Agenda:

Background on Trauma and Substance Abuse and Overview of *Seeking Safety*

9:00am – 10:30am

Background Rates of trauma and substance abuse

- Clinical presentations
- Treatment challenges
- Assessment and community resources

10:30am-10:45am

Break

10:45am – 12:00pm

Treatment

- Stages of treatment
- Overview of *Seeking Safety*

12:00pm-12:30pm

Lunch

12:30pm – 1:00pm

Video on trauma and substance abuse

1:00pm-2:15pm

More on *Seeking Safety*

- Evidence base
- Specific interventions
- Frequently asked questions

2:15pm-2:30pm

Break

2:30pm-3:30pm

Clinical demonstration

- Video demonstration of *Seeking Safety* topic, “Asking for Help” with real clients
- Break into small groups and practice session, Asking for Help
- “Tough cases”: discussion of clinical scenarios that may arise

© Najavits, 1996 (updated 2017), Treatment Innovations, Newton Centre, MA. Downloaded from www.treatment-innovations.org / Training

Seeking Safety

Title: *Seeking Safety:* An evidence-based model for trauma and/or substance abuse

Trainer: certified to provide this training by Lisa Najavits, the developer of *Seeking Safety*. To see or verify our list of certified trainers, please see www.treatment-innovations.org / About us / Team. Lisa supervises each trainer on each training, including preparation and materials. Slides, videos, and content are identical to those Lisa uses the trainer audiotapes all trainings (including the one at your site, if you allow it) so they can be reviewed for quality.

Martha Schmitz, Ph.D.is a senior trainer and consultant with Treatment Innovations. For over a decade, she has offered continuing education workshops and supervision in the treatment of PTSD and substance abuse to clinicians throughout the United States and abroad. She began working with Lisa Najavits in 2000 in a postdoctoral fellowship on Seeking Safety research at McLean Hospital. Dr. Schmitz is currently a staff psychologist at San Francisco VA Medical Center and an Assistant Clinical Professor at the University of California at San Francisco School of Medicine. She received her doctorate in counseling psychology from the University of Missouri at Columbia after earning her master's and bachelor's degrees from the University of California at Davis. She has collaborated on several research projects in both the United States and France. Her clinical and research interests include posttraumatic stress disorder, substance abuse, and resiliency in survivors of trauma. She is based in San Francisco, CA. For details, see her complete resume.

Summary: The goal of this presentation is to describe *Seeking Safety,* an evidence-based model for trauma and/or substance abuse (clients do not have to have both issues). By the end of the training day, participants can implement Seeking Safety in their setting if they choose to.*Seeking Safety* teaches present-focused coping skills to help clients attain safety in their lives. It is highly flexible and can be conducted in any setting by a wide range of clinicians and also peers. There are 25 treatment topics, each representing a safe coping skill relevant to both trauma and/or substance abuse, such as "Asking for Help", "Creating Meaning", "Compassion", and "Healing from Anger". Topics can be done in any order and the treatment can be done in few or many sessions as time allows. *Seeking Safety* strives to increase hope through emphasis on ideals; it offers exercises, emotionally-evocative language, and quotations to engage patients; attends to clinician processes; and provide concrete strategies to build recovery skills. In this training we cover (a) background on trauma and substance abuse (rates, presentation, models and stages of treatment, clinical challenges); and (b) overview of *Seeking Safety* including evidence-base*;* and (c) clinical implementation such as use of the model with specific populations. Assessment tools and national resources are also described. Learning methods include PowerPoint, video, exercises, role-play, and discussion. For more information on *Seeking Safety* see www.seekingsafety.org.

Objectives:

1) To review current understanding of evidence-based treatment of trauma and substance abuse
2) To increase empathy and understanding of trauma and substance abuse
3) To describe *Seeking Safety,* an evidence-based model for trauma and/or substance abuse
4) To provide assessment and treatment resources
5) To identify how to apply *Seeking Safety* for specific populations, such as homeless, adolescents, criminal justice, HIV, military/veteran, etc.

References:

Najavits, L.M. (2017). *Recovery from trauma, addiction or both: Finding your best self.* New York: Guilford.

Lenz, A. S., Henesy, R., & Callender, K. (2016). Effectiveness of Seeking Safety for co occurring posttraumatic stress disorder and substance use. *Journal of Counseling & Development, 94*(1), 51-61. doi:10.1002/jcad.12061

Najavits, L. M. (2015). Trauma and substance abuse: A clinician's guide to treatment. In M. Cloitre & U. Schynder (Eds.), *Evidence-based treatments for trauma-related disorders*: Springer-Verlag.

Substance Abuse Mental Health Services Administration (SAMHSA) (2014). TIP: Trauma Informed Care in Behavioral Health Services *Treatment Improvement Protocol (TIP) Series*. Washington, DC: Substance Abuse Mental Health Services Administration (SAMHSA), Department of Health and Human Services.

Ouimette, P., & Read, J. P. (Eds.). (2014). *Handbook of Trauma, PTSD and Substance Use Disorder Comorbidity*. Washington, DC: American Psychological Association Press.

Herman, J. L. (1992). *Trauma and Recovery*. New York: Basic Books.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Najavits, L. M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD In K. A. Witkiewitz & G. A. Marlatt (Eds.), *Therapist's Guide to Evidence Based Relapse Prevention: Practical resources for the mental health professional* (pp. 141-167). San Diego: Elsevier Press.

Najavits, L. M., & Hien, D. A. (2013). Helping vulnerable populations: A comprehensive review of the treatment outcome literature on substance use disorder and PTSD *Journal of Clinical Psychology, 69*, 433-480.

Provided by Treatment Innovations (www.treatment-innovations.org / www.seekingsafety.org) for your personal use. For information on adapting / training others please contact us at info@treatment-innovations.org or info@seekingsafety.org. Thanks!

Seeking Safety:
An evidence-based model for trauma and/or addiction

Lisa M. Najavits, PhD
Boston University School of Medicine
Veterans Affairs Boston

Seeking Safety

- Training or treatment
- Highly flexible
- No training nor certification required (public-health oriented); can be done by any clinical staff & peers
- The lowest-cost PTSD model available
- Easy; safe
- Used for over 20 years
- For any type of trauma, any substance type and can also be applied to other addictions.
- Can be used with people who have just trauma issues or just addiction (don't have to have both) and also for general stabilization

Implementation

- For complex, vulnerable populations
- Non-English speaking (translated into numerous languages); diverse clients

Seeking Safety evidence

- Strong research support for PTSD with SUD-- Division 12 (Psychotherapy) of the American Psychological Association (APA)
- Strong research support for adults and modest research support for adolescents for SUD -- Society of Addiction Psychology (Division 50) of the APA
- Highest level of evidence (level A) -- International Society for Traumatic Stress Studies treatment guidelines
- Supported by research evidence for adults and promising research evidence for adolescents-- California Evidence-Based Clearinghouse
- National Registry of Evidence-Based Practices and Programs of the Substance Abuse and Mental Health Services Administration

Trauma

- DSM-5 (narrower definition): experience, threat, or witnessing of death, serious injury or sexual violence
- SAMHSA (broader definition): events experienced as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

DSM-5
Posttraumatic Stress Disorder

1. Trauma (experience, threat, or witnessing of death, serious injury or sexual violence)
2. Intrusion
3. Avoidance
4. Negative thoughts and mood
5. Arousal and reactivity
6. More than one month
7. Functional problems
8. Not due to substance use, etc.

DSM-5 *Substance use disorder*

11 symptoms to ask about…

MILD = 2-3
MODERATE = 4-5
SEVERE = six or more

Clinical Importance

- Comorbid PTSD/SUD associated with
  - worse treatment outcome
  - greater psychiatric, medical, legal, and social problems
  - lower functioning
  - worse coping
  - more positive views of substances

Explore substance use in the context of PTSD

- Why are they using?

How is PTSD addressed?

- <u>Present-focused</u>
- <u>Past-focused</u>

Recovery phases

Safety

Mourning

Reconnection

(Herman, Trauma and Recovery, 1992)

Seeking Safety

- Safety plan
- Safety contract
- Check-in on safe behaviors
- Safe coping skills
- Present-focused

Format

- Up to 25 topics
- Group or individual
- Open / closed
- Women, men, or mixed
- Adult / adolescent

Session

- Check-in
- Quote
- Content (discussion and rehearsal)
- Check-out

Check-In

1. How are you feeling?
2. What good coping have you done?
3. Any substance use or other unsafe behavior?
4. Did you complete your commitment?
5. Case management update

Topics

- Introduction / Case Management
- Safety
- PTSD: Taking Back Your Power
- Substance Abuse
- Asking for Help
- Detaching from Emotional Pain (Grounding)
- Taking Good Care of Yourself
- Setting Boundaries in Relationships

Topics

- Community Resources
- Recovery Thinking
- Compassion
- Creating Meaning
- Commitment
- Honesty
- Coping with Triggers
- Healing from Anger

Topics

- Discovery
- Self-Nurturing
- Getting Others to Support Your Recovery
- Respecting Your Time
- Healthy Relationships
- Integrating the Split Self
- Red and Green Flags
- The Life Choices Game (Review)
- Termination

Check-Out

1. Name one thing you got out of the session (and any problems with it)
2. What is your new Commitment?

End-of-Session Questionnaire

- How helpful was today's session? Topic? Handout? Therapist?
- How much did the session help your PTSD? Your substance abuse?
- How can the treatment be more helpful?

All rated 0 - 4

The SAFE COPING Sheet

	OLD WAY	NEW WAY
Trigger	My partner won't stop hassling me about my drinking.	⇒
★**YOUR COPING**★	I say "Shut up—it's my life." I try to drink when my partner won't see it.	Things I could do: • Give my partner the Al-Anon number. • Say what I want (without being rude). • Ask my therapist for feedback.
Consequence	I feel alone. I've alienated everyone.	A little better. At least I'm trying to do something constructive.

How SAFE is your old way of coping?__ How SAFE is your new way of coping?__

Safe Coping Skills

- Grounding
- Ask for help
- Persistence
- Cry
- Honesty
- When in doubt, do what's hardest
- Avoid avoidable suffering
- Ask others
- Inspire yourself
- Leave a bad scene
- Move toward your opposite
- Compassion
- Try an experiment
- Find meaning
- Take responsibility
- Say what you really think

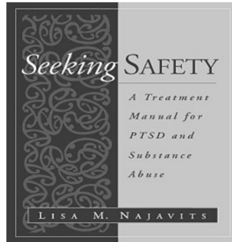
The Treatment Philosophy

- Safety
- Integrated treatment
- Ideals
- Cognitive, behavioral, interpersonal, case management
- Structure / flexibility
- Simple language
- Clinician processes

For More Information

www.seekingsafety.org
www.treatment-innovations.org

Seeking Safety Book



Also, a new book...

- Includes some elements of SS
- Self-help and/or clinician-led
- 35 short chapters
- Exercises
- *Recovery voices* (personal recovery stories, each chapter)
- Reflection questions
- Culturally sensitive
- Many new topics, e.g., *Social pain; The culture of silence; How do people change? ; Wish vs. reality; Body and biology; Dark feelings*

Trauma-Informed Treatment

- Routine assessment for trauma and PTSD
- Trauma-informed services vs. trauma-specific services

Culture / diversity

- Respect cultures
  - Healing traditions
  - Language and examples
- Do not assume the treatment needs to be adapted
- Diversity training for staff
  -

Examples of Studies

Seeking Safety Outcomes

- Over 20 pilot studies including:
  - Veteran / military
  - Criminal justice
  - Female samples
  - Male samples
  - Peer-led
  - Problem gambling
  - Inpatient, outpatient, residential
- Over 10 controlled and/or randomized controlled trials
  - Veterans
  - Low-income urban women
  - Adolescent girls
  - Women in community treatment
  - Women in prison
  - Men and women outpatients
- 3 multisite trials
  - Homeless women veterans
  - Women with co-occurring disorders/violence
  - Women in community treatment

www.treatment-innovations.org has a summary of each study

Men and Women with PTSD and alcohol use disorder (AUD) (Hien et al., 2015)

Randomized controlled trial, outpatient, 12 sessions (partial dose study); individual format (Seeking Safety plus sertraline versus Seeking Safety plus medication placebo); n=69, primarily African-American. Both conditions showed significant improvement in both PTSD and AUD at end of treatment, with gains sustained on both sustained at 6- and 12-month followups. The SS/sertraline condition had greater reduction than SS/placebo on PTSD but not AUD.

Peer- versus Clinician-Led Seeking Safety (Crisanti et al., under review)

Randomized ontrolled trial; outpatient, weekly group SS in context of TAU in rural New Mexico (primarily Hispanic); peer- versus clinician-led; n=291. Baseline, 3 and 6 month followups. Significant improvements over time with no difference between clinician vs. peer-led SS: ASI drug use, PTSD Checklist, mental health functioning, coping skills. No improvement on physical health functioning.

Seeking Safety vs. Creating Change (Najavits et al., under review)

Randomized ontrolled trial; outpatient men and women veterans; 17 weekly individual SS vs. CC in context of TAU; n=52. Baseline, end of treatment, 3 month followup. Significant improvements from baseline through end of treatment, with gains sustained at followup, and no difference between treatments: ASI alcohol, drug use, PTSD Checklist, PTSD diagnosis; mental health; quality of life, self-efficacy, SUD cognitions (all medium to large effect sizes). No change on 3 secondary measures. High satisfaction and safety profile.

Low-Income Urban Women (Hien et al., 2004)

Randomized controlled trial, outpatient, 3 months, individual format (Seeking Safety, Relapse Prevention; and TAU non-randomized control); n=107. At end of treatment, SS and RP improved in PTSD, substance use, and psychiatric symptoms, while TAU worsened. At 6- and 9-month follow-up, both SS and RP sustained greater improvement than TAU in PTSD and substance use symptoms.

Adolescent Girls (Najavits et al., 2006)

Randomized controlled trial, outpatient, individual format (Seeking Safety vs. TAU); n=33 (18 vs. 15). Significantly better outcomes for SS than TAU, including substance use and associated problems, some trauma-related symptoms, cognitions related to PTSD and SUD, and several other areas of pathology (e.g., anorexia, somatization). Effect sizes were generally in the moderate to high range. Some gains were sustained at 3-month follow-up.

Homeless Women Veterans (Desai et al., 2008, 2009)

11 VA sites. Controlled study: 359 women in TAU versus 91 women in SS (2 phase study). Group treatment, 26 sessions. pre-treatment versus 6 months later. At end of treatment (6 months), SS outperformed TAU in PTSD symptoms, avoidant behavior, social support and days worked; both conditions improved in substance use, self-esteem, general psychiatric symptoms, medical symptoms, hypervigilance, and days homeless.

Men Veterans (Boden et al., 2012)

Randomized controlled trial, VA; outpatient, twice-weekly SS in context of TAU versus TAU-alone (dosage identical); group format; n=96. SS significantly outperformed TAU in drug use over time (31% greater reduction), as well as greater treatment attendance, client satisfaction, and increase in active coping. Both conditions improved over time in alcohol use, with no difference between them.

Implementation

Implementation

- Discussion vs rehearsal
- Balance
- "How did you cope?"

Rehearsal

- Interpersonal topics: e.g, role-plays
- Cognitive topics: e.g., think-aloud
- Behavioral topics: e.g., walk-through

Implementation

- Format first
- Covering material
- Both trauma and substance abuse
- Your own style
- Cross-training

Process

- Session safe
- Problem solving / support
- Feedback constructive
- Trauma bond
- 80/20 guideline
- Avoid overcontrolling

Tips

Check-In:

- Clients do not comment
- All 5 questions each
- Don't read questions
- Take notes
- Volunteer
- Don't intervene
- "No good coping": Safe Coping List
- Brief support / concern
- Redirect
- Questions 1 & 2 separate
- Update, news
- Commitment Sheet

Tips

Quote
- As written
- Respond positively
- Don't "teach"

Handouts:
- Scan
- "Reactions?"
- Try different ways

Check-Out
- 1-2 minutes
- Same as check-in
- Listen; no wrong answers
- *Ideas for Commitment*, but offer help

Implementation (continued)

- Link trauma / addiction
- Current, specific client problems
- Not "school"

Articles

- Implementing Seeking Safety
- Training clinicians in Seeking Safety
- Overviews of Seeking Safety (book chapters)
- Outcome studies (various)

All at www.seekingsafety.org, Library

How to Start on *Seeking Safety*

- Chapters 1, 2 & one topic
- Try roleplay or with clients
- "Tough cases"
- Observe a session
- Visit www.seekingsafety.org

For any use

- Grounding
- Safety
- PTSD: Taking back your power
- Asking for help
- Healing from anger
- Coping with triggers

"Adaptation"

- Within vs outside the model

Frequently Asked Questions (FAQs)

FAQ

- "How long should the session and the treatment be?"

--Whatever fits the agency, but in general the more the better. Sessions have ranged from 45 minutes to 2 hours, and from just a few sessions to six months of treatment.

FAQ

- "Do clients have to have a formal diagnosis of PTSD and substance use disorder"

--No. It's very common for clients to have a trauma or substance abuse history (or just one of these).

FAQ

- "Can the skills be applied to other addictive behavior (e.g., bingeing, cutting, gambling)?"
- --Yes. That is how it's been implemented in practice and seems to go well. However, you also would want to refer out to other focused treatments (e.g., eating disorder treatment).

FAQ

- "Any suggestion for naming the group?"

--Avoid names such as "Trauma Group" or "PTSD Group"-- rather, try "Seeking Safety Group", "Safety Group", or "Coping Skills Group"

FAQ

"What background does the clinician need?"

- No specific degree required (has been run with various counselors, case managers, etc.)
- More subtle characteristics do matter:
  - Want to work with this population (e.g., some clinicians may not be a good match for trauma/PTSD or SUD)
  - Willingness to use a manual and follow format
- But more research needed on this topic

FAQ

- "Should groups be open or closed?"

--Open groups are the easiest in many settings; however, it's been tried in both formats.

FAQ

- "With all the handouts, how do I select what to focus on?"

--Prioritize any unsafe behavior a client reported at check-in

--Go where the client goes: Have clients scan handouts and ask "What strikes you? What would you like to focus on?"

FAQ

- "Should a client join Seeking Safety only after an initial stabilization period?"

--It was designed for use from the very start of treatment, and for all types of treatments (e.g., inpatient, residential).

FAQ

- "What if a client brings up trauma details during the session?"

--Redirect *kindly and supportively*

--Explain that group needs to stay safe for all clients and trauma details can be triggering

--Describe readiness for trauma processing (for individual treatment): ability to stop using, cutting; ability to ask for help, etc.

FAQ

- "How do I select clients for the treatment?"

--Be inclusive: allow all clients unless a problem occurs

--Select clients who want to be in the treatment

FAQ

- "Are there particular issues for group treatment?"

--Plan the number of clients based based on session length (remembering check-in is 5 minutes each)

--Limit the number of clients who over-dominate (e.g., manic)

FAQ

- "How can I adapt the treatment for short time frames?"

--Try breaking it into smaller chunks (e.g., 2 12-session phases)

--Try running it more times per week

--Allow clients to just do what topics they can

--Select key topics (e.g., Safety, PTSD, Grounding, Asking for Help)

FAQ

- "How should absences or dropouts be handled?"

--Open door: Welcome clients back, no matter how many sessions they miss

--Consumer approach: Allow clients to drop out without feelings of shame or failure

FAQ

- "What if clients try to use the style accepted in other groups-- lots of confrontation and feedback?"

--Explain that because this group focuses on trauma, the style needs to be different: giving each person space to talk, focusing on own recovery not others', providing support rather than confrontation.

FAQ

- "Do clients get dismissed from the treatment for not showing up, or not doing commitments?"

--No. Only dismiss a client who is directly a threat to group (e.g., threat of physical harm to other members, selling drugs)

FAQ

- "What if a client can't read the material?"

--Summarize it briefly

--Ask other clients to read small sections out loud

FAQ

- "What if I plan to do the topic 'Grounding' and the client says she was evicted from her home that week?"

--Change to a different topic that is relevant (e.g., Community Resources)

FAQ

- "Can you do mixed-gender groups?"

--It's been done that way, but only when the clients are willing, and when none have a history of being perpetrators.

FAQ

- "How do I limit the check-in to 5 minutes per client?"

--Two steps: validate and contain (e.g., "You're bringing up very important material, but in the interest of time, I'd like to ask you the next check-in question)

--Make a plan to return to it later in the session

--Ask the client's permission (e.g., "Would you be okay if I interrupt you there, so others get a chance to check in too?")

FAQ

- "Are there liability issues in having substance abuse counselors treat PTSD?"

--Focus on psychoeducation, coping skills (*not trauma "processing")*

--Have mental health backup and refer out when needed

--Provide supervision and peer support

FAQ

- How can a client best be added to an on-going (open) Seeking Safety group?
  - Do topic 1-A *Introduction* individually or in small subgroup (to orient new clients)
  - Consider also doing *PTSD: Taking Back Your Power* (to help client learn about trauma and PTSD)

From: Najavits, LM (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford

Asking for Help

SUMMARY

Each of the disorders—PTSD and substance abuse—leads to problems in asking for help. Today's topic encourages patients to become aware of their need for help, and provides guidance in how to do so effectively.

ORIENTATION

"It feels like the telephone weighs a thousand pounds."

"I lose whether I get help or not. If I get help, I feel guilty; if I don't, I feel humiliated and alone."

"How hard is it to ask for help? I think it's easier to give up cocaine than to ask for help."

"Everyone in my life has hurt me one way or another. I guess I'll have to try to trust. It's not easy—I can't take any more hurt."

For both PTSD and substance abuse, others' help is essential. It has been said, "The power of drugs equals the need for help. . . . They are as closely related as supply and demand in economics, as inseparable as pressure and volume in behavior of gasses. . . . The gun is pointed at my head: get help or die" (DuWors, 1992, pp. 97–99). Similarly, for severe PTSD it has been said that healing can take place only in the context of relationships (Herman, 1992).

There are good reasons why patients may find it hard to reach out for help. They may have had no one to trust while growing up; they may feel a need to keep up an image as someone "strong"; they may have learned that asking for help evokes punishment. For many patients with PTSD, sufficient help was not available at the time of the trauma, and they may

feel unable to seek help now when it is more available to them. Substance use may have come to seem like the only "help" they could get. Some patients may have sought help from systems that failed them, such as treatment systems ignorant about PTSD or substance abuse, or legal systems that may have punished them rather than providing treatment. For a description of one patient's dilemmas in asking for help, see "A Patient's Story: Why It's Hard to Ask for Help" at the end of this topic.

Today's topic provides explicit instruction in how to reach out more often, and more effectively, toward others. This skill can literally save lives in times of need. Because there are many people in patients' lives who truly cannot or will not provide help, a key theme is learning to move on to others who can, even if only to treaters. See also the topic *Setting Boundaries in Relationships* for more on getting patients to say "yes" to help from others.

Countertransference Issues

Some therapists, particularly if they grew up in a supportive environment, underestimate patients' obstacles in seeking help. They may believe that the problem is mostly in patients' perceptions rather than in reality, and they may be unaware of some real dangers in reaching out for help. See "Suggestions" (below) for more on this issue.

SESSION FORMAT

1. ***Check-in*** *(up to 5 minutes per patient)*. See Chapter 2.
2. ***Quotation*** *(briefly)*. See page 170. Link the quotation to the session—for example, "Today we'll focus on asking for help. That may feel like a big risk for some people—but it is incredibly important to learn to take that risk and reach out."
3. ***Relate the topic to patients' lives*** *(in-depth, most of session)*.
   a. *Ask patients to look through the handouts*:
      Handout 1: Asking for Help
      Handout 2: Approach Sheet
   b. *Help patients relate the skill to current and specific problems in their lives.* See "Session Content" (below) and Chapter 2 for suggestions.
4. ***Check-out*** *(briefly)*. See Chapter 2.

SESSION CONTENT

Goals

- ☐ Discuss effective ways to ask for help.
- ☐ Rehearse how to ask for help.
- ☐ Explore patients' experiences in asking for help.

Ways to Relate the Material to Patients' Lives

★ ***Role plays.*** The best situations to role-play are current, real-life situations that patients raise. Also, patients can choose upcoming events that provide an opportunity to reach out for help. If a patient has had any unsafe behavior since the last session (substance use, starting a physical fight, self-cutting, unprotected sex, suicide attempt), it is strongly recommended that this be the top priority in rehearsing the skill. For example, you might say, "Role-play the last time you used a substance. Whom could you have called? What could you have said?" Other role-play ideas include "Tell your therapist you don't feel safe," "Call a friend when you are feeling lonely," "Ask someone to go with you to a self-help meeting," "Ask your partner to help you review the material in this treatment," or "Call someone if you feel like hurting yourself or someone else."

★ ***Work on the Approach Sheet (Handout 2).*** Help patients identify a current situation that would benefit from asking for help, and process how to go about it. The goal is to get patients out of the assumptions "in their heads" and into finding out "what's real." Thus, guide them to fill out the first three boxes of Handout 2, the blank Approach Sheet (what help they need help, whom they can ask, and what they predict will happen). Then, before the next session, they can try actually asking for the help specified and observe whether their prediction was accurate (filling out the fourth box in the sheet).

To help create a success experience, make sure that patients are truly trying something new and not just going through the motions; try to set up a situation with the most likelihood of success (e.g., asking someone safe); explicitly discuss how to prepare if a request for help doesn't go well; explore practical and emotional obstacles to following through on the assignment; and, when patients come to the next session, process what happened. If it didn't go well, the idea is to help patients learn something constructive from the experience (e.g., "I'm able to take a risk," or "Now I know I need to find other people to ask help from"). Also, find out *how* they asked for help, and give honest feedback and instructions on more effective ways.

★ ***Discussion***

- "What do you most want help with?"
- "Why is asking for help such a crucial coping skill?"
- "Was there a time recently when you needed to call someone for help, but didn't?"
- "Is it harder to ask for help with your PTSD, your substance abuse, or both equally?"
- "Why might PTSD and substance abuse make it hard for you to ask for help?"
- "What happens when you do not ask for help?"
- "Are there any successes you've had in asking for help? What made those possible?"
- "Do you think you can learn to ask for more help?"
- "How can you cope if the other person refuses to help?"
- "If you feel an impulse toward a destructive behavior, do you know whom you would call and what you would say?"
- "Why would asking for help make you more *independent* in the long run?"
- "Can you 'coach' the other person in advance on what you want him or her to say?"

Suggestions

✦ ***You may want to introduce the topic with a simple, forceful statement:*** "I am going to tell you one of the greatest secrets of recovery you will ever hear. This is like a law of physics and as solid as the ground we walk on: You need help from others to recover." Allow patients to respond to this, and praise any positive examples they provide of asking for help.

✦ ***Out-loud rehearsal is typically most effective.*** Having patients rehearse how they would ask for help tends to be more engaging than a general discussion. Thus role plays and the Approach Sheet generally work best.

✦ ***Note that some patients have no one safe to ask help from.*** This is a very real situation for some people. In this case, the goal becomes practicing asking help from treaters (e.g., a hotline, an AA member or sponsor, a therapist). It is usually less helpful to "debate" with patients whether particular friends or family members really would be there for them—patients' instincts may be accurate, and the goal of the session is to have them locate help anywhere they can. Treaters are an excellent source for mastering the skill of asking for help, and over time, patients may then be able to move on to developing a safe support network of nontreaters. Patients can be encouraged even now to get involved in activities that will help them to build a support network (e.g., self-help groups, leisure activities, religious organizations). However, some patients are not yet capable of utilizing these, in which case treaters become the "fall-back" option. You may also want to offer patients resources from Handout 1 in the topic *Community Resources*, which provides many toll-free numbers for obtaining informational help. Here too, just practicing reaching out is the goal.

✦ ***Be sure to take very seriously that there may be valid reasons why asking for help is genuinely dangerous for some patients at this point.*** Sometimes patients have abusive partners who will hurt them if they seek help; at other times, emotional obstacles may be dangerous (e.g., "If I don't get the help I ask for, I become suicidal"), or treaters/treatment systems are unhelpful. The most important strategy is usually to empathize with patients' fears and to redirect them to safe options. For example, a patient can plan on asking for help just before or during a therapy session (such as making a call in the therapist's office) to be able to process how it went. It is not helpful, in contrast, to respond with simplistic "cheerleading" such as "Just keep trying with your partner," or "You can do it!"

✦ ***Encourage patients to instruct people in their lives about the kind of help they need.*** For example, one concern patients raise is that if they ask for help before using a substance, the other person will try to talk them out of it. Try to have patients rehearse explicitly in advance what they want the other person to say—for example, "I cannot stop you from using, but I am worried about you," or "I will just listen to anything you want to say." See the topic *Getting Others to Support Your Recovery* for more on this.

✦ ***It may be safest to start with concrete, physical help rather than emotional help.*** For example, asking a friend for a ride to a self-help meeting may be easier than asking for advice on a complex emotional problem. The goal is to take a step, however small, toward reaching out to others in a time of need. Adjusting the level of difficulty of the task (not too hard, not too easy) is key. Also, patients should select someone who truly has the potential to help, not a

"hopeless case," such as a family member who has abused them or a friend who has refused to help in the past.

✦ ***Any time is better than no time.*** Sometimes patients believe that they can only ask for help before using (or other such events) and once they've begun a self-destructive act it is too late to reach out. Process ways to ask for help at any point in the sequence, as in this example:

Before: "Call someone when you have a drug craving, before you use."
During: "If you're at a bar, go to the pay phone and call your sponsor."
After: "Call a friend the next day to discuss what happened."

✦ ***Identify ways to cope with rejection* before *it happens.*** Rehearse how patients might handle it if a person refuses a request for help. Cognitive strategies may be especially helpful, such as explanations that are not self-blaming: "I guess the person I asked just isn't as generous as I had thought," "I can learn from this and try again later with someone else," "I need to give myself credit for trying, even if it didn't work out as I had hoped."

✦ ***Persistence matters.*** Patients should not give up easily. Offer suggestions, such as "You may have to ask twice for someone to 'hear' you," or "If one person can't help you, try another person immediately."

✦ ***Patients may be afraid of becoming too dependent if they ask for help.*** It is often a surprise that in fact it makes them more *independent* in the long run. Learning to recognize and prioritize one's needs, knowing how to put a request for help into words, tolerating the vulnerability of such a request—all of these empower patients and increase strength and self-esteem. Asking for help means that one is not afraid of people and can join with others safely.

✦ ***Notice how patients ask for help, particularly in the role plays.*** You may need to give honest feedback and instructions on more effective ways to ask for help. For example, one patient said, "I told my partner that she was totally unhelpful and that she had to start helping me from now on." This person needed guidance in softening the approach.

✦ ***Some patients may not understand the quotation.*** You may want to emphasize that it suggests the importance of taking risks in life. Not taking risks, though it may feel "self-protective," can keep one alone and isolated. Reaching out for help is an important risk to take.

Tough Cases

* "I'm always helping others, but no one helps me."
* "I can ask for help in role plays, but not in real life."
* "I don't have anyone in my life to ask help from."
* "Whenever I ask for help, I get rejected."
* "I can't ask for help when I feel like using—I don't want to be talked out of it."
* "I'm calling you from a pay phone and I need help right now; I'm going to kill myself."
* "My family does not want me to get help from anyone except them."
* "When I was growing up, I was beaten if I asked for help."
* "As a Latino in this society, I can only ask for help from other Latinos."

A PATIENT'S STORY: WHY IT'S HARD TO ASK FOR HELP

"My trauma started around the time I was about 5 or so. Always around nighttime, when the lights went out, it was a scary time. Bad things happened in the dark. I would pretend to be asleep but that didn't matter. If I closed my eyes, it would go away. But that wasn't true. I would hold onto my doll for comfort. Sometimes I would hold on so tight I thought her head would pop off.

"So why didn't I ask for help? If only I went for help, I could have stopped the whole thing. But I didn't. I did nothing; I let it all happen. Was I stupid? Or maybe I liked it? Please give me the answers—I don't have them. I feel dirty, always feeling dirty. Growing up, and even now when I think about it, it was always my fault. I didn't stop any of it. Even after the rape at 11 years old, I still didn't tell anyone. Even as an adult, I let it go on in my marriage. An adult! I should have stopped it then. But I didn't. I'm just a little girl crying for help but not doing anything about it.

"Well, yes, my trauma did happen as a little girl. That's just it—a little *girl. This man was very powerful. There was no way I could stop this person who was terrifying me. No, I am not stupid, and I did not enjoy it. It sickens me when I think about it. I couldn't go for help because then my sisters would have been hurt. I was helpless. He was my father, a very powerful figure in my life. I may not have gotten help then, but I'm getting help now. It's never too late to ask for help. I will get my life in order and stand on my own two feet. If I talked then, bad things would have happened. Well, no more. I will not be hurt any more in my life."*

Quotation

"And the trouble is, if you don't risk anything, you risk even more."

—Erica Jong
(20th-century American writer)

From *Seeking Safety* by Lisa M. Najavits (2002).

Asking for Help

MAIN POINTS

★ It is very common to have difficulty asking for help if you have PTSD and substance abuse.

★ You must get help from others to recover. No one can do it alone.

★ In learning to ask for help, start "small": Practice on safe people, with simple requests.

★ Try to ask for help before a problem becomes overwhelming. But you can call any time—*before*, *during*, or *after* a hard time.

★ Prepare how you'll handle it if the person refuses your request for help.

★ In asking for help, you don't have to "spill" everything.

★ Asking for help makes you stronger and more *independent* in the long run.

★ Learning to ask for help may feel very awkward at first.

★ If there is no one in your life to ask help from, work on building a support network.

★ When asking for help, be gentle—no demands, threats, or insults.

★ Discover whether your fears are accurate: Compare your *prediction* to *reality*.

★ Carry in your wallet a list of phone numbers you can call.

From *Seeking Safety* by Lisa M. Najavits (2002). Copyright by The Guilford Press. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

Approach Sheet

★ *Fill in the first three parts now. Later, after you've approached the person, fill in the last part.*
(1) Who will you talk to?
(2) What will you say?
(3) What do you predict will happen?
(4) What did happen in reality?

★ *You may want to ask yourself:*

- What did you learn from trying this?
- Did you get what you wanted, or at least part of what you wanted?
- Is there anything you might do differently next time?
- How do you feel about your experience?
- How difficult was it?

From *Seeking Safety* by Lisa M. Najavits (2002). Copyright by The Guilford Press. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

Ideas for a Commitment

Commit to one action that will move your life forward!
It can be anything you feel will help you, or you can try one of the ideas below.
Keeping your commitment is a way of respecting, honoring, and caring for yourself.

✦ Option 1: Write a list of people you can call when you are having problems (e.g., wanting to talk, feeling afraid, drug cravings, needing a ride, etc.). Include friends, family members, self-help sponsors, treaters, hotlines, drop-in centers, and anyone else you can think of (see example below).

List of people to call for help
1. My friend Martha: 466-4215 or 252-7655
2. My therapist (Dr. Klein): 855-1111 or can page at 855-1000
3. My AA sponsor (Barbara): 731-1502

✦ Option 2: Go for it! Fill out the Approach Sheet.

APPROACH SHEET–EXAMPLE

Fill in the first three parts now. Later, after you've approached the person, fill in the last part.
(1) Who will you talk to? My friend Elizabeth.
(2) What will you say? "Please help me not drink at the party tonight—you can help by not offering me any alcohol and checking in with me at times during the party to see if I'm okay."
(3) What do you predict will happen? She won't want to help me. She'll think I'm pathetic.
(4) What did happen in reality? I called Elizabeth. She was very willing to watch out for me at the party, and also gave me the phone number for a good AA group in town. She didn't convey any judgment or negative views of me.

From *Seeking Safety* by Lisa M. Najavits (2002). Copyright by The Guilford Press. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

2017 / Lisa Najavits, PhD / Treatment Innovations / Short version of basic handouts

To download long version of these handouts (including educational resources and assessments):
www.seekingsafety.org *(section Training / Materials / Handouts)*

PTSD

DSM-V definition: After a trauma (the experience, threat, or witnessing of physical harm, e.g., rape, hurricane), the person has each of the following key symptoms for over a month, and they result in decreased ability to function (e.g., work, social life): intrusion (e.g., flashbacks, nightmares); avoidance (not wanting to talk about it or remember); negative thoughts and mood; and arousal (e.g., insomnia, anger).

Simple PTSD results from a single event in adulthood (DSM-V symptoms); Complex PTSD is not a DSM term but may result from multiple traumas, typically in childhood (broad symptoms, including personality problems)

Rates: 10% for women, 5% for men (lifetime, U.S.). Up to 1/3 of people exposed to trauma develop PTSD.

Treatment: if untreated, PTSD can last for decades; if treated, people can recover. Evidence-based treatments include cognitive-behavioral-- coping skills training and exposure, i.e., processing the trauma story.

Substance Abuse

"The compulsion to use despite negative consequences" (e.g., legal, physical, social, psychological). Note that neither amount of use nor physical dependence define substance abuse.

DSM-V term is "substance-related and addictive disorder", which can be mild, moderate, or severe.

Rates: 35% for men; 18% for women (lifetime, U.S.)

It is treatable disorder and a "no-fault" disorder (i.e., not a moral weakness)

Two ways to give it up: "cold turkey" (give up all substances forever; abstinence model) or "warm turkey" (*harm reduction*, in which any reduction in use is a positive step); *moderation management*, some people can use in a controlled fashion-- but only those not dependent on substances, and without co-occurring disorders).

The Link Between PTSD and Substance Abuse

About PTSD and substance abuse

Rates: Of clients in substance abuse treatment, 12%-34% have current PTSD. For women, rates are 33%-59%.

Gender: For women, typically a history of sexual or physical childhood trauma; for men, combat or crime

Drug choice: No one drug of choice, but PTSD is associated with severe drugs (cocaine, opioids); in 2/3 of cases the PTSD occurs first, then substance abuse.

Recommended treatment strategies

Treat both disorders at the same time. Research supports this and clients prefer this.

Decide *how* to treat PTSD in context of active substance abuse. Options: (1) Focus on present only (coping skills, psychoeducation, educate about symptoms) [safest approach, widely recommended]. (2) Focus on past only (tell the trauma story) [high risk; works for some clients] (3) Focus on both present and past

Know that treatments helpful for either disorder alone may be problematic if someone has both disorders (e.g., emotionally intense exposure therapies, benzodiazepines), and should be evaluated carefully prior to use.

Diversity Issues

In the US, rates of PTSD do not differ by race (Kessler et al., 1995). Substance abuse: Hispanics and African-Americans have lower rates than Caucasians; Native Americans have higher rates than Caucasians (Kessler et al., 1995, 2005). Rates of abuse increase with acculturation. Some cultures have protective factors (religion, kinship).

It is important to respect cultural differences and tailor treatment to be sensitive to historical prejudice. Also, terms such as "trauma," "PTSD," and "substance abuse" may be interpreted differently based on culture.

Seeking Safety

About *Seeking Safety*

- ✧ A present-focused model to help clients (male and female) attain safety from PTSD and substance abuse.
- ✧ Up to 25 topics that can be conducted in any order, doing as many as time allows:
    - Interpersonal topics: Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources
    - 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)
- Other topics: Introduction/Case Management, Safety, Life Choices, Termination

✧ Designed for flexible use: can be conducted in group or individual format; for women, men, or mixed-gender; using all topics or fewer topics; in a variety of settings; and with a variety of providers (and peers).

Key principles of *Seeking Safety*

- Safety as the goal for first-stage treatment (later stages are mourning and reconnection)
- Integrated treatment (treat both disorders at the same time)
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
- Four content areas: cognitive, behavioral, interpersonal, case management
- Attention to clinician processes: balance praise and accountability; notice your own emotional responses (fear, wish to control, joy in the work, disappointment); all-out effort; self-care

Additional features

- "Headlines, not details" in relation to trauma.
- Identify meanings of substance use in context of PTSD (to remember, to forget, to numb, to feel, etc.)
- Optimistic: focus on strengths and future
- Help clients obtain more treatment and attend to daily life problems (housing, AIDS, jobs)
- Harm reduction model or abstinence
- 12-step groups encouraged, not required
- Empower clients whenever possible
- Make the treatment engaging: quotations, everyday language
- Emphasize core concepts (e.g., "You can get better")

Evidence Base

Seeking Safety is an evidence-based model, with over 40 published peer-reviewed study articles and consistently positive results. See www.seekingsafety.org, section Evidence. Studies include pilots, randomized controlled trials, multi-site trials.

Resources on *Seeking Safety*. All below are available from www.seekingsafety.org.

✧ **Implementation / research articles / Fidelity Scale** can be freely downloaded.
✧ **Training:** training calendar and information on setting up a training (section Training).
✧ **Consultation:** on clinical implementation, research studies, evaluation projects.
✧ **Book:** *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. Has the clinician guide and all client handouts. Also available in over 10 languages including **Spanish, French, German, Chinese**.
✧ **DVD training series**
✧ **Online learning**
✧ **Teaching Guide to Introduce Seeking Safety to your agency**
✧ **Poster:** poster of over 80 safe coping skills, full-color, scenic background; large format (24 x 30") or 1-page format (in English or Spanish).
✧ **Card deck:** all of the safe coping skills and quotations on cards, with ideas for games. English or Spanish.
✧ **Magnets, key chain** to remind clients of the skills.

Contact Information

Contact: *Treatment Innovations*, 28 Westbourne Road, Newton Centre, MA 02478; 617-299-1610 [phone]; info@treatment-innovations.org [email]; www.seekingsafety.org or www. www.treatment-innovations.org [web]

Would you like to be added to the Seeking Safety website to list that you conduct Seeking Safety? If so, please email info@seekingsafety.org your basic information OR fill out the online entry on the website. *Example:* Boston, MA: Karen Smith, LICSW; group and individual Seeking Safety; private practice with sliding scale. 617-300-1234. Karensmith@netzero.com.

Safe Coping Skills (Part 1)

from "Seeking Safety: Cognitive- Behavioral Therapy for PTSD and Substance Abuse"
by Lisa M. Najavits, Ph.D.

1. Ask for help- Reach out to someone safe **2. Inspire yourself-** Carry something positive (e.g., poem), or negative (photo of friend who overdosed) **3. Leave a bad scene-** When things go wrong, get out **4. Persist-** Never, never, never, never, never, never, never, never, never give up **5. Honesty-** Secrets and lying are at the core of PTSD and substance abuse; honesty heals them **6. Cry-** Let yourself cry; it will not last forever **7. Choose self-respect-** Choose whatever will make you like yourself tomorrow **8. Take good care of your body-** Eat right, exercise, sleep, safe sex **9. List your options-** In any situation, you have choices **10. Create meaning-** Remind yourself what you are living for: your children? Love? Truth? Justice? God? **11. Do the best you can with what you have-** Make the most of available opportunities **12. Set a boundary-** Say "no" to protect yourself **13. Compassion-** Listen to yourself with respect and care **14. When in doubt, do what's hardest-** The most difficult path is invariably the right one **15. Talk yourself through it-** Self-talk helps in difficult times **16. Imagine-** Create a mental picture that helps you feel different (e.g., remember a safe place)
17. Notice the choice point- In slow motion, notice the exact moment when you chose a substance **18. Pace yourself-** If overwhelmed, go slower; if stagnant, go faster **19. Stay safe-** Do whatever you need to do to put your safety above all **20. Seek understanding, not blame-** Listen to your behavior; blaming prevents growth
21. If one way doesn't work, try another- As if in a maze, turn a corner and try a new path **22. Link PTSD and substance abuse-** Recognize substances as an attempt to self- medicate **23. Alone is better than a bad relationship-** If only treaters are safe for now, that's okay **24. Create a new story-** You are the author of your life: be the hero who overcomes adversity **25. Avoid avoidable suffering-** Prevent bad situations in advance **26. Ask others-** Ask others if your belief is accurate **27. Get organized-** You'll feel more in control with lists, "to do's" and a clean house **28. Watch for danger signs-** Face a problem before it becomes huge; notice red flags **29. Healing above all-** Focus on what matters **30. Try something, anything-** A good plan today is better than a perfect one tomorrow **31. Discovery-** Find out whether your assumption is true rather than staying "in your head" **32. Attend treatment-** AA, self-help, therapy, medications, groups- anything that keeps you going
33. Create a buffer- Put something between you and danger (e.g., time, distance) **34. Say what you really think-** You'll feel closer to others (but only do this with safe people) **35. Listen to your needs-** No more neglect- really hear what you need **36. Move toward your opposite-** E.g., if you are too dependent, try being more independent **37. Replay the scene-** Review a negative event: what can you do differently next time?
38. Notice the cost- What is the price of substance abuse in your life? **39. Structure your day-** A productive schedule keeps you on track and connected to the world **40. Set an action plan-** Be specific, set a deadline, and let others know about it **41. Protect yourself-** Put up a shield against destructive people, bad environments, and substances **42. Soothing talk-** Talk to yourself very gently (as if to a friend or small child)

With appreciation to the Allies Program (Sacramento, CA) for formatting this Safe Coping List.
© Guilford Press, New York. From: Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002).
Only for personal use (with clients); for any other use contact <info@seekingsafety.org> or <permissions@guilford.com>

Safe Coping Skills (Part 2)

from "Seeking Safety: Cognitive- Behavioral Therapy for PTSD and Substance Abuse"
by Lisa M. Najavits, Ph.D.

43. Think of the consequences- Really see the impact for tomorrow, next week, next year **44. Trust the process**- Just keep moving forward; the only way out is through **45. Work the material**- The more you practice and participate, the quicker the healing **46. Integrate the split self**- Accept all sides of yourself; they are there for a reason **47. Expect growth to feel uncomfortable**- If it feels awkward or difficult you're doing it right **48. Replace destructive activities**- Eat candy instead of getting high **49. Pretend you like yourself**- See how different the day feels **50. Focus on now**- Do what you can to make today better; don't get overwhelmed by the past or future **51. Praise yourself**- Notice what you did right; this is the most powerful method of growth **52. Observe repeating patterns**- Try to notice and understand your re-enactments **53. Self- nurture**- Do something that you enjoy (e.g., take a walk, see a movie) **54. Practice delay**- If you can't totally prevent a self-destructive act, at least delay it as long as possible **55. Let go of destructive relationships**- If it can't be fixed, detach **56. Take responsibility**- Take an active, not a passive approach **57.Set a deadline**- Make it happen by setting a date **58. Make a commitment**- Promise yourself to do what's right to help your recovery **59. Rethink**- Think in a way that helps you feel better **60. Detach from emotional pain (grounding)**- Distract, walk away, change the channel **61. Learn from experience**- Seek wisdom that can help you next time **62. Solve the problem**- Don't take it personally when things go wrong- try to just seek a solution **63. Use kinder language**- Make your language less harsh **64. Examine the evidence**- Evaluate both sides of the picture **65. Plan it out**- Take the time to think ahead-it's the opposite of impulsivity **66. Identify the belief**- For example, shoulds, deprivation reasoning **67. Reward yourself**- Find a healthy way to celebrate anything you do right **68. Create new "tapes"** Literally! Take a tape recorder and record a new way of thinking to play back **69. Find rules to live by**- Remember a phrase that works for you (e.g., "Stay real") **70. Setbacks are not failures**- A setback is just a setback, nothing more **71. Tolerate the feeling**- "No feeling is final", just get through it safely **72. Actions first and feelings will follow**- Don't wait until you feel motivated; just start now **73. Create positive addictions**- Sports, hobbies, AA… **74. When in doubt, don't**- If you suspect danger, stay away **75. Fight the trigger**- Take an active approach to protect yourself **76. Notice the source**- Before you accept criticism or advice, notice who's telling it to you **77. Make a decision**- If you're stuck, try choosing the best solution you can right now; don't wait **78. Do the right thing**- Do what you know will help you, even if you don't feel like it **79. Go to a meeting**- Feet first; just get there and let the rest happen **80. Protect your body from HIV**- This is truly a life-or-death issue **81. Prioritize healing**- Make healing your most urgent and important goal, above all else **82. Reach for community resources**- Lean on them! They can be a source of great support **83. Get others to support your recovery**- Tell people what you need **84. Notice what you can control**- List the aspects of your life you do control (e.g., job, friends…)

© Guilford Press, New York. From: Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Only for personal use (with clients); for any other use contact <infoseekingsafety.org> or <permissions@guilford.com>

Lisa Najavits, PhD

Detaching From Emotional Pain (Grounding)

WHAT IS GROUNDING?

Grounding is a set of simple strategies to *detach from emotional pain* (for example, drug cravings, self-harm impulses, anger, sadness). Distraction works by **focusing outward on the external world**-- rather than inward toward the self. You can also think of it as "distraction," "centering," "a safe place," "looking outward," or "healthy detachment."

WHY DO GROUNDING?

When you are overwhelmed with emotional pain, you need a way to detach so that you can gain control over your feelings and stay safe. As long as you are grounding, you cannot possibly use substances or hurt yourself! Grounding "anchors" you to the present and to reality.

Many people with PTSD and substance abuse struggle with either feeling too much (overwhelming emotions and memories) or too little (numbing and dissociation). In grounding, you attain balance between the two-- conscious of reality and able to tolerate it.

Guidelines

- Grounding can be done any time, any place, anywhere and no one has to know.
- Use grounding when you are: faced with a trigger, having a flashback, dissociating, having a substance craving, or when your emotional pain goes above 6 (on a 0-10 scale). Grounding puts healthy distance between you and these negative feelings.
- Keep your eyes open, scan the room, and turn the light on to stay in touch with the present.
- Rate your mood before and after to test whether it worked. Before grounding, rate your level of emotional pain (0-10, where means "extreme pain"). Then re-rate it afterwards. Has it gone down?
- No talking about negative feelings or journal writing. You want to distract *away* from negative feelings, not get in touch with them.
- Stay neutral-- no judgments of "good" and "bad". For example, "The walls are blue; I dislike blue because it reminds me of depression." Simply say "The walls are blue" and move on.
- Focus on the present, not the past or future.
- Note that grounding is *not* the same as relaxation training. Grounding is much more active, focuses on distraction strategies, and is intended to help extreme negative feelings. It is believed to be more effective for PTSD than relaxation training.

WAYS TO GROUND

Mental Grounding

- Describe your environment in detail using all your senses. For example, "The walls are white, there are five pink chairs, there is a wooden bookshelf against the wall..." Describe objects, sounds, textures, colors, smells, shapes, numbers, and temperature. You can do this anywhere. For example, on the subway: "I'm on the subway. I'll see the river soon. Those are the windows. This is the bench. The metal bar is silver. The subway map has four colors..."
- Play a "categories" game with yourself. Try to think of "types of dogs", "jazz musicians", "states that begin with 'A'", "cars", "TV shows", "writers", "sports", "songs", "European cities."
- Do an age progression. If you have regressed to a younger age (e.g., 8 years old), you can slowly work your way back up (e.g., "I'm now 9"; "I'm now 10"; "I'm now 11"…) until you are back to your current age.
- Describe an everyday activity in great detail. For example, describe a meal that you cook (e.g., "First I peel the potatoes and cut them into quarters, then I boil the water, I make an herb marinade of oregano, basil, garlic, and olive oil…").
- Imagine. Use an image: *Glide along on skates away from your pain*; *change the TV channel to get to a better show*; think of *a wall as a buffer between you and your pain.*
- Say a *safety statement*. "My name is ____; I am safe right now. I am in the present, not the past. I am located in _____; the date is _____."
- Read something, saying each word to yourself. Or read each letter backwards so that you focus on the letters and not on the meaning of words.
- Use humor. Think of something funny to jolt yourself out of your mood.
- Count to 10 or say the alphabet, very s..l..o..w..l..y.
- Repeat a favorite saying to yourself over and over (e.g., the Serenity Prayer).

Physical Grounding

- Run cool or warm water over your hands.
- Grab tightly onto your chair as hard as you can.
- Touch various objects around you: a pen, keys, your clothing, the table, the walls. Notice textures, colors, materials, weight, temperature. Compare objects you touch: Is one colder? Lighter?
- Dig your heels into the floor-- literally "grounding" them! Notice the tension centered in your heels as you do this. Remind yourself that you are connected to the ground.
- Carry a *grounding object* in your pocket-- a small object (a small rock, clay, ring, piece of cloth or yarn) that you can touch whenever you feel triggered.
- Jump up and down.
- Notice your body: The weight of your body in the chair; wiggling your toes in your socks; the feel of your back against the chair. You are connected to the world.
- Stretch. Extend your fingers, arms or legs as far as you can; roll your head around.
- Walk slowly, noticing each footstep, saying "left","right" with each step.
- Eat something, describing the flavors in detail to yourself.
- Focus on your breathing, noticing each inhale and exhale. Repeat a pleasant word to yourself on each inhale (for example, a favorite color or a soothing word such as "safe," or "easy").

Soothing Grounding

- Say kind statements, as if you were talking to a small child. E.g., "You are a good person going through a hard time. You'll get through this."
- Think of favorites. Think of your favorite color, animal, season, food, time of day, TV show.
- Picture people you care about (e.g., your children; and look at photographs of them).
- Remember the words to an inspiring song, quotation, or poem that makes you feel better (e.g., the Serenity Prayer).
- Remember a safe place. Describe a place that you find very soothing (perhaps the beach or mountains, or a favorite room); focus on everything about that place-- the sounds, colors, shapes, objects, textures.
- Say a coping statement. "I can handle this", "This feeling will pass."
- Plan out a safe treat for yourself, such as a piece of candy, a nice dinner, or a warm bath.
- Think of things you are looking forward to in the next week, perhaps time with a friend or going to a movie.

WHAT IF GROUNDING DOES NOT WORK?

- Practice as often as possible, even when you don't "need" it, so that you'll know it by heart.
- Practice faster. Speeding up the pace gets you focused on the outside world quickly.
- Try grounding for a looooooonnnnnggg time (20-30 minutes). And, repeat, repeat, repeat.
- Try to notice whether you do better with "physical" or "mental" grounding.
- Create your own methods of grounding. Any method you make up may be worth much more than those you read here because it is *yours*.
- Start grounding early in a negative mood cycle. Start when the substance craving just starts or when you have just started having a flashback.

© Guilford Press, New York. From: Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Only for personal use (with clients); for any other use contact <infoseekingsafety.org> or <permissions@guilford.com>

Lisa Najavits, PhD

Taking Good Care of Yourself

Answer each question below "yes" or "no."; if a question does not apply, leave it blank.

DO YOU…

♥Associate only with safe people who do not abuse or hurt you? YES___ NO___
♥Have annual medical check-ups with a:
•Doctor? YES___ NO ___ •Dentist? YES___ NO ___
•Eye doctor? YES ___NO ___ •Gynecologist (women only)? YES ___ NO ___
♥Eat a healthful diet? (healthful foods and not under- or over-eating) YES ___ NO ___
♥Have safe sex? YES ___ NO ___
♥Travel in safe areas, avoiding risky situations (e.g., being alone in deserted areas)? YES ___ NO ___
♥Get enough sleep? YES ___ NO ___
♥Keep up with daily hygiene (clean clothes, showers, brushing teeth, etc.)? YES ___ NO ___
♥Get adequate exercise (not too much nor too little)? YES ___ NO ___
♥Take all medications as prescribed? YES __ NO___
♥Maintain your car so it is not in danger of breaking down? YES ___ NO ___
♥Avoid walking or jogging alone at night? YES___ NO ___
♥Spend within your financial means? YES___ NO ___
♥Pay your bills on time? YES___ NO ___
♥Know who to call if you are facing domestic violence? YES___ NO ___
♥Have safe housing? YES___ NO ___
♥Always drive substance-free? YES___ NO ___
♥Drive safely (within 5 miles of the speed limit)? YES___NO___
♥Refrain from bringing strangers home to your place? YES___ NO ___
♥Carry cash, ID, and a health insurance card in case of danger? YES___ NO ___
♥Currently have at least two drug-free friendships? YES ___ NO ___
♥Have health insurance? YES___ NO ___
♥Go to the doctor/dentist for problems that need medical attention? YES__NO__
♥Avoid hiking or biking alone in deserted areas? YES___ NO ___
♥Use drugs or alcohol in moderation or not at all? YES ___ NO ___
♥Not smoke cigarettes? YES ___ NO ___
♥Limit caffeine to fewer than 4 cups of coffee per day or 7 colas? YES ___ NO ___
♥Have at least one hour of free time to yourself per day? YES ___ NO ___
♥Do something pleasurable every day (e.g., go for a walk)? YES___ NO___
♥Have at least three recreational activities that you enjoy (e.g., sports, hobbies— but not substance use!) ? YES___ NO___
♥Take vitamins daily? YES___NO___
♥Have at least one person in your life that you can truly talk to (therapist, friend, sponsor, spouse)? YES___NO___
♥Use contraceptives as needed? YES___NO___
♥Have at least one social contact every week? YES___NO___
♥Attend treatment regularly (e.g., therapy, group, self-help groups)? YES___NO___
♥Have at least 10 hours per week of structured time? YES ___ NO ___
♥Have a daily schedule and "to do" list to help you stay organized? YES___NO___
♥Attend religious services (if you like them)? YES___ NO___ N/A___
♥Other: ________________________________ YES ___ NO ___

YOUR SCORE: (total # of "no's) ______

Notes on self-care:
Self-Care and PTSD. People with PTSD often need to learn to take good care of themselves. For example, if you think about suicide a lot, you may not feel that it's worthwhile to take good care of yourself and may need to make special efforts to do so. If you were abused as a child you got the message that your needs were not important. You may think, "If no one else cares about me, why should I?" Now is the time to start treating yourself with respect and dignity.
Self-Care and Substance Abuse. Excessive substance use is one of the most extreme forms of self-neglect because it directly harms your body. And, the more you abuse substances the more you are likely to neglect yourself in other ways too (e.g., poor diet, lack of sleep).
Try to do a little more self-care each day. No one is perfect in doing everything on the list at all times. However, the goal is to take care of the most urgent priorities first and to work on improving your self-care through daily efforts. "Progress, not perfection."

© Guilford Press, New York. From: Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Only for personal use (with clients); for any other use contact <infoseekingsafety.org> or <permissions@guilford.com>

Najavits, LM (2002)

Creating Meaning in PTSD and Substance Abuse

MEANINGS THAT _HARM_	DEFINITION	EXAMPLES	**MEANINGS THAT _HEAL_**
Deprivation Reasoning	Because you have suffered a lot, you deserve substances (or other destructive behavior).	*--I've had a hard time, so I'm entitled to get high.* *--If you went through what I did, you'd cut your arm too.*	**Live Well.** A happy, functional life will make up for your suffering far more than will hurting yourself. Focus on positive steps to make your life better.
I'm Crazy	You believe that you shouldn't feel the way you do	*--I must be crazy to be feeling this upset.* *--I shouldn't have this craving.*	**Honor Your Feelings**. You are not crazy. Your feelings make sense in light of what you have been through. You can get over them by talking about them and learning to cope.
Time Warp	It feels like a negative feeling will go on forever.	*--This craving won't stop.* *--If I were to cry, I would never stop.*	**Observe Real Time.** Take a clock and time how long it really lasts. Negative feelings will usually subside after a while; often they will go away sooner if you distract with activities.
Actions Speak Louder than Words	Show distress by actions, or people won't see the pain.	*--Scratches on my arml show what I feel* *--An overdose will show them.*	**Break Through the Silence.** Put feelings into words. Language is the most powerful communication for people to know you.
Beating Yourself Up	In your mind, you yell at yourself and put yourself down.	*--I'm a loser.* *--I'm a no-good piece of dirt.*	**Love—Not Hate--Creates Change.** Beating yourself up does not change your behavior. Care and understanding promote real change.
The Past is the Present	Because you were a victim in the past, you are a victim in the present.	*--I can't trust anyone.* *--I'm trapped.*	**Notice Your Power.** Stay in the present: I am an adult (no longer a child); I have choices (I am not trapped); I am getting help (I am not alone).

The Escape	An escape is needed (e.g., food, cutting) because feelings are too painful	*--I'll never get over this; I have to cut myself.* *--I can't stand cravings; I have to smoke a joint.*	**Keep Growing.** Emotional growth and learning are the only real escape from pain. You can learn to tolerate feelings and solve problems.
Ignoring Cues	If you don't notice a problem it will go away.	*--If I just ignore this toothache it will go away* *--I don't abuse substances.*	**Attend to Your Needs.** Listen to what you're hearing; notice what you're seeing; believe your gut feeling.
Dangerous Permission	You give yourself permission for self-destructive behavior.	*--Just one won't hurt.* *--I'll just buy a bottle of wine for a new recipe*	**Seek Safety.** Acknowledge your urges and feelings and then find a safe way to cope with them.
The Squeaky Wheel Gets the Grease	If you get better you will not get as much attention from people	*--If I do well, my therapist won't notice me.* *--No one will listen to me unless I'm in distress.*	**Get Attention from Success.** People love to pay attention to success. If you don't believe this, try doing better and notice how people respond to you.
It's All My Fault	Everything that goes wrong is due to you.	*--The trauma was my fault* *--If I have a disagreement with someone, it means I'm wrong.*	**Give Yourself a Break.** Don't carry the world on your shoulders. When you have conflicts with others, try taking a 50-50 approach (50% is their responsibility, 50% is yours).
I am My Trauma	Your trauma is your identity; it is more important than anything else	*--My life is pain.* *--I am what I have suffered..*	**Create a Broad Identity.** You are more than what you have suffered. Think of your different roles in life, your varied interests, your goals and hopes.

© Guilford Press, New York. From: Najavits, L.M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (2002). Only for personal use (with clients); for any other use contact <info@seekingsafety.org> or permissions@guilford.com