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A Comparison of Veterans Who Repeat Versus Who Do Not Repeat a Course of Manualized, Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder

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Despite evidence that cognitive-behavioral therapy (CBT) for posttraumatic stress disorder (PTSD) is effective, some individuals do not experience clinically significant reduction or remission of their PTSD symptoms. These individuals may return for additional PTSD-focused psychotherapy. However, there is no research to know whether PTSD treatment repeaters have worse symptoms prior to the initial treatment episode or display differences in other pretreatment characteristics versus nonrepeaters. Research is also needed to explore whether treatment repeaters exhibit PTSD symptom changes during an initial or second course of treatment. The current study examines differences in pretreatment characteristics and treatment response among U.S. military veterans who participated in either a single course (n = 711) or in two separate courses (n = 87) of CBT for PTSD through an outpatient Veterans Affairs PTSD treatment program. Veterans completing two courses of CBT for PTSD were more likely to be married and employed and more likely to drop out of their initial course of treatment versus those who completed a single course. Hierarchical linear models showed that reductions in PTSD symptoms during treatment were not different for those who completed a second versus single course of CBT for PTSD. However, for those participating in two courses of CBT for PTSD, a relapse in PTSD symptoms was observed between the first and second course. These findings show that a second course of CBT may be viable for those with ongoing PTSD symptoms.

Keywords: posttraumatic stress disorder; psychotherapy; cognitive behavior therapy; treatment outcomes; veterans

The Department of Veterans Affairs (VA) has been engaged in a national initiative to disseminate evidence-based, cognitive-behavioral psychotherapies for the treatment of posttraumatic stress disorder (PTSD; Karlin, & Cross, 2014). Beginning in 2006–2007, the VA began training clinicians in cognitive processing therapy (CPT) and prolonged exposure (PE) therapy (Cook & Stirman, 2015). In addition, the VA has begun to disseminate cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD; U.S. Department of Veterans Affairs, 2016). Although these cognitive-behavioral therapies are shown to have benefits for treating PTSD, these therapies are not a panacea for all veterans with PTSD. Between 30% to 51% of veterans who receive CBT for PTSD fail to exhibit clinically significant improvement in their PTSD symptoms (Steenkamp, Litz, Hoge, & Marmar, 2015). For those who continue to exhibit problems with PTSD, some return to receive an additional course of cognitive behavioral therapy (CBT) for PTSD (i.e., CPT, PE, or CBCT for PTSD).

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Unfortunately, there is no research to date to know whether individuals who repeat a second course of CBT differ from those who complete only one course of CBT for PTSD. By identifying differences between these groups, clinicians would be able to proactively target individuals who are prone to repeat treatment and address the factors that lead to these individuals needing a second course of treatment. In addition, there is no research to know whether those who repeat CBT for PTSD demonstrate reductions of PTSD symptoms during the initial course of treatment. Finally, it is unclear if these individuals who repeat a second course of CBT for PTSD show symptom reduction during their second course of treatment. It is important to understand whether repeating CBT for PTSD is effective so that recommendations can be made as to whether a second course of CBT for PTSD is an evidence-based option, or if other interventions need to be considered.

Failure to respond to CBT for PTSD may be explained by a variety of factors. Noncompliance with CBT homework assignments may inhibit patients' mastery of skills, such as the ability to challenge trauma-related cognitions or eliminate avoidance behaviors, both of which are hypothesized to be key mechanisms of change in CBT for PTSD (Cahill, Rothbaum, Resick, & Follette, 2009). A poor fit between patients' preferences and abilities versus the requirements for the treatment protocol may also play a role in patient nonresponse. For example, patients who are reluctant to complete written CBT homework assignments due to poor self-efficacy regarding their writing abilities may respond poorly to CBT protocols that require written assignments. In addition, low therapist fidelity to CBT protocols or poor therapeutic alliance may also be factors that explain a lack of positive response to a course of CBT for PTSD.

Empirical studies that have attempted to identify factors that predict veterans' treatment response to CBT for PTSD have produced mixed findings. One study compared veterans meeting full diagnostic criteria for PTSD versus subthreshold PTSD. A study by Dickstein, Walter, Schumm, and Chard (2013) examined whether veterans who exhibit pretreatment subthreshold PTSD symptoms versus those meeting full diagnostic criteria for PTSD differed in degree of PTSD symptom change during CPT. Although those exhibiting subthreshold PTSD had less severe clinician- and veteran-rated PTSD symptoms at pretreatment and posttreatment, the groups did not differ on degree of improvement in PTSD symptoms during treatment. Several studies have found that pretreatment PTSD and depression severity significantly predict differential response to CBT for PTSD, such that higher pretreatment PTSD and depression predicted being categorized within a latent class characterized by higher PTSD symptoms during and following treatment (Elliott, Biddle, Hawthorne, Forbes, and Craemer, 2005; Schumm, Walter, & Chard, 2013). In contrast, neither Kehle-Forbes et al. (2016) nor Miles and Thompson (2016) found pretreatment, veteran-rated PTSD symptom severity to be associated with veteran-rated PTSD symptom changes during treatment.

Premature dropout may interfere with patients' abilities to obtain and retain the necessary skills for reducing PTSD symptoms. Recent naturalistic studies have found that 46% to 49% of veterans prematurely drop out from CPT and PE (Kehle-Forbes et al., 2016). Findings from these studies are mixed as to whether PE versus CPT is associated with less dropout. Kehle-Forbes et al. found higher dropout in PE versus CPT, whereas Miles and Thompson did not find significant differences in dropout between CPT and PE. In the study by Kehle-Forbes et al., younger veterans were found to be more likely to drop out of treatment. Miles and Thompson found that veterans who had histories of combat trauma were more likely to complete treatment versus those who did not have combat trauma histories. In addition, those with histories of childhood trauma were less likely to complete CBT for PTSD versus those without such trauma histories. Although it is plausible that premature treatment dropout may be a factor that contributes to why some veterans return for additional CBT for PTSD, studies have yet to examine this possibility. Research is also needed to examine whether premature treatment dropout and factors associated with dropout from CBT for PTSD (e.g., younger age, type of traumatic experiences) are also related to whether veterans engage in a second course of CBT for PTSD.

The aim of this study was to examine whether veterans who engage in two courses of CBT for PTSD were different from those who engage in a single course of CBT on pretreatment symptoms of PTSD and depression and in trajectory of change in PTSD symptoms during treatment. We hypothesized that those who engaged in a second course of CBT for PTSD will exhibit less PTSD symptom reduction during their initial course of CBT for PTSD versus those who engage in only a single course of CBT for PTSD. This hypothesis is based upon the assumption that individuals who engage in a second course of CBT for PTSD will demonstrate less within treatment gains during the initial course of CBT for PTSD, thereby requiring additional treatment to address their PTSD symptoms.

We also had several exploratory aims. Prior studies have been mixed as to whether pretreatment PTSD and depression are predictive of PTSD symptoms