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Foreword

The availability of evidence-based treatments for posttraumatic stress disorder (PTSD) has changed dramatically over the past 2 decades, driven in part by large allocations of funding to expand the care for service members and veterans returning from the wars in Iraq and Afghanistan, who now routinely receive services not available to past generations of warriors. Two trauma-focused psychotherapies, prolonged exposure (PE) and cognitive processing therapy (CPT), mandated for uniform dissemination across Veterans Affairs (VA) facilities, have become the dominant treatments in the United States. Funding for research, including randomized clinical trials, has also expanded, and since these wars began, the VA and the Department of Defense (DoD) have produced three revisions of the clinical practice guideline for PTSD (in 2004, 2009, and 2017).

The most striking change in the latest VA/DoD PTSD clinical practice guideline, informative to clinical practice internationally, is that medications (particularly those targeting serotonin reuptake) are no longer considered equivalent to trauma-focused psychotherapy for the primary treatment of PTSD. The evidence review suggested that individual trauma-focused psychotherapy produced higher and longer lasting effect sizes than medications.

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While the increased availability of trauma-focused treatment is good news for service members, veterans, and civilians suffering from the aftermath of trauma, the reality is that progress overall is not as rosy as we would expect after so many years of effort. The foundation for current clinical treatment with PE, CPT, and most other evidence-based trauma-focused therapies involves the same core components delivered over 12 or more 50- to 90-minute sessions, principally repetitive exposure to the traumatic narrative in some fashion and cognitive restructuring or meaning making. The efficacy of these available therapies has not improved over the years due to a number of factors, not the least of which is low engagement among those most in need of services combined with very high noncompletion rates. Efficacious approaches that can be delivered more efficiently and with greater patient satisfaction have been urgently needed for a very long time.

Enter written exposure therapy (WET), the subject of this book, and arguably one of the most exciting developments in traditional trauma-focused psychotherapy for PTSD. WET is the product of more than 15 years of progressive scientific inquiry that explored such domains as the minimum effective dose of exposure therapy, the optimal delivery methods (with multiple nuances), and mechanisms of efficacy, culminating in an exceptional randomized head-to-head noninferiority trial of WET versus CPT. Like many scientific discoveries, the findings were startling, surprising even the principal investigators themselves (the authors of this book).

Noninferiority is a technical term referring to a clinical trial design in which the study is statistically powered to provide reasonable confidence in the equivalence of two treatments. Research has shown that WET is indeed "noninferior" to CPT in efficacy for PTSD (based on both clinician-administered and self-report measures), as well as depressive symptoms, with results holding for a full year after treatment. However, what is most startling is that the results were achieved with about a tenth of the therapist's time. While CPT required 12 individual, face-to-face, hour-long clinical sessions delivered weekly, WET achieved the same outcomes in only five sessions, each of which involved approximately 20 minutes of face-to-face therapy combined with 30 minutes of writing (alone, while remaining in the clinical setting) during which the patient wrote about their traumatic experience. Also startling was the significantly lower dropout rate from treatment for WET participants compared with the CPT group (6% vs. 40%).

Thus, WET is much more than "noninferior." It is a potential game changer in PTSD treatment offering equivalent efficacy in a fraction of the time and with significantly higher patient satisfaction (lower dropouts) than the most commonly used standard evidence-based trauma-focused therapy. Moreover,

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WET is already included under the highest treatment recommendation in the 2017 VA/DoD clinical practice guideline based on clinical trials involving WET and other written narrative exposure therapy approaches (including a dismantling study of CPT). Thus, WET can be considered fully evidence-based, on par with CPT, PE, and other trauma-focused treatments. WET is also a uniquely straightforward "off-the-shelf" treatment that licensed mental health professionals can feel comfortable delivering as soon as they have read and digested this manual.

This manual satisfies an urgent need for an effective, time-efficient trauma-focused treatment that does not induce patients to run for the clinic door. The nonproprietary nature of WET, requiring no further training or certification, lends itself to wide dissemination in mental health clinics and potentially other settings, such as primary care (with appropriate mental health consultation). For all of these reasons, this groundbreaking book will undoubtedly become an essential addition to the libraries of mental health professionals who treat patients with PTSD.

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WRITTEN EXPOSURE THERAPY for PTSD

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INTRODUCTION

Every year, millions of people are exposed to trauma at home, at work, and in war zones and suffer in its wake. Although treatments for posttraumatic stress disorder (PTSD), including prolonged exposure, cognitive processing therapy, and eye-movement desensitization and reprocessing, are effective, many individuals are not able to access them because they often cannot find providers who offer these treatments, because they do not live near a provider who does, or because they cannot afford to take the time off from work or time away from other obligations or pay for 10 to 15 one-hour therapy sessions. Clinicians also confront barriers that impede their ability to offer these treatments competently to their clients. For instance, substantial training is required to learn how to effectively administer the aforementioned PTSD treatments (e.g., attending workshops over several days, followed by close supervision until the provider displays competency in administering the treatment). Even if they do manage to get the required training and certification, clinicians are often not able to use these treatments because of competing clinical demands and limited staff resources. The barriers for both clients and providers underscore the need to identify alternative PTSD treatments that are brief and do not require extensive provider training. In other words, we

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need treatments for PTSD that are more widely accessible to both providers and clients.

Written exposure therapy (WET) is a brief five-session treatment we developed to meet this need. It is cost-efficient and requires little clinical training compared with other interventions, and it has proven to be effective at treating different types of trauma. We believe that WET is one of the most promising new treatments for PTSD. In response to the large number of requests we have received from clinicians who wish to use this therapy with their clients, we have written this book as a comprehensive WET treatment manual for mental health practitioners.

OVERVIEW OF WET

The first session of WET requires approximately 1 hour, and the subsequent four sessions require approximately 40 minutes each. The core feature of WET is the written trauma narratives that clients complete during each of the five sessions. The first session of the WET protocol is longer than the other sessions because the clinician spends some time explaining what PTSD is, how it develops, and why repeatedly writing about a traumatic experience in a particular manner is beneficial. During the trauma narrative writing, the client writes about a specific trauma event in great detail, describing the emotions and thoughts that were experienced during the event. The writing instructions are scripted to ensure that clients receive the treatment in a highly consistent manner. The writing instructions evolve over the course of the writing sessions, such that clients begin by writing a detailed account of their trauma experience in the earlier sessions and then progress to describing the impact the event had on their life in the later sessions. Clients write about their trauma experience for 30 minutes each session. Then, the therapist has a 10-minute check-in with the client about his or her experiences in writing about the traumatic event (but not about the traumatic event itself). No between-session assignments are given. The brevity of the treatment, both in terms of number of sessions and duration of sessions, in combination with the lack of between-session assignments results in an efficient treatment that is well tolerated by clients and easy for providers to implement.

As is described in Chapter 2, we have conducted studies with a variety of adult trauma survivors (e.g., sexual assault, physical assault, childhood abuse, combat), and these studies show that WET is an efficacious treatment for PTSD. Even though the treatment focuses on writing about one specific event, individuals who have experienced multiple or chronic traumas (e.g., childhood abuse, military combat) can be successfully treated

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with WET as well. WET has not been tested with individuals under the age of 18 and so we recommend that it be used only with adults. Based on the evidence demonstrating the efficacy of WET to date, it is now recommended as a first-line treatment by the Department of Veterans Affairs and Department of Defense PTSD Clinical Practice Guidelines (Management of Posttraumatic Stress Disorder Work Group, 2017). In all the clinical trials conducted with WET to date, providers have had either master's- or doctorate-level training in clinical psychology as well as experience with other trauma-focused treatments. Consequently, we believe that this book will be most useful to providers who already have a background using trauma-focused treatments.

HOW TO USE THIS BOOK

We recognize that mental health treatment providers with a variety of education and training backgrounds may use this book. Accordingly, we have included chapters at the beginning of the book that provide an overview of the PTSD diagnosis and a brief guide to assessing PTSD. In Chapter 1, we describe contemporary theories underlying currently available evidence-based PTSD psychotherapies, highlight the common elements of these approaches, and describe how these theories apply to WET. In Chapter 2, we describe the research we conducted to better understand the necessary and sufficient components of PTSD treatment and how this work culminated in the development of the WET protocol. We believe that this background information regarding the development of WET will be helpful for readers to better understand why certain features of the treatment should not be changed. In this chapter, we also describe the results of prior research demonstrating that WET is efficacious in the treatment of PTSD.

Chapter 3 focuses on assessing whether a patient has PTSD and determining whether WET is an appropriate treatment. We provide practical information on ways in which PTSD symptoms can be assessed, as well as consideration of how to assess for other mental health problems. We also discuss using WET when a client has symptoms of PTSD but does not appear to meet full diagnostic criteria for the disorder. We describe how assessment should continue to be conducted during the course of treatment to evaluate whether WET is achieving the desired reductions in PTSD symptoms, as well as using assessment at the end of treatment to determine whether additional treatment (whether with WET or another intervention) is needed.

Chapter 4 provides a comprehensive description of the WET protocol and how it should be delivered. It includes session-by-session instructions that

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should be read verbatim to the client. These instructions are also presented in an appendix at the end of the book so that clinicians can create copies of the instructions and them hand out to clients during sessions. Throughout Chapter 4, we discuss how clinicians should handle a variety of issues that might arise when using the treatment. In addition, we provide examples of how clinicians should approach the check-in process at the end of the writing sessions. Chapter 5 answers frequently asked questions by clinicians regarding the use and delivery of WET. The last chapter in the book, Chapter 6, presents a variety of case examples that demonstrate various principles and potential outcomes of the WET protocol. These case examples address some of the most frequently asked questions we receive from clinicians regarding how to manage specific client scenarios (e.g., what to do with clients who have experienced multiple traumas, clients who dissociate, and clients who are highly reluctant to confront their trauma memory).

Although the book was written as a guide to WET for mental health treatment providers, it can also be used as a resource for graduate students in psychology and social work who are interested in learning more about treatments for trauma survivors. The book is not intended to be used as a self-help resource for trauma survivors, nor is it intended to be a treatment manual for paraprofessionals, because no studies have examined whether WET can be successfully implemented by non–mental health practitioners (e.g., peer counselors). Consistent with Section 2, Competence, of the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017), only licensed mental health treatment providers with appropriate experience and training should use WET.

We hope that readers find this book and the tools it describes useful in their clinical work with trauma survivors. We also hope this book increases the dissemination of and patient access to an efficient PTSD treatment that will hopefully help many trauma survivors with PTSD who want treatment but may have difficulty obtaining it.