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The implementation of prolonged exposure: Design of a multisite study evaluating the usefulness of workshop with and without consultation

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ABSTRACT

This randomized trial examines the dissemination and implementation of prolonged exposure (PE) therapy for posttraumatic stress symptoms in U.S. Army medical treatment facilities. The study compares two PE training models: Standard PE training, comprised of a 4-day workshop only, and Extended PE training, comprised of a 4-day workshop plus expert case consultation. Behavioral health providers (N = 180) across three medium-to-large Army installations will be randomly assigned to either Standard PE training or Extended PE training. Changes in provider attitudes will be examined across groups. After completing PE training, the use of PE components with patients reporting posttraumatic stress symptoms and clinical outcomes of these participating patients (N = 500) will be examined. This article describes the rationale and methods of the study. In addition, a number of methodological issues in conducting a multisite naturalistic study in the U.S. Army are discussed.

1. Introduction

Due to the large number of returning military personnel with posttraumatic stress disorder (PTSD), there is an increased need for military behavioral health providers who are trained to competently deliver evidence-based treatments for PTSD. Prolonged exposure (PE) is an efficacious treatment for PTSD and posttraumatic stress (PTS) symptoms [1] that is recommended in numerous practice guidelines [2]. However, relatively few behavioral health providers deliver PE [3–5], consistent with the low use of exposure therapy in the treatment of other anxiety disorders [6] and low rates of evidence-based treatment delivery in general [7,8]. One reason for the low utilization of PE

Abbreviations: ASF, Additional Services Form; AUDIT, Alcohol Use Disorder Identification Text; BSSI, Beck Scale for Suicidal Ideation; CAPS-5, Clinician-Administered PTSD Scale for DSM-5; CEQ, Credibility/Expectancy Questionnaire; CPT, cognitive processing therapy; CSQ, Client Satisfaction Questionnaire; IRB, institutional review board; MI, Motivational Interviewing; MINI, Mini International Neuropsychiatric Interview; PCL-5, PTSD Checklist-5; PE, prolonged exposure; PHQ-9, Patient Health Questionnaire-9; PTS, posttraumatic stress; PTSD, posttraumatic stress disorder; TBES, Therapist Beliefs about Exposure Scale; STAXI-2, State-Trait Anger Expression Inventory; US, United States; VA, Veterans Administration

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among providers is the lack of adequate training. A study by Becker et al. [9] found that only a minority of providers surveyed had any training in PE, and that inadequate training was the most common reason for not using PE with PTSD patients. It follows that providing effective training to mental health providers would increase their use of PE.

One of the most ambitious initiatives to disseminate evidence-based treatments to date involved training providers in PE and cognitive processing therapy (CPT) [10] throughout the Veterans Administration (VA) system in the United States. Following training, 45% of VA providers reported using PE regularly with their PTSD patients [11]. Importantly, the initiative included case consultation (i.e., supervision) with two PE training cases following a 4-day PE workshop. Consultation significantly increased providers' self-confidence in delivering PE and anticipated benefits from PE; it also significantly decreased anticipated problems in delivering PE [12]. Consistent with these findings, research on Motivational Interviewing (MI) for substance abuse showed that training via workshops alone yields limited increased proficiency in delivering MI [13,14], whereas adding case consultation significantly increases provider MI proficiency [15,16]. These findings are important because high levels of provider competence have been linked to superior patient outcomes for numerous evidence-based treatments [17–19].

Although research to date suggests that post-workshop case consultation increases the adoption of newly learned skills to clinical practice, consultation requires a significantly greater investment of clinician time and financial resources. However, if the workshop-only training model does not effectively change provider behavior, there is a limited return on the training investment and decreased access to evidence-based treatments for military service members seeking care for PTSD. Thus, it is important to determine whether training that includes a workshop plus case consultation is superior to workshop training alone, given that adding consultation is significantly more resource-intensive.

2. Methods

This study will be a two-armed randomized trial comparing two methods of training for U.S. Army behavioral health providers to provide PE for posttraumatic stress symptoms or PTSD. The study will include two groups of research participants: provider-participants and patient-participants. Under institutional agreements for IRB review, the Madigan Army Medical Center Institutional Review Board (IRB) served as the reviewing IRB for the three military sites. The protocol was also reviewed and monitored by the University of Pennsylvania IRB and the U.S. Army Human Research Protections Office.

2.1. Research hypotheses

This study will compare two PE training models: Standard PE training (workshop only) and Extended PE training (workshop plus consultation). We hypothesize that:

1. Compared to the Standard PE training, the Extended PE training will result in higher provider self-efficacy, more positive attitudes towards PE, and higher expectations of therapeutic change following PE.
2. Compared to the Standard PE training, Extended PE training will result in greater provider use of PE components when treating patients with posttraumatic stress.
3. Compared to the patients of providers who undergo Standard PE training, patients of providers who undergo the Extended PE training will demonstrate greater reductions in symptoms of posttraumatic stress and related problems (e.g., depression, anger) and will report greater satisfaction with the treatment received.

2.2. Provider-participants

Provider-participants will include up to 180 behavioral health providers at three medium-to-large U.S. Army medical treatment facilities. Provider-participants will be randomly assigned to either Standard PE training (i.e., a 4-day PE workshop) or Extended PE training (i.e., a 4-day PE workshop followed by expert consultation with two PE clinical training cases). Provider-participants will be active duty and civilian behavioral health providers in the Army whose job duties include providing individual psychotherapy to adult patients. It is estimated that approximately 20% of the patients seen by these providers have trauma-related difficulties. Exclusion criteria for provider-participants include definite plans to terminate their position or relocate in the next year, or extensive previous training in PE defined as previous participation in a 4-day PE training workshop at any time and self-reported use of PE to treat four or more patients with posttraumatic stress symptoms in the past year.

2.3. Patient-participants

In addition to the provider-participants, the study will enroll up to 500 patient-participants with posttraumatic stress symptoms who are receiving individual psychotherapy from a participating provider. Patient-participants will have clinically significant posttraumatic stress symptoms, defined as a severity score of 25 or greater on the Clinician-Administered PTSD Scale for DSM-5 [20]; this cutoff score has been used in previous research [21]. Meeting full diagnostic criteria for PTSD is not an inclusion criterion because the need for treatment is better determined based on symptom severity than diagnosis. Exclusion criteria for patient-participants include current bipolar disorder I or psychotic disorder (as determined by the Mini International Neuropsychiatric Interview [22]), evidence of a moderate or severe traumatic brain injury (as determined by the inability to comprehend the baseline screening questionnaires), or current suicidal ideation severe enough to warrant immediate attention (as determined by the Beck Scale for Suicidal Ideation [23]).

2.4. Procedures

Behavioral health providers at three U.S. Army medical treatment facilities will be invited to participate in a 4-day PE workshop to be conducted at the military site by PE experts from the University of Pennsylvania's Center for the Treatment and Study of Anxiety. The PE expert conducting the workshop will be trained by and will work closely with the first author (E.B.F), the developer of PE. As part of the PE workshop, the military providers will receive training materials and treatment manuals. Each on-site principal investigator will present information about the study to all behavioral health providers at their site who provide psychotherapy. Behavioral health providers who meet the inclusion and exclusion criteria will be invited to participate in the study. The research coordinator and research assistant at each site will assist with the coordination of recruitment, screening, and informed consent of provider-participants.

Following the 4-day workshop, participants randomized to the Extended PE training will receive weekly telephone consultation from a PE expert for two PE clinical training cases including the review of videotapes made of their care of these two supervised cases. We expect consultation to last approximately 6 months. These clinical training cases will not be study participants, and providers will obtain consent from their patients to video-record using a separate clinical consent document. The video recordings of the clinical training cases will be labeled with the provider's study number and securely mailed directly to the University of Pennsylvania Center for the Treatment and Study of Anxiety and tracked for receipt. In accordance with the clinical consent, these video recordings are destroyed immediately after they are reviewed. Participants randomized to the Standard PE training group will