Expressive writing therapy for victims of trauma

Case study from Gaza

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Summary : As writing appears to have many benefits, the future of writing and workbooks needs to be explored further. It is still unclear how effective writing may be in a more naturalistic setting. A more studies using such technique compared to other sort of therapy for traumatized children will highlight the efficacy of such intervention in areas of war and conflict.

All types of therapy mentioned before are (debriefing, verbal narrative therapy, or CBT) had similarities in dealing with cognitive functions of the children and tried to help children in overcoming their adversities and trauma after exposure to traumatic events by developing coping strategies. But, such types are different in number of sessions, presence of children in safe place, and experience of the therapist which could influence the outcome of such therapy.

So, such therapy need to be developed for children in the near future (e.g. techniques, structure of sessions, training for therapists, where it could be used, etc) and how this should be best evaluated.

Introduction: Psychological treatment for PTSD in children

There are very few randomized controlled trials of any therapy with children, let alone therapies specifically for PTSD. Early intervention is attractive if it could be shown that it prevented later development of PTSD or other disorders but, as with adult studies, there have been few published properly controlled trials of any early intervention. Many of these programs have been defined as variations of 'debriefing' (critical incident stress or psychological) and 'trauma/grief-focused' therapy, although these terms have been used for different types of interventions (Dyregrov, 1999). In all early intervention the first and foremost principle is to ensure that the child feels safe and secure, while secondly making sure that he or she is provided with information and clarification about what happened and the state of family members and friends.

However, a number of studies have described or evaluated different models of interventions for PTSD among children who had suffered abuse, experienced natural disasters, or exposed to community violence. These predominantly adopt psychodynamic or cognitive therapeutic frameworks, and a variety of techniques, with the broad aim of enabling the child to make links between trauma, emotions and beliefs, which can subsequently be challenged and modified. These have been designed for the classroom, the family, the individual child, or a group of children exposed to similar events (Pynoos R, Nader K. , 1988).

Debriefing interventions have not been as well evaluated with children as with adult victims of trauma. Galante and Foa (1986) developed a seven-session group treatment program for children living in Italian villages, who had been exposed to an earthquake. The treatment aimed at facilitating communication, discussion of fears, myths and beliefs, discharge of feelings, and empowerment in building their future. Drawing, story-telling, and role-play were used. The program was found to reduce both earthquake fears and the number of children at risk of developing emotional and behavioural problems. A similar trauma and grief-focused school-based program, consisting of four group and two individual sessions, following an earthquake in Armenia, led to improvement in PTSD but not depressive symptoms (Goenjian et al, 1997). A ten-session group therapy model for adolescent survivors of homicide set up goals of providing grief education, facilitating thoughts and feelings about grief, and reducing traumatic symptoms (Salloum et al, 2001). The Critical Incident Stress Debriefing (CISD) is a structured group program, which has been widely used in disaster counseling, predominantly with adults, with positive findings (Campfield K & Hills, 2001).

Cognitive-behavioural interventions, mainly in group settings, have been associated with decrease in PTSD symptoms among children who experienced single incident stressors (March et al, 1998). King et al. (2000) studied 36 sexually abused children aged 5–17 years who met criteria for PTSD. There were 12 children in each of 3 conditions: CBT with child and family; CBT with child alone; waiting list control. Treatment conditions consisted of 20 sessions. Using ADIS-C to assess PTSD, there was a significant improvement on PTSD ($p < .05$) as well as on self reported anxiety scales. Both ways of delivering CBT were equally effective compared to the control group.

Cohen et al. (2004) showed that Trauma Focuse-Cognitive Behaviour Therapy reduced PTSD, depression and total number of behavioural problems compared to a child-centred treatment for sexually abused children. The Trauma Focuse-Cognitive Behaviour Therapy included training in expressive techniques, understanding of the relation between thoughts, feelings and behaviour, gradual exposure, cognitive processing of the event, joint sessions between parents and children, psychoeducation about sexual abuse or training of parents in parent management skills. The child centred treatment emphasised building a strengthening trusting relationship before children and parents themselves chose how and if they wish to approach the sexual

abuse. The therapist was actively listening, reflecting, showed empathy and supported them in talking about feelings and showed confidence in the children's and adult's coping strategies. Although the work was client centred, written psychoeducative information about sexual abuse was provided and during two sessions the children were prompted to share their feelings about the sexual abuse

Eye movement desensitization and reprocessing (EMDR) is a more recently described intervention, during which the child identifies distressing memories, related imageries and sensations, and trauma-related negative self-cognitions, which are linked to eye movements, before being reprocessed into positive cognitions (Rogers S, Silver S , 2002).

Group psychosocial support and basic medical care had a superior effect on internally displaced mothers' and children's mental health in post-war Bosnia and Herzegovina (Dybdahl, 2001).

Chemtob, Nakashima and Carlson (2002) found that three treatment sessions resulted in substantial reduction of PTSD, anxiety and depressive symptoms in children with prolonged psychopathology, following exposure to a hurricane in Hawaii one year earlier, compared with waiting list controls. There has been even more limited evidence on the application of such programs in children who experienced war trauma.

Thabet & Vostanis (2005) in a study to evaluate the short-term impact of a group crisis intervention for children aged 9-15 years from five refugee camps in the Gaza Strip during ongoing war conflict. Children were allocated to group intervention (N=47) encouraging expression of experiences and emotions through story telling, drawing, free play and role-play; education about symptoms (N=22); or no intervention (N=42). Children completed the CPTSD-RI the CDI pre- and post-intervention. No significant impact of the group intervention was established on children's posttraumatic or depressive symptoms. Possible explanations of the findings are discussed, including the continuing exposure to trauma and the non-active nature of the intervention.

There is a long standing tradition among torture survivors in South America to write testimony that both helps them express their reactions and acts as a record of what happened to them. More recently using narrative technique is increasingly incorporated in cognitive behavioural therapy with adults (Neuner & Elbert, 2005). Treatment for adult war victims and refugees such as testimony psychotherapy (Weine et al, 1998) could be also applied with children. A recently developed psycho educational treatment program includes cognitive-behavioural techniques and various activities to help children develop coping strategies in the aftermath of war, in order to prevent the need for later treatment (Smith et al, 2002). This raises the question whether psychological programs can be used for children exposed to trauma, *during* (rather than *after*) ongoing war conflict, i.e. set up as crisis interventions while the trauma continues.

In the therapy process of children affected by stress and trauma, the process of disclosing about stressful or painful traumatic events is often considered essential. One such manner is through expressive writing about stressful or traumatic experiences. Expressive writing is related to improvements in health and well-being, across a wide array of outcomes and participant characteristics. As expressive writing requires limited involvement of other individuals, is relatively low cost, and portable, it has tremendous potential as self-help. In particular, this type of intervention may be an effective means to reach populations unwilling or unable to engage in psychotherapy.

In this paper I will try to explain the origin of writing expressive therapy and examine the efficacy of such therapy generally in adults and specifically in children because few studies had been conducted for this type of therapy for traumatized children in area of continuous conflict and war.

Mechanisms of action of expressive writing for recovery from trauma

There was a question why is expressive writing beneficial? Researchers had hypothesized that its benefits were due to participants being able to circumvent the personal and social constraints preventing them from disclosing their thoughts and emotions regarding traumatic experiences. By not disclosing, participants were forced to actively inhibit their thoughts and emotions surrounding the traumatic event. Disclosing about the stressful or traumatic event was thought to reduce the negative influences of inhibition (e.g., disinhibit) and therefore reduce the risk of illness. Perhaps surprisingly, the notion that the effect of writing is due to the reduction in inhibition has received little support from research. Inhibitory personality styles are not reliably related to the benefits of disclosure (Smyth and Helm,2003)

Additionally, writing about traumatic events that have been previously disclosed does not appear to have different health benefits than writing about traumatic events that have not been disclosed (Greenberg & Stone, 1992). Another very interesting study developed by Greenberg, Vortman, and Stone (1996) found that writing about an imagined trauma can provide health benefits. The authors suggest that perhaps the act of confronting an emotion, real or imagined, and being able to control it, leads to increased affective regulation (i.e. clients see themselves as able to handle intense and challenging emotional experiences .

In attempt to further quantify the efficacy of the expressive paradigm with clinical populations, Frisina, Borod, and Leopre (2004) conducted meta-analysis similar to Smyth (1998) that examined the results of true experimental; design studies done with clinical populations (i.e., PTSD, severely depressed, cancer, arthritis). After meta-analysis of 9 studies (including Kovac and Rang, 2000; Schoutrop et al, 2002; Stanton et al, 2002), the authors found expressive writing to significantly improve health. However, they found the paradigm to be more effective on physical than psychological outcomes and less robust on clinical populations when compared to health ones.

Expressive writing may promote alterations in memory structure, making the memory more coherent and organized (Smyth & Greenberg, 2000). Research suggests that the reorganization of the traumatic memory into a narrative may be a critical factor in expressive interventions for traumatized individuals (DeSavino et al., 1993) and for expressive writing more generally (Smyth, True, & Souto, 2001). However, research suggests that merely writing about an event may not be sufficient to produce benefit. Rather, the writing may need to be narrative in format (Smyth et al., 2001).

Pennebaker (1990, 2004) has long demonstrated that writing about emotional events can have very positive effects. Neuner et al. (2004) have developed their narrative exposure therapy technique (NET) and used it in an Rehabilitation Center for Torture with adult refugees in the Sudan. The treated group made significant improvements.

The technique is now being used in a series of smaller studies with children (Schauer et al., 2004). Yule et al (2005) adapted the writing/testimony/narrative approach for use with groups of adolescents exposed to or bereaved through war and disaster and found benefit for those adolescents.

No evidence so far of use of this therapy with children. This would need adapting for children's development such as cognitive capacity, understanding, and communication.

Expressive writing case illustration

Presenting problem/client description of a child from Gaza Strip

Khalid was a 10-year-old boy, in the third primary class, with three siblings. Khalid was presented with a diagnosis of posttraumatic stress disorder (PTSD) (IES-13 items- 53 scores) resulting from exposure to shelling and bombardment of their area in Gaza. Khalid came with other symptoms of reexperiences of traumatic events, hyperarousal, avoidance, and fears of being killed, and fear on his brothers to extend he behave aggressively of anyone of them leave the house.

Case formulation

Khalid was referred to GCMHP by his family; he was conceptualized as having PTSD and phobia exacerbated by recent traumatic experiences such as witnessing bombardment of the area, shelling of the houses, recurrent incursion. Our primary therapeutic goals were to promote cognitive and emotional processing regarding his past and current trauma, reduce intrusions, fears, and the negative affect associated with thoughts of the traumatic events. After the initial assessment of the child we decided to intervene by individual psychotherapy using drawings, talking about the traumatic experiences he had and his ways of coping with such events. Beside we decided to start a new method of therapy "expressive writing" which consisted of 6 sessions of writing. Each writing session was conducted for 15 minutes with 10 minutes break. Each week he had 2 sessions of writing beside the break of 10 minutes. In the first session, I asked the child to write about his deepest emotions and thoughts about the trauma. What he saw and felt, and what he remember. The he put his paper in a small box and had a break for 10 minutes. The second session for the first day, Khalid was asked to explore his thoughts and feelings and write about all the ways he remember the trauma-sights, sounds, smells, memories, thoughts, and dealings. In the second day, the first session was about his family or other powerful emotions or experiences he have not told others about. Then he was asked to finish in 15 minutes and put his papers in the box again and to go for a break for 10 minutes. In returning for the second session, Khalid was asked to write a story about what happened to him and what he did to help him in surviving. Again he was asked to write about he remember about the trauma. Again when he finished, he put his papers in the box and I told him "*by putting the papers with your writing in the box as you had left the bad feelings and thought off your shoulder*". In the third day, I told him that "*this the last day of the project. Over the last two days , you wrote about your thoughts and feelings about a very difficult event in your life*". Today, we will be focusing on other aspects of these events. I asked him to think about other persons who has gone through a similar event, what to say that person about what helped him to overcome this trauma. He was given 15 minutes to finish writing about this and then to put the papers in the box. After 10 minutes break, I asked him to write about the imagination on being 10 years from now and he is looking back to this moment. How he will think about the event? What does it mean to him now and what do he think he will see as the most important part when he look back on it in ten years time. After finishing the writing he was asked to put the papers in the box. I told him " It may have been hard for you to write over these days you may already have learned that the writing about you experiences you have organised your story better. You can use on your own at any time in the future. Remember to leave all these feelings and memories behind you put please keep the pencil just to remind you of the new skills you have learned.

Outcome and Prognosis

Upon completion of the sessions, Khalid felt that the writing had been very helpful and valuable to him. He reported that he felt more “peaceful” and that he was
optimistic about his brothers safety and future. When evaluated one 2 months later, Khalid reported improved fears, better sleep, and reductions in anxiety symptoms.

References

. Campfield, K.,& Hills, A. (2001). Effect of timing of critical incident stress debriefing (CISD) on posttraumatic symptoms. Journal of Traumatic Stress, 14, 327-340.

. Chemtob, C., Nakashima, J., & Carlson J .(2002). Brief treatment for elementary school children with disaster-related posttraumatic stress disorder. Journal of Clinical Psychology, 58, 99-112.

. Cohen, J.A., Deblinger, E., Mannarino, A.P., & Steer, R.A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 393–402.

. DeSavino, P., Turk, E., Massie, E., Riggs, D., Penkower, D., Molnar, C., & Foa, E. (1993, August). The content of traumatic memories: Evaluating treatment efficacy by analysis of verbatim descriptions of the rape scene. Paper presented at the 27th annual meeting of the Association for the Advancement of Behavior Therapy, Atlanta.

. Dybdahl, R (2001). Children and mothers in war: an outcome study of a psychosocial intervention program. Child Development, 72,1214-1230

. Dyregrov, A .(1999). Helpful and hurtful aspects of psychological debriefing groups. International Journal of Emergency Mental Health,1, 175-181.

. Frisina, P.G., Borod, J.C., & Lepore, S.J. (2004). Ameta-analysis of the effects of written emotional disclosure on the health outcomes of clinical population. The Journal of Nervous and Mental Disease, 192 (9) 629-634.

Kovac, S.H. & Range, L.M. (2002). Does writing about suicidal thoughts and feelings reduce them? Suicide and Life-Threatening Behavior, 32 (4), 428-440.

. Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. Journal of the American Academy of Child Psychiatry 25: 357-363.

. Goenjian, A., Karayan, I., Pynoos, R., Minassian, D., Najarian, L., Steinberg, A., & Fairbanks, L. (1997). Outcome of psychotherapy among early adolescents after trauma. American Journal of Psychiatry, 154, 536-542.

. Greenberg, M.A., & Stone, A.A. (1992). Emotional disclosure about traumas and its relation to health: Effects of previous disclosure and trauma severity. Journal of Personality and Social Psychology, 63, 75–84.

. Greenberg, M.A., Wortman, C.B., & Stone, A.A. (1996). Emotional expression and physical health: Revising traumatic memories or fostering self-regulation? Journal of Personality and Psychology, 71 (3), 588-602.

. King, N.J., Tonge, B.J., Mullen, P., Myerson, N., Heyne, D., Rollings, S. et al. (2000). Preventive intervention for maltreated preschool children: Impact on children’s behavior, neuroendocrine

activity, and foster parent functioning. Journal of the American Academy of Child Psychiatry, 39, 1347–1355.
. Lepore, S., & Smyth, J. (2002). The writing cure: How expressive writing promotes health and emotional well-being. Washington, DC: American Psychological Association.
. Neuner, F., Schauer, M., Klasnick, C., Karunkara, J., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. Journal of Consulting and Clinical psychology, 72, 579-587.
. Pennebaker, J.W. (1990). Opening up. The healing power of confiding in others. New York: William Morrow.
. Pennebaker, J.W. (2004). Theories, therapies, and taxpayers: On the complexities of the expressive writing paradigm. Clinical Psychology: Science and Practice, 11, 138–142.
. Perrin, S., Smith, P., &Yule, W. (2000). The assessment and treatment of posttraumatic stress disorders in children and adolescents. Journal of Child Psychology and Psychiatry, 41, 277-289.
. Pynoos, R.,& Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: research implications. Journal of Traumatic Stress, 1, 444-473.
. Rogers, S., & Silver, S. (2002). Is EMDR an exposure therapy? A review of treatment protocols. Journal of Clinical Psychology, 58, 43-59.
. Salloum, A, Avery, L.& McClain, R (2001) Group psychotherapy for adolescent survivors of homicide victims. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1261-1267.
. Schoutrop, M.J., Lange, A., Hanewald, G., & Davidovich, U. (2002). Structured writing and processing major stressful events: A controlled trial. Psychotherapy and Psychosomatics, 71, 151-157.
. Smyth, J.M., & Greenberg, M.A. (2000). Scriptotherapy: The effects of writing about traumatic events. In J. Masling & P. Duberstein (Eds.), Psychodynamic perspectives on sickness and health (pp. 121–164). Washington, DC: American Psychological Association.
. Smith, P., Dyregrov, A., Yule, W. (2002) Children and war: teaching survival techniques. Children and War Foundation, Bergen.
. Smyth, J .M. (1998). Written emotional expression: effect size, outcome types, and moderating variables. Journal of Consulting and Clinical Psychology, 66 (1), 174-184.
. Smyth, J.M., True, N., & Souto, J. (2001). Effects of writing about traumatic experiences: The necessity for narrative structuring. Journal of Social and Clinical Psychology, 20, 161–172.
. Smyth, J., & Helm, R . (2003). Focused Expressive Writing as Self-Help
. for Stress and Trauma. Psychotherapy in Practice, 59(2), 227–235.
. Stanton, A.L., Danoff-Burg, S., Sworowski, L.A., Collins, C.A., Branstetter, A.D., Rodriguez-Hanley, A., et al. (2002). Randomized, controlled trial of written emotional expression and benefit finding in breast cancer patients. Journal of Clinical Oncology, 20 (20), 4160-4168.
. Thabet, A.A., Karim, K., & Vostanis P . (2005). Group crisis intervention for children during ongoing war conflict. European Child and Adolescent, Psychiatry, 14, 262-269.
. Yule, W., Dyregrov, A., Neuner, F., Pennebaker, J., Raundalen, M., Emmerik, A. (2005). Writing for Recovery, A manual for structured writing after disaster and War. Children and War Foundation, Bergen, Norway.
. Weine, S., Kulenovic, A., Pavkovic, I., Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees. American Journal of Psychiatry, 155, 1720-1726.

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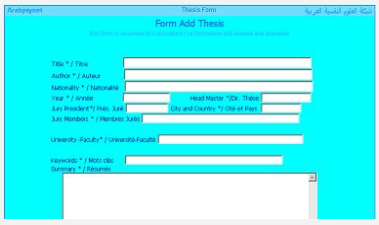

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