Mediterranean Journal of Clinical Psychology

ISSN 2282-1619

MJCP

Volume 14, n 2, 2026

Health Psychology

Autobiographical Memory Writing Intervention with Cancer Survivors: A Study Protocol

*Maria Luisa Martino [1] *, Adele Nerini [2], Ermelinda Quarata [2], Matilde Cesaro [3], Michela Conte [2], Gaetano Facchini [2], Chiara Barraco [2], Andrea D'Arienzo [2], Antonella Nicastro [2], Maria Francesca Freda [1], Ida Bolognini [2]*

Abstract

A cancer diagnosis and its subsequent treatment can disrupt a person's sense of identity, temporal continuity, and personal meaning. Psychological distress often persists beyond the active treatment phase. Although cancer survivorship is increasingly recognised as a long-term psychosocial condition, there are limited structured interventions that specifically address this phase. Although narrative and writing-based approaches have shown potential in promoting meaning-making and identity reconstruction, existing paradigms mainly rely on expressive writing protocols. Interventions targeting autobiographical memory and narrative identity remain under-explored. This innovative protocol outlines the design and planned evaluation of the Autobiographical Memory Writing Intervention (AMWI): a four-month, co-conducted intervention for cancer survivors, delivered by a psycho-oncologist and a narrative coach. The programme consists of eight fortnightly sessions: the first and final sessions are dedicated to psychometric and qualitative assessment, and the six intermediate sessions constitute the autobiographical intervention. During these sessions, participants engage in guided autobiographical activities based on structured writing prompts and shared clinical meta-reflection. They progressively move from exploring personal identity to reconstructing cancer-related narratives. A quasi-experimental mixed-methods design will be implemented in two phases: first, a feasibility and micro-pilot phase with pre- and post-assessments; then, a controlled phase including a comparison group of survivors who decline the intervention but agree to complete assessments, with a three-month follow-up. Primary outcomes include psychological distress, depressive symptoms, anxiety, and trauma-related symptoms, while secondary outcomes include autobiographical memory processes and perceived social support. Narrative materials will be analysed qualitatively and integrated with quantitative findings. The expected outcomes are related to improvements in psychological well-being resulting from integrating one's personal cancer story into one's autobiographical identity. The evaluation of the clinical efficacy of AMWI will involve extending current clinical approaches targeted at cancer survivorship to offer a more comprehensive alternative using different devices of semiotic mediation and multilayered discursive channels to empower clinical implications.

[1] Department of Humanities, Federico II University, Naples, Italy
[2] Oncology Unit, Santa Maria Delle Grazie Hospital, Pozzuoli, Italy
[3] Free University of Autobiography, Anghiari, Italy
E-mail corresponding author: marialuisa.martino@unina.it

Keywords:
Autobiographical writing, Cancer survivors, Clinical psychology, Narrative identity, Psycho-oncology, Psychological well-being, Study protocol.

Received: 8 June 2026
Accepted: 9 August 2026
Published: 15 August 2026

Citation: Martino, M. L., Nerini, A., Quarata, E., Cesaro, M., Conte, M., Facchini, G., Barraco, C., D'Arienzo, A., Nicastro, A., Freda, M. F., & Bolognini, I. (2026). Autobiographical memory writing intervention with cancer survivors: A study protocol. *Mediterranean Journal of Clinical Psychology, 14*(2).
https://doi.org/10.13129/2282-1619/mjcp-5473

1. Introduction

1.1 Cancer Survivor and Identity

It is a widely acknowledged fact that the onset of cancer can constitute a challenging experience, with the potential to exert a significant impact on a person's physical, emotional and social well-being, both during and following treatment (Devlin et al., 2017; Martino et al., 2023).

The psychological impact can be considerable in particular regarding the risk of interruption to subjective temporal continuity, this may result in a crisis of meaning, impacting the patient's personal self-narrative (Martino et al., 2021; Neimeyer, 2019).

In recent times, cancer has become a significant health concern on a global scale. For instance, in 2018, the number of new cases was estimated to be 18.1 million, with a further 9.6 million deaths. Whilst there has been an increase in the incidence of cancer in many countries, there has also been a decline in mortality rates in many regions worldwide. This has resulted in a considerable number of individuals either living with the condition or surviving it (Bray et al., 2018; De Vincenzo et al., 2022; Fitzmaurice et al., 2017).

The cancer survivor condition is defined as the time from diagnosis to five years; over five years is defined as long-survivorship (Mahvi et al., 2018). Cancer is increasingly regarded as a chronic condition that requires ongoing management in daily life. The repercussions of cancer treatment on patients' quality of life and well-being extend well beyond the conclusion of therapy, potentially impacting years of life. It is well established that cancer survivors are prone to experiencing a wide range of symptoms and adverse challenges. These can include depression, anxiety, sleep disturbances, fear of death and/or recurrence (Burney, 2019; Lee & Kim, 2026; Miniati et al., 2020). In order to address these challenges, it is useful to facilitate the reconstruction of self-identity within a new continuity of one's life story. This scenario needs psychological support interventions aimed at facilitating patients' recovery from the cancer experience.

The psychological reorganisation that follows a cancer diagnosis has been examined from two complementary theoretical perspectives. According to meaning-making models, highly stressful events create a discrepancy between the meaning attributed to a specific situation and an individual’s broader system of beliefs, goals, and expectations. Adaptation depends on the processes through which this discrepancy is progressively reduced (Park, 2022). Similarly, literature on post-traumatic growth suggests that confronting highly challenging life events can result in positive changes in self-perception, interpersonal relationships, and life priorities.

Such transformations are closely intertwined with the reconstruction of one's life narrative (Tedeschi & Calhoun, 2004). Both perspectives identify narrative integration as a key mechanism through which illness can be incorporated into a personal narrative, providing a theoretical rationale for supportive interventions that engage with autobiographical material.

These processes are rooted in autobiographical memory, which, according to the self-memory system model, is not conceived as a repository of fixed records, but rather as a dynamic reconstruction process through which transient memories are generated from a hierarchically organised knowledge base, under the direction of the working self's goals (Conway & Pleydell-Pearce, 2000). Within this framework, the specificity of autobiographical memory, namely, the ability to retrieve memories relating to a particular event that occurred at a specific time and place, is a clinically relevant dimension, and reduced specificity has been consistently associated with emotional disorders (Williams et al., 2007).

Alterations in autobiographical functioning have also been observed in individuals with cancer. In a controlled study, participants with a cancer diagnosis retrieved fewer specific autobiographical memories than the control group. In approximately half of these participants, the illness experience had become a self-defining memory characterised by perceptions of threat to physical integrity and reflections on the meaning of life (Nieto et al., 2019). Among adolescent and young adult cancer survivors, autobiographical memory and future-oriented thinking have likewise been identified as potentially modifiable cognitive processes associated with cancer-related adjustment and subsequent psychological outcomes (Sansom-Daly et al., 2018). Taken together, these findings suggest that autobiographical memory is not only the material through which narrative interventions are developed, but also a psychological process that may be affected by the cancer experience. Therefore, it may constitute a relevant target for intervention.

1.2 Writing, Memory and Identity Reconstruction

In the context of illness narrative, which emphasizes the patient's subjective interpretation of their illness, significant attention has been devoted to the impact of cancer on patients' lives. This field has explored strategies to promote psychosocial recovery and adaptation, both during the treatment phase and in the post-treatment period (Martino et al., 2026; Merz et al., 2014; Schellekens et al., 2024). Recent literature demonstrates the emergence of an array of writing paradigms, predicated on a multitude of theoretical perspectives. These paradigms function through disparate psychological mechanisms, yielding a range of outcomes (Kaptein, 2021). However, the absence of alternative paradigms, such as autobiographical writing, autopathobiography, or memory-based writing, which could offer more profound insights into identity reconstruction and post-traumatic growth, is evident.

It is evident that these paradigms offer an efficacious method for addressing the processing and integration of the cancer experience within a novel continuity of the self-narrative and autobiographical memory (Martino et al., 2024). Within the Narrative Identity framework (Thomsen et al., 2025), the reconstruction of a critical or traumatic experience through the use of autobiographical memories is implied. The correlation between the temporal dimensions, spanning from past to present and future, serves to empower patients by facilitating the inscription of experiences within their life narratives and the subsequent archiving thereof in the form of memory. It has been demonstrated that past autobiographical memories have the capacity to provide the psychological resources required to facilitate adaptation to the present experience (Martino et al., 2024). This process of reinterpretation gives rise to a novel interpretation of the continuity of life story. It is recommended that future studies provide greater insight into this area. The present body of research demonstrates that autobiographical writing can act as a valuable source of emotional support for patients with cancer, as well as for their caregivers and healthcare providers (Martino et al., 2026). The empirical basis of writing-based interventions largely derives from the experimental disclosure paradigm attesting improvements in physical health, psychological well-being, physiological functioning, and general functioning, alongside a transient increase in distress immediately following writing (Frattaroli, 2006; Lai et al., 2023; Smyth, 1998). Within oncology field, reviews of writing interventions have likewise reported heterogeneous findings across different paradigms and populations (Martino et al., 2026; Merz et al., 2014). Overall, these findings suggest that the effects of writing may depend less on emotional disclosure per se than on the conditions through which written material is subsequently processed and elaborated, a consideration that directly informs the design of the present intervention.

Structured interventions based on autobiographical recall have a long-standing tradition outside oncology. The Autobiographical Writing Paradigm developed by McAdams (2008) within the life story model of identity enables individuals to create evolving life narratives that provide purpose and integrity. The Guided Autobiography method is a structured approach to the composition of personal narratives. It involves the integration and connectivity of personal recollections and life events to create a written life story. In this process, significant life events are selected for narration, thereby conferring stability and continuity on thin self-portrait. The integration of these events serves to reflect and address changes in self-identity over time. However, these approaches have been developed primarily with older adults and within group-based formats and their application to the specific challenge of identity reconstruction following cancer remains largely unexplored (Birren & Deutchman, 1991).

Moreover, a recent review underlined the need for additional studies to be conducted on a wider range of cancer types, with a focus on those that are less commonly studied such as beyond breast cancer (Martino et al., 2026). Within oncology, where reduced access to autobiographical memory has been documented among cancer patients, evidence suggests that the narration of illness-related memories is not emotionally neutral: narrated memories appear to be more emotionally elaborated than non-narrated ones, and participants who narrated negative illness-related memories showed a decrease in negative emotions alongside an increase in more complex emotional states (Fioretti & Smorti, 2017). This finding is particularly relevant to the present protocol, as it supports the assumption that guided narration of autobiographical material may influence the emotional quality of recalled memories, rather than merely their content.

Consequently, this study will be conducted on the basis of the development of an innovative and structured intervention, called Autobiographical Memory Writing Intervention (AMWI) for cancer survivors, which has been designed to encompass eight sessions. AMWI's innovative approach moves beyond the traditional model of expressive writing (Pennebaker, 1997), where writing occurs in an experimental setting over a short period. Instead, it embeds the writing process within a clinical relationship that evolves over time through face-to-face and asynchronous activities. This written activity then becomes a catalyst for further exploration of the self, which in turn guides the intervention. Furthermore, the co-presence of the clinical psychologist and the narrative coach in autobiographical writing enables the use of semiotic mediation tools (e.g. writing, clinical dialogue, shared poetry, silent books and memories) and multi-layered discursive channels (e.g. written, oral and visual), thereby broadening the intervention's impact.

Notably, the written text is not kept private but shared throughout the intervention to help guide it. In the expressive writing paradigm, the produced text is not usually reread or discussed (Merz et al., 2014). In AMWI, however, writing carried out in a personal notebook between sessions is revisited and shared in the subsequent session in the presence of both the narrative coach and the psycho-oncologist. This review does not constitute a psychotherapeutic session, but rather a process of shared meta-reflection on the narrative material produced. In this process, the themes and insights emerging from the writing are revisited and further explored. In this respect, the intervention draws on the tradition of narrative medicine and guided autobiography (Birren & Deutchman, 1991; Charon, 2007). However, it differs from these traditions in that it is carried out on an individual basis and is part of a hospital-based care pathway rather than taking place in group or training contexts.

Furthermore, AMWI explicitly targets autobiographical memory processes rather than treating them as an indirect outcome. The expressive writing paradigm is primarily concerned with the emotional disclosure of a stressful event (Pennebaker, 1997). In this clinical context, however, the focus is on retrieving specific autobiographical memories and re-elaborating them within a new narrative continuity of the self. This approach is based on existing literature on the specificity of autobiographical memory as a clinically relevant variable (Williams et al., 2007). In terms of assessment, it incorporates process measures, such as the Self-Defining Memory Task and its associated Rating Sheet, alongside conventional indicators of distress (Martino et al., 2024; Singer & Blagov, 2000). Therefore, the intervention is not limited to detecting a reduction in symptoms; it also allows us to observe the mechanism through which such a change is expected.

Finally, the intervention targets a phase and a population that are underrepresented in the literature on writing interventions in oncology. Most existing studies focus on women with breast cancer and are conducted during active treatment. In contrast, the AMWI is oriented towards the survivorship phase following the conclusion of treatment and towards patients with any type of cancer. This phase is characterized by a decline in psychological support precisely when tasks of identity reorganization emerge (Martino et al., 2026).

The primary aim of this study is to evaluate the effectiveness of the AMWI on the psychological well-being of cancer patients by evaluating changes before, during and after the intervention.

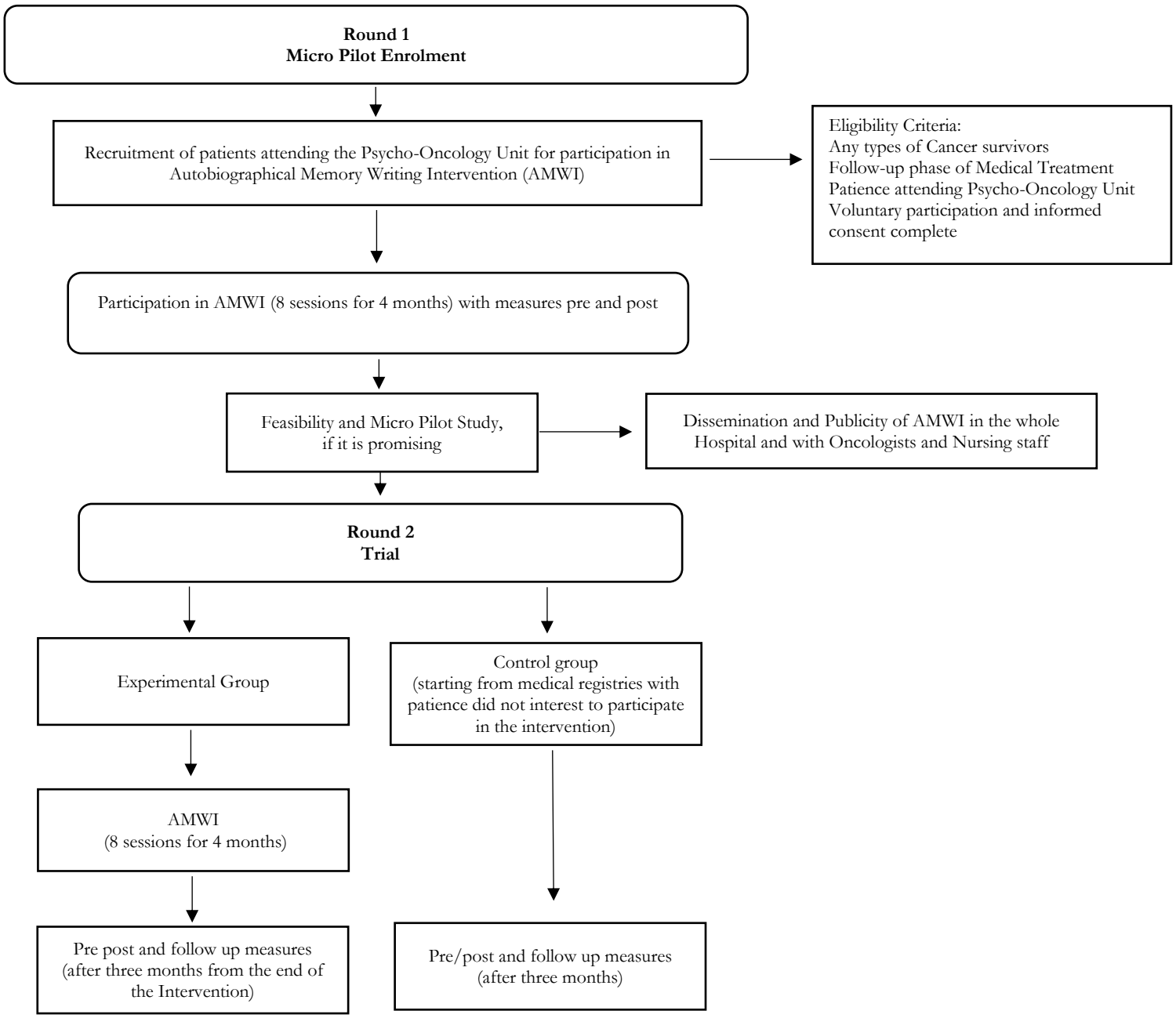
2. Method

2.1 Study design

The present study uses a quasi-experimental design, took place at the Hospital Santa Maria delle Grazie di Pozzuoli, Italy, by the Psycho-Oncology Unit in collaboration with the Department of Humanities, Psychology Section, of the Federico II University of Naples, Italy (Figure 1). The quasi-experimental design is rooted with the aim of extending AMWI access to a large cohort of cancer survivors, to ensure that no patients requiring support are overlooked. This constitutes the fundamental mission of the psycho-oncology unit. During the first round, which is to be conducted as a feasibility and micro-pilot study, the outcomes will be measured at the beginning and conclusion of the structured intervention period. In the second round, contingent upon the findings of the feasibility and micro-pilot study, additional follow-up measures will be incorporated, along with the establishment of a control group comprising patients who do not express a desire to participate.

Figure 1

Flowchart of Research Design



2.2 Study Participant and Recruitment

In the first round of the study, participants eligibility criteria are as follows: Any types of Cancer survivors, Follow-up phase of Treatment (end of treatment), Patients currently treated by the Psycho-Oncology Unit, Voluntary participation and informed consent complete.

Exclusion Criteria are as follows:

Patients with severe cognitive difficulties; Patients with other medical conditions; Presence of pre-existing psychiatric disorders; Presence of severely depressed mood.

Exclusion criteria are assessed through the oncological medical records and the clinical history available in the chart.

2.3 Participants Recruitment

For the first round, the study will be offered to patients who are already being treated by the psycho-oncology unit. Psycho-oncologists will introduce the study to eligible patients during their follow-up psychological support.

In the second phase flyers and popularization presentations will be used to raise the public awareness of the study in the whole hospital with oncologists, staff and patients. Once the AMWI shows some interest of the study, informed consent and detailed explanation to recruit into the study will be given.

2.4 Sample size and power calculations

Sample size and power calculation for the second round is based on the primary outcome (reduction of DASS-21). The small effect size used for the calculation of required sample size is based on literature reviews and assumptions of median score of cancer survivors (Bottesi et al., 2015; Zainal et al., 2013).

The sample size for this study was determined via a priori power analysis performed using G*Power software (version 3.1.9.7). The calculation was configured to detect a statistically significant difference between the control group ($M = 4.8$) and the study group ($M = 3.9$) regarding DASS-21 scores.

With a significance level ($\alpha = .05$) and a statistical power ($1 - \beta$) of .80, the analysis indicated that a minimum of 51 participants was required. To account for an anticipated dropout rate of approximately 15%, the final recruitment target was set at 60 participants to ensure that the study maintains sufficient statistical power throughout the analytical phase.

2.5 Intervention and Measures Procedure

The innovative and structured AMWI is a supportive individual intervention targeted for cancer survivor to promote identity reconstruction and recovery after treatments aimed to reduce psychological symptoms that accompany this phase (tab 1).

Table 1

The topic details of each session and procedure of session administration

Autobiographical Memory Writing Intervention for Cancer Survivors AMWI							
Session 1	**Session 2**	**Session 3**	**Session 4**	**Session 5**	**Session 6**	**Session 7**	**Session 8**
Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes	Duration: 60 minutes
	After 15 days +/- 5 days	After 15 days +/- 5 days	After 15 days +/- 5 days	After 15 days +/- 5 days	After 15 days +/- 5 days	After 15 days +/- 5 days	
	Write freely using any input that emerges during the meeting (shared poetry, silent book)	Write freely using any input that emerges during the meeting (shared poetry, silent book)	Write freely using any input that emerges during the meeting (shared poetry, silent book)	Write freely using any input that emerges during the meeting (shared poetry, silent book)	Write freely using any input that emerges during the meeting (shared poetry, silent book)	Write freely using any input that emerges during the meeting (shared poetry, silent book)	
Welcoming in the AMWI path	Autobiographical Writing Tasks *What writing means to me...* *- Story of my name*	Autobiographical Writing tasks *The story about your birth: describe the story of your coming into the world as you imagine it, as you believe it happened.*	Autobiographical Writing tasks *Objects tell stories, objects tell stories about me, they tell stories about parts of me*	Autobiographical Writing tasks *My biography: 5 images that tell my story.* *I tell my story through 5 photos.*	Autobiographical Writing tasks *The words of the cure/cancer - The words to say it* *- The words I've never said*	Autobiographical Writing tasks *An episode of care given and an episode of care received* *- I remember: the words of care*	
	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	Reflection and sharing of themes, cue and concerns emerged+ psychic elaboration of the writing experience	
Baseline Administration: Dass-21 Tale Eps Distress Termomether Ies-R Mspss Self-Defining Memory Task Self-Defining Memory Rating Sheet Case Report Form (CRF) to collect patient data. Monitoring qualitative questionnaire	.		MidTerm Administratio: Monitoring qualitative questionnaire				Post Intervention Administration: Dass-21 Tale Eps Distress thermometer Ies-R Mspss Self-Defining Memory Task Self-Defining Memory Rating Sheet Monitoring qualitative questionnaire

The eight-session sequence is theoretically grounded in the narrative identity framework (Thomsen et al., 2025), which posits that the elaboration of potentially traumatic experiences requires a previously established narrative foundation upon which these experiences can be integrated. Accordingly, the initial sessions focus on autobiographical domains unrelated to illness, including the personal meaning of writing, the story of one's name, birth narratives, and

objects and images carrying personal history. These activities serve three interconnected purposes: reactivating access to specific autobiographical memories (Williams et al., 2007), creating a safe narrative space within the therapeutic relationship and re-establishing a sense of temporal continuity of the self that extends beyond the illness experience. This approach is consistent with the view that autobiographical memories of the past may provide psychological resources for coping with present challenges (Martino et al., 2024), and with the life story model of identity, according to which the selection, organization and integration of meaningful life events contribute to the coherence and stability of personal identity (McAdams, 2008; McAdams et al., 2006).

The intervention also follows a progressive gradient of semiotic immersion. Early sessions engage participants with the self through symbolic and relatively indirect forms of access (such as names, family narratives, personal objects, and photographs) whereas later sessions progressively introduce the direct narration of the cancer experience. Only after this autobiographical foundation has been consolidated do participants approach illness-related themes, including the meanings associated with cancer and care, unspoken words, and experiences of giving and receiving care. This sequencing allows cancer to be positioned as one meaningful chapter within a broader life narrative, rather than as the central organizing element of identity. The final transition from illness-focused narratives to narratives of care aims to facilitate the reconstruction of agency and relational identity beyond the patient role.

Moreover, the gradual structure of the intervention is intended to support emotional containment by distributing the activation associated with illness narration across a therapeutic process extending over four months. This differs from brief expressive writing paradigms, in which emotionally charged material is often addressed within a single writing episode (Merz et al., 2014).

2.6 Intervention Procedures and Delivery

The programme consists of eight sessions delivered at two-week intervals. The first and eighth sessions are dedicated to assessment. The initial session focuses on welcoming the participant, establishing the autobiographical setting and therapeutic alliance and introducing autobiographical writing as a tool for self-exploration and psychological care. The final session is devoted to post-intervention psychometric and qualitative assessment, together with a concluding reflection on the autobiographical experience.

The six intermediate sessions constitute the core autobiographical intervention. The specific objective of each session, together with the corresponding autobiographical writing prompt, is presented in Table 1.

2.7 Setting and Session Structure

The AMWI programme is delivered face-to-face and on an individual basis in the outpatient facilities of the Psycho-Oncology Unit. All sessions are conducted in the presence of the participant, a psycho-oncologist and a narrative coach. Each of the six intervention sessions lasts approximately 60 minutes and follows a standardised structure designed to ensure methodological consistency while enabling participants to become progressively familiar with the process of autobiographical writing. Each session comprises five sequential phases. The session begins with a brief welcome phase (5 minutes) to help participants transition into the autobiographical work and re-establish continuity with the previous meeting. During this phase, the autobiographical framework and the focus of the current session are revisited briefly. This is followed by a period of free, non-directed writing (10 minutes), during which participants are invited to write spontaneously without a specific prompt. This initial writing activity is intended to facilitate entry into autobiographical mode and promote narrative flow. The central phase (20 minutes) is dedicated to the autobiographical writing prompt, introduced by the narrative coach, which participants complete individually in a confidential and supportive environment. The fourth phase (20 minutes) is devoted to shared reflection on the writing experience. Participants are invited to read their text aloud and decide which parts they wish to share. The discussion focuses primarily on the experience of writing and the process of making meaning, rather than the interpretation of narrative content. The narrative coach facilitates reflection by supporting participants' meaning-making processes, while the psycho-oncologist monitors participants' emotional responses and intervenes only when emotional containment or clinical support is required. The session concludes with a brief closing phase (five minutes), during which the experience is summarised and the writing task to be completed before the next meeting is introduced. The autobiographical prompts follow the progression described in Table 1 and are presented in an identical form to all participants to ensure procedural standardisation across the intervention. The narrative coach introduces the prompts at the end of the non-directed writing phase, and they are not individually adapted except when minor reformulations are required according to the facilitation strategies described below.

2.8 Professional Functions and Clinical Interventions

The AMWI will be co-conducted by an expert psycho-oncologist from the Hospital's Psycho-Oncology Unit and a narrative coach affiliated with the Free University of Anghiari (Italy), with specialized training in Narrative and Coaching methodologies. The intervention is structured around the integration of distinct yet complementary professional functions. The narrative coach leads participants through the narrative tasks and the autobiographical writing process, fostering narrative organization, expressive depth, and the construction of a coherent personal

storyline. This role serves educational, reflective and formative purposes and does not involve clinical assessment or psychotherapeutic practice. Concurrently, the psycho-oncologist adopts a facilitative clinical stance, supporting the emotional processing and re-signification of the cancer experience, promoting meaning-making processes, facilitating the emergence of psychological insight, monitoring participants' emotional responses, safeguarding the therapeutic setting, providing emotional containment, identifying the emergence of clinically significant psychological distress and intervening when further psychological assessment or specialized clinical care is indicated. This co-conducted framework enables a synergistic integration of narrative expression and psychological clinically grounded reflection. AMWI is conceived as supportive psychological clinical intervention integrated within the psycho-oncological care pathway, rather than as a psychotherapeutic treatment.

2.9 Management of Emotional Reactions

Participants may experience difficulties initiating writing, feelings of inhibition, narrative blocks and intense emotional activation during the programme. Such experiences are considered an integral component of the autobiographical process and are welcomed, though participants are not encouraged to force narrative production. The following strategies are adopted to facilitate engagement: normalising narrative blocks as a possible aspect of autobiographical writing; acknowledging participants' right to remain silent and their freedom not to share the texts they produce; reformulating writing prompts in more concrete terms or tailoring them more closely to participants' lived experience; using open-ended questions to facilitate access to autobiographical memories without directing or shaping their content; introducing alternative autobiographical cues, such as personal objects, photographs, keywords, sensory memories or mental images, when recall proves difficult; emphasising the writing process rather than the quality or completeness of the written text; and respecting each participant's individual pace of reflection and meaning-making. If a narrative block is accompanied by clinically significant emotional distress, the psycho-oncologist will provide supportive clinical interventions focused on empathic listening, emotional containment, and affect regulation. They will also evaluate whether further individual clinical assessment or referral is warranted.

2.10 Between-Session Activities

At the end of each of the first seven sessions, participants are assigned an autobiographical writing task to be completed independently in a personal notebook during the interval preceding the subsequent session, resulting in a total of seven assignments. Each written task is brought to the following session and read aloud by the participant. Participants retain full control over the disclosure of their personal material, deciding which portions of the text they wish to share,

while any additional writing produced spontaneously and beyond the scope of the assigned prompt may remain private. This approach safeguards participants' autonomy regarding self-disclosure while supporting continuity and progression of the autobiographical process across sessions.

2.11 Training of Professionals Involved and Documentation of Intervention Delivery

The narrative coach received specific training in the autobiographical methodology developed by the Free University of Autobiography of Anghiari (Italy). The psycho-oncologist is a psychotherapist trained in clinical psychology, with specific expertise in psycho-oncology, acquired through dedicated training and several years of clinical experience within the hospital-based Psycho-Oncology Unit.

2.12 Timing of Assessments

The psychometric instruments administered at baseline, as reported in Table 1, are completed before the start of the programme and prior to the first session. The qualitative monitoring questionnaire is administered during the first session and repeated at the midpoint of the programme. During the seventh session, the questionnaire is administered again, and participants are asked to bring it to the final session, where it is collected and archived together with the other study materials. Post-intervention assessment, including the repetition of the psychometric instruments and the qualitative questionnaire, is conducted during the eighth session.

2.13 Sociodemographic and Clinical Data

Sociodemographic and clinical characteristics are collected at baseline through a Case Report Form (CRF) specifically developed for the study. The CRF includes information on age, gender, marital status, educational level, occupational status, tumour site, disease stage, date of diagnosis, treatments received and time elapsed since completion of active treatment. Throughout the intervention, the CRF is also used to document participant attendance and session dates. Data collected through the CRF are used to describe sample characteristics, compare baseline profiles between the intervention and comparison groups, and monitor intervention delivery, including participant attendance, attrition and any deviations from the planned schedule.

2.14 Primary Outcomes

DASS-21 (Bottesi et al., 2015) is a 21-item self-report measure, on a Likert scale ranging from 0 to 3, designed to assess the severity of general psychological distress and symptoms related to depression, anxiety, and stress.

Distress Thermometer (Gil et al., 2005) is a self-report measure, on a Likert scale ranging from 0 to 10, designed to measure, identify, and manage emotional and physical distress in cancer patients.

IES-R (Weiss, 2007) is a 22-item self-report measure, on a Likert scale 0-4, designed to assess distress caused by a traumatic event and can assist clinicians in assessing Post Traumatic Stress Disorder (PTSD).

2.15 Secondary outcomes

Self-Defining Memory Task (Singer & Blagov, 2000) is a qualitative task aimed at recollecting and writing three self-defining memories accompanied by a Self-Defining Memory Rating Sheet, a 12-item self-report measure, on a Likert scale 0-6 designed to assess affects and emotions intensity.

Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) is a 12-item self-report measure designed to assess the perception of social support.

2.16 Patient Safety and Process Monitoring.

Participants will be monitored throughout the study by trained project staff, who will intervene if any negative reactions are observed during the assessment procedures or the workshop activities. Participants will be free to withdraw from the study at any time without consequences and will be encouraged to consult their personal physicians for routine medical care. Researchers may also withdraw a participant from the study if serious psychological difficulties arise or if the participant expresses a reason to discontinue the psychological intervention.

To support the monitoring of participants' experiences during the AMWI, three qualitative questionnaires will be administered at different stages of the autobiographical writing intervention. The first questionnaire, administered at the beginning of the program, aims to encourage participants to reflect on their relationship with autobiographical writing. Through open-ended questions, it explores the perceived meaning and usefulness of writing about oneself, the motivations for participating in the workshop, and any previous experiences with personal writing (e.g., journals, diaries, or informal notes). The goal is to foster initial self-reflection and to gather insights into participants' expectations and prior familiarity with autobiographical practices.

A second questionnaire will be administered midway through the AMWI to explore participants' reflections on their ongoing experience. Using the metaphor of a train journey, participants are invited to describe the different stages of the process and to reflect on the role and usefulness of writing about themselves during the first part of the workshop. They are also asked to

reconsider and expand the definition of autobiographical writing they initially provided, allowing researchers to capture evolving perceptions and meanings attributed to the writing process.

At the end of the AMWI, a third qualitative questionnaire will be administered to explore participants' overall reflections on the experience. Participants will be invited to describe what they take away from the program and to represent the meaning of the experience through a word, image, sensation, song, title, film, or metaphor. This final questionnaire aims to capture participants' concluding interpretations of the journey and the personal significance attributed to the autobiographical writing process.

2.17 Data Analysis

We will evaluate the effects of AMWI intervention on every quantitative outcome. During the first round, the paired T-test pre-post intervention will be performed. During the second-round phase, a multivariate analysis of variance (ANOVA) statistical procedure for repeated measures with a two-way mixed factorial design will be performed. In particular, there will be a series of ANOVA, where the dependent variable will be the level of symptoms related to the scales of DASS-21, Distress Thermometer and IES-R detected at T0–T1–T2. The factor between the groups is Group (experimental/control). Statistical significance level is set at $p < .05$. All statistical analyses will be performed using SPSS Statistics for Windows (version 25.0, IBM). Effect sizes (Cohen's d and partial η^2) together with 95% confidence intervals will be reported. Missing data, participant attrition, and protocol deviations will be documented and described. Where the proportion of missing data is minimal, complete-case analyses will be performed; if missingness exceeds predefined thresholds, appropriate sensitivity analyses and, where justified, multiple imputation methods will be considered. In addition, we are aware of the use of participants who decline the intervention as a comparison group may introduce self-selection bias, as these individuals may differ from intervention participants in terms of psychological characteristics, motivation, coping resources, or readiness to engage in psychosocial support. The decision was based on ethical and practical considerations inherent to the clinical setting. Since the intervention is offered as an optional supportive service, random allocation to intervention versus non-intervention was not considered feasible or ethically appropriate at this stage of the project. Consequently, the comparison group consists of patients who declined participation while still consenting to complete the assessment protocol. To manage this choice, baseline sociodemographic and clinical characteristics, as well as psychological measures, will be compared between groups to evaluate initial comparability. Where appropriate, statistical adjustment for baseline differences will be considered in the analyses, and any remaining imbalance will be acknowledged when interpreting the findings.

2.18 Qualitative Analysis

The study uses a mixed-methods design in which quantitative and qualitative findings will be integrated during the interpretation stage. Quantitative outcomes will provide evidence regarding changes in psychological well-being, whereas qualitative analyses will explore participants' subjective experiences, narrative processes, and meaning making associated with the intervention. Integration will follow a triangulation approach, identifying areas of convergence, complementarity, and divergence across data sources. The narrative textual material produced during the writing sessions will be undertaken to qualitative in deep analysis using Reflexive Thematic Analysis (Braun & Clarke, 2006) and the Narrative Function Coding System (Freda et al., 2023), in order to highlight the central themes proposed by the participants and to identify the transformative modes and functions of the narrative articulation of the autobiographical memories (narrative markers of integration and psychic elaboration). In addition, a qualitative-quantitative analysis using T-LAB software (Lancia, 2004) will be conducted with a Cluster Analysis (Denzin & Lincoln, 1994) of the main themes that emerged through word associations (chi-square); projections of these on the factorial plane in order to highlight specific positions of subcategories of participants.

With regard to self-defining memories, the coding method proposed by Singer and Blagov (2000) will be followed, focusing on markers of content, specificity, integrative meaning, and affective response.

3. Ethics Statement

The study was approved by the ethics committee of Campania Region (protocol number 25/25). All participants will be informed about the study goals. Written informed consent will be obtained from all participants or their legal guardians prior to the study enrollment according to the Declaration of Helsinki. All participant information and data will be stored securely and identified by a coded ID number only to maintain participants' confidentiality.

4. Dissemination

The results of the study are to be published in open-access and international journals. Moreover, the results will be showcased at conferences, in addition to being discussed during hospital staff meetings and clinical health psychology lectures at the Federico II University of Naples.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Authors' Contribution

M.L.M., A.N., M.C., and E.Q.: Conceptualization, Methodology, Writing – Original Draft, Writing – Review & Editing. M.Ce.: Methodology. I.B.: Project Administration. M.F.F., A.Ni., A.D., C.B., and G.F.: Supervision.

AI Disclosure Statement

The authors declare that no artificial intelligence (AI) tools, including generative AI systems, were used in the conception, design, analysis, interpretation of data, drafting, or writing of this manuscript. All intellectual content, scientific reasoning, and manuscript preparation were carried out solely by the authors.

References

1. Birren, J. E., & Deutchman, D. E. (1991). Guiding autobiography groups for older adults: Exploring the fabric of life. Johns Hopkins University Press.
2. Bottesi, G., Ghisi, M., Altoè, G., Conforti, E., Melli, G., & Sica, C. (2015). The Italian version of the Depression Anxiety Stress Scales-21: Factor structure and psychometric properties on community and clinical samples. *Comprehensive psychiatry*, *60*, 170–181. https://doi.org/10.1016/j.comppsych.2015.04.005
3. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
4. Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R. L., Torre, L. A., & Jemal, A. (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: a cancer journal for clinicians*, *68*(6), 394–424. https://doi.org/10.3322/caac.21492
5. Burney, S. (2019). Psychological issues in cancer survivorship. *Climacteric*, 22(6), 584–588. https://doi.org/10.1080/13697137.2019.1606795
6. Charon, R. (2017). The principles and practice of narrative medicine. Oxford University Press.
7. Conway, M. A., & Pleydell-Pearce, C. W. (2000). The construction of autobiographical memories in the self-memory system. *Psychological Review, 107*(2), 261–288. https://doi.org/10.1037/0033-295X.107.2.261
8. De Vincenzo, F., Cosentino, C., Quinto, R. M., Di Leo, S., Contardi, A., Guidotti, S., Iani, L., & Pruneti, C. (2022). Psychological adjustment and heart rate variability in ovarian cancer survivors. *Mediterranean Journal of Clinical Psychology, 10*(1), 1–18. https://doi.org/10.13129/2282-1619/mjcp-3318
9. Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Sage Publications, Inc.
10. Devlin, E. J., Denson, L. A., & Whitford, H. S. (2017). Cancer treatment side effects: a meta-analysis of the relationship between response expectancies and experience. *Journal of Pain and Symptom Management*, *54*(2), 245–258. https://doi.org/10.1016/j.jpainsymman.2017.03.017
11. Fioretti, C., & Smorti, A. (2017). Narrating positive versus negative memories of illness: Does narrating influence the emotional tone of memories? *European Journal of Cancer Care, 26*(3), e12524. https://doi.org/10.1111/ecc.12524
12. Fitzmaurice, C., Allen, C., Barber, R. M., Barregard, L., Bhutta, Z. A., Brenner, H., Dicker, D. J., Chimed-Orchir, O., Dandona, R., Dandona, L., Fleming, T., Forouzanfar, M. H., Hancock, J., Hay, R. J., Hunter-Merrill, R., Huynh, C., Hosgood, H. D., Johnson, C. O., Jonas, J. B., … Naghavi, M. (2017). Global, Regional, and National Cancer Incidence, Mortality, Years of Life Lost, Years Lived With Disability, and Disability-Adjusted Life-years for 32 Cancer Groups, 1990 to 2015: A Systematic Analysis for the Global Burden of Disease Study. *JAMA oncology, 3*(4), 524–548. https://doi.org/10.1001/jamaoncol.2016.5688
13. Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin, 132*(6), 823–865. https://doi.org/10.1037/0033-2909.132.6.823

14. Freda, M. F., Lemmo, D., Auriemma, E., De Luca Picione, R., & Martino, M. L. (2023). From sense to meaning: Narrative Function Coding System for the experience of illness. *Qualitative Research Journal*, *23*(1), 41–61. https://doi.org/10.1108/QRJ-06-2022-0081
15. Gil, F., Grassi, L., Travado, L., Tomamichel, M., & Gonzalez, J. R. (2005). Use of distress and depression thermometers to measure psychosocial morbidity among southern European cancer patients. *Supportive care in cancer*, *13*(8), 600–606. https://doi.org/10.1007/s00520-005-0780-0
16. Kaptein, A. A., 2021. Writing cancer. Support. *Care Cancer 29* (8), 4375–4380. https://doi.org/10.1007/s00520-020-05920-0
17. Lai, J., Song, H., Wang, Y., Ren, Y., Li, S., Xiao, F., Liao, S., Xie, T., & Zhuang, W. (2023). Efficacy of expressive writing versus positive writing in different populations: Systematic review and meta-analysis. *Nursing Open, 10*(9), 5961–5974. https://doi.org/10.1002/nop2.1897
18. Lancia, F. (2004). Strumenti per l'analisi dei testi. Introduzione all'uso di T-LAB. Milano: Franco Angeli.
19. Lee, Y., & Kim, E. (2026). Effect Size of Factors Influencing Colorectal Cancer Survivors' Quality of Life: A Systematic Review and Meta-Analysis. *Cancer Medicine,* 15(5), e71841. https://doi.org/10.1002/cam4.71841
20. Mahvi, D. A., Liu, R., Grinstaff, M. W., Colson, Y. L., & Raut, C. P. (2018). Local cancer recurrence: the realities, challenges, and opportunities for new therapies. *CA: a Cancer Journal for Clinicians*, *68*(6), 488–505. https://doi.org/10.3322/caac.21498
21. Martino, M. L., Nerini, A., Quarata, E., Facchini, G., Barraco, C., D'Arienzo, A., Nicastro, A., Cesaro, M., Freda, M. F., & Bolognini, I. (2026). Writing interventions with cancer survivors: which paradigms for which effects? A systematic review. *European Journal of Oncology Nursing*, *80*, 103045. https://doi.org/10.1016/j.ejon.2025.103045
22. Martino, M. L., Lemmo, D., & Gargiulo, A (2021). A review of psychological impact of breast cancer in women below 50 years old. *Health Care for Women International*, 42(7-9), 1066–1085. https://doi.org/10.1080/07399332.2021.1901901
23. Martino, M. L., Lemmo, D., Moylan, J., Stevenson, C., Bonalume, L., Freda, M. F., & Singer, J. A. (2023). The role and function of autobiographical memory narratives during the emotional processing of breast cancer treatment: an empirically-derived memory coding system. *International Journal of Environmental Research and Public Health*, *20*(2), 1492. https://doi.org/10.3390/ijerph20021492
24. Martino, M. L., Sebri, V., Singer, J., Madow, K., Giudice, A. V., Mazzoni, D., Freda, M. F., & Pravettoni, G. (2024). Specificity and integration of meaning in self-defining memories of breast cancer survivors: clinical reflections to promote a narrative identity integration. *Frontiers in Psychology*, *15*, 1433266. https://doi.org/10.3389/fpsyg.2024.1433266
25. McAdams, D. P. (2008). *Personal narratives and the life story*. In: John, O.P., Robins, R.W., Pervin, L.A. (Eds.), *Handbook of Personality: Theory and Research*. The Guilford Press, pp. 242–262.

26. McAdams, D. P., Bauer, J. J., Sakaeda, A. R., Anyidoho, N. A., Machado, M. A., Magrino- Failla, K., White, K. W., Pals, J. L. (2006). Continuity and change in the life story: A longitudinal study of autobiographical memories in emerging adulthood. *Journal of personality*, *74*(5), 1371–1400. https://doi.org/10.1111/j.1467-6494.2006.00412.x.
27. Merz, E. L., Fox, R. S., & Malcarne, V. L. (2014). Expressive writing interventions in cancer patients: a systematic review. *Health Psychology Review*, *8*(3), 339–361. https://doi.org/10.1080/17437199.2014.882007
28. Miniati, M., Miccoli, M., Ciacchini, R., Orrù, G., & Conversano, C. (2020). Defensive responses to stressful life events associated with cancer diagnosis. *Mediterranean Journal of Clinical Psychology, 8*(1). https://doi.org/10.6092/2282-1619/mjcp-2384
29. Neimeyer, R. A. (2019). Meaning reconstruction in bereavement: Development of a research program. *Death Studies*, *43*(2), 79–91. https://doi.org/10.1080/07481187.2018.1456620
30. Nieto, M., Navarro-Bravo, B., Moreno, B., Ocana, A., Serrano, J. P., Boix Gras, C., Ricarte, J., Fernández-Aguilar, L., Ros, L., & Latorre, J. M. (2019). Functioning of autobiographical memory specificity and self-defining memories in people with cancer diagnosis. *PeerJ, 7*, e8126. https://doi.org/10.7717/peerj.8126
31. Park, C. L. (2022). Meaning making following trauma. *Frontiers in Psychology, 13*, 844891. https://doi.org/10.3389/fpsyg.2022.844891
32. Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8*(3), 162–166. https://doi.org/10.1111/j.1467-9280.1997.tb00403.x
33. Sansom-Daly, U. M., Wakefield, C. E., Robertson, E. G., McGill, B. C., Wilson, H. L., & Bryant, R. A. (2018). Adolescent and young adult cancer survivors' memory and future thinking processes place them at risk for poor mental health. *Psycho-Oncology, 27*(12), 2709–2716. https://doi.org/10.1002/pon.4856
34. Schellekens, M. P., Zwanenburg, L. C., & van der Lee, M. L. (2024). Resilience in the face of cancer: on the importance of defining and studying resilience as a dynamic process of adaptation. Current Oncology, 31(7), 4003–4014. https://doi.org/10.3390/curroncol31070297
35. Singer, J. A., & Blagov, P. S. (2000). *Classification system and scoring manual for self-defining autobiographical memories*. Unpublished manuscript, Connecticut College.
36. Smyth, J. M. (1998). Written emotional expression: Effect sizes, outcome types, and moderating variables. *Journal of Consulting and Clinical Psychology, 66*(1), 174–184. https://doi.org/10.1037/0022-006X.66.1.174
37. Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01
38. Thomsen, D. K., Cowan, H. R., & McAdams, D. P. (2025). Mental illness and personal recovery: A narrative identity framework. *Clinical Psychology Review*, 116, 102546. https://doi.org/10.1016/j.cpr.2025.102546

39. Weiss, D. S. (2007). *The impact of event scale: revised.* In Cross-cultural assessment of psychological trauma and PTSD (pp. 219-238). Springer US. https://doi.org/10.1007/978-0-387-70990-1_10

40. Williams, J. M. G., Barnhofer, T., Crane, C., Hermans, D., Raes, F., Watkins, E., & Dalgleish, T. (2007). Autobiographical memory specificity and emotional disorder. *Psychological Bulletin, 133*(1), 122–148. https://doi.org/10.1037/0033-2909.133.1.122

41. Zainal, N. Z., Booth, S., & Huppert, F. A. (2013). The efficacy of mindfulness-based stress reduction on mental health of breast cancer patients: a meta-analysis. *Psycho-oncology*, *22*(7), 1457–1465. https://doi.org/10.1002/pon.3171

42. Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment, 52*(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2

DOI: 10.13129/2282-1619/mjcp-5473