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Provider Perspectives on Choosing Prolonged Exposure or Cognitive Processing Therapy for PTSD: A National Investigation of VA Residential Treatment Providers

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Abstract

As part of a longitudinal mixed-methods investigation on implementation of two evidence-based psychotherapies (EBPs) for Posttraumatic Stress Disorder, 164 mental health providers from 38 Department of Veterans Affairs (VA) residential treatment programs across the U.S. were asked questions about their decision-making for using Prolonged Exposure and Cognitive Processing Therapy. Many providers viewed both EBPs as equally efficacious and encouraged veterans to decide for themselves which treatment they wished to engage in. Some providers said that it was hard to know which EBP would be the most effective for a given patient, and that occasionally they started work with a veteran thinking that a particular EBP would work and were surprised when the veteran did not receive the full potential benefit of the intervention. Other providers noted that their decision-making regarding which EBP to use depended on the type and nature of the veterans' index trauma, memory of the trauma, and traumatic stress symptoms (e.g., fear versus guilt). Additional factors that impacted the choice of EBP included whether the patient already had one of the treatments before or if a provider deemed one as more compatible with their previous training. Implications for clinical practice as well as the design and improvement of training and implementation efforts are discussed.

Keywords

evidence-based practice; posttraumatic stress disorder; veterans

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Almost 10 years ago, the U.S. Department of Veterans Affairs (VA) began a signficant investment of resources to provide their mental health workforce with training, supervision, staffing and support in over 15 evidence-based psychotherapies (EBPs; Karlin & Cross, 2014). This national effort provided both the opportunity and funding to be trained in these modalities, supervision and consultation with treatment developers and key opinion leaders, and champions in each medical facility to support EBP integration. Two EBPs for posttraumatic stress disorder (PTSD) were part of this national training initiative (Karlin et al., 2010): Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2016). Since this national initiative, use of PE and CPT in the VA health care system has been somewhat variable. Two regional studies have suggested low levels of PE and CPT receipt (e.g., Finley et al., 2015; Shiner et al., 2013), whereas a nine-site study of outpatient programs across the U.S. indicated a range of utilization, including substantial numbers of providers who report frequent use (Sayer et al., 2017).

Although PTSD has a particular relevance for military personnel and veterans, it also is a disorder that affects up to 10% of the general U.S. population. Ruzek and Rosen (2009) argued the imporantance of disseminating EBPs for PTSD given the high prevelance and impact of trauma, which is widely known to cause emotional and behavioral consequences, and the availability of EBPs to mitigate or improve these negative outcomes. The VA training initiative offers an excellent opportunity to understand the dissemination and implementation of EBPs in a highly resourced health care system. Findings may have relevance to other health care systems (Solberg, 2009) as well as mental health providers in private practice.

A recent synthesis of VA research and evaluation efforts regarding implementation of PE and CPT indicated that one of the most important facilitators to delivery was clinician beliefs regarding efficacy of these EBPs (Rosen et al., 2016). Provider views of PE and CPT have been measured in several studies. In one study, providers demonstrated significant increases in their attitudes toward the utility and effectiveness of CPT after completing a training workshop (Chard et al., 2012). Similar results were found following PE training with providers showing an increase in positive and a decrease in negative patient outcome expectancies post-workshop (Ruzek et al., 2016). In addition, VA residential treatment providers' specific positive views of PE and CPT were related to the increased use of these treatments (Cook, Thompson & Schnurr, 2014). To date, however, there has been limited research examining what influences clinician beliefs about specific EBPs or their choice regarding treatment selection.

Studies on provider decision-making around choosing an EBP for PTSD have typically focused solely on exposure therapy (e.g., Litz, Blake, Gerardi, & Keane, 1990; van Minnen, Hendriks, & Olff, 2010). However, recently one study presented 274 VA mental health providers trained in both PE and CPT with a quantitative checklist of 29 factors (e.g., current depression, strong guilt, current self-injury, combat trauma, etc.) asking if these influenced their clinical treatment selection for PTSD (Raza & Holohan, 2015). Most providers (63–81%) reported that they would use PE or CPT for the majority of the factors presented (i.e., single [n = 158] or multiple traumas [n = 155], combat [n = 193] or non-combat trauma [n

=199], military sexual trauma [*n* = 177], depression [*n* = 166], anger [*n* = 145], disgust [*n* = 154], and general anxiety [*n* = 168]). Providers were more likely to select PE over CPT when a veteran had low literacy or poor cognitive functioning, mild, moderate, or severe traumatic brain injury (TBI), single as opposed to multiple traumas, or current panic attacks. Providers reported that they were more likely to select CPT over PE when a veteran had strong guilt or shame or subthreshold PTSD. Factors such as history of dissociation, current substance dependence, and acts of perpetration resulted in the least provider consensus. Similar results were found in a study investigating factors that influenced providers' overall use of either PE or CPT in VA residential treatment programs (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014). In this study, providers identified three broad themes that impacted EBP use: presence of psychiatric comorbidity, cognitive limitations, and level of patient motivation. In another investigation, 16 mental health providers from two VA medical centers reported that patient readiness (e.g., willing to engage in trauma-focused psychotherapy, adequate coping skills, low suicidal risk, and relatively stable home environment) and presence of co-morbidities influenced decision to use PE or CPT (Osei-Bonsu et al., 2016). Findings on provider perspectives of patient readiness to engage in trauma-focused therapies were echoed by PTSD outpatient clinic directors (Hamblen et al., 2015), as well as PTSD residential treatment providers (Cook, Simiola, Hamblen, Bernardy, & Schnurr, 2017). Together, this suggests both patient and provider-level factors may contribute to VA providers' clinical decision-making for treating veterans' with PTSD.

Since there are no current guidelines (e.g. American Psychological Association, 2017; VA & Department of Defense, 2017), or as yet definitive empirical evidence, to direct the selection between PE and CPT for PTSD, some have advocated for evidence-based principles and critical thinking to guide choice (DeRosa, Amaya-Jackson, & Layne, 2013). The purpose of this paper is to extend the findings of Raza and Holohan (2015) by using qualitative analyses to better understand VA PTSD residential treatment providers' decision-making around using PE or CPT in their clinical programs. The residential treatment setting is an ideal setting to conduct such research, as patients are removed from external stressors, such as relationship, job or housing difficulties, and providers can deliver the treatments over an extended period of time without interruption. In addition, these settings have a relatively high implementation of EBPs, particularly CPT, giving providers a lot of experience and an in-depth perspective (Cook et al., 2013). Lastly, most veterans admitted into VA residential programs have severe, chronic PTSD and complicated life problems (Walter, Varkovitzky, Owens, Lewis, & Chard, 2014). Taken together, it was hypothesized that providers in this setting would expand previously identified factors that influence treatment selection. VA provider perspectives on the choice and preference of PE and CPT may provide helpful information to facilitate the dissemination and implementation of trauma-focused EBPs in private and other public mental health systems.

Method

Participants and Procedure

Data presented in this paper are part of a five-year longitudinal mixed-methods investigation of the implementation and sustainability of PE and CPT in VA residential treatment

programs across the United States (**, 2014). This study was exempted for review from the Yale Human Research Protection Program and approved by the VA Connecticut Health Care System's Institutional Review Board. Data presented here come from the final year of data collection (2015). Participants were recruited from VA residential PTSD treatment programs reporting patient outcome data to the VA Northeast Program Evaluation Center. Since the methodology of the study was first published (see **, 2012), two of the 38 programs closed, and four new programs were added, leaving 40 programs available for study. Two sites completed the survey only, leaving 38 sites in the current sample. Data presented in this manuscript was obtained through qualitative methods only. Within those 38 sites, a total of 214 VA residential PTSD treatment directors, providers, and staff were contacted to participate in the semi-structured interview. Of the 214 people approached to participate, 164 (76.7%) completed the qualitative interview.

Demographic information about the sample is presented in Table 1. A majority of providers were White (81.0%), psychologists (44.2%) or social workers (35.0%), and had been practicing clinically for, on average, 13.91 years. Although the vast majority of providers were trained in PE or CPT, some were not actively providing either of these therapies in their residential program. Only four (2.4%) providers in the entire sample had no training (VA or informal) in either PE or CPT. Further, only 29 (17.7%) providers had training in CPT but no training in PE, and six (3.7%) had PE training but no CPT training. All providers in this sample were included here as all were involved in helping veterans choose either PE or CPT, referring them to another therapist for the therapy they themselves might not offer, or referring them to another program for a treatment not offered in their program.

Implementation of PE and CPT varied across sites. For PE, five (13.2%) sites did not adopt the treatment, two (5.3%) de-adopted the treatment (after adopting PE for a period of time they stopped using it), eight (21.1%) adopted elements (e.g., in vivo exposure) of the treatment, 13 (34.2%) provided the full treatment to select veterans, eight (21.1%) provided PE to veterans in a particular trauma track, and two (5%) adopted PE as the core of all of their programming. For CPT, four (10.5%) sites did not adopt the treatment, three (8.0%) adopted elements of the treatment, six (15.8%) provided the full treatment to select veterans, 11 (28.9%) provided CPT to veterans in a particular trauma track, and 14 (36.8%) adopted CPT as the core of their treatment program. Only one site did not adopt any elements of either PE or CPT.

Telephone interviews lasted for approximately 30–60 minutes and were conducted by one of two psychologists (**, **). A semi-structured interview, modified from a previous guide (**, 2012), was utilized to allow for content coverage as well as conversational flow. Each interview session was audio-recorded and transcribed. The following questions were included and are the main focus of this paper: "Who do you think benefits from PE and/or CPT?," "How do you choose which treatment [PE or CPT] to use?," and "Do you have a preference for one treatment over the other? If so, why?"

Data Analysis

Data were analyzed from a grounded theory standpoint using open, axial, and selective coding. Written transcripts from the 164 interviews were reviewed by three licensed clinical

psychologist coders (**, ** and **). Each transcript was independently reviewed in its entirety and coded for all answers that were relevant to the current study questions. The raters compared their lists and any areas of discord were discussed until a consensus was achieved.

The initial guiding questions centered on what factors go into a provider's decisional process in choosing EBPs, specifically PE or CPT. We coded to determine the factors that related to providers' preference for utilizing PE and providers' preference for utilizing CPT. Text from the transcribed interviews that supported the themes was extracted and reviewed by all authors.

Results

Providers indicated that there are two broad themes that impacted their decision-making regarding selection of PE or CPT as a treatment modality: their own considerations and veteran variables, with several sub-themes composing each. Table 2 is a summary of provider perspectives regarding their decision-making when choosing between PE and CPT for veterans with severe, chronic PTSD.

Provider-Specific Considerations

Belief in treatment efficacy (*n* = 128; 78.0%).—Generally, providers indicated that they viewed both treatments as effective. They explained that, in their opinions, neither treatment was superior or "better" than the other. In programs where both treatments are offered to veterans, providers purport that they discuss both treatment options equally with their veterans rather than emphasizing one treatment above the other. Specifically, providers said that they use their conceptualization and understanding of the veteran's problems and goals for recovery as well as the veteran's preference to jointly determine which treatment they initiate. As one provider explained, getting to know the veteran assists in decision-making, "We arrange phone calls up front … get to know them and through that interaction with them you just kind of get this intuitive sense. what therapy is better for healing them." Some providers also reported difficulty knowing if or which treatment a veteran might respond to better.

Provider preferences (*n* = 60, 36.6%).—Comfort, experience and compatibility with previous training and theoretical understandings of PTSD influenced provider choice in treatment delivery. Providers whose education in graduate school and training focused on exposure therapy reported greater familiarity and comfort around delivering PE. Other providers expressed greater familiarity and comfort with CPT techniques that are central to cognitive behavioral therapy (CBT). One provider said, "Because I've had CBT for so long that CPT is just very much what I do. I'm very comfortable in CPT. Personally I will always kind of lean towards CPT just because it's comfortable and I know it almost backward and forwards." Relatedly, providers' conceptualization of how PTSD develops and resolves influenced their decision to use either PE or CPT. As one provider said, "PE really goes straight for the jugular on the core of what PTSD is, which is basically never ever wanting to be vulnerable or helpless. … It's like it goes directly against the PTSD's grain, you know?" Another said, "For me, PE just makes more sense. The emotional processing theory makes

more sense to me intuitively, and I guess it just fits in better for me, and maybe that's why I can explain it better."

Providers also addressed how these EBPs impact them personally and affect their delivery over time. Many providers stressed how challenging it can be to work with trauma survivors, and how choosing a treatment they enjoy doing can counteract potential burnout. As one provider said, "I kind of like CPT compared to PE. CPT is less of a drain on my mood. … There's such an intellectual component engaging with the patient. It's actually easier for me to tolerate emotionally doing it." Another provider explained, "I do prefer CPT. … I think it's like more – I don't want to say the word 'fun,' but more of a cognitive challenge for me. So my brain likes it."

Integrating treatment approaches (*n* = 41, 25.0%).—Finally, providers spoke about how, at times, they felt that there was no need to choose between PE or CPT. Rather they believed that veterans would benefit from an integration of elements of PE and CPT. For example, one provider said, "Right now I have someone on my caseload who is doing CPT, but they're doing in vivo work too; hierarchy and SUDS [Subjective Units of Distress] and all that." Another provider stated, "We need the combination CPT/PE type of thing. I find so many of the guys that the CPT is really useful for them, but they need to do more trauma processing like they do in PE." Collectively, providers acknowledged that the literature currently does not indicate that PE and CPT should be delivered together.

Patient-Specific Considerations

Type and nature of index trauma and trauma memory (*n* = 44, 26.9%).—Some providers explained that the nature of their veteran's trauma guided their decision to use PE or CPT. For example, when a focal or a clear singular index trauma could be identified, providers reported that they more often used PE. As one provider said, "PE might be good when we're stuck with this one particular traumatic event," and another elaborated, "What I'm looking for PE is someone who has a very distinct index trauma. Not someone who necessarily has multiple traumas, though that sometimes can work, but something that is very distinct." For some providers, identifying a single discrete trauma was seen as a challenge involved with using PE, particularly when working with combat veterans, as they noted it was difficult for these veterans to identify just one incident that was particularly bothersome.

Symptom presentation (*n* = 74, 45.1%).—Providers explained that veteran's symptoms influenced their decision about which EBP to use. Indeed, providers identified that if the veterans' primary struggles were with avoidance and hyperarousal, they would be more likely to use PE. Alternatively, when the veterans' primary presentation was cognitive distortions about themselves, others or the world, CPT was generally the preferred choice. There were discrepancies between providers in their decision-making about the appropriate EBP for those with more complex psychiatric and personality presentations.

The affective component of the veteran's trauma reactions also played an important role in providers' decision to choose one of these EBPs over the other. Providers reported using PE when a veteran presented with intense fear associated with the trauma, whereas providers

stated using CPT more frequently with veterans who had predominant guilt. One provider explained, “If there is more self-blame, there is a lot of focused guilt that CPT was sort of the way to go, and then if it was sort of more of they’re re-experiencing or just more sort of agitation, hyperarousal, that PE would be more indicated.” Additionally, some providers explained that veterans with moral injuries (i.e., difficulty accommodating war-related actions that go against their previously developed moral judgments), self-blame, depressed mood, dissociation, and ruminative thoughts were seen as more likely to benefit from a course of CPT. For example, one provider stated the following:

> What I’ve found is that people can go through, they can do PE, they’ve worn out a lot of the memory, a lot of the anxiety, they’ve processed it, but were kind of left with this residual guilt that for whatever reason the PE didn’t seem to touch as well.

Cognitive styles (*n* = 65, 39.6%).—Veteran cognitive styles also influenced providers’ choice of EBP. Some providers reported that PE was preferred for those veterans who tended to intellectualize their traumatic experiences and associated problems because it required the veteran to experience emotions. As one provider said, “Veterans who tend to get real heady, you know who like to spend a lot of their time in their heads and thinking about stuff rather than feeling things, we often times will ask them to try PE, because we want them really in touch with something other than their thought process.” PE was also preferred for veterans who had difficulties considering alternatives to various situations as providers felt this would pose a barrier for challenging beliefs, as required in CPT. In contrast, CPT was reported to be an appropriate modality for veterans who are regarded as “psychologically-minded” and “insightful.”

Veteran treatment history (*n* = 28, 17.1%).—Another factor that influenced providers’ choice of PE or CPT was whether the veteran had previously engaged in either of the therapies. Providers explained that if someone had completed a course of either EBP, and still had unresolved symptoms, they were more inclined to offer the other treatment rather than a second course of the prior treatment. However, providers generally stated that this would not be the only factor that influenced their decision.

Veteran preference (*n* = 37, 22.6%).—Of the VA PTSD residential treatment programs that offered both PE and CPT, providers explained that the veteran’s choice weighed heavily in a shared decision-making about the treatment modality used. One provider clearly articulated this process, “The short answer is we let the veteran decide. We give them the information on both CPT and PE. We give them the DVDs, we watch them, and we talk with them.” Many providers explained they provide their veteran with both treatment options and then give a recommendation for either PE or CPT. However, these providers acknowledged that veteran buy-in superseded their own inclination for which treatment might be more effective, stating that, “If they have a strong preference either way, that’s what we typically tend to go with.”

Discussion

This study reports on the decision-making of VA residential PTSD treatment providers when considering whether to recommend PE or CPT in the treatment of PTSD. Both patient and provider variables were deemed as influential. Providers indicated that a number of their own considerations impacted their choice between PE and CPT: 1) their belief that both treatments are effective; 2) their preference for and comfort with one over the other; and 3) preference for integrating the two EBPs to address a veteran's symptom presentation. In addition, a number of providers explained that rather than choosing between one of these EBPs, they sometimes integrated the two treatments depending on a veteran's symptom presentation.

In general, findings from this qualitative investigation from VA PTSD residential treatment providers closely mirror results from a quantitative study of VA PTSD providers that found providers tend to select EBPs in line with patient-level factors (Raza & Holohan, 2015). Providers in this study identified several patient factors as influencing their treatment choice. They listed cognitive and personality types as well as type of trauma exposure and symptom manifestation as ways of determining which treatment to use. For example, when veterans presented with high levels of trauma-related guilt, some providers stated they would lean toward use of CPT over PE. This is consistent with previous research by Nishith, Nixon, and Resick (2005), which found that CPT was more effective in reducing guilt associated with the trauma, as compared to PE, in the treatment of female civilians with rape-related PTSD. Alternatively, in this investigation, when the fear activation was greater, providers reported that they more frequently chose PE. While both of these clinical decisions have some limited empirical data, further investigation is warranted with larger sample sizes, and with male and female survivors who have a range of traumas and presenting problems. Other patient factors, such as psychiatric comorbidity and patient readiness, have also been identified in providers' choice of PE and CPT (Osei-Bonsu et al., 2017).

Our study extends findings of Raza and Holohan (2015) by identifying provider factors that influence the decision to use either of PE and CPT. Namely when providers' confidence in the efficacy of the treatment was equal, a provider's level of comfort and experience with one EBP over the other influenced their choice regarding which therapy to deliver. In addition, our results are consistent with findings from van Minnen et al.'s (2010) study, which showed that patient preference for treatment was associated with what treatment the provider chose to use. Indeed, many providers in this qualitative investigation regarded both PE and CPT as equally effective, and stated that they often engage in shared decision-making with their veterans and support their patient's preference for one treatment over the other. Consistent with the Institute of Medicine's recommendation for patient centered care (Richardson et al., 2001), providers in this study expressed high value in the ability to present both treatment options (PE or CPT) to veterans when both were available in their program. Past research suggests shared deliberation that involves, but is not limited to the provision of information is essential when eliciting patient preferences (Epstein & Peters, 2009). In a recent revision of the VA and DoD (2017) guidelines for the treatment of PTSD in veterans and military personnel, providers are encouraged to use a collaborative approach to treatment planning, such as the one developed by Mott and colleagues (2014).

Some providers also indicated that choosing which EBP to deliver was related to their job satisfaction and potential burnout. This seems in line with work by Voss Horrell, Holohan, Didion, and Vance (2011) describing the rewards and challenges of working with traumatized veterans who served in the wars in Iraq and Afghanistan. The authors encouraged providers to diversify their caseload by not only working with veterans struggling with traumatic stress, and increase their control and autonomy within their caseload by doing their own appointment scheduling, as ways to mitigate vicarious traumatization and burnout. In an investigation of VA PTSD outpatient providers, both satisfaction with the use of PE and CPT (Finley et al., 2015) and exhaustion (Garcia et al., 2015) were reported at high levels. It is possible that national mandates (VA & DoD, 2017) or other requirements to use EBPs may impact clinical care and increase staff turnover.

Some providers also explained that they integrate components of PE and CPT. Most often, this involved incorporating in vivo exposure into CPT or adding cognitive restructuring to PE. Adaptations to EBPs in the general psychotherapy arena are common and have even been speculated as necessary and possibly improve provider satisfaction (Wiltsey-Stirman et al., 2013). In a previous wave of data collection in our longitudinal investigation of the use of PE and CPT across VA residential treatment programs, ** (2014) found that PE was more likely to be incorporated into another framework (e.g., CPT), but that CPT was more likely to experience tailoring, tweaking or refining (e.g. modification of worksheets) by providers. However, the efficacy of these, and other ways of combining PE and CPT, has not yet been empirically established.

Several limitations to this study should be noted. First, the data come from open-ended interview questions that were mostly, but not universally, answered by all providers. Themes were not analyzed based on provider characteristics (e.g., age, gender, profession, years practicing clinically), though this may be an important endeavor for future research. This research included only VA residential PTSD treatment programs, which represents a small and distinct faction of care, treating the most chronic and severe patients with complicated symptom presentations and life circumstances. While data comes from providers in 38 VA PTSD residential treatment programs across the U.S., these results may not be representative of all VA PTSD programming across the county. Replication of these findings in other VA outpatient and non-VA settings is needed before broad generalizations can be made.

Clinical Impact

The results presented here may have implications for front-line providers engaged in clinical practice with trauma survivors. Although more research is needed, decision-making trees for providers considering use of PE and CPT, similar to the one created by Litz et al. (1990) or Mott, Stanley, Street, Grady, and Teng (2014) could be helpful. Table 2 provided here may assist providers in navigating the decisions around treatment applicability and increasing the reach of these two EBPs. Although this might be viewed as a potential tool or aid in making similar choices, until further empirical evidence from randomized controlled trials, this should be viewed more as a work in progress and less of a definitive guide. These findings also have potential implications for treatment developers and organizations engaging in dissemination and implementation efforts of PE and CPT, as well as other trauma-focused

EBPs. Information on provider decision-making regarding treatment selection can identify perceived complicating factors to the use of PE and CPT during training and consultation. Some of these choices may be influenced by lack of information or access to the most current research, and therefore, addressing such issues directly may help to dispel misinformation.

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Clinical Impact Statement:

This manuscript provides information regarding how VA residential treatment providers choose between two EBPs, Prolonged Exposure and Cognitive Processing Therapy, for veterans presenting with PTSD, and may be helpful to others who are interested in using these treatments.

Table 1.

Sociodemographic Variables of the Sample

Variable	M (SD)	% (N)
Age	44.84 (10.73)	
Gender (Female)		64.4 (105)
Race		
White		81.0 (132)
African American		4.9 (8)
Other		9.6 (14)
Unknown		5.5 (9)
Profession		
Psychologist		44.2 (72)
Social worker		35.0 (57)
Psychiatrist		7.4 (12)
Other		13.5 (22)
Years practicing clinically	13.81 (9.82)	
Years employed by VA	8.05 (7.59)	
Years in residential setting	6.05 (6.56)	
Highest Training Level – PE		
No training		20.1 (33)
Read the manual/informal training		23.8 (39)
Attended a VA-sponsored training		12.8 (21)
Completed case consultation		7.9 (13)
Achieved provider status		31.7 (52)
Became a consultant		3.0 (5)
Became a VA national trainer		0.6 (1)
Highest Training Level – CPT		
No training		6.1 (10)
Read the manual/informal training		12.8 (21)
Attended a VA-sponsored training		20.1 (33)
Completed case consultation		7.3 (12)
Achieved provider status		50.0 (82)
Became a VA national trainer		3.6 (6)
Providers with some training in both CPT and PE		

Note. CPT = Cognitive Processing Therapy; PE = Prolonged Exposure

Table 2.

VA PTSD Residential Treatment Provider Decision-Making for Choosing Prolonged Exposure and Cognitive Processing

What is the type and nature of index trauma and trauma memory?
PE: single incident trauma; memory for event is intact
CPT: more than one trauma; memory for event(s) may be limited
What are the primary symptoms for the patient?
PE: avoidance and hyperarousal symptoms; fear reactions
CPT: dissociative symptoms; guilt and self-blame reactions; moral injuries
What is the patient's cognitive or personality type?
PE: those who intellectualize; those who are resistant to challenging beliefs
CPT: those who are insightful and "psychologically-minded"
Has the patient received a course of either CPT or PE before?
PE/CPT: If patient has unresolved symptoms after one course of treatment, may want to offer the alternative treatment modality
After providing psychoeducation about both treatments, which does the patient prefer?
PE/CPT: May want to defer to patient's choice due to "buy in"
What is the patient's problem and what are their goals?
PE/CPT: Choose the EBP most in line with conceptualization of patient's problem and the patient's goals

Note. This decision-tool is based solely on real-world provider responses to a semi-structured interview and is not necessarily supported by randomized control trials or dismantling studies.