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Personality Disorders and Genesis of Trauma
Existential Analysis of Traumatized Personality Disorders

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Abstract:

The topic of traumatization is of particularly great existential relevance. In existential analysis the specificity of grave traumatization is considered to be the experience of "horror" at seeing the abysmal side of one's being (instead of the void). This central experience in traumatization is looked at on two levels. The process level is examined via an analysis of the self-structure, with the existential-analytical model of self-structure being close to the one propounded by Christian Scharfetter. On the structural level all four fundamental dimensions of fulfilled existence are touched by grave traumatization. This explains the genesis of PTSD (post-traumatic stress disorder) as well as the high co-morbidity factor of this disorder. As a direct consequence of trauma the interaction with the existential structure is reduced, causing a loss of world, relationship, self and future. Characteristic coping reactions accompany all experience – above all the death-feigning reflex and activism on the first fundamental motivation.

Therapy must restructure the existential fundamental references and the functioning of the person. The model of the fundamental motivations provides specific therapeutic steps to overcome the existential deracination and to mobilise the functions of the person with the help of non-specific factors such as dialogue and encounter.

Key words: trauma, PTSD, existential analysis, fundamental motivations, personal existential analysis

1. Introduction

An accident on the freeway: a fully loaded bus hits the barrier and ~~,~~ the side is ripped off. Passengers~~, and passengers~~ tumble out of the out-of-control bus as it overturns. Screaming, crying, bleeding, broken and unconscious bodies lie scattered over the road. Unsuspecting witnesses come on to the scene, suddenly encountering this hell with the music of the car sound system still in their ears, still in a holiday mood or perhaps having just had a matrimonial quarrel. Their reality is suddenly changed fundamentally. A normal, happy life is suddenly plunged into depths that have never before been experienced. Like someone who bangs his head into an invisible glass door they are temporarily completely disoriented and are suddenly completely lost. Encountering the scene of the accident people stand around on the freeway in a state of confusion with no idea of what to do. Most seem to be paralysed; others assess the

situation and automatically start to position warning signals and administer first aid to the nearest casualties.

When we stand back from the shock of such a scenario and consider the effects on the survivors and the people who were first on the scene, it can be easily imagined that all involved will suffer from shock. However, the subsequent development will be different depending on the individual and this raises a psychologically relevant question: why does an event of this type traumatize one person and have no effect on another? Why does an event become an *experience* for one person and a *trauma* for another? And what makes it a *continuing* disorder?

There are several reasons for investigating this question in depth. The following comments place the topic in a larger framework and may provide more information:

- It is the psychological-anthropological question of the *vulnerability and sensitivity* of the person. What makes a person vulnerable? Why does something cause us pain? The following items address these questions.
- The situation includes the psychological-philosophical topic of *experience of overwhelming shock*, of horror that displaces all else. What makes such an effect possible and what is the connection?
- It is worth considering such a question for personal reasons, since it is a part of *human reality* as much as death itself. One could ask what one would do oneself in such circumstances and how one could help on the scene of such an event. This inquiry may help us not to overlook, reject or ignore this reality and the possibility of its occurrence and possibly require us not to repress or inhibit it. We are considering the *risk*, even as a *psychologically healthy person*[1] without a specific vulnerability, of succumbing to a *psychological disorder*. This is applicable for both adults and children.
- There are also *professional* reasons for considering these questions. We know how common traumatic disorders are and that for a long time psychotherapy did not consider the effect of trauma. Today research has clarified the relevance of trauma for the occurrence of traumatic developments resulting from losses. This topic poses a particular challenge for existential analysis. However, the catastrophic event, the total disruption of existential stability is far less of a topic in existential literature compared to failure, absurdity or death.

We know that we could all become *witnesses* or even *victims* of a scenario of this type. Human life does not protect us from these aspects of reality. Knowledge or consciousness, science or belief cannot protect us against the shock if we are confronted with such a scene. We may not even be able to conduct our daily life if we were continuously aware of the possible depths of existence. Therefore, a person *adapts* to a picture of reality that appears secure, manageable, clear, reliable and trustworthy. Most people manage quite well with this view of reality.

However, this view can be shattered unexpectedly and shake our view of reality to the foundations. In extreme situations such as natural disasters, life-threatening or fatal accidents, or unprecedented human brutality that ignores the value of human life and existence, the rules and regulations of culturally "domesticated reality" no longer apply. The *operative patterns* such as behaviour and attitudes with which we confront everyday reality fail in such extreme situations. The traumatic experience is

[1] Gender-specific terms apply to both sexes.

confronted with completely new experiences for which one is neither *adapted* nor has any *method of adapting* to them. In such cases, instead of the question "how does the person cope with the trauma?" it is reversed: *how does the trauma change the person?*

2. Trauma, post-traumatic stress disorder (PTSD) and post-traumatic personality disorder

What identifies a trauma? Trauma is understood as a damaging event *outside customary human experience"* (Vermetten, Charney, Brenner 2000, 67). In DSM IV it is restricted to events in which a person is personally or sees others exposed to *death* or serious *physical injury*. This results in an intense subjective reaction of fear, helplessness or terror (ibid.). The restriction of the definition to confrontation with death or serious physical injury means that DSM IV defines the trauma much more narrowly than ICD 10 (ibid. 70), which links the events to the subjective magnitude of an experience that does not occur in the normal life of a person.

This distinguishes a trauma from normal stress factors and from injuries that are a normal part of every life. Only traumas that exceed the normal processing capacity of a person are considered as the cause of a PTSD, because they have an *overwhelming dimension* and therefore result in *unusually strong reactions*. The person confronts a force, an immensity and magnitude of destruction that renders him completely helpless and evokes fright and terror.

More than half of all people (60% of men, 51% of women) experience such an event at least once in their lives (ibid. 67; Kessler, Sonnega, Bromet, Hughes, Nelson 1995).

The symptoms of PTSD are classified into three categories (Vermetten et al. 2000, 71f.):

- *Reliving the event*: at least one symptom of the "echo symptoms": vivid memories; stressful dreams; repeated reliving of the event; intense physical stress at reminders of the event.
- *Avoidance behaviour*: at least three symptoms of the groups of feelings of numbness, restricted ability to respond and avoidance.
- Sustained symptoms of *increased excitability*: at least two symptoms such as sleep disorders, irritability or outbursts of anger, concentration disorders, excessive vigilance, extreme fear response.

Reliving the experience, avoidance behaviour and increased excitability have something in common: they are phenomena of a processing attempt, i.e. symptoms of a process. The PTSD can therefore be considered as a *symptomatic process*. The person is at such a high level of excitability that all three anthropological dimensions have the effect of functional disorders: *somatic* (vegetative symptoms, loss of weight, motor disorders), *psychological* (feelings, sleep, diurnal variations, lack of interest, motivation force, concentration) and *personal* (self-worth, concept of life and standard of living, attention and motivation). The experience stresses the person, the ego structures are weakened, with the result that the person no longer reaches his potential.

This diffuse range of symptoms becomes more precise if the PTSD becomes a **post-traumatic personality disorder** (or personality change as defined in ICD 10, F 62.0). The range of confused, restless and acute symptoms settles into a defensive attitude to

the world combined with a notable loss of self. This "barricading" of the personality is based on a restricted relationship to the world and the self. The five characteristics of the "enduring personality change after catastrophic experience" (ICD 10) can be assigned to these two basic personal references:

a) restricted relationship to the world

1. hostile or distrustful attitude towards the world
2. social withdrawal

b) restricted relationship to self

1. feelings of emptiness, hopelessness
2. chronic feeling of being on edge and feeling of being threatened
3. estrangement

After a disastrous experience of this type *normal relationships* cannot be initiated or maintained. The world is simply too *threatening* and the subject is *weakened* to the extent that other people (who in many traumatic experiences are part of the cause) can no longer be borne. The general withdrawal from the world under the shadow of continuing fear is associated with a loss of self with inner emptiness and estrangement.

3. Terror as an existential topic of traumatization

The question of what confronts a person when the reaction is so strong is unavoidable. The symptoms indicate an *extreme* experience, which in contrast to a "normal fear" is *overwhelming* and therefore cannot be considered part of "normal human experience".

Goethe (n.d. 370) has defined such unusually strong experiences that exceed all familiarity and predictability very precisely with the terms "wonder" and "terror" in *Poetry and Truth* (Book 16): "Nature acts by eternal, necessary, quasi-divine laws that even the divinity cannot change. All men are unconscious in this and perfectly united. One sees how a natural event that indicates understanding, reason, but also simply arbitrariness, makes us astounded, even horrified. …. In contrast, a similar horror overcomes us if we see the person acting unreasonably against generally accepted customary laws, without understanding against his own advantage and that of others. To get rid of the horror that we feel we convert it immediately to censure, to loathing, and we try to remove ourselves from such a person in reality or in thought."

We are oppressed by terror and unbearable feelings if the framework of law, ~~or~~ customary expectations or what is viewed as natural is displaced from their normal track. Such an event destroys all trust. An experience of this type is a trauma. The characteristic feature of the trauma experience appears to be not so much the fear but rather the experience (perception) of an *overwhelming incomprehension of reality*, which cannot be compared with anything. Freyd (1994) came to similar conclusions in investigations of the cause of early childhood interpersonal traumas where she found primarily a *breakdown of trust* (we would understand that as the immediate result of the experienced "incomprehension" and the deepest comprehensible symptomatology). Experiences of this type naturally cause fear[2] (primarily and probably in hindsight), but in the acute situation they primarily trigger *terror*. We define terror as *complete incomprehension of something previously unknown, whose*

[2] However, Freyd (1994) is of the decided opinion that it is not fear that is in the foreground of the experience but this *betrayal of trust*. This is ultimately also what results in the development of *dissociations* (and not the classical fear reactions).

presence was considered impossible. A PTSD would therefore have a thematic core: the confrontation with the content of the terror, and particularly with the incomprehension in which we are plunged against all expectations of the reality facing us. It is as if reality has betrayed the person – but the person is still bound to reality and cannot continue to survive without it (note the similarity with the experience of the child with the parents – and when this lifeline of relationship is betrayed by abuse; Freyd bases her trauma theory on such experiences).

For better understanding of the incomprehension we must consider the specifics of terror more closely. Terror is basically a form of *astonishment*; the only difference is that the object of the astonishment is not an incomprehensible value or an excessively large magnitude but its object is the *incomprehension of the abysses of existence*. When expressed in speech the feeling of terror says: "Is this possible? This is simply impossible! But it is possible!"

We can experience feelings of this type at an accident of the type described at the beginning of the article, or when we hear of wartime atrocities, see pictures of concentration camps, or ~~and~~ see the collapse of the World Trade Center on 11 September 2001 on television. We can also experience terror if we are informed of a serious or incurable disease. Whenever we experience terror trust is destroyed. Terror does not always involve danger to self, as with the fright of a fall, but more the *incomprehension* and the *loss of trust* in the self.

While no attention is paid to this term in psychology (although terror is described as a feeling accompanying fear), Emmanuel Levinas in his early work (1947) has developed a deep understanding of this experience. It can be considered a basis for an existential understanding of terror and trauma. Levinas considers what is experienced in terror as something different from fear. Unlike fear, terror is triggered by something that *is*. While someone experiencing fear is confronted with potential *nothing*, with terror it is the *self* that triggers the shock. The essence of terror is that "it actually exists" and not that there is *nothing* there. Levinas specified this being as the "anonymous" self, the "apersonal flow of self" that overwhelms the person. This self is not the "giving" self, the "cared-for" or "anxious" self, as described by Heidegger, but the "anonymous noise" that "exists". Therefore, in the experience of terror we encounter a *paradox of self*. Our usual experience of self is that it conveys protection, space and stability. It is the foundation of the "in-the-world self" (Heidegger), it is ground beside the abyss. Now this trust is broken by the experience of "what *does* exist", something that is absolutely not anticipated and probably cannot be anticipated, and that as self is capable of posing an extreme threat to one's own self.

The repeated or extreme experience that the self "has no foundation" eliminates the person's base in the world. Without a base the person is powerless against an experience that is out of control and which he can no longer process. The result of this is an "interruption", as Kleber and Brom (1992) refer to it in more technical psychological language, by the "drastic destruction of basic assumptions and expectations" (Kleber 2000, 728).

The trauma concepts based on Antonovski's (1997) coherence feeling are also included in this framework of shattered continuity. For example, Frommberger, Stieglitz, Straub, Nyberg, Schlickewei, Kuner, Berger, Brügner (1999) were able to demonstrate with victims of serious accidents that the cognitive and emotional reactions in victims of traffic accidents who developed a PTSD were independent of the seriousness of the injury but correlated with the *feelings of coherence* (i.e. the

subjective meaning of the negative event). A good feeling of coherence had a negative correlation with the development of a PTSD. This means that if a difficult or traumatic event can be assigned to a coherent cause, the traumatic effect of the event seems to be weakened.

Of course, the result is a lasting experience of the danger based on such a cognitive background and based on the experience "that the self has no foundation". This causes fear. In the *cognitive-behaviour therapeutic model* of Ehlers and Clark (2000)[3] this sustained feeling of being threatened is one of the main reasons for the development of a PTSD. In our view this model applies relatively late in the line of development of the trauma.

For the sake of completeness a psychodynamic concept of trauma development is mentioned. As stated by Gabbard (2000) the traumatization is also attributed to the subjective meaning of the stressor and not to an objectively measurable degree of severity. A PTSD will only develop if the traumatic experience resonates with a *childhood trauma*. In such a case the shock is so strong that the effects can no longer be regulated and somatisation and alexithymia occur.

4. Psychodynamics in the excessive demands

What the person experiences places an excessive demand on his processing capacity. The lack of capacity in coming to terms with the experience, to align the self with the experience and to retain a sense of place results in an "existential insecurity" (Butollo, Rosner, Wentzel 1999, 184) leading to an *oscillation* in the reactions. Overactivity and passivity occur simultaneously. Attempts to approach and process the experience, alternate with phases of paralysis and fatigue. As a result the person oscillates between intrusion and denial, between continued reliving of the experience and avoidance behaviour, between increased excitability and desensitization. Three of the four basic coping reaction stages, as described in existential analysis (e.g. Längle 1998), seem to be mobilized simultaneously, and two of them in the area of all four basic dimensions of existence. This makes the degree of the structural threat or destruction clear (compare the neurosis, where the fixation is generally primarily manifested in one single coping mechanism). Table 1 shows an overview of the reactions:

Disorders of FM (fundamental motivation)**: basic feeling**	**Basic movement (avoidance attempt)**	**Paradoxical movement = activism (management attempt)**	**Defence dynamics in non-escaping (aggression type)**	**Overwhelming experience (play-dead reflex)**
1st FM --> fear	**Flight**	**Fight**	*destructive*: hate	**Paralysis**
2nd FM → depressive	**Retreat**	achieve	*relationship search*: anger	**Exhaustion, resignation, apathy**
3rd FM → hysterical	**Retreat to distance**	Justification, agree	*dissociation*: rage / irritation	**Dissociation (separation,**

[3] They derive the development of the experience of danger from "excessively negative appraisals (added meanings) of the trauma and/or its sequelae". In our view the negative evaluation should not be viewed as random but as an emotional perception and attitude toward the content of the experience.

		(overplay)		**rejection)**
4th FM → suicidal and dependent	**Provisional engagement**	Provocation, idealization, fanaticism, para-existentialism	*Context formation*: playful aggression, cynicism, anger	**Stupor**

Tab. 1: The forms of automatic protective behaviour (coping reactions) classified by topics of fundamental motivations (from Längle 1998, 23). The coping reactions that are mobilized by the traumatic terror are underlined.

All forms of the *overwhelming experience* (the play-dead reflex) can be found simultaneously in the PTSD and they dominate the picture. The play-dead reflex of all four fundamental motivations can be found simultaneously: paralysis, apathy, dissociation[4] and stupor. All layers of existence are affected simultaneously only in severe disorders. The picture is paired with the mobilization of the protective **basic movement**, which also extends over all four basic dimensions of existence: avoidance, withdrawal, distance and provisional engagement. In addition, and as if to emphasize the fear dimension, which is included in the PTSD, the reaction stage of the **activism of the first fundamental motivation** is mobilized, struggle in the form of intrusions, stressful dreams, reliving the trauma, etc.

Because virtually no progress in processing the trauma is made in this simultaneous mobilization of opposite behaviours, it is not surprising that 86% of PTSDs develop a *comorbid dissociative disorder* (Bremner et al 1998, in Vermetten et al 2000, 80). The development of a dissociation must be considered as a strong reaction. D*issociation* represents a failure of the "integrative function of the consciousness, the memory, the personal identity and the self-perception and the perception of the environment" (Kapfhammer 2000, 152f.). This makes it clear that the ductus of the loss of self and world of the PTSD is assumed in the phenomenon of dissociation. An *intermediate position* between the acute PTSD and the deeper personality disorder approaches this phenomenon, formerly identified as hysterical neurosis.

5. The structure of the ego after Scharfetter

We have noted that the terror to which a person is exposed in the trauma explodes the normal processing capacity of the person. This overstrains the processing structure of the ego. The site of processing, the integration or separation of impressions is the *ego*. What are the structures of the ego that cannot withstand the experience? A brief description of an ego concept is required first to show the effect of the pathology. The ego concept of existential analysis (EA) can generally be linked to Scharfetter's ego concept.

Scharfetter (2002, 72-116) describes the ego as the "experience and behaviour centre that locates itself in the social context, primarily in the world, the destination for the incoming, the site of connections that links the present with the past and future, processing and transmission site for everything efferent" (Scharfetter 2002). It is the site in which "all these functions are combined to a unified being" (Scharfetter 2002).

[4] In the case of severe dissociation there is significantly more human traumatisation and breaches of trust by people on whom one is dependent. Dissocation primarily helps to enable continuing, necessary communal living (e.g. children in families) (Freyd 1996, DePrince & Freyd 2001, Freyd 2003).

Scharfetter ascribes different dimensions or aspects, which he shows graphically as concentric circles where the inner circles penetrate the peripheral circles and are thus contained in them. In this representation the inner core is the **ego vitality** and experience of the obvious "I am" with its embodied presence and positivity (Scharfetter 2002). In EA this basic dimension of the human being is the topic of the first basic condition of existence. Existence begins with the basic experience of the "I am" or the "I exist", through which as a result we receive power and energy, which becomes the basis of the being-ability and the *ability*.

This is followed by the ego activity: to experience the self as autonomous in action and behaviour; to experience "I am" what experiences, feels, thinks, expects, etc. This dimension finds its equivalent in EA in a combination of the first and second fundamental motivations, in experiencing the power of one's own ability and experiencing the vitality.

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The **ego coherence** is the experience of solidarity, unity, association of the efforts and forces in our self-being. In EA we speak of the ego attachment in the third fundamental motivation. It is the consistent experience of internal unity, which is marked by singleness and uniqueness (as the basis of the difference from others – seen below).

Consider for a moment. If these dimensions are considered against the background of the PTSD, it is easy to imagine that the shock attacks precisely these ego dimensions. The last-named unity of the ego (ego attachment of experience and behaviour) is shocked by the magnitude of the break-in and placed in question in its life-meaning and understanding of self, at least by the monstrousness of the experience, even if it is not placed in an extreme relative position. Can persons still consider themselves "internally coherent" if life plays such games with them that they *have nothing to counter them with*? Can *internal* consistency be retained in the face of an experience of such inconsistency and a break in experience of the world? We could imagine that the trauma of the ego activity acts against, drowns it and forces us to experience that we are not the actors, the persons in control in important existential events. The trauma attacks the ego right through to its core and reaches topographically into the deepest core of this scheme. The independent, physical presence, the natural "I am" of complete vital feeling and the strong feeling of being in tune can no longer be experienced. It is frozen, stupefied, without feeling, insecure.

The unspoken, intimate question after such catastrophes is something like the following: "Do *I* still exist or is it only this shock, this wave, this brutality that has long since extinguished me?" The *feeling of ego in this higher dimensional reality* seems no longer *possible* to the subject. It seems to me that this *central phenomenon of the trauma* *experience* implants itself into the higher dimensions of the ego. It is the internal "impression" of the incomprehensible, the experience of something that "really cannot exist" – now "a self no longer exists".

Scharfetter describes the **ego demarcation** as the capacity to distinguish itself from the non-ego, which on one hand enables the formation of the ego and on the other hand establishes the control of reality. EA in the distinction of the ego shows a *prerequisite for the capacities* of the ego or the third fundamental motivation: that of *self-observation*, the self-perception that is possible by one distinction and is reinforced by the distinction by a feedback loop. This boundary to the world is irreparably broken; the ego-protecting and ego-forming boundary is broken. Scharfetter (74) mentions the fact that in pathological cases the result may be the

formation of a wall or a "defenceless overwhelming of the 'non-ego' from the outside". This is exactly what happens in the trauma and is re-experienced again and again in the flashback.

What happens with the **ego identity**? Scharfetter describes them as experiencing the self above and beyond time: "… a person knows that from birth until today that he is the same person who can refer to himself as 'I' (…) in spite of the transition from his own and the environmental perception in the course of the life" (74). This identity is broken and divided into two by the trauma. The person no longer experiences himself as the same person that he was; he has become another person, a stranger to himself. There is a now, a before and an after.

Scharfetter finally describes the **self-image** as an ego dimension: that which someone considers as himself, which also includes the feeling of self-worth. This dimension does not appear to be *directly affected* by the trauma but are still involved in an ***indirect*** fashion. The traumatized person is exclusively involved with the management of the experience to such an extent that there is no strength and no interest in the self-worth. The elementary is now more important.

Scharfetter considers the **ego strength** to be the result of the interplay of these dimensions. In his opinion this can be considered as a "very global construct" (77). However, the special feature of this theory is that the *ego strength is very dynamically understood* as a "*quality* of different ego functions" (Scharfetter acknowledges that Federn (1956) has also referred to this). Scharfetter suggests that this quality of the interplay of the individual ego functions makes the high *adaptability* and *synthesis capacity* of the ego comprehensible.

6. The ego structure in the existential analysis understanding

The concept of the ego structure in EA, which was derived phenomenologically within the framework of a personal approach, is structured similarly to the dynamic of the ego strength described by Scharfetter. It is probable that these parallels are the result of a common phenomenological process. The **ego strength** is seen in the conception of EA in the interplay of these capacities, which correspond to the last *three dimensions of Scharfetter*. The ego derives its strength by education and the application of specific capacities on which the *self-being* is based (Längle 1999a, b, c; 2002a, b, c). Phenomenological studies (such as Eckhard 2000, 2001; Längle 1999a, 2002a, c, d) show that this requires three prerequisites:

1. The **self-perception** results in formation of a boundary and the separation of ego and non-ego, from the own and the other. The differentiation of boundaries and differences is the basis for every *dialogue*. Exchange is only possible if a difference exists.
2. The **self-assessment** is an ego activity, which is often overlooked, but which must be viewed as *constitutive for ego formation*. A personal understanding in which the person is understood as someone who exists in himself underlines the capacity of self-acceptance and also for self-distancing (Frankl 1996, 234ff.; Längle 1999b, c; 2002 a; Tutsch 2000). This essence of being a person also brings the necessity of expressing an *opinion* with it. The opinion on the self will specify the discovered *boundary* and the *self* circumscribed by the boundary, "making it to one's own". The ego is only *consolidated* in the self-assessment, i.e. in the specification of what one considers oneself, what is seen

to belong to one, what is seen as corresponding to all one's plans, forms of experience and actions. It is a form of "placement to oneself", of internal demarcation towards oneself, *taking oneself seriously* in what one actually is and helping him to the *breakthrough*. This is the *actual integrative activity* by which the ego identity is effectively based.

It is specifically the full development of this capacity that is interrupted by the *traumatic experience*. The experience of shock within the experience results in a loss of ego integrity and the traumatized person is faced with questions such as: "What still belongs to me? How shall I position myself before myself when this monstrous experience places every prior experience in the shade? Is there really an essence that still belongs to me and will not be snatched from me in the next instant by a wave of terror as if it was not mine?"

3. **Self-esteem** completes the self-integration. The person explicitly presents himself to what he can esteem in himself, and the *self-worth* is based on this. This gives the feeling of ego-bonding its *shelter*, its rounding, so the capacity of critical self-assessment is transferred to a *feel for the positive* in one's own decisions and actions. This activity is self-forming to a high degree. In the *trauma* one's own actions are paralysed or are placed in the shadow of the events to such a degree that they no longer have any meaning for the subject. Self-esteem for an assessment of one's own decisions and actions is no longer possible. The rounding of the self-formation no longer exists; this greatly *reinforces* the feelings of *emptiness* and *alienation*.

The ego functions alternate with the *being seen by others, and*, in fact, are only impacted at all by the I-You interaction. If the person experiences atrocities caused by other persons, the ego functions are attacked to a greater degree and their effect is paralysed. This may be the reason that the probability of developing a PTSD after a trauma caused by the *brutality of persons* is ten times higher than for victims of natural disasters (40-50% in battle situations and rape compared to less than 5% in natural disasters) (cf. Kessler, Sonnega, Bromet, Hughes, Nelson 1995, cited by Friedmann 2004, 14).

7. Trauma effect

In the existential-analytical theoretical model the effect of the trauma has a dual topography. The intensity of the event causes a marked change at the **structural level** of the existential anchorage and a persistent blockade of the **process function** in the existential completion.

7.1 Effect on the structure of existence

The Scharfetter model described above with its three basal ego functions could be set in parallel with the first three basic existential motivations. In our theoretical model Scharfetter's additional ego functions correspond to the prerequisites of self-formation, i.e. *within* the third fundamental motivation. An addition would note that in DSM IV there is an additional trauma effect, the feeling of a *restricted future* (Vermetten et al. 2000, 74). The more serious form of the disorder, the personality change (ICD 10), involves an even more intensive form of this feeling, *hopelessness*. In the existential analytical model this means that the **4th fundamental motivation** in

the serious trauma is also affected (we have already seen with the coping reaction that those of the 4th fundamental motivation are also activated).

Based on the internationally described symptomatology, we note that the serious trauma – viewed in the existential paradigm – *extends to all four basic conditions* and largely blocks them. In view of this model this gives rise to the conclusion that the trauma has such serious consequences that it affects *all* structural levels of the being. For example, in the case of a neurosis, the effect of the trauma is focused on a *specific*, *single* topic of basic existential conditions. A PTSD or an enduring personality disorder has as its topic *existence in its totality*. The experience of a serious trauma shakes the dimension of the being-ability, blocks the relationship to life, including the vital feeling of value and the life relationship, erases the ego functions, with the result that self-image, identity and self-worth are reduced. Ultimately, the trauma eliminates the belief in a future, in a development in which one's own life and actions could improve (cf. Frommberger et al. 1999). And, unlike *personality disorders* such as borderline, narcissism, histrionic etc., a main and auxiliary topic is not affected but *all* topics are *more or less equally* in play.

If the effects of the trauma result in a **lasting personality disorder** (ICD 10), it is represented as a *fixation of the deficits of all four fundamental motivations*:

1. FM: hostile/distrustful attitude to the world
2. FM: social withdrawal
3. FM: feelings of emptiness
4. FM: feeling of hopelessness; chronic feeling of nervousness
   [referred to as frustrated equivalent of activity]

A fixation in all dimensions of existence also explains the high *comorbidity* of PTSD with fear, depression and dissociative disorders (70 – 85% per Kapfhammer 2000, 157; 86% per Vermetten et al. 2000, 79), somatisation disorders and substance-related disorders (Vermetten et al. 2000, 78). From the point of view of the existential-analytical theoretical model this proneness can be explained by the weakening of the structure of the fundamental motivations in which there are accentuations as a result of personality properties, prior experiences, direct effects of trauma etc. This is the interface to the developments of specific personality disorders resulting from the trauma under which the borderline personality disorder is definitely in the first position.

The Russian existential analyst Natalia Ignatiseva (see 2005), who has been working with persons with very serious traumas in a neurological clinic in Moscow for years, informed me of an interesting idea regarding the development of personality changes. She views the central occurrence of the effect of the trauma initially quite generally in a *reduction of the consciousness and activity position*, which affects all fundamental motivations. As a result this effect is combined with a series of physical symptoms, a loss of psychological resilience, a loss of personality and future vision. Because the person has *lost access to himself* (and to the fundamental motivations) as a result of the trauma effect, he is *dependent on other people* to establish and open this access for him. Becoming accustomed to this assistance from outside becomes in their experience a major reason for the development of a *personality change*.

7.2 Effects at the process level

If a person loses the structural element of existence, the internal and external processing collapses. The effects of the trauma cause the person to lose *access to all personal resources* and therefore to his *ego activity*. Based on the ego functions trauma can be seen as a *confrontation shock*, which results in *complete* **ego blockade**. In EA the confrontation ability of the ego is described in the method of Personal Existential Analysis (PEA) (Längle 1993, 2000). The seriously traumatized person is therefore not only shaken in the anchorage in all four basic dimensions of existence but at the same time – and this makes treatment of the trauma so difficult – the traumatized person suffers under a *protracted PEA paralysis*. He is so overwhelmed by the impression that he is unable to comprehend the primary emotion, regardless of the overwhelming phenomenal content. Comprehension, opinion, formation of the will and ultimately an adequate expression behaviour - all this personal processing strength is subject to the weight of the impression. Instead of the processing the *old* images reappear again and again in the back of the primary emotion. They soon replace the feeling and emotional deafness increases. Apathy, lack of feeling, anhedonia is the result. The activity is transferred to the reaction level and is ruled by avoidance behaviour. The person is as if frozen, shocked. Because of the walled-in status attempts to become active simply generate nervousness, irritation, over-stimulation – symptoms of overwhelming defence, but still symptoms of life that is still stirring. It could be referred to as the *sign of life of the ego*, which reacts with overwhelming feelings of terror; increased vigilance and sleeplessness under the continuing psychological threat (cf. the symptom list in ICD 10).

The problem of the PTSD is that it is not a suffering *process* but a suffering *status*. PTSD is actually an incapacity even to achieve suffering under these conditions. It is less suffering than paralysis that acts to alleviate the unbearable, intensive pain, similar to how depression leads less to sadness than to freezing in a state that is similar to sadness. The *freezing* in the PTSD is based on the loss of anchorage in the foundation of existence. It is a state of being overwhelmed by the experience of: 1. shock 2. loss 3. pain and 4. incomprehension, corresponding to the four basic structures of existence, as described above. The *traumatic stress* is, therefore, not caused by *processing* the suffering but by the incapacity of making progress in this essential process.

a) Impeded processing

Every adaptation to a new situation fundamentally requires *psychological strength and intellectual presence*, particularly if the situation involves the loss or death of a person to whom one was close. Processing the situation requires care and time, during which the person is immersed in memories and develops visions for the future. Traumas are processed by the same principle as the processing of problems, losses and suffering. The central problem is always to position the ego in the new reality, to recapture its *aliveness*, to restructure the *self-image* and identity in exchange with the new, and to discover the *sense horizon*, i.e. to place the new in a reasonable, larger context.

A major component of *trauma processing* is that the effect of the event is so overwhelming that the *ego does not settle to its own, stable activity*. It is overwhelmed again and again by the enormity of the event. Every attempt at processing ends in a *digestive* convulsion and collision with the overdimensional destruction. The emotional and cognitive observation application is paralysed again and again; the person gives up and avoids trying to be able to find some *relief* in a *paralysis of*

feelings and not to have to relive the memory of the traumatization yet again. However, the dynamics of life prevent any relief; it demands restructuring of its form and its capacities. A good physical analogy can be found for the psychological situation, which resembles the *choking* and accompanying stomach pain after eating rotten food. The traumatized person suffers similarly under the "choking and vomiting of the indigestible". This includes sudden cramp-like, overwhelming and passivating re-experiences of the event against which the person is powerless.

The special situation of the traumatized person is now that he remains caught in these psychological convulsions – he *cannot* really process the experience because the ego structures are insufficient; and he *is not capable* of processing it because the feelings are so strong. Therefore, the traumatized person does not enter a compensation process but persists in a vital event of *coping reactions*. They protect the traumatized person against what he cannot *accept*, what he cannot bear (2nd fundamental motivation). He feels that he can no longer live in direct contact with the experience. He feels that he can no longer *be what he was* before in such a world, and no longer knows who he actually is (3rd fundamental motivation). The destructive drama of the event leaves no room for development into the future, for hope of having something *constructive* that could be placed against such destructive effects.

The Vienna poet Johanna Vetter (2005, 30) has expressed this clearly:

STILL
AND AGAIN AND AGAIN
THE CLOSED DOORS OPEN
THE TUNNEL WITH THE CONSCIOUSNESS OF THE INESCAPABLE
THE ULTIMATE LOSS

IMPRENETRABLE ICE WALLS
RAVISHING THE BREATH
CHANGING COLOURS TO GREY

DEVOURING THE NOW AND THE NEXT
IN THE PAST
(…)

b) Consequences of trauma

The prevention of personal processing of the experience also suppresses the exchange of dialogue in the basic existential relationships. The weakening of the four basic existential dimensions affects the existential process as follows:

1. The experience destroys the feeling that **a genuine, effective life** would be possible in the world. The basis for the being a part of the world is lost. The loss of the *relationship to the world* results in a changed and weakened experience of one's own *physical being*.
2. Another consequence is the blockade in the **internal resonance** during the experience. The capacity for sensitive feeling is restricted; the *emotional* connection to the values appears to be torn away. This removes the vital reference in experience by which a *feeling of time* comes into the experience. This is virtually eliminated in traumatized persons – there is no structure of consecutive processes, the trauma is always present.

3. The experience blocks the **internalization** of and **internal opposition** to the terrifying experience. Because of its overdimensional aspect it prevents real consideration and consciousness. Therefore, a personal "implementation" of the occurrence and integrative measures do not occur. The experience remains "outside", distant from the ego, must not become one's own and must not become a part of one's existence.
4. Because of the contents of the impression of continuously new overwhelming, paralysing memories and also because of the weakened personal-existential structures there is no **outlook** that will open a view **to a future worth living**. The frame in which life is now confined is like a desert, with no horizon of values or a development that would give one a purpose.

The trauma explodes all these *interactions with the basic dimensions of existence* that give a structure in a type of "existential basic dissociation" (which then continues repetitively as if in a fugue). The four fundamental existential references are blocked; such a world is no longer *bearable*; a life of this type loses its attractive force and warmth; a person has become a stranger to himself and no longer finds *access to himself*; and also not to a world in which the most valuable can be destroyed at any time and unforeseeably in the worst possible way. A future of this type is not *constructive*, it does not contain *reasonable becoming* and growth.

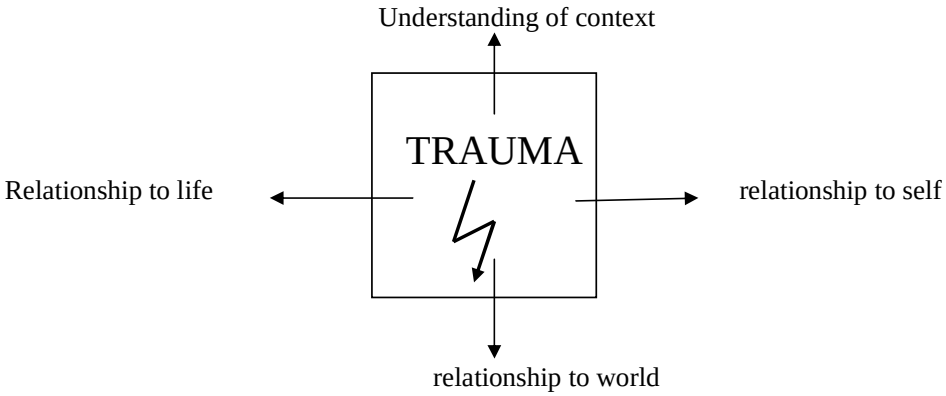

Fig. 1: The trauma explodes the existential coherence, which is systematically included in the concept of the four basic dimensions (fundamental motivations) of existence.The trauma *explodes the existential coherence* in all relevant dimensions of existence and removes the foundation for conducting the processing (as included in the personal existence analysis) from the ego, as a result of which the existential execution of the person is prevented.

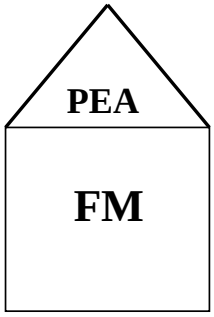

Fig. 2: The connection between *structure of existence* and *processing capacity* can be represented so the processing capacity of the ego is based on the structural experience. If the experience yields to the structure, the processes can no longer be fully completed.

This restriction of structure and process shows once again how serious the problem of a PTSD is from an *existential* point of view. The execution of existence is destroyed throughout the complete bandwidth of the existential basic dimensions and eliminates the foundation of the process function. The overwhelmed process level has a destabilizing effect and blocks the existential basic relationships by feedback loop. This causes a *disorder of one's own coherence of being* in the PTSD. This is experienced as a "loss of self" with feelings of being a stranger, which we understand as a symptom of the 3rd fundamental motivation. The access to one's own personal being, the "being with oneself" is lost. The PTSD results in a serious disorder of the *integrity* and the *integrative potency* of the ego, as a result of which the ego becomes no more than a shadow of itself.

c) Coping reactions

Such a serious threat to the being breaks through the defence structures and the last possible stage of defence is resorted to: the *play-dead reflex*. The almost completely overwhelmed personality finds the last remnant of a protective activity in the form of passive, quiet behaviour as the last chance of survival. This is a fundamental movement of the existential dimensions and an *activism* if the first fundamental motivations are only a secondary presence – a hint that the PTSD is positioned most closely to *fear* and the reference to the world.[5] The massive implementation of (psychodynamic) coping reactions is at the expense of the (personal) dialogue with the self and with the outside world.

8. Restructuring personal functions as basis for therapy

We have seen that the wide-ranging rigidity and blockade of personal strengths results in a loss of the existential anchorage. The basic references of the fundamental structures of existence are lost, and the basic conditions of a fulfilled, stable existence cannot be restored by the absence of the process dynamics.

The most fundamental effect of the trauma is the shock to the *basic trust*. This destroys the feeling that "there is always something that catches us and provides a base". Basic trust is a trust in "something greater", which is known to transcend and hold humans (a world, a cosmos, a divine order). The person could rely on this, this greatness was experienced and provided a psychological-spiritual base, orientation, resistance to shock (Freyd 2003 described this disappointment in the case of social traumas as "betrayal", a shock to trust by breaking faith and betrayal).

In addition to the basic trust we have already seen that the other basic foundations of existence are broken, as it were "wrenched from their base": the basic relationship to life, to one's own personal depth and to one's development into the future. Because of the lack of processing functions this can also not be restored. *Outside assistance* is therefore necessary to initiate this process. Against this background it is quite

[5] In comparison to this: the *neuroses* seem to operate primarily by a fixation on the first and/or second defence stage, the *personality disorders* seem to react by a fixation on the fourth and second (play-dead reflex and activism); the *psychoses* must primarily react with the fourth stage (play-dead reflex) alone.

understandable that the traumatized person needs other people, and that a basic feeling of being abandoned becomes established if this person remains alone. The presence and company of other people who do not relate to the terror but resist it with him should have a healing influence without any other expert intervention.

Rödhammer (2002) was able to present the initial empirical evidence of the positive influence of personal-existential competencies on the processing of traumas in a study of 40 accident victims. Persons with low scores on the existence scale (Längle, Orgler, Kundi 2000) reacted to the accident with brooding, dissociation, avoidance and negative thoughts of themselves. The author considered the reduced capacity for trauma processing as a result of a reduced capacity to respond openly to other persons. If depression, fear, aggression or psychotism occurred, the dysfunctional trauma processing increased even more, which is understandable with the increasing reduction of the exchange of dialogue with the world around them.

The restructuring of the personal-existential competencies, i.e. the *specific* therapy, can be systematized based on the basic structures of existence. The general topics of the therapy can be named with the aid of their contents:

Systematic starting points of therapy	**Concrete topics of therapy**
1. Reference to the actual, **factual world** and its perception	Disturbed image of **reality**; trust, no capacity for reality (core assumptions of reality)
2. Reference to **values that can be experienced** and their instinctive contact	Incapacity to see oneself in **relationship**; loss of strength of basic relationship and its life-sustaining value; apathy, lack of motivation
3. Reference to one's **own self** and the integrative capacity of the ego	**Weakness of feeling**; resigned attitudes and behaviours, lack of guidance of the person; shame
4. Reference to the **larger context** and participation in development/growth/ becoming (change to positive)	**Lack of orientation**, senselessness, desperation, hopelessness

Tab. 2: Concrete topics for treatment of the trauma or the PTSD are derived in accordance with the shaken dimensions of existence (basic existential motivations).

A variety of concrete topics are derived as the *result* of this "existential rootlessness". They are listed briefly below:

1. Initially there is deep **insecurity** in the "world of being": the traumatized person is existentially confused, and "no longer knows himself". He no longer knows "what reality is" and on what he can rely. The existential insecurity generates the feeling that the *catastrophe* will break in *at any time* and destroy everything that is trusted and everything that is secure. Previous assumptions of reality, its reliability and its cohesion are destroyed (Janoff-Bulmann 1992 describes it as a destruction of basic assumptions – of "patterns" – of the internal and external reality that no longer apply). The experience brings the traumatized person into *virtual psychosis*[6], which affects the dimension of the trust in reality: what is reality? Can

[6] Unlike the psychosis the competence of reality is of course retained.

a reality from which one has suddenly fallen into a fearsome abyss as if over a cliff be trusted? The feeling towards the world is *mistrust, hopelessness* in the sense of the person who is unable to allow himself to trust that all is well and is unable to find a base in this feeling.

2. The **anesthetised feelings**, the loss of experience. It is virtually impossible to be touched by something because this stirs up an indescribable suffering. Even if this is something beautiful and good that could touch the traumatized person, he can and will not accept it, because in the next instant he may be attacked just as suddenly and mercilessly and the rekindled spark of life may be extinguished again. This makes it impossible to accept relationships and to continue with life. An apathetic attitude remote from all contacts and encapsulated in a protective enclosure makes the suffering bearable and reduces the danger of retraumatisation. The worst aspect is the occasional feeling of having failed oneself. This often generates *unrealistic feelings of guilt* in the trauma victim.
3. The **loss of identity** occurs as a result of the *destruction of the capacity of integration* of the ego to a certain degree. The knowledge of the self is lost, and the person no longer knows who he actually is because what the ego could do formerly is no longer there (van der Kolk & Fischer, 1995, refer to the destruction of the explicit contents of memory that define the self). The intuitive self-experience becomes confused, flickers, cannot form a stable image of itself. The traumatized person becomes disoriented and loses hold on reality. The feeling of failure and vulnerability in one's personal depth becomes a feeling of *shame.*
4. Finally the traumatized person falls prey to **desperation, hopelessness** and suffers from **loss of meaning**. The person is torn from *connections*,[7] is no longer embedded in an ordered cosmos but is overwhelmed by chaos and destruction. Smyth (1998) in a meta-analysis found that the *sensual understanding* is basic for acceptance of the new experience. The question of the sense of the experienced has preoccupied people for decades, as shown be the example of a Canadian study (Silver, Boom, Stones 1983). Eighty percent of women after sexual abuse are still preoccupied with the sense question even 20 years after suffering the abuse. Fifty percent of them experience this question as a compulsion that drives them again and again and reopens wounds (and conversely guide the symptoms of the PTSD back into the suffering of the meaningless as in a vicious circle – Wirtz 1989, 152). The *perspective of growth and ripening*, a happy end to life, one's own actions and being are buried under the ruins of the experience. There is actually no future left after such a trauma, nothing left to which one is *oriented* and capable of experiencing, nothing that one could approach, or that could move one towards *fulfilment.*

The *possibilities of development* are lost *in two ways*: firstly, in engagement with the world and secondly, with the other. The threat dominates – there is no foundation left in the *self*, no force for development is perceptible and the strength and structure for a process is not present. From an existential perspective, the feeling of loss, the "demolition of the path of life", may result in *desperation* and *hopelessness* in the sense that there is a lack of any trust in a future that could be *good*.

[7] Van der Kolk & Fischer (1995) refer to the critical role of the trauma in the context of life, which is "deformed", thereby destroying all set purposes in life

The consequences of such an *existential uprooting* are that we can experience a type of *abyss* during therapy for PTSD (as also with many other serious personality disorders). They correspond to neuro-anatomical, neurobiological, neurophysiological and neuropsychological changes, such as increased activity of the amygdala (disorder of the world of feelings), reduction in the volume of the hippocampus, deterioration of the regulation in the orbito-frontal cortex (which is linked with a particular susceptibility to PTSD) etc. (see e.g. Hüther 1997, 2002; Stein et al. 1997; Schore 2001; Kent et al. 2003). All applications of insight, practice and improvement fail again and again and the old symptoms, images, modes of behaviour, reactions and comprehensions reappear. The clarity of feelings that are processed during therapy sessions, the intentions, motivations and decisions are lost again almost as soon as the patient is at home again. My colleague Hans Zeiringer once compared the loss of these structures with patients after a *stroke*: therapeutic measures can only be effective and sustained to the degree that the neurological structure regenerates after the insult. Many stroke patients largely recover, others remain with permanent damage. For understanding and practical work it is helpful to consider the processes in a PTSD analogous to the psychological plane (see also Hüther 2002). The effect of this obstinate stagnation in therapy on the therapist should not be underestimated. Feelings of powerlessness and incompetence are quickly generated in the counter-transfer. The treatment demands great efforts from the therapist, a genuine assessment of the therapist's capacities and an ability to retain one's self-image (van der Kolk et al. 1996).

9. Coming into dialogue

To make progress at the start of therapy we consider the work on the dialogue and the guidance of the patient to be central on several levels. The *guided dialogue* offers structure and on the other hand the *processing capacity* of the patient is encouraged and awakened. The guidance of the dialogue is important not only because of the implicit *avoidance behaviour* but also because of the non-contextualized, associative functioning of the traumatized *memory* (both are applicable, in common with the above-mentioned continuous feeling of threat by excessive negative evaluations, as factors in the development of PTSD in the cognitive-behavioural model of Ehlers & Clark, 2000). Esterling et al. 1999 note that *unconducted* dialogues or solitary writing at home are often more damaging than if no such activities take place.

Stephens (2002) conducted multiple studies that show that there is sufficient empirical evidence to demonstrate that the deterioration of speech as a result of a trauma makes psychological and physical health worse. In contrast, the studies provide sufficient evidence to demonstrate that speaking (or writing in addition) about a trauma has positive effects on psychological and physical health. Pennebaker, Mayne and Francis (1997) state that speaking and writing are two independent processes that are therefore applied in parallel. The former is the need to prepare a history or explanation of the event and the latter is more about the necessity of naming the feelings.

In order to face the world again after a trauma the shock of being addressed in a close personal manner is extremely important[8]. The shocked, mutilated person needs

[8] Translator's note: the writer suggests that the therapist should address the patient in the familiar form (*Du*) instead of using the formal doctor-patient relationship (*Sie*).

someone whom he can trust, who is close to him, who respects and guides him, and who also sometimes contradicts him and restricts him,[9] and who believes that he will develop and has a future. The familiar form of address embodies the *counterpole of his judgment*, meets him with the specific qualities of an *existential rootedness*, which he in some way takes over for the patient and presents it to him as a likeness (Stuhe, Wirth 1990). The *personal rigidity* should be slowly relaxed by the attitude of the therapist and the communication by dialogue, and this should enable the existential structure to develop new roots. This will *personalize* the apersonal blockade resulting from the trauma and allow it to be penetrated by the person (van der Kolk, McFarlane, Weisaeth 1996). At this point it is particularly important not to force – this will only cause retraumatization (Roderick, Schnyder, 2003). The therapist must consider the increasing formation of structure in all existential areas – it releases more process capacity as a countermove. In my opinion, the question of w*hich* existential structures grow first still needs to be investigated as to whether this has a standard sequence or is different from case to case depending on the personality of the patient and/or the therapist. This also applies to the question of how the structure formation affects the ego functions and their release.

A *central* point for the therapist is to build up a constructive *internal dialogue*. The impulse for this is derived from a good, trustworthy, empathetic *external* dialogue, which acts as a model and path for the internal dialogue.[10] From the point of view of *development history* the person does not develop alone but by encountering the other. In a PTSD the person begins existentially "from the beginning" again and therefore needs the other to establish access to the self, to establish trust in one's own body, to detect the feelings as one's own again, to build up a new identity and to move on into the future. Persons traumatized by *abuse* are in particular need of reliable, well-meaning, protective encounters in which they can see their own personal strengths reflected to gain access to themselves again and to be able to see themselves. Victims of abuse in particular also have a directly *destroyed self-image* in addition to the destructive view of the world caused, for example, by a natural disaster. What they saw, what was done to them is counter to every possible form of self-acceptance. Therefore, these patients lose themselves again and again, no longer see themselves and fall instantly into the same loss of self that they experienced in an acute form. For example, if an acquaintance takes their hand or may become the source of force (May 1972).

In addition to these perception disorders with reference to oneself, powerful *psychodynamic counterreactions* may also be caused by these *continuous losses of oneself*. To lose oneself again and again is repeated, painful, retraumatizing experiences of being unable to stand up for oneself. Because the structural preconditions are not present, the traumatized person experiences his own failure and falls into self-hate and self-disgust. Without an opposite who sees the traumatized person and *retains the structure for him*, these persons are virtually incapable of escaping the vicious circle. They need the external dialogue as nourishment for

[9] Lutgendorf and Antoni (1999) found that the danger of intrusions and negative influences increased with the number of words used for transcribing – a symptom of dissociative-histrionic processing that requires containment by another person.

[10] E.g. Janoff-Bulman 1992; on the meaning of language as structure formation for the healing process, see Pennebaker, Mayne and Francis 1997; writing about the trauma is also healing, so long as it is emotionally loaded, as measured by fewer visits to physicians and fewer diseases: Pennebaker and Beall 1986; see also the meta-analysis by Smyth 1998, which comes to the same conclusion in spite of diverging results in the total.

intellectual-spiritual growth and for the structure of a genuine internal dialogue appropriate to themselves and the situation. The internal dialogue is essential, since it is the only way in which what has been retained is implemented, its availability established and integrated into the ego.

10. Guidelines for practical therapy

In conclusion, actual work areas should be listed for practical therapeutic work. The therapy stages are classified as follows in accordance with the existential-analytical structural model and the lists of the specific structures of the ego involved in the suffering related to the trauma.

1. **Reality (relationship to the world):**

   Work on the core assumptions (assumptions of reality, i.e. the **image of the world**); work on and exercises in ***sustainable*** structures, particular on the ***acceptance*** of what is there (corresponding to the first fundamental motivation).

2. **Values and relationships (relationship to life):**

   Attention: application of the therapeutic relationship, that has a sustaining function (and usually its reliability is tested by the patient at the start of therapy and therefore it also requires active participation by the therapist – see Grassmann 2004, 46f.); the ***feelings*** are integrated into the therapy step-by-step with active empathy (with "minimum difference" to the traumatic experience – Grassmann); **partiality** in the relationship (Wirtz & Zöbeli 1995) and the therapist expressing opinions.

3. **Restructuring the self (relationship to self)**

   Guidance by the therapist; work on implementation of small steps of ***freedom*** and controlling one's own life; enabling and guiding towards one's own ***opinions***. Central process work with the aid of the **PEA** towards step-by-step processing of the traumatizing experiences. Hyer & Brandsma (1999) emphasize that treatment of the trauma alone is not sufficient; it is more important to treat the person and that person's self-image.

4. **Restoration of a contextual relationship (relationship to sense):**

   Existential turn and integration of the ***situative sense*** (Frankl); ***ontological sense*** and spirituality (Wirtz & Zöbeli 1995); yielding the non-understanding to "overwhelming reality".

This process contains primarily *restructuring* elements. The mobilization and integration of *resources* is the basis of the therapy after the disasters of the traumatic experience. The first task is to establish the most necessary items for survival and to establish a little room for movement. In this sense the basic existential motivations and personal resources can be seen as the prerequisites for "post-traumatic growth" (Jaffe 1985; Calhoun, Tedeschi 2000; Tedeschi, Calhoun 2004), which is supported by the study of the influence of the basic existential capacities (Rödhammer 2002). The growth at the trauma offers a variety of options, such as a greater estimation of the value of life in general, deeper interpersonal relationships, a clearer feeling for one's personal strength, altered priorities, a richer intellectual and spiritual life (Tedeschi et al. 2004, 1).

It is important not to overlook the fact that the **confrontation** with the traumatizing experience and its processing represents a critical point in the treatment of the trauma (for an overview see Schnyder 2005, 496ff.). A *retraumatization* is likely without prior release of stress and without mobilization of resources (e.g. experience of a new base, new relationship to values and emotionality). Naturally, from the point of view of the therapist it would be desirable for the patient to achieve a sustained, even final release from pain. The therapy should most preferably have a "causal" effect and not simply symptomatic. This therapeutic ambition and the unthinking countertransfer of the patient's desire for healing may result in approaching the trauma experience too boldly, too early, too directly etc. (Roderick et al. 2003). It is important to keep in mind that much serious traumatization *cannot be processed* but the only option is to learn to resume life in the form of a *new* changed life "in spite of" or "with" the experience. This is because sometimes the only possibility is to exhaust the remaining options and to rebuild the self *beside* the ruins. Viktor Frankl with his famous "*in spite of everything* say Yes to life" is of this opinion. In my experience and view it is virtually *impossible* to process a serious trauma to the extent that complete internal *rest* is achieved and pain is no longer experienced. Such a major experience can *never lose its monstrous character* – in that case the traumatization and terror would only be excessive reactions and ignore their existential depth and serious character.

Only if *sufficient structure* is available can the healing process be started. The intrusions must first be countered with structure formation to provide a barrier against them. If this is achieved, the processing of the trauma can be started, e.g. with the PEA, so the patient will not feel completely lost in the face of the intrusions. Sensitive application of the PEA also provides an indication of whether the time of trauma processing is suitable. Simonet & Daunizeau (2002) wrote the following on successful trauma management: "Without wanting to deny the victim role, the experience can be integrated and will result in a change of identity. These people 'die in themselves' to become born again – as others. In the consciousness of their vulnerability and the brittleness of their interior and exterior world they achieve the deeper sense and are in a better position to value the moment" (cited by Lavallée & Denis 2004).

While in the case of normal psychological disorders one or two basic conditions of existence have become a problem, the experience of a trauma wrenches the whole basis of existence off its foundations by an overwhelming impact. Because none of the "four roots" of existence are now firmly based and are unable to nourish the self, there is initially nothing on which therapy can "position" its bridge and have a "free movement" in the process. The simultaneous effect of the disorder of all dimensions of the self explains the *complexity* of the trauma therapy and the spontaneous difficulty in helping the victims. This may be a reason that psychiatry and psychotherapy have overlooked the specific trauma effect for decades. Frankl (1946, 1996) with his preoccupation with the "psychology of the concentration camp" was a pioneer in this field and emphasizes the necessity of intellectually addressing the sense as essential for overcoming the terrifying experience. However, until the 1990s Frankl was virtually never taken seriously in psychotherapy with his "psychology from the spirit". This helplessness in the face of the trauma accompanied by the displacement goes along with the rejection and denial of *abuse events* that had its beginning in Freud's historically fatal error in classifying trauma therapy as a cause of the neurosis (Freud 1896; Atwood, Orange 2000).

This work will give us as psychotherapists – and particularly existential analysts – an impulse to view life in its *deepest structure* and *incomprehensibility* and to work more

on our own *anchorage* in the basis of the personality. In this way the work with the traumatized person will not only serve the affected person but will benefit us all and indirectly will assist our own personal growth.

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