Testimony Therapy:

Treatment Method for Traumatized Victims of Organized Violence

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Former political prisoners in Chile gave testimony of their traumatic experiences, which resulted in diminishing their posttraumatic symptoms. Based on this experience, testimony therapy has been developed and used in treatment of traumatized victims of war or other organized violence. This short-term therapy, as it applied in the treatment of traumatized asylum seekers and refugees in Centrum '45/De Vonk in the Netherlands, is described in this article. The therapy consists of 12 sessions in which patients tell their life stories, including the traumatic experiences. The narrative is reflected in a written document that, for example, can be read to family and friends, or be sent to a historical archive. This article discusses the preliminary research data on the effects of testimony therapy. Finally, hypotheses on the working mechanisms of testimony therapy are offered.

INTRODUCTION

Traumatized victims of war or political violence give testimony of their experiences in different situations and for different reasons. They might tell about their experiences in the media, to human rights organizations or even in therapy. Sometimes, they volunteer to tell their story, sometimes they are forced to tell, for example, to obtain asylum.

Testimony therapy was first described by the Chilean psychologists Cienfuegos and Monelli (1). During the Chilean dictatorship, they tried to get in touch with former political prisoners of the regime. They collected their stories as a way of documenting the oppression, but they also discovered that giving testimony in this way seemed to help these former prisoners.

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In testimony therapy, people are invited to tell their life stories, including the traumatizing experiences. In this approach, the political context of the traumatizing events is being stressed. The stories are tape-recorded and a verbatim report of every session is made. Together, these reports form a document that contains the patients' life stories, including the traumatic experiences. Patients and therapists sign these documents. Patients decide how they want to use them; they can keep them for themselves, give a copy to family or friends, or send it to a human rights organization.

Testimony therapy is also carried out with refugees. The Danish therapists Agger and Jensen (2) report positive results based on case studies with refugees from various countries. Weine, Dzubur Kelanovic, Pavkovic, and Gibbons (3) carried out testimony therapy with Bosnian refugees in the U.S.A., with a positive outcome. Laub (4) described testimony therapy with Holocaust survivors. By now, testimony therapy has found its way into textbooks and articles on trauma treatment with refugees (5-18).

So far, testimony therapy has been applied specifically with traumatized victims of war or organized violence. Because of the positive clinical results, we decided to introduce this method in our institute, Centrum '45/De Vonk in Noordwijkerhout, the Netherlands, and to conduct a pilot study in preparation for a controlled outcome study.

For a better understanding of the context of our work, we will briefly describe Centrum '45/De Vonk; then, the treatment protocol, as applied at our center, will be introduced. This will be illustrated with some case examples. Next, outcome studies on the effects of testimony therapy will be presented. Finally, we will describe theoretical ideas about the testimony therapy as a method of trauma treatment, followed by some concluding remarks.

TRAUMA TREATMENT FOR ASYLUM SEEKERS AND REFUGEES AT CENTRUM '45/DE VONK

Centrum '45/De Vonk is a national institute for the treatment of the psychic sequelae of organized violence. Patients are asylum seekers or legal refugees in the Netherlands and victims of war. They are traumatized by several severe experiences of violence or other extremely stressful events, such as imprisonment, threats to life, witnessing or undergoing torture, hunger, thirst, and death of family members. Patients suffer from severe posttraumatic stress disorder (PTSD). Symptoms are intrusions, nightmares, severe anxiety, disturbances in memory and concentration, sleep

disturbances, avoidance of trauma-related stimuli, and hyperarousal. Often patients also suffer from other kinds of anxiety disorders or mood disorders (19). Their current insecure situation as asylum seekers adds to their problems. Most patients do not speak Dutch. Therapy is carried out with help of an interpreter.

The case of Mr. S. is an example of the situation of patients at our institute.

Vignette 1

In 1995, Mr. S., a Bosnian, arrived in the Netherlands from the former Yugoslavia. He had been imprisoned in one of the camps, set up by the Serbs in Bosnia Herzegovina, where he had been severely beaten and tortured. He had lost contact with his family members who had to leave the area. He managed to flee and ended up in Holland. His family was located by the Red Cross and they were reunited. Although he is extremely happy to be with his family, Mr S. suffers from nightmares and sleep disturbances. He is easily irritated and often looses his temper. He hits his children but feels very ashamed of that afterwards. He avoids other Bosnians because he is afraid to be reminded of his home country. He was referred by the medical doctor of an Asylum Seekers Center.

PROTOCOL FOR TESTIMONY THERAPY

At Centrum '45/De Vonk, a protocol[1] has been developed based on the descriptions from earlier studies (1-3) as well as psychotherapists' experiences with the therapy. To our knowledge, this is the first elaborate protocol for this therapy. At some points, our protocol differs from earlier descriptions. The number of sessions is set at twelve, whereas others used six on average (3) or twelve to twenty (2). Based on our experience, twelve sessions seem to be sufficient to tell the complete story and to generate a document. The protocol is designed for the traumatized asylum seekers and refugees who seek help at our institute and who are diagnosed with trauma-related disorders (as opposed to traumatized victims of war who come to bear testimony for different reasons, as in the project of Weine et al.[3]). The protocol contains instructions for therapists. Also, inspired by the experience of our therapists, we added a special feature, namely, the drawing of a line in one of the first sessions, reflecting the major events of the patient's life. This drawing helps in planning later sessions. Schematic presentation of the therapy protocol is shown in Table I.

[1] An authorized protocol can be obtained from the first author.

Table I. OVERVIEW OF TESTIMONY THERAPY

# Session	Topic
1	Introduction, psycho-education PTSD, information about therapy
2	Outline of life history, discussion about the use of the document
3 & 4	*Period 1*
	Account of life before traumatic experiences took place
5 & 6	*Period 2*
	Account of traumatic experiences
7	Reading and editing first part of document
8 & 9	*Period 3*
	Account of life after traumatic experiences took place
10 & 11	*Period 4*
	Account of current situation and expectations
	Reading and editing second part of document
12	Signing of the document
	Termination

The testimony (or the translation by the interpreter) will be tape recorded and written out by the therapist. In this way, a document is created that reflects the patient's experiences.

Before starting the testimony, the patient gets psycho-education about trauma therapy, in particular about testimony therapy, as well as information about PTSD. As mentioned, the therapist and patient make a general overview of the patient's life history by drawing a line reflecting the lifespan and marking important life events along the line. Also, patient and therapist discuss the final purpose of the document. Then, the testimony starts. The patient tells his/her story chronologically. The story is divided in four periods: the period before the traumatic experiences took place, the period of the traumatic experiences, the period afterwards and, finally, the current situation and the future. When parts of the document are finished, the patient might want to read it (or being read to, when the patient is not able to read him/herself). The text can be edited: the patient should be able to identify with the story. Reading and editing can be done at any time. In the protocol, we planned session 7 and part of session 11 for this. When the document is ready, patient and therapist sign it, if desired, as a way of acknowledging the importance of the document. As discussed in the first session, the patient might then want to give or send the document to someone else or to an organization.

Vignette 2

A patient from Bosnia states: "Initially, I didn't have any hope. Now, during the testimony therapy, I can open my heart. It is quite a relief. I don't know yet what I will do with the document, I will see. I want everybody to know what has happened to us; how bad people can be, what we are capable of. It is unthinkable what has happened in Bosnia, barbarous. Everything nature has given us can be destroyed in a fraction of time."

THERAPIST'S ROLE

The therapist's role is to support the patient and to structure the story, if necessary. He/she steers when the patient seems to avoid essential details, and he/she slows the process down when the patient is at risk of getting overwhelmed by memories. The therapist encourages the patient to tell his/her story, but the focus is not exposure as such.

Vignette 3

T: The police shot and your friend got hit. You were helping him and then they arrested you?
P: He was hit by a bullet and I thought he had died.
T: And in prison you thought you were going to die yourself.
P: Yes.
T: Did they mistreat or torture you in prison?
P: Yes (*silence*).
T: Do you want to tell about it? I can tell from your face that it is hard to think about these things, isn't it?
P: (*silence, crying*).
T: What kind of memories come up?
P: The prison (*points at his head*).
T: Your head?
P: With (*makes gesture*)
T: With a gun? Your head? Did they hit your head with a gun?
P: Yes, everywhere, not only there. It was terrible.
T: I can see a mark there. Did they hit you everywhere?

The therapist helps to define the political and historical context of the traumatic events. He/she never calls the testimony into question, but may ask for clarifications when there are contradictions or historically incorrect facts in the story.

INDICATION CRITERIA

Based on earlier studies and clinical experience, we formulated indication criteria. The first criterion is trauma-related symptoms, which are the first reason for care. In relation to trauma, patients usually struggle with the dilemma of avoidance versus disclosure. When patients do not wish to speak about their experiences, testimony therapy of course will not work out. When they do want to talk about their memories, a careful evaluation must be made of the risk of getting overwhelmed by intense flashbacks and nightmares. In testimony therapy, patients must be informed beforehand that it is important to commit themselves for the duration of the therapy. After all, the goal of this therapy is to draw up the testimony document.

Our patients are interviewed after they have finished the testimony therapy and are asked their opinion about the therapy. The following excerpt shows the dilemma patients often feel (to avoid rather than open up) and the eventual positive evaluation of this particular patient.

Vignette 4

The patient states that he thinks the therapy helped him to process the traumatic experiences. He thinks the method is difficult and demanding and only suitable for very strong people. It relieved him to tell his story but it also brought back the memories and sadness. Being an introvert, he doesn't like to talk about himself, but in the end it has helped him and he feels better now. Certain things he didn't tell. That is why he didn't recover completely, he thinks. In the future he might have his children read the document.

RESEARCH DATA

Two uncontrolled studies into the effects of testimony therapy show preliminary positive results of the intervention. Cienfuegos and Monelli (1) conducted the testimony method with traumatized victims of the Pinochet regime. They treated their patients (N = 39), who suffered from posttraumatic stress symptoms, in a clinical setting. As a result of giving testimony, the symptoms decreased, in particular, in victims of torture. The researchers do not describe how they assessed this symptom reduction.

Weine et al. (3) used the testimony therapy with Bosnian refugees in the USA. They adjusted the method (fewer sessions in a nonclinical setting) and carried out an outcome study with 20 participants. Symptoms and level of functioning at pretherapy were assessed with the Post Traumatic Stress Disorder (PTSD) Symptoms Scale (20), the Beck Depression Inventory (21) and the Global Assessment of Functioning Scale (GAF) (22). The

assessment was repeated at the termination of therapy and two and six months afterwards. At the conclusion of the therapy, a decrease in PTSD symptoms and depression was found, as well as an increase in the scores on the GAF-scale. This progress continued during the follow-up period.

Concluding, these outcome studies tend to show a positive effect of testimony therapy on the PTSD symptoms. However, it is clear that these preliminary results need to be confirmed in controlled studies with more participants. We plan to carry out such a study with a waiting-list group as a control.

TESTIMONY THERAPY AS A METHOD OF TRAUMA TREATMENT

As mentioned, we do not yet know for sure whether testimony therapy has a positive outcome nor how it works. However, based on the knowledge of trauma treatment and on literature on testimony therapy, we can hypothesize what might be the mechanisms at work. First, we will review the viewpoints of the most important authors dealing with testimony therapy. Then, we will discuss testimony therapy from a cognitive-behavioral perspective.

Cienfuegos and Monelli (1), who were the first to describe the positive effects of giving testimony, discuss the working mechanisms of testimony therapy from a psychoanalytic, as well as an existential vantage point. They presume that catharsis is at work. They posit that giving testimony brings suppressed emotions out in the open. It channels the intense emotions, in particular anger, caused by the traumatic experiences. Besides that, the testimony helps in the process of finding meaning by providing the political context for the trauma. Cienfuegos and Monelli also stress the importance of the sharing of the experiences with others. The acknowledgment by significant others counteracts the isolation that many victims experienced during and after the traumatic events.

Important work with testimony therapy is carried out by the psychoanalyst Laub (4), who is himself survived the Holocaust as a child. He mainly works with Holocaust victims and their families. He hypothesizes that the importance of a testimony lies in the fact that the person who testifies creates an engaged and meaningful audience: the therapist and significant others. In this way the traumatized person who, generally speaking, felt extremely lonely and isolated during the traumatic period, re-establishes the connection with others. Laub also uses the psychoanalytic concept of the therapist as a temporary "container" of those feelings patients cannot yet contain themselves. The therapist becomes a witness by

listening to the patients' testimony and contains the story until the patients have processed their feelings and are able to own the story themselves.

Agger and Jensen (2) suggest that in particular in the case of victims of torture, often political prisoners, the reconnection with the political commitment helps to process the traumatic experiences. Therefore, in the testimony the political context of the events is stressed.

Weine (18) emphasizes the importance of the political context of the testimony, as well. He stays close to the original concept of political testimonies through which the oppressed are given a voice. In his opinion, the testimonies work at an individual level, but should also help the society to recover after a very traumatizing period. At the individual level, giving testimony in a safe and holding environment may address the fragmentation and isolation caused by the traumatization. When the fragmented memories coalesce, a comprehensible overview of what has happened may evolve. According to Weine and Laub (4), producing a testimony document creates a counterweight to processes of splitting and denial. The document can serve as a tangible proof of the reality of the trauma and it provides a means to share this with others. In addition to that, Weine (18) stresses how testimony projects can contribute to the reconciliation of a fragmented society. He refers to the Bosnian situation in which ethnic groups that have become murderous enemies have to find new ways to live together. Weine advocates extensive testimony projects in which many professionals and others are involved in order to develop a "civic dialogue on survivors' remembrances" (18, p. 164). Different realities are put forward by the victims of the Bosnian war. When a sincere dialogue is being carried out, it might open a way for a traumatized society to reconcile.

Whereas these authors use a psychoanalytical and existential vantage point, it might also be helpful to reframe the working mechanisms of testimony therapy in cognitive-behavioral terms, which are now commonly used in trauma therapy.

A main characteristic of trauma is the inability to talk about or to remember the traumatic experiences without being flooded by them. Gradual exposure to the painful memories has proved to decrease the main symptoms of PTSD, namely, avoidance and re-experiencing. Also, inadequate cognitions are specific to unresolved trauma. The traumatized person might develop cognitions that hinder psychological well-being, for example, "everybody is my enemy," and "life won't bring any good anymore." Exposure to the traumatic memories, as well as the adjustment

of inadequate cognitions are the main ingredients in the state-of-art trauma therapies (23).

Testimony therapy seems to include both mechanisms. While composing the testimony, the traumatized person is gradually exposed to the traumatic memories. The person tells about the experiences and then reads the story or it is being read to him/her so he/she can revise it. The painful events are brought back to memory in a controlled way and in a safe environment (8). Slowly, this will desensitize the memories and as a result, the memories can he tolerated and the urge to avoid them will diminish.

Testimony therapy also aims at adjusting inadequate cognitions. While giving testimony, patients evaluate their experiences and might change inadequate perceptions of them. The events are put in a historical and political context, which might help patients to better understand what happened. Also, the patients' perception of themselves as helpless victims of violence might change into the perception of themselves as active persons. This effect might be brought about by the patients' active participation that the therapy requires: he/she reads (or listens when it is being read) and revises the document.

Based on their research on writing about stressful events, Pennebaker and Seagal (24) and Schoutrop (25) conclude that disclosure has a positive impact on psychological and physical health. Pennebaker and Seagal (24) hypothesize that the construction of a story of the traumatic events is the crux in the process of recovery. Pennebaker (26) states: "Movement towards the development of a narrative is far more predictive of health than having a coherent story per se. The construction of a story rather than having a constructed story, then, may be the desired endpoint of writing and, by extension, of therapy"(p. 546). What is the working mechanism in constructing a narrative? Pennebaker (24) refers to people's need to understand the world around them. By forming a story, particularly when something stressful has happened, the events become organized, more simple and understandable. "Translating distress into language ultimately allows us to forget or, perhaps a better phrase, move beyond the experience" (p. 1251). Their research showed that the use of insight and causal words while writing about traumatic events resulted in greater health improvement than without this kind of words (27). The use of these words implicates a cognitive reappraisal of the events. Exactly this cognitive reappraisal is shown in research to be most helpful in processing traumatic events as compared to exposure only (28). In testimony therapy too, an essential feature is the construction of a narrative. Although we cannot

generalize the research results just like that, we can hypothesize that in testimony therapy as well, the construction of the narrative is beneficial.

Applying the concepts of the attachment theory, Holmes (29) comes to a similar conclusion. Comparable to the narratives of persons with a disorganized state of mind, often a result of early traumatization, the narratives of persons traumatized as adults are fragmented and incomplete as well. The narratives often show lapses in monitoring of reasoning, such as lack of logic or lack of reality testing when discussing the trauma. Lapses in the monitoring of discourse are characteristic as well, such as prolonged silences, a focus on details or unfinished sentences (30). Holmes suggests that the therapist supports the traumatized person in forming a coherent narrative corresponding more closely with the traumatic experience. Turning trauma into a coherent narrative means challenging the narrative defenses, such as psychic numbing, dissociation of feelings from the story, selective forgetting or fragmentation. Initially, this might be in direct conflict with the tendency to avoid the trauma memory. The therapist then needs to "stand for the part of the victim's self that could not bear to look at what is done to her" (29, p. 92). Eventually, the traumatized person might be able to integrate the dissociated parts into a coherent narrative of the experiences.

Another beneficial aspect of testimony therapy is the signing of the document. This can be seen as a ritual closure of the therapy, the last phase. Although, so far, there are no research data available, the beneficial effects of the use of rituals in therapy are described in many case studies (31-33). Lange (33) presumes that the concept of the self-perception theory clarifies this phenomenon, namely, new behavior initiates new cognitions, attitudes, and emotions. Possibly, the ritual emphasis on the conclusion of a period of trauma helps to move on to a new phase in life.

Finally, the patient and therapist will discuss the use of the document. This discussion might also change the patients' perspective. They might want to share their story with others. In this way they connect with others and make an investment in the future. The choice of the use of the document might reinforce social sharing with family, friends or others. In addition to the cognitive reappraisal, the social sharing is known to contribute to recovery after traumatic experiences (25, 34). In writing therapy it adds to the beneficial impact when the writer addresses the letter to a significant other. Generalizing this, we might presume that it is beneficial to patients when they have in mind to whom to address the document.

CONCLUDING REMARKS

So far, testimony therapy has been described as a therapy method specifically for traumatized asylum seekers and refugees. It seems the only method designed particularly for this group of patients. Thus, at Centrum '45/De Vonk, a specialized center for care of traumatized asylum seekers and refugees, it made sense to introduce this therapy. Our group of patients might find the method "appealing," because they might see it as a way to prevent further violence or war. They might want to tell their children, they might feel the need to let others know what happened to them or to their people. Also, it might offer the occasion for the first time to tell their complete story to someone who does not interrogate and judge, who is genuinely interested in their story. In this sense, testimony therapy might be a useful addition to the repertory of trauma treatment. The method offers a structured way of disclosure and documenting the traumatizing events, even to people who have little education or who are illiterate, because, in that case, the document will be read to them.

As opposed to writing therapy (28), another method of trauma treatment, in testimony therapy, the story of the traumatic events is told in face-to-face sessions instead of written alone at home (which is in many cases the asylum seekers center, where people share rooms). It also means that, from the start, the patients work on connecting with another person. In addition to that, the therapist can intervene quickly and easily in the therapy process. This might be an advantage when patients suffer from severe PTSD symptoms.

A disadvantage might be that testimony therapy is a relatively labor-intensive method for the therapist. If preferred, a summary of the patient's story might be made instead of a verbatim version. Also, in some cases, patients might be able to transcribe the tapes of the sessions themselves.

Relatively little has been written about trauma treatment with asylum seekers and refugees who are victims of organized violence. Based on clinical experience and scarce research data, testimony therapy looks promising and further exploration seems worthwhile. A controlled study is needed to answer questions about the effectiveness and efficiency. In addition, exploration of the possible working mechanisms is needed to understand what works and what helps to improve our treatment methods.

REFERENCES

1. Cienfuegos AJ, Monelli C (1983). The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry, 53,* 43-51.

2. Agger J, Jensen SB (1990). Testimony as ritual and evidence in psychotherapy for political refugees. *Journal of Traumatic Stress, 3,* 115-130.
3. Weine SM, Dzubur Kelanovic A, Pavkovic I, et al. (1998). Testimony psychotherapy with Bosnian refugees: A pilot study. *American Journal of Psychiatry, 155,* 12, 1720-1726.
4. Laub D (1995). Truth and testimony: The process and the struggle. In C. Caruth (Ed.), *Trauma, explorations in memory.* Baltimore, MD: Johns Hopkins University Press.
5. Başoğlu M, Mineka S (1992). The assessment and diagnosis of torture events and symptoms. In M. Başoğlu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 201-218). Cambridge: Cambridge University Press.
6. Bustos E (1990). Dealing with the unbearable: Reactions of therapists and therapeutic institutions to survivors of torture. In P. Suedfeld (Ed.), *Psychology and torture* (pp. 143-161). New York, NY: Hemisphere.
7. Chester B (1990). Centers for victims of torture. In P. Suedfeld (Ed.), *Psychology and torture* (pp. 165-180). New York, NY: Hemisphere.
8. Herman JL (1992). *Trauma and recovery.* New York: Basic Books.
9. Randall GL, Lutz EL (1991). *Serving survivors of torture. A practical manual for health professionals and other service providers.* Washington DC: American Association for the Advancement of Science.
10. Rohlof H, Groenenberg M, Blom C (1999). *Vluchtelingen in de GGZ.* [Refugees in Mental Health Care]. Utrecht: Stichting Pharos.
11. Staer A, Staer M (1995). *Counselling torture survivors.* Copenhagen: IRCT.
12. Turner SW, MacIvor RN (1997). Torture. In D. Black, M.C. Newman, J.M. Harris-Hendriks, G.C. Mezey (Eds.), *Psychological trauma: A developmental approach* (pp. 205-215). London: Gaskell.
13. Turner SW (2000). Psychiatric help for survivors of torture. *Advances in Psychiatric Treatment, 6,* 295-303.
14. Van der Kolk BA, McFarlane AC, Weisaeth L (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York: Guilford Press.
15. Van der Veer G (1992). *Counselling and therapy with refugees: Psychological problems of victims of war, torture and repression.* New York: Wiley.
16. Van Dijk A, Schreuder JN (2001). De getuigenis als therapie. Beschrijving van een kortdurende therapeutische methode voor getraumatiseerde slachtoffers van politiek geweld. [Testimony as therapy. A short-term therapy for traumatized victims of political violence]. *Tijdschrift voor Psychotherapie, 27,* 24-34.
17. Van Dijk A, Schoutrop MJA (2002). Getuigenistherapie, een geprotocolleerde behandeling bij getraumatiseerde slachtoffers van georganiseerd geweld. [Testimony therapy, a protocolled treatment for traumatized victims of organized violence]. *Tijdschrift voor Directieve Therapie, 22,* 4, 399-411.
18. Weine SM (1999). *When history is a nightmare; Lives and memories of ethnic cleansing in Bosnia-Herzegovina.* New Brunswick, NJ: Rutgers University Press.
19. Kleijn WC, Hovens JEJM, Rodenburg JJ, Rijnders RJP (1998). Psychiatrische symptomen bij vluchtelingen aangemeld bij het psychiatrisch centrum De Vonk. [Psychiatric symptoms in refugees referred to the "De Vonk," psychiatric centre]. *Nederlands Tijdschrift der Geneeskunde, 142,* 1724-1728.
20. Foa EB, Riggs DS, Rothbaum B (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress, 6,* 459-473.
21. Beck AT, Erbaugy JK, Mock JE, et al. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561-671.
22. American Psychiatric Association (1995). *Diagnostic and statistical manual of mental disorders.* Washington DC: APA.
23. Foa EB, Keane TM, Friedman MJ (2000). *Effective treatments for PTSD: Practice guidelines from the International Society of Traumatic Stress Studies.* New York: The Guilford Press.
24. Pennebaker JW, Seagal JD (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology, 55,* 1243-1254.
25. Schoutrop MJA (2000). *Structured writing and processing traumatic events.* Doctoral thesis, Universiteit van Amsterdam, Amsterdam. Available from author.

26. Pennebaker JW (1993). Putting stress into words: Health, linguistics, and therapeutic implications. *Behaviour Research and Therapy, 31,* 539-548.
27. Pennebaker JW, Mayne TJ, Francis ME (1997). Linguistic predictors of adaptive bereavement. *Journal of Personality and Social Psychology, 72,* 863-871.
28. Schoutrop MJA, Lange A, Hanewald GJFP, et al. (2002). Structured writing and processing major stressful events: A controlled trial. *Psychotherapy and Psychosomatics, 71,* 151-157.
29. Holmes J (2001). *The search for the secure base. Attachment theory and psychotherapy.* Hove (G.B.): Brunner-Routledge.
30. Cassidy J, Mohr JJ (2001). Unsolvable fear, trauma, and psychopathology: Theory, research, and clinical considerations related to disorganized attachment across the life span. *Clinical Psychology: Science and Practice, 8,* 3, 275-298.
31. Imber-Black E (1989). Idiosyncratic life cycle transitions and therapeutic rituals. In B. Carter, M. McGoldrick (Ed.), *The changing family life cycle.* Needham Heights MA: Allan and Bacon.
32. Herz Brown F (1989). The impact of death and serious illness on the family life cycle. In B. Carter, M. McGoldrick (Ed.), *The changing family life cycle.* Needham Heights MA: Allan and Bacon.
33. Lange A (2000). *Gedragsverandering in gezinnen.* [Behavior changes in families]. Groningen: Wolters Noordhoff.
34. Rimé B (2001). The social sharing of emotion: Interpersonal, social and collective effects. In A.van Dijk (Ed.), *Testimony of trauma, symposium proceedings.* Oegstgeest: Centrum '45.