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Using Fidelity Assessments to Train Frontline Clinicians in the Delivery of Cognitive-Behavioral Therapy for PTSD in Persons with Serious Mental Illness

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Abstract

Objective—Despite the growth in empirically supported interventions for the treatment of serious mental illness, these evidence-based practices are often not available to clients seeking services. One barrier to dissemination has been the difficulty of training frontline clinicians. This study was conducted to evaluate whether frontline clinicians could be trained to implement an empirically supported cognitive-behavioral therapy (CBT) program for posttraumatic stress disorder (PTSD) in persons with serious mental illness by providing them with session-by-session feedback on practice cases using a standardized fidelity measure.

Method—Twenty-five clinicians at five agency sites were trained in the CBT for PTSD program and delivered it to 35 practice cases over a 6-month period. Weekly feedback based on recorded sessions was provided to clinicians using the fidelity scale, with a criterion of competence established to designate “certification” in the program. PTSD and depression symptoms were monitored over the course of treatment for the practice cases.

Results—Two clinicians dropped out, and of the 23 clinicians, 21 (91%) achieved certification in the CBT program with their first case, and the remaining two (9%) achieved it with their second case. PTSD and depressive symptoms in clients decreased significantly during treatment, suggesting clinical benefits of the program.

Conclusions—The results support the feasibility of training frontline clinicians in the CBT for PTSD program using regular feedback based on the fidelity measure, and indicate that most clinicians can achieve competence in the model with a single practice case.

Significant progress has been made in the development of effective interventions for the treatment of posttraumatic stress disorder (PTSD) over the past 25 years, with the strongest evidence supporting the efficacy of prolonged exposure therapy and cognitive restructuring (1). However, most research on the treatment of PTSD has been conducted in general population samples or with individuals exposed to specific types of traumas (e.g., combat,

rape). Furthermore, active psychosis or suicidal ideation have been generally accepted as contraindications to the treatment of PTSD (2). Because of these concerns about the clinical fragility of people with serious mental illnesses, until recently little attention has been paid to the treatment of PTSD in these individuals (3), despite their high rates of trauma exposure (4, 5) and co-occurring PTSD (6).

To address this problem, two clinical research groups have adapted treatment principles of PTSD based on research on the general population to persons with serious mental illness. Frueh and colleagues have developed and pilot tested an exposure therapy approach for individuals with a psychotic disorder (7, 8). Mueser, Rosenberg, and Rosenberg (9) developed a 12–16 week individual cognitive-behavioral therapy (CBT) program for clients with serious mental illness and PTSD. The program includes training in breathing retraining and education about PTSD, with a primary focus on teaching cognitive restructuring to address core beliefs related to trauma which are believed to underlie PTSD symptoms (10). Two pilot studies (11, 12) and one randomized controlled trial (13) support the feasibility and efficacy of this program.

Although one of the aforementioned controlled trials demonstrated clinical benefits of the CBT for PTSD program, the clinicians were mainly Ph.D. level therapists who were specifically hired and trained for the study. This raises the question of whether the program can be successfully implemented in more of a “real world” context in which publicly funded services are typically provided by clinicians who have less extensive formal training in the delivery of psychotherapy (14). As most public mental health services for clients with serious mental illness are provided by Master’s level therapists, there is a need to determine whether the CBT for PTSD program can be delivered with good fidelity by these clinicians.

There is strong evidence that frontline clinicians can be successfully trained to deliver CBT (15–19). Previous studies suggest that the best way to train clinicians at community agencies is through a review of the treatment model in a didactic seminar, followed by closely supervised case work (8, 20, 21). In this study, we evaluated whether frontline clinicians treating an ethnically-diverse, urban population could be trained in the CBT for PTSD program via training seminars, and by providing session-by-session feedback using a standardized fidelity scale. We report data on therapist fidelity to the CBT for PTSD model, clinician satisfaction with the training program, client retention in the program, and treatment outcomes for clients who participated as training cases.

Method

The study protocol, informed consent, and all study-related materials were reviewed and approved by the Institutional Review Boards at XXX. The program for training clinicians in the CBT for PTSD model was developed as part of an NIMH grant to evaluate the model when delivered by frontline clinicians in a randomized controlled trial. Although the costs of weekly supervision and expert consultation (described below) were covered by the grant, clinicians billed available insurance for the CBT sessions.

Therapist Training, Supervision, and Fidelity Monitoring

The trained therapists were frontline clinicians employed by a large, public sector mental health provider serving primarily low income, inner-city clients. This agency employed over 41 clinicians and the participating therapists either volunteered directly for the training or expressed interest and were approved by their administrators to participate. In order to maintain continuity in the usual care clients were receiving, their current treating clinician or case manager did not provide the PTSD treatment. However, as the clinicians who treated

PTSD were members of clients' treatment teams, the CBT program was fully integrated with other mental health services that clients were receiving.

PTSD Treatment Clients

Training cases were clients with serious mental illness who were recruited from the same large, urban mental health agency employing the trainee therapists. Clients were enrolled in partial day hospital programs or outpatient treatment programs. As part of the agency's commitment to better identifying and treating clients with comorbid PTSD, screening was introduced as part of the standard intake procedure. Clients were first screened with a brief trauma history questionnaire, followed by (if they reported experiencing any traumatic event in their lifetime) a self-report PTSD screening measure (see Measures). If they met criteria for a probable diagnosis of PTSD, they were then asked if they wanted more information about the treatment study. All participants gave written informed consent, and were offered a \$30 dollar honorarium for participation in the assessments.

Eligibility criteria for participation were: (1) primary chart diagnosis of major depression, bipolar disorder, schizophrenia, or schizoaffective disorder; (2) met State of XXX criteria for serious mental illness, including functional disability with minimum 2 years duration; (3) had a current diagnosis of PTSD, confirmed through clinical interview; (4) were at least age 18 and capable of providing informed consent; (5) had no psychiatric hospitalizations or suicide attempts in the prior 2 months and were not dependent on substances in the prior 3 months; (6) had sufficient fluency in English to participate in the treatment and complete the assessments.

Measures

CBT for PTSD Fidelity Scale

The format of this scale was based on the Problem-Solving Treatment Adherence and Competence Scale (PST-PAC) developed by Hegel and colleagues (22), a 7 item, 5-point Likert scale measure designed to evaluate the ability of family medicine residents to implement a manualized problem solving intervention for depression in primary care. Like the PST-PAC, the CBT for PTSD Fidelity Scale was developed to provide a combined measure of adherence to and competence in implementing the CBT for PTSD model, which together are conceptualized as "fidelity" to the program. The scale includes 17 items, each rated on Likert-scales (1–5), about the quality of teaching specific components of the CBT program (e.g., psychoeducation, breathing retraining, cognitive restructuring), structuring of the session (e.g., agenda setting, homework review), the interpersonal effectiveness of the therapist, and overall session quality. Ratings of 1 or 2 represent unacceptable fidelity, ratings of 3 represent minimally acceptable fidelity, while ratings of 4 or 5 represent good or excellent fidelity. The scale was used to monitor therapist fidelity in the first controlled trial of the CBT program (13). A copy of the scale is included as an Appendix to this article.

For the present study, following training on use of the scale, the intraclass correlation coefficient for five raters across all the items on the scale, based on 30 co-rated sessions, was .82, indicating good inter-rater reliability. Coefficient α for the early sessions of the CBT for PTSD program (session 1–3), including the 12 items that were rated for all of these sessions (agenda setting, homework review, use of educational materials, psychoeducation, assignment of homework, trauma focus, manual adherence, teaching effectiveness, interpersonal effectiveness, pace of session, reduction of client stress, and overall session quality), was .84, indicating satisfactory internal reliability. Similarly, coefficient α for the later sessions of the program (sessions 4–16), including the 12 items that were rated for these sessions (agenda setting, homework review, cognitive restructuring, development of action plans, assignment of homework, trauma focus, manual adherence, teaching

effectiveness, interpersonal effectiveness, pace of session, reduction of client stress, and overall session quality) was .90, indicating high internal reliability.

Clinician Satisfaction

Two years after the initial training conference, therapists were asked to rate their satisfaction with the supervision and the written fidelity ratings in terms of perceived helpfulness to the clinician (0 = did not help; 1 = helped; 2 = helped very much), as well as their overall training experience (0 = unsatisfactory; 1 = satisfactory; 2 = excellent). These data are presented in Table 1.

Trauma and PTSD Screening

An abbreviated 16-item version of the *Traumatic Life Events Questionnaire* (TLEQ) (23) was used to screen lifetime trauma history for all clients at the agency. This version of the TLEQ has been successfully used to screen for trauma exposure in previous research on the CBT for PTSD program in this population (13). It assesses the presence of the types of trauma experienced by the participant (e.g., “Has anyone threatened to kill you or seriously hurt you?”).

The *PTSD Checklist* (PCL) (24) was used to screen and identify cases with probable PTSD. The PCL includes one question for each DSM-IV PTSD symptom, requiring the respondent to rate the severity of each symptom over the past month on a 5-point (1–5) Likert scale (range: 17–85). The PCL has good test-retest reliability and convergent validity in people with serious mental illness (25). A total score of 45 or greater on the PCL was used to identify cases of probable PTSD (24).

Symptom Monitoring

The severity of PTSD and depressive symptoms were monitored over the course of the CBT program following the procedures outlined in the treatment manual (9). PTSD symptoms were assessed using the PCL. Depressive symptoms were monitored with the *Beck Depression Inventory* (BDI-II) (26). The BDI-II is a commonly used self-rating scale that contains 21 items, each rated on a four-point (0–3) Likert scale (range: 0–36). Scores of 0 to 10 define the normal range, scores of 11 to 16 define “mild” depression, scores of 17 to 30 define “moderate” depression, and scores of 31 and higher define “severe” depression (27).

The self-report symptom assessments were completed by the client at the beginning of the first CBT session, every third session thereafter, and again at the last session. The results of these assessments were reviewed by the therapist with the client immediately after they were completed, with the therapist often working with the client to address distressing symptoms during the treatment session. For example, if a client reported a high level of distress on the PCL item “Repeated, disturbing memories, thoughts, or images of the stressful experience,” the therapist might suggest helping the person use cognitive restructuring to address those feelings.

The CBT for PTSD Program

The program is provided over 12–16 weekly sessions, guided by three main therapeutic aims (9): 1) to provide education to help clients conceptualize their trauma-related symptoms as common, learned responses to a traumatic event; 2) to teach clients a breathing retraining skill to help them manage and reduce anxiety; and 3) to teach clients the skill of cognitive restructuring to enable them to cope with and change their upsetting emotions through identifying and challenging maladaptive thoughts and beliefs which are often related to their traumatic experiences. Homework assignments are developed at the end of each session to

promote generalization of skills learned in therapy to daily living. The program includes client handouts and worksheets, and provides clinicians with both clear structure and goals, while also permitting flexibility in tailoring the material to clients' personal experiences and current circumstances, as well as guidelines for dealing with common challenges related to serious mental illness, such as affective instability, cognitive impairment, and psychotic symptoms.

Procedures

The methods for training clinicians included didactic presentations, directed reading, watching videotapes of treatment cases, role-plays, supervision, and fidelity-based feedback on practice cases. Following an initial two-day on-site training conference, each clinician treated a minimum of one practice case in the CBT program. Sessions were audio-recorded and reviewed by clinical supervisors or expert consultants for quality and fidelity. A one-day follow-up training was conducted one-year after the initial training. On-site weekly group supervision was provided by one of two clinical supervisors, with one of three expert consultants usually joining by telephone. Clinic administrators ensured that time was reserved in clinicians' schedules for the CBT sessions, supervision, and attendance at the training conferences.

The two supervisors were Ph.D. clinical psychologists. One supervisor (XXX) had formerly been a member of the clinical staff at one of the sites, where he had received training in the CBT program and had subsequently supervised clinicians at that site in implementing the program for a pilot study (11). The second supervisor (XXX) participated in a subsequent training in the CBT program, and treated one case with the program while receiving weekly supervision from one of the consultants prior to supervising the frontline clinicians for this project.

The two on-site supervisors and one of the consultants (XXX) were trained in the use of the CBT for PTSD Fidelity Scale by the other two consultants who developed the scale (XXX, XXX). The items on the scale were first reviewed together, followed by discussion of ratings over a series of jointly rated sessions. Finally, inter-rater reliability of ratings was assessed, as previously described in the CBT for PTSD Fidelity Scale section.

Narrative and quantitative fidelity feedback on the CBT for PTSD Fidelity Scale were sent via e-mail to each therapist trainee by one of the supervisors or consultants usually within a week of completing each session (and in most cases, prior to the subsequent session with that client). Group supervision involved a review of the progress of each of the therapists' clients, including new data on PTSD and depression monitoring when available, discussion of challenges and potential solutions, and occasional role plays to practice or demonstrate skills for implementing the program and addressing challenges. Supervision did not involve formally reviewing the feedback to the therapists on the CBT for PTSD Fidelity Scale, although therapists had the opportunity to ask questions about the feedback if they chose. The on-site supervisor led the weekly supervision sessions, with the consultants providing additional feedback as needed. The supervisors also collected the progress notes, BDI and PCL sheets completed by clients, and audio-recorded therapy sessions during supervision.

All clinicians completed at least one practice case with a client in the CBT for PTSD program. If a client dropped out before completing the program, then the clinician treated another practice case. A criterion level of skill in treating the practice cases was established with the fidelity scale in order to "certify" therapists as competent at providing the CBT for PTSD program. Because cognitive restructuring is introduced in the fourth session, which is assumed to be the most critical therapeutic method in the program for improving PTSD (9), "certification" in the program was defined as achieving an average overall fidelity rating of

at least 3.5 (between “adequate” and “good”) on the fourth through last session of a completed case. Clinicians whose average score fell below this criterion with their first case treated a second practice case, which was monitored with feedback provided using the same procedures as with the first case.

Results

Therapist and Client Characteristics

A total of 25 frontline clinicians were trained to provide the CBT for PTSD program. Two clinicians dropped out of the training. Key characteristics of the therapists trained are presented in Table 1. The treated clients' characteristics are summarized in Table 2.

Therapist Fidelity Ratings

A total of 285 CBT sessions from the 25 clinicians were rated for fidelity, with a mean of 11.40 sessions per clinician ($SD = 6.73$, number of rated sessions ranged from 2 to 30 per clinician, mode = 14, median = 10.5). Among the 23 clinicians who completed the training, 21 (91%) met the certification criterion for competence in the CBT for PTSD program with their first completed practice case, and the remaining two clinicians met the criterion with their second practice case. Fidelity ratings are summarized in Table 2. Fidelity ratings averaged 3.6 or above for almost all components of treatment, indicating that clinicians provided the program with good to excellent fidelity across most of its components.

Therapist Satisfaction Ratings

Satisfaction ratings are summarized in Table 1. On average, clinicians reported that the on-site group supervision was “very helpful,” and the written fidelity feedback was between “helpful” and “very helpful,” with the mean closer to the latter. They all rated the training experience as “excellent.”

Client Retention in Treatment

We defined treatment drop-out *a priori* as failure to complete at least half (6) of the minimum 12 sessions specified in the CBT program (12), in order to ensure that clients would receive at least 3 sessions of cognitive restructuring. Using this criterion, 8 of 34 (or 24%) of clients enrolled in the program dropped out of treatment. A variety of reasons for drop-out were identified, including ongoing litigation related to trauma that exacerbated symptoms, medical problems, and leaving or being transferred out of the program treatment center. Among the remaining 26 clients, 24 clients completed the 12–16 session CBT program. One client completed 8 sessions, but terminated early in order to enter a substance abuse rehabilitation program. Another client terminated after 10 sessions by mutual agreement with the therapist that she had gained maximum benefit from the program. There were no differences between clients who were exposed to the program and those who dropped out in demographic or clinical characteristics at baseline (Table 1).

Treatment Outcomes

The effectiveness of the CBT program for PTSD was assessed by evaluating improvement in client self-reported PTSD and depressive symptoms on the PCL and BDI-II, respectively, administered at the first session and every third session thereafter. The means for the PCL and BDI-II for clients who completed the program are depicted in Figure 1. The participants' PCL scores between the screening ($M = 58.46$, $SD = 15.85$) and at the first session ($M = 57.48$, $SD = 11.09$) were not significantly different.

To evaluate statistical change, we fit random intercept and random slope models for the BDI-II and PCL outcomes (28). Results indicated a significant decline both BDI-II and PCL symptom severity over time, with an average rate of decline for BDI-II of 4.05 points per assessment, and a decline of 5.02 points on the PCL per assessment ($ps < .001$). Random slopes (variation of individual slopes around average) were marginally significant for both BDI ($p = .08$), and PCL ($p = .09$), indicating marginally significant variation among the clients in their rate of improvement in PTSD and depressive symptoms over time.

Discussion

The results indicate that frontline clinicians can be trained to deliver the CBT for PTSD program to a criterion level of competence. Among the 23 clinicians who participated in the training, 21 (91%) achieved “certification” in the CBT for PTSD program with their first practice case, and the other two clinicians achieved it with their second case. Thus, following an initial training and with weekly supervision meetings and fidelity-based written feedback, high levels of competence in the CBT for PTSD treatment model were attained by all of the clinicians working with typical clients with serious mental illness, usually with a single practice case.

The clients who participated as training cases demonstrated substantial and clinically significant improvements in PTSD symptoms and depression severity when treated by Masters’ level clinicians who were learning the CBT for PTSD program. The average score on the PCL did not decline significantly from the initial screening (58.46) to the first CBT session approximately three weeks later (57.48), but then fell steadily every three sessions to a final score of 33 at the last treatment session, below the cut-off score of 45 used to screen for PTSD cases. The average score on the BDI-II fell from 38 at the first treatment session, considered “severe” depression, to 8 at the last session, which is in the “normal” range (27). These practice cases were receiving other standard services for their disorders, and minimal exclusion criteria were required for clients to participate in the program. Thus, these training cases were similar to other clients with serious mental illness and PTSD at the agency, suggesting that the skills for treating these clients may generalize to the broader population of clients for whom the program was developed.

The clinical improvements in the practice cases are similar to the reductions in PTSD symptom severity and depression observed in the initial pilot study and randomized controlled trial of the CBT for PTSD program (12, 13). These results provide external validation for the effectiveness the training program and certification process by demonstrating clinical improvements based on independent ratings of symptom severity by the clients themselves. The findings are also encouraging because they suggest that implementing the training program for frontline clinicians was associated with immediate benefits in improved PTSD and depressive symptoms to the first clients with serious mental illness who received the intervention. Thus, there did not appear to be a significant “learning curve” for clinicians to develop competence in the program and provide clinically effective treatment.

The drop-out rate of clients in the CBT for PTSD program was 26%. This is similar to the rates of drop-out reported in two previous open clinical trials of this program for clients with serious mental illness, including 14% in the New Hampshire study (12), 26% in the New Jersey trial, as well as the rate of 19% in the New Hampshire-Vermont randomized controlled trial (13). A slightly higher drop-out rate (35%) was reported in a small open trial of an exposure therapy-based program for PTSD in people with schizophrenia or schizoaffective disorder (29). In addition, a meta-analysis of 34 randomized controlled trials of CBT for psychosis reported that seven studies (21%) had drop-out rates higher than 25%

(30). These findings suggest that the rate of drop-out in the present sample was comparable to that found in other studies of the CBT for PTSD program, as well as studies of CBT for psychosis.

In addition to the success of the training model in teaching the CBT for PTSD program to frontline clinicians, and the positive clinical outcomes of the training cases, the therapists reported high levels of satisfaction with the training. All of the clinicians rated the training experience as excellent, 92% found the supervision very helpful, and 83% reported that the written fidelity feedback was very helpful. Furthermore, only two of the 25 clinicians (8%) dropped out of the training, providing some additional evidence of therapist satisfaction with the training experience. Two aspects of the training experience may have contributed to the satisfaction of the clinicians with the process. First, the session-by-session feedback, including quantitative and narrative input based on the fidelity scale, may have provided timely reinforcement to clinicians for effective implementation of the treatment model, and recommendations for change that enabled them to modify and improve their skills over the course of therapy. Second, the routine monitoring of PTSD and depressive symptoms during the treatment program, which indicated an average reduction of about 5 points for PTSD symptoms on the PCL and 4 points for depressive symptoms on the BDI-II every three sessions, may have provided therapists with concrete evidence of their clinical effectiveness, contributing to feelings of personal and professional satisfaction.

The present findings suggest that the CBT for PTSD program, and the approach to training clinicians in the model, has promise for addressing the lack of access to evidence-based practices for treating PTSD in the serious mental illness population (3). The fact that a large number of clinicians working at five different sites with an ethnically and racially heterogeneous population of clients with serious mental illness could be successfully trained in the model provides additional support for the potential generalizability of the treatment model and training approach. It should be noted that the CBT for PTSD Fidelity Scale was primarily used in this study as a tool to facilitate the training of frontline clinicians, and to ensure that they met a minimum level of competence in delivering the program, prior to treating clients in a controlled evaluation of the program. Subsequent research using the scale in this project will address whether certified therapists maintain acceptable levels of fidelity after the initial training period, and explore the potential relationship between therapist fidelity to the CBT model and client outcomes.

There are some study limitations that should be noted. First, the therapists were volunteers, and may not be representative of all clinicians at the sites. Second, we do not know if the therapists continued to use the model with fidelity once intensive supervision ended. Third, although client self-reports indicated significant improvements in PTSD and depressive symptoms over the course of treatment, assessments by independent evaluators were not conducted, nor were outcomes of the treated clients compared to a control group. Despite these limitations, this study supports the feasibility and utility of the model employed for training frontline clinicians to provide the CBT for PTSD program to clients with serious mental illness.

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Appendix CBT for PTSD Fidelity Scale

Therapist: _____ Location: _____

Client ID: _____ Session #: _____ Date of Session: _____

Rater: _____ Date of Rating: _____

For each item, assess the therapist on a scale of 1–5 and record the rating on the line next to the item number.

	1	2	3	4	5	NA
	Poor	Borderline	Satisfactory	Good	Excellent	Not Applicable
____ 1. Agenda Setting						
	Articulate specific agenda					
	Identify other issues					
	Implement specific agenda					
____ 2. Homework Review						
	Review prior homework					
	Praise all efforts					
	Troubleshoot obstacles					
____ 3. Overview of Program						
	Focus of treatment program					
	Length of program & logistics					
	Description of treatment components					
____ 4. Crisis Plan						
	Rationale					
	Discussion of nature of crises					

- Warning signs of crisis
- Identification of resources
- Discussion of response plan
- Written crisis plan
- ____ 5. **Breathing Retraining**
 - Rationale
 - Explanation
 - Demonstration
 - Practice by client
- ____ 6. **Use of Educational Materials**
 - Utilize handouts & worksheets
 - Distribute & review materials
 - Elicit & answer questions
- ____ 7. **Psychoeducation**
 - Information about trauma & PTSD
 - Information about associated symptoms
 - Elicit client's symptoms
 - Answer questions
- ____ 8. **Cognitive Restructuring**
 - Thought-feeling model
 - Connect negative feelings to thoughts
 - Challenge thoughts
 - Generate alternative thoughts
 - Practice alternative thoughts
- ____ 9. **Development of Action Plans**
 - Identify realistic concerns
 - Establish feasible goal
 - Explore possible options
 - Develop specific plan to address problem
- ____ 10. **Trauma Focus**
 - Effects of trauma & PTSD on functioning
 - Monitor & discuss PTSD symptoms
 - Connection between trauma & beliefs
 - Challenge trauma-related beliefs
 - Cope with traumatic memories
- ____ 11. **Assign Homework**
 - Develop homework assignment
 - Collaborate with client
 - Make specific plan
 - Troubleshoot obstacles
- ____ 12. **Manual Adherence**
 - Follow session format
 - Use of manual rationale & teaching strategies
 - Show flexibility in face of problems
- ____ 13. **Teaching Effectiveness**

- Instill motivation to learn information & skills
- Teach information & skills
- Modeling/Practice of skills
- Adaptation of skills as needed
- Reinforcement of small steps/Shaping
- Encouragement
- Use significant others to facilitate learning

____ 14. **Interpersonal Effectiveness**

- Facilitate communication (empathic nature)
- Use client's own language & phrases
- Warm/Confident/Professional
- Provision of hope

____ 15. **Pacing and Efficient Use of Time**

- Session length kept to 1 hour
- Efficient structuring of time
- Tactful limiting of peripheral & unproductive discussion

____ 16. **Reduction of Client Distress**

- Identify & respond to client distress
- Empathy to show understanding
- Use of education or CBT skills to reduce distress
- Make plan to address persistent distress

____ 17. **Overall Session Quality**

Figure 1.

Results of Client Outcomes among CBT Completers (N = 26)

Note. BDI= Beck Depression Inventory-II, scores range 0–36 with high scores indicating more severe depression; PCL = PTSD Checklist, scores range 17–85 with high scores indicating more severe PTSD.

Table 1

Characteristics of Participating Clinicians

	<u>N</u>	<u>%</u>
Age		
40 and above	12	48
Below 40	13	52
Gender		
Male	5	20
Female	20	80
Race/Ethnicity		
White	17	68
African American	5	20
Hispanic	1	4
Asian	2	8
Other	0	0
Discipline		
Social Worker	8	32
Certified Counselor	6	24
MA level Psychologist	4	16
Intern (Psychology, Social Worker)	5	20
Nurse	1	4
Ph.D. level psychologist	1	4
Highest Degree		
Bachelor level	1	4
Master level	23	92
Ph.D. level	1	4
Type of service program		
Outpatient	11	44
Partial Hospitalization	14	56
	<u>Mean</u>	<u>SD</u>
# years in profession	10.08	7.14
Satisfaction with onsite group supervision	1.92	0.29
Satisfaction with written feedback	1.83	0.39
Satisfaction with overall experience	2.00	0.00

Note: Satisfaction with supervision and feedback ratings based on: 0 = did not help, 1 = helped, 2 = helped very much; satisfaction with overall experience ratings based on: 0 = unsatisfactory, 1 = satisfactory, 2 = excellent.

Table 2

Clinical and Demographic Characteristics of CBT for PTSD Program Participants

Demographic/Clinical Characteristics	Participants (N = 35)		Program Completers (N = 26)	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Male Gender	10	29	7	27
Race				
African-American	12	34	7	27
European-American	18	51	15	58
Hispanic	4	11	3	12
Other	1	2	1	4
Marital Status				
Never Married	26	76	18	69
Divorced/Widowed/Separated	8	31	7	27
Married	1	4	1	4
Psychiatric Diagnoses				
Schizophrenia/Schizoaffective	12	34	11	31
Bipolar/Major Depressive	23	66	15	43
Trauma History*				
Car Accidents	8	30	5	26
War	5	18	4	21
Sudden Death	19	70	14	74
Robbery	10	37	6	32
Victim of Community Violence	14	52	10	53
Witnessing Community Violence	15	56	9	47
Being threatened	18	67	11	58
Child physical abuse	17	63	12	63
Witnessing Domestic Violence	21	78	16	84
Domestic Violence	19	70	14	74
Childhood Sexual Assault by older people	18	67	14	74
Childhood Sexual Assault by peers	12	44	9	47
Adult Sexual Assault	12	44	9	47
Being Stalked	15	56	10	53
Other	12	44	7	37
	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>
Age	45.29	10.65	46.52	10.49
Education	12.17	1.89	12.08	1.98

Note.

* Participants (n=35), Treatment completers (n=26)

Table 3

Ratings on the CBT for PTSD Fidelity Scale for 25 Clinicians on their First or Second Practice Cases

	<u>Sessions 1–3 (N = 71)</u>		<u>Sessions 4–16 (N = 214)</u>	
	<u>M</u>	<u>S.D.</u>	<u>M</u>	<u>S.D.</u>
Agenda Setting	3.79	.90	4.20	.97
Overview of Program	4.17	.94	4.00	1.00
Pacing and Efficient Use of Time	4.04	.85	4.16	.92
Manual Adherence	4.49	.74	4.36	.81
Crisis Plan	3.81	.83	4.43	.79
Breathing Retraining	4.17	.75	4.17	.75
Use of Educational Materials	4.30	.61	4.29	.74
Informative Psychoeducation	3.94	.81	3.95	.60
Effective Cognitive Restructuring	NA	NA	3.90	.82
Development of Action Plans	NA	NA	3.82	.88
Trauma Focus	NA	NA	3.89	1.11
Homework Review	3.86	.99	3.97	.89
Assign Homework	3.63	1.00	3.80	.93
Teaching Effectiveness	4.26	.73	4.13	.89
Interpersonal Effectiveness	4.54	.63	4.61	.58
Reduction of Client Distress	4.33	.72	4.10	.75
Overall Session Quality	3.91	.68	3.91	.76

Notes: Possible scores on each item of the Fidelity Scale range from 1 to 5 with higher scores corresponding to better fidelity.

Ratings were based on 285 sessions, among which 71 sessions were at or before session three, while 214 sessions were from session 4 till 16. Cognitive restructuring started at session 4.