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# Expressive writing as an adjunct to talk therapy : considerations for a creative intervention for depressive disorders

Anna C. Hogeland

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Anna Chase Hogeland  
Expressive Writing as an Adjunct to  
Talk Therapy: Considerations for a  
Creative Intervention for Depressive  
Disorders

### **ABSTRACT**

This theoretical thesis offers considerations for expressive writing as an adjunct to talk therapy, particularly for adults with depressive disorders and ruminative thoughts. This thesis asks: how do theories and empirical studies inform the use of expressive writing as an adjunct to talk therapy in adults with depressive disorders to decrease ruminations, and how can clinicians integrate this treatment intervention into practice? The primary aims of this thesis are to expand upon the limited knowledge about the therapeutic effects of expressive writing, to offer direction for further research, and to propose a model for the implementation of expressive writing into session time. Narrative Therapy and Relational-Cultural Theory serve as clinical orientations to interpret and implement the intervention. The effects of the writing exercises on the therapeutic alliance are discussed throughout the thesis. Direction is offered for further research on expressive writing to diversify clinicians' repertoire of techniques to treat adults with depression and ruminations. The thesis concludes with a proposed model for implementing expressive writing into practice that may serve as a feasible and therapeutic intervention.

**EXPRESSIVE WRITING AS AN ADJUNCT TO TALK THERAPY:  
CONSIDERATIONS FOR A CREATIVE INTERVENTION FOR DEPRESSIVE DISORDERS**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirement  
for the degree of Master of Social Work.

Anna Chase Hogeland

Smith College School for Social Work  
Northampton, MA 01063

2013

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Mom & Dad—Thank you for your unending support, encouragement, and home’s quiet refuge. I am privileged to have you two as parents.

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## **CHAPTER I**

### **Introduction**

“Writing is a form of therapy,” wrote Graham Greene, an English novelist who suffered from bipolar disorder throughout his life (Greene, 2007, p.xx). “Sometimes I wonder how all those who do not write, compose or paint can manage to escape the madness, the melancholia, the panic fear which is inherent in a human situation” (p.xx). Greene’s diagnosis was named and analyzed through years of psychoanalysis, and he independently managed his symptoms through creative and expressive writing of letters, diary entries, and stories (Greene, 2007; West, 1997). Greene’s use of writing as a therapeutic outlet is not unique; novelists, poets, and diarists have released and dissected their inner turmoil through the written word for centuries. Among countless other writers, Virginia Woolf, Sylvia Plath, Ernest Hemingway, Leo Tolstoy, and Joan Didion have used writing to express and to find meaning in their suffering. While these writers have been gifted with articulation and fame, their conditions and need for expressive catharsis are shared by a wide spectrum of individuals who experience feelings of depression and ruminative thoughts of hopelessness and helplessness. This theoretical thesis elucidates the potential therapeutic effects of expressive writing as an adjunct to talk therapy for such individuals.

Philosophers and theorists across discipline, time, and culture have recognized the value of expression (Turner, 1986). The benefit of the acknowledgment, analysis, and release of what’s inside us, through a myriad of techniques, has been the founding notion of therapeutic treatments since the emergence of psychology as an academic field (Mitchell & Black, 1995). Historically, the primary model of treatment has been individual talk therapy, but early philosophers and psychoanalysis noted the value of creativity, art, and other expressive outlets for troubled

individuals (Winnicott, 1971). Since Freud’s “talking cure” gained clout in the early twentieth century, verbal therapy has largely eclipsed the use of other, nonverbal expressive outlets in academic and clinical discourse—most notably dance, mindfulness exercises, art, music and, the focus of this thesis, expressive writing (Carlson, 1997; Lepore & Smyth, 2002).

This theoretical thesis strives to address this void in research and practice and the potential benefits of incorporating creative expressive treatments into clinical social work’s repertoire, specifically the use of expressive writing as an adjunct to talk therapy for adults with depressive disorders. This thesis asks: *how do theories and empirical studies inform the use of expressive writing as an adjunct to talk therapy in adults with depressive disorders to decrease ruminations, and how can clinicians integrate this treatment intervention in practice?* While the therapeutic alliance is not the central focus of the thesis, the impact of EWTs on the alliance will be addressed throughout the paper as an important factor in the effectiveness of the intervention. The primary aims of this thesis are to expand upon the limited knowledge about the therapeutic effects of expressive writing, to offer direction for further research, and to propose a model for the implementation of expressive writing into session time. To inform the incorporation of expressive writing, this thesis draws from the clinical theoretical orientations of Narrative Therapy (NT) and Relational-Cultural Theory.

### **Clarification of Terms**

**Expressive Writing Treatment (EWT).** EWT is a broad term for therapeutic treatments that involve expressive writing as a primary or secondary intervention. Unlike non-expressive writing, expressive writing involves reflection and emotional exploration (Sloan, Feinstein, & Marx, 2009). Non-expressive writings include reports of past and future events without reflection and emotional evaluation (*expression*). Many quantitative studies on this topic similarly define expressive and non-expressive writing and assign control and experimental groups accordingly

(Baikie, Geerligs, & Wilhelm, 2011; Bhullar, Schutte & Malouff, 2011; Sepra, Buhrfeind, Pennebaker, 1994; Sloan et al., 2009). By this definition, expressive writing targets the cyclical, emotionally suppressive nature of the depressive symptom of rumination.

**Adults with depressive disorders.** This population is arguably the largest social workers serve. An estimated 20% of individuals experience depression at least once in their lives; and of those 20%, 75% to 90% will likely have another depressive episode or prolonged depressed mood (Gorter, Rude, & Pennebaker, 2006).<sup>1</sup> In this thesis, ‘adults’ refers to persons eighteen or older of any race, ethnicity, gender identity, sex, religion, sexual orientation, socioeconomic status, and cultural background. Depressive disorders include the DSM-IV’s (2000) descriptions of major depressive disorder (MDD), single episode (diagnostic code 296.2) and recurrent (296.3); dysthymic disorder (300.4); and depressive disorder not otherwise specified (NOS) (311). The shared emotive symptoms for depressive disorders include decreased interest or pleasure in activities, diminished ability to concentrate, feelings of worthlessness, hopelessness, and guilt, as well as recurrent, intrusive and repeating negative thoughts (rumination) (DSM-IV, 2000). The disorders are distinguishable in the “onset, duration, persistence, and severity” of the emotive and neurovegetative symptoms (DSM-IV, 2000, p. 374). This thesis will focus on depressive disorders and rumination’s role in perpetuating them—yet the benefits of expressive writing could apply to many individuals who experience ruminative thoughts who do not precisely meet the criteria of a depressive disorder diagnosis.

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<sup>1</sup> The Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (2000) estimates the lifetime risk for Major Depressive Disorder (MDD) is 10% to 25% for women and 5% to 9% in men (p. 372). As depression is often underreported and undertreated, the precise percentage of adults who experience depression is difficult to estimate; yet the available statistics demonstrate the profound numbers of treated and untreated individuals who experience depressive symptoms.



**Rumination.** The focal symptom of this thesis is rumination, a pervasive and perpetuating operationalized symptom of depression. Psychologist and professor Susan Nolen-Hoeksema (1998), a prominent researcher of rumination and its toll on physical and emotional wellbeing, defines rumination as

focusing passively and repetitively on one's symptoms of distress ("I'm so tired and unmotivated." "I can't concentrate.") and on the meaning of those symptoms ("Why can't I get going? "My spouse is going to leave me if I don't get my act together.") without taking action to correct the problems one identifies (p. 216).

Researchers have also described rumination as brooding on a negative or intrusive thought without self-reflection (Bagby & Parker, 2001; Burwell & Shirk, 2007). Numerous studies of treatments that target rumination posit that distraction by a positive stimuli, external focus, insight, and expressive catharsis are the most effective cures (Burwell & Shirk, 2007; Ingram & Smith, 1984; Pyszczynski, Holt, & Greenberg, 1987; Treynor, Gonzalez, & Nolen-Hoeksema, 2003). The following chapters will further discuss rumination and the potentially antidotal effects of expressive writing.

**Adjunct.** This thesis discusses expressive writing as an adjunctive, supplementary exercise to diversify and to increase the benefits of talk therapy—not as a primary treatment method. Many previous studies (both qualitative and quantitative) have researched expressive writing as a primarily self-administered treatment without the presence or guidance of a clinician (Baikie et al., 2011; Davidson, Schwartz, Sheffield, McCord, 2002; Lepore, & Gerin, 2002; Norman, Lumley, Dooley, & Diamond, 2004). The comparably fewer studies that have explored the integration of expressive writing into talk therapy with a clinician have confirmed its benefits and called for further research on the treatment (Gortner et al., 2006; Graf, Gaudiano, & Geller, 2008; Mazza, 1996; Lepore & Smyth, 2002). Adjunctive EWTs include letter writing,

journaling, creative storytelling and poetry, as well as worksheets or open prompt written assignments between sessions.

**Talk therapy.** In this thesis talk therapy refers to psychodynamic and integrative approaches with elements of behavioral therapies, namely cognitive-behavioral therapy (CBT) and dialectical behavioral therapy (DBT). Many contemporary clinical social workers draw from both the psychodynamic doctrine of meaning-making and the behavioral treatments' attention to distorted thoughts and maladaptive behaviors into their practice. This integrative approach tailors to meet the clients' personalized needs and to comply with agency structure and many insurance plans' preference of empirically supported treatments (Heller & Northcut, 2002). Rumination is often understood as a cognitive function, and thus warrants the attention of cognitive and behavioral treatments as well as psychoanalytic (Alloy, 1991; Arney et al., 2009; Davidson et al., 2002). Yet while some clinicians are creatively integrative, clinical social workers often exclude other expressive and creative therapies such as art, music, mindfulness, dance, and writing. This thesis illuminates this divide and explores ways of integrating verbal and nonverbal treatments into clinical practice.

**Therapeutic alliance.** Broadly defined, the therapeutic alliance (also referred to as the helping alliance or working alliance) is the collaborative relationship between therapist and client to enhance the benefits of treatment for the client (Bordin, 1994; Horvath & Luborsky, 1993; Greenson, 1965). Research on the value of the therapeutic alliance indicates that the quality of the alliance—based on empathy, mutual engagement, trust, communication and commitment to treatment goals—often correlates with positive outcomes in therapy that can extend past termination (Ardito & Rabellino, 2011; Horvath & Greenberg, 1994; Horvath & Symonds, 1991). This thesis addresses the role of expressive writing in treatment as a potential tool to

strengthen the alliance to achieve therapeutic gains for clients with rumination and depression.

### **Applied Theories**

**Narrative Therapy (NT).** Developed from the innovative techniques and writings by Michael White and David Epston in the 1990's, NT emphasizes the importance of analysis of storied experiences, externalization of the problem, and increasing personal agency in one's narrative (Abels & Abels, 2001; Angus & McLeod, 2004; Phipps & Vorster, 2011; White, 2007). The value of the subjective experience is built upon a constructivist philosophy, wherein each viewpoint and story is valued and used to create a multi-dimensional understanding of an experience and to recognize the absence of an objective, authoritarian truth in a positivist sense (Bruner, 1986; Carlson, 1997; Phipps & Vorster, 2011).

I have chosen to implement insights from NT to support the use of EWTs for its emphasis on the storied experience and co-construction of narratives that promote insight and agency in one's personal narrative. Clinicians and researchers have primarily used NT as form of talk therapy, yet some have incorporated artistic methods with narrative techniques (Angus, 2012; Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2001; Carlson, 1997). NT and expressive writing naturally complement each other; but few researchers have used NT and EWTs to promote one another in published literature, and even fewer studies are conducted by and for social workers. White and Epston (1990) reference the appropriate application of NT in writing treatments. They explicitly state that while they focus on talk therapy, writing gives new meaning and a "temporal dimension" that has been neglected in the therapy world (p.35). This thesis reexamines the potential fusion of narrative practices and the written implementation into talk therapy.

**Relational-Cultural Theory (RCT).** Built upon the foundation of object-relations and feminist theory, RCT proposes that relational dynamics are integral in one's development and

identity. This perspective was developed at the Stone Counseling Center at Wellesley College by clinicians Judith Baker Miller, Judith Jordan, Janet Surrey, Irene Stiver and Alexandra Kaplan in the last decades of the twentieth century. The theory emphasizes the importance of social identity and power dynamics in one's sense of self and relational pattern as well as the value of authenticity and mutual empathy in the therapeutic relationship (Jordan, 2009; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller & Stiver, 1997). RCT's perspective offers a way to interpret and address diverse population of clients' feelings of shame, isolation, and disempowerment. RCT-oriented clinicians can utilize EWTs to contribute to the relational connection and authentic communication between therapist and client, which could diminish the client's sense of isolation and unworthiness of empathy. This thesis draws from the insights of RCT to inform the way in which therapists comprehend and address their clients suffering as well as to elucidate how EWTs can be effective intervention to alleviate ruminative negative thoughts and relational disconnections.

### **Implications for Social Work**

The implementation of nonverbal expressive outlets in talk therapy is largely absent from the academic and clinical discourse, particularly for clinical social workers. Investigating and strengthening the bridge between verbal and written narratives in treatment will diversify clinicians' repertoire of techniques and will give clinicians an opportunity to utilize a range of innovative modalities. The National Association of Social Work (NASW) Code of Ethics (2008) calls upon social workers to enhance the wellbeing of their clients and to practice tailored treatment models for each client's needs. By actively developing new and nuanced methods of attunement to adults with depressive symptoms (arguably one of social workers' largest client populations), social workers more effectively serve their clients and profession. EWTs can be

effective intervention for this population and they warrant the attention of the clinical community.

Most of the research referenced in this thesis is primarily by and for psychologists and psychiatrists, yet social workers are a large and integral part of the audience of mental health clinicians. A stronger voice from social work would be valuable to research and discussion, as social workers possess the unique skills to understand clients as individuals within their environment as well as to develop innovative ways to treat them. Most social workers are clinicians (or were at one time) and many social workers have worked intimately with adults with depression (Bureau of Labor Statistics, 2012). The clinical social work community has a sophisticated and diverse knowledge of these clients' needs and the shortcomings of their treatment models. Social workers manage the transition from theories and studies into practice, and from practice into studies and theories. Virtually all the literature on expressive writing notes its underutilized therapeutic value and calls for further research, which presents an opportunity for social workers to become active participants in the study and implementation of innovative EWTs. My hope is that this thesis will engender discussion and direction for further research as well as increased incorporation of expressive writing into clinical social work practice.

The following chapter will describe the conceptualization and theoretical methodology of this thesis. Chapter III provides a review of structured and unstructured EWTs, their empirical support, and discussion of the therapeutic agents in expressive writing. Chapter IV and V elaborate upon the principles and applications of NT and RCT, respectively. The thesis concludes with Chapter VI, which offers synthesis of the preceding chapters, consideration of further research, and a proposed model for the incorporation of expressive writing into session time.

## **CHAPTER II**

### **Conceptualization and Methodology**

This chapter elaborates upon the constructivist analytic frame and the interplay of the applied concepts in this thesis. The chapter will begin with a description of constructivism and its applicability to EWT in clinical social work practice. Next, this chapter will explore the role of the therapeutic alliance, treatment goals for rumination, and NT and RCT's relevance as theoretical orientations for expressive writing as an adjunct to talk therapy. The chapter will conclude with a discussion of the strengths and limitations of the theoretical methodology and the writer's bias.

#### **Constructivism**

As postmodern perspectives have come to dominate contemporary academia and clinical practice, social workers and other clinicians increasingly adopt a constructivist orientation to try to understand and treat their clients (Carlson, 1997; Heller & Northcut, 2002; Hoyt, 1998). This thesis also uses a constructivist approach to treatment, as it respects the subjective experience and the value of reframing—thereby perpetuating the movement away from the positivist mindset in which there is a single, objective truth (Bruner, 1986; Hoyt, 1998).

EWT and other creative therapies focus on the individual's perspective on herself and her experience as well as the value of co-construction and reframing through various mediums, such as art, music, movement and/or writing (Carlson, 1997). These therapies evolve from the ideas imbedded in postmodernism, post-structuralism, and Foucault's notion of the power as knowledge (Bruner, 1986; Foucault, 1980; White & Epston, 1990). Phipps and Vorster (2011) describe how through a constructivist perspective,

there are no grounds whatsoever for determining what counts as true knowledge...because the act of knowing is subjective or interpretive, the knower is unable to acquire direct or objective knowledge and is thus unable to determine unequivocally its truth (p. 135).

Thus the client has the power to create a subjective reality and knowledge (both of self and environment), and the therapist validates and contributes to the client's knowledge and narrative. Moreover, the constructivist therapist "believes in a socially constructed reality" and "emphasizes the reflexive nature of therapeutic relationships in which client and therapist co-construct meaning in dialogue or conversation" (Hoyt, 1998, p.3). Expressive writing can serve as a creative medium for this co-construction and dialogue between therapist and client, and in so doing can potentially strengthen the therapeutic alliance and the client's sense of agency over impairing symptoms (Carlson, 1997).

The mutual engagement in constructivist therapy allows for a recreation of a more strengths-based narrative, which could also address and diminish depressive symptoms and rumination. With the audience of an attuned therapist, the client's narrative (written, oral, or artistic) is material available for collaborative revision. The therapist can identify and guide a dissection of the problem-saturated areas of the narrative—ruminations on themes of loneliness, low self-esteem, guilt, and other symptoms of depression—while also pointing to moments of strength and resilience (NT elaborates upon these strategies). This collaboration builds from and establishes trust and rapport, and it can be an agent in strengthening the therapeutic bond, eroding ruminations, and increasing the client's insight and confidence.

### **Conceptualization and Theoretical Methodology**

The attached concept map visually illustrates the interplay of the ideas in this thesis (Appendix A). Expressive writing as an adjunct to talk therapy is the central concept of this

thesis, and the surrounding concepts influence the method of implementation and understanding of its effectiveness and applicability to the focal client population. The introduction of this treatment originates in the therapeutic alliance and the client's symptoms and corresponding treatment goals. This thesis focuses on clients with depressive symptoms, particularly rumination, with treatment goals of increasing insight and agency in overcoming the symptoms through expression and processing with the therapist. The theories of NT and RCT illuminate why and how EWT could be effective for adults with depressive disorders, most notably the theories' shared emphasis on the subjective narrative and attention to client's context in her interpersonal and societal systems.

The strengthening of the therapeutic alliance allows for this collaborative interaction and progression of treatment. Through therapist's attunement and client disclosure and trust, the therapeutic alliance provides a platform from which therapist and client can co-construct treatment goals and strategies for symptom management (Applegate, 1997; Angus, 2012; Wong & Pos, 2012). The notion of therapeutic alliance in part evolved from Winnicott's idea of the "holding environment," the secure frame and bond between therapist and client (Coleridge, 1996; Winnicott, 1971). In the holding environment, the therapist contains and accepts all parts of the client and treatment occurs. The emphases on the holding environment and therapeutic alliance have become hallmarks of contemporary clinical social work practice (Wong & Pos, 2012). With mutual engagement in the therapeutic alliance, both the therapist and client can tailor treatment goals to address problematic symptoms (Horvath & Luborsky, 1993).

Promoting insight through expression and analysis are common methods of treatment for several symptoms, particularly rumination and other depressive symptoms (Graf et al., 2008; Harrington & Loffredo, 2010; Watkins, 2004). By progressing toward these treatment goals, the client with depression may be able to recognize and understand the repetitive negative thoughts



and to use modes of expression to articulate and overcome the depressive affect. Expressive writing as an adjunct to talk therapy provides a mode for this expression. The writing also serves as a tangible document that captures ruminative patterns and indicates progress (or lack of progress) over the course of treatment. While the writing may be therapeutic and offer rich material for discussion in session, the writing could also server as an alternative outlet for rumination and even contribute to the ruminative process. The therapist may be mindful of this risk and remain attuned to when the writing serves as a progressive or regressive agent, as discussed in more depth in the final chapter.

This thesis will explore the use of insight as an intervention for creating new thought patterns in place of ruminations, as increasing insight without the aim to overcome rumination does not appear to be a substantially effective method. Past studies on treatments for depression have indicated that an internal focus for adults with depression (who have been shown to generally be more internally focused than those without depression) increases rumination and negative affect, while external focus can more effectively break the ruminative cycle (Cox, Enns, & Taylor, 2001; Nolen-Hoeksema, 1998; Pyszczynski et al., 1989; Watkins, 2004). Rather than perpetuating the internal focus, some researchers have promoted distraction from the negative affect as an antidote for rumination (Bagby & Parker, 2001; Ingram & Smith, 1984; Nolen-Hoeksema & Morrow, 1993). Pyszczynski et al. (1989) propose that “inducing external focus in people who are chronically self-focused...should reduce the intensity of their emotions,” and reductions in depressed mood may be “brought about by a reduction in self-focus” (p. 355). Reducing the focus on the self may lessen some symptoms of depression, but it also risks colluding with avoidance of addressing and dissecting the causes of the depression.

While these studies challenge the value of self-focus and insight in overcoming rumination, they do not explore alternative ways in which insight may help to manage

rumination. There remains a void of research on the potential benefit of collaboratively restructuring the cognition and the negative narrative, rather than self-focused attention without further agenda (Pourjalali, Skrzynecky, & Kaufman, 2009). This thesis reexamines the value of insight as achieved through expressive writing with a NT perspective, which encourages “the generation of resurrection of alternative and more rewarding stories of lives and relationships” and a new relationship with the problem and oneself (White & Epston, 1990, p. 65). In other words, the aim of the writing intervention is to change the ruminative pattern of “focusing passively” to focusing proactively on symptoms and its effect on the self (Nolen-Hoeksema, 1998).

NT and RCT provide further theoretical guidance and practical techniques for the therapeutic implementation of EWT. Concisely, NT offers strategies for engaging with client narratives to externalize the problem and develop a more nuanced and positive perspective of the client and her relationship to her symptoms. RCT provides a progressive understanding of the paramount role of relational bonds in formation identity, development, and the individual’s sense of self and power. These theories both value the individual’s subjective narrative and relational context as well as the attunement and contribution of the therapist. Narrative and relational therapists—many clinicians draw from both theories—view their clients and their narratives as dynamic and greatly influenced by their social and environmental surroundings. The therapist’s role is to listen, validate, challenge, and elicit latent strengths. The therapist’s differential use of self, authenticity, and engagement is crucial to relational and narrative treatment, and these methods can be applied both to oral narratives and adjunctive expressive writing exercises. Thus the concepts in these theories offer guidance in the method of implementation of EWT and the role of the therapist in engaging with the written material.

## **Strengths and Limitations**

Unlike empirical studies, theoretical studies rely on concepts and previous studies rather than original research with participants. The strength of the theoretical framework is its allowance to synthesize theories and to draw from the results and gaps in literature and empirical studies to propose alternative ways of thinking about a phenomenon. This thesis does not test the phenomenon with participants in an empirical study or offer substantive methods of evaluation; therefore, the thesis does not contribute new qualitative or quantitative data on the effects of expressive writing. Rather, this thesis provides direction for new areas of empirical and theoretical research on the topic to continue to generate discussion regarding the implementation of expressive writing into clinical social work practice.

The treatment modality presented in this thesis is applicable to a wide spectrum of individuals, but it is not an appropriate treatment intervention for all. Expressive writing may be a beneficial intervention for adults with depressive disorders regardless of their sex, gender identity, race, ethnicity, religion, sexual orientation, socioeconomic status, and culture. These factors—while largely formative in one’s identity and worldview—do not provide substantial indication of who would and would not benefit from EWTs. This thesis proposes that EWT is applicable to a diverse population of adults with depressive symptoms, yet I recognize that there is a void of empirical research on how various types of treatment affect individuals with unique combinations of the above identifying factors.

My proposal of EWTs presumes the client is fluent and literate in the language in which they are treated and already demonstrates cognitive capacity to lucidly write, read, remember, reflect, and develop insight. Adults with limited cognitive development and chronically tangential thoughts are not the targeted population for this treatment, as expressive writing may decrease self-esteem and their sense of agency and cause more frustration than therapeutic

benefits. Broadening the participant criteria and target population to include those who struggle with cognition, language, and literacy could enhance research on the effectiveness on writing as a *new* means of catharsis and expression as well as include populations that could benefit greatly through collaborative writing. This is an area for further research.

**Writer's bias.** My interest in this intervention stems from personal experiences and anecdotal accounts of the therapeutic effects of expressive writing. In the day treatment center where I was a social work intern for my first-year field placement, I witnessed the therapeutic benefit of expressive and creative treatments on adults with chronic mental illness. Art, dance, mindfulness and writing elicited unique insights and confidence in virtually all who participated. I also find the act of writing in a variety of forms—from journaling, creative fiction, non-fiction, even academic essays—activates a latent energy, strength, and awareness of my internal and external environment.

While I am passionate about expressive writing and have witnessed its beneficial effects, I recognize that my personal interest influences my support of this treatment. Furthermore, my knowledge and experience is limited; I am currently a graduate student with relatively little clinical exposure. During the writing of this thesis I designed and co-led a 'Writing and Relaxation' group for patients on an inpatient psychiatric unit. The group involved a guided mindfulness exercise, time to write during group with music, followed by time to read the work to the group and discuss the experience of the exercise. The participants, adults with acute psychiatric symptoms, evoked creative and affect-rich pieces that often revealed their strengths and internal process not expressed in verbal discussion. Many other clinicians share my experience of writing, yet the exercise is widely under-utilized in the clinical setting. With the presentation of this thesis I hope to increase the understanding of writing's therapeutic function and to promote discussion on the implementation of EWT.

## CHAPTER III

### **Expressive Writing as a Therapeutic Intervention**

Expressive writing requires exploration, reconstruction and refinement of feelings, thoughts, and experiences in a form available for others to view and interpret (Helsel, 2011; Pennebaker, 1997; Sloan, Feinstein, & Marx, 2009). Clinicians across disciplines have been aware of the therapeutic value of expressive writing for decades, and some have developed and incorporated structured and unstructured writing exercises as supplements to talk therapy (Lepore & Smyth, 2002). Yet the theoretical and empirical support for expressive writing as an adjunctive therapy remains sparse, and therapists arguably underutilize the intervention (Kelley & Williams, 1986; L'Abate & Sweeney, 2011; Leavitt & Pill, 1995; Pennebaker, 1997). By gathering what researchers have already studied about the benefits of expressive writing and why it works, clinicians can become informed about how to implement this treatment into practice for individuals with depression and ruminations.

This chapter describes both the structured and unstructured ways in which clinicians have used and studied EWTs until now. The structured treatments described are Proffoff's Intensive Journal Method (1977), L'Abate and Cox's Programmed Writing (1992), and Pennebaker's writing paradigm for improving physical health (1997). The unstructured treatments are writing with metaphor through creative stories and poetry, journaling, and letter writing between therapist and client or client and a third party (or herself). Next, the chapter elaborates upon the therapeutic mechanisms of expressive writing as derived from the empirical findings and theoretical conclusions of both structured and unstructured writing interventions: 1) emotional inhibition theory, 2) emotional expression and catharsis, 3) cognitive restructuring and adaptation, and 4) emotional regulation. This chapter provides a historical and clinical context of EWT that

elucidates the strengths and limitations of EWTs and areas for improvement for future methods of implementation.

### **Structured EWTs**

Structured EWTs are prescribed, formulated methods of expressive writing as a therapeutic intervention (Esterling, L'Abate, Murray, & Pennebaker, 1999). Empirical studies test and support these treatments, yet relatively few clinicians adopt the methods into practice (L'Abate & Sweeney, 2011). I discuss the three most prominent structured writing treatments in chronological order; firstly the Progoff's Intensive Journal (1977), secondly L'Abate and Cox's Programmed Writing (1992), and finally Pennebaker's writing paradigm for improving physical health (1997).

**Progoff's Intensive Journal Method.** Self-administered journal therapy predates psychoanalysis by centuries—yet it was not formally developed into a clinical practice until psychoanalyst Ira Progoff presented his Intensive Journal Program (1977, 1992) after decades of facilitating therapeutic journal workshops. Progoff's interest and promotion of the therapeutic value of journaling evolved from his analysis of psychological development he found in the journals of Freud, Adler, Jung, and Rank as well as his positive personal experience with journaling (Epple, 2007; Progoff, 1992). Through his study, Progoff learned how journaling often effectively increased insight, growth, and sense of internal and interpersonal connectedness. Progoff subsequently developed a structured treatment—the Intensive Journal Method—to apply the therapeutic value of journaling to a wide audience.

Progoff's program involved group journal writing workshops independent from individual therapy with a clinician. Participants in the workshops wrote in a journal divided in four parts: 1) lifetime dimension (historical data); 2) dialogue dimension (relational aspects of life); 3) depth dimension (symbolic dreams and images); and 4) meaning dimension (inner

experiences and spiritual aspects of life) (Progoff, 1992). These sections were designed to reflect the sections within ourselves. Participants—“practically anyone” who was interested in attending the journal workshop with or without a psychiatric diagnoses—wrote in each section of the journal in an effort to develop a more comprehensive self-awareness (“About the workshops,” n.d.). At the beginning of the workshop, the facilitator guided participants through the journal divisions. The facilitator was often an educator, minister, artist, or counselor who has received training and a certification in the Progoff method (no other formal degree was required for the position) (“About the workshops,” n.d.). The group then engaged in a quiet moment when the participants contemplated their goals and areas of their life they hope to improve with the method. This was followed by time to write and to “focus inward at the depth of our inner being, in the context of the wholeness of our life” (Progoff, 1992, p. 9).

The participants may have shared and discussed their writing, yet the workshops were primarily designed to be an independent activity within a supportive atmosphere (Progoff, 1992). Discussion and feedback about the writing from the group and facilitator were not part of the workshop; rather, the journal was meant for individual reflection. Progoff describes how working solitarily in a room with others “deepens the atmosphere, creating a silent psychic energy or support that we do not feel when we are working alone at home” (“About the workshops,” n.d.). Progoff hoped that writing and reflecting on the journal entries would help participants to realize their inner strengths and resilience and to influence a more positive future (Gibson, 1993). Thus the primary purpose of the workshops was not to study the content and effect of the journals, but instead to provide a “sanctuary” for those who desire a creative means to insight and growth and a place to “quietly appraise his relation to his life” (Progoff, 1992, p. 17).

The workshops were relatively informal with loose recruitment measures, participant criteria and evaluation methods; thus they did not lend themselves to quantifiable measure of

their effectiveness. The few empirical studies that have evaluated the Progoff method include facilitating Intensive Journal workshops with inmates to aid them in self-transformation and rehabilitation (McNair, 1999) as well as to welfare recipients looking to improve their job skills, literacy, and self-esteem (Sealey & Duffy, 1977). In both settings, the participants reported an increase in their confidence and comfort with expressive writing. In a more recent study, social worker Dorothea Epple (2007) conducted an exploratory qualitative study of the Intensive Journal as an adjunct to psychotherapy. Epple measured the effects of the Intensive Journal Method on fourteen participants (all with professional backgrounds in writing and high education levels) who used the journal method for eight years. The participants reflected positively on journal method, and some expressed:

The journal has given me a place in which to experience myself and to discover my existence...it is a way of making contact with strengths of powers within myself which may tend to habitually overlook or minimize...I accessed my inner wisdom and, after that, I knew that everyone has inner wisdom” (p. 297).

Some participants also found the skills and insight from the writing exercises applicable to their professional and creative lives, and many independently engaged in expressive writing (plays, books, poems) apart from the Intensive Journal workshops. Epple proposes that the Intensive Journal has a place in the therapeutic relationship, positing that the journal as a supplement to therapy could “facilitate the narrative process and the construction of a coherent story” (p. 297). She observed that the journal “helps one link the conscious and unconscious in an integral unity, bringing a new awareness that restructures the prior conscious view and moves one forward with life,” thereby deepening the client’s insight and content of the therapeutic work (p. 292).

While clinicians often recommend journaling outside of treatment as a therapeutic adjunct, they primarily do so without Progoff’s four divisions and group workshops (Epple,



2007). Progoff's method has not gained much traction in the clinical community, perhaps in part due to its design without therapist involvement, its sparse empirical support, and the logistics of facilitating a group workshop. A concern of some clinicians is that the free-form writing may only further exacerbate negative symptoms like ruminating thoughts. Progoff also identifies this risk; he calls the trend "wandering around in circles" (Levine & Calvanio, 2007, p. 323). Moreover, the workshops are not conducive to the schedules of many clinicians in private practice and community mental health agencies; to run a group requires time and resources to recruit participants and to train the facilitator. Despite its sparse utilization in traditional therapy settings, Intensive Journal workshops continue to be held regularly in several countries with an active online community ("Schedules and locations," n.d.). Progoff's promotion of expressive writing in conjunction with verbal psychoanalysis has raised awareness of the treatment's therapeutic benefits and potential as a supplement to talk therapy (L'Abate & Cox, 1992; Lepore & Smyth, 2002). His contribution of the first structured incorporation of journal writing as a therapeutic exercise acted as a platform from which L'Abate, Pennebaker, and other preceding clinicians could learn, experiment, and revise.

**L'Abate's Programmed Writing Treatment.** The subsequent structured writing program was introduced by psychologist Luciano L'Abate and his colleague Janet Cox in their text *Programmed Writing: A Self-Administered Approach for Interventions with Individuals, Couples, and Families* (1992). L'Abate was concerned that free form writing found in Progoff's method would allow those with more negative frames of mind to apply their perspective to their writing, thereby contributing to ruminations for individuals with depression. Thus he hypothesized this population would be better served with guided prompts than a blank page (L'Abate, 2007). Programmed Writing introduces writing assignments outside of psychotherapy

as an adjunctive, “secondary prevention” treatment. L’Abate promotes expressive writing assignments as a

supplementary and complementary form of experience and expression that overlaps little with conventional ‘talk’ psychotherapy. It may allow the exploration and elaboration of areas that have not been touched upon during verbal sessions; it may be a more comfortable medium for people who cannot express themselves well orally...clients learn to think through and reflect on previously impulsive and repetitive patterns of behavior (p. 14).

Unlike the Intensive Journal, Programmed Writing’s adjunctive approach makes room for the therapist’s involvement. L’Abate recommends that the therapist assign, interpret, and discuss the writings with the client. He posits that the “condition of reciprocity” between writer and reader (client and therapist) enhances the benefits of reflecting on the piece and the therapist’s understanding of the client’s thoughts and emotions (p. 11). Furthermore, by sharing writing with the therapist, the client tests for and/or demonstrates trust of the therapist; and this gesture can strengthen the therapeutic alliance and aids progress in treatment (Angus, 2012; Carlson, 1997).

L’Abate and Cox’s text provides several lists of writing prompts for individuals, couples and families with various presenting problems, including alcoholism, codependency, domestic violence, lying, and depression. Clients with depression were asked to write their answers to questions like “what does depression mean to you?” and “where do you believe your depression comes from?” Clients then rank the prevalence of their feelings related to depression, such as “uncertainty about the future,” “feeling hopeless and empty,” and “broodiness” (a form of ruminative thought) (p. 123). Over the course of four weeks, the clients’ homework is to focus on the feeling they rated number one (and feeling number two for week two and so on through week four) and to elaborate on “what makes it come about,” go away, where it comes from, and

other prompts. After the exercise, the assignment asks clients to give the writing to their therapist and to discuss the answers in treatment.

As he continued to develop his treatment and theory, L'Abate's focus shifted to distance writing and cyber therapy—a form of treatment that did not include the face-to-face, in-person dynamic between therapist and client (L'Abate & Kern, 2002). He turned his attention to online connections to address the increasing limitations on clinicians' time to practice one-on-one psychotherapy, a model he predicts is “slowly but inevitably giving way to one professional-many participants at a distance, online, and through a hierarchy of personnel” (L'Abate & Sweeney, 2011, p. 131). L'Abate asserted that distance did not jeopardize the therapeutic alliance as clinicians may predict. To support his assertion, L'Abate cites a study by Germain, Marchard, Bouchard, Guay and Drouin (2010) that evaluated the therapeutic alliance through videoconferencing versus face-to-face therapy for 46 participants with PTSD. The researchers concluded that there was “no significant difference” of the alliance's strength between the two methods (L'Abate & Sweeney, 2011, p. 14). While this study supports the resilience of the therapeutic alliance over video and distance, it does not measure how workbooks and written correspondence in L'Abate's method impact the alliance and clients' progress and engagement in treatment.

Few empirical studies have evaluated the Programmed Writing and distance writing method specifically, yet L'Abate and his colleagues have conducted significant research on the use of workbooks and written homework with specific and incremental prompts in both distanced and face-to-face therapy. Notably, L'Abate is an author, if not the lead author, on nearly all the studies that evaluate his own program. L'Abate's results largely indicate that when the workbooks between therapy sessions yielded positive outcomes for several types of mental health ailments and interpersonal dilemmas (Esterling et al., 1999; L'Abate, L'Abate, & Maino,

2005; L'Abate & Sweeney, 2011; Smyth & L'Abate, 2001). In a exploratory retrospective analysis of a decades of the authors' outpatient practices with and without workbook homework assignments, L'Abate, L'Abate, and Maino (2005) found that individuals, couples and families who used workbooks between sessions attended up to six times as many sessions as those who did not. This study further concluded that the treatment is cost-effective and does not require significant additional training or involvement of the therapist. The researchers hypothesized that the workbook helped clients to “feel better about the therapeutic process, and therefore, they would stay in treatment longer” (p. 27).

L'Abate attributes the treatment's success to the client's increased sense of awareness through guided written disclosure. The treatment can be especially effective for those with depression and rumination. L'Abate observes, “writing can improve self-knowledge because clients no longer need to ruminate and obsess but are able to get these recurring thoughts out of the self so that they and their therapists can look at them” (p.19). The therapist's role in reading the writings with the client is to help the client to reframe the negative thoughts and feelings and to increase an understanding of the client's positive attributes. While L'Abate noted how free form writing can fuel ruminations, he did not address how workbooks' guided prompts may also contribute rather than diminish ruminative thoughts and negative frames of mind. He also did not discuss how writing could increase the client's low self-esteem or the risk that the client may censor her writing to protect herself from exposure and vulnerability to the therapist (L'Abate, 2007).

In addition to its threat to the therapeutic alliance, the time commitment required of both the client and the therapist to the exercises and their prescribed style may in part explain the resistance to its incorporation. L'Abate addresses the resistance of some clinicians to adopting his program and other structured writing in workbooks, yet he notes that therapists are

increasingly utilizing workbooks in practice (L'Abate & Kern, 2002; L'Abate & Sweeney, 2011). L'Abate's attention to the therapeutic effect of expressive writing for a wide spectrum of client populations (including individuals struggling with depression and rumination) and his hypothesis of how to implement the writing into the treatment room provide valuable guidance into new ways clinicians can incorporate EWTs into practice.

**Pennebaker's Expressive Writing Paradigm.** Psychologist James Pennebaker, arguably both the most prolific and influential researcher on EWTs, has extensively studied the healing effect of expressive writing on physical and emotional wellbeing (Baikie, Geerligs, & Wilhelm, 2011). His interest in the impact of inhibition—"the effortful holding back of the impulse to disclose about a traumatic life event" (King, 2009, p. 120)—led him to investigate the healing value of expression, insight and catharsis through expressive writing as the primary therapeutic intervention. Pennebaker's findings consistently confirmed and elaborated upon expressive writing's healing effect (Pennebaker, 1989; Pennebaker, 1997; Pennebaker, Mayne, & Francis, 1997; Sexton & Pennebaker 2009). He confidently promotes the treatment as a "preventative health measure" for those with a wide spectrum of physical and psychological ailments (Sexton & Pennebaker, 2009, p. 265).

Influenced by both behavioral and psychodynamic theories, Pennebaker developed an expressive writing paradigm to assess if and how expressive writing could diminish stress-induced health problems. In his expressive writing paradigm, Pennebaker (1997) asked participants in the experimental group to write for fifteen to thirty minutes each day for three to five consecutive days. The participants, who ranged from prisoners to end-stage cancer patients, wrote in a laboratory or at home. The reader, a researcher or clinician, did not provide the participant with feedback on the writing—their role was to analyze and make meaning from the written work to evaluate its effect. Pennebaker prompted them to write:

your very deepest thoughts and feeling about an extremely important emotional issue that has affected your life. In your writing, I'd like you to really let go and explore your very deepest emotions and thoughts...the only rule is that once you begin writing, continue to do so until your time is up" (p. 162).

The control group wrote about non-emotional, shallow topics like lists of activities and events. Pennebaker found that while the exercise was initially upsetting to many participants as they recalled painful memories and feelings, "the overwhelming majority report that the writing experience was valuable and meaningful in their lives" (p. 162.) Participants in the experimental groups showed long-term improvements in mood and wellbeing as well as higher grades, greater initiative to find jobs, and increased attendance rates at work and school.

In later studies, Pennebaker observed that the greater use of words associated with insight, causality, and cognitive activity in the narratives were also associated with increased physical and emotional wellbeing (King, 2002; Pennebaker, Chung, Ireland, Gonzales, & Booth, 2007; Pennebaker, Mayne, & Francis, 1997; Tausczik & Pennebaker, 2010). Pennebaker and his colleagues quantified the words with the Linguistic Inquiry and Word Count (LIWC), a software program he designed to find and analyze words in written disclosures (Pennebaker et al., 2007). The program flags and sorts words into several categories, including "standard linguistic dimensions" (and, the, but), personal concerns (work, home, hobbies), and psychological "target words" relating to affect, cognition, or biological processes. The word *cried*, for example, is a target word found in five categories: sadness, negative emotion, overall affect, verb, and past tense verb (Pennebaker et al., 2007). The LIWC serves as a quick and relatively objective sorter of word choice. This data can inform the interpreter's (therapist or researcher) of what sorts of words the client employs and neglects and the possible effect on her wellbeing. Pennebaker and his colleagues have used LIWC techniques in a retrospective study of word choice in past

narratives as predictors of physical and emotional wellbeing in written disclosures of men who lost their partners to AIDS to predict post bereavement distress (Pennebaker et al., 1997). The results suggest that greater usage of “target words” correlate with improved health, which supports the implementation of EWT with therapist’s encouragement of expressive, affective words and content (Esterling et al., 1999).

Since these findings, researchers have employed Pennebaker’s expressive writing paradigm (with slight variations) to study several participant populations with a wide spectrum of physical and psychological conditions. Studied populations include college students, psychiatric inpatients, Holocaust survivors, as well as those with chronic pain, breast cancer, PTSD, and several other groups both in the U.S. and abroad (Frattaroli, 2006; Sexton & Pennebaker, 2009, p.267). The studies have consistently shown reduction in harmful physical symptoms and increases in self-esteem, mood, and motivation to heal (Davidson et al., 2002; Graf et al., 2008; Lepore, & Gerin, 2002; Norman et al., 2004; Stanton & Danoff-Burg, 2002). Frattaroli’s (2006) meta-analysis of 140 studies of Pennebaker’s paradigm shows that in nearly every case the treatment had *at least* a “small but significant effect” (Sexton & Pennebaker, 2009, p. 267). Frisina, Borod and Lepore’s (2004) meta-analysis reveals “the benefits of expressive writing do not discriminate” between populations and diagnoses.

Pennebaker’s paradigm proved to be especially effective in studies that prompted the participants to write with an emphasis on their strengths, goals, and previously undisclosed traumas (King, 2001; L’Abate & Cox, 1992; Sexton & Pennebaker, 2009). The exercise was also particularly beneficial for adults with depression and ruminative thoughts (Gortner, Rude, & Pennebaker, 2006; Norman et al., 2004). Many participants of these studies demonstrated an increase of positive insight, future-oriented thinking, and proactive movement toward achieving

their goals (King, 2001; King & Miner, 2000; Sexton & Pennebaker, 2009). A participant in the Gortner, Rude and Pennebaker (2006) study on EWT for rumination reflected after the exercise,

I am very bad at getting emotions out. I certainly don't express them to many people...Being forced to sit down and write out my feelings literally changed me...writing down my thoughts is a positive alternative to keeping everything bottled up inside. So this experiment gave me an outlet (p. 300).

The study found that the exercise reduced brooding more so than the reflective component of rumination—thereby suggesting that the negative judgments of the emotional experience are the “active ingredient” in rumination’s depressive effects (p. 300). Gortner et al. provide one of the only studies on expressive writing’s effects on rumination, and the positive findings call for further research and application of the treatment for this population.

While researchers continue to study the effects of Pennebaker’s expressive writing paradigm on several populations, very few clinicians employ his program in their practice (Kerner & Fitzpatrick, 2007). Its absence may be due in part to clients and/or therapists’ perception of the assignments as punitive or busywork as well as the paradigm’s lack of attention to how therapists should process the writings with the client. Pennebaker did not give clear guidance on how therapists could incorporate the paradigm, and the paradigm did not include feedback from the therapist about the writing. Moreover, the paradigm’s purpose was to *study and evaluate* the healing effects of expressive writing rather than to develop a practical method of therapeutic treatment. In Pennebaker’s paradigm the writing assignments are the primary mode of therapy; his view that writing “is a process of self-exploration, to be carried out without an audience” may deter clinicians from assigning (not to mention collaborating on) the writing exercises (Sexton & Pennebaker, 2009, p. 269). Thus while Pennebaker made great contributions



to the study of the treatment, his focus was not on the *adjunctive* role of expressive writing exercises.

**Strengths and limitations of structured writing.** The structured writing programs by Progoff, L'Abate and Pennebaker are amenable to empirical study and quantifiable data on the effectiveness of the interventions. The studies have largely yielded positive findings for a wide variety of participant populations, including adults with depression and rumination. The results speak to the value of expressive writing as an alternative and supplementary therapeutic intervention to talk therapy. These treatments also offer an alternative form of clinical engagement to address the expense and constraints of individual face-to-face treatment. This alternative may be particularly beneficial for geographically distant clients who cannot regularly attend sessions, do not easily express themselves through verbal communication, as well as those who desire more structure and continued engagement between sessions.

While the structured nature of the programs allowed for quantification and support of the treatments' success, the format may also in part account for the reluctance of many clinicians to adopt the programs (Kerner & Fitzpatrick, 2007). A notable commonality in these structured programs is their virtual independence of talk therapy with a clinician. The treatments do not provide substantial room for collaboration with the therapist or a place for the writing in the treatment room; Progoff's workshops take place without therapist involvement, L'Abate's writing homework is meant for in between sessions, and Pennebaker's paradigm is primarily a design to evaluate rather than incorporate expressive writing's healing effects. Furthermore, these treatments assume a cognitive capacity and comfort in writing of the client and ask for additional training, time and resources of the therapist. A further concern is the way in which the structured writing—particularly L'Abate's distance writing—can hinder the therapeutic alliance and the therapist's attunement to the client's engagement and progress. The writings an also

serve to exacerbate ruminations rather than break the negative thought cycle. These treatments require the clinicians' interest and comfort in reading and discussing her client's work as well as the ability to afford the time and expense of the workbooks and trainings. Despite these limitations, the empirical findings derived from the structured programs on the value of EWT have contributed to clinical understanding and appreciation for the interventions. These findings offer support for EWT as an empirically-based method, which heightens its appeal to agencies and insurance plans. This appeal increases the feasibility of implementing the adjunct into practice.

### **Unstructured EWTs**

While less empirically researched than the programmed writings described above, unstructured writing treatments appear to be more popular and widely incorporated supplements to talk therapy (Kaufman & Kaufman, 2009; Kerner & Fitzpatrick, 2007). Unstructured writing treatments include writing exercises in therapy that do not strictly follow a prescribed program; rather, the therapist provides a prompt or encourages free-form expressive writing for a client who they assess may benefit from an alternate expressive medium (Esterling et al., 1999). Three common unstructured therapeutic expressive writing exercises are 1) employing metaphor in creative stories and poetry; 2) journaling between sessions; and 3) letter writing between client and therapist, another party, or parts of herself. Some clinicians with diverse theoretical approaches implement these exercises, and many individuals self-administer these treatments with or without the encouragement of a therapist (Legowski & Brownlee, 2001). These exercises both predate and evolved from the structured writing programs; the apparent therapeutic value of writing provides the basis for the structured writing programs, and, in turn, the structured programs contributed a more sophisticated and empirically supported understanding of expressive writing's therapeutic value as a more informal adjunct.

**Writing with metaphor: Creative storytelling and poetry.** “Metaphor,” writes Paivio, “is a solar eclipse. It hides the object of study and at the same time reveals some of its most salient and interesting characteristics when viewed through the right telescope” (Huckins, 1992, p. 232). Through storytelling and poetry, therapists encourage clients to use metaphors and creative license to rewrite, reframe, and communicate about their experiences and symptoms. This treatment is especially appropriate for clients with unresolved conflicts and uncertainty about the future who have difficulty verbalizing their pain (Huckins, 1992; Mazza, 1996). As Leavitt and Pill (1995) observe in their clinical practice, metaphor in creative writing can act as a “more primary process than conversation,” as “metaphor facilitates rapid access of innermost thoughts, often in disguised form, thus making them easier to approach and ultimately confront” (p. 139). The metaphorical writings may reflect the content of ruminations and other factors contributing to the client’s depression as well as the reasons she struggles to break the ruminations. This dialogue between therapist and client may strengthen the therapeutic alliance while enabling work with the client’s affect-rich material.

Through the use of metaphor and creativity, clients can write stories of their “alter-ego” (an allegory of themselves) who overcomes adversity and resolves past conflicts. By developing these stories, the client can begin to embody this alternative narrative and character and adopt her strengths (Furman, Downey, Jackson, & Bender, 2002; Legowski & Brownlee, 2001; White & Epston, 1990). Metaphor in poetry can also serve as an agent of expression and communication. Caruth and Ekstein (1966) observe that the client may

choose the metaphor as a sort of alibi, a conscious allusion which is a way of implying what he wants to communicate without actually committing himself, a way of simultaneously keeping and revealing a secret (Huckins, 1992, p. 233).

The metaphor provides therapists with a deeper understanding of the client's emotions and cognitions, and it offers the clients a vehicle of expression that can maintain a sense of protection against full disclosure.

As constructivist therapies continue to develop and expand, creative storytelling and poetry are increasingly found in clinical practice (Furman et al., 2002; Legowski & Brownlee, 2001). Empirical studies on these treatments are few, yet those that have been conducted promote the therapeutic value of creative writing and they call for further research and implementation of the treatment (Huckins, 1992; Mazza, 1996). Clinicians who employ NT techniques particularly endorse the use of metaphor and storytelling in writing, as it can be an exercise in externalizing and reconstructing one's narrative (Legowski & Brownless, 2001; White & Epston, 1990).

**Journal writing.** Journaling is perhaps the most common therapeutic writing supplement to talk therapy. Clinicians often suggest journal writing as a self-soothing coping strategy between sessions, especially in times when clients feel socially isolated and overwhelmed by intrusive thoughts (Lepore & Smyth, 2002). Epple (2007) finds that both journal writing and talk therapy focus on a "process of quieting one's self, reflecting within, identifying ideas, epiphanies, strengths, potentials, and living with these potentials in the world" (p. 289). When the client shares her journal entries with the therapist, she allows for intimate access to her psyche. Freud (1919) likened the journal entry to "a little gem" that gives the therapist an opportunity "to obtain such a clear and truthful view of the mental processes" (p. 341). Thus reading the journal entries—and, perhaps to a lesser degree, hearing a client's summary of the entries—can provide the therapist with an intimate view of the client's internal monologue laden with material for therapeutic attention (Thompson, 2011).

While many clinicians encourage journaling, clients often use journals independently from treatment and do not share their entries with their therapists (Mazza, 1996; Ullrich & Lutgendorf, 2002). In these cases, the journal serves as a solitary technique to process and record thoughts and feelings, yet the insights derived from these entries may inspire the topic of sessions with the therapist. If the client channels her thoughts more easily and authentically to the journal rather than to the therapist for fear of judgment and exposure, the absence of the journal entries from the treatment room could deepen the schism between the internal dialogue of the client and the communication of client to therapist. Sharing or discussing the content of the journals during session may diminish the potential for this ‘split.’ Moreover, the journal can serve as a more accurate reflection of the client’s internal and external experience between sessions than their verbal recollection in the treatment room (Ullrich & Lutgendorf, 2002). A number of clinicians do invite journal entries into practice, and some allow for time to write in the journal during session time (Thompson, 2011); yet these forms of incorporation has not been sufficiently empirically studied or widely adopted.

**Letter writing.** Written correspondence through letters (both electronic and postal) is another common mode of expressive writing to complement talk therapy. Clinicians primarily use letter writing as an unstructured, *ad hoc* exercise for clients they predict may benefit from directed communicative expression, such as those with ruminative thoughts about a conflict or “unfinished business” with another person (Sloman & Pipitone, 1991).<sup>2</sup> Many clinicians encourage their clients to write letters to a family member, an abuser, or to themselves (or a part of themselves), either with or without the intention to deliver the letter. Some clinicians also use

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<sup>2</sup> Letter writing is also part of the structured, evidenced-based Cognitive Analytic Therapy (CAT). CAT incorporates letter writing to and from the therapist to strengthen the therapeutic alliance, to engage the client in her treatment goals, and to process termination (Hamill, Ried, & Reynolds, 2008; Keefe & Berk, 2009).

email or postal letters to engage in correspondence with their clients between sessions and even after termination, particularly for clients who are geographically distant and unable to frequently attend sessions in person (Terry, 2010). Writing and reflecting on letters between sessions can be a self-soothing act of expression and communication that increases insight and awareness of the problem (Nau, 1997; Roberts, 2008). Rasmussen and Tomm (1992) note that “there is no other system of psychotherapy in which the client has so much more control over the rate, depth, and intensity of his or her personal therapeutic work” as in the act of constructing a therapeutic letter (Nau, 1997, p. 4).

NT’s incorporation and promotion therapeutic letter writing has been especially influential in how clinicians use letter writing in therapy (Hamill et al., 2008; Keefe & Berk, 2009; Mazza, 1996). White and Epston (1990) observe that the letters to and from clients provide a tangible record of the treatment that hold both therapist and client accountable for the work and progress. They posit that the “co-created discourse” of the letters and their content are “shared, dialogical rather than a professional monologue and, due to their visibility to all parties, can be easily amended, contested, or confirmed” (p. 126). Letters also act as an alternative means of expressive communication to the therapist and client or other recipient of the letter (client’s family member, friend, or other relation). This means can double as an exercise in storying and externalizing the experience causing the client pain; these concepts will be discussed in more detail in the next chapter.

Through the narrative lens, many clinicians encourage clients to write letters to “the problem.” (In NT, “the problem” is the symptom, illness, or dynamic that is the cause of the client’s suffering. Naming the problem begins the process of externalizing the problem from the individual or family and increasing the sense of understanding and control over the problem) (Payne, 2006). By sharing the client’s letter with the therapist, the therapist can help the client to

identify and reframe the problem the letter addresses. In a case example of letters in NT by Freeman (2011), a 12-year-old boy writes a letter to his recently-deceased older brother about how much he misses him. Although the younger brother was aware that the older brother was no longer able to receive the letter, by writing the letter he gave voice to the way in which his brother's death affected him. The exercise revealed the younger brother's processing to the therapist and to the boy's parents, and it allowed him to "express and externalize his reactions safely in the face of societal taboos against expressing his feelings about loss" (p. 13).

Nau (1997) describes a case in which he creatively urged his client Andy (who was resistant to many interventions) to write a letter to his amputated leg. This exercise enabled Andy to articulate the grief and anger he felt over the loss of his leg that he was hesitant to communicate in talk therapy. Andy shared the letter with Nau, which deepened the therapeutic connection and provided Nau with a rich understanding of Andy and how to address his conflict. For clients like Andy who have difficulty verbally expressing their thoughts and feelings, writing a letter to themselves can elicit latent affect and process. In these cases, the letter acts as a sort of Winnicottian (1971) transitional object; it is a tangible symbol that represents "me" and "not me," a cleavage imperative for development and creative exploration. As a transitional object, the letter aids the client in learning the distinction between fantasy and reality as well as separation of the problem and the self (Hamill et al., 2008; Keefe & Berk, 2009).

Some therapists, with a narrative or another orientation, have engaged in the collaboration of editing the letter—whether the intent is to send it or not—to give clients an outlet to articulate and communicate problems while enhancing a sense of agency and involvement in their treatment. In family therapy, therapists have collaborated with parents on how to write a letter to their child about the presenting conflict (ie the child's tantrums or reluctance to attend school) (Sloman & Pipitone, 1991). Children also write letters with their

therapists to communicate to their parents and abusers, which has been found especially therapeutic with children who have difficulty understanding and articulating their feelings and reaction to abuse (Sloman & Pipitone, 1991). “Healing letters” are another form of therapeutic letter-writing; adult and child victims of sexual violence write these letters to their abusers (many of whom are unknown) as a way of channeling their unresolved and undirected anger, distress, and confusion (Dolan, 1991; Nau, 1997).

In addition to letters written by the client, letters from therapists to clients also serve as valuable, permanent records of the intervention and insight the therapist communicates to the patient. Therapist-written letters can be quite valuable between sessions and after termination (Keefe & Berk, 2009; Terry, 2010). Perhaps most importantly, in the letter from the therapist, “the written word can be a powerful validation of the patient’s experience and undeniable proof that their story has been heard” (Keefe & Berk, 2009, p. 316). When the client receives the letter and reads it between sessions, the therapist’s letter can validate the client and remind her of the therapist’s support. While a letter from the therapist can be valuable, it requires additional time of the therapist allotted for each client that the therapist’s schedule may not allow. A further complication is balancing the client’s expectations of the correspondence with the boundaries set within the therapeutic dyad. If the therapist is unable to meet the client’s desired frequency or quantity of letters—or if the therapist is a more active correspondent with some clients more than others—the therapeutic alliance is at risk for rupture and treatment may regress.

### **How Expressive Writing Works**

Researchers of both structured and unstructured EWTs have developed theories about how and why the treatment can be therapeutically effective. The most prevalent concepts to explain the effects of expressive writing are 1) emotional inhibition, 2) emotional expression and catharsis, 3) cognitive restructuring/adaption, and 4) emotional regulation.



**Emotional inhibition.** Expressive writing may be beneficial in part because the exercise acts as an outlet for inhibited negative emotions. Pennebaker and his colleagues (Pennebaker, 1989; Pennebaker, 1997; Pennebaker et al., 1997; Sexton & Pennebaker 2009) have contributed significant findings to the study of prolonged inhibition and its negative effects on the body as well as how expression and confession can help to remedy those effects. Active inhibition, Pennebaker (1989) observes, requires that “individuals must consciously restrain, hold back, or in some way exert effort to *not* think, feel, or behave” (p. 231). Pennebaker adds that inhibited feelings and thoughts will likely “surface in the forms of ruminations, dreams, and associated cognitive symptoms” (p. 231). Over time, the effort of inhibition becomes a chronic physical and psychological stress, which often leads to poor health outcomes, such as hypertension, low energy, and poor sleep and appetite (Greenberg, Wortman, & Stone, 1996; King, 2002; Sexton & Pennebaker, 2009). The antidote to inhibition and rumination is often confrontation of the thoughts and feelings through expression and confession to oneself and/or others, and writing about these inhibited feelings helps to process and release them (Graf et al., 2008; Greenberg et al., 1996; Pennebaker, 1997; Sexton & Pennebaker, 2009). For those who chronically inhibit their feelings, the physical repercussions of suppressing emotion are more severe. Even for those with alexithymia (limited awareness of emotions), expressive writing can lower the negative physiological effects of chronic inhibition (Lumley, Tojek, & Macklem, 2002).

**Emotional expression and catharsis.** In a similar vein, researchers of expressive writing also attribute the treatment’s success to the benefits of expressing one’s past traumas, ruminating thoughts, and negative feelings. Sexton and Pennebaker (2009) describe how expressing and directly confronting an emotional upheaval can result in emotional changes leading to habituation and extinction...The emotions associated with a trauma become dulled and do

not carry the same weight, thereby reducing anxiety and helping improve daily functioning” (p. 268).

By confronting the troubling thoughts/feelings or memory of trauma, one also engages in a cathartic release. In addition to the freeing of latent energy, the catharsis can increase insight and mastery over inhibited emotions (Greenberg et al., 1996; King, 2001; Pennebaker & Seagal, 1999). L’Abate and Cox (1992) posit that after writing-induced catharsis and disclosure, “clients no longer need to ruminate and obsess but are able to get these recurring thoughts out of the self so that they can their therapists can look at them” (p. 19). Pennebaker (1989) agrees; he elaborates that the benefit of catharsis is not primarily derived from the rapid “venting” of negative thoughts, but rather by the insight one achieves through observing the content of the cathartic expression.

**Cognitive restructuring and adaption.** Expressive writing has also shown to be effective because it provides a safe medium for one to identify and reframe the negative cognitions that enable inhibition and exacerbate symptoms, such as thoughts about low self-esteem, loneliness, pessimism, and ruminations (Alloy, 2001; King, 2002; Pennebaker & Seagal, 1999; Sexton & Pennebaker, 2009). Writing about the cognitions illuminates the thoughts and conveys them to the therapist. Engaging in expressive writing can alter cognitive structuring to help clients to name their thoughts and to deepen their understanding of themselves and their symptoms (Ullrich, & Lutgendorf, 2002). As Boyer (1983) observes,

clear writing leads to clear thinking...perhaps more than any other form of communication, writing holds us responsible for our words and ultimately makes us more thoughtful human beings...writing is an essential skill for self-expression and the means by which critical thinking also will be taught (L’Abate & Cox, 1992, p. 20).

Pennebaker's empirical studies that dissect narratives with the Linguistic Inquiry and Word Count (LIWC) supports this theory (Pennebaker et al., 1997; Pennebaker et al., 2007; Tausczik & Pennebaker, 2010). Pennebaker finds that a higher prevalence of words in participant's written narratives associated with cognitions (ie "I thought that" or "I imagined") correlates with a reduction of negative health symptoms, even more so than emotion words (ie "I feel angry, sad," etc) (Pennebaker et al., 1997; Pennebaker et al., 2007; King, 2002). A hypothesis for the reason of the disparity is cognitive restructuring is more feasible than emotional restructuring. The cognitive restructuring through expressive writing can be particularly effective in treating ruminations, as these intrusive thoughts draw from cyclical negative cognitions pattern (Arney et al., 2009; Gortner et al., 2006; Nolen-Hoeksema, 1998).

**Emotion regulation.** In addition to gaining control and awareness of one's cognitions, expressive writing can improve insight and mastery over emotional regulation and self-soothing. Those who suffer from depression, anxiety, and other disorders often have difficulty regulating their emotions and understanding what triggers them (Lepore et al., 2002). Increased self-awareness through expressive writing can lead to a greater ability to regulate emotions, as the insight may give one a feeling of control over her emotions (Greenberg et al., 1996; King, 2001; Sexton & Pennebaker, 2009). This sense of control and agency in one's emotions is crucial to engendering changes in feelings, thoughts, and behaviors (Alloy, 1991; Davidson et al., 2002; Gortner et al., 2006; Greenberg et al., 1996). King (2001, 2002) has found that those who write directly about their "best possible selves" and goals for the future are particularly successful in regulating their emotions and being proactive and optimistic in future planning. Thus attention to emotional processes (both positive and negative) through expressive writing can heighten one's sense of self-understanding and power to regulate emotions, which can diminish negative cognitions, feelings, ruminations, and other burdensome symptoms.

## **Conclusion**

This chapter elucidates expressive writing's empirical and anecdotal support as a therapeutic intervention for a wide spectrum of symptoms, including depression and rumination. The prominent structured EWTs—those developed by Progoff, L'Abate, and Pennebaker—experimented with how to use the intervention as a primary or secondary treatment with largely positive outcomes. While empirically supported, these structured treatments are rarely seen in clinical practice primarily due to their requirements of additional training and time. Clinicians appear more receptive to unstructured implementations of expressive writing, such as using metaphor in creative writing and poetry, journaling between sessions, and letter writing. Researchers and clinicians who have studied EWTs posit that the mechanisms that make the treatment effective can be understood through emotional inhibition, emotional expression and catharsis, cognitive restructuring/adaption, and emotional regulation. Both the unstructured and structured writing treatments consistently yield positive results, yet the treatments still remain curiously absent from many practices and clinical trainings.

By gaining an understanding and appreciation of the short history of expressive writing as an adjunct to talk therapy, therapists can learn what works, what does not work, and how to make the treatment more effective and amendable to practice. The literature presented in this chapter informs the model of EWT discussed in the final chapter of this thesis. Traces of NT and RCT are already embedded in the treatments and theories about expressive writing. Through the lens of these theories clinicians can alter the utilization of EWTs and increase their understanding and awareness of the intervention, particularly for adults with depression and ruminative thoughts who seek a creative expressive outlet. The following chapters aim to convey the principles and applications of NT and RCT to frame the incorporation of these theories into the thesis's proposed model for an expressive writing intervention.

## CHAPTER IV

### **Principles and Applications of Narrative Therapy**

Since social workers Michael White and David Epston unveiled Narrative Therapy (NT) in their text *Narrative Means to Therapeutic Ends* (1990), the treatment has become one of the most influential clinical theories in the postmodern era (Angus & McLeod, 2004; Carlson, 1997). At the core of NT is the value of the subjective narrative and the context of oneself within the family and culture. Evolving from and perpetuating the growth of constructivist philosophy, NT challenges clinicians to question their objectivity and authority and frees clients from oppressive dominant narratives. NT privileges verbal processing, yet its doctrines and techniques can influence the method of incorporation of expressive writing as an adjunct to talk therapy.

This chapter begins with a description of the theorists who influenced NT, namely the works of Bateson, Bruner and Foucault. Next, the chapter discusses NT's primary principles of storying lives, externalizing and mapping the problem, and finding unique outcomes. Following is a review of the empirical and case studies of NT and its creative applications in treatment. The chapter concludes with a discussion of the critiques of NT and considerations for future directions.

#### **Theoretical Orientation**

The zeitgeist in academia of postmodern and constructivist thought set the stage for the development of NT in the late twentieth century (Tomm, 1989). White studied a multitude of philosophers and anthropologists; in his writings are the voices of Edward Bruner (1986), Derrida (1978), Geertz (1983), Goffman (1974), Turner (1969, 1986), and Myerhoff (1982) (Abels & Abels, 2001; White, 2000; White & Epston, 1990). Of particular influence were the works of scholars Bateson, Bruner, and Foucault. White's interpretation and synthesis of these

theories lay the foundation of NT. An understanding of these ideas enhances the appreciation and comprehension of NT's theoretical orientation, principles, and goals.

**Bateson.** Gregory Bateson (1971, 1979) was a British anthropologist who expounded upon the theory of “the mind” and the “interpretive method”—the way we make sense of the world and find meaning in existence (White, 2004; White & Epston, 1990). He challenged the concept of objective reality (a positivist notion) and proposed that the context determines the interpretation of an event (a postmodern view). Facts, by this logic, do not exist in their common conceptualization. Thus it is through “news of difference” that we understand change and time, and with the pattern and connections between change and time we ascribe meaning (White & Epston, 1990). Bateson described meanings as static maps of a territory, a metaphor White uses to illustrate the web of interpretations of a problem (Polkinghorne, 2004).

Bateson wrote of how people make meaning and create an identity from their culture and experience (White, 2004). White inferred from Bateson that the “the structure of narrative provides a principle frame of intelligibility through which people engage in the activity of making sense of their experiences of life” (White, 2004, p. 42.) Thus the dominant narratives are the bedrock of culture, and culture is the foundation of identity and meaning. White incorporates this understanding into practice by dissecting cultural themes in personal narratives and noting patterns, both positive and negative, and their effect on the client's sense of self and the problem. Bateson and White also see the family's culture and narrative as tremendously formative of oneself, a dynamic that is the focus of NT with families (Polkinghorne, 2004).

**Bruner.** American psychologist Jerome Bruner (1986, 2004), one of the most influential theorists of education and constructivism, promoted the value of subjective realities and narratives of cultures and individuals. He observed how “we organize our experience and our memory of human happening mainly in the form of a narrative—stories, excuses, myths, reasons

for doing and not doing” (Abels & Abels, 2001, p. 1). Bruner proposed two modes of thought: the narrative mode and the logico-scientific mode. The narrative mode is the method of meaning making, while the logico-scientific mode is a pragmatic orientation that finds explanations through mathematical analysis of data and objective facts (Bruner, 1986). NT, by definition, privileges the narrative mode (as described in more depth in the principles of NT).

Bruner also used a “text analogy” to liken the evolving interpretations of literary texts upon each new reading to the dynamic messages within personal narratives (Madigan, 1992; White, 2000). These innately subjective narratives of ourselves give our lives and identities meaning and context, and we use these narratives to communicate with others (Bruner, 2004). While we may interpret the narratives as objective fact, Bruner is clear that they are subjective, amorphous, and not representative of the whole truth (a concept that Bruner disavows); rather, they are only one truth of one version of ourselves (Bruner, 2004, p. 5).

White embraced Bruner’s idea that people attribute meaning to their lives by “plotting their experience into stories, and that these stories shape their lives and relationships” (White & Epston, 1990, p. 79). Like Bateson, Bruner used the image of a map to illustrate the landscape of the story and interconnectedness of its concepts. He observed that when we read a text or tell a narrative, it’s as if we are “embarking on a journey without maps...in time, the new journey becomes a thing in itself, however much its initial shape was borrowed from the past” (Bruner, 1986, p. 36; White & Epston, 1990). White (2000) employs this map analogy to describe the context of the problem and its influence on the client. White endorsed Bruner’s message that “we *become* the autobiographical narratives by which we ‘tell about’ ourselves”—a notion that supports NT’s emphasis on expressing and challenging “problem-saturated” narratives (White & Epston, 1990, p. 127). Thus Bruner provided White with one of the primary principles of NT: the

notion that by telling and reconstructing our narratives we can change the outcome of our own story and our self-perceptions.

**Foucault.** Perhaps most influential in the construction of NT are the ideas of Michel Foucault (1978, 1980), French philosopher and “historian of systems of thought” (Madigan, 1992; Tomm, 1989, White & Epston, 1990, p. 1). Foucault’s theories of subjectification and the fusion of knowledge and power provide the foundation of NT’s practice of externalization and emphasis on the social context’s crucial role in our identity and self-perception (Madigan, 1992; White, 2000). Concisely put, Foucault observes that those in more powerful societal positions and cultural structures objectify the populous as human subjects for study and control. This power imbalance then leads to subjectification, a process in which we internalize the objectification and turn ourselves into subjects (Foucault, 1980; Madigan, 1992).

As we undergo subjectification, we define ourselves according to cultural norms and the way we perceive others to see us (think the internalized ‘gaze’ of Bentham’s Panopticon).<sup>3</sup> The cultural norms act as repressive systems of power, and our relationship to power determines the actions we take and how we define ourselves (Foucault, 1980; Lock, Epston, Maisel, & de Faria, 2005). Foucault sees power and knowledge as so inextricably correlated that he uses them as twin terms, i.e. power/knowledge or knowledge/power. As power/knowledge defines identities and norms it represses, “alternative truths,” and by accessing these alternative truths we can begin to reverse the process of subjectification (Foucault, 1978; Madigan, 1992).

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<sup>3</sup> Utilitarian philosopher Jeremy Bentham (1787) proposed an architectural design for a “Panopticon,” a construction that enabled a managerial gaze to observe over many for social governance. The Panopticon has become a “metaphor for the disciplinary mode of domination,” in which one with power can efficiently observe and subordinate the majority in an institutionalized system (McKinlay & Starkey, 1998, p. 3). Foucault (1995) noted the primary effect of the Panopticon was “to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power” (p. 201)—in other words, the inmate (or citizen) internalizes the observing dominant gaze.



Foucault heavily influenced White's ideas that the dominant narrative is never the only or complete story of a person or a history, and that we naturally subject ourselves according to the "truths" of cultural norms (White & Epston, 1990). The ideas of subjectification and repression of alternative truths provide the basis for White's notions of externalizing the problem and summoning the subordinate, more strengths-focused narrative. Through externalizing conversations, one engages in the undoing of the internalization of the "gaze" (subjectification) and the definition of self in relation to cultural norms and power dynamics. In response to Foucault's hypothesis, narrative therapists strive to separate from the dominant narrative, challenge the techniques of power, and resurrect the subjugated truths.

### **Principles of NT**

NT employs unique methods to name and extract the "problem," a symptom or troublesome interpersonal dynamic that is the presenting concern. Narrative therapists emphasize the importance of storying lives, externalizing the problem, mapping the problem, as well as finding and developing unique outcomes. By employing these methods with clients, NT strives to promote a more nuanced and strengths-based comprehension of the past, present, and future.

**Storying lives.** NT is premised on the idea that the meaning of our identity and experience is found in and expressed through the telling of the stories about our histories and ourselves. White saw that most conversations, between two people or within oneself, are "shaped by at least the rudimentary requirements of a story—they have a beginning, a turn of events and an ending;" each story reveals the dominate narrative and potential for revision and resurrection of subordinate narrative (White & Epston, 1990, p. 79). NT posits that people want to tell the story of their lived experience, and clinicians can collaborate on the examination and "re-authoring" the story with a more positive, strengths-based outcome (Abels & Abels, 2001).

NT operates within Bruner's idea of the narrative mode, the alternative orientation to the logico-scientific mode of interpretation. In a logico-scientific mode, the subject (client) is a passive victim of events and circumstance. Through the narrative mode, the subject is a protagonist and active participant in her world—a world “of interpretative acts, a world in which every retelling of a story is a new telling, a world in which persons participate with others in the ‘re-authoring,’ and thus in the shaping, of their lives and relationships” (Ables & Ables, 20001, p. 82). Therefore, the narrative therapist privileges the person's interpretation of her lived experience, “encourages a perception of a changing world,” and names subjective views and multiple perspectives (p. 83). The narrative therapist also strives to invoke a sense of agency and authorship of the client's life and versions of her story.

By practicing within the narrative mode, the therapist seeks the alternative, less often told story. White (1990) notes that alternative stories “either emerge from within the dominant story or are discovered to be running along the parallel tracks, but have been suppressed or not admitted onto the record” (p. 127). Stories of particular therapeutic value are those previously untold and those with unexpected outcomes or narratives of triumph and resilience (Angus, 2012; Osatuke et al., 2004). Polkinghorne (2004) notes how by articulating the dominant story, “clients become alert to how it has operated to produce distorted and limited interpretations of their life events” (p. 60). Subsequently, after deconstruction and examination of the story, the dominant story “begins to appear as simply one possible view of one's self, not necessarily the correct view” (p. 60). By hearing and valuing the client's narrative, the therapist gains access to the client's insight about herself, her story, and how she ascribes meaning to it all—which acts as the ready draft for therapeutic revision and the subject of externalizing conversations and unique outcomes.

**Externalizing the problem.** While working within one's narrative, the therapist aims to externalize the illness or negative agents from the client. Through externalization the problem becomes its own entity, and the client's relationship to and the problem itself becomes the problem (White & Epston, 1990; White, 2000). A simple exercise in externalization is to move from referring to the problem as "I'm depressed" to "I suffer from depression." Once the client sees the problem as separate rather than an ingrained quality, she can objectify and even personify the problem (Abels & Abels, 2001). The therapist can assist the client to find agency in controlling and reducing the problem. The externalizing process is a reversal from the pattern that the problem dominated and inhabited them, which mirror's Foucault's process of subjectification and internalized dominance (Lock et al., 2005; Madigan, 1992; Tomm, 1989).

The method of externalization is primarily through *externalizing conversations*, dialogues that define the problem as separated from the client and expose suppressed strengths and alternate narratives (Abels & Abels, 2001; White, 1990). In these conversations, the therapist introduces the problematic themes of the story and guides externalization. Questions like "how is the problem affecting Johnny's life?" and "what is it doing to his friendships?" can cleave the problem from the person, assigning name or characteristics to the problem (the classic example is 'Sneaky Poo,' the personified name of a boy's encopresis) (Tomm, 1989). Metaphor can also act as an externalizing agent; images like "escaping the problem," "declining or refusing invitations to cooperate with the problem," and "taming the problem" infuse a sense of individuation, agency, and potential for freedom from the problem (White, 2007, p. 32-33). As the client divorces from the problem, she finds space and freedom to feel her latent strengths and potential for positive change (Tomm, 1989).

**Mapping the problem.** White borrows Bruner and Bateson's metaphor of stories as maps to explain the context and influence of the problem in the clients' lives. Maps of the

problem serve the function of any map: to provide orientation and guide us on our journeys. In NT, the therapist and client use the map

to assist us in finding our way to destinations that could not have been specified ahead of the journey, and they contribute to an awareness of the diversity of avenues that are available to preferred destinations, avenues that can be charted and rendered familiar (White, 2007, p. 5).

The maps illustrate, sometimes literally, the connections between the problem and the clients as well as the relationships between the client, other people affected (family members or other close social relations) (Abels & Abels, 2001). The maps give the therapist and the client a better sense of the context of the problem and its connection to the client.

The therapist collaborates with the client in mapping the influence of the problem by asking *relative influence questions*. These questions lead the externalization of the problem while it addresses links between the client, family, and problem. By asking the client and family questions about the impact of the problem, how they react to it, and who else is involved with the problem, the therapist begins to have a picture, a map, of where the problem fits into their lives (Abels & Abels, 2001). The therapist's understanding and client's insight about the context of the problem direct the process of changing the map to reflect and produce more unique and positive outcomes within the narrative.

**Unique outcomes.** Under the dominant, typically problem-saturated narrative are often *unique outcomes*, or times in which the problem was more obsolete. White adopted the concept of unique outcomes from Goffman (1961), who theorizes that in understanding the course of one's life, unique outcomes are often neglected in the "social strand," which is likened to the dominant story. White notes that the unique outcomes of the past can "facilitate performances of

new meanings in the present, new meaning that enable persons to reach back and to revise their personal and relationship stories,” (White & Epston, 1990).

By challenging client statements such as “I never had a friend,” with questions like “can you remember a time when that wasn’t true?” the therapist elucidates the unique outcomes to the client. When the client tells of a friend she had when she was younger, she can begin to realize that the problem is not always as all-consuming as it may feel. This process, what Myerhoff (1982) calls *re-authoring*, or retelling the past to reflect a more nuanced and strengths-based narrative can have tremendous therapeutic value (White, 2004). Future-oriented questions like “what would it be like to get over the problem?” also convey that the client has choice and agency in the course of their lives (Tomm, 1989). Unique outcomes may be rare, but White asserts that the client only needs one unique outcome to develop new understanding of herself and the role of the problem (White & Epston, 1990).

### **Research on NT**

Many contemporary clinicians have adopted NT techniques into their repertoire, yet researchers have conducted relatively few empirical studies to judge the method’s effectiveness. Most of the support for NT comes from case studies and anecdotal success rather than clinical trials with quantifiable data (Amundson, 2001; Keeling & Nielson, 2005). Vromans and Schweitzer (2011) hypothesize that this gap in research is due in part to “fundamental differences in theories of knowledge distinguishing postmodernist from modernist thought” as well as the sense that “narrative approaches are less easily operationalized and, therefore, less easily subjected to empirical evaluation” (p. 4). To address this dilemma, Angus (2012) developed the Narrative Process Coding System (NPCS) to evaluate the correlation between disclosure, meaning making, and emotional differentiation on treatment outcomes. The advent of the NPCS eases the quantification of narratives, which may encourage future empirical study of the

treatment. The limited research findings available show NT often yields positive outcomes for many populations, although few have studied the treatment's effect on adults with depressive disorders.

**Empirical support.** Empirical studies on NT's value as a clinical orientation largely support a variety of applications of NT. Researchers have studied the treatment with families (Besa, 1994; Silver, Williams, Worthington & Phillips, 1998), young thieves (Seymour & Epston, 1989), and women with anorexia in groups (Weber, Davis & McPhie, 2006). Among the sparse research on NT for adults with depressive disorders are studies by Boritz, Angus, Monette, Hollis-Walker, and Warwar (2011), Angus (2012), and Vromans and Schweitzer (2011). These studies indicate that NT can be quite effective for this population, and the findings warrant further research and practice of narrative techniques to treat depression.

Boritz and his colleagues (who include Angus) (2011) examine how over-general autobiographical memory (ABM)—narratives that omit specific memories and the emotions they evoke—relates to expressed emotional arousal in brief emotion-focused therapy (EFT) and client-centered psychotherapy for depression. The researchers concluded that participant disclosure of more specific and emotional memories increased the tolerance for negative emotions. They add that affective disclosure is also “central to how therapists identify core conflictual interpersonal patterns and develop an empathic understanding of clients’ key concerns during therapy sessions” (p. 16). To elaborate upon Boritz’s findings, Angus provided a theoretical report based on prior empirical research on how client narratives in psychotherapy contribute to insight and emotional awareness in EFT for adults with depression. Angus found that emotive storytelling contributed to the clients’ confidence, “compassionate view of self,” and the healing effect of the therapeutic relationship (p. 376). These studies offer valuable

insights on how eliciting emotional narratives can bring significant positive changes to adults with depression and call for further research on the technique.

Australian researchers Vromans and Schweitzer (2011) also conducted a study about NT's validity as a treatment for depression. Their study evaluated the effect of NT compared to evidence-based treatments on symptom alleviation and interpersonal relatedness with adults with depressive disorders. The study included 47 participants from ages 22 to 60 and 24 narrative therapists. The participants attended eight sessions of NT and assessed their depressive symptoms and interpersonal relatedness pre-therapy, post-therapy, and again three months later. Results revealed that nearly 75% of the clients had "reliable improvement" of their symptoms, 61% moved into the "functional population" and over 50% had "clinically significant gains" (p. 11). These results show NT's comparable effectiveness to CBT and other evidenced-based treatments. The study was limited by its design of repeated measures of a single and small sample without a control group (the researchers thought a randomized control trial would be "unethical and impractical" for this study); yet this study, one of the only empirical studies on NT to date, shows considerable data that NT can be beneficial for adults with depressive disorders.

**Case studies.** The majority of the literature on NT is case studies in which the clinician experiments with incorporating narrative techniques and then evaluates the effect on the client. White (1990, 2004, 2007) provides several case applications of his techniques, and clinicians have mimicked his approach on their own patients with largely similar success. Case studies reveal NT's impact on clients with bipolar disorder (Ngazimbi, Lambie, & Shillingford, 2008), elders with dementia (Young, 2010), adults with schizophrenia (Lysaker, Davis, Eckert, Strasburger, Hunter & Buck, 2005), children (Freeman, Epston & Lobovitz, 1997) as well as a wide spectrum of couple and family dynamics (Chrzastowski, 2011; Kim, Prouty, & Roberson,

2012; Saltzburg, 2007; Shalay & Brownlee, 2007). As with the empirical data, case studies with clients with depression are few in number (Vromans & Schweitzer, 2011). That said, while depression is not the primary problem, feelings of depression are likely a part of the problem in many family dynamics and individual symptoms for which NT was therapeutic.

The following two case studies provide clinical examples of NT in practice and serve as support for NT interventions. Cashin (2008) provides a clinical case example of NT with a “Justin,” a 13-year-old boy with Asperger’s disorder who had recently been suspended from school for verbally abusing his teacher. In the first session with Justin and his mother, Justin’s mother provided the therapist with the dominant narrative of the problem: Justin’s difficulty controlling his impulses and adhering to social norms. With Cashin’s urging, Justin and his mother were able to describe Justin as separate from his anger (the problem), which Justin named “the bang.” The externalization gave room for Justin and his mother to recognize his strengths and elucidated both triggering and calming stimuli. As the bang became an entity of its own separate from Justin, he gained control over his anger and left treatment as “Bang Buster Justin.”

Freeman (1996) describes a case of a couple with a newborn; the couple came to her practice after they had already filed for divorce. Both husband and wife thought the other one had changed after the baby was born and they no longer felt they were compatible. Freeman guided the couple through mapping the problem, which enabled them to see that cultural patriarchal patterns and the expectations of their parents’ had greatly influenced their interpretation of gender roles in parenting—roles that did not coincide with how either of them interacted with each other before the birth of their baby. Within a year of treatment the couple had ceased divorce proceedings. They relearned how to name the problems when they arose, identify their origins, and find agency in overcoming them together.



**Creative applications of NT.** While primarily a talk therapy, innovative clinicians have applied NT principles and techniques to creative therapies with positive outcomes (Caldwell, 2005). Carlson (1997) proposes an integration of art therapy and NT; he understands creating artwork as an exercise in externalization and deconstruction in a different medium for self-expression. He posits that the collaboration and analysis of artwork can strengthen the therapeutic alliance, in part because of the importance of the work's audience. Carlson also observes that artwork can expose unique outcomes, as the "very personal nature of the art enhances the ability of clients to express hidden aspects of themselves that they might not otherwise reveal" (p. 274). Subsequent studies of the narrative approach to art therapy found success in symptom management for women with breast cancer (Collie, Bottorff, & Long, 2006), children (Hecker, Lettenberger, Nedela & Soloski, 2010), and clients who have difficulty expressing themselves with words (Ball, Piercy & Bischof, 1993; Cobb & Negash, 2010), and depression (Penwarden, 2006).

Keeling and Nielson (2005) are among the few researchers who have studied expressive writing as another method for NT. In their experimental study, seven Indian women in the U.S. wrote a correspondence of letters between themselves and the problem (ie apprehension, loneliness, short temper) and drew pictures of their relationship with the problem. One participant reflected that writing externalized the problem—it helped her to "get it out, because it was like inside of me" (p. 447). The researchers conclude that writing and creating artwork appeared to empower the women to "address their problems out of the richness of their own resources," and they propose these creative adjuncts "may be a means of achieving thorough processing of issues while saving face, without sacrificing the therapeutic alliance" (p. 448). The positive outcomes and seamless integration of NT into creative therapies calls for more attention

to expressive writing with a narrative lens and gives reason to predict the combined treatment will show therapeutic benefit as well.

### **Writing in NT**

NT uses verbal processing as the primary mode of therapeutic engagement, yet writing has a distinct and important role in the treatment. Written adjuncts in NT include certificates of achievement for conquering the problem, therapist-recorded logs on client's progress, and, as described in the previous chapter, letter writing between therapist and client (White & Epston, 1990). The purposes of writing in NT are primarily to keep records and mark progress rather than to serve as a means of expression, although White promotes the therapeutic value of expressive writing in externalizing and mapping the problem. White (1990) cites Stubbs's (1980) observations that "written language does not directly represent spoken language," and thus a piece of writing makes content "easier to study and consider critically, and this in turn leads to more discoveries" (p. 33-34). Stubbs further argues that writing can transform and strengthen the therapist-client relationship and promote independent thought.

White notes written work's utility as a temporal progress tracker, which he sees as "much neglected in the therapy world" (White & Epston, 1990, p. 35). Moreover, White sees writing as a method to organize and record thoughts and to find new insights. White and Epston (1990) acknowledge their preference for verbal processing rather than writing primarily due to time pressures; although they admit that after writing the book they have been "forced to question the wisdom of being organized in such a way that time is often such a determining factor" (p. 37). White also notes how "written means to therapeutic ends need not always be extensive, serial, and time-consuming" (p. 107). (The final chapter will address how to accommodate writing given time constraints and productivity measures). Given White's insights on the value of

writing in treatment, expressive writing as an alternative or supplementary mode of storytelling may be a natural component to the narrative practice.

**Letter writing and certificates.** NT utilizes written correspondence as an adjunct to talk therapy in seven different types of letters: 1) letters of invitation for clients reluctant to come to therapy; 2) “redundancy letters” that reinforce one’s role in the family, between family members or from therapist to client; 3) client-written letters during termination that predict their status in six months; 4) counter-referral letters from the therapist to referring clinician about the client’s strengths and progress; 5) letters of reference from the therapist to client’s family noting the client’s competency and change; 6) letters for special occasions from the therapist to client’s family to explain and prepare them for what the client may experience during a momentous gathering, and 7) brief letters primarily from therapist to client about missed appointments, unfinished thoughts, validation and encouragement (Abels & Abels, 2001; White & Epston, 1990). Counter documents, or certificates of achievement over the problem (ie Certified “Monster-Tamer & Fear-Catcher”) also act as written components to NT, particularly for children (Freeman & Combs, 1996; White & Epston, 1990, p. 193).

Notably, most of the types of letters in NT are from the therapist to the client. Though letters between client and family members are also part of the written adjunct, one could argue that the therapist is utilizing the expressive exercise more so than the client. This does not discount the value the therapist’s letter could have on the client—she will have a tangible message from the therapist that may continue to give her support even after their time in treatment together ends—but the writing is not of the client’s own expression of her narrative (Bacigalupe, 1996).

White also uses letters as substitutes for case records, since the permanency and rich content of the letters are often more accurate reflections of the work than other accounting

methods (White & Epston, 1990). Letters from the client capture the client's processing and impasse at the time, and letters to the client reveal the intervention and reaction of the therapist. White sees the act of sharing letters about the client with the client as a way to keep the therapist accountable while also equalizing of the power dynamic—moreover, “their futures may be shaped” by the letters of which they are the primary subject (p. 126). Narrative clinicians Abels and Ables (2001) attribute the benefit of writing and sharing letters to

something about seeing things in writing that makes it more believable than being told about it. We are more likely to accept the truth of the written word...having something in hand, something solid, a letter, adds an important element to the helping session (p. 104).

Bacigalupe (1996) has also incorporated NT letters into practice and also shares his progress notes with his clients. He observes that when “writing procedures become part of the therapeutic activities, the client may have a greater opportunity to take a proactive stance in therapy” (p. 364). He proposes that writing about, to, and with clients is a “step forward in integrating collaborative, reflexive, and liberating aspects of postmodern systemic therapy” (p. 371).

### **Limitations and Critiques**

Clinicians have widely embraced NT's innovations due to the intuitive and approachable nature of the theory and its recurrent success with a diverse population of clients. As NT has become more popular and been incorporated into practice and curriculums, critiques of the treatment have also emerged. The primary critiques of NT target the philosophical exclusivity and the subsequent rift in family therapy, the recreation of the power imbalances that NT professes to dismantle, and the lack of theoretical support for NT's series of techniques. Doan, a self-named narrative therapist, has witnessed NT become “philosophically violent...in a sense of holding an opinion to be true and demanding that others hold it as well” (in Flaskas et al., 2000).

In this view, NT is competing with, rather than integrating and evolving from, other family therapy theories, namely systemic and Milanian practices (Amundson, 2001; Hayward, 2003). Minuchin (1998) is particularly critical that NT has “misplaced the family” and “returned to an emphasis on individual psychology” (Hayward, 2003, p. 185).

Furthermore, Minuchin sees NT as disguising the power imbalances inherent in the therapist-client dyad, as “control does not disappear from family therapy when it is re-named ‘co-creation’” (White, 2000, p. 101). The active involvement and powerful influence of the narrative therapist could be interpreted as a replication of the process of subjectification, thus “the very practices [NT] sought to take on may be sneaking in through the back door” (Amundson, 2001, p. 175). Others have noted this contradiction and likened the narrative practice to “colonization,” “discursive violence,” “evangelical,” and “coercive” (Flaskas et al., 2000; Hayward, 2003, p. 189). Amundson (2001) also calls attention to the lack of empirical data and the inadequacy of multiple case studies to support the effectiveness of NT’s clinical techniques.

Many NT therapists have responded to these critiques in an effort to make NT a more integrative practice (Hayward, 2003). White himself engages in the constructive criticism of his own work, and he acknowledges how

all acts of power in the name of therapy are equal—if it is not possible to differentiate between those acts that are more imposing from those that are less imposing—then we don’t have anywhere to go in terms of questioning therapeutic practice, and there will be no impetus for us to find ways of making what we do more accountable to the people who consult us (White, 2000, p. 100).

As the continued challenging and tailoring of NT has progressed into the embracement of a more inclusive genre of narrative therapies, the principles of NT become integrated into contemporary

practices, and, inevitably, future developments in psychotherapy (Flaskas et al., 2000; Hayward, 2003).

## **Conclusion**

This chapter described NT's theoretical orientation, principles, and applications as an emerging popular treatment. NT's practices of storying lives, externalizing and mapping the problem, and finding unique outcomes to challenges to the dominant narrative have shown (in admittedly little empirical support, particularly for depression) therapeutic benefit for a variety of individuals and families. Of particular relevance to this thesis is NT's application to creative therapies and incorporation of written exercises. Integrating methods of NT into expressive writing as an adjunct to talk therapy has the potential to strengthen the therapeutic value of expressive writing for adults with depression. The following chapter will discuss Relational-Cultural Theory, an orientation that provides a complimentary theoretical approach to expressive writing interventions.

## CHAPTER V

### **Principles and Applications of Relational-Cultural Theory**

Relational-Cultural Theory (RCT) offers a progressive way to understand development, identity, and the therapeutic relationship that can enhance the application of EWT. The founding mothers of RCT—Jean Baker Miller, Judith Jordan, Alexandra Kaplan, Irene Stiver and Janet Surrey—collaboratively created RCT at the Stone Counseling Center at Wellesley College (Jordan et al., 1991). These women wrote several essays in the 1980's and 1990's called *Work in Progress* papers that became the bedrock of what they later coined as RCT. This theory's attention to the involvement of the therapist, individual experience and the dynamic, relational nature of identity compliments NT's insights into the value of storying lives and collaborative treatment between client and therapist. Together, RCT and NT inform the understanding and implementation of expressive writing as an adjunctive therapy, particularly with adults with depression and rumination. While RCT particularly focuses on women's relational identities, the concepts of RCT can be applied to clinical work with both men and women of all races, ethnicities, and sexual and religious orientations (Duffey & Somody, 2011; Jordan, 2009).

This chapter will first describe the theoretical roots and orientation of RCT and its context as a progression of self psychology, object relations, and feminist theory. Next, the chapter discusses the theory's core concepts: mutual empathy, growth-fostering relationships, disconnections and the relational paradox, authenticity, and power and relational images. Following will be a review of the applications and empirical support of RCT. The chapter concludes with a discussion of the limitations and critiques of RCT and corresponding responses.

#### **Theoretical roots of RCT**

RCT proposes a greater emphasis on the study of the role of relationships in human development and psyche, an approach derived from several preceding theorists and theories across psychodynamic traditions. The origins of the doctrines of RCT are primarily found in object relations, self-psychology, and feminist theory. These theories began to cleave away from Freudian drive theory's focus on the growth of the "self" as an autonomous identity (a concept RCT rejects); they note the importance of our relationships with others, particularly during childhood, in our development and wellbeing (Jordan, 2009; Jordan et al., 1991). While more relational than drive theory, object relations, self-psychology and feminist theory do not see the relationships with others and societal structures as paramount to the identity and development as they are in the view of RCT.

**Object relations.** As one of the first offshoots of drive theory, object relations perspective begins to acknowledge the power of relationships in human development. Still oriented within a drive framework, object relations theorists—namely Melanie Klein, Donald Winnicott, Harry Guntrip and Ronald Fairbairn, contributed to the initial understanding the role of early interpersonal connections. Klein (1952) noted the importance of our early relationships as “the center of the emotional life,” a concept Winnicott (1960) later adopted and expanded (Jordan, 1991, p. 84). Winnicott studied the earliest relational connections: the effect of the mother's attunement on the mood and behavior of the infant. He noticed that an infant with a “good enough mother”—a mother who is more often than not able to interpret and attend to the infant's needs—will be an infant who is more capable of self-soothing and expressing her needs (Surrey in Jordan, Surrey, & Kaplan, 1991). The infant-mother relationship is at the crux of early development for Klein and Winnicott, yet their ideas are embedded in the aggressive-libidinal impulse model that endorses the concepts of individual drives as primarily formative to development of self (Jordan, 1991; West, 2005).



Guntrip (1973) and Fairbairn (1959) place greater value on the role of relational experiences in one's development. Fairbairn's notion of "mature dependence" relies on giving and receiving empathy and care. He sees individuality as obsolete when separated from relationships, "for it is only in its relationships to these objects that its true nature is displayed" (Jordan, 1991, p. 85). Guntrip focused on the mutuality of "appreciation, communication, and sharing" inherent in personal object relations and its imperative role in healthy growth and relational connection (Jordan, 1991, p. 85). Like Klein and Winnicott, Guntrip and Fairbairn elucidate the importance of relational connections in development within a primarily psychoanalytic, drive theory orientation of the individuated "self" as an autonomous unit.

**Self psychology.** From object relations theory evolved self-psychology, which further explored relationships' importance and the value of empathy in relational communication within and beyond the therapeutic relationship. Self-psychology was primarily developed by Kohut (1984), who drew attention to our need for "selfobjects"—significant persons whom the infant sees as non-autonomous being meant to fulfill a need—who are essential for the development of healthy narcissism, self-esteem, and self-cohesion (Banai, Mikulincer, & Shaver, 2005; Jordan, 2009). Kohut believed that throughout our lives we all depend on others to help us make meaning and become a cohesive self; although he promoted movement away from the dependence on others, as he saw dependence as indicative of immaturity. This notion of relational dependence as immature is one that RCT acknowledges and reframes, as the connotation targets the 'feminine' attributes of subservience and attachment to men and children (Jordan, 2009). Daniel Stern (1986) adds his observations of the infant as an active, rather than passive, participant in her relationship with the mother, therefore rejecting the idea of other as "object" (Jordan et al., 1991).

Kohut also spoke to the importance of empathy in relationships, a concept integral to RCT framework. He defined empathy as “a fundamental mode of human relatedness, the recognition of the self in the other; it is the accepting, confirming, and understanding human echo” (Jordan, 1991, p. 69). Carl Rogers (1951) recognized the role of empathy in relationships as well, including within the therapist-client dyad (Stiver, 1991). Rogers’s emphasis on therapist attunement, authenticity, and empathy formed the basis of his client-centered therapy, a predecessor to RCT’s “relationship-centered therapy” (Jordan, 2009, p. 16). RCT expands upon these theorists’ observations to study and promote the bi-directional, mutual relational process and its role in development and identity (Stiver, 1991).

**Feminist theory.** RCT both evolves from and contributes to feminist theory of women’s growth. West (2005) sees RCT as a “transparent overlay” map over feminist therapy, as RCT offers clarification and emphasis in various locations of the feminist orientation. RCT builds on feminist therapy’s focus on power differentials, relational patterns, and socio-cultural context of women and other subordinated groups (Walsh, 1997; West, 2005). The writings of Carol Gilligan (1982) and Belenky, Clinchy, Goldberger and Tarule (1986) were particularly influential to the Wellesley women (Jordan et al., 1991; West, 2005). Gilligan reframed models of development to incorporate women’s voices and experiences, and she analyzed the “centrality of connection in women’s sense of self” and its effect on her relationships and resiliency (Jordan et al., 1991). Belenky and her colleagues coined the term “connected knowing,” an alternative way of interpreting knowledge and engaging in relationships unique to women (Jordan et al., 1991). The RCT ideas of therapeutic authenticity, judicious disclosure, and using the therapeutic relationship as a corrective experience also have their roots in feminist theory’s applications to therapy (Tantillo, 2004).

Feminist theory inspired Miller's *Toward a New Psychology of Women* (1976), the book that marked the beginning of the Stone Counseling Center's *Work in Progress* papers and the genesis of RCT (Stiver, 1991). This text moves "from a deficiency model of women to a position where we saw, named, and valued women's strengths" (Jordan et al., 1991, p. 2), and posits women's "sense of self becomes very much organized around being able to make and then maintain affiliation and relationships" (Stiver, 1991, p. 52). Miller's text marks the joining of feminist and psychodynamic theory as well as the origins of RCT, a more innovative relational approach that encompasses the development of women, men, and all those subjugated to dominant societal structures.

### **Core Concepts of RCT**

RCT offers several innovative principles and methods of understanding relational development. Jordan (2009) succinctly presents the theory's seven core concepts:

1. People grow through and toward relationship throughout the life span.
2. Movement toward mutuality rather than separation characterizes mature functioning.
3. Relationship differentiation and elaboration characterize growth.
4. Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
5. Authenticity is necessary for real engagement in growth-fostering relationships.
6. In growth-fostering relationships, all people contribute and grow or benefit.  
Development is not a one-way street.
7. One of the goals of development from a relational perspective is the development of increased relational competence and capacities over the life span (p. 24).

RCT's unique rhetoric and conceptions of mutual empathy, growth-fostering relationships, disconnections and the central relational paradox, authenticity, power and relational images are discussed in greater detail in the following sections.

**Mutual empathy.** Expanding from Kohut's and Rogers's acknowledgment of the crucial role of empathy in relational development, RCT emphasizes the *mutual* exchange of empathy in relationships, including the therapeutic dyad. Empathy in this context consists of simultaneous affective and cognitive components; the affective element is the feeling of connectedness, while the cognitive element is the thought that this feeling belongs to another (Kaplan, 1991; Miller & Stiver, 1997; Walker & Rosen, 2004). Duffey and Somody (2011) explain how mutual empathy is created between therapist and client when

both participants in a relationship are affected by the other...rather than hiding behind a mask of neutrality, counselors not only allow themselves to be affected by the experiences of their clients, they communicate this to the clients through words and actions" (p. 228).

Thus the therapist displays an empathic reaction to the client's story, and, in reaction, the client sees herself as worthy of empathy and relational connection (Comstock et al., 2008; Miller & Stiver, 1997). Engaging in mutual empathy is not purely intuitive; it is skill the therapist learns and practices. In so doing, the therapist becomes more culturally competent in working with clients within a variety of social contexts (Comstock et al., 2008; Kaplan, 1991). The client's experience of validation through mutual empathy in the therapeutic relationship can serve as a reparative, growth-fostering relationship that can lead to greater empowerment, agency in overcoming shame, and a sense of self as one who has agency within relationships and whose pain is worthy of empathic response (Jordan, 2001; Walker & Rosen, 2004).

**Growth-fostering relationships.** At the core of RCT is the perception that connection in relationships, rather than independence and autonomy, are agents of growth and wellbeing. Growth-fostering relationships are those in which mutual empathy and authentic communication and interest transpire (Duffey & Somody, 2011). These relationships are imperative for positive self-esteem and relational resiliency. Social isolation and the absence of growth-fostering relationships are what RCT views as the root of most suffering, and through growth-fostering relationships healing can occur (Jordan, 2001, 2009) Miller (1986) notes five observable “good things” that come from growth-fostering relationships: each person 1) feels a greater sense of “zest” (vitality, energy); 2) feels more able to act and does act; 3) has a more accurate picture of herself and the other person; 4) feels a greater sense of worth; and 5) feels more connected to the other person(s) and feels a greater motivation to connect with others (Duffey & Somody, 2011, p. 227). RCT seeks to establish a growth-fostering relationship in the therapeutic dyad to serve as a reparative connection as well as a paradigm for relationships outside of treatment. Engaging in growth-fostering relationships heal past and present relational disconnections, thus the therapeutic work is primarily to provide clients with connection and a relationship in which “they begin to reconnect with themselves and bring themselves more fully into relationships with others” (Jordan, 2001, p. 97).

**Disconnection and relational paradox.** Inevitable in relationships, including the therapeutic dyad, are periods of disconnection: episodes in which there is an absence of mutual empathy, understanding, and effective communication. Disconnections happen on an individual relational level as well as a societal, institutional level, especially for those belonging to minority and marginalized groups (Duffey & Somody, 2011). When a disconnection occurs one feels a loss of energy and confidence in relational competency, and the opposite of the five “good things”: shame, fear, frustration, humiliation, self-blame. Additionally, and perhaps the most

painful, one may feel *condemned isolation*—the feeling that one is not worthy or capable of connections (Comstock et al., 2008). In response, we develop *strategies of disconnection* to “keep parts of ourselves out of connection, the parts that we have come to believe are unacceptable...they are attempts to maintain connection in the only way a person can find in the midst of great fear” (Miller, 2008, p. 155). In other words, strategies of disconnection serve as a defensive measure to avoid being hurt, excluded, or marginalized (Comstock et al., 2008). RCT asks therapists to honor and validate these strategies and to try to understand their origins and adaptive function while working with the client to develop ways to connect without experiencing fear of feeling too vulnerable and exposed.

The strategies of disconnections’ protective and defensive functions are indicative of the *central relational paradox*, a pattern in which one desires connection but does not fully engage in developing relationships. Jordan (2009) observes,

in the face of repeated disconnections, people yearn even more for relationship, but their fear of engaging with others leads to keeping aspects of their experience out of connection...the individual alters herself or himself to fit in with the expectations and wishes of the other person, and in the process, the relationship itself loses authenticity and mutuality, becoming another source of disconnection (p. 102).

This paradox of distancing ourselves as we strive for connection is often found within the therapeutic relationship, particularly among abuse and rape trauma survivors (Miller, 2008). RCT proposes that therapist acknowledge and normalize disconnections and the central relational paradox within the therapeutic and personal relationships, as overcoming disconnections leads to stronger connections. The therapeutic relationship can then act as a reparative experiment in connection that leads to greater insight, intimacy, and relational resilience (Comstock et al., 2008).

**Authenticity.** In the context of RCT, authenticity refers to the “capacity to fully represent ourselves honestly in relationships” evidenced by responsiveness, mutual empathy, and selective disclosure (Duffey & Somody, 2011, p. 229). RCT encourages therapists’ authenticity and affective response to clients, which can validate the client’s experience and promote the capacity for self-empathy necessary for the development of growth-fostering relationships (Walker & Rosen, 2004). Such authentic disclosures may include the therapist revealing she was touched by the client’s story or naming a perception that the client has distanced herself from the therapist. RCT sees the emotional responsiveness of the therapist (and other people in the client’s life) as “essential to the healing of patterns of relational disconnection and negative relational images”(Jordan, 2009, p. 51). RCT also speaks to the concern of many clinicians that self-disclosure through emotional response can lead to blurry boundaries. Jordan (2009) advises clinicians to carefully chose the “one true thing” to share with clients so as to avoid “amygdala authenticity”—disclosure superfluous, irrelevant information that may stall or regress treatment and take the focus off the client (p. 64).

**Power dynamics and relational images.** RCT also calls attention to power dynamics and imbalances in all interpersonal relationships as well as in the context of cultural and societal systems. One of the tools for maintaining the hierarchy of power are *relational images*, or “concepts that people hold about relationships that guide behavior” generated from previous experiences, relationships, and internalized negative stereotypes about the group to which one belongs (ie women, LGBT individuals, and people of color) (Duffey & Somody, 2011, p. 230; Miller & Stiver, 1997). This concept evolves from Patricia Hill Collins’s (1990) notion of *controlling images*: stories about groups and individuals that reinforce social hierarchy and stereotypes, ie the ‘Welfare Mother’ or ‘the Jezebel’ (Comstock et al., 2008; Miller, 2008; Walker & Rosen, 2004). The dominant groups create these images to hold each group in their

tier on the hierarchy in order to maintain the status quo, which places the dominant group in their position (Miller, 2008; Miller & Stiver, 1997).

RCT sees relational and controlling images as manifestations of the human drive to *power-over*—to exert one’s dominance over weaker groups to feel safe and confident in a more empowered position (Jordan, 2009; Miller, 2008; Walker & Rosen, 2004). These images largely dictate our sense of ourselves and our potential strength and future. RCT proposes that through mutual empathy and growth-fostering relationships, particularly that with the therapist, relational images can be challenged and reworked (Walker & Rosen, 2004).

In a similar strategy to NT’s aim to expose the subordinate narrative, RCT therapists seek to elicit exceptions to relational images. Jordan (2009) provides a clinical example of this technique:

An adult who developed the relational image “When I need something, my vulnerability exposes me to physical abuse” may begin to learn in therapy a competing relational image: “When I need something, my needs are respected and there is a possibility that I can find a way to get them safely met” (p. 50).

The relational therapist looks for relationships in which the relational image was not evident (mirroring “unique outcomes” in NT) to note that the negative perception was not always there and will not always be there. RCT encourages the therapist to address the power imbalance inherent in the therapeutic relationship as well so as to minimize the reenactment of subordination and entrenching of relational images in the client (Miller, 2008).

### **Applications of RCT**

RCT is primarily a clinical philosophy rather than a set of therapeutic techniques, yet empirical studies and case vignettes have assessed and supported the applied theory’s effectiveness on various populations. In addition to the studies described in greater depth below,



researchers and clinicians have evaluated RCT treatment for women with various disorders in a short-term outpatient group (Oakley & Addison, 2005), mentoring adolescents (Spencer, 2006; Spencer, 2007; Spencer, Jordan, & Sazama, 2004), women with cancer (Kayser & Sormanti, 2002; Kayser, Sormanti, & Strainchamps, 1999), individuals who engage in self-injurious behavior (Trepal, 2010), as well as women with post-partum depression (Paris, Gemborys, Kaufman, & Whitehill, 2007). The findings consistently show positive outcomes from relational approaches and call for further research and implementation of the treatment in practice. Studies also relevant to RCT are the compelling research on the importance of attachment and relational consistency and strength to the neurobiological development of the brain (Chugani, 2001; Eisenberg & Lieberman, 2004; Goleman, 2006). These findings support RCT's claim that relational patterns are formative in our development and identities (Duffey & Somody, 2011; Jordan, 2009).

In order to measure the effect of RCT's approach, some researchers employ the *Mutual Psychological Development Questionnaire* (MPDQ) and the *Relational Health Indices* (RHI). Genero, Miller, Surrey and Baldwin (1992) developed the MPDQ to measure "perceived mutuality" within one's relationships. This 22-item self-report scale quantifies the participant's perspective of the six elements of perceived mutuality: empathy, engagement, authenticity, zest, diversity and empowerment. Developed by Liang and her colleagues, the RHI targets growth-fostering connections with a 37-item measure that assesses engagement, authenticity, and empowerment/zest within relationships (Liang, Tracy, Taylor, & Williams, 2002; Liang, Tracy, Taylor, Williams, Jordan, & Miller, 2002). These scales ease the quantification of relational techniques on several populations in various settings, and they have largely showed that the RCT approach yields positive therapeutic outcomes for the studied groups.

Much of the RCT research to date assesses the association between relational disconnections in familial and romantic relationships and the severity of a client's eating disorder (Sanftner et al., 2006; Sanftner, Ryan & Pierce, 2009; Sanftner & Tantillo, 2001; Sanftner, Tantillo, & Seidlitz, 2004). In a case study, Tantillo (2004) evaluates the use of therapist self-disclosure in treatment with a woman with anorexia. Tantillo answers the client's request for advice by saying, "I feel like I am in a bind. I want to honor your request for me to be honest and 'tell you the way it is,' yet part of me is concerned that when I do, you will hear this as an invalidation of your experience" (p. 52). Tantillo finds that that self-disclosure enhanced the therapeutic connection and demonstrated authenticity. Regarding treatment for eating disorders, she concludes,

the individual is able to let go of eating disorder symptoms as she is able to (a) identify the connections between her relationships with food and her relationships with the self and others, and (b) develop mutually empathic and empowering relationships with others inside and outside the therapy office (p. 53).

These studies indicate that RCT's framework provides a new way to both comprehend and to treat clients with eating disorders, as an RCT approach can address and seek to repair the relational disconnections that may be at the root of the disorders. While RCT's applicability to treating depression and ruminations are not the primary focus of these studies, they address features of eating disorders (distorted and obsessive thoughts, low self-esteem, pessimism, etc.) that often stem from or exacerbate depression (McCarthy, 1990; Stice, 2002). More research on RCT for depression and rumination is called for, yet the existing studies on RCT speak to the potential as a valuable intervention for these symptoms.

Another body of research on RCT targets growth-fostering connections with the RHI scale. Liang et al. (2002) found that the RHI revealed that college-age women with relational

health had greater emotional wellbeing and adjustment and that growth-fostering relationships within communities are correlated with lower rates of depression and stress (Duffey & Somody, 2011; Jordan, 2009). RHI has also assessed growth-fostering relationships and perceived mutuality in men (Liang, Tracy, Glenn, Burns, & Ting, 2007) and mentoring relationships (Liang, Tracy, Kauh, Taylor, & Williams, 2006). Liang and her colleagues' studies expand the participant pools beyond young women, and their findings support the use of an RCT lens to understand and address a wide spectrum of populations and disorders.

Few of these studies focus on RCT treatment for depressive disorders, though Alexandra Kaplan, one of the founders of RCT, observes how one's relational development can largely account for symptoms of depression, particularly for women. Kaplan (1991) notes that depression is "overwhelmingly" more prevalent in women than in men; this is due in part to women's psychological and relational development and the cultural emphasis on autonomy and independence generally attributed to men (p. 206). Drawing from her observations over her years as a relational clinician, Kaplan sees that a poor history of relationships often contributes to the core elements of depression: low self-esteem, feelings of loss, as inhibition of anger, aggression, and assertiveness. Kaplan asks that we reconsider our conception of depression as a state that is in reaction to others and instead address how formative relational history and connections with others is in our emotional wellbeing. By approaching depression with RCT framework, therapists can rework relational images of "needy" or "dependent" and encourage clients to embrace the importance of their relationships, thereby increasing their confidence, insight, and relational competency.

### **Limitations and Critiques**

The response to RCT has been largely positive and the *Work in Progress* papers are part of academic curriculums and agency framework; yet some clinicians have reservations about the

theory and its implications. The primary critiques of RCT come from feminist theorists and those who adhere to a traditional psychoanalytic school of thought in which the therapist appears neutral with limited affect (Barnett & Rivers, 2004; Walsh, 1997). RCT founders have addressed these concerns and offer clarification and defense of their approach.

Feminist theorists argue that RCT's emphasis on women's relational skills reinforces the gender dichotomy and stereotypes rather than creating progressive change (Barnett & Rivers, 2004; Westkott, 1997). This separation and essentialism of masculine (independent and assertive) and feminine (dependent and passive) qualities perceived in RCT "replaces the old male model with a new model of female chauvinism" (Walsh, 1997, p. 360). Westkott (1997) asserts that RCT and the theory of women's development further perpetuate male privilege rather than empowering women, and RCT's emphasis on women's relational skills keeps them in their subordinate, dependent roles. Feminist theorists also challenge the applicability of RCT to women of color and other minority groups, as the Wellesley women were all well-educated, heterosexual white women with assumed privilege and social capital (Walsh, 1997).

In response to these critiques, Jordan (2009) articulates that RCT tries to dismantle the dichotomies of "selfish versus selfless or self versus other," and instead promotes the study of mutual growth and development (p. 19). Jordan also challenges the claim that RCT is essentialist, as

RCT has often viewed gender, the part that emphasizes difference, as formed by stereotypes, power dynamics, and sex role standards that are imposed in child development. In fact, the only essentialist position that RCT holds is its belief that we all grow through and toward relationship throughout the life span (p. 20).

Kaplan (1991) acknowledges the limitations of her cohort as white, heterosexual, educated women. She notes the Wellesley women are conscious of their limitations and so she used "our

own viewpoints as validly as we could as a basic frame, or template, from which to expand on the scope of women's development in range, nuance, breadth, and specificity" (p. 5). Many clinicians of color and various sexual orientations embrace RCT as an inclusive framework for these groups, as RCT addresses cultural subordination and the social construct of power (Comas-Diaz, 1994; Tatum, 1997; Turner, 1997). *Women's Growth in Diversity* (1997), a book of essays by clinicians edited by Jordan, aims to address the nuanced experiences and relational developments of women with a wide spectrum of identities and cultural contexts.

Clinicians who practice a more traditional, psychoanalytic practice voice concerns that careless self-disclosure and mutual empathy may lead to blurry boundaries and could turn the client into the caretaker of the therapist, a role reversal that could invalidate the client and reinforce the feminine role (Ragins & Kram, 2007; Miller, 2008). Surrey (1991) articulates that RCT promotes judicious self-disclosure for the benefit of the client rather than therapist catharsis; she clarifies,

we certainly do not mean disclosing anything and everything with no sense of purpose, impact, timing, or responsibility, nor do we suggest an inattention to the complex power dynamics of this [therapeutic] relationship...mutuality does not mean equality, sameness, or a simplistic notion of mutual, personal disclosure" (p. 11).

RCT theorists further assert that the therapist's authentic, affective response of empathy and the self-disclosure of the client's impact on the therapist provides the client with validation, confidence, and relational resilience (West, 2005; Miller, 2008).

## **Conclusion**

This chapter describes the theoretical orientation, core concepts, applications and empirical support of RCT as well as a discussion of the limitations and critiques of the theory. RCT's innovative contributions to the study of development and identity with notions of mutual

empathy, growth-fostering relationships, disconnections and the relational paradox, authenticity, and power and relational images offer a progressive framework to address our increasingly diverse societal and client population. In conjunction with the principles of NT, RCT's attention to the role of the therapist in attributing power to individual experience can inform the implementation of EWTs for adults with depression and rumination. A proposed model of this implementation will be discussed in the following, final chapter of this thesis.

## CHAPTER VI

### Discussion

The preceding chapters have reviewed the literature on EWTs and the clinical theories of Narrative Therapy (NT) and Relational-Cultural Theory (RCT) to support the implementation of expressive writing interventions. This thesis aims to address the gap in the research on creative expressive treatments in clinical social work's repertoire, specifically the use of expressive writing as an adjunct to talk therapy for adults with depression and ruminative thoughts. This chapter provides a discussion in response to this thesis's primary questions: *how do theories and empirical studies inform the use of expressive writing as an adjunct to talk therapy in adults with depressive disorders to decrease ruminations, and how can clinicians integrate this treatment intervention in practice?*

This chapter will start with a concise review of the theoretical orientation and concepts in the previous chapters and their pertinence to EWT. Following is a presentation of a new interpretation of EWT informed by these concepts and proposed a model for incorporating expressive writing into treatment. Next will be a discussion of the implications of the thesis's findings for social work practice and considerations for future research. This chapter concludes with a summary of the thesis's goals and questions, strengths and limitations of the methodology, and a call for greater attention to therapeutic expressive writing.

### Review of Conceptualization and Methodology

**Constructivism.** This thesis endorses a constructivist approach to therapy, as it values the subjective experience and challenges the notion of a single objective truth. Contemporary social work academics and clinicians have widely adopted a constructivist view to clinical theory and practice (Carlson, 1997; Heller & Northcut, 2002). Constructivism manifests in treatment as

the therapist and client finding meaning in the client's experience through collaborative dialogue and mutual engagement (Bruner, 1986; Hoyt, 1998; Phipps & Vorster, 2011). In addition to talk therapy, the client's expressive writing of her narrative can serve as an alternative medium of communication and collaboration in the therapeutic dyad.

**Population.** The focal client population for this treatment is adults with depressive symptoms, particularly rumination. As listed in the DSM-IV (2000), symptoms for depressive disorders include decreased interest or pleasure in activities, diminished ability to concentrate, feelings of worthlessness, hopelessness, and guilt, as well as recurrent, intrusive and repeating negative thoughts and ruminations. Researcher Nolen-Hoeksema (1998) and her colleagues view rumination as an operationalized symptom of depression, marked by repetitive cycles of negative thoughts without one's action to cease or change the thought. The ruminations take a prominent toll on physical and emotional wellbeing in many individuals with depression, anxiety, and other psychiatric troubles (Armey et al., 2009; Nolen-Hoeksema, 1998; Nolen-Hoeksema & Morrow, 1993; Pourjalali et al., 2009).

This thesis proposes that writing as an alternative mode of expression may help to diminish the ruminative thoughts by articulating the factors that exacerbate and diminish them. The process of writing and reflecting on the piece could thereby enhance insight and awareness of what helps and what does not help the ruminative cycle. Studies on the treatments for rumination indicate that shifting the client's attention on the ruminative thought from passive to active and introducing external focus are often effective interventions (Cox, Enns, & Taylor, 2001; Nolen-Hoeksema, 1998; Pyszczynski et al., 1989; Watkins, 2004). The thesis proposes that these methods can be achieved through EWT in addition to verbal processing. While expressive writing may help to cease the ruminative cycle, the treatment also has the potential to serve as another mode through which the client ruminates. The clinician may be mindful of this



risk and speak to this effect if the clinician or client assess that the writing seems to feed the ruminations, as discussed in more depth below.

**Methodology.** This theoretical thesis conceptualizes EWT through the lenses of NT and RCT as clinical orientations relevant to the method. These theories inform the implementation of EWTs, which aim to promote insight and decrease ruminations for adults with depressive disorders. Reviewing the structured and unstructured EWTs provides the knowledge of ways clinicians have utilized writing in treatment and how and why the intervention was effective or ineffective. The literature offers guidance about the therapeutic agents of expressive writing and how it can become a more successful intervention. A review of NT and RCT—two contemporary clinical theories that are gaining empirical support and endorsement in the field—gives therapeutic interpretations and tools to inform the implementation of EWT. This thesis synthesizes these bodies of literature to develop a new conceptualization and method of implementation of EWT for contemporary clinical practice.

### **Review of EWTs**

Researchers and clinicians have incorporated expressive writing into practice for decades, and many individuals with depression (and other psychiatric impairments) self-administer writing as a therapeutic exercise. Some researchers have developed structured modules for EWT, most notably Progoff's Intensive Journal Method (1977, 1992), L'Abate and Cox's Programmed Writing (1992), and Pennebaker's writing paradigm for improving physical health (1989). These structured EWTs are prescribed, therapeutic writing exercises that offer empirical support for expressive writing interventions (as describe in more depth in Chapter III).

**Structured EWTs.** Ira Progoff's Intensive Journal Program formalized journal therapy and served as the first structured EWT. Participants in the program wrote in a sectioned journal in a group workshop independently from therapy. The workshops aimed to aid participants in

gaining access to and finding resilience within the various parts of themselves. Clinicians did not widely endorse the program, perhaps due to the time and logistics of facilitating a workshop, its exclusion of therapist involvement, and the relatively sparse empirical support of the method. Despite its sparse implementation in treatment with a clinician, Progoff's promotion of the therapeutic value of expressive writing increased attention and development of expressive writing interventions (Epple, 2007).

L'Abate and Cox (1992) introduced a subsequent structured writing treatment in their text *Programmed Writing: A Self-Administered Approach for Interventions with Individuals*. This treatment includes writing assignments as adjunctive, "secondary preventions" to verbal psychotherapy (p. 14). L'Abate and Cox provided a series of prompts for written expression tailored to specific presenting problems, and they encouraged the client to share the writing with the therapist. This "condition of reciprocity" between the client and therapist, they believed, could strengthen the therapeutic alliance and increase both the client and therapist's insight about the client's condition. This understanding and connection would inspire a more nuanced and effective approach to addressing the client's problems (L'Abate & Cox, 1992; L'Abate & Kern, 2002).

Pennebaker's paradigm involved participants with a wide spectrum of psychosocial profiles writing about their "deepest thoughts and feelings" outside of therapy for fifteen to thirty minutes a day (Pennebaker, 1997, p. 162). The prolific research on the effectiveness of this intervention, particularly on physical symptoms of stress and inhibition, consistently confirmed and elaborated upon expressive writing's healing effect (Pennebaker, 1989; Pennebaker, 1997; Pennebaker, Mayne, & Francis, 1997; Sexton & Pennebaker 2009). Of particular relevance to this thesis is the Gortner, Rude, and Pennebaker study (2006) that revealed how expressive

writing was largely successful in reducing the brooding and the negative judgments inherent in ruminative thought processes.

**Unstructured EWTs.** Rather than use a structured method, some clinicians incorporate unstructured expressive writing adjuncts in treatment (Kaufman & Kaufman, 2009; Kerner & Fitzpatrick, 2007). Unstructured EWTs include writing with metaphor through creative stories and poetry, writing in a journal, and letter writing between therapist and client or client and a third individual (or to herself). These unstructured EWTs do not strictly follow a prescribed program; rather, the therapist creates the prompt for a client who may benefit from an alternate expressive outlet. The empirical and anecdotal support for these treatments elucidate the feasibility and benefit of incorporating EWT as an adjunct to verbal processing for some individuals.

Therapists have employed creative storytelling, poetry, and metaphorical images with clients to aid them in expressing and communicating their internal processing (Furman et al., 2002; Huckins, 1992; Legowski & Brownlee, 2001; Mazza, 1996). Many of these adjuncts involve the client writing outside the treatment room and sharing the story with the clinician, either by reading it aloud or discussing its themes and her reflections (Huckins, 1992; Leavitt & Pill, 1995; Mazza, 1996). In a similar vein, many clients write expressively in a journal between sessions, either as encouraged by the clinician or as a self-administered coping exercise (Lepore & Smyth, 2002; Ullrich & Lutgendorf, 2002). Journal writing largely takes place outside the treatment room, though it is possible that some clients read their journal entries to the therapist during sessions. While the content of the entries may reflect the discussion in treatment, the journal offers a unique insight into the internal processing of the client that can supplement the verbal expression to the therapist.

Another common unstructured EWT is letter writing—electronic or postal, with or without intent to send—which uses written expression as a form of communication and often a means of cathartic release (Nau, 1997; Roberts, 2008; Sloman & Pipitone, 1991; Rasmussen and Tomm, 1992). Letters between client and therapist, client and a third party, and the client to herself or “the problem” (a tool in NT practice) supplement the verbal processing and provide the opportunity for the client to articulate the content of her ruminative thought (Hamill et al., 2008; Keefe & Berk, 2009; Mazza, 1996; White & Epston, 1990).

**How EWTs work.** The research on these treatments speaks to the therapeutic agents of expressive writing, notably emotional inhibition, emotional expression and catharsis, cognitive restructuring, and emotional regulation. Pennebaker and other researchers found that active inhibition—the conscious restriction of expression—often causes impairing emotional and physiological stress (Greenberg, Wortman, & Stone, 1996; King, 2002; Pennebaker, 1989; Sexton & Pennebaker, 2009). Confronting and releasing the inhibited expression through writing can help to alleviate the tension associated with rumination.

In a similar vein, studies have shown that expressive writing about troubling thoughts, feelings, and memories can increase insight and mastery over the inhibited emotions (Greenberg et al., 1996; King, 2001; L’Abate & Cox, 1992). The expression is also a form of catharsis, a process that Pennebaker (1989) believes can be beneficial due to the satisfaction that comes from “venting” as well as the insight clients can gain from the material they have released through the cathartic act. Writing about intrusive thoughts and ruminations may also be a tool for cognitive restructuring, as the process of writing and reflecting on the cognitions can aid the client in naming, understanding, and ultimately altering their thought patterns (L’Abate & Cox, 1992; King, 2002; Sexton & Pennebaker, 2009). EWT can address emotional regulation as well; as the client expresses and shares her narrative she may gain a greater understanding of her emotions

and their origins. This insight can inspire a sense of control over the feeling that can increase the client's confidence and success in regulating her negative emotions (Alloy, 1991; Davidson et al., 2002; Gortner et al., 2006; Greenberg et al., 1996).

**Discussion.** The structured and unstructured EWTs provide methods to implement expressive writing as an adjunct to talk therapy and speak to its effectiveness as a therapeutic intervention. Research on these treatments, particularly on Pennebaker's paradigm, provide quantitative and qualitative data to support the integrity of writing as an expressive, therapeutic outlet for adults with diverse psychiatric symptoms, including rumination and depression. Notably, the writing exercises in both structured and unstructured treatments primarily took place outside the treatment room—and rather than the content of the writing itself, the client's reflections of the writing exercise served as the material for data and discussion.

In spite of the convincing, if relatively small, body of empirical and anecdotal evidence, there appears to be a resistance in the social work field to embracing creative therapies as legitimate and trustworthy interventions (Kerner & Fitzpatrick, 2007). Literature on this resistance is sparse, but through informal discussions with social workers (and my conjecture) I perceive some components of the resistance include a lack of awareness and training about EWTs, a perception that writing adjuncts demand greater time and resources, and a discomfort around employing a new method. An informal review of the curriculums of several schools for social work revealed virtually no courses or trainings on creative therapies, as clinical social work programs largely privilege verbal processing and evidenced-based practices that many agencies and insurance companies endorse. Thus many social workers are not trained in EWTs as students, and so many may not consider using them as interventions. Pertaining to rumination specifically, some clinicians are concerned that the writing may contribute to rather than relieve the ruminative process; therefore, the exercise could stall or regress the treatment and take up

session time (L'Abate & Sweeney, 2011). A model for how to implement EWT in light of these considerations will be presented later in this chapter.

### **Theoretical Interpretation of EWT**

Though the lenses of NT and RCT, clinicians can understand and incorporate EWT in a new and potentially more accessible form. These contemporary theories are premised on constructivist values, which place greater emphasis on the benefit of the collaborative partnership between therapist and client. This active role of the therapist is largely absent from traditional psychoanalytic theoretical orientations (Hoyt, 1998; Jordan, 2009). The involvement of the therapist as one who guides and supports the narrative empowers one's sense of self and agency can help to diminish the severity and frequency of the hallmark symptoms of depression—feelings of hopelessness, isolation, low self-esteem, and the negative ruminations that often perpetuate depression.

**NT's applicability to EWT.** The therapeutic work in NT derives from the client's narrative of herself and her experiences and the therapist's active listening and guidance in eliciting unique outcomes (times when the "problem" was absent or diminished) (White & Epston, 1990). Through externalizing conversations and mapping the problem, the therapist helps the client to see her positive attributes and validity in her story (Abels & Abels, 2001). The therapist and client develop and process the story and look for latent strengths and alternative endings. This exercise aims to increase the client's insight, confidence, and agency over the problem and its role in her life (Abels & Abels, 2001; Tomm, 1989; White, 2007; White & Epston, 1990).

White and Epston speak to the value of therapeutic writing, although they privilege verbal processing in treatment (White & Epston, 1990). NT does not explicitly address how the verbal telling of the story may limit the authenticity of the client's narrative, particularly for

those who do not communicate most fluidly in interpersonal conversation. The client may be more candid and comprehensive in writing the story independently and sharing it with the therapist in session. NT does discuss that unlike a written document, oral communication is impermanent and unavailable for future revision and reflection. Reading letters and old versions of the narrative, as if browsing archived journal entries, serves as an accurate account of the process at the time of the writing and reveals where progress has (and has not) occurred for both the therapist and the client (Bacigalupe, 1996).

Writing in NT is primarily done by the therapist for the client. White and Epston promote their use of letter writing as a means of delivering messages and continuing engagement between sessions, especially for those who do not regularly attend session or who live distantly from the therapist. Other forms of writing in NT are certificates of achievement for conquering the problem and therapist-recorded logs on client's progress. While the therapist does most of the writing in NT, these written adjuncts illustrate the feasibility of incorporating writing into the therapy, the value of a written document as a record of thoughts and progress, and the role of written correspondence between sessions as an agent to the therapeutic relationship and progress outside of session time (Bacigalupe, 1996; Rasmussen & Tomm, 1992; Terry, 2010; White & Epston, 1990).

The effectiveness of the artistic and creative applications of NT support the use of expressive writing for a diverse participant population as an alternative way to tell the story and externalize the problem (Ball et al., 1993; Caldwell, 1005; Cobb & Negash, 2010; Penwarden, 2006). Of particular relevance is the Keeling and Nielson (2005) study in which the participants, some of whom suffered from depression, drew pictures of the problem and wrote letters between themselves and the problem (described in more detail in Chapter IV). The researchers conclude that writing and creating artwork appeared to empower the women to confront their problems,

and they propose these creative adjuncts allow for processing with diminish exposure and threat to the therapeutic alliance.

This study offers support of writing as a way to express, process, and discuss the problem with the therapist and prompts further consideration of a NT approach to EWTs. Writing narratives may enhance the visibility of unique outcomes and the dominant, problem-saturated story. With a piece of paper, the therapist and client can use a pen to cross out negative words and circle positive ones, thereby allowing for a more tangible document and visual aid with which to map the problem and elicit the subordinate narrative. In addition to re-telling the narrative, re-writing will provide the client with a version available for later reflection and revision as well as an additional means of communication and expression.

**RCT's applicability to EWT.** RCT's emphasis on the value of interpersonal relationships in development and identity calls for relationally attuned therapists and a dynamic alliance. RCT sees the relational network and quality of relationships as formative and integrated parts of the self—and so challenges the notion of the self as an individuated being (Jordan et al., 1991; Jordan, 2009; Miller & Stiver, 1997). As a relatively new and progressive framework, RCT offers a contemporary approach to treatment that calls upon the therapist's authenticity, empathy, and occasional judicious disclosure in engaging with a diverse population of clients (Miller, 1986; Stiver, 1991). This approach challenges the preceding dominant view that the therapist should appear rather unaffected by the client's narrative. RCT's innovative notion of the self, relationships, and the role of the therapist can be applied to EWT, as the writing can be another method of conveying mutual empathy, minimizing relational disconnections, and addressing the central relational paradox.

EWT as an adjunct to talk therapy addresses many of the components of RCT and the theory's view of clients as relational, dynamic, and seeking connection. In addition to the



therapeutic value the process of writing may have for the client, incorporating the client's writing into the sessions provides the therapist with access to material the client may not express verbally and an opportunity to engage in mutual empathy. The narrative may reveal the client's relational images, her relational network and history, her experiences of relational disconnections, as well as her sense of power and discrimination in cultural and societal contexts—aspects of the treatment that RCT sees as of paramount importance (Jordan, 2009; Miller & Stiver, 1997). In turn, this communication increases the therapist's understanding of the client and allows her to be more attuned to the client's needs.

When the client shares the expressive writing with the therapist, she may feel exposed, vulnerable, and fearful of an invalidating response, especially if the narrative is of a particularly painful topic. Thus sharing the writing both communicates the client's internal processing and serves as a test of the therapist's attunement. If the therapist responds to an emotional narrative with appropriate and authentic empathy, the client may feel worthy of empathy and experience an increased sense of safety and acceptance in the therapeutic relationship (Duffey & Somody, 2011). An attuned reaction could validate both the client's subjective experience and her method of expression; this could be especially meaningful for clients who are more comfortable expressing themselves through writing and those who lack confidence in sharing their writing. Alternatively, incorporating EWT may increase the likelihood of a relational disconnection if the client feels invalidated or misunderstood by the therapist's response—yet the exercise may provide an opportunity to address and repair the disconnections. The repair leads to a strengthening of the therapeutic alliance and relational resiliency that could be generalizable to the client's other relationships (Comstock et al., 2008; Duffey & Somody, 2011; Jordan, 2009).

EWT can also be a useful tool to address the central relational paradox, a pattern in which one desires connection but does not fully engage in developing relationships (Jordan et al., 1991;

Miller, 2008). This paradox can manifest in treatment as clients not fully disclosing their narrative and vulnerabilities to the therapist, a strategy of disconnection that defends the client from invalidation after their exposure and a greater sense of isolation (Jordan, 2009). While it runs the risk of becoming another strategy of disconnection, writing may be a means through which the client can share herself more fully with the therapist. The written document can act as both a buffer and a vehicle of communication of components of the client that she may resist revealing to the therapist. Sharing her writing could allow the client to convey her wish for a connection with the metaphorical shield of reading and writing instead of speaking. For some clients, speaking and maintaining eye contact may increase their fear of judgment and rejection. Once the content is revealed and the therapist responds with validation, the therapist and client may find more ease in discussing the narrative through verbal processing. Thus the client can strengthen her connection with the therapist by sharing her expressive writing while retaining an initial measure of defensive protection of full exposure.

The incorporation of EWT within the frameworks of RCT and NT could engender positive alterations in cognitive and emotional processing of the ruminative thoughts. Many adults with depression are internal processors and may not most fluidly express themselves with verbal, interpersonal communication. Gaining agency in creating a narrative and sharing it may diminish feelings of helplessness, a low sense of worth, and isolation, the condition that RCT sees as the primary cause of human suffering (Jordan, 2001; Walker & Rosen, 2004).

### **Proposal for Implementation of EWT**

As indicated above, the theoretical frameworks and existing literature on EWT offer support for the incorporation of expressive writing as an adjunct to talk therapy, especially for adults who suffer from depression and ruminative thoughts. This thesis introduces a way in which expressive writing can be implemented into practice that does not demand added time,

resources, or expertise of the therapist. The application I propose is quite simple: 1) assess the client's interest and introduce writing as an alternative form of expression, and 2) invite the client to share her writing during session time. This intervention differs from other EWTs in that the writing is all for and by the client and the content is shared to the therapist in session. Imperative to the intervention is a preliminary discussion with the client about the risks and limitations of the exercise. Following are considerations for practical techniques for the assessment of the applicability of the intervention to the client, the incorporation of the writing into session time, the discussion on guidelines before engaging in the exercise, as well as resources available to therapists.

**Assessment.** To assess whether an EWT may be an appropriate exercise for the client, the therapist may ask the client early in treatment if she at times finds more ease in expressing herself through writing. Clients more likely to endorse the adjunct may be those who already journal, write creative stories, poetry and/or letters, or clients who may struggle with interpersonal engagement and have the cognitive capacity to engage and benefit from expressive writing. To minimize the degree of vulnerability and exposure the client may feel in reading and writing (as well as possible transference of a demoralizing English teacher or parent), the therapist may convey that there is no good or bad writing, no grades, no right or wrong way to do the exercise, and that the writing is for the client, not for the therapist.

The therapist may also address that the client always has the option to opt out of sharing the writing. Words like assignment and homework may increase the client's anxiety and diminish the value of the writing. Rather, instead of setting deadlines and giving assignments without an assessment of client's needs and requests, the therapist may invite the client to determine the nature of the writing and if or when she would like to share it. Some clients may prefer prompts to guide their writing to a blank page. For clients the therapist assesses may

benefit from more structure and those who request it, the therapist can offer sheets from a workbook (perhaps one of L'Abate's) or prompts for open writing (such as "describe a memory you think about often"). Normalizing the feelings of exposure and vulnerability the client may experience at the prospect of sharing her writing could reduce any performance anxiety or shyness the client may anticipate or experience. The therapist could introduce this exercise in the beginning phase of treatment or in later stages when there is greater rapport and trust. The exercise may also be implemented if either the therapist or client feels the treatment has plateaued and another style of intervention may be useful to continue progress.

**Incorporating writing into session.** If the client endorses the exercise and shares her writing in session, she may provide rich material for discussion with the therapist. The client may read her writing for the first portion of the session for roughly 10 minutes (or another length of time to which both therapist and client agree that allows substantial time for discussion). A discussion before the client reads the piece on the amount of session time dedicated to the reading may diminish client's sense of being "cut off." The reading and discussion can also offer a structure to the session, which could act as a holding environment that many clients find containing (Coleridge, 1996; Winnicott, 1971; Wong & Pos, 2012).

In a collaborative discussion following the reading, the therapist and client can process the narrative's content, find opportunities for development of insight, and discuss the client's experience of writing, sharing, and talking about the piece. In creative writing, the work could center on finding the character in the client and the client in the character (and other characters as reflective of those in the client's family and social network) as well as dissection of the metaphors and imagery in the piece—if the therapist and client are comfortable engaging in this type of dialogue. This latent material can offer both the client and the therapist insight into the client's view of herself, her environment, her strengths and the causes of her symptoms.

To minimize superfluous time and involvement of the therapist, postal and electronic correspondence and other writing by the therapist could be minimal. Similarly, the client could only share the writing during session time, rather than sending the piece to the therapist before or after session. The therapist is therefore not responsible for reviewing and commenting on the piece between sessions; the sharing and discussion takes place exclusively within the confines of treatment time. The therapist may refrain from keeping the client's writings in her files or office as another measure to ensure the limits of the therapist's extracurricular involvement. If the client offers the writing to the therapist, the therapist may explain that it is not her practice to house the writings and that keeping the writings with the client eliminates the liability of misplaced writing and its risk of breaching confidentiality.

**Preliminary discussion on guidelines.** Before the client engages in the exercise, a preliminary discussion on the risks and guidelines will help ensure the mutual understanding of the intervention. This dialogue may aid the resiliency of the therapeutic alliance if the treatment does not have the desired effect. As the therapist introduces the intervention, she may stress that the client is not obligated to write or share the writing and that she is encouraged to say if she feels the writing is hindering her treatment. An early discussion of the therapist's limitations in keeping the writing and reading material outside of session time may inform the client's expectations to prevent a relational disconnection. As mentioned above, the therapist may also normalize the feelings of exposure and vulnerability the client may feel as she shares her writing as well as the emotions that may surface during the act of writing before she engages in the treatment. Agreeing upon the amount of time spent on reading the writing may also precede the client's sharing; this discussion may protect against the exercise usurping the majority of a session and the client's sense of interruption and dismissal.

Additionally, the therapist may speak to the possibility that the intervention may not be effective in diminishing her ruminations. A primary risk to EWTs for ruminations is their potential to further entrench the client in the cyclical thoughts. To ensure that the exercise remains therapeutic and valuable, the therapist may intermittently assess the client's comfort and experience of sharing and discussing the writing. The therapist could also maintain an awareness of whether or not the exercise seems to be increasing ruminations or colluding with the client's avoidance of interpersonal engagement with the therapist and treatment; rather than a tool to strengthen the connection, the client (and the therapist) may "hide behind" her writing as a shield from exposure and connection. The therapist may address this behavior by asking the client what she feels the writing adds to treatment and to mindfully disclose her observation that the writing may be contributing to the ruminations and disconnections.

**Resources for therapists.** As this treatment is not appropriate for every client, some therapists may not be prepared or interested in incorporating expressive writing into their practice. Therapists for whom talk therapy has produced meaningful sessions for their client population and are not looking for another tool as well as those who do not find writing a feasible or attractive method may refrain from the exercise. For therapists who are interested in EWTs but do not feel confident in their grasp of NT and RCT enough to bring it to treatment, a few accessible resources may be provide further clinical examples and theoretical explanation.

For clinicians who want to learn more about EWT in practice, informative articles include Sexton and Pennebaker's "The healing powers of expressive writing" (2009), Leavitt and Pill's "Composing a self through writing: The ego and the ink" (1995), as well as "Integrating writing into psychotherapy practice: A matrix of change processes and structural dimensions" (2007) by Kerner and Fitzpatrick. In addition to *Narrative Means to Therapeutic Ends* (1990) by White and Epston, Nau's "Andy writes to his amputated leg: Utilizing letter writing as an

interventive technique in brief family therapy” (1997) provides a case study using writing and NT (discussed in more detail earlier in this thesis). Jordan’s book *Relational-cultural therapy* (2009) and the article “Relational-cultural theory: A framework for bridging relational, mutli-cultural and social justice competencies” (2008) by Comstock, Hammer, Strentzch, Cannon, Parsons, & Salazar both offer a concise, approachable introduction to the principles of RCT and how it can be applied to practice. These resources will increase the therapist’s knowledge, competency and confidence in their clinical work and incorporation of EWTs with an NT and RCT theoretical orientation.

In addition to the above resources and the information found in this thesis, a therapist unfamiliar to therapeutic writing, NT and RCT may be advised to have supervision from a clinician with more knowledge and experience in these modalities. With competent supervision, a therapist could more readily identify if and when the writing is a therapeutic adjunct and when it contributes to ruminative and avoidant patterns.

### **Implications for Social Work Practice and Research**

The empirical and anecdotal evidence on EWTs endorses the exercise as an effective intervention, and virtually all the literature notes the gap in research on these treatments and calls for further study. Social workers are committed to enhancing the wellbeing of their clients and using their clinical judgment and expertise to implement appropriate treatments tailored to each client’s needs. EWT could be another intervention for one of the largest populations clinicians treat: adults with depression and rumination. A creative therapy like expressive writing will widen the breadth of social work’s repertoire of techniques and may yield positive treatment outcomes for many clients. This treatment may be revised as an intervention for clients with a wide spectrum of symptoms and presenting problems, as rumination and feelings of depression are found in several psychiatric conditions (DSM-IV, 2000). EWTs could also be applied in a

group setting—an expanding sector of social work practice in light of tightening budgets and restructuring of many agency practices (Bieling, McCabe, & Antony, 2009). Anecdotally, the ‘Writing and Relaxation’ group I co-facilitated during the writing of this thesis (described in Chapter II) demonstrated the feasibility and positive effects writing can have in a group dynamic.

Social workers and other mental health clinicians already use expressive writing and creative therapies in practice, yet the treatment is not taught in most social work school curriculums or sufficiently empirically studied. More dialogue across disciplines of clinicians on training material for expressive therapies could ease its implementation into social work training. Continuing education lectures in which clinicians present ways they have utilized EWT can prompt a critical discussion of the potential effect of these interventions. These measures can increase the awareness, effectiveness and implementation of expressive writing in the field of clinical social work.

### **Strengths and Limitations**

This thesis relies on theoretical formulation rather than empirical support, a methodology with inherent strengths and limitations. Unlike empirical studies, theoretical studies utilize concepts and previous studies for data rather than an original participant study. This method limits evaluation measures and outcome results that could further elucidate the strengths and weaknesses in the proposed treatment. An advantage of the theoretical framework is its ability to synthesize theories and to draw from the results and gaps in past literature and empirical studies on EWT to propose an alternative conceptualization and implementation of the treatment. This thesis does not offer new qualitative or quantitative data on the effects of expressive writing to the field of clinical research. Rather, this thesis promotes consideration for new areas of empirical and theoretical research on EWT to continue and expand the discussion on these treatments.



A limitation of the treatment is its inapplicability of a large population of clients. EWT may be a beneficial treatment for adults with depressive disorders (and other psychiatric symptoms) regardless of their sex, gender identity, race, ethnicity religion, sexual orientation, socioeconomic status, and culture—yet EWT does not seem to be an appropriate intervention for clients who do not demonstrate a cognitive capacity to lucidly write, read and reflect upon their writing. Clients with tangential thought process, difficulty with literacy, and/or who become easily frustrated may also not benefit from this treatment, as the writing can increase confusion and challenge the client’s self-esteem and progress in therapy. This intervention also excludes clients who write in a language in which the therapist is not fluent; this could cause a rift of understanding and connection between the therapist and client and could diminish the value of the narrative as material for discussion. Thus EWTs primarily target clients who already use writing outside of treatment as a self-administered therapy or who possess the cognitive capacity to engage in the intervention. Research on forms of EWT for those who struggle with cognition, language, and literacy remains an area for further study, as these populations may find substantial benefit from employing writing into treatment.

My promotion of expressive writing in therapy stems from my personal interest and experience as well as my clinical observations, a bias which has likely influenced my attraction to and interpretation of the literature. As a graduate student, I have relatively little clinical exposure and experience of this method in treatment. The writing of this thesis inspired me to design the ‘Writing and Relaxation’ group on an inpatient psychiatric unit during my internship, which has confirmed my support of this method and has influenced my proposed application. The group members read their expressive writing to the group—a short story, a description of a memory, a recording of their present thoughts, a poem or song lyrics. The material they

presented was rich with content absent from their oral conversation, and they have expressed gratitude for the opportunity to use an alternative form of expression.

## **Conclusion**

This theoretical thesis aims to address the gap in literature and implementation of EWT's as an adjunct to talk therapy for adults with depression and rumination. To answer the thesis's questions about the effects of EWT's and how they can be implemented into practice, the thesis provides a review of the literature on ways expressive writing has been used in treatment with and incorporation of the theoretical framework of NT and RCT. This review supports EWT as an effective intervention for many client populations and promotes further discussion, research, and implementation of these interventions.

This thesis offers a model to apply EWT informed by NT, RCT, and structured and unstructured writing treatments. In this application the therapist 1) assess the client's interest and introduce writing as an alternative form of expression, and 2) invites the client to share her expressive writing during session time. I anticipate that the exercise will be a beneficial and alternative outlet and coping strategy for many clients, and that bringing written narratives into treatment will deepen the therapeutic work and diminish prevailing and debilitating symptoms.

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**APPENDIX A: CONCEPTUAL FRAMEWORK**

