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ORIGINAL PAPER

In Their Own Words: Clinician Experiences and Challenges in Administering Evidence-Based Treatments for PTSD in the Veterans Health Administration

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Abstract
The aim of the present study was to increase the understanding of clinician experiences with administering two evidence-based psychotherapies (EBPs) for PTSD (Cognitive Processing Therapy and Prolonged Exposure therapy) in the Veterans Affairs Healthcare System (VA). The study assessed clinician perceptions through the use of two, one-hour focus groups and employed a rigorous data analysis approach, Consensual Qualitative Research. Clinicians who work in an outpatient PTSD clinic at a New England VA, and who routinely administer EPBs for PTSD, participated in the study. Results were categorized into seven domains by the coding team, including 1) EBP Strengths, 2) EBP Weaknesses, 3) Challenges Specific to the Veteran Population, 4) Perceived EBP Effectiveness, 5) Active Ingredients for Treating PTSD, 6) Treatment Structure and Process, and 7) Suggested Changes/Improvements to EBPs. These domains are discussed in detail, with several core ideas falling under each domain. Operational definitions and representative quotes are provided. Overall, clinicians provided a balanced perspective and identified both strengths and weaknesses of the EBPs for PTSD. They identified several challenges in applying these treatments to veteran populations, and shared their beliefs about treatment effectiveness, how they use these treatments in their clinical practice, and how they would change the treatments if given an opportunity to do so. In this way, the study offers a small but important step in attempting to address the science-practice gap related to EBP for PTSD implementation efforts in the VA.

Keywords Evidence-based psychotherapies · PTSD treatment · Clinician perceptions · Implementation challenges · Veteran mental health

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One of the most prevalent mental health diagnoses among United States veterans presenting for treatment in the Veterans Affairs Healthcare System (VA) is Posttraumatic Stress Disorder, or PTSD [1]. When left untreated, PTSD can become a chronic condition with significant cost to veterans, their families, and society [2]. PTSD has been found to be associated with problems such as depression, substance abuse, and an increase in psychosocial stressors [3–6]. There are currently several evidence-based psychotherapies (EBPs) for PTSD, including Cognitive Processing Therapy (CPT) [7] and Prolonged Exposure therapy (PE) [8]. These treatments are promoted as "first line" treatments for PTSD by the VA [9] and are both manualized, trauma-focused, and short-term in nature, ranging from 9 to 15 sessions on average.

A body of research supports the efficacy of both PE [10, *see* 11] and CPT [12], and the benefits of evidence-based treatment have been widely accepted [13], though are not without debate. Despite demonstrated treatment efficacy, ample criticisms of the use of manualized treatments exist, among them the lack of ecological validity in controlled outcome studies [14, 15]. It has also proven challenging to implement highly structured and manualized treatments into heterogeneous, naturalistic clinical settings with diverse populations [16] such as the VA [17].

Challenges specific to the veteran population include the fact that both CPT and PE were developed and primarily evaluated in civilian populations. Few studies have conducted systematic randomized controlled trials to examine the utility of these treatments for veterans or combat-related PTSD specifically [18–20], with some notable exceptions [e.g. 21–23]. However, of these trials one focused exclusively on female veterans with few who were exposed to combat [22] and one exclusively on military sexual trauma [23]. Other research on EBPs for PTSD has found smaller effects from treatment among veterans than civilian populations [24] and that veterans with combat trauma showed less improvement overall following PTSD treatment [25, 26]. In light of low engagement [26] and relatively high dropout rates from these treatments among veterans [26, 27] there remains some question about the generalizability of existing research to this population. While direct comparisons of dropout between civilian and veteran populations have not been undertaken to date, dropout rates from EBPs for PTSD have also been found to be relatively high in non-VA practice settings [28]. Furthermore, some studies with veterans have found low rates of remission, continued symptomatic distress, or maintenance of PTSD diagnosis following evidence-based treatment [20, 26, 29, 30]. Recently, a large clinical trial conducted at the Department of Defense found that after undergoing CPT 50% of veterans still remained significantly symptomatic [31]. Another recent trial which examined PE effectiveness among military personnel found similar results, with only 50% of individuals treated experiencing remission at the end of treatment [32].

Evidence-based treatments are often developed and tested in controlled research contexts, rather than in naturalistic clinical settings. Differences in outcome across settings reflects the "science-practice" gap, which has persisted for decades despite ongoing efforts to address it [16, 33]. There are also a lack of avenues for bidirectional feedback in EBP implementation efforts, with implementation often a top-down policy directive with limited input from clinicians regarding their reactions to and perceptions of EBPs. The result is that relatively little is known about how clinicians feel about EBPs for PTSD and what implementation difficulties exist in the clinical contexts in which they work. Clinicians do not often have opportunities to share their experiences or expertise with researchers in an effort to better inform treatments or their adaptations to increase success in real-world clinical practice. Recent work has examined VA clinicians' decision-making process for utilizing EBPs for PTSD, with the focus on when and why providers choose to use an EBP with a particular veteran or not [34]. This work found that clinicians generally focus on two main processes – patient

"readiness" to engage in trauma-focused treatment, as well as the presence and nature of comorbid conditions. This study represents an important step forward in terms of decreasing the science-practice gap and working to increase communication between clinicians and researchers. While some studies have examined VA clinicians' utilization of EBPs for PTSD and global beliefs about treatment effectiveness [35], there is much that remains unknown about their perceptions of and experiences with these treatments once the decision has been made to use an EBP. We know that only a small percentage of veterans with PTSD engage in and complete EBPs for PTSD [36, 37] but there is a dearth of information on why this occurs, particularly given the widespread availability of CPT and PE in the VA [38] and administrative pressures to provide such treatments [9]. One large-scale survey of clinicians treating PTSD found that many of them do not use exposure therapy to treat PTSD despite familiarity with the PE protocol and its components [39]. Given these issues, it is important to increase our understanding of how clinicians are experiencing EBPs for PTSD in the VA, what problems or struggles occur in their implementation efforts, and any suggested changes or improvements they may have that could help to improve treatment utilization and efficacy.

The present study was designed in order to increase our understanding of implementation challenges associated with utilizing EBPs in VA PTSD specialty clinics, where implementation is mandatory. Clinicians were asked about their experiences with CPT and PE in order to offer them a venue through which to share their experiences and thoughts about PTSD treatment in the VA. The study was intended to be exploratory, and was conducted with no a priori hypotheses.

Method

The present study was part of a larger investigation into the implementation of EBPs for PTSD in a New England VA PTSD clinic. The focus of the study was on understanding clinician perceptions and experiences of utilizing EBPs in their treatment of PTSD.

Participants All participants ($N = 8$) were clinicians working in the outpatient PTSD clinic at the VA [*redacted for review*]. Participants were formally trained by the VA in Cognitive Processing Therapy ($n = 8$, 100%) and/or Prolonged Exposure Therapy ($n = 6$, 75%). Participants had previously consented to participate as study clinicians in a larger psychotherapy process and outcome study on EBPs for PTSD in the clinic. Therapists were mostly female ($n = 7$, 87.5%), Caucasian ($n = 7$, 87.5%; one participant was Black) and ranged in age from 30 to 61 ($M = 41.75$, $SD = 11.87$). One third of participants were licensed practitioners and full-time staff ($n = 6$, 75%) while the remaining two were trainees (psychology postdoctoral fellows) under supervision. Licensed practitioners were approved by the VA as CPT/PE providers following their training, with the two postdoctoral clinicians eligible for provider status upon licensure. Clinicians represented several disciplines, including psychology ($n = 5$, 62.5%), social work ($n = 2$, 25%), and psychiatric nursing ($n = 1$, 12.5%). Therapists had worked at the VA for an average of 7 years ($M = 7.88$, $SD = 7.78$) and most had experience providing EBPs for PTSD for at least 2 years.

Procedure The full study was approved by the local VA Human Subjects Committee. Informed consent was obtained from all clinicians prior to their enrollment in the study. As

part of their enrollment in the larger study, clinicians ($n = 12$)[1] were invited to participate in one of two voluntary focus group meetings that occurred in early 2017 approximately one month apart. Clinicians were able to choose the focus group that best worked with their schedule. All clinicians in the study were actively treating cases using at least one EBP for PTSD. Focus groups took place in a private conference room in the VA, were held at mutually agreeable times based on clinician availability and preference, and lasted for one hour. Focus groups were run by the first author and responses were recorded by the first author and a trained research assistant (the second author). Responses were transcribed verbatim by paper and pencil during the groups. Immediately following the focus groups, responses were reviewed and compared to ensure that all narrative data was adequately and accurately captured. As a further check for data accuracy and following the principle of "member checking" [40], participants were subsequently provided with summaries of the narrative data collected from their group and invited to review the comments for accuracy. No substantive edits to the transcriptions were required as the result of this process. Narrative data was then reviewed and analyzed by the coding team for the study.

Measures A structured interview was created for the purpose of the focus group. The interview was created by the first author, who has experience in interview construction, in collaboration with the third author and other investigators on the full study protocol. The interview was created based on a review of the literature on the topic, and was refined through an iterative feedback process among the study team. The interview contained 13 open-ended questions designed to capture a full and diverse range of clinician perceptions related to the implementation of EBPs in their clinical practice. Interview questions were open-ended in nature and focused on attempting to understand clinicians perceptions of, experiences with, feelings about and professional opinions of evidence-based treatments for PTSD. Questions also intended to assess if clinicians experienced any unique challenges with implementation in the veteran population, as well as their beliefs about the treatment of PTSD more generally. A copy of the complete interview protocol can be found in Appendix.

Data Analysis Descriptive data was analyzed by using the SPSS (version 22) statistical program. All narrative data was analyzed using the Consensual Qualitative Research (CQR) [41] coding system. CQR is an established, rigorous team-based approach to classifying and interpreting qualitative data [42]. The CQR method relies on the principle of consensus, achieved by intentionally inviting and taking into account multiple and diverse viewpoints. The coding team for the study was stable and consisted of a core group of two psychologists and two research assistants. Three members served as primary coders and a senior psychologist (the third author) served as the auditor for the coding team. The role of the auditor is to review coding at all phases of the process to both evaluate the decisions made by the coding team as well as to identify and challenge any groupthink that might occur within the core group. The auditor is tasked with providing an outside perspective to ensure overall clarity as well as individual decisions made by the team during the consensus process. The auditor is also tasked with helping to resolve any coding disputes that may occur during data analysis.

[1] Nine out of the twelve study clinicians elected to participate in one of the focus groups. One participant was unexpectedly unable to attend the scheduled focus group, resulting in data from eight clinicians. Participation was voluntary and optional. Information on why the remaining three clinicians opted not to participate was not collected.

The procedures outlined in the CQR manual were closely followed during the data analysis process, as were subsequent recommendations by Hill et al. [42]. In reviewing narrative responses, coders are tasked with creating *domains* (topic areas) and *core ideas* (the main points of each domain), and are then able to create categories that can be quantified to describe trends or consistencies in the data. The domains were initially derived from the structure of the interview, and were then modified and adapted throughout the coding process as needed based on the data. Core ideas were derived from narrative data and offered clear descriptions of participant responses to interview questions. Cross analysis then occurred in an effort to synthesize the data and achieve a higher level of abstraction about its overall meaning. As is recommended [42], all coding team members immersed themselves in each individual case throughout data analysis. At all stages of the process, team members worked individually and then brought their results to team meetings where the consensus process occurred. During these meetings, discrepancies were carefully reviewed and resolved to create a synthesis of the data, which was then submitted to the auditor for further review. Results are described as *general* when they apply to all, or all but one, of the cases reviewed; *typical* when they apply to at least half of the cases; and *variant* when they apply to a few select cases only.

Training All members of the coding team were extensively trained in CQR prior to data collection. The first and third author have previous experience conducting studies using CQR as well as other qualitative methodologies. The first author was responsible for training the other two members of the coding team in the procedure. Consistent with recommendations for training in CQR [42], team members first studied the CQR manual and read sample studies on their own. The coding team then met as a group on two separate occasions to review the manual and coding procedure and discuss how it would apply to the current study. Ample opportunity was provided for questions, concerns, or clarifications about the process. All team members reported comfort with the method before gaining access to the study data, and were encouraged to bring up questions or aspects they found confusing/challenging at any point during the coding process.

Expectations and Biases Consistent with recommendations for conducting CQR studies [42], both researcher expectations and biases were identified and extensively discussed prior to data collection or analysis. One member of the coding team and the auditor both have previous clinical experience with the treatments under study, and thus necessarily have their own perceptions of the utility and value of the treatments. Both individuals have been trained in and provided the treatments in the VA, and acknowledged both positive and negative experiences using the treatments in their clinical practice. It was therefore the expectation of these researchers that both strengths and weaknesses would likely be identified during the focus groups and that some limitations of the treatments exist. The other two members of the coding team had no formal exposure to the treatments prior to the study, and thus offered a relatively unbiased viewpoint about them during the coding process. It was believed that this composition of the coding team offered an appropriate balance and served as an internal check against clinical biases based on personal practice and experience.

Results

Domains Seven core domains were identified through the analysis of focus group responses, which include: 1) EBP Strengths, 2) EBP Weaknesses, 3) Challenges Specific to the Veteran

Population, 4) Perceived EBP Effectiveness, 5) Active Ingredients for Treating PTSD, 6) Treatment Structure and Process, and 7) Suggested Changes/Improvements to EBPs. Information was also obtained related to how clinicians would design a new treatment for PTSD if they were given the opportunity to do so. A complete list of domains with operational definitions, core ideas, and representative quotes is provided in Table 1.

EBP Strengths

Two themes that emerged are that there are advantages to using EBPs for PTSD and the treatments have several important strengths. The most commonly identified strengths were the fact that the treatments were evidence-based, with many comments made about the helpfulness of the treatment structure – that they are short-term, direct, and relevant/focused to the presenting problem (*general*). Several clinicians emphasized the face validity of the treatments and the utility of working with the trauma directly (*typical*). It was also seen as important that the treatments were supported by the VA and that resources were available for implementation and delivery (*typical*). A few participants also commented on how structured treatments offer a shared experience and a common language for both clinicians and veterans (*variant*). The element of exposure across treatments was seen as helpful in reducing symptoms (*general*), and the treatments were seen as fairly efficacious at symptom reduction overall (*typical*). It was noted that, for some veterans, improvements can occur as early as the initial engagement in exposure. One clinician stated *"It is nice to be able to offer a treatment that has evidence to support it."*

EBP Weaknesses

Another theme was that EBPs for PTSD have significant limitations, predominantly that they are too short-term and overly structured in nature. There was generally unanimous agreement about the two main perceived weaknesses of the treatments – lack of flexibility (*general*) and not enough time (*general*). The protocols were seen as somewhat rigid and overly structured, with limited space for, or guidance about how to work with other issues when needed. In general, 12–15 sessions was seen as not enough time to adequately work through and resolve traumatic events and their sequelae (*typical*). Clinicians felt that many veterans were fairly symptomatic after completing a protocol and still required individual therapy (*typical*); treatments were seen both as helpful but also as not quite enough (*typical*). One clinician summarized the issue: *"You can do the best job in the world, but many veterans are still symptomatic or still want or need something more."*

There was also general consensus that the EBPs fit and work well for some, but not all, veterans (*general*). Clinicians felt as if they were pressured to employ an "EBP or nothing" approach in their work, as well as pressure to "cure" PTSD in the very short timeframe allotted (*typical*). One clinician stated, *"It is pretty much all we offer with no flexibility… the VA culture is like it's 'EBP or nothing,' which isn't always helpful and doesn't work for everyone."*

Regarding CPT, some participants felt that there were too many worksheets and too much focus on bringing everything back to one isolated incident (*typical*). One clinician stated *"Sometimes it feels like you are just 'throwing worksheets' at whatever issue they come up with, which works in some cases but not all, and can also feel disingenuous, repetitive, or impersonal."* Others felt that the cognitive model just didn't fit in every case, particularly in situations where the veterans thinking about a trauma was not irrational and did not contain any "distortions" (*variant*).

Table 1 Operational Definitions of Qualitative Coding Domains

DOMAIN	Operational Definition, Core Ideas & Sample Quotes
EBP Strengths	Positive aspects, strengths, and/or perceived advantages of EBP treatments. Core Ideas: short-term, concrete & structured, relevant (trauma focus), have face validity, evidence-based, supported by VA, high success rates/good outcomes Representative Quote 1: *"It is nice to be able to offer a treatment that has evidence to support it."* Quote 2: *"They (EBPs) have face validity – they tackle the trauma head on."*
EBP Weaknesses	Negative aspects, weaknesses, and/or perceived disadvantages or shortcomings of EBP treatments. Core Ideas: lack of flexibility, inadequate time/# of sessions, overly structured protocols, symptom persistence/ PTSD not resolved (treatments seen as "not enough"), EBPs fit for some but not all, too many worksheets, limitations of the cognitive model, biased privileging of EBPs above other options, narrow focus that doesn't fit with complex trauma, treatment elements can be a "tough sell" Representative Quote 1: *"When it works, it works great. But it 'works' for only a minority of veterans."* Quote 2: *"The EBPs get applied very rigidly, and it can feel forced in a way. Some veterans will say 'can't I just talk about it?' without all the other elements that come into play, like the worksheets."*
Challenges Specific to the Veteran Population	Perceived challenges specific to applying these treatments to a veteran population Core Ideas: high number of comorbidities and other issues, complex trauma is the norm especially with combat exposure (one "index trauma" can be invalidating), over-identification with and attachment to the trauma or the PTSD diagnosis, the secondary gain issue that comes from service connection, male and military socialization, Representative Quote 1: *"There are so many comorbidities in this population: substance use, chronic pain, depression, health problems... And for some, like Vietnam vets, these issues have been going on for years… It just doesn't fit the overly structured, short-term, in-and-out treatment model we have."* Quote 2: *"The PTSD becomes kind of ego-syntonic – for a lot of these veterans, it becomes part of their experience and identity. And they are not always willing to let that go or to give that up."*
Perceived EBP Effectiveness	Clinician perceptions and beliefs about the effectiveness of the EBP treatments. Core Ideas: most of the time there is some improvement/symptom decrease for treatment completers, estimated that about half of veterans finish the treatments, substantial improvement for some veterans, EBPs don't work every time or with every veteran, treating PTSD should not be "one size fits all," different things work for different people Representative Quote 1: *"The treatments simply do not work all of the time."* Quote 2: *"The treatments seem to work with people who are coming in with a good baseline. When they were healthy and well-adjusted before the trauma. But that is not the case with veterans with more complex trauma histories."*
Active Ingredients for Treating PTSD	Perceptions about the active ingredients of EBPs and in treating PTSD generally. Core Ideas: exposure (via talking or writing), working through trauma and its impact, emotional engagement and affective expression, support from a group or from others, putting a traumatic event in context, working on guilt/blame/shame, finding acceptance in yourself and in the therapy relationship, corrective relational experience in therapy, nonspecific factors (alliance, unconditional positive regard, nonjudgmental stance), homework and making behavioral changes

Table 1 (continued)

DOMAIN	Operational Definition, Core Ideas & Sample Quotes
	Representative Quote 1: *"There is a level of acceptance that is critical. You have to accept what happened, and you have to accept yourself and what you did or didn't do in the moment. You need to accept yourself and others, and the fact that you will be forever changed. When you can accept this, you can find peace."* Quote 2: *"The worksheets are definitely not the curative factor. What works is helping people dig in and address it. They need to face it, and talk about it. But the (CPT) manual gives no other options for doing this other than the worksheets."*
Treatment Structure and Process	General thoughts on treatment fidelity and adherence – the importance of sticking to the manual versus allowing flexibility if/when needed. Core Ideas: importance of following the manual unless you cannot, necessity of flexibility (degree and type varied), general sense of needing more time than the EBPs allow, preference for flexible and individualized administration Representative Quote 1: *"You can use the basic principles of the treatments, but you can do it without all of the structure and in a way that is more organic and flexible."* Quote 2: *"I always feel rushed with CPT."*
Suggested Changes/ Improvements to EBPs	Suggested changes and/or improvements to EBP treatments. Core Ideas: additional time (to build trust and attend to process issues, deeper trauma processing, for termination, etc.), increased flexibility, importance of therapy relationship/alliance, more guidance for working with multiple traumas, more focus on treatment principles rather than following protocols, add in optional elements to address other issues (e.g. depression, anxiety), reduce homework and out of session tasks (overly burdensome), cut back on worksheets (CPT) Representative Quote 1: *"There is this built-in pressure to get better, be better after the 12 sessions. It isn't realistic and then it leads to negative feelings of shame and guilt when that doesn't happen."* Quote 2: *"Often times there are issues of abandonment and disconnect from others. If someone gets into their trauma and begins to open up, it is incompatible with the "12 weeks and you are out" mentality. Then the termination itself isn't dealt with, or happens too soon, or both."*

Challenges Specific to the Veteran Population

One theme that emerged was that there are several challenges in attempting to implement EBPs for PTSD to veterans. The EBPs for PTSD were created and originally tested in civilian populations and then disseminated to the VA for implementation. The most prominent issue that was identified were the number of comorbidities and complexities inherent in the veteran population, both in terms of diagnostic profile as well as developmental and military trauma exposure (*typical*). An isolated diagnosis of PTSD was seen as uncommon among veterans, and the vast majority of trauma presentations were described as complex in nature and involved repeated exposures (such as with combat trauma) or occurred in the context of existing pre-military/developmental trauma. One clinician discussed this issue, *"The people we see… they need so much more. The traumas and the PTSD are so much more complex here. The sheer number of traumatic events presents a challenge… These guys have seen a lot."* The idea of choosing one "index trauma," which is required in both PE and CPT, was seen as potentially invalidating for a veteran who had experienced multiple or repeated traumatic events (*typical*). Other issues that emerged included veterans over-identifying with and developing attachment to

their trauma or diagnosis (becoming part of their veteran identity/experience or feeling that it is deserved because of what they did/did not do) (*variant*), the possibility of secondary gain for maintaining a PTSD diagnosis for service connected veterans (*variant*), and the role of both male and military cultural socialization on treatment-seeking and engagement (e.g. the "suck it up and drive on" mentality, avoidance of emotional experience) (*variant*).

Perceived EBP Effectiveness

There were somewhat mixed feelings about the effectiveness of the EBP treatments among clinicians. A major theme that was identified was that the EBPs are effective in some, but not all, cases. Overall, it was believed that many veterans who completed treatment demonstrated at least some improvement/symptom reduction (*general*). It was acknowledged that some veterans make very large gains (*typical*), and also that the treatments do not seem to work in every situation, or for every veteran (*general*). Dropout was also identified as a problem, with participants estimating that only about half of veterans who begin these treatments complete them (*general*). Several clinicians felt that the treatments were useful but not the only means of resolving PTSD (*variant*). One summarized, *"Different treatments work for different patients, and different clinicians. It is not just a 'one size fits all' model."*

Active Ingredients for Treating PTSD

The importance of facing and working through the traumatic event emerged as a salient theme regarding perceived active ingredients of treatment. Clinicians were in agreement that the principle of exposure was central to both treatments, and to the resolution of PTSD more generally (*general*), with the specific format and duration of exposure deemed to be less important (*typical*). Other core elements that were identified as curative included a "working through phase" for the trauma(s) (*typical*), emotional engagement and affective expression (*typical*), helping to put a traumatic event in context (*typical*), working through feelings of guilt/blame/shame (*typical*), acceptance (*variant*), having a corrective experience in therapy (*variant*), homework to facilitate behavioral changes (*variant*), and nonspecific/common factors such as the working alliance and unconditional positive regard (*variant*). These general principles of treatment were seen as more important than the specific EBP protocols. One stated, *"At the end of the day you really just have to be a good clinician. And that has nothing to do with the protocols or manuals. You have to trust yourself and connect to your patients."*

Treatment Structure and Process

Participants shared their thoughts on treatment adherence and the importance of fidelity versus flexibility. There was somewhat of a split between clinicians, with two separate themes identified. Some clinicians indicated that they follow the manual unless there is a reason why they feel that they can/should not (*variant*), and some noting that they prefer a flexible and more individualized application at baseline (*variant*). However, all agreed that at least occasional flexibility was useful or necessary at times (*general*). Flexibility consisted of altering treatment length, such as adding sessions to complete protocol tasks or allowing for extra sessions to address other events/stressors either during or after standard administration. Many clinicians indicated feeling the need for "wiggle room" in the manuals (*typical*). Pertaining to trauma disclosure, one stated, *"You have to understand that some of these people*

have held onto these stories for life. The treatments, as they are, make you feel like you have to rush it. Like you have to get them to tell you everything so quickly, right away, and that just isn't going to happen in a lot of cases. It takes time to get it out. We need to be willing to be there through the process, for however long it takes."

Suggested Changes/Improvements to EBPs

Clinicians had several suggestions for ways to change or improve the EBP treatments. The two most universal ideas involved the need for additional time and increased flexibility. While clinicians acknowledged not wanting to keep veterans in treatment longer than was necessary (*variant*), most felt that 12–15 sessions was simply not enough time to achieve all of the goals set out in the treatments (*typical*). The short time frame was also seen as problematic for working with PTSD due to needing time to build an alliance and help veterans open up and face the trauma (*typical*), dealing with process and interpersonal issues that are common in trauma populations (*variant*), and needing more attention to termination and feelings of abandonment once veterans have shared their narratives (*variant*). They also indicated feeling constrained by the lack of guidance on working flexibly with the manual and the lack of space to address other issues or work on associated problems (*variant*). One summarized both of the issues succinctly, *"The treatments need to be more flexible. They have to account for that. I mean, seriously, they would not be only 12 sessions. That is just not enough time."* Clinicians also expressed a strong interest in working with the principles of the treatments rather than following overly scripted protocols. One stated, *"I would move away from the specific manuals and focus on applying the general principles that cut across the trauma-informed treatments. There are key principles in both interventions, and they can be used interchangeably and together for the best effects."*

Discussion

The goal of the present study was to gain a deeper understanding of clinician experiences with, and perceptions of, two commonly used evidence-based psychotherapies for PTSD, Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE). These data enhance and extend existing work that has focused on understanding clinician decision-making with respect to determining if they want to utilize CPT/PE or not with individual veterans in their clinical practice [34]. Clinicians in the present study provided ample information about the perceived strengths and weaknesses of CPT and PE, as well as challenges they have experienced in trying to apply these civilian-developed treatments to veterans. Clinicians also shared their perceptions about the effectiveness of the treatments with veterans and their beliefs about the critical elements that are necessary to treat PTSD. Finally, they offered their thoughts on the tension between fidelity and flexibility, a common debate in the psychotherapy literature [43], and provided suggestions for how they would change or improve the EBPs if given an opportunity to do so.

Overall, clinicians offered a fairly balanced view of the treatments, speaking to both their strengths and weaknesses. The evidence-base and support within the VA for using EBPs was seen as a significant strength. Despite this, clinicians indicated feeling somewhat put off by perceived pressures to treat PTSD using only EBPs and the dismissal of alternative approaches. The short-term and structured nature of the treatments was seen as both a strength

and a weakness. Clinicians appreciated the focus on going directly after the trauma, though also found the proscribed session amounts fairly limited in terms of adequately meeting all treatment goals. Perhaps this conflict emerges from the tension between increasing access to care (seeing as many patients as possible in as short a time frame as possible), a context in which effective short-term treatments are helpful, and the desire clinicians have to provide high-quality, regular, and consistent care which can be a process and take time. This issue may be particularly relevant to VA clinicians in light of recent efforts to reduce or eliminate wait times [44, 45], and is also occurring as part of the larger healthcare system [46].

The primary weaknesses that were identified were not enough time built into the protocols and a lack of flexibility or sufficient guidance on how to use the manuals flexibly. This is interesting in light of recent research which has found that flexible administration, such as adding sessions to the CPT protocol, has no negative impact on treatment outcome [47]. This finding is also consistent with recommendations to apply manualized treatments flexibly in the veteran population, given their unique experiences, and to prioritize patient-centered delivery of evidence-based care [29]. More generally, it is possible that short-term treatments may not be as effective with veterans, as research has demonstrated the need for longer-term care to resolve more chronic symptom presentations [48, 49]. Other weaknesses that were noted included a narrow focus on only one trauma, too much structure in terms of session time and tasks (e.g. worksheets), and the general framing of the EBPs as a "quick fix" which is inconsistent with participants' clinical experience. The clinicians emphasized the nuanced and individualized nature of psychotherapy and felt that PTSD treatment should not be viewed or promoted as a "one size fits all" model.

Clinicians felt that the EBPs had significant utility in achieving symptom reduction and were very helpful for some veterans. This finding is consistent with research demonstrating that VA clinicians using EBPs for PTSD in their work generally rate PE and CPT as effective treatments [35]. However, in this sample of 128 providers, only 28.9% of clinicians rated PE as "very effective" and only 16.4% gave this same rating for CPT [35]. One possible interpretation of this finding is that some treatment providers may feel that there is room for improving existing treatments or their application. The present study provides some additional information about clinician perceptions of the EBPs and their strengths and weaknesses in more depth. While study clinicians had positive feedback about the treatments, they also felt that they did not seem to "fit" or work well for every veteran, and shared their feelings about the importance of alternative and/or more flexible approaches. This is consistent with research demonstrating the importance of perceived fit between patient attitudes/preferences and treatment approach [50, 51]. This finding is also consistent with meta-analytic research demonstrating that therapist adherence to a specific treatment protocol is not associated with symptom change [52]. Meta-analytic studies have found a lack of evidence that specific components of evidence-based treatments are responsible for treatment outcome [53], or a very modest impact of adding specific ingredients to treatment protocols in component studies [54].

Treatment issues such as high dropout rates were addressed, which is consistent with the literature documenting high rates of dropout from EBPs among veterans receiving mental health treatment in the VA [27, 55, 56], as well as high dropout rates generally for EBPs for PTSD [28]. Clinicians felt that most veterans who finished an EBP demonstrated at least some improvement by termination. However, many clinicians also felt that while the treatments were effective, they may not be "enough" for every veteran in terms of adequately resolving PTSD and being able to terminate from individual treatment. One study using veteran self-report to

measure outcome found overall symptom reduction but also relatively high symptom levels remaining at treatment termination in a naturalistic VA setting [27]. The general consensus seemed to be that the treatments had much to offer, but that in many cases something more was needed. This sentiment was expressed both in the context of broadening and extending existing treatments as well as the need to investigate and promote alternative approaches. Specific to existing treatments, clinicians felt that more time, flexibility, and guidance about working with more complex presentations would be helpful. More generally, they expressed an interest in treatments that were more principle than protocol-based, removing some of the step-by-step structure and allowing for more clinical freedom, judgment, and incorporation of other techniques as well as attention to nonspecific/common factors.

Implications for Policy and Practice

While the present study sample is small and the results should be considered preliminary in nature, it nonetheless offers a more nuanced and in-depth look at clinician perceptions and experiences using EBPs for PTSD than has been conducted to date. While the data should be interpreted with caution and not overgeneralized, they offer an important first step in helping to bridge the science-practice gap as it pertains to the use of evidence-based treatments for PTSD in the VA. These data suggest that much could be gained from increasing collaboration between academic contexts where treatments like CPT and PE are developed and clinicians working in naturalistic settings. Evidence-based practice is a cornerstone of our field and of the utmost importance to the viability of psychology as a science. Evidence-based practice is defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" [57]. An important component of this definition is the fact that research data need to be incorporated with other variables, a factor that is often neglected in the push to increase the use of evidence-based treatments. While it is critically important for our field to have treatments with a solid evidence base, research cannot and should not be the only determining factor in making complex treatment decisions when serving diverse populations. When treatments created in strictly controlled academic contexts attempt to be disseminated to complex clinical service delivery systems like the VA without adequate bidirectional feedback, challenges can ensue [16, 58]. The present example of EBPs for PTSD demonstrates that lack of engagement [59]; low utilization by clinicians [39], high dropout rates [26–28], and mixed feelings about the treatments may all play a role in creating barriers to effective implementation. It is important to work with all stakeholders of evidence-based treatments, including clinical providers and the recipients of psychological services, throughout the dissemination and implementation process. Identifying problems or challenges when attempting to use EBPs in real-world clinical practice can help better inform research and ultimately improve treatment effectiveness. Such efforts have the potential to result in protocol adaptations or modifications that may be more acceptable to clinicians and veterans, which would in turn make the treatments more likely to be valued and utilized. They may also reveal ways in which additional education and training in EBPs may aid clinicians in their implementation efforts and improve service delivery. Stakeholder feedback is also crucial to help develop alternative approaches when a specific protocol is deemed not to be a good fit. Treatment guidelines and institutional policies would likely be better informed by such feedback. More flexibility and openness to alternative approaches may also help to attenuate some of the ongoing debate and controversy surrounding treatment guidelines and their overemphasis on EBPs [*for some examples, see* 60, 61, *and* 19].

Limitations The current study has several limitations, most notably the very small sample of clinicians utilized in the focus groups. While qualitative data is labor intensive and necessitates smaller samples [62], it would have been preferable to have a larger, more diverse, and more representative sample of VA clinicians. The current sample is restricted to clinicians from one PTSD clinic in a New England VA, and it is unknown how much their opinions and sentiments may generalize to clinicians in other VAs in different parts of the country. The clinician sample was also fairly homogeneous (primarily female and white), and it would have been preferable to have had more diverse representation in terms of gender and race/ethnicity. The clinicians in the study had all previously elected to participate in a research study taking place in the PTSD clinic, and responses may therefore not generalize to clinicians who elected not to participate. However, despite the fact that clinicians were taking place in a research protocol, focus groups were framed as wanting to assess their experiences providing EBPs generally as part of their regular work in the clinic. Questions were tailored to their perceptions of the treatments in their own clinical practice and were not limited, or specific to, the therapeutic dyads participating in the research study. It is also important to note that participation in the research study did not request or encourage any deviation from how clinicians would naturally deliver these treatments (the goal was to examine treatments as they were naturally occurring, with limited interference from the research team). Furthermore, while a rigorous data analysis paradigm was employed, the interpretation of qualitative data always involves some inherent subjectivity. Focus groups were transcribed and not audio recorded, which opens up some potential for error or misunderstanding, even despite the use of member checking. Finally, focus groups consisted of colleagues and contained one supervisor/trainee pair. It is possible that the focus group format and the potential for group/ power dynamics may have impacted participant openness or willingness to disclose certain information.

Despite these limitations, the current study offers an in-depth look at the perceptions and experiences of a small sample of VA clinicians utilizing EBPs for PTSD in their routine clinical practice. Research of this nature therefore offers an important step towards bridging the science-practice gap by helping to understand the perspective of clinicians, the target audience for the dissemination and implementation of evidence-based treatments. In this way, it is our hope that this preliminary study sparks a conversation between practitioners and researchers on a larger scale, and may pave the way for productive discussions about ways to augment existing treatments or the possibility of creating alternative approaches. Over time, such discussions that bring together practitioners and researchers can only serve to inform and improve the treatment of PTSD within the VA, ultimately in service of the goal of better serving our nations veterans.

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Compliance with Ethical Standards

Conflict of Interest Jennifer Doran declares that she has no conflict of interest. McKenna O'Shea declares that she has no conflict of interest. Ilan Harpaz-Rotem declares that he has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Appendix

Clinician Focus Group Questions

The purpose of this focus group is to learn more about your experiences administering trauma-informed evidence-based psychotherapies for PTSD in a VA outpatient clinic. There are no right or wrong answers; rather, I am interested in your opinions, perceptions, and ideas. The information you provide will be reported collectively and without specific identifiers, and all data will be shared in aggregate form.

1. Is there a treatment model or approach you prefer when treating a veteran with PTSD (PE, CPT, something else)?
2. What do you think are the greatest strengths of the EBPs (PE and CPT)?
3. What do you think are the greatest weaknesses of the EBPs?
4. What have your experiences been like trying to administer trauma-informed EBPs for PTSD in the VA? Have you encountered any difficulties or problems with implementation?
5. Do you think there are any specific challenges in trying to apply the EBP protocols to a veteran population?
6. Do you believe that the EBPs are effective and should be considered first-line treatments for PTSD?
7. Do you believe that EBPs are effective a) all the time for everyone, b) in most cases, c) in some cases/some of the time, d) in a few/select cases, or e) never. Why? Who do you believe they are the most effective and appropriate for?
8. What would you change, if anything, about the EBP treatments?
9. What do you think are the most important interventions, techniques or therapy "ingredients" for treating PTSD? This can include techniques in or beyond the EBP models.
10. Have you treated PTSD successfully without using PE or CPT? If so, what have you used and what do you think made it an effective approach?
11. Do you prefer to administer PE and CPT as manualized, or do you tend to deviate from or personalize the protocol? How do you modify or change the protocols, if applicable?
12. Do you have any suggestions for improving the EBPs specifically, or the treatment of PTSD in the VA more generally?
13. If you were going to design a new treatment for PTSD, what might it look like? What elements would you include?

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