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

# Beyond Binary Thinking: Providing Best Practice Treatment to Veterans with PTSD

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## ABSTRACT

In "Written Exposure Therapy as Step One in Reducing the Burden of PTSD: The Composite Cases of 'Alex,' 'Bruno,' and 'Charles'" (Austern, 2017), I presented three composite case study examples of how veterans suffering from PTSD may benefit from written exposure to their trauma memories. For one case (Bruno), Written Exposure Therapy (WET) was the initial treatment in a stepped-care approach that culminated in Prolonged Exposure therapy. However, for the two others, WET became a standalone treatment. In two commentaries on the cases, Cigrang and Peterson (2017) and Sloan and Marx (2017) discuss the development and efficacy of WET, WET implementation strategies, and practice implications of WET (e.g., the potential to reduce clinician burnout). In my response to these commentaries, I aim to contribute to the bourgeoning discussion of how mental health providers can best incorporate this promising writing-based treatment (WET) into their existing approaches to working with veterans suffering from Post-Traumatic Stress Disorder (PTSD). My response will address themes raised by my composite case studies and by the commentaries, including how stepped-care service delivery models may have the potential to make PTSD care more efficient.

*Key words*: PTSD; military combat; veterans; trauma; exposure therapy; Prolonged Exposure; Written Exposure Therapy (WET); writing; stepped care; case studies; clinical case studies

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I would like to begin by thanking the authors who provided thoughtful and insightful commentaries on my study. Drs. Sloan and Marx (2017) are the creators of Written Exposure Therapy (WET), so I am honored to receive their feedback on my work. Their commentary offers a fascinating glimpse into the development of the treatment, providing us with the story behind some of their notable research and thinking that ultimately led to the creation of WET. I am also honored to receive the feedback of Drs. Cigrang and Peterson (2017), who have made highly significant contributions to the PTSD treatment literature as well. Their commentary likewise offers a unique perspective on treatment development, as they discuss how they created a brief, flexible adaptation of Prolonged Exposure (PE) for active duty military service members

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deployed to Iraq. My response to these commentaries strives to further explore some of the themes the authors have raised here regarding the use of stepped care when treating Post-Traumatic Stress Disorder (PTSD).

## WET AS A STANDALONE THERAPY

One key question is whether a stepped care model can be useful in reducing the global burden of treating PTSD and if so, how WET might fit into that model. I understand that Sloan and Marx want to emphasize that WET is designed to be a standalone therapy, and that it is a significant finding that such an efficient therapy like WET can be a successful standalone therapy in some clinical contexts. On the other hand, this is not inconsistent with also employing WET in a stepped-care context, just as other standalone therapies can be employed in this way. In fact, somewhat paradoxically, I actually obtained the idea of working with WET in a stepped-care context from a quote in Sloan and colleagues' 2013 article, "Written Exposure Therapy for Veterans Diagnosed with PTSD: A Pilot Study." In the Discussion section, they write:

> In addition, written exposure therapy may be particularly useful within a stepped care approach environment. For example, written exposure therapy may be used with veterans endorsing PTSD symptoms who present to a primary care clinic. Written exposure therapy might also be used as an initial treatment for PTSD, followed by a determination as to whether or not the veteran requires additional treatment (Sloan, Lee, Litwack, Sawyer, & Marx, 2013, p. 278):

In any event, I suggest that it is important to further research those clinical situations in which WET can be a standalone treatment (as in my case of Alex), and those other clinical situations in which WET can be a part of a stepped-care model (as in my cases of Bruno and Charles).

## DISTINGUISHING BETWEEN "FIRST-LINE" AND "SECOND-LINE" PSYCHOTHERAPIES

Sloan and Marx's emphasis on WET as a standalone therapy also highlights the more important issue of how we define and associate meaning with regard to treatment efficacy. In their commentary they share exciting news that WET will be considered a front-line, standalone treatment in the next VA/DoD PTSD Practice Guidelines (Management of Post-Traumatic Stress Working Group, 2017). (Note that this appears to have already been published since their commentary was written); yet they also suggest WET may function as an "alternative treatment." Interestingly, there appears to be a binary opposition between what we consider front-line/first-line/standalone vs. "alternative" PTSD treatments. Steenkamp and colleagues (2015) distinguish between "first-line" and "second-line" psychotherapies, where first-line psychotherapies are trauma-focused whereas second-line psychotherapies are often not. The newest VA/DoD PTSD Practice Guidelines similarly dichotomizes, recommending individual, manualized, trauma-focused psychotherapy as the "primary" treatment for PTSD. Within this category, the guidelines further differentiate between the three psychotherapies with the strongest evidence from Randomized Clinical Trials (RCTs)—that is, Prolonged Exposure (PE) Therapy, Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing Therapy

(EMDR)—versus newer approaches demonstrating sufficient efficacy (e.g., WET).

It would appear that a hierarchical binary opposition is in operation here, where any synonym for "first-line" (i.e., efficacious) is the preferred term while "second-line" or "alternative" (i.e., less or not efficacious) is the non-preferred term. Binary oppositions have been found to be problematic by some theorists (e.g., Derrida, 1981) on the grounds that one term gains privilege while the other is subjugated. Cognitive theorists have also criticized binary oppositions, referring to them as "either-or assumptions" (Kovacs & Beck, 1978), "all or nothing," or "black and white" thinking, which frequently oversimplifies our more complex, grey-shaded reality. Dividing the array of our therapeutic options for treating PTSD into first- and second-line treatments may risk oversimplifying complex clinical realities.

Elbow (1993) argues that binary oppositions are not necessarily problematic as long as we "affirm both sides of the dichotomy as equally true or necessary or important or correct." This is easier to do when we engage in thought experiments than when we attempt to tackle the politicized burden of treating PTSD. The provision of first-line treatments to patients suffering from PTSD is hypothesized to both alleviate symptoms and cut costs (Tanelian & Jaycox, 2008; Tuerk et al., 2013), which is generally agreed upon as "preferred" in comparison to the provision of alternative treatments which risk veterans not benefitting; consequently, providers are strongly encouraged to offer first-line treatments.

However, we must remember that despite the reduced costs associated with trauma-focused therapies, the patient demand for them may exceed the supply of available providers. Kazdin and Blase (2011) argue that individual psychotherapy is unable to alleviate the growing burden of mental illness due to the limited capacity of this service, and therefore we must explore additional service delivery models (e.g., stepped care). Furthermore, as we know, there are a multitude of obstacles in the way of veterans receiving (e.g., Shiner et al., 2013), completing (Hembree et al., 2003), and responding to these first-line treatments (Bradley, Greene, Russ, Dutra, & Westen, 2005; Steenkamp et al., 2015). Providers seeking to offer these treatments may also face obstacles, including working in an understaffed clinic with low emotional support from co-workers (Finley et al., 2015). As Finley and colleagues noted, providers were more likely to offer supportive care (i.e., an alternative, second-line, non-preferred treatment) than PE or CPT, which may potentially be associated with these systemic issues.

## THE ISSUE OF PROVIDER BURNOUT

Thus, there may be tension between providers wanting to deliver these first-line therapies, on the one hand, and competing organizational demands within healthcare systems such as time constraints (Karlin et al., 2010), on the other. In their commentary, Cigrang and Peterson (2017) call attention to the issue of provider burnout. Burnout may occur when providers experience exhaustion, cynicism, and inefficacy in the face of chronic emotional and interpersonal stressors at work (Maslach, Schaufeli & Leiter, 2001). Recent research has examined how organizational factors impact burnout, and findings indicate that high caseloads may contribute to the exhaustion of providers (that is, PTSD Clinical teams [PCT]) in the Veterans Health Administration (VHA; Garcia, McGeary, McGeary, Finley, & Peterson, 2014; McGeary et al., 2016). Garcia and colleagues (2014) recognize that there are high economic and

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social costs to these clinicians burning out and thus recommend supporting VHA infrastructure to guard against burnout.

Cigrang and Peterson (2017) suggest that WET in particular and stepped-care models in general can "lighten the load" and thus serve this purpose. If a provider is using WET with at least some proportion of their caseload, they may experience less exhaustion than if they are expected to deliver PE or CPT with their entire caseload; and this may be an important topic to explore in future research. While patients are completing their writing in another room, WET providers have the majority of the session time available to them. Although some providers may be tempted to use this time to complete other work-related tasks, this time could also potentially be used for self-care practices that may help guard against burnout. For example, recent research has examined how therapists' own mindfulness practice may positively influence their awareness of self-care needs, capacity for self-compassion, and capacity for empathy (Keane, 2014). Even a three-minute breathing space meditation might be helpful for providers to practice in the allotted time.

## THE ROLE OF MOTIVATIONAL INTERVIEWING

Another interesting suggestion by Cigrang and Peterson (2017) involves the role that Motivational Interviewing (MI) principles and techniques may play in the early stages of treatment planning with veterans suffering from PTSD. As they note, there is a dearth of published studies examining how MI principles can be used in this fashion. The research thus far has largely examined how standalone MI interventions may impact subsequent treatment engagement (Murphy, Thompson, Murray, & Uddo, 2009; Seal et al., 2012). Additionally, an unpublished doctoral dissertation using a pragmatic case study methodology clinically explored how three MI-informed pre-treatment sessions can positively impact a veteran's subsequent course of CPT (Farber, 2015). One aspect of these study designs worth considering is the potential delay of trauma-focused PTSD treatment due to the frontloading of an MI intervention.

This has been a hot topic among PTSD treatment researchers over the past few years—what exactly is necessary to provide patients with in order to increase "readiness" before attempting to engage them in trauma-focused psychotherapies? The current thinking is *nothing*! Hamblen and colleagues (2015) remind us that no published quantitative group data exists supporting the claim that veterans must achieve a particular level of readiness prior to EBP initiation, which is in contrast to conventional wisdom that preparatory work (e.g., skills groups) is necessary. This gung-ho spirit is echoed in another recent paper by De Jongh et al. (2016) examining the construct of "complex PTSD." While conventional wisdom argues for a required stabilization phase prior to initiating first-line, trauma-focused treatments like PE and CPT with complex PTSD, De Jongh et al. argue that this is not necessary due to lack of supporting data and that providers should thus initiate EBP immediately.

Cigrang and Peterson (2017) advocate weaving MI principles into the patient education and treatment phase, which sounds more akin to current recommendations than having a standalone MI intervention up front. Another option is the use of a "Shared Decision Making" intervention during treatment planning, which has been found to increase patient motivation in discussing treatment options with providers (Mott, Stanley, Street, Grady, & Teng, 2014). Given

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that Mott and colleagues found this intervention increased the likelihood of EBP selection, it may be an important component for providers to employ during treatment planning. In fact, Shared Decision Making is identified as an area for recommended research in the 2017 VA/DoD PTSD Clinical Practice Guidelines. As Cigrang and Peterson (2017) remind us, patient education and preference may be important factors associated with treatment outcome.

## THE WET VERSUS CPT NONINFERIORITY CLINICAL TRIAL

Treatment outcome (e.g., reduction in PTSD symptom severity) remains the customary benchmark with which we evaluate psychotherapies. However Kazdin and Blase (2011) argue that we need to think beyond effect sizes and consider each treatment in the context of broader treatment portfolios. The forthcoming outcome data from the ongoing WET vs. CPT non-inferiority, randomized clinical trial (RCT) described by Sloan and Marx (2017; also see Sloan, Marx, & Resick, 2016) will help answer the question of whether WET will demonstrate similar efficacy as CPT. Until then, we can agree that WET does meet at least two of the three assumptions important for treatments within stepped-care service delivery models outlined in Bower and Gilbody's review (2005). Sloan and colleagues (2013) found that WET is efficient (i.e., 5 sessions of trauma-focused treatment with minimal therapist contact) and acceptable (i.e., well-tolerated with low dropout rates) to veterans. Once the new data from the noninferiority trial is published, we can better ascertain whether WET meets the equivalence assumption (i.e, demonstrates equivalent efficacy as CPT).

And yet, WET already appears to be an invaluable new treatment to add to our growing portfolio of PTSD treatments. WET is trauma-focused and exposure-based, which are integral components of other effective PTSD treatments like PE and CPT. However, WET has numerous advantages over PE and CPT, such as fewer sessions, lack of homework, and a stronger potential for dissemination (e.g., it can be easily delivered by masters-level clinicians). It can have a significant role in the portfolio even if CPT outperforms it when the clinical trial data is published. If even some proportion of veterans achieve symptom remission from WET and do not require PE or CPT, it will result in significant cost reduction and an increase in the efficiency and capacity of healthcare systems utilizing the therapy. In particular, overburdened healthcare systems may want to consider WET for these reasons. Sloan and Marx (2017) mention that the Boston Veterans Administration routinely offers WET in addition to PE or CPT, and that they are collecting WET implementation data. This will provide extremely useful information for providers who may be interested in incorporating WET into their portfolios, but may be unsure how to do so.

## TREATMENT PORFOLIOS

The concept of treatment portfolios reminds me of Elbow's (1993) suggestion that we can appreciate both sides of binaries as useful. Individual trauma-focused treatments can represent a sizeable portion of our PTSD treatment portfolio, but we need additional tools in our toolbox. For example, my composite case study of Alex represents veterans who are offered PE or CPT and who are ambivalent about engaging in treatment. If WET were not presented as an option, he may have left the treatment planning session feeling demoralized. Instead, he completed WET and achieved clinically and quantitatively important benefit. To borrow an analogy from the financial

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world—successful investment portfolios are typically diversified (Lintner, 1965).

When I engage in treatment planning sessions with veteran patients seeking psychotherapy for PTSD, I offer the widest range of therapeutic options I possibly can. I explain that certain therapies have the greatest research support (i.e., PE and CPT), while others are unlikely to lead to any meaningful symptom reduction (i.e., supportive therapy), but ultimately it is the veteran's choice. I am excited to reconfigure my presentation to acknowledge that WET is now considered a primary treatment in the updated VA/DoD PTSD Clinical Practice Guidelines. It would be helpful to have testimonials and/or other qualitative data from WET completers to help educate and engage new patients. For example, when I was working in the VHA, as a therapist I had access to videos of patients who had completed PE or CPT, videos which were designed to be helpful prospective clients. Lately, in order to promote treatment engagement with new patients, I have shared the findings from a recent qualitative study on veterans' positive perspectives about engaging in and completing PE or CPT (Hundt, Barrera, Arney & Stanley, 2017).

Many of the topics discussed here are listed as knowledge gaps and recommended research in the new VA/DoD PTSD Clinical Practice Guidelines (http://www.healthquality.va.gov/), such as improving treatment motivation and engagement; the role of treatment choice; models of implementation, including costs, value, and feasibility; and novel implementation approaches of effective interventions. This suggests to me that we are on the right track in the way we are thinking about these issues. However, it is possible that stepped care may be a controversial approach for some people given that it may seem counterintuitive to not immediately jump to the treatment with greatest efficacy.

Although PTSD is no longer considered an anxiety disorder in DSM-5, it is worth highlighting findings from a very recent paper on the treatment of anxiety to illustrate this point. Stein and Craske (2017) advocate a stepped care approach to treating anxiety beginning with lifestyle interventions (e.g., physical exercise, patient education, MBSR) before initiating CBT or pharmacotherapy. While they acknowledge that most patients will need to be stepped up from step 1 to step 2, they argue that it is worth beginning with low-cost, safe, and accessible interventions given that some patients may benefit from these alone. After the article was promoted on Twitter, someone posted this response: "To treat Agoraphobia? To treat Panic Disorder? Why not just start with CBT and be finished in less than 20 weeks?" (BClinicalPsych, 2017).

I guess binary thinking dies hard!

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