Written Exposure as a Treatment for PTSD

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Disclosure

• I have nothing to disclose.
Why do we need a new treatment for PTSD?

- Problems with treatment engagement and utilization
  - A substantial proportion of those in need of PTSD treatment do not seek it
  - About one third of those that seek treatment dropout before completion (Imel et al., 2013)

- Provider implementation of CPT and PE
  - Providers not using PE and CPT after receiving extensive training (Borah et al., 2013; Finley et al., 2014)
Identifying alternative treatment options

• Should include exposure to trauma memory (Institute of Medicine, 2007)

• 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.
Is written disclosure efficacious for individuals with trauma exposure and at least moderate PTSD severity?
Is Written Disclosure Beneficial for Trauma Survivors?

Is written disclosure efficacious for individuals with PTSD?
Written Disclosure as an Intervention for PTSD

Sloan, Marx, & Greenberg (2011). *Behaviour Research and Therapy*
Altering Written Disclosure to be Beneficial for PTSD

• Added psychoeducation of PTSD

• Added treatment rationale

• Directed writing about a specific trauma event, with focus on detail and emotion felt at the time of the event

• Increase dose to 5, 30 minute sessions
Participants

• 46 adults with a primary diagnosis of motor vehicle accident related PTSD

• Average age of 41, 65% women, racially diverse (37% Caucasian, 37% African-American)

• Median time since MVA was 20 months

Sloan, Marx et al. (2012). *Behaviour Research and Therapy*
Randomization
$N = 46$

Written Exposure
$(n = 22)$
2 (8%) dropped from treatment

Follow-up
5 week: $n = 22$
3 month: $n = 22$
6 month: $n = 22$

Waitlist
$(n = 24)$

Follow-up
5 week: $n = 24$
3 month: $n = 24$
Efficacy of Written Exposure Treatment for PTSD

Sloan, Marx et al. (2012). *Behaviour Research and Therapy*
WET vs. other PTSD treatments

![Diagram showing CAPS Total Score over different assessment periods (Pre, Post, 3-Month, 6+ Month) for different treatments: CPT, WET, PE, MA.](image-url)
Is WET noninferior to a front line PTSD treatment?
Design of current study

• 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)
Hypotheses

• Participants randomly assigned to WET will show noninferior outcome in PTSD symptom severity post-treatment relative to participants randomly assigned to CPT

• WET will demonstrate a significantly lower dropout rate than CPT
Participants

• Randomized to date $N = 75$
• Mean age 43 ($SD = 12.4$)
• Heterogeneous sample
  • 59% women
  • 50% White (41% African-American)
• Mixed index trauma events
  • Physical assault: 39%
  • Sexual assault: 27%
  • Car accident: 16%
Randomization
$N = 75$

WET
$(n = 37)$
6% dropped from treatment

CPT
$(n = 38)$
36% dropped from treatment

Follow-up
6 wk: $n = 36$
12 wk: $n = 34$
24 wk: $n = 28$
36 wk: $n = 27$
60 wk: $n = 21$

Follow-up
6 wk: $n = 34$
12 wk: $n = 33$
24 wk: $n = 27$
36 wk: $n = 27$
60 wk: $n = 20$
Why do people dropout of CPT?

- Too distressing = 7
- Felt better = 1
- Other = 2
- Unknown = 4
Trauma writing differences?

• In clinic versus between session assignment

• Moderators of treatment outcome for both CPT and WET
Stay tuned for outcome findings....
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