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Exposure, relaxation, and rescripting therapy could treat residual nightmares following PTSD treatment

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Dear editor,

The article by Tripp and colleagues in the September 2020 issue provides an important contribution to the literature regarding residual PTSD symptoms following psychotherapeutic and pharmacological treatments. Following treatment, the three PTSD symptoms that were most likely to persist were sleep disturbances (63%), hypervigilance (47.3%), and nightmares (45%). While the authors call attention to psychotherapy treatments targeting sleep disturbances as a possible future direction (i.e., Cognitive Behavioral Therapy for Insomnia; CBT-I), the authors expressed relative uncertainty regarding treatment approaches that can address residual nightmares following PTSD treatment. We are writing to address this uncertainty by recommending the use of an established psychotherapeutic treatment approach for post-traumatic nightmares (PTN) called Exposure, Relaxation, and Rescripting Therapy (ERRT; Davis & Wright, 2006).

The persistence of PTN following treatment for PTSD has been evidenced in several prior studies, and both PTN and sleep difficulties are noted as hallmarks of PTSD (Germain, 2013). PTN and sleep difficulties are also known to play an important role in the development and chronicity of PTSD. Further, PTN may also be an independent condition comorbid with PTSD, not just a symptom of PTSD. As such, they often warrant targeted clinical intervention with psychotherapeutic treatments such as ERRT.

The treatment components of ERRT involve psychoeducation about trauma, nightmares, and sleep, sleep habit modification, relaxation training, and nightmare exposure and rescripting over three to five weeks of treatment (Davis & Wright, 2006). Three randomized clinical trials conducted with civilian adult populations have shown that ERRT can significantly reduce nightmare frequency and severity, as well as sleep disturbances more generally, and decrease symptoms of PTSD and depression (Davis & Wright, 2007; Rhudy et al., 2010; Pruiksma et al., 2016). Two of these trials utilized a waitlist control condition (Davis & Wright, 2007; Rhudy et al., 2010), while the other used a modified version of ERRT as an

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Conflicts of Interest Statement

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active comparator (Pruiksma et al., 2016). In the latter trial, both versions of ERRT showed a significant reduction in PTN and related sleep difficulties. Two separate clinical trials used a modified version of ERRT for military populations (ERRT-M), which demonstrated efficacy for treatment of PTN (Balliett et al., 2015; Pruiksma et al., 2020). The first of these was a non-randomized open arm trial conducted with military veterans (Balliett et al., 2015), and the second was a randomized trial that used a minimal contact active comparator condition with active duty military personnel (Pruiksma et al., 2020).

Ongoing clinical trials are being conducted by our laboratory, and one of these trials is examining the combined effects of ERRT and Cognitive Processing Therapy for PTSD. Meanwhile, another of these trials is investigating the comparative efficacy of CBT-I and ERRT for reducing nightmares, sleep problems, and suicidal ideation. A recent review by Waltman and colleagues (2018) examined the empirical support for both pharmacologic and non-pharmacological treatments for PTN, and this review recommended ERRT and imagery rehearsal therapy (IRT) as the preferred non-pharmacological options for treating PTN. IRT is a similar psychotherapeutic intervention for PTN that utilizes nightmare exposure and rescripting, but it does not include the relaxation or sleep habit modification components that ERRT does. Thus, ERRT might also provide additional benefit when compared to IRT for the residual sleep disturbances found to persist following PTSD treatment. A single pharmacological intervention for PTN has been disseminated (i.e., Prazosin), but its efficacy has recently shown mixed empirical support. Thus, Prazosin is no longer considered a first-line treatment for PTN (Waltman et al., 2018).

In conclusion, we would like to reiterate the importance of this work by Tripp and colleagues (2020) as it demonstrates that first-line PTSD treatments do not sufficiently treat all PTSD symptoms, including sleep disturbances and PTN. Therefore, we agree with the authors' recommendation for adjunctive sleep treatments such as CBT-I, but we would also recommend that ERRT be considered as a possible treatment for residual PTN following PTSD treatment.

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References

Davis JL, Wright DC, 2006 Exposure, relaxation, and rescripting treatment for trauma-related nightmares. J Trauma Dissociation. 7(1), 5–18. [PubMed: 16618692]

Davis JL, Wright DC, 2007 Randomized clinical trial for treatment of chronic nightmares in trauma-exposed adults. J Trauma Stress. 20(2), 123–33. [PubMed: 17427914]

Balliett NE, Davis JL, Miller KE, 2015 Efficacy of a brief treatment for nightmares and sleep disturbances for veterans. Psychol Trauma. 7(6), 507–15. [PubMed: 26010113]

Germain A, 2013 Sleep disturbances as the hallmark of PTSD: where are we now? Am J Psychiatry. 170(4), 372–82. [PubMed: 23223954]

Pruiksma KE, Cranston CC, Rhudy JL, Micol RL, Davis JL, 2016 Randomized controlled trial to dismantle exposure, relaxation, and rescripting therapy (ERRT) for trauma-related nightmares. Psychol Trauma. 10(1), 67–75. [PubMed: 27977223]

Pruiksma KE, Taylor DJ, Mintz J, Nicholson KL, Rodgers M, Young-Mccaughan S, Hall-Clark BN, Fina BA, Dondanville KA, Cobos B, Wardle-Pinkston S, Litz BT, Roache JD, Peterson AL, STRONG STAR Consortium, 2020 A pilot randomized controlled trial of cognitive behavioral treatment for trauma-related nightmares in active duty military personnel. J Clin Sleep Med. 16(1), 29–40.

Rhudy JL, Davis JL, Williams AE, McCabe KM, Bartley EJ, Byrd PM, Pruiksma KE, 2010 Cognitive-behavioral treatment for chronic nightmares in trauma-exposed persons: assessing physiological reactions to nightmare-related fear. J Clin Psychol. 66, 1–18. [PubMed: 19941327]

Tripp JC, Norman SB, Myra Kim H, Venners MR, Martis B, Simon NM, Stein MB, Allard CB, Rauch SAM, PROGrESS Study Team, 2020 Residual symptoms of PTSD following Sertraline plus enhanced medication management, Sertraline plus PE, and PE plus placebo. Psychiatry Res. 291, 113279. [PubMed: 32763541]

Waltman SH, Shearer D, Moore BA, (2018). Management of post-traumatic nightmares: a review of pharmacologic and nonpharmacologic treatments since 2013. Curr Psychiatry Rep. 20, 108. [PubMed: 30306339]