Integrated Group Treatment of Women's Substance Abuse and Trauma

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ABSTRACT. Substance abuse and trauma co-occur at very high rates among women in clinical settings. However, clinical programs that address both problems are rare, due in part to knowledge deficits and attitudinal barriers in both substance abuse and mental health treatment settings. We describe core competencies for clinicians who treat women with co-occurring substance abuse and trauma, and some of the challenges these patients pose to more traditional treatment models. We also outline an integrated approach to treating these women, which incorporates elements of the relational model, motivational interviewing, emotional regulation, and distress tolerance and seeking safety. Finally, we describe the application of this model to group treatment through a pair of clinical vignettes.

KEYWORDS. Dual diagnosis, women, trauma, integrated treatment, substance abuse

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SUBSTANCE ABUSE AND TRAUMA

Scope of the Problem

Substance abuse and trauma co-occur at very high rates in clinical settings, with between 30% and 60% of women in substance abuse treatment settings meeting DSM criteria for post-traumatic stress disorder (PTSD), and even larger numbers reporting a lifetime history of traumatic events (Kessler, Sonnega, Bromet, Hughes, Nelson et al., 1995). Women in substance abuse treatment have rates of PTSD approximately two to three times higher than those reported by men (Najavits et al., 1998). There is some evidence that patients with PTSD fare worse in traditional treatment than patients with other co-occurring disorders, or those with substance abuse alone (Oumiette, Finney, & Moos, 1999), and that these patients present an unusually severe clinical profile at the beginning of treatment (Najavits, Weiss, & Shaw, 1997). Especially common is the presence of borderline personality traits, which have been found to be more common in this population than among women with PTSD or substance abuse problems alone (Oumiette, Wolfe, & Chrestman, 1996).

Unfortunately, clinical programs that address both problems are rare. When these patients present to primary substance abuse programs, they often report that they were never asked about a history of PTSD or traumatic experiences. It is even less common for such patients to receive truly integrated treatment that addresses both problems concurrently (Brown, Stout, & Gannon-Rowley, 1998). In substance abuse treatment settings, this is due in part to a reluctance to treat a population that can often be challenging, presenting with repeated suicidal crises, self-injury, interpersonal problems, and relapses to substance use. Similarly, it is not uncommon for clinicians in mental health settings to fail to assess for symptoms of substance abuse, and to harbor negative opinions about such patients (e.g., Najavits et al., 1995).

Pros and Cons of Traditional Programs and Models

Twelve-step organizations are unique in their availability and as a source of intensive support. The bonds formed in 12-step programs are often invaluable to recovery. As of 2005, Alcoholics Anonymous (AA) reported almost 1.2 million members and more than 52,000 meetings in the United States alone (AA Fact File, 2005). In addition, a host of 12-step organizations have arisen over the last several years to meet the specific needs of subsets of the substance-dependent population. Narcotics Anonymous

(NA) arose in response to the growing numbers of people who abuse substances other than alcohol. Dual Recovery Anonymous (DRA) is specifically intended for those who are chemically dependent and are also affected by an emotional or psychiatric illness. In addition to these offshoots, both AA and NA offer a range of specialty meetings, including meetings for women only, which may be more suitable for some women with substance abuse and trauma. However, DRA and specialty meetings are relatively uncommon and, outside of major metropolitan areas, may be difficult to attend regularly. Furthermore, in our experience, although many women with trauma histories benefit from DRA meetings, they report that these meetings are still predominantly male and focus primarily on severe and persistent mental illnesses such as schizophrenia and bipolar disorder.

Traditional substance abuse treatment programs may be inappropriate for some women with substance abuse and post-traumatic symptoms. Such programs have tended to rely strongly on facilitating 12-step involvement, confronting denial, providing psychoeducation about addiction, and enforcing treatment compliance through behavioral constraints. Some of the problems encountered by women in traditional substance abuse treatment settings include:

- *Confrontational interventions*. Although client-centered models of addiction treatment such as motivational interviewing (Miller & Rollnick, 2002; Velasquez, Stephens, & Ingersoll, 2006) are becoming more widely accepted, there is still a widespread belief that addiction is characterized by a deeply entrenched, pathological denial of substance-related problems and that aggressive confrontation is necessary to break through this denial. Although evidence has accumulated that a confrontational style is counterproductive with most patients (Miller et al., 1995), such an approach may be particularly poorly tolerated by women who have been the victims of aggression and who may be especially prone to mistrust and vigilant for signs of interpersonal danger.
- *Rigid insistence on 12-step meeting attendance*. Many women with substance abuse and post-traumatic symptoms, particularly those with borderline personality traits, are especially resistant to all forms of interpersonal control. Mandated attendance at 12-step meetings may threaten their fragile sense of autonomy and self-control and may therefore be met with quiet resistance or more overt episodes of acting out behaviors. Such reactions are often poorly tolerated in traditional addiction treatment, and can be misinterpreted as indicating a lack

of motivation to address substance use. In many programs, failure to attend 12-step meetings as required would be considered grounds for discharge from the program.

- *Emphasis on powerlessness*. Traditional substance abuse treatment emphasizes the need for patients to accept their powerlessness over substances, surrender their will and lives to a higher power, and maintain lifelong involvement in 12-step meetings. Some (Walters, 2002) have suggested that these ideas may be particularly inappropriate for women, especially those who have suffered abuse at the hands of those in positions of power and for whom dependence and unquestioning reliance may trigger feelings of hopelessness, vulnerability, and fear.
- *An exclusive focus on substance use*. Traditional 12-step treatment models have tended to assume that psychiatric symptoms resolve with abstinence from substances. Although this is often true, especially for mild to moderate mood and anxiety symptoms, for many women in early recovery post-traumatic symptoms are intense and disabling, and may require more intensive psychosocial interventions than traditional practitioners are able to provide. However, it is not uncommon for professionals and 12-step program members to advise women to ignore symptoms in early recovery, or to tell them that it is inappropriate to discuss issues other than substance use at 12-step meetings. Compounding this is the intolerable shame experienced by many women in discussing trauma histories, especially in the presence of men.
- *An exclusive focus on abstinence*. PTSD symptoms often emerge with renewed intensity as women initiate abstinence, and thus represent a potential trigger for relapse (Brady, Killeen, Saladin, Dansky, & Becker, 1994). In addition, even mild symptoms of substance withdrawal may create a level of physiological arousal that is intolerable to patients with preexisting symptoms of post-traumatic arousal (Jacobsen, Southwick, & Kosten, 2001). Clinically, this presents a particular challenge with patients with co-occurring borderline personality traits who may have particular difficulties modulating mood and tolerating aversive experiences. Similarly, traditional substance abuse treatment models have been intolerant of the use of any psychotropic medications as an adjunct to recovery. Women with trauma and addiction may require targeted use of a range of medications to support their recovery and to manage symptoms of hyper-

arousal associated with PTSD. This may include short-term use of benzodiazepines and other "mood-altering substances." Despite the fact that AA has long acknowledged the legitimate role of psychotropic medications in recovery (AA World Services, 1984), it is not uncommon for such women to be told by traditional substance abuse treatment providers or 12-step group members that they are not "truly in recovery".

- *Male-dominated 12-step meetings*. Twelve-step programs such as AA were traditionally developed by and for men. Although this has changed dramatically over the years, women still comprise only 35% of AA membership (AA Fact File, 2005). This can be particularly problematic for women who have experienced traumatic victimization, most often at the hands of men. Many women, especially those experiencing the emotional intensity of early abstinence, may find that prolonged exposure to men in a group setting, along with the tacit expectation of emotional self-revelation and trust, triggers intolerable feelings of fear and anxiety. Similarly, simple demonstrations of group unity, such as holding hands or exchanging hugs may be experienced as threatening and intrusive among those with histories of sexual victimization.

Specific Needs of Female Trauma Survivors in Addiction Treatment

Women with histories of trauma and substance abuse require clinicians who understand the unique needs of women in substance abuse treatment and the complex interplay between these two problems. Successful outcomes will require practitioners to provide integrated treatment that addresses both problems simultaneously. Such an approach requires knowledge both of substance abuse and mental health and the flexibility to shift the primary focus of treatment from one to another as the clinical picture changes. Specifically, such women require clinicians who:

- *Understand the interrelationship between substance abuse and trauma*. Substance abuse and trauma may interact in complex and unpredictable ways. These include:
  - *Substances as coping mechanisms*. For many, use of substances represents a desperate attempt to avoid anxiety and stimuli associated with specific traumatic events. Traumatic stimuli and

traumatic reexperiencing become strongly conditioned triggers for substance use, which subsequently becomes a maladaptive coping mechanism for avoiding emotional experience and suppressing frightening memories. Similarly, some substances, especially stimulants such as cocaine and methamphetamine, can induce a temporary sense of elation, euphoria, internal self-control, or interpersonal effectiveness that may be absent when not under their influence. Many women with trauma report that they only feel normal when under the influence or that they cherish the feeling of invulnerability that comes with substance use. Clinically, it can be very difficult to help patients to break these associations and to become willing to develop new coping skills.

- *Substances as risk factors for traumatic experiences*. It has long been recognized that abuse of alcohol and other drugs increases the probability that a woman will be exposed to traumatic victimization (Abbey, Zawacki, Buck, Clincon, & McAuslan, 2001). The picture becomes more complicated in women who have experienced physical or sexual assault in childhood. Subsequent abuse of alcohol and other drugs increases the probability that these women will expose themselves to dangerous situations, and thereby suffer additional episodes of victimization. Women who abuse stimulants such as cocaine and methamphetamine in particular are prone to feelings of invulnerability while under the influence that may cause them to ignore signs of danger and potential victimization. Practitioners working with these women need to be able to intervene effectively when confronted with patients who, wittingly or unwittingly, reexpose themselves to traumatic experiences.
- *Substance use as a form of self-injury or self-punishment*. For many women with trauma histories, episodes of substance use are triggered by feelings of self-loathing and a desire for self-punishment. In some instances this reflects an unconscious urge to expose themselves to physical or emotional danger. In others it represents an attempt at self-sabotage, which serves to reinforce their self-image as defective or incompetent. It is important for clinicians to recognize that for these women relapse may not be triggered by a craving for the drug experience, or by a need to escape emotional distress, but rather by a need to recreate a familiar state of self-loathing and self-hatred. Even when relapse is not motivated by a need for self-punishment, for some women guilt,

shame and self-hatred become strongly conditioned, automatic reactions to accidental relapse.

- *Appreciate the relational nature of treatment and recovery*. Even in the absence of trauma-specific problems, women's substance abuse may be related to interpersonal relationships in a way that men's are not. There is some evidence that, compared to men, women with substance abuse problems seek treatment more often due to concerns about the effect of their substance use on others, and may enter treatment with more guilt related to parenting and partner roles (Gomberg, 1999). A strong therapeutic alliance may be particularly important to successful treatment with these women. Given that past relationships have been marked by violations of trust and abuses of authority, a corrective emotional experience in the form of a steady, empathic, nonpossessive relationship may be especially important with this population.
- *Can assess and respond to crisis and self-injury*. Working with women with substance abuse and trauma histories requires at minimum that clinicians be able to screen for suicidality, distinguish self-injury from suicidal intent, refer to a psychiatrist or other mental health practitioner where appropriate, and help patients to learn alternative coping mechanisms. Traditional substance abuse counselors usually have limited training in crisis intervention and assessment and often do not appreciate the complicated interrelationship between self-injury, relational disruptions, and emotional distress. Similarly, traditional substance abuse counseling, with its primary emphasis on achieving and maintaining abstinence, often does not address crucial issues of emotional regulation, distress tolerance, social skills, and self-soothing. These are particularly crucial clinical skills given the problems with emotional lability that are so common in this population.
- *Respond productively to resistance and low motivation*. Traditional substance abuse treatment has been criticized for being confrontational and adopting a simplistic and counterproductive view of resistance to change (Miller & Rollnick, 2002). This is likely to be particularly problematic with women with trauma and substance abuse problems. Such women, having suffered mightily at the hands of destructive authoritarian figures, may be especially reactive to attempts at coercion. They are often wary of authority figures, and respond to authority with provocative hostility, withdrawal, or

deferential appeasement. Such women are more likely to respond well to an approach that emphasizes their autonomy and strengths and that responds in a nondefensive and nonconfrontational manner to resistance or low motivation for change.

- *Address dissociation and traumatic reenactment*. Dissociative states pose unique clinical challenges. It is vital that providers working with women with trauma and addiction be able to recognize early signs of dissociation and intervene with grounding techniques that promote reengagement with the environment. Similarly, such women often unconsciously reenact aspects of their original traumatic event(s), sometimes by engaging in destructive romantic relationships or exposing themselves to dangerous situations. In some cases, returning to environments associated with substance use reflects traumatic reenactment rather than a desire to use substances. Such women require practitioners who can help them to understand such unconscious motivations and work on developing other coping skills.

PROGRAM COMPONENTS

In response to the needs of this population, Princeton House Behavioral Health has developed an outpatient treatment program aimed at helping women with co-occurring substance abuse and trauma symptoms. Treatment is offered at the partial hospital and intensive outpatient levels of care and the primary modality is group treatment. Below we describe the conceptual underpinnings of this program as well as our approach to managing some commonly encountered clinical dilemmas.

This program represents a synthesis of the approaches and also has been influenced by other outstanding models, including dialectical behavior therapy (Linehan, 1993) and skills training in affective and interpersonal regulation (STAIR; Cloitre, Cohen, & Koenen, 2006). Although this model applies specifically to women with trauma and addiction, similar efforts have been directed toward men as well (e.g., Fallot, Harris, & the Community Connections Men's Trauma Workgroup, 2001).

Motivational Interviewing

As defined in the most recent edition of *Motivational Interviewing: Preparing People to Change* (Miller & Rollnick, 2002), Motivational interviewing (MI) is "a client-centered, directive method for enhancing

motivation to change by exploring and resolving ambivalence" (p. 22). MI is firmly rooted in the humanistic psychotherapy tradition and focuses primarily on applying client-centered principles and techniques to creating focused conversations around behavior change. Using open-ended questions, reflections, affirmations, and summaries, MI practitioners seek to elicit and tacitly reinforce patient statements indicative of desire or confidence in the possibility of change. MI is structured without requiring the therapist to be didactic and therefore permits practitioners to remain focused without overtly dictating the goals of process of treatment. Although MI does include specific techniques, it is grounded in a client-centered, strength-based approach to patients and therefore emphasizes the importance of an empathic, respectful, and collaborative relationship in helping to elicit motivation and strategies for change. Although MI was originally conceived as an individual treatment modality, recent work has begun to describe adaptations for group treatment (Velasquez, Stephens, & Ingersoll, 2006).

MI has several advantages with this population. First, its nonconfrontational, empathic stance is likely to be more tolerable to women with trauma histories than more traditional, highly confrontational approaches. Second, MI describes approaches to "rolling with resistance" that can help clinicians avoid power struggles with patients and set appropriate boundaries without being punitive. Third, by emphasizing the importance of "meeting the patient where she is," MI is compatible with harm reduction approaches, which emphasize small but meaningful changes in the direction of eventual abstinence. Fourth, MI explicitly disavows the "expert trap," wherein the clinician adopts a hierarchical, top-down approach to treatment, in favor of a more egalitarian approach focused on developing competencies within the context of a collaborative relationship. Fifth, MI is an approach that seeks to identify and elicit patient strengths and may therefore implicitly challenge the sense of defectiveness, incompetence, and shame that so often characterizes women with histories of trauma.

Relational Model

One of the legacies of childhood trauma is a disruption in the development of adaptive interpersonal schema that would normally emerge from secure attachment relationships. Instead, the person with a history of abuse often develops the belief that "to be interpersonally engaged means to be abused" or "abuse is a way to be connected" (Cloitre, Cohen, & Koenen,

2006, p. 16). Such schemas frequently lead to repeated experiences of revictimization, powerlessness, or loss of agency. Survivors of childhood trauma must often restructure their blueprint for relating if they are to function effectively.

Our treatment model is designed to help women develop the ability to change their maladaptive patterns of relating through growth-promoting interpersonal interactions. This model is based upon the basic philosophy of empowering women through relationships that foster mutual empathy, growth, and connection. The Relational-Cultural Model of Development (Miller, 1986), developed at the Stone Center of Wellesley University, is rooted in the assumption that the central organizing principle in a woman's development is a sense of interpersonal connection. Therefore, therapeutic approaches based on this model stress the importance of growth-fostering relationships that allow mutual empathy and an authentic representation of the self in the relationship. This means that others are responsive to one's experience, resulting in feeling heard and understood. These relationships are based on mutual respect, an acceptance of each other's influence, and the safety to experience vulnerability within the relationship.

Because of its emphasis on the curative power of egalitarian relationships, the relational model is ideal for settings in which group therapy is the predominant modality. Working through the connections and disconnections in relationships both with peers and with professionals, the patient is able to develop and practice new schemas for relatedness. These schemas eventually replace entrenched beliefs that are grounded in negative emotions such as fear, powerlessness, helplessness, guilt, or shame. Instead, these "corrective" experiences allow openness to change and growth as each participant has equal power and influence to effect change over their environment.

Emotional Regulation and Distress Tolerance

Individuals who have suffered interpersonal trauma often experience functional impairment resulting from difficulty modulating emotions, PTSD symptoms, and interpersonal problems. Responses may fluctuate between expressions of intense emotion to attempts to over-control or "stuff down" those emotions, often resulting in disruptions in interpersonal relating. Marsha Linehan was one of the first psychologists to begin discussing these disturbances in managing intense emotion, as a result of her work with chronically suicidal patients. Dialectical behavior therapy (Linehan,

1993) was developed as a treatment program incorporating both group and individual treatment modalities and was designed to help reduce emotional over-reactivity by providing patients with alternative ways of responding to internally or interpersonally generated emotional experiences. Building on this approach, Cloitre, Cohen, and Koenen (2006) have developed a program that targets the range of symptoms resulting from PTSD, emotional regulation, and interpersonal impairments. We have found it useful to incorporate some of the principles and techniques of affective and interpersonal regulation from both of these programs. Patients are taught to identify and manage their physiological, cognitive, social, and emotional reactions in a way that allows them to tolerate intense negative emotions and increase opportunities to experience positive emotions and relationships. Issues of emotional reactivity, distress tolerance, self soothing, dissociation, self injury, substance abuse, lack of assertiveness, difficulty trusting others, and repeated victimization are some of the areas addressed. Developing self-regulation and distress tolerance provides opportunities for the patients to experience and learn to tolerate emotional connections in relationships, and to become more emotionally and authentically engaged within those relationships.

Seeking Safety

Seeking safety, an integrated treatment approach developed by Najavits (2002), specifically targets women with comorbid PTSD and substance use disorders. The goals of safety and the restoration of lost ideals are communicated in a language that emphasizes respect, protection, and healing. Using a cognitive-behavioral model, the treatment approach is structured, psychoeducational, and solution-directed. Its philosophy complements that of the relational model, both emphasizing compassion for the patient's experience and returning a sense of control to the individual, while at the same time integrating support and accountability.

As it is designed to be used in a short-term, group format, our program has integrated many aspects of this approach into treatment. Employing the psychoeducational approach, the women are taught to understand the interactions between their addictive behaviors and the PTSD symptoms they experience. They learn more adaptive skills to use when coping with the difficult symptoms of arousal, numbing, and intrusion, thereby reducing their dependence on the substances they had previously used to avoid these destabilizing symptoms of PTSD.

OTHER PROGRAMMATIC ISSUES

Urine Drug Screening

Urine drug screening (UDS) with this population poses some unique challenges, and if not handled with sensitivity, may serve as a trigger for prior traumatic experiences. Patients may experience UDS as a punishment, or as a humiliating or frightening loss of autonomy, especially when UDS results are used as a basis for discharge from the program. Staff observation during specimen collection may evoke feelings of shame and bodily invasion and may be particularly triggering for survivors of sexual abuse. Upon being confronted with positive UDS results, women with trauma histories may implausibly deny the results and experience staff skepticism as a recapitulation of trauma-related episodes in which significant others failed to believe them. For all of these reasons, in traditional substance abuse programs women in trauma histories are prone to becoming involved in fruitless struggles with staff over UDS, especially when issues of trust, power, and privacy are triggered.

In our program, these issues are handled in several ways. First, and perhaps most important, UDS is presented to staff and patients alike as a collaborative exercise. Staff are encouraged to create an atmosphere in which the first priority is an honest discussion of the results and their implications for treatment. UDS results are never used in a punitive manner, and positive UDS results alone are never used as a criterion for involuntary discharge from the program. Second, whenever possible, UDS is administered to the group as a whole, rather than singling out individual patients suspected of using. This helps to avoid triangulation and potential rivalries between patients.

As a result, we have experienced relatively few power struggles with patients over UDS. Surprisingly, some patients who have experienced more traditional substance abuse treatment have initially expressed dismay that patients are not discharged for positive UDS, expressing the concern that our program is "too permissive," and may be allowing patients to "get away with" substance use. Interestingly, we routinely have patients request UDS, as many experience it as a tangible marker of therapeutic progress a tool for helping them to stay on track.

12-Step Involvement

Our program supports, but does not mandate 12-step involvement. Women with little or no exposure to recovery programs are encouraged

to attend, and clinicians work with patients to navigate the twelve steps and, when necessary, translate the principles into language that is more consistent with the needs and experiences of these women.

We have found several principles important in facilitating 12-step participation with women with trauma histories. First, we do not adhere to a strict disease model of addiction. Rather, we emphasize the complex interrelationship between trauma and substance use and educate patients about the role substances can play in shielding them from painful thoughts, feelings, and memories. Clinicians are willing to switch from a primary focus on substance abuse to PTSD symptomatology, depending on the prominence and relative urgency of each problem. Women who have received treatment in traditional substance abuse programs sometimes report having been told that their psychiatric symptoms would resolve quickly with abstinence, and having been accused of "being on the pity-pot" or failing to "work the program" if they failed to abstain. As a result, for many women with trauma histories exclusively focusing on immediate abstinence can be experienced as invalidating. For this reason, although we advocate abstinence as a primary treatment goal in almost all instances, we adopt a primary harm reduction model that recognizes that, for many women, substance use has served a defensive function, and that abruptly discontinuing use may result in overwhelming emotions that can trigger relapse. Second, we have found it necessary in some instances to "translate" 12-step principles into language that is compatible with patients' experiences. For example, we frame 12-step involvement as "an invitation to build community" and frequently frame spirituality in terms of Mother Earth or Goddess spirituality. This is particularly helpful with patients who report suffering sexual abuse at the hands of clergy or having been made to feel sinful by a religious community. Third, we provide patients with self-help materials specifically geared toward women. Particularly helpful in this regard is the Hazelden publication entitled, "A Woman's Way Through the Twelve Steps."

Third-Party Relationships

It is not unusual for patients in our program to be referred by family services or the legal system, and for these services to request regular progress updates. Such third-party relationships are fraught with peril with this population and must be managed with care. Survivors of interpersonal trauma are particularly sensitive to issues of secrecy, loyalty, and inappropriate boundaries. Mistrust of authority and anxiety about secrecy may lead them to engage in defensive behaviors that traditionally have been

labeled as "splitting." We address these concerns by maintaining absolute transparency regarding any communication with third parties. For example, letters regarding the patient's progress are not only provided to the patient, but often are addressed to the patient as well. This simple measure helps patients to feel "communicated with" rather than "talked about," and to reduce anxiety about third-party communications.

CLINICAL EXAMPLES

Patient A entered our treatment program after failing several traditional treatment programs. She presented with a long history of heroin dependence, and ongoing sexual abuse by a family member as a child. The patient had internalized her childhood abuse in the form of an "inner critic" that was self-loathing and punitive of her failed attempts at sobriety. At initial intake, she was stuck in a cycle in which abstinence resulted in the emergence of PTSD symptoms that were too overwhelming to tolerate without adequate coping skills. Lacking these skills, the patient would relapse to heroin use, reinforcing her addictive behavior and her trauma-based perception of herself as "worthless" and "hopeless."

Using motivational interviewing, the program staff approached her resistance to change by developing discrepancy through the use of a decisional balance in which the pros and cons of using heroin were explored. She was able to identify the way in which using substances helped her to manage her emotional distress and reduce her post-traumatic memories but also resulted in retraumatization by recreating her childhood messages about herself and putting herself in dangerous situations such as prostituting herself for drugs. Unlike previous treatment episodes, our staff reframed her substance use as a maladaptive coping mechanism for managing PTSD symptoms, which therefore reflected in part an impulse towards self-care. They also helped her to link her ambivalence about treatment to her trauma history, rather than punish her for her relapses. As a result, she became more receptive to working on replacing her substance use with skills learned through seeking safety.

Second, staff and other patients helped her to identify ways in which her trauma history led her to avoid emotionally charged situations by using substances. She was then able to incorporate emotional regulation and distress tolerance coping skills. Specifically, she was able to practice emotional mindfulness when faced with emotional triggers for relapse, allowing her to experience her emotions in an authentic and nonjudgmental

way. Moreover, coping skills groups focused on helping the patient develop grounding and containment techniques rather than relying on maladaptive attempts at coping with her PTSD symptoms through drug use. A clinical case in point:

> Early in treatment, Patient A told the group that her flashbacks and nightmares had become unbearable since she had stopped using heroin. She was unsure about her ability to maintain abstinence in light of these exacerbated symptoms. Group members related to her and gave examples of their struggles to maintain sobriety when experiencing heightened PTSD symptoms. They also were able to describe their use of grounding and containment skills learned in treatment to control trauma symptoms, thus making it easier to prevent relapse. One group member explained to Patient A that her use of deep breathing helped her to relax in the face of flashbacks, and focusing on her five senses reminded her that she is in the present and not in the past. Another group member indicated that she found imagery to be useful, and that she visualized storing her memories in a box to be taken out later and dealt with during a therapy session. Patient A was skeptical, stating that she had "tried that New Age stuff before and it doesn't work for me." At this point, the group leader intervened to provide education to Patient A about the usefulness of grounding and containment skills: "Containment and grounding skills are ways to gain control over your PTSD symptoms by identifying your symptoms, using a skill to manage them, and setting them aside to deal with later. Imagery, deep breathing, mindfulness, journaling, and paying attention to your five senses are examples of grounding and containment skills you might use." The group leader then normalized the patient's experience: "It makes sense that the idea of using these skills seems insufficient to manage your flashbacks. Most women who turn to drugs and alcohol to manage PTSD symptoms do so because it is initially quick and effective in stopping symptoms. With time and practice, however, grounding and containment skills can be quite effective without the negative consequences of substance use." Patient A worked both individually and in groups throughout treatment to identify the specific skills that worked best for her.

Initially, Patient A was extremely anxious about urine drug screens because previous treatment programs had discharged her for relapse. However, our program views urine drug screens as a therapeutic tool to explore

ambivalence, rather than an attempt "catch" the patient in her substance use. Our staff infused the process of drug screening with the motivational interviewing principle of supporting self-efficacy by conveying their belief in the patient's ability to change and by promoting the use of drug screens as a way to structure collaborative conversations about the patient's struggle to manage her painful emotions.

Finally, our program helped Patient A to reconnect with AA. In the past, she had disliked the confrontational approach of the more traditional, dogmatic 12-step support groups, which she experienced as requiring her to admit her "powerlessness" and adopt a self-punitive stance towards relapse. Involvement in such groups became another way in which she recreated her self-critical childhood messages about herself, only promoting the occurrence of relapse as a way of minimizing her distress. The empowering nature of our treatment approach allowed her to become involved in AA groups in a manner consistent with her new understanding of her addiction. She returned to meetings for women only and was able to develop a new relationship with her sponsor that was encouraging, supportive, and empathic rather than dogmatic, threatening, or submissive.

Patient B was a single 40-year-old Caucasian woman who was referred to our program after an inpatient hospitalization for a suicide attempt. She had a 10-year history of brief outpatient treatment episodes in which she would repeatedly begin and then terminate, or be terminated from, treatment. She reported a history of severe parental neglect, sexual abuse in adolescence by a teacher, and rape. She drank alcohol to sabotage success; to reinforce feelings of shame, guilt, and worthlessness; and to escape emotional pain, and she had a long history of chronic suicidality and self-harm via cutting. Strengths included a successful work history in a medical helping profession from which she derived a great sense of self-worth and meaning. At the time of admission, she had isolated herself from all relationships in her life outside of work and had very poor social support. She had a past history of volatile romantic relationships and had difficulty trusting and intense fears of abandonment.

The initial task that this patient addressed with the treatment team was to develop compassion towards herself, build her self-efficacy, and decrease debilitating shame and self-loathing. Using components of the seeking safety model, she began to recognize that her alcohol use, cutting, and suicidal ideation were attempts to escape intrusive trauma memories and feelings of abandonment and worthlessness. A clinical example will illustrate this point.

> During her third week in the program, the patient indicated during morning check-in that she had drunk alcohol to intoxication and deliberately cut herself the previous night following a distressing phone conversation with her estranged mother. She discussed the incident in group and expressed intense feelings of disgust and hopelessness that she would ever be able to change this behavior. The group responded in a supportive manner by relating examples of times when they had used substances in response to difficult interactions with their families of origin. One group member described experiencing a relapse after 3 months of sobriety at a family reunion in which she had contact with a family member who had been a perpetrator of sexual abuse. Another group member indicated marijuana use was a means of coping with ongoing contact with abusive parents on whom she was financially dependent. The overall mood of the group was somber and depressed. The group facilitator reflected that the patient's feelings were intense and seemingly intolerable, and suggested that although seeking an end to such overwhelming emotion is normal and healthy, perhaps the means by which the patient sought to end her pain was maladaptive. By reframing the symptoms as understandable efforts to manage post-traumatic stimuli, the therapist was able to help the entire group better understand the interconnected nature of PTSD and substance abuse, and begin to identify alternative means of coping with intense emotion.

Another essential component of her treatment involved drawing on her past success in her professional career. Here, the motivational interviewing technique of developing discrepancy was essential. The patient was helped to build discrepancy between her desire to be a caring and loving person through her career, and her inability to care for and love herself as evidenced by excessive drinking, isolating, and cutting:

> Patient B attended a group in which another member was preparing for discharge and discussing plans to return to work. The patient responded by reminiscing about the joy and satisfaction she took from her work helping others, highlighting an ability to respond effectively to crisis situations, help others feel at ease, and work under pressure. She expressed fear she would not be able to return to this level of functioning and verbalized self-deprecating thoughts about her substance abuse. Group members responded by validating her strengths. One group member stated that she felt Patient B's feedback in groups

> had been instrumental to her own recovery. A second group member identified with Patient B's feelings of hopelessness, but also indicated that she could see growth since beginning the program, particularly a greater willingness to reach out to others. The group facilitator highlighted the discrepancy between group members' observations of the patient's strengths and her negative self-evaluation.

By internalizing this discrepancy she was better able to apply the strengths she used in caring for others (compassion, persevering under stress, and finding creative solutions to problems) to her own self-care and risk relating more authentically to her peers.

The patient struggled to maintain safety, at times taking extra medication and cutting during program hours. She was able to identify these episodes as attempts to moderate overwhelming emotions while seeking help from staff when she felt unable to do so verbally. She was encouraged to stay connected with her treatment team and work through difficult feelings and issues. This ran contrary to a prior experience in another program in which "acting out" had resulted in her being discharged from treatment, reinforcing her trauma-related belief that she would be abandoned. Consistent with principles of the relational model, as she became more able to relate honestly to staff without avoiding conflict. She also became better able to do so with other group members, and eventually to build compassion and acceptance for herself. For example:

> The patient was seen by a staff member pacing the hallways during group time, and the staff member asked her about her emotional state. She reported difficulty staying in group because of feeling angry and overwhelmed by the intense emotional content. The staff member coached her in seeking safety skills such as communicating her feelings with the group and developing grounding and containment skills. She was then encouraged to return to group and practice these skills. The patient returned to group and was able to verbalize her discomfort and current feelings. She apologized to the group for having stormed out, and discussed the impact of her trauma history on her relationships, along with her intense anger that her traumatic history continued to have power in her life. Patient B then experienced support from group members. The facilitator thanked Patient B for sharing her experience and commended her on her courage in returning to group and identifying her feelings. One group

member indicated that she also was angry that trauma was continuing to impact her life, but that understanding the connection gave her a greater sense of self-control.

In this example, the patient found that staying connected with others allowed her to experience resolution, social support, and a decreased sense of being overwhelmed. The healing relationship with the group contradicted her expectations and, indeed, her experience in prior relationships by helping her to see that conflict could be tolerated without resulting in either violence or abandonment.

The "asking for help" module of the seeking safety model also helped the patient to see that although she found it easy to help others, she had difficulty asking for help for herself. She had a strong desire to connect with and be accepted by staff. However, she was particularly hesitant and resistant to building connections with other patients unless it was as a helper or an expert. She began by asking for concrete things (i.e., needing tissues in the group rooms) and was gradually able to reach out to others when she experienced emotional pain or felt unsafe.

Maintaining extra-therapeutic support was particularly difficult for this patient. She reported having no friends, maintaining an ongoing but distant relationship with her family, and having experienced a series of unsuccessful and violent romantic relationships. All of these experiences complicated her ability to trust and to build new relationships. This difficulty intensified around 12-step involvement, as she initially refused to attend meetings outside of her treatment program. Rather than confronting her resistance, staff used principles of motivational interviewing to "roll with her resistance" and to encourage her to identify the specific difficulties she had with AA, especially the idea of "powerlessness." Because of her history of abuse, she felt that her power had already been stolen from her and she was "unwilling to give up any more (power)." Because of her aversion to the 12-step philosophy, the patient was encouraged to find other ways of building social support for her recovery. She gradually increased her involvement with her local church, developed new, sober hobbies such as bowling, joined a bowling league, and began regularly attending a self-help sexual abuse survivors support group. In this way she was empowered to make her own choices in finding resources that would support her addiction recovery and trauma recovery.

SUMMARY AND CONCLUSIONS

Addressing the treatment issues for women with comorbid PTSD and substance abuse disorders is complex. Moreover, treatment outcomes with this population tend to be poor. An understanding of the intricate interrelationships between a patient's trauma history and her substance use can be vital to effective treatment with this population. In the group-focused treatment program described above, we have combined the principles of a relationally focused model with motivational interviewing techniques and emotional regulation and distress tolerance skills to better engage and treat this difficult population.

Through group-focused treatment, our women's trauma and addiction program combines a client-centered, relational approach with skills training. It represents an effort to integrate evidence-based practices from the mental health and substance abuse treatment fields into a coherent package that provides seamless treatment for both disorders. We seek to help patients develop an understanding of the relationship between their substance abuse and traumatic experiences, while improving coping skills for dealing with those feelings, situations, memories, and relationships associated with the abuse history that may be likely to trigger a relapse.

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