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Availability of Evidence-Based Treatments for PTSD in Civilian Institutional and Private Practice Settings: A Case Study in Asheville, NC

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Abstract

Psychological trauma is a common experience for many individuals at some point in their lifetime. Recent studies find that 80-90% individuals will experience at least one traumatic event and 5-10% of the population will develop Post-Traumatic Stress Disorder (PTSD) in their lifetime. With PTSD occurring to almost 1 in 10 individuals, it is clear that access to treatment should be readily available, including in civilian settings. Unfortunately, the availability of quality treatment for civilian PTSD varies widely, with geographic area being one important factor for access. Psychotherapy is a common mode of PTSD treatment, and multiple psychotherapy treatments have been designated as evidenced-based treatments (EBTs) for PTSD. To investigate the availability of psychotherapy EBTs for PTSD in a specific location, Asheville, N.C., the current study completed a survey of PTSD psychotherapy services. Asheville is a smaller city in a mountainous region of Western North Carolina. The sample drew upon private practice providers from the Psychology Today website (n=199) and a survey of local institutional/agency contexts. Although the sample is not fully representative of PTSD providers in Asheville, the database of providers is reasonably comprehensive. This study had two hypotheses. First, it was hypothesized that the survey will find gaps in the availability of EBTs for PTSD in both private practice settings and institutions in the area. Second, it was hypothesized the survey will indicate many private practice settings and institutions/agencies will offer non-EBT services for PTSD, i.e., services that do not have an evidence-basis for treatment PTSD. Descriptive statistics were used to evaluate these hypotheses. The results for institutions/agencies show a gap in EBTs. Many private providers claimed EBT, but these claims appear problematic. It seems that there is good evidence for a large amount of non-ebt services being provided related to ptsd.The results suggest there is a lack of access to high quality care for PTSD in a single urban, mountain context.

Key Words: Evidence-Based Treatments, PTSD, North Carolina

1. Introduction

Around 80-90% of individuals go through at least one possibly traumatic event at some point in their lifetime.[1] From this population, 5-10% of the population will develop Post-Traumatic Stress Disorder (PTSD).[2] PTSD is described by the Anxiety and Depression Association of America as "...a serious potentially debilitating condition that can occur in people who have experienced or witnessed a natural disaster, serious accident, terrorist incident, sudden death of a loved one, war, violent personal assault such as rape, or other life-threatening events." PTSD is a widespread problem that affects numerous citizens. PTSD leads to large lower quality of life, reduced physical health, mental suffering, and worse social relationships. With an increasing recognition of the effect PTSD has on an individual's life, it is essential that treatments are effective.[3]

Many treatments have emerged to address PTSD, but not all treatments are proven to be successful. Out of all the various treatments available, psychotherapy approaches have been found to be very effective in reducing symptoms, sometimes resulting in full remission. Specifically, several Cognitive Behavioral Therapies (CBT) have been found to be the most effective out of all modes of psychotherapy. Prolonged Exposure and Cognitive Processing Therapy

are example of two CBT approaches that have been shown to be effective in treating PTSD. In addition, Eye Movement Desentization and Reprocessing (EMDR), sometimes labeled a CBT approach, has been shown to reduce PTSD symptoms.[4]

Large scale efforts have been made to provide EBTs for PTSD in military-related populations, such as in the Veterans Administration.[5] In contrast, the current study focuses on the question of EBT access in the civilian context. Other studies have shown that there is generally a lack of EBT access for civilians in rural communities.[6]

Although it has been proven that evidence-based practices are effective, not all therapists have been found to use them. This may be a result from the rising use of pharmaceuticals and use of other psychotherapy treatments.[7] In Asheville, NC, we hypothesize a similar case of evidence-based practices not being offered by many therapists in the area. We hypothesize that 1) the survey will convey gaps in the availability of EBTs for PTSD in both private practice settings and institutions in the area. And 2) the survey will indicate many private practice settings and institutions/agencies will offer many services that do not have an evidence-basis for treatment PTSD.

2. Methods

To investigate individual providers, we researched different therapist databases to find the most extensive one for Asheville, NC. In our search, we found many different databases that provided lists of therapists and their descriptions. Out of all the online resources, the PsychologyToday.com "find a therapist" database was the most comprehensive and descriptive list of individual providers in the Asheville area. Although other online resources provided information and other means of evaluating therapists, PsychologyToday provided the most therapists that were currently practicing. In addition, other online databases often duplicated or appeared to draw from the PsychologyToday database. When searched in Fall 2015, the PsychologyToday.com "find a therapist" database provided 221 therapist results when we searched under the category "Trauma and PTSD." Later review found multiple duplicates of therapist profiles. Eliminating duplicates resulted in a final dataset of 199 unique therapist profiles. We collected the following information from the 199 therapist profiles on the PsychologyToday website: treatment focus, treatment orientations, and training certifications. (In addition, Brown and Quindara (NCUR, 2016) collected and reviewed further variables from this database.)

The therapist profiles included 114 different treatment orientations. The PsychologyToday website provided a standard list of treatment orientations, but therapists were also able to enter in their own orientation if it was not provided in the standard list. In addition, 3 different PTSD related training certifications were listed by therapists. Based on a literature review, we categorized the following treatments as EBTs for PTSD: Prolonged Exposure, Cognitive Processing Therapy, Trauma-focused Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Cognitive Behavioral Couples Therapy, and Dialectical Behavioral Therapy.[8] Any therapist profile containing a treatment orientation or training certification related to these EBTs for PTSD was designated as a therapist claiming EBT provision. On the PsychologyToday website, the general term "Cognitive Behavioral Therapy" was part of the standard list of orientations, and any therapist with this orientation listed was also designated as claiming EBT provision.

The data in the individual provider database was originally stored in a Microsoft Excel spreadsheet. The data was then transferred into SPSS 23 for analyses. Data cleaning and data integrity checks were carried out by the two authors and their advisor.

To investigate civilian institutions/agencies that provide trauma and PTSD-related psychotherapy services, we began with web searches focusing on the Asheville area. We also consulted with two clinical psychologists associated with UNC-Asheville. Based on these efforts, we developed a list of 10 institutions/agencies in the area that advertised providing, or were known to provide, psychotherapy treatments for trauma and PTSD. The list of agencies and institutions included: All Souls Counseling Center, Brookhaven Retreat, Carolina Partner, Crest View Recovery Center, Meridian Behavioral Health, Mission Health Copestone, October Road Inc, Park Ridge Health, and Pavillon Treatment Center.

The advisor for this project, Dr. Keith Cox, a PTSD researcher and clinician, contacted the institutions/agencies in order to speak with clinical directors at each site. Using an open-ended interview style, Dr. Cox prompted an initial survey of psychotherapy services. The interview asked the clinical directors the specific treatments for PTSD at their site. The interview script began with the following, "We are conducting a survey of psychotherapy services in the Asheville area for trauma and PTSD-related services. Could you please tell me about what kind of psychotherapy services [agency/institution name] offers?" If the initial response was unclear with regard to EBT availability, follow up questions were asked to clarify the presence or absence of EBT services. Clinical directors that listed "Cognitive Behavioral Therapy" or "CBT" as a treatment option were asked to clarify the nature of the Cognitive Behavioral

Therapy provided. Dr. Cox developed the following site categorizations: 1) provides EBTS, 2) unclear if EBT provided, 3) does not provide EBTs, 4) refers out for PTSD-focused treatment, and 5) not able to reach clinical director. Based on the interview responses, Dr. Cox assigned a site categorization for each site.

3. Results

In the PsychologyToday individual provider database, we calculated descriptive statistics for treatment orientation and training certifications. The mean number of treatment orientations listed by the individual therapists is 7.93(Standard deviation = 7.931). (See Table 1.) 75% of the individual therapists listed at least one EBT among their treatment orientations. (See Table 3.) 13 individual therapists, or 4%, listed a training certificate for an EBT for PTSD. (See Table 4.)

We found the average number of orientations to be noteworthy, and so ran further descriptive analyses. When it came to listing orientations, 31% of therapists designated five or fewer orientations, while 47% of therapists reported 8 or more orientations. See Table 2 for a frequency table on the number of orientations listed.

Of the 10 institutions/agencies on the original list, information about trauma and PTSD psychotherapy services was obtained from 6, while 4 were unresponsive to phone calls. Of the 6 institutions/agencies that provided information, 2 were designated as, "provides EBTs", 1 institution/agency was designated as, "unclear if EBT provided", 2 were designated as, "does not provide EBTs", and 1 was designated as, "refers out for PTSD-focused treatment."

3.1. Tables

Table 1. Average Number of Treatment Orientations (N=186)

	Number of Self-Reported Orientations:
Mean (Standard Deviation)	7.93 (3.72)
Median	7.0000
Mode	4.00

Table 2. Frequency of Self-Reported Treatment Orientations (N=186)

Number of Orientations Self-Reported	Frequency	Percent	Cumulative Percent
2.00	6	3.2	3.2
3.00	9	4.8	8.1
4.00	22	11.8	19.9
5.00	20	10.8	**30.6**
6.00	22	11.8	42.5
7.00	19	10.2	**52.7**
8.00	15	8.1	60.8
9.00	11	5.9	66.7
10.00	15	8.1	74.7
11.00	13	7.0	81.7
12.00	10	5.4	87.1
13.00	8	4.3	91.4
14.00	7	3.8	95.2
15.00	7	2.2	97.3
16.00	4	.5	97.8
17.00	1	.5	98.4

18.00	1	1.1	99.5
19.00	2	.5	100.0
20.00	1	100.0	

Table 3. Number of Therapists that Self-Reported at Least One EBT Orientation (N=190)

	Frequency	Valid Percent
No EBT Orientation	48	25.3
EBT Orientation	142	**74.7**

Table 4. Number of Therapists Listing Evidence-based Treatment Certification for PTSD (N=199)

	Frequency	Percent
No EBT Certification	186	96.0
EBT Certification	13	4.0

4. Discussion

The results appear to indicate that the first hypotheses, lack of access to EBTs for PTSD, was supported among institutions and agencies but was not supported among private practice therapists. We argue below that, with regard to private practice therapists, this interpretation of the results is possibly inaccurate. In addition, the results appear to support the second hypotheses that non-EBTs for PTSD are widely offered.

At the institutional level, only 2 of the 6 institutions interviewed were able to give clear evidence of EBT's for PTSD. For many civilians it is easier to seek help from institutions and agencies before researching individual providers. However, from our research, it is evident that civilians seeking help for PTSD or trauma from institutions/agencies are disadvantaged. Only 1 in 3 institutions/agencies claim usage of EBTs. Moreover, all of the 10 institutions or agencies in our survey claimed, on their websites, to treat trauma or PTSD. Since institutions/agencies are generally easily accessible and highly suggested resource for civilians, the availability of effective treatment is necessary. This is especially the case if the institution or agency is claiming to treat trauma and PTSD.

The individual therapist data appears to present broader access to EBTs, as 75% of individual therapists reported the use of at least one EBT orientation. With an overwhelming percentage of therapists claiming multiple orientations, the quality of the treatment comes into question. With the consultation of another clinical psychologist, the advisor for this paper, Dr. Cox argues that a therapist is likely to be well-trained in two or three orientations and potentially five orientations at most. From this, we suspect that therapists that list 8 or more orientations are likely to be claiming multiple orientations in which they are not well-trained or with which they do not have demonstrated competency. This is especially problematic as 47% of the private practice sample claimed 8 or more orientations. For this reason, we suspect the accuracy of the orientation claims of a large percentage of the private practitioners. We suspect the percentage of therapists using EBTs for PTSD is much smaller than 75%. This belief is supported by the fact that only 4% of this sample of private practitioners claimed a certification in an EBT for PTSD. We take the certification claim to be a more trustworthy indicator of EBT service provision.

Regarding hypothesis two, the study indicates that many therapists offer non-EBTs to treat PTSD. Of the all the individual providers that claim to treat PTSD on the PsychologyToday database, 25% did not list a single EBT orientation. Furthermore, many therapists that listed an EBT as one of their treatment orientations, listed a number of non-EBTs. Many therapists listed one EBT while listing three, five, or even ten, non-EBTs. This suggests the possibility that many private practice therapists are treating patients with non-EBTs. We only suggest this as an interpretation, though, as the PsychologyToday website did not provide information on which orientation a therapist generally used, or used first, in treating trauma and PTSD. For institutions and agencies, 1 of 6 did not provide clear evidence of an EBT, while 2 of 6 provided clear evidence of non-EBTs. Thus, a third to a half of surveyed institutions/agencies offered non-EBTs for PTSD. Thus, both the private practice and institution/agency evidence suggest that non-EBTs for PTSD are widely offered.

This study has a few limitations. It is uncertain of how representative our sample is. With individual providers, we feel confident that 199 therapists includes a large majority of private practice therapists that treat PTSD in Asheville. Thus our private practice database is a reasonably comprehensive sample. However, a random sample of all private practice therapists would improve the ability to make claims about representativeness of the sample. When it comes to institutions/agencies, we only obtained information on 6 out of 10. We cannot determine if the survey results would look different if the other four responded. Our list of 10 might also be missing institutions/agencies that provide trauma and PTSD services. In addition, we relied on self-reported data in an interview report of clinical directors for the institutions/agencies, and we relied on a therapist online profile advertisement for the private practice therapists. Both of these methods might give biased results. Further research needs to consider other methods to determine EBT availability.

There seems to be a large availability of treatments for PTSD, but a large gap in the amount of EBTs available for civilians. Many EBTs are inaccessible for civilians and many non-EBTs are being offered. It is likely many patients, without knowing it, are being offered non-EBTs. From this data, the effectiveness of PTSD treatment in the Asheville area for civilians is still unknown.

5. Conclusion

Evidence-based treatment availability for civilians suffering PTSD in the Asheville area likely contains large gaps. A third of surveyed institutions/agencies offer EBTs. Individual therapists are found to claim to provide EBTs in large numbers, but it is unclear as to what treatments are actually being used. Moreover, it appears that non-EBTs for PTSD are being offered widely by both private practice providers and in institution/agency contexts..

Our conclusions are not error free. Although we find that many therapists offer non-EBTs, we do not know what treatments are being highly suggested from therapists or institutions/agencies. More research must be done in efforts to discover what treatments are being recommended to and used with patients with PTSD..

6. References

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