EXISTENTIAL THERAPY (DASEINSTHERAPY): A THERAPEUTIC RESPONSE WITH MALES TRAUMATISED BY INTIMATE PARTNER OR FAMILY VIOLENCE [1]

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ABSTRACT

The author discusses working from an existential perspective with individuals traumatized by aggression in intimate partner relationships and family settings. He poses three questions: What do clients from widely different Western populations who have been harmed emotionally in ways that lead them to seek outside help require from clinical psychologists and other mental health practitioners, especially with a view to the prevention of further aggression in their lives? What are the features of a modality of psychotherapy that is effective with this diverse population? What is therapeutic in relationships with such individuals that leads to an abatement of aggression in their lives?

Keywords: psychotherapy, existential therapy, male studies, men in therapy, daseinstherapy

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My topic this morning is how therapists may best work with an individual who has experienced aggression directed toward the person or against others and has sought counsel because of its effects on the individual's emotional life. In keeping with the international context of this conference, I ask whether a therapeutic approach can be identified that is applicable with such adults across nationalities and cultures and is effective regardless of the individual's sex and sociocultural status. I will suggest that an existential approach can meet the challenge.

I. First, some necessarily brief and therefore incomplete clarifications regarding a number of concepts are in order. I want to say a bit about trauma, violence, aggression, existence, and therapy.

As we have heard this weekend, recent research (see the Appendix below) is quite clear that when there is aggression in intimate partner relationships, in every case both individuals involved are at the very least emotionally harmed in some way whether or not this is noticed initially or acknowledged by both individuals. Considered psychodynamically, interpersonal aggression is necessarily dyadic.

We now know that men as often as women are the object of such emotionally damaging behavior. However, men are much less likely to report such experiences to friends or medical and criminal justice personnel. When there is physical damage and a man requires emergency room care, for example, he is likely to attribute his injuries to an accident. When harmed emotionally, men commonly suppress reactions other than secondary reactive anger, which often incites further aggressiveness. A man who appears in the office of a psychiatrist, social worker or clinical psychologist to discuss what has happened to him is still rare.

The consequences of such experiences—especially feelings of fear and helplessness—often add up to the symptoms of what since about 1980 psychiatry has referred to as posttraumatic stress disorder (PTSD), a condition first identified as "shell shock" in men who had been overwhelmed by the conditions of combat during World War One. Later (c. 1985), the disorder was more famously associated with adult women who reported that during early childhood they had experienced violent relationships with older males, often their fathers. PTSD was also more widely diagnosed in both male and female adults who as children had experienced multiple serial acts of aggression at home or in the community.

Another finding mentioned this weekend is that work with individuals who have experienced intimate partner or familial aggression has had in general limited therapeutic effectiveness especially in preventing further experiences of aggression from occurring. This disheartening admission by clinicians is, of course, one reason for our conference. My contribution is meant to suggest one way to improve the record of psychotherapeutic work with the population that concerns us.

So much by way of a brief and unfairly simplistic look back at some of the findings we have heard about so far at this congress and elsewhere in reports of research on our theme.

II. As further context for my remarks, I would like to note a few ideas that have guided my thinking on our topic. *First*, there is the obvious fact that responses to experiences of aggression observed, endured or perpetrated vary significantly depending on the person's sex and age, and the broader cultural ethos in which the individual exists. Are there principles of psychological treatment that can transcend these differences?

Second, we should recall that what is judged to be "objectively" violent or aggressive by an outside observer may be registered by the person subjected to it as a very different experience, both in kind and degree. For example, an individual who has since early childhood been exposed to chronic mishandling—ranging from persistent yelling and humiliations to excessively harsh "disciplinary" punishments—may as an adolescent or adult barely respond to an instance of name-calling or shoving, which to someone relatively "innocent" of aggression is perceived as shockingly violent. An individual who has rarely or never been exposed to interpersonal aggression while growing up might be profoundly affected by observing or experiencing a single slap or harsh name called out at a person, especially when delivered by someone with whom the person harmed is on intimate terms in what heretofore had been a mild, loving relationship.

These problems of *interpersonal perception* between individuals who are at different levels of maturity, socialization, acculturation, and power make our topic extremely complex. As you will see, they are especially relevant for how a patient in counseling or psychotherapy responds to the therapist's words. I should add that the dynamics of interpersonal perception discussed with notable insight by the Scottish psychiatrist R.D. Laing beginning in the 1950s as part of his social phenomenology has been very influential on my own thinking about therapy.

III. I move on now to a few words about basic concepts. Our discussions this weekend began with the assumption that certain experiences are *traumatic*; namely, those perceived to be violent or aggressive or both. Therefore a few words about the meaning of *trauma* are in order.

As a young therapist, I asked one of my earliest mentors—a seasoned psychiatrist and psychoanalyst—what he considered to be the most important single principle to keep in mind when working with people in psychoanalytic psychotherapy. It was the sort of question a naïve beginner asks.

I expected to hear something like "point of arrested development" or "degree of regression" or "extent of dissociation." To my surprise, he said *the extent of perceived trauma the individual has endured—which*, he added*, we nearly always underestimate.* I thought I would then hear as an example of it something like sexual aggression or other interpersonal violence. The example he gave, however, was the experience of the death of a teenage boy's younger brother.

Our cases regularly involve interactions between people that are florid, noisy, and chaotic. On the other hand, as in my mentor's example, being "abandoned" by a loved sibling can be as traumatizing as a blow to the body that was a deliberate expression of hostility, rage, or anger. It is always necessary to understand aggression from the perspective of *perceived* aggression, since that is what counts as traumatic for a person.

In general, as we know, what is traumatizing renders the individual temporarily overwhelmed by the physiological responses of defensive arousal and the numbing emotional feeling of being unable to make sense of what has happened and to respond to it adequately. "It dos not compute." Traumatized, one may become agitated or immobile in the stillness of incapability. The response to an event that is traumatizing may be a loud scream and crying. Or it may be stunned silence.

The well-known tardive appearance of fear and anxiety in the scenario of cases of Posttraumatic Stress Disorder come to mind here. After initial emotional and cognitive freezing, a response finally occurs, perhaps days, months, or even years after exposure to traumatizing events. Such initial non-responsiveness may be of special importance among males, who from boyhood on are socialized to not express emotions, whether they are pleasant or painful. For boys, often the only socially approved emotional reaction is anger and that may be forbidden by

threats of further aggressiveness in the form of retributive punishments by parents or other elders. Years later, however, the expression of anger may finally be disinhibited and with damaging (including self-damaging) results in sudden, unanticipated outbursts of aggressiveness.

Next, it is important to clarify three related concepts before thinking about our work with individuals who have experienced *interpersonal transactions* that are traumatizing: these are *hostility, aggression,* and *violence*. The phenomena are often not carefully enough distinguished, but to do so is important for our consideration of therapeutic work.

First, *hostility*. Hostility is a disturbance of affect that may or may not lead to its expression in words or other acts. Thoughts about revenge and plans to implement impulses to strike out often accompany or immediately follow feelings of hostility, but such thoughts and impulses and the hostility that engendered them may be masked by a facial expression and overall comportment that suggest composure, even calm. "Inside," however, the hostility is livid and may move on to rage. Yet neither the hostility nor the rage may be externalized.

Next, *violence* and *aggression*. *Violence* is behavior involving physical force intended to damage the object toward which it is directed and perhaps even to kill it if the object is a living being. There is violence in the slaughtering of animals that will be eaten and in some sports, and there is often violence when in the interests of survival one instinctively tries to ward off or escape from a perceived attack on one's body or person. There is violence when two people argue or come to blows. But now comes the crucial distinction.

In interpersonal transactions we must distinguish between violence from *aggression*, which is always affectively motivated. The hunter does not hate the deer he shoots to procure venison for the dinner table. He feels no hostility toward the animal before going on the hunt. The football player or boxer does not hate his opponent on the field or in the ring. Neither are motivated by hostility. Violence does not imply aggression, but the person who lashes out at another, screaming at or striking the other person, is inevitably motivated by hostility, perhaps even by rage.

But now consider the following example. Walking along a crowded Manhattan sidewalk, I once saw an adult woman push a small male child off the sidewalk into the space between two

parked cars. My response was powerful. I felt shocked by the adult's behavior and compassion for the child. Everything changed, however, when I realized that the woman had seen a runaway vendor cart barreling down the sidewalk heading toward the child whose back was turned to it. The little boy was also shocked by his mother's surprising, sudden violent gesture and stood there between the parked cars crying—until his mother went to him after the cart had passed and crashed into a parked car several yards away.

The adult's shove had saved the child from being struck by the cart and likely sustaining serious injury. She hugged him profusely, explained what had happened and what could have happened, and comforted the boy. That took some doing. We may wonder how well he understood the gesture or his mother's explanation of it.

By now she, too, was crying. She was a hero, not an aggressor. Her behavior had been violent but not aggressive.

This is important when considering interpersonal aggression. In fact, I wonder whether we should in general speak of intimate partner aggression or familial aggression instead of intimate partner violence, since what we are talking about is always motivated by disturbed affect.

I have not forgotten the Dollard-Miller model of aggression—that aggression is caused by frustration—and I think it is worth considering. I only want to establish that interpersonal aggression is always motivated by negative affect—but perhaps instead the impatience consequent to frustration.

IV. Next, I want to say something about *therapy* in general and what is *therapeutic*. This will lead me to comment on the notion of *existence*.

What do we intend to accomplish when we sit down with someone in the intimate setting of the consulting room? My concern is that most psychotherapists implicitly think of the other as an object—a *what*, whether it be (1) an ego at odds with its id, conscience, and the outside world; or (2) a thinking critic of his or her own thoughts; or (3) a machine-like emitter of chunks of behavior (operants) that may be ignored, rewarded or punished by others in the interpersonal environment; or, finally, (4) a brain that somehow "has" feelings and motives and "talks" to itself between its hemispheres.

I prefer to think in terms of the uniquely human being, the person who exists, a *who*. This is the only being that exists, not a being that in any sense ever *is* something fixed once and for all in its features—a *what*. Here we are in the world of existence or what has been famously termed *Da-sein* by the German philosopher Martin Heidegger.

You now see why I call the approach I take in therapy *existential*. It is directed at the existence, the *Da-sein* of the other.[2]

The existential therapeutic stance does not concern itself with the nationality, language spoken, class, level of education, sex, or gender of the other. It can be applied in cases of experienced interpersonal aggression here in Germany, in Canada, or the States. Recent reports of clinical psychologists working in China with whom I am acquainted suggest that the broadly humanistic and existential-phenomenological approach of which existential therapy is the paradigm is also effective in "non-Western" cultures. In fact, its popularity there is extraordinary.

As you have guessed, I take a certain position with respect to the venerable psychodynamic and cognitive-behavioral approaches so well known and widely employed in contemporary counseling and psychotherapy. Here I can only summarize the basics of existential therapy and identify what I believe is therapeutic about it, but without being critical of those other perspectives. Given what we have heard about the limited degree of effectiveness of *psycho*therapeutic interventions with individuals who have experienced traumatizing aggression in intimate relationships, the existential view I take will, I hope, be welcomed in our discussion without necessarily rejecting and discarding other approaches.

It is often said that people come to therapy because *they want to change* or *to be changed*. It is said by some that understanding one's past is the best means for effecting change in the present and preparing one for a better future—a future, for example, without aggression. Alas, no life will be free of violence of various kinds. Others, in the tradition of cognitive-behavioral therapy, broadly conceived but especially in the modality known as rational-emotive behavior therapy (REBT), suggest that we only need to think differently than we do about what is

[2] Currently, I prefer the term daseinstherapy to term existential therapy.

important to us and reframe our thoughts in order to neutralize the effects of the past experiences and prevent them from being repeated in the future.

I take a different view about what motivates a person to consult a therapist. It seems to me that if *acting on one's own* a person seeks what the genuine therapist can provide, it is because *one's existence has changed*. One's world has changed. In everyday terms, we say one's whole "life" and every aspect of it has changed, even though one may not be consciously aware *that* something has changed. There is only a sense of uncanniness. Or one may know *that* something has changed but not know just *what the "that" is*. "Something feels different" but just what that means is unclear. People seek therapy, not to change but because one's world has changed.

The existential therapist does not set out to "fix" or other alter or change the other.

What distinguishes existential therapy from other forms of *psycho*therapy is that it is *non-interventional* and must be experienced as such by the other who has come to consult with us. The goal of existential therapy is *to provide an interpersonal situation in which the other is able to recover his present* (*Gegenwart*). That such provision is perceived as non-interventional turns out to be crucial when working with individuals who have experienced interpersonal aggression, especially males. Medical treatment, giving advice or information, retraining or imposing disciplines, offering custodial care, inspiration or exhortation—all of these, and the traditional forms of psychotherapy are interventional.

If this sounds odd to you and you are saying to yourself, "But we must *do* something, we must step in," I reply: (a) As physicians and other healthcare providers we are obligated to intervene when someone is agitated, confused and disoriented, and we may elect to chemically quiet his nervous system until and so that he can reflect on his existence. (b) As a culture we must authorize certain people to step in and stop patterns of interpersonal aggression between men and women, parents and children when they are occurring. For this purpose, we have police. (c) Beyond that, we must also attempt to educate or re-educate adults who are aggressive. For this we have special schools and rehabilitation centers. (d) As social workers, we must inform and assist relatively helpless, uninformed or incapable people negotiate the bewilderingly complex system of mental healthcare institutions. Finally, (e) as teachers we must embody certain values of civility and model rationality.

However, as therapists working with men and women who have been subjected to aggressive acts or who have carried them out against others, our goal is not to effect change, but only to acknowledge that it has taken place and to make way for the other to bring about existential orientation in his or her world.

Existential therapy is offered precisely without intervening in the life of the other. A certain kind of *Fürsorge* (solicitude or concern) is shown—what Heidegger termed *vorausspringende Fürsorge*—namely, concern for the other's existence that steps aside and makes way for the recovery of the other's *present*. By contrast there is the intervening, *einspringende Fürsorge* of medical and social social practices, schooling, and active support of the kinds I've mentioned.[3]

To be clear, since this often comes up in discussions of existential therapy, to attempt to *be* nothing to the other does not mean *doing nothing*. The effort to make way (*vorausspringen*) requires continually monitoring when the other entreats us to help solve a problem, advise, or reconstruct a past and plan for a future. To abstain from the other's ordinary everyday desire for us to step in (*einspringen*) and modulate his temporal orientation for him is hard psychological work for the therapist.

We will not always be successful in staying out of the way of the other's recovery of his or her present, but this should not prevent us from continuing to pursue our goal: permitting a situation and conditions to be maintained for the brief span of the therapeutic hour in which recovering one's present is the work to be done by the other sitting across from us. We remain aware that the other must leave us and return to the real world where his existence does not first matter. This requires ending our meeting. Is this a form of intervention, after all? I leave this open as an important question for discussion.

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[3] Here I would invite the interested listener to have a look at my book *After Psychotherapy* (New York: ENI Press, 2016) and a pair of articles "The Return of the Therapeut. The Genuine Psychotherapist," in the *International Journal of Psychotherapy* **18**(1), 2014, pp. 5-18, and **18**(2), 2014, pp. 5-20.

V. This is especially important for the group we are concerned with this weekend. Paradoxically, with someone whose symptomatology has been determined by traumatizing experiences of interpersonal aggression, potentially any intervention will likely be experienced (consciously or unconsciously) as aggressive. This is why, I believe, medical treatment—and here I refer especially to psychiatry—as well as social work and the modalities of psychotherapy, which are based on the medical model, have not been effective in working with individuals traumatized by aggression.

In every intervention something literally *comes between* the one providing treatment and the other, between an agent and a patient. By contrast, the *sine qua non* of a genuinely therapeutic alliance from the existential perspective is a concern and intimacy that precludes anything getting in the way of contact between the two existing human beings.

The nationality, language spoken, cultural heritage, race, ethnicity, age, sex, gender or political position of the therapist is seen to be irrelevant to the therapeutic purpose if one takes an existential approach since existence is the *possibility* for any identity, whether it be established as a socioeconomic, religious, gendered, or otherwise cultural.

In attempting to establish a therapeutic alliance, every psychotherapist tries to be even, fair and kind, but that is not enough when the other has been sensitized (as allergists say) to the emotional toxins that produced the original traumatic response. A concerted effort to *not intervene* is the most promising way to respectfully approach the other's privacy and allow that unique relationship we term therapeutic to form.

To *be nothing* to the other is the "technique" of the existential therapist. *To be a therapist* to the other is, alas, unavoidable by definition, but to strive to *not* be anything else to him is a goal that we can pursue. Clearly, the physical and personal realities of the therapist, who is after all a living, breathing person with physical features immediately discernible to the other sitting across from him cannot be eliminated. On the other hand, it is possible for the other to effect what the phenomenologists terms an *epoché* (a temporary suspension of belief) with respect to those realities. This is another element of existential "technique."

Explaining just how this and our *being nothing to the other* are accomplished exceeds the scope of my presentation. It will have been enough to suggest this morning that existential therapy is, I believe, the indicated modality in working with individuals whose presenting complaint is a history of perceived aggression. Following two more comments on classical psychoanalysis and Gestalt therapy, I will explain why.

Classical psychoanalysis, which positions the analyst out of sight of the analysis and in a situation where only two disembodied voices can be heard, one of them saying little or nothing, was perhaps most promising among the early psychotherapies as an existential therapy. Communication between the not consciously known of one person and the not consciously known of another is enhanced by hiding the physical realities of the analyst—appearance, including gender and ethnicity, age and habits of self-presentation—and even minimizing vocal utterances. But even here at least one intervention is always required (apart from demanding a fee) and that is, of course, invoking the seemingly harmless fundamental rule—to say anything that comes to mind—which no matter how gently put nevertheless remains an injunction and therefore an intervention, albeit a much much less harsh one than the "Think straight, buddy!" of rational-emotive behavior therapy. And given the inevitability of resistance, in practice it turns out that the psychoanalytic injunction must be urged again and again on the analysand.

A few words about Gestalt therapy may be in order since it appears to have a great deal in common with the approach I am describing and advocating. As I understand it, drawing attention to the immediate shared situation and as therapist immersing oneself in it with the patient is a principal therapeutic goal of Gestalt practice. Gestalt therapists aim to expose and expand the immediate perceptual experience of the patient, share it and become involved in it. In order to do so however, the Gestalt therapist must intervene. The famous interaction between "Gloria" and Frtiz Perls of *early* Gestalt therapy fame has merely been seen by nearly every psychotherapist who wants to understand the modality. Ultimately concerned with drawing the patient closer, Perls first forcefully encounters her. I should add that Gestalt therapy has developed in many ways since Fritz (who was originally trained as a psychoanalyst), especially thanks to the work of his wife, Laura. The approach remains interventional, however. Like all the others, if entering the shared field of "the moment" is the Gestalt therapist's goal, the aim of existential therapy is to permit the other access to his or her own present but not to somehow

share in it.

VI. Now permit me to express myself more carefully on why this approach works especially well with individuals whose most intimate relationships have been chronically marked and marred by aggression the point is that they will be especially sensitive to what is perceived to be any intrusion, invasion, or penetration of their world—whether we conceptualize this world as the body's social space or the intrapsychic space of the self.

Spoken words, which can affect even the most self-assured of us when harshly uttered by someone whom we have respected, admired or entrusted with our well-being, are registered if at all only with great caution by those who in the past have been frequently humiliated, even punished with words as well as blows. The words of even the most well-meaning, soft-spoken physician, social worker, or psychotherapist are easily misconstrued as intending harm and are therefore deflected by the selective inattention of the patient. Words by default are perceived as admonishment, imperatives representing the peremptory redirection of one's behavior by the therapist.

The therapist must take an approach that does not lock the other in a bond, even one that is sincerely intended to be nonconstrictive. Such *bonds* are easily experienced as *binds* by the group of patients we are considering.

Knowing that no matter how well-meaning or gently offered in dulcet tones or prefaced by disclaimers a verbal intervention may be, we must realize how easily it may be taken as *edging* against the other's somatic and emotional boundaries, the physical and emotional surfaces of the person's world, his or her skin or that membrane of sensibility we call the self.

Any behavior perceived as an intervention, even if honestly intended to be therapeutic, implies a power differential. We must not forget that all of our patients have been in some sense overpowered.

Finally, let us consider the therapist's own understanding of aggression, including experiences of it in his own life.

It is sometimes claimed that individuals who have themselves experienced a certain problem such as addiction to substances like tobacco, alcohol or other drugs, and have

"overcome" the addiction, have been prepared by their life experiences for working with people currently in bondage to one of those substances. Similarly, the experience of having "survived" sexual abuse and being motivated to help others learn how to cope with its traumatic effects and no longer feel the stress that reliving it retrospectively produces, is sometimes said to have prepared someone to be a counselor or therapist who specializes in working with those who are experiencing the repercussions of interpersonal aggression, sexual or otherwise. The idea is that reliving past traumata in the presence of someone who has "been there" but has transcended its effects will be therapeutic. He made it; so can I.

I doubt, however, that this makes sense—and the research once again suggests that such individuals have had as little success as psychotherapists of whatever modality, and for this reason. The survivor as therapist will have had a strong reaction to aggression and will want an end to it in the life of the client he sits with. But being a survivor is being something to the other and this is precisely what the therapist who takes an existential approach wants to avoid. Obviously, his urgings will be experienced as interventions.

If the existential approach suggested here is viable, it works because the practitioner assiduously attempts to abstain from advocating for a way of life for the other, knowing that one's only "job" is to provide a situation in which a way is made for the other to recover and resume his or her present. Precisely *not* addressing as such the aggressions purported or known to have been experienced is the *desideratum*. What has in fact happened is of great importance to the physician or policemen, but as every therapist knows only the psychological reality of the other matters, no matter what a surveillance camera may have recorded or eye witnesses may report.

Stepping in (intervening), is yet one more stepping on the present of the other, the present that has been abandoned and from which the other has taken refuge in a recollected past or an imagined future. To *not* intervene in a life that has been filled with aggressive "interventions" therefore holds the most promise therapeutically for preventing them in the future. There *can* be a general therapeutic response to interpersonal aggression with intimates that has been traumatizing.

APPENDIX: SUMMARY OF RESEARCH PRESENTED

Highlights of research presented at the conference may be summarized as follows. Intimate partner violence is prevalent throughout the Western world. Despite attention to the issue and substantial research from a variety of perspectives, prevention and treatment efforts have limited effectiveness. Our science of what contributes to partner violence needs to more carefully explicate mechanisms to lay the ground work for more impactful interventions. Mounting evidence suggests that dyadic processes lead to aggression. Both partners in a relationship contribute risk and protective factors. The ways in which those men and women contribute to aggression are more similar than different.

Research from the USA since the 1970s has shown that men and women perpetrate aggression against one another at roughly similar rates, even though women are more often physically injured as a result of the aggression. Male victims of partner aggression must overcome internal barriers such as shame and fear in order to reach out for help.

Current research supports that a significant number of men experience violence from a partner but few studies have explored men's victimization experiences of both aggression and control.

Men experience significant verbal and physical aggression as well as control, manipulation and psychological abuse. They report facing significant barriers in help-seeking and often have not told anyone about their abusive experiences.

Anyone can become the target of aggression, but aggression is not experienced uniformly in any given population. Different forms of aggression (such as partner aggression, aggression against children, sexual aggression, youth aggression including bullying) cumulate in high-risk populations and communities and show common risk and protection factors with respect to both victimization and use of violence. Data from monitoring the German population's health points to the key significance of structural and functional family risk scenarios in the origins and prevention of various forms of aggression as well as the transgenerational propagation of violence.

Connections between experiencing traumatizing events, the diagnosis of PTSD, and interpersonal aggression have been identified. Studies have explored (1) PTSD among female survivors of family violence, (2) the association between combat exposure, PTSD, and the occurrence of aggression among male veterans in their families, and (3) the association between experiencing traumatic events as children, PTSD, and males' current use of aggression in their families.

The work of the father of the field of family aggression research, Murray A. Straus, PhD, must be recalled. He studied family violence, developed the *Conflict Tactics Scales*, and mentored thousands of

students and colleagues. Straus was a courageous scholar who brought the issue of family violence to public attention and tackled controversial issues. His work on gender symmetry in partner violence perpetration and victimization prompted death threats and calls to ban his work. He did not waiver in his commitment to studying and raising awareness about family violence.

A simple and effective way to identify violent couple types has been worked out. The typology developed by the late Murray Straus is basic. This typology differentiates man-only, woman-only, and both-partner violent couples. Studies of violent couple type rates and differences have been carried out. The theoretical and practical implications of implementing these types in professionals' treatment of partner violence are far-reaching. Such implementation can improve interventions and mediate commonly held ideological, theoretical and therapeutic concepts.

AUTHOR PROFILE

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