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Infusing Values Into Written Exposure Therapy: A Comparison Study

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INFUSING VALUES INTO WRITTEN EXPOSURE THERAPY: A COMPARISON STUDY

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Written Exposure Therapy is a brief, efficacious intervention for the treatment of PTSD symptoms. The WET protocol calls for the infusion of values into therapeutic work, however, does not detail how to incorporate these values work into the highly scripted treatment. This study compared the standard WET protocol with WET infused with values. The study examined differences across the two conditions on seven variables (PTSD scores, depression scores, value importance and consistency, quality of life, psychological flexibility, customer satisfaction, and therapeutic alliance). The sample was largely homogenous in gender, ethnicity, sexuality, and reported index trauma. The sample was largely white (75.00%), female (81.25%), and heterosexual (68.75%), with domestic violence (43.75%) and witnessing suicide (18.75%) being the primary reported traumas. A total of 23 participants were enrolled in the study. Overall, 18 completed at least one session and 16 participants completed all five sessions of the treatment and follow-up surveys. Large effect sizes were found depression (g=.88) and PTSD (g=.72) reported symptoms during treatment and quality of life (g=.91) at the two-month follow-up in favor of the WET+ condition. Differences in dropout rates were statistically significant ($x^2=3.91; df=1; p=0.048$). Six participants dropped from the standard WET condition, and one dropped from the value-enhanced WET condition. The implication of these findings is that treatment tolerability and symptom reduction was possibly increased by the addition of values.

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by

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I want to dedicate this work to my family and those with whom I’ve served. As a proud member of a strong military lineage that has faced unthinkable hardship, my wish for you is this: may all that you have endured become distant thunder as you have already shown you can face the storm.

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INTRODUCTION

Psychological Distress Following Traumatic Events

In the United States, approximately 60% of men and 50% of women will experience at least one trauma in their lifetime (National Center for Posttraumatic Stress Disorder, nd). Of those, US population surveys indicate that 7-8% will go on to develop PTSD (Keane et al., 2006). PTSD can impact those diagnosed across multiple contexts, including social, occupational, familial, and educational functioning. PTSD is known to interfere with daily functioning, and symptoms can include intrusive recollections, distressing thoughts and emotions, distorted sense of blame, feelings of detachment, and avoidance (American Psychiatric Association, 2013). Additionally, PTSD is known to have a high comorbidity rate with depression, with 49% of individuals being diagnosed with both disorders (Walter et al., 2018).

Given the prevalence rates of PTSD, the need for efficacious, readily available, evidence-based treatments are critical. Exposure based treatments are considered the gold-standard for treating PTSD (LoSavio et al., 2021; Morissette et al., 2022; Sloan & Marx, 2019). While exposure-based treatments are effective, they are often 8 to 12 sessions in length and can frequently have long waitlist times to access a trained provider. The time commitment required, or the cost associated with 8 to 12 sessions may be prohibitive for individuals wanting to engage in care. Fortunately, an exposure-based treatment only consisting of five sessions has emerged that has been proven to treat PTSD.

Written Exposure Therapy (WET)

WET is a structured and scripted, five session, evidence-based treatment designed to reduce PTSD symptoms (Sloan & Marx, 2019). WET has been shown to be an efficacious and well-tolerated PTSD treatment, with similar reduction rates of PTSD symptoms as compared to

other evidence-based therapies that require more sessions. Regardless of initial PTSD severity, depression severity, delayed or non-delayed expression of PTSD, or other demographic factors, symptoms were reduced (LoSavio et al., 2021).

The two main components of WET are imaginal exposure and cognitive restructuring (Sloan & Marx, 2019). Imaginal exposure is done via a writing exercise, where clients write, in as much detail possible, the details of their trauma for thirty minutes. During the same exercise, cognitive restructuring is taking place as clients reflect on the trauma. This reflection can consist of the meaning of their trauma, how it has affected their life, and how it has impacted their relationships.

Although WET is a fairly new therapy, research has found several promising findings. WET has been shown to maintain symptom improvement three months after treatment termination (Morissette et al., 2022), similar to other evidence-based exposure treatments. WET also has been found to be effective whether delivered in-person or via telehealth methods (LoSavio et al., 2021). While in the early stages of research, current research appears to be promising for WET to become a brief, easily accessible treatment for PTSD.

The Importance of Values

Values clarification is a process by which people come to understand their own values and how these values guide their lifestyle (Harris, 2021). Values can be thought of as behavioral standards and needs that drive a person forward through life. These stable qualities of behaving establish inherently positive reinforcers for individual behavioral choices when someone is acting in the direction of their values, or as punishers when one is not pursuing their values (da Silva Ferrerira et al., 2019). Values essentially act as individually crafted rules that govern behavior across settings. They are unique to each individual and are influenced by a number of

factors: family, life experiences, culture, religion, community, amongst many others. Clarifying values can help people learn more about themselves and develop goals they hope to achieve, including therapeutic goals.

Values allow for finding the meaning in situations and let clients orient their lives to what they find the most meaningful and purposeful for them as individuals (Lejeune & Luoma, 2019). A common refrain in values work is "creating a life worth living". Initiating conversations with clients about their personal values allows them to connect with what is most important to them, even while enduring moments of suffering.

Rather than focusing on pure symptom reduction, which is the primary target of most evidence-based treatments, incorporating values work attempts to have clients be willing to notice aversive events that are inherently part of everyday living while living according to their values (Matheus & Caserta, 2020). When clients engage in valued action it does lead to reductions in psychological suffering. Acceptance and Commitment Therapy (ACT) proposes that one of the primary drivers of suffering is the disconnect between clients living according to values. By incorporating values clarification into existing evidence-based exposure treatments, we may be able to simultaneously target symptom reduction and increase overall quality of life. Infusing values into treatment aids clients in clarifying priorities, goals, and most importantly, in regard to trauma-informed care, implementing change in their lives. Trauma work is notoriously difficult with high attrition rates and having a benchmark for "why" a client is engaging in this difficult work may be a key component in maintaining engagement in difficult therapeutic work.

Values and Exposure

There is a wealth of evidence supporting exposure evidence-based treatments for PTSD, including Written Exposure Therapy (WET; LoSavio et al., 2021; Morissette et al., 2022; Sloan

& Marx, 2019). However, low treatment engagement remains a problem in exposure-based PTSD treatment (Phillips et al, 2020), with up to 50% dropping from treatment (Foa et al., 2007; Peterson et al., 2019; Rauch et al., 2009; Schottenbauer et al., 2008). This may be due to avoidance, which is characteristic of PTSD. Increasing treatment engagement is vital to treatment success for all evidence-based therapies.

Recently, incorporating Acceptance and Commitment Therapy (ACT) into existing evidence-based treatments for PTSD has emerged as a method to increase treatment engagement (Phillips et al., 2020). Within that study, the two primary concepts from ACT proposed to help mitigate low PTSD treatment engagement were cognitive defusion and values clarification. In addition to cognitive defusion, Grau and colleagues (2020) indicated that the experiential avoidance component of ACT carries significance and also proposed values as a relevant component of ACT for people reporting elevated PTSD symptoms. Further support for infusing ACT into exposure-based work comes from Hochard and colleagues (2021). This study suggested that committed action towards values has been shown to increase social support seeking behaviors for those experiencing mental distress, which is a known protective factor in those with PTSD. In order to target these components, a therapy targeting avoidance and incorporating explicit values clarification for the individual client is needed.

Integrating values-based work and exposure-based treatment has been found to reduce treatment attrition rates and tolerability (Ramirez et al., 2021). The fusion of ACT concepts and prolonged exposure also has resulted in increased psychological flexibility and overall functioning. However, research in this area is just beginning and has been limited to military populations in intensive outpatient settings without control groups to serve as a comparison. Examining how one specific concept from ACT (values) may be a helpful first step in

ascertaining which concepts from ACT have the most impact when combined with traditional exposure-based therapies. Having an active control treatment group to serve as a comparison point is necessary to determine if these changes were simply a by-product of decreased symptoms of PTSD and therefore overall increased psychological functioning, or rather the incorporation of ACT components intro treatment.

The Present Study

The current study investigated whether the standard WET protocol enhanced with values clarification reduces attrition rates (an indicator of treatment acceptability) and psychological symptoms more than the standard WET protocol alone. Additionally, the study examined whether the added values clarification increased overall quality of life and psychological flexibility post treatment. The WET protocol describes that values are important to treatment goals, however, offers no details as to how to incorporate this into the treatment. By adding an explicit structured values clarification component to WET, the study examined if any differences emerged between WET alone vs WET plus values clarification. To address the research questions, self-report data was collected on demographic variables, experienced traumatic events, trauma-related symptoms, depressive symptoms, and quality of life measures.

The following research questions were addressed in the proposed study:

1. *Question 1:* Does adding a values clarification to WET reduce psychological symptoms more than standard WET protocol?
    a. Does a full dose of WET+ reduce trauma-related symptoms more than WET?
    b. Does a full dose of WET+ reduce depressive symptoms more than WET?
2. *Question 2:* Does adding a values clarification to WET reduce psychological symptoms more than standard WET protocol at the two-month follow-up?

a. Are reductions in trauma-related symptoms higher at two-month follow-up for the WET+ condition?
b. Are reductions in depression symptoms higher at two-month follow-up for the WET+ condition?

3. *Question 3:* Does adding a values component to WET treatment enhance overall post treatment outcomes?
    a. Does a full dose of WET+ increase overall psychological flexibility as compared to WET post treatment?
    b. Does a full dose of WET+ increase overall quality of life as compared to WET post treatment?
    c. Does a full dose of WET+ increase valued action as compared to WET post treatment?
4. *Question 4:* Does adding a values component to WET treatment enhance overall post treatment outcomes at two-month follow-up?
    a. Does a full dose of WET+ increase overall psychological flexibility as compared to WET at two-month follow-up?
    b. Does a full dose of WET+ increase overall quality of life as compared to WET at two-month follow-up?
    c. Does a full dose of WET+ increase valued action as compared to WET at two-month follow-up?
5. *Question 5:* Does adding a values component to WET result in lower treatment attrition rates?

METHOD

Participants

Participants were recruited largely from social media platforms, restricted to those over the age of 18 and currently residing in the state of Michigan. All recruitment used the social media recruitment script (Appendix J) and the study recruitment flyer (Appendix K). Interested participants reached out to the study's designated email address. Potential participants were then contacted to schedule an informed consent session. Participants needed to identify an index trauma that met DSM 5 Criterion A traumatic event criteria and had a PTSD Checklist for DSM-5 (PCL-5) score of at least 31, which indicated they would benefit from trauma focused treatment. If they did not have a Criterion A trauma or a score of at least 31 on the PCL-5, they were excluded from further participation. Additionally, those who had prior or were currently receiving mental health treatment for the identified index trauma, or had any psychotropic medications changes within the last eight weeks were excluded.

Thirty-eight participants were screened, 11 failed to meeting inclusionary criteria and 4 declined to participate further. Twenty-three (60.5%) met inclusion criteria and were randomized. Of those 23, 4 in WET discontinued after the eligibility session, 2 participants discontinued after receiving the first session (1 in WET and 1 in WET+), and 1 participant in WET after the fourth session. Thus, 16 participants completed all five sessions of WET or WET+. All of these participants also completed the two-month follow-up. The data for the 7 dropouts are described individually. The group analyses are based on the completer sample of 16.

The demographics indicated that the completion sample was largely female (81.25%), white (75.00%), and had some college (37.5%). Domestic violence (43.75%) and witnessing

suicide (18.75%) were the most prevalent index traumas endorsed. Childhood abuse and sexual assault were endorsed at the same levels by participants (12.25%). Outside of those four types, the other two types of index traumas endorsed were a motorboat accident with the near death of a child and a drive-by shooting to the participant's home occurring while eating dinner. No statistically significant differences between groups on any of the demographic variables were found. Table 1 is a summary of the demographic characteristics of the final completer sample with corresponding statistics.

Table 1

Completer Sample Demographics (N=16)

Variable	**Total *n***	**Total %**	**WET+**	**WET**	**x^2**	***df***	***p***
Gender					1.47	2	0.48
Male	2	12.50%	1	1			
Female	13	81.25%	8	5			
Nonbinary	1	6.25%	0	1			
Ethnicity					4.15	3	0.25
White	12	75.00%	7	5			
Hispanic/Latino	2	12.50%	0	2			
Black/African American	1	6.25%	1	0			
Native American	1	6.25%	1	0			
Sexuality					4.92	2	0.09
Heterosexual	11	68.75%	5	6			
Bisexual	4	25.00%	4	0			
Asexual	1	6.25%	0	1			
Education					7.53	5	0.18
HS/GED	2	12.25%	2	0			
Some College	6	37.50%	2	4			
Associates Degree	2	12.25%	0	2			
Bachelors Degree	4	25.00%	3	1			
Masters Degree	1	6.25%	1	0			
Doctoral Degree	1	6.25%	1	0			
Index Trauma					2.26	5	0.81
Domestic Violence	7	43.75%	4	3			
Sexual Assault	2	12.25%	1	1			
Childhood Abuse	2	12.25%	1	1			
Witnessed Suicide	3	18.75%	1	2			
Motorboat Accident	1	6.25%	1	0			
Drive by Shooting	1	6.25%	1	0			

Measures

Demographic Questionnaire

This investigator-developed questionnaire asked questions for participants to indicate their basic demographics, including birthdate, gender identity, ethnicity, sexual orientation, education level, ethnicity, state of residence, student status, and military status (see Appendix B). Additionally, participants were asked about any current or past mental health treatment as well as any psychotropic medication use.

Life Events Checklist (LEC-5)

The Life Event Checklist (LEC) consists of seventeen categories of traumatic events (Blevins et al., 2015; see Appendix C), as well as having participants identify an index trauma. Participants indicate whether their exposure to each event was through personal experience, witnessing, learning about, or occupational experience.

PTSD Checklist for DSM-5 (PCL-5)

The Posttraumatic Stress Disorder Checklist (PCL) is widely used to assess for PTSD symptom criteria in the Diagnostic and Statistical Manual of Mental Disorders (see Appendix D). The PCL-5 is a psychometrically sound measure of PTSD symptoms that represent the most up-to-date criteria within the DSM-5 (Blevins et al., 2015). It consists of a 20-item self-report measure that assesses for the 20 DSM-5 symptoms of PTSD (U.S. Department of Veterans Affairs, 2016). Higher scores indicate greater symptom severity. Scores above 31 indicate that the person taking the measure may benefit from a trauma related treatment. The self-report scale ranges from 0-4 for each symptom. The rating scale includes the descriptors “Not at all,” “A little bit,” “Moderately,” “Quite a bit,” and “Extremely” (U.S. Department of Veterans Affairs,

2016). This measure has been found to have strong internal validity and reliability, Cronbach's α = .94 and test–retest r = .82 (Blevins et al., 2015).

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a 9-item self-report measure that assesses for symptoms of depression. This measure has been found to have strong internal validity and reliability, Cronbach's α = .89 and test–retest r = .84 (Kroenke et al., 2001; see Appendix E). The self-report scale ranges from 0-3 for each symptom. The rating scale includes the descriptors "Not at all," "Several days," "More than half the days," and "Nearly every day". Higher scores indicate greater symptom severity.

Valued Living Questionnaire (VLQ)

The VLQ is a 20-item self-report measure that assess the 10 valued domains of living (see Appendix F). These domains are family, marriage/couples/intimate relations, parenting, friendship, work, education, recreation, spirituality, citizenship, and physical self-care. The 10 areas are rated on a scale of 1-10, indicating the level of importance and how consistently they have lived in accord with those values in the past week. The instrument has shown good test-retest reliability (r=.90; Wilson et al., 2010). In this study, values importance and consistency subscales were scored separately at all time-points to assess for possible changes in either subscale.

Psy-Flex

The Psy-Flex is a 6-item self-report measure that assesses for psychological flexibility, mindfulness, well-being, and meaning in life (see Appendix G). The self-report scale ranges from 1-5 for each question. The rating scale ranges from "very seldom" to "very often". The

instrument has shown good reliability with Raykov's coefficient across samples at 0.91 (Gloster et al., 2021).

Quality of Life Scale (QOLS)

The QOLS is a 15-item self-report measure that assess the five conceptual domains of quality of life (see Appendix H). These domains are material and physical well-being, relationships, social/community/civic activities, personal development and fulfillment, and recreation. The five areas are rated on a scale of 1-7, ranging from terrible to delighted. Higher summed scores indicate higher quality of life, with healthy normative samples averaging around 90. The instrument has shown good test-retest reliability, r=.84 (Burckhard & Anderson, 2003).

Customer Satisfaction Questionnaire (CSQ)

The CSQ was originally used to measure and assess consumer satisfaction with health and human services (Attkisson & Greenfield, 2004; see Appendix N). For this study this measure will be administered post-treatment to evaluate the participant's satisfaction of treatment. The CSQ reports a single score measuring a single dimension of overall satisfaction. This instrument has shown good validity ($\alpha > 0.80$).

Working Alliance Inventory – Short Revised (WAI-SR)

The WAI-SR is a 12-item self-report measure of therapeutic alliance that assesses three aspects of therapeutic alliance: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy and (c) development of an affective bond (Munder et al, 2010; see Appendix O). The items are rated on a scale of 1-5, ranging from seldom to always. Higher scores across the three aspects indicated higher alliance. This instrument has shown good validity ($\alpha > 0.80$).

Procedure

Individuals interested in learning more about becoming participants were directed to contact the graduate student investigator at an email established for the purposes of the study. Once contacted, individuals established a meeting with the graduate student investigator to meet virtually through WebEx, a HIPAA compliant videoconferencing application. Due to the virtual nature of the study, access to a computer, webcam, and internet were required for both the informed consent and all further study sessions. Participants were emailed the WebEx link and the informed consent document 24-hours prior to the consent session. Participants were informed that they were welcome to review the document, however it was reviewed fully with them during the scheduled session. During the session, the informed consent document (Appendix A) was reviewed, study requirements were described, and participants had the opportunity to ask any questions they may have had. The potential participant was then asked to indicate their consent or non-consent using the Qualtrics form. Those that elected not to consent were given a list of alternative mental health resources (Appendix I).

For those that provided consent, they then completed a semi-structured interview and the self-report questionnaires. Mental health treatment, both current and past, and index trauma were reviewed verbally. Participants were then assigned a participant ID in order to complete the remainder of the Qualtrics measures throughout the course of the study. The Life Events Checklist (LEC-5), the PCL-5, and Patient Health Questionnaire (PHQ-9), and demographic questionnaires were filled out by the participants via Qualtrics using their participant number. Interested individuals were considered eligible for the study if they (1) were over the age of 18; (2) identified an index trauma meeting Criterion A for PTSD; (3) had a PCL-5 score of at least 31; (3) had sufficient memory of the event to benefit from WET; (4) were not currently receiving

mental health treatment for the index trauma; and (5) did not have any psychotropic medication changes in the previous eight weeks.

Once the participant had completed all of the pretreatment measures, the researcher examined the measures to confirm all inclusion criteria had been met. If they were not met, or if any of the exclusion criteria were confirmed, the individual was informed they were not eligible to participate and was given the list of alternative mental health resources (Appendix I). If all inclusion criteria were met, the first session was scheduled at the end of the session.

Once eligibility was established, participants were randomized into either the WET or values enhanced WET (WET+) condition. A random number generator was used to generate either a 1 (WET+) or 2 (WET). The first participant was assigned to the group that was randomly generated, and the next participant was assigned to the other condition to ensure equal distribution of participants across conditions.

The active control condition was consistent with standard WET protocol. The other condition was consistent with the standard WET protocol with an added values clarification component that was delivered in the first treatment session and a values check-in during all subsequent sessions of WET. Participants' first treatment session occurred approximately one week after the informed consent and pre-treatment measures were obtained. All sessions thereafter were scheduled weekly until treatment was complete.

Regardless of the condition, the start of each session began the same, and the follow-up surveys were administered in the same way. To ensure participant safety, and to follow standard virtual therapy guidelines, physical locations were collected. Additionally, PCL-5, PHQ-9, Valued Living Questionnaire (VLQ), Quality of Life Scale (QOLS), and the Psy-Flex, were administered via Qualtrics at the start of each session for data collection purposes. The

Customer Satisfaction Questionnaire (CSQ) and Working Alliance Inventory – Short Revised (WAI-SR) were administered at the conclusion of each session via Qualtrics. Measures were administered seven times over the course of the study (see Table 2).

Table 2

Times During the Study When Measures Were Administered

Approximate Time in Study	Research Activity	Measures Administered
Pretreatment Assessment		
Beginning	Informed consent session	Demographics Questionnaire, LEC-5, PCL-5, PHQ-9
Intervention		
2-6 weeks	WET and WET+ Sessions 1-5	PCL-5, PHQ-9, VLQ, QOLS, Psy-Flex, WAI-SR, CSQ
Follow Up Assessment		
14 weeks	Two months after session five	PCL-5, PHQ-9, VLQ, QOLS, Psy-Flex

Assessing Risk and Safety Planning

Qualtrics was structured such that any endorsement of item nine on the PHQ-9 alerted the graduate student investigator. Though the Columbia Suicide Severity Rating Scale (C-SSRS; see Appendix Q) to assess suicidality was in place should a participant indicate they were at risk for suicidality, no participants indicated active suicidality throughout the course of the study.

Active Control Condition: WET Alone

In the active control condition, the research therapist followed WET protocol, with a 30-minute HEADSS (Appendix P) assessment added to the first treatment session following the standard WET protocol for the first session to act as a balance to the 30-minutes values clarification in the treatment condition (Marx & Sloan, 2019). All participants received sessions via WebEx virtually. WET consists of five sessions. Per WET protocol, the first session consisted of psychoeducation on trauma and therapeutic rationale. All subsequent sessions were

identical per WET protocol. These sessions largely consisted of the session writing task, focused on the participants index trauma. Per protocol, participants were asked to write about their index trauma in as much detail as possible, including sensory information, thoughts and feelings, and the various aspects of the event as it occurred with a writing implement and paper. No electronic means of writing were permitted per WET protocol recommendations. The therapist monitored the participants as they completed the writing task. Following the completion of the task, the session was concluded with check-in per protocol.

Treatment Condition: WET+ Values Clarification

In the WET+ condition, the first treatment session incorporated a 30-minute values clarification component following the standard WET protocol. Psychoeducation on trauma and the therapeutic rationale were given prior to engaging in the values clarification. This 30-minute addition focused on psychoeducation regarding values, as well as identifying their own values from the 10 domains of values from the VLQ: family relations, marriage/couples/intimate relations, parenting, friendships/social life, career/employment, education/personal growth and development, recreation/fun/leisure, spirituality, citizenship/environment/community life, and health/physical well-being. Participants were informed that values are not the same as goals, which are achievable milestones. Rather, values are areas in our lives in which we can have constant movement or can be considered an ongoing process. For example, being a loving, caring partner versus being married, or having a strong work ethic versus obtaining a promotion. Participants were informed that there are no "correct" values, regardless of what they have been previously taught, and that they are highly individual to each person. If any of the 10 domains did not apply to the participants, they were allowed to skip that domain and move to subsequent domains as the therapist moved through the values clarification. At the end of this clarification,

they engaged in identifying their own values and ranking them in order of importance. This initial values clarification served as the foundation for subsequent inquiries prior to engaging in the writing task. Their identified values served as the foundational guide to the prompt of "what is the why that guides you to doing this work today". This resulted in the first session being 90 minutes in length.

All subsequent sessions followed standard WET protocol (Marx & Sloan, 2019) with an added values check-in. The values check-in began prior to engaging in the writing assignment. The therapist asked the participant to think about their values and why they engaged in the exercise prior to writing their trauma narrative. They were asked "what's your why? What's your why right now"? The remainder of the session was identical to treatment conditions highlighted in the active control condition above. All sessions were scheduled weekly once treatment began.

Data Collection and Confidentiality

This study was conducted virtually, with the therapist and all participants physically residing in the state of Michigan. All study sessions were completed using WebEx, which has sufficient safeguards for privacy, e.g. HIPAA compliant, ability to lock the virtual conference room.

Participants' responses were coded using their participant ID assigned to them during the consent process. The list of participant IDs with participant identifying information was stored separately to keep anonymity throughout the study. The informed consent document was a separate survey within Qualtrics to ensure confidentiality. All other survey data was collected with the participant ID. This gave the ability to link all data points to a single participant. The

ID will consist of the last four digits of their phone number and the numeric month of their birth, i.e., 033005 for someone with the last four digits of 0330 and born in May.

All recorded sessions were stored in a secure, HIPAA compliant OneDrive folder. Only members of the research team had access to the secure folder. Research members that had access to the folder were educated on confidentiality and confidential practices to ensure HIPAA compliance.

Finally, this study utilized a web-based survey application that Western Michigan University has made available to faculty, students, and staff in the College of Arts and Sciences. Qualtrics© states that all participant data is protected through both encryption and firewalls. In addition, all data remains confidential and safe-guarded through the Health Insurance Portability and Accessibility Act (HIPPA) and Health Information Technology for Economic and Clinical Health Act (HITECH). The Qualtrics® system allows users to develop web-based surveys, conduct basic analyses, record participant data, and export data.

Design

This study used a pre-test post-test control group design with repeated measures to investigate the impact of adding values clarification to virtually delivered WET on the reduction of PTSD and depression symptoms. The standardized WET protocol served as the control group for comparison.

Research Therapist

Sessions for both the treatment and control conditions were provided by a graduate level therapist who is currently enrolled in a clinical psychology Ph.D. program. The therapist has completed the requisite coursework and has over 1,000 supervised clinical hours with clients.

Any supervision or clinical consultation needed throughout the study was provided by the PI who is a licensed clinical psychologist.

Treatment Fidelity and Therapist Competency

After all sessions for the protocol were completed, fidelity and therapist competency were assessed by two graduate research assistants (GRA) on recorded treatment sessions. All sessions were recorded and 10 videos were randomly pulled from each treatment condition. GRAs were trained on the WET session scripts (Appendix L) from the treatment protocol (Marx & Sloan, 2019), as well as the values clarification script (Appendix M), and HEADSS Assessment (Appendix P) in order to ensure adherence and compliance with the protocol. GRAs spent three hours in total training with the graduate student investigator on WET protocol fidelity, values clarification scripts, and therapist competency assessment. During the course of training, samples were used to illustrate various study components. GRAs reviewed the Qualtrics survey used for assessment during the training for understanding of the task. Questions were asked and answered during the course of the training. The Adherence and Competence Ratings measure (Appendix R) was used to review 20 randomly selected sessions across treatment conditions. Interrater reliability was not assessed due to the video randomization. Regardless, GRA findings were highly stable, with little variability within the responding across competency and fidelity checks. Fidelity results are presented in Table 3. The one significant departure from treatment protocol was a participant that was consulted on with the primary investigator. Participant 6 (WET+) disclosed during the course of the study that she was diagnosed with borderline personality disorder. Sessions frequently involved emotion regulation strategies prior to engaging in the writing task.

Table 3

Adherence and Competence Ratings

Variable	*Yes*	No
Therapist followed WET script with fidelity during the session.	100%	0%
Did any significant problems arise during the session that led to a significant departure from the treatment protocol?	5%	95%
Therapist engaged participants in values recall (applicable protocol)	100%	0%

Competency was measured across seven questions with a seven-point Likert scale. The scale ranged from poor (1) to excellent (7). Competency results are presented in Table 4.

Table 4

Competency Results

Question	Mean	Std Dev
Therapist provided appropriate feedback after writing exercise.	6.90	0.30
Therapist exhibited good rapport with the patients.	6.90	0.30
Therapist exhibited accurate empathy.	7.00	0.00
Therapist engaged participants in a professional manner.	7.00	0.00
Therapist addressed questions or problems	7.00	0.00
Therapist structured time efficiently and was able to keep the focus of the session on the issues appropriate for the session.	6.95	0.22
Please give a rating of the therapist's overall skills as demonstrated in this session.	7.00	0.00

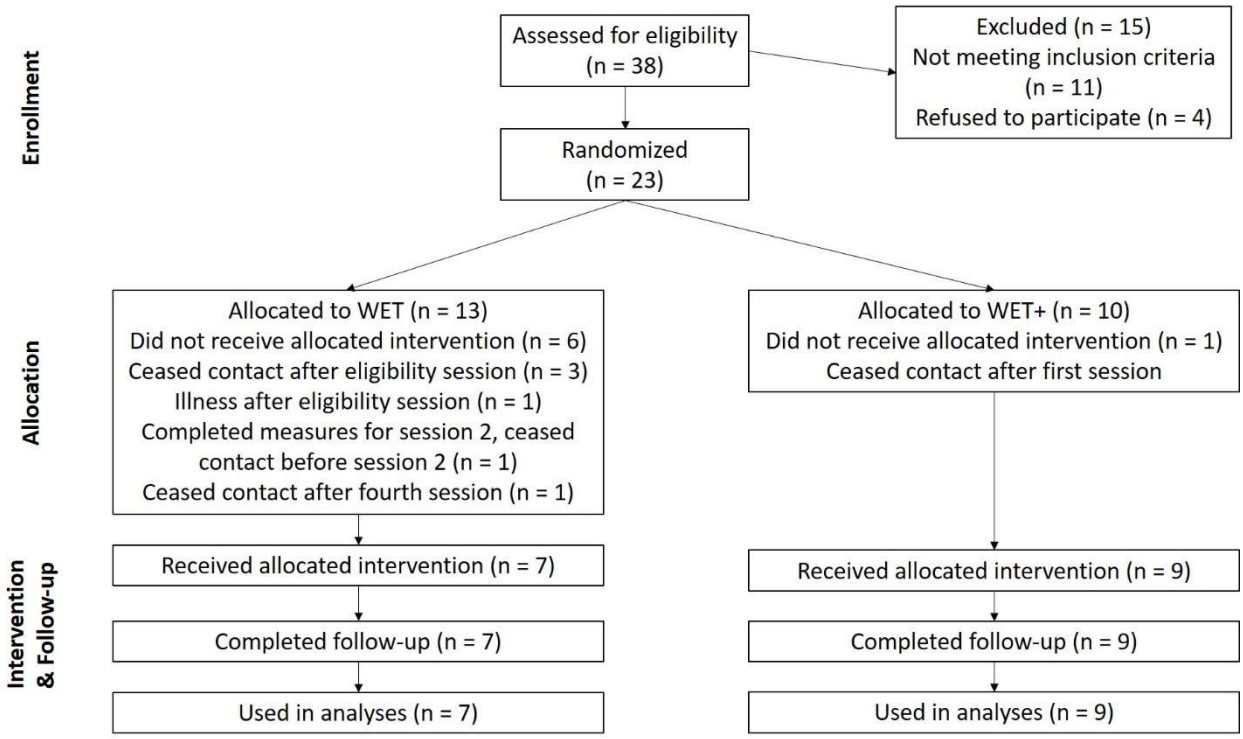
RESULTS

Participant Flow

Participant flow is displayed in a CONSORT diagram (see Figure 1). Thirty-eight individuals completed informed consent and assessed for eligibility. Of the 23 participants who began the study, 16 completed the full treatment protocol and follow up assessment at two-months. Participants were recruited from March 2023 to May 2023 and follow-up was completed in August 2023.

Figure 1

CONSORT Diagram



Non-completers

Seven participants withdrew from treatment over the course of the study, six from the WET condition and one from the WET+ condition. The following details their overall

demographic information, index trauma, and their reported symptoms and outcome measures (when available).

1. Participant 20 (WET) was a 53-year-old, white, heterosexual female. She reported domestic violence as her index trauma. Her reported scores at eligibility were 48 (PCL-5) and 12 (PHQ-9). She ceased contact with the graduate student investigator after her eligibility session.
2. Participant 21 (WET) was a 38-year-old, white, bisexual female. She reported childhood abuse as her index trauma. Her reported scores at eligibility were 36 (PCL-5) and 16 (PHQ-9). She ceased contact with graduate student investigator after her eligibility session.
3. Participant 22 (WET) was a 42-year-old, white, bisexual female. She reported domestic violence as her index trauma. Her reported scores at eligibility were 54 (PCL-5) and 23 (PHQ-9). She ceased contact with graduate student investigator after her eligibility session.
4. Participant 23 (WET) was a 44-year-old, white, heterosexual female. She reported witnessing the drowning of a friend as her index trauma. Her reported scores at eligibility were 72 (PCL-5) and 20 (PHQ-9). She ceased contact with graduate student investigator after her eligibility session.
5. Participant 3 (WET) was a 32-year-old, mixed race (White, African American, Latina, American Indian), bisexual female. She reported childhood sexual abuse as her index trauma. She completed the first session of WET and the pre-session measures for session two. She was unable to be contacted after submitting her pre-session measures. Her reported scores at eligibility were 38 (PCL-5) and 11 (PHQ-9). At session one her

reported scores were 44 (PCL-5), 17 (PHQ-9), 7 (VLQ-I), 6.5 (VLQ-C), 51 (QOL), and 21(PsyFlex). Her reported session two scores on the measures she did complete prior to ceasing contact with graduate student investigator were 27 (PCL-5), 11 (PHQ-9), 61 (QOL), and 23 (PsyFlex).

6. Participant 9 (WET) was a 41-year-old, white, heterosexual female. She reported childhood abuse as her index trauma. Her reported scores at eligibility were 70 (PCL-5) and 22 (PHQ-9). At session one her reported scores were 70 (PCL-5), 24 (PHQ-9), 4.3 (VLQ-I), 8 (VLQ-C), 44 (QOL), and 15 (PsyFlex). She completed a total of four sessions prior to ceasing contact with the graduate student investigator. Her reported scores at session four were 41 (PCL-5), 14 (PHQ-9), 7 (VLQ-I), 2.8 (VLQ-C), 48 (QOL), and 18 (PsyFlex). Even without completing the full protocol, this participant experienced clinically significant changes in her reported PTSD (29-point change) and depression (8-point change) symptoms reported.
7. Participant 18 (WET+) was a 50-year-old, white, asexual female. She reported childhood abuse as her index trauma. Her reported scores at eligibility were 50 (PCL-5) and 17 (PHQ-9). At session one her reported scores were 51 (PCL-5), 19 (PHQ-9), 6.1 (VLQ-I), 4.4 (VLQ-C), 40 (QOL), and 22 (PsyFlex). She ceased contact with graduate student investigator after her first session.

Examination of Differences at Baseline

During the eligibility/consent session, PCL-5 and PHQ-9 data were collected from participants to determine eligibility. Preliminary analyses in the form of independent samples t-test were performed and Hedges g effect size estimates were calculated to determine whether randomization produced comparable groups. Statistically significant differences, or the presence

of medium-large effect sizes estimates would suggest initial differences in the groups that would inform later analyses. Effect size differences were found for each variable (Table 5). Hedges g was used for effect sizes due to the small sample size of the study. PCL-5 had a medium effect size (g=.39) and PHQ-9 was found to have a large effect size (g=.79).

Table 5

Initial Means Across Protocol Conditions on Baseline Data

	WET+ (n = 9)		**WET (n = 7)**		**Statistics**		
	M	***SD***	***M***	***SD***	***t***	***p (2/1)***	***g***
PCL-5	50.11	13.92	44.57	12.79	-.82	.43/.21	.39
PHQ-9	15.44	5.50	10.86	5.49	-1.66	.12/.06	.79

Examination of Differences Immediately Prior to Session 1

Primary outcome variables for this study were PTSD scores (PCL-5), depression scores (PHQ-9), value importance and consistency (VLQ-I/C), quality of life (QOLS), and psychological flexibility (Psy-Flex). These variables were collected at each therapy session and at the two-month follow-up. Given the effect sizes found in the initial comparison of baseline data, an independent t-test was used to compare the possible mean differences between the two conditions at the first treatment session (Table 6). The differences in mean scores between WET and WET+ conditions prior to the initiation of treatment appeared to be trending in the direction of greater than what might be expected by sampling variation alone. This test was used to determine if the participants assigned to the two protocols differed from each other.

Table 6

Means, Standard Deviations, T-test and Effect Size Data Across Protocol Conditions on Five Psychological Variables Prior to Session 1

	WET+ (n = 9)		WET (n = 7)		Statistics		
	M	***SD***	***M***	***SD***	***t***	***p (2/1)***	***g***
PCL-5	57.22	8.59	49.71	12.88	-1.40	.18/.09	.67
PHQ-9	17.33	5.66	12.43	5.80	-1.70	.11/.06	.81
VLQ-I	6.46	1.32	7.47	1.12	1.63	.13/.06	.76
VLQ-C	4.51	2.29	5.56	2.10	.94	.36/.18	.45
QOL	50.78	12.65	63.71	17.41	1.73	.11/.05	.82
PsyFlex	17.44	3.13	18.71	5.06	.62	.55/.27	.30

The analyses comparing the two groups prior to session 1 showed medium to large effect sizes on all variables except psychological flexibility. This indicates that randomization was not completely successful, and the groups were different at treatment initiation. Given the effect sizes, we can assume that if these differences held to a larger sample size, statistical significance would be found. These differences were taken into account in subsequent analyses. To address the research questions one and three, repeated measures ANOVA were used. Two groups by six time points were used to test time, time x treatment, and treatment group effects for PCL-5 and PHQ-9 scores due to those measures being collected from eligibility/consent through session five. Two groups by five time points were used to test to test time, time x treatment, and treatment group effects for VLQ-I, VLQ-C, QOL, and PsyFlex due to those measures only being collected during treatment.

Research Question 1a

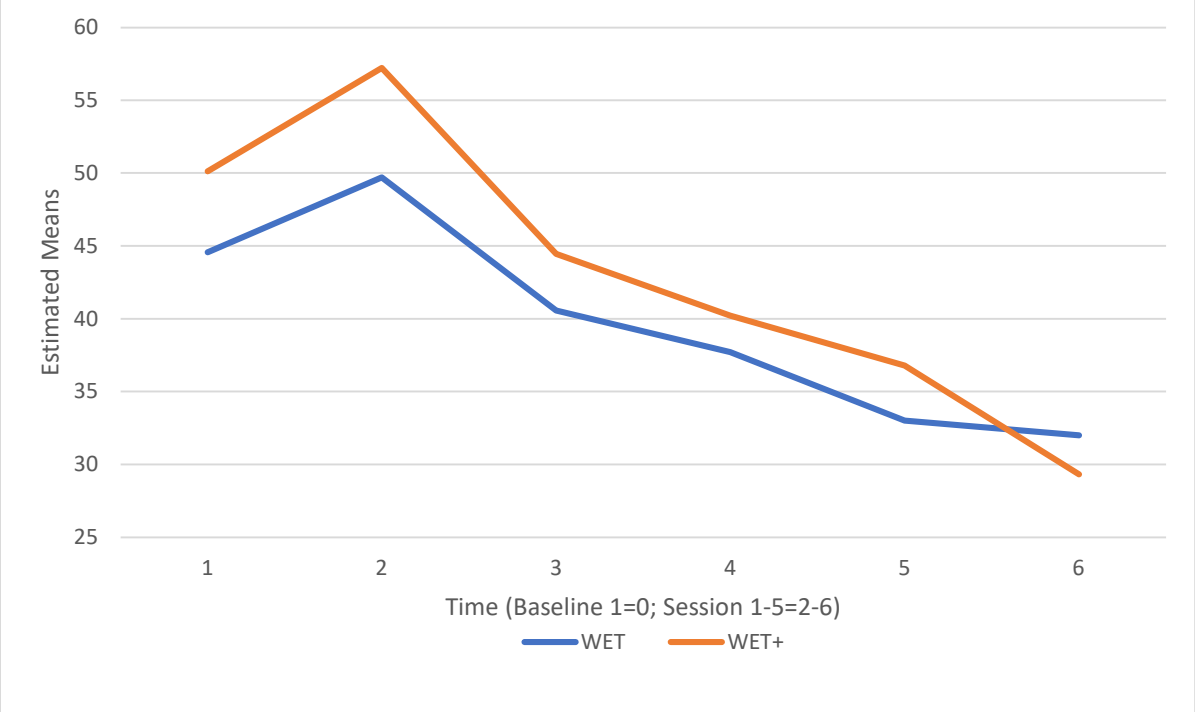
A 2 x 6 repeated measures ANOVA was utilized to analyze the PCL-5. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated ($p = .03$), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' PCL-5 scores

showed a statistically significant decrease over time (F (2.98, 41.66) = 19.64, $p < .001$). No time by treatment interaction effects were found (F (2.98, 41.66) = .84, $p = .48$). As shown in Figure 2, the significant time effect in the absence of an interaction term suggests significant trauma symptom reduction occurred regardless of treatment condition.

Given that the WET+ condition had more severe initial PCL-5 scores (See Table 6 and Figure 2) the amount of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the PCL-5 trended toward significance ($t = 1.52$, $p_{(1\text{-tailed}/2\text{-tailed})} = .08/.15$) and the Hedges g estimate revealed a large effect size (g=.72) favoring the WET+ condition (see Table 7).

Figure 2

PCL-5 Estimated Mean Scores from Baseline to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET+ PCL-5 mean scores started a standard deviation above the WET condition and was lower upon treatment completion.

Research Question 1b

A 2 x 6 repeated measures ANOVA was utilized to analyze PHQ-9 scores. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p<.001), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' PHQ-9 scores showed a statistically significant decrease over time (F (1.70, 23.83) = 10.96, p < .001). No time by treatment interaction effects were found (F (1.70, 23.83) = 2.44, p = .12). As shown in Figure 3, the significant time effect in the absence of an interaction term suggests significant depression symptom reduction occurred regardless of treatment condition.

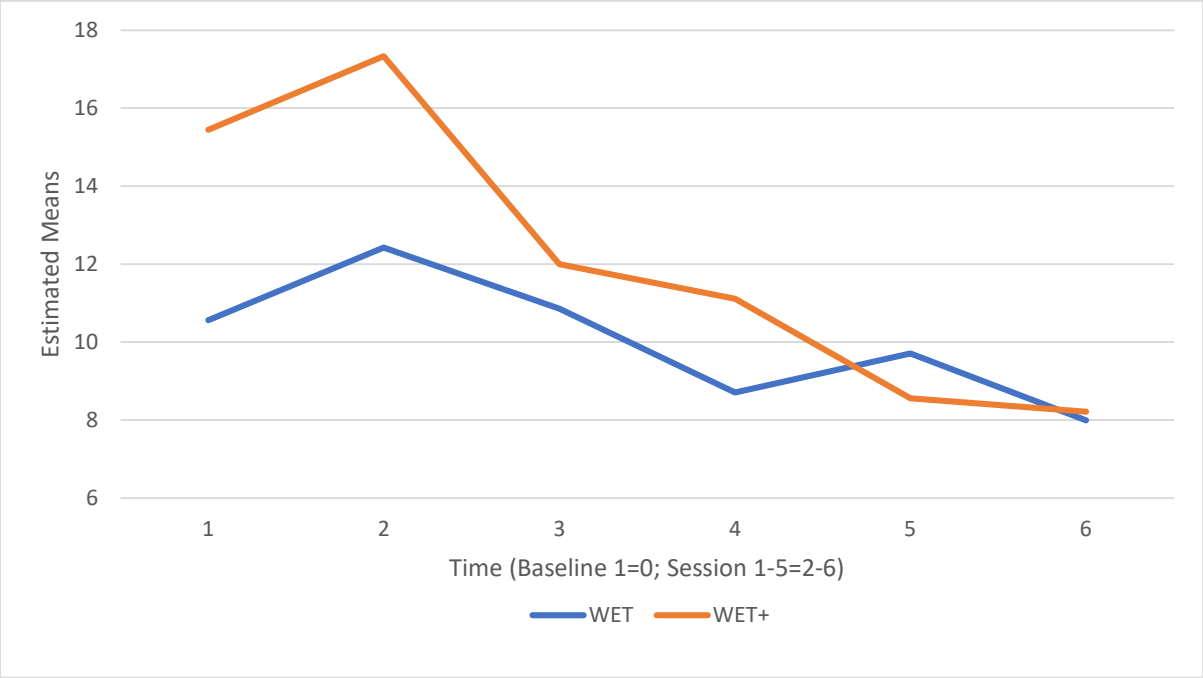
Given that the WET+ condition had more severe initial PHQ-9 scores (see Table 6 and Figure 3) the amount of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the PHQ-9 trended toward significance (t = 1.85, $p_{(1\text{-tailed/2-tailed})}$ = .04/.09) and the Hedges g estimate revealed a large effect size (g=.88) favoring the WET+ condition (see Table 7).

Research Question 3a

A 2 x 6 repeated measures ANOVA was utilized to analyze the Psy-Flex. Mauchly's Test of Sphericity indicated that the assumption of sphericity was not violated (p = .37). Analyses indicated that the participants' Psy-Flex scores showed a statistically significant decrease over time (F (3.11, 43.56) = 6.32, p = .001). No time by treatment interaction effects were found (F (3.11, 43.56) = .76, p = .53). As shown in Figure 4, the significant time effect in the absence of an interaction term suggests significant increase in psychological flexibility occurred regardless of treatment condition.

Figure 3

PHQ-9 Estimated Mean Scores from Baseline to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET+ PHQ-9 mean scores started more than a standard deviation above the WET condition and approximately equal upon treatment completion.

Table 7

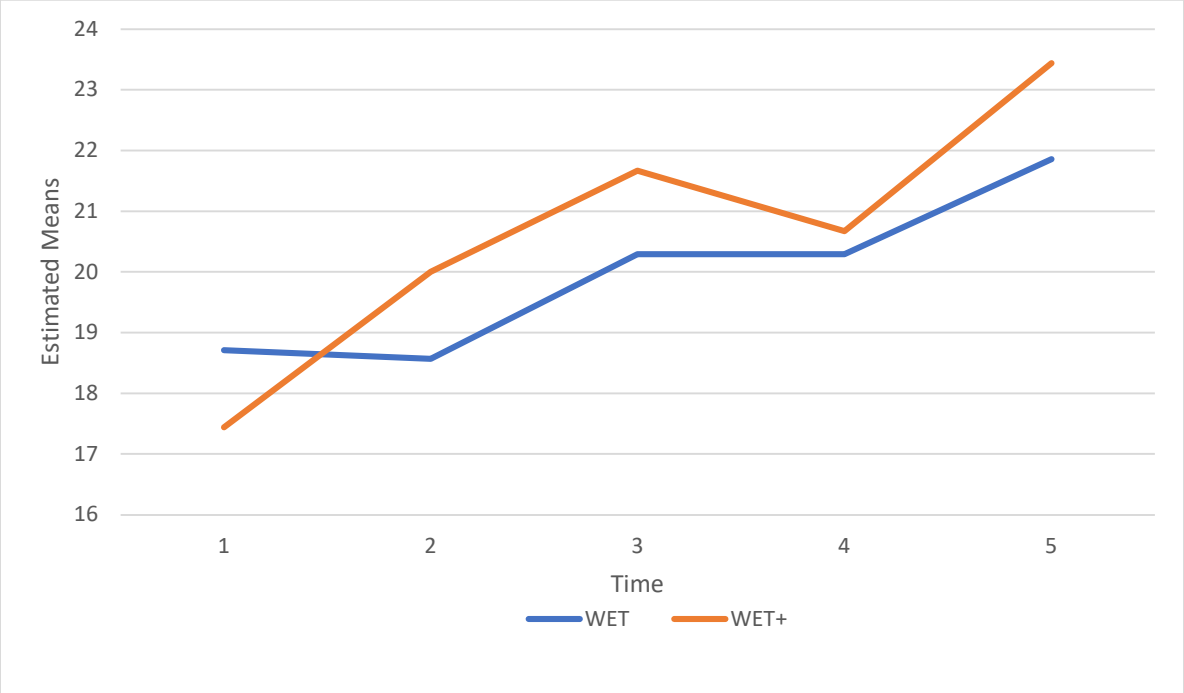
Means, Standard Deviations, T-test and Effect Size Data on Simple Change Scores (Session 1-5) Across Protocol Conditions on Five Psychological Tests

	WET+ (n = 9)		**WET (n = 7)**		**Statistics**		
	M	***SD***	***M***	***SD***	***t***	***p (2/1)***	***g***
PCL-5	27.89	10.53	17.71	16.25	1.52	.15/.08	.72
PHQ-9	9.11	5.06	4.43	5.00	1.85	.09/.04	.88
VLQ-I	.02	.86	.29	.77	-.64	.54/.27	.76
VLQ-C	1.40	2.49	1.7	2.34	-.25	.81/.40	.45
QOL	13.56	17.69	6.57	9.95	.93	.37/.18	.44
PsyFlex	6.00	4.87	3.14	3.02	1.36	.81/.41	.65

Given that the WET+ condition had lower initial Psy-Flex scores (see Table 6 and Figure 4) the degree of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the Psy-Flex was not significance (t = 1.36, $p_{(1\text{-tailed/2-tailed})}$ = .81/.41) and the Hedges g estimate revealed a medium effect size (g=.65) favoring the WET+ condition (see Table 7).

Figure 4

Psy-Flex Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET+ Psy-Flex mean scores started lower than the WET condition and were higher upon treatment completion.

Research Question 3b

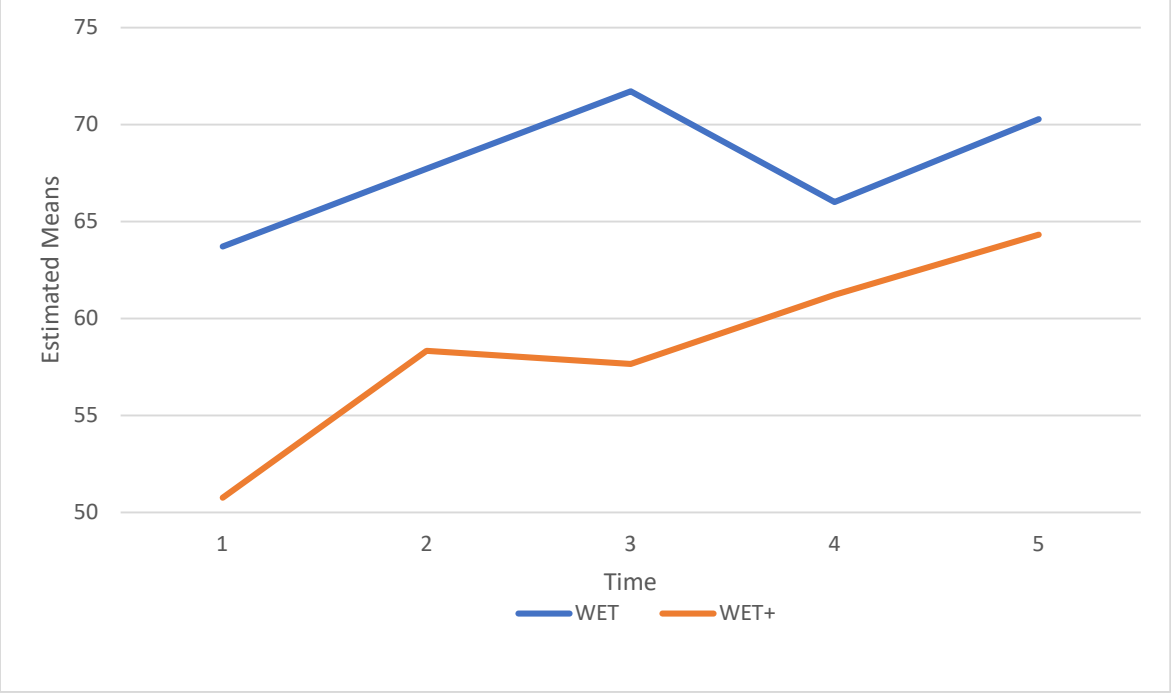
A 2 x 6 repeated measures ANOVA was utilized to analyze the OQL. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .004), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' QOL scores

showed a statistically significant decrease over time (F (2.19, 30.72) = 4.55, p = .02). No time by treatment interaction effects were found (F (2.19, 30.72) = 1.36, p = .27). As shown in Figure 5, the significant time effect in the absence of an interaction term suggests significant quality of life improvement occurred regardless of treatment condition.

Given that the WET+ condition had lower QOL scores (see Table 6 and Figure 5) the amount of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the QOL was not significant (t = .93, $p_{(1\text{-tailed/2-tailed})}$ = .18/.37) and the Hedges g estimate revealed a small effect size (g=.44) favoring the WET+ condition (see Table 7).

Figure 5

Quality of Life Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET+ Quality of Life mean scores started a standard deviation lower than the WET condition and were within a standard deviation upon treatment completion.

Research Question 3c

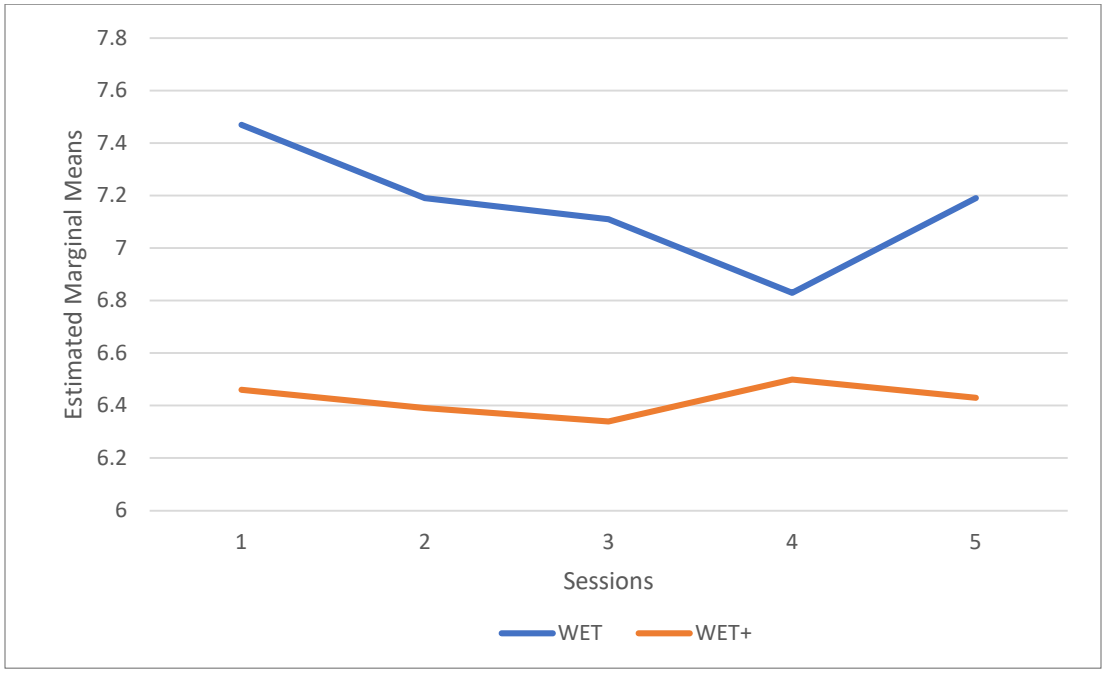
A 2 x 6 repeated measures ANOVA was utilized to analyze the VLQ-I. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .05), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' VLQ-I scores showed no statistically significant change over time (F (2.38, 33.35) = .68, p = .54). No time by treatment interaction effects were found (F (2.38, 33.35) = .85, p = .46). As shown in Figure 6, the lack of a significant time effect suggests no change in values importance occurred regardless of treatment condition.

Given that the WET+ condition had lower initial VLQ-I scores (see Table 6 and Figure 6) the amount of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the VLQ-I was not significant (t = -.64, $p_{(1\text{-tailed/2-tailed})}$ = .27/.54) and the Hedges g estimate revealed a large effect size (g=.76) favoring the WET+ condition (see Table 7).

A 2 x 6 repeated measures ANOVA was utilized to analyze the VLQ-C. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .00), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' VLQ-C scores showed a statistically significant increase over time (F (1.95, 27.25) = 4.99, p = .02). No time by treatment interaction effects were found (F (1.95, 27.25) = .47, p = .62). As shown in Figure 7, the significant time effect in the absence of an interaction term suggests significant values consistency improvement occurred regardless of treatment condition.

Figure 6

VLQ-I Estimated Mean Scores from Session 1 to Session 5

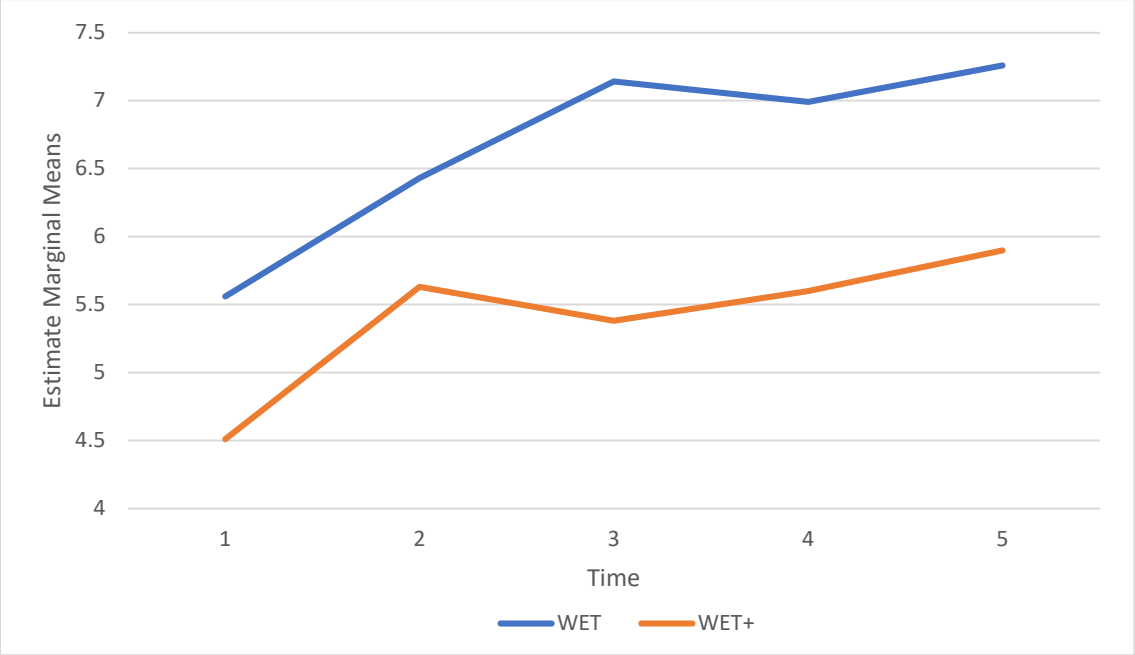


Note. This figure demonstrates the differences between treatment conditions. VLQ-I scores remained relatively stable throughout treatment.

Given that the WET+ condition had lower initial VLQ-C scores (See Table 6 and Figure 7) the amount of change participants experienced was examined. Change scores between session one and five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one to session five on the VLQ-I was not significant (t = -.25, $p_{(1\text{-tailed/2-tailed})}$ = .40/.81) and the Hedges g estimate revealed a small effect size (g=.45) favoring the WET+ condition (see Table 7).

Figure 7

VLQ-I Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. VLQ-C scores increased in both conditions.

Effects from Posttreatment to Two Month Follow-up

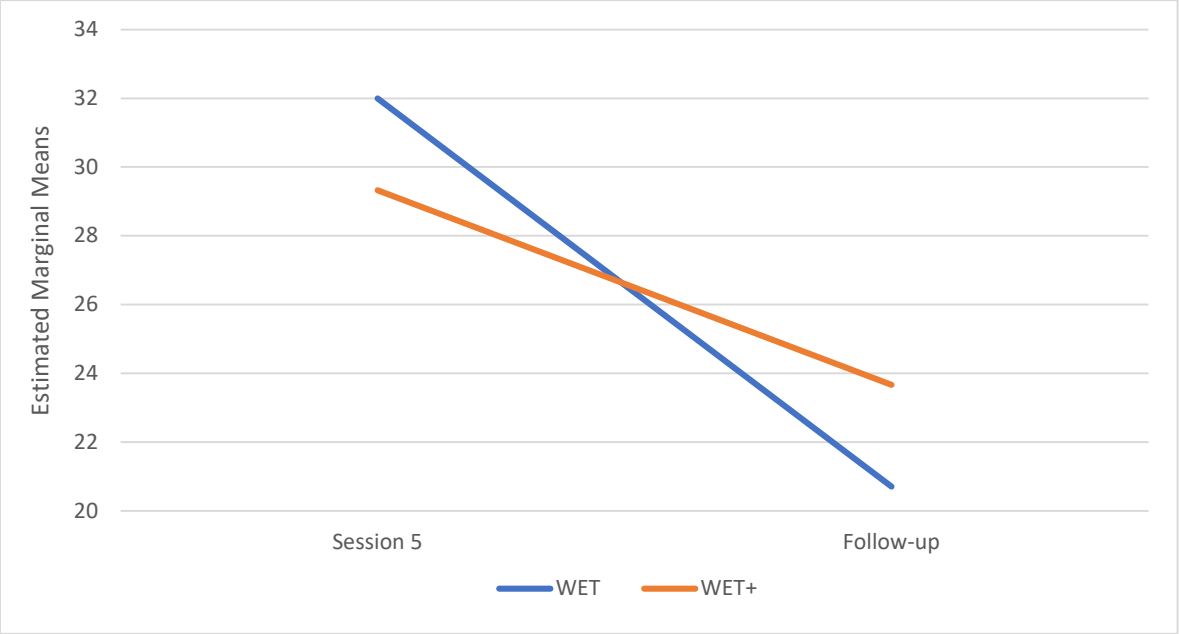
Analyses were conducted to examine changes in the two months after the completion of participation.

Research Question 2a

To test for time and time x condition effects, a 2x2 repeated measures ANOVA was conducted. Analyses indicated a statistically significant decrease in trauma symptoms between session five and the two month follow-up ($F(1, 14) = 12.25$, $p = .00$). No time by treatment interaction effects were found ($F(1, 14) = 12.25$, $p = .265$). The time effect in the absence of an interaction term indicates that continued improvement occurred at follow-up regardless of treatment condition (see Figure 8).

Figure 8

PCL-5 Estimated Mean Scores from Session 5 to Follow-up



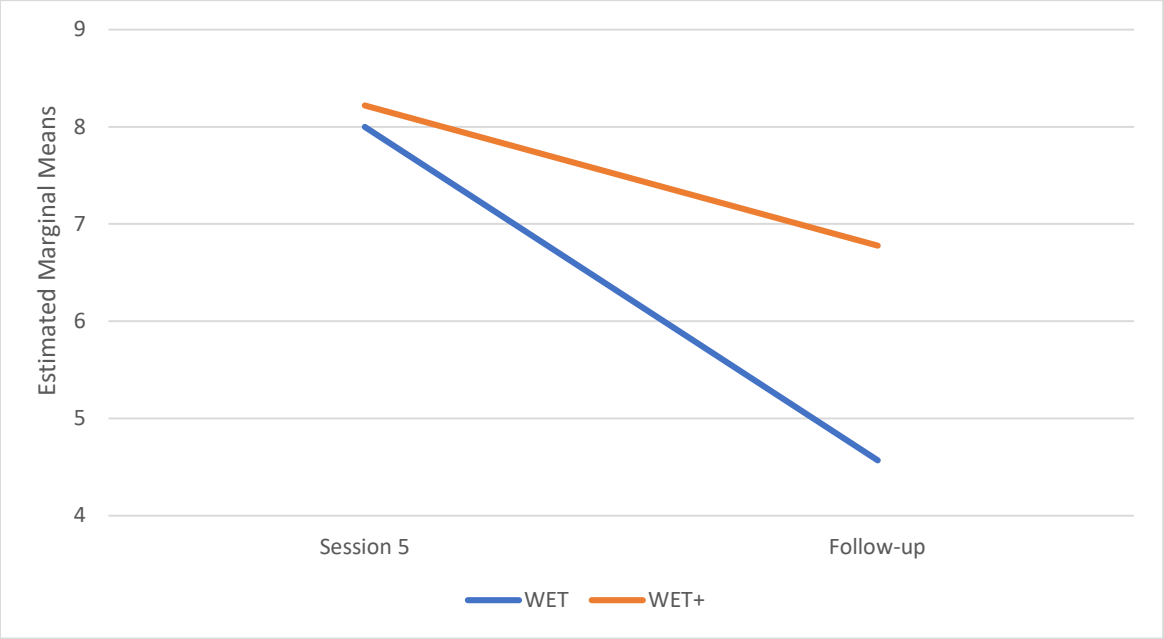
Note. This figure demonstrates the differences between treatment conditions. PCL-5 scores continued to decrease through follow-up.

Research Question 2b

To test for time and time x condition effects, a 2x2 repeated measures ANOVA was conducted. Analyses indicated a statistically significant decrease in depression symptoms between session five and the two month follow-up ($F(1, 14) = 4.55$, $p = .05$). No time by treatment interaction effects were found ($F(1, 14) = .75$, $p = .40$). The time effect in the absence of an interaction term indicates that continued improvement occurred across follow-up regardless of treatment condition (see Figure 9).

Figure 9

PHQ-9 Estimated Mean Scores from Session 5 to Follow-up



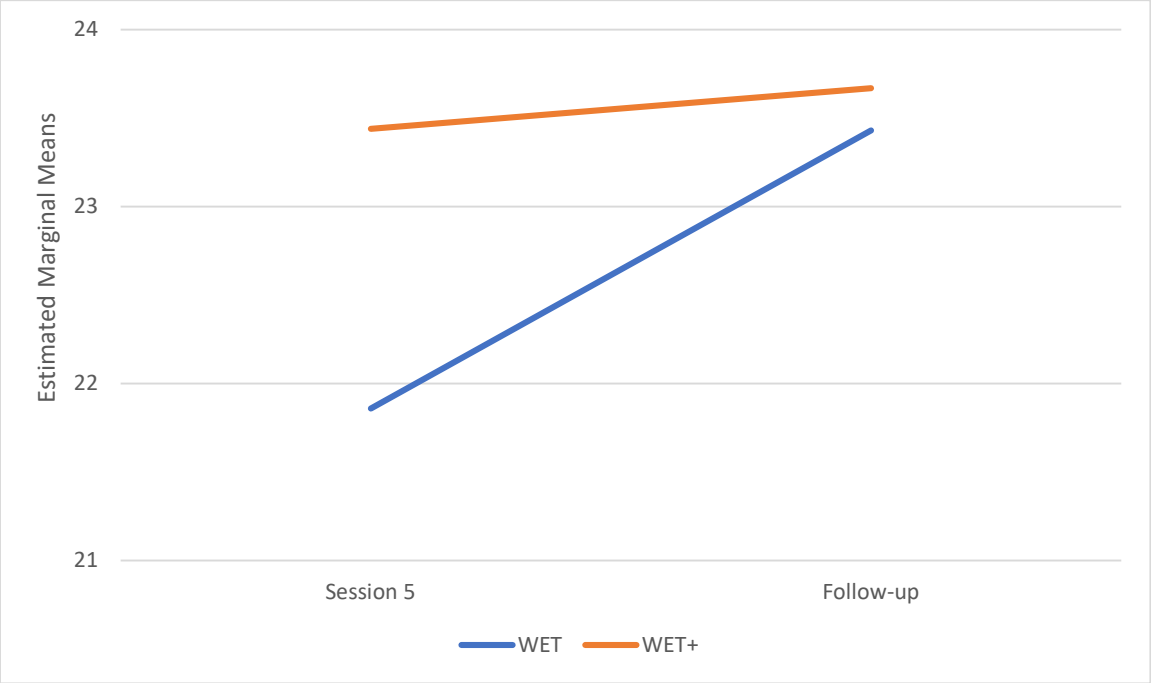
Note. This figure demonstrates the differences between treatment conditions. PHQ-9 scores continued to decrease through follow-up.

Research Question 4a

To test for time and time x condition effects, a 2x2 repeated measures ANOVA was conducted. Analyses indicated a no statistically significant change in psychological flexibility symptoms between session five and the two month follow-up ($F(1, 14) = 1.90$, $p = .19$). No time by treatment interaction effects were found ($F(1, 14) = 1.08$, $p = .32$). The time effect in the absence of an interaction term indicates that continued improvement occurred across follow-up regardless of treatment condition (see Figure 10).

Figure 10

Psy-Flex Estimated Mean Scores from Session 5 to Follow-up



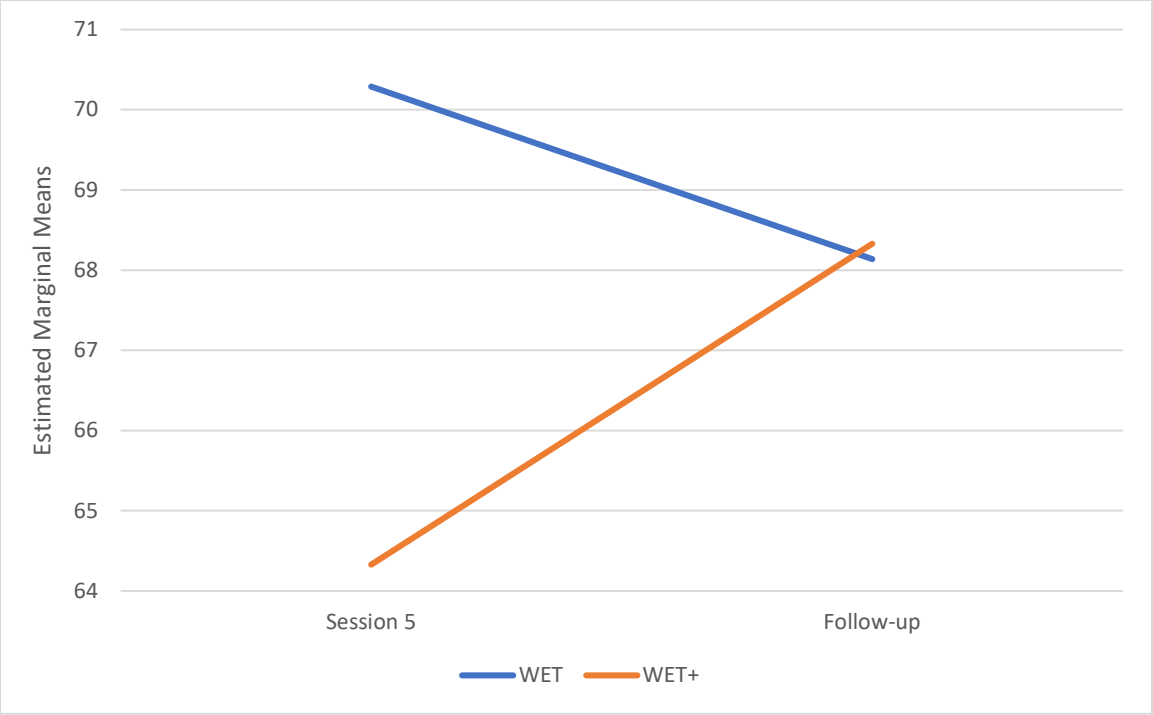
Note: This figure demonstrates the differences between treatment conditions. Psy-Flex scores continued to increase through follow-up.

Research Question 4b

To test for time and time x condition effects, a 2x2 repeated measures ANOVA was conducted. Analyses indicated a no statistically significant diffrence in quality of life symptoms between session five and the two month follow-up ($F(1, 14) = .14$, $p = .72$). No time by treatment interaction effects were found ($F(1, 14) = 1.51$, $p = .24$). The time effect in the absence of an interaction term indicates that continued improvement occurred across follow-up regardless of treatment condition (see Figure 11).

Figure 11

QOL Estimated Mean Scores from Session 5 to Follow-up



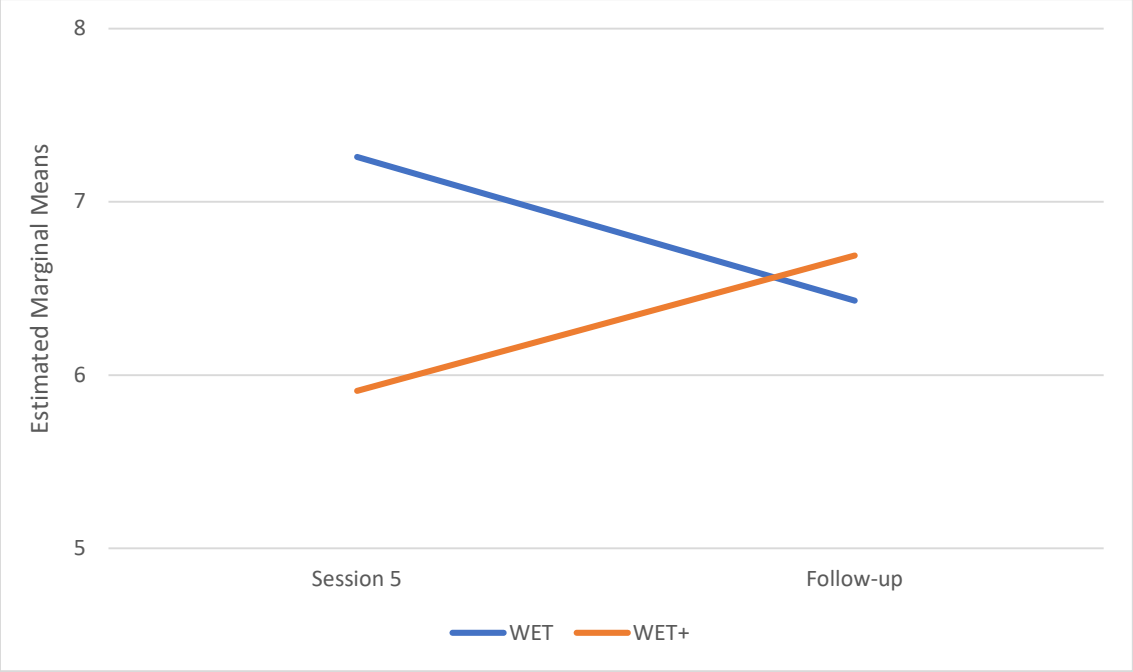
Note. This figure demonstrates the differences between treatment conditions. Psy-Flex scores continued to increase through follow-up.

Research Question 4c

To test for time and time x protocol effects, a 2x2 repeated measures ANOVA was utilized. No time ($F(1,14) = .16$, $p = .70$) or time by treatment interaction effects were found in values importance ($F(1,14) = .04$, $p=.85$) were found, indicating that values importance remained unchanged through follow-up. The time x condition interaction on values consistency scores was statistically significant, ($F(1.95, 27.25) = 4.75$, $p < .05$) while the time effect was not ($F(1,14) = .01$, $p=.95$). As illustrated in Figure 12, the interaction effect was the result of values consistency decreasing over follow-up among those who received WET while increasing among those who received WET+.

Figure 12

VLQ-C Estimated Mean Scores from Session 5 to Follow-up



Note. This figure demonstrates the differences between treatment conditions. VLQ-C scores continued to increase through follow-up in the WET+ condition and decreased in the WET condition.

Effects from Pretreatment to Follow-up

Given the trends and medium-large effect sizes found when comparing the amount of change during treatment across the two condition (see Table 7), the amount of total change from pretreatment to follow-up was examined. Independent t-tests compared the mean differences in changes scores between session one and follow-up between the two conditions. The results are presented in Table 8. None of the mean differences reached conventional two-tailed statistical significance. The effects sizes for the PLC-5 (g = .28) and VLQ-I (g = .16) were small. The amount of trauma symptom change was very similar across the group and the importance they accorded their values did not change. A small-medium effect (g = .33) favoring WET+ was found on change in psychological flexibility. Likewise, medium (g = .47) and medium-large (g =

.68) effects suggested greater change over time in depressive symptoms and values consistent action in the WET+ condition. Finally, a large effect size (g = .91) that trended toward conventional two-tailed statistical significance (t = 1.92, $p_{(1\text{-tailed}/2\text{-tailed})}$ = .04/.08) suggested significantly greater change in quality of life for those in WET+.

Table 8

Means, Standard Deviations, T-test and Effect Size Data on Simple Change Scores (Session 1 to Follow-up) Across Protocol Conditions on Five Psychological Tests

	WET+ (n = 9)		**WET (n = 7)**		**Statistics**		
	M	***SD***	***M***	***SD***	***t***	***p (2/1)***	***g***
PCL-5	33.56	14.54	29.00	16.67	.58	.57/.28	.28
PHQ-9	10.56	5.43	7.86	5.55	.98	.34/.17	.47
VLQ-I	.01	1.34	-.19	.81	.34	.74/.37	.16
VLQ-C	2.18	1.93	.87	1.63	1.43	.18/.08	.68
QOL	17.56	15.23	4.43	11.03	1.92	.08/.04	.91
PsyFlex	6.22	4.82	4.71	3.73	.17	.51/.25	.33

A Chi-square independence test showed that attrition rates differed significantly between groups (x^2*=3.91; df=1; p=0.048*). Six participants dropped from the standard WET protocol, and one dropped from the WET+ condition at various stages of treatment (Figure 1). However, examination of the timing of the attrition (as presented in Figure 1) showed that 4/6 WET drop outs occurred after the eligibility session and prior to session 1. Among those who attended treatment session 1 there were 2 drop-outs in WET and 1 in WET+.

Clinically Significant Improvements

The PCL-5 and PHQ-9 both have point changes that indicate clinically significant changes. Clinically significant change reflects the practical effects of treatment. This change generally reflects whether the change experienced by the individual has a noticeably real effect on their everyday life. A reduction of 5-10 points on the PCL-5 indicates a reliable change that

is not due to chance, and a 10–20-point change represents a clinically significant change in trauma symptoms (U.S. Department of Veterans Affairs, 2016). A reduction of 5 points on the PHQ-9 indicates a clinically significant change in depression symptoms (McMillan et al., 2010). To determine clinically significant change, a simple change score was conducted from session one to session five as well as session one to follow-up. A score reduction of 10 or more points indicated clinical significance on the PCL-5. A score reduction of 5 or more points indicated clinically significance on the PHQ-9. Results can be seen in Table 9.

Table 9

Clinical Significance by Participant Using Simple Change Scores

Participant	Protocol	PCL Session 1-5 Change	PCL Session 1-Follow-up Change	PHQ Session 1-5 Change	PHQ Session 1-Follow-up Change
1	WET+	50*	55*	19*	18*
2	WET+	35*	37*	8*	8*
4	WET	18*	47*	4	15*
5	WET+	14*	5	9*	5*
6	WET+	19*	21*	11*	9*
7	WET	31*	31*	5*	6*
8	WET	11*	26*	4	5*
10	WET+	26*	31*	6*	11*
11	WET	11*	22*	3	1
12	WET	-4	4	-4	5*
13	WET+	22*	44*	8*	14*
14	WET+	24*	42*	14*	18*
15	WET+	33*	28*	5*	2
16	WET+	28*	39*	2	10*
17	WET	46*	53*	13*	16*
19	WET	11*	20*	6*	7*

Note. *denotes clinically significant change.

Overall, 15 participants initially experienced clinically significant reductions in trauma related symptoms and 11 experienced clinically significant reductions in depression symptoms. At the two-month follow up, 87.5% (14 of the 16) of treatment completers experienced a

clinically significant reduction in either trauma or depression scores. Of the 16 participants, 68.75% (11 of the 16) experienced a clinically significant reduction in both depression and trauma related symptoms.

Customer Satisfaction and Working Alliance Inventory

To assess data from the customer satisfaction survey and the working alliance inventory, similar analyses were used on all aspects of the WAI (goal, task, and bond) and overall customer satisfaction scores from all sessions. Repeated measures ANOVA, two groups by five time points, and simple change score independent t-tests were used.

Customer Satisfaction Survey

Upon examination of the customer satisfaction survey, immediate differences emerged between conditions. Given the informed consent used, participants were aware of the experimental aims of this study. An independent t-test was used to compare the possible mean differences between the two conditions at the first treatment session. The differences in mean scores between WET (M = 24.86, SD = 3.19) and WET+ (M = 29.11, SD = 2.85) conditions at the initiation of treatment showed statistical significance ($t = 2.81$, $p_{(1\text{-tailed/2-tailed})} = .01/.01$) and the Hedges g estimate revealed a large effect size (g=1.34) favoring the WET+ condition.

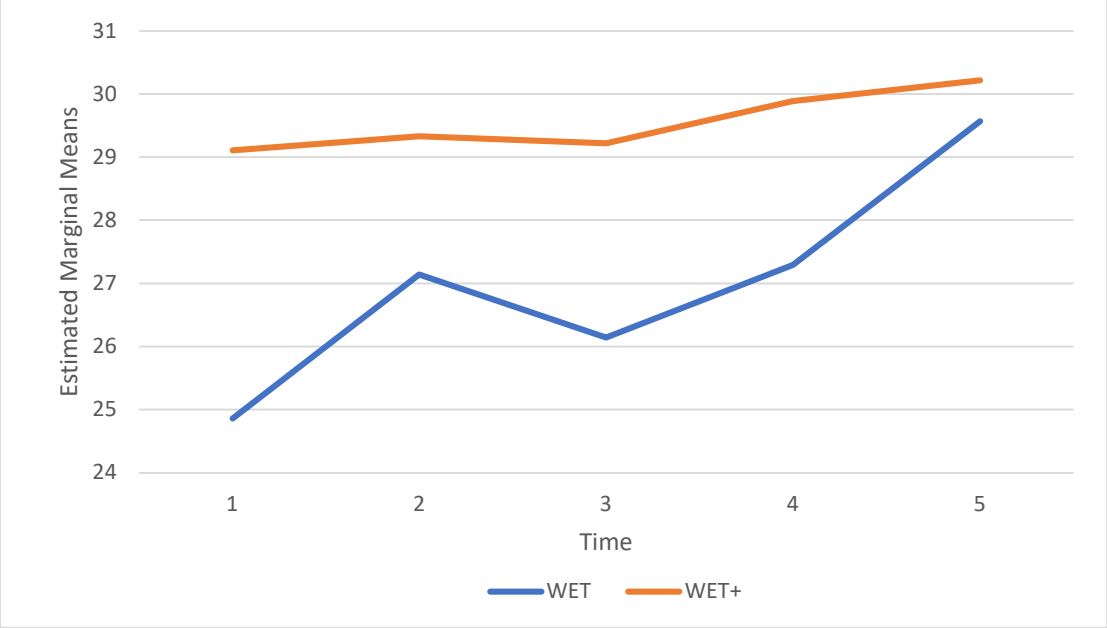
A 2 x 5 repeated measures ANOVA was utilized to analyze the CSS. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .01), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' CSS scores showed a statistically significant increase over time (F (2.58, 30.10) = 7.29, $p < .001$). Time by treatment interaction effects were trending towards significance (F (2.58, 30.10) = 2.66, $p = .07$). As shown in Figure 11, the trending significant time effect in the absence of an interaction term

suggests significant customer satisfaction improvement occurred regardless of treatment condition.

Given that the WET+ condition had higher CSS scores (See Table 10 and Figure 13) the amount of change participants experienced was examined. Change scores between session five and follow-up were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one and session five on the CSS was significant ($t = 2.50$, $p_{(1\text{-tailed}/2\text{-tailed})} = .01/.03$) and the Hedges g estimate revealed a large effect size (g=1.19) favoring the WET+ condition (see Table 10).

Figure 13

CSS Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET CSS mean scores started lower than the WET+ condition and were similar upon treatment completion.

Table 10

Means, Standard Deviations, T-test and Effect Size Data on Simple Change Scores (Session 1-5) Across Protocol Conditions on on CSS and WAI

	WET+ (n = 9)		WET (n = 7)		Statistics		
	M	***SD***	***M***	***SD***	***t***	***p (2/1)***	***g***
CSS	1.11	1.27	4.71	4.11	2.50	.03/.01	1.19
WAI-Goals	1.00	2.24	1.57	1.27	-.60	.56/.28	.29
WAI-Task	2.77	2.11	4.00	2.71	-1.02	.33/.16	.49
WAI-Bond	-0.11	.33	.71	1.38	-1.75	.10/.05	.83

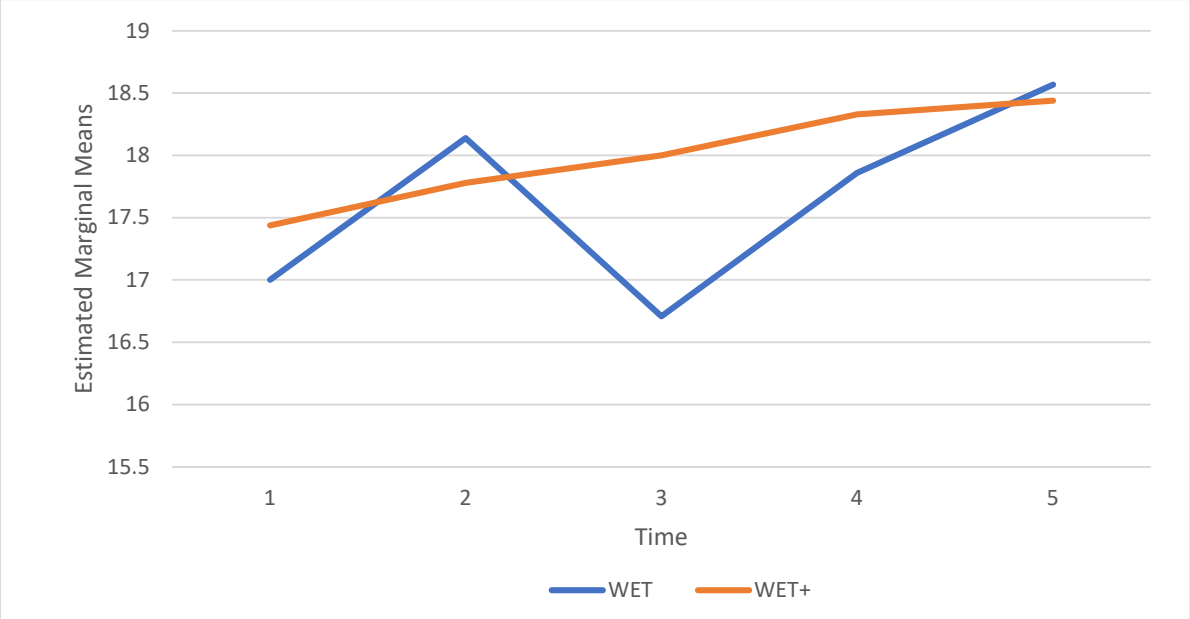
Working Alliance Inventory-Goal

A 2 x 5 repeated measures ANOVA was utilized to analyze the WAI-G. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .00), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' WAI-G scores were not statistically significant over time (F (2.50, 34.93) = 2.05, p = .13). Time by treatment interaction effects were not statistically significant (F (2.50, 34.93) = .74, p = .51). As shown in Figure 14, the lack of time effect and the absence of an interaction term suggests no changes in goal agreement regardless of treatment condition.

Consistent with other testing (See Table 10 and Figure 14) the amount of change participants experienced was examined. Change scores between session one and session five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session five to follow-up on the WAI-G was not significant (t = -.60, $p_{(1\text{-tailed/2-tailed})}$ = .28/.56) and the Hedges g estimate revealed a small effect size (g=.29) favoring the WET condition (see Table 10).

Figure 14

WAI-G Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET WAI-G mean scores were more variable than the WET+ condition and were similar upon treatment completion.

Working Alliance Inventory-Task

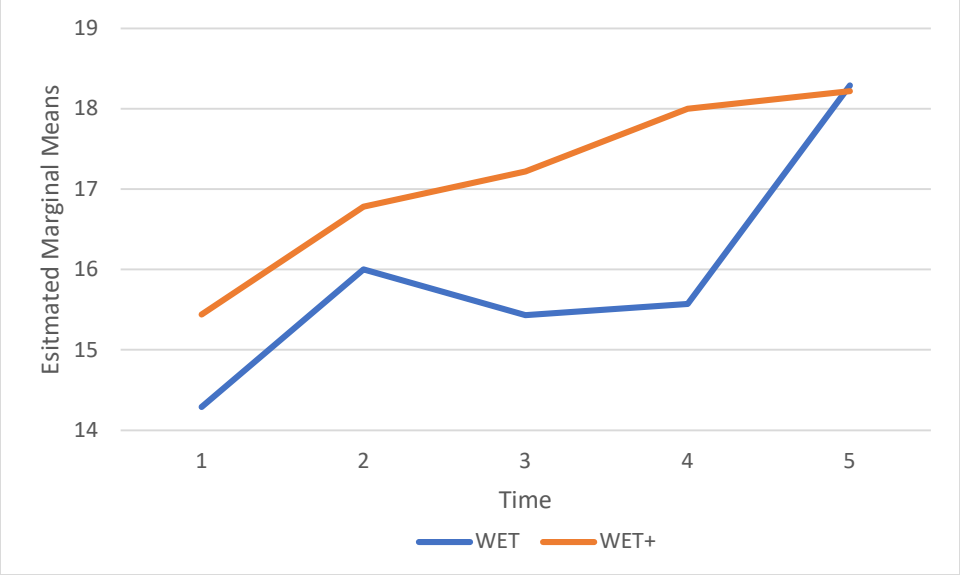
A 2 x 5 repeated measures ANOVA was utilized to analyze the WAI-T. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated (p = .00), so the Greenhouse-Geisser correction was used. Analyses indicated a statistically significant change in participants' WAI-T scores over time (F (2.47, 34.54) = 11.27, $p < .001$). Time by treatment interaction effects were not statistically significant (F (2.47, 34.54) = 1.75, $p = .18$). As shown in Figure 15, the significant time effect in the absence of an interaction term suggests significant task agreement improvement occurred regardless of treatment condition.

Consistent with other measures, (See Table 10 and Figure 15) the amount of change participants experienced was examined. Change scores between session one and session five were calculated and independent samples t-tests performed on the change scores. The

independent samples t-test examining change from session five to follow-up on the WAI-T was not significant (t = -1.02, $p_{(1\text{-tailed}/2\text{-tailed})}$ = .16/.33) and the Hedges g estimate revealed a medium effect size (g=.49) favoring the WET condition (see Table 10).

Figure 15

WAI-T Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET WAI-T mean scores similar to the WET+ condition throughout treatment and were similar upon treatment completion.

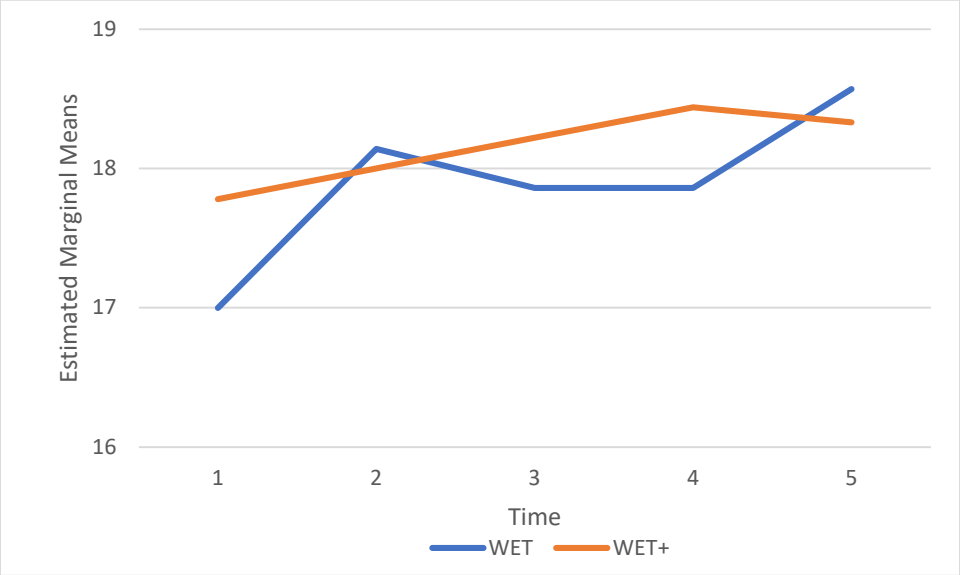
Working Alliance Inventory-Bond

A 2 x 5 repeated measures ANOVA was utilized to analyze the WAI-T. Mauchly's Test of Sphericity indicated that the assumption of sphericity was violated ($p < .001$), so the Greenhouse-Geisser correction was used. Analyses indicated that the participants' WAI-B scores did not reflect statistically significant change over time (F (2.31, 32.33) = 1.21, p = .32). Time by treatment interaction effects were not statistically significant (F (2.31, 32.33) = .40, p = .71). As shown in Figure 14, the lack of time effect and the absence of an interaction term suggests no changes in therapeutic bond regardless of treatment condition.

Consistent with other measures (See Table 10 and Figure 16) the amount of change participants experienced was examined. Change scores between session one and session five were calculated and independent samples t-tests performed on the change scores. The independent samples t-test examining change from session one and session five on the WAI-B was significant (t = -1.75, $p_{(1\text{-tailed/2-tailed})}$ = .05/.10) and the Hedges g estimate revealed a large effect size (g=.83) favoring the WET condition (see Table 10).

Figure 16

WAI-B Estimated Mean Scores from Session 1 to Session 5



Note. This figure demonstrates the differences between treatment conditions. WET WAI-B mean scores similar to the WET+ condition throughout treatment and were similar upon treatment completion.

Discussion

The present study sought to identify whether or not adding a values component to WET would enhance treatment outcomes or impact attrition rates. Examining the variables of post-traumatic stress, depression, quality of life, values, and psychological flexibility, comparisons were made from pre-treatment engagement through post-treatment as well as the effects of time

throughout treatment. Independent t-tests were used to compare both pre/post treatment outcomes as well as treatment/follow-up outcomes. Repeated measures ANOVA was used to examine the effects over time.

WET, with or without the values component, was associated with statistically and clinically significant decreases in trauma and depression symptoms. Although a newer EBP for trauma, this study confirmed that WET is an efficacious treatment for PTSD. All treatment responders, regardless of condition, maintained their treatment gains at the two-month follow up assessment, similar to Morissette et al. (2022) findings. This study was conducted via tele-health administration and had a variety of demographic variables and trauma types. While domestic violence (43.75%) and witnessing suicide (18.75%) were the largest trauma types examined in this study, childhood abuse, sexual assault, a near fatal boating accident and experiencing a drive-by shooting were also reported. Both delayed and non-delayed expression of symptoms were reported. As LoSavio et al. (2021) reported, none of these factors affected symptom reduction. The study results replicate and extend the growing body of literature supporting WET as an efficacious treatment for trauma. As Twohig et al. (2018) found in their study adding Acceptance and Commitment Therapy to exposure treatments to obsessive-compulsive disorder, no statistically significant between-group differences were found. However, there items that were trending towards significance and there were large and medium effect sizes found in favor of the WET+ condition on several variables. PCL-5 (g=.72) and PHQ-9 (g=.88) were both found to have large effect sizes, indicating that even without statistical significance, if the differences held that were found in this study in a larger sample size, statistical significance would be found. This suggests that the addition of structured values clarification may be a useful addition to WET. This is further supported by the medium effect size in psychological flexibility (g=.65).

These findings may indicate that adding values contributes to increased symptom reduction and overall treatment tolerability while in treatment, which is notoriously difficult in EBPs for trauma (Phillips et al, 2020).

The follow-up data revealed that quality of life (g=.91) had large effects and that values consistency (g=.68) had medium effect sizes in favor of WET+. So, while the initial effects appear to have shifted from mental health symptoms to overall post-treatment outcomes, effect sizes show that if the effects hold to a larger sample, statistical significance is well within reach. Adding values to WET, at least for the purposes of this study, aided in larger symptom reductions while in treatment and post-treatment outcomes two months following treatment completion.

The WET+ group started out with somewhat worse functioning across measures than the WET group. Within-treatment change scores generally favored WET+. Furthermore, they appeared to persist with medium-large pre to follow-up changes in depression, value consistency and quality of life favoring WET+. Thus, it may be that while both were highly effective in decreasing trauma symptoms, WET+ added value seen in impacts in areas like quality of life and values consistency. Such effects would be consistent with ACT, where values were taken from. However, great caution is warranted in interpreting the WET+ advantages. These results typically did not reach conventional statistical significance and while they could represent an enhanced treatment effect of adding values to WET, they might also be the result of sampling variation and differential regression to mean (i.e.., if WET+ participants were initially more severe there was more room for regression to the mean to occur). Given that values were the only protocol difference between WET and WET+, the differential effect favoring WET+ on the first client satisfaction scale ratings and the engagement in values consistent behavior from the end of

treatment to follow-up are interesting. Future research further examining the explicit inclusion values into WET is warranted.

Previous research has shown that up to 50% of those attempting trauma EBPs will drop from treatment (Foa et al., 2007; Peterson et al., 2019; Rauch et al., 2009; Schottenbauer et al., 2008). WET has shown to have lower treatment attrition than other trauma EBPs, with dropout rates ranging from 6% to 23.5% (Sloan et al., 2022; Thompsons-Holland et al., 2019). This study found similar findings with more standard trauma EBP dropout rates within the standard WET condition (46%) and dropout rates closer to initial 2019 reported WET dropout rates in the WET+ condition (10%). The groups differed significantly in treatment attrition ($x^2=3.91$; $df=1$; $p=0.048$). Ramierez et al. (2021) found that integrating ACT and exposure-based treatment reduces attrition rates and increases trauma EBP tolerability. However, that study was limited to military populations in an intensive out-patient setting without a control group which differs from the current study. When examining the results of the present study, which had an active control condition, statistical significance was reached. When examining the attrition rates in each treatment condition, the low attrition rate in the values condition does provide encouraging support that adding values may increase overall treatment tolerability. Asking participants to reflect on their "why they are choosing to engage in this treatment" may have encouraged them to tolerate emotionally difficult material. Even with no noted statistically significant differences between conditions across the treatment outcome measures, if more people can withstand trauma treatment without dropping out, adding a values component may prove to be a powerful addition for treating individuals with trauma. Finding the meaning in difficult situations and creating purpose (Lejeune & Luoma, 2019) may allow for more engagement in treatment and reduce overall PTSD rates.

It is important to note that this study supports a tentative argument for tolerability alone. To have more support for this argument, more participants would have needed to engage in the actual protocol prior to dropping from treatment. Customer service satisfaction was not collected during the baseline/consent session, so it is unknown if that was a factor in their decision making. The majority of participants that dropped from the study did so prior to engaging in any session material, therefore not contacting either condition and it is likely is more confirmatory evidence of the systemic avoidance that is characteristic of PTSD or the result of sampling variation and cannot be attributed to the addition of values as the majority of the attrition occurred before the first session. If the participants did not contact the values clarification, nor the prompt for values prior to engaging in the writing task, it cannot be argued the values alone made the treatment more tolerable. The statistical significance regarding attrition needs coupled with the effect sizes found throughout the study in order to argue that values increase tolerability. Large and medium effect sizes found in decreasing symptoms may have allowed participants to tolerate treatment longer due to the relief they were experiencing during difficult therapy engagement.

This study found that regardless of a values clarification or values recall, PTSD and depression rates were lowered across both conditions. It appears that the major benefit in this study of adding a values component to WET is to increase treatment tolerability and possibly having greater reductions in symptoms. In order to firmly claim this finding, additional large sample size studies need to be conducted. While exposure-based treatments are the gold-standard for treating PTSD (LoSavio et al., 2021; Morissette et al., 2022; Sloan & Marx, 2019), having a brief, tolerable, efficacious treatment is vitally important given the national rates of PTSD. While other group differences were not statistically significant, adding values may be

considered when engaging someone that has had difficulty with tolerating trauma treatment in the past. By engaging their own personal "why," potential recipients of WET may be able to withstand the difficulty of trauma treatment.

This could be further supported by the very large effect size (g=1.19) and statistical significance ($t = 2.50$, $p_{(1\text{-tailed}/2\text{-tailed})} = .03/.01$) in the initial customer satisfaction survey. While this is tentative support to the supposition, incorporating values work could contribute to increased satisfaction when participating in difficult trauma treatment. However, given that the large effect size was limited to the initial treatment session only, it could also be interpreted as the initial satisfaction experienced by participants for being in the test condition of a research study following the consent session. This is further supported by working alliance results. All WAI results trended in the direction of the WET condition. Analyses indicated that throughout treatment, therapeutic bond (g=.83) and task agreement (g=.49) were stronger initially in the WET+ condition, but very similar upon treatment completion. Given either possibility, additional blinded research would be needed to clarify which supposition has the best support.

Limitations and Future Directions

One of the limitations of this study was the sample size. Given effect sizes found in depression and trauma symptom reductions across groups, it is likely that adding values will affect symptom reduction in any meaningful way if these differences maintain to a higher sample size. The majority of participants in both groups achieved statistically significant reductions in reported symptoms regardless of protocol assigned. However, given that the WET+ condition had large effect sizes in trauma and depression symptoms reduction and medium effect size in psychological flexibility during treatment, as well as the large effect size in quality of life and medium effect sizes in values consistency at follow-up, it is possible with a more robust sample

size, statistical significance could be found for adding the values component to the standard WET protocol. Effect size can be used to assess practical significance rather than solely using statistical significance when assessing treatment outcomes (Rosnow & Rosenthal, 1988). Practical significance implies that the change is large enough to be meaningful in the real world for individuals. Without relying on large sample size studies, this often is a way to measure how meaningful the differences between groups are. This study found some large effect sizes in the group comparisons when examining if an added component of values decreases symptoms, increases outcome measures, and overall treatment attrition. Having a larger sample size may show both large effect sizes and statistical significance. This would add stronger support to the supposition that adding values increases treatment tolerability and has effects on symptom reduction or outcome measures. Ideally, this research would be done with more variability in trauma types, gender, and ethnicity representation as well. It is possible that having a larger, more robust sample across these variables may reveal if adding values is more powerful in certain situations or just as a general adjunctive technique that may increase tolerability.

Another limitation of the study was that there was only one therapist providing treatment across both conditions. Therapist factors have been found to contribute significantly to treatment dropout rates while delivering trauma focused EBPs (Sayer et al., 2023). Research has found that depending on therapist efficacy, the rates of drop out can differ as much as 51.8% between top quartile therapists and those in the bottom performing quartile. The sole therapist for this study has trained in trauma focused treatments in trauma focused settings for a large portion of her training. This may have impacted treatment adherence and dropout rates. Future studies should endeavor to utilize different therapists across conditions to mitigate any therapist factors that may influence outcomes.

If at all possible, future studies could examine the addition of values and their impacts in other measures of psychological flexibility as well. Length of survey battery was a consideration when compiling this study. The use of the Psy-Flex was determined to be the best measure due to the number of questions. Other measures, such as the Multidimensional Psychological Flexibility Inventory (Grégoire, S. et al., 2020) could be used for a stronger assessment of psychological flexibility to fully ascertain if psychological flexibility is changed by adding values.

Regardless of limitations, the effect sizes and treatment retention found in adding values have implications for further research. Future studies could examine if adding values in larger sample sizes is found to have impacts similar to what was found within this study. Treatment tolerability remains one of the most difficult aspects of PTSD treatment. Finding ways to increase tolerability in inherently difficult exposure-based treatment is an important aspect of helping those dealing with trauma-based symptoms. The more tolerable treatment is, the more people would potentially be willing to engage with treatment, regardless of difficulty. Additionally, having large effect sizes in valued living post trauma treatment speaks to people engaging in lifestyle choices that are meaningful. Finding a life worth living after trauma has broad implications for the overall wellness for those seeking therapy.

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Appendix A

HSIRB Consent and Approval Documents

Western Michigan University
Department of Psychology

Principal Investigator:	Amy Naugle, Ph.D.
Student Investigator:	Maegan Campbell, M.S., M.A.
Title of Study:	Infusing Values into Written Exposure Therapy: A Comparison Study

You are invited to participate in this research project titled " *Infusing Values into Written Exposure Therapy: A Comparison Study "*

STUDY SUMMARY: This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary. The purpose of the research is to determine the impact of adding values to Written Exposure Therapy (WET+) as compared to standard Written Exposure Therapy (WET) in the reduction of posttraumatic stress disorder (PTSD) symptoms. Additionally, this project will serve as Maegan Campbell's dissertation, for the requirements of the Western Michigan University (WMU) Clinical Psychology Ph.D. program.

You will be considered eligible to participate if you (1) are over the age of 18; (2) identify an index trauma meeting Criterion A for PTSD; (3) have a PCL-5 score of at least 31; (3) have sufficient memory of the event to benefit from WET; (4) are not currently receiving mental health treatment; and (5) are not currently, nor have taken within the past eight weeks, any psychotropic medications. If you take part in the research, you will be asked to complete self-report measures following informed consent. These measures will ask you to report any potential traumatic events occurring during your lifetime, the severity of any potential PTSD symptoms, the severity of any potential depression symptoms, and questions about your basic demographics. It is expected these measures will take approximately 15-30 minutes to complete. Following this informed consent session, you will be asked to attend five treatment sessions in which WET or WET+ will be delivered. You will be randomly assigned to either WET or WET+ therapy. These 60-minute sessions will include filling out self-report measures on PTSD symptom severity, depression symptom severity, and quality of life measures as well as writing about a trauma that you may have experienced. Depending on what condition you are assigned to, the first session may include a 30-minute values clarification exercise.

Your total participation in the study will take place across 14 weeks. This will include five 60-minute research sessions (potentially one 90-minute research session depending on condition): the present informed consent and pretreatment session, treatment sessions one through five, and one follow-up session two months after session five. This will also include seven 15–30-minute surveys. The first of those seven surveys will be completed today, during our meeting, if you consent to participant. In total, your time in the study will be approximately 6.5 to 7.5 hours.

Possible risk and costs to you for taking part in the study may be discussing unpleasant thoughts and emotions, specifically related to any trauma you have experienced. Depending on your past experiences, this could also include discomfort in discussing and answering survey questions about potential traumatic events, and the core writing exercises that comprise of WET. Potential benefits of taking part may include decreased distress, lessening of PTSD symptoms, and new skills from engaging in the research sessions. Additionally, you will be sent a $10 electronic, Amazon gift card for your completion of a two month follow up survey.

Agreeing to be randomly assigned to either the Written Exposure Therapy condition or the values enhanced WET condition is the option within this research study. An alternative to taking part in this research study is to seek mental health support from another provider. This might include interventions that have proved effective for a variety of mental health concerns: Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Cognitive Processing Therapy (CPT). If you would like a list of resources in locating mental health treatment options, you may ask the research therapist at any time and one will be provided to you.

The following information in this consent form will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form. After all of your questions have been answered and the consent document reviewed, if you decide to participate in this study, you will be asked to indicate consent on this study's electronic Qualtrics consent form.

What are we trying to find out in this study?

The purpose of the research is to determine if adding values clarification to Written Exposure Therapy aids in the reduction of PTSD symptoms or helps sustain long term quality of life changes. Finding effective and efficient ways to support those affected by PTSD is important.

Who can participate in this study?

You can participate in this study if you are over the age of 18, have an index trauma meeting Criterion A for PTSD, a have a PCL-5 score of at least 31, have sufficient memory of the event to benefit from WET, and are not currently, nor have taken within the past eight weeks, any psychotropic medications. Additionally, you must have consistent access to a computer, webcam, and internet throughout the duration of the study.

Where will this study take place?

The five treatment sessions will take place through Webex, a HIPAA compliant videoconferencing application. Sessions will be recorded and reviewed by a member of the research team to assure all treatment tasks have been completed. Video recordings will be stored in a secure university OneDrive account that is HIPAA compliant and only accessible to the research team. For the seven online surveys, Qualtrics® will be used to record the data obtained. Qualtrics® is a secure, HIPAA compliant application. These survey responses will be stored

separately from participants' identifiable data. A unique code will be assigned to each participant so your survey responses are not tied to your name.

What is the time commitment for participating in this study?

Your total participation in the study will take place across 14 weeks. This will include five 60 minutes research sessions (potentially one session being 90 minutes depending on conditions assigned): the present informed consent and pretreatment session. This will also include seven, 15-30 minute surveys. The first of those seven surveys will be completed today, during our meeting, if you consent to participant. In total, your time in the study will be approximately 6.5 to 7.5 hours.

What will you be asked to do if you choose to participate in this study?

If you take part in the research, you will be asked to complete self-report measures following informed consent. These measures will ask you to report any potential traumatic events occurring during your lifetime, the severity of any potential PTSD symptoms, the severity of any potential depression symptoms, questions about your basic demographics, and quality of life measures. You will complete these measures a total of seven times during the study. Following this informed consent session, you will be asked to attend five, one hour treatment sessions (one session may be 90 minutes depending on condition assigned) in which WET will be delivered. These sessions include psychoeducation about trauma, information about WET, writing about your trauma in as much detail as possible, and discussing impacts of treatment with the therapist. Links to the above surveys will be sent to you prior to sessions on scheduled session days. If you have a phone capable of receiving text messages, you will be asked to provide your phone number so reminder texts can be sent to you regarding the treatment sessions. If you do not have a phone capable of receiving text messages or prefer to not receive text messages, email reminders or reminder phone calls can be utilized instead.

What information is being measured during the study?

During your participation in the study, video recordings of the treatment sessions will take place to assure the research therapists are performing all the relevant session tasks. Additionally, your participation would include filling out various self-report measures. These measures will ask about (1) PTSD symptoms, (2) depression symptoms, (3) quality of life (4) lifetime traumatic experiences, (5) values, and (6) demographic information about yourself.

What are the risks of participating in this study and how will these risks be minimized?

Possible risk and costs to you for taking part in the study may be discussing unpleasant thoughts and emotions, specifically related to any trauma you have experienced. Depending on your past experiences, this could also include discomfort in discussing and answering survey questions about potential traumatic events, and the core writing exercises that comprise of WET. However, this intervention may serve to decrease your distress and all research study therapists are trained in emotion regulation skills should you need support in the moment.

What are the benefits of participating in this study?

Potential benefits of taking part may include decreased distress, lessening of PTSD symptoms, and new skills from engaging in the research sessions. Additionally, this study may indirectly others with PTSD by improving the by finding novel ways to implement WET treatment.

Are there any costs associated with participating in this study?

There are no costs associated with participating beyond your time.

Is there any compensation for participating in this study?

Yes, you will be sent a $10 electronic, Amazon gift card for your completion of a two month follow up survey.

Who will have access to the information collected during this study?

Only research team members will have access to the data collected. If the results of the study are presented at a conference or published in any form, only anonymous participant data will be presented or published so that you are not identifiable from the information given.

However, it should be noted that there are specific limitations to confidentiality in this study. All research therapists on the study are mandated reporters. This means there are three specific situations in which information may need to be shared outside of the research study. 1. If you disclose thoughts of suicide with immediate risk to yourself and do not feel you can keep yourself from acting on these thoughts. 2. If you disclose thoughts of homicide or plans of serious harm to someone else and do not feel you can keep yourself from acting on these thoughts. 3. If you disclose information about possible abuse or neglect of a child or vulnerable adult. Disclosure will only occur when mandated.

For thoughts of suicide or homicide, the research therapist will have a conversation with you about your level of safety and what support or resources may be needed to minimize the need for disclosure. If you disclose thoughts of suicide on a survey outside of a research session, a research therapist will contact you by phone within 24 hours to discuss your level of safety. If you do not answer, a voicemail will be left and an email will be sent requesting you contact the research study phone number. To protect your confidentiality, the voicemail and email will state the reason for the call is to "follow up about a recent survey you submitted."

What will happen to my information or biospecimens collected for this research project after the study is over?

Your personal information collected during this study may be stored and used for future research. After information that could identify you has been removed, de-identified information collected for this research may be used by or distributed to investigators for other research without obtaining additional informed consent from you.

What if you want to stop participating in this study?

Your participation is voluntary. You can choose to stop participating in the study at any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience no consequences if you choose to withdraw from this study.

Additionally, the investigator can also decide to stop your participation in the study without your consent.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Amy Naugle at 269-387-4726 or at amy.naugle@wmich.edu. You may contact the student investigator, Maegan Campbell, at 269-290-1430 or at maegan.l.campbell@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8298 if questions arise during the course of the study.

This consent has been approved by the Western Michigan University Human Subjects Institutional Review Board (HSIRB) on "(study approval date)." Do not participate in this study if the date is older than one year.

By typing my full name, I indicate that I have read this informed consent document and that the risks and benefits have been explained to me.

Add buttons to click:

I agree to participate in this research study

I do not agree to participate in this research study

If you do consent to participant in this research study, please type your full name below:

Name: _____

IRB-2022-345 - Initial: 2021 Full Board Approval_ VChair

do-not-reply@cayuse.com <do-not-reply@cayuse.com>
Wed 1/18/2023 12:01 PM
To:Amy Naugle <amy.naugle@wmich.edu>;Maegan Louise Campbell <maegan.l.campbell@wmich.edu>

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: January 18, 2023

To: Amy Naugle, Principal Investigator

Re: Initial - IRB-2022-345
Infusing Values into Written Exposure Therapy: A Comparison Study

This letter will serve as confirmation that your research project titled Infusing Values into Written Exposure Therapy: A Comparison Study has been reviewed by the Western Michigan University Institutional Review Board (WMU IRB) and **approved** under the **Full** .

The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application. **Please note:** This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., ***add an investigator, increase number of subjects beyond the number stated in your application, etc.***). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB or the Associate Director Research Compliance for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

Stamped Consent Document(s) location - Study Details/Submissions/Initial/Attachments

The Board wishes you success in the pursuit of your research goals.

Sincerely,

For a study to remain open after one year, a Post Approval Monitoring report (please use the continuing review submission form) is required on or prior to (no more than 30 days) December 21, 2023 and each year thereafter until closing of the study. When this study closes, complete a Closure Submission.
Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.

Appendix B

Demographic Questionnaire

Demographic Questionnaire

1. Birthday
2. Gender
3. Race/ethnicity
4. Sexual orientation
5. Educational level
6. Are you currently residing in the state of Michigan?
7. Are you a student?
8. Are you serving or have previously served in the military?
    a. If yes, are you currently active duty?
        i. Which branch of the military are you serving?
        ii. If no, which branch of the military did you serve?
            1. What were your years of service?
9. Have you ever received any mental health treatment, e.g. therapy?
    a. If yes, are you currently receiving mental health treatment, e.g. therapy?
        i. What are you currently receiving treatment for?
10. Are you currently taking medications for any mental health diagnoses?
    a. If yes, which medications are you currently taking?
    b. If yes, when did you begin taking the medication?

Appendix C

Life Events Checklist for DSM-5 (LEC-5) with Criterion A

Life Events Checklist for DSM-5 (LEC-5) with Criterion A

For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

1. Natural disaster
    a. Flood
    b. Hurricane
    c. Tornado
    d. Earthquake

2. Fire or explosion

3. Transportation accident
    a. Car accident
    b. Boat accident
    c. Train wreck
    d. Plane crash

4. Serious accident
    a. At work
    b. At home
    c. During recreational activity

5. Exposure to toxic substance (for example, dangerous chemicals, radiation)

6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)

7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)

8. Sexual assault
    a. Rape
    b. Attempted rape
    c. Made to perform any type of sexual act through force or threat of harm

9. Other unwanted or uncomfortable sexual experience

10. Combat or exposure to a war-zone
    a. In the military
    b. As a civilian

11. Captivity
    a. Being kidnapped
    b. Abducted
    c. Held hostage
    d. Prisoner of war

12. Life-threatening illness or injury

13. Severe human suffering

14. Sudden violent death (for example, homicide, suicide)

15. Sudden accidental death

16. Serious injury, harm, or death you caused to someone else

17. Any other very stressful event or experience
    a. Briefly identify the event you were thinking of _____

If you have experienced more than one of the events in Question #1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

a. Briefly describe the worst event (for example, what happened, who was involved, etc.).

b. How long ago did it happen?

c. How did you experience it?
    i. It happened to me directly
    ii. I witnessed it
    iii. I learned about it happening to a close family member or close friend
    iv. I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
    v. Other, please describe _____.

d. Was someone's life in danger?
    i. Yes, my life
    ii. Yes, someone else's life
    iii. No

e. Was someone seriously injured or killed?
    i. Yes, I was seriously injured

ii. Yes, someone else was seriously injured or killed
iii. No

f. Did it involve sexual violence? Yes No

g. Did the event involve serious injury or death to a close family member or close friend? Y/N
    i. Was it due to some kind of accident or violence, or was it due to natural causes?
        1. Accident or violence
        2. Natural causes

h. How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?
    i. Just once
    ii. More than once (please specify or estimate the total number of times you have had this experience _____)

Appendix D

PTSD Checklist for DSM-5 (PCL-5)

PTSD Checklist for DSM-5 (PCL-5)

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:

Not at all (0), a little bit (1), moderately (2), quite a bit (3), extremely (4)

1. Repeated, disturbing, and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?

16. Taking too many risks or doing things that could cause you harm?

17. Being “super alert” or watchful or on guard?

18. Feeling jumpy or easily startled?

19. Having difficulty concentrating?

20. Trouble falling or staying asleep?

Scoring

PCL-5 weekly has a total score range of 0-80, with higher scores indicating greater PTSD symptom severity.

0-10: no or minimal symptoms reported
11-20: mild symptoms reported
21-40: moderate symptoms reported
41-60: severe symptoms reported
61-80: very severe symptoms reported

Appendix E

Patient Health Questionnaire–9 (PHQ-9)

Patient Health Questionnaire–9 (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?
Not at all (0), several days (1), more than half the days (2), nearly every day (3)

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or staying asleep, or sleeping too much

4. Feeling tired or having little energy

5. Poor appetite or overeating

6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead or of hurting yourself in some way

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all, somewhat difficult, very difficult, extremely difficult

Scoring
0: no depressive symptoms
1-4: mild
5-9: moderate
10-14: moderate
15-19: moderately-severe
20-27: severe

Appendix F

Valued Living Questionnaire

Valued Living Questionnaire

Below are areas of life that are valued by some people. We are concerned with your quality of life in each of these areas. One aspect of quality of life involves the importance one puts on different areas of living. Rate the importance of each area (by circling a number) on a scale of 1-10. 1 means that area is not at all important. 10 means that area is very important. Not everyone will value all of these areas, or value all areas the same. Rate each area according to **your own personal sense of importance.**

Area	not at all important									extremely important
1. Family (other than marriage or parenting)	1	2	3	4	5	6	7	8	9	10
2. Marriage/couples/ intimate relations	1	2	3	4	5	6	7	8	9	10
3. Parenting	1	2	3	4	5	6	7	8	9	10
4. Friends/social life	1	2	3	4	5	6	7	8	9	10
5. Work	1	2	3	4	5	6	7	8	9	10
6. Education/training	1	2	3	4	5	6	7	8	9	10
7. Recreation/fun	1	2	3	4	5	6	7	8	9	10
8. Spirituality	1	2	3	4	5	6	7	8	9	10
9. Citizenship/ Community Life	1	2	3	4	5	6	7	8	9	10
10. Physical self care (diet, exercise, sleep)	1	2	3	4	5	6	7	8	9	10

In this section, we would like you to give a rating of how consistent your actions have been with each of your values. We are **not** asking about your ideal in each area. We are also **not** asking what others think of you. Everyone does better in some areas than others. People also do better at some times than at others. **We want to know how you think you have been doing during the past week.** Rate each area (by circling a number) on a scale of 1-10. 1 means that your actions have been completely inconsistent with your value. 10 means that your actions have been completely consistent with your value.

Area	not at all consistent with my value									completely consistent with my value
1. Family (other than marriage or parenting)	1	2	3	4	5	6	7	8	9	10
2. Marriage/couples/ intimate relations	1	2	3	4	5	6	7	8	9	10
3. Parenting	1	2	3	4	5	6	7	8	9	10
4. Friends/social life	1	2	3	4	5	6	7	8	9	10
5. Work	1	2	3	4	5	6	7	8	9	10
6. Education/training	1	2	3	4	5	6	7	8	9	10
7. Recreation/fun	1	2	3	4	5	6	7	8	9	10
8. Spirituality	1	2	3	4	5	6	7	8	9	10
9. Citizenship/ Community Life	1	2	3	4	5	6	7	8	9	10
10. Physical self care (diet, exercise, sleep)	1	2	3	4	5	6	7	8	9	10

Appendix G

Psy-Flex

Psy-Flex

The questions refer to your experiences in the **last seven days**.

1. Being present. Even if I am somewhere else with my thoughts, I can focus on what's going on in important moments.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

2. Being open for experiences. If need be, I can let unpleasant thoughts and experiences happen without having to get rid of them immediately.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

3. Leaving thoughts be. I can look at hindering thoughts from a distance without letting them control me.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

4. Steady self. Even if thoughts and experiences are confusing me I can notice something like a steady core inside of me.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

5. Awareness of one's own values. I determine what's important for me and decide what I want to use my energy for.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

6. Being engaged. I engage thoroughly in things that are important, useful, or meaningful to me.

very often (5) often (4) from time to time (3) seldom (2) very seldom (1)

Appendix H

Quality of Life Scale (QOL)

Quality of Life Scale (QOL)

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

1	2	3	4	5	6	7
Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted

1. Material comforts home, food conveniences, financial security	1	2	3	4	5	6	7
2. Health- being physically fit and vigorous	1	2	3	4	5	6	7
3. Relationships with parents, siblings & other relatives- communicating, visiting, helping	1	2	3	4	5	6	7
4. Having and rearing children	1	2	3	4	5	6	7
5. Close relationships with spouse or significant other	1	2	3	4	5	6	7
6. Close friends	1	2	3	4	5	6	7
7. Helping and encouraging others, volunteering, giving advice	1	2	3	4	5	6	7
8. Participating in organizations and public affairs	1	2	3	4	5	6	7
9. Learning- attending school, improving understanding, getting additional knowledge	1	2	3	4	5	6	7
10. Understanding yourself- knowing your assets and limitations- knowing what life is about	1	2	3	4	5	6	7
11. Work- job or in home	1	2	3	4	5	6	7
12. Expressing yourself creatively	1	2	3	4	5	6	7

13. Socializing- meeting other people, doing things, parties, etc	1	2	3	4	5	6	7
14. Reading, listening to music, or observing entertainment	1	2	3	4	5	6	7
15. Participating in active recreation	1	2	3	4	5	6	7

Appendix I

Resources

Resources

National Suicide Prevention Lifeline
24 hour hotline: 1-800-273-8255
Website: https://suicidepreventionlifeline.org/

Crisis Text Line
Text: "HOME" to 741741
Website: https://www.crisistextline.org/

United Way
Alliance for Information and Referral Systems
24 hour resources line: dial 211 to reach your local line
Website: http://www.211.org/

SAMHSA
Substance Abuse and Mental Health Services Administration
24 hour resources line: 800-662-HELP (4357)
Website: https://www.samhsa.gov/find-treatment

CDC
Centers for Disease Control and Prevention
COVID-19: Coping with Stress
Website: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html

NAMI
National Alliance on Mental Illness
Helpline and Mental Health Resources
Website: https://www.nami.org/Support-Education/NAMI-HelpLine/Top-HelpLine-Resources

Appendix J

Social Media Recruitment Script

Social Media Recruitment Script

Western Michigan University psychology researchers are currently seeking participants for a PTSD intervention study! Please see the attached flyer and consider sharing with anyone in the state of Michigan who may qualify.

Appendix K

Recruitment Flyer

Recruitment Flyer

Our research team is currently seeking Michigan residents who are interested in participating in a five-session intervention study. The goal of our research is determining if enhancing an evidence-based treatment for PTSD will change treatment outcomes.

Who is eligible? Individuals over the age of 18, meet criteria for an index trauma, and who have consistent access to a computer, webcam and internet.

How much time will this take? In total, you would attend seven, one-hour sessions with a researcher. You would also be asked to complete a 20–30-minute, online survey seven times over a period of 14 weeks.

Who should I contact if I am interested? You can contact the research team for more information, or to participate, at XXXXXX@gmail.com or at 269-290-1430.

Receive five, free therapy sessions and earn $10!

Approved by Western Michigan University's IRB

Appendix L

WET Session Scripts

WET Session Scripts

Session 1:

Welcome introduction.
First session: Psychoeducation of PTSD and rationale for writing about the trauma (10-15 minutes)
PHYSICAL: Survivors of traumatic experiences often go through changes in their physical reactions, emotions, thoughts, and behaviors in the wake of such experiences. Examples of changes in physical reactions may include increased fatigue, nausea (feeling sick to your stomach), sweating or chills, shock, dizziness, chest pains, trouble breathing, and numbness.
EMOTIONAL: Examples of emotional changes may include increased nervousness, fear, grief, depression, hopelessness, helplessness, anger, irritability, feeling overwhelmed, guilt, and vulnerability.
COGNTIIVE: Examples of changes in thinking may include increased: Thinking that your future will be cut short Difficulty in remembering things, trouble making decisions, confusion, difficulty concentrating," flashbacks" or reliving experience, nightmares, intrusive or unwelcomed thoughts, too many thoughts at once, and memory gaps.
BEHAVIORAL: Examples of changes in behavior may include increased startle, hypervigilance, being withdrawn from others, being overly dependent upon others, changes in appetite, changes in sleep, increased substance abuse (alcohol, drugs, medication), problems with emotional or physical intimacy, inability to trust or have loving feelings, apathy, loss of spirituality, risk taking, and suicidal impulses and behaviors.
UNIQUE: Each person may differ in the ways in which these reactions are experienced. Some may be very familiar but others may not. Many of these reactions become part of the trauma survivor's everyday life, and do not seem unusual to them. Take a moment to think about how many of the above symptoms are present for you since the traumatic event.
Are any of these symptoms familiar to you?
AVOIDANCE: The manner in which a trauma survivor attempts to cope with his or her trauma symptoms usually has an impact on everyday activities. If a trauma survivor has recurring thoughts and memories of his or her trauma, s/he may attempt to push them out of their mind by using substances (alcohol and/or drugs), becoming a workaholic, staying away from other people, or using anger and aggressive behavior to either distract oneself or remove any reminders of the trauma from the current circumstances These strategies may give the trauma survivor short-term relief but over the long-term can be problematic for a variety of reasons. In other words, sometimes a survivor's attempt to cure or to cope with reactions to a traumatic event can become a problem in itself.

Importantly, approaches that one might use to deal with non-traumatic events do not work very well in dealing with trauma. People will sometimes tell trauma survivors to "forget about it," and to get on with their lives. This approach may work well in many different situations, but one does not just forget about traumatic events.

MEMORY: One of the reasons that this advice does not work is that events that are experienced as traumatic are remembered differently from non-traumatic events. The memory of a trauma may be stored in a splintered fashion as a protection from re-experiencing the full impact of the

trauma. Consequently, survivors may have amnesia for large segments of time during the trauma. Or they may remember some details of past traumas but may not have any feelings attached to these memories. They may experience overwhelming anxiety or fearfulness without understanding the cause. Certain situations may trigger "flashbacks" to earlier traumas and they might feel that they are actually reliving the past.

RECOVERY: To successfully recover from the traumatic event, it is important that you confront that experience by recounting it, repeatedly, in as much detail and with as much emotion as possible. By repeatedly recounting the event, you will be able to correct for the splintered fashion in which the memory may have been stored. You will also find that recounting the experience will result in you feeling like you have more control over the memory rather than feeling as if the memory controls you. Over the next several sessions, I will be asking you to repeatedly recount the trauma experience by writing about the experience.

General directions for the writing sessions

Over the next 5 sessions I would like you to write about your trauma. Don't worry about your spelling or grammar. I would like you to write about the details of the trauma as you remember it now. For example, how the trauma event happened and were there other people involved. In writing about the details of the trauma, it is important to write about specifics of what happened and what you were feeling and thinking as the trauma was happening. Try to be as specific in recounting the details as possible. It is also important that you really let go and explore your very deepest emotions and thoughts about the trauma. You should also keep in mind that you have 5 sessions to write about this experience, so you don't need to be concerned with completing your account of the trauma within today's session. Just be sure to be as detailed about the trauma as possible and also to write about your thoughts and feelings as you remember them during (and immediately after) the trauma.

Specific instructions for session 1

For your first writing session, I'd like you to write about the trauma starting at the beginning. For instance, you could begin with the moment you realized the trauma was about to happen. As you describe the trauma it is important that you provide as many specific details as you can remember. For example, you might write about what you saw (e.g., headlights of the car approaching you, person approaching you), what you heard (e.g., car horn, screeching tires, person threatening you; explosion), or what you smelled (e.g., blood, burning rubber). In addition to writing about the details of the trauma, you should also be writing about your thoughts and feelings during the trauma as you remember it now. For example, you might had the thought "I'm going to die," "this can't be happening,", or "I'm going to be raped?" And, you might have had the feeling of being terrified, frozen with fear, or anger at another person involved.

Remember, you don't need to finish writing about the entire trauma in this session. Just focus on writing about the trauma with as much detail as possible and include the thoughts and feelings you experienced during and immediately after the trauma. Remember, the trauma is not actually happening again, you are simply recounting it as you look back upon it now.

(ANY QUESTIONS?)

Prompt for SUDs (pre)
WRITE FOR 30 Minutes
Prompt for SUDs (post)
Query about experience of writing.

Normalize high SUDs if present
If low SUDs, why? (Should decrease but if too low maybe avoidance)

To be said to patient at the conclusion of the first writing session

You will likely have thoughts, images, and feelings concerning the trauma you just wrote about during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings, whatever they might be, rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that may come up.

(The goal of this prompt is to remind the patient to not avoid thoughts, images, and feelings surrounding the trauma memory.)

Session 2:

Check in from the week
Feedback of first trauma narrative.

- Followed instructions?
  - Details without thoughts and feelings?
  - Events pre-trauma and not trauma?
- Focused on index event?
  - Different trauma to avoid?
  - Different trauma that was more distressing?
- Amount written?

Instruct to write

Today, I want you to continue to write about the trauma as you look back upon it now. If you feel that you didn't get the chance to completely describe the trauma in the last writing session, then you can pick up where you left off. If you completed writing about the trauma event in the last session, please write about the entire trauma again. While you are describing the trauma I really want you to delve into your very deepest feelings (e.g., fear, shock, sadness, anger) and thoughts (e.g., "is this really happening," "I'm going to die"). Also, remember to write about the details of the trauma. That is, describe the setting, people involved, what you saw, heard, and felt. Also remember that you are writing about the trauma as you look back upon it now.

SUDs (pre)
Write for 30
SUDs (Post)
How was writing experience?

To be stated to the patient at the conclusion of the second session

As I stated at the end of the first session, you will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow

yourself to have these thoughts, images, feelings, whatever they might be, rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.

Session 3:

Check in from the week
Feedback of second trauma narrative.

- Followed instructions?
    - Details without thoughts and feelings?
    - Events pre-trauma and not trauma?
- Focused on index event?
    - Different trauma to avoid?
    - Different trauma that was more distressing?
- Amount written?

Instruct to write

In your writing today, I again want you to continue writing about the trauma event as you think about it today. If you have completed writing about the entire trauma event you can either write about the trauma again from the beginning or you can select a part of the trauma that is most upsetting to you and focus your writing on that specific part of the experience. In addition, I would also like you to begin to write about how the traumatic experience has changed your life. For instance, you might write about whether or not the trauma has changed the way you view your life, the meaning of life, and how you relate to other people. Throughout your writing I want you to really let go and write about your deepest thoughts and feelings.
ANY QUESTIONS?
SUDs (pre)
Write for 30
SUDs (Post)
How was writing experience?

To be stated to the patient at the conclusion of the third session

You will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.

Session 4:

Check in from the week
Feedback of third trauma narrative.

- Followed instructions?
    - Details without thoughts and feelings?
    - Events pre-trauma and not trauma?
- Focused on index event?
    - Different trauma to avoid?
    - Different trauma that was more distressing?
- Amount written?

Instruct to write

I want you to continue to write about the trauma today. As with your writing in the last session, you can select a specific part of the trauma to write about; that is, the part of the trauma that was most upsetting to you. Today, I would also like you to write about how the trauma event has changed your life. You might write about if the trauma has changed the way you view your life, the meaning of life, and how you relate to other people. Throughout the session I want you to really let go and write about your deepest thoughts and feelings.
ANY QUESTIONS?
SUDs (pre)
Write for 30
SUDs (Post)
How was writing experience?

To be stated to the patient at the conclusion of the second session

You will likely have thoughts, feelings, visual images concerning the trauma during the course of the upcoming week. It is important that you allow yourself to have these thoughts, images, feelings rather than trying to push them away. Please try to allow yourself to have whatever thoughts, images, feelings that come up.

Session 5:

Check in from the week
Feedback of fourth trauma narrative.

- Focus on impact of trauma
- How to address for future

Instruct to write

Today is the last session. I want you to continue to write about your feelings and thoughts related to the traumatic event, and how you believe this event has changed your life. Remember that this is the last day of writing and so you might want to try to wrap up your writing. For example, you might write about how the traumatic experience is related to your current life and your future. As with the other writing sessions, it is important for you to delve into your deepest emotions and thoughts throughout the session.
ANY QUESTIONS?
SUDs (pre)

Write for 30
SUDs (Post)
How was writing experience?
Reminder that they have learned to cope with PTSD symptoms. If sx come up in the future you have skill(s) to manage. All instructions have been provided, you may continue to use materials in the future.
IF they continue to have sx:

1) Continue WET
    a. Need more time for same trauma
    b. Need to address 2nd trauma
2) Consider a different EBP for PTSD
3) If sx are not specific to PTSD, consider other EBPs for specific problems (i.e. EBP for Depression, SUD)

Appendix M

Values Clarification Script

Values Clarification Script

Deep down inside, what is important to you? What do you want your life to stand for? What sort of qualities do you want to cultivate as a person? How do you want to be in your relationships with others? Values are our heart's deepest desires for the way we want to interact with and relate to the world, other people, and ourselves. They are leading principles that can guide us and motivate us as we move through life.

Values are not the same as goals. Values are directions we keep moving in, whereas goals are what we want to achieve along the way. A value is like heading West; no matter how far West you go, you never reach it. A goal is like the river or mountain or valley we aim to cross whilst traveling in that direction. Goals can be achieved or 'crossed off', whereas values are an ongoing process. For example, if you want to be a loving, caring, supportive partner, that is a value – an ongoing process. If you stop being loving, caring and supportive, then you are no longer a loving, caring, supportive partner; you are no longer living by that value. In contrast, if you want to get married, that's a goal - it can be 'crossed off' or achieved. Once you're married, you're married – even if you start treating your partner very badly. If you want a better job, that's a goal. Once you've got it - goal achieved. But if you want to fully apply yourself at work, that's a value – an ongoing process.

The following are areas of life that are valued by some people. Not everyone has the same values, and this is not a test to see whether you have the "correct" values. Think about each area in terms of general life directions, rather than in terms of specific goals. There may be certain areas that you don't value much; you may skip them if you wish. There may be areas that overlap – e.g. if you value hiking in the mountains, that may come under both physical health and recreation. It is also important that you write down what you would value if there were nothing in your way. What's important? What do you care about? And what you would like to work towards?

For each of the areas we are about to go through, please write down a few words to summarize your valued direction. For example "to be a loving, supportive, caring, partner". At the end of the exercise, we will rank order each of these summaries on a scale of 0 (low importance) to 10 (high importance).

1. Family relations. What sort of brother/sister, son/daughter, uncle/auntie do you want to be? What personal qualities would you like to bring to those relationships? What sort of relationships would you like to build? How would you interact with others if you were the ideal you in these relationships?

2. Marriage/couples/intimate relations. What sort of partner would you like to be in an intimate relationship? What personal qualities would you like to develop? What sort of relationship would you like to build? How would you interact with your partner if you were the 'ideal you' in this relationship?

3. Parenting. What sort of parent would you like to be? What sort of qualities would you like to have? What sort of relationships would you like to build with your children? How would you behave if you were the 'ideal you'.

4. Friendships/social life. What sort of qualities would you like to bring to your friendships? If you could be the best friend possible, how would you behave towards your friends? What sort of friendships would you like to build?

5. Career/employment. What do you value in your work? What would make it more meaningful? What kind of worker would you like to be? If you were living up to your own ideal standards, what personal qualities would you like to bring to your work? What sort of work relations would you like to build?

6. Education/personal growth and development. What do you value about learning, education, training, or personal growth? What new skills would you like to learn? What knowledge would you like to gain? What further education appeals to you? What sort of student would you like to be? What personal qualities would you like to apply?

7. Recreation/fun/leisure. What sorts of hobbies, sports, or leisure activities do you enjoy? How do you relax and unwind? How do you have fun? What sorts of activities would you like to do?

8. Spirituality. Whatever spirituality means to you is fine. It may be as simple as communing with nature, or as formal as participation in an organised religious group. What is important t to you in this area of life?

9. Citizenship/ environment/ community life. How would you like to contribute to your community or environment, e.g. through volunteering, or recycling, or supporting a group/ charity/ political party? What sort of environments would you like to create at home, and at work? What environments would you like to spend more time in?

10. Health/physical well-being. What are your values related to maintaining your physical well-being? How do you want to look after your health, with regard to sleep, diet, exercise, smoking, alcohol, etc? Why is this important?

Now that we've gone through each of the domains, let's rank each of your notes. It's okay to have several values scoring the same number. We then can begin to find out which areas and specific values are most important to you.

Appendix N

Consumer Satisfaction Questionnaire

Consumer Satisfaction Questionnaire

Please help us improve our treatment by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of the treatment you have received?
   4 3 2 1
   Excellent Good Fair Poor

2. Did you get the kind of treatment you wanted?
   1 2 3 4
   No, definitely No, not really Yes, generally Yes, definitely

3. To what extent has the treatment met your needs?
   4 Almost all of my needs have been met
   3 Most of my needs have been met
   2 Only a few of my needs have been met
   1 None of my needs have been met

4. If a friend were in need of similar help, would you recommend this treatment to him or her?
   1 2 3 4
   No, definitely not No, I don't think so Yes, I think so Yes, definitely

5. How satisfied are you with the amount of help you have received?
   1 2 3 4
   Quite dissatisfied Mildly dissatisfied Mostly satisfied Very satisfied

6. Has the treatment you received helped you to deal more effectively with your problems?
   4 Yes, they helped a great deal
   3 Yes, they helped
   2 No, they really didn't help
   1 No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the treatment you have received?
   4 3 2 1
   Very satisfied Mostly satisfied Mildly dissatisfied Quite dissatisfied

8. If you were to seek help again, would you make use of this treatment again?
   1 2 3 4
   No, definitely not No, I don't think so Yes, I think so Yes, definitely

Appendix O

Working Alliance Inventory – Short Revised (WAI-SR)

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

2. What I am doing in therapy gives me new ways of looking at my problem.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

3. I believe___likes me.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

4. ___and I collaborate on setting goals for my therapy.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

5. ___and I respect each other.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

6. ___and I are working towards mutually agreed upon goals.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

7. I feel that___appreciates me.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

8. _____ and I agree on what is important for me to work on.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

9. I feel _____ cares about me even when I do things that he/she does not approve of.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

11. _____ and I have established a good understanding of the kind of changes that would be good for me.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

12. I believe the way we are working with my problem is correct.
seldom (1) sometimes (2) fairly often (3) very often (4) always (5)

Note: Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12; Bond Items: 3, 5, 7, 9

Appendix P

HEADSS Assessment

HEADSS Assessment

Below are some sample questions for each of the domains of the HEADSS Assessment

Home
Who lives with you? Where?
What are relationships like at home?
Ever institutionalized? Incarcerated?
Recent moves?
New people in home environment?

Education and employment
Do you work? What do you do?
Are you in school?
Any recent changes to school or employment?
Favorite aspects of your job/school?

Activities
What do you do for fun?, where? When? With friends or family?
Sports--regular exercise?
Church attendance, clubs, projects?
Hobbies--other activities?
Reading for fun--what?
TV--how much weekly--favorite shows?
Favorite music?

Drugs
Use by peers?
Use by young person? (include tobacco, alcohol)
Use by family members? (include tobacco, alcohol)
Amounts, frequency, patterns of use/abuse, and car use while intoxicated?
Source--how paid for?

Sexuality
Orientation?
Number of partners?
History of pregnancy/abortion?
Sexually transmitted diseases--knowledge and prevention? Contraception? Frequency of use?
Comfort with sexual activity, enjoyment/pleasure obtained?
History of sexual/physical abuse?

Suicide/Depression
Sleep disorders (usually induction problems, also early/frequent waking or greatly increased sleep and complaints of increasing fatigue)
Appetite/eating behavior changes
Feelings of 'boredom'

Emotional outbursts and highly impulsive behavior
History of withdrawal/isolation
Hopeless/helpless feelings
History of past suicide attempts, depression, psychological counseling
History of suicide attempts in family or peers

Appendix Q

Columbia Suicide Severity Rating Scale (CSSRS)

Columbia Suicide Severity Rating Scale (CSSRS)

Suicide Screening (Intake, Session 1, and as needed thereafter)
C-SSRS, Posner

Patient full legal name:_____ DOB: _____
Address (street, city, state, zip code):_____
Phone number(s): _____
Name of emergency contact person: _____ Phone number:_____

SUICIDE IDEATION PROMPTS	Past month	
Ask Questions 1 and 2. (Questions are **bolded and underlined**).	YES	NO
1. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** Describe: E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** Describe: As opposed to "*I have the thoughts but I definitely will not do anything about them*."		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** Describe:		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Describe examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but	**YES**	**NO**

didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

FACULTY/LICENSED PSYCHOLOGIST(S) CONTACT INFORMATION

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Expanded Suicidality Interview for Current Warning Signs (to further support the assessment from 1-5 above)
(adapted from Rudd & Joiner, 1998; Cukrowicz et al., 2004; Posner [C-SSRS]; Linehan et al., 2012)

1) Frequency, intensity, duration of suicidal ideation

- ***How frequent/intense/persistent are the thoughts of killing yourself?***
  - How often have you been having these thoughts? (1 = < 1/week, 2 = 1/week, 3 = 2-5/week, 4 = daily, 5 = daily+)
  - How intense are the thoughts when they occur? (1 = not at all, 2 = little, 3 = some, 4 = very, 5 = extremely)
  - How long do they last? (1 = fleeting, 2 = < 1 hr, 3 = 1-4 hrs, 4 = 4-8 hrs, 5 = 8+ hrs)

2) Reasons for Ideation

- ***What sort of reasons do you have for thinking about wanting to die or killing yourself?***
  - End pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling), get attention, revenge, or a reaction from others? Both/all of the above?
  - 1 = Completely to get attention/revenge/reaction, 2 = Mostly to get attention/revenge/reaction, 3 = Equally attention/revenge/reaction and end/stop pain, 4 = Mostly end/stop pain, 5 = Completely end/stop pain

3) Specificity of plans

- ***Have you been thinking about how you might do this?***
- Have you been thinking about how (what, when, where) you might kill yourself?
- When people think about suicide sometimes they think about what, how, when, or where... have you had any of these kinds of thoughts?
- Have you thought about methods, ways of committing suicide?

- Have you started to work out or worked out the details of how to kill yourself?

4) Availability of method(s), availability of opportunity

- ***Do you currently have access to [method]?***

5) Preparatory behaviors of any type

- ***Have you worked out the details? Have you done anything, started to do anything, or prepared to do anything to end your life?*** Have you taken any steps to prepare for killing yourself?
- Have you acted on these thoughts in any way?

6) Self-control

- ***Do you feel in control of your behavior right now?***
- Are you *impulsive*, angry, agitated, in physical pain, (ab)using substances?
- Have you had times when you felt out of control? Recently? When?
- What were you doing when you felt out of control (substance use)?
- How do you feel when you think about the future?
- Can you stop the thoughts or the feeling of wanting to die? (1 = easily, 2 = little difficulty, 3 = some, 4 = very difficult, 5 = unable)
- Could you rate how much in control you feel? (1 – I feel completely in control, 2 – I feel in control, 3 – I feel equally in and out of control, 4 – I feel more out of control, 5 – I feel almost no control).

7) Reasons for living, not acting / deterrents

- ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stop you from wanting to die or acting on thoughts of committing suicide?***
- You haven't acted on these thoughts, what keeps you alive right now? What keeps you going?
- What would need to happen for you to be a bit more hopeful?
- What's kept you going in the past when you've had these thoughts?
- What's your support system like?
- Has treatment been helpful to you in the past?
- Could you rate the impact of these reasons for living in deterring a suicide attempt? (1 – definitely will stop me, 2 – probably will stop me, 3 – uncertain, 4 – probably will not stop me, 5 – will not stop me).

8) Intent

- ***Have you had some intention of acting on these thoughts/plans?***
- ***Do you have any intention of acting on the thoughts of suicide today?***
- Do you feel you could commit suicide?
- Could you rate your immediate intent on a scale of 1 to 5 (1 – I have no intent to kill myself today, 2 – I don't plan to kill myself today, 3 – It is possible I could kill myself today, 4 – It is likely that I will kill myself today, 5 – I am going to kill myself today)?

Risk Characterization and Intervention

(Joiner et al., 1999)

Level of risk	Clinical Activities
NONEXISTENT no identifiable suicidal symptoms, no past history of suicide attempt, no or few other risk factors	○ Document risk assessment was completed
MILD multiple attempter with no other risk factors non-multiple attempter with suicidal ideation of limited duration and intensity (i.e., no or mild symptoms of resolved plans and preparations, and no or few other risk factors)	• Give emergency numbers for facilities in your community where the patient can receive services in the event a crisis occurs and/or you are unavailable. • Regularly assess level of suicide risk so that appropriate changes can be made if risk level increases. • Document risk assessment and actions taken to ensure the safety of the patient.
MODERATE multiple attempter with the presence of any other notable factor non-multiple attempter with the presence of moderate to severe symptoms of resolved plans and preparations non-multiple attempter with the presence of no or mild symptoms of resolved plans and preparations, and moderate to severe symptoms of suicidal desire and ideation, and at least two other notable risk factors	• Consider alternatives to emergency facilities. For example, suppose that you have a patient who is depressed and talking about suicide but has no immediate plan of action. The patient tells you that s/he does not think s/he will kill her/himself, but cannot stop thinking about it. Before emergency services, consider measures to support the patient. ○ increasing the frequency or duration of sessions ○ ensuring the availability of emergency or crisis services (e.g., 1-800-suicide), telephone monitoring, and frequent reevaluation. ○ making patient aware of steps to take in the event that a crisis occurs. This may include listing problem-solving steps on a “coping card” the patient can keep. Developing a SAFETY PLAN and giving the client copies ○ with the patient’s consent, consider involving friends or family that the patient can stay with. ○ ask for agreement to make direct contact with you before taking action.

	• Contact the supervisor and seek professional consultation in the event that there is ambiguity in the actions that are appropriate. • Document risk assessment and actions taken to ensure the safety of the patient.
SEVERE multiple attempter with any two or more other notable risk factors non-multiple attempter with moderate to severe symptoms of resolved plans and preparations, and one other risk factor	• If you decide that the patient should go to an emergency mental health care facility then the patient should be informed of this. • Hopefully, the patient will go voluntarily. • Chances are the patient will refuse. At this point you will clearly explain to the patient that you want him/her to go to a facility for an evaluation and that it may or may not involve an overnight stay. • Do your best to convince the patient to go voluntarily. If you are successful in this endeavor, call an appropriate agency (e.g., Police Department) in your area for a "voluntary" evaluation. Be clear when you make this call to inform them who you are, where you are calling from, exactly what you need, and provide information requested about the patient. The patient being evaluated is still your patient and you are to follow through until the patient has been evaluated. • See Flowchart #1 below • If you learn that your patient is in crisis but is not currently in your care, try to get him/her to come to your clinic or facility, if the crisis is occurring during normal business hours. If the patient comes to your facility, proceed as outlined above. • Give the patient a time limit for arriving at your facility. You could say, "I am expecting you to be here within an hour. If you are not here, I will send someone to your house." • If you have doubts about whether or not the patient will come to your facility, call the appropriate police agency as specified below. • Always determine where the patient is when s/he calls. If the patient will not reveal this information, get the phone number from where the patient is calling because police have phone directories that can locate addresses. • Do not invite patients to your facility who are imminently homicidal. • See Flowchart #2 below
EXTREME multiple attempter with presence of severe symptoms of resolved plans and preparations non-multiple attempter with severe symptoms of resolved plans and preparations, and two or more other risk factors.	

Safety Plan Free app: Suicide Safety Plan

(Adapted from Linehan, 2012; Rudd et al., 2006; Stanley & Brown, 2012)

During stressful times it is helpful to plan ahead on how to take care of yourself and provide yourself with the safety and care you deserve. This form will help us develop a safety and self-care plan for you.

Step 1: Warning signs. Identify what specifically is upsetting me, what are some things that might make things worse for me or that will signal me that I need to use strategies to say safe.

1.

2.

3

Step 2: What are more reasonable things I will say to myself in response to suicidal thoughts

1.

2.

3.

Step 3: Personal coping strategies. What are some activities or things that I will do to distract myself or enjoy myself without needing to contact anyone. (Examples: go for a walk, listen to music, play with a pet, read a book, watch a funny show/movie, eat a favorite food, surf the internet for funny material, exercise, etc.)

1.

2.

3.

Step 4: Social coping strategies. What are some social situations I will put myself in or some people that I will contact or interact with to distract or enjoy. (Examples: call a friend or family member, go to the mall/store/coffee shop, text/facebook with a friend or relative that is upbeat/positive).

1.

2.

3.

Step 5: Who are some people (for youth: adults) who I will specifically ask for help/support if Steps 2-4 do not work and I'm feeling worse. If the thoughts continue, get specific, and I find myself preparing to do something I will call.

1. Name: Phone

2. Name: Phone

Step 6: Who are the professionals or agencies I will contact if I am in crisis. If I feel suicidal and don't feel like I can control my behavior after steps 2-5 I will call or go to:

1. Gryphon Place Phone: 211 or 269-381-HELP (4357)
2. Emergency Phone: 911
3. Suicide and Crisis Hotline Phone: 988
4. Michigan Crisis and Access Line Phone: 1-844-44 (MICAL)
5. Crisis Textline Text: HOME to 741741
6. Kalamazoo Community Mental Health 24 hour Crisis Line: 269-373-6000 or 1-888-373-6200
7. TRANS lifeline (no active rescue policy, run by trans people for trans and questioning individuals): Phone: **(877) 565-8860**
8. The Gay, Lesbian, Bisexual and Transgender (GLBT) National Hotline: (888) 843-4564
9. The GLBT National Youth Talkline (youth serving youth through age 25): (800) 246-7743
10. The Trevor Project (for LGBTQ+ young people ages 13-24): 1 (866) 488-7386
11. Blackline (anonymous and confidential 24-hour hotline geared towards the Black, Black LGBTQI, Brown, Native and Muslim community) Phone: 1 (800) 604-5841
12. Borgess Hospital Emergency Room
    Address: 1521 Gull Rd.,
    Kalamazoo, Ml49048
    Phone: 269-226-7000
    269-226-8000
13. Bronson Methodist Hospital Emergency Room Address: 601 John St.. Kalamazoo. Ml,49007 Phone: 269-341-7654

Step 7: Prevention: Making the environment safe. I will do the following things to keep my space safe:

1.

2.

Step 8: Commitment. I am committed to safety and self-care. I agree to implement this plan should my suicidal thoughts increase.

Print Name: _____ **Signature:** _____

It is important to be as thorough as possible in your documentation. When documenting sessions involving risk assessment err on the side of being overly inclusive in your progress note.

The client should be given multiple copies of any safety plan developed and a copy must be included in their research file.

Taking a history of suicide attempts (to further support the assessment from item 6 in the C-SSRS screener above)
(Adapted from Rudd & Joiner, 1998; Cukrowicz et al., 2004; Posner [C-SSRS]; Linehan et al., 2012)

Have you ever made a suicide attempt?
How many times?

[If within the past 3 months] ***Please tell me first about the most recent time you felt suicidal?***
[If more than 1] ***Please tell me first about the time you felt the most suicidal?*** [start with whichever is applicable but complete for all attempts]

What did you do?

Did you_____ as a way to end your life?
Did you want to die (even a little) when you_____?
Were you trying to end your life when you _____?
Or -- Did you think it was possible you could have died from_____?
Or -- Did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

What was the result? [Actual Lethality]

0 = No physical damage or very minor physical damage (e.g., surface scratches).
1 = Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).
2 = Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3 = Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4 = Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).

Potential Lethality

0 = Behavior not likely to result in injury

1 = Behavior likely to result in injury but not likely to cause death

2 = Behavior likely to result in death despite available medical care

Why did you do it? What were the circumstances? What was going on in your life?

How did you feel about surviving?

Has there been a time when you started to do something to end your life, but someone or something stopped you before you actually did anything?

Has there been a time when you started to do something to try to end your life, but you stopped yourself before you actually did anything?

Have you done anything else to harm yourself?

Have you engaged in any non-suicidal self-injurious behavior?

Has anyone in your family died by suicide?

Appendix R

Adherence and Competence Ratings

Adherence and Competence Ratings
*Adapted from Frueh et al., 2007

1. Therapist followed WET script with fidelity during the session.
(1) yes (2) no

2. Therapist provided appropriate feedback after writing exercise.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

3. Therapist exhibited good rapport with the patients.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

4. Therapist exhibited accurate empathy.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

5. Therapist engaged participants in a professional manner.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

6. Therapist addressed questions or problems.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

7. Therapist structured time efficiently and was able to keep the focus of the session on the issues appropriate for the session.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

8. Did any significant problems arise during the session that led to a significant departure from the treatment protocol?
(1) yes (2) no

9. Please give a rating of the therapist's overall skills as demonstrated in this session.
(1) poor (2) barely adequate (3) mediocre (4) satisfactory (5) good (6) very good (7) excellent

For Values enhanced:
10. Therapist engaged participants in values recall
(1) yes (2) no