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Violence Survivors With Posttraumatic Stress Disorder: Treatment by Integrating Existential and Narrative Therapies

Kristen W. Day

The author proposes the addition of narrative and existential therapies to current empirically based treatments for victims of interpersonal violence who are experiencing posttraumatic stress disorder (PTSD). A brief history of PTSD, current diagnostic criteria, and cultural influences in relation to this disorder are addressed.

The breadth of interpersonal violence is continuously expanding. According to Broman-Fulks et al. (2006), epidemiological studies estimated that between 50% and 70% of individuals in the United States have experienced some form of interpersonal violence during their lifetime. Interpersonal violence and trauma are exceedingly complex phenomena that have cultural, social, political, and psychological implications (Carlson, 2005; De Silva, 1993; Goto & Wilson, 2003). One constant commonly associated with interpersonal violence is the prevalence of posttraumatic stress disorder (PTSD) among survivors of such violence (Phillips, Rosen, Zoellner, & Feeny, 2006). The complexity of working with survivors of interpersonal violence who are experiencing PTSD makes it imperative for clinicians to provide holistic treatment that attends to all of these layers. In this article, I propose an integration of existential and narrative therapies with current evidence-supported approaches to treating the aforementioned population. First, I briefly define interpersonal violence, then provide a history and review of the diagnostic criteria for PTSD, which frequently results from such crimes. I then address cultural influences that could have an impact on diagnosis and treatment, followed by current treatments within the mental health field. Finally, I review the essential components of existential and narrative approaches and conclude with a discussion of how a combination of these treatment modalities could be beneficial for counselors in their work with survivors of interpersonal violence.

INTERPERSONAL VIOLENCE

Interpersonal violence is defined here as an encounter that "threatens or manifests bodily or emotional harm" (Gore-Felton, Gill, Koopman, & Spiegel, 1999, p. 294). There are various forms of interpersonal violence, for example, sexual assault, domestic violence, executions, emotional abuse of children and spouses, terrorist attacks, mass shootings, torture, and other forms of homicide. The diffusion of impact can range from a single victim of assault to thousands

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affected by a mass shooting. Unfortunately, interpersonal violence is becoming a more common occurrence across the United States (Gore-Felton et al., 1999). In 2002, an estimated 1.6 million people across the globe died from self-inflicted, interpersonal, or communal violence. Of these, one third were homicide victims, and about 170,000 died as a direct result of mass violence (World Health Organization, 2007). The disruptive effects of interpersonal violence can be a determinant of mental health (Satcher, Friel, & Bell, 2007). Because of the growing evidence of such violence, it is important to understand the psychological consequences of it (Gore-Felton et al., 1999).

PTSD

History

PTSD is a relatively new diagnostic category, although pathological responses to stressful events have been acknowledged in various contexts for decades (De Silva, 1993). The study of psychological trauma has been chronically forgotten because it provokes powerful controversy and requires one to encounter the essence of human vulnerability and villainy (J. Herman, 1997). It has been postulated that the conception of this disorder was in the late 19th century and was originally referred to as *hysteria*. At the time, most physicians considered hysteria to be a "disease proper to women and originating in the uterus" (Sgroi, as cited in J. Herman, 1997, p. 10). French neurologist Jean-Martin Charcot was one of the founding scientists to study the controversial disorder. Through various case studies, Charcot was able to demonstrate that the root of hysterical symptoms was psychological (J. Herman, 1997).

Charcot later passed the proverbial investigative torch to physicians Sigmund Freud, Josef Breuer, and Pierre Janet. Through conversations with patients, Janet developed the concept of dissociation as a defense mechanism to traumatic events (De Silva, 1993). Although Janet, Freud, and his colleague Breuer were in different countries, all began to conceptualize that hysteric symptoms were camouflaged representations of traumatic events that had been displaced into the unconscious mind (J. Herman, 1997). These investigators also unearthed how verbalizing memories associated with traumatic events lessened hysteric symptomatology in their patients. Although Freud made vital contributions to the field of mental health and the development of this phenomenon, he later recanted his initial hypothesis that hysteric symptomatology was associated with exploitative premature sexual encounters because of colloquial rejection. This recall disempowered many patients and stifled initiative in the field that would have led to the further development of his ideas and efforts to treat this cluster of symptoms (J. Herman, 1997).

Diagnosis and Assessment

Although this symptomatology dates back several centuries, the diagnosis of PTSD did not appear in the *Diagnostic and Statistical Manual of Mental Disorders* until its third edition (*DSM-III*; American Psychiatric Association [APA], 1980). Criteria were further refined and defined in the current edition of the *DSM (DSM-IV-TR;* APA, 2000). Symptomatology begins with exposure to a

markedly distressing personal experience "involving actual or threatened death, serious injury, other threat to one's personal integrity, witnessing a traumatic event that involves death or serious injury, learning of threats or actual injury resulting in acute harm or death of a family member or close associate, or sudden destruction of one's home or community" (APA, 2000, p. 463). In addition, the following criteria must be met and persist for more than 1 month:

1. The person has been exposed to a traumatic event in which his or her response includes intense fear, helplessness, or horror.
2. The traumatic event is consistently re-experienced via intrusive thoughts, recurrent nightmares about the incident, feeling or acting as if the past event is currently occurring, severe levels of psychological distress when exposed to internal or external reminders of the event, and/or physical reactivity when exposed to such cues.
3. Persistent avoidance of stimuli associated with the trauma and a numbing response as signified by avoidance of conversation and/or activities associated with trauma, inability to recollect aspects of trauma, decreased interest in significant activities, detachment from others, and loss of future oriented ideation.
4. Increased arousal as indicated by inability to fall or stay asleep, enhanced irritability, difficulty concentrating, hypervigilance, and/or heightened startle response. (APA, 2000, pp. 467–468)

Although any life-threatening event can generate psychological repercussions, interpersonal violence is especially likely to produce severe PTSD symptoms (McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000). Current research has targeted war veterans as the predominant population when studying PTSD (North, Smith, & Spitznagel, 1997). Yet this diagnosis is not confined to the battlefield. Community-based studies have demonstrated a lifetime prevalence of PTSD in about 8% of the U.S. adult population (APA, 2000; De Silva, 1993). PTSD has also been reliably represented in a wide range of countries, including all populated continents (De Silva, 1993; Goto & Wilson, 2003; Sack, Seeley, & Clarke, 1997). PTSD has affected various cultural, ethnic, and religious groups. With such a significant prevalence, it is essential to consider the cultural context of traumatic stress so that individuals who have been diagnosed with PTSD are assessed and treated effectively (De Silva, 1993).

CULTURAL INFLUENCES ON PTSD

Although interpersonal violence is a globally dispersed phenomenon, the definition and associated psychological reactions have yet to be universally established (De Silva, 1993; Kroll, 2003). Research still lacks a concrete delineation concerning the interaction of genetic and environmental factors, specifically the impact of national, ethnic, social, and cultural influences on prognosis (De Silva, 1993; Lanius, 2007). The relationship shared between culture and the psychological effects of PTSD is complex and has been found to surmount certain cultural and language barriers (Wilson, as cited in Goto & Wilson, 2003; Sack et al., 1997). The notion that

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PTSD is solely a biologically based reaction to trauma independent of culture is a naïve and universalistic concept (Kroll, 2003). Traditionally, culture has been considered a filter of personal experiences, including the appraisal of traumatic events (Goto & Wilson, 2003). According to Kroll, an individual's psychological response to trauma is influenced by his or her cultural norms. Although there have been similarities regarding common symptom manifestation across various cultures, it would be faulty to assume that current Westernized treatments that focus on cognitions and beliefs can be used cross-culturally (Goto & Wilson, 2003; Kroll, 2003; Sack et al., 1997).

Within the mental health field, there is also a call for culturally sensitive therapies that take discourse and power issues into account when treating survivors of interpersonal violence. It is essential, therefore, that treatment approaches consider the cultural context of the survivor, as well as the "symbolic and moral meanings attached to the traumatic events" (Kroll, 2003, p. 669).

CURRENT PSYCHOTHERAPEUTIC TREATMENTS

According to J. Herman (1997), a leader in the field of trauma treatment, there are three key components to assisting individuals recover from psychological trauma. In the immediate aftermath of trauma, it is first essential to secure the client's safety (J. Herman, 1997). After safety has been established, the second task is remembering and mourning, which entail reconstructing the traumatic event. Finally, it is important to empower the client to reconnect with supportive networks (J. Herman, 1997). Traditional treatment of trauma-related disorders is often considered an individual process (Merscham, 2000). Although there is not a consensus on the most appropriate strategy for treating survivors of violence, predominant treatment modalities reflected in the literature are cognitive behavioral therapy (CBT), exposure therapy, anxiety management, psychoeducation, and the use of selective serotonin reuptake inhibitors (Amstadter, McCart, & Ruggiero, 2007; Foa, Hearst-Ikeda, & Perry, 1995; Gore-Felton et al., 1999; Litz & Gray, 2002; Marotta, 2000; Schnurr et al., 2007). The five techniques can be combined as a multimodal approach, with meta-analytic findings demonstrating that CBT has shown the largest effects (Amstadter et al., 2007; Schnurr et al., 2007).

Cognitive behavioral treatment attempts to alter maladaptive thought patterns to improve emotional and behavioral reactions associated with the traumatic experience (Schnurr et al., 2007). The predominant focus of treatment is to reduce trauma-related stress by enhancing the client's awareness of his or her "negative thoughts and dysfunctional beliefs and to modify them via cognitive restructuring techniques" (Amstadter et al., 2007, p. 643). Cognitive restructuring, relaxation techniques, enhancement of positive coping, and assertion skills are other approaches used when treating clients experiencing PTSD (Foa et al., 1995; Gore-Felton et al., 1999). Anxiety management is another treatment approach that teaches clients how to effectively manage physical symptoms associated with distress (Amstadter et al., 2007).

Exposure therapy involves directly exposing clients to trauma cues with the goal of desensitizing and decreasing the client's anxiety over time. Therapists

use either imagined or in vivo exposure to induce fearful or anxious responses (Amstadter et al., 2007). Another type of exposure treatment that has accumulated a small body of empirical research is eye movement desensitization and reprocessing (Carlson, 2005). This short-term method combines elements of cognitive behavioral, psychodynamic, body-based, and other approaches, the goal of which is to process disturbing memories (Shapiro & Maxfield, 2002). Using the focus on therapist-directed dual attention stimulus, the client is able to integrate new associations with traumatic memories (Shapiro & Maxfield, 2002).

The goal of psychoeducation for survivors of interpersonal violence is to provide current information about the prevalence of such criminal acts and typical psychological responses. The essence of psychoeducation is to counteract the negative thought patterns formulated after victimization and the positive reinforcement of healthy coping skills. Risk reduction strategies, normalization, and issues involving safety are also addressed (Amstadter et al., 2007).

According to J. Herman (1997), "recovery can take place only within the context of relationships" (p. 133). Although the aforementioned traditional treatment modalities involve multiple components, there appears to be a lack of evidence regarding cultural influences, reestablishing connections, and empowering the client to take ownership of his or her choices. CBT does provide techniques that assist the therapist in assessing and correcting a survivor's negative thought processes and illogical beliefs, yet it is questionable how that approach comprehensively promotes the re-creation of the trauma narrative. The client's entire worldview needs to be considered so that growth and second-order change can be promoted; thus, using a postmodern approach that incorporates internal processing and consideration of contextual influences could enhance treatment outcomes. Existential and narrative therapy in particular may be well-suited to a holistic approach.

SUGGESTED TREATMENTS FOR SURVIVORS OF PTSD

Existential Therapy

Existential therapy is a phenomenological journey that denounces the deterministic view of human nature and assists clients in finding value, significance, and purpose in their lives (Dreyfus, 1962; Fernando, 2007; Seligman, 2006). This approach is not based on a system of techniques but rather is a sincere attempt to understand the client's worldview via the therapeutic encounter (Dreyfus, 1962). The overarching theme of this theory is to authentically connect with one's real self in the present moment (Fernando, 2007). When a client is able to establish this connection, awareness is heightened, as is the ability to find and satisfy parts of the self that have been denied previously (Bugental & Bracke, 1992; Fernando, 2007). The inevitability of our and our loved ones' deaths, freedom to make our lives as we will, isolation or ultimate loneliness, and meaninglessness are four inescapable givens that ground our existence (Yalom, 1989). These premises spark the anxiety in the individual that arises when she or he is confronted with the issue of fulfilling life's potentialities (May, Angel, & Ellenberger, 1958; Yalom, 1980).

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Although death is inevitable, human beings endlessly attempt to negate this truth via denial, distraction, and personification (Yalom, 1989). Existentialists propose that humans are free agents with the ability to choose their way of being (Dreyfus, 1962). With this choice comes the assumption of responsibility, which can serve as a catalyst for change (Dreyfus, 1962; Yalom, 1989). *Existential isolation* refers to the undeniable distance that exists between self and others, even in the most intimate relationships (Yalom, 1989). *Meaninglessness* signifies a loss of significance associated with one's purpose and certainty of universal meaning (Dreyfus, 1962). Existential therapists strive to assist clients in paving productive paths for their suffering rather than alleviate emotional pain (Fernando, 2007). Assisting the client in "discovering possibilities where none seemed previously to exist, is an intrinsically powerful experience for those who have felt powerless and empty" (Bugental & Bracke, 1992, p. 31).

Narrative Therapy

Narrative therapy is a strength-based social constructive model that stresses empowerment and the intersubjectivity of the client (da Costa, Nelson, Rudes, & Guterman, 2007). This approach encourages clients to illustrate their dominant stories that are assumed to be influenced by cultural, societal, familial, political, and historical contexts (Monk, 1997; White & Epston, 1990a). An open and nonjudgmental consideration of the client's cultural context is an essential component in establishing the collaborative therapeutic relationship because it allows the client to be heard on his or her own terms (McGill, 1992; Richert, 2003).

During the process of joining, the narrative therapist extends much effort in listening empathetically as a means of validating the client's experience, seeking immersed meaning and themes, and examining external factors that affect the client's ability to move toward his or her goals (Petersen, Bull, Propst, Dettinger, & Detwiler, 2005; Richert, 2003). Using this collaboration and emphasis on themes, the therapist can externalize and deconstruct the problem as a means of cocreating a new story that is saturated with the client's strengths, assets, and preferred outcomes (K. C. Herman, 1998; Richert, 2003; White & Epston, 1990b). By focusing on these factors, the therapist is able to incorporate an optimal worldview, empowering the client to live in ways outside his or her typical narrative, thus positively reinforcing newly established meanings and goals (Kirven, 2000; Richert, 2003).

This treatment modality is driven by the idea that therapeutic encounters are subjective and culturally infused (Gremillion, 2004). Consolidating psychological development with societal phenomena establishes the groundwork for multicultural applicability when treating individuals with PTSD (McGill, 1992). By considering macro- and microinfluences as well as personal strengths, this approach could be used with people from varying backgrounds and those having traumatic stories. It is important, therefore, for counselors to consider how growth can be multidimensional.

THE BENEFIT OF INTEGRATING PSYCHOTHERAPIES

Existential issues sparked by traumatic experiences are "notably less discussed in the trauma literature than are the cognitive, affective, and somatic impacts,

although this seems to be an emergent theme" (Jenmorri, 2006, p. 45). According to Bracken (2001), PTSD symptomatology is rooted in an individual's loss of meaning after crisis and is "intimately bound up with the cultural dynamics of post-modernity" (p. 736). Culture imbues the experiences of its members with meaning and purpose. The experience of trauma is embedded within a cultural context, as communities sustain situated narratives that infuse meanings into how one interprets particular experiences (Lewis & Ippen, 2004). I believe that this interweaving adds existential–narrative components to current evidence-supported treatment modalities, which could enhance successful outcomes when treating survivors of interpersonal violence experiencing PTSD symptoms. Grendlin (as cited in Richert, 2003) has argued that the process of creating meaning is the interaction between symbols and living in the moment; thus, this collaboration could holistically assist a survivor of interpersonal violence restory and restore his or her lost sense of meaning. Both approaches share a phenomenological perspective that values the internal and external forces that help shape a client's subjective worldview (Richert, 2003; Roysircar, 2004).

To be effective, the therapist should consider how the client's belief systems, values, lifestyle, and modes of problem solving mold his or her worldview (Thomas, 1998). Narratives are powerful scripts that set the stage for thoughts, feelings, and actions. They influence the individual's conception of the past, movement in the present, and how the future is envisioned (Jenmorri, 2006). Incorporating the client's story within his or her worldview allows for a more in-depth analysis of dysfunctional beliefs and enables the therapist to embrace existing differences, thereby laying the foundation for intra- and interpersonal restoration (McGill, 1992). In addition, these models allow for the search for meaning, and they seek to explore and restory the client's sense of purpose. By using storytelling to elicit meaning, the client has a framework for depicting and reprocessing his or her trauma story (Richert, 2003). Telling one's story in a here-and-now modality opens up the potential to loosen the grip of the past pain to work with the suffering and to recover one's lost sense of being (Bugental & Bracke, 1992). Being present-focused could also assist the therapist in normalizing the client's experience as well as expose and desensitize the client to his or her pain, both of which are goals of the previously reviewed CBT and exposure treatments.

Narrative and existentialist therapists generate authentic encounters that could empower the client to adapt the problem-focused thoughts that engulf his or her narrative (Richert, 2003). The therapist is a coexplorer who assists the client in actualizing and mapping past meanings derived from traumatic events that currently affect the client as a means of reconstructing such meanings to fit a more accepting perspective (Lantz, 1995; Yalom, 1980). In essence, by focusing on the client's story within an empathetic, nonjudgmental way, the therapist is able to provide a space for scaffolding new perspectives, thereby cocreating an experience that challenges the client's typical narrative and promotes refinement of assertion skills (Beaudoin, 2005; Richert, 2003). Thus, this combination would infuse both the content and process components of effective treatment by addressing the verbal and nonverbal cues presented through the process of exploring the trauma narrative and its underlying meanings (Richert, 2003).

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A single act of interpersonal violence could encompass exposure to the threat or possibility of death, restricted freedom, and isolation from support and rescue. To recover the lost sense of power, an individual must become aware of and connect with the anxiety and residual emotions associated with these givens to redefine the trauma and strengthen his or her sense of self (Bugental & Bracke, 1992). To facilitate reframing that trauma so that it can be a catalyst to greater understanding of self, the therapist needs to empower the client to realize that he or she is responsible for responding to and overcoming his or her own pain. Hope is another key component that can empower a client to elicit meaning from a traumatic experience (Frankl, 1959). When combined with insight, hope can strengthen the possibility of actively healing and enable the client to reframe the suffering as an avenue for affirming his or her inner strength and meaningfulness (Jenmorri, 2006).

Use of externalization may enable the client to take a collective appraisal of his or her misery to reduce avoidance and immobilization toward channeling pain and creating future goals (Fernando, 2007). Once connected with his or her pain, the client might be more inclined to embrace anxiety management techniques versus sustain avoidance and numbing mechanisms, which ultimately fuel negative coping skills. Through the use of externalization, mapping of meanings, and respect for the external and internal influences that shape the client's worldview, this integrated approach could empower individuals with PTSD to redevelop their trauma narratives within the context of a supportive relationship. Infusing existential and narrative components within a cognitive-based treatment approach not only would empower clients to restructure their cognitions but also would enable them to fully experience their suffering, thus strengthening their self-awareness and allowing them ultimately to regain the essence of personal power and meaning.

FOSTERING HEALING IN THE FACE OF TRAUMA

The following clinical example depicts how a counselor can use the proposed integration when working with a victim of interpersonal violence. It is derived from current research and my clinical experiences and concludes with proposed treatment suggestions.

> Claire (a fictional composite of several clients) is a 19-year-old woman who came to the college counseling center for "nervousness" and "high levels of anxiety." She is an only child in a Christian family and is from a rural area. She is in her sophomore year of college and is seeking treatment to assist her in coping with symptoms associated with a sexual assault she experienced the previous year at a fraternity party. She acknowledged that she had become more anxious and nervous over the last year and is having difficulty sleeping. She is finding it more difficult to concentrate in her classes, and her attendance is dropping because of her efforts to avoid being in proximity to others. In addition, she is spending more time alone in her room because she does not want to interact with her roommate and believes people think she is "easy" because she was intoxicated at the time of the assault; she did not reveal that she did not consent to intercourse.

Clients are the authors of their own lives. Each moment is scripted in multiple layers that are socially constructed and defined by cultural ideals (Beaudoin, 2005). As the example illustrates, clients who have experienced sexual assault will often develop PTSD symptoms and initially interpret the choices made during the trauma event, their associated reactions, and their adjusted self-concept in a self-deprecating light. To provide holistic treatment, the counselor should address both PTSD symptoms and the client's narratives that have been distorted after such an attack. External stimuli, people within the individual's support system, and distressful thoughts that serve as a reminder of the attack are often avoided by survivors of sexual assault (Jaycox, Zoellner, & Foa, 2002). Self-blame is also common and could reinforce the client's avoidance of social support (Ullman, Townsend, Filipas, & Starzynski, 2007). Nightmares are a common symptom of 60% of individuals diagnosed with PTSD and can reinforce feelings of powerlessness and restlessness (Kilpatrick et al., as cited in Krakow et al., 2002).

Common general assumptions held by rape survivors are that the world is not safe and that they are unable to cope with their symptoms and stress. In addition, it is not uncommon for sexual assault survivors to designate negative identity labels to themselves as illustrated in the following statements: "If I could not speak up for myself, does that mean I am easy?" or "I am so weak; I should have fought back harder" (Beaudoin, 2005). Therapeutic interventions that are based on existential and narrative components should externalize and deconstruct such scripts and emphasize that one's identity and the meaning associated with the traumatic event are personally determined.

By reconstructing the traumatic narrative, Claire is given the space to reconnect with her identity and is encouraged to see how that identity is not defined by what others have done to her but rather by her ownership of responses, intentions, and congruency with her core values (Beaudoin, 2005). Bringing these thoughts and assumptions to the forefront by working with the therapist in the here and now enables Claire to extract meaning from the traumatic experience. Re-creating meaning and purpose is central to positive growth in trauma work (J. Herman, 1997; Tedeschi, Park, & Calhoun, 1998). Also, because this integration focuses on the strength and authenticity of the therapeutic relationship, Claire is able to learn how to reconnect with others. Because Claire is grappling with the aftermath of sexual assault, perceived growth could be derived from "changes in perception of self, changed relationships with others, and a changed philosophy of life that includes a deeper appreciation for life, along with new directions and priorities" (Calhoun & Tedeschi, 1998, p. 358). After Claire has learned and effectively utilized relaxation, and positive coping and assertion skills, she will have the foundation necessary to begin speaking directly about the trauma. This verbalization not only serves as a desensitization tool but also enables Claire to rewrite her role in the culturally influenced trauma narrative. By addressing her thoughts, feelings, and associated choices, Claire could redraft the meaning derived from this experience and how she could use this insight to become an agent of change in defining her future life chapters.

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