Integrating embodied narratives in narrative therapies for PTSD

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"…the body is not just a structure of limbs and organs, nor merely a realm of sensations and movements. It is also a historically formed body whose experiences have left their traces in its invisible dispositions." (Fuchs, 2012 p. 20)

Introduction

Narrative therapies are based on the idea that self-narratives function as an important tool for maintaining a healthy mental condition (Schechtman, 2007). However, there are different ways in which self-narratives affect people's lives. In chapter one, I explain that patients suffering from Posttraumatic Stress Disorder (PTSD) develop self-narratives that are 'too rigid' or 'too coherent' as a compensation for their mental fragility or fragmentation that resulted from their traumatic experiences (Janssen, 2014). During the traumatic event itself, the conscious and reflective function of the patient was shut down because of the high secretion of stress hormones, only sensorial and bodily functions were active. Traumatic events and flashbacks thereof are described as snapshots, smells, sounds, or sensations in the body. This severely attacked both the memory system and the body of the patient, which is one of the reasons for the fragile and fragmented state of the PTSD patient.

Over the past years, self-narrative therapies have been developed for treating patients suffering from PTSD that target rigid self-narratives (Jongedijk, 2014). These therapies aim to change rigid self-narratives by integrating positive memories into the mainly negative memories that constitute the self-narrative (Neuner et al., 2004). In other words, therapist and patient re-reflect on the self-narrative. These narrative therapies seem to be a good treatment for treating PTSD symptoms. However, the treatment is conditionally recommended because the treatment outcomes are not as effective as other therapies for treating PTSD (American Psychiatric Association, 2017).

Completely discarding narrative therapies would be inconsiderate. There might be aspects of the therapy that are not working properly and that could be adjusted. In chapter two, I use the model explaining hyperreflexivity in psychopathology and apply that to explain the symptomatology of PTSD. The hyperreflexivity model (Fuchs, 2011) explains that patients suffering from anxiety, mood- and sleep disorders, hyper reflect on their lives. In these cases, a shift is observed from the experience of 'being a body' to 'having a body'. This shift means that the body fails to be a medium and becomes a hurdle for the patient. The patient overcompensates by 'explicating the implicit' and this results in increased self-observation, pre-planning of actions, which results in a vicious circle that maintains the state of 'having a body'.

By using the hyperreflexivity model (Fuchs, 2011) I argue that the lack of efficacy of narrative therapies may be due to the fact that they do not consider this fundamental shift between states of embodiment. Because PTSD patients already tend to hyper reflect on their self-narrative and this stimulates the state of 'having body', I argue that re-reflection is the wrong approach to decrease rigidity in self-narratives of PTSD patients.

In order to make narrative therapies more effective, in chapter three, I propose an adjustment of the concept of the self-narrative that considers the 'having body' state of PTSD's patients. Traditional accounts of self-narratives explain the self within the self-narrative purely psychologically (Schechtman, 2007). In recent years it has been argued that the body plays an important role in a person's self-narrative, and that the standard concept of self-narrative needs to include conditions of embodiment (Menary 2008). Menary (2008) advocates for an embodied self-narrative and points out that an 'experiential self' is both the narrator of the self-narratives and the one that experiences.

Recently, another narrative concept was discussed in the literature, namely, the body narrative. Gallagher and Hutto (2017) distinguish body narratives from embodied narratives by stating that the former is not 'a story (...) generated *about* the body, but a story generated *by* the body'. In chapter one, I touched upon the issue of flashbacks that are non-verbal experiences. Therefore, the body narrative may be a concept to work apply in narrative therapies as well. However, the concept of a body narrative seems to be hard to defend. A body does not explicate a narrative in words and accepting the body narrative as a valid concept would lead to pan-narrativism (Gallagher & Hutto, 2017). However, in the case of flashbacks in PTSD, using this concept could be of value because it explains narrative structures without the initial need of verbalizing that structure. Even though I will not defend that the body speaks of its own, I do think that the body narrative is a valuable concept for self-narrative therapies for PTSD.

In the fourth chapter, the function and application of body narratives and embodied narratives into therapeutic techniques will be discussed. Existing therapies such as play therapy and working with objects already emphasize the need of letting a bodily dialogue develop before it is verbally reflected upon by either the therapist or the patient (Rucinska & Reijmers, 2014). Psychomotor therapy also contains therapeutic techniques that are in line with the concept of embodied self-narratives. To target the PTSD patient's hyperreflection, these techniques should be integrated into current forms of narrative therapies. It will be concluded that working with a novel concept of a self-narrative that includes conditions of embodiment will lead to better results in narrative therapies for PTSD.

Chapter one: Self-narrative therapies for rigid self-narratives in PTSD patients

1.1 Overview

In this chapter, the prevalence, cause, and symptomatology of Posttraumatic Stress Disorder (PTSD) will be discussed by using the Diagnostic and statistical manual of mental disorders (DSM-V, American Psychological Association, 2013). I will briefly give my interpretation of the basic structures underlying the illness.

Narrative therapies are one way to treat PTSD. The rationale behind this therapy is based on the idea that a distorted self-narrative is an important maintenance factor of PTSD. Adherents of narrative therapies argue that by restructuring the self-narrative, PTSD will be dissolved on a fundamental level, since the restructuring of the self-narrative also affects the identity or person behind this narrative. Even though these narrative models may seem logical in application to PTSD, I will argue that the physical nature of the traumatic experience and the way in which the symptoms affect the body are underexposed. By using behavioral, neurological and epidemiological examples, it will become clear that PTSD patients experience much more physical problems during the trauma and in the aftermath of trauma than acknowledged by literature of adherents of narrative therapies.

The chapter will be concluded with the statement of a problem that results from the narrative therapies that are based on a mental model of self and the physical nature and the effects of trauma that contradict this rationale. By approaching narrative therapies from a different angle, their rationale could be revised, and the resulting therapies should be more effective for the treatment of PTSD.

1.2 Posttraumatic Stress Disorder: development and symptoms

Posttraumatic Stress Disorder may develop after the experience of a trauma. PTSD has a life-time prevalence of 6.8% - 7.8% in the US population. The nature and amount of trauma required for the development of PTSD varies widely, as does the severity of the symptoms. A single, non-interpersonal trauma (a natural disaster for example) can cause PTSD in 20% of patients. In repeated, interpersonal trauma such as childhood abuse the chance is 48,5% (Kessler et al., 1995). Refugees in South-Sudan who have been exposed to torture and war almost all developed PTSD (Neuner et al., 2004). This indicates a clear dose-effect, meaning that regardless of genetical structure and social emotional development, after a certain amount of trauma, everyone develops PTSD.

A strict description of a traumatic event is given in the Diagnostic and Statistical Manual (DSM-V, American Psychiatric Association, 2013). Trauma is described as an event in which the patient is exposed to actual or threatened death, serious injury or sexual violence. This means that it rules out emotional abuse, bullying (without the actual threat of death), or witnessing the natural death of a loved one (Friedman, 2013). These restrictions feel counterintuitive to some researchers and therapeutic practitioners (Brewin et al., 2009) who argue for a more flexible application of the A-criterion in clinical practice and the DSM-5. The categorization by the DSM, however, is based on statistical research and shows that most cases only develop PTSD after violations of physical integrity.

After the experience of a traumatic event in which physical integrity is violated (called the A-criterion), the DSM-V has subdivided five clusters of symptoms (A to E) and three further requirements to control for other explanations of these symptoms (F to H), which are presented in Table 1.

Table 1.

Posttraumatic Stress Disorder symptoms necessary for a diagnosis according to the DSM 5[a]

Criterium A (one required). Exposure to, witnessing or learning about a traumatic experience
Criterium B (one required). Reliving the trauma by having intrusive thoughts, nightmares, flashbacks, experiencing emotional distress or a physical reaction after being reminded of the trauma
Criterium C (one required). Avoidance of trauma-related thoughts or feelings, or reminders
Criterium D (two required). A worsened ability to recall the trauma, negative assumptions about self and the world, an exaggerated blame of self or the perpetrator, a negative affect, a decreased interest in activities, and feelings of isolation, difficulty experiencing positive affect
Criterium E (two required). A worsened ineffective arousal regulation such as irritability or aggression, risky or destructive behavior, hypervigilance, a heightened startle reaction, difficulty in concentrating, or sleeping problems
Criterium F (required). Symptoms should last more than a month
Criterium G (required). Symptoms create distress or a functional impairment

Criterium H (required). Symptoms cannot be explained by other illnesses or the use of medication or drugs

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[a]American Psychiatric Association (2013)

Even though the aim of the DSM is to globally standardize the requirements of giving a PTSD diagnosis, the description of and rationale behind these symptoms are widely debated. For example, it can be argued that adding certain symptoms will lower the base rate too much for giving a diagnosis (Green et al., 2016) which will heighten the prevalence of PTSD. Brewin et al. (2009) argue for a more restricted set of symptoms that only consist of 'core' elements and exclude non-specific symptoms such as the B-symptoms aside from nightmares and flashbacks and certain cognitive disfunctions (under cluster D), that could also be ascribed to depressive disorders. In other words, there is an ongoing debate on the right mixture of symptoms to get to the most effective diagnosis (that rules out both false positives and false negatives).

More important for the purpose of this thesis is an analysis of the underlying structure behind the symptoms, and the relation between the symptom clusters. Therefore, the symptomatology is discussed more in-depth to get a sense of a patient experiencing PTSD. After having experienced several traumatic events, involving a violation of the physical or sexual integrity of oneself or of someone else, the B-cluster describes how the patient relives the traumatic event un-purposefully, where 'reliving' means that the trauma is not thought of but rather 'felt'. The C-cluster describes the pervasive avoidance of these reliving symptoms described by the B-cluster. Examples of these symptoms include driving around an extra block to avoid reminders and staying at home for weeks. Interesting are the seemingly contradicting clusters that create tension in the patient. There is a continuous tension between control, expressed in avoidance behaviour (C-cluster) and the patient's awareness that their intrusive memories (B cluster) will trump their avoidance. Also, patients express externalizing behaviour, in which the patient is 'offloading' inner tension by acting out to others (E-cluster) as well as internalizing behaviour, in which patients keep all the 'emotional dirt' for themselves (D-cluster). Patients continuously aim for a delicate balance between memorizing the trauma and avoiding it, but this is generally unmanageable. This disbalance often creates stress and pervasive problems in their occupational functioning, households and relationships with family and friends.

1.3 Rigid self-narratives in PTSD patients

There is a feature of PTSD that is regarded more as a maintenance factor of PTSD than as a symptom. This maintenance factor originates from the pervasive impact of the traumatic event on the memory system of the patient, which causes problems with retrieval and recollection of trauma-related memories (Janssen, 2014). To put this in a behavioural context, when patients tell about the traumatic event, they suddenly switch to visual or solemn language, are disoriented in the chronology of their story, or confuse their perpetrator with themselves. This fragmented retrieval of trauma extrapolates to their description of self, as expressed by a patient: "I go from being a kick-ass professional woman to a whimpering child, to a furious bitch, to a pitiless eating machine in the course of ten minutes. I have no idea which of these I really am." (Van der Kolk, 2014, p. 285). Summarizing, it is observed that PTSD patients have a diminished ability to distinguish between appearance and reality, to discriminate between feelings of self and of others (thinking that one's feelings are the same as someone else's feelings), and to know that a feeling is temporary and changes under circumstances (Main & Goldwin, 1998). I will call this 'fragmentation of self'.

Jongedijk (2014) argues that the inability to integrate the different events and versions of self in life is a core problem in PTSD patients. The effect of this fragmented self is that patients compensate for this fragmentation of self by reframing or retelling their self-narrative in a very rigid fashion. This is done by confabulating parts to connect the fragmented parts of the story into a single whole that is comprehensible for the patient. To be sure, confabulation is not limited to PTSD patients; it has a cognitive efficiency function which simplifies complex events (Pennebaker & Seagal, 1999). PTSD patients, however, confabulate their self-narratives in a different and more distorted fashion (Jongedijk, 2014). Conway and Pleydell-Pearce (2002) differentiate between two functions within the 'self-memory system'. The first of these functions is the "adaptive correspondence" function that enhances correspondence between actual events and storage of these events within in the memory. The second function is the "coherence of self" function, which serves to create logical ties between the events in order to let all the memories be part of a story related to one coherent self. In healthy subjects these functions are generally in balance, resulting in a 'healthy' autobiography. However, for PTSD patients it seems to be the case that the high fragmentation of self, results in a compensation by using the "coherence of self" function in the self-narrative.

Healthy subjects may experience different roles throughout their lives without problems. For PTSD patients, switching between different roles seems to be problematic. The traumatic event and negative memories are overrepresented in the self-narrative, and all the memories surrounding the traumatic event are regarded as negative. Also, life events before the traumas are described as

extremely happy or good. Patients regard their trauma as an irreversible turning point in their lives which changed their lives forever, in a negative way (Berntsen & Rubin, 2002).

1.4 Self-narrative treatments: rationale and pitfalls

The distortion of self-narratives in PTSD patients is the reason why some theorists have turned to narrative therapies for PTSD. Adherents of narrative theories argue that a 'well-functioning' self-narrative is an important item in a person's toolkit that is needed for maintaining a healthy mental condition. When someone faces a problem, this can be overcome by trying to incorporate it in an overall narrative of one's life. When it is put in context, it will make more sense and it will therefore also guide one to a further step or a way out of one's problems (Schechtman, 2007). Self-narrative therapies aim to change rigid self-narratives by re-reflecting on them. The rationale of self-narrative treatments is that by changing rigid self-narratives, the fragmentation within the self will be affected, too. During therapeutic sessions, different life-events are systematically and chronologically talked through and each traumatic event in the patient's life is discussed to reduce the extrapolation of traumatic memories to contextual, neutral or happy memories. By integrating good and neutral memories into the rigid and negative emotional self-narrative, patients are forced to rethink their past and to turn the self-narrative into a more balanced one (Jongedijk, 2014).

Narrative identity theories (Schechtman, 2007) and self-narrative therapies (Jongedijk, 2014) seem to provide a plausible rationale for treating rigid self-narratives. However, current research on the efficacy of one version of narrative therapy, Narrative Exposure Therapy (NET), only shows medium treatment results. The American Psychiatric Association (2017) has indicated NET as a conditionally accepted therapy for the treatment of PTSD, because even though most research shows a reduction in symptoms, the therapy does not lead to a remission of PTSD. In other words, the therapy is not ineffective, but improvement on certain aspects may help to make the therapy more effective.

I argue that the rationale behind narrative therapies may be overlooking some fundamental aspects of PTSD. To start with, re-telling a self-narrative may reinforce control and avoidance of the trauma (cluster C symptoms), because it stimulates patients 'to get hold of' the trauma. This may eliminate rather than stimulate the integration of memories into the life story, by taking more distance from the memories by putting it in a 'story format'. Secondly, it seems impossible to access the traumatic memory by merely re-telling it. Some adherents of self-narrative therapy acknowledge this weakness in their rationale. "Turning trauma into a coherent narrative means challenging the narrative defences, such a psychic numbing, dissociation of feelings from the story, selective

forgetting or fragmentation. Initially, this might be in direct conflict with the tendency to avoid the trauma memory." (van Dijk, Schoutrop & Spinhoven, 2003, p. 92). In spite of this acknowledgement, however, the rationale behind narrative therapies has not been revised.

Van der Kolk (2014) mentions how a rigid self-narrative in PTSD patients may function as a 'cover story'. The patient uses this cover story as a 'hands-on' story and a background belief for herself and as a story in order to answer questions to family, friends and therapists. Re-telling this 'cover story' does not necessarily have to make the self-narrative less rigid but may reinforce the coherence of the self-memory system and rather stimulates the rigidity of the self-narrative.

In short, while the aim of narrative therapies is to restructure a fragmented autobiography into a more flexible one by retelling it, they may instead be disregarding the fundamental structure of PTSD symptoms. I should explain now what I mean by this 'fundamental structure'. In the example mentioned earlier, one of Van der Kolk's patients was unable to integrate different roles of self into one basic self (2014). Neurologically, this could be explained by a lack of self-referential systems. fMRI data show that the medial prefrontal cortex, which plays a significant role in self-referential processes, is less active in PTSD patients (Janssen, 2014). This suggests a connection between diminished self-referentiality and the inability to integrate the fragmented self. Healthy subjects can have different roles 'belong to' and refer to their unitary basic self, which explains why it is easier for them to integrate and to switch between these selves.

Impaired self-referentiality may reveal a common root of the fragmentated self and rigid self-telling in PTSD. Without a 'basic self' to refer to, it is much harder to place the different traumatic events in a logical order on a timeline. This is where rigid self-telling as a compensatory function comes from. By creating a rigid self-narrative, the patient creates a 'narrative self' to serve as a referent to give coherence to traumatic life events. In narrative therapies, the aim is to restructure a self-narrative, but it seems that a 'basic self' is still lacking. Instead of pushing patients to find their 'balanced self-narrative', it would seem to make more sense to start with the scattered 'basic self' behind the narrative.

1.5 Physical aspects of trauma

One way to approach the basic self and the root of PTSD, is to start with the traumatic experience. This is the cause of PTSD, and probably the cause of the fragmentation of the patient. As described in paragraph 1.3, the traumatic event has a pervasive influence on the memory system of the patient. However, other systems are involved as well. During trauma, the patient secretes high levels of stress hormones, which involves someone's fight-, flight-, or freeze response (Schauer & Elbert,

2010). Because of the activation of this response, other functions of the body are shut down. Both the experience and the memory storage of the traumatic event are affected by the shutdown of the other functions. Because of the activation of the fight- flight- or freeze response, the experience and the memory storage are neurologically processed via perceptual, visceral and proprioceptive systems. When patients are asked to retrieve a traumatic memory and were put in an fMRI, it was shown that Broca's area was inactive (van der Kolk, 2014). This area of the brain plays an important role in language production and comprehension. The shutdown of this area during the retrieval of the traumatic memory may show something about the nature of the traumatic experience. Therefore, it could be argued that traumatic events are mainly word-less experiences (Schauer & Elbert, 2010). The memory that stays intact is based on perceptual, visceral and proprioceptive information. In other words, after trauma the body 'keeps a score' while the speech-involving 'mind' gets blank (van der Kolk, 2014).

Another example in which the speech-involving 'mind' is blank is dissociation. Schauer and Elbert (2010) explain how patients who are abused repeatedly, while being dependent on the perpetrator (such as abused children or tortured prisoners) learned that fighting, flighting or freezing has not been effective. The 'last resort' function, or final defence mechanism is to switch to another mode of being, in which the patient does not experience the trauma anymore and 'leaves the scene'. Dissociation can be experienced consciously as in an out-of-body experience or unconsciously, in which the patient experiences a 'blur'. During dissociation, the experience of pain and fear is temporarily shut down, too. The mind is not even aware of what is happening. Even though people may not remember their traumatic event, these persons do develop PTSD symptoms afterwards. This shows that the memory of the event can be stored somewhere else than in the default memory system.

The bodily score of traumas is also expressed in other forms. A biological cause is the change the hormonal stress system, also called the Hypothalamic-Pituitary-Adrenal axis (HPA-axis). This system has had such a thorough blow during the traumatic experience(s), that HPA-system is somehow 'rebooted'. Yehuda et al. (1996) compared cortisol (stress hormone) secretion of PTSD subjects with the secretion of cortisol of healthy subjects. The PTSD group constantly secreted the same amount of stress, whereas the healthy group secreted stress after stressful stimuli but got back to a lower 'baseline' secretion. PTSD patient's HPA-axis is overly stimulated and therefore doesn't differentiate between threat and danger anymore. This is expressed in behaviour by the agitation, hypervigilance and concentration problems that PTSD patients experience. Throughout their lives, trauma survivors may auto mutilate, develop substance abuse, express extreme sexual behaviours or develop eating disorders. They may somatise their mental problems by developing

fibromyalgia, migraines, digestive problems, irritable bowel syndrome, chronic fatigue, and some forms of asthma, without any 'physical' explanation for these diseases (Boscarino, 2004; Lauterbach et al., 2005).

To sum up, during traumatic events the bodily fight-, flight-, freeze-, or dissociation systems take over and speech structures in the brain are deactivated. Yet, the body seems to be keeping a score, as is clear from the development of PTSD symptoms and other physical illnesses at later stages. To relive a traumatic event, triggers are rather visual, motoric or sensorial than verbal. During therapy smells, sounds, lighting, tactile structures or tastes related to the trauma are offered to the patient to elicit the traumatic memory. In other words, the experience, recall and aftermath of trauma cannot only be retrieved by merely thinking or talking about it. Instead, the basis of these memories is bodily, and therefore the retrieval of trauma is initially a wordless experience. Catching the trauma in words seems to be a secondary act.

1.6 Conclusion and Hypothesis

This chapter presented the cause and structure behind PTSD's symptomatology. It was shown how the physical nature of the traumatic event and the long-term consequences of stress to the body enhance fragmentation of the 'basic self'. Rigid self-telling seems to have a compensatory function of fragmentation of self and lack of self-referentiality. Self-narrative therapies aim to address the rigid self-narratives by PTSD patients. However, the traumatic event and intrusive memories thereof have a basic wordless character. To make self-narrative therapies more effective, the traumatic memory must be accessed more directly. I argue that this should be done by using the body. The result of this could be that general self-relation systems are reinforced and therefore the fragmentation of self may decay. This leads to my hypothesis:

In order to make narrative therapies more effective for PTSD patients, the narrative approach must start by focusing on the physical and basic self in order to not miss the core of the wordless trauma. This means that narrative therapies should not focus exclusively on the 'told' story of the patient but also on the memory contained in the body. This will avoid a reinforcement of the rigid self-narrative by retelling it and lead to a stronger and balanced new self-narrative.

Chapter 2: Hyperreflexivity as an alternative explanatory model of PTSD

2.1 Overview

In the previous chapter, Posttraumatic Stress Disorder was discussed in terms of the standard description of the DSM-V. I evaluated the underlying structures behind the symptomatology and discussed how relates to rigid self-narratives. In the second part, I evaluated the use of narrative therapies as a treatment for rigid self-narratives. Even though the rationale of the treatment seems justified, narrative therapies as yet do not seem to be particularly efficacious. I discussed reasons for this lack of efficacy and argued that narrative therapies should consider the underlying the fragmentation of the basic self. PTSD patients use self-narratives to compensate for their fragmentation, but re-telling the self-narrative may actually increase its rigidity rather than make it more flexible. Instead, I argue for a narrative therapy that focuses on the fragmented self that is distorted as a result of repeated trauma. This focus needs to include the body and the physical aspects of trauma.

This chapter describes a hyperreflexivity model for taking the body into account in mental disorders, and argues that this model can be applied to PTSD. Instead of focusing on verbal memory, the hyperreflexivity model explains PTSD from the basic self, starting with the body. This appears to be a better way to free patients of the rigidity of the self-narrative. Applying the hyperreflexivity model to narrative therapies also shows that the rationale behind narrative therapies is backfiring. Deen from the perspective of the hyperreflexivity model, narrative therapies in their current form cannot be recommended as a treatment for PTSD.

2.2 Introduction of the hyperreflexivity model

The hyperreflexivity model is described by Fuchs (2011) and based on phenomenological models of psychopathology. Fuchs applied his model to different anxiety and sleep disorders; I suggest that it can also be applied to PTSD. The model describes how patients suffering from mental health problems tend to 'hyper-reflect' on themselves. Even though reflection seems to be a useful tool in situations that require attention such as learning, or coping with new situations, hyperreflection is an extreme form of reflection that freezes people in the reflective mode.[1] The point of Fuchs's model is that hyperreflexivity has consequences on the subject's body and basic self.

[1] There is another concept that seems synonymous to hyperreflection, rumination. Hyperreflection, however is different from rumination in the sense that rumination is more 'cognitive' and seems to have more specific semantic references, whereas hyperreflection is a more basic mode of looking at the world. The explanation of the hyperreflexivity model might give more insight on the understanding of this difference.

Hyper-reflection induces a shift from 'being a body' to 'having a body' and places the patient in a state of 'pre-calculation'. These concepts have their roots in phenomenology, and were introduced by Merleau-Ponty (1945). In clinical practice these concepts may be applied as follows. In the pre-calculative state, patients start thinking of every act they take and every movement they make. All this pre-planning and thinking further induces the distance between the 'mind' and the 'body' of the patient. The body becomes a hurdle instead of a helpful and transparent tool. Merleau-Ponty addressed the fundamental ambiguity between 'being a body' and 'having a body' in every human being. In healthy subjects, learning, or developing new habits creates a temporary state of having body, which is expressed in clumsiness or readjustment of bodily states. However, this state dissolves after a while into a state of becoming or being a body, and the person starts to 'forget oneself' while applying the new skill. This ambiguity between two bodily modes is normal. But Merleau-Ponty pointed out that in pathological cases, the state of 'having body' is maintained and is less likely to dissolve into a 'being body'.

A second consequence of the patient being in this pre-calculative state, is that the patient compensates for the gap between thinking of acts and participating in acting by 'making the implicit explicit'. Because the patient cannot escape the pre-calculative state, the patient tries to overcome the gap between the thinking mind and acting body by explicating possible acts in words or thoughts. This, in turn, reinforces the estrangement of the patient from his own body, instead of reconciling the ambiguity between having body and being body.

Summarizing, hyperreflection describes how patients suffering from mental issues have shifted from being body to having body because of fruitless brooding in the state before acting. The gap between thinking and acting is overcome with more thinking, which rather reinforces the state of 'having body' instead of reconciling body and mind, or 'being body'.

In the next paragraph, the hyperreflexivity model is applied to PTSD's main cause, the traumatic event, and the reliving symptoms resulting from the traumatic event.

2.3 Hyperreflexivity and the traumatized body

There are some misconceptions about traumatic memories that critics of PTSD have used in their arguments. Critics argue that since many memories are confabulations, traumatic memories could also be 'made up'. They conclude that PTSD may not be a valid diagnosis or is at least not different from any 'default' depression or anxiety disorder (Baldwin, Williams & Houts, 2014). Critics seem to forget that PTSD patients' recall of traumatic memories is different from other memories. Traumatic memory in PTSD does not rely on an inference from something hidden in the past, but traumatic memory is brought to the present because the trauma is *relived* rather than remembered.

Unfortunately for the patient, in contrast to other unpleasant memories, traumatic memories are extremely accurate, not vague or hidden.

In the Clinician-Administered PTSD Scale (Weathers, et al., 2013), a flashback is described as a dissociative reaction in which the trauma is replayed. In extreme cases this dissociation means a complete loss of awareness of spatiotemporal surroundings. The patient may also act as if the trauma happens again, and this can last between some minutes and an hour in extreme cases. Van der Kolk (2003) describes a flashback experience related by his patient "Nancy":

> It is as if time is folded or warped, so that the past and present merge, as if I were physically transported into the past. Symbols related to the original trauma, however benign in reality, are thoroughly contaminated and so become objects to be hated, feared, destroyed if possible, avoided if not. For example, an iron in any form—a toy, a clothes iron, a curling iron, came to be seen as an instrument of torture (…). (Van der Kolk 2003, p. 198).

In this example the traumatic event and the meaning of surrounding objects is transported from the past to the present. Also notice the patient's description of time as folded, merging the present with the past. This discriminates flashbacks from memories. Memories take place on a mental 'timeline', a feeling of something from the past, associated with certain feelings and surroundings. Flashbacks, by contrast, are present experiences, vivid and physically real. Also, the body acts as if the trauma is happening again, and the experience is disconnected from its spatiotemporal surroundings.

There are other forms of dissociation that sometimes develop as defence mechanisms during extreme or repetitive trauma (Schauer & Elbert, 2010). In these forms of dissociation, the trauma is not 'brought' to the present experience of the patient. Dissociative experience is preceded by triggers but is rather experienced as a feeling of fogginess or being estranged from your own body. Patients experience that their hands or feet do not belong to their body, or as if a robot takes over their bodies. Moreover, surroundings may feel strange: for example, the world may look like you're watching it through a fish-eye lens, or other visual distortions may be experienced. In other words, patients feel divided from the world, and their body feels strange. Important to note is the difference with psychosis, where the subject usually does not feel 'strange' but feels like he has found the truth. Therefore, dissociation is a magnifier of the two poles between 'having body' and 'being body', whereas psychosis seems rather be unipolar state (of having found one truth).

The hyperreflexivity model can explain these reliving symptoms in relation to the basic self in the following way. The traumatic event has affected the body in such a way that the body seems

to have fixed itself in a mode of adjusting to danger. In order to stay away from the danger, the patient tries to 'stay away' from her body, thereby avoiding the state of 'being body'. However, during reliving and dissociative symptoms, it seems that the pre-calculative mind, intended to control the outer world associated with danger and chaos, has temporarily lost control. The body, adjusted to the past and its associated danger, takes over and reunites the 'mind' with the body. This mode of mind and body can be described as a temporary suspension of the pre-calculative state. This is a very unpleasant feeling for the patient and magnifies the ambiguity between having and being body. These sudden moments where the body takes control emphasizes how the body has lost it embeddedness within the mind and vice versa.

In sum, the physical nature of traumatic memories shows that the trauma is physically present and not a mental recall. Instead, the body brings the trauma to the present and functions as a 'time machine'. There is no confabulation in the traumatic memory itself. The pre-calculative state of the PTSD patient, intended to control the body that is still adjusted to the traumatic past, temporarily loses its grip. The flashback or other forms of dissociation elicit the tension between being body and having body by a temporary suspension. After these reliving symptoms, the patient finds safety again in his pre-calculative state and being disconnected from the body. The equilibrium is rather found in the 'having body' state.

As explained in paragraph 2.2, there is a secondary consequence of the pre-calculative state, which is the use of rigid self-telling to overcome this fundamental state of having body caused by trauma. The next paragraph explains how rigid self-narratives result from trauma and how this is explained by the hyperreflexivity model.

2.4 Hyperreflexivity applied to PTSD

In healthy subjects, the body mediates between self and the world as a transparent medium. This makes our relationship to the world immediate. The body is usually taken for granted, as a medium to interact with the world. The hyperreflexivity model describes how in mental illness, the body becomes an obstacle that blocks free interaction with the external world. What was taken for granted suddenly becomes unfamiliar or strange, what was implicit becomes explicit and enters the focus of attention.

In PTSD, the body is still adjusted to the traumatic past, and the mind is used to over thinking about the past by conscious and intentional thinking during the day. This creates a further gap between the state of the body, attuned to the past, and the state of the mind, which tries to control the past. The estrangement between mind and body is shown by an example in PTSD patients who lack the integration of sensorimotor information and their conscious thinking. In

research conducted by McFarlane (2010), traumatized subjects were blindfolded and given objects in their hands, such as car-keys. Whereas healthy people recognized the car-keys by their shape, weight, temperature, texture and position, traumatized patients could not recognize the car-keys without looking at them.

Still, patients have a minimal natural tendency to interact with the outer world. Because of the disconnection with the body, they compensate by 'explicating the implicit'. The body needs the pre-calculative state and cannot trust the bodies senses. This is achieved via a supplementary calculation and analysis of anything that comes in the patient's focus of attention with the aim to overcome the opacity of the body. Even though the pre-calculation is conducted with the aim of overcoming a disconnection to the world, it conversely results in a more hyperreflective state.

2.5 Hyperreflexivity applied to narrative therapies

Whereas self-narrative therapies aim to overcome a fragmented self by retelling the self-narrative, the hyperreflexivity model shows that re-reflecting on the self-narrative could lead to even more reflection, which is more likely to increase the rigidity of the self-narrative than to make it go away. Taking the hyper-reflection model into account, it becomes clear that narrative therapies need to be revised. A narrative therapy that considers the shift from 'having a body' to 'being a body' because of the hyperreflective tendency in patients may be more effective in the treatment of PTSD.

Avoidance is an important symptom in PTSD that functions as a defence mechanism which in the long term reinforces hyperreflection. The hyperreflective state of PTSD patients gives the patient a feeling of control and avoidance of connection to their body, but finally results in "fruitless brooding, empty reflection or compulsive personal observation" (Fuchs, p. 243). The aim of self-narrative therapies is to integrate positive memories in the self-narrative, and to make this self-narrative more balanced. However, the body will probably be reinforced in its state of having body, and the self-narrative therapy functions as another way of 'explicating the implicit', which finally further reinforce the pre-calculative state.

A second reason why narrative therapies in their current form are not effective enough is the partial access to the traumatic memory. By merely *talking* about the traumatic event, the patient cannot be brought back to the embodied traumatic state.[2] Fuchs calls the verbal medium for going back to certain states 'reflexive consciousness', and argues that it is "not capable of, so to speak,

[2] A counterargument could be that you could re-traumatize a patient by going back to the traumatic state and that it is not necessary for healing of trauma. However, in order to start targeting triggers related to trauma, an understanding must be developed about feelings of unsafety. Once the body experiences trauma again in a safe environment, neutral associations with former threatening objects can develop. The latter point will be elaborated on in later chapters.

going back to the source of embodied enactions, either spatially or temporally." (p. 242). This can be compared to other bodily enactions that are not subject to conscious control such as sleeping, laughing or sexual arousal. Once you force yourself to it, it works in the opposite direction. In PTSD, the traumatic experience has many bodily aspects that must be triggered to get back to the memory of the trauma. When, during narrative therapies, patients try to access it by talking about it, the clue of the trauma might not be accessed in its full extent.

In sum, a PTSD patient's estranged or 'cut-off' body shows the gap between the mind and the body, which is overcome by hyperreflection, and this is further reinforced by self-narrative therapies that re-reflect on self-narratives. Even though the 'cover story' (van der Kolk, 2003, p. 43), might seem more flexible, the bodily experience of the trauma is not involved, which further induces the state of having body. Secondly, narrative therapies cannot really access the whole traumatic experience by verbal means, since the trauma contains a lot of non-verbal aspects.

2.6 Conclusion

This chapter described the hyperreflexivity model, based on concepts rooted in phenomenology (Merleau-Ponty, 1945), and applied it to PTSD. It was used to evaluate how the 'basic self' is fragmented by trauma. The traumatized body is associated with the dangerous past and is therefore disconnected from the mind. This disconnection is, in turn, overcompensated with avoidance and control over the with the body and the past. This overcompensation further ratifies the shift from 'being body' to 'having body', maintained by the patient via the pre-calculative state. Meanwhile, flashbacks and dissociation may backlash on patients with their inability to control the underlying bodily trauma. Even though the aim of self-narrative therapies is to make the self-narrative more flexible, they reinforce the state of having body. In order to increase the efficacy of self-narrative therapies, the intensified tension between having and being body needs to be addressed. This way, a reconciliation between the two states will work on the lack of self-referentiality, which enables an integrated and balanced self-narrative.

Chapter three: The embodied narrative and body narrative in PTSD

3.1 Overview

In the first chapter, it was explained that trauma is experienced and recalled by PTSD patients in a wordless mode. Also, the patient is not capable of integrating different states into a 'basic self', which makes the 'self' fragile and fragmented. This was supported by neurological research that showed a lack of self-referential processes in the brain of PTSD patients. The question that was addressed was whether a change of self-narrative through verbal means only constitutes an effective treatment of PTSD. With a fundamental distortion of the self, the fragmentation of the self within the self-narrative may not be resolved by re-reflecting on the narrative.

In the previous chapter, the hyperreflexivity model is used to explain how PTSD patients use their 'mind' to overcome their 'having body' state, which reinforces the rigidity of their self-narratives. Even though rigid self-narratives serve as an avoidance of their traumatic past, flashbacks suddenly and intrusively overcome the patients and break through that avoidance. Somehow, the body cannot forget the trauma even though the 'mind' of the patient constantly avoids memories thereof. The bodily memory could therefore be described as 'a message conveyed by the body'. Traditional forms of narrative therapies do not acknowledge the bodily symptoms of PTSD and reinforce the rigid use of their self-narratives.

Even though traditional forms of narrative therapies will maintain or reinforce a distorted 'basic self', these therapies do not have to be rejected. A reformulation of the self-narrative into an embodied self-narrative emphasizes the traumatized body in the analysis of PTSD's pathological picture. In this chapter, I will propose an adjustment of the concept of narrative that also includes the body.

Adherents of traditional self-narrative therapies (Schechtman, 2007) are severely criticized (Strawson, 2004). However, the embodied self-narrative that considers a basic, embodied self (Menary, 2008; Slors, 1998) could provide an alternative to traditional self-narrative therapies. In this chapter, this alternative is evaluated in relation to the understanding of PTSD. The description of the bodily message in PTSD is compared with the concept of an embodied self-narrative and a body narrative and both concepts are explored as possible concepts that could be integrated into narrative therapies. The difference between embodied self-narratives and body narratives in application to PTSD is discussed. Flashbacks may be better explained by the body narrative since they have a non-verbal character. However, criticism on the concept of a body narrative must be evaluated in order to make sure this concept can add value for understanding the symptomatology and the treatment of PTSD.

3.2 The traditional account of self-narratives

The traditional account of self-narratives is described by Schechtman (2007). She describes the self within the self-narrative as a 'collection of narratives' from the past, but narratives can also be extrapolated to predict the future of a subject's life. The narratives should be coherent and chronologically organized over the course of the subject's life and are conscious but could also unconsciously serve as background narratives. The unconscious functioning of background narratives makes the self-narrative an all-encompassing but summary of the self. Since all life events are explained by narratives, consciously and unconsciously, it is also exclusionary. There is nothing besides narratives that constitutes a self.

A couple of problems with this account must be addressed. First, the self-narrative is diachronic, which means that it covers the complete lifespan of the subject (Strawson, 2004). Diachronicity taken together with coherency, minimizes room for change within the subject's identity. The narrative rather 'fix' someone's future passed on the past than it describes experiences and remains open for unexpected narratives. Therefore, experience must rather fit into the self-narrative than that experience shapes the self-narrative, whereas it seems more realistic that it could go both ways. Summarized, the main problem with the traditional self-narrative is that because the 'self' is explained by all-encompassing and diachronic narratives, it enhances the rigidity of the self-narrative.

Because of the fundamental character of narratives to the constitution of self, the explanation of self in the self-narrative is based on an infinite regression. The self as the protagonist of the narratives can only be described by the self-narrative. Menary (2008) argues that the description of self in the self-narrative as a collection of narratives will make the self an *abstraction* or a *representation* of something that must always be explained by another narrative. However, many experiences are not preceded by any narrative, such as narratives describing anger or fear. Menary gives the example of being hit by a ball on his arm during a cricket match (2008, p. 73) and argues that it was *him* and not a narrative self, experiencing the pain of the ball. The experience of pain was direct and was not experienced via a narrative of pain. However, the person experiencing pain could narrative about his pain, and this could shape other narratives.

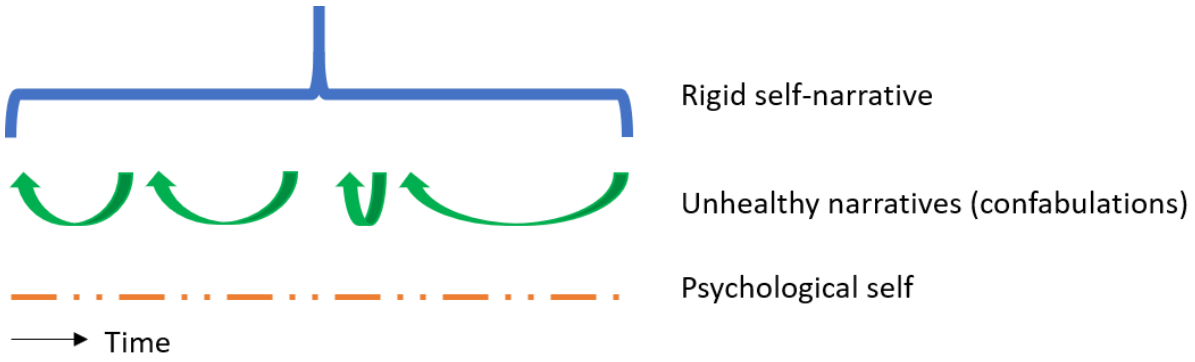
Instead of narratives preceding any experience, experience and narrative reciprocally influencing each other. An alternative to the traditional self-narrative should acknowledge that there is also direct experience without the intervention of a narrative. This alternative describes the narrative self in a more flexible manner and allows experience to change the self-narrative over time.

3.3 The Traditional account of self-narratives and PTSD

It varies widely between individuals to what extent and in what way self-narratives are used and how 'healthy' the use is. As is described in previous chapters, PTSD patients suffer from a lot of distorted memories and overcompensate for that by confabulating more than healthy subjects do (Jongedijk, 2014). The function of self-narratives in PTSD patients reinforces a rigid narrative and therefore a rigid application or use of the narrative. Figure 1 shows how confabulations adhere to a rigid self-narrative and how a healthy use of more flexible self-narratives is disabled since the self is led by the diachronic and all-encompassing self-narrative.

Figure 1.

Rigid self-narratives in PTSD patients



This figure depicts the psychological self, which is naturally disrupted by sleep, daydreaming but also by flashbacks and concentration problems (orange line, bottom). This is compensated for by an overly coherent self-narrative (blue line, top) which is thick lined because it functions as a life manual for the PTSD patient. Confabulations fill up disruptions in the self-narrative (arrows arise from the rigid self-narrative and point to the self-narrative), but do not affect the psychological self.

I argue that the self-narrative as described by the traditional account can be useful to get insight in PTSD patients rigid self-telling. In healthy populations, coherency in the self-narrative is useful when reflections on life must be made, such as during periods of distress or when someone learns new skills. During those moments, a self-narrative can provide guidance in life. However, PTSD patients use their coherent self-narrative rigidly and as a static fact. There is no allowance for a change in the narrative about the past, and not for a possible future change of the self. This rigid use of the self-narrative was described by the hyperreflexivity model that showed that it functions as an overcompensation for the detachment of their bodies. The patient seems to lack a basic self from which a flexible self-narrative can constructed without the need to overcompensate. Instead, the

self-narrative is used as a life manual that keeps the patient within the conceptual or pre-calculative state. PTSD patients stay away from the participation to life and observe life from a distance.

In other words, because traditional self-narratives seem to work in a similar fashion as the functioning of self-narratives in PTSD patients, this could be an explanation why treatment is not as effective as needed (American Psychiatric Association, 2017) since it seems to reinforce rigidity instead of making self-narratives more flexible. Addressing the detached body and the lack of experience in shaping the self-narrative might be a first step to develop more effective narrative therapies.

3.4 Embodied self-narratives

The traditional account is purely psychological and leads to a false distinction between the self as a collection of narratives and a self that experiences. Schechtman explicitly argues that the narrative self and the experiential self should not be regarded as co-extensive (2007, p. 178). However, the experience and narrative reciprocally influence each other. The traditional self-narrative creates an abstract and disembodied self while the embodied self-narrative requires the self to be anchored in situated bodily experiences. Menary describes this as follows "There is a more fundamental sense of self, that is the embodied, feeling self, feels and perceives, is happy and sad, before it ever narrates." (Menary, 2008, p. 73).

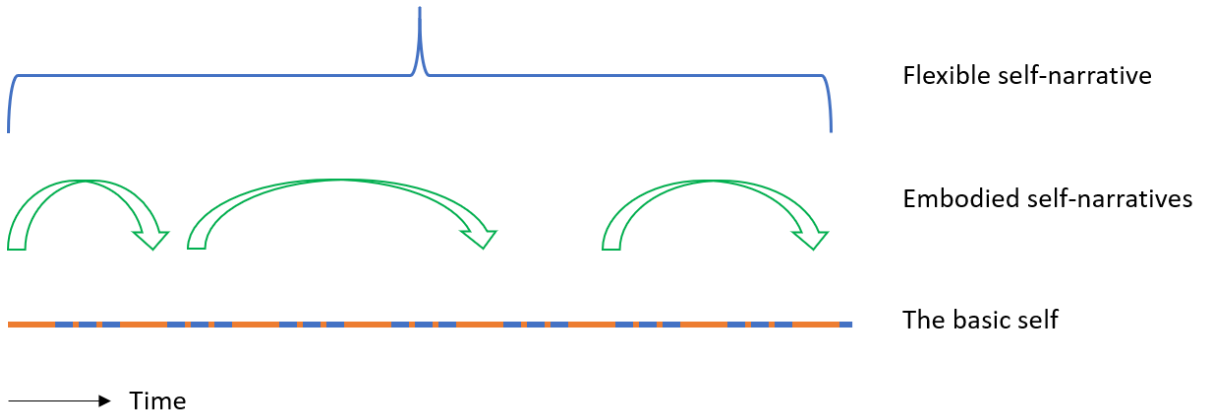
The influence of embodied experience can be described as follows by Slors' description of psychological continuity (Slors, 1998). Narratives may result from embodied, lived experience that creates a sequence of perceptions. The sequence of perceptions can be explained by the body's movements through space that enable perceptions, formed by positions of the body and the senses. In some cases, when something stressful is experienced, the subject may feel the need to contextualize an experience by narrating about it. In other cases, narratives may motivate the subject to go somewhere or make a certain decision which influences the body's movements and the embodied experience that follows from the narratives.

The verbal narrative, which can be used as a tool to reflect and contemplate may help to structure thoughts or to find guidance. However, in the embodied self-narrative, the self is not always coherent, and the order of events is not strictly chronological. Self-narratives may rather function as a rough estimation of the past and future and decisions can be loosely inferred from this self-narrative. The self within the self-narrative develops over time, and the self-narrative will be different with every retrieval. In Figure 2, the embodied self-narrative is depicted and in the description below the differences with Figure 1 are explained. This figure describes the embodied

account of self-narratives and could serve as an example for how self-narratives could be used in a less rigid way.

Figure 2.

The embodied self-narrative



The self-narrative (thinner lined than in Figure 1) is used flexibly and as a tool. Healthy narratives are pointed towards the basic self instead of toward the rigid self-narrative in Figure 1 because they do not have to confabulate to 'plaster' parts of the rigid self-narrative. The embodied self-narratives are also hollow instead of filled, because they are not fixed, they change under circumstances since they are embodied. The basic self is constituted by psychological consciousness and the body (orange, (psychological) and blue (bodily) lines are integrated, bottom), which is why there is no need for a compensatory use of the self-narrative.

Summarized, the embodied self-narrative is constituted by the body taking a route which creates a sequence of perceptions from which a narrative structure arises. Psychological states, perceptions and experiences result from the route of the body and from this a narrative structure may follow. The reverse can also be applied: narratives may guide the body taking specific routes that influence experience and perceptions. Either way, self-narratives are not an abstraction of experience but are anchored by experience. In contrast to the traditional account, the self contains different states of self since they are united in one basic self that allows the self to stay the same even though psychological states vary over time. This makes the basic self 'non-static' since it allows the self to change over time by embodied experience.

3.5 The embodied self-narrative and PTSD

To understand the value of the embodied self-narrative in narrative therapies, it must be shown how the embodiment of PTSD influences the patient's self-narrative. The hyperreflexivity model gave insight in some fundamental aspects of the embodiment of PTSD. I will describe some examples of these fundamental aspects and some behavioural symptoms to show how the embodied self-narrative is more comprehensive in the understanding of PTSD than traditional self-narratives.

In the first chapter, it was explained that the traumatic event is a sensorial and physical experience and is mainly non-verbal. The aftermath of repeated stressful trauma severely distorts the body in many ways. Examples of 'bodily detachment' are described previously by McFarlane's research (2010) on the disability of patients who could not identify car-keys by mere touching. Della Penna (as cited in Blakeslee & Blakeslee, 2009) described his therapy with obese PTSD patients who were treated with body-focused therapies, mainly based on exercising and relaxation techniques. His patients experienced an immense fear when they felt how they located themselves in their bodies by relaxing and focusing on their body. In other words, when patients were treated by shifting from the pathological 'having body' into the healthy 'being body' mode, they felt extremely anxious.

PTSD patients are often used to their own bodily detachment, so they don't notice this distortion anymore. Besides the general symptoms that may follow from this, it could also disturb their interaction with other people. An example of embodied narrative structure in PTSD is displayed by 'Jim', a PTSD patient treated and described by body therapist Erskine (2014). Jim took part in a group therapy with other PTSD patients. Because Jim was detached from his body, he seemed to have expanded his peri-personal space[3] and therefore invaded other people's space.

> When he entered the office, he piled his coat on top of other peoples' coats rather than using his own hanger. He left his shoes where others tripped on them. He often plopped down on the sofa almost on top of others. He put his feet on someone's lap. People in the group began to find him a nuisance (…) I observed that he was lacking in exteroceptive sensitivity and limited in knowing the boundaries of interaction between his own and other peoples' bodies. (Erskine, 2014, p. 25).

Jim suffered from childhood traumas and learned to put himself in other people's faces since he would otherwise not be seen. It is not a conscious choice made by Jim but a fundamental change in the way he experiences his body, the boundaries of his body and the relation of his body to the space around him. 'Peri-personal space' is shaped by someone's culture and personality but also by

[3] A concept coined by Blakeslee and Blakeslee (2009) that describes the composition of the body's space in relationship to its surroundings.

traumatic experiences. Jim's embodied narrative structure influences his bodily positions, his perceptions and his gestures. This has impact on his interaction with other people and his response to their avoidance of him. The structure of embodied experience arises directly from the way he presents himself and his body. This represents the way Jim experiences his life, his lack of interaction and his dysfunctional efforts to achieve a connection with other people. Jim's disturbed embodied structure has shaped important parts of his self-narrative.

The estrangement of PTSD patients from their bodies results in that they do not feel how their bodies influence their interaction with others. Other examples of distorted embodied narrative structure are withdrawn appearances, for example by avoiding looking in people's faces. Since the patient is detached from her body, she is not aware of the influence of the withdrawal of her body on her life. A traditional self-narrative therapy would ignore the bodily part and focus merely on a told story of the patient. Even though she could describe feelings of isolation, her bodily positions, her facial gestures and her physical participation to life will be less evaluated. By ignoring the influence of PTSD on the body, a lot of information and therefore possible solutions would be missed.

Integrating the embodied narrative structure of PTSD patients is likely to enhance the efficacy of narrative therapies. Using the concept of embodied self-narratives will not only influence the self-narrative by creating awareness of the patient's body structure, it will open the possibility to gather new experience that shapes the self-narrative and makes it more flexible.

3.6 Body Narratives

The embodied self-narrative is an adjustment of the self-narrative and acknowledges the embodiment of PTSD and the influence this has on the self-narrative. However, in the embodied self-narrative as described by Menary (2008), the embodied structure is merely 'ripe for narration'. The embodied self-narrative only becomes a narrative after the bodily narrative structure is explicated in words. A flashback of a traumatic experience is described as non-verbal, and immediate verbal reflection limits the understanding of the flashback.[4] Since the embodied self-narrative requires a verbalization of embodied narrative structure, this approach may limit the understanding of the trauma and trauma related triggers.

4 The traumatic memory is an embodied experience, explained by the hyperreflexivity model this experienced cannot be retrieved verbally. Fuchs writes "reflexive consciousness is not capable of, so to speak, going back to the source of embodied enactions, either spatially or temporally." (Fuchs, 2011, p. 242)

In this paragraph the body narrative is explored as a concept that is better aligned with flashbacks than the embodied self-narrative. Even though the body narrative is practically part of an embodied self-narrative, discussing this concept separately emphasizes the bodily structure of traumatic experiences. By postponing any verbal reflections there is more room for the unfolding of bodily events which could be valuable information for the embodied self-narrative. However, my aim is to stay away from the semantic discussion about the fundamental concept of a body narrative. Instead, I want to answer the question in the affirmative only for the specific case of flashbacks in PTSD, because it has consequences for the development of therapeutic techniques in narrative therapies for PTSD.

Gallagher and Hutto (2017) clarify the concept of a body narrative by discriminating it from the embodied narrative. A body narrative is not a story *about* the body, but a story *generated by* the body. According to Gallagher and Hutto, accepting a body narrative will devaluate the concept of narratives and leads to pan-narrativism.[5] Embodied experience is rather 'ripe for narration' than that it already includes narrative content. Gallagher and Hutto give the example of a geologist forming a story about the earth's stratified layers. They argue that it would be a mistake to confuse the layers with the narrative, or to claim that the layers themselves constitute a narrative structure. They also claim that what seems to hold for the stratified layers of earth, also holds for the body.[6]

Figure 3.

Embodied self-narrative

The embodied experience is 'pre-verbal' and must be verbalized in order to become a narrative. The embodied experience is narratively structured and therefore 'ripe for narration'. Gallagher and Hutto (2017) use the example of the stratified earth's layers and show that these layers are only put in a narrative and sensible order after the geologist has formed a story about the layers.

[5] The concept of narratives will be devaluated when they can be found everywhere, in materials, plants, the dark side of the moon, and further.
[6] They add "For, unless a special case can be made to distinguish them, what holds for stratified layers of earth also seems to hold for what goes on in and with our bodies." (p. 5).

There may be examples of embodied experience that show that they have more narrative characteristics than being merely 'ripe for narration'. I argue that for a message to be conveyed, it does not necessarily have to be verbal. There are examples of non-verbal stories that are accepted as narratives in colloquial language and understanding. A ballet contains a narrative structure, a beginning, development, climax and resolution, it has meaning, and the movements are placed in a sensible order. The audience looks and grasps the narrative that is displayed by dance movements. Another example is provided by mute black-and-white movies. Visitors watch this comprehensive non-verbal story from beginning to the end. The movie makes sense, evoked emotions, and gave the visitor message or a narrative to take home.

The examples of a ballet and a black-and-white film are different from the example put forward by Gallagher & Hutto about the earth strata. In the story formed about the earth's strata, the storyline is added by the narrator and therefore the narrative was only complete after a verbalization of the (narrative) structure. In the examples I put forward the story line is included in the narrative structure of the embodied experience. The bodies bring forward a narrative by perceptions, sensorial sensations and bodily expressions. Adding a verbalization to these narratives do not devaluate the non-verbal narrative. In other words, the audience or visitors watching non-verbal narratives do not need a verbal explication of the narrative.

Overall, body narratives could be part of an embodied self-narrative, since taking the body narrative apart from an embodied self-narrative will result in another form of false dualistic distinctions between experience and narrative. The body narrative is not different from an embodied narrative but is of extra value for understanding some PTSD symptoms because it acknowledges that the embodied narrative has a narrative structure even if it is not verbalized.

3.7 The Body Narrative in application to flashbacks

In the previous section, it was discussed that some would say that there is no such thing as a body narrative. I think that all persons, including PTSD patients, have something like a body memory that has narrative aspects. However, in this section I focus on the body narrative explaining a flashback because that part cannot be accessed verbally. In the case of PTSD, using the concept of a body narrative creates access to the unfolding of trauma memory. Therefore, it should be used in narrative therapies.

I argue that a body narrative does meet the general narrative conditions (Gergen & Gergen, 1988). These include that a narrative must include a story goal or a message, that the events within

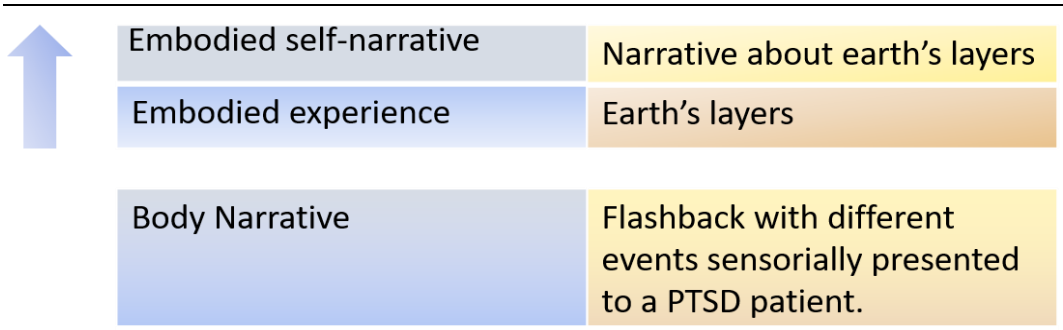
the narrative must be related to this message and that the events must be placed in a sensible order. Flashbacks contain a message, which is usually a sign of warning of physical or sexual threat. There is a meaningful content related to that goal, which is expressed by visceral and bodily sensations, such as pain in a limb, light-flashes, heart racing, different tastes or smells. Finally, a patient experiences a sequence of events in a sensible order. Some PTSD patients report the traumatic event being replayed as if they are watching a very lively video, others describe a flashback as a lost sense of time, outside any past, present, or future. A previous example (Van der Kolk, 2003, p. 198) by patient "Nancy" described her flashbacks as if she was physically transported into the past and that symbols are thoroughly contaminated by the original trauma, so neutral objects are seen as objects of torture. Her example showed how during the flashback the trauma is immediately enacted. For Nancy, the association related to the artefacts can be ascribed to the life-threatening situation during the traumatic event. Even though the display of events may not be chronological, the order is logical to the patient.

However, a flashback cannot be ascribed to any other physical reaction. It is distinct from other bodily reflexes such as knee-reflexes or startle responses. When a trauma is re-experienced, the body replays a body memory based on a script, in which an unfolding of different events within a certain time span takes place. In comparison to the earth's stratified layers, these layers don't have a start, tension span, and an end. A knee reflex contains an immediate reaction to an action. However, a flashback is more extensive than a knee reflex because the body expresses the unfolding of more than two events, or one reaction, in a specific order. The unfolding of these events can be expressed and retrieved years or decades after the event happened, but still contains the exact unfolding of the events.

Examples of black-and-white films, the ballet and flashbacks show that not everything that is non-verbal is only a narrative after it is put into words. In the case of PTSD, the embodied experience of the flashback is only accessed by and therefore better conveyed by a body narrative than by a verbal narrative. A conceptual comparison between the embodied narrative and the body narrative is depicted in Figure 4. Whereas in the embodied self-narrative, embodied narrative structure must be verbalized for the structure to become a narrative, for the body narrative, the embodied narrative structure a narrative without verbalizing it.

Figure 4.

Comparison between an embodied self-narrative and a body narrative



The difference between the two steps of the embodied narrative and the direct route of the body narrative are displayed. Whereas embodied self-narratives need to go in the direction of the arrow via the 'narrative box' in order for it to be a narrative, there is not a need for the flashback to go to the box that adds narrative structure before it to be a narrative.

It is important to explore how body narratives and embodied self-narratives might enhance efficacy in narrative therapies for PTSD. In the next chapter the body and embodied narrative concepts will be applied to therapeutic therapies for PTSD.

3.8 Conclusion

The traditional account of self-narratives mirrors the way PTSD patients use their self-narratives: the self is an abstraction of the experiencing self which does not allow for change. The PTSD patient compensates for its bodily detachment, the state of having a body instead of being a body, by using the self-narrative as a rigid life manual in order to participate in life.

The alternative embodied account of the self-narrative shows how the reverse is also possible. Experiences and narrative influence each other reciprocally. The embodied account is an important adjustment that must be made in narrative therapies for PTSD, especially since many PTSD symptoms are physical.

Flashbacks are not sufficiently explained by an embodied self-narrative. Since this embodied self-narrative still requires verbalization and the traumatic memory is not grasped by the patient by verbal means. A narrative bodily structure seems to convey a message in flashbacks. Therefore, it provides a viable concept for the explanation of traumatic experience. The body narrative is proposed as a possible concept to include in narrative therapies, especially since the trauma is the core of PTSD's symptomatology.

Critics argue that a body narrative cannot exist because the body cannot generate story by itself since a story must be verbal. I argued against that by arguing that bodily expressions are explicit and non-verbal, such as in other examples like black-and-white film, a ballet, and flashbacks. There are no 'mentally added subtitles' needed to understand what message is conveyed via the means of the body.

However, it must still be discussed if and in what way the acknowledgement and integration of a body narrative into the embodied self-narrative will increase the efficacy of narrative therapies for PTSD. In the following chapter, the concepts will be evaluated in therapeutic settings and examples of current therapeutic techniques working with bodily memory and scripts will be given.

Chapter 4: The application of body narratives.

4.1 Overview

In the previous chapters, I put forward the problem of the rationale behind traditional self-narrative therapy. This therapy consists of a re-telling of the verbal narrative for the patient to implement a balanced self-narrative by including good memories in the self-narrative consisting of an extrapolation of negative memories. Adherents of the traditional self-narrative argue that by making the self-narrative balanced, this resolves fragmentation within PTSD patients (Jongedijk, 2014). Research shows a lack of effectivity of narrative therapies in treating PTSD, and therefore narrative therapy is only a conditionally recommended treatment for PTSD (American Psychiatric Association, 2017). In previous chapters, I showed that the rationale behind this therapy needs to be reconsidered by using embodied self-narrative concepts in narrative therapies. Using the concept of the body narrative as a part of the embodied self-narrative helps to get access to the non-verbal traumatic memory.

In order to develop the right treatment for PTSD, trauma must be uncovered. In traumatized patients, the 'physical root' of the trauma extends well beyond flashbacks. For example, during daily life, the continuous secretion of stress hormones influences behavior such as being constantly on guard and having a heightened startle response. This stress is also expressed in other physical forms, as explained by patient Jim (Erskine, 2014, p. 25), who was detached from his peri-personal space and therefore intruded other people's space. In this chapter, I will use figures to explain more in-depth how the rationales behind the traditional concept and the embodied concept work out in therapy. Access to the bodily trauma enable the patient and therapist to change physical and emotional reactions to the memories of the traumatic event. Targeting the physical reaction to trauma is an important start to gain insight into trauma related triggers, but the changing embodied structure in daily life should also be addressed. Therefore, after understanding the unfolding of the bodily trauma, the embodied self-narrative should be verbalized in narrative therapy so it can be changed.

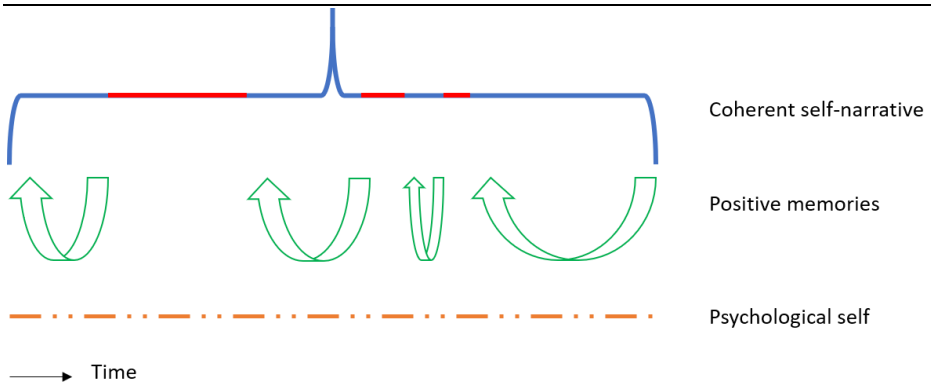
4.2 Traditional self-narrative therapies versus embodied self-narrative therapies

Traditional forms of narrative therapy aim to restructure a disturbed self-narrative in PTSD patients by integrating positive memories into the previously dominant negative memories (Jongedijk, 2014).

Figure 5 visualizes the intended functioning of a self-narrative and Figure 6 depicts how this rationale works out differently since the PTSD patient is described merely psychologically.

Figure 5.

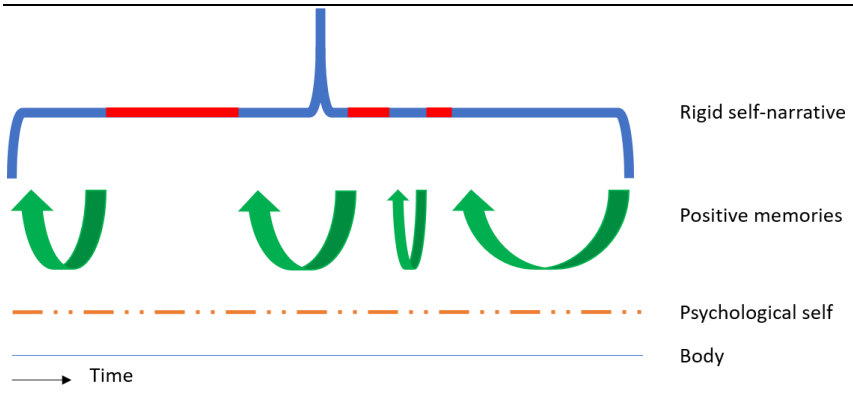
Traditional self-narrative rationale



The coherent self-narrative with traumatic episodes (red parts), are balanced by adding positive memories to the self-narrative (green arrows). The coherent self-narrative heals the fragmented psychological self by balancing negative traumatic memories with positive memories.

Figure 6.

(Dis)functioning of the traditional self-narrative rationale for PTSD patients



The positive memories reinforce the rigid self-narrative (thick lined), even though the content may be more balanced, the psychological self and the body (thin lined) are forgotten in the rationale and remain fragmented. Because the PTSD is already detached from its body, reinforcing the rigid self-

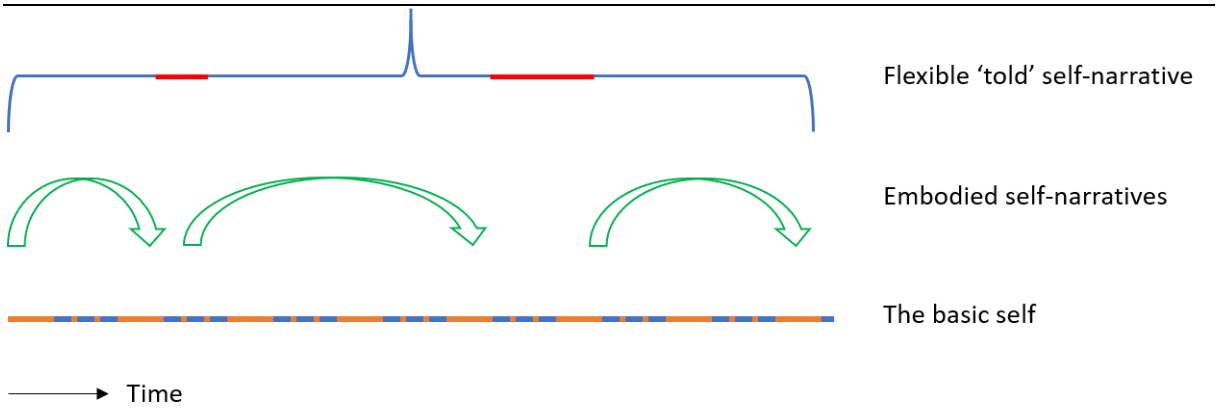
narrative maintains the fragmentation of the basic self. This yields a weak basis to reconstruct a balanced verbal self-narrative.

Figure 5 depicts the intended aim of the rationale behind traditional self-narrative therapy (Jongedijk, 2014). The idea is that restructuring the self-narratives will function as an overcompensation for the implicitness of trauma. However, in Figure 6, the figure shows it lacks an acknowledgement of the distorted 'having body' mode since it does not consider hyperreflexivity in PTSD patients. Therefore, it rather functions as an overcompensation for the implicitness of trauma. The traditional self-narrative makes the self-narrative even more rigid and maintains the detachment of the psychological self from its body. As explained previously, this keeps the patient in a pre-calculative state, in which she is continuously planning every action or decision to make that restrains her participation in life. Therefore, an alternative account of narrative therapies must include the body since the basic self is embodied and not merely psychological. In Figure 6, the body is added to the figure to show that it is separate from the psychological self.

The embodied self-narrative is introduced in the previous chapters. Figure 5, depicting the traditional self-narrative rationale and Figure 7, depicting the embodied self-narrative rationale will be compared. After that, it will be compared whether the intended embodied self-narrative rationale in Figure 7 would work in treating PTSD patients (Figure 8).

Figure 7.

Embodied self-narrative rationale



The embodied self-narrative is both psychological and bodily (blue uninterrupted line, since bodies continue to exist during sleep and daydreaming). Embodied self-narratives arise from the embodied

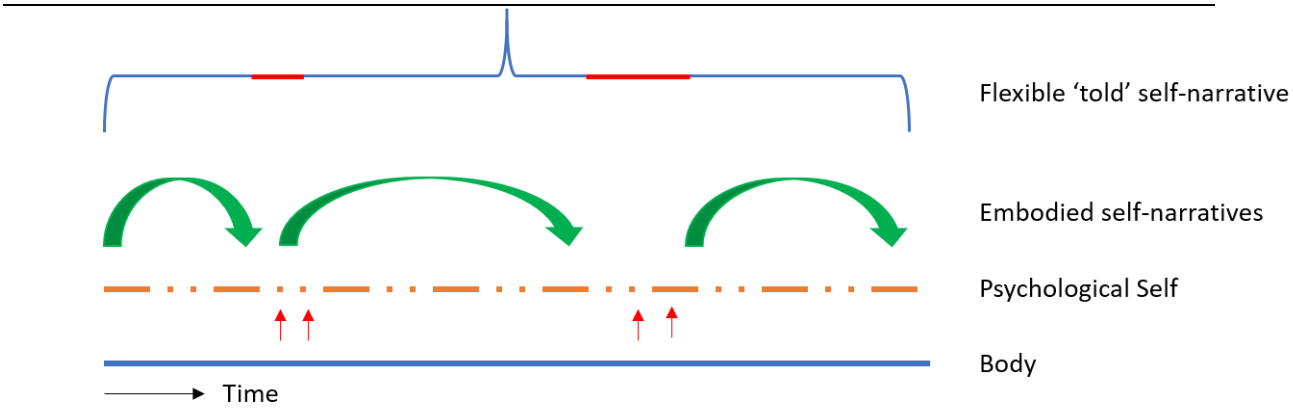
experience, as depicted by the direction of the arrows. In contrast to traditional self-narratives, these narratives are not needed to enhance coherence in the overall self-narrative because the basic self is a strong fundament. Therefore, the overall 'told' self- narrative is more flexible.

First, the arrows in Figure 5 are pointing toward the self-narrative and the arrows in Figure 7 pointing toward the basic self. In the embodied self-narrative rationale, narratives are not intended to make the self-narrative more coherent, but to integrate the fragmentation in the basic self. Also, the self is described merely psychologically in Figure 5 whereas in Figure 7, the psychological self and the body are together an embodied, or basic self. By making the basic self a stronger fundament, the self-narrative does not have to compensate for the fragmentation in the basic self. Therefore, the self-narrative can be flexible and allows the self to stay the same even though embodied states vary over time. Instead of the overall self-narrative being rigid (thick lined) in Figure 5, in Figure 7, it rather functions as a tool (thin lined).

In figure 8, embodied self-narrative therapy is explained with the additive of body narratives and with the distortion of the 'having body' state of the PTSD patient.

Figure 8.

Functioning of embodied self-narrative rationale for PTSD patients



The body narratives describing the traumatic body memory (red arrows) arise directly from the body. After they unfold, they are can be verbalized into embodied self-narratives. The psychological self (orange dotted) is detached from and the body (blue, continuous). However, because of the integration of body narratives into the embodied narrative, the detachment will decrease. The green arrows are the embodied self-narratives, that include body narratives. The told self-narrative is more

flexible (thin-lined) because the basic self is strong enough that it does not need to function as a compensation for a fragile and fragmented self.

Embodied self-narratives are healthier in the sense that they reinforce embodiment of the basic self, whereas a traditional self-narrative rather reinforces the rigidity of the self-narrative. This is depicted by the green arrows pointing to the self-narrative in Figure 6, and to the arrows pointing to the basic self in figure 8. The integration of the body narratives into embodied self-narratives will dissolve the distorted detachment from the body. The body (blue line) gets closer to the psychological self (orange line), which induces the shift from back having body to being body. With a basic self in which body and psychology are reunited, a more flexible self-narrative can be told. This narrative may function as a way of eliciting the memory of the traumatic event and is therefore a starting point for treatment. Besides eliciting the traumatic memory, the body should become strong, safe and reliable for the patient in order to get rid of the fundamental PTSD symptomatology.

4.3 Embodied self-narrative therapies further explored

In clinical practice, embodied narratives should be applied as functional tools in narrative therapies. The elicitation of the traumatic memory will need some separate space before it is verbalized in order to elicit the structure of the traumatic memory. Under surveillance of a therapist, the patient will slowly return physically to the event to explore the scene, the fears and emotions that came up and the unfolding of the traumatic events. The associated bodily and visceral perceptions that represented the patient's vulnerability and defenselessness are re-experienced. The focus must be put on fluctuating internal sensations that are embedded in the re-enactment of the trauma. It may seem like an aversive and re-traumatizing experience. However, letting the patient re-experience the trauma in a safe environment, the old and threatening stimuli are mixed with safe and current stimuli which will lower the intensity of the feelings (Caldwell, 2016). Analogously to the traditional self-narrative therapy, a balancing of the integration of positive and negative experiences is the aim of this re-experience. Whereas in traditional self-narratives, this is done verbally, here, the body integrates the experience of feelings of danger and feelings of safety.

Secondly, eliciting the body narrative gives the patient and the therapist a possibility to go to the root of the traumatic feelings and evokes insight into triggers from the trauma that influence the patient in daily life. The restructuring of the body narrative will restructure these motoric responses

by ‘mixing’ the (traumatic) memory with a current (safe) space and new motoric responses could be influenced by therapists who carefully and sequentially enact motoric responses (Caldwell, 2016). The body narrative structure is ‘replayed’ and new meanings are added in which the body is more activated to intervene in the situation. Whereas previously the patient is overwhelmed by feelings in the body and pains and emotions that follow from them, now the patient experiences control because she knows how the structure of the body narrative. By using the body and embodied self-narratives in narrative therapies, the aim is to shift from having body to being body, and thereby decrease detachment from her body and use it instead.

An important function of the previous two applications of the body and embodied narratives is that they ‘anchor’ the verbal self-narrative. A body narrative can ‘correct’ confabulated self-narratives. As opposed to told self-narratives, the body narrative is not susceptible to confabulation.[7] The simple argument for this is that our physical surroundings and body limit stories because they influence the way we act, whereas imagination is somehow ‘limitless’. The body anchors the free flow ‘anything goes’ character of stories (Rucinska & Reijmers, 2014). Caldwell (2016) mentions that confabulation is formed by the left hemisphere of the brain which includes the interpreter mechanism, whereas the right hemisphere processes direct experiences and emotions. “What this may point to is the likelihood that by postponing the explanatory narratives of the left hemisphere, and engaging directly with conscious movements that can directly and accurately express the feelings welling up in the right hemisphere, we can avoid the trap of trying to figure out whether a recovered memory is true or not.” (Caldwell, 2016, p. 262). An example of how this correctional model can be applied to the re-experience of trauma could be patient Nancy (Van der Kolk, 2003, p. 198) who associates any iron object with threat, that evokes stress and anxiety. Instead of talking about the object as it not being a threat, the patient should try to point to the object, touch it, or throw it. If the narrative around the object is not corrected by embodied experience, the patient can rigidly tell herself that the object is safe with the possibility that the subject keeps avoiding and gets even more estranged from the object.

The functioning of the body and embodied narrative concepts will be made more explicit in the next section where I discuss existing therapeutic techniques in which body narratives unfold, sometimes into embodied narratives.

[7] Unless a subject experiences psychosis or is in an intoxicated or other medical condition.

4.4 Therapeutic techniques in which body narratives and embodied narratives are applied

Psychomotor therapy (Ogden, Minton, & Pain, 2006) explores the traumatic memory by putting the patient's body in specific positions, sometimes with the help of gymnastic objects (an exercise ball, a bench, or a mat). These positions evoke specific sensations and emotions in the patients, since the motoric maps associated to the trauma are activated. For example, a sexually abused patient might re-experience her trauma of being raped while her body is positioned in the same way as it was during the rape. In this position, she immediately feels the pain in her lower belly and starts sweating and feeling tense. These sensations are a starting point for the unfolding of her body narrative. The 'bodily fluctuating sensations' depict both the past traumatic memory but are in the therapeutic setting mixed with current environmental states which are safe and trustworthy. Van der Kolk describes these moments as 'somatic re-enactments of the undigested trauma' (p. 101). It is only at these moments that the associations of trauma can be unlearned bodily, and this should be done by letting the patient finish the bodily script by adding and activating defence movements. Movements of defence can be the start of a body narrative in which the patient achieves a feeling of regaining control. This feeling of control starts with achieving awareness. The patient anticipates for the bodily tensions that will follow which already gives her feelings of control. Awareness may further develop by being able to describe the body narrative structure, such as locating spots in the body where pressure, heat, or muscular tension is felt.

A possible next step could be to add a new ending to the body narrative. This can be done by sequentially re-experiencing the unfolding of events within the bodily script and then enact alternative final movements and sensations. Patients may finalize defence mechanisms that were suppressed and unlearned during repeated trauma. Instead of defence- and helplessness, the patients should physically experience to defend themselves or fight back. This can be performed by acting against 'another body'. In clinical practice, this will be the body of the therapist. The patient might softly push that body or approach the body centimetre by centimetre. The patient expands the minimal physical boundaries and learns how to act out against others by using the power that she previously detected in her body narrative structure. Finally, this results in a restructured body narrative in which defence mechanisms are switched from a suppressed to an active mode. This technique will reinforce patients to 'carve' their own peri-personal space and shift from having body back to a healthy state of being body.[8]

[8] And by carving a peri-personal space, patients don't have to overcompensate for this, such as described in Erskine's patient 'Jim' (Erskine, 2014, p. 25)

Another technique is described by Rucinska and Reijmers (2014). The 'staying within play' technique requires a postponement of verbalization of experiences during play. This is done in order to obtain new meanings in interaction with objects and other bodies without taking away the potential creativity that may come out of bodily interactions. Rucinska and Reijmers propose a form of play therapy with objects that is especially beneficial to patients who are approaching their problems 'too analytically'. As explained in Chapter two, because of their pre-calculative stance, PTSD patients are also 'too analytical'. Their hyperreflexivity results in a use of words which carry fixed meanings and only fit into a rigid self-narrative. In play therapy, the aim is to replace words with objects. An embodied dialogue with the use of objects allows for a broader range of possibilities to interpret them. On the other hand, since words have a smaller 'degree of freedom' for interpretation, they can pull the patient back in rigid thinking. Using objects creates more perspectives and freedom to find a meaning in embodied encounters within therapy (for example with other bodies and objects). The 'staying within play' technique stresses that the embodied dialogue should not be interrupted verbally before it is unfolded. As Rucinska and Reijmers explain:

> One does not need to *think* about the possibilities, analysing them in advance, but learns to 'see' on the spot such as potentialities only in the process of interacting with the objects, which further affect the way we think about them. What playing does is it allows one to expand on a set of behaviours with possibilities that are directly present to us. (Rucinska & Reijmers, 2014, p. 45)

The last sentence addresses another important aspect which was discussed in the previous chapter. The false distinction between body narratives being implicit and verbal narratives being explicit is not applied in this technique. The focus in play therapy is to just observe the unfolding of bodily gestures, actions and expressions and let these bodily structures convey the message.

As explained by the pre-calculative mode in the hyperreflexivity model, PTSD patients experience that others or objects overwhelm the patient and that the patient lacks any sense of influence or control over them. Rucinska and Reijmers (2014) argue that by playing with objects, patients develop new perspectives and reposition themselves towards those objects. The positioning of the patient toward the object creates an embodied experience of agency. An important aspect of staying within play therapy is the use of objects, so the patient 'offloads' her problems onto these objects. The function of other objects or bodies might previously have been associated with threat, but by letting the patient play with these objects, their meaning is not fixed but is determined by playing.

The ‘anchoring function’ of the body and surrounding objects are also related to this because the physical surroundings limit the imaginative and rigid told self-narrative. Instead of looking at an iron as a murder machine, they use it differently, as a paperweight, as a bookstand, or to iron their clothes. This puts an end to their continuous pre-calculative state and fear of threat. Moreover, it will stimulate their use of the body which should remove their detachment from the body. Patient John got ‘stuck’ by analysing his past and expected future goals. After the play therapy, in contrast, he reported that “he felt differently afterwards: ‘not so in my head’ and ‘not so heavy’.” (Rucinska & Reijmers, 2014, p. 43).

One important conclusion in line with a technical use of the body narrative is addressed by Rucinska and Reijmers (2015). The purpose of involving play is “to enhance dialogue in therapy *rather than* uncover hidden meanings.” (Rucinska & Reijmers, 2015, p. 1) In traditional forms of therapy, the idea is that by talking only, the dialogue will be enhanced because of the uncovering of hidden meanings. However, the interaction between bodies and objects will not uncover hidden meanings but rather produce new meanings.

Finding new meanings is important in the treatment of PTSD. After the traumatic event, flashbacks and other associated triggers with the trauma are acknowledged and ‘worked through’, and the patient must feel there is a new ‘way forward’. The hyperreflective patients will get extra depressed by evaluating how to move forward but not being able to put their thoughts into action. Patients may obtain some insight by retelling a self-narrative, but at the same time, they may feel disabled to escape the behaviour that marked their past. Therefore, acknowledging and restructuring the body narrative should be done first in order to start working with embodied self-narratives so patients can restructure their verbalized self-narrative.

4.5 Conclusion

After having proposed the body narrative as a necessary and functional component in narrative therapies for PTSD patients in previous chapters, in this chapter I discussed how the concept of the embodied narratives could be applied to narrative therapies. I did this by comparing the rationale of traditional self-narratives with embodied self-narrative rationales for the treatment of PTSD patients. I elaborated further on how the body and embodied concepts could be applied to clinical practice by discussing some existing techniques and forms of therapy that are used in clinical settings that make use of structures that are non-verbal and resemble body narratives.

Looking back at the problem formulated in the first chapter, trauma must be retrieved physically in order to not miss the plot of the traumatic experience. This makes the body and embodied narrative of big value for treatment, and the body narrative even necessary to access the unfolding of the events and its associated triggers. After the trauma is uncovered in its full extent, awareness of this trauma could alleviate physical symptoms of PTSD. In this chapter it was described how traumatic stimuli could be retrieved in a safe environment for the association to be changed from 'completely dangerous' to 'potentially safe'. Also, the unfolding of the body narrative depicting the trauma itself can be restructured by a replaying of the trauma but changing the last events from defencelessness into gaining control. This will restore the patient's bodily detachment and integration of the traumatic memory into the embodied self-narrative.

Conclusion

In this thesis, it was explained how merely re-reflecting upon a self-narrative may balance the told self-narrative of the patient, but it does not affect the underlying distorted 'basic self' of the PTSD patient. PTSD patients suffer from distortions in their 'basic self' which is expressed in problems with self-referentiality, or the inability to integrate physical information with mental information processes. The hyperreflexivity model explained how in different anxiety- and mood disorders, patients tend to hyper reflect on themselves and their actions, which creates a pre-calculative state and distance to participate with the world. I applied this model to explain the rigidity of self-narratives of PTSD patients and concluded that targeting the embodied state is more effective, since achieving a more solid 'basic' and embodied self will decrease the rigidity of self-narratives.

Embodied self-narratives were defended by Menary (2008) and Slors (1998) and I evaluated their models and their adjustment to the traditional abstract self-narrative model (Schechtman, 2007). The latter model describes the self as a purely psychological construct. Using the traditional model in narrative treatments for PTSD would further reinforce the disembodied state of the traumatized patient. However, the embodied self-narrative considers the basic self that experiences the things he or she may narrate about. With the use of the embodied self-narrative in therapy, the distorted 'having body' state of the PTSD patient will be considered and could therefore be addressed during therapy.

In some cases, the concept of the body narrative must also be considered to use for therapeutic techniques in therapy, because it emphasizes the wordless structure of the body memory of the trauma. The unfolding of the traumatic events during a flashback is of great value to get insight in trauma related triggers and feelings the patient experienced during trauma. Letting this physical structure unfold without verbally reflecting on it creates insight in the trauma that could otherwise not be accessed. The body narrative could be called a narrative because it doesn't have to be interpreted by verbal means by the direct experience by the patient. However, the body narrative is part of an embodied self-narrative that should be shared with the therapist so new meanings and interpretations can be shared.

Even though in clinical practice there is no difference between an embodied self-narrative and a body narrative, the latter concept is important to defend in relation to the treatment of flashbacks. It is needed to make room for wordless techniques in narrative therapies for PTSD. I only defend a use of the body narrative in the context of traumatic experiences and narrative therapies. Instead of only focusing on physical symptoms, it is important to see how the embodied and body narrative are related to each other. This should also be applied to treatment, since the treatment

cannot be merely physical either. The aim is an integration of a focus on physical symptoms, but also talking about the traumatic memories after the embodied structures are elicited. However, only talking and putting it in narratives will not do justice to the physical aspects.

Emphasizing the non-verbal aspects of PTSD's symptomatology and the challenges and opportunities that come with it may inspire therapists and developers of treatments for PTSD. Besides the importance of an embodied account of PTSD because of the symptoms basic structure, there are also other reasons to work with non-verbal techniques. Immigrants in the Netherlands have a higher change to develop PTSD and are often more severely traumatized (Fazel et al., 2015). At the same time, their drop-out rates in therapy are much higher (Blom et al., 2010) in the Dutch mental health systems. This could be explained by cultural, religious and language barriers during therapy. Embodied approaches to treatments for PTSD may decrease the threshold for participation since it less language focused which could increase the efficacy of treatment for those patient populations.

In this thesis, I discussed different models and theories behind the psychopathology of Posttraumatic Stress Disorder, narrative models, examples of PTSD patients experiencing flashbacks, therapeutic techniques and some behavioural and neurological research on PTSD. I explored the possibility for an adjustment of narrative therapies for treating PTSD that considers states of embodiment. Even though I discussed some examples of therapeutic techniques, I did not write a manual for embodied self-narrative therapy. My aim was to provide a rationale behind a therapy that acknowledges the fundamental, embodied structure of PTSD's symptomatology and creates access to the wordless experience and memory of trauma. With this proposal I hope to contribute to the development of better treatments for PTSD patients.

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