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Claire Creely

Lesley University, cceely@lesley.edu

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Running Head: THE EFFICACY OF JOURNAL WRITING TOWARDS POST-TRAUMATIC
GROWTH

The Efficacy of Journal Writing in Assisting Survivors of Sexual Trauma towards Post-Traumatic

Growth

Capstone Thesis

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Claire Creely

Expressive Arts Therapy

Kelvin Ramirez, PhD, LCAT, ATR-BC

Abstract

Along with a cultural shift in the United States to advocate against sexual assault, there is an increase in literature suggesting clinical interventions to promote transformation following trauma by sexual assault. Historically, research and clinical application has focused on post-traumatic stress disorder, but there is an increase in literature that encourages clinical intervention following trauma to encourage survivors to intercept symptoms of post-traumatic stress and transform their experience into post-traumatic growth. Journal writing therapy may be an efficient, evidence-based therapeutic technique for encouraging this transformation towards post-traumatic growth. A review of the literature on writing therapy practice and post-traumatic stress disorder was used to compare and expand upon available literature on journal therapy and post-traumatic growth. Journal writing assists by decreasing symptoms of post-traumatic stress and promotes a context for post-traumatic growth to occur. Journal writing can be applied to target specific indicators of PTG, including increased social interest, finding meaning in life, and coping skills. Through identifying specific coping skills, reflecting to identify meaning of the traumatic experience, and providing exposure to the trauma, journal therapy encourages transformation through emotional disclosure and present insight.

Keywords: journal therapy, writing therapy, post-traumatic stress, post-traumatic growth, sexual assault

The Efficacy of Journal Writing in Assisting Survivors of Sexual Trauma towards Post-Traumatic
Growth

Introduction

The prevalence of sexual assault is not only culturally relevant in the United States, but also significant to an individual's cognitions, behaviors, and interaction in society. Most recently, the social media movement, Me, Too, in October 2017 catalyzed a widespread proclamation of those affected by sexual abuse to emphasize the numbers and diversity of people affected. The movement started when actress Alyssa Milano posted to social media a status asking people who had experienced sexual abuse to post the words "me, too." Within 24 hours, Twitter confirmed that the status had been reposted half a million times, and weeks following showed the spread of the movement across several social media and news platforms. A similar movement called "Time's Up" also used social media and written, socially shared expression to identify sexual harassment as well as advocate how to systematically end it. The Me Too and Time's Up movements are only two examples in recent history in which the survivors who participated used written proclamations on a public platform to express their experiences. These expressions on social media may only represent a small portion of the population affected by sexual abuse and subsequent trauma, though have proven significant examples in how written expression of traumatic experience have unified people otherwise isolated in community and action. The movements exemplify the common themes of silence, shame, and isolation associated with sexual trauma, and suggests the solution of finding community, creating interpersonal connections, and using a different medium to express and speak out.

There is a significant difference between verbally speaking to an audience about trauma and using writing as a modality to express one's experience with trauma (Van Emmerik, Kamphuis, and Emmelkamp, 2014). Writing therapy may be the strongest form of therapy that helps survivors of trauma acknowledge and move on from their trauma (Van Emmerik et al., 2014). Writing therapy is not a novel approach to recovering from post-traumatic stress disorder (Stepakoff, 2004). Journal therapy more specifically as a form of writing therapy takes narration of the traumatic experience a step further by shifting the survivor's relationship to trauma in a way that cuts through avoidance and distance from the trauma (Keenan, Lumley, and Schneider, 2014). While there is evidence supporting the efficacy of forms of writing therapy to assist individuals towards recovery from post-traumatic stress disorder, there is more recently an emerging field of research focusing more specifically on post-traumatic growth as opposed to post-traumatic stress disorder (Keenan et. al, 2014). By focusing on the strengths and character changes that a person may experience through trauma, writing therapy practices can support an individual survivor to avoid symptoms of post-traumatic stress disorder and approach their experience more directly and effectively.

Journal writing as a specific writing intervention addresses the themes of both post-traumatic stress disorder, or PTSD, and post-traumatic growth, or PTG, by offering a canvas to transform silence to words, isolation to interpersonal connection, and shame to practiced, concrete expression and transformation. Clinicians who are working within a current medical climate that focuses more on pathology than healing have the potential to reframe their focus when working with trauma survivors to encourage a more positive context for growth. This capstone thesis explores the efficacy of journal writing as a writing therapy option in supporting survivors of sexual trauma towards post-traumatic growth.

Literature Review

PTSD Following Sexual Assault

In order to understand the need to pursue research on effective interventions for post-traumatic stress disorder following sexual assault, it is important to understand the significance of sexual assault and PTSD in current society. Every 98 seconds, an American is sexually assaulted (Rape, Abuse, & Incest National Network [RAINN], 2018). Sexual assault can affect any age or gender and is defined as a sexual activity between two or more people that occurs against one of the person's will. To clarify the language often used to discuss sexual assault, sexual violence differs in definition from sexual assault. Distinguishing the two provides a clearer understanding of which traits of the traumatic experience may correlate with PTSD symptoms. Sexual violence is a more inclusive phrase that includes non-physical acts as well, including stalking behaviors. Sexual assault, which specifically involves sexual coercion and touching behaviors, is one of the most likely traumas to lead to PTSD (Kessler, 2000; Ozer et al., 2003, in Shors & Millon, 2016).

Individuals can be forced into a sexual activity through physical or non-physical forces. Most sexual assault happens between two people who have an existing relationship, with a reported 76% of sexually assaulted women being attacked by a current or former partner or friend, and 18% by strangers (Tjaden & Thoennes, 1998, in "PTSD: National Center for PTSD," 2016). The sensitive nature of reporting assaults does not lead to accurate statistics for how prevalent assault is amongst people; however, studies show that people ages 12-34 are at highest risk in the United States for sexual assault, and that one in every six women and one in every thirty-three men have experienced sexual assault in their lifetime. Twenty-one percent of transgender students have experienced sexual assault, as opposed to 18% of cisgender females

and 4% of cisgender males. Statistics collected by RAINN (2018) documented that one in 10 sexual assault survivors was male. As evidenced, sexual assault is prevalent across demographics, and is a concern that if addressed can benefit individuals and present-day American society.

Some initial reactions following a sexual assault include experiencing intense or unpredictable emotions, repeated memories or nightmares of the event, difficulty concentrating or sleeping, and feeling jumpy or on edge (“PTSD: National Center for PTSD,” 2016). Some more extreme symptoms that may follow the event include numbness, detachment, difficulty in recalling key parts of the assault, reliving the event through repeated thoughts or nightmares, avoidance, anxiety, and increased arousal (“PTSD: National Center for PTSD,” 2016). Rothbaum, Foa, Riggs, Murdock, and Walsh (1992) found that 94% of women who were raped reported symptoms that merited a diagnosis of PTSD in the two weeks following the traumatic experience. A person who experiences these symptoms immediately after the traumatic event and up to a month following may be diagnosed with Acute Stress Disorder (ASD). The DSM-5 criteria for ASD requires individuals to experience those symptoms immediately after the traumatic event and up to a month following (American Psychiatric Association [APA], 2013). The extended duration of a month or more after a traumatic event may indicate that the individual may be suffering from PTSD.

According to the DSM-5, post-traumatic stress disorder is a trauma and stressor related disorder that can develop after an individual is exposed to a traumatic event. The 5th edition of the DSM distinguishes PTSD in a new category of Trauma-and Stressor- Related Disorders. All conditions included in this category require exposure to a traumatic or stressful experience in order to be diagnosed with a trauma- or stressor- related disorder. Post-traumatic stress disorder

differs specifically because an individual must report exposure to trauma, re-experiencing the trauma, avoidance of trauma-related stimuli, negative thoughts or feelings that began or worsened after traumatic experience, and trauma-related reactivity and arousal that began or worsened after traumatic experience, as well as report that these symptoms last more than a month following the traumatic experience, that the symptoms create distress or functional impairment, and that symptoms must not be due to medication, substance use, or illness (APA, 2013). While the DSM-5 does not explicitly include features in its definition of trauma that make a sexual assault traumatic, sexual assault can be understood as trauma by considering trauma as “1.) the nature of the event itself, 2.) the person’s subjective experience of it, and 3.) the physical and emotional response to it” (McNally, 2005, in Shors and Millon, 2016). Post-traumatic stress disorder reportedly affects 8 million Americans, can occur at any age, and tends to be more prevalent in women (Psychology Today, 2017). The National Women’s Study reports that almost one third of rape survivors suffer from PTSD (“PTSD: National Center for PTSD,” 2016). Co-morbid issues that may accompany PTSD in sexual assault survivors include anger, shame, guilt, social problems, sexual problems, substance use, major depressive disorder (MDD), and suicidal ideation, with a recorded 13% of rape survivors attempting suicide (“PTSD: National Center for PTSD,” 2016).

While there is no consistent way for an individual to respond after experiencing a sexual assault, there is a high likelihood of experiencing one or more of these symptoms, especially PTSD. It is also difficult to predict how long these symptoms will manifest, and how often they may reoccur over one’s lifetime. Several scholars are searching for correlations between resiliency and PTSD, as well as other factors that may indicate an individual’s reaction to PTSD (for example see, Lancaster, Klein, & Heifner, 2015; Grad & Zeligman, 2017; & Blanchard,

2013). If a person can cultivate resiliency, they may not only have a greater chance of counteracting the mentioned common symptoms that follow a sexual assault, but they may be able to experience post-traumatic growth, or PTG. This capstone thesis is intended to highlight the process of recovery through journal writing to provide some preliminary understanding in the transformation from trauma to post-traumatic growth.

The susceptibility of an individual to develop post-traumatic stress disorder are at the root of fostering post-traumatic growth. If so, perhaps these traits can be focused on in the recovery process and used to reshape into PTG. Shelvin, Hyland and Elklit (2014) tested whether ASD can be a valid predictor of PTSD. Acute Stress Disorder was introduced to the DSM-IV to differentiate immediate responses after trauma from PTSD, as well as to identify trauma survivors who were at high risk for developing PTSD (Shelvin et al., 2014). However, ASD is not a general predictor for PTSD, as several studies show that “an ASD diagnosis fails to identify more than half of all individuals who subsequently develop PTSD” (Shelvin et al., 2014). Over half of people who develop PTSD did not show symptoms of ASD in their first month following the trauma, and ASD only serves as a modest predictor of PTSD.

In order to more accurately observe correlations between ASD and PTSD and perhaps predict PTSD, Shelvin et al. (2014) subcategorized ASD into four groups with distinguishing differences in severity of symptoms. They used data from a large sample of female sexual trauma victims and used latent profile analysis to identify groups that share similar symptom profiles. Participants were female rape victims who contacted the Center for Rape Victims at the University Hospital of Aarhus, Denmark between 2002 and 2012. The Center offers help to victims who contact them within 30 days after being raped. Participants provided information and were assessed two weeks following their initial contact with the Center, and three months

following. Shelvin et al., (2014) identified the four subgroups as high ASD, low ASD, Intermediate, and low-avoidance – high-arousal. The traits that were measured for each group were disassociation, re-experiencing, avoidance, and arousal. Each of the subcategories were formed based on their patterns of experiencing certain clusters of these symptoms. Those in the high ASD group experienced high levels of all four symptoms, and were the largest group, accounting for over half of the total sample. The low ASD group comprised the smallest group and were identified as those who experienced all four symptoms of ASD at low levels. The Intermediate group displayed moderate levels of disassociation, re-experiencing, and arousal, without qualifying for the diagnosis of ASD. The low-avoidance – high-arousal group similarly displayed moderate levels of disassociation and re-experiencing, low avoidance, and very high levels of arousal symptoms. Participants in the high ASD group had a 70% probability of later developing PTSD, while those in the low ASD group had a low probability of developing PTSD. Individuals in the Intermediate group had a 25% chance of developing PTSD, and individuals in the low-avoidance – high-arousal group had a 49% chance of developing PTSD. The findings suggested that “although individuals in each of the two intermediate classes experience very similar overall levels of distress, a person’s risk of later developing PTSD is doubled if they report experiencing high levels of arousal” (Shelvin et al., 2014).

This study suggested that, though ASD may not be a statistically accurate way to predict a person developing PTSD due to the different variations of the disorder, that focusing on the variations, especially arousal symptoms, might be a more accurate predictor. Another predictor found was age, and that those who reported assault occurring at younger ages were more likely to develop PTSD (Brewin, Andrews, & Valentine, 2000, in Shelvin et al., 2014). Shors and Millon (2016) also discussed how sex plays a role in responses to stress, referencing studies of

the role of the hippocampus in response to stressful situations. They supported that “exposure to the stressful event that impairs learning in females actually enhances learning in males” (Shors & Millon, 2016). While it is still unclear why PTSD is more prevalent in females than in males, differences in response to stress and trauma by sex may be related to the different “stress responses that occur during the trauma, which are modulated at the time of trauma by ongoing hormonal systems to impact engaged brain circuits related to learning and memory in the future” (Shors & Millon, 2016). Other areas of the brain that are affected by trauma beyond the hippocampus are the amygdala, insula, and the prefrontal cortex (Fonzo et al., 2010; Bruce et al., 2012; Simmons et al., 2008; Bryant et al., 2008; in Shors & Millon, 2016).

While there are many variations of personal profiles that experience PTSD, it can be argued that age, sex, certain brain functions, and levels of ASD symptoms, especially high levels of arousal, may be indicators for the probability of developing PTSD. Those who experience sexual trauma at a younger age, are female, have a smaller hippocampal volume (Gilbertson et al., 2002; Pitman, 2001; in Shors & Millon, 2016), and experience some of the ASD symptoms with high levels of arousal symptoms, may be more vulnerable to developing PTSD. However, PTSD does occur in individuals who do not experience these traits, and there is still not enough evidence in studies to fully predict the onset of PTSD. With these highlighted traits, though, one might transition to consider how these traits may be altered to transition from PTSD to PTG.

Post-Traumatic Stress Disorder and Post-Traumatic Growth

Post-traumatic growth (PTG) is defined as positive psychological change that can occur after trauma. While there is still a lack of integration in the field of psychology when it comes to naming and defining PTG, the most accepted model of PTG is proposed by Tedeschi and

Calhoun (2004), in which PTG occurs in the following five life domains: appreciation for life, positive social relationships, personal strength, spirituality, and new possibilities (Grad & Zeligman, 2017). Trauma survivors have reported “at least one positive change after traumatic events, the most frequently reported being stronger and more intimate interpersonal relationships” (Helgeson, Reynolds, & Tomich, 2006; Sawyer, Ayers, & Field, 2010; in Grad & Zeligman, 2017). One meta-analysis of 87 cross-sectional studies concluded that PTG resulted in lower levels of depression and higher levels of well-being following trauma (Helgeson et al., 2006; in Grad & Zeligman, 2017). Post-traumatic growth clearly is the desired outcome as opposed to PTSD following trauma, especially considering the cognitive, social, behavioral, and emotional symptoms that accompany PTSD. In the following section, I will continue to outline examples in research of how PTG connects to PTSD, and how PTG can be encouraged following trauma.

One method of understanding how humans respond to stressful life events is through the lens of Individual Psychology. Adler (1938/ 1998) reported that “individuals respond to life’s problems depending on their levels of social interest, and in their response they reveal their own personal interpretation of the meaning of life” (in Grad & Zeligman, 2017). Adlerian scholars include in the four major tasks of life: love, friendship, work, and finding meaning in life. As sexual trauma can affect an individual’s response to love, friendship, and work through the different symptoms of PTSD and ASD, perhaps the most detrimental symptom of trauma is the “erosion of a person’s sense of purpose and meaning in life” (Solomon, 2004; in Grad & Zeligman, 2017). Theorists suggested that a person’s sense of meaning in life, as well as social interest, are significant indicators of mental health, as low levels of meaning and social interest correlate with hopelessness, depression, hostility, anxiety, perceived life stress, anxiety,

pathology, and substance abuse (Miller, Denton, & Tobacyk, 1986; Newbauer & Stone, 2010; Kim, Noh, & Oh, 2007; Fish & Mozdierz, 1991; Keene & Wheeler, 1994; in Grad & Zeligman, 2017).

Social interest was defined by Adler as “a feeling of community, an orientation to live cooperatively with others, and a lifestyle that values the common good above one’s own interests and desires” (Guzick, Dorman, Groff, Altermatt, & Forsyth, 2004; in Johnson & Smith). Levels of social interest can be used to predict an individual’s psychological health and adjustment (Ansbacher, 1968/1991; Manaster, Zeynep, & Knill, 2003; in Johnson & Smith). One way to predict and foster the development of social interest is through an open, empathetic, and expressive family dynamic. Johnson, Smith, and Nelson (2003) found that young adults who identify with experiencing family cohesion and expressiveness with low levels of conflict also experienced higher levels of social interest. Those who experienced stress in the home as children often withdrew when they felt their sense of security was threatened. Understanding one’s nuclear family or immediate support group may illuminate a person’s understanding of their place in the community and desire to connect with others. Therefore, a person’s immediate support group, or group they were closely associated with developmentally, may impact their levels of social interest and ultimately ability to cope with stressors.

Grad & Zeligman (2017) found that there was not substantial research exploring the connection between PTG, meaning in life and social interest. They sought in their own research to understand this relationship, as well as if meaning in life and social interest can predict PTG. Their study (2017) assessed college students through two online measures, including the Early Trauma Inventory Self Report – Short Form, which assesses physical, emotional, and sexual abuse, as well as general traumatic experiences that occur before the age of 18; and the BASIS-A

Inventory, which measured Adlerian lifestyle constructs in the form of self-report scales categorized by Belonging/ Social Interest, Going Along, Taking Charge, Wanting Recognition, and Being Cautious; the Post-Traumatic Growth Inventory, which measures the degree of positive changes experienced following trauma; the Meaning in Life Questionnaire, which measures the individual's presence of meaning of life and search for meaning in life; and a demographic questionnaire (Bremner, Vermetten, & Masser, 2000; Kern, Wheeler, & Curllette, 1997; Tedeschi & Calhoun, 1996; Steger et al., 2006; in Grad & Zeligman, 2017). They found that social interest is a significant predictor of PTG, which is supported by Adler's (1956) argument that social withdrawal causes emotional distress, which may be overcome by increased social interest. Social interest, further, correlates with a generally affirmative attitude towards life and meaning, fostered by when an individual experiences a sense of belonging in an intimate social group (Grad & Zeligman, 2017). The security in these relationships helps combat challenging situations and encourages individuals to create and foster new, positive relationships. Those who did experience PTG also experienced high levels of meaning in life, which may correlate with their search to find meaning in their suffering which leads to growth and enhanced life satisfaction (Calhoun, Cann, & Tedeschi, 2010; Janoff-Bulman, 1992, 2006; in Grad & Zeligman, 2017).

While social interest is a significant predictor of PTG, the strongest predictor of PTG according to Grad and Zeligman (2017) is the presence of life meaning. Social interest correlates with meaning, responsibility, and purpose, though one's perspective of life and understanding of their life's meaning offers the opportunity to shift perspectives of a traumatic event. Adler (1956) explains this phenomenon when he stated, "We are influenced not by our facts but by our opinion of facts," and again when he says in 1931, "No experience is a cause of success or failure. . .

Meanings are not determined by situations. We determine ourselves by the meanings we ascribe to situations” (Grad and Zeligman, 2017, p. 192). Grad and Zeligman (2017) use the support of their own research in conjunction with previous research on PTG to support that life meaning and social interest are the two strongest predictors for PTG. If a person maintains and pursues strong social interest, as well as searches for meaning in their trauma, they may be able to transform their reaction to a traumatic event into PTG.

Other correlates that have been recognized with PTG include: personality characteristics, coping, social support, religion, spirituality, demographics, and the characteristics of the stressor (or trauma) itself (Helgeson et al., 2006; in Spilkin, 2018). Specific personality characteristics that strongly correlate with PTG include extraversion, optimism, self-esteem, hardiness, and self-efficacy (Spilkin, 2018). Post-traumatic growth is more strongly associated with approach-oriented coping, one of two main forms of coping that frequently follow trauma, which involves an individual actively addressing their emotions and seeking to change their situation post trauma. More specifically, the “ability to self-regulate or manage anger and distress is positively related to PTG,” suggesting that teaching individuals how to regulate negative emotions may be a beneficial intervention in working towards PTG (Spilkin, 2018). Coping can be either emotion focused or task focused. A longitudinal study by Manne (2004) found that expressing emotions, both positive and distressing, was a significant predictor of PTG (Spilkin, 2018). The theory behind why emotional expression may predict PTG is that “emotional expression creates more intimacy and social support, more affect regulation and distress tolerance, and an increased sense of self-efficacy” (Spilkin, 2018). Task-based, or problem-solving, coping correlates as well with PTG as the individual is still engaged in a response, as opposed to freezing, distancing, etc.

Post-traumatic growth might be misinterpreted as resiliency. While resiliency may assist a trauma survivor towards PTG, the difference between the two processes is that resiliency returns a person to their baseline, while PTG occurs when an individual has actually experienced positive growth that has changed their worldview for the better. Understanding how one might predict PTG may offer a pathway to redirect those who may not otherwise naturally experience PTG following trauma, and can inform clinicians how to create an environment for an individual post-trauma in which they can experience positive growth.

Writing Therapy

Writing therapy is a form of trauma focused cognitive behavioral therapy that uses expressive writing to analyze and transform negative thoughts or emotions. Writing therapy has historically been used with PTSD, and will be examined here to support the applicability of writing therapy to develop PTG. Writing therapy, as an evidence-based treatment for PTSD, “constitutes a useful treatment alternative for patients who do not respond to other evidence-based treatments” (van Emmerik, A., Reijntjes, A., & Kamphuis, J., 2013). One strong benefit of writing therapy that differentiates it from more traditional CBT is its interpersonal accessibility. Van Emmerik et al. (2013) argued on this unique aspect of writing therapy, stating “internet adaptations of writing therapy for PTS may be especially useful for reaching trauma survivors in need of evidence-based mental health care who live in remote areas or who prefer to retain their anonymity.” Writing therapy is comprised of several different forms of therapeutic writing, which will be specified for the focus of PTG. In order to understand how writing therapy, and more specifically journal therapy, may be used to encourage PTG, one must first understand how writing therapy has been historically adapted to work with PTSD.

James Pennebaker (1997) is considered by many the founding father of writing therapy, and pilots a new surge of research on the physical and mental health benefits of writing with his original study of the Basic Writing Paradigm. His original study method assigned participants randomly to two different groups, a control and an experiment group. Each group was assigned a different topic, and asked to write on their topics for 3-5 days, 15-30 minutes each day.

Participants in the control group were asked to write about unemotional, superficial topics, such as their daily schedule. The prompt for the experimental group was:

For the next 3 days, I would like for you to write about your very deepest thoughts and feeling about an extremely important emotional issue that has affected you and your life. In your writing, I'd like you to really let go and explore your very deepest emotions and thoughts. You might tie your topic to your relationships with others, including parents, lovers, friends, or relatives, to your past, your present, or your future, or to who you have been, who you would like to be, or who you are now. You may write about the same general issues or experiences on all days of writing or on different topics each day. All of your writing will be completely confidential. Don't worry about spelling, sentence structure, or grammar. The only rule is that once you begin writing, continue to do so until your time is up. (p. 162)

Pennebaker (1997) noted that one of the more powerful aspects of the writing paradigm is that "when individuals are given the opportunity to disclose deeply personal aspects of their lives, they readily do so" (p. 162). He does continue to include that "even though a large number of participants report crying or being deeply upset by the experience, the overwhelming majority report that the writing experience was valuable and meaningful in their lives." The results of Pennebaker's study lead to the assumption that writing about emotionally disturbing events that

one has experienced leads to increased immunity, fewer doctor's visits, and significant reductions in distress, to name a few. Pennebaker's (1997) study, however, is somewhat limited in that his results of writing therapy were similar to results of verbally sharing their trauma, and defines this as a result of disclosure itself. More recent studies have specified the differences between writing modalities, including journal writing in regards to individuals suffering from PTSD.

Van Emmerik et al. (2013) referenced Pennebaker's (1997) work and expanded on it by stating that "writatives produced in writing therapy for PTS offer promising new ways to investigate trauma recovery, such as the identification of linguistic indicators of (un)successful trauma processing or comorbid depressive symptoms." Van Emmerik et al. (2013) offered an adaptation to Pennebaker's (1997) model in their research method: "First, in the self-confrontation phase, participants were instructed to describe their trauma in the first person, present tense, and in as much detail as possible (including sensory perceptions and painful thoughts and feelings). Second, in the cognitive reappraisal phase, participants formulated positive, encouraging advice to an imagined friend who had experienced a similar event. Third, in the sharing and farewell ritual phase, participants wrote a letter about their trauma and its impact on their life and future." They found in their study that writing therapy resulted in significant reductions of PTSD and depressive symptoms, with comparable success to CBT.

Writing therapy is an effective modality for PTSD and recovery as it uses image exposure to traumatic experiences, as used in other PTSD treatments. Such disclosure of traumatic experience is a form of social sharing and social support, within the control of the writer. However, there are key differences between writing therapy and writing alone. Murray (2002) warned that "venting emotions alone--whether through writing or talking--is not enough to

relieve stress, and thereby improve health... to tap writing's healing power, people must use it to better understand and learn from their emotions.” There is also a danger of rumination in writing, which can be supported through the therapeutic process, but may not always be helpful for an individual working through trauma alone. One study suggests that “people who relive upsetting events without focusing on meaning report poorer health than those who derive meaning from the writing. They even fare worse than people who write about neutral events. Also, those who focus on meaning develop greater awareness of positive aspects of a stressful event” (Murray, 2002). Pennebaker alludes to this concern as well: "People who talk about things over and over in the same ways aren't getting any better," he says. "There has to be growth or change in the way they view their experiences" (Murray, 2002). The process of writing therapy involves a threshold of handling stress, self-regulation, and engaging in interpersonal relations within a safe container, all of which are factors that assist toward PTG.

Journal Writing Therapy

Journal therapy, also referred to as journal writing therapy, is defined by the Center for Journal Therapy as “the purposeful and intentional use of reflective writing to further mental, physical, emotional, and spiritual health and wellness” (Journal Therapy, 2018). As opposed to journal writing, journal therapy is less focused on recording events and more focused on supporting therapeutic growth through analyzing and creating dialogue with their thoughts and concerns. Journal therapy is intended to be reflective, introspective, and intentional in nature, and takes the traditional practice of journaling a step deeper by using recording thoughts and experiences as a medium for creating and exploring one’s healing process. Much as a painter uses paints, a musician uses instruments, so does the writer use their words and thoughts on their experiences.

Journal writing is perhaps one of the most accessible forms of writing therapy, involving methods typically centered around personal free write in a contained space. Journals themselves are being used for a number of different therapeutic techniques, beyond the act of traditional journal writing. Journals are becoming more common for therapeutic use in older children, adolescents and adults, but many are using research to support the benefits of using a journal with young children as well. The journal itself may be used to “house many creative interventions, as a tool of reference for the therapist and child, as a means of organizing many projects, and as a termination gift of reflection for the young child [or client] who will surely face changing feelings about any presenting problems throughout his/ her lives” (Palmer, 2015). Journal writing is malleable and is constantly being theoretically and practically adapted depending on the needs of an individual.

Since Pennebaker’s early studies in 1989, the idea of writing as a method of healing has become more widespread. His 1989 studies are now being expanded to more common, everyday forms of writing, such as keeping a journal or diary at home (“Psychology Today,” 2017). Pennebaker affirmed “given the impact that writing studies are having in the media and the large number of people who keep diaries, it is incumbent on us to begin exploring how writing affects people outside the lab” (Pennebaker, 2002, in Tan, 2008). More recent studies support how “externalizing... emotions into a journal has been reported to reduce stress and promote wellbeing” (Whitney, 2015). Whitney’s (2015) study specifies that it may not necessarily be the act of journal writing itself, but the modality of journal writing elicits “*emotional disclosure*, the active ingredient [in producing stress reduction]”. It is the potency of emotional disclosure which has the greatest effect on long-term stress reduction, and this disclosure is encouraged through the act of private journal writing.

There is an emphasis in both Whitney (2015) and Pennebaker's (1989) examples that the emotional disclosure through journal writing is intended to be performed over a series of sessions. Lancaster, Klein, and Heifner (2015) exemplified through their study how a single episode of journal writing does not lead to significant increases in growth, and may even lead to increased levels of distress. Increasing distress after writing is a reoccurring concern, and should perhaps be taken into account when discerning the appropriate intervention for a person recovering from trauma. Weiss, Bold, Contractor, Sullivan, Armeli, and Tennen (2018) demonstrated that individuals – in their study, college students – who have a trauma history “experience a greater degree of fluctuation of shifts in negative emotional intensity.” This is important to note when working with a population that experiences more negative mood fluctuations due to their trauma, and potentially introducing a therapeutic modality that risks lowering mood and perhaps even re-exposing them to their trauma. However, within the safe holding of a therapeutic relationship, and using the structures of journal therapy to expand upon traditional journal writing that involves raw emotional disclosure, journal writing has been shown to be beneficial for long term growth and recovery.

Journal writing in regard to PTSD provides a pallet for emotional disclosure, as well as exposure of the individual to their trauma in a safe and controlled container. Pennebaker originally saw an increase in growth and decrease in health risks through daily journal writing, despite the risks of yielding negative emotions or mood fluctuations. Journal therapy can be compared to exposure therapy, which runs similar risks and considerations when working with a population that is experiencing lower levels of emotional regulation. Marsh and Spates (2002) urged for the use of writing to not just be a supplement to therapy, but for the effectiveness of structured writing as therapy. Lang (1979) countered their perspective that journal writing may

be too upsetting and therefore inappropriate for clients with trauma by theorizing that “the more complete the treatment-related evoked re arousal is along dimensions constituting the established fear network (emotions, behavior, sensations, and thoughts), the greater is the likely success of treatment,” and that flooding methods may be more effective than systemic desensitization for certain fears (in Marsh & Spates, 2002). Marsh and Spates (2002) conducted an experiment in which they compared a journal writing intervention to EMD/R, as two similar exposure techniques. Their method exemplifies the structures and clinical context that differentiates journal writing from journal therapy:

Participants assigned to the structured writing condition were asked to visualize the event, label it, and then, using the SUDS [Subjective Units of Distress Scale], rate their level of distress regarding the traumatic event. Then they were asked to identify a present cognition associated with the event and to identify a cognition that they would like to believe concerning the traumatic event. They were asked to rate this last statement as to its believability according to the VoC Scale [Validity of Cognition] (see Shapiro, 1995). They were given paper and pen and instructed to write about the traumatic event and to include a narrative of the events that occurred, as well as the cognitions, emotions, and sensory (physiologic) responses associated with the trauma. They were interrupted at approximately 15-min intervals during the 1-hr session and asked to rate current subjective distress according to the SUDS. At the conclusion of the session, they were again asked to rate the traumatizing event according to the SUDS and the cognitive statement according to the VoC Scale. Finally, their writings were collected and placed in a confidential file (Marsh & Spates, 2002, p. 583).

They found that writing therapy provided similar results to EMD/R, giving it credibility as an exposure therapy technique. Because it can be considered a form of exposure therapy, Marsh and Spates (2002) do advise that this type of writing be supervised by a clinician who has experience in traumatic stress, as many of their participants demonstrated emotional responses concurrent with those frequently expressed through exposure therapy. For example, such specific prompts may be more harmful than helpful if given as a homework assignment for the individual to complete unsupervised; but in the presence of a clinician who has experience working with trauma and exposure, can prove highly beneficial for both mental and physical health.

Journal Writing Therapy through Blogging

Emotional disclosure in a structured setting may have increased benefits if an aspect of social interest is introduced to the therapeutic process. Journaling publicly, such as blogging, allows for the social interest piece to further encourage a transition towards PTG. Traditional journaling may take on social aspects as well, including sharing journal entries in a therapeutic relationship, in a group setting, or transforming a journal entry into a piece of art that can be shared or performed. A notable form of journal writing is blogging, defined as “an online journal or diary organized typically in reverse chronological order, consisting of user-generated content in the primary form of writing” (Tan, 2008). Tan (2008) urged the significance of noting blogging as a notable form of self-therapy, providing support that “there is a significant *global* population of bloggers and readers” (Tan, 2008). In this lens, journal writing is used in an organized manner for an audience limited by the blogger, or “journal writer” (Tan, 2008). Blogging differs as a form of journal writing because it presents the intimacies of a private diary while making one’s personal writing accessible as a type of “socialized diary” (Tan, 2008). This

type of social interaction that comes with socialized journaling can have different results than, for example, the more traditional and lab-controlled journal writing of Pennebaker's 1989 studies.

Post-traumatic growth is more likely to occur with the support of a social group, as well as reframing of one's perspective to apply meaning to the individual's traumatic experience. Journal writing offers a strong platform for the transformation of one's perspective, and can be incorporated socially as well. Journal writing can take the form of an online blog, discussion forum, or social media post, as the #MeToo movement mentioned in the Introduction. These posts are living documents, and can be edited, commented on, shared, and incorporated with other media, such as images, sounds, etc. The individual can control who sees their posts depending on the platform they choose, thus creating an opportunity to be shared within an intimate group of people and creating a boundary of support as opposed to open vulnerability. There is, however, the risk of negative feedback and response when sharing to a group. Individual journal writing, that might occur in a private journal or computer document, allows a space for the individual to explore meaning and track their own process. These more private pieces of journal writing can later be shared with a therapist, peers, or other social group to make a social interest connection. Jirek (2017) suggested that narrative coherence and reconstruction correlate strongly with positive growth in journal writing and can indicate the level of development in an individual's writing.

Discussion

As evidenced by the literature, writing therapy, specifically journal writing therapy, is a beneficial therapeutic technique for encouraging post-traumatic growth. Journal writing assists

by decreasing symptoms of post-traumatic stress, and allowing a context for post-traumatic growth to occur. As previously highlighted, indicators of PTG include increased social interest, finding meaning in life, and coping skills. Two forms of coping can be adapted through therapeutic journaling: emotional and task-based coping. Journal writing can be applied to identifying specific coping skills, reflective in nature to identify meaning, providing exposure to the trauma to encourage transformation through emotional disclosure and present insight, and can be adapted in social contexts to increase social interest.

Journal writing therapy continues to expand on Pennebaker's (1988) original findings of the physical and mental benefits of expressing events and emotions through consistent writing. One reason journal writing benefits those recovering from trauma is through the act of emotional disclosure, supported by Whitney's (2015) research. Marsh and Spates (2002) affirm that though an increase in distress may occur with such emotional disclosure, journal therapy can be compared to exposure therapy in the benefits yielded from flooding techniques, and that individuals benefit more with greater emotional reaction. When using journal writing therapy among populations experiencing greater emotional inconsistency, journal writing therapy may best be directed in a clinical setting. While journal writing is largely accessible, especially over long distance, it may be most beneficial when used therapeutically in a controlled, clinical setting, to assist individuals with emotional reactions to exposure, as well as to specify writing prompts and disclosure.

Journal writing therapy can provide survivors of sexual trauma the tools needed to transform their pain into growth, by focusing on exposure to their past trauma, identifying changes and transformation in their writing and their emotional reactions as they write over a period of time on their trauma, and share their pieces with the therapist or others for further

exploration, connection, and impact. Through emotional disclosure and exposure to the trauma in a contained, directed, and reflective space, an individual may further understand concepts of meaning and pursue social interest through their writing, thus supporting a few of the diverse benefits of journal writing therapy.

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THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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