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Clinicians' views on treating posttraumatic stress disorder and substance use disorder☆

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Abstract

The dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder (SUD) is reported to be both highly prevalent and highly challenging. In this study, 147 clinicians were surveyed on their degree of difficulty and gratification in working with each disorder (PTSD, SUD) and their combination; specific types of difficulties and gratifications; and personal and professional characteristics. The dual diagnosis was perceived as more difficult than either disorder alone; but, interestingly, gratification in the work was higher than its difficulty. Areas of greatest difficulty were clients' self-destructiveness, case management, and dependency; areas of greatest gratification were teaching new coping, developing expertise, and helping clients achieve abstinence. In general, difficulty and gratification appeared to be separate constructs, rather than simply opposites. Those finding the work most difficult were more likely to be in a mental health setting and to have no personal history of trauma. Clinical implications are discussed. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Substance abuse; Trauma; PTSD; Posttraumatic stress disorder; Chemical dependency

1. Introduction

The dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder (SUD) is known to be a difficult treatment challenge (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Root, 1989; Najavits, 2002). Compared to patients with either disorder alone, patients with both disorders have worse symptom and functioning levels, worse outcomes, a greater number of additional co-occurring disorders, and higher treatment utilization (Najavits et al., 1998; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Brady et al., 1994; Ouimette, Wolfe, & Chrestman, 1996; Ouimette, Brown, & Najavits, 1998).

It is also known that clinicians who treat substance abuse are a key factor in treatment outcome. Indeed, empirical studies indicate the clinician appears to have more impact on outcome than either the type of treatment or patient baseline characteristics (Najavits, Crits-Christoph, & Dierberger, 2000; Najavits & Weiss, 1994; Project MATCH Research Group, 1998; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Luborsky, McLellan, Woody, & O'Brien, 1985; McLellan, Woody, Luborsky, & Goehl, 1988).

In the current study, the goal was to link these two areas; that is, the study of clinicians and the dual diagnosis of PTSD and SUD. Greater understanding of how clinicians perceive their work with this population might offer insights to improve training, which in turn could potentially improve clinical care. With rates for this dual diagnosis estimated up to 34% in substance abuse treatment samples, it represents a substantial area of service provision (Najavits, Weiss, & Shaw, 1997; Najavits et al., 1998; Goldenberg et al., 1995; Brown, Recupero, & Stout,1995; Grice et al., 1995). Among women it is even more common, with rates up to 59% (Najavits et al., 1997; Fullilove et al., 1993; Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995).

Four specific questions are addressed in this research report. First, from the clinician point of view, how difficult and how gratifying is the treatment of clients with this dual diagnosis? Included in this are clinicians' ratings of areas

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believed to represent particular difficulties (e.g., clients' anger, self-destructiveness, dependency) as well as particular gratifications (e.g., helping clients become abstinent from substances, serving as a parent figure, teaching coping skills). Second, what are the characteristics of the respondents who find this work most difficult? Extreme respondents (those whose ratings were at the "most difficult" end of the scale) are compared to the rest of the sample. Third, what clinician characteristics, for the sample as a whole, might help explain clinician perception of treatment difficulty and gratification? A number of variables are explored, including objective clinician professional characteristics (e.g., years of clinical experience, theoretical orientation, clinical setting), objective personal characteristics (e.g., age, gender), and subjective professional characteristics (e.g., levels of burnout, enjoyment of conducting treatment, and perceived effectiveness). Fourth, clinicians were asked to describe, in their own words, the most difficult dilemmas and emotions they encounter in the work; these qualitative findings are also presented. It can be noted these questions overlap to some degree (e.g., the issue of difficulty occurs in both questions 1 and 2), but are differentiated for the purpose of this article as each one represents a separate data analysis. The sample were 147 attendees at workshops on the clinical treatment of PTSD and SUD who voluntarily filled out an anonymous questionnaire on these topics.

2. Materials and methods

Attendees of three professional workshops on PTSD and SUD were invited to fill out the Clinician Survey on PTSD and Substance Abuse (Najavits, 2000) on a voluntary, anonymous basis. The workshops were conducted by the author in geographically diverse areas (Ann Arbor, Michigan; Cromwell, Connecticut; and Boston, Massachusetts). A total of 147 people filled out the survey, which was provided at the beginning of the workshop and handed in at the break.

The Clinician Survey consists of 40 items, with two parts. Part 1 asks respondents to rate their difficulty and gratification with a list of topics relevant to PTSD and SUD, scaled 0 to 3, with 0 indicating "not at all" and 3, "a great deal." Part 2 obtains background information about the respondents, including professional characteristics (e.g., training, work setting, and theoretical orientation); personal history of PTSD, trauma, and SUD[1]; as well as five ratings of self-perceived satisfaction with their therapy/counseling work (e.g., liking of it, effectiveness, and burnout) rated 0%–100%. Four theoretical orientations were listed (plus "other") and respondents were asked to provide a percentage breakdown by orientation, totaling 100%. Thus, for example, a clinician might list "20% CBT, 40% psychodynamic, 40% systems." This allows a more fine-tuned understanding of theoretical orientation than simply checking off one orientation, as it is known that many clinicians combine orientations. Items for the survey were developed based on the author's experience conducting treatment with this patient population, as well as training and supervising clinicians.

Data analysis was comprised of descriptive statistics for all items on the survey, paired samples *t*-tests to compare particular items of interest, and two-tailed Pearson correlations to relate professional characteristics to key items.

[1] These were described as follows: "'PTSD' refers to patients who have lived through trauma, and continue to have symptoms from that. 'Substance use disorder' refers to any substance abuse or dependence. Note that full DSM-IV definitions of the disorders were provided during the workshop.

3. Results

3.1. Characteristics of the sample

The mean age of the sample was 44.22 years (SD = 11.45), with a majority of women (n = 91, 61.9%), and mean number of years clinical experience at 12.03 (SD = 9.00). Primary work setting was about equally divided among substance abuse (n = 46, 31.3%), mental health (n = 42, 28.6%), or both (hereafter called "dual diagnosis"; n = 38, 25.9%); 16 (10.9%) listed settings other than these, such as a homeless shelter or forensic practice, and 5 (3.4%) were missing. Professional training was as follows (note that participants could report multiple degrees): social work, n = 44 (including bachelors and masters); certified alcohol and drug counseling (CACD), n = 41; master's degrees, n = 22; Ph.D.s of a professional nature (e.g., psychology or social work), n = 15; pastoral counseling, n = 5; nursing, n = 9; physicians, n = 5 (four psychiatrists and one general MD); other, n = 17 (e.g., probation officer, masters in business administration); and no professional training, n = 8. Primary theoretical orientation was, in order of prevalence, cognitive-behavioral (n = 46, 31.3%), eclectic (n = 38, 25.9%), psychodynamic/psychoanalytic (n = 17, 11.6%), 12-step (n = 12, 8.2%), cognitive-behavioral and 12-step equally (n = 8, 5.4%), systems (n = 4, 2.7%), no model (n = 1, .7%), other (n = 4, 2.7%), and missing data (n = 17, 11.6%). Finally, respondents were asked whether they personally had experienced PTSD, trauma, or SUD. About one-third reported PTSD (n = 47, 32%), about one-third reported trauma (n = 51, 34.7%), and over half reported SUD (n = 80, 54.4%).

3.2. Results for the full sample

Table 1 reports respondents' perception of difficulty in treating the dual diagnosis of PTSD and SUD, each of the disorders separately, as well as 12 related areas (e.g., domestic violence, HIV risk). Table 2 reports the same for gratifications in the work.

Table 1
Difficulties in treating clients with PTSD and SUD

Difficulties	*n*	*M*[a]	*SD*
Overall difficulty			
Dual diagnosis	146	1.90	0.94
PTSD alone	130	1.28	0.83
Substance abuse alone	141	1.14	0.96
Specific difficulties			
Self-destructiveness (e.g., suicidal thinking, cutting, burning)	118	1.72	0.86
Case management needs	138	1.68	1.02
Clients' dependency (e.g., needing a lot of care)	117	1.63	0.90
Domestic violence	139	1.53	0.89
Clients' anger	147	1.48	0.91
De-escalating clients (e.g., when they are dissociating, agitated, or upset)	142	1.43	0.85
Not knowing how to work with these clients	141	1.31	0.83
Setting boundaries	147	1.24	0.89
Hearing painful details of trauma	142	1.22	0.83
Countertransference	116	1.12	0.67
HIV/AIDS	138	1.11	0.89
Clients' sadness	146	0.99	0.80

[a] Ratings are scaled 0–3, from "not at all" to "a great deal."

Several findings are evident. First, Table 1 indicates the dual diagnosis was rated more difficult to treat than either disorder alone. Paired sample *t*-tests were used to test this statistically and were indeed significant. That is, the mean for dual diagnosis was higher than the mean for PTSD (1.88 vs. 1.27, $t = -8.52$, $df = 129$, $p < .000$); and than the mean for SUD (1.87 vs. 1.14, $t = -10.61$, $df = 139$, $p < .000$). The PTSD and SUD means were not significantly different from each other.

Second, Table 2 indicates gratification in the work appears equally high for the dual diagnosis and for each of the disorders considered separately. Indeed, based on paired sample *t*-tests, there were no significant differences between them.

Third, the ratings of difficulty and gratification were compared. Surprisingly, respondents reported significantly higher ratings of gratification in the work than difficulty with it, in each of the three areas. That is, gratification from treating the dual diagnosis was higher than difficulty treating it ($M = 2.29$ vs. $M = 1.90$, $t = -3.69$, $df = 143$, $p < .000$); gratification treating SUD was higher than difficulty treating it ($M = 2.26$ vs. $M = 1.15$, $t = -8.92$, $df = 137$, $p < .000$; and gratification treating PTSD was higher than difficulty treating it ($M = 2.30$ vs. $M = 1.29$, $t = -9.32$, $df = 126$, $p < .000$).

Tables 1 and 2 also list issues associated with treatment of the dual diagnosis. The areas rated most difficult (in Table 1) were self-destructiveness, case management, and dependency. The areas rated least difficult were sadness, HIV/AIDS, and countertransference. In Table 2, the highest gratifications were teaching new coping, developing expertise, and helping patients abstain from substances. Relatively lower ratings were obtained for serving as a parent figure and listening to trauma histories, although these were still in the mild-to-moderate range of the scale.

The pattern of intercorrelations between the key variables of the study was also explored. Interestingly, difficulty and gratification in the three content areas (PTSD, SUD, dual diagnosis) were not highly correlated, indicating these are not simply "flip sides" of each other. Specifically, PTSD difficulty and gratification were correlated at $r = -.18$ ($p < .05$, $n = 127$); SUD difficulty and gratification were correlated at $r = -.42$, ($p < .000$, $n = 138$), and dual diagnosis difficulty and gratification were correlated at $r = -.17$ ($p = .05$, $n = 144$). Also notable was that difficulty of PTSD and SUD work was correlated only at $r = .39$ ($p < .000$, $n = 128$), and gratification of PTSD and SUD work was correlated only at $r = .30$ ($p < .000$, $n = 125$); these also suggest whatever clinicians are responding to in PTSD and SUD are more different than similar. Higher correlations were obtained for the relationship between the dual diagnosis and the disorders individually: the correlation between difficulty of dual diagnosis work with PTSD work was $r = .62$ ($p < .000$, $n = 129$), and with SUD work was $r = .64$ ($p < .000$, $n = 140$).

Finally, respondents were also queried on general perceptions of their work (not specific to dual diagnosis). Overall, there appeared to be a high liking for conducting therapy/counseling ($M = 83.76$, $SD = 20.28$, $n = 111$), a high degree of feeling energized, stimulated, and gratified by the work ($M = 80.67$, $SD = 17.98$, $n = 109$), a high likelihood of choosing the same career again ($M = 79.62$, $SD = 24.90$, $n = 110$), a high perception of effectiveness as a clinician ($M = 74.75$, $SD = 20.76$, $n = 107$), and a low degree of burnout ($M = 32.23$, $SD = 26.72$, $n = 107$).

3.3. Description of extreme respondents

The next analysis compared the subset who reported the greatest difficulty treating the dual diagnosis (3 on the 0–3

Table 2
Gratifications in treating clients with PTSD and SUD

Gratification	*n*	*M*[a]	*SD*
Overall gratification	145	2.29	0.71
Dual diagnosis	145	2.29	0.71
PTSD alone	128	2.29	0.76
Substance abuse alone	138	2.26	0.80
Specific gratifications	145	2.29	0.71
Teaching coping skills	118	2.80	0.46
Developing expertise	116	2.74	0.53
Helping clients attain abstinence	117	2.65	0.59
Obtaining insight about yourself	118	2.30	0.88
Listening to trauma histories	146	1.32	1.06
Serving as a parent figure	116	1.15	.99

[a] Ratings are scaled 0–3, from "not at all" to "a great deal."

scale) to those who reported less difficulty (2 or below on the scale). Forty-five respondents comprised the former group (31% of the full sample) and 101 the latter group (69% of the full sample), with one respondent excluded due to missing data on this variable. Independent samples *t*-tests were used for all continuous variables and chi squares for all categorical variables.

A clear pattern is evident in the results. Eleven variables were significant out of 51 tested (exceeding the 2.5 that would have been expected by chance). The most notable findings were that the extreme group, compared to the less extreme group, had fewer respondents with a personal history of trauma (10 vs. 41, $\chi^2 = 5.66$, $df = 1$, $p < .017$), and their primary work setting was more often a mental health setting (22 vs. 19, $\chi^2 = 13.86$, $df = 1$, $p < .000$). All of the other variables that distinguished the two groups were difficulty ratings of various aspects of treating the dual diagnosis (of the 12 difficulty areas, 8 were significant, with the extreme group always reporting greater difficulty than the less extreme group). These data are not given here as such differences reflect the fact the two groups were, by definition, differentiated based on their overall difficulty with the dual diagnosis.

Interestingly, the groups largely did not differ in the gratification variables, except for the finding of less gratification treating substance abuse by the extreme respondents ($M = 2.05$ vs. $M = 2.36$, $t = -2.17$, $df = 135$, $p = .03$). This suggests despite reporting the dual diagnosis work difficult, they were not less gratified by such work than the rest of the sample. They also did not differ in any of the self-perception variables, indicating they did not report more burnout or more likelihood of choosing a different career; nor did they report less effectiveness as a clinician, less enjoyment of their clinical work, or less energy/ stimulation from it. Finally, they did not differ on virtually any of the objective descriptors, either personal (age or gender), or professional (degree of allegiance to any of the seven theoretical orientations, any of the seven training degree types, years of clinical experience, trainee status, primary substance abuse work setting, or primary dual diagnosis setting).

3.4. Relationship of clinician characteristics to survey responses

Finally, two sets of analyses explored whether particular clinician characteristics might help explain perception of the work. In the first analysis, all clinician characteristics were evaluated in relation to the two main study variables: difficulty and gratification in working with the dual diagnosis of PTSD/SUD. In the second analysis, we evaluated whether clinicians' own personal history (of SUD, trauma, and PTSD) might relate to their perception of the work. Because this question has not been addressed in prior research, we chose to analyze this as comprehensively as possible, relating clinicians' personal history to all six major study variables (difficulty and gratification in working with the dual diagnosis, and PTSD and SUD separately). For both sets of analyses, independent samples *t*-tests were used for categorical variables and two-tailed Pearson correlations were used for continuous variables, using the full sample of respondents. Note that while many comparisons were conducted, the percent found significant (15%) exceeded the rate that would be expected by chance (5%).

3.4.1. Clinician characteristics

In professional training, the only degree type showing a difference was that of Ph.D.s, who reported more difficulty treating the dual diagnosis than non-Ph.D.s ($M = 2.50$ vs. 1.86, $t = -2.44$, $p = .02$, $df = 141$). For clinical setting, there were several findings: respondents in a mental health setting reported more difficulty and less gratification treating the dual diagnosis than those not in a mental health setting (for difficulty, $M = 2.39$ vs. 1.71, $t = -4.12$, $p < .000$, $df = 140$; for gratification, $M = 2.05$ vs. 2.39, $t = 2.62$, $p = .01$, $df = 140$); and respondents in a dual diagnosis setting reported greater gratification treating the dual diagnosis than those not in such a setting ($M = 2.54$ vs. 2.22, $t = -2.36$, $p = .02$, $df = 115$). For theoretical orientation, only 12-step orientation showed a significant association: the greater one's alliance with the 12-step orientation, the less difficulty doing dual diagnosis work ($r = -.21$, $p = .016$, $n = 129$). For self-perception as a clinician, greater energy/stimulation with one's work was associated with more gratification treating the dual diagnosis ($r = .23$, $p = .002$, $n = 109$). Finally, clinicians' age was significant, with higher age associated with greater difficulty with treating the dual diagnosis ($r = .19$, $p = .05$, $n = 114$).

3.4.2. Personal life experience

Respondents with a history of SUD indicated less difficulty treating both PTSD and SUD than those without such a history (for PTSD, $M = 1.13$ vs. 1.54, $t = 2.75$, $p = .007$, $df = 120$; for SUD, $M = 0.99$ vs. 1.42, $t = 2.60$, $p = .01$, $df = 130$). They also indicated more gratification treating both PTSD and SUD than those without such a history (for PTSD, $M = 2.45$ vs. 2.04, $t = -2.95$, $p = .004$, $df = 119$; for SUD, $M = 2.36$ vs. 2.06, $t = -2.13$, $p = .035$, $df = 128$). Respondents who reported a trauma history indicated less difficulty treating both SUD and the dual diagnosis than those without a trauma history (for SUD, $M = .92$ vs. 1.13, $t = 2.21$, $p = .03$, $df = 128$; for dual diagnosis, $M = 1.59$ vs. 2.12, $t = 3.18$, $p = .002$, $df = 133$), and reported more gratification with SUD treatment ($M = 2.53$ vs. 2.08, $t = -3.27$, $p = .001$, $df = 126$). No significant results were obtained for those with a PTSD history.

3.5. Participant comments

Participants were also given the opportunity to write about both the "most difficult dilemmas" and the "most

Table 3
Most difficult dilemmas and emotions in treating the dual diagnosis[a]

- "Finding trauma treatment in my geographic area"
- "I work in a substance abuse facility where they want us only to focus on the substance abuse, but it is clear that treating the PTSD is a necessary part of treatment"
- "I get angry when I do an intake and realize that years of substance abuse and mental illness have been misdiagnosed–many times diagnosis is major depression not PTSD"
- "Fear of what to do when client is flooding with emotion–sometimes I freeze"
- "Frustration when substance abuse worsens and interferes with the trauma work"
- "Anger about what's been done to the clients, what they have suffered"
- "Fear of not doing enough or doing too much"
- "Some anger when women clients return to an abusive partner"
- "Upset at social injustice/sociopolitical system that allows abuse of women and children"
- "Fear of the client when escalating anger in the session"
- "What to treat first when the work is limited by the 'damaged care system'–working with these clients requires time"
- "Finding referrals that are willing to accept these clients"
- "Getting too drawn into trauma history to the point of not wanting to hear more pain"
- "How to decide whether the patient needs hospitalization"
- "Anger directed at me by clients who are frustrated by life"
- "My own history of abuse"
- "Trusting self report–dealing with lying"

[a] This table lists of the most common responses to two open-ended questions on the survey.

difficult emotions" they struggle with in treating the dual diagnosis. Many were repeated by multiple respondents and added material not queried on the survey. Table 3 provides a list of these.

4. Discussion

The goal of this study was to survey clinicians' perceptions of difficulties and gratifications in treating the dual diagnosis of PTSD and SUD. Several main findings emerged.

First, the dual diagnosis was rated more difficult to treat than either disorder alone (PTSD, SUD), offering yet more evidence — yet this time from clinicians' perspective — on the challenge of this work. Second, and quite surprising, gratification in treating the dual diagnosis was rated higher than its difficulty. This seems important to emphasize as gratifications are rarely queried in clinical studies, yet may hold important clues to better training and selection of therapists. When considering the often low pay, high stress, and systems constraints in which many clinicians work when treating this dual diagnosis, it makes sense that they are doing it perhaps most for reasons intrinsic to the work. Indeed, as one respondent wrote, "Through my work I have continued to become a better human being, not just a better therapist." Or another: "As difficult as it is, this work pushes me to find new aspects of my own humanity, to honor that, and then to turn it around and use it to help my clients — they are my teachers!" The finding that ratings of difficulty and gratification were not highly correlated also suggests these appear to be separate constructs, not simply "flip sides" of each other. Indeed, the extreme respondents (those who found the dual diagnosis work most difficult) were no less gratified by the work than the rest of the sample. Clinical implications might include helping clinicians explicitly identify their gratifications in the work, helping them use these to reduce difficulty levels, and perhaps developing formal scales to select therapists who genuinely find the work gratifying. It should be noted too this study may well have had a sampling bias in that clinicians who chose to attend the workshops and fill out the survey were likely those most positive about the work. A broader sample might report different levels of difficulty and gratification.

Third, respondents' personal histories of trauma and SUD clearly influenced their perceptions of the work. Those with a history of either trauma or SUD had a more positive view of the work (with PTSD, SUD and/or the dual diagnosis) than those without such a history. And, the respondents who reported the most difficulty treating the dual diagnosis (the "extreme" group) reported a lower frequency of trauma than the rest of the sample. It appears clinicians' experience of these issues gives them greater ease in the work, perhaps due to stronger identification with patients or less fear of clients' sometimes intense affects. In the SUD field, a clinician's own history of SUD is often acknowledged and presumed to be a positive feature. Trauma histories, however, are rarely acknowledged or presumed to be a positive attribute in either the SUD or mental health fields, perhaps reflecting societal discomfort and even blame about trauma (Herman, 1992). Greater recognition of the importance of clinicians' own trauma history might be an area of growth that could aid clinical supervision and training. It is also important to note, however, that while being in recovery for SUD is valued in the SUD field, research has *not* shown this clinician characteristic to be a positive predictor of patient outcomes. That is, clinicians in recovery do not evidence better outcomes than clinicians not in recovery, despite over 50 studies on this topic (McLellan et al., 1988). Thus, it is essential to continue to research how actual outcomes are impacted by clinicians' personal histories, without making the assumption that self-reported positive views of the work necessarily indicates ability to achieve more positive outcomes. Indeed, this is worth emphasizing about all the findings from this survey: clinicians' perceptions of difficulty and gratification may be important in terms of their own work satisfaction, but whether they show any relationship to outcome is as yet entirely unclear.

More positive views of the dual diagnosis work were associated with several additional clinician characteristics. Specifically, those who were more positive were more likely to have a 12-step orientation, to work in a dual diagnosis setting, to be non-Ph.D.s, to be younger in age, to feel more energized and gratified by their clinical work in general, and *not* to be in a mental health setting. These may reflect the

aphorism that "to know it is to love it" — that is, all of these features likely reflect greater familiarity, training, and experience with the dual diagnosis. Many clinicians still do not receive much, if any, formal instruction and supervision in the treatment of SUD and dual diagnosis. This is particularly true in the mental health field, which remains quite split from the substance abuse field. Indeed, it is sometimes a formal policy to refer out patients until they are clean and sober. Such clinicians may struggle more with the dual diagnosis than those in substance abuse settings, and it is not uncommon for them to have negative perceptions of substance abuse treatment (Najavits, 2002). The lack of training in substance abuse was even more pronounced in earlier times, which may explain why younger clinicians appear more positive about treating the dual diagnosis. It is also possible those in mental health settings, Ph.D.s, and non-12-step may simply have elected not to work with this population because they like it less, regardless of training and experience with the work. Here too, it must be emphasized that positive perceptions of the dual diagnosis work may have no connection to actual outcomes. The 12-step orientation, with its spiritual focus, might simply be associated with more positive views of life in general, compared to a psychodynamic/analytic orientation, for example, which emphasizes the "dark side" of life in its focus on conflict and aggression. A study in which clinicians were asked to rate their emotional responses to substance abuse patients, for example, found that 12-step clinicians had more positive emotions than did psychodynamic clinicians, although here too the relationship to outcome was not addressed (Najavits et al., 1995).

Fourth, and finally, the specific types of difficulties rated in the survey can provide a map for improved training for work with this dual diagnosis. Patients' self-destructivess, case management needs, and dependency were the top three difficulties. These can be interpreted in a number of ways; for example, as a reflection on systems issues (i.e., clients are not getting adequate treatment resources, thus putting a heavy burden on the clinician); or as a reflection on clinicians' internal distress at seeing patients' who are so self-destructive and needy. In the open-ended questions on the survey (summarized in Table 3), both of these themes were highly prominent. Clinicians often do not get formal training in how to handle self-destructiveness and case management; these in particular may need more concerted attention. However, no mean for any area of difficulty reached 2.0 on the 0–3 scale; all difficulties were, on average, in the low to moderate range. Yet this should not obscure the fact that approximately one-third of the sample rated their work with this dual diagnosis as extremely difficult; such clinicians may need particular assistance and training. Who these clinicians are also needs more study. They did not differ from the rest of the sample in the usual characteristics that are studied (e.g., training, experience, orientation) nor in their overall views of their clinical work (e.g., burnout, enjoyment).

The highest-rated gratifications were also interesting: teaching new coping, developing expertise, and helping clients achieve abstinence. All of these reflect action-oriented strategies, compared to the lowest-rated gratifications (serving as a parent figure, listening to trauma histories), which could be interpreted as more passive. It could be that clinicians need to feel a sense of control and mastery when working with a population who so often are out of control. It also may highlight the relevance of coping-skills forms of treatments for this dual diagnosis.

Finally, it is noteworthy that this sample of clinicians reported high satisfaction with their clinical work in general and a low rate of burnout. This suggests even among clinicians who feel positive about their work, difficulties with this dual diagnosis arise.

All results of this study need to be interpreted in light of its methodology. Strengths include its high sample size, diversity of respondents in professional characteristics, and the fact that it appears to be the first study on this topic. Limitations of the study include the large number of statistical tests conducted (although efforts were made to address the rate of actual versus chance findings), the use of a survey that has not been psychometrically validated, and the lack of data on outcomes by which to more deeply understand the survey findings. Future research can, it is hoped, address these areas.

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