2014

Predicting Use of Evidence-Based Treatments by Helping Professionals for the Treatment of Posttraumatic Stress Disorder

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May 2011

Submitted in partial fulfillment of requirements for the degree:

Master of Arts in Psychology

at the

Cleveland State University

May 2014

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Counseling, Administration, Supervision, & Adult Learning, May 7, 2014

Student's Date of Defense: May 7, 2014

PREDICTING USE OF EVIDENCE-BASED TREATMENTS BY HELPING PROFESSIONALS FOR THE TREATMENT OG POSTTRAUMATIC STRESS DISORDER

SEAN A. LAFLEUR

Abstract

Research suggests that evidence-based treatments (EBTs) for posttraumatic stress disorder are underutilized by counselors, psychologists, and other helping professionals (Becker, Zayfert, & Anderson, 2004; Van Minnen, Hendriks, & Olff, 2010). The current study examined factors that may predict use of EBTs by helping professionals including theoretical orientation, workplace setting, training, client preference, and highest degree held by the helping professional. Training was the only factor found to significantly predict the use of EBTs, suggesting that training may be key in disseminating EBTs and increasing their use.

Keywords: treatment choice; PTSD psychotherapy; CBT; DBT; EMDR; PE; helping professionals; training

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CHAPTER I

INTRODUCTION

Many helping professionals treat clients diagnosed with posttraumatic stress disorder (PTSD, as defined in the *Diagnostic and Statistical Manuel of Mental Disorders-5* [DSM-5], 2013), but still little is known of how these professionals choose the type of treatment to use. The type of psychotherapy used to treat a disorder has been left to the educated decision of the clinician in practice. The question of what may predict the type of treatment that a psychotherapist chooses for a client demands much research in order to ensure that the most effective psychotherapies are being utilized, while at the same time promoting clinical discretion and freedom of psychotherapeutic orientation.

Individuals suffering from PTSD, and clients seeking mental health treatment in general, often come into contact with multiple helping professionals. In this case "helping professional" will be defined to include licensed professionals, such as mental health nurses, psychologists, medical doctors or psychiatrists, counselors, and licensed social workers. For example, an individual experiencing PTSD may be the resident of a community mental health group home, attend community counseling services, and frequent a victims' resource center; thereby having a social worker, a psychologist (or a

psychiatrist if medications are needed), and a counselor to choose from when seeking treatment. Such an individual may even experience multiple helping professionals filling each of these roles over a matter of years. The possibilities of treatment vary greatly, given that each of these helping professionals will also have their own therapeutic orientations and preferred methods of treatment, including but not limited to: psychodynamic, behavioral (or cognitive behavioral), cognitive, humanistic (i.e. existential, gestalt, client-centered), interpersonal, or systems, and dialectical behavior therapy (DBT), stress inoculation therapy (SIT), cognitive processing therapy (CPT), or cognitive therapy (CT).

Among psychosocial treatments for PTSD, a few specific interventions have been found to be empirically supported, with evidence of their efficacy and effectiveness in controlled studies and clinical practice. These therapies include cognitive behavioral therapy (CBT), DBT, eye movement desensitization and reprocessing (EMDR), and prolonged exposure therapy (PE; Rauch, Eftekhari, & Ruzek, 2012; Cahill, Rothbaum, Resick, & Follete, 2009; Tarrier & Sommerfield, 2004; Becker & Zayfert, 2001).

Evidence-based psychotherapies have been shown to vary in their effectiveness when compared to one another. Tarrier and Sommerfield (2004) found that although there was no difference in outcomes when comparing CBT and imaginal exposure therapy (without the use of in-vivo exposure, one essential component of prolonged exposure therapy) no difference was found at 12 months post-treatment, and CBT was more effective at eliminating or reducing symptoms at the 5-year follow-up point. Taylor et al. (2003) found exposure therapy to be a more efficient and effective means of delivering treatment and reducing symptoms than EMDR or relaxation training. Roy-

Byrne et al. (2010) compared the use of a CBT, psychotropic medication, both, or usual care for a variety of anxiety disorders, and found that the flexible treatment options of CBT and medication combinations were more effective than usual treatment. These variations in effectiveness illustrate how therapy choice may affect the treatment outcome. If some therapies are more effective than others, then, in the best interest of the client, helping professionals ought to be more inclined to use certain therapies that may decrease symptoms more efficiently for clients.

In a review of the literature of prolonged exposure therapy, Rauch, Eftekhari, and Ruzek (2012) found PE to be easily disseminated and effective across cultures, among clinicians of varying disciplines, and for patients of varying complexity, including comorbid and dual diagnosis populations. In a meta-analysis of trials that included PE, Powers and colleagues (2010) found that PE significantly reduced PTSD symptoms at post-treatment and at follow-up in comparison to the wait-list control or psychological placebo, but that it did not fare better than CT, CPT, EMDR, or SIT. Barrera, Mott, Hofstein, and Teng (2013) found that group therapy using CBT with exposure therapy tended to have a higher attrition rate than individual CBT with exposure therapy; however, no difference was found in effect size between group CBT with exposure than those without exposure therapy. Individual therapy may yield a better commitment to treatment for some clients than a group setting. Social support significantly predicted positive outcome for patients being treated with exposure therapy for PTSD (Trasher, Powers, Morant, Marks, & Dalgleish, 2010).

Tuerk et al. (2013) studied the utilization of PE for PTSD by the Department of Veterans Affairs. They found that use of PE increased patient completion and decreased

the number of sessions, cost, and morbidity of symptoms. Among the 60 patients in the study, 70% completed treatment, and those who completed treatment had a 45% reduction in annual mental health service utilization and cost compared to those who did not complete treatment. Use of PE did not deter completers or non-completers from future mental health services (Tuerk et al., 2013), despite the popular assumption among helping professionals that exposure therapies are emotionally exhaustive for patients (Rauch, Eftekhari, & Ruzek, 2012).

Research has repeatedly shown that exposure therapies are underutilized (Becker, Zayfert, & Anderson, 2004; Feeny, Hembree, & Zoellner, 2003; Van Minnen, Hendriks, & Olff, 2010). If helping professionals fail to utilize these evidenced-based therapies (EBTs), this clearly limits the likelihood that trauma survivors with PTSD will receive an EBT. Although there is some debate within the mental health community about the necessity of the use of EBTs, some psychologists and other mental health professionals have promoted the idea that the use of EBTs is a sound and ethical practice that promotes initiating treatment for clients using the best available approach(es). Organizations such as the International Society for Traumatic Stress Studies (ISTSS), the Department of Veterans Affairs (VA) and the Department of Defense (DoD), the National Institute of Mental Health (NIMH), the United Kingdom National Institute for Clinical Excellence (NICE), and the Australian National Health and Medical Research Council (NHMRC) all suggest the use of specific EBTs for the treatment of trauma and stress related disorders (Forbes et al., 2010; National Collaborating Centre for Mental Health [NCCMH], 2005; DoD/VA, 2010). If a psychotherapy is evidence-based, meaning that it has been empirically supported across multiple studies, then the likelihood of its consideration for

use in the clinical realm ought to be greater. CBT, DBT, EMDR, and prolonged exposure therapy should be used more often if trauma-focused organizations are promoting them as EBTs.

This study examined potential influenced on helping professionals' treatment choice for clients with PTSD by considering the helping professional's views of treatments, clients' preference for treatment, workplace bias, clinical judgment, and intergroup attributes for support in explaining therapy preference. This study seeks to explore possible factors that may lead to the underutilization of certain EBTs. Specifically, the current study seeks to answer the following research question: What effect do training, degree attained, workplace setting, client preference, and theoretical orientation have on helping professionals' therapeutic preference for

1.1 REVIEW OF THE CURRENT LITERATURE

1.1.1 Helping Professionals' Opinions of Treatment

Helping professionals have varying opinions about the use of evidence-based therapy. One theory is that professionals will adhere to treatments that more closely aligned with their theoretical orientation and that they will maintain fidelity to that treatment. The clinical use of psychodynamic/psychoanalytic therapy and CBT and the prototypical treatments used by clinicians claiming either a cognitive-behavioral or psychodynamic theoretical orientation were examined by Schottenbauer, Arnkoff, Glass, and Gray (2006). A factor analysis found three primary treatment approaches utilized by psychodynamic clinicians (expressive psychotherapy, supportive psychotherapy, psychodynamic-integrative) and four treatment approaches utilized by cognitive-behavioral clinicians (cognitive-behavioral therapy, CBT-integrative psychotherapy,

humanistic-experiential/CBT, relationship-oriented CBT). The authors suggest that the therapies used do not always match the orientation claims, further stating that "both psychodynamic and CBT [clinicians] actually ranked items to describe a more integrative approach" (p.118). They found that more heterogeneity exists within treatments even among clinicians claiming the same therapeutic orientation (p. 117). This means that therapeutic orientation may not play as crucial a role in treatment choice as has been assumed.

A study by Lucock, Hall, and Noble (2006) examined influences on clinical psychologists in their first through third years of training compared to more experienced "qualified" psychological therapists in the United Kingdom. The qualified psychological therapists ranged in professional backgrounds, including: clinical psychology, counseling, nursing, psychotherapy, medicine, occupational therapy, and other (not specified). Their therapeutic orientations included: CBT/cognitive therapy, psychodynamic/psychoanalytic, integrative, varied/eclectic, persons-centered/gestalt/humanistic, systemic, and group analytic. They found that the three most influential factors on the qualified psychological therapists' clinical practice were current supervision, professional training, and post-qualification training, while the clinical psychologists in training reported no single factor that was most influential, but that "professional training" was most mentioned. Neither group listed evidence-based research or client preference as highly influential on their practice.

Knowing how helping professionals perceive the effectiveness, safety, and acceptability of treatments can help us to understand which treatments they prefer, especially when PE is often mistaken as unsafe. Cloitre et al. (2011) defined

effectiveness in treatment as being "likely to decrease complex trauma symptoms by 75% and improve general functioning" (p. 620). They defined *safety* as "unlikely to increase severity of symptoms, impulse behaviors, or suicidality" (p. 621). *Acceptability* was defined as "likely to promote engagement, responsiveness, and retention in treatment" (p. 622). Narration of trauma memories and emotion focused/regulated therapies were rated the most highly among helping professionals for effectiveness, safety, and acceptability. These qualities are found in exposure-based therapies, yet some helping professionals are still hesitant to use these therapies (Becker, Zayfert, & Anderson, 2004; Feeny, Hembree, & Zoellner, 2003; Rauch, Eftekhari, & Ruzek, 2012; Van Minnen, Hendriks, & Olff, 2010).

Resistance to use EBTs has even been found among trauma professionals. Gray, Elhai, and Schmidt (2007) studied trauma professionals' attitudes toward utilization of evidence-based practices, sampling from members of ISTSS, which is a premiere international organization for professionals who specialize in trauma and stress related disorders such as PTSD. According to clinicians in their study, the primary barriers to use of EBTs included insufficient time to learn, finding time for training, lack of generalizability of literature to client populations, the expense of training, and working with patients who have unique characteristics. They also found that younger respondents tended to hold more favorable opinions of EBTs, and a greater willingness to use EBTs such as exposure-based CBT.

Trauma experts were found to be less likely to choose imaginal exposure (IE) therapy for patients due to lack of training and comorbidity rates among patients in a study by Van Minnen, Hendriks, and Olff (2010). This suggests that despite empirical

support for the use of exposure therapy, the patient's preference and lack of familiarity on the part of the therapist are greater influences on therapeutic preference than effectiveness; however, they found "no beneficial effect of superior training in IE on the judgments of and preference for IE" (p. 317), but rather the "superior training in IE was associated with a higher preference for EMDR and a lower preference for supportive therapy" (p. 317). This suggests that the clinician may not be as objective as they may hope to be.

Russell and Silver (2007) found in a survey of mental health professionals employed by the military of VA that out of 133 respondents 90% did not utilize cognitive therapy, EMDR, exposure therapy, or stress inoculation therapy, which were approved by the VA and DoD for treatment. The majority of respondents reported insufficient training as the reason for not utilizing these therapies. Sprang, Craig, and Clark (2008) examined the factors affecting trauma treatment practice patterns. Helping professionals involved in the study included psychiatrists, social workers, psychologists, professional counselors, marriage and family therapists, drug and alcohol counselors, and psychiatric nurse practitioners, creating a representative sample of the state of Kentucky. They found gender and training to be the most significant factors effecting treatment choice. Female social workers and psychiatrists were found to prefer psychodynamic approaches to CBT when compared to males in their respective cohorts. The study also found that psychiatrists were more likely to suggest psychopharmalogical treatment before psychotherapy. Training and degree attained were found to affect treatment preference. Opinions of empirical evidence influenced by common and specific factor models may also affect treatment preference.

Wampold (2010) discusses the reliability and validity of psychotherapy research. He categorized helping professionals into two schools of thought: those who are advocates of specificity and those who are common factor advocates. Advocates of specificity believe that specific components of psychotherapy create distinctions between effective and non-effective models of treatment, and that the type of therapy matters. Common factor advocates believe that specific components of psychotherapy do not create distinctive outcomes between models of treatment, or that type of therapy matters. The current study is not arguing for either viewpoint, but rather is simply using these models as a means to explain the perspective of helping professionals.

1.1.1.1 Clinical Judgment

Cline (1985) defines clinical judgment as "the impression formed by a member of the helping professions of the client he [or she] meets with an overtly consultative purpose related to a problem of social or personal well-being" (p. 369). Spengler and colleagues (2009) found in a meta analysis of clinical judgment studied that clinical judgment rarely improved over time. One possible theory to explain the choice of a psychotherapy by a helping professional is the in-group/out-group bias. In this case, a therapist may view a distinction between self as expert and client as other. Thorne (1961) discusses the idea of defensiveness among clinicians and the need for clinicians to distance themselves from the idea of self-produced error. Taking an "expert role" and separating the self from the client in this hierarchy may create a bias toward self-judgments being perceived as sound, and responsibility for any failures of treatment to produce change being placed on the client.

Group membership and biases are reliant upon one's identity and commitment to self or group membership. According to Gordon (1968) the social individual is influenced by "attributive characteristics (objective social identity and subjective social identity), roles and memberships, and the individuality of the person, " while Tajfel and Turner (1986) propose a "continuum individual-group" whereby members of a group first find their identity within the group rather than through relationships within the group (as cited in Ammi, 2007, pp. 73-74). Deschamps further elaborates by defining "egocentricity," or self within the group, and "sociocentricity" where group membership is esteemed before the self (as cited in Ammi, 2007, p. 75). Identity can then be considered as an influential factor when predicting behavior.

The *theory of planned behavior* is defined by Ajzen and Madden (1986) states that behavior is affected by the perceived level of difficulty of the task (as cited in Bagozzi, Gurhan-Canli, & Priester, 2002, p. 72). While the *theory of reasoned action* states that action results purely from the intentions of the acting individual (Bagozzi, Gürhan-Canli, & Priester, 2002, p. 69). Behavior and intention were not measured directly in the current study, however these theories could lend insight into external factors' (i.e., group membership, theoretical orientation, workplace setting, degree attained) effect on choice and other factors' (i.e., training, client's preference) effect on choice and perceived difficulty.

1.1.1.1.1 *Client preference of treatment*

When a client has a preference for a certain type of treatment, the helping professional must choose whether or not to follow the client's suggestion, while simultaneously considering the effect of this choice on rapport and the client's

engagement in treatment, as well as the effectiveness of that therapy type administered by that therapist and for that disorder. Swift and Callahan (2009) note that the APA (2006) best-practice standards include consideration of client preference, which was a factor in their meta-analysis on the client treatment preferences and outcome. In their study, they found that providing clients with preferred treatment reduced attrition rates by half that of those receiving non-preferred treatment. This was further supported in a meta-regression analysis of 33 studies including 6,058 clients (Swift, Callahan, Ivanovic, & Kominiak, 2013). Swift and Callahan (2009) also found a small but significant effect size for greater improvement among clients whose treatment choice was favored over those whose choice was not matched. It is true that not all clients may have a preference or desire to choose a therapy type; however, based on their results, Swift and Callahan have suggested that a shared decision-making model between client and helping professional might be optimal to improve outcomes and reduce the likelihood of early termination (2009).

Tarrier, Liversidge, & Gregg (2006) found that despite expected discomfort, many clients preferred the use of exposure and cognitive therapies. Jaeger, Echiverri, Zoellner, Post, and Feeny (2009) explored the factors associated with client choice of exposure therapy, and found that fear of treatment was not a significant predictor of choice. Both studies contradict the client preference of the previously mentioned study, van Minnen, Hendriks, and Olff (2010), and definitive reasons for the variation has yet to be found. Becker et al. (2009) found that among law enforcement professionals 90% of participants preferred the use of cognitive processing therapy or exposure therapy as their primary and secondary choice of treatment as opposed to brief eclectic psychotherapy,

EMDR, critical incident stress debriefing, psychodynamic therapy, or medication treatment. The current study will consider client preference as a possible influence on helping professionals' treatment choice. The in-group/out-group bias between professional and client could offer an explanation for why a helping professionals would not take a client's preference into consideration, but may instead adhere to the treatment they or their cohort use most.

1.1.1.1.2 *Other effects on judgment*

Heffler and Sandell (2009) looked at the role of learning style in choosing one's therapeutic orientation. They described the learning styles of cognitive behavioral therapists as "think[ers] and do[ers]" or rational pragmatists, whereas psychodynamic therapists were described as "feel[ers] and watch[ers]" or intuitive observers. They found orientation to be related to learning styles, which suggests that internal attributes may effect orientation. Guest and Beutler (1988) found that supervision has minimal long-term impact on the formation of therapeutic orientation, meaning that mentorships may not be as impactful in developing a similar orientation. These studies suggest that orientation may be more internally ascribed, which could lead to an in-group/out-group bias; however, little research has been done in this area to suggest any effect of theoretical orientation on outcome.

1.1.2 Workplace Bias

Despite the best intentions of helping professionals to provide what they may see as the best treatment for a client, organizational factors such as workplace protocol and national guidelines can limit or broaden what is considered to be acceptable treatment. In accordance with the National Institute Clinical Excellence (NICE) guidelines,

psychotherapists in the United Kingdom are encouraged to use CBT for the majority of diagnoses (Benns-Coppin, 2008). The United Kingdom Institute for Health and Clinical Excellence also support the use of trauma-focused CBT and EMDR (NCCMH, 2005). The VA/DoD guidelines encourage the use of EBTs and trauma-focused treatments, and suggest the following psychotherapies: cognitive-based therapies, exposure-based therapies, SIT, DBT, imagery rehearsal therapy, and psychodynamic therapy (2010).

Group conformity has been found to occur more often when fewer choices are offered (Curtis & Desforges, 2013), allowing social influence to hold a greater impact and limiting the conflicting options of the chooser. If workplace or policy limitations are in effect, then the likelihood of conformity to an institution's therapy choice is greater.

As a means of expanding the use of EBTs in the VA, Karlin et al. (2010) sought to provide training in cognitive processing therapy (CPT) and prolonged exposure therapy (PE). They found that after training in CPT and PE, the clinicians reported witnessing better improvement by patients with PTSD than in past experience. The primary factors preventing them from using these therapies in the past were unfamiliarity and fear of discomfort with exposure. Yet, great efforts have been made in training practitioners and disseminating exposure based therapy in the VA system (Steenkamp & Litz, 2014; Eftekhari, Ruzek, Crowley, Rozen, Greenbaum, & Karlin, 2013). The clinical use of such EBTs should have increased in resent years due to such efforts, suggesting a higher current use of PE in the VA system.

The use of theories regarding the helping professional's views of treatments, workplace bias, clinical judgment, and intergroup attributes with regard to client preference and peer group preference will guide this study. The underutilization of

EBTs, as evidenced earlier can lead to increased cost and the prolonging treatment for clients suffering from PTSD. Despite recent efforts in the past decade by the ISTSS, the VA/DOD, and NIMH in producing guidelines of best practice for treating trauma and stress-related disorders, the shift to using EBTs like exposure therapy has been slow in its progression. Understanding the factors that affect therapeutic preference can help in better understanding what might affect the dissemination of EBTs in real world clinical practice. The study examined the effects of client preference, workplace setting, training, degree attained, and theoretical orientation on helping professionals' primary therapeutic preference in the treatment of PTSD. Specifically, this study hypothesized the following:

H1: The presence of training will predict the use of EBTs by helping professionals for treating PTSD.

H2: Highest degree attained will affect the treatment choice. A Ph.D. in psychology will yield the highest use of PE, while other degrees will be more likely to use CBT.

H3: Theoretical orientation will have no significant effect on the helping professional's treatment choice, except when it relates to client preference.

H4: CBT will be the most used treatment over PE, DBT, and EMDR.

H5: Workplace setting will have little effect on treatment choice outside of the VA.

CHAPTER II

METHOD

Data was collected by surveying helping professionals about treatment preference and factors that affect preference. The variables of client preference, workplace setting, degree attained, theoretical orientation, and training was used to predict group membership within treatment choice and to determine which predictors, if any, are relevant. Client preference was defined as "influential," "somewhat influential," or "non-influential" as a self-reported measure. The original question asked for client preference to be ranked in comparison to 7 other factors including: "type of traumatic event the client experienced," "characteristics of the client," "your familiarity with different treatments," "the severity of the client's symptoms," "length of time since the trauma," "presence of comorbidity," and "symptom presentation", and was recoded into three levels.

Workplace setting was defined as: "private practice," "community mental health," "medical center," "VA medical center," "university counseling center," "academic department, university," "academic department, medical school," "non-profit," "other military/government organization," or "other." Highest degree attained included: "Master of Science in Nursing (M.S.N.)," "Doctor of Education (Ed.D.),"

"Medical Doctor (M.D.)," "Doctor of Philosophy (Ph.D.)," "Psychology Doctorate (Psy.D.)," "M.A.," "Bachelor's degree," "M.S.," "D.S.W.," "Ed.S.," "multiple degrees," and "prefer not to answer." Theoretical orientation included: "Psychodynamic/Psychoanalytic," "Cognitive," "Behavioral (or Cognitive Behavioral)," "Humanistic (Existential, Gestalt, Rogerian)," "Interpersonal," "Systems," "Eclectic/Integrative or Other," and "Prefer not to answer." The types of treatment were limited to: cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR), and prolonged exposure (PE), all of which were included in one variable labeled "evidence-based treatment use," which was the dependent variable coded as "1 = use" and "0 = no use." The final variable of training was assessed by asking whether or not the participant had received training in each of the previously listed types of treatment.

2.1 Participants

The participants for this study were recruited from the American Psychological Association Division 56 (Trauma), the International Society for Traumatic Stress Studies, and the Association for Behavioral and Cognitive Therapies by email using membership databases, and include helping professionals with various licensure and educational backgrounds including psychologists, counselors, psychiatrists, social workers, medical doctors, researchers, and academics. The majority of participants, 63.7%, identified as female (N = 121), while 35.8% identified as male (N = 68). The mean age of the participants was 43.66-years-old and ranged from approximately 21 to 68 years of age. The mean number of years of experience was 14.47 years, with a range of 1 to 40 years. Participants were also asked the number of clients with PTSD that they directly

treatment. The mean number of clients treated was between "26 to 50" clients, with a range of "less than 5" to "100+," and a modal selection of "100+". Of the total participants (N = 260) only 190 met the criteria for inclusion in the evidence-based treatment (EBT) use or no use by responding "yes" or "no" to use of CBT, DBT, EMDR, or PE, leaving 70 cases of missing data. The missing cases were removed from the analysis leaving (N = 190).

2.2 Procedure

The researcher used previously collected data. In the previous study, participants completed an online questionnaire through surveymonkey.com, which took approximately 20-25 minutes to complete. The participants were asked to respond to questions addressing their degree, training, theoretical orientation, workplace setting, training in the use of specific EBTs for PTSD including CBT, DBT, EMDR, and PE, as well as what effect client preference may have on their decision to use specific EBTs for treating PTSD.

2.3 Research Design

The data was analyzed using logistic regression in order to predict use of EBTs for treatment of PTSD and to determine which predictors, if any, may have been correlated with that choice. A binary logistic regression was used with a dependent variable of "EBT use" (a combination of CBT, DBT, EMDR, or PE use) was coded for "use" or "no use." The independent variables of "training in EBT use," "workplace setting," "highest degree attained," "theoretical orientation," and "client's (presenting with trauma) treatment preference" were all entered into Block 1.

A second series of logistic regressions was conducted in order to determine if a particular treatment choice might have affected the outcome. Each of the four were designed with the dependent variable of each respective treatment use (CBT; DBT; EMDR; PE) coded for "use" or "no use." The independent variables were all entered into Block 1, which included "workplace setting," "highest degree attained," "theoretical orientation," "client's (presenting with trauma) treatment preference," and "training" in either CBT, DBT, EMDR, or PE, each respective to its own dependent variable.

CHAPTER III

RESULTS

The first hypothesis that the presence of training will predict the use of EBTs by helping professionals for treating PTSD was tested using a logistic regression and was found to have overall significance for predicting EBT use [χ^2 (df = 31, N = 190) = 47.963, p = 027, Cox & Snell R^2 = .248]. The independent variable (IV) of "training in EBT use" was also significant in predicting EBT use (p = .007). An additional Pearson Chi-square was run in order to test EBT use compared to EBT training [χ^2 (df = 1, N = 184) = 13.219, Phi = .268, p = .000]. Although the overall dependent variable (DV) of "theoretical orientation" was not found to significantly predict "EBT use", the level of "humanistic (existential, gestalt, rogerian)" did show significance in predicting the DV (p = .038); however, this most likely occurred to the limited number of cases (5) that chose this orientation. The second, third, and fifth hypothesis were not supported, however, the fourth hypothesis that CBT would be used most was supported (n = 132; see Table 4)

Table 1
Binary Logistic Regression for Prediction of Evidence-Based Treatment Use (N = 190)

Model	Block	Scale	R^2	p-value	χ^2
1	1	EBT	.248	.027	47.963

2	1	CBT	.138	.106	41.106
3	1	DBT	.319	< .000	65.314
4	1	EMDR	.586	< .000	150.868
5	1	PE	.502	< .000	118.364

Notes: Raw scores used for all analyses. Cox and Snell R^2 utilized.

The additional logistic regressions for each EBT use were found to have similar results. The prediction of "CBT use" was found to not be significant, [χ^2 (df = 31, N = 170) = 41.106, p = .106, Cox & Snell R^2 = .215]. The DV "DBT use" was found to have overall significance of predicted use [χ^2 (df = 31, N = 170) = 65.314, p < .000, Cox & Snell R^2 = .319]. The IV of "training in DBT use" was also significant in predicting DBT use (p < .000). Although the overall IV of "workplace setting" was not found to significantly predict DBT use, significance was found in predicting the DV was found for the levels "medical center" (p = .025), "VA medical center" (p = .014), and "academic department, medical school" (p = .022). The DV "EMDR use" was found to have overall significance of predicted use [χ^2 (df = 31, N = 171) = 150.868, p < .000, Cox & Snell R^2 = .586]; however, no other predictor variables were found to be significant. The DV "PE use" was found to have overall significance of predicted use [χ^2 (df = 31, N = 170) = 118.364, p < .000, Cox & Snell R^2 = .502]. The IV of "training in PE use" was also significant in predicting PE use (p = .000).

Table 2

Summary of Logistic Regression Analysis of Variables Predicting Use of EBTs for Treating PTSD

Varibles	*B*	S.E.	Wald Test (*z*-ratio)	Odds Ratio	*p*-value
EBT					
Training	-5.564	2.056	7.325	.004	.007
Orientation					
Humanistic	-4.089	1.971	4.306	.017	.038
CBT					
DBT					
Training	2.671	.517	26.642	14.455	.000
Workplace					
Medical Center	-3.307	1.480	6.006	.037	.025
VA Medical Center	-3.222	1.315	4.995	.040	.014
Academic Department (Medical School)	-3.676	1.600	5.282	.025	.022
EMDR					
PE					
Training	4.784	.953	25.185	119.544	.000

Note: $p < .05$ for significance

CHAPTER IV

DISCUSSION

The first hypothesis that "The presence of training will predict the use of EBTs by helping professionals for treating PTSD," was found to be empirically supported. Training was found to influence helping professional's approach to treatment. These findings suggest that the majority of helping professionals in the study do not use treatments that they have not been trained to use, and that better efforts in training helping professionals in the use of EBTs such as CBT, EBT, EMDR, and PE may assist in making these treatments available for more clients diagnosed with PTSD. This means that researchers, healthcare organizations, and helping professionals should consider making efforts to refocus on more effective methods of disseminating treatments that have been empirically supported, thus decreasing healthcare costs while increasing long-term patient outcomes and satisfaction. The *theory of planned action* may support the outcome that helping professionals use EBTs when they have been trained to use them (Bagozzi, Gurhan-Canli, & Priester, 2002). If the perception of difficulty in using certain EBTs like PE is higher then this could possibly prevent the desire to be trained or even the use of PE post-training.

The second hypothesis that "Highest degree attained will affect the treatment choice. A Ph.D. in psychology will yield the highest use of PE, while other degrees will be more likely to use CBT," was not found to be empirically supported. The third hypothesis that "Theoretical orientation will have no significant effect on the helping professional's treatment choice, except when it relates to client preference," was not found to be empirically supported for CBT, DBT, EMDR, or PE, but was found to be a significant predictor for EBTs overall when it came to the humanistic theoretical orientation. The fourth hypothesis that "CBT will be the most used treatment over PE, DBT, and EMDR," was found to be empirically supported. The fifth hypothesis that "Workplace setting will have little effect on treatment choice outside of the VA," was found to be empirically supported, but only with predicting DBT use. This means that despite efforts of dissemination of EBTs (Russell & Silver, 2007; Van Minnen, Hendriks, & Olff, 2010) in the VA, the use at the time of data collection had still not significantly changed. This study confirmed the findings in previous research which found that helping professionals are reluctant to use EBTs that they do not feel to be adequately trained in using. This study has helped to narrow the focus to training in regard to factors correlated with EBT use. Training may be a key factor in the majority of reluctance toward EBT use for treating PTSD as previous studies suggest (Sprang, Craig, & Clark, 2008).

Some limitations to this study fall under the research design. The survey question examining the subjects' use of treatment was not a forced comparison model, and therefore this limited the type of statistical analysis that could be used. A logistic regression was chosen due to the creation of four dichotomous (yes/no) variables when

considering the four types of treatment (CBT, PE, EMDR, and DBT), which may have left overlap between cases.

Further studies could be conducted on client preference and its affect of therapeutic preference in a way that does not rely entirely on self-report. No measure was used to consider if the client even presented with a preference. If the helping profession was not working with a client who had a preference, then this would rarely influence the treatment consideration of the helping professional. Given the nature of self-report, a more objective measure may be more useful. This could also be said of therapeutic orientation and treatment choice, given that fidelity to a pure form of one's theoretical orientation and a standardized form of chosen treatment were not objectively measured. The use of EBTs for other treatment populations could also be examined to see if trauma-focused helping professionals are a confounding variable in EBT use. Since this study only focused on members of trauma-focused organizations, then perhaps exploring other organizational memberships use of EBTs might yield different results.

Substantial efforts have been made in the dissemination of evidence-based treatments (Steenkamp & Litz, 2014; Eftekhari et al. , 2013; McHugh & Barlow, 2010; Gunter & Whittal, 2010; Frueh et al., 2009; Cohen & Mannarino, 2008), yet the extent of their use in clinical settings is still limited (Becker, Zayfert, & Anderson, 2004; Feeny, Hembree, & Zoellner, 2003; Van Minnen, Hendriks, & Olff, 2010). Understanding the factors that influence the use of EBTs can aid in this effort to provide effective treatment to those who suffer from trauma and stress-related disorders such as PTSD. This current study sought to determine if members of three prominent trauma-focused organizations (American Psychological Association Division 56 (Trauma), the ISTSS, and the

Association for Behavioral and Cognitive Therapies) were using EBTs and what factors may influence their utilization of these treatments.

TABLES

Table 3
Crosstabulation of EBT Use x EBT Training

		Evidence-Based Treatment Use		Total
		Do not use EBTs	Use EBTs	
EBT Training	No Training	4	4	8
	Training	16	160	176
	Total	29	164	184

Table 4
Summary of Variables Predicting Use of EBTs for Treating PTSD

Varibles	Use (n)	Use (%)	No Use (n)	No Use (%)
EBT	168	88.4	22	11.6
CBT	132	69.5	58	30.5
DBT	52	27.4	138	72.6
EMDR	44	23.2	146	76.8
PE	82	43.2	108	56.8

Table 5
Workplace Setting Descriptives

Workplace Setting	Frequency	Percent
Private Practice	41	21.6
Community Mental Health	20	10.5
Medical Center	16	8.4
VA Medical Center	57	30.0
University Counseling Center	3	1.6
Academic Department, University	21	11.1
Academic Department, Medical School	16	8.4
Prefer not to answer	2	1.1
Other Government or Military Organization	7	3.7
Non-Profit	6	3.2
Other	1	.5
Total	190	100.0

Table 6
Theoretical Orientation Descriptives

Theoretical Orientation	Frequency	Percent
Prefer not to answer	1	.5
Psychodynamic/Psychoanalytic	19	10.0
Cognitive	15	7.9
Behavioral (or Cognitive Behavioral)	88	46.3
Humanistic (Existential, Gestalt, Rogerian)	4	2.1
Interpersonal	5	2.6
Systems	3	1.6
Eclectic/Integrative or Other	55	28.9
Total	190	100.0

Table 7
Highest Degree Attained Descriptives

Highest Degree Attained	Frequency	Percent
M.S.N.	1	.5
Ed.D.	1	.5
M.D.	7	3.7
Ph.D.	94	49.5
Psy.D.	13	6.8
M.A.	31	16.3
M.S.W.	20	10.5
Bachelor's Degree	6	3.2
M.S.	3	1.6
D.S.W.	4	2.1
Ed.S.	8	4.2
Prefer not to answer	2	1.1
Total	190	100.0

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APPENDIX

PTSD Therapist Survey

Please Answer The Following Questions:

1. What is your Gender?
    a. Male
    b. Female
    c. Prefer not to answer

2. How old are you? (enter X if you prefer not to answer): _____

3. What is the highest degree(s) you've obtained?
    a. M.S.N.
    b. Ed.D.
    c. M.D.
    d. Ph.D.
    e. Psy.D.
    f. M.A.
    g. M.S.W.
    h. Bachlor's Degree
    i. Prefer Not To Answer,
    j. Other (please specify): _____

4. Please indicate the licensure you currently hold:
    a. Mental Health Nurse
    b. Psychologist
    c. Physician (Psychiatrist)
    d. Physician (Other)
    e. Counselor (LCC, MFT)
    f. Social Work (LISW, MSW)
    g. Prefer not to answer
    h. Other (please specify): _____

5. How many years have you been practicing? (enter X if you prefer not to answer): _____

6. What is your theoretical orientation?
    a. Psychodynamic/Psychoanalytic
    b. Cognitive
    c. Behavioral (or Cognitive Behavioral)
    d. Humanistic (Existential, Gestalt, Rogerian)
    e. Interpersonal
    f. Systems
    g. Prefer not to answer
    h. Eclectic/Integrative or Other (please specify): _____

7. Which setting best describes where you spend the majority of your professional time?
    a. Private Practice
    b. Community Mental Health
    c. Medical Center
    d. VA Medical Center
    e. University Counseling Center
    f. Academic Department, University
    g. Academic Department, Medical School
    h. Prefer not to answer
    i. Other (please specify): _____

8. Are you a member of any of the following professional organizations? Please check all that apply.
    a. American Counseling Association (ACA)
    b. American Psychological Association (APA)
    c. American Mental Health Counselors Association (AMHCA)
    d. Association of Behavioral and Cognitive Therapies (ABCT)
    e. International Society for Traumatic Stress Studies (ISTSS)
    f. Prefer not to answer

9. Are you currently working on any research studies related to trauma and/or PTSD?
    a. Yes
    b. No
    c. If yes, please provide a brief (1-2 sentence) overview of the study and your role:

        _____

10. In an average week, how many clients do you treat overall? (enter X if you prefer not to answer): _____

11. In an average week, how many clients with PTSD do you treat? (enter X if you prefer not to answer): _____

12. In your career, how many clients with PTSD have you directly treated?
    a. Less than 5
    b. 6-10
    c. 11-25
    d. 25-50
    e. 51-100
    f. 100+
    g. Prefer not to answer

13. How familiar are you with the following treatments for PTSD?

	Not at all familiar	Slightly familiar	Somewhat familiar	Very familiar	Prefer not to answer
Acceptance and Commitment Therapy					
Cognitive Behavioral Therapy					
Dialectical Behavior Therapy					
Emotional Freedom Techniques/Energy Therapy					
Eye Movement Desensitization and Reprocessing (EMDR)					
Narrative Exposure Therapy					
Present Centered/Supportive Therapy					

Prolonged Exposure					
Stress Inoculation Therapy (SIT)					
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)					
Virtual Reality Exposure Therapy					
Other					

Specify other: _____

14. Have you been trained in the following treatments for PTSD?

	Yes	No	Prefer not to answer
Acceptance and Commitment Therapy			
Cognitive Behavioral Therapy			
Dialectical Behavior Therapy			
Emotional Freedom Techniques/Energy Therapy			
Eye Movement Desensitization and Reprocessing (EMDR)			
Narrative Exposure Therapy			
Present Centered/Supportive Therapy			
Prolonged Exposure			
Stress Inoculation Therapy (SIT)			
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)			
Virtual Reality Exposure Therapy			
Other			

Specify other: _____

15. When you propose a treatment plan to a client with PTSD, do you prefer to:
    a. present one treatment option to the client, as my recommended treatment approach.
    b. present a range of possible treatment options, from which the client could choose.

16. Of the PTSD clients you have treated, approximately what percentage have presented to you with an idea about the specific type of psychosocial treatment they are interested in (for example, "I am interested in undergoing analysis" or "I have read about cognitive behavioral treatment")?
    a. Less than 5%
    b. 5-10%
    c. 10-25%
    d. 25-50%
    e. 50-75%
    f. 75% or more
    g. Prefer not to answer

17. Of the treatments below, which would you identify as an Empirically-Supported Treatment (EST) for PTSD, meaning there is compelling data to support the superiority of this treatment over others as a first-line treatment?

	EST	Not an EST
Acceptance and Commitment Therapy		
Cognitive Behavioral Therapy		
Dialectical Behavior Therapy		
Emotional Freedom Techniques/Energy Therapy		
Eye Movement Desensitization and Reprocessing(EMDR)		
Narrative Exposure Therapy		
Present Centered/Supportive Therapy		
Prolonged Exposure		
Stress Inoculation Therapy (SIT)		
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)		
Virtual Reality Exposure Therapy		
Other		
Specify other:		

18. Do you currently use any of the following treatments with PTSD clients? If yes, with what percentage of PTSD clients do you use the following treatments? Please make sure the percentages add up to 100%.

	Yes/No	Percentage
Acceptance and Commitment Therapy		
Cognitive Behavioral Therapy		
Dialectical Behavior Therapy		
Emotional Freedom Techniques/Energy Therapy		
Eye Movement Desensitization and Reprocessing (EMDR)		
Narrative Exposure Therapy		
Present Centered/Supportive Therapy		
Prolonged Exposure		
Stress Inoculation Therapy (SIT)		
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)		
Virtual Reality Exposure Therapy		
Other		
Specify other:		

19. In general, what variables do you take into consideration when choosing a particular treatment for a client? Please rank the following variables, with 1 being the most important factor and 6 being the least important (enter X if you prefer not to answer).
    a. ____ Characteristics about the client
    b. ____Your familiarity with treatments
    c. ____The severity of the clients symptoms
    d. ____Client preferences in treatment choices
    e. ____Presence of comorbidity
    f. ____Symptom presentation

20. What variables do you take into consideration when choosing a particular treatment for a client who has suffered a trauma? Please rank the following variables, with 1 being the most appealing and 8 being the least appealing (enter X if prefer not to answer).
    a. ____Type of traumatic event the client experienced
    b. ____Characteristics of the client
    c. ____Your familiarity with different treatments
    d. ____The severity of the client's symptoms
    e. ____Client preferences in treatment choices
    f. ____Length of time since the trauma
    g. ____Presence of comorbidity
    h. ____Symptom presentation

21. Please place a check mark in the appropriate spaces below if you believe that, in general, the following client problems might be worsened or exacerbated by any of the treatments listed.

	Cognitive Processing Therapy	Eye Movement Desensitization and Reprocessing (EMDR)	Present Centered/ Supportive Therapy	Prolonged Exposure	Stress Inoculation Therapy (SIT)	Prefer not to answer
Substance Abuse/Dependency						
Suicidality						
Self-injury						
Homicidality						

Physical Aggression/ Violence						
Reexperiencing Symptoms						
Avoidance Symptoms						
Emotional Numbing						
Increased Arousal						
Dissociation						
Overwhelming Anxiety						
Alliance with Therapist						
Interpersonal Problems						
Desire to Drop Out of Therapy						
Other						
Specify other:						

22. Which of the following influences your decision to not use the following treatments as an intervention for PTSD?

	Cognitive Processing Therapy	Eye Movement Desensitization and Reprocessing (EMDR)	Present Centered/ Supportive Therapy	Prolonged Exposure	Stress Inoculation Therapy (SIT)	Prefer not to answer
I have limited or no experience/training						
I do not have confidence in this treatment based on the						

data						
I do not have confidence in this treatment based on my clinical intuition						
I do not fully understand the rationale						
I do not feel prepared to manage potential negative side effects likely to be evoked by this treatment						
I am concerned that this treatment would be too emotionally difficult for me personally						
This treatment does not allow me to tailor treatment to meet my clients' needs						
This treatment does not fit with my conceptualization of PTSD						
I am concerned this treatment will have a negative effect on the						

therapeutic relationship						
I am concerned my client may decompensate						
I prefer to approach each client individually vs. using manualized treatments						
This treatment requires too much time						
I cannot get appropriate insurance approval						
Other						
Specify other:						

23. How comfortable are you with discussing trauma with patients?
    a. Very comfortable
    b. Somewhat comfortable
    c. Slightly comfortable
    d. Not at all comfortable
    e. Prefer not to answer

24. What variables make you most reluctant to discuss trauma?
    a. personally do not feel comfortable discussing trauma
    b. I'm afraid that my client will decompensate
    c. I'm afraid that my client will become stressed
    d. I'm afraid of appearing insensitive
    e. I'm afraid of transference or countertransference reactions
    f. None of these are true for me
    g. Prefer not to answer
    h. Other (please specify): _____

25. Please indicate whether the following client characteristics would contraindicate the use of the following empirically supported treatments below.

	Cognitive Processing Therapy	Eye Movement Desensitization and Reprocessing (EMDR)	Present Centered/ Supportive Therapy	Prolonged Exposure	Stress Inoculation Therapy (SIT)	Prefer not to answer
Any Comorbid Diagnoses						
Comorbid Depression - Severe						
Comorbid Depression - Mild/ Moderate						
Comorbid Bipolar Disorder						
Comorbid Anxiety Disorders						
Comorbid Substance Abuse/Dependence						
Comorbid Psychotic Disorder						
Comorbid Dissociative Identity Disorder						
Suicidality - With Specific Plan or Intent						
Suicidality - No Plan or Intent						

Homicidality						
Physical Aggression/Violence Byclient to others						
Physical Aggression/Violence By other to client						
Dissociation - Severe						
Dissociation - Mild/Moderate						
Severe Numbing						
Severe Anger						
Low Levels of Social and Interpersonal Support						
Past Treatment Non-Response						
Past Adherence Problems in Psychotherapy						
Other						
Specify other:						

In the following series of questions, you will be presented with a series of case descriptions. Please read each case carefully, and indicate which treatment you would be most likely to choose for this individual. Please explain your choicein the box below. Please explain your contraindications (if any).

26. Brent is a 37 year old African American male, who lost his son to a horrible car accident, in which he was driving, five years ago. He has rarely left his house to avoid driving and reexperiences the accident in his head every day. Since the accident, his wife has left him due to his increased irritability. He has come into your office with hopes to begin to recover and get his life back on track before he loses everything he has once loved.
    Please indicate which treatment you would use to treat this client:
    a. Acceptance and Commitment Therapy
    b. Cognitive Behavioral Therapy
    c. Dialectical Behavior Therapy
    d. Emotional Freedom Techniques/Energy Therapy
    e. Eye Movement Desensitization and Reprocessing (EMDR)
    f. Narrative Exposure Therapy
    g. Present Centered/Supportive Therapy
    h. Prolonged Exposure
    i. Stress Inoculation Therapy (SIT)
    j. Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
    k. Virtual Reality Exposure Therapy
    l. Other
    Please Explain your choice below:

    _____
    _____
    _____
    _____
    _____

27. Jenna is a 42 year old Caucasian female who suffers from both PTSD and Bipolar Disorder. About 2 years ago Jenna was mugged while walking home. The perpetrator stole her purse and threatened to kill her. Jenna has suffered from reccurring and distressing thoughts of the event and avoidance of being alone since the trauma. In addition to her presentation of PTSD symptoms, Jenna has also experienced periods of depression and mania throughout her life. Shortly after the trauma occurred, Jenna experienced a depressive episode in which she lost a significant amount of weight, and had poor appetite, insomnia, and suicidal ideation. More recently, however, Jenna had a manic episode in which she engaged in sexual intercourse with multiple partners, and maxed out 2 of her credit cards over a 10-day period. Jenna is seeking treatment in order to try to deal with the trauma, reduce her PTSD symptoms, and regain a sense of control in her life.

    Please indicate which treatment you would use to treat this client:

    a. Acceptance and Commitment Therapy
    b. Cognitive Behavioral Therapy
    c. Dialectical Behavior Therapy
    d. Emotional Freedom Techniques/Energy Therapy
    e. Eye Movement Desensitization and Reprocessing (EMDR)
    f. Narrative Exposure Therapy
    g. Present Centered/Supportive Therapy
    h. Prolonged Exposure
    i. Stress Inoculation Therapy (SIT)
    j. Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
    k. Virtual Reality Exposure Therapy
    l. Other

    Please Explain your choice below:

_____
_____
_____
_____
_____

28. Maria, a 20 year old Asian female, presents with excessive alcohol and other drug use for the past year. She has informed you that she was raped by a friend two years ago at a college party, and that she believes it was her fault because she was drinking that night. She has not disclosed much more about the incident and seems reluctant to treatment. Since the rape, Maria has had difficulty concentrating in school, problems falling asleep, and avoidance of males that resemble the man who raped her. Maria says she uses alcohol and drugs to make her feel numb. Maria usually has 57 drinks on most days of the week, and occasionally will smoke marijuana while she is intoxicated. You have learned that after previous therapies, she abruptly stops treatment just when there seems to be some progress. Her parents are worried about Maria and have insisted she seek treatment with a therapist.

    Please indicate which treatment you would use to treat this client:

    a. Acceptance and Commitment Therapy
    b. Cognitive Behavioral Therapy
    c. Dialectical Behavior Therapy
    d. Emotional Freedom Techniques/Energy Therapy
    e. Eye Movement Desensitization and Reprocessing (EMDR)
    f. Narrative Exposure Therapy
    g. Present Centered/Supportive Therapy
    h. Prolonged Exposure
    i. Stress Inoculation Therapy (SIT)
    j. Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
    k. Virtual Reality Exposure Therapy
    l. Other

    Please Explain your choice below:

_____
_____
_____
_____
_____

29. Greg is a 31 year old Caucasian male who is an Iraqi War Veteran. Four years ago while Greg was serving in the army in Iraq, he was shot in his leg. Due to complications resulting from his injury, Greg had to have his right leg amputated. Greg endured months of therapy and now uses a prosthetic leg. Greg experiences symptoms of an exaggerated startle response, and recurring nightmares of the shooting. Greg also has a lot of anger and pent up frustration directed at the military. He often has thoughts of wanting to go back and kill the Iraqi soldier who did this to him and has even thought of malicious ways in which he would carry out this attack. Greg recognizes that the traumatic event is consuming his life and would like to seek treatment to help him deal with his PTSD.
    Please indicate which treatment you would use to treat this client:
    a. Acceptance and Commitment Therapy
    b. Cognitive Behavioral Therapy
    c. Dialectical Behavior Therapy
    d. Emotional Freedom Techniques/Energy Therapy
    e. Eye Movement Desensitization and Reprocessing (EMDR)
    f. Narrative Exposure Therapy
    g. Present Centered/Supportive Therapy
    h. Prolonged Exposure
    i. Stress Inoculation Therapy (SIT)
    j. Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
    k. Virtual Reality Exposure Therapy
    l. Other
    Please Explain your choice below:

_____
_____
_____
_____
_____

30. John is a 63 year old Caucasian farmer. Two months ago, he was the victim of a carjacking. While John was waiting at a red light near the center of the city, a man came bursting out of a nearby building, waving a gun. He ran up to John, sticking the gun through the open window and screaming that he would blow his brains out. John was dragged from the car and struck repeatedly with the end of the gun. Then the man climbed into John's truck and took off, running over John's leg in the process. Since the trauma, John has been having trouble getting his work done. He has repeated intrusive thoughts of the assailant running up to him and persistent nightmares about the attack. Police have recovered John's truck, but he refuses to drive it. In fact, just looking at the truck causes John to experience shortness of breath, accelerated heart rate, and cold sweats. John refuses to go into town anymore. He also refuses to talk about the incident. He is withdrawn, unresponsive, and solitary. He has been hyper-alert to signs of danger and especially mistrustful of strangers. He has been working hard to improve the "security" of his farm, putting up motion-detector lights and electric fencing. He has also been prone to outbursts of anger, surprising friends and family, who have always known him to be warm and gregarious. He seeks therapy at the urging of his mother, to whom he is very close.
    Please indicate which treatment you would use to treat this client:
    a. Acceptance and Commitment Therapy
    b. Cognitive Behavioral Therapy
    c. Dialectical Behavior Therapy
    d. Emotional Freedom Techniques/Energy Therapy
    e. Eye Movement Desensitization and Reprocessing (EMDR)
    f. Narrative Exposure Therapy
    g. Present Centered/Supportive Therapy
    h. Prolonged Exposure
    i. Stress Inoculation Therapy (SIT)
    j. Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
    k. Virtual Reality Exposure Therapy
    l. Other
    Please Explain your choice below:

_____
_____
_____
_____
_____

31. Considering each of the case examples you just read, to what extent did the following variables influence your treatment choice?

	No Influence	Somewhat Influence	Greatly Influence	Prefer not to answer
Client age				
Client Gender				
Client Race				
Type of Trauma				
Symptom severity				
Amount of time since trauma ocured				
Comobidity				
Your personal treatment preference				

32. How often do you attempt to incorporate research findings into your own practice?
    a. Nerver (0% of the time)
    b. Not often (1-25% of the time)
    c. Slightly often (25-50% of the time)
    d. Often (51-100% of the time)
    e. Very often (75-100% of the time)
    f. Prefer not to answer

33. Some clinicians have concerns about incorporating the use of empirically supported treatments (ESTs) into their treatment approach or repertoire. Other clinicians simple opt not to or don't feel adequately trained to provide these treatments. What are the factors that interfere with your use of ESTs for PTSD? Check all that apply.
    a. Lack of knowledge about ESTs
    b. Lack of funding for training in ESTs
    c. I don't agree with the validity of the "ESTs" movement; the data are inconclusive at this point
    d. I don't have interest in learning about ESTs
    e. The state of the science is in its infancy; more research is needed before we begin to claim some therapies as "evidence based" and others as not
    f. Time constraints prohibit the use of ESTs
    g. I have seen evidence that disputes the effectiveness of mainstream ESTs
    h. I do not want to use a manualized treatment
    i. The mainstream ESTs don't fit with my theoretical background
    j. Results of treatment outcome studies don't generalize to the population I serve
    k. Using ESTs limits my ability to be creative in treatment and use the art of psychotherapy
    l. Editors and powerful others overlook or actively suppress data that contradict the use of mainstream ESTs
    m. This does not apply to me, I do provide ESTs
    n. Prefer not to answer
    o. Other, please specify: _____

34. What makes a treatment seem like a reasonable option to you as a clinician? Please rank the following variables from 1 to 13, with 1 being the most important variable you consider when thinking about the appeal of a treatment (enter X if prefer not to answer).
    a. ____ Empirical support for treatment
    b. ____ Ease of use
    c. ____ Familiarity with the treatment
    d. ____ It is scientific in nature
    e. ____ It is endorsed by my work setting or professional organization
    f. ____ It is theoretically sound
    g. ____ I have used it successfully in the past
    h. ____ It seems like one that my clients would accept or tolerate
    i. ____ I enjoy providing the treatment
    j. ____ I believe in the effectiveness of the treatment
    k. ____ The treatment is brief
    l. ____ The treatment would foster a strong therapeutic alliance
    m. ____ My colleagues use this treatment
    a. ____ Other (please specify) : _____

35. Which systematic or organizational factors influence your decision to use a particular treatment?
    a. None of these apply to me
    b. My agency or clinic encourages the use of specific treatments
    c. My clinic provides training in new treatment options
    d. My clinic gives me discretion in choosing a therapy for my client
    e. My supervision and setting lend themselves to trying new treatment options
    f. Prefer not to answer
    g. Other (please specify): _____

36. How much does the duration of your relationship with a client influence the treatment that they are given?
    a. Does not Influence
    b. Slightly Influences
    c. Somewhat Influences
    d. Greatly Influences
    e. Prefer not to answer

37. How easily can you access literature from research journals?
    a. Research articles are very inaccessible
    b. Research articles are somewhat inaccessible
    c. Research articles are somewhat accessible
    d. Research articles are very accessible
    e. Prefer not to answer

38. How much time (in minutes) do you spend per week reviewing the literature, searching for studies, and retrieving empirical articles? (enter X if prefer not to answer) _____

39. Please tell us the number of empirical articles that you read per week. (enter X if prefer not to answer) _____

40. Due to the urgent need for increased access to evidence-based psychological treatments, efforts have been made to improve dissemination of these interventions. Below, please indicate from which programs (if any) you have received training on evidence-based psychological treatments for PTSD.
    a. Improving Access to Psychological Therapies Program (IAPT)
    b. Veterans Health Administration (VHA)
    c. National Child Traumatic Stress Network (NCTSN)
    d. None of these
    e. Prefer not to answer
    f. Other (please specify): _____

41. If you received training from any of the programs above, please tell us which treatment you received training in (enter X if you did not receive training through any of these programs or if you prefer not to answer). _____