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Treatment Challenges Associated with Comorbid Substance Use and Posttraumatic Stress Disorder: Clinicians' Perspectives

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Abstract

A significant proportion of individuals with substance use disorders (SUDs) meet criteria for comorbid posttraumatic stress disorder (PTSD). This comorbidity confers a more complicated clinical presentation that carries with it formidable treatment challenges for practitioners. The current study examined sources of difficulty and gratification among clinicians (N = 423) from four national organizations who completed an anonymous questionnaire. As expected, the findings revealed that comorbid SUD/PTSD was rated as significantly more difficult to treat than either disorder alone. The most common challenges associated with treating SUD/PTSD patients included knowing how to best prioritize and integrate treatment components, patient self-destructiveness and severe symptomatology, and helping patients abstain from substance use. The findings increase understanding of SUD/PTSD treatment challenges, and may be useful for enhancing therapist training programs, supervision effectiveness, and designing optimal SUD/PTSD interventions.

INTRODUCTION

Epidemiologic surveys demonstrate substantial comorbidity of substance use disorders (SUDs) and other psychiatric conditions.[1–4] Recent data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which surveyed more than 43,000 adults in the United States, found that 40.9% of individuals with an SUD had a comorbid lifetime mood disorder and 29.9% had a comorbid lifetime anxiety disorder.[5] A frequently co-occurring anxiety disorder is posttraumatic stress disorder (PTSD).[6,7] The comorbidity of SUDs and PTSD results in a more complicated clinical presentation and treatment prognosis, including higher rates of Axis I and II disorders, higher relapse rates, more medical and interpersonal problems, and poorer aftercare attendance.[8–17]

Not surprisingly, patients with comorbid SUDs and PTSD present a formidable challenge to even the most seasoned clinicians and consensus regarding ideal treatment practices for SUD/PTSD patients is lacking. Contrary to many patients' treatment preferences,[18–21] the majority of SUD/PTSD patients receive SUD treatment only.[21,22] Exposure-based therapies, which are the gold standard in treatment for PTSD, are underutilized by clinicians.[23] Reasons for this are varied, and include a concern that exposure-based therapies will induce relapse or clinical deterioration.[23–25] However, the few studies that have investigated the tolerability and efficacy of addressing PTSD among individuals with SUDs do not indicate any increased risk of use or relapse, but rather demonstrate significant reductions in craving and substance use.[26–30]

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Little research has been conducted to date on clinicians' perspectives of working with this dually diagnosed population. In one study of 147 clinicians attending professional workshops for Seeking Safety, an integrated SUD/PTSD treatment, Najavits[31] found that individuals with co-occurring disorders were perceived by clinicians as more difficult to work with as compared to individuals with either disorder alone. In addition, certain clinician and work setting characteristics were associated with greater difficulty in treating SUD/PTSD patients. For example, clinicians without a personal history of trauma or SUD, Ph.D.-level clinicians, and those working primarily in a mental health setting reported the greatest difficulty in working with SUD/PTSD patients.[31]

The goal of the current study was to build on previous work investigating clinicians' perspectives of treating SUD/PTSD patients, with a particular emphasis on areas of difficulty. Specifically, quantitative and qualitative information was gathered regarding common treatment challenges and dilemmas associated with treating SUD/PTSD patients. Such information is critical for improving therapist training programs and enhancing SUD/PTSD interventions.

MATERIALS AND METHODS

Participants were 423 clinicians who completed the Clinician Survey on PTSD and Substance Abuse.[31] An invitation to participate in the study was sent to four national organizations via their member listservs: the College on Problems of Drug Dependence, Association for Behavioral and Cognitive Therapies, International Society for Traumatic Stress Studies, and the National Institute on Drug Abuse's Clinical Trials Network. Clinicians were invited to participate in a brief, anonymous, online survey regarding their views of treating patients with alcohol or drug use disorders and comorbid PTSD. Participants did not receive compensation.

The Clinician Survey on PTSD and Substance Abuse[31] is a 40-item questionnaire that inquires about how gratifying and difficult it is to work with patients with SUDs, PTSD, or both; what areas are most difficult in treating this dual diagnosis; and common emotions clinicians experience when working with SUD/PTSD patients. The survey also collects, for example, demographic data; years and type of training (eg, social worker, doctoral-level psychologist, psychiatrist, certified alcohol/drug counselor); primary work setting (eg, mental health, substance abuse, dual diagnosis program); and theoretical orientation.

Descriptive analyses were conducted for questionnaire items of interest. Independent samples t-tests, analyses of variance (ANOVAs) and bivariate correlations were used to test associations between variables of interest. Alpha was set at .05 for all analyses.

RESULTS

Demographics

Table 1 presents the demographic and descriptive characteristics of respondents. The average number of years of clinical experience was 14.4 years among professionals and 3.9 years (*SD* = 2.1) among clinicians still in training. As can be seen, training backgrounds and work settings were diverse.

SUD/PTSD Treatment Challenges

Table 2 presents the mean responses to items assessing difficulties associated with treating SUD/PTSD patients. As can be seen, respondents rated the treatment of the dual diagnosis as the most difficult, followed by SUDs alone, then PTSD alone (F (2, 750) = 101.10, $p < .001$). The most difficult aspects of treating SUD/PTSD patients included self-destructive behaviors

(eg, suicidal ideation, cutting), heavy case management needs (eg, finding services, referrals), and patients' dependency (eg, needing high levels of care).

Dilemmas—Clinicians were also asked to report in an open-ended fashion about common dilemmas in treating SUD/PTSD patients. Examples describing the three most commonly reported areas of difficulty are found in Table 3. Approximately15% of the sample reported struggling with treatment integration or implementation issues and 13% reported struggling with patients' severe symptomatology and self-destructive behaviors. Some clinicians (7.8%) endorsed the challenge of helping patients abstain from alcohol or drug use during treatment.

A minority of clinicians reported a lack of appropriate supervision or training (3.8%). This often involved clinicians reporting that they had training in one area (eg, PTSD), but did not feel competent to treat the comorbid conditions (eg, SUDs), and hence would refer the patient out. Several clinicians also reported that the treatment setting that they practiced in did not support integrated treatment (3.5%), and 2.6% of the sample reported a concern that patients' substance use would escalate due to addressing the PTSD.

Emotions—The most commonly reported emotions associated with treating SUD/PTSD patients were frustration and anger (22.9%). Clinicians reported experiencing these emotions as a result of patients' self-destructive behaviors, substance use, missed appointments, lack of insight, or poor judgment. In addition, clinicians reported experiencing anger toward the patient's perpetrator and because of the slow progress of therapy. Sadness was the second most commonly reported emotion (10.6%) in clinical work with SUD/PTSD patients.

SUD/PTSD Treatment Sources of Gratification

Sources of gratification, which could be useful targets of emphasis during supervision or therapist training, were also examined (see Table 4). Significant differences by diagnostic group were observed, F (2, 704) = 24.80, $p < .001$. Treating PTSD alone was rated as the most gratifying, followed by the dual diagnosis, then SUDs alone ($p < .001$). Common sources of gratification included developing expertise in working with this patient population, teaching patients new coping skills, and helping patients become abstinent from alcohol and drugs.

Clinicians uniformly responded with more gratification than difficulty in treating patients with SUDs alone [M = 2.24 vs. 1.04, t(378) = −14.82, $p < .001$]; PSTD alone [M = 2.51 vs. .89, t (369) = −24.95, $p < .001$]; and with the dual diagnosis [M = 2.38 vs. 1.51, t(370) = −12.72, $p < .001$]. Correlations between ratings of difficulty and gratification indicated inverse relationships for each diagnostic group ($p < .001$). As the perceived difficulty of treating patients increased, the gratification decreased.

DISCUSSION

This study investigated challenges involved in treating patients with SUDs, PTSD, or co-occurring SUD/PTSD. Clinicians (N = 423) from varying training backgrounds and treatment settings participated. The findings underscore how challenging and intense SUD/PTSD clinical work can be, even for experienced clinicians (the average number of years of clinical experiences was 14.4 years).

Consistent with previous research,[31] clinicians rated comorbid SUD/PTSD as the most difficult group to treat. One of the most unique and challenging issues for therapists in treating SUD/PTSD is understanding when and how to best integrate the different treatment components for trauma and SUDs. Typically, SUD/PTSD patients who present for treatment are still actively using substances or in early remission. Many SUD/PTSD patients will relapse at some point during treatment, whether enrolled in an integrated or standard substance use treatment

program. How much "clean time," therefore, is needed before working on the trauma? When is the optimal time to introduce trauma/PTSD work? Should trauma work be discontinued if the patient relapses? Can patients who significantly decrease but still continue to use substances still benefit from trauma work? Clearly, these are important questions that need to be addressed in future research so that treatment guidelines may be established.

Although inconclusive at this point, the extant literature does provide some information to help address these concerns and guide clinical efforts. First, many of the empirically investigated integrated SUD/PTSD treatments strongly encourage, but do not require, abstinence from substance use before beginning trauma work.[27, 33] These treatments have been shown to result in significant improvements in both SUD and PTSD symptoms, demonstrating that abstinence is not absolutely essential before patients can benefit from concurrent trauma work. Indeed, addressing the trauma may help facilitate reduction in substance use for patients who are continuing to use in order to cope with trauma-related symptoms.

Regarding the ideal time in treatment to initiate trauma work, integrated treatments generally introduce trauma work following an initial phase focused on substance use. During the initial phase, which may last from one to three months,[17,31,32] patients are taught coping skills (eg, drug refusal skills, coping with triggers, problem solving, relaxation training) to help achieve or maintain abstinence or significantly reduce alcohol and drug intake. Patients receive psychoeducation beginning at the very first session, however, about the interrelationship between PTSD and SUDs. Indications that a SUD/PTSD patient is prepared to engage in trauma work (eg, prolonged exposure) include, for example, significant reductions in substance use, significant reductions in or absence of self-harming behaviors or suicidal ideation, a solid understanding of the rationale for trauma work and what it will involve, adequate learning and adoption of healthy coping skills, a collaborative patient-therapist agreement to begin trauma work, and realistic expectations regarding the potential initial difficulties of engaging in trauma work and the importance of sticking with it by using healthy coping skills.[32,34,35] In summary, some length (eg, one to three months) of abstinence or significantly reduced substance use is encouraged before beginning trauma work, although it remains unclear exactly how much time is necessary for trauma work to be beneficial.

The findings from this study identify severe symptomatology and self-destructive behaviors as another common challenge of treating SUD/PTSD patients. In the event of a crisis, the decision to move forward with trauma work in would depend on several factors (eg, successful resolution of the crisis, extent of the crisis, patient's willingness). Because avoidance is strongly characteristic of both PTSD and substance abuse, clinicians working with SUD/PTSD patients need to consider whether a patient might be attempting to avoid discussing the trauma through such a crisis. As indicated earlier, many patients relapse during treatment. A lapse does not necessarily represent a crisis and does not always require a delay in trauma work. In fact, it may not be beneficial (from an avoidance perspective) to defer trauma work when a patient lapses. Rather, relapse prevention skills should be reviewed, the difference between a lapse and a full-blown relapse emphasized to protect against the abstinence violation effect, and a functional analysis performed to help identify antecedents of the use.

Supervision of SUD/PTSD clinicians can be improved by addressing these common challenges and by helping clinicians to build the necessary skills and expertise. Given the common challenges associated with severe symptomatology and self-destructiveness, it is important for supervisors to instruct and review with SUD/PTSD therapists their crisis intervention skills, distress tolerance techniques, anger management and disarming techniques, negative affect management, and ways to handle patient dissociation. Because of the extensive case management needs that many SUD/PTSD patients have, therapists and supervisors should have available a list of local services in the community (eg, housing, vocational rehabilitation,

domestic violence shelters) that patients can access. This will help take some of the burden off the clinician.

Supervisors can also assist by helping clinicians balance the more challenging aspects of treating SUD/PTSD patients with the sources of gratification. This may help prevent or reduce therapist burn out. The top three sources of gratification in working with SUD/PTSD patients were developing expertise in working with these clients, teaching clients new coping skills, and helping clients become abstinent from substances. Surveys such as the one used in this study can be modified and used by supervisors to assess challenges and sources of gratification among SUD/PTSD their supervisees, and then tailor supervision efforts and goals accordingly.

Limitations

While this study was anonymous, the findings are based on self report and, as such, biases may exist. Clinicians from four national organizations were invited to participate. As such, the findings may not generalize well to clinicians outside of those organizations. Data on treatment outcome was not collected in this study; thus, it is unclear how clinicians' perspectives impact treatment outcome. A strength of the study is the large sample of clinicians who participated with diverse training backgrounds, work settings, and theoretical orientations.

CONCLUSIONS

The findings underscore the significant challenges that exist on multiple levels in treating comorbid SUDs and PTSD. One of the most common and unique challenges associated with treating SUD/PTSD patients involves knowing how to best integrate treatment components for PTSD and SUD symptoms. Clinicians frequently struggle with questions regarding when to initiate or defer trauma work and how to deal with continued patient substance use. While more research is clearly needed to help conclusively answer these questions, the extant literature provides some tentative guidance and supports the use of integrated psychosocial therapies that address both SUDs and PTSD concurrently. The findings from this study help increase understanding of the issues involved in providing treatment to SUD/PTSD patients, and may be helpful in improving therapist training programs, supervision practices, and the design of integrated treatment manuals for comorbid SUDs and PTSD.

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TABLE 1

Respondent demographics (N = 423)

Age, M ± SD	45.0 years ± 12.2
Gender	56.7% female (*n* = 240)
	26.0% male (*n* = 110)
	17.3% did not report (*n* = 73)
Years of clinical experience, M ± SD	14.4 years ± 10.1
Primary work setting	
Mental health	25.1% (*n* = 106)
Substance abuse	24.8% (*n* = 105)
Dual diagnosis	20.8% (*n* = 88)
No response	16.3% (*n* = 69)
Other	13.0% (*n* = 55)
Training background[*]	
Ph.D.[†]	36.4% (*n* = 154)
Certified Alcohol and Drug Counselor (CACD)	19.4% (*n* = 82)
Master's degree	12.1% (*n* = 51)
Social work[‡]	10.6% (*n* = 45)
Psychiatrists and other physicians	8.0% (*n* = 34)
Pastoral counseling[§]	2.8% (*n* = 12)
Nursing	0.9% (*n* = 4)
Other	20.3% (*n* = 86)
Primary theoretical orientation	
Cognitive-behavioral	43.3% (*n* = 183)
Eclectic	27.9% (*n* = 118)
Psychodynamic or psychoanalytic	2.1% (*n* = 9)
12-step	1.9% (*n* = 8)
Systems	1.4% (*n* = 6)
No response	20.1% (*n* = 85)
Other	3.3% (*n* = 14)

[*] Participants were permitted to report multiple degrees; thus, percentages may not add up to 100%.

[†] Includes doctorate degrees in clinical psychology, Psy.D.s, and social work.

[‡] Includes bachelor's and master's degrees.

[§] Includes master's and doctoral level.

TABLE 2

SUD/PTSD treatment challenges

Difficulties	M	SD
Overall difficulty treating*		
SUDs alone	1.05	1.00
PTSD alone	0.91	0.85
Dual diagnosis	1.54	0.99
Specific difficulties		
Clients' self-destructiveness	1.62	0.89
Case management	1.59	0.92
Clients' dependency	1.44	0.76
Domestic violence	1.37	0.90
Clients' anger	1.35	0.84
De-escalating clients (eg, when dissociating or agitated)	1.32	0.80
Hearing painful details of trauma	1.04	0.81
Not knowing how to work with these clients	0.99	0.82
Setting boundaries	0.96	0.86
Counter-transference toward these clients	0.86	0.69
Clients' crying/sadness	0.77	0.78
HIV/AIDS	0.71	0.85
Other difficulties	0.83	1.07

Each item rated on 0–3 scale, from "not at all" to "a great deal."

* Significant difference by diagnostic group: SUD/PTSD > SUDs > PTSD ($p < .001$).

TABLE 3

Common SUD/PTSD treatment dilemmas: Quotes from clinicians

I. Treatment implementation issues (14.9%)

- Whether to treat their PTSD or to refer them for substance abuse treatment first. Whether to do exposure work with people who are either (1) newly sober and struggling with sobriety or (2) who are using at a level that is slightly problematic, but perhaps not destructive.
- When to start intense therapy for PTSD if they have difficulty remaining abstinent from substances.
- Prioritizing targets for intervention (eg, knowing when to address trauma-related difficulties or problematic substance use concurrently, when timing is right to embark on trauma-focused treatment).
- Order in which to address issues. Question of use of exposure techniques and when in treatment to apply.
- Managing the session, especially when I am planning exposure work with a client and then end up needing to address a relapse or other crisis situation.
- Integrating empirically supported treatments for both disorders and determining the proper length of sobriety that a client needs to achieve prior to working on the trauma symptoms.
- How much to address trauma for people who still have issues of substance abuse.

II. Severity of patient's symptomotology and self-destructiveness (12.8%)

- Suicidal ideation or gestures.
- Poor impulse control, particularly with regard to self-harm. Helping them to tolerate the emotional sequalae of trauma, especially when these worsen during early recovery.
- Persistent re-experiencing symptoms can be quite frustrating for the clinician and cause the patient to feel that no progress is being made. Comorbid Axis II disorders often provide a plethora of complications, particularly those in cluster B.
- Ongoing domestic violence, particularly with women patients who stay in these abusive relationships.
- Clients who shut down and don't want to discuss trauma or any other private areas.

III. Helping patients abstain from substance use (7.8%)

- The tenacity of the substance use as a coping strategy when the new skills taught are clearly being utilized by the client, but they continue to use the chemicals.
- The dilemma of self-medicating with illegal substances.
- Getting the patient to abstain from chemical or other dissociative comforting measures and be able to utilize other, healthier self-comforting skills, and also to begin to be able to face, acknowledge, and deal with extremely dysphoric feelings.
- Helping them to accept and feel emotions through painful situations DRUG FREE.
- Developing enough affect tolerance to do the trauma work without using. Gaining enough sobriety to begin trauma work.
- Being able to focus on the substance abuse first in order to get to the PTSD issues, because clients tend to self-medicate in order not to deal with the trauma.

TABLE 4

SUD/PTSD Sources of Treatment Gratification

Gratification	M	SD
Overall gratification treating*		
SUDs alone	2.23	0.85
PTSD alone	2.51	0.69
Dual diagnosis	2.37	0.70
Specific sources of gratification		
Developing expertise in working with these clients	2.69	0.58
Teaching clients new coping skills	2.66	0.67
Helping clients become abstinent from substances	2.60	0.69
Obtaining insight about yourself	2.02	0.96
Listening to trauma histories	1.20	1.01
Serving as a “parent figure” to clients	1.01	0.93

Note. Each item rated on 0–3 scale, from “not at all” to “a great deal.”

*Significant difference by diagnostic group: PTSD > SUD/PTSD > SUDs ($p < .001$).