Rewriting the Trauma Narrative: The Effectiveness of Autobiographical Writing in the Treatment of PTSD and Complex Trauma

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This paper is dedicated to my two children who inspire me everyday to be the most authentic version of myself so that I may model for them what it means to be a complex, messy, creative, and fulfilled human being.

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Abstract

Trauma survivors experience a wide range of chaotic and distressing symptoms that have long-term effects on their mental, emotional and physical health, as well as their relationships and overall sense of self. With such a pervasive and chronic impact, it is crucial to develop treatment options that target the cognitive, somatic and relational impairments caused by trauma. Autobiographical writing is one option for an integrated treatment approach and this paper explores its efficacy as a treatment intervention for psychotherapy clients with PTSD and complex trauma. Supported by the stage model of treatment developed by Judith Herman, this paper demonstrates the capacity of autobiographical writing to engage psychoanalytic narrative reconstruction and embodied, creative practice to provide a well-rounded treatment option for survivors. Specifically, autobiographical writing supports trauma recovery by providing the survivor with a safe opportunity to break their silence, taking control of the story and be witnessed.

Increasing numbers of psychotherapy clients are presenting with symptoms of trauma characterized by chaotic, reactive and dissociative behaviour (Morrison, 2014; van der Kolk, 2014). There is still a lack of understanding of the full complexity of trauma and how it affects survivors but there is a growing wealth of research on the topic and significant leaps forward in treatment options in the past couple decades (van der Kolk, 2014). However, a focus on trauma research and treatment has not historically been the case which, as argued by Herman (1997) in her seminal book *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, is because it is such a difficult topic to face, with early professionals in the field being unwilling to validate the truth of trauma in our society. It wasn't until soldiers were experiencing symptoms of psychological distress after returning from war and the women's movement brought the realities of violence against women (VAW) to light that the field of psychology accepted trauma as a significant factor in mental and emotional distress (Herman, 1997). Today we understand psychological trauma can occur following major traumatic events like war, accidents, and violence, while also resulting from childhood neglect and other relational traumas (CMHA, 2013; Herman, 1997; Morrison, 2014). There is a growing field of research supporting the hypothesis that some of the mental health disorders defined by the *Diagnostic & Statistical Manual* (DSM), such as Borderline Personality Disorder, Attention Deficit Disorder and Substance Use Disorder are the result of various forms of trauma and thus developing effective ways of treating trauma is critical (Herman, 1997; Maté, 1999).

This paper will contribute to the body of research on trauma treatment and specifically explore the research question: Is autobiographical writing an effective therapeutic treatment for trauma? Research on trauma shows the act of telling the story of the event can reduce mental,

emotional and physical trauma symptoms (Herman, 1997; Pennebaker & Beall, 1986; Oke, 2008). In fact, many of the leading researchers in the field of trauma argue that telling the story of the trauma is a critical component of the healing process (Herman, 1997; Pennebaker & Beall, 1986). Furthermore, various forms of writing: expressive, journaling, autobiographical writing, poetry and spiritually focused writing have been shown to be effective in the treatment of trauma and other presentations of psychological distress (Frisina, et. al., 2004; Glass et. al., 2019; Hoyt & Yeater, 2011; Pennebaker & Beall, 1986; Ruini & Mortara, 2021; Springer, 2006; Vaughn & Swanson, 2006; Wiggins, 2011).

The second question explored in this paper will be the mechanism of change through the autobiographical writing process. How does this form of writing act as a therapeutic intervention for processing trauma? Research with survivors of trauma have suggested that the act of writing externalizes the experience and allows the survivor to see the event from a more objective perspective (Sagi, 2021; Ruini & Mortara, 2021; Vaughn & Swanson, 2006; Wiggins, 2011). It was originally expected that this research would lead to an exploration of narrative therapy as the psychotherapeutic approach engaged during autobiographical writing however, psychoanalysis emerged as a more commonly used framework for the understanding of autobiography. The concept of the personal narrative reconstruction as the focus of psychoanalysis presented itself through the work of Sophia Richman (2002, 2006, 2009), Gilead Nachmani (2005) and Dori Laub (2005). The use of the *life story model* as developed by Dan McAdams (2008) supports the understanding of the value of the personal narrative and its use in the therapeutic process. Contributing to clinical applications, this paper will also explore important ethical considerations when using AW as a therapeutic tool: writing causes an initial increase in emotional distress before a decrease in overall trauma symptoms, cultural considerations, stigma and the influence

of the therapist on the narrative (Hoyt & Yeater, 2011; Pennebaker & Beall, 1986; Ruini & Mortara, 2021).

As we gain a deeper understanding of the effects of various types of trauma and how many clients presenting with psychological distress may be experiencing trauma-related symptoms, trauma treatment techniques need to be well-researched and accessible for both therapists and clients. From their narrative review of therapeutic writing, Ruini and Mortara conclude "writing makes thoughts more real and transforms mental states in(to) something concrete as feelings, whereas thoughts and reflections expressed orally can easily disappear when the psychotherapy session ends" (2022, p. 31). The wide use of therapeutic writing in the field of psychotherapy shows that this type of intervention can be effective for many clients and integrates well with different therapeutic schools of thought. This paper will explore the effectiveness of autobiographical writing on the treatment of trauma and how the act of writing about a traumatic event can result in a decrease of trauma symptoms. Bringing together Herman's stage model for trauma treatment, the act of narrative reconstruction from a psychoanalytic perspective and an embodied, creative experience as recommended by the work of Bessel van der Kolk, this paper outlines three ways in which autobiographical writing may contribute to trauma healing: breaking the silence, taking control of the story, and being witnessed.

Understanding Trauma

Trauma is a complicated and diverse experience, and the psychological community is still developing a comprehensive understanding of how it occurs, why it affects some people more than others and how it can be treated (CMHA, 2013; Herman, 1997; Morrison, 2014; van der

Kolk, 2014). Trauma symptoms include depression, anxiety, mood swings, dissociation, flashbacks and intrusive memories, hyperarousal, and other forms of mental, emotional, and physiological distress (CMHA, 2013; Herman, 1997; Morrison, 2014; van der Kolk, 2014). Despite a complicated history in the field of psychology, we now understand psychological trauma can occur following major traumatic events like war, accidents, and violence, while also resulting from childhood neglect and other relational traumas (Herman, 1997; Morrison, 2014; van der Kolk, 2014).

It is estimated that approximately 9% of Canadians will be diagnosed with PTSD at some point during their lives with higher rates of trauma found among women, Indigenous people, first responders and military personnel (CMHA, 2013). Furthermore, many leaders in the field of trauma research believe that numerous mental health disorders defined by the Diagnostic & Statistical Manual (DSM), such as Borderline Personality Disorder, Attention Deficit Disorder and Substance Use Disorder may be caused by various forms of trauma (Herman, 1997; Maté, 1999; van der Kolk, 2014). This paper will contribute to the body of research on trauma and specifically explore the efficacy of autobiographical writing as an intervention for treating trauma, attempting to build on our understanding of how this form of therapeutic writing helps to rewrite the trauma narrative that defines the individual's experience and exacerbates their emotional, mental and physical distress.

Early Understandings

The study of trauma in the field of psychology has been marked by stops and starts over a period of more than a hundred years, a pattern due to, as argued by Herman (1997), the psychological community's unwillingness to face the reality that psychological trauma caused by

humans is rampant. The first documented research of trauma occurred in the late 1800s in Europe as pioneering psychiatrists Jean-Martin Charcot, Pierre Janet and Sigmund Freud began to work with women diagnosed with hysteria (Herman, 1997). At the time, hysteria was considered an affliction marked by erratic and complicated symptoms and only experienced by women, thus theorized to originate in the uterus and resulting in it being named hysteria (Herman, 1997). Charcot was a French neurologist using the modern sciences of psychiatry and neurology to study hysteria and focused on establishing the psychological basis for many of the physical symptoms presented by his patients (motor paralysis, convulsions, amnesia and sensory losses) (Herman, 1997). However, he showed little interest in the inner psychological workings of his patients, labeling their speech as "vocalizations" and discounting any of the content shared by his clients as frivolous (Herman, 1997).

Having studied with Charcot, Janet and Freud sought to identify the cause of hysteria and moved beyond observation and classification of symptoms (Herman, 1997). Both men chose to treat the female patients in their care in a very uncommon manner at the time by listening to them, and as a result heard countless stories of physical and sexual abuse that had been enacted upon these women as children and as adults (Herman, 1997). From their work, both Janet and Freud concluded that hysteria was due to psychological trauma and recognized that their patients were overwhelmed by memories and flashbacks of the traumatic event (Herman, 1997). This led Freud to write The Aetiology of Hysteria, published in 1896, where he presented his theory that the hysteria experienced by these women was caused by the abuse they experienced (Herman, 1997). However, the response from his peers was inconsistent with many of them turning away from his work due to the challenge in facing the prevalence of such atrocities (Herman, 1997). This unwillingness to accept the degree of trauma being inflicted upon women resulted in a

professional discomfort with the topic of trauma and further advancement of the work done by Janet and Freud stalled (Herman, 1997). Freud abandoned his theory and in later development of psychoanalysis suggested that girls derive pleasure from the sexual abuse they experience, abandoning his original trauma theory altogether (Herman, 1997).

A few decades later, soldiers returning from the First World War were experiencing the same symptoms as those women diagnosed with hysteria and at the time it was thought that these men were weak, that their struggles were due to their own moral failures and did not deserve treatment (Herman, 1997; van der Kolk, 2014). If they did receive treatment it came in the form of shaming and punishment for their lazy and cowardice behaviour (Herman, 1997; van der Kolk, 2014). When their symptoms were first taken seriously, it was thought that they were due to the concussive effects of explosives during combat, hence the term Shell Shock, but it did not result in much improvement in the treatment approach (Henke, 1998; Herman, 1997). Eventually an argument arose for more humane treatment and the psychoanalytic approach of talk therapy was engaged with some soldiers with the goal of treatment being the return to combat (Herman, 1997; van der Kolk, 2014). What was discovered through this approach to treatment was that the soldiers were deeply loyal to the other soldiers in their unit and their desire to return to their fellow soldiers was the biggest motivator of their healing thus many soldiers returned to combat as soon as they were able (Herman, 1997; van der Kolk, 2014). However, although the treatment offered alleviated enough of their distress for them to return to war, many symptoms persisted and followed these soldiers for the rest of their lives (Herman, 1997; van der Kolk, 2014). It wasn't until the Vietnam War when veterans organized themselves, forming a group called Vietnam Veterans Against the War, that the public came to know the lasting psychological impact of war (Herman, 1997; van der Kolk, 2014). The bravery of these soldiers led to

extensive research on the effects of war and ultimately the recognition of a condition called Post-Traumatic Stress Disorder, PTSD (Herman, 1997; van der Kolk, 2014).

At the same time, the feminist movement had initiated its own exploration of trauma through *Consciousness Raising Groups* which brought women together to tell their stories in an environment where they would be believed, challenging the silence and secrecy that had kept these women trapped in abuse and violence (Herman, 1997). The goal of these groups was to bring to light the atrocities faced by women (and children) in their homes and take collective action toward social change (Herman, 1997). This led to the establishment of the first rape crisis centres in the 1970s and the definition of rape as an act of violence threatening women's lives rather than a sexual act desired by women (Herman, 1997). These brave feminists worked against ridicule, shame and an unfair legal system to support survivors of rape and other forms of domestic violence, eventually leading to research illuminating the dramatic degree of the abuse inflicted upon women and children and the same trauma symptoms that had been found in soldiers (Herman, 1997). Herman argues that the advancement in the understanding of trauma has only been possible through the political relevance of war and the feminist movement, and, publishing her book in the late 1990s, expressed hope that the study of trauma would not be forgotten once again by the psychological community.

Current Research

More than two decades later, Herman's worry that trauma may once again be pushed aside and forgotten can be laid to rest. Research in the field has made huge gains in the understanding of how traumatic events affect people, with advances in neuroscience now demonstrating actual physical changes in brain development and function among those who have

experienced trauma, with studies showing trauma and chronic stress lead to dysregulation of the autonomic, limbic, motor and arousal systems (D'Andrea et al, 2012; Payne et al., 2015; van der Kolk, 2014; van der Kolk et al, 2016). These neurological changes contribute to the impulsive, chaotic and emotionally reactive behaviours that are typical of many trauma survivors as well as the depressed, low affect and frozen-like presentation of other survivors (Payne et al., 2015; van der Kolk, 2014).

Along with an increased understanding of how singular or specific traumatic events like war and violence effect people, research has shown ongoing trauma such as childhood emotional abuse and neglect, as well as the witnessing of domestic violence in the home, can lead to PTSD symptoms (D'Andrea et al, 2012; Spinazzola et al., 2021). However, studies have shown the PTSD diagnosis to be insufficient in encapsulating the presentation of trauma at among children and adolescents, leading to suggestion that *Developmental Trauma Disorder* (DTD) be added to the DSM as a diagnosis for this form of complex trauma that occurs during a child's development (D'Andrea et al, 2012; Spinazzola et al., 2018; Spinazzola et al., 2021). D'Andrea et. al. (2012) argue that DTD is due to *interpersonal victimization*, defined as harm caused by the actions of others and usually including elements of malevolence, betrayal, injustice, and immorality, and includes neglect, emotional abuse, severe bullying, caregiver mental illness, witnessing domestic violence and other forms of violence in the home and community. Their findings show that children who have experienced interpersonal victimization often qualify for diagnoses other than PTSD, such as Major Depression Disorder, Generalized Anxiety and Oppositional Defiant Disorder, resulting in poor treatment outcomes when a trauma-informed approach is not integrated into the therapeutic process (D'Andrea et al, 2012; Spinazzola et al., 2018; Spinazzola et al., 2021). These symptoms include but are not limited to problems with

emotion regulation, impulse control, attention and cognition, dissociation, self-esteem and interpersonal relationships (D'Andrea et al, 2012). Studies of youth who have experienced complex trauma show that insecure attachment is common among maltreated children, and this is linked to poor psychological and physical health outcomes (Kinniburgh, et al, 2005).

Long before neuroscience was able to illustrate altered brain development among survivors, it was agreed that trauma symptoms were the result of the trauma experience not being cognitively integrated, as evidenced by the fragmented memories and sense of being stuck in the trauma. This traumatic shutdown, as argued by Laub (2005), is due to the loss of good object relation during a trauma. Childhood abuse and neglect, as well as the witnessing of domestic violence causes chronic and severe trauma symptoms because it is the child's caregiver, their object of safety and stability, who is the perpetrator of the abuse (Laub, 2005; Nachmani, 2005). Laub argues that the abusive or neglectful caregiver takes on the bad object role due to his or her actions, and since the child must keep its connection to the caregiver for safety, the child identifies with this bad object resulting in a destruction of the sense of self. In her work with survivors of childhood sexual abuse, bibliotherapist Sagi recognizes the affect of the abuse on the sense of self and writes that self-doubt is "engraved on the soul of a girl who is sexually abused by someone close to her" (2021, pp. 151-152). Unlike other psychanalytic perspectives, Laub argues that this can occur in infancy with caregivers and throughout the lifespan with other important people, or brought on by the survivor's inability to be their own good object and help themselves escape harm during traumatic events. In order to sustain this distorted reality, the trauma survivor must engage internal splitting, leading to the survivor feeling like they exist in two worlds – the present world and the trauma world. The lack of an internal good object leads to the brain's inability to access symbolization and make meaning of the trauma and integrate it

into the larger personal narrative (Laub, 2005; Nachmani, 2005). Van der Kolk (2014) argues that this inability to process trauma on a symbolic level is at the heart of PTSD and complex trauma.

In addition to an increased understanding of the emotional and cognitive distress caused by trauma, studies have shown trauma linked to stress-related diseases such as heart disease and chronic illness such as fibromyalgia (van der Kolk, 2014). The 1998 study into Adverse Childhood Experiences (ACE) demonstrated that the effects of trauma are felt across the lifespan with the experience of childhood traumas significantly increasing the likelihood of substance misuse, mental illness, risky behaviours and poor physical health in adulthood, with these findings being repeated in subsequent studies (Felitti et al., 1998; Finkelhor et. al., 2015; Kerker et. al., 2015). Across the literature there is extensive support for the argument that trauma symptoms manifest as not only psychological distress but also physical stress-related diseases (Pennebaker and Beall, 1986; van der Kolk, 2014).

Furthermore, the effects of trauma can be felt beyond the lifespan through *intergenerational trauma transmission* (Laub, 2005; Maté, 1999; Nachmani, 2005). Laub and Nachmani both refer to the interaction between traumatized caregivers and their children, with a lack of affect or the presence of depression in the caregiver resulting in the child identifying with the negative emotion. Gabor Maté, in his book *Scattered Minds: The Origins and Healing of Attention Deficit Disorder* (1999), theorizes that ADD/ADHD is caused by attachment trauma during infancy when one of the primary caregivers is emotionally unavailable or unable to attune to their child, possibly due to their own trauma. For all types of trauma, research now shows that

across the lifetime and beyond, traumatic experiences affect the development of the individual, their mental stability, physical health and relationships.

Treatment of Trauma

As the field of psychology has come to better understand the causes and effects of all forms of trauma, there have been many different treatment approaches developed ranging from traditional talk-therapy to somatic experiencing. The American Psychological Association (APA) strongly recommends several cognitive and exposure-based approaches that seek to reconstruct the trauma narrative and desensitize the survivor to the trauma experience (APA, 2017). As argued by D'Andrea et al. (2012) in relation to working with children, it is important to use a trauma-informed approach even when there has been no formal trauma diagnosis. With the many researchers in the field of trauma now theorizing that many diagnoses from the DSM are manifestations of trauma, it could be argued that all psychotherapy should occur from a trauma-informed position. Although there are many different therapeutic approaches to the treatment of trauma, in exploring the mechanism of change in autobiographical writing this paper will focus on Herman's Stage Model, and how psychoanalytic and somatic approaches are engaged in the writing process.

Herman's Stage Model

Trauma treatments are often staged based, with one of the original and most referenced models developed by Judith Herman following these three steps: establish safety, reconstruct trauma story and restore connection to community. The importance of establishing safety is well understood across the research and should always be the first step in trauma treatment with an understanding that it must be continuously re-evaluated and revisited throughout the treatment

process (Herman, 1997; Kinniburgh et. al., 2005; Uy & Okubo, 2018). One of the most important ways to develop safety for the survivor is to give them agency over the therapeutic process. In order to facilitate this, the therapist should be sure to use informed consent throughout the therapeutic process and encourage the survivor to make decisions for themselves (Herman, 1997). This requires the therapist to focus on empowering the survivor, providing empathy and a willingness to bear witness to the survivor's experience as they wish to tell it. Proper diagnosis and medication may also play an important role in establishing safety, as well as tending to practical needs such as medical attention, housing and the safety of dependents. Establishing safety often requires the engagement of external resources and may happen quickly but with more complex presentations of trauma, it may take months or even years for the client to be stable enough to take the next step in treating trauma (Herman, 1997). Herman maintains that trauma processing interventions should not occur until safety and stability are established, and the therapist must be prepared to switch back to stabilization should the survivor's safety become questionable at any point during treatment.

Once the survivor has sufficient safety and stability, a reconstruction of the trauma story is the next step in treatment (Herman, 1997). Herman argues that the healing agent at this stage of recovery is the presence of truth as the survivor sees it. Helping the survivor reconstruct the story, from their experience pre-trauma to the present will help them understand what led to the traumatic event and fully integrate the experience into their larger understanding of themselves. Herman presents two forms of early trauma treatment: flooding and testimony, both of which utilize exposure to written narratives as a means to gain control over the distressing emotional states experienced by the survivor (Herman, 1997). Herman contends that any writing that is done about the trauma should be read aloud in therapy so that the therapist may assist the

survivor in deconstructing unhelpful aspects of the narrative and engage self-reflection in support of integration. Emphasizing the importance of the survivor telling their story, Herman writes "remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims." (Herman, 1997; p. 1).

The third stage in Herman's model is reconnection. At this stage, the survivor has developed a complete narrative of the trauma and processed their associated emotions, and now must incorporate their healing into their relationships (Herman, 1997). Survivors may feel that the trauma has forever changed them, and they need to integrate these new parts of themselves into their life, for example women who have been raped may choose to take self-defence classes as a way to overcome lingering and realistic fear of another attack (Herman, 1997). For many survivors, the perpetrator of the trauma was someone close to them and thus they may need to end certain relationships and create new, supportive connections. It may be difficult to navigate the re-engagement with challenging relationships and Herman makes a note that therapist should thoughtfully evaluate which relationships are supportive of their client's healing. Beyond their family and existing relationships, Herman reflects that many survivors find a sense of purpose in using their experience to help others through activism or direct service work, making a difference for other survivors or even preventing trauma. However the relational needs present for a client, it is a key aspect of trauma recovery to re-engage in healthy relationships and define one's place in society with the coherent sense of self developed through the remembering and reconstructing process.

Psychoanalytic

Since the early research on trauma, the "talking cure" of Freudian fame has been thought to be an effective treatment for suffering survivors (Herman, 1997; van der Kolk, 2014). Psychoanalysts have long provided treatment that aligns with Herman's second stage of trauma treatment, remembering and reconstructing the trauma story (Murdock, 2017; Richman, 2006). The objective of a psychoanalytic approach lies in the reconstruction of the trauma narrative via symbolization and meaning making, with the witnessing and interpretation of the analyst (Laub, 2005; Murdock, 2017).

As argued by Laub from an object-relations approach, the traumatic experience leads to the loss of the internal good object, destroying the survivor's ability to engage symbolization and meaning making. Psychoanalysis and the process of telling one's story engages symbolization, and both the internal thou and the therapist act as the object, providing an opportunity to repair the damage done by the trauma (Laub, 2005, Murdock, 2017). Thus, the goal of psychoanalysis when treating trauma is to restore the internal good object or the internal thou which was destroyed by the trauma through narrative reconstruction (Laub, 2005). In his application of Laub's theory to autobiographical writing, psychoanalyst Gilead Nachmani (2005) argues that in the writing process the writer both gives testimony and bears witness, deepening the internal object representation. The power of this internal object is paramount in the process of narrative reconstruction as "one comes to know one's story only by telling it to one's self, to one's internal 'thou'" (Laub, 2005, p. 315).

The role of the therapist is crucial in this process. They engage collaboratively with the client in the deconstruction and reconstruction of the narrative, being thoughtful to not influence

the client's story (Herman, 1997; Laub, 2005). Throughout this process, the therapist empowers the client to clearly articulate their experience and connect emotions to the story, improving the client's self-knowing (Nachmani, 2005). Nachmani argues that it is through this collaborative reconstruction of the trauma narrative that the pre- and post-trauma selves are integrated, leading to a coherent sense of self and reduction in trauma symptoms. It is the process of narrative reconstruction, both with the internal thou and the external therapist, that allows for the restoration of the good object and resulting cognitive integration of the narrative (Nachmani, 2005).

Embodied/Somatic Therapy

When the advances of neuroscience made deeper understandings of the somatic experience of trauma possible rather than just observable behaviour manifestations, the concept of self-regulation was added to the field of trauma treatment (Kinniburgh, et al, 2005; van der Kolk, 2014). Poor regulation can be described as a lack of connection to body states and emotional experiences, which can lead to a decreased capacity to read social cues and navigate minor stressors (Kinniburgh, et al, 2005; van der Kolk, 2014). This lack of regulation may be a key contributor to the chaotic and turbulent experience of PTSD and complex trauma (van der Kolk, 2014; Payne et. al., 2015; Warner et al., 2014)

Somatic Experiencing targets the regulation of the nervous system through the interoceptive, kinesthetic and proprioceptive experiences of the client (Payne et al., 2015). Research shows that learning to regulate the nervous system leads to significant decreases in trauma symptoms (Payne et al., 2015; van der Kolk et al., 2016). Neurofeedback training uses brain-computer interaction devices (BCI) to provide a simple visual representation of cognitive

activity, allowing the survivor to learn to manage intense internal arousal which is a fundamental component of trauma recovery (van der Kolk et al, 2016). These types of interventions have thus far shown to lead to significant decreases in trauma symptoms with large numbers of participants no longer qualifying for a PTSD diagnosis (van der Kolk et al, 2016). Other frameworks that focus on self-regulation have had similar results, such as ARC: Attachment, Regulation & Competency, and SMART: Sensory Motor Arousal Regulation Treatment, showing reduced symptoms of PTSD, anxiety and depression among children and adolescents (Kinniburgh, et al, 2005; Warner et al., 2014).

Although research on somatic approaches is still limited, there is a growing body of research on the effectiveness of embodied therapy such as play therapy, creative art therapy, and dance and movement therapy (Warner et al., 2014; van der Kolk, 2014). Preliminary studies have shown yoga to be an effective treatment for chronic PTSD among women, with a significant number of participants no longer meeting the diagnostic criteria following a 10-week yoga series which included only 1 hour of yoga per week (Nguyen-Feng et. al., 2020; van der Kolk et. al., 2014). Somatic treatments for trauma vary but existing research indicates that when trauma is treated in an embodied, wholistic approach, there is relief in trauma symptoms (van der Kolk, 2014). Thus, the practice of autobiographical writing as a treatment for trauma provides an accessible, creative, and embodied intervention option, in addition to a means for narrative reconstruction.

Autobiographical Writing for Trauma Treatment

Autobiographical Writing (AW) is a form of writing that focuses on the writer's life experience, including personal reflection on their thoughts and emotions in a way that reveals

them to the reader (Henke, 1998; Richman, 2005; Ruini & Mortara, 2021). This form of writing exposes the narrative identity of the writer – the stories they have constructed about their life that make meaning of their experiences and situate their identity within the social context (McAdams, 2008; Richman, 2005). Dan McAdams is one of the pioneers in research on autobiography and has developed a *life story model of identity* which, he argues, is composed of ever-evolving narratives about the self throughout the lifetime, influenced by both past and present experiences (McAdams, 2008; McAdams & McLean, 2013). A key concept in his model is the *dialogical self* defined by Hermans (1996), which develops from a narrative that is co-created by the many selves as well as the external characters in an individual's life. Thus, argues McAdams, an individual's identity develops in direct relation to the stories about their lives and experiences which are co-created by the individual and their interactions with others and culture. These narratives are developed to organize life events, give meaning to challenges, situate oneself in the larger social context and define a purpose to one's life (Hermans, 1996; McAdams, 2008). McAdams argues,

> "the stories we construct to make sense of our lives are fundamentally about our struggle to reconcile who we imagine we were, are and might be in our heads and bodies with who we were, are, and might be in the social contexts of family, community, the workplace, ethnicity, religion, gender, social class, and culture writ large. *The self comes to terms with society through narrative identity."* (McAdams, 2008, pp. 242-243)

McAdams and McLean (2013) argue that narrative identity provides unity and cohesion of the self across the lifetime. With the understanding that trauma disrupts cognitive processing of memories, meaning making and integration, it can be argued that without the capacity to

construct a cohesive narrative, the trauma survivor will struggle with their sense of identity throughout their lives (Laub, 2005; van der Kolk, 2014). From a psychotherapeutic perspective, the reconstruction of the narrative is crucial to support healing from trauma and McAdams reflects on "psychotherapy as fundamentally a process of story reformulation and repair" (2008, p. 248). Of particular importance when exploring the use of autobiography for trauma treatment, McAdams and McLean sought to identify the factors that contribute to *redemption sequences*, those points in the narrative that "mark a transition in a life narrative account from an emotionally negative scene to a positive outcome or attribution about the self" (2013, p.233). Seven themes emerged in their study: communion, redemption, agency, contamination, meaning making, exploratory narrative processing, coherent positive resolution, with agency and meaning making being the strongest factors in contributing to healthy narrative development and the presence of redemptive sequences in the narrative. This supports other findings on trauma treatment that highlight the survivor's need for control over their lives and treatment (Herman, 1997; Sagi, 2021), and the importance of meaning making (Laub, 2005; Nachmani, 2005; van der Kolk, 2014). Another interesting factor identified in this study is *exploratory narrative processing* which they define as "the extent of self-exploration as expressed in the story. High scores suggest deep exploration or the development of a richly elaborated self understanding" (McAdams & McLean, 2013, p. 234). This deep exploration may be more possible through a written narrative than the verbal narrative shared in the therapist's office, thus furthering the argument that AB is an effective intervention when treating trauma.

Sophia Richman, a psychoanalyst who treats trauma through creative transformation and autobiographical narratives wrote her own memoir, *A Wolf in the Attic: The Legacy of a Hidden Child of the Holocaust* (2002), about her experience as a young Jewish child in Poland

pretending to be Catholic and hiding her father in the attic of the house they rented. Despite decades of successful work with a psychoanalyst, Richman (2009) found that it was only when she finally wrote her story that she felt a true sense of relief from her pain. She argues "autobiographical writing is an attempt to master experiences of grief and psychic pain of various degrees and various types. Telling's one's story is a healing experience for anyone who has suffered and longed for a witness to that suffering." (Richman, 2006, p. 648). Literary professor Suzette A. Henke explores women's trauma narratives in her book *Shattered Subjects: Trauma and Testimony in Women's Life-Writing* (1998) and questions whether the psychoanalyst is needed at all or if the writer, in their role as both author and imaginary reader, is sufficient to remember and reconstruct the narrative. She argues that the writer takes on the role of psychoanalyst as well as patient during the AW process and that this gives the survivor complete agency over their story, one of the essential objectives of trauma treatment. In her examination of Miriam Katin's two graphic memoirs about her Holocaust trauma, Oostdijk (2018) argues that the self-reflective creative process of drawing and writing provided an embodied means for Katin to transform her trauma experience and alleviate many of the negative effects of the Holocaust on her life and family, without the use of a therapist.

In *The therapist's notebook for integrating spirituality in counseling: Homework, handouts, and activities for use in psychotherapy,* Vaughn and Swanson (2006) offer direction on the use of spiritual autobiography in therapy and contend that autobiographical stories allow the writer to see their lives more objectively. This may allow the client to see patterns they may not otherwise recognize and learn to understand these patterns as a way to develop a more coherent sense of self. They argue that "by writing their story instead of only telling it, clients are engaged in a more in-depth reflective process" (Vaughn & Swanson, 2006, p.211). In her

work with female survivors of sexual abuse, Bibliotherapist Bella Sagi has found many of her clients turn to autobiographical poetry to express and process their traumatic history. She argues that writing pulls the survivor out of the darkness of the abuse and into the light of testimony with one client professing "only when I began writing did I start living" (Sagi, 2021, p. 150).

It is well understood that many of the negative effects of trauma are due to a damaged cognitive state driven by fragmented memories and suppressed emotions (Herman, 1997; Laub, 2005; Nachmani, 2005; van der Kolk, 2014). Although verbal narrative reconstruction has proven to be an effective intervention for trauma treatment (APA, 2017; Laub, 2005), the writing process may offer a more reflective experience that optimizes agency, organizes thoughts, and clarifies emotions (Henke, 1998; Nachmani, 2005; Richman, 2009). Furthermore, the creative nature of AW offers an opportunity for an embodied experience of the narrative, emotions and ultimately the repaired sense of self (van der Kolk, 2014). Analyzing autobiography from a trauma perspective, this literature review has highlighted three ways in which this form of writing acts to help process trauma: breaking the silence; taking control of the story; and being witnessed.

Breaking the Silence

Historically there has been an expectation of silence from those who have experienced trauma whether it was soldiers returning from war or women and children living in abusive homes (Herman, 1997). This code of silence or secrecy, imposed by the perpetrator, the victim's family or society as a whole, creates an internal tension for the survivor as they oscillate between wanting to hide or deny what happened to them, and the need to share their experience (Herman, 1997). In most instances of trauma, the perpetrator will do everything possible to hide the truth,

crafting lies and discrediting the victim, sometimes to such an extent that the victim may question if the abuse happened at all (Herman, 1997; Laub, 2005; Sagi, 2021). Thus, telling the truth about what happened is an act of defiance, bravery and agency on the part of the survivor (Herman, 1997; Sagi, 2021). Inherent to autobiographical writing is the act of documenting something that may have been expected to stay secret and thus, as a therapeutic intervention, this form of writing offers the survivor an opportunity to break the code of silence imposed upon them (Richman, 2006; Richman, 2009; Sagi, 2021).

True to the intention of client agency, the creative nature of AW allows survivors to communicate their trauma as well as their experience of being silenced. Sagi (2021) has found many of her clients have been unwilling or unable to speak aloud the atrocities that have happened to them but through poetic autobiography there are ways to represent the silence as well as the trauma, as demonstrated in this excerpt from a poem written by a woman in her study: “When I was young it was the forbidden word/You don’t say it to daddy to avoid getting beaten/You don’t say it to mommy so she won’t cry/…You don’t say it…” (Sagi, 2021, p.155). Through writing, these survivors are able to not just speak their truth, but gain agency in how they present their story. Another poem from the study expressed the survivor’s unwillingness to talk about what happened to her but ends with the line “Yet I will do it, someday…” (Sagi, 2021, p. 156). From these examples, it becomes clear that writing can be used creatively to express different aspects of their trauma, including the silence, and gives the survivor the agency to claim both as within their control.

Although one can understand the power gained by the survivor when they choose to tell their story, the act of breaking the silence seems to have a deeper impact on the experience of

trauma. Testimony or confession, contends Pargament (2007), is a common act of purification in Western traditions and sees the experience as a form of catharsis, citing the practice of *Expressive Writing* (EW) developed by James Pennebaker. Expressive writing is the act of writing about one's thoughts and feelings related to a traumatic event or stress in general, usually numerous times over the course of a few days or weeks as part of a therapeutic process (Acar, & Dirik, 2019; Frisina et al., 2004; Pennebaker & Beall, 1986). Pennebaker and Beall (1986) in their landmark study on the effects of EW trauma symptoms, found that the act of writing the details of a traumatic event as well as the emotions related to it, led to an increase in psychological and physical well-being. One participant commented afterward, "although I have not talked with anyone about what I wrote, I was finally able to deal with it, work through the pain instead of trying to block it out. Now it doesn't hurt to think about it." (Pennebaker & Beall, 1986, p. 279). From this study, Pennebaker and Beall put forward the theory that the survivor's efforts to keep their traumatic experience secret requires a significant inhibition of actions, thoughts and feelings, and that this inhibition effort causes stress in the body which accumulates over time leading to stress-related diseases. In support of EW and other forms of AW, Pennebaker and Beall argue "the mere act of writing about an event and the emotions surrounding it is sufficient to reduce the long-term work of inhibition" (1986, p. 281).

The original EW study was limited with only forty-six participants, but the effects of EW have been replicated in countless studies since. In their meta-analysis of nine EW studies, Frisina et al. (2004) confirmed the original finding that EW improves health, possibly with greater effects on physical rather than psychological health. Researching how EW may improve trauma resilience, Glass et. al. (2019) studied the effects of a 6-week expressive writing program called *Transform Your Life: Write to Heal* on participants who had experienced a traumatic event or

significant emotional upheaval in the previous year. At the end of the six weeks, there was a significant decrease in stress, depression, and rumination along with an increase in resilience. In their study with 132 survivors of the 2016 Louisiana flooding, Mosher et al., (2021) found spiritually oriented EW promoted meaning in life at 1-month and 6-month follow ups, theorizing that this process allowed participants to successfully repair their relationship with the sacred after the disaster. Across the literature, EW has shown to have positive effects on psychological and physical well-being among healthy populations as well as those suffering from psychological distress and trauma symptoms (Acar & Dirik, 2019; Frisina et al., 2004; Hoyt & Yeater, 2011; Pennebaker & Beall, 1986; Ruini & Mortara, 2022).

As originally theorized by Pennebaker & Beall (1986), the act of writing down difficult emotions, thoughts and feelings seems to lead to a catharsis-like experience of the release of tension in the body, leading to an alleviation of PTSD and complex trauma symptoms. This catharsis, along with the sense of agency that comes from telling the truth about one's trauma experience, suggests the act of breaking the silence through AW may be one of the ways this form of writing helps to heal PTSD and complex trauma.

Taking Charge of the Story

The act of narrative reconstruction is considered a fundamental aspect of trauma treatment and recovery (Herman, 1997; Laub, 2005). Drawing from McAdams' principles of the self and story, humans are considered natural storytellers who construct the story of themselves through selective autobiographical memories as well as their hopes for their future (McAdams, 2008). Those who experience trauma construct a trauma narrative which consists of fragmented memories, family myths, social norms, and other influences to explain what happened to them

and why (Laub, 2005; McAdams, 2008; Oke, 2008; Sagi, 2021). When a trauma survivor chooses to work with their trauma narrative in a therapeutic process, it is essentially the reconstruction of their sense of self through the new narrative development (Henke, 1998; Richman, 2009). It is thought that self-disclosure, combined with the externalizing of the narrative, allows for the sense of self to stabilize in relation to the event (Pennebaker & Beall, 1986). Like all other aspects of trauma treatment, it is crucial that the survivor have agency over the narrative reconstruction – determining the aspects of the story that are important, how the story will be told, at what speed it will be done and who the narrative will be shared with. Richman (2006) emphasizes the value of this empowerment, as the survivor can take the traumatic experience, something they had to helplessly endure, and transform it into a story that they control. From the perspective of the dialogical self, Hermans (1996) argues that the writing process allows the survivor to be both the author and the protagonist in their story, and by holding these two roles, the survivor has the ability to construct a narrative of their choosing.

It is thought that the objective of remembering and retelling the trauma narrative, as well as the larger personal narrative within which the trauma occurred, helps to integrate the fragmented memories in the brain (Herman, 1997; Laub, 2005; Nachmani, 2005). It is through this process that the dissociation and sense of being split between two worlds resolves as the narrative is woven together with previously forgotten details and fully processing emotions, integrating the trauma into a healthier, more comprehensive personal narrative (Herman, 1997; Richman, 2006) Richman (2009), in her reflection on her own experience of autobiographical writing about her family's experience of the Holocaust, found the process of narrative reconstruction through writing allowed her to access symbolization and meaning making, leading to the development of a coherent narrative rather than one filled with secrecy, fear and

unanswered questions. Oostdijk (2018) reflects on a similar process in Katin's graphic memoirs as Katin, who was a baby during the Holocaust, gains knowledge of the war and her mother's experience through the creative process, ultimately leading to a degree of trauma resolution through the narrative reconstruction.

The process of narrative reconstruction is used in many different forms of trauma treatment, from the flooding and testimony interventions described by Herman to the cognitive based therapies now defined by the APA (APA, 2017; Herman, 1997). The APA suggests Narrative Exposure Therapy (NET) as an evidence-based intervention for treating trauma showing medium to large reductions in PTSD symptoms (APA, 2017). This form of treatment involves creating a timeline of the client's life, including the traumatic events, and works to desensitize the client to the trauma through exposure via the autobiographical account (Lely et al., 2019). From their meta-analysis of 16 studies on NET, Lely et al. found that "by connecting these anxiety-provoking implicit memories with episodic context, the autobiographic memory is rebuilt, allowing for reduction of anxiety" (Lely et al., 2019, p. 2). NET does not always include actual writing of the narrative but in Uy and Okubo's (2018) study of Cambodian Refugee women living in the United States, they adapted NET to include writing a well as sharing with others. From a feminist perspective, these researchers focused on fostering post-traumatic growth for these women who had experienced high levels of gender-based trauma, again emphasizing the power of agency and the therapist seeing the client as an expert on their life (Uy & Okubo, 2018). Orang et. al. (2018) provided NET sessions to Iranian women experiencing ongoing intimate partner violence (IPV), finding that NET was helpful even when the survivor is unable to escape the violence with a decrease in PTSD symptoms and depression at 3 and 6 month follow ups, as well as some reduction in IPV experiences. It was argued by the researchers that

the reflective process of NET gave the women a better understanding of how and when the violence occurred, sometimes highlighting actions they could take to avoid or limit the violence. NET interventions have also been shown to decrease PTSD symptoms in children and adolescents (Peltonen & Kangaslampi, 2019), while also demonstrating great results for older participants, and those with multiple traumas due to the focus on the full lifespan of the survivor (Lely et. al., 2019).

Taking control of the story, determining what is shared and how, and rebuilding a comprehensive narrative are fundamental aspects of trauma recovery. Not only does the survivor gain agency in their lives, but they are also able to integrate the trauma into their larger personal narrative. This integration decreases the sense of fragmentation and cognitive shutdown that is so common among trauma survivors (Herman, 1997; Laub, 2005). Constructing the new narrative through the physical process of writing may enhance the therapeutic effects, contributing to greater agency and meaning making for the survivor.

Being Witnessed

Autobiographical writing offers the opportunity for the trauma survivor to have their story witnessed, something they may not have experienced due to the silence that often surrounds traumatic experiences (Richman, 2006; Saig, 2021). This witnessing is enacted by three different groups: the therapist themselves as discussed earlier, those with whom the author chooses to share their story, and with an internal witness that is conjured through the autobiographical process (Henke, 1998; Richman, 2009; Sagi, 2021). Richman (2009) argues that the imaginary or internal witness is an integral aspect of what makes writing an effective treatment for trauma, at times taking the form of a parent or other influential figure. She reflect

that it is only in our imagination that we have control over another and their responses. Richman writes, “it is my contention that the imaginary witness is a dissociated self-state serving the crucial function of mirroring, affirming, and validating our experience.” (2009, p. 74). From her research and clinical work, Sagi (2021) argues autobiographical trauma writing provides a means of rehabilitating the damaged witness function, leading to integration of the split aspects of the traumatized self.

From the object-relations perspective of childhood abuse and neglect, Laub (2005) explains this as a restoration of the internal good object which was damaged through the abuse. In his application of Laub’s theory to autobiographical writing, Psychoanalyst Gilead Nachmani argues that telling one’s story through AW is an expression of object representation, as the narration offers meaning and integration. This is done by reconnecting the survivor to who they were before the trauma and allowing for the emotions of grief and anger to be fully expressed through writing and in the safe space of the therapist’s office (Nachmani, 2005). This connection with the internal object through AW may be a transitional experience that then supports the survivor to eventually reconnect with others. In their reflections on writing for trauma treatment, both van der Kolk and Pennebaker agree that the point of this type of writing is to write to oneself (van der Kolk, 2014).

The witnessing extends beyond the internal self to the social context for those who choose to share their reconstructed narrative with others. Herman (1997) argues that trauma victims need a supportive social context and the final step in trauma treatment is the reconnection of the survivor with loved ones, as well as those who may better understand their experience. Sharing their story fights the shame and sense of isolation that is so common among

survivors (Richman, 2006; Sagi, 2021). For those who have experienced developmental trauma, sharing their story with their family may help heal fractured relationships but also comes with a risk of increased ostracization or potential re-traumatization of other family members (Herman, 1997). Depending on the complexities of the trauma and those involved, survivors may find a safer audience among strangers or those who have had similar life experiences, as evidenced by the success of testimony in 12-Step programs (Vaughn & Swanson, 2006).

McAdams argues that the presence of a real audience, such as a reader, pushes the author to better clarify the meaning of their story, deepening the potential for integration and rich narrative development (McAdams, 2008). In her study of trauma narratives shared online, Sagi (2021) reflects on the online space and how it provides connection with those who have had similar experiences through comments and discussion group engagement. When survivors share their story in a supportive social context, they are able to better internalize their new narrative and sense of self (Sagi, 2021). Ultimately, stories are not just about the individual themselves, rather they can only be understood within the social context that defines the experience of the individual and how they see their themselves in relation to others (McAdams, 2008). This may lead survivors to share their autobiographical writing to raise awareness about the type of trauma they experienced (Gilmore, 2019; Herman, 1997). Many write to remember the lives lost, as is common among survivors of the Holocaust, with these stories contributing to the collective memory of widespread trauma (Oostdijk, 2018; Richman, 2009). Henke (1998) argues that autobiographies from marginalized groups are inherently subversive as they challenge the dominant narrative of those in power. The #metoo movement is an example of widespread awareness raising through the willingness of women to share their accounts of sexual trauma publicly (Gilmore, 2019; Sagi, 2021). In this way, the act of storytelling works to help others

find their own stories, possibly providing them with the first opportunity to put into words what has happened to them (Vaughn & Swanson, 2006).

The witnessing potential of autobiographical writing is multilayered with the capacity of the therapist and society to bear witness to the survivor's testimony, as well as their ability to be their own internal witness. This internal witnessing may restore the damaged sense of self that was destroyed through the trauma and sense of helplessness. The therapist as witness offers the survivor a safe place to be believed and acknowledged for their experience. The witnessing of others, either family and friends or society, helps the survivor re-engage in their relationships and provide a sense of purpose through activism and advocacy. Autobiographical writing provides a process to restore the internal witness function while also creating something that can be shared with others and used to positively affect the lives of other survivors.

Ethical Considerations

There are several important ethical considerations the therapist must evaluate when determining the suitability of AW for trauma treatment. Autobiographical writing is inherently vulnerable, potentially putting a client at risk for re-traumatization and must be pursued cautiously, with the same care and concern for survivor stability and safety as any other trauma treatment (Herman, 1997). Research on Pennebaker's EW demonstrate an initial increase in distress following trauma writing sessions and the potential for rumination after writing (Frisina et al., 2004; Pennebaker & Beall, 1986; Ruini & Mortara, 2022), and further research has shown that the initial increase in distress may be greater for those with PTSD symptoms (Hoyt & Yeater, 2011). However, all the studies on EW show a decrease in distressing symptoms at follow up, indicating that it is in the period immediately following writing that the therapist

should be aware of a potential increase in distress and be thoughtful to mitigate the risk by ensuring proper resources are in place to maintain the client's safety (Hoyt & Yeater, 2011). Although this research is specific to EW, the risk for increased distress should be evaluated and tended to when using any form of trauma-focused writing in a therapeutic setting (McAdams & McLean, 2013; Ruini & Mortara, 2022).

In this respect, it is important to evaluate if the client is an appropriate client for writing therapy and if so, obtain their full consent before implementing any interventions. Some clients may feel insecure about their writing abilities and/or struggle with learning disabilities and language barriers (Ruini & Mortara, 2022; van der Kolk, 2014). Different clients who choose to write as part of their therapy will create different types of autobiographical writing and this should be supported by the therapist, again enforcing the client's agency to tell their story their way (Sagi, 2021). Finally, language itself has limitations and survivors may find it difficult to find the words to describe all aspects of their experience, thus other creative practices may help support full expression and exploration of the trauma (Herman, 1997; Oostdijk, 2018; van der Kolk, 2014).

The influence of the therapist should also be considered and monitored throughout the therapeutic process. As the therapist supports the client to deconstruct their existing narrative and reconstruct a new one, there is the potential for the therapist to influence the new narrative. Richman (2009) argues that narrative reconstruction done through writing may minimize this potential and better empower the client to define their own story. Laub (2005) also cautions the therapist to be aware of their own trauma and the potential for counter-transference, specifically highlighting blind spots or a reluctance to explore certain aspects of the client's story, leading to

a re-enactment of the silence imposed by the abuse in the therapeutic alliance. Again, the use of AW led by the survivor may decrease the risk of counter-transference interfering with the therapeutic process and re-creating the experience of being silenced.

Culture is another important consideration when using writing as a therapeutic intervention. As defined by McAdams (2008), stories are cultural texts and reflect the norms, rules and traditions of one's culture. In particular when the narrative spans the lifetime, culture can be seen reflected in the expectations and decisions of any individual (McAdams, 2008). Culture can also influence trauma, particularly in the case of gender-based violence which may be justified in certain traditions (Oke, 2008; Orang et al., 2018; Uy & Okubo, 2018). It is important that the therapist be aware of how culture and familial expectations may impact the writing process and engage the survivor to explore these factors, while maintaining the survivor's agency over what they share and how (Ruini & Mortara, 2022). Stigma may play a significant role in a survivor's willingness to share their story and family values of privacy may pose challenges, making it difficult to complete the final stage of Herman's model, reconnection, through AW (Herman, 1997). Families may not want the survivor to share their written narrative and be uncomfortable with activism and advocacy work related to the trauma (Herman, 1997).

Conclusion

Once thought to be a sign of weakness, trauma symptoms are now understood to have extensive long-term biopsychosocial effects on the individual as well as the potential for transgenerational transmission. With this understanding, it is imperative to develop safe, effective, and accessible interventions to treat trauma from a sustainable, wholistic and systemic perspective. The culmination of research on trauma to date highlights its pervasive and chronic

effect on the mental, emotional, and physical well-being of survivors, and as argued by van der Kolk among many others, a dynamic, embodied treatment method may provide the best results. Autobiographical writing is one possible intervention to provide a therapeutic reconstruction of the survivor's narrative, leading to symbolization, meaning making and ultimately integration.

Although narrative reconstruction can and does occur verbally in the therapist's office, the use of AW may enhance the survivor's sense of agency, increase their capacity for objectivity and provide an embodied creative outlet for their pain. Richman (2009) compared her experience of psychanalysis with writing her memoir, describing analysis as a process of taking things apart and writing as a process of putting them back together. Writing offers the survivor a greater sense of control over the story and provides a sense of continuity that may not be possible through verbal narration. This allows the writer to take an active role in reflection and access a deeper sense of self-knowing.

This research topic was chosen because of the researcher's personal and professional interest in autobiographical writing and thus the second research question was the true curiosity: how does autobiographical writing help process trauma? This focused the research on identifying the components of established trauma therapy within the AW process, highlighting Herman's Stage Model, the act of narrative reconstruction in psychoanalysis and the embodied, creative experience of writing. It was difficult to weave the integrated approach together and the interaction between each therapeutic approach and AB is needed in order to further develop this research.

The majority of the research on writing therapy focuses on measurable and structured programs, such as EW and NET, which present a limited understanding of the writing process.

Additionally, there is a lack of research on the somatic experience of writing outside of Pennebaker's EW and thus more research in this area is warranted. From a creative perspective, writing can elicit experiences that are not easily measured such as spiritual connection, creative flow and transformation. For a more comprehensive understanding of the essence of the craft of writing, it may be interesting to include references from famous works on the topic, such as *The Artist's Way* by Julia Cameron, *The Creative Habit* by Twyla Tharp and *Big Magic* by Elizabeth Gilbert. Reflecting on her creative experience, Richman writes "the words seemed to flow effortlessly, as if they had been waiting a lifetime for this moment. The emotions blocked by years of numbness now burst forth, and a creative flow of ideas spilled onto the page" (2009, p. 71). The creative process of AB offers an embodied experience that does not occur in the therapist's office when engaging traditional narrative reconstruction.

Beyond the scope of psychotherapy, research in this area could support writing teachers who are faced with reading and marking narratives of trauma and abuse, unsure how to provide sufficient support to their students. As found in the studies on yoga as trauma treatment, it may prove helpful to develop trauma-informed training for writing teachers so that they are better equipped to avoid re-traumatization of their students and understand the importance of safety and agency for any survivor. Therapists may also be surprised by autobiographical writing brought into session by a client and thus an overall understanding of how to work with these types of materials would be helpful in any therapy training program. Many survivors of trauma turn to writing instinctively to process their experience and this in itself is a strong indicator of the cathartic, therapeutic effect of autobiographical writing.

References:

Acar, D., & Dirik, G. (2019). A current paradigm: Written emotional disclosure. *Current Approaches in Psychiatry, 11*(1), 65-79. DOI: 10.18863/pgy.364852

American Psychological Association. (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. Retrieved from www.apa.org/ptsd-guideline/ptsd.pdf

Bjorøy, A., Madigan, S. & Nylund, D. (2016). The practice of therapeutic letter writing in narrative therapy. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (pp. 332-348). Sage Publications. dx.doi.org/10.4135/9781529714968.n21

Canadian Mental Health Association. (2013). *Post-Traumatic Stress Disorder.* CMHA British Columbia. Retrieved December 12, 2021, from https://cmha.bc.ca/documents/post-traumatic-stress-disorder-2/.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry, 82*(2), 187–200. doi.org/10.1111/j.1939-0025.2012.01154.x

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245–258. doi.org/10.1016/s0749-3797(98)00017-8

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse & Neglect*, *48*, 13–21. doi.org/10.1016/j.chiabu.2015.07.011

Frisina, P. G., Borod, J. C., & Lepore, S. J. (2004). A meta-analysis of the effects of written emotional disclosure on the health outcomes of clinical populations. *Journal of Nervous & Mental Disease, 192*(9), 629–634. https://doi.org/10.1097/01.nmd.0000138317.30764.63

Gilmore, L. (2019). #MeToo and the Memoir Boom: The Year in the US. *Biography, 42*(1), 162+. https://link.gale.com/apps/doc/A587080636/AONE?u=otta77973&sid=bookmark-AONE&xid=156d5a39

Glass, O., Dreusicke, M., Evans, J., Bechard, E., & Wolever, R. Q. (2019). Expressive writing to improve resilience to trauma: A clinical feasibility trial. *Complementary Therapies in Clinical Practice*, *34*, 240–246. https://doi.org/10.1016/j.ctcp.2018.12.005

Henke, S. (1998). *Shattered subjects: Trauma and testimony in women's life-writing*. St. Martin's Press.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror*. Basic Books.

Hermans, H. (1996). Voicing the self: From information processing to dialogical interchange. *Psychological Bulletin, 119*(1), 31-50.

Hoyt, T., & Yeater, E. A. (2011). The effects of negative emotion and expressive writing on posttraumatic stress symptoms. *Journal of Social and Clinical Psychology, 30*(6), 549–569. doi.org/10.1521/jscp.2011.30.6.549

Kerker, B. D., Zhang, J., Nadeem, E., Stein, R. E. K., Hurlburt, M. S., Heneghan, A., Landsverk, J., & McCue Horwitz, S. (2015). Adverse childhood experiences and mental health, chronic medical conditions, and development in young children. *Academic Pediatrics, 15*(5), 510–517. doi.org/10.1016/j.acap.2015.05.005

Kinniburgh, K. J., Blaustein, M., Spinazzola, J., & van der Kolk, B. A. (2005). Attachment, self-regulation, and competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals, 35*(5), 424–430. doi.org/10.3928/00485713-20050501-08

Laub, D. (2005). Traumatic shutdown of narrative and symbolization. *Contemporary Psychoanalysis, 41*(2), 307–326. doi.org/10.1080/00107530.2005.10745863

Lely, J. C. G., Smid, G. E., Jongedijk, R. A., W. Knipscheer, J., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: A review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology, 10*(1), 1550344. doi.org/10.1080/20008198.2018.1550344

Maté, G. (1999). *Scattered minds: The origins and healing of attention deficit disorder.* Vintage Canada.

McAdams, D. (2008). Personal Narratives and the Life Story. In L. A. Pervin, R. W. Robins & O. P. John (Eds.), *Handbook of personality: Theory and research* (pp. 242-262). Guilford Press.

McAdams, D., & McLean, K. (2013). Narrative Identify. *Current Directions in Psychological Science, 22*(3), 233-238. DOI: 10.1177/0963721413475622

Morrison, J. (2014). *DSM-5 Made Easy: The clinician's guide to diagnosis*. Guilford.

Murdock, N. (2017). *Theories of counseling and psychotherapy: A case approach*. Pearson.

Mosher, D. K., Hook, J. N., Captari, L. E., Hodge, A. S., Bellegarde, N., Davis, D. E., McElroy-Heltzel, S. E., Choe, E. J., Van Tongeren, D. R., Davis, E. B., & Aten, J. D. (2021). Spiritually oriented expressive writing and promoting positive outcomes after a natural disaster. *The Counseling Psychologist*, *49*(6), 847–881. doi.org/10.1177/00110000211010499

Nachmani, G. (2005). Proof of life. *Contemporary Psychoanalysis, 41*(2), 327–340. https://doi.org/10.1080/00107530.2005.10745864

Nguyen-Feng, V. N., Hodgdon, H., Emerson, D., Silverberg, R., & Clark, C. J. (2020). Moderators of treatment efficacy in a randomized controlled trial of trauma-sensitive yoga as an adjunctive treatment for posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(8), 836–846. https://doi.org/10.1037/tra0000963

Oke, M. (2008). Remaking self after domestic violence: Mongolian and Australian women's narratives of recovery. *Australian and New Zealand Journal of Family Therapy (ANZJFT)*, *29*(3), 148–155. https://doi.org/10.1375/anft.29.3.148

Orang, T., Ayoughi, S., Moran, J. K., Ghaffari, H., Mostafavi, S., Rasoulian, M., & Elbert, T. (2018). The efficacy of narrative exposure therapy in a sample of Iranian women exposed to ongoing intimate partner violence-a randomized controlled trial. *Clinical Psychology & Psychotherapy*, *25*(6), 827–841. https://doi.org/10.1002/cpp.2318

Pargament, K., (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred.* Guilford Press.

Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology*, *6*. doi.org/10.3389/fpsyg.2015.00093

Peltonen, K., & Kangaslampi, S. (2019). Treating children and adolescents with multiple traumas: A randomized clinical trial of narrative exposure therapy. *European Journal of Psychotraumatology*, *10*(1), 1558708. doi.org/10.1080/20008198.2018.1558708

Pennebaker, J. W., & Beall, S. K. (1986). Confronting a traumatic event: Toward an understanding of inhibition and disease. *Journal of Abnormal Psychology*, *95*(3), 274–281. doi.org/10.1037/0021-843x.95.3.274

Richman, S. (2002). *A wolf in the attic: The legacy of a Hidden Child of the Holocaust*. Hawthorne Press.

Richman, S. (2006). Finding one's voice: Transforming trauma into autobiographical narrative. *Contemporary Psychoanalysis, 42*(4), 639-650. 10.1080/00107530.2006.10747136

Richman, S. (2009). Secrets and mystifications: Finding meaning through memoir. *Psychoanalytic Perspectives*, *6*(2), 67–75. doi.org/10.1080/1551806x.2009.10473055

Ruini, C., & Mortara, C. C. (2022). Writing technique across psychotherapies—from traditional expressive writing to new positive psychology interventions: A narrative review. *Journal of Contemporary Psychotherapy*. *52*, 23–34. doi.org/10.1007/s10879-021-09520-9

Sagi, B. (2021). “Only when it’s written here”: Personal writing as testimony in the aftermath of childhood sexual abuse. *Journal of Poetry Therapy*, *34*(3), 150–163. doi.org/10.1080/08893675.2021.1921475

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2021). Developmental trauma disorder: A legacy of attachment trauma in victimized children. *Journal of Traumatic Stress, 34*(4), 711–720. doi.org/10.1002/jts.22697

Spinazzola, J., van der Kolk, B., & Ford, J. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress, 31*(5), 631–642. doi.org/10.1002/jts.22320

Springer, W. (2006). Poetry in therapy: A way to heal for trauma survivors and clients in recovery from addiction. *Journal of Poetry Therapy, 19*(2), 69–81. doi.org/10.1080/08893670600756632

Uy, K. K., & Okubo, Y. (2018). Re-storying the trauma narrative: Fostering posttraumatic growth in Cambodian refugee women. *Women & Therapy, 41*(3-4), 219–236. doi.org/10.1080/02703149.2018.1425025

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

van der Kolk, B., Hodgdon, H., Gapen, M., Musicaro, R., Suvak, M., Hamlin, E., & Spinazzola, J. (2016). A randomized controlled study of neurofeedback for chronic PTSD. *PLOS ONE, 11*(12). doi.org/10.1371/journal.pone.0166752

van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder. *The Journal of Clinical Psychiatry*, *75*(06). doi.org/10.4088/jcp.13m08561

Vaughn, M. & Swanson, K. (2006). "Any life can be fascinating": Using spiritual autobiography as an adjunct to therapy. In K. B. Helmeke & C. F. Sori (Eds.), *The therapist's notebook for integrating spirituality in counseling: Homework, handouts, and activities for use in psychotherapy*. (pp. 211-219). The Haworth Press.

Warner, E., Spinazzola, J., Westcott, A., Gunn, C., & Hodgdon, H. (2014). The body can change the score: Empirical support for somatic regulation in the treatment of traumatized adolescents. *Journal of Child & Adolescent Trauma*, *7*(4), 237–246. doi.org/10.1007/s40653-014-0030-z

Wiggins, M. I. (2011). Spiritual Journaling. In J. D. Aten, M. R. McMinn & E. L. Worthington (Eds.), *Spiritually Oriented Interventions for Counseling and Psychotherapy* (pp. 303-318). American Psychological Association. dx.doi.org/10.1037/12313-012