

Existential Therapy: A Useful Approach to Trauma?

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Abstract

Literature has suggested that the cyclical nature of psychological trauma can lead to enduring long-term effects on individuals and those around them. This review examines the effects of psychological trauma and its relationship with existential therapy, not to endorse a particular approach in isolation, but to explore a variety of understandings of psychological trauma pertinent to counselling psychology. Despite being relatively unexplored with regards to psychological trauma, favourable empirical evidence is beginning to amass for existential therapy. A review of the contributions (and limitations) of existing approaches to trauma therapy is initially considered before the focus turns to the contribution that existential therapy might make. van Deurzen's existential dimensions (1997) and Jacobsen's existential conceptualisations of crisis are considered in some depth, along with the limitations and empirical challenges of existential therapy. Speculative practical and therapeutic implications are identified and relevant future research is suggested.

Keywords: existential therapy; psychological trauma; posttraumatic stress disorder; trauma therapy

Introduction

A traumatic incident is a shocking and emotionally overwhelming situation in which an individual experiences or perceives a threat to the physical and/or psychological integrity of self or others, resulting in a reaction of intense fear, helplessness or horror (American Psychiatric Association [APA], 2000; Lodrick, 2007; Rothschild, 2000). It has long been apparent that such experiences can lead to psychological problems, with possibly the first cataloguing of traumatic symptoms documented on Sumerian cuneiform tablets following deaths in battle (Ben Ezra, 2001, cited in Grey, 2007). More recently, acts of terrorism such as the attacks in the United States on September 11 2001 and widespread natural disasters such as the tsunami in Southeast Asia in 2004 have been increasingly formulated from the perspective of trauma by professionals and the media (Courtois & Gold, 2009). Indeed, trauma is increasingly being recognised not as a specialised area, but a fundamental aspect of human experience (Gold, 2008).

This paper begins by addressing some responses to traumatic events and the effects of traumatisation documented within the literature, before briefly outlining the key features of posttraumatic stress disorder (PTSD) and compiling some of the current therapeutic options for trauma therapy. Stolorow (2007) made a personal and philosophical reflection on the psychological and emotional impact of trauma, defining it as 'an experience of unbearable affect' in a context in which there is an 'absence of adequate attunement and responsiveness to the [individual's] painful emotional reactions' (p.9-10). Reactions to traumatic events vary considerably, ranging from relatively mild responses, creating minor disruptions in the person's life, to severe and debilitating reactions. It is common for those who are exposed to traumatic events to experience intrusive thoughts and images, accompanied by attempts at avoidance, emotional numbing, and increased arousal (Joseph, 2010).

van der Kolk (1996) wrote that 'traumatised people lead traumatic and traumatising lives' (p.11, cited in Lodrick, 2007, p.10). Themes of repetition are indeed central: the individual may be subjected to intrusive replays of the original trauma (Lodrick, 2007). Trauma re-

enactments are common and take the forms of re-victimisation, self-injurious and self-harming behaviours and externalizing the trauma by victimising others (van der Kolk & McFarlane, 1996).

Totton (2005) writes that traumatic experiences in childhood can have enduring profound effects on traumatic experiences as an adult, influencing the traumatised person's responses and creating patterns of hyperarousal or dissociation together with a tendency to re-enact traumatic experiences (Perry *et al.*, 1995; Schore, 2000). Wainrib (2006) argues that traumatic events can generate severe psychological reactions that can manifest anytime. For some, the effects last throughout their remaining lifetimes and traumatised individuals have been found to have elevated rates of psychiatric diagnosis including major depression and alcohol or drug dependence (Wainrib, 2006). High co-morbidity rates of trauma and psychosis are also evident in the literature. Bebbington *et al.*, (2004) identified associations between psychotic disorders and early victimisation experiences, Janssen *et al.*, (2004) reported a significant cumulative relationship between trauma and psychosis, while Shevlin *et al.*, (2007) observed a positive relationship between occurrences of childhood trauma and self-reported experiences of hallucinations.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: APA, 2000)* outlines PTSD as the development of characteristic symptoms of distress or impairment that are present for over one month after exposure to a traumatic event. Banyard (1999) described its cyclical nature, outlining three main clusters of symptoms: re-experiencing phenomena, avoidance/numbing and increased arousal. However, Foa *et al.* (2008) argues that this diagnostic framework is inherently limiting, and reports a growing consensus for multimodal interventions. It has been argued that PTSD is not a neutral term, but a social construction (Maddux *et al.*, 2004, cited in Joseph 2010) that may inadvertently pathologise normal and natural reactions to traumatic events. Joseph (2010) also states that the very diagnosis of PTSD and the medicalisation of trauma reactions essentially deny the existential nature of such responses and stifle people's ability to emotionally process their experiences in meaningful and purposive ways

Approaches to Therapy

The National Institute of Clinical Excellence (NICE, 2005) guidelines advocate a course of trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) for PTSD, with research overwhelmingly appearing to demonstrate their efficacy (e.g. Moss, 2009). Hemsley (2010), highlights that within a CBT approach, the principal mechanisms for change are considered to be improvement through emotional processing of the trauma using repeated exposure and amelioration through cognitive restructuring of the event (Resick et al., 2008). However, the current options of intervention are by no means categorical or indeed immobile, and scope for advancement and innovation is highlighted in the literature. For instance, Ryan (2010) argues that advances in the treatment of psychological trauma have emerged in the light of recent developments in neuroscience, while Tarrier (2010) has called attention to the development of positive psychology which may offer further treatment options.

There has also been a move to challenge existing options of intervention within the literature. Pitchford (2009) maintains that contemporary approaches to trauma are flawed, primarily because of the narrow focus on symptom management as opposed to acknowledging the barriers people have to expressing their freedom in choices and will (May, 1999; Paulson & Krippner, 2007). Hemsley (2010) argued that CBT, for example, assumes that it is the individual's inability to adequately process the traumatic experience that has led to the development of symptoms (Taylor, 2007) which makes little room for inclusion of other modalities and implies that practitioners have knowledge of the client's internal world. Hemsley (2010) developed this reasoning to argue that just using CBT for PTSD reinforces the medical model of intervention without acknowledging that every theoretical model offers a heuristic focus for the level of intervention (Roth & Fonagy, 2005). Hemsley (2010) comments that this undermines professional autonomy within the National Health Service (NHS) and private practice, since insurance companies could demand for interventions consistent with NICE guidelines (Fairfax, 2008). Tarrier (2010), meanwhile, argues for continual innovation,

which will come from recognition of variability and heterogeneity and the development of new treatment strategies' (p. 140).

Trauma therapy is a complex biological, psychological and social project that unfolds in stages over time and may involve many different modalities to reach a stage of optimal recovery (Herman, 1992). This rationale invites practitioners to acknowledge the idiosyncracies of their clients, and acknowledge a greater range of contributing factors that could be overlooked by a medicalised approach with a primary focus on specific symptoms. With recent developments and emerging alternatives, counselling psychologists are faced with convoluted and perhaps tough decisions to make about which approach corresponds with their therapeutic manner but also best serves the needs of their individual clients.

At this point, we turn from what much of the traditional literature has said and look to the contribution that existential theory and practice can offer the understanding of trauma.

Existential Therapy

While existential therapy is ultimately a creative, evolving process, Cooper (2003) highlights that it is also a diverse and difficult to define body of psychological theory, practice, and research reflecting an existential influence with the aim of exploring human reality from the perspective of the client. Iacovou (2009) notes that while existential therapy incorporates a broad spectrum of practitioners who administer a variety of approaches - including Existential Analysis, Existential-Humanistic Therapy, Daseinanalysis and Logotherapy - there are some collective themes. For instance, the answers to fundamental philosophical questions that underpin the way the world is perceived and the psychological and interpersonal difficulties encountered shape the theory and practice of existential therapy (Boss, 1979; Cannon, 1991; Cohn, 1984). The therapeutic process is the experiencing of one's existence, and the client's identity is not understood as a fixed matter. Rather than pathologising the client, existential therapy 'does not seek to cure or explain, it merely seeks to explore, describe and clarify in order to try to understand the human predicament' (van Deurzen, 1997, p.3).

Yalom (1980) described existential therapy as a homeless waif that did not belong anywhere, resolving the problem of definition by listing the themes relating to existence (e.g. isolation, freedom). This review follows a similar example, by considering how of existential therapy could be applied to trauma. To do this, van Deurzen's existential dimensions (1997) - a development of Binswanger's (1958) framework - and Jacobsen's (2006) existential conceptualisations of crisis are considered in some depth.

Existential Dimensions: A Perspective on Trauma

van Deurzen (1997) claimed that 'as human beings we are complex bio-socio-psycho-spiritual organisms, joined to the world around us in everything we are and do' (p.94). Essentially, the author describes a four-dimensional forcefield that we are constantly concerned with: physical, social, psychological and spiritual. The dimensions begin with the relationship between ourselves as a physical body and the natural environment: the biological forces that regulate us within the physical dimension. Secondly, the author describes the social dimension: our social and cultural network through which we relate to others. We are thirdly modulated by the psychological dimension which concerns our personality, character and mental processes, and finally by our relationship to the framework of meaning through which we experience and conceive the world on a spiritual dimension (van Deurzen, 1997). The four dimensions within which existence takes place span polar opposites manifesting as paradoxes, dilemmas, contradictions and conflicts; each with connections and overlaps which prevail when considering their implications as an approach to trauma.

Physical Dimension

The client's existence in the physical dimension pertains to the body, health, and the natural world. Focusing on this dimension consequently informs the therapist's understanding of the client's world in a physical sense, and the impact of a traumatic event upon it. Throughout life the basic challenge of our physical survival remains a continuously threatened primary

concern, since as van Deurzen (1997) claims, we are firstly regulated by physical, biological and natural forces. Similarly, psychological trauma leads to, among other things, a heightened sense of mortality and physical vulnerability (Sadavoy, 1997),

Jacobsen (2006) conceptualised crisis, a term sometimes used interchangeably with trauma (du Plock, 2010), as being associated with three dimensions: loss, adversity and the opening of existence. The individual in crisis loses something, faces adversity, and has the opportunity to define his or her life at a deeper level. Jacobsen's (2006) 'crisis as loss' conceptualisation can involve direct and physical losses of a specific object or person that the client subsequently misses, resulting in grief. Jacobsen (2006) observes that when something is lost, so is a part of oneself that was attached to that person or thing. Bollnow (1966) made a similar connection when discussing bereavement, claiming that '...the bereaved does not inhabit his or her world in the same way as before. Therefore the death of a loved one is loss of existence. The individual shrinks. The death of a loved one is a piece of one's own Death' (p.66, cited in Jacobsen, 2006, p.44). This sense of loss therefore, whether induced by a bereavement or altered circumstances resulting from trauma, can be perceived as both an unfamiliar environment for the individual to inhabit and an intensified impression of one's own mortality.

Just as trauma can elevate our sense of mortality, it potentially induces a range of physical consequences which continue to threaten it: Kendall-Tackett (2009) notes, for instance, that people who have experienced traumatic events have elevated rates of serious and life-threatening illnesses including cardiovascular disease, diabetes, gastrointestinal disorders, and cancer. Tarrier (2010) also highlights emerging evidence that there is an interaction between the psychological and physical injuries that arise from a trauma, in that physical injury can prolong PTSD by constantly triggering memories of the trauma and its consequences (Jenewein *et al.*, 2009; Sharp & Harvey, 2001).

Social Dimension

Psychological trauma can be considered through the lens of the social dimension with regards to our habitual and cultural responses to trauma, our instinctive responses to threat, and the social impact of trauma. van Deurzen (1997) writes that we are social creatures, inserted into a cultural network which we assess, categorise and ultimately need to connect with, extending this into a social commentary about the abandonment of our ancestral history. Denham (2008) described the varied ways people experience, construct and transmit traumatic experiences intergenerationally within American Indian families, revealing that the family's history of trauma and their related narratives appeared to function as a significant carrier of cultural and family identity. Embedded within the trauma narratives were numerous strategies for resilience, or non-pathological adaptive responses and abilities to maintain equilibrium after experiencing adversity (Bonanno, 2004; Conner, *et al.*, 2003; Dion-Stout & Kipling, 2003; Luthar *et al.*, 2000). Similarly, van der Hart (1983) described the tribal culture Navahos, for whom to be sick is to become fragmented, to be healed is to become whole, and to be whole one must be in harmony with family, friends and nature. An aim of existential therapeutic work is to help a client to become more authentic, more aware of their existence (Cooper, 2003) which would generally include an exploration into a client's social dimension, beliefs, values and experiences,

Psychological trauma no doubt disturbs the social dimension, evidenced in trauma-related literature that describes our instinctive responses to threat. Our struggle for survival requires us to distinguish between those who will protect or attack, and when fearful many people trigger their social engagement system (Porges, 1995). Lodrick (2007) distinguishes '*friend*' as the earliest defensive strategy available to us, evident even in the child who smiles - or even laughs - when being scolded. Lodrick (2007) also distinguishes the survival strategies coined by Cannon (1929): '*fight*', which involves the threatened individual responding with overt aggression, and '*flight*' as a means of putting space between oneself and the threat. Defining a traumatic event is by no means simple and has changed over the years (Ozer &

Weiss, 2004), calling into question what kind of experiences are traumatic and for whom. It would seem that our mode of existing within the social dimension affects our response to trauma, or indeed whether we find an event traumatic at all.

Psychological trauma also appears to impact upon us socially. Research (Maercker, 2008a, 2008b; Nietlisbach & Maercker, 2009a, 2009b) has revealed how features of post-traumatic symptomatology and interpersonal factors may provoke an increase of social exclusion which may be an additional emotional burden for trauma victims. PTSD is often accompanied by impairment of psychosocial functioning that is not reflected within the recommendations by NICE (Hemsley, 2010); and McFarlane and Van der Folk (1996) argue that symptoms such as repression, denial and dissociation have a social as well as an individual consciousness.

Psychological Dimension

van Deurzen (1997) writes that we are regulated by our personality, character and mental processes; referring to the personal space which we protect and develop in relation to our established physical and social dimensions. While trauma may shatter the world around us, it may also require a prematurely defined 'self' to develop, which will eventually falter and become depleted. The formation of self is described by van Deurzen (1997) as a constant challenge, an ongoing process, but if physical and social well-being has been acquired at some point, a more positive experience can be drawn upon to overcome difficulties. Similarly Jacobsen's (2006) conceptualisation of 'crisis as loss' includes psychological losses of a connection with the mind or soul or existential losses of a relationship with self or other. Though the potential for trauma is consistently prevalent, so is the possibility of generating bonds of emotional attachment within which debilitating emotional pain can be held, constructed as more manageable, and ultimately integrated (Vogel, 1994). Here, the social and psychological dimensions interweave; just as Herman's (1997) commonality and reconnection theory suggests that people affected by trauma need to reconnect and rediscover themselves as well as to connect with those who have endured similar circumstances. This relational interplay suggests an inter-connection between the existential

dimensions and Jacobsen's (2006) crisis conceptualisations in approaching trauma therapeutically, perhaps exemplifying the therapist's requirement to step back and question multiple possibilities.

Jacobsen's (2006) 'crisis as adversity' dimension outlines existential givens, which an individual must learn to accept or face living under false premises. Trauma can enduringly affect one's sense of being-in-the-world by altering our preconceptions: the world is unpredictable and can offer no guarantee of security or consistency (Stolorow, 2007). Such concepts epitomise the subjective conceptualisation of trauma, with therapeutic implications that listening to the subtleties of interpretation and remembrance, nuances of affect and self-experience and idiosyncratic social constructions could provide insight into the client's unique posttraumatic response (Harvey, 1996).

Spiritual Dimension

van Deurzen (1997) suggests that we are modulated by our relationship to the overall framework of meaning through which we experience the world and make sense of it on a spiritual dimension. Trauma can indeed provoke an altered philosophy of life that may include spiritual beliefs (Park *et al.*, 1996). When exposed to trauma, the client can experience a level of death awareness that enables them to more clearly and richly experience the joys, meanings, values and life purposes (Frankl, 1969; Yalom, 1980). Jacobsen's (2006) 'crisis as loss' dimension includes loss of meaning and world-view, but his conceptualisation of 'crisis as an opening-of-existence' also resonates here. Trauma presents the therapist with an opportunity to help the client discover a paradoxical respect for life that occurs in response to the proximity of death, identified by Frankl (1969) as "finality meanings".

It may be that trauma can result in growth, inasmuch as adversity and distress can push someone to develop. Parkes (1971) characterises traumas as 'psychosocial transitions', explaining that individuals must 'restructure [their] ways of looking at the world and [their] plans for living in it' (p.101). Research suggests that a range of traumas can precipitate

positive development, for example, cancer (Cordova *et al.*, 2001; Taylor, 1983); HIV infection (Schwartzberg, 1994); rape (Ashley, 2005; Burt & Katz, 1987; Veronen & Kilpatrick, 1983); incest (Silver *et al.*, 1983); bereavement (Calhoun & Tedeschi, 1989; Lehman *et al.*, 1993; Schwartzberg & Janoff-Bulman, 1991); heart attacks (Affleck *et al.*, 1987) and disasters (McMillen *et al.*, 1997). Jacobsen (2006) describes this concept like a crack in the ground '...the crack allows the individual to look deep into something very significant. In this way, the crisis becomes existential and can become a personal turning point, a new life possibility' (p.46). This is precisely what a traumatic event does, and this analogy has profound therapeutic implications, for it is precisely when the ground opens up before us – when the carpet is swept from under our feet – when we are disturbed, distressed and derascinated - that we potentially have a rare opportunity to work with awareness not previously experienced.

Therapeutic Implications

In working therapeutically with a trauma, du Plock (2010) cited Jacobsen's (2006) paper suggesting that it could work almost as a guide: which advocates that the client would need to confront and articulate losses, be afforded the opportunity to sense, acknowledge and express feelings, while confronting the material that was split off during the traumatic event. The therapist ultimately collaborates with the client to induce meaning, implications and possible consequences.

Feelings and Moods

van Deurzen-Smith (1988) summarised the most common feelings that emerge after a trauma as a wheel/circular experience. This is similar to researchers from other frameworks (e.g. van der Kolk 1989), who suggest that feelings succeed one another in a cycle. van Deurzen suggests that each has a destructive and a constructive side, and the client may need to experience and understand the varying feelings that surface, become accustomed to them and learn something from them about one's way of life. Boss (1994) discussed moods as

ways in which an individual's relationship with the world may manifest. Boss stressed the need for the individual to be able to sense their varying moods and gradually open themselves up to them, so that they are able to meet the world freely and be present to what emerges. This perhaps exemplifies the importance of the therapist's engagement with personal therapy, requiring the therapist to have worked through their own existential concerns, feelings and moods, since they themselves may experience intense feelings and a traumatised client's process of recovery could be extensive.

Reintegration

du Plock (2010) commented that when someone experiences a trauma, their defences are activated and some events are so horrific that the consciousness cannot contain them. Jacobsen (2006) cites Spinelli's (1994) theory of dissociated or divided consciousness, in which certain aspects of a traumatic experience are placed into one of two 'compartments' of consciousness. The more humiliating or anxiety-ridden memories are placed in one compartment, while the more positive memories allocated to the other, and a potential task is for the individual to gradually attempt to recall these details in therapy. An important part of the repair process would also be the confrontation of the client's beliefs and assumptions that could influence the client's stance towards their memories.

Reconstruction

Jacobsen (2006) observed how therapy can generate a more positive interpretation for the trauma survivor, as they re-attribute meaning to the traumatic event. This resembles but goes beyond cognitive restructuring (e.g. Ehlers & Clark, 2000), as the reconstructed meaning and orientation of one's life can be characterised by a more intense and intimate life containing features like reconciliation and acquiescence to one's existence. Jacobsen (2006) provides case examples from an interview to illustrate positive reconstructions of cancer patients, which could have been developed to include Spinelli's (1994) suggestions about the self-

construct, which he proposed was maintained and validated by a remembered past that has flexible meaning and significance.

The Therapeutic Relationship

The pertinence of the social dimension to trauma draws attention to a central preoccupation for existential therapy: the role of the therapeutic alliance. Existential therapy recognises the relational aspect of life and of therapy, therefore helping clients to become aware of their experiences, potentialities, and means of interaction with the therapist (Bugental, 1978; May, 1995; Schneider & May, 1995; Yalom, 1980). The nature of the relationship may differ from more classical kinds of therapy: for instance the existential therapist functions as a person in a meaningful encounter with another person. This is particularly pertinent to traumatised clients, as case examples concerned with trauma have previously illustrated how the development of the therapeutic relationship has significantly contributed to resolution of thematic issues that defined the therapeutic trauma work (Roth & Batson, 1993), acknowledging that the dynamic process of recovery from a trauma can only occur within the context of a meaningful therapeutic relationship. Roth and Batson (1993) maintain that there is a distinctly humane understanding of the role of the therapist as someone to bear witness to the trauma, to be a real partner in the re-experiencing of the trauma, and of course to provide a safe environment in which to do the trauma work. With relevance to existential work, Lantz (2004) highlights that existential therapists generally believe that effective therapy evolves out of the therapist's willingness to utilise the self to facilitate relationship, action and reflection experiences that help the client work through and struggle with the ultimate issues of human life during the therapeutic process (Frankl, 1969; May, 1983; Mullan and Sangiuliano, 1964; Whitaker, 1976; Yalom, 1980).

Empirical Considerations

When reviewing this literature, it is evident that empirical evidence is beginning to amass that recognises the contribution that existential theory and practice can offer our understanding of

trauma. Empirical work in this area may have its challenges, however, and it is indeed one of the most under-researched approaches in counselling and psychotherapy (Cooper, 2004). A core epistemological theme within existentialism is concern for the uniqueness and irreducibility of human experience, and traditional scientific methods seem inadequate to the task of understanding the meaningful complexities of human experience (Boss, 1979; May & Yalom, 1995; Norcross, 1987). Epistemologically, existential therapy is impeded this way as “the basic tenets of existential therapy are such that empirical research methods are often inapplicable or inappropriate” (Yalom, 1980, p. 10). While in the world of ‘evidence-based-practice’ (EBP), therapies are increasingly expected to demonstrate efficacy and efficiency (Rowland and Goss, 2000), existential therapists have expressed reservations about the use of systematic experimental research methods to generate knowledge about the practice and effectiveness of existential therapy and for many such experimental research methods are best replaced with the process of participation (Lantz, 2004). Chalquist (2009) has even suggested that unrestrained empiricism is itself a version of trauma; an intellectualised resistance from experiencing the world on its own terms.

Therapy is fundamentally a complex human endeavour, and easy to measure efficacy studies fail to generate rich qualitative data to truly illustrate the experience. Spinelli (2003) noted that existential-phenomenological research is primarily qualitative-interpretative, which essentially searches for meaning rather than aims to collect facts, and endeavours to understand rather than explain. Spinelli (2003) also highlighted developments in existential-phenomenological research methodologies relevant to counselling psychology research which have focused on hermeneutic single-case efficacy design (Elliot, 2001) and multiple-case depth research (Schneider, 2001). As a further example, Lantz (2004) describes Grounded Theory as a research method for existential therapy: a qualitative, phenomenological and inductive approach that aims to identify data, data themes and emerging theory that is grounded in observation of the study population (Glasser and Strauss, 1967; Lantz, 1987, 2002). The author maintains that this kind of study acquires credibility through the use of prolonged observation, methodological triangulation, data triangulation, peer debriefing and reflection to

work towards accurate and dependable observation (Glasser and Strauss, 1967; Greenlee and Lantz, 1993; Lantz, 1987, 2002).

While existential therapy remains relatively under-researched, empirical evidence for other cognitive-behavioural approaches is more widespread, though the nature of these studies has been challenged. For instance, the demand for EBP has focused on quantitative studies that address a finite number of parameters and struggle to examine complex interactions (Coote *et al*, 2004), while limitations such as attrition have been identified to suggest that evidence is frequently overstated or under explained (Foa *et al.*, 2008). The difficulty with EBP seems to be its insistence on a specific form of 'measurement' with the assumption that if it cannot be measured then it is not 'real' (Hart & Hogan, 2003; Michell, 2003, cited in Nowill, 2010).

van Deurzen (1997) postulates that physical life is based upon a cycle of need: to fill an empty stomach. We also once enjoyed the process of gathering food and eating at the same time: the effort was as important as the goal. However, we have since learnt to postpone gratification, and work is perceived as depleting and exhausting. The natural cycles in which pleasure and effort are commensurate have been replaced with unnatural cycles of entitlement, comfort, instant gratification and whatever else might reinforce such views (van Deurzen, 1997). This depiction reflects an over-simplified prioritising of quick-fix solutions for psychological trauma, while simplifying - if not negating - the core issues. Research has indicated that the long-term benefits of CBT are not quite as clear and certain as sometimes portrayed (e.g. Rowe, 2007; Rufer *et al.*, 2005). Just as van Deurzen (1997) observes that we prefer to outsmart nature and obtain our livelihood with minimal effort, the reality is that we gain relatively little, for the journey is everything, and the 'goal' is indefinable and ever-shifting, according to the individual's perspective and the passage of time. Trauma seemingly affects us all at some point. For some, the real work on personal development after a trauma is on reshaping ourselves, reconnecting with natural cycles within and without, and restoring a sense of meaning to life. This can ultimately be a rewarding effort, the very challenge of our physical existence.

Conclusions: Integration and Future Research

This review considered the potential for the use of existential therapy for working with psychological trauma. Despite broad philosophical underpinnings and definitions, the issues raised by existential therapy appear to be universally perceived and basic to human experience (Yalom, 1980), suggesting that they could be integrated into almost any approach (van Deurzen, 1997). This paper is not intending to endorse a new prescriptive methodology, but an integration and incorporation of other methods so that the practice of counselling psychology continues to evolve. CBT is recommended within The NICE guidelines, with a concentration on symptoms and diagnostic criteria (Hemsley, 2010), yet this fails to adequately provide a rich understanding of responses to trauma (McHugh & Treisman, 2007) – an issue that an existential therapeutic approach can help correct. People can only heal from trauma if supported as whole beings and provided a safe channel to explore their world and reconnect with themselves (Herman, 1997; Paulson & Krippner, 2007). The responsibility of counselling psychologists therefore ultimately lies in understanding their clients' anxieties and experiences rather than coercing them into conforming to a therapeutic model.

Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional psychology (BPS, 2005). Indeed, a commitment to good practice, as outlined by the British Psychological Society (BPS: 2005) and the British Association for Counselling and Psychotherapy (BACP: 2010), is to keep up-to-date with the latest knowledge, implying that counselling psychologists have a continual ethical responsibility to explore how alternative approaches could be used to benefit clients. While empirical evidence is beginning to amass for existential therapy, further projects should be monitored and evaluated to provide support for existing findings and expand data. Perhaps purely empirical methods are inadequate to comprehend the idiosyncratic meanings we assign to trauma, presenting both an obstacle to the acceptance of an existential approach but also a necessity that cannot be overlooked; for to define is to limit and to manualise is to generalise. So it is possible that more is needed; namely, a willingness to experiment and

explore other approaches; to identify ways in which these approaches may be integrated; and to constantly question and debate the accepted methods as reflective and critical practitioners.

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