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Use of Reflective Journaling to Understand Decision Making Regarding Two Evidence-Based Psychotherapies for PTSD: Practice Implications

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Abstract

As part of a longitudinal investigation on implementation of 2 evidence-based psychotherapies (EBPs) for posttraumatic stress disorder, psychotherapists from 38 Department of Veterans Affairs residential treatment programs across the United States were asked to complete reflective journals every 4 months for a 1-year time period in regard to their successes and challenges in using prolonged exposure and cognitive processing therapy. This paper provides content analysis on the reflective journals of 24 of these providers. Five main themes were identified: EBPs are great but not sufficient for patients in residential treatment with chronic posttraumatic stress disorder and complicated life circumstances, and thus, more treatment is necessary after discharge. Modifications were made or thought needed for optimal outcome and successful delivery of these 2 EBPs; some providers blended aspects of prolonged exposure and cognitive processing therapy; what happens when providers and patients do not agree on choice of which EBP to first implement; and provider concerns on when to discontinue an EBP. Reflective journaling appears to be a promising way for trainers and treatment developers to gather important information about the clinical application and decision-making process for front-line providers, which may offer

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Clinical Impact Statement

This paper offers a reflective journaling worksheet that may aid clinical providers in their own decision-making process and treatment planning when choosing between EBP models for trauma treatment.

insight into how to improve EBP implementation and sustainability. Incorporating reflective journaling and strategies for accomplishing this into training, supervision, and consultation may also be 1 strategy for increasing feedback, expanding implementation, and informing ways to increase sustainability of EBPs in populations with multiple clinical and psychosocial needs.

Keywords

evidence-based treatment; posttraumatic stress disorder; reflective journal

Implementation and sustained use of evidence-based psychotherapies (EBPs) is an international priority (Terwindt, Rajan, & Soucat, 2016). Despite extensive empirical data for the efficacy of specific psychotherapies for specific disorders, an implementation gap exists between best practices identified by research and what is provided in routine clinical care. Although the long-standing assumption was that evidence from clinical trials would prove persuasive enough to change clinical practice, decades of systematic study of diffusion of innovations indicate that innovations do not sell themselves (Rogers, 1962, 2003).

Narrative inquiry, such as the use of provider reflective journaling or diary data, may be a unique and effective means to understand and promote evidence-based health practices (Riley & Hawe, 2005). This type of methodology can enable researchers to see what providers' value most as influencing their thinking and decisions (O'Connell & Dyment, 2013). Indeed, reflective journaling is a popular and effective pedagogical tool to promote learning in medicine, nursing, and education (e.g., Nanda et al., 2013; Rocklein, 2014). In particular, journaling has been shown to increase critical thinking and application of new knowledge (Marchigiano, Eduljee, & Harvey, 2011) and improve professional practice through critical reflection (Mathieson, 2016). More specifically, research has shown that mental health professionals who have the additive component of reflective worksheets in addition to a standard cognitive-behavioral therapy training model, report greater use of skills and awareness compared with those who do not use reflective worksheets (Bennett-Levy & Padesky, 2014).

The practice of reflective journaling has been used in not only the development of training programs but also research and clinical practice (Rocklein, 2014). For example, reflective journaling may assist in understanding a patient's responses to treatment and thus inform decision making regarding adherence or adjustments during a course of treatment (Coulson & Homewood, 2016). In addition, reflective practice can help with improving psychological literacy (e.g., understanding, skills, capabilities, awareness, competence, critical thinking, and problem-solving attributes of a mental health provider; Coulson & Homewood, 2016). Journal writing may provide a window for reflection, helping providers gain insights into the process by which EBPs are utilized. In addition, providers may respond to semistructured interviews about implementation of EBPs based on aggregated impressions of their experience with patients and may be biased toward recalling the most difficult cases, and they might make decisions after giving those too much weight. Journaling about individual cases may provide researchers with richer or more accurate information about day-to-day decision making of frontline providers. Just as important, this might also help therapists

reflect on their practice, which has been shown to increase use of evidence-based practice more effectively (e.g., Bennett-Levy, & Padesky, 2014).

Supervision, consultation, and personalized feedback from experts on provider's journals likely offer a unique and powerful opportunity to gain insight into one's practice. In the complex clinical worlds within which many providers in large organizations practice, with shrinking resources and expanding needs, self-reflection may serve to enhance care delivery. Studies in other fields (nursing, medicine, library science) have shown that reflective journaling can increase self-awareness, enhance learning, and foster the development of critical thinking as well as facilitate one's curiosity, self-development, and empowerment (e.g., Lasater, & Nielsen, 2009). Reflecting on one's practice through journaling may allow for introspection, concept attainment, problem solving, action planning, and reorganization. Documenting clinical decision-making processes and reviewing them over time may allow a provider to examine how they might respond to the same or similar events in the future. In addition, because the reflective journal can be completed by the provider, for the provider, it could be thought of as a low-cost intervention that can supplement consultation and supervision.

The U.S. Department of Veterans Affairs (VA) undertook an unprecedented national training initiative on 16 EBPs (Karlin & Cross, 2014) including two for posttraumatic stress disorder (PTSD), prolonged exposure (PE: Foa, Hembree, & Rothbaum, 2007), and cognitive processing therapy (CPT; Resick, Monson, & Chard, 2016). Numerous efforts were made to assist in the training and implementation of these two EBPs (Karlin et al., 2010), including policy changes mandating their availability at all VA facilities (Department of Veterans Affairs, 2008), designation of local EBP coordinators at each medical center, and a PTSD mentor program to help PTSD clinic managers make organizational changes (Bernardy, Hamblen, Friedman, Ruzek, & McFall, 2011).

Both PE and CPT are cognitive-behavioral treatments that are trauma focused, meaning they target traumatic memories and their impact. In brief, PE is an eight- to 15-session manualized individual therapy with four primary components: psychoeducation about trauma; breathing training; in vivo exposure (hierarchy of avoided trauma-related situations and stimuli and then hierarchical exposure to these safe but avoided situations and stimuli); and imaginal exposure (verbal retelling of the most distressing trauma). CPT is a 12-session manualized individual, group or combined individual and group therapy that challenges unhelpful trauma-related beliefs and thoughts and explores the impact of trauma on their view of self, others, and world. PE and CPT have been studied in numerous randomized controlled trials with civilian (e.g., Foa et al., 2005; Resick et al., 2008) and veteran samples (for review, see Steenkamp & Litz, 2013) and are considered EBPs for the treatment of PTSD (e.g., American Psychological Association, Guideline Development Panel for the Treatment of PTSD in Adults, 2017; VA & Department of Defense, 2017).

Reports on the use of PE and CPT across the VA health care system continuum of care (e.g., outpatient, residential) have been variable. Some studies suggest low levels of EBP receipt in particular regions or settings (e.g., Shiner et al., 2013), whereas others indicate more moderate to high delivery (Sayer et al., 2017). One setting that has relatively high

implementation of EBPs, particularly CPT, is the VA PTSD residential setting (Cook et al., 2013). Although patients in residential programs often have more severe PTSD and complicated life problems than outpatients (Walter, Varkovitzky, Owens, Lewis, & Chard, 2014), residential settings provide an ideal opportunity to deliver EBPs and to closely monitor potential symptom exacerbations over the course of treatment. Additionally, residential programs also provide a structured environment and offer several adjunctive treatment options to address the complex multimorbidity and case management needs.

A recent synthesis of research and evaluation efforts regarding implementation of PE and CPT across the VA health care system indicated that one of the two most important facilitators to their delivery were provider beliefs regarding efficacy of these EBPs (Rosen et al., 2016). Despite emerging research demonstrating effective use of PE and CPT for patients with PTSD and psychiatric comorbidities (e.g., Roberts, Roberts, Jones, & Bisson, 2015; van Minnen, Zoellner, Harned, & Mills, 2015), there continues to be provider concern about the use of the EBPs with patients who have severe, complex presentations. In a previous report from this longitudinal investigation, VA residential PTSD treatment providers expressed concern about the efficacy of PE and CPT when veterans presented with severe psychiatric comorbidities(i.e., suicidal ideation, dissociation, and substance abuse), moderate to severe cognitive limitations, and low motivation (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014). These concerns have been echoed by other providers in North America, Europe, and other continents (e.g., Lu, Plagge, Marsiglio, & Dobscha, 2016; van Minnen, Hendriks, & Olff, 2010).

The Veteran Health Administration (VHA) is the largest naturalistic health care setting in the United States. Better understanding of clinical practice in the VHA affords the opportunity to inform communities of practice and the dissemination of trauma-focused EBPs in all sectors of the mental health care system. The VHA has worked to offer and implement the highest standard of care for the treatment of PTSD through use of EBPs. An integral component of this is increasing the understanding of provider choice and preference for particular EBPs such as CPT and PE.

The purpose of this paper is to understand and gain insight into decision making regarding EBPs for the treatment of PTSD through providers' use of reflective journaling. More specifically, we asked a purposive sample of psychotherapists from 38 VA residential PTSD treatment programs across the United States to complete reflective journals every 4 months for a 1-year time period. Open-ended questions were given to prompt providers to reflect on their use of PE and CPT, specifically any notable surprises (good or bad) they had using the treatments, successes in delivery, and observed or noted challenges/shortcomings of using PE or CPT in the treatment of their patients.

Method

Participants and Procedure

Data for this study come from a mixed method, 4-year longitudinal investigation on the implementation and sustained use of PE and CPT in 38 VA residential PTSD treatment programs across the United States. This study was deemed exempt from formal review by

the Yale Human Research Protection Program because of the low perceived risk and was approved by the VA Connecticut Health Care System Institutional Review Board.

VA PTSD residential treatment programs typically range from 6 weeks to 3 months (Cook, Dinnen, Simiola, Bernardy, Rosenheck, & Hoff, 2014). Although there is an average length of stay for a program, the length of stay is individualized to the veteran needs and can vary within and across programs. Discharge from these programs does not ensure or guarantee that PTSD is resolved but that the veteran had improved enough to be able to continue treatment at the outpatient level of care and does not require the residential level of care for the treatment of PTSD and other clinical needs.

The full methodology and sample demographics have been published previously (Cook et al., 2013; 2014). Of the 214 people ap proached to participate in the larger investigation, 171 (80%) participated in the study, of which 15 (8.8%) completed the interview portion only and seven (4.1%) completed the survey only. Twenty-five people in the original recruitment sample (11.7%) had retired or left their position in the residential PTSD program and 18 (8.4%) did not respond to recruitment attempts.

Data used for this report come from the fourth and final wave of data collection. A purposive sample of VA PTSD residential treatment providers who participated in the larger investigation were asked to engage in reflective and structured journaling three times for 1 year to gain more timely and rich information regarding their decision making about PE and CPT. In particular, we approached providers who were actively using the treatments and thus could speak to experiences with implementation. Of the 35 providers approached, 26 people agreed to participate in the reflective journaling exercise. Of those, 24 completed at least one entry; 13 have completed all three entries, five completed two entries, and six completed one entry. In total, 55 completed journal entries were analyzed.

Participant characteristics for the 24 individuals who completed at least one journal entry are included in Table 1 along with a comparison of those who were approached but did not complete the exercise.

Measures

The reflective journaling form was modeled on the work of Wise, Spiegel, and Bruning (1999) and included open-ended questions asking providers to reflect on their use of PE and CPT. Specifically we asked providers to indicate any notable surprises (good or bad) they had using the treatments, successes in delivery, and observed or noted challenges/ shortcomings of using PE or CPT in the treatment of their patients.

Providers were informed that the purpose of this journaling was to obtain an understanding of their on-the-ground, in-the-moment, decision-making process regarding their use of CPT and PE. Providers were told there was no right or wrong answers and that this journal entry was based on their thoughts, feelings, and experiences with these treatments. Providers were also reminded that their journals were to be used for research purposes only and not to be used to penalize them for nonuse or supervision of their work. We took every precaution to reduce or eliminate burden on providers. For example, similar to Riley and Hawe (2005), we

offered flexibility in how reflective journaling was recorded (e.g., electronic diaries, handwritten notes, e-mails, or a combination) and reiterated that they could change recording methods throughout the course of the data collection.

Data Analysis

The coding method was developed using grounded theory (Glaser & Straus, 1967). Each journal entry was independently reviewed by two of the authors (J.C., E.M.). To facilitate analysis, we developed a codebook using a priori codes from the journal (e.g., notable surprises providers had using PE or CPT, successes in delivery, and challenges of using either treatment with their patients). The raters compared their independently achieved lists of themes, and any areas of discord were discussed among authors until a consensus was achieved. Text that supported the themes was extracted and most frequently noted ones related to decision making are presented below.

Results

Given the small number of providers who completed the reflective journals, particularly across the three time points, a fairly exhaustive list of themes is presented below. Information on the number of times and the number of providers who gave information consistent with each theme is also given.

EBPs Are Great but Not Sufficient and More Treatment Is NecessaryAfter Discharge

Fifteen of the 24 providers who completed any of the reflective journals noted how effective PE and CPT were but how the veterans in VA residential PTSD treatment often had moderate to severe PTSD and complicated life circumstances that warranted additional treatment after discharge. In addition, these providers noted this theme in their journals at least 34 times. One participant said, “I haven’t had patients admitted who had straight-up PTSD without many other complicating factors that put safety and stabilization first on the treatment list.” Another provider discussed, “I am doing PE with a patient now. She is a transgendered individual who is on the high-risk watch list due to her ongoing level of suicidality. She came to us specifically to be in a safe place to do PE, although she is otherwise homeless and jobless. It is only because the referring program will take her back to deal with housing and vocational/financial issues upon discharge that we agreed to take her.”

The providers spoke about how such a different symptom constellation may mean that the patient needs more sessions of an EBP or supplemental therapies. “A veteran with a very complicated trauma history (i.e., severe sexual, physical, emotional abuse in early childhood through teens) and repeated MST [military sexual trauma] was very challenging… . He definitely needed additional therapy/support beyond the 12-session CPT protocol to further reinforce/improve upon gains made.”

Providers elaborated that many of the patients had histories of repeated and severe traumatic experiences and “combat was just the tip of the iceberg.” For example, one provider said, “I also have had a very difficult case, also high risk for suicide, complete PE last week. I had suspicions at times if the veteran was going to be able to get through his first imaginal

[exposure] due to reports of depersonalization and visible intense shaking. He required me to prompt multiple times for ‘what happened next’ and ‘what did it look like,’ but sure enough, he got through it.” The providers spoke about doing one course of an EBP usually focused on one trauma and does not adequately address all of their patients complicated clinical and psychosocial treatment needs. Providers report that their patients often need additional treatment and possibly another course of an EBP. “Thinking about how CPT and PE are great, but often with complex trauma, therapy will continue. It does not end with completing these treatments.” Another provider echoed, “Working in a residential program—veterans have 8 weeks to get what they need—working with a veteran who is just now “getting it” and he’s halfway finished. His anger was extensive and his ability to trust any of us has taken some time—He needs the additional time to be successful and will not get it here with us.”

Modifications Made for Perceived Better Outcomes or Successful Delivery

Fifteen providers reported using their clinical judgment to modify or add adjunctive components to PE and CPT protocols because they believed this would optimize the potential for therapeutic success and ongoing engagement. This theme was mentioned 30 times, suggesting that for many this was a significant issue. This included things like incorporating culturally relevant materials into the EBP and adding on to a completed protocol by going back over some aspects of the treatment in a different way, focusing on particular modules, and adding extra session(s)/time throughout the protocol for extended processing of material. For example, one provider explained, “We had approximately six sessions [of PE] with very little resulting movement in the intensity and frequency of his PTSD symptoms. He was complying with the treatment, but we were stuck. Interestingly, he had studied to become a [religious leader] prior to going into the military… . I decided to incorporate more spiritual and existential questioning into my PE trauma processing with him, and treatment took off!”

Another provider wrote of a patient who attempted CPT on an outpatient basis in both group and individual formats but was unable to complete the protocol. The provider explained that when the patient was admitted to the residential program, she was able to complete a modified version of CPT successfully. The provider wrote, “I basically did another modified course of CPT, focusing only on intimacy… . As she put it, we cut out all the fat, and just got to the meat.” Several other providers reported allowing extra EBP session(s) for extended processing of material that came up during imaginal exposure or to deal with perceived pressing issues. They explained that this seemed to facilitate continued treatment engagement and kept patients progressing toward completion.

Avoidance and Resistance Are Primary Barriers to Successful Completion of EBPs

Fourteen of the 24 providers noted that avoidance or resistance was a significant barrier in the successful completion of PE and CPT. Across those therapists, this theme was noted 19 times. These barriers were not isolated to one treatment over the other but emerged as a commonality across residential treatment for PTSD. Many providers used the journals as opportunities to reflect on whether they had avoided alongside the veteran (analogous to ones of fears related to the engagement in a trauma-focused psychotherapy). One provider

expressed recognition that they had “inadvertently engaged in treatment that reinforced his defenses and turned into a power struggle; I unwittingly colluded with him on his avoidance.” Other providers noted that challenges to their work included “finding different ways to help patients increase their emotional engagement” and “confronting avoidance strategies” with their patients. Providers noted that resistance often appeared in not doing homework assignments, failing to show for appointments, and an overall sense of lack of investment or buy-in from the veteran, which could be conceptualized as part of the avoidance symptom cluster of PTSD.

The Role of the Therapeutic Relationship in EBP Delivery

Seven providers mentioned eight times that the success of PE or CPT was, in part, due to the strength of the therapeutic relationship. One provider noted that their patient viewed them as someone who was “like a mom … you lead, guide, support, and take my hand, never gave up on me, always supportive, backed off and presented different options for ways to proceed when I needed it.” Another provider described what could be akin to an alliance rupture in which a veteran shared his distrust about the therapist’s decision to sit through an alarm that did not require a reaction. In completing an Antecedent-Behavior-Consequence (ABC) worksheet, and with encouragement from both the provider and group members, the veteran generated alternative beliefs about whether the therapist would intentionally cause harm to the patients and also about how sitting through the alarm was an invaluable therapeutic progress. The provider concluded that “this helped us open up dialogue in a safe way and were able to continue on successfully with treatment.”

When and How to Discontinue an EBP

Nine of the 24 providers also reflected on decisions made about when to recommend and engage in shared decision making to discontinue CPT or PE because of limited therapeutic benefit, not being engaged in the treatment, or not following through with treatment recommendations (e.g., homework completion). Those nine providers mentioned this theme 13 times. Providers expressed a desire for veterans to recover while also recognizing the importance of maintaining fidelity to the model. There is some flexibility within each protocol (e.g., number of sessions), however, when there is continued lack of therapeutic benefit after thoroughly working to address PTSD symp tom distress, then it was frequently determined to discontinue treatment and consider alternative treatment options (e.g., greater focus on depression treatment, relapse prevention, social or interpersonal skills). Also, providers reported sometimes discontinuing treatment when the veterans’ avoidance or other barriers to engagement reinforced negative cognitions about oneself or treatment efficacy.

One provider said, “Given incompletion of homework assignments (i.e., impact statement, ABC sheets) since starting CPT, we discussed motivation and commitment for CPT at this time as well as the impact that avoidance is having on his symptoms and recovery. A veteran acknowledged that he has been avoiding completing homework, often ‘finding other things do,’ and also said, ‘I sometimes just forget. My memory is horrible.’ His thoughts and feelings related to treatment were examined and processed, with the veteran agreeing that, at this time, it would be best to discontinue CPT until he is able to commit to completing homework assignments and attending weekly sessions regularly.”

Another provider said, “One vet I am treating continues to experience significant anxiety before, during and after his PE exposures. He started off with a high baseline level of anxiety, but after three exposure sessions, his emotions don’t seem to be dissipating very much, and he is having so much trouble sleeping that he requested we move from twice-weekly sessions to once-weekly sessions. He remains committed to the treatment, but I do wonder when the appropriate amount of time is to determine that exposures aren’t helping. Do we continue for four, five, six, more exposures before we determine that the treatment approach is doing more harm than good? I plan to check in with the veteran after our next exposure (his fourth) to see what he thinks is helping/not and, if need be, to modify the protocol and/or switch to a different treatment format.”

Helping Patients Trust in the Process of Trauma Recovery and Maintain Motivation

Eight of the 24 providers remarked on the success of the EBP, depending on the patient staying motivated and trusting in the process of their own recovery. The providers noted this 10 times. For example, a provider stated that “trusting the process of CPT-C [CPT-cognitive only] helped him move forward and the group (co hort) actually moved him more than the staff.” Another explained that it was important for her as a provider to foster hope, engagement, and determination to help veterans “trust the process until they can start to see the changes themselves.”

When Providers and Patients Do Not Agree on EBP Choice

Four providers mentioned that, at times, they disagreed with their patients about which treatment would be a better fit to reach their treatment goals and achieve recovery from PTSD. Of those providers, they noted this six times. However, most providers spoke to respecting and deferring to patient preferences and understanding the importance of patient buy-in and belief in the value of patients engaging in the treatment they prefer. For example, one provider explained, “I gave a veteran the option of CPT or PE and I really pushed for PE, but he ended up choosing CPT-C [CPT-cognitive]. I respected his decision and kept in mind that both therapies work equally well and I needed to trust that CPT-C would work for this veteran.” Another provider reflected, “The PE case was challenging and we ended up terminating the therapy. He was making little movement with the therapy, and honestly there appeared to be little investment. He spoke in stuck points, which prompted me to [wish I] suggested CPT, but he tried that a few years ago and also did not have much movement in symptoms… . I think he is more invested in the idea of not getting better than believing that he can.”

At times, providers identified reasons to recommend a change in treatment course from CPT to PE or vice versa. As one provider shared, “[I was] conducting PE with a veteran who was making up his responses to the PE homework. I realized it is much easier to ‘fake’ doing PE homework right before the session than it is for CPT and think CPT would have been a better fit and way to keep him accountable without him feeling shame or that he had to ‘fake’ doing homework and we could discuss homework completion and purpose in the context of therapy.” In many of the journal entries, providers spoke to the importance of taking the time to do a thorough biopsychosocial assessment to help guide treatment decision making.

Providers Trusting Their Experiences

Four providers discussed the importance of trusting their experience of the treatment and whether the patient was meeting treatment goals in a timely fashion. For example, one provider explored a therapeutic impasse in which she was inclined to confront a patient for avoidance but was able to trust in the process of recovery and approach things differently. The provider noted that "she presented as very motivated for treatment and actively engaged in all activities on her treatment plan. However, at about Session 6, she decided to just stop doing worksheets… . When I had her discuss her homework, she had mentally done several worksheets, was able to readily identify undermining beliefs, was able to challenge them, and replace them with more fitting beliefs that led to consequences with which she was pleased. It was a good reminder that not all patients work at the same pace in the same way and that you have to get your head out of a manual sometimes and just be a good therapist."

Using PE and CPT Together

Three of the 24 providers noted how they used components of PE and CPT to supplement areas of a treatment that they did not think was adequate for the patient. The providers noted this 11 times. One provider said, "I find it extremely useful to integrate CPT components—stuck point identification, Socratic questions, etc.—into PE during the processing of the imaginal exposure and when discussing barriers to engaging in in vivo exposure. Also, I use components of PE in CPT. For example, I talk about components of habituation (using PE terms) related to the reading of the trauma account for CPT." Several providers reflected that the perceived shortcoming of one treatment could be augmented by another. For example, one provider expressed belief patients could benefit from identifying their Subjective Units of Distress Scale (SUDS) level when reading the trauma account to track distress levels and progress. Providers often expressed that these supplements to the protocols still upheld the spirit of the treatments and were not perceived as major deviations.

Thematic Differences Between PE and CPT

Although providers frequently noted which treatment they were providing, and the ameliorative effects of their chosen EBP on PTSD symptoms, there were minimal thematic differences found in the reflective journaling between PE and CPT. Providers noted that they found the reflective journals to be helpful in both evaluating the therapeutic progress in their patients but also in recognizing and reviewing the effectiveness of the modality itself. As an example, one provider noted her perceptions of the varying course of progress between the two types of treatments: "For my CPT cases, the veterans start to improve very quickly, are very much distressed during Sessions 4 and 5, and then improve steadily after that (PTSD Checklist [PCL] scores also reflect this). For PE, it seems like it takes longer to see the improvement (often until the fifth or sixth session), but then it drastically improves very quickly (rapid drops in PCL) scores." However, there were two providers who noted that PE occurred quite rapidly (e.g., "We wrapped up with the shorter end of the typical number of sessions" and "This is the shortest length of PE [six sessions] I've ever had with a patient"). Thus, it seems that the journals appeared to be foundations to strengthen providers' confidence in the chosen modality.

Discussion

This is the first study to utilize reflective journaling in understanding the implementation of EBPs for PTSD. Results here reveal both unique and overlapping findings with what has already been reported in the literature. In particular, several other studies have found that modifications were being made to PE and CPT protocols (e.g., Chard, Schumm, McIlvain, Bailey, & Parkinson, 2011; Cook et al., 2013; Kaysen et al., 2013) including blending aspects of these two EBPs for PTSD. What has been less discussed in the dissemination and implementation of PE and CPT is what happens when providers and patients do not agree on choice of which EBP to implement and how this disagreement may impact treatment engagement and outcome as well as provider concerns on when to discontinue an EBP.

In the recent clinical practice guideline for the management of PTSD (Department of Veterans Affairs & Department of Defense, 2017), the VA and Department of Defense encouraged providers to engage patients in shared decision making regarding treatment. Shared decision making is a process by which patients and providers work together to make choices about the patient's care. In this model, patients and providers share their respective expertise and engage in a dialogue to arrive at a mutually agreed-upon plan for care. Preliminary evidence suggests that shared decision making can feasibly and effectively occur in the treatment of PTSD (Mott, Stanley, Street, Grady, & Teng, 2014). Because there is no single best EBP for PTSD, patient preferences are crucial in treatment selection (Simiola, Neilson, Thompson, & Cook, 2015). A recent survey study revealed that adults with PTSD symptoms were not aware that certain trauma-focused psychotherapies were effective (Harik, Matteo, Hermann, & Hamblen, 2017). Shared decision making can thus inform patients of their treatment options and help patients' base treatment decisions on accurate information, and it was encouraging that providers in this study described efforts to work collaboratively with patients to identify the most appropriate treatments.

There is no protocol or standardized way that VA providers are mandated to present these two EBPs to their patients. In fact, there are likely multiple ways to engage in shared-decision making about trauma-focused treatments. One way is to engage in a dialogue with the patient regarding treatment options and develop a treatment plan based on patient specific goals, values, and preferences. Part of this conversation would be for the provider to educate the patient about treatment options, including benefits and risks, side effects, and expectations. Providers might use additional products (e.g., white-boards, pamphlets) to help illustrate the treatments and ask for permission to involve family members in accordance with patient preferences. The VA's National Center for PTSD developed an online PTSD treatment decision aid to assist veterans, their families, and other health care providers in learning about several treatmentoptions, includingmedications(https://www.ptsd.va.gov/public/treatment/therapy-med/ptsd_treatment_decision_aid.asp) . This tool contains videos of providers explaining how these treatments work, allows the patient to build a chart to compare the treatments they like the most, and print a personalized summary.

Several providers indicated in their reflective journals some instances in which they did not agree with their patients on the treatment that would be the best fit for a patient. In addition to engaging in shared decision making, it is important to understand why someone chooses a

particular EBP. This process provides important clinical information about decision-making capabilities and skills as well as enriching the engagement in treatment choice and throughout the treatment. Asking questions should not be confused with questioning decisions. The curiosity and desire to understand decisions in treatment from the initial meeting is another way to build therapeutic alliance. However, additional research that provides better guidance about whether specific treatments might work better, or be more successful in engaging a particular patient, may be helpful in guiding patients and therapists toward the treatments that would set them up for the best chance of success. This seems particularly relevant when the patient asks the provider for their opinion as to what would be their recommended treatment if the patient does not have a preference.

Providers frequently endorsed the perceived need to modify the protocols to address patient needs and complex symptom presentations. Tailoring treatments to fit within patients' culture, repetition of elements or extension of the protocol to allow adequate time for mastery, and integration of elements from the other EBP were commonly endorsed. These findings, in conjunction with other findings regarding treatment adaptation (Cook et al., 2014) are important information for training and program implementation. It may be important to provide additional information about how to adapt the treatment while preserving the key elements of the treatment. Recent research has demonstrated the critical elements of CPT include identifying and addressing assimilated stuck points, regardless of the form of CPT (Farmer, Mitchell, Parker-Guilbert, & Galovski, 2017), and randomized controlled trials indicate that combining PE and cognitive restructuring does not increase the efficacy of the treatment (Foa et al., 2005). Addressing these issues in training and supervision may help to dispel misinformation and guide providers toward making adaptations that will be effective when needed. For example, reading the trauma account in CPT is not intended to be a form of exposure in the same manner that imaginal exposure in PE is, and thus, SUDs ratings and psychoeducation about habituation are not necessary or appropriate in CPT. Importantly, when integrating EBPs, attention must be paid to ensuring adequate dose, consistency with the underlying theory, and symptom change and engagement levels after integration occurs. The use of practice-level data and program evaluation are important ways to evaluate whether adaptations are having the desired impact in routine care settings (Wiltsey Stirman, Gamarra, Bartlett, Calloway, & Gutner, 2017).

Veterans who attend VA residential programs often have severe mental health symptoms and complicated life circumstances. Although residential programs provide individualized treatment plans, the VA residential treatment programs are time limited (average length of stay is typically between 6 and 12 weeks; Cook et al., 2014). The providers pointed out that although the EBPs were very helpful to veterans in this relatively short length of stay, veterans require therapy and support in applying knowledge and skill after discharge. Discharge planning to an outpatient level of care along the continuum of care that has services to meet the needs and preferences of the veteran is crucial. For example, some veterans are homeless, new to sober living, living in environments that have differing level of support for their recovery, and will benefit from continued care as they transition from the residential level of care to a lower level of care. Similarly, if there is a discrepancy between a veteran and their provider in regard to which EBP to initiate, there may not be time to begin another full course of an EBP or it may be determined a residential level of care is not

warranted or clinically indicated to engage and benefit from another EBP, and this can be done on an outpatient basis. Additionally, some veterans may benefit from services offered along the continuum of care, such as an intensive outpatient program or weekly outpatient EBP, targeting residual symptoms such as sleep problems, or additional issues such as substance abuse relapse prevention or relationship problems.

Unlike practitioners in independent practice, providers in large health care organizations, such as the VA, do not typically keep separate case notes. In the VA, all progress notes are supposed to be documented in a nationally accessed computerized patient record system, using a template after PE or CPT sessions. There is often little space in these notes or time in a providers schedule to write about their own reactions and process with the treatments and patient or discuss system barriers and challenges related to EBP use. In addition, comparison or reflection of different responses between patients likely does not occur on a regular basis, if at all, because VA providers are not allowed to put other patients' information in another patient chart. Although there is a section in these templates to add additional session information, they do not specifically prompt providers to discuss what led to the treatment success or lack thereof. Additionally, even for those providers who may utilize case notes, the use of structured writing prompts may be helpful in directing providers to reflect thoughtfully and meaningfully on the EBP intervention specifically.

Indeed providers often shared that journaling helped them to slow down and really think about their experiences with their patients and how these treatments may be impacting the patients' treatment trajectories. Many of them expressed a liking for this process because they expressed how the demands of their jobs sometimes did not allow for this process otherwise. It provided the opportunity to think about their overall experiences with CPT and PE rather than just session by session with each case. Many noted that the journaling validated the challenges and complexity of the work in a way that they found supportive.

In addition, reflective journaling is a resourceful and practical way to have clinical practice influence research and protocol refinement/development. Often the populations recruited in validating a manual protocol have several exclusion criteria that do not match the clinical population presenting in residential treatment programs. The results presented here have implications for treatment developers and organizations undergoing dissemination efforts of PE and CPT as well as potentially other treatments. Reflective journaling may be a good way to learn about things to consider with cooccurring and complex populations when updating and broadening the implementation of manualized treatment with co-occurring clinical populations. A good example of treatment re finement is the updated CPT manual (Resick et al., 2016), for which revisions were informed by updated scientific findings (e.g., that flexibility in treatment length and off-protocol crisis sessions that use CPT principles to address current significant stressors may be warranted) and clinical practice. Thus, it seems that providers should have some flexibility in their clinical schedules to add or extend sessions when additional time is needed to deal with crisis or other things that may need to be addressed but not in lieu of the EBP.

Bruno and Dell'Aversana (2017) qualitatively analyzed psychology students' reflective journals, noting that writing about work experiences enhanced observational skills. They

also advocated for the use of teacher feedback as an agent of reflection. For those providers who may not have access to a peer supervision or consultation network, students who desire additional training and support, and even experienced providers who find themselves struggling with a particular case, reflective journaling work can be used to actively reflect on their work to ensure optimum treatment outcomes.

In fact, La Torre (2005) suggests that providers write down their initial thoughts and responses and simply return to the written work later to provide their own feedback. The benefit of reflective journaling for therapists has been noted before, specifically referencing the need for therapists to review their own patterns and behaviors as well as reflect on the in-session experiences that transpire (La Torre, 2005). An Appendix has been included, which incorporates the writing prompts used in the current methodology, as well as additional writing prompts garnered from the content analysis. Providers may find it helpful to use the worksheet as both a preparatory and decision-making tool in addition to a means of actively reflecting on treatment processes and outcomes on an ongoing basis.

From study design through analysis and summary, we strived to remain aware and focused on eliminating sources of researcher or provider bias. However, we acknowledge that bias can find its way into any research and were committed to identify and reduce the sources of bias to deliver the highest-quality research possible. For transparency purposes, all five of the authors are practicing clinical psychologists trained in and delivering a range of trauma treatments, including these two evidence-based psychotherapies. In regard to confirmation bias, we did not have any hypothesis or belief that we were trying to confirm and operated from a grounded theory approach. However, we understand that confirmation bias is deeply seated in everyone's understanding and filtering of information. To minimize bias, we had two independent reviewers and spoke as a team to continually reevaluate impressions and challenge preexisting assumptions. We also stayed very true to what the providers actually said in their journals. Rather than summarizing what the providers said, throughout the results, we used their own words. In reading the candor in the providers' journals, it does not appear that they expressed acquiescence bias or were simply yea-saying to these EBPs. We also believe based on the responses that we read that the majority of these providers were not looking to present themselves in a way that they would be accepted or liked (social desirability). They seemed to understand that there was no right or wrong answer and expressed their honest point of view.

There are several limitations that should be noted. First, the results come from only 24 VA residential PTSD programs of a larger sample of nearly 200. Because of concerns regarding provider burden and time, as well as experience and interests, we purposively chose to ask a relatively select group of providers to engage in this innovative but potentially time-consuming aspect of the study. By choosing people who were doing CPT or PE somewhat regularly, we do not know about decisions of providers who use these treatments less often. Second, reflective journaling relies on provider self-report, which may be impacted by decision-making biases, such as confirmation bias, lack of knowledge, and demand characteristics. Additionally, this study focused on residential PTSD treatment programs, which represents a relatively small and unique faction of VA care, treating the most chronic and severe patients. Residential programs provide a protective environment in which barriers

to EBPs are likely less than an outpatient setting, which may be less structured. They also often have additional support building, not only with programming but also with staff such as peer support specialists. Results presented may not be generalizable to other programs and providers, particularly outpatient programs. In addition, the Department of Veterans Affairs & Department of Defense (2017)'s most recent guideline for the treatment of PTSD recommends individual trauma-focused EBPs over pharmacologic and other nonpharmacologic interventions for the primary treatment of PTSD. That guideline states that the limited data on the efficacy of group therapy, including group CPT, for PTSD indicate that it is not as effective as individual therapy (Resick et al., 2017). The high use of group CPT in the VA PTSD residential programs (Cook et al., 2015) may have influenced some of the providers' responses here. Additionally, it is not clear when the providers were delivery CPT versus CPT-cognitive only in a group or individually. Finally, because of the small sample size, we were unable to identify any discernible differences in thematic information when examining provider demographic variables. However, we acknowledge that this information could be useful in understanding how care delivery may be impacted by these provider-level variables and therefore see this as an opportunity for future research with a larger sample size.

To promote accuracy, comfort, and burden in engaging in reflection (Corbin Frazier & Eick, 2015), future implementation efforts or research investigations may provide professionals with choice in multimedium approaches to journaling (written vs. video journals). Examining the reflective journal entries of psychotherapy novices versus experts or those of providers of varying theoretical orientation or disciplines may provide insights into clinical decision making regarding EBPs. In summary, reflective journaling can provide important insights into the process by which psychotherapy providers use, modify, and discontinue EBPs by capturing provider perspectives about their most current and recent experiences, some of which may be forgotten by the time they could be surveyed or interviewed. The use of reflective journaling may also facilitate treatment developers and supervisors' understandings of facilitators and barriers to providers' use of EBPs as well as the successes and challenges in their delivery. We encourage additional research using this method to complement other investigations into the implementation of EBPs.

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Appendix: A Sample Reflective Journal Worksheet for Providers

This reflective journal is designed to help understand providers' on the ground, in the moment, decision-making process regarding their use of__ (a particular EBP[s]) ___. There are no right or wrong answers. This is about your thoughts, feelings, and experiences with these treatments.

Thinking about your use of _____ over thepast month:

How did you make the decision to use ___?

Have you experienced any notable surprises (good or bad) when using the treatment?

What successes did you notice in your delivery of ___?

What challenges or shortcomings did you notice in your delivery of ___? What are your next steps based on the above answers (e.g., continued treatment as is, modify or adapt EBP strategies, change EBP)?

The next time you confront a similar clinical situation, what, if anything, might you do differently?

How does this experience contribute to your clinical practice and learning?

What are the implications of this experience to your use of _____?

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Table 1

Comparison of Participants Who Completed Reflective Journaling Versus Those Who Did Not

Variables	Completed reflective journaling (*n* = 26)	Did not complete journaling (*n* = 9)
Age	*M*=42	*M*=44
Gender (female)	83%	69%
Race		
White	83%	86%
African American	9%	5%
Other	9%	9%
Profession		
Psychologist	70%	46%
Social worker	22%	40%
Psychiatrist	0%	7%
Other	6%	9%
Year in clinical practice	*M* = 11	*M* = 14
Years employed by VA	*M* = 6	*M* = 8
Years working in residential setting	*M* = 4	*M* = 6