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ENHANCING BIOPSYCHOLOGICAL UNDERSTANDINGS OF POSTTRAUMATIC
STRESS

A Sociohistorical Perspective of PTSD: How Scientific Explanations and
Approaches to Posttraumatic Stress can be enhanced by the Humanistic Psychology
and the Narrative Experience of Trauma

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Abstract

Current understandings of posttraumatic stress today have been built upon the foundations of Freudian psychoanalysis, which has continued to dominate mainstream psychology, in recent times being empirically backed by modern-day cognitive psychology and neuroscience. However, the implication which these physiology-centric explanations hold is that they have a tendency to reduce mental distress caused by trauma to a disorder, namely posttraumatic stress disorder (PTSD). Trauma involves a psychologically distressing event occurring within the external world, separate from an individual, and has been identified as an experience. To fully conceptualise and gain a greater understanding of the effects of trauma on people – as both groups and individuals – the narrative mode of human experience, the role of existential meaning has in recovering from trauma, and how trauma affects people on a spiritual level must not be disregarded. Research from significant areas of humanistic and narrative psychology, including prominent Holocaust survivor and psychiatrist Victor Frankl, has been detailed in respect to traumatic events and how they are experienced by people for important consideration.

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A Sociohistorical Perspective of PTSD: How Scientific Explanations and Approaches to Posttraumatic Stress can be enhanced by the Humanistic Psychology and the Narrative Experience of Trauma

*The world he thought he knew no longer made sense to him, and he began to change –
Nicholas Sparks, “The Longest Ride”*

Trauma has become a prominent topic in recent years, particularly with the growth of social media and increased globalisation. Empirical evidence suggests that most people will experience at least one traumatic experience in their lifetimes (Ogle et al., 2013). Though there is no total consensus on what constitutes a traumatic experience, regardless of the nature of a distressing event which one goes through, a majority of people will have at least some short-term symptoms of severe psychological distress. In most cases, these symptoms will gradually subside after a few weeks without any need for formal intervention, but a small proportion of people will go on to develop more long-term mental health problems.

There have been several prominent ‘trauma-turns’ in the past century and a half in particular. While reports of trauma and suffering have been reported since antiquity, trauma only began to be fully conceptualised in the 19th century with Charcot, Janet, and Freud, leading to the diagnosis of hysteria and Freud’s notorious seduction theory (Birmes et al., 2010). The connection of traumatic events to physiology which was established by Freud is now the most widely recognised understanding of how severely distressing events affect the human psyche.

The Etymology of Trauma

The word ‘trauma’ originated in the late 17th Century and literally translates to ‘wound’ in Greek, in reference to an injury in or on the body (Caruth, 2014; Traverso & Broderick, 2010). It is thought to be derived from the Proto-Indo-European root ‘tere-’, which means ‘to rub, turn’

(Zolkos, 2010). It was not until the late 1800s that trauma came to refer to that of a psychological nature as well, with the affronting nature of the World Wars spurring people to recognise the extent of the effect of trauma on the human mind (Bruner, 2000; Pedersen, 2015). This is most notably seen with Freud, who initially proposed that physical symptoms of hysteria observed in patients was the result of childhood sexual abuse which had been repressed in adulthood. As a result, the word ‘trauma’ can be vague in its use and definition. In the medical realm, it is often referred to as traumatic injury, which is when an external object comes into forceful contact with the body and results in damage (Richmond et al., 2000). Specifiers are often attached when speaking of physical trauma due to the varying natures in which it can manifest, such as blunt trauma, penetrating trauma, or major trauma, to name a few (Traverso & Broderick, 2010). Psychological or psychic trauma, on the other hand, is less specialised in its manifestation (Moskowitz et al., 2018). Often on its own, the word ‘trauma’ generally is implied as that of a psychological nature. The DSM-5 currently defines psychological trauma as “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p. 271; Pai et al., 2017). Regardless of the origins of the word, trauma has always been considered to be a type of wound, a perspective which has dominated the understanding of it today (Garland, 2018). Nowadays, it more often than not refers to damage to the mind, an external assault which pervades the inner experience of a person and damages their sense of self, identity, and understanding of the world (Erikson, 1991).

There is a deeply complex relationship between all forms of scientific theory and the popular culture of the times (Beer, 1996; Cooter & Pumfrey, 1994; Serres & Latour, 1995). Our psychological understandings and clinical practices surrounding trauma, PTSD, and other posttraumatic phenomena do not exist in a vacuum, rather they have been influenced by the

sociohistorical contexts in which they were constructed. Moving forward in the diagnosis, comprehension, and treatment of trauma, we need to realise where these forms of knowledge have come from, what zeitgeist they were developed in, and how that has affected what we understand now. The ways in which we describe and explain ourselves, others, and the world are determined by and are the outcomes of relationships. The language which we use to talk about something determines its reality within a particular context. We need to delve into the narratives that these perspectives of trauma do say, and possibly more importantly, what they do not.

Precursors and Beginnings of Trauma Studies

While it has been a topic to researchers since antiquity, in the form of severe emotional distress and suffering, interest in the mechanisms and aetiology of trauma really only began in the middle 17th Century with the rudimentary beginnings of neuroscience, neurology, and in particular, the conceptualisation of hysteria (van der Kolk, 2000).

Before any systematic organisation and attribution of brain anatomy and activity, more physically expressed symptoms, such as psychosis, emotional outbursts, and flashbacks – all characteristic of posttraumatic stress – were viewed in Western society as having supernatural, spiritual, or demonic sources (Farreras, 2019; Hinshaw, 2015; Rabkin, 1974). These individuals were painted by society as being extreme and bizarre, with inappropriate cases of psychological dysfunction being viewed as ‘monstrous’, deviant, withdrawn, and needed to be removed from civil society (Foucault, 1965; Goffman, 1961; Horwitz, 2020). This discrimination led to the construction of asylums, sanatoriums, which became the main form of care for severe mental illness in the 19th and a majority of the 20th Century (Anthony & Liberman, 1986; Chow & Priebe, 2013). The practice of psychiatric institutionalisation, or involuntary detention, was mostly punitive and dubious in nature, said to have similar characteristics to prisons,

concentration camps, and monasteries (Goffman, 1961). Asylum patients had limited freedoms and were closed off from the rest of society for extensive periods of time, with all aspects of their lives following set schedules which were strictly enforced and dictated by the institution the entire time they were there (Corrigan & Kleinlein, 2005; Walmsley, 2005). They also often experienced physical and social abuse, which dehumanised them and removed them from their past roles and identity, forcing them to take on an institutional role – a process Goffman referred to as the ‘mortification of self’ (1961). In the cases of total institution, patients’ everyday activities were carried out in the immediate company of a large group of people (Chow & Priebe, 2013). Those who were admitted to asylums essentially received custodial care, despite many of them not having broken the law, and suffered from the stigma of being a psychiatric patient due to their normal social roles being taken away from them (Lloyd et al., 2006; Thensen, 2001). Though the process eventually became more human within the 20th century, with asylums being renamed psychiatric hospitals and inmates referred to as patients, institutionalisation continues today in some shape or form (Chow et al., 2019). Reports of conditions from previous patients tell of the alienating, isolating, and inhumane conditions which the mental institutions kept them in, particularly in the 20th Century, when exponential population growth and major industrial development occurred (Fakhoury & Priebe, 2007; Ofori-Atta et al., 2010).

It was only with the development of the medical concept of hysteria that this began to change. Hysteria was initially thought of as afflicting unstable or malingering women, originating from abnormal ‘wanderings’ of the uterus, and was used as a catch-all diagnosis for any unidentified ailments (Scull, 2009). It arose out of a need to characterise neurological symptoms which could not be otherwise explained by the understandings of anatomy at the time (van der Kolk, 2014). Most commonly reported symptoms included emotional outbursts,

susceptibility to suggestion, and muscular fits, contractions, and paralysis, although there was never consensus about a comprehensive set of characteristics solely for hysteria. (Beard, 1905; Briggs, 2000). In some cases, physicians were sceptical that symptoms were real at all, believing that some ‘hysterical’ patients were in fact faking their symptoms (Thurschwell, 2009). Thought to need a firm-handed solution, treatments varied from magnetic action on affected areas of the body – a process known as mesmerism - to the distribution of smelling salts, which were used to quell emotions should they arise (Maines, 2001; Tasca et al., 2012). Perhaps the most famous cure at the time came in the form of Silas Weir Mitchell’s ‘rest cure’ for neurasthenia, a slightly less violent form of hysteria, in which patients were placed in isolation from friends and family, in immobility and lack of intellectual stimulation, as well as an excessive diet in which women were expected to gain over 20kg (Bassuk, 1985; Thurschwell, 2009). Hysteria was originally thought to be a result of witchcraft, demonic possession, or other supernatural causes (Trimble & Reynolds, 2016). But with improving diagnostic techniques and tools, diagnoses of hysteria began to decline and eventually, the perception of it changed from having spiritual or ethereal sources towards being a mental illness with a functional or psychological cause (Chodoff, 1974; Freud & Breuer, 1895).

There were several significant figures in the late 19th Century who influenced the systematic study of posttraumatic stress prior to Sigmund Freud, who is arguably the most well-known researcher of psychological trauma (van der Kolk, 2014). One of his mentors, Jean-Martin Charcot – known to many in the field as the ‘founder of modern neurology’ – supposed hysteria was a result of neurological disorder in an attempt to dispel any supernatural explanations behind it and tried to treat it medically (Charcot, 1889; Clarac et al., 2009; Micale, 1989). A neurologist by trade, he is best known for his work in the neurological unit at the

Hopital de la Salpêtrière, where he studied many patients who displayed a plethora of focal neurological changes symptoms collectively diagnosed under the designation of hysteria (Ellenberg, 1970; Goetz, 2006). His intense interest in hysteria often had him mislabeled as a psychiatrist and although he never hypothesised that psychological distress could be the primary cause of neurological symptoms, his work and views remain engrained in neuroanatomy. Between 1878 and 1893, Charcot conducted numerous studies attempting to pinpoint neurological correlates of hysteria, many of which were accompanied by theatrical demonstration and presentation of the (usually female) hysterical body in the form of his patients, which gained him both scientific and social notoriety (Micale, 1993; Stephenson, 2001). He was one of the very first researchers to hypothesise that hysteria could be associated with trauma, which helped pave the way for other researchers to understand the neurological origins to symptoms occurring from combat or industry associated events (Goetz, 2016; van der Kolk, 2014).

However, it was one of Charcot's students, Pierre Janet, who would ultimately become fundamental in future understandings of the mechanisms of trauma. Janet was one of, if not the first to identify the dissociation which was often observed with traumatic memories (van der Hart & Horst, 1989). In terms of hysteria, he considered it to be a result of deep-set tendencies towards a narrowing of the consciousness – or the congenital preposition of one's unconscious being easier to access and act upon (van der Kolk & van der Hart, 1989). This understanding emerged out of his life-long interest in hypnosis, a procedural phenomenon where a specialist induces an alternative state of consciousness in an individual. The hypnotic state is thought to involve focused attention and reduced peripheral awareness which allows for an increased response to suggestion and therefore prompting changes in perceptions, thoughts, or behaviours

(Elkins et al., 2015). He published the first book-length scientific account of posttraumatic stress - *L'automatisme psychologique* - which proposed that the root of hysterical symptoms (a select few of which are now collectively known as posttraumatic stress disorder) was a result of the improper integration of traumatic memories (van der Kolk & van der Hart, 1989).

Unlike Charcot, Janet also spent time speaking with his patients in conjunction to studying their physical and neurological symptoms, as his main goals lay with treating his patients while Charcot's primary focus was understanding the phenomena and mechanisms of hysteria (van der Kolk, 2014). With this conceptualisation of traumatic dissociation, by the time Freud was practising, hysteria was considered to be a diagnosable medical condition with origins in a diseased or injured nervous system. Freud was able to build on his mentors' previous work to formulate one of his most longstanding ideas today. Freud himself was of the belief that hysteria was a psychosomatic disorder, an affliction of the mind expressed through the body, which could be broadly defined as a condition characterised by symptoms like anxiety, fainting, seizures, paralysis, and amnesia – in conjunction with exaggerated, irrational, or inappropriate emotional behaviours (Beattie & Lenihan, 2008; Freud, 1997a; Freud & Breuer, 1895). He saw hysteria as the manifestation of unresolved traumatic childhood memories, namely childhood sexual abuse, and perceived it as a dysfunction of a regular mental process as opposed to abnormal psychopathology (Freud, 1971). Freud also believed that hysteria could affect both men and women, famously noting in 1897 that he himself had hysteria as a result of his work, a moment of self-analysis emerging from the death of his father (Halberstadt-Freud, 1996). This largely put to rest the idea that hysteria was an illness associated with the uterus, therefore a condition that solely afflicted women.

Because of this more physiologically grounded perspective, researchers at the time began to move towards more scientific and analytical approaches in the study of hysteria (Devereux, 2014; Janet, 2007). As a result, throughout its relatively short history, researchers in all areas of psychology have strived to establish the field as a hard science, which includes the inclusion of experimental research, statistically significant results, and quantitative data (Hatfield, 1995; Watson, 1913). Today this effort can be most easily seen through the proliferation of cognitive-behavioural therapy (CBT) as the mainstay theory and intervention used in treating almost all forms of psychological distress from depression and anxiety to eating disorders and insomnia (Barrera et al., 2013; Hundt et al., 2013; Otte, 2022; Pigeon, 2010). CBT's status as a "gold standard" for psychotherapy is thanks to vigorous experimental studies and reviews, and the therapeutic approach is known as one of the only ones which has shown to be empirically and significantly effective in the treatment of many forms of mental distress (David et al., 2018).

Posttraumatic Stress Disorder (PTSD)

The dominant psychiatric and psychological understanding of trauma today is through posttraumatic stress disorder, a diagnosis which emerged from observations of American soldiers returning from the Vietnam War (Wong & Cook, 1992). PTSD is defined as a trauma- or stressor-related disorder which develops after direct or vicarious exposure to a traumatic event, series of events, or circumstances. The event must be in reference to actual or threatened death, sexual violence, or serious injury and must include at least one of each of the following sets of symptoms. Firstly, there must be the presence of intrusion symptoms, such as: recurrent nightmares; repeated involuntary and intrusive distressing memories of the event; dissociative reactions – such as flashbacks – which feel as if an individual is re-experiencing the event; intense and/or prolonged psychological distress and marked physiological reactions in response

to internal or external stimuli which resemble an aspect of the event. Secondly, there must also be symptoms of persistent avoidance, or efforts to avoid distressing memories, emotions, thoughts, or external stimuli which evoke any of these. Individuals must also display at least two of the symptoms from the following categories – cognitive and reactive. The first, negative alterations to cognition and mood in relation to the traumatic event, including: persistent negative emotional state; dissociative amnesia; exaggerated negative beliefs or expectations of self, others, or the world; distorted cognitions about the cause of the event; feelings of detachment and estrangement from others; and/or marked diminishment and participation in significant activities and interests (American Psychiatric Association, 2013). Lastly, individuals also need to show alterations in arousal and reactivity beginning or worsening after the traumatic event occurred, such as: sleep disturbances; concentration issues; hypervigilance and an exaggerated startle response; reckless or self-destructive behaviours; and irritable behaviour with no obvious source of provocation. These disturbances must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; occur for at least a month after the event; and cannot be attributed to the physiological effects of another substance (e.g., medication, alcohol, psychedelic substance) or medical condition. PTSD is a devastating issue with high rates of chronicity and comorbidity which interferes with one's capacity to work, create, and love through a complicated interplay of genetics, biology, individual psychological factors, and the environment (Jain, 2019; Lasiuk & Hegadoren, 2006).

Particularly within the last 25 years or so, there has been a rapidly increasing interest in traumatic stress syndromes in the medical field, behavioural and social sciences, and even legal areas (van der Kolk et al., 1994). When viewed from a historical perspective, this is in no way surprising, and is even understandable, taking a retrospective look at some of the major events

having occurred within the past century. Not only have we gone through two world wars, numerous nationalistic and colonial wars, civil violence, and instances of mass genocide, there have been several notable catastrophic disasters – both man-made and natural in origin, famine, an increasing awareness of domestic violence and childhood sexual abuse; multiple pandemics from the plague to human immunodeficiency virus (HIV) and most recently, COVID-19; as well as countless more events of collective and individual distress (Wilson, 1994).

The PTSD diagnosis has been through several iterations over the decades, with the differences between them reflecting sociocultural and political influences of the times as well as developments in evidence-based research into the nature of trauma and its sequelae (Friedman & Marsella, 1996). Before its official induction into the Diagnostic and Statistical Manual of Mental Disorders (DSM), one of the earliest descriptions of PTSD was in the mid-1800s where the phenomenon was referred to as ‘railway spine’, which was thought to occur in individuals who had experienced the violent shock of a railway collision due to the frequent occurrence of the symptoms with train accidents (which were relatively common at the time) (Erichsen, 1867). Despite the name, Erichsen did not confine diagnosis of the disorder to only those involved in railway accidents, noting that the same effects could possibly occur from other incidents of injury or distress in everyday life. Many historical diagnoses such as ‘shellshock’ and ‘combat fatigue’, which emerged after the periods of World War I (WWI) and World War II (WWII) respectively, described the same characteristics appearing in veterans of those times (Lasiuk & Hegadoren, 2006; van der Kolk et al., 1994). Its diagnostic predecessor, gross stress reaction, was initially introduced into the first version of the DSM in 1952, in which the main causal factor was listed as stressful environmental events such as natural disasters or war (Andreasen, 2004). The gross stress reaction category was removed from the DSM-II without any clear

reason, leaving no diagnosable cause to which pathological reactions to trauma could be attributed until PTSD was finally established in 1980 (Spitzer et al., 2007).

It is also important to recognise that the field of psychology as a scientific discipline largely emerged out of medicine, particularly when speaking about psychology from a Westernised context, where much of the psychological protocol and standards are determined by the American Psychological Association, or APA for short (Benjamin Jr., 1997). The DSM was originally designed in North America for psychiatrists, pharmaceutical and health insurance companies, the legal system, and researchers, rather than for psychologists (Shorter, 2013; Wilson, 1993).

Clinical psychologists largely came into the fray to help with the influx of veterans returning from WWII displaying posttraumatic stress symptoms known as “shell shock” at the time. From previous experience from WWI, there was a general agreement that one of the best preventative interventions for shell shock was to implement treatment as soon as possible. Medical doctors - which include psychiatrists - were inundated with treating physical injuries and wounds, so psychologists were brought in to meet this demand (Alessndri et al., 1995; Benjamin Jr., 1997). The PTSD diagnosis was in part created so these clinical psychologists had an agreed, universal standard to assess and identify the specific characteristics and symptoms of the disorder to move forward with treating traumatised individuals. Further, female psychologists, who were excluded from the war effort, created their own council – the National Council of Women Psychologists - to help give young mothers advice for child rearing and to help communities as a whole deal with the stresses bought on by the war (Compas & Gotlib, 2002). To meet all these needs, the USA Veteran Association put huge investments into setting up doctoral-level clinical psychology programs. Prior to this, there was no formal training

program – tertiary or otherwise – in clinical psychology, and the USA went from no qualifications in the field to over half of the PhDs in the country being awarded in clinical psychology by 1950 (Compas & Gotlib, 2002).

A relatively new diagnosis, PTSD has caused controversy since its inception in the DSM-III, with its criteria changing drastically with each subsequent edition and its revisions (Friedman et al., 2007; McHugh & Treisman, 2007; North et al., 2016). It was a marked move away from the psychoanalytical perspective which dominated the field of psychology up until the 1970s and distanced its symptomology from sexual abuse, which had been the predominant aetiology of trauma since the 1880s. After the revision of the fourth edition in 1994, much of the relevant literature in psychology was rife with critical arguments concerning the definition of trauma and whether PTSD was a valid diagnosis at all (Pai et al., 2017). Furthermore, the reification of PTSD was a direct reaction of political and professional influence of psychiatrists advocating for compensation for Vietnam veterans and protest from feminist groups who were attempting to resist and make known the social silencing of sexual and domestic violence (Luckhurst, 2018).

Though controversial in its conception, the addition of PTSD to the DSM revolutionised the way psychologists and psychiatrists alike understood, interpreted, and treated victims of trauma (Najavits, 2002). It reinforced the idea that extenuating external circumstances could affect mental wellbeing and that trauma itself could be an etiological agent causing psychopathology, filling a niche within clinical psychiatry (Andreasen, 2010; van der Kolk, 2002). The introduction of the PTSD category linked clinically significant psychological distress to exposure to a significant stressor, rather than issues originating within the individual (van der Kolk et al., 1994). Those who had been deeply affected by distressing events in their life finally had some sort of validation and justification to their abnormal reactions that continued to occur

long after the traumatic event had passed (van der Kolk, 2014). The conceptual framework of PTSD led to the set of symptoms associated with it to be diagnosis of complex bio-behavioural changes, giving posttraumatic stress a medical basis, which could then be catered for and treated within the healthcare system (McFarlane, 1988). Regardless of conflicting opinions and concerns about its universal assumptions surrounding psychobiological outcomes, the psychiatric, PTSD approach remains one of the dominant ways of understanding trauma today (Quosh & Gergen, 2008),

Trauma as an Experience and Trauma Narratives

Understanding the human experience started with the emergence of cognitive psychology, which came to be a formal field of psychological study as a challenge and criticism to the behaviourist approach (Chomsky, 1959; Friesen, 2005). Where behaviourism assumed that psychological phenomena which were unable to be physically observed sat outside the realm of empirical science, cognitive psychologists fought to apply the scientific method to the study of human cognition and emotion (Lyons, 1999; Nagowah & Nagowah, 2009). A particularly notable figure in this field, Jerome Bruner, highlighted the importance of language in the development of human cognition and from this proposed that there were two different modes of thought - paradigmatic and narrative (Bruner, 2009). Where paradigmatic cognitions fall under what is considered to be the method of science, grounded in classification and categorisation, Bruner believed this could not account for people's perceptions of everyday life. This led to the idea of the alternative, narrative form of thought, which Bruner saw as responsible for the organisation of an individual's interpretations of events and interactions in the world in storied structures (Bruner, 2009). These two patterns of thinking were considered by Bruner to be, while

distinctive, both fundamental. Bruner's work would become influential in the development of narrative psychology.

Ideas of how people perceived themselves, others, and their reality began changing from that of a closed system to that of an experience of openness. Bruner himself advocated for a more holistic understanding of the human mind and its cognitive processes as opposed to the computer-model which dominated the early 1900s (Bruner, 1964, 2013; Greenfield, 2016). He saw world-making through narrative as a principal function to the mind, and this was something which needed to be taken into account in the analysis of both human cognition and the application of psychotherapy. However, up until around the 1980s, stories were considered to be too 'soft' and human lives too singular and vast to be encompassed by a generalised narrative (Crossley, 2000). It was only with the evolution of personality psychology away from the trait model and more towards exploring broader issues of central concern to human lives that narrative psychology was formally established. Developmental, social, clinical, cognitive, counselling, and industrial -organisational psychology researchers were becoming increasingly interested in story concepts and narrative methodologies, with terms like 'story' and 'narrative' helping people convey coherence and meaning within people's lives (McAdams & Ochsberg, 1988). This was further evidenced in research into sociocognitive contingencies; dynamics of behaviour; intrinsic goals and individual motivations; and the structural organisation of all traits (e.g., OCEAN by McRae & Costa, 1990) (Crossley, 2000).

Narrative psychology, at its core, is the study of how humans use narratives and construct stories to deal with their experiences in life, and subsequently, heavily focuses on human experiences as they are lived, experienced, and interpreted for each individual (Crossley, 2000; Sarbin, 1986; Schiff, 2012). Using a social constructivist approach, it assumes an interpersonal,

intersubjective, and collaborative dialectic between the meaningful participation in social life and intergroup relations and meaningful use of language (Bruner, 1991). There is a large focus on the interpretative nature of meaning which distinguishes narrative psychology from other traditional approaches. It assumes meaning is inherent within all human activity and experience, and people attempt to understand that meaning through use of stories (i.e., narratives) and the medium of language (Polkinghorne, 1988). This need to seek meaning is thought to come from the inherent social cognition and adaptation humans develop from growing up within societies and communicating with others naturally leads to reflection and introspection, and in turn that leads to the concept of meaning and inquiring into what that meaning entails (Crossley 2000). As fundamentally social creatures, it makes sense that people learn to understand the world and its interactions through listening to others, and in turn, using that information to engage in self-reflection (Gergen, 2011; Schultz, 1972). Constructing narratives, in this sense, becomes a methodology - when people create their own stories, they are articulating what is or has happened in their lives to both comprehend and cope with those events (Schiff, 2012). Human experience and behaviour are meaningful, therefore, to understand ourselves, others, and our environments, we need to explore the ideologies and structures of meaning (i.e., language) that make up our minds and our worlds (Polkinghorne, 1988). People think, perceive, imagine, interact, and conduct moral decisions according to narrative structures (Sarbin, 1986). This has been shown through an implicit use of plot, of which we are surrounded in through myths, folklore, popular television, movies, and religious histories and fables, and use to help us interpret our own lives (Clark, 2001). We place ourselves at the centre of experience in order to make sense of what has, is, or will, happen to us, in addition to sociocultural, historical, and temporal contexts (Sarbin, 1990). The kind of consciousness we value is often in the form of a

narrative, which deals in the human or human-like intention and action, as well as the vicissitudes and consequences which mark their course (Bruner, 1985; Oakley, 2007). As a result, humans are constantly engaged in the process of creating themselves and actively engage in narrative philosophy - this is the tenet of narrative psychology. Today, narrative psychologists believe that one of the greatest challenges that contemporary psychology faces is understanding narrative thought and applying the knowledge of this everyday form of thinking to explanations, assessments, and interventions concerning both normal and abnormal psychological processes (Murray, 2015). There is so much of a heavy emphasis on the scientific and methodological understanding of posttraumatic stress that how it is experienced and understood in the everyday, as a part of one's life, is neglected. Where experimental and empirical models are criticised for the shallow and likely inadequate construct of the 'self', humanistic perspectives place an immense amount of responsibility on individuals and human agency to determine it (Crossley, 2000). This extreme binary fails to account for the complexity of the human experience being both something a person is engaging in as well as concurrently happening to them, which is pertinent when dealing with posttraumatic stress. Unlike other psychological disorders, the main issue in trauma and PTSD is people's realities (van der Kolk, 2014).

People generally have a very set idea of how the world works. Each of us have a personal theory of reality, coherent schemas about ourselves, others, and the world which developed over time, and we use to comprehend and navigate the physical and social constraints of reality (Janoff-Bulman & Timko, 1987). This is known as the assumptive world, which organises our experiences and motivates or directs behaviours (Kauffman, 2013; Landsman, 2013; Parkes, 1971). Our fundamental assumptions comprise the core of our cognitive system and therefore our recollection of past memories, understanding present events, and anticipation of potential futures

(Epstein, 1998). Subsequently, most people in the modern Western world generally have benign positive beliefs about themselves, others, and the world (Taylor, 1989). While not all people hold these basic assumptions, they are thought to be adaptive to believe that we, and others, are inherently 'good' and thought to be a way of having some measure of control over our lives (Janoff-Bulman, 2010; Thompson & Janigian, 1988). These deeply entrenched clauses about the world are automatic: often we are unaware of them consciously and presume these conditions will persist without need for any proof. Therefore, they are most resistant to change (Janoff-Bulman, 2010). We use these meaningful narratives for us to be able to understand and make sense of the world and others, how we interact with our environment, and the thoughts and emotions associated with those behaviours all boil down to meanings (Luckhurst, 2018). Therefore, it makes sense that humans intrinsically seek meaning – particularly in the face of negative events, where it often feels as if our entire understanding of reality has been irrevocably changed (Eagle, 2005; Landsman, 2013; Steger & Park, 2012). In the face of an absolute obliteration of the structure of everyday life, core beliefs about the self, others, and the world as a whole, these stories and other modes of narrative therapy have the capacity to bring the beginnings of coherence back to the human experience (Baerger & McAdams, 1999).

The idea of narrative has been extrapolated to all components of human life to the point it is theorised that identity itself takes the form of a story, complete with its own settings, scenes, plot, characters, and themes (McAdams, 1985). The life story model of identity, outlined by Dan McAdams (1985), assumes that people living in modern societies begin to reconstruct their personal past, perceive the present, and anticipate the future in terms of an internalised and evolving self-story. This process is thought to start around late adolescence to early adulthood. While people's life stories are based upon biological fact, they go beyond them considerably.

Life stories are psychosocial constructions that are co-authored by the person themselves and are embedded within (i.e., given meaning) the sociocultural context that person's life is situated in (McAdams, 2001, 2013). In constructing narrative identity, people selectively appropriate aspects of their experiences and imaginatively construe both their past and future to construct stories that make sense to oneself and others (McAdams & McLean, 2013). In this sense, individual life stories reflect cultural values and norms, including assumptions about race, gender, and class order to vivify life to make it more and/or less meaningful.

This integrative narrative of self provides modern life with some modicum of psychosocial purpose and unity in a world of individualised, subjective experience. Life stories are intelligible within a particular cultural frame, yet also are differentiated from person to person. A person's dynamic life story is a key component of what constitutes the individuality of a person within a particular family and situated among a specific group of friends and acquaintances, who exists within a particular society at a particular historical moment (McAdams, 19993; Gregg, 1991). People differ with respect to their self-defining stories in the same way they differ from each other on more conventional psychological characteristics, such as traits, motives, and IQ (Neisser, 1976, 2014). For example, life stories can be compared and contrasted with respect to thematic lines such as agency versus communion, or redemption versus contamination. In terms of trauma narratives, there is often a comparison of locus of control (internal or external), attributions, and the presence of or search for meaning (Bulman & Wortmann, 1977; Janoff-Bulman & Frieze, 1983; Silver et al, 1983). Through the narrative perspective, people experience a (chronological) flow meaning - whether through detection or construction - in light of major life events, particularly if they are negative (Braid, 1996). Socialisation, repetition, and explicit learning help people create a schema of how everyday life

is meant to look, what they are meant to expect, how they are meant to act and how others will most likely react (Garro, 2000; Kuethe, 1962; Leahy, 2002). “Trauma” is characterised as so because it does not conform to our everyday, normal sense of reality – by definition, traumatic events are disorientating (Crossley, 2000; Hobson et al., 2001; Neimeyer, 2004).

Heidegger (1962) characterises this through a concept called Angst (immense anxiety or dread), where one can experience a sense of disintegration that affects the entirety of their being and what they do. He describes this as being similar to the sensation of vertigo, where one is faced with an ‘abyss’ in the absence of anything to grab onto - and it is this sense of groundlessness which leaves people feeling untethered in themselves and their actions (Cooper, 1990). Angst is most commonly seen as a reaction to seriously traumatising events, such as bereavement, terminal illness, or divorce, and is characterised by nothing ‘making sense’ anymore. This kind of existential crisis emphasises our tendency to constantly draw implicit connections between events, places, people, aims, values, and beliefs, as well as how we take these for granted (Crossley, 2000). When one aspect of the ‘story’ is removed (e.g., a loved one dies or leaves), the entire complex configuration of memories, associations, hopes, and fears is broken - and with it, the sense of who we are and why we are here. Frank (2013) defined this as ‘narrative wreckage’, where the events and experiences of life assume a role of senseless progression. That is, where actions become ‘mere sequence’ and the only objective becomes ‘getting through the day’ and the completion of said actions is purely for the sake of it rather than any meaningful reason. Because of this, we are constantly adding and referring to these schemas to try and maintain or create a more stable, ordered narrative structure to our lives to avoid the inevitable incoherence and chaos of the universe (Carr, 1986). A baseline is necessary to relatively compare and cognitively interpret all life happenings. On the other hand, traumatic

events, disrupt this idealisation, particularly because of their rarity (Kauffman, 2013; Triplett et al., 2012).

As well as contradicting one's general experience of life, trauma upsets the sense of connection grouping a series of events, and this disruption results in abstraction and the loss of the ability to ground "regular" events into a coherent reality (Steger & Park, 2012). People find themselves unable to make sense of themselves, their perspectives, and the world – all of which majorly challenge our concept of identity and reality, which is deeply upsetting (Crossley, 2000; Greenberg, 1995; Janoff-Bulman, 2013). Subsequently, it disrupts and resists the narrative structure of life, and results in an incoherence of who someone is as a person through challenging beliefs, attributions, and pre-existing connections and, essentially, elicits a search for meaning in life in order to re-establish purpose, coherence, and significance (Decker, 1993; Hayles, 2006). Incomprehension of the 'mere sequence' is seen as chaotic, it results in the disintegration of events and leaves life and the human condition with no explanation and no sensibility, so traumatic events can be seen as a potential threat of meaninglessness (Carr, 1986). All of this is not to say that traumatic events do not have a narrative structure themselves, rather they upset the autobiographical narrative that an individual uses to describe and comprehend their own reality (Janoff-Bulman & McPherson Frantz, 1997).

Thompson and Janigian (1988) highlight negative events as being very influential in searching for meaning as they have the ability to cast doubt on the accuracy of one's views or make it impossible for one to reach important goals. There are three characteristics of negative events that are likely to challenge their life scheme and initiate a search for meaning. Firstly, people generally have benign positive beliefs about themselves, others, and the world. It is thought to be adaptive to believe that we, and others, are inherently 'good' and thought to be a

way of having some measure of control over our lives. These beliefs generally make us assume we are invulnerable to disaster and are difficult to reconcile after a highly undesirable, negative experience. A traumatic event is proof that we are in fact vulnerable to disaster and that we do not have an effective grasp or control of a particular area in our lives, therefore negative events are likely to prompt questioning surrounding the validity of one's world and self-views.

Similarly, victimisation - or the act of a negative event happening to someone - is likely to seem unjust if we view ourselves as good people, which may also be hard to understand. Negative events generally make it less likely - if not impossible - to reach or realise future goals. Seriously traumatising experiences have been shown to have great detriment to an individual's physical, psychological, and social well-being (Updegraff & Taylor, 2021). Victimisation can possibly result in physical disability, financial hardship. Previous goals may come to be perceived as unrealistic, unfeasible, or unwise to follow. Finally, negative events tend to challenge personal and world views if they raise issues of mortality or a sense of limited time, often a threat to personal survival. People who are abruptly faced with their mortality, such as terminal cancer patients or survivors of mass tragedies, often find themselves initially preoccupied with concerns surrounding life and death, a condition known as the "existential plight" (Weismann & Worden, 1976). Threats to survival can change our immediate views of ourselves and the world, so the meaning of one's life and assumptions surrounding their reality can take on a different significance and relevance. While positive events affecting one's sense of meaning are possible, they would have to be extreme enough to elicit such a change. These events are rare, as positive events tend to not have as high an emotional valence as negative events do (Bohanek et al., 2005; Bowen et al., 2018).

Within American (i.e., USA) society, a particularly pertinent narrative viewed as important to individual identity today is the psychological theme of redemption (McAdams, 2004). The redemptive narrative arc entails starting at in a position of suffering to a greater status or place in life (McAdams, 2015). Stories of redemption often detail how people believe they have been given a ‘second chance’ and feature themes of personal agency and exploration (McAdams & McLean, 2013). These kinds of narrative arcs are most often told, imagined, and lived by many highly productive American individuals who score high on quantitative measures of generativity (McAdams, 2008). Interestingly, the presence of redemption sequences in life stories have been found to be positively linked to self-report measures of self-esteem, life satisfaction, and a sense of coherence, as well as negatively associated with depression (McAdams, 2001). These kinds of stories may help individuals to sustain hope and confidence needed to endure short-term obstacles and reinforce long-lasting commitments to improving other’s lives (McAdams & Bowman, 2001; McAdams & McLean, 2013). In recovering from traumatic events, the most successful outcomes involve individuals constructing a redemptive story surrounding the adversity they suffered and interacting that event within a broader, self-defining life story (McAdams & Jones, 2017).

The narration of trauma comes to define what it meant to the conscious human experience – not only for the individual, but also researchers, psychologists, and those close to people who have experienced it. It is important to remember there is a universality in the phenomena of mental distress, suffering, and trauma themselves - as all humans will experience these at some point in their lives - but the ways these are known and how one articulates that knowledge are highly subjective and specific to the individual experiencing them, something which cannot just be extra polished from physiological responses (Frankl, 1988). Psychologists

and medical specialists alike began to look at trauma differently after WWII, where the influx of soldiers and veterans presenting with shellshock required a different approach to be able to effectively and humanely treat all these traumatised individuals, perhaps not beginning with but certainly alongside Frankl.

Trauma in Contemporary Culture

Today, “trauma” is a term now used flagrantly across media in a variety of different forms and with varying definitions to describe all sorts of negative events – regardless of whether they can be considered diagnostically traumatizing or not. As a result, the concept of trauma has permeated our everyday lives and can be seen all around us, from social media to academia (Pandell, 2022). For example, the words “traumatic” and “traumatizing” are used within everyday vernacular to describe even the most minor of inconvenient happenings (Follette & Vijay, 2009; Weegmann, 2006).

One prominent source of trauma narratives in Western pop culture is entertainment (Kleber, 2019; Smethurst & Craps, 2015). Many movies and television series use a device known as a ‘trauma plot’ as the basis of a story, in which subjecting the protagonist to immense emotional distress or grievous harm to themselves or someone they care about is necessary to provide them with a reason to change ideals or motivate behaviour (Heidarizadeh, 2015). Within fictional plots, the discovery or revelation of trauma within these narratives essentially acts as payoff in the story and moves it along (Balaev, 2008; Pandell, 2022). In recent years, there has been an uptick in media depicting the dramatization of traumatic events, such as the HBO TV series Chernobyl about the nuclear reactor meltdown in the city of the same name; the movie Dunkirk, which covers the evacuation during WWII (Martinez et al., 2019; Zhukova, 2022). Some of the most popular fictional television series and movie sagas predominantly feature, from

Star Wars to Game of Thrones, from depictions of natural disasters; man-made catastrophes; instances of death, rape, and torture; and apocalyptic circumstances (Covey, 2023; Dykes, 2021; Erll, 2011). Podcasts and documentaries about true and unsolved crimes have also become increasingly popular within recent years (Dowler et al., 2006; Murley, 2008), and as of 2022, #trauma on the popular social media app, Tiktok, had 6.3 million posts – with the content of these posts ranging from explanations of PTSD and tips from registered therapists on how to deal with posttraumatic stress to everyday people’s own experiences as to what they considered traumatic events in their lives (Pandell. 2022). Even our journalism is flooded with current events pertaining to trauma of some kind, from homicides to drunk-driving accidents, all of which are reported in the news media as stories of the living suffering from grief and paying their respects to the dead or lost (Kitch, 2009).

The psychologists and psychiatrists covered in this paper, as well as their works, have become prolific in contemporary culture. *The Body Keeps the Score* by Bessel van der Kolk was named a best-seller by the New York Times in 2017 and, although occasionally dropping out, has remained within the top three spots on the list for 242 weeks (Best Sellers – Books – the New York Times, 2023). Viktor Frankl’s *Man’s Search for Meaning*, as of 2022, had sold over 16 million copies and been translated into 52 languages (Noble, 1997). Freud himself is perhaps the most influential and well-recognised psychologists both in and out of the field, and Freud’s psychosexual theories are generally heard of in the lay world (to varying degrees of praise or disgust). The narratives these men managed to articulate clearly resonate with people and given that they are all to do with trauma, it can be assumed that it is something about the sharing of psychological distress caused by traumatic incidents which others find relatable, or at the very least, understandable. Through selling these trauma narratives in popular media, it reinforces the

idea that trauma is an inevitable part of life (Hartman, 1995; Rothe, 2011). It almost seems as if we now live in a culture where trauma has become part of the zeitgeist.

As a result of an over-saturation of trauma narratives within society, there is growing confusion within the general population as to what the definition of “traumatic” is. Many forms (and deliveries) of pop psychology and self-help books define trauma as broadly and simply as an ‘unpleasant event’ and the resulting reactions to that, even if a person responds in a psychologically healthy or expected way (Kidd, 2005; Ruglass & Kendall-Tackett, 2014). While this means that there is increased awareness of the effects trauma can have on psychological wellbeing, destigmatisation the shame and guilt associated with posttraumatic stress and getting help for it, as well as the breeching of taboo surrounding issues such as incest (from intra-family sexual assault/abuse) (Walker, 2005), it could be argued that the word ‘trauma’ has somewhat lost its original meaning. While traumatised individuals are generally seen as people who have suffered and therefore are deserving of our concern and aid, they are also seen as individuals who suffer for us and are subsequently given special compensation for doing so (Reisner, 2003). Traumatic experiences are real and can cause severe psychological distress, but the nature of the word “trauma” is changing from something denoting intense emotionally distressing experience to a fantasy of the privileges which suffering allows and are projected onto the sufferer by others. Narratives of trauma are no longer just stories of the human experience of immense psychological (and in some cases, physical) pain and overcoming it, but rather a set of characteristics (Reisner, 2003). The idea of trauma has become conflated with the universal, healthy, and very human experience of suffering. Subsequently, people’s understanding of trauma is changing from an acute event seen as an abnormality to something which is happening all around us, both in our individual lives and within society as a whole.

Many researchers believe that we have been slowly moving towards a ‘trauma-conscious’ society, with some citing that we are already experiencing an unnoticed epidemic of traumatic stress and that is a problem which is only going to get worse (Conti, 2022; van der Kolk, 2014).

Trauma and Interpersonal Victimhood

In accordance with social identity theory (Tajfel & Turner, 1979), rather than being a generalisation of the tendencies of individuals, the psychological characteristics of human beings as social animals reflect and inform social nature. This means a person can identify as an individual and/or as a member of a group depending on the situation in which they find themselves in. People who have gone through traumatic events often feel united in their experiences, which may not always be the same physically, give people a shared emotional understanding of how a harrowing experience can change one’s personal outlook on themselves, others, and the world (Janoff-Bulman, 2010; Landsman, 2013). When something completely disrupts one’s understanding of the world to the point it is almost incomprehensible despite having happened to them, individuals who have gone through similar traumatic experiences can form a sense of cohesion with each other (Tosone et al., 2003). This mutual understanding allows for group membership and can allow an individual alone to represent what the group have in common (Carlson et al., 2017; Reicher et al., 2005).

People have been found to be more resilient in the face of trauma when valued social identities which they resonate with can be maintained or new identities can be developed (Muldoon et al, 2018). Additionally, these old or new positive identities can be foundational for posttraumatic growth if they revitalised or extend the self. On the flip side, identity formation in traumatised individuals can also result in them taking on the label of “victim” as part of their personal or public identity (Balaev, 2008). The proclivity to doing this is known to researchers as

the tendency for interpersonal victimhood (TIV), or the enduring feeling that or is a victim across different types of interpersonal relationships (Gabay et al., 2020). In identifying as a member of the victimised group, their social identity becomes pertinent, and they begin to see themselves in accordance with the norms, values, and personal understandings of that group membership rather than an individual (Liu & Laslo, 2007). People are then motivated to view their group in a socially favourable manner compared to who they perceive as the outgroup. The narration of experiences of adversity also allows a means for social categorisation, where a person depersonalises themselves to appear as a stereotypical representation of the group as a way to differentiate themselves from an outgroup.

The identity of “victim” is generally assumed by an individual if they believe that: a) they were physically, emotionally, or otherwise harmed; b) they were not the one responsible for the occurrence of the harm-inflicting event; c) they were unable to prevent the harmful event in any way; d) through their value system, are morally right and suffering from injustice bestowed upon them; and finally, e) they deserve sympathy as a result of this injustice (Bar-Tal et al., 2009). Based off of these prerequisites, Gabay and colleagues (2022) propose that the construct of TIV is founded within four dimensions - the need for recognition [of suffering]; the tendency for moral elitism; the lack of empathy for others’ suffering; and the tendency for rumination over past and/or future interpersonal offences.

The recognition of experienced trauma and victimisation refers to an individual’s motivation to have their status as a victim recognised, acknowledged, and empathised by others. This is a typical response, thought to help rebuild a person’s belief in the world as a fair and just place and restores confidence in their perception of reality as ‘right’ (Gabay et al., 2020). Additionally, when in pain, victims generally want their perpetrators to own up to their

wrongdoing and express remorse for their unjust actions as well as garner compassion and support from others (Baumeister et al., 1994; Noor et al., 2010). This validation of trauma and victimisation has been found to be important for therapeutic recovery (Herman, 2015; Marercker & Müller, 2004; Noor et al., 2012).

Moral elitism refers to the dichotomy perspective of immaculate morality of the self and the immorality of the perpetrator, which appears in victimhood as moral superiority and a clear sense of differentiation (Urlic et al., 2010). Seeing the self as highly moral, just, and ethical is thought to be a coping mechanism against painful thoughts and emotions associated with traumatic events. Thus, accusing others as being unfair and selfish, whilst simultaneously up keeping the belief of one's moral elitism, may help control those the victim perceives as aggressors at an individual level (Gabay et al., 2020). Collective Victimhood works in a similar way, where the out-group's social identity, image, goals, and values are emphasised as being wicked or unjust against the supposed victimised group (Noor et al., 2017).

Finally, rumination speaks to repetitive focus on the symptoms of one's distress and one's efforts to draw attention to it from others (Nolen-Hoeksema, 2000). This includes highlighting the possible causes of victimisation and any potential consequences rather than attempting to find any solution. Rumination is a well-known habit and is recognised as a self-destructive behaviour characteristic of individuals experiencing mood disorders such as depression and anxiety (Harrington & Loffredo, 2010; Kirkegaard Thomsen, 2006). It has been implicated in cognitive impairments, including dysexecutive function, attention, and social dysfunction (Brinker et al., 2003; Morrison & O'Connor, 2005). While it has also been theorised to be a form of self-focus and self-reflection, the positive effects associated with it are

counteracted by the negative ones, as listed above (Takano & Tanno, 2009; Smith & Alloy, 2009).

In terms of trauma studies, this rumination would refer to excessive focus on a specific situation, which would include identifying the nature of the traumatic event; the individuals, groups, or other external forces which may have caused it; and retelling their experiences in different interpersonal contexts to elicit an emotional response and present the self as a victim (Wade et al., 2008). Interestingly, the tendency for interpersonal victimhood (TIV) is heavily rooted in the relationships individuals have with their primary caregivers (Gabay et al., 2020). Subsequently, TIV affects people's emotions, cognitions, and behaviours in what they perceive to be hurtful situations throughout their lives. TIV can therefore be considered to be an enduring personality disposition mediated by an individual's subjective experience of trauma and victimhood within interpersonal relations (Gabay et al., 2022). People who display a high TIV often experience daily interpersonal victimhood more often, at a greater intensity, and for a longer duration than those who people with low TIV (Gabay et al., 2022). Those who view themselves as enduring victims generally react more strongly to negative stimuli, are more likely to hold grudges and seek revenge, as well as feel more entitled to engage in immoral behaviours in order to punish others (Ley, 2020; Zitek et al., 2010). Victim syndrome is associated with decreased wellbeing, poor social connections, and self-destructive and antisocial behaviours (Gollwitzer et al., 2009). The mindset can also encourage a lack of personal responsibility, a tendency to blame others for problems and shortcomings, which can come with a myriad of other detrimental consequences in one's personal and interpersonal experience of the world (Gabay et al., 2022).

It is crucial to note that both the experience of trauma and victimisation are not equivalent to or with possessing a victimhood mindset or TIV. TIV can develop without necessarily enduring any form of trauma and vice versa, someone can undergo a great amount of trauma and victimisation and not develop a victimhood mentality. However, it is important to note that there is some overlap between victimisation and TIV in terms of both psychological processes and consequences, with individuals who identify more with being a victim more prone to exhibiting symptoms of PTSD (Berntsen & Rubin, 2007; Maercker & Müller, 2004). Through a social constructivist and narrative approach, victimhood is not simply just an objective fact about some persons or groups, rather it is an interactional, discursive process where victim category membership must be appropriately interpreted - nothing can be assumed (Davis, 2005).

Competitive Victimhood

Given the subjectivity of the experience of trauma and ambiguity of social life, coupled with TIV, it is not a surprise that this sense of victimisation can become a source of tension and means of justification between people - both collective groups and individuals. This is a concept known as competitive victimhood, or the tendency for an individual to see themselves or their ingroup as having comparatively suffered more relative to others or an outgroup (Young & Sullivan, 2016), a social phenomenon which is becoming increasingly more common. Over the past twenty-five years, journalists, activists, and academics alike have spoken out for and called attention to oft neglected and unnoticed victims of varying kinds of rape, abuse, addictions and mental disorders, codependencies, hate crimes, and institutional wrongdoings among many other things. As seen in the US in the 1960s, people became attuned to and sensitised to victims and victimisation, to the point that by the 70s, victimisation had become a widespread ideology (Best, 1997). As this ideology gained traction within key institutional structures, it laid the

groundwork for a set of social arrangements which now support the identification of large groups of victims - a victim industry. Engaging in CV helps individuals and groups have a sense of increased agency and restored moral image; however, it is also associated with a lack of forgiveness and trust in the out group, which causes a substantial barrier to reconciliation - in some cases, it has been shown to foster hate for others in the out group (Young & Sullivan, 2016).

The victim mindset is characterized by the sense that one is constantly being preyed upon, they often feel powerless and helpless in the face of adversity. Those who have a victimhood mindset tend to have an external locus of control. That is, they are of the belief that the course of their life is determined by the actions of others and other external forces, with little regard for their own actions, self-efficacy, and at times, self-worth (Bar-Tal et al., 2009). People find it easier to justify maladaptive and perhaps problematic behaviours with past experiences rather than strive for change - a process which many people find is difficult. It is easier to see the self now as a product of trauma and that being an endpoint rather than discovering or attempting to find who they are and how they identify beyond it. People report feeling as if they are unable to control themselves and their emotional, cognitive and behavioural reactions which they may perceive as irrational given the circumstances and find it easier to blame others than to take responsibility for oneself and their own personal suffering (McNally, 2003).

The dominant understandings of posttraumatic stress disorder, similarly, explain the enduring suffering caused by traumatic events as largely outside of the individual's control. Today, the mechanisms behind PTSD are largely explained through neuropsychological means, citing changes in biology – the physical organ of the brain and the central nervous system – as the main cause behind many of the symptoms characteristic of posttraumatic stress. These

symptoms are viewed as being caused by rapid, automatic, and subconscious physiological responses triggered by a dysfunctional, traumatised central nervous system, which paints PTSD and its sequelae as immensely difficult – if not impossible - to acknowledge, recognise, and overcome. Subsequently, the interventions and treatments for PTSD are heavily based upon this rhetoric. Traumatised individuals also present with the moral component of TIV, reporting that in attempting to better themselves and alleviate the symptoms of posttraumatic stress, they are dishonouring their trauma and others who have suffered from a similar experience (van der Kolk, 2014). Among trauma survivors, there seems to be a need to bear witness to it, a moral responsibility to be able to tell of their experience. One can find meaning in sharing their experiences, though that does involve reliving it and can also result in hyperfixation and an inability to move on from the trauma, which can again invoke greater TIV.

What perhaps is of greatest concern here, is the idea that society becomes so inundated with victims and persons holding on to different victimhood identities, that people become completely desensitised to the true crux of the issue - preventing the frequency, prevalence, and occurrence of victimisation in the first place, as well as helping those who underwent traumatic incidents to recover and grow from their experiences. Examples of this have already been seen throughout group-selective mass atrocities, where victims and victimised groups are delegitimising of another social group's subjective experience of victimisation, dehumanising of out-groups, and reducing the very much human experience of trauma and hurt into a seemingly factual list of reasons why people are entitled to act against others (Cole, 2007; Rosenberg et al., 2016).

In this thesis, we are going to cover the history of trauma studies from Freud's era to now, as well as a look into some of the largely overlooked humanistic and existential

perspectives of psychology through one of the most prominent psychologists in this area – Viktor Frankl. We will speak to the dominant rhetoric surrounding PTSD, its aetiology, mechanisms of action, and interventions; the benefits and potential shortcomings of having a dominant rhetoric surrounding psychological distress – particularly when it is considered to be largely determined by external circumstances and the environment, such as posttraumatic stress. Reactions to a mono-dimensional approach to PTSD, including the emergence of different approaches, the nature of trauma as a narrated, human experience and need to find a balance between the different domains of psychology and even science as a whole when considering the treatment of “disorders” such as PTSD are also discussed.

*After all, when a stone is dropped into a pond, the water continues quivering even after the stone
has sunk to the bottom — Arthur Golden, “Memoirs of a Geisha”*

Chapter 1: Freudian Understandings of Trauma

Sigmund Freud was born in Freiberg, Moravia, in 1856 but moved to Vienna, Austria at a young age, the place where he would come to spend most of his life. The first of eight children, his family struggled financially, and his childhood was wrought with familial strife – from his parents getting divorced, the death of one of his brothers, and one of his earliest, closest childhood friends moving away (Jones, 1953). Despite his hardy upbringing, Freud flourished in school, known to be a high-achieving student that loved literature and became proficient in eight languages (Hothersall & Lovett, 2022). He studied to become a Doctor of Medicine at the University of Vienna, completing his studies in 1881, before being specialising in neuropathy and becoming an established academic in 1885 (Gay, 1998). It was during this time where he would go to Paris on a three-month fellowship to study alongside Jean-Martin Charcot where he would find a passion for medical psychopathology (Aguayo, 1986). Working with Charcot, who specialised in studying hysteria and the use of hypnosis as a treatment method, inspired Freud to begin using hypnosis in his own clinical work upon his return to Vienna and would set him on the path to developing and founding psychoanalysis (van der Kolk 2014). Nearing the end of his life the German annexation of Austria occurred, leading him to leave Austria to escape Nazi persecution due to his status as someone who both born Ashkenazi Jewish and was a professor by trade (Edmundson, 2007; Freud & Walsh, 2013). He sought asylum in London and continued practicing his psychoanalytic therapies until his death in 1939 (Gay, 1998).

Looking back from the 21st Century, some have dismissed Sigmund Freud’s works as a relic of the past, and not up to the standards of psychological science today. However, when

analysing Freud's work, it is important to note that both Freud himself and his systems of thought were products of the Victorian Era – a time where there was a large discrepancy between men and women as equals, so Victorian society surrounded the strengths and needs of the middle-class male (Tosh, 2008). It was also a period of pivotal social change; people were beginning to become aware of sexuality and the topic of sex as something they thought about and privately indulged in but were not very open about (Decker, 1992). In fact, sexuality was more or less considered as a masculine privilege, whereas women were expected to be sexually chaste and were relegated to sacrifice, frigidity, or simulated pleasure (McDougall, 2018). This societal thinking affected Freud's own views on women, which rarely took his clinical observations into account, with his understanding of female sexual development focusing on the notion that girls were simply defective boys (Cohler & Galatzer-Levy, 2009). Historians of the 19th century view hysteria as being inseparable from the social standing of women at the time, where they were constantly having to negotiate between society's expectations of them and their own personal circumstances (Digby, 1992; Murdoch, 2013). Hysteria has even come to be viewed as a form of resistance to the societal expectations placed upon middle-class, bourgeois women (Thurschwell, 2009). At the time, it was often considered to be a disorder of gender as well as sexuality so resultingly, Freud's patients were predominantly women from the middle-upper classes (although, there were a few men), and neuroses were often connected with the female sex (Dmitriw, 2015; Thurschwell, 2009). It is no secret that a majority of academics and researchers in psychology nowadays regard Freud's theories as wildly inaccurate and largely outdated in terms of present-day understandings of gender, mental illness, and cognitive functioning (Baum, 1984; Cohler & Galatzer-Levy, 2009). Even some of his contemporaries thought that the spread and influence of psychoanalysis throughout Europe and to North America was harmful to some

extent (Wittgenstein & Rhees, 1968). There is widespread agreement that Freud focused too narrowly on sex, particularly in infants and children, with his work regarding women and female sexuality has gained more and more notoriety over the years (Brooks & Woloch, 2000). His use of hysteria as a diagnosable mental illness during the 19th and 20th Centuries has affected the practice of women's mental health even today (Jones, 2010; Tasca et al., 2012).

In spite of all this, Freud remains an influential figure in psychology to this very day. Aspiring psychologists and psychiatrists alike are taught about the works of Freud, whether that be through specialising in the psychoanalytic, studying the more contemporary psychodynamic theories of the mind, or even just to criticise the plausibility of his ideas (Grünbaum, 2018). Inadvertently, and whether it is formally recognised or not, Sigmund Freud is a pioneer of the modern-day understandings of trauma. The concept of psychological trauma played a significant role in his understanding of the human psyche and psychoanalysis as a whole (Fletcher, 2013), with one of his earliest works with Josef Breuer – *Studies in Hysteria* (1895) – claiming that all hysteria can be boiled down to unpleasant events in early life. Freud's definition of trauma varied over the years as his theories did. In the early development of his work, when he was detailing the complexities of the unconscious, symptom formation, and the aetiology of hysteria, he described trauma as being an environmental factor which intrudes upon and overwhelms the ego to the point it cannot cope healthily through abreaction or associative elaboration (Khan, 1963). Whereas during his contemplation of the death drive, trauma was seen as any form of external excitation which is powerful enough to breach the protective shield of the conscious and resulting in an inability to block the mental apparatus from being inundated with substantial amounts of stimulus (Keiser, 1967; Terr, 1979). Despite not ever having a strict, coherent definition for trauma, Freud recognised that it had devastating effects on the human psyche and

managed to articulate it in a way which would come to resonate with researchers beyond his own time.

Psychoanalysis: History of Repression and Trauma

Freud's first reference to repression is in *Studies in Hysteria* (1895), a publication written during his time working with Josef Breuer in the treatment of Anna O, perhaps one of the most famous case studies in psychology of all time (Starman, 2013). Anna O was woman who was afflicted with several psychosomatic symptoms, such as partial paralysis; refusal to eat or drink out of paranoia; visual, aural, and vocal disturbances, as well as mood swings and hallucinations (among other things). She was ultimately diagnosed with hysteria and the two found that hypnosis aided greatly in getting Anna to narrate her experiences, after which her symptoms would cease or were at least reduced (Boag, 2012; Freud & Breuer, 1895). Breuer supposed that her symptoms were correlated to specific psychological traumas which had split from her consciousness and became pathogenic within her body, and that hypnosis allowed Anna to be more open to discussing traumatic events and provided a release for distressing thoughts – a form of mental catharsis known as abreaction (Breuer & Freud, 1893). Freud was of the opinion that open conversation about one's past experiences was crucial in treating psychosomatic symptoms, however, seeing the fallibility of hypnosis and not wanting patients to rely on it as a crutch, he eventually came to abandon the practice and would come to part ways with Breuer (Gravitz & Gerton, 1984; Hammond, 2013; Malcolm, 1977).

Under his own steam, he moved towards free association, where he encouraged patients to speak whatever came to their consciousness freely and without censorship (and presumably without judgement) in an attempt to remember their past in a conscious state (Kris, 2013; Lohsher & Newton, 1996). Freud argued that free association allowed patients to claim their own

issues by speaking for themselves, rather than simply succumbing to, and reconfirming the analyst's suggestions (Thurschwell, 2009). The emphasis of treating hysteria through using free-flowing dialogue would later become the origins of talk therapy, which is still heavily used today (Launer, 2005; MacCabe, 1981). Through this process, he observed that it was extremely difficult for patients and began to postulate that there must be some sort of psychical mechanism interfering with a patient's ability to retrieve autobiographical information. Given the great resistance patients met when trying to recall past events, he eventually concluded there was an active process where certain thoughts – often of distressing nature – were constrained to the unconscious and intentionally prevented from entering conscious awareness (Boag, 2006; Freud, 1910/1977). Unlike Janet before them, Breuer and Freud realised that unpleasant experiences were separated from the consciousness due to a process called motivational forgetting, and those traumatic memories subsequently become pathogenic and cause symptomology in the body (Boag, 2012; Freud, 1938/2012; van der Hart & Horst, 1989). However, while someone can repress something from their conscious, they will never be able to fully expel the memory from their mind and thus unpleasant memories will always remain until acknowledged (Wittels, 1924). In this sense, hysteria could be explained as a disease of reminiscence and that hysterics mainly suffer from 'reminiscences' (Blum, 1999; Breuer & Freud, 1895; Eysenck, 1956). That is, hysteria can be seen as the neurological manifestation of unresolved memories of trauma. This definition was especially important at the time, as it implied there is conflict between the different levels of the mind and supposes a way to explain the development and aetiology of psychopathology in terms of mental dynamics of a multi-layered mind (Boag, 2012).

To further aid understanding of this dynamic, Freud developed the topographical model of the human psyche, a system which is the basis of several of Freud's other theories, such as

seduction theory and the notorious oedipal theory, better known as the theory of psychosexual development (Fegulla, 2002; Freud, 1924). According to this model, the mind is comprised of three interacting agents: the id, the superego, and the ego – which roughly align with pleasure, morality, and reality respectively. The id is seen as the locale of the libido; it is oriented towards one's primal, internal instincts and passions (Fegulla, 2020). It is the part of the mind which is present at birth and is governed by the pleasure principle – the instinctual seeking of pleasure and avoidance of pain to satisfy psychological and biological needs – so seeks pleasure and instant gratification regardless of the consequences (Freud, 1923/1989; Kennedy, 2020; Rennison, 2015). Most of the time, the expressions of the id remain repressed via the ego, but they will try to find alternate ways to express impulses considered as inappropriate, amoral, or excessively sexual by society, which we previously regarded as perfectly acceptable before the development of the superego (Carlson et al., 2009; Freud, 1936). Freud (1977) has notably called the id the “dark, inaccessible part of our personality” (p. 105) while also considering it to be the inheritance of the species – the primal, base instincts present in all animals to ensure their propagation. Contrarily, the superego develops in later life, and can essentially be considered to be the moral conscience; it is the ethical component of personality and is governed by the morality principle, providing the moral standings for the ego and conscious to operate under (Cherry, 2016; Fegulla, 2002; Reich, 1954). It aims to police what it regards as unacceptable desires from the id, with its criticisms, prohibitions, and inhibitions forming one's conscience, and its positive aspirations and values represent one's ideals of perfection, or ‘ego-ideal’ (Groot, 1962; Lapsley & Stey, 2011; Sandler et al., 1963). The superego judges behaviour according to the cultural, societal, and contextual norms that one has learned from their parents and society and motivates us to act in socially acceptable ways (Kennedy, 2020). Finally, the ego acts as the

mediator between these two opposing forces; it aims to satisfy the desires of the id in a way which is tolerable to the moral standings of the superego (Freud, 1923/1989; Loewald, 1951). Finally, the ego can basically be equated to one's perception of the world around them and is governed by the reality principle – or the ability of one to observe the 'reality' of the external world and act accordingly (Freud, 1997b; Freud, 2018). The ego is also thought to provide protection from the superego in the event that the latter becomes excessively moral to the point of self-destructiveness and crippling guilt (Fegulla, 2002; Hartmann, 1959). Freud sometimes viewed the ego as grappling with three threats – the external world, the aggressive pleasure drive of the id, and the severity of the superego (Freud, 1923/1989). These three components of the human psyche – the id, the superego, and the ego – as well as the demands of the real world, are all in a constant struggle with each other as they all attempt to get their needs met (Cramer, 2015; Vaillant, 1992).

Freud recognised the immense responsibility placed upon the ego as the sole facilitator between reality, morality, and pleasure, and believed feelings of anxiety would emerge within an individual if the ego became unable to mediate these forces effectively (Vaillant, 1992). Anxiety, being an undesirable emotion, is an emotion that one naturally wants to reduce, and to do that, the ego employs a variety of unconscious protective techniques known as defence mechanisms (Brenner, 1981; Freud, 1894/2014). It is important to note that the ego – a usually conscious agent – resorts to the unconscious in order to avoid being overwhelmed by anxiety and is always unaware that it has resorted to doing so. In doing this, it allows defence mechanisms to operate in ways that distort reality (Bovey & Hede, 2001; Ursin & Olf, 1993; Winnicott, 2018). Through this assumption, repression can be understood as a defence mechanism where the ego aims to ensure any stress-provoking information is prevented from entering one's conscious by subduing

the instinctual cravings and satisfactions of the id, which conflict with other tendencies and principles of the superego and ego (Boag, 2006; Erdelyi, 2005; Freud, 1922). It is an unconscious psychological operation which acts to protect a person from anxiety arising from internal conflict or external stressors, without them being aware of it. If the ego is under stress – such as from inappropriate desires from the id, intense moral guilt from the superego, or from environmental factors in the external world, it consistently engages in repression it to protect themselves from repeatedly having to recall a painful or distressing experience or thought (often in Freud’s case, this was unsightly desires and fantasies) (Kennedy, 2020).

In this sense, repression can be considered to be a sign of normal functioning, as there needs to be some degree control over the childish, unconstrained, and potentially immoral or aggressive desires of the id for one to function in and be accepted into society (Billig, 1999; Boag, 2012). Psychoanalytic reasoning implies that our strongest desires – therefore signs of repression - are able to be seen in everyday life, such as through the Freudian slip (discussed further down), and through the content of our dreams, without being detrimental to our functioning, but also recognises that repression does not always go right. To Freud, psychological neuroses were a manifestation of repression ‘gone wrong’, where repression fails and the unconscious is allowed into the realm of the conscious, unbeknownst to the ego itself (Eagle, 2000; Solms, 2004). Repression of trauma can therefore be seen as the ego simply disregarding an unpleasant event from even happening, a distortion of one’s autobiographical narrative to selectively not remember a certain part and keeping it in an undisclosed past, and that trauma making itself known through unconscious psychological means. And it is the intensity of that distressing event – in conjunction with a more immediate precursor – which resulted in the hysteria seen in patients, such as Anna O.

Repression is the most foundational concept in psychoanalysis with Freud (1989a) himself remarking it as being the cornerstone which all of psychoanalysis is founded upon (Bower, 1990). The entire construct of unconsciousness is based off repression as a hidden mental space where we keep the parts of ourselves that we do not wish to know, the experiences we wish never happened, the thoughts we would rather not have, and the emotions we would rather not feel (Mannoni, 2015). And where else is the perfect place to store all our traumas than tucked away in the back of our minds?

The Importance of the Pleasure Principle: Pain Avoidance

Freud's background as a neurologist led him to the overarching belief that pain and pleasure were crucial in the comprehension of human behaviour, having noted from his anatomical studies that the nervous system has the "most decided" inclination to avoid pain (Boag, 2012; Freud, 1966). So, in the same way, the mind naturally tends to defence – or an aversion to directing psychic energy in ways that result in displeasure (Masson, 1985). This is certainly true of repression, which Freud noted individuals unconsciously utilised to avoid having to remember traumatic experiences. It can be described as the defence against desires inconsistent and incompatible to the ego that elicit unpleasure, such as shame, guilt, embarrassment, or psychological pain. This reaction, thus repression, can be seen as analogous to the physical body's withdrawal from a painful stimulus, acting to minimise the immediate distress following a traumatic event (Boag, 2012). Mental activity is viewed through the constant relations, negotiations, and equilibriums between the different parts of the mind, where disagreement and conflict resulted in neurological upsets that cause the ego to employ defence mechanisms such as repression (Garland, 2018). The entire point of repression is to avoid

displeasure and can be said to have failed if it does not prevent painful anxiety emerging in the psyche, even if the consciousness itself is unaware of that failure (Freud, 1922).

Subsequently, we can see that repression can only occur in the context of the tension between a single or few ideas required to be repressed in the id and the dominant majority of ideals which comprise the ego (Freud & Breuer, 1895). He believed that while having components of personality that ascribe to both reality and morality, individuals are fundamentally driven by the pleasure-pain principle – in which they are motivated towards behaviours which produce pleasure and avoid unpleasure (Freud, 1946, 1955). This can be explained by the fact that the id is the only aspect of personality which is present from birth and represents the basic survival instincts of a species (Fegulla, 2002). Were there no other confining factors, such as societal norms, morals, and values, the id would completely dictate our ways of behaving and neither the superego nor the ego would ever need to develop. This intrinsic drive to seek pleasure can also be seen, although more discreetly, through the ego. The ego orients itself towards perceptions of the real world and ascribes to order, reason, and sanity, motivating the id's wants towards behaviours which will benefit an individual in the long-term (Noam et al., 1984). While it translates the wills of the id into thoughts, feelings, and behaviours which align with the constraints of reality – it is still has the same end goal of pleasure. Because of this, Freud says that it is unwarranted to view the id and the ego as opposing forces, going as far as to say that the ego is simply the organised part of the id that has been influenced by the external world and the principles of reality. They cannot be fully separated from each other and are but two components of one balancing system (Freud, 1936).

Given that repression is a result of conflict between the id and ego, psychopathological symptoms, neuroses, and other neurodivergent reactions can be considered maladaptive ways of

attempting to establish mental equilibrium (Freud, 1951). It is important to note that this idea of maintaining homeostatic balance is an underlying theme in practically all his theories, where unmanaged tension between two psychological components – the id and the ego, the conscious and the unconscious, the memory of trauma and the desire to forget it ever happened – his ideas of hysteria and neuroses were based on the idea that one was going through internal, mental conflict (Brenner, 1994). A lot of this was in reference to Freud's theory of psychosexual stages, where the id focuses its pleasure-seeking energies towards specific erogenous zones – oral, anal, phallic, latency, and genital - as an individual moved through childhood development to puberty (Rutter, 1971). It is thought that infants are polymorphously perverse, meaning that they can gain sexual pleasure from any part of their bodies, and that socialisation guided the instinctual libidinal drive into what was considered healthy adult (hetero-)sexuality. Again, there was a need to find a balance between the demands of infantile sexual desire and the socially acceptable ways in which this was achieved. Gratification in all five stages would result in a healthy personality in adulthood. Yet, were one to be deprived of satisfaction in any of them, they would become fixated within that particular stage as an adult (Blum, 1949). For example, a person fixated in the oral stage, which approximately covers the period from birth to a year old, may exhibit particular habits focused on the use of the mouth, such as smoking, gum-chewing, eating, or kissing (Glover, 1925). This is where another peculiar underlying idea emerges in Freud's work, one which would come to be very important in his understandings of trauma in his later career – attachment. The stages of psychosexual development and the failings in moving on from those stages in an adequate timeframe can be considered to be an (unhealthy) attachment – or fixation - to specific, unfulfilled pleasurable thoughts, feelings, acts whilst disregarding the distressing events or experiences that denied that satisfaction (Freud, 1924). People are thought to hold on to

what ails them in an unconscious attempt to consciously recognise that something distressing happened to them, which results in psychopathological symptomology, and by only bringing it to the present can it be resolved. Through this understanding, the basic premise of what Freud was for so long trying to understand is “what do people want?” – What motivates people towards certain behaviours, and, perhaps most importantly, what happens when people do not get what they want?

It is interesting to note that much of the time when Freud refers to pleasure or unpleasure in his work, it is almost always strictly in a sexual sense in one way or another, although Freud’s observations of the World Wars caused him to change his mind on a purely internal model of psychopathology, moving away from seeing the inner workings of the id as the primary instigator of neuroses. One of his lesser-known publications ‘*Beyond the Pleasure Principle*’ (1955) narrates his experiences in treating ‘shell-shocked’ soldiers of WWI, and what is more, is that this argument was met with scepticism by many of his followers (Cohen, 1980). This is not to say that Freud abandoned his claim that human behaviour was driven by the pleasure-pain principle, one may even argue to say far from it, rather that there had to be something else involved.

Freud’s Treatment of Hysteria and Repressed Memories

To most people, when they think of Freud’s therapeutic techniques, they imagine an old man with a notebook talking to someone lying on a couch – and in fairness to them, they would not be far off in their guess of what Freud did to help his clients (Lohsher & Newton, 1996; Schachter & Kächele, 2010). A model of his office from 1886 can be seen today in the Freud Museum in London, including the very settee he used in his sessions (Nixon, 2005). Despite having an aversion to his patients looking at him (hence the couch) and the incredulousness

raised at the thought of Freudian psychology, Freud's 'talking cure' helped transform the field of psychotherapy, despite its content being questionable at times (Hammond, 2013; Solms, 2004; Westen, 1998). It was considered a radical shift at the time, as not only did Freud and Breuer consider the symptoms of hysteria to be real with a psychological cause, but they also listened to their patients' stories and believed a cure could be found from within them (Thurschwell, 2009). Psychoanalysis eventually came to be grounded in the idea that associations and connections hidden within the unconscious would be able to help a patient make sense of their past, and by doing so, resolve any unsettled conflict arising from prior trauma.

Much of Freud's early work focused on the repression of distressing thoughts and feelings – most often stemming from infantile and childhood sexual trauma – being the root and exclusive cause of hysteria in adults (Boag, 2012). One of his first prominent ideas was seduction theory, where sexual mistreatment at an early age was an essential prerequisite for hysterical and/or obsessional behaviour in later life, and it was not the original abuse which was traumatic, but rather the remembrance of it (Balaev, 2018). As a child, one simply does not have the capacity to process such a distressing event in a way which makes sense to them, so the memory is simply locked away in the unconscious until it is triggered by a similar painful instance in adulthood where it can presumably be processed. It is only after its reactivation by a contemporary event that the trauma can come to be known and worked through. This emerges as hysteria or neuroses due to the recollection of the previously repressed event inflicting a psychological pain upon the individual, however, if dealt with correctly, it also allows for value to be ascribed to that traumatic event and allow one to make sense of it (Balaev, 2018).

Though the ideas of seduction theory were later assumed to be abandoned, the mechanisms in which Freud believed trauma worked were not (Eissler, 1993; Israëls &

Schatzman, 1993). Throughout his entire career, Freud would go on to assert that certain external events could contribute to abnormal psychological symptoms, but rather that they were simply triggers which reawakened confounded issues of the id which had not been resolved in development (Freud, 1922; Freud & Breuer, 1895). To him, psychopathology was a result of the conflict between repressed traumatic memories attempting to be made conscious, and once those memories were uncovered and brought to consciousness, the symptoms would disappear (Freud & Breuer, 1985). However, it was not the actual event of trauma which caused hysterical symptomology, rather it was the reactivation of this memory through a similar, contemporary event which resulted in the ‘return of the repressed’ – a conscious experience which unlocks or reminds the unconscious of something within (Boag, 2012). The explanations of the past and what happened to you is the cure; patients find their own explanations for their symptomology simply by remembering – in a logical and reasonable way - what happened to them (Wittel, 1924). The basis of Freud’s treatment of the distressing repressions causing hysteria was a process known as abreaction – the replication of a distressing event in order to reexperience thoughts and emotions experienced at the time of the trauma and therefore be able to work and move through them (Akhtar, 2018). It is thought that through discharging the emotional excess, through dramatic re-enactment to therapeutic dialogue, psychological catharsis is achieved, and one can begin to move on from whatever ails their mind (Breuer & Freud, 1893). Once one’s trauma was brought into the conscious and released into the present, in light of mature and rational reasoning, it would lose its compulsive power and gradually cease to be distressing to them (Solm, 2004). This was most often done through techniques such as dream interpretation, transference neuroses, and free association.

What we can note about Freud's methods of treating trauma is that it is a very retrospective process. Freud and Breuer (1955) even referred to the symptomology caused via repression as *pathogenic reminiscences*. Patients are encouraged to delve into past events in order to become aware of and understand them, and through doing so are meant to come to ease with themselves. Freud defines trauma in relation to the process of its remembrance and as an event trapped within the unconscious which causes dissociation, or the fracturing of the ego, with hysteria manifesting as abnormal states of consciousness caused by the split ego. A complete comprehension of the events in the past, once laid out and made sense of, is meant to soothe the psyche of the present, and allows one to move on with their life. While this places the self in the present, it does not show any orientation towards the future and Freud never really developed a system for moving beyond trauma aside from retro- and introspection.

Development of Traumatic Neuroses & its Treatment

Later in life, however, Freud gained a disillusion with the world – having been witness to both WWI and WWII. Too old to serve in either, but old enough to watch his sons serve, he started to rethink his theories of trauma when treating WWI veterans who came to him with psychosomatic symptoms relating to their war experiences (Berger, 1997). Obviously, patients' hyper-fixation on traumatic events confused Freud, as his belief was that above all else, people strive for pleasure, to which the repeated remembering of an unpleasant experience was completely counterintuitive to (Chu, 1991). Why would people, especially the former soldiers harrowed by the horrors of war, seek to reexperience events that caused them such pain and unpleasure? It is through this he came to realise that the aggression and utmost violence which people engaged themselves in during combat could not just be caused by an individual's inner libido alone, and it was in this period he began to move away from strictly sexual motivations

and towards ‘pleasure’ beyond that of carnal desire (Gertz, 2010). In addition to observing the bloodshed of the war, there were three main pieces of conflictual evidence which went directly against Freud’s clause that all mental happenings are automatically directed towards and regulated by the pleasure-pain principle, which late in his career impelled him to the preposition of the dual-drive principle (Freud, 1920/2003).

The first was the aforementioned ‘war neuroses’ observed in veterans of WWI, where they would repeatedly re-enact their traumas of combat in the form of viscerally physical night terrors and flashbacks (Freud, 1920/2003). This was particularly interesting to Freud because, through his understanding of the human mind and behaviour up until that point, dreams were a tool for wish fulfilment - or the indirect satisfaction of a desire through unconscious thought processes – in line with the pleasure principle (Amacher, 1964; Adams-Silvan & Silvan, 1990; Freud & Crick, 1999). As of such, dreams are in theory meant to recall and retell healthy experiences in the past. Yet the repeated nightmares brought the former soldiers anything but. What Freud was witnessing would today be called the involuntary symptoms of PTSD, a condition which would not be fully conceptualised until decades after him – yet these war neuroses intrigued him, remarking in his work that “people have shown far too little surprise at this phenomenon” (Freud, 1920/2003, p. 51). To him, the nightmares these combatants had seemed like an unconscious, though highly counterintuitive, act of repeated participation in a traumatic experience, where the function of the nightmares was to express the anxiety that was absent or disallowed at the time of the event (Freud, 1920/2003).

The second discrepancy came through observations of his grandson engaging in a game which Freud himself would come to call *fort/da* (or away/there respectively, in English), which was the final bit of evidence that compelled him towards thinking beyond the pleasure principle.

Whilst his grandson was in his care, he observed the young boy playing with a wooden spool tied to some twine, where he would repeatedly throw the spool away, muttering “o-o-o-o” to himself, to only pull it back with the string and say “da!” (Freud, 1920/2003; Aycock, 1993). Freud and the child’s mother inferred the first utterance to be child’s version of the German “fort”, which roughly translates to “gone away”, and the second, *da*, as the German “there”. This struck Freud as odd, as it appeared that the child was simply throwing a toy which he enjoyed playing with away – an unpleasurable event – before reeling it back in. He eventually concluded that this game as the boy’s way of coping with uncontrollable circumstances of departure, particularly of his mother, where she would occasionally leave the house without him – an event which, to the child’s understanding at the time, would be highly distressing. Through repetition of displeasure, Freud supposed that the child was trying to achieve or assert a sense of mastery over his own reactions to an inevitable and distressing incident. By being an active participant in the separation of a pleasurable stimulus, he inferred the boy would attain a sense of control over the situation, as opposed to being a passive recipient of distress (Freud, 1920/2003). Using the spool as a representation of his mother, Freud’s grandson was able to symbolically control her unpredictable comings and goings, and by doing so, experienced pleasure in the mastery over the wants of the id -which were to have his mother always (Blau, 1982).

Lastly, he also began to find problems with his theory of the pleasure-pain principle in treating his civilian patients and their hysteria, which he assumed to be caused by inefficient inhibition of the id, or the pleasure drive, by the ego. More often than not, these patients too were obliged to continuously engage in their trauma, willingly even, as opposed to simply remembering the experience in retrospect as an outside observer (Pasquinelli, 2015). Engaging in abreaction and scenography (re-enactment of traumatic events) was thought to aid in gradually

healing the initial psychic shock of the trauma and sever the mnemonic relation with pain consciously and in the present, yet Freud consistently noted that patients would rather repeat repressed experiences as contemporary events. There was very little effort from patients to recollect their past traumas as an outside observer from a temporal distance, and they were far more comfortable using psychotherapy as a safe space to reexperience the psychic consequences of their traumatic memories, rather than using it as a tool to move through from it (Levy, 2000; van der Kolk, 2014). He gave this phenomenon the name repetitive compulsion, where one would unconsciously replicate the experience of trauma or its circumstances, such as aspects of the situation present at the time possibly in an attempt to gain some sort of proficiency to make up for the past (Grant & Crawley, 2002; Freud, 1920/2003; Malcolm, 1988). Originally used to explain the repetitive nightmares of battle which veterans experienced, this assumption has been extrapolated to any trauma that one may experience and continually seek to repeat, whether that be literally (such as in the case of a flashback) or symbolically re-enacting original traumas, for example, a woman who was abused as a child repeatedly choosing abusive partners as an adult (Cloitre et al., 2002). The patient is unable to remember what the entirety of what is repressed, yet facing up to what cannot be remembered is thought to be essential part needed for proper abreaction. So instead, they are obliged to repeat that trauma as a current experience as opposed to recollecting it as a past experience (Chu, 1991; Freud, 1920/2003). In his observance of these patients, Freud speculated that these repeated traumas manifested as a constant and essential character trait, which remained the same and compelled one to find an expression of the same experience (revictimization) through repetition. He called this the fate neuroses (Freud, 1920/2003).

This sense of mastery and a compulsion of destiny did not satisfy Freud's search in terms of being an independent drive, nor was a satisfactory answer to what lay beyond the pleasure principle. Psychiatrists and psychologists today have found that resolution to trauma is not really achieved via repetition compulsion either (Chu, 1992; van der Kolk, 2014). In fact, it is thought that repetition of trauma through reliving it in therapy may reinforce one's fixation on it and tends to only lead to increased mental distress and self-hatred (van der Kolk, 2014). Freud re-acknowledged the role that trauma had in the development of hysteria in *Beyond the Pleasure Principle*, but after WWI, he never really got around to integrating his prior ideas surrounding infantile and childhood sexual abuse and hysteria with the hysterical symptoms he came to associate with war neuroses.

Whether that was intentional or not, the traumas caused by war were viewed as different to those caused by sexual or even by unfulfilled psychosexual development. He concluded that in 'ordinary' psychoneuroses, the driving factor is the ill-wills of the libido which threatens the ego from within oneself in the form of conscious or unconscious (sexual) fantasies (Breuer & Freud, 1893; Freud & Breuer, 1895). It has been previously explained how the pleasure principle motivates people towards instant gratification of their desires, which are usually presented in the form of an object. Freud uses this term in a way that does not necessarily mean a physical item, rather an object can be an external thing, a person, or internal images, thoughts, feelings, as well as the relations between all of them (Greenberg & Mitchell., 1983). Previous explanations using a strictly sexual aetiology had only been applicable in demonstrating and treating hysteria and transference neuroses in civilians, although had not been accepted in regard to narcissistic neuroses – which include dementia praecox (the early term for schizophrenia), paranoia, and melancholia (Spotnitz & Meadow, 1995). These conditions are characterised by a lack of object

relations and a fixation of an early state of libidinal narcissism, where the ego and superego have less sway in determining one's actions and leading an individual to remain highly egocentric and out of touch with reality – there is less reason and rationale in those with this kind of neuroses and therefore, one cannot utilise therapeutic techniques for treating traumatic neuroses of peace time (Freud, 1917/1977; Freud et al., 2022).

All of this is not to say that Freud did not think that trauma could occur outside of war, in fact, quite contrary. With traumatic neuroses – including those of war, it is the psychological consequences that occur as the immediate reaction to an external event, such as a natural disaster or severe accident (Freud, 1920/2003). Trauma in this sense is understood as the resulting state of mind in which an individual is not prepared for danger and danger occurs; one's consciousness becomes so overwhelmed by external, excitatory stimuli that it disrupts the mental topography of the mind (Zepf & Zepf, 2008). Subsequently, one experiences a highly tense state of excitation during a dangerous situation which is felt as anxiety, a type of displeasure that cannot be mastered by simply discharging it. Freud describes this as analogous with the birthing process, a time where an individual would have no adequate means of controlling the event and its effects at their disposal (Freud, 1920/2003). During traumatic events, the ego is attempting to protect itself from an external force which is conceptualised within itself, which allows for conscious fixation on that force (Adams-Silvan & Silvan, 1990). For soldiers and other combatants, this other force has been speculated to be another ego and it is the conflict between the old ego of peacetime, which focused on satisfaction and satiation of personal wants and desires, and the new ego of war, which is strictly focused on survival due to the circumstances one is consciously experiencing (Freud et al., 2022). War neuroses were believed to emerge due to the peace-ego being threatened with death due to the risky undertakings of the war-ego. They

are a defensive response that the old ego employs to protect itself from its newly formed, parasitic double, which it views as a threat to its life (Freud et al., 2022). Freud believed that this is why war neuroses only occurred in those of the National Army – that is, civilians who were conscripted – and rarely was observed in professional soldiers or mercenaries. Therefore, it can be said that traumatic neuroses, both of peacetime and of war, can occur either without any reference to any form of ego-conflict, as in between the ego and the id, or without reference to the ego at all (Freud et al., 2022).

From these observations, he believed that there had to be something more primitive, instinctual, and elementary that overrode the pleasure principle, something that sought return to the same thing over and over. What he eventually concluded was that organic life desired to return itself to an earlier state of being – that is, an inorganic form from which the life initially came from – and that the aim of life is death (Freud, 1920/2003; Lear, 2002). All of this led to the creation of the dual-drive model, where Freud hypothesised another motivating force in the human psyche known as the death drive – commonly called ‘Thanatos’ among his followers and psychoanalysts after him, though never referred to it as that himself (Freud, 1920/2003; Jones, 1953). The death drive opposes Eros – an individual’s innate tendency toward survival, reproduction (ergo, sex), and other creative, life-producing drives – such as the ones governing pleasure (Green, 2018) – and hence the nickname ‘Thanatos’. Freud conceptualised this as a drive towards death and destruction, although it is more precisely defined as aiming to eliminate tension within the psyche which, when expressed outwardly, manifests as aggression, self-destructive behaviours, and repetitive compulsion (Berne, 1975). Also known as the nirvana principle, the life and death drives strive to coexist in a constant state of equilibrium or constancy, where too much stimulation (i.e., pleasure) will cause one to desire its cessation and

motivate behaviour in a way to do so to achieve a state of nirvana (Freud, 1920/2003). If the stimulation and tension become too painful, then nirvana is viewed as analogous to death, where it represents a return to non-being (Segal, 1993). From this perspective, an organism's avoidance of danger is only done to prevent a premature death and trauma is so unbearable that it may cause one to attempt to shortcut the natural transition (Berne, 1975). Freud identifies psychic trauma as resulting from fright, not fear – it is the abrupt intrusion of an alien experience that was unexpected, and that the conscious was unprepared for (Keiser, 1967; Terr, 1979). The trauma lies more in the unexpectedness than the intrusion itself, with the immediate reactions of the overstimulated, overwhelmed ego being the cause of psychopathology, rather than the event itself. The compulsive repetition following a traumatic experience is an attempt to remember what was never consciously experienced in the first place, as it happened before an individual was even prepared to experience it – the trauma is an event without a witness (Caruth, 2016). Repetition compulsion, in general, is a manifestation of the death drive, where the psyche seeks to revert back to a previous state of being, an unconscious desire to resolve trauma by working through it and re-establishing a mental equilibrium. Thus, while pleasure is the primary goal, it is a pleasure derived from pain avoidance, from the attachments and fixations we find in our struggle for survival (Kernberg, 2009).

Attachment is an important aspect of Freudian psychoanalysis, we have seen its importance in the psychosexual stages and the pleasure drive – there is great pleasure in having reliable, secure attachments and these attachments can cause great pleasure. John Bowlby (2005), a famed psychologist specialising in attachment theory, posits that we are happiest throughout our lives when life is systemised as a series of experiences from the secure base provided by attachment figure(s). These include people, places, routines, norms, and values, as

well as the relationships between them. Trauma can be understood as the destruction of attachment, where the safe, secure attachments we have between ourselves, others, and the world, are jarringly disrupted (Lindermann, 1944). The disturbance of these bonds can occur both through immediate annihilation, such as in an accident, war, or disaster, or a slow, steady loss, such as childhood neglect occurring in the household. And in the same way that trauma can destroy the attachments we have, a lack of attachments can result in trauma - isolation and loneliness cause a complete and utter disillusionment of the existence of safe, secure attachments to anything (Mikulincer et al., 2015). Not only does this shatter the positive assumptions of attachments going forward, but also interferes with the ability to retrospect on memories of previous safe, secure attachments one once managed to establish, it proves that any relationship between anything can be severed in an instant (Liotti, 2006). All that remains is the memory of the trauma itself. As a result, the symptoms of trauma become objects of attachment. Repetitive compulsion is a manifestation of the attachment formed between an individual and the only reliable object left – the symptoms of their trauma. Unlike other objects, people, relationships, places, and the like, the horror they carry with them will always be there. Trauma neuroses become the only attachment one has left in the wake of disaster, so we hold on to them, as the idea of a life without any attachments is even worse.

It should be noted that the death drive is one of Freud's most scrutinised theories. It is thought to be incoherent, sloppy, and inconsistent in its arguments, with some critics claiming it defies evolutionary biology itself (Lind, 1991; Mills, 2006). Freud's entire formulation of the death drive has been considered to be problematic due to the fact he was grappling with several different ideas at the time, some of which were contradictory and incompatible with one another (Carel, 2006). While it was a highly contested concept within psychoanalysis among Freud's

followers, never gaining the coherence or weight in the same way his earlier material did, the dual-drive system allowed Freud to explain the experience of trauma beyond that of a sexual nature. His articulation of ‘traumatic neuroses’ helped him – and other researchers – to build a more fully fleshed out paradigm for treating and understanding the nature of distressing events and what they do to the mind.

Contemporary Understandings of Repression and Repressed Memory

The repressed memory is a supposed psychological phenomenon where one finds themselves unable to recall autobiographical information, particularly of a traumatic or stressful nature (Lego, 1996; Loftus, 1993). This occurs in a predisposed subset of the population, where during the processing of an emotional event, an individual may not be able to consciously attend to it if the material becomes too traumatic or emotionally intense, leading to it becoming unconscious (Brown et al., 1998). The concept is largely based on Freud’s work with repression, where his first mention and discussion surrounding repressed memories was in one of his essays on Anna O, *The Aetiology of Hysteria* (1962). Victims cannot remember the traumatic events until they are in a psychologically safe space to do so, often years later, as the experience was so upsetting that they simply are incapable of recalling them until prompted or there is enough distance from them (Brown et al., 1998). Depending on the extent of the repression, this can leave victims nearly completely unaware of the abuse, trauma or accident that has befallen them, yet can still experience detrimental psychological effects (Herman & Schatzow, 1987). An apparent inability to recollect traumatic events implies there is some form of inhibitory mechanism which hinders conscious retrieval of the memories of that distressing experience. Therefore, if a person claims they have remembered an experience of trauma, such as an episode of childhood abuse, then those who ascribe to the theory will assume the memory has been repressed – as why else would

an individual ‘forget’ such a harrowing event? (McNally, 2012). The idea of repressed memories also belays a particularly confusing conundrum – if we have secrets from ourselves and wish to forget them, we must not only forget them, but forget that we have forgotten them (Billig, 1999). By this logic, if we wish to repress something, not only do we have to repress the memory itself, but also the fact we have and are repressing it (McNally, 2012). How does the unconscious mind continuously repress a memory if it is meant to repress the fact that it is repressing that memory at all?

While there is widespread belief in repressed memories among psychoanalysts, psychologists, and even amongst the general public, the existence of repressed memories – and even repression itself – is a highly contested topic today (Anderson & Levy, 2002; Bowers & Farvolden, 1996; Goodman et al., 2003; Powell & Boer, 1994). Repression has generally failed to gain strong empirical support among the varying fields of psychology and so much of repressed memories – from their existence to their mechanisms - has come to be disproven through contemporary cognitive science, neurology, and psychiatry (Kraemer & Golding, 1997; Loftus, 1996; Patihis et al., 2021). Our understanding of autobiographical memory and how the mind processes information – particularly that of a traumatic nature – has grown greatly since the development of Freud’s idea of repression (van der Kolk, 2014). Memory, particularly long-term memory, has now come to be understood as a reconstruction rather than total recall (Loftus & Palmer, 1974). Due to multiple interdependent cognitive structures, the recollection of an experience is the combination of different memory traces – such as emotions, sensations, and thoughts, associated with the event. The constructive method works by encoding specific patterns of perceived physical features, along with interpretative conceptualisation and semantic functions which rejoins to the incoming information (Schacter, 1989). This means that there is no

single area in the brain that any complete memory is stored and is rather an amalgamation of different aspects of an experience that are combined within the recollection process (Hemmer & Steyvers, 2009). Forming a coherent representation of any memory requires a great level of complexity and therefore is quite demanding on the brain which can result in an incomplete or incorrect recall (Hirt et al., 1995; Torres-Trejo & Cansino, 2016). If the combination of memory traces fails, there can be faults in memory, and in the absence of information, people will supplement what they have managed to remember with other available personal knowledge and schemas to fill in the gaps (Schacter & Coyle, 1995). This provides us with a deeper, fuller, more coherent version of an episode, despite it often being distorted (Patihis et al., 2013).

Additionally, the reconstructive process means that one's recollection of a particular episode can be skewed or distorted by other interfering cognitive functions, such as personal perceptions and biases, social influences, and knowledge about the world, which can further lead to errors in remembrance (Schacter et al., 1998). Therefore, even within the normal realm of functioning, the mind can produce errors, distortions, and illusions within memories which are thought to be basic and widespread in humans (Patihis et al., 2013; Schacter, 2012).

In this sense, 'repressed' memories may simply be a function of normal working memory and the forgetting of trauma does not necessarily mean it has been repressed. However, the nature of memory as reconstructive allows for it to be subjected to other psychological phenomena during that reconstructive process. A particularly pertinent example of this is false memories, which are a psychological phenomenon where an individual recalls an event which either happened differently than it actually occurred, or that did not happen at all (Loftus, 1997). While there is a difficulty in establishing a historical truth in any form of memory recollection, a history of trauma is especially relevant to false memories, due to those with trauma

symptomology are thought to be more susceptible to memory deficits and therefore more likely to fill in or add in their own interpretations to specific memorable events (Sarbin, 1995).

Furthermore, some aspects of repressed memories are simply unfalsifiable or uncheckable.

Specific, transient details such as whether or not a door was open or shut, cannot be confirmed unless there was another witness and eyewitness testimonies have been proven to be notoriously unreliable (Gonsalves & Paller, 2002; Loftus et al., 1995). In terms of recalling memories, people are vulnerable to the powers of suggestion and can be swayed into believing something happened when it did not just through mentioning it enough times (Zaragoza & Mitchell, 1996).

As seen in the Loftus & Palmer (1972) automobile accident study, participants were able to be manipulated into believing that certain aspects of an event were memory rather than a

manipulation by the experimenter(s). Misinformation has been shown to change an individual's recollection of events in significant ways, especially after a period of time has allowed the

original memory to fade, as is often the case with 'repressed' memories (Loftus, 1997; Stalberg & Maass, 1997). There is not enough evidence from the flow of narrative truth which comes

from the recovery of repressed memories to be used within the forensic setting, particularly when repressed memories have not been shown to be any better (or worse) in the recollection of

trauma and abuse than continuous memory (Piper et al., 2008; Sarbin, 1995; Schefflin & Brown, 1996).

It has become so controversial over the years that clinical psychologists who study in support of repressed memories have – or have at least tried to - retire the term, opting to adopt the term 'dissociative amnesia', though this has not done much to change the negative connotations and problematic belief in the phenomenon (Brown et al., 1999; Otgaar et al., 2019, 2022; Pope et al., 1998). In fact, clinical psychologist, Richard McNally (2005) has stated that

the repressed memory is one of the most pestilent pieces of pseudoscience to infect the field of psychology and the subsequent recovered memory therapy is one of the worst therapeutic interventions for mental distress since the lobotomy.

Much of Freud's work today is discredited as pre-scientific, though credit must be given when its due - Freud was one of the forerunners of considering trauma as something more psychological and based in the mind, rather than being caused by a physiologically dysfunctional brain, a perspective which has continued on throughout the study of trauma - and overall mental health - today (Boorse, 1976; Jessor, 1958; Putnam, 1973). Despite this, there is a lot of his theory which has been proven 'wrong' through modern medical advancements and a changing zeitgeist. While his conceptualisation of trauma was valid, the solutions he believed in are today regarded as questionable at best. There are only many explanations and very few solutions, and through this theory, Freud paints a much more pessimistic view of human nature, assuming that aggression would simply not exist in people were there not some underlying trauma or severe frustration in early development (Kernberg, 2009).

To Freud, the posttraumatic experience can be understood as an involuntary hyper-fixation and attachment to the past, where pathological symptoms emerge as a result of unresolved thoughts and emotions surrounding distress have been repressed in an effort to maintain psychological homeostasis and regular mental functioning. However, in doing so, people tend to lose sight of how to structure their lives in the future, and while understanding distressing events that disrupted their ways of being is good and allows a sense of closure, people are left unsure how to go forward. The nature of trauma is incomprehensible and haunting, so much to the point where one comes to view their life as from the perspective of who they became because of their distress, or the history of their trauma (Bradley, 2020). This failure to consider

the future could potentially be blamed by Freud's stance on pleasure as the motivating force in life. Pleasure is a very immediate and deals with satisfying wants in the present, with the id being described by Freud himself as constantly seeking instant gratification regardless of morality. In a way, Freud views psychic trauma as a result of fright – not fear. Traumatized individuals are characterized as being stuck in the past, frightened into not moving forwards, and if we are taught to or innately aim to avoid tension in our lives, how are we meant to deal with it when we need to, other than to just relive it?

To live in the body of a survivor is to never be able to leave the scene of the crime. I cannot ignore the fact that I live here. – Blythe Baird

Chapter 2: The Impact of Freud on Contemporary Trauma Studies

Freud and his works became prolific within the realms of psychology and psychiatry, as well as beyond, so he gained a great following – both in life and posthumously. His work was reinvigorated through the psychodynamic perspective and has often been used within the study of literature throughout the past century and is still utilised in these ways today (Forter, 2007; Roudinesco, 2016; Thurschwell, 2009; Wallerstein, 2006). Though a lot of his work can be (and is still) deemed controversial, it is hard to deny that Sigmund Freud revolutionised the field of psychology and provided us with some of the most significant and long-standing psychological ideas today (DiCenso, 2005; Shakow & Rapaport, 1964; Storr, 2001). Some of the key concepts of his theories include the significance of childhood experiences in determining adult behaviour; the importance of talking therapy; conflict between different parts of the self and the beginnings of cognitive dissonance; as well as introducing the idea of the unconscious cognitive, affective, and motivational processes – all propositions which see a lot of support and research in many of the different areas of psychology currently (Weber, 2000; Westen, 1998). The nature of his theories marked a turning point in the field of psychology and understanding of mental illness, with him being one of the first thinkers to posit that psychopathological – or in his day, ‘hysterical’ – symptoms could not strictly be a result of brain anatomy, claiming that hysteria disregarded the distribution of nerves that made up the physical organ of the brain (Fletcher, 2013). While this in part was driven by a hesitance to formally claim that structure-x caused symptom-y due to the primitive understandings of the human brain at the time, this train of thought – from studying neuroses as damaged physical tissues to abstract, psychical phenomena

– would come to change the trajectory of psychopathology and trauma studies forever (Neu, 1991).

Freud's *raison d'être* for proposing and articulating the theory of psychoanalysis was to bring psychological phenomena into the realm of natural science, for researchers to consider the mind to simply be another part of nature – much like Charcot before him (Solm, 2021). He aspired to describe psychological processes without any supernatural embellishments, even those considered to be abnormal, and would speak about psychological dysfunction in respect to what was known as a normal 'spiritual' life (Enckell, 1981). When hysteria came to be seen as a medical issue, Freud viewed its symptomology as a maladaptive manifestation of the biologically driven desire for pleasure in conflict with the moral standings of society. Despite his best efforts, Freud's conceptualisation of the human psyche was vague, and some would say mysterious. While he was wholly of the belief that the components of the pleasure principle – the id, the ego, and the superego – were placed in the brain, he was reticent to attribute psychological functions and structures to any known anatomy of the brain due to the rudimentary nature of neurobiology and neuroscience at the time, though expressed the hope that one day, clearer, more specific relationships between these two aspects could be determined (Kernberg, 2009).

Freud's work met with a lot of scrutiny. Despite this, the idea of traumatic neuroses came to dominate the fields of medicine and psychiatry from around 1895 to the conclusion of the Vietnam War era in the U.S., to the point where it was essentially rewritten into the DSM-I as the gross stress reaction (Wilson, 1994). Furthermore, he managed to describe the core PTSD symptom clusters outlined in the revised DSM-III in *The Introductory Lectures to Psychoanalysis*, published in 1917 – nearly 70 years before PTSD was articulated (van der Kolk et al., 1994).

Emergence of Psychopharmacology

The period after the Second World War allowed for many scientific advancements to be made, including the invention of psychotropic drugs, with the 1950s being named the ‘golden decade of psychopharmacology’ (López-Muñoz & Alamo, 2009). Despite the vast history behind talking therapy from Freud alongside support from other prominent psychologists in the later mid-20th century like Carl Rogers, Abraham Maslow, and Aaron Beck (Maslow 1965, 1971; Rogers, 2012/1951), therapists often struggled with treating people with more explosive symptoms and most often institutionalised them as a result (van der Kolk, 2014).

It was the invention of the first antipsychotics in the 1960s and the first antidepressants not long after, that transformed the treatment of severe mental illness (Drake et al., 2003). This discovery, along with rapid social change spurred by the state of the world post-WWII, led to a shift in how clinicians and researchers saw and approached psychological disorders (Drake et al., 2003; Kirkby, 2005). People who had been previously demonised and thought to be incurable suddenly had viable treatment options and perceptions of mental illness shifted from abnormality veering on supernatural to just that, illness (Ban, 2007). With the creation and distribution of antipsychotics, the number of people admitted to mental hospitals in the United States alone dropped from over 500000 in 1955 to less than 100000 in 1996 (Torrey, 1998 in van der Kolk, 2014). Involuntary commitment was made nearly redundant, with the rapid development of psychopharmacological interventions allowing many countries to move towards the modern, institutional psychiatry and community-based care that we know today (Lamb, 1993; Thornicroft & Bennington, 1989).

As these drugs revolutionised the treatment of mental illness, doctors finally felt competent in the treatment of psychological disorders because they offered an alternative to the

complex, nuanced talk therapies, which some individuals – particularly men – struggled to engage in (Hyde et al., 2005). Not only did they seem to work, but they provided a fast, straightforward, and readily available solution to poorly understood psychopathology to highly distressed individuals. This, in conjunction to the limited availability and long wait times for talk-based psychotherapy provided by the state and the often-exorbitant prices of private services, allowed a quick solution in the face of a rising mental health crisis and a lack of mental health professionals in general (Kakuma et al., 2011; Schofield et al., 2011; Thomas et al., 2009). The fact that these harrowing displays of mental distress could be resolved, or at least subdued, through medical means also seemed to solidify the notion that psychological issues were largely a problem of the physical anatomy of the brain (Dumit, 2003; Ramachandrai et al., 2011). With the ever-increasing number of people taking antidepressants and other psychogenic medications, however, many researchers came to notice that they came with a plethora of different side effects. Common side effects of modern antidepressants, such as selective serotonin reuptake inhibitors (SSRIs) include insomnia, drowsiness and fatigue, sexual dysfunction, weight gain, dry mouth, and shaking hands or tremors (Cascade et al., 2009; Papakostas, 2008). Furthermore, the efficacy of these drugs has increasingly been coming into question in recent years. Some even go as far as to say that antidepressants are no better than a placebo, which has led to psychiatrists and clinicians to question whether the benefits of these drugs outweighed the drawbacks.

It is also important to point out that, even today, we do not quite understand the full extent of how psychotropic drugs work to alleviate depressive, anxious, and traumatic symptomology. For example, the most common medication used to treat those afflicted by PTSD is antidepressants, particularly SSRIs (Asnis et al., 2004; Bernardy & Friedman, 2015; Williams

et al., 2022). There have been many theories surrounding but the most commonly known one is the monoamine hypothesis, which predicts that a deficiency of serotonin, norepinephrine, and dopamine within the central nervous system produces depressive symptoms (Delgado, 2000). However, despite being the most enduring proposal put forth thus far, many limitations to it have been found and psychiatrists and psychologists alike criticise its inadequacy (Hindmarch, 2001). Most commonly questioned is the latency period between antidepressant administration and effect, regardless of a usually rapid increase in synaptic serotonin (Tome et al., 1997). SSRIs and other antidepressants can take several weeks to have any noticeable increase in mood (Dale et al., 2011). As another example, some individuals experience no improvements in depressive symptoms despite a marked increase in serotonin levels after the administration of SSRIs (Dale et al., 2011). Other known antidepressants, such as, do not even act on any monoamine systems, and pharmacological experiments to induce a monoamine depletion in healthy individuals found no significant increases in depressive symptoms compared to a control population (Delago, 2000; Hamon & Blier, 2013). From these findings, it is likely safe to conclude that there is more to depressive and anxious symptomology than a dysfunction in the serotonin (or other monoamine) system. Regardless, the scientific community continues to cling to the monoamine hypothesis due to its importance in solidifying the biochemical paradigm into psychiatry, enhancing psychiatry's prestige and both validating and promoting the psychopharmacological treatment of depression and other mental disorders (Baumeister et al., 2003).

Antidepressants have become the frontline treatment for a variety of mental illnesses, from depression, anxiety and panic disorders, OCD, to eating disorders such as bulimia and issues with pain like fibromyalgia (Sansone & Sansone, 2008; Schatzberg, 2000). Research has found psychopharmacological treatments for PTSD to be similarly effective (Albucher &

Liberzon, 2002). But, if all it took to cure trauma was a tiny, little pill, why is it that still so many people are still on them? Van der Kolk knew that were antidepressants and other psychogenic drugs effective, that people would be able to stop taking them once their symptoms stopped without the fear of them coming back. But concerningly, since their widespread distribution and in the 1950s, the rate of antidepressant prescriptions has only increased and continues to trend upwards, even today (Bachmann et al., 2016; Zito et al., 2002). These numbers are similar across all age groups, with antidepressants being prescribed to children as young as two years old (Zito et al., 2000). In New Zealand, antidepressants dispensed to youth populations has increased by 53% over the past five years (Te Hiringa Mahara, 2023)– an issue which is becoming of greater concern to researchers and psychologists (Mojtibai, 2008; Ofllson & Marcus, 2009). With the easy accessibility of these medications alongside the high cost and lack of availability of psychotherapeutic practitioners, people are becoming more and more reluctant to seek out talking-based therapies.

Technological Advancements in Neuroscience

At the same time as psychopharmacology was coming into prominence, researchers were also exploring new avenues in neuroimaging. Scientists and medical professionals had been long aware that there was some degree of localisation to the human brain, with famous case studies such as Phineas Gage and Patient (Corkin, 1984; Ratiu et al., 2004). In the mid 20th Century, particularly during neurosurgery, surgeons would notice that direct cortical stimulation would activate or inhibit different behaviours, implying a specificity and degree of localisation which was far greater than could be observed at the time (Savoy, 2001). Like many other areas of research, medicine and neurology underwent massive change with the Digital Revolution (Bryan, 2003; Hirschtritt & Insel, 2018). In conjunction with PTSD finally being introduced into

the DSM-III, specialists focused on trauma shifted towards rapid research proliferation and vast acquisition of knowledge on a global level (Wilson, 1994). In the United States, the 1990s were dubbed the “Decade of the Brain” by the president at the time, George H.W. Bush (Jones & Mendell, 1999; Orbison et al., 2017). This period was characterised by deep scientific pursuit and the integration of technology (modernisation), allowing researchers in neurology, psychiatry, and psychology to delve into and understand the brain more than we ever had before.

Basic forms of MRI (magnetic resonance imaging) and CT (computerized tomography) scans came about in the 1970s and 80s (Bigler, 2017). The development of these neuroimaging techniques removed the need for intrusive diagnostic methods such as biopsy and surgical exploration and led to an explosion of research attempting to assess and localise brain function within healthy human volunteers (Savoy, 2001). Prior to this, much of what was known about the brain had been inferred from lesion studies and direct stimulation. However, that does mean that this data was from what is in essence, damaged brains (Vaidya et al., 2019). This period of “brain-mapping”, as it is commonly known, was characterised by an explosion of neuroanatomical research (Baillet et al., 2001). With the ability to identify brain-behaviour correlates, different treatments and interventions proposals skyrocketed in the fields of psychology and psychiatry (Filipek, 1999; Savoy, 2001). A lot of previous theories surrounding trauma have been based in behavioural observation and abstract hypotheticals of the mind – Freud’s concepts of the id, superego, and ego are intangible, immeasurable, and immaterial, unlike chemical reactions or evolution. Neuroimaging techniques have allowed us to understand the anatomy and physiology of the brain in incredible amounts of detail, far beyond what psychiatrists like Freud could ever have dreamed of (van der Kolk, 2014).

Neuropsychological Explanations of Trauma: “The Body Keeps the Score”

In 2014, van der Kolk released his now critically acclaimed book, *The Body Keeps the Score*, a title which would eventually become a New York Times best-seller (*Best Sellers - Books - the New York Times*, 2023). Today, it has sold over 2 million copies and has been translated into 36 languages (*The Body Keeps The Score*, Retrieved 2023). He sought to redefine trauma as we know it through going over the historical origins of posttraumatic stress and how it was conceptualised, assessed, and treated from WWI to present (Ray, 2015). Filled with a plethora of case studies and experimental breakthroughs over the past 30 years, the book begins by going over the definition and nature of psychological trauma. While we are all familiar with the acute trauma caused by direct exposure to a highly distressing event, such as a natural disaster, an accident, and/or physical or sexual abuse, traumatic events can also be chronic and enduring, such as episodes of childhood neglect. After an extensive and rapturing dive into the neurochemistry and biopsychology from which the symptoms of trauma emerge, van der Kolk claims that with this new understanding of the aetiology of trauma, there needs to be an upheaval in how clinicians such as psychologists, psychiatrists, and doctors treat those with posttraumatic stress, providing a comprehensive list of interventions. He concludes with a potential future diagnosis for the Diagnostic Statistical Manual (DSM) – a developmental trauma disorder.

Van der Kolk grew up in post-WWII Holland, so his first array into trauma was that of a personal level. His father had been very vocally against the Nazi regime and was subsequently detained in an internment camp until the end of the war. Similarly, his uncle had been captured in combat by the Japanese and was sent to work over the River Kwai as a slave labourer in Burma. Furthermore, his mother had had some sort of undisclosed trauma in her childhood which was triggered whenever a young van der Kolk asked about it, and as a result he would

often be blamed for upsetting her (van der Kolk, 2014). Much of his personal experience with trauma is that of a vicarious nature. These early observations would come to spark van der Kolk's interest in studying psychiatry and later specialising in traumatic stress and its effects on the brain. Similar to Freud, van der Kolk specialised in psychiatry, meaning that he initially studied medicine before going on to his primary focus in neuropsychology.

While trauma had been a topic of interest in psychology since Freud's era, this was reinvigorated with the return of American veterans from the Vietnam War. For van der Kolk, this arose in the form of his role as a staff psychiatrist at the Boston Veteran Administration Clinic (VA). It was his work with veterans which sparked his ventures into a new, revolutionary understanding of trauma. In the initial chapters of his book, van der Kolk describes the first client he worked with at the VA, a man named Tom who had served in Vietnam ten years prior. Before enlisting, he had graduated as the valedictorian of his class and enrolled with the Marine Corps immediately after his graduation as was in his family tradition. Within the army, he soon became a platoon leader in charge of a group of eight other Marines due to his natural athleticism, intelligence, and leadership skills. At the end of his tour duties, he was honourably discharged and simply wanted to move on with his life and put Vietnam behind him. While outwardly, that appeared to be the case – despite having graduated from law school, married his high school sweetheart, and having two sons, Tom felt completely disconnected from his life. There was a conflict between his actual inner experience and what he thought he should be feeling, an idea that echoes from Freud's pleasure principle.

He reported about how he had spent the recent holiday weekend drinking and looking at old photos from his service days rather than with his family. Many aspects of the celebrations – the fireworks, the summer heat, and dense foliage where his family would spend the weekend –

reminded him too much of Vietnam and would apparently “drive him crazy” (p. 8, in *van der Kolk, 2014*). He also had nightmares about a previous ambush in which all the members of his squad were killed or injured, and these night terrors were so horrible he feared falling asleep and often forced himself to stay awake the entire night. His sleep was subsequently interrupted constantly, and he behaved angrily and aggressive towards his family, the noise of his children at times made him so angry that he would leave the house in order to prevent himself from hurting them. Tom was upset that he struggled to feel any real affection for his wife and sons, and in times where he should have been happy, he felt dead inside. It was only with high-risk activities, such as excessively drinking or driving at dangerously high speeds on his motor bike that he could calm himself down or feel alive, as such. And van der Kolk would find over the years that many others like Tom shared in their difficult experiences of returning to civilian life.

As the VA became inundated with veterans seeking psychological help and with a lack of qualified doctors, van der Kolk and his team were allowed to start a group for young Vietnam veterans until one-on-one therapy could begin. After an initial period of discomfort and tension, once one veteran started speaking about his helicopter crash, the rest of the room immediately began to engage, speaking about their own traumatic experiences with great intensity. In the weeks that followed, these men would return to the group and repeat the process. Van der Kolk found, to his amazement, that they found meaning and resonance in speaking to each other, where there had previously only been terror and emptiness. These men were united by their shared experiences by vicariously reliving them together, which gave them a renewed sense of comradeship that had been crucial to surviving their war experiences. It was easier to relive those terrible moments than it was to return to civilian life, and in some cases, was the only way that these men could feel alive again. Somehow, the trauma which caused them so much immense

pain and upset was the only thing which could give them meaning. How could these men, who had previously been fine, who had functioned well in society, become so detached and withdrawn despite being removed from the immediate, negative circumstances?

Driven by a passion and intrigue to further understand the mechanisms of the brain and its role in trauma, van der Kolk's investigations led him to what would become a pivotal work for him – *The Traumatic Neuroses of War* by Abram Kardiner (1941). A psychiatrist himself, Kardiner helped in the treatment of WWI veterans in the post-war period and published his observations from his patients in preparation for the presumed influx of 'shell-shocked' soldiers of WWII. These patients displayed several common symptoms, including chronic hypervigilance and sensitivity to perceived threat, strong emotional reactions, and detachment and withdrawal with themselves, others, and the world, despite prior functioning – findings eerily similar to those found in van der Kolk's in his cohort of patients. What Kardiner named as 'traumatic neuroses' is analogous to what we now call PTSD.

Importance of Brain-Body Connection

During his early studies, van der Kolk concluded that to be able to heal, we need to understand how the human organism works – it was our comprehension of the anatomical structures and physiological systems of the body which allowed us to see a problem and therefore fix it. However, the mind is not so clear cut, as would become evident to van der Kolk during his psychiatry rotation. He was struck by the disparity between how much research had gone into the psychological issues which clinicians and doctors were treating, and how little they knew about the actual mechanisms of the brain – the origin of those problems – behind them. But with the development of the neuroimaging technology as described above, and a better understanding of the mechanisms of the brain in general, psychiatrists and psychologists were

able to gain highly accurate and real-time scans of the activity occurring in the brains of PTSD patients during their symptoms (van der Kolk, 2014).

Within these scans, van der Kolk and his colleagues discovered that, during flashbacks and recollections of their traumatic events, these individuals showed an abnormal amount of activation within the limbic system – also known as the mammalian brain. This part of the brain includes structures such as the amygdala, the hippocampus, the thalamus and hypothalamus: they are ancient and primitive structures of the brain that are activated during threat to survival episodes.

Traumatic events are fundamentally a threat to survival. In instances of severe distress, the amygdala is activated so an individual can act quickly and ensure their physical safety (Davis, 1992). However, in doing so, other areas of the brain – such as those involved with neurocognitive processes like executive functioning, concentration, and learning - are disengaged so resources can be prioritised in the face of death or grievous harm (Drigas & Mitsea, 2021; Olf et al., 2014). It is theorised that the rapid and excessive activation of the limbic system, alongside hypo-arousal in the rational prefrontal cortex and adjacent structures, results in the experience of the trauma to not be properly consolidated into long-term memory (Halligan et al., 2003). A lack of integration subsequently causes the traumatic event to only be remembered through affective states or somatosensory elements associated with it (van der Kolk & Fisler, 1995). When attempting to recall trauma into consciousness or presented with a stimulus reminding them of the event, instead of presenting as a linear, autobiographical narrative, it is experienced through customary response patterns – such as physical sensations, immediate emotional responses, and behaviours which might otherwise seem irrational. The physical reactions one has responding to trauma are detached from the psychological ones, and that these

psychological symptoms originate entirely in the somatic response at the time of the trauma - an idea which came to be the seminal ethos to his approach. Van der Kolk therefore conceptualises the symptomology of PTSD as an experience of intrusive re-remembering, where, regardless of the form of trauma that was experienced – be it combat-related, rape, a natural disaster, or anything else – the central nervous system (CNS) reacts consistently to situations which are perceived as overwhelming, threatening, or uncontrollable with hypervigilance (van der Kolk, 2014; van der Kolk & van der Hart, 2014). This response was conditioned in the person through the physiological reactions which the body and brain underwent during the original incident of trauma, so may include (but is not limited to) emotional outbursts and blunting, muscle tenseness, or a raised heart rate (Hayes et al., 2012). These reactions are often considered to the person as irrational or overdramatic as they are usually cognitively aware they are safe but are unable to control their affective responses and, while not permanent, are hard to change due to being deeply ingrained within highly primal, automatic, and subconscious areas of the brain.

Traumatised individuals are not only trapped within a constantly overactive physical state, but also perceive the world in a fundamentally different manner to those who have not been traumatised. Using Rorschach tests to test veterans' perceptions and imaginations, van der Kolk found that the brains of people who have experienced traumatic events have essentially been rewired to act and live most effectively within a distressing environment (van der Kolk & Ducey, 1989). Of 22 veterans shown a blot with colour, 17 of them reacted to the image as if they were reliving a war time event – or experiencing a flashback. These images were often described in terms of viscera and other gore associated with wartime combat as opposed to the generally expected sometimes whimsical images that most people see – such as butterflies, dancing people, or men on unicycles (Brown et al., 2013). Through this, it can be discerned that

traumatised individuals tend to superimpose the memory of their trauma onto the reality around them and subsequently struggle to properly decipher what is happening in the external environment (Balaev, 2018; Cohen, 1985).

Interestingly, the other 5 participants showed an even more concerning response, in that they did not seem to react at all. These veterans, when shown the inkblots, would often reply by stating the image was ‘nothing’, or ‘just a bunch of ink’ – which, while technically true, is considered to be a contrary reaction to such a test. The ambiguity of the Rorschach test is meant to elicit a search-type response, where an individual is expected to parse and use imagination to read into an ambiguous stimulus (Giromini et al., 2010). Imagination is vital for the quality of life; it allows us to explore beyond our routine existence by fantasising about the different possibilities in life and gives us the opportunity to contemplate new possibilities (Andrews, 2014). When people are sporadically and constantly made to remember the past, or the last time where they felt a deep involvement and intense emotions, they suffer from a loss of mental flexibility and lack of imagination (Pederson, 2014). They are unable to create goals and envision a better future, therefore experience a deep sense of hopelessness (Lynch & William, 1974; Smith, 1982; Spencer et al., 1997). The men who saw nothing in the tests had lost the capacity to let their imagination extrapolate from their everyday reality, whereas the men who saw images of past combat and war did not display the mental flexibility which characterises imagination and simply relived the same memory over and over.

Through this, van der Kolk asserts that PTSD can be described as a condition where the body – via autonomic functioning from the brain - continues to defend against a threat which occurred in the past, and even uses Freud and Breuer’s analogy of a pathological reminiscence

when describing the effects of a traumatic event on a person. The ways in which PTSD symptomology is expressed and why are outlined below.

Autonomic Hyperarousal

Van der Kolk attributes most of the symptomology of posttraumatic stress to dysfunction in the limbic system, a collection of brain structures which are not only deeply involved in the processing of memory and emotions, but also is considered as one of the many brain systems which helps to regulate visceral processes of the autonomic nervous system (ANS), such as respiratory and heart rates, blood pressure, digestion, and pupillary response (McCorry, 2007; Rajmohan & Mohandas, 2007). In times of stress, the threat-detecting amygdala sends a distress signal to the hypothalamus – the centre of the brain which communicates danger to the rest of the body through the hypothalamic-pituitary-adrenal (HPA) axis (Joseph & Whirledge, 2017). This cascade results in the production of the stress hormones cortisol and adrenaline, which in turn spurs the activity of the sympathetic nervous system (SNS) to activate the ‘fight-or-flight’ response (Jansen et al., 1995). Once any perceived danger has passed, the level of cortisol and adrenaline go down – replaced by self-soothing hormones such as oxytocin and noradrenaline – and the parasympathetic nervous system (PNS) activates to return the body to a state of calm, allowing the body to recover (Recordati, 2003).

All systems in the brain have an optimal level of functioning that an organism usually acts to maintain, in which it can carry out its designated roles and allow us to properly engage in everyday life. However, when experiencing trauma, the limbic system is presented with either hypo- or hyperarousal, which forces it out of its optimal range of function and subsequently traps an individual in an overactive fear response due to the memory of the trauma not being processed properly and being experienced as an even occurring in the present. This reaction can therefore

continue to occur long after the traumatic event has passed and can be reactivated through certain triggers and stressors which remind the individual of the original trauma event. In other words, the ANS is acting as if it were continuously under mortal threat, which leads to the body becoming unable to rely on its instinctual reactions as a genuine source of warning (van der Kolk & van der Hart, 2014). Chronic activation of the SNS can result in depressive symptoms, reduced immune response, elevated heart rate and blood glucose levels, as well as an inability for the body to regulate these reactions and keeps it in constant anticipation of danger (Esler & Kaye, 2000; Won & Kim, 2016). These health impairments are largely due to the excessive levels of cortisol circulating the bloodstream, which then travels to all areas of the body (Lowrance et al., 2016).

Hypervigilance, Emotional Disturbances & Psychosomatic Reactions

The loss of normal neuromodulation caused by trauma often results in an impairment in emotional regulation as well (van der Kolk & van der Hart, 2014). An inability to control one's emotional reactions leads people affected by posttraumatic stress to be overly hypervigilant, restless, and have an exaggerated startle response (Butler et al., 1990; Morgan et al., 1997). Unremarkable stimuli can cause those with PTSD to immediately become extremely upset without them fully knowing or understanding what caused them to be, leading to overreactive fight reactions of anger, fear, and panic, or a flight-like response in which they shut down and freeze. For example, a woman who was raped may experience panic as a result of an unknown man approaching her – the conditioned stimuli, out of fear that she may be raped again. Due to the levels of hyperarousal in the autonomic nervous system, both children and adults experience sleep disturbances as they often do not feel safe enough or sufficiently calm themselves enough to do so (Nappi et al., 2012). Many PTSD patients have insomnia out of a fear of having

traumatic nightmares and some report waking themselves up in the midst of dreaming out of fear that their dreams may evolve into trauma-induced night terrors (van der Kolk & van der Hart, 2014).

These emotional disturbances can also get in the way of an individual being able to accurately identify and articulate internal states, thoughts, and feelings, or the ability to learn to do so (van der Kolk et al., 2014). People who have experienced trauma, particularly those who experienced it in childhood, often struggle to verbalise or translate somatic sensations into basic emotions, such as happiness, anger, and fear (Pennebaker, 1993). In the absence of words or symbols, these unnamed emotions are simply experienced in the form of physical issues. This is known as alexithymia, or emotional blindness, where one is only able to relate to the world through their physical body (van der Kolk, 2014). Therefore, distress is experienced in the manifestation of somatisation disorders and through material organs as opposed to psychological states.

Dissociation & Numbing

After World War II, there was a greater focus on psychological treatment occurring as soon as possible after exposure, before acute stress was able to fully set in, which greatly reduced psychiatric casualties in the immediacy (McNally et al., 2003). However, rates of drug and alcohol abuse in veterans was very high, as they would often turn to these substances to avoid confronting or examining traumatic memories or the constant onslaught of uneasy, physical sensations resulting from them (Crocq & Crocq, 2022). Substance abuse, among other dangerous, high-risk behaviours would soon be discovered to be a form of self-numbing (Kerig et al., 2012; Khanzian, 1997; Litz et al., 1997). Van der Kolk himself observed this within the veterans at the Boston VA, where excessive alcohol and substance abuse was a method used to

escape the constant sensations of terror and fear associated with PTSD and their memories of combat and violence associated with the Vietnam War. He suggests that because people with PTSD struggle to control their emotional reactions and are aware that these can be irrelevant or unsuitable, they spend a great amount of energy on controlling their external expressions by avoiding any distressing internal sensations (van der Kolk & van der Hart, 2014). The emotional numbing seen with PTSD may be expressed through depression, adhedonia, lack of motivation, psychosomatic symptoms, or dissociative states (Feeny et al., 2000; Kashdan, Elgar, & Frueh, 2006). People may become withdrawn and isolate themselves, feel as if they are simply ‘going through the motions’ of life rather than living it. Due to hyperfocusing on their internal state of being, PTSD patients do not attend to or pay attention to the demands of the environment, and subsequently report feeling detached from the world, others, and themselves (Feeny et al., 2000; Horowitz, 1986).

From a neuroscientific perspective, the sense of self is rooted within a vital connection in the physical body (Damasio, 1999; Mahler & McDevitti, 1982). The dysregulation of the limbic system has been found to be a necessary prerequisite for dissociation to occur (van der Kolk & van der Hart, 2014). Traumatized people are often afraid of feeling, as the areas in the brain responding to emotion – such as the amygdala – continue to generate sensations analogous to helplessness and fear. These sensations persist in the absence of any overt threat and keep the mind and body shut off from external stimuli. As a result, these people lose access to their immediate reality and the sensory world is largely off limits. People then lose the sense of being in their own bodies, feel physically uncomfortable within themselves but are unable to pinpoint exactly what is wrong, which van der Kolk describes as another form of alexithymia regarding the sense of self. Unlike other symptoms of PTSD, dissociation and numbing are solely an

internal experience and becomes a part of a patients' baseline functioning after the traumatic event (Bromberg, 2014; Price & Thompson, 2007). This leads to them resigning to their emotional numbness, giving up on recovery and unfortunately sabotaging their own ability to resolve their trauma through psychotherapy (Horowitz, 1986; Kerig et al., 2012)

Memory Disturbances & Learning Difficulties

The excessive physiological arousal associated with traumatic events has been shown to affect multiple aspects of memory function. The hippocampus, a structure which is vital for the integration and storage of long-term memories; visual, aural, and written aspects of experience, such as conversations, places, or words; contextual details; positional and spatial relationships; as well as new learning, is located within the limbic brain (Joseph, 1999). Subsequently, it plays a large role in the recollection and remembrance of events, which can be affected by prolonged stress and emotional arousal such as that which occurs within trauma. Stress-induced secretion of corticosteroids, norepinephrine, and enkephalins occurring during traumatic events result in dendritic death and atrophy of the hippocampus, a structure in the brain (van der Kolk & van der Hart, 2014)

Hippocampal dysfunction means that people with PTSD are not only affected by the dissociative amnesia surrounding the traumatic event itself, but also struggle in remembering ordinary events and learn from new experiences (Joseph, 1999). A loss of maturational achievements is often observed alongside a diagnosis of PTSD, with patients reverting to immature or earlier modes of stress coping (van der Kolk & van der Hart, 2014). In adults, this is generally expressed in excessive dependency and hesitancy surrounding the making of rational, autonomous decisions (Aupperle et al., 2012; Steele, van der Hart, & Nijenhuis, 2001). Whereas in children, who are already at a lower developmental level, this regression may be seen through

an inability to care for oneself in more basic areas, such as feeding themselves or toilet training (Hamblen & Barrett, 2016). Younger children can also experience other early developmental issues such as delayed speech or selective mutism, separation anxiety, cognitive impairments, and inappropriate or antisocial behaviour (Anstendig, 1999; Bolton et al., 2004; Bücker et al., 2012). The hypervigilance, impairments in executive function, memory issues, and concentration difficulties seen in those affected by posttraumatic stress reflect and may be mistaken as attention-deficit disorder (ADD) in both adults and children (van der Kolk & van der Hart, 2014).

In conjunction to the dissociative amnesia and poor remembering, people with PTSD often experience intrusive remembering of memories when faced with external or internal triggers associated with what happened to them (Ehlers et al., 2004). Injections of lactate, a substance formed with anaerobic activity – which also stimulates the ANS – has been found to elicit flashbacks and panic attacks in people diagnosed with PTSD (Fu & Levine, 2013; Rabinowitz & Enerbäck, 2020; van der Kolk & van der Hart, 2014). Therefore, any form of activity which induces physiological arousal has the potential to trigger traumatic memories, physical sensations, and emotional reactions that are inappropriate to the situation at hand. Combine with an overactive, unregulated ANS, this often means that traumatised individuals are unable to predict when or where something may trigger a distressing memory – both internally and externally.

Trauma, as previously established by Freud, is unsettling. It is both unbearable and intolerable, shattering the safe, stable narrative of one's life up until the point it occurred. Most people who have experienced such – be it war veterans, rape survivors, or children in abusive homes – often become so overwhelmed and upset when trying to recall the traumatic event that

they actively try and deny it, force it from their minds and move on as if nothing ever happened (Chu, 1991; Janoff-Bulman & Timko, 1987; Krystal, 1978). Van der Kolk agrees with this, but further, is able to locate this in specific areas of the brain and its functions that produce the psychological phenomena associated with PTSD.

Treatment of Trauma: Limbic System Therapy

Van der Kolk establishes that trauma is an experience which traps one in the moment of trauma, in order to move through that, one must be able to reorient themselves to the present and live in the moment, rather than constantly relive the terror of their previous experiences. Regardless of when the event occurred, be it ten years in the past or beyond fifty, the changes within his patients' brain activity during the trauma meant they were unable to bridge the gap between those distressing experiences and their current lives. Therefore, it is imperative to consider the entire organism within the treatment process – from the brain and the central nervous system, the reactions those cause within the body, to the consciousness and experience of living. So, in the same way that van der Kolk realised that psychopharmacology could not be a sole intervention to treat trauma, he also observed that talking therapy could only get so far, and there needed to be a revision in the way which we approached PTSD and mental distress (Wylie, 2004).

Where Freud explains this through the repressed memory, van der Kolk's theory of trauma is based in biology. The experience of trauma begins in the material body, where memories of trauma are embedded deep within the viscera and all parts of functioning - physical and psychological – are affected (van der Kolk, 2014). Trauma fragments the way that people experience the world through altering the neurochemistry of the brain, which transforms all

aspects of reality, from the language we use to describe the events that happened to us, to the sense of self, and how people interact with others in the future (McFarlane & Bookless, 2001).

As a result of being biologically and instinctually driven, these cognitive, behavioural, and affective responses are largely outside of an individual's conscious awareness, causing people to question themselves and their minds. A big part of van der Kolk's theory of trauma is that the symptomology of it is the disparity between one's logical, conscious thoughts versus the panicked, frenzied reactions in their bodies, and it is the lack of control which people feel that makes patients feel as if they have been intrinsically broken. People become of two minds after a traumatic experience – the rational mind which is able to recognise there is no threat within their present experience of reality, and the instinctual brain which is still trapped within the moment of trauma. Reminiscent to Freud, van der Kolk conceives trauma as a failure of the mind to process the physiological reactions to a distressing experience – or, as previously stated, an event without witness. Interestingly, this conceptualisation shows similarities to Freud's id and ego.

The treatment of trauma therefore becomes a matter of control, where van der Kolk encourages people to take back autonomy through interventions which assist in soothing the discordant brain and allowing for the restoration of executive functioning, self-confidence, and the capacity for creativity and playfulness (van der Kolk, 2014). To do this, there are three principal concepts which are necessary in treating PTSD: the processing and coming-to-terms with the memory of an overwhelming traumatic experience; mastering control over automatic biological and physiological stress reactions; and re-establishing secure interpersonal relationships and social efficacy (van der Kolk et al., 2014). He calls this overall approach limbic system therapy, to which there are several interventions he recommends for reregulation of the emotional brain, several of which are explored below.

Antidepressants & Other Psychotropic Medications

Van der Kolk was involved in some of the very first studies researching the efficacy of SSRIs in the treatment of PTSD, specifically Prozac or fluoxetine (e.g., Davidson & van der Kolk, 1996; van der Kolk, et al., 1994; van der Kolk et al., 1995). Within his 1994 study, they found that the SSRI fluoxetine, more commonly known as Prozac, was an effective antidepressant in treating PTSD, with the most marked improvement in arousal and blunting symptoms in comparison to a placebo-group and a control sample. Moreover, SSRIs are also thought to be effective due to their efficacy on comorbid disorders which can often occur in conjunction with PTSD, such as depression, panic disorder, social phobia, and obsessive-compulsive disorder (Bernardy & Friedman, 2015; Friedman et al., 2003). Antidepressants have also been found to show both acute and sustained improvements in the quality of life in patients diagnosed with PTSD, with SSRIs, tricyclic antidepressants, and monoamine oxidase inhibitors considered as some of the first line treatments of PTSD (Albucher & Liberzon, 2002; Seedat et al., 2006).

Medication is an irrefutably important tool in healing from traumatic symptomology, particularly in the sense of survival from day to day, however – as mentioned before – there is growing ambivalence about the benefits of psychogenic medications versus the wide array of side effects which can be had (Stein et al., 2006). Antidepressants and other psychotropic drugs can alleviate some of the emotional weight of mental distress and allow a person to sustain everyday functioning, but (without any other form of intervention) do not provide any significant, long-term changes once discontinued. Van der Kolk concluded that, ultimately, all medication does is mask the symptomology of trauma until it can be properly resolved and

therefore cannot be used as the sole or primary treatment when treating those with PTSD (van der Kolk, 2001).

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR, also known as eye movement desensitising and reprogramming (EMDR), is a process where patients are asked to engage with their traumatic memories whilst being exposed to alternating bilateral stimulation of some kind – usually visual (Shapiro, 1996). Originally developed in the 1980s, the first studies on EMDR ... While sceptical at first, van der Kolk found himself intrigued with the practice upon hearing about it from one of his patients who had seen considerable improvement in her posttraumatic stress after completing several sessions, and went on to be trained in the practice (van der Kolk, 2014).

The exact mechanisms of EMDR are still up for debate, particularly in relation to the eye movement component of the treatment. EMDR researchers distinguish it from being a form of exposure therapy. This lack of knowledge incites many researchers in trauma studies to be sceptical of the effects of EMDR and whether it genuinely has any more efficacy than placebo, control, or antidepressants, and whether there is any meaningful contribution of these treatments beyond therapeutic allegiance (Rosen, 2023). There have also been many contradictory results in testing the effectiveness of EMDR. A meta-analysis of 11 studies between 1989 and 2013 on the effects of EMDR on PTSD compared to CBT found that EMDR was slightly better than CBT in decreasing total PTSD scores (Chen et al., 2015). This study found that EMDR may be better suited to PTSD patients with greater intrusion symptoms and hyperarousal, but also noted due to the limited studies and the poor quality of these studies, caution should be taken when drawing conclusions. More recently, meta-analyses have uncovered that there were indications of publication bias in studies of EMDR for the treatment of PTSD, with only around 15% of studies

of having a low risk of bias (Cuijpers et al., 2020). Furthermore, the majority of this pool of studies found that EMDR was more effective than other PTSD treatments, whereas studies with low risk of bias found no significant difference between EMDR and other forms of therapy, showing a considerable inclination of research allegiance in many EMDR studies. EMDR is found to be more effective against a waitlist or no-treatment control and other unvalidated or placebo interventions, but when compared to another validated treatment that involves any degree of exposure therapy, there is no obvious advantage of using EMDR. When compared to other validated treatments for PTSD and simple phobias, EMDR was observed to be statistically and clinically inferior (Cahill et al., 1999; Devilly, 2002). Some have even gone as far as to conclude that the eye movement mechanism is not even necessary or significantly useful (Davidson & Parker, 2001; Perkins & Rouanzoin, 2002; Specter & Read, 1999).

On the other hand, there have been many cases where EMDR has been found to be significantly effective in the treatment of PTSD (e.g., Chemtob et al., 2000; Marcus et al., 1997; Maxfield & Hyer, 2002; Wilson et al., 1997). Presently, the most prominent theory of how it works is Shapiro's Adaptive Information Processing model, in which posttraumatic stress and other symptomology is a failure of adequately processing a traumatic memory (Shapiro & Laliotis, 2011). The saccadic bilateral movements or stimuli used in EMDR are thought to help with proper processing of distressing events, allowing the reintegration of the traumatic memory into the autobiographical past and letting the body recognise it is no longer in a threatening situation (Rosen, 2023; Shapiro & Forrest, 2001). It is thought that these saccadic eye movements are reminiscent of rapid-eye movements (REM) observed in dream-sleep and unlock a repressed part of the nervous system that means the brain can properly encode the experience of trauma as an event which has passed. Therefore, the memory can be observed as just that – a

memory – rather than being experienced as a collection of somatosensory sensations which cause an individual to relive their trauma. Through Single Photon Emission Computed Tomography (SPECT) completed post-EMDR treatments, it was found that two areas of the brain had become particularly hyper activated during this process – the anterior cingulate gyrus – which is involved in emotional processing and behaviour regulation; and the left frontal cortex – often associated with language related movement and grammatical processing (Gabrieli et al., 1998; Harmon-Jones et al., 2003; Levin et al., 1999; Posner et al., 2007). These findings show that the successful treatment of PTSD is not necessarily dependent on reducing arousal of the limbic system but enhancing the ability of a person to differentiate real from imagined threat (Levin et al., 1999). Van der Kolk himself carried out his own research into the effectiveness of EMDR in comparison to antidepressants in the alleviation of posttraumatic symptoms. He and his colleagues found that at 6-months post treatment, 75% of the adult participants who had undergone the EMDR therapy had achieved asymptomatic functioning – that is, little to no symptoms of PTSD – compared to none in the antidepressant group (van der Kolk et al., 2007).

While we do not entirely understand how EMDR works and why it is not effective for all individuals, van der Kolk emphasises that it is still a relatively new psychological intervention. Despite its infancy, the emerging evidence is that EMDR has shown significant effectiveness in the treatment of PTSD in adults and has been showing encouraging signs of efficacy within children (Ahmad et al., 2007; Korn, 2009; Seidler & Wagner, 2006). He likens the treatment to the antibiotic penicillin in this manner, where whilst it was discovered and found effective in 1928, but its mechanism of action was not completely articulated until 1956 (Bennett & Chung, 2001; Yocum et al., 1979).

He also uses antidepressants as another example of an intervention which has been shown to have some effect and is used to treat a multitude of mood disorders, the ways in which they work have not been fully described (van der Kolk, 2014). While we do not know the details of EMDR's efficacy, it is possible to see that it has significant benefits reducing nightmares, flashbacks, and intrusive remembrance, which have shown to be resistant against other forms of treatment (Martin et al., 2021). EDMR allows people to observe their own traumatic experiences in a different perspective without requiring them to verbalise it to another person, providing a method for healing from trauma without the need to talk about it. Van der Kolk saw this as beneficial and revolutionary for a couple of reasons. Firstly, given the deactivation of key language areas in the left temporal lobe, patients often find it hard to verbalise their experiences, let alone their emotions and cognitions surrounding it. Secondly, it could be carried out without the need to spend an arduous amount of time establishing a therapeutic alliance, shortening the treatment time whilst still being effective.

Neurofeedback Therapy

In his attempts to utilise the immense diagnostic power of these newfound neuroimaging systems for the treatment of PTSD, van der Kolk and his colleagues began experimenting with several neuroscientific techniques. One of these methods is neurofeedback, a technique which takes advantage of the electrical nature of brain activity and emerged out of the discovery and use of electroencephalography (EEG). Electrical brain activity had been observed in animals as early as the 1800s, but not in humans until 1929 by Hans Berger, the inventor of the electroencephalogram (Hammond, 2011; Masterpaqua & Healey, 2003). Through his work, it was found that electrocortical activity could be detected and recorded in the form of different

wave frequencies, which correlate to different states of consciousness, attention, and behaviour (Masterpaqua & Healey, 2003; Niv, 2013).

While in the past, there had to be subdermal insertion of wires, modern-day EEG uses electrodes attached to the skin of the scalp to capture signals emitted from the superficial layers of the brain, making EEG an easy, non-invasive method for observing brain activity. Van der Kolk initially encountered EEG when conducting analysis of neurological activity during sleep though was unsure of its uses in terms of researching trauma at the time. It was not until Clark and colleagues (2000) picked up van der Kolk's ideas of using EEG for trauma studies, who carried out an analysis of the brain activity within traumatised patients versus a control group. They found that individuals who had not undergone a traumatic event produced a coherent pattern within the EEG which showed clear processes of filtering, focus, and cognitive analysis, whereas those afflicted by trauma produced brainwaves which were uncoordinated and incohesive in pattern. In particular, people with a hyperactive fear response consistently showed a poorly defined P300 response – the pathway responsible for core information processing – as well as not generating an N200 response – the pathway which filters irrelevant information to assist focus (Clark et al., 2000). These further validated behavioural observations and internal brain scans which van der Kolk found in his patients, that traumatised individuals struggle to maintain fixed attention and process new information from the external environment.

Visual observation of brain activity and the maladaptive wave patterns associated with posttraumatic stress allowed a method to track changes in traumatic responses in the face of different stimuli and intervention options in real time, which led to van der Kolk to seek out specialists in neurofeedback to aid in treating his PTSD patients. Neurofeedback is a form of biofeedback that centres around changing neuronal activity (Hammond, 2011; Sitaram et al.,

2017). Biofeedback is the process of gaining greater awareness of the physiological functions of a certain part or system in the body in order to change or control the body intentionally and at will (Schwartz & Andrasik, 2007). It has been described as helping the brain and nervous system to function better, by either restoring or implementing desired, healthier patterns of behaviour and inhibiting unfavourable ones (Niv, 2013). By observing EEG patterns in patients with PTSD, researcher can use superficial electrical stimulation and positive reinforcement to encourage the brain to engage more in certain frequencies and less in others to help create new, beneficial patterns of brain behaviour. At its core, it is a form of operant conditioning, where the brain is encouraged to remake and strengthen connections within the limbic system corresponding to safety and calm through a reward-driven game simulation (Gunkelman & Johnstone, 2005; Sherlin et al., 2011). Therefore, it can operate completely outside of an individual's awareness, similarly to EMDR.

Neurofeedback begins with reading neural activity, generally with EEG, and observing different frequency levels and their levels of reoccurrence (Sitaram et al., 2017). During neurofeedback, these are measured and analysed through specialised computer software to amplify and identify the specifics of an individual's synaptic responses, which are then displayed to the client as contingent auditory, tactile, or visual feedback. This is usually in the form of a computerised game simulation (Masterpaqua & Healey, 2003). By use of positive reinforcement, these real-time responses allow an individual to accordingly adjust how they are interacting with the simulation. Early studies of neurofeedback therapy showed desirable results in improving psychological dysfunction rising from attention-deficit/hyperactivity disorder (ADHD), mood disorders, anxiety disorders, and other disruptive behaviours (Baehr et al., 1999; Masterpasqua & Healey, 2003; Schoenberg & David, 2014). And now, with the advancement of neuroimaging

techniques allowing insight into deeper cortical structures of the brain during episodes of negative activity, many of these disorders are thought to have physiological bases (Boas et al., 2019; Clement & Chapouthier, 1998; Durston, 2003).

As a form of therapy for posttraumatic stress, neurofeedback focuses on rewiring maladaptive brain circuitry formed during trauma and sustaining the overactivated trauma response, which includes feelings such as shame, fearfulness, and rage (Niv, 2013; van der Kolk, 2014). It also helps in the reregulation of the limbic system, allowing patients to be able to control emotional reactions, behaviours, and thoughts associated with constant danger, and has been found to significantly reduce PTSD symptoms, even in chronic cases (Gapen et al., 2016; van der Kolk et al., 2016).

Yoga and Mindful Movement

Van der Kolk cites that a big issue with the treatment of traumatic symptomology today is how little attention paid to educating and teaching patients about self-management and self-awareness – two key skills which are imperative to recovery.

One of the ways memories of helplessness persist is through being stored within the body, particularly within areas which were affected – this may be the head or back in those affected by physical assaults, the genitals and rectum in victims of sexual abuse, or the limbs for those involved in traumatic accidents (van der Kolk, 2014). To recognise the transitory nature of thoughts and emotions is to recognise that fleeting physical sensations are not all-controlling. In the psychotherapeutic component of his work, van der Kolk (2014) would often get his patients to focus on physical sensations and observe them for what they are – just sensations which had a beginning and an end. Changing or at least acknowledging physiological reactions from this more neutral standpoint means individuals can shift perspectives and allows consideration of

options other than the automatic and habitual responses enforced by traumatic events. This way, trauma survivors can become aware of what is happening within their own bodies, understand their inner experience, and therefore make peace with it. He found that interestingly, the practice of yoga was highly similar to what he had been implementing in his clinic, with some of the key principles of yoga being viewing the body as a holistic entity composed of multiple interrelated dimensions, and that healing comes from within, allowing students to gain a greater sense of autonomy on their own rather than from an external source (Emerson et al., 2009; Woodward, 2011).

This mindfulness has also been attributed to several other forms of exercise such as rhythmic drumming known as ngoma found throughout Africa, capoeira and Brazilian jujitsu in Brazil, and a variety of martial arts across the Asian continent from tai chi, wushu, and qigong in China; karate, judo, and aikido in Japan; to taekwondo and hapkido in Korea (van der Kolk, 2014). With the exception of yoga, there is very little research on the psychological effects and possible benefits of these mindful forms of activity in the Western sphere, and even then, most of the Western practice of yoga focuses on the physical poses and breathing techniques. But what little research that has been done into these has found there are significant benefits which are worth further investigation (Haydicky et al., 2015; Naves-Bittencourt et al., 2015; Vinesett et al., 2015; Wall, 2005). Today, much of contemporary, Western mindfulness is performed whilst stationary and is more similar to meditation in this way (Germer, 2004; Kirmeyer, 2015). This is not particularly useful to those with traumatic symptomology, where their bodies are primed for action due to hyperarousal. Yoga is therefore seen as more effective in its uses as an intervention for trauma due to its integration of movement. The regular practice of mindfulness in this way has been observed to calm the sympathetic nervous system (Baer, 2003; van der Kolk, 2014).

There are also other social and economic benefits of and increased feasibility for implementing yoga and other mindful activities in treating PTSD (Gallegos et al., 2017). These activities are often delivered in a group setting, which may take the pressure off an individual in a therapeutic space and encourage participants to play an active part. Furthermore, the certifications needed to teach these modalities are not as the strenuous and time-consuming doctoral study needed for practicing psychology and psychiatry which means that it can be more accessible and allows for a greater number of clinicians to meet demand (Gallegos et al., 2017). Yoga and other forms of mindfulness generally do not require any specific or specialised equipment therefore can be implemented and augmented in a patient's home, where they may feel more comfortable and more likely to engage with it.

Efforts to bring these mindful principles into psychological care has already begun to occur with the implementation of them into therapeutic approaches such as acceptance and commitment therapy (ACT) and CBT, particularly in disorders where anxiety is a primary symptom (Khalsa et al., 2015; Pull, 2009). Several interventions using yoga as an alternative or adjunct to psychotherapy and antidepressant medication have found it to be effective in decreasing reexperiencing, hyperarousal, and other PTSD symptoms (Jindani et al., 2015; Mitchell et al., 2014; van der Kolk et al., 2014b).

Van der Kolk brings clarity to some of Freud's incoherent theories through a stronger foundational understanding of brain anatomy, physiology, and neuroscience, much in the way that Freud himself hoped. The physiological responses within the body are seen as the explanatory bridge to the harrowing experience which trauma wrecks upon the mind. However, while he talks about the importance of preserving the humanity of people who have undergone

extreme distress and the necessity of finding language to describe traumatic experiences as a way to integrate them into their past and therefore allow themselves to be present, there is no escaping the implications of biology. Whether he wanted to or not, van der Kolk implies that trauma is to be seen as a largely physiological issue, with the subsequent psychological issues seen as epiphenomena that arise as a result of the dysfunction of the brain. That much is evident in the title of the book – it is the *body* that keeps the score.

Although the world is full of suffering, it is also full of the overcoming of it – Helen Keller

Chapter 3: From Physiology to Experience

It is interesting to observe just how much overlap in the central themes of Freud's and van der Kolk's theories of trauma persist, in spite of the scrutiny which psychoanalysis endured within the mid 1950s. Van der Kolk cites Freud multiple times within his works and similarities can be seen within their theories. For example, van der Kolk argues our natural tendency is to have a homeostatic manner of trauma management, where the aim is to maintain a state of functioning in by avoiding dealing with psychical distress caused by the autonomic reactions of the body. While he implies that we do not have a drive towards pleasure, we certainly have an innate compulsion *away from* biological imbalance. However, trauma is unfortunately a very common experience, with around 70-85% of people experiencing some form of traumatic event within their lifetime (Epstein, 2013). Given the experience of trauma is a near universal thing, spending our entire lives attempting to avoid it, or in the constant pursuit of pleasure, is unrealistic (Balaev, 2014; Buse et al., 2013; Gerber & Gerber, 2019). Furthermore, while it is natural for all humans to go through the trials and tribulations of life resulting in sadness and suffering, not all people who go through trauma will experience posttraumatic stress disorder (PTSD) (Yehuda, 2004).

Different definitions of trauma have varying levels of social utility, meaning that they proliferate and are deemed more useful within certain contexts, depending on how they benefit society (Loewenstein et al., 1989), and the particular interventions or theories trauma is conceptualised through determines the treatment process (Bath, 2017; Cicchetti & Toth, 1997; Wasco, 2003). In most modern societies, the definitions, mechanisms, and interventions we use to explain trauma and traumatic reactions are mainly from a physiological perspective, where

trauma is thought to cause malfunction within the physical entity of the brain which goes on to affect the rest of the body and mind, as explained through van der Kolk's neuropsychological perspective. Biological explanations of mental illness tend to have greater credibility in contemporary Western societies due to the fact they legitimise particular perspectives of social reality (Horwitz, 2020). For example, the persistence of the monoamine hypothesis reinforces a biological narrative to mental disorders, which serves as a heuristic to guide research, enhances psychiatry's standing, and creates a niche in the pharmaceutical industry (Baumeister et al., 2003). In emphasising a neuropsychological approach, there is somewhat of a dehumanising of trauma study and treatment, where there is a harder focus on the biological 'truth' of the physical effects of trauma and unfortunately reducing a very human experience – that of immense suffering – to anatomy and neurochemistry.

Regardless of this predominant perspective, no subjective human experience, imbued with personal emotions and fundamental changes to identity, can be boiled down to biology - not even something which seems so deeply ingrained in the body like trauma. There is a universality in neuroscience – van der Kolk's work leads us back to the notion that symptomology is largely to be explained rather than moved through or "treated" (Bartolomeo et al., 2017; Müller, 1996), but to help further understand how trauma affects people, it is pertinent to go beyond anatomical and physiological changes.

Frankl: Early Life and Psychiatric Beginnings

Viktor Emil Frankl was born 26th of March 1905, in Vienna, Austria, in the midst of the declining Austro-Hungarian empire and throughout his life, bore witness to great political instability, philosophical change, and scientific upheaval during the 20th Century (Berend, 2001; Frankl, 2008). His interest in psychology and meaning in life began during his high school years,

when he took night classes in applied psychology and philosophy. He was eventually contacted by Sigmund Freud wanting to publish one of his papers from these classes, a correspondence which would continue well into Frankl's academic career (Frankl, 1988). He eventually came to study medicine, specialising in psychiatry and neurology, much like Freud before him. He began his academic career studying in psychiatry and psychology under Freud and later Alfred Adler – another driving researcher in Viennese psychology, eventually coming into regular contact with many of the prolific figures in both psychology and philosophy – such as the aforementioned Freud, Martin Heidegger, Rollo May, and Gordon Allport to name a few – to discuss their hypotheses, and opinions on each other's works (Frankl, 1988). From his clinical beginnings, he was always interested in mental health and wellbeing, setting up cost-free counselling for teenagers in several cities around Austria, including Vienna (Frankl, 1959). After completing his doctorate in medicine, Frankl was appointed to be in charge of the women's suicidality ward at the Psychiatric University clinic before eventually opening his own clinic in 1937, where he was working with adolescents with depression and in suicide prevention before his arrest, and subsequent detainment by the Nazis (Frankl, 1946/1959).

By the late 1930s, psychologists were beginning to become increasingly interested in the uniquely human aspects of existence, concepts such as love, hope, creativity, being, individuality, and – most importantly – meaning among them (Baumeister, 1987; Cushman, 1990). By the 1950s, when humanistic psychology had established itself as its own subset of the field, psychologists such as Abraham Maslow, were arguing that there needed to be a third force in psychology after the heavily sexualised psychoanalysis and the reductive cognitive-behaviourist perspective, to which Frankl concurred (Bugental, 1964; Frankl, 1988; Maslow, 1968, 1969). His idea that meaning was the biggest motivating factor in human life was

something he was contemplating before his incarceration in Nazi concentration camp. It caused him to be expelled from Alfred Adler's academic circle and to venture out on his own (Klingberg, 2001). Frankl's development of logotherapy began in post-WWI Austria, a time where it had been ravaged in the war and were rife with poverty and despair, struggling with the collapse of the Austro-Hungarian Empire (Becker & Novy, 1999; Dana, 1992; Silverman, 2012). Soon after, WWII commenced, and Viktor Frankl found himself in the heart of one of the worst genocides in history - the Holocaust. He lost both parents, his brother, his wife, and the beginnings of what would become his magnum opus in the form of his early manuscript for 'Man's Search for Meaning' (Frankl, 1946/1959). On top of that, he was subjected to the worst physical and psychological conditions in the modern era. His abstract theory came to be his lived experience, where he claims he found meaning in spite of - and perhaps because of - the immense suffering both within and around him.

Logotherapy came to be around the time when dominant Judeo-Christian hegemony was beginning to fray in Europe. For the latter part of the 16th Century, societies fought over land and domination was seen as necessary to flourish, which included assimilation of minorities into the conquerors' ways of living (Crossley et al., 2006; Simons, 1901). As a result, logotherapy could possibly be seen as one of the markers for the end of Europe's modernist era. Certainly, it is associated with the humanistic movement in psychology (Hilgard, 1980). Human life was greatly affected in the 20th Century as a result of overwhelmingly rapid scientific and industrial advancement, and with the quick changing social and cultural norms of the world, the nuances and uncertainties of life increased too (Okan & Ekşi, 2017). This, alongside the rise of existentialism and loss of faith in God and a civil religion caused by the absolute horror of WWII meant many people were slowly shifting away from both religion and spiritual faith itself

(Habersmas, 2008; Santiago, 2012). Dissolution of a singular dominant religious narrative led to an explosion of spiritual and existential exploration, allowing the world to move towards a pluralistic view of life, faith, and meaning (Stern, 1992). The beginnings of narrative awareness first emerged in *Man's Search for Meaning*, and further grew within his later works as psychology, along with rest of the Western World, transitioned from a place of hegemonic ideology to pluralistic narratives concerning meaning in life (Esping, 2010).

Despite their differences in opinions, it is clear to see that Frankl's theories reflect similar aspects to those seen in the works of Freud and Adler, hence logotherapy became known as the Third School of Viennese Psychology. While specific and unique at an individual treatment level, logotherapy is largely nomothetic in nature – something shared with Freud and Adler. Frankl argues for *the Will to Meaning*, a universal drive which motivates human behaviour and survival in the same way that pleasure did for Freud. He had a very dialectical idea to wellbeing, of the mindset that (unavoidable) suffering was a necessary path to happiness, rather than an obstacle, and in allowing oneself the freedom to suffer. He was of the mindset that adversity was not meant to steal or rob people from having a meaningful existence – that there may not be any reason for the trauma people inevitably would undergo in their lives, but its experience does not have to be in vain.

Frankl & The Will to Meaning

Viktor Frankl is one of the lesser well-known humanistic psychologists to emerge from this era, but who pioneered the field with his autobiographical account 'Man's Search for Meaning' (1959a) and later theoretical framework of logotherapy, known as the 'Will to Meaning' (Frankl, 1988). His theories, while not as prominent as those of Freud, became known as the third school of Viennese psychology alongside Freud's 'Will to Pleasure' and Adler's

‘Will to Power’ (Barnes, 2000; Pytell, 2001) with Carl Rogers calling his works some of the most important contributions to psychology in the past 50 years (at the time of release) (Frankl, 1988; Längle & Sykes, 2006). After the war, once he began clinical practice again, Frankl observed as much within many of his patients; there was a general trend that the world as a whole was moving away from religion. While he never believed that humanity would truly be devoid of it, he recognised there were fewer and fewer universal truths which people could grasp at (Frankl, 1988).

Frankl proposed that meaning is a primary motivator in life and human experiences are inherently filled with meaning, famously known for quoting Nietzsche’s: “he who has a why to live for can bear almost any how” (Crossley, 2000; Das, 1998; Nietzsche, 1967 in Frankl, 1946/1959). He was also one of the first to propose that humans have an innate desire to both seek and have meaning through the interactions and perspectives they have in and of the world, rather than being motivated by other base drives to conduct these activities through another inciting desire and created one of the first existential frameworks for psychology (Frankl, 1988, Von Devivere, 2018). Frankl believed meaning to be so influential as a motivator in life that people would be willing to sacrifice necessities for survival and security, sexual gratification, power, and in some cases even their lives for a worthy cause (Frankl, 1946/1959, 1975, 1988; Lantz, 1992).

From this assumption, logotherapy has three main principles, which make up Frankl’s concept of man (Frankl, 1955). It assumes there is a meaning in life; that life has a meaning - not necessarily objective - and this is unique and specific to each man, can only be fulfilled by him alone, and only after its fulfilment will it achieve a significance that will satisfy his will to meaning (Frankl, 1946/1959). Meaning exists in all circumstances and at any time, regardless of

how desolate the circumstances seem, so it can be found moment to moment, but Frankl also recognised and acknowledged a ‘super-meaning’, which refers to an ultimate meaning beyond the capacity of human understanding (Fabry, 1988; Frankl, 1988; Lantz, 1992). In this case, Frankl suggests that we are faced with an inability to understand the infinite nature of meaningfulness and that ultimate meaning is trust in some form of order in the universe - and humans are simply a part of that, rather than having to endure the meaninglessness of life, as proposed by several nihilistic philosophers (Starck, 2003). This is an interesting claim as it ultimately implies meaning is a narrative and is subjective in nature, therefore cannot be assumed to have a nomothetic status across all people’s lives.

Frankl believed our uniquely human capacity of potentially seeing, regulating, and accepting oneself allows us freedom from our physical and psychological drives, as well as from external determinants such as heritage, instincts, and environment. While these factors can influence our behaviours, thoughts, and emotions, they do not determine who we are and therefore we can act beyond them (Frankl, 1988). He asserts against pan-determinism, that human behaviour is simply a syndrome of social, biological, and genetic conditions. Unlike animals, which are bound to an environment triggering drives specific to the instinctual make up of a species, humans are open to the world and can break through the barriers of environment (Frank, 1988). People have the capacity to actively reach out and attain meaning in a world which is teeming with others to assist in this process (Frankl,1988). It is because of this that we have the freedom to find meaning in the events and experiences of our lives and are obligated to do so - something Frankl defines as the concept of responsibility. When nothing is fated, it means there is no cosmic justice, no absolute morality, no order, or fairness, and therefore no inherent rules to live by (Baumeister, 2008; Levy & McKenna, 2009). So, as we are able to be

free from external influences, man is responsible for the realisation of the meaning in his life and the values he ascribes to it to give that meaning, and this is known as the freedom of will (Batthyany, 2019; Marshall, 2012). This ability to focus beyond ourselves, to shift from extrinsic to intrinsic motivations, and establishing the self in relation to others is known as self-transcendence, and Frankl argues that it is this that makes us fully human (Frankl, 1966; Kimble & Ellor, 2001, Wong, 2016). Self-transcendence, in his view, is the essence of existence, and to be fully human means to be directed away from oneself (Frankl, 1988).

Finally, the eponymous will to meaning focuses on finding a reason or an argument to be happy, but not specifically finding happiness in and of itself. It is the basic striving of man to accomplish meaning and purpose, and profoundly opposed to motivational theories of his peers which are based on the homeostasis principle – that man is rudimentarily concerned with achieving and maintaining inner equilibrium through reducing tensions in his life (Frankl, 1988). This is a perspective to which Frankl found much agreement - particularly in criticism against Freud's work – with several psychologists in the field of humanistic psychology stating that psychoanalysis, despite any and all efforts to revitalise it, will never be able to get away from its fundamental end goal of pleasure, ergo homeostatic satisfaction (Allport, 1955; Bühler, 1959). Frankl quotes Bühler (1968), who conceives man as “living with intentionality”, which means living with purpose, and subsequently has a primary orientation towards creation and to values. Frankl argued that while pleasure and power - the drives focused on by Freud and Adler respectively - will result in accomplishment and fulfilment in the material world, these are simply consequences of reaching an end, but not an end themselves (Frankl, 1972, 1988). To Frankl, happiness, and by proxy pleasure, is something which ensues – something automatic and spontaneous in the nature of its occurrence. Happiness therefore cannot be pursued, as in making

it the objective of motivation, one makes happiness the object of his attention and in doing so, loses sight of the reason behind that happiness and subsequently the happiness itself will fade away (Frankl, 1988). In a similar vein, those who strive for and exhibit their power and status will eventually be dismissed as status seekers, sooner or later – the objective of seeking status causes status to be lost and thus. This is a process known as hyper-intention. Success and happiness must happen, simply as a result of living one's life intentionally, and the less one cares for them, the more likely they are able. Both happiness and success are substitutes for fulfilment, and through this logic, Frankl views the will to pleasure and the will to power as mere derivatives of the will to meaning – pleasure is merely an effect of meaning fulfilment, and power is simply a means of to an end. That is, while power cannot always be achieved, achieving power is an invaluable prerequisite of striving for meaning, and consequently will result in pleasure (Frankl, 1988). Hedonistic desires such as wealth, lust, and superiority oppose self-transcendence, therefore people who strictly pursue power and/or pleasure live in frustration and fall into an existential vacuum.

According to Frankl, there are three ways people are able to discover meaning in our lives; through creating work or doing deeds which extend beyond oneself, experiencing or encountering something or someone; and choosing one's attitude towards their fate - no matter how miserable that seems in the moment (Frankl, 1988; Later, 2008; Starck, 2003). By distancing oneself from a situation and viewing it from outside themselves allows for a different perspective on the circumstances, as well as a changed meaning and to Frankl, the most poignant way to do this was through love directed towards others (Starck, 2003).

Frankl recognised meaning as salient to positive psychological well-being, understanding that one's search - 'will' - to meaning could be obstructed and if it was, an individual would

experience some form of distress (Frankl, 1946/1959, 1988). He named this phenomenon ‘existential frustration’, where one’s sense of meaning is misdirected towards immanent desires and consequently struggles to identify meaningful life goals to live for (Frankl, 1946/1959). This results in one feeling unsettled and wanting more out of life, with the consistent struggle for meaning leading to a sense of defeat that manifests itself through feelings of meaninglessness, purposelessness, and emptiness; general dissatisfaction with life; a lack of goal orientation; and boredom, apathy, listlessness, and/or despondency (Frankl, 1972, 1988; Von Devivere, 2018). When one has nothing to live for, they have no reason to live, and it is this experience of a total lack of meaning to make one’s life worthwhile that creates a void - a state of internal emptiness which Frankl coined the ‘existential vacuum’ (Frankl, 1959, 1962; Hillmann, 2004). This ‘vacuum’ creates a sort of ‘spiritual’ chasm in oneself which people are driven to fill, but most people’s attempts to soothe this only provide a temporary sense of relief, as people often misguidedly chase after hedonistic, superficial things (Boeree, 1998). Continued existential frustration would lead to noögenic or nöetic neuroses which he defined as a ‘breakdown’ or the experienced meaninglessness from when existential frustration is dealt with in a maladaptive manner (Crumbaugh & Maholick, 1964). It entails the subsequent responses to frustrated meaning, often exhibited as behaviours which are detrimental to the self, others, and society (Frankl, 1946/1959, 1988). Thus, it is the manifestation of existential frustration as (though not exclusively) depression, addiction, violence, and the appreciation of material pleasures (e.g., sex) which are considered to be forms of psychopathology, in a conventional sense. Interestingly, Frankl acknowledged that each generation has their own unique set of symptoms, or ‘maladaptive behaviours’, which are culturally and temporally specific, which he called ‘collective neuroses’ (1988). He also understood that the sociocultural and historical contexts

which he grew up in would influence ways he, and others of his cohort, physically expressed this experience of existential frustration.

Despite great interest and previous work surrounding mental illness, particularly depression and suicidality, Frankl noted that one's search for meaning – even in its frustration – was not any form of mental illness nor clinical symptomology, but rather a problem of spiritual distress (Frankl, 1962). While not pathological in itself, existential frustration can be distressful and lead to psychological neuroses, though not in the traditional sense pertaining to chronic mental illness (Frankl, 1988). Frankl discerned this existential blockage was not always neurotic, and that some amount of mental conflict was necessary, or even healthy. In the same way that happiness would always ensue one way or another, he believed that all humans would at some point in their lives be subjected to the Tragic Triad – that is, guilt, death, and unavoidable suffering (Lukas, 1990) – but denied that suffering was necessary to find meaning. Rather, he preached that meaning could still be found in spite of suffering being inevitable, such as in the face of an incurable disease, or (in his case) a concentration camp. He called this tragic optimism, or the ability of being optimistic and having hope despite the tragic triad, and the capacity to find meaning during the inevitable tragedies of human existence (Frankl, 1988; Leung, 2019; Lukas, 1990). He even goes as far as to say how we deal with the challenges of our lives shows who we are, more so than any form of happiness every could (Frankl, 1946/2020)

When asked to define meaning, Frankl would say “what is meant”. He recognises that each individual is unique and is imbued with idiosyncratic sociocultural, historical, and temporal contexts – therefore could not have no meaning, as the world has specific, special obligations and opportunities reserved for him alone (Frankl, 1946/1959, 1988). This definition of meaning differs from contemporary ones in that he does not believe that meaning is constructed (e.g.,

Baumeister, 1991; King & Hicks, 2009; Steger et al., 2008), but instead is demanded of us out of a responsibility to respond to the circumstances which life places unto us. It already exists, we simply have to find it. Interestingly, Frankl argued against the idea that the will to meaning is simply another drive, despite viewing meaning as a necessity in life. Were we to view it as another drive, man would simply be, again, reduced to being basically concerned with his inner equilibrium. And if this the case, man would seek to fulfil meaning for his sake, rather than for its own (Frankl, 1988). Regardless of people having a primary tendency to seek meaning in their lives, there needs to be an intentionality associated with that – something which lies beyond oneself in the form of experiences, relationships, or deeds, or – were that not possible – a change in attitude towards the current circumstances ailing one's life. It is, in a very strict sense of the word, a will. However, Frankl struggles to conceptualise this at different points in his theory, with contemporary existential psychologists still struggling in clearly defining what the search for meaning is without characterising it as a drive (Dyck, 1987; Russo-Nether et al., 2016).

Trauma from a Logotherapeutic Perspective

Frankl was one of the first to recognise that trauma was fundamentally disruptive to one's ideas of life and his own experiences in the concentration camps allowed him a unique perspective on trauma (Das, 1998). He notes that former prisoners of the camps often dislike speaking of their experiences, how they believed that there was no need for an explanation for those who had been inside and that those who had not would never be able to understand how they had felt then or now (Frankl, 1946/1959). He came to realise that courage is a necessity in sharing trauma, in the retelling of an intimate experience of pain and suffering. It is hard for any of us in this day and age to imagine the utmost horrors of the Holocaust and when reading his tale, one cannot help but feel deeply despite the incomprehensible magnitude of the torture

which Frankl endured. He describes being detained alongside his fellow men, stripped of all personal belongings in a decontamination unit, forced to undress, showered, and shaved, remarking all that any of them were left with was their naked existence (Frankl, 1946/1959, p.12). Being a trained clinician, Frankl was particularly lucky in being assigned as a doctor looking after those affected by typhus, ensuring that prisoners did not die. He eventually came to use his skills as a psychiatrist, helping fellow inmates how to overcome and deal with the near-unbearable trauma and shock of their circumstances (Gilbert, 2004). To aid with this, he even set up a watch unit within his camp to eschew suicide and help individuals combat their despair. In his observations of life inside the concentration camps and the chronic trauma they were faced with, Frankl identified three key psychological reactions that all inmates had to some extent – a deep sense of shock at their initial admission, apathy which came with acclimatisation to camp life, and finally a depersonalisation and disillusionment which arose if they survived long enough to be liberated (Frankl, 1946/1959). These stages can be reflected in other experiences of trauma and can even be superimposed on to the symptoms of PTSD as understood today.

Stage One: Shock and Denial

On first admittance to the concentration camps was generally characterised by shock horror; a disbelief that something as horrid as that was happening to them - something which confounds all victims of trauma (van der Kolk, 2014). Frankl is aware that traumatic events have a disorientating effect on our lives, that we often experience a denial or unshakable disturbance in response to them – he experienced this first-hand himself. He observed this during his own detainment process, packed in a train of over five hundred people travelling over several days and nights. shared relief all the passengers on his train held when they passed through Auschwitz and the saw the Kapos – specially assigned prisoners chosen to overlook manual labour units and

carry out administrative duties in the camps. Despite being aware of the horrors occurring within the concentration camps, upon seeing this particular troop of prisoners, Frankl felt that everything would be okay, and that camp life would not be as bad as they thought (Frankl, 1946/1959). However, the Kapos only made up a small, select few inmates and were not a representation of the majority, as he would soon come to learn. Frankl refers to this as the ‘delusion of reprieve’, or the belief that just as all hope seems lost, one would be relieved of whatever burden is to be placed upon them, such as a condemned man being reprieved of execution at the very last minute.

As previously mentioned, Frankl cites meaning as being a necessity for human existence, even if the frameworks and crux of meaning are often outside conscious awareness (Landsman, 2013). The will to meaning is made most apparent in experiences which are overwhelming and do not have any discernible cause, reason, and therefore, no meaning (Steger & Park, 2011). Trauma, by definition, overloads our usual abilities to cope and adjust (Landsman, 2013). It pervades the entirety of one’s experience, upsetting cognitive, emotional, and behavioural ways of functioning. The incomprehensibility of trauma lies in the fact that it does not align with our fundamental principles of how the world *should* work, it upends the most rudimentary meanings in our lives, and that is what makes it so psychologically distressing (Altmaier, 2016). For example, while antisemitism had been growing within Europe in the lead up to WWII, the Jewish people were faced with a complete upheaval of life as they knew it within a matter of days (*Expulsion, Deportation and Murder - History of the Jews in Vienna*, 2007). Frankl, like thousands of others, went from enjoying his productive niche of clinical psychiatry in a well reputed job and living in a highly civilised society, to abruptly being faced with unrelenting evil, constant death, and a severe deterioration of social order and justice. The inhumane conditions of

deprivation and unspeakable violence witnessed by those detained would have completely and utterly decimated their bedrock prepositions about human nature (McAdams & Jones, 2017). In the worst-case scenario, the upsetting of the assumptive worlds meant these individuals were simultaneously grieving the loss of what they once knew and having to cope with unbearable trauma as well as being unable to adapt reconstruct a meaningful personal reality. Nevertheless, there is evidence which suggests that this form of complex grief can prompt personal growth as well as despair, adding to a survivor's sense of meaning, rather than just taking away from it (Neimeyer & Prigerson, 2002). How we narrate our own lives can influence how we perceive ourselves in respect to the world and what our actions mean in the grand scheme of things so for the prisoners, these meanings were literally a case of life or death. A failure to retain old meanings from life before or find and sustain new ones through internalisation threatened existence, and those who were unable to find any meaning simply gave up and died (Frankl, 1946/1959; McAdams & Jones, 2017).

Stage Two: Acclimatisation

After that initial adjustment, the inmates found themselves becoming indifferent to their horrific conditions. Not only to distract one from the all-consuming longing for home and family, a pain which was felt deeply and acutely to the point where one could not function, but also to protect themselves from being affected by his own disgust at the malice and ugliness which surrounded him. The simplest form of this can be seen in the merest of external forms. For example, Frankl explains how it was the newest prisoners who given the worst jobs. They were made to clean the lavatory area and clear sewage and any signs of mortification at this were punished by the supervising Kapo officers, which meant everyone quickly learned to subdue their normal reactions. They were conditioned into a state of apathy, where they simply did not

care about their conditions anymore, and Frankl describes this insensitivity which they developed as a necessary form of protection. During a shift in the typhus ward, Frankl recalls blankly watching as a man died and the rush of prisoners that ran to him, scavenging the body for all that it could offer, stripped bare of his meagre belongings before being dragged out the door to be disposed of. There was no period of mourning, no sadness or sympathy, or even jealousy at that soul not having to suffer with them, just nothing. In enduring chronic, complex trauma, life becomes about survival, the prisoners' former beliefs and values abandoned in favour of everything that helped kept them alive.

This emotional dissociation has been observed in those diagnosed with PTSD as a response to trauma (Foa & Hearst-Ikeda, 1996). Detachment is hypothesised as a coping mechanism to allow one to deal with ongoing anxiety associated with trauma, which can be evidently seen in Frankl's accounts. Blunted affect is considered to be one of the key symptoms of PTSD, which is often seen in veterans who served in combat and ambulance officers – both jobs where one can be exposed to particularly violent and gruesome events (Amdur et al., 2000; Clohessy & Ehlers, 1999). What Frankl describes is what is now known as escapism, in which one 'leaves' reality through emotional and/or cognitive means due to unsatisfying, distressing, or negative circumstances in their environment, finding delight or security within a fantasy world (American Psychological Association, 2021; Henning & Vorderer, 2001). It is not the act of engaging in an alternate experience which is satisfying in and of itself, but rather helps one to distance oneself from the traumatising experiences of the real world and avoid unpleasant current or ongoing events (Hirschman, 1988). Today, this is most commonly seen in use of mass media, where people vicariously gain pleasure and enjoyment through entertaining and absorbing media worlds (Hastall, 2017). Notably, threatening psychological states, including anxiety, depression,

and exhaustion have been found to motivate escapism, and because of this, psychological escapism is most often perceived in the negative sense. That is, it is generally studied in terms of excessive engagement in obsessive coping mechanisms, such as with internet use and social media consumption, or coping using maladaptive behaviours such as alcohol and substance abuse, gambling, and bingeing (Patrick & Hayden, 1999; Seryczyńska, 2019). Those stereotypically deemed escapist are usually considered to be depressed people who cannot deal with the problems of everyday life and therefore run away from them, instead turning to a place where we see ourselves as better, more important, and happier than we actually are (Longeway, 1990). Escapism in psychology is usually viewed as analogous to avoidance, which is something generally associated with Freud's perspectives (Panova & Lleras, 2016). But an alternative conceptualisation of an 'escapist' is one who is looking for a solution to their problems and is attempting to find a way out and when escapism motivates a person to behave in ways to relieve or reconcile with excess emotion, it can have a therapeutic effect (Longeway, 1990; Seryczyńska, 2019). Many researchers are now identifying a more nuanced, multidimensional idea of psychological escapism, understanding that people can overcome numbness, sadness, and stagnation through use of positive forms of escapism, such as engaging in various expeditions, social activities, and personally fulfilling hobbies (Igorovna, 2015; Stenseng et al., 2015). In moderation, escapism is a useful technique which allows reprieve from worries, boredom, or routine in the everyday world (Seryczyńska, 2019). For Frankl, it was a way to alter one's experience of reality – even if momentarily. A temporary rewriting of the narrative mode of being, if you will.

Where we have a variety of different forms of media, literature, art, and leisure which we can indulge in, Frankl and his compatriots only had their own imaginations at their disposal, and

it was this powerful tool which helped him carry on throughout his time in the concentration camps. Psychological and emotional detachment from the harrowing conditions meant that prisoners could create a rich, inner world which allowed for reprieve from life inside the concentration camps (Frankl, 1946/1959). The intensification of one's internal experience allowed for them to have a mental refuge in the present via imagined events of the past or anticipated events of the future (Delaney et al., 2010). With the limitlessness of the imagination, one is able to explore and play around with both important memories, but also those of mundane activities. Vivid dreams and nightmares allowed another form of escape, with Frankl recounting how he prevented himself from waking a fellow prisoner who appeared to be having a nightmare at the last minute, sadly realising whatever painful, detailed imaginative experience he was going through could not possibly be worse than the reality in which they were living.

Frankl points to a particularly gruelling day of slave labour in the dead of winter where the inmates are returning to camp. Ailed by bloated, frostbitten feet and bone-deep fatigue, supporting each other as they marched in sync, lest they be prodded and beaten by the guards, one of them remarked "if our wives could see us now! I do hope they are better off in their camps and don't know what is happening to us!" (Frankl, 1946/1959, p. 30). This prompts him to recall the image of his own wife, let himself have a conversation with her in his thoughts, which led Frankl to realising one of his core ways to find meaning. Despite not knowing where she was, or even if she was even alive at that point, and despite having absolutely nothing else to his person, the thought of his wife alone was enough for Frankl in that moment. He came to the epiphany that the love he had for his wife extended far beyond his physical or even psychological person, but deep in his inner, spiritual self. Love, being an interpersonal emotion that is long lasting, positive, and directed outwards, was one of the only available lifelines that an

individual had to find meaning within the desolate reality of the concentration camps (Frankl, 1946/1959). The social relationships people have with one another are thought to provide meaning in one's life and aid in fostering resilience in those exposed to trauma (Schnell, 2009; Sippel et al., 2015).

Hope is very close relationship to meaning; as meanings change, so does hope (Kessler, 2019). Those that lost hope in the future, their individual future, would lose hold of their spiritual resolve and eventually would succumb to physical and mental decay (Frankl, 1946/1959). For example, those that put a tangible, hypothetical date to their release would find themselves despairing when that day would pass. One of his compatriots, a senior block warden who Frankl only referred to as 'F', confided in him about a dream he had during February of 1945. F told him that he had heard a prophetic voice which would answer his questions for anything he wanted to know, to which F had asked when the war would be over, they would be liberated, and ultimately, when his suffering would end. In his dream, F was told their freedom would come on the 30th of March – a month out from when he told Frankl about this. F was convinced that the voice he heard would be right and subsequently became full of hope and optimism, though as the supposed deadline drew closer, the war news which spread throughout the camp insinuated it was highly unlikely that their liberation would arrive on that date. Frankl then tells how on the 29th of March, F became severely ill, succumbing to delirium and unconsciousness by the 30th – the day which he had been told they would be free, and on March 31st, he had died. This observation was also noted by the chief doctor of their camp, who told Frankl that the death rate in the camps spiked between the end of December 1944 and January 1st, 1945, beyond what they had ever seen. To an outsider, removed from the need for spiritual endurance, these prisoners had died of typhus. But, in this doctor's opinion, the increase in deaths was not attributed to

increased labour, reduced food or water, a turn in weather, or even a new epidemic of typhoid.

Rather, it was the result of a majority of prisoners holding on to the hope that they would be home by Christmas, a wish which turned out to be naïve. As Christmas came and went, these inmates lost their courage and the accompanying disappointment was so great it broke through their powers of spiritual resistance, leading to them just giving up on living.

Escaping through powerful, imaginative narratives imbued with hope, purpose, and future expectation allowed Frankl and his fellow companions both detach themselves from the dehumanisation they were forced to endure and allowed an alternate experience which had a coherent assumptive world. Those who managed to hold on to a sense of hope for the future were the ones who were able to persist and, in the end, were the ones who survived to see freedom.

Stage Three: Reintegration into Everyday Life

When they were finally liberated, Frankl described a sense of numbness that washed over the prisoners and a similar sense of disbelief like that which affected them upon their imprisonment. It is hard for someone to just go back to their previous ways of life after overcoming immense trauma, which may be obvious to us now but was a very new idea in psychology after WWII (Frankl, 1946/1959). In the same way their sudden detainment and subsequent maltreatment was hard to believe, the abruptness of their release made the idea of freedom hard to grasp. After all this time, when they had been dreaming of this day for literal years, how was it that they felt nothing towards it? Many of the prisoners had dreams of liberation, of being set free and allowed to return home to family and friends, only for them to be shattered when the morning whistle shrilled to wake them up for day after laborious day. How were they to know whether this was yet another imagined, falsified illusion setting them up for disappointment?

Frankl realised that they were undergoing a psychological phenomenon known as depersonalisation. Depersonalisation is a dissociative state where one experiences a sensation of detachment from themselves, such as between mind and body, or feeling like a detached, outside observer of oneself (Phillips et al., 2001; Sierra & Berrios, 2001). People who experience this often report alterations in the experience of time, sensation, emotions, and reality, all of which Frankl detailed within his accounts (Noyes & Kletti, 1977). It was this which protected many of the prisoners from the devastating psychological effects of living in such horrific conditions and subject to unjust maltreatment and emerged out of a necessity to avoid being beaten, starved, or sent to the gas chambers (Shilony & Grossman, 1993). Returning to civilised life meant undoing years of constant conditioning which had rendered the inmates apathetic and unresponsive to external factors and events and undoing this deep depersonalisation often occurred in several stages.

There was a marked disparity between the reactions of the body and the mind immediately upon release. The physical body can begin recovering from trauma immediately, after constant starvation and the expectations of labour, the newly freed would eat and drink ravenously when they were allowed the opportunity, slept for as long as their bodies would allow them, would speak for the sake of speaking, simply because they could without the fear of punishment. However, the process of regaining one's humanity, took a little longer, and it was only after those primal biological needs were – at least partially – replenished which the mind was able to begin to heal in the same way. While it was easy to shatter benign, taken-for-granted assumptions, values, and beliefs about themselves, others, and the world with one reality-changing negative event, it is much harder to relearn those attitudes, motivations, and behaviours once returned to a safe environment, simply because of how violently and easily they were

proven wrong. Frankl and his comrades spent years enduring the harsh reality of concentration camps and this fundamentally changed how they viewed the world and the core assumptions which came with that perspective. It was a necessity to be able to survive the brutality of the Nazi regime, so when there was no longer that threat to their lives, the former prisoners had to learn how to just exist the world again, from what to expect, how to act, and how to think and feel within it. After living for so long in an environment with no morals, it is not unexpected for it to take some time for these former prisoners to relearn how to live in a civil society. Unlike with their admission, which was associated with a sharp sense of devastation due to the nature of the trauma they had. Frankl views this as a psychological equivalent to how a deep-sea diver was at risk of 'the bends', or decompression sickness, were he to abruptly emerge to the surface. Divers need to rise slowly from the high-pressure environments of deep water to allow the nitrogen in their air supply to slowly and safely be removed through the lungs. Without allowing adequate time for this to occur, the nitrogen forms bubbles in the blood and results in detrimental effects to the physical body (Mahon & Regis, 2011). In the same way, were someone not properly readjusted to everyday life after immense and prolonged mental pressure provided by the strict and punishing environment of the concentration camps, their moral and spiritual health can suffer in the aftermath of trauma, something Frankl coined as 'deformation' (Frankl 1946/1959). Soon after their release, some of the previously imprisoned began to display acts of unjustness and malice that pervaded the camps, although now, they were the instigators. Now freed, they believed that they were justified in their vindictiveness, in exploiting and mistreating others, due to their previous experiences. Frankl speaks of one of his friends in which he observed this moral deformation, which was more often than not revealed through insignificant things. The two of them were walking across a field to reach their encampment and came across

an area of crops. As Frankl attempted to avoid it, his friend grabbed him by the arm and dragged them through it and damaging them. When he tried to reason that they should not ruin the crops, his friend became enraged, shouting about how his entire family had died and the conditions they had endured to gain back their freedom, as if his previous suffering validated any mistreatment or wrongdoing which he did or would do. This leads back to the idea of competitive victimhood, Frank's friend felt entitled to this digression as a result of having suffered previously and shows the potential poor acclimatisation to everyday life after experiencing trauma.

The mental health of those who had endured the intense trauma of the Holocaust could further be affected upon returning home by two fundamental experiences which characterise the aftermath of trauma – bitterness and disillusionment. The first, bitterness, came about as a result of the lack of reaction and/or inaction from the world upon learning about the trauma one had gone through. Given the absolute horror which he had endured, the unresponsiveness of others upon being told that narrative was obviously hurtful. Frankl recalls feeling so disgusted with humanity at the apparent superficiality and emotionlessness in response to the horror of the concentration camps, citing wanting to crawl into a hole and never see or hear from humans again. The disparity between the reality of someone who has been traumatised - with their assumptions about a safe, predictable world absolutely annihilated, versus that of a person with no lived experience of that trauma - much less any understanding of what surviving it entailed or meant, often elicits a feeling of resentment in victims (Brudholm, 2006; Zemblyas, 2008). However, it is important to note the bitterness comes from a place of subjectivity – what Frankl and other Holocaust survivors experienced and describe is viscerally harrowing to a point that those with an undisrupted assumptive world would simply not be able to fully comprehend it,

therefore act upon it. The intensity of the trauma Frankl endured completely goes against what they know and their lived realities.

The second experience was something known as disillusionment, or a sense of disappointment or despair at the discovery that something is not as good as it seemed or was imagined (Janoff-Bulman & Berg, 2014; Maher et al., 2020). Where those who survived realised that, despite their release, their suffering did not end and no hard-earned, long-awaited happiness that came after, a sentiment that Frankl – among many – experienced. Upon discovering that both parents, his brother, and his wife had all perished as a result of the Holocaust, Frankl described feeling the experience of anguish anew (Frankl, 1946/1959). His purpose for survival, which had sustained him through the worst experiences of his life was definitively gone. He was, for the second time, left with absolutely nothing but his existence, and it was the lack of meaning and purpose in existence which he found the hardest to overcome.

Logotherapeutic Approaches to Trauma & Its Criticisms

It makes sense that Frankl's works are centralised around moving through trauma, seeing it as an opportunity, and changing your attitudes surrounding dire circumstances in order to survive - that was his reality in the four concentration camps he lived through. It was the most useful credo to ascribe to at the time. Even after his release and the conclusion of WWII, adjusting back into civil society, Austria was immediately occupied by the Allies and, while recognised as a victim of the Nazi regime, was still poor and devastated – perhaps even more so than after WWI. Psychology after WWII became increasingly focused on healing the psychological damage caused by the utter devastation caused by the global conflict, most often from a disease model of human functioning (Seligman, 2002). So, a lot of the time this meant that the more humanistic aspects of the healing experience were pushed aside.

Frankl strived to change this, pushing for a focus on the individual and their own ideas of meaning and purpose in their lives as a way to overcome immense trauma and distress. In respect to his own life, Frankl perceived his experiences as the universe presenting him with an opportunity to respond well to adversity, rather than unjustly cheating him of any (Frankl, 1946/1959, 1959). When Frankl finally managed to publish his manuscript just after WWII, PTSD was not recognised as a mental disorder. Before 1987 (Turnbull, 1998), there was no strict set of symptoms which characterised a clinical definition of trauma, so people were left to figure out how to define their trauma for themselves and what it meant for them by themselves. For Frankl, coping and overcoming his trauma was a matter of meaning-making, the creation of alternate narratives to help one endure a horrible reality, leading to the conceptualisation of his theory of logotherapy. Any modern-day problems in our own lives seem to pale in comparison to the atrocities he went through, though it is exactly this form of juxtaposing which Frankl aims to avoid (1946/1959). While he recognised that the events he endured are of nightmarish and almost unreal proportion, he also acknowledged that suffering is relative. To explain this, he uses the analogy of the behaviour of gas – that is, even if a finite amount is spilled into an empty chamber, it will fill the chamber fully and evenly regardless of the quantity (Frankl, 1946/1959, 1953). Therefore, suffering completely fills the human mind and consciousness, no matter how great or little the suffering is. The extremity of Frankl's own experiences does not mean that his theories cannot be applied to what one might consider 'lesser' forms of trauma, further emphasising how one's journey is their own and not to be extrapolated to a generalised journey of healing.

Meaning in life has been found to be an important psychological construct in theory but there is a lot of hesitance in carrying out empirical research due to uncertainty surrounding how

to measure it (Chamberlain & Zika, 1988). Efforts to empirically prove the tenets of logotherapy have been of increasing interest in the past few decades, with several psychometric measures involving life meaning and purpose being proposed. The purpose-in-life (PIL) and seeking of notice goals (SONG) tests created by James Crumbaugh and Leonard Maholick (1964, 1977) are probably the earliest instances of this. They found that noogenic neuroses were not identical to any other conventional diagnostic categories. Rather, noogenic neurosis was its own new clinical syndrome and the results from the PIL lend support to Frankl's concepts of noogenic neurosis and the existential vacuum/frustration (Crumbaugh & Maholick, 1964). Both the PIL and the complementary SONG tests have been found to be reliable and valid instruments for measuring purpose or meaning in life and are significantly and positively correlated with measures of self-concept, self-esteem, internal locus of control (Crumbaugh, 1968; Phillips, 1980; Reker, 1977; Reker & Cousins, 1979). From the current research, it is believed that meaning in life is a multidimensional construct and that meaning is able to be found in multiple different ways, though PIL is thought to be the best general measure for the construct (Chamberlain & Zika, 1988). Arguably, however, the will to meaning appears to be unmeasurable construct (Dyck, 1987). More recently, the meaning-in-life questionnaire (MLQ) created by Steger and colleagues (2006), was created to try and measure the presence of meaning in life and the search for meaning in life through two subscales. The evidence from the three studies which they carried out found that both of these measures were reliable, valid, and structurally sound measures of the presence and search for meaning. They believed that from this instrument, and others which helped narrow down the multiple dimensions of meaning, would enable a more accurate estimation and analysis of the relationship between meaning and other related constructs.

Using these tools, meaning has been found to be a crucial and influential construct in psychological well-being and in some cases, human survival, with a presence of meaning in life being associated with increased mental well-being, positive affect, and increased life satisfaction in both Eastern and Western contexts (Ho et al., 2010; King et al., 2006; Reker et al., 1987; Steger & Frazier, 2005; Zika & Chamberlain, 1992). Conversely, a lack of meaning is correlated to negative psychological outcomes, such as depression, anxiety, distress, and hopelessness (Hedayati & Khazaei, 2014; Steger et al., 2009, 2013; Westgate, 1996), as well as higher rates of substance abuse, suicidality (Steger, 2018). Those who report having greater meaning in life tend to engage in activities and experiences which help to buffer negative psychological effects, like being more socially connected, be involved in religious practice, or partaking in work which they are passionate about or find meaningful (Grouden & Jose, 2015; Steger et al., 2010; Stavrova & Luhmann, 2016; Ward & King, 2017; You & Lim, 2019; Yeager & Bundick, 2010). An empirical investigation into the logotherapeutic model carried out by Joshi and colleagues (2014) found the search for meaning, existential vacuum, and existential frustration (via the will to pleasure and the will to power) were all found to be significantly and negatively correlated with life satisfaction, whereas the presence of meaning in life had a positive, significant relationship with life satisfaction.

Specific Logotherapeutic Techniques

At first glance, the practical techniques used in logotherapy make it appear extremely similar to CBT and ACT. However, having been fully conceptualised against a backdrop of severe suffering, logotherapy stands out as a natural approach for the treatment of traumatic experiences. It has been found to be effective in the treatment of PTSD and acute stress, as well positive outcomes in clients suffering from depression, anxiety, phobias, obsession and

addictions, chronic pain/health conditions, and significant life changes (Bahar et al., 2021; Cho, 2008; Frankl, 2006; Robotmili et al., 2015; Soetrisno et al., 2017). Implementing principles of logotherapy into current forms of psychotherapy has the potential to improve the efficacy and effectiveness of contemporary interventions for multiple forms of psychological distress, particularly those who have gone through trauma (Ameli & Dattillo, 2013; Schulenberg et al., 2013; Smith, 2012).

One of the greatest advantages of logotherapy is its ability to empower people - it is all about overcoming. Frankl maintained that due to our ability to engage with the nööological dimension, we can therefore be challenged by life to turn tragedy into triumph by distancing ourselves from the situation (Frankl, 1946/1959). Frankl highlighted these techniques as evoking the uniquely human capacity of self-transcendence to overcome the stranglehold of fear and victimization that causes clients to run away from or to fruitlessly fight their problems. By gaining a greater perspective of our distress, we can see it for what it is and then deal with it in a way that will change things for the better, increasing an individual's capacity to be proactive. In doing so, we experience nööological growth (Shantall & Shantall, 2020). Frankl outlined three main logotherapeutic techniques, outlined below.

Socratic Dialogue

Similar to the Socratic questioning process used in Roger's Client-Centred Therapy and CBT, Socratic dialogue is a technique used in logotherapy to guide an individual through a process of self-discovery in their own terms. Where Socratic questioning focused on helping people to deconstruct and restructure anxious thoughts or automatic negative cognition on their own, Socratic dialogue is used by therapists to analyse and assist an individual to understand their own thoughts, feelings, and reactions to help them realise they may hold the answers to

their own existential struggles. Within a logotherapeutic perspective, this technique is used to help individuals identify personal meaning, purpose, and freedom within conversation, therefore ultimately their lives. Socratic questioning enables an attunement to what is fact and what is cognitive skew in the client's life and interpersonal existence. As it is recognised to be a phenomenological inquiry, it is hard to carry out empirical research on the technique (Warne, 2022). However, use of the Socratic method, in either its questioning or dialogue form, has been found to be effective in the treatment of mental distress via cognitive-behavioural psychotherapy approaches, notably in the treatment of depression and anxiety (Braun et al., 2015; Overholser & Beale, 2023).

Dereflection

In his practice of psychology and psychiatry, Frankl observed that one of the pressing issues individuals face when coping with mental distress was that they were often overly self-absorbed in the issues or the attainment of specific goals pertaining to the issue. Based off of the logotherapeutic concept of self-transcendence, dereflection is the intentional effort to shift one's attention away from an issue or attainment of a goal – what he called hyperintention (Frankl, 1975).

Originally developed to help address sexual dysfunction, impotence or frigidity - also known as sexual neuroses - in male-female relationships (Frankl, 1975), dereflection moves us out a state of being consumed with negativity, worry and lament, and directs our attention to what there is, right now, waiting for us to do or to be. In doing so, it helps and an individual break out of a cycle of unnecessary and avoidable suffering (Costello, 2019). Dereflection is aimed at helping individuals distance themselves from negative psychological stressors, complaints, and issues towards more positive points of view. For example, implementation of

dereflection has been found to improve the psychological wellbeing of children within broken homes (I.e., divorced or separated parents) after five sessions (Rachmi et al., 2022).

While this could be mistaken as a form of toxic positivity, dereflection is meant to spurn one to look beyond themselves for a solution rather than resolving to remedy a problem on their own. By redirecting one's attention away from a hyperfixation, people allow themselves the capacity to look outwards and gain purpose and meaning through focusing their energy on others. It counters excessive introspection through distracting the individual from their symptoms and focusing on something else.

Paradoxical Intention

Paradoxical intention (PI) is a psychotherapeutic technique used to reduce recursive anxiety by repeatedly rehearsing an anxiety-inducing pattern of behaviour or thought, usually in an exaggerated and overly amusing manner (Frankl, 1959/1984). Humour, Frankl recognised, is a deeply human characteristic which we can use for self-preservation of the soul, citing his and other prisoners' use of creating funny stories and finding humour in their fears to help maintain sanity, but also as an act of resisting and distancing themselves from the complete inhumanity of their unfortunate circumstances (Frankl, 1946/1959; MacKinlay, 2014). Aptly named, it involves paradoxically engaging in what scares clients most. For example, someone who struggles with a fear of rejection would intentionally place themselves in situations where they would be rejected. The fear is thought to be removed when action or intention focuses on what is feared most, and Frankl viewed humour as a useful tool when the fear becomes paralysing (Frankl, 1946/1959). What paradoxical intention aims to do is help patients attain three characteristics – using humour to get them to recognise the nonsensical nature of their fears and compulsions; help them focus on achieving enduring change in their inner attitudes through the development of fundamental

confidence in the future and gaining the proper perspective on the relative importance of different objects and scenarios; and finally, to pay increased attention to influencing the self to engage in self-distancing, rather than understanding the concept of self-distancing itself (Lukas, 1982). paradoxical intention assists us in defeating our fears by defiantly facing them so as to be able to get on with our lives in a real, confident and courageous way.

It is most often used in the treatment psychosomatic disorders such as insomnia and forms of obsessive-compulsion, where performance anxiety often hinders a person unable to complete their hyper-intended goal. In doing a ridiculous version of the opposite of what one wants to achieve, it reduces the anxiety surrounding that goal (Ascher & Efran, 1978; Fabry, 1982). Most of the symptoms of anxiety are a result of fear associated with the inability to perform a task or action, leading to a vicious circle of anticipatory anxiety. Paradoxical intention attempts to break this cycle by teaching a patient to distance themselves from the action, gain control over it and eventually, bring about its removal through substituting the psychologically detrimental fear with a paradoxical wish (Frankl, 1960, 1988). This is often done in a wildly outlandish manner, allowing a patient to appreciate the humour in their exaggerated responses. Observation of this means individuals are able to see the non-catastrophic consequences of their anxiety-inducing stimuli first-hand and allows them to conclude for themselves the unlikelihood of the feared outcome happening at all (Ascher, 2002). It is used similarly to dereflection, though where dereflection directs attention away from anxieties and negative cognitions by a method of external distraction, paradoxical intention counteracts anticipatory anxiety through the ridicule of negative consequences and the inherent silliness in the likelihood of a client's worst-case scenarios.

The administration of paradoxical intention has been found to be effective in the treatment of a variety of forms of psychological distress and has a sound evidence base (Fabry, 2010; Jansson- Fröjmark et al., 2022). A large amount of the research has carried out several experiences showing that clients suffering from insomnia who were exposed to paradoxical intention reported significant improvement on several measures of sleep behaviours when compared to subjects in both placebo and no-treatment controls (Ascher & Efran, 1978; Ascher & Turner, 1979; Broomfield & Espie, 2003). In comparison to self-statement training used in other psychotherapies, paradoxical intention was found on ANCOVAs to have superior effects on severe agoraphobia one-month post-treatment (Mavissakalian et al., 1983), with a similar result of increased benefits coming from a comparison of the treatment of agoraphobia with paradoxical intention versus gradual exposure (Ascher, 1981). Case studies have found that, in conjunction with relaxation training, paradoxical intention has been found to be effective in the amelioration of intrusive obsessive-compulsive tendencies, with one of the patients remaining symptom-free six-weeks post-treatment (Adshead et al., 1988; Lewis, 2016).

However, despite these techniques, much of Frankl's own work in terms of grounding logotherapy as a form of treatment lay in case studies (see Frankl, 1998). Like Carl Rogers (1977, 1986) and his client-centred approach, Frankl focused on the process of therapy as a means to deliver and provide evidence for the validity of logotherapy, and much of his practice was informed by his metaphysical assumptions (Reitinger, 2015). This meant that while he had a few specialised logotherapeutic techniques, he emphasised that the choice of treatment implemented with any concrete case was more so dependent on the individuality of the patient as well as the personality of the therapist (Frankl, 1975).

Additionally, there have been several criticisms which have come to light with Frankl's approach. In the past, it has been seen as too philosophical, existential, and did not take into consideration the psychodynamic and biological parts of the human being (Längle, 2019). It has been considered more to be a philosophy of life rather than a 'scientific' psychotherapeutic school, a system of values, and has even been questioned to be a secular religion based off questionable metaphysical premises (Pytell, 2006; Reitingger, 2015; Weisskopf-Joelson, 1975). Connected to this, an interesting point which many scholars studying Frankl have noted is his pointed effort to not emphasise his Jewish ethnicity or religion in *Man's Search for Meaning* – which is ultimately about being a Holocaust survivor (García-Alandete, 2023). He speaks briefly about general religiosity as a tool which can be used as a form of meaning-making or finding purpose, though notably makes little to no mention of his Judaism within his psychological theories, or even his own autobiographical narrative. Logotherapy is not meant to choose between theism and humanism, as religion itself is a human phenomenon which must be considered earnestly in conjunction to the person themselves. Due to the nature of the nature of logotherapy, Frankl believed that he could not include a confession of any personal convictions of things which border the line between theology and psychiatry, because that would only be meaningful to him (Frankl, 1988).

Frankl's methods rely heavily on self-efficacy and making the autonomous choice towards your own attitude towards your suffering. From this, it could possibly be interpreted that Frankl believed having a positive attitude was what determined one's capability to make it through the camps and those who did not have the mental capacity to uphold that were the ones who ultimately perished (Langer, 1982). There is also the implication that there is full personal responsibility placed upon the individual to recover, that is, it is completely up to them to find

the hope, motivation, and preserve range towards healthy, healing behaviours, which can be overwhelming for some people (Slade, 2009; Tew et al., 2012). On the contrary, logotherapy has been viewed to be authoritarian and prevents the personal discovery of meaning. Rollo May, one of Frankl's critics argued that during logotherapeutic sessions, many of the answers to the clients' questions would be answered by the therapist. In doing so, the therapist would dictate much of the process and subsequently removing much of the patient's personal responsibility (May, 1961). He believed that logotherapy presents a plain solution of all of life's problems, which would implicitly undermine the complexity of human life itself. In his explanations, Frankl keeps a high level of abstraction in his practice of logotherapy, with little emphasis on the search for meaning as a subjective construct which is open to interpretation, influenced by context, and saturated with social positions, such as gender (Gilligan, 1982). There is a lack of consideration for intersectionality as well as the content to individuals' stories which provide them with meaning, leaving logotherapy as fragmented and without a concrete foundation.

These critiques, alongside its vague nature and the many blurred lines between its stance as a philosophy and a therapy may be what caused it to fade out from the mainstream of psychotherapy in the 1980s.

To live is to suffer; to survive is to find some meaning in the suffering - Gordon Allport

Chapter 5: Discussion & Further Considerations

Despite the efforts of the humanistic psychology movement in the mid to late 1970s, the mechanisms and theories underlying our explanations for trauma and its aetiology are still heavily grounded in biology. Given its physiological foundations, and the early origins of psychology in an association with medical science, it is not at all surprising that Frankl's perspective fell out of favour when understanding trauma (Clark, 2014). Humanistic psychology peaked in the 1970s, and it began to fade with the hippies who subscribed to many of its premises. Much of the humanistic approach was pushed to the side in favour of cognitive-behavioural and neuropsychological methods, which could be quantitatively explored, proven or disproven, and peer-reviewed through experimental research (Elkins, 2009). As a result, the area of trauma studies has been undergoing a crisis of dehumanisation – where there is harder focus on the biology of trauma rather than the effects on the human psyche, in some way reducing human experience to anatomy and physiology (Silver, 1995). This medicalized and biological view of trauma, though sophisticated, also might have the unintended effect of reducing human agency to overcome or transcend traumatic experiences. It implies that our subjective experiences of the world are all able to be explained through biological processes, as if the way we construct our own narratives and realities do not influence our actions, thoughts, and emotions, and that psychological and existential (or noological) experiences of trauma cannot help in overcoming the physical and psychological effects which trauma has on a person.

Dominant psychological understandings of trauma are generally dependent on the abreactive model of trauma (Balaev, 2008). The history of PTSD has been established to be associated with hypnotism, dissociation, and a conflict between responses of the body and rationalisations of the mind, which has led to the prominent understanding of PTSD as a disorder

of intrusive reexperiencing, avoidance, hyperarousal, and negative changes in emotions and cognitions related to the trauma (Pedersen, 2015; Quosh & Gergen, 2008). It is clear to see contemporary understandings of trauma are built upon the foundation of the psychoanalytical perspectives established by Freud. From as early as Janet, it has been established throughout dominant trauma theory and interventions that there is a tension, not only within a traumatised individual, but also between groups which view trauma as formative and those who see it as an exceptional event (Reisner, 2003). In contemporary Western society, science places much more precedence on the doctor and the pill as being more important interventions than psychotherapy and other talk-based practices. This is in part due to the prestige associated with medicine and biologically grounded theories but is also because it is one of the most economical and cheapest solutions to treating an increasing number of people suffering from mental distress (van der Kolk, 2014).

Defining trauma strictly or predominantly through the experience of sexual abuse in childhood constructs a very specific image of what trauma is, looks like, and is viewed or understood in both professional and everyday contexts. Interestingly, both Freud and van der Kolk both initially emphasised the impact of childhood sexual abuse as one of the primary factors influencing traumatic symptomology, with sexual trauma being the entire basis for psychoanalysis for Freud at one point. Van der Kolk states that trauma is everywhere, not just on the battlefield or in refugee camps and other inhumane environments that subject someone to abject suffering. He cited the famous Felitti and colleagues (1998) Adverse Childhood Experiences study, or ACEs, where a fifth of US citizens reported being sexually abused in childhood and a quarter of Americans grew up with alcoholic relatives and/or were physically abused to the point where it showed on their body. These results have been replicated both

previously and after this seminal study (Giano et al., 2020; Gorey & Leslie, 1997; Wilson et al., 2015). Furthermore, a third of couples engage in domestic violence and one in eight individuals witnessed their mother being physically abused, with some research placing overall numbers at around 61% of men and 51% of women in the USA experiencing some catastrophic event within their lifetime (Felitti et al., 1998; Friedman & Friedman, 2015). This trauma is profuse, not only affecting those directly exposed to it, but those around them. Individuals exposed to family violence in childhood often find it difficult to establish and maintain stable, trusting relationships in adulthood, and partners of those suffering from PTSD tend to develop depression, which in turn can lead to their children growing up to be insecure and anxious (Feldman & Downey, 1994).

However, the majority of people who experience trauma will not go on to develop PTSD. In the United States, it is estimated that while around 70% of people will experience some form of traumatic event in their lifetimes, only 6-8% will go on to develop symptomology severe enough to classify as a diagnosis of PTSD (US Department of Veteran Affairs, 2023). Terms like ‘pathological reminiscences’ and PTSD implicate the experience of trauma as a disease or injury, further allowing researchers and clinicians to apply a medical model of disability and focus on immediate symptom remediation rather than resolving the devastating upset caused to one’s entire reality. Freud and van der Kolk both use the analogy of a tumour to describe trauma, something which is to be completely removed in order to be treated – something which can seem impossible in the face of traumatic experiences and memories. Before trauma has occurred, there should be minimal differences in structural anatomy and physiology of the brain in a person who does develop PTSD versus the brain of a person who does not. The formation of PTSD therefore cannot be solely dependent on the physiology of the brain and there must be other factors – be it

psychological, sociological, economical, or otherwise – which either buffer the effects of the brain’s biological processes or help build resistance to them (Frankl, 1988). This form of account also struggles to account for the dynamic nature of the brain and the anatomical and physiological differences among individuals, as well as how these differences can interact with the environment and external stressors (Murensanu et al., 2021; Shaw & McEachern, 2001). Van der Kolk briefly acknowledges this capacity to rebound from traumatic experiences without need for intervention, though it is mostly in an anecdotal manner. The superiority associated with medicine and biology means that the descriptions and explanations of posttraumatic stress are unintentionally reductionist (Bentall, 1999; Kirschner, 2013). A physiology-dominant view of posttraumatic stress only provides a descriptive theory of trauma and assumes a singular path in its symptomology and experience, which we know is not entirely the case (Bentall, 1999; Sedler, 2016). Through this perspective, people are reduced of their agency to change and resist succumbing to dysfunction, and unintentionally emphasises the position of being a victim of trauma.

Trauma and Reductionism

In a world which views all negative experiences as being ‘traumatic’ to some degree, it is no surprise that many psychiatrists and psychologists are becoming concerned that people - practitioners and patients alike – are beginning to pathologise expected, albeit negative, experiences of the human condition (Pandell, 2022). However, as previously established, trauma and suffering are not the same. While trauma is an unfortunately common but specific occurrence, suffering is a universal human experience. Suffering, in a general sense, is the experience of unpleasantness, particularly in the context of harm or the threat of harm to an individual. Those who experience a distressing event may not become psychologically

traumatized but will almost certainly experience some mental distress because of it, and this predicted or anticipated experience of suffering is mistakenly defined as trauma and misconstrued into a medical problem – a process known as medicalisation (Busfield, 2017; Metzl & Herzig, 2007).

But it is also clear that not all suffering leads to trauma. Frankl captures this idea through his construct of noogenic neuroses, where seemingly physiological and psychological symptoms arise due to a block in the search for meaning in one's life. While this existential frustration is distressing, it is not and should not be considered an illness, rather one of the most reassuring signs that one is truly human. In a world which places far more emphasis on the 'bio-' part of 'biopsychosocial' approach, with an overdiagnosis of depression and anxiety, and an over prescription of antidepressants running rampant, the pathologising of 'regular' or 'expected' distress and everyday problems (Aikens et al., 2005; DuBois & Frankl, 2005; Linden, 2020). There is also a need to recognise that suffering is part of the human experience, to differentiate normative distress from PTSD, as Frankl has in his conceptualisation of the 'Tragic Triad', the three inevitable experiences of tragedy in life of guilt, grief, and unavoidable suffering (North et al., 2009). Medicalisation is thought to be proliferating modern life more and more, and while there is debate between patients, clinicians, and other actors in the health sector over whether it should continue to be supported or resisted, it is generally agreed amongst researchers that medicalisation is detrimental in the long-term (Clark, 2014).

It is also important to recognise that there are economic and societal motivations behind the psychopharmacological movement. Upon first commercially entering the market, the manufacturing of psychotropic drugs provided thousands of jobs and incomes and continues to do so today (van der Kolk, 2014). Billions of dollars have been dedicated to neuroscience

research and the pharmaceutical industry to both find the biological bases of mental disorders and to identify new molecular entities and medical devices for treating them (Cosgrove et al., 2012; Dorsey et al., 2006). The dominant medical strategies set in place for treating mental distress have also unconsciously – and unfortunately – lead to the transformation of life into capital, where the brain becomes the subject (Shaw & McEachern, 2001). Antidepressants and CBT carve out their niche in the market by creating brain chemistries or behavioural and thought patterns which assist or even enhance one’s “human capital” – that is, their financial contribution to the providers’ self-interests. This means that there can often be ulterior motives for the continuation of antidepressants and other psychopharmacological treatments, despite their questionable efficacy and effectiveness.

In the same way this dominant, neuropsychological understanding of trauma and PTSD generalises everything by assuming a universality through a biomedical model. It also draws all the intervention focus to individual level suffering (Kirmayer et al., 2007; Lehrner & Yehuda, 2018). This means there is little focus on more systemic issues which contribute to the living conditions and detrimental environmental factors that influence one’s vulnerability to severe distress in the face of trauma, or systemic trauma itself (Khasnabis & Goldin, 2020; Smith, 2012). External relational and social influences of mental illness such as intergenerational trauma, problematic family structures and relationships, justice systems, and socioeconomic wellbeing are largely ignored by clinicians when biology is favoured (Yudofsky & Hales, 2002).

This is not to say that the biological perspective is in any way ‘bad’ or ‘wrong’ in any sense of the words. On the contrary, the pursuit of a deeper comprehension of the brain and the neuropsychological underpinnings of cognition, behaviour, and mental illness have undeniably helped us understand and treat traumatic symptomology (van der Kolk, 2014). Anatomical and

physiological explanations of human behaviour are not only perfectly valid and proper ways to understand the trauma experience, but also help us to put it into words, for both for others and ourselves (Midgley, 1984; van der Kolk, 2014). However, conceptualising trauma as a primarily biological issue paints the harrowing, distressing experiences described within van der Kolk's case studies in a fatalistic light, where one is emphasised as being a victim of trauma, which is never entirely the case as we well know now. There is a growing need for there to be more of a consideration of the environmental and external factors influencing one's ability to recover from trauma without it impairing their functioning, or their capacity to be resilient (Bonanno & Mancini, 2012).

Positive Psychology Movement

The movement of positive psychology – which aligns with many of the goals of logotherapy and other humanistic approaches - only really came into prominence around the late 1990s (Seligman, 2003). It is defined as the scientific study of human flourishing and functioning across a variety of different levels, including biological and psychological, but also personal, relational, institutional, cultural, and over global dimensions of life (Seligman & Csikszentmihalyi, 2000). Much like humanism, positive psychology aims towards positive subjective experiences, studying and utilising positive individual traits and institution promises to improve people's quality of life and prevent the prevalence of depressive pathology, rather than exclusively focusing on the pathology itself. This hyperfixation on aetiology and explaining the mechanisms, characteristics, and features of psychopathology are considered by positive psychologists to result in a model of the human being which lacks in the positive aspects of being human which make life worth living. According to its founder, Martin Seligman (2019), positive psychology emerged to address some of the shortcomings of mainstream psychology

which he had observed separate to any humanistic perspectives. However, in embracing and striving for the scientific empiricism, which is so highly valued within psychology, positive psychology falls a little short of the mark. Despite its best efforts to bring a quantitative understanding to the subjective experiences of life, positive psychology unintentionally assumes that a mechanistic epistemology underlies the human condition.

Much of the modern use of logotherapy is actually in conjunction to concepts in second-wave positive psychology, such as posttraumatic growth and resilience (Southwick et al., 2016; Tedeschi & Riffle, 2016; Wong, 2016a, 2016b). Frankl realised that individuals will inevitably have to suffer at some point in their lives – as this is the nature of human existence – and recognised that, even in moments of regular sadness, we can shift our perspectives on what we are experiencing, what that means, and why those external events occurred, if for any reason. The inevitable suffering one experienced would fundamentally mean nothing in the regular world, a realm of material success, but it was possible for one's suffering to mean something – even if it were just something for that individual themselves (Frankl, 1988). Giving meaning to something allows for one to experience personal growth and find purpose, which takes that meaning and gives it direction, motivating people towards certain behaviours and creation of goals (Tedeschi & Riffle, 2016). This in turn would allow one to cope with extreme trauma if they were ever unfortunate enough to have to experience that. These ideas are highly reflective of a number of second-wave psychological interventions and approaches, some of which have been directly influenced by Frankl. Logotherapy and Franklian psychology have been found to be effective in the treatment of PTSD yet is both not very well known outside of the USA and therefore hardly practiced (Lantz, 1992; Smith, 2012). Given the potential which it holds,

utilising this approach in the treatment of traumatic symptomology holds much promise for changing people's lives (Schulenberg et al., 2008).

These ideas are not entirely new, notions of integrating aspects of the human condition and historical processes of living have been previously known to psychologists. From Maslow's self-actualisation and theory of motivation (1968), Rogers' fully functioning person (1963), and Jacobs's positive mental health (1958), research and focus on positive psychological functioning has been around since before the creation of positive psychology, often by decades (Waterman, 2013). Positive psychology has helped to systematise a philosophy of life which has been a topic of debate among anthropology and sociology since classical times, but have previously been marginalised by psychoanalysis, behaviourism, and cognitive perspectives (Fernández-Ríos & Novo, 2012). Amidst continued disagreement amongst humanists and positive psychologists today, these two schools of thought share a recognition that a further perspective in psychology is needed besides just the neurological (Rich, 2001; Waterman, 2013). The humanistic psychologists criticise positive psychology for taking the study of human potential and wellbeing towards empirical theory, research, or therapies, whereas the positive psychologists cite the humanists as being one of many important influences, but not the main progenitor of positive psychology. They do not find it particularly useful to draw upon the insights and contributions the humanists brought to the field (Friedman, 2014; Waterman, 2013). These different perspectives, however, should not be considered independently, nor are better off pursuing their own individual agendas, as proposed by Waterman. It has been argued that this is a short-sighted view that is likely to have crippling, if not dire, effects on the future of psychology as a whole and there are many potential avenues for positive psychologists and existential-humanistic researchers to collaborate (Schneider 2014).

The Rise and Fall of Humanism in Psychology

Despite most of the significant cultural philosophies to emerge from Post-WWII Western Europe being defined by the importance of the human experience, humanism fell out of favour within the field of psychology relatively quickly. As outlined previously, it is clear that psychology ultimately emerged out of psychiatry and has largely attempted to be considered a natural science in the same way its medical counterparts are (Blumberg & Feigl, 1931). For knowledge to have any intellectual standing within the natural sciences, it must have some form of empirical proof, be it experimental, biological, or medical. To be taken seriously in the academic field of science, psychological research had to move away from purely theoretical ideas and towards observable, concrete hypotheses which could be tested and proven (Hunter, 2004; Miller, 1999; Rathunde, 2001). The field of humanism seems to hover between being a field of psychology, a philosophy, and a social movement, and refuses to define itself concretely as any of these things (Roman, 2016). Therefore, it is no surprise that researchers of psychology have striven towards theories of distress which can be experimentally tested and proven. But as a result, mainstream psychology has been labelled throughout history as increasingly positivist (Allport, 1943; Danziger, 1979; Teo & Teo, 2018).

Known as the ‘Third Force of Psychology’, humanism psychology is both a social movement and an enduring perspective within the field, emerging as an offshoot of personality psychology (Maslow, 1956; Smith, 1990). Humanistic psychologists criticised the traditional psychology perspective of man and its strict, exclusive commitment to observable stimuli, stressors, and reactions that could undergo experimental manipulation (Giorgi, 1981; Polkinghorne, 1992). It gained traction due to key figures such as Maslow, Rogers, James Bugental, and Clark Moustakas in the 1950s with the humanistic movement (DeCarvalho, 1991).

Soon after its founding, it was picked up by 1960s counterculture and other branches emerging from humanistic field with an increasingly prominent spiritual-mystical, existential, and/or phenomenological emphasis, such as trans-personal psychology (Smith, 1990). Humanism does not fit within the medicalised model of the human being and is largely dismissed and not well respected by other subsets of psychology due to its predominantly hermeneutic nature (Robbins, 2016; Smith, 1990).

Some of the basic tenets of humanistic psychology are: understanding the self and others as a multidimensional whole greater than the sum of their interrelated parts; acknowledging the importance of a full life history and highlighting the individual; recognising there is an intentionality in human existence and the need for goals for a healthy life (Benjafield, 2010). From the perspective of Western thought, humanism is a philosophy where human life is thought to be irreducible compared to other forms of life – whether that be material or divine (Davidson, 2010). Waterman (2013, 2014) has also argued that the philosophical foundations of humanistic psychology lie in phenomenology and has related it to writings of French existentialists, such as Jean-Paul Sartre and Albert Camus (Churchill & Mruk, 2014; Morley, 2014). Existentialism emerged as a counterargument to essentialism – or the idea that everything was predetermined by one’s essence or state of being, with prolific philosophers such as Kierkegaard and Nietzsche initially proposing the idea that there is no inherent meaning within the universe and by proxy, no essence (Guignon, 2004; Stewart, 2016). A common phrase associated with this epistemology is “existence precedes essence” - that is, we are born without any pre-existing purpose, and it is up to us as individuals to figure out what our own “essence” (i.e., purpose in life) is through the ways we choose to live (Sartre, 2007). This was a very radical idea at the time, as it placed an immeasurable amount of responsibility on people themselves, and also showed the digression of

meaning as a universal, generalised construct to an individualised conceptualisation that was wholly subjective in nature (Hicks & King, 2009). This school of thought became integrated into psychological thought/theories as existential psychology and psychotherapy during the mid 20th Century - particularly after the horrors of WWII (Frankl, 1949/1956). Even prior to the Second World War, Frankl was engaging with the idea that meaning was an imperative motivator in life and has even stated himself that existentialism is one of the main features of psychotherapy in general (Frankl 1967; Magrini, n.d.). However, unlike Sartre and other atheistic existentialists, who suggest that life is ultimately meaningless, Frankl was inspired by the 20th Century German and Swiss philosophers like Heidegger, Binswanger, and Jaspers, whose focus lay in the meaning of being and how entities appeared in the way they were (Boeree, 1998). This set Frankl's style of existential analysis apart from that of the French existential philosophers. Within logotherapy, Frankl places a heavy focus on recognising the value of individual uniqueness and that each person's experience of meaning and life is different from the next (Das, 1998; Esping, 2010). He viewed logotherapy and existential analysis as a metaphorical compass, used to identify and follow our existential or noological needs, as well as the importance of meaning and light in spite of circumstances (Breitbart et al., 2004; Zaiser, 2005).

In terms of his existential-humanistic perspective, Frankl in particular was largely limited in his theory by the influence of the predominant understandings of traumatic events and the mind at the time. When he was beginning to formulate his work in the early 1900s, Freud's place in academia was well-established and his theories surrounding trauma in regard to depth psychology were prevalent in Viennese society (Fancher, 2000). Freud first defined what a drive was in 1915, stating they fell between somatic and psychical in nature, were a mental representation of a stimuli that originated within the body and motivated. Drives were considered

to be a way to measure the demand that the mind placed on motivating one to particular activities as a consequence of [the mind] being linked to the body (Freud, 1915/1957). They were seen as an innate part of the psyche which helped to balance primal animalistic desires driven by the instinctual brain and the functioning and safety of the body in respect to the external world and its expectations as known by the rational mind (Hull, 1952). The field of psychology became dominated by different hypothesised drives in the first half of the 20th century, with drives usually being physiological needs such as thirst, hunger, or sleep, which lead to a reductionist-deterministic view in that our thoughts, behaviour, and emotions are ultimately dictated by biological urges (Pribram, 1960; St Clair Gibson et al., 2018). Drive theory was originally based in psychoanalysis, meaning that any proposed drives were rooted in the idea of a homeostatic model of the human being and that the functioning of the human mind ultimately serve the evolutionary imperatives of survival and reproductive success (Deci & Ryan, 2013; Solms, 2021). In naming logotherapy the ‘Will to Meaning’, he essentially – and unfortunately - labeled it as a drive, regardless of him going on to explain that meaning itself was agentic and fluid for each individual. This, in conjunction with the criticisms of logotherapy detailed previously are most likely some of the reasons that logotherapy never managed to catch on in the same way Freud’s theories did. Furthermore, Freud had the advantage of a more rudimentary science on his side, whereas Frankl was attempting to establish his theory at the same time as cognitive-behavioural and the already well-established psychoanalysis.

It is clear to see that Frankl’s approach to overcoming trauma emphasises mustering the agency – or find the will to meaning – to endure highly distressing events. But like many other humanists, Frankl did not have concrete, empirically proven solutions, or methodologies to gain any amount of traction in mainstream psychology and the treatment of posttraumatic stress.

However, as seen with Frankl's life narrative, development of logotherapy, and its contributions to understanding the experience of trauma, the humanistic approach allows a perspective about how extremely distressing events affect the psyche and one's subjective perspective of reality, particularly in relation to posttraumatic stress (Melton & Schulenberg, 2008). Other work which has gone into narrative psychology and the importance of a narrative mode of being also helps emphasise the power of Frankl's autobiography and what he was trying to achieve with logotherapy (Bushkin et al., 2021).

Many of the theories emerging from this area are highly individualised, therefore providing a generalised approach to treatment based on average samples is contradictory to the humanistic perspective. However, even without empirical bases, the humanistic psychologists have contributed a vast amount of understanding about the human condition to the field of psychology (DeRoberis, 2013; Wertz, 1998). Notably, that there is a degree of human agency in the process of therapy and therefore in the process of recovery (Williams, 1998). No one can ever force anyone else to "get better" – it must be an active and fully autonomous choice for individuals to try and better themselves. However, unlike neuroscientific methods, these humanistic insights have so far not been empirically proven. At its core, humanism emphasises the individuality and full functioning of the human being, and that only in standing amidst traumatised individuals, empathising and truly listening to them, can therapists, researchers, and other specialists begin to understand the meaning of their suffering (Seachris, 2009).

Future Directions for Trauma Studies

Despite there being a well-established theoretical understanding that posttraumatic stress is caused by a complex set of interconnected, interrelated issues encompassing all aspects – biological, genetic, sociological, and psychological – trauma, like many forms of mental illness,

is still managed through a medical model. Van der Kolk, and many prominent researchers involved in psychology today, stresses the importance of PTSD having a physiological basis in both understanding how trauma affects people and how to treat it. But it is important for psychologists to not place all the emphasis of treating trauma solely within the biological sphere. This homeostatic idea of trauma management gives the implication that traumatised individuals are locked in the past and the way to deal with that is for the psyche to maintain a state in which it can control the body by avoiding anything prompting or reminding them of that initial distress. It ignores the self-transcendence identified by Frankl, treating the human being as a closed system which is unable to look or be directed beyond itself (Frankl, 1966). While techniques such as abreaction or neurological reprogramming help patients work through trauma in the past, allow them to remain in the present, there is little anticipation of the future or the prevention of potential future experiences of trauma in the same way there is within logotherapy. However, if logotherapy is to be considered seriously as an effective psychotherapy, there is an urgent need for the development of its therapeutic techniques (Längle, 2015).

The general understanding which people have is that there is no meaning in loss, in tragedy, or in trauma (Kessler, 2019), but Frankl argued against this. While there is a lot of debate about the exact definition(s) of meaning, the psychological construct of meaning in life is mostly agreed to be composed of three components - purpose, significance, and coherence (King et al., 2016; Martela & Steger, 2016; Mascaro, 2014). Purpose pertains to having goals, direction, and/or a specific role in life which influences one's thoughts, emotions, and behaviours - they have a clear idea of what they are doing in their life and why. Significance describes the extent to which a person believes their life has importance, value, and worth, and the hope that their life will have (and will continue to have) a lasting impact on the world across both time and

space. This is sometimes referred to as 'existential mattering' and encompasses the sense that what a person is or what they are doing with their life is important to them (Costin & Vignoles, 2020). Finally, coherence is the comprehension of one's experiences as having some degree of structure, routine, and predictability which allows one to make sense of their life in terms of past, present, and imagined future, as well as the ability to integrate memories into a singular, coherent life narrative (George & Park, 2016; Heintzelman et al., 2013; King & Hicks, 2021). In other words, when an event aligns with one's previous experiences and preexisting beliefs or expectations (King & Hicks, 2009). In addition to these three components, it has been proposed that meaning in life also needs to provide a sense of fulfilment to the individual (Reker & Wong, 1988), with Wong (2013) formulating a four-part framework known as the PURE model - an acronym which describes the four constituents necessary to define meaning; purpose, understanding, responsible action, and enjoyment/evaluation. Where purpose and coherence keep relatively the same definitions, Wong points to a moral obligation and behavioural aspect of meaning - responsible action. This includes recognising one's own freedom of will and personal agency, as well as the sensible exercise of these freedoms. Responsible action involves viewing circumstances beyond oneself, recognising solely they are responsible for their actions and reactions, consideration of what is morally right and appropriate to do when choosing what actions to take, and considering the demands of the situation (Wong, 2010, 2012, 2013; Reker & Wong, 1988). It also encompasses an emotional aspect, where one assesses the level of satisfaction (or dissatisfaction) they have regarding a specific situation or their life as a whole (Wong, 2010, 2012, 2013). Engaging in self-reflection and evaluation allows one to recognise whether they are satisfied, and therefore happy, with their life, and if they are not, allows the

motivational drive to change something in their lives and search for something which gives them more meaning (Wong, 2014).

Studies have found that people can identify their lives as having some sense of meaning and purpose which can be longed for through tools such as with the PIL test and MLQ, without necessarily defining these terms, instead relying on peoples' intuitive understandings of meaning and its relevance to their lives (Heintzelman & King, 2014; King & Hicks, 2021). These assessments measure a subjective, indirect perception of one's life as meaningful or not and there have also been criticisms that some of these psychometric tools confound meaning with other related variables, such as mood or affect (Ryff, 1989; Steger et al., 2013). However, despite not being able to definitively quantify it, people are able to recognise whether or not their lives are meaningful to them, as well as what thoughts and emotions are associated with that knowledge. While it may seem problematic, or at the least, counterintuitive, to include the name of a construct within the items which attempt to measure it, these measures have allowed academics to identify and study the importance of meaning to life - whatever that entails. It is through this conceptualisation that we have come to comprehend the importance of other factors to a meaningful life and the effects meaning (or lack thereof) can have on an individual, particularly adverse events (Martela & Steger, 2016; King & Hicks, 2021).

The immediate period after a traumatic experience is a crucial time in a survivor's recovery process as it is within this time that a narrative of the event is generated and constructed, as well as a cognitive conceptualisation and processing of those events (Tuval-Mashiach et al., 2005). (Rogers, 1957). Producing a trauma narrative has been hypothesised to facilitate recovery from posttraumatic pathology through aspects such as emotional catharsis, linguistic representation, anxiety habituation, and identification of purpose and value in spite of

adversity (Kaminer, 2006). Less developed trauma narratives have been correlated with increased severity of later PTSD symptoms; however, benefits have been found regardless of linguistic capability, dependent on the content of the trauma narrative rather than any grammatical or syntactical features (Amir et al., 1998; Jaeger et al., 2014; Kleim et al., 2018). Positive emotional expressions in their trauma narratives were found to be associated with decreased psychological distress while negative ones were linked to posttraumatic specific symptoms and physiological effects at two to three weeks after narratives were collected (Eid et al., 2005). Even van der Kolk, despite his methods being heavily based in neuropsychology, recognised the importance of putting words or a story to one's trauma in order to acknowledge, understand, and be able to move past it. Feeling listened to and understood also causes changes within the limbic brain, allowing people who have been traumatised to articulate and reorganise their complex feelings and thoughts surrounding a distressing event (Lamendella, 1977; Schore, 2009). He considers the ability to communicate fully is the opposite to being traumatised, where having the capacity to find words where they were once absent and being able to share one's deepest experience of pain and suffering with another human being is one of the most profound connections and experiences one can have (van der Kolk 2014). On the other hand, repressing the event and remaining silent on the matter reinforces the isolation and loneliness felt post-trauma, sharing about it with others helps to gain other perspectives on the experience and ultimately reminds people that they are part of the human race. The narratives of people who have suffered illnesses or trauma are often experienced by us as emotionally moving and the power of these stories emerges from the assumed link between the 'truth' of a story and the suffering present at the telling of the story (Frank, 1995).

The relation between truth and suffering can be traced back to the Ancient Greeks and is still dominant in our thinking today. In Ancient Greece, slaves were tortured to force them to give evidence against their masters, so torture became seen as a tool which could produce ‘truth’, and from this we have come to believe that truth can be produced from the suffering of the body and mind (duBois, 1991). This rests on the belief that the body produces a form of truth at the extremes of suffering, a belief which still dominates today's ideologies (Frank, 1993). In this sense, a trauma narrative can be seen as an ultimate form of truth because it comes from expressions of the body, and solidifies the idea that trauma is something which is dominantly experienced within the physical form.

Narration of one’s experiences is the way in which individuals interact with their environment and external situations in order to build an identity for themselves (Liu & Laszlo, 2007). Depending on circumstances, including other’s and societal institution’s expectations, individuals are persuaded to act, think, and feel in particular ways (Turner et al., 1987). This shared cultural knowledge influences the ways in which people act within situations and employ it to conform to appropriate norms for a particular situation and behave in ways characteristic to certain identities. In essence, people choose to take up different identities or social labels within different scenarios and are able to shift between self-categorisations to suit their desired outcomes. They are able to position themselves as being a part of an ingroup and can accordingly respond to being labelled as a member of an outgroup. This has been discussed in terms of trauma using TIV, where individuals who categorise themselves as a victim take up beliefs and engage in behaviours which will garner them attention and concern (Gabay et al., 2022; Kaufman, 2020). People who identify with the victim category also will show diminished empathy for others, regardless of whether they are adversarial or not, yet will act as if they hold

the moral high ground. These cognitions and behaviours allow individuals who have experienced traumatic events to take on a social categorisation which justifies behaviours which may not be in line with how they would usually act or are viewed as vindictive or inappropriate. There is a sense of agency in how an individual perceives themselves and how they portray themselves to the world through their social identities.

Stories of trauma also help give traumatised individuals an explanation of why they are suffering and give words to emotions, thoughts, and other reactions which they may have not been able to articulate before. Explanations for the aetiology and mechanisms of trauma as well as narrations of distress also allow validation of their experience as something traumatic and facilitate diagnosis and the addressing of issues like insomnia, irrational emotional reactions (such as rage), nightmares, and catatonia (van der Kolk, 2014). Additionally, they also allow for a target of blame, which is a universal human trait which helps people feel good whilst feeling bad (Alicke, 2000; Malle et al., 2014). There is also a tendency for marginalised people - usually victims - to find their voice, which has often been stolen, where the narration of the marginalised peoples was written from the outside. This can be seen as a taking back a capacity to value the self and the ability to transform and change through the way they narrate their lives (Crossley, 2000). Traumatized individuals often feel a need to bear witness to what happened to them, to tell the truth of their experiences and story as well as validate their suffering and their peers which suffered with them (van der Kolk, 2014). In this sense, trauma narratives are a form of advocating for people who have gone through similar experiences of distress which have deeply affected them and their lives (Joseph, 2015). Trauma narratives are used to rebuild an individual's shattered sense of identity, value, and meaning, therefore, in the face of trauma, finding a meaning in life is necessary for recovery (Caruth, 2016; Crossley, 2000).

The benefits of writing a narrative have been empirically proven, with the act of organising one's experiences into a narrative form (such as writing) serving as a way to organise complex emotional experiences (Krantz & Pennebaker, 1996; Pennebaker & Seagal, 1999). Being made to spontaneously write about a traumatic experience is also a form of self-reflection which forces individuals to think about events differently (Pennebaker, 1989) and by creating and reinforcing a coherent schema of a previously incoherent trauma through narrative, trauma-related stimuli – such as reminders or experiences – may be able to be assimilated into memory more easily and efficiently (Markus, 1977). It forces an order on to an overwhelming and often incomprehensible experiences by enforcing chronological structure, causal explanation, repeating themes, and the appreciation of a listener's point of view (Pennebaker, 1989; Esterling et al., 1999). These constructs have been found to be accessible to an individual for long periods of time after their formation, from weeks to even years (Fazio et al., 1986; Higgins, et al., 1982). James Pennebaker, the forerunner of expressive writing therapy, has carried out over 200 experiments with his students and colleagues researching how, when, and why written therapy works (Pennebaker, 2010). Even without having undergone any great emotional distress, the act of writing about important emotional experiences for as little as 15 minutes over three days has been shown to bring boosts in mental and physical health across different ages, genders, social classes, cultures, and personalities (Pennebaker, 1993). While the links to PTSD itself are still up for debate, it is believed that transforming thoughts and feelings about personally upsetting events into language may be able to help with improvements in social, psychological, behavioural, and biological measures of health and it is clear that expressive writing can have therapeutic benefit in those suffering from psychological distress (Pennebaker & Chung, 2007; Pennebaker, 2010). On the contrary, not confiding in significant experiences has been positively

associated with increased rates of stress-related disease, rumination, and (Pennebaker, 1989; Pennebaker & Beall, 1986).

It has been found that participants of all types from these studies, varying in age, education, life experiences, and social backgrounds, all disclose to an immense range and depth when detailing about traumatic experiences (Pennebaker, 1997). Given the opportunity, people are ready and willing to go into great lengths of detail about deeply personal aspects of their lives, even when those events may have been incredibly painful. Within Pennebaker's studies, despite a majority of participants reporting feeling deeply upset and/or crying during the writing process, almost all of them agree that the writing experience itself was a meaningful and valuable thing to have done (Pennebaker, 1997). Self-report studies have shown that written disclosure about distressing events, while painful at the time, bring about significant, long-lasting reductions in distress when compared to writing about non-emotional control topics (Smyth, 1996).

Franklian Perspective: Meta-clinical Implications of Psychotherapy & Dimensional Ontology

As previously established, trauma is understood to be a multifaceted, sociological issue, the aetiology and interventions used for it are still heavily grounded within medicine and natural sciences. On the other hand, Frankl had an interesting conceptualisation of humans as a species and their unique nature. Where Freud and van der Kolk aimed to establish humans as simply being another species, Frankl recognised as humans as having something which distinguishes us from animals (Solms, 2021). He noted that as long as psychologists, psychiatrists, therapists, and other mental health specialists interpreted their task in terms of applying techniques and

dynamics, they have missed the point. To Frankl (1988), approaching human beings in terms of techniques implies a necessity to manipulate them in ways for said techniques to work, and to see them and their minds purely in terms of dynamics or biological systems implies reifying them, or reducing them to an object governed by the laws of said dynamics or biological systems. In doing so, specialists fail to connect with and reach the hearts of those whom they wish to aid. He noted people can immediately sense and notice the manipulative nature of these approaches, when they are being considered in the general, rather than as an individual, and are being swayed to fit into a model (Bugental & Sapienza, 1992). This is easily observable today in the state of public-funded mental healthcare in many countries. For example, in New Zealand, a large proportion of clinical psychologists practice in CBT. CBT is generally considered as the ‘gold-standard’ of psychotherapy for several mental illnesses, including the ever-prevalent depression, anxiety, and PTSD (David et al., 2018; Shubina, 2015; Watkins et al., 2018; Weersing et al., 2006) and therefore is emphasised within both the New Zealand and Australian education systems leading to clinical registration (Kazantzis & Munro, 2011). It is a highly directive technique, but one that requires buy-in from the client to work.

Because of this, Frankl identified psychotherapy as depending on its concept or theory of man and the philosophy of life underlying it. Without these, there could be no psychotherapy, whether that was something that psychologists and psychiatrists fully realised or not. Frankl specifically calls out psychoanalysis as being no exception to this, noting how Paul Schilder called psychoanalysis a *weltanschauung* – a German term which roughly translates to a particular philosophy or view of life and the world (Habermas & McCumber, 1989). Therefore, there cannot be any issues regarding psychotherapies being based on a *weltanschauung*, but whether the *weltanschauung* which it is founded on is right or wrong, in the sense of whether or not the

humanity of man is maintained within its theory. For example, psychologists and theories which adhere to the “machine” or “rat” model disregard and neglect the human quality of their patients (Frankl, 1988), something which feels rather pertinent with Freud’s idea of man as driven purely by pleasure or van der Kolk’s implication that man and his symptoms of trauma can be unintentionally reduce to dysfunctional brain anatomy and activity.

Throughout his career, Frankl heavily advocated against reductionism - he recognised very early on that there has to be a multidimensional approach towards treating any form of neuroses. However, with the rise of psychopharmacology in the 1960s, its simplicity and ease in treatment of mental illness, psychologists would struggle to find a balance between the neurobiology of the brain and the abstract and elusive phenomena of the mind, an imbalance that still characterises the field today (Lovallo, 2015). Even in 1988, Frankl realised the dominance and proliferation of psychopharmacological interventions in treating mental distress, noting “we live in an age of the Pill” (p. 45). One of the pillars of logotherapy – the freedom of will – was created in opposition to pan-determinism, which was the principle that characterised a lot of the psychotherapeutic approaches to man at the time, such as behaviourism and psychoanalysis. This philosophy basically posits that man is at the whims of nature and nurture; that a person’s behaviour is solely determined by their biology and upbringing (Frankl, 1989). What Frankl was most against in terms of this, was the idea that man was incapable of standing against these predeterminants. He recalls being asked by Huston C. Smith, a scholar of religious studies, whether he – as a professor of neurology and psychology – would concede to the idea that man is subject to conditions and determinants, to which he answered yes (Frankl, 1988). As a specialist in those two fields, Frankl recognises humans are not free from all conditions, be they biological, psychological, or sociological, but made note that he was also the survivor of four concentration

camps. His experiences in those camps gave him insight to the surprising capacity that man is (and always remains) able to resist and endure the worst of conditions, to make a choice against the external circumstances of his suffering, the biology of sickness and fatigue, and the psychological burden of hopelessness and despair associated with the Holocaust. He observed that, despite suffering greatly, those who had a strong sense of purpose and reason to live had greater survival behaviours than those who did not (Starck, 2003). For him, this presented itself in many forms, most notably in the memory of his wife and desire to complete his manuscript, which he would go on to do throughout the two and a half years he was imprisoned by writing it on scraps of paper he found (Frankl, 1946/1959; Starck, 2003).

This deeply human aptitude to detach oneself from any circumstances he may face is what Frankl called self-detachment. By virtue of this, man is also able to detach from himself, and in doing so, fully takes a stand against his own biological and psychological conditions and determinants (Frankl, 1988). The freedom of will which he describes is not so much as freedom from all conditions, but the freedom to make his own meaning of whatever conditions may confront him. In this sense, a person is free to shape his own character and is therefore responsible for what he possibly has made of himself. As opposed to being purely reliant on the features of our character or our drives and instincts, what matters is the stand we take towards those circumstances – and it is the capacity to take a stand which makes us human. To be able to detach ourselves from both biological and psychical phenomena implies an ability to ascend above them and into a different dimension of being, one which Frankl named the noological dimension, or the dimension of noetic phenomena (Frankl, 1988). He identified this as the space in which uniquely human phenomena, such as humour and heroism, are located, and also used the term spiritual dimension interchangeably with noological. It is important to note that when

Frankl defined existential distress as being a problem of the spirit, he did not necessarily mean in a religious sense, and that the noological dimension strictly referred to anthropological matters rather than theological. In the same thread, “logos” – which directly translates to “spirit”, refers to the humanness of an individual, as well as the meaning of being ‘human’ (Frankl, 1988).

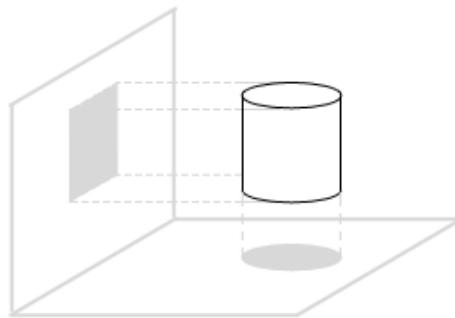
So, similarly to Freud, Frankl conceptualises the mind in terms of three different components – biological, psychological, and noological, or spiritual – but argues against these being organised in layers. He did not believe it was possible to consider the somatic, psychic, and noetic modes of being as entirely separate from each other, which is implicated if man is conceived in the form of biological, psychological, and noological strata. Rather, somatic, psychic, and noetic phenomena could all occur within the same plane – that is, of human existence – but how we reflect and detach ourselves from them depended on which dimension in which they were being perceived. The dimensions are all connected but hold no higher (in terms of superiority) order over one another, similar to the dimensions of space. Frankl described this as his dimensional ontology for conceptualising the human psyche and its experiences in an attempt to preserve the humanness of man in the face of reductionism.

Dimensional ontology has two laws. The first, “one and the same phenomenon projected out of its own dimension into different dimensions lower than its own is depicted in such a way that the individual pictures contradict one another” (Frankl, 1988, p. 9). To demonstrate this, Frankl uses the projection of a cylinder out its three-dimensional state into the horizontal and vertical two-dimensional planes. Horizontally, it casts a rectangular shadow, but vertically, it shows a circular one – these shapes contradict each other in the way that they come from the same shape yet depict completely different things. The point here is that a cylinder cannot be understood purely from the horizontal and vertical shadows it casts – they are but projections of

a bigger picture. In the same way, the effects of trauma cannot be understood purely from the cognitive distortions nor from the fluctuations in neurochemicals and stress hormones and changed brain physiology. It assumes that neuroses of any kind are innately ambiguous and upon first observations, it is nearly impossible to discern a singular cause or stressor prompting them to manifest.

Figure 1.

First law of Frankl's dimensional ontology

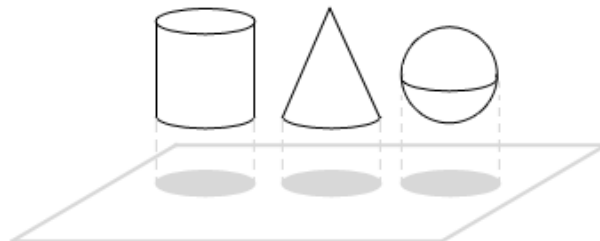


Secondly, “different phenomena projected out of their own dimension into one dimension lower than their own are depicted in such a manner that the pictures are ambiguous” (Frankl, 1988, p. 10). Frankl asks us to consider the projection of a cylinder, a sphere, and a cone from three-dimensional space. Vertically, all these shapes project the same shadow - a circle – but when viewed from a different angle, horizontally, they appear vastly different in appearance. Symptomology of trauma may have a biological, psychological, or spiritual cause, but by simple observation of a symptom as it is presented, we cannot discern which it is. For example, PTSD should not be considered purely through biological changes in the HPA, dysfunction in the

limbic system, and hyperarousal in the autonomic nervous system, but also cognitive components such as particular beliefs and assumptions one has about their symptoms or experience of trauma, as well as the external environmental situation(s) which an individual is positioned. The spiritual reaction and how a person believes that their symptoms, as well as the traumatic event itself, have affected their experience of themselves, the world, and others also should be considered. This law also explains the need for specialists to step back from the projected images of the person in other dimensions than the psychiatric diagnosis does one acknowledge who that patient is as a person, their experience of life, and what they want to achieve through their existence (Hallowell, 2009). To view one only from a singular perspective essentially means to dehumanise him (Madarang, 2017)

Figure 2.

Second law of Frankl's dimensional ontology



Frankl proposed his laws of dimensional ontology not to explain the mind-body problem, but to show how the mind-body problem cannot be solved. It did not make sense to Frankl that a dysfunction in repression – a psychic phenomenon – could be the sole cause of bodily neurotic

symptoms, such as paralysis, which could also be explained through a physiological source (Leontiev, 2013). Dimensional ontology highlights the need to have a holistic overview of the effects of trauma on a person, as well as the ways we explain its mechanisms and provide interventions.

Frankl accurately describes the mechanistic approach of the dominant aetiology and treatment of trauma in the current era very well using this paradigm and recognised this as early as 1988. Frankl (1988) would call the dominant approach biologism, where trauma is reduced down to ‘nothing-but’ biology. It is at this point where the science turns into an ideology, where an increasing number of scientists tend to make overgeneralised statements for the human condition based off limited, mono-dimensional findings. With this framework, Frankl aimed to emphasise that somatic, mental, and existential manifestations of posttraumatic stress – or symptoms of any assumed physiological or psychological disorder – do not exist within their own separate vacuums. Rather, they all coexist but are perceived differently depending on what plane of existence one is viewing them from. Frankl noted how while there can be many different epistemological explanations to describe the source or reasoning behind particular symptoms, the reality is that any form of neuroses can only really be understood by analysing them from several different perspectives. He argued that we should be moving away from the idea that the body and the mind act separately and against each other, rather are connected and very much interactive. There is no moral authority or hierarchy to be placed on the, nor do these different notions about trauma need to contradict one another. In this sense, the effects of trauma are only fully conceptualised when taking all viewpoints into consideration.

Frankl also asserted that logotherapy is not to be used as a sole intervention for the treatment of mental distress, rather it is a theoretical perspective to be used in a therapist’s

approach to treatment (Frankl, 1959; Southwick et al., 2006). It was not designed to be a cure all and Frankl recognised the need to integrate techniques from the different schools of psychology in creating an intervention specifically catered to the client being treated. Logotherapy is not a panacea, but within its delivery highlights the central themes of Frankl's work – to help the trauma victim to achieve self-transcendence, to act and love outside of themselves, through identifying the specific, unique meaning opportunities which can be found within memories of that trauma and the terror associated with it (Lantz, 1992). Frankl was always striving towards a multidimensional, holistic way of the treatment of distress, something which was largely ignored by his peers.

Further Implications & Considerations: Psychology and Cultural Contexts

Another thing to take into consideration is that this understanding of trauma narratives and the human experience of trauma has largely been examined and studied within WEIRD populations - that is, countries and societies which are: Western, Educated, Industrial, Rich, and Democratic. Subsequently, the knowledge of psychology, cultural norms, families, and value systems which is most readily available is that examined through a WEIRD lens.

In analysing the current literature surrounding narratives and trauma, or a majority of psychology, it is important to remember a large majority of experimental psychological research is carried out within American tertiary institutions through psychology undergraduates (Henrich et al., 2010b). Additionally, it is often implicitly assumed there is little variation in fundamental cognitive and emotional psychological phenomena across populations and that the subjects of these university studies are of a 'standard' which is representative of the majority of the human population. Yet, as aforementioned, life stories are highly individualised and are dependent on the sociocultural contexts which one is embedded in. The narratives which people are surrounded

with and the ones which they create for themselves are all imbued in their actions, through the subjective experience of the world and how one comprehends different inner realities, to cultural rites of passage such as marriage, funerals, and other meaningful ceremonies (Sarbin, 1986). These ways of life infuse people with moral conflicts and hypothetical issues which are pertinent and relevant in their particular culture from very early childhood into early adolescence and eventual adulthood (Howard, 1991). While each participant is most likely to have a different experience of trauma and differing interpersonal and social realities, the societies and environments which these individuals are situated within are restricted to this WEIRD prototype.

Bauer and colleagues (2006) note how narratives that chart the movement from suffering to an enhanced state often follow a redemptive arc, which is a culturally-shaped script where modern – particularly American – society is viewed as having upwards social mobility, liberation, atonement, recovery, and/or self-actualisation. Life narratives are reflections of the sociocultural worlds which an individual's life gains existential meaning, therefore no research which focuses on a subset of the population can be extrapolated and generalised to the rest of the world. Most educated Americans anticipate hearing stories of how personal adversity leads to growth and find these narratives particularly compelling and coherent (Pals & McAdams, 2004). Thus, McAdams (2008) argues that redemption is a dominantly American phenomenon, therefore, these perspectives cannot be considered as universal, and it is very likely that there are cultural and personal variations in the manifestations of individual and group-level traumatic experiences.

It is thought that WEIRD societies only represent approximately 12% of the human population and are thought to be some of the most psychologically unusual people on the planet, yet they make up about 90% of psychological study samples (Arnett, 2008; Henrich et al.,

2010a). Which means the findings of a majority of prominent psychological research cannot be extrapolated to account for the 'general' population either. Where those from WEIRD societies tend to be individualistic, analytical, nonconformist, and focused on personal growth, a majority of the world's population do not. Non-WEIRD countries, despite the vast amount of them, have often been lumped together as being collectivist and interdependent, with a motivation to conform (Henrich et al., 2010a). However, non-WEIRD countries are simply defined as those which do not apply to at least one of the five characteristics, so for example, Japan is considered as a non-WEIRD country due to not being Western even though it is educated, industrialised, rich, and democratic (Kotera et al., 2023). This means there is a wide range of variation within the non-WEIRD countries themselves which is not accounted for as well.

Individuals from WEIRD societies aim to highlight their identity as a minority victim and gain attention, recognition, praise, and even compensation for the fact, rather than to conform. It is interesting that narratives of trauma are presumed to have so much social currency in countries which on average tend to experience far less levels of suffering and traumatic events.

Redemptive narratives are thought to be a largely American psychological phenomenon- that is, developed and displayed in a WEIRD country. It is possible that because a massive level of suffering is unfortunately common for these individuals, the shock value and empathy which traumatic events are meant to elicit from others is more or less normal to them, therefore they are desensitised to the concept of victimisation and instead just view it as a part of life (Bradbury, 1998; Johnson et al., 2009; Nguyen-Gilliam et al., 2008). In a similar way, developed countries where there is less suffering and adversity may become to see the crises going on in non-WEIRD societies as normal due to wide scale coverage on mass media such as the news (Pandell, 2022).

The historical narratives of WEIRD cultures, including events of colonisation and oppression of

other minorities, tend to try portraying them as acting for the betterment of humanity, morally correct, and justify their actions through the potential threat from the outgroup (Noor et al., 2012, 2017).

The narrative of traumatic experiences and how they affect people outlined within this thesis is but one perspective that is more easily accessible and available to investigate in depth. Efforts into studying small-scale communities have vastly grown over the past few decades, but besides from this relatively niche area and the overwhelming amount of psychological study in WEIRD populations, there is very little accounting for the middle ground (Barrett, 2020). Research which goes beyond the parameters of WEIRD and the binary of modern, industrialised society and small, selected communities needs to be carried out. Broadening the theoretical and empirical scope of trauma and narrative research centred around a representative map of the human psychological and behavioural phenomena would allow for a fuller, richer understanding of the individual and collective narration of trauma and how it is experienced, and ultimately, human nature (Barrett, 2020).

Conclusion

Paradigmatic thought has arguably dominated much of the theory and discipline of psychology for the past century or so, with a heavy emphasis placed on the scientific validity and reliability of knowledge used to understand human psychological processes and phenomena (Sarbin, 1986). Like all subsets of the field, we have seen how trauma studies is rife with mechanistic and organic metaphors, and what is considered as the gold standard for both assessment and treatment of PTSD and other symptoms of posttraumatic stress has been determined by these bio psychological explanations. Perhaps as best described by Frankl, “the only question is whether a neuroses of a given psychiatrist is representative of the neuroses of the

time in which he lives” (Frankl, 1988, p. 105). While it is necessary and beneficial to have a biological understanding of trauma, we must not forget that it is ultimately a life experience, and that the experience of life is not analogous to a science. It is tempting to reach for a biomedical model of mental health and illness, as it provides coherent answers and reasoning to what appears to be irrational distress. But, similarly to how the explanatory gap is yet to be explained, the human brain, mind, and condition is far more complex than we can currently fathom. To reduce its functioning to mere biology would be a disservice to the individual experience.

Dimensional ontology provides a framework for this holistic approach which psychologists across all domains have been trying to implement. Biological, psychological, and nöölogical - which encompasses facets of experience which can only be regarded as purely human, such as spirituality, empathy, and the existential drive for a purpose and sense of meaning in life - can all be observed through the expression of an individual’s functioning. And through its structure, reinforces that these aspects, while separate and very diverse in nature, intrinsically intersect each other and therefore cannot be regarded in isolation. Regardless of whether it is willfully ignored or seen as epiphenomenal, being human will always involve a capacity to look beyond the self, others, and the present moment (Frankl, 1949/1956). A humanistic approach to psychotherapy, or even the aetiology of trauma does not have to contradict a neuropsychological one but can act to complement and even enhance the understanding of the experiences those affected by trauma go through. Frankl ultimately was concerned with preserving the unity of the human being (Previn, 1960). Further research must be invested to address the skew in the treatment of trauma towards strictly biological and experimentally proven intervention methods and understandings.

We know that trauma is upsetting. It is paralysing and inexplicably life changing but it is not something we must simply succumb to. Rather than viewing posttraumatic stress as a biopsychological failing, trauma should be seen as an experience of adversity to overcome and learn from. Ultimately, as Frankl (1946/1959) puts it, life is not something to which we need to question and assign meaning, rather something that questions us and asks us how we are going to react to the world.

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