

Therapeutic Writing

An Exploratory Speech–Language Pathology Counseling Technique

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This exploratory qualitative study investigated the use of therapeutic writing for counseling long-term caregivers of spouses with brain injury and neurogenic communication disorders. Three participants wrote an average of six single-spaced pages of text. After analysis of the written text, the common themes of onset of diagnosis, anger, grief, and similarities in coping mechanisms were identified. Additional information about the value of therapeutic writing was obtained. Therapeutic writing appears to be a promising technique to use for counseling caregivers. On the basis of the caregiver's written text, the counseling needs related to neurogenic communication disorders can be addressed more efficiently. **Key words:** *brain injury, counseling, long-term caregivers, therapeutic writing*

DURING the early stages of rehabilitation of neurogenic communication disorders in adults, the patient and caregivers have a team of health care professionals available to them who can provide discipline-related counseling about behavior, emotion, physical function, cognition, and communication. Rao (2003) described how patients and caregivers feel initially when going through the rehabilitation and counseling process. He stated that there is a steady reduction in “energy and enthusiasm” when working with communication disorders and that, gradually, the real-

ity of “a life-long struggle against these barriers saps the soul and exasperates the psyche” (Rao, 2003, p. 18). Although counseling may reduce these discouraging outcomes, the accessibility to professionals for counseling often diminishes following discharge from rehabilitation and outpatient services. On the basis of clinical experience, this may be due to lack of insurance coverage for counseling services, inability to take time off work or out of a busy schedule for counseling sessions, lack of financial resources, and inaccessibility to community resources such as group counseling.

The American Speech-Language-Hearing Association (2007) scope of practice states that speech–language pathologists (SLPs) can provide the clinical service of counseling “regarding acceptance, adaptation, and decision making about communication . . .” (p. 7). This is especially important when counseling caregivers about the persistent deficits associated with neurogenic communication disorders. Speech–language pathologists also must recognize when counseling issues related to emotion, feelings, or mental health are outside of the scope of practice and require referrals to other health care professionals (Bradshaw & Gregory, 2014).

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Undoubtedly, whether caregivers have access to counseling services or not, all caregivers at one time or another will experience grief. Luterman (2008) stated that after any “catastrophic change” such as a brain injury, “it is the loss of the expected future that is grieved so deeply” (p. 52). Speech-language pathologists work with patients and caregivers who are grieving the loss of communication abilities. Few individuals expect that communication disorders following brain injury can have such a profound effect on the daily interactions between the patient and the caregiver. Learning to cope with these losses can be an important part of the rehabilitative process.

Both Luterman (2008) and Holland (2007) have emphasized that in-person counseling related to communication disorders requires that SLPs learn to listen carefully to patients and caregivers and to encourage self-expression of feelings and concerns. The expression of feelings and concerns related to a communication disorder can only be accomplished if the SLP, the patient, and the caregiver have a relationship built on trust (Jones, 2003). Holland (2007) reminded clinicians that counseling helps families live successfully after unexpected traumatic events that affect communication. She suggested that counseling begin early in treatment and “continue as life with a problem is lived” (Holland, 2007, p. 19). Luterman (2008) also reminded clinicians that grieving can be cyclical in nature. Thus, although the caregiver may appear to have transitioned through the grieving process, the expectation that the process of grieving is complete is often inaccurate. At this point, SLPs should “reinforce a practical approach to coping with life’s changes and stressors” (Rao, 2003, p. 17).

Often, SLPs have a limited number of therapy sessions when working with patients with neurogenic communication disorders that are reimbursed by insurance and counseling opportunities may be missed. Simmons-Mackie and Damico (2011) discussed the importance of not missing these opportunities. They reminded SLPs that counseling re-

lated to communication-based emotional issues can decrease time reserved for therapy, but the discussions can build relationships, increase “authentic communication,” and enhance problem solving (p. 348). Realistically, however, all counseling needs for the caregiver cannot be addressed adequately in the short period of time often designated for therapy.

Caregiver research in the field of sociology has discovered that the quality of the relationship with the person with brain injury, the type and intensity of caregiver tasks, self-efficacy in performing these tasks, length of time the caregiver has been in the caregiver role, and personal coping strategies can all contribute to caregiver burden (Gräbel & Adabbo, 2011; Iecovich, 2011; Savage & Bailey, 2004; Wilks, Little, Gough, & Spurlock, 2011). It is possible, even probable, that neurogenic communication disorders would influence caregiver burden. After patients and their caregivers complete rehabilitative services and return home, there can be limited interaction with the SLP; thus, long-term caregiver concerns related to neurogenic communication disorders remain uncertain.

Additional considerations for counseling for communication disorders should include an awareness of cultural background and the cultural perception of asking for help and talking about feelings, individual personality (introvert vs. extrovert), social relationships between people (e.g., different status), and the time needed to process information (Battle, 2012). For some caregivers, meeting the counseling needs through verbal interaction can be achieved; however, for others, a different mechanism may be more effective.

THERAPEUTIC WRITING

Therapeutic writing is an approach that can provide a different mechanism for counseling. Moreover, therapeutic writing may address the problems associated with a limited number of therapy sessions and with cultural and personal differences in verbally discussing emotions and concerns related to

communication disorders. Kerner and Fitzpatrick (2007) described therapeutic writing as being similar to writing a memoir or autobiography. *Journaling* is another term that is used frequently to describe written emotions and feelings (Friehe, Bloedow, & Hesse, 2003). This type of writing incorporates a personal narrative and allows one to be creative in documenting one's life experiences and story (Gullette, 2003). Different methods of writing have been used to reconstruct personal reactions to stressful situations and moderate emotional reactions to both chronic and acute stressors and crises (Kerner & Fitzpatrick, 2007). Riessman (2008) suggested that written narratives are particularly salient forms of exploring sensitive situations, such as the experiences of victims of trauma for whom words may not come easily.

Therapeutic writing has been used to counsel patients in the disciplines of psychology, nursing, and social work. Writing has been used for years in the field of psychology (Pennebaker, 1993, 1997), in which therapeutic writing may be implemented with or without psychotherapy to improve mental and physical outcomes (Esterling, L'Abate, Murray, & Pennebaker, 1999; Pennebaker, 1993, 1997). L'Abate (1991) reported that the use of therapeutic writing was found to be cost-effective. Pennebaker and Seagal (1999) found that encouraging people to write stories provided them with the opportunity to understand their experiences and learn more about themselves. The authors also stated that the use of writing enhances a sense of predictability and control over one's life (Pennebaker & Seagal, 1999). In the psychology literature, most of the therapeutic writing assignments have required a specific amount of daily writing time, such as 15-20 min a day (Pennebaker, 1993, 1997; Pennebaker & Seagal, 1999). The early research in psychology investigated the number of words written and analyzed the written text for emotional words (Pennebaker, 1997; Pennebaker & Seagal, 1999). Although Pennebaker (n.d.) continues to recommend a specific amount of time for daily writing, he also recommends al-

lowing the writer greater freedom and overall time to formulate narratives about broad topics related to the individual (<http://homepage.psy.utexas.edu>).

Nursing researchers have reported on the therapeutic narrative, but their approach is usually oral as opposed to written (e.g., Johnson, Cook, Giacomini, & Willms, 2000; Smith, Zahourek, Hines, Engebretson, & Wardell, 2013). One exception to this was described by Furnes and Dysvik (2012), who explored the impact of therapeutic writing among participants in a chronic pain management program as part of an effort to identify nonpharmaceutical approaches to complaints of chronic pain. Therapeutic writing in this study enhanced participants' self-reflection and insights into their experiences with pain, allowing most, although not all, to discover that writing had been "valuable and liberating" (Furnes & Dysvik, 2012, p. 3377). As Gale, Mitchell, Garand, and Wesner (2003) argued, clients' narratives are valuable "as a therapeutic tool to guide clinical practice" (p. 82) and to enhance nurses' application of a theoretical approach to care.

The field of social work uses written narrative to gather information to explicate needs for social change (Riessman & Quinney, 2005) and for clients to make sense of their experiences, which is especially important in transition stories (Martin, 1998). Martin (1998) experimented with "direct scribing," a method of capturing narratives by transcribing them *verbatim* as participants recounted their stories (p. 1). This gave participants an opportunity to edit their stories both as they were written and at the completion of the interviews. Asking participants to explain what their stories meant further empowered them. Martin argued that this writing method "amplified muted voices for social change" (p. 1). As she explained, because "anybody could write with the help of direct scribing, writing became increasingly accepted as a method for doing therapeutic work" (p. 2).

In the field of communication disorders, Friehe et al. (2003) suggested that SLPs recommend that clients use therapeutic writing

or “journaling to record feelings and events to create a platform for discussion” and “to learn more” about their counseling needs, “especially if circumstances limit family involvement” (p. 217). For caregivers, therapeutic writing may be essential to self-exploration and the ability to cope with caregiver stress related to communication disorders. The process of therapeutic writing achieves what more restrictive interview questions cannot. That is, they “open up topics and allow respondents to construct answers in ways they find meaningful” (Riessman, 2008, p. 25). Although the use of therapeutic writing is well documented for counseling in other disciplines, its use has not been studied thoroughly in the field of speech–language pathology.

Simmons-Mackie and Damico (2003) supported the use of qualitative analyses for “descriptive and naturalistic forms of assessment that enable us to collect data in authentic contexts” (p. 146). Clinical researchers should select the “methods and discovery procedures that best fit the phenomena under investigation” (p. 149). In keeping with this view, the aims of this article are to explore the following two questions: How does therapeutic writing assist the well-being of long-term caregivers whose spouses have brain injury?, How do the caregivers cope with these challenges? Given the importance of communication in caregiving, we hoped to discern meanings and themes in the caregivers’ written accounts.

METHODS

Qualitative methods are particularly suitable for exploratory research examining meaning, emotion, and individuals’ experiences. Within the range of qualitative methods and methodologies (Denzin & Lincoln, 2011) that have proliferated in recent decades, the current study focused on the use of thematic narrative analysis as described by Riessman (2008). We were interested in the subjectivities of the individual case studies and the themes across cases that were subsequently analyzed in the participants’ written accounts.

This approach differed from grounded theory (Charmaz, 2005; Glaser & Strauss, 1967) because the integrity of the individual’s story was respected and the researchers did not concentrate on the themes alone (Reissmann, 2008). Also, in contrast to most grounded theory approaches, procedures, and processes (Corbin & Strauss, 1990), a priori concepts were brought from each author’s discipline: sociology and social work, public health, and speech–language pathology. All members of the team agreed that the needs of long-term caregivers of brain-injured spouses had not been sufficiently studied and required an open-ended approach. We also were aware of the various etiologies of brain injuries, with origins as diverse as sports injuries, war trauma, accidents, and cerebrovascular accidents, all of which required the support of caregivers during rehabilitation. We determined that if this exploratory study could begin to outline some of what the spouses of adults recovering from brain injury go through, perhaps more could be done to support all caregivers.

Participants

A referral sampling method was used to identify participants. Inclusionary criteria for participation in this exploratory study were (a) being the primary caregiver to a spouse or significant other with a diagnosis of brain injury, (b) speaking and writing in English as the person’s primary language, and (c) being in the relationship at least 5 years postdiagnosis of brain injury in one’s significant other.

On the basis of these criteria, three female caregivers participated in the study. The participants were between 61 and 63 years of age ($M = 62$ years) at the time they completed the therapeutic writing. The mean age of the participants at the time their spouses were diagnosed with a brain injury was 54 years (51–59 years). The participants individually identified their ethnicity as being Hispanic, Asian, and White. The mean number of years of marriage prior to the diagnosis of brain injury was 15 years. See Table 1 for caregiver demographic information. Prior to diagnosis,

two of the spouses with brain injury had full-time professional employment and one was retired. At the time of this study, two of the spouses had returned to their prior employment status, although one of these had modified hours at work and required the assistance of another employee. All of the caregiver participants were employed full-time and remained married to their spouses. The researchers verified that all participants were willing and able to compose written accounts of their stories.

Data collection

The study was approved by the Northern Arizona University institutional review board. Consent forms were mailed and obtained from the caregiver participants before beginning the study. After consenting to participate, each of the participants was contacted via e-mail and received written instructions about therapeutic writing. Because this was an exploratory study, the researchers provided minimal instructions. The participants were asked to provide the following:

Please write about how brain injury has affected your life and describe some of the coping strategies that you have used. You can compose your story using hand-written text or writing on a computer. Spelling and grammar are not the focus of this research study. We are more interested in your experiences related to brain injury.

The term, *therapeutic writing*, was not used in the instructions to avoid biasing the participants' reactions to the narrative process, and no incentives were provided to them. In addition, all participants knew their

writing was going to be analyzed for possible publication.

The researchers employed an *unstructured* qualitative format, best used to explore the topic without imposing the researchers' own views (Rubin & Rubin, 1995). Esterling et al. (1999) referred to this type of writing as "open-ended" in which the author of the text can write "whatever comes to mind" (p. 80). Pennebaker (2010) recommended "broad topics" for writing to encourage individuals to "write about what is bothering them rather than what you [the professional] think is bothering them" (p. 24). Therefore, no explicit questions were asked because the researchers did not want to constrain the participants' ideas. Participants were not limited to a specific number of pages of written text, what specific areas to target, or what topics they could or could not address. The only exception was the request for the participants' coping strategies. This type of writing is referred to as "focused and guided" (Esterling et al., 1999, p. 80). The open, unstructured format allowed the participants to use the written narrative as a therapeutic tool; it also provided the researchers with data from which to gather a broad array of experiences and identify common themes.

Participants were given 3 months to complete the therapeutic writing task. Because all of the caregiver participants had full-time jobs and provided care at home to their spouses with brain injury, the researchers wanted to be sensitive to the writers' needs and allow them ample time to tell their stories. This time allotment is also supported by Pennebaker (1997) and Smyth (1998), who suggested that

Table 1. Caregiver demographics

Participant	Age	Years Married Before Injury	Ethnicity	Diagnosis of Spouse
1	62 years	19	Hispanic	TBI
2	63 years	17	Asian	TBI
3	60 years	9	White	ABI

Note. ABI = acquired brain injury; TBI = traumatic brain injury.

writing over longer periods of time might be more effective than writing assignments for shorter periods of time.

After receiving the written text from the participants, all of them were contacted by e-mail again at the end of the study to obtain clarification of the written text and to ask them how they felt about the process of therapeutic writing. A *semi-structured* approach was used for follow-up clarification questions (Rubin & Rubin, 1995). This approach elicited more specific information for the researchers to analyze at the end of the study. Participants received a final e-mail within a week of obtaining their responses from the researchers to thank them for their participation in the study.

Data analysis

This qualitative exploratory study implemented thematic analyses of the therapeutic written text. Two researchers independently reviewed the written text at the end of the study for common themes. Next, they compared the themes identified to ensure that they were present in all of the participants' written text. The themes were further analyzed by the SLP researcher to determine relevance to counseling of caregivers of spouses with neurogenic communication disorders.

RESULTS

The caregiver participants wrote five to eight pages ($M = 6$) of single-spaced, typed text. Independent thematic analyses by two of the researchers revealed that all of the therapeutic writing samples discussed the following: the onset of diagnosis, unpredictable anger as a symptom of brain injury, chronic grief, and coping mechanisms. The similar themes are presented with support from selected portions of the written samples.

Onset of diagnosis

For all of the caregiver participants, the diagnosis of brain injury was an important story to share in therapeutic writing. In each case, this reflected a life-changing loss. The

diagnoses supported the context for the later themes of unpredictable anger as a symptom of brain injury and chronic grief. In the cases of traumatic brain injury (TBI), the delineation of when their spouses' lives changed occurred immediately.

The telephone rang; it was a policeman. He said something like, "Your husband has been injured and has been taken to the hospital." I grabbed the car keys. I remember thinking that I had to hurry as if willing my body to get me there more quickly. I cried and prayed all the way." (Participant 1)

It all happened so suddenly. A phone call. Sit down, [my friend] said, "Your husband's been in an accident and is on his way to the emergency room." The driver of a pick-up truck hit him so hard that he flew backward over the truck, leaving his shoes behind. It was a "hit and run." (Participant 2)

The participant who learned of her spouse's acquired brain injury (ABI), however, had noted changes in communication for some time before obtaining the diagnosis.

He was confusing words: ladders became steps, table became chair. He was frustrated. We sat down and reviewed all the situations over the past month. Yes, there was a change. After months of multiple tests, Carl¹ emerged with a diagnosis of multiple strokes, and no cure. (Participant 3)

Although all of the caregiver participants received a diagnosis, this did not prepare them for the long-term changes associated with cognition and/or communication. Participant 3 mentioned in her therapeutic writing that the health care professionals that she encountered appeared to be more "health uncaring professionals" who did not consider the emotions or physical fatigue associated with being the caregiver after receiving the initial diagnosis.

Participant 2 also reported that health care professionals were not listening to her concerns about her spouse.

According to the doctors, there was "nothing wrong" because he scored "well" on the tests. They

¹This is a pseudonym.

did NOT know what he was complaining about. Maybe they were scoring the wrong things. (Participant 2)

Unpredictable anger as a symptom of brain injury

All of the caregiver participants wrote about how their spouses periodically demonstrated unpredictable anger. Many of the examples that were presented were related to deficits in cognition and/or communication. For instance, for the patients who had TBI, the deficits in sustained attention, working memory, organization, problem solving, judgment, and executive functions such as inhibition and lack of insight seemed to trigger the anger.

At times I do think that he is very aware of his lack of clear thinking, and I think that contributes to his anger. His fuse is very short. However, his behavior is sometimes so unreasonable that I could scream! He has always been judgmental but is becoming worse. (Participant 1)

He was frustrated because he could not keep a thought together. He talked, and talked, and talked. He grumbled about not being able to remember things. He was lucky to be alive. Where was his gratefulness? He was angry all the time. He blamed us for all that was wrong. (Participant 2)

For the patient with ABI, the caregiver described problems with anomia and auditory comprehension that seemed to be associated with the unexpected anger. For this individual, the participant described gradual changes in cognitive abilities that may have contributed to the miscommunications and related frustrations.

“You’re wrong! It’s this way . . .” I’m sure that he truly believes what he’s saying, but I sometimes wonder if he is also reassuring himself that he remembers correctly. As he is losing control of his abilities, he is not getting it right all the time. As he is losing control, he is lashing out at everyone else (not just me) who doesn’t get it right. (Participant 3)

Chronic grief

Another common theme among the caregiver participants was the constant remembrance of how the spouse was before the in-

jury. All three participants described a deep sadness that was chronically present in their lives. The participants wrote about grieving for what had been lost.

I did not physically lose my husband, but he is not the person that I fell in love with or the man that I married. At times I see some of his real personality, but most of the time it is not there. I am still in daily grief because every day I realize all over again that he is limited in most daily activities. Grief is a constant. (Participant 1)

What do you say when the love of your life says hurtful things and doesn’t remember two minutes later why he said what he said? It is angry one minute and loving the next. How does one prepare for this? (Participant 2)

The man who stands before me has a beautiful heart. He is my soul partner, and the kindest spirit I have ever known. Another stands before me, too—one who is slowly losing parts of himself. I want the first one back. He wants the first one back too. But it cannot be. (Participant 3)

Coping

The caregiver participants in this study have lived with a spouse with chronic brain injury for many years. Although they have faced numerous challenges, they reported being committed to their relationships. Our rationale for recruiting caregivers whose spouses were at least 5 years post-brain injury was that these caregivers must have developed some helpful coping strategies that might be useful for other caregivers of family members diagnosed more recently with brain injury.

The first common theme identified for coping was the use of physical exercise to relieve stress. These caregiver participants were the primary communication partners and providers of care for the majority of the time; yet, they viewed making time for themselves as extremely important.

Exercise is a powerful way of physically relieving the constant stress. I would begin the exercise class with clenched hands and as the session progressed, I would make a conscious effort to open them. It was a long time before I could exercise without having to think about keeping my hands open. (Participant 1)

I joined a gym and hired a drop-dead gorgeous personal trainer. It was great! I took up boxing. I learned the look of mental toughness; the “give me all you got and I will take it and if I choose to, I will give back to you whatever you give me” look. (Participant 2)

For me, dancing is the best coping strategy—a physical workout and an emotional release in one. I close my eyes, and I just go where my feet take me. Dancing re-energizes me. It helps me be there for Carl when I need to be. (Participant 3)

The next common theme was the use of humor when communicating with family members and friends. Laughter relieves the stress of everyday difficulties. Participant 3 stated, “When you can, if you can, laugh.” All of the caregiver participants identified times when laughing with friends or family assisted them in overcoming anger, hurt feelings, and sadness. Two of the participants also identified laughing and joking with their spouses with brain injury even during challenging situations.

Finally, all three participants were deeply committed to sharing their stories with other caregivers who might feel isolated in their grief or incapable of coping in the situation of living with a family member with brain injury. Therapeutic writing allowed the participants to reflect personally on the changes that occurred so far in their lives.

Writing my story made it clear to me that some of the initial pain and horror had subsided but re-reading it still made me cry. (Participant 1)

Writing made me feel better in a sense that I felt relieved. I am, finally, after a dozen years, not defining my memories by “after the accident,” or “since the accident.” (Participant 2)

I don’t think I would have realized how far I have come without writing it all down this way. Writing has helped me find my center—in my relationship and in myself. And being a part of this writing project makes me feel as if I am helping others. (Participant 3)

Two themes that were identified by the independent reviewers but not mentioned in all of the participants’ written accounts were religion and family. Religious faith and a con-

nection to church friends during the recovery process were important for Participant 1 to share. Although Participants 2 and 3 also described information related to spirituality, it was not specific to religion. Participants 1 and 2 also described family interactions in their therapeutic writing. Interactions between the parent with brain injury and his children often were described as being negative and involving confusion, yelling, and anger among all family members.

DISCUSSION

Speech-language pathologists build relationships with patients and family caregivers while providing therapy. These relationships often have lasting effects, and when the patient’s needs require modifications related to changes in employment, communication expectations, or return to school, SLPs may be contacted for maintenance and/or reevaluation of patients’ skills (Sohlberg & Turkstra, 2011). Because of realistic time constraints and limited insurance coverage when providing therapy for neurogenic communication disorders, SLPs may not be able to dedicate entire sessions strictly to counseling, particularly with caregivers. Thus, during the sessions for maintenance and/or reevaluation, therapeutic writing can be a practical and valuable tool to address the counseling needs of caregivers of patients with brain injury.

Therapeutic writing offers caregivers a unique way to tell their stories and helps SLPs understand the essential issues so that they can focus counseling and therapeutic efforts on specific areas related to cognition and/or communication deficits that are revealed through the stories. This can be accomplished by the caregiver writing a memoir or autobiography (Kerner & Fitzpatrick, 2007), by personal narrative (Riessman, 2008), or through journaling (Friehe et al., 2003). Holland (2007) and Luteran (2008) reported that caregivers may continue to have changes in their counseling needs related to neurogenic disorders. This study identified themes that were relevant to speech-language pathology

and the long-term counseling needs and factors related to caregiver resiliency. Given the participants' enthusiasm about sharing their stories, therapeutic writing may prove to be a beneficial counseling tool.

Implications drawn from the common themes

On the basis of the common themes identified in this exploratory therapeutic writing study, some clinical considerations are provided. Caregivers can be in shock after receiving the initial diagnosis, but early counseling about the brain injury and possible changes to expect in cognition and/or communication can be extremely valuable. From past clinical experience and caregiver report, caregivers often do not hear what is being said to them in the initial stages of recovery. At that point, they have multiple concerns, such as health of the family member, cost of care, acute recovery and setbacks, and meeting multiple health care professionals. Therapeutic writing can inform the clinician about caregiver concerns so the clinician can begin to prepare the caregiver for future communication expectations. Continued sharing through therapeutic writing can lead to an open dialogue between the caregiver and the SLP throughout the patient's care. Such communication is imperative so that questions and information related to neurogenic disorders can be reviewed or discussed further.

Unpredictable anger as a symptom of brain injury

Speech-language pathologists who work with neurogenic communication disorders are familiar with the challenges related to changes in cognition and/or communication following brain injury. They assume that caregivers understand how these changes will influence the interactions with their spouses, but knowledge of deficits does not guarantee that feelings related to symptoms of brain injury will diminish over time. Unpredictable anger, a symptom related to brain injury, would be an important area for the SLP to address in counseling. Counseling about the

anger, how it is related to the brain injury, and the residual problems associated with cognition and/or communication would need to be reviewed and discussed with the caregiver.

Caregivers need frequent reminders from the SLP that recurrent angry statements directed at them should not be taken personally but should be attributed to the brain injury. Often, it is assumed that education about the brain injury and residual behaviors associated with cognitive and/or communication problems is completed by an SLP in the early stages of rehabilitation. These assumptions may prove to be incorrect, and when counseling opportunities arise, the current SLP can provide the much-needed education.

Chronic grief

In terms of grieving, SLPs can provide counseling to the caregivers about the lifelong changes associated with neurogenic communication disorders. The most challenging aspect of caregivers' grieving is its cyclical and chronic nature. Even though the brain injury diagnoses occurred more than 10 years prior to the therapeutic writing, all caregiver participants were still vulnerable to feelings of chronic grief as their new norm. Therapy recommendations can be provided to the patient with brain injury to modify cognitive and/or communication abilities. This may lessen or change the impact of grieving on the caregiver. However, if the SLP becomes concerned about the extent and length of grieving and possible depression, other health care referrals must be made.

In the therapeutic writing, there was evidence of the caregivers' acceptance of the spouses' residual cognitive and/or communication deficits; however, all of the participants continued to experience their spouses' anger and their personal grief. Although many health care professionals learn about the linear stages of grief presented by Kübler-Ross (1969), Luterman (2008) reminded SLPs that even though the caregiver may appear to accept the cognitive and/or communication changes associated with brain injury, the act of grieving "has fluid

boundaries and is cyclical in nature rather than linear” (p. 49). Speech–language pathologists may find it useful to encourage caregivers to practice therapeutic writing several times during the course of therapy. As the caregiver practices therapeutic writing and reviews the written text with the SLP, this process should build further confidence and trust in the counseling relationship.

Limitations, strengths, and need for further research

Several limitations are evident in this exploratory study. First, the number of case studies was small ($N = 3$). However, the researchers intentionally selected a few case studies to analyze for emergence of common themes in the therapeutic writing of long-term caregivers that may be especially relevant to SLPs. The large amount of written text from the case studies was not only surprising but also provided adequate text from which to gather multiple, recurrent themes. However, it is uncertain if the themes identified in the current study related to the initial diagnosis, unpredictable anger as a symptom of brain injury, chronic grief, religion, family dynamics, and coping mechanisms of physical exercise and humor would remain constant if a larger number of therapeutic written samples were analyzed. It is also unknown if the same themes would have been identified if the writing had taken place at different time periods in the caregivers’ adaptation to the recovery process. Finally, a study with a larger sample of participants could include a follow-up focus group for caregivers to share the benefits and problems of using therapeutic writing.

Second, no formal follow-up session was completed with the participants to obtain information on the prolonged effects of therapeutic writing. Rather, this exploratory study was conducted to determine if any common themes existed in the written text of long-term caregivers that SLPs could use to enhance the counseling experience. Also, although no pre- and post-outcome measures were used to assess the value of therapeutic writing, the caregiver participants provided

positive written comments as presented in the results.

Third, the participants in the current study self-identified their ethnic backgrounds, which were all different. Yet, because of the limited sample size, any ethnic differences related to caregiving could not be evaluated. Although some research has identified racial differences in perceived burden (e.g., Brown & Keith, 2003; Coon et al., 2004; Wallagen & Yamamoto-Mitani, 2006), other studies have shown no significant differences in caregiver experiences (Sun, Kosberg, Kaufman, & Leeper, 2010; Sun, Kosberg, Leeper, Kaufman, & Burgio, 2010). Future research is needed in this area to ensure SLPs’ cultural competence in the process of counseling caregivers from diverse backgrounds through the language of written text.

Finally, the findings from this study cannot be generalized to all long-term caregivers. The participants in the present study were females, 60+ years of age, all with full-time employment, and in long-term relationships with spouses with traumatic or acquired brain injuries. It is possible that different themes in the therapeutic writing would have emerged if the participants were younger, male, beginning their careers, or unemployed. In addition, it is unknown if different themes would have been identified in the therapeutic writing of caregivers of spouses with brain injury in relationships of less than 5 years.

In this exploratory study, all participants reported that therapeutic writing was a valuable exercise. The act of writing was cathartic even for the participants who did not believe that they could write. The commitment to sharing stories of resilience was important because caregivers have counseling needs related to neurogenic disorders for an extended period of time (Holland, 2007; Luterman, 2008).

Although the caregivers acknowledged that their situations were ongoing and not unique, they also indicated that they were the only ones who could write their stories. This finding reiterates the need for SLPs to offer a technique such as therapeutic writing in which caregivers whom they counsel have control

over the stories that they narrate. As Frank (1997) described the narrative for the person with an illness, "Stories have to repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going" (p. 53). So, too, a caregiver's narrative helps the SLP guide the caregiver toward personal empowerment and a redefinition of self in his or her new role with the spouse with brain injury.

As this small study suggests, therapeutic writing has a role to play in counseling caregivers. For SLPs, therapeutic writing informs the clinician as to which areas should be of primary focus during counseling, making the counseling session more efficient and effective. Other health and social service providers may enhance the quality of life for caregivers of spouses with brain injury by incorporating more therapeutic writing into their intervention strategies for this population as well.

Another strength of this study was the age of the participants and the length of their relationships. The long-term caregivers had enough time postdiagnosis to reflect on the nature of cyclical grieving in their writing. The coping methods and the narratives of resiliency of the relationships among the participants can provide ideas and directions when counseling caregivers of recently diagnosed spouses with neurogenic communication disorders. Through narratives, caregivers may be invited to explore "what they wish to *become* in this experience" (Frank, 1997, p. 159).

Future studies related to therapeutic writing and speech-language pathology are needed and should seek to overcome the lim-

itations of the current exploratory study. The participants in the current study were given 3 months to compose their stories; additional studies will be needed to determine how time constraints affect therapeutic writing for caregivers in more acute phases of recovery and during rehabilitation. These studies could also consider varying the degree of openness in the therapeutic writing and/or provide suggestions for topics for caregivers who are less comfortable with writing. Interactive and responsive journaling techniques also could be explored in which the SLP or other professional offers comments related to concerns raised by the caregiver. Finally, being cognizant of the demands in the lives of full-time working professionals who are simultaneously providing caregiving is vital.

Conclusion

There is much in the speech-language pathology literature about suggestions and techniques to use for verbally counseling patients and caregivers in the acute, rehabilitation, and outpatient stages of recovery (Andrews, 2004; Friehe et al., 2003; Holland, 2007; Luterman, 2008). However, additional research is needed in the area of counseling long-term caregivers of patients with neurogenic disorders. The results from this preliminary qualitative study suggest that therapeutic writing is a promising means of supporting coping strategies. This tool for counseling may be especially valuable if there are time restrictions on therapy and if caregivers do not feel comfortable verbalizing their thoughts and feelings in therapy sessions.

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