

## A national survey of clinicians' views of evidence-based therapies for PTSD and substance abuse

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This study was a nationwide survey of 205 Veterans Affairs (VA) staff on their views of 11 psychotherapy models for posttraumatic stress disorder (PTSD), substance use disorder (SUD), or comorbid PTSD/SUD. For each model, staff rated four key areas: level of implementation, helpfulness overall, helpfulness for PTSD/SUD, and desire for training on it. They also provided quantitative and qualitative information on general questions related to PTSD/SUD treatment. Results indicated that most respondents were already using one or more models, and they reported significantly different ratings of the models in each of the four key areas addressed, with some models quite consistently appearing at the top or bottom of the list. Furthermore, the more the clinicians had implemented a particular model, the more helpful they found it. A factor analysis of the models indicated four factors that appeared related to their content, rather than to how much they were liked. Finally, qualitative comments emphasized a desire for more training on PTSD/SUD topics and models, a broader array of psychotherapies to be implemented in VA, and more guidance on the use of PTSD models in the context of SUD. Results are discussed in terms of methodology, the need for replication, how ratings may have been affected by lack of experience with particular models, and the need for further research on adoption of evidence-based practice models.

**Keywords** PTSD, substance abuse, treatment

### INTRODUCTION

Co-occurring posttraumatic stress disorder (PTSD) and substance use disorder (SUD) is a major concern in both veteran and community samples (Erbes et al., 2009; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Not only is this a common comorbidity, but it is also associated with substantial psychiatric and functional impairment (Ouimette & Brown, 2002). New veterans from Iraq and Afghanistan are evidencing concerning rates of both of these disorders (Erbes, Westermeyer, Engdahl, & Johnsen, 2007; Seal, Bertenthal, Miner, Sen, & Marmar, 2007; VHA Office of Public Health and Environmental Hazards, 2008), and there are now efforts underway in both the military and veteran affairs (VA) to try to help with these problems.

Psychotherapy remains one of the primary modes of treatment for this population, especially as there are as yet limited medications that have been found effective for them (Institute of Medicine, 2007; Najavits et al., 2008). There are various psychotherapy models for PTSD, SUD, and their combination, and a substantial number of outcome studies on such models (Carroll & Onken, 2005; Foa, Keane, Friedman, & Cohen, 2008; Najavits et al., 2008). Yet relatively less studied is how much clinicians actually like particular models compared to others. Two models may have comparable efficacy (ability to reduce patient symptoms), yet have quite different levels of adoption (use of the model by clinicians). Simply establishing a model as effective is no guarantee that clinicians and programs will adopt it, and there are various reports in the literature on such adoption gaps for particular models (including Exposure Therapy for PTSD, Behavioral Couples Therapy, and Eye Movement Desensitization and

Reprocessing (Becker, Zayfert, & Anderson, 2004; Cook, Biyanova, & Coyne, 2009; Fals-Stewart & Birchler, 2001; Russell, 2008).

There is also growing recognition in both the PTSD and SUD fields that evidence-based models appear to show comparable efficacy (Benish & Wampold, 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Imel, Wampold, Miller, & Fleming, 2008; Morgenstern & McKay, 2007; Najavits, 2007). Thus, the next generation of research may benefit from a stronger focus on how and why some models are adopted by clinicians. Models may differ even when designed for the same client population. They may vary in their degree of flexibility, difficulty to learn it, cost, which clinicians can do it (based on degree or training), how the model converges or conflicts with existing practices, and basic appeal (readability, format). The key questions thus become: how much do clinicians like particular models compared to others? What aspects of the models influence their adoption? How much do they sustain use of particular models over time (especially when extrinsic influences are withdrawn such as pressure from a supervisor, program, or roll-out effort)?

Various studies have explored clinicians' views of therapy manuals (with "manual" referring to a book that describes a psychotherapy model in detail). In general, these studies indicate positive views of manuals (Barry et al., 2008; Godley, White, Diamond, Passetti, & Titus, 2001; Haug, Michael, Tajima, Gruber, & Guydish, 2008; Najavits, Weiss, Shaw, & Dierberger, 2000; Najavits et al., 2004), although two studies have found more mixed results (Addis & Krasnow, 2000; Lucock, Hall, & Noble, 2006). Moreover, some manuals, and specific elements of manuals, are perceived more favorably than others (Barry et al., 2008; Haug et al., 2008; McGovern, Fox, Xie, & Drake, 2004; Najavits et al., 2000, 2004). Clinician factors also play a role: clinicians in academic settings value the theory and evidence base of manuals more than community clinicians (Addis & Krasnow, 2000; Barry et al., 2008); cognitive behavioral clinicians are more positive about manuals than psychodynamic clinicians (Addis & Krasnow, 2000; Lucock et al., 2006; Najavits et al., 2004); and less experienced clinicians are more positive about manuals than experienced therapists (Addis & Krasnow, 2000).

The purpose of the present study was to explore clinicians' views of therapy models relevant to PTSD/SUD. We know of only a few other studies that asked clinicians to provide comparative ratings of different models (Barry et al., 2008; Haug et al., 2008; McGovern et al., 2004), and all of these were in the SUD field and inquired about how much models were being used rather than satisfaction with them. McGovern et al. (2004) found that clinicians had implemented some SUD models more than others (12-Step Facilitation, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, and Relapse

Prevention Therapy were rated higher than Contingency Management and Behavioral Couples Therapy). Haug et al. (2008) similarly found that the most frequently employed SUD models were CBT, Motivational Interviewing, and 12-step facilitation; the less frequently used were Psychodynamic, Multidimensional Family Therapy, Contingency Management, Brief Strategic Family Therapy, and Behavioral Couples Therapy. Barry et al. (2008) surveyed 40 clinicians on their views of 12 SUD manuals, and found some to be more used than others; however, it was a brief report that focused on general aspects of manuals and did not provide actual data on each model. Other studies have addressed the views of manuals generally (Addis & Krasnow, 2000; Najavits et al., 2000, 2004), or ratings of just one model rather than across models (Brown et al., 2007; Hills, Rugs, & Young, 2004; Najavits et al., 2004). No study thus far has addressed clinicians' views of manuals relevant to comorbid PTSD/SUD. Moreover, we know of no study on this topic within the VA. The VA is the largest mental health treatment system in the country, and has grown over the past several years as veterans are returning from Iraq and Afghanistan. There are major efforts in VA to disseminate psychotherapy treatments (Department of Veterans Affairs, 2008), and yet at this point, little VA research on clinicians' views of these. Thus, this study is both a general one to explore views of several prominent treatment models for PTSD and/or SUD, and also a project relevant to VA in particular. Clinicians were asked to rate their impressions of models whether or not they had direct experience with them.

## METHODS

We conducted a nationwide survey of 205 VA staff (Najavits, Norman, Kosten, & Kivlahan, in press). All were VA clinicians or program managers currently working with veterans who had PTSD/SUD. We sought to obtain respondents from all professional backgrounds (e.g., substance abuse counselors, psychologists, psychiatrists, social workers, and rehabilitation counselors) and all levels of care (e.g., inpatient, outpatient, and day program). The inclusion criteria were: (1) currently on staff at VA; and (2) currently in contact with PTSD/SUD clients. To preserve anonymity, recruitment was conducted online, across the country, and as broadly as possible so that at no point would the study team be able to identify who filled out the survey. Members of a national VA workgroup on PTSD/SUD were asked to distribute the online survey link to as many VA clinicians and program managers as they could via e-mail. The workgroup is part of the VA substance abuse quality enhancement research initiative (QUERI), and all the authors of this article are affiliated with it. All survey recipients were encouraged to further forward the same e-mail to others who could then complete it themselves

and also forward it on, thus using a “snowball” procedure to recruit a broad and anonymous sample. Neither the research team, workgroup members, nor anyone else inside or outside of VA could ever know the complete list of who was invited to fill out the survey nor who chose to complete it. The survey was conducted until we met our targeted sample of at least 200 respondents.

The survey (Najavits, 2007) was a one-time assessment of quantitative and qualitative information on PTSD/SUD treatment. It was adapted from an earlier version used with community-based clinicians (Najavits, 2002a) to change wording and add items relevant to VA, and also to add the ratings of specific treatment models that are the basis for this article. A separate paper on the same VA sample provides general views on treating PTSD/SUD (Najavits et al., in press). This article is based on a grid that respondents filled out listing 11 therapy models in the following order: 12-Step, Motivational Interviewing, Contingency Management, Relapse Prevention, Seeking Safety, Eye Movement Desensitization and Reprocessing (EMDR), Exposure Therapy for PTSD, Cognitive Processing Therapy, General Cognitive Behavioral Therapy, Supportive Therapy, and Dialectical Behavior Therapy. For each model, respondents answered four questions, each scaled from 1 to 5 (with 1 indicating “not at all” and 5 indicating “greatly”): “How much have you implemented this model?” (question 1); “How helpful is this model overall?” (question 2); “How helpful is this model for PTSD/substance abuse clients?” (question 3); and “How much would you want training in this model?” (question 4). Also, respondents were asked how much training they wanted on PTSD, SUD, PTSD/SUD, assessment, and alternative substance abuse treatments (e.g., controlled use, harm reduction), all using the same rating scale. Finally, they could add in qualitative comments at various points in the survey (e.g., “How would you like to see services improved for PTSD/substance abuse clients in your program or generally?”).

Data were analyzed using paired-sample *t*-tests for comparison of models. We were unable to use more sophisticated analyses for these comparisons because some models had relatively fewer people rating them and if we included only people who rated all the 11 models, the sample sizes would have been substantially reduced and unrepresentative (for some questions, down to 45 or 50 respondents). However, to offset the likelihood of Type 1 error, in reporting our results we note how many paired-sample *t*-tests were conducted *versus* how many were significant. Only findings significant at 0.05 or less are listed. For basic characteristics of the sample, we used descriptive statistics. To explore the relationship between the four primary questions (listed above), we conducted two-tailed Pearson correlations. Finally, we conducted a factor analysis on question 3 to try to identify clusters

of models, using principal components analysis with varimax rotation and Kaiser normalization.

## RESULTS

### Participant characteristics

Our sample comprised 37.6% doctoral level psychologists ( $n = 77$ ), 30.7% social workers ( $n = 63$ ), 10.7% certified substance abuse counselors ( $n = 22$ ), 9.3% psychiatrists ( $n = 19$ ), 6.8% nurses ( $n = 14$ ), 6.3% master’s level psychologists ( $n = 13$ ), 4.9% bachelor’s level professionals ( $n = 10$ ), 2.9% vocational or rehabilitation counselors ( $n = 6$ ), 1% pastoral counselors ( $n = 2$ ), and 0.5% non-psychiatrist physicians ( $n = 1$ ). Respondents reported spending an average of 14.18 h per week treating SUD ( $SD = 17.16$ ), 8.64 h treating PTSD alone ( $SD = 15.04$ ), 10.36 h treating co-occurring PTSD and SUD ( $SD = 12.55$ ), and 7.82 h treating other clients ( $SD = 13.79$ ). Most respondents (81.5%,  $n = 167$ ) conducted psychosocial clinical services; 12.2% ( $n = 25$ ) conducted medical (e.g., psychiatric) treatments; 30.2% ( $n = 62$ ) were administrators or directors of programs that provided clinical services, 20.5% ( $n = 42$ ) were researchers, 27.3% ( $n = 56$ ) were clinical supervisors, 15.1% ( $n = 31$ ) were trainees, 2% ( $n = 4$ ) were administrators of programs that did not provide clinical services. Note that respondents could endorse more than one professional category. Respondents also responded to two satisfaction questions, scaled 1–5 (“not at all” to “greatly”): “How much do you like your work?” ( $M = 4.61$ ;  $SD = 0.56$ ); and “How effective do you feel as a clinician?” ( $M = 4.11$ ;  $SD = 0.63$ ).

Most respondents reported that the primary focus of their setting was mental health (41.1%,  $n = 83$ ); followed by substance abuse (27.2%,  $n = 55$ ), dual diagnosis (23.8%,  $n = 48$ ), medical (2%,  $n = 4$ ), and other (5.9%,  $n = 12$ ). On level of care, most reported working in outpatient programs (60.5%,  $n = 124$ ), followed by residential treatment (17.6%,  $n = 36$ ), intensive outpatient programs (e.g., day treatment programs) (11.7%,  $n = 24$ ); inpatient programs (1.5%,  $n = 3$ ), and 18 respondents (8.8%) did not complete this item. For type of VA setting, most reported working in a VA hospital (77.1%,  $n = 158$ ), followed by a community-based outpatient clinic (12.2%,  $n = 25$ ), specialty care (3.9%,  $n = 8$ ), or Vet Center (3.4%,  $n = 7$ ) and 7 respondents (3.4%) did not complete this item. On theoretical orientation, they were given a list of major theoretical orientations and asked to rate how much they adhered to each, totaling 100%. Cognitive CBT was the highest ( $M = 51.04$ ,  $SD = 27.61$ ), followed by “other” ( $M = 23.88$ ,  $SD = 23.88$ ; e.g., eclectic, humanistic, mindfulness-based, and Motivational Interviewing); then psychodynamic/psychoanalytic ( $M = 21.19$ ,  $SD = 21.19$ ), 12-Step ( $M = 15.99$ ,  $SD = 22.36$ ), systems ( $M = 10.42$ ,  $SD = 13.24$ ), and no model ( $M = 1.05$ ,  $SD = 19.89$ ).



Table I. Implementation of treatment models.

Treatment model	“How much have you implemented this model?” <sup>a</sup>			Never heard of the model <sup>b</sup>
	<i>M</i> <sup>a</sup>	SD	<i>n</i>	<i>n</i>
Supportive Therapy (SUP)	4.13	0.98	185	0
General CBT	4.08	1.08	186	1
Relapse Prevention (RP)	4.05	1.15	191	0
Motivational Interviewing (MI)	3.51	1.22	192	2
12-Step (12-S)	3.23	1.51	188	0
Seeking Safety (SS)	2.99	1.55	175	7
Cognitive Processing Therapy (CPT)	2.94	1.54	175	2
Dialectical Behavior Therapy (DBT)	2.52	1.45	163	6
Exposure Therapy for PTSD (EXP)	2.50	1.36	170	4
Contingency Management (CM)	2.36	1.30	146	19
EMDR	1.44	0.95	173	4

Notes: <sup>a</sup>Ratings are scaled 1–5, from “not at all” to “greatly”.

<sup>b</sup>Respondents are non-overlapping with the rest of the sample in columns to the left.

SUP is higher than MI, 12-S, SS, CPT, DBT, EXP, CM, and EMDR.

CBT is higher than MI, 12-S, SS, CPT, DBT, EXP, CM, and EMDR.

RP is higher than MI, 12-S, SS, CPT, DBT, EXP, CM, and EMDR.

MI is lower than SUP, CBT, and RP; higher than SS, CPT, DBT, EXP, CM, and EMDR.

12-S is lower than SUP, CBT, and RP; higher than DBT, EXP, CM, and EMDR.

SS is lower than SUP, CBT, RP, and MI; higher than DBT, EXP, CM, and EMDR.

CPT is lower than SUP, CBT, RP, and MI; higher than DBT, EXP, CM, and EMDR.

DBT is lower than SUP, CBT, RP, MI, 12-S, SS, and CPT; higher than EMDR.

EXP is lower than SUP, CBT, RP, MI, 12-S, SS, and CPT; higher than EMDR.

CM is lower than SUP, CBT, RP, MI, 12-S, SS, and CPT; higher than EMDR.

EMDR is lower than SUP, CBT, RP, MI, 12-S, SS, CPT, DBT, EXP, and CM.

### Ratings of specific treatment models

Tables I–IV present the results for each of the four questions on the 11 models.

#### Implementation of models (question 1)

Table I provides how much respondents reported implementing each model. It is notable that Supportive Therapy, CBT, and Relapse Prevention were significantly higher than eight other

Table II. Helpfulness of treatment models.

Treatment model	“How helpful is this model overall?”		
	<i>M</i> <sup>a</sup>	SD	<i>n</i>
Seeking Safety (SS)	4.10	0.96	144
Relapse Prevention (RP)	4.07	0.83	176
Motivational Interviewing (MI)	4.02	0.96	177
General CBT	4.02	0.84	176
Cognitive Processing Therapy (CPT)	3.95	0.95	140
12-Step (12-S)	3.89	0.90	171
Supportive Therapy (SUP)	3.75	0.97	179
Exposure Therapy for PTSD (EXP)	3.67	1.06	132
Dialectical Behavior Therapy (DBT)	3.65	1.14	129
Contingency Management (CM)	3.32	1.01	104
EMDR	2.81	1.31	93

Notes: <sup>a</sup>Ratings are scaled 1–5, from “not at all” to “greatly”.

SS is higher than 12-S, SUP, EXP, DBT, CM, and EMDR.

RP is higher than 12-S, SUP, EXP, DBT, CM, and EMDR.

MI is higher than SUP, EXP, DBT, CM, and EMDR.

CBT is higher than SUP, EXP, DBT, CM, and EMDR.

CPT is higher than SUP, CM, and EMDR.

12-S is higher than CM, EMDR; lower than SS, RP.

SUP is higher than CM, EMDR; lower than SS, RP, MI, CBT, and CPT.

EXP is higher than EMDR; lower than SS, RP, MI, and CBT.

DBT is higher than EMDR; lower than SS, RP, MI, and CBT.

CM is higher than EMDR; lower than SS, RP, MI, CBT, CPT, 12-S, and SUP.

EMDR is lower than all 10 other models.

manual-based models. At the other extreme, EMDR was significantly lower than all other models. Yet the vast majority reported using at least one of the manualized models, and typically more than one, indicating that use of evidence-based practices (EBPs) is strong within VA (although the amount and quality of implementation cannot be verified as these findings are solely self-report). Also notable were the number of respondents who had never heard of some models, with Contingency Management by far the least well known. Of the 55 *t*-tests conducted, 45 were significant (82%), most at 0.001 or below.

#### Helpfulness of models overall (question 2)

Table II summarizes the ratings of the overall helpfulness of each model. Two models, Seeking Safety and Relapse Prevention, were significantly higher than six other models; next in line were Motivational Interviewing and CBT, which were higher than five other models. Lowest were EMDR (lower than all other models) and Contingency Management (lower than seven other models). However, it must be noted that the latter two were rated by fewer respondents ( $n = 93$  and  $n = 104$ , respectively); although these are still substantial numbers for a survey of this type. Of the 55 *t*-tests

Table III. Helpfulness for PTSD/SUD clients.

Treatment model	“How helpful is this model for PTSD/substance abuse clients?”		
	<i>M</i> <sup>a</sup>	SD	<i>n</i>
Seeking Safety (SS)	4.29	0.89	145
Relapse Prevention (RP)	4.06	0.84	169
General CBT	3.88	0.90	170
Motivational Interviewing (MI)	3.86	0.97	169
Cognitive Processing Therapy (CPT)	3.85	0.98	137
Supportive Therapy (SUP)	3.67	1.01	170
Dialectical Behavior Therapy (DBT)	3.56	1.16	117
Exposure Therapy for PTSD (EXP)	3.43	1.02	125
12-Step (12-S)	3.42	0.92	188
Contingency Management (CM)	3.23	1.01	96
EMDR	2.73	1.25	93

Notes: <sup>a</sup>Ratings are scaled 1–5, from “not at all” to “greatly”. SS is higher than all 10 other models.

RP is higher than CBT, MI, SUP, DBT, EXP, 12-S, CM, and EMDR; lower than SS.

CBT is higher than SUP, DBT, EXP, 12-S, CM, and EMDR; lower than SS, RP.

MI is higher than SUP, DBT, EXP, 12-S, CM, and EMDR; lower than SS, RP.

CPT is higher than SUP, DBT, EXP, 12-S, CM, and EMDR; lower than SS.

SUP is higher than 12-S, CM, and EMDR; lower than SS, RP, CBT, MI, and CPT.

DBT is higher than EMDR; lower than SS, RP, CBT, MI, and CPT.

EXP is higher than EMDR; lower than SS, RP, CBT, MI, and CPT.

12-S is higher than EMDR; lower than SS, RP, CBT, MI, CPT, and SUP.

CM is higher than EMDR; lower than SS, RP, CBT, MI, CPT, and SUP.

EMDR is lower than all 10 other models.

conducted, 32 were significant (58%), most at 0.001 or below.

### Helpfulness of models for PTSD/SUD (question 3)

Table III presents the ratings for how helpful each model is for PTSD/SUD. Seeking Safety was the highest (rated more helpful than all other 10 models); then Relapse Prevention (higher than 8 other models); and then the next three models (CBT, Motivational Interviewing, and Cognitive Processing Therapy), all of which were higher than 6 models. At the other end, EMDR and Contingency Management were lowest (EMDR lower than all other models, Contingency Management lower than six other models). Notably, in this table, the four highest models and the two lowest models were the same as in Table II, indicating that there is a strong relationship between overall helpfulness and helpfulness for PTSD/SUD in particular. Of the 55 *t*-tests conducted, 53 were significant (96%), most at 0.001 or below.

Table IV. Desire for training in specific models.

Treatment model	“How much would you want training in this model?”		
	<i>M</i> <sup>a</sup>	SD	<i>n</i>
Seeking Safety (SS)	4.07	1.14	172
Exposure Therapy (EXP) for PTSD	3.67	1.28	163
Cognitive Processing Therapy (CPT)	3.57	1.31	163
Dialectical Behavior Therapy (DBT)	3.55	1.40	157
Motivational Interviewing (MI)	3.50	1.38	181
Relapse Prevention (RP)	3.39	1.30	179
General CBT	3.12	1.33	178
Contingency Management (CM)	2.93	1.32	136
EMDR	2.75	1.63	144
Supportive Therapy (SUP)	2.59	1.43	172
12-Step (12-S)	2.21	1.26	177

Notes: <sup>a</sup>Ratings are scaled 1–5, from “not at all” to “greatly”. SS is higher than all 10 other models.

EXP is higher than RP, CBT, CM, EMDR, and SUP, 12-S; lower than SS.

CPT is higher than RP, CBT, CM, EMDR, and SUP, 12-S; lower than SS.

DBT is higher than RP, CBT, CM, EMDR, and SUP, 12-S; lower than SS.

MI is higher than CBT, CM, EMDR, SUP, and 12-S; lower than SS.

RP is higher than CBT, CM, EMDR, SUP, and 12-S; lower than SS, EXP, CPT, and DBT.

CBT is higher than EMDR, SUP, and 12-S; lower than SS, EXP, CPT, DBT, MI, and RP.

CM is higher than SUP, 12-S; lower than SS, EXP, CPT, DBT, MI, and RP.

EMDR is higher than 12-S; lower than SS, EXP, CPT, DBT, MI, RP, and CBT.

SUP is higher than 12-S; lower than SS, EXP, CPT, DBT, MI, RP, CBT, and CM.

12-S is lower than all 10 other models.

### Desire for training in the models (question 4)

Table IV provides how much respondents endorsed a desire for training in the models. Seeking Safety again was higher than all other models. However, the next three diverged from the previous tables: Exposure Therapy for PTSD, Cognitive Processing Therapy, and Dialectical Behavior Therapy were higher than six other models. Also at the low end, results were different than in prior tables. 12-Step was lower than all other models; followed by Supportive Therapy (lower than 8 models), and EMDR (lower than 7 models). Of the 55 *t*-tests conducted, 45 were significant (82%), most at 0.001 or below.

### Correlation between the four questions

We also conducted correlations between the four primary questions. Interestingly, although most were positive and significant, they were also mostly at low-to-moderate levels, suggesting that the four questions

were largely tapping different constructs. Implementation of models had a 0.38 correlation with Helpfulness of Models Overall ( $p < 0.001$ ,  $n = 195$ ) and 0.33 with Helpfulness of Models for PTSD/SUD ( $p < 0.001$ ,  $n = 191$ ), and was not correlated with Desire for Training. Helpfulness of Models Overall had a 0.40 correlation with Desire for Training ( $p < 0.001$ ,  $n = 190$ ), but had a much higher correlation with Helpfulness of Models for PTSD/SUD ( $r = 0.82$ ,  $p < 0.0001$ ,  $n = 192$ ). Finally, Helpfulness of Models for PTSD/SUD had a 0.43 correlation with Desire for Training ( $p < 0.0001$ ,  $n = 187$ ).

### Correlations within models

We also analyzed whether questions 1 and 2 were correlated within each model, in short, whether “to know it is to love it” (the more it is implemented, the more it is perceived as helpful). As questions 2 and 3 were highly correlated, we only explored this topic in relation to question 2, and only among respondents who had implemented it at all (greater than 1 on question 2 for that model, as otherwise respondents are rating treatments they have not actually used). Overall, we found indeed that the more the respondents had implemented each model, the higher they rated its overall helpfulness. Correlations were generally in the high-to-moderate range; in descending order they are: Contingency Management ( $r = 0.68$ ,  $p < 0.001$ ,  $n = 89$ ); Supportive Therapy ( $r = 0.68$ ,  $p < 0.001$ ,  $n = 176$ ); CBT ( $r = 0.60$ ,  $p < 0.001$ ,  $n = 173$ ); EMDR ( $r = 0.63$ ,  $p < 0.001$ ,  $n = 36$ ); Exposure Therapy ( $r = 0.61$ ,  $p < 0.001$ ,  $n = 101$ ); Cognitive Processing Therapy ( $r = 0.59$ ,  $p < 0.001$ ,  $n = 116$ ); Seeking Safety ( $r = 0.55$ ,  $p < 0.001$ ,  $n = 127$ ); Motivational Interviewing ( $r = 0.55$ ,  $p < 0.001$ ,  $n = 180$ ); Dialectical Behavior Therapy ( $r = 0.45$ ,  $p < 0.001$ ,  $n = 95$ ); Relapse Prevention ( $r = 0.45$ ,  $p < 0.001$ ,  $n = 171$ ); and 12-Step ( $r = 0.31$ ,  $p < 0.001$ ,  $n = 144$ ). Here too it is notable that models that were rated low by respondents overall nonetheless show high correlations in this analysis (e.g., Contingency Management, EMDR), indicating that those who implement them most also value them highly even if they are a minority within the sample at large.

### Factor analysis of models (using question 3)

Table V presents the results of the factor analysis on the 11 treatment models for data from question 3 (“How helpful is this model for PTSD/substance abuse clients?”). Most models loaded primarily on one factor. Factor 1 might be termed, “SUD stabilization models” in that all three (Seeking Safety, Contingency Management, and 12-Step) are SUD models that are generally focused on early-stage recovery and stabilization. Two other models also loaded highly on this factor (Relapse Prevention and Motivational Interviewing), reinforcing the idea that this factor focuses on SUD stabilization treatments. Factor 2 might be termed, “general models” (composed

Table V. Factor analysis of “Helpfulness for PTSD/SUD clients”.

	Factor			
	1	2	3	4
<i>Rotated factor matrix</i>				
Seeking Safety	<b>0.78</b>			
Contingency Management	<b>0.67</b>		0.38	
12-Step	<b>0.59</b>			
Supportive Therapy		<b>0.77</b>		
Cognitive Processing Therapy		<b>0.72</b>		
General CBT		<b>0.65</b>	0.30	
Relapse Prevention	0.49	<b>0.50</b>		
Dialectical Behavior Therapy			<b>0.79</b>	
Exposure Therapy for PTSD			<b>0.71</b>	0.31
Motivational Interviewing	0.45		<b>0.52</b>	
EMDR				<b>0.91</b>

Notes: Rotation converged in five iterations. Factor loadings less than 0.30 are excluded from this table. Bold font indicated primary factor loading per therapy model.

primarily of Supportive Therapy, Cognitive Processing Therapy, and CBT), none of which are specific to SUD. Relapse Prevention also loaded on this factor, but at virtually the same level as on factor 1. Factor 3 might be termed, “specialized models” as it is composed primarily of Dialectical Behavior Therapy and Exposure Therapy for PTSD. Motivational Interviewing also loaded on this factor, but at virtually the same level as factor 1. Finally, factor 4 is composed solely of EMDR, which might be termed the “outlier model” in that all of the prior tables indicated that it was rated lower than all others by those who had not used it. However, it is interesting that the factor loadings are not simply a repetition of findings from the tables generally. For example, factor 1 includes one model that was highly rated across the tables (Seeking Safety) and two that had quite low ratings (Contingency Management and 12-Step). Thus, the factor analysis appears to be clustering models based more on content than on how much they are liked.

### General resources

Table VI summarizes the ratings for five resource areas relevant to PTSD/SUD. Notably, the most desired resource was training in PTSD/SUD, which was significantly higher than all others in the table. However, all of the resources in the table were rated highly, suggesting areas in which the VA can provide resources that are desired by front-line providers. It is notable that, in addition to the training needs, respondents also want assessment tools and information on alternative substance abuse treatment models (non-abstinence-based methods such as controlled use and harm reduction).

Table VI. General resources.

“To improve services for PTSD/SUD clients, the following would be helpful”	<i>M</i>	<i>SD</i>	<i>n</i>
General training on PTSD/SUD <sup>a</sup>	4.30	0.94	179
Assessment tools	3.87	1.18	165
General training on PTSD	3.86	1.16	173
Alternative substance abuse treatments (e.g., controlled use, harm reduction)	3.81	1.31	172
General training on substance abuse	3.78	1.14	173

Notes: <sup>a</sup>In paired-sample *t*-tests, “General training on PTSD/SUD” was significantly higher than all other means in this table. No other comparisons were significant.

### Qualitative comments

Respondents offered many write-in comments that offer an important understanding of their experiences in treating PTSD/SUD. The main paper on this dataset offers a detailed summary of their comments (Najavits et al., in press). Here, the focus will be solely on comments related to specific treatment models. The key themes are as follows.

### Broadening the base of therapies in VA

Several respondents commented on a desire for VA to focus a broader array of treatments, including psychodynamic, EMDR, stress inoculation, Motivational Interviewing, and Seeking Safety. One of them wrote, “There are barriers to patients when they do not ‘fit’ the treatments that are available.” Indeed, they reported following various models that had not been listed on the survey, such as narrative therapy, mindfulness approaches, behavioral therapy, client-centered therapy, eclectic, acceptance and commitment therapy, hypnotherapy, schema therapy, psychodrama, solution-focused therapy, interpersonal therapy, object relations therapy, Rogerian, humanistic, peer group therapy, feminist, and existential.

### Training needs

Many respondents expressed a wish for more training: “During more than 15 years of clinical work in a VA setting, I have had to ‘scrounge’ to get training in treatment of PTSD, PTSD/Substance Abuse (e.g., discover resources, learn from the vets, pay my own tuition and travel to attend professional training seminars. “I have asked for additional training in PTSD. I have had to depend on using a training manual I was e-mailed. I also need information on the many policies, and benefits that are available.” Various training areas were mentioned including training in EBPs for comorbid PTSD/SUD; medication education; best practices training; compassion fatigue and burn-out; training on specific models (as mentioned above); co-occurring disorders, including Axis II; and treatment for homeless veterans and women. Also, one respondent said, “Provide education on the actual

combat scenarios experienced in current conflicts, equipment and terminology, videos, expectations, etc. Most clinicians are operating in the dark about what these soldiers and Marines actually experienced.”

### More complex understanding of the relationship between PTSD and SUD

Various respondents raised issues that they felt were not yet sufficiently addressed: “Deciding which disorder is the more urgent right now and whether the behavior I’m seeing is attributable to the one or the other.” “Knowing how much substance use is too much to begin/sustain treatment for PTSD.” Several brought up concerns about conducting trauma exposure in SUD clients: “When to use exposure vs. coping especially when the patient wants to tell stories but get so distressed and triggered by it they end up using again.” “Worrying that doing trauma exposure will agitate them and they will relapse. And if they relapse they may act impulsively and violently (aggressive towards others, suicide attempt, overdose, etc.)” “Sometimes it is difficult to strike a balance between teaching coping skills and allowing a group member to talk about their experience when it is ‘bubbling’ over.” “If we waited till all vets with PTSD stopped using before we treated them our clinics would be empty! On the other hand if they are too impaired, nothing gets through. It’s a delicate balance.” “I take a relapse as evidence that the patient does not have adequate coping skills for trauma processing.” Several expressed beliefs about using various treatments: “I treat both issues at the same time although do not do exposure work until SUD is stable for 3–6 months.” “They need coping skills treatment before being able to engage in trauma-based intensive therapy. Many lack the basic self nurturing skills to handle the intense emotions.” “Too often manualized treatments involve rigid strictures on clinicians’ interventions that force clinicians to choose between following the protocol and meeting their clients where they are.”

## DISCUSSION

This is the first known study to survey clinicians’ views of manualized therapies relevant to PTSD/SUD treatment. It was an anonymous nationwide survey of 205 VA providers that addressed 11 different therapy models and several ancillary topics. The main findings were as follows. First, most clinicians reported already using one or more of the 11 therapies, suggesting that evidence-based practice is “alive and well” within the VA. Second, they held strong opinions on the different models, with many significant differences on each for the four primary questions in the survey (“How much have you implemented this model?”; “How helpful is this model overall?”; “How helpful is this model for PTSD/substance abuse clients?”; and “How much would you want training in this model?”). For implementation, the top models were Supportive Therapy,



CBT, and Relapse Prevention and the lowest model was EMDR. For helpfulness, both overall and for PTSD/SUD, Seeking Safety and Relapse Prevention were the highest and EMDR and Contingency Management were the lowest. On desire for training, the highest were Seeking Safety, followed by Exposure Therapy, Cognitive Processing Therapy, and Dialectical Behavior Therapy; the lowest was 12-Step, followed by Supportive Therapy. However, even though the differences were statistically significant, most models were rated on average at the midpoint of the 1–5 scale or higher (i.e., 3 or above). A third main finding was from the factor analysis, which suggests that there are four factors onto which the models cluster. These might be termed “SUD stabilization models,” “general models,” “specialized models,” and “outlier model.” These factors appear to summarize the content of the models, rather than simply how much they are liked or used. A fourth finding is what might be called, “to know it is to love it” – the more clinicians had implemented a particular model, the more helpful they found it. This is particularly important to note as some models listed have had formal roll-outs in VA (e.g., CPT and PE) whereas other models also known to be effective (e.g., EMDR, CM) have not. Thus, clinicians may not have been exposed to some models and their ratings may reflect impressions that could change with greater exposure. For example, a recent study compared two VAs: one in which EMDR had been implemented and one in which it had not been (Cook, Biyanova, & Coyne, 2009). Staff at the former perceived strong benefit from EMDR whereas staff at the latter had a much more negative view of the model. Our fifth major finding was that implementation, helpfulness, and desire for training had low intercorrelations, indicating that these largely tapped separate concepts. Sixth, qualitative comments emphasized a wish for a broader array of psychotherapies to be implemented within VA; a strong desire for training on various models and topics relevant to PTSD/SUD, more guidance on the safety and use of PTSD treatments in the context of SUD, and more focus on non-abstinence-based approaches to SUD such as harm reduction and controlled use.

Overall, VA clinicians have positive views of manualized therapies for PTSD and/or SUD. They also clearly rated some models more highly than others, reinforcing the idea that simply establishing a model as scientifically effective is not sufficient – among EBPs, clinicians like and adopt some more than others. While we did not explore what they especially liked or disliked about the models, this would be a fruitful area for future research. Also of interest would be the degree to which they implement models with fidelity *versus* modifying them to adapt to their patients and setting. One prior study, e.g., found positive ratings of four SUD models, but low ratings of wanting to

implement the models without changes (Najavits et al., 2004).

A question that must be raised is whether the presence of the principal investigator (PI), who was the developer of one of the models in the survey (Seeking Safety; Najavits, 2002b) may have had an impact on the findings. We made every attempt to structure the study to avoid this, by conducting the survey online, fully anonymously, and using a “snowball procedure” in which a workgroup was sent the initial survey link to send on to others, who could then forward it on to others, and so on indefinitely. This ensured that respondents knew that their responses, and even whether they answered the survey, could never be known to the PI. However, it cannot be ruled out that some more subtle impact may have occurred in that those who chose to respond or forward the survey may have had a positive allegiance to her or to Seeking Safety, as her name was listed as PI per VA Internal Review Board requirements. On the other hand, the positive views of the Seeking Safety model in this study may simply reflect that it was the only model specifically designed for PTSD/SUD comorbidity among all 11 models. Prior studies of clinicians view of Seeking Safety have also consistently found positive ratings for it (e.g., Brown et al., 2007; Hills et al., 2004).

Many of our results reinforce previous research in this area. For example, prior studies, similar to ours, have found high ratings for Motivational Interviewing, Relapse Prevention, and CBT, and relatively low ratings for Contingency Management. Note, however, that prior surveys did not have the same list of treatments as ours and thus a complete comparison is not possible.

Strengths of this study include a large sample size, a broad range of respondents (in terms of VA setting, professional degree, role, level of care, and theoretical orientation), a larger number of models than any prior survey of this type, the anonymity of the research, and a large number of statistically significant findings. The study also had several weaknesses including reliance on self-report (we thus cannot verify whether clinicians’ are actually implementing particular models, for example); the fact that respondents rated models in which they may not have had training nor direct experience; the sample having being solely VA staff (i.e., civilian clinicians might provide quite different ratings); the large number of statistical tests (although the number statistically significant vastly exceeded the number that would be expected by chance); lack of specificity on why they liked or disliked particular models; and one-time administration of the survey, which means that we cannot determine whether their views change over time. Nonetheless, this study goes beyond any previous research on this topic, and is a first for VA and the PTSD/SUD field. It is hoped that future research will expand on these findings with greater methodological rigor, larger samples, and more



in-depth questioning on why clinicians rate some models higher or lower. Exploration of clinician factors in relation to results would also be of interest.

The field of treatment dissemination and adoption is young. Both areas – and they quite distinct concepts – need more research. Continued mutual dialogue is essential between the main agent in the dissemination process – the treatment developer – and the main agent in the adoption process – the clinician.

**Declaration of interest:** Dr Najavits is the developer of the Seeking Safety model. Also, she is director of Treatment Innovations, which provides consultation, training, and materials related to psychotherapy, including Seeking Safety.

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