Emplotting the Traumatic Self: Narrative Revision and the Construction of Coherence

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This book is premised on a view of human beings as inveterate narrators, constructors of personal, familial, and cultural stories that punctuate, organize, and attribute meaning to experience. Seen in this light, stories serve both a mnemonic and a performative function, consolidating a sense of who we are as the protagonists of our accounts, and scripting the ways we engage in our lives with others. This deepened understanding of narration suggests that it does more than simply represent human experience; it literally constitutes human experience, as well as our identities as social beings. Thus, anything that frustrates our efforts to "story" experience serves psychologically to destroy human life. In this chapter, we will explore one set of all-too-prevalent experiences that defy narration — the encounter with traumatic events — and sketch the outlines of an emerging constructivist conception of both the impact of trauma and its treatment. This chapter is therefore part of a broader attempt to understand distress as a breakdown in the human "effort after meaning," and to articulate the concrete implications of this constructivist perspective for the helping professions (Neimeyer, 2001; Neimeyer & Raskin, 2000; Neimeyer & Stewart, 1999).

We will approach this task first by noting the frequency of traumatic stress in contemporary society, briefly describing its symptomatic expressions. We will then consider the dominant normative approach to its conceptualization and more idiopathic alternatives, the latter of which are more coherent with a constructivist perspective. This will provide a springboard into a more extended discussion of narrative models of knowing and their applicability to the phenomenon of posttraumatic stress, which not only radically challenges survivors' ability to cope in conventional social contexts, but also undermines their very sense of self-continuity. Finally, we will conclude with an extended case study that exemplifies this narrative model and illustrates its possible relevance for clinical assessment and psychotherapy.

Prevalence of Traumatic Stress

Traumatic experiences exist in an abundant supply, encompassing such events as physical or sexual assault, natural catastrophe, random violence or murder, genocide, and complicated bereavement, such as that associated with the suicide of a loved one, or with an unexpected and mutilating death through motor vehicle accidents (Neimeyer, 1998; Stewart, 1999). Yet not everyone who experiences a traumatic event manifests the psychological symptoms of posttraumatic stress disorder or other anxiety disorders (American Psychiatric Association, 1994). In a sample of low income and urban-dwelling young adults the lifetime prevalence rates of exposure to traumatic events (such as being assaulted or witnessing murder) was 39.1%. Of these individuals, the rate of PTSD was 23.6% (Breslau, Davis, Andreski, & Peterson, 1991). Snow, Stellman, Stellman, and Sommer (1988) estimated PTSD prevalence rates of 1.8% to 15% in a sample of 2,858 American Legion members who served in Southeast Asia, depending upon how traumatic experiences and combat exposure were defined. Summarizing a national study of Vietnam veterans, Hyer (1994) cited point prevalence estimates of 13% to 17.4%. The American Psychiatric Association (1994, p. 426) estimates 1% to 14% of all persons experience clinically significant symptoms of PTSD some time during their lives. And finally, studies of complicated grief, in which the bereaved struggle with traumatic distress in the wake of profound loss, place its incidence at 10% to 20% (Neimeyer, Prigerson & Davies, 2002). Despite the variability in incidence within these studies and across various populations, it is clear that exposure to traumatizing events is all too common even in technologically-advanced western societies, and it is probable that such experiences are still more prevalent in societies that are undergoing civil turbulence, where natural catastrophes are more frequent and uncontrolled, and where widespread disease is unchecked by the availability of modern medical services and public health programs.

Normative and Idiopathic Perspectives of Trauma

When response to a traumatic event is marked by posttraumatic stress disorder, three primary symptom clusters characterize the survivor's adjustment. The first involves persistent reexperiencing of the traumatic event through dreams, intrusive recollections, or behaving as if the traumatic event were recurring. The second symptom cluster involves the avoidance of stimuli associated with the trauma. This may entail a general numbing of responsiveness as well as detachment from others. The third cluster of symptoms includes sleep and concentration difficulties, hypervigilance, impulsiveness, and heightened physiological reactivity (American Psychiatric Association, 1994, pp. 424–426).

Until recently, the development of normatively-defined PTSD was considered to be related to the objective significance of the experienced event. Thus, earlier editions of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1987, p. 247) stipulated that the traumatizing event was "outside the range of human experience and … would be markedly distressing to almost anyone." In the current revision of the DSM, a wider range of distressing events and experiences have been recognized as phenomena that potentially could result in PTSD symptoms. The framers of the current DSM also have emphasized the subjective effects of the trauma on the person. As a result, "trauma" is defined largely in terms of its impact on the survivor, rather than by features intrinsic to the instigating event itself. Nonetheless, the emphasis is on responses of the survivor that presumably follow directly from the traumatizing event.

Anchoring the basis of a psychological reaction primarily in the actual event experienced by the individual obscures what the person of the victim brings to the traumatic event as an active meaning-making participant. Such an exclusively realist and objectivist emphasis does not reflect the person's "premorbid" personality, life experiences, and core ways of construing people, things, and events in life. Hyer's (1994) case formulation model has expanded the definition of trauma beyond classes or categories of events themselves. In his specification, the lifestyle or essence of the person is a function of core ordering processes (schemata) used to organize the world. Lifestyle also stems from personality traits, beliefs, and symptoms. Hyer (1994) maintains that trauma disrupts integrated functions of both the personality and core ordering processes such that the person becomes influenced by the "overwhelming pull of symptoms" (p. 12).

Sewell (1996) and Sewell, Cromwell, Farrell-Higgins, and Palmer (1996) have developed a constructivist model of trauma focusing on how the victim defines his or her experiences. Sewell (1996, 1997) maintains, consistent with personal construct theory (Kelly, 1955), that individuals make meaning of events by processing them in the context of phenomena previously experienced. As novel experiences are encountered, overarching constructs are created to relate these experiences to the existing construct system. In this way the individual's meaning system is extended and elaborated as new experiences are encountered and then construed.

Sewell (1996) has demonstrated empirically that traumatic events preclude such elaborative processing which is at the core of meaning-making. The traumatic event remains as an isolated and unprocessed collection of fragmented memories. Unelaborated traumatic experiences have the effect of biasing the anticipation of future events in an extremely enduring and polarized way. For any new experience that may possess minor threat, the construct system of the victim predicts the occurrence of the full traumatic experience. By failing to elaboratively process the trauma, the person's core identity structures become

compromised. This, in turn, leads to the symptoms of depression, anxiety, depersonalization, and dissociation that were discussed above.

From Sewell's constructivist perspective, therefore, a traumatic experience could be anything that results in the aforementioned type of polarized and fragmented construing. This perspective acknowledges the very individualized nature of both the traumatic experience as well as the person's attempt to cope with it.

The Narrative Nature of Existence

Sewell's constructivist account of trauma resonates with narrative descriptions of life experiences. Emplotment, the activity and operation of a narrative, organizes the events and experiences of life into a coherent, ever-evolving life story (Polkinghorne, 1991; Terrell & Lyddon, 1995; Vogel, 1994). These stories help a person to understand and respond adaptively to the occurrences and events of life. Some regard narrative to be the basic way in which life experiences are organized meaningfully over time (Atkinson, 1995; Bruner, 1986; Mair, 1988, 1989; Polkinghorne, 1988, 1991; Russell & Van den Broek, 1992; Sarbin, 1986; Terrell & Lyddon, 1995; Wigren, 1994). Sarbin (1986) asserts that events in the world, or historical acts, are understood in the context in which they occur. This process of contextualizing historical acts in an ongoing way comprises a narrative. Such narrative, Sarbin maintains, is a root metaphor for psychology. The possibilities of the narrative metaphor have inspired numerous researchers.

Narrative conceptualizations of psychological processes provide more than apt analogies or intriguing clinical heuristics. Empirical research in domains that are central to self-definition (autobiographical memory and language use) have supported the hypothesis that human meaning systems are organized in narrative terms. Concerning autobiographical memories, there is evidence of narrative structure in both memory patterns themselves, and in the ways autobiographical episodes are recalled (Barclay, 1996; Howe & Courage, 1997; Rubin, 1998; Russell & Van den Broek, 1992). Regarding the former, Linton (1986) and Barsalou (1988) have observed that, as similar events are repeated over time, they become stored in large scale structures in memory known as "event structures" or "extendures." These fundamental units tend to integrate thematically-related material over time and could underlie the narrative structure of the human memory (Robinson & Swanson, 1990).

Language also plays a critical role in the way meaning is attached to the self and to one's lived experiences (de Shazer, 1994; Shotter & Gergen, 1989). The person's particular "languaging" of a narrative can indicate the ways that she or he relates to it. For instance, the use of the first person "I" in narratives suggests both more vivid autobiographical memories and a greater level of agency or involvement (Rubin, 1998). Conversely, the predominant use of the second person "me" in the narrative might convey a more passive or observational

involvement. The use of different verb tenses in a narrative also can reveal the person's temporal relationship to a particular experience or role (Pillener, Desrochers, & Erbanks, 1997). Finally, the use of imagistically rich and detailed language in establishing the setting of a story and the motives of its central characters enhances its fictional plausibility, while also opening the narrative to new and different tellings (Neimeyer, 2000). Thus, appreciation of narratives as organizing schemes implies a need to understand their style, as well as their structure.

Narrative Conceptualizations of Problems in Living

While there have been some attempts to characterize life problems as stemming from "broken," "decomposed," or "gapped" narratives (see Neimeyer & Stewart, 1998, for a brief review), an adequate taxonomy of life problems from a storied perspective has yet to emerge. Although a more elaborate scheme for understanding narrative "breakdown" could take many forms, we believe that a clinically useful taxonomy, minimally, should focus on the following: (1) the person's role or self-characterization in the story; (2) the extent to which the person is able to emplot lived experiences adequately in terms of organizing life themes; (3) the entry and exit of significant characters, settings, or themes; (4) the explicit or implicit goals towards, or away from, which the emplotted events move; and (5) the person's sense of authorship over the resulting narrative.

Numerous "narrative diagnoses" could be framed along these dimensions. For example, a client's immersion in a new geographic setting, or the appearance of significant new characters in his or her emotional life, may temporarily challenge the client's ability to incorporate them meaningfully into an existing narrative, and force modification of a once familiar "story line" for life. Some clients may have little sense of authorship of their lives, and instead feel compelled to live out a dominant (and sometimes oppressive) narrative "written" by others in their family or culture (Monk, Crockett, Winslade, & Epston, 1996). Still other clients may grieve the loss of principal persons, places, projects, or even parts of the self, necessitating a profound revision of a once meaningful life script, which must now be reauthored along different thematic lines (Neimeyer, 1998, 2001).

Narrative Conceptualizations of Trauma

Several constructivist clinicians have begun to work toward a narrative conceptualization of traumatizing life events (Neimeyer & Stewart, 1998). Almost by definition, traumatic experiences fragment a client's narrative structure for organizing and anticipating life events, while presenting the survivor with urgent experiences that resist integration into his or her pre-established meaning system (Neimeyer, 2004). Perhaps even more dramatically, such events

as being sexually assaulted, witnessing the murder of a loved one, surviving a combat "fire fight," or watching one's home and family be washed away by a flash flood, can disrupt the consolidation of the sensory and autobiographical memory processes that comprise narratives (McNally, Litz, Prassas, Shin, & Weathers, 1994; Siegel, 1995). That is, the sights, sounds, smells, and sensation experienced during the event, along with the person's felt experiences of fear, horror, or shock, are often "bundled together" and become the trauma memory.

Because these memories were encoded in an intense, unelaborated, and primitive form, they resist assimilation into one's ordinary declarative memory, which is implicated in the construction of narrative (van der Kolk & van der Hart, 1991). Such traumatic memories may be so poignant and isolated that they give rise to a "traumatized self," which is unrelated to the survivor's previous sense of identity, but which can itself provide the person with an identity as a "victim," "refugee," "widow," "crash survivor," and so forth (Neimeyer & Stewart, 1998). In severe cases of combat trauma, for example, this role constriction can take the form of nearly exclusive self-characterization as someone with PTSD, a role that carries fixed implications of being irreparably damaged and alienated from mainstream society (Klion & Pfenninger, 1996). Although preemptive identification with this constricted role may have had understandable survival value at an earlier point, inflexible identification with the traumatized self can set in motion a vicious circle of social validation for this reduced script, as others avoid or marginalize the survivor.

As an essential part of the person, the traumatic self constrains the other possible selves. That is, as long as the traumatic self exists in its original, unelaborated form, the cognitive, perceptual, and emotional processes invoked during its creation will place limits on the psychological resources that are available for maintaining and enhancing the premorbid selves (Klion & Pfenninger, 1996). The narrative, meaning-making processes of the former selves become more like those of the traumatic self. The subjective experiences of such a constrained and fragmented existence may give rise to the often-repeated lamentations that "I am not the person that I once was" or that "I lost part of my self that day and I haven't been the same since."

Psychotherapy

This conceptualization stresses two issues that should be considered in providing psychotherapeutic interventions for trauma victims. First, the conceptualization places primacy upon the victim's selfhood and how basic psychological processes of the person may be temporarily or permanently altered by the traumatic experience. During and after the traumatic experience, a person's "symphony of selves" becomes discordant and incoherent with the introduction of the traumatic role and self. Therapeutic interventions should be responsive to

the fundamental challenge to the "psychological embodiment" of the person following traumatization.

A second and related implication of the above conceptualization is that psychotherapy with the traumatized person involves not only diagnosing the way the person's primary narrative is incomplete or damaged, but also finding ways to join the traumatic self and associated narrative with the pre-existing selves and primary narrative. That is, psychotherapy involves weaving the traumatic self and premorbid selves together in the present, in a way that fosters not only the retelling of the past, but also the performance of a new narrative in the future (Neimeyer & Arvey, 2004).

The narrative conceptualization of trauma presented above can inform many types of interventions for the treatment of trauma. In considering the diversity of available approaches, it may be helpful to remember that many different therapeutic interventions can affect the narratives people construct. In this way, narratives are treated as objects of psychotherapeutic intervention. For example, in the early stages of treatment, therapists can assist trauma survivors in managing acute symptomatology through anger management training, or graded task assignments, to overcome tendencies toward social isolation (Sewell, 1997). Viewing these cognitive-behavioral interventions through the lens of narrative theory, the therapist can then ask, "What does this say about you that you were able to take control of a previously uncontrollable rage, or face the fears that were holding you hostage in your home?" "As you continue to move forward in this self-assertive direction, what does this imply about the form your life might take a year from now? Five years from now?" Such questions can help consolidate concrete progress made using techniques arising in other perspectives, by assisting survivors to integrate the gains not only into their repertory of coping skills, but also into their expanded narrative of self.

As a psychotherapeutic method, a number of narrative or constructivist techniques can have more general therapeutic effects than just narrative repair or reconstruction. We will briefly discuss a few of these narrative methods, and then selectively exemplify their use in actual cases of trauma therapy.

Regarding general approaches to treatment, a consensus is emerging that psychotherapy of PTSD may be both multimodal and multiphasic (Hyer, 1994). During the active phases of treatment, psychotherapy optimally occurs on at least two general levels (Stewart, 1995). The first level involves intense emotional exploration of the sequence of traumatic events and of their impact on the victim's life. In many respects work at this level involves the exploration and expression of the victim's traumatic self. The second tier of treatment involves more reflective and integrative work. Here, the person may move in and out of his or her experience of the trauma to weave together the traumatic self identity with other identities. The activity of experiencing and subsequent reflecting is particularly consistent with Guidano's (1995) "movieola technique," in which the therapist slowly pans the "camera" of therapeutic attention over the scene of the

traumatizing event, in order to help the client first articulate, and then attribute meaning to the experience. Narrative therapy techniques and therapeutic work on narratives may be focused on either or both of these levels.

Constructivist practitioners have developed several specific narrative approaches to psychotherapy and to the treatment of trauma. Stewart (1995), for example, helps combat trauma victims deconstruct their traumatic memories and develop a more integrated set of selves through the construction of character sketches, values clarification exercises, and drawings that have as their goal the development of consistency across situations. She further helps victims develop a sense of continuity across their lifespans through the completion of an autobiographical repertory grid, lifegraphs, and construction of autobiographies. Similarly, Neimeyer (1995) believes a client's narrative activity in psychotherapy (such as storytelling and/or journal writing) serves the vital intrapersonal function of helping establish a continuity in his or her lived experience. Such narrative techniques as loss characterizations, meaning reconstruction interviews, metaphoric stories, and memory books can be especially relevant to the task of assimilating loss, effectively reauthoring a story of self and others that has greater wholeness and perspective (Neimeyer, 1998). The use of such techniques can help trauma victims understand themselves in ways that are more integrated, flexible, and self-aware, with a greater sense of control over their life experiences.

A hallmark of constructivist narrative interventions concerns their emphasis not only upon ameliorative goals (such as the reduction of symptoms) and restorative goals (for example, the return to premorbid functioning), but also upon elaborative goals (such as the construction of new, possible selves) (Harter & Neimeyer, 1995). Attention to the traumatic past is supplemented with helping the individual develop beyond the point at which the trauma was encountered. This emphasis is also evident in Sewell (1996) and Sewell *et al.* (1996) in describing how growth of the combat victims beyond the trauma is accomplished by having the victims actively and elaboratively process their traumatic memories along with memories of other events (and selves) that did not involve this trauma. Such outcomes are consistent with a growing body of evidence that post-trauma adaptation can promote greater maturity, empathy, and spiritual or philosophic development in a substantial minority of people whose lives have been shaken by profound losses of many kinds (Tedeschi & Calhoun, 2004).

Many of the aforementioned narrative techniques share a common change ingredient. First, by writing, drawing, explaining, or comparing life events, narrative techniques induce more extensive cognitive processing (memory recall and attention) of these phenomena. Second, once such a processing focus is established for disparate experiences that previously were unbound by a common narrative, then the interrelationships, commonalities, and discrepancies of the experiences may be incorporated into new, overarching narratives. Narrative therapeutic techniques foment the processing of experiences at multiple levels

so that meaningful relationships are created where no relationships, or less meaningful ones, existed previously.

In summary, constructivist and narrative theorists are beginning to offer a novel set of concepts and procedures that hold promise for shedding new light on the experience of trauma and its aftermath. Several of these emphases are illustrated in the case studies below.

Case Study One: How Did This Happen, and Who are We Now?

Barry F. was a forty-eight-year-old teacher, who contacted one of the authors (RAN) for therapy at the advice of a friend.[1] He described his concern about the adjustment of his fifteen-year-old stepson, Matt, following a "crisis in the family," and asked if I could see him in therapy "just to assess the situation." When I asked that the whole family accompany him to this first session, Barry was audibly silent, then noted tersely that the family consisted only of himself and his son, and that he would gladly accompany him to the meeting. Sensing that there was much more in this response that deserved to be unpacked in session, I established a time for them to come in for an initial consultation.

When we met, the unspoken words behind his laconic telephone response were quick to emerge in the form of a controlled account of a traumatic event that unfolded in their home only six weeks before. As his stepson sat silent, staring at the floor, Barry related how, coming home early and unannounced from work, he heard his wife, Lisa call their four-year old daughter, Valerie, back to the bedroom. Suddenly, as Barry walked to the refrigerator for a beer, two gunshots rang out from the back of the house, and Barry froze for a moment, unable to comprehend what was happening. The subsequent minutes were a blur of horror for him: his running back to the bedroom which was filled with the smell of gunpowder; seeing the crumpled body of this little girl on the floor, her blood seeping out into the gray carpet; his fiercely turning on his wife, only to be knocked back against the wall by a gunshot to his chest; his stepson's entering the room as he staggered forward again, the two of them finally wresting the gun from the wife's grasp; and his wife's collapsing to the floor and dying, the second shot before he entered the room having been to her own chest. The last thing he remembered before losing consciousness was their somehow getting him and his daughter into the car, as Matt drove them to the emergency room. He awoke seven hours later, having survived surgery, to learn that two of his family members were dead, and the third was in police custody under suspicion of murder.

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1.   Identifying information has been altered to preserve the client's anonymity.

Needless to say, the murder/suicide decimated not only Barry's family, but also his assumptive world. Although he acknowledged his marital tensions with Lisa and her increasingly "paranoid" behavior in the months preceding the deaths, he had continued to believe that things would somehow work out, and that "God would take care of things." The killings cruelly cut these threads of consistency in an otherwise stormy life and relationship, and left him and Matt alternating between posttraumatic numbness and aching, avoidance, and flashback to the terrible event. As the tale unfolded, Barry's tears were met by Matt's apparent stoicism, although both acknowledged struggling desperately with the question of "why" this had happened to them, and how they could move ahead with lives that seemed to have ended with those of Lisa and Valerie.

At this early point in therapy, my role was that of a respectful and deeply concerned listener, an audience to a tale of terror too traumatic to share except in sharply abridged form to anyone else. Thus, rather than attempting to "package" the account or move quickly toward a forced resolution or solution to their anguish, I helped them "unpack" the setting of the story further, going over it in slow motion detail, each augmenting the other's perceptions with his own. Using this "movieola" method (Guidano, 1995) in the fourth session, we soon began to encounter vivid sensory images that had been edited out of their earlier tellings. Two in particular stood out to Barry: the impassivity of his wife's expression as she leveled the gun at his chest and pulled the trigger, and the feral mask of rage that twisted her visage moments later as her son ran into the room to assist his stepfather. Shifting from setting to theme, we then wondered together about the possible meaning of these two contrasting images. Barry shivered, and ventured an interpretation: Lisa had planned coldly to kill her daughter (and Barry, too, as the opportunity arose) to punish him for his alleged "sexual abuse" of her, and became enraged when confronted with the son who failed to support her view of his father's culpability. With this painful but plausible plot structure forming the skeleton of a new, if agonizing narrative of the family's history, we began to weave a more coherent account of Lisa's motives, and what her "meltdown" meant for each of the survivors.

As this provisional explanation crystallized for Barry, he began to feel his way through the torn fabric of his life for those strands of meaning and identity that remained viable (such as his relationship to his adolescent stepson), and those that were no longer sustainable (such as his career as a teacher, which daily confronted him with the painful reminders in his young students of the daughter he no longer had). Guilt, understood as dislodgment from his core identity constructs associated with being a husband and father (Kelly, 1955), emerged as a predominant issue, as Barry attacked himself for having "turned a blind eye" to his wife's escalating anger and accusations, rather than press the two of them to "get help" for the family. A thematic focus on his insufficiency as a partner opened old wounds from previous failed marriages, in which Barry enacted the script of a kind of fairy tale gone wrong — romantically falling in love at first

sight, only to have his seemingly childlike trust in his spouse degenerate into controlling suspicion of her infidelity. As we examined this procrustean narrative pattern, Barry began to link the reenactment of this script with Lisa to the cycle of sexual estrangement in the marriage that planted the seeds of her distrust about his sexual involvement with their daughter, an involvement that he and Valerie continued to deny. The tearful exploration of his role in the tragic drama of Lisa's final months prompted several individual sessions, in which he reflected on who he had been, and who he wanted to be, as a man, a parent, and (perhaps) a husband.

Not surprisingly, the gradual reconstruction of a life story took a different form for Matt, who struggled initially to bridge his view of the mother who had always "been there for him" with the image of the woman who had seemed bent on taking the lives of everyone in the family. His "solution" was to construct two different "mothers," one before, and one after the "mental illness" that he blamed for her murderous actions. Likewise, he tended to compartmentalize the story of the trauma, and instead elaborate other subplots in his life, especially those concerned with his friends and girlfriend. The most useful therapeutic moments for Matt came in joint sessions with his stepfather, as they renegotiated their respective roles in relation to each other, in a way that gave each the support he wanted from the other. Although the discussion and facilitation of their connection was often poignant for both, it also was frequently practical, as they jointly "rewrote the script" of mundane household scenarios (such as preparing dinner together) in light of their loss.

In summary, Barry and Matt's case illustrates mainly the heuristic use of narrative as a metaphor for the rebuilding of lives shattered by trauma, a metaphor that sensitized us to their shared and separate struggle to make sense of not only the trauma itself, but also the larger life stories in which it was embedded. In this work, their stories were often also the object of our attention, and therapy consisted of gentle encouragement to explore the gap between their account of their experience and the horrific elements of plot and motive it struggled to contain. Occasional use of explicit narrative methods (for example, the movieola technique) advanced this "effort after meaning," although the stories that took shape provided no simple reassurance that their lives or selves would ever again be the same. Ultimately, however, both father and son were able to allow the image of their shared trauma to recede, at least occasionally, permitting them jointly, and individually, to reflect on the possible futures that remained open for them both.

Case Study Two: Where Does this Fit?

Mark W. was a forty-two-year-old man referred to therapy with one of the authors (RAN) by a regional managed care organization for the treatment of a cluster of personal, occupational, and relational problems, following a violent

and traumatic assault he had suffered approximately one year earlier.[2] At the time of the attack, he was working with a state utility company repairing electrical lines, a job he had held successfully for fourteen years. While making a residential call, he was approached by four young men who demanded his wallet, and when he reached into his pocket, pistol whipped him to the ground and proceeded to beat him savagely until he lost consciousness. As a result of the assault he suffered extensive damage to his abdomen and, especially, to his head, requiring a total of seven facial and dental reconstructive surgeries to restore a normal appearance.

In his own terms, Mark reported feeling "just confused" by his post-assault adjustment. He noted that he was "pissed off all the time," particularly feeling an urge to "want to hurt people who harass others." This sense of barely suppressed rage at interpersonal situations that he viewed as involving victimization had become a primary concern, both of Mark himself and of those involved with his treatment. The significance of this issue was underscored by his report of an incident in which he "blanked out" and physically accosted a belligerent customer in a drugstore who he viewed as "attacking" an undeserving sales clerk. Despite his generally congenial and cooperative demeanor in therapy, Mark noted that he always felt "a fire burning inside" that only needed the kindling of an encounter with someone he viewed as a "predator" to leap into full blaze.

Although Mark's vivid anger and its potential for physical expression clearly commanded therapeutic attention, he also complained of a number of other symptoms that were consistent with the diagnosis of posttraumatic stress disorder that he had received during several weeks of inpatient psychiatric treatment following his medical stabilization. These included intrusive recollections of his assault, often accompanied by spontaneous crying and elevated anxiety, marked sleep disturbance, chronic physiological activation (which he described as "shaking inside"), and general avoidance of social situations. Mark also reported difficulty in concentrating on reading, television, and other activities for extended periods of time, in part because of intrusive "daydreams" regarding the assault and his fantasized revenge against his assailants. Psychological testing confirmed his difficulties with elevated anxiety and depression, and uncontrolled anger. It was not surprising, therefore, that Mark's already distant marriage had disintegrated into a formal separation under the further pressure of his immobilization and unpredictability, and that he had been placed on indefinite medical leave from his job out of concern not only for Mark, but also for those with whom he would come into contact.

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2.   Identifying information has been altered to preserve the client's anonymity.

History of treatment

Following his brief inpatient treatment, Mark was discharged to the care of a respected psychiatrist and psychologist, who followed him for several more months in outpatient treatment. Mark reported no real gains from the antidepressant medication he was prescribed from the physician, an impression that was corroborated in the psychiatrist's own treatment summary. Moreover, the cognitive behavioral strategies employed by Mark's psychotherapist (such as relaxation training, response prevention, and rational disputation of his self-defeating thoughts) had produced only transitory symptom relief. Thus, after nearly a year of marginal therapeutic progress, Mark was referred to me for more specialized outpatient treatment of his posttraumatic adjustment.

As Mark recounted his story in our first session, I was struck by his statement that "I don't know myself anymore; I feel like I'm losing my mind. It's like I've lost who I was." As I encouraged him to elaborate on this remark, he stated that "I don't know if I can get back to who I was, but I don't like what I am. It's like I can't remember the piece that has consumed me." This theme of disrupted identity and lost memory had apparently been neglected in previous therapy, which was more focused on symptom relief than on helping Mark reconstitute a viable new sense of self that accommodated the trauma while not being confined to it.

Jigsaw memories

As a first step toward an exploration rather than elimination of the trauma memories, I metaphorically described Mark's recollection of the assault in our second session as a "jigsaw puzzle from which some of the pieces seemed to be missing." He resonated to this image, saying he could recall isolated fragments of the attack and its aftermath, but "the whole picture didn't come together." This suggested a collaboratively designed homework assignment, which consisted of Mark's writing these fragmentary memories, sensory details, and so on, on separate index cards, and then adding new details as any came to mind. He was then to reconstitute a more coherent narrative of the attack sequence by arranging the cards in chronological order, concentrating on any gaps in an attempt to bridge the fragments in a plausible fashion. Because I anticipated that this reimmersion in the trauma would likely be distressing to him, we constructed a list of "time out" strategies he could use to "break the tension" associated with the task (among them, in his case, listening to classical music, and walking). Engagement in this metaphoric "solving" of the "jigsaw puzzle" of Mark's assault represented one means of exploring the sequence of traumatic events, as recommended in constructivist accounts of treatment (Hyer, 1994; Stewart, 1995).

Mark faithfully tackled the assignment, in spite of his self-consciousness about his writing — something he had done relatively little of since completing high school at age eighteen. He brought in the completed narrative the following

week, scrawled in red ink on a series of index cards. He began with, "Walking toward the pole with the transformer, noticed four men [here he crossed out "men" and substituted "things"] under streetlight. …" The remainder of his unedited prose appears below.

> When I got to pole they came running toward me spread out where I couldn't run. They came up to me and put a 9 mm Ruger Automatic to my head. Said what you got raised my hands said take it. When they got what they wanted they hit me in the head with the gun and I went to the ground. He said you motherfucker before he hit me on the ground. Remember flashes of bright light it was so bright I couldn't see anything. All these guys were kicking me in the head. But one in particular was running back and jumping on my face. I remember feeling intense rage mostly at the one jumping on me. I was thinking how I could hurt him easy if I could get up. I decided it would be worth getting shot just to get one good shot to his nose with the palm of my hand with an upward thrust. I decide was going to do this no matter what but every time I raised up I would get knocked back to the ground. I tried many times to do this, I would guess, 20 times.

In discussing his construction of this account in our subsequent session, Mark noted that he "remembered things I couldn't before," as new recollections "came to me every day" he worked on the narrative. In particular, he became aware of a number of sensory details of the attack, as well as his efforts to resist his assailants. For example, he described how he "just remembered the heel of the cowboy boot [worn by his most vicious assailant] coming down. The heel is very vivid. … I'll never forget it as long as I live." The only feeling he could recall during the attack was rage, though he acknowledged, "I should have been scared."

As we considered together the fragmentation of memories associated with the trauma, we gradually broadened the discussion to include his continuing sense of fragmentation in his life. Mark connected this with his subsequent disruption of interpersonal relationships, and recognized that his tendency to "hole up inside himself" was in fact an old, familiar pattern, anchored in childhood events that flashed vividly to mind. This sort of "serial accessing" of "emotional truths" can unfold rapidly in response to a therapy that examines the client's disowned "need" to maintain the symptom (in this case, his seclusiveness), despite the pain associated with it (Ecker & Hulley, 1996). This suggested that an exploration of his broader life narrative, beyond the assault per se, would be an important aspect of his therapy.

Biographical Grid

Although Mark acknowledged that "rehashing and figuring out the incident with somebody else almost made him feel good," it was clear that more than a reconstruction of the trauma event itself was necessary to give Mark a greater sense of wholeness and meaning. I therefore introduced a second strategy, the Biographical Grid (Neimeyer, 1985), as a means of both assessing and focusing therapeutic attention on the broader life narrative of which the trauma episode was part.

As a variant of repertory grid technique (Kelly, 1955; Neimeyer, 1993), the administration of the Biographical Grid includes three distinct steps: (1) identification of significant life events or stages; (2) elicitation of life themes or personal meanings; and (3) weaving events through with themes. Here, we will briefly summarize its use with Mark, deferring to other publications for a more detailed exposition of the procedure and its interpretation (Neimeyer & Stewart, 1998).

As a first step in the procedure, I discussed with Mark particular autobiographical memories that anchored his sense of self at various points in the life trajectory. I began my inquiry with the question, "From your early childhood, what events stand out for you in shaping your identity in important ways, or representing who you were at that time?" Mark immediately responded by recounting a vicarious trauma that occurred when he was seven years old, in which his father was nearly electrocuted in an industrial accident. As a result of this injury, his father was removed to a medical facility in a distant city for nine months, accompanied by his mother. Mark wept as he recalled this experience of being functionally "orphaned," left in the custody of a little-known aunt and uncle. Other significant anchor points for his construction of self included his participation in Little League baseball, a proud early childhood experience when he independently rode his tricycle home from the neighborhood swimming pool to the chagrin of his worried parents, and the persistent abuse by bullies during his high school years, which Mark finally overcame by positioning himself as a "crazy" and unpredictable "loner" who would "go down swinging." Finally, as we moved into Mark's adult life, he nominated still other episodic memories that included the "proud moment" at age twenty-six when his son was born, the attack that precipitated his treatment, and (at my prompting) a present self, future self, and ideal self that conveyed who he now was and might yet become.

As a second step in the Biographical Grid procedure, we sought to tease out the themes that Mark used to organize the important events of his life narrative. This involved my asking him to systematically compare and contrast the self-defining moments elicited earlier, describing ways that they were alike and different. For example, presented with images of himself at the time his father was injured, when his son was born, and his ideal self, Mark distinguished the latter two elements, which he associated with "liking himself," from the former,

which he associated with "hating himself."[3] In response to other comparisons, he discriminated between the Little League years and high school, on the one hand, and his assault at age forty-one, on the other, because at the first two points in time, he was "able to keep what was his," whereas during the attack, he was "violated." Likewise, he differentiated his present and future self, which he associated with "a fire always there," from his self-image while in Little League when he was "able to reason." Thus, in the span of a single session, we were able to evoke a number of emotionally resonant themes that defined both his senses of continuity and discontinuity over time.

Although a picture of the significant shifts and continuities in the respondent's life experience begins to emerge in the above two steps, the third step in the Biographical Grid procedure explicitly invites the person to weave autobiographical memories through with interpretive constructs. This may be done qualitatively in the course of the interview (for example, by asking, "In which of these other times did you experience yourself as violated?"), although it can also be done in more precise, quantitative form, in keeping with repertory grid methods in general (Fransella & Bannister, 1977; Fromm, 2004). Several features of Mark's responses were of clinical interest. First, it became clear that his narrative was organized into two diametrically-opposed clusters of self-images, one of which contained his positively-valenced self elements — on the tricycle, when playing baseball, when his son was born, and even in high school, when he successfully struck back at his persistent bullies until they "steered clear of him." This tight grouping of self-identities closely approximated his ideal, and was woven through with constructs implying control, ability to reason, liking himself and others, happiness, and keeping what was his. In sharp contrast, both his current, posttraumatic self and his projected future self were tightly linked, recapitulating in virtually every detail the themes he associated with his experience at age seven in the aftermath of his father's injury. Now, as then, Mark viewed himself as hating others as well as himself, as having lost control, and as disgusted, sad, and violated. Moreover, all three identities were linked to his experiencing a "fire inside," as well as with anger and chaos. No life events bridged or articulated these two opposing clusters of situated self identities, suggesting an instability in self image associated with vulnerability to depression and other forms of distress.

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3. This same "triadic sort" method of construct elicitation has been used and documented for other forms of grid technique, as discussed by Fransella and Bannister (1977), Fromm (2004) and others. Although I employed this procedure in the more intimate context of a clinical interview, a host of computer-based grid elicitation and analysis programs could also be employed with the Biographical Grid procedure (Bringmann, 1992; Sewell, Adams-Webber, Mitterer, & Cromwell, 1992).

In summary, the Biographical Grid suggested that Mark had assimilated the experience of his recent assault into the meaning structure associated with an earlier trauma in his life, namely, the multiple losses tied to his father's injury. Both left him contemptuous of self and others, both triggered a smoldering rage and impotence associated with a sense of violation. But in neither case could he find ways to accommodate these traumatic selves into the larger texture of his primary narrative, leaving him isolated in a regressive identity that was radically discontinuous with his pretraumatic self. The result was a life story that was painfully incoherent, with no clear way of integrating his experience of loss into the preexisting structure of his life. While speculative, it is tempting to conjecture that the isolation of his previous traumatic identity in the text of his life posed a vulnerability factor for his later development of PTSD in response to the assault, providing a ready-made but fragmentary template within which to give meaning to his subsequent attack.

Discussion of these patterns with Mark in the next session was powerful, for him as well as for me. For example, when I asked him to reflect on the striking parallel between his construction of his life at age seven and following his attack, he replied, "I never thought about it, but it makes good sense. It's a real eye-opener. It's like I'm at the same place in life as when I was in first grade. Hmm. … I never put that together before." Likewise, asked to consider the polarization of his situated identities into two non-overlapping groupings, Mark responded, "I often thought that there was no in-between, life was either good or it sucks. I kind of always thought this way, even before the attack happened. It just came to me now, I don't think I ever realized it. I just thought everyone was that way."

The results of Mark's Biographical Grid were instructive in identifying Mark's resources as well as his liabilities. This was illustrated by his response to my question concerning "what strengths he had at age seven that let him re-engage the world at age nine." Mark hesitated for a moment, and then noted that he "just made myself do it," because he "was going downhill and had nothing to lose." He went on to observe that he was "procrastinating now, avoiding people because I was so uncomfortable with them." We further considered the facilitative role of organized baseball in "drawing him out of himself" and giving him a safe way of "reconnecting with others." Indeed, it was the upward life trajectory established by his Little League and Pony League years that buoyed him into his more turbulent late adolescence, and gave him the conviction that he could resist, rather than submit to the bullying of his high school peers.

My remaining nine sessions of therapy with Mark first explored, then enacted, and finally consolidated the potential for reconstruction suggested by our discussion of the Biographical Grid. Mark surprised me in the fifth session by proudly announcing his stiffness from having played a "pick-up game of baseball" in his neighborhood, his first in over fifteen years. With genuine astonishment and excitement, I validated the powerfully symbolic importance of this "unique

outcome," which represented an enacted form of resistance against the oppressive influence of the "dominant narrative" of his identity as a trauma victim (White & Epston, 1990). By session eight Mark had begun to envision an alternative future, one predicated on his gaining additional training in mechanics at the community college level. This ability to orient toward a possible future that was different than the traumatic past was itself a remarkable achievement, one that he followed with concrete exploration of job retraining as an alternative to accepting long-term psychiatric disability. Naturally, the road to reconstruction of his primary sense of self was not an unswerving one, and he occasionally reported "getting sidetracked" by traffic confrontations, abrasive interactions with his in-laws in the course of his divorce, and other events that once again cued up his urge to retaliate against the "attacks" of others. Gradually, however, we were able to identify self-monitoring strategies that enabled him to "enter" and "leave" this traumatic self identity more easily, although this required considerable fortitude for him to develop.

How can we understand Mark's experience of "rebiographing" (Howard, 1991) in the context of psychotherapy? At the most general level, he appeared to have restored his elaborative meaning making about the events surrounding his victimization, literally and figuratively rewriting a coherent story of the assault that encompassed his previously fragmentary recollections of it. As he did so, and subsequently reinstated this powerful but isolated sequence in the script of his life, he was better able to move from it to more empowering self-identities that engaged the world and other people less stereotypically and more adaptively.

At another level, he seemed to have recovered the threads of his more optimistic primary narrative, the one that was instantiated in his earliest childhood, his baseball years, and his young adulthood. In other respects, however, his reconstructed identity did not simply recapitulate the thematic structure of these simpler times. Indeed, for some weeks he grieved the "loss of innocence about life" that he associated with them. He felt partially compensated for this loss, however, by his enlarged capacity to "be empathic with others who are hurting or crazy," and by his greater ability "to deal with anger openly, rather than passively, the way he used to."

In summary, Mark's case illustrates the use of several explicit narrative methods (for example, jigsaw memories and the Biographical Grid), while also adopting narrative as a conceptual framework for therapy. By first immersing himself in the fragmented story of his assault and working toward a more adequate account of the experience, Mark began to scaffold the trauma in thematic, as well as sensory terms. This thematic exploration was considerably extended by our elicitation of significant self-defining moments from his biography, whose careful discussion permitted us to glimpse the ways in which his response to the attack had recapitulated his response to earlier adversities in his life. Likewise, these narrative methods prompted him to recognize and reengage his own strengths in response to these events, allowing Mark to move beyond

posttraumatic stress, to posttraumatic growth (Tedeschi, Park, & Calhoun, 1998).

Conclusion

Obviously, the broad range of constructivist psychotherapies (Mahoney, 1995; Neimeyer & Bridges, 2003; Neimeyer & Mahoney, 1995, Neimeyer & Raskin, 2000) is too rich in theory to be conveyed in a discussion of a single disorder, and too multifaceted in practice to be illustrated in one or two brief case studies. But as a relatively new field of research and practice, the area of trauma and loss invites novel conceptualization, and we have tried to respond to this invitation by extending a constructivist account of posttraumatic stress and providing concrete examples of its application. In doing so, we are aware that the narrative model we have found compelling on a heuristic level is only beginning to be evaluated empirically, just as its concrete ramifications for the helping professions require further elaboration and refinement. We hope that the present chapter makes a modest contribution to this effort, and that the reader will join us in exploring the implications of constructivism for helping clients rework the sometimes fragmentary and entangled themes of their life narratives.

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