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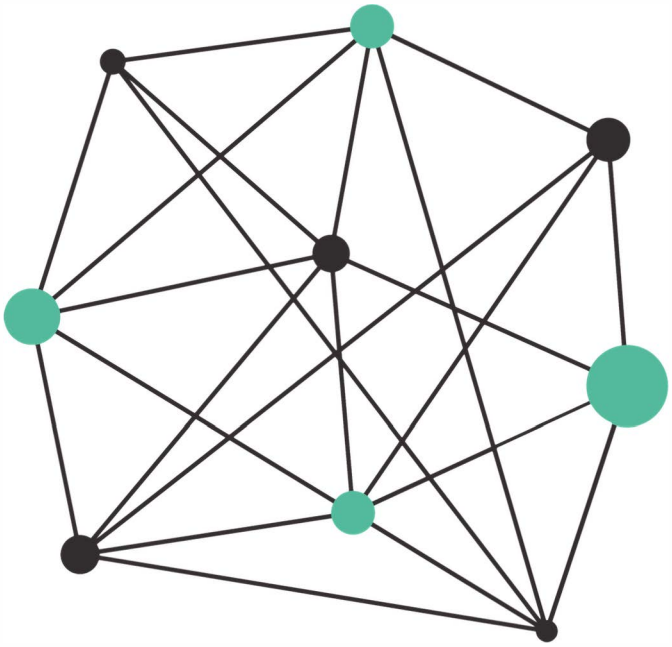
Perspectives on Trauma

The Journal of the Complex Trauma Institute



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Content

Editorial

Introducing the Journal of the Complex Trauma Institute: Opening Dialogues on Trauma

The Complex Trauma Institute (CTI) Team

Our understanding and perception of trauma have developed and changed greatly throughout history. Evolving from terms such as 'shell-shock' following World War I, to the inclusion of post-traumatic stress disorder (PTSD) to the DSM-III in 1980 and to the advances made in understanding the biological mechanisms underlying trauma in more recent years (Friedman, Resick & Keane, 2007). In particular, Stephen Porges (2017) has introduced a paradigm shift in our understanding with his Polyvagal Theory, helping us to realise that the metabolic shutdown of the immobility response is a crucial factor in the experience of trauma alongside the well-known metabolic arousal of 'fight-flight'. Bessel van der Kolk, Peter Levine, Pat Ogden, Babette Rothschild, Francine Shapiro and many others have contributed to understanding the biological mechanisms underlying trauma and developed powerful new ways of alleviating the impact of trauma, working from a body-up rather than a head-down approach.

Our own journey within the field of trauma began with creating the Complex Trauma Therapists' Network (CTTN), which was founded by Dzmitry Karpuk in 2012. Dzmitry and his colleagues encountered many clinicians with limited training in working with trauma from their formative years in University and other accredited courses. By founding CTTN, the aim was to fill this gap in education, create a supportive professional network and foster professional and personal development. Part of this work was hosting three conferences on perspectives on complex trauma and its treatment with the collaboration of the University of York.
In 2020, the Complex Trauma Institute (CTI) was established to broaden the scope of training and support offered to mental health professionals, expand within research and allow an open platform in which like-minded professionals could discuss trauma openly. Within this context, we find ourselves publishing the first issue of 'Perspectives on Complex Trauma', the Journal of the Complex Trauma Institute.

This first issue includes various articles, ranging from research papers to personal reflections, with views from authors based in the United Kingdom, Germany and Canada. The first section of this journal includes articles that will open contemporary dialogues in diverse fields of complex trauma. Our second section comprises articles where our authors give informative accounts of their experiences in working with diverse trauma-informed approaches.

The first issue of 'Perspectives on Trauma' is at its early stages. This year has proven challenging for everyone, let alone for new projects needing time and motivation. Our editorial and review process is not yet as we aspire it to be. We are (currently) a small team, which we are looking to expand and our editorial and review process is evolving as we publish this first issue. Therefore, we hope you may wish to be involved in our journal publication and ask you to get in touch if you were interested in becoming part of our editorial or peer-review teams.

We hope that this journal will widen the circle of those prepared to share their knowledge and expertise and also their struggles and questions with their colleagues. We encourage readers to respond to our writers through letters to the journal and direct correspondence. Our aim is for all our debates and disagreements to be carried out in a supportive and non-defensive manner. If you are a member of the CTI, we invite you to use our forum for such discussions. We also invite readers to submit articles, studies, thoughts and experiences.

We hope you enjoy this first issue and we greatly look forward to hearing from you.

Acknowledgements
We want to thank our authors, reviewers and proof-readers for their patience and efforts for making this project a reality. We would also like to thank our CTI team for contributing to our editorial and for their support over the last year.

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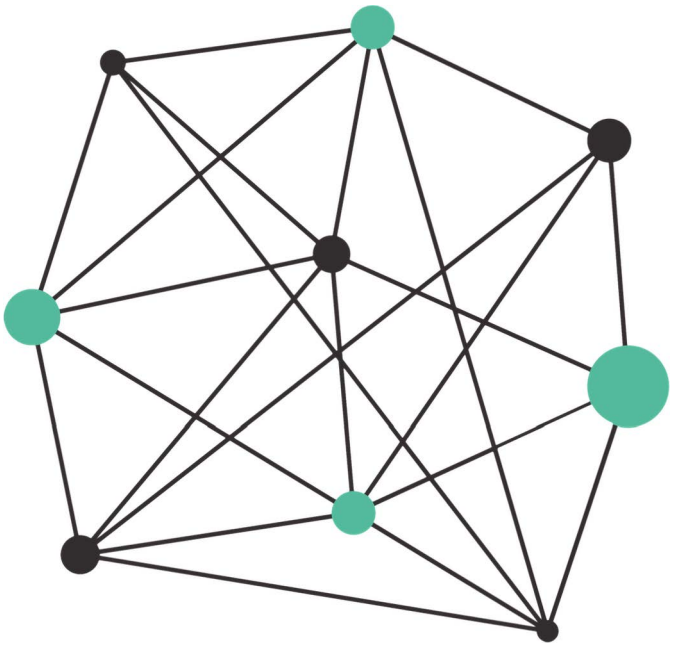
Section I

Perspectives on Complex Trauma



What is Complex Trauma?

Michael Guilding

Abstract

Diagnostic criteria relating to trauma, in ICD-11 and DSM 5, are presented as lists of symptoms with no attempt at understanding the mechanisms of trauma, or at seeing them in the context of human biological and social systems. This seriously limits their usefulness to the psychological therapist. This paper is an attempt at such an understanding, starting from the perspective of the biological fear system. It argues that trauma is an autonomic nervous system dysfunction in which fear responses cannot de-activate, and that complex trauma is the chronic failure of fear system de-activation and the impact of this failure on a wide range of other systems with detrimental consequences for physical and mental health and social integration.

Introduction

In this paper I want to put forward the argument that Trauma is a condition in which the biological fear system has failed to switch off in the aftermath of the threat that triggered its activation, and that Complex Trauma is the result of a *chronic* failure of fear system de-activation and of the dysfunctional impact of this failure, over time, on a complex network of biological, behavioural, cognitive, relational and social systems. I want to explain in some detail what I am referring to as the 'fear system', and why it might in certain circumstances fail to deactivate, before looking at the devastating consequences of this failure on the highly complex and finely balanced organism of the human person.

Defining the fear system

My definition of the 'fear system' covers the oldest aspects, in evolutionary terms, of our biological responses to threat. Stephen Porges (2011) describes three separate stages in the evolution of our response to threat. The earliest developing response, immobility, is a metabolic shutdown evolving around 500 million years ago, which allows a prey animal to appear dead to a predator. The next stage, evolving around 300 million years ago, is quite the opposite response, a heightened mobilisation which delivers a sudden burst of energy to allow a prey animal to run from or fight off a predator. This second stage has long been popularised under the term 'fight-flight', while an understanding of immobility is a more recent development. The third stage, evolving only in mammals around 80 million years ago, is the development of a social engagement system in which the primary response to threat is to seek care from others.

These three threat-response systems have their own control networks in the brain and are activated in the body by three different branches of the autonomic nervous system (see 'Fig. 1').

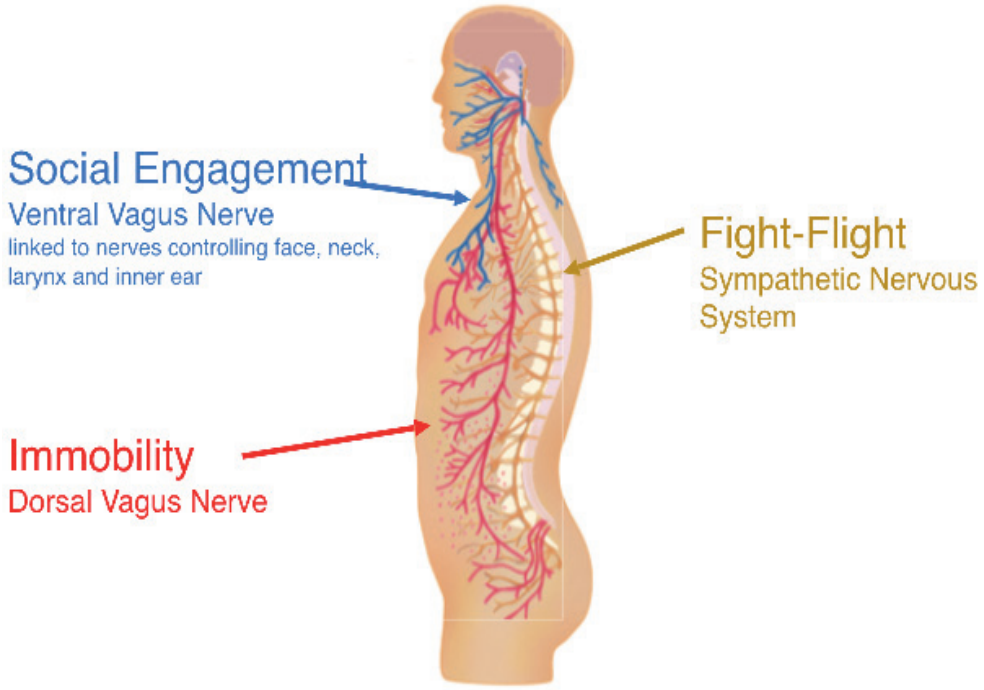


Fig.1 - The three-part autonomic nervous system.

Immobility is brought about by the activation of the dorsal vagus nerve (coloured red) which goes from the brainstem to all the major organs of the body. Fight-flight is triggered by the sympathetic nervous system (coloured gold) which goes via the spine to all the major organs, and the social engagement system (coloured blue) is activated by the metabolic calming mediated by the ventral vagus nerve, linking the brainstem to the heart and the lungs, and connected at the brainstem with the cranial nerves controlling the muscles of the face, neck, larynx and inner ear (Porges, 2011).

I am using the term 'fear system' to cover the two older non-social threat-response systems, immobility, which I will also refer to as fear-collapse[1], and heightened mobilisation, which I will also refer to as fear-arousal. I am going to bring one further biological response under the general umbrella of the fear system, and that is the orienting response, the reaction to the first indications of danger, as this plays an important part in the biology of complex trauma. The orienting response confusingly goes under many names, but I am going to refer to it as fear-alert.

I want to look at these three components of the fear system, first of all noting biological changes and relating this to predation among animals, hence the illustrations, but then putting this into the context of human experience since we share these biological systems with the other mammals[2].

1 The body's immobility response can be triggered by a number of threats such as fluid loss, infection, toxins or exhaustion (Levine, 2010). When using the term 'fear-collapse' I am purely referring to the immobility response *when it is triggered by the activation of the fear system*, whether this relates to a real physical threat, traumatic memories, disturbing attachment emotions or negative thoughts.

2 While there are undoubtedly huge differences within mammalian species in the development of a social engagement system, the older threat-response systems are common to all mammals, including humans. As Peter Levine notes (2010), '…since we share the same survival parts of the brain with other mammals, it only makes sense that we share their reactions to threat' .

Fear alert – Orienting to threat

Fear-alert is the response to a potential danger, just sensed, when there is a need to find out more about what and where the danger is. When this response is activated the body becomes tense and motionless, with a raised heart rate[3], and hearing, eyesight and sense of smell become more acute. The startle response is heightened including a stronger signal in the nerves controlling the limb muscles, and the withdrawal of signal in the ventral vagus nerve which effectively removes the "calming brake" on the heart (Kolacz & Porges, 2018; Baldwin, 2013). This potentiates the body for immediate violent activity if the threat is perceived to be imminent.

When humans experience fear-alert, the obvious thing we notice is our tension as we hold ourselves still, and the fact that we often hold our breath, as the noise of our breathing can interfere with hearing sounds of danger. We may rarely notice enhanced perception but are more likely to be aware of our thoughts. These are entirely focused on potential danger, and our general sense is of being wary and on-edge.

Fear arousal – Active defence (fight or flight)

Once the danger is obvious and close the brain's fear centre, the amygdala, triggers a huge number of changes in the body, via the sympathetic nervous system, to enable survival through fight or flight (Sapolsky 2004).

An immediate release of adrenaline causes the heart rate to shoot up, and the chambers of the heart expand to increase the volume of blood pumped with each heartbeat. The interlinked systems of the hypothalamus, the pituitary gland and the adrenal glands are activated to produce a series of cortisol-based hormones which trigger the release of glucose and other nutrients into the bloodstream from storage cells throughout the body.

The blood stream is now nutrient-rich, and blood is being pumped at higher speed and greater volume to the muscles of the limbs, hugely boosting strength and speed. The blood supply to the gut and other areas non-essential in crisis is shut down by a narrowing of blood vessels, and sweating enables the body to prevent overheating. The small muscles at the base of hair follicles contract, so hair stands on end, making the prey look bigger in an attempt to scare off a predator.

The hormone vasopressin is released to retain water in case of injury and blood loss, and non-opioid painkillers[4] are released so the pain of injury is numbed and does not detract from the effort to survive. The amygdala also inhibits the activity of the cortex[5] eliminating all focus on anything apart from the danger at hand.

3 This can follow an initial drop (Schauer & Elbert, 2010). Might this perhaps be an evolutionary throwback to the more primitive immobility response?

4 Painkillers which don't cause drowsiness, and therefore don't interfere with fight or flight actions.

When fight-flight is activated in humans, the onset may be experienced as a sudden wave of upwards-moving energy with the heart pounding in the chest. We may also experience nausea and other abdominal discomfort as the gut shuts down, sweating as the body's cooling system operates, dry mouth as vasopressin prevents water loss and goosebumps as muscles contract at the base of hair follicles. If we are hurt or injured, we may not feel any pain in the moment, and our ability to think is hugely limited; all our thinking mind will do in these circumstances is focus on danger and how to avoid or eliminate it.

Fear arousal – 'Locked' defence and 'tipping point' (freeze and fright)

However, when we cannot run or fight, we go into freeze[6], like a 'rabbit in the headlights'. The fear-arousal response is still fully active with pounding heart and stress hormones in the bloodstream (Le Doux 1998), but the muscles lock and are held in rigid tension which can result in trembling. This state of 'flight or fight response put on hold' (Kozlowska et al., 2015) can switch back instantly to flight if an escape route presents itself.

If there is no escape, it can switch to fight as a last resort, hence the expression 'fighting like a cornered rat', but it also easily slips into fright.

Fright is the peak of fear arousal when there is no escape and no perceived chance of survival. This is the tipping point where fear-arousal switches into fear-collapse (Schauer & Elbert, 2010). Peter Levine notes that this is most likely to happen where a sense of terror and a sense of being trapped are combined, hence the frequency of the experience of fear-collapse during rape (Levine, 2010).

For humans the state of freeze is aptly described as being 'petrified', in other words 'turned into stone'. Externally we are rigid, though we might 'shake with fear', as our tense muscles start trembling, but internally our heart is pounding. Alongside sweating, nausea and dry mouth we might feel lightheaded or dizzy and our mind can blank. This may be combined with a sense of our legs going from under us as we reach the tipping point into fear-collapse.

5 The most recently evolved part of the brain which, among many other functions, governs thinking, willed actions and much social behaviour including language.

6 There is much confusion around the use of the term 'freeze'. Some writers (e.g. Schauer & Elbert, 2010) use it to describe the orienting response, which I prefer to call 'fear-alert', and others (e.g. Levine, 2010; Van der Kolk, 2014) use it to describe an immobility collapse. Kozlowska et al. in my view muddy the waters by applying the word 'freeze' to three different biological responses within one page of text (2015). Fear-alert, freeze and immobility do all have a common element of being motionless for a time, but they belong to different biological states. I understand the stillness of fear-alert as being underpinned by a *moderate* muscular tension which could switch into powerful action, but also quickly relax into rest. However, I see the freeze state as involving a stronger, more rigid muscular tension which is holding in check the powerful energy of fear-arousal which cannot calm quickly. As for using the term freeze to describe fear-collapse, this makes no sense to me at all. Immobility is often referred to as 'tonic' immobility owing to the fact that in this state muscles have no 'tone' or tension – they are floppy or flaccid. The word freeze is associated in our minds with the rigid state of water, so it perfectly fits the 'locked' or rigid state of fear-arousal and creates confusion if applied to fear-collapse. Joseph LeDoux provides an account of the freeze state which makes it clear that it belongs to fear-arousal. He describes a rat, subjected to a fear conditioning experiment which '…stops dead in its tracks and adopts the characteristic freezing position – crouching down and remaining motionless, except for the rhythmic chest movements required for breathing. In addition, the rat's fur stands on end, its blood pressure and heart rate rise, and stress hormones are released into its bloodstream' (Le Doux, 1998). I think that the definition of 'freeze' is only one part of a wider confusion in the literature of threat-response which may not have fully digested the Polyvagal Theory of Stephen Porges (2011) and still relies on an understanding of tonic immobility formulated decades previously (Gallup, 1977).

Fear collapse – Passive defence (immobility)

When fear-arousal has failed to save us and death seems imminent, the body goes into metabolic shutdown – fear-collapse. There are two mechanisms for this. In the first and possibly the earliest form of shutdown (Kolacz & Porges, 2018) the brain releases opioid painkillers[7] into the bloodstream. In the second the dorsal vagus nerve triggers a sudden drop in heart rate and blood pressure by widening blood vessels as in a faint (Porges, 2017). This means that the cells of the brain, muscles and major organs are starved of oxygen and nutrients, and the cell respiration cycle that provides the energy driving each cell slows or stops. In the brain, the cortex shuts down first, followed by the limbic system[8]. The activation of fear-collapse means that the prey suddenly collapses, and appears to be dead, lying limp and unresponsive on the ground, often with eyes open and showing little sign of breathing. This metabolic collapse serves as a key survival strategy as it triggers a shutdown of the predator's attack instinct, and this can open up a window of opportunity for escape, particularly if a predator has to fight off competition.

As humans we experience fear-collapse as a downward drop in energy, or a 'sinking feeling'. We feel faint, our posture slumps, and our muscles feel heavy as lead. We might feel nauseous as the gut shuts down, and may lose control of our bladder or bowels. We can experience numbness which dampens our emotional responses along with a sense of unreality or being 'out of body'. As we descend into fear-collapse, it becomes increasingly difficult to think; the phrase 'thinking through treacle' catches a sense of cognition slowing down, and eventually thinking ceases. Our ability to be sociable, with its control system in the cortex, is also gradually paralysed. We lose the ability to make sense of social cues and can no longer hear the human voice properly (Porges, 2011). As the limbic system is shut down, we lose all emotional responses including our sense of fear (Levine, 2010). While the victims of serious accidents, violent assault or rape may experience a full fear-collapse including physical prostration, I would argue that most people are familiar with fear-collapse in less extreme forms, as I hope will be clarified below in my comments on low mood, depression and dissociation.

The fear system and trauma

If we list the ways we experience the activation of the fear system (Fig. 2 next page) and the behaviours they trigger (fighting, fleeing, avoiding, freezing, collapsing) it is clear that trauma symptoms cover the whole range of fear system responses.

When these biological changes happen in the body in response to a real physical threat, they are potentially life-saving and are not thought of as trauma. What we describe as trauma are the same responses triggered in the aftermath of the original threat by experiences that carry any sort of echo or reminder of the original threat, or responses triggered by less significant or imagined threats.

7 Painkillers which induce drowsiness, unlike those released in fear-arousal.

8 The limbic system is a part of the brain that is older in evolutionary terms than the cortex and controls our emotional responses and social instincts such as affectional bonds.

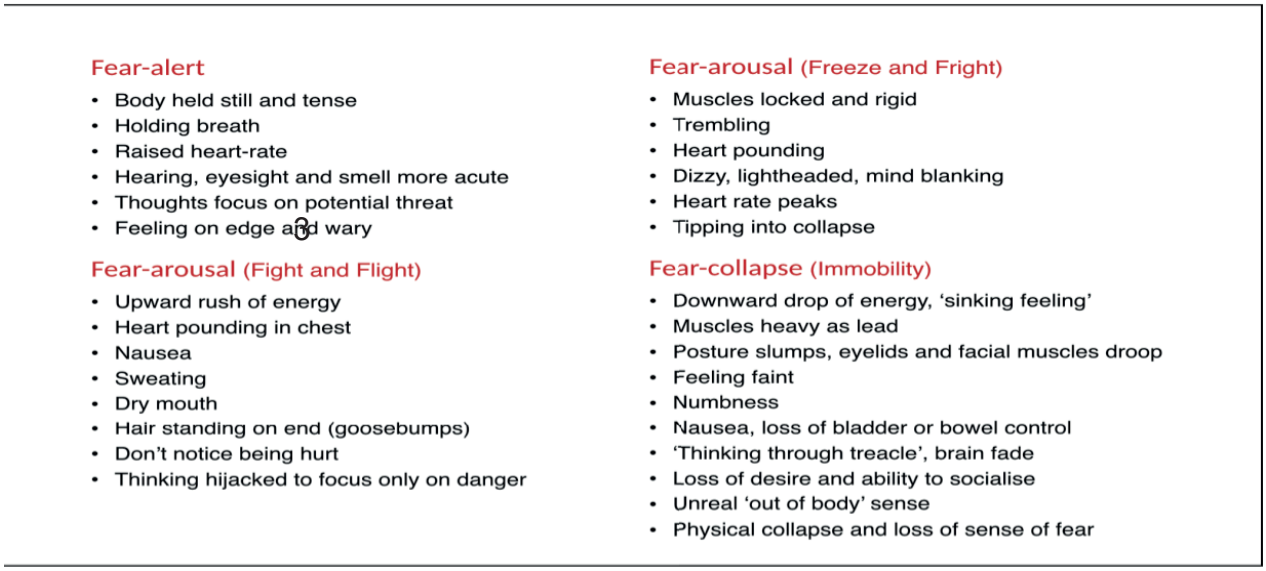


Fig.2 - Fear System Responses and Trauma Responses.

How the fear system 'Goal-Corrects'

Why is it that some experiences of major threat can be recovered from quickly, while others leave a long-lasting traumatic legacy? This happens because in some cases the fear system is unable to switch off after a threat and remains chronically activated, which can be seen as a problem of "goal-correction" (Heard & Lake, 1997). Biological systems are goal-corrected. This means that they are triggered by a threat or a need, for example hunger, and switch off when their goal is met, for example by eating until full. The Fear System is triggered by threat. It switches off when the goal of survival is met. If it fails to switch off, it remains chronically active (unregulated) and we have a type of 'fear disorder', just as, when the biological systems that tell us we have eaten enough fail to work properly, we can have an eating disorder.

Why does the fear system fail to switch off? To answer this we need to look back at the context of the evolution of the fear system – the struggle between prey and predator. If an animal is attacked by a predator, but manages to escape by the activation of its fear system in fight or flight, it then burns off the energy generated by the fight-flight response in its escape, reaches a place of safety and rests. The muscles relax, heart rate returns to calm, stress hormone production ceases, and the fear system switches off until it is next needed[9].

However, if the fight-flight response does not result in escape, and the animal is caught by a predator and goes into fear-collapse, there are two further ways the fear system can switch off. The first way is that a 'window of opportunity' for escape can arise, in which case fear-collapse suddenly switches back to fear-arousal, and the animal gets away, reaches a place of safety and rests[10].

The second way the fear system can switch off following a fear-collapse, is when the immediate context becomes a safe place, as in the example in footnote 11 below when the predator is chased off by other animals who do not constitute a threat to the prey. What happens then is that the animal comes out of fear-collapse with deep, spontaneous abdominal breathing, followed by a period of shaking or trembling, which is very different from the shaking of the freeze state[11]. These mechanisms 'reset' the nervous system, and the fear system switches off (Levine, 2010).

The key factor is safety. If there is no place of safety in the aftermath of a serious threat, the fear system cannot switch off. In trying to understand what this means, let's start by looking at what happens when there is a place of safety and the fear system can switch off.

9 I am using the term 'switches off' very loosely. A more correct description is that it goes into 'vigilant quiescence' (Heard & Lake 1997, p. 41)

10 For a video illustration see https://michaelguilding.com/2019/02/27/prey-and-predator-illustrations-of-the-fear-system-in-action/, third example.

11 For a video illustration see https://michaelguilding.com/2019/02/27/prey-and-predator-illustrations-of-the-fear-system-in-action/, second example].

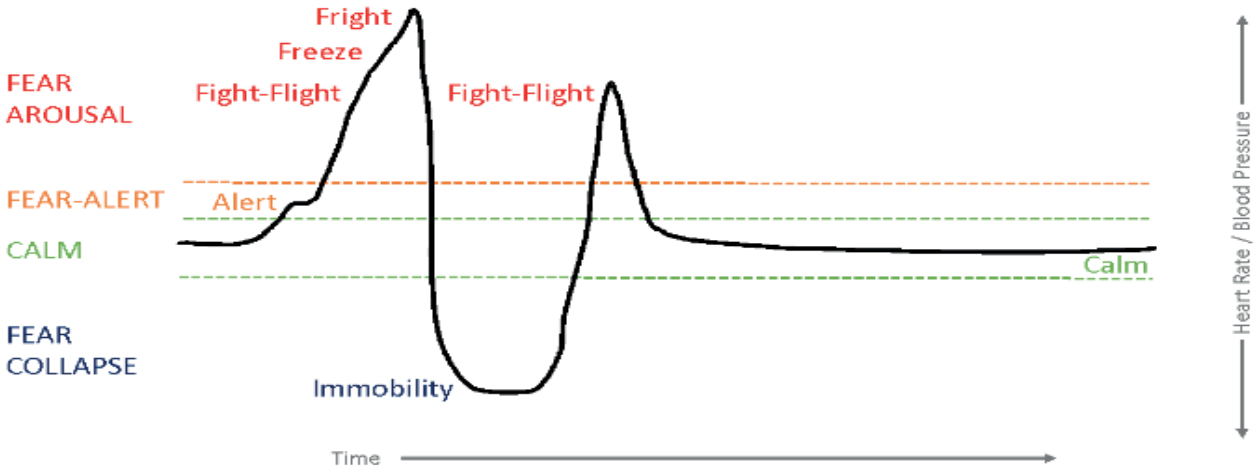


Fig.3 - When the Fear System is able to switch off.

In 'Fig. 3' we see a chart illustrating metabolic arousal and collapse in the example just given where an animal tries to escape a predator, is caught and goes into collapse, and then a window of opportunity presents itself and there is a successful escape. The animal would start in a place of calm, go into fear-alert when danger was sensed, and then into fight-flight or freeze when the danger was imminent. At the moment of capture the heart rate would peak in fright triggering an immobility collapse. Then once an opportunity for escape presented it would switch back into fight-flight and escape to a place of safety and rest until a state of calm was reached[12].

When the fear system fails to 'Goal-Correct'

However, where there is no place of safety that can be reached after the original threat, the body cannot calm. This is illustrated in 'Fig. 4'. The first part of this graph is identical to 'Fig. 3', showing arousal, collapse and the switch back into arousal of the original threat. However, in the absence of a place of safety and calming the animal remains in fear-alert. In this state the nervous system is much more volatile and less serious threats can trigger further states of arousal and collapse that again only resolve into fear-alert, rather than relaxing into calm. In this way an ongoing cycle can be established which can repeat continuously at any indication of threat.

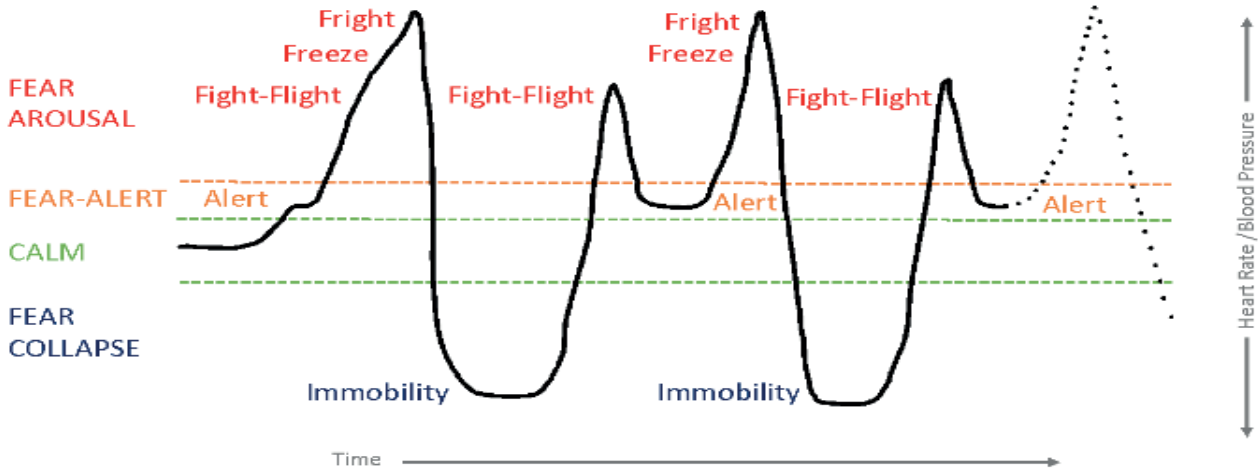


Fig.4 - When the Fear System fails to switch off.

12 It is important to note that we do not go through all the stages of fear arousal illustrated in 'Fig. 3' in a set order, nor do we choose which state will be activated, as these are automatic processes acting far faster than thinking. Fight or flight may be triggered without freeze, and freeze without fight or flight. Certain threats may activate fright immediately without any intermediate steps, and fright can switch into a fear-collapse so suddenly that it is only the collapse which is noticed.

If we translate this into our experience as humans, there are additional factors which contribute to continued fear activation. As highly social beings, social rejection is experienced as a major threat which triggers the physicality of the fear system response, but physically acting out our responses to social rejection may be impossible or inappropriate. An additional complication comes from the fact that our cognitive development as humans has given us the ability to think about the future and thus to terrify ourselves by imagining a huge variety of future threats.

However, the physical activity of fighting and running that can reset the fear system is not available in response to future imagined threats. In the case of either social rejection, or future imagined fears, the creation of a place or a sense of safety may be impossible, and with no ability to relax we get stuck in a continuing cycle of chronic fear activation as our fear system cannot reset through intense physical activity, or through deep breathing and shaking.

When the fear system fails to switch off, systems which were part of its goal-correction become dysfunctional, so effectively the longer the fear system remains active, the harder it becomes to deactivate.

At a physiological level, tension that is not released following a threat builds into a chronic state of tension in the body. This prevents both the deep breathing and post-threat shaking that reset the fear system, and contributes to chronic shallow breathing which favours sympathetic nervous system dominance and the continuance of fear system activation (Tabor et al. 2019).

At the level of hormone production, if the state of fear activation continues for too long the cortisol receptors in the brain, which shut down production when cortisol is no longer required, become desensitized. This disables an important feedback loop, making it more difficult for the fear system to deactivate (Sapolsky, 2004).

At the level of the autonomic nervous system, chronic fear activation disables what is perhaps the most important mechanism in switching off the fear response. This is the ventral vagus nerve, described by Porges as the 'calming brake' on the heart, which connects directly to the heart's sino-atrial node, its inbuilt pacemaker. The sino-atrial node prompts the heart to beat at c. 90-100 beats per minute, perfect for the fear-alert stage and for a sudden switch into fight-flight. However, when the ventral vagus nerve is activated, it overrides this default setting and slows the heart rate down to around 60 beats per minute[13] bringing us into a state of calm.

In the face of a threat, the activating signal on the ventral vagus nerve is withdrawn in order to enable the heart rate to rise in fear-alert and fear-arousal. However Kolacz & Porges (2018) note that when the fear system is chronically active, in other words when the ventral vagal signal is chronically withdrawn, this signal becomes 'dampened' or weakened. So, to use an analogy, just as a leg muscle will atrophy if not used for walking for a time, so the strength of signal on the ventral vagus will weaken if it is withdrawn for too long in fear activation.

The impact of the weakened ventral vagus

It should be noted, however, that the 'calming brake' description given to the ventral vagus is only one half of the story. The ventral vagus nerve does not just slow down the fast heartbeat of fear-arousal, but also speeds up the slow heartbeat of fear-collapse, acting as a regulator of the volatility of the autonomic nervous system under threat (Porges, 2017).

13 This is highly variable in individual cases.

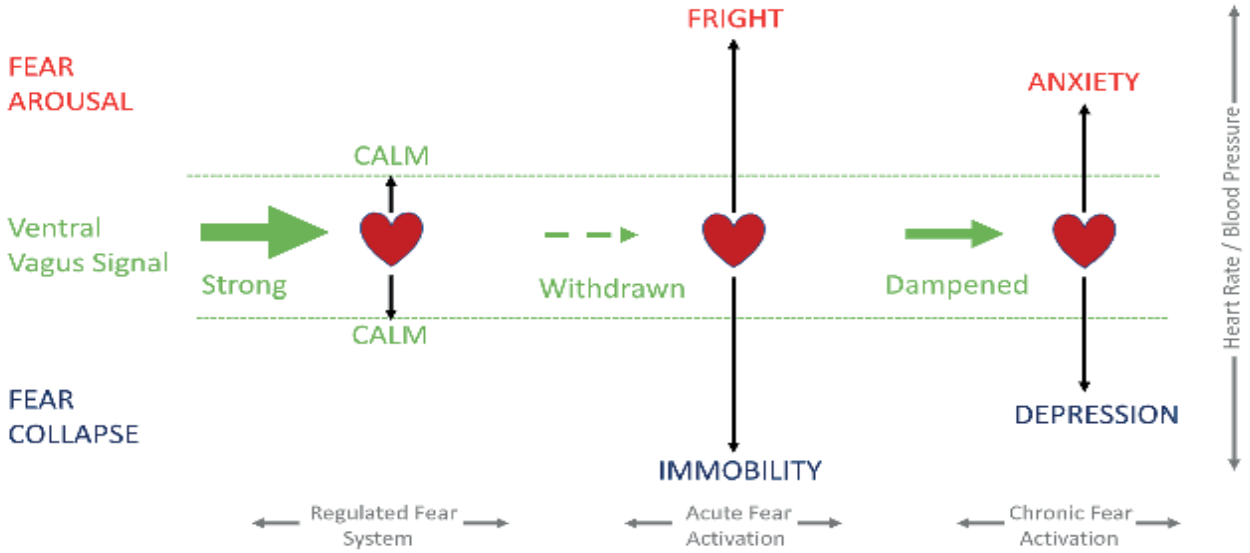


Fig.5 - Fear regulation and the weakened ventral vagus.

'Fig. 5' is an attempt to illustrate the implications of a weakened ventral vagal signal. The left side of the diagram represents the regulated fear system with a strong signal on the ventral vagus. In the face of less serious or imagined threats this restrains both the rise of heart rate in fear arousal and its fall in fear collapse resulting in the maintenance of relative calm under threat. In the middle of the diagram we see acute fear system activation where the ventral vagal signal is withdrawn. Here, in the face of a real and present threat, there is no restraining force to prevent the peak of fear arousal in fright or the full extent of fear-collapse in immobility. On the right side of the diagram we see the result of chronic fear system activation. There is a signal on the ventral vagus so there is some restraining power but in the face of less serious or imagined threats this is insufficient for regulation, and the dampened signal results in 'intermediate' states of fear-arousal or fear collapse .

Making sense of anxiety and depression

I have categorised these intermediate states of arousal and collapse as anxiety and depression. I think that many could accept a definition of anxiety as a chronic state of fear-alert with frequent switches into fight-flight, but depression has always been less well understood.

Seeing depression as an immobility response that can only be *partially* regulated by a weakened ventral vagus signal makes complete sense of the loss of energy in depression as this is a real metabolic shutdown, not something 'just in the mind'. It also makes sense of the loss of the desire and the ability to socialise due to a shutdown of areas in the cortex controlling the social engagement system, and also the slowing and failure of thinking as cognitive systems in the cortex are disabled[14].

14 See https://michaelguilding.com/rethinking-depression/ and https://michaelguilding.com/2019/02/18/depression-a-biological-response-to-threat/ for the development of my thoughts on this topic.

Mapping the psychological Impact of complex trauma against fear system responses

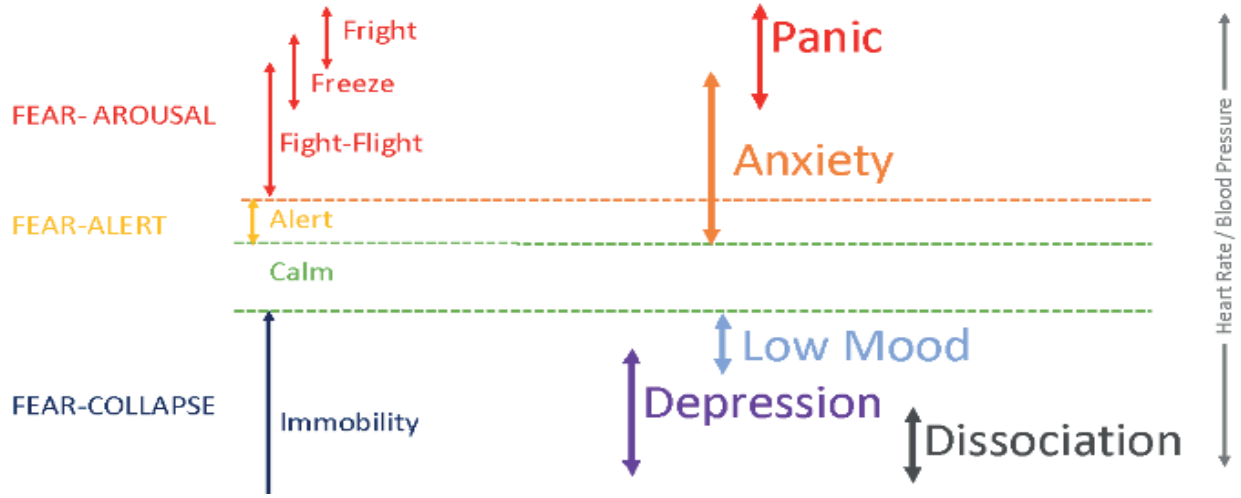


Fig.6 - Conditions associated with chronic fear system activation.

'Fig. 6' is an attempt to map the common terms we use to describe our experience of fear system activation alongside the biological responses of fear-alert, fear-arousal and fear-collapse. Anxiety, as noted above, is a persistent state of fear-activation varying from fear-alert to fight-flight. The symptoms of panic place it at the higher end of fear arousal covering freeze and fright and possibly also the initial sensations of tipping into a fear-collapse, e.g. 'feeling dizzy, *unsteady*, lightheaded or *faint*' (American Psychiatric Association, 2000).

I see low mood as a state where the immobility system has been triggered but there is still reasonably good ventral vagal regulation. Where there is less effective regulation I am suggesting that the immobility response is experienced as varying degrees of depression on a continuum from low mood through to severe depression[15].

Alongside this in more severe states of depression and immobility is the phenomenon of dissociation[16]. This is a very poorly defined concept, but I see the sense of unreality and being 'out of body' that it describes as being our experience of the numbing opiates released by the brain in immobility, or our experience of perceptual parts of the cortex being disabled by oxygen starvation as a result of the metabolic shutdown, or both[17].

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15 I struggled with this hypothesis initially because while it was compatible with a pattern of cycling between anxiety and depression, it did not explain anxiety experienced *at the same time as* depression. However, I now think that when the immobility response activates in intermediate states of fear-collapse, the sympathetic nervous system can still function, which makes sense of highly distressing symptoms in which anxiety can be experienced alongside debilitating depression. This sympathetic nervous system co-activation ceases in a full fear-collapse as the limbic system shuts down and our sense of fear disappears. The interrelation of these biological systems is complex and fig. 6 deliberately oversimplifies both in representing anxiety and depression purely as opposing states of arousal and collapse, and also in combining heartrate and blood pressure on the y-axis as if they always worked in tandem.

16 Porges (2017) speculates on the basis of Polyvagal Theory that "there may be gradations in reactions to life threat from total shutdown and collapse mimicking the death feigning responses of small mammals to an immobilisation of the body during which the muscles lose tension and the mind dissociates from the physical event."

17 This view of dissociation as belonging to fear-collapse has been challenged by colleagues who use the term more broadly to also encompass the 'dizzy brain' and disconnect from reality experienced in the freeze and fright stages of fear-arousal. It makes sense to me that the way we perceive our own body could be profoundly affected by the non-opioid painkillers released in fear-arousal which are powerful enough for soldiers not to notice major injury in battle. The narrow focus on danger and survival in fear-arousal clearly also affects our perception of our surrounding reality. My sense is that these interior and exterior perceptions generated by fear-arousal are different from those experienced in fear-collapse, and I wonder if we need another word for the fear-arousal sensations. However, I am aware that there is real difficulty involved in observing and describing fear reactions which are not static phenomena but switch rapidly between different biological responses, and I wonder whether some experiences of dissociation in the context of panic may be generated by the sudden tipping into immobility that can be part of the 'fright' response.

The complexity of complex trauma

At this stage I want to go back to my opening definition of complex trauma as a chronic failure of the body's fear system to deactivate once the threat that triggered it has passed, and the dysfunctional impact of this failure over time on a complex interconnected network of biological, behavioural, cognitive, relational and social systems. We have just looked at the impact of this failure on the autonomic nervous system leaving it over-responsive to threat, stuck in hypervigilant fear-alert, and cycling between fear-arousal and fear-collapse.

In the simplest form of trauma which might meet the criteria for a PTSD diagnosis, with a single threat of relatively short duration experienced by an adult, the impact, in terms of hypervigilance accompanied by the triggering of terror, aggression or depressive collapse, can have a debilitating effect on wellbeing and functioning. However, this can often be alleviated in a fairly straightforward way within a few sessions of EMDR or one of the body-based psychotherapies (e.g. Ogden et al., 2006).

In complex trauma however where there were perhaps multiple threats of long duration and the impact on the autonomic nervous system was not alleviated over time, the failure of the fear system to goal-correct has wide-reaching consequences. The continuing volatility of the autonomic nervous system which results from this failure affects multiple systems which become dysfunctional and create feedback loops in which this dysfunction becomes more and more entrenched. This is particularly the case when threats were suffered in infancy and childhood, and even more so where the parent or parents who are the child's fundamental source of safety are themselves the threat.

In these circumstances the task of training the autonomic nervous system out of hypervigilance and hyper-reactivity into calm becomes highly complex, no simple short-term intervention is effective, and painfully won progress in one area can easily be wiped out by a threat in another area. I have already noted the psychological impact of an unregulated fear system in terms of anxiety, panic, low mood, depression and dissociation, but will now look at the other areas or systems that become dysfunctional as a result of complex trauma, and, in their turn, contribute to the chronic triggering of fear responses.

The impact of the unregulated fear system on physical health, pain and energy

The unregulated fear system, as it cycles between extreme metabolic activity and metabolic shutdown, hugely stresses the whole organism causing cardiovascular disease, gastrointestinal disorders and, dependent on whether stress is intermittant or continuous, either over-stimulating the immune system, causing autoimmune illnesses such as rheumatoid arthritis, or lowering immune function, opening the body up to a whole range of viral or bacterial infections (Sapolsky, 2004).

Unregulated fear activation can also cause dysfunction in our pain-signalling systems. The ventral vagus nerve that is the key factor in regulating our fear system responses also has an important role in inhibiting pain signalling throughout the nervous system. When the signal on the ventral vagus is weakened through chronic fear activation, its ability to inhibit pain signals can fail, resulting in chronic pain conditions (Kolacz & Porges, 2018).

Additionally, unregulated fear activation can cause dysfunction in our systems of energy production. Sapolsky (2004) writes very clearly about the huge energy drain involved in repeated activations of fear-arousal. This is not just the considerable amount of energy required to fight or run for your life, but also the amount of energy taken up in the process of continually releasing nutrients into the bloodstream from storage cells, and then putting them back into storage if they are not burnt up in fight-flight, resulting in ongoing energy deficit. Fear-collapse also creates an energy deficit as the metabolic shutdown disables aerobic (oxygen-based) energy production, and chronic anaerobic energy

production involving the production of lactic acid and then its subsequent reprocessing uses up more energy than is actually produced (Myhill, 2014). The cycling between fear-arousal and fear-collapse created when the fear system cannot deactivate may be a key contributor to energy disorders such as Chronic Fatigue Syndrome (Gupta, 2002).

So, the unregulated fear system disrupts the normal functioning of many other biological systems[18] creating chronic conditions of physical illness, pain and fatigue. These in their turn negatively impact a person's mood, mindset, ability to relate to others, to work and to earn a living and thus their sense of personal autonomy and their ability to make changes to, or move out of, external circumstances that may be keeping them trapped in continuous fear activation.

The impact of the unregulated fear system on patterns of behaviour

Our fear response is essentially a physical reaction to threat so it shows itself most clearly in our behaviours. We are born with our fear system fully developed but without the ability to regulate it. This regulation has to be provided at first by our parents responding in an attuned way to our needs and soothing our fears. Our biological systems for regulating fear reactions develop in response to this good early nurture (Hart, 2011). However, if our parents are unable to regulate their own fear responses, and as a result are anxious, depressed, angry or preoccupied, these biological systems don't fully develop and we can potentially live our whole lives with a fear system that cannot properly deactivate.

In more serious cases where the parents not only fail to create a context of safety for the child, but are themselves the source of danger, as in the case of physical, sexual or emotional abuse and neglect, the child lives in a permanent state of fear system activation, driving behaviours in adult life such as self-neglect, self-harm, avoidance, violence, or addiction. Each of these bring practical consequences that make breaking out of the cycle of fear more and more difficult.

Self-neglect repeats patterns of early mistreatment, and can perpetuate fear system activation. Self-harm can be a risky attempt at self-regulation, activating opioid painkillers to dampen emotional distress, where shame can compound isolation and inhibit careseeking. Avoidant behaviours, driven by chronic states of either fear-arousal in flight mode, or of fear-collapse, progressively shut down opportunites for careseeking and self-development and can lead to an intensification of anxieties. Violent and offending behaviours, driven by chronic states of fear-arousal in fight mode, prompt hostility from others, further traumatisation within the prison system, and a progressive dislocation from the wider society. Addictions such as the use of drugs, alcohol or gambling, which are an attempt to self-sooth or self-vitalise in the context of the emotional turbulence of an unregulated fear system (Maté, 2012), can destructively alter neurological functioning, put an end to supportive relationships and impair the ability to work.

The impact of the unregulated fear system on patterns of thinking and education

In their different ways both fear-arousal and fear-collapse profoundly affect our ability to think. In fear-arousal the amygdala inhibits the cortex and focuses our thinking purely on detecting and surviving danger. Any other information may be heard, but it cannot be processed at the time. A chronic state of fear-arousal ensures that, over time, this focus on danger becomes habitual, negatively affecting the way we think about others and the world we are living in. This habitual outlook keeps re-triggering our fear system responses and closing down any openness to potential help.

In fear-collapse, oxygen starvation disables the cells of the cortex. As the body is de-energised, what thinking remains becomes hopeless. At a certain stage of collapse we are unable to process

18 Even affecting cells at a genetic level by shortening the telomeres which protect DNA during cell reproduction (Tyrka et al., 2010).

anything we may hear, and we then become unable to hear clearly what is said to us[19], and the mechanisms for memory encoding and recall fail.

Putting all this together, it is clear that fear system activation severely hampers effective learning and education. A child from a home where there has been no emotional regulation, cycling between fear-arousal and fear-collapse, may not able to take in and process information and may not be able to cope with school work. At the time this will be a severe blow to the child's self-esteem, but in the longer term it can limit life-options and income potential and thus can become an obstacle to escaping from a fear-dominated environment.

The impact of the unregulated fear system on relationships

Fear system activation affects our social engagement system in two key ways. In fear-arousal, where we focus only on danger, we automatically start seeing those around us as a source of danger. In fear-collapse our entire social engagement system is disabled as the cortex and then the limbic brain shut down and we lose both the desire and the ability to relate to others. Chronic fear system activation thus has a disastrous impact on our ability to make and sustain relationships. As the social engagement system is our primary means of responding to threat and enabling 'survival with wellbeing' (Heard, Lake & McCluskey, 2009) by maintaining connectedness with others, this locks us into a feedback loop of reliance purely on the isolating responses of the fear system.

As our relationships with our primary caregivers form a template for future relationships, those with a history of good fear regulation are able to trust others and maintain relationships of equality which are supportive and companionable, and which then contribute hugely to the ongoing regulation of fear responses. However, children who have been unable to seek care from parents often struggle to be able to trust or seek care from others in later life, and trauma suffered in infancy and early childhood in relational contexts can create deeply defensive patterns of relating to others such as are seen in personality disorders (Zhang et al., 2012). Where the fear system is chronically active, relationships tend to be unequal. The relationship pattern can become 'one-up, one-down', with one party dominant and the other submissive (Heard & Lake 1997), either fixed in these roles, or switching between them in highly volatile exchanges. Where the 'other' is viewed as a threat, the fear response is to control them, either directly through force, or intimidation, or indirectly through various forms of manipulation. Such relationships cannot be safe places, though they may be familiar places, and so they contribute to the ongoing failure of the fear system to deactivate.

The impact of the unregulated fear system on our social context

I have focused up to this point on the impact on individuals of an unregulated fear system, but individuals are part of societies, and fear-driven reactions of individuals and groups over time profoundly affect the culture and workings of human societies and can turn them into unsafe contexts for many, creating feedback loops which further dysregulate the fear systems of individuals. In fear-arousal, both individually and as societies, we focus on danger, and we then find danger in any sort of *difference*, be it race, nationality, tribe, class, gender, religion or sexuality[20]. When societies react to difference with fear responses, the process of 'othering' (Brons, 2015) can result in oppression, persecution, war and genocide. In this way complex trauma begets behaviours in groups, nations and cultures which inflict profound harm, endlessly perpetuating the problem of complex trauma throughout the generations.

Conclusion

In this article I have tried to describe the mechanism behind the experience of trauma as a failure in goal-correction of the fear system and to show how, if this is not alleviated in a timely fashion, this can become a chronic condition, a 'fear system disorder' which, becoming more engrained over

19 As the muscles of the inner ear, that control the tension of the eardrum which enables us to distinguish the human voice from background noises, start to fail (Porges, 2017).

20 See Nussbaum (2018) for a contemporary account of fear system activation in society.

time and affecting an ever wider number of related systems, becomes progressively harder to rectify. This chronic condition of continuing fear system activation is what we mean by Complex Trauma.

Complex trauma impacts every aspect of human experience from the volatility of the autonomic nervous system and the resultant anxiety and mood disorders, to chronic states of physical illness, pain and fatigue. It can establish patterns of self-neglect and self-harm, and avoidant, violent or addictive behaviours, disable cognition and inhibit educational opportunity. It lies at the root of personality disorders and can destroy trust and and supportive relationships. It can undermine the ability to earn a living, trapping people in hostile environments, with a loss of status, autonomy and power, and leaving them with little sense of belonging to society. It can overwhelm whole societies resulting in the worst crimes against humanity, and have an impact across generations.

In a following article I will look at a number of implications for psychological therapies that arise from this understanding of complex trauma, and give examples of the application of this perspective in clinical practice. In a further related article I will examine the difficult but crucial task we have as therapists of regulating our own fear system responses. Without this self-regulation there can be no place of safety for our clients, and only from this place of safety can the work to alleviate complex trauma begin.

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Growing strong in limbo: Evaluating the impact of a short term dramatherapy intervention with an adolescent client seeking asylum

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Abstract

The purpose of this paper is to examine and evaluate the impact of a short-term dramatherapy intervention with an adolescent client seeking asylum. An overview of literature of recent writing in psychoanalysis, psychology, intercultural therapy and dramatherapy provides a brief summary of the psychological impact of forced migration on the adolescent asylum seeking population, highlighting in particular the simultaneous impact of the upheavals of identity associated with adolescence, migration and trauma. A narrative case study provides a rich description of the intervention. Qualitative content analysis was used to identify prominent themes related to client difficulties, coping strategies and engagement with dramatherapy techniques. The results of this analysis are discussed in light of prominent dramatherapy literature and the co-relation between core dramatherapy processes and the increase in the client's coping abilities are evaluated. The study concludes that the short-term dramatherapeutic intervention was able to contribute to the enhancement of the client's resilience, however highlights the necessity of involvement of multiple agencies in addressing the complex needs of separated asylum seeking children.

Introduction

In the year ending June 2020, the UK received 2,868 applications for asylum from unaccompanied children who were displaced whilst separated from their closest family members (Refugee Council). The majority of children arriving alone in the UK have witnessed and, in an overwhelming number of cases, experienced severe trauma, both prior to and during the process of displacement. It is of vital importance that we evaluate the impact of exile on children who have been forcibly displaced and separated from their closest family members, and that we invest resources to aid and alleviate some of the effects of this intense upheaval. In this article I argue that creative trauma-informed therapeutic approaches are uniquely placed to create a safe space for renegotiation of new identity in the face of the significant upheaval of identity, which occurs at the intersection of adolescence, migration and trauma. Informed by an overview of existing literature, I provide an overview of a short-term dramatherapy intervention with an adolescent client, where I focus on how dramatherapy's ability to combine a variety of tools, including embodied work, projection and play, contributed to the strengthening of resilience and to the increase of coping ability.

Fazel and Stein (2020) argue that, in order to enable separated children to live fulfilling lives, there is a need for a variety of different avenues of support, which include 'individual, family, group, and school based interventions as well as cooperation between agencies and professionals working together as part of cross-cultural teams in an extended outreach manner'.

Echoing this, this paper proposes that whilst a particularly useful tool, therapeutic intervention should form one part of a larger fabric of connection, which can only be facilitated if agencies work together towards the common goal of improving life chances of separated children.

Overview of literature

In fleeing their countries of origin, separated children are simultaneously affected by the identity upheavals of migration and adolescence (Akhtar, 1999; Grinberg and Grinberg, 1989; Sharabany and Israeli, 2008). These are further exacerbated by trauma experienced at various stages of their journey (Fazel and Stein, 2002; Papadopoulos, 2011). It has been widely recognised that trauma and difficulties do not end with arrival in the host country, with a high chance of exacerbation of 'mental health problems associated with pre-flight experiences (…) by the lack of emotional or social support (Chase, Knight and Statham, 2008), by poor housing and accommodation and insecurity (Marriott in Chase et al., 2008), and by experiences of social exclusion and racism' (Levenson and Sharma in Chase et al., 2008). In a study conducted by Fazel and Stein (2002), the most prominent mental health concerns of adolescent asylum seekers in the UK were 'post-traumatic stress disorder, anxiety with sleep disorders and depression', with the incidence of anxiety between 49% to 69%, steeply rising in 'prevalence […] if at least one parent had been tortured or if families have been separated.' Chase Knight and Statham (2008) outline the most frequent problems identified by unaccompanied children themselves as 'missing family, disturbed sleep, feeling alone, headaches and panic attacks, depression, eating problems and anxiety'. These symptoms can be understood in the context of the traumatic experience of the 'survival' phase of the refugee experience as a normal reaction to a difficult situation (Blackwell, 2005; Alayarian, 2007), however therapists working with the client group agree that if exposure is prolonged and difficulties unprocessed, there exists a potential for pathological complications, including 'extreme memory loss, repeated attempts at suicide, psychosis and acute depression' (Chase, Knight and Statham, 2008).

Specific to the use of therapy during the traumatic phase of intense uncertainty experienced by the adolescent asylum seeker, it is acknowledged that direct focus on trauma recollection may be counterproductive (Dokter, 1998) and therapists are instead encouraged to adopt a trauma-informed, strength based approach (Sajnani, 2004). Sharabany and Israeli (2008) echo Winnicott's concept of transitional space in describing the therapy room as playing 'the role of a bridge, […] a transitional no man's land for processing the old and the new, [able to offer] a mental connection to the old and the missed, while in itself may be experienced as strange and unfamiliar, like the new location.' Many adopt an 'aesthetically distanced' narrative approach, such as the Dulwich Centre's 'Tree of Life' tool, which 'invite[s] young people to speak about their lives in ways that make them stronger' (Dulwich Centre, accessed 2020).

Lahad (2007) argues that the role of dramatherapy in this context is to create a 'fantastic reality, a temporary safe space away from the pain experienced in reality. In this liminal space an alternate narrative can be created that enhances mental resilience (Lahad in Sajnani, 2014). Dramatherapists working with survivors of trauma begin by 'providing the client with a structure and a relationship that fosters enough of a sense of safety for the client to take some risks' (Redfern in Sajnani, 2004), before continuing to work towards the assessment of coping strategies and mobilisation of inner resources (Winn, 1994; Lahad, 1997). Following the setting up of a safe framework, therapeutic work may move towards the reintegration of split-off parts of clients identity, before honouring one's losses and allowing oneself to move forward (Redfern, 2014; Winn, 1994). Dramatherapy can also be useful in supporting maintaining cultural identity (Dokter, 1998) by providing emotional refuelling to those who cannot return to their country of origin (Tummala-Narra, 2005). Similarly, it can act as a bridge towards integrating aspects of the culture of the host county and marking rites of passage from one country (or life stage) to the next (Zwart and Nieuwenhuis in Dokter, 1998). Group interventions provide an important psychosocial aspect of therapy, whereby stories are exchanged, burdens are shared and trauma can be normalised (Landis in Sajnani et al., 2014).

Methodology

This article explores the use of dramatherapy in a single case study; by describing the therapeutic process with one individual client in depth, I aim to provide an insight into how the discipline can be applied in fostering emotional wellbeing of unaccompanied adolescent clients. In addition, data recorded in weekly client CARE questionnaires (Jordan, 2012) and therapist notes was analysed using conventional qualitative content analysis (Hsieh and Shannon, 2005), which enabled me to step back from being directly involved in the research and instead take on a role of an observer. I hope that by combining qualitative information generated by direct participation in the therapy process with a more distanced analysis of themes emergent in notes and questionnaires, a richer and more accurate account of the case in question emerges.

Case Study

Client

Ha Ngoc (pseudonym chosen by client) is a 16-year-old Vietnamese girl, who arrived in the UK alone as an unaccompanied child at the age of 15. Both Ha Ngoc's parents are deceased and Ha Ngoc believes that her only surviving family member, an older sister, is currently living in the UK. However, Ha Ngoc has had no contact with her sister since prior to her departure from Vietnam. Shortly after her initial foster placement began, Ha Ngoc went missing and was later found in a different part of the country; this led to the raising concerns of trafficking. However, due to insufficient evidence the case closed and Ha Ngoc was placed in her second foster placement. At the time of beginning of therapy, Ha Ngoc was in this second foster placement, awaiting a decision on her asylum application and had just become enrolled in full-time secondary education. Ha Ngoc had no previous experience of therapy and was referred for therapy by her foster carer, the main areas of concern identified by referrer were: sadness, depression, sleeping, isolation, immigration and possible suicidal ideation.

Therapist

As a Czech therapist practising in the UK working with separated children from a variety of cultures, I am aware of the interplay of cultures and migratory experiences in the therapy room. Throughout my work with Ha Ngoc the main cultural identities were: Vietnamese client, Czech therapist, Vietnamese interpreter, British setting, African foster family, state of limbo between country of origin and host country. Clinical supervision and personal therapy were important tools to help me better identify underlying cultural beliefs and biases and to separate my own material associated with migration from that which belonged to Ha Ngoc.

Interpreter

Throughout therapy we used one female telephone interpreter, who came across as intuitive, able to relate difficult material and hold accompanying silences, and I often heard my own tone and inflection replicated in her translations. As Ha Ngoc's command of the English language improved over time and as we began working in an embodied way, the regular interpreter was invited to take a step back in sessions and rather than interpreting all material word for word, to respond to invitation by Ha Ngoc to translate whatever she struggled to understand or express in English.

Assessments and aims for therapy

Assessment

During the initial assessment session, Ha Ngoc was invited to complete a standardised assessment questionnaire (YP CORE), this was repeated in our 6th and 12th sessions to monitor clinical change. Ha Ngoc's initial score placed her in a moderate area of difficulty in areas of concern consistent with those identified by her foster carer on the referral form[1].

[1] Moderate difficulties are defined in the YP CORE manual as 'problem is causing significant difficulty in one or more areas of day to day functioning, and/or is moderately affecting overall functioning' (Twigg & McInnes, 2010).

In addition to the difficulties outlined in the questionnaire, however, Ha Ngoc spoke extensively about experiencing physiological difficulties, including sleep disturbances, severe fatigue, headaches and body aches.

From my experience of working with separated children and from an overview of numerous publications describing therapeutic work with Vietnamese refugees (see e.g. Schoen, 2005 ; Dao, Nguyen & Nguyen, 2012) this emphasis on somatic symptoms is not uncommon, and is often indicative of underlying psychological difficulties. Dao, Nguyen & Nguyen (2012) outline in their study of working with Vietnamese clients that 'refugees [who] were diagnosed with depression initially presented with somatic complaints, such as headache, backache, and difficulty sleeping' and 'sleep difficulties and physical pain [were] commonly reported in Vietnamese refugee and immigrant patients suffering from depression and anxiety'.
This type of reporting has been associated with cultural perceptions related to mental health, whereby mental illness tends to be stigmatised within the Vietnamese community (Nguyen, 2009 in Dao, Nguyen and Nguyen), where expressing emotions may be perceived as an indication of weakness (Purnell, 2008) and can lead to 'losing face' of the individual and compromising the honour of the family. Further, Dao, Nguyen & Nguyen (2009) note that 'anxiety and depression are considered to be normal parts of life that individuals are expected to endure as part of cultural virtue' and are therefore less likely to seek help in their alleviation. In addition to possible cultural stigma, I was aware of the fact that Ha Ngoc had only just met me and talking to a complete stranger about any of her complaints must have already been very difficult.

Initial formulation
The results of Ha Ngoc's YP-CORE questionnaire, combined with continued observation and consideration of context, indicated moderate to severe difficulties in areas of concern including depression, anxiety, trauma, physical symptoms, subjective wellbeing and general functioning (see Figure 1, Twigg & McInness, 2010). Presentation of these symptoms is consistent with a normal reaction to extraordinarily difficult circumstances of the survival phase of the refugee experience (Papadopoulos, 2011); therapeutic intervention is recommended to increase coping strategies to minimise possible later pathological manifestations.

Dimension	Item	Severity/ Intensity	Item N◦
Subjective wellbeing	My problems have felt too much for me	Hi	7
Symptoms - anxiety	I've felt edgy or nervous	Lo	1
Symptoms - depression	I've felt unhappy	Lo	9
Symptoms - physical	It's been hard to go to sleep or stay asleep	Lo	8
Symptoms - trauma	My thoughts and feelings distressed me	Hi	6
Functioning - general	I've felt able to cope when things go wrong Pos	Hi	3
Functioning - general	I've done all the things I wanted to Pos	Hi	10
Functioning - close relationships	There's been someone I felt able to ask for help Pos	Lo	5
Functioning - social relationships	I haven't felt like talking to anyone	Hi	2
Risk/Harm to self	I've thought of hurting myself	Lo	4

Aims for therapy

Based on observation and information provided during the first session, I identified as primary aim the creation of a safe transitional space (Sharabany and Israeli, 2008; Winn, 2008; Redfern, 2014; Lahad, 2014) where Ha Ngoc could find respite from everyday stress, begin to process difficult emotions and start working on formulating a new, resilient, identity within her new circumstances. This would be facilitated by referring to the therapeutic modality of the organisation, including focus on (a) therapeutic relationship by modelling a positive and consistent interaction with someone representative of the host culture (Birkett, 2006), (b) bearing witness to Ha Ngoc's process and offering to hold difficult material and (c) normalisation of difficult experience (Winn, 1994) through psychoeducation. As a dramatherapist, my primary aim was to work creatively on establishing a 'language' or means of expression that would give Ha Ngoc the ability to process her difficulties, without becoming overwhelmed.

Therapy process

Beginning: *Building a relationship*

The beginning phase of therapy Ha Ngoc was able to use imaginative projection in finding representation of each aspect of the working alliance, demonstrating her ability and willingness to engage with creative work. She also readily embraced filling out our weekly CARE questionnaires, which aimed to provide an opportunity to reflect on the therapy process. In one of our early sessions, Ha Ngoc referred to a postcard she had picked at the beginning of the session to represent how she was feeling; she explained that the lone flower pictured in the postcard represented how alone, vulnerable and breakable she was. In tears, Ha Ngoc shared that things felt too much for her and she did not want to go on anymore, or did not know how. Ha Ngoc asked, 'Why can't I be happy?' and continued to cry. I acknowledged Ha Ngoc's feelings and, suggested that perhaps the therapy room could become a place where she does not have to hold everything herself; instead it could be a place where she can come to rest, regain energy, and experience having her worries temporarily held by me.

Building on this, I drew on Winn's (1994) guidance of working with trauma in early stages, introducing relaxation exercises as well as working within the literal containment of a sand tray. During sand tray work, Ha Ngoc was invited to create sociograms, which would allow me to further assess where she saw herself in relation to others and how she made use of close relationships in coping with difficulty. Ha Ngoc engaged well with small world projection in these activities and showed reflective ability in identifying and assessing her support network in the UK as well as indicating complicated feelings of the loss of relationships with her birth family (for an example, see Vignette 1).

Vignette 1:

Ha Ngoc was invited to work further with the sand tray. She created an island in the middle of the sand tray and placed a shell on it to represent herself. Another shell was placed in a far corner, 'out in the sea' and this one represented Ha Ngoc's deceased parents. Another shell was placed nearer the island, however still in the sea; this one represented Ha Ngoc's missing sister. On the island next to her shell, Ha Ngoc placed black stones which represented her foster carer, social worker, friends and me/organisation. When asked if there is anything she would like to change about the picture she created, Ha Ngoc picked up the shell representing her sister and brought it to the island, beside the shell representing herself, completing a full circle. I reflected on how difficult the situation of not knowing must be and made space for Ha Ngoc to sit with the difficult feeling for a moment.

During the middle phase of therapy, Ha Ngoc continued to engage well with projection. She was invited to use postcards whilst checking-in with her feelings and became increasingly articulate in drawing connections between the images she chose and her state of mind or what was going on in her life. We continued to work using relaxation and body work, as Ha Ngoc found these a safe way of arriving in the room and getting ready to work dramatically. In this phase of therapy, body scans were built on to more elaborate guided visualisations, with imagery chosen to embed ideas of creating an internal safe space (e.g. see Winn, 2008). We were thus able to begin working with imagination and mindfulness as coping strategies for dealing with overwhelming emotions and distressing thoughts.

It was through working with the body and guided visualisations that we found a way into working in sustained dramatic reality (Pendzik, 2006), and began to develop a language that would allow Ha Ngoc to explore diffi cult emotions in a contained way. As we continued to improvise with movement, various emotions began to be played out, and gradually Ha Ngoc became able to embody, hold and engage with a range of feelings (see Vignette 2).

Vignette 2:

Ha Ngoc was invited to explore her conflicting feelings through the creation of embodied sculpts. We began by working together on sculpting happiness, where I was the sculptor and Ha Ngoc was the sculpture. Ha Ngoc readily embodied my suggestions, standing tall, lifting her head and smiling. In the next step, Ha Ngoc sculpted me into sadness. A great weight was placed on my shoulders, my feet grew heavy and my head dropped, with my gaze fixed firmly on the ground. Together, we 'fixed' each of these sculpts, making sure to remember details of posture. We then proceeded to explore the 'space in between', discovering a series of adjustments that our bodies needed to make to move between the two fixed sculpts. We repeated the same activity with anger and surprise, two emotions suggested by Ha Ngoc. At the end of the session, Ha Ngoc reflected on how sadness can be all consuming and overtakes the whole body, and that it was a relief to be able to 'take it off'. At the beginning of the session, Ha Ngoc resisted acknowledging that she felt anger at all, however at the end of the session she relayed that anger was present in her sadness.

End: *From ending to a new beginning*

The end phase of therapy was indeed dominated by endings. Ha Ngoc was invited to use her time in the therapy room to process the leaving of her social worker and to begin preparing for the end of therapy. Ha Ngoc chose to create Chinese New Year cards for her departing social worker, her foster mother, for me and herself. She was able to articulate feeling thankful for the support of others, whilst openly acknowledging her own strength and expressing wishes for herself for the future, which was in stark contrast to the uncertainty of how to go on from the beginning of therapy. In her final session, Ha Ngoc was able to relate images and other materials in her dramatherapy folder to material explored in sessions and reflect eloquently on time spent in therapy. She expressed surprise at the length of time she spent attending sessions and commented on how much of a part of her life therapy became, however, she also stated that she felt ready/strong enough to end. Ha Ngoc reflected that at the start of therapy she found talking about her feelings overwhelming, however now she found it much easier.

Analysis of data

Client questionnaires and therapist's notes were collated and scanned for data related to three predetermined categories: (1) client difficulties, (2) coping strategies, and (3) engagement with dramatherapy techniques. Following thorough content analysis, a number of themes emerged within each of these clusters, these are recorded in Figures 4, 5, and 6 below.

Figure 4: **Client complaints/difficulties**

- **Depression:** Complaints related to unhappiness, helplessness, resignation and low mood.
- **Loss and grief:** Associated with distress and grieving for family members who are either deceased or missing.
- **Isolation:** Feelings of isolation and withdrawal within host country; related to peers, school environment, foster family, as well as overall sense of not belonging.
- **Suicidal ideation:** Expression of a wish to give up, not go on, as well as any concrete plans of self-harm.
- **Physical symptoms:** These included primarily sleep disturbances, insomnia and fatigue, as well as headaches and body aches.
- **Anxiety:** Feelings related to sense of fear, distress, nervousness and feeling on edge.

Figure 5: **Coping strategies**

- **Reaching out:** concrete examples of Ha Ngoc reaching out to others for help.
- **Reaching in:** concrete examples of Ha Ngoc calling on her existing internal coping strategies, such as belief systems and use of imagination. Also evidence of utilising new strategies explored in therapy, such as mindfulness techniques and affect articulation when not in session
- **Sense of external support:** awareness and mention of support networks, including foster family, social worker, teachers, peers, and therapist
- **Sense of inner strength:** awareness and mention of own strength and sense of agency, explicitly articulated by Ha Ngoc

Figure 6: **Engagement with dramatherapy**

- **therapeutic relationship:** references to the therapeutic relationship and sense of benefit from coming to sessions and shared experience
- **cultural refuelling:** (based on Akhtar's concept of 'emotional refuelling') references to home country, and cultural traditions, which were explored in the therapy room
- **relaxation:** working through the body, breathing techniques, body scans and guided imagery
- **mirroring:** client and therapist working together in an embodied way, copying each other in fostering client's sense of self in relation to another
- **embodied emotion:** building on mirroring work to create sustained sculpts and explore difficult emotions
- **small world projection:** using projection to contextualise client experience, either within the containment of a sand tray or using postcards, COPE trauma cards and other objects for self-reflection
- **dramatic reality:** sustained periods of activity in the '*as if*' realm, including embodied improvisations, role work, and the empty chair technique
- **life-drama connection:** instances of reflection, where client specifically drew parallels between life and the therapy

The emergent themes were then scored by occurrence/number of mentions for each phase of therapy and recorded in separate charts for client questionnaire data and therapist's data. Results of YP-CORE outcome measures taken in sessions 1, 6 and 12 were also collated and similarly charted, to provide a control measure for data gathered by thematic analysis. In case of Ha Ngoc's questionnaires, difficulties and coping strategies were recorded as two series within one chart; Ha Ngoc used her questionnaires to reflect in detail on what she found helpful in sessions, and her difficulties and coping strategies were often communicated in more general terms.

Regarding engagement with dramatherapy techniques, I scored Ha Ngoc's questionnaires for mentions of positive engagement with dramatherapy techniques, based on items 2, 3, 4[2] in the questionnaires, and subtracted any negative mentions in the same category. Similarly, within my therapist's notes I looked for positive engagement, where I noted that Ha Ngoc responded well to the activity, and subtracted times of resistance.

Discussion of results

During the beginning phase, when her difficulties were reported to be the most prominent and her coping strategies at lowest level (Figures 7, 8 and 9), Ha Ngoc responded well to activities involving projecting herself, her problems and her relationships with others into external objects (as was the case in sand tray work and working with postcards and images). Casson (2004) highlights as core feature of projective play its capacity to enable clients to externalise and concretise. He posits that the 'process invites the person first to look out into the world, at an object, and associate with it, in

[2]Questionnaire items:

1. Today we discussed/did…
2. What surprised me was…
3. Today I enjoyed/didn't enjoy…
4. What I am going to take away from this session/what helped me was…

effect grounding them in here and now reality, […] shifting the focus from the anxious self onto some reliable object in the environment'. Winn (1994) remarks on often beginning work with clients who have suffered trauma using projective techniques, because of their containing and distancing qualities. By engaging with projective play at the beginning of therapy, Ha Ngoc was able to distance herself from her difficulties for short periods of time and gain insight into her situation, all the while having her experience validated and witnessed by me.

During the beginning phase, Ha Ngoc was also able to find a place to rest and recuperate using a variety of relaxation and guided imagery techniques; Winn stresses the importance of relaxation in the beginning of working with survivors of trauma in establishing a sense of safety in the therapy room.

Having become more comfortable as time went on, Ha Ngoc proceeded to involve both her mind and body in play during the middle phase of therapy, initially actively engaging with imitative play. Jennings (1999) highlights that imitative play 'encourages experiences of both 'we' and 'I', the development of trust in oneself and in another'. This was instrumental in both developing Ha Ngoc's sense of self, and creating trust in the therapeutic relationship. As the therapeutic relationship evolved and Ha Ngoc began to feel safer in the room, she began to take more risks in her play, all the while witnessed and supported by the therapist. Jones highlights the importance of imaginative play in so far as it 'allows access to own spontaneity' and 'enables clients to try out new configurations or possibilities'. Play is therefore instrumental in facilitating both assimilative and accommodative processes in coping. By trying on different configurations in play, Ha Ngoc was better able to access her own resources and coping strategies, as well as allow for the accommodation of new configurations in her lived experience.

The accommodation and integration of traumatic experience and subsequent developmental growth was further facilitated by the exploration of embodiment of diffcult emotions.

Figure 7: Difficulties and coping strategies

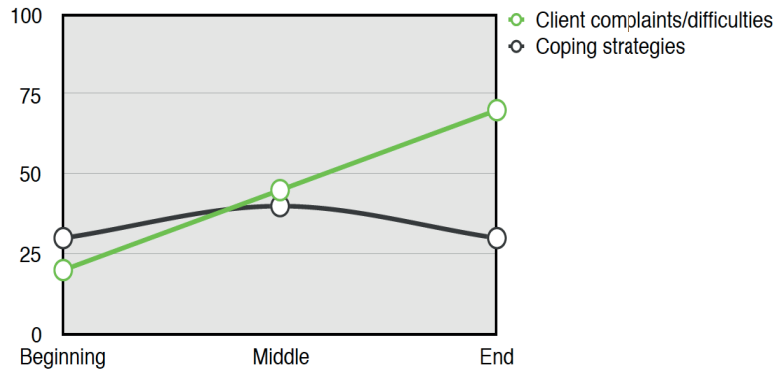


Figure 8: Client difficulties (therapist notes)

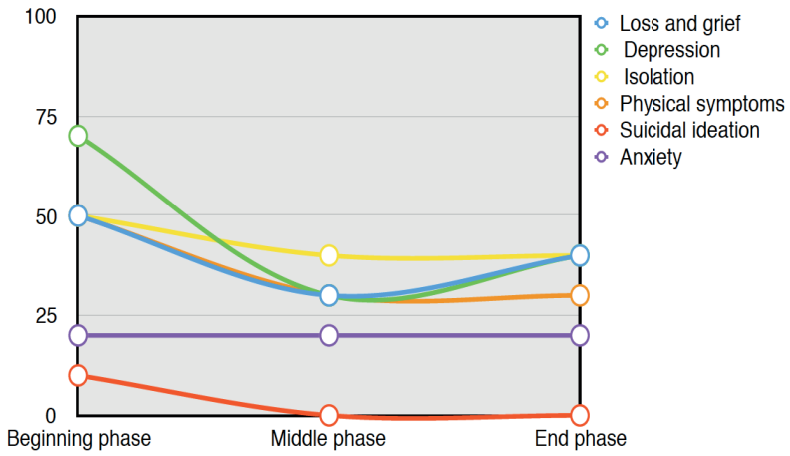


Figure 9: Client coping strategies (therapist notes)

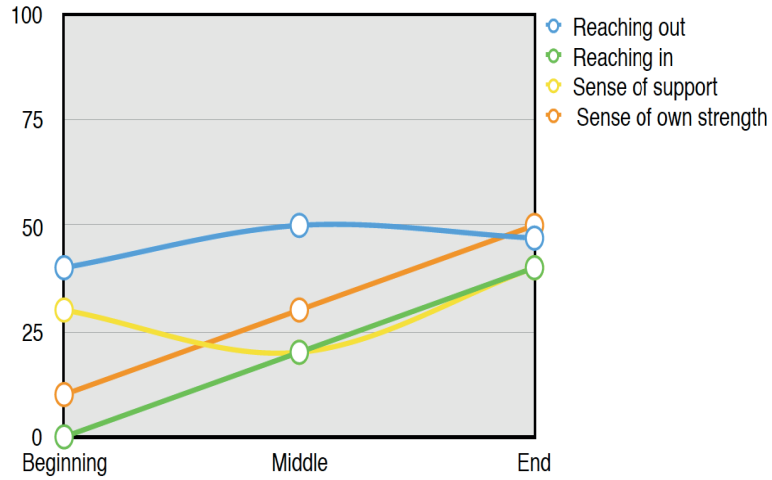
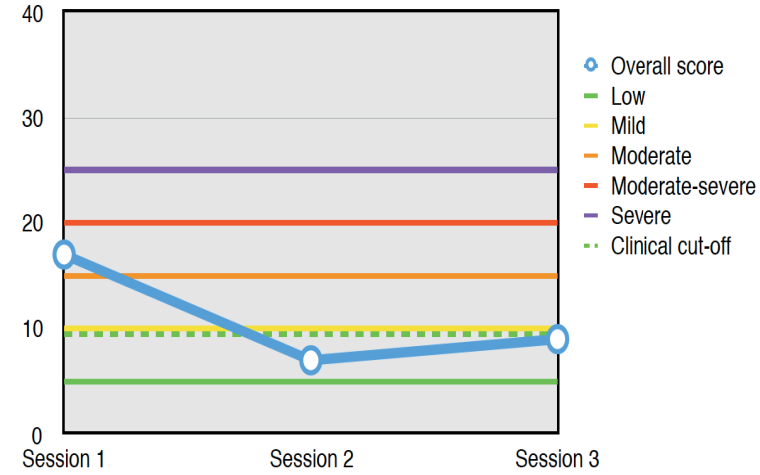


Figure 10: YP-CORE outcome measure



Jones (2007) points to the capacity of embodied play to allow 'clients to express something that has been held-in through physical means', and to do so safely in the presence of another; 'a thing they can physically embody and share may make this less frightening than the isolating experience of terror'. Muller-Thalheim (1975, in Jones, 2007) 'suggests that expressing problematic material and emotions through the arts changes the relationship to the problems of feelings', whereby 'real fear [for example] is being converted into fictional fear and is, therefore, more able to be faced, talked about and dealt with' (Muller-Thalheim in Jones). Once creatively expressed and shared, difficult emotions are stripped off their unspeakable status and become more manageable, inside the therapy room and out. Having worked with her emotions in an embodied way, Ha Ngoc was gradually more able to articulate and hold them, increasing her ability to cope when faced with diffcult situations and feelings.

During the end phase of therapy, Ha Ngoc engaged in short improvisations within dramatic reality; people and situations were brought into the therapy room from the outside, and engaged with akin to 'a rehearsal for life' (Emmunah, 2000 in Jones). As a consequence of increased emotional articulation and the ability to try on difficult situations in a safe environment, Ha Ngoc increasingly began to make connections between the work done in the dramatherapy room and her own lived experience, further strengthening her coping ability by bringing awareness of own processes into the conscious realm.

Figure 11: Engagement with dramatherapy (therapist notes)

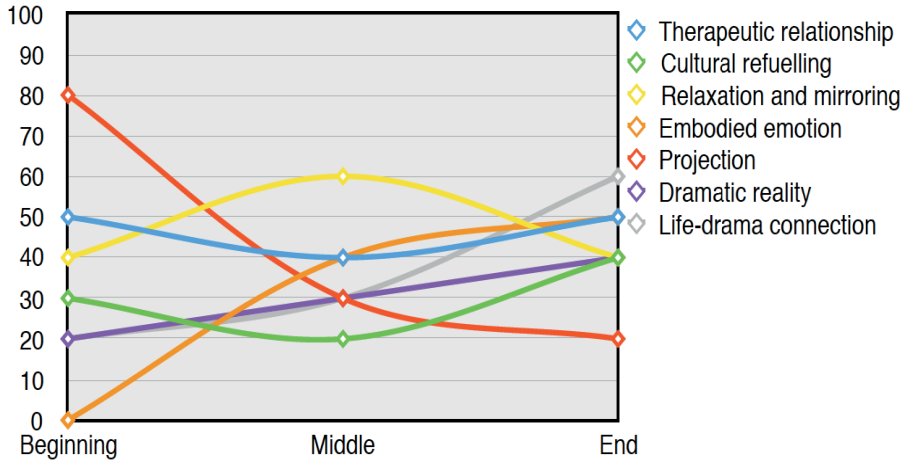
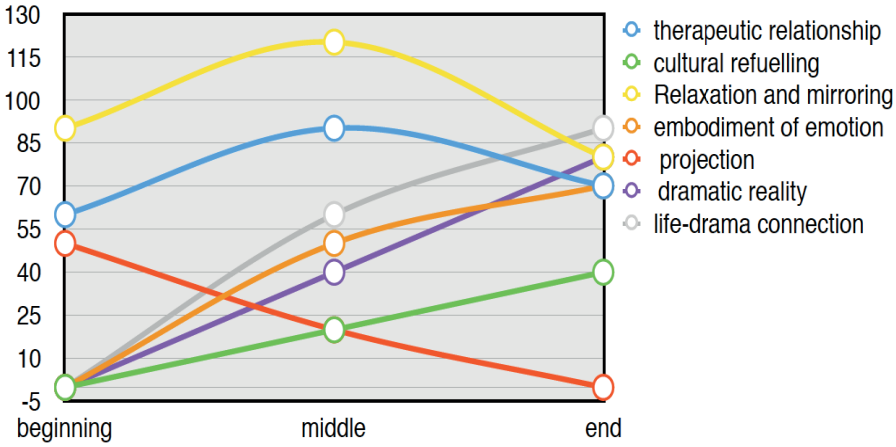


Figure 12: Engagement with dramatherapy (client questionnaires)



Themes of therapeutic relationship and cultural refuelling were undeniable throughout the study. Therapeutic relationship is a key feature of therapy across client groups and modalities, and has been defined as 'the feelings and attitudes that therapist and client have toward one another and how these are expressed' (Norcross et al, 2010). Working with traumatised asylum seeking adolescents, therapeutic relationship fulfils a variety of functions, including that of a container for difficult material, the involvement of the therapist as listener and witness to therapeutic change (Goodman in Jones, 2007), as co-creator of imagined realities, and a sounding board in negotiating new identity in a new culture (Tummala-Narra, 2009). Ha Ngoc was able to engage with me in a trusting and reliable relationship, which was sufficiently boundaried to prevent separation difficulties when the short-term intervention came to an end.

Tummala-Narra (2009) and Dokter (1999) both write about the role of (drama)therapy in the migrant's negotiation of new identity vis a vis the culture of their country of origin and that of the host country. Through sensitive and imaginative engagement with the aspects of Ha Ngoc's culture that she brought into the therapy room, I was able to encourage Ha Ngoc to try on aspects of both cultures in order to begin to integrate aspects of each into her new identity. Whilst references to Ha Ngoc's country of origin were present throughout the course of therapy, it was during the end phase that Ha Ngoc became better able to refer to her home culture without becoming overwhelmed by feelings of nostalgia (Akhtar, 1999). Instead, she took pride in sharing her customs with me, encouraging me to partake in paying tribute to important aspects of her culture.

Alternative explanations/consideration of context

In evaluating whether the change observed in Ha Ngoc was brought upon by her involvement with dramatherapy or other contextual factors, alternative explanations present themselves.

Increased command of language: During the 18 weeks she attended therapy, Ha Ngoc's command of the English language improved. An increased command of the language of the host country is associated with a reduced sense of isolation in migration (Nawyn et al, 2012), and could thereby provide an alternative explanation for Ha Ngoc's increased sense of belonging and use of support networks. By becoming more proficient in the language of her foster family and peers, Ha Ngoc was better able to reach out to others, and possibly to do so more effectively as she acquired new vocabulary that enabled her to better express her needs.

Strengthening of bonds: Overtime, Ha Ngoc's bonds with her support network grew, as she had spent a longer time living with her foster family as well as attending the same school. This could also point to an alternative explanation for her increased sense of belonging and use of support.

Loosening of restrictions: As Ha Ngoc spent more time living with her foster family and attending school, fears of her absconding and risk being re-trafficked subsided, and she was therefore allowed greater freedom both by her foster family as well as her social worker. In practice, this meant that she was able to forge new connections within the Vietnamese community and make greater use of existent ones. This allowed her greater access to emotional refuelling to her culture, and could therefore serve as an explanation for her being able to begin integrating her new cultural identity.

As outlined by Fazel and Stein above, therapeutic intervention forms only a part of a larger framework involving multiple agencies and professionals working to support separated children, and does therefore need to be viewed in this context. Based on the examination of alternative explanations of change, it is possible to infer that Ha Ngoc's external coping strategies ('reaching out' and 'sense of support') increased at least in part due to a greater involvement with her foster family, peers and the Vietnamese community. The dramatherapy intervention served as a complement to the support provided by other agencies, providing a space where internal coping strategies ('reaching in' and 'sense of own strength') could be reinforced in the context of a growing support network. The cooperation of individuals, agencies and professionals is crucial in supporting separated children and Ha Ngoc's case serves as an illustration of the positive impact of the involvement of multiple sources of support.

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We need to talk - differential understandings and responses to domestic abuse and violence

Dermot Brady

Abstract

This article summarises a presentation to the Complex Trauma Institute (CTI) in July 2020 and a subsequent online seminar. Domestic abuse is a common theme when considering complex trauma, as Herman (1989) noted and addressed by more recent researchers and commentators (see, e.g. Van Der Kolk, 2015). Domestic abuse is a site of knowing and not knowing, denial and action. While we can work with people who have experienced violence and abuse in their intimate relationships, the field is contested and politicised. Differential understandings, processes and professional remits concerning domestic abuse are addressed. In the development of responses to domestic abuse and complex trauma, early writers and activists saw their work as grounded in wider social movements. Over time neoliberal discourses and practices have become dominant, replacing the idea of social change as the part of remit of the state with the concept of government as a minimalist actor supporting free markets. Neoliberalism is arguably inimical to the delivery of public services and this has implications for those who have experienced complex trauma. An understanding of the different professional languages, research and practices in use, in tandem with an understanding of the importance of how services are funded, designed and delivered have implications for both practitioners and more broadly in Herman's terms, those in need of safety, remembering and mourning, and commonality.

Introduction

Domestic abuse is both an ancient and contemporary issue. The world's great pieces of literature and folklore are full of tales that provide insights into community wisdom and beliefs relevant in their own times and contexts and interpretable through contemporary understandings (see, e.g., Warner, 2000). Collectively we have always talked about abusive behaviour between people, but equally, we continually re-evaluate our understanding in the light of current practice developments and new understandings, which often involve re-imaginings of human behaviour; this is as true for domestic abuse as it is for complex trauma; Herman called this 'episodic amnesia' (1994). The most recent contemporary movements in the domestic abuse field in western societies can be traced to grassroots movements in England and the US. In England, the first refuge was started in Chiswick, West London in 1974. Refuges are the single biggest providers or services to domestic abuse victims/survivors in the UK. They are responsible for residential services and outreach work, specialist provision, and a significant campaigning and social change mission. The sector is diverse, with many providers of services and an increasing number of providers from the not for profit and private sectors entering the market (ONS, 2020 - but worth considering Harkin, 2019).

In the early 80s, inter-agency approaches were developed in Duluth in the US (Pence & Sheppard, 1990), which have had a global impact in the development of thinking on domestic abuse and inter-

agency practice in particular. Although often associated with models of working with men, the main focus in Duluth was on making private violence a matter for public discourse and action and ensuring that different agencies had a common understanding about what was involved and what to do about this. This generated the idea and practice of the Coordinated Community Response, which is summarised as 'An interagency effort to change the climate of tolerance of battering by institutionalizing practices and procedures which centralize victim safety and offender accountability in domestic assault related cases'. (Pence & Sheppard,1999)

Herman's seminal work (1994) noted the earlier focus of attention of trauma practitioners on people who experienced trauma through their service activities, typically in the armed forces, police and so on; it became evident that there was a large group of people who experienced complex trauma in their families and/or intimate relationships. In hindsight, this is not surprising. Herman states in her first sentence (acknowledgments, vii) that the work 'owes its existence to the women's liberation movement'.

The feminist ideas underpinning the Duluth model saw domestic abuse as a deliberate and intentional expression of patriarchy. Herman explores why we forget about violence and abuse. There is a contract of forgetting and denial between those who survive abuse and those who witness it and critically those who perpetrate it: 'When the victim is already social devalued (a woman, a child) she may find that the most traumatic events of her life take place outside the realm of social validated reality. Her experience becomes unspeakable'. (Herman, 1994)

There is a commonality in not seeing, not expressing and denying the experience of others and creating the circumstances for the possibility of 'othering', as expressed by Cohen (2001): 'Denial may be neither a matter of telling the truth nor intentionally telling a lie. There seem to be states of mind, or even whole cultures, in which we know and don't know at the same time.'

Pence, Herman and Cohen spoke a common language in some respects. They understood the need for social and political movements to drive changes on a wider scale beyond the personal experiences of those they wrote about and on whose behalf they advocated. In Duluth, the aspiration was to change expectations for enforcement of the existing law where it was commonly not applied. Their early efforts have led to changes in our understanding of the nature of domestic abuse and, in particular its pervasive and continuous nature and effects in the most serious of cases. The development of our collective understanding of domestic abuse concerning the concepts of coercive control (Stark, 2007) and stalking (Monckton-Smith, 2020), health outcomes (Chandan et al., 2019, 2019b), elder abuse (Benbow, Bhattacharyya & Kingston, 2018) and the experiences of and impact on children (Callaghan & Alexander, 2015; Gadd et al., 2013; Holt, Buckley & Whelan, 2008) has grown significantly. Other areas of knowledge and practice in the field have also developed. This would not have been a surprise to Ellen Pence, but the focus on children as victims and survivors was not a strength of the early models. Still less, was the experience of male victims, particularly in heterosexual cis-gendered relationships, which, although highly contested particularly in relation to prevalence (see, e.g. Archer, 2000; Dutton, 2011), is generally accepted. In fact, as our knowledge around abuse has grown, we see the research and literature expand to a level where it is generally not possible for all but the most determined practitioner (as distinct from the average researcher) to get to grips with the complexity and diversity that is now extant, to say nothing of being able to evaluate what is out there critically. There are some 78,000 academic papers published globally every month. We now know about domestic abuse, or interpersonal violence depending on your discipline and professional orientation, from children to parents, between older and younger people, LGBTQI+ relationships and so on. It might be argued that these distinct threads suggest a need for and between those working and researching in the field and indeed those living with and surviving abuse to understand each other's professional and personal languages, as well as each other's experiences.

Domestic abuse prevalence and discourses

To persuade those in power to spend their budgets, early interventions made good use of evidence to advance their arguments. Falk and Helgeson (Shepard & Pence, 1999) talked about how they gathered information in real-time to influence local policing. This was extremely effective and much copied. In the UK and elsewhere this catalysed increased research on prevalence, risk assessment and interventions. Furthermore, it led to, among other findings, perhaps the best-known statistics concerning domestic abuse; that a woman is killed by a current or former intimate partner every three days in the UK. This is now generally taken as axiomatic (The Femicide Census, 2020), although it does not tell us the full story. The reality is actually much worse, as the true figure is that around 10 people a week in the UK lose their lives as a direct result of domestic abuse. Monckton-Smith, Szymanska and Haile (2017) included child deaths, suicide and domestic homicides to bring a new perspective. What is clear, however, as noted by Ingala Smith and O'Callaghan in comparing the current report with earlier work is that

> (...) one of the most striking things is how little has changed in those ten years. It is both heartbreaking and, frankly, makes us so angry because we, and all those who work on responses to men's violence against women, seem to be shouting our findings, our understanding, our advocacy, into a void. (Long et al., 2020, foreword by Ingala Smith & O'Callaghan)

Compare this to other domestic violence and abuse approaches that see this as gender-neutral (Archer and Dutton, ibid). In this understanding men and women are equally violent and abusive in their relationships, and the politically driven attempt by Duluth and those they have influenced is evidence-free and politically motivated. The gender-symmetry argument continues, although Johnson posited other reasons for findings that Ingala Smith and O'Callaghan would certainly dispute as far back as 2008; he gives an interesting account (2017) on the development of his work that gives new perspectives on this increasingly partisan debate. The gender-neutral position might be seen as being based on an assumption of the neutrality and dispassionate nature of scientific research. It is unhelpful to criticise psychology as a discipline. However, it does not generally assume an overarching social mission (in direct contrast to the main domestic abuse service providers), has its own methodical and replication issues (Ioannides, 2005) and has a basic sampling error – Arnett pointed out in 2008 that most psychological research come from populations in Western, educated, industrialised, wealthy and democratic societies, so is not able to speak for human behaviour beyond those parameters. Indeed, it is equally clear that it is engaged in its own reflection on these issues. As practitioners, we need to be tuned into professional languages and the assumptions that underpin them. This is important for complex trauma as people are likely to access help through various agencies and professionals.

Neo-liberalism and managerial ingress in human services

Neo-liberalism is arguably the dominant political discourse in developed and developing societies and has brought a significant rise in global and national inequality. This impacts services where complex trauma will initially present and traumagenic consequences for those services.

Neoliberalism can be defined as, '(...) the doctrine that market exchange is an ethic in itself, capable of acting as a guide for all human action - has become dominant in both thought and practice throughout much of the world.' (Harvey, 2005, abstract)

Neoliberalism prioritises the needs of markets over the needs of people. As a philosophy that is so deeply embedded in our ways of thinking and acting as invisible (there is no alternative…), there is ample evidence (see e.g., Wilkinson and Picket, 2009; Dorling, 2015) that neoliberal approaches lead to gross inequalities. In this context globalisation arguably becomes a misnomer for oppression, which tends to reproduce in services as a particular ethos and approach. There is a relationship between market dominance of service models, the reduction of the state as an agent of change and social justice and the concentration of public assets in private hands. Public services become the minimum that can be delivered without increases in taxation and are increasingly top-down crisis

intervention models planned at central governmental level with scant regard paid to the voices of those receiving services. Ritzer (2005) summarised this in the idea of 'McDonaldization' – that services can be delivered on a business model as a sort of franchise that can be predicted and planned (Dustin, 2007). This does not work so well in human services as people tend not to be that predictable or compliant.

Discussion

What does this have to do with complex trauma? Complex trauma and interventions are developing knowledge and practice. At the moment, the idea of complex trauma is arguing for its own space, as described by Van Der Kolk (2014). For practitioners and researchers, the case for additional attention and action on complex trauma is clear. Still, if models of service delivery lag behind actual need and funding is predicated on existing rather than emerging need (Van Der Kolk's discussion on the DSM-5 [2013] comes to mind here), then the needs of those with complex trauma are less likely to be addressed. Who will pay? Those who can, might, if they are fortunate enough to find the right therapist, while those experiencing domestic abuse and trauma in contact with public services will find it difficult to meet their needs.

When public systems become unable to meet the needs of the communities they serve, this is not without consequence to those who work in them. (Bloom, 2012; Bloom & Farragher, 2013) Clearly, the priority should always be those who require help, but managerial models have consequences for all concerned and can generate parallel processes. Trauma-organised systems extend beyond families and individual relationships to replicate the patterns of 'mindless action systems' within services. It seems likely that those experiencing complex trauma are mostly likely to appear in public services at the doors of mental health, substance and alcohol misuse, child protection and older adult services, but are not likely to be recognized as needing specific rather than generic services. Ubiquitous models of service design, nominally based on need but more likely based on need as decreed by central government remits for commissioners, have led to fractured services working in silos (Hood et al., 2020; 2020a). Risk need and responsivity models are often anything but, and the tiering of what is offered stems from professional knowledge and discretion.

Conclusion

Early writers and activists who were concerned with domestic abuse and trauma tended to see their work with the context of broader social movements and discourses. As responses and research developed over time there has been a growth in our understanding and knowledge of these issues and there are challenges for practitioners and others in assimilating new perspectives and evidence. At the same time neoliberal discourses have become dominant and have implications for service design and delivery and arguably a focus on the individuality of traumagenic experience divorced from its social context. This might be tantamount to a new forgetting and denial. Herman's conceptions of safety, remembrance and mourning, and commonality are both individually and socially located and reaffirming the social aspect of these ideas and the experiences of those experiencing complex trauma has the potential to improve our practice, to build partnerships with other professional disciplines and to advocate for those changes in broader social forces that contribute to individual traumagenic experience.

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Towards a systemic lens in trauma work

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Abstract

Research and treatment in the context of trauma are situated largely within the context of an individual. This article invites practitioners working in trauma care and treatment to incorporate a systems lens into their practice. It offers a bringing together of ideas, both of individual treatment and the wider consideration of the family system and the relational aspects of trauma. The article offers some ideas and tools that could easily be applied to an individualised model to bring a systemic lens to trauma work.

Practitioner points

- Systemic Principles can be applied to the context of trauma work in support of the survivor's recovery.
- Dominant narratives in current trauma treatment foreground individualised treatment methods.
- Systemic practice is under-theorised in the context of trauma treatment but can be usefully applied to existing frameworks.
- The use of a systemic lens offers a valuable contribution to the context of trauma treatment.
- Systems informed practice could contribute to a context for empowerment, healing and recovery within the family.

Introduction

'The first goal of trauma recovery should and must be to improve your quality of life on a daily basis' (Rothschild, 2010)

We are writing following our experiences of delivering and attending the Complex Trauma Conference at York University in July 2019 and from the perspective of our own training and work in the field of complex trauma, both from a human rights and private practice context. As systemic therapists, it felt appropriate and important for us to open a dialogue around systemic work in the field of trauma amidst the predominant narrative of individualised treatments.

Whilst trauma is not a new concept, the treatment of trauma is a relatively new and emerging theoretical field of development. Care and treatment of trauma are currently conceptualised as an individual challenge to mental health, requiring individualised treatment through therapeutic rehabilitation, medication or combined methods (NICE, 2014). This position is supported and underpinned via historical ideas of psychiatry and the biomedical model of treatment through Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Disease (ICD) criteria (American Psychiatric Association, 2000 and World Health Organisation, 2020).

As systemic therapists, we are deeply aware that these structural ideas are discrete, deficit-based, and fail to consider the relational nature of human beings. Over the years, we have become

increasingly aware of the foregrounding of individualised treatments. The biomedical model of trauma treatment has become a dominant cultural treatment narrative, creating a context in which the therapist 'must' and 'ought' (Pearce & Pearce, 2000) to view trauma treatment. However, we would argue that by implication, these structural ideas can invite the therapist to overlook the relational support system around the survivor. How can we 'improve the quality of daily life' unless we give more consideration to those significant others and the family system?
Barnes (1998a, 2005) highlights evidence suggesting that the family's perceptions of the amount of stress caused by the experience of the traumatic events (on the individual) can also profoundly impact family dynamics, creating tensions around resilience and coping. Many of us are trained and experienced in delivering trauma-informed interventions, but how often do we consider or include the family system?

Therapists spend roughly an hour a week with survivors to navigate the presentation of trauma. However, the remainder of their time is spent with loved ones outside of the therapeutic space. Imagine the possibilities of working with survivors and their caregivers together, supporting family members to understand the nature of trauma responses, and supporting the recovery process!
Humans are relational and seek support, comfort, love and reassurance from within their closest relationships, but trauma symptoms can isolate and take us away from our sense of self. So, how can we introduce the idea of including significant others within the family system into the therapeutic process of treatment?

In adopting the idea of a 'systemic lens' we invite the reader to consider the client within the context of their family relationships and communications, focusing on how they affect and are affected by each other. Trauma symptoms can be exacerbated and potentially maintained within family behaviour patterns and communications in a way that can at times hinder the recovery process. Still, equally, there is huge potential for families to offer a place of relational healing and recovery.
In this dialogue, we offer some key systemic ideas to enable therapists from differing disciplines to incorporate a systemic lens when working with the effects of trauma and consider the client within their wider family context. There are many other systemic methods and techniques, but we mention only a few for the sake of brevity.

Clinical framework for trauma-informed practice
It is important to note that as systemic therapists, we do not abandon the traditional ideas associated with trauma care and treatment altogether, as many of these are well evidenced. Instead, we seek to facilitate a more balanced approach allowing space for the relational. We incorporate Herman's (1992) three-phase trauma treatment model as the predominant approach in our work with families. Guiding frameworks are essential, given that there is a limited commentary on the role of systemic practice in trauma treatment. In its absence, we have been influenced by systemically informed evidence-based practice (Stratton, 2016). Johnstone (2018) suggests that maintaining a trauma-informed framework for clinical practice allows us to combine ideas from psychiatry, attachment theory, and neurobiology. We extend Johnstone's (2018) ideas by advocating the integration of a systemic lens into this framework.

Beliefs and attitudes about trauma - An appeal to the reader
Your own stance on trauma, trauma survivors and their families is important as it will inform your 'way of being' (Rogers, 1980) within the therapeutic relationship and how you take into account the family and the survivor in your approach. We invite you to reflect upon your own values, beliefs and attitudes towards mental health in general and in particular trauma. What is your understanding or awareness of the relational impacts of trauma? In what ways do you take the relational context into account in your work as a therapist?

Tedeschi's (1999) ideas of Post-Traumatic Growth (PTG) and Papadopoulos (2007) idea of Adversity Activated Development (AAD) encourage both survivors and the therapist to re-frame or re-author

the idea of 'symptoms' toward ideas of coping, survival, resilience and personal growth. Whilst Papadopoulos writes about refugees, his ideas can readily be applied to any population, highlighting the idea that where there is an exposure to adversity, this may prompt or activate personal development in relation to resilience, strengths and potentials.

Irreverence - A survival strategy for therapists

As mentioned earlier, the field of trauma is dominated by psychiatric/biomedical narratives, with the ideas of symptoms and diagnoses inviting 'oughtness' (Pearce & Pearce, 2000) toward how we should approach our work in the field of trauma. For example, we 'ought' to use Eye Movement and Desensitisation Therapy (EMDR) or Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) as this is what NICE guidelines suggest.

Cecchin, Lane and Ray (1994) speak of the idea of 'irreverence' as a 'therapist strategy for survival', particularly in a world dominated heavily by psychiatric models of treatment. We would argue, particularly in the arena of trauma work. We feel strongly that therapists need to look 'outside of the field determined by the masters and do something different' (Bertrando, 2019) to enable more flexibility of approach to trauma treatment and incorporate fast emerging ideas and research. To hold a tentatively irreverent position toward the structural dialogues and frameworks provided by NICE guidelines, DSM and ICD criteria will open space allowing therapists to 'integrate' emerging ideas into the field of trauma work of which a 'systemic lens' could be part.

Assessing and engaging the family system

All too often, we have encountered survivors who continue to struggle with trauma symptoms despite participating in 'trauma processing' treatments. In our experience, this is often due to the 'problem' being maintained within the interactional patterns of the family system, which can get stuck in a vicious cycle. Systemic therapy seeks to stabilise both the individual and the entire family system. An enduring idea in systemic therapy is that family systems can maintain potentially unhelpful ideas that can sustain distress within the family. We would encourage using a relational tool such as 'Score-15' (Stratton et al., 2010) alongside individualised assessment scales to check for trauma-related symptoms.

The 'Genogram' and 'Ecomaps' (McGoldrick & Gerson, 1985; Rempel, Neufeld & Kushner, 2007) are useful assessment tools to help therapists to look beyond the individual. Genograms can be completed with the individual or with a family group. It can prompt the therapist to hold the client's family in mind and consider the family system's potential needs. It is important to remain curious about the family's dominant narrative around trauma symptoms and traumatic events to consider the impact of these ideas on family dynamics and communication

The family unit can be a valuable resource supporting the rehabilitation process, potentially supporting and creating safety for the client (Mason, 1993). Where there is an opportunity to work with family members, they should be invited to talk as openly as possible about shared and individual experiences using curiosity and neutrality (Cecchin, 1987).

Whole family and individual psychoeducation: Phase I - Safety and Stabilisation

'Safety and Stabilisation' (Herman, 1992), as part of the first phase of trauma-focused therapy, is a crucial part of the scaffolding that will support a survivor's recovery. Therefore, it is important that the family understands the impact of trauma on the individual and the whole family system. It is essential for developing understanding of mind–body responses to distressing events (Van Der Kolk, 2014), to increase resources, to support co-regulation and to find a healthy way to manage the psychological and physical reactions to trauma and thus to make the family system a safer context, supporting the strengthening of a sense of internal safety in the survivor.

This phase should offer a focus on skills building to support the family (and survivor) to develop an understanding and a normalising (White, 2007) of symptoms. It is important for both the survivor and their family members to understand and manage the impact outside the therapy room, particularly as we know that trauma impacts personality, people's behaviour, and family dynamics.

When an individual is triggered and experiences a lack of 'internal safety' (Van Der Kolk, 2014), it is important for the family to feel empowered with the knowledge and understanding of trauma symptoms and how to support their loved ones in managing trauma triggers. Including a systemic lens in the treatment of trauma is to 'respect the power of families to heal…' (Figley, 1989) for the therapist to give back power to families to heal one another and to witness the family as an 'antidote' (Figley & Figley, 2009).

Patterns of Connectedness: Phase II - Remembrance and Mourning

The use of individual approaches at stage two, 'Remembrance and Mourning' (Herman, 1992), can be significant. However, we find that it is also important to continue the psychoeducational work with families alongside the individual processing. Family members often require scaffolding and time to increase their understanding of the process of recovery. As therapists, we are aware that processing can destabilise the individual during this phase of treatment, but family members are often unaware of this. Drawing on Perry & Pollard's (1998) ideas on neurobiology, trauma and co-regulation, family members can be encouraged to support the individual to regulate outside of the therapy room during this phase of the treatment. It is important that family members be prepared and aware of what processing trauma entails to support and maintain recovery.

Processing together can also be an important part of 'Remembrance and Mourning'. We do not necessarily refer to the specifics of the trauma experience, though this can be very helpful in some contexts, but to 'meaning making' together. This entails listening and talking about how the trauma has impacted family life and relationships, mourning a previous experience of family and developing a coherent narrative about how to go on together and what is needed from within the relationships to enable recovery. Figley and Figley (2009) advocate 'meaning making' as a process whereby traumatic events are explored within the family, the community and the wider cultural and socio-economic context of the experience. They emphasise that 'traumatic experience creates memories that often are co-constructed through interpersonal interaction with others' and highlight the importance of the 'relational' role in trauma treatment.

Avoidance as a belief

We encourage therapists to note patterns of avoidance, either in the therapy room or within family relationships. Avoidance can emerge as a key belief (and a symptom) following a traumatic event, both for the survivor and the family system. It can be viewed as a protective mechanism in managing the magnitude of the traumatic events, the resulting symptoms and the subsequent impact on the family system. Therapists should be aware that the 'unvoiced' (Burnham, 2018) or unspoken can have the effect of maintaining trauma symptoms.

There may be times when pursuing individualised treatment without involvement to empower the family system could limit the likelihood of full recovery. Smith (2013) particularly highlights the value of family members bearing witness to and bringing the 'unspeakable into the realm of conversation.' Where a therapist becomes aware of avoidance within the family system, a secondary piece of family or couple work could be undertaken to process the trauma relationally.

Changes in attachment narratives

In attachment theory, Bowlby (1988) explains how significant family relationships and relational challenges can stem from the initial bonds between children and their caregivers. We also know that attachment patterns can change over the life course and following trauma. Holding a systemic lens in trauma work encourages therapists to consider attachment patterns and narratives prior to and following traumatic experiences. Using a 'Genogram' can be a useful method of exploration with the family in the room.

Working with the family toward a more open, coherent, and integrated narrative may affect positive change within the family system (Crittenden, 2008; Fonagy et al., 1991). It is important to note that there may be exceptions to working with the family system. This would include when there is family

system. This would include when there is family violence or issues with safety.

Consider collaborative efforts across systems: Phase III - Reconnection

'Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery...' (Herman, 1992)

An important part of rehabilitation and trauma recovery is re-connecting with the family system and the wider systems around the family. As therapists, it is important to facilitate conversations around external support, such as who else is working with the family and what is their role? We need to consider if any other services can form a support network around the family. Agencies and organisations working with them can help create a wider 'external sense of safety' for both the individual survivor and the family members. Both the 'Ecomap' and 'Genogram' tools used in the initial assessment are useful for revisiting throughout phase three to help the therapist hold in mind both the family system and its wider context.

Fostering a systems lens in terms of the wider family context is an important part of all phases of trauma care, but to place it just within the third phase of trauma treatment can create a false dichotomy. A systems approach to a 'team' or services around the family should begin at the point of assessing the needs of the whole family. That way, the 'systemic lens' forms a holistic support in the recovery and rehabilitation of the entire family unit.

Conclusion

'Resolution of trauma is never final: Recovery is never complete. The impact of a traumatic event continues to reverberate throughout the survivor's life cycle.' (Herman, 1992)

Just as the resolution of trauma is never final, so too is our struggle to understand it. We hope to invite further conversation, learning, and interest in systemic thinking with families and trauma treatment. This article has posed many questions that challenge the dominant position in trauma treatment and the family system's omission as part of the treatment process. Our ambition has been to speak about the flexibility and capacity of a systemic lens to empower families to heal and grow together following trauma. For those therapists faced with pressure to use powerful structural ideas to use powerful structural ideas such as the medical model and individualised approaches to inform trauma treatment, we hope to have provided an alternative narrative to facilitate the inclusion of family members in the recovery process.

Our intention in presenting these systemic ideas is to invite future conversation, learning, curiosity, and of course, inclusion in practice. Systemic therapies need to do more to highlight the importance of working within and with the family system in terms of trauma and build a framework for practice. As Van der Kolk (2014) suggests, 'Traumatized human beings recover in the context of relationships... The role of those relationships is to provide physical and emotional safety…and to bolster the courage to tolerate, face, and process the reality of what has happened.'

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Socially excluded, disadvantaged, exposed to trauma - It's time to look beyond the label

Dr Diane Harrison

Abstract

Research into the subject of probation is often limited to professional perspectives and it rarely portrays the views of the service user. Harrison (2020) conducted a qualitative study looking at access to mental health services, education and vocational training by those supervised by probation. The study conducted twelve in-depth semi-structured interviews with young men aged 18-25 who were being supervised by the probation service. Findings from this study provided an insight into the participants' lives and their experiences of accessing these services. Additionally, the study recognised a high prevalence of childhood trauma; 90% of the participants had experienced multiple adverse childhood experiences. Excerpts/qualitative data from the Harrison (2020) study, demonstrate the range of adverse childhood experiences that those who become involved with the criminal justice system have been exposed to. Furthermore, discrimination and ostracisation are discussed to highlight the impact of rejection and social exclusion that these young men experience. In this article, I advocate for these young men not to be labelled and discriminated against but to be treated as individuals who are survivors of trauma and who can be supported to move forward toward positive life outcomes, by ensuring appropriate services are provided.

Introduction

While researching young male offenders' experiences of access to mental health services, education and training while under the management of probation services, I was disturbed to discover the amount and severity of trauma experienced by these participants throughout their lives.

Furthermore, when discussing my research with other professionals, I was shocked by the adverse reactions to my advocacy of this marginalised and often disadvantaged population from some counsellors and other mental health professionals. Therefore, I would like to share some of my research findings so that this population can be recognised as more than a label (offender). Furthermore, I suggest that this population should be recognised not by the label of 'offender' but as individuals whose needs may include trauma-informed interventions to overcome adverse childhood experiences and trauma and often require support to reconcile their experiences and improve their life outcomes. Those who treat trauma survivors can have a unique and special role in supporting this vulnerable and socially excluded population by advocating for and offering services that meet their often-complex needs.

Common Experiences

The findings from my study (Harrison, 2020) suggested that there was a range of shared experiences between the participants (young men aged 18-25 who were being supervised by probation services), which impacted their access to support services, such as being excluded from school (institutional rejection) and being subjected to a range of adverse childhood experiences such as abuse or neglect (relational rejection). Eleven of the twelve participants from the Harrison study (2020) disclosed that they had been subjected to a range of adverse childhood experiences. Additionally, research suggests that there are links between childhood adversity and criminality in adulthood.

A report by the Scottish Government (Scottish Government, 2018) stated that exposure to childhood adversity increased the likelihood of being /becoming incarcerated by 20 times.

These findings are supported by political and academic research with male offenders which recognises that they are a socially-excluded group who often lack opportunities to promote their own wellbeing (Parodi & Sciulli, 2012). On the 30th of June 2019, there were 254,165 male offenders in contact with England's probation service (Ministry of Justice, 2019). As a consequence of social exclusion, it is suggested that many suffer from poor health and reduced employment prospects. 'Table 1' compares mental health problems between the general population and the prison population (Centre for Mental Health, 2011). No such detailed information appears to be available for those being managed by probation services. Moreover, due to being marginalised in society male offenders are often situated within a vicious cycle of offending, being unemployed, substance misuse and poverty (Smith & Stewart, 1997; Social Exclusion Unit, 2002).

Comparison of Mental Health Problems between the General and Prison Populations

	Prison Population	General Population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Table 1 - Comparison of Mental Health Problems between the General and Prison Populations (Centre for Mental Health, 2011)

Social exclusion does not impact these offenders alone; we all pay the price economically and socially (Grieve & Howard, 2004). For example, an increase in long term health and social care costs for those who have experienced social exclusion is higher than the general population (Leigh-Hunt et al., 2017). It is therefore crucial that social factors associated with this marginalised population are considered. Researchers have recognised the influence that social environments have on human development and the individual life course. Theories such as Bronfenbrenner's (2004) ecological systems theory have provided accepted explanations for the influence of human development, health and social environments. For example, the environments experienced by the lower classes who incidentally make up the majority of the probation population. Bronfenbrenner's theory (2004) proposed that the environment and situation to which you are exposed to while growing up affects every aspect of your life, including ways of thinking, experience and emotional reactions.

The impact of social and environmental factors on child development

Although there is no identifiable risk factor that appears to account for becoming involved in crime, prior exposure to difficult and challenging environments is often a factor in the lives of those who become engaged with the criminal justice system. Research has consistently supported a strong association between adverse childhood experiences and crime, due to the increase in risk-taking

behaviours which are harmful to health and sometimes associated with criminal behaviours (Public Health Wales NHS Trust, 2015).

Experiences in childhood can frame and control current choices and decisions, such as accessing support services. Therefore, before reviewing mental health, education and probation in more detail, it is important to recognise the impact childhood can have on health, education, life-outcomes and becoming involved with crime.

From a social constructionist view, childhood is recognised as developing within the confines of the social world to which a child is exposed. Therefore, children can and are often exposed to an unjust world in which theories, principles and ideals are inconsistent with social justice. The impact of this exposure is increasingly being recognised (Bellis et al., 2016; Brown et al., 2009; Dube, Cook, & Edwards, 2010; NHS Health Scotland, 2017).

Research has documented how children who experience stressful and poor-quality childhoods are more likely to become involved in criminal activity and substance abuse (Brown et al., 2009). Experiencing chronic stress in childhood may be due to neglect, domestic violence or dysfunctional family lives. However, not all children subjected to difficult childhoods will become involved in criminal activities or behaviours (Felitti et al., 1998).

Adverse Childhood Experiences (ACEs) is a term used to describe a child's exposure to a range of negative social and environmental situations. The U.S. Health Maintenance Organisation, Kaiser Permanente, and the Centre for Disease Control and Prevention investigated associations between childhood maltreatment and later-life health and wellbeing. These research findings were grouped into three areas and included ten specific adverse childhood experiences as displayed in 'Figure 1' (Felitti et al., 1998).

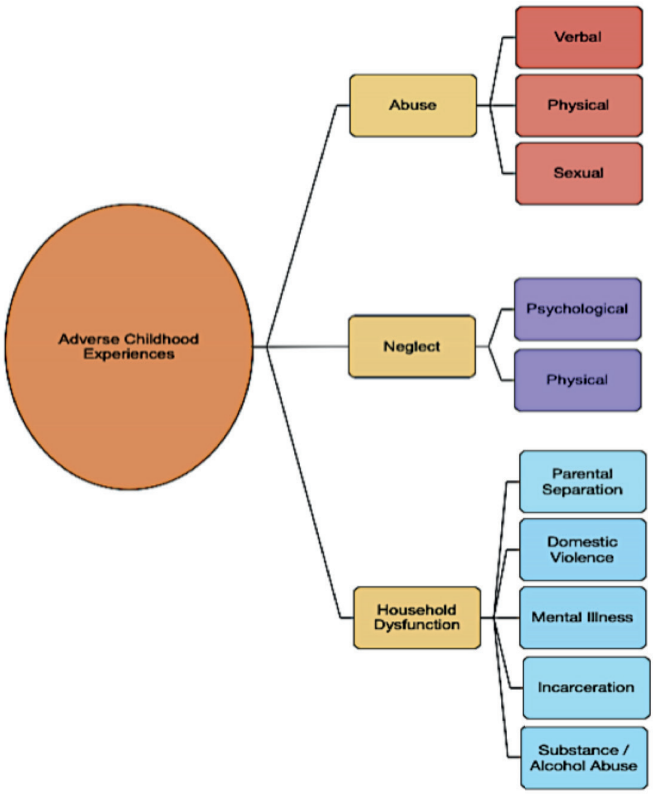

Figure 1 - Figure 1 Adverse Childhood Experiences
Adapted from Adverse Childhood Experiences (Felitti et al., 1998)

The literature on ACEs is growing and is becoming recognised in policies that shape the practice of criminal justice agencies. The ACE study has both strengths and limitations and needs to be viewed accordingly (Edwards et al., 2017; Hartas, 2019). Nonetheless, the research by Felitti et al., (1998) has helped focus attention on the complexity of social and environmental factors on health and well-being, highlighting inequalities at a population level rather than an individual level. Although there are conflicting views of the ACE study, other researchers have linked trauma and difficult childhoods to offending behaviour and engagement with the criminal justice system (Dierkhising et al., 2013; Fox, Jennings, & Piquero, 2014). Interestingly, the participants in the study conducted by Harrison (2020) had experienced at least one and often several of the seven areas identified by Felitti et al., (1998): psychological, physical or sexual abuse, domestic violence, households where members were substance abusers, suffered mental health difficulties, or were imprisoned. Domestic violence, physical and drug use by family members were among the highest adverse experiences disclosed by those who took part in the Harrison study (2020).

Furthermore, childhood trauma and difficult childhoods have been associated with poor mental health and low educational attainment, resulting in economic, social and health deprivation in adulthood leading to social exclusion (Holt, Finkelho & Kantor, 2007; Turner, Finkelhor & Ormrod, 2010). If the impact of childhood difficulties influences adulthood, it is reasonable to suggest that their previous experience is impacting those adults being managed by probation. Therefore, adverse childhood experiences need to be considered when exploring current mental health difficulties (Hughes et al., 2017). It has also been suggested that these difficulties may have a link with whether a person becomes involved with the criminal justice system (Felitti et al., 2019; Hartas, 2019; Scottish Government, 2018)

Excerpts from the research

Above I have introduced adverse childhood experiences, and as previously stated many of those who find themselves engaged with the criminal justice system have been subjected to those experiences as defined by Felliti et al. (1998). I will now share some of the experiences of individuals who are currently being managed and supported by probation. Excerpts are taken from participants of a study conducted by Harrison (2020).

Vernon reported that he had been subjected to regular physical abuse by his father from an early age and throughout his childhood. He found it difficult to recount how this abuse had impacted his thoughts and feelings, although he did recognise how he was powerless to prevent his abuse.

'Err I used to get hit with a belt, I used to get locked in rooms, erm, yeah it wasn't the best... I learnt the hard way, erm, I don't speak about it but...yeah.'

Vernon consequently felt powerless as an adult, unable to reconcile his experiences, often becoming violent in stressful situations. This resulted in Vernon attempting to take his own life on multiple occasions and becoming involved with the criminal justice system.

'I crashed my motorbike at 100 mph trying to kill myself.'

Peter spoke of how his father had made him feel unwanted, impacting Peters' self-worth. Peter found his father's behaviour toward him deeply distressing. Furthermore, Peter's response was to attract the attention of his father without considering that his behaviour would have negative implications.

'He used to kick me out in the mornings at 8 o'clock 'cause, he didn't want me in the house...this was when I was young... he's disowned me do you know what I mean ... I mean so it's hard to deal with.'

Peter went on to state recriminations against himself, for not leading a 'better life'. Low self-worth was a common theme among the participants.

Harry spoke about how his childhood had made him feel unloved and how this had impacted how he had valued himself.

He spoke of being envious of other children who had biological parents and who had not been taken into care.

'I just didn't have no love as a child innit because I had a lack of love it just err let me see it created it opened err a whole can of worms and loads of different other issues.'

More than 90% of the interviewees of the Harrison (2020) study were exposed to multiple traumas. Vernon, who had been physically abused by his father, was also sexually abused by a male relative making it difficult for him to build trust with men, often feeling threatened by them. This reaction caused Vernon to become involved with the criminal justice system:

'I was never violent towards a woman, so there was no risk towards her or anything like that it's more towards men you know like, they wouldn't send a man to my house cause that would be it, that would be it ...'

Vernon sounded resigned to his reactions as though he had little control over them. However, Vernon has received help and support from his probation officer to build trusting relationships and is now enjoying studying at University.

Trust was a central theme with many of the participants describing how their trust had been breached as children. Several of the participants were subjected to physical violence from parental figures. Percy spoke of being exposed to violence from his mothers' partner, leaving him feeling unsafe and fearful.

'I'd just leave school, and I'd run, and run and run and until I got to my door, and I'd lock the door, and I knew that front door was locked so, nobody else was getting in.'

Whilst Alistair stated quite flatly that he did not trust anyone and that he had difficulties in establishing trusting relationships with others.

'Like I don't trust people, it takes me a long time to like.'

The impact of rejection and ostracisation

The excerpts above are just a small selection which demonstrates how, as children, these young men had been socially excluded, treated with little care or attention to their emotional and physical welfare. These young men had been rejected and ostracised throughout their lives at macro, meso and micro levels. The participants had been discriminated against as 'other' as children or discriminated against for their class, race or gender, to name a few. 'Table 2' demonstrates the various ways in which these young men had been discriminated against and thus socially excluded from an early age. From government policies to day to day relationships.

Examples of macro, meso and micro levels of discrimination

Macro: Socioeconomic/Political Context	Meso: Institutional/Practice	Micro: Individual Level
Competition for resources Power imbalance Racism, stereotypes, misconceptions	Failure to recognise and meet the needs of the population Barriers to service provision Inequalities in services and outcomes	Lower System understanding Mistrust/fear of service providers Lower literacy, social and cultural capital

Table 2. Examples of macro, meso and micro levels of discrimination (Ogwezi et al., 2020)

Understanding the Impact of rejection

The literature investigating rejection and ostracisation proposes that rejection and ostracism can potentially be harmful to our sense of self. We have evolved an efficient warning system to immediately detect and respond to any such experiences (Williams & Baumeister, 2003). This warning system activates our fight, flight or freeze responses, governed by real or perceived threats. Therefore, we should consider the impact of past experiences of rejection and ostracism and how they can trigger a system that is intended to provide protection from current threats and can direct and influence behaviour. Furthermore, it has been suggested that those who have experienced rejection and trauma could become overly sensitive, leaving them in a state of hyperarousal (Van der Kolk, 2014). Van der Kolk and Van der Hart, (1989) stated that 'Hyperarousal causes memories to be split off from consciousness and to be stored as visual images or bodily sensations. Fragments of these "visceral" memories return later as physiological reactions, emotional states, nightmares, flashbacks, or behavioural re-enactments', Therefore, it is possible that this innate system could be influential in the participants' current access to support services as their histories of abuse and neglect continue to impact their wellbeing. Overall, these findings are in accordance with those of trauma victims as reported by Van der Kolk (2014) and Van der Kolk and Hart (1989).

Conclusion

Above I shared some of the excerpts and findings from a qualitative analysis of young male offenders' experiences. The adverse childhood experiences, rejection and ostracisation experienced by these young men throughout their lifespan is evident. Therefore, it is reasonable that they should be given equitable access to services that support positive development and increased life chances. This includes access to services such as those offered by trauma-informed counsellors who have the power and opportunity to lead the way in offering a non-judgemental attitude and environment to these young men. One in which they can be supported to overcome the impact of trauma and its impact on their day to day lives. Furthermore, the benefits of offering appropriate support for this socially excluded population has the potential to benefit society as a whole. Sadly, counsellors do not often have direct power or opportunity to organise or configure service provision. However, as a profession, counsellors have the means to instigate change and advocate for socially excluded groups such as those labelled 'offender' by bringing attention to the advantages of providing appropriate mental health services that meet the needs of this population.

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The Survive/Thrive Spiral: A visual integration of Polyvagal Theory and Internal Family Systems

Ruth Culver

Abstract

Polyvagal Theory (Porges, 2011) and Internal Family Systems (Schwartz, 1995) are two models gaining significant attention within the growth in awareness of complex trauma and its profound and simultaneous effects on the mind and body. This article introduces 'The Survive/Thrive Spiral' (referred to in the text as 'Spiral') - my infographic exploring the parallels between two of our primary systems of protection: the nervous system, viewed through the lens of Stephen Porges' (2011) Polyvagal Theory, and the psychological system, represented by Richard Schwartz's (1995) Internal Family Systems Therapy (IFS). The 'Spiral' offers a reference tool for exploring how trauma affects the psyche and facilitates mindful awareness of the brain–body connection. It illustrates how these two protective systems are interdependent, each constantly reflecting and influencing the other. This article outlines how the graphic came into being and offers case studies demonstrating how it can support clients to develop increased calm and self-compassion.

Origins

Re-traumatisation in therapy came sharply into focus for me during a year-long experiential trauma training that often left participants, including me, with overwhelm, dissociation or backlash. As I began to recognise and understand what was happening, I realised this had also been my experience as a client in talk therapy, by being asked to sit with overwhelming feelings without the skills to tolerate or process them. And although I had been able to help many clients with processing trauma as a clinical hypnotherapist, I was concerned a few had experienced similar effects from our work. I continued to study, and was relieved to find more trauma-informed, embodied practices offering a middle way between too slow and too fast.

Being a visual learner, I began to map physical and emotional signifiers side by side on paper to understand the interactions between mind and body. An early prototype of the graphic was built around a well-known representation of Dan Siegel's (2002) 'Window of Tolerance'. However I was troubled by its placement of hypo-arousal and hyper-arousal on opposite sides of the regulated zone, inferring that we pass through this balanced state when moving from one survival state to the other. Porges' explanation of the process as a hierarchy solved this problem, and I owe a debt to my exceptional supervisor for introducing me to Porges' work (via Deb Dana's Polyvagal Theory in Therapy [2018]). She also suggested a spiral shape for my graphic, being more somatically related to the feeling of moving through autonomic states than the arrows I had been using, and opened the door to Schwartz's IFS model, which finally provided me with the language and landscape to truly understand and bring compassion to adaptive behaviours, and which now forms the basis of all my therapeutic work.

Orientations

Although both theories deserve more in-depth exploration than space allows, I briefly introduce Polyvagal Theory and IFS for those readers who may be unfamiliar with the terms:

- Polyvagal Theory proposes an evolutionary hierarchy of human response to safety and danger, outlining a three-stage autonomic nervous system (formerly understood as binary) and offers the term 'neuroception' (Porges, 2004) to describe how our subconscious awareness activates specific neural circuits and survival behaviours.

- Internal Family Systems is an embodied psychotherapy that understands the mind as naturally multiple, with an internal system made up of 'parts' (called 'sub-personalities' or 'ego states' in other therapeutic approaches [Watkins & Watkins, 1997]) and an unchanging, universal 'self'. IFS is non-pathologising, regarding conditions such as bipolar, depression, addictions or chronic fatigue to be the best way our system found to manage overwhelming emotions.

At this point, I invite readers to turn to the graphic, as it offers a summary of key points from both models.

'The Survive/Thrive Spiral (Infographic featured in the next page)'

Corresponding to traffic-light colours in many countries, the horizontal red, yellow and green bands across the chart refer directly to the Polyvagal nervous system states outlined in the right-hand column. The red 'freeze' zone features a 'mixed-state' I call 'submit', which occurs when 'fight', 'flight' and 'collapse' are all unavailable for various reasons, so we find a dissociated way to keep going using 'low-tone' sympathetic activation that has a pervading quality of 'dorsal vagal' shutdown.

The behaviours of our 'Protector Parts' are the aspects of IFS on the 'Spiral' that directly co-relate to the Polyvagal zones, and so feature in the same colours across the chart. The other two main elements of IFS ('exile parts' and 'self') are shown as spherical shapes in the central column. Whereas 'protectors' are behavioural (and can be regarded as what is often called ego or personality), 'exiles' and 'self' are more existential - aspects of our essence/being (or yin) rather than of action/doing (or yang).

The brief 'I' sentences in the central column offer a shortcut to understanding each zone's core feeling and build upon those used in a Polyvagal diagram created by Trauma Releasing Exercises (TRE) trainer Steve Haines (2016).

A note on the word 'resilience', which here is used to convey the ability to self-regulate: to move through autonomic nervous system states in response to the needs of the current situation and - this is key - to return to the grounded zone of 'ventral vagal' when danger has passed. People with a more resilient system will also have more flexible access to the pleasurable aspects of the sympathetic state (e.g. exercise and play) and of the 'dorsal vagal' state (e.g. meditation, intimacy and rest).

Ideally, we develop this resilience in childhood, through attuned adults providing us with consistent co-regulation, and modelling their self-regulation for us to gradually learn. Without this, we develop instead one of key features of complex trauma: living life in a hypo- or hyper-aroused state, with little or no access to the calm of 'ventral vagal'. The root of the 'Spiral' is shown embedded in 'self' - the calm, curious and compassionate core essence within us all proposed by IFS. The main focus of IFS therapy is to build access to 'self', thus providing the safe, attuned presence needed for our 'protectors' to relax their extreme behaviours and for our 'exiles' to heal from their burdens of overwhelming emotions and negative beliefs.

TRAUMA: IFS & THE NERVOUS SYSTEM

Internal Family Systems | PolyVagal Theory

SURVIVAL

RESILIENCE

FREEZE PROTECTORS

COLLAPSE e.g. chronic fatigue, inertia, fainting, narcolepsy, seeking sleep, oblivion or death.

SUBMIT e.g. depression, apathy, keeping quiet, dissociation, delusion, spiritual bypassing, fawning, going blank, addictions that numb.

EXILES

Without the support to process them, overwhelming feelings must be stored away. This creates a reservoir of banished, often young, parts holding **unprocessed rage, terror, grief, shame & hopelessness**, sometimes as physical symptoms. In exile, they keep trying to be heard & helped, activated by familiar events.

Protectors try to keep Exiles away, either as **proactive 'Managers'** or **reactive 'Firefighters' -** using whatever survival strategy they originally found to help.

FIX PROTECTORS

e.g. hyper-vigilance, bullying, quitting, rebelling, flashbacks, inflammation, rushing, anxiety, lying, perfectionism, controlling, bracing, criticising, OCD, self-harm, addictions that distract.

SELF-CONNECTED

Parts feel safe to relax & work as a team. Needs & feelings can be spoken & met. Resilience develops. Possibility for individuation, play, trust, growth, spontaneity, intimacy, learning, healthy boundaries, creativity, rest, repair & flourishing.

SELF

(aka soul / inner knowing / core self) A mindful, embodied reservoir of clarity, curiosity, compassion, calm & confidence. Being not doing.

I CAN'T

I HURT

I MUST

I CAN

I AM

FREEZE

- **COLLAPSE**
  Dorsal Vagal (PNS)
- **SUBMIT**
  HYPO-aroused Sympathetic NS

Seeking safety via DISCONNECTION

FIX

- **FIGHT**
- **FLIGHT**

HYPER-aroused Sympathetic NS

Seeking safety via ACTION

FLOW

SELF/CO-REGULATION

Ventral Vagal (PNS) with flexible access to other ANS states

Finding safety in CONNECTION

THE SURVIVE/THRIVE SPIRAL

Updated 11/20

Clinical Uses

The 'Spiral' graphic was originally created as a wall poster for working with groups. It has proved helpful not only as a psycho-education tool but also as an anchor for self-connection in an environment where multiple nervous systems could be activated.

With one-to-one clients, my use of the graphic varies greatly. When clients have strong analytical parts, it can be useful to explore it near the beginning of therapy. For others, it can offer a pause or a new perspective mid-therapy. With clients whose system is chronically overwhelmed, I might only introduce the central column's simple words to gently support the noticing and naming of 'parts' key to IFS. Sometimes, the 'Spiral' does not feature - it all depends on the client.

Perhaps most of all, the 'Spiral' provides a route to understanding that unwanted behaviours or conditions a client may have battled with for years are the result of a biological imperative, not the result of a character flaw. Understanding this can lead to a huge decrease in shame and pave the way for compassion-based healing.

Here are a few (anonymised) case studies of how the 'Spiral' has proved useful in practice:

- Rita came to me in a very dis-regulated state, terrified that her self-harming and suicidal ideation had increased. One of her chief 'protectors' proved to be an intellectual part, which forbade any attention to feelings, physical or emotional. Another 'protector' part was extremely cynical about therapy, certain there was nothing she had not tried, and nothing would work. Rita's analytical parts relished using the first session to explore the 'Spiral'; she rapidly began naming her parts, so we mapped them onto a skeleton template. At the end of the session, she described her emotions and physical sensations of relief at discovering a scientific explanation for self-harming; she shed a few tears, declaring them to be the first for many years. The following week she returned, her intellectual part having done research to support her understanding, the cynical part made no re-appearance, and we were able to commence IFS therapy.

- Sean had started therapy numerous times over several decades but always abandoned it quickly after becoming overwhelmed by strong feelings. As he outlined this in the first session, I turned to the 'Spiral' to explain why coming down the 'Spiral' out of 'freeze' involves encountering both repressed 'fight/flight' energy and the trapped emotions of 'exiles', but that IFS gave us a way to do this slowly and safely. In an email after the session, he wrote, 'seeing it on paper laid out like this, I finally understand that depression is not a sickness to feel ashamed of, but just my nervous system kicking in to protect me! I've only tried therapy before because my wife threatened to leave me, but now for the first time I sense I can go ahead, understanding it's a process and I can come out the other side.'

- Jeanette is a young adult with a bipolar diagnosis who had always refused therapy. Her parents invited her to watch a webinar in which I explain the 'Spiral', after which she wrote: 'I've realised so many things from the lecture - that when things seem okay I might actually be numbed out because it's not true that "I CAN" deal with difficulties that come up. And that sometimes I don't feel defeated - and instead feel "I CAN", which is an amazing feeling! And that it's all about feeling safety, which I don't think I do. And it makes sense that when it gets too hard to make a decision - it's because too many parts are conflicting. I think it would help soon to find someone to work with one-to-one and basically map it out so I can recognise things more when they happen, as I get too overwhelmed by not understanding.'

Conclusion

Although I did not set out to create a tool for others to use, the 'Spiral' graphic unexpectedly went viral on Facebook in early 2020. I now receive regular emails from mental health practitioners across the world, who are using it in a broad range of therapeutic settings, from sex therapists to those working with torture survivors, refugees, and urgent care psychiatric units.

Their messages show the 'Spiral' can be equally useful in conjunction with modalities other than IFS, as this review from Germany outlines, 'The Spiral helps me as a practitioner get a picture of what might be happening in their nervous system and how the symptoms they are presenting may play out in the modality I use. It additionally gives me language to explain to the client how they may have a more regulated nervous system as a result of the therapy.'

Most moving for me are the messages from laypeople, such as this email from Sam in Australia: 'Your picture helped me understand that I'm not broken - I just got stuck.'

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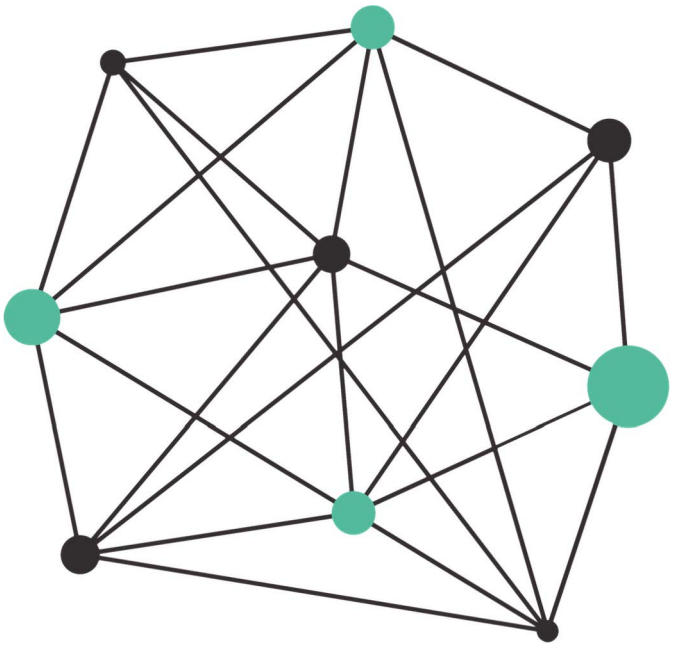
Section II

Complex Trauma in Practice



Reconstructing self and personhood when the assumptive world is shattered by trauma

Karla Dolinsky

Abstract

Healing complex trauma often involves many layers of therapeutic processing. At times, the trauma event can be processed, and the client reports feeling better or 'healed from the event', yet symptoms may linger. The author presents an intervention of a series of questions aimed at reconstructing the sense of self and personhood when the assumptive world is shattered by trauma.

Introduction

My private practice as a psychotherapist focuses mostly on complex trauma, grief and loss. My clients live with distresses after motor vehicle incidents, childhood or recent sexualised violence, betrayals such as infidelity, terminal diagnosis, life-altering injury, death of a loved one, witnessing the violent destruction of another human being and other traumatic events.

It has often been the case that my client and I come to a stable place in the therapy once the trauma events are processed. We consider this a 'success'; we have found ways to 'make sense of' and heal from the events and the client feels relief and continues with their lives. For some clients, it can be the case that there is still something 'not quite right'. The client may return or simply go through their days with trauma symptoms, perhaps lingering anxiety, depressive spells, nightmares or feelings of discomfort and lack of grounding. I became curious about what was going on for them and what we had missed.

Reflecting on Herman's three stages of trauma treatment (Herman, 2002), I begin a client's journey with many stabilisation sessions to establish safety and address dysregulated somatic responses. I am often curious about where the client is grounded and how much of that grounding orientation was lost with the trauma. I do body-based work and strength-based work before directly engaging in trauma processing. As the work continues to where we process the trauma, perhaps by re-telling the story of the events, I am aware of beliefs or assumptions that are communicated that may be disruptive to the client's healing. The transition from trauma to healing is often a complex process.

Throughout my career and in my personal life, I have experienced many transitions and enormous change. I noticed that sudden transitions are often challenging for people, and they cannot seem to adjust to the new situation. Often the situation was a factor of a trauma. For a long time, I called this 'Crisis of Faith'. In times of crisis, my religious friends might ponder, 'Where is God in all of this?'.

The Assumptive World

I discovered that there was a theoretical perspective that calls our current reality the 'assumptive world' and that loss of the assumptive world often is a factor for individuals who have experienced trauma.

> There is a sense in which traumatic loss of the assumptive world is a paradigm for the psychology of change, in that there is a kernel of trauma at the psychological core of all change experience; when we understand the traumatic loss of the assumptive world, we understand a core wound of all bereavement. (Kauffman, 2002, p.2)

The theory of the assumptive world looks at our basic internal organising principle. The assumptive world, for each of us, is the world we know. It is the world of remembering, of temporality, expectations and beliefs. It is our way of conserving our unique reality. The theory was introduced in the thanatology literature by C. M. Parkes. Parkes (1971) saw it as our individual internal truth, including everything we know or think we know, our prejudices, beliefs, schema, our interpretation of the past, the present, plans, and future expectations. Any change in the 'life space' may disrupt and require reconstruction of the assumptive world.

Two decades later, Ronnie Janoff-Bulmann considered the concept of 'change in the life space' and expanded on Parkes' idea, using the lens of the assumptive world to look at trauma as an aspect of that 'change in the life space'. Janoff-Bulmann (1992) was looking at the core of our internal world. The assumptive world, for her, contained our basic truths of self and the external world, including how we orient ourselves amid all of the dynamic interplays. The theory holds that believing is an act of conscious intention and value. The assumptive world is anchored in our belief and value systems. The traumatic loss of this authority or construct of the assumptive world will bring about devaluations. Beliefs of goodness, self-worth, illusion, meaning and being all have the potential to be damaged and devalued in trauma. Therefore, the person is oriented to a new reality after the trauma. The person has to process 'what happened' and their relationship to what happened, relationship to self, self in the world, relationship to beliefs and values. Healing this may be a transition the person must move through to be situated in this new reality or belief. At times, this processing is not obvious in our therapy.

I began reflecting on my small portion of clients who had successfully processed their trauma (mostly through Eye Movement Desensitisation and Reprocessing [EMDR] and other accepted trauma interventions) yet still struggled with feeling 'whole' or still experienced general anxiety and had challenges moving forward. I realised that a large part of that assumptive world that was lost was where they were grounded. This might include an identity or sense of self linked to the job that was lost or retired from, the person who had died, the relationship that ended or the physical ability that was threatened.

In addition to this small group of clients I just mentioned, it was the case that I had clients who came to me for therapy who had been seeing other counsellors for more than 20 years. I discovered that what was often requiring some attention was not the original trauma but instead their deeper loss of the assumptive world. It seemed like experiencing the original trauma and then processing the trauma had altered their view of themselves and who they might be in the world. We had not realised that part of the healing and processing they were doing also required learning who they were now in the world – the new world and the new sense of self, including how that all fit together. I started to see that what had been missed was part of the larger healing process and included a further integration and understanding of themselves and the new reality of their self in the world. This is more obvious for those whose trauma is a loss of limb but sometimes missed when it is a motor vehicle incident or loss of employment.

Perhaps the assumptive world, externally, is what we generally examine and attend to when we process the trauma event. Furthermore, perhaps there is another component to it, therapeutically, where we might work on the body and self. Not only in terms of somatic work but work with the loss of the assumptive world in terms of 'sense of self' and/or how the self was related to the aspects of the external world that was lost. I began to look at how the old sense of self might relate to the new and how it now interacts with the world. It may be helpful for me to offer definitions for my use of terms.

When I make reference to the sense of self, I refer to who we know ourselves to be. This may or may not be valid in the world, but it is how we see ourselves, often in terms of morality or other value judgements, including physical traits. 'I am tall, athletic, curious, honest, have a good sense of humour, etc.' The idea of personhood is tightly linked to the concepts of citizenship, equality and liberty, so is the individual's relationship to others. I am using it here to refer to what we know of our own personal place in our community, society and the world.

Reconstructing the sense of self and personhood

I find there to be great value in questions as therapeutic interventions. Therefore, over the span of several years, I formulated a series of questions for clients whom I felt would benefit from this process of re-alignment of their sense of self and personhood. These questions also help me learn about the client in a unique way, as they become curious and introspective about who they know themselves to be.

The series of questions are as follows,

'Who do I know my self to be?'
'How does this self show up in the world?'
'What roles do I inhabit in life?'
'What are the counter-roles and how do I interact with these?'
'What do I value?'

I will briefly go through how I interpret the questions.

'Who Do I Know My Self to Be?'

I ask, 'Who do you know yourself to be?' rather than, 'Who are you?', as the former has more objective quality to the question. The question is a curious look at how the client sees their self in this moment, from this framework of their life. A person's relationship with the world requires at least two things – the physical assumptive world and the self within it. As a therapist, I cannot bring back the 'job that is lost', but I can reinforce the client's orientation to the self. Clients often lose sight of themselves while in the midst of trauma. Asking them to orient themselves to whom they know themselves to be and open up discussions around an exploration of self and personhood can help them ground within themselves rather than in the outside world that is part of the loss.

In our discussions that arise from these questions, we may discover qualities and judgments that have not surfaced previously. The question requires the client to be introspective beyond basic labels of being a firefighter or the list of their accomplishments. The curious nature of the discussion it opens up (for both therapist and client) fosters the client's possibility to ground within the assertions and strengths they see within themselves. It will also offer the therapist a framework to discover where the client may have self-judgment, shame, loathing, or need for self-compassion.

'How Does This Self Show Up in the World?'

In this experience of introspection, it is also helpful to ask the question, 'How does this show up in the world?'. This allows the client to offer stories and examples to reinforce who they know themselves to be, further strengthening the connection to the self. It also helps them see where their beliefs about themselves may or may not have evidence in the real world or the qualities that may be present in any 'exceptions'.

‘What Roles do I Inhabit in Life?’
The next question I ask to explore with the aim to connect with the sense of self and personhood is, ‘What roles do you inhabit?’. This can be, woman, mother, daughter, sister, wife, aunt, boss, client, athlete, etc. Ask the client to be curious about all of the roles, such as knitter, dog-owner, neighbour, and so on. This will help the client realise the vast range of connections they have with others and with themselves. The answers bring a fuller picture of their life to the client. In this exploration and curiosity, we can happen upon possible sources of their anxiety or distress. It can also be used as a ‘strengths-based’ intervention to highlight how rich their life may actually be, even amid the many losses, in addition to how their life positively influences those around them. Seeing the full extent of their connections in the world can help the client see that they are grounded in and supported by more than those aspects of the assumptive world altered by the trauma.

‘What are the Counter-Roles and How Do I Interact with These?’
Then I ask, ‘What are the counter-roles to these roles you inhabit?’. For instance, one can be a mother, and the counter-roles are her three children. This opens up curiosity about how her role as a mother is different to each of the children and how each of the children have different roles in her life. This allows the client to further ground themselves in their own sense of self and sense of personhood, rather than be grounded in the external world that may be lost through the trauma. For instance, we sometimes discover that what lingers is a sense of letting down others or being seen in a different light by others. Perhaps the client feels they have disgraced or shamed their ‘self’. Certain roles and counter-roles may have experienced fundamental shifts that have not previously come up in the therapeutic discussions. This is a strong exercise that helps remind our clients who they are, to ground in the self, and we can use it to re-story through strengths-based therapeutic interventions.

The final questions are around what does the client value. I also include questions around principles and priorities. This introspection will further orient the client to their self, their priorities and how they move in the world.

Case Study
To illustrate this therapeutic technique, I offer the following case study. One of my clients, who had been in a motor vehicle incident, was only mildly hurt but was seriously challenged with anxiety. This anxiety was new in their life. The accident resulted in a fatality, so to me, it made sense that this newly developed anxiety might be in response to the death. We processed the event, everything around it and all of the factors we could think of around the anxiety. Still, the nightmares came, the startle reflex was very high and panic attacks would appear approximately weekly.

My client reported that this was very unlike them because they were always adventurous and brave before the incident. My client was an avid outdoors person who would free climb sheer cliffs and continued to do so after our first bundle of sessions where we processed the accident. The client also continued to drive with confidence and was still attending school successfully. So, I began to be more curious about what they believed about their life before the trauma. We came up with the question, ‘Who do you know yourself to be?’. As we worked through the questions, I noticed some themes around how the client referenced themselves. My client stated that they were resourceful, practical and had a ‘get it done’ attitude. I also learned more about how they had been a first responder in the past and had experienced situations involving loss of life many times. However, they now experienced distress because they were completely immobilised when in the presence of emergency vehicle lights and sirens. This was very new information and had not been something the client was fully aware of themselves.

After these discussions prompted by the questions, we came up with a new EMDR target to process the Negative Cognition (NC) of ‘I can’t handle this’. This was a cognition that had not surfaced until moving through the questions. This NC was related to the accident and tied to the client’s past, who

they knew themselves to be, and who they expected to be at the time of the accident and after our therapy but felt they were no longer. Thus, another layer of distress was hidden in the trauma. This was an aspect of where their assumptive world had shattered. With minimal processing, we resolved what was lingering from the trauma and the client reported that they felt a lifting of weight and distress. We were able to discuss the many micro-decisions as well as the obvious decisions the client made that evidenced their resourceful, capable, practical frame of mind and behaviours, even in the moments of distress in the accident. It enabled them to believe again that 'I can handle this'.

Several weeks later, the anxiety, nightmares and startle remained resolved. Through the questions, the client had reconstructed their sense of self and personhood, and the questions helped us come upon the focus we were missing for the final stage of processing through EMDR.

Conclusion

At times, there will be clients who find these exercises mundane. Some clients are not keen to do what they feel is such a simple or obvious exercise. They may think they know about these matters already until they have to start talking about it, begin to really be questioned, answer, and be actively engaged in the open curiosity required to delve into the answers fully. The simple but fundamental questions will often connect the client to a depth and foundational knowledge that will facilitate their healing from trauma. These questions are strong therapeutic exercises in self-expression and self-understanding. They offer a client a possible alternative place to ground when their assumptive world is shattered by trauma.

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Holding on to hope: A practitioners experience of working with children who have experienced sexual abuse trauma

Sarah Palmer

Abstract

This experiential article discusses my work as a National Society for the Prevention of Cruelty to Children (NSPCC) practitioner with children who experience complex trauma due to sexual abuse. The article discusses my initial thoughts and expectations around working with this client group and how my assumptions were challenged by my experiences with the children I worked with.

Using an example from practice, the article illustrates the importance of understanding physical, emotional and relational transference and countertransference to help children process and give voice to emotions and experiences that they are unable to verbalise. The article also looks at the emotional and physical impact of working with children who have experienced sexual abuse upon me and outlines the importance of self-awareness, good supervision, and self-care to understand my own needs and practice safely and effectively.

‘That must be so hard to hear all of those children’s stories’.
‘I would just get so angry at the people who hurt children’.
‘I could not do it. It’s just too upsetting’.

These are some examples of the most common responses from friends, family and others that I meet when I tell them I work with 4- to 19-year-old children who have experienced sexual abuse. When I first started working in the field, I too wondered how I would help children without becoming overwhelmed with sadness, anger and feelings of sheer horror around what they had been through. I remember reading a detailed referral form and feeling so small and insignificant, wondering how I could ever ‘be enough’ to be able to help this child recover from such a senseless act.

My early experiences

I entered the therapy room in those early sessions with a sense of trepidation and was armed with extensive research and training into the impact of sexual abuse. I was ready to face the enormity of the task. I felt that I had to have all the knowledge and be the best practitioner. However, what I was met with blew away my preconceived ideas around how children who have been sexually abused would be and what they would need me to be. Here were the children, shy, angry, tired, hyperactive, bored, rude, polite, curious, disinterested, funny and downright cheeky.

I learned from those early sessions with children that their adverse experiences are only part of their identity. As a whole, they are beings with interests, hopes and dreams, worries, likes and dislikes. They are not just the stark story of sexual abuse that is written on their referral form.

I quickly realised that my own perceptions and assumptions were going to block my ability to help

children recover from sexual abuse. Those early sessions taught me to expect the unexpected. There I was with a perfectly planned session, backed up by the theory and ready to go. Only to be told, 'you talk too much!'. I quickly learned that whatever my agenda for the session was, I needed to be prepared to change course mid-session. I realised that I needed to draw on my knowledge 'in the moment' to meet the child where they were on that particular day. Because of this, I have now developed keen skills in emergency games such as Jenga, Snap, Uno and many more.

The effects of trauma on children and communication

One of the most important things that I have learned from working with children who have experienced trauma is that they often cannot voice their experiences and feelings. One of the impacts of trauma can be that access to the part of the brain that deals with language, thought and reasoning goes 'offline', making it difficult to talk about what has happened (Van der Kolk, 2014). Also, a younger child may not have developed the language and concepts needed to talk about what happened and how they feel. In The Body Keeps the Score - Mind, Brain and Body in the transformation of Trauma (2014), Bessel Van Der Kolk describes how heightened emotional states increase limbic brain activity. This makes it difficult to access the prefrontal cortex. This part of our brain is responsible for language, thought and cognition. Within my sessions, I learned that it is important to notice other ways in which children might communicate with me.

An example from practice

This is where it is important to pick out themes in the children's play, noticing and reflecting these back to the child and helping them when they become stuck or distressed. Another important aspect of this is being able to pick up on the transference and countertransference that occurs between myself and the child.

I once sat in a session with an 8-year-old boy as he played with toy cars. He separated them into two groups. One group were 'babies' who played together. The other group were 'baddies' that wanted to steal the 'babies'' toys when they were asleep. As the play continued, I noticed that the boy became increasingly anxious, repeating that the 'baddies' were coming. I noticed his breathing becoming shallow. I noticed that I was feeling tension in my limbs and was experiencing a sense of fear. I noticed my breathing had also started to become shallow. I grounded myself by breathing deeply into my belly and shifting my posture to release tension. I wondered aloud if any other toys could help the 'babies'. The boy looked anxiously around the room and said he was unsure. I pointed to some of the toys that were in the room. He suddenly exclaimed, 'Airplane!'. With a big smile on his face, he flew the plane over the 'babies' and told me that the plane was protecting them. His breathing returned to normal, his anxiety seemed to decrease, and his play moved on to the 'babies' having adventures with the airplane.

My reflections

When working with children by closely observing their play and presence in the therapy room, I noticed that I would experience sensations and feelings in my own body. I also experienced strong emotions that seemed to come out of nowhere. As outlined in the example, my mind and body picked up on strong emotions, physical sensations and possibly unprocessed memories that the boy may have been unable to verbalise or make sense of. Likewise, the boy was likely to be picking up on my emotions and physical responses. This made my own regulation of mind and body important to help him feel emotionally and physically contained. I believe this enabled him to calm and regulate enough to begin to access his prefrontal cortex and begin creating his own strategies to alleviate his distress.

Another aspect of working in this way is reflecting upon the roles that play out within the session. Who do I become? Who does the child become? What do we represent to each other?

Whilst working with the boy, there were times when I felt the overwhelming urge to rescue and comfort him. To tell him everything would be fine or to make the 'baddies' go away myself. There are many different layers to this. One is my own response to a frightened child based upon my own experiences and needs. There is also the role that the child is seeking from me, a protective parent or adult figure. Being aware of transference and countertransference and exploring this through supervision was important. Stepping blindly into these roles could have prevented the boy from finding his own strategies to resolve his difficult feelings. Sensing these unspoken feelings in the room can take a toll on my emotional health and physical wellbeing if I do not take steps to understand what is happening and take care of myself. Good supervision, in which I can be open and honest about how I am feeling and how I am being affected by my work, is essential in separating my own feelings from those of the child and understanding what is happening in terms of transference and countertransference.

I have also begun to practice many of the techniques that I share with the children I am working with. For example, checking in with my breathing and slowing it down where necessary. I might also perform a grounding exercise, such as becoming aware of my posture and the seat beneath me. Regular mindfulness practices, such as yoga and guided meditations, help me improve my own self-regulation and increase my awareness of what is going on for me.
On a day-to-day basis, awareness of my own emotional and physical wellbeing has improved and I have started to understand more around what I need to do to take care of myself.

My journey in working with children's trauma continues. Every day I am learning and discovering more about the children I work with, understanding complex trauma, the therapeutic process and my own self. It is a journey that I am glad to be on.

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When worlds collide - The process of embodied experience

Rod Aungier

Abstract

As humans, we have undergone constant evolution in body, mind and culture. As therapists, we broadly accept psychoanalytic, behavioural and humanistic/existential paradigms as the three forces operating currently within a psychotherapeutic approach. Nestling within the humanistic/existential approach is the idea of embodiment and embodied approaches. I present a short overview of the (process-oriented) embodied approach and the principles it has adopted since it emerged on the scene. An extract from an embodied session is used to illustrate the approach and highlight the elements involved in the interaction. In particular, the idea of field theory is discussed as an important element within the embodied context.

Introduction

One of the more interesting supervision sessions I had in my early training days was when the supervisor asked me to imagine my client as a metaphorical car. 'Make sure you check the fuel and oil levels and maybe kick the tyres to see if they're properly inflated' he would say - meaning, see how the client is getting their basic needs met and maybe challenge them a little to see how robust they are. Good advice at the time I thought, but what if I lifted the hood and all I saw was steam? Possibly the easy answer was to top up the water levels. Still, I was left thinking that whilst it was quite a good approach, the one difficulty I had was that I was approaching this as a mechanic and the client was a mechanical construction. In the real world, we are both human beings with all the differences (background, upbringing, culture, education to name but a few) and yet also the fundamental sameness – two living bodies meeting in a shared space. In the therapeutic space, I realised that I needed to get from 'How can I as an expert help you?' to 'How can we help each other using the expertise we have between us?' Of course, it is not that simple, but conceptually the idea of two bodies inhabiting the same space has been explored by many over the years.

Alfred Adler (1870-1938), the pioneer of Individual Psychology suggested that, 'The only way to study a human being is to study how the person moves in solving life problems' (Adler, 1938). If we extrapolate here, we can come to the idea that two people moving to solve the problems within their co-inhabited space could be both challenging and useful and the idea of a co-created reality space was possibly born, if not fully explored at the time.

Holism and Reductionism

Holism and reductionism are both sides of the methodology coin and, in my view, reductionism is seen as the scientific approach, whereas holism is criticised as being unscientific. Holism came from the Greek word meaning all, entire, total and suggests that all the components of any system whether it be biological, chemical, economic, social, physical, linguistic, etc. can only be understood as a whole rather than any reduction to its parts. Aristotle summarised it in the Metaphysics (1908) as 'The whole is more than the sum of its parts'.

Reductionism can be seen as the explanation that a complex system can be seen by reducing it to its fundamental parts. Biology and chemistry are examples of this.

This leads me to surmise that the world is split into those who believe in science and those who are against science. Personally, I really like the idea that the complete answer is probably closer to the middle ground. That science is finding answers that do not fit completely within a reductionist paradigm and likewise the reverse. Whilst I fully endorse holism, I am grateful for the scientific breakthroughs that have improved lives for everyone over our lifetimes.
In the meantime, I will tread a fine line between the scientific and the metaphorical in putting across the idea of embodied experience and working with embodied processes therapeutically.

Working with the body
The idea of an embodied field first came to me from James Kepner's book Body Process: A Gestalt approach to working with the body in psychotherapy (1997).
Kepner (1997) suggested that posture, movement and bodily experience are all relevant in therapy and developed the idea of body awareness within the therapist's structural framework to see the client in a whole person context rather than focusing simply on mental events and conditions. The Gestalt approach was considered a useful set of fundamental principles for working with the body of the client. Still, it required the addition of a relational approach and some breakthroughs in science, particularly the discovery of mirror neurons to refine the system to become an embodied field phenomena approach.

Working with the relationship
The relational element within the embodied field can be summed up by the great author and philosopher Martin Buber (1878-1965) who suggested that there are only two relationships that exist in reality: The I–It and the I–Thou relationship. In his book I and Thou, translated from the original German, he explains that in an I–It relationship you have a subject and an object (You are the I and the other is the It). This relationship is not a true relationship because it is a monologue rather than a dialogue and only exists to satisfy the whims and desires of the I person. The It person is an object and therefore not seen as a separate self. As an example, you will treat your phone in an I–It scenario, it is simply there to provide you with a service to connect with others.

In an I–Thou relationship, there is a holistic co-existence between two individual equal subjects who engage in dialogue in an undefined way which creates something unique and beyond objectification. An I–Thou relationship evolves as the two subjects grow with each other over time and, as you might imagine, is a useful way to be in a therapeutic space.
An understanding of I–Thou versus I–It is useful for the therapist as a measure of how they are in the embodied field - a client who is being treated in an I–It way will obviously respond in a Subject–Object way, and this makes the therapy far less fulfilling for either party.

Working with field theory
The other key element to add to the relational dynamic is the idea of a field phenomenon – a hypothetical construct with the idea that we are all partially in our own world and partially in another's world and within which there is scope for contact, dialogue and mutual growth at the contact boundary. Embodied therapists talk of the 'shared field' or the 'co-created field' and Gestalt therapy mentions the 'situational field'.
The idea of field theory was first proposed by Kurt Lewin (1890-1947) and was part of the Holistic movement of the time. Lewin observed the interaction between physical field forces such as those between the poles of magnets (push and pull forces) and translated these into metaphorical forces such as a driving force for change versus resistance to change in the interaction between people and their environment.
Lewin (1952) suggested that 'behaviour has to be derived from a totality of coexisting facts, and these coexisting facts have the character of a" dynamic field" in so far as the state of any part of this field depends on every other part of the field.' This idea of co-existence and a dynamic field encompassing and affecting both people within a therapeutic field has been adopted by some of the humanistic therapies. In particular those with a relational emphasis and the idea of seeing the

'total situation' is embraced by those, such as myself, who consider that all human beings are contained within an interconnected, interdependent, interactive complex field.

My learning journey

In my personal learning journey on the way to eventually embracing the idea of a process-oriented embodied approach to therapy, I learned experientially. That is, I participated in a long term group process where most of my preconceptions about the people I was with changed over the years through contact and dialogue (and a lot of challenge!). Learning to be authentic was key in Gestalt and listening and tuning into your own body process was invaluable. Recognising that I barely breathed when challenged by a group member or noticing how tight my stomach would get if I wanted to speak were early milestones in my embodied education.

Having embraced the idea that listening to your own body was useful I furthered my knowledge by attending post-graduate training and one, in particular, was around learning how movement patterns I developed and adopted from birth onwards were all solutions to developmental challenges in my life. This understanding, more than most, gave me an embodied awareness of how my adapted adult movement patterns could be understood and worked with to give me a more cohesive approach to the world. I also gained an ability to 'tune in' to both my own processes and sense a shift in the relational field between myself and my client, which gave both me and my client choices for exploration.

The three pillars of Gestalt; Field theory, Phenomenology and Dialogue work as a framework for me alongside the post-graduate training I attended in Somatic Developmental Psychotherapy, Embodied Relational Therapy and Embodied Relational Gestalt. This mixture informs my current approach, which I imagine is similar to most other therapists I come across – we all learn our core subject and then tailor it according to our tastes or inclinations. The key for me, with my approach, is that I am only part of the puzzle. My client and I shape the field we interact in and there will be clues in the dialogue and also in the resonating embodied field that, properly paid attention to and worked with, can lead to 'win-win' situations on both sides as well as growthful contact. To illustrate this point, I present a small piece from my early days of learning embodied work. I was working for an agency working with alcohol misuse and my primary approach was Gestalt therapy. However, I was really learning how to work in my own unique way to make the best of what I knew.

A session with Mark

My first impression of Mark (pseudonym) was of size and power and caught me unawares. He was a big and tall man and he had burst into my office with a lot of movement whilst I was on my way to the door to open it (he hadn't knocked). His head was held back (chin up) and his eyes failed to focus on mine, but they darted quickly around the room. When he saw the chair for clients, he went over and quickly sat in it, crossing one leg over the other. He then proceeded to lift his foot up and down sharply and regularly.

I felt shaken and unprepared in this initial encounter and when I sat in my own chair, I became aware that I wanted to play for time to rebalance myself. 'So tell me about yourself and why you've come here?', I said. Mark launched into his story- he was a self-made businessman who had become quite wealthy (later, when he left, I saw him drive off in a very expensive car). Alcohol had been an integral part of his life until things started to go wrong and then, alcohol eventually became the only thing in his life.

As he was talking, I found myself becoming resentful because I could not relax - I felt unsafe and ungrounded. In short, I was still unprepared.

His legs were swinging in a jerky and quick manner and his head movements were also jerky, with his eyes trying to focus anywhere but in the space between us. He was talking of all the reasons why he had to come and seek therapy, mentioning the many ways in which he had tried to solve his problems and how the people who should have been understanding of his situation actually were not.

All the time he was speaking, I was monitoring my body's current state. I felt tension in my chest and throat and noticed my head had travelled as far away from him as I could make it. This made me wonder whether I was trying to escape or at least be a safe distance away from (I can only guess at) the danger of being with Mark. Part of me was attempting to concentrate on listening whilst another part of me was looking forward to the end of the session, have a nice drink and a relaxing deep breath!

Mark started to tell a story of how he had paid his brother a lot of money to lock him in his bedroom at home to stop him finding a way to get hold of alcohol. Hearing this story, something shifted in me - the enormity of the situation (and possible desperation) – paying your own brother to imprison you because you do not have the inner resources to find a solution to your own addiction problem. So I responded quite loudly with, 'Wow!' This had an effect. Mark immediately looked at me and held my gaze for the first time. I noticed my eyes teared and I felt my chest shake briefly. I repeated 'Wow!' and blew out my cheeks, feeling tension releasing in myself. Mark replied in a slightly flippant way, remarking that it was an expensive business, but he could afford it. I riposted with, 'Yes, quite expensive for your soul though' and I added, 'Your brother must really love you to actually do that for you'.

Mark replied again with a slightly dismissive answer, but I felt that there was a difference in my body at this point and I became aware that some tuning in was happening. It felt like my eyes met him more fully and my head had moved forward bringing the rest of my body with it. My chest felt softer and a little more natural. Mark, in his turn, was swinging his legs less vigorously and his eyes would meet mine more and more during the conversations, settling for slightly longer each time. His conversational tone became deeper, and his words impacted me more (seeming more authentic). It felt to me that therapy had begun at that point and we had established a dialogue albeit there was a long way to go. We eventually worked for the full 24 sessions and Mark left, having given me an unrequested (but pleasing) bear hug! I hear that Mark is doing very well these days and I am also grateful for the experience I had working with him.

Discussion

Context is everything, they say, and the context, in this case, was simply two human beings in the same room together. One person was there for help, and of course, I was there intending to help. It felt like two different worlds colliding and such it was: two people with very different experiences and adaptations to life and definitely two different expectations, so how to proceed?

I was aware of my own bodily reactions which informed me that there was some resonance – some cause and effect that would be useful to pay attention to when the time is right but the time did not feel right initially; it merely served to keep me informed of what was going on. 'Sometimes you need to find "the bridge"', I remember one of my trainers saying - meaning find a way to reach the other person through all the defences and adaptations and offer a way to meet in the middle. My belief is that the bridge was established during my 'Wow' intervention. Because it was authentic, it could get through Mark's negative misconceptions and it was enough for his previously strongly defended guard to be lowered enough for a brief genuine connection which could pave the way for further genuine contact over time.

It was also useful that I was able to stay authentically connected because the size of Mark and his style of relating were clearly resonating with me bodily. I believe he was reminding me of my abusive father. However, my awareness and the fact that I had worked on those elements around my father and his bullying were key in helping me to stay focused and retain positive regard for Mark's own (probable) early developmental challenges. I did not know at the time, but later Mark told me about his own bullying father. Ruella Frank in the synopsis to her book The first year and the rest of your life, states that:

> The movement repertoire that develops in the first year of life is a language in itself and conveys desires, intentions and emotions. This early life in motion serves as the roots of ongoing nonverbal interaction and later verbal expression - in short, this language remains a key element in communication throughout life. (Frank and La Barre, 2010, Synopsis)

Clearly, the embodied language between myself and Mark had a shared element of early trauma and adjustment (and possible mistrust?) which required the building of the relational bridge before we could both feel safe enough to progress. I operate in what is called a process-oriented way as opposed to a goal-oriented way and the process is not always smooth, as evidenced in the text about the session with Mark. There can be an ebb and flow in the process and there can also be what has been described to me over the years (but I have never found a reference in the literature) as a 'frozen process'.

'Frozen process' as I see it and experience it, is when the natural and spontaneous embodied movement gets blocked and freezes up. The example in the session could be that Mark's ability to reach out fluidly with his eyes had been frozen over the years due to self-inhibition owing to fear of the consequences (perhaps trauma-related) and this makes communication difficult when the other comes up against a barrier whilst trying to reach in (and I did get a sense that there was only so far I could reach over to Mark with my eyes). At this point there are choices to be made – push further in and risk Mark going further away (or reacting badly to what could be seen as an invasion) or negotiate from the point of best contact and look for some way of thawing out the process. In the event, I believe my intervention contained enough reaching out without threat, to connect with Mark for him to reach back albeit briefly and establish the bridge and thereafter a working alliance. Once Mark became aware of his own process, an embodied dialogue was possible. It has been said that awareness is the only goal in therapy and I find this to be true but equally, I think embodied awareness as a goal is also a fine achievement.

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Working with a five-year-old child's nightmares: a short case study

Valerie Long

Abstract

This paper outlines the integration of the systemic, experiential, embodied reprocessing (SEER) method of trauma-informed therapy (Karpuk, Stoneham, and Davies, 2019) into my clinical practice as a Person-Centered counselor by introducing a case study in which I worked with a child's nightmares. The case study outlines the therapeutic intervention, illustrating a creative and embodied way of working with childhood trauma.

Introduction

My initial degree completed in 2008 was in Person-Centered Counselling. Over the years, I have incorporated other theories and training into my practice, one being a systemic, experiential, and embodied reprocessing (SEER) method of trauma-informed therapy, which has become an integral part of my practice. This additional training consisted of workshops on working with nightmares during the first and second stages of complex trauma recovery (Karpuk and Dawson, 2016), part of this training included the 'SEER' method introduced in this paper (Karpuk, Stoneham, and Davies, 2019).

This article outlines the integration of this trauma-informed training into my clinical practice through a case study of a five-year-old child who experienced nightmares due to a series of events that seemed to have traumatised him. I decided to share this case study as it may be interesting to other clinicians, demonstrating creatively, through art-making, an approach to working with childhood trauma using the 'SEER' method of trauma-informed therapy (Karpuk, Stoneham, and Davies, 2019) as part of the intervention.

The definition of trauma I refer to in this paper is 'any experience that causes the child unbearable psychic pain or anxiety' (Kalsched, 1996).

Case Presentation

The referral for this piece of work came to me through a phone call from a previous client who had concerns about her five-year-old grandson, Danny (pseudonym). Both Danny and his mother, Sarah[1] (pseudonym), attended and participated in three face-to-face sessions. Each session lasted for fifty minutes and all sessions were held in a therapy centre. Danny's father did not attend any of the three sessions. However, he participated in the therapeutic process, which involved a systemic and collaborative intervention between Danny, his parents, and myself as the therapist.

Sarah contacted me by telephone and explained that Danny had changed from a loving, well-behaved boy into an abusive, aggressive child with rage outbursts. Both his parents were at their 'wits' end' not knowing what had caused this change in behaviour. Sarah was concerned about his mental health.

[1] Sarah, the child's mother, gave consent to publish this intervention.

This behaviour seemed to surface at bedtime when Danny was told that he had to end the game he was playing with his sister and go to bed. Danny would become aggressive, throwing things, kicking out and screaming abuse at his parents. He was fine when he was told, '20 minutes to go, 10 minutes to go'. However, when he was told 'now, please put your games away' Danny would, at this point, become uncontrollable. Danny would sit on a chair in the middle of the room, refusing to sit on any chair near a wall. He was afraid of going upstairs to bed and would (or could) not tell his parents why. The only way his parents managed to calm him was by walking him upstairs; one in front of him and one behind. They had to stay with him until he fell asleep. Every night he would wake screaming in terror and could not be calmed until his parents took him into their bed.

The Therapeutic Intervention

During the initial session, Danny mentioned his deceased grandfather and talked about seeing his grandfather's changes before he had died of cancer. He also explained that although his father was fine at the moment, he had been seriously ill the previous year. Danny responded positively to being listened to and being heard in the session. He was eager to engage.

During the second session, Danny shared some details of his nightmare which was a box[2] floating at the top of the stairs in his home, in a corner near the ceiling. This sounded like a potential source to his distress, acted out as outbursts of anger. I asked Danny if he could tell me a little more about this box and he said, 'it's quite a big box, like a delivery cardboard box'. I asked in what way it was like a delivery box. Danny said, 'it opens at the top with two flaps and has a picture on the side'. I asked if his parents had many items delivered and he replied 'yes'. This explained the connection to the description of the box Danny presented. I asked if the floating box was empty or whether it had anything inside. Danny was hesitant at this point before stating 'it has a head and two hands inside, but I cannot see a face because it is in shadow and the hands are next to the head'. He explained that he was afraid and worried about his family. The head and hands were threatening and he was afraid something bad was going to happen. Danny stated that, when he woke in the night, this box was in his bedroom floating near the ceiling, in the corner of his bedroom. He could see the head and hands as before. Danny was scared and cried out for his parents to come. His parents would come and take him into their bed where he could sleep soundly.

I asked Danny about his friends and home life. He was a studious boy who didn't get into fights. He liked science projects at home and had previously done well in school. He stated he had a group of friends he played with at break time. Recently, another boy, who was not part of his usual friendship group would ask to play. I asked Danny what happened when the boy joined in the game with him and his friends. Danny explained that the boy broke the game up and took his friends away from him, so he sat alone on a bench by a wall. Sometimes his best friend came back and sat beside him. Danny explained that sometimes, in the playground, he would feel hands on his back giving him a big shove but when he turned around all he could see were heads and he couldn't see the face of who shoved him. This was an opportunity to help Danny to shift his attention from nightmare narrative to his bodily experiences associated with nightmare objects and apply embodied re-processing (Karpuk, Stoneham, and Davies, 2019). At this point, it seemed important for Danny to establish some safety, to feel more protected. I asked Danny, 'Who would you choose to be your hero and protect you, or what would it be? It could be a cartoon character, a person, an animal… what would you choose?' (Karpuk and Dawson, 2016). He replied, 'my dad'. I asked Danny if he liked drawing and he said, 'yes, my dad is also very good at drawing'. I asked Danny to do the following once he returned home. I requested Danny to ask his father to help him draw the delivery box that he saw in his nightmares to help him view the nightmare from the observer's stance and approach safely alienated bodily sensations and experiences (Karpuk, Stoneham, and Davies, 2019). Danny was eager to do this. It was agreed that Danny would guide dad to get the picture just as Danny described it and that they would do this together. I then requested that when the picture was completed, Danny

[2] In the original conversation, Danny names a specific brand of delivery box. To avoid the mention of a commercial body I have altered Danny's exact words.

should tear it up and put it in a tin (i.e., a baked bean or soup tin) and then take it somewhere safe. Danny had a garden and it was agreed that this would be the safe place. To complete my instructions, dad was to set fire to the drawing and they were to watch it burn together.

I suggested this process as being immersed in a collaborative process and in the art-making would enable Danny to engage with his bodily felt sense (see, e.g. Gendlin, 1981). The combination of using his father as the protective hero, the embodied approach of art-making and processing the traumatising box in a physical manner allowed for a restructuring of the trauma and a 'body-shift' to take place (Karpuk and Dawson, 2016). Mum was also part of the collaborative work. She said she had lots of tins and would wash one and save it for Danny and dad. This intervention involved Danny's parents as a protective factor, who he was worried about following his grandfather's death and his father's illness. Moreover, it involved the 'physical' destruction of the threat he was experiencing at school, visualised by Danny in his nightmares as a delivery box.

During the third session, Sarah stated the night of the drawing was the first night in a long time they had all slept through. Danny said the delivery box was still there, but it was empty now and he was not afraid of it anymore. Danny's mother said that he was relaxed and back to normal. I asked mum to speak to the school and explain what had happened in the playground and how it had affected Danny. Sarah stated there were only two weeks left of the school term and it would be fine, that she would rather leave it now things had settled. I suggested that it would be in Danny's best interest, for his wellbeing, to make the school aware. My concern was that the issue may re-emerge and Sarah agreed to speak to the school. Danny was part of this decision and said 'I would like that'.

I received a telephone call from Sarah saying everything was fine and Danny would not need to attend any more sessions. I recommended a closing session to provide Danny with an ending to the therapy. Sarah said she would come back to me, however, Danny did not attend a closing session.

Reflection

Danny attended the clinic with his mother, Sarah. The presenting issue was Danny's refusal to go to bed and every night he would wake screaming in terror, leading him to further aggressive behaviour. It was agreed with Danny that his father would draw a picture of the delivery box Danny saw while describing it to him. Involving dad, who was Danny's protective figure, helped Danny engage with the drawing and processing the nightmare.

The therapeutic relationship was built on the Person-Centred core conditions of empathy, congruence, and unconditional regard (Rogers, 1980), which allowed Danny to talk openly about his fears. The loss of his grandfather and subsequent illness of his father, appeared to act as a trigger for Danny's fear that something bad would happen. It seemed that the combination of this fear and the negative playground experiences had overwhelmed Danny, causing the nightmare of the delivery box. The therapeutic act was the externalising of the threatening object, which was informed by the 'SEER' method, moving away from a focus on narrative to an embodied approach (Karpuk, Stoneham, and Davies, 2019). The specific action of burning the nightmare was the last step of nightmare re-processing as a part of completing actions or impulses that were thwarted at the time of the trauma and seemed was the most creative and appropriate way for Danny.
Sarah commented the night of the drawing was the first good night's sleep the family had in a long time, signifying change had taken place. Then, Sarah decided to end the sessions. Continuing the sessions with a planned ending would have been preferred, providing closure for Danny.

I chose Karpuk and Dawson's (2016) trauma-informed method in this intervention as it provides a sense of safety for the client, is creative in nature, and sits comfortably with my core values and my training in Person-Centered Counselling. As with other contemporary trauma-informed experts (see, e.g. Levine, 1997), the training facilitated by Karpuk and Dawson (2016) emphasises body-focused

approaches to address trauma. Through this method, I have learned to change the approach to my clinical work, by focusing on the client's experience of trauma and how it affects their body rather than their narrative. In the case of Danny, it allowed us to focus on how to process the nightmare by using embodied techniques (drawing, burning, walking in the garden, etc.) rather than focusing on talking about the nightmare narrative (Karpuk, Stoneham, and Davies, 2019). Although it would have been my preference to continue working with Danny in a closing therapy session, it seemed that the aims of therapy the family were expecting had been achieved. The systemic approach of involving the family, use of embodied techniques of art-making and experiential usage of externalising and 'physically' destroying the threatening nightmare seemed to have a positive impact on Danny, whose nightmares were reduced to a less frightening delivery box.

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Working creatively to manage high levels of negative emotions

Isa Julgalad

Abstract

This paper describes the creative and sensory methods I use in my practice when working with people who have experienced trauma. One part of this article outlines emotional stress in the context of trauma and the second part describes different techniques I use for emotional regulation.

Introduction

This article will try to give the therapist and their client tools to interrupt high levels of negative emotions, such as hyperarousal, anger, self-hatred, guilt, critical inner voices or sadness. The examples in this article will focus on anger because I feel it is the most intense and because anger is often the visible emotion, like the flame of a fire. To me, the fuel or oil inciting and combusting this fire often seems a combination of feelings including tension, hopelessness, despair and emotional pain.
Anger can lead to reactions towards the self (e.g. self-harm), dangerous behaviours that put the person at risk, smashing or hitting objects, or outbursts towards others. Once clients can soothe the anger (turn down the flame), they can explore beyond this emotion and be in touch with other deeper feelings such as pain and sadness.

Trauma and emotional stress

First, let us first consider emotional stress in the context of trauma. Your clients might have experienced a single trauma, a cumulative range of traumatic events or complex trauma. The sequence of traumatic events could include primary and secondary traumatic experiences or a long term trauma with a repeating cluster of similar threads and trauma aspects (e.g. an alcoholic friend or partner with outbursts, a stalking ex-partner, etc.). There may have been a worthwhile break in between, with moments of quietness to take a breath, but not for the long term.

The events that your clients have experienced can be very diverse, but you may also find many similarities. When my clients talk about their emotional stress, they describe it as a sense of being lost, without having a sense of what is right for them, craving orientation, experiencing chaos and confusion within their mind or body; with mixed feelings of rage, anxiety or fear, overwhelm and shame. They often experience an inner voice that judgmentally criticises why they are not 'functioning'. A critical inner voice that has been shaped and internalised by the negative statements people made in their lives. My clients' circumstances and the necessity to adapt and continue to function despite their pain and to prevent danger or punishment have often led them to emotional dysregulation and using maladaptive coping skills.

To regulate this, I find it useful to be concrete. In my work, I like using sensory techniques to explore and regulate emotions. I try to understand whether a person is highly activated and tense (active sympathetic nervous system) or nearly numbed and low (active dorsal vagus nerve). Furthermore,

I get curious about what is upsetting them. In my sessions, I ask myself, 'What sends their nervous system out of balance?' so that I can proceed with the most appropriate intervention.
If you want your client to use regulation techniques, you can find inspiration from other professionals and/or methods. To continue, I will describe my own practice and the sources I have found useful when working with emotional stress.

The roots of my work
Like myself, you might find inspiration from Dr Anna Jean Ayres (Ayres Sensory Integration, n.d.) and PhD. Marsha Linehan (2014).
Dr Ayres is known for her sensory integration work, which is based on how the body responds to sensory stimulation and how the environment is perceived by our senses, such as touch, gravity, proprioception, sight, smell, hearing and taste. 'Ayres Sensory Intervention' work has been found 'effective with problems such as learning difficulties, hyperactivity and attention deficit, dyspraxia, and autism.' (Ayres Sensory Integration, n.d.)
My work is also influenced by Dialectical Behavior Therapy (DBT), the approach created by PhD Linehan. This became a popular intervention for people with a Borderline Personality Disorder diagnosis because it became obvious that emotion regulation and distress tolerance skills could positively impact people with emotion regulation difficulties or with a history of trauma. DBT contains a resourceful toolbox that includes mindfulness training, interpersonal effectiveness, emotion regulation and distress tolerance skills. Essential work on realisation and insight on perspectives is also part of it. For example, you can experience a temporary feeling that seems impossible to endure. However, you are still a human that is always more and larger than this time-limited feeling. The feeling will pass; you will 'survive' and keep breathing.

Having given a brief introduction to the methods that have inspired me, the following sensory techniques I use in my practice might be useful to consider. When experiencing slight tension, I invite clients to use soft sensory strategies like squeezing a soft ball. For middle-range tension, it might be good to use a massage ball with medium hardiness or press and stroke the arm's skin with porcupine massage balls. The person can be stimulated but in moderation. For strong tension, clients can use wooden acupressure massage balls with unsharp thorns; you can really feel them when touching. The latter can cause slight pain, which could be used with clients who self-harm, to gradually reduce sensory stimulation. If touch does not work, some people prefer starting with gustatory or olfactory stimuli such as chilli flavoured sweets that are really spicy, very sour sweets or smelling salts. These can be useful when no other softer stimuli work. When using these sensory tools, it makes sense to set a sequence according to the order of intensity your client wants to work with.
This article continues with a brief intervention that integrates the theory I have outlined and my practice as a therapist working on an inpatient adult psychiatric ward.

Understanding your client
Before I begin work with my clients I create a formulation for the intervention, based on the client's desired experience. I spend some time with them to discover what it is that they are feeling and what it is that they want to feel. I try to listen, ask, explore and get a sense of what bodily sensations the client is yearning for. What does the person crave? How could they experience that? Once these questions are answered, I develop an intervention with the appropriate exercises. My preference is to create soft approaches first.

Case Study
Let us look at one of my interventions with 'Mrs S.', a 47-year-old woman who experienced complex trauma in the form of neglect, emotional abuse and sexual abuse with C-PTSD (Complex Post-Traumatic Stress Disorder) symptoms playing a large part in her life.
She felt emotional stress in the form of intense anger towards herself and her mother. I also had a sense that beneath this anger, there were feelings of despair.
In our interaction, I had a feeling that she wanted to self-harm. Not necessarily in the therapy ses-

sion, but I could sense that the risk of self-harm, especially in the evening or at night, was present.

Part I - Regulating emotional stress with sensory stimulation

'Mrs S.' and I talked about her tension and emotional state. She already had some knowledge about sensory stimulation. At this point, to find out more about my client, I try to discover how they are in the current moment. For example, I ask the question, 'what does your finger want to do?' It might sound funny, unfamiliar or strange to begin with, but it might work for your client to become more embodied. If it feels safer, you could ask this after your client has done a couple of finger movements and is already body-focused.

I used this approach with 'Mrs S.' and gave her a piece of paper, asking her to create something useful with it. She made a paper ball that had one little sharp edge (Image 1, below). I asked her where in her body she would like to use it. She instantly chose a soft spot; this was the innermost sensitive part of her wrist. 'Mrs S.' thought that this intense stimulation would be useful. So she pressed the sharp edge against her wrist.

Image 1 - A paper ball with one little sharp edge.

I could ask my clients to stay with this sensation, but I also offer some guidance when appropriate. For instance, I encouraged her to find some other body parts to focus on shifting and hurting herself less. I worked with her to find stimulation with less intense self-harm and reduce the pain as much as possible. Some of my suggestions were, 'Maybe touch different parts of your head with the sharp edge of the paper ball. Or maybe stroke it against one of your fingers, then change to another finger. So, maintain the sensory focus and change to different parts of your body.'

While exploring other parts of her body, she decided to use it on her arm, where it was stimulating but not that painful. This exercise allowed her to explore different parts of her body in a new way, creating new experiences. Instead of wanting to cause pain, she became curious about the different sensations in her body and the different sensations of the paper's intensity against her skin. She seemed most surprised about the sensation caused by the stimulation at the back of her head.

With this method, clients can become more self-aware about different sensations on their skin and body. As you continue with the therapy intervention, you could gradually suggest being more gentle with the stimulation as clients can cope with softer sensations rather than needing intense ones.

Often, the clients I work with will seek extreme physical sensations, like pain. They may cut themselves, scratch themselves or hit diverse body parts against hard objects - this can be a way to release anger, feel pain or distract from emotions by creating greater physical pain. With this method, I seek to reduce the intensity of the pain clients inflict on their bodies by using less intense sensory stimulation.

Part II - Creating positive feelings with a sensory approach

During a different therapy session, 'Mrs S.' described herself as having unbearable tension. When I asked concrete questions about this tension, I felt that powerlessness and not having control were a strong part of her distress. In my explorations, I became curious about whether she could experience the opposite (control and power) within the therapy space. Instead of redirecting my client's attention away from negative feelings and ignoring these, my approach was to let 'Mrs S.' become more aware of her emotions and then try to explore ways to create a positive feeling. One that the client needed in the present moment, one that she could be comfortable with and manage.

I showed her how to rip a sheet of paper into two, rip the halves into halves, and so on until the pieces of paper were tiny (Image 2, below). I talked to her about taking control and doing the ripping mindfully and at a prolonged speed. A speed in which she could focus on her power and control, to enable her to see the effects of her actions happening right before her eyes. I wanted to give her a way of being active, focussed on her actions, in control and powerful (because she can destroy the paper). This was highly effective, and she still enjoys this process.

Image 2 - Slowly ripping up paper.

In this intervention, my client was working from a sense of powerlessness to a place of empowerment. As she ripped the paper, she imagined ripping the 'problem' that was causing her to feel powerless. If you find it appropriate, you could invite your clients to work with this kind of visualisation. However, I would be mindful. For example, if your client has anger management issues, it could potentially influence their sense of anger in various ways, which could become uncontrollable. Therefore, I would recommend noticing your client's reactions as they could potentially be imagining that they are ripping a real person apart. They may become calmer or quieter, or their rage might intensify. Observe the long term effects of your interventions and review this with your client.
Some clients may find it easier to process their emotions with embodied movements and through using visualisation techniques. For example, throwing the object that represents the 'problem' in the bin or brushing it away from their shoulders.

Reflections

As 'Mrs S.' regulated her emotional stress with sensory stimulation and created positive feelings with a sensory approach, she became more self-aware of her bodily sensations and her emotions. This allowed her to recognise the different levels of her emotions' intensities. By recognising these, she found the most appropriate tools to create soothing physiological responses to different distress levels. As the intervention progressed, I also tried to develop a language that allowed the client to express her emotions with words. For example, I would ask questions such as, 'Can you show me

the level of intensity of your emotion? Is it high, medium or low today?' I would raise my arm to mimic the different levels of intensity. This was helpful for the client to visualise and have an embodied sense of her feelings.
The aim of my work with 'Mrs S' was to reduce her emotional stress. We achieved this by gradually reducing a very intense sensory stimulation (self-harming) to a less intense sensation (ripping paper). As I explained earlier in this article, you can create a sensory succession plan at the early stages of therapy that includes different sensory intensities. For instance, 'Mrs S.' chose the following sequence: ripping paper, a rubber band to stretch, using the crumpled paper with the little edge, sour sweets and finally chilli flavoured sweets. Once we had created this sensory plan, 'Mrs S.' knew that these tools were available to her if she felt extremely agitated and needed a tool to self-soothe.

In systemic therapy, we aspire to speak kindly to clients and to make them feel empowered. We want the person to understand that they carry the responsibility of their work, are continuously learning how to be an expert and can make positive choices and good decisions on their next crossroads. Validate their self-awareness, curiosity, skills and honesty. Stay curious. It might be new and unusual. Be kind, not only to your client, but also to yourself whilst creating more awareness and trusting the creative process. It will make you both more self-sufficient and equipped to manage complex trauma.

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