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A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD

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Abstract

Although research supports the efficacy of exposure therapy for PTSD, some evidence suggests that exposure is under-utilized in general clinical practice. The purpose of this study was to assess licensed psychologists' use of imaginal exposure for PTSD and to investigate perceived barriers to its implementation. A total of 852 psychologists from three states were randomly selected and surveyed. An additional 50 members of a trauma special interest group of a national behavior therapy organization were also surveyed. The main survey results indicate that a large majority of licensed doctoral level psychologists do not report use of exposure therapy to treat patients with PTSD. Although approximately half of the main study sample reported that they were at least somewhat familiar with exposure for PTSD, only a small minority used it to treat PTSD in their clinical practice. Even among psychologists with strong interest and training in behavioral treatment for PTSD, exposure therapy is not completely accepted or widely used. Clinicians also appear to perceive a significant number of barriers to implementing exposure.

Keywords: PTSD; Exposure; Cognitive behavioral therapy; Survey

Substantial evidence supports the efficacy of exposure therapy for PTSD (Foa, Keane, & Friedman, 2000). Yet, as with empirically supported treatments (ESTs) for many other disorders (Barlow, Levitt, & Bufka, 1999), exposure appears to be under-utilized in clinical practice (Foy et al., 1996). In one of the few papers to examine the clinical utilization of exposure therapy for PTSD, Foy et al. discussed the low utilization of exposure within VA clinics, which are major

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centers for PTSD treatment in the United States. Foy et al. cited unpublished data by Fontana, Rosenheck and Spencer (1993) indicating that exposure was used to treat fewer than 20% of 4000 veterans with PTSD and that it was used as the primary treatment in only 1% of cases. Foy et al. also cited unpublished data (Kagan et al., 1993) indicating that, in a program devoted to delivering exposure therapy for veterans with PTSD, exposure was successfully implemented in only 38% of cases. The obstacles to implementation in "unsuccessful" cases included psychiatric comorbidity (19%), task problems (19%), patient refusal (16%) and medical contraindications (8%). Research also suggests that, even among experts, exposure utilization appears to be lower than might be expected. In one of the few other reports of exposure therapy utilization, Litz, Blake, Gerardi and Keane (1990) reported that exposure was used in only 58% of cases treated by 11 nationally recognized experts in the use of exposure therapy for PTSD.

The limited data on exposure therapy utilization suggest that systematic attention to the myriad of factors that can affect clinical use of exposure is warranted, particularly if advocates of ESTs want to see exposure therapy implemented on a broader scale in general clinical practice. Convincing practitioners to use exposure for PTSD on a routine basis likely will not be an easy task. ESTs such as exposure therapy have been a clinical option for a significant period of time, and it appears that telling practitioners that such treatments exist and that they should use them does not lead to widespread utilization of such interventions. Although the data described by Foy et al. (1996) demonstrate that patient barriers can interfere even when therapists are trained and committed to delivering exposure, it is likely that therapist factors play an equally important role in determining whether or not exposure therapy for PTSD is widely utilized.

Several authors have noted that therapists avoid using exposure because they do not understand it and/or are uncomfortable with it (Boudewyns & Shipley, 1983; Fontana et al., 1993, cited in Rogers, 1998). Dissemination of exposure therapy also hinges on other therapist factors, such as ease, cost, and availability of training; willingness to receive training; availability of supervision; general clinical myths about exposure for PTSD as a whole; and clinical lore and personal beliefs about the specific contexts and conditions for its use. In addition, such therapist variables as knowledge and comfort may interact with a variety of patient variables, such as avoidance or initial worsening of symptoms, to result in low utilization. Finally, professional background and theoretical orientation may play a role in the delivery of ESTs such as exposure therapy. In the US, the majority of clinical services are delivered by private mental health practitioners of varying professions, educational experiences, theoretical orientations, and opinions about the role of research in clinical practice. Ultimately, the widespread use of exposure for PTSD likely will depend more upon their attitudes and beliefs about exposure and PTSD than on the opinions of the investigators who develop and test exposure therapy.

In response to calls for increasing dissemination of ESTs, some investigators have begun to examine whether clinicians with limited background in behavior therapy can be trained to effectively deliver exposure therapy (Foa, 2001). This research addresses a very important question, namely *can* such therapists learn to do this treatment. Other questions, however, remain unanswered, such as whether therapists who *can* be trained will want to be trained, can be trained within real world financial constraints, and will use the intervention routinely once trained. Unfortunately, our impression has been that many clinicians who are trained in exposure do not routinely use it with the majority of their PTSD patients. Thus, in addition to adequate training, other factors such as trust in the intervention, comfort in administering it, and confidence in one's ability to