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Implementation of Cognitive Therapy for PTSD in routine clinical care: Effectiveness and moderators of outcome in a consecutive sample☆

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ABSTRACT

Objective: Trauma-focused psychological treatments are recommended as first-line treatments for Posttraumatic Stress Disorder (PTSD), but clinicians may be concerned that the good outcomes observed in randomized controlled trials (RCTs) may not generalize to the wide range of traumas and presentations seen in clinical practice. This study investigated whether *Cognitive Therapy for PTSD* (CT-PTSD) can be effectively implemented into a UK National Health Service Outpatient Clinic serving a defined ethnically mixed urban catchment area.
Method: A consecutive sample of 330 patients with PTSD (age 17–83) following a wide range of traumas were treated by 34 therapists, who received training and supervision in CT-PTSD. Pre and post treatment data (PTSD symptoms, anxiety, depression) were collected for all patients, including dropouts. Hierarchical linear modeling investigated candidate moderators of outcome and therapist effects.
Results: CT-PTSD was well tolerated and led to very large improvement in PTSD symptoms, depression and anxiety. The majority of patients showed reliable improvement/clinically significant change: intent-to-treat: 78.8%/57.3%; completer: 84.5%/65.1%. Dropouts and unreliable attenders had worse outcome. Statistically reliable symptom exacerbation with treatment was observed in only 1.2% of patients. Treatment gains were maintained during follow-up ($M = 280$ days, $n = 220$). Few of the selection criteria used in some RCTs, demographic, diagnostic and trauma characteristics moderated treatment outcome, and only social problems and needing treatment for multiple traumas showed unique moderation effects. There were no random effects of therapist on symptom improvement, but therapists who were inexperienced in CT-PTSD had more dropouts than those with greater experience.
Conclusions: The results support the effectiveness of CT-PTSD and suggest that trauma-focused cognitive behavior therapy can be successfully implemented in routine clinical services treating patients with a wide range of traumas.

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A substantial number of randomized controlled trials (RCTs) have established the efficacy of trauma-focused cognitive behavioral treatments (TF-CBT) in posttraumatic stress disorder (PTSD) (for reviews see Australian Centre for Posttraumatic Mental Health, 2007; Bisson et al., 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Kitchner, Roberts, Wilcox, & Bisson, 2012; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Stein et al., 2009). These RCTs have shown very large effect sizes in treating PTSD symptoms and associated symptoms of depression and anxiety for a range of TF-CBT programs. There is as yet less evidence on how effective such treatment programs are when applied in routine clinical settings. Clinicians are often concerned that that the good outcomes observed in RCTs may not generalize to the wide range of traumas and presentations seen in clinical practice.

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Do the effects of TF-CBT programs generalize to routine clinical care?

Several factors are conceivable that could potentially limit the extent to which the treatment effects observed in RCTs generalize to patients seen in routine clinical practice. Although most RCTs studied clinically pertinent samples with moderate to severe PTSD and associated comorbid conditions, they applied certain inclusion and exclusion criteria. The selection may influence outcome, for example, by increasing the average size of improvement by requiring a minimum severity or by excluding difficult-to-treat patients. One of these potential factors is that many RCTs selected patients who suffered from discrete traumas such as physical or sexual assault or traffic accidents (but may have also experienced additional other traumas, e.g., Bryant, Moulds, Guthrie, Dang, & Nixon, 2003; Ehlers et al., 2003; Foa et al., 2005; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Schnurr et al, 2007), whereas in clinical practice patients may require treatment for wider range of traumas including prolonged and multiple traumatic events. It remains unclear whether the exclusion of certain demographic groups such as men, people older than 65 years of age, or comorbid conditions such as borderline personality disorder influences the overall treatment effects. Second, there have been concerns about a possible risk of symptom exacerbation with exposure to trauma memories (e.g., Tarrier et al., 1999). Although initial reports have found symptom exacerbation to be uncommon in RCT samples (e.g., Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Hackmann, Ehlers, Speckens, & Clark, 2004), clinicians may be concerned that this problem may be more common in patients seen in routine clinical care. A third concern relates to treatment dropouts. Many of the earlier RCTs reported completer-only analyses. If dropout rates are substantial, completer analyses may overestimate the efficacy of treatments. Some RCTs have observed high dropout rates of between 25 and 43% with trauma-focused PTSD treatments in RCTs (e.g., Foa et al., 2005; Power et al., 2002; Resick et al., 2002; Schnurr et al, 2007), although the average dropout rate may not be higher than for other PTSD treatments (Hembree et al., 2003). Fourth, in RCTs treatment is usually delivered by therapists who receive specialized training and supervision in TF-CBT, and clinicians with less training and supervision may find it difficult to replicate their results. Thus, there is a need to empirically investigate how well the excellent outcomes of TF-CBT observed in RCTs can be replicated in routine clinical settings where patients are not selected for RCT suitability and treatment is delivered by therapists with a range of prior experience with TF-CBT.

Preliminary evidence suggests that TF-CBT programs can be successfully implemented in routine clinical services (for reviews see Cohen & Mannarino, 2008; Stewart & Chambless, 2009). Foa et al.'s (2005) RCT of *Prolonged Exposure* for sexual assault survivors found equivalent outcomes for expert therapists and newly trained therapists working in a community center. Karlin et al. (2010) reported that veterans treated with *Prolonged Exposure* or *Cognitive Processing Therapy* following an extensive therapist training program implemented in the Veteran Health Administration showed a 30% decrease in PTSD symptoms in completer analyses (see also Monson et al., 2006; Tuerk et al., 2011). Levitt, Malta, Martin, Davis, and Cloitre (2007) and Brewin et al. (2010) reported large improvements in outreach programs for survivors of 9/11 and the London bombings who suffered from PTSD.

Gillespie, Duffy, Hackmann, and Clark (2002) trained therapists from a range of professional backgrounds in *Cognitive Therapy for PTSD*, a version of TF-CBT that builds on Ehlers and Clark's (2000) model of PTSD. The therapists treated an unselected group of patients seeking treatment for PTSD after the Omagh bombing in Northern Ireland and achieved similarly good outcomes as those observed in RCTs. Duffy, Gillespie, and Clark (2007) further successfully disseminated this treatment to an unselected group of patients who had experienced traumas in connection with the civil conflict in Northern Ireland, the majority of whom had experienced multiple traumatic events.

Whilst these initial studies evaluating the effectiveness of TF-CBT for PTSD are promising, they are limited in number, and further studies of larger samples of unselected patients with PTSD following the wide range of traumatic events seen in clinical settings are needed to determine the effectiveness of TF-CBT programs. The present study describes treatment outcomes of consecutive referrals to a National Health Service outpatient clinic treated with CT-PTSD. The clinic was newly opened in April 2001 and thus provided an opportunity to train new therapists in delivering this treatment, and to study treatment effectiveness, moderators of treatment outcome and possible therapist effects in a consecutive patient sample from a defined catchment area.

Moderators of treatment effectiveness

The study investigated candidate moderators of the effectiveness of TF-CBT in routine clinical settings. We were interested in whether selection criteria for randomized controlled trials actually predict treatment response, and whether other aspects of clinical history, comorbidity or trauma history moderate treatment outcome. Kraemer, Wilson, Fairburn, and Agras (2002) distinguish two types of predictors of outcome. *Nonspecific predictors of outcome* influence the overall severity of symptoms, but do not influence the slope of treatment-induced improvement. Some TF-CBT studies have correlated candidate predictors with symptom severity at the end of therapy and have generally found that patients with more severe symptoms of PTSD and depression at the beginning of treatment have more remaining symptoms at the end of treatment (e.g., Blanchard et al., 2003; van Emmerik, Kamphuis, Noordhof, & Emmelkamp, 2011; van Minnen, Arntz, & Keijsers, 2002; Schulz, Resick, Huber, & Griffin, 2006). A *moderator* of treatment effectiveness is a variable that influences the slope of improvement (Kraemer et al., 2002). Several studies of TF-CBT attempted to identify moderators of treatment response in RCTs (e.g., Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Feeny, Zoellner, & Foa, 2002; Kubany et al., 2004; Rizvi, Vogt, & Resick, 2009; Tarrier, Sommerfield, Pilgrim, & Faragher, 2000; van Emmerik et al., 2011) and routine clinic samples (e.g., Gillespie et al., 2002; Richardson, Elhai, & Sareen, 2011; Rosenkranz & Muller, 2011; van Minnen et al., 2002). The results were often inconsistent and few moderators have been identified. Variables that were shown in some studies to be associated with less favorable treatment response included

- *demographic variables* such as male sex (Blain, Galovski, & Robinson, 2010), younger age (Rizvi et al., 2009; Taylor, Fedoroff, & Koch, 1999), higher level of education (Ehlers et al., 2005) or ethnic minority (Walling, Suvak, Howard, Taft, & Murphy, 2012);
- *comorbidity* with other *anxiety disorders* or high symptoms of anxiety and arousal (Rosenkranz & Muller, 2011; Tarrier et al., 2000; but see van Minnen et al., 2002; Richardson et al., 2011; for negative findings); with *depression or suicidal ideation* (Duffy et al., 2007; Tarrier et al., 2000; but see van Minnen et al., 2002; Richardson et al., 2011; for negative findings); *substance abuse* (van Minnen et al., 2002; but see Richardson et al., 2011; for negative findings); personality disorders (Clarke, Rizvi, & Resick, 2008; Feeny et al., 2002); use of *psychotropic medication* (van Minnen et al., 2002), and *permanent physical disability*

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