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Case Studies Demonstrating the Benefits of Expressive Writing in Treatment of Ptsd and other Traumas, Particularly for Male Clients in Brief Therapy Settings

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Abstract

This paper provides a demonstration the effectiveness and advantages of using the technique known as 'Expressive Writing' as a quick and effective way to work with particularly post-traumatic stress and other traumas in various brief therapy settings. The paper will also offer some neurological/psychological theoretic concepts that might explain how or why the method works and what might explain its effectiveness and particularly why the effect size for the method is larger for males than females. The technique is seen as a positive and time efficient technique as an adjunct to the more traditional techniques such as CBT as used in the brief therapy settings as offered by EAP providers and IAPT services in primary care and it can also be used by clients, particularly men, who do not have easy access to therapeutic help because, for example, they are in prison. The model is an extension of techniques developed in the US by Pennebaker & Smyth. The paper will also discuss how it has been found that the method is particularly effective with male clients who may find it a much more acceptable treatment method.

Key Words: Treatment of Ptsd

Introduction

The suicide rate for men in England and Wales in 2019 was the highest for two decades. Males continued to account for around three-quarters of suicide deaths registered in 2019 (Office of National Statistic, 2020). This would suggest that the mental health services are not equally reaching the males in Britain or the services that are being provided are not helping men with their issues.

I am not only a psychologist and psychotherapist but I am also an expert witness. In the last few years, I have covered many kinds of cases for the courts, many of which have been men in the criminal justice system.

My experience of these cases has prompted the question about how many men in prison are there because they are suffering from PTSD and have not had the opportunity to be diagnosed and helped.

The focus of the paper is, first, to recognise that somehow men/boys are suffering because it seems that the certain issues that they are suffering from, in this case trauma. are not being address in a way that they can make use of. Further, even when they are seeing people, the methods used to help them are perhaps, inappropriate, so they don't benefit from them and so they opt out of using the services and then maybe keeping their distresses to themselves.

Alternatively, they can feel they don't know that they need help or feel the help that's there, doesn't suit them, so they might instead act out their feelings with violent offending and end up in prison, or take out the anger on themselves and commit suicide.

Hence, it is suggested that we need to look at different kinds of help that might work better for men and boys. Thus, I want to share a method that seems to be very

effective in helping people deal with their traumas, one that seems even more effective particularly with men (Smyth, 1998). This technique has become to be known as Expressive Writing.

The Use of Expressive Writing in the Treatment of Trauma & PTSD for Men & Boys

I began to use this technique with traumatised victims of particularly traffic accidents as in my private practice I was receiving numerous referrals of this kind. The technique which I was evolving seemed to be working very successfully where clients were given, as homework, to write the story of their trauma with the feelings they had had and are having. I also began to extend this to having clients write about their earlier traumas, including those of childhood abuse, which was often connect to, and it seems, the cause of them experiencing PTSD for events that do not cause others to experience PTSD (Liddle & Solanski, 2002).

Firstly, I want to briefly describe the definition of PTSD so as to differentiate it from the immediate experience that all people might feel after a traumatic event because such events do not necessarily lead to PTSD. I feel this point is important. I will also illustrate both the definition and the use of Expressive Writing by case studies which has been anonymised and by slightly changing the details, to prevent the individuals be identified.

The word "trauma" comes from the Greek and means wound or injury. Whilst physical trauma has always been recognised, psychological trauma was only briefly acknowledged in the last wars (i.e. labelled "shell shock "). But the loss of the Vietnam War led to the formulation of PTSD.

Donald had a motor cycle accident. A car rammed into him while he was stationary at a zebra crossing and he was thrown into the air and his bike was wrecked. He fractured his hands and arms, injured his knees, all his joints were affected, and he suffered pain for some time afterwards. He then suffered from back pain, but nothing physically could be found to be wrong. He was experiencing of flash-backs and nightmares of him flying through the air, and he could not get onto a motor bike again when, before, he enjoyed this. He felt he could have died. He could not look at the road where it happened without fear. He was now extra vigilant and had difficulty enjoying driving even a car. He was getting neck and back tensions and was taking a long time to leave his home as he had developed OCD where he was constantly checking the windows and doors to check there were locked. He was doing this at least 20 times and counting. From the symptoms manifested, it was suggested that this client was suffering from Post-Traumatic Stress Disorder (PTSD). In order to examine whether this was the case, it may be important to clarify how PTSD is defined and what is known about the typical symptoms.

DSM-IV-TR & DSM-5 (2000 & 2013) define the essential feature of Posttraumatic Stress Disorder as having to fulfil a number of criteria. PTSD is therefore defined as the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity. Other events qualifying for a criterion, known as criterion A, include but are not limited to: exposure to war as combatant or civilian; threatened or physical assault (i.e. childhood physical abuse, mugging); child sexual abuse; sexual trafficking; being taken hostage or kidnapped; terrorist attack; torture; incarceration as a prisoner of war; natural disasters; severe road traffic accidents.

The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2 – DSM-IV). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B – DSM-5), persistent avoidance of stimuli associated with the trauma or trauma related thought or feelings (Criterion C – DSM-5).

Suffers can experience two or more negative alterations in cognitions & mood associated with a traumatic event and this began with that event or worsened after the event. This is seen as Criterion D. In Criteria D there is also an inability to remember important aspects of the traumatic event due to dissociative amnesia, and often persistent exaggerated negative beliefs about oneself, others or the world i.e. "No one can be trusted". Thus, another client, Colin, who was suffering from PTSD after another motoring accident, believed that those about him were about to attack him, so he would attack first, thus he was getting into numerous fights with strangers, yet before the accident he was seen as a calm and caring person. Within criterion D there would be persistent distorted cognitions about the causes and consequences of the traumatic event leading to self-blame.
Donald believed he had to keep his children safe and it was his fault if anything happened to them, so he would repeatedly check the doors and windows were closed before leaving the home. There would be persistent negative emotional states (Anger - Colin; Shame – Donald). There would also be markedly diminished interest in significant activities; feeling detached or estranged from others, such as Colin's behaviour to isolate himself from everyone, believing others were a threat to him, and he had a persistent inability to experience positive emotions i.e. love, joy.

Symptoms are considered normal if experienced immediate after a trauma, if they persist up to 3 months they are seen as acute PTSD, and chronic if extend beyond 3 months. (Rick et al, 1998; Williams et al, 1994; Andrews et al, 2007). The symptoms for the above clients were apparently present for over nine months after the event hence fulfilling Criterion F.

Suffers can experience prolonged distress at exposure to internal or external cues resembling the traumatic event so avoid an environment that is likely to expose them to such cues. Internal or external cues that symbolise or resemble those associated with the traumatic event can also produce marked psychological distress and/or physiological reactions. All these reaction are noted in Criterion B – DSM-5.

Survivors experience trauma memories, trauma reminders or flashbacks and the attempt to avoid such memories or reminders can make living with a survivor feel like living in a war zone or living in constant threat of vague but terrible danger. Thus, for Colin, he made his environment into a war zone, as for example,

he was frequently smashing his fists into the walls of his home around his girl-friend such that his girl-friend became terrified and hence the relationship did not survive. He continued to feel he was in a war with everyone around him. (van der Kolk & Fisler, 1995).

The fact that sufferers often relive trauma memories, avoiding trauma reminders, and struggling with fear and anger, results in interference with survivors' ability to concentrate, listen carefully and make co-operative decisions, so problems often go unresolved for a long time, significant others may come to feel that dialogue and teamwork are impossible, hence probably the cause of Colin's partner leaving him. Donald had trouble focussing on his studies and spent considerable time checking the security of his home (Foa & Hearst-Ikeda, 1996).

One of the questions concerning PTSD is about what causes the mind to process traumatic events in such a way that the symptoms of PTSD are produced. It is well to remember that while events might be objectively horrendous/traumatic not everyone reacts to such events in the same way. In my work, I regularly see people suffering from PTSD as the result of an accident. The accident itself, while being something we could all do without, some of the clients had accidents that were not necessarily extreme as accidents go, yet they experienced PTSD, while others, who may have had a similar accidents, would not.

It is thought that one of the processes that people might use in order to cope with a traumatic event, as mentioned above, is that of 'dissociation'. Dissociation is a failure to integrate experiences/memories perceptions etc. that are normally associated with the event, symptoms such as amnesia, depersonalisation; de-realisation & identity confusion result from 'biological response' and may serve to reduce awareness of intolerable information. There can also be for example: emotional numbness; mental blanking (inability to think); inability to speak (Dell & O'Neill, 2009; Holmes et al, 2005; Kennedy et al, 2013; Kennerly, 2009; Van der Hart et al, 2006).

The different types of responses to trauma are not surprising in that people's responses to stress per se will be different, in that some experience body tensions in differing part of their bodies, while others express it in moods or illness etc. Why these differences occur is one question, but the point above, was that, first, there is the need to recognise that each manifestation can be an expression/symptom indicating that the client has experienced some form of trauma that was psychologically unmanageable so sub- consciously they needed to find a strategy for surviving mentally, an experience that seemed life threatening etc. So, the clients had to find a way to process the event, frequently by dissociation. The point here being, that, to date, there has developed a considerable understanding of dissociation, but little idea about its roots or how to treat it, and it is this that I wish to address.

But first, as suggested above, clinical experience with the diagnosis of PTSD has shown that there are individual differences regarding the capacity to cope with catastrophic stress/trauma so that while some people exposed to traumatic events do not develop PTSD, other do (Keane et al, 1987). Some explanation may lie in the finding that those with previous traumatic histories may present a greater risk of experiencing PTSD as the result of a trauma (Brady et al, 2000).

The difference may be due to the different ways that the individual learnt to cope with their earlier life/childhood traumas and this might be dependent on the age they were when experiencing the earlier trauma or apparently, to them, life threatening or fearful experiences. The latter, may also explain how it is that men find it more difficult to find ways to process trauma as they may have been socialised, as children, not to react, or to block their feelings, about fearful experiences (e.g. 'big boys don't cry!).

If the process for coping is a form of dissociation where the experience is not integrated into their concepts of their memories and histories, then the logical step for helping people to deal with the experience of PTSD is to find ways to help them integrate their experiences into their memories and perceptions.

An example could be my client, Donald, who developed severe OCD, such that he was jeopardizing his career as he was arriving very late for work, taking so long to leave his house. But during therapy he recalled flying through the air thinking, 'What will happen to my children if they lose their father'. He was soon able to connect this thought with his own traumatic experience as a child when his own father had been murdered. When Donald's father was assassinated, he was not able to grieve as he immediately had to be smuggled away from his family to safety, all alone with strangers. When he was able to record in writing for himself, for the first time, what happened for him as a 9 year old child, the OCD behaviour disappeared. For, Colin, when he was able to write an angry letter to the driver about what happened to him and what he was feeling (a letter not sent), his murderous feelings towards the driver disappeared.

With respect to Donald, what happened here was that I worked towards reactivation and reintegration of the compartmentalised memory of his childhood memories and that of his accident with particular reference to the memory of the thoughts that he had had while flying through the air (Holmes et al, 2005). This relates too, to the concept of 'Working self' which is seen as one of several schemas which interpret and respond to internal and external input. The 'working self' is similar to 'working memory' related to the self, from moment to moment, it selects representations of the self, based on past experiences and present context. The individual will have several working selves (Conway & Pleydell-Pearce, 2000).

Much of the 'working self' can have its origin in the concept of self we gain from childhood. Thus, it has also been found that insecure attachments in childhood positively correlate with a high risk of developing PTSD after a traumatic event in adulthood (Schore, 2002). Thus, it is suggested, the critical difference between individuals in their response to traumatic events, will be the recurrence of life threatening and other traumatic experiences particularly if the present traumatic experiences echoes (confirms) previous anxiety provoking or traumatic experiences particularly those from very early on in that person's childhood.

In the case of another client, Bob, who was hit by a truck taking a corner too fast and falling on him, during his childhood, he was terrified of his father who was frequently violent towards his

mother and his father's aggression was unpredictable. The suggested childhood experienced of Bob would have provided him with a pre- disposition for reacting to traumatic events with PTSD as the present life threatening experience would have echoed earlier anxiety provoking/life threatening experiences which were not dealt with. For Bob, this would have been his on-going anxiety/fear of his father and hence his poor relationship with his father which has been seen as correlating with a son's poor mental health resilience as an adult (Miller, 2013). One of the reasons for Bob experiencing symptoms of PTSD was that his accident echoed the life threatening fear of his father and his lack of control generally over his life, as his father controlled what happened to him in his development. This overall feeling of lack of control would have also have been a possible pre-cursor for the on-going depression and anxiety (Miller, 2013) and a diagnoses of depression and anxiety are seen as major risk factors for developing PTSD as a result of a later trauma (Brewin et al, 2000; Halligan & Yehuda, 2000).

Studies have found that children learn their anxiety coping strategies from their parents (Eley et al, 2015). Significantly, a study in the Netherlands has found that a child's development of anxiety coping strategies, particularly for boys, is more influences by the father's responses to stress than the mother's (Moller et al, 2015). Also, children's school behaviour, again particular boy's behaviour, is strongly linked with the father's influence on that behaviour, is not only significant, but may be more significant than mother's e.g. father's harsh parenting is more strongly linked to aggression than is mother's harsh parenting (Lloyd et al, 2003; Velleman, 2004; Jaffee et al, 1990; Chang et al, 2003; Wang & Kenny, 2014). In fact, father's high involvement with their sons (as measured by reading, method of disciplinary, taking trips) is associated with fewer behavioural problems and lower criminality and substance misuse (Sarkadi et al, 2008; Flouri, 2005; Pleck & Masciadrelli, 2004; Lloyd et al, 2003, Clark, 2009; Lamb, 2010). But in much of my working experience (working as a social worker with violent offending boys) their only experiences of their fathers would be ones where they would occasionally appear on the scene and would be aggressive and abusive towards their mothers and/or to them.

Neurological underpinnings

However, given this understanding of the root of the PTSD responses, the question to ask is 'what can best help the individual to recover?'. Before exploring this, it might be useful to understand what is going on in the brain to promote the on-going fear responses. It is now established that a pathological response to stress reflects the functions of a hyper-excitable amygdala (Halgren, 1992), that fear-potentiation of startle is mediated through the amygdala, which directly projects to the brainstem startle centre (Davis, 1989), and that the memory processes of the amygdala are amplified by extreme stress (Corodimas, 1994). These amygdala-driven startle and fear-freeze responses would be, as suggested above, learnt responses often from childhood and models that the children have for coping. It was also suggested above, particularly for boys, that the most powerful models for learning how to deal with stress comes from the models they had from their fathers.

The role of the amygdala in the limbic system is the monitoring of nearly all sensory stimuli and is involved in regulating fear and aggression; in charge of emotional learning in early life and somatic organisation of experience; prepares organism for action in face of danger receiving input either via neo-cortex or from rough fast thalamic input and activating fight, flight and freeze behaviour as in PTSD. But it is the role of the Hippocampus that is critical also in the fear responses.

The Hippocampus integrations and discriminations, it enables remembering of a sequences of events, converts *implicit* memory into *explicit* mental images which is important in PTSD; it i*ntegrates memories* from different sensory modalities and commits spatial and temporal dimensions to memory. Excess and chronic exposure to stress hormones (cortisol) will change synapses and dendrites in hippocampus causing: Atrophy due to traumatisation, and probably increased vulnerability to PTSD later on because of loss of co-ordination by hippocampus of sensorimotor systems and affective systems. Smaller hippocampal volume has been reported in several stress-related psychiatric disorders, including: PTSD, borderline personality disorder and dissociative disorders which, as mentioned above are a response to trauma.

However recent studies that have focussed on the hippocampus in black cab drivers in London found that those who were successful in learning 'the knowledge' increased the size of their hippocampus and when they retired it decreased in size again. Taxi driver study indicated that the 'Learning of the Knowledge' caused the Hippocampus to grow in its volume of grey matter which basically demonstrated the plasticity of, at least, this part of the brain, knowledge of which may be important in the treatment of client with respect to their stress responses (Maguire et al, 2000).

The focus of this paper was to examine ways in which the processing of traumatic experiences can be re-rooted such that the intervention of the amygdala and its triggering of neuroendocrinal hormones can be inhibited. The above focussed neurologically and historically, on what sets up the preconditions which predisposes the individual to reacting to traumatic events with repetitive fight or flight responses which is the feature of PTSD reactive responses. But the point of this paper was also to look at ways to alter that response. Thus, I would like now to connect the thinking towards the theoretical views concerning Narrative therapy.

Narrative therapy

The point of narrative therapy/conversation is not about giving advice (White, 1997), is not about normative judgements or evaluations from positions of authority. Basically, as many therapist can attest people come to therapy to tell their story (McLeod, 1998) and by doing so they can, as it were, externalising the problems (White & Epston, 1990; Morgan, 2000). Through the process of communicating their problems, the client presents their story potentially laden with the experiences, attitudes, beliefs and understandings as the story is constructed via those beliefs etc. The narrative can encourage de-construction and critical appraisal of their strong emotions/trauma. Hence it can be seen as

a literate means to a therapeutic end (White & Epston, 1990; Foucault, 1979; White 1997). The process of telling the story allows them to endeavour to construct a coherence, to connect the dots, and make sense of their experiences. Focussing just on their emotional responses does not allow them to do this.

When in stress mode all senses are narrowed down to survival mode making seeing the bigger picture and hence coherence, difficult to attain. The traditional models of therapy invite or reignite trauma, internalised feelings are often ignored and the contextual element dismissed. Narrative therapy focusses on experiencing and contextualising trauma as a force outside of the person and does not seek to define the person by their experience, by creating autobiographical details can produce 80% clinical improvement in a short time (Ertl et al, 2011). People encode their individual narrative as coherent memories in the brain.

Psychologically healthy individuals have meaningful, logical and vibrant self-stories whereas faulty self-narratives are synonymous with emotional difficulties. Numerous studies indicate that disarranged, unassimilated narratives of traumatic experiences lead to PTSD. Hence, finding a way to be able to construct healthy narratives of traumatic experiences corresponds to a healthy recovery process. Relating our stories in a coherent logical way, changes us and hence the story has the power to heal (Mehl-Madrona, 2005).

The difficulty can be for those with multiple traumas or on-going traumas like that of child abuse. In this situation the client is encouraged to construct a narrative of his or her whole life, from birth to the present while focusing on the detail report of the traumatic experiences. Narrative treatment methods have the potential to be effective because they make use of the persons own life story and are short-term and hence costeffective and seems to compare favourably with treatments such as interpersonal or CBT techniques and may require less professional training than other therapies as it revolves more around the ability to listen well to stories and to just enable the client totell their story in a structured coherent way. The client does most of the work by tellingtheir story over and over again until they habituate to the aroused emotional reactions that is, learning that the memories themselves are not scary.

In my practice, whilst I was interested in encouraging clients to tell their stories, sometimes their stories were long and could not be condensed in the 1 hour or the limited number of sessions that they had available in the settings providing both EAP treatments and IAPT High Intensity Treatments in the NHS. I also felt that even talking about their experience did not necessarily help them integrate the experience into their working memory and it was hard particularly for many of my male clients to express the emotions that went with those memories either through embarrassment concerning those feelings or their difficulties allowing themselves to feel them. But more pragmatically, I felt that they might better be able to create a coherence in their story if they were able to write it in their own time where they would not have to censor themselves for fear of what I, or others, might think.

I therefore reasoned that writing might help those suffering from even more immediate emotionally arousing memories. I also found that speaking about the event whilst it help them to rehearse what was in their minds, it was not as effective or did not have the same impact as writing. I thus began developing a protocol for getting people to use what I later discovered was being called 'Expressive Writing'.

Expressive writing, as I can now call it, is, I believe, consistent with the techniques and reasoning for the effectiveness of Narrative Therapy i.e. everyone wants to tell their story. But I believe Expressive Writing goes further, as writing their stories gives it more coherence, order and makes their stories more concrete, and so, the suggestion is, that their story is stored more effectively.

But before I relate what I have discovered is an effective protocol for such treatment and give examples of its effectiveness, it would be well to look at what has been found in the research about the effectiveness/benefits of Expressive Writing in the treatment of Trauma.

Expressive Writing in the treatment of Trauma

Over the last 30 years there has been a considerable amount of research since the first study of Pennebaker & Beall (1986) which showed that writing about traumatic or stressful events has physical and emotional benefits. Pennebaker & Beall noted writing about traumatic experiences produced increases in short-term physiological arousal and long term mental and physical benefits. They suggested that clients could do this over a number of days, maybe 3-5 sessions of no more than about 20 minutes per session (20 minutes being the maximum concentration span of any individual), though the number of sessions will depend, I suggest, on the gravity or length of the traumatic experience (Pennebaker, 1994, 1997a; 1997b; Smyth & Pennebaker, 1999). The research showed that there were usually short-term increases in distress, negative mood and physical symptoms, but as with Pennebaker's research, my clients reported that they felt lighter and relief, even immediately after the first writing session.

Other studies found that those who had traumatic histories or post-traumatic stress disorder (PTSD) shown improvements in physical health and symptomology (Greenberg et al, 1996; Sloan & Marx, 2004; Schoutrop et al, 1997; 2002). Some studies suggested that expressive writing was detrimental for adult survivors of childhood abuse (Batten et al, 2002) though this would seem to be contrary to the comments made by writers who have written and published their stories of their abuse where they comment that writing their story had allowed them to move forward in their lives.

But it may be, as suggested above, that the researchers expected the narration of such events to be done in a limited time and for some, maybe, it can take some time to relate all the events and the feelings about those events. Interestingly, a meta-analysis found that the effects sizes were greater for males than for females (Smyth, 1998) as it seems this form of expression was more acceptable to men.

This is my experience, in that males maybe more reticent to

express their real emotions to others but in the privacy of their own writing (in my protocol I would encourage them to keep their writing private, for their eyes only {password protected}, so that they do not censor or restrict their expressiveness, for fear of others seeing it and worrying what others would think).
Pennebaker & Beall (1986) also make the important point that the benefits are greater if the client writes about the event with the associated emotions than if they only wrote about the emotions or the events, alone. Pennebaker (1985) suggested the explanation was that the active inhibition of thoughts and feelings about a traumatic event require physical effort and serves therefore as a cumulative stressor on the body and is associated with increased physiological activity, obsessive thinking or rumination.

Clients come saying they are desperate to stop thinking about the event, they are desperate to forget and try to not to think about it but admit that this doesn't work as they continue to have flashback and nightmares, so they think that I am mad to suggest that as their strategy is not working (quote: Einstein – 'To keep doing the same thing and expecting a different outcome, is the definition of madness') then we are going to do the opposite – they are going to do everything to remember!

Pennebaker suggested confronting the trauma through talking or writing about it with the associated emotions reduces the physiological work of inhibition hence lowering the overall stress on the body and translating the event into words enable cognitive integration and understanding (Pennebaker, 1985). However, I suggest here, that Pennebaker has not fully appreciated the difference between relating the events verbally and in writing. Yet, he notes, through his and other's research, that expressive writing as against verbal relating, is more effective.

Writing requires much more processing than the spoken word; it requires coherence, order and integration, and hence I suggest uses different parts of our brains, perhaps eventually by-passing the emotional brain (the amygdala). Writing and systematic memory requires processing through the hippocampus which, as discussed above, is implicated in memory, remembering a sequences of events, spatial and temporal, and integrates memories from different sensory modalities. Thus, it is suggested that the expressive writing allows for a coherent narrative reflecting increasing cognitive processing of the experience (Van der Kolk et al, 1996). The writing may help the writer organise and structure the traumatic memory (Harber & Pennebaker, 1992).

It is for this reason that I try to get clients to use their computers to write their story/stories, as they can re-structure, as they progress, to get order to their story, and add in the appropriate places, memories that were omitted at the time when they first recorded it; they can cut and paste, if they find the memories need to be re-organised. Their instructions are to keep going until they feel nothing has been left out.

Some clients have said they feel more in touch with their emotions when they write by hand, but then they have still felt it was helpful to transcribe what they had written onto the computer to ensure its coherence. By asking clients to keep going until they feel there is nothing left also produces prolonged exposure as they have to keep reading it (another advantage of writing over talking) to check they have not left anything out (the re-reading can also trigger forgotten parts of the memory of the event – often the most painful parts, the parts they try to forget – but not very successfully!).

This repeated reading and adding (I don't suggest repeated writing) may produce extinction of negative emotional responses (Lepore et al, 2002; Sloan & Marx, 2004; Sloan et al, 2005). It is suggested that to produce immediate emotional habituation requires 45-90 minutes of writing, but this view, I think, forgets that after brief writing sessions of even 20 minutes, the brain does not stop processing and further sessions over days seem to produce this effect, even if the actual sessions are for only 20 minutes, the maximum time most can tolerate the emotional arousal. However, in some instances, the clients have said once they have started, they wanted to keep going and wrote until they were exhausted, but were still instructed to keep re-visiting what they had written, daily, until nothing was left to write about.

Bob, Donald and Colin revisited

Bob found the writing particularly difficult so avoided writing for quite a few sessions, but as he was getting upset that he was not able to go out to take photos, a pastime he previously enjoyed, he forced himself to write and found in the process he was able to venture out further afield on his own and the nightmares and flashbacks disappeared. He wrote not just about the accident but also about his experiences at the hands of his father.

Donald spent time not only writing about what happened in the accident but also writing about what happened and how he felt, when his father was assassinated and what followed. As he progress with writing about this, his OCD disappeared and he was able to resume his training without risking losing his position because of arriving late for his training sessions when he was spending time checking doors and windows 20 times before he could leave. OCD is seen as an avoidance behaviour, so while he was worrying about the doors and windows, he didn't have to think about his real worry, which was about the security of his children, as he had not processed what had happened to his own security as a child of 9 years of age and hence how his children's lives were different from his own experience as a child.

For, Colin, when he was able to write an angry letter to the driver about what happened to him and what he was feeling (a letter not sent), his murderous feelings towards the driver disappeared.

Thus, for each of the above mentioned clients, and many more that I have treated in this way, it has proved to be an effective brief treatment protocol. However, it is important to say that while this method is very effective in that the clients can do the hard work between sessions, this does not suggest that they do not need the support of psychological professional to encourage them through the process and to help them to be sufficiently motivated to not put off going through the process as they had been warned that the process is very painful.

So, with another client, John, who was in prison after violently assaulting someone and who had experience numerous traumatic

events while in the army being posted to Afghanistan and Iraq, I encouraged him to writing what happened to him, both from his time in the army but also the traumatic events he experienced in his childhood (e.g. witnessing his twin brother being run over), while he was in prison and to ask for a forensic psychologist to support him in this process (he may be only been able to do this using hand-writing as perhaps a laptop may have not been available to him). The support is essential as all clients would feel short-term distress during the process.

But it has been found that the short-term distress does not appear to be detrimental or pose a longer term risk to clients thus answering those who worry about the possibility of re-traumatising the clients by this procedure (Hochemeyer et al, 1999). Thus, seeing their therapist, or a supporting worker, during this process allows them also to report and make themselves aware, consciously, of the effect of the writing on their emotions and to feedback how it has allowed them to 'feel lighter' and to let go and to move forward. Further, because the main tasks are carried out in the client's own private time, then this saves time in the clinical setting, so allowing for the process to be supported by perhaps less trained staff, requiring fewer sessions and perhaps not requiring the use the traditional weekly therapy model, but allows for the use of more variable flexible frequencies. This would allow for the process to carry on using fewer sessions as used in EAP (Employment Assistance Programmes) or in IAPT (Improve Access to Psychological Treatment) Primary services. Further, it should be noted that it is not perhaps accidental that the examples that I have given are all males, this is not to say it doesn't work with females, as it does, but these males were all males who would never normally have sought out help and came to believe that talking about what happened would not help them as all they wanted to do was to forget about what happened. Also, it should be noted, that they had not immediately sought help, e.g. Colin had tried to drink away the problem before coming, Donald had developed OCD for some time before seeking help and John did not ask for help until he ended up in prison.

Conclusion

75% of all suicides in Britain are males, suggesting that somehow males are not gaining access to help or that the mental health help is not reaching them. Therefore, the services have to think of more innovative ways to offer help. In this paper I wanted to illustrate one way, that of 'Expressive Writing', which seems to work well in helping people, particular males, deal with trauma, Also, I wanted to focus on what particularly might lead sufferers of trauma to go onto experience PTSD, which I have suggested, may be the cause of many males, for example, ending up in prison and killing themselves.

Further, the advantage of 'Expressive Writing' is that it can be used by clients in their own time and settings, perhaps with the need for less intensive input from professionals, so may be more pragmatic in reaching those who may not have ready access to help such as men in prison, etc. The purpose of this paper was not to be able to say exactly why the method works, as I believe that may require more research, but to suggest what might be happening. To give perhaps a rational as to how it is that 'Expressive Writing' is an effective tool in the treatment of PTSD, particularly for men.

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