The Emory Treatment Resistance Interview for PTSD—Short Version (E-TRIP-S)

Boadie W. Dunlop, MD; Nathaniel L. Phillips, MS; and Barbara O. Rothbaum, PhD

Abstract

Objective: Failure to benefit from treatments for posttraumatic stress disorder (PTSD) is common. We previously developed the Emory Treatment Resistance Interview for PTSD (E-TRIP), the first tool to evaluate treatment resistance in PTSD. Here, we provide a simplified version of the scale, the E-TRIP-Short version (E-TRIP-S), that assesses prior responses to first-line evidence-based psychotherapies and medications for PTSD.

Methods: US military personnel and veterans (N = 102) being evaluated for treatment through a specialized academic medical center PTSD clinical program from May 2019 to February 2020 were interviewed by trained assessors. Descriptive statistics of the E-TRIP-S psychotherapy and medication scores were evaluated to provide preliminary evidence regarding the utility of the measure.

Results: Among those seeking care in an intensive outpatient program for PTSD, the majority of those with prior exposure to evidence-based interventions showed elevated E-TRIP-S scores. Only 11/39 (28.2%) of psychotherapy-treated and 12/52 (23.2%) of medication-treated patients reported that a prior treatment "definitely helped" for their intrusion or avoidance symptoms, indicating limited benefit from previous treatments and providing proof of concept for the measure. One-quarter of those who failed to benefit from one modality (ie, an evidence-based psychotherapy or medication) reported being definitely helped when treated with the alternative modality.

Conclusion: The E-TRIP-S offers a simplified method for assessing treatment resistance among PTSD patients. Preliminary results suggest that the E-TRIP-S may contribute to clinical care by informing treatment selection for individuals and may support research by identifying treatment-resistant patients for testing new interventions or for stratifying patients based on prior treatment outcomes in clinical trials.

J Clin Psychiatry 2025;86(4):25m15956

Author affiliations are listed at the end of this article.

Posttraumatic stress disorder (PTSD) is a common, frequently persisting mental health disorder, estimated to have a lifetime prevalence of approximately 6.8% in US civilians and 3%–5% of people globally.[1] Rates among US military veterans range from 10% to 30%, depending on the era of service.[2] Treatments for PTSD include trauma-focused psychotherapies or medications such as selective serotonin reuptake inhibitors (SSRIs) or venlafaxine.[3–5] A recent meta-analysis[6] and an Agency for Healthcare Research and Quality review[7] failed to identify evidence of differential efficacy between medication and trauma-focused psychotherapy. The largest randomized controlled trial (RCT) directly comparing these treatments found no significant difference between sertraline with extensive medication management or Prolonged Exposure therapy plus pill placebo on symptomatic improvement[8] or residual symptoms posttreatment.[9]

Despite their proven efficacy compared to control interventions, nonresponse rates in RCTs of trauma-focused psychotherapy or SSRIs are approximately 40%–50%,[10–12] with poorer outcomes typically observed among military personnel with PTSD.[13,14] There is broad recognition that novel interventions for patients who fail to respond to standard treatments are urgently needed.[15,16] A reliable method for identifying such treatment-resistant PTSD (TR-PTSD) patients is a necessary component for making advances in developing therapeutics and understanding the biology of this disorder.

In 2014, we published the Emory Treatment Resistance Interview for PTSD (E-TRIP)[17] to identify patients with poor prior response to PTSD treatments and quantify the level of resistance based on the number of treatments failed. The E-TRIP has been used in clinical trials,[18–20] and a recent study found that prior medication failure as assessed by the E-TRIP predicted a 6.6-point smaller difference between vortioxetine and placebo on the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5).[19] However, the length and complexity of the

Clinical Points

- Failure to benefit from psychotherapy and medication treatments for posttraumatic stress disorder (PTSD) is common, but the field lacks a brief tool to assess treatment-resistant PTSD (TR-PTSD).
- The clinician-administered E-TRIP-Short version (E-TRIP-S) evaluates outcomes to first-line PTSD treatments (evidence-based psychotherapies, selective serotonin reuptake inhibitors, and venlafaxine).
- The E-TRIP-S could inform next-step treatments in clinical care and evaluate novel therapeutics and the biology of TR-PTSD in clinical research.

E-TRIP may be a barrier to its more widespread adoption. Here, we report on the initial development of a shorter and more simply scored version of the E-TRIP, the E-TRIP-Short version (E-TRIP-S; see Supplementary Appendix 1).

METHODS

Setting

Administration of the E-TRIP-S was assessed in US military personnel and veterans referred to the Emory Healthcare Veterans Program (EHVP) in Atlanta, Georgia, a part of the Warrior Care Network. This network consists of 4 coordinating academic medical centers that provide intensive treatment to post-9/11 military veterans and service members suffering from invisible wounds, including PTSD, major depression, and anxiety disorders.[21] The core treatment provided through EHVP is a 2-week intensive outpatient program (IOP) involving daily psychotherapy, medication management, and a variety of adjunctive services. All patients with PTSD treated through the IOP received Prolonged Exposure (PE), an evidence-based psychotherapy, though each patient's treatment plan is personalized based on patient preferences.

Referrals to the program came from Veterans Affairs providers, active military providers, community providers, the Wounded Warrior Project, and self-referral. Primary reasons for nonacceptance to the IOP program were serious substance use disorder that required detoxification, inability to reside in Atlanta for 2 weeks, a serious unstable medical illness, or other factors that could disrupt the treatment. All patients whose data contributed to this report consented to the use of their clinical records for research purposes, and the project was approved by the Emory University Institutional Review Board (Study 00005947).

Assessments

The E-TRIP-S was administered by an assessor during an intake conducted either in person or by telephone for determining whether a patient was appropriate for treatment through EHVP. Sex was determined based on self-report. At the intake assessment, patients were assessed for PTSD using the CAPS-5,[22] a structured interview for diagnosing and assessing the severity of PTSD according to *DSM-5* criteria. Formal diagnoses of disorders other than PTSD were made using the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders.[23]

E-TRIP-S Development

The development of the E-TRIP-S was guided by the desire to build an assessment that could be administered and interpreted with greater ease than the E-TRIP, which encompassed a wide array of potential treatments, including those with and without evidence of efficacy in PTSD. The E-TRIP also allowed for variability in the PTSD symptom targets of treatment, based on patients' responses. These components required a high level of clinical expertise to administer. Simplifying the tool to create the E-TRIP-S required numerous changes to the composition of the scale, as detailed below.

First, to reduce the number of prior treatments to be assessed, we limited the E-TRIP-S to the evidence-based psychotherapies and medications recommended as first-line interventions by leading PTSD treatment guidelines at the time the scale was developed.[3,4] Thus, for trauma-focused psychotherapies, we included PE, Cognitive Processing Therapy (CPT), and eye-movement desensitization and reprocessing therapy. For medications, we included all SSRIs and venlafaxine; treatment guidelines vary in whether they recommend only specific SSRIs versus SSRIs as a class[24]; as with the E-TRIP, we opted to include all SSRIs. We maintained the same definitions of minimum levels of dose and duration that constitute adequate exposure to a treatment as used on the E-TRIP, aiming to strike a balance between "optimal" vs "routine" treatment delivery.[17] For medication, an adequate treatment exposure was defined as a minimum of 8 weeks of treatment at the minimum effective dose recommended on the package insert for treatment of major depression, which is consistent with other reviews.[25–28]

For the psychotherapies, a definition of adequate prior treatment requires addressing the tension between requiring the optimal number of sessions to achieve maximum benefit versus the observation that patients who drop out of the therapy before completing the full course may do so because they are not responding to treatment or because they have already achieved full benefit. We addressed this issue by reviewing the number of sessions used in the clinical trials demonstrating efficacy by our inclusion criteria. For exposure-based

Table 1.
Comparison of *DSM-5* and *ICD-11* Diagnostic Criteria for PTSD

	DSM-5	*ICD-11*
Trauma exposure	Actual or threatened death, serious injury, or sexual violence	An extremely threatening or horrific event or series of events
Symptoms (*DSM-5* cluster)	(B) Intrusions (C) Avoidance of stimuli (D) Negative alterations in cognitions and mood (E) Alterations in arousal and reactivity	Reexperiencing Avoidance of reminders ... Perceptions of heightened current threat
Minimum duration	More than 1 month	Several weeks
Life impact	Clinically significant distress or impairment of functioning	Significant impairment in functioning

treatments, we identified 2 analyses reporting response rates by session number, which found that attending 6 or more sessions was associated with greater improvement.[29,30] In addition, multiple studies examining time to dropout report that the majority of patients who drop out of PE or CPT do so before session 6 (mean time to dropout about 3 sessions), indicating that those who complete 6 sessions were highly likely to complete a full course of therapy.[31–35]

Dropout after session 6 is very uncommon for patients who are improving, indicating they are likely to remain in the treatment until maximum benefit is reached or until the treatment is completed. The converse of dropout due to inefficacy or intolerability is dropout due to achieving maximal benefit before completing a "full course" of treatment.[32] Several studies have found a significant percentage achieved large gains before session 6.[33,36,37] Taking these factors into consideration, and the need to achieve a balance between "optimal" and "routine" treatment delivery, we concluded that 6 sessions is an appropriate cut-point for this balance to determine the lower limit to reflect an adequate therapy course.

Second, on the E-TRIP-S, each treatment is evaluated only with respect to its effect on the 2 core symptom clusters of PTSD: cluster B, Intrusion, and cluster C, Avoidance. By narrowing the focus to these symptom clusters, we improve the efficiency of the interview and focus on core symptoms of PTSD to avoid evaluating improvement based on common comorbid symptoms such as low mood, anhedonia, insomnia, and irritability. In addition, focusing on these core symptom clusters enhances the E-TRIP-S' compatibility with *ICD-11* criteria, which exclude all of the cluster D and most of the E symptoms of the *DSM-5* criteria (see Table 1).[38,39]

Third, effectiveness studies of PTSD treatments have increasingly reported the outcome of "meaningful change," which aims to identify patients who have clinically benefited from treatment, even if they fall short of remission.[40] However, most patients in clinical care will not have repeated rating scales administered through treatment or understand the scores. Consequently, we opted to evaluate treatment outcomes using the patient's impression of improvement on the core symptoms of PTSD (described below). Single question patient-reported outcomes, such as the Patient Global Impression[41] and the Antidepressant Treatment Response Questionnaire,[42] are frequently used to evaluate benefits of psychiatric treatments. Using a self-reported outcome reduces the level of PTSD expertise required by the assessor, thereby broadening the settings in which the E-TRIP-S could be used. However, we designed the E-TRIP-S not as a self-administered questionnaire, but as a structured interview to be administered by an assessor with reasonable knowledge of PTSD to allow for clarification of the meaning and goal of the questions.

On the E-TRIP-S, for each adequate course of treatment received, the patient is asked to rate on a 3-point Likert scale whether it "(1) didn't help; (2) helped a little; or (3) definitely helped." For each treatment that the patient endorses that the treatment "definitely helped," the assessor then asks about which of the *DSM-5/ICD-11* specific symptoms for each of the 2 core symptom clusters (5 symptoms for intrusion and 2 for avoidance) for which it "definitely helped." If the patient does not endorse that the treatment "definitely helped" any of these 7 core symptoms, then the treatment is considered to have failed, and all symptoms are scored as not having been helped. Thus, "didn't help" and "helped a little" represent levels of inadequate treatment response, given that partial improvement is associated with poorer long-term outcomes.[43] The outcome of "definitely helped" or "definitely improved" has proven clinical validity in assessing the outcomes of other conditions in medicine.[44] The Psychotherapy Treatment Resistance Score thus ranges from 0 to 3, as there are 3 types of psychotherapy assessed. The Medication Treatment Resistance Score also ranges from 0 to 3. Due to the number of marketed SSRIs, there are more than 3 medications assessed on the E-TRIP-S. Thus, it is possible for patients to fail to benefit from many of them despite only having been exposed to 1 drug mechanism of action. Thus, the E-TRIP-S Medication Treatment

Resistance Score is capped at 3, such that patients who failed ≥3 adequate medication trials are scored as "3." The E-TRIP-S Total Score is simply the sum of the Psychotherapy Resistance Score and the Medication Resistance Score, which therefore can range from 0 to 6.

Statistical Analysis

All analyses were conducted using R[45] and RStudio.[46] Descriptive statistics were used to summarize demographic and clinical characteristics, prior treatment engagement, treatment outcomes, and treatment resistance rates. For continuous variables, means and standard deviations were reported; for categorical variables, frequencies and percentages were calculated. Treatment outcomes were summarized by the number and percentage of participants who endorsed being "definitely helped" by each intervention, as well as the distribution of symptom-specific improvements (eg, intrusions only, avoidance only, or both). Notably, internal consistency reliability was not estimated using Cronbach α or related indices, as the E-TRIP-S items are conditional on treatment exposure and therefore not administered uniformly across participants. Because each item is only rated by individuals who received the corresponding treatment, the assumptions underlying internal consistency estimates (such as equal item applicability and parallel measurement across respondents) do not hold. Instead, we provide descriptive statistics for treatment-level and total resistance score.

RESULTS

One hundred two patients with CAPS-5-diagnosed PTSD were assessed with the E-TRIP-S at intake. Demographic and clinical characteristics of the sample are presented in Table 2.

As shown in Table 3, although 58 of the 102 patients reported prior psychotherapy for PTSD, only 39 (67.2%) had received at least 6 sessions with an evidence-based therapy. Similarly, although 63 reported receiving a medication for PTSD, only 52 (82.5%) had received an adequate duration of treatment with an SSRI or venlafaxine. Thirty (29.4%) patients had received at least 1 adequate course of treatment with both a psychotherapy and a medication.

The reported efficacy of prior treatments was generally in line with published results from other effectiveness studies of PTSD treatments (Table 4). Among patients who had received at least 1 course of evidence-based psychotherapy, 11/39 (28.2%) reported that it "definitely helped" with at least 1 intrusion or avoidance symptom. Among patients who had received at least 1 evidence-based medication, 12/52 (23.1%) reported that it "definitely helped" with an intrusion or

Table 2.
Demographic and Clinical Features

Characteristic	Mean	SD
Age, y	39.8	8.4
	N	**%**
Female	47	46.1
Race		
White	55	53.9
Black	35	34.3
Other	7	6.9
Unknown/not reported	5	4.9
Hispanic	9	8.8
Education		
Graduate school	20	20.6
College	47	48.5
High school	30	30.9
Military status		
Discharged	43	42.6
Medically retired	28	27.2
Retired	10	9.9
Active duty	14	13.9
National Guard	4	4.0
Reserves	2	2.0
Service connection: eligible for VA benefits	75	74.3
Comorbid MDD	58	56.9
Comorbid anxiety disorder	22	21.6
Comorbid substance use disorder	27	26.5
Comorbid TBI	19	18.6

Abbreviations: MDD = major depressive disorder, TBI = traumatic brain injury, VA = Department of Veterans Affairs.

Table 3.
Prior Treatments Assessed via E-TRIP-S

Treatment	N[a]	% of All patients
Evidence-based psychotherapy—total	39	38.2
PE	17	16.7
CPT	23	22.5
EMDR	8	7.8
Evidence-based medication—total	52	51.0
Citalopram	12	11.8
Escitalopram	11	10.8
Fluoxetine	17	16.7
Paroxetine	12	11.8
Sertraline	23	22.5
Venlafaxine	13	12.7
Other SSRI	1	1.0
≥1 Psychotherapy and ≥1 medication	30	29.4

[a]Several patients endorsed receiving multiple treatments, leading to treatment counts that exceed the total number of patients who endorsed receiving psychotherapy or medication.
Abbreviations: CPT = cognitive processing therapy, EMDR = eye movement desensitization and reprocessing, PE = prolonged exposure therapy, SSRI = selective serotonin reuptake inhibitor.

Table 4.

Outcomes to Individual Treatments

	PE (n = 17)	CPT (n = 23)	EMDR (n = 8)	Medication (n = 52)
No. (%) of patients "definitely helped" by treatment	5 (29.4%)	3 (13%)	3 (37.5%)	12 (23.1%)
Symptom cluster improved				
Intrusions only	0	0	3	10
Avoidance only	0	0	0	0
Both	5	3	0	2

Abbreviations: CPT = cognitive processing therapy, EMDR = eye movement desensitization and reprocessing, PE = prolonged exposure therapy.

Table 5.

Treatment-Resistant Patients per Treatment Modality

Intervention type	Treatment	Received treatment (n)	Treatment-resistant (n)	Treatment-resistant (%)
Psychotherapy	PE	17	12	70.6
	CPT	23	20	87.0
	EMDR	8	5	62.5
Medication	Citalopram	12	9	75.0
	Escitalopram	11	9	81.8
	Fluoxetine	17	12	70.6
	Paroxetine	12	10	83.3
	Sertraline	23	18	78.3
	Venlafaxine	13	10	76.9
	"Other"	1	1	100.0

Abbreviations: CPT = cognitive processing therapy, EMDR = eye movement desensitization and reprocessing, PE = Prolonged Exposure.

avoidance symptom. Three other patients reported a medication definitely helped, but not for these two symptom domains. Overall, 19/61 (31.1%) of patients reported they were definitely helped by either a medication or a psychotherapy, with 4 of those reporting being definitely helped on a core symptom by both forms of treatment.

Among the 9 patients who received more than 1 type of psychotherapy, 5 (55.6%) benefited from the second therapy after failing the first. Of the 19 patients who had trials with multiple medications, only 3 (15.8%) responded to one having failed others. There were 20 patients who failed to benefit from psychotherapy who also had a trial on medication, 5 of whom (25%) reported they were "definitely helped" by the medication. Similarly, 3/12 (25%) of the patients who failed to benefit from medication were "definitely helped" by one of the psychotherapies.

Table 5 presents treatment resistance rates by intervention type (ie, psychotherapy, medication) and treatment. Among those who received each respective intervention, rates of resistance—defined as failing to endorse being "definitely helped" with at least 1 intrusion or avoidance symptom—ranged from 62.5% to 87.0% for psychotherapies. For medications, resistance rates ranged from 70.6% to 100%. Notably, resistance was high across all treatments in the present sample, with most interventions showing resistance rates above 75%.

DISCUSSION

This report provided a preliminary assessment of the clinical application of the E-TRIP-S, a briefer instrument for assessing PTSD than the original E-TRIP.[17] In this sample of individuals seeking admission to an intensive treatment program, the E-TRIP-S demonstrated that most patients who had received at least 1 evidence-based treatment had failed to meaningfully improve on the core PTSD symptoms of intrusion and avoidance, consistent with effectiveness trials of medication and psychotherapy treatment for PTSD, particularly for self-reported outcomes among veterans with significant comorbidity treated in real-world settings.[47–49] This is not surprising as all patients were presenting for a higher level of care for PTSD, a 2-week intensive outpatient program. Notably, a pattern was identified in that all patients who benefited from either PE or CPT reported that they were "definitely" improved in both intrusion and avoidance symptoms; in contrast for all but 2 patients who benefited from medication, the

improvement was limited to intrusion symptoms only. Success with a subsequent medication after failure with 1 medication was infrequent (15.8%), whereas switching between psychotherapies had a higher success rate (55.6%). Taken together, these data suggest that the E-TRIP-S may be used to assess patients' responses to prior treatments; we recommend administering the E-TRIP-S following administration of the CAPS-5 or CAPS-5-R to aid as a reference for assessing improvement for specific PTSD symptoms.

We included all SSRIs as evidence-based treatments for PTSD, consistent with several treatment guidelines, though it should be noted that uncertainty continues to exist whether the SSRIs are all efficacious in the treatment of PTSD.[5,50] There are no adequately sized trials indicating that serotonin-norepinephrine reuptake inhibitors other than venlafaxine are efficacious as treatments for PTSD. Our use of the 8-week threshold as the minimum duration to qualify as an adequate trial of these medications is well-grounded in an analysis of change over time in seven 12-week placebo-controlled clinical trials of SSRIs and venlafaxine for PTSD, which found that the degree of change after week 8 was minimal.[19]

For the evidence-based psychotherapies, we used a minimum of 6 sessions to define an adequate trial based on the rate of change in PTSD observed in clinical trials and the patterns of treatment dropout. Although patients can clearly accrue additional benefits after 6 sessions, it is also the case that a significant proportion of patients can improve substantially before session 6. Indeed, 2 effectiveness studies that used an 8-week cut-point for PE treatment found relatively low rates of achieving meaningful change if such gains had not been achieved by week 8.[51,52] Importantly, treatment dropout after session 6 is uncommon, indicating that completing 6 sessions is strongly predictive of completing a full treatment course.[31–35] Although applying a minimum session number greater than 6 would more definitively identify treatment-resistant individuals, this gain needs to be balanced against the cost of excluding the many patients who discontinue due to lack of benefit and those who terminate because they have already fully benefited.[33]

An alternative approach to defining TR-PTSD was proposed by Sippel and colleagues.[53] Similar to the Thase and Rush staged model of treatment-resistant major depressive disorder,[54] these authors proposed 2 "stages" of TR-PTSD. Stage 1 requires "nonresponse to 2 evidence-based treatments for PTSD recommended by a recent clinical practice guideline delivered with fidelity and at an effective dose, at least one of which is a full course of trauma-focused psychotherapy," and stage 2 TR-PTSD occurs when patients have failed ≥3 such treatments.[53] The E-TRIP-S is compatible with determining the stages of TR-PTSD as defined by Sippel and colleagues[53] as it evaluates the evidence-based psychotherapies recommended by clinical practice guidelines for PTSD and has the additional benefit of assessing responses to guideline-recommended medications. One area of possible discrepancy, however, is the duration of psychotherapy required. Sippel and colleagues'[53] staging model requires a "full course" of PTSD (undefined in the staging model), which has been defined by others to be 8–15 sessions of PE[55] or 12 sessions of CPT.[56]

The primary limitation of this work is the need for rigorous psychometric evaluation of the E-TRIP-S to establish its reliability and validity. First, future work is needed to empirically evaluate the E-TRIP-S's reliability. Given the aforementioned limitations of traditional internal consistency estimates for the present measure, investigations of test-retest stability and interrater agreement may be particularly useful. Second, subsequent empirical investigations should aim to establish the measure's nomological net by examining associations with related constructs such as PTSD symptom severity, functional impairment, and treatment engagement. Longitudinal investigations—such as testing whether E-TRIP-S scores predict future treatment outcomes or service use—will also be important for clarifying its clinical and research utility. Another potential limitation was our decision to include only the reexperiencing and avoidance symptoms to assess treatment response. Meta-analyses and systemic reviews of network analyses of PTSD symptoms have identified 2 cluster E symptoms, hypervigilance and increase startle response, as core aspects of PTSD; the other cluster E symptoms show less specificity for the disorder.[57,58] Future development of the E-TRIP-S could examine whether assessing improvement in hypervigilance or startle improves the utility of the instrument. A final limitation is that the current sample was drawn from a specialized academic medical center serving US military personnel and veterans with a 2-week intensive program, which may limit generalizability to other treatment contexts or populations.

In conclusion, the E-TRIP-S offers a simplified and faster method for assessing treatment resistance among PTSD patients than the original E-TRIP. Its structure allows for clinicians with less PTSD experience to administer it after minimal training, and the assessment can be performed remotely because there is no patient-completed component of the E-TRIP-S. Identification of treatment resistance is important for selecting treatments for individuals, developing novel therapies for PTSD, and stratifying patients in clinical trials.

Article Information

Published Online: October 1, 2025. https://doi.org/10.4088/JCP.25m15956

Submitted: May 12, 2025; accepted August 14, 2025.

To Cite: Dunlop BW, Phillips NL, Rothbaum BO. The Emory Treatment Resistance Interview for PTSD—Short Version (E-TRIP-S). *J Clin Psychiatry* 2025;86(4):25m15956.

Author Affiliations: Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia (Dunlop, Rothbaum); Department of Psychology, University of Georgia, Athens, Georgia (Phillips).

Corresponding Author: Boadie W. Dunlop, MD, 12 Executive Park Dr NE, 3rd Floor, Atlanta, GA 30329 (bdunlop@emory.edu).

Relevant Financial Relationships: Dr Dunlop has received research support from Beckley PsyTech, Boehringer Ingelheim, Compass Pathways, Intra-Cellular Therapies, National Institute of Mental Health (NIMH), Reunion Neuroscience, and the Usona Institute and has served as a consultant for Biohaven, Cerebral Therapeutics, Myriad Neuroscience, NRx Pharmaceuticals, Otsuka, and Sage. **Dr Rothbaum** has received research support /grants from Wounded Warrior Project, National Institutes of Health, Department of Defense, National Science Foundation, Bob Woodruff Foundation, MAPS; is a stockholder in Virtually Better; has been paid as a consultant by Otsuka, Psychwire, Senseye, MAPS, Lykos, Jazz Pharmaceuticals, GoodCap, Transcend, Penumbra; serves on the scientific advisory boards for Anxiety and Depression Association of America (ADAA), National Center for PTSD; serves on the Board of Directors for GratitudeAmerica; and receives royalties from Oxford University Press, APPI, and Emory University. Emory Healthcare Veterans Program is supported by a grant from the Wounded Warrior Project. The terms of these arrangements have been reviewed and approved by Emory University in accordance with its conflicts of interest policies. **Mr Phillips** reports no relevant financial relationships.

Funding/Support: The authors acknowledge, with gratitude, critical support from Wounded Warrior Project, who has supported the Emory Healthcare Veterans Program and served as a partner in the Warrior Care Network, dedicated to filling gaps in mental health care for the invisible wounds of war in service members, veterans, and military families.

Role of the Sponsor: The funding source had no input into the collection, analysis, or interpretation of the study data.

Data Availability Statement: Research data are not shared.

Acknowledgments: The authors acknowledge, with gratitude, critical support from Wounded Warrior Project, who has supported The Emory Healthcare Veterans Program (EHVP) and served as a partner in the Warrior Care Network-dedicated to filling gaps in mental health care for the invisible wounds of war in service members, Veterans, and military families.

ORCID: Boadie Dunlop: https://orcid.org/0000-0002-4653-0483;
Nathaniel Phillips: https://orcid.org/0000-0003-0347-0449;
Barbara Rothbaum: https://orcid.org/0000-0002-8793-7124

Supplementary Material: Available at Psychiatrist.com.

References

1. Stein DJ, McLaughlin KA, Koenen KC, et al. DSM-5 and ICD-11 definitions of posttraumatic stress disorder: investigating "narrow" and "broad" approaches. *Depress Anxiety*. 2014;31(6):494–505.
2. Na PJ, Schnurr PP, Pietrzak RH. Mental health of U.S. combat veterans by war era: results from the National Health and Resilience in Veterans Study. *J Psych Res*. 2023;158:36–40.
3. American Psychological Association. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (2017). American Psychological Association; 2024. Accessed January 18, 2025. https://www.apa.org/ptsd-guideline/
4. Schnurr PP, Hamblen JL, Wolf J, et al. The management of posttraumatic stress disorder and acute stress disorder: synopsis of the 2023 U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline. *Ann Intern Med*. 2024;77(3):363–374.
5. Dunlop BW, Davidson JRT. Pharmacotherapy for posttraumatic stress disorder. In: Simon N, Hollander E, Rothbaum BO, et al, eds. *The American Psychiatric Association Textbook of Anxiety, Trauma and OCD-related Disorders*. American Psychiatric Association; 2020:519–541.
6. Sonis J, Cook JM. Medication versus trauma-focused psychotherapy for adults with posttraumatic stress disorder: a systematic review and meta-analysis. *Psychiatry Res*. 2019;282:112637.
7. Hoffman V, Middleton JC, Feltner C, et al. Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update. In: *Comparative Effectiveness Review No. 207*. Agency for Healthcare Research and Quality; 2018.
8. Rauch SAM, Kim HM, Powell C, et al. Efficacy of prolonged exposure therapy, sertraline hydrochloride, and their combination among combat veterans with posttraumatic stress disorder: a randomized clinical trial. *JAMA Psychiatry*. 2019; 76(2):117–126.
9. Tripp JC, Norman SB, Kim HM, et al. Residual symptoms of PTSD following sertraline plus enhanced medication management, sertraline plus PE, and PE plus placebo. *Psychiatry Res*. 2020;291:113279.
10. Eftekhari A, Ruzek JI, Crowley JJ, et al. Effectiveness of national implementation of prolonged exposure therapy in Veterans Affairs care. *JAMA Psychiatry*. 2013;70: 949–955.
11. Ipser JC, Stein DJ. Evidence-based pharmacotherapy of post-traumatic stress disorder (PTSD). *Int J Neuropsychopharmacol*. 2012;15:825–840.
12. Schottenbauer MA, Glass CR, Arnkoff DB, et al. Nonresponse and dropout rates in outcome studies on PTSD: review and methodological considerations. *Psychiatry*. 2008;71:134–168.
13. Friedman MJ, Marmar CR, Baker DG, et al. Randomized, double-blind comparison of sertraline and placebo for posttraumatic stress disorder in a Department of Veterans Affairs setting. *J Clin Psychiatry*. 2007;68(5):711–720.
14. Davidson J. Pharmacotherapy of post-traumatic stress disorder: going beyond the guidelines. *BJPsych Open*. 2016;2(6):E16–E18.
15. Krystal JH, Davis LL, Neylan TC, et al. It is time to address the crisis in the pharmacotherapy of posttraumatic stress disorder: a consensus statement of the PTSD Psychopharmacology Working Group. *Biol Psychiatry*. 2017;82:e51–e59.
16. Dunlop BW, Rothbaum BO. Medication-assisted psychotherapy for PTSD. *PTSD Res Q*. 2019;30:1–15.
17. Dunlop BW, Kaye JL, Youngner C, et al. Assessing treatment-resistant posttraumatic stress disorder: the Emory Treatment Resistance Interview for PTSD (E-TRIP). *Behav Sci*. 2014;4:511–527.
18. Clinicaltrials.gov. https://clinicaltrials.gov/ct2/show/NCT04174170; Accessed April 20, 2025.
19. Dunlop BW, Rakofsky JJ, Newport DJ, et al. Efficacy of vortioxetine monotherapy for posttraumatic stress disorder: a randomized, placebo-controlled trial. *J Clin Psychopharmacol*. 2021;41(2):172–179.
20. Lang AJ, Malaktaris A, Maluf KS, et al. A randomized controlled trial of yoga vs nonaerobic exercise for veterans with PTSD: understanding efficacy, mechanisms of change, and mode of delivery. *Contemp Clin Trials Commun*. 2021;21:100719.
21. Rauch SAM, Yasinski CW, Post LM, et al. An intensive outpatient program with prolonged exposure for veterans with posttraumatic stress disorder: retention, predictors, and patterns of change. *Psychol Serv*. 2021;18(4): 606–618.
22. Weathers FW, Bovin MJ, Lee DJ, et al. The Clinician-Administered PTSD Scale for DSM–5 (CAPS-5): development and initial psychometric evaluation in military veterans. *Psychol Assess*. 2018;30(3):383–395.
23. Tolin DF, Gilliam C, Wootton BM, et al. Psychometric properties of a structured Diagnostic Interview for DSM-5 Anxiety, Mood, and Obsessive-Compulsive and Related Disorders. *Assessment*. 2018;25:3–13.
24. Hamblen JL, Norman SB, Sonis JH, et al. A guide to guidelines for the treatment of posttraumatic stress disorder in adults: an update. *Psychotherapy*. 2019;56(3): 359–373.
25. Katz C, Stein M, Richardson JD, et al. A review of interventions for treatment-resistant posttraumatic stress disorder. In: Selek S, ed. *Different Views of Anxiety Disorders*. InTech; 2011:251–270.
26. Friedman MJ. Current and future drug treatment for posttraumatic stress disorder patients. *Psychiatr Ann*. 1998;28:461–468.
27. Davidson JR, Rothbaum BO, van der Kolk BA, et al. Multicenter, double-blind comparison of sertraline and placebo in the treatment of posttraumatic stress disorder. *Arch Gen Psychiatry*. 2001;58:485–492.
28. Davidson J, Rothbaum BO, Tucker P, et al. Venlafaxine extended release in posttraumatic stress disorder: a sertraline-and placebo-controlled study. *J Clin Psychopharmacol*. 2006;26:259–267.
29. Glenn D, Golinelli D, Rose RD, et al. Who gets the most out of cognitive behavioral therapy for anxiety disorders? The role of treatment dose and patient engagement. *J Consult Clin Psychol*. 2013;81(4):639–649.
30. Foa EB, Yusko DA, McLean CP, et al. Concurrent naltrexone and prolonged exposure therapy for patients with comorbid alcohol dependence and PTSD: a randomized clinical trial. *JAMA*. 2013;310:488–495.
31. Brown WJWJ, Saulnier KG, Allan NP, et al. Dropout from prolonged exposure among individuals with posttraumatic stress disorder and comorbid severe mental illness. *J Affect Disord Rep*. 2022;10:100405.
32. Holmes SC, Johnson CM, Suvak MK, et al. Examining patterns of dose response for clients who do and do not complete cognitive processing therapy. *J Anxiety Disord*. 2019;68:102120.
33. Gutner CA, Gallagher MW, Baker AS, et al. Time course of treatment dropout in cognitive-behavioral therapies for posttraumatic stress disorder. *Psychol Trauma*. 2016;8(1):115–121.
34. Galovski TE, Blain LM, Mott JM, et al. Manualized therapy for PTSD: flexing the structure of cognitive processing therapy. *J Consult Clin Psychol*. 2012;80(6): 968–981.

35. Garcia HA, Kelley LP, Rentz TO, et al. Pretreatment predictors of dropout from cognitive behavioral therapy for PTSD in Iraq and Afghanistan war veterans. *Psychol Serv*. 2011;8:1–11.
36. Wiedemann M, Stott R, Nickless A, et al. Cognitive processes associated with sudden gains in cognitive therapy for posttraumatic stress disorder in routine care. *J Consult Clin Psychol*. 2020;88:455–469.
37. Barbano AC, van der Mei WF, Bryant RA, et al. Clinical implications of the proposed ICD-11 PTSD diagnostic criteria. *Psychol Med*. 2019;49:483–490.
38. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Publishing; 2013.
39. ICD-11: World Health Organization. *ICD-11: International Classification of Diseases, 11th Revision*. World Health Organization; 2022. Accessed January 6, 2025. https://icd.who.int/browse/2025-01/mms/en#2070699808.
40. Jacobson NS, Truax P. Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *J Consult Clin Psychol*. 1991;59(1): 12–19.
41. Guy W. Clinical Global Impressions. In: *ECDEU Assessment Manual for Psychopharmacology*. US Department of Health, Education, and Welfare; 1976: 217–222.
42. Chandler GM, Iosifescu DV, Pollack MH, et al. RESEARCH: validation of the Massachusetts General Hospital Antidepressant Treatment History Questionnaire (ATRQ). *CNS Neurosci Ther*. 2010;16(5):322–325.
43. Larsen SE, Bellmore A, Gobin RL, et al. An initial review of residual symptoms after empirically supported trauma-focused cognitive behavioral psychological treatment. *J Anx Disord*. 2019;63:26–35.
44. Eklund A, De Carvalho D, Pagé I, et al. Expectations influence treatment outcomes in patients with low back pain. A secondary analysis of data from a randomized clinical trial. *Eur J Pain*. 2019;23(7):1378–1389.
45. R Core Team. *R: A language and environment for statistical computing*. R Foundation for Statistical Computing; 2023. Accessed January 16, 2025. https://www.R-project.org.
46. Posit Team. *RStudio: Integrated Development Environment for R*. PBC; 2023. Accessed January 16, 2025. https://posit.co.
47. Shiner B, Westgate CL, Gui J, et al. A retrospective comparative effectiveness study of medications for posttraumatic stress disorder in routine practice. *J Clin Psychiatry*. 2018;79(5):18m12145.
48. Weber M, Schumacher S, Hannig W, et al. Long-term outcomes of psychological treatment for posttraumatic stress disorder: a systematic review and meta-analysis. *Psychol Med*. 2021;51(9):1420–1430.
49. Maguen S, Madden E, Holder N, et al. Effectiveness and comparative effectiveness of evidence-based psychotherapies for posttraumatic stress disorder in clinical practice. *Psychol Med*. 2023;53(2):419–428.
50. Cipriani A, Williams T, Nikolakopoulou A, et al. Comparative efficacy and acceptability of pharmacological treatments for post-traumatic stress disorder in adults: a network metaanalysis. *Psychol Med*. 2018;48:1975–1984.
51. Ready DJ, Lamp K, Rauch SAM, et al. Extending prolonged exposure for PTSD veterans: when is enough really enough?. *Psychol Serv*. 2020;17(2):199–206.
52. Sripada RK, Ready DJ, Ganoczy D, et al. When to change the treatment plan: an analysis of diminishing returns in VA patients undergoing prolonged exposure and cognitive processing therapy. *Behav Ther*. 2020;51(1):85–98.
53. Sippel LM, Holtzheimer PE, Friedman MJ, et al. Defining treatment-resistant posttraumatic stress disorder: a framework for future research. *Biol Psychiatry*: 201(84):e37–e41.
54. Thase ME, Rush AJ. When at first you don't succeed: sequential strategies for antidepressant nonresponders. *J Clin Psychiatry*. 1997;58(suppl 13): 23–29.
55. Foa EB, Hembree EA, Cahill SP, et al. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics. *J Consult Clin Psychol*. 2005;73:953–964.
56. Rothbaum BO, McSweeney LB. Patients need to remain in treatment for PTSD to receive the full benefit. *J Anxiety Disord*. 2019;68:102156.
57. Isvoranu AM, Epskamp S, Cheung MW. Network models of posttraumatic stress disorder: a meta-analysis. *J Abnorm Psychol*. 2021;130(8):841–861.
58. Birkeland MS, Greene T, Spiller TR. The network approach to posttraumatic stress disorder: a systematic review. *Eur J Psychotraumatol*. 2020;11(1):1700614.

The Journal of Clinical Psychiatry

Supplementary Material

Article Title: The Emory Treatment Resistance Interview for PTSD—Short Version (E-TRIP-S)

Authors: Boadie W. Dunlop, MD; Nathaniel L. Phillips, MS; and Barbara O. Rothbaum, PhD

DOI Number: 10.4088/JCP.25m15956

LIST OF SUPPLEMENTARY MATERIAL FOR THE ARTICLE

1. **Appendix 1** Emory Treatment Resistance Interview for PTSD—Short Version

DISCLAIMER

This Supplementary Material has been provided by the authors as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

Appendix 1

Patient ID:	Date:	Interviewer:
E-TRIP-S	**OVERVIEW**	

EMORY TREATMENT RESISTANCE INTERVIEW FOR PTSD - SHORT VERSION (E-TRIP-S)

The E-TRIP-S is a semi-structured interview that assesses a patient's prior response to treatments for PTSD. The interview is most efficiently administered after an initial PTSD assessment has been conducted with the patient so that they are familiar with the concept of intrusion and avoidance symptoms.

Prior to beginning the assessment, it is necessary for the interviewer to establish the time of onset of the patient's PTSD. Only treatments administered after the onset of the PTSD should be assessed for efficacy in completing the E-TRIP-S.

Read questions in **bold font** as they are written. Text in *italic font* provides instructions for the interviewer.

For the psychotherapies, if a patient is uncertain of the type of therapy they received, reading the description of each therapy may prove helpful. Check the box next to the name of each type of psychotherapy for which the patient received an adequate trial. An adequate psychotherapy trial is usually a minimum of 6 sessions. If the patient does not clearly endorse having received an adequate trial with any of the psychotherapies described, then check the "No evidence-based therapy for PTSD" box and move on to the medications section.

For the medications, both the generic and trade (brand) names of the medications should be read to the patient. An adequate medication trial requires at least 8 weeks of treatment at the minimum effective dose, listed on the form. Check the box next to the name of each medication that the patient received for an adequate trial. If the patient does not clearly endorse having received an adequate trial for any of the medications, then check the "No evidence-based medication for PTSD" box and move on to the scoring section. A maximum of three medications are scored as failures; other additional medication failures do not increase the Medication Resistance Score.

Patient ID:	Date:	Interviewer:

E-TRIP-S

PSYCHOTHERAPY TREATMENTS

Have you ever received psychotherapy (talk therapy) for the treatment of PTSD? ☐ Yes ☐ No ☐ No evidence-based therapy for PTSD

What type(s) of therapy did you receive?

When did you receive the therapy (therapies)? *(Confirm therapy was after PTSD onset)*

Trauma-Focused Therapy	Therapy Description
Prolonged Exposure (PE)	You repeatedly went over the memory of the traumatic event by saying it out loud with the therapist and possibly by listening to a recording of you saying it at home.
Cognitive Processing Therapy (CPT)	You talked with the therapist about the "stuck points" that were the aspects of the event that were most upsetting to you
Eye Movement Desensitization and Reprocessing (EMDR)	You went through the memory of the traumatic event while doing something repetitive, like following the therapist's finger from side to side with your eyes

When you completed the PTSD psychotherapy treatment, did you feel that it: 1) didn't help; 2) helped a little; or 3) definitely helped?

Treatment	☐ PE	☐ CPT	☐ EMDR
	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped

*If a treatment **definitely helped**, ask the patient, "**What symptoms did the therapy definitely help with?**"*
For each treatment that definitely helped, place a check mark for each symptom that the patient states was helped.

Intrusion symptoms	PE	CPT	EMDR
Intrusive memories			
Distressing dreams			
Dissociative reactions			
Cued psychological distress			
Cued physiological reactivity			
Avoidance symptoms	**PE**	**CPT**	**EMDR**
Avoidance of memories, thoughts, feelings			
Avoidance of external reminders			

Patient ID:	Date:	Interviewer:

E-TRIP-S

MEDICATION TREATMENTS

Have you ever received medication for the treatment of PTSD? ☐ Yes ☐ No

☐ No evidence-based medication for PTSD

What type(s) of medication did you receive?

When did you take the medications(s)? *(Confirm therapy was after PTSD onset)*

Did you find that the medication(s): 1) didn't help; 2) helped a little; or 3) definitely helped?

☐ Citalopram (Celexa) 20 mg/day	☐ Escitalopram (Lexapro) 10 mg/day	☐ Fluoxetine (Prozac) 20 mg/day	☐ Paroxetine (Paxil) 20 mg/day	☐ Sertraline (Zoloft) 50 mg/day	☐ Venlafaxine (Effexor) 75 mg/day	☐ Other SSRI Name: (_____)
☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped	☐ Didn't help ☐ Helped a little ☐ Definitely helped

*If a treatment **definitely helped**, ask the patient, "**What symptoms did the medication definitely help with?**"*
For each treatment that definitely helped, place a check mark for each symptom that the patient states was helped.

Intrusion symptoms	Citalopram	Escitalopram	Fluoxetine	Paroxetine	Sertraline	Venlafaxine	Other SSRI (_____)
Intrusive memories							
Distressing dreams							
Dissociative reactions							
Cued psychological distress							
Cued physiological reactivity							
Avoidance symptoms							
Avoidance of memories, thoughts, feelings							
Avoidance of external reminders							

Patient ID:	Date:	Interviewer:
E-TRIP-S	**SCORING**	

A treatment is considered "Failed" if the patient states that it **DID NOT** meet both of the following criteria:

1. "Definitely helped"
2. Helped with at least one intrusion or avoidance symptom

Score one point for each failed treatment

Psychotherapy Treatment Resistance Score (range is 0-3): _____

Medication Treatment Resistance Score (range is 0-3): _____

TOTAL TREATMENT RESISTANCE SCORE (sum of above, range 0-6):_____

NOTES