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VA Residential Treatment Providers' Use of Two Evidence-Based Psychotherapies for PTSD: Global Endorsement versus Specific Components

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Abstract

Objective—Despite a growing body of knowledge about the dissemination of evidence-based psychotherapies (EBPs), their actual use in clinical settings is not well understood. The purpose of the current study was to compare self-reported component use with global use for two EBPs for posttraumatic stress disorder (PTSD), Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT).

Method—174 providers from 38 VA PTSD residential treatment programs were asked about both global use and component use of PE and CPT.

Results—Among frequent users of these EBPs, component use was generally high, especially for low-intensity and non-specific components. For each form of treatment, there were a small number of providers who reported using the treatment frequently but did not use most of the key components of the treatment.

Conclusions—These findings highlight the importance of understanding the modifications that providers make to EBPs, and suggest the importance of flexibility within fidelity to these treatments.

Keywords

Implementation; Evidence-Based Practice; Posttraumatic Stress Disorders; Exposure Therapy; Cognitive Therapy

Evidence Based Treatments for Post-Traumatic Stress

There has been dramatic growth in efforts to disseminate evidence-based psychotherapies (EBPs) for the treatment of posttraumatic stress disorder (PTSD), both within and outside of

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the U.S. (e.g., Jacob, Neuner, Maedl, Schaal, & Elbert, 2014; Karlin et al., 2010; Lloyd et al., in press). Two frequently disseminated EBPs for PTSD are Cognitive Processing Therapy (CPT; Resick & Schnicke, 1993) and Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007). CPT is typically a 12-session individual or group protocol focused on emotional processing of the traumatic memory and identifying and modifying maladaptive thoughts related to the traumatic experience. PE is typically an 8 to 15 session individual protocol with key ingredients of imaginal and in vivo exposure. Imaginal exposure involves repeatedly recounting the traumatic memory out loud; in vivo exposure reintroduces patients to situations that are objectively safe but otherwise avoided due to trauma-related distress. There is a psychoeducational component to both CPT and PE that includes education about reactions to trauma and PTSD and the theory behind how the treatments work. Both EBPs have proven effective in randomized control trials (RCTs) (Monson et al., 2006; Schnurr et al., 2007). However, these interventions are relatively infrequently utilized in clinical practice (Becker, Zayfert & Anderson, 2004; Gray, Elhai, & Schmidt, 2007), and when they are they are not routinely delivered in sufficient dose to benefit patients (Mott et al., 2014; Shiner et al., 2013).

Implementation of EBPs in Clinical Practice

An issue that remains unresolved in understanding the implementation and sustained use of EBPs is whether providers who adopt them use all of the particular components of these treatments or whether they only use certain components. In other words, when a given therapist says that he or she uses CPT or PE with patients, it is not always clear what this means. One question is the amount of such treatment that is actually administered (Becker et al., 2004). A related question is whether the EBP that is administered by clinicians resembles, in essence, the EBP that has been studied in RCTs and empirically shown to lead to patient improvement. Namely, how often are the key components of an EBP used by providers in practice (Barber, Triffleman & Marmar, 2007; Carroll, 2013)?

This question should be distinguished from research that evaluates fidelity to protocols, which includes an assessment of use of components in clinical and translational trials (e.g., Barber et al., 2007; Resick et al., 2008; Schnaider et al., 2013; Stein et al., 2012), but do not provide information about what providers do in routine practice with patients. In clinical work, providers likely modify EBPs because they believe (rightly or wrongly, explicitly or implicitly) that such modifications will make the treatment more palatable or more effective with their particular patient population or treatment setting (Cook et al., 2014; Davis et al., 2013). Ad hoc adaptations made in clinical practice may point to possible refinements of EBPs that have the potential to engage patients in treatment and improve their outcomes and provider buy-in, but alternatively, these adaptations may limit treatment effectiveness (Stirman et al., 2015). Thus, adaptations and modifications to EBPs can be fidelity-consistent (e.g., not interfering with core or key components of the protocol), or fidelity-inconsistent (altering or removing a central aspect of the protocol; Stirman et al., 2015). Adaptations and modifications to EBPs can be fidelity-consistent (e.g., minor changes that do not interfere with core or key components of the protocol), or fidelity-inconsistent (altering or removing a central aspect of the protocol; Stirman et al., 2015).

Although some treatments have empirically determined the core elements of the treatments necessary to produce good outcomes, others define core elements based on the theory behind why the treatment works. The designation of core elements in PE and CPT has been both empirically and theoretically driven. Although most “unique and essential” elements were identified by theory, research on CPT and PE has varied the number of sessions in the protocol (e.g., Galovski et al., 2013) and a dismantling study determined that a written trauma account was not necessary to produce good clinical outcomes for CPT (Resick et al., 2008).

Thus, it is important to understand how EBPs are actually administered by clinicians. There is some reason to suspect that a substantial number of therapists who report or believe they are administering EBPs are not administering them as designed or may not be including the components thought to be most important to patient outcomes. Indeed, global self-ratings of adherence for PE and CPT in clinical practice appear to be modest. For example, roughly two-thirds of Department of Veterans Affairs (VA) therapists report adhering “most of the time” for PE and roughly one-half report adhering “most of the time” for CPT (Finley et al., 2015). Wilk et al. (2013), in a study of Army therapists, found low rates of component use for CPT, although rates for PE were marginally higher. Although these discrepancies have been most often studied and noted in cognitive-behavioral EBPs (Hogue et al., 2015; Wilk et al., 2013), similar inconsistencies appear present in other types of therapy (Sharp et al., 2005). At least one third of therapists who utilize trauma-focused cognitive-behavioral therapy (CBT) for the treatment of maltreated children do not report using the central components of CBT (e.g., Allen & Johnson, 2012).

The Use of Self-Report to Assess Component Use

How accurate are such self-reports? Chapman, McCart, Letourneau, and Sheidow (2013) found that therapists and trained raters were generally consistent with treatment experts in their ratings of adherence to a substance abuse treatment protocol. Similarly reasonable agreement in treatment integrity ratings was found among community therapists, supervisors, and observers who used motivational enhancement therapy (Martino, Ball, Nich, Frankforter, & Carroll, 2009), and modular treatments for youth in community mental health systems (Ward et al., 2013). However other studies indicate that therapists overestimated the extent to which they implemented family therapy and motivational interviewing/CBT interventions (Hogue, Dauber, Lichvar, Bobek, & Henderson, 2015). Along those lines, therapists had the poorest reliability ratings on adherence to a manualized 12-step facilitation treatment targeting stimulant abuse as compared to supervisors, study-related raters, and non-project related raters (Peavy et al., 2015).

The Current Study

Given the limited data on component use in PE and CPT, capitalizing on the evaluation of the VA national training initiative (Karlin & Cross, 2014) provides an initial opportunity to examine the relationship between rates of component use and overall frequency of use. In this study, provider self-reported component use in PE and CPT was examined in a nationwide sample of nearly 200 providers of VA residential PTSD treatment (Cook et al.,

2014). For each of the two EBPs (and for both group- and individual-administered CPT), providers' global reports of their use of these approaches were compared with their reports of the use of each specific component of the treatment. Given the limited research available on component use in clinical practice, specific hypotheses were premature. Instead, this exploratory study examined the links between global reports of PE and CPT and the self-reported use of particular components of these treatments.

Method

Participants

The overarching design of the study has been presented elsewhere (Cook et al., 2013; Cook et al., 2014). In brief, the data presented here are part of a longitudinal investigation of implementation of PE and CPT in 38 VA PTSD residential treatment settings that reported patient outcomes to the VA's Northeast Program Evaluation Center. This represented 241 providers, however due to staff turnover, 229 were available to participate, and 201 supplied survey data. One hundred and seventy-four of these contributed sufficient survey data for these analyses. There were no significant differences between those included in the analysis sample and those not included (Cook et al., 2014). The sample is described in Table 1. Overall, nearly two-thirds of the sample were women and a large majority were white. Slightly more than half of the sample were psychologists, with social workers being the second most common profession.

Measures

Demographics—As part of the study, participants were asked several demographic questions. Specifically, they were asked to self-report gender, race/ethnicity, and what their primary profession was. For race/ethnicity, response options were: White, African American, Hispanic, American Indian/Alaska Native, Asian/Pacific Islander, and Other; because of the small number of respondents who reported anything other than White or African American race/ethnicity, the remaining response options were collapsed in these analyses. For profession, response options were: Psychiatrist, psychologist, social worker, nurse, rehabilitation therapist, vocational therapist, drug/alcohol counselor, non-psychiatrist physician, and other; because most respondents were psychologists or social workers, the remaining response items were collapsed in these analyses.

Global Use of Treatment—Global self-report of EBP use was assessed using a series of three self-report items assessing: (1) use of PE administered on an individual basis; (2) use of CPT administered individually; and (3) use of CPT administered on a group basis. Each item assessed the proportion of patients to whom the treatment was administered. For example, the item assessing PE read, "How often do you conduct PE on an individual basis?" and response options were on a 6-point scale, ranging from *less than 10%* (1) to *with over 90% of clients* (6). "Not applicable" was also included as an option, but these providers were not included in these analyses, as they were not even rare users of the treatment. To allow ease of interpretation and comparison with the report of particular component use, this scale was trichotomized for these analyses. Specifically, overall self-rated use was categorized as frequent (50%–100% of clients), occasional (10%–49% of clients), and rare

(less than 10% of clients). These single-item measures correlate with attitudes toward treatments (Cook Dinnen, Thompson, et al., 2015), and with prior intentions to use treatments, as well as prior reported use of treatments (Cook et al., 2014).

Use of Treatment Components—For PE and CPT, respectively, fidelity checklists previously used in RCTs were used, assessing the use of each component of the treatment. The unique and essential items used to measure use of treatment components were drawn from treatment manuals created by treatment developers. Although these have not been validated, previous research (e.g. Foa et al., 2005; Resick et al., 2008) has demonstrated good rater agreement when multiple observers completed these measures. The preface to these checklists read, "When you do PE or CPT, thinking about all the veterans you treated for PTSD in the past three months, for what percentage of your veterans have you used the following practices?" For PE, this involved self-report on 15 components. The items comprising the various components are presented in Table 2. The 20 components of CPT are presented in Table 3. The ratings for these items used the same 6-point response scale used in the global rating: "1 – less than 10%" to "6 – with over 90% of clients." These responses were dichotomized into "frequent" (50% or more of clients) or "less than frequent" (less than 50% of clients).

Analyses

The primary purpose of this analysis was a description of the patterns of reported use, although inferential statistics were used to examine links between therapist attributes and use. Specifically, chi-square analyses were conducted crossing therapist attributes with membership in use groups. The relationship between global reported use and reported use of components of treatment was examined using cross-tabs. Of particular interest were instances in which a given provider reported being a frequent user of a given modality, but reported not frequently using defining components of the treatment. These individuals' patterns of use of components were further examined descriptively, providing the proportions with each pattern of use.

Results

There were limited significant links between therapist attributes and use (see Table 1). Gender of therapist was not significantly related to use. African American therapists were over-represented among those reporting frequent use of CPT individual. Psychologists were over-represented among occasional use of PE. Respondents who were neither psychologists nor social workers were over-represented among rare users for all three modalities.

Table 2 presents information about use of key and other components of PE among the rare, occasional, and frequent groups. The key components had high rates among frequent users (81.0% – 85.7%) but relatively low rates among rare (37.8% – 64.9%) and occasional users (34.5% – 51.7%). Participants reported high use of several of the other components—discussing avoidance and PTSD, describing trauma reactions, and reviewing homework—these three components were highest among frequent users (100%) and only slightly lower among rare users (81.1%–94.6%). The remaining components were reported more among

frequent users (47.6%–90.5%) than among occasional (31.0%–70.0%) and rare users (18.9%–62.6%).

There were four participants who identified as frequent PE users who did not use all the key components. Three of these participants failed to use all four key components, while an additional participant used three of the four key components, but failed to process imaginal exposure with patients. Two of the four participants *only* reported discussing avoidance and PTSD and the trauma reaction and reviewing homework, and the other used only these common components, as well as the PE materials (administer Structured Trauma Interview; use Subjective Units of Distress Scale, view educational DVD), but engaged in no other components of PE.

Table 3 presents information about use of key and other components of individually administered CPT among the rare, occasional, and frequent groups. The key components had high rates among frequent users (89.1% – 97.8%) but lower rates among rare (65.7% – 68.6%) and occasional users (44.1% – 88.2%). The remaining components were reported more among frequent users (63.0% – 97.8%) than among occasional (38.2%–85.3%) and rare users (17.1%–85.7%). Aside from “read trauma narrative aloud”, the components were used by at least 78% of the frequent users.

There were nine frequent users of individual CPT who had any non-use of the six key components. Most of these (six) were each not using a single component. Two frequent users were missing a small number of components, and one was missing all six key components. This participant also reported use of few of the other components.

Table 4 presents information about use of key and other components of group-administered CPT. The key components had high rates among frequent users (83.9% – 94.6%) but lower rates among rare (27.3% – 45.5%) and occasional users (63.6% – 91.8%). The remaining components were reported more among frequent users (51.8% – 96.4%) than among occasional (45.5%–72.7%) and rare users (31.8%–68.2%). Aside from “write trauma narrative” and “read trauma narrative aloud”, the components were used by at least 60% of the frequent users.

There were ten frequent users of group CPT that had any non-use of the six key components. Six of these were missing one or two components, while the other four were missing either five or six components. These four participants reported use of few components of group CPT in general. Of the ten non-users of key components, most were female, white, and psychologists.

Discussion

This study compared global reports of PE and CPT use with use of each specific component of the treatment in a national sample of VA PTSD residential treatment providers. Overall, there was a high rate of endorsement of component use, although not universal, among providers who described themselves as frequent users of these EBPs. In general, use of key components was consistently high among these providers. As well, these providers usually

had higher rates of component use than self-described rare or occasional users of the treatments.

As noted earlier, these data were collected as part of a larger study of implementation of EBTs in the VA health care system (Cook, Dinnen, Coyne et al., 2015). As part of this study, prior analyses of qualitative interviews with providers suggested that modifications of treatments were common, and that a substantial number of providers made such modifications (Cook et al., 2014). This set of analyses used more rigorous data to detail which components were retained by providers, and the degree to which this component use related to their global reports. The current study was the first examination of this issue in this data set.

Less Frequently Used Components

There were some components that were not commonly used by self-reported frequent users of the treatments, a finding more consonant with earlier VA survey assessing outpatient providers showing modest component use (Finley et al., 2015). In particular, among those who reported frequent use of PE, the likely non-essential educational DVD component was used by less than half. It may be that programs often do not have easy access to DVD players or related media and components that rely on such specific technology may be less portable. Updated educational videos providing an overview of PE are available through the VA Sharepoint website (Eftekhari, 2009) and may be being used by providers who do not have access to DVD players and related media. Innovative methods, such as smartphone applications, may also assist in provider implementation and adherence, and patient compliance with EBPs (Reger et al., 2013).

Among frequent users of CPT, the trauma narrative component was the least commonly used, although still used by a majority. Having patients read trauma narratives aloud was the least commonly used, and for CPT group, having patients write a trauma narrative also occurred in less than two thirds of providers. A dismantling study (Resick et al., 2008) found that CPT is similarly efficacious with or without the trauma narrative; the version of CPT without trauma narrative is also known as CPT-Cognitive (CPT-C). Thus, removal of the trauma narrative is not necessarily a fidelity-inconsistent modification, and may allow patients to engage in efficacious treatment without revisiting traumatic memories through a detailed narrative. However, the findings suggest that more patients are assigned a trauma narrative than asked to read it aloud. Patient factors may be an explanation: some patients may refuse to complete the trauma narrative or may not have adequate recollection of the traumatic event to construct a trauma narrative. However, when the trauma narrative is assigned, not reading it aloud in session could reinforce avoidance of uncomfortable emotions. This suggests that several patients either do not complete this element of the protocol when assigned (in which case the protocol specifies that a narrative account should occur in session), or that therapists make a fidelity-inconsistent adaptation (Stirman et al., 2015) in not having it read aloud, or narrated, if the writing was not completed prior to the session, in session.

The possibility of using CPT-C and removing the trauma narrative from the CPT protocol without a loss of efficacy may be one of the reasons why almost 70% of VA residential

programs report implementing this EBT as a full or partial protocol, while the most common level of implementation for PE was having select patients received it (Cook et al., 2014). This may also partially explain higher rates of dropout in PE (Kehle-Forbes, Meis, Spoont, & Polusny, 2016). Additional flexibility of the CPT is that it can be delivered in group format and thus has been considered less resource and time intense by VA providers (Cook, Dinnen, Coyne et al., 2015).

Frequently Used Components

Alternatively, there were several components that were frequently used by most providers, regardless of whether they were frequent, occasional, or rare users of these treatments. For PE, these components appeared to be components that were less specific, such as discussing avoidance, describing trauma reaction, and reviewing homework. These are components of generic CBT approaches to trauma treatment (Roth & Pillig, 2008), although homework and buy-in to homework is likely an underappreciated component of success in PE (Bluett et al., 2014). As well, the Structured Trauma Interview was also frequently used by providers who were not frequent users of PE. This might be viewed as a standard way to gather detailed information on a patient's traumatic experiences and thus may be simply used for assessment purposes rather than part of the intervention per se. Finally, for CPT, the Beliefs About Shame and Guilt handout, which does not appear in the most recent version of the protocol (Resick, Monson, & Chard, 2014), was nonetheless commonly used by those who did not frequently use CPT. One reason that providers may be using this handout without completing the full protocol of CPT, and despite its exclusion from the more recent update of the protocol may be to address issues of moral injury with their patients. It has been postulated that veterans are often confronted with moral and ethical situations in the line of duty that can lead to potentially injurious events when they are unable or fail to prevent situations that juxtapose deeply held moral beliefs (Litz et al., 2009).

Limitations and Future Directions

Limitations of this investigation should be acknowledged. First, the data used for this study come from provider self-report and thus may be influenced by memory as well as demand characteristics. More generally, self-reported practices may not necessarily indicate what clinicians actually do (Hoyt, 2002), and concerns have been raised about their validity (e.g., Hogue et al., 2015; Peavy et al., 2015). Concerns about self-report are especially heightened given the use of single item measures. On the other hand, in some research, provider self-reports about practice correlate highly with expert raters and observers (Chapman et al., 2013; Martino et al., 2009).

Objective measures of PE and CPT utilization might include video samples of random therapy sessions or patients' perceptions of use or automated record-keeping. Triangulation of this self-report data with other sources would augment these self-report findings. Data for this study were collected prior to the VA implementation of PE and CPT progress note templates. Future investigations could include data from those administrative progress notes and thus could establish the concurrence of subjective provider report and more objective rater reports of implementation. This study focused on VA residential PTSD treatment providers. In addition to likely treating more severe patients, the residential setting

parameters (e.g., 6–12 week length of stay; multiple sessions per week) differ from outpatient settings. This may allow for greater adherence to protocols.

Some of the findings require further investigation. There were a handful of providers who reported frequent use but did not use all of the key components of the respective EBPs. The interpretation of these providers' reports is unclear. It is possible that they erred in describing themselves as frequent users. Alternatively, it is possible that these providers misconstrued the treatments that they were administering. An additional possibility is that they had adapted the treatments for their particular contexts. In any case, these providers tended to resemble the providers who self-described as using the treatments frequently *and* used key components frequently, suggesting there is no simple explanation for this phenomenon.

More generally, although fidelity to treatment is methodologically emphasized in evaluating treatments, there is limited empirical data on its importance for clinical outcomes, and what limited data there is available suggests that at least some "core" components can be removed or modified (e.g., Resick et al., 2008). However, most modifications in clinical practice have not been evaluated for the effects on clinical efficacy.

Implications

One area that warrants potential consideration in both VA and civilian sectors in order to promote the dissemination of EBPs from research to community clinics involves a concept called "flexibility within fidelity." Kendall and Beidas (2007) proposed that in order to smooth the dissemination process, providers should be permitted some latitude in EBP delivery. This fits with findings from a RCT supporting the efficacy of a flexibly administered CPT protocol in a multiply traumatized, community sample of male and female assault survivors (Galovski, Blain, Mott, Elwood, & Houle, 2012). However that study was closely monitored for deviations from the protocol and only allowed particular deviations (increasing the number of sessions based on assessment of client gains across a number of domains and inserting up to two sessions to address significant psychosocial stressors or client emergencies). In addition, the process of implementing CPT to low and medium resource countries, such as Iraq, has involved iterative adaptations such as simplification of content and cultural modification (Kaysen et al., 2013). When combined with measures of symptom change for a large sample, data on adaptations that are made in routine care could facilitate an empirical investigation on which components of EBPs are in fact essential for symptom change (Chambers & Norton, in press). This information could inform decisions about how to adapt or modify EBPs in routine care settings. In the interim, the data that we present in this study may be used to inform training and ongoing support of clinicians, as well as the design of research to investigate the impact of more common forms of adaptation.

Tremendous progress has been made in the dissemination of EBTs for PTSD in children and adults (CATS Consortium, 2007; Karlin et al., 2010). Further methodologically sound research is likely needed to understand optimal implementation strategies to assist providers to use EBPs with a balance between fidelity and flexibility.

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Table 1

Demographic Comparison of Groups Defined by Global Reported Use.

Variable	Rare/Non- Users	Occasional Users	Frequent Users
PE	50.0% (87)	37.9% (66)	12.1% (21)
Gender (female)	49.1% (56)	39.5% (45)	11.4% (13)
Race: White	47.9% (70)	38.4% (56)	13.7% (20)
Race: African American	70.0% (7)	30.0% (3)	0
Race: Other	55.6% (10)	38.9% (7)	5.6% (1)
Profession: Psychologist	38.8% (38)	46.9% (46)*	14.3% (14)
Profession: social worker	57.9% (33)	32.2% (19)	8.5% (5)
Profession: Other	84.2% (16)*	5.3% (1)	10.5% (2)
CPT Individual	33.9% (59)	39.7% (69)	26.4% (46)
Gender (female)	30.7% (35)	39.5% (45)	29.8% (34)
Race: White	34.9% (51)	41.1% (60)	24.0% (35)
Race: African American	10.0% (1)	30.0% (3)	60.0% (6)*
Race: Other	38.9% (7)	33.3% (6)	27.8% (5)
Profession: Psychologist	30.6% (30)	43.9% (43)	25.5% (25)
Profession: social worker	27.1% (16)	39.0% (23)	30.5% (18)
Profession: Other	68.4% (13)*	15.8% (3)	15.8% (3)
CPT Group	48.9% (85)	19.0% (33)	32.1% (56)
Gender (female)	50.0% (57)	17.5% (22)	30.7% (35)
Race: White	45.9% (67)	19.9% (29)	34.2% (50)
Race: African American	50.0% (5)	20.0% (2)	30.0% (3)
Race: Other	72.2% (13)	11.1% (2)	16.7% (3)
Profession: Psychologist	48.0% (47)	20.4% (20)	31.6% (31)
Profession: social worker	45.6% (26)	19.3% (11)	35.1% (20)
Profession: Other	63.2% (12)*	10.5% (2)	26.3% (5)

Note: Percentages reported represent the proportion of those in the demographic group with the given frequency membership.

Asterisks indicate demographic groups disproportionately represented in the user group, using chi-square tests at $p < .05$.

Table 2

Global Endorsement of Use of PE with Endorsement of Components (N = 87).

Variable	Overall	Rare/None (−10%)	Occasional (10–50%)	Frequent (51–90+%)
N		37	29	21
Key Components				
Construct In Vivo Hierarchy	60.9% (53)	59.5% (22)	44.8% (13)	85.7% (18)
Assigned In Vivo Homework	65.5% (57)	64.9% (24)	51.7% (15)	85.7% (18)
Conduct 30 to 45 Min IE	48.3% (42)	37.8% (14)	34.5% (10)	85.7% (18)
Process Imaginal Exposure	48.3% (42)	40.1% (15)	34.5% (10)	81.0% (17)
Other Components				
Describe Imaginal Exposure	66.7% (58)	59.5% (22)	58.6% (17)	90.5% (19)
Teach Breath Training	57.5% (50)	48.6% (18)	55.2% (16)	76.2% (16)
Conduct Imaginal Exposure Hot Spots	43.7% (38)	37.8% (14)	31.0% (9)	71.4% (15)
Listen to Audiotape of Session	40.2% (35)	24.3% (9)	34.5% (10)	76.2% (16)
Listen to Audiotape of IE	41.4% (36)	29.8% (11)	34.5% (10)	71.4% (15)
View Educational DVD	29.9% (26)	18.9% (7)	31.0% (9)	47.6% (10)
Administer Structured Trauma Interview	66.7% (58)	62.6% (23)	70.0% (20)	71.4% (15)
Use Subjective Units of Distress Scale	62.1% (54)	48.6% (18)	58.6% (17)	90.5% (19)
Discuss Avoidance PTSD	93.1% (81)	94.6% (35)	93.1% (27)	100% (21)
Describe Trauma Reaction	92.0% (80)	89.2% (33)	89.7% (26)	100% (21)
Review Homework	90.8% (79)	81.1% (30)	96.6% (28)	100% (21)

Table 3

Global Endorsement of Use of Individual CPT with Endorsement of Components (N = 115).

Variable	Total	Rare/None (−10%)	Occasional (10–50%)	Frequent (51–90+%)
N		35	34	46
Key components				
Write Trauma Impact Statement	82.6% (95)	65.7% (23)	88.2% (30)	91.3% (42)
ABC Worksheets	75.7% (87)	68.6% (24)	58.8% (20)	93.5% (43)
Challenging Questions Worksheet	74.8% (86)	68.6% (24)	52.9% (18)	95.7% (44)
Problematic Thinking Worksheet	73.0% (84)	65.7% (23)	50.0% (17)	95.7% (44)
Challenging Beliefs Worksheet	73.0% (84)	68.6% (24)	44.1% (15)	97.8% (45)
Final Impact Statement	68.7% (79)	65.7% (23)	44.1% (15)	89.1% (41)
Other Components				
Read Trauma Impact Statement	78.3% (90)	60.0% (21)	85.3% (29)	87.0% (40)
Write Trauma Narrative	61.7% (71)	45.7% (16)	55.9% (19)	78.3% (36)
Read Trauma Narrative Aloud	47.0% (54)	17.1% (6)	55.9% (19)	63.0% (29)
Final Impact Statement	68.7% (79)	65.7% (23)	44.1% (15)	89.1% (41)
Identifying Emotions Handout	67.8% (78)	60.0% (21)	38.2% (13)	95.7% (44)
Self Esteem Handout	68.7% (79)	60.0% (21)	41.1% (14)	95.7% (44)
Handouts of Worksheets for Homework	75.7% (87)	68.6% (24)	52.9% (18)	97.8% (45)
Beliefs Shame Self Blame and Guilt	86.1% (99)	85.7% (30)	70.6% (24)	97.8% (45)
Intimacy Module	72.2% (83)	74.3% (26)	41.1% (14)	93.5% (43)
Safety Module	73.0% (84)	74.3% (26)	41.1% (14)	95.7% (44)
Trust Module	70.4% (81)	74.3% (26)	38.2% (13)	91.3% (42)
Power and Control Module	72.2% (83)	74.3% (26)	41.1% (14)	93.5% (43)
Power and Control Handout	70.4% (81)	68.6% (24)	41.1% (14)	93.5% (43)
Intimacy Handout	72.2% (83)	74.3% (26)	41.1% (14)	93.5% (43)
Esteem Issues Handout	70.4% (81)	74.3% (26)	41.1% (14)	89.1% (41)

Table 4

Global Endorsement of Use of Group CPT with Endorsement of Components (N = 89).

Variable	Overall	Rare/None (−10%)	Occasional (10–50%)	Frequent (51–90+%)
N		22	11	56
Key components				
Write Trauma Impact Statement	74.2% (66)	36.4% (8)	91.8% (9)	87.5% (49)
ABC Worksheets	76.4% (68)	45.5% (10)	63.6% (7)	91.1% (51)
Challenging Questions Worksheet	77.5% (69)	40.9% (9)	63.6% (7)	94.6% (53)
Problematic Thinking Worksheet	76.4% (68)	45.5% (10)	72.7% (8)	89.3% (50)
Challenging Beliefs Worksheet	70.8% (63)	40.9% (9)	63.6% (7)	83.9% (47)
Final Impact Statement	73.0% (65)	27.3% (6)	63.6% (7)	92.9% (52)
Other Components				
Read Trauma Impact Statement	67.4% (60)	36.4% (8)	45.5% (5)	83.9% (47)
Write Trauma Narrative	58.4% (52)	45.5% (10)	72.7% (8)	60.7% (34)
Read Trauma Narrative Aloud	50.6% (45)	36.4% (8)	72.7% (8)	51.8% (29)
Identifying Emotions Handout	69.7% (62)	31.8% (7)	63.6% (7)	85.7% (48)
Self Esteem Handout	70.8% (63)	36.4% (8)	72.7% (8)	83.9% (47)
Handouts of Worksheets for Homework	78.7% (70)	50.0% (11)	63.6% (7)	92.9% (52)
Beliefs Shame Self Blame and Guilt	86.5% (77)	68.2% (15)	72.7% (8)	96.4% (54)
Intimacy Module	75.3% (67)	40.9% (9)	63.6% (7)	91.1% (51)
Safety Module	76.4% (68)	40.9% (9)	63.6% (7)	92.9% (52)
Trust Module	76.4% (68)	40.9% (9)	63.6% (7)	92.9% (52)
Power and Control Module	76.4% (68)	40.9% (9)	63.6% (7)	92.9% (52)
Power and Control Handout	75.3% (67)	45.5% (10)	63.6% (7)	89.3% (50)
Intimacy Handout	76.4% (68)	40.9% (9)	63.6% (7)	92.9% (52)
Esteem Issues Handout	75.3% (67)	36.4% (8)	63.6% (7)	92.9% (52)