

Supplemental Questions from CDP Presents WET Webinar

THEORY/PROTOCOL QUESTIONS:

Doesn't taking distance limit the benefit of exposure?

We have not found this to be the case as patients are very engaged in the exposure. Moreover, for some patients, writing about the trauma is easier than reporting it to a provider as they are not concerned about potential judgement.

Can you please say a bit more about how you may instruct the client to use a distance perspective/how do you describe distancing perspective to clients?

We simply instruct patients to write about their trauma event "as they look back upon it now." Instructions also remind patients that they trauma is not happening now, rather, they are describing the trauma as they "look back upon it now."

Do they write about their emotions during the trauma or their emotions about it now?

The instructions are to write about the emotions that the patient experienced during the trauma. Thus, it's the emotions that they remembered experiencing during and immediately after the trauma.

What happens when they become emotionally activated in the session and can't write anymore?

Patients will sometimes tell the provider that they cannot write anymore because they are too distressed. The provider should redirect the client to write in such instances by giving them encouragement (You are doing a great job, keep going). Typically, this type of redirection works well.

Many of my clients with PTSD disassociate. How would this be handled during the session?

We have had patients dissociate during the session. However, we find this is less likely to happen given the presence of the therapist and the activity of writing. For patients that do dissociate, we suggest the provider teach them some simple grounding techniques they can use when the feel dissociation coming on.

Would you recommend WET for a client with PTSD who has suicide risk?

Yes, we have used WET with clients that have suicidal risk that is low to moderate. Of course, clients with high levels of risk should first be stabilized before proceeding with any trauma-focused treatment. We have found that suicidal ideation significantly reduces with WET, similar to what has been found for other trauma-focused treatments.

What if the client has limited emotional awareness (to the point of not even being able to label their emotions) and/or poor emotion regulation skills?

We suggest that in such cases the provider talks with the client about physiological symptoms they have when they think about or write the trauma and to include those symptoms in their writing. We have found that even clients with poor emotion regulation skills do well with WET, perhaps because there are no outside of session assignments.

What if the client has difficulty putting themselves in the mindset to write about their trauma in the allotted time?

Typically, patients can readily recall their traumatic experiences. The more common issue is that the patient cannot get through writing about the entire trauma event. The instructions tell the patient that they should not worry about getting through the entire trauma event in one session as they will have additional sessions to focus on the experience. Another common issue is that patients feel concerned about the details of the event they cannot recall. In such instances, the provider would reassure the patient that they just want them to focus on what they do remember and not to worry about the rest. We commonly find that the things they don't remember do come back to them as they write about the event.

I assume that the provider is sitting there while the writing is going on?

Yes, we recommend that provider remain in the room with the patient during the writing. The provider also keeps track of the time and then stops the patient when 30 minutes has elapsed.

Is there a way to modify for a client who has issues with writing due to physical limitations?

We have used a digital recorder for a handful of patients who could not write for various reasons (e.g., legally blind, hand damage). However, a person can talk a lot faster than they can write and if you are going to use a verbal recounting of the trauma event then it's really a different treatment. Overall, I would consider other treatment approaches if a client is unable to physically write.

How is WET different from Narrative Exposure Therapy

NET is an autobiographical accounting of one's life with a particular focus on their trauma experiences. The patient gives the account to the therapist (verbally) while the therapist types or writes the account. In contrast, in WET the patient solely focuses on one trauma event and writes it while the therapist is in the room. There is no verbal recounting of the trauma event to the therapist in WET. The number and duration of sessions is also different in NET.

With operations tempo and provider availability, time between sessions can be lengthy. Does this dilute WET impact?

The longest time frame between the sessions that we have studied is one week. There is data (Gutner et al., 2016) that the longer the time between trauma-focused treatment sessions, the less treatment gain. I would expect that is also the case for WET but I don't have data to directly address that question.

Does WET significantly reduce rage toward perpetrator (if there is a perpetrator)?

In general, patients generally experience a cognitive shift such that they feel more hopeful about their future as well as feel that they can move forward from their traumatic experiences. Thus, feelings of rage would likely decrease. That said, it is appropriate to feel anger towards perpetrators but the goal is for clients to not have that anger impair their functioning.

Should the clinician not engage with patient during written portion of session?

That is correct. The clinician should remain in the room but not talk with the client as that would remove the client from the exposure. I suggest that clinicians find something to read and try to sit in a way that they can still see the client in their peripheral vision but not staring at the client during the writing.

RESEARCH/FUTURE DIRECTION QUESTIONS:

Are there any outcome studies comparing clients with "simple" versus complex PTSD?

We have studies potential moderators of treatment outcome with WET and we have not found treatment outcome differences between simple vs. complex PTSD.

Have any of the subjects had PTSD from incest years/decades before, and is outcome similar to other causal events?

Yes, absolutely. We have had a high number of participants in our studies that had PTSD from chronic childhood abuse. They have good outcome and their outcome is not different from participants with a single event.

In military sample how many were women and did group include MST as contributing event to PTSD?

As the study is ongoing and no analyses have been conducted yet, I do not know the answer to this question about how many females are included in the study with service members. I would guess that it's between 10-20% but that is a guess. I do know that MST is the index event for some of the service members.

What was the differences among Veterans, specifically, combat vs. noncombat or officers vs. enlisted, or even higher ranking Service members/Veterans vs. lower enlisted? Do you notice any variance between active duty and national guard/reserve populations?

The data for veterans that I presented was a sample of 33 participants so we did not conduct subgroup analyses because it would be too small for meaningful findings. We hope to address such questions in the recently started study in VA, in which we plan to enroll 150 veterans.

Among military sample, was there a difference in outcomes based on therapist with active duty experience compared to therapists with no active duty experience?

We have not yet examined outcome data for the study conducted with service members so I cannot answer this question. The findings should be available fall of 2020.

Are you incorporating any of the published military moral injury scales in current study?

Yes, moral injury is included in the battery of measures in the military study we are conducting.

I am curious about your thoughts on integration of MDMA-assisted Psychotherapy with these findings given the response of that treatment through the FDA on phase 3 trials?

The findings from MDMA studies to date are very encouraging and I would expect similar positive findings would be obtained with WET. However, we have not data to directly address this question.

I work with federal offenders, many who have literacy issues, learning disabilities, and/or limited education. Also, these individuals often have little confidence in their ability to communicate in writing - even to themselves. Is there any evidence this issues may be treatment interfering, and do you have any suggestions for facilitating buy-in, and engagement? (Any data on how WET may work in individuals who are incarcerated? Is this something that could be implemented now? What training is required?)

We have constantly examined education level and verbal ability as a possible moderator of WET and have never found it to impact the outcome of WET. In fact, we have had individuals with as little as 3rd grade education and they do well with the treatment. Keep in mind that writing about the trauma is a way to get the patient to engage the trauma memory. The actual quality of the writing does not impact outcome.

As for using WET with incarcerated individuals, there is some data that should be published soon examining this question in a pilot study. The findings were very promising and clients had very good outcomes.

Could WET be used with Veterans with Alcohol Dependence if they are sober in a controlled environment (residential treatment setting)?

Yes, we use WET in such settings all the time, and we do have some data that suggests that not only is WET effective with PTSD treatment gains but also helps treatment with SUD.

Is this appropriate to do with adolescents?

This is a great question. We have not yet tested WET with adolescents but I don't see any reason why it would not work with this population. As long as they have normal cognitive development, it should be fine.

TELEHEALTH:

How do you implement WET via Telehealth? What modifications need to be made?

The only real modification would be to collect the narrative. One would need to have the patient send it to provider via secure message (scan using app on phone and then email) or therapist could take a screen shot with the web camera. I would recommend staying in contact with patient while they doing the writing via keeping the web camera on. I would recommend against using telephone as it is more difficult to stay connected with the patient and collecting the narrative is more complicated. Also, one would want to send the instructions for each session to the patient in advance of the session.

Since the client is asked to do WET in long-hand writing, what is the best method to collect their writing? How do you check the narrative to provide feedback?

You simply ask the patient to give you the narrative at the end of the session. Therapist can give back the narrative to the patient at the next session or hold onto all the narratives and give back at the end of treatment. As for feedback, providers are wanting to examine the narrative for how well the patient followed the directions. The treatment manual provides detailed instructions for reviewing the narratives and providing feedback to clients.

ADDITIONAL TRAINING:

Is there a training specific for WET and how can I access it?

The VA is providing trainings for VA providers. If someone is a VA provider they can contact me and I will direct you to the person who keeps a list of interested providers to contact for upcoming trainings. We are working with CDP to offer training for providers outside of VA.

If a provider or chaplain is unfamiliar with WET could they follow the written guidelines/manual and use the intervention or would one need additional training?

As long as someone has training in cognitive behavioral treatment, and specifically exposure-based treatments, they should be able to pick up WET just by following the manual. If someone does not have this type of training background, additional training would be recommended.