Ron, 40, was in the infantry for 18 years until he was discharged in 2010. “I never thought I’d be one of those guys with an alcohol problem.” He used to be really fit and at the top of his game at work until he was sexually assaulted by a senior officer. Mired in shame and resentment, he started drinking daily and getting into fights. He was soon discharged and his life spiraled downhill. He didn’t have a job and didn’t have anything to do with his time except sit and watch TV. He felt useless, so he drank more to try to escape the pain. “The medicine for my pain was what I knew best—alcohol.” Four years after he was discharged it got to a point where all he could think about was alcohol—getting the cash together, finding alcohol, and drinking. He had alcohol after every meal and more during the night to be able to sleep better. Soon he couldn’t climb three flights of stairs without coughing up and he gained weight due to poor diet. He was angry at everyone and everything, including hating himself for
fighting back more during the sexual assault. He had no financial means to support himself except for his pension. His family tried to be supportive for a while but eventually stopped contact after he repeatedly lied about going to Alcoholics Anonymous and treatment that he wasn’t really attending. His Dad said, “We learned that we shouldn’t enable him; he has to face the consequences of his addiction.” He feels lonely but figures they are better off without him. It’s just a burden to others and don’t belong anywhere—not in the military, not on the outside.” He is having increasing suicidal ideation.

This story illustrates some of the challenges facing people who have suffered military sexual trauma (MST) as well as the clinicians who work with them. Clinicians often struggle with issues such as, “How can I help him express the alcohol problems if I don’t have training in addiction treatment?” “What do I do if he is not motivated to decrease his alcohol use?” “Should I require him to go to Alcoholics Anonymous (AA)? What if he is willing to go?” “How do I decide if he should go to detox?” “If we work on his PTSD will his alcohol problems likely get better or worse?” “Are there medical issues that need to be addressed, given how much he has been drinking?” And there are often many more questions that arise.

MST AND SUBSTANCE ABUSE

As described elsewhere in this volume, MST is a term that encompasses acts of physical assault, sexual assault, and stalking or harassment that occur during active military service (Suris & Lind, 2008). It is an important issue that many clinicians face in their practice (Kimerling, et al., 2007).

Moreover, MST is associated with an increase in substance use disorder (SUD) among veterans (Creech & Borsari, 2014; O’Brien & Sher, 2013). Research on Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans indicates that for both women and men, those who report a history of MST are more likely to present with SUD than those without a history of MST (Kimerling et al., 2010). Furthermore, in a study conducted among outpatients in the Veterans Health Administration, the prevalence of alcohol abuse was two times higher in those who reported a history of MST than those who did not report MST (Hankin et al., 1999).

The most commonly abused substances by military personnel are alcohol, followed by cocaine and marijuana (Seal et al., 2011). However, opioid abuse is also a serious concern, especially among those with chronic pain (Edlund, Steffick, Hudson, Harris, & Sullivan, 2007). However, there is little research generally on illicit substance use among military members as such use is a crime that typically results in discharge from military service (Saxon, 2011). In addition, in military settings (as well as nonmilitary settings), physicians often fail to assess substance problems (Weller, 2005).

Co-Occurrence of Posttraumatic Stress Disorder and Substance Abuse Disorder With MST

SUD and posttraumatic stress disorder (PTSD) often co-occur. Among people with SUD, the lifetime prevalence of PTSD is 36% to 50% and the current PTSD prevalence is 25% to 42% (Jacobsen, Southwick, & Kosten, 2001). Research on OEF/OIF veterans shows an estimated co-occurrence rate of 25% to 50% (Gulliver & Steffen, 2010). People with the comorbidity, moreover, have more severe symptoms, require specialized treatment, and have poorer treatment outcomes than those without such diagnosis (Seal et al., 2011). They also may present with thoughts of self-harm, suicidal ideation, violent tendencies, and other high-risk behaviors (Najavits, Schmitz, Gotthardt, & Weiss, 2005).

Various hypotheses have been proposed to explain the co-occurrence of PTSD and SUD in patients with a history of trauma, including self-medication, common vulnerability, and increased risk of SUD due to the presence of PTSD and vice versa (Jacobsen et al., 2001; Seal et al., 2011). PTSD typically occurs before SUD, which is known as the traumatogenicity theory of SUD (Najavits, Weiss, & Shaw, 1997). In addition, SUD and PTSD have been often found to co-occur across different populations as the presence of either disorder increases the risk of the other (Najavits et al., 1997).

Need for an Integrated Approach

Conventionally, most SUD treatment programs focused on attaining stabilization or abstinence before addressing mental illnesses such as PTSD (Seal et al., 2011). Addressing MST requires attention to both PTSD...
SUD that may occur together in MST survivors. However, it is not
usual to deliver care at different facilities, but rather to engage in an
integrated approach that addresses each without worsening the other
(Najavits, 2009). In addition, an integrated model is more cost-effective
and more sensitive to patients’ needs (Najavits et al., 1997). This chap-
ter offers a detailed summary of the Seeking Safety Model, which is
designed to address both PTSD and SUD. We focus in particular on its
importance to MST.

SEEKING SAFETY—AN OVERVIEW

Seeking Safety is an evidence-based therapy that has been widely used
to help people with a history of trauma and substance abuse. The web-
site www.seekingsafety.org provides detailed information and out-
tines on the model.

The Seeking Safety manual (Najavits, 2002) offers clients coping
skills that can improve their lives. It helps them to regain a sense of
safety,” which includes safety from substances, unhealthy relation-
ships, and impulses to hurt self or others (Najavits, 2009). Although
the model was originally designed for PTSD and SUD, it has been
applied to a wide range of clients, including those with just one
other disorder, or those that subthreshold on them. Seeking
Safety has been used among diverse populations including men,
men, adolescents, veterans, the homeless, the mentally ill, school-
children, and criminals (Najavits, 2009). Research indicates positive
findings across a broad range of studies including pilots, controlled
and randomized controlled trials, and multisite trials (Najavits &
Stuart, 2013).

Seeking Safety offers 25 topics that address cognitive, behavioral,
and interpersonal skills (Najavits, 2002). Every topic in Seeking Safety
dresses a specific coping skill to clients (Table 7.1). The topics can be
built in individual or group sessions, and if group, can be open groups
that clients can join in anytime (Najavits, 2002).

Seeking Safety sessions are structured yet flexible. Topics and hand-
sheets can be conducted in any order, and session length and pacing can
vary based on program needs. The structure provides a “safe container”
that clients know what to expect, offering a routine that can be very
fulfilling in the context of the often chaotic nature of their lives when

<table>
<thead>
<tr>
<th>TABLE 7.1 SEEKING SAFETY TOPICS</th>
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<tbody>
<tr>
<td>1. <strong>Introduction to treatment/case management.</strong> Topic covers (a) introduction to treatment, (b) getting to know the client, and (c) assessment of case management needs.</td>
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<tr>
<td>2. <strong>Safety [cognitive].</strong> Main focus of the treatment. Provides a list of 80 safe coping skills to help clients.</td>
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<td>3. <strong>PTSD: Taking back your power [cognitive].</strong> Four different handouts provided. The main goal is to provide information and understanding of the disorder.</td>
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<td>4. <strong>Detaching from emotional pain (grounding) [behavioral].</strong> Designed to help clients fight emotional suffering. Focuses on three different types of grounding—physical, mental, and soothing. Techniques are demonstrated through an experiential exercise.</td>
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<td>5. <strong>When substances control you [cognitive].</strong> Eight handouts are provided: (a) “Do you have a substance abuse problem?” (b) “How substance prevents healing from PTSD”; (c) “Choose a way to give up substances”; (d) “Climbing Mount Recovery” an imaginative exercise to prepare for giving up substances; (e) “Mixed feelings”; (f) “Self-understanding of substance abuse”; (g) “Self-help groups”; (h) “Substance abuse and PTSD: Common questions.”</td>
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<td>6. <strong>Asking for help [interpersonal].</strong> This topic encourages clients to understand their problems and seek help for the same.</td>
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<td>7. <strong>Taking good care of oneself [behavioral].</strong> Clients are encouraged to explore how well they are taking care of themselves. They are also asked to take immediate action to improve any such self-care problems.</td>
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<td>8. <strong>Compassion [cognitive].</strong> Clients are taught that only a loving approach toward oneself will result in a permanent change and that blaming oneself will not help in any way.</td>
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<td>9. <strong>Red and green flags [behavioral].</strong> These “danger and safety signs” signs are discussed in detail. A safety plan is devised to deal with mild, moderate, and severe danger situations.</td>
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<td>10. <strong>Honesty [interpersonal].</strong> Clients explore the role of honesty in recovery and role-play specific situations.</td>
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<tr>
<td>11. <strong>Recovery thinking [cognitive].</strong> Rethinking tools such as List Your Options, Create a New Story, and Imagine are used to guide clients away from negative thoughts associated with SUD and PTSD.</td>
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<tr>
<td>12. <strong>Integrating the split self [cognitive].</strong> Clients are guided to notice and overcome splits. Splitting is a primary defense in patients with SUD and PTSD.</td>
</tr>
<tr>
<td>13. <strong>Commitment [behavioral].</strong> Clients are offered strategies to help them keep promises to self and others.</td>
</tr>
<tr>
<td>14. <strong>Creating meaning [cognitive].</strong> Meanings that are harmful versus healing are discussed in detail with a focus on assumptions related to PTSD/SUD.</td>
</tr>
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(continued)
TABLE 7.1
Seeking Safety Topics (continued)

Table 7.1 continued...

Community resources [interpersonal]
A list of nonprofit resources is offered to help the client in his or her recovery.

Setting boundaries in relationships [interpersonal]
Clients explore ways to maintain healthy boundaries in their relationships. Domestic violence information is also provided.

Discovery [cognitive].
"Staying stuck" or cognitive rigidity is a common problem faced by PTSD/SUD patients. Discovery offers strategies to help clients stay open to new experiences and knowledge.

Getting others to support your recovery [interpersonal]
Clients are encouraged to identify people who are supportive, neutral, and destructive to their recovery. They are provided with strategies to seek help and family members may be invited to take part in the session.

Coping with triggers [behavioral].
A simple step method is provided to clients to help them fight triggers associated with PTSD and SUD.

Respecting your time [behavioral].
Clients are encouraged to address time management in various aspects of their lives.

Healthy relationships [interpersonal].
The contrasts between healthy and unhealthy relationship beliefs are explored and clients are guided to notice how PTSD and SUD lead to unhealthy relationships.

Self-nurturing [behavioral].
Safe and unsafe self-nurturing practices are explored to give clients an understanding of what constitutes a safe self-nurturing practice.

Healing from anger [interpersonal].
Topic deals with strategies to deal with anger as a part of recovery from PTSD and SUD.

Life choices game [combination].
Toward the end of the treatment, the clients review the treatment manual by playing a game. During the game, they are asked to pull from a box of slips of paper that list a challenging life event (e.g., your partner is having an affair). The clients respond by saying how they may cope with that situation using game rules that focus on coping.

Termination.
Clients discuss the end of the program—what they liked and what they disliked. They also finalize their aftercare plans.

NOTE: This table continues on the following pages.

TABLE 7.2
Seeking Safety Session Structure

Table 7.2 continued...

1. Check-in.
The goal of check-in is to find out how the client is doing (up to 5 minutes per patient). Clients report on five questions. Since the last session (a) How are you feeling?; (b) What good coping have you done?; (c) Talk about your substance use and any other unsafe behavior; (d) Did you complete your commitment?; and (e) Community resource update.

2. Quotation.
The quotation is a brief device to help emotionally engage clients in the session (up to 2 minutes). A client reads a quotation out loud. The clinician asks "What is the main idea in the quotation?" and links it to the topic of the session.

3. Relate the topic to clients’ lives.
The clinician and/or the client can choose any of the 25 topics (see Table 7.1) that feels most relevant. This is the heart of the session, with the goal of meaningfully connecting the topic to clients’ experiences (30–40 minutes). Clients look through the handouts for a few minutes, which may be accompanied by the clinician summarizing key points (especially for clients who are cognitively impaired). Clients are asked what they most relate to in the material and the rest of the time is devoted to addressing the topic in relation to specific and current examples from clients’ lives. As each topic represents a safe coping skill, intensive rehearsal of the skill is strongly emphasized.

4. Check-out.
The goal is to reinforce clients’ progress and give the clinician feedback (a few minutes per client). Clients answer two questions: (a) Name one thing you got out of today’s session (and any problems with it) and (b) What is your new commitment?

Reprinted with permission from Najavits (2006).

found to be extremely safe in its almost 20 years of use (Najavits, 2009; Najavits & Hien, 2013). There is also a strong case management component to refer clients to additional care.

Per Najavits (2002), the Seeking Safety session format helps to build structure and safety. It comprises the following elements.

The following are the key features of Seeking Safety, as described in Najavits (2009).

PRINCIPLES OF SEEKING SAFETY

- Flexible: Can be used in any setting; for any treatment length; any trauma type; any substance; any gender; and individual or group treatment.
Evidence based: The model thus far established as effective for co-occurring PTSD and substance abuse.

Present focused: Addresses current issues; does not delve into detailed exploration of the past; however, it can be concurrently used with models that do focus primarily on the past.

Integrated treatment: Addresses both substance abuse and trauma although it can be used to treat either one alone.

Teaches coping skills: To help build resilience and increase safety.

Can be combined with any other treatments: Can be used alone or in conjunction with other treatments the client is receiving; it also includes an intensive case management component to help clients engage in other treatment programs.

Targets four domains: Cognitive, interpersonal, behavioral, and case management: to help the “whole person.”

Simple engaging language: Avoids scientific jargon and long words. The goals are simple, emotionally compelling words: “safety,” “respect,” “honor,” “healing.”

Public health emphasis: Low cost to implement; can be used by any clinician, client, and program.

**EXAMPLE OF A TREATMENT COURSE**

To help illustrate how Seeking Safety can be used in practice, we describe how the model was used with Ron, the military member in the case example at the start of this chapter.

**The Treatment**

The primary goal of Seeking Safety is to encourage client safety by building coping skills in relation to both trauma and substance abuse. First, Ron said he did not want to attend therapy at all. He was encouraged to try a few sessions rather than commit to anything long-term. We discussed how Seeking Safety can address both his MST and alcohol problems, in contrast to prior treatments that addressed only alcohol. With a lot of encouragement and praise for his efforts, he was later engaged in Seeking Safety and attended 14 sessions over the 6 months.

The therapy helped Ron to make some positive changes in his lifestyle and behavior, although with some ups and downs along the way. With the topic *Taking Good Care of Yourself*, we focused on improving his nutrition, exercise, and routine medical and dental care. He came to see that he had let go of these out of disgust for his body after the MST incident. *Healthy Relationships* helped him to reconnect more with his family members and friends with whom he had lost touch. The topic *Honesty* helped him to talk more about the impact of the MST and launch him to read about other male survivors. Each session we worked helped him to apply coping skills to his day-to-day life.

One of the most important issues was his alcohol use disorder. We worked on having him link his drinking to his trauma distress, which he said was really helpful: “I never realized how far they were.” He was referred to a physician to discuss how to safely reduce his use (necessary when a patient has had chronic and severe alcohol dependence, with daily use, such as Ron had had). We set weekly goals to try to reduce his use, yet without ultimatums or judgment, which typically drive a patient out of treatment. We explored how he perceived military culture as encouraging drinking—“That’s how you fit in, you had to drink them under the table; it’s just what we did.” He explored how to be strong and sociable without drinking and how to regain a sense of masculinity that was eroded due to the sexual assault: “It’s like now I decide how to live—not letting others decide it for me.” We also worked to build supports and, although he was never willing to attend AA meetings, he was willing to try SMART Recovery electronic meetings, where his identity would not be known and where he could focus on coping skills for alcohol problems. We worked on topics such as *Healing from Anger, Compassion, Creating Meaning*, and *Integrating the Split Self* to encourage him to work on the self-hatred that MST and alcohol had induced. We explored how, no matter how strong a soldier he was, he could not overpower his assailant. Ron said he liked Seeking Safety because it gave him specific guidance on how to move forward, and was very practical while also compassionate about his experiences. At the last session, he brought in a picture of himself at the start of his military career and talked about wanting to become “like that guy again—idealistic, taking on the world, but now also being aware of how some battles are within the self rather than on the outside.”
Section II  Treatments for Military Sexual Trauma

Chapter 7  Substance Abuse, MST, and the Seeking Safety Model

SEEKING SAFETY IN MST SURVIVORS: GUIDANCE FOR CLINICIANS

Seeking Safety has evidenced positive outcomes on both PTSD and SUD veterans, as well as other variables (Najavits & Hien, 2013). For example, a study of male veterans (Boden et al., 2014) found that Seeking Safety resulted in better drug-use outcomes such as increased treatment attendance, active coping, and client satisfaction when compared to treatment-as-usual. Also, a study by Desai, Harpaz-Rotem, Najavits, and Rosenheck (2008) found positive results for Seeking Safety with homeless women veterans. Seeking Safety was associated with several beneficial clinical outcomes in this population and there is evidence that the therapy could be delivered effectively by case managers with very little or no previous experience (Desai et al., 2008). A recent study at the Walter Reed National Military Medical Center found positive outcomes on numerous variables in a pilot study. Moreover, Seeking Safety has been widely adopted in Veterans Affairs (VA) and Department of Defense (DoD) settings, with strong satisfaction and widespread use. For example, it is used in the majority of VA hospitals (Kivlahan, personal communication, March 15, 2013; see also Cook, Walser, Kane, Hisek, & Woody, 2006; Najavits, Norman, Kosten, & Kivlahan, 2010; Norman, Wilkins, Tapert, Lang, & Najavits, 2010; Weller, 2005).

Several themes can help guide the use of Seeking Safety for military veterans by clinicians who choose to use the model for MST patients.

- Adaptation for MST populations
  Part of the flexibility of Seeking Safety is that it is highly adaptable to any client population with trauma and/or SUD (Bernhardt, 2009). For example, the title Seeking Strength can be used with active duty military who must go into harm’s way, and also can be useful generally with males as an alternate title (Najavits et al., 2009). It may also be useful to use the word “training” instead of “treatment” to make it more appealing in an active military setting (Najavits, 2009). In addition, examples that emphasize bonding similar to that in a military setting must be explored (e.g., bonding like warriors or teams).

- Difficulty with emotions
  Military and veteran clients may have difficulty expressing feelings during sessions as they may perceive it as a sign of weakness that goes against military training. Controlling emotions is a strong part of military training, and military culture generally discourages expression of vulnerable feelings. All of the Seeking Safety topics are designed to help clients express feelings while also letting them maintain healthy management of feelings to prevent unsafe behavior (Najavits et al., 2009).

- Challenges in treatment engagement
  A clinician’s report says that veterans appear to be more difficult to engage in treatment than other groups. For clients who may be resistant to the idea of treatment, ideas include letting them attend a few trial sessions to see if they like it, describing it as a “class” or “training” rather than treatment, and conducting it in fewer sessions (Najavits et al., 2009).

- PTSD as an entry point
  Some clinicians reported that offering PTSD treatment as a starting point worked well for veterans who refused substance abuse treatment (Norman et al., 2010). In Seeking Safety this is called “leverage one disorder to help the other”—engage clients to work on whichever disorder they are most motivated on, gradually helping them see the benefit of working on the other as well (Najavits, 2002).

- Reintegration into civilian life
  This is a key issue to be addressed among veterans (Norman et al., 2010). They may feel isolated and misunderstood after separation from the military, and coping skills that work in military settings may not work well in civilian settings (Najavits et al., 2009). Finding ways to help veterans connect with other veterans and focusing on reconnection with family can help ease the transition to civilian life (Norman et al., 2010).

- Seeking Safety as a gateway to other treatments
  The Case Management component of Seeking Safety helps engage clients in additional treatments of all kinds. Also, the first-stage, highly engaging nature of Seeking Safety can help clients build stabilization that helps them move into second-stage treatments such as exposure therapy for PTSD (Norman et al., 2010).

- Anger management
  Veterans are taught to channelize their anger into aggression while in service, making it difficult to change that pattern once they are back in civilian life (Najavits et al., 2009). The Seeking Safety topic Healing from Anger is directly relevant to coping with anger
Section II  Treatments for Military Sexual Trauma

problems, and they can be referred to anger management treatment as well if needed.

In 2012, a Seeking Safety group was started at the Joint Base Lewis-Chord in the state of Washington to offer help to sexually assaulted soldiers. It was called Trauma Recovery Group and soldiers were welcomed to share their traumatic experiences. The clients were allowed to wear civilian clothes to promote stronger trust, independent of military rank. Seeking Safety was a central component of the group. Each week, safe coping skills were taught using the Seeking Safety handouts, and the Seeking Safety format (e.g., check-in and check-out) encouraged soldiers to apply the coping skills in daily life. Soldiers referred by social workers and nurse case managers at the clinic could also refer themselves into the group. The biggest challenges to engage the soldiers in the group. It was observed that many soldiers had never talked openly about their MST. They often reported anxiety or dissociation during sex, fear of engaging in sex, and lack of assurance. Substances were sometimes used as a way to manage such feelings in the short term. They were encouraged to reduce substance use and to understand that sexuality problems may have been related to the MST. This helped to reduce their sense of shame, and some who needed additional treatment were referred to a sex therapist. The soldiers completed the treatment with greater hopefulness and garnered stronger support network to help them through their recovery from trauma and substance abuse. Although there was more work to be done, the soldiers learned that others shared a similar history and that recovery was possible.

CONCLUSION

SDD and SUD are often directly related to MST experiences. SUD is underrecognized and underreported (Weller, 2005), yet is crucial to address given its relatively high rates in military and veteran populations (Shach & Borsari, 2014; O’Brien & Sher, 2013). Co-occurrence of PTSD and SUD requires a careful treatment plan in which both disorders are addressed, but in ways that can stabilize rather than “open up” greater dissociation, especially in early recovery. Seeking Safety is the most evidence-based model for such work, and it offers a present-focused, coping-skills approach that has been found to be highly feasible and popular for military and veteran clients, besides evidencing positive outcomes. MST is one of the most common types of trauma for military and veterans, and early intervention is key to help encourage resiliency as quickly as possible and prevent a chronic course of both disorders. The Seeking Safety approach appears to converge well with military culture as it is highly structured, goal focused, and has gained strong satisfaction among racially and ethnically diverse populations as well as among both genders. It is a low-cost model that was designed for public-health relevance, which can be easily implemented across all levels of care. It can also be combined with any other model, including any other evidence-based SUD and/or PTSD models.

GOVERNMENT RESOURCES RELATED TO SUBSTANCE ABUSE TREATMENT

www.drugabuse.gov: “Related Topics” on the home page offers information on substance abuse in military life

www.kap.samhsa.gov: Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment (CSAT) provide various clinical publications to aid substance abuse treatment.


www.niaaa.nih.gov: The National Institute on Alcohol Abuse and Alcoholism

www.health.org: National Clearinghouse for Alcohol and Drug Information

www.nattc.org: Addiction Technology Transfer Centers

www.aa.org: Alcoholics Anonymous

www.smartrecovery.org: SMART Recovery (alternative to AA)

REFERENCES


