CHAPTER 6

Seeking Safety: An Implementation Guide[1]

LISA M. NAJAVITS

SEEKING SAFETY IS a widely used, evidence-based model (Najavits, 2007b). Originally designed for co-occurring posttraumatic stress disorder (PTSD) and substance use disorder, over time it has been applied to other populations as well. Its core goal is expressed in the title: to encourage clients to attain greater safety—to surmount the chaos and destruction so common in trauma and substance abuse.[2]

This chapter offers ideas on implementing the model—a sort of quick guide that can be used in conjunction with the actual manual. This chapter also addresses themes that have emerged since the publication of the manual in 2002. It has been inspiring to hear how the model has been used over the years by so many different people. Thus, this chapter is part of an ongoing dialogue that has enriched and deepened the work over time. Models of therapy are, in this sense, not static entities, but evolve in relation to clients, clinicians, and programs, with much new learning all around.

OVERVIEW OF SEEKING SAFETY

Seeking Safety was begun in the early 1990s. The manual was published in 2002, after a decade of development based on clinical experience, research, and

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1. Sincere thanks to all who have contacted me over the years to share their experiences and offer new ideas on how to apply Seeking Safety in different contexts. Also, my deep appreciation to several associates who have worked closely with me on training and consultation: Martha Schmitz, Ph.D.; Kay Johnson, LICSW; and Kevin Reeder, Ph.D.

2. *A note on terms.* For simplicity, "substance abuse" will be used throughout rather than "substance use disorder," although the model can be applied to clients with substance abuse or dependence, as well as other addictions. "Trauma" will be used rather than "PTSD" as the model is applied to traumatized populations broadly, not just to those who meet PTSD criteria.

clinician training. The title of the treatment—Seeking Safety—expresses its central idea: When a person has PTSD and/or substance use disorder (SUD), the most urgent clinical need is to establish safety. *Safety* is an umbrella term that signifies various elements: safety from substances; safety from dangerous relationships (including domestic violence and substance-using friends); and safety from extreme symptoms, such as suicidality and dissociation.

Many of these destructive behaviors reenact trauma—having been harmed through trauma, clients are now harming themselves or others. *Seeking safety* refers to helping clients free themselves from such negative behaviors and, in so doing, to move toward freeing themselves from trauma at a deep emotional level.

Seeking Safety is a cognitive behavioral therapy that can be used from the start of treatment. It can be conducted with males and females, in individual or group modality. It was designed to explore the link between trauma and substance abuse, but without delving into details of the past that could destabilize clients during early recovery. Its goal is a present-focused, empathic approach that "owns" and names the trauma experience, validates the connection to substance use, provides psychoeducation, and offers safe coping skills to manage the often overwhelming impulses and emotions of these co-occurring disorders. It is an integrated therapy that focuses equally on trauma and substance abuse, at the same time, from the start of treatment, but in a way that is designed to be as safe, supportive and containing as possible. The research supporting the effectiveness of Seeking Safety is summarized in Appendix A of this book.

The concept of safety is designed to protect the clinician as well as the client. By helping clients move toward safety, clinicians are protecting themselves from treatment that could move too fast without a solid foundation. Increased substance use and harm to self or others are of particular concern with this vulnerable population. Thus, seeking safety is both the clients' and clinicians' goal.

KEY POINTS ABOUT SEEKING SAFETY

Seeking Safety Has the Following Features:

- *Early-stage treatment:* designed to stabilize clients; can be used from the start of treatment.
- *Integrated treatment:* addresses trauma and substance abuse at the same time, although it can also be used for either one alone.
- *Teaches coping skills:* to help build resilience and increase safety.
- *Present-focused:* addresses current issues; does not delve into detailed exploration of the past; however, it can be used concurrently with models that do focus primarily on the past.

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- *Idealistic:* strives to build hope.
- *Evidence-based:* the only model thus far established as effective for co-occurring PTSD and substance use disorder.
- *Targets four domains:* cognitive, behavioral, interpersonal, and case management: to help the "whole person."
- *Offers 25 topics:* each topic provides a clinician guide and client handouts; the clinician can do as few or many topics as time allows, in any order.
- *Engaging:* uses quotations, creative exercises, poignant examples.
- *Flexible:* can be used in any setting; for any treatment length; any trauma type; any substance; both genders; and individual or group treatment.
- *Clinician-sensitive:* addresses the clinician role in detail, including self-care and countertransference.
- *Structured:* to use time well and to help clients feel comfortable.
- *Public health emphasis:* low cost to implement; and can be used by almost any clinician, client, and program.
- *User friendly:* organized, easy-to-follow format.
- *Compassionate tone:* honors what clients have survived; respects their strengths.
- *Practical:* focuses on rehearsal of new skills, psychoeducation, and specific tools to help clients move forward in recovery.
- *Relevant to different subgroups:* successfully used with adolescents, military, veterans, homeless, domestic violence, criminal justice, racially/ethnically diverse, mild traumatic brain injury, people who cannot read, and others.
- *Can be combined with any other treatment:* can be used alone or in combination with any other treatments the client is receiving; it also includes an intensive case management component to help clients engage in other treatments.
- *Simple, engaging language:* avoids scientific jargon and long words; the goal is simple, emotionally compelling words, such as "safety," "respect," "honor," and "healing."

See the *Seeking Safety Manual* (Najavits, 2002b) and the website www .seekingsafety.org for detailed background and description of the model.

SEEKING SAFETY TOPICS

There are twenty-five topics, each representing a *safe coping skill* relevant to both trauma and substance abuse (see Table 6.1). The topics address different domains: cognitive, behavioral, interpersonal, case management, or a combination:

Cognitive topics

PTSD: Taking Back Your Power; Compassion; When Substances Control You; Creating Meaning; Discovery; Integrating the Split Self; Recovery Thinking

Behavioral topics

Taking Good Care of Yourself; Commitment; Respecting Your Time, Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding)

Interpersonal topics

Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Healing from Anger; Community Resources

Case management

Introduction/Case Management

Combination

Safety; The Life Choices Game (Review); Termination

Table 6.1
Seeking Safety Treatment Topics

(1) Introduction to Treatment/Case Management
This topic covers: (a) Introduction to the treatment, (b) Getting to know the client, and (c) Assessment of case management needs.

(2) Safety [combination]
Safety is described as the first stage of healing from both PTSD and substance abuse and the key focus of the treatment. A list of over 80 Safe Coping Skills is provided and clients explore what safety means to them.

(3) PTSD: Taking Back Your Power [cognitive]
Four handouts are offered: (a) "What Is PTSD?" (b) "The Link Between PTSD and Substance Abuse" (c) "Using Compassion to Take Back Your Power" and (d) "Long-Term PTSD Problems." The goal is to provide information as well as a compassionate understanding of the disorder.

(4) Detaching from Emotional Pain (Grounding) [behavioral]
A powerful strategy, "grounding," is offered to help clients detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world away from negative feelings.

(5) When Substances Control You [cognitive]
Eight handouts are provided, which can be combined or used separately: (a) "Do You Have a Substance Abuse Problem?"; (b) "How Substance Abuse 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 Use"; (g) "Self-Help Groups"; and (h) "Substance Abuse and PTSD: Common Questions."

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(6) *Asking for Help [interpersonal]*
Both PTSD and substance abuse lead to problems in asking for help. This topic encourages clients to become aware of their need for help and provides guidance on how to obtain it.

(7) *Taking Good Care of Yourself [behavioral]*
Clients explore how well they take care of themselves using a questionnaire listing specific behaviors (e.g., "Do you get regular medical checkups?"). They are asked to take immediate action to improve at least one self-care problem.

(8) *Compassion [cognitive]*
This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of "beating oneself up," a common tendency for people with PTSD and substance abuse. Clients are taught that only a loving stance toward the self produces lasting change.

(9) *Red and Green Flags [behavioral]*
Clients explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of "red and green flags" (signs of danger and safety). A Safety Plan is developed to identify what to do in situations of mild, moderate, and severe relapse danger.

(10) *Honesty [interpersonal]*
Clients discuss the role of honesty in recovery and role-play specific situations. Related issues include the following: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn't accept honesty?

(11) *Recovery Thinking [cognitive]*
Thoughts associated with PTSD and substance abuse are contrasted with healthier "recovery thinking." Clients are guided to change their thinking using rethinking tools such as List Your Options, Create a New Story, Make a Decision, and Imagine. The power of rethinking is demonstrated through think-aloud exercises.

(12) *Integrating the Split Self [cognitive]*
Splitting is identified as a major psychic defense in both PTSD and substance abuse. Clients are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these.

(13) *Commitment [behavioral]*
The concept of keeping promises, both to self and others, is explored. Clients are offered creative strategies for keeping commitments, as well as the opportunity to identify feelings that can get in the way.

(14) *Creating Meaning [cognitive]*
Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as Deprivation Reasoning, Actions Speak Louder Than Words, and Time Warp. Meanings that are harmful versus healing in recovery are contrasted.

(15) *Community Resources [interpersonal]*
A lengthy list of national nonprofit resources is offered to aid clients' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help clients take a consumer approach in evaluating treatments.

(16) *Setting Boundaries in Relationships [interpersonal]*
Boundary problems are described as either too much closeness (difficulty saying "no" in relationships) or too much distance (difficulty saying "yes" in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided.

(continued)

Table 6.1

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(17) Discovery [cognitive]
Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called "staying stuck"). Discovery is a way to stay open to experience and new knowledge, using strategies such as Ask Others, Try It and See, Predict, and Act "As If." Suggestions for coping with negative feedback are provided.

(18) Getting Others to Support Your Recovery [interpersonal]
Clients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as a letter that they can give to others to promote understanding of PTSD and substance abuse. A safe family member or friend can be invited to attend the session.

(19) Coping with Triggers [behavioral]
Clients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change who you are with, what you are doing, and where you are (similar to "change people, places, and things" in AA).

(20) Respecting Your Time [behavioral]
Time is explored as a major resource in recovery. Clients may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues such as: Do you use your time well? Is recovery your highest priority? Balancing structure versus spontaneity, work versus play, and time alone versus in relationships are also addressed.

(21) Healthy Relationships [interpersonal]
Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief "Bad relationships are all I can get" is contrasted with the healthy belief "Creating good relationships is a skill to learn." Clients are guided to notice how PTSD and substance abuse can lead to unhealthy relationships.

(22) Self-Nurturing [behavioral]
Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other "cheap thrills"). Clients are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse.

(23) Healing from Anger [interpersonal]
Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered.

(24) The Life Choices Game (Review) [combination]
As part of termination, clients are invited to play a game as a way to review the material covered in the treatment. Clients pull from a box of slips of paper that list challenging life events (e.g., "You find out your partner is having an affair"). They respond with how they would cope using game rules that focus on constructive coping.

(25) Termination
Clients express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. An optional Termination Letter can be read aloud to clients to validate the work they have done.

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KEY POINTS ABOUT THE TOPICS

It is not necessary to conduct all twenty-five topics. Indeed, significant improvements have been found with clients who attended fewer than half of the twenty-five topics (Hien, Cohen, Miele, Litt, & Capstick, 2004; Najavits, Gallop, & Weiss, 2006; Najavits, Weiss, Shaw, & Muenz, 1998). Conduct as many topics as time allows. Even a few topics during a short stay can help clients improve coping skills and build awareness of trauma and substance abuse. Some programs conduct segments of four, eight, or twelve topics (or any other number); clients come to one segment and then decide if they want to continue to the next segment.

Topics can be conducted in any order. There is no right or wrong sequencing. The clinician may do them in the order listed in the manual or may select whatever feels most relevant at each session. For individual therapy, the client can choose a topic from the list (although many clients prefer the clinician to choose).

Each topic is independent of the others. This allows the treatment to be conducted in open groups if desired (clients can join at any time). It also means that if clients miss any topics, they can return at any point, as each topic stands on its own. These considerations are especially important for substance abuse treatment, where retaining clients is a challenge.

They are called "topics" rather than "sessions" because each topic can be done over several sessions. Indeed, clients often prefer that as it gives them more opportunity to absorb the material.

Each topic has multiple handouts. The idea is to explore whatever is most relevant to clients. Just like the topics themselves, handouts within each topic can be done in any order, using as few or as many as desired.

SESSION FORMAT

Seeking Safety sessions are structured to emphasize good use of time, appropriate containment, and setting goals and sticking to them. For clients with trauma and substance abuse, who are often impulsive and overwhelmed, the predictable session structure helps them know what to expect. It offers, in its process, a mirror of the focus and careful planning necessary for recovery.

Sessions are conducted with the following four parts (see Table 6.2):

1. *Check-in:* Brief questions to find out how clients are doing.
2. *Quotation:* A quotation is read aloud to emotionally engage clients in the session.
3. *Handouts:* Handouts are used to explore a new coping skill.
4. *Check-out:* Brief questions to reinforce clients' progress and close the session on a positive note.

Table 6.2
Session Format

1. CHECK-IN

The goal of the check-in is to find out how clients are 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) Describe 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 the 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 client select any of the 25 treatment topics (see Table 6.1) that feels most relevant. This is the heart of the session, with the goal of meaningfully connecting the topic to clients' experience (30–40 minutes). Clients look through the handout 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?

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KEY POINTS ABOUT THE FORMAT

The format serves many purposes. It keeps the treatment on track and uses time well. Clients consistently state that it helps them feel safe as they know what to expect. In group modality, it promotes boundaries and sharing of time, rather than letting any member overdominate the session. At a deeper level, the structure promotes processes to counteract the impulsivity, chaos, and disorganization of PTSD and SUD (i.e., pacing, planning, organization).

The same format is used for individual or group treatment. The structure works well in both individual and group modalities. Clients consistently say they like the structure and it quickly comes to feel natural to them.

For large groups, the format can be shortened. Some programs have very large groups of twenty to forty clients. For such large groups, you can reduce the check-in and check-out. You could ask just one or two questions with only a few clients responding. For example, at check-in: *"Can anyone name an example of good coping they did this week?" "Does anyone want to share if they had substance use or other unsafe behavior this week?"* For the check-out

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"Does anyone want to share one thing you got from today's session?" If possible, base the size of the group on how much time is available so clients can each go through the full check-in and check-out, but if you need to cut these down, you can. You can also model the check-in and check-out so clients see what level of detail you are looking for.

Try it. Some clinicians believe their clients won't like the format or may themselves feel uncomfortable with a structured session. Keep an open mind. Try it and learn from clients' responses to it.

CLIENT SELECTION

Seeking Safety was originally designed for PTSD and substance use disorder. Over time, it has been applied to a wider range of clients, such as those who could simply benefit from improved coping skills. In part, this is because many treatment programs focus less on formal diagnoses than on general treatments that many different clients can attend. Also, most of the Seeking Safety topics are broad enough to apply to issues beyond trauma and substance use (e.g., Asking for Help, Compassion, Honesty, Creating Meaning, and Taking Good Care of Yourself). Further, both clinical and research experience consistently evidence the model to be safe and thus it can be applied without concern for evoking adverse events (Killeen et al., 2008).

The outcome research on Seeking Safety has also broadened in scope over time. In early studies of the model, all clients met criteria for current PTSD and substance use disorder; later studies loosened these criteria to a wider range of clients and still found positive outcomes (e.g., Desai, Harpaz-Rotem, Rosenheck, & Najavits, 2008, 2009; Morrissey et al., 2005).

In sum, no specific client selection or readiness appear needed for Seeking Safety, other than the guidelines suggested below.

KEY POINTS ABOUT CLIENT SELECTION

Seeking Safety has been successfully used with many different types of clients, including the following:

- Racially/ethnically diverse
- Adolescent
- Seriously and persistently mentally ill (e.g., psychotic)
- Homeless
- Domestic violence
- Military and VA
- Illiterate
- Low cognitive functioning/mild traumatic brain injury

- Complex PTSD
- Criminal justice
- Multiple comorbidity
- Various addictions (gambling, food, internet, sex, pornography)
- Subthreshold PTSD and substance use disorder
- Personality disordered
- Active substance users
- Different settings (outpatient, residential, inpatient, community care, private practice, outreach)

The model is for both men and women. A common misunderstanding is that the model is only for women, based on early research that focused on women. However, by the time the model was finalized and published as a book (Najavits, 2002b), it explicitly targeted both genders. The book includes examples from both men and women as well as gender-neutral language. Four studies on Seeking Safety have been conducted on men, all with positive results. [An article summarizing the use of Seeking Safety with men is now available (Najavits, Schmitz, et al., in press)].

Be as inclusive as possible. It is recommended to invite anyone into the treatment who has an interest, and only remove someone who presents a clear danger to others or is otherwise not able to participate. For groups, clients who are appropriate for any group are appropriate for Seeking Safety—no additional requirements apply. The goal is to monitor clients over time and evaluate whether Seeking Safety is helpful to them, using the check-in and check-out, the End of Session Questionnaire, and the End of Treatment Questionnaire [see Chapter 2 in the Seeking Safety book (Najavits, 2002b) for more on this topic].

Encourage clients to apply the coping skills broadly. The skills can apply to many life problems beyond trauma and substance abuse. For example, Asking for Help may be relevant to finding a job or apartment, dieting, or resolving a relationship conflict.

Use the case management component of Seeking Safety to engage clients in additional treatments. For example, a client with pathological gambling could be referred to Gamblers Anonymous; a client with an eating disorder could be referred to an eating disorder program.

Tell clients to ignore the terms "PTSD" or "substance abuse" in the handouts if these do not apply. This has worked fine, without a need to alter the materials. Clients are guided to use what is relevant and ignore the rest. Also, some clinicians use the terms *trauma* and *trauma symptoms* rather than "PTSD," for simplicity.

Allow clients to try the treatment before committing to it ("Try before you buy") Encourage clients to participate in several sessions (or, for group treatment,

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even just sit in and observe), and then decide if they want to join. The key is to respect their decision and empower their choice. If they decide not to participate, it is important to honor that without judgment.

Clients can be at any stage of recovery. Some clients may still be actively using substances; others may have been abstinent for some period of time. They can learn from each other, just as in Alcoholics Anonymous, where participants are at all stages of the recovery process. (Of course, if clients show up for a session intoxicated, they should be sent home and encouraged to come to the next session sober.) Note, too, that motivation to cut down on substance use is not a requirement for participating in Seeking Safety—sometimes motivation is the result of the treatment, rather than present at the beginning. With regard to trauma as well, clients may be at any stage of the trauma recovery process. That being said, some programs have enough clients at different stages of recovery that they choose to create homogenous groups ("early recovery," etc.), which is also fine.

Clients do not need to be stabilized first. Seeking Safety can be used from the start of treatment. It was designed as a first-stage therapy to help create stabilization. Thus, do not assume that Seeking Safety will be "too much" unless it is tried first or there are other reasons for concern (e.g., a psychotic client who needs medication stabilization).

CLINICIAN SELECTION

Seeking Safety has been successfully conducted by a wide range of clinicians— including substance abuse and mental health counselors, social workers, psychologists, psychiatrists, bachelor's level counselors, case managers, nurses, clinical trainees, domestic violence advocates, school counselors, pastoral counselors, and paraprofessionals. We have never heard of adverse events in any setting. The model focuses on coping skills in the present, and thus is safe to use and easy to learn. Originally, various criteria were sought, such as a mental health degree and particular types of background, such as cognitive-behavioral therapy (CBT) or substance abuse. But over time it became clear that far more important than such professional characteristics were more subtle, subjective criteria. Clinicians who genuinely enjoy working with these clients—perhaps perceiving their work as a mission or calling—bring to the work a level of commitment that no credential per se can offer. Similarly, clinicians who are open to the value of a treatment manual, viewing it as a resource that can help improve the quality of the work, are able to make the best use of the material. Because there are no strict criteria for clinician selection, the treatment is usable in a wide range of settings. Many substance abuse programs, for example, do not have staff with advanced degrees or formal mental health training. Also, because the treatment focuses on stabilization rather than

trauma processing, it does not exceed the training, licensure, or ethical limits of most clinicians.

KEY POINTS ABOUT CLINICIAN SELECTION

Any clinician can conduct Seeking Safety. No specific degree or experience is required. This is not to minimize the importance of well-trained clinicians, nor to underestimate that this client population can be challenging. However, any clinician in any setting that is legitimately providing treatment to these clients can use Seeking Safety. There are no additional requirements, as there is no evidence to suggest the need for such.

Several clinician characteristics are helpful. The most important qualities are the desire to work with this client population; willingness to use a manual based treatment; and positive interpersonal characteristics such as empathy, respect, and being "real."

All clinicians need to recognize their limits. Some issues require experts in other areas. For example, bipolar disorder, eating disorders, psychotic disorders, and dissociative identity disorder typically require expert consultation for medications and other treatments. Thus, although any clinician can conduct Seeking Safety, other staff are typically needed as well. The Seeking Safety topic, Introduction/Case Management, offers detailed suggestions for this process. A second area of potential limitation is clinicians' own personal response to the work. If clinicians find that they are excessively triggered when conducting the treatment, have inability to set healthy boundaries, or express aggression or sadism toward clients, they need to step back to determine what personal work they need to do before they are safe to conduct therapy with this clientele.

Consider a try-out using the manual. This can help determine whether a clinician is a good match for the treatment. The clinician reads Chapters 1 and 2 of the Seeking Safety book (which provides background information), then selects one or two treatment topics to conduct with real clients. The clinician can thus get a feel for it without a huge time investment. Similarly, when hiring clinicians, the same procedure can be used, but the session could be audiotaped for a supervisor to listen to and perhaps rate using the Seeking Safety Adherence Scale (see below for more on that tool). For a more detailed description of the try-out process, see www.seekingsafety.org (section Articles, subsection Seeking Safety).

CLINICIAN TRAINING

There are many ways to learn Seeking Safety. Training can occur by simply reading the book, through onsite training, the Seeking Safety video training

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series, phone consultation, or some combination of these. See www.seeking
safety.org (section Training) for various options and a calendar of upcoming
trainings. There is also an article on training clinicians in Seeking Safety
(Najavits, 2000). The most helpful strategies emphasize direct experience of
the model.

When onsite training occurs, it typically ranges from one to two days and
covers the following topics:

- Background
- In-depth description of the model
- Clinical demonstration of a session
- Implementation ideas
- Experiential exercises (small-group conduct of a session; grounding
exercise; role-play of "tough cases," etc.).

The training can be adapted to focus on particular client populations (e.g.,
adolescents, military or veterans, prisoners, women or men, domestic vio-
lence). There is time for question and answer, and discussion is encouraged.
There is no limit on the number of people who can attend training. The
training is conducted by Lisa Najavits or an associate who is trained and
supervised by her; the list of associates can be found at www.seekingsafety.
org (section Training, then Training Calendar, "associates"). Others have
created their own training on the model, but we have no way to determine
their quality as only the associates provide her training, use her materials, and
are supervised by her.

Note, however, that training is not required for Seeking Safety at this point.
This is because the model is safe (see earlier in this chapter), it is not hard to
learn, and we strongly value a public health focus that puts few obstacles in
the way of implementation. Also, from a research perspective, there is no
evidence yet of what kind of training, if any, is essential. (This is actually true
of almost all models of psychotherapy.) However, some agencies like to
provide Seeking Safety training to help introduce the model to their staff, to
inspire confidence in using it, and to discuss specific implementation issues at
their site. Also, some people learn best through multimodal training rather
than simply reading the book. Thus, various training options are offered.
Similarly, certification in the model is offered, but is not required (i.e.,
verifying clinicians' competence in conducting the model).

KEY POINTS ABOUT TRAINING

Various types of training are available. These include video-based training,
onsite training, reading the manual, phone consultation, or some mix of

these. There is no one way, but many. See www.seekingsafety.org (section Training).

Cross-training can be helpful. If a clinician has no background in trauma or substance abuse, training in these can be sought as needed. Clinicians may also benefit from training in related areas such as domestic violence, gender-sensitive treatment, diversity training, or specific subpopulations such as adolescent treatment, military/VA, criminal justice, or others.

Training can be helpful but is not required. Training can help launch successful use of the model and provide information and engaging exercises to build familiarity with it. It is not required at this point because there is no evidence as yet that it needs to be. Future research will, hopefully, address this issue.

Certification can be helpful but is not required. Certification involves submitting audio- or videotapes of actual sessions and having them rated on the Seeking Safety Adherence Scale. It is sometimes done for research or agency purposes to verify that clinicians are conducting the model in a competent, helpful way, per the manual. However, certification is not required at this point until there is evidence that it is needed. If certification is desired, contact info@seekingsafety.org. Certification can be conducted by our team from a distance. A clinician audiotapes one or more sessions, which are then reviewed by one of our associates and rated on the Seeking Safety Adherence Scale. The clinician receives feedback over the phone and if desired can also receive the completed adherence scale. The goal of this certification process is to provide clinically useful feedback based on real sessions. Once clinicians achieve strong adherence, they can be identified as "certified." This typically takes from one to three tapes.

GETTING STARTED

The best way to get started is to . . . get started. Seeking Safety actually requires only a small amount of preparation. It is now recommended to simply read a small part of the book and then try it. This contrasts with advice in the book, which suggested reading the whole book first. We no longer recommend this as it is not needed and may be overwhelming on the front end given the book's length (400 pages). The key is to just "dive in."

It is equally important to keep an open mind. Clinicians sometimes hold beliefs such as, "My clients won't like some of the topics," "I don't know if this format will work," "What I currently do is good enough," and "A present-focused model can't possibly work as well as a past-focused model." The bottom line is to *learn from clients* what works and what doesn't. Rather than assuming anything at the start, try the manual as written and watch how clients respond. This is part of the empowerment philosophy—to hear their views rather than deciding for them. Thus far, clients are generally highly

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positive about the model. In sum, take an "agnostic" position—you don't have to believe it will work, but don't assume it won't either.

Finally, know that you can do this. Clinicians sometimes feel intimidated, especially if this is their first time using a manual, or if they have not specialized before in trauma or substance abuse. Sometimes they worry that they need to do it "just right" for it to work. Most find that it quickly feels comfortable and that there is a lot of room for flexibility. Indeed, in a multisite study on twenty-six clinicians' use of the model, the majority (60 percent) reported that it took them less than a month to feel comfortable with the model, and typically about three weeks (Brown et al., 2007). The majority of clients in that same study (n = 157) reported that it took them two weeks or fewer to feel comfortable with the model (Brown et al., 2007). Clinicians from many different theoretical orientations and backgrounds have used it successfully. Try it to discover your own point of view.

KEY POINTS ABOUT GETTING STARTED

You do not need a lot of preparation. The simplest way to start is by reading the first two chapters in the Seeking Safety book: Overview (Chapter 1) and Conducting the Treatment (Chapter 2). Then select one of the twenty-five treatment topics that appeals to you. Asking for Help is a good choice as it's the shortest one in the book. Conduct it with a client or group, or role-play it with a colleague, and see how it goes. You can then move on to additional topics one at a time.

Once you are familiar with one topic, the rest follow the same structure. The model was designed to be user-friendly. Each topic provides the clinician guide, followed by the client handouts. Below is a summary of each part.

a. *Clinician Guide:* The clinician guide offers ideas on how to use the session topic. They are 5 to 8 pages and formatted with headers and bold fonts for easy viewing. Each clinician guide has the following parts:
   - *Summary:* The gist of the topic
   - *Orientation:* Why the topic is important
   - *Countertransference issues:* To help notice reactions to clients
   - *Goals:* "Big picture" ideas to focus the session
   - *Ways to relate the material to clients' lives:* Strategies to help clients learn the skills
   - *Suggestions:* Clinical tips for implementation
   - *"Tough cases":* Challenging statements clients may say in relation to the topic
b. *Client Handouts:* Client handouts come after the clinician guide. They have the following parts:

- ○ *Quotation:* An inspiring quote to read aloud
- ○ *Handouts:* Several pages that relate to the topic; these may include key points; worksheets; coping strategies; exercises; etc.
- ○ *Ideas for a commitment:* Suggestions for homework

Copy all of the handouts for clients. Some topics have a lot of handouts, and there is not enough time to cover them fully in one session. Nonetheless, it is suggested to give a copy of all of the topic's handouts at the session. Clients can skim them during the session to focus on what matters to them, and they can read the full set of handouts between sessions.

Practice the skills in your own life. Although the topics are simple in concept, they are not easy to do. For example, many people, not just clients, struggle with Taking Good Care of Yourself, Asking for Help, and so on. Clinicians who use the skills in their own lives become better at teaching them to clients.

Elicit client feedback. This is a key principle. Client feedback builds your confidence as you see how they respond, and it offers an opportunity to correct problems. There are three major ways within the model to obtain client feedback:

a. The *check-out* at the end of each session
b. The *End-of-Session Questionnaire* (in Chapter 2 of the book)
c. The *End-of-Treatment Questionnaire* (in the last chapter of the book)

Obtain additional background, if desired. Some clinicians like to obtain information beyond the manual. This may include *formal training* in the model (see the section Training earlier in this chapter), *additional readings* (such as those listed at the end of this chapter), and *watching films* related to trauma or substance abuse (there is a list in the Reference section of the Seeking Safety book). These can all bring to life important background on trauma and substance abuse.

Learn the format first, then the content. This may seems backwards, but it works well. The content of the topics are intuitively understandable (Compassion; Healing from Anger; Coping with Triggers, etc.). However, the format may feel awkward until you try it for a few sessions.

IMPLEMENTATION

Although the model is very straightforward, some points about implementation are worth highlighting. These are based on use of the model in many different settings as well as learning from issues clinicians have raised.

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In addition to the points below, see: the manual itself (Najavits, 2002b) and several articles related to implementation listed in the Additional Reading section at the end of this chapter (especially Najavits, 2000, 2002a, 2004b, 2007b).

KEY POINTS ABOUT IMPLEMENTATION

Offer many coping skills, rather than "one right way." The model offers many coping skills. Clients can choose what works for them and let go of any that are not helpful. This empowerment approach respects the fact that there is no one right way to cope—what works for one person may not work for another. As long as it is *safe coping*, it is good coping. For example, when craving a substance, one client might call a friend for help. Another might go for a long walk alone until the craving decreases. These are very different ways of coping, but both represent *safe* coping.

Keep the room safe for all. Safety is a broad concept—and part of the work is helping clients experience the feeling of safety in the treatment itself. The clinician is thus ideally like a "good parent" within professional bounds—ensuring that clients do not scapegoat each other, using time well, calming clients who become too distressed, and maintaining a respectful stance. Moreover, because *Seeking Safety* focuses on trauma, the tone of the group may be different than typical substance abuse groups. Clients are encouraged to focus primarily on their own recovery, and to interact with each other using support and problem solving rather than confrontation. Thus, telling a client he is "too self-pitying" or "in denial" would be seen as detracting from the emotional safety of the group.

Identify trauma themes. Most substance abuse clients focus on their addiction because that is what caused the most obvious problems in their lives and is most noticeable to their families and others. They are typically referred to substance-abuse treatment programs, where trauma themes may not be prominent. Thus, the clinician needs to explicitly raise trauma themes so clients become more aware of them. For example: *"The hopelessness you are describing is very common in trauma survivors"; "I wonder if your difficulty taking care of yourself is related to your trauma"; "I hope you will learn to forgive yourself— you have lived through so much pain"; "Your strong startle reflex is common in people with PTSD."* Clients may not bring up trauma on their own even after they have learned about it (e.g., in the Seeking Safety topic, PTSD: Taking Back Your Power).

Find your own style. The flexibility in the model honors clinicians' own styles and preferences when conducting the work. Some clinicians move faster, some slower. Some like to use worksheets, some do not. Some bring in humor,

artistic exercises, or other personal touches. The model should feel like it brings out your best work, in ways that suit your personality.

Balance the coping skills and client issues. If the session focuses too much on coping skills, it can feel like school. If it focuses too much on client issues, it can become unfocused without productive movement. The goal is thus to balance between these—interweaving the coping skills and client issues.

Know that you cannot cover all of the material in one session. Many topics have lengthy handouts that cannot be covered all at once. It is fine to cover what you can and what is most relevant that day for clients.

Rehearse the "tough cases." For each topic, there is a list of "tough cases"—challenging statements clients may say in relation to the topic. On the topic Safety, for example, a client may say, "I don't want to stay safe. I want to die." It helps to brainstorm responses to such statements. For example, responses by the clinician might include the following:

"We need to take that very seriously. Do you feel in danger of hurting yourself?"

"I really hear your feelings of wanting to die. I also wonder whether there is another part of you that wants to survive?"

"People who suffer severe trauma sometimes think of suicide. Might your feelings relate to the trauma you went through?"

Teach clients that in any situation, good coping is possible. The basic philosophy of the treatment is that there is always a way to cope safely with any situation. This is not to say that there are easy answers or that good coping is simple. Clients' situations are often complex. But the idea is to keep returning to the idea that good coping is possible—for example, no substances or harm to self or others.

Encourage "headlines, not details." In Seeking Safety, clients are guided to name their traumas (if they choose to) and to explore how these play a role in the present. Discussing trauma is encouraged, as long as it does not move into detailed descriptions of trauma. "Headlines, not details" is a phrase to remember this principle.

Learn ways to redirect and contain. To move through the session, the clinician sometimes needs to interrupt or stop a client. For example, a client who exceeds the time limit during check-in may need guidance. You might say, *"Let me ask you to stop there; I want to make sure everyone gets a chance to check in"*; or, *"I know there's a lot more to that, but please go to the next question. We can return to more details later."* You can also create procedures to keep the session on track. For example, one Native American program had a "talking stick" that was passed to each client during check-in, while another client kept track of the time.

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Watch for power dynamics. Many trauma and substance-abuse clients are vulnerable to power dynamics issues. They typically have experienced abuse of power and may have strong reactions to power and control. This includes being overly passive or overly dominant, scapegoating, projecting power issues onto the clinician or group, and reenactments (e.g., roles of victim, perpetrator, bystander, rescuer). It is helpful to watch how power is used in the room and to strive for an empowerment approach—for example, invite, create choices, and ask permission. How the clinician uses power will be closely observed by clients. They are often highly sensitive to issues of fairness, rules, sharing of time, and other implicit power messages. However, just as important as empowerment is not letting clients take over in unhealthy ways—not allowing yourself or others to be mistreated during the session.

Use alternate methods if a client cannot read. The model has been conducted successfully with clients who are illiterate or who have impaired cognitive functioning or mild traumatic brain injury. The concepts are easy to understand: for example, "compassion" and "taking good care of yourself." You can summarize key points for the client and discuss them out loud. If conducting a group, clients who are able can read small sections out loud to help those who cannot read. There is also a complete version of the book now available for the blind and dyslexic (www.rfbd.org).

Give honest feedback. Clients need more than support and validation. They also need honest critical feedback at times. For example, the substance-abuse client who decides to get a job at a bar needs to hear that this is not a good plan. Being able to identify honest strengths and weaknesses helps clients feel that you really see what is going on and want to help them fully.

Understand that working on the present does not mean avoiding the past. There is sometimes an assumption that because Seeking Safety focuses on the present, it is encouraging avoidance of the past. This is not true. Clients are encouraged to name their traumas as part of Seeking Safety and to discuss how they impact them. They are simply asked not to explore lengthy and graphic details about the past, as the primary focus is present-day coping skills. Seeking Safety can, moreover, be used with any past-focused therapy when clients are ready for that (e.g., exposure therapy or eye movement desensitization and reprocessing). Indeed, two studies have used a combination of Seeking Safety and a past-focused model (Najavits et al., 2005; Brown, in preparation). Seeking Safety can help clients better tolerate past-focused models.

Understand that present-focused therapy is not "less than" past-focused. Studies that have directly compared present- versus past-focused PTSD approaches have found both to produce positive outcomes, without significant differences between them (e.g., Marks, Lovell, Noshirvani, Livanou, & Thrasher,

1998; Najavits, 2007a; Schnurr et al., 2003), except for one study, which found a small effect size difference (Schnurr et al., 2007). Thus, past-focused treatment is not the "real" or better treatment at this point. More research is needed to better understand when and under what conditions present- and past-focused PTSD methods are needed, for substance-abuse clients and others. See Coffey, Dansky, and Brady (2002); Coffey, Schumacher, Brimo, and Brady (2005); and Najavits et al. (2005) for more on this issue.

Discuss and rehearse the skills. Clients will readily discuss a skill when given handouts. However, they will not typically move into rehearsal of the skill and thus need guidance from the clinician on that. For example, if the topic is Healing from Anger, clients will easily offer their reactions and comments. But it is up to the clinician to also encourage them to actively rehearse new approaches to anger, such as role-playing staying calm during a confrontation; or doing a think-aloud to coach oneself down from anger. As John Dewey famously said, to "learn by doing" is the most powerful method of growth (1983).

Ask the "big ticket" question: How did you try to cope? The essence of the model is to develop safe coping skills. Thus, a core question is how clients coped with recent situations (e.g., triggers, tough times, negative feelings, challenges). Early in treatment, clients often give answers such as, "I don't cope—I just drift along" or "What is coping?" As they move through the treatment and acquire greater awareness of coping, they will usually provide better answers (e.g., "I tried grounding and talking to my sponsor.") Throughout, encourage clients to notice how they tried to cope (or not), how successful it was, and how they can improve their coping.

Try different ways of rehearsing the skills. Frequent rehearsal of coping skills helps clients use them when new situations arise. There are many different methods, including the following:

- *Do a "walk-through"*: Clients identify a situation where the safe coping skill might help, then describe how they would use it. For example, in the topic Asking for Help: *"If you felt like using, whom could you call? What would you say?"*
- *In-session experiential exercise:* The clinician guides clients through an experience rather than simply talking about it. For example, the skill of grounding is demonstrated in a 10-minute exercise during the session.
- *Role-play:* The client tries out a new way of relating to another person by practicing out loud. This is one of the most popular methods for interpersonal topics.
- *Identify role models:* Clients think of someone who already knows the skill and explore what that person does. For the topic Commitment: *"Do you know anyone who follows through on promises?"*

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- *Say aloud:* Clients practice a new style of self-talk out loud. For example, on the topic Compassion, *"When you got fired from your job this week, how could you have talked to yourself compassionately?"*
- *Process perceived obstacles:* Clients anticipate what might happen if they try to implement the skill. For example, in Setting Boundaries in Relationships, *"What might your partner say if you requested safe sex?"*
- *Involve safe family/friends:* Clients are encouraged to enlist help from safe people, as in the topic Getting Others to Support Your Recovery.
- *Replay the scene:* Clients identify something that went wrong and then go through it again as if they could relive it. For example, *"What would you do differently this time?"* A Safe Coping Sheet is designed for this process or it can be done more informally.
- *Discussion questions:* For every topic, ideas to generate discussion are offered.
- *Make a tape:* Create an audiotape for clients to use outside of sessions as a way to literally "change old tapes." For the topic Compassion, for example, kind, encouraging statements can be recorded.
- *Review key points:* Clients summarize the main points of the handout that are meaningful to them.
- *Question/Answer:* The clinician asks questions about the topic, for example *"Does anyone know what the letters 'PTSD' stand for?"*

Educate all staff. It is helpful to get everyone "on the same page," even if only some will conduct Seeking Safety. This builds a common language and philosophy, and enhances cohesiveness of the program. Staff education about the model can be done as an in-service, during a regular staff meeting, or as a more formal training. There are also some topics that all staff can learn, such as Detaching from Emotional Pain (Grounding), Safety, and PTSD: Taking Back Your Power. In the trauma field, the concept of trauma-informed treatment also fits this framework—all staff learn the importance of trauma, such as what it is, how common it is, and how it presents in clients' behavior (Fallot & Harris, 2001).

Find a kind way to steer away from overly intense details. Clients will sometimes delve into too much detail about trauma or substance abuse—"war stories" or lengthy narratives. A client may say, "This topic, Coping with Triggers, reminds me of all the horrible body parts I saw in Iraq—I remember coming into a dark town we thought was abandoned, and I stepped on a human leg covered in blood, and there was all this pus oozing, and when I looked to my left I saw. . . . " At this point, the client is describing graphic details that are not necessary for the coping skills work. Thus, validate, but redirect back to the present. For example, *"Mark, I'm going to stop you there. What you're talking about is very important. But let's explore how this relates to the present.*

Our goal is to work on the current impact of trauma and substance abuse." As long as this is done in a compassionate way, clients accept the redirection, and it keeps the session safe for all.

Choose session length and pacing to fit your setting. Sessions can be held weekly, twice weekly, or any other frequency. The length can be 1 hour, 1.5 hours, or any other length. For example, in a jail or inpatient setting where clients leave quickly, some clinicians hold sessions every day so clients can get as much as possible. Do whatever works best in your clinical context.

If time is limited, select key topics. At this point, there is no research to identify which topics are most or least important. However, some suggested ones are: Safety, Detaching from Emotional Pain (Grounding), Asking for Help, Honesty, Taking Good Care of Yourself, Compassion, Recovery Thinking, Red and Green Flags, and Healing from Anger. Also, depending on the client, PTSD: Taking Back Your Power or When Substances Control You may also be priorities. In general, choose topics that clients are not receiving elsewhere. For example, Coping with Triggers can be helpful, but if the client has a lot of other substance-abuse programming, triggers may be covered elsewhere in treatment.

Use a triage approach for deciding what to work on. Clients will come to the session with numerous problems. As you listen during check-in, identify those you may want to return to. Often those will be the most dangerous behaviors, such as substance use and self-harm. However, strive to balance time so that higher-functioning clients get their needs met, too.

Relate process issues to trauma and substance abuse. Some of the most challenging scenarios relate to processes in the session, rather than the overt content. Examples include clients who reject all suggestions, who harshly confront other group members, or who keep failing to do commitments or to keep appointment times. It is helpful to address these behaviors, but in a "face saving" way that is related back to trauma and substance abuse. For example, a client who rejects all suggestions could be told, *"It sounds like you don't like any of our ideas. Many people with trauma and substance abuse feel hopeless about the future—do you think you are feeling hopeless right now?"* The goal is to help clients see how they are coming across, in a compassionate way.

Attend to your experiences. Observe closely what arises as you do the work. This may include the impact of your own experience of trauma and substance abuse, countertransference, self-care issues, and secondary traumatization. (The latter refers to developing trauma symptoms when exposed to traumatized clients.) Also important are negative processes such as neglect, sadism, power struggles, inability to hold clients accountable, and becoming victim to clients' abusiveness. In sum, you are a crucial part of the treatment, one who helps bring it to life. Notice both the gratifications and difficulties that arise

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Interestingly, research indicates that clinicians who treat trauma and substance abuse clients feel more gratification than difficulty with the work (Najavits, Norman, Kosten, Kivlahan, in preparation; Najavits, 2002a).

Note several points about group treatment:

- *Leadership:* Groups can be singly or co-led; either way is fine.
- *Name:* Use a name that will be appealing, such as Seeking Safety Group or Coping Skills Group rather than Trauma Group.
- *Group size:* The size can vary based on your program. Some run small groups of three to eight clients; some run medium-sized groups (nine to fifteen clients) and others run large groups (sixteen or more). Depending on group size and length of the session, you may have to cut down the check-in and check-out (see The Seeking Safety Format earlier in this chapter).
- *Group rules:* Do not review group rules at each session. It is unnecessary for Seeking Safety, and it can alienate clients and reinforce a "one-up" power dynamic. The goal is to create a welcoming, supportive tone. If a problem arises, remind clients of the rules at that point (see the Treatment Agreement in the topic Introduction/Case Management).
- *Contact outside of sessions:* There is no rule about whether clients can have contact outside of sessions—some programs encourage it, some are neutral, and others discourage it.
- *Mixed-gender groups:* Seeking Safety can be done successfully in mixed-gender format. Sometimes this is necessary in settings where there are few of one gender. Make sure all clients know that it will be mixed gender and that they can choose whether to join. If possible, encourage them to try a few sessions before they decide. Also, avoid putting clients with major current perpetration issues in with victims of such perpetration (e.g., sexual abusers with sexual abuse survivors). Note, too, that mixed-gender groups can be very positive for some clients. One female VA client, who had survived military sexual trauma, said that her mixed-gender group helped her develop a more balanced view of men. Their emotional support helped her go beyond seeing them all as predators (Najavits, Schmitz et al., in press).

Consider ways to help clients decrease substance use. Seeking Safety provides various options for reducing use, in keeping with current research and understanding about addiction. These include *abstinence* (clients give up all substances forever), *harm reduction* (decreasing use, usually with a goal of ultimate abstinence), or *controlled use* (decreasing use, with a goal of still being able to use in the future at safe levels). The choice will depend on the philosophy of you and your program, the client's needs, and other factors. An abstinence

approach is the most common, but alternative approaches may occur when clients are less severe, are in outpatient care, or when the client is unwilling to engage in abstinence. See the topic When Substances Control You.

If desired, you can be listed as a Seeking Safety provider. If you or your program provides Seeking Safety, you can be listed on the Seeking Safety website. Send an email to info@seekingsafety.org and include specific information: your name, phone, and/or email; whether you provide group or individual Seeking Safety; and any other details you would like to include. Providers listed on the website are not screened for quality; it is simply a resource for those who are trying to locate a Seeking Safety clinician.

Try rating yourself or others on the Seeking Safety Adherence Scale. The scale can be downloaded from www.seekingsafety.org (section Assessment). There is both a brief and a long version. They provide a way to evaluate whether a clinician is "in sync" with the model.

ADAPTATION

Learn from Clients

Some clinicians read the book and say, *"My clients won't like some of these topics," "They won't understand the language," "They won't like the format," "I'd like to change the materials,"* and *"My clients need the materials adapted to their culture."* It is strongly encouraged, however, to try the model as is and *only adapt it based on clients' consistent feedback.* Use the "End of Session Questionnaire" (in Chapter 2 of the Seeking Safety book) and the "End of Treatment Questionnaire" (in the topic Termination). If clients consistently provide criticism or suggestions based on these questionnaires, then adapt accordingly. Thus far, the model has been successfully used as is with many different clients. The principle, therefore, is to base adaptation on client responses rather than on preexisting assumptions.

There Are Two Kinds of Adaptation: Within the Model and Outside the Model

"Within the model" means making use of the flexibility that is part of Seeking Safety. Adaptations within the model include varying the session length, pacing, and number of sessions; using examples relevant to your clients; conducting topics and handouts in any order; using group or individual format; going as slow or fast as needed; adding in artwork, games, and other creative exercises; and using it with any other necessary treatments. Adapting "outside the model" means making changes that are not part of it—such as spending the entire session discussing the quotation; changing the check-in

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and check-out questions; and not giving handouts at all. The bottom line is that the treatment usually goes well by adapting within the model. Adaptations outside the model should generally be done carefully, based on clients' feedback.

EXAMPLES OF ADAPTATION

Below are some examples of adaptations for different types of clients.

Adaptations for Adolescents Seeking Safety has been used with both male and female adolescents. Thus far, it is the only model for trauma and substance abuse that has shown positive outcomes with adolescents (Hamilton, Vargo, & Najavits, 2006; Najavits et al., 2006). There is no separate version for adolescents, as it has worked as is with them. However, it is helpful to apply it in ways that are appropriate for that age group. This includes the following:

- Use relevant examples, such as school, parents, dating, sports.
- Create fun, engaging exercises:
  - Encourage artwork. For example, the handout "Climbing Mount Recovery" (page 155 of the manual) could be done as a collage, painting, or mural.
  - Try the Seeking Safety card deck and poster (see Implementation Materials earlier in this chapter).
  - Develop a scavenger hunt to collect new coping skills.
- Have sessions with the adolescent's parents, using the topic Getting Others to Support Your Recovery.
- Communicate with the school guidance counselor, teachers, doctors, or others as may be helpful, using the topic Case Management.
- Explore the Seeking Safety topics out loud if an adolescent resists or has difficulty reading the handouts.

Adaptations Based on Gender Seeking Safety was designed for both men and women. There is sometimes a perception that the model is for females, given that much of the research has been conducted on women. However, both research and clinical experience support its use with both genders (Hamilton et al., under review; Najavits, 2007; Najavits, Liese, & Heath, 2005; Najavits, Schmitz et al., in press; Weaver, Trafton, Walser, & Kimerling, 2007). The published manual uses gender-neutral language and examples from both genders, as it was intended for both. It can also be conducted in mixed-gender groups (see the earlier section Implementation for more on that topic). Thus far, there are no particular aspects that are less useful with one gender than

another. Yet, sensitivity to gender is important. Gender-based adaptations include the following.

- Read books and other resources on gender-based psychology (psychology of men and women), especially in relation to trauma and substance abuse.
- Explore how trauma and substance abuse may violate gender roles. For example, men who survive interpersonal violence may feel less manly, strong, and in control. Women substance abusers may feel devalued with stereotypes of "bad mother," "lush," and "loose."
- Identify gender patterns. For example, females are more often the victims of sexual assault; males more often experience combat and crime (Najavits, Weiss, & Shaw, 1997). Males and females may differ in relationship problems (e.g., females more often engaging in unsafe relationships; males more often isolating).
- Read the chapter on use of Seeking Safety with men (Najavits, Schmitz, et al., in press) and also research reports on its use with women and men (see www.seekingsafety.org, section Outcomes).
- Recognize that many aspects of the work transcend gender—for example, developing a recovery identity, reducing symptoms of trauma and substance abuse, and attaining safety.

Adaptations for Military/Veterans Seeking Safety has been used in the VA since the mid-1990s and is currently implemented in numerous VAs around the country, as well as in active duty military settings. With increasing numbers of returning veterans, there is a now a strong focus on this population. Examples of adaptations include the following.

- Consider the name *Seeking Strength*. Military personnel must go into harm's way, and thus the term *Seeking Safety* may be inaccurate for them. Most military are men, and the term *strength* may be more appealing than "safety." (For others, however, this might imply that they are weak—thus be sensitive to whatever term they prefer.) Also, note that the manual remains the same even if an alternate title is used; there is no separate version.
- In active duty military settings, consider naming the group "training" rather than "treatment," as the latter may be stigmatized.
- Use examples that emphasize the bonding that occurs in military settings (e.g., bonding like warriors or teams).
- Address prominent concerns for military and veterans: difficulty with feelings (which are often devalued or "trained out" in military contexts), issues with perpetration of violence (feeling "like a monster"); betrayal

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such as when they are not supported on their return; difficulty readjusting to civilian life; and issues with authority and control. Women in the military also have major challenges such as high rates of military sexual trauma, being vastly outnumbered by men, and trying to function in a highly male-oriented culture.

- Understand how trauma and substance abuse may occur in the military. Traumas typical in military settings include military sexual trauma, handling bodies or body parts, watching buddies die, and traumatic brain injury. Substance abuse may be either encouraged (as in the Vietnam era) or discouraged (as in the current era).

Adaptations Based on Ethnic and Racial Diversity   The Seeking Safety book includes examples and language reflective of diverse experiences. Thus far, it has obtained high client satisfaction and positive outcomes with minorities. Rates of diversity in published trials include 100 percent minority in Hamilton et al. (under review); 77 percent minority in Hien et al. (Hien et al., 2004), 65 percent minority in Desai et al. (2008); 61 percent minority in Gatz et al. (2007); 35 percent minority in Zlotnick, Najavits, & Rohsenow (2003); and 21 percent minority in Najavits et al. (1998). Examples of adaptations for diverse populations include the following.

- Explicitly discuss racism, poverty, cultural messages, and intergenerational legacies of trauma and substance abuse. For example, a clinician might ask, "What cultural or family messages did you learn about trauma? Some people hear, 'You must have caused it' or 'Stop complaining.' Substance abuse messages might include, 'It's normal to drink a lot,' 'Our family doesn't have problems,' or 'Live for today—don't worry about tomorrow.'"
- Provide cultural context (e.g., for Latinos, concepts such as *familismo* and *marianismo* and acculturation stress).
- Explore the meanings of trauma and substance abuse within cultural frameworks (e.g., trauma may be so pervasive that it is perceived as a norm; substance abuse may involve culturally specific rituals and meanings).
- Offer extra readings that relate to particular subgroups.
- Use Seeking Safety translations, such as the Spanish version and other languages as described in the appendix to this chapter (Implementation Materials).

General Adaptations   The ideas below were suggested by clinicians all over the country. They are applicable to many different clients and highlight the creativity that can occur in the work.

- A "grounding table" at the back of the treatment room with various small objects and soothing materials. If clients become upset during a session, they are encouraged to use the grounding table to help calm down, while the rest of the group continues.
- Holiday-themed cutouts listing clients' commitments, such as sham rocks for St. Patrick's Day and hearts for Valentine's Day.
- Each of the safe coping skills drawn as artwork and posted on the wall.
- Creating collages using pictures cut out from magazines to illustrate any of the Seeking Safety topics.
- An orientation group to present key Seeking Safety topics in psycho educational format; this allows the clinician and clients to see if it feels like a good fit.
- An alumni group conducted on a drop-in basis so that clients can return for support as needed.
- Letting clients go through Seeking Safety a second time, if desired.
- Games and experiential exercises. One clinician set up an empty-chair exercise for the topic Integrating the Split Self. The client was encouraged to "speak to another side of you, to offer support and guidance."
- Adding additional materials, such as information on the biology of trauma and substance abuse, and new resources.

ASSESSMENT

Assessment of trauma, PTSD, and substance abuse is a major area in its own right. For a detailed exposition on assessment considerations with these co-occurring disorders, see www.seekingsafety.org (section Assessment). This section of the website provides a book chapter on this important topic (Najavits, 2004a), as well as links to the Seeking Safety Adherence Scales and some other measures.

SUMMARY

It is hoped that this chapter has offered useful ideas for implementing Seeking Safety. We have covered topics such as a basic description of the model, its evidence base, implementation, and how to get started. In addition to providing practical information, the goal has been to encourage comfort with the work and gratification in conducting it. If you would like to communicate about your use of the model, please email info@seekingsafety.org at any time.

RESOURCES

WEB-BASED RESOURCE

Seeking Safety: www.seekingsafety.org

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IMPLEMENTATION MATERIALS

Various materials are available to help with implementation of Seeking Safety. Some materials are free; others have a cost. Each is described below and is available from www.seekingsafety.org (section Order). The only required implementation material is the book itself. The optional materials offer ways to enhance implementation, many of which were suggested by clinicians over the years.

1. *The Seeking Safety book:* Also known as the Seeking Safety manual, this is the essential implementation guide (Najavits, 2002b). It has both the clinician guide and client handouts, as well as background chapters.
2. *Foreign language translations:* The complete Seeking Safety book is available in Spanish, French, and German; the handouts are available in Swedish. Translations of the complete book are currently under way in Dutch, Chinese, and Polish.
3. *Version for the blind:* The manual is available in recorded format to qualified individuals at Recordings for the Blind and Dyslexic (www .rfbd.org). It is 22 hours long.
4. *Training videos/DVDs:* The Seeking Safety training videos were developed on a grant from the National Institute on Drug Abuse. They offer an efficient method of training for programs that cannot offer onsite training or that need to retrain clinicians due to staff turnover. All of the videos are available in either video (VHS) format or DVD format and can be obtained as a set or separately. The training videos are as follows. Other training options are described earlier in the chapter (Clinician Training).

Video 1: Seeking Safety.

This is a 2-hour training video in which Lisa Najavits presents a 2-hour version of her standard training on the model. It also includes clips from real clinicians and clients who have used the model. Notes appear on-screen with the lecture, like a live lecture with PowerPoint slides. The video covers background on trauma and substance abuse, an overview of Seeking Safety, and ideas for implementation.

Video 2: Therapy Session: Asking for Help

This is a 1-hour video of Lisa Najavits conducting a group Seeking Safety session with real clients, unscripted, using the topic Asking for Help from the manual. The clients are women with severe PTSD and substance abuse, although the video is relevant for both genders and any setting. The video opens with brief background about the clients in their own words. Throughout, notes appear at the bottom of the screen to highlight teaching points, such as parts of the format as they occur and why specific interventions were chosen.

Video 3: A Client's Story [part 1]

This is a 20-minute video in which a man describes his experiences of childhood sexual abuse and addiction and his recovery process. Males with childhood abuse and addiction remain an underidentified group and this client's honesty helps bring these issues into the open.

Example of Teaching Grounding to a Client [part 2]

This 16-minute video shows Lisa Najavits teaching the skill of grounding to a real client. The client is a man in a correctional setting who had never heard of grounding prior to this video. Lisa reads the grounding script from the Seeking Safety manual and obtains the client's feedback, unscripted.

Video 4: Adherence Rating Session: Healthy Relationships

This 1-hour video shows a social worker conducting a group session with real clients, using the topic Healthy Relationships from the manual. The session illustrates both good and poor elements and serves as the basis for using the Seeking Safety Adherence Scale. Viewers can compare their rating of the session on the Seeking Safety Adherence Scale to the expert rating (which can be downloaded free from www.seekingsafety.org, section Order). This learning exercise is relevant for clinical or research purposes, including interrater reliability estimation.

5. *Poster of the Safe Coping Skills:* The topic Safety in the manual has a list of eighty-four safe coping skills. Examples are "Inspire yourself," "Talk yourself through it," "Persist," "Get organized," "Seek understanding, not blame," and "Leave a bad scene." A poster of the complete list of safe coping skills is available in English or Spanish. It is full color, 24 by 30 inches, professionally produced, with a calming nature scene background.

6. *Seeking Safety card deck:* This deck has 112 cards: all 84 safe coping skills from the Seeking Safety manual, all 24 quotations from the manual, and 3 exercises. The cards can be used as a game or to help remember key points from the manual. An ideas card suggests ways to play games, for groups or individuals. Each card is color-coded (peach = relationship skills, blue = action skills, purple = quotations, etc.). The cards offer a fun way to learn and practice the ideas from Seeking Safety, for both adults and adolescents.

7. *Adherence Scale:* This scale provides a way to rate whether clinicians are using the model per the book. It is also known as a fidelity scale. There are two versions of the Adherence Scale, both available free at www.seekingsafety.org (section Assessment). All the scales below can be filled out either by clinicians themselves as self-ratings to help

monitor their own work, or by someone else such as a supervisor or observer.

a. *The Seeking Safety Adherence Scale—Brief Version:* This version is one page and designed for clinical use for those who want a brief way to assess adherence (Najavits, Liese, & Heath, 2007). It has two sections: interventions and processes. Examples of items are: "The facilitator did a check-in at the start of the session and worked to keep it brief (up to 5 minutes per person)" and "The facilitator focused the discussion on safe coping skills." All items are rated 0 to 3 ("not done" to "done thoroughly"). This scale has not yet undergone psychometric evaluation.

b. *The Seeking Safety Adherence Scale:* This version is thirteen pages and was originally designed for research (Najavits & Liese, 2000). It can also be used for clinical or supervisory purposes. It has three sections: format, content, and process. Examples of questions are, "Handouts" (a format item); "Focus on trauma/PTSD" (a content question); and "Level of engagement" (a process item). Each item is rated for two qualities: adherence (how much the clinician did the behavior) and helpfulness (the impact of the behavior). Scaling is from 0 to 3 and includes anchors for each item. A separate score sheet is also available for the rater to list scores and related notes. The scale has shown solid psychometric characteristics in a major multisite trial, using ratings of 257 Seeking Safety sessions (e.g., internal consistency at .82) (Miele et al., submitted).

c. In addition to the above scales, a one-page *Format Checklist* is available (Najavits, 2003). It was developed early on to rate clinicians' use of the Seeking Safety format. It can still be used for this purpose, or the Adherence scales described above could also be used.

8. *Articles:* A large number of articles can be downloaded for free from www.seekingsafety.org (sections Outcomes and Articles). These include scientific studies of the model, descriptive articles about the model, and articles on PTSD and substance abuse.

9. *Website:* The website www.seekingsafety.org has the following sections: Seeking Safety; Outcomes; Articles; Training; Frequently Asked Questions; Assessment; Order, and Contact.

Key Points about Implementation Materials   The only required material is the book. The book provides the clinician guide and client handouts for each topic.

The optional materials can enliven the work or address needs beyond the book. For example, the poster and card deck offer colorful, fun ways to convey the safe coping skills. The videos offer a simple way to train new staff, which can be

especially important in programs where there is staff turnover. The Adher
ence Scale can help keep the work on track.

For information on any materials, see www.seekingsafety.org. Some are
available only from the website. This includes most translations of the Seeking
Safety book, the Adherence Scale, training videos, poster, and card deck.

You can suggest further implementation materials. New ideas are wel
come. E-mail info@seekingsafety.org.

Use of the Materials

Questions such as the following sometimes arise about how Seeking Safety
materials can be used or adapted:

- Copying the handouts
- Creating new versions
- Translating the book
- Use of the materials for research

The book and all Seeking Safety materials are copyrighted, and it is thus
necessary to know about their fair use—how to use the materials within legal
bounds. Different treatment manuals vary in these parameters, based on
whether they are public domain; who owns the copyright; and general
intellectual property issues. For Seeking Safety the key points are outlined
below.

*Key Points about Use of the Materials   The Seeking Safety handouts can be copied for
personal use.* Guilford Press, which owns the copyright to the Seeking Safety
book, offers the following description of how the book handouts can be
copied: "An individual (one person) can use the handouts without writing
for permission. However, a clinic (or agency, program, institution) does not
qualify as the "individual purchaser." The Limited Photocopy License is
quite specific about what can and cannot be done. For clinics or multiple users
we ask that they write for permission and tell us how many clinicians would
use how many books. If it's only two or three, we might approve this at no
charge; otherwise, we assess a small licensing fee or ask that they purchase
additional copies of the book for multiple users. Part of the reasoning is we
want clinicians to have all the necessary background information included in
the text when using the handouts. For inquiries, see www.guilford.com
(Permissions), or call 800-365-7006.

The materials are available from various sources. The Seeking Safety book
can be obtained via the website (www.seekingsafety.org), but also from
booksellers such as Amazon.com, local bookstores, or the publisher. Most

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other Seeking Safety materials (translations, posters, card deck) can only be obtained via Treatment Innovations, which produces them (see www .seekingsafety.org, section Order; orders@seekingsafety.org; 617-731-1501). The audiobook version for the blind and dyslexic is available only from www.rfbd.org.

There is no electronic version of the book or handouts. People sometimes inquire whether it is possible to obtain a copy of the book (or handouts) on CD, in PDF form, as a download from the web, or other electronic versions. There are no such electronic versions of the book, nor any separate version of the handouts alone. Guilford Press, which owns the copyright, does not allow these other formats. They believe that the handouts need to be used in conjunction with the clinician guide and thus do not want to separate them.

Permission is needed to translate or distribute the materials. It is wonderful when clinicians or researchers have an interest in the model. Some have asked whether they can translate the book into another language. Others have inquired about modifying the book or parts of it, such as for domestic violence clients, adolescents, criminal justice populations, veterans, or others. However, the copyright is owned by Guilford Press and it requires formal, written, advance permission for any such translation or modification of the materials intended for distribution. Thus, a clinician could modify the materials for use with his or her own clients, but could not distribute the modified version to any other clinicians or programs, either as a hard copy or electronically. See www.guilford.com (Permissions) or call 800-365-7006. Note that Lisa Najavits does not own the copyright to the book and thus cannot formally give permissions; however, she can help facilitate contact with Guilford if needed. Also, she has assisted with all prior translations and can facilitate communications with Guilford Press, discuss key wording issues to attend to on translations, and, if needed, can distribute the translation from the Seeking Safety website. E-mail info@see kingsafety.org.

Consider creating a separate document—this does not require formal permission. The simplest way to describe and distribute ideas on modifications to the manual is to write a journal article, book chapter, or separate document of some kind. You can refer to the Seeking Safety book, but you may not modify it or reprint any parts of it directly. For example, you could write an article on your experiences conducting the model with adolescents, suggested language changes, examples you used, artwork, or any other modifications. You can publish such a document in any way you choose, as long as none of the actual Seeking Safety content is reproduced there. Also, you may want to contact info@seekingsafety.org if you are interested in adapting the book. It can be helpful to discuss options and learn about current projects.

ADDITIONAL SUGGESTED READINGS

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