

To Ron Geirnis, Shannon  
Rogers, Erica Yuen, Stephanie  
Zeigler, Peter-Tuek, & Phillippe  
Cummingham, in gratitude for  
your excellent contribution /  
**Victimological Advances**  
**in Theory, Policy and Services**

A festschrift in honor of

**JOHN PETER JOSEPH DUSSICH, Ph.D.**

Professor Emeritus,

California State University, Fresno

Sincere regards,

John P. Dussich

Edited by Tod Tollefson, Ph.D.

July 15, 2015

John P.

# Barriers to Completing Treatment for Veterans With PTSD

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## Abstract

Despite the effectiveness of evidence-based therapies in treating PTSD, many veterans terminate treatment early, limiting potential benefits. Therefore, research is needed to investigate factors that contribute to early treatment termination. To this end, the present study used a telephone survey to investigate treatment completion barriers with 32 veterans who withdrew early from evidence-based PTSD interventions delivered either in-person or via telehealth at a Veterans Affairs Medical Center (VAMC) in the southeastern United States. Commonly reported treatment barriers and implications of those barriers are discussed. The perceived relevance of treatment and stressors that compete with treatment emerged as leading barriers in this sample. Accordingly, assessing and addressing such barriers at the initiation and throughout the course of treatment may reduce early termination of effective care for veterans with PTSD.

*Keywords:* treatment barriers, PTSD, veterans, telehealth

## Introduction

Posttraumatic stress disorder (PTSD) affects between 11% and 20% of U.S. veterans from the Iraq and Afghanistan wars, 10% from the Gulf War and 30% from the Vietnam War (Tanielian & Jaycox, 2008). Effective interventions such as prolonged exposure (PE) exist (Foa et al., 1999; Hembree et al., 2003; Schnurr et al., 2007) and have been evaluated with respect to military-related PTSD (Rauch et al., 2009; Thorp, Stein, Jeste, Patterson & Wetherell, 2012; Tuerk, Yoder, Ruggiero, Gros & Acierno, 2010; Tuerk et al., 2011; Wolf, Strom, Kehle & Eftekhari, 2012; Yoder et al., 2012). However, despite positive treatment outcomes, traditional dropout rates from evidence-based treatments such as PE range from 20% to 26% (Hembree et al., 2003) when measured across various study settings,

populations and sample sizes (see also Schottenbauer, 2008, for a review). The range of reported dropout is even larger among veterans (Gros, Yoder, Tuerk, Lozano & Aciermo, 2011; Nacasch et al., 2010; Rauch et al., 2009; Schnurr et al., 2007; Thorp et al., 2012; Tuerk et al., 2010; Tuerk et al., 2011; Yoder et al., 2012) and active duty personnel (Cigrang et al., 2011), where early termination rates vary from 13% (Nacasch et al., 2010) to 38% (Schnurr et al., 2007). Reducing dropout in military PTSD treatment settings is particularly important because preliminary data indicate that when a full course of treatment is delivered, more than half of patients no longer meet the criteria for PTSD, and the majority of those who do not lose their diagnosis nonetheless experience significant symptom improvement (Cigrang et al., 2011; Foa et al., 1999; Rauch et al., 2009; Steenkamp & Litz, 2012; Tuerk et al., 2011). In addition, two recent studies ( $N = 60$ ,  $N = 70$ ) conducted by separate research teams at different VAMC facilities found strikingly similar significant long-term reductions in mental health service utilization for PE treatment completers but not for those who dropped out of the evidence-based care (Meyers et al., 2013; Tuerk et al., 2012). Such findings highlight the need to systematically examine and address factors that contribute to dropout. Unfortunately, existing studies find few consistent addressable predictors.

There is ample research investigating potential predictors of dropout in PE. Existing studies focus on individual factors, such as age (Erbes, Curry & Leskela, 2009; Garcia, Kelley, Rentz & Lee, 2011; Harpaz-Rotem & Rosenheck, 2011), gender (van Minnen, Arntz & Keijsers, 2002), race (Cook, Thompson, Harb & Ross, 2013; Lester, Resick, Young-Xu & Artz, 2010; Rosenheck, Fontana & Cottrel, 1995), employment status and SES (Foa et al., 1999; Foa, Rothbaum, Riggs & Murdock, 1991); co-morbid conditions, such as depression (Zayfert et al., 2005), general anxiety (van Minnen et al., 2002), substance use and anger (Riggs, Rukstalis, Volpicelli, Kalmanson & Foa, 2003; van Minnen et al., 2002); and pre-morbid functioning, such as baseline severity of PTSD symptoms (Bryant et al., 2007; Marks, Lovell, Noshirvani, Livanou & Thrasher, 1998; Bryant et al., 2007). However, reliable predictors of dropout have not yet been identified (van Minnen et al., 2002), and specific reasons for dropout, rather than immutable demographic risk factors, have yet to be studied.

The purpose of the present study is to identify non-demographic factors, identified by veterans, that prevent them from completing an entire course of exposure-based PTSD treatment. Treatment was delivered through either home-based telehealth or in-person exposure-based therapy sessions. Understanding these barriers to both types of treatment modalities is crucial to increasing patient retention and the benefits that come with completing an entire course of PE treatment.

## **Methods**

### *Procedures*

Participants were 32 veterans who had dropped out of one of two ongoing PTSD treatment research studies at a Veterans Affairs Medical Center in the southeastern United States. One of the studies compared 8 to 12 sessions of PE delivered through home-based telehealth versus in-person PE therapy sessions (Strachan, Gros, Yuen et al., 2012). The other study compared eight sessions of exposure combined with behavioral activation delivered through home-based telehealth versus in-person therapy sessions (Strachan, Gros, Ruggiero et al., 2012). The dropout rate for patients in both of these ongoing studies was approximately 27% with the mean number of sessions completed for those dropping out equal to 3.88 ( $SD = 1.36$ ). Both treatments utilized evidence-based techniques such as *in vivo* exposure, imaginal exposure and behavioral activation.

Participants who withdrew from PTSD treatment after receiving two or more sessions were contacted by telephone with an invitation to participate in a follow-up survey of treatment completion barriers. Fifty-nine veterans were called and contact was made with 41, 32 of whom agreed to participate. For the veterans who declined, the most common reason for declining was a lack of interest.

### *Measure*

The Barriers to Therapeutic Exposure Participation Scale was administered by trained clinicians to participants over the telephone. This measure asked participants to rate how often they experienced a variety of barriers that might have interfered with treatment using a 5-point Likert scale ranging from 0 (e.g., Never a problem) to 4 (e.g., Very often a problem). This measure was adopted from the Barriers to Treatment Participant Scale (BTPTS; Kazdin, Holland, Crowley, & Breton, 1997) and modified to apply specifically to adult patients who have received exposure therapy. The original items on the BTPTS were intended to be used with families, and therefore some of the items pertained to children, such as "My child had trouble understanding treatment." Items such as this were modified to apply to the adult patient, for example, "I had trouble understanding treatment." In addition, four items were removed: "My child refused to come to the sessions"; "I was billed for the wrong amount" (patients in the current study were not billed); "My child was sick on the day when treatment scheduled" (there is already an item pertaining to the adult individual being sick on a scheduled treatment day); and "My child was never home to do the assigned homework." Five additional items were added to the measure: "Crises at work made it hard for me to attend sessions"; "I had trouble with other family members at home, which made it hard to participate in treatment"; "I was too tired after school to participate"; "The atmosphere of the sessions made it uncomfortable for appointments";

and "Treatment took time away from spending time with my spouse/partner." The original items on the BTPS were developed from focus groups with providers and then validated with an outpatient sample of families. The BTPS demonstrated high levels of internal consistency ( $\alpha = .86$ ) and higher scores were associated with higher rates of treatment dropout, fewer weeks in treatment and higher rates of appointment cancellations and no-shows. The authors of the measure suggested that the items could be divided into four general categories: stressors and obstacles that compete with treatment, treatment demands and issues, perceived relevance of treatment, and relationship with the therapist (Kazdin et al., 1997).

### Participants

Participants were 32 veterans with a mean age of 48.5 ( $SD = 15.1$ ). Race was predominantly Black/African American (53%) and White (47%). Three percent of patients identified their ethnicity as Hispanic/Latino and 3% of patients were female. Theaters included OIF/OEF (25%), the Persian Gulf (38%) and Vietnam (38%). Of the participants, 53% received treatment through telehealth and 47% received treatment in person.

### Results

The mean score for each of the potential treatment barriers was calculated across participants and for specific subgroups. The most commonly endorsed treatment barriers across all participants were related to the categories of perceived relevance of treatment (see Figure 1) and stressors/obstacles that competed with treatment (see Figure 2). With regard to perceived relevance of treatment, many of the veterans reported that the treatment did not seem to be working ( $m = 2.72$ ,  $SD = 1.46$ ), that treatment was not what they expected ( $m = 2.41$ ,  $SD = 1.48$ ) and that they lost interest in attending sessions ( $m = 1.66$ ,  $SD = 1.77$ ). With regard to stressors/obstacles that competed with treatment, many of the veterans reported that they experienced much stress during the course of treatment ( $m = 2.44$ ,  $SD = 1.50$ ), that treatment added another stressor to their life ( $m = 2.19$ ,  $SD = 1.62$ ) and that finding a place to park for sessions was difficult ( $m = 1.94$ ,  $SD = 1.93$ ). Some of the other more commonly endorsed barriers included specific treatment demands (see Figure 3), such as the amount of work required ( $m = 1.38$ ,  $SD = 1.62$ ) and difficult homework assignments ( $m = 1.17$ ,  $SD = 1.66$ ), as well as feeling like they had to give too much personal information to the therapist ( $m = 1.25$ ,  $SD = 1.57$ ) (see Figure 4).

Statistical tests of significance between subgroups were not conducted due to low  $N$ , but several patterns were observed. Finding a place to park was the top barrier reported by veterans receiving in-person treatment ( $m = 2.67$ ;  $SD = 1.80$ ) but was of less concern for those receiving home-based telehealth ( $m = 1.29$ ;  $SD$

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= 1.86). Veterans receiving home-based telehealth were less likely to report that their job got in the way of having a session (in-person  $m = 1.33$ ,  $SD = 1.50$ ; telehealth  $m = 0.35$ ;  $SD = 1.00$ ) or that they were too tired after work to participate in a session (in-person  $m = 1.60$ ,  $SD = 1.68$ ; telehealth  $m = 0.47$ ,  $SD = 1.07$ ). Veterans 45 years and older were more likely to report that treatment did not focus on their life and problems (older group  $m = 1.30$ ,  $SD = 1.42$ ; younger group  $m = 0.17$ ,  $SD = 0.39$ ), whereas veterans under 45 were more likely to report that treatment conflicted with work/school/social activities (younger group  $m = 1.67$ ,  $SD = 1.61$ ; older group  $m = 0.55$ ,  $SD = 1.15$ ), that they lost interest in attending sessions (younger group  $m = 2.58$ ,  $SD = 1.93$ ; older group  $m = 1.10$ ,  $SD = 1.45$ ) or that improvement led to treatment no longer being necessary (younger group  $m = 1.58$ ,  $SD = 1.08$ ; older group  $m = 0.60$ ,  $SD = 0.94$ ). And finally, with regard to race, African American patients were more likely than Caucasian patients to report that crises at home made it harder to attend sessions (African American  $m = 1.47$ ,  $SD = 1.38$ ; Caucasian  $m = 0.13$ ,  $SD = 0.52$ ).

## Discussion

There is a significant need to identify modifiable factors predictive of early withdrawal from evidence-based treatment for PTSD by veterans. Despite the effectiveness of exposure-based treatments for PTSD, a significant proportion of veterans do not obtain benefits that appear to be likely when a full course of treatment is delivered. The present study identifies several modifiable barriers to successful treatment completion, as viewed by the veterans themselves. Major reported barriers included perceived relevance of treatment (treatment not working, treatment not what patients expected and loss of interest in attending sessions), high levels of stress during treatment, treatment demands (amount of work required, difficult homework assignments) and revealing personal information to therapist. These results suggest that the context within which treatment rationale is being offered could benefit from modification so as to improve patients' understanding of what treatment entails and why this approach is relevant to them, personally. Revisiting this rationale and related treatment requirements and characteristics multiple times throughout the first few sessions, and emphasizing personal relevance of treatment to a specific patient might reduce patient dropout rate. In addition, addressing how one might balance the demands of treatment with other life stressors, and weaving a problem-solving approach to address these issues throughout treatment sessions, might also improve treatment retention. It is also pertinent to mention that some patients might have perceived this treatment to be less relevant to them personally due to the potential of sub-clinical PTSD symptoms and/or misdiagnosis of PTSD during the initial assessment, particularly for patients with generalized anxiety.

In addition, some initial but limited support is provided for the notion that treatment barriers could differ between subgroups according to treatment modality (e.g., telehealth versus in-person). This is particularly relevant given the fact that telehealth is increasingly being offered as a means by which to address treatment barriers. Recognition that this solution might present certain new problems is important and useful. In general, veterans receiving telehealth reported fewer logistical problems such as parking, scheduling and interfering work commitments. It is also possible that older adults terminating treatment early who have combat experience several decades ago might perceive certain aspects of trauma-focused therapy as less relevant to their current lives. However, if they are experiencing PTSD symptoms, particularly intrusive ideation, exposure treatment and its focus on traumatic memories could well be relevant, and the manner by which treatment rationale is given might require modification. Meanwhile, younger adults might have greater difficulty managing the time commitment for therapy with other activities. In addition, it is possible that non trauma-related psychosocial problems (e.g., crises at work or home) could interfere with treatment to a greater degree for certain ethnicities, such as Black/African American veterans.

A major limitation of this study is the small number of participants. Out of 52 veterans who terminated treatment early after two or more sessions, only 54% participated in this study, highlighting the difficulty of collecting follow-up information from patients who have left treatment. Given the small number of participants, the analyses and the conclusions that can be drawn from this study are limited. However, the study provides evidence that the presented method of data collection employed is feasible in this difficult population, and results provide preliminary information regarding the most common treatment barriers that Veterans with PTSD face. Note that the treatment barriers rated by participants in this study were limited to the items on the Barriers to Therapeutic Exposure Participation Scale. Future research could employ a mixed methods approach where participants and family members are asked open-ended questions about their reasons for dropout with quantitative and qualitative analyses identifying the most common themes.

Assessing and addressing treatment barriers throughout the course of treatment has the potential to improve treatment response and reduce early termination for veterans with PTSD. Focusing on adaptive and maladaptive responses to treatment as they occur in the natural ecology of the individual, family and the community, could be a particularly effective approach for patients who do not respond to traditional outpatient services. A multi-systemic approach to assessment and treatment will surely inform the next generation of evidence-based treatments for PTSD that are geared toward reaching an increased number of veterans and providing more effective and relevant services.

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Figure 1. Means for Perceived Relevance of Treatment

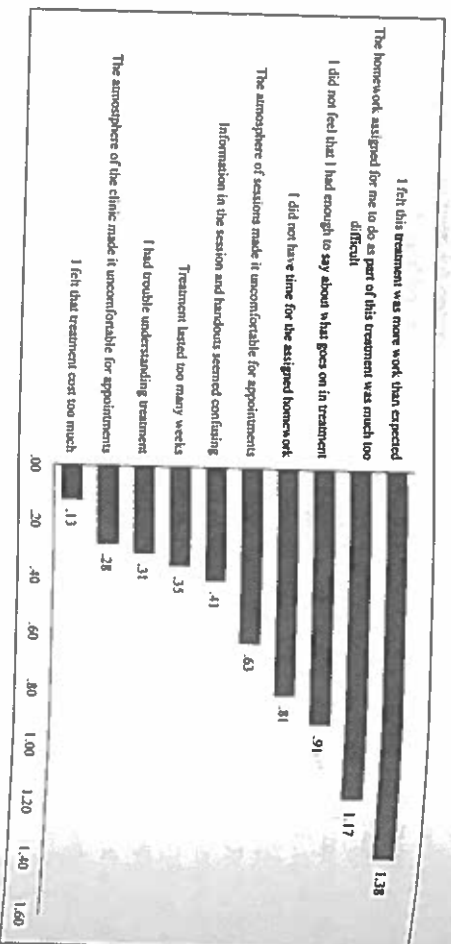


Figure 2. Means for Stressors/Obstacles That Compete With Treatment

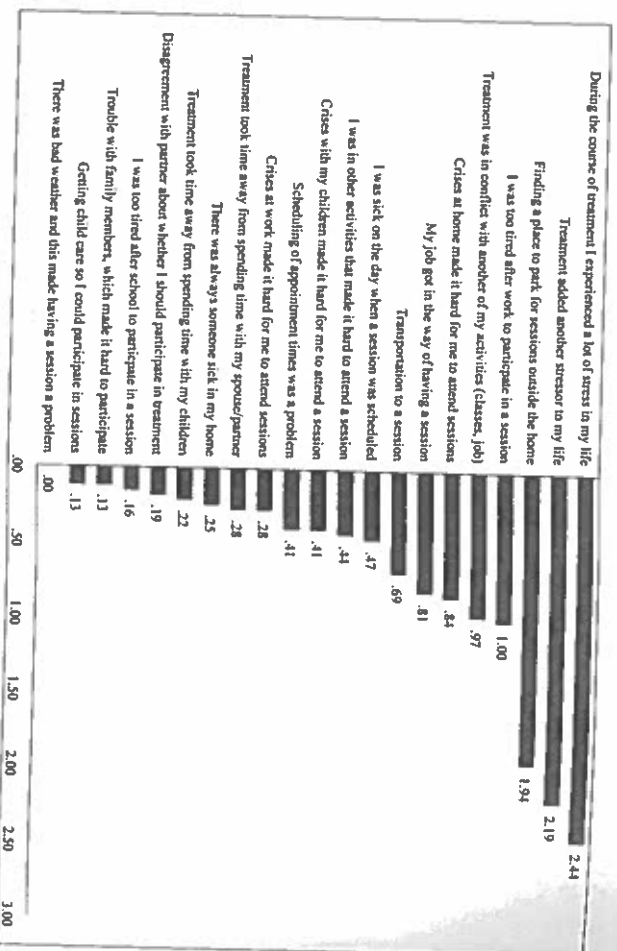


Figure 3. Means for Treatment Demands and Issues

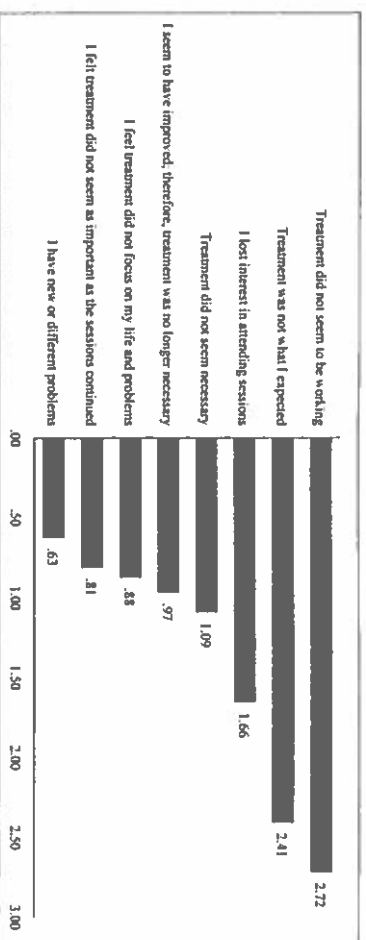


Figure 4. Means for Relationship With the Therapist

