

If you or your patients would like to provide feedback or suggestions about your experience with the Seeking Safety treatment, please fill out the survey below. At the end of the survey is information about where to send it in. Thanks!

Seeking Safety -- Feedback Questionnaire

Your honest feedback about the Seeking Safety treatment would be greatly appreciated so that possible future revisions can be as helpful as possible. **Both patients and clinicians can fill out the first two pages; the third page is for clinicians only.** Return the form by mail, fax, or email (see last page); and answer only the questions you choose to. Thank you!!

How many sessions of Seeking Safety have you done?

Please use the following scale:

-3	-2	-1	0	+1	+2	+3
Greatly harmful	Somewh at harmful	A little harmful	Neutral	A little helpful	Somewh at helpful	Greatly helpful

★ How helpful is THE TREATMENT ★

- ___ How helpful is the treatment *overall*?
- ___ How helpful is the treatment *for PTSD and substance abuse*?
- ___ How helpful is the treatment *for PTSD alone*?
- ___ How helpful is the treatment *for substance abuse alone*?

★ How helpful are each of the SESSIONS ★

- | | |
|---|---|
| ___ Safety | ___ Commitment |
| ___ PTSD: <i>Taking Back Your Power</i> | ___ Red and Green Flags |
| ___ Detaching from Emotional Pain (Grounding) | ___ Substance Abuse: <i>When Substances Control You</i> |
| ___ Asking for Help | ___ Community Resources |
| ___ Compassion | ___ Recovery Thinking |
| ___ Taking Good Care of Yourself | ___ Healthy Relationships |
| ___ Setting Boundaries in Relationships | ___ Getting Others to Support Your Recovery |
| ___ Honesty | ___ Healing from Anger |

- Discovery Self-Nurturing
- Fighting Triggers Integrating the Split Self
- Respecting your Time Life Choices Game (review)
- Creating Meaning Termination

★ How helpful are the PARTS of the manual ★

- *Safety* as the priority of treatment
- The *integrated* treatment (the focus on both PTSD and substance abuse)
- The focus on *abstinence from all substances*
- The focus on *ideals* (e.g., honesty, compassion)
- The focus on *learning coping skills*
- The focus on *cognitive* skills
- The focus on *behavioral* skills
- The focus on *interpersonal* skills
- The focus on *community resources*
- The use of *quotations*
- The *check-in / check-out* (if any parts you didn't like, write on back of pg.)
- The *patient session handouts*
- The *Commitments* ("homework")
- The *Safe Coping List* (e.g., "persistence")
- The *Safe Coping Sheet* (i.e., "old" versus "new" way)
- The *Core Concepts of Treatment*
- The *list of further resources* outside this treatment
- The *length of treatment* (25 sessions)

- ___ The *amount of written material* provided in the manual
- ___ The *illustrations*
- ___ The *structured approach* (the organized, session-by-session plan)
- ___ The *empirical basis* of the treatment (i.e., it has been scientifically evaluated)
- ___ Other: _____ (add more on back of page if needed)

The next four questions are for clinicians only:

- ___ The *therapist guide* for each session
- ___ The *bibliography* of further reading
- ___ The “*tough cases*” section
- ___ The emphasis on *therapy process* (e.g., countertransference)

Please rate the next 4 questions 0% (not at all) to 100% (totally):

- How *frequently will you use* what you learned in this treatment in the future _____%
- How *easy to understand* is this treatment? _____%
- How *innovative* (creative, different from other treatments) is this treatment? _____%
- To what extent would you *recommend* this treatment to someone else? _____%
- How *long* did it take you to feel *comfortable* with this treatment? _____
(please answer using a time frame, e.g., 1 week, 6 months, etc.)
- **YOUR AGE:** _____ **YOUR GENDER:** __Female __Male
- **HAVE YOU EXPERIENCED:** [*clinicians: please answer this question too*]
TRAUMA No/Yes **PTSD** No/Yes **SUBSTANCE ABUSE** No/Yes

★ IN YOUR OWN WORDS ★
(please write answers on back of page)

- What do you consider the *best / worst aspects* of the treatment program?
- What *modifications* would you like to see made to the program (e.g., longer? shorter? topics to add? topics to delete?)
- Are there particular *types of people* you feel the program is especially helpful / unhelpful for?
- Any *other comments*?

THANK YOU! Please return this survey in any of the following ways:
Mail: Lisa Najavits, McLean Hospital, 115 Mill St., Belmont MA 02478
Fax: 617-855-3605
Email: <Lnajavits@hms.harvard.edu>
 Note: If you would like to be on the mailing list for future publications/materials on PTSD and substance abuse, feel free to send your address and write “Add to mailing list”.

FOR CLINICIANS ONLY

★ YOUR PROFESSIONAL BACKGROUND ★

- **THEORETICAL ORIENTATION** (please fill in percentages to total 100%)
[Note: if you are eclectic, please identify the percentage of each orientation you use, or else fill in "no model" if you do not follow any orientation.]

___ Cognitive-behavioral
___ 12-step
___ Psychodynamic / Psychoanalytic
___ Systems
___ No model
___ Other: _____

___ **TOTAL [above should total 100%]**

- **PRIMARY DIAGNOSES OF YOUR PATIENT POPULATION** (please total to 100%):

___ Substance Abuse
___ Trauma Survivors/PTSD
___ Affective Disorders (e.g., depression, bipolar disorder)
___ Psychosis
___ Personality Disorders
___ _____ (Other)

___ **TOTAL [above should total 100%]**

- **YOUR WORK SETTING** (check all that apply):

___ Outpatient clinic ___ Private practice ___ Inpatient ___ Detox ___ Residential ___ Prison
___ VA ___ Other: _____

- **PRIMARY POPULATIONS THAT YOU WORK WITH** (check all that apply):

___ Geriatric ___ Adult ___ Adolescent ___ Child ___ Males ___ Females ___ Veterans ___ Prisoners
___ Other: _____

- **HOW MANY HOURS PER WEEK** do you currently spend *directly treating patients* ___

- **YEARS EXPERIENCE:** _____ (only include years after training). If you are in training now, how many years of training have you had thus far? _____

- **YOUR PROFESSIONAL TRAINING** (check all that apply). [If you are currently in training, check off the training program you are in.]

___ Social worker (MSW, LICSW) ___ Certified alcohol/drug counselor (CAC)
___ Doctoral-level psychologist (PhD, PsyD, EdD) ___ Master's-level psychologist (MA/MS)
___ Psychiatrist (MD) ___ Pastoral counselor ___ AA (or other 12-step) sponsor
___ No professional training ___ Other: _____

- **HOW MANY TREATMENT MANUALS HAVE YOU READ?** _____

Please answer each below 0% (not at all) to 100% (totally)

- How much do you *enjoy conducting clinical work*? _____%
- How "*burned out*" do you feel by your clinical work? _____%
- How likely is it that you would *choose a career as a clinician again* _____%
- How *effective a clinician* do you believe you are in general? _____%
- How would you rate your current *ability* to conduct this treatment? _____%

- How helpful would it be to have a *videotape* to accompany the manual, demonstrating actual in-session techniques/procedures? _____%
- What kind of *training or experience* do you think is necessary for a clinician to successfully use this treatment program? (write on back of page)