Written Exposure Treatment for PTSD

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Overview

- What is PTSD?
- How was Written Exposure Therapy developed?
- How do we know WET works?
- How do you administer WET?

What is PTSD?

Trauma and Stress Related Disorders

- An inappropriately severe response to a trauma across a long period of time, resulting in functional impairment, can appear in many ways

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

Major changes from DSM-IV to -5

- Posttraumatic Stress Disorder
  - More specific about how event was experienced
  - Subjective reaction eliminated
  - Four major symptom clusters rather than three
  - Developmentally sensitive for kids ages 6 or younger

- Reactive Attachment Disorder now divided into two distinct diagnoses
  - Emotionally withdrawn/inhibited (RAD)
  - Indiscriminately social/disinhibited (Disinhibited Social Engagement Disorder)

Common Features across TSRDs

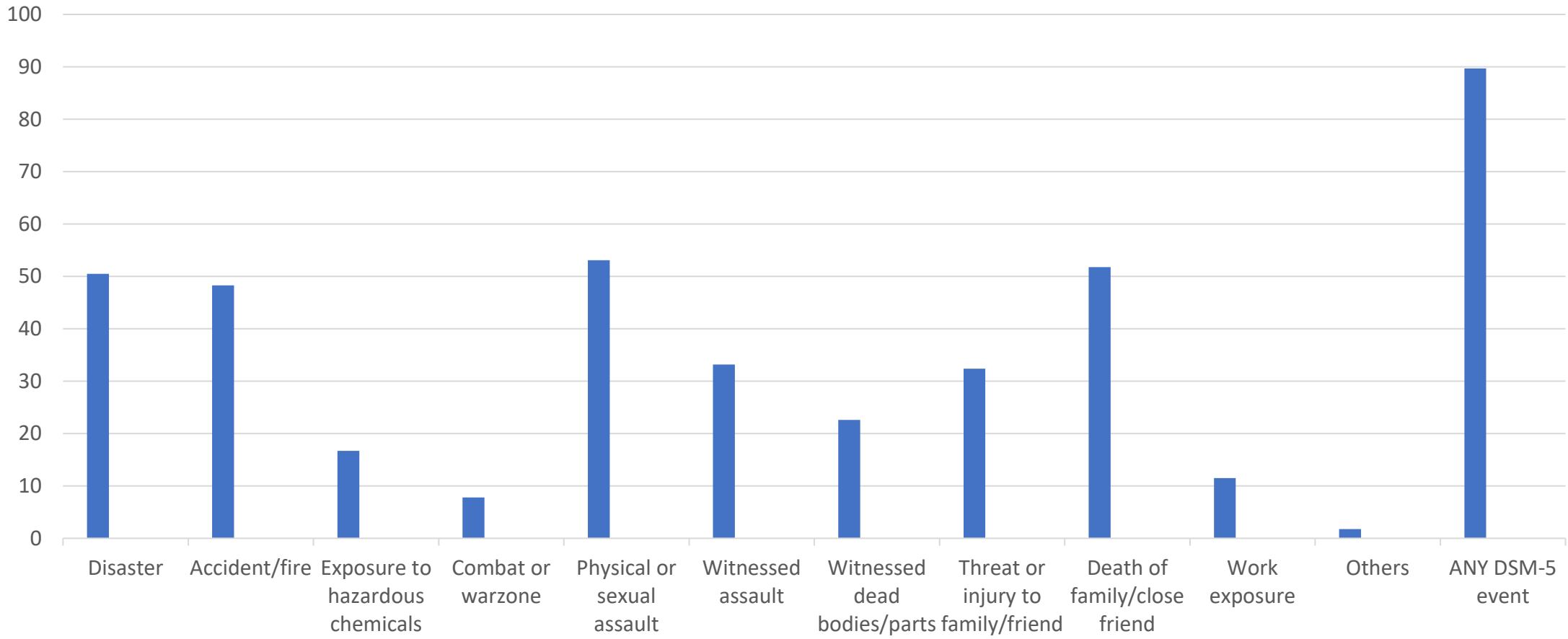
- Intrusive Memories
- Avoidance
- Negative changes in thinking and mood
- Changes in emotional reactions

PTSD in the DSM-5

- Criterion A: Exposure

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:
  - Direct exposure
  - Witnessing, in person
  - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse)
    - This does not include indirect non-professional exposure through electronic media, television, movies or pictures

Exposure to DSM-5 Traumatic Events



(Kilpatrick et al., 2013)

PTSD in the DSM-5

- Criterion B: Intrusion symptoms (at least 1)

1. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the event(s) were recurring
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the event(s)
5. Marked physiological reactions to reminders of the event(s)

PTSD in the DSM-5

- Criterion C: Persistent avoidance of stimuli associated with the trauma (at least 1)

1. Avoids internal reminders (thoughts, feelings, or physical sensations) that arouse recollections of the traumatic event(s)
2. Avoids external reminders (people, places, conversations, activities, objects, situations) that arouse recollections of the traumatic event(s).

PTSD in the DSM-5

- Criterion D: Negative alterations in cognitions and mood that are associated with the traumatic event (3 or more)

1. Inability to remember an important aspect of the traumatic event(s)
2. Persistent and exaggerated negative expectations about one's self, others, or the
3. Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)
4. Pervasive negative emotional state
5. Markedly diminished interest or participation in significant activities
6. Feeling of detachment or estrangement from others
7. Persistent inability to experience positive emotions

PTSD in the DSM-5

- Criterion E. Alterations in arousal and reactivity that are associated with the traumatic event (3 or more)

1. Irritable or aggressive behavior
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

PTSD in the DSM-5

F. Persistence of symptoms (in Criteria B, C, D and E) for more than one month

G. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

H. Not due to medication, substance or illness

DSM-5 PTSD, Preschool Subtype

- Relative to broader diagnosis for those over 6 years, several changes
- Criterions A and B – no change
- Criterions C and D – only need 1 symptom from either one
  - C cluster – no change
  - D cluster – 4 instead of 7 symptoms
    - Does not include amnesia, foreshortened future, persistent blame of self or others
- Criterion E – only 2 symptoms needed
  - Preschool does not include symptom of “reckless behavior”

PTSD Specifiers

- With dissociative symptoms
  - The individual's symptoms meet the criteria for PTSD and the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization
   - Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body
   - Feeling as though one were in a dream, feeling a sense of unreality of self or body or of time slowly moving
2. Derealization: Persistent or recurrent experiences of unreality of surroundings
   - The world around the individual is experienced as unreal, dreamlike, distant, or disordered

PTSD Specifiers

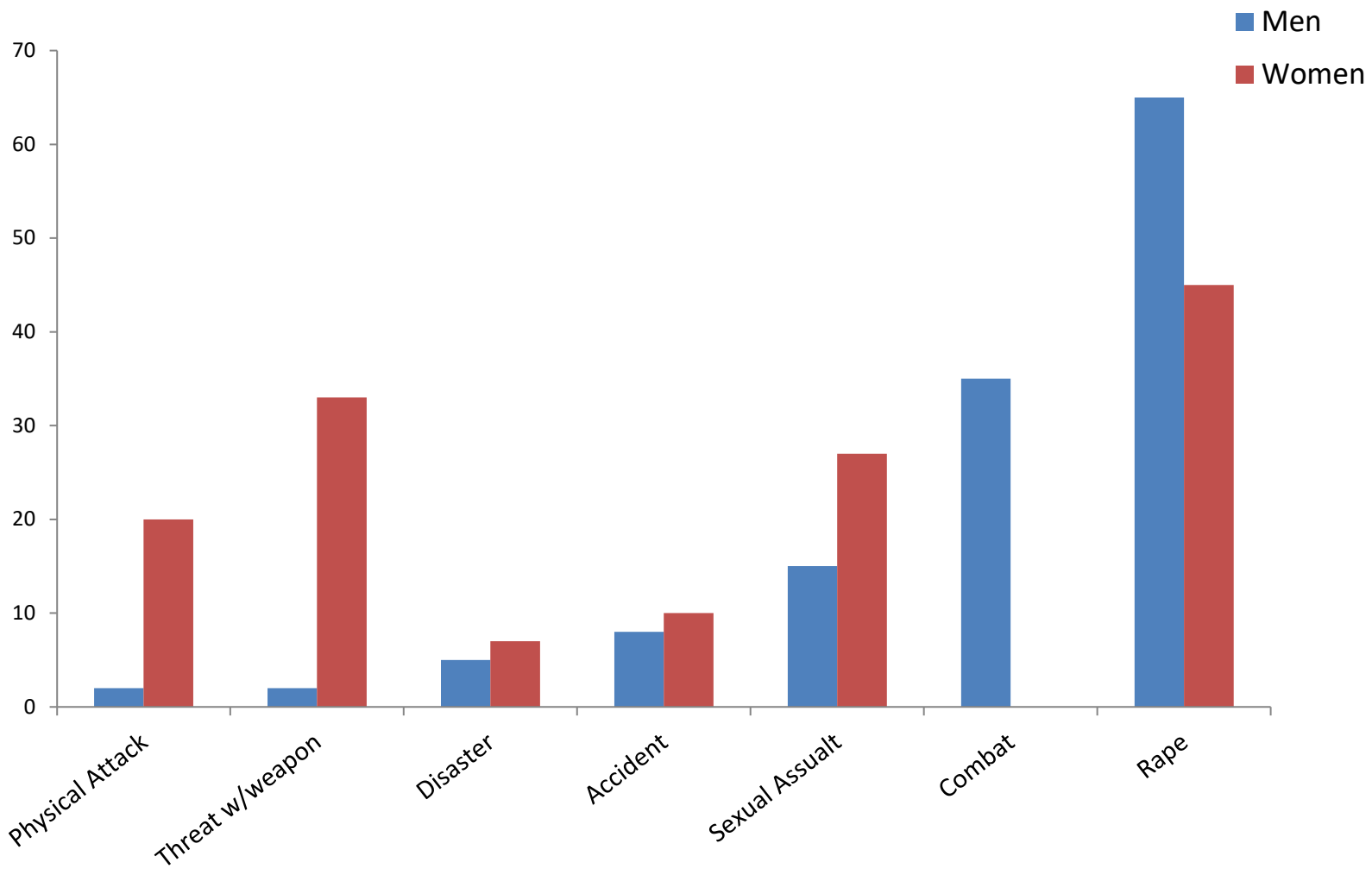
- With delayed expression
  - If the full diagnostic criteria is not met until at least 6 months after the event.

PTSD Prevalence

- Almost 90% of adults have experienced a traumatic event in their lifetime
- More than 25% experience multiple traumas
- Lifetime rate for composite PTSD is 9.4%, current rate 4.2%
- Lifetime rate for same event PTSD is 8.3%, current rate 3.8%

Trauma exposure alone does NOT mean someone will develop PTSD

PTSD as a Function of Type of Trauma

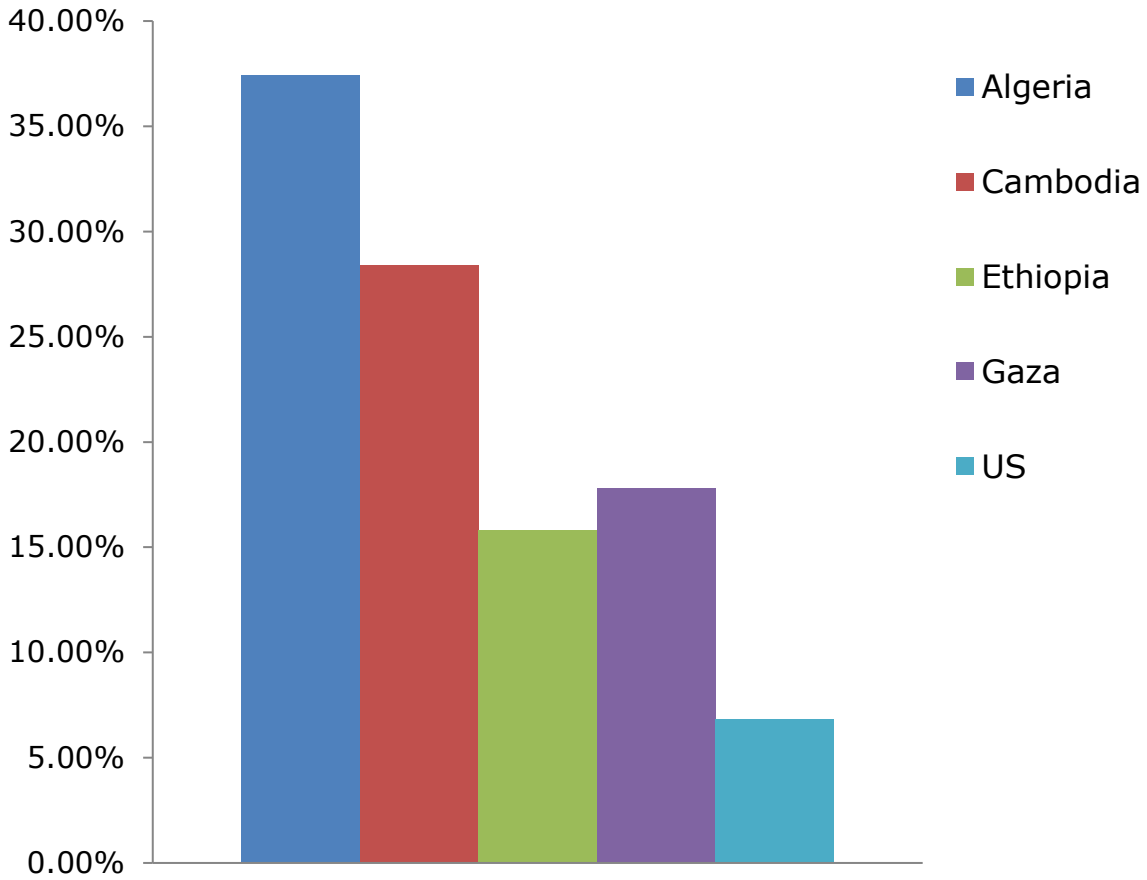


Kessler et al., 1995, 1999

Most Vulnerable Populations

- Those whose experience was especially terrifying or extreme
- Children between 5-10 years of age, especially if separated from parents
- Those without strong social support networks
- Those with a prior history of any type of traumatic experience

PTSD is Higher in Populations with More Trauma



Lifetime PTSD in four post-conflict settings and US

De Jong et al., 2001

PTSD Risk Factors

- Pretraumatic event:
  - Female gender
  - Some genetic factors (*LGLAS13* variants)
  - Childhood trauma
  - Previous psychiatric problems
  - Lower level of education
  - Lower socioeconomic status
  - Minority race

PTSD Risk Factors

- Peritraumatic event:
  - Greater perceived threat or danger, and helplessness increases risk
  - Unpredictability and uncontrollability of traumatic event also increases risk

- Posttraumatic event:
  - Lack of social support, life stress, attributions

Gender Differences

- Much higher rates in females in civilian populations
- Equal rates seen in military populations, although some controversy over this

Impact of PTSD

- Elevated risk of mood, other anxiety, and substance abuse disorders
- 6x greater chance of suicide that other mental disorders
- Greater functional impairment across domains
- Reduced quality of life
- Elevated risk of poor physical health (heart disease, Type II diabetes, GI)

Treatment

- PTSD can be successfully treated, across the lifespan

- APA's clinical practice guidelines "strongly recommends" four interventions for use, all variations or adaptations of CBT
  - Cognitive behavioral therapy
  - Cognitive processing therapy
  - Cognitive therapy
  - Prolonged exposure

- Some other treatments (meds, EMDR) have "conditional recommendation"

CBTs for PTSD

- The various forms of CBT are much more effective than medications in reducing PTSD symptoms

- Medication is more readily available and can be useful for treating comorbid problems *or* lowering symptoms enough to be able to engage in doing CBT
  - SSRIs are most well studied, outperform placebos
  - Venlafaxine (Effexor), a SNRI, slightly outperforms SSRIs

CBTs for PTSD

- General shared components are
  - Psycho-education
  - Anxiety management
  - Exposure to feared memories/situations
  - Cognitive restructuring

- Enormous amount of literature showing that exposures are the key aspect and driver of change

Why do we need a new treatment?

- Very high dropout rate (18-65% of clients)
- Approximately 1/3rd of clients are non-responders for gold-standards
- Low use of CPT and PE, even after receiving training
- High cost of delivery
  - 12-15 sessions of 50-90 minutes each

Development of WET

Written Exposure Therapy

- Drs. Denise M. Sloan and Brian P. Marx developed the WET
  - Professors, clinicians, and researchers at the National Center for PTSD and Boston University School of Medicine

- Developed over past 20 years to help address issues with
  - Client non-compliance
  - Cost and time
  - Training expense and non-fidelity

Development of WET

- Built on work by Pennebaker in 1980s and his “expressive writing procedure” that used 20 minutes on three consecutive days

- Tested with those meeting PTSD criteria by Sloan and Marx (2004)
  - Showed decreases in self-report fear, PTSD symptoms, and salivary cortisol

- Further experimental work over next 8 years guided changes
  - Add psychoeducation and treatment rationale
  - Increase dose to 5 sessions, each with 30 minute writing exposure
  - *Very* directed writing with focus on details of trauma and emotions

Issues addressed by WET

- Client dropout is only 10%
  - Starts exposure in session 1, no between session homework
- Lower training curve
  - Typically a single 6 hour workshop, followed by consultation
  - Scripted nature means very high treatment fidelity and better outcomes
- Easier implementation
  - Shorter treatment times
  - More clients treated per provider

How do we know WET works?

Major WET Outcome Studies

- Adults with motor vehicle accidents (Sloan et al., 2012)
  - 46 adults in active or waitlist control condition
  - Significant and long term reduction (6 month follow up) in PTSD symptoms
  - Only 5% of active WET participants still met PTSD at 3 month follow up, compared to 75% of control group
  - Large changes in driving behavior
  - Treatment viewed as highly satisfying and effective by participants

Major WET Outcome Studies

- Pilot study with military veterans (Sloan et al., 2013)
  - Uncontrolled trial with 7 male vets

- Well tolerated, well received
  - Only 1 dropped out
  - 5/7 no longer met PTSD criteria at 3-month follow-up
  - 6/7 had clinically significant improvement at 6 months

Major WET Outcome Studies

- Noninferiority randomized controlled trial comparison of WET to CPT (Sloan et al, 2018)
  - 126 civilian and veteran adults with PTSD diagnoses

- WET in 5 sessions was as effective as 12 sessions of CPT
  - CAPS score differences of less than 5 points
  - Much lower dropout rate (6% vs. 39%)
  - No differences in treatment satisfaction or therapeutic relationship
  - 9-month effect size of 1.08 vs. 1.25

Major WET Outcome Studies

- Long-term follow-up (Thompson-Hollands et al., 2018)
  - Tracking same participants as previous study, but up to 60 weeks post-WET
  - WET remained non-inferior to CPT
  - Both had large effect sizes (WET *d* = 1.23; CPT *d* = 1.38)
  - Both showed large decreases in depressive symptoms

- At 60 weeks post-treatment, 68% of those who received WET no longer met PTSD criteria (an increase from 48% at 36 weeks)

Major WET Outcome Studies

- First published study outside of US is from Korea (Park et al, 2021)
  - Significant reductions of PTSD diagnosis and symptom severity scores
  - At 6 weeks, 60.9% of patients no longer met PTSD criteria; at 12 weeks, it had increased to 68.2%; and 77.8% by 24 weeks
  - Depressive symptoms and functional impairment also decreased
  - Dropout rate of 8%

My Personal Experience

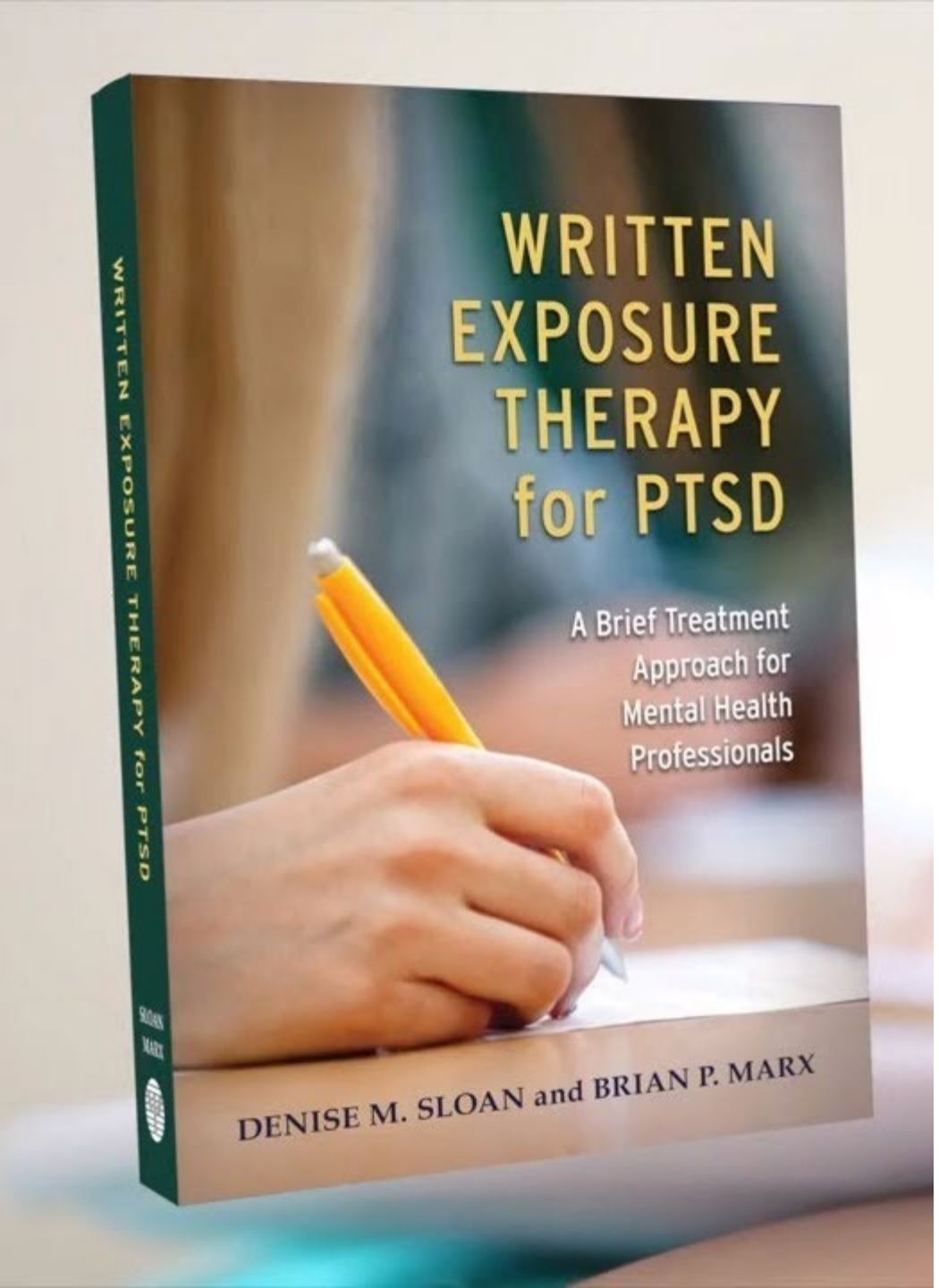
- Successful treatment of adolescents and adults for a wide variety or traumatic events since 2016
  - Kidnapping
  - Sexual assault
  - Motor vehicle accident
  - Combat trauma
  - Religious-based trauma
  - Aversive childhood experiences

- Delivered both in person and via videoconferencing telehealth

Summary

- WET is an efficacious and well tolerated treatment for PTSD
  - Appears to be *at least* as effective as CPT, with 1/3 of the treatment dose
  - Continues to show improvements across a year post-treatment
- Very low dropout rates compared to other gold-standard treatments
- Research shows equal efficacy for civilian and military populations
- High levels of reported satisfaction

How do you conduct WET?



- Full treatment manual published in 2019 from APA Books
- Various webinar trainings also available
- Post-training, consultation with an expert provider is recommended for multiple cases (usually 10)

Protocol Outline

1. Initial intake and assessment
   - Determination of appropriateness for WET

2. Session 1
   - 60 minutes
   - Psychoeducation, treatment rationale, 30-minute exposure

3. Sessions 2-5
   - 40 minutes
   - Check in, 30-minute exposure

Initial Intake & Assessment

- Determine if person meets PTSD criteria, as well as severity
  - Life Events Checklist (LCE)
  - Clinician Administered PTSD Scale (CAPS)
  - PTSD Checklist (PCL-5)

- Determine presence of comorbidity

- WET appears to work well for single or multiple traumas, for a wide age range in adults

WET Contraindications

- Trauma with no or very little memory of the event(s)
- If client is at risk of ongoing trauma
- Resistance to confronting trauma memories
- Client is unable to write in clinician's native language(s)
- If PTSD is not the primary presenting problem

Key Protocol Points

- Read the scripts *exactly* as written
  - End product of 15 years of scientific research and development
- Have clients write for the *full* 30 minutes
  - No distractions (phones, watches, music)
- Commit to at least weekly sessions (but can do do two sessions per week with equal results)

Key Protocol Points

- Selection of a specific trauma event, even in case of multiple traumas
  - Will broaden in later writing sessions

- Measuring distress levels
  - Use SUDS ratings (0-100) immediately before and after writing
  - Normal for high post-writing SUDS after first two, maybe even third writing

- Prepare client for symptom increase immediately following first session

Session 1

- Basic psychoeducation about PTSD
- Introducing treatment rationale for WET
- Discuss Subjective Units of Distress
- Conduct first writing exposure

Session 1

- During treatment rationale, tell client you are going to be reading instructions out loud
  - Makes sure they are receiving the treatment as it is intended
  - Read them **verbatim**

- Emphasize writing works best when you are fully engaged and writing the whole time
  - If you complete it before time is up, you restart it from the beginning
  - No breaks, no distractions

Session 1

- Introduce subjective units of distress scale (SUDS)
  - 0 (no anxiety) to 100 (most anxiety you have ever felt)

- Let them know SUDS should go down across time
  - Highest level will occur with the first writing session

Session 1

- Read the script prompt exactly as written, then check understanding by having them explain it back to you

- Inform them you will now let them write for 30 minutes
  - If they are at low risk of dissociation (based on prior assessment), you can leave the room and come back 30 minutes later
  - If at risk of dissociation, or if needed for other reasons, you can stay in the room, but be unobtrusive

Session 1 pre-writing script

“Over the next 5 sessions I would like you to write about your trauma. Don’t worry about your spelling or grammar. I would like you to write about the details of the trauma as you remember it now. For example, how the trauma event happened and were there other people involved. In writing about the details of the trauma, it is important to write about specifics of what happened and what you were feeling and thinking as the trauma was happening. Try to be as specific in recounting the details as possible. It is also important that you really let go and explore your very deepest emotions and thoughts about the trauma. You should also keep in mind that you have 5 sessions to write about this experience, so you don’t need to be concerned with completing your account of the trauma within today’s session. Just be sure to be as detailed about the trauma as possible and also to write about your thoughts and feelings as you remember them during (and immediately after) the trauma.”

Session 1 pre-writing script

“For your first writing session, I’d like you to write about the trauma starting at the beginning. For instance, you could begin with the moment you realized the trauma was about to happen. As you describe the trauma it is important that you provide as many specific details as you can remember. For example, you might write about what you saw (e.g., headlights of the car approaching you, person approaching you), what you heard (e.g., car horn, screeching tires, person threatening you), or what you smelled (e.g., blood, burning rubber). In addition to writing about the details of the trauma, you should also be writing about your thoughts and feelings during the trauma as you remember it now. For example, you might had the thought “I’m going to die,” “this can’t be happening,”, or “I’m going to be raped?” And, you might have had the feeling of being terrified, frozen with fear, or anger at another person involved. Remember, you don’t need to finish writing about the entire trauma in this session. Just focus on writing about the trauma with as much detail as possible and include the thoughts and feelings you experienced during and immediately after the trauma. Remember, the trauma is not actually happening again, you are simply recounting it as you look back upon it now.”

Session 1

- When writing stops, do brief check in (“How did that go?”) of less than 10 minutes

- Should be focused on experience of writing, not details of trauma
  - How it felt to do the writing
  - What was difficulty or challenging about the writing

- Conclude with second script:

Session 1 post-writing script

“You will likely have thoughts, images, feelings concerning the trauma you just wrote about during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings, whatever they might be, rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that may come up.”

Sessions 2-5

- Clinician reads what client wrote to check that they followed directions between session
- Check in about how things went between sessions
- Provide feedback about previous writing session to keep them focused and on track
- Give writing instructions, check SUDS, do exposure for 30 minutes, check SUDS, give debrief

Session 2 pre-writing script

“Today, I want you to continue to write about the trauma as you look back upon it now. If you feel that you didn’t get the chance to completely describe the trauma in the last writing session, then you can pick up where you left off. If you completed writing about the trauma event in the last session, please write about the entire trauma again. While you are describing the trauma I really want you to delve into your very deepest feelings (e.g., fear, shock, sadness, anger) and thoughts (e.g., “is this really happening,” “I’m going to die”). Also, remember to write about the details of the trauma. That is, describe the setting, people involved, what you saw, heard, and felt. Also remember that you are writing about the trauma as you look back upon it now.”

Session 2 post-writing script

“You will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings, whatever they might be, rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.”

Session 3 script

“In your writing today, I again want you to continue writing about the trauma event as you think about it today. If you have completed writing about the entire trauma event you can either write about the trauma again from the beginning or you can select a part of the trauma that is most upsetting to you and focus your writing on that specific part of the experience. In addition, I would also like you to begin to write about how the traumatic experience has changed your life. For instance, you might write about whether or not the trauma has changed the way you view your life, the meaning of life, and how you relate to other people. Throughout your writing I want you to really let go and write about your deepest thoughts and feelings.”

Session 3 post-writing script

“You will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.”

Session 4 script

“I want you to continue to write about the trauma today. As with your writing in the last session, you can select a specific part of the trauma to write about; that is, the part of the trauma that was most upsetting to you. Today, I would also like you to write about how the trauma event has changed your life. You might write about if the trauma has changed the way you view your life, the meaning of life, and how you relate to other people. Throughout the session I want you to really let go and write about your deepest thoughts and feelings.”

Session 4 post-writing script

“You will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings, whatever they might be, rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.”

Session 5 script

“Today is the last session. I want you to continue to write about your feelings and thoughts related to the traumatic event, and how you believe this event has changed your life. Remember that this is the last day of writing and so you might want to try to wrap up your writing. For example, you might write about how the traumatic experience is related to your current life and your future. As with the other writing sessions, it is important for you to delve into your deepest emotions and thoughts throughout the session.”

Session 5 post-writing action

- Readminister symptom measures to check progress
- Discuss if follow-up sessions are needed
- Plan for check-ins to monitor progress

Following Up

- Most clients will not need further treatment
- If symptoms are still present, can continue to do WET or switch to another evidence-based treatment (PE, CPT)
  - Most likely to happen if client didn't follow instructions during first several sessions of writing
- For those with multiple traumas, you can essentially restart the protocol, now focusing on the next trauma memory

Delivery via Telehealth

- Can be successful over telehealth, with some slight modifications
- Have clients leave their camera and mic on, but turn yours off
  - Allows for monitoring of potential dissociation or not writing the full time, but makes them not feel like they are being stared at
- After each session, client will need to send in a scanned copy or photo of their writing for therapist to see, with feedback provided at the start of the next session

Summary

- WET is an effective, fast, easy to administer treatment for PTSD
- Research shows comparable outcomes to much longer, more intensive gold-standard treatment
- *Very important* to follow protocol and not deviate for optimal outcomes

Questions?

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