Written Exposure Therapy: A Brief PTSD Treatment

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ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS

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

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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)

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Identifying Alternative Treatments

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

2. Should be efficient for both providers and clients

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Journal of Abnormal Psychology
1986, Vol. 95, No. 3, 274–281

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0021-843X/86/$00.75

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.

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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)

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Is Written Disclosure Efficacious for Individuals with Trauma Exposure and at Least Moderate PTSD Severity?

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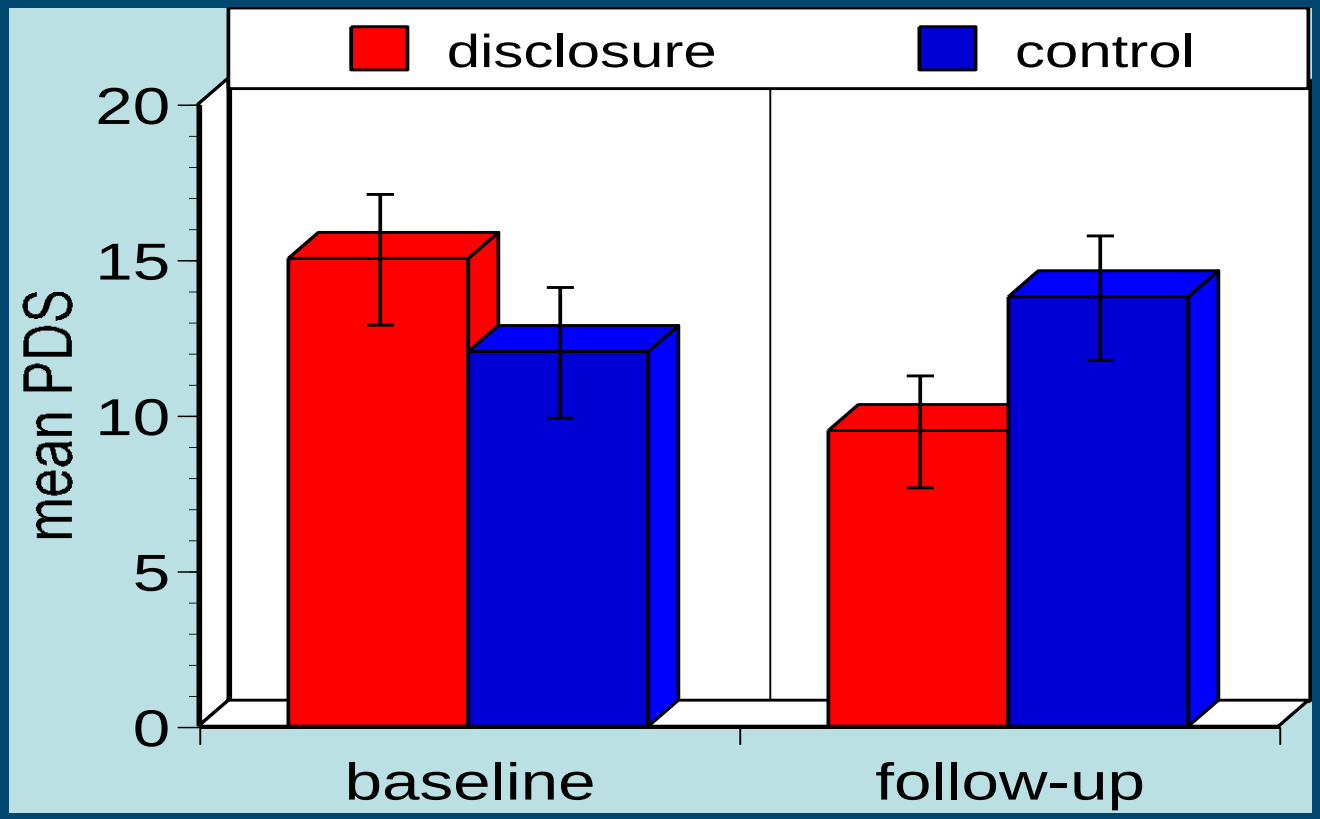
Is Written Disclosure Beneficial for Trauma Survivors?



Sloan & Marx (2004). *Journal of Consulting and Clinical Psychology*

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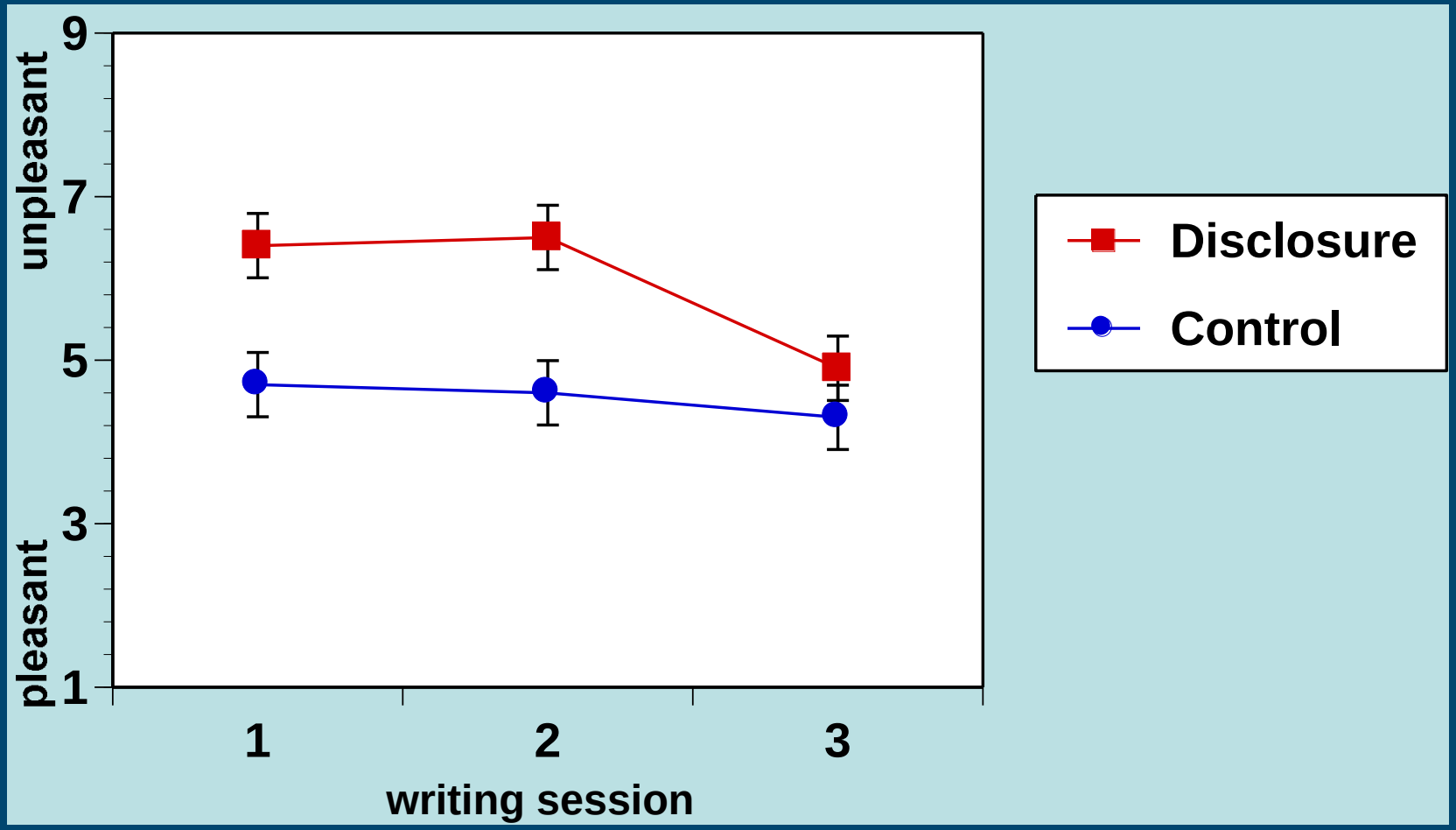
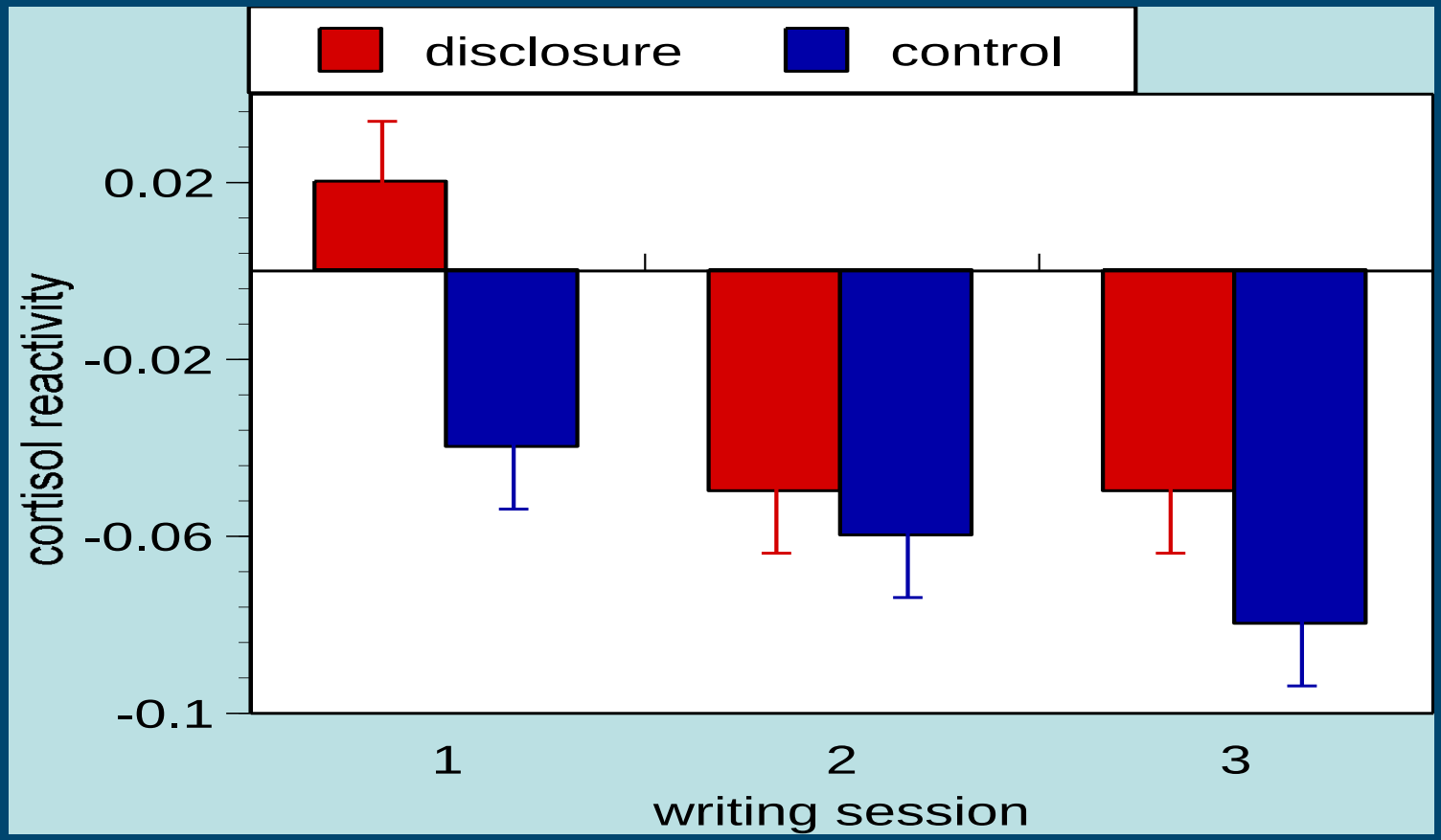
Extinction of Fear Response



Sloan & Marx (2004). *Journal of Consulting and Clinical Psychology*

Salivary Cortisol Reactivity



Sloan & Marx (2004). *Journal of Consulting and Clinical Psychology*

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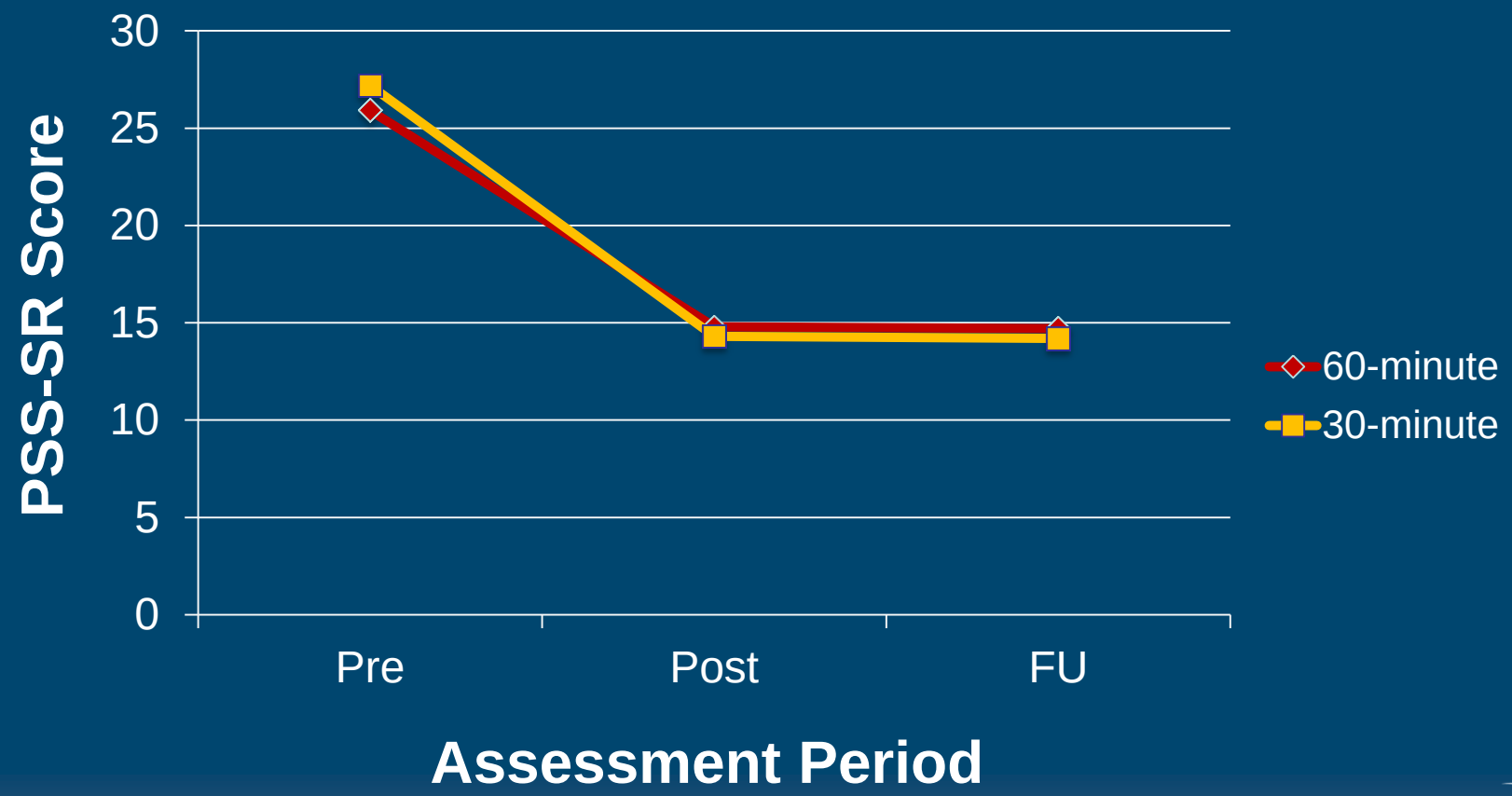
30 vs. 60 Min of Imaginal Exposure



van Minnen & Foa (2006). *Journal of Traumatic Stress*

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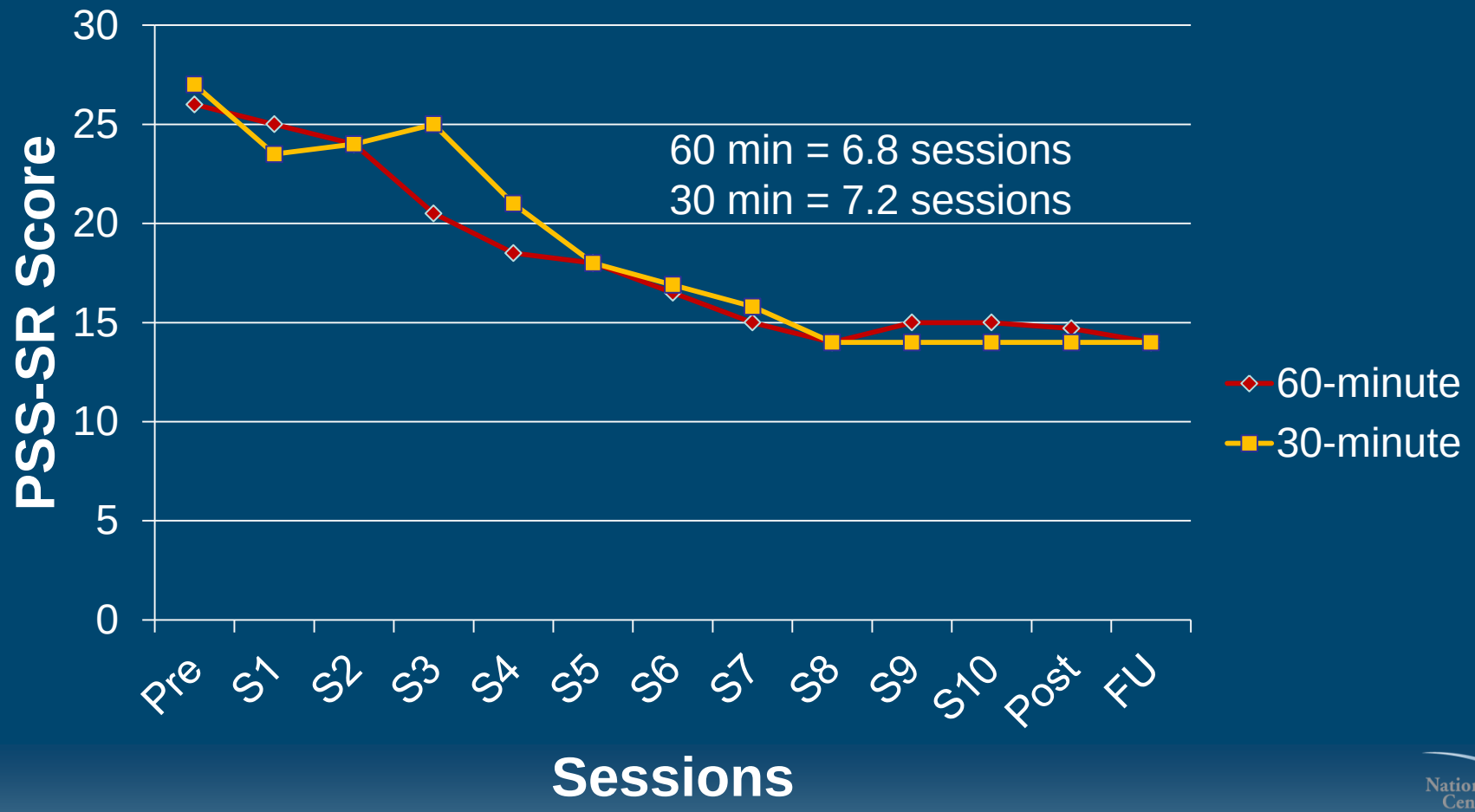
How Many Treatment Sessions Are Needed?



van Minnen & Foa (2006). *Journal of Traumatic Stress*

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Behavior Therapy 46 (2015) 328–341

Behavior Therapy

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

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Does Writing About the Same Trauma Memory Matter?

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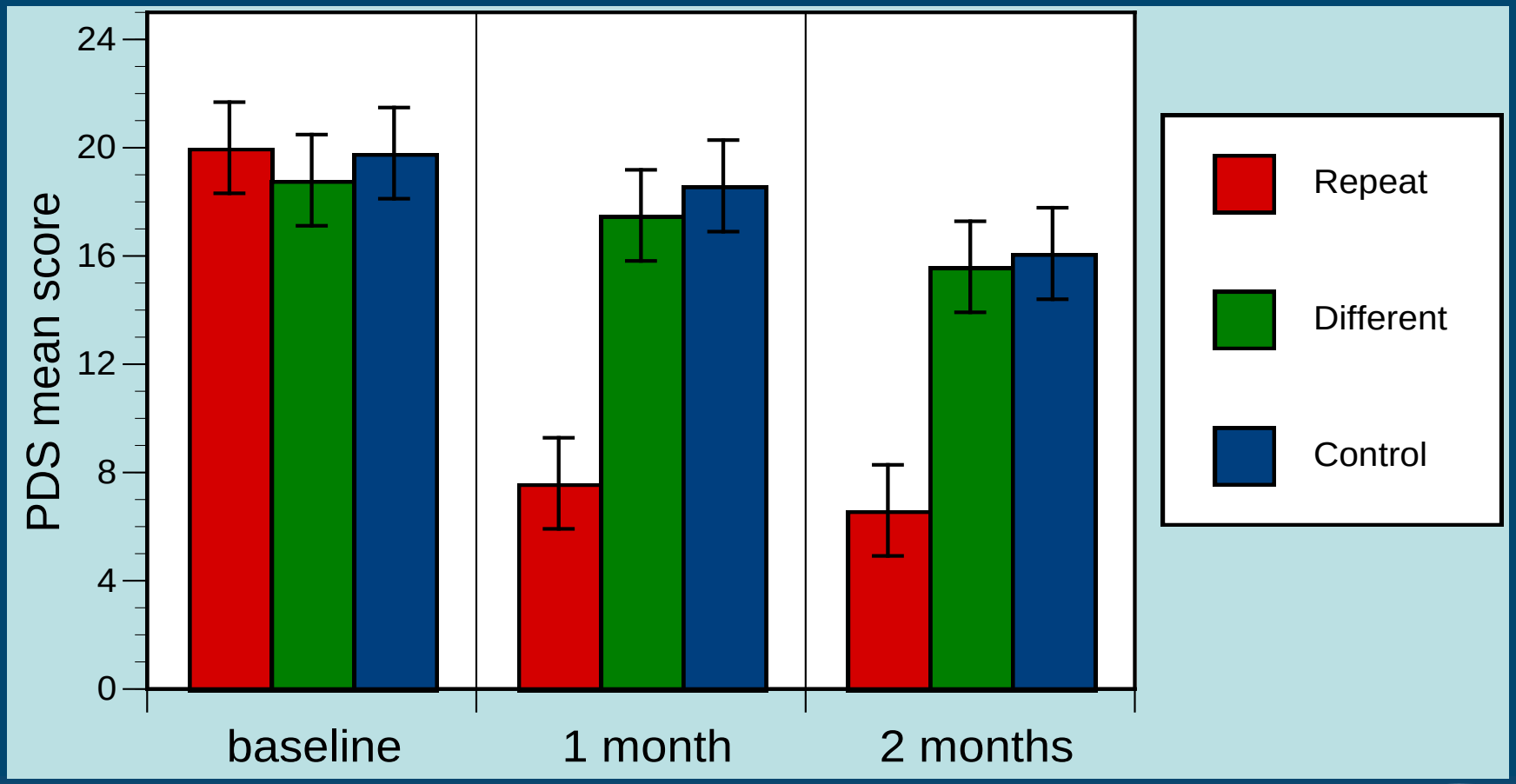
Writing About the Same or Different Traumatic Events



Sloan, Marx, & Epstein (2005). *Journal of Consulting and Clinical Psychology*

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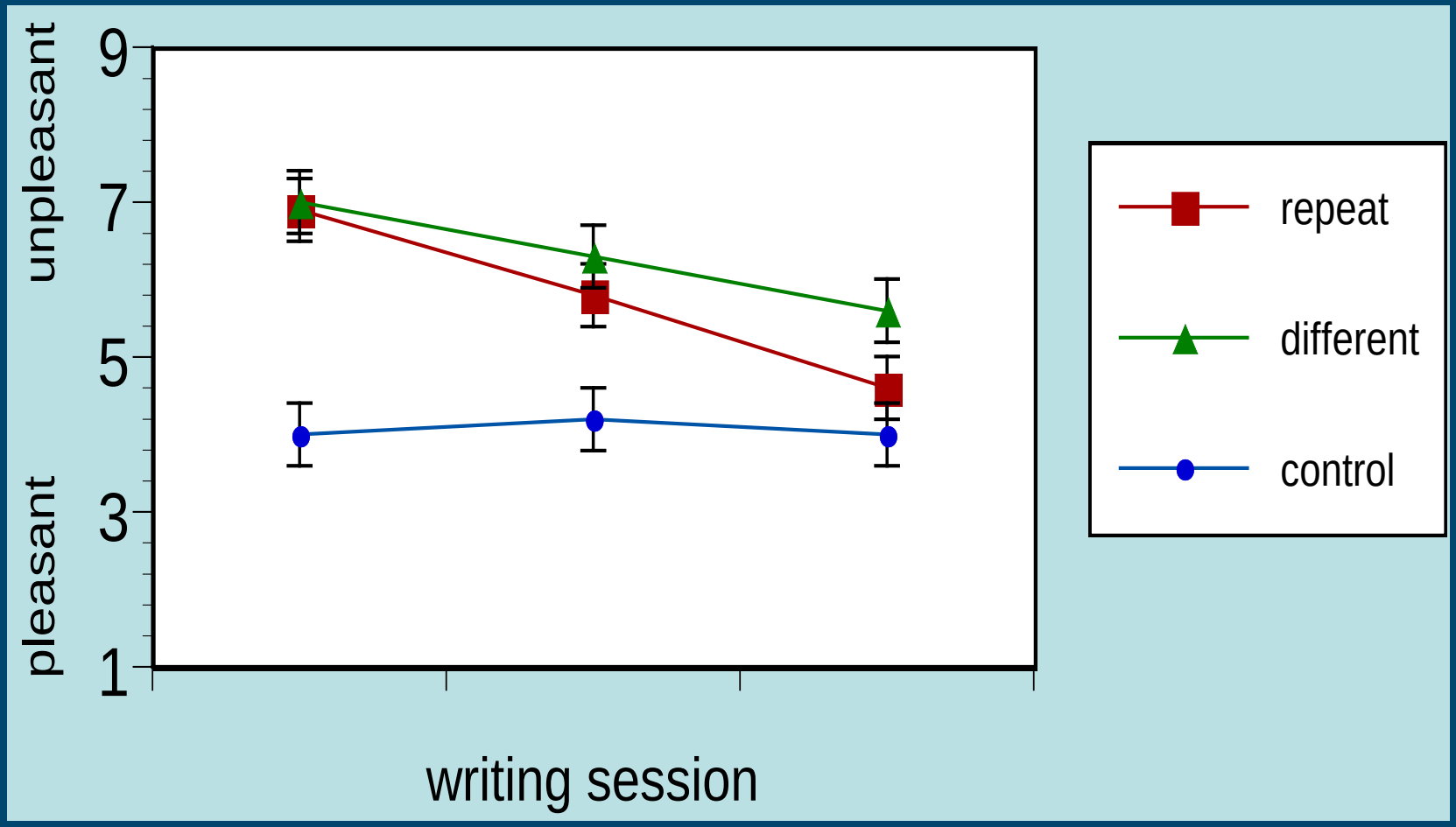
Extinction of Fear Response



Sloan et al. (2005). *Journal of Consulting and Clinical Psychology*

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What about people who meet diagnostic criteria for PTSD?

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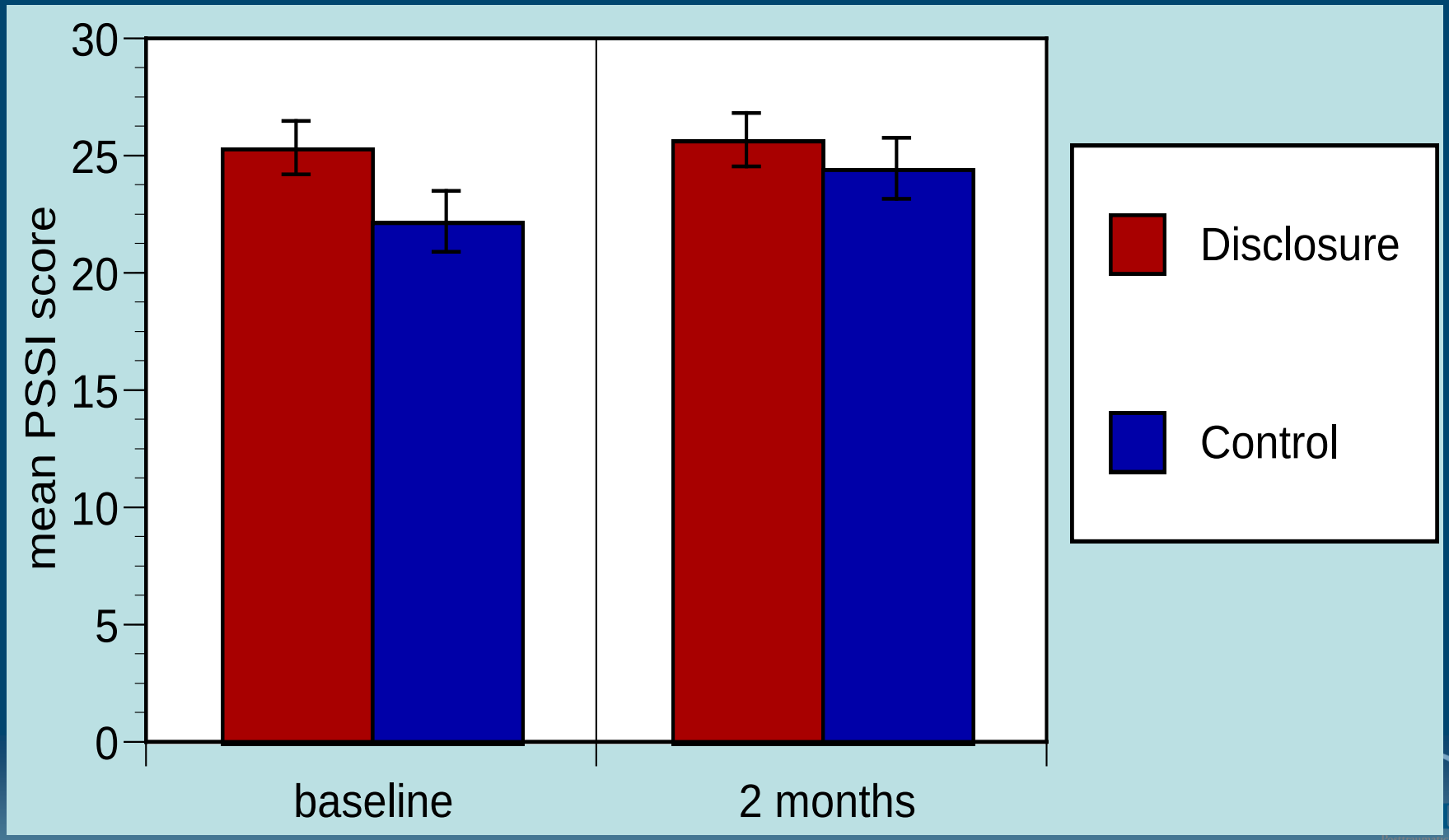
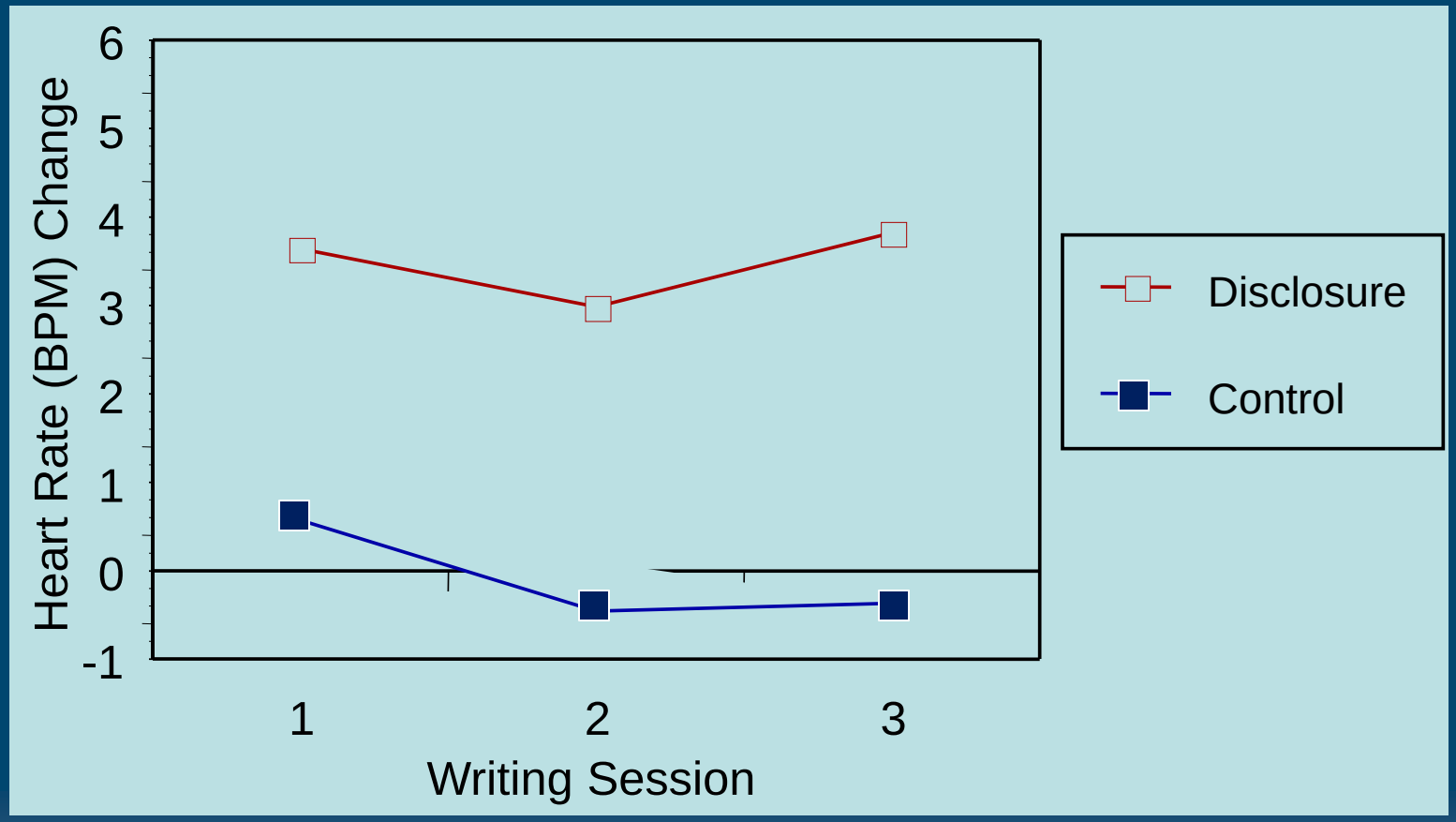
Written Disclosure as an Intervention for PTSD



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*

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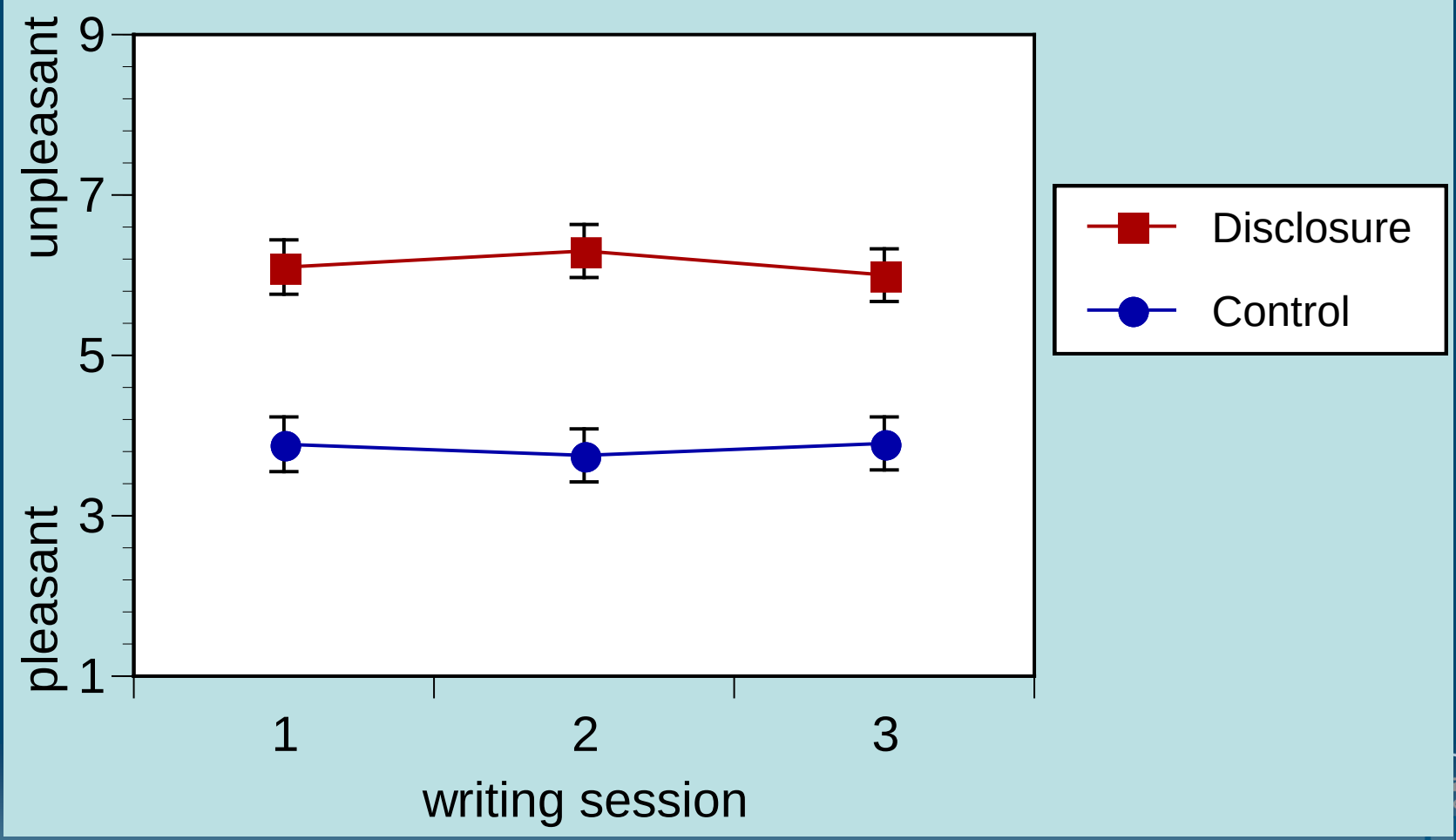
Self-Reported Valence as a Function of Condition and Session



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

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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

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Writing Instructions

- Instructions to write about event “as you look back upon event.”
  - Distancing perspective informed by social psychology literature

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Facilitating Adaptive Emotional Analysis: Distinguishing Distanced-Analysis of Depressive Experiences From Immersed-Analysis and Distraction

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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 & Scheir, 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 under-

Emotion

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Stepping Back to Move Forward: Expressive Writing Promotes Self-Distancing

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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.

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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

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Procedure

- Therapist reads narrative before next session and provides feedback, if needed

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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

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Efficacy of WET

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Randomization
N = 46

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

Waitlist
(*n* = 24)

<u>Follow-up</u>
5 week: *n* = 22
3 month: *n* = 22
6 month: *n* =22

<u>Follow-up</u>
5 week: *n* = 24
3 month: *n* =24

Sloan, Marx et al. (2012). *Behaviour Research and Therapy*

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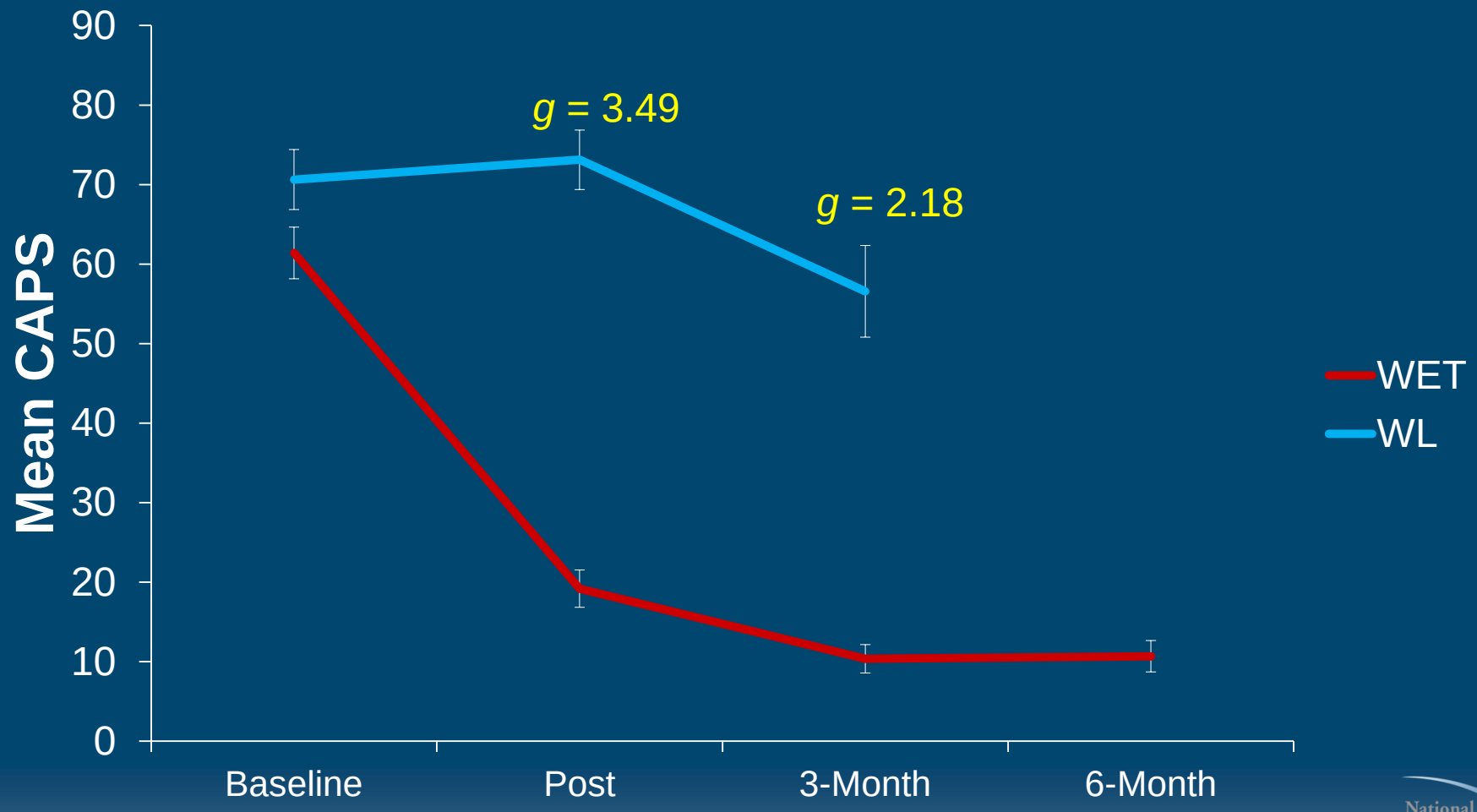
Efficacy of Written Exposure Treatment for PTSD



Sloan, Marx et al. (2012). *Behaviour Research and Therapy*

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Percentage of PTSD Diagnosis by Condition

Treatment *n* (%)	Wait List *n* (%)
Post 2 (9%)	21 (88%)
3 month 1 (5%)	15 (75%)
6 month 0 (0%)	-----

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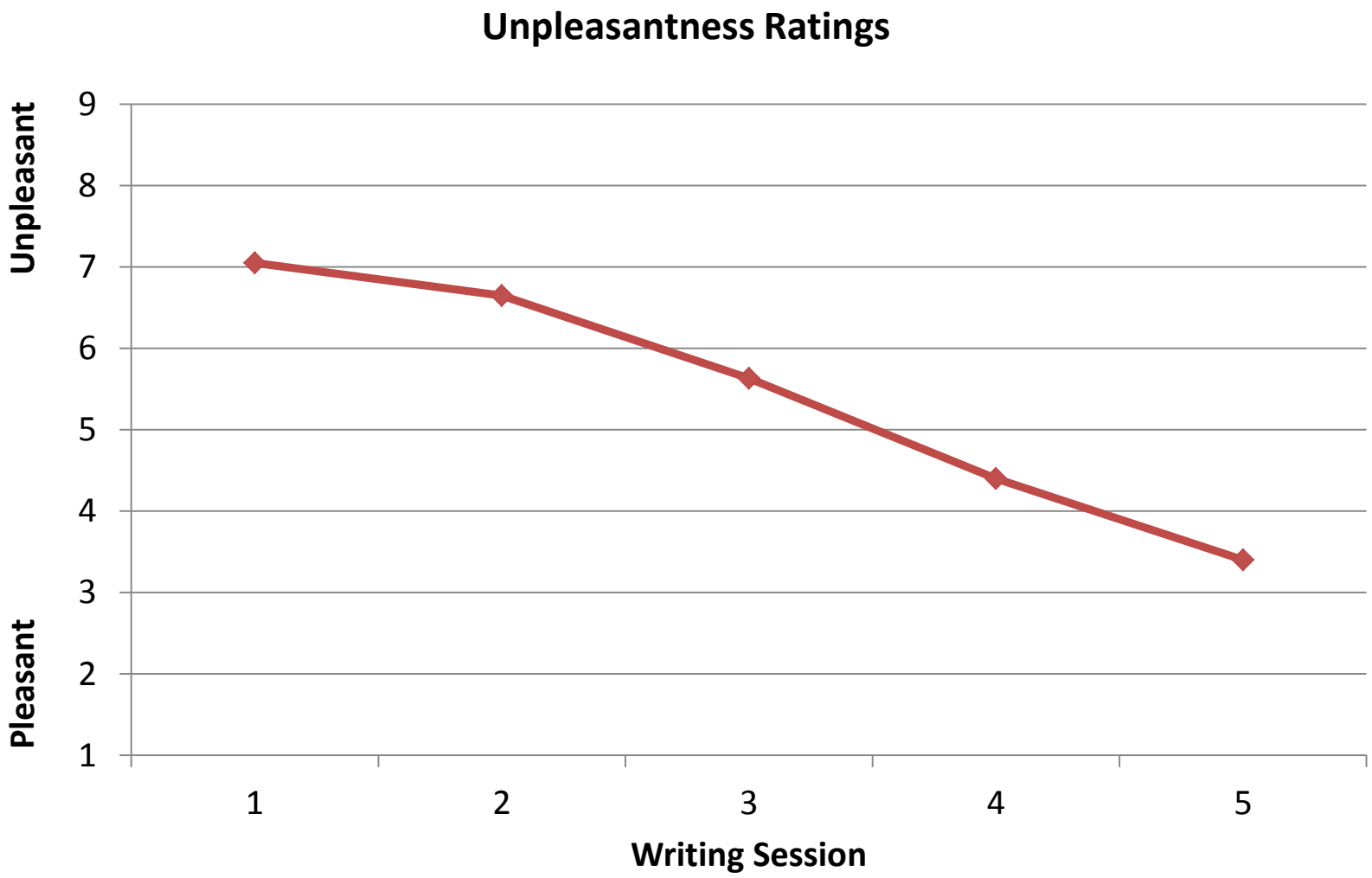

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Behavior Therapy 47 (2016) 66–74

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Mechanisms of Change in Written Exposure Treatment of Posttraumatic Stress Disorder

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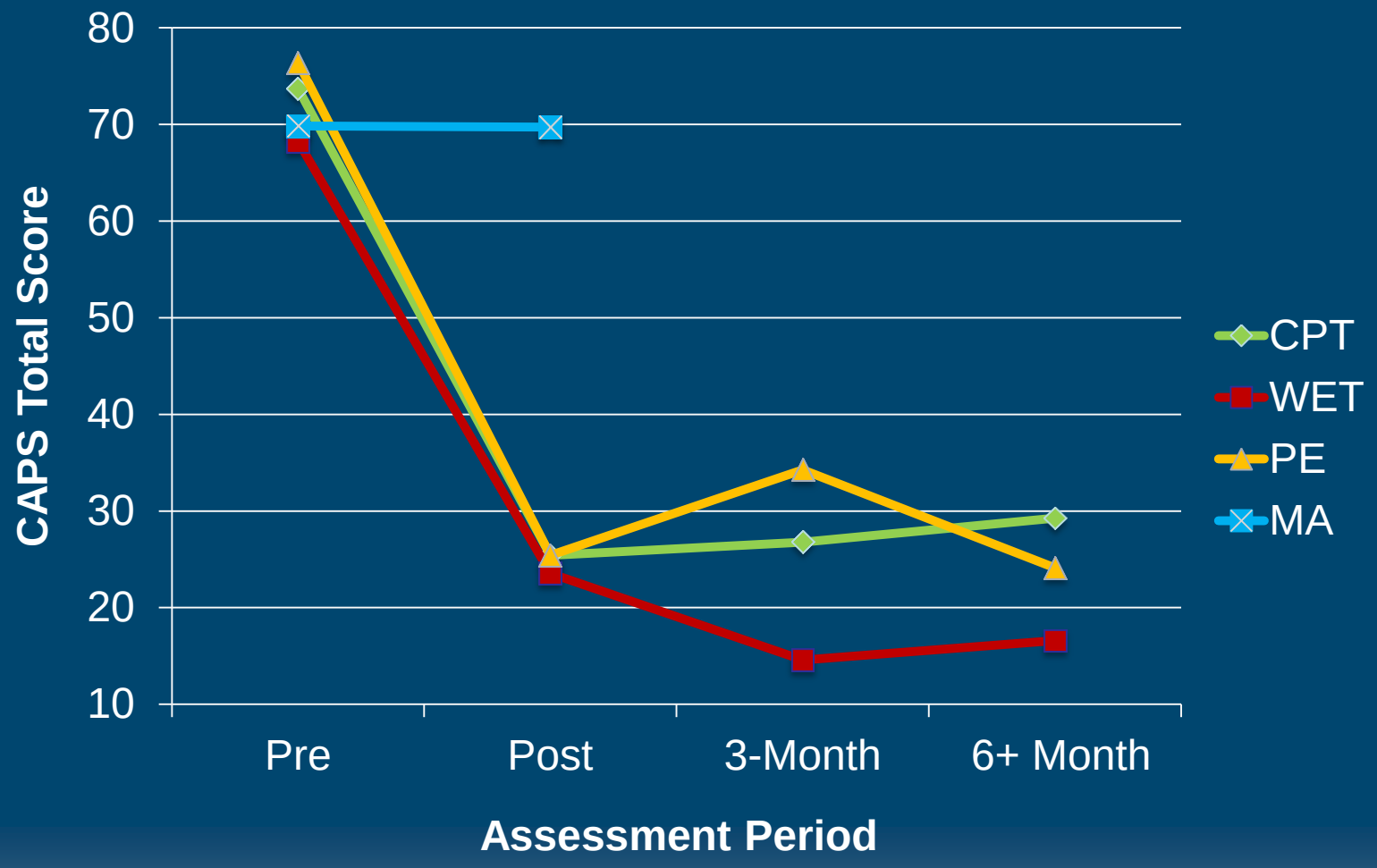
Although the effectiveness of exposure therapy for PTSD is recognized, treatment mechanisms are not well understood. Emotional processing theory (EPT) posits that fear reduction within and between sessions creates new learning, but evidence is limited by self-report assessments and inclusion of treatment

THERE IS CLEAR EVIDENCE THAT EXPOSURE TREATMENT FOR POSTTRAUMATIC 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



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Is WET Non-Inferior to a First Line PTSD Treatment?

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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*

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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

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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)

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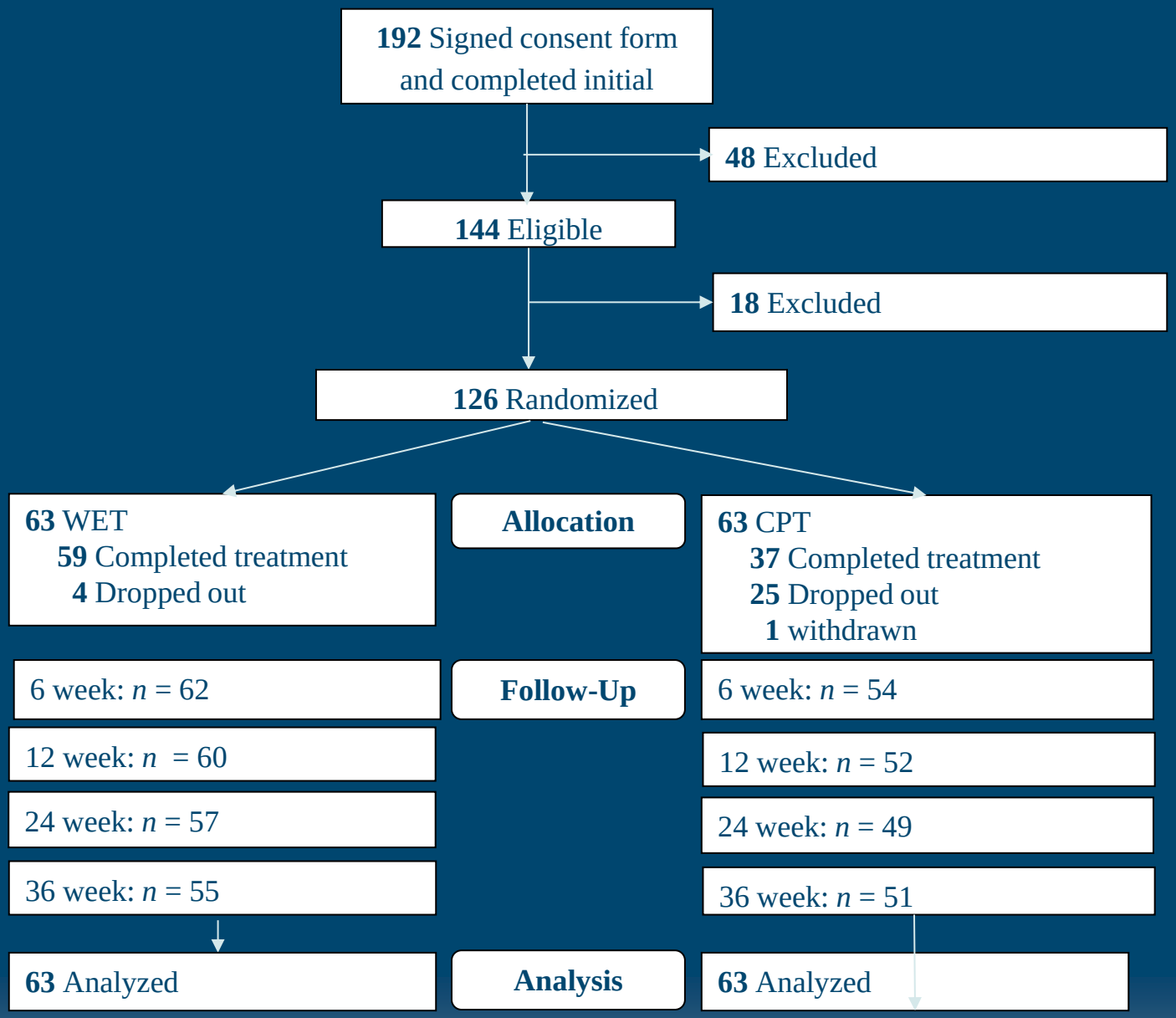
Sample Characteristics

Characteristic	#/Mean	%/(SD)
Gender		
Men	66	52.4
Women	60	47.6
Age	M = 43.86	(14.58)
Education		
High school or less	33	26.2
Some college	33	39.7
College Degree	50	20.6
Graduate/Professional Degree	17	53.2
Ethnicity		
Non-Hispanic	114	90.5
Hispanic	12	9.5
Race		
White	69	54.8
Black	43	34.1
Other	12	9.5
Asian	2	1.6
Annual household income (%≤$25,000)	67	53.2
Index event		
Adult non-sexual assault	24	19.1
Child sexual assault	20	15.9
Adult sexual assault	19	15.1
Combat-related	16	12.7
Sudden death (non-combat) or violence to a friend or loved one	13	10.3
Other (e.g., other accident)	13	10.3
Child non-sexual assault	11	8.7
Motor vehicle accident	10	7.9



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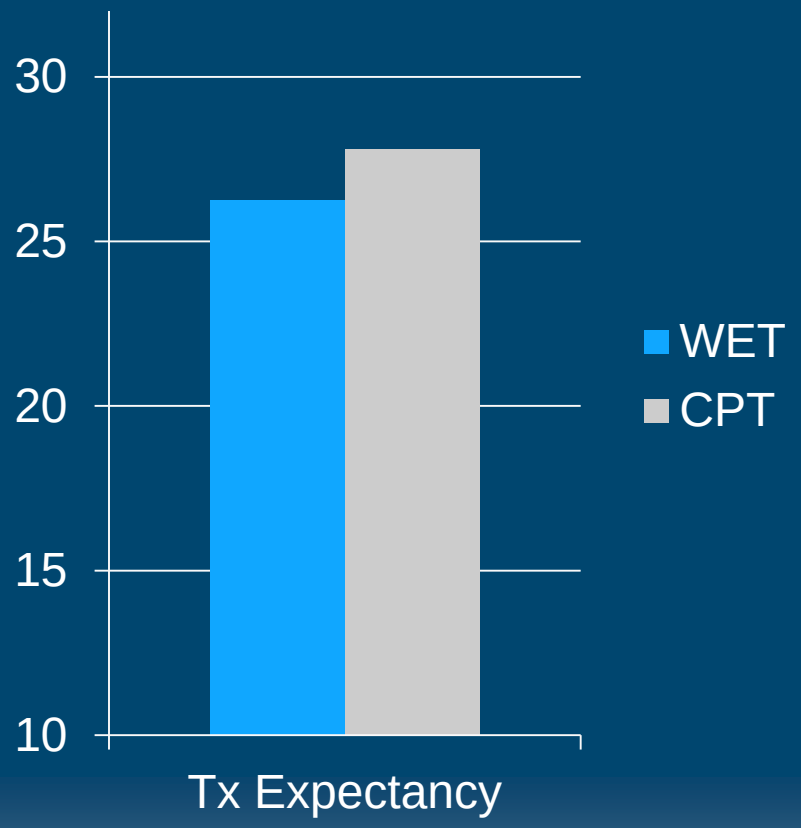
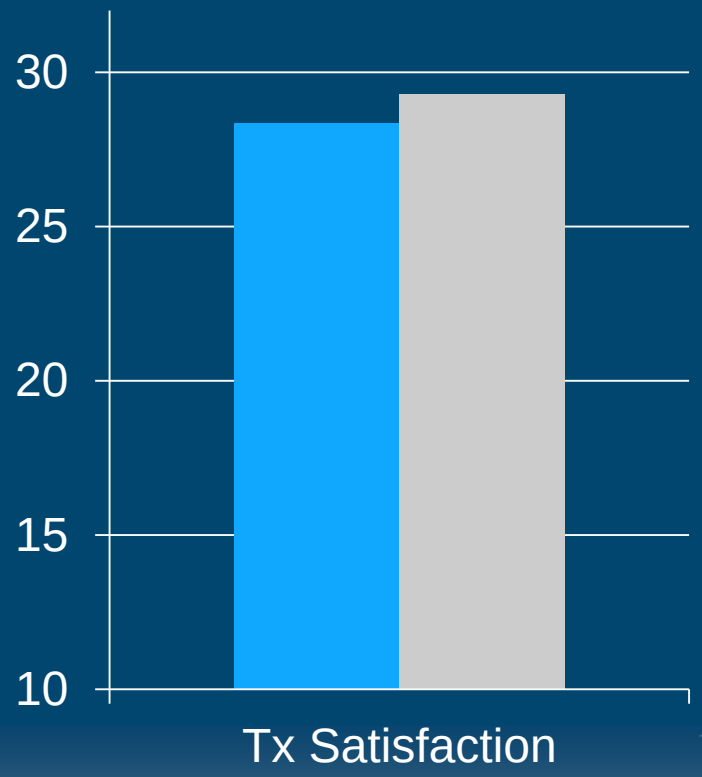
Therapy Process Measures





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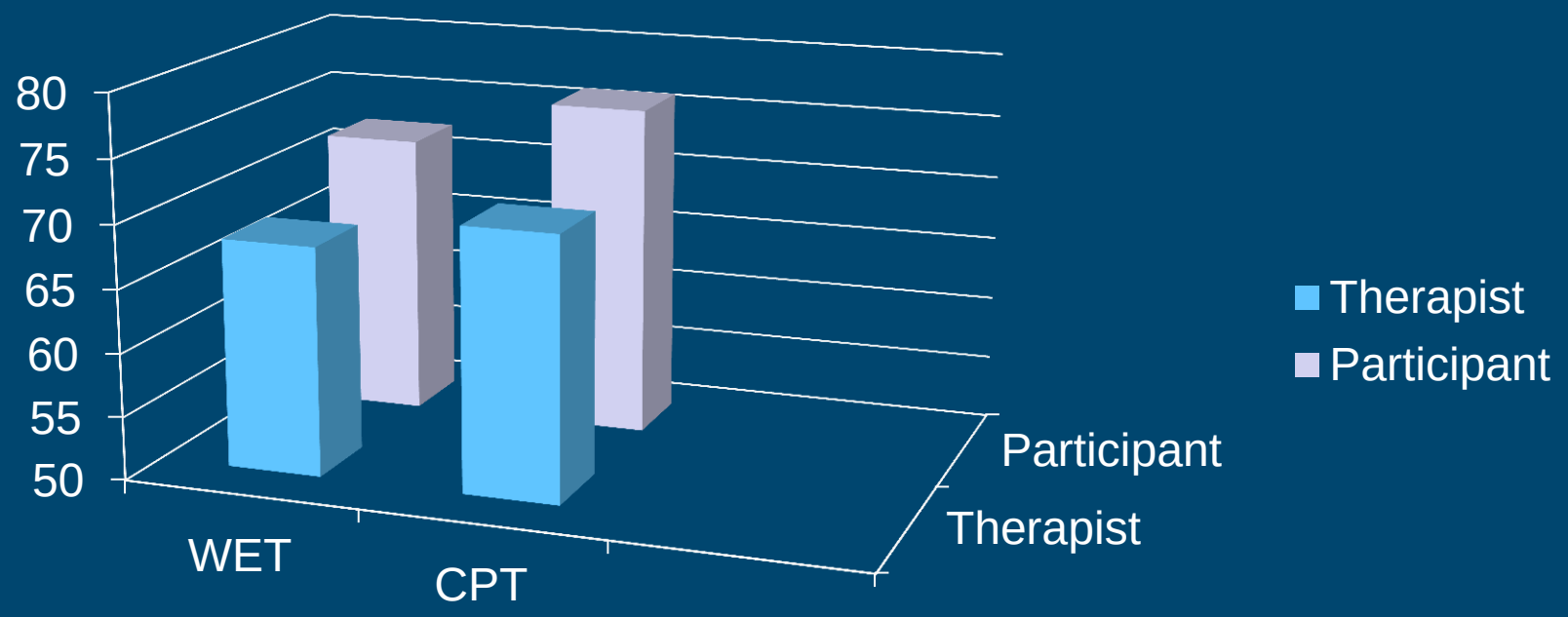
Working Alliance



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Reasons for Dropout

	WET (*n* = 4)	CPT (*n* = 25)
Too distressing	1	14
Unknown	2	5
Too busy for tx	0	3
Medical problems	0	1
Not motivated for tx	0	1
Feeling better	0	1
tx not meeting their needs	1	0

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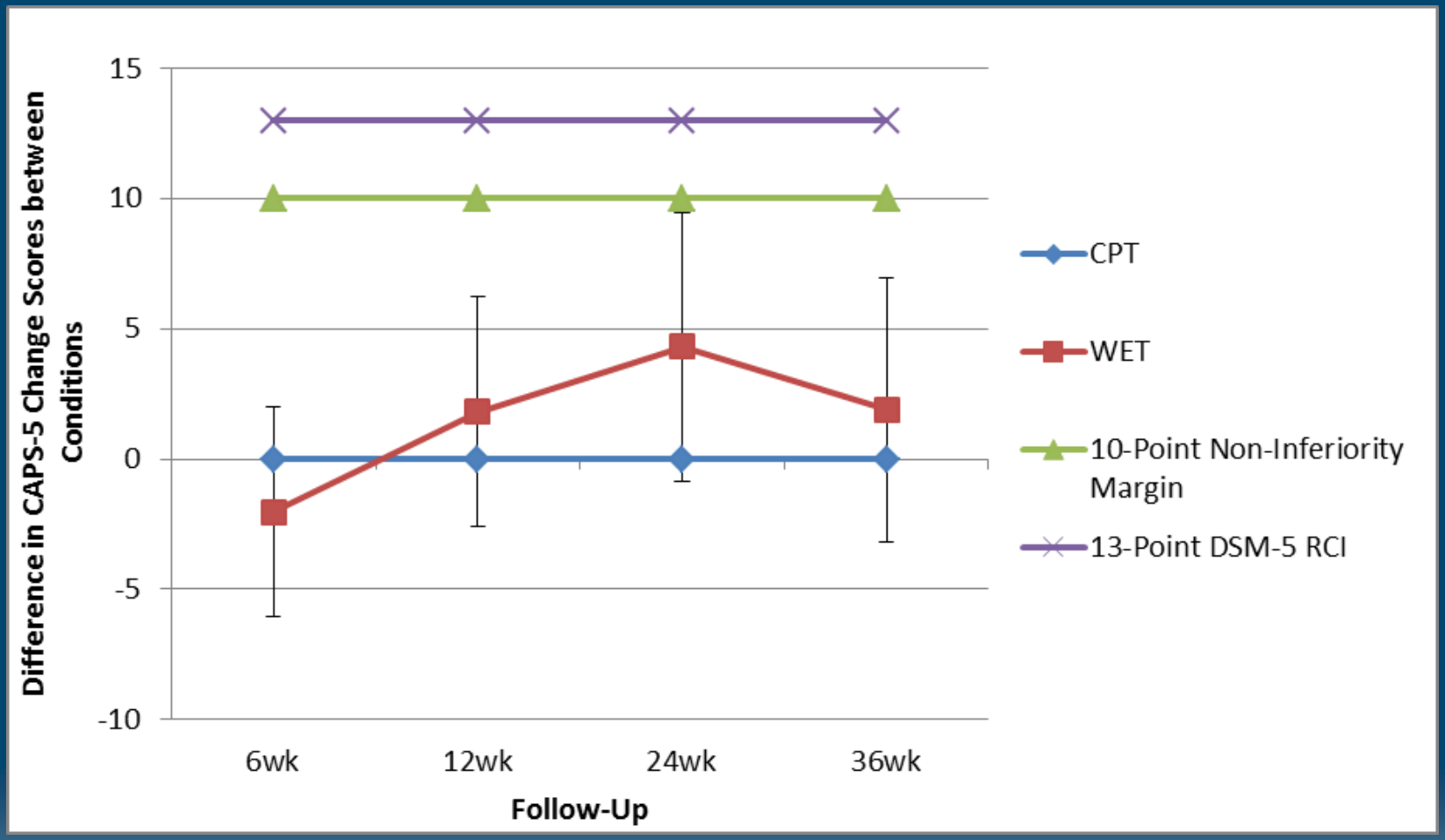
Non-Inferiority Findings



Sloan, Marx, Lee, & Resick (2018). *JAMA Psychiatry*

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Effect Sizes (*d*) for Treatment Outcome

	Within-Condition Effect Sizes			
	Baseline to 6-weeks	Baseline to 12-weeks	Baseline to 24-weeks	Baseline to 36-weeks
CAPS-5				
WET	.51	.82	.97	1.08
CPT	.38	1.13	1.38	1.25
	Between-Condition Effect Sizes			
	6-weeks	12-weeks	24-weeks	36-weeks
CAPS-5	.16	.14	.29	.13

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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

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Descriptives

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

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Moderators

	Full Sample		WET		CPT	
Moderator	***B***	***SE***	***B***	***SE***	***B***	***SE***
Sex	-0.99	0.79	-0.52	1.07	-1.27	1.20
Age	0.05	0.03	0.04	0.04	0.05	0.04
Education	**-0.43***	**0.22**	-0.07	0.28	**-0.86***	**0.33**
PTSD severity at baseline (CAPS-5)	-0.07	0.04	-0.09	0.06	-0.03	0.06
Symptom duration (CAPS-5)	0.01	0.01	0.02	0.00	0.01	0.01
FSIQ (WTAR)	-0.06	0.03	0.02	0.05	**-0.14***	**0.05**
# Comorbid Disorders (SCID)	-0.36	0.31	-0.51	0.37	-0.37	0.54
Depression (BDI-II)	-0.02	0.04	0.02	0.05	-0.04	0.05
MDD (SCID)	-0.66	0.86	0.15	1.15	-1.38	1.32
Peritraumatic Dissociation (PDEQ)	0.03	0.04	-0.01	.05	0.08	0.06

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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.

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ISTSS International Society for Traumatic Stress Studies

BRIEF REPORT

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

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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.

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CAPS Total for Each Veteran at Each Assessment

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

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)

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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

National Center for PTSD
Posttraumatic Stress Disorder

Funding support

- NIMH - R01MH095737
- NIMH - R34MH077658
- NIMH - R03MH068223
- DoD - W81XWH-15-1-0391

National Center for PTSD
Posttraumatic Stress Disorder

PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS

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

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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Welcome users of VHA TRAIN!

To obtain continuing education credit please return to www.vha.train.org after the lecture.

TRAIN help desk: VHATRAIN@va.gov

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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

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CEU Process (for VA employees)

Registration

Register in TMS.

(See link under "Web Links" on right here if you have not registered.)

Attendance

Join via TMS and listen to the lecture.

Posttest

NO POSTTEST

Posttest is no longer required for this lecture.

Evaluation

Return to TMS and complete evaluation found in your "To-Do List."

Certificate

Print certificate from the "Completed Work" section of TMS.

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UPCOMING TOPICS

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

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

For more information and to subscribe to announcements and reminders go to www.ptsd.va.gov/consult