

VA PTSD Clinic Director Perspectives: How Perceptions of Readiness Influence Delivery of Evidence-Based PTSD Treatment

Jessica L. Hamblen and Nancy C. Bernardy
National Center for PTSD, Veterans Affairs Medical Center,
White River Junction, Vermont and Geisel School
of Medicine at Dartmouth

Kathleen Sherrieb
Geisel School of Medicine at Dartmouth

Fran H. Norris
National Center for PTSD, Veterans Affairs Medical Center,
White River Junction, Vermont and Geisel School
of Medicine at Dartmouth

Joan M. Cook
Yale School of Medicine and National Center for PTSD,
Veterans Affairs Connecticut Health Care System,
West Haven, Connecticut

Claudine A. Louis
National Center for PTSD, Veterans Affairs Medical Center,
White River Junction, Vermont

Paula P. Schnurr
National Center for PTSD, Veterans Affairs Medical Center,
White River Junction, Vermont and Geisel School
of Medicine at Dartmouth

Despite extensive data from randomized controlled trials supporting the efficacy of evidence-based treatments (EBTs), the adoption of these interventions in the Department of Veterans Affairs (VA) and the Department of Defense has been markedly slow. Qualitative interviews were conducted with a nationally representative sample of 38 directors of specialized posttraumatic stress disorder outpatient programs in VA medical centers about implementation of two EBTs. Every director confirmed that EBTs, specifically prolonged exposure and cognitive processing therapy, were provided in their program. It was nearly universal, however, for these treatments to be preceded by preparatory groups. The consensus among directors was that these groups improve readiness for trauma-focused EBTs, help veterans to make informed decisions about their treatment plans, improve coping skills and symptom management, and decrease the likelihood of no-shows for scheduled EBTs. The concept of readiness for trauma-focused EBTs guided program development

This article was published Online First January 19, 2015.

JESSICA L. HAMBLEN received her PhD in clinical psychology from the State University of New York at Buffalo. She is an associate professor of psychiatry at the Geisel School of Medicine at Dartmouth and the deputy for education at the National Center for PTSD, White River Junction, Vermont. Her interests are in developing, disseminating, and evaluating cognitive behavioral treatments for PTSD and related conditions.

NANCY C. BERNARDY received her PhD in biological psychology from the University of Oklahoma Health Sciences Center and a clinical psychology degree from Yale University. She is the director of the PTSD Mentoring Program at the National Center for PTSD, White River Junction, Vermont and associate director of clinical networking. She is an assistant professor of psychiatry at the Geisel School of Medicine at Dartmouth. Her publications have focused on strategies to improve prescribing practices for PTSD and the dissemination of effective PTSD treatments.

KATHLEEN SHERRIEB received her DrPH in public health from Harvard School of Public Health. She is the program evaluator for the PTSD Mentoring Program and the PTSD Consultation Program at the National Center for PTSD, White River Junction, Vermont. Her previous publications have focused on community resilience related to disaster and terrorist events.

FRAN H. NORRIS received her PhD in community/social psychology from the University of Louisville. She is a retired research professor of psychiatry at the Geisel School of Medicine at Dartmouth, where she was affiliated with the National Center for PTSD, White River Junction, Vermont. Her interests include the epidemiology of posttraumatic stress, cross-cultural studies, the mobilization and deterioration of social support

after disasters, and systems issues in providing disaster mental health services.

JOAN M. COOK received her PhD in clinical psychology from Nova Southeastern University. She is currently an associate professor in the Yale School of Medicine, Department of Psychiatry, New Haven, Connecticut. She has numerous publications in the traumatic stress and geriatric mental health fields, including scientific papers on the phenomenology, assessment and treatment of older adult trauma survivors. She is a member of the American Psychological Association's Guideline Development Panel for PTSD.

CLAUDINE A. LOUIS received her PhD in pharmacology and toxicology from Dartmouth College. She is a research health science specialist at the National Center for PTSD, White River Junction, Vermont. Her research interests include the effectiveness and delivery of evidence-based treatments to veterans with PTSD.

PAULA P. SCHNURR received her PhD in experimental psychology from Dartmouth College. She is acting executive director of the National Center for PTSD, White River Junction, Vermont and had served previously as deputy executive director since 1989. She is research professor of psychiatry at the Geisel School of Medicine at Dartmouth and editor of the Clinician's Trauma Update-Online. Her research focuses on the treatment of PTSD and risk and resilience factors associated with response to traumatic events.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Jessica L. Hamblen, National Center for PTSD (116D), VA Medical Center, 215 North Main Street, White River Junction, VT 05009. E-mail: jessica.hamblen@dartmouth.edu

and flow throughout the programs. Implications for increased implementation of EBTs include developing and disseminating standardized ways of explaining their rationale and expected outcomes. Future research directions, such as empirically identifying veterans who are willing to participate in and benefit from these EBTs, are also noted.

Keywords: evidence based treatment, posttraumatic stress disorder, provider perspectives, readiness for treatment

Implementation of evidence-based treatments (EBTs) is a national public health priority. Despite extensive data from randomized controlled trials supporting the efficacy of EBTs, the adoption of these interventions in the Department of Veterans Affairs (VA) and the Department of Defense has been markedly slow (Institute of Medicine, 2014). In response to the *President's New Freedom Commission on Mental Health (2003)*, the VA set forth a vision to transform mental health treatment by offering specific EBTs for particular conditions when clinically indicated (Karlin & Cross, 2014).

In 2007, the VA initiated training and consultation in two EBTs for posttraumatic stress disorder (PTSD; Karlin et al., 2010), starting with cognitive processing therapy (CPT; Resick & Schnicke, 1993) and then a year later adding prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007). In brief, in CPT patients learn to identify and challenge unhelpful thinking patterns related to trauma and replace them with more adaptive and less distressing ways of thinking, and in some versions write and read aloud a trauma narrative. In PE patients confront trauma-related situations that are objectively safe but avoided due to trauma-related distress (in vivo exposure) and trauma memories through repeated recounting out loud of the details of the most disturbing event (imaginal exposure).

The national VA training program in PE and CPT included a multiday face-to-face training followed by intensive supervision on at least two cases. Providers are considered to be trained once they reach the established fidelity criterion. In addition, the VA offered numerous other top-down initiatives to enhance implementation, including a mandate that all veterans receiving treatment for PTSD be offered PE or CPT when clinically indicated (U.S. Department of Veterans Affairs, 2008), the development of a mentoring program to improve communication between regional and national clinic managers (Bernardy, Hamblen, Friedman, Ruzek, & McFall, 2011), and the appointment of at least one staff member at each medical center to serve as an evidence-based psychotherapy coordinator. Evaluation of outcomes of patients who served as training cases for therapists in the national training initiatives has shown substantial improvement in PTSD and depression (Chard, Ricksecker, Healy, Karlin, & Resick, 2012; Eftekhari et al., 2013).

The VA typically offers a range of mental health services for PTSD, including treatment in general mental health, PTSD specialized outpatient programs, community-based clinics, telemental health, and intensive residential programming. The majority of veterans with PTSD are seen in general mental health. More complicated cases are referred to the specialized PTSD outpatient programs, where the majority of EBTs for PTSD are delivered. Fifty-four percent of veterans seen in these settings have at least one other comorbid Axis I disorder, 29% have a substance abuse diagnosis, and 7% have a traumatic brain injury (Hoff, Shea, Gray, McCasland, & Petrokaitis, 2012).

At present, national VA administrative data cannot be used to determine how many veterans with PTSD receive PE or CPT system-wide because no administrative code is available to differentiate PE and CPT sessions from general psychotherapy sessions. Implementation in outpatient settings, however, appears to be low. A review of charts from a subsample of veterans in PTSD care at six New England outpatient PTSD clinics in 2010 found that only 6.3% of veterans received at least one session of PE or CPT. For those veterans that received at least one session, the mean number of EBT sessions received was six (Shiner et al., 2013), fewer than the required 10–12 sessions. Another study focused on 796 veterans in a single large PTSD outpatient program who had attended at least one individual psychotherapy session between 2008 and 2012 with a provider trained in PE or CPT. Although 70% of the veterans who initiated PE or CPT completed the treatment, only 11% began this type of treatment (Mott, Stanley, Street, Jr., Grady, & Teng 2014). These findings suggest that, in addition to access and availability, there seem to be additional factors influencing the use of these two EBTs for PTSD in the VA health care system.

There may be unique barriers to the implementation of trauma-focused EBTs, which typically involve revisiting or processing traumatic memories, beliefs, and reminders (Becker, Zayfert, & Anderson, 2004; Cook, Schnurr, & Foa, 2004). These challenges include provider beliefs to do no harm, provider and patient concerns of symptom worsening, and beliefs that other treatments may be needed first or in addition to EBTs due to patients' complicated comorbid conditions and life circumstances (Cook et al., 2004). Some of these latter concerns were expressed in a recent study of providers across 38 VA residential PTSD programs (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014). Although the majority of providers indicated no contraindication to the use of PE and CPT, others identified three broad reasons veterans were perceived to be less suitable candidates for PE and CPT: psychiatric comorbidities (i.e., substance dependence, dissociation, paranoia, personality disorders), cognitive limitations (due to both traumatic brain injury and organic causes), and low patient willingness or motivation. These factors are inconsistent with research findings demonstrating that veterans with multiple comorbidities can successfully participate in trauma-focused treatments (e.g., Monson et al., 2006; Schnurr et al., 2007).

The VA is one of the largest providers of health care services in the world. With unprecedented federal funding and top-down administrative support for the EBT initiatives, the VA has a unique opportunity to study the implementation of EBTs relative to less controlled and less resourced health care systems (Solberg, 2009). Although it is widely known that training in a new practice is insufficient for wide scale adoption (Davis et al., 1999), the VA is engaging in numerous additional strategies, such as supervision,

consultation, and the creation of communities of practice, to support implementation and sustained use of EBTs.

Despite these key policy and training elements, implementation of EBTs for PTSD in VA remains limited. We examined VA PTSD clinic director perspectives on implementation of PE and CPT in a nationally representative sample of PTSD outpatient programs to better understand the local challenges being faced. Specifically, we inquired about the types of services that are offered as part of the specialized PTSD outpatient programs, particularly PE and CPT, with a focus on how programs decide which treatments to offer and to whom. Finally, we discuss perceived barriers to implementation of these EBTs.

Method

Participants and Procedure

A complete list of the 120 VA PTSD specialized outpatient programs across the U.S. was created. Each program was coded on urbanicity (metro vs. nonmetro), region (Northeast, Southeast, Midwest, and West), and program size (small, medium, and large, defined according to thirds of the distribution of the number of patients served and the number of clinic personnel). Programs ranged in size from 200 to 3,700 veterans served annually. Programs were organized into strata on the basis of these three characteristics, and then 40 clinics were selected randomly for inclusion in the study. Two specialized outpatient programs were subsequently nonrandomly added to the frame because one region had been omitted in the random selection process.

E-mails were sent to the program directors of these 42 specialized programs explaining the purpose of the study and requesting their participation. Directors were assured that the information would not be described in terms that identified them or their facilities. Of the 42 programs, 38 directors provided interviews on 39 programs (one director reported on two separate programs), for a response rate of 92.8%. Of the 38 directors who completed the interview, most were psychologists ($n = 31$; 82.0%) followed by social workers ($n = 5$; 13.0%) and psychiatrists ($n = 2$; 5.3%). Fifty percent of the directors were female.

Vietnam veterans comprised the largest number of patients in the specialized programs. Veterans from Iraq and Afghanistan were the second largest and fastest growing group. Fewer than half (41.0%) of the programs indicated that they still had pre-Vietnam era Veterans (e.g., World War II and Korean War Veterans). Gulf War Veterans comprised the smallest portion. About a quarter of programs ($n = 10$; 26%) accepted veterans with any trauma type, whereas half limited acceptance to veterans with any military trauma ($n = 20$; 51%). Six (15%) had an even narrower focus and accepted combat trauma only. Three programs (8%) did not report on their eligibility criteria.

Measures

The semistructured interview consisted of questions related to psychosocial treatments offered, how programs decide which treatments to offer and to whom and challenges in delivery of EBTs. Each director was asked: (a) "Please describe how your clinic operates from patient intake to patient discharge." (b) "Tell us about the treatments in use in your clinic, including PE and CPT."

(c) "What are the primary things that have influenced your clinic's patient flow and treatment program?" and (d) "Tell us about some of the challenges you face and what you have found helpful to overcome those challenges." Each question was followed by probes to use as necessary to obtain the desired information. Following pretesting at two sites not selected for the study, the interview protocol was revised slightly for use in the field. The revision reordered questions and probes to facilitate a more detailed and linear narrative from respondents.

Analysis

We employed numerous strategies to ensure reliability of our data, including standardization of the interview, audiotaping, and professional transcription. All codes were defined prior to this process, definitions were revised, and concrete examples were included to assist the coders. The codes that we used were a word or short phrase from the research objectives and resulting interview questions (e.g., use of PE, use of CPT, use of other treatments offered, barriers to implementation of PE, barriers of implementation of CPT, etc.).

We utilized two standard practices to improve the reliability and validity of our coding (Bradley, Curry, & Devers, 2007). First, we had two doctoral-level interviewers (CL and KS) independently code interviews. Second, the coders met to review discrepancies. If consensus could not be reached, the coinvestigators (JH, NB, and FN) made final determinations. Codes were then entered into Atlas.ti version 7.0 (Muh, 2011).

After the coding was complete the full team met together on multiple occasions to discuss and explore the meaning of textual units that had been coded together topically. In addition, half of the interviews were reread and analyzed holistically for further insights into program models, a concept that crossed topical boundaries of the coded text.

Results

Table 1 provides a brief summary of the use of PE and CPT in VA outpatient PTSD clinics, use of other treatments offered in those clinics, and the barriers to implementation of PE and CPT.

Use of PE and CPT

Every director confirmed that PE and CPT were offered to veterans in their programs. However, few directors were able to indicate either the numbers or proportions of veterans who had received these treatments in the past or who were currently receiving these treatments in their program. Overall, directors expressed enthusiasm for the use of PE and CPT. Highly favorable attitudes were conveyed by directors saying, "We have pretty strong allegiance to EBTs," and, "Almost everybody on our team is either certified in CPT or PE." Directors typically said that their providers are strongly encouraged to use PE and CPT. Many noted that they see results among patients who have received these treatments, and that they aim to create expectations from the beginning that, "We're going to make you better if you do the work."

According to the directors, EBTs seemed more likely to be offered to veterans returning from Iraq or Afghanistan who were initiating treatment for the first time. Some programs mentioned

Table 1
Director Perspectives: Summary of Major Findings

Use of PE and CPT
PE and/or CPT are offered to veterans in all programs
Providers believe in the efficacy of PE and CPT
Positive results are observed when veterans engage in PE and CPT
Veterans returning from Iraq or Afghanistan are more likely than veterans of other eras to be offered PE or CPT
Many programs offered a trauma focused track as well as a symptom management track
Use of other treatments
Preparatory groups ranging in length from a single orientation session to skills based groups lasting several months usually precede PE and CPT
Many programs offered additional treatments such as Acceptance and Commitment Therapy and Seeking Safety
Barriers to the implementation of PE and CPT
Structural barriers include scheduling problems related to 90 min treatment sessions for PE, resource barriers including not having enough trained providers, and attitudinal barriers including a belief that other treatments were more effective
Veteran barriers include lack of time and unwillingness to participate in groups or discuss trauma

trying to transition older era veterans into an EBT. One director said, “We’ve steadily been kind of taking our longer-term Vietnam veteran patients and we have kind of an ongoing rolling evidence-based CPT groups, where we’re treating a core group of around 10 Vietnam veterans at the same time.”

Treatment tracks in PTSD specialized outpatient programs were common. The rationale for having multiple tracks was often the concern regarding veterans’ readiness for trauma-focused EBTs. For example, one director noted that patients can choose either symptom management or trauma-focused therapy (PE or CPT) as the focus of their work. Even veterans who are assessed as ready for an EBT at intake sometimes do “a few pretreatment sessions” before entering PE or CPT.

A small number of outpatient programs were offering only EBTs with few, if any, exceptions. These programs either were strongly research oriented or were specifically set up as specialty clinics to provide PTSD EBTs to veterans and were able to refer veterans to general mental health clinics for non-PTSD related issues. In other programs once patients were diagnosed with PTSD they remained in specialized PTSD outpatient program “for life,” with no authority for providers to discharge patients or refer them for continued care.

Use of Other Treatments

It was nearly universal for PE and CPT to be preceded by other clinical activities, typically preparatory groups, that were described as being mandatory in most cases. This topic arose in 30 of the 39 program interviews; 27 of 30 (90.0%) offered these groups. This was true even in programs where intake was preceded by an orientation to the program. The length of these preparatory groups ranged from 1–12 sessions. Of the programs that offered preparatory groups, 22.2% ($n = 6$) offered a single session, 22.2% ($n = 6$) offered 2–3 group sessions, 29.6% ($n = 8$) offered 4–6, and 26.0% ($n = 7$) offered 7–12 (mostly weekly) group sessions.

Some groups were considered to be orientation groups while others were psycho-educational, skills-based, or a blend. Orienta-

tion groups were typically one to two sessions. As one director described, “They go into what’s called a PCT orientation group, where it’s a group they attend one time, they understand the menu and range of services we offer within the PCT.”

Psycho-educational groups ranged from a few sessions to substantially longer. One director said, “We meet two hours a day . . . it’s 12 weeks and every week it’s a different topic related to PTSD. It’s completely psycho-ed. Not (sic) process to it at all.” Another said, “We have an Understanding PTSD class, which is three sessions, once a week for three weeks . . . part of that class is not only talking about common reactions to trauma and helping to understand PTSD, but we do spend a whole session talking about all the treatment options available.” Some psycho-education groups are combined with motivational enhancement (e.g., [Murphy & Rosen, 2006](#)) or other brief coping skills or symptom management components.

The skills groups were reportedly the longest in duration. For example, one director explained “there’s eight sessions and it really covers symptoms of PTSD, and the tools to manage the intensity, the frequency, and the duration of those symptoms . . . we also teach them about grounding skills . . . (and) cover things like anger and sleep, and memory and medications for PTSD, relaxation skills, fight/flight/freeze responses, those kinds of things.” Another director described a very linear 32–52 week program, “If you’re coming in and you’re going through the kind of straight integrated program that we’ve developed, you would have 10 weeks in a PTSD 101 group. Then you would have 10 weeks in the PTSD and anger management group and then complete your trauma-focused work.” Dialectical behavior therapy (DBT; [Linehan, 1993](#)), treatment for sleep problems, anger management and motivational enhancements were also frequently mentioned as being included in the groups.

The consensus among directors was that these groups are important because they improve readiness for treatment, help veterans to make informed decisions about their treatment plans, improve coping skills and symptom management, and decrease the likelihood of no-shows for scheduled EBTs. One concern voiced repeatedly was whether patients were sufficiently motivated to attend and actively participate in PE and CPT. A typical comment was, “Why we instituted the (name omitted) classes, in part it deals with motivational enhancement, motivational interviewing, and I think it reflects a change in that therapy for PTSD is not really a passive process but that it’s an active process and what we want to do is try and assess a person’s ability to participate in that practice. Are they able to show up for four sessions of a (name omitted) class, are they able to do homework?” Other directors saw the classes as a way to decrease no-shows for EBTs, explaining, “We used to do an orientation and it helped because the people that have no intention of coming to mental health would no-show at the orientation and it wouldn’t take up a provider’s time.”

Some directors saw the groups as ways to prepare veterans for PE and CPT, stating, “They can determine if the patient is ready to go ahead and start intensive treatments,” and “We watch them for readiness for trauma treatment.” Others used the skills groups to establish “safety and stability.” One director observed, “Patients aren’t ready for treatment right away. They are raw and dysregulated.” Treatment dropout from PE and CPT was seen as an indication that patients were not ready, explaining, “about a third

are dropping out and typically they're not dropping because they don't need it."

In addition, it was not uncommon for options other than PE and CPT (such as anger management and psycho-education) to have equal or at least strong secondary emphasis in the menu of clinical services. Thus, in addition to PE and CPT, most clinics offered a variety of other treatments (in group format) with varying levels of efficacy shown in randomized controlled trials for PTSD, including acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), seeking safety (Najavits, 2002), mindfulness (e.g., King et al., 2013; Segal, Williams, & Teasdale, 2012), DBT (Linehan, 1993), and skills training in affect and interpersonal regulation (STAIR; Cloitre, Koenen, & Cohen, 2006).

Barriers to the Implementation of PE and CPT

Directors mentioned different types of barriers to delivering PE and CPT, including structural, resource, or attitudinal. One structural challenge was the 90-min sessions required for PE, which complicated scheduling. Resource issues specifically involved not having enough providers or enough trained providers available. It can take significant time to become a trained PE or CPT VA provider. This was echoed by directors who said, "Staff carry caseloads of over 120 (patients)." In other cases, the issue had more to do with therapists' caseloads being "saturated" with long-term patients and therefore not having openings or time available to offer PE or CPT.

The shift to EBTs was described repeatedly by directors as a "culture change . . . (where providers) are slowly sort of leaning more toward the idea that folks can move on." In describing the clinic providers, one director said, "Nonevidence based people, people that have very biased inaccurate views about evidence based care . . . they don't refer people to treatment because they say they are not ready . . . or they pooh-pooh evidence-based care." Another said, "You have individuals who have been doing this work for years, why in the world would they give up providing the care particularly when they're good at it?" In some clinics, directors reported that providers were concerned that PE or CPT could even be harmful, "We had a number of folks who were pretty set on the chronic support group model . . . (they believed) patients cannot handle doing the evidence-based treatments. We are going to make them worse." Some directors described turnover of these providers as positive because newer hires were more likely to be oriented toward EBTs and less likely to view PTSD as a chronic incurable illness.

Veterans were also perceived as having barriers to EBT care. According to directors, some veterans had practical reasons for declining PE and CPT such as time and travel requirements and work conflicts. One director said, "It's the time commitment, both in terms of being at the hospital as well as how much time it takes between sessions." Others said veterans from Iraq and Afghanistan, in particular, expressed an unwillingness to participate in group treatments. This was particularly problematic because often CPT group was the only available EBT. According to several directors, many veterans "are unwilling to speak about their trauma." Directors observed that this barrier is to be expected given the prominence of avoidance in the PTSD symptom profile. One director thought these two EBTs needed more emphasis on alliance building before they would appeal to veterans. In addition,

some veterans, particularly long-standing patients, were viewed as skeptical that they could be helped by PE or CPT. Some veterans were viewed as fearful of getting better. As one director said, "Many vets are locked into the idea that they are sick" and another stated, "They wonder, am I going to lose my service connection?"

Discussion

We sought to understand if and how two EBTs (PE and CPT) were being delivered in specialized VA PTSD outpatient programs, how providers determine who gets those services, and barriers to implementing these treatments. Every PTSD clinic director confirmed that PE and/or CPT were available in their program. However, it was unclear how many veterans were actually offered and received those treatments. This is especially concerning given that these programs are designed to treat PTSD specifically; the majority of veterans with PTSD are actually seen in general mental health where there are fewer PE and CPT trained providers. While a small number of clinics were using these EBTs with few, if any, exceptions, the vast majority offered preparatory groups that veterans were required to complete prior to entry into PE or CPT. This perception of need for readiness for trauma-focused EBTs guided program planning and service provision in numerous ways and was critical to the delivery of these treatments.

Discussions of the functions of the preparatory groups almost inevitably paralleled discussions of patient "readiness." A study of veterans from Iraq and Afghanistan who screened positive for PTSD supports directors' perceptions that some patients may not feel ready (Stecker, Shiner, Watts, Jones, & Conner, 2013). When asked to identify beliefs most influential in their treatment-seeking behavior, about 35% of those veterans reported that they were not emotionally ready for treatment. An important difference though is that while veterans in that study were not treatment-seeking, veterans seen in specialized PTSD outpatient clinics have already initiated treatment. Of course, seeking care does not always imply acceptance of treatment and there may be multiple reasons that patients enter care and reasons they want to remain in care. Regardless, it is likely that in this case the provider as much as the patient is involved in making decisions about patient readiness.

Readiness has been described as a "patient's positive attitude and preparedness to enter into a therapeutic relationship for the purpose of resolving problems" (Ogrodniczuk, Joyce, & Piper, 2009, p. 427). Despite considerable interest in the topic, few studies have measured readiness in regard to treatment. Two recent studies described the development of readiness measures, although neither predicted patient outcomes. Utilizing interventionist chart notes, Trusz and colleagues (Trusz, Wagner, Russo, Love, & Zatzick, 2011) identified barriers impacting delivery of cognitive-behavioral therapy (CBT) with acutely injured trauma survivors at risk for developing PTSD. The researchers then used this information to develop a CBT readiness assessment tool and rated patients as part of the baseline intervention component of a second trial. Of the nine general domains identified, lack of engagement (37%), clinical barriers such as psychological symptoms or disorders (35%), and logistical barriers such as work, childcare, or transportation issues (25%) were classified as the largest impediments to CBT (Trusz et al., 2011). Ogrodniczuk and colleagues (2009) also developed a readiness for psychotherapy measure and found a relationship between readiness, treatment preference and motiva-

tion in 467 patients who were assessed at intake. Patients who preferred not to receive any treatment were less distressed, less willing to work hard on their problems, and less willing to discuss personal issues than those who said they wanted individual psychotherapy or group therapy.

To our knowledge, no empirical evidence yet exists to support the perception that patients must achieve a point of readiness before PE or CPT can be delivered effectively. In fact, in a study comparing four trials of EBTs for PTSD to waitlist, EBTs including PE were associated with significantly less symptom worsening than waitlist (Jayawickreme et al., 2014). A strong concern about the findings here is that veterans who may be able to tolerate and do well in trauma-focused EBTs may be unnecessarily delayed in receiving treatment or may not initiate them at all.

That said, some patients may not initially be able to participate in and benefit from trauma-focused treatments. This idea has been tested in a randomized controlled trial of STAIR (Cloitre et al., 2006). In fact, STAIR was designed to build skills thought to be necessary to tolerate exposure therapy. Women with child sexual abuse histories who received STAIR prior to exposure therapy had improved PTSD outcomes and less drop-out than those who received supportive therapy prior to exposure (Cloitre et al., 2010). However, the study did not include a condition where participants went directly into exposure therapy. Therefore, no conclusions can be made as to whether those same patients would have been able to tolerate or benefit equally well if they had attended exposure alone. Without such data, providers must rely on their clinical intuition to determine who should receive EBTs. It is critical that the field determine what patient and provider characteristics influence decisions to initiate PE and CPT and to examine empirically their impact on treatment outcome.

Another consideration is how providers are explaining PE and CPT as potential treatment options to their patients. One way to control for providers' perceptions of readiness is to develop standardized ways of explaining the rationale and expected outcomes of EBTs. Many tools currently exist that have been used in treatment trials (e.g., Feeny, Zoellner, & Kohana, 2009; Mott, Stanley, Street, Grady, & Teng, 2014). Additionally, there are videos and patient handouts that describe PE and CPT such as *Understanding PTSD Treatment* available on the National Center for PTSD website (National Center for PTSD, 2013).

VA offers a unique opportunity to study implementation of EBTs for PTSD in a controlled setting. While these findings are of particular relevance to the VA, there are also implications for other health care systems and providers. For example, national health care systems such as in Canada or the United Kingdom or Health Maintenance Organizations that determine which treatments are reimbursable can benefit from understanding providers' perspectives on delivery of EBTs for PTSD. Training and support are insufficient if the goal is widespread implementation of these practices. Programs must understand the perceived barriers in order to adequately address concerns and help to restructure clinics to overcome service delivery challenges.

There are several limitations of this investigation. Although interviewers followed a semistructured guide, some directors did not provide substantive answers to all questions and all responses were not followed up on equally well. In addition, our interview did not assess what factors providers used to determine veterans' readiness to engage in EBT. It would have been beneficial to have

providers make standardized ratings on which factors impede entry into an EBT for PTSD that could be compared across interviewees. While qualitative data are important and often lead to new insights, in some cases we were unable to quantify certain statements, especially when they came up as an aside rather than as response to a direct question. In this way we could have provided a more accurate estimate of how many providers identified a particular clinic barrier, had negative beliefs about PE or CPT, or had the option of referring patients back to general mental health if they were uninterested in receiving PE or CPT.

One rationale consistently stated in this study was that preparatory groups improve readiness for treatment. There is a need to better understand providers' definitions of readiness and how providers determine a patient's readiness to engage in EBT. Once identified, readiness characteristics should be tested empirically. For example, a readiness assessment tool for CBT for PTSD (e.g., Trusz et al., 2011) could be used to predict entry, completion, or outcomes associated with EBTs. Such a tool could be invaluable in that providers could accurately determine which patients should receive EBTs for PTSD and that patients receive these treatments as soon as they can benefit from them. In the interim, the Institute of Medicine (2014) recommends that EBTs should be the frontline treatments for PTSD. The impact of preparatory groups on initiation of an EBT as well as innovative programs and services need to be evaluated to determine their efficacy and effectiveness.

In summary, there was considerable diversity in program models with programs tending to vary on a number of dimensions. Program directors observed that their clinics were in the midst of a culture change away from a long term disease model and toward a short term recovery model. This tended to result in era-based disparities such that Vietnam veterans engage in ongoing support groups while newer veterans are more likely to receive EBT. Perceptions of readiness lent further support to the notion that treatment tracks are a necessity. Finally, difficulty in tracking patients and their outcomes makes it hard to evaluate the effectiveness of program designs.

References

- Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy, 42*, 277–292. [http://dx.doi.org/10.1016/S0005-7967\(03\)00138-4](http://dx.doi.org/10.1016/S0005-7967(03)00138-4)
- Bernardy, N. C., Hamblen, J. L., Friedman, M. J., Ruzek, J. I., & McFall, M. E. (2011). Implementation of a Posttraumatic Stress Disorder Mentoring Program to improve treatment services. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*, 292–299. <http://dx.doi.org/10.1037/a0024847>
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research, 42*, 1758–1772. <http://dx.doi.org/10.1111/j.1475-6773.2006.00684.x>
- Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., & Resick, P. A. (2012). Dissemination and experience with cognitive processing therapy. *Journal of Rehabilitation Research and Development, 49*, 667–678. <http://dx.doi.org/10.1682/JRRD.2011.10.0198>
- Cloitre, M., Koenen, K. C., & Cohen, L. R. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York: Guilford Press.
- Cloitre, M., Stovall-McClough, K. C., Noonan, K., Zorbas, P., Cherry, S., Jackson, C. L., . . . Petkova, E. (2010). Treatment for PTSD related to

- childhood abuse: A randomized controlled trial. *The American Journal of Psychiatry*, 167, 915–924. <http://dx.doi.org/10.1176/appi.ajp.2010.09081247>
- Cook, J. M., Dinnen, S., Simiola, V., Thompson, R., & Schnurr, P. P. (2014). VA residential provider perceptions of dissuading factors to the use of two evidence-based PTSD treatments. *Professional Psychology: Research and Practice*, 45, 136–142. <http://dx.doi.org/10.1037/a0036183>
- Cook, J. M., Schnurr, P. P., & Foa, E. B. (2004). Bridging the gap between Posttraumatic Stress Disorder research and clinical practice: The example of Exposure Therapy. *Psychotherapy: Theory, Research, Practice, Training*, 41, 374–387. <http://dx.doi.org/10.1037/0033-3204.41.4.374>
- Davis, D., O'Brien, M. A., Freemantle, N., Wolf, F. M., Mazmanian, P., & Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *JAMA: Journal of the American Medical Association*, 282, 867–874. <http://dx.doi.org/10.1001/jama.282.9.867>
- Department of Veterans Affairs. (2008). *Uniform mental health services in VA medical centers and clinics (VHA Handbook 1160.01)*. Washington, D.C.: Department of Veterans Affairs.
- Eftekhari, A., Ruzek, J. I., Crowley, J. J., Rosen, C. S., Greenbaum, M. A., & Karlin, B. E. (2013). Effectiveness of national implementation of prolonged exposure therapy in Veterans Affairs care. *Journal of the American Medical Association Psychiatry*, 70, 949–955. <http://dx.doi.org/10.1001/jamapsychiatry.2013.36>
- Feeny, N. C., Zoellner, L. A., & Kahana, S. Y. (2009). Providing a treatment rationale for PTSD: Does what we say matter? *Behaviour Research and Therapy*, 47, 752–760. <http://dx.doi.org/10.1016/j.brat.2009.06.007>
- Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide*. New York: Oxford University Press.
- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.
- Hoff, R., Shea, J., Gray, S., McCasland, K., & Petrokaitis, E. (2012). *The long journey home XXI: Treatment of posttraumatic stress disorder in the department of veterans affairs: Fiscal year 2012 service delivery and performance*. West Haven, CT: Department of Veterans Affairs, Northeast Program Evaluation Center.
- Institute of Medicine. (2014). *Treatment for posttraumatic stress disorder in military and veteran populations: Final assessment*. Washington, D.C.: National Academy Press.
- Jayawickreme, N., Cahill, S. P., Riggs, D. S., Rauch, S. A. M., Resick, P. A., Rothbaum, B. O., & Foa, E. B. (2014). Primum non nocere (first do no harm): Symptom worsening and improvement in female assault victims after prolonged exposure for PTSD. *Depression and Anxiety*, 31, 412–419. <http://dx.doi.org/10.1002/da.22225>
- Karlin, B. E., & Cross, G. (2014). From the laboratory to the therapy room: National dissemination and implementation of evidence-based psychotherapies in the U.S. Department of Veterans Affairs Health Care System. *American Psychologist*, 69, 19–33. <http://dx.doi.org/10.1037/a0033888>
- Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., . . . Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663–673. <http://dx.doi.org/10.1002/jts.20588>
- King, A. P., Erickson, T. M., Giardino, N. D., Favorite, T., Rauch, S. A., Robinson, E., . . . Liberzon, I. (2013). A pilot study of group mindfulness-based cognitive therapy (MBCT) for combat veterans with posttraumatic stress disorder (PTSD). *Depression and Anxiety*, 30, 638–645. <http://dx.doi.org/10.1002/da.22104>
- Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 74, 898–907. <http://dx.doi.org/10.1037/0022-006X.74.5.898>
- Mott, J. M., Stanley, M. A., Street, R. L., Jr., Grady, R. H., & Teng, E. J. (2014). Increasing engagement in evidence-based PTSD treatment through shared decision-making: A pilot study. *Military Medicine*, 179, 143–149. <http://dx.doi.org/10.7205/MILMED-D-13-00363>
- Muhr, T. (2011). *User's manual for Atlas.ti V6.0*. Berlin, Germany: Atlas.ti scientific software development, GmbH.
- Murphy, R. T., & Rosen, C. S. (2006). Addressing readiness to change PTSD with a brief intervention: A description of the PTSD motivation enhancement group. *Journal of Aggression, Maltreatment & Trauma*, 12, 7–28. http://dx.doi.org/10.1300/J146v12n01_02
- Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.
- National Center for PTSD. (2013). Understanding PTSD treatment. Retrieved from <http://www.ptsd.va.gov/public/treatment/therapy-med/index>
- Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2009). Development of the readiness for psychotherapy index. *Journal of Nervous and Mental Disease*, 197, 427–433. <http://dx.doi.org/10.1097/NMD.0b013e3181a61c56>
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report (DHHS Publ. No. SMA-03-3822)*. Rockville, MD: U.S. Department of Health and Human Services.
- Resick, P. A., & Schnicke, M. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, NJ: Sage.
- Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. T., Chow, B. K., . . . Bernardy, N. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: A randomized controlled trial. *JAMA: Journal of the American Medical Association*, 297, 820–830. <http://dx.doi.org/10.1001/jama.297.8.820>
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. (2012). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
- Shiner, B., D'Avolio, L. W., Nguyen, T. M., Zayed, M. H., Young-Xu, Y., Desai, R. A., . . . Watts, B. V. (2013). Measuring use of evidence based psychotherapy for posttraumatic stress disorder. *Administration and Policy in Mental Health and Mental Health Services Research*, 40, 311–318. <http://dx.doi.org/10.1007/s10488-012-0421-0>
- Solberg, L. (2009). Lessons for non-VA care delivery systems from the U.S. Department of Veterans Affairs Quality Enhancement Research Initiative: QUERI series. *Implementation Science: IS*, 4, 9. <http://dx.doi.org/10.1186/1748-5908-4-9>
- Stecker, T., Shiner, B., Watts, B. V., Jones, M., & Conner, K. R. (2013). Treatment-seeking barriers for veterans of the Iraq and Afghanistan conflicts who screen positive for PTSD. *Psychiatric Services*, 64, 280–283. <http://dx.doi.org/10.1176/appi.ps.001372012>
- Trusz, S. G., Wagner, A. W., Russo, J., Love, J., & Zatzick, D. F. (2011). Assessing barriers to care and readiness for cognitive behavioral therapy in early acute care PTSD interventions. *Psychiatry: Interpersonal and Biological Processes*, 74, 207–223.

Received June 16, 2014

Revision received November 17, 2014

Accepted November 18, 2014 ■