Written Exposure Therapy: A Brief PTSD Treatment

Denise M. Sloan, Ph.D. & Brian P. Marx
National Center for PTSD at
VA Boston Healthcare System &
Boston University School of Medicine

Disclaimer: The views expressed in this presentation are solely those of the presenters and do not reflect an endorsement by or the official policy or position of the U.S. Army, the U.S. Air Force, the Department of Defense, the Department of Veterans Affairs, or the United States Government.
Disclosure: The presenters receive royalties for the published manual for Written Exposure Therapy.

Do you have experience working with patients that have PTSD?

Do you have experience delivering trauma-focused therapy?

PTSD

- Develops after exposure to potentially traumatic event that is beyond typical stressor
  - Violent personal attacks (physical and sexual)
  - Natural disasters
  - Combat
  - Accidents (car accidents)

PTSD Criterion A

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
  - Direct exposure
  - Witnessing the trauma
  - Learning that a relative or close friend was exposed to a trauma
  - Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

PTSD *DSM-5* Criteria

- PTSD is a Trauma- and Stressor-Related Disorder with 8 Criteria:
  - Criterion A: Stressor Criterion
  - Criterion B: Intrusion Criterion
  - Criterion C: Avoidance Criterion
  - Criterion D: Negative Alterations in Cognition or Mood Criterion
  - Criterion E: Arousal and Reactivity Criterion
  - Criterion F: Duration (at least 1 month since event)
  - Criterion G: Clinically Significant Distress/Impairment
  - Criterion H: Not attributable to effects of substance/medical condition

Commonly Used *DSM-5* PTSD Instruments

- Screen:
  - Primary Care PTSD Screen (PC-PTSD-5)
  - https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
- Self-Report
  - PTSD Checklist (PCL-5)
  - https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
- Interview
  - Clinician Administered PTSD Scale (CAPS-5)
  - https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

PCL-5 Example Items

PCL-5

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

The event you experienced was _____ on _____.
(event) (date)

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4

Written Exposure Therapy Development

Journal of Abnormal Psychology
1986, Vol. 95, No. 3, 274–281

0021-843X/86/$00.75

Confronting a Traumatic Event: Toward an Understanding of Inhibition and Disease

James W. Pennebaker and Sandra Klihr Beall
Southern Methodist University

According to previous work, failure to confide in others about traumatic events is associated with increased incidence of stress-related disease. The present study served as a preliminary investigation to learn if writing about traumatic events would influence long-term measures of health as well as short-term indicators of physiological arousal and reports of negative moods. In addition, we examined the aspects of writing about traumatic events (i.e., cognitive, affective, or both) that are most related to physiological and self-report variables. Forty-six healthy undergraduates wrote about either personally traumatic life events or trivial topics on 4 consecutive days. In addition to health center records, physiological measures and self-reported moods and physical symptoms were collected throughout the experiment. Overall, writing about both the emotions and facts surrounding a traumatic event was associated with relatively higher blood pressure and negative moods following the essays, but fewer health center visits in the 6 months following the experiment. Although the findings and underlying theory should be considered preliminary, they bear directly on issues surrounding catharsis, self-disclosure, and a general theory of psychosomatics based on behavioral inhibition.

Writing about the most traumatic or stressful event of one's life in detail with emotions and feelings

Three, 20-minute writing sessions

Results in beneficial physical and psychological outcomes

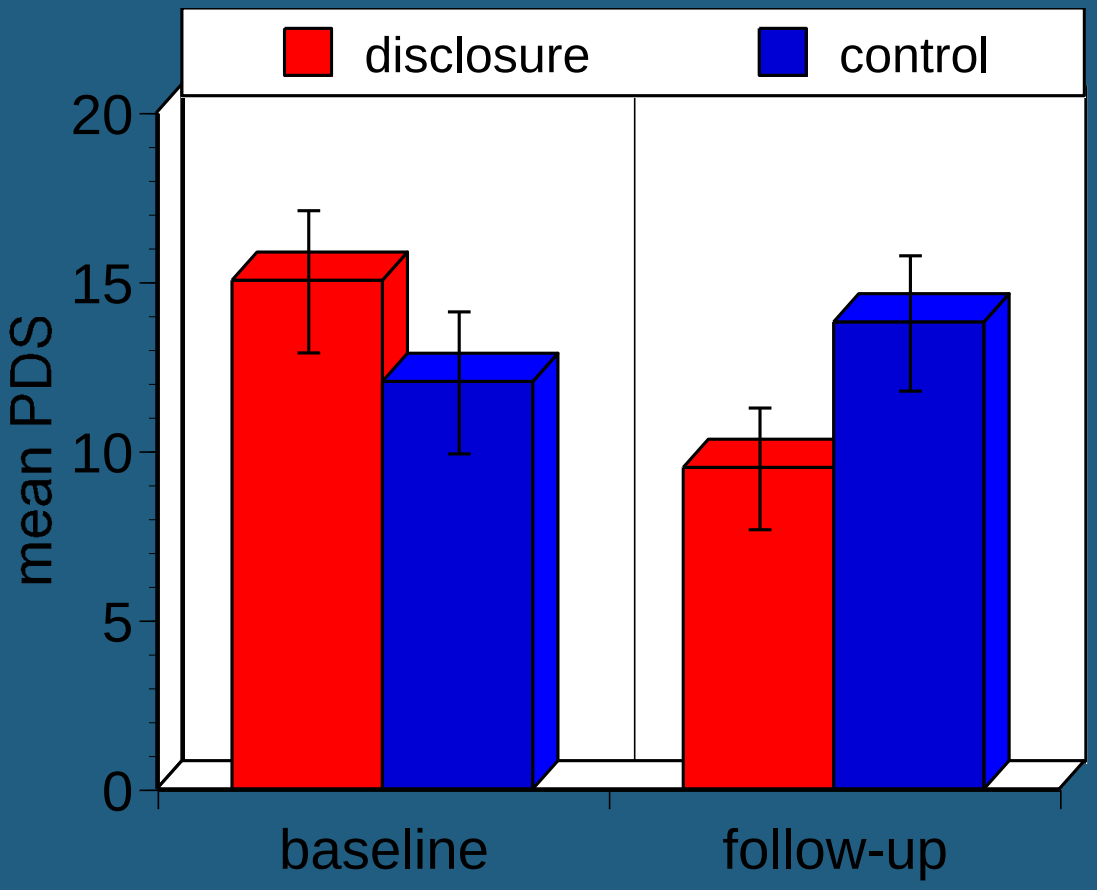
Written Disclosure Procedure

- Would this work with people with traumatic stressor exposure and at least moderate PTSD symptom severity?
- Two key elements lead to successful exposure-based therapy outcome
  - Initial activation of pathological fear response
  - Extinction of fear responding across treatment sessions (Foa & Kozak, 1986)

Expressive Writing for PTSD Symptoms

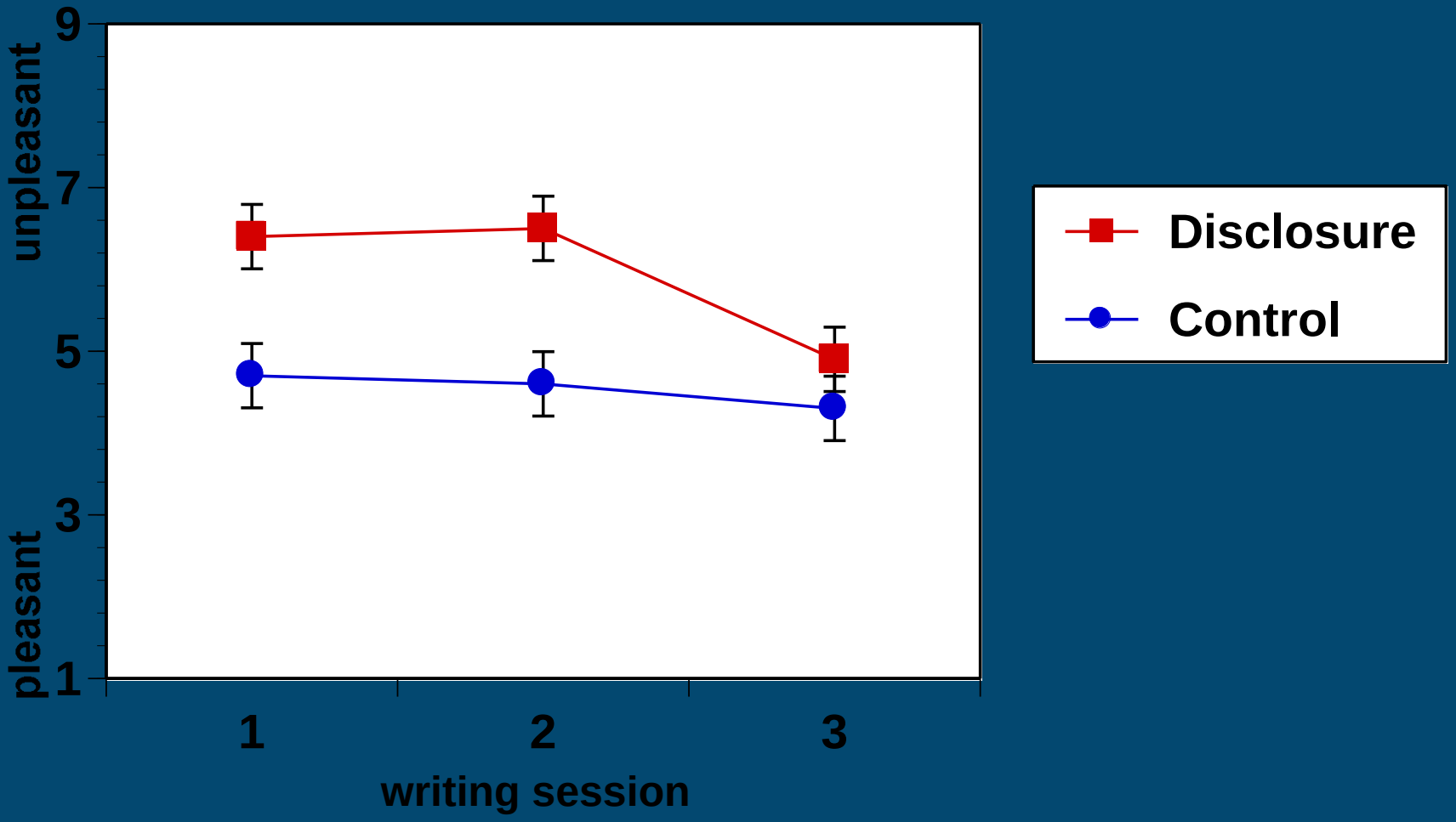
- Not sufficient dose for extinction of pathological fear responding
- Control condition: asked to write about how they spent their time each day with no emotions or opinions

Is Written Disclosure Beneficial for Trauma Survivors with PTSD Symptoms?



Sloan & Marx (2004). ***Journal of Consulting and Clinical Psychology***

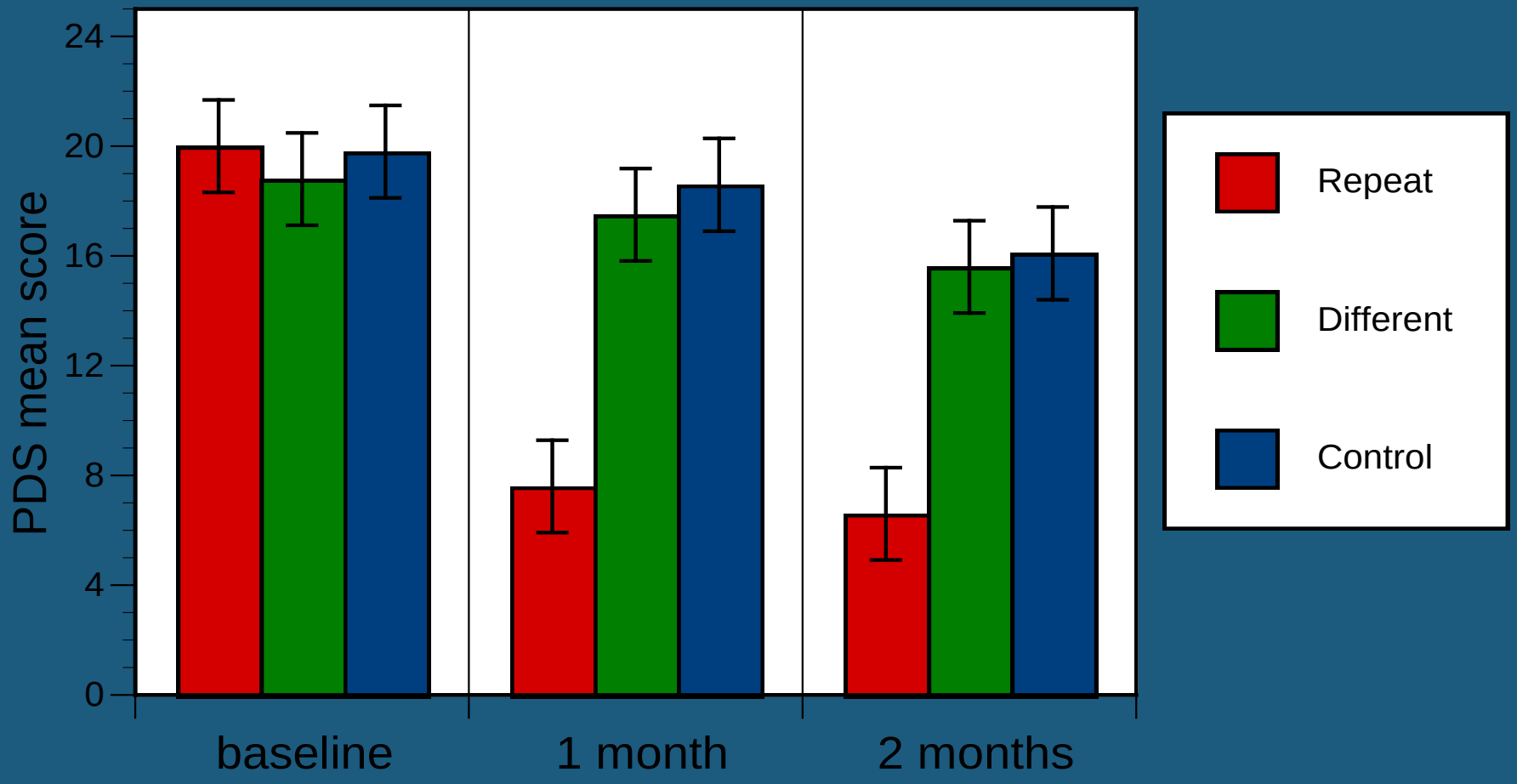
Extinction of Fear Response



Sloan & Marx (2004). *Journal of Consulting and Clinical Psychology*

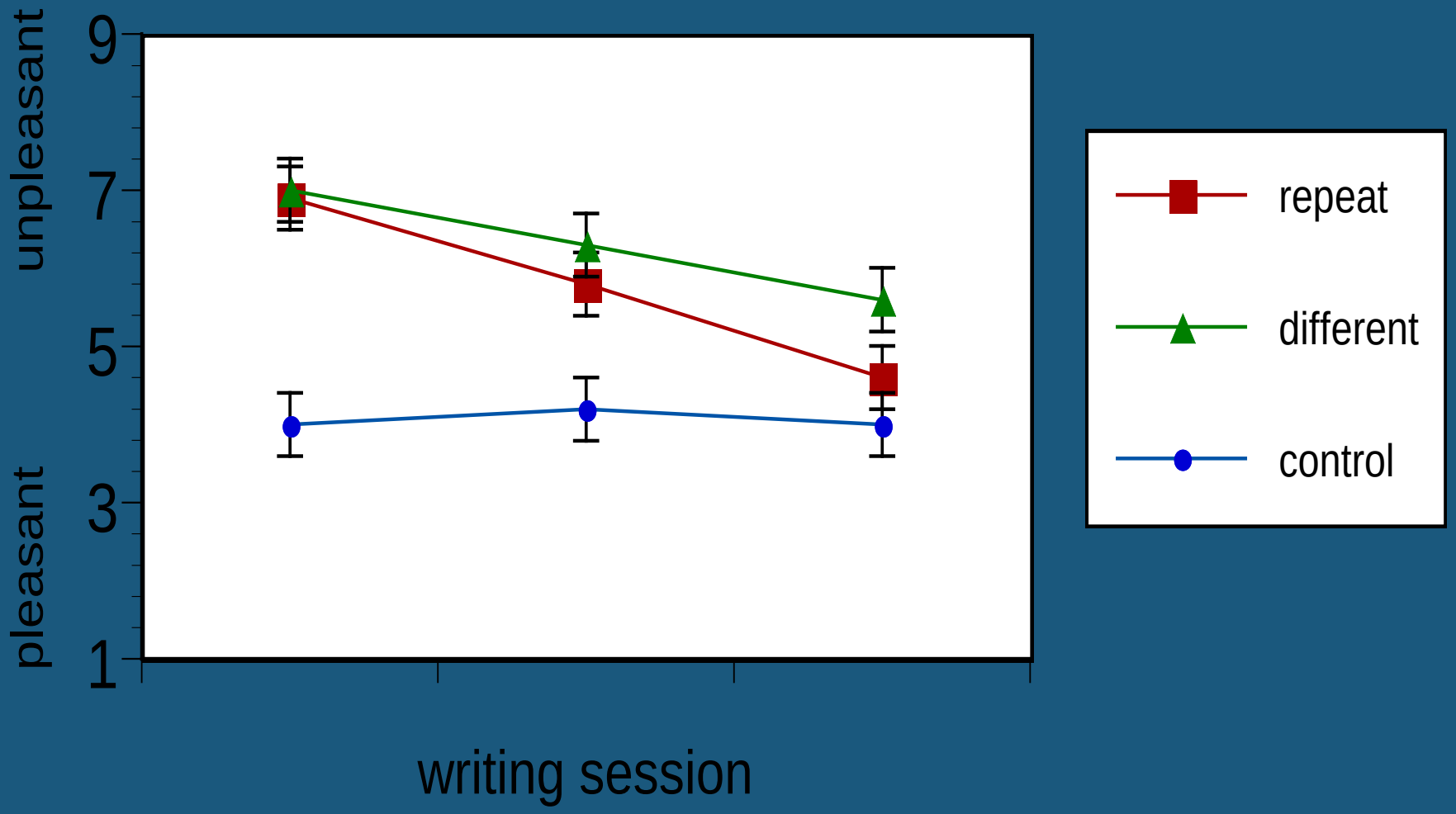
Does Writing about the Same Trauma Memory Matter?

Writing about the Same or Different Traumas



Sloan et al. (2005). *Journal of Consulting and Clinical Psychology*

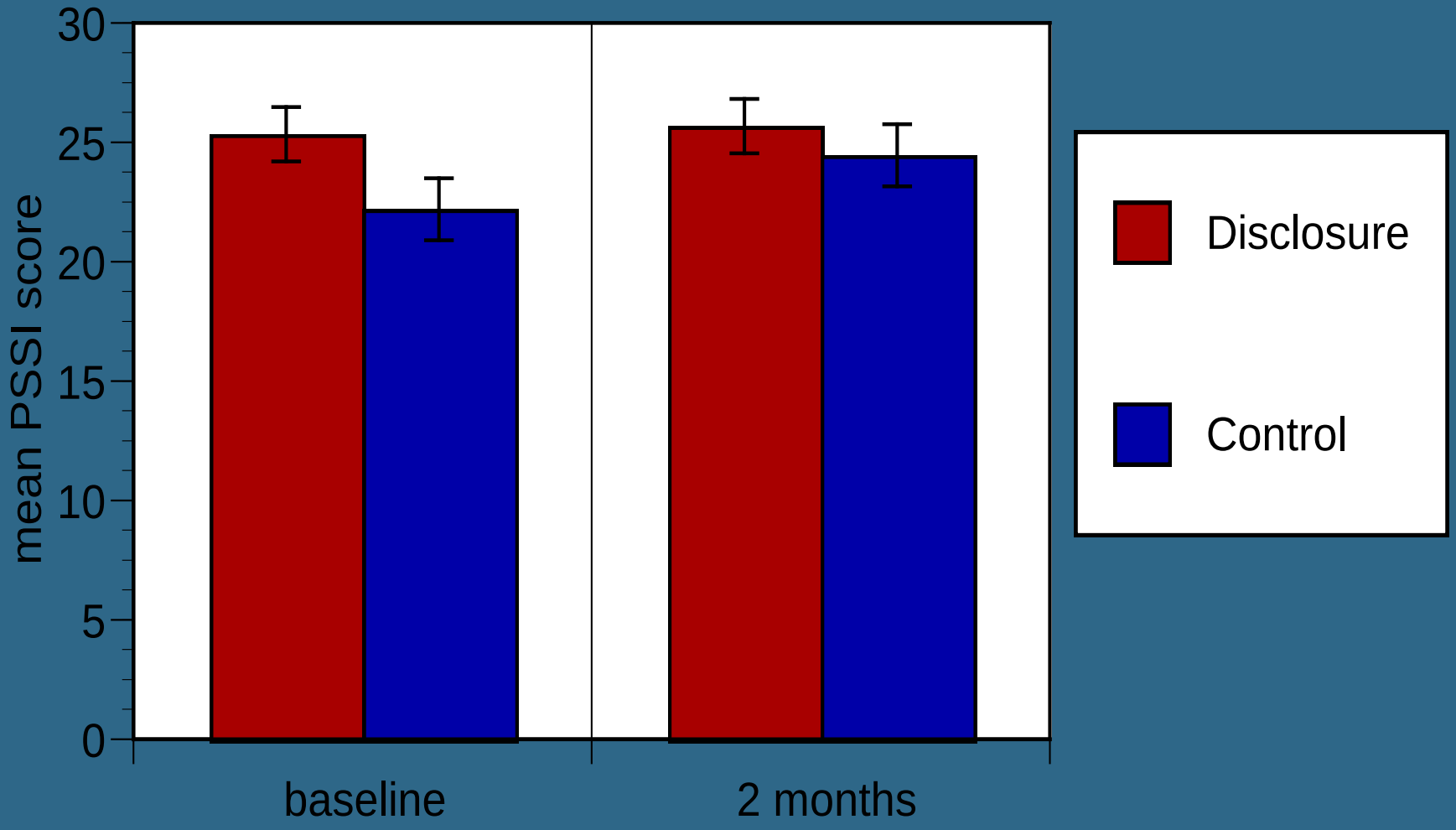
Extinction of Fear Response



Sloan et al. (2005). *Journal of Consulting and Clinical Psychology*

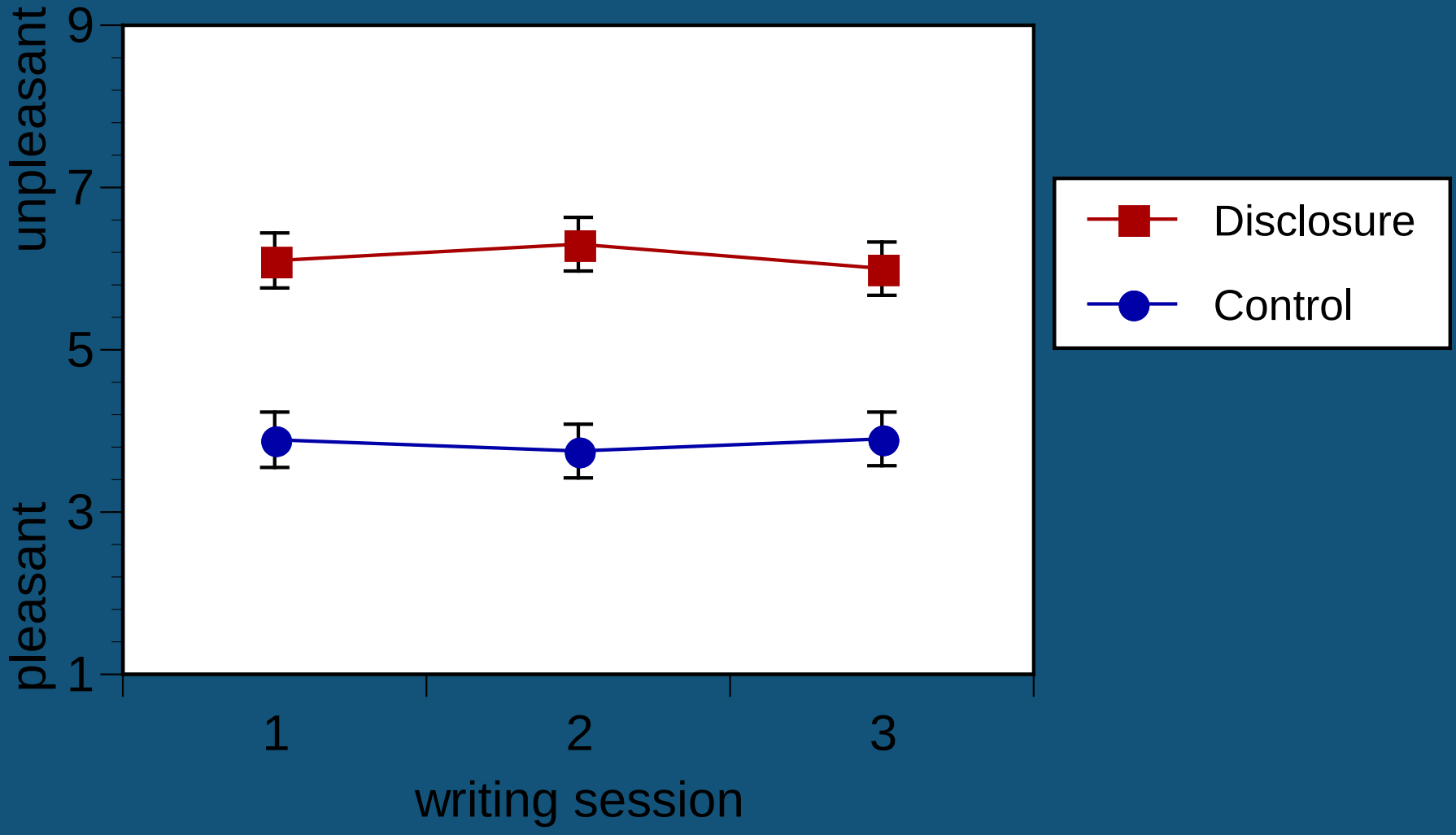
What about People who Meet Diagnostic Criteria for PTSD?

Written Disclosure for PTSD



Sloan, Marx, & Greenberg (2011). *Behaviour Research and Therapy*

Self-Reported Valence as a Function of Condition and Session



Sloan et al. (2011). *Behaviour Research and Therapy*

Insights from this Study

- Need larger exposure dose
- Importance of providing treatment rationale
- Need some feedback after writing session

Altering Expressive Writing to be Beneficial for PTSD

Added psychoeducation of PTSD	Added treatment rationale	Increase dose to 5, 30 minute sessions
Directed writing about a specific trauma event, with focus on detail and emotion felt at the time of the event and thoughts about the event	Writing using a distance perspective	No between session assignments

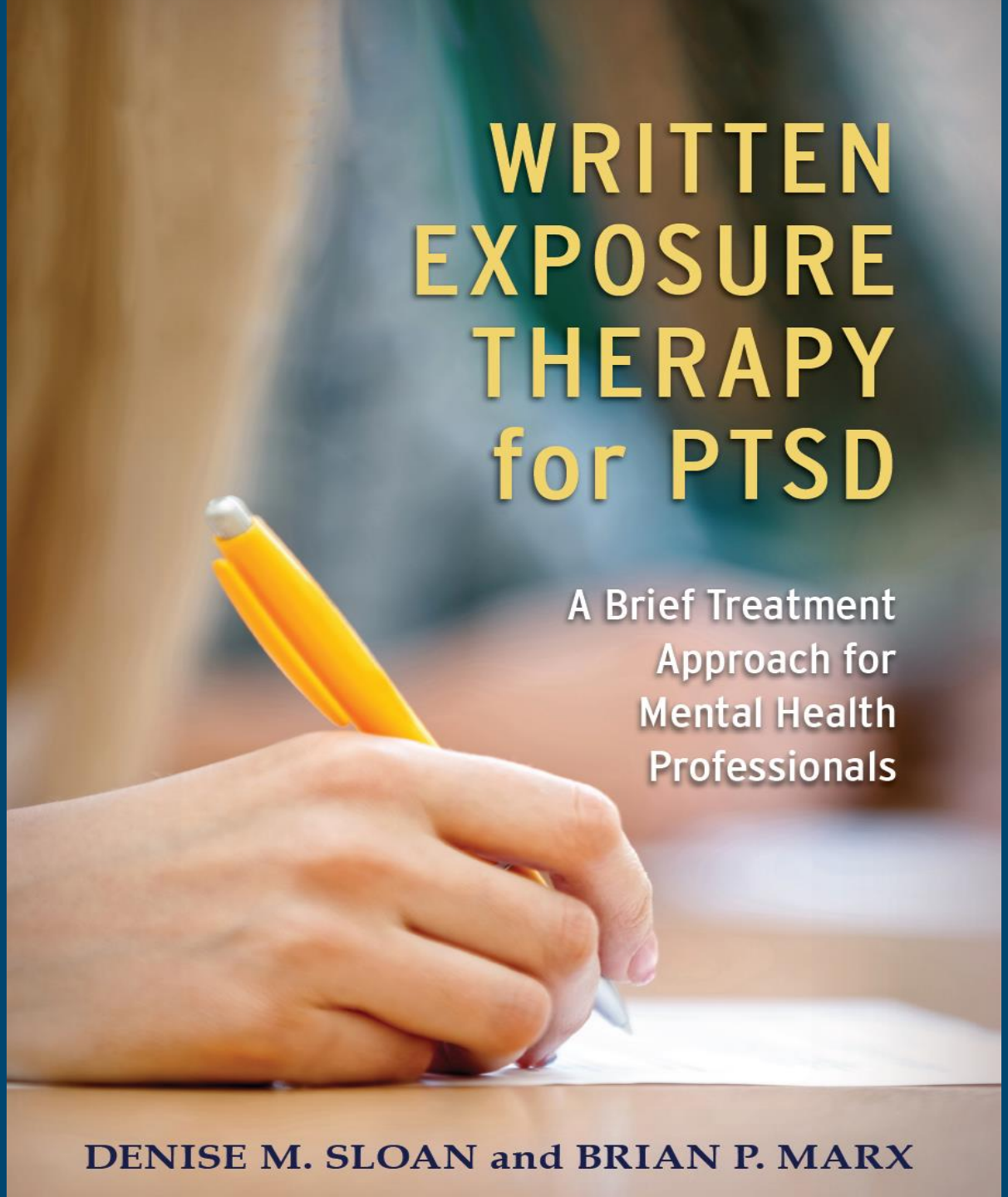
Writing Instructions

- Instructions to write about event “as you look back upon event.”
  - Distancing perspective informed by social psychology literature

Is WET a New Treatment?

- No
- It's imaginal exposure that is repackaged to be efficient and tolerable
- More tolerable:
  - Distance perspective
  - Writing in session; no homework
  - 5 sessions, exposure is contained

- WET is included as a recommended (first line) PTSD treatment in the VA/DoD Clinical Practice Guidelines for PTSD (2017)
- https://www.ptsd.va.gov/understand_tx/talk_therapy.asp


WRITTEN EXPOSURE THERAPY for PTSD
A Brief Treatment Approach for Mental Health Professionals
DENISE M. SLOAN and BRIAN P. MARX

Empirical Support for WET

Behaviour Research and Therapy 50 (2012) 627–635

Contents lists available at SciVerse ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Written exposure as an intervention for PTSD: A randomized clinical trial with motor vehicle accident survivors

Denise M. Sloan [a,*], Brian P. Marx [a], Michelle J. Bovin [a], Brian A. Feinstein [b], Matthew W. Gallagher [a]

[a] National Center for PTSD, VA Boston Healthcare System and, Boston University School of Medicine, 150 S. Huntington Avenue, Boston, MA 02130, USA
[b] Stony Brook University, Department of Psychology, Stony Brook, NY 11794, USA

ARTICLE INFO

Article history:
Received 18 November 2011
Received in revised form
22 June 2012
Accepted 12 July 2012

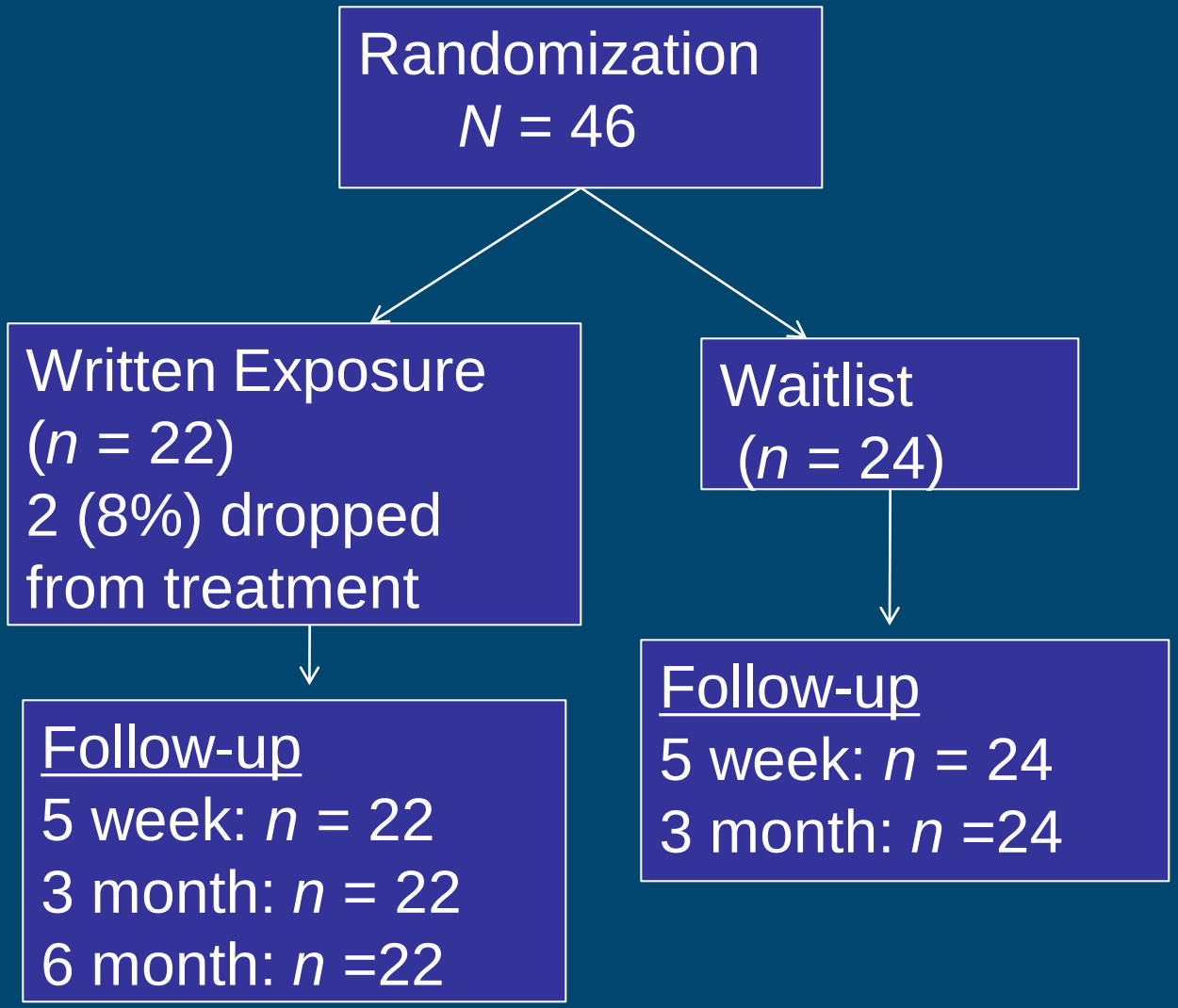
Keywords:
Trauma
PTSD
Clinical trial
Exposure treatment
Motor vehicle accident

ABSTRACT

The present study examined the efficacy of a brief, written exposure therapy (WET) for posttraumatic stress disorder (PTSD). Participants were 46 adults with a current primary diagnosis of motor vehicle accident-related PTSD. Participants were randomly assigned to either WET or a waitlist (WL) condition. Independent assessments took place at baseline and 6-, 18-, and 30-weeks post baseline (WL condition not assessed at 30 weeks). Participants assigned to WET showed significant reductions in PTSD symptom severity at 6- and 18-week post-baseline, relative to WL participants, with large between-group effect sizes. In addition, significantly fewer WET participants met diagnostic criteria for PTSD at both the 6- and 18-week post-baseline assessments, relative to WL participants. Treatment gains were maintained for the WET participants at the 30-week post baseline assessment. Notably, only 9% of participants dropped out of WET and the WET participants reported a high degree of satisfaction with the treatment. These findings suggest that a brief, written exposure treatment may efficaciously treat PTSD. Future research should examine whether WET is efficacious with other PTSD samples, as well as compare the efficacy of WET with that of evidence-based treatments for PTSD.

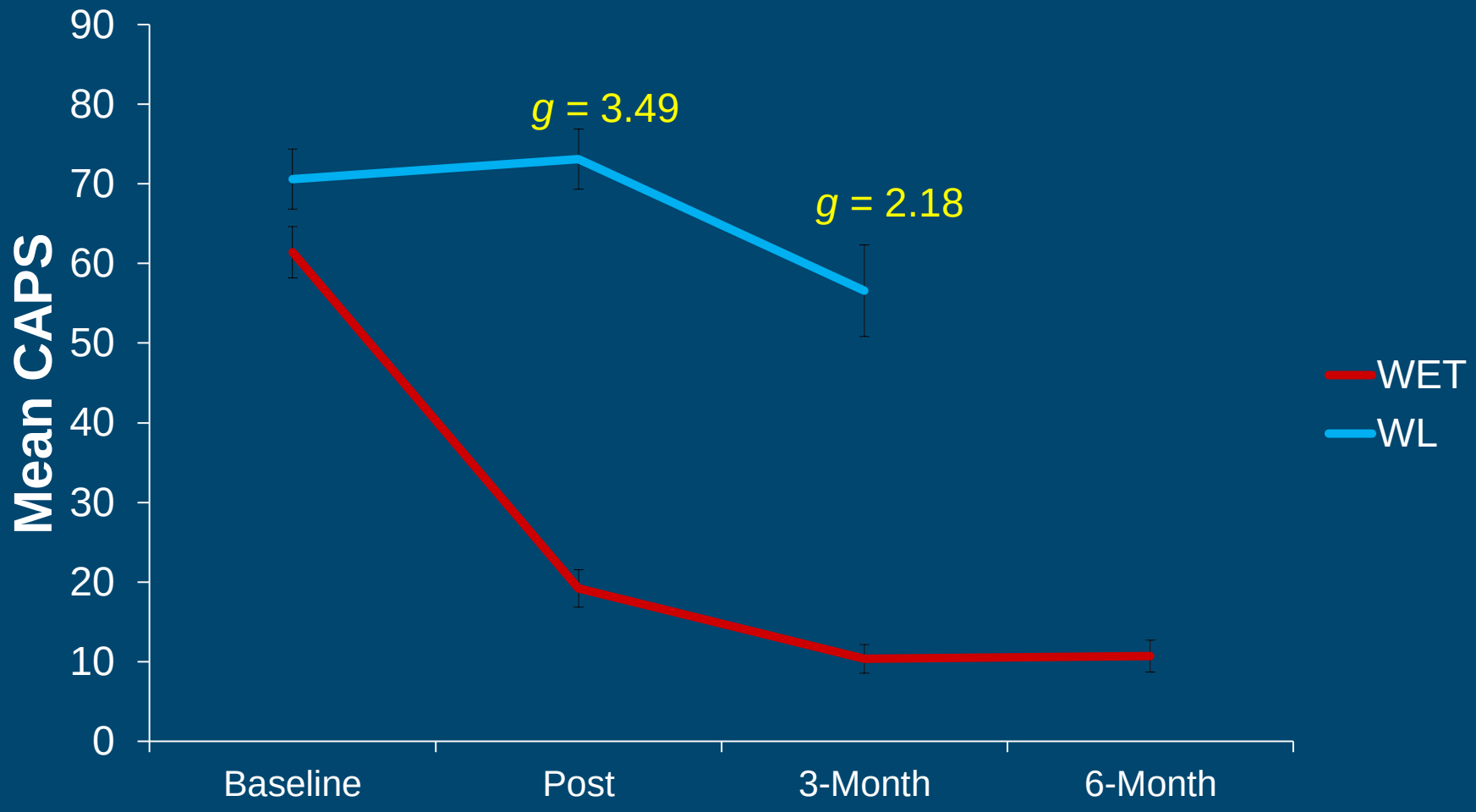
Participants

- 46 adults with a primary diagnosis of motor vehicle accident related PTSD
- Average age of 41, 65% women, racially diverse (37% Caucasian, 37% African-American)
- Median time since MVA was 20 months



Sloan, Marx et al. (2012). *Behaviour Research and Therapy*

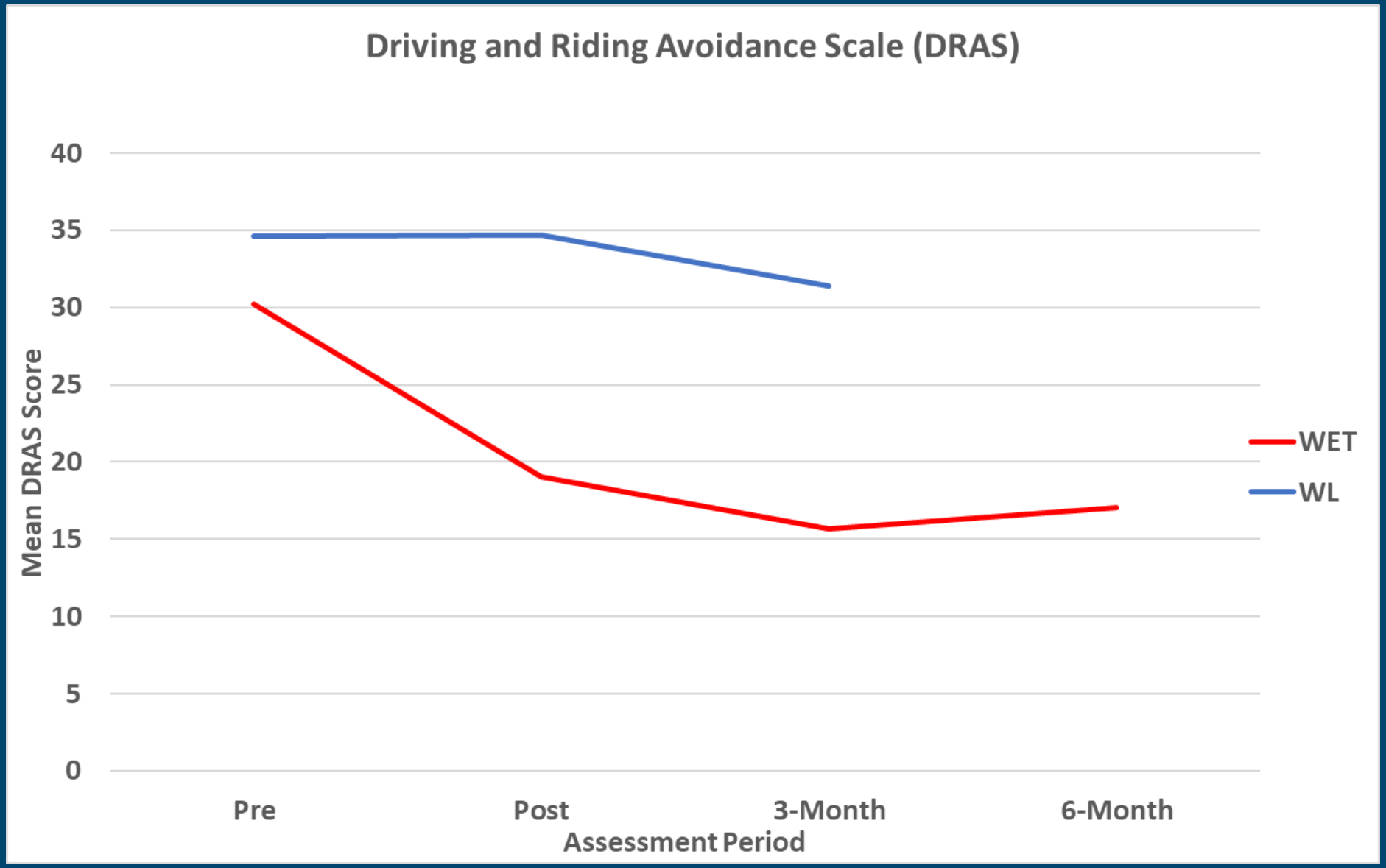
Efficacy of Written Exposure Therapy for PTSD



Sloan, Marx et al. (2012). *Behaviour Research and Therapy*

Percentage of PTSD Diagnosis by Condition

Treatment *n* (%)	Wait List *n* (%)
Post 2 (9%)	21 (88%)
3 month 1 (5%)	15 (75%)
6 month 0 (0%)	-----


Driving and Riding Avoidance Scale (DRAS)
Mean DRAS Score
40
35
30
25
20
15
10
5
0
Pre
Post
3-Month
6-Month
Assessment Period
WET
WL

Is WET Non-Inferior to a more time intensive PTSD Treatment?

JAMA Psychiatry | Original Investigation

A Brief Exposure-Based Treatment vs Cognitive Processing Therapy for Posttraumatic Stress Disorder
A Randomized Noninferiority Clinical Trial

Denise M. Sloan, PhD; Brian P. Marx, PhD; Daniel J. Lee, PhD; Patricia A. Resick, PhD

Supplemental content

IMPORTANCE Written exposure therapy (WET), a 5-session intervention, has been shown to efficaciously treat posttraumatic stress disorder (PTSD). However, this treatment has not yet been directly compared with a first-line PTSD treatment such as cognitive processing therapy (CPT).

OBJECTIVE To determine if WET is noninferior to CPT in patients with PTSD.

DESIGN, SETTING, AND PARTICIPANTS In this randomized clinical trial conducted at a Veterans Affairs medical facility between February 28, 2013, and November 6, 2016, 126 veteran and nonveteran adults were randomized to either WET or CPT. Inclusion criteria were a primary diagnosis of PTSD and stable medication therapy. Exclusion criteria included current psychotherapy for PTSD, high risk of suicide, diagnosis of psychosis, and unstable bipolar illness. Analysis was performed on an intent-to-treat basis.

INTERVENTIONS Participants assigned to CPT (n = 63) received 12 sessions and participants assigned to WET (n = 63) received 5 sessions. The CPT protocol that includes written accounts was delivered individually in 60-minute weekly sessions. The first WET session

Inclusion/Exclusion Criteria

- Inclusion
  - Current diagnosis of PTSD
  - Not currently engaged in psychotherapy for PTSD
  - If taking medication, stable dose for at least 1 month
- Exclusion
  - Diagnosis of substance dependence
  - Diagnosis of psychosis
  - High suicidal risk

Non-Inferiority Design

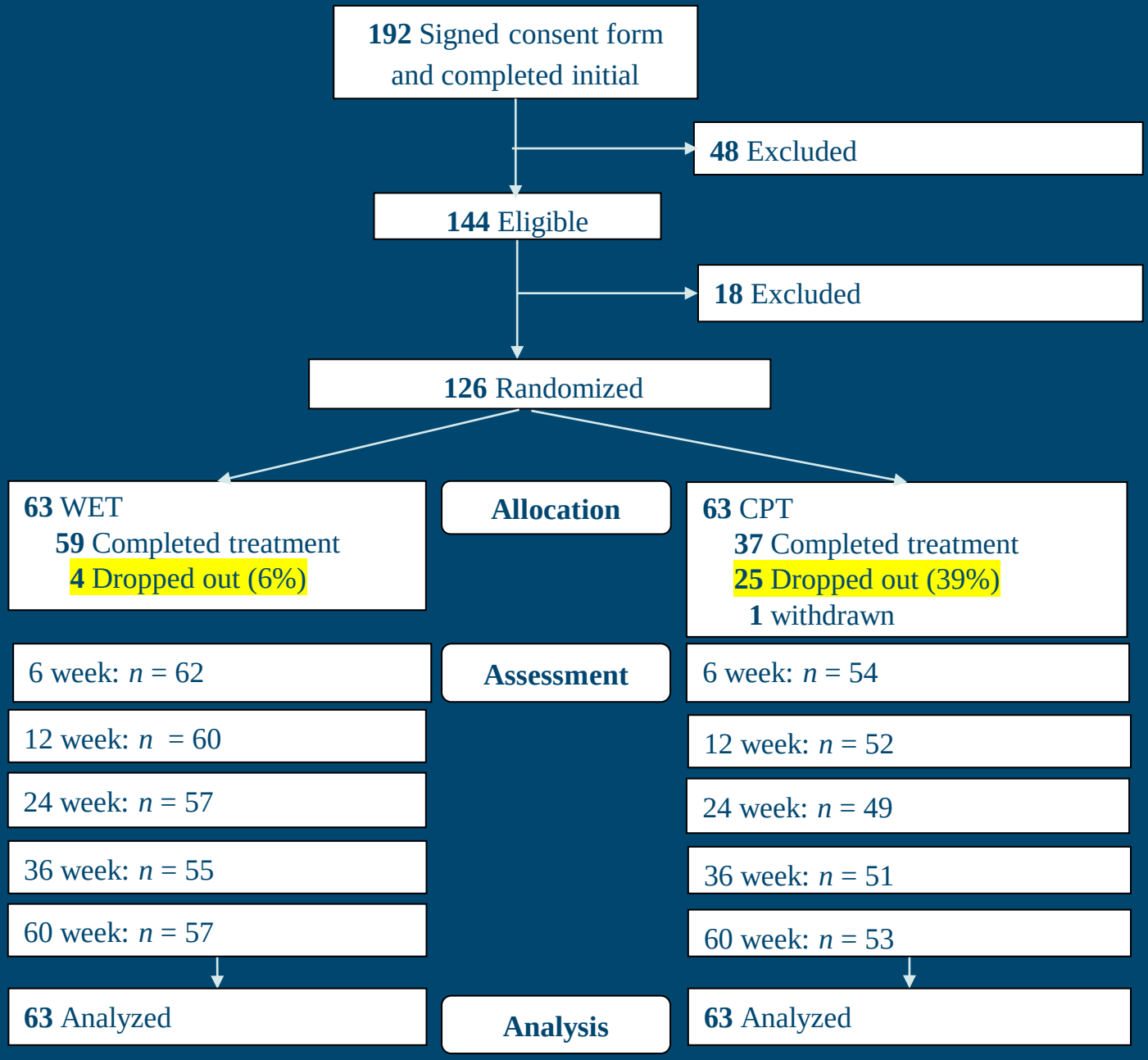
- Randomly assigning 126 adults diagnosed with PTSD to either WET or Cognitive Processing Therapy (CPT)
- Assessments at 6-, 12-, 24-, 36-, and 60 weeks post first treatment session
- Primary treatment outcome is PTSD symptom severity (CAPS-5)

Demographics

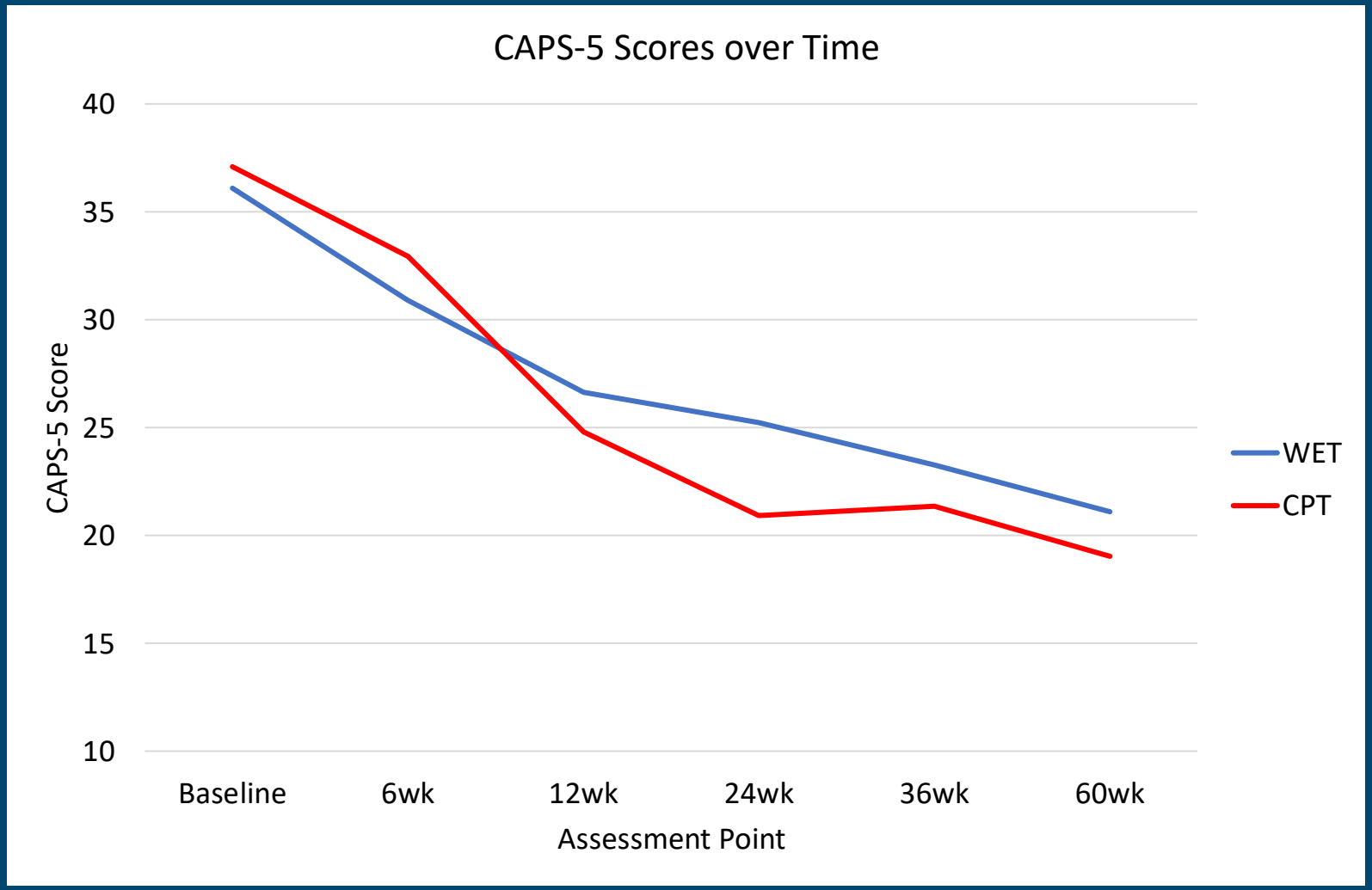
- Female: 48%
- Mean Age: 43.86
- % White: 54.8
- Annual income <$25,000: 52%

Reported Trauma Index Events

	n	%
Index event		
Adult non-sexual assault	24	19.1
Child sexual assault	20	15.9
Adult sexual assault	19	15.1
Combat-related	16	12.7
Sudden death (non-combat) or violence to a friend or loved one	13	10.3
Other (e.g., other accident)	13	10.3
Child non-sexual assault	11	8.7
Motor vehicle accident	10	7.9

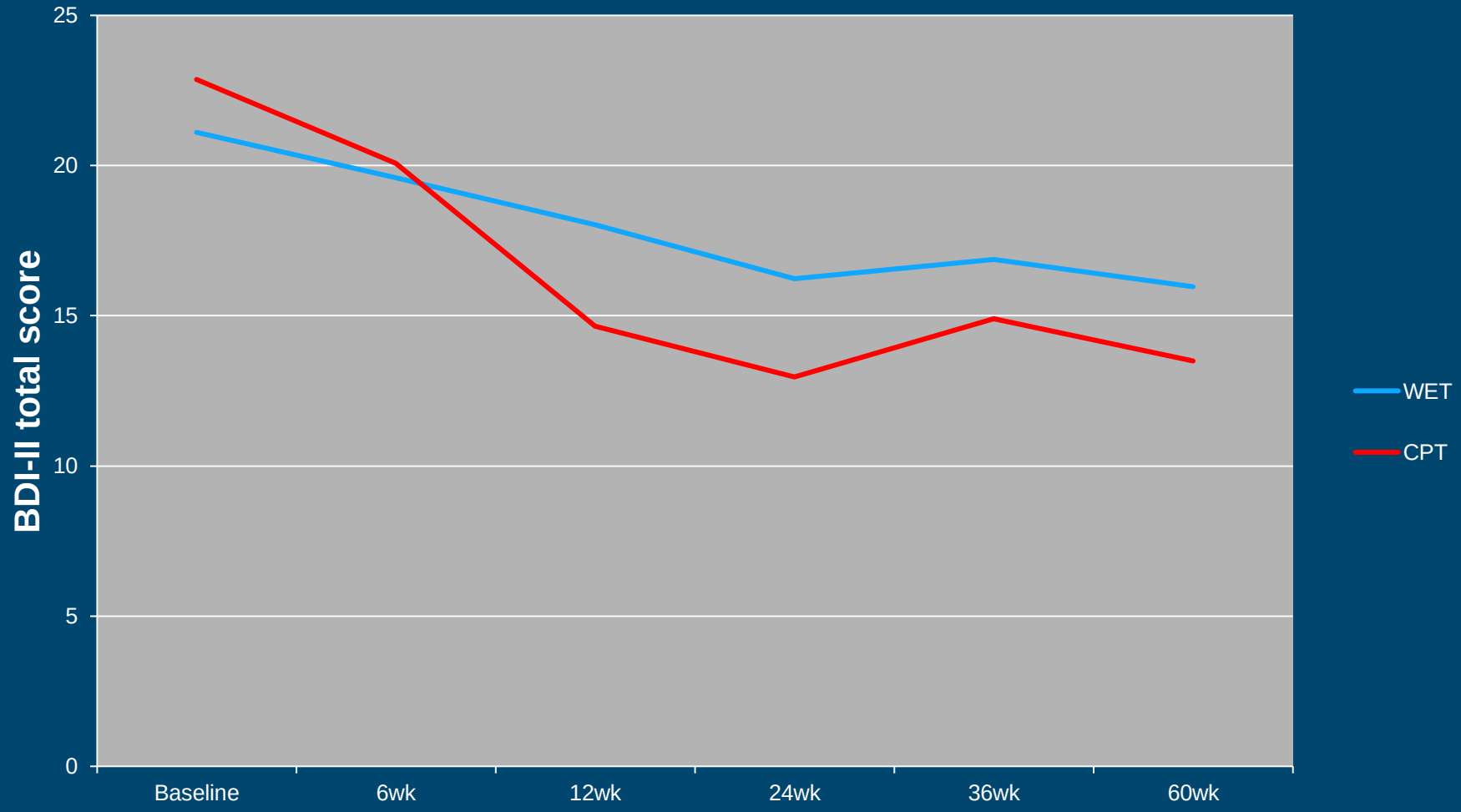

192 Signed consent form and completed initial
48 Excluded
144 Eligible
18 Excluded
126 Randomized
63 WET
59 Completed treatment
4 Dropped out (6%)
Allocation
63 CPT
37 Completed treatment
25 Dropped out (39%)
1 withdrawn
6 week: n = 62
Assessment
6 week: n = 54
12 week: n = 60
12 week: n = 52
24 week: n = 57
24 week: n = 49
36 week: n = 55
36 week: n = 51
60 week: n = 57
60 week: n = 53
63 Analyzed
Analysis
63 Analyzed

WET vs. CPT



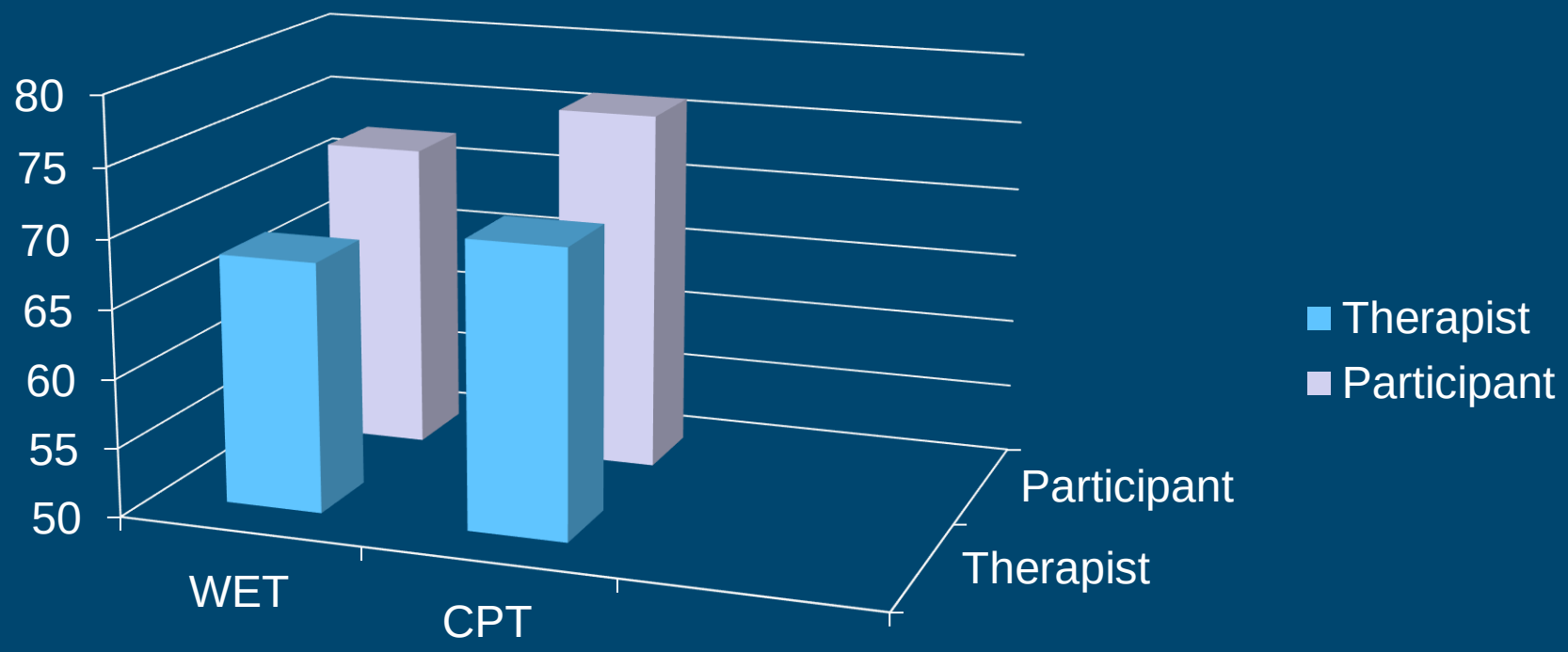
Sloan, Marx et al. (2018). *JAMA Psychiatry*

Change in Depression Symptom Severity



Thompson-Hollands et al. (2018). *Depression and Anxiety*

Working Alliance



Do some patients do better in WET than others?

Moderators

	Full Sample		WET		CPT	
Moderator	***B***	***SE***	***B***	***SE***	***B***	***SE***
Sex	-0.99	0.79	-0.52	1.07	-1.27	1.20
Age	0.05	0.03	0.04	0.04	0.05	0.04
Education	**-0.43***	**0.22**	-0.07	0.28	**-0.86***	**0.33**
PTSD severity at baseline (CAPS-5)	-0.07	0.04	-0.09	0.06	-0.03	0.06
Symptom duration (CAPS-5)	0.01	0.01	0.02	0.00	0.01	0.01
FSIQ (WTAR)	-0.06	0.03	0.02	0.05	**-0.14***	**0.05**
# Comorbid Disorders (SCID)	-0.36	0.31	-0.51	0.37	-0.37	0.54
Depression (BDI-II)	-0.02	0.04	0.02	0.05	-0.04	0.05
MDD (SCID)	-0.66	0.86	0.15	1.15	-1.38	1.32
Peritraumatic Dissociation (PDEQ)	0.03	0.04	-0.01	.05	0.08	0.06

Marx et al. (2021). *Behavior Therapy*

Review

Psychotherapy for Military-Related PTSD
A Review of Randomized Clinical Trials

Maria M. Steenkamp, PhD; Brett T. Litz, PhD; Charles W. Hoge, MD; Charles R. Marmar, MD

IMPORTANCE Posttraumatic stress disorder (PTSD) is a disabling psychiatric disorder common among military personnel and veterans. First-line psychotherapies most often recommended for PTSD consist mainly of "trauma-focused" psychotherapies that involve focusing on details of the trauma or associated cognitive and emotional effects.

OBJECTIVE To examine the effectiveness of psychotherapies for PTSD in military and veteran populations.

EVIDENCE REVIEW PubMed, PsycINFO, and PILOTS were searched for randomized clinical trials (RCTs) of individual and group psychotherapies for PTSD in military personnel and veterans, published from January 1980 to March 1, 2015. We also searched reference lists of articles, selected reviews, and meta-analyses. Of 891 publications initially identified, 36 were included.

FINDINGS Two trauma-focused therapies, cognitive processing therapy (CPT) and prolonged exposure, have been the most frequently studied psychotherapies for military-related PTSD. Five RCTs of CPT (that included 481 patients) and 4 RCTs of prolonged exposure (that included 402 patients) met inclusion criteria. Focusing on intent-to-treat outcomes, within-group posttreatment effect sizes for CPT and prolonged exposure were large (Cohen *d* range, 0.78-1.10). CPT and prolonged exposure also outperformed waitlist and treatment-as-usual control conditions. Forty-nine percent to 70% of participants receiving CPT and prolonged exposure attained clinically meaningful symptom improvement (defined as a 10- to 12-point decrease in interviewer-assessed or self-reported symptoms). However, mean posttreatment scores for CPT and prolonged exposure remained at or above clinical criteria for PTSD, and approximately two-thirds of patients receiving CPT or prolonged exposure retained their PTSD diagnosis after treatment (range, 60%-72%). CPT and prolonged exposure were marginally superior compared with non–trauma-focused psychotherapy comparison conditions.

Original Investigation | Psychiatry

January 11, 2022

Effect of Written Exposure Therapy vs Cognitive Processing Therapy on Increasing Treatment Efficiency Among Military Service Members With Posttraumatic Stress Disorder

A Randomized Noninferiority Trial

Denise M. Sloan, PhD[1,2]; Brian P. Marx, PhD[1,2]; Patricia A. Resick, PhD[3]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2022;5(1):e2140911. doi:10.1001/jamanetworkopen.2021.40911

Visual Abstract

Active Duty Service Members with PTSD

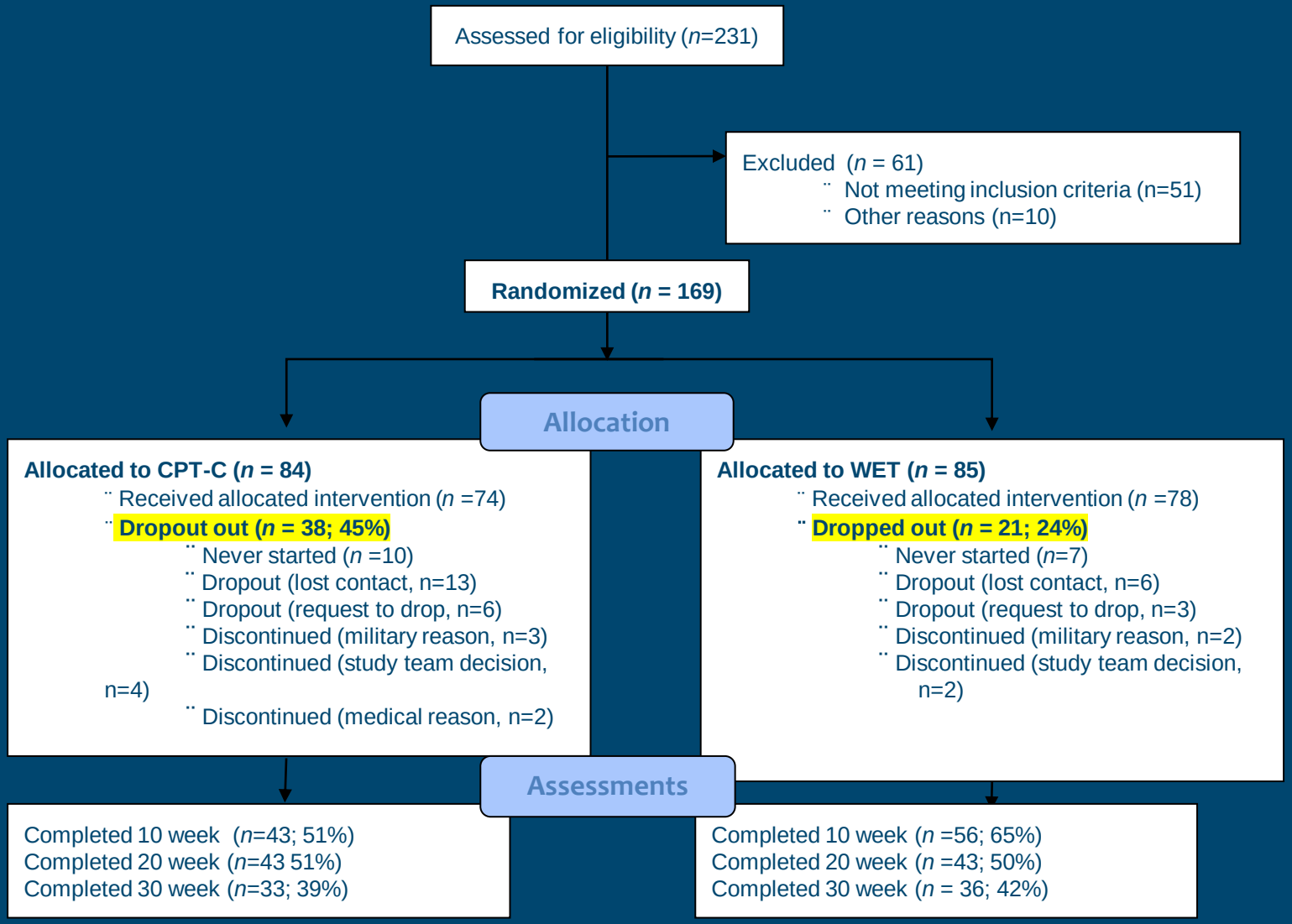
- Randomly assigning 169 men and women service members PTSD to either WET or CPT, cognitive only (CPT-C)
- Assessments at 10-, 20-, 30-weeks post first treatment session
- Primary treatment outcome is PTSD symptom severity (CAPS-5)

Sloan et al. (2022). *JAMA Network Open*

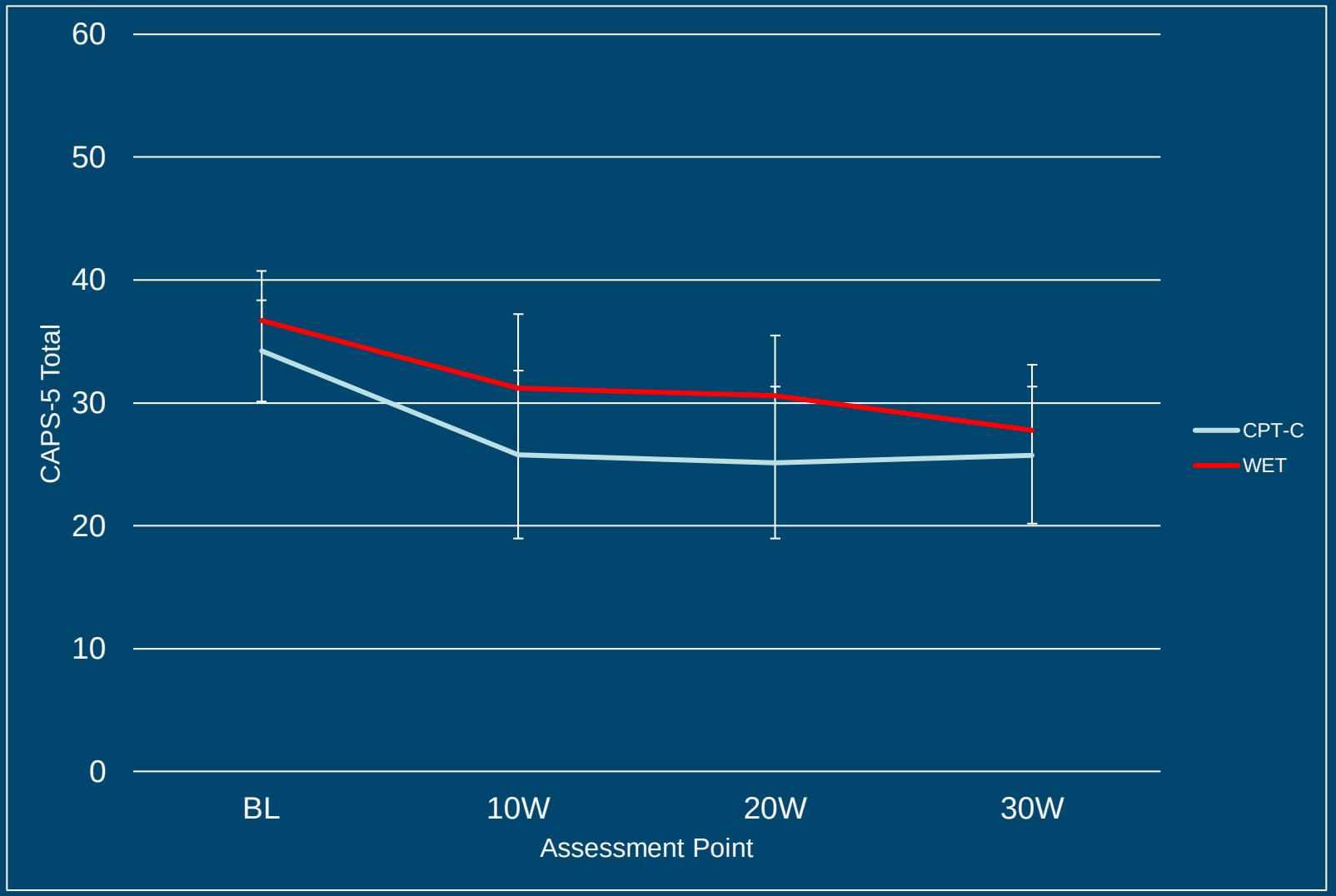
Demographics

- Male = 80.6%
- 91% enlisted in U.S. Army
- Ethnicity: 35% White, 34% African-American, 25% Hispanic, 6% other
- Average years in military = 12 (7.8)
- At least some college education = 77%
- Married or cohabitating = 77%
- **PTSD related to combat event: 75%**

Study Flow Diagram



CAPS-5 Total Scores by Condition

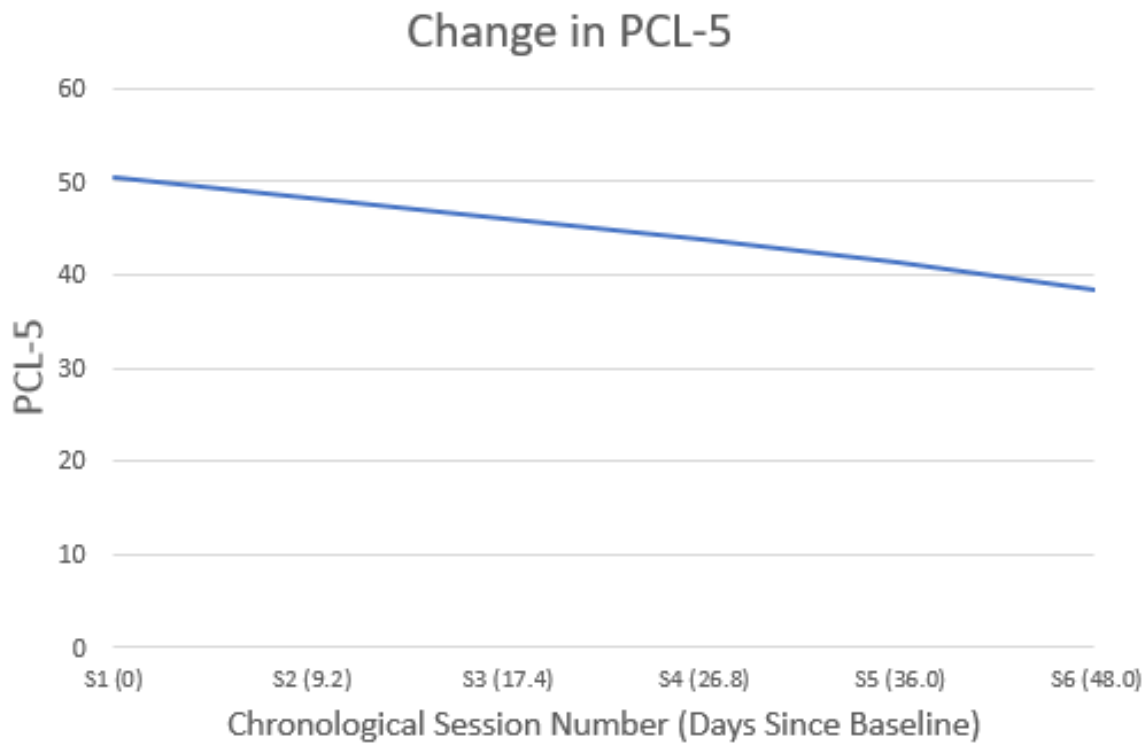


VA Provider Training Program

WET Implementation Program

- 277 veterans treated by 83 clinicians across 24 sites

Veteran Outcome Measures (ITT)



Clinically significant change across 6 sessions of WET

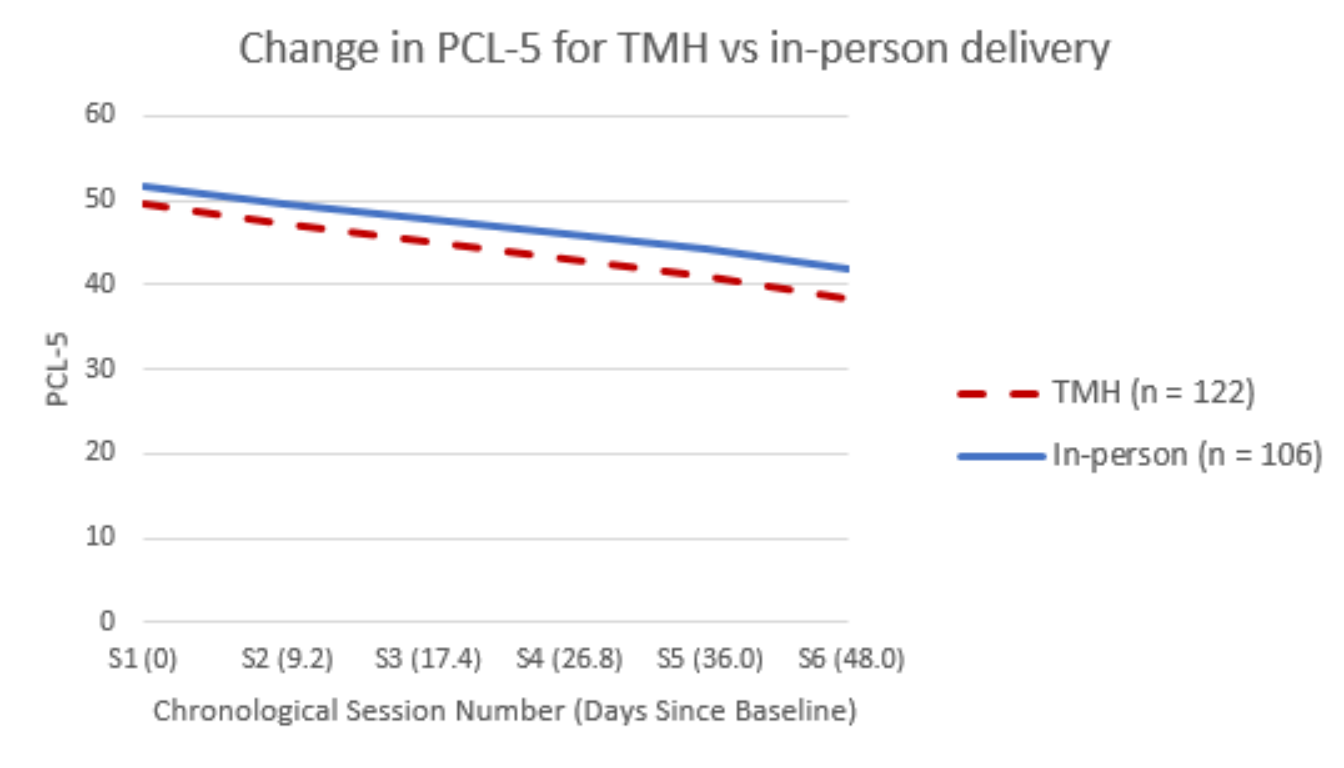
- M = -12.1

A large effect size

- Cohen's *d* = 0.84

LoSavio et al. (in press). *Psychological Trauma: Theory, Research, Practice & Policy.*

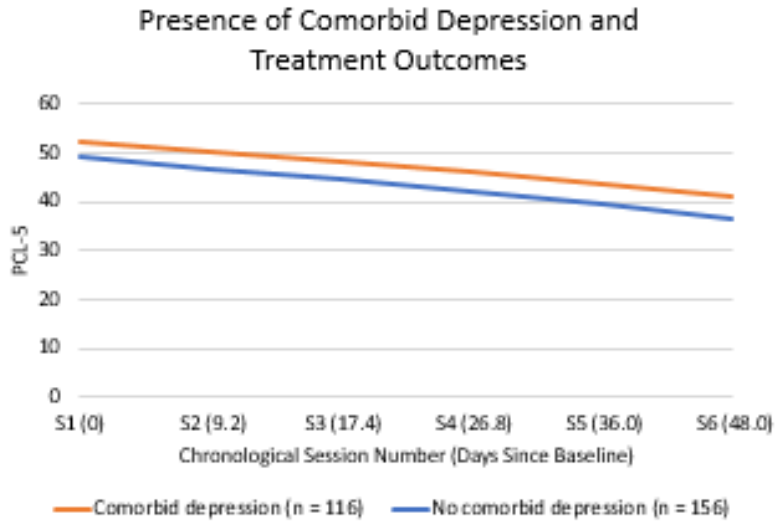
WET Delivered via Telemental Health



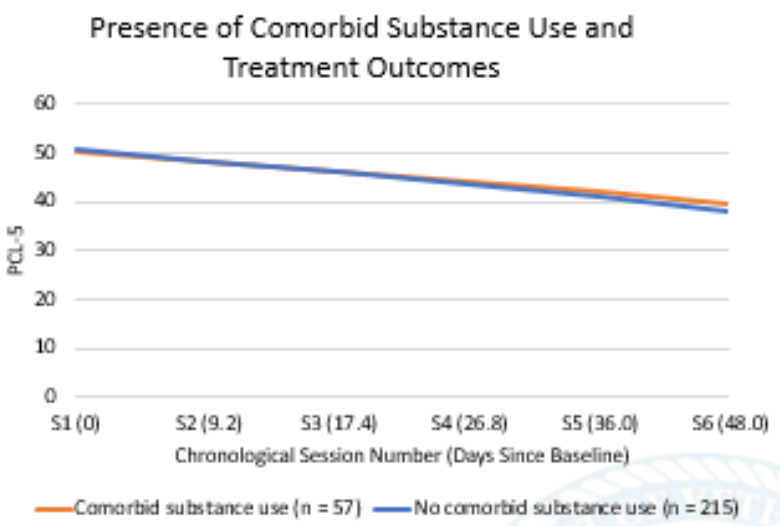
Clinically significant change was noted for both in person (M = -9.62) and TMH (M = -11.20) groups across WET, with patients in both the TMH (*d* = 0.77) and in person groups (*d* = 0.67) demonstrating large pre-post effect sizes.

There was no significant time by condition interaction, *b* = -0.04, *t*(105.22) = -0.53, *p* = .60

Comorbid Diagnosis and Symptom Change



- No significant time by presence of comorbidity interaction for depression, $b = 0.02$, $t(171.01) = 0.48$, $p = .64$
- Patients with comorbid depression ($M = -11.5$; $d = 0.80$) and those without comorbid depression ($M = -12.7$; $d = 0.88$) both demonstrated clinically significant reductions in PCL-5 and large effect sizes of change



- No significant time by presence of comorbidity interaction for substance use, $b = 0.03$, $t(174.00) = 0.54$, $p = .59$
- Patients with comorbid substance use ($M = -10.9$; $d = 0.75$) and those without ($M = -12.5$; $d = 0.87$) both demonstrated clinically significant reductions in PCL-5 and large effect sizes of change

Who is Not a Good Candidate for WET

- PTSD is not primary diagnosis
- No memory of the trauma
- Unwilling to do trauma-focused therapy
- Active psychosis
- Heavy substance use and refuse to not use 2 hours before and after session
- Physical issues that prohibit ability to write

Who is a good candidate for WET

- Comorbid Axis I disorders
- Personality disorders
- Chronic/Severe PTSD
- Multiple traumas/Chronic trauma exposure
- Traumatic brain injury
- English not primary language

Delivering WET

Written Exposure Therapy adapted for Primary Care

6 sessions

- Session 1:
  - Psychoed of PTSD & treatment rationale
- Sessions 2-6:
  - Check in and feedback, 20 min writing, check in about writing

General Structure of Treatment

- Reading script verbatim
- Writing for the full 20 minutes
- Spacing of sessions
- Selecting trauma event
- Indexing distress levels before and after writing
- Preparing for an increase in symptoms
- Therapist reads narratives between sessions

Script

- Script should be read verbatim except personalizing trauma event and examples

Preparing for Treatment

- Session 1 assumes PTSD assessment has already occurred
- Important to clearly identify trauma event to be focus of treatment
  - Multiple trauma events are common among those who have PTSD

Session 1

Psychoeducation	Treatment rationale	Describe SUDS
• Check in to ask whether PTSD symptoms seem familiar to them but keep it short	• Make sure client understands rationale for writing about trauma experience several times	• 0-100 scale

WET Session 1 Outline

- Read PTSD psychoeducation information
- Read Treatment rationale
- Describe SUDS
- Additional discussion regarding trauma event to be focus of the treatment, if needed
- Schedule next session

WET Session 2 Outline

- General overview of writing instructions
- Writing instruction for Session 2
- Take SUDS
- Writing for 20 minutes
- after writing take SUDS
- Check in about how writing went
- Discussion about feeling worse before feeling better and how that might affect returning to treatment
- Give instructions not to avoid during the course of the week
- Collect the narrative

Session 2 Instructions Cont'd

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), 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.

WET Session 2 Outline

- General overview of writing instructions
- Writing instruction for Session 2
- Take SUDS
- Writing for 20 minutes
- after writing take SUDS
- Check in about how writing went
- Discussion about feeling worse before feeling better and how that might affect returning to treatment
- Give instructions not to avoid during the course of the week
- Collect the narrative

Check-In

How did the writing go for you?

What was it like to write about the event?

Did you remember more than you thought you did?

Was it easier or harder than you expected?

Instructions at End of Session

- *You will likely have thoughts, images, or feelings concerning the trauma that you just wrote about during the course of the upcoming week. It is important that you allow yourself to have the thoughts, images, 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.*

Collection of Narrative

- Need to collect narrative to read and give feedback
  - Return narratives to patient at end of treatment
- What if patient doesn’t want to give therapist the narrative?

Reading Narrative after Session

- Narrative is collected at end of session 1
- Read narrative before session 2
  - Do not read while in session 2
- Examine narrative for how well instructions were followed
  - Were emotions included
  - Does narrative include description of trauma event

Session 3 Outline

- Check in about past week
  - Did thoughts come up about the trauma event?; what did patient do if thoughts came up?
- Give feedback on narrative from session 2
  - Positive feedback and what can be improved
- Writing instruction for Session 3
- Take SUDS
- Writing for 20 minutes
- after writing take SUDS
- Check in about how writing went
- Give instructions not to avoid during the course of the week
- Collect narrative

Session 3 Instructions

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.

Check-In

- Were they able to follow the feedback
  - Did they write about emotions?
  - Did they focus writing on traumatic event?

Reading the Narrative

- Were instructions followed?
  - Were emotions and thoughts included?
  - Was the traumatic event the focus of writing?

Session 4 Outline

- Check in about how past week
  - did they have thoughts about trauma event? Were they able to have thoughts or did they push thoughts away?
- Give feedback on narrative from session 3
- Writing instruction for Session 4
- Take SUDS
- Writing for 20 minutes
- after writing take SUDS
- Check in about how writing went
- Give instructions not to avoid during the course of the week
- Collect narrative

Session 4 Instructions

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.

Session 5 Outline

- Check in about past week
- Give feedback on narrative from session 4
- Writing instruction for Session 5
- Take SUDS
- Writing for 20 minutes
- after writing take SUDS
- Check in about how writing went
- Give instructions not to avoid during the course of the week
- Collect narrative

Session 5 Instructions

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.

Session 6 Outline

- Check in about past week
- Give feedback on narrative from session 5
- Writing instruction for Session 6
- Take SUDS
- Writing for 20 minutes
- After writing take SUDS
- Check in about how writing went
  - What did patient write about in terms of how they will move forward?
- General discussion about improvement/changes the client has had during the course of the treatment
- Don’t collect narrative; discuss what to do with narratives that have been collected

Ending at Session 6

- Discuss skills the patient has learned and how these skills should be used moving forward
- Treatment should end if patient received good symptom reduction and feels satisfied with outcome

Ending at Session 6 or Adding Additional Sessions

- Consider whether additional sessions are needed – this would be decided before session 5
  - Did patient follow instructions throughout?
  - Are SUDS scores still high and PCL still high?

Adding Sessions

- Focus on another trauma event
  - Can add additional sessions to address another event but will likely only need a couple of sessions

Session 6 Instructions

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.

Examples of Narratives

FAQs

- Can I alter the frequency of sessions?
- Can I use WET with someone who is abusing substances or is suicidal?
- What if SUDS doesn’t change?
- What if the client stops writing during the session?

FAQs

- In what type of settings can WET be used (outpatient, residential)?
- Deciding if WET should be used versus another trauma-focused treatment?
- Given the brevity and low dropout, why not always use WET to treat PTSD?

Delivering WET via Telemental Health

Disclaimer

All of the information presented is in addition to regular telemental health standards of practice with informed consent for telehealth

You should discuss the limits to confidentiality

You should discuss the best means for sharing information via secured channels

- Written Exposure Therapy should be conducted in videoconferencing
- Only use phone if there is no other option

SESSION CONTENT

Session Materials

- The patient should have access to the instructions during the session
  - Provide in advance (ok to give all 5 sessions) via regular mail or in person (see telehealth packet)
  - Provide in advance via secure messaging (see telehealth packet)
  - Share provider screen (dual monitors) during the appointment*
  - Type/copy the exact instructions into the chat box during the appointment*
- Patients will need access to paper and a pen/pencil
  - Encourage lined paper
  - Do NOT have them type the narrative
  - Do NOT have patients edit or add to the narrative after the session

* Patients should be provided with a copy of the instruction to retain for their use.

During 20-minute writing time

- Keep VC appointment open during the entire time
- Inform the patient you will be available to them throughout
- Mute your microphone to avoid ambient noise
- You may wish to move your camera slightly askew to avoid staring at the patient if you continue to use your monitor
- May need to ask patient to move their camera so you can see them writing

If video is lost…

- Attempt to reconnect
- Call the patient immediately
- Continue the appointment via phone rather than discontinuing the session

Collecting the Narratives

- Each sessions narrative should be collected in advance of the next session
  - Secure messaging (preferred)
    - Scan and send (Scanbot – free app)
    - patient takes a photo and sends via secure messaging *
    - Other apps that allow for scanning
  - Fax (clinic approved)
    - Ensure someone is on site to receive
  - Screenshot (quality/readability may vary)
    - Your patient may hold the written narrative up to the camera and the therapist uses screen capture
      - Print Screen function
      - Snip and Sketch
    - If saving to the computer consider storage that is secure (ex: H drive or similar)
    - Consider de-identifying (not with name on paper and using file name that is de-identified
  - Mail
  - Other e-mail based and clinic policy (dropping off narrative at clinic)

* Discuss with patient that taking pictures on a cell phone means this information may be stored in the phone as well as in back ups (i.e. possibly accessible to other family members)

Maintaining Fidelity

- Do NOT have the patient read you the narrative
- Do NOT have the patient type the narrative and send
- BOTH of these change the intervention

Essential Elements

You must collect the narrative.

An essential part of treatment is to review the narrative and provide feedback.

Therapists concerns about working with trauma-survivors

Challenges of Working with Trauma Survivors

- Reading the stories themselves
  - Stories can be difficult to hear
- May become more aware of dangers
- Judgments about trauma
  - Blaming victims
  - Reactions to individuals not protecting others
- Strong reactions toward perpetrators
- Feelings of helplessness
- “Shared trauma” for those who have also experienced traumatic events
- Demands and need is high!

Benefits of Working with Trauma Survivors

- There is the possibility of a powerful sense of satisfaction with this work
  - Patients can show huge improvements in treatment
  - Sense of making a difference (meaning & purpose)
- Development over time of a much stronger:
  - Sense of strength
  - Self-knowledge
  - Confidence
  - Respect for human resiliency

Secondary Traumatic Stress

- Common among treatment providers
- Includes symptoms similar to PTSD that can occur in providers who frequently listen to trauma histories
- Symptoms include re-experiencing, avoidance, and hyperarousal. It has cognitive, emotional, and interpersonal aspects as well
- The association between burnout and STS is high

Ways to Address Secondary Traumatic Stress

- Awareness
  - Noticing if you are having these reactions
- Balance
  - Life Balance
  - Sleep, exercise, diet
  - Taking breaks
- Connections
  - Workplace/supervisor support
  - Consultation
  - Collegial support/personal support
- Seek professional help when necessary

Accessible tools to support clinician self-care

COVID Coach

- Tools for self care
- Relaxation and coping skills

https://www.ptsd.va.gov/appvid/mobile/COVID_coach_app.asp

Sleep

- Based on CBT-I
- Program for addressing sleep problems

https://www.ptsd.va.gov/appvid/mobile/cbticoach_app_public.asp

Mindfulness

- Mindfulness tools

https://www.ptsd.va.gov/appvid/mobile/mindfulcoach_app.asp

Questions?