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“It didn’t fit for me”: A qualitative examination of dropout from prolonged exposure and cognitive processing therapy in veterans

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Abstract

Trauma-focused psychotherapies, such as prolonged exposure and cognitive processing therapy, are the most effective forms of treatment for posttraumatic stress disorder. These treatments are commonly delivered in the Veterans Health Administration; however, dropout means that some veterans fail to benefit. Ending treatment prematurely is a common problem across psychotherapies, with on average, 20% to 25% of patients dropping out. The purpose of this study was to examine veterans’ self-reported reasons for dropping out of prolonged exposure or cognitive processing therapy. Veterans who dropped out from prolonged exposure or cognitive processing therapy (N= 28) completed qualitative interviews about their experiences. Interviews were coded by two coders using grounded theory. Therapy-related barriers were the largest category reported, and included lack of buy-in to the rationale or specific therapy tasks, believing that treatment was not working, alliance issues, or switching to a different treatment. Practical barriers and finding treatment “too stressful” were also common reasons for dropout. This research provides information that can shape how PTSD treatments are delivered in healthcare settings. Therapy-related barriers were the largest group, suggesting that providers may need to find more effective ways to communicate the rationale for these therapies or to tailor them to individual patients’ needs.

Keywords

Posttraumatic stress disorder; exposure-based psychotherapy; dropout; qualitative methods; interview; PTSD; evidence-based psychotherapy; qualitative; patient perspectives; barriers

Trauma-focused therapies are considered the most effective forms of psychotherapy for posttraumatic stress disorder (PTSD), according to clinical practice guidelines from the American Psychological Association (APA, 2017) and the Department of Veterans Affairs (VA/Department of Defense, 2017). In particular, prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007), cognitive processing therapy (CPT; Resick, Monson, & Chard, 2017), and eye movement desensitization/reprocessing therapy (Shapiro, 1989) have received empirical support for their effectiveness in both civilians and military veterans and are considered evidence-based psychotherapies for PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Steenkamp & Litz, 2013). Within the VA healthcare system, two of these treatments, PE and CPT, have been disseminated through national training efforts. Although national rates of PE and CPT engagement in VA remain low (Watts, Shiner, Zubkoff, Carpenter-Song, Ronconi, & Coldwell, 2014), implementation has been improving, with up to half of eligible veterans in some specialty PTSD clinics now receiving PE or CPT (Hundt, Harik, Thompson, Barrera, & Miles, 2017; Kehle-Forbes, Meis, Spoont, & Polusny, 2016).

However, attrition or dropout from psychotherapy, defined as ending therapy prematurely any time after completing at least one session, remains a problem across mental health disorders. A meta-analysis of psychotherapy attrition and dropout estimated a mean dropout rate of 19.7% in adult psychotherapy patients, across all disorders. The range of attrition, however, was quite wide (0% to 74%; Swift & Greenberg, 2012), suggesting that heterogeneity of treatment approaches, settings, patients, and providers may contribute to the wide variability. Dropout rates were greater among treatments that were open-ended and non-manualized, those that did not specify a disorder that was the primary focus of treatment, and when administered by trainee providers. Rates were also higher among younger, less educated, unemployed, and substance-misusing patients (Fenger, Mortensen, Poulsen, & Lau, 2011). Dropout is strongly associated with poor therapeutic alliance (Sharf, Primavera, & Diener, 2010).

Dropout rates are similar for PTSD as for other disorders (Imel, Laska, Jakupcak, & Simpson, 2013). Among PE and CPT patients (including among veterans) in particular, dropout varies largely among studies, ranging from a low of 13% in one study of PE among individuals with combat- and terror-related PTSD (Nacasch et al., 2011) to up to approximately 40% in other studies (Foa et al., 2005; Schnurr et al., 2007).

Dropout from randomized controlled trials, however, may not reflect dropout that occurs in real-world clinical practice, given tight controls on diagnostic comorbidity and potential incentives for study participation in randomized controlled trials. In VA outpatient specialty PTSD clinics, dropout has been up to 50% (e.g., Miles & Thompson, 2016). Nationally, the median number of PE or CPT sessions among those who received such therapies is five, suggesting significant dropout (Watts et al., 2014). Individual differences may be related to dropout: veterans with prior inpatient stays, veterans of Operations Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), and those with childhood trauma are more likely to drop out of evidence-based psychotherapy (Harpaz-Rotem & Rosenheck, 2011; Miles & Thompson, 2016; Mott, Mondragon, et al., 2014). In addition, practical/logistical barriers such as transportation can lead to dropout from PE and CPT (Hernandez-Tejada, Zoller, Ruggiero, Kazley, Acierino, 2014). Among patients in a PTSD-focused residential program,

greater attrition was related to greater PTSD symptom severity, lower improvement in functioning during treatment, and greater substance use (Szafranski, Gros, Menefee, Wanner, & Norton, 2014). A review of dropout from PE and CPT in veterans and civilians suggested that dropout is related to a variety of sociodemographic factors, PTSD severity, and comorbidity (Najavits, 2015). Overall, attrition appears to be common in real-world clinical settings; and undertreated PTSD can lead to a variety of occupational, relationship, and societal consequences (Kessler, 2000; Sareen et al., 2007).

Although prior research has established rates of dropout and clinical and demographic characteristics associated with dropout and qualitatively examined veterans' reasons for refusing PE and CPT (Hundt, Helm, Smith, Lamkin, Cully, & Stanley, in press), to our knowledge, no studies have qualitatively examined veterans' self-reported reasons for dropping out of PE or CPT in routine practice. This information may be crucial to efforts to fully implement these evidence-based treatments and ensure that veterans obtain the full benefit of a course of psychotherapy. It is particularly important to understand the perspectives of Veterans in the real world settings because military culture shapes Veterans' perspectives on mental health and treatment (Coll, Weiss, & Yarvis, 2011) and Veterans with PTSD may respond differently to psychotherapy than civilians (Steenkamp & Litz, 2013). Patients who are dissatisfied with their treatment may refuse future psychotherapy, preventing them from receipt of effective treatments. Thus, the purpose of the current study was to conduct a qualitative examination of reasons for dropout from these treatments, to try to understand the real-world barriers to completion of PE and CPT in Veterans Health Administration (VHA) PTSD clinics.

Method

Participants

We recruited veterans from a VHA PTSD clinic who had completed at least one session of PE or CPT but dropped out before completing at least a minimum dose (defined as eight sessions, as in Tuerk et al., 2013). PE is a variable-length treatment, meaning that therapists and patients can elect to complete anywhere from eight to 15 sessions, and CPT is typically 12 sessions; although variable-length CPT can flex the number sessions (Galovski, Blain, Mott, Elwood, & Houle, 2012). Patients in PE and CPT who experience early improvements may terminate and be considered "early completers" (Foa, et al., 2007; Resick, et al., 2017). Thus, we selected eight sessions as a conservative cutoff to ensure that all patients included were dropouts, rather than early completers, and we verified via chart review that no patients were early completers.

The final sample of participants included 28 veterans who were primarily male (see Table 1), and largely African American, white, or Hispanic/Latino. Although many participants had multiple traumas, we identified the index trauma as documented in the medical record by the PTSD assessor. Participants' index traumas included noncombat military accidents/deaths, military sexual trauma, trauma from combat in Iraq and Afghanistan, nonmilitary traumas such as natural disasters, childhood trauma or the violent death of a loved one, and trauma from combat in other war eras (Table 1).

Environment

The PTSD clinic from which these patients were recruited functions as a sub-specialty clinic providing trauma-focused psychotherapy to veterans simultaneously enrolled in the General Mental Health Clinic (GMHC). The primary purpose of the clinic is to deliver evidence-based psychotherapies for PTSD, although some non trauma-focused treatments are also available. Most veterans attended a group orientation and then an individual evaluation to confirm diagnoses, identify the index trauma, and discuss psychotherapy options. Although all PTSD clinic therapists presented the rationale for PE or CPT as the first-line treatments for a primary diagnosis of PTSD, including written handouts and promotional videos, veterans had the final say in their choice of treatment.

Procedure

This study was approved by the local IRB and VHA Research and Development Committee. From the VHA electronic medical records, we obtained a list of patients completing an intake assessment into a VHA PTSD clinic between January 1, 2015, and August 1, 2016. A research assistant completed initial chart reviews ($n = 583$) to identify patients meeting inclusion criteria—specifically, that patients completed between 1 and 8 sessions of PE or CPT and were classified as a dropout according to their therapist. The first author verified in the medical record that inclusion criteria were met for each patient the research assistant deemed eligible. Eighty-eight (15%) patients were excluded for not meeting enrollment criteria for the PTSD clinic (e.g., not meeting PTSD diagnostic criteria); 222 (38%) were excluded because they did not engage in PE or CPT, 146 (25%) were excluded because they completed PE or CPT treatment or were actively engaged in one of those treatments at the time of recruiting, 25 (4%) CPT dropouts were excluded after reaching saturation, defined a priori as the point when three consecutive transcripts within a given interview category rendered no new thematic concepts in that group (Morse, 1995; Aita & McIlvain, 1999), and nine (2%) were excluded because they were prior patients of the first author, leaving 93 patients (16%) eligible for the study. Five to seven days after sending an opt-out letter to the 93 eligible patients, a research assistant attempted to contact them by phone. Of the 93 patients who received letters, 57 patients (61%) agreed to participate, 13 declined participation, and we were unable to contact 23 patients. Twenty-nine patients verbally agreed but did not return consent forms and/or complete the interview before recruitment ended, leaving 28 enrolled in our study.

Participants completed informed consent and consent to audio record via mail prior to beginning telephone qualitative interviews. All interviews were audio recorded and saved on a HIPAA-compliant server. Interviews ranged from 27 to 65 minutes and were conducted from February 2016 to September 2017. Interviews were conducted by the first author and another member of this research team with qualitative training. The research team developed a qualitative interview guide that queried participants' experiences in VHA PTSD care, including the process of seeking care, positive and negative experiences in PE and CPT, their buy-in to the treatment, family and friend support to be in treatment, and reasons they discontinued the treatment. Thus, the data collected allowed for contextualizing dropout within an overall picture of experiences in seeking and attending treatment. As guided by grounded theory, we developed the interview questions to be phrased as neutrally and non-

leadingly as possible, in order to elicit from the respondent their own ‘story’ of treatment, from the beginning to middle to end. Interview questions regarding dropout were: “It looks like you completed (#) of sessions, which is less than the typical number for that treatment. Tell me about how you stopped going to that treatment.” Follow-up probe questions, when necessary, included “Were there any things that got in the way of attending sessions for you?” “How long did you think about stopping before you actually stopped?” We ended recruitment when we reached data saturation.

A formal chart review, conducted by a research assistant and verified by the first author, was used to obtain quantitative data. This included demographic variables such as age, gender, and race; clinical variables including comorbid diagnoses and index trauma as assessed by the PTSD clinic intake provider, number of PE or CPT sessions completed, and any documentation by the therapist of reasons for discontinuation.

Data Analysis

Audio recorded interviews were transcribed by a professional service. The first author and a research assistant trained in qualitative methods reviewed transcripts to determine initial codes using grounded theory. The analysis was guided by grounded theory, in which theme codes generated during data analysis are used to construct a theory, rather than coding based upon theory or prior research (Glaser & Strauss, 1967). We applied principles of grounded theory analysis to generate theory that best fits the data and to preclude the use of theories that may inadequately portray the data. This popular analytical approach in qualitative inquiry has been recommended for use in qualitative psychology research (Ponterotto, 2005). After the two coders independently coded the first transcripts using codes they independently developed, a codebook with definitions of codes and example quotations was derived from consensus and used to guide final coding of all transcripts. Each transcript was then coded by both coders, and discrepancies were resolved through discussion. After the first six practice transcripts, kappa for the rest of the transcripts was $\kappa = .96$. We linked quotations to multiple codes as appropriate and used a qualitative data-management software package for coding and analysis (Atlas.ti V6.0 [Atlas Ti Scientific Software Development GmBh, Berlin; Muhr, 2011]). Frequencies and percentages of patients endorsing each theme were examined, as well as co-occurrence between categories, measured as the percentage of patients endorsing various combinations of themes.

Results

Veterans noted a variety of reasons for treatment noncompletion. Based upon discussion and consensus within the research team, the barriers expressed were condensed into the following categories: practical, emotional, treatment-related, and system-related reasons (see Table 2). The mean number of barriers expressed by veterans was 2.5 ($SD = 1.0$). Except for the few cases where differences were specifically noted in the results, there were no apparent differences between PE and CPT.

Practical Reasons for Noncompletion

Over half of our sample ($n = 16$, 57%) endorsed at least one practical reason for treatment noncompletion. The most common of these were that work or school made scheduling appointments difficult or took up too much of their time to make treatment attendance practical ($n = 7$, 25% of the total sample). Several noted that this was compounded by unsupportive supervisors, long hours at work, or the combination of work and school. For example, an African-American male veteran with OEF/OIF combat trauma in group CPT said, “When it came to the point where it was jeopardizing my job, you know, the therapy come later, man. I gotta get paid.”

The second most common practical reason was that family obligations interfered with treatment completion ($n = 6$; 21%). This included caretaking for family members with serious illnesses or major surgeries and caretaking of children or special-needs family members. These veterans often seemed to prioritize their family responsibilities above receiving care for their PTSD, which may have seemed less urgent to them by comparison. As an African-American male veteran with other military trauma in PE commented, “The problem was that I couldn’t keep it up on a week-by-week basis because my wife and her health.” Overall, it appeared that veterans may have decided to drop from treatment by weighing the relative urgency of their current symptom severity vs. the priority of the competing demand (work or caretaking).

Emotional Reasons for Noncompletion

The most common emotional reason was the belief that the therapy was too difficult or stressful ($n = 10$; 32%), in that treatment caused an escalation of symptoms or patients did not have confidence they would be able to handle the emotional challenge of trauma-related therapy. This happened both for PE patients ($n = 6$; 60% of PE patients) and for CPT patients ($n = 4$; 22% of CPT patients), although this reason was more common in PE patients. “I just couldn’t do it...it was too much, every time I played it (the recording of the trauma) back or heard it, I felt like I was in it again,” said one African-American female veteran with military sexual trauma in PE. For those in group CPT, this sometimes took the form of thinking that it was too stressful to listen to the struggles or stories of other veterans with trauma.

Therapy-Related Reasons for Noncompletion

Therapy-related barriers included lack of buy-in to treatment, alliance issues, feelings that the treatment did not work for them and referral to a different treatment.

Buy-in to treatment.—Lack of buy-in to the treatment rationale or specific therapy tasks was a common theme (14; 50%). This included misunderstanding of the therapy rationale, disagreement with exposure principles, preferring a present-centered focus, believing the therapy could help for others but not them, objecting to tasks such as worksheets in CPT, or otherwise feeling the therapy rationale “didn’t fit for me” (African-American female veteran with civilian interpersonal trauma in PE). A Latino male veteran with OEF/OIF combat trauma in individual CPT commented, “They just want to go into the past, but we need or what I need is how to cope with what I have right now, and then everyday civilian life,

instead of just regressing and getting to the roots.” Some reported feeling strongly encouraged to select PE or CPT, even if they did not have complete buy-in. This often appeared to reflect promotion of EBPs, in which the provider gave options but told the patient, probably correctly, that an evidence-based therapy, as compared to a non-evidence-based therapy, or a specific choice (e.g., PE vs. CPT) was the most recommended, given their issues or presentation. This sometimes led veterans to engage in a treatment to which they did not fully buy-in or feel comfortable with. “They told me that I had other options, but they were like, well, this is kinda like the best for you, and I was like, uhh, well, I guess I’ll do it because I don’t want to do something that doesn’t fit me,” said an African-American female veteran with military sexual trauma in PE.

Alliance.—Six patients (21%) reported that alliance issues with their provider contributed to discontinuing treatment. Examples of this included feeling the provider was frustrated with them or having difficulty relating because the provider was from a different age group or a civilian: “I couldn’t...relate because they were never in the military,” said a white male veteran with OEF/OIF combat trauma in individual CPT. Other alliance related issues included lack of time to build alliance before being encouraged to “jump in” to difficult therapy tasks too quickly, as an African-American female veteran with military sexual trauma in PE said,

“She said it in a very nice way and a very calming manner; however, you just have to know when to ask a person. Like, see, if the person has gained your trust, or see if the person has let the wall down to you before you just be like, okay, well, you need to record yourself.

Treatment “didn’t work” for them.—Five veterans (n = 5; 18%) reported that the treatment “didn’t work” for them. They reported that exposure was not getting easier with time; that their beliefs were not changing; or symptoms were subjectively worsening rather than improving, which convinced them treatment was not working. All five of these veterans also endorsed either lack of buy-in or that PE/CPT was too stressful, suggesting significant overlap of these categories. Chart-review data indicated that these veterans had typically completed three to five sessions, which may not have been enough to expect substantial improvement. As one Latino male veteran with other military trauma in group CPT who had completed five sessions said, “I just gave up because it wasn’t...I wasn’t getting anywhere... They were trying to convince me that it’s gonna happen. You’ve just got to give it a little more time, and it wasn’t working.”

Referred to different treatment.—Seven patients (25%) reported that they had a conversation with their therapy provider or psychiatrist in which they decided to discontinue the treatment. In most cases, this was due to difficulties tolerating exposure or regularly attending sessions, the severity of a co-occurring disorder, or the provider’s recommending an alternative treatment or a higher level of care, including dialectical behavior therapy, residential PTSD treatment, or substance-abuse treatment. “They didn’t think therapy once a week was good for me. It wasn’t going to be helpful, and they recommended inpatient,” said an African-American female veteran with military sexual trauma in group CPT. In all cases,

we verified in the medical record that the provider referred the patient to a higher level of care or alternative treatment.

System-Related Reasons for Noncompletion

Few patients (4; 14%) reported VHA system-related reasons for noncompletion. These represented scheduling issues, limited hours, continuity of care, and negative experiences with non-PTSD providers.

Co-occurrence Between Barrier Categories

Next, because the coders commented upon the frequency with which certain themes co-occurred, we examined overlap between broad categories of barriers. Given the sample size and qualitative nature of this study, we did not examine this statistically but rather descriptively. Veterans describing an emotional barrier were more likely to also endorse a treatment-related barrier (90%) rather than a practical barrier (40%), suggesting strong overlap between emotional and treatment-related barriers. Conversely, veterans describing a treatment-related barrier were more likely to endorse an emotional barrier (45%), compared to a practical barrier (30%).

Positives and Facilitators

Although this is a sample of dropouts, they also reported positive experiences in PE and CPT. For example, 14 (50%) reported that they would definitely and two (7%) that they would maybe be willing to try PE or CPT again, after resolution of practical barriers, connection to a new therapist, or development of further coping skills: "I'm almost done with dialectical behavior therapy, and then we can try CPT again, and this time it'll work better because I have more tools in my work belt," commented a white female veteran with other military trauma in individual CPT. Seventeen (61%) reported a positive, as compared to a neutral or negative, attitude about their therapist: "I couldn't have asked for a better therapist," said a white male with other military trauma in individual CPT. Seven veterans (25%), particularly those who had completed five+ sessions, reported some benefits from PE or CPT despite noncompletion, in that they learned helpful skills or experienced partial relief from symptoms: "Prolonged exposure helped me out getting outside the house," said a Latino male with OEF/OIF trauma in PE. Eight ($n = 26\%$) reported that they continue to use on their own at least one thing they learned in PE or CPT, such as calm breathing or cognitive restructuring.

Discussion

In this qualitative study of 28 veterans who dropped out of PE or CPT, we found that the single largest category, mentioned by over two-thirds of the sample, was therapy-related barriers. This category included lack of buy-in to rationale or specific tasks, lack of improvement in therapy, and agreement with the therapist to switch to another treatment or level of care that might better fit the veteran's needs. The second largest category of barriers was practical barriers, such as work or school conflicts; and the third largest category was emotional barriers, such as finding treatment too stressful. Although, for the purposes of the analyses, these were treated as distinct categories, there is likely a significant overlap

between emotional barriers and therapy-related barriers. For example, a brief increase in PTSD symptoms upon starting exposure therapy may have led to both the belief that therapy was too stressful (categorized under emotional barriers) and to the belief that treatment was not working (categorized under therapy-related barriers). PTSD is a disorder in which avoidance plays a central role; overall these results suggest that the very nature of PTSD makes it difficult to do the things that are needed to engage in psychotherapy. In contrast to the barriers noted by veterans, many also had positive things to say about PE and CPT, despite dropping out. These ranged from positive buy-in to good therapeutic alliance and finding some of the skills they learned helpful.

Compared to a prior study qualitatively examining reasons for non-initiation of PE and CPT (Hundt et al., in press), the current study found relatively more therapy-related reasons for dropout and relatively fewer system-related reasons. Emotional and practical barriers were roughly of the same frequency as in the non-initiators. This suggests that system-related barriers are more likely to prevent entry into therapy, whereas buy-in and therapy-related issues are more likely to prevent completion. This may also suggest that veterans with ambivalent or uncertain buy-in may be willing to give the therapy a chance, even if only a brief one, which provides a limited window for interventions that can sustain treatment engagement. This is particularly concerning given that some patients may experience initial worsening of symptoms in PE or CPT (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002), which may then confirm the patient's skepticism of the treatment and trigger dropout.

The most common individual barrier in the sample was lack of buy-in or the perception that PE and CPT do not "fit" for some veterans. Although it is impossible to say whether these veterans would have benefitted if they fully participated in a course of PE or CPT, their perception that the treatment was not or would not meet their needs led to disengagement. Future research should examine the most effective ways to communicate the benefits and rationale of these treatments, while at the same time allowing veterans choices and shared-decision making (Mott, Stanley, Street, Grady, Teng, 2014), potentially using strategies such as motivational interviewing (Miller & Rollnick, 2012). Therapy-related barriers also included lack of therapeutic alliance in some cases, which is consistent with prior research showing that therapeutic alliance strongly predicts dropout (Sharf, Primavera, & Diener, 2010). Given the role of trust in PTSD, veterans with PTSD may be mistrusting of therapists (Resick, Monson, & Chard, 2017); future research should examine both the role of alliance in PE and CPT and how alliance can be fostered and may differ for veterans with PTSD.

The second group of barriers, and the most straightforward to address, was practical barriers, mentioned by 57% of the sample. This is consistent with some prior studies (Hernandez-Tejada, et al., 2014) indicating that logistical barriers such as transportation can contribute to dropout from PTSD treatment. The VA's implementation of extended hours, along with the advent of telehealth delivered to the patient in his/her home, office, or mobile device has the potential to circumvent a multitude of practical barriers and increase engagement in care (Lindsay, et al., 2015). Although PE and CPT were originally designed as once-weekly treatments, newer research suggests that they may also be effective in intensive "massed" formats (Blount, Cigrang, Foa, Ford, Peterson, 2014) that allow veterans to finish treatment more quickly or to fit treatment into short periods such as while on semester break. These

alternative-delivery models and formats allow veterans greater flexibility in fitting treatment into their lives, and this greater choice in format may help them overcome practical barriers to engagement.

The third largest barrier, endorsed by a significant minority of veterans, was that exposure-based psychotherapies were too stressful or difficult for them at that time. Stage-based models of PTSD treatment may allow veterans to build skills before engaging in exposure (Harned, Korzlund, & Linehan, 2014). PE and CPT can also be delivered as part of more intensive residential programs, which can make them more tolerable for patients who need extra support (Cook, Simiola, Hamblen, Bernardy, & Schnurr, 2017). At this point, however, no data exist to indicate which veterans need to build coping skills and emotion regulation to successfully complete PE or CPT. Recommending that some veterans delay PE and CPT to build readiness may only delay access to the most effective treatments; while, on the other hand, starting PE or CPT when a patient is truly “not ready” has the unfortunate side-effect of creating an experience of treatment failure, which could contribute to negative beliefs about future therapy. Additional data are needed to inform the practice of evidence-based psychotherapies—specifically, information about which veterans are likely to be able to successfully navigate an exposure-based psychotherapy, which may lead to a temporary increase in PTSD symptoms and requires emotional and behavioral self-regulation skills. Future research should examine individual differences in emotion regulation, distress tolerance, and other intrapersonal variables as predictors of completion of PE and CPT. Additionally, future research should examine the degree to which PE and CPT can be “flexed” to meet individual patient needs for slower or more gradual exposure or to address symptoms of co-occurring disorders without diluting the effectiveness of these treatments.

Limitations

We recruited only veterans from one VHA PTSD clinic; future research should examine the relative importance of these barriers in other geographic regions and treatment settings. Given that we defined dropout as completion of seven or fewer sessions, we may have missed “late dropouts” who completed eight+ sessions of a treatment. Additionally, only a quarter of the dropouts we identified participated in the study. Although veterans were assured of the confidentiality of their research data, social desirability and concerns about privacy may have altered responding. Using self-report inherently introduces the possibility of bias, and it may be the case that other factors outside of conscious awareness influenced dropout. Future research might benefit from examining whether certain characteristics lead to risk of dropout. For example, perhaps intolerance of uncertainty may lead to dropout when participants are uncertain whether the treatment will work, or anxiety sensitivity may make a brief increase in symptoms intolerable, and this is then labeled by the patient as “the treatment didn’t work” or “it was too stressful.” Identification of patient characteristics that increase risk for dropout may allow implementation of targeted interventions tailored to each patient.

Conclusions

This qualitative study of veteran attrition from evidence-based psychotherapies for PTSD found that that buy-in, practical barriers, and finding treatment stressful contributed to dropout, although many veterans reported at least one positive aspect to PE or CPT. Future research should identify veterans at risk of dropout and individually tailored approaches to prevention.

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Table 1

Veterans' Demographic Characteristics

	# of Participants(<i>n</i> = 28)	%	PE Drops (n=10)	CPT Drops(n=18)
Gender				
Female	11	39%	4	7
Male	17	61%	6	11
Race/Ethnic				
Non-Hispanic white	7	25%	1	6
African American	17	61%	7	10
Hispanic/Latino	4	14 %	2	2
Mean Age	45.32 (SD = 15.2)		46.5	44.7
Trauma Type				
Combat	8	29%	1	7
OEF/OIF	7	25%	1	6
Vietnam	1	4%	0	1
Military Sexual Trauma	7	25%	3	4
Other military trauma	8	29%	4	4
Nonmilitary trauma	5	18%	2	3

Note. OEF/OIF = Operation Enduring Freedom (Afghanistan)/Operation Iraqi Freedom (Iraq); PE = prolonged exposure; CPT = cognitive processing therapy

Table 2

Most Commonly Expressed Barriers to Completing PE and CPT

Theme	Frequency	
	(n)	(%)
Practical Barriers	16	57%
Employment/college	7	25%
Caregiving/family	6	21%
Other	3	11%
Emotional Barriers	12	43%
Treatment too stressful	9	32%
Other	3	11%
Therapy or Therapist Related Barriers	20	71%
Buy in to rationale/therapy tasks	14	50%
Alliance issues/'pushed too fast'	6	21%
Patient felt treatment was not working	5	18%
Patient referred to different treatment or higher level of care	7	25%
VHA System-related Barriers	4	14%

VHA = Veterans Health Administration