

# Other-Being: Traumatic Stress and Dissociation in Existential Therapy

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## Abstract

In the present article, we set out to conceptualize and reframe posttraumatic stress and dissociation from an existential perspective. We employ an Other(s)-focused lens for understanding trauma, which we define as an evaluation of a response to a painfully unpredictable Other who can be a person or event. In this way, we propose that what is traumatizing is the person, or Being, in relation to an Other who traumatizes. Traumatic stress is a term which encapsulates a Being's meaningful and chosen responses to an Other who traumatizes. Dissociation is a unique phenomenon in which a person attempts to escape the Other who traumatizes by forging a felt sense of space between the person and the trauma. Existential therapy, then, is a relationship with a new Other who embodies and highlights ways of being with the trauma which honor rather than escape the pain. Finally, we put forth a therapeutic way of being which is attuned to the uniqueness and agency of the individual taking up the trauma.

## Introduction

Traumatic stress and dissociation are frequent topics of scholarship, practice, and debate within the field of psychology. There are myriad understandings of trauma phenomena, including historical, cultural, social, political, medical, and psychological. There are also several manifestations of trauma which carry a constellation of diagnostic labels: depression, anxiety, stress disorders, dissociation, somatoform disorders, brief psychosis, substance abuse and dependence, borderline personality disorder, and most recently, complex posttraumatic stress disorder (Briere & Scott, 2006; Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Individuals who experience trauma incur higher healthcare costs, more frequent medical visits, and lower overall health (Campbell, 2002; Frayne, et. al, 2004; Herman, 1992).

With such high stakes and vast implications following trauma, it is perhaps not surprising that much work has been done to identify risk factors for being a victim of trauma. Of these, being poor, a person of color, and a woman are the most prominent, suggesting that those who tend to be marginalized from society are also the most likely to be victimized by trauma (Briere & Scott, 2006, p. 14). Additionally, having lower-than-average coping skills, nervous sensitivities, or a previous history of mental illness/trauma, can predispose someone to trauma (Briere & Scott, 2006, p. 14). For those who find themselves in a traumatizing situation, immediate responses of anger, shame, or guilt indicate an increased probability of traumatic stress (Andrews, Brewin, Rose, & Kirk, 2000; Leskela, Diepurink, & Thuras, 2002; Stolorow, 2007). Situations involving intentional violence, as in domestic violence or combat, as well as sexual victimization are typically seen as the most traumatic (e.g., Andrews et. al, 2000; Campbell, 2002; Foa & Rauch, 2004; Foa & Rothbaum, 1998; Keane, Fairbank, Caddell, & Zimering, 1989; Sar, Akyuz, & Dogan, 2006).

These risk factors differ from historical understandings of trauma. Freud (1922) theorized a "repetition compulsion" that indicated an effort to "master" the trauma (Herman, 1992), an understanding which mirrors present-day understandings of re-experiencing phenomena. Janet (1919) wrote about a need to "assimilate" traumatic experiences into a person's ongoing life, and he saw helplessness as the primary condition to rectify in trauma therapy. More recently, psychiatrist Judith Herman (1992) wrote: "Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force" (p. 33). Fellow psychiatrist Mardi Horowitz (1986) also wrote about trauma as a fracture in "inner schemata," supporting the more recent view of trauma as having a profound impact on what continental philosopher Martin Heidegger called one's being-in-the-world (Heidegger, 1927/1962). Stolorow (2007) married psychoanalytic and existential understandings to conclude trauma represented a dissolution of "'absolutisms' that allow one to experience one's world as stable, predictable, and safe" (p. 19).

This article sets out to demonstrate how conceptualization and care from an existential standpoint are not only viable, but even congruent with more medically-modeled ways of understanding trauma. We reframe The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) criteria for Posttraumatic Stress Disorder to provide a bridge between attending to the practicality of working within a standardized system of care and honoring the unique pain of the individual. Toward this end, we employ an Other(s)-focused lens for understanding trauma, which we define as an evaluation of a response to a painfully unpredictable Other who can be a person or event. In this way, we propose that what is traumatizing is the person, or Being, in relation to an Other who traumatizes. Traumatic stress is a term which encapsulates a Being's meaningful and chosen responses to an Other who traumatizes. Dissociation is a unique phenomenon in which a person attempts to escape the Other who traumatizes by forging a felt sense of space between the person and the trauma. Existential therapy, then, is a relationship with a new Other who embodies and highlights ways of being with the trauma which honor rather than escape the pain. By fully engaging the uniqueness of Being in the traumatizing situation, it is possible to create a therapeutic environment which facilitates expansion rather than reduction.

### Posttraumatic Stress

As the primary diagnostic tool used by those who practice psychology and psychiatry, the DSM-5 delineates five main symptom categories, one or more of which must be present in order to be diagnosed with Posttraumatic Stress Disorder (American Psychiatric Association, 2013). DSM-5 added a symptom category for disturbances in mood, but otherwise DSM-IV-TR frames the disorder quite similarly (American Psychiatric Association, 2000/2013). DSM-5 Criteria A defines a traumatic event as something which can be experienced personally, as a bystander, or even as someone learning secondhand of the event which might occur once or several times over a period of months or years (American Psychiatric Association, 2013, p. 271). Though several theories seek to explain the aftermath of trauma, there is a generally agreed-upon distinction between posttraumatic stress disorder (PTSD) and what has more recently been identified as complex trauma (Briere & Scott, 2005; see also Herman, 1992). Posttraumatic stress disorder has typically been framed as a response to a single, time-limited event, whereas complex trauma reflects the recurrent, severe, and often developmental difficulties experienced by individuals whose etiology is far more convoluted (van der Kolk et al., 2005).

What all traumatic events seem to have in common is an encounter with finitude: the existential given of non-negotiable uncertainties and inescapable limitations of what we can control or orchestrate in life reminds us of the ever-present possibility of death. Trauma also evokes what is often referred to in the literature as a shattering (e.g., Herman, 1992; Janoff-Bulman, 1992; Joseph & Linley, 2005, 2008; Stolorow, 2007), which throws us toward our own end and reminds us of the ephemeral nature of being. Paidoussis-Mitchell (2012) found that individuals who are traumatically bereaved undergo a similar phenomenon, which she refers to as an ontological awakening. In any case, trauma represents an irreversible shift in one's life story, or historicity. The experience of trauma, whether omnipresent or encapsulated in a single event, highlights the truth that we live in a world in which we are chronically vulnerable to an Other who can hurt us.

Herman (1992) recognizes the fateful role of the Other, politicizing it while invoking a sense of social responsibility for the way traumatic responses manifest in survivors of trauma: "In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting. Repression, dissociation, and denial are phenomena of social as well as individual consciousness" (p. 9). With her words, Herman taps into the existentiality of all meaningful situations, which are taken up uniquely but also in the world (Heidegger, 1999, p. 97). It is only through awakening to the uniqueness, or mineness in Heidegger's (1999) language, of the traumatic event that a person can locate or differentiate themselves from the rest of the world. What we all have in common as human beings is our radical uniqueness, which paradoxically maroons us and renders us inextricable from other people, whose perception of us we rely upon to know we exist (de Beauvoir, 1972, p. 7). Put another way, we are all being(s)-in-the-world who are simultaneously alienated from and yet painfully close to Others who cannot know our pain as we do. This existential ambiguity is what allows for the felt sense of being "torn from a communal fabric" (Stolorow, 2007, p. 20) while still being integral to it.

Being(s)-in-the-world are subject to unknowing Others, who might stigmatize and subjugate, but they are also agents of their own existence. Heidegger writes about Dasein, or the mineness of a person's agency this way: "And because Dasein is in each case essentially its own possibility, it can, in its very Being, 'choose' itself and win itself; it can also lose itself and never win itself; or only 'seem' to do so" (Heidegger, 1999, p. 123). This enframing expands on Herman's understanding and elucidates the relationship between the individual's meaning-making and trauma as a phenomenon in the world. Meaning is disclosed in a person's unique taking up of a situation. If we choose the meaning of a situation and call

it trauma, it discloses that we choose it to be traumatic. It does not feel like a choice when a person is buckling under the gravity and mattering of the event; nevertheless, once the meaning is unfolded, it is agency, not forced traumatization as Stolorow (2007) suggests, that appears in the foreground. We know this to be true because of fact that two people experiencing the same event can come away from it unscathed or traumatized, depending on the meaning ascribed to the situation. In this way, agency is not choices; it is choice. It is important to establish that while the event is most often inflicted, imposed, and even institutionalized by an Other in the case of rape used as a tactic of war, it is by definition personalized and lived out in a way which reflects the chosen meaning of the life that is forever altered.

Locating a person's agency in the midst of trauma is perhaps a hallmark distinction between an existential trauma therapy and other more medically-modeled ways of working. Criteria B of PTSD in DSM-5 highlights this discrepancy with its description of "intrusion symptoms"--a term borrowed from Herman (1992) meant to indicate a re-experiencing of the trauma. Herman's (1992) stance on trauma is that it is a victimization; that is, a moment in which a person is stripped of his or her agency and subjected to the will of an Other. This moment, then, replays in the person's mind via flashbacks, nightmares, and persistent thoughts or images (Yehuda, 2004). While this is a widely-recognized trauma phenomenon, there are many possible meanings for the kind of re-experiencing that often occurs following trauma. Existentially, a person's *habitas* (Merleau-Ponty, 2002), or tendency toward conjuring a traumatic event or image upon external prompting can also be understood as an existential resurrection. In fact, the person is not re-experiencing the trauma, as it is in the past and temporally inaccessible. But an individual resurrects the event as a way of honoring the trauma's place in his or her story-- even actively taking up the event in the present using the mind's eye. As such, the present moment represents a convergence of that which has altered the person's story and that which has not yet come to pass; the resurrection is an ecstases, in Heidegger's (1927/1962) terms. In this sense, the person's experience is not merely a "traumatic reliving" (Stolorow, 2007, p.25), but rather a re-construction comprised of the past event and the anticipated painful future lived out in the present.

Indeed, resurrection as re-call or re-collection might be an attempt to escape the pain inherent in a trauma narrative by collapsing the ontic into the ontological, or believing that the unique moment of the trauma is actually a universal truth (Heidegger, 1927/1962). For example, in the case of a woman who was raped as a young girl by her mother's boyfriend who was a tall man with brown hair, it might be difficult to tolerate standing by a tall man with brown hair at the bus stop as an adult due to her past experience. It was a particular man with brown hair who raped her as a child, but often individuals who are living with deep-seated traumatic stress generalize their trauma to other situations, thus, exacerbating the feeling that one is unsafe and vulnerable in the world. Of course, this felt sense is complicated by the existential pain that comes with being a human whose safety is always uncertain to a degree. Existential pain is a vivid encounter with our smallness as human beings in light of that which is ontological (T. DuBose, personal communication, September 4, 2013). In this way, existential pain can be transformed by coming to terms with the non-negotiable limitations faced in a traumatic situation, but often the pain remains in place if "what ifs and if onlys" attempt to overcome what cannot change (DuBose, 1997). Trauma is an encounter with human vulnerability, or the possibility that any one of us at any time can be preyed upon or abused by an Other being. Traumatic stress, then, we argue, is a realistic response to the experiential knowledge that this is the case and not a deficit needing to be extinguished.

Hypervigilance is encapsulated in Criteria E in the DSM-5 (American Psychiatric Association, 2013), and it is generally the primary focus of PTSD treatment (Briere & Scott, 2006). It is also the way of being in the world which sediments, to use Spinelli's (2007) term, the afflicted ways of mooding referenced by DSM-5 Criteria. Existentially, however, hypervigilance is one route through which existential pain expresses itself in the world. One is understandably vigilant so as to not be sideswiped again, which is indeed a lived experience of self-care. Indeed, hypervigilance constricts one's experiences of trust, but this itself is another agentic choice due to chosen privileging of values and projects, and it can be re-chosen.

When a trauma occurs, the tectonic plates of the soul shift toward the disturbing truth that the Other is unpredictable. A person's historicity, or story, is forever altered following such a realization, and it is difficult to know how to be in a world which does not have to be benevolent. At the same time, part of our thrown and non-negotiable limitations as human beings is that we are faced with choices and stances at any and every moment. One of those choices might lead to being preoccupied by efforts to escape the uncertainty intrinsic in existence. Such a person might develop a habit of sitting with one's back to the wall or might adhere to strict self-imposed guidelines about when one can be out of the house or what one can wear in public; he or she might embody reminders of the trauma through chills, shakes, and rapid heart rate (Paidoussis-Mitchell, 2012; van der Kolk et al., 1996). It is easy to jettison these ways of being by declaring them irrational--many trauma protocols seek to desensitize a person to these kinds of responses via repeated exposure. However,

this is faulty engineering, as these responses might not be ‘hyper’ at all--increased vigilance and self-protection might be radically sensible given the person’s experience bumping up against the limits of one’s autonomy. Hence, hypervigilance might be reframed as hyper-attunement, or a chosen way of being in the world which is highly sensitive and adjusted to the precarious nature of living.

As with any way of being, hyper-attunement has its limits. It is exhausting to maintain that level of awareness, and any project which has as its goal to avoid pain is futile. Perhaps it is most painful for human beings braving life after trauma to realize that single-event trauma is in fact an illusion. As founding logotherapist Frankl (1963) suggests, loss, and even horror, is part of the human experience. But Frankl’s decidedly optimistic enframing might eschew horror prematurely. Paradoxically, the savvy trauma survivor learns, either on one’s own or within a therapeutic relationship, that being-toward-Death (Heidegger, 1927/1962) is the way to preserve life. That is, one’s traumatic recognition of the potential to die suggests that one is, in fact, still alive. This is in contrast to the popular meaning-based therapeutic stance that until one finds meaning, he or she is in a state of unresolved cognitive processing (e.g., Hegelson, Reynolds, & Tomich, 2006; Linley & Joseph, 2012). We propose that trauma does not cast meaning into the lost and found; rather, meaning is already lived out through one’s being-in-the-world. The horror of trauma is--by definition-unresolved, and the fact that one is still alive to live unresolved suggests a more intimate relationship with life and death. Such a person goes on living by inviting finitude, or courageously leaning into the possibility that uncertainty and unknowability opens one to new possibilities, to what is hopeful. And with time, a delicate balance is struck between honoring historicity and opening oneself to new outcomes, others, and the Other.

### **Dissociation**

Dissociation is generally understood in the literature as being the strongest predictor PTSD (Marmar et al, 1994; Koopman, Classen, & Spiegel, 1994). In general, it is an attempt existentially to gain a felt sense of spatiality (Heidegger, 1927/1962) from the self and the event. While this separation may work to a degree, the person is unable to create a literal separation from the self because one cannot become disembodied. Depending on the degree of the person’s need for separation from the world, one’s dissociation may vary. On one end of the spectrum, an individual may feel less present in the moment; on the other, an individual may take up new ways of being, as in one who develops multiple personalities.

One way dissociation manifests is through “blackouts,” or lived experiences of feeling separated even from one’s own memory. This dissociative phenomenon may be different between children who black out and adults who dissociate but remember the event. Perhaps children dissociate (Chu & Dill, 1990; Saxe et al, 1993) and “black out” more often (Sar et. al, 2006; Weniger, Sachsse, & Irle, 2008) because their historicity suggests a more trusting relationship with the ontological. In a sense, they have not built up the scar tissue that comes with living with existential pain. Whereas the traumatized war veteran has more lived experience with finitude, the young child who is being repeatedly molested by her father may be harshly confronted with her limitations for the first time. As she struggles into adulthood, she responds by choosing to create space from such realities.

Existentially, blackouts may be provoked by a hyper-attunement to the painful quality of Being in a traumatizing situation. We can distinguish through the phenomenology of the trauma what Buber (1970/1996) called the personified “thou” from the inanimate “it.” Relating to a trauma as if the trauma itself were an Other being might be the existential root of dissociation, as in the case of the young woman who was molested by her father (a “thou”). This is not to say that a “thou” trauma must result from complex trauma involving another person, or that an “it” trauma only pertains to inanimate events such as natural disasters. For example, trauma resulting from a natural disaster may be an amalgamation of a “thou” who has grown in significance over time, or a felt sense that someone greater than myself (e.g. a God) is abusing me. But needing an abusive mother to be an “it” as a way to avoid contending with an Other I love who is harming me would be an example of an interpersonal trauma relegated to “it” status.

As alluded to before, dissociation can take many forms, depending on how engulfed the person feels by the trauma. In an extreme case, the young woman who was molested by her father might take up different personalities as a new ontic way of negotiating the “thou” trauma’s presence in her story. Regardless, her dissociation is a way to artificially rewind and eliminate her pain by delegating it to an Other who is better-equipped to handle the assault. However, the Others are her, as she is them: the difference is a felt separation of experience. Once the young woman begins to experience the world from the purview of her Others, the world tends to view her as “crazy” or abnormal. Being viewed as crazy is a frequent occurrence with all manifestations of dissociation, as individuals who are actively dissociating might exhibit a dissociative, or vacant stare in their moment of felt separation. Instead of understanding these dissociative states as faulty or abnormal, we suggest they are a human reaction to moments when severe trauma has come too close. The young woman who

dissociates has simply undertaken a process of “disorganizing and reorganizing [her] sense of being-in-time” (Stolorow, 2007, p. 20).

Simply put, the young woman who dissociates is decidedly Being-dys-integrated or dys-connected in the world. When she is reminded of her trauma (triggered), a protective way of being (e.g., dissociative stare, dissociative blackout) takes over so she can move through the situation unscathed. By dys-integrating the self, she can be other than traumatized. But co-existentially (Heidegger, 1927/1962), this protection from the present moment keeps her from recognizing the newness of the situation; that is, the present situation and people in it are different from the original trauma. This woman, in effect, is using her agency to dissociate rather than brave the uncertain world.

When dissociating, one may experience a felt “loss of control” which can be understood as an attempt to reject agency. The person who dissociates has agency, as choice is a given, but he or she is not immediately aware of its enactment--hence the felt loss of control. From such a perspective, the person, or Being, who is no longer present in the moment, is not responsible for what happens or maybe even what has happened in the past. However, the Being whose agency is subdued via dissociation never escaped agency to begin with. The attempt to reject agency would seem paradoxical because the loss of control was the root of the trauma in the first place. But her dys-integrated Being becomes existentially sedimented (Spinelli, 2007) in forfeiting control as a means of protecting herself from owning the raw encounter with her existential thrownness and finitude.

### Treatment

In this section, we will outline conventional understandings of trauma treatment before introducing our existential approach. First, let us fully understand the word “treatment.” It has been defined in many ways, including the use of an agent to give properties, as well as the medical administration of a dose, which stems from the Latin word *Trahere*, meaning to “draw” or “pull” (Oxford, 2013). While we refer to our actions with clients as types of “treatment,” please note that we do not see our relationship as a type of treatment in the manner defined above. Rather than giving properties and dosing away an individual’s suffering, it is the therapist who instead is administered a dose of the person’s experience. As the therapist absorbs and metabolizes his or her suffering, the person experiences the therapist as a real Other; that is, a full human being who hears the pain and feels the gravity of the situation in his or her gut.

To briefly summarize the timeline of evidence-based approaches to trauma treatment, we start with Foa and Kozak (1986). Foa and Kozak (1986) found activation and habituation to be central to symptom reduction. That is, they would activate, or initiate an acute experience of the original emotions inspired by the traumatic event, in order to habituate, or desensitize the traumatized individual to them (Foa & Kozak, 1986). Later, Foa collaborated with Rothbaum (1998) to conclude that the problem was the meaning-making around the trauma. This prompted Foa and Rothbaum (1998) to move toward a cognitive-behavioral approach to eliminate faulty thinking like, “I am to blame for being raped.” Next, Foa worked with Hembree and Rauch (2003) to solidify prolonged exposure, an expansion of her earlier work on activation and habituation in which she employed imaginal and in vivo exposure as methods of symptom reduction. Imaginal exposure refers to a re-telling of the traumatic event, whereas in vivo exposure refers to the present-moment re-experiencing of the trauma via homework assignments (Hembree, Rauch, & Foa, 2003). Foa and Rauch (2004) combined prolonged exposure and cognitive restructuring. The addition of cognitive restructuring to the exposure therapy provided a route to both desensitization and replacement of maladaptive thinking.

Van der Kolk et. al (1996) were working around the same time but focusing on affect dysregulation. That is, they found the subjective experience of intense emotion to be more central to the distress than the maladaptive thinking. Foa and Rauch (2006) eventually put forth a similar theory called emotional processing theory, in which they emphasized the fear response as being the gateway emotion to reducing the anxiety symptoms they saw as underpinning trauma. Positive psychology offers an interpretation of Cognitive-Emotional Processing Therapy, which incorporates many of the above ideas while returning to the idea of meaning-making. Hegelson, Reynolds, and Tomich (2006) posit that the subjective distress associated with trauma comes from the search for meaning, which they refer to as unresolved cognitive processing. Linley and Joseph (2011) add that finding meaning allows the traumatized individual to assemble a “new assumptive world”-- a shift which not only reduces symptoms, but promotes posttraumatic growth.

Similar to Linley and Joseph, our approach to trauma therapy is a reframing of more cognitive-emotional treatment methods that takes into account the deeper meaning of the trauma.

Briere and Scott (2006) return to the idea that activation is the essential element needed to reduce symptoms. Thus, they prescribe a step-wise approach to trauma: “In order to extinguish emotional-cognitive associations to a given traumatic

memory, they must be 1) activated, 2) not reinforced, and ideally 3) counterconditioned” (p. 132-133). From our stance, trauma treatment might be seen to 1) activate, 2) validate, and 3) integrate. It is important to note that these three elements are just that; we do not endorse a step-wise model of care in which there is a *pour soi*, or observer in de Beauvoir’s language, and *en soi*, or observed patient whom the treatment is done unto (de Beauvoir, 2009). Instead, we advocate a relationship in which two individuals come to know one another as human beings.

We welcome and warmly acknowledge the importance of the activation phenomenon. However, we might add for the purpose of clarification and differentiation that activation is a naturally occurring process which does not have to be probed, guided, or initiated by the therapist. We suggest the activation is introduced by the client’s own experience in the world, as life circumstances probe activation on their own. If a woman veteran wishes to delay discussion of the traumatic events from war for, let us say, four weeks and prefers to talk about television instead, that is her choice and an existential therapist honors the agency of the individual who perceives television to be paramount in that moment (Merleau-Ponty, 2002). Indeed, it is not our role as therapists to decide what is important to discuss, as what is important is discussed. We trust that if this veteran is authentically traumatized from her experiences in war, her experiences will eventually probe her to discuss these traumas when she is ready. Most importantly, respecting choice not only avoids re-traumatization but creates an empowering atmosphere that fosters courage to “face it.” That is not to say that the therapist lies dormant; the therapist employs a phenomenological process of descriptive clarification (Spinelli, 1997) to mine assumptions or abstractions as they arise. Thus, activation occurs at the individual’s pace—a leap of faith on the part of the therapist, who may be working within a time-limited model or feeling pressure from third parties to perform. Though crisis situations may call for a more direct probing of the traumatic material on the part of the therapist (Jacobsen, 2006), it is possible and preferable to be guided by the client, who is infinitely more familiar with their own experience.

In concordance with the next element of our existential trauma therapy, we choose to validate the person’s experience of the trauma as opposed to the more cognitive stance of “not reinforcing” it. In our view, not reinforcing someone’s response or “cognitive-emotional associations” (Briere & Scott, 2006, p. 123) to the trauma denies the person’s meaning-making by adding guilt and subtracting credence from the experience. That is, the therapist who systematically eliminates emotional primacy of the traumatic memory by selecting only certain less-activating associations invalidates the mattering of the experience. In effect, this invalidation induces an “I’m sick” belief in the individual who might feel guilty for disappointing the therapist by feeling the full weight of his or her authentic experience. Existentially, radically validating the very response that is the most troubling and horrifying to the individual is the human thing to do; we wish to avoid alienating or pathologizing the human condition as invalid or maladaptive, as it is the tie that binds the human relationship which underpins the therapy. This stance is empirically supported by Coker et al. (2002) who found a healing component to sharing trauma relationally.

Radical validation is the therapeutic element which sets apart an existential approach. Briere and Scott (2006) wish instead to “extinguish” reminders of the trauma. Though we acknowledge the almost-gravitational pull to relieve the individual’s burden as a therapist, we reject the notion that pain is necessarily extinguished in order for the person to go on living. The individual’s participation in the present moment is evidence in itself that time has moved forward, even if the person feels left behind in his or her efforts to resurrect or relate differently to that which has come to pass. For this reason, we distinguish and discern a person’s ontic positioning, or locate his or her unique way of taking up the trauma in light of the contingent limitations we all face as human beings (Heidegger, 1927/1962).

To extinguish the response to the trauma would seem to be an attempt to eliminate the actual existence of the event, as one cannot help but respond to an event in some way. Even if we could extinguish a maladaptive response, the traumatic event will always be a piece of the person’s historicity and memory. Thus, we suggest discernment as a way of finding meaning in the traumatic event, as anything that is traumatic must be innately meaningful to the person. Without validating the experience, the person may begin to feel guilt surrounding the event, thus stunting his or her ability to live out meaning.

Integration is an element of treatment which can be seen as an existential alternative to the kinds of counter-conditioning present in more cognitive models of therapy (Briere & Scott, 2006). Integration is not a goal of therapy, *per se*, but is something that typically occurs within the relationship as a result of clarifying a person’s being-in-the-world (Heidegger, 1999). Counter-conditioning might be an unnecessarily mechanized project in the therapy; perhaps engaging a process of mourning can promote new, sustainable ways of being in light of the trauma. DuBose (1997) expands upon DeSpelder and Strickland’s (1987) work on mourning to conclude: “The mourning process is [a] rebuilding of a new self-in-a-life-world. This process focuses less on the personal reactions of someone to loss and more on the readjustment to the social arena: mourning is the most public expression of loss” (DuBose, 1997, p. 368). In this way, integration is both a movement and a recognition of that which has already moved with the passage of time. Most succinctly, integration is what

happens when the traumatized individual finds his or herself at a loss. As the trauma moves definitively into the past, the present moment in therapy becomes evidence in itself that the individual has already “moved on” as it were. In this way, therapy is a way to account for the ways in which the individual has used his or her agency in the interim since the trauma. The overwhelming question “How will I get by?” is pared down to “How am I already getting by, and do I want to proceed differently?”

To us, complete integration is not a goal unless it is what the client desires. Nonetheless, integration can be best understood as learning a new way of relating to the trauma and the world (e.g., learning new coping skills). We do not advocate a directional movement toward integration in the image of the therapist, but prefer to walk with an individual as they find a way of living in the world that may or may not include resurrection and hyper-attunement. We may offer alternative ways of being-in-the-world when the person becomes stuck, but ultimately, integration lies within the person’s own agency to settle into existential givenness in their own way. For the person who does not wish to fully integrate, he or she adopts a way of being-in-the-world that is dys-integrated or comprised of several different meaningful ways of living.

### Conclusion

The field of psychology continues to move toward a goal-oriented model of care which emphasizes fixing a broken Being rather than witnessing the life that goes on living. With the advent of DSM-5, a vigorous discussion has been ignited regarding the treatment and conceptualization of diagnoses whose characteristic syndrome cannot be explained and cured using a purely biological model. The question remains whether the DSM-5 can be promoted as an entirely empirical model of present psychological phenomena. DSM-5 is still littered with residue from a time when psychology and psychiatry still agreed that care took precedent over precise diagnostics and measurement--a notion which is decreasingly palatable to the medically-modeled faction of psychology, as evidenced by the NIMH’s vow to replace it with an entirely neurologically-based diagnostic manual (Lane, 2013). Trauma is certainly a phenomenon at the centerfold of this debate as the field recognizes the almost endless etiologies and manifestations, few of which can be adequately represented in a one-size-fits-all diagnostic manual of any sort. This debate is what inspired the present theoretical discussion, as the current thrust toward empirically-validated “treatments” and vetting of psychology for a “hard-science” status calls for clarification from those who hold steadfastly to less reductionist approaches to psychological care. By putting forth an existential understanding of traumatic stress and dissociation in particular, a foundation for dialogue across theoretical orientations can be initiated as psychologists grapple with these paradigmatic shifts in their practice.

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