

An Overview of Written Exposure Therapy



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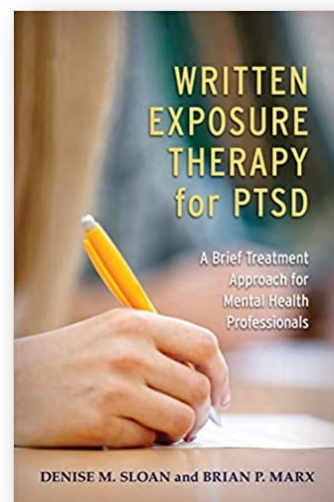
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Learning Objectives

- Distinguish components of Written Exposure Therapy from other evidence-based psychotherapies for PTSD
- Analyze three tasks performed by the therapist when conducting Written Exposure Therapy
- Evaluate research studies on the effectiveness of Written Exposure Therapy

Written Exposure Therapy

- Written Exposure Therapy for PTSD: A Brief Treatment Approach for Mental Health Professionals (2019)
- Developed by Drs. Denise Sloan and Brian Marx
- Known as WET



Overview of WET

- Brief, 5-session protocol with scripted instructions
- 1st session is 60 min, remaining sessions are 40 min
- Patients write continuously about target trauma for 30 min each session
- Minimal therapist intervention
- No homework



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VA/DoD Clinical Practice Guidelines (2017) verdict?

“sufficient evidence to recommend use”



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2 Critical Treatment Components

1. Therapeutic exposure

Patient confronts trauma memory by writing trauma narrative over 5 treatment sessions

2. Processing and cognitive restructuring

Patient processes trauma memory and modifies cognitions on own (not prompted by therapist in session)



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Origins and Research

Why and how was WET developed?

Barriers to Existing EBPs for PTSD*

Behavioral Health Providers

- Need substantial training and time/prep to become proficient
- Feel overburdened and face competing clinical demands
- Concerned patients will become too distressed
- Concerned about own reactions/ability to cope with patients' traumas

Patients

- Don't have time for or can't afford 10-15 sessions
- Find homework onerous or don't have time for it
- Concerned they will become overly distressed or decompensate
- Can't find an EBP therapist near them

*Existing EBPs for PTSD referred to above include PE, CPT & EMDR.

Origins of WET

Evolved from Pennebaker & Beall's study of expressive writing (1986)

- College students were randomly assigned to write about a stressful/traumatic experience or a superficial topic for 15 min on 4 consecutive days
- Participants who wrote about stress/trauma had reduced student health center visits vs. controls

Repeated studies have shown the benefits of expressive writing on physiological and psychological health.

Interview with Dr. James Pennebaker



How Does Expressive Writing Help?

Slows down thinking and helps individuals:

- Understand events and feelings in new and productive ways
- Construct a narrative to contextualize the trauma and organize ideas
- Achieve closure that tells the brain its work is done

“Expressive writing gives us the opportunity to stand back and reevaluate issues in our lives.”

(Pennebaker)



Origins of WET

- Sloan & Marx saw similarities between expressive writing about stress/trauma and exposure-based PTSD therapies.
- Initially, they didn't think this intervention would work for those with PTSD-defined trauma due to treatment brevity.

It did.

They continued their studies and refined the intervention to its present form.

Exposure-Based Writing Therapies for PTSD: A Systematic Review and Meta-Analysis (2021)

Not many RCTs yet

- 13 identified by Dawson et al. (2021) looking at all writing therapies for PTSD, WET included*

Findings:

- Writing therapies are better than waitlist or placebo writing
- Compared with other psychotherapies, writing therapies are non-inferior, although somewhat better gains were found with other therapies
- **2 specific RCTs with WET**
 - These were of higher quality and showed promising evidence
 - Replication needed for stronger evidence base

There have been studies on WET since Dawson's (2021) meta-analysis.

Dawson et al., 2021

RCT Comparing WET to CPT in Mixed Sample (2018)

- WET compared to CPT
 - Hypothesis 1: WET will be non-inferior to CPT
 - Hypothesis 2: WET will have a significantly lower dropout rate than CPT
- Used original CPT version that has patients write 2 trauma accounts (at home after sessions 3 & 4), and Dr. Patricia Resick, CPT co-founder, gave oversight to the CPT arm
- Randomly assigned 126 adults with PTSD and mixed types of trauma to either WET (63) or CPT (63)
 - 74% (93) civilians; 26% (33) military veterans; 52% (66) male; 48% (60) female
- Assessments at 6, 12, 24, 36, and 60 weeks post first treatment session because of different treatment lengths (5 sessions for WET vs. 12 sessions for CPT)
- Primary outcome was CAPS-5

Findings:

- **WET was non-inferior to CPT, and WET had significantly less dropouts**
 - **40% (25) dropouts in CPT (32% within first 5 sessions); 6% (4) dropouts in WET**

(Sloan et al., 2018)

RCT Comparing WET to CPT in Service Members (2022)



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- WET compared to CPT
 - Hypothesis: WET will be non-inferior to CPT
- Used CPT version without trauma narratives; sessions were twice a week
- Randomly assigned 169 active duty service member adults to either WET (85) or CPT (84)
 - Almost all Army (167); 80% (136) male; 20% (33) female
- Assessments at 10, 20, 30, and 36 weeks post first treatment session because of different treatment lengths (5 sessions for WET vs. 12 sessions for CPT)
- Primary outcome was CAPS-5
- Findings:
- **WET was non-inferior to CPT**
 - There was no hypothesis about dropout rate, but when explored, no difference found when limited to analyzing first 5 sessions (dropout rate was 24% for CPT & WET)

(Sloan et al., 2022)



Effectiveness of WET in VA Health System (2021)

- WET delivered to 277 veterans in person (106), via telehealth (122), or a combination (49)
- Majority of participants were white, male, with military-related trauma
- Hypothesis: WET delivered in VA clinics by VA providers will be associated with significant reductions in PTSD and depression symptoms and improvements in functioning
- Explored whether certain patients responded better to WET based on demographics, trauma type, and comorbidity; also explored WET outcomes by delivery format
- Portion of care took place during COVID-19, resulting in changes to delivery

Findings:

- Patients showed significantly reduced PTSD and depression symptoms and functional impairment on self-report measures
- No differences in effectiveness by delivery format; no moderators of PTSD treatment outcome
- 25% (70) dropped out of WET overall
- Telehealth-delivered WET was associated with lower dropouts (21% vs. 34% for in-person WET)
- Patients who completed a full course of WET had higher mean years of education

(Losavio et al., 2021)



Summary of Research Findings

- ✓ WET appears to be efficacious and well tolerated.
- ✓ Unclear about whether WET reduces dropouts.
- ✓ Telehealth-delivered WET appears to work as well as in-person WET.
- ✓ More research is necessary.
 - For whom will this treatment work best?
 - Under what circumstances will this treatment be the better option?
 - How does it compare to other EBPs?
- ✓ Not yet a top-rated treatment for PTSD like PE, CPT, or EMDR, but there is sufficient evidence to recommend its use.

Implementing WET

Who Is Appropriate for WET?

Recommended if patient:

- has PTSD or subclinical PTSD and is experiencing significant distress and dysfunction
- has a clearly identified Criterion A event



Not recommended if patient:

- has no memory or only scarce details of trauma
- is at risk of ongoing trauma or imminent safety concerns
- has strong reservations about confronting trauma memories
- has impairment not caused by PTSD or PTSD is not the primary diagnosis
- can't write in primary language of therapist

Patient Tasks in WET

- Write about index trauma for 30 min
- Focus on thoughts, feelings, and other details
- Don't worry about punctuation or grammar
- If finish early, go back to the beginning and continue writing
- In between sessions, allow trauma-related thoughts, images, and feelings to come up without pushing them away

Therapist Tasks in WET

- Read instructions verbatim
- Collect SUDS before and after each writing period *
- Track progress through weekly self-report measures (e.g., PCL-5, PHQ-9).
- Perform 10-min check-in at end of each session, focusing on patient's writing experience without engaging in processing

*Introduce Subjective Units of Distress Scale (SUDS) prior to first session.

Check-in after Patient Writes



Therapist Tasks (cont)

- Before next session, read patient's written narrative
 - Goal is to evaluate writing assignment:
 1. Did patient follow instructions or only write about facts?
 2. Did they write about events that led up to trauma but not the actual trauma?
 3. Did they stick with target trauma or shift?
 4. How is length? Did they only write a few sentences?
- At next session, provide feedback to patient about following the instructions, not content



The Environment

- **Minimize distractions**
 - Silence phones/gadgets
 - Consider noise from therapist
- **Patient writing alone vs. in room with therapist?**
 - Pros and cons for both
- **Handwriting vs. typing?**
- **Delivered in person vs telehealth?**



Selecting the Target/Index Trauma



Focus on the traumatic event that:

- is most related to PTSD symptoms and closely tied to avoidance
- is most difficult to avoid reminders of despite attempts
- causes the most distress
- stands out the most or is most prominent
- patient has a good memory for and can write details about

If several such events, pick one and focus on it

Structured Format for All Sessions

1. Give screening assessments prior to start (e.g., PCL-5, PHQ-9)
2. Briefly check in, then provide feedback about previous week's written narrative
3. Read session instructions for this week's writing assignment and give patient a printed copy
4. Collect SUDS before patient begins to write
5. Set a 30-minute writing period (therapist timed)
6. Collect SUDS after patient writes
7. Check in about writing experience
8. Wrap-up
 - Collect patient's written narrative
 - Read end-of-session script
 - After session, read patient's written narrative and be prepared to provide feedback next session

Session 1

- Inform patient you will read instructions verbatim
- **Read overview script** – provide general information about PTSD and why writing will be beneficial
 - Pause after describing PTSD symptoms
Are any of these familiar?
 - Provide treatment rationale
 1. to correct splintered memory storage
 2. to gain more control over memory

Session 1 (cont)

- Address questions, ensure understanding
- Read first writing assignment script
- Then use structured format (which is the same for all sessions)
 - 30-minute writing period; collect pre/post-writing SUDS
 - Check in about writing experience
 - Collect patient's written narrative
 - Read end-of-session script
 - After session, read patient's written narrative and be prepared to provide feedback next session

Writing Instructions: Session 1

“Over the next 5 sessions I would like you to write about your trauma. Don’t worry about your spelling. 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 whether other people were 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.”

Writing Instructions: Session 1 (cont)

“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 five 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) your trauma.”

Writing Instructions: Session 1 (cont)

“For your first writing session, I’d like you to write about the trauma starting at the very 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 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, (car horn, screeching tires, person threatening you, explosion), or what you smelled (e.g., blood, burning rubber).”

Writing Instructions: Session 1 (cont)

“In addition to writing about 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 have had the thought, “I’m going to die,” “This can’t be happening,” or “I’m going to be raped”. And you might have felt terrified, frozen with fear, or angry at another person involved. Remember you don’t need to finish writing about the entire trauma in this session. Just focus on writing with as much detail as possible and include your 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.”

End-of-Session Instructions (sessions 1-4)

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

Sessions 2-4

- Follow standard session format
- Provide more feedback about patient’s written narratives as they are learning what to do
- As sessions progress, feedback usually becomes easier and shorter
- Monitor screening assessments and pre/post-writing SUDS for changes
 - ~session 2, patients may show a spike in symptoms
 - ~session 4, patients often report significant decrease in avoiding previously triggering places and activities
 - If no decrease in symptoms after session 3, discuss why

Instructions: Session 3

Change in writing instructions:

- How has trauma impacted life?
- Option to focus on a specific part

If patient has not done an adequate job writing in sessions 1 & 2, delay change in instructions

“I want you to continue writing about the trauma as you think about it today. If you have completed writing about the entire trauma you experienced, 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.”

Instructions: Session 4

Continue with change in writing instructions from Session 3

- How has trauma impacted life?
- Option to focus on specific part

“I want you to continue write about the trauma today. As with your writing in the last session, you can select a part of the trauma that is 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 whether 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.”

Session 5: Final Session

- Standard format through post-writing check-in

At end of session, review treatment and progress

- What was beneficial?
- Remind patient they have tools to continue coping with symptoms and the written WET instructions for future reference
- Areas for more work?

Options If There Are Residual Symptoms

- Add more writing sessions if 5 sessions were not enough
- Do WET again but with another trauma
- Use a different EBP for PTSD
- Address other symptoms through another EBP appropriate for those problems (e.g., CBT-D for depression)

Reminders

- Prior to Session 1, spend time with patient selecting a discrete trauma connected to their PTSD symptoms
- Collect self-report measures before each session
- Remind patient to write about the same trauma for all 5 sessions and to write continuously for the full 30 minutes
- Read scripts verbatim each session
- Provide written instructions to patient
- Collect SUDS before and after patient writes
- Don't check in with patients or interject as they write (i.e., stay quiet)



Reminders (cont)

- Be sure to time the writing period
- Consider giving a 5-minute warning
- Prepare for a temporary increase in symptoms and normalize
- Don't assign homework!



Only instruct patients to not avoid trauma-related thoughts, feelings, and images during the week

Other Questions

- Telehealth
 - Screen on or off while patient writes?
 - How to collect written narratives?
- Can WET serve as a primer for another EBP?
- Can WET be used with acute stress disorder or a recent trauma?
- Can WET be combined with PE?



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2 Case Examples

Limitations Based on Clinical Experience

- Minimal therapist intervention
 - Challenging not to process and use cognitive restructuring
 - Some patients are disadvantaged without therapist assistance
- 30 minutes may not be enough writing time for some patients
- Little guidance about what to do when patients are highly aroused after writing
- Change in instructions starting in session 3
 - Can be confusing to patients
 - May not give enough doses of exposure to the full trauma
- Protocol's brevity may not leave enough time to solidify long-term gains
- A lot to accomplish in final session; termination feels abrupt
- May not work as well with chronic PTSD or multiple traumas



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Frequently Asked Questions

What if patient stops writing before 30 minutes?

What if patient dissociates?

What if patient doesn't want me to read their trauma narrative?



What if patient writes the whole time but it is too brief?

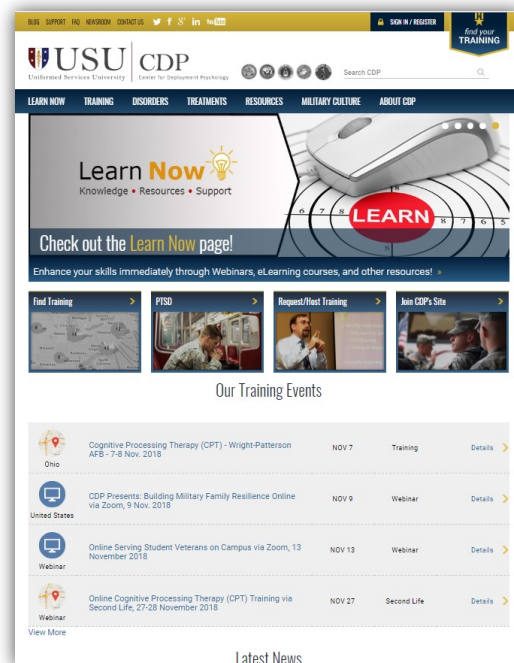
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deploymentpsych.org

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, suicide prevention, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



Other Learning Opportunities



- CDP Presents - Monthly Webinar Series
 - Live and archived
 - CEs free for live, small fee for on-demand CEs
 - View archived webinars free for no CEs
- On-demand Courses
 - Military Culture
 - Deployment Cycle
 - Intro to PE and CPT
 - ...and more!



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Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

- Consultation resources
- Printable fact sheets, manuals, handout, and other materials
- FAQs and 1:1 interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids



Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their username and access the "Provider Portal" section at Deploymentpsych.org.



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