

WRITTEN EXPOSURE THERAPY: AN EMERGING LOW-DOSE, HIGH-IMPACT INTERVENTION FOR PTSD

CHP Grand Rounds September 19, 2019

Pamela L. Holens, Ph.D., C.Psych.
Department of Clinical Health Psychology
Max Rady College of Medicine

Rady Faculty of
Health Sciences



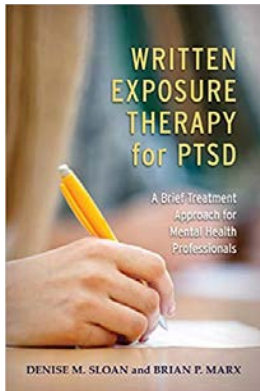
UNIVERSITY
OF MANITOBA

Conflicts of Interest

- I have no commercial, financial, or other relationships or interests that could be considered a conflict of interest with the topic of today's presentation

Acknowledgements:

1) Much of today's material comes from this book:



2) Thank you to the following clinicians at the Winnipeg OSIC for giving this treatment a trial run and sharing their experiences:

- Kaitlin Born, MSW
- Dr. Sarah Chaulk
- Dr. Natalie Mota

Objectives

- To review the current evidence-based treatments for Posttraumatic Stress Disorder including Written Exposure Therapy
- To learn about early clinical outcome data from a Written Exposure Therapy trial at the Winnipeg Operational Stress Injury Clinic
- To learn how to implement Written Exposure Therapy

Outline

- What is PTSD and Who Does it Affect?
- Overview of Evidence Based Psychotherapies for PTSD
- Critical Components of EBP's for PTSD
- Why do we Need a new PTSD treatment?
- Development and Efficacy Findings of W.E.T.
- Initial W.E.T. Findings from the Winnipeg OSI Clinic
- Steps to Implement W.E.T.

What is PTSD and Who Does it Affect?

Psychological disorder that results from exposure to a traumatic event.

- BUT:
 - Although most individuals are exposed to at least one trauma over the course of their lifespan, only a small fraction of those will actually develop PTSD (Kessler et al., 2005).
- Risk Factors:
 - Repeated exposures (Kessler et al., 2005)
 - Female (twice as likely as male; Seedat et al., 2009)
 - Military service in combat zone (approx. 25%, Fulton et al., 2015)

PTSD DSM-5 Diagnostic Criteria

- Criterion A – Exposure to Trauma
 - Exposure (direct or indirect) to actual or threatened death, serious injury, or sexual violence
- Criterion B – Intrusions (1 or more)
 - Recurrent unwanted memories, nightmares, flashbacks, physiological and/or psychological distress when confronted with reminders
- Criterion C – Avoidance (1+)
 - Avoidance of stimuli that are reminders of the event (e.g., people, places, thoughts)
- Criterion D - Negative Alterations in Cognitions & Mood (2+)
 - Persistent/exaggerated negative beliefs about self/others/the world, distorted thoughts regarding cause or consequences of the event, persistent negative emotional state, loss of interest or participation in activities, sense of detachment or estrangement from others
- Criterion E – Marked Alterations in Arousal & Reactivity (2+)
 - Irritable/angry behaviour, poor concentration, sleep difficulties, exaggerate startle response, hypervigilance
- All present 1 month +, causing sig. distress/impairment, not due to . . .

Evidence Based Psychotherapies for PTSD

2017 American Psychological Association Guidelines

- Strongly Recommended:
 - Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2016)
 - Prolonged Exposure Therapy (PE; Foa, Hembree, & Rothbaum, 2007)
 - Cognitive Behavior Therapy (Bryant et al., 2011)
 - Cognitive Therapy (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005)
- Recommended:
 - Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1989)
 - Brief Eclectic Psychotherapy (Gersons, Carlier, Lambers, & van der Kolk, 2000; Lindauer et al., 2005)
 - Narrative Exposure Therapy (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Stanmakr, Catani, Neuner, Elbert, & Holen, 2013)

Evidence Based Psychotherapies for PTSD

U.S. Department of Veteran Affairs and Department of Defense (Management of Posttraumatic Stress Disorder Work Group, 2017)

- Individual, manualized, trauma-focused therapies with a primary component of exposure and/or cognitive restructuring to facilitate the processing of traumatic experiences
 - Prolonged Exposure Therapy (PE)
 - Cognitive Processing Therapy (CPT)
 - Eye-Movement Desensitization and Reprocessing (EMDR)
 - Specific cognitive behavior therapies for PTSD (Blanchard et al., 2003; Bryant et al., 2008; Ehlers, Mayou & Bryant, 2003; Ehlers et al., 2014; Kubany et al., 2004; Watson & Marks, 1971)
 - Brief eclectic psychotherapy
 - Narrative exposure therapy
 - Written narrative exposure (includes WET)

Critical PTSD Treatment Components

Therapeutic Exposure

- Clients confront internal and external reminders of the trauma, repeatedly, until they no longer experience clinically significant distress associated with the reminder
- Extinction of conditioned fear response or inhibitory learning?
- IL = learning new responses to trauma cues that compete with and prevent old responses (Craske et al., 2014)

Cognitive Therapy/Restructuring

- Cognitions, emotions, and meanings associated with the trauma are examined
- Challenging of incorrect assumptions
- Evidence that beliefs inconsistent with the facts are corrected through repeated recounting of the trauma experience (Bryant et al, 2003; Foa et al, 2005).

Why Do We Need a New Treatment for PTSD?

- Problems with treatment engagement and utilization
 - Approximately one third of those that seek treatment drop out before completion; drop-out rates are even higher in VA and DoD settings (Hoge et al., 2014; Keller & Tuerk, 2016).
- Provider implementation issues with CPT and PE
 - Many providers do not use CPT or PE even after receiving extensive training (Borah et al., 2013; Finley et al., 2015)

Development and Efficacy Findings of W.E.T.

- Arose from the authors' interest in an expressive writing procedure studied by Pennebaker and Beall (1986) which appeared to have wide-ranging benefits
 - Writing about a stressful or traumatic experience for 20 minutes a day for 3 consecutive days
 - Numerous published studies demonstrating physical and psychological health benefits (see review by Frattaroli, 2006).
- Sloan & Marx (2004) examined the use of Pennebaker & Beall's protocol with individuals diagnosed with PTSD.
 - Significant reduction in PTSD symptoms in those assigned to the expressive writing condition vs those in control group

Development and Efficacy Findings of W.E.T.

After a variety of tweaks and trials . . .

An efficacy study comparing WET with CPT (Sloan, Marx, Lee, & Resick, 2018):

- Participants: 126 men and women diagnosed with PTSD due to any type of traumatic event
- Hypothesis: WET would prove non-inferior to CPT
 - Use of gold-standard CAPS-5 measure of PTSD
 - CAPS non-inferiority margin previously established as 10 points
- Results: WET shown to be noninferior to CPT with a mean difference of no more than 4.3 points at all posttreatment and follow-up assessments

Development and Efficacy Findings of W.E.T.

Additional Findings:

- Far less premature drop-out (6% WET, 39% CPT)
- No significant difference in measure of satisfaction with treatment
- No significant difference in treatment expectancy
- No significant difference in reports of therapeutic bond by therapists or participants (using Hatcher & Gillaspy's 2006 Working Alliance Inventory – short form)

Development and Efficacy Findings of W.E.T.

Follow-up paper by Thompson-Hollands, Marx, Lee, Resick, & Sloan in 2018:

- Treatment gains maintained long term (at 60 weeks follow-up) for both CPT and WET
- Significant reduction in depression symptoms for participants in both CPT and WET, with no significant between-group differences observed

Additional findings:

- Efficacy of WET not affected by diagnostic severity or number of past traumatic events
- WET outcomes not impacted by intelligence or education level

WET Trials at Winnipeg OSI Clinic

Session-by-session changes in PCL-5 scores

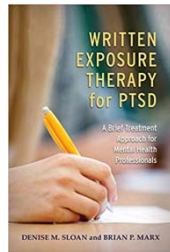
Standard clinical cut-off = 33

* Clinically significant change from baseline

	Session 1	Session 2	Session 3	Session 4	Session 5
Client 1	56	30*	32*	26*	19*
Client 2	62	34*	36*	30*	28*
Client 3	57	57	46*	38*	37*
Client 4	55	48	48	37*	36*
Client 5	61	60	54	50*	60
Client 6	56	54	51	Switched to CPT	
Client 7	41	37	33	Early completion	
Client 8	48	27*	8*	Early completion	

Steps to Implement W.E.T.

1) Buy the treatment manual:



2) Assess the client:

- Presence/absence of PTSD
 - CAPS-5 (with LEC-5)
 - PTSD module from SCID-5
 - PCL-5
- Comorbidity
 - SCID- 5
 - PHQ
 - MMPI-2
 - BDI-II

The Life Events Checklist for DSM-5

Standard Instructions:

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that:

- (a) it happened to you personally;
- (b) you witnessed it happen to someone else;
- (c) you learned about it happening to a close family member or close friend;
- (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder);
- (e) you're not sure if it fits; or
- (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

1. Natural disaster (for example, flood, hurricane, tornado, earthquake)
2. Fire or explosion
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)
4. Serious accident at work, home, or during recreational activity
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)
9. Other unwanted or uncomfortable sexual experience
10. Combat or exposure to a war-zone (in the military or as a civilian)
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)
12. Life-threatening illness or injury
13. Severe human suffering
14. Sudden violent death (for example, homicide, suicide)
15. Sudden accidental death
16. Serious injury, harm, or death you caused to someone else
17. Any other very stressful event or experience

Clinician Administered PTSD Scale-5 (CAPS-5)

Sample Question: "In the past month, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams?"

- Follow-up question to assess frequency:
 - "How often have you had these memories in the past month?"
- Follow-up questions to assess intensity:
 - "How much do these memories bother you?"
 - "Are you able to put them out of your mind and think about something else?"

PCL-5

3-digit ID # (e.g., 002-102-04): _____ Date (yyyy/mm/dd): _____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "on edge" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Steps to Implement W.E.T. (cont.)

3) Determine if WET is an appropriate therapy

- Is PTSD the primary diagnosis causing impairment?
- How much does the client remember?
- Can they select one trauma to focus on?
- Is there ongoing risk of trauma (e.g., DV)?
- Strong reservations in client?
- Is client able to write in a language the therapist understands?

4) Deliver WET and continue monitoring symptoms throughout treatment

- PCL-5
- SUDS

W.E.T. Delivery

Five sessions:

- Session 1: 60 minutes
 - *Introduction to Written Exposure Treatment* (read verbatim)
 - General info about symptoms of PTSD, how PTSD is maintained, why writing about their experience will be beneficial
 - Check in on understanding, questions
 - *General Writing Instructions and Specific Instructions for Session 1* (rv)
 - Give client 30 minutes to write
 - Brief check-in and reading of *Instructions for Concluding Session 1* (rv)
- Sessions 2 through 5: 40 minutes each
 - Provide brief feedback on previous session's writing
 - Read *Specific Instructions for Session X* (rv)
 - Give client 30 minutes to write
 - Brief check-in and reading of *Instructions for Concluding Session X* (rv)

Thank you

- Questions?
- Sample readings from the treatment manual?