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Narrating Trauma and Re-establishing Self-Coherence: A Conceptual Review of Autobiographical Memory, Narrative Coherence, and Psychotherapy

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ABSTRACT

Traumatic memories are often described as fragmented, sensory, cue-dependent, or difficult to place within an autobiographical context. Such descriptions have encouraged the view that narrating trauma restores self-coherence by converting poorly integrated experience into a coherent autobiographical memory. This theoretical/conceptual review evaluates that proposition across developmental narrative research, autobiographical memory theory, contemporary posttraumatic stress disorder (PTSD) models, linguistic research, and psychotherapy. The review argues that trauma-related memories may be disorganized or weakly contextualized, but they are not invariably non-narrative or impossible to integrate. Narrative coherence is therefore best treated as a multidimensional feature of autobiographical representation rather than a direct index of psychological integration or clinical recovery. Orientation, referential sequencing, evaluation, temporal organization, and narrative density can provide useful descriptive information, but their clinical meaning depends on task, language, culture, arousal, and treatment context. Recent evidence supports associations between some forms of narrative disorganization and PTSD while also showing substantial heterogeneity across studies and measurement methods. Clinically, narrativization is central in some interventions, such as narrative exposure approaches, but is only one pathway among cognitive, exposure-based, relational, embodied, and non-verbal processes used across trauma therapies. A research agenda is proposed that separates narrative form from symptom change, tests within-person mechanisms longitudinally, and combines linguistic analysis with clinical, cognitive, cultural, and embodied measures.

Keywords: Autobiographical Memory, Autobiographical Narrative, Trauma Memory, Narrative Coherence, Self-Coherence, Posttraumatic Stress Disorder, Psychotherapy, Linguistic Analysis.

Introduction

The psychological aftermath of trauma raises a deceptively simple question: what does it mean for a distressing experience to become part of a person's autobiographical past? Classical trauma theories often answered by contrasting fragmented, sensory, and involuntary trauma memories with coherent, contextualized, and voluntarily retrievable autobiographical memories. In parallel, developmental and narrative traditions emphasized that people learn to organize experience through socially shared stories. These traditions converge on an intuitively compelling proposition: narrating traumatic experience may help reconnect an event with temporal context, personal meaning, and a continuing sense of self. Yet the proposition becomes problematic when narrative coherence is treated as either necessary or sufficient for recovery.

The present article is a theoretical/conceptual review focused primarily on the intersection of autobiographical memory, trauma-related psychopathology, narrative coherence, linguistic analysis, and psychotherapy. Developmental research is considered because it explains how autobiographical narration is socially scaffolded, but the article is not a developmental review. Similarly, linguistic categories are used to clarify how narrative organization can be described; they are not proposed as stand-alone diagnostic tests. The central clinical question is narrower: under what conditions does the organization of traumatic experience in language provide meaningful information about autobiographical integration, and what role can narrativization plausibly play in psychotherapy?

A useful starting point is to distinguish the event from its later representation. Experiencing trauma does not generate one uniform type of memory. Posttraumatic stress disorder (PTSD), acute stress disorder (ASD), dissociative symptoms, intrusive recollection, autobiographical-memory disturbance, and ordinary distress after adversity overlap but are not interchangeable constructs. Contemporary diagnostic frameworks define PTSD and ASD by symptom patterns and duration rather than by a required form of trauma narrative (American Psychiatric Association, 2022). Accordingly, a fragmented account may occur without PTSD, and a person with clinically significant PTSD may still give a globally coherent account of what happened.

Theoretical models nevertheless provide reasons to expect relationships between memory organization and posttraumatic symptoms. The dual-representation model proposed partially distinct forms of trauma representation (Brewin et al., 1996), whereas cognitive accounts emphasized inadequate contextualization, problematic appraisals, and memory processes that maintain a sense of current threat (Ehlers & Clark, 2000). More recent reviews preserve the value of these questions while emphasizing heterogeneity in voluntary memories, involuntary memories, and flashbacks and warning against a single, categorical account of traumatic memory (Brewin, 2025).

The literature on trauma-memory coherence has itself become an empirical controversy. Findings from exposure-treatment studies suggested that reductions in disorganization can accompany symptom improvement (Foa et al., 1995); however, later work questioned whether incoherence is a general property of trauma memory (Rubin, 2011; Rubin et al., 2016). A meta-analytic debate has further shown that conclusions depend strongly on how coherence and disorganization are operationalized: global organization, local disorganization, coding method, and comparison condition are not equivalent (Taylor et al., 2022; Brewin & Field, 2024). This mixed evidence makes a revised conceptual framework necessary.

The argument developed here is therefore deliberately qualified. Narrativization can support autobiographical contextualization, reflective distance, communicability, and meaning-making, but linguistic coherence is not identical to self-coherence, memory integration, or recovery. Trauma can also be processed through affect regulation, corrective learning, cognitive reappraisal, embodied regulation, interpersonal experience, and other mechanisms that do not require a polished narrative. Foundational work remains relevant because it identifies enduring constructs—episodic memory, autobiographical narrative, social co-construction, and emotional processing—but contemporary evidence is

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used to delimit rather than merely repeat those historical claims.

Conceptual Framework: Memory, Narrative, Self-Coherence, and Recovery

Autobiographical memory refers broadly to memory for personally experienced events and knowledge that contribute to a sense of personal continuity. It draws on episodic recollection, semantic self-knowledge, and executive processes rather than constituting a single isolated store. Tulving's distinction between episodic and semantic memory remains foundational, especially the idea that episodic remembering includes a form of self-referential awareness (Tulving, 1985). The self-memory system later emphasized that autobiographical remembering is constructed through interactions between autobiographical knowledge and current goals (Conway & Pleydell-Pearce, 2000). These frameworks are useful without requiring the assumption that traumatic material is stored in one qualitatively separate system.

Autobiographical narrative is the communicative representation of personal experience in discourse. It selects events, orders them, marks relations among them, and conveys why they matter. Narrative identity theories extend this idea from single memories to broader life stories through which people construct continuity and meaning (McAdams, 2001). The fact that identity can be narrated, however, does not mean that identity exists only in narrative form. Bodily states, relational expectations, affective patterns, habits, cultural meanings, and non-verbal forms of memory also participate in the continuity of self.

Narrative coherence describes properties of the account rather than the person as a whole. Coherence may refer to temporal order, contextual orientation, causal connections, thematic consistency, or the listener's ability to follow the story. The multidimensional approach developed in lifespan narrative research is particularly useful because it discourages a single global judgment of whether a story is simply coherent or incoherent (Reese et al., 2011). A narrative can be temporally clear but emotionally detached, richly detailed but poorly contextualized, or thematically meaningful while containing local disruptions.

Self-coherence is used here to denote a broader subjective and psychological sense that one's experiences, values, emotions, and autobiographical past can be understood as belonging to a sufficiently continuous self. It is not directly observable in grammar. Narrative organization may contribute to self-coherence, but a coherent story may also reflect rehearsal, social convention, emotional distancing, intellectualization, or a strong storytelling style. Consistent with this caution, studies outside trauma have not supported the use of narrative coherence as a simple proxy for overall personality functioning or psychological health (Dimitrova & Simms, 2022), and clinical research has likewise failed to show a simple one-to-one association between autobiographical narrative coherence and emotional-disorder severity (Vanderveren et al., 2020).

Clinical recovery is broader still. In PTSD, improvement can involve reductions in re-experiencing, avoidance, negative alterations in cognition and mood, and hyperarousal; greater functioning; restored flexibility; and improved quality of life. None of these outcomes requires a particular narrative form by definition. The conceptual model in this article therefore treats narrative coherence as a possible correlate, process indicator, or treatment target in some contexts—not as a universal mechanism or criterion of recovery. Table 1 summarizes the memory and narrative constructs used throughout the review.

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Table 1.

Working distinctions among memory and narrative constructs relevant to trauma

Construct	Working definition	Relevance to trauma	Interpretive caution
Episodic memory	Recollection of specific events with temporal-spatial context and a sense of personal re-experiencing.	May support contextualized recall of a traumatic event and its relation to past versus present.	Episodic qualities vary continuously; trauma does not imply absence of episodic representation.
Semantic/autobiographical knowledge	General knowledge about the self, periods of life, people, places, and recurring experiences.	Can provide the broader framework into which an event is interpreted and located.	Meaning can be maladaptive as well as adaptive; semanticization is not automatically recovery.
Perceptual/procedural representation	Perceptual, motor, physiological, and habitual learning that may occur with limited verbal access.	Helps explain why cues, bodily reactions, or action tendencies can persist after trauma.	It is too strong to claim that severe trauma is necessarily stored only or primarily in a procedural/sensorimotor system.
Autobiographical narrative	A socially and linguistically organized account of personal experience.	Can contextualize events, communicate meaning, and support reflective reappraisal.	Narrative form is influenced by culture, language, audience, rehearsal, and task demands.
Narrative coherence	Temporal, contextual, causal, and thematic organization of an account.	May covary with some aspects of trauma processing and PTSD in some studies.	Not equivalent to self-coherence, memory accuracy, or clinical recovery.
Self-coherence	A broader sense of continuity, intelligibility, and ownership across experience and time.	Can be challenged by trauma and rebuilt through multiple psychological and relational pathways.	Cannot be inferred from linguistic coherence alone.

Developmental Origins of Autobiographical Narration

The developmental literature is relevant because autobiographical narration is learned in interaction. Children do not simply retrieve fully formed life stories from memory; caregivers help them select events, supply temporal and contextual information, label emotions, and explain causal relations. Early research on mother-child reminiscing showed substantial variation in how adults scaffold conversations about the past (Fivush & Fromhoff, 1988). Later theoretical work described autobiographical memory as emerging at the intersection of cognitive development, language, culture, and social interaction (Nelson, 1993; Fivush et al., 2011).

A frequently discussed distinction is between relatively elaborative reminiscing, in which caregivers ask open questions and add contextual or emotional detail, and less elaborative or repetitive styles. Elaborative interaction is associated with richer later autobiographical accounts and emotional language (Fivush, 1991). This finding is important for the present argument because orientation, reference, and evaluation are not merely formal devices learned in school; they are practiced in social exchanges in which memories are made relevant to another person.

The developmental evidence should not, however, be converted into a deterministic pathway from early caregiver style to adult trauma narrativization. Adult autobiographical memory is shaped by later language development, education, culture, attachment experiences, emotion regulation, repeated rehearsal, social support, psychopathology, and the nature of the traumatic event. Cultural conventions also determine what counts as an appropriately detailed, emotionally expressive, or self-focused account. Thus, developmental dialogue provides one foundation for narrative competence rather than a fixed template that predicts whether a later trauma will be integrated.

This qualification also changes the interpretation of psychotherapy. The therapist-patient dialogue may recreate some functions of collaborative remembering—clarification, temporal placement, emotional labeling, and meaning-making—but therapy is not a simple repetition of parent-child co-construction. Adults bring mature cognitive capacities, established self-schemas, cultural narratives, defensive strategies, and multiple memory systems to the

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encounter. The developmental analogy is therefore heuristically useful but clinically incomplete.

Narrative Organization and Its Clinical Interpretation

Narratives are conventionally organized enough for a listener to understand who was involved, what happened, where and when it occurred, and why the event matters. Classical narrative analysis described recurrent structures through which speakers establish setting, action, consequence, and evaluation (Labov & Waletzky, 1967). Work on autobiographical remembering likewise emphasized that narrative constraints shape the communicability of remembered experience (Barclay, 1996). These traditions are most useful clinically when their categories are treated as descriptive dimensions rather than as rules for a 'successful' or psychologically healthy story.

Temporal organization concerns relations among events, including sequence, duration, and shifts between the remembered event and the present act of remembering. Temporal markers can help a speaker place an event in the past and differentiate 'then' from 'now.' Causal and conditional language can indicate efforts to connect actions and consequences. Yet a highly ordered chronology can coexist with persistent fear or avoidance, and temporary temporal disruption can be understandable during high emotional arousal. The clinical question is therefore not whether the story is perfectly linear, but whether changes in temporal contextualization accompany changes in symptoms, appraisals, or functioning.

Orientation, reference, and evaluation describe complementary functions. Orientation establishes relevant context—who, where, when, and under what circumstances. Referential content identifies the events and actions that constitute the account. Evaluation communicates emotional significance, interpretation, and why the story is worth telling. Evaluation is especially relevant to self-related meaning because it links remembered events to beliefs, emotions, and current identity. Nonetheless, evaluative richness is not intrinsically adaptive: repeated catastrophic interpretations may increase narrative elaboration while maintaining PTSD.

Narrative density requires similar caution. In the older formulation, density refers to the relative amount of propositional information. Too little information may make an account difficult to follow, whereas excessive detail may obscure the central event. Clinically, neither high nor low density should be interpreted in isolation. Sparse narratives may reflect avoidance, memory limitations, cultural norms, or a concise communication style; dense narratives may reflect vivid recollection, rumination, repeated rehearsal, or the demands of an interview. Density is therefore a contextual descriptor, not a severity score.

For trauma research, these distinctions suggest three possible roles for linguistic variables. First, they can be descriptive categories that characterize how a person recounts an event. Second, they can function as candidate clinical markers if they reliably covary with symptoms or change during treatment. Third, they can be proposed as mechanisms only when evidence shows that change in the linguistic process temporally precedes and statistically explains clinical improvement. Most existing studies support the first role, some support the second, and substantially fewer establish the third. Table 2 presents these dimensions and their appropriate clinical interpretation.

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Table 2.

Narrative organization dimensions and clinically cautious interpretation

Dimension	Linguistic function	Potential clinical question	Caution
Temporal/contextual organization	Locates events in time and place; differentiates past event from present narration.	Does improved contextualization accompany reduced present-tense threat or intrusion?	Linear chronology is neither necessary nor sufficient for recovery.
Orientation	Establishes who, where, when, and relevant background.	Can the speaker locate the event within a broader autobiographical context?	Amount of orientation depends on audience, culture, and task.
Referential function	Specifies actions, events, actors, and sequence.	Are central event relations understandable without excessive gaps or repetition?	Detail can increase through rehearsal without psychological integration.
Evaluation	Expresses emotion, appraisal, significance, and relation to the self.	How is the meaning of the event changing over time?	More evaluation may include maladaptive appraisals or rumination.
Narrative density	Amount of propositional information relative to narrative length.	Are extreme sparsity or overload changing with treatment and arousal?	No universal optimal density; interpretation requires context.
Local disorganization	Repetition, unfinished clauses, abrupt shifts, contradictions, or unclear referents.	Does local disruption covary with PTSD symptoms or dissociation within person?	Local disorganization can coexist with globally coherent storytelling.

Trauma Memory, PTSD, Acute Stress, and Dissociation

Traumatic memory is a descriptive term, not a diagnosis. PTSD is a disorder defined by a constellation of symptoms persisting beyond the acute posttrauma period, whereas ASD is restricted to the early aftermath of trauma and includes a somewhat different symptom organization (American Psychiatric Association, 2022). Dissociation can occur in either context and can include depersonalization, derealization, altered awareness, or memory disturbance, but dissociation is not synonymous with trauma memory. Likewise, intrusive images, voluntary autobiographical recall, and autobiographical-memory specificity are distinct phenomena that should not be collapsed into a single construct.

Historical models were influential because they drew attention to the unusual sensory vividness, involuntary retrieval, and contextual fragmentation sometimes reported after trauma. Early work described traumatic memories as relatively invariant sensory-affective fragments and contrasted them with ordinary narrative memory (van der Kolk & Fisler, 1995). Emotional-processing theory proposed fear structures connecting stimuli, responses, and meanings, with exposure allowing corrective information to modify the network (Foa & Kozak, 1986). The dual-representation model distinguished verbally accessible and situationally accessible representations (Brewin et al., 1996). Cognitive theory later emphasized poor elaboration and contextualization of trauma memories together with negative appraisals and maladaptive coping (Ehlers & Clark, 2000).

These models remain conceptually useful, but several of their strongest formulations require qualification. It is plausible that intense arousal narrows attention and enhances some perceptual features while weakening contextual encoding, and cue-driven bodily or perceptual responses may be experienced without immediate verbal mediation. It does not follow that severe trauma is stored categorically in a primitive procedural or sensorimotor memory system. Human memory systems interact, and the same event can support perceptual, semantic, episodic, physiological, and action-related learning. Contemporary reviews therefore favor questions about the relative availability, contextualization, involuntariness, and control of different trauma-memory expressions rather than a rigid verbal-versus-sensorimotor dichotomy (Brewin, 2025).

Evidence concerning narrative fragmentation is mixed. In an influential exposure study, trauma narratives became longer and less fragmented as PTSD symptoms improved (Foa et al., 1995). Such findings supported the idea that organization may improve during successful processing. In

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contrast, later analyses argued that memories for trauma can be as coherent as, or even more coherent than, memories for other important events, depending on how coherence is defined and measured (Rubin, 2011; Rubin et al., 2016). A meta-analysis by Taylor and colleagues questioned a robust association between trauma-memory disorganization and PTSD (Taylor et al., 2022), whereas a subsequent reanalysis by Brewin and Field concluded that a substantial association emerges when established measures of disorganization are considered and methodological differences are modeled (Brewin & Field, 2024).

Recent clinical-theoretical work similarly treats personal narrative disruption as a potentially important but non-exclusive process in trauma-related disorders (Wiesepape et al., 2025). The most defensible conclusion is not that either side has demonstrated a universal property of trauma memory. Rather, coherence is multidimensional and measurement-sensitive. Global coherence ratings can miss local disorganization; narrative tasks differ in preparation time and social context; and symptom severity, repeated retelling, treatment exposure, dissociation, and event characteristics all influence discourse. This also means that apparently contradictory findings may partly reflect different levels of analysis. A person can know the overall chronology of an assault yet experience vivid cue-triggered fragments, momentary temporal confusion, or abrupt shifts when recounting specific segments.

Autobiographical-memory disturbance in PTSD also extends beyond the trauma account itself. Iranian trauma survivors with PTSD, for example, showed reduced flexibility in retrieving specific autobiographical memories across changing task demands (Piltan et al., 2021). Daily-life research suggests that posttraumatic stress symptoms are also related to qualities of positive autobiographical memories, including accessibility, coherence, vividness, and distancing (Contractor et al., 2024). Other work indicates that childhood experiences can moderate associations between PTSD symptoms and positive autobiographical memory characteristics (Miguel-Alvaro et al., 2024). These findings broaden the field beyond the assumption that the core deficit is simply an incoherent narrative of the traumatic episode.

The distinction between narrative form and autobiographical integration is therefore crucial. An event may be verbally well described yet remain associated with catastrophic appraisals, avoidance, shame, or physiological reactivity. Conversely, a person may recover substantial functioning while retaining gaps, sensory fragments, or uncertainty about details. Table 3 reframes the older binary contrast between 'trauma memory' and 'narrative memory' as a set of dimensions that can vary independently.

Table 3.

Trauma-related memory features as dimensions rather than a binary contrast

Dimension	Pattern sometimes observed with trauma-related distress	Pattern suggesting greater contextual integration	Qualification
Voluntary control	Recall may be strongly cue-driven or difficult to regulate.	Greater capacity to approach or disengage from recall intentionally.	Intrusions can coexist with accurate and coherent voluntary memories.
Sensory-affective intensity	Vivid images, bodily reactions, sounds, smells, or intense affect.	Sensory material is more clearly located within an autobiographical context.	Sensory vividness is not itself evidence of pathology or a separate memory system.
Temporal-spatial context	Moments may feel immediate, decontextualized, or difficult to place.	Clearer discrimination of past versus present and event boundaries.	Context can be verbally known while emotional threat remains high.
Narrative organization	Local repetition, abrupt shifts, unfinished clauses, or unclear relations may occur.	More stable sequencing and contextual links across retellings.	Global coherence and local disorganization can coexist; measures are method-sensitive.
Meaning/appraisal	Threat, guilt, shame, defeat, or permanent-change meanings may dominate.	More differentiated and updateable appraisals compatible with current safety.	A coherent but maladaptive story may maintain symptoms.
Autobiographical flexibility	Reduced access to specific, positive, or alternative memories may occur.	More flexible access to varied autobiographical material and perspectives.	This is broader than the coherence of the trauma narrative itself.

Linguistic Features of Trauma Narratives

If trauma-related processes are expressed in discourse, linguistic analysis can provide an additional observational level between subjective report and broader clinical outcome. Early studies examined emotion words, causal language, pronouns, temporal markers, sensory expressions, incomplete clauses, repetition, and the organization of event sequences. More recent work has expanded this approach using computational linguistic methods and larger feature sets. A 2025 systematic review identified recurring signals across lexical, semantic, syntactic, discourse, and paralinguistic domains, while also documenting substantial heterogeneity and risk of bias (Quillivic et al., 2025).

Several classes of features are theoretically rlevant. Affective and semantic language can indicate threat, fear, helplessness, shame, or interpretation. Cognitive-process words can signal causal reasoning, perspective taking, or attempts at meaning-making. Temporal markers and grammatical tense may index whether an event is located as past or represented with present immediacy. Pronoun use can reflect perspective and self-reference, although its meaning varies across languages. Disfluencies, repetitions, unfinished clauses, and abrupt referential shifts can index local disruption, but they may also arise from ordinary speech production, emotional arousal, bilingualism, or interviewer behavior.

For these reasons, linguistic features should not be used as stand-alone diagnostic markers of PTSD. Even when multivariate classifiers show promising discrimination, performance can be inflated by small samples, publication bias, dataset-specific vocabulary, or confounding by demographic and contextual variables. Clinical interpretation requires replication across trauma types, languages, cultures, and elicitation tasks. The same linguistic form can carry different meanings: passive constructions may reflect helplessness in one context, conventional style in another, and a deliberate distancing strategy in a third.

The strongest use of linguistic analysis may therefore be longitudinal and within-person. Instead of asking whether a single narrative 'proves' integration, research can test whether changes in contextualization, evaluative flexibility, local disorganization, or self-reference track or precede changes in symptoms. This approach is more consistent with psychotherapy process research and avoids converting descriptive language categories into presumed mechanisms. Table 4 provides a condensed framework that replaces the overloaded list of indicators often used in earlier trauma-narrative research.

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Table 4.

Condensed linguistic framework for studying trauma narratives

Domain	Examples	Potential interpretation	Key limitation
Affective-semantic	Emotion words; threat/danger; shame; helplessness; sensory descriptors.	Salience, affective intensity, and dominant meanings.	Frequency does not distinguish adaptive emotional processing from rumination or distress.
Cognitive-evaluative	Causal words; insight terms; appraisals; mental-state language.	Meaning-making, perspective, explanatory structure.	Causal language can encode maladaptive beliefs as well as reappraisal.
Discourse-structural	Temporal order; contextual orientation; repetition; unfinished clauses; local contradictions.	Degree and location of narrative organization or local disruption.	Highly sensitive to task, interviewer, transcription, and coding method.
Grammatical-reference	Tense; active/passive voice; first-person versus generalized reference; deixis.	Perspective, agency, temporal positioning, self-reference.	Strong cross-linguistic and cultural variation limits simple interpretation.
Production/paralinguistic	Pauses; latency; disfluency; speech rate; prosody where available.	Arousal, retrieval difficulty, monitoring, or emotional engagement.	Not specific to trauma and influenced by anxiety, language fluency, and recording conditions.

Clinical and Psychotherapy Implications

Psychotherapy can sometimes be understood as a context in which experiences are revisited, reorganized, and related to a broader sense of self. That formulation is clinically useful only if it does not reduce diverse trauma treatments to narrative reconstruction. Current evidence-based practice includes therapies whose primary procedures and hypothesized mechanisms differ substantially. The 2023 VA/DoD guideline strongly recommends several individual trauma-focused psychotherapies and distinguishes among treatments rather than treating all trauma therapy as one narrative method (Department of Veterans Affairs & Department of Defense, 2023).

Narrative Exposure Therapy (NET) most directly supports the article's narrative thesis. NET constructs a chronological autobiographical account in which traumatic events are placed within a broader lifeline and revisited with contextual and emotional detail. Meta-analytic evidence supports clinically meaningful improvement, while also showing heterogeneity and limits in the evidence base (Wei & Chen, 2021; Raeder et al., 2023). Even here, however, clinical benefit does not demonstrate that formal coherence is the sole mediator. Exposure, emotional engagement, contextual learning, meaning, and repeated retrieval may all contribute.

Prolonged Exposure (PE) uses repeated imaginal and in vivo exposure to reduce avoidance and promote new learning. Trauma recounting is explicit, and narrative change may occur across sessions; early work indeed found reduced fragmentation during exposure (Foa et al., 1995). Yet PE is not adequately described as teaching clients to tell a polished story. Its therapeutic rationale centers on approaching trauma-related memories and cues and modifying fear and avoidance through corrective learning. Meta-analytic evidence for exposure-based PTSD treatment supports substantial symptom effects without requiring narrative coherence to be specified as the active mechanism (McLean et al., 2022).

Cognitive Processing Therapy (CPT) places greater emphasis on trauma-related beliefs and appraisals, such as beliefs concerning safety, trust, power, esteem, intimacy, guilt, and blame. Versions of CPT have historically varied in how much written trauma narration they require, underscoring the fact that cognitive change can occur without extensive narrative reconstruction. Contemporary process findings in cognitive therapy for PTSD likewise indicate that changes in maladaptive cognitive processes and coping can precede symptom improvement (Wiedemann et al., 2023). Narration may provide material for reappraisal, but reappraisal itself is conceptually distinct from narrative coherence.

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Eye Movement Desensitization and Reprocessing (EMDR) provides another important boundary condition. EMDR involves activation of traumatic memory while bilateral stimulation and structured processing procedures are used; it does not require prolonged, detailed verbal recounting in the same manner as PE or NET. A pilot randomized study found changes in autobiographical-memory narrative complexity and specificity following a group EMDR intervention (Poli et al., 2022), but such findings should be interpreted as possible consequences or correlates of treatment, not proof that coherent narration mediates EMDR efficacy. The broader clinical point is that substantial memory updating may occur when verbal elaboration is limited.

Psychodynamic and relational therapies often attend closely to how experience is represented in language, how affect is symbolized, and how personal meanings emerge within the therapeutic relationship. In these approaches, narrative co-construction may be central, but the therapeutic relationship contributes more than a conversational audience. It can provide affect regulation, interpersonal learning, recognition, and opportunities to revise relational expectations. A stable alliance is often clinically valuable, especially for complex presentations, yet it should not be presented as universally necessary for trauma integration. Some effective interventions are highly structured, brief, written, or delivered with relatively limited relational elaboration.

Embodied and non-verbal pathways provide a second boundary condition. Trauma is experienced not only as a story but also through physiological arousal, posture, action tendencies, pain, sleep, attentional bias, and interpersonal behavior. A biopsychosocial and culturally situated account of recovery therefore should not privilege language to the exclusion of bodily and contextual processes (Seyed Alitabar, 2025). The same principle applies as care becomes increasingly mediated by digital systems: therapeutic meaning remains embedded in embodied and relational contexts rather than reducible to text production alone (Seyed Alitabar, 2026). These considerations do not diminish the value of narrative; they place it within a broader body-mind-culture framework.

Expressive writing illustrates both the promise and limits of narrativization outside a strong dialogical relationship. Pennebaker's classic work suggested that putting stressful experience into words and increasing causal or insight language could be associated with health-related benefits (Pennebaker, 1993). Updated evidence is more qualified. Network meta-analysis indicates that expressive writing can reduce PTSD-related symptoms in some comparisons, but effects vary and methodological limitations remain (Gerger et al., 2022). A later meta-analytic review also reported delayed benefits for depression, anxiety, and stress in some samples (Guo, 2023). Writing may therefore be useful for some people without establishing that dialogue or formal coherence is universally required.

Across therapies, narrativization is best understood as a family of processes: approaching memory, placing it in context, differentiating past from present, labeling emotion, revising appraisals, linking the event with other autobiographical knowledge, and communicating experience to another person. Different treatments recruit different subsets of these processes and may reach similar clinical outcomes through partially distinct routes. Table 5 makes these differences explicit.

Table 5.

Role of explicit narrativization across selected trauma-related psychotherapies

Approach	Primary therapeutic emphasis	Role of explicit trauma narrative	Implication for the present model
Narrative Exposure Therapy (NET)	Chronological life narrative, exposure, contextualization of repeated trauma.	Central and explicit.	Strong example of narrative contextualization, but coherence should not be assumed to be the sole mechanism.
Prolonged Exposure (PE)	Approach to trauma memories/cues, reduction of avoidance, corrective learning.	Detailed recounting is prominent in imaginal exposure.	Narrative change may accompany exposure; symptom change need not depend on polished storytelling.
Cognitive Processing Therapy / cognitive therapy	Modification of maladaptive appraisals and coping processes.	Variable; extensive written narrative is not essential in all versions.	Demonstrates that cognitive updating is separable from narrative-form change.
EMDR	Trauma-memory activation with structured processing and bilateral stimulation.	Verbal description can be brief relative to PE/NET.	Memory integration may occur without extensive narrative elaboration.
Psychodynamic/relational therapy	Meaning, affect, defensive organization, interpersonal and relational patterns.	Often important as co-constructed meaning, but not the only process.	Narrative and relationship interact with affective and interpersonal change.
Expressive writing / written exposure	Structured writing about stressful or traumatic experience.	Central, but can occur without live dialogue.	Shows that verbalization may help some people without proving dialogue is universally necessary.
Embodied/somatic or multimodal approaches	Regulation of bodily arousal, awareness, action tendencies, and integrated experience.	May be secondary or optional.	Provides a clear boundary condition against treating language as the only pathway to integration.

A Research Agenda for Narrative, Memory, and Trauma

A more precise research program should begin by separating constructs that have often been treated as interchangeable. Narrative coherence, autobiographical-memory coherence, memory specificity, involuntary intrusion, self-coherence, dissociation, and clinical recovery should be measured independently. Studies can then ask whether one predicts another and under what conditions. This would avoid circular reasoning in which a coherent narrative is defined as integration and then used as evidence that integration has occurred.

Second, researchers should distinguish levels of coherence. Global story organization, local referential disruption, temporal contextualization, causal meaning, and evaluative integration may show different relationships with PTSD. The disagreement between recent meta-analytic conclusions illustrates how much depends on measurement choices (Taylor et al., 2022; Brewin & Field, 2024). Pre-registration of coding rules, blinded reliability checks, and open linguistic datasets would make these debates more cumulative.

Third, mechanism claims require longitudinal within-person designs. If narrativization contributes causally to recovery, change in specified narrative features should occur before, and statistically account for, later change in symptoms or functioning. Repeated sampling during treatment could compare trajectories across NET, PE, CPT, EMDR, and written interventions. Client narratives have already been used to predict outcome across written exposure and CPT, illustrating the feasibility of process-focused analyses (Alpert et al., 2023).

Fourth, cultural and linguistic validity should be treated as a core design issue. Narrative conventions differ in self-focus, chronology, emotional explicitness, agency, and acceptable disclosure. Computational markers trained in one language should not be assumed to generalize to another. The systematic linguistic literature now provides enough candidate variables to support cross-cultural replication, but not enough evidence to justify universal thresholds (Quillivic et al., 2025).

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Finally, future research should be multimodal. Linguistic change can be examined alongside symptom measures, autobiographical-memory tasks, physiological reactivity, behavioral avoidance, therapeutic alliance, and functioning. Such designs are better aligned with a body-mind-culture model and can test when language is a mechanism, when it is a marker, and when it is simply one expressive channel among several.

Conclusion

This review proposes a restricted rather than universal role for narrativization in trauma processing. Theoretically, autobiographical narration can help locate an event in time, connect it with other self-knowledge, communicate its meaning, and create reflective distance between the experiencing self and the remembering self. Developmental research supports the social origins of many narrative skills, and trauma theories provide plausible mechanisms through which contextualization and reappraisal could matter.

Empirically, the strongest conclusion is conditional. Some studies and recent meta-analytic work support an association between trauma-narrative disorganization and PTSD, but findings vary with the level and method of coherence measurement. Autobiographical-memory difficulties in PTSD also include flexibility, specificity, positive memory access, cue-driven intrusions, and appraisal—not only narrative fragmentation. Linguistic variables are therefore promising process measures but not diagnostic proxies for psychological integration.

Clinically, narrativization is central in some therapies and supportive in others, while effective trauma treatment can also proceed through exposure, cognitive updating, memory reconsolidation-related processes, embodied regulation, and relational change. Narrative coherence should consequently be treated as one important dimension of trauma recovery rather than its defining principle. The next step for research is to test specific narrative processes prospectively, across treatments, languages, and cultures, and to determine when changes in language genuinely mediate improvement rather than merely accompany it.

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The authors of this article declared no conflict of interest.

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Authors' Contributions

All authors equally contribute to this study.

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