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Treatment-Related Beliefs and Reactions Among Trauma-Focused Therapy Completers and Discontinuers: A Qualitative Examination

Elizabeth Alpert^{1, 2}, Alexandra Gowdy-Jaehnig³, Tara E. Galovski^{1, 2}, Laura A. Meis^{1, 3, 4}, Melissa A. Polusny^{3, 5}, Princess E. Ackland^{3, 4}, Michele Spont^{3, 4, 6}, Helen Valenstein-Mah⁷, Robert J. Orazem³, Paula P. Schnurr^{6, 8}, Kathleen M. Chard^{9, 10}, and Shannon M. Kehle-Forbes^{1, 3, 4}

¹ National Center for PTSD Women's Health Sciences Division, VA Boston Healthcare System, Boston, Massachusetts, United States

² Department of Psychiatry, Boston University Chobanian & Avedisian School of Medicine

³ Center for Care Delivery and Outcomes Research, Minneapolis VA Health Care System, Minneapolis, Minnesota, United States

⁴ Department of Medicine, University of Minnesota

⁵ Department of Psychiatry & Behavioral Sciences, University of Minnesota

⁶ National Center for PTSD Executive Division, White River Junction, Vermont, United States

⁷ Lyra Health, Burlingame, California, United States

⁸ Department of Psychiatry, Geisel School of Medicine, Dartmouth College

⁹ Cincinnati VA Medical Center, Cincinnati, Ohio, United States

¹⁰ Department of Psychiatry & Behavioral Neuroscience, University of Cincinnati School of Medicine

Prolonged exposure (PE) and cognitive processing therapy (CPT) for posttraumatic stress disorder (PTSD) are effective, but some patients do not respond adequately, and dropout rates are high. Patients' beliefs about treatment and perceptions of treatment components influence treatment outcomes and may be amenable to change through intervention. The present study sought to identify beliefs and reactions to PE and CPT that differentiated completers who screened negative for a PTSD diagnosis after treatment (PTSD-), completers who screened positive for a PTSD diagnosis after treatment (PTSD+), and discontinuers who attended six or fewer sessions. Thematic analysis was used to identify themes in qualitative data collected via retrospective semistructured interviews with 51 completers (19 PTSD- after treatment, 32 PTSD+ after treatment) and 66 discontinuers of PE/CPT. Participants were demographically diverse veterans across service eras. Treatment-related beliefs and reactions differentiating these groups included perceived helpfulness of treatment, self-efficacy in engaging in treatment, anticipatory anxiety and concerns, interpretations of ongoing symptoms, and perceived consequences of treatment on functioning. Further, some patterns seemed to differ in early treatment sessions compared to during the active components of treatment. Findings point to potentially malleable targets that could be intervened upon to improve trauma-focused treatment outcomes.

Impact Statement

Evidence-based PTSD treatments are available, but a significant number of patients do not experience meaningful symptom reduction, and a significant number do not complete treatment. This study identified treatment-related beliefs and reactions differentiating participants who discontinued treatment early and who completed treatment and screened positive versus negative for a PTSD diagnosis after treatment. Findings point to processes that could be targeted to improve PTSD treatment completion rates and symptom outcomes.

Keywords: posttraumatic stress disorder, trauma-focused treatment, dropout, qualitative, veterans

Evidence-based treatments for posttraumatic stress disorder (PTSD), including prolonged exposure (PE; Foa et al., 2019) and cognitive processing therapy (CPT; Resick et al., 2017), are widely available in the Department of Veterans Affairs (VA). However, a

significant number of patients do not complete PE and CPT (Cooper et al., 2023; Kline et al., 2018), with rates of discontinuation as high as 60% observed in large samples of veterans receiving these treatments in VA care (Maguen et al., 2019; Sayer et al., 2022). Although some

Elizabeth Alpert  <https://orcid.org/0000-0002-9870-799X>

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Correspondence concerning this article should be addressed to Elizabeth Alpert, National Center for PTSD Women's Health Sciences Division, VA Boston Healthcare System, 150 South Huntington Avenue (116B-3), Boston, MA 02130, United States. Email: Elizabeth.Alpert@va.gov

patients who discontinue PE and CPT early experience symptom reduction (Szafranski et al., 2017), those who complete treatment experience greater symptom improvement relative to treatment noncompleters (Berke et al., 2019; Holmes et al., 2019). Further, treatment responses can be suboptimal, with up to two thirds of patients retaining a PTSD diagnosis at the end of treatment (Steenkamp et al., 2015). A better understanding of discontinuation and nonresponse in trauma-focused treatments is needed to inform intervention strategies that will enhance retention and improve treatment outcomes.

Studies examining predictors of discontinuation and nonresponse in trauma-focused PTSD treatments often examine demographic characteristics and pretreatment psychopathology as predictors, but findings are inconsistent (Cooper et al., 2023; Sciarrino et al., 2022). Younger age is the only demographic variable to emerge as a consistent predictor of discontinuation (e.g., Imel et al., 2013; Maguen et al., 2019; Rizvi et al., 2009). Findings on demographic predictors of symptom response have been mixed, with some studies identifying demographic predictors of poorer treatment response, including male gender (Wade et al., 2016), older age (Litz et al., 2019; Resick et al., 2020), and non-White (Grau et al., 2022) and African American race (Resick et al., 2021; Tuerk et al., 2011), and other studies not reporting demographic differences in response (Gros et al., 2011; van Minnen et al., 2002; Zoellner et al., 1999). Studies examining baseline symptom severity as a predictor of treatment response have also had mixed results, with some studies finding that more severe baseline PTSD and depression symptoms predicted worse symptom response (Kline et al., 2021; Litz et al., 2019; Resick et al., 2021) and another study finding that greater baseline depression predicted better response (Rizvi et al., 2009).

It is important to move beyond demographic characteristics and baseline symptom characteristics when examining predictors of PTSD treatment outcomes (Cooper et al., 2023; Rubel et al., 2017; Youn et al., 2019) and instead focus on identifying processes occurring *during* treatment that relate to outcomes. Such processes may be malleable and can serve as intervention targets to improve retention in care and symptom response. Many studies have examined within-treatment predictors of PTSD symptom improvement in trauma-focused treatments. For example, a stronger therapeutic alliance (Keefe et al., 2022; Sijercic et al., 2021; Sripada & Walters, 2023) has been found to relate to better symptom outcome in PTSD treatments. In exposure-based therapies such as PE, a reduction in fear across sessions has been found to predict greater symptom improvement (Cooper, Clifton, & Feeny, 2017; Sripada et al., 2016). Change in trauma-related cognitions over the course of treatment has also consistently emerged as a predictor of symptom response across PTSD treatments (for reviews, see Brown et al., 2019; Cooper, Clifton, & Feeny, 2017; Sripada et al., 2016). Specific types of cognitions that predict response include negative beliefs about the self, the world, and self-blame (e.g., McLean et al., 2019; Zalta et al., 2014), as well as overaccommodated beliefs (global, exaggerated beliefs) and accommodated beliefs (healthy, balanced beliefs; Dondanville et al., 2016; Iverson et al., 2015).

While numerous studies have examined within-treatment predictors of PTSD symptom response, fewer studies have examined within-treatment predictors of treatment discontinuation. Evidence suggests worse therapeutic alliance (Holdsworth et al., 2014; Hundt et al., 2017, 2020) and more avoidance of homework tasks (Alpert et al., 2020; Cooper, Kline, et al., 2017; Stirman et al., 2018) predict discontinuation, as do less exploration of negative emotions and

greater expression of overgeneralized beliefs in narratives written during treatment (Alpert et al., 2020).

The beliefs that patients form about treatment and their interpretations of treatment components may be particularly relevant, as they are both related to treatment outcomes and may be amenable to change in order to improve response and retention. Multiple theories suggest that if patients hold negative beliefs and attitudes toward treatment, they are more likely to discontinue early and less likely to benefit. Such theories include the theory of planned behavior (Ajzen, 1991, 2015; see Meis et al., 2021, for an application to PTSD treatment), cognitive theory (Beck & Dozois, 2011), and social cognitive theory (Bandura, 2004). Yet little is known about how treatment-related cognitions during treatment may impact treatment outcomes. Treatment-related beliefs and interpretations that have been related to early discontinuation include low buy-in to the treatment rationale early in treatment (Hundt et al., 2020; Taylor, 2003), perceptions that ongoing symptoms mean treatment is not working (Kehle-Forbes et al., 2022), worry that treatment will have a negative impact on functioning (Kehle-Forbes et al., 2022), low self-efficacy in being able to handle the difficult emotions involved in therapy (Wells et al., 2023), and perceptions that treatment is not worth the distress involved (Hundt et al., 2017, 2020). A few studies have also examined relationships between treatment-related beliefs and symptom response. Treatment expectancies early in treatment (i.e., beliefs treatment will be helpful) have predicted better symptom response in trauma-focused treatment (Litz et al., 2019; Price et al., 2015), although other studies have not found this relationship (Graham et al., 2018; Kirsch et al., 2018).

Kehle-Forbes et al. (2022) recently conducted a qualitative study that involved interviewing veterans who began PE or CPT in VA clinics and then completed or prematurely discontinued treatment. This study is the data source for the present examination. Interestingly, though patients often cite logistical barriers and distress during treatment as reasons for discontinuing (Browne et al., 2021), this study (Kehle-Forbes et al., 2022) found that discontinuers and completers reported similar amounts of symptom exacerbation and logistical barriers during treatment. Rather, it was patients' *interpretations* of their symptoms and logistical barriers that differentiated discontinuers from completers. For example, discontinuers more strongly endorsed beliefs that ongoing symptoms meant treatment was not working, worries about treatment negatively impacting their functioning, and perceptions that treatment was not worth prioritizing in light of life stressors (Kehle-Forbes et al., 2022). Interpretations such as these may be modifiable, and if altered, patients may engage more in treatment, promoting both treatment completion and symptom improvement. Kehle-Forbes and colleagues did not differentiate among treatment completers who did and did not respond to treatment, and they did not examine participants' reactions to treatment at different points during treatment. While one suboptimal treatment outcome is early discontinuation, another suboptimal outcome is nonresponse despite treatment completion, and it is important to differentiate the experiences of patients in this group.

The Present Study

The aim of the present study was to extend the findings of Kehle-Forbes et al. (2022) by identifying and exploring in greater depth patients' treatment-related beliefs and interpretations during PE and CPT that relate to treatment discontinuation versus completion, and

further, by examining differences among completers who screened negative (PTSD-) versus positive (PTSD+) for a PTSD diagnosis after treatment. We also examined beliefs patients reported having in early treatment sessions compared to during active components of treatment. Qualitative research can help to better elucidate the multifaceted processes of treatment engagement and outcomes by allowing us to learn from patients' experiences to identify relevant processes that may not have been previously examined (Meis et al., 2023). Identifying treatment-related beliefs and interpretations occurring during treatment that differentiate treatment discontinuers from completers, and further, PTSD- completers from PTSD+ completers, can help us develop interventions to both keep patients engaged in treatment and ensure they benefit from care.

Method

Data Source

The present study is a secondary analysis of qualitative data collected via semistructured interviews conducted by Kehle-Forbes et al. (2022) with a national sample of veterans who received PE or CPT as part of routine clinical care at VA clinics. All participants provided informed consent, and all study procedures were approved by the Institutional Review Board at the Minneapolis VA. Purposive sampling was used to capture key population variations, including gender (men and women veterans), service era (Vietnam, post-Vietnam/Gulf War, and post-9/11), treatment (PE and CPT), and modality of CPT (individual and group). Additional details on sample stratification and selection, sample demographics, and study procedures can be found in Kehle-Forbes et al. (2022). All procedures for this secondary data analysis were approved by the Institutional Review Board at VA Boston Healthcare System.

Participants

Participants in the original study were 126 veterans who either discontinued ($n = 66$) or completed ($n = 60$) group or individual PE/CPT treatment. Forty four (34.9%) were women, 82 (65.1%) were men, 73 (57.9%) were White, 34 (27.0%) were Black or African American, 16 (12.7%) identified as another race, and the race of three participants (2.4%) was unknown. Eighteen participants (14.3%) were Hispanic or Latino, and 106 (84.1%) were not Hispanic or Latino; the ethnicity of two participants (1.6%) was unknown. Discontinuers were eligible if they attended six or fewer treatment sessions, were categorized as a discontinuer by their provider in the electronic medical record (EMR) or had a 6-week lapse since their last PE/CPT session, and did not have a note in the EMR designating a "final session" as outlined by the PE/CPT protocols. Noncompletion was defined in the original study (Kehle-Forbes et al., 2022) as completing six or fewer sessions based on evidence that rates of treatment discontinuation decline sharply after the sixth session (Gutner et al., 2016). These inclusion criteria were meant to exclude participants who may have discontinued treatment prior to Session 6 due to rapid response. Discontinuers were excluded if their therapist was actively engaged in outreach at the time of recruitment, more than 3 months had passed since their final treatment session, it was clear from the EMR that they would not have been able to complete treatment (e.g., they moved out of the area), or their therapist initiated early termination. Completers were eligible if they

finished at least 10 PE or 12 CPT sessions or their EMR had a templated note indicating the final treatment session occurred, and no more than 3 months had passed since their final session. The present study sought to classify completers who screened negative versus positive for PTSD after treatment, so the present sample included all 66 discontinuers and the 51 completers (85.0%) who returned a PTSD symptom measure collected as part of the study.

Procedure

Veterans who completed or discontinued PE or CPT in routine clinical care in VA were identified using VA administrative data generated by templated progress notes in the EMR. The final sample was identified via manual chart review of a random subsample of veterans for eligibility criteria and letters and calls to eligible veterans inviting them to participate in a 90-minute phone interview to discuss their experience in PE or CPT. Interviews were conducted by four doctoral-level and one masters-level interviewers with degrees in clinical or counseling psychology. Participants were compensated \$75 for completing the interview. Veterans who agreed to participate in the study were mailed a PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) and were asked to return the completed measure.

Classification of Completers Who Screened Positive Versus Negative for PTSD After Treatment

To classify completers as screening positive versus negative for a PTSD diagnosis after treatment, screening status was defined as likely presence or absence of PTSD diagnosis after treatment based on participants' score on the PCL-5 that was returned as part of the study. Pretreatment PCL-5 scores were not available to examine change in symptoms during treatment, given that participants did not consent to participate in the study until after completion of PE or CPT. The PCL-5 is a 20-item self-report measure that assesses the frequency and severity of *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* PTSD symptoms and is widely used throughout VA to assess PTSD symptom severity. The suggested threshold for a probable diagnosis of PTSD is a PCL-5 total score of 31–33; the present study used 31 as a conservative cutoff to define diagnostic screening result. Completers with a PCL-5 total score <31 were categorized as screening PTSD- ($n = 19$, 37.3%), and participants with PCL-5 ≥ 31 were categorized as screening PTSD+ ($n = 32$, 62.7%). Although five discontinuers (7.6%) screened negative for PTSD after treatment, discontinuers were analyzed as one group, as we were interested in discontinuation as a suboptimal outcome of treatment regardless of PTSD screening status after treatment. The greatest gains are generally observed among patients who complete treatment (Berke et al., 2019; Holmes et al., 2019), and discontinuers in the present study left treatment before Session 7 without agreeing with their providers on early termination.

Qualitative Interviews

Interviews with discontinuers focused on contributors to participants' discontinuing treatment and efforts to complete treatment. Interviews with completers focused on contributors to participants' completing treatment and challenges to treatment completion. Questions were developed based on the theoretical models guiding the study (the theory of planned behavior, Ajzen, 1991, 2015;

cognitive theory, Beck & Dozois, 2011; and social cognitive theory, Bandura, 2004) and designed to elicit beliefs related to PTSD and treatment. Specific questions prompted participants to retrospectively report on their reactions to treatment early in treatment (e.g., after hearing the treatment rationale; example question: “At that point [the first session], what did you think about whether it [treatment] was going to help with {primary concerns}?”) and during the active components of treatment (e.g., during in vivo and imaginal exposure in PE and cognitive restructuring and written impact statements and trauma accounts in CPT; example questions: “During your time in treatment, you {name specific treatment elements that they completed}. What was that like for you?” “Did you think it was going to be helpful?” “How did you react to it?”). All study interviewers had either masters- or doctoral-level degrees in counseling or clinical psychology, had prior experience conducting qualitative interviews, and participated in study-specific training regarding the interview approach and guidelines.

Coding and Analysis

As part of the original study, interviews were audio recorded, professionally transcribed, reviewed for accuracy, and coded by the study team using thematic analysis. Seven top-level codes were identified based on the theoretical models guiding the study and transcript content, and then lower-level subcodes were developed deductively based on transcript content. While the codebook was in development, two coders jointly read transcript segments and established codes, then all coders met to discuss the codebook. Once the codebook was established, 20% of transcripts were coded by two coders independently, and discrepancies were resolved between the two coders, or if they could not resolve the disagreement, among the coding team. Biweekly meetings were held among all coders to resolve discrepancies, prevent rater drift, discuss codebook modifications, and identify emerging themes.

For the present secondary analysis, 10 subcodes were identified that were relevant to the study aims. All transcript segments to which those subcodes had been applied were deidentified and then reviewed by two independent coders (Elizabeth Alpert and Alexandra Gowdy-Jaehnig), and thematic analysis was used to identify similarities and differences among discontinuers, PTSD– completers, and PTSD+ completers. The two coders first independently reviewed the content of each subcode and identified themes relevant to the research questions, with no a priori coding categories. Each coder then independently created a summary of similarities and differences among groups based on those themes, and then coders met to consent on discrepancies and create a final joint summary of that subcode. All discrepancies were resolved by consensus. After the 10 subcodes had been summarized jointly, the coders worked together to create memo summarizing cross-cutting themes, which was shared and discussed with two additional authors (Tara E. Galovski and Shannon M. Kehle-Forbes), and final themes were extracted and agreed upon.

Results

We identified five distinct yet interconnected themes differentiating the treatment-related beliefs and reactions of discontinuers, PTSD– completers, and PTSD+ completers: (a) perceived helpfulness of treatment, (b) self-efficacy in engaging in treatment, (c) anticipatory

anxiety and concerns, (d) interpretations of ongoing symptoms, and (e) perceived consequences of treatment on functioning. Table 1 presents a summary of similarities and differences across groups for each of these themes.

Perceived Helpfulness of Treatment

Participants retrospectively reported on their perceptions of PE’s or CPT’s helpfulness both at the beginning of treatment (i.e., expectancies after hearing the treatment rationale) and as they went through the active components of treatment. The expectancies participants reported having early in treatment ranged widely and did not clearly align with outcome status. Many reported hope that treatment would help, often combined with another sometimes conflicting belief about the helpfulness of treatment, such as skepticism or a belief that treatment would or would not help. One PTSD– completer said, “I was still pretty skeptical because I’d been avoiding these thoughts for the past 10 years of my life. . . . But the side that did make it so hopeful was that others had done this.” PTSD+ completers were more likely than the other two groups to report they held the belief that treatment would *not* help (a sizable minority of participants across groups). Discontinuers were more likely than the other two groups to report they held the explicit belief early in treatment that treatment *would* help (approximately half of discontinuers and a smaller minority of the other two groups). A few PTSD+ completers and discontinuers, but no PTSD– completers, indicated they believed early on that treatment would be a fix-all or work immediately. One discontinuer stated, “I thought it was going to be an instant cure.” Participants in all three groups expressed that it seemed worth it to try treatment.

When asked about perceptions of the helpfulness of treatment as treatment progressed into the active components, participants across groups focused more on aspects of treatment that were helpful than unhelpful. The extent of perceived helpfulness of treatment during the active components was generally consistent with outcome status. As would be expected, PTSD– completers spoke more than the other two groups about aspects of treatment that they perceived to be helpful, and very few discussed aspects that were perceived as unhelpful. PTSD– completers also described more than the other two groups that it took some time for treatment to help, that treatment was difficult but got easier and more helpful over time, and that treatment helped more than they had expected. One PTSD– completer described,

The first couple of weeks I was kind of doing it because [my therapist] said to, you know? I wasn’t sure what I was doing, but I was kind of doing it. But after about three or four weeks, I was starting to understand the impact on me.

Another PTSD– completer reported, “At first I was pretty skeptical about how it would work, but the benefit I’ve seen from it is far greater than I originally imagined.” A small number of PTSD– completers described that incremental progress led to overall therapy success; one such PTSD– completer described “small incremental increases in the way that I had success” and becoming “continuously more positive about [treatment] as I saw more results.”

The majority of PTSD+ completers perceived some helpfulness, with a minority perceiving that treatment was unhelpful. Those who reported perceiving some aspect of treatment as helpful cited gaining new insight, challenging stuck points in CPT, the breathing exercise in PE, and in vivo exposure helping them reduce avoidance in PE. Although a minority of PTSD+ completers, a significant

Table 1
Similarities and Differences Among Discontinuers and Completers Who Screened Negative (PTSD-) and Positive (PTSD+) for PTSD After Treatment

Theme and timing during treatment	Similarities across groups	Unique to PTSD- completers	Unique to PTSD+ completers	Unique to discontinuers
Perceived helpfulness of treatment				
Early in treatment	Held multiple, at times conflicting expectancies about helpfulness, including hope and skepticism Treatment seemed worth a try	No expectation that treatment would be a fix-all or work immediately	More expectancy than the other groups that treatment <i>would not</i> help	More expectancy than the other groups that treatment <i>would</i> help
During active components	Focus was more on components that were helpful than unhelpful	Focused more than the other groups on helpful aspects of treatment Narrative that symptoms got worse before they got better or progress was incremental	Focused more than PTSD- completers but less than discontinuers on unhelpful aspects Some narrative of active components being helpful, but more than PTSD- completers, narrative of difficulty without helpfulness	More of a focus than the other groups on aspects that were unhelpful
Self-efficacy in engaging in treatment				
Early in treatment	Experienced doubt about being able to talk about trauma or complete homework	More uncertainty about ability to complete treatment No belief they <i>could not</i> complete treatment	Less likely than the other groups to believe they could complete treatment, and more likely to doubt ability to complete treatment aspects	Among those who expressed doubt in ability to complete treatment aspects, some cited the reason that they did not believe they would want to engage in these tasks
During active components		Higher self-efficacy in completing active components Avoidance in the context of figuring out how to complete tasks	Lower self-efficacy than PTSD- completers but more than discontinuers Some described avoidance in context of figuring out how to approach tasks; others only reported avoidance	Lower self-efficacy than the other groups in ability to complete treatment tasks Stronger narrative that treatment tasks were too much to handle or of not being able to complete them
Anticipatory anxiety and concerns—early in treatment and during active components	Concerns about what was to come	Fewer concerns than the other groups	More concerns than PTSD- completers, but less extreme concerns than discontinuers	More extreme concerns than the other groups
Interpretations of ongoing symptoms—during active components	Experienced ongoing symptoms during treatment	More positive interpretations or reframing of ongoing symptoms Fewer negative interpretations of ongoing symptoms than discontinuers	Fewer negative interpretations of ongoing symptoms than discontinuers	More negative interpretations of ongoing symptoms and conclusions about treatment due to ongoing symptoms
Perceived consequences of treatment on functioning—early in treatment and during active components		Fewer concerns about the impact of treatment on functioning than discontinuers	Fewer concerns about the impact of treatment on functioning than discontinuers	More concerns about the impact of treatment on functioning than the other groups

Note. PTSD = posttraumatic stress disorder.

number of participants in that group expressed a narrative that treatment procedures were difficult and they completed them anyway, without describing benefit, even when asked about the helpfulness of treatment. One PTSD+ completer who described difficulty but did not report benefit said, “I didn’t miss any of my homework. Anything that she requested me to do, even when it was tough to do, I did.” Another such PTSD+ completer described imaginal exposure in PE as follows: “I didn’t like doing it, but I did it anyway because she threw out the little challenge. She told me about everybody that quits. And said, well, I’m not. And I’m sitting here thinking, I’m not a quitter.”

On the other hand, discontinuers expressed more than the other two groups that something about treatment was unhelpful, with the majority perceiving that treatment was not helping or not working in some way. Aspects of treatment that more than one discontinuer cited as unhelpful included the breathing exercise in PE, homework, and talking about traumatic experiences. A significant minority of discontinuers and a smaller minority of PTSD+ completers further described something about treatment that was very unhelpful or made things worse, such as feeling like they got stuck in the memory or relived their trauma too vividly. One discontinuer explained, “Once we would leave, I wasn’t focused on the rest of the day. I was more stuck on what we were reliving. And I would be spaced out throughout the rest of the day of still reliving.”

Self-Efficacy in Engaging in Treatment

PTSD– completers, PTSD+ completers, and discontinuers differed in their expression of self-efficacy in engaging in treatment and their ability to handle the tasks of PE or CPT. Interestingly, at the beginning of treatment, PTSD– completers and discontinuers were more likely than PTSD+ completers to report they had specifically believed they *could* complete treatment. Other PTSD– completers described being uncertain as to whether they would be able to complete treatment (e.g., “I wasn’t sure”); this sentiment was more common among PTSD– completers than the other two groups. PTSD+ completers were more likely than the other groups to report they had doubt about completing treatment or a particular aspect of treatment. Participants across groups described thinking they would not be able to talk about their trauma or do the homework, with some specifically citing listening to the session recording and in vivo exposures in PE and writing assignments in CPT. Many participants did not provide reasons for these beliefs; others cited concerns they would not have the emotional energy to complete treatment tasks, would not be “strong enough” to do so, or would not trust their therapist enough to disclose details about their trauma. Multiple discontinuers elaborated that they did not think they would be able to participate in certain treatment tasks because they expected they would not want to and presumably would therefore decline to engage. Only one PTSD+ completer and a small minority of discontinuers stated they had believed early in treatment that they *could not* complete treatment.

During the active components of treatment, PTSD– and PTSD+ completers described high self-efficacy in being able to engage in the tasks of treatment, whereas discontinuers expressed the most concern about their ability to complete the tasks of treatment. PTSD– and PTSD+ completers described ways they coped during sessions and practice work so they could complete difficult treatment elements, and PTSD– completers also discussed avoidance in the context of

figuring out how to approach difficult treatment tasks instead. For example, a PTSD– completer described,

I guess I dreaded doing those in vivos, but since we started at the other end of the spectrum, the very first in vivos that I was assigned, I kind of felt like, “Oh, that’s not so bad.” And then kind of still had that dread of doing the bigger ones later, but every time we took a step up the ladder I guess I had built confidence from the one before or the ones before. So every time we took a step up it was just kind of like, “Oh, that wasn’t as bad as I thought it was going to be,” again all the way up. And then in the end even the big bad ones that I’d been dreading from the beginning weren’t as bad and I was able to successfully do those too.

PTSD+ completers’ reactions to active treatment components suggested less self-efficacy for engaging in treatment tasks than PTSD– completers, yet more than discontinuers. PTSD+ completers discussed having been worried about being able to complete upcoming treatment elements and then doing them and getting through them. One PTSD+ completer explained,

I didn’t know if was going to get through talking about the trauma because sometimes I’d just break down and start crying. But I kept talking about it more, like I’d just start crying less, and I guess it reminded me that it’s good to talk about it so I could deal with it.

Some PTSD+ completers also described ways of coping so they could handle engaging in treatment components, but others described avoidance without a narrative of eventually completing treatment tasks. One PTSD+ completer described that writing the trauma account in CPT “was difficult. I actually avoided it until the last night, before I had treatment the next day, to write it. I tried to avoid it even as I wrote it. I didn’t get it all the way written.”

Discontinuers expressed the lowest self-efficacy related to being able to handle engaging in treatment as they went through the active components. Some cited low self-efficacy as their reason for discontinuing treatment. They described worries both early in treatment and throughout treatment that they would not be able to handle what was coming up in treatment. More than the other two groups, they described the active components of treatment being “too much” or not being able to complete them, and they also described ongoing symptoms during treatment as being too much to handle. For example, when describing a particular in vivo exposure assignment in PE, one discontinuer said, “That was the worst one, actually. That was the one that became the kicker of me not being able to do the treatment anymore because envisioning everything all over again, I couldn’t handle it.” Another discontinuer described telling his therapist, “I can’t do the sessions because it’s to the limit.”

Anticipatory Anxiety and Concerns

Participants across all groups expressed concerns about what was to come in treatment, but future concerns were a particular focus among PTSD+ completers and discontinuers. PTSD+ completers and discontinuers recalled having more concerns than PTSD– completers early in treatment about what was to come in treatment. Participants reported concerns about talking about their traumatic experiences, the exposure components of treatment, reliving the trauma, thinking about trauma memories between sessions, showing emotions in front of others, being judged by their therapist or group members, or having aspects of their stories or their role in what happened challenged. Some participants—mostly PTSD+ completers and discontinuers—reported

they had more extreme concerns early in treatment, such as treatment causing them to go crazy, lose control, become stuck in the memory, become nonfunctional, or become violent. Concerns early in treatment about increased substance use, becoming more depressed, and becoming suicidal due to the treatment were almost exclusive to discontinuers. Examples of concerns reported by discontinuers in early sessions were, “my anger getting out of control and causing harm,” “[substance use] relapse,” “I’d be left with no one,” “it would make a wreck of me, put me in depression,” “going crazy,” “I could harm myself,” and “suicide.”

As participants moved into the active components of treatment, the pattern was similar; participants across groups, and particularly discontinuers, continued to express concerns about what was ahead in treatment. Participants specifically expressed concerns about talking about the trauma in future sessions, completing and reading aloud the written account in CPT, in vivo exposures in PE, and the emotions that approaching trauma content would bring up. PTSD+ completers and discontinuers expressed concerns about intense reliving of the trauma during the active components of treatment, and discontinuers continued to express the most intense concerns (e.g., treatment causing them to go crazy or unravel, being torture, harming their physical health, or significantly harming their functioning).

Interpretations of Ongoing Symptoms

As previously reported (Kehle-Forbes et al., 2022), completers and discontinuers in this sample reported experiencing similar levels of ongoing or worsening symptoms during treatment, but their interpretations of this experience differed. When considering PTSD– and PTSD+ completers separately in the present study, this pattern of findings was maintained. PTSD– and PTSD+ completers shared a narrative that in hindsight, their symptom worsening was part of a trajectory in which their symptoms ultimately improved. Some PTSD– completers also reported positive reframes of ongoing symptoms, such as,

Well, to one degree or another I had just about a whole suite of symptoms ... but I handle them a lot better, you know. I’m able to recover a lot quicker now from them and not worry about it and not dwell on it.

As previously reported, (Kehle-Forbes et al., 2022), discontinuers reported more negative meaning of ongoing symptoms, drew more negative conclusions about treatment’s overall efficacy because of ongoing symptoms, and expressed more concerns about the implications of worsening symptoms, which for many contributed to their decision to discontinue treatment.

Perceived Consequences of Treatment on Functioning

Consistent with prior findings from this sample (Kehle-Forbes et al., 2022), discontinuers expressed more concerns than both PTSD– and PTSD+ completers about the impact of treatment on their functioning at work, at school, at home, and in their relationships. Early in treatment, discontinuers endorsed more concerns than both PTSD– and PTSD+ completers that treatment would harm their functioning. During the active components, discontinuers more than PTSD– and PTSD+ completers focused on the impact of ongoing symptoms on their functioning and described perceptions that treatment had a serious or extreme negative impact on their

functioning, such as the potential or actual end of a romantic relationship, potential or actual job loss, or serious mental health deterioration. Only discontinuers reported believing treatment caused them to lose their ability to function completely.

Discussion

This study examined differences in treatment-related beliefs and reactions among PE and CPT patients who completed treatment and experienced likely loss of diagnosis (PTSD– completers), completed treatment and did not experience likely loss of diagnosis (PTSD+ completers), and discontinued treatment before the end (discontinuers). Participants in these three groups varied in their perceived helpfulness of treatment, self-efficacy in engaging in treatment, anticipatory anxiety and concerns, interpretations of ongoing symptoms, and perceived consequences of treatment on functioning. Further, reports of these reactions differed when participants were asked about their experiences early in treatment compared to during the active components of treatment.

Reports of expectancies of treatment helpfulness early in treatment varied widely, and both hope and skepticism were common across groups. The belief that treatment *would* help was more common among discontinuers than the other two groups, and the belief that treatment would *not* be helpful was more common among PTSD+ completers than the other two groups. Reported perceptions of treatment helpfulness aligned more with outcome status as would be expected during the active components of treatment; PTSD– completers found treatment helpful, the majority of PTSD+ completers described treatment as helpful and a significant minority described a difficult experience without describing it as helpful, and discontinuers described more aspects of treatment that were unhelpful than the other two groups. This pattern of findings suggests that patients’ reported expectations early in treatment may not necessarily be a prognostic indicator of treatment retention, although the express belief that treatment will *not* help may be a warning sign of retaining a diagnosis after treatment. Additionally, discontinuers generally shifted from believing that treatment would be helpful early in treatment to perceiving treatment to be unhelpful more so than the other groups, potentially suggesting that their expectations were not met, generating disappointment. It may be that PTSD– and PTSD+ completers’ uncertainty and skepticism early in treatment, and the absence among PTSD– completers of viewing treatment as a cure-all, reflect more realistic viewpoints about difficult treatments and could be protective against disappointment and unmet expectations that may contribute to the decision to discontinue treatment. If patients express the expectation that treatment will be an immediate solution to their problems, it may be worth discussing the ways in which treatment is more realistically likely to help them.

Previous findings have been mixed as to whether treatment expectancies in early sessions predict PTSD treatment outcome (e.g., Graham et al., 2018; Kirsch et al., 2018), and the present finding that PTSD+ completers were more likely than the other groups to express the belief treatment would *not* help is consistent with studies finding a significant association between treatment expectancy and PTSD symptom outcome (Litz et al., 2019; Price et al., 2015). Additional research shows that hope throughout the course of PTSD treatment is an important predictor of treatment outcome (Gilman et al., 2012). If patients report an expectancy that treatment will not help in early sessions, it could be beneficial for

clinicians to validate their concerns, reassure them that many who benefit from treatment are skeptical at first, and explore and address the underlying reasons for their concerns, for example, by challenging treatment-related stuck points (Galovski et al., 2020). Such adaptations can help personalize treatment while maintaining fidelity to the treatment protocols. It may be that many clinicians already engage in these practices, but there is likely variability in how effectively these strategies are utilized. Qualitative research such as the present study is valuable for generating hypotheses; future research will be important to test these empirical questions.

Self-efficacy to engage in the tasks of treatment also varied across groups and over the course of treatment, aligning more clearly with outcome status during the active components of treatment. PTSD-completers and discontinuers were more likely than PTSD+ completers to report the belief in early sessions that they *could* complete treatment, with other PTSD- completers expressing uncertainty; across the sample, PTSD- completers were more likely than the other two groups to express uncertainty in early sessions that they could complete treatment. Some participants across all groups expressed doubt that they would be able to engage in treatment tasks, with PTSD+ completers being most likely to express doubt early in treatment. This suggests that low self-efficacy may be a warning sign of poor response. If self-efficacy is low, studies might test the benefit of clinicians exploring reasons for patients' doubts regarding their ability to complete treatment tasks and balancing validation with directly addressing patients' concerns (Epstein & Street, 2007; Street et al., 2009). On the other hand, overly confident self-efficacy early in treatment may be a warning sign of discontinuation risk. Future research is needed to test how therapists might respond effectively in these cases; therapists might discuss reasons for patients' confidence while planning ahead for potential obstacles to engagement. When considering discontinuers' early confidence together with other themes identified in this study, it seems their early confidence coexisted with significant anticipatory anxiety and concerns, which may have conflicted with and eventually overshadowed their confidence in their ability to complete treatment.

It is notable that a few discontinuers who expressed low self-efficacy early in treatment elaborated that they did not think they would complete treatment or certain components because they expected they would not want to tolerate the discomfort involved, and presumably, they would therefore decline to engage. Self-efficacy in managing one's symptoms predicts later health outcomes (Lorig et al., 1999, 2005), so when patients express such thinking, it may be helpful to explore the difference between not *wanting* to complete a difficult task and not being *able* to do it, revisiting the rationale, titrating the procedure if possible (Foa et al., 2019), and conveying both encouragement and empowerment to help patients succeed (Epstein & Street, 2007; Street et al., 2009). Indeed, it was previously reported that in the present sample, completers described more support from therapists specifically in completing the tasks of treatment than discontinuers (Kehle-Forbes et al., 2022).

As participants moved into the active components of treatment, PTSD- and PTSD+ completers generally expressed self-efficacy in being able to engage in the tasks of treatment, whereas discontinuers expressed less self-efficacy. A previous study also found that some discontinuers of PE expressed low self-efficacy in being able to handle the difficult emotions involved in therapy (Wells et al., 2023). In the present study, many discontinuers described their doubt as contributing to their decision to discontinue treatment. Low

self-efficacy related to treatment can hinder engagement in the treatment process, yet is also likely amenable to intervention (Meis et al., 2021). When patients express concerns that they "won't be able to handle" an aspect of treatment, it may be helpful for clinicians to explore their feared consequences and help them reframe their thinking about their ability to tolerate and overcome difficulties in treatment (Galovski et al., 2020). It may also be helpful to empathize with the difficulty of treatment and ensure a shared understanding of why short-term distress is part of the therapeutic process and can contribute to long-term benefit (Epstein & Street, 2007; Street et al., 2009). Future studies are needed to examine the extent to which therapists already engage in these strategies and to test the hypothesis that additional use of these strategies would enhance retention in treatment.

Participants across groups expressed concerns about treatment and the content of future sessions. PTSD+ completers and discontinuers focused more than PTSD- completers on these concerns. Additionally, PTSD+ completers and discontinuers early in treatment, and discontinuers throughout the active components, voiced the most extreme concerns, such as treatment causing them to go crazy, lose control, become stuck in the memory, harm their physical health, or become nonfunctional, violent, depressed, or suicidal. These anticipatory concerns may have been related to lower self-efficacy to engage in treatment and more negative interpretations of ongoing symptoms or functioning difficulties during the active components. In addition, multiple PTSD- completers and some PTSD+ completers reported that treatment was eventually helpful, even if they experienced symptom worsening before ultimate improvement. While discontinuers' experiences had they continued in treatment are unknown, completers' reports of treatment taking some time to help suggest that some discontinuers may stop engaging when their distress is highest and before potentially seeing long-term benefit.

Research is needed to examine how clinicians might optimally respond to patients' treatment-related concerns. Studies could test whether it is helpful for clinicians not only to share with patients that increases in distress and symptoms are common during treatment but further to describe what this might look like (e.g., increased irritability or intrusive memories) and to convey that these experiences are often temporary and do not necessarily lead to catastrophic outcomes or lack of meaningful change by the end of treatment (Larsen et al., 2022). Clinicians might partner with patients to manage treatment-related distress and jointly explore risk of negative consequences of treatment, as well as possible benefits of treatment despite a potential temporary increase in difficulty, in order to reframe potentially exaggerated expectancies and to prevent negative outcomes from occurring. Clinicians are often unaware of the types of concerns that may contribute to poor outcomes (Meis et al., 2023), so asking patients about their concerns throughout treatment can provide the opportunity to intervene more effectively, whether through problem-solving (Shulman et al., 2019) or another adjunctive procedure, or through bolstering PE or CPT elements (e.g., challenging treatment-interfering stuck points, empowering patients to engage in exposure) to retain patients in care.

Kehle-Forbes et al. (2022) reported findings from this sample related to interpretations of ongoing or worsening symptoms as well as concerns about the impact of treatment on functioning. When considering PTSD- and PTSD+ completers separately in the present analysis, these groups expressed similar beliefs and reactions to

each other, maintaining previous findings that discontinuers reported similar levels of ongoing or worsening symptoms as both PTSD– and PTSD+ completers, but they interpreted these experiences more negatively. Discontinuers also expressed more concerns about treatment impacting their functioning at work, school, home, and in their relationships than both PTSD– and PTSD+ completers, consistent with Kehle-Forbes et al. (2022) findings. One participant expressed he wished he had been warned that treatment may make him temporarily more irritable with family members so he could discuss this with them in advance; clinicians might consider such an approach. In some cases, treatment may have consequences for patients' functioning, and this should be addressed. For example, clinicians might problem solve with patients to prevent negative functional consequences (e.g., not scheduling sessions immediately before work) and address difficulties patients do experience so they may be less likely to leave treatment at the peak of their distress. Additionally, massed treatment formats, in which therapy is delivered with more frequent sessions over a shorter time period, have demonstrated promise in reducing symptoms and improving retention (Galovski et al., 2022; Ragsdale et al., 2020; Wachen et al., 2019). Such programs may be helpful for patients who express concerns about functioning, as a massed format can allow patients to take leave from school or work and in some cases live away from home while they focus on engaging in care.

Strengths, Limitations, and Future Directions

The present study's qualitative approach allowed for a nuanced examination of participants' treatment-related beliefs and reactions to PE and CPT in their own words. The qualitative approach also facilitated identification of novel themes differentiating the experiences of PE/CPT discontinuers and completers as well as the generation of hypotheses to be tested in future research. Further, this investigation extended prior findings in this sample (Kehle-Forbes et al., 2022) by comparing the experiences of discontinuers to both PTSD– and PTSD+ completers, contributing to understanding of processes of treatment engagement and response. Participants included a significant number of women veterans, were demographically diverse, and comprised a national sample of veterans across service eras, giving confidence to the completeness of themes reported. Research is needed to determine whether findings extend to nonveteran samples.

A key limitation of this study is that interviews were retrospective, so participants' reports of their experience may have been biased by their treatment outcomes, particularly when recalling their reactions early in treatment, and it is difficult to know to what degree participants' beliefs changed over the course of treatment. Prospective data collection is needed to examine changes in PE and CPT patients' reactions to treatment and their PTSD symptoms in real time throughout their course of care. Additionally, the PTSD scores used to categorize PTSD– and PTSD+ completers were collected with different timing across patients. Scores were collected on average 6 weeks and no more than 3 months after the end of treatment, so these scores likely capture meaningful information about loss of diagnosis soon after treatment's end. Further, a conservative cutoff on a PTSD symptom measure was used to approximate treatment response. No pretreatment score was available to categorize participants based on change in symptoms. It is possible that PTSD+ completers could have started with a high PCL-5 score, experienced significant symptom reduction, and still had a post-treatment PCL-5 score above 31. PTSD+ completers were likely

a heterogeneous group, with some who would report meaningful change and others who would not. Additionally, the small number of discontinuers who screened PTSD– after treatment did not allow for comparisons separating this group from other discontinuers. PTSD– discontinuers may have had more positive treatment-related beliefs that may have led to treatment working faster for them, and they may have differed from PTSD+ discontinuers in other important ways that warrant future study. Finally, the present study only included participants who discontinued before Session 7, so further research is needed to explore the experiences of patients who discontinue in the later sessions of treatment. Future research could also include seeking patients' feedback as to what they believe would have helped them feel more confident to manage their fears and concerns in order to continue to engage in PTSD treatment.

While the present findings provide unique insight into complex and relevant treatment processes, additional studies are needed to clarify the role of these processes in treatment response and completion in real time. Further, empirical support is needed for the interventions suggested here; they should be the targets of future studies. Research is specifically needed to understand the extent to which capitalizing on existing elements of PE and CPT, and better clinician training in how to do so, versus augmenting the treatments with additional procedures, can improve patients' outcomes and maximize retention in care. Gaining a better understanding of potentially malleable processes involved in treatment response and completion is an important step toward the ultimate goal of developing effective intervention strategies to optimize PTSD treatment outcomes.

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