



Dissemination and implementation of prolonged exposure therapy for posttraumatic stress disorder



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ABSTRACT

Posttraumatic stress disorder (PTSD) is a highly prevalent, often chronic and disabling psychiatric disorder that is associated with significant adverse health and life consequences. Although several evidence-based treatments (EBTs), including Prolonged Exposure therapy (PE), have been found effective and efficacious in reducing PTSD symptomology, the majority of individuals with this disorder receive treatments of unknown efficacy. Thus, it is imperative that EBTs such as PE be made available to PTSD sufferers through widespread dissemination and implementation. We will review some of the efforts to increase the availability of PE and the common barriers to successful dissemination and implementation. We also discuss novel dissemination strategies that are harnessing technology to overcome barriers to dissemination.

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1. Introduction

Posttraumatic Stress Disorder (PTSD) is a highly prevalent psychiatric disorder that affects 3.4% of men and 8.5% of women during their lifetime (McLean, Asnaani, Litz, & Hofmann, 2011). In the absence of effective treatment, PTSD frequently becomes a chronic and disabling disorder that is often comorbid with major depression, other anxiety disorders, substance abuse disorders (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Breslau, Davis, & Schultz, 2003), medical problems (Schnurr, Spiro, & Paris, 2000) and is associated with low quality of life (Zatzick et al., 1997; Zayfert, Dums, Ferguson, & Hegel, 2002). Given the substantial personal distress, public health and societal costs associated with chronic PTSD, it is heartening that there are effective interventions for PTSD available. Evidence-based treatments (EBTs) for PTSD include prolonged exposure therapy (PE; e.g., Bryant et al., 2008; Foa et al., 1999, 2005; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Schnurr et al., 2007; for a review and meta-analysis see Powers, Halpern, Ferenschak, Gillihan & Foa, 2010), cognitive processing therapy (CPT; Chard, 2005; Monson et al., 2006; Resick et al., 2008, 2002), cognitive therapy (e.g., Ehlers et al., 2003; Tarrier & Sommerfield, 2004), stress-inoculation therapy (e.g., Foa et al., 1991; 1999) and eye movement desensitization and reprocessing (EMDR; e.g., Power et al., 2002; Rothbaum, Astin, & Marsteller, 2005; Taylor et al., 2003).

EBT for PTSD is greatly underutilized (e.g., Foa, Gillihan, & Bryant, *in press*; Kessler, 2000; Rosen et al., 2004), resulting in unnecessary suffering, increased healthcare costs, and workplace absenteeism (Greenberg et al., 1999; Hoge, Terhakopian, Castro, Messer, & Engel, 2007), despite a wealth of evidence that EBTs for PTSD can be effectively disseminated. While much of this research has focused on PE, dissemination studies have also examined other EBTs. For example, Gillespie, Duffy, Hackmann, and Clark (2002) found community therapists who received training in cognitive therapy for PTSD and ongoing supervision effectively administered treatment in an open trial. Similarly, a study by Neuner et al., 2008 showed that a manualized exposure treatment called narrative exposure therapy was effectively delivered to refugees in southern Uganda by lay counselors chosen from within the refugee community. While acknowledging these promising results, we focus on the dissemination of PE, which has the greatest supportive evidence and has been the subject of wider dissemination efforts than other treatments for PTSD. This review provides an overview of efforts to disseminate PE, and a description of the successes, barriers, and challenges involved in promoting the adoption of PE in mental health systems.

1.1. Prolonged exposure therapy for PTSD

Prolonged exposure (PE) is a specific exposure therapy program designed to help PTSD sufferers to emotionally process their traumatic experiences through repeated revisiting and recounting their trauma memories (imaginal exposure), and repeated, gradual approach to trauma-related, safe, situations that the person avoids because there are trauma reminders (in vivo exposure). PE consists of two principal components: (a) in vivo exposure to trauma

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reminders, usually in the form of between-session assignments; (b) imaginal exposure to the memory of the traumatic event in session followed by processing of the exposure experience. Two additional less central components are: (c) psychoeducation about the nature of trauma and (d) training in controlled breathing.

Numerous randomized controlled trials indicate that PE is effective in reducing PTSD symptoms (see Cahill, Rothbaum, Resick & Follette, 2009), and is associated with rapid change and maintenance of treatment gains over time (e.g., Foa et al., 2005; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Taylor et al., 2003). In addition to greatly reducing PTSD symptoms, PE is shown to lessen symptoms of depression, general anxiety, guilt, anger, and anxiety sensitivity, and improves social functioning and health (Keane, Marshall, & Taft, 2006; Rauch et al., 2010). Moreover, PE is effective in treating PTSD related to a wide range of traumas as well as PTSD in comorbid populations, including traumatic brain injury (National Center for PTSD, 2010), alcohol dependence (Foa et al., submitted for publication), borderline personality disorder (Harned, Rizvi, & Linehan, 2011), and major depression (Hagenaars, van Minnen, & Hoogduin, 2010). Importantly, the efficacy of PE has been established by many independent research groups around the world.

Given the large number of studies supporting the efficacy of PE, it has been identified in the joint VA-Department of Defense Clinical Practice Guideline for PTSD (VA-DoD Clinical Practice Guideline Working Group, 2003) as “strongly recommended” for use with veterans with PTSD. The 2007 report issued by the Institute of Medicine (IOM) concluded that exposure therapy was the sole treatment for PTSD with sufficient evidence for its efficacy.

1.2. What makes prolonged exposure a good candidate for dissemination?

As noted above, there are a number of treatment programs that have empirical evidence for their efficacy. However, not all efficacious treatment programs are equally suited to widespread dissemination. Treatments that should be considered good candidates for dissemination must have evidence of efficacy among PTSD sufferers from a wide range of traumas and demographic backgrounds, complex clinical presentations, and comorbid diagnoses. In addition, they must be relatively simple and streamlined, have a treatment manual that contains a step-by-step guide for the clinician, and be acceptable to PTSD patients.

As noted above, PE has an extensive evidence base in support of its efficacy from studies conducted by independent research groups from different countries. The studies encompass a number of different trauma types, including child and adult sexual and nonsexual assault, combat, terrorism, motor vehicle accidents, and natural disasters. In addition, PE's efficacy is comparable across various demographic backgrounds, and has been shown to work with patients who have comorbid diagnoses like depression, personality disorders, and alcohol dependence. PE is also a relatively simple, streamlined program that is presented in a structured manual (Foa, Hembree, & Rothbaum, 2007). Compared to other EBTs for PTSD, the techniques used in PE are simple and easy to learn and straightforward to deliver. Finally, several studies have shown that patients prefer exposure therapy over other types of treatment. For example, PE is preferred over medication (among women exposed to trauma: Angelo, Miller, Zoellner, & Feeny, 2008; among women with PTSD: Feeny, Zoellner, Mavissakalian, & Roy-Byrne, 2009), and over other EBTs for PTSD (Becker, Darius, & Schaumburg, 2007).

1.3. The challenge of disseminating evidence-based treatment

As noted above, many people suffering from PTSD do not receive EBT, in part because a majority of mental health professionals provide medications or psychotherapies for PTSD that have not

been empirically supported (e.g., Becker, Zayfert, & Anderson, 2004; Minnen, Hendriks, & Olf, 2010). Studies show that the availability of a highly effective EBT does not ensure that therapists will use this treatment. In fact, the majority of therapists in community mental health clinics do not use EBTs (Freiheit, Vye, Swan, & Cady, 2004). One reason for the large discrepancy between the high efficacy of PE and its low utilization is the lack of adequate training in EBTs. In a survey of licensed psychologists, Becker et al. (2004) found that the vast majority of therapists reported no or modest training in treating PTSD, and very few reported utilizing PE. Lack of training was the most frequently cited reason for not using imaginal exposure. Consistent with these data is research showing that evidence supporting the efficacy of a given treatment has little impact in psychologists' decisions about which treatments to utilize (Cook, Schnurr, Biyanova, & Coyne, 2009). These findings highlight the need to develop effective dissemination strategies, a topic to which we discuss below.

2. Disseminating prolonged exposure in Philadelphia

The CTSA began disseminating PE to mental health clinics in the Philadelphia community with the goal of assessing the feasibility of training community mental health professionals to deliver PE and to compare their treatment outcomes to those of PE experts. The community sites were Women Organized Against Rape (WOAR) and the Sexual Assault Counseling and Education (SACE) program in Temple University's Counseling Center. Previous to CTSA involvement, WOAR and SACE trauma survivors were typically provided supportive counseling by master's level counselors or social workers with no previous training in CBT, clinical research, or delivery of manualized treatments. These providers first participated in a 5-day PE training workshop conducted by CTSA staff. Workshop participants learned about the theory behind PE, the efficacy of PE, and were provided instruction on the administration of PE interventions (e.g., the rationale for treatment, in vivo and imaginal exposure, managing under- or over-engagement). After the workshop, therapists participated in a 3-hour weekly group supervision where they reviewed and discussed ongoing therapy cases. Therapists received 2-day “booster” workshops that were offered once or twice per year for the first two years.

Despite engagement with the workshops and supervision, implementation of PE among the community clinic therapists was slow. Initially, the therapists were reluctant to use the treatment with their patients because the treatment and its rationale were so different from the counseling approach that they were accustomed to using. Through the efforts of the CTSA supervisors and the clinic director, the therapists gradually began to implement PE. Once they experienced success with their first few PE patients, they adopted the treatment with enthusiasm. The comparison of treatment outcomes showed that the community clinic therapists had equivalent outcomes to those of PE experts from the CTSA (Foa et al., 2005).

2.1. Lessons learned

The major lesson learned from this local dissemination project was that support from clinic management is important to help overcome a culture that is not supportive of EBTs. Support from the director of WOAR was critical to the eventual adoption of PE by the clinic therapists. The proximity of the clinic to the expert-supervisors was an advantage, allowing the use of the traditional face-to-face supervision. This supervision format was not possible in a subsequent study by Schnurr et al. (2007), in which the PE therapists were located in VA centers across the country. In this study, the supervision format was modified such that therapists mailed session recordings to their supervisor, who would review the tape

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