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***“Growing from an Invisible Wound”* A Humanistic-Existential Approach to PTSD**

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Additional information is available at the end of the chapter

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Abstract

From a humanistic and existential perspective, posttraumatic stress disorder (PTSD) can be understood as a normal response to a threatening existential event. The humanistic-existential approach to understanding and treating PTSD also places particular emphasis on the meaning of the traumatic experience and on the awareness of the existential part of the self. Such an understanding conveys to a different approach to trauma assessment and potential for healing in the clinical encounter. In this chapter, we wish to provide a humanistic-existential understanding of trauma. To do so, we review the key humanistic-existential concepts for trauma conceptualization, assessment, and intervention. Afterwards, we present two different short case studies to illustrate and understand the humanistic-existential psychotherapeutic process and its diversity. In conclusion, we discuss the contribution and limits of a humanistic-existential approach to trauma conceptualization, assessment, and healing.

Keywords: humanistic-existential approach, meaning, posttraumatic growth, post-traumatic stress disorder

1. Introduction

From a humanistic-existential perspective, posttraumatic stress disorder (PTSD) can be understood as a *“normal response”* to a threatening existential experience. Such an experience may disturb our sense of inhabiting the world in a safe, coherent, and meaningful manner. As Greening [1] puts it: *“when we experience trauma, our relationship with existence itself is shattered.”*

The term “*Trauma*,” from the Ancient Greek “*trauma*,” refers to the notion of “*wound*” or “*damage*.” In that sense, PTSD may refer to the wound left by an experience that disrupted the person’s previous relationship to self, to others, and to the world. Trauma survivors are often said to live with an “*invisible wound*” in a state of relative chaos that may be left unnoticed. The only concrete manifestations of such internal suffering may narrowly be reduced to a visible configuration of symptoms.

As a matter of fact, mainstream approaches to “*assessing*” and “*treating*” PTSD are repeatedly criticized for their propensity to solely focus on the visible aspects of trauma: symptoms [1, 11, 12]. Therefore, the humanistic-existential perspective may be understood as a complement to the pathology-focused model, which may mainly aim at improving symptom management. The humanistic-existential approach to PTSD may not focus primarily on symptom, or even on the traumatic event itself. It may rather emphasize the exploration of the lived experience of the individual and, most importantly, of its existential meaning.

In this chapter, we aim to discuss how PTSD may be conceptualized, recognized, and healed from a humanistic-existential perspective. To do so, we will review the basic foundations of the humanistic-existential approach. We will explore its unique understanding of human being and his potential for growth and healing. We will also suggest how the humanistic-existential approach can offer a different outlook on trauma comprehension and healing through the introduction of two different case studies. Finally, we will discuss the limits and contributions of the humanistic-existential approach and its implications for the therapist’s stance.

2. Humanistic-existential approach: introduction and foundations

2.1. History and premises

Known as the “*third force*” in psychology, the humanistic-existential approach was founded in the 1940s in the United States. This movement was created as a distinct complement to the dominating behavioral and psychoanalytic traditions. Inspired by the existential and phenomenological philosophies, the founders of humanistic-existential psychology believed that the subjective experience is the starting point from which all comprehension may emerge [2–4]. A few authors are commonly associated to the humanistic-existential movement, notably Maslow, Rogers, Bugental, Frankl, May, and Yalom.

With such a focus on subjectivity, humanistic-existential psychologists rely on phenomenology to explore and understand the meaning of different human experiences. Phenomenology may be described as the investigation of the “*lived experience*,” as opposed to the study of an objective reality. Phenomenology, both as a clinical stance and as a research method, involves bracketing all assumptions about the world (and about the other) to illuminate the essence and the meaning of an experience. Phenomenologists aspire to get as close as possible to “*what it is like*” to be the other person, and to “*what it is like*” to experience the world as he or she does. Thus, humanistic-existential psychology is essentially concerned with the way a patient

experiences his symptoms or illness, as opposed to the actual presence (or absence) of symptoms or diagnosis.

In the 1960s, the founders of the humanistic-existential movement defined their approach by five premises, articulated by Bugental [5]. First, *human beings, as humans, supersede the sum of their parts. They cannot be reduced to components, symptoms, or behaviors.* This premise calls for a holistic comprehension of the human experience. It also calls for the necessity to explore an individual's experience beyond symptoms and behaviors. It aspires to honor and comprehend the uniqueness of each individual, and the unique meaning of one's lived experience.

The second premise states that *human beings have their existence in a uniquely human context.* As a result, the individual experience must be approached and comprehended in the light of its unique contextual reality. Humanistic-existential psychology is concerned with *being*, seen as an expression and influence of societal, cultural, and individual reflections that capture the most personal of experiences [6]. This assumption may remind us that the psychotherapist also develops his subjective comprehension of the reality from his own context.

Third, from a humanistic-existential perspective, it is presumed that *human beings are aware and aware of being aware.* Awareness and consciousness of awareness are major distinctive traits of human beings. Most importantly, it is believed that human potential for growth and healing is possible through the process of increasing awareness of one's experience of self, of others, and of the world. Greater awareness may allow the possibility to make choices and to exert one's existential freedom. As Frankl [7] puts it, humans carry the freedom and the ability to find meaning as long as they are conscious.

Fourth, *human beings also have the ability to make choices and therefore have responsibility.* Awareness and freedom inevitably come with the responsibility to act according to our will and values. It also accounts for recognizing one's responsibility—as opposed to biological or environmental determinism. Existential responsibility is believed to be one of the fundamental challenges of human existence, along with finiteness, isolation, and absurdity [8]. Human being cannot avoid confrontation to the absurdity of the modern world and—to some extent—to the absurdity of the human condition itself. Existential responsibility calls for the recognition of the inherent limitations and possibilities of our human condition. Most importantly, humans have the responsibility to search and create meaning out of life's journey. For Frankl, man's ultimate freedom and responsibility refers to his capacity to choose the attitude toward different life situations. Since death, loss, and suffering are intrinsically a part of what it means to fully experience life, the ultimate freedom and responsibility is to create meaning out of suffering [9].

Consequently, from a humanistic-existential perspective, *human beings are believed to be intentional, to aim at goals, to be aware that they cause future events, and to seek meaning, value, and creativity.* For instance, Frankl believed that (1) human beings carry the ability to find meaning as long as they are conscious; (2) they have a basic will to find such meaning; and (3) they carry within themselves the knowledge that life has meaning.

In summary, humanistic-existential psychology reintroduces the subjective experience as the first instance of the human existence. It relies on phenomenology and emphasizes the impor-

tance of the “*here and now*” knowing that the only moment we directly experience is “*right now*” — as we become aware of ourselves in the world. The humanistic-existential psychologist is concerned with the human experience as a whole, and recognizes the meaning and value of nonhedonist emotions and experiences, such as suffering, conflict, grief, guilt, and death. Inevitable loss, mortality, and absurdity are part of the human condition and are recognized as existential universal realities that all beings have to face and adjust to with their unique, creative, yet complex manner [8]. Those existential challenges and the suffering that comes with it are normal, but are also worthy and may be transforming. As such, suffering may open an opportunity for change and for potential healing and growing. Humanistic-existential psychotherapists have genuine interest and curiosity for every individual potential for growing and healing.

2.2. Human potential for growing and healing

The etymology of the term “*healing*” refers to “*wholeness*” or being “*whole*.” From the humanistic-existential point of view, psychotherapy may signify “*to make more whole*.” Wholeness may therefore be understood as a sense of completeness, integrity, and coherence. It may as well mean to exist more fully as a human being, including with the condition of being mortal. For May [10], health and healing means “*to experience more fully, deeply, consciously, and authentically one’s existence*.” The psychotherapy process consequently involves the exploration of barriers people may have, preventing them from experiencing and expressing their freedom in choices and will [11, 12]. Healing may as well be understood as a process that leads to a deeper and fuller engagement with the self, with others, and with the world. As Jager [13] puts it, “*being human means standing in a relationship to others, to things, and to the world*.” Healing may therefore occur in a relationship that allows the narration and reflection of one’s subjective experience. The other’s presence can be understood as a key allowing us to become more aware of ourselves, of the other, and of the world [14].

2.3. Healing together: the humanistic-existential encounter

It is within the clinical encounter that the process of healing can occur. The psychotherapeutic relationship involves the validation and value of the individual’s unique way of being. It also implies the recognition of the singular contribution of the therapist’s subjectivity. Hence, the psychotherapeutic encounter can be understood as a process of shared discovery in which the meaning of the patient’s lived experience is explored, understood, and eventually transformed. Repeated events of “*meaning*” and of mutual comprehension of the patient’s lived experience may allow a deeper awareness and more freedom of choice and will. New freedom, allowed and supported by the therapeutic relationship, opens up the possibility to seek and cocreate new meanings. The psychotherapist is therefore involved in articulating, comprehending, validating, and contributing to the patient’s search of meaning [15].

The humanistic-existential therapeutic encounter, as a unique and intersubjective space of cocreation, aims at supporting, promoting, or restoring the individual’s fundamental sense of self-cohesion [16]. As Quintin [15] puts it, psychological suffering is not something that can be fixed with expertise, opinions, or advices. The humanistic-existential stance rather refers to a

process of discovery of new meanings to replace one's old assumptions about the world that are no longer true. Previous meanings, as relic of the past, may obstruct the patient's sense of inhabiting the world in a free and meaningful way in his current life's situation. Old meanings cease to be coherent with the patient's actual experience of the world. Disruption of meaning or "*shattered assumptions*" [17] is at the core of the humanistic-existential comprehension of trauma.

3. Trauma: a humanistic-existential perspective

3.1. Trauma: taking a different path

In this section, we will explore how the humanistic-existential approach may shed a different light on the trauma experience and healing process. To do so, we will see how the humanistic-existential perspective can complement the bio-medical model, as both stem from distinct epistemological roots. Hence, we will review the common definitions of PTSD and will introduce the notions of subjectivity and meaning in trauma comprehension, recognition, and healing.

The humanistic-existential approach is concerned with how the individual experiences himself in the world. Therefore, it relies on the subjective experience and on its idiographic meaning as the starting point of comprehension and healing. From its Greek origin "*idios*," idiographic notably means "*applying to the individual*." Thus, idiographic exploration focuses on understanding the individual as a unique, holistic, and complex entity. It depends on detailed and descriptive explorations such as biography and case study to develop in-depth and intimate comprehension of the unique individual experience. Idiographic understandings are often contrasted with "*nomothetic*" research or assessment that primarily focuses on uncovering general patterns of behavior having a normative basis. For instance, nomothetic research on PTSD may want to develop an objective description of its symptomatology and to identify its risk factors and predictors of recovery. Such knowledge would apply to people generally as patterns, statements, or laws [18].

Another epistemological distinction may be necessary to understand how the humanistic-existential approach can complement the dominant psychopathology-centered model. Within the biomedical approach, PTSD is considered as a disorder, with universal characteristic features known as "*symptoms*." It is understood as an entity that exists "*objectively*" as long as its diagnosis criteria are met, despite contexts, nations, or culture. For instance, we may state that *Hannah*—who is a Holocaust survivor—and *Gloria*—who recently witnessed a major car accident—both suffer from PTSD, as they present with similar symptoms such as nightmares, avoidance, flashbacks, difficulty to concentrate, and mood alteration. Such a statement would refer to an "*etic*" approach to PTSD that is not specific to particular contexts, cultures, or nations. On the other hand, an "*emic*" perspective may try to develop a singular yet complex comprehension of Hannah's and Gloria's lived experiences of trauma. It would deeply explore their subjective world and the different meaning of their experience. It would inquire: "*How is it like to experience trauma for Hannah*?" "*How is it like for Gloria*?"

Based on its basic premises, the humanistic-existential perspective would necessarily approach trauma with an emic-idiographic perspective, as opposed to the etic-nomothetic stance. It may try to look beyond symptom and diagnosis to approach the unique meaning that trauma takes for a specific individual at this particular moment in his life.

3.2. Beyond symptoms: the invisible wound

Commonly accepted descriptions of PTSD involve exposure to a traumatic event that meets specific stipulations and symptoms [19]. The Diagnostic and Statistical Manual of Mental Disorder (DSM-5) currently identifies the trigger to PTSD as exposure to actual or threatened death, serious injury, or sexual violation. Different categories of symptoms characterize PTSD symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (p. 271).

By the nature of its definition, DSM-5 identifies a traumatic event as a trigger to the disorder. The resulting disorder may be understood as the indicator of an invisible wound left by the traumatic event. Therefore, the traumatic event is not the pathology, but rather the event that disrupted someone's existence, by revealing major existential threats: finiteness, disintegration, and assaults to integrity and dignity of the self and/or of a fellow human being. As Greening [1] evokes:

“What happens when we are traumatized? In addition to the physical, neurological and emotional trauma, we experience a fundamental assault on our right to live, on our personal sense of worth, and further, on our sense that the world (including people) basically supports human life. Our relationship with existence itself is shattered. Existence in this sense includes all the meaning structures that tell us we are a valued and viable part of the fabric of life.”

Greening captures the essence of the lived experience of trauma, and points out the deep disruption of existential meaning that it reveals. Surviving trauma is like waking up in a world that does not make sense anymore. In his book *“Shattered Assumptions,”* Janoff-Bulman [17] argues how trauma devastates our experience and understanding of the world we live in. Healthy human development throughout childhood is indeed facilitated by a perception of the world as being safe, benevolent, and meaningful, and the self as worthy. However, such beliefs could also contribute to the development of an *“illusion of invulnerability”* or, in existential terms, of avoidance of the part of absurdity of the human condition. Trauma reveals something about existence that cannot be integrated in a coherent and meaningful understanding of the self and the world. Symptoms are often seen as the biological, the psychological, and the existential self who is trying to adjust and integrate the meaning of what happened and, most importantly, the meaning of one's existence given a new existential reality.

As such, trauma survivors cannot heal from trauma unless they are supported as whole beings [6], including their existential self. Striving for health, wholeness, and meaning may be facilitated by the humanistic-existential encounter. This psychotherapeutic process first involves the exploration of the lived experience of trauma, of its meaning, and of past existential assumptions that have been shattered. It also involves building and cultivating new

awareness of what is still meaningful for an individual. Increasing existential awareness allows the exploration of new, different, and meaningful ways to connect to self, to others, and to the world. As such, it evokes not only healing, but also existential growing.

Humanistic and existential psychology has the premise that the human being has an inner tendency and potential for healing, but also for growing [5]. Hence, we can ask how people grow from trauma. Tedeschi and Calhoun [20] coined the term *posttraumatic growth* to capture the positive psychological changes they had witnessed as clinical psychologists among their patients who were coming to terms with highly stressful and challenging life events. "*Posttraumatic growth*" refers to the transformative process that can lead to positive changes after trauma. It has been a fertile notion to capture the transformation that may occur from gaining more existential awareness, and how it can transform one's relationship to self, to others, and to the world.

Of course, as trauma itself, posttraumatic growth is complex [21]. Its relationship with the trauma itself may be multifaceted. Here, we do not aim at reviewing the concept exhaustively, but explore the type of transformations that may be experienced by individuals who experience trauma. Our synthesis of diverse writings reveals indeed that there are new ways of relating and connecting to self, to others, and the world. Well-known transformation resulting from trauma reported by patients include: "*changes in the self*" or in the "*relationship to the self*." Such changes may take the form of an increased perception of personal strength, maturity, and spirituality [22]. An increased sense of personal worth and acceptance of one's vulnerability, sensibility, and humanity have also been reported by trauma survivors.

Such personal transformation with the relationship to self may also be mirrored in the experience of relating to others. Patients who survived trauma and healed from it are often moved by the compassion, sensibility, and care of others; feeling better connected to the people surrounding them, and experiencing more deeply or more consciously the preciousness of existing bonds.

Greater awareness and gratitude spread out and contribute to "*a greater appreciation for life*" in general [20, 23]. In fact, in a study examining the role of gratitude in PTSD in a sample of Vietnam War veterans, it is suggested that the experience of gratitude may be integral to this process of healing from trauma. For survivors, more gratitude may mean more pleasure in the small things in life, identification of new possibilities for one's life [22]. Enhanced appreciation of life itself has also been reported. For many, trauma was a trigger to reflect on life's meaning and absurdity. Despite distress, getting more awareness to the suffering aspects of life may also mean more awareness of its humanity and beauty. Existential awareness may allow clarity of life priorities, and more freedom to see "*new opportunities*." In short, for some people, healing and growing from trauma transformed their experience of the world itself.

3.3. Growing from adversity

A recent review of posttraumatic growth among individuals who had suffered severe physical injuries particularly caught our attention to understand the essential meaning of posttraumatic growth. Based on the meta-synthesis of qualitative research conducted with physically injured

trauma survivors, Kampman et al. [24] tried to capture the meaning of such an experience. The analysis highlights essential themes to describe the significance posttraumatic growth may take for physically impaired individuals following trauma.

First, the analysis suggests that the trauma experience forced individuals to question the very basis of their existence. It deeply moved them from their essential core. The findings of Kampman et al. highlight how traumatic injury may trigger existential awareness and force individuals to deeply reflect on the meaning and purpose of their lives. Posttraumatic growth also involves the contemplation and acknowledgment of the unchanged aspects of life, as well as the recognition of the changed aspects of life that are positive. Such an increase in existential awareness may lead to greater sense of meaning and purpose in life. Kampman et al. also noted in individuals a new awareness for physiological and psychological potential despite limitations, and gratitude for the fulfilling meaningful aspects of life that remain unchanged and that can still be part of life (e.g., physical activity, arts, travel). In other terms, it allowed people to experiment their world more fully and more consciously.

Finally, Kampman et al. insist on the deep personal qualities that can be developed from the experience of suffering. In fact, this is reflected in the statement of a participant in Salick and Auerbach (2006) study [cited by 24, p. 289]: *"I guess suffering makes you feel more human. You relate to other people."* Kampman et al.'s essential theme "humanity" tries to capture the increased sense of humanity developed among trauma participants. The authors define this new sense of humanity by altruism, kindness, and act of love toward fellow human beings.

3.4. Posttraumatic growth and existential awareness: making the invisible more visible

Posttraumatic growth can be comprehended as the increased existential awareness that is triggered by the traumatic event. Of course, the experience of trauma is not sufficient in itself to facilitate existential growth [20]. However, one of the recurrent themes in understanding the meaning of posttraumatic growth is the enlargement of existential awareness. Such awareness accounts for fuller appreciation of life and gratitude for the different sources of meaning in life remaining unchanged. Existential awareness may trigger an existential wound, but also reveal existential meaning.

Existential meaning in life was notably introduced in clinical psychology by Viktor E. Frankl (1905–1997). One cannot fully appreciate Frankl's work without considering his exceptional life's story. Austrian and born in Vienna from a Jewish family, psychiatrist and neurologist, Frankl lived for 3 years in different concentration camps during World War II. This period of suffering helped him to pursue the development of the existential approach.

Alongside with the premises of humanistic-existential psychology, the psychotherapeutic approach of Victor E. Frankl is based on meaning and responsibility. It is also based on the premise that human beings need to find a meaning to their life. Like the humanistic-existential movement, Frankl's approach is characterized by a unified understanding of all dimensions of a human being: physical, psychological, and existential. For Frankl, the existential self is the core of the human being, the essence of our humanity. This existential self carries in itself the drive of its expression and recognizes the occasions that allow this expression. It contains

resources that the individual can mobilize, allowing him to face disturbing and traumatizing situations.

Frankl had three more deep convictions about human being: (1) *The liberty of choice*, which supports that human beings carry the liberty and capacity of finding a meaning as long as they are conscious. Liberty of choice does not deny biological, psychological, or psychosocial determiners, but rather refers to the human capacity of consciously choosing an attitude when facing conditions of life. Frankl also believed in (2) *the choice of meaning*, which maintains that human beings possess an intrinsic will of finding meaning in life. Last, Frankl put forward the third concept (3) *meaning of life* which states that human beings know deep down inside that life has a meaning. The principle of the choice of meaning reminds us that human beings are motivated to find a meaning to their lives, that they are attracted by this search for meaning, rather than being pushed to act by some force or drive. Finally, the meaning of life refers to the meaning that each person gives to particular moments of his life, and not to a universal ultimate meaning that could be revealed at the end of life.

3.5. Man's search for meaning

For Frankl, three avenues contribute to give meaning to life: (1) *creative*, (2) *attitudinal*, and (3) *experiential values*. All these represent reasons why life has meaning. Deep recognition, concrete embodiment, and full awareness of these values allow human beings to face suffering and absurdity of the modern world.

Creative values represent what we bring to the world and those around us, anything we contribute to and create. Those values include, among other things, the meal that we prepare or the comfort we bring to a patient. What makes those simple actions significant is the level of consciousness in which they are set in. No matter how those actions can seem common, recognizing our contribution to a situation or to someone else's life adds to the meaning of our own life and brings satisfaction.

Experiential values signify that meaning can emerge from experiences as simple as appreciating beauty, whether it is artistic, natural, or in the experience of love; in fact, everything that is given to us, that we did not need to work for. The natural beauty of mountains, masterpieces of artists, as well as encouraging and loving relationships are given gratuitously and help us find a meaning and reasons to live. To Frankl, the salvation of man resides in his capacity to love (and to appreciate). Even if life can be generous and has the possibility to add meaning to our existence, a lack of consciousness and sensibility can keep us from seeing and enjoying it. Therefore, increasing our presence and consciousness is necessary to benefit from experiential values.

For Frankl, the third source of meaning resides in *attitudinal values*. He explains that meaning can come from the acceptance of situations that we cannot change and through a change of attitude toward inalterable situations. For example, death situations that involve physical, mental, and emotional suffering have the potential to bring meaning to the life of an individual and his family. Frankl suggests that human beings develop a greater spiritual and existential maturity and grow out of suffering, which can be enriching and strengthening. As such, Frankl

deeply believed that the suffering experienced from trauma may be transformed in an opportunity for growth. When the physical self, or even the psychological self, are threatened by trauma, the individual faces new forms of suffering. To be tolerated, this suffering has to be transformed in opportunities to find meaning. The possibility to give a meaning diminishes psychological suffering. Inevitable suffering can offer the opportunity to discover a meaning. Conscience is the tool that enables the identification or discovery of meaning. For Frankl, despite life experiences, human beings always have an opportunity to discover a meaning through creative, experiential, and attitudinal values.

For Frankl, if living necessarily involves suffering, surviving means giving meaning to suffering. As such, surviving from trauma would mean giving meaning to suffering and searching for new life meanings. Frankl's approach, alongside with humanistic-existential basic premises on human being, healing and growing offers support to explore, identify, and transform the experience of suffering from trauma. In the following section, we will explore how the humanist-existential approach, inspired by Frankl's theory among others, can concretely inspire psychotherapy with PTSD patients.

4. Different path on trauma and healing: two case studies illustrating a humanistic-existential therapeutic process

4.1. From object to subject: Mark's path through healing connexions

I first met Mark while I was working on an oncology ward as a psychologist. Mark had been diagnosed with lymphoma a few months earlier. His tumor had grown fast and spread to major lymph nodes. Mark started his treatment with great energy, hope, and trust to "*fight*" his cancer and go back to his "*normal, busy life.*"

However, one of Mark's lymph nodes, located on the right side of his neck, had grown fast and altered his ability to breathe, talk, and eat normally. Therefore, Mark had to go through surgery to remove the mass. During his surgery, he experienced the so-called "*awareness*"—a rare phenomenon reported by some patients under general anesthesia. Awareness usually occurs when one of the medications given fails. In fact, usually, different types of medications are given: one intends to "*cause unconsciousness*" and the other one to "*relieve pain.*" If the medication to render the patient unconscious fails, awareness may occur, although no pain is experienced. In other words, the patient wakes up, becomes aware of what is going on in the operating room, and of what is being done to his body. However, the patient has no mean to signify his awareness because of the muscle paralysis induced by the anesthesia. Therefore, the medical team does not know about the patient's experience, unless it is reported after anesthesia. In some cases, PTSD may arise after intraoperative awareness, causing the patient to require counseling for an extended period [25].

Mark was referred to me by his oncology nurse to whom he reported that "*he saw everything.*" He was distressed, but also very aggressive and upset about what happened during the surgery. He mentioned that the surgeon was treating him as a dead animal, and that he felt

like *"a piece of fabric under a sewing machine."* In fact, it seemed that Mark's awareness occurred precisely when the surgeon was stitching his neck following tumor removal. Mark wanted to leave the hospital as he no longer felt safe there. He refused meeting his surgeon and oncologist for postoperative follow-ups not trusting them anymore. He mentioned he would rather die home alone than to be assaulted by disrespectful physicians. Mark's medical condition (postoperative, immunosuppressed) and psychosocial situation (living by himself) made it impossible for him to go back home. His nurse convinced him to meet with me and to tell me his story of what happened in the operating room.

I first met Mark 2 days after his surgery, at his bedside. He was quite agitated and hyperaroused. His nurses confirmed that he was awake and agitated most of the time and that he refused all medications. He would take some pain killers, but only if they were administered by a particular nurse he trusted. Our first meetings allowed Mark to tell his story in details and to slowly build alliance with him, as he felt quite threatened by the whole medical team. I spent a few sessions seeing Mark every day, sometimes twice a day, to see how he was doing. Slowly, but surely, he started trusting me. He was still quite hyper and slept very little; despite the pain medication he was taking. At several times, we had multidisciplinary team meetings about his case to facilitate the team's understanding of his situation and to pay more attention to the way they approached him, knowing he felt threatened. As a matter of fact, Mark's young surgeon felt terrible about what had happened. At some point, he mentioned: *"I don't recall being rough or different with this patient... I had no choice to manipulate his body to remove the tumour... I don't know... maybe I wasn't careful enough."* The medical team validated that, indeed, it was a hard procedure and, although every medical gesture was well-intended, it must be traumatizing to experience such body manipulation while being awake. While I was building trust with Mark, I realized that his hyperaroused state made exploration difficult. I started thinking that introducing a light medication may facilitate our therapeutic process. Mark was still sleeping very little and experienced recurrent nightmares of his body being cut into small pieces and thrown away in the garbage as a waste. He would wake up in the dream, realizing that his body was cut into pieces and then, would actually wake up.

Regular sessions with Mark allowed further exploration of his lived experience of the surgery and nightmares. Mark kept asking to go home so he could rest and sleep. I validated his subjective experience of assault to his body during surgery and, as a result, that his body did not feel safe to rest. I mentioned that this state of hyperarousal might in fact be overwhelming for him and for his whole body. Hence, he asked: *"can we do something about it"*? I told him that we had different choices: we could wait a little longer, try relaxation techniques, or introduce a light medication that would help him feel calmer. Mark raised his fear of being asleep at the hospital and that his body would be mistreated. I validated this fear of being mistreated as a result of feeling mistreated by his surgeon. I also shared that I trusted his current medical team. He finally agreed to take a little dose of medication at night, so he could rest.

The following sessions allowed deeper exploration of Mark's experience of being assaulted. Indeed, although no assault to Mark's body was intended, he experienced a fundamental assault by the surgery experience, and it shattered his assumptions that his medical team was there to support him and care for his life. At some point, he reported how he felt like a rotting

carcass and, likewise, that is what will happen to him when he dies from his cancer. His body will be thrown away like a waste, with nothing left. At this point, I actually had the thought that Mark may be afraid of dying from his cancer, although he kept emphasizing his hope and trust. I was also struck by how he experienced himself as a body uniquely, like nothing would be left of him after his death. However, at this stage, such intervention or interpretation appeared to be premature so I gave more reflection to Mark's experience of himself and his body. From a phenomenological stance, the sensitive body is not an object in the world, but the place of anchoring from which it is lived by experience. Mark's PTSD happened notably from the awareness of being treated as an object by individuals he trusted.

I was then able to explore and validate Mark's experience of being treated as a "thing." One week after surgery, since nobody had clearly explained to him the "awareness" phenomenon, I decided to. Providing a rational explanation of Mark's experience was not used to confront him with the objective reality, but to start exploring other meanings in what had happened. Mark developed the understanding that the medical team did not know about his experience, including the surgeon. Although this information seemed to have partially comforted him, he added:

"They should be more careful." – They should care more about people... we are not cars, nor animals and we are not dead yet."

The day after, I was at Mark's bedside when his surgeon went by to assess the wound. Mark did not say much. He was not very collaborative, but did not display any aggressive behavior. As the surgeon quickly left, still feeling embarrassed about the situation, I asked Mark: "How was it to see him?" He responded that "it was ok, but that the surgeon still doesn't care." I asked him: "How do you think that your surgeon feels about what happened with you experiencing awareness and feeling mistreated in the operating room?" He responded that "surgeons don't feel anything; otherwise they wouldn't be able to do their job." As of that moment, there was a transformation that allowed Mark to relate differently to his surgeon and to his experience. We could therefore agree that he experienced an assault, but that such assault was not against him as a person, but against his cancer to cure the disease present in his body.

From then on, PTSD symptoms of hyperarousal lowered, but Mark still had nightmares. When he left the hospital after surgery, I continued seeing him as an outpatient, since he still needed to receive chemotherapy treatments. Because he was feeling much better physically, we started a deeper exploration of the story of his life and his experience of illness.

4.1.1. Mark's personal history and psychotherapy process

Mark had been divorced for nearly 10 years and had little contact with his three children, aged between 15 and 20 years. His mother was still alive and he also had a brother. Both lived in a distant city and so family contacts were quite limited. Since his divorce, Mark reported "having a series of relationships," none of which lasted more than 2 years.

Mark describes himself as a "doer." He dedicated the bulk of his time and personal resources to work. He filled many jobs, often in the field of management for various engineering and

telecommunication companies. On several occasions, he attempted to start up his own business, with no success. Mark was curious, a hard worker and very ingenious. He constantly had new ideas for solving all kinds of practical problems, but had a hard time completing his projects. Enthusiasm often led him to become scattered and overloaded. Thus, he accumulated aborted projects despite his innovative ideas. Left with a feeling of failure, he occasionally blamed others and claimed bigger financial rewards for his work. In fact, Mark lived under precarious financial conditions. When he received his cancer diagnosis, he was living with his then-girlfriend who supported him financially. Mark's girlfriend ended the relationship few weeks following the diagnosis, as she felt she could not cope with it. He expressed being concerned and having regrets not having built any material and financial heritage for his children.

During our sessions, it occurred to me that Mark was very labile. He would fluctuate between expansion movements, during which he was extensively discussing about his past accomplishments, and moments of profound distress where he would connect with his terror of death, a feeling of deep solitude, and his suffering of being ill. His chemotherapy treatments made him very symptomatic. It was stealing away his energy and affecting his ability to center himself and concentrate. He came to explicitly question the meaning and goal of his life. Along uncertainty, a constant monitoring of the progression of his tumor led him to first experience total despair and later idealized an improbable future in which he would be fully healed and where he would finally succeed in accomplishing the grandiose projects he was dreaming of.

At one point, I reflected to Mark how success at work had always been an important aspect for him. He agreed and added that it was, until now, the only important thing for him. In some way, it had been the unique source of meaning in his life. After a while, he was able to open up to the idea of having other sources of meaning in life, which were more consistent with the limitations imposed by the disease. In parallel to this exploration, Mark's life experiences led him to open up to various experiential values; he occasionally mentioned being touched by the care he was receiving, although he did not feel safe at first. Moreover, Mark felt good about the fact that the oncology personnel recognized him, remembered his name, and his situation from week to week. He also recalled passing by his surgeon while walking to his chemo treatment. His surgeon asked him how he was doing and, as a mean of connecting with him in a positive way, mentioned he did his best. Mark reported the event with mixed feelings of gratitude and sadness. Afterwards, he did not report having the same recurrent nightmare.

Mark also felt a lot of sadness and compassion toward the other patients he was in contact with and whose situation was sometimes more precarious than his. Often, Mark treated this information as insignificant details. However, during session, we started taking more time to stop and deeply explore these states of compassion and gratitude. By giving it time and attention, these states became more meaningful to a point where they eventually were consciously named as one of the meanings in his life. Because life contained such bursts of compassion and fraternity, it felt worth living.

Thus, the experience of being ill and the psychotherapy allowed Mark to raise his awareness to a new meaning through experiential values. Moreover, we came to identify an important role of suffering in the discovery of new values and sources of meaning. Compassion became

possible with the experience of being sick. Suffering could then become a transcending experience and allow for new possibilities of being.

Several months later, Mark had to be hospitalized again for pneumonia. He felt extremely isolated and suffered even more. I continued visiting him at bedside. He could phrase that he was terrified by the idea of dying. His suffering was so important that he even wished to die. However, being accompanied through his solitude allowed him to realize the importance of emotional bond and human connexion. This growing awareness led him to rebuild contact with his children and ask for his mother and brother to visit him. To this day, Mark still has contact with two of his children. The relationship is sometimes hectic, but he satisfies himself from having found the courage to reunite with his family.

Further to his hospitalization, Mark was admitted to a long-term care facility where he currently lives at a relatively independent level. He is assisted in managing his medical situation, which calls for constant monitoring. His gratitude toward life increased. He changed his need to fulfill himself into a modest but concrete implication in the center where he lives. He puts his ingenuity to the service of other residents by improving life conditions, by performing valuable services, and organizing new activities. Sometimes, he mentions that he wished he had "*done more*," but he realizes that his actions have never been that concrete to contribute to the world around him. Most importantly, this became a source of meaning for him. Mark lives modestly but in a much consistent way.

On several occasions, Mark shared his feeling of failure for not having accumulated a material heritage. In the face of this unchangeable situation, the last stage of the psychotherapy permitted a change of attitude. He certainly did not have money, a house, or any objects to leave behind. Nevertheless, the richness of his experience was invaluable. He had faced illness with courage and committed to a profound transformation through a physical challenge. Hence, he was not leaving anything material behind, but his legacy was one precious teaching. This thought was very comforting for Mark who has now engaged in writing his story for his children.

After just over a year of psychotherapy, Mark still lives with a cancer although currently medically controlled. The progression of his illness is constantly monitored and he is well aware that relapse may occur at any time. However, for the first time, he reports that even if his cancer reoccurred, he could leave with no regret. He also keeps inside the profound truth that he is capable of a humble happiness, that he was able to transcend suffering, and that his illness will never steal away his gratitude, his good actions, and his capacity to love. It is therefore with confidence in his ability to transform psychologically that Mark views the future. He remains sad and sometimes anxious about the suffering that awaits him, but these fears do not dominate him as before.

Mark's psychotherapeutic process allowed the exploration and some transformation of his relationship with himself, others, and his world. It allowed some reintegration and reconstruction of different part of himself. As he said, he metamorphosed from doing to a being. The therapeutic encounter and the support received by the medical team and the exchange with his surgeon enabled him to rebuild and reconnect with a sense of humanity and with a

view of a world as meaningful, caring, and benevolent. Mark no longer defines himself as a doer. He has come to experience himself as a relational and existential being, with a past, a present, and a future. He also sees his current illness as a transformative experience. He considers this transformation as an opportunity for legacy and transmission that is not material, but that may support his children in their own search of meaning and purpose in life.

4.2. Eleanor: meaning of survival

I met Eleanor, 22, a few years ago while I was starting my private practice as a psychologist. Eleanor has lived in Canada for 12 years. She left Rwanda—her country of origin—in 1998, following the 1994 genocide against Tutsis. Eleanor was referred to me by Dr. Lemond, one of my previous clinical supervisors, who had been Eleanor's psychologist a few years ago. Dr. Lemond was now retired and she called me to meet with Eleanor, as she knew I had worked in Rwanda with survivors in the past. With Eleanor's approval, Dr. Lemond sent me a short report of her story and healing process. Dr. Lemond had been involved with Eleanor shortly after she immigrated to Canada as a refugee. She saw Eleanor as an outpatient at the children mental health facility where she was working at the time.

When Eleanor called me, she quickly mentioned being tired and having some nightmares "again" but that those "were not the same as they used to." Eleanor mentioned that she would prefer not having to tell her story again, especially since that "her current situation was not related to her past." To Eleanor, it did not make sense to talk so much about the past and she explicitly mentioned seeking consultation to feel better in the present and to go on with her future.

I had considerable hesitation about reading Eleanor's story before actually meeting her, especially given her insistence that her current difficulties were not related to her past. Having worked in Rwanda before, I had heard many stories of trauma: most survivors had witnessed horrors perpetrated by neighbors, had escaped death during weeks, had to deal with grief for an entire family; family they had seen perish in violent deaths... and more... I certainly did not want to have strong preconceptions that may reduce Eleanor's whole experience to her traumatic story. I also wanted to connect with Eleanor's strength and current life experience. Nevertheless, given Eleanor's consent and probable expectations about me knowing her story, I decided to read Dr. Lemond's report. After reading, as consciously and as reflexively as possible, I tried "suspending all judgments about what would be real" about the person she had become years after. I wanted to take a phenomenological stance that would allow the exploration of Eleanor's subjective current life experience of the here-and-now.

4.2.1. Eleanor's story

Eleanor was 6 years at the time of the genocide. As a member of a Tutsi family, she had grown in a world of tensions in which her identity as a Tutsi defined her as a minority. The mass killings in Rwanda happened from April to June 1994, following the crash of the presidential plane by extreme Hutu radicals. Then, massacre against Tutsi started.

Six-year-old Eleanor and her family were attacked in mid-April 1994, at home, overnight. Eleanor had witnessed the cruel killing of her mother, father, and big sister as she was hiding

under her sister's bed. Being the youngest of a family of four kids, Eleanor did not have her own bed and used to sleep either on cushion, on the floor, or sometimes in her big sister's bed after begging her for a little room. The night of her family killing, Eleanor was on the floor right beside her sister's bed, who was already asleep.

Eleanor could not sleep as she was noticing a conversation between both her parents in the living room who were worried about the recent death of close Tutsi community members. Eleanor recalled being so afraid while listening to her parents' conversation that she could not sleep. At some point, she noticed more and more noises coming from outside. She recalled hearing men yelling and women screaming. Afraid of those distressing noises, she hid under her sister's bed. Noises became louder and louder until she realized that there were people in her house. She recalled hearing her mother's and father's voices, but could not remember what had been said. At that point, her sister woke up and screamed for her mother. Eleanor remembered that people entered the room. She heard screams and hits that seemed to her as not having lasted long. After a while, there were no more noises. Eleanor, terrified and distressed stayed under the bed for hours, as she recalled it. She finally got out of her hiding place and discovered the bodies of her mother, father, and sister. Afraid, she left the house and went hiding into the woods for ... "*a while*," as she remembered.

Somehow, Eleanor made her way—alone—to a refugee camp close to the border of Uganda. She lived there by herself for almost a year, taken care of by nongovernmental organization (NGO)¹ workers. At some point, a Canadian NGO worker named Marissa, accompanied by someone from the Canadian embassy, happened to be looking for her. As mentioned in Dr. Lemond's report, Eleanor reported feeling confused while speaking with Marissa and "*the other Mzungu*."² *This Mzungu, she was very nice to me. She just explained to me that I had an aunt in Canada who was looking for her family members here, in Rwanda.*

As a matter of fact, Eleanor happened to have an aunt, Eglantina, in Canada. Eglantina, aged in her early fifties, was actually the sister of Eleanor's grandmother. She had left Rwanda in the 1980s. She had fallen in love with a Canadian humanitarian worker and the couple married in Rwanda in the 1980s. Very aware of the ethnic conflict that was getting increasingly violent, they decided to fly to Canada and live there. Eglantina still had some contact with her family in Rwanda, but could not reach them during the genocide. In the fall of 1994, Eglantina started actively searching for her family by making contact with different Canadian and foreign NGOs. As her research was progressing, she discovered that most of her family had perished. The whole process has been accompanied with great grief and losses.

Fortunately, she was able to find Eleanor and, as a mean to reconnect with her Rwanda origins and traumatic losses, adopted her. Eglantina facilitated her immigration to Canada as a refugee. Eleanor flew to live with Eglantina and her husband, Louis. Both Louis and Eglantina offered a supporting environment to Eleanor. By the time Eleanor started school in Canada, she was almost 10. Needless to say she was struggling with adjusting to this completely new and different world. She experienced more and more anxieties, and struggled with adjusting

¹ Non-governmental organization

² This term is a familiar designation given to white people in Rwanda.

to different life areas. She had frequent nightmares and night terrors, panic attacks almost every day, social anxiety, introversion, tear bursts, etc. At school, she could not concentrate and she did not seem to be able to make contact with other kids, nor teachers. Following Eleanor's teacher's advice, Eglantina and Louis sought professional help at the outpatient children clinic close by. From the age of 11–15, Eleanor has been followed by Dr. Lemond.

4.2.2. Meeting with Eleanor

The first meetings with Eleanor allowed the exploration of her current life's situation. I also explored Eleanor's experience of therapy as a kid, and the meaning that therapy have for her. She mentioned feeling very grateful for the help provided by Dr. Lemond. The therapist, who she recalled as a nice, kind, and very patient woman, reminded her of her own mother. From her first psychotherapy process, Eleanor reported that it felt good to have someone knowing her complete story. She also mentioned that although she had a hard time with telling the things she saw, it helped her to stop thinking about it. With time, her images had become blurrier every day, to a point that she could not quite remember her parents' traits. Eleanor had tearful eyes when talking about it, but also stated that she learned to live with it. She mentioned still struggling at times with not knowing what happened to her brothers who were not home the night of the killings as they were studying in a boarding school in another city.

Eleanor said that therapy enabled her to feel calmer about her souvenirs and more *"ok with everything that happened. It took three years for me to be cured from my trauma,"* she said. She added that *"the techniques with the eyes (EMDR)³* helped her to feel calmer. Eleanor was aged 16 when she completely stopped seeing Dr. Lemond. She recalled feeling quite well; she was doing well at school and managed to graduate from high school. Excelling in school, Eleanor decided to go to college, and to become a nurse. She was still living with Eglantina and Louis, who kept supporting her in her new life project. Although Eleanor had some difficulty adjusting to *"so much studying,"* she felt happy with her choice.

Eleanor became increasingly anxious as she started her first practical training. Although she felt proud about her career choice, she mentioned feeling sick when being at the hospital. She also reported feeling dizzy, not being able to think clearly, and experiencing confusion in the presence of sick people. She precisely described an event in which she was in the emergency room and had to witness her supervisor do the assessment of a 10-year-old girl who had been in a major bike accident. The young girl had multiple fractures, and blood all over her. The smell of blood made Eleanor instantly sick and she had to leave the room to vomit.

This event made Eleanor even more anxious. She was afraid of falling in front of everybody. As a result of her anxiety symptoms, she started missing days of training. She would stay in her room all day either sleeping or watching TV shows to change her mind. Eglantina and Louis started being concerned about Eleanor's change in mood and behavior. They first interpreted it as a lack of motivation to work hard. Eleanor kept saying that she was tired and

³ EMDR stands for Eye Movement Desensitization and Reprocessing. This type of therapy is commonly used for the treatment of traumatic memories. For more details, see [26].

started to lie about her schedule or obligations. Quite upset about her attitude, Louis and Eglantina tried to confront her. Eleanor recalled a conversation with Louis, in which he mentioned: *“You should feel responsible to do something meaningful with your life.”*

After this conversation, although Eleanor’s anxieties were still present, depressive symptoms took over: she was sleeping more and more, staying in her room all day, and not eating. She reported being tearful at times, without understanding why. Following Eglantina’s suggestion, Eleanor started to consider psychotherapy again.

4.2.3. Eleanor’s current experience and psychotherapy process

I started exploring Eleanor’s current situation, as she experienced it. I tried to suspend all my preconceived interpretations, and to inquire about how she felt here and now. I notably asked Eleanor about the reasons that brought her to seek psychotherapeutic help. She responded by asking me if I knew her story. I answered that I had spoken with Dr. Lemond and that I had read about her psychotherapy process with her. Then, Eleanor responded that her current situation was not about her past. So, I asked her what was going on for her. She responded *“I am tired all the time.”* Therefore, I explored Eleanor’s fatigue, asking her to further describe her experience of being tired:

M: *How is it like for you when you’re fatigued?*

M: *How is it like for you when you’re fatigued?*

E: *I don’t know... I just feel like sleeping...*

M: *And... how is it like when you actually sleep?*

E: *It depends... sometimes it’s good...I don’t feel anything, so it’s good...but sometimes I have nightmares...again...*

M: *Again?*

E: *Yeah... I used to have them when I was younger... But they are not the same. They are not about the past.*

M: *Do you feel comfortable sharing one of your nightmares with me?*

E: *...Yeah...it’s always the same that keeps coming back...*

M: *Okay... Tell me about it...*

Then, Eleanor explained that she always dream of being at the hospital, as a nurse. In her dream, there are people crying and screaming for help. There are people everywhere and not enough staff to take care of them. At some point, Eleanor’s supervisor asks her to be more efficient and to work faster. She tries to get someone’s medication and then she freezes. She cannot move. People scream louder and louder and Eleanor’s supervisor yells at her to hurry up, but she cannot. She usually wakes up after her supervisors tells her she is fired for being lazy, useless, and worthless.

Eleanor kept her eyes on the floor while narrating her dream. When she finished and looked up at me, her eyes were in tears. I delicately asked her what made her tearful. She responded feeling guilty about not being strong enough to become a real nurse, who actually cares for others. I was surprised with such a statement and further explored what it meant for her not to be "*strong enough*." Then, she reported the incident in the emergency room, where she felt sick seeing the young girl who was injured and covered with blood following her bike accident. She reported feeling bad for the young girl and feeling guilty for not being able to provide a proper response to the situation, as was expected from her.

Although Eleanor mentioned her feeling about the situation, we agreed to discuss it further since the event seemed to have precipitated some of her current suffering. In a following session, we discussed the scene again, with phenomenological exploration. We explored bodily sensations she had experienced back then, as well as the bodily sensations she may experience while remembering the scene. To her, the smell of blood was particularly unbearable and she would be nauseous in the session just remembering it. Gently, I dared to inquire what images came to her mind while smelling blood. She then recalled the view of her family, covered with blood and explained how she ran away from it as a little girl. Crying loudly, she expressed that maybe she should have stayed there and died with them; or maybe they were still alive. She should have tried to save them. She felt like betraying her sister by hiding under her bed. She should have died with them. She described herself as weak and selfish to have escaped instead of facing her destiny. She should have at least tried to save them and to be courageous enough to face death doing so. Why did she think that her life had more value than her parent's or sister's? Why them and not her? She was now stuck to survive. Even worse, she had to do something worth with her life so she could pay back her debt, but was too weak and worthless to actually do it.

Phenomenological and detailed exploration of Eleanor's experience of fatigue, sleep, nightmares, and bodily sensations allowed revealing her feelings of guilt and worthlessness. In fact, Eleanor experienced herself as being guilty to survive and in debt toward life and her family. As she was trying to pay back her debt as a survivor, she felt stuck—again—with a sense of worthlessness and weakness.

With Eleanor, therapy involved slowly trying to reinterpret her past differently and to find new meanings in her experience as a child and as the only survivor of her family. Psychotherapy aimed at exploring and sharing about her story, so that she could slowly build a new understanding of herself, as being resilient, courageous, and compassionate. As a therapist, I started supporting her whole being, including her unique qualities. At some point, I even mentioned that I wished she could see herself as I saw her. We worked on developing her self-compassion. We worked on understanding her sensibility and great empathy toward others as a strength she developed through her own suffering.

We also revisited the strength, discipline, and resilience she had to exert to survive physically and emotionally. We discussed how she had already healed from most of her traumatic experience and that now, there was an opportunity for growing from it by existing more fully as a whole person, not only as a survivor in debt. We discussed how such a process of growth

was complex and profound, and that it required time. We worked on reintegrating her story in a different way, so she could try to relate to herself, to others, and to the world more freely.

While Eleanor seemed to slowly get better (having more energy and no more nightmares), she wanted to know more about “*growing*” from trauma. At this point, I decided to lend her my book “*Man’s search for meaning*” [27], in which Frankl tells about his own history of concentration camps and in which he extrapolates his theory on life’s meaning. Eleanor was particularly moved by the understanding that suffering may have meaning. Following this reading, she initiated rich and deep discussions about the different sources of meaning in her own life. Notably, she mentioned increasing her awareness and gratitude of the value of the relationship she had with her adoptive parents. She would still feel guilty at times for what the world has given her, but would also be able to relate to her experience differently, which motivated her for a fuller engagement toward life. In fact, Frankl’s strong thoughts about self-engagement toward life empowered Eleanor to continue to search for and to create her own unique and valuable way of living a purposeful existence.

In the meantime, Eleanor continued to take nursing classes on a part-time basis. She temporarily postponed her practical training and started volunteering at the hospital to see if she could develop a new way to relate to others’ illness and suffering. By volunteering, Eleanor experienced rich human contact and compassionate care with patients and got progressively used to witnessing suffering. She created significant bonds with patients and other caregivers, and received good feedback on her listening abilities, kindness, and compassionate way of being. Such bounds may have facilitated her sense of worth and value. Eleanor started giving meaning to her suffering, thinking that her past history contributed to cultivate her sense of humanity and compassion. We worked on cultivating this self-compassion, especially when her feelings of guilt and worthlessness would surface.

After a moment, Eleanor felt that she was ready “*to fly a bit on her own.*” The overall psychotherapy process lasted 18 months, on a regular weekly basis. Before saying goodbye, Eleanor and I identified what her next challenge may be: for the first time, she was thinking in building an intimate relationship with someone. Although the idea pleased her, she was still terrorized by physical and psychological intimacy and quite aware of the challenges it would be to develop attachment toward someone. She fluctuated between states of hope (being with someone), desire for self-protection, and preservation (it is easier to be alone) or self-depreciation (no man would be interested in me). To date, Eleanor still struggles with self-worth at times, but has come a long way from the first time I met her.

5. Discussion

By presenting Mark’s and Eleanor’s cases in detail, we wanted to show how PTSD can take various forms of expression. Its experience and healing process are complex and unique to every individual, despite common symptoms. PTSD may be understood as a complex experience that has biological and psychological components, but also cultural and existential. A humanistic-existential approach to PTSD emphasizes the exploration of the patient’s lived

experience, as well as the idiographic meaning that trauma takes for the individual. By relying on phenomenology and on the safety of the therapeutic encounter, a humanistic-existential psychotherapy for PTSD aims at exploring new meanings for the traumatic event and new meanings to surviving, healing, and growing.

In both cases, we wanted to show how the therapeutic process aimed at exploring the history and the lived experience of Mark and Eleanor. In both cases, the exploration process allowed to shed light on the meaning of the traumatic experience itself, as well as the disrupted meanings of life as it was experienced here and now. The co-comprehension enabled by the therapeutic encounter made possible the exploration of other meanings of the event, and of a search for new meanings in life. In both cases, the psychotherapeutic process involved exploration, comprehension, and reconstruction. This sequence should not be seen as linear, but as a repeated and iterative process.

We have chosen cases that honor the diversity and the complexity of PTSD manifestations, origins, recovery, and, most importantly, meaning. In both cases, we offered a humble, yet incomplete view of the meaning of humanistic-existential psychotherapy with trauma patients. With both cases, we also wanted to show how humanistic-existential psychotherapy can be complemented by other approaches.

For instance, in Mark's case, symptom management was first ensured by medication for allowing conditions of deeper exploration. As a matter of fact, exploration may not be possible if the person is constantly in a state of arousal. In Eleanor's case, she had already completed 3 years of psychotherapy before addressing the existential aspects of her traumatic history. Moreover, in the future, Eleanor may again be confronted with life's situation that will reopen her wound. Major grief or loss could trigger PTSD symptoms and another psychotherapeutic process may be helpful at that time. Such experience may not be understood as static conditions that can be treated, but as major existential challenges that may as well be an opportunity for existential growth.

The humanistic-existential psychotherapy has often been criticized for being too intellectual or too abstract. By presenting concrete, yet incomplete case studies, we aimed at illustrating different ways to approach PTSD from a humanistic-existential perspective. That being said, such an approach may not be relevant or helpful with all PTSD patients. In the cases presented above, both Eleanor and Mark were able to verbalize their lived experience and reflect upon their existence. In that sense, they already had significant existential awareness.

However, the therapeutic process being coconstructed between the therapist and the patient, we can imagine how different therapists may have approached Mark's and Eleanor's stories differently. Different path would have been as valuable. The humanistic-existential movement represents a great diversity of approaches that may differ in their philosophical roots, premises, definitions, and views of psychotherapy. Although of crucial importance, more detailed descriptions of those nuances appeared to be beyond the scope of this chapter.

Humanistic-existential psychotherapy may also share theoretical thoughts or even therapeutic techniques with other approaches. In fact, some third wave cognitive psychotherapy may

include relaxation techniques such as mindfulness meditation that are congruent with the approach we presented. It is also close to Frankl's description of experiential values. Moreover, Frankl's belief in man's ability to take a different attitude toward situations that cannot be changed may be part of the acceptance and commitment therapy. However, the humanistic-existential approach distinguishes itself from others by its focus on increasing existential awareness and, therefore, freedom of being. Such a freedom accounts for new existential responsibilities: to live a life that is coherent and meaningful.

6. Conclusion

Accompanying patients like Mark and Eleanor, as a humble facilitator of their deep and meaningful transformation was a privilege. For PTSD patients, being in presence of a well-intended witness through the exploration of their suffering may be the first step to allow the reconstruction of human connectedness that is often disrupted by trauma.

For the therapist, the recognition of the other as a sensitive subject, a fellow human being who experienced traumatic suffering, may as well be a transformative experience that should not be left unnoticed. Patients' existential suffering also represents our own suffering as human beings. Others' suffering may as well be the suffering we all share—or will share—as a result of our human condition of being mortal, aware, free, and responsible.

In recent years, there has been increasing interest for the experience of professionals working with individuals who suffered from trauma. In fact, the concept of posttraumatic growth may as well apply to professionals. Arnold et al. [28] claimed that therapists also experience positive changes in many areas of their lives such as relationship to self, others, and to the world. Being in touch with human's profound suffering and transformative growth may be a source of existential meaning for therapist. In a recent study, Ben-Porat [29] actually suggests that secondary exposure to trauma can lead both to distress and traumatic growth. Potential for human connection and supporting work environment may allow therapists to develop and maintain a balance between potential distress and growth.

As a therapist, and as an existential being, both life and work offers intense moments of human connections and may be deeply and existentially meaningful. Cultivating awareness and sensitivity may also help therapists to fully appreciate the beauty and uniqueness of human connections. By allowing ourselves to be existentially touched by our client's lives, we have to be open to also be transformed by the therapeutic encounter. In the tribute to his mentor Rollo May, Pitchford [6] captures the essence of the ultimate, free, and responsible existential engagement we have as humanistic-existential therapists working with suffering and growing individuals:

"I had to freely choose whether or not to take risks in my own life, to take responsibility for those risks, or to remain in a state of comfort, avoidance, and security. I knew that if I were to avoid risks, I could potentially miss out on discovering further potentialities about myself."

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