size (Lenz et al., 2016).

The above findings suggest emerging evidence that SS can be effective in reducing PTSD symptoms and SUD, however all studies included within Lenz et al., (2016) used US samples. The authors found that cultural differences between participant groups within included studies moderated the effect sizes found which the authors speculated could be due to the delivery of materials of Seeking Safety not resonating with participants from certain cultures if materials and their delivery were not adapted or made relevant to these cultures. Therefore it is important to explore whether Seeking Safety is acceptable to individuals experiencing PTSD and SUD within countries outside the US and therefore, likely to experience a different culture.

Seeking Safety in UK Services

There is a lack of research evaluating SS in the UK and it is not currently recommended as a psychosocial treatment by UK guidelines (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017). This guidance states trauma focused treatments using exposure have been effective in reducing PTSD severity in those with comorbid SUD but that individuals may require initial stabilisation; however, it does not give a specific recommendation as to the approach to stabilisation.

This study aimed to evaluate the acceptability of SS as a stabilisation treatment for individuals with comorbid PTSD and substance misuse who attended a substance misuse service in the UK. It did this primarily by exploring the reported experiences of individuals who attended SS and secondly by evaluating the impact of SS on self-reported psychological wellbeing (i.e. improving mood, anxiety, and PTSD symptoms) and substance misuse. By doing so it aimed to help inform if its

continued use is acceptable and inform any potential future modifications to its delivery within the service.

Method

Design

The study used a convergent parallel mixed methods design (Cresswell & Plano Clark (2011)). The theoretical drive was inductive (Morse & Niehaus, 2009) with the aim of exploring and describing participants' experience of the SS group (Qualitative) and any impact it had on their psychological wellbeing and substance misuse (Quantitative). The qualitative and quantitative aspects were independent (Schoonenboom, 2017) with the qualitative component the dominant aspect of the design. Data on participants mental health and substance misuse, routinely collected by the service before, at the mid-point and after Seeking Safety, were used to supplement the understanding of the acceptability of the group. The qualitative and quantitative results were integrated at the inferential stage (Teddlie & Tashakkori, 2009).

Participants

Opportunity sampling was used to recruit service users who had attended a SS group run by the service since 2017. Exclusion criteria were: (1) attendee was no longer under the caseload of the service, (2) the participant's keyworker advised that it would not be appropriate to make contact or (3) the participant had attended less than 4 sessions. This was a pragmatic decision based on participants' level of exposure to the Seeking Safety group after attending 3 sessions or less. Seven participants (≥ 18 years of age) who met criteria for PTSD and were in contact with substance misuse services took part.

Ethical Approval and Considerations

Approval was granted by the University of Bath, School of Psychology Ethics Committee (Code: 18-344) and the relevant NHS Research and Development team. Participants provided their written informed consent to take part in the interview and for their questionnaire responses to be used for the study. It was emphasised that their decision to take part or not would not impact on their care. They were informed they could end the interview at any point without giving a reason. Participants who did not want to take part in the interview were also given opportunity to complete a questionnaire version of the interview schedule. The interviews took place at the Drug and Alcohol Service. Participants were made aware that they could check in with a member of the substance misuse staff team at the end of the interview if they wished. Following the interview participants were debriefed and given the opportunity to ask questions.

Description of the group

For a full description of SS please see Najavits (2003). The group comprised of 25 weekly sessions. The first half of each session involved a “check-in” where participants each answered 5 questions (1) “how are you feeling?”, (2) “what good coping have you done?” (3) “have you engaged in substance use or other unsafe behaviour?” (4) “did you complete your commitment”, (5) community resource update. The second half focused on different “topics” related to cognitive, behavioural, or interpersonal domains which involved provision of psychoeducation and discussion, skill teaching and practice. Emphasis was given to safety as the first priority and attention given to therapist processes. Sessions concluded with a structured “check-out”. The rolling nature of the topics meant that new participants could join at any topic. Each session lasted 2 hours with a short break halfway through. The group was facilitated by a Clinical Psychologist (Primary Facilitator), who always remained the same, and a Drug and Alcohol Key Worker (Secondary Facilitator). The primary facilitator had over 10 years’ experience in delivery of CBT and Dialectical Behaviour Therapy (DBT) group interventions and was experienced in working with PTSD and SUD presentations. They had shadowed SS run by another service and were provided clinical supervision by the facilitator of that group. At the time of recruitment the primary facilitator had 3 years’ experience of facilitating a SS group.

Interview Schedule

The interview schedule (supplementary materials, available via request from author) was developed via discussion with the group facilitator using their knowledge of the group procedure and service aims and the first author’s supervisor. It was also guided by the study aims of finding out if the group had been acceptable to participants and if they deemed it helpful for their identified difficulties of PTSD symptoms and substance use. A number of potential questions falling into different categories were drafted. These included how participants found out about the group and their hopes before starting, specific questions about what participants found helpful and/or unhelpful about the “topics”, and if it was helpful in making change in their difficulties. There were also questions about how information was presented, the size of the group and the process for new members joining and questions asking about the relationship between group members and the group facilitators. A draft of the interview schedule was sent to a person with personal experience (PPE) of mental health difficulties and of attending therapeutic groups for feedback, following which amendments were made to enhance readability.

Quantitative Measures

Participants' psychological wellbeing and substance use was measured using a variety of self-report questionnaires routinely used by the Substance Misuse Service. Participant anxiety and depression symptoms were measured with the Generalised Anxiety Disorder-7 (GAD-7) and Patient Health Questionnaire (PHQ-9) respectively. PTSD symptomology was measured using the Impact of Events Scale Revised (IES-R), whilst the Alcohol Use Disorders Identification Test (AUDIT) and Severity of Dependence Scale (SDS; Castillo et al. 2010) were used to measure alcohol and other illicit substance use severity, respectively. Finally, the Importance/Confidence scale was used for participants to indicate how important they deemed it to reduce their substance use and their confidence in making this change (Rollnick et al., 1997). All measures have demonstrated good specificity, sensitivity and reliability (Spitzer et al., 2006; Arroll et al., 2010; Kroenke et al., 2001; Creamer et al., 2003; Weiss & Marmar, 1997, Saunders et al., 1993, Selin, 2003).

Procedure

Participants completed questionnaires on mental health symptomology and substance use before, at the mid-point and following the final session of the SS group. Participants were informed of the study and given the opportunity to take part in the interview after questionnaires were already completed. Participants took part in the interviews between 2 weeks and 18 months after completing their final session of SS. Group facilitators informed group members about the study and provided the information sheet. Participants informed the facilitators if they would like to take part and an interview with the first author was arranged. Interviews lasted between 35 and 50 minutes.

During the interview, a method of summarising back to the participant their response was adopted, akin to that used in motivational interviewing (Rollnick, 1995) to allow participants opportunity to contemplate their response to facilitate further elaboration.

Analysis

Qualitative

Participants' interviews were analysed in line with the 6 phases of Thematic Analysis described by Braun and Clarke (2006). Analysis was carried out inductively and not driven by pre-existing theoretical interests (Braun & Clarke, 2006) with the aim of understanding participants "lived experience" of attending the SS group (Schwandt, 2000) as opposed to the experience of living with PTSD and SUD.

The author adopted a contextualist stance which recognises that access to "reality" is mediated by socio-cultural lenses (Braun and Clarke, 2013) as such, consideration was given to the fact that all participants were white adults, born and raised in the UK and residing in the south of

England. Most participants had experienced a cognitive behaviourally informed therapy prior to SS whilst the ethos of SS itself may have influenced their choice of language in responding to questions.

The author conducted and transcribed all interviews and removed identifying information. Transcripts were read and re-read and semantic level codes were generated and applied to the data. Codes were grouped into initial themes and then refined into broader overarching themes with subthemes. During the refinement stage, it became apparent that one subtheme related specifically to those who did not complete the group. Due to the small number of participants who did not complete it was felt that including such themes could enable specific identification of participants and therefore breach anonymity, such themes were therefore omitted. The views of participants who did not complete the group are represented in other themes.

Quantitative

Due to the small sample and missing data, group level inferential statistics on symptom change were not conducted. The number of participants' scores meeting criteria for reliable and/or clinically significant change for each measure was calculated (excluding SDS due to a lack of data for participants identifying substances other than alcohol). Reliable change was determined for the GAD-7, PHQ-9 and IES-R using previously determined cut-offs (Clark and Oates, 2014). For the AUDIT it was determined using the method described by Christensen and Mendoza (1986), using male and female normative data reported in Shevlin and Shorter (2007). Participants were determined to have achieved clinically significant change when their scores changed from being above, to below published cut-offs representing the likely presence of a disorder (Clark and Oates, 2014; de Meneses-Gaya et al., 2009). Group level descriptive statistics are also presented.

Results

Seven (five male, two female) participants out of a potential 22 took part. Participants were aged between 29 and 50 years and included individuals who completed and did not complete the entire 25-week program. It is important to note that the COVID-19 lockdown brought further recruitment to a premature end.

Qualitative

Seven overarching themes with underlying subthemes were identified.

(i) Strengthening the Foundations of the Self

All participants reported new insights or life changes they had made which they considered helpful. Some of these were active and tangible such as engaging in meaningful activity. Others reflected changes made to their perspectives on life, new understandings reached or a change in

relationship with themselves, such as seeing themselves as more in control of their lives or treating themselves with compassion.

Understanding of Self and the Role of Substances. Six participants described new understandings and insight of patterns that played out in their lives including the role of difficult life experiences and emotions in these patterns.

“because I used to be like, ‘why the hell am I so anxious?’ and I used to get angry about the fact that I was anxious... this sort of gave me a better insight, you know, ‘I’m anxious because of that... what I’ve been through’”

They also spoke about increased awareness of the role substances had in maintaining their difficulties.

“my problem with alcohol was, I would use it to run away from my life ...”

Alternative Perspectives. Most participants described that the group provided new or alternative perspectives on life or difficulties, with three participants citing quotes presented as a source of this.

“It was quotes by famous people, like Ghandi and bloody, some poets and stuff, but they were really deep and meaningful, you know, it really gave me a lot of food for thought, an alternative way of looking at things”

For four participants, this change of perspective led to a more compassionate approach to both themselves and to others in the group. as opposed to previous self-criticism.

“I have learnt to speak to myself like a friend...does that make sense? I find that the language is a lot softer, and more understanding, rather than I’m a failure”

“you learn to think they are doing the best they can at that given time”

Empowerment, Agency and Activity. Five participants reported feeling empowered to exert agency over their lives in relation to boundaries and assertiveness.

“growing up I just wasn’t really aware of what healthy boundaries are, and um, yeah, I think, seeking safety has, um, really made me think about what boundaries actually are...”

“ it empowered me to realise that I can help myself, yeah, “this is in my hands”, you know, “I don’t have to be that victim”, where I thought that I had no choice, I learnt that I had choices.”

For many this increased agency led to engagement in activities they found rewarding or provided a sense of purpose in their lives.

“...because I used to be quite in to [1], like [] years ago, I got into it quite big time, but my mental health took a big dive ..., but, since I’ve been coming here I’ve been going again”

(ii) Evocation and Management of Emotions

All participants reported how attending SS evoked emotions in session which provided opportunity to better recognise and respond in alternative ways than substances. While difficult, most reported how this gave them a positive experience of experiencing emotions without becoming overwhelmed and therefore feel more in control of their emotional experience.

“Seeking Safety has made me realise that actually I can control those emotions that I was woken up with, you know, that dream last night, its not owning me, and I wouldn’t have been able to do that before Seeking Safety.”

However, one participant reported how sometimes these emotions would continue outside of the group and led to the use of substances to manage these feelings.

“Well for the first few months, all I would do after that session was straight out and score... because it brought up feelings”.

(iii) Safety and Validation Provided Relationally

Whilst emotions were evoked, all participants commented about feeling safe and contained in the group environment. This helped participants share their difficulties which was met with support and validation.

Facilitator as Container. All participants commented how the primary facilitator was key in establishing safety and containment. They spoke positively about how the facilitator had clear boundaries, was consistent and gave provision at the end of the group to individually discuss difficult things that may have emerged.

“I don’t know one person who doesn’t speak highly of them, and they trusted them, but it wasn’t about being told what to do at all, it was always about empowering us to, ‘you can do this’, and potentially ‘how you can do it?’”.

Group Connection as Source of Support and Validation. Participants discussed how SS provided opportunity to reconnect with others, something that some were out of practice of and had initial concerns about.

¹ Removed to protect anonymity

“because I got quite withdrawn from people you know, so coming here and having to deal with people, just getting used to being around people and stuff, I found it very useful on that front”.

The positive experience of reconnecting was rewarded with a further source of support, normalisation and validation of their difficulties and safety in the company of others.

“being in that room with people that even though I didn’t know exactly what had happened to them, just knowing there were other people who had gone through this experience and are living with trauma um, I don’t want to use the word normalise, but in a way that normalisation process sort of like helped me realise that actually, you know, its not my fault and its not just me”.

Challenges to Relational Safety. Whilst the group mostly felt safe and supportive, participants discussed difficulties when there was a change to the group environment such as a new member joining, someone attending under the influence of substances, or the primary facilitator being absent.

“I think [facilitator], was away for a week, and I think in the group, they built up such a kind of relationship with [facilitator] that I think people did find that quite difficult”

Participants also reported finding it difficult when the boundaries of inside and outside the group were blurred such as the secondary facilitator also being the assigned key worker for some group members,

“I felt that that was inappropriate because [2] was a key worker”.

Seeing other members they knew from the group outside the group environment, particularly if other members had relapsed in terms of substance use also had an impact on their sense of safety within the group environment.

“people that I met in there that I saw outside that would ask me for drugs and stuff ...then I’d see them in there and, to, it actually felt like my life was under threat”.

(iv) Readiness and Commitment

All participants touched on the theme of readiness to engage in the group and feeling a need to be able to commit wholeheartedly to the group before starting.

Where SS Fitted in the Path to Recovery. For many, SS was not their first experience of therapy. Some commented that previous approaches were not a good fit for them, whereas others could see the link between previous therapy and SS and therefore could use SS to build on previous

² Removed to preserve anonymity

learning. Some participants reflected how they were previously not in the right frame of mind to start SS whereas others reflected that it may have been helpful if they were offered the group at an earlier point in their recovery. This subtheme also shared some relation to the Seeking Safety is Not an Island (vi) theme expanded on below.

“the group is set up in such a way that, you need to be in a, in a good enough state to be able to get here, stay here, get something from it and come back again, and I absolutely wasn’t”.

“I moved into a dry house, I did the one [group] for depression anxiety first, then I moved into the next place and then I started Seeking Safety, so the timings were perfect”.

Preparedness and Ability to Commit. Five participants discussed the importance of being able to commit fully to the group before starting. They were aware of the amount of commitment required and saw this as a positive in helping them remain engaged.

“I couldn’t just do bits, I couldn’t have a little finger in here, a little finger in there, impossible, its kind of, you’re in or you’re out”.

(v)Content and Delivery

There was strong agreement amongst participants around what was more and less helpful about the content and delivery of SS.

Concrete, Practical and Simple. Six of the participants reported valuing learning that was simple, concrete and practical. Participants often struggled to name anything specific and instead emphasised the importance of practicing skills during the session. For two participants, practicing these skills meant they became embedded into their day to day life.

“now self-care has become the cornerstone of my life”.

Focus on the Present. Sessions focusing on the present, as opposed to the past, was valued by five participants. Checking-in was helpful, as was grounding, which participants attributed as helping them recognise emotions and how they were feeling. Participants also valued the fact that specific trauma memories were not the focus so it was less likely these were re-experienced within the group environment.

“I think its been helpful in the sense that all these topics are very grounding...all these are about coming back into yourself and anchoring you”

“because we weren’t delving into the past...and again, I think that’s probably smart, because you don’t want to whole group bringing up terrible memories and everyone leaves”.

Consolidation. While participants found lots of the content helpful there was also desire to focus on less new material and give more time to consolidate and reflect on what they had already learnt.

“There were certain points that felt for me, that I could really reach somewhere, and then there was no way of kind of, no space to reflect on it, it would be moving on straight away”.

However, others considered certain topics a better fit for certain people and therefore covering a wide range of topics over the course of the group was helpful.

“I would get something out of it at the beginning, some would get what they wanted at the end”.

Those who were able to make the time to practice and consolidate and maintain the skills found noticeable benefits.

“but you had to keep training, you had to keep working, I had to, its like doing physio here, if I don’t do it, I seize up, if I didn’t keep doing the techniques and you walk through [city], walk mindfully. You know, pay attention to what you are seeing and suddenly you start to feel alive”.

Skill of the facilitator. Underlying the content and delivery was the skill of the primary facilitator, commented on by six participants. Participants reported how the facilitator had to flexibly find a balance between asking questions that were challenging without being overly provoking, managing time, as well as holding in mind participants’ varying learning styles and adapting how the material was presented accordingly.

“Somebody that can listen, somebody that can, uh, explain it in many ways, the same thing in different ways, which [facilitator] can. Gives you time to speak, doesn’t interrupt you. Write it on the white board, so it’s got a visual impact as well...I learn more that way”

(vi) Seeking Safety is Not an Island.

Despite participants attributing SS as contributing to many positive life changes, all participants reported other sources of support that were also key in making change. Whether this be previous therapy, a change in social circumstances or the support of the substance misuse service and other services more widely, participants highlighted it was a collection of input, rather than SS in isolation, that facilitated change.

“rather than just down to Seeking Safety, I think that’s down to the overall effect of coming to [the substance misuse service]. It’s given me an opportunity to put more of a positive spin on my life...”

(vii)Ending: Next Steps and Overall Impression.

Participants discussed how the group ended and their experience following its conclusion, whilst all participants, including those who did not complete the entire group, had an overwhelmingly positive opinion of their participation in SS.

Next Steps. Whilst praising the way the ending was marked, two participants reported missing attending SS.

“I’m quite sorry it’s come to an end just because of that, it’s left a bit of a hole”

One of the aims of SS is to provide stabilisation for later direct trauma intervention, however, at the time of the interview only one participant was undergoing specific therapy for trauma, however three reported SS was helpful in preparing them for such work.

“I know that I needed those tools, I didn’t appreciate it before I started Seeking Safety because I thought, you know, “quick fix”, have the therapy, I’m going to be absolutely fine, then I learnt, no, actually it doesn’t work that way”

Overarching Positive Impression. All participants expressed an overall positive view of SS and were grateful to have taken part, reflecting on how much their lives had changed.

“It was really positive for me, it was the first real turning point to getting my life back, and I feel like I’ve got my life back now”

Quantitative

Descriptive statistics are presented in Table I. Data were not available at the post stage for three participants for the GAD-7 and PHQ-9, four participants for the IES-R, two for the AUDIT, one for the SDS and three for the Importance/Confidence measure.

Insert table I here

The number of participants who made reliable and or/clinically significant change are presented in Table II. For participants with data available both Pre and post stage, there was a reliable reduction in GAD-7 and PHQ-9 scores for three of four participants. Two of three participants had a reliable reduction in IES-R scores whilst two of two participants had reliable reduction in AUDIT scores. For those who scored above clinical cut-offs scores at the start of the group and had data available at the post stage, 2 of 3 made clinically significant change in GAD-7 and PHD-9 Scores, one of three had a change in IES-R scores and one of one made this change in AUDIT scores. It is also important to note

that at the time of the interview all participants who completed the group³ reported being abstinent from alcohol and/or substances use.

³ *N* not reported to preserve anonymity

Table I
Scores at Pre, Mid and Post Group

Measure	Pre		Mid		Post		Clinical cut-off scores
	<i>n</i>	M (SD)	<i>n</i>	M (SD)	<i>n</i>	M (SD)	
<i>Mental Health</i>							
GAD-7	7	13.9(4.7)	7	11.9 (5.9)	4	5.5 (4.4)	≥15 indicates “severe symptoms”
PHQ-9	7	16.7 (9.2)	7	13.6 (7.1)	4	5.8 (4.6)	≥20 indicates “severe symptoms”
<i>IES-R</i>							
Intrusion	7	22.1 (6.8)	7	20.9 (9.6)	3	14.7 (8.5)	-
Avoidance	7	20.5 (4.4)	7	17.7 (4.5)	3	19.3 (5.0)	-
Hyperarousal	7	17.0 (3.9)	7	14.7 (6.9)	3	9.0 (4.0)	-
Total	7	59.7 (11.0)	7	53.3 (19.9)	3	43.0 (14.1)	≥33 indicates “probable PTSD” ¹
<i>Substance Use</i>							
AUDIT	5	16.4 (16.0)	5	14.4 (14.9)	3	1.0 (1.0)	≥8 indicates “harmful alcohol use”
SDS	2	13.5 (7.0)	2	11.0 (5.7)	1	15 (<i>na</i>)	≥5 indicated “likely dependence on substances”
Importance	5	8.0 (4.5)	4	9.3 (1.5)	2	10.0 (0.0)	-
Confidence	3	4.3 (4.9)	4	6.8 (3.4)	0	-	-

Notes. GAD = Generalised Anxiety Disorder; PHQ = Patient Health Questionnaire; IES-R = impact of events scale – revised; AUDIT = Alcohol Use Disorder Identification Test; SDS = Severity of Dependence Scale; M = Mean; SD = Standard Deviation

¹Creamer et al., 2003

Table II
Number of participants making reliable and/or Clinically significant change

	Pre to mid		Pre to post	
Reliable	<i>N</i> ¹	<i>n making change</i>	<i>N</i> ¹	<i>n making change</i>
GAD-7	7	2	4	3
PHQ-9	7	4	4	3
IES-R	7	3	3	2
AUDIT	3	1	2	2
Clinically significant	<i>N</i> ²	<i>n making change</i>	<i>N</i> ²	<i>n making change</i>
GAD-7	6	2	3	2
PHQ-9	5	2	3	2
IES-R	7	1	3	1
AUDIT	3	0	1	1

Notes:

¹ = participants with data available at both relevant time points

² = participants scoring above cut-off at pre time point and data available at both time points.

Discussion

This study aimed to evaluate the acceptability of SS as a stabilisation treatment for individuals with comorbid PTSD and substance use attending a substance misuse service in the UK. It explored the reported experiences of individuals attending SS with comorbid PTSD and SUD within a UK service and the impact of SS on self-reported psychological wellbeing and substance use. By doing so it hoped to offer recommendations to the service as to whether it should continue to use SS as an approach to stabilisation as well as any adjustments or modifications that could be made in its application, based on participant views. Recommendations were formulated based on the data gathered during this study and fed back to the substance misuse service (Supplementary materials available from author).

During the interviews, participants touched on a number of concepts concerning their experiences of SS and aspects that were more or less helpful. Participants had an overwhelmingly positive opinion of SS, and many reported significant changes they had made to their lives. Participants described having a better understanding of themselves and the interaction between substance use and mental health. The clinical management of substances guidelines highlight “meaningful activities” (e.g. jobs, volunteering and mentoring) as important to promote (Clinical Guidelines on Drug Misuse and Dependence, 2017), and participants discussed how SS helped them engage in these. Participants valued the teaching of concrete, practical and simple skills, highlighting

grounding as particularly helpful, which resonates with the reported experience of participants in US studies (Empson et al., 2017). Strengths of the group included the good therapeutic alliance and connection to other group members, creating a safe environment in which difficulties could be explored which again is consistent with qualitative data from previous studies (Empson et al., 2017). However, participants spoke how group dynamics were impacted when the primary facilitator was absent, or if they had another professional relationship with a secondary facilitator (i.e. keyworker). New members entering the group was also seen as disruptive at times.

Participants had helpful suggestions about other aspects of the group, commenting on the amount of information provided and wanting more time for consolidation of previous material, however others recognised covering a broad range of topics meant it was more likely all attendees would find something that was helpful. Clarity could also be useful concerning the next steps following the end of the group as participants noted something missing in their lives, whilst there did not appear to be a clear pathway from completing this stabilisation group to progressing to trauma specific therapy. NICE guidance on the management of individuals with mental illness and substance use suggests that service users should be involved in their care planning (NICE, 2016), therefore greater information concerning this area could be helpful in considering SS within this process.

Further consideration of the point at which people enter the group could be useful, with some participants describing needing to feel stable before starting, whereas others noted what they had learnt may have been helpful earlier in their recovery. This may suggest offering SS at multiple points during an individual treatment journey may be helpful.

Participants also highlighted that it was a combination of different input, rather than SS alone that contributed to positive changes in their lives. Whilst this suggests the impact of SS alone cannot be considered as part of this evaluation, it would appear to reflect good practice in line with the NICE guidance which recommends a multifaceted treatment approach to comorbid substance use and mental health difficulties (NICE, 2016). Lenz et al., (2016) also considered that the availability of wider sources of support, alongside SS, could have been responsible for differences in effect sizes found between studies of SS. Participants' experience described in the current study provide further evidence that other sources of support may be important.

A real strength of SS that emerged was participants' sense of safety in the presence of the facilitators and other group members. Such a response may have relevance for the treatment of "complex PTSD". Individuals with a diagnosis of complex PTSD often find it difficult to trust other people and feel close in relationships (WHO, 2018) and therefore safety in the context of a therapeutic relationship is a key component of treatment. Therefore, it may be SS has potential value as an approach to treatment of complex PTSD and highlights the importance of prioritising the group space as one that provides emotional and relational safety.

Given the very small sample making up the quantitative aspect of the study it is difficult to meaningfully compare the results of this component of the current study with previous studies. Nevertheless, for those attending SS with data available at pre and post time points, the majority made reliable and clinically significant reductions in depression and anxiety symptomology which is in line with previous studies (Najavitis, 2005; Tripodi et al., 2017). The results of the thematic analysis potentially add some explanation as to this effect. Participants discussed how they engaged in activity that was important to them, became more compassionate towards themselves and were able to re-connect with others. All these factors have been associated with improvements in depression symptomology (Ekers et al., 2014; Craig et al., 2020; Werner-Siledler et al., 2017).

Only one of three participants made clinically significant change in PTSD symptomology (two of three made reliable change). It is perhaps logical that reduction in PTSD symptoms in the current study were not as pronounced as for depression and anxiety given there is a deliberate lack of focus on trauma in SS and focus on trauma is central to effective treatment of PTSD (Ehlers and Clark, 2000). The qualitative results add some context to this showing that whilst there was not much evidence of PTSD symptom reduction, participants complimented the lack of focus on trauma and recognised the need for stabilisation work prior to such focus. Whilst PTSD may have not reduced, participants also indicated that they felt more in control of their emotions and less overwhelmed which is important for stabilisation, and may make participants less reliant on substances to manage emotions which may break the maintenance cycle of comorbid PTSD and substance misuse (Khantzian, 1997). Unfortunately the questionnaire data for substance misuse was not valid. Inspection of the wording for both the AUDIT and SDS revealed participants were asked to report on substance use over a period of time that would have included the weeks prior to the start of the group even when being asked about substance use at the end of the group⁴, therefore it cannot be used as a valid indicator of change.

Limitations

It is important to highlight that the interpretation of transcripts and generation of themes will have been inevitably influenced by the first authors socio-cultural background and psychotherapeutic training. Therefore the author's background, of a white male trainee psychologist, attending a course with a strong cognitive behavioural orientation should be held in mind when considering the themes that were derived from the data.

The small sample of seven of a potential 22 attendees, is the biggest limitation, as the themes generated may not be representative of all group attendees. Further, the small number of participants who did not complete the group may represent selection bias in that those who are in a better place in

⁴ The SDS using the wording "before the start of treatment", while in the AUDIT the items refer to alcohol use in "the previous year".

their recovery may be more able to engage in providing feedback. Participants attending less than 4 sessions were not asked to participate means the results do not reflect their perspectives. While the current study provides some indication that some individuals attending SS made reliable and clinically significant change, the sample size was small, was reduced further by missing data, and as indicated by the thematic analysis, was confounded by the wider impact of support sources available generally. Therefore inferences cannot be drawn concerning the independent impact of Seeking Safety on mental health symptomology in UK based service users. This will require further studies with more robust methodology. The main strength of the study lies in the qualitative component, providing evidence that SS was well received and appeared to contribute to a number of positive changes participants made in their lives.

Conclusions

This study has shown preliminary support for SS as an acceptable approach in the UK to treating individuals with substance misuse and PTSD. Participants spoke positively about the group and cited it, along with a combination of other factors in parallel, as a key reason for positive changes they had made in their lives. This feedback was provided to the service along with recommendations. The limitations of the current study preclude the results being generalised more widely than the current sample or wider clinical recommendations being made. Nevertheless, we hope this initial attempt at reporting the experiences of UK participants attending a SS group will stimulate further research with robust methodology of the effectiveness of SS as a stabilisation treatment for comorbid PTSD and substance use in the UK.

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Table S1
Reasons for Not Taking Part

Reason	<i>n (%)</i>
Opted out	2 (13)
No longer under caseload of the service	5 (33)
Physically unwell	1 (7)
Attended less than 4 sessions	4 (27)
Uncontactable	3 (20)

Table S2***Recommendations for the Delivery of Seeking Safety***

Facilitators and co-facilitators

Participants highlighted the importance of the primary facilitator and the need for someone who has sufficient awareness of boundaries and the different needs of all attendees. The group is one that relies not just on the presentation of information but the flexible holding in mind of the emotions and learning styles of multiple people at one time. It is key that the primary facilitator of this group is someone who holds these skills and provides consistency over the course of the group.

Revisiting the group co-facilitator's role could be useful. The evaluation suggests that, if possible, co-facilitators that do not have a relationship with attendees in another capacity (e.g. keyworker) could be useful. Availability of such individuals may be limited, therefore if not possible, discussion concerning this in relation to boundaries may be help.

It is also recommended that maintaining the protected time at the end of the group for the primary facilitator to respond to concerns that emerged during the course of the group is important. All participants valued this, however at times felt the facilitator had limited time at the end of the group.

Beginning and ending the group

The results suggest that reviewing the points at which individuals can begin the group would be useful, with new members joining at the midpoint was at times viewed as disruptive. However, the length of the group may mean having multiple entry points is important and that greater support for both the group and the individual joining it could facilitate this process.

The service should consider offering further support and follow-up to individuals who drop out of the group prematurely, perhaps highlighting this and clarifying the process related to this at (including support available and where the group can be re-accessed) the start of the group and/or during the assessment. It is possible as part of this process offering a follow up appointment as standard could be useful to consider.

A further recommendation is considering a process to ensure feedback from individuals who do not complete the group is regularly requested so this can feed into the cycle of reviewing the group.

SS is suggested as a stabilisation treatment for later trauma work. Only one participant that completed the SS group included in this evaluation had gone on to complete trauma work at the time of the interview, with some having a sense of where they were on the waiting list for this and others not clear what came next. It is therefore suggested the

clinical service consider this, especially in relation to mapping a clear treatment pathway for what follows the SS group in relation to options for completing later trauma work.

Participants also talked about how a hole had been left by the group ending. It may be worth considering a more gradual ending to the group (i.e. a gradual reduction in frequency of the sessions) or a session specifically focusing on scheduling activity for the day and time the group used to take place.

Things to continue

There were many aspects that participants valued and saw as key to the positive changes they were making, including: understanding the relationship between substances and emotions, grounding, keeping things simple and practical, being clear about not discussing trauma, what they feel comfortable disclosing, the use of meaningful quotes, finding opportunities to engage in meaningful activity, building assertiveness and awareness of boundaries and a compassionate approach to difficulties. It will be important that these aspects are retained. It is also important to encourage participants make use of the wider support of substance misuse services (e.g. other groups and activities).

Outcome monitoring

NICE guidelines (2016) emphasise the importance of using measures to document change. The evaluation suggests that the wording for the Severity of Dependency Scale (SDS) and Alcohol Use Disorders Identification Test (AUDIT), related to how participants viewed their substance use “in the week before treatment” and the “last year”, is applicable to the pre assessment rather than post treatment. It is recommended that consideration be given to this to ensure the measures used are suitable to measure change over time.

There was a smaller sample size in terms of quantitative data than anticipated, related to missing data, especially post group measures. It is recommended that the process for the completion of measures is reviewed e.g. planning in dedicated time to complete the questionnaires at the end of the group.
