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Responses of a Sample of Practicing Psychologists to Questions About Clinical Work With Trauma and Interest in Specialized Training

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This study reports on selected findings from a survey conducted by the American Psychological Association Practice Organization, which assessed the number of hours per month that practicing psychologists estimated they spent treating trauma survivors and their interest in additional clinical training on trauma-related issues and topics. Respondents reported 14.3 mean number of hours spent working with trauma survivors over the past month. Of the 76% of the sample who treated any trauma patients, the mean was 16.9 hours. Although trauma psychology is not currently an integral component of the standard curricula in graduate-level education, generalist psychology practitioners are treating trauma-related concerns in their clinical practices. It is imperative therefore to ascertain if they are adequately trained in specialized trauma recognition, assessment, and treatment. The fact that almost 64% of survey respondents expressed interest in participating in educational endeavors to learn more about trauma-related clinical topics suggests that such a need exists and that more training opportunities, including ongoing continuing education offerings, should be organized.

Keywords: psychotherapy, evidence-based practice, professional practice, stress disorders, posttraumatic, education

Many individuals in the United States are exposed to traumatic events at some point in their lives (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), a statistic that extends to individuals in other countries around the world (e.g., De Vries & Olff, 2009). Conservative estimates indicate that almost 60% of Americans have experienced at least one event in their lifetime that would be considered traumatic, such as child maltreatment, interpersonal violence, natural disaster, war, or serious accident, (Breslau et al., 1998). Although the majority of individuals who experience a single potentially traumatic event do not have long-term negative consequences, a substantial minority (especially those who are multiply traumatized, particularly during childhood) develop significant mental and behavioral health difficulties (Courtois & Ford, 2009; Kilpatrick et al., 2003). Indeed, traumatic exposure has been implicated as a risk factor for numerous major mental disorders, including depression, substance abuse/dependence, Posttraumatic Stress Disorder (PTSD), other anxiety disorders (Green et al., 2010; McLaughlin et al., 2010), dissociative disorders, and personality and developmental disturbances and disorders. In addition, trauma is associated with physical health problems, negative health behaviors such as smoking and excessive alcohol consumption, poor social and occupational functioning, and overall decreased quality of life (Kessler, 2000). Naturally, a history of traumatic exposure and related disorders and problems in functioning are much more prevalent in clinical samples than in the general population. Thus, the relevance of trauma to general clinical practice is very high (Gold, 2004).

Exposure to trauma and its potential and resultant negative consequences have been recognized as a public health problem of major proportion (U.S. Department of Health & Human Services, 2003; U.S. Surgeon General, 1999). Although the scientific literature on traumatic stress is large and growing exponentially, most psychologists and other medical and mental health providers have only a cursory knowledge of the impact of trauma and related treatment. Events of national and international scope throughout the past decade, such as the terror attacks of September 11th, the wars in Iraq and Afghanistan, and devastating natural disasters such as the Asian tsunami of 2004, Hurricane Katrina, and the Haitian earthquake have deepened public awareness of the of different types of trauma and their potential posttraumatic consequences. In addition, there is an increased societal acknowledgment over the past several decades of the scope of interpersonal violence, both inside and outside of the home and family. This

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improved awareness has likely had the effect of encouraging a greater number of trauma survivors to seek mental health services for their posttraumatic reactions. This, in turn, will lead to an associated need for mental health professionals to be knowledgeable and trained in delivering such specialized services.

There are likely additional reasons for the increase in those seeking trauma-specific treatments. For example, there are now empirically sound assessments for traumatic exposure and PTSD (Wilson & Keane, 2004) and well-established efficacious treatments for PTSD in both children and adults (for review, see Foa, Keane, Friedman, & Cohen, 2009). Certainly the existence of psychometrically reliable and valid diagnostic assessment tools suggests increasing accuracy in diagnosis and potentially referrals for trauma-specific treatments.

Relatedly, there are also now governmental agencies dedicated to the understanding and addressing the needs of trauma survivors (e.g., the National Center for PTSD and the National Child Traumatic Stress Network). More specifically in 1989, in response to a U.S. Congressional mandate, the Department of Veterans Affairs created the National Center for PTSD to serve as a research and education center of excellence on PTSD, with primary purpose of improving the well-being of American veterans (National Center for PTSD, 2011). In addition, through grants awarded through numerous federal agencies, the National Child Traumatic Stress Network was established in 2000 to improve access to care, treatment, and services for children and adolescents exposed to traumatic events through academic and community-based collaborations (Pynoos et al., 2008). Both the National Center for PTSD and the National Child Traumatic Stress Network have trained large numbers of clinicians to deliver evidence-based treatments for PTSD. For example, over the past several years, two evidence-based psychotherapies, Prolonged Exposure and Cognitive Processing Therapy, have been nationally rolled out within the U.S. Department of Veterans Affairs (Karlin et al., 2010). Numerous efforts to disseminate and implement evidence-based trauma treatments took place following the 9/11 terrorist attacks in New York City (e.g., Amsel, Neria, Marshall, & Suh, 2005; CATS, 2007; Norris & Rosen, 2009). In addition, several state governments have engaged in training their mental health workforce in trauma-specific treatment (e.g., Northwestern University Mental Health Services and Policy Program, 2008). It may be that some governmental agencies recognize that engaging in trauma-specific treatments is an important avenue for efficient and effective delivery of services as well as cost containment.

Unfortunately, trauma-related material is not routinely included in the professional training of most psychologists, nor is it included in the training of allied professionals (Courtois & Gold, 2009). At present, the best available data on the inclusion of trauma psychology in undergraduate and graduate training in psychology comes from a systematic series of web-based searches by the Division 56 Education and Training Committee (American Psychological Association, 2009). In addition, the Association of Psychology Postdoctoral and Internship Centers (APPIC) reports there are currently 171 postdoctoral or graduate internships offering a major in trauma, PTSD, or sexual abuse with an additional 614 offering intensive study in these fields as a minor (APPIC, 2011). The findings indicate that there are still relatively few clinical or counseling programs and internship sites that routinely offer such topics as part of their training. The result is a major gap in service needs and the ability to deliver specialized trauma-relevant and responsive services (Courtois, 2001). This is especially problematic since the treatment of trauma survivors has been found to have relational, topical, and risk management challenges that are different than those found in other treatment populations and that can confound the therapist and interrupt the therapy. Moreover, if not managed knowledgeably, these challenges can overwhelm and harm both the therapist (through vicarious traumatization) and client (through retraumatization).

In order to best prepare to meet the need of the expanding population of trauma survivors seeking mental health services, more information is desirable regarding psychologists' current practice patterns, background training to provide services, and interest in additional training. An initial step in gathering this important information was undertaken by the joint efforts of the American Psychological Association's Practice Organization (APAPO) and APA's Division of Trauma Psychology (Division 56). Items on the amount of clinical time spent working with trauma survivors and interest in additional training in trauma were added to a survey of practicing psychologists conducted by the APAPO. The purpose of this article is to report on preliminary findings in response to these trauma-specific questions.

Method

The APAPO added two items to a web-based survey which was conducted in September 2010. One item was an estimation of the amount of time practicing psychologists spent in the treatment of traumatized clients (i.e., "In your last typical month of professional practice, how many hours did you spend in clinical work with traumatized patients?"). The second item was psychologists' perceived need to develop greater expertise in providing services to traumatized clients via additional training (i.e., "If specialized training opportunities were offered to advance your expertise in working with trauma patients, how likely would you be to participate?"). The potential responses were: *not at all*, *a little*, *somewhat*, *very much*, and *completely*.

In addition, participants were asked a number of other questions including whether they provided direct psychological services and the number of years they had provided such services. In the survey, direct psychological services were defined as any psychological services delivered through face-to-face interaction with a patient/client, such as clinical interviewing, psychotherapy, psychological/personality assessment or testing, and other related services.

E-mail invitations were sent by the APAPO to a random selection of 1,973 (out of 37,343) practicing psychologist members. The APAPO is a companion organization to APA, whose members are psychologists who provide mental and behavioral health services and who are licensed to practice in their respective jurisdictions. The APAPO promotes the professional interests of practicing psychologists in all settings.

It is estimated that approximately 20% of the invitations did not reach their intended recipient, either due to invalid e-mail addresses or spam filtering. Each potential participant was sent three reminders to complete the survey. The first reminder was sent two months after the survey launched, while the second and third were sent a month after the previous reminder. Two hundred nineteen individuals looked at the survey but did not answer any questions and 276 individuals participated. Of these, 263 provided complete

data and 13 provided partial information. Eysenbach (2004) suggested that in the reporting of web-based surveys, various response metrics, such as view, participation, and completion rates, should be reported. Lack of information about the number of unique visitors to the website prevented calculation of exact view and participation rates. An estimate of participation rate is the number of website survey registrations (219 + 276 = 495) divided by the number of subscribers who were sent e-mails (1,973) is almost 40%, which is likely very conservative because it is unlikely that every subscriber who was sent an e-mail visited the website. The completion rate among individuals who consented to participate was 95% (263 out of 276).

Regarding the representativeness of the sample, there do appear to be differences between participants and the APAPO membership in regards to several demographics, namely age, gender, and ethnicity. The APAPO membership appears to be younger (X = 53.3 vs. 57.7 years), have more women (57% vs. 48%), and contain more ethnic minorities (5.5% vs. 4.8%) than survey respondents.

Results

The mean age of participants was 57.7 years (*SD* = 8.8) with a range from 31 to 81. Fifty-three percent were men. Ninety percent were White/Caucasian, 1.5% Hispanic, 1.1% Black/African American, 1.2% other, and 4.2% declined to answer the question on race/ethnicity. Two hundred sixty one participants reported that they provided direct psychological services (95.6%) and 12 did not (4.4%). Thus, responses below are based only on those who provide direct services. The mean number of years in practice was 26.7 years (*SD* = 9.6), with a range of 4 to 55 years.

Of the 245 who provided a response to the two trauma questions, the mean number of hours spent working with trauma survivors was 14.3 (*SD* = 18.5) with a minimum of 0 and a maximum of 92. Of those, 16% did not spend any time working with trauma survivors over the past month; 25% spent a little time (1–5 hours); 50% spent some time (6–15 hours); and 9% spent a good deal of time working with trauma survivors (16–92 hours). Of those who reported any clinical work with trauma survivors (*N* = 206; 84%), the mean number of hours was 16.9 (*SD* = 19.0).

Regarding interest in specialized training opportunities in trauma psychology, 23 (10.5%) responded that they had *no interest*, 45 (19.9%) endorsed *a little*, 72 (31.9%) indicated *somewhat*, 63 (27.9%) said *very much*, and 16 (7.1%) said *completely*. The relationship between time spent working with survivors and interest in specialized training was examined. Spearman's rho (.372) was significant at p. <001, indicating that 37.2% of the variance in interest in training is explained by time spent working with survivors. More specifically, the majority (61.5%; 24 out of 39) of those who did not do any clinical work with trauma survivors expressed little to no interest in specialized training. The majority (61.3%; 48 out of 62) of those who reported conducting a little clinical work with survivors expressed at least some interest in specialized training. The majority (81%; 117 out of 144) of those who worked some or often with trauma survivors expressed interest in additional training.

Discussion

This first step in gathering data on practicing psychologists' current clinical work with trauma survivors and interest in specialized training is informative despite the fact that the sample size was small, the percentage of respondents fairly low, and the representativeness of the sample is unknown. For example, the mean number of hours spent working with trauma survivors in a typical month was reported by this cohort to be 14.3 hours. Given that trauma is widespread in the general population and that rates are known to be higher in clinical populations, it might be assumed that trauma may be a more pervasive issue in clinical practice than reported by this sample. It remains an open question as to whether individuals experiencing trauma-related problems are being adequately identified by therapists and are receiving appropriate or sufficient treatment.

Given that trauma-related topics are not currently integral components of the standard professional training curricula in psychology and allied professions (Courtois, 2001; Courtois & Gold, 2009), it is likely that psychologists (and other medical/mental health professionals) have had inadequate training in the recognition, assessment, and treatment of trauma. While trauma is not always the primary, direct, or sole cause for all psychological problems, it may be a hidden variable that increases client's risk or compounds difficulties or prevents recovery from other mental health disorders. Moreover, as the complexity of trauma increases, developmental and comorbid conditions also increase (e.g., dissociation, complex PTSD), creating an even greater need for specialized knowledge and skills pertinent to these issues (e.g., Courtois & Ford, 2009). Therapists who work with trauma and who have little to no specialized training run the risk of practicing outside of their area of competence.

The extreme circumstances in which some traumas occur and the attendant psychological consequences can create conditions that increase the risk for practitioners, including their ability to set and maintain appropriate therapeutic boundaries and limits. Specialized training helps therapists to know of the various "treatment traps" and risks that are common in this population and to develop skills and strategies in their management (Chu, 1988). In addition, the conditions that promote the occurrence of certain types of trauma and exacerbate the effects of trauma require the practitioner to be sensitive and responsive to social, political, and cross-cultural issues. Age, ethnicity, disability status, gender, and sexual orientation become critical components to integrate into culturally competent trauma practice (Brown, 2008). In a related vein, the conditions of traumatic exposure create personal and relational difficulties in many survivors that enter the treatment process, including mistrust, problems of emotion regulation, and ambivalence about the possibility of recovery (e.g., Cloitre et al., 2010). Mental health professionals working with traumatized clients should be trained to expect such relational process and client characteristics, and receive training and supervision in ways to most productively approach and work with these issues.

There are additional reasons to insure adequate training in the trauma-specific treatment. It is suspected that without adequate training, well-intentioned clinicians may collude with their client's avoidance symptoms, and thus potentially reinforce beliefs that treatment is not effective or is too painful to consider. Addition-

ally, without adequate training, clinicians may retraumatize the client.

Increasing promotion of evidence-based treatment of PTSD has thus far had limited impact on patterns of community practice (Becker, Zayfert & Anderson, 2004; Gray, Elhai, & Schmidt, 2007; Pignotti & Thyer, 2009; Rosen et al., 2004; Sprang, Craig, & Clark, 2008). For example, Becker and colleagues (2004) assessed the use of imaginal exposure for PTSD in a random sample of licensed psychologists from three states. Even though roughly half reported at least some familiarity with exposure therapy for PTSD, only a minority used it in clinical practice. Additionally, attitudes toward and utilization of evidence-based practice were examined in a sample of ISTSS members, the majority of whom were psychologists (Gray et al., 2007). While most reported being favorably inclined toward using empirical research to inform their clinical work, less than half reported that they primarily used evidence-based treatments for PTSD.

Although information from the present study came from only two survey items, the magnitude of interest reflected in the data is striking, particularly because the survey was aimed at practicing psychologists in general, not trauma practitioners in particular. Indeed, the use of the phrase "traumatized patients" might have influenced the responses that were received and indicate underreporting of services. For example, it is possible that clinicians might have only included hours where they focused on PTSD instead including other trauma-related deleterious mental and behavioral health outcomes such as depression, economic problems, occupation problems, and chronic pain/health problems. Thus, different phrasings might have led to even larger reports of the number of hours in practice with trauma-exposed clients working on a range of issues. More research is needed in regard to which practitioners provide psychological services to trauma survivors, what they are currently doing, and what kinds of training prepared them (e.g., graduate coursework, practicum placement, internship rotation, specialized internship, postdoctoral training, on-the-job training, and informal experience). Further information is also needed on what additional training practitioners need in order to provide high quality services and on what topics (e.g., particular types of trauma, information on assessing trauma-related pathology treatment) and formats (e.g., weekend workshops, web-based instruction, video courses) they would be interested in accessing training.

Perhaps one of the most important findings was that clinicians who are not seeing "traumatized patients" do not report an interest in educational opportunities. Given the scope of trauma exposure and its consequences, it seems quite surprising that these clinicians do not have trauma-exposed clients in their practices who are actually dealing with trauma-related emotional, social, or economic consequences. One fundamental question from these data then is how the traumatic stress field reaches out to those clinicians who don't believe they have a stake in trauma education.

Fundamental to successful matriculation in work with traumatized populations is adequate supervision and consultation, both for practicing clinicians and those still in training. Movement toward a competency-based model of training and assessment has taken hold in the broader field of psychology and numerous other health care disciplines (APA, 2006; Epstein & Hundert, 2002). Although not yet proposed in trauma training, a competency-based framework can assist in identifying the training and assessment needs of students and practitioners working with traumatized populations. The cube model for competency development (Rodolfa et al., 2005) provides a means for assessing learning and outlines competency attainment at each stage of a psychologist's career (from doctoral training through continuing education). Essential to mastery of competencies at each stage is the provision of support and feedback through supervision, consultation, and mentoring.

Recognition of the current lack of standardization and accessibility to trauma-specialized training has led to a call for the integration of trauma into the standard curriculum for psychology students and highlights the unique opportunity practicum, internships and externships, and clinical training courses provide in their unparalleled access to supervised clinical experience (Courtois, 2001; Courtois & Gold, 2009; Hatcher & Lassiter, 2007). The current lack of a formal curriculum, formal supervision, and means of assessment for trauma training extends into the professional workforce, placing the burden of accessing trauma training resources on individual clinicians motivated by their exposure to traumatized individuals in their practice (Courtois & Gold, 2009). The fact that almost 64% of the sample expressed interest in participating in educational endeavors to learn more about trauma and its treatment suggests both the need and the imperative for additional training, both in the professional training curriculum and in continuing education endeavors.

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