Written Exposure Therapy: A Brief PTSD Treatment

Denise M. Sloan, Ph.D. & Brian P. Marx, Ph.D.

VA National Center for PTSD, VA Boston Healthcare System, Boston University School of Medicine
Learning Objectives

- Describe how Written Exposure Therapy was Developed
- Understand the evidence base for Written Exposure Therapy
- Identify the core elements of Written Exposure Therapy
Why Do We Need a New Treatment For PTSD?

• Problems with treatment engagement and utilization
  • About one third of those that seek treatment drop out before completion, with higher rates in VA and DoD settings (Hoge et al., 2014; Keller & Tuerk, 2016)

• Provider implementation of CPT and PE
  • Many providers not using PE and CPT after receiving extensive training (Borah et al., 2013; Finley et al., 2015)
Identifying Alternative Treatments

1. Should include exposure to trauma memory (Institute of Medicine, 2008)

2. Should be efficient for both providers and clients
Confronting a Traumatic Event: Toward an Understanding of Inhibition and Disease

James W. Pennebaker and Sandra Klihr Beall
Southern Methodist University

According to previous work, failure to confide in others about traumatic events is associated with increased incidence of stress-related disease. The present study served as a preliminary investigation to learn if writing about traumatic events would influence long-term measures of health as well as short-term indicators of physiological arousal and reports of negative moods. In addition, we examined the aspects of writing about traumatic events (i.e., cognitive, affective, or both) that are most related to physiological and self-report variables. Forty-six healthy undergraduates wrote about either personally traumatic life events or trivial topics on 4 consecutive days. In addition to health center records, physiological measures and self-reported moods and physical symptoms were collected throughout the experiment. Overall, writing about both the emotions and facts surrounding a traumatic event was associated with relatively higher blood pressure and negative moods following the essays, but fewer health center visits in the 6 months following the experiment. Although the findings and underlying theory should be considered preliminary, they bear directly on issues surrounding catharsis, self-disclosure, and a general theory of psychosomatics based on behavioral inhibition.
Written Disclosure Procedure

• Would this work with people who had Criterion A stressor and at least moderate PTSD symptom severity

• Two key elements lead to successful exposure based treatment outcome
  • Initial activation of pathological fear response
  • Extinction of fear responding across treatment sessions (Foa & Kozak, 1986)
Is Written Disclosure Efficacious for Individuals with Trauma Exposure and at Least Moderate PTSD Severity?
Is Written Disclosure Beneficial for Trauma Survivors?

Extinction of Fear Response

Salivary Cortisol Reactivity

30 vs. 60 Min of Imaginal Exposure

How Many Treatment Sessions Are Needed?

- 60 min = 6.8 sessions
- 30 min = 7.2 sessions

Are 60-Minute Prolonged Exposure Sessions With 20-Minute Imaginal Exposure to Traumatic Memories Sufficient to Successfully Treat PTSD? A Randomized Noninferiority Clinical Trial

Nitsa Nacasch
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Jonathan D. Huppert
The Hebrew University of Jerusalem

Yi-Jen Su
National Taiwan University

Yogev Kivity
The Hebrew University of Jerusalem

Yula Dinshtein
Tel-Aviv Brull Community Mental Health Center

Rebecca Yeh
Edna B. Foa
University of Pennsylvania
Does Writing About the Same Trauma Memory Matter?
Writing About the Same or Different Traumatic Events

Extinction of Fear Response

Sloan et al. (2005). *Journal of Consulting and Clinical Psychology*
What about people who meet diagnostic criteria for PTSD?
Written Disclosure as an Intervention for PTSD

Sloan, Marx, & Greenberg (2011). *Behaviour Research and Therapy*
Heart Rate Change as a Function of Condition and Session

Sloan, Marx, & Greenberg (2011). *Behaviour Research and Therapy*
Self-Reported Valence as a Function of Condition and Session

Sloan, Marx, & Greenberg (2011). *Behaviour Research and Therapy*
Study Insights

- Participants had diagnostic interview before writing sessions
- Lack of treatment rationale
- Need some feedback after writing session
Altering Written Disclosure to be Beneficial for PTSD

- Added psychoeducation of PTSD
- Added treatment rationale
- Increase dose to 5, 30 minute sessions
- Directed writing about a specific trauma event, with focus on detail and emotion felt at the time of the event
Writing Instructions

• Instructions to write about event “as you look back upon event.”
  • Distancing perspective informed by social psychology literature
Facilitating Adaptive Emotional Analysis: Distinguishing Distanced-Analysis of Depressive Experiences From Immersed-Analysis and Distraction

Ethan Kross
Columbia University

Ozlem Ayduk
University of California, Berkeley

Two studies examined the psychological processes that facilitate adaptive emotional analysis. In Study 1, participants recalled a depression experience and then analyzed their feelings from either a self-immersed (immersed-analysis) or self-distanced (distanced-analysis) perspective. Participants in the distanced-analysis group focused less on recounting their experience and more on reconstruing it, which in turn led to lower levels of depressed affect. Furthermore, comparisons to a distraction group indicated that distanced-analysis was as effective as distraction in reducing depressed affect relative to the immersed-analysis group. Study 2 replicated these findings and showed that both 1 day and 7 days after the feelings. Analyzing why one is feeling a certain way may provide people with important insights that meaningfully influence how they behave, think, and feel in the future (e.g., Carver & Scheier, 1998; Duval & Wicklund, 1972; Martin & Tesser, 1996). Understanding the reasons underlying one’s feelings is particularly relevant for coping with negative experiences. Substantial evidence suggests that it is helpful to process and analyze negative feelings to reduce the frequency and intensity of emotional disturbances (e.g., Greenberg, 2002; Pennebaker & Graybeal, 2001; Rachman, 1980; Stanton, Kirk, Cameron, & Danoff-Burg, 2000). For example, a key objective of cognitive therapy is to help clients understand
Stepping Back to Move Forward: Expressive Writing Promotes Self-Distancing

Jiyoung Park  
University of Massachusetts, Amherst

Özlem Ayduk  
University of California, Berkeley

Ethan Kross  
University of Michigan, Ann Arbor

Prior research indicates that expressive writing enhances well-being by leading people to construct meaningful narratives that explain distressing life experiences. But how does expressive writing facilitate meaning-making? We addressed this issue in 2 longitudinal studies by examining whether and how expressive writing promotes self-distancing, a process that facilitates meaning-making. At baseline in both studies, participants reflected on a distressing life experience. In Study 1 participants were then randomly assigned to write about their distressing experience or a non-emotional topic for 15 min on 3 consecutive days; in Study 2 participants were randomly assigned to write or think about their distressing experience or write about a non-emotional topic for the same amount of time. One day following the intervention, expressive writing participants in both studies self-distanced more when they reflected over their distressing experience compared with participants in the other conditions, which in turn led them to experience less emotional reactivity 1 month (Studies 1 and 2) and 6 months (Study 2) after the intervention. Analyses using data from both studies indicated that expressive writing reduced physical symptoms indirectly through its effects on self-distancing and emotional reactivity [that is, expressive writing group (vs. comparison groups) → greater self-distancing → less emotional reactivity → fewer physical symptoms]. Finally, linguistic analyses using essays from both studies indicated that increased use of causation words and decreased use of negative emotion words and first-person singular pronouns predicted increases in self-distancing over time. These findings demonstrate that expressive writing promotes self-distancing and illustrate how it does so.
Procedure

• Instructions read to participant and then they are left alone to complete writing assignment

• Therapist re-enters room at end of writing and checks in with participant about how writing went
  • “how did the writing go for you?”
  • Not a processing session
Procedure

- Therapist reads narrative before next session and provides feedback, if needed
Is WET a New Treatment?

• Because changes are substantial, protocol now referred to as Written Exposure Therapy

• Not a new treatment but rather a treatment (imaginal exposure) approach that is repackaged to be efficient and tolerable
Efficacy of WET
Randomization
$N = 46$

- **Treatment** ($n = 22$)
  - 2 (8%) dropped from treatment

- **Waitlist** ($n = 24$)
  - Follow-up
    - 5 week: $n = 24$
    - 3 month: $n = 24$
    - 6 month: $n = 22$

Sloan, Marx et al. (2012). *Behaviour Research and Therapy*
Efficacy of Written Exposure Treatment for PTSD

Mean CAPS

Baseline Post 3-Month 6-Month

Sloan, Marx et al. (2012). *Behaviour Research and Therapy*
## Percentage of PTSD Diagnosis by Condition

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Wait List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post</strong></td>
<td>21 (88%)</td>
</tr>
<tr>
<td>Post 2 month</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>3 month</td>
<td>15 (75%)</td>
</tr>
<tr>
<td>3 month</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>6 month</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>6 month</td>
<td>-----</td>
</tr>
</tbody>
</table>
Mechanisms of Change in Written Exposure Treatment of Posttraumatic Stress Disorder

Blair E. Wisco
National Center for PTSD, VA Boston Healthcare System and Boston University School of Medicine
University of North Carolina at Greensboro

Aaron S. Baker
National Center for PTSD, VA Boston Healthcare System and Boston University School of Medicine
University of La Verne

Denise M. Sloan
National Center for PTSD, VA Boston Healthcare System and Boston University School of Medicine

Although the effectiveness of exposure therapy for PTSD is recognized, treatment mechanisms are not well understood. Emotional processing theory (EPT) posits that fear reduction within and between sessions creates new learning, but evidence is limited by self-report assessments and inclusion of treatment placebos. There is clear evidence that exposure treatment for post-traumatic stress disorder (PTSD) is effective (Institute of Medicine, 2008). What is not well understood is the mechanism of change in exposure treatment for PTSD. The most commonly cited theory for why exposure works is emotional processing...
WET vs. Other PTSD Treatments

CAPS Total Score

Assessment Period

Pre  Post  3-Month  6+ Month

CPT
WET
PE
MA
Is WET Non-Inferior to a First Line PTSD Treatment?
Study Goals

- Hypo 1: WET will be non-inferior to CPT in terms of PTSD outcome
- Hypo 2: WET will have significantly lower dropout rate than CPT

Exploratory aim: Examine moderators of PTSD treatment outcome

Sloan, Marx, Lee, & Resick (2018). JAMA Psychiatry
Inclusion/Exclusion Criteria

• Inclusion
  • Current diagnosis of PTSD
  • Not currently engaged in psychotherapy for PTSD
  • If taking medication, stable dose for at least 1 month

• Exclusion
  • Diagnosis of substance dependence
  • Diagnosis of psychosis
  • High suicidal risk
Non-Inferiority Design

• Randomly assigning 126 adults diagnosed with PTSD to either WET or Cognitive Processing Therapy (CPT)

• Assessments at 6-, 12-, 24-, 36-, and 60 weeks post first treatment session

• Primary treatment outcome is PTSD symptom severity (CAPS-5)
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>#/Mean</th>
<th>%/(SD)</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>66</td>
<td>52.4</td>
</tr>
<tr>
<td>Women</td>
<td>60</td>
<td>47.6</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 43.86</td>
<td></td>
<td>(14.58)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>33</td>
<td>26.2</td>
</tr>
<tr>
<td>Some college</td>
<td>33</td>
<td>39.7</td>
</tr>
<tr>
<td>College Degree</td>
<td>50</td>
<td>20.6</td>
</tr>
<tr>
<td>Graduate/Professional Degree</td>
<td>17</td>
<td>53.2</td>
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<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
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<tr>
<td>Non-Hispanic</td>
<td>114</td>
<td>90.5</td>
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<tr>
<td>Hispanic</td>
<td>12</td>
<td>9.5</td>
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<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>69</td>
<td>54.8</td>
</tr>
<tr>
<td>Black</td>
<td>43</td>
<td>34.1</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>9.5</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>1.6</td>
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<tr>
<td><strong>Annual household income (%≤$25,000)</strong></td>
<td>67</td>
<td>53.2</td>
</tr>
<tr>
<td><strong>Index event</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult non-sexual assault</td>
<td>24</td>
<td>19.1</td>
</tr>
<tr>
<td>Child sexual assault</td>
<td>20</td>
<td>15.9</td>
</tr>
<tr>
<td>Adult sexual assault</td>
<td>19</td>
<td>15.1</td>
</tr>
<tr>
<td>Combat-related</td>
<td>16</td>
<td>12.7</td>
</tr>
<tr>
<td>Sudden death (non-combat) or violence to a friend or loved one</td>
<td>13</td>
<td>10.3</td>
</tr>
<tr>
<td>Other (e.g., other accident)</td>
<td>13</td>
<td>10.3</td>
</tr>
<tr>
<td>Child non-sexual assault</td>
<td>11</td>
<td>8.7</td>
</tr>
<tr>
<td>Motor vehicle accident</td>
<td>10</td>
<td>7.9</td>
</tr>
</tbody>
</table>
192 Signed consent form and completed initial assessment

144 Eligible

48 Excluded

18 Excluded

126 Randomized

63 WET
  59 Completed treatment
  4 Dropped out

6 week: n = 62
12 week: n = 60
24 week: n = 57
36 week: n = 55

63 Analyzed

Allocation

63 CPT
  37 Completed treatment
  25 Dropped out
  1 withdrawn

6 week: n = 54
12 week: n = 52
24 week: n = 49
36 week: n = 51

Analysis

63 Analyzed
Therapy Process Measures

- Tx Expectancy
- Tx Satisfaction

Comparison between WET and CPT
### Reasons for Dropout

<table>
<thead>
<tr>
<th>Reason</th>
<th>WET ($n = 4$)</th>
<th>CPT ($n = 25$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too distressing</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Too busy for tx</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Medical problems</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Not motivated for tx</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Feeling better</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>tx not meeting their needs</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Non-Inferiority Findings

Sloan, Marx, Lee, & Resick (2018). *JAMA Psychiatry*
Effect Sizes ($d$) for Treatment Outcome

<table>
<thead>
<tr>
<th></th>
<th>Within-Condition Effect Sizes</th>
<th>Between-Condition Effect Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline to 6-weeks</td>
<td>Baseline to 12-weeks</td>
</tr>
<tr>
<td>CAPS-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WET</td>
<td>.51</td>
<td>.82</td>
</tr>
<tr>
<td>CPT</td>
<td>.38</td>
<td>1.13</td>
</tr>
</tbody>
</table>
Moderators of Outcome

• “What treatment, by whom, is most effective for this individual, with that specific problem, and under what set of circumstances?”

• Paul, 1967
## Descriptives

<table>
<thead>
<tr>
<th></th>
<th>WET</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Age</td>
<td>44.89 (14.81)</td>
<td>42.83 (14.40)</td>
</tr>
<tr>
<td>Estimated FSIQ</td>
<td>101.37 (11.95)</td>
<td>104.70 (10.61)</td>
</tr>
<tr>
<td>CAPS-5 Total Score</td>
<td>36.10 (8.91)</td>
<td>37.10 (10.07)</td>
</tr>
<tr>
<td>(baseline)</td>
<td>36.10 (8.91)</td>
<td>37.10 (10.07)</td>
</tr>
<tr>
<td>Symptom Duration (months)</td>
<td>201.40 (193.54)</td>
<td>187.35 (166.88)</td>
</tr>
<tr>
<td># Comorbid Disorders</td>
<td>1.31 (1.40)</td>
<td>1.00 (1.34)</td>
</tr>
<tr>
<td>(SCID)</td>
<td>1.31 (1.40)</td>
<td>1.00 (1.34)</td>
</tr>
<tr>
<td>BDI-II Total Score</td>
<td>21.11</td>
<td>22.87</td>
</tr>
<tr>
<td>(baseline)</td>
<td>21.11</td>
<td>22.87</td>
</tr>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Female</td>
<td>30 (47.62%)</td>
<td>30 (47.62%)</td>
</tr>
<tr>
<td>≥ Some College</td>
<td>42 (66.67%)</td>
<td>49 (77.78%)</td>
</tr>
<tr>
<td>MDD (SCID)</td>
<td>18 (28.57%)</td>
<td>19 (30.16%)</td>
</tr>
</tbody>
</table>
## Moderators

<table>
<thead>
<tr>
<th>Moderator</th>
<th>Full Sample</th>
<th>WET</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>B</td>
</tr>
<tr>
<td>Sex</td>
<td>-0.99</td>
<td>0.79</td>
<td>-0.52</td>
</tr>
<tr>
<td>Age</td>
<td>0.05</td>
<td>0.03</td>
<td>0.04</td>
</tr>
<tr>
<td>Education</td>
<td>-0.43*</td>
<td>0.22</td>
<td>-0.07</td>
</tr>
<tr>
<td>PTSD severity at baseline (CAPS-5)</td>
<td>-0.07</td>
<td>0.04</td>
<td>-0.09</td>
</tr>
<tr>
<td>Symptom duration (CAPS-5)</td>
<td>0.01</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>FSIQ (WTAR)</td>
<td>-0.06</td>
<td>0.03</td>
<td>0.02</td>
</tr>
<tr>
<td># Comorbid Disorders (SCID)</td>
<td>-0.36</td>
<td>0.31</td>
<td>-0.51</td>
</tr>
<tr>
<td>Depression (BDI-II)</td>
<td>-0.02</td>
<td>0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>MDD (SCID)</td>
<td>-0.66</td>
<td>0.86</td>
<td>0.15</td>
</tr>
<tr>
<td>Peritraumatic Dissociation (PDEQ)</td>
<td>0.03</td>
<td>0.04</td>
<td>-0.01</td>
</tr>
</tbody>
</table>
Review

Psychotherapy for Military-Related PTSD
A Review of Randomized Clinical Trials

Maria M. Steenkamp, PhD; Brett T. Litz, PhD; Charles W. Hoge, MD; Charles R. Marmar, MD

IMPORTANCE Posttraumatic stress disorder (PTSD) is a disabling psychiatric disorder common among military personnel and veterans. First-line psychotherapies most often recommended for PTSD consist mainly of “trauma-focused” psychotherapies that involve focusing on details of the trauma or associated cognitive and emotional effects.

OBJECTIVE To examine the effectiveness of psychotherapies for PTSD in military and veteran populations.

EVIDENCE REVIEW PubMed, PsycINFO, and PILOTS were searched for randomized clinical trials (RCTs) of individual and group psychotherapies for PTSD in military personnel and veterans, published from January 1980 to March 1, 2015. We also searched reference lists of articles, selected reviews, and meta-analyses. Of 891 publications initially identified, 36 were included.

FINDINGS Two trauma-focused therapies, cognitive processing therapy (CPT) and prolonged exposure, have been the most frequently studied psychotherapies for military-related PTSD. Five RCTs of CPT (that included 481 patients) and 4 RCTs of prolonged exposure (that included 402 patients) met inclusion criteria. Focusing on intent-to-treat outcomes, within-group posttreatment effect sizes for CPT and prolonged exposure were large (Cohen d range, 0.78-1.10). CPT and prolonged exposure also outperformed waitlist and treatment-as-usual control conditions. Forty-nine percent to 70% of participants receiving CPT and prolonged exposure attained clinically meaningful symptom improvement (defined as a 10- to 12-point decrease in interviewer-assessed or self-reported symptoms). However, mean posttreatment scores for CPT and prolonged exposure remained at or above clinical criteria for PTSD, and approximately two-thirds of patients receiving CPT or prolonged exposure retained their PTSD diagnosis after treatment (range, 60%-72%). CPT and prolonged exposure were marginally superior compared with non-trauma-focused psychotherapy comparison conditions.
BRIEF REPORT

Written Exposure Therapy for Veterans Diagnosed with PTSD: A Pilot Study

Denise M. Sloan,¹,²,³ Daniel J. Lee,²,³ Scott D. Litwack,² Alice T. Sawyer,²,³ and Brian P. Marx¹,²,³

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²VA Boston Healthcare System, Boston, Massachusetts, USA
³Psychiatry Department, Boston University School of Medicine, Boston, Massachusetts, USA

There is a need to identify alternative treatment options for posttraumatic stress disorder (PTSD), especially among veterans where PTSD tends to be more difficult to treat and dropout rates are especially high. One potential alternative is written exposure therapy, a brief intervention shown to treat PTSD among civilians effectively. This study investigated the feasibility and tolerability of written exposure therapy in an uncontrolled trial with a sample of 7 male veterans diagnosed with PTSD. Findings indicated that written exposure therapy was well tolerated and well received. Only 1 of the 7 veterans dropped out of treatment, no adverse events occurred during the course of treatment, and veterans provided high treatment satisfaction ratings. Clinically significant improvements in PTSD symptom severity were observed for 4 veterans at posttreatment and 6 veterans at the 3-month follow up. Moreover, 5 of the 7 veterans no longer met diagnostic criteria for PTSD 3 months following treatment. These findings suggest that written exposure therapy holds promise as a brief, well tolerated treatment for veterans with PTSD. However, additional research using randomized controlled trial methodology is needed to confirm its efficacy.
### CAPS Total for Each Veteran at Each Assessment

<table>
<thead>
<tr>
<th></th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>3 month f/u</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran 1</td>
<td>90</td>
<td>80</td>
<td>63*</td>
</tr>
<tr>
<td>Veteran 2</td>
<td>49</td>
<td>27*</td>
<td>13*</td>
</tr>
<tr>
<td>Veteran 3 – dropped tx</td>
<td>63</td>
<td>44</td>
<td>15*</td>
</tr>
<tr>
<td>Veteran 4</td>
<td>45</td>
<td>23*</td>
<td>16*</td>
</tr>
<tr>
<td>Veteran 5</td>
<td>45</td>
<td>44</td>
<td>25*</td>
</tr>
<tr>
<td>Veteran 6</td>
<td>88</td>
<td>53*</td>
<td>69</td>
</tr>
<tr>
<td>Veteran 7</td>
<td>64</td>
<td>23*</td>
<td>20*</td>
</tr>
</tbody>
</table>

Note: 5 of the 7 Veterans no longer met PTSD diagnostic criteria at the 3 month f/u assessment. *clinically significant reduction
Active Duty Service Members

- Randomly assigning 150 men and women service members PTSD to either WET or CPT, cognitive only (CPT-C)
- Assessments at 10-, 20-, 30-weeks post first treatment session
- Primary treatment outcome is PTSD symptom severity (CAPS-5)
Future Directions

• Implementation studies
  • Pilot data collected at VA PTSD specialty clinic
• Comparative effectiveness study conducted with veterans diagnosed with PTSD
• Effectiveness study conducted in primary care setting
Funding support

- NIMH - R01MH095737
- NIMH - R34MH077658
- NIMH - R03MH068223
- DoD - W81XWH-15-1-0391
Please enter your questions in the Q&A box and be sure to include your email address.

The lines are muted to avoid background noise.
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To obtain continuing education credit please return to www.vha.train.org after the lecture.

TRAIN help desk: VHATRAIN@va.gov
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS

(866) 948-7880 or PTSDconsult@va.gov

CEU Process for users of VHA TRAIN (non-VA)

Registration → Attendance → Evaluation → Certificate

Register in TRAIN.

Listen to the lecture.

Return to TRAIN for evaluation.

Follow the directions to print certificate.

TRAIN help desk: VHATRAIN@va.gov
CEU Process (for VA employees)

1. **Registration**
   - Register in TMS.
   - (See link under “Web Links” on right here if you have not registered.)

2. **Attendance**
   - Join via TMS and listen to the lecture.

3. **Post**
   - Posttest is no longer required for this lecture.
   - **NO POSTTEST**

4. **Evaluation**
   - Return to TMS and complete evaluation found in your “To-Do List.”

5. **Certificate**
   - Print certificate from the “Completed Work” section of TMS.

Contact Information:
(866) 948-7880 or PTSDconsult@va.gov
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS

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www.ptsd.va.gov/consult
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### UPCOMING TOPICS

**SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 21</td>
<td>PTSD Treatment Via Telehealth</td>
<td>Leslie Morland, PhD</td>
</tr>
<tr>
<td>March 21</td>
<td>What We Know about PTSD and Opioids</td>
<td>Elizabeth Oliva, PhD &amp; Jodie Trafton, PhD</td>
</tr>
<tr>
<td>April 18</td>
<td>Balancing Clinical Flexibility while Preserving Efficacy in Delivering EBPs for PTSD</td>
<td>Tara Galovski, PhD</td>
</tr>
<tr>
<td>May 16</td>
<td>Brief Prolonged Exposure for PTSD</td>
<td>Sheila Rauch, PhD</td>
</tr>
<tr>
<td>June 20</td>
<td>What the Latest Research Tells Us about Treating PTSD Nightmares</td>
<td>Philip Gehrman, PhD</td>
</tr>
<tr>
<td>July 18</td>
<td>The Continuum of Care for PTSD Treatment</td>
<td>Kelly Phipps Maieritsch, PhD</td>
</tr>
<tr>
<td>August 15</td>
<td>An Evidence-Informed Approach to Helping Clients after Disaster or Mass Violence: Skills for Psychological Recovery</td>
<td>Patricia Watson, PhD</td>
</tr>
<tr>
<td>September 19</td>
<td>PTSD and Women's Mental Health</td>
<td>Suzanne Pineles, PhD</td>
</tr>
</tbody>
</table>

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