Cyberseminar Transcript

Date: June 12, 2018

Series: HSR&D Career Development Award Enhancement Initiative

Session: Veterans’ Experienced Barriers to Engagement in PTSD Psychotherapy

Presenter: Natalie Hundt, PhD

*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at* [http://www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm](file:///C:\Users\VHASLCMyersK\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.IE5\73RXHSNF\l)

Rob: And as it’s just at the top of the hour, we’re going to go ahead and get things started. I'd like to turn things over to our presenter today, which is Natalie Hundt, who is an investigator at the Houston COIN and a staff psychologist at the Michael E. DeBakey VAMC. Natalie, can I turn things over to you?

Dr. Natalie Hundt: Yes.

Rob: Slides look great.

Dr. Natalie Hundt: Great. Hi everyone. So as Rob said, I'm Natalie Hundt. I'm on my third year of an HSR&D CDA. I'm going to be talking to you today about some qualitative data about Veterans’ perspectives on the barriers that they’ve experienced to both just starting evidence-based psychotherapies for PTSD and also to completing those evidence-based psychotherapies for PTSD.

So first I'd like to thank financial support for my Career Development Award, the South Central MIRECC, and the Houston HSR&D COIN, as well as Dr. Karin Thompson and the staff of the Houston PTSD Clinic and the research assistants who worked on this project.

So before we get started, I'd like to kind of know who my audience is. So Rob, if you would bring up the poll question. And the question is basically what is your role with regards to PTSD? So trying to figure out how many of you are psychotherapy providers or conduct EBPs for PTSD specifically. And if you’re more of a researcher but also have clinical practice, feel free to answer this on the basis of your clinical practice side of your job.

Molly Kessner: This is Molly Kessner, and I’m going to go ahead and jump in real quick for Rob Auffrey. So thank you so much to our attendees for answering that poll. I'm going to go ahead and, whoops, I'll read through the results real quick. So 24% of our respondents selected not a healthcare provider; 7% selected non-mental health provider; 17% mental health provider who does not routinely conduct psychotherapy; 28% responded provider who does routinely conduct psychotherapy; and 38% provider who conducts EBPs for PTSD, for example PE, CPT, or EMDR. So thank you once again to our respondents, and we are back on your poll, or I'm sorry, back on your slides now.

Dr. Natalie Hundt: Great. Thank you so much. So it looks like definitely split across all of these with a weighting towards people who do conduct EBPs. So I'm going to give kind of a brief overview then. So the two evidence-based psychotherapies that the VA has really been promoting for PTSD are PE, or prolonged exposure, and CPT, or cognitive processing therapy. And both of these are time-limited cognitive behavioral therapies that are shown to be effective. And the VA has put a lot of resources into training providers and implementing these therapies across the nation.

So ideally what should happen when a Veteran walks into a PTSD clinic is that they encounter a lovely VA clinician who offers them one of these evidence-based psychotherapies, and then obviously ideally what would happen is that they would accept that evidence-based psychotherapy, and they would complete that, and everything would be great and wonderful in their life from then on out. And unfortunately what happens all too frequently is they go down these other pathways, which are dropping out of that evidence-based psychotherapy without experiencing clinical benefit or refusing it to start with.

And so the focus of today’s talk is really going to be on these two kind of possible outcomes of this trajectory, the patients who drop out of evidence-based psychotherapy and the patients who refuse that evidence-based psychotherapy.

So some background information. We have data from our, it looks like the little key didn’t show up on this one, but we have data showing that up to 50% of Veterans who are even in a very evidence-based psychotherapy clinic do not initiate evidence-based psychotherapy. So this data, the red portion is 47% did not initiate evidence-based psychotherapy even after being offered it. And I think the green one is people who did CPT, and the blue is people who did PE. And this is in a sample that we recently published.

And then for dropout, rates of dropout from evidence-based psychotherapies range from 13 to 40% in randomized controlled trials and possibly even higher in routine clinical settings, up to 50%. And some data suggests that the average number of EBP sessions that patients complete is about five when these protocols are designed to be about 12 sessions, plus or minus. So that suggests that many patients are not completing the full number of sessions.

So prior research has examined barriers to PTSD treatment in general, but they tend to look at any kind of treatment, not specific to just evidence-based psychotherapies. And there are other treatments for PTSD, things like medication, support groups, supportive psychotherapy, et cetera. The prior research has found that things like logistical barriers prevent access to PTSD treatment, stigma, as well as beliefs that discourage treatment seeking, and those are beliefs like I'll get better on my own or it’s not that bad or I will be weak if I need help. And there’s also a fair amount of research on the predictors of dropout, especially in randomized controlled trials. And unfortunately the research has been a little bit mixed on what exactly predicts dropout. But there are no prior qualitative studies of Veterans who refuse evidence-based psychotherapies or qualitative studies of dropout from PE and CPT in routine clinical practices in VA. So the aim of this research is to understand the Veterans’ own experiences about their reasons they refused those psychotherapies or dropped out of those psychotherapies in routine clinical practice in the VA setting.

And so what we did was we recruited patients who came to a PTSD clinic intake assessment, and we required them to come to that intake assessment mainly to make sure that they actually had PTSD. And so we were trusting that the routine clinical providers in the PTSD clinic would give a reasonably good and accurate diagnosis. And we also required that their provider, whoever was doing the clinic intake, decided that they were appropriate for PE or CPT. So if the person doing their clinic intake, which was not a study provider, it was a routine clinical practice, for example that person decided that the patient needed substance abuse treatment or DBT or something else, then they would not have been recruited for this study. So we only recruited patients who their treating provider deemed them appropriate and tried to refer them to or tried to engage them in PE or CPT.

And we recruited two types of patients, those who either did not engage in PE or CPT within that subsequent year post intake. And we set it for a year just in case patients needed to delay for one personal reason or another or they had trouble getting an appointment quickly. We assumed if they didn’t make it in within a year, they probably weren’t going to. And then we also recruited Veterans who started PE or CPT but dropped out. So our final sample ended up being 52 Veterans, and we stratified by refusers and dropouts, so we ended up with 24 refusers and 28 dropouts. And those of you familiar with PE and CPT probably know that PE is only offered individually, so we had 10 patients who received PE individually and dropped out, and CPT is offered both in a group and in individual format. So we tried to make sure that we had enough patients of both group and individual format to be able to examine that.

These are the demographics of the sample that was included in our study. So we had about 30% women, and we did try to oversample women just because in the past we have found in other qualitative work that sometimes being female in the VA is kind of qualitatively different experience than being male in the VA. And we also had a very diverse demographic group in terms of race and ethnicity, which is pretty consistent with our geographic region. The mean age was 45, and the most common index trauma was being an OEF/OIF combat Veteran. And we also had a fair number of military sexual trauma survivors. And then the second largest group, index trauma group, was an 'other' trauma group, and that’s basically anybody who doesn’t have combat or MST as their index trauma. So that includes things like childhood abuse, intimate partner violence, training accidents, being a crime victim in a civilian world, pretty much anything that you can imagine.

And with these Veterans, we did a 30- to 60-minute qualitative interview, and we asked them about everything in terms of their mental health treatment journey. So we just started off with tell me about how you got into mental health treatment in the first place, and so we kind of went chronologically through their experiences with why they even decided to seek mental health treatments, what they did first, what happened next, and we asked them about all kinds of attitudes, experiences, opinions. And then finally, as we got to the end of the interview, we asked specifically about why they either refused, and we worded that trying to be nonjudgmental. So we said things like, so it looks like you were offered the therapy. Can you tell me why you didn’t end up doing that therapy? And in the sample of dropouts, we asked them a lot of questions about what their experiences were like in that treatment. And then we asked the question in terms of, so it looks like you completed three sessions, and that’s less than is typically done. Can you tell me how that came to be? So we were trying not to make people feel like we were judging them for dropping out or refusing.

And we audio recorded all of these interviews, we transcribed them with a professional transcription service, and we coded them using a grounded theory approach, really trying to avoid having preconceived notions influence how we coded things. And we strategically chose two coders, one of which was a experienced PE/CPT therapist who might be able to pick up on kind of the therapy-specific things that were coming out of what the Veterans said. And then the other coder had training in medical sociology and was not a mental health provider, hoping that that person could kind of balance out with a more objective perspective. And we coded and analyzed all these data using ATLAS.ti version 6, and then we also did chart reviews to get more objective data about the Veterans’ treatment. So for example we have data on the number of sessions that the dropouts completed before they dropped out. But I'm going to be talking primarily about the qualitative data today rather than the chart review data.

So first I want to talk about the themes that emerged from the refuser sample. And I just want to remind everybody that our definition of refuser is just anybody who came to an intake assessment, was diagnosed with PTSD, was deemed appropriate by their provider for PE or CPT but did not start that treatment within a year post intake. And so it really contained sort of two subgroups, which I think of as active refusers and passive refusers.

Sharon: Hey, Denise, this is Sharon.

Rob: I apologize for audio problems that we’re having. I'm not sure what’s going on. I'm going to try to contact Natalie. Natalie, this is Rob. I'm not sure if you hit the mute button or something. Oh, I see your call was dropped. You can go ahead and call back in or you can switch to computer audio if you have a computer headset.

Dr. Natalie Hundt: Hi. I just called back in.

Rob: We can hear you.

Dr. Natalie Hundt: Great. Okay. So I'm just going to keep going. So as I was saying, we had some patients who were passive refusers who may have canceled or no-showed their appointments and then dodged phone calls and just never ended up coming in.

So before I go through the themes that came out of here, I'm just going to mention that there were a pretty wide variety of themes, and we ended up condensing those into five categories. And the five categories kind of hung together in terms of what made sense logically, and there are subcategories underneath those five categories. And the average number of barriers that a patient noted was 4.2 barriers. And I think this is important because it’s not simply that there was one barrier that was preventing them from starting PE or CPT; it was really multifactorial. And oftentimes the barriers interacted with each other. So before I go through the categories, I'm going to give one example of a patient, and this was a patient who was OEF/OIF combat Veteran who was in college. And he didn’t drive, and so he didn’t have transportation. He had to take a bus from an hour and a half away. And so he was taking one bus, transferring to another bus, then getting to the VA. And so for him, it was both a transportation issue and also not wanting to interfere with his school schedule. But also he had concerns about sort of the emotional part of the therapy. He was concerned that it would be emotionally taxing, and it really interacted with the transportation barrier because he said if I come to therapy and I talk about all these really emotionally difficult things to talk about, then I have to ride home on a public bus, and if I am crying or I'm upset, everyone on the bus is going to be staring at me. I'm going to be uncomfortable. And so it wasn’t just a transportation barrier and it wasn’t just an emotional barrier. It was the two of those things interacting with each other. And he sort of gave some indication that he might have been willing to do the emotionally taxing part of therapy if he didn’t have to ride home on the bus. He might have been able to put up with riding home on the bus if he wasn’t afraid that he would be so emotionally overwrought while riding home on the bus.

So I'm going to go through all of the five categories now. So the first category was practical barriers, and 46% of the refusers had a practical barrier that was getting in the way of them starting therapy. And among those, work or college was the most prevalent. That was at 33%. And then other common barriers were things like transportation or distance to the VA, and then an 'other' category, which tends to include caregiving and physical health.

The second of the five categories is something that we ended up calling knowledge barriers. We really struggled with how to describe this or explain this, but what ended up happening was that a quarter of our sample had no recollection of PE, CPT, or any of the exposure or cognitive principles that their therapist or therapists over the multiple appointments they might have had explained to them. And we did verify in the chart review portion of the study that they had had these therapies explained to them at least one time, some of them up to three times. And so what we are sort of assuming here is that perhaps they came in for an intake assessment, they were going through all the details of their trauma, they were given a new diagnosis of PTSD, and perhaps they just really weren’t in a place where they were able to process all this technical information that was being thrown at them about the therapies that were available. And many of these patients could give no description whatsoever of any of the therapies that they were offered during their treatment seeking.

The third main category was emotional barriers, and for those of you who work with PTSD patients, I'm sure you’re quite familiar with avoidance as an emotional barrier. So this is a quote from a female Veteran I thought was really powerful. So she says, “The only thing that’s been holding me back is me and my insecurity, my fear. It’s nothing that I would want to do, but I know that I need to do something.” And then a smaller number of Veterans noted that difficulty trusting the therapist would be a barrier as well.

The fourth main category was therapy-related barriers with some Veterans noting lack of buy-in to the therapies that they were offered, some of them noting poor alliance with the therapist that they met during the intake assessment process. Some of them noting desire for alternative treatments like art therapy, yoga, or equine therapy. And then some of them noting sort of the assessment process or the process of getting into treatment as a barrier itself. So for example, if a Veteran came in, perhaps they started with their PCP, and maybe they told their PCP how they were raped, and then their PCP sent them to primary care mental health, and they had to tell that person how they were raped. And then they got sent to general mental health and a psychiatry appointment. They had to tell their psychiatrist about their trauma, and then they had to come to the PTSD clinic. And so they had the sense of I’m getting shuffled around to all these different providers, and everyone is asking the same questions, and it takes forever, and I kind of feel like I'm not a priority or I'm getting shuffled around, and that that turned them off to the process of seeking mental health treatment.

And finally the largest category of barriers was VA system-related barriers. And the VA system-related barriers are often not specific to mental health but more to the VA system as a whole. So for some of these, they were a negative experience with a VA medical provider, negative experiences with a non-PTSD clinic VA mental health provider. And so this quote here, this Veteran was saying, “Most of the doctors that I’ve encountered at the VA just rush you through, you know, just ‘mm-hmm, mm-hmm.’” And so from their perspective, they felt like if they had had a negative experience with another type of provider at the VA, that that led them to question sort of the quality of the care at the VA or the patient centeredness of the care at the VA, and that made them a little bit more skeptical about what would my therapist be like. Would they just be like the other doctor that I had trouble with or the other doctor that I had who didn’t listen to me?

Some other Veterans noted negative experiences with VA staff or clerks. This gentleman’s quote said, “You’d better know where your doctor’s appointment is, because if you’re going to ask information, for one, they’re acting like you’re asking them for a kidney, and two, you’re interrupting their personal phone call.” And this is a very kind of a minor hassle really, but from the perspective of the Veteran, this leads to kind of an overall negative impression of the VA, and so when the Veterans were explaining what this was like, they were saying, you know, I drove an hour to get here. I drove around the parking lot looking for a space for 20 minutes. I walked half a mile in the Houston heat to get inside, and then someone was rude to me, and then you know I waited in the waiting room for 30 minutes, and it’s just all these little hassles kind of adding up to make the experience of seeking care be [unintelligible 21:35] experience. And if they were already kind of hesitant about the idea of doing a trauma-focused therapy, that that made it so much easier to just say, no, I'm done with this. I don’t want to go through all that hassle.

Other things that Veterans noted were sort of a lumped-together category that we ended up calling inefficiencies in care/red tape/lack of follow-up. So this is things like I wanted a mental health consult and somehow the consult got lost. It fell through the cracks, and it ended up having to be replaced, or I tried to call and nobody called me back. Some of the things in this category were, many of them were outside of mental health, so it was the entire process of getting into the VA in the first place, getting a PCP, getting any appointments at all, that the whole thing felt kind of daunting or overwhelming.

A quarter of the refusers mentioned the experience of the VA itself as a nontherapeutic environment. So these patients had PTSD, and so they were already hypervigilant about being in crowded public places and may have felt very uncomfortable in the hallways and the waiting rooms. And for the women in particular, I think this had a different flavor. So this quote is from a female Veteran with military sexual trauma history, and she was saying, “I was the only female in there.” She’s talking about our waiting room. “People will come up and bother me. People talking, coughing on you, and touching you and asking you questions. Usually I sit there with my purse clutched like I'm at the subway station in New York or something.” So this is a very clear image that she did not feel safe or comfortable in that environment. And again when you combine that with some hesitancy about maybe the emotional side of treatment or trusting your therapist or wanting to divulge your trauma, that this would make it so much easier to just avoid the entire situation of treatment.

A small proportion of Veterans had difficulty navigating the VA system, just being confused about how to get the services that they wanted. So some Veterans were, for example, confused about the difference between a psychiatrist and a psychologist and a social worker and a case manager.

And then lastly I want to talk about the positive experiences that the refuser group had. So the refusers’ experiences were not uniformly negative. And in fact 75% of them remembered PE or CPT or at least described the treatment that sounded like PE or CPT, 56% of them explicitly bought in to exposure principles, 79% of them felt involved in their treatment choices, and 83% of them really liked the VA PTSD therapists that they met during their time seeking treatment, even if they didn’t go on to engage in evidence-based psychotherapy. So I just want to be clear that these folks did not have a uniformly negative experience and, in fact, were able to say several positive things about the treatment here at the VA.

So next I want to talk about the dropout sample. And again, just to remind you of the definition of dropout, so dropout would be anybody who did at least one session of PE or CPT but did not complete that therapy. And we set a limit of eight sessions that they, if they did more than eight, we called that sort of close enough to completion, but we also verified in the chart review that their therapists themselves did not consider that patient a completer, trying to make sure that we weren’t including any patients who would be considered sort of early responders or early completers.

So in the dropout sample, the mean number of barriers expressed was 2.5. So again, dropping out of these therapies is really a multifactorial kind of issue. And there were a few differences in the reasons that patients dropped out of PE versus CPT. Where there are differences, I will note that as I go through the themes that came out.

So again one of the very common issues was practical reasons for dropping out. And again work and college was the most prevalent of those. And this was often compounded by unsupportive supervisors or difficulty getting leave, shift work, and things like that. And then other common themes were family obligations, physical health, or moving away from the VA during, moving away from the physical location like to another out-of-town location during their treatment.

And then another common barrier, just as in the refusers, was emotional reasons. So many Veterans mentioned that the therapy felt too stressful for them. So this is a quote from a female Veteran with military sexual trauma who was in prolonged exposure, and her quote is, “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.” And this was one of the themes that was more common in prolonged exposure than in cognitive processing therapy. And of course when I say more common, I don’t mean statistically; I just mean qualitative data in small samples, it appeared to be more common in PE patients.

And then really the biggest category for reasons that patients dropped out of PE and CPT was therapy or therapist-related reasons. So a very common reason was their buy-in to the rationale for that treatment, and this is really a mixed bag, the reasons that people gave. So some of them wanted a more present-centered focus rather than returning and discussing the trauma. Some of them had really a misunderstanding of the rationale. Some of them just didn’t, they understood it, but they just didn’t think it made sense, and some of them really wanted more kind of alternative treatment. And then a small number of patients had issues with specific therapy tasks that they were asked to do or homework assignments that they were asked to do. And in fact all of these patients were CPT patients, so this is the theme that I noted was more common in CPT than in PE. And these patients used terms like they were confusing or repetitive.

Some patients dropped out because of alliance issues, and again this is a very mixed bag. I don’t think I heard the same story from any patient of why they didn’t feel like they connected with their therapist. Some patients felt pushed into the treatment when they were kind of hesitant or they felt pushed to go too quickly in the treatment itself. So for example, moving to more challenging exposures too quickly or moving to talking about details of the trauma too quickly. And they felt that they might have been able to stay if things had gone a little bit more at their own pace.

Eighteen percent of the dropouts reported that they dropped out because they felt that treatment didn’t work for them. So this quote, this is a gentleman in group CPT who said, “I just gave up because it wasn’t, I wasn’t getting anywhere. They were trying to convince me that it’s going to happen. You’ve just got to give it a little more time, and it wasn’t working.”

Now the chart review data for all of these Veterans who are categorized in this group, we found that these patients completed anywhere from three to five sessions. So it’s not necessarily that we would expect the treatment to be showing clear signs of working by session three or five, and so perhaps this was sort of a mismatch of expectations, that the patient was expecting to see progress more quickly than was realistic.

And then a quarter of our dropouts had what appeared to be a mutual decision between themselves and their therapist that they needed a different treatment or level of care. And so some of these patients were, they discontinued outpatient PE or CPT in favor of a referral to a residential program that might offer PE or CPT while in residential. Or they were referred to a different treatment to treat a comorbid disorder that appeared to be interfering with the success of the therapy. So this quote is from a patient who really needed a higher level of care. And again with the chart review data we verified that this indeed was the reason, and many of these patients did go on to other forms of treatment.

And then just as in the refusers, we also looked at system-related reasons, but this was really quite rare in the dropouts. So system-related reasons were a big reason that patients refused therapy in the first place, but it looked like once they got into the evidence-based psychotherapy that any kind of frustrations with the system had a pretty minimal impact on dropout.

And then again, I want to talk about positives that the patients in the dropout group noted. So 50% of the dropouts were willing to try an evidence-based psychotherapy again. And this was much more common in the Veterans who dropped out primarily because of the practical reason or those who were referred to a different treatment or a higher level of care. So for example, one Veteran said, “I’m in DBT right now, but you know when I finish DBT, my therapist and I have a plan for me to go back and try PE again.” And over 60% had a very positive experience with the therapist, and about a quarter of the dropout sample experienced some benefit from the evidence-based psychotherapy, that they noted that there were some things that had improved in their life as a consequence of the short course of treatment that they did have. And also about a quarter noted that they continued to use a skill that they learned in that evidence-based psychotherapy. So for example, they continued to use the idea of cognitive restructuring or in vivo exposures to try and sort of do self-help kind of interventions for themselves.

So I always get this question when I talk about this data, so I just want to say this is qualitative data and you really shouldn’t be doing any kind of statistics. But people always ask me, so I went ahead and put this slide up comparing the refusers versus the dropouts in terms of how common the themes were. So it really looked like practical reasons were very common and about the same for both the refusers and the dropouts, that emotional reasons also were pretty much equal across refusers and dropouts, and therapy-related reasons may be, some people think this is slightly more common in the dropouts. And then sort of a bigger difference is VA system-related reasons were much more influential at preventing people from starting therapy. And as I said earlier, they’re much less likely to cause people to drop out of these evidence-based psychotherapies.

So in terms of what I make of these data, practical barriers were preventing both initiation of evidence-based psychotherapies and completion of evidence-based psychotherapies, and the VA has really done a lot to address practical barriers. VA has been implementing Telehealth with the video to the home, doing things like helping with transportation with the DAV vans, and also been investigating things like mass delivery formats or weekend treatment options to help people fit treatment into their schedule. And I think that practical barriers are the most straightforward and perhaps the easiest to address if the financing is there to make these things work.

But there are also a lot of other barriers, and so as I said earlier, frustrations with the VA are one of the main things that prevented initiation of care. And so I think we need to pay attention both to barriers that are owned by mental health, so those are things like increasing continuity of care, shortening the assessment process, helping patients get into mental health more quickly. We know that patients who are sort of ready and are asked to wait or be on a wait list often kind of drop off and that if you can get them while they’re eager and ready, they’re more likely to follow through. But I also think that we need to pay attention to barriers that are not owned by mental health, and so those are things like customer service experience of being a patient at the VA as a whole, the patient centeredness at the VA as a whole, the quality of care in all of our departments, as well as things like patient-on-patient harassment that might happen in the hallways.

And so the Veterans really had a hard time separating out this is my opinion of the VA versus this is my opinion of VA mental health. They really saw us as sort of a monolithic whole and that if there were deficiencies in one part of the system that really made it hard to trust the system as a whole. And if they were having negative experiences in terms of even just starting to get into VA treatment, like if it was hard to get enrolled in the VA in the first place, if it was hard to get a PCP appointment, if they were having difficulty getting phone calls returned from their physical health providers, that that often made them hesitant to sort of further engage with VA and feel confident about the care that they would be receiving here.

And then as I mentioned before, frustrations with the treatment itself were a big reason that patients dropped out of evidence-based psychotherapies. And I think this is sort of a harder nut to crack. So I think some things that might be helpful would be examining the most effective ways to obtain buy-in. So perhaps we’re explaining these treatments in ways that aren’t really hitting home for Veterans, and perhaps we need to examine how do I word this or how do I explain this that really helps Veterans understand this and buy into this? And perhaps we also need better ways to predict who may end up having that comorbid disorder interfere with their engagement in PE and CPT. So for example, what level of substance abuse does it need to be before we really say this person is not appropriate, or what are integrated treatment options that might address this comorbid disorder simultaneously and to promote success in that evidence-based PTSD treatment at the same time that we’re addressing the comorbid disorder.

So there are many limitations to the study. It’s a small sample, 52 patients. And we are limited to one geographic region, and it’s very possible that the patients who self-selected to be in the study may have been sort of the more dissatisfied customers at the VA who may have wanted to kind of share the frustrations and the experiences that they had. And this is obviously self-report and retrospective reporting, but nevertheless, I think it was really important data to understand the Veterans’ perspective of what it is like being a patient here in the VA and how that affects their willingness to seek care. And in fact when I presented this data at the Houston PTSD Clinic, one of the therapists, I'll remember her comment, she said, you know, I’ve switched PCPs for less stuff than this, you know, outside of VA, so you know, why would I expect my patients to put up with, you know, these sort of minor hassles or frustrations. I'm really not surprised that patients are turned off to care because of things that happen outside of mental health.

So this data, a couple of the studies from this are in press and some are under review, but I'm happy to talk to anybody if anybody has any similar data or projects or just wants to talk about this stuff. Please feel free to contact me at my VA e-mail or on Skype messenger.

So I think we’re ready for questions if anybody has any questions.

Rob: Thank you, Dr. Hundt. Could you actually back up one slide so that the . . .

Dr. Natalie Hundt: Sure.

Rob: . . . audience members can see your contact information.

Dr. Natalie Hundt: Okay.

Rob: We do have . . .

Unknown speaker: [Unintelligible 38:49]

Rob: At this time we do have one comment.

Dr. Natalie Hundt: Mm-hmm.

Rob: And audience members, if you’d like to ask a question or make a comment, please go ahead and use the questions section of the GoToWebinar dashboard. I see a couple more are coming in, so I'll go ahead and launch in. This person says being asked to tell their story over and over may also have been re-traumatizing. I've heard this from other patients.

Dr. Natalie Hundt: Absolutely. Yeah. And it’s the tension between what we need to do our jobs and what is right for the Veteran. So I've been in places where, actually I was a therapist or a psychologist in the post-appointment clinic a while back, and I was probably the first mental health person that the patient, that the Veteran had seen after getting discharged from the military. And so that’s a situation where you really do need the full details of the trauma, at least enough to ensure that it meets the criterion A for PTSD. But yeah, I think anything that we can do to sort of limit the number of different people or different kind of episodes of treatment the better. And I think there’s always tensions with that. PCMHI is a wonderful service, and it’s great for patients to be able to get same-day access. But at the same time, that adds kind of another person that the Veteran may have told their story to over their treatment trajectory.

Rob: Thank you. Next question: Did this study in any way identify possible provider bias that Veterans just are not interested in mental health treatment for PTSD and may not ask or suggest treatment?

Dr. Natalie Hundt: Yeah, that’s a good question. So this sample was recruited from within a PTSD clinic. And so by that point we’ve already kind of self-selected down to patients who actually were referred, whether they were referred from primary care or from general mental health or from somewhere else. And so as part of the methodology, we were only looking at patients who actually came to an intake assessment in the PTSD clinic. And as I said, we were doing that to make sure they actually had PTSD and were appropriate according to their therapist. And so we really don’t have much information at all about Veterans who may be still, for example, floating around outside of mental health who just either weren’t interested or nobody has offered it to them. We really don’t know a whole lot about those patients. But I will say for context that this is a very, the clinic that they were recruited from is a very EBP heavy clinic. So over half of the patients in the clinic do go on to receive EBP, and there are other treatment options, but it’s definitely the clinic that pushes EBP. So it still could be possible that perhaps when the providers are offering this, they’re offering these therapies in a way that sort of makes it sound like they’re offering it but discouraging it, but we really don’t know. That didn’t come out as a theme in any of the data. And in fact, as I mentioned, it was sort of the other way around, that sometimes patients felt like their therapists were sort of overly pushing EBP or overly pushing them to get into it even when they weren’t fully feeling personally ready, which may or may not have actually been ready.

Rob: This next question actually sort of addresses what you just were talking about. Right now it seems like Veterans are most likely the ones deciding between CPT and PE based on their understanding of both options. How do you think providers can help steer Veterans toward the treatment that they’d be most likely to complete in order to, I'm sorry, decrease dropout?

Dr. Natalie Hundt: Yeah, so I don’t think that we really have good data on which patients are more appropriate for PE versus CPT. A lot of the studies, at least the ones that I've seen, suggested that there is not a clear pattern of the type of patient who is better for one or the other. Hopefully the new, I mean the cooperative study that’s going on might shed some light upon that, but my perspective really is that whichever treatment the Veteran thinks is going to be better for them is probably the treatment that is better for them because so much of this is about buy-in, about willingness to take the emotional risks of not avoiding. And so really I think the shared decision-making perspective is probably the most helpful perspective to have of presenting the pros and the cons of both therapies and letting the Veteran be the decider, sort of the final decider, maybe with some input from the therapists themselves.

Rob: Thank you. This person writes, I was a few minutes late. Was there any discussion of a framework or theory that was used at the beginning of the presentation, or was it just grounded theory?

Dr. Natalie Hundt: In terms of the qualitative approach, that would be just grounded theory. I'm not sure if they’re talking about sort of like a qualitative approach or they’re talking more of a conceptual theoretical framework.

Rob: Okay. Well, they can write in and clarify. For refusers, I'm wondering about what brought them to the door of the PCT despite non-PCT barriers for them to say no without trying the treatment. What are your thoughts on this?

Dr. Natalie Hundt: Yeah. Yeah, no, that’s a really good question. We do have data on that because we started with asking them the entire story of why did you seek treatment in the first place, what did you do first, what happened next, so just trying to get a very chronological picture of their journey into treatment and then maybe back out of treatment. And so one of the biggest motivators was really family, so family members saying something’s not right here. You really need to get some help. And some of the other big issues were impairments in their life. So really we didn’t get a sense that patients were coming into treatment because of distress. In the DSM criteria, you have to have either impairment or distress in order to meet criteria for PTSD, but most of these patients were not saying I was so distressed, I was so upset. They were saying it was impairing my roles. I wasn’t able to be the kind of father I wanted to be. I wasn’t able to be the kind of husband I wanted to be. I was getting into trouble at work or I was having legal problems. It was much more about the consequences in their life. And it seemed like the refusers, even though they did sort of ultimately not engage in evidence-based psychotherapy, they were still pretty acutely aware of the need for treatment and were, from a motivational interviewing perspective, sort of in the contemplation phase, that they were sort of knowing that they needed it but also having all these barriers that occurred and concerns about treatment and kind of stuck in that ambivalence about treatment.

Rob: Thank you. This next questioner also explains that they came in late. Did this study use the old method of delivering CPT? The new method does not require the trauma narrative.

Dr. Natalie Hundt: Yeah. So based on the timeline, we were, so we were recruiting during sort of the changeover. And so some of the patients probably were recruited during the kind of the old CPT, although in the past it was kind of optional. So I don’t actually have data, although I could probably go back to our chart review data and find out whether these patients were, more of them were doing CPT-C versus the old version of CPT. I'm sorry I don’t have data on that.

Rob: Next question: To what extent may reported therapy-related barriers mask for avoidance?

Dr. Natalie Hundt: Yeah, absolutely. And that’s actually in, at least in the refuser sample is already in press. And so the, gosh, I'm trying to remember which paper this ended up in, but we actually looked at overlap in barriers, and so we were able to show that the emotional barriers and the therapy-related barriers, there was a huge amount of overlap in the patients who endorsed those. And so it really did seem like if you were concerned about the emotional experience of doing a trauma-focused treatment that you were more likely to also have maybe some concerns about buy-in or some difficulties in alliance or some of the other therapy-related barriers. So I think it is in some ways kind of a false splitting of things that are really overlapping and kind of intertwined. But when they talked about their concerns, they presented them as separate concerns, and so that’s why I ended up putting them into separate categories. But I do think it would be very interesting to sort of examine the overlap and what’s affecting what, but oftentimes the patients themselves may not have full insight into that process that’s happening for them.

Rob: Thank you. What are the percentages of Vets participating in alternate therapies with EBT?

Dr. Natalie Hundt: Yes. So I don’t have those data in front of me. For the dropouts, I want to say about 30% of them were doing some other kind of therapy either before, during, or after. And so in our clinic, they’re allowed to do multiple therapies. They might be doing PE and also at the same time, for example, be doing a group CBT for insomnia. And in the refusers, we actually had a fair number of patients, and I have the data but not in front of me, I'm sorry I forgot that. We actually had a fair number of refusers seek treatment outside the VA. And I want to say it was about maybe 20% of them ended up getting mental health treatment, psychotherapy, from a non-VA source. And all of those patients had private insurance or TRICARE, so they were able to afford to kind of vote with their feet if they were frustrated with the VA and get their mental health treatment elsewhere. And then many of our other patients didn’t have another option because they just financially didn’t have access to treatment outside the VA or they weren’t aware of things like VA Choice, and so they just simply were not in any kind of treatment.

Rob: Okay, thank you. Has there been any research on the decision tool on the National PTSD website? This helps Veterans choose between CPT and PE. How useful is this? How often is it utilized?

Dr. Natalie Hundt: Yeah. I am going to have to defer that to my friends at the National Center for PTSD. So Juliette Harik was one of the prime developers of that, and I believe that they are trying to evaluate it, but I don’t know the current status of that. And I absolutely do think it’s a wonderful project, and I think we absolutely should be evaluating it to find out what the effect is. And in one of the sort of early studies that Juliette did, she did find, I believe, that the shared decision-making approach did help more patients start PE and CPT.

Rob: There are quite a few more questions, so we’ll just keep going.

Dr. Natalie Hundt: Okay.

Rob: Can you talk a little bit about anything that stood out from the chart review with respect to the dropouts? Were providers noting any kind of problems with the patients’ engagement . .

Dr. Natalie Hundt: Yeah.

Rob: . . . that could be addressed?

Dr. Natalie Hundt: Yeah, that’s a really good question. That’s a really good question. That’s one of the reasons I wanted to do the chart review. So oftentimes there was hardly anything in the chart or what was in the chart was inconsistent with what the Veteran reported in the qualitative interview. And so oftentimes what was in the chart was something like, oh, the Veteran says they’re too busy right now. They’ll call back later. But then the Veteran said, oh, well, I told them I was too busy, but really I just didn’t think it was working. I didn’t agree with it. I didn’t like it. And again, it’s hard to say where the truth lies in terms of what was really going on. And again, this is retrospective reporting, so I'm not 100% sure exactly what was going on. But I did get the sense that oftentimes they weren’t sharing their concerns with their therapist and sometimes maybe even felt embarrassed or afraid of offending their therapist if they shared their concerns about the therapy or about if they had alliance issues especially. They weren’t going to bring that up with their therapist. They would just vote with their feet and disappear.

Rob: Thank you. This is a long one, so I'm going to try to truncate it a bit. It’s not unusual for a Veteran to engage in a PTSD evaluation in the PTSD clinic to document a diagnosis for PTSD when they are engaged in a C&P claim. Was data collected from the chart regarding that sort of thing?

Dr. Natalie Hundt: Yeah. So we do have data. However, so I totally agree with you that that could be part of the motivation. I just want to say that not a single one of our refusers or drops ever mentioned anything about that being a motivation. Now obviously there probably were self-presentation concerns about saying something like that in a research study. And we have data on whether they were previously service connected, whether it was for PTSD or some kind of mental health concern. But it’s really hard to tell from the chart whether they’re, for example, seeking an increase. That kind of thing is just rarely documented or it’s rarely documented accurately. So I really can’t speak very much to that, although I do agree it’s probably a concern.

Rob: Thank you. Can you speak to the state of knowledge re: the efficacy of current EBPs for treating complex trauma?

Dr. Natalie Hundt: That’s a big question. So I think the research suggests that the EBPs that are out there are sort of the best thing that we have. They may not be fully effective, and they’re not effective for every patient. But so far, as far as my reading of the literature, there isn’t a whole lot else that has been shown to be more effective than PE or CPT. Certainly there are times when a patient might have, for example, a long trauma history and end up with a comorbid BPD diagnosis. And obviously in that case, something like the DBT plus PE protocol is probably more appropriate. But I'm probably going to defer the rest of my answer. So it’s a big question.

Rob: Do you have a sense that time of recommended treatment right after discharge from service or later may impact willingness to accept and participate in care?

Dr. Natalie Hundt: Mm-hmm. So I think the research on that suggests that if anything, OEF/OIF Veterans are less likely to engage in trauma-focused therapies. But the differences are not striking. So plenty of OEF/OIF Veterans do engage in trauma-focused psychotherapy. And in terms of the qualitative data itself, I am trying to think about what was in the data. This didn’t really come out as a big theme. Certainly there were patients who mentioned things like I've been dealing with this for 30 years, and I was actually really glad to get into treatment to finally be able to do something about it.

Rob: Okay, thank you. Are you aware of any VA healthcare systems that regularly refer Veterans with PTSD and combat-related trauma to an art therapist rather than CPT?

Dr. Natalie Hundt: I am not. One of the Veterans in the sample mentioned that she received art therapy at a different VA, but I'm not sure how much they were offering that, and I'm not quite sure of the evidence for the efficacy for the complementary and alternative treatments for PTSD. Certainly there’s more research for things like meditation and mindfulness than there is strong evidence base for things like art therapy. But Veterans were interested in it, so I think, again, it’s a tension between do we offer these things to help engage Veterans in any kind of care if that’s all they’re willing to do, or do we say no, we need more research on these things. And I don’t necessarily have strong feelings one way or the other. But I'm not, to answer your answer, no, I'm not aware of any VAs, but I'm certainly not an expert on what other VAs offer.

Rob: Okay. We’re winding down. We have two more. This person asked the previous question about how Veterans select PE versus CPT, and follow-up is do you know of any studies of Veterans using the PTSD decision aid on the PTSD VA website?

Dr. Natalie Hundt: I do not know of any published studies yet. Again, I would probably defer to the [unintelligible 58:02] PTSD team in White River Junction. I don’t know if any of them are on. I don’t see any of their names on the list. But I do know that Juliette Harik was sort of the prime developer of that online tool, and in one of her pilot studies before it was online, it was a paper version. And she did find that using the shared decision-making approach, I believe, led more Veterans to initiate PE or CPT than Veterans who were not given the shared decision-making session intervention. But that was pilot data.

Rob: Okay, thank you. This is actually a follow-up to, I think, the first question I asked. And I apologize for it being so out of order, but this person says, in other words are we assuming that Veterans are not interested in treatment and that is the beginning point for interaction with Veterans regarding mental health and need for treatment?

Dr. Natalie Hundt: Gosh, I hope not. I mean it’s, I really hope not. It’s possible. I mean these data don’t really speak to that a whole lot because, again, these were all Veterans who were recruited after showing up at an intake appointment. So these were Veterans who, at least things went right enough that they had a PTSD clinic consult, they got it scheduled, they showed up to it, and their therapist said yes, you do have PTSD and come be in our clinic and get treatments. So I mean I think it’s certainly possible that we may have sort of unconscious biases and attitudes that may be sometimes interfering with how we talk about treatment. But I don’t know of any research on that, and these data don’t really speak to that.

Rob: Wonderful. Thank you, Dr. Hundt, for preparing and presenting today for this very important and interesting research topic. Do you have any closing comments or should we just move ahead?

Dr. Natalie Hundt: No, just thank you guys for coming and for all the thoughtful questions.

Rob: Great. Thanks again. And audience members, please stick around for a few moments and fill out the survey that comes up when I close the webinar shortly. And one more time, thank you very much, Dr. Hundt, for your work for this incredibly important research topic and your research on it. Thanks again, everybody, and have a good day.

[ END OF AUDIO ]