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BRIEF REPORT

Presenting Concerns of Veterans Entering Treatment for Posttraumatic Stress Disorder

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Patient-centered care involves engaging patients as partners in establishing treatment priorities. No prior studies have examined what specific problems veterans hope to address when they enter posttraumatic stress disorder (PTSD) treatment. Veterans starting outpatient ($n = 216$) and residential ($n = 812$) PTSD treatment in 2 multisite care management trials specified (open-ended) the 2 or 3 problems that they most wanted to improve through treatment. Over 80% mentioned PTSD-symptom-related concerns including PTSD or trauma (19.2% to 19.9% of patients), anger (31.0% to 36.7%), sleep problems (14.3% to 27.3%), nightmares (12.3% to 19.4%), and estrangement/isolation (7.9% to 20.8%). Other common problems involved depression (23.1% to 36.5%), anxiety not specific to PTSD (23.9% to 27.8%), relationships (20.4% to 24.5%), and improving coping or functioning (19.2% to 20.4%). Veterans' treatment goals varied significantly by outpatient versus residential setting, gender, and period of military service. Our findings confirm the importance of educating patients about how available efficacious treatments relate to clients' personal goals. Our results also suggest that clinicians should be prepared to offer interventions or provide referrals for common problems such as anger, nightmares, sleep, depression, or relationship difficulties if these problems do not remit with trauma-focused psychotherapy or if patients are unwilling to undergo trauma-focused treatment.

Patient-centered care involves engaging patients as partners in establishing treatment priorities. Agreement on therapeutic goals improves working alliance and psychotherapy outcomes (Tryon & Winograd, 2011). However, few studies have specified what problems patients are seeking to improve when they begin posttraumatic stress disorder (PTSD) treatment. The symptoms of PTSD are heterogeneous, ranging from intrusive thoughts to anger, emotional numbing, social isolation, and sleep disturbances (American Psychiatric Association, 2000). Co-occurring anxiety, depression, and substance use are common (Pietrzak, Goldstein, Southwick, & Grant, 2011). PTSD also contributes to interpersonal and vocational problems (Schnurr, Lunney, Bovin, & Marx, 2009). Patients may enter treatment ready to change some behaviors, but not others (Rosen et al., 2001).

The present study used intake data from two multisite controlled trials to examine what presenting problems veterans most commonly wanted treatment to improve, and whether presenting problems varied by outpatient versus residential treatment setting, period of service, and gender. We also assessed whether veterans expected that PTSD treatment would be more effective in resolving some problems than others.

Method

Participants

Outpatient treatment sample. These participants were recruited prior to their third visit in a new stage of PTSD treatment at one of three U.S. Department of Veterans Affairs (VA) medical centers. All were newly entering PTSD treatment, moving from psychoeducation to active psychotherapy, or moving from present-centered to trauma-focused psychotherapy. Patients were excluded if they were active-duty military personnel, receiving another form of telephone-based support, currently involved in another trial, or were identified by their provider to have active psychosis or traumatic brain injury with

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significant cognitive impairment. Of the 846 patients approached, 223 (26.3%) agreed to participate and 216 (96.9%) reported one or more treatment goals.

Outpatients' mean age was 48.16 years (SD = 14.14). Ninety-three (43.1%) were Iraq or Afghanistan war veterans, 29 (13.4%) were women, and 121 (56.0%) were married. There were 104 (48.1%) participants who were Caucasian, 63 (29.2%) were African American, 26 (12.0%) were Latino, and the remainder were from other ethnic groups or of mixed ethnicity. Co-occurring psychiatric disorders diagnosed in the prior year included depression (n = 99, 45.8%), anxiety disorders other than PTSD (n = 42, 19.4%), substance use disorders (n = 32, 14.8%), bipolar disorder (n = 11, 5.1%), and schizophrenia (n = 1, 0.4%). There were 103 (47.7%) participants with a service-connected disability.

Residential treatment sample. These were participants in a randomized controlled trial of telephone support after discharge from residential treatment (Rosen et al., 2013). Participants' presenting problems were assessed within 14 days of admission to one of five VA residential PTSD treatment programs. Patients were excluded if they were on active duty, could not provide informed consent due to cognitive impairment, discharged from treatment in less than 15 days, or transferred from residential treatment directly to another inpatient treatment program. Of 1,025 eligible patients, 837 (81.7%) agreed to participate, and 812 (97.0%) reported one or more treatment goals.

Residential patients' average age was 50.16 years (SD = 12.40). There were 219 (26.9%) who were Iraq or Afghanistan veterans, 109 (13.4%) were women, and 348 (42.9%) were married. There were 514 (63.3%) Caucasian residential participants, 177 (21.8%) were African American, 43 (5.3%) were Latino, with the remainder from other ethnic groups or mixed ethnicity. Co-occurring psychiatric disorders diagnosed in the prior year included depression (n = 658, 81.0%), anxiety disorders other than PTSD (n = 248, 30.5%), substance use disorders (n = 449, 55.3%), bipolar disorder (n = 105, 12.9%), and schizophrenia (n = 35, 4.3%). Roughly two thirds (n = 560, 69.0%) had a service-connected disability.

Measures

Treatment goals and treatment expectancies were assessed using a procedure developed by Battle, Imber, Hoehn-Saric, Nash, and Frank (1966). Participants wrote in the three problems for which they most wanted help and rated how they thought treatment would impact each problem using an 11-point Likert scale from −5 = *make it much worse* to +5 = *make it much better*. Patients' symptoms at intake were assessed with the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) and the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). Psychiatric diagnoses received during treatment visits in the prior year were determined from VA administrative data.

Data Analysis

Coding of participant responses was guided by qualitative data-analysis theories (Ryan & Bernard, 2003), in which researchers let the data from the participants guide emerging hypotheses. Participants' responses were compared for their similarities and differences using the comparison method (Boeije, 2002). Participants' treatment goals were recorded in their own words (e.g., "hyper alertness," "get jumpy easily"). Similar codes (e.g., jumpy, easily startled) were then grouped into themes (e.g., startle/jumpy), and then into larger categories (e.g., hyperarousal/hypervigilance). Categories that might reflect symptoms of PTSD or another disorder (e.g., lack of interest, difficulty concentrating) were included under PTSD.

Omnibus χ^2 tests done at the level of problems assessed whether presenting problems varied by treatment setting, gender, and period of military service (Operation Enduring Freedom/Operation Iraqi Freedom [OEF/OIF] vs. prior periods); if significant, additional χ^2 tests done at the level of participants were used to identify which specific problems differed by subgroup. Analysis of variance was used to compare outcome expectations for different problems.

Results

Participants' mean PCL scores (outpatient M = 63.44, SD = 14.23; residential M = 67.78, SD = 11.27) and mean CES-D scores (outpatient M = 37.30, SD = 8.57; residential M = 40.80, SD = 9.65) were both above thresholds for likely PTSD and depression. Outpatients listed an average of 2.74 problems (SD = 0.55) and residential patients listed an average of 3.20 problems (SD = 0.93).

Most outpatients (88.4%) and residential patients (86.0%) mentioned at least one PTSD-symptom-related problem. The most prevalent PTSD-related concerns involved anger, followed by sleep problems, nightmares, estrangement/isolation, and intrusive thoughts (see Table 1). Less than 1% of patients mentioned avoidance as a problem. Over one in four participants mentioned symptoms of depression and mentioned anxiety not necessarily related to core PTSD symptoms (e.g., panic, fear of crowds). Roughly one in five patients mentioned goals of improving relationships (e.g., trust, communication, intimacy, family), and improving coping or functioning (e.g., fitting into society, functioning in the real world, and specific behavior change goals).

Presenting problems varied by setting, omnibus $\chi^2(36, N \text{ of problems mentioned} = 2{,}899) = 426.64$, $p < .001$. Residential patients were more likely than outpatients to want help with estrangement/isolation and depression, whereas outpatients were more likely to want help with nightmares, sleep, and dealing with sexual abuse (see Table 1). Treatment goals varied by war era among outpatients only, omnibus $\chi^2 = (35, N \text{ of problems mentioned} = 593), = 53.94, p = .021$. Outpatient OEF/OIF veterans were more likely than prior cohort veterans to cite anger (38.7% vs. 25.2%), $\chi^2(1, N = 216) = 4.52$, $p = .034$; or hypervigilance (11.8% vs. 2.4%), $\chi^2(1, N = 216) = 7.70$, $p = .006$;

Table 1
Goal categories by gender and treatment setting

Goal categories	Outpatient sample				Residential sample				
	Total ($n = 216$)	Male ($n = 187$)	Female ($n = 29$)	Difference by gender	Total ($n = 812$)	Male ($n = 702$)	Female ($n = 110$)	Difference by gender	Difference by setting
	%	%	%	χ^2	%	%	%	χ^2	χ^2
PTSD	88.4	89.8	79.3	2.72	86.0	87.7	74.5	13.74**	0.89
PTSD or trauma	19.9	19.8	20.7	0.01	19.2	18.7	22.7	1.01	0.05
Intrusive thoughts	8.3	8.6	6.9	0.09	10.6	11.7	3.6	6.50**	0.96
Nightmares	19.4	20.9	10.3	1.77	12.3	12.7	10.0	0.63	7.28*
Lack interest/motivation	2.8	3.2	0.0	0.96	1.2	1.1	1.8	0.36	2.66
Estrangement/isolation	7.9	7.0	13.8	1.62	20.8	22.1	12.7	5.05*	19.28**
Numbness	4.2	3.7	6.9	0.62	3.4	3.6	2.7	0.20	0.25
Guilt/self-blame	4.2	4.3	3.4	0.04	4.4	4.3	5.5	0.31	0.03
Sleep problems	27.3	31.0	3.4	9.61**	14.3	15.7	5.5	8.10**	20.50**
Anger	31.0	33.7	13.8	4.64*	33.7	39.6	18.2	18.78**	2.41
Difficulty concentrating	5.6	5.6	10.3	1.46	3.3	3.3	3.6	0.04	2.33
Hypervigilance	6.5	6.4	6.9	0.01	4.7	4.8	3.6	0.31	1.09
Sexual trauma	4.2	2.7	13.8	7.78**	1.1	0.3	6.4	32.06**	9.28**
Anxiety	27.8	27.3	31.0	0.18	23.9	23.8	24.5	0.03	1.38
Depression	23.1	23.0	24.1	0.03	36.5	38.5	32.7	1.33	13.53**
Substance abuse	5.6	6.4	0.0	1.97	9.1	9.5	6.4	1.16	3.08
Cognitive problems	3.7	3.7	3.4	0.01	1.7	1.4	3.6	2.75	3.19
Other mental health issues	3.7	3.2	6.9	0.96	5.0	4.8	6.4	0.46	0.68
Coping/functioning	20.4	18.2	34.5	4.11*	19.2	17.0	33.6	17.06**	0.14
Medical problems	5.6	5.3	6.9	0.12	3.3	3.7	0.9	2.31	2.33
Relationships	20.4	18.7	31.0	2.35	24.5	23.6	30.0	2.08	1.62
Positive self-concept	6.5	4.8	17.2	6.40**	7.4	5.3	20.9	34.00**	0.21

Note. Presenting problems mentioned by less than four of the participants in both samples (not shown) included avoidance, dissociation, foreshortened future/general negative expectations, negative thoughts about self, and practical challenges (housing, finances, etc.). PTSD = posttraumatic stress disorder.

*$p < .05$. **$p < .01$.

and less likely to mention nightmares (10.8% vs. 26.0%), $\chi^2(1, N = 216) = 7.88$, $p = .005$; or sexual trauma as presenting problems (1.1% vs. 6.5% vs. 1%), $\chi^2(1, N = 216) = 3.91$, $p = .048$.

Presenting problems varied by gender among both outpatients, omnibus χ^2 (35, N of problems = 593) = 66.53, $p < .001$) and residential patients, omnibus χ^2(36, N of problems = 2306) = 170.52, $p < .001$). Women were more likely than men to want help with coping/functioning, positive self-concept, and sexual trauma (see Table 1). Men were more likely than women to want help with anger and sleep; among residential patients, they were more likely to want help for intrusive thoughts and estrangement/isolation.

Outcome expectancies varied by problem among residential patients only, $F(10, 1878) = 5.58, p < .001$. Residential patients were most confident that treatment would improve substance abuse ($M = 3.97, SD = 1.44$) and coping/functioning ($M = 3.56$, $SD = 1.46$), and least confident it would improve nightmares ($M = 2.53, SD = 2.04$), sleep problems ($M = 2.79, SD = 1.84$), and depression ($M = 2.94, SD = 1.70$).

Discussion

Our findings reaffirm that PTSD affects patients' lives in diverse ways. We found differences in presenting problems by treatment setting, war era, and gender, but also considerable individual variation within these groups. This suggests the value of a patient-centered approach that engages patients as partners in identifying treatment goals (Murphy, Thompson, Murray, Rainey, & Uddo, 2009).

Our findings also indicate the importance of presenting treatment rationales in ways that address patients' specific concerns. Although avoidance and guilt are respectively central to the formulations underlying prolonged exposure therapy (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (Resick & Schnicke, 1993), few patients spontaneously identified either avoidance or guilt as presenting problems. Psychoeducation regarding trauma-focused treatments therefore needs to convey how reducing avoidance or self-blame can help patients achieve other goals.

Trauma-focused treatments often alleviate a broad range of symptoms, yet not all problems remit with these treatments. Clinicians should be prepared to treat or provide referrals for complaints such as anger (Morland, Love, Mackintosh, Greene, & Rosen, 2012), sleep quality (Maher, Rego, & Asnis, 2006), nightmares (Casement & Swanson, 2012), or relationship difficulties (Monson, Macdonald, & Brown-Bowers), if these issues do not improve with overall PTSD treatment or if patients are unwilling to undergo trauma-focused psychotherapy.

The strengths of the present study include patients specifying goals in their own words, large and geographically diverse samples, and comparison of findings across outpatient and residential treatment settings. The study also has some limitations.

Veterans may have not mentioned important problems such as employment or housing, which they did not expect mental health treatment would address. Our findings from help-seeking veterans treated in VA PTSD specialty programs may not generalize to nonveterans, people treated in primary care, or people not seeking treatment. Despite these limitations, our results shed valuable light on the diversity of concerns that lead veterans to seek PTSD treatment.

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