Introduction

- Despite extensive data supporting the efficacy of exposure-based PTSD treatments and increasing efforts to train clinicians to deliver these treatments, adoption has been limited.
- Emerging evidence suggests that many clinicians choose not to provide these treatments due to concerns about the acceptability and appropriateness of these treatments for their clients (Osei-Bonsu et al., 2016; Zubkoff et al., 2015).
- Including consumers in implementation efforts may help to increase client engagement in PTSD treatment (Rosen et al., 2016).
- Many providers also report trying to increase engagement by using a stage-based approach, such as the integrated Dialectical Behavior Therapy (DBT; Linehan, 1993) and DBT Prolonged Exposure protocol treatment (DBT + PE; Harned et al., 2012).
- Uses a stabilization stage in which DBT is used to address higher-priority targets and increase behavioral skills before progressing to a trauma-focused treatment stage in which the DBT PE protocol is used to treat PTSD.
- In efficacy trials with suicidal and self-injuring women with PTSD and borderline personality disorder, a majority (74%) reported a preference for the combined DBT + DBT PE treatment over either DBT or PE alone (Harned et al., 2013).
- Still, little is known about clients’ own perceptions of their abilities to engage in exposure-based PTSD treatment, particularly when they have severe comorbid problems.

The Current Study

- The primary aim was to explore consumers’ perspectives on DBT + DBT PE and was conducted as part of a larger project focused on implementing this treatment in public mental health agencies in Philadelphia.
- A mixed-methods approach was used to enable in-depth exploration of clinician perspectives on the appropriateness, acceptability, and feasibility of DBT + DBT PE.

Method

Participant Selection

- Purposive sample (n = 19; 100% female; Mage = 35.3, 50 % racial/ethnic minorities) from two Philadelphia-based public mental health agencies that had participated in an earlier DBT initiative and were considering participating in the DBT + PE implementation project.
- All clients were receiving outpatient or residential DBT services (M = 18.5 months) for borderline personality disorder and/severe emotion dysregulation, and 79% self-reported a diagnosis of PTSD.

Procedure

- Two 90-minute focus groups were conducted in fall 2015 (one on-site at each agency) and facilitated by the authors.
- All participants were given a copy of the Study Information Statement and a psychoeducational handout describing PTSD, PE, and the combined DBT + DBT PE treatment.
- Once all questions about the study were addressed, we began audio-recording the discussion.
- Participants were then asked questions about the perceived appropriateness, acceptability and feasibility of DBT + DBT PE, including their general perspectives on the treatment, interest in receiving it, and potential barriers.
- At the end of the focus group, participants were given a brief anonymous survey that included the measures described below and received $50 for completing the study. All study procedures were approved by the University of Washington and Philadelphia Department of Public Health IRBs.

Measures

- Demographics. Self-report gender, age, education, racial and ethnic background, PTSD diagnostic status, and number of months receiving DBT at the agency.
- Treatment expectancies. 2-item adapted version of the Expectancies Questionnaire (EQ; Shaw et al., 1999) to assess expectations of improvement and helpfulness of DBT + DBT PE. Items were rated on a 1-7 scale with higher scores indicating more positive treatment expectancies.
- Treatment preference. Assessed using an adapted version of Zoellner and colleagues’ (2003) treatment choice measure. Participants responded to a forced choice item asking if they had PTSD would they prefer to receive DBT alone, PE alone, or a combined DBT and PE treatment.

Data Analysis

- A grounded theory approach was used in which the authors independently reviewed transcripts from both focus groups in order to identify emerging broad themes and sub-themes. Both authors then coded the transcripts, allowing for any additional categories to emerge. After coming to an agreement on all categories, each author re-coded the transcripts independently and any areas of disagreement were discussed until a consensus was reached. All coding was completed using QSR NVivo 10 software.
- Quantitative data on treatment expectancies and preference were examined via descriptive analyses.

Results

Consumer-Identified Barriers and Facilitators to Engaging in DBT + DBT PE

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td><strong>Fear of trauma-focused treatment</strong></td>
<td><strong>Need for PTSD treatment</strong></td>
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<td>Ex: “I’m kind of afraid to talk about it and deal with it and get into the details about it, because I’m afraid I might break down.”</td>
<td>Ex: “I’ve been abused as a child growing up…It led to my pain and suffering. I’m going through now, my mental health…I’m faced with so many personalities in my mind. And then I have flashbacks. It’s very painful.”</td>
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<td>3 (15.8%)</td>
<td>12 (63.1%)</td>
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<tr>
<td><strong>Negative prior PTSD treatment experience</strong></td>
<td><strong>Buy-in for the treatment rationale</strong></td>
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<td>Ex: “[PE as a stand-alone treatment] did more harm than good.”</td>
<td>Ex: “I think avoiding is not a good thing. I think you should face your fears.”</td>
</tr>
<tr>
<td>3 (15.8%)</td>
<td>7 (36.8%)</td>
</tr>
<tr>
<td><strong>Therapist-related concerns</strong></td>
<td><strong>Stage-based approach to PTSD treatment</strong></td>
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<td>Ex: “Going back to what you said about saying the trauma out loud and I guess acknowledging it, but in DBT they tell us we can’t bring that.”</td>
<td>Ex: “I think it’s really good that they put the DBT first, because…it gives you the tools to deal with the things that come up in exposure therapy.”</td>
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<tr>
<td>2 (10.5%)</td>
<td>8 (42.1%)</td>
</tr>
<tr>
<td><strong>Logistical concerns</strong></td>
<td><strong>Desire for intensive therapy</strong></td>
</tr>
<tr>
<td>Ex: “I think you can hear in the rooms.”</td>
<td>Ex: “I would love to come twice a week.”</td>
</tr>
<tr>
<td>3 (15.8%)</td>
<td>3 (15.8%)</td>
</tr>
</tbody>
</table>

- On average, clients expected that the combined DBT and DBT PE treatment would be both helpful (M = 6.4 out of 7) and lead to considerable improvement (M = 6.3 out of 7) in PTSD.
- Following the focus group discussions, 90% of clients (n = 17) reported wanting to receive the DBT PE protocol as part of their DBT treatment.

Discussion

- Despite clients’ concerns about readiness and potential worsening, they overwhelmingly wanted to receive an exposure-based PTSD treatment when offered in a stage-based manner.
- Consumers found the treatment to be highly acceptable, as nearly all participants reported a preference for DBT + DBT PE compared to DBT or PE alone.
- Buy-in for the treatment rationale emerged as a significant facilitator of consumer willingness to engage in DBT + DBT PE, which is consistent with prior research indicating perceived treatment efficacy and belief in treatment mechanisms are the strongest predictors of consumer choice of exposure therapy for PTSD (e.g., Feeny et al., 2009; Kehle-Forbes et al., 2014).
- Consumers also indicated that the stage-based approach of DBT + DBT PE increased their willingness to engage in the treatment.
- In general, the use of a stage-based approach to PTSD treatment appeared to help address the treatment-related barriers reported by clients, including fear of trauma-focused treatment and negative prior experiences of non-stage-based PTSD treatments.
- One hundred percent of clients who reported these concerns also expressed receptivity to DBT + DBT PE.
- In spite of the greater frequency and duration of therapy sessions in DBT PE compared to DBT, few clients reported logistical barriers to engaging in the treatment.

Implications

- The present findings suggest several potential consumer-focused implementation strategies, including providing consumers with psychoeducational information, increasing opportunities for peer modeling and supporting, and using a shared decision making approach, that may improve consumer engagement in trauma-focused, evidence-based treatments and, by extension, increase their uptake.
- In sum, results suggest that implementation efforts should encourage clinicians to make collaborative decisions with clients about whether and how to deliver exposure-based PTSD treatments.

This research was funded by a grant from NIMH (R34MH082143) to the second author.