

Commentary on Written Exposure Therapy as Step One in Reducing the Burden of PTSD: The Composite Cases of "Alex," "Bruno," and "Charles"

**Stepped-Care Approaches to Posttraumatic Stress Disorder:
Sharpening Tools for the Clinician's Toolbox**

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ABSTRACT

Austern (2017) presents three composite Veteran case studies using Written Exposure Therapy (WET; Sloan, Lee, Litwack, Sawyer, & Marx, 2013) as a first-level intervention in a larger stepped-care model for PTSD. The relatively minimalist WET intervention may be appealing to Veterans with PTSD who have opted not to seek out more time and therapist-intensive treatments. In addition, writing has been used effectively in other protocols as a method of achieving exposure to memories of traumatic experiences. Austern's three cases demonstrate a range of success in using WET to engage Veterans in evidence-based treatment and reduce suffering associated with PTSD. We comment on the current status of the research literature on stepped-care models for PTSD, the potential value of incorporating Motivational Interviewing principles and specific homework tasks into these efforts, and the promise that abbreviated interventions and stepped-care approaches may hold for helping clinicians manage their clinical caseloads and avoid burnout.

Key words: PTSD; veterans; stepped care; prolonged exposure therapy; composite case studies; clinical case studies

**RECENT HISTORY OF TREATMENTS
FOR PTSD IN MILITARY VETERANS**

When we first wrote in 2004 about helping U.S. military service members during deployment with trauma-related symptoms, the war in Iraq was less than two years old (Cigrang, Peterson, & Schobitz, 2005). Fatalities had pushed past 1000 U.S. men and women killed while the number of wounded in Iraq went over 10,000 (iCasualties.org). In 2004, the first large-scale

post-deployment behavioral health survey found significant increases in rates of posttraumatic stress disorder (PTSD) associated with combat exposure (Hoge et al., 2004). Of particular concern, most Soldiers and Marines who screened positive for a mental disorder were not seeking out mental health care. These early results alarmed military leadership and many were concerned about the paper's implications for post-deployment planning.

In Iraq, we adapted the prolonged exposure (PE) therapy protocol developed in state-side specialty clinics (Foa, Rothbaum, Riggs, & Murdock, 1991) for use in a combat zone where the mental health clinic was a tent. Service members sought us out or were referred for help due to impairing levels of symptoms following exposure to combat-related trauma. Universally, military members we treated were motivated to remain in theater, return to duty, and complete their deployment. At the time, there was not a single publication on treatment of Acute Stress Disorder or PTSD in active duty military or activated guard/reserve. While the published work on PE showed good effectiveness for PTSD (Foa et al., 1999; Foa, Rothbaum, & Fur, 2003; Foa, Rothbaum, Riggs, & Murdock, 1991), most research had been conducted using lengthy treatment protocols with civilians who had experienced assault or motor vehicle accidents (Harvey, Bryant, & Tarrier, 2003). Out of the necessity of working within the constraints of Iraq, our adaptation of PE flexibly applied the use of imaginal exposure in three to four treatment sessions and encouraged in vivo exposure to relatively safe settings (e.g., eating at the dining facility) as homework (Cigrang et al., 2005). The brief PE protocol was later manualized and efforts made to further evaluate its use in other deployed settings (Peterson et al., 2015).

Flash forward thirteen years to the present day—U.S. military are still boots-on-ground in harm's way in Iraq, Afghanistan, and surrounding locations. Almost 7000 U.S. military personnel have been killed while deployed in support of Operation Enduring Freedom (OEF) and Operation Iraq Freedom (OIF). Over 52,000 have been injured (www.defense.gov/casualty.pdf). The extended duration of the wars has encompassed deployments for over 2.6 million men and women (Institute of Medicine, 2014), frequently spanning the entirety of individual military service from enlistment to discharge and subsequent help-seeking in the Veterans Health Administration (Harpaz-Rotem & Rosenheck, 2011). Multiple deployments have become commonplace, resulting in two or more years of cumulative deployments for many service members (Baiocchi, 2013). Prospective studies on the impact of OEF/OIF deployments have confirmed that exposure to combat-related trauma significantly increase rates of PTSD (Cigrang et al., 2014; Hoge, Auchterlonie, & Milliken, 2006; Milliken, Auchterlonie, & Hoge, 2007; Smith et al., 2008), resulting in a current estimated prevalence of 23% among OEF/OIF veterans (Fulton et al., 2015). Significant numbers of the service members who develop deployment-related mental health conditions still do not seek help (Hoge et al., 2006; Tanielian & Jaycox, 2008). Earlier indications that OEF/OIF veterans most in need of mental health assistance also perceive greater social stigma with help-seeking has been replicated (Snyder et al., 2016), but the relationship between stigma and actual receipt of help is still not well understood (Sharp et al., 2015).

Our experience and understanding of treating PTSD in service members and veterans using PE therapy has increased since 2004 (Peterson, Foa, & Riggs, 2011; Peterson, Luethcke, Borah, Borah, & Young-McCaughan, 2011). Most veterans with chronic PTSD show clinically

significant improvements after receiving the standard PE protocol (Rauch et al, 2009; Tuerk, et al., 2011). Subsequent studies have found that important adaptations to the PE protocol can be made without compromising effectiveness, such as using 60-minute sessions versus the traditional 90 minutes (Nacasch et al., 2015), delivery in a group therapy format (Smith et al., 2015), using an intensive outpatient format (Blount, Cigrang, Foa, Ford, & Peterson, 2014), and even PE via home-based telehealth (Acierno et al., 2017). Protocol flexibility is clearly needed in the face of evidence that current practice is not reaching many veterans with PTSD who would likely benefit from treatment (Vaughn, Schell, Tanielian, Jaycox, & Marschall, 2014).

STEPPED-CARE MODELS OF PTSD TREATMENT

The case report by Austern (2017) is an excellent example of varying the method and intensity of exposure-based therapy in an effort to reach those veterans who have not opted for the traditional protocol. More specifically, the author argues that first offering a briefer treatment that minimizes homework and face-to-face time with a therapist may be more acceptable to veterans who are reluctant to commit to a longer protocol. Viewed from a stepped-care model, the brief intervention could prove to be sufficient help by itself or serve as an “on-ramp” to more intensive treatment options. It may provide an important additional tool to the clinician’s toolbox.

In Austern’s (2017) example, the method of exposure is writing-out a detailed narrative of the traumatic experience connected with PTSD symptoms (Written Exposure Therapy; Sloan, Lee, Litwack, Sawyer, & Marx, 2013). Flexible thinking about use of exposure therapy for PTSD includes variations in how exposure to the traumatic memory is achieved. We find it useful to remind ourselves that exposure is a well-established principle of effective psychotherapy that cuts across specific approaches and manualized treatment protocols (Beutler & Martin, 2000). Traditional PE, which has the greatest level of empirical evidence for effectiveness (Institute of Medicine, 2007), uses a verbal re-telling of the traumatic experience in-session (imaginal exposure) and listening to the recorded narrative repeatedly as homework (Foa, Hembree, & Rothbaum, 2007). However, the use of writing as a means of achieving exposure to and processing of upsetting memories is not new. Hervey Allen, in the preface to his famous memoir of World War I combat experiences (Allen, 1934), penned the following:

After returning home in 1919, I found myself much troubled at night by memories of war and often unable to sleep. It occurred to me that I might rid myself of the subjective war by trying to make it objective in writing. Taking in mind the material mentioned above, and adding to it what I still so vividly remembered, I whipped the whole into shape without any thought at the time of publishing it. The medicine worked, although perhaps the style of the utterance suffered. (p. xxiv)

Other examples of therapeutic writing as a means of exposure include the original version of Cognitive Processing Therapy (CPT) for PTSD, which included having the patient write out an account of the traumatic experience and read it aloud to the therapist (Resick et al., 2008). We use a similar process of written exposure and emotional processing in our brief PE protocol developed for use in integrated primary care settings (Cigrang et al., 2011; 2015). A notable

application of PE principles and the written trauma narrative was developed by researchers working with Uganda and Sudan war refugees suffering from PTSD (Neuner et al., 2008; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). In Narrative Exposure Therapy (NET) the therapist creates a written chronological narrative based on the patient's repeated and detailed re-telling of their traumatic experiences. The final written narrative is given to the participant at the last treatment session. What is particularly intriguing about NET is that the relatively low complexity of the method allowed the use of lay counselors from the refugee community to deliver the PE-based treatment—"neighbors treating neighbors" (Neuner et al., 2008).

Written Exposure Therapy (WET; Sloan et al., 2013) is an exceptionally minimalist exposure therapy; bereft of much therapist contact and eschewing any specific homework tasks. As Austern (2017) notes, this may render the therapy a good fit for the first therapist-guided intervention following purely self-help resources in a stepped-care treatment model for PTSD. Of course, it is important to point out that comprehensive stepped-care models for PTSD that have been systematically evaluated in randomized clinical trials are relatively rare. A notable exception is Stepped Enhancement of PTSD Services Using Primary Care (STEPS-UP; Belsher et al., 2016), which combined multiple psychosocial and pharmacological PTSD treatment options of varying intensities in primary care, referral to specialty mental health services as needed, and centralized tracking of patient progress. When compared to active-duty patients receiving standard primary care services, STEPS-UP resulted in patients receiving a greater number of mental health encounters. In addition, STEPS-UP appeared to better match clinically complex patients with higher intensity treatment (Belsher et al., 2016).

The building blocks for further testing of stepped-care models are now available. Web-based self-help protocols are being evaluated for veterans with PTSD (Brief, Rubin, Enggasser, Roy, & Keane, 2011). PTSD treatments for use in primary care are also being tested and have found that some veteran participants do "step-up" to more intensive services after completing the abbreviated protocol (Cigrang et al., 2015; Harmon, Goldstein, Shiner, & Watts, 2014; Possemato, Bergen-Cico, Treatman, & Allen, 2016). What is currently lacking is methodologically rigorous trials examining the potential advantages and disadvantages of different stepped-care approaches to PTSD. One caution voiced in earlier discussions of stepped care is that failure to respond to a low-intensity treatment for PTSD may discourage patients from seeking more intensive treatments (Davison, 2000). The composite cases of Alex and Charles represent examples of veterans who could have benefitted from more intensive services following WET, but chose not to. The extent to which their choice was influenced by their experiences with WET is unknown, but certainly important to examine in future studies.

Austern's (2017) composite case examples represent a diversity of veteran variables that a mental health provider may encounter in working with the military population. These include differing U.S. war eras (e.g., Vietnam, Desert Storm, OIF, etc.); trauma types (e.g., life threat to self, moral injury, military sexual assault, etc.); and racial/ethnic diversity. Commonalities, though, are evident in PTSD symptomatology and impairments, including withdrawal and avoidance, persistent emotional distress including significant irritability, and strained relationships with significant others. Our anecdotal experiences treating active duty military

have fostered the understanding that formal help-seeking often occurs in the context of a high level of individual distress, i.e., the “miserableness factor,” and the potential loss of a valued relationship due to the PTSD symptoms. The composite case “Alex” is a good example of this common scenario. Indeed, recent research on help-seeking by OEF/OIF veterans has corroborated the impression that severity of distress is a better predictor of actual receipt of help than perceived stigma (Harpaz-Rotem, Rosenheck, Pietrzak, & Southwick 2014; Hoerster et al., 2012; Snyder et al., 2016).

There was a significant level of irritability directed by the veteran towards the provider in Austern’s (2017) composite cases, occurring closely with expressed ambivalence toward treatment participation. A handful of studies have found that negative attitudes toward mental health treatment (e.g., mistrust of mental health professionals or beliefs that mental health care doesn’t work) are associated with lower interest in and reduced likelihood to seek help (Brown, Creel, Engel, Herrell, & Hoge, 2011), although this finding has not always been replicated (Snyder et al., 2016).

THE ROLE OF MOTIVATIONAL INTERVIEWING (MI)

Given that Austern’s (2017) case series focuses on those veterans who have not taken advantage of the traditional, more intensive PTSD treatment opportunities, providers working with this subgroup of veterans may need above-average clinical skills for responding to patient skepticism and reluctance. Austern (2017) does not provide much detail in how he navigates these interpersonal interactions successfully beyond normalizing and validating expressed feelings. In our own clinical practice and supervision of graduate students, interns, and postdoctoral fellows, we have come to value and rely heavily on motivational interviewing principles (MI; Miller & Rollnick, 2012). Expressing empathy, “rolling with resistance,” supporting self-efficacy, and “developing discrepancy” are valuable MI strategies to consider in the early stages of patient education and treatment planning. MI is explicitly intended to explore ambivalence, strengthen intrinsic motivation, and increase confidence for making changes; and it seems a good fit for work with veterans similar to Austern’s composite cases.

To our knowledge, there are no peer-reviewed publications evaluating the use of the MI style when first meeting with veterans seeking help for PTSD. Seal and colleagues (Seal et al., 2012) demonstrated that an MI intervention targeting treatment engagement delivered in phone contacts with OEF/OIF veterans resulted in significantly greater follow-through to treatment (62%) compared to telephone contacts with standard treatment referral content (26%). These promising results help make the argument for incorporating MI into future stepped-care trials involving veterans with PTSD who are ambivalent toward treatment-seeking.

THE ROLE OF THERAPEUTIC HOMEWORK

In WET, the client engages in written exposure to the traumatic memory at the therapist’s clinic or office. Austern (2017) advises case “Alex” that “people do better when they visit the clinic in person to complete their writing, as opposed to writing at home” (p. 102). This

assertion is attributed to personal communication with the creator of WET (Denise Sloan), though no empirical support for this practice is cited.¹ Likewise, WET does not ask the patient to engage in writing about the trauma as homework, but includes a general encouragement to not avoid any trauma-related memories in between sessions.

Practitioners of traditional PE may feel that the absence of specific exposure activities as homework (i.e., listening to recordings as imaginal exposure and engaging in in-vivo exposure using an exposure hierarchy) is a serious shortfall. However, they may be surprised to learn that there are few studies that have examined the relationship between homework completion and treatment outcome in PE, and the findings have been mixed (for review see Cooper et al., 2017). For example, an earlier randomized trial comparing PE and CPT found better outcome for participants who completed half or more of their assigned homework, but the difference was significant for only 1 of the 12 study measures (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). In a recently published study using data drawn from a randomized trial involving PE (N = 116), Cooper and colleagues (Cooper et al., 2017) did find that higher adherence to the imaginal exposure homework was predictive of greater symptom improvement, increased odds of achieving PTSD remission, and better global end stage functioning. Thus, future trials of WET as an entry-level step in a larger program of PTSD intervention may want to reconsider the value of keeping the intervention minimalist (i.e., no written exposure as homework to encourage uptake by veterans), versus encouraging homework to potentially enhance treatment effectiveness.

BURNOUT PREVENTION

One additional advantage of the WET and stepped-care approach that was not highlighted by Austern (2017) is the potential benefit for trauma therapists. The burden of heavy clinical caseloads is a major factor related to burnout in Veteran Health Administration providers (Garcia, McGeary, McGeary, Finley, & Peterson, 2014; McGeary, Garcia, McGeary, Finley, & Peterson, 2014). The WET approach may lighten the load for busy behavioral health providers. In addition, trauma-focused treatments such as PE may not only be difficult for clients, a number of studies have evaluated the impact of these treatment approaches on behavioral health providers (Cieslak, Anderson, Bock, Moore, Peterson, & Benight, 2013; Garcia, McGeary, Finley, McGeary, Ketchum, & Peterson, 2016). These factors may also have contributed to the challenges that have occurred with the dissemination and implementation of PE throughout the Department of Defense (Borah et al., 2013). The WET and stepped-care approaches might be additional tools for helping behavioral health providers manage their clinical caseloads and avoid burnout.

¹ Editor's note: In the second commentary by Sloan and Marx (2017), the developers of WET, these authors describe the most recent clinical and empirical rationales for WET elements like writing in the clinic rather than at home.

CLIENT PREFERENCE FOR TYPE OF TREATMENT

In a final point we applaud Austern's (2017) practice of carefully reviewing with each client the evidence base for PTSD treatments and collaboratively empowering the client to choose one of the options (or none at all). There is a growing body of literature in support of the notion that outcomes are improved when the PTSD treatment received matches the client's preference for treatment, i.e., the treatment you think is best for you is best for you (Le, Doctor, Zoellner, & Feeney, 2014; Zoellner, Feeny, & Bittinger, 2009). The Department of Veterans Affairs has wisely built into their specialty clinic intake process an orientation group received very positively by veterans that explains psychotherapy and pharmacotherapy treatment options for PTSD (Schumm, Walter, Bartone, & Chard, 2015). We recommend a similar emphasis on understanding and matching patient preferences to PTSD treatments be present in all future studies of stepped-care models.

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