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When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors

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ABSTRACT

To investigate when and why therapists opt for or rule out imaginal exposure (IE) for patients with posttraumatic stress disorder (PTSD), 255 trauma experts were randomized to two conditions in which they were presented with four cases in which the patients' comorbidity and treatment preferences were manipulated. The results confirmed IE to be an underutilized approach, with the majority of professionals being undertrained in the technique. As predicted, the patient factors influenced the expert's choice of therapy: in case of a comorbid depression, IE was significantly less preferred than medication. Also, IE was significantly more likely to be offered when patients expressed a preference for trauma-focused treatment. The therapist factors were also found to be importantly related to treatment preferences, with high credibility in the technique being positively related to the therapists' preference for IE. Perceived barriers to IE, such as a fear of symptom exacerbation and dropout, were negatively related to the perceived suitability of the treatment when patients had suffered multiple traumas in childhood. The results are discussed in the light of clinical implications and the need of exposure training for trauma professionals.

Despite the strong evidence for the efficacy of exposure techniques in the treatment of posttraumatic stress disorder (PTSD; Cahill, Rothbaum, Resick, & Folette, 2009), the approach is underutilized in clinical practice (Becker, Zayfert, & Anderson, 2004; Rosen et al., 2005). In their survey, Becker et al. (2004) showed that a large majority (83%) of the 207 licensed doctoral-level psychologists questioned never opted for exposure therapy to treat their PTSD patients. But what are the reasons for this underutilization? Why do therapists fail to exploit exposure-based treatments for this population in spite of their proven effectiveness? Which therapist-related and patient-related factors are implicated here and how do they interact (Becker, Darius, & Schaumberg, 2007)? Although mostly explorative in nature, some studies have begun to delineate predictive factors of clinicians' treatment preferences. To add to the existing knowledge, apart from a comprehensive therapist survey, we conducted a controlled study among experts working in this trauma field in which we evaluated the effects of several therapist and patient factors on the preference for one of four recommended and widely used treatments for PTSD.

Therapist factors

Training in and experience with exposure for PTSD are likely to influence the decision to use the approach. When Becker et al. (2004) asked the practising psychologists in their survey to rate these two factors, they found that only 31% had had formal training in the use of imaginal exposure (IE) and that this group was more likely to report current use of the technique than the untrained respondents. When asked to list the factors that prevented them from using IE, the respondents indicated limited training (60%) as the most important factor. Sprang, Craig, and Clark (2008) found that specialized trauma training resulted in a more frequent use of trauma-specific treatment approaches (among which exposure) as opposed to no preference for a treatment approach.

Another factor likely to influence the decision to use exposure is its perceived credibility, i.e., the way the therapist' interprets the rationale and effects of the technique and his or her personal stance towards it. Although some studies showed that the patient's confidence in and preference for the treatment was related to the therapist's choice for prolonged exposure therapy (see e.g.,

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Zoellner, Feeny, Cochran, & Pruitt, 2003), few studies have directly addressed associations between the therapist's views of and his/her use of the approach. Frueh, Cusack, Grubaugh, Sauvageot, and Wells (2006) did study clinicians' perspectives on cognitive behavioural therapy (CBT) for PTSD and found that many of the respondents reported a fear of addressing the trauma directly (also see Waller, 2009) and that they had little faith in their ability to help PTSD patients effectively using exposure techniques. Devilly and Huther (2007), moreover, observed that especially inexperienced therapists found exposure therapy less credible than cognitive therapy, decreasing the likelihood that they would choose a trauma-focused approach like exposure.

In addition to low treatment credibility, the barriers therapists perceive to exposure might also inhibit their use of the technique. These include the often-noted perception that exposure techniques are more distressing than other interventions (Devilly & Huther, 2007), that they may exacerbate symptoms (Frueh et al., 2006) especially in patients with comorbid disorders (Becker et al., 2004), or that exposing patients to their traumas will lead to treatment dropout and revictimization (Cahill, Foa, Hembree, Marshall, & Nacash, 2006; Cook, Schnurr, & Foa, 2004; Ruscio & Holohan, 2006). There are also practitioners who believe that exposure techniques are only suitable for survivors of discrete or single-incident traumas and that these survivors must be relatively stable and healthy (Cook et al., 2004; Ruscio & Holohan, 2006). In Becker et al.'s (2004) survey, clinicians reported fewer barriers to exposure when they were more experienced in treating PTSD patients.

Finally, Sprang et al. (2008) found the therapist's sex to be a determinant in treatment preference: compared to their male counterparts, female therapists were less likely to avail themselves of CBT including exposure, while Devilly and Huther (2007) observed that the female respondents estimated the distress caused by exposure as more severe than the male respondents.

Patient factors

Patient variables, such as comorbidity and treatment preference may also be of importance in the therapists' choice of treatment. Becker et al. (2004) reported that a large number of clinicians (37%) saw any comorbid diagnosis as a likely contraindication for exposure (IE) for PTSD. Exploring patient preferences for exposure versus medication, Zoellner, Feeny, and Bittinger (2009) reported a similar trend: fewer therapists opted for exposure when PTSD patients had a concurrent depression. Najavits (2006) observed that clinicians rated present-focused treatment (e.g. supportive counselling) more positively than past-focused treatment (e.g. exposure therapy) for PTSD patients with comorbid substance abuse.

The patient's preference for a particular treatment may also be important in determining the clinician's choice of treatment, with several studies suggesting that PTSD patients may be more receptive to exposure than is indicated by current clinical practice utilization rates. In two studies, women with and without PTSD preferred prolonged exposure to medication (sertraline; Angelo, Miller, Zoellner, & Feeny, 2008; Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2008), which is in line with findings that trauma victims in general seem to prefer a psychological treatment (counselling) to medication (Roy-Byrne, Berliner, Russo, Zatzick, & Pitman, 2003). Also when other alternative (psychological) treatment options were offered, respondents in an analogue study showed a strong preference for CBT-based treatments, including exposure, despite the high levels of discomfort anticipated with exposure (Tarrier, Liversidge, & Gregg, 2006). These results were replicated in the analogue study by Becker et al. (2007), in which the respondents predominantly indicated exposure or another CBT variant as the therapy of choice over other treatments including supportive therapy, Eye Movement Reprocessing and Desensitization (EMDR) and medication. It must be noted, however, that these 'patient preference' studies not always concerned actual PTSD patients; some included participants who had been traumatized but did not develop PTSD, or respondents who were presented with 'what if' cases. This may have important implications for the reported treatment preference outcomes and thus complicates the interpretation of the results. For instance, in the Becker et al. (2007) study, the patients' preference for exposure therapy was less pronounced when the data of the PTSD patients were analyzed separately. Possibly, avoidance symptoms typical of this population negatively affected the patients' willingness to undergo exposure treatment. Finally, the credibility of a treatment (Becker et al., 2007; Zoellner et al., 2003), personal positive reactions to a treatment (Becker et al., 2007), the assumed underlying mechanisms of a treatment (e.g. "I have to talk about it"; Angelo et al., 2008), and treatment effectiveness (Cochran et al., 2008) were all found to be related to the patients' preference for exposure-based therapies.

In view of the notion that, despite its proven effectiveness, exposure therapy is underutilized in the treatment of PTSD, the aim of the present study was to examine which therapist and patient factors foster or inhibit the choice for exposure therapy in trauma professionals working in this field. To this end we first explored whether the participating therapists (1) used exposure therapy in their practice, (2) were trained in the treatment approach, (3) regarded the therapy as credible, (4) perceived barriers preventing them from offering the therapy in their practice, and finally (5) whether these variables differed between male and female therapists. We subsequently examined if and how the use of and training in exposure techniques were related to treatment credibility and perceived barriers. To determine whether these relationships were specific to exposure therapies, we included three other guideline-recommended or well-known PTSD treatments in our survey: EMDR, another trauma-focused treatment internationally recommended for PTSD (Foa, Keane, Friedman, & Cohen, 2009), and two non-trauma-focused treatments: pharmacotherapy, which is also mentioned in PTSD treatment guidelines, and present-centred supportive counselling, a widely used treatment approach not specifically included in official PTSD treatment guidelines but yielding positive effects (see Mc Donagh-Coyle et al., 2005; Schnurr et al., 2007). Because it is underutilized in PTSD, we expected the participating therapists to use exposure therapy less often relative to the other treatment options and to be less (well) trained in the approach, and that they would consider exposure therapy less suitable (reflecting low treatment credibility) for and see more barriers to its use in this population. We also hypothesized that the therapists that were (better) trained in the technique and more experienced in its use in PTSD patients would find the approach more suitable (reflecting high treatment credibility) and mention fewer or less prohibitive factors.

In the second, experimental part of our study we presented 255 trauma experts with four videotapes each showing a PTSD patient. Having viewed a tape, the therapists were asked to indicate on a list specifying the four treatment options to what extent they thought the treatment would be suited for this particular patient. In addition, we manipulated the choice of treatment by randomizing the respondents to two conditions in which the patient variables 'comorbid depression' and 'patient preference' were introduced. Because trauma type and trauma severity are known to influence treatment preferences, each condition included two types of trauma: (1) a single trauma suffered in adulthood and (2) multiple traumas suffered during childhood. We expected a comorbid