

RESEARCH ARTICLE

Treatment outcomes for military-affiliated clients with posttraumatic stress disorder in a community mental health network

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[Correction added on 17 September 2025,
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Abstract

Treating posttraumatic stress disorder (PTSD) in military-affiliated populations, including veterans, active duty service members, and their families, remains a significant challenge in the mental health field. Most research on PTSD treatment outcomes has been conducted in controlled trials or within VA and military settings, limiting its generalizability to other clinical environments. This study examined treatment outcomes for 2,717 military-affiliated clients receiving treatment for PTSD within a community mental health network. Treatments included cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), or prolonged exposure (PE), with outcomes measured using the PTSD Checklist for *DSM-5* (PCL-5) throughout treatment. Clients who attended at least four sessions showed substantial symptom reductions for CPT ($\Delta M = 19.3$, $d = 0.98$; EMDR ($\Delta M = 16.6$), $d = 0.86$; and PE ($\Delta M = 17.4$), $d = 0.87$, all of which exceeded improvements seen with other treatments ($\Delta M = 12.6$), $d = 0.71$). Analyses of clinically meaningful change thresholds showed similar results across treatments, with 51.9% of CPT, 47.8% of EMDR, and 53.1% of PE clients experiencing a PCL-5 score reduction of at least 18 points after four or more sessions. Dropout prior to four sessions was notable, with 27.5%–40.1% of clients across treatment groups discontinuing treatment before reaching this threshold. Overall, the findings provide real-world evidence supporting the effectiveness of CPT, EMDR, and PE in military-affiliated populations and validate their continued use in community mental health settings.

Posttraumatic stress disorder (PTSD) is a significant mental health challenge, particularly among military-affiliated individuals, including veterans, active duty service members, and their families (Judkins et al., 2020; Steenkamp et al., 2018; Wisco et al., 2022). Evidence-based psychotherapies (EBPs), such as cognitive processing therapy (CPT;

Resick, Monson, & Chard, 2024), prolonged exposure (PE; Foa et al., 2019), and eye movement desensitization and reprocessing (EMDR; Shapiro, 2018), are widely recommended for PTSD treatment, supported by clinical trial data and systematic reviews (American Psychological Association, 2025; Haagen et al., 2015; Lewis et al., 2020;

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U.S. Department of Veterans Affairs [VA]/U.S. Department of Defense [DoD], 2023). Although these treatments have demonstrated efficacy in controlled trials, their real-world effectiveness remains a concern, particularly in military populations. For instance, although EMDR is recognized as a first-line treatment in some guidelines, the American Psychological Association (2025) recommends it as a second-line treatment, and other reviews have questioned both the effectiveness of EMDR compared to waitlist controls for military personnel (Kitchiner et al., 2019) and the quality of the EMDR research overall (Steenkamp et al., 2015). However, at least one—albeit small—study reported positive results for EMDR in an active duty population (McLay et al., 2016). Despite these critiques, EBPs consistently outperform non-trauma-focused therapies (Lee et al., 2016), yet they remain underutilized in clinical practice (Benfer et al., 2023; Sripada et al., 2018; Watts et al., 2014). This gap is particularly notable given that most research on military-affiliated individuals has been conducted within VA or DoD (Jacoby et al., 2022), leaving a critical need to understand outcomes for individuals seeking care outside these systems. This study aimed to address this gap by examining real-world outcomes for CPT, PE, and EMDR in a network of community-based mental health clinics serving military-affiliated populations.

The implementation of EBPs in real-world settings presents unique challenges and opportunities. Although clinical trials provide robust evidence for the efficacy of EBPs, their findings may not always generalize to routine clinical practice due to differences in patient populations, provider training, and systemic constraints (Doran & DeViva, 2018; Schneider et al., 2020). Naturalistic studies have highlighted significant dropout rates and incomplete treatment engagement, further complicating the translation of research findings into practice (Kehle-Forbes et al., 2016; Niles et al., 2018). Barriers to implementation include provider preferences and systemic limitations (Hundt et al., 2016) as well as client misconceptions about treatment processes (Larsen et al., 2025). Despite these challenges, real-world data (RWD) studies have yielded valuable insights. For example, Jacoby et al. (2022) compared military and civilian clients receiving PE or CPT in community settings and found that although both groups responded to treatment, civilians exhibited better outcomes. Such findings underscore the importance of examining EBPs in diverse clinical settings to better understand their effectiveness outside of controlled trials.

The comparative effectiveness of different PTSD treatments remains an area of active investigation. Although both PE and CPT have shown modest differences in symptom reduction within VA settings (Maguen et al., 2023), highly powered clinical trials have failed to identify meaningful differences in efficacy between the two (Schnurr

et al., 2022; Sippel et al., 2023). Real-world studies, such as those by Maguen et al. (2023), have found that veterans who complete PE or CPT experience better outcomes than matched controls, though the magnitude of improvement is smaller than in clinical trials. These findings may not generalize to veterans seeking care outside the VA, as only 61% of veterans who served following the September 11, 2001, terrorist attacks (9/11) with probable PTSD receive VA mental health care, and less than half of these individuals use the VA exclusively (Elbogen et al., 2013). Similarly, EMDR has shown promise in some studies, but evidence for its effectiveness in combat-related PTSD remains equivocal, with some studies limited by small sample sizes and limited comparisons against other first-line treatments (McLay et al., 2016; Verstrael et al., 2013).

Importantly, RWD lacks the randomization and control of clinical trials, necessitating caution in direct comparisons between treatments. Accordingly, the present study does not include statistical comparisons across treatment types, focusing instead on outcomes within each treatment group. As shown in Zaorsky et al. (2022), even minor changes in modeling decisions can lead to dramatically different conclusions when making direct comparisons based on observational data. These concerns were more explicitly described by Alemayehu and colleagues (2011), who noted that even studies that apply advanced techniques for comparative effectiveness are vulnerable to hidden confounders. In the data we utilized for this study, treatments are not randomized and may reflect differences in clinician or client preference; presentation, symptom severity, comorbidities; or logistical factors that cannot be measured or for which analyses cannot adjust but could conceivably bias the results. Thus, the results in this manuscript are presented individually for each treatment without comparison.

Variability in treatment length complicates the interpretation of real-world effectiveness studies. Although the National Center for PTSD (n.d.) indicates treatment lengths of eight to 15 sessions for PE, 12 sessions for CPT, and four to 12 sessions for EMDR, actual practice and research findings indicate considerable flexibility. For example, PE is typically delivered in eight to 15 sessions (McLean & Foa, 2011); EMDR may range from five to 15 sessions depending on trauma complexity (de Jongh et al., 2024; Navarro et al., 2018); and CPT is increasingly delivered flexibly, with clients completing treatment as early as four sessions or extending to 18 sessions based on symptom resolution (Galovski et al., 2012; Resick, LoSavio, et al., 2024). Additionally, studies have statistically estimated “median effective doses,” defined as the number of sessions at which 50% of clients achieve clinically meaningful improvement. Holder et al. (2020a, 2020b) identified a median effective dose of four sessions for PE and seven

sessions for CPT (individual format), using a 10-point change on the PTSD Checklist for *DSM-5* (PCL-5; Weathers et al., 2013) as the threshold. Furthermore, Maguen et al. (2019) found that 75% of veterans receiving PE achieved clinically meaningful change by Session 8, a milestone sometimes used to operationalize treatment “completion” in prior research. Based on this literature, we selected four sessions as a proxy for early treatment response and eight sessions as a benchmark for full or near-complete treatment, enabling standardized comparisons across EBPs while accounting for typical dose–response patterns. These thresholds allowed us to examine both early and more complete response patterns across diverse EBPs despite differences in their typical session counts. By anchoring analyses to these two clinically and empirically supported milestones, we aimed to enhance the interpretability of treatment effectiveness in real-world settings.

There is a pressing need for further research on the real-world effectiveness of EBPs, particularly in identifying patient-level predictors of treatment response. Recent studies have highlighted the importance of considering racial disparities and gender differences in EBP outcomes, with women often showing larger symptom reductions than men (Kimerling et al., 2018; Maguen et al., 2023). Military-affiliated clients tend to exhibit smaller symptom reductions than civilians, with multiple factors, such as trauma type, comorbidities, and systemic barriers to treatment, influencing outcomes (Dillon et al., 2019; Kitaj & Goff, 2024; Straud et al., 2019). The current study expands the growing body of literature by examining real-world outcomes for military-affiliated clients with PTSD, providing valuable insights for clinicians, clients, and mental health systems serving this population. Our primary hypothesis was that clients who received evidence-based treatments (PE, CPT, EMDR) would demonstrate clinically meaningful reductions in PTSD symptoms over time. By addressing gaps in the current evidence base, this research can help inform clinical decision-making and improve the delivery of effective PTSD treatments in real-world settings.

METHOD

Participants and procedure

Study overview

Participants were U.S. military veterans, active duty service members, and their adult family members who completed an episode of mental health care at a Cohen Veteran's Network (CVN) clinic between August 2021 and January

2025. Data used in the study were obtained from clients at referral, during an intake assessment, and at the conclusion of treatment, as outlined later. Only clients with a PTSD diagnosis (i.e., an *International Statistical Classification of Diseases and Related Health Problems* [10th ed.; *ICD-10*; World Health Organization, 2016] code of F43.10, F43.11, or F43.12) were retained for the current project. There were no exclusion criteria for comorbid conditions or risk factors. All clients who met the diagnostic criteria and had data for at least two PCL-5 administrations were included in the analytic sample. Data was queried from a data warehouse maintained by the CVN Network Information Systems department. The data used for this study was part of a limited data set. The current project was determined to be exempt from institutional review board (IRB) review by the Western Control Group IRB (Protocol Number CVN3).

Settings

CVN is a not-for-profit philanthropic network of community-based mental health clinics serving post-9/11 military veterans (regardless of discharge status), current service members, and their families (e.g., children, spouses/significant others, parents). Cohen Clinics are not affiliated with the VA or DoD but accept referrals from both. CVN partners with local organizations to operate Cohen Clinics based on a clearly defined clinical and operating model. CVN grants the partner license and financial resources to implement the CVN clinical model, and the partner provides the clinic with management and fiscal oversight. In this way, CVN's approach resembles a social franchise model.

Currently, there are 22 Cohen Clinics across 15 states in the continental United States, Alaska, and Hawaii, operated by 14 local partner organizations. Clinic locations are chosen based on market research related to the size, needs, and resources within the local military community. Clinicians delivering care at Cohen Clinics include licensed providers or those under supervision, representing a range of disciplines, such as social work, counseling, marriage and family therapy, and psychology. The use of evidence-based and evidence-informed practices is central to the CVN model and is facilitated through a comprehensive training program for a range of EBPs to address the presenting problems of CVN clients, including, but not limited to, PTSD (e.g., PE, CPT), couples and family concerns (e.g., emotion-focused therapy, parent–child care), and other mental health concerns (e.g., cognitive behavioral therapy for insomnia, collaborative assessment and management of suicidality).

Diagnostic and clinical indicators

Diagnoses for all episodes of care were retrieved from diagnostic codes listed in the EHR. These diagnoses are made during the comprehensive biopsychosocial assessment that initiates clinical care. All diagnoses are entered by the clinician for each episode of care. Regarding demographic data, due to data availability, client sex was used in the current study (collected as part of the billing process). Similarly, during the time these data were collected, race and ethnicity were collected as a single item, and, thus, the included groups (Asian, Black or African American, Hispanic/Latino, and White) represent a mixture of racial and ethnic groups. Client types in the current study include U.S. military veterans, active duty service members, and their adult family members. If a client reported more than one of these types (e.g., the client is a veteran and has a spouse who has also served), they were coded in the following order: active duty, veteran, family member.

The PCL-5 was collected at intake and during treatment. The final measure completed during the episode of care was used as the last treatment assessment. The assessment protocol requires the administration of the PCL-5 during the biopsychosocial assessment, using the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) Criterion A traumatic event identified during the assessment process. The number of treatment sessions was collected directly from the EHR. The EBP used during each session is recorded by the clinician during the documentation process. Clinicians are prompted to choose which EBP or EBPs were used from a drop-down list.

Measures

PTSD symptoms

The PCL-5 (Weathers et al., 2013) is a brief and widely used measure of PTSD symptoms mapped to the *DSM-5* criteria for the disorder. The scale contains 20 items that are scored on a Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The PCL-5 has shown excellent test-retest reliability ($r = .86$) and internal consistency (Cronbach's $\alpha = .96$) in veterans and was supported as a valid screening tool for PTSD when using a cutoff score of 31–33 (Bovin et al., 2016). In this study, only total PCL-5 scores were available; thus, indicators of item reliability are not reported.

Data analysis

Data management

Several data filters were applied for the current study. First, only adult clients with a PTSD diagnosis were included in the study. Additionally, given the data analytic plan, inclusion in the current study required that a client had completed the PCL-5 at least twice to assess symptom change, and each client's first and last scores only were retained for the analysis. The last scores were taken from the final session in which the measure was completed, which may not have been the last treatment session. Regarding treatment type, the lists of treatments provided during each session were converted to three count variables, one for each of the EBPs (CPT, PE, and EMDR). For clients who received a PTSD diagnosis but were not treated with one of the three EBPs, the total number of treatment sessions was used in all analyses but was not broken down by treatment type given the wide number of treatment options and patterns. Finally, a PCL-5 change score was created for each client by subtracting the discharge score from the intake score. Thus, scores with a positive value indicate a score decrease on this measure (i.e., a reduction in symptom severity).

Analytic plan

Statistical analyses were performed using R (Version 4.2.2). The primary aim of the analysis was to assess the effectiveness of different EBPs, as well as other treatments (e.g., cognitive behavioral therapy, acceptance and commitment therapy, emotion-focused therapy), in treating clients with PTSD symptoms. Key analyses focused on treatment engagement, symptom change, and demographic influences on treatment outcomes.

First, descriptive methods were used to examine the number of clients who initiated each of the three EBPs and the number and percentage of clients who continued treatment through each subsequent session (up to eight or more) for each treatment group. Next, pre-final assessment change and effect sizes (Cohen's d) were calculated for each treatment group at two levels: clients who completed at least four sessions and those who completed at least eight sessions of the treatment. As previously described, these cutoffs were selected based on prior research identifying four sessions as a common early response point and eight sessions as a benchmark for typical treatment completion, allowing for standardized

TABLE 1 Percentage of clients who completed each session, by treatment

Treatment	Number of sessions (%)							
	1	2	3	4	5	6	7	≥ 8
PE	100.0	87.5	82.0	72.5	66.0	54.5	46.0	40.0
CPT	100.0	89.8	80.3	71.4	63.0	53.7	46.9	42.4
EMDR	100.0	85.4	72.9	59.9	51.8	41.9	35.0	27.3

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

comparisons of effectiveness across EBPs with differing recommended lengths. Additionally, as noted, due to a lack of case control, these outcomes were not compared between treatments. Next, for each treatment group, the percentage of clients who achieved clinically significant change (i.e., an 18-point PTSD symptom score reduction on the PCL-5; Marx et al., 2022) was calculated for participants who completed at least four sessions; we then repeated the change and cutoff analyses for clients who were above the screening threshold (PCL-5 score greater than 32) at intake. Finally, we examined the role of various demographic factors in the change scores of clients who received at least four sessions of each EBP. For the current study, we examined sex and client type. Given the overlap between client type and sex, we also examined outcomes for client type broken out by sex.

RESULTS

Descriptive statistics were computed for client initiation and engagement across each treatment group. In total, 2,717 clients met the inclusion criteria for the current study (i.e., having a PTSD diagnosis and at least two PCL-5 scores). The total number of clients who completed each treatment and the percentage who completed each session are displayed in Table 1. For PE, 200 clients began treatment, with 145 (72.5%) completing four or more sessions and 80 clients (40.0%) completing eight or more sessions. In contrast, 873 clients began CPT treatment, with 623 (71.4%) completing at least four sessions and 370 (42.4%) completing eight or more sessions. Finally, EMDR had 554 clients begin treatment, with 332 (59.9%) completing four or more sessions and 151 (27.3%) completing 8 or more sessions. In terms of overall treatment length, clients who received at least one session of PE completed an average of 6.77 sessions of PE (range: 1–25) and 3.95 sessions of non-PE treatment during their episode of care; CPT clients averaged 7.11 sessions of CPT (range: 1–25) and 3.41 sessions of non-CPT treatment; and EMDR clients averaged 5.51 sessions of EMDR treatment (range: 1–29) and 5.29 sessions of non-EMDR treatment.

TABLE 2 Mean symptom change^a, by treatment group and session count, for all participants and among those who screened positive for posttraumatic stress disorder (PTSD)

Treatment	≥ 4 sessions			≥ 8 sessions		
	ΔM	n	d	ΔM	n	d
All participants						
PE	17.4	145	0.87	19.3	80	0.95
CPT	19.3	623	0.98	24.3	370	1.23
EMDR	16.6	332	0.86	18.0	151	0.96
Other	12.6	1,014	0.71	13.5	738	0.77
Intake PCL-5 score > 32						
PE	19.7	130	1.04	23.0	69	1.24
CPT	22.0	522	1.13	27.3	308	1.48
EMDR	19.7	265	1.04	22.6	118	1.36
Other	15.3	791	0.87	16.3	572	0.92

Note: PE = prolonged exposure; CPT = cognitive processing therapy; EMDR = eye movement desensitization and reprocessing; PCL-5 = PTSD Checklist for DSM-5.

^aPTSD Checklist for DSM-5 score reduction.

For clients who completed at least four treatment sessions, PTSD symptom score change, and effect size were calculated for each treatment. As shown in Table 2, PE yielded an average symptom change of 17.4 points for clients who completed at least four sessions, with a corresponding Cohen's *d* effect size of 0.87. CPT produced an average change of 19.3 points, *d* = 0.98, and EMDR showed an average change of 16.6, *d* = 0.86. Cohen's *d* values indicated a large effect for all EBPs. For clients who completed at least eight treatment sessions, average symptom changes were higher, with PE showing a mean change of 19.3 points, *d* = 0.95, CPT showing a mean change of 24.3 points, *d* = 1.23, and EMDR showing a mean change of 18.0 points, *d* = 0.96. Other treatments for PTSD (i.e., excluding CPT, EMDR, or PE) were aggregated and assessed for comparison, demonstrating an average change of 12.6 points, *d* = 0.71, for participants who completed four or more sessions, and 13.5 points, *d* = 0.77, for those who completed eight or more sessions. Next, we examined the percentage of clients who achieved clinically significant change, defined as a PCL-5 score reduction of 18 points or more, and found that 51.9% of CPT clients met this criterion, 47.8% of EMDR clients met the criterion, and 53.1% of PE clients met the criterion. We then repeated these analyses among clients who scored above the commonly used screening cutoff score of 32 on the PCL-5 at intake. These mean change results are presented in Table 2. The clinically significant change percentages were 57.3% for CPT clients, 53.6% for EMDR clients, and 57.7% for PE clients. As expected, the changes for each treatment were higher in this subsample; however, the results overall are consistent with the full sample.

TABLE 3 Mean posttraumatic stress disorder (PTSD) symptom score change^a, by treatment group and client subgroup, for clients who completed a minimum of four treatment sessions

Variable	PE		EMDR		CPT	
	ΔM	<i>n</i>	ΔM	<i>n</i>	ΔM	<i>n</i>
Sex						
Male	15.1	86	13.3	176	17.2	327
Female	20.8	59	20.3	155	21.8	295
Client type						
Veteran	19.4	66	16.3	152	20.3	255
Active duty	10.9	54	12.8	106	16.2	248
Adult family	29.5	19	24.3	64	24.2	104
Client type and sex						
Veteran male	16.9	41	13.8	96	19.9	143
Veteran female	23.4	25	20.9	55	21.0	111
Active duty male	12.2	41	11.4	70	14.2	165
Active duty female	6.5	13	15.6	36	19.7	83
Adult family male	50.0	1	25.2	5	25.2	9
Adult family female	28.3	18	24.3	59	24.1	95

Note: PE = prolonged exposure; CPT = cognitive processing therapy; EMDR = eye movement desensitization and reprocessing.
^aPTSD Checklist for *DSM-5* score reduction.

Finally, demographic differences in symptom change were examined for clients who completed at least four sessions of each treatment. Mean changes for each treatment, stratified by sex, client type, and both sex and client type, are presented in Table 3. Generally, female clients showed more change than male clients, and family members showed more change than veterans. Both groups showed more change than active duty service members. Additional demographic details for each treatment group, including race/ethnicity, age, and sex, are provided in Supplementary Table S1.

DISCUSSION

The aim of this study was to examine treatment outcomes for three EBPs for PTSD—PE, CPT, and EMDR—in a community-based mental health setting serving military-connected clients. The findings indicate that completion rates were relatively similar across treatments, though EMDR had slightly lower retention compared to CPT and PE. Across all three EBPs, clients who completed at least four sessions experienced reductions in PTSD symptoms, with effect sizes in the large range. Symptom reductions were greater for clients who completed at least eight sessions than for those who completed fewer sessions. Other treatments beyond the three EBPs were also associated with symptom improvement, though effect sizes were lower compared to EBP treatments. When the analyses

were restricted to clients with a PCL-5 score at or above the clinical cutoff at intake, symptom reductions were larger while maintaining similar overall patterns. These results contribute to the growing body of RWD on PTSD treatment outside of VA and DoD settings, reinforcing the effectiveness of EBPs in diverse clinical environments. These findings provide insight into treatment engagement and symptom change among military-connected clients receiving PTSD treatment in community-based care.

The results reinforce that CPT, PE, and EMDR are all beneficial in real-world clinical settings where inclusion criteria are often broader and client presentations can be more complex and varied than in clinical trials (Jacoby et al., 2022; Maguen et al., 2023; McLay et al., 2016). Clinicians can confidently offer any of these evidence-based treatments to military-connected clients as primary approaches above other EBP or non-EBP treatment options, tailoring their approach to individual client needs and preferences. Although CPT and PE, both cognitive behavioral interventions, have long-established efficacy in military populations, EMDR has had less support for its role in treating trauma-related symptoms in these populations and remains unsupported for combat-related PTSD (Kitchiner et al., 2019). However, this study provides additional evidence supporting its continued use within military-connected clients. Patterns of symptom change varied by client type, with family members experiencing the largest improvements, followed by veterans, and then active duty service members. Additionally, sex differences emerged, with female clients generally experiencing greater symptom change than male clients, and these differences appeared to interact with client type. These findings align with previous research showing that civilian populations often experience larger symptom reductions than military populations (Dillon et al., 2019; Jacoby et al., 2022; Kitaj & Goff, 2024), highlighting the need for the continued exploration of factors influencing treatment response across different demographic groups.

Our findings are consistent with the strong empirical support for EBPs for PTSD, yet engagement remains a significant challenge, with many veterans failing to initiate or complete treatment (Borah et al., 2017; Kehle-Forbes et al., 2016; Maguen et al., 2019). For example, among veterans with a PTSD diagnosis receiving care at the VA in 2015, only 8.5% attended at least one session of an EBP (Sripada et al., 2018). Client-, clinician-, and clinic-level barriers have all been identified in previous work (McLean et al., 2024; Sayer et al., 2017). Clinician-related barriers can play a critical role, with hesitancy stemming from concerns about symptom exacerbation (van Minnen et al., 2010), doubts about real-world effectiveness compared to clinical trials (Hundt et al., 2016), and a lack of adequate training and confidence in delivering EBPs (Finch et al.,

2020; McLean et al., 2024). These provider factors are particularly important given evidence linking therapist effects to early dropout and adequate dose rates for PTSD treatments (Sayer et al., 2022). Moreover, organizational and clinic-level influences, such as institutional support, further impact treatment availability and uptake in military settings (Borah et al., 2017). Addressing these barriers through targeted education, ongoing clinical training, and increased emphasis on treating PTSD with EBPs is essential to improving engagement and retention (Hundt et al., 2016). CVN's commitment to EBPs and rigorous training in the delivery of EBPs may, thus, partially explain the findings of the current study. Additionally, active duty and veteran clients face unique challenges that impact treatment engagement and outcomes, including military-specific trauma exposure (e.g., combat exposure, military sexual trauma, moral injury), reintegration challenges, and concerns about how seeking PTSD treatment could affect one's military career (Straud et al., 2019; Tanielian et al., 2016).

This study has several strengths, firstly, the use of real-world data from a large and diverse clinical sample. Secondly, the inclusion of veterans, active duty service members, and family members enhances the generalizability of the findings beyond VA or military health system settings. Additionally, the study benefits from the regular assessment of clinical outcomes and weekly session tracking of EBPs, allowing for a detailed examination of treatment engagement and response in a community-based care environment. Much less is known about treatment outcomes for military family members (Mansfield et al., 2010). Given the significant symptom reductions observed in this study among family members, future research should continue to explore their unique treatment needs and experiences as an important but often overlooked subpopulation (Strong, 2018).

Several study limitations should also be noted. The nonrandomized design limits causal inferences regarding treatment effectiveness, and differences in client selection for each therapy may have influenced outcomes in unknown ways. Additionally, the study relied on diagnostic data rather than presenting problems, meaning that clients who did not receive an EBP may have had different treatment goals or clinical needs. Another limitation is the inability to assess treatment fidelity, as clinician adherence to protocols was not measured or assessed. We also did not account for provider-level factors, such as clinician experience or the degree of training with each EBP, despite evidence that these variables can impact treatment effectiveness. Finally, variability in treatment length, which we were unable to examine, as session-level dates were not extracted in the current data query; session attendance, including no-shows and cancellations; and the mix of in-

person and telehealth delivery across episodes of care may have introduced additional heterogeneity into the findings. Though our measurement-based care model enables the collection of PCL-5 scores even for clients who attend only a few treatment sessions, the availability of outcome data still varies depending on both treatment duration and the timing of measure administration, limiting our ability to systematically assess outcomes for all clients who discontinue treatment early.

Future research should explore predictors of treatment response, including demographic and clinical characteristics, to refine treatment-matching strategies. Although previous efforts to identify indicators of treatment matching have not yielded conclusive results (Schnurr et al., 2022), this may further highlight the importance of shared decision-making and client understanding of the differences between the treatments prior to initiation (Larsen et al., 2024). Further, larger samples may allow for propensity matching or other similar techniques, such as those used by Maguen and colleagues (2023). As noted, the treatment outcomes for EMDR in the current study demonstrated large effect sizes, comparable to PE and CPT, a finding that is not consistent in military populations (Kitchiner et al., 2019). More research is needed to clarify the heterogeneity of the findings within this population. Treatment fidelity is difficult to assess in effectiveness and real-world studies but may be more feasible with the emergence of AI technologies (Creed et al., 2022; Imel et al., 2019), and the inclusion of these technologies in future studies should be explored. Additionally, studies examining long-term outcomes and relapse rates following treatment completion could provide valuable insights into the persistence of treatment effects.

This study underscores the effectiveness of CPT, PE, and EMDR in reducing PTSD symptoms among military-affiliated clients receiving care in a community-based setting. Given the comparable outcomes across these EBPs, clinicians should consider their training and expertise, as well as client preferences and potential barriers to engagement, when recommending a specific treatment. Shared decision-making remains essential in facilitating treatment engagement and optimizing outcomes (Hessinger et al., 2018). Furthermore, these findings contribute to the growing recognition of community-based mental health care as a viable and effective option for military populations, expanding access to high-quality PTSD treatment beyond traditional VA and military health system settings.

AUTHOR CONTRIBUTIONS

Steven L. Lancaster: Conceptualization; Writing—original draft; Methodology; Formal analysis; Data curation. **Stephanie J. Renno:** Writing—original

draft; Writing—review and editing. **David J. Linkh:** Methodology; Supervision; Writing—review and editing; Conceptualization.

OPEN PRACTICES STATEMENT

The data that support the findings of this study are available upon request from the corresponding author at steven.lancaster@cohenveteransnetwork.org. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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