Moderator: Welcome to the VA HSR&D Investigator Insights Podcast Series. In this episode, Career Dissemination Coordinator Diane Hanks speaks with Center for Care Delivery and Outcomes Research Investigator Shannon Kehle-Forbes. They're discussing her work, understanding why Veterans either complete or discontinue trauma-focused therapy for PTSD.

Diane Hanks: PTSD is a term where most people know it's post-traumatic stress disorder.

Shannon Kehle-Forbes:

Sure.

Diane Hanks: It's used all over the place these days. But trauma-focused therapy is not something that I think a lot of people are familiar with. If you could just give us a brief description of what that entails?

Shannon Kehle-Forbes:

Trauma-focused therapies are the frontline therapies for PTSD. In systematic reviews and in clinical practice guidelines, they're typically recommended as the first-line treatment for PTSD. They're often done individually, but sometimes will be done in group settings. And what they focus on is going back and working with the content of the trauma memory in some way.

The two most widely used trauma-focused therapies in VA are Prolonged Exposure Therapy, which is PE, and Cognitive Processing Therapy, which is CPT. And both of those try to modify the thoughts that you have after being through trauma. When we go through a trauma, our thoughts about ourselves, our world, and other people change. Both therapies try to modify those thoughts back to a more balanced worldview.

And they just come at it a little bit differently. Prolonged exposure or PE does it through having you confront reminders of your trauma that you may have been previously avoiding, so both the memory of your trauma, and then also things in your environment.

Diane Hanks: You get desensitized –?

Shannon Kehle-Forbes:

You get desensitized.

Diane Hanks: – To those triggers?

Shannon Kehle-Forbes:

And through the desensitization, you also then…. They've shown that part of the mechanism is that you learn new thoughts that doesn't supplant those previous thoughts that you had developed after your trauma. And CPT also works by modifying those thoughts, but goes at it, kind of, more explicitly, targeting the thoughts. You work with your therapist to identify what are called stuck points, which are beliefs that you developed after the trauma. And you put those thoughts on trial. And you see, if they're an accurate representation of the world. And through kind of putting them on trial, you may change your perspective.

Diane Hanks: Can you tell us a bit about your study and your findings?

Shannon Kehle-Forbes:

As you can imagine, if you're going back and confronting thoughts about your trauma –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Either through PE or CPT, that's really difficult to do. And we know that anywhere from one to two-thirds of Veterans who start PE or CPT don't finish the treatment.

Diane Hanks: And is that because it becomes too traumatic?

Shannon Kehle-Forbes:

That's a good question. that's what we didn't know, and that's what we tried to find out with the study. There have been some prior studies where they were trying to predict quantitatively who dropped out and who stayed in these treatments. And they failed to, kind of, find consistent predictors across studies.

We thought, "Let's take a qualitative approach, and go in, and talk to Veterans who have just finished a course, and see what they have to say." We spoke with a national sample of 60 Veterans who had completed PE or CPT, and 66 Veterans who had –

Diane Hanks: Who dropped out.

Shannon Kehle-Forbes:

– Dropped out. Yes.

Diane Hanks: Okay.

Shannon Kehle-Forbes:

To try and understand the differences in their experiences. And we asked them both, "How were you able to complete or why did you drop out?" But then we also asked them about a bunch of things that we theorized might be important that they may not explicitly state as their reason.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

But where we might see differences between the completers and dropouts. Some of the interviews were 90 minutes long.

Diane Hanks: My gosh.

Shannon Kehle-Forbes:

We have a treasure trove of data. And we've learned so much. But I think I'll try to highlight a couple of interesting things. One of them –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Are the number of similarities between people who complete and drop out. There are a number of ways that their experiences are the same. And some of them are things that I as a clinician and other clinicians have hypothesized might be why people are dropping out. And now, this is showing it happens among the completers, too. Those things are things like feeling like the treatment is really difficult. The treatments are hard for everyone.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

No one wants to do it. No one wants to confront the memory of their trauma. It's hard. It's emotionally taxing. Almost everyone who we spoke to perceived as though they got worse before they got better.

Diane Hanks: Did anyone have trouble remembering the trauma so that they could confront it?

Shannon Kehle-Forbes:

You don't have to have a full memory –

Diane Hanks: Okay.

Shannon Kehle-Forbes:

– To participate in PE or CPT. You have to have some memory of it to work with.

Diane Hanks: Okay.

Shannon Kehle-Forbes:

Sometimes as people work through the trauma, particularly, I, myself tend to deliver PE more often clinically. And in PE, we'll see people who start to get pieces of a fact that they may have forgotten or it becomes more detailed or more vivid. Some people never remember all of the pieces and that may just be –

Diane Hanks: As, like, a protective mechanism, yeah.

Shannon Kehle-Forbes:

– \_\_\_\_\_ [00:04:56] that they sustained a head injury during the trauma or some other –

Diane Hanks: Right.

Shannon Kehle-Forbes:

– Reason why

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– They've lost their piece. But not remembering it wasn't necessarily associated with dropout. There was that sense of feeling people think that you go to a therapist's office, and you sit and talk to someone nice for an hour.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

And you'd leave feeling better.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

And that's not how PE and CPT work. Over the course of weeks or months you will start to feel better, the vast majority of people will.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

But right after that session –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– You don't feel better.

Diane Hanks: Right.

Shannon Kehle-Forbes:

And we found one of the things that differentiated the dropout from the completers is that dropouts expected that they would feel better after the session. They just kind of had a different model of how –

Diane Hanks: Right.

Shannon Kehle-Forbes:

– This therapy would work. And when they left the session feeling worse they took that as evidence that the treatment wasn't working. Then, that would be one reason –

Diane Hanks: Right.

Shannon Kehle-Forbes:

– Why they might drop out. The biggest thing that we found differentiating those two groups, those who finished and those who didn't, was their relationship with their therapist, and the specifics of that relationship. Almost everyone who we talked to liked their therapist, which is good, right? Therapists tend to be warm, caring, empathetic people.

Diane Hanks: Right.

Shannon Kehle-Forbes:

They liked their therapist. But those who completed, their therapists really saw it as the Veteran and the therapist being in the trenches or having a shared mission together of getting to the end of treatment. What we ended up calling that was that they built rapport in the context of the therapy. It wasn't just chit-chat, "How's the weather? I have a dog, here's a picture," they were talking about more in detail the Veteran's experience in the treatment. And then joining them in that and helping problem-solve ways to make it through –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– And giving the Veteran more autonomy, and choice in moving through what is a manualized, and fairly strict protocol, both for –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– PE or CPT.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

Being a little bit more flexible, helping them make those choices, serving as a cheerleader, reminding them of progress, making accommodations for them, as I said, and so was that. Everyone who had roadblocks, it was hard for everyone. And having that really strong, specific type of therapeutic relationship to help.

Diane Hanks: Did you find a difference between the Prolonged Exposure Therapy and the CPT therapy?

Shannon Kehle-Forbes:

That's a good question. We did look to see if there were many differences between the two. And overall, they were very similar. The two differences that emerged a little bit –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Was the Veterans who completed CPT had more complaints or dislikes about the logistics of CPT. There is a lot of worksheets and there is a lot of writing. And those worksheets lead you through how to identify and challenge your thoughts. And as you go through the therapy, the worksheets get more and more complex. And a lot of Veterans in CPT who did not finish reported not liking that, and having that –

Diane Hanks: It felt like homework.

Shannon Kehle-Forbes:

– Be \_\_\_\_\_ [00:07:49] reason. Yes. Well, we actually call it homework.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

Some, we try not to sometimes.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

But we call it homework and it felt like homework. And it was complicated. It was hard. More people in CPT, kind of, mentioned this, that structure of not liking it better than PE.

Diane Hanks: Right.

Shannon Kehle-Forbes:

And in PE, more people mentioned that after session, the stress that I was talking about.

Diane Hanks: Yes.

Shannon Kehle-Forbes: Which in PE, you do imagine –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Exposure to your trauma memory directly –

Diane Hanks: Right.

Shannon Kehle-Forbes:

– Which as you can imagine, especially early in therapy –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Is very –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Distressing for people.

Diane Hanks: Right.

Shannon Kehle-Forbes:

It's not uncommon for a Veteran to leave those sessions still feeling some strong emotion.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

Both experience that arousal and those bad feelings –

Diane Hanks: Right, right.

Shannon Kehle-Forbes:

– But then those who couldn't finish, kind of, took that forward and said, "I feel bad so my wife is going to get angry at me –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Or, "I'm not going to be able to concentrate at work."

Diane Hanks: Right.

Shannon Kehle-Forbes:

They, kind of, took it to the next step of –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– It having an impact in their functioning, and in their lives –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– And reported that as a reason for dropping out.

Diane Hanks: Right, because you have to redirect so quickly. And that can be hard.

Shannon Kehle-Forbes:

We do know that based on Veterans' report, the number of, kind of, major and minor life stressors that occurred when they were in the treatment seemed to be pretty similar. Both groups had other stuff going on outside of therapy, of course.

Diane Hanks: Right.

Shannon Kehle-Forbes:

But those who dropped out, we don't know if it's, that they're already kind of in a more precarious position so that a small disruption may be more catastrophic for them?

Diane Hanks: Right.

Shannon Kehle-Forbes:

If they maybe didn't have the same reserves or skills in terms of coping with that, kind of –?

Diane Hanks: Right.

Shannon Kehle-Forbes:

– Able to compartmentalize it and move on?

Diane Hanks: Right.

Shannon Kehle-Forbes:

Or if it was more cognitive style and attribution where they tend to catastrophize –?

Diane Hanks: Right.

Shannon Kehle-Forbes:

– The impact of something?

Diane Hanks: What are their next steps?

Shannon Kehle-Forbes:

For this project, we wanted to do the observational study because we had no, really, we didn't know at all what was happening. Now that we have a sense of that, we're looking to move on to an intervention study where we developed an intervention to hopefully help improve retention rates.

Diane Hanks: And can you talk about the intervention a little bit?

Shannon Kehle-Forbes:

I can. Yes, it's still in development.

Diane Hanks: Okay.

Shannon Kehle-Forbes:

We're still thinking through it. But the therapist's behavior will be one target of the intervention because that's something that just stood out so clearly.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

And I think the therapists want to have a good relationship –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– With their Veterans –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Or providing specific ways to build that relationship that will also keep them in treatment. I think –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– The therapists might like. There is another piece that we found that it wasn't just the PE or CPT therapist, but the entire care team, and the completers joined in keeping people in treatment. If they had another therapist who was maybe a case manager or their psychiatrist –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– For those who completed, they played an active role. For example, we've heard lots of people when they started therapy, their sleep started to become disrupted. Psychiatrists, for example, for the completers, they'll play a role of providing just short-term, so sleep meds –

Diane Hanks: Yeah, yeah.

Shannon Kehle-Forbes:

– To help them get through that hump so they could stay with it. Or a case manager might help them shore up their coping skills so that they could –

Diane Hanks: It's a point system.

Shannon Kehle-Forbes:

– Make it through.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

I think part of an intervention can be also bringing in the rest of the care team, and making it –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Kind of, a clinic or a care team mission to help make this person –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Help them through. And then I do think that there will be, although probably smaller or a Veteran component. There are some people who are looking at peer support for adherence. That is something that could potentially be used for those without a support system. It's not something that Veterans spontaneously talked about a lot in our interviews, but that may be because it's not a resource that they've had access to.

Diane Hanks: Right. Because you've had such extensive interviews, can you tell us a bit about the benefits and challenges of working with the Veterans?

Shannon Kehle-Forbes:

It was extremely helpful, I think, just to be able to hear so many Veterans' experiences. And as a therapist myself, when a patient stops coming to treatment, you don't know what happens to them.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

You don't get to have that conversation.

Diane Hanks: Right, right.

Shannon Kehle-Forbes:

Getting to have that conversation with so many Veterans was really useful. Also, VA is a place where you could do this, where you couldn't do it elsewhere. The dissemination of PE and CPT within VA is, kind of, unprecedented. Finding a national sample of Veterans who had recently finished or not finished PE or CPT, it couldn't have happened anywhere else. I think it was the unique setting and unique opportunity here to really understand the problem.

One challenge, obviously, was the volume of data that we have. There is obviously a lot of richness in there that I think can be really helpful in intervention development. I think another challenge for me in talking to the Veterans was that the Veterans who had not finished were really discouraged. They felt like they had been failed and they had been told that PE and CPT were the answer. Research suggests that they are the answer for a lot of people.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

It was challenging to listen to, kind of, that despair from some people, I think.

Diane Hanks: Yes.

Shannon Kehle-Forbes:

But also motivating in the fact that it makes me even more determined to –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– Come up with an intervention. Because I think that we know that dropout is probably hard for Veterans. But I was surprised at, kind of, the level at which they thought as a self-failure.

Diane Hanks: Yes. Yes.

Shannon Kehle-Forbes:

Yes.

Diane Hanks: Well, they're used to completing the mission.

Shannon Kehle-Forbes:

Yes.

Diane Hanks: And this was, like, "I couldn't complete the mission."

Shannon Kehle-Forbes:

Yes.

Diane Hanks: Is there anything else that you'd like to add?

Shannon Kehle-Forbes:

The study wouldn't have been possible without some strong support from our operational partners. And we worked closely with the National Center for PTSD in this study. And they've also been helpful in disseminating the findings thus far, and I imagine will play a strong role in the next step of intervention.

And both the prolonged exposure, and Cognitive Processing Therapy rollouts have been involved in this project, and are represented from each as a co-investigator on this study to make sure that, hopefully, what we find can be incorporated into the wide-scale training –

Diane Hanks: Right.

Shannon Kehle-Forbes:

– Of therapists that's happening. And all those people work within the Office of Mental Health and Suicide Prevention. They've really been supportive of the project, and I think see failure of completing these treatments –

Diane Hanks: Yes.

Shannon Kehle-Forbes:

– As one of the major problems that they're facing right now.

Diane Hanks: Yes.

Moderator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research and do not necessarily reflect current or to be implemented VA policy. To learn more about this research visit the VA HSR&D website at www dot hsrd dot research dot VA dot gov.