

# Present- Versus Past-Focused Therapy for Posttraumatic Stress Disorder/Substance Abuse: A Study of Clinician Preferences

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This study explored clinicians' views on present- versus past-focused posttraumatic stress disorder (PTSD) treatments for clients with the dual diagnosis of substance-use disorder (SUD) and PTSD. Clinicians ( $N = 133$ ) attending a professional workshop were administered a questionnaire on the relative appeal and importance of each type of treatment, parameters for administering them (e.g., group vs. individual format), and whether clients' abstinence from substances was necessary. Clinicians' personal and professional characteristics were also measured and related to their views of the treatments. Results indicated consistently greater endorsement for present- than for past-focused PTSD treatment but clear interest in both modalities and their combination. A majority believed they could treat PTSD/SUD clients but also believed that clients need to be abstinent before engaging in past-focused PTSD treatment. Clinician characteristics associated with lower ratings of past-focused treatment included length of clinical experience, higher degree of burnout, and mental health as a primary work setting. Relatively higher ratings of past-focused treatment were found among clinicians who had a personal history of trauma and/or SUD and were from a substance-abuse primary work setting. Discussion includes methodological limitations of this study and directions for future research. [*Brief Treatment and Crisis Intervention* 6:248–254 (2006)]

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The past decade has seen a dramatic increase in posttraumatic stress disorder (PTSD) treatment research, including the development of new treatments, their evaluation in outcome trials, and greater diversity of client samples. At this point, there are two major models of evidence-based psychotherapy treatments for PTSD:

present focused and past focused (Najavits, in press). In past-focused models, the client tells the trauma story in full detail as a way to face the feelings that arise from it. In present-focused models, the client learns coping skills to improve functioning (e.g., social skills, relaxation, grounding, and cognitive restructuring). Examples of past-focused models include eye movement desensitization and reprocessing and exposure therapy. Examples of present-focused models include stress inoculation training and anxiety management. Research indicates, overall, that both present- and past-focused models are effective, neither outperforms the other,

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both outperform treatment-as-usual, and the combination of both models does not outperform either one alone (Najavits, in press).

Dissemination of PTSD treatment models raises a variety of issues, including how to train clinicians in the models, what promotes adoption of them, and what clients and settings are appropriate for them. Historically, for example, clients with co-occurring PTSD and substance-use disorder (SUD) have been excluded from PTSD treatment trials, as it was believed that they were too vulnerable to tolerate past-focused PTSD treatments until they attained abstinence (Keane, 1995; Solomon, Gerrity, & Muff, 1992). Also, research indicates that clinicians have been less likely to implement past-focused PTSD models despite a strong empirical base for them (Zayfert & Becker, 2000; Zayfert et al., 2005).

In this study, the goal was to explore clinicians' views on present- and past-focused PTSD treatment models for clients with PTSD and SUD (the first study of its kind). This dual diagnosis population is important for several reasons. First, this dual diagnosis is common (e.g., among males with lifetime PTSD, 52% develop alcohol-use disorder; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Second, clients with both disorders are known to have greater severity and worse outcomes than those with either disorder alone (Najavits, Weiss, & Shaw, 1997; Ouimette & Brown, 2002). Third, clinicians find these clients challenging (Najavits, 2002). Thus far, treating both PTSD and SUD at the same time appears a promising approach in terms of both positive outcomes and client preferences (Najavits, 2004). Yet, the question of which PTSD treatment models to use with such dual diagnosis clients has been relatively little studied. Greater understanding of clinicians' perception of PTSD treatments may help to improve the dissemination process, including realistic awareness of the obstacles involved.

Thus, a sample of 133 clinicians attending a workshop on PTSD and SUD were invited

to complete a measure that targeted specific questions about present- and past-focused PTSD models, as well as clinician background characteristics. Questions of interest included the relative appeal and importance of present- and past-focused PTSD models, considerations in implementation (e.g., group vs. individual format and short-term vs. long-term treatment), and the relationship between such perceptions and clinician characteristics (e.g., gender, primary setting, personal history of trauma/PTSD/SUD, and level of burnout).

## Method

### *Procedure*

Clinicians attending a professional workshop on PTSD and SUD were invited to fill out the study questionnaire (Najavits, 2001) on a voluntary, anonymous basis. The workshops were conducted by the author in seven geographically diverse areas (Palo Alto, CA; Columbus, GA; Westborough, MA; Farmington, CT; Stockton, CA; Madison, WI; and Oakland, CA). A total of 133 people filled out the survey, which was provided at the beginning of the workshop and handed in at the first morning break of the training. Workshops ranged from 1–2 days in length. Clinicians were not paid for participating in this study.

### *Measure*

The study questionnaire consisted of 31 items, with two parts. The first part asked clinicians to rate their view of two different types of PTSD treatment: past focused (telling the trauma story) and present focused "trauma coping skills". The questionnaire instructions noted that all questions were in reference to clients with current SUD. See Tables 1 and 2 for the questionnaire items (Part 1), all of which were

**TABLE 1.** Comparison of Two PTSD Treatment Types

| Question   | <i>n</i> | Past focused<br>(telling the<br>trauma story)<br>mean (SD) | Present focused<br>("trauma coping<br>skills") mean (SD) | <i>t</i> |
|--|----------|--|--|----------|
| 1. How appealing is conducting this type of treatment to you?  | 133      | 66.41 (30.28)  | 89.32 (17.25)  | -7.68*** |
| 2. How important do you believe this type of treatment is for substance-abuse clients, at some point in treatment? | 131      | 73.28 (28.75)  | 91.65 (17.26)  | -7.25*** |
| 3. I believe it is outside the bounds of my professional training to do this type of treatment                     | 128      | 26.08 (32.22)  | 19.77 (28.59)  | 2.64**   |
| 4. I believe it is important to obtain specialized training/supervision before doing this treatment                | 130      | 84.48 (25.14)  | 76.45 (29.89)  | 3.65***  |
| 5. I believe this treatment can be conducted safely in group format  | 132      | 54.81 (34.84)  | 83.05 (24.27)  | -9.11*** |
| 6. I believe this treatment can be conducted safely in individual format   | 133      | 84.11 (19.72)  | 90.38 (17.27)  | -3.75*** |
| 7. I believe this treatment can be conducted safely in short-term treatment (4 months or less)                     | 129      | 44.52 (32.07)  | 67.29 (32.61)  | -8.06*** |

Note. All analyses are paired-samples *t* tests.

\**p* < .05, \*\**p* < .01, and \*\*\**p* < .001.

scaled 0–100%, with 0% indicating *not at all* and 100% *a great deal*.

The two types of PTSD treatment were briefly described on the survey as follows. "Treatment 1: Telling the trauma story. In this treatment, the goal is to talk about past traumas in detail. The client describes everything she/he can remember about the trauma. The client's painful feelings get stirred up (e.g., sadness, anger), but

after telling the story over and over, these feelings go down. Treatment 2: Trauma Coping Skills: In this treatment the goal is to help the client learn skills to cope with the trauma in the present. This might include, for example, learning to ask for help, to rethink situations, to avoid triggers, to self-nurture, to be assertive, etc."

Part 2 of the questionnaire obtained background information about the clinicians (age

**TABLE 2.** Additional Questions

| Question  | Mean (SD)     | <i>n</i> |
|---|---------------|----------|
| 1. I believe it is important that substance-abuse clients do both types of treatment (learning coping skills and telling their trauma story). | 79.96 (25.46) | 133      |
| 2. I believe the best I can do is to refer the client out for trauma treatment rather than treat it myself.                                   | 33.06 (34.67) | 125      |
| 3. I believe it is important for clients to be abstinent from substances before telling their trauma story.                                   | 52.74 (35.04) | 131      |
| How many months should the abstinence be?   | 9.75 (21.74)  | 83       |
| 4. I do not believe the client should focus on any type of trauma treatment until the client is abstinent from substances.                    | 36.36 (35.48) | 129      |
| How many months should the abstinence be?   | 9.07 (21.59)  | 80       |

and gender), including professional characteristics (e.g., experience, training, work setting, and theoretical orientation); personal history of PTSD, trauma, and SUD; and four ratings of perceived satisfaction with the work (how much the clinician likes conducting counseling, how burned out she/he is by counseling, and how gratifying/difficult it is to work with PTSD/SUD clients). For rating of theoretical orientations, five were listed (plus *other*) and clinicians were asked to provide a percentage of 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.

### Data Analysis

Data analysis consisted of (a) descriptive statistics for all items on the survey; (b) paired-samples *t* tests to compare clinicians' views of the two treatment types, and (c) one-way analysis of variance with least-significant difference as the post hoc test, independent-samples *t* tests, and two-tailed Pearson correlations to evaluate clinicians' professional and personal characteristics in relation to survey responses about the two treatments. Only results significant at  $p < .05$  or below are included.

## Results

### Characteristics of the Sample

The mean age of the sample was 43.24 years ( $SD = 10.23$ ), with a majority of women ( $n = 99, 72.8\%$ ), and mean number of years of clinical experience at 11.91 ( $SD = 113.62$ ). Primary work setting was divided among mental health ( $n = 58, 42.6\%$ ), substance abuse ( $n = 20, 14.7\%$ ), or both ( $n = 42, 30.9\%$ ); 12 (8.8%)

listed settings other than these, such as a homeless shelter or domestic violence center, and 4 (2.9%) were missing. Professional training was as follows (with some participants reporting multiple degrees): social worker,  $n = 38$ ; certified counselor (including alcohol/drug and mental health counselors),  $n = 27$ ; master's level and doctoral level psychologists,  $n = 32$ ; nursing,  $n = 13$ ; psychiatrists,  $n = 2$ ; other,  $n = 13$  (e.g., recreational therapist and case coordinator); and  $n = 11$  missing. Primary theoretical orientation was, in descending order, cognitive behavioral ( $n = 55, 40.4\%$ ); eclectic ( $n = 29, 21.3\%$ ); psychodynamic/psychoanalytic ( $n = 12, 8.8\%$ ); 12-step ( $n = 7, 5.1\%$ ); alternative orientations ( $n = 7, 5.1\%$ ), such as art therapy, bioenergetics, somatic education, hypnotherapy, existential therapy, and systems models ( $n = 5, 3.7\%$ ); no model ( $n = 2, 1.5\%$ ); other ( $n = 4, 2.9\%$ ), such as occupational therapy and case management; and missing data ( $n = 15, 11.0\%$ ). Finally, clinicians were asked whether they personally had experienced trauma, PTSD, or SUD. Over half reported trauma ( $n = 75, 55.1\%$ ), and over a quarter reported PTSD ( $n = 36, 26.5\%$ ) and/or SUD ( $n = 31, 22.8\%$ ). Clinicians were offered the option under PTSD of stating "don't know what PTSD is," but none endorsed this.

### Results for the Full Sample

Table 1 and 2 provide data on the full sample for each of the questionnaire items in Part 1.

Table 1 offers a comparison by the two treatment types and indicates a significant difference on every item. The direction of these differences indicated consistently greater wariness about the use of past-focused therapy than of present-focused therapy for SUD clients with PTSD. Nonetheless, both types of treatment were valued, and the majority of clinicians indicated a willingness to engage in them. Particular concern about the use of

past-focused therapy with this population focused on the use of it in group modality, in short-term treatment of 4 months or less, and prior to a period of sustained abstinence from substances. A majority of clinicians endorsed a combination of the two types of PTSD treatment and a need for training/supervision in each type. Only one third indicated that they would refer out a substance-abuse client out for PTSD treatment rather than treating it themselves.

### ***Clinician Characteristics***

This study also sought to evaluate whether several key clinician characteristics (gender, personal history of trauma/PTSD/SUD, primary work setting, length of clinical experience, and level of burnout) were associated with responses to the two types of PTSD treatment. Each clinician characteristic was evaluated in relation to 14 variables from Part 1 of the questionnaire. Note that there was a high correlation between the appeal and importance of each of the two treatment types ( $r = .69, p < .001$  for past-focused therapy and  $r = .43, p < .001$  for present-focused therapy), and thus, these were combined into one variable for each treatment type. Due to the large number of variables analyzed and the exploratory nature of this work, results should be interpreted tentatively. Also, no analyses were conducted based on theoretical orientation, type of training, or workshop location as there were too many categories within each of these variables to interpret meaningful results, given our sample size.

The first analysis was based on gender ( $n = 99$  females and  $n = 32$  males). Significantly more females believed that exposure treatment was outside the bounds of their professional training ( $M = 21.19$  vs.  $M = 14.94, t = -2.46, df = 74.81, p < .05$ ), but no other variables were significant based on gender. Next, responses were evaluated based on personal history of trauma

( $n = 75$  who experienced trauma and  $n = 51$  who did not). Those who experienced trauma were significantly more likely to endorse the appeal/importance of past-focused therapy ( $M = 74.41$  vs.  $M = 61.11, t = 2.6, p < .01$ ) and gratification in working with PTSD/SUD clients ( $M = 75.26$  vs.  $M = 64.08, t = 2.42, p < .05$ ). Similarly, those with a personal history of SUD ( $n = 31$ ) compared to those without ( $n = 87$ ) indicated higher endorsement for the appeal/importance of past-focused therapy ( $M = 76.69$  vs.  $M = 64.81, t = 2.01, p < .05$ ), more gratification in working with PTSD/SUD clients ( $M = 89.27$  vs.  $M = 65.37, t = 6.44, p < .001$ ), less difficulty in working with them ( $M = 24.82$  vs.  $M = 41.24, t = -2.71, p < .01$ ), and less burnout ( $M = 12.50$  vs.  $M = 25.43, t = -3.20, p < .05$ ). No differences were found based on PTSD history ( $n = 36$  with a history of PTSD and  $n = 64$  without).

Next, results were compared based on primary work setting (mental health,  $n = 58$ ; substance abuse,  $n = 20$ ; or both,  $n = 42$ ). Clinicians from substance-abuse settings were more likely to believe that present-focused therapy was outside the bounds of their professional training ( $M = 43.00$ ) than those from mental health ( $M = 7.50$ ) or both ( $M = 23.81$ ),  $F = 14.22, p < .001$ . With regard to past-focused therapy, those from substance abuse were more likely to believe that it was outside the bounds of their professional training ( $M = 45.53$ ) than those from mental health ( $M = 16.93$ ),  $F = 6.61, p < .01$ ; yet, those from substance abuse also found past-focused therapy more appealing/important ( $M = 77.00$ ) than those from mental health ( $M = 62.00$ ),  $F = 3.49, p < .05$ . (Also, those from mental health found past-focused therapy significantly less appealing/important,  $M = 62.00$ , than those from both,  $M = 73.94$ .) Those from substance abuse were also more likely to refer a PTSD client out ( $M = 52.63$ ) than those from mental health ( $M = 31.95$ ) or both ( $M = 32.91$ ),  $F = 5.36,$

$p < .01$ . Interestingly, however, those from substance abuse were more likely to feel gratification working with this clientele ( $M = 89.11$ ) than those from mental health ( $M = 61.89$ ) or both ( $M = 76.10$ ),  $F = 10.98$ ,  $p < .001$ , and less likely to view them as difficult ( $M = 26.39$ ) than those from mental health ( $M = 46.13$ ) or both ( $M = 32.93$ ),  $F = 4.29$ ,  $p < .05$ . Length of clinical experience had a low negative correlation with the appeal/importance of past-focused therapy ( $r = -.20$ ,  $p < .05$ ), for viewing it as outside the bounds of their professional training ( $r = -.28$ ,  $p < .001$ ) and for believing that SUD clients should do both types of trauma treatment ( $r = -.23$ ,  $p < .01$ ). The more burned out the clinician, the less appealing/important past-focused therapy appeared ( $r = -.18$ ,  $p < .05$ ), the more it appeared outside the bounds of their professional training ( $r = -.27$ ,  $p < .01$ ), the more likely they were to refer out a PTSD/SUD client ( $r = -.20$ ,  $p < .05$ ), the less they liked conducting counseling ( $r = -.25$ ,  $p < .01$ ), the less gratified they were by the work ( $r = -.24$ ,  $p < .01$ ), and the more difficult they found it ( $r = .25$ ,  $p < .01$ ).

## Discussion

This appears to be the first study conducted on clinicians' views of two types of PTSD treatment in the context of SUD: past focused (telling the trauma story) and present focused ("trauma coping skills"). These two treatment models are evidence based (Najavits, in press), yet quite different in their approach. Strengths of the study include a relatively high sample size ( $n = 133$ ), a frontline sample of clinicians in diverse settings, and the attempt to relate clinician characteristics to their views of PTSD treatments.

Several key findings emerged. First, present-focused PTSD treatment was, overall, rated significantly more positively than past-focused

treatment on each of the seven variables on which they were compared. This included level of appeal; importance; viewing the treatment as within the bounds of one's training; the need for specialized training; and implementation in group, individual, and short-term modalities. Moreover, a majority believed the clients need to sustain abstinence from substances for an average of 10 months prior to doing past-focused PTSD treatment. These findings are generally in keeping with prior literature that indicated some level of wariness about past-focused PTSD treatment models, particularly for SUD clients (Keane, 1995; Solomon et al., 1992; Zayfert & Becker, 2000).

Nonetheless, there appeared to be a strong level of interest in past-focused PTSD treatment, as evidenced by high average ratings for its appeal (66% on the 0–100% scale) and importance (73%). There were also fairly wide standard deviations on each item, indicating a broad range of reactions. The majority of the sample liked the idea of combining present- and past-focused PTSD treatments (80% average rating), and only a minority believed in referring out PTSD/SUD clients (33%) or delaying PTSD treatment altogether until clients attain abstinence. It is noteworthy that some of these beliefs are in keeping with new trends in the current evidence base, such as the idea of treating both PTSD and SUD in an integrated fashion, rather than delaying treatment of PTSD. For other perceptions, the evidence base is not yet clear (such as whether combining past- and present-focused PTSD treatments is more effective than either one alone for SUD clients).

Clinician characteristics that were associated with less enthusiasm for past-focused PTSD treatment included higher level of burnout, longer clinical experience, and mental health as a primary work setting. Those with greater enthusiasm for past-focused PTSD treatment were more likely to have their own personal history of trauma and/or SUD and to work in

a substance-abuse primary work setting. However, those from a substance-abuse primary work setting were also more likely to refer out a PTSD client and to believe that past-focused PTSD treatment was beyond the bounds of their professional training. Such clinician differences may imply a greater need to focus on which clinicians are best suited for the different types of trauma treatment. It would also be important to understand how training in PTSD treatment models might impact clinicians' perceptions and to evaluate the degree to which their concerns are accurate based on actual client outcomes.

Limitations of the study include nonrepresentative sampling (it was a sample of convenience), absence of data on clinician performance (the study evaluated solely their beliefs and self-reported characteristics), and lack of exploration as to why clinicians rated past-focused PTSD treatment relatively lower than present-focused. Such lower ratings might reflect, for example, a lack of training on such models or, alternatively, more substantive resistance such as not wanting to hear painful trauma stories. This area appears ripe for further development, given the evidence base for PTSD treatment models at this point and the large number of patients with this dual diagnosis in clinical practice.

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