

***Commentary on “Back to the Future”: Narrative Treatment for Post-Traumatic,  
Acute Stress Disorder in the Case of Paramedic Mr. G***

**Acute Stress Disorder and Forms of Narrative Disruption**

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**ABSTRACT**

Intervening with persons in the immediate aftermath of potentially traumatic events poses a number of challenges for clinicians. Particularly in clinics that serve military personnel or other populations whose livelihoods may depend on regaining functioning efficiently following trauma, there is a need for sensitive and effective psychotherapies for acute stress disorder (ASD), a diagnostic category which attempts to capture maladaptive responses to trauma within the initial four weeks. In this context, Palgi and Ben-Ezra (2010) developed “Back to the Future,” a novel treatment for ASD guided by narrative and constructivist understandings of posttraumatic adjustment (e.g., Neimeyer, 2009; White & Epston, 1990). One of the distinctive aspects of Palgi and Ben-Ezra’s approach involves a departure from exposure-oriented models of psychotherapy so as not to strengthen the substantive core of the traumatic experience for the survivor—called the “traumatic nucleus”—in the early adjustment period. My discussion of Palgi and Ben-Ezra’s case of Mr. G and related general issues uses a framework of three common forms of narrative disruption after trauma. Specifically, I first discuss “narrative dominance” as a particular strength of the “Back to the Future” model and raise a general question about the possible negative ramifications of the ASD diagnosis itself. I next discuss “narrative dissociation” and its implications for the nature of the diagnosis of ASD. Finally, I discuss “narrative disorganization” and several empirical studies that suggest the importance of exposure in directly addressing the “traumatic nucleus” among ASD sufferers, in contrast to the recommendations of the “Back to the Future” model to minimize attention to this component in the acute adjustment period.

*Key words:* trauma; acute stress disorder (ASD); narrative therapy; constructivism; exposure; narrative disruption in ASD

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It was with great interest that I reviewed Yuval Palgi and Menachem Ben-Ezra’s (2010) “Back to the Future’: Narrative Treatment for Post-Traumatic, Acute Stress Disorder in the Case of Paramedic Mr. G.” As a former student of Robert Neimeyer, one of the leading theorists and researchers of narrative-constructivist understandings of trauma and loss (e.g., Neimeyer, 2002, 2006, 2009), and as someone with strong continuing clinical and research involvement with this

model, I appreciate Palgi and Ben-Ezra's application of a number of narrative and constructivist ideas in developing their novel, "Back to the Future" treatment for Acute Stress Disorder (ASD). In contrast to post-traumatic stress disorder (PTSD), ASD is a condition that may develop during the initial month following a potentially traumatic event (PTE) and includes several symptoms not included in the PTSD diagnosis (e.g., dissociation).

At present, I am in the midst of completing a postdoctoral fellowship focusing nearly exclusively on soldiers and veterans returning from the current military campaigns in Iraq and Afghanistan. I am always excited and encouraged by successful treatment cases for trauma, such as Palgi and Ben-Ezra's comprehensive description of Mr. G's recovery from the consequences of his terrifying and grotesque experience. Although I work in a VA hospital and typically do not directly encounter survivors in the acute adjustment period (i.e., within the first four weeks post-trauma), I am familiar with the immediate, trauma-related issues many soldiers and veterans face as they attempt to meet the demands of progressing in their military careers or returning to civilian life. I am also familiar with the narrative-inspired procedures that guided Palgi and Ben-Ezra's intervention with Mr. G as well as more traditional exposure treatments (e.g., prolonged exposure; Foa & Rothbaum, 1998).

From a narrative-constructivist perspective, military combat and other PTEs become traumatic insofar as they defy one's attempts at narrative processing. As with Mr. G's ultimately successful but terrifying endeavor to carry the dismembered terrorist from across enemy lines under the salient threat of capture, injury, or even death, these events can disrupt the plot and thematic structure that governs an individual's life story. In other words, to the extent that the experience overwhelms the narrative processes relevant to organizing historical events into an integrated, cohesive whole and destroys one's fundamental assumptions about the self and world, PTEs can undermine the *what* and *why* of a survivor's existence. Therefore, in broadly narrative terms, psychological trauma at least partly signifies a breakdown in the ability to organize a micro-narrative involving a specific traumatic experience into a broader macro-narrative that consolidates one's self-understanding, establishes a characteristic range of emotions and goals, guides engagement in the social world, and allows for the possibility of a hopeful and purposeful future (Neimeyer, 2002, 2006, 2009).

Below I organize my discussion of specific aspects of the case of Mr. G and related general issues in terms of three common forms of narrative disruption after trauma: "narrative dominance," "narrative dissociation," and "narrative disorganization."

## **NARRATIVE DOMINANCE**

### ***The Nature of Narrative Dominance, One of the Strengths of the Palgi and Ben-Ezra Model***

From a narrative-constructivist perspective, there are several interrelated but distinct pathways of narrative disruption after trauma with possible relevance to Mr. G's situation and the diagnosis and treatment of ASD. One of these, which I term "narrative dominance," involves the traumatic experience gaining dominance in the survivor's self-narrative. In addressing the potential for narrative dominance with Mr. G, Palgi and Ben-Ezra's intervention thoughtfully

employs principles from what might be termed the Australian or New Zealand School of narrative therapy (see Monk, Winslade, Crocket, & Epston, 1997 and White & Epston, 1990 for clinically useful examples of this perspective). This approach principally aims to deconstruct the pathogenic role of socially, politically, or culturally enforced accounts of an individual or group's identity in favor of possibilities that allow for greater personal agency and life satisfaction. As with Mr. G's struggle not to become the next "victim of trauma" in his family, dominant narratives threaten to overrun an individual's sense of identity, limiting conceptions of self strictly to those that are externally governed or problem-saturated. Such a process of narrative dominance aligns with the landmark perspective of trauma discussed by Palgi and Ben-Ezra (e.g., Bernstein, 2001; Neisser, 1982; Rubin & Kozin, 1984). For persons struggling to overcome the consequences of life-threatening and horrific events like Mr. G, the meanings associated with the trauma can become too cohesive and central and can serve as a reference point for organizing other more mundane life events.

In these instances, individuals may over-accommodate their fundamental beliefs to match the trauma such that their identities become dominated by a traumatic self (Stewart & Neimeyer, 2001). Instead of maintaining cognitive flexibility to integrate newer, more positive emotional experiences, the traumatic self elaborates subsequent life experiences that are only congruent with the post-traumatic identity. In turn, the traumatic self may become increasingly internalized and function as a kind of mental magnet for attracting and retaining experiences that serve to confirm this highly negative perspective. Research on PTSD—the condition involving several clusters of trauma-related symptoms beyond four weeks after the traumatic event—has indeed found that individuals suffering from this condition tend to perceive themselves as "damaged goods" and incompetent to deal with challenges in their life (Foa et al., 1999). This type of breakdown in one's self-narrative may undoubtedly contribute to social isolation, substance abuse, and other maladaptive coping strategies that inevitably decrease the chances of recovery and exacerbate the survivor's trauma-related problems over time. Moreover, the dominance of a post-traumatic identity can be generalized to other personal and social experiences as well, sometimes causing the repetition or reenactment of the traumatic theme with loved ones (e.g., unconsciously identifying oneself as victim in intimate relationships or guiltily sabotaging attempts at contentment after the trauma).

From my standpoint, the greatest strength of Palgi and Ben-Ezra's intervention pertains to preventing this process of narrative dominance. I appreciate the emphasis on challenging the tendency of many survivors to over-accommodate the self-narrative in a manner that will only limit their opportunity for recovery and reconstructing a sense of meaning and purpose in life. In the case of Mr. G, he was at risk for adopting and conforming to his familial notion of becoming another "victim of terror." Such a narrow appraisal of his situation may have caused him to surrender more preferred aspects of his identity, such as being a capable and compassionate paramedic. As a result, Mr. G may have been vulnerable for abandoning his career and retreating into an isolated but subjectively safer existence. Likely with the aid of Palgi and Ben-Ezra's narrative-inspired treatment, Mr. G regained his footing in the world during the three months post-trauma. Through the identification of historical anchors in his past and also considering "sparkling moments" in his sister's life story which similarly conflicted with her label as a trauma victim, Mr. G succeeded in not relinquishing the authorship role for future chapters in his life narrative.

### ***A General Concern About the ASD Diagnosis***

The success of Palgi and Ben-Ezra's case of Mr. G is certainly impressive. Prospective longitudinal studies have shown that around 60 to 80% of persons who meet criteria for ASD during the four weeks following a trauma indeed go on to display persistent post-traumatic stress symptoms after four weeks, qualifying them for a PTSD diagnosis (see Harvey & Bryant, 2002 for a review of the empirical literature). This evidence suggests that Mr. G had a greater than likely probability of not regaining functioning as efficiently as he did without the aid of treatment, highlighting the need for close clinical attention at the time Mr. G presented to Palgi and Ben-Ezra's clinic. While I may have attempted to use watchful waiting for a greater length of time before initiating treatment, Mr. G's mental health history and generally anxious disposition, combined with his intense distress symptoms, would have likely indicated the need for timely intervention. Nonetheless, without minimizing Palgi and Ben-Ezra's success with Mr. G, I have general concerns about ASD's elevation to a diagnosable mental health disorder in the 4<sup>th</sup> edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV; American Psychiatric Association, 1994). It seems possible that by diagnosing early responses to PTEs as somehow pathological, 20 to 40% of which will be self-limiting in nature (Foa & Rothbaum, 1998; Harvey & Bryant, 2002), mental health professionals may inadvertently contribute to processes of narrative dominance of the traumatic experience for some survivors.

One of the features of narrative-constructivist approaches to psychotherapy involves a non-pathologizing view of human suffering and immediate reactions to adverse life events in particular (Neimeyer, 2009). While many individuals will expectedly experience significant distress in the first month following a potentially traumatic stressor, I fear that DSM-IV's attempt to categorize these difficulties as a "disorder" ultimately pathologizes distressing but normative reactions to incredibly stressful life events. As a constructivist- and empirically-minded clinician, my concerns regarding the ASD diagnosis resemble the dilemma for VA providers about current health initiatives and disability regulations for the "signature injury" of mild traumatic brain injury (mTBI) among soldiers returning from Iraq and Afghanistan (Hoge, Goldberg, & Castro, 2009). Many of these men and women unfortunately had repeated concussions over their deployments and struggle with memory problems, inattention, irritability, and headaches. Encouragingly, these cognitive symptoms (if they are primarily the result of mTBI) will likely remit over a period of time based on the nature of the injury, the person's internal healing processes, and the person's utilization of psychosocial resources. With the aid of treatment, the prognosis of recovery from ASD is very similar. Thus, the message needs to be conveyed to ASD sufferers that their distress symptoms are not necessarily a signal of more difficulties to come but rather should remit with the passage of time, as frequently accompanied by psychotherapy. By labeling their acute stress reactions as a disorder, I fear that many helping professionals may be in danger of contributing to the formation of a dominant narrative that could interfere with the person's recovery over time (e.g., the survivor believing that he or she is psychologically weak for having a "mental health disorder" immediately following trauma).

## **NARRATIVE DISSOCIATION**

### ***The Nature of Narrative Dissociation***

Dissociation in the self-narrative is a second form of narrative disruption with potential relevance to Mr. G. From a narrative-constructivist perspective, "narrative dissociation" may

become problematic to the degree the survivor develops “silent stories” over time that are dissociated from and that resist acknowledgement in the public domain and within the rest of his or her private world (Neimeyer, 2002, 2006). Used in this way, dissociation may cause both a breach of sociality and compartmentalizing of awareness in a classical psychodynamic sense. In most instances of narrative dissociation, each of these maladaptive processes reciprocally causes the other. Namely, the attempt to prevent a traumatic and incongruent private story from finding expression in intimate relationships may reinforce a hyper-vigilant form of self-monitoring and segregation of threatening recollections, leading to feedback that reinforces the need to suppress the traumatic story. In these situations, narrative dissociation ensures that attempts at relational support will usually result in empathic failure, as the most important aspects of the plot structure of the traumatic narrative will remain hidden, fragmented, and without social validation.

### ***Dissociation and the Diagnosis of ASD***

The diagnosis of ASD was chiefly motivated by the idea that dissociation is a critical element of maladjustment to trauma. Theorists have proposed that dissociation in the acute adjustment period may impair a survivor’s ability to process central aspects of the trauma and emotionally resolve the experience over time (van der Kolk & van der Hart, 1989). Although narrative dissociation certainly has a role in the development and maintenance of PTSD for many persons, research suggests its importance may be equaled or overshadowed by other narrative processes. Whether the person engages in conscious or automatic attempts at coping, it has been proposed that dissociation may best be viewed as a strategy that only select survivors utilize to modulate hyper-arousal and deal with distressing emotions rather than a primary indication of maladjustment per se (Davidson & Foa, 1991). Empirical evidence in fact suggests that dissociative symptoms during the first month post-trauma may not be predictive of future problems for all individuals but only for a subset who engage too heavily in narrative dissociation (see Harvey & Bryant, 2002 for review). For example, in their work with motor vehicle accident survivors, Harvey and Bryant (1998, 1999) found that many individuals who went on to struggle with chronic PTSD did not display dissociative symptoms in the first month after the accident. Hence, in its current form, the dissociation-emphasized criteria for ASD may exclude many of the survivors who will potentially face the most significant trauma-related difficulties over time.

Consistent with Mr. G’s complaints of recurrent intrusive images, insomnia, vomiting and other somatic symptoms, these research findings indicate that narrative dissociation is likely one of several important symptoms for many of the trauma survivors most vulnerable for developing chronic PTSD. However, as demonstrated by Palgi and Ben-Ezra’s attention to other aspects of Mr. G’s experience in their treatment, research suggests that the absence of dissociative symptoms should not distract clinicians from focusing on other processes of narrative disruption following a traumatic stressor.

## **NARRATIVE DISORGANIZATION**

### ***The Nature of Narrative Disorganization***

Whether in the immediate adjustment period or during years following the event, a central unifying feature of ASD and PTSD involves intense re-experiencing symptoms. As seen in Mr. G’s intrusions of trauma-related imagery, narrative disorganization is a third way in which

trauma may disrupt one's narrative capabilities. Theorists from a number of perspectives have conceptualized maladjustment to PTEs as arising from an inability to organize recollections of the event into a coherent narrative (e.g., Ehlers & Clark, 2000; Janoff-Bulman, 1992; Neimeyer, 2002, 2006; van der Kolk & van der Hart, 1991; Siegel, 1995; Wigren, 1994). From a physiological perspective, memories encoded under stressful conditions are frequently under-organized and resist cortical processing (Siegel, 1995; van der Kolk & van der Hart, 1991). Immersion in horrific experiences such as Mr. G's task of collecting body parts in enemy territory may flood the brain with an array of neurotransmitters, engraving vivid sensory memories of the event that can be fused with troubling emotions of terror, despair, or helplessness (Siegel, 1995; van der Kolk & van der Hart, 1991). Therefore, the traumatic nucleus emphasized by Palgi and Ben-Ezra in their conceptualization may be solidified. Contrary to more cortical recollections, the traumatic nucleus would be held beneath the level at which narrative processing occurs in the amygdala in the form of fragmented and disturbing images, sensations, and emotions. When later events occur that bear some resemblance to the cues associated with the initial trauma, rapid appraisal processes associated with this part of the limbic system result in hyper-arousal and vulnerability to further intrusive memories.

Considering this physiological disorganization in narrative terms, traumatic memories could be viewed as being "pre-narrative" in that the recollections fall outside the domain of autobiographical memory processes (Neimeyer, 2002, 2006). As a result, psychological trauma can leave the survivor with a recurrent and disorganized stream of images that are greatly at odds with the implicit plot structure of his or her prior life story (Stewart & Neimeyer, 2001). Unlike events that are more easily integrated, psychological trauma cannot be fitted into one's macro-narrative as readily. Instead, the experience can remain as an isolated and unprocessed collection of memory fragments that shape the anticipation and elaboration of future events in problematic ways. In contrast, when the memory reaches an ideal narrative form, these issues with emotion regulation may not occur with the same regularity, as the previously distressing affects get connected to and contained in a specific episode or sequence enabling coherence and continuity in the self-narrative (Wigren, 1994). In keeping with Palgi and Ben-Ezra's emphasis on promoting continuity in the self-narrative by traveling back and forth between the past and future in therapy with Mr. G, if the survivor is to integrate the trauma into his or her life story, the experience usually must become woven into the larger narrative fabric of his or her life.

### ***The Therapeutic Role of Exposure in ASD***

The possibility that narrative disorganization in the traumatic nucleus among ASD sufferers may mediate longer-term problems is suggested by the apparent link between resolution of PTSD and increased coherence in the trauma memory (Foa & Rothbaum, 1998). A concern I have about Palgi and Ben-Ezra's proposed treatment pertains to their seemingly firm reluctance to implement exposure-oriented interventions. Based on my review of the literature and clinical experiences, I would speculate that a sizeable subset of ASD sufferers may not obtain long-term benefit from "Back to the Future" based on the model's commitment to not revisiting the traumatic nucleus in therapy. Palgi and Ben-Ezra's purpose in not confronting the core of the trauma experience is to not exacerbate trauma symptoms and also provide the survivor with an immediate sense of relief. Their rationale is that by revisiting the trauma in the acute phase, clinicians may be in danger of reinforcing the traumatic nucleus and interfering with the client's

natural forgetting and reconstructive memory processes. It seems reasonable that sufferers of ASD for whom recurrent images are not a cause of significant distress may not benefit from exposure. As Palgi and Ben-Ezra discuss in their conceptualization, the traumatic nucleus may not have been consolidated for these ASD sufferers. It would reasonably follow that a different therapeutic approach possibly addressing another form of narrative disruption, such as Palgi and Ben-Ezra's strong focus on narrative dominance, could provide a good option for clinicians in these cases.

Notwithstanding their insightful review of the relation between memory research and traumatic stress, I believe Palgi and Ben-Ezra probably underestimate the narrow or even immediate time window at which the traumatic nucleus becomes consolidated for most trauma survivors. In addition, I fear they may overlook compelling evidence on the helpfulness of exposure treatments with this population. Palgi and Ben-Ezra base their caution about exposure in part on findings for psychological debriefing. From my standpoint, discouraging results of debriefing interventions that simply provide survivors with psychoeducation and an opportunity to ventilate distressing emotions likely has more to do with other contextual factors than revisiting the trauma. Parallel to the meta-analytic findings of my colleagues and me (Currier, Neimeyer, & Berman, 2008) regarding differences in the efficacy of psychotherapies with bereaved persons based on the targeted population, I would speculate that the absence of careful assessment and clearly specified inclusion criteria about who receives an intervention has a greater role to play than attempts at emotional processing of the trauma per se. The group format of psychological debriefing and potential lack of adequate dosage and structure also represent important qualitative differences from the exposure-based therapies that I would endorse for ASD.

As mentioned above, given the probability that the majority of trauma survivors who meet criteria for ASD will go on to develop PTSD without the aid of psychotherapy, clinicians certainly need access to sensitive and effective therapies. It is encouraging to me that randomized controlled studies (RCTs) of interventions during the first several weeks post-trauma that directly revisit the traumatic nucleus have significantly decreased rates of PTSD (i.e., imaginal exposure; Bryant et al., 1998, 1999; Foa, Hearst-Ikeda, & Perry, 1995), findings which do not align with Palgi and Ben-Ezra's concern that exposure may not be tolerated in the acute phase. In addition, results from a more recent RCT study of ASD sufferers by Bryant and his colleagues (Bryant et al., 2008) found that the group assigned to imaginal exposure combined with in vivo exercises had considerably better outcomes in terms of PTSD, depression, and anxiety than the group assigned to a cognitive-oriented intervention without exposure. Although exposure can be extremely demanding for client (and therapist), and may initially increase distress in some cases, evidence from these studies indicates the power of emotionally processing the traumatic narrative in this manner for many survivors.

These treatment outcomes may be further supported by findings from primary research studies on the maladaptive effects of avoidance-based coping among ASD and PTSD sufferers. A number of independent programs of research have documented a strong tendency among the 10 to 20% of trauma survivors who develop ASD to rely on thought suppression and distraction as primary strategies for dealing with trauma (see Harvey and Bryant, 2002 for a review). Of course, in keeping with Bonanno's (2004) clarion call for clinicians to respect patterns of

resilience after trauma or loss, some survivors will of course effectively utilize repressive coping and should not be viewed with suspicion. However, these people will likely not manifest acute stress reactions as Mr. G did or seek mental health treatment for issues associated with the event. Based on my understanding of the research literature on cognitive factors in posttraumatic adjustment and daily clinical encounters with men and women struggling with combat-related PTSD, it appears that successful efforts at repressive coping represent more of a stable personality trait than a skill set that can be deeply instilled in a time-limited psychotherapy. While Palgi and Ben-Ezra's challenge of narrative dominance and insightful focus on promoting continuity in the survivor's life story offer important expansions to popular cognitive-behavioral methods for treating ASD, I fear that broad-scale refraining from revisiting the traumatic nucleus in psychotherapy may limit healing from narrative disorganization in the majority of cases and may even strengthen many survivors' maladaptive efforts at avoidance-based coping over the long-term.

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