Facilitation of spontaneous healing in an ageing individual presenting with Complex PTSD: A SHIP® perspective

C Kieser-Muller
24913766

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Promoter: Prof. V Roos
Co-promoter: Dr JO Steenkamp

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SUMMARY

Trauma does not reside in events themselves but is the result of the subjective perception of individuals of a threat(s), which sets in motion autonomic physiological processes that enable a fight or flight response. Trauma produces profound changes in the psychobiological system of individuals and manifests as a Post-Traumatic Stress Disorder (PTSD) and/or a Complex Post-Traumatic Stress Disorder (C-PTSD). Psychotherapists in a "uni-consciousness" approach deal with traumatised clients from a cognitive-behavioural, interpersonal or problem-solving perspective. In contrast, psychotherapy from a biopsychosocial perspective, approaches psychotherapy with traumatised clients from a "multi-consciousness" perspective. A multi-consciousness perspective explains complex trauma manifestations as a multisystem dis-ease. The aim of this research was to describe the facilitation of spontaneous healing in an ageing female individual (46 years) presenting with C-PTSD from a SHIP® perspective by using her experiences before psychotherapy while observing shifts during and on completion of psychotherapy. SHIP® proposes that traumatised clients are in a continuous process of spontaneous healing and autonomic self-regulation to restore their psycho-biodynamic balance. In applying SHIP®, psychotherapists use intra-translators and inter-translators. An intra-translator refers to an internal individual specific field (ISF), which manifests as repetitive and/or intense somatic sensations or feelings. Inter-translators are the verbalisation of projection statements concerning a specific issue in relation to people and the environment (external ISFs). This study was approached from a descriptive and explanatory perspective. Qualitative research and a single case study

design were chosen. The participant was exposed to developmental trauma and a variety of subtle and shock trauma-activating events over her lifespan (more than 15 incidents). On completion of psychotherapy that spanned over seven years, the verbatim process notes of the 127 SHIP® sessions, a life sketch and a personal reflection of the participant on the process of psychotherapy were used as data. Data were analysed using key SHIP® constructs to conduct a deductive category application after which a thematic analysis was conducted to identify experiences and shifts. Experiences before therapy were related to several intra-translators (more than 17) indicating somatic dis-ease, such as fibroids; chronic lower back pain; nightmares; anxiety attacks; an exaggerated startle response; and feelings, such as helplessness, anxiety and unworthiness. Several repetitive projection issue statements were identified. Shifts during psychotherapy were noticed in 1) the movement from the acute trauma-activating event to developmental trauma indicating that old unresolved residual trauma energy was still lodged in the system of the participant; 2) in the here-and-now of the psychotherapeutic context through spontaneous healing reactions (SHRs), which enabled the participant to discharge on-hold activation energy and through integration; 3) in relation to activators when previous stimuli no longer activated the neurobiological system of the participant; and 4) by reconnecting the disconnected biopsychosocial system of the participant, which manifested as a relief of somatic distress, an ability to regulate emotions, improved attention and cognition, a changed belief system and enhanced relational regulation. This research contributes to the destigmatisation of normal reactions and expressions (symptoms) of psycho-biodynamic systems of individuals to

trauma and how the, it (normal reactions and expressions) can be used as healing messages of chronic dis-ease of traumatised individuals. SHIP® − as a psychotherapeutic approach − provides a framework to deal holistically with trauma spectrum manifestation dis-ease but its effectiveness can be enhanced by including neuropsychological-based knowledge to create safety and using small amounts of activation. Despite the destructive impact of trauma on individuals as they age, it is possible to be healed and to re-connect with the part of the self and other individuals.

Key words:

Complex-PTSD; developmental trauma; ageing individual; SHIP®; spontaneous healing; trauma spectrum manifestation

OPSOMMING

Trauma is nie in enkele gebeurtenisse opgesluit nie, maar is die gevolg van individue se subjektiewe belewenis van bedreigings wat fisiologiese refleksprosesse aktiveer wat ’n veg- of vlug-reaksie in staat stel. Trauma veroorsaak diepgaande veranderings in individue se psigobiologiese stelsel en manifesteer as ’n Post-Traumatiese Stresversteuring (PTSV) of ’n Komplekse Post-Traumatiese Stresversteuring (K-PTSV). Psigoterapeute wat van ’n “een-bewustheid”-benadering gebruik maak, benader getraumatiseerde kliënte vanuit ’n kognitief-gedrags-, interpersoonlike of probleemoplossings-perspektief. In teenstelling hiermee, psigoterapeute wat fokus op ’n biopsigososiale perspektief benader psigoterapie met getraumatiseerde kliënte vanuit ’n “meervoudige bewustheidsperspektief”. ’n Meervoudige bewustheidsperspektief verduidelik komplekse trauma manifestasies as ’n meervoudige stelselsiektetoestand. Die doel van hierdie navorsing was om die fasilitering van spontane heling te beskryf van ’n ouer vroulike individu (46 jaar) met K-PTSV-simptome vanuit ’n SHIP®-perspektief deur gebruik te maak van haar ervaringe voor psigoterapie terwyl skuiwe gedurende en met voltooiing van psigoterapie waargeneem kon word. SHIP® stel voor dat getraumatiseerde kliënte deurlopend betrokke is in ’n proses van spontane heling en outonome selfregulering om hulle psigo-biodinamiese balans te herstel. In die toepassing van SHIP® gebruik psigoterapeute intravertalers en intervertalers. ’n Intravertaler verwys na die interne individueel-spesifieke veld wat herhaaldelik manifesteer en/of intense somatiese sensasies of gevoelens. Intervertalers verwys na die verbalisering van projeksie-stellings oor spesifieke knelpunte wat verband hou met individue en die omgewing (eksterne

individueel-spesifieke velde). Hierdie studie was benader vanuit ’n beskrywende en verduidelikende perspektief. Kwalitatiewe navorsing en ’n enkele gevallestudie-ontwerp is gebruik. Die deelnemer was blootgestel aan ontwikkelingstrauma en ’n verskeidenheid van subtiele en skoktrauma-aktiveringsinsidente tydens haar lewensduur (meer as 15 insidente). Nadat psigoterapie oor die bestek van sewe jaar afgehandel is, is die proses-aantekeninge van die 127 SHIP®-sessies, ’n lewenskets asook ’n persoonlike refleksie van die deelnemer oor die proses van psigoterapie as data gebruik. Data is ontleed deur gebruik te maak van SHIP®-kernkonstrukte om ’n deduktiewe kategorie-toepassing te doen. Daarna is ’n tematiese analise gedoen om belewenisse en skuiwe te bepaal. Belewenisse voor terapie het verband gehou met verskeie intravertalers (meer as 17) wat ongemakstoestande soos fibrose; kroniese lae rugpyn; nagmerries; angsaanvalle; ’n oordrewe skrikrespons en gevoelens soos hulpeloosheid, angstigheid en onwaardigheid veroorsaak het. Verskeie herhalende projeksie-stellings is geïdentifiseer. Skuiwe gedurende psigoterapie is waargeneem in 1) die beweging van ’n akute trauma-aktiveringsinsident na ontwikkelingstrauma wat aandui dat ou onverwerkte residuele trauma-energie steeds in die deelnemer se stelsel teenwoordig was; 2) in die hier-en-nou van die psigoterapeutiese konteks deur spontane helingreaksies wat die deelnemer in staat gestel het om ontslae te raak van latente aktiveringsenergie en deur integrasie; 3) aktiveerders wat verband hou met vorige stimuli wat nie meer die neurologiese stelsel van die deelnemer aktiveer nie; en 4) deur die herverbinding van gediskonnekteerde biopsigososiale stelsel van die deelnemer wat gemanifesteer het as ’n verligting van somatiese ongemak, die

vermoë om emosies te reguleer, verbeterde aandagspan en kognisie, ’n veranderde waardesisteem en verhoogde verhoudingsregulering. Hierdie navorsing het bygedra tot die destigmatisering van normale reaksies en uitdruk (simptome) van individue se psigobiodinamiese stelsel as gevolg van trauma en hoe dit aangewend kan word as helingsboodskappe van chroniese siektetoestande van getraumatiseerde individue. SHIP® − as ’n psigoterapeutiese benadering – verskaf ’n raamwerk om op ’n holistiese manier te werk met trauma-spektrum manifestasie-siektetoestande. Die effektiwiteit kan verhoog word deur die insluiting van neuropsigologies-gebaseerde kennis om veiligheid te verseker en deur gebruik te maak van klein hoeveelhede aktivering. Ongeag die destruktiewe impak van trauma op individue tydens die verouderingsproses, is dit wel moontlik om te genees en om weer met dele van die self en met ander individue verhoudings te bou.

Sleutelwoorde:

Komplekse Post-Traumatiese Stresversteuring (K-PTSV); ontwikkelingstrauma; veroudering van ’n individu; SHIP®; spontane heling; trauma-spektrum manifestasie

PREFACE

- In this document, references to sources are formatted according to the American Psychology Association (APA) guidelines (6th edition).

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CHAPTER 1: ORIENTATION TO THE RESEARCH

The introductory chapter contextualises the research within international and national trauma trends. It presents different definitions of trauma and suggests an encompassing definition, which will guide the discussion on trauma-related components and treatment models suggested for trauma and accumulated trauma, such as Complex-Post Traumatic Stress Disorder (C-PTSD). A motivation is provided for the proposed use of the Spontaneous Healing Intrasystemic Process (SHIP®) as a treatment model. The problem statement flows from the gap identified in research related to ageing people who have experienced trauma, and the therapeutic models which inform the aim of the study. This chapter also presents the ontological and epistemological position of the researcher and concludes with an outline of all the chapters.

1.1 CONTEXTUALISING THE STUDY

Most individuals are likely to experience at least one incident of trauma over a lifetime (Williams et al., 2007). Research in the United States of America indicates that 60.7% men and 51.2% women will be exposed to a catastrophic incident at least once during their life (Friedman, 2003). In contrast, South Africans are likely to experience multiple trauma experiences as a result of the entrenched norm of violence that underpins social interactions (Human Rights Watch, 1995; Williams et al., 2007).

The history of Apartheid with its state-sponsored violence and the consequent struggle for liberation have contributed even more to an entrenched culture of violence. Today, South Africa is considered as one of the most violent countries in the world (Nedcor, 1996; Williams et al., 2007). Since the

transition from Apartheid to democracy in 1994, xenophobia has flared up, especially against foreign black Africans (Attias-Donfut, Cook, Hoffman, & Waite, 2012). Xenophobia can be identified as the fear of that which is perceived to be foreign or strange, characterised by a negative attitude, dislike, fear or hatred. In South Africa, xenophobia also involves violent practices that result in bodily harm and damage to property (Attias-Donfut et al., 2012).

Violence towards women is especially high in South Africa. It is estimated that a woman is raped every minute and that girls who are 15 years old and younger account for up to 50% of the rapes (Brysiewicz, 2001). South Africa has been labelled the “rape capital of the world” (Williams et al., 2007, p. 854). South Africa is also rated among the most violent countries in the world owing to its very high homicide rate (Brysiewicz, 2001) with a total of 17 805 murders and 17 537 attempted murders in 2015 (Crime Stats, 2016) and widespread child abuse (Edwards, 2005; Jewkes, Levin, & Penn-Kekana, 2002) with 2389 reported cases of child abuse or neglect in 2015 alone (Crime Stats, 2016).

Trauma symptoms were originally identified in war situations, especially among soldiers who have been exposed to combat (Friedman, 2016). A syndrome similar to Post-Traumatic Stress Disorder (PTSD) was observed as early as in the American War of Independence in 1780 and was labelled “cowardice” (Friedman, 2016). Similar trauma reactions were noted in the American Civil War and in the First World War; the condition was described as “nostalgia” and later as “battle fatigue”. It was known as “battle exhaustion” in

both the Korean and the Vietnam Wars (Friedman, 2016; Van der Kolk, McFarlane, & Weisaeth, 1996). Victims of the Nazi concentration camps in the Second World War displayed the same symptoms (Friedman, 2016; Scaer, 2005). In the South African Border War in northern Namibia, it was known as "going bossies" (Gibson, 2010).

In 1952, the American Psychiatric Association (APA) produced the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I). The DSM-I included a diagnosis of gross stress reactions because clinicians became increasingly aware of the fact that traumatic reactions are not exclusively a military phenomenon but may follow any traumatic situation, including situations in a civilian environment (Friedman, 2016). For reasons, which are not entirely clear, this diagnosis was excluded from the DSM-II in 1968 (Wilson, Friedman, & Lindy, 2001). For inexplicable reasons, there was no official diagnosis, identification or treatment for trauma victims between 1968 and 1980 (Wilson et al., 2001). In 1980, post-traumatic stress was again included in the DSM-III where it was described as a rare catastrophic event that evokes significant symptoms of distress in most people (Solomon & Siegel, 2003). It is generally believed that the reinstatement of a post-traumatic stress diagnosis can be attributed to the vast number of trauma victims from the Vietnam War (Friedman, 2016; Kaplan & Sadock, 1988). Although the definition remains the same, the DSM-IV (American Psychiatric Association, 2000) further refined the concept of trauma from an exceptional, external event (as in the DSM-III) to an individual psychological reaction to an overwhelming event (Friedman, 2016).

In the DSM-IV (American Psychiatric Association, 2000), two important insights were added to the definition of trauma 1) the subjective nature of trauma − people subjectively evaluate experiences or perceptions (information obtained through the senses) of actual or perceived threats of death or physical injury; and 2) people experience trauma when they witness physical threats to other people. What distinguishes it as trauma is that “the person’s response involved intense fear, helplessness, or horror” (p. 471).

Recent definitions of trauma propose a different focus. Scaer (2005, p. 2), for example, defines trauma “as a continuum of variable negative life events occurring across the lifespan”. In this definition, two types of trauma are distinguished, namely acute and developmental trauma. However, this definition does not make it clear by whom the life events are assessed as negative and these two types of trauma do not necessarily provide an indication of what constitutes the nature of trauma. In this regard, Levine’s (1997) explanation provides more clarity: Trauma is any event that produces the necessary physiological effect, causing an unresolved freeze response or a dissociation due to an overwhelming feeling of helplessness. It is clear from this definition that any event can be perceived as threatening. When individuals perceive a threat, their autonomic processes (physiological response), which prompt them to fight the threat or escape from it, are set in motion (the necessary effect is produced). If they are not able to execute the desired behaviour of fighting or fleeing, they experience powerlessness (an overwhelming feeling of helplessness). The elevated levels of energy that

were generated by the autonomic physiological processes to enable fight or flight then become frozen in the body (unresolved freeze response) or when the psychological defences are flooded and individuals do not have another choice they dissociate − also called a freeze or immobility response.

Trauma implies a rupture in the psychological, biological and sociological boundaries of individuals (JOS, 2002; Scaer, 2005). For the purpose of this study, the following encompassing definition is proposed: Trauma is not event-specific, but the result of the unsuccessful execution of the autonomic psychobiological survival responses (fight or flight) of individuals set in motion by the subjective evaluation of a once-off or repetitive, acute or subtle threat(s) that raptured their boundaries (psychological, biological and/or sociological) or by witnessing boundary violations of other individuals, which can result in an overwhelming feeling of helplessness or dissociation.

From this definition, the ontological position and epistemological assumptions of the researcher are explained, because this position and these assumptions explain the choice of method for the research, but also illustrate the position of SHIP® psychotherapists.

1.2 ONTOLOGICAL POSITION AND EPISTEMOLOGY

Ontology refers to beliefs about what there is to know about the world – whether or not social reality exists independently of human interpretations and practices (Clarke & Braun, 2013; Snape & Spencer, 2003). Without engaging in an in-depth philosophical debate, the position of the researcher and SHIP®

psychotherapists is proposed as a critical realist position (realism-relativism). It is held, for example, that a mind-independent truth (realism) exists about the types of trauma, trauma-activating events, impact of trauma and treatment models for trauma. However, trauma occurs in the nervous system of individuals and this means that each individual develops his or her unique psychobiological constellation and socially located interpretation in relation to trauma (relativism).

Informed by critical realism, the epistemology of contextualism also draws on a realist and relativist position (Clarke & Braun, 2013). In applying SHIP®, psychotherapists moves between these two positions. They draw on existing, mind-independent knowledge about the psychobiological processes that are set in motion when individuals perceive a threat to their physical, psychological and social boundaries, and move to a relativist position when discovering the unique configuration of the systemic reaction of individuals when its homeostasis is disturbed. In reporting the research, the researcher also moved between these different positions and tried to present interpretations of perceptions of trauma in a SHIP® context (Clarke & Braun, 2013). In this context, the movement between positions was observed when describing the client's interpretation of acute and developmental trauma (relativism) and psycho-education was used to explain the psychobiological processes that are activated when the human system perceives a threat (realism).

In light of the ontological position of critical realism and the epistemology of contextualism, the different components collectively referred to as trauma are discussed, namely: trauma-activating events; the impact of trauma-activating events; psychobiological survival responses; developmental trauma and trauma over the lifespan; and trauma spectrum manifestations.

An in-depth discussion of trauma is provided in Chapter 2, but for introductory purposes the different components of trauma, as indicated in the definition, are delineated shortly to indicate the gap in existing published SHIP® literature. The traumatic nature of everyday life experiences is determined by the subjective experience and meaning attached to them by victims (Scaer, 2005). This means that individuals are not necessarily equally traumatised by the same event. Any event with the potential to overwhelm the psychobiological resources of individuals is a trauma-activating event (JOS, 2002; Scaer, 2005; Steenkamp, Van der Walt, Schoeman-Steenkamp, & Strydom, 2012). Events that act as catalysts in evoking trauma ranges from acute/shock trauma to subtle (soft/“little”) traumas (Levine, 1997).

Acute trauma-activating events, also referred to as shock trauma, are defined as trauma that manifests when a single potentially life-threatening and dangerous traumatic incident occurs and the capacity of individuals to respond effectively to the threat is overwhelmed (Heller & LaPierre, 2012), such as natural disasters, sexual abuse, assault, rape, serious motor vehicle accidents, illness or medical procedures (Herman, 2001; Levine, 1997; Van der Kolk et al., 1996).

Subtle trauma-activating events can be identified as ongoing, hidden and intangible trauma-activating stimuli (Courtois & Ford, 2009; Heller & LaPierre, 2012). Exposure to an environment filled with domination, verbal assaults, abusive expectations, emotional blackmail and unpredictable responses are examples of potential sources of subtle trauma (Cloitre, 2012; Heller & LaPierre, 2012; Levine,1997; Scaer, 2005; Solomon & Siegel, 2003; Steenkamp, 2014). Trauma is a psychobiological experience that occurs when people feel helpless even in the absence of physical harm (Scaer, 2005).

Trauma-activating events have the following impact: When individuals are confronted with a perceived threat, complex integrated feedback responses are activated, which involve both physiological (the body) and psychological (the psyche) responses (Herman, 2001). A combination of psychological symptoms of emotional regulation difficulties (e.g., depression, anxiety, worry, phobias, feelings of hopelessness, feelings of helplessness, excessive guilt, shame, feelings of emptiness, powerlessness or inadequacy), disturbances in relational capacities (e.g., continual repetition of unhealthy relationship patterns, withdrawal, isolation, lack of trust, fear of abandonment, boundary problems), alterations in attention and consciousness (e.g., dissociation, problems with concentration, memory function, decision-making or distraction), and adversely affected belief systems (e.g., negative thinking patterns and beliefs about the self) can be experienced (Nijenhuis, Spinhoven, Van Dyck, van der Hart, & Vanderlinden, 1998). The choice between

fight/flight and immobility/freezing is not consciously made; it is an instinctive physiological reaction to promote safety and survival (Porges, 2011).

The development of trauma can be seen in the unsuccessful execution of the fight or flight response, resulting in a freeze response − also referred to in literature as the immobility response. Exposure to an overwhelming experience normally triggers an emergency response by launching a biochemical cascade of hormones. These stress hormones prepare organisms for the intense neuromuscular activity needed for mobilisation during a fight or flight response (Rothschild, 2000; Van der Kolk et al, 1996).

When the fight or flight response is unsuccessful, the immobility response − also known as the freeze response − is activated (Levine, 1997; Scaer, 2005). Freezing is an instinctive and unconscious survival reaction (Levine, 1997). This primitive response is wired into almost every organism and plays a key role in the development and shift of trauma symptoms (Herman, 2001). Scaer (2005) explains that dissociation is a perceptual experience and physiologically the same as freezing. The freeze response is characterised by dissociation due to a neurological disconnection and this process keeps the incomplete past in the present (Van der Kolk, 2001). The on-hold residual energy (energy that would have been expended during the fight or flight response) does not disappear but remains in the body (Levine, 1997) until it is processed and integrated (felt and experienced) through a very important physiological process called freeze discharge (Rothschild, 2000). The inhibition of the freeze discharge appears to be related to a sustained state of

helplessness, entrapment or disempowerment (Scaer, 2005). Unless the residual energy is released, individuals often remain stuck in a traumatic maze and continue to experience distress (Levine, 1997).

Psychobiological systems are characterised by self-regulation (Juhan, 2003). The autonomic **psychobiological survival response** associated with trauma involve the innate psychobiological process consisting of feedback that aims to achieve homeostasis (Porges, 2011; Ogden, Minton, & Pain, 2006). Overwhelming experiences contribute to psychobiological dysfunction and can set up a cascade of potential disorders (Ogden et al., 2006), thereby forming the basis for understanding the implications of complex traumatic stress (Courtois & Ford, 2009).

Developmental trauma stems from childhood (Heller & LaPierre, 2012) and may include acute traumas at an early age (Courtois & Ford, 2009; Heller & LaPierre, 2012) along with repetitive encounters of subtle and/or intense trauma-activating events (Heller & LaPierre, 2012; Steenkamp, 2014). The traumatic nature of everyday life experiences can be determined by the way they are experienced by individuals and the meaning attached to them. The meaning is grounded in earlier life exposure and has a cumulative effect on all facets of the life of individuals over time. The progressive loss of resilience is felt as accumulated negative life experiences build up over years of freeze/dissociation incidents (Nijenhuis et al., 1998; Porges, 2011; Scaer, 2005).

Over a lifetime, individuals can be exposed to multiple acute trauma incidents (Solomon & Siegel, 2003). An increase in developmental trauma exposure is associated with more complex adult dis-ease symptomatology (Putnam, Harris, & Putnam, 2013). Across a lifespan, symptoms resulting from recent trauma may not only be distressing, but may also serve to intensify dormant symptoms related to preceding unresolved trauma (Follette, Polusny, Bechtle, & Naugle, 1996).

Levine (1997) argues that trauma can be defined by the debilitating symptoms experienced after a trauma-activating event, which Steenkamp (2014) refers to as trauma-spectrum manifestations. Trauma produces profound and sometimes lasting changes in the psychobiological system of individuals (Bremmer, 2005; Myss, 1996), which can cause extensive dis-ease (Miller, 2000; Natalie & Middelbrooks, 2011). Dis-ease refers to multi-systemic changes, such as bodily pain, neurological impairments, emotional complaints and atypical behaviour − all of which are physical manifestations resulting from unresolved trauma (Herman, 2001; Levine, 1997; Scaer, 2005; Solomon & Siegel, 2003). Trauma-spectrum manifestations can be classified as Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (C-PTSD).

PTSD is a clinical manifestation of the failure to integrate traumatic memories (Ogden et al., 2006) resulting in chronic symptoms of re-experiencing, avoidance and hyper-arousal after a trauma-activating event(s). Research has found that the current PTSD diagnosis often fails to reflect the serious

psychological harm that occurs with prolonged and repeated trauma together with the impact of exposure to a range of different traumatic events over a lifespan (Follette et al., 1996; Natalie & Middelbrooks, 2011; Van der Kolk, 1987). For this reason, the diagnosis of C-PTSD has been incorporated. C-PTSD is characteristic of the complex consequence of exposure to repeated or prolonged occurrences or multiple forms of interpersonal trauma (Herman, 2001).

1.3 TREATMENT MODELS OF TRAUMA AND C-PTSD

Despite the attention given to accurately diagnose PTSD and C-PTSD, research and literature on effective psychobiological treatment models for C-PTSD (for all ages, including ageing individuals) are scarce. Consequently, the somatic symptoms commonly experienced by persons with C-PTSD are not addressed holistically.

Initially, treatment models focused on the process of evaluating thoughts and feelings regarding trauma (Van der Kolk et al., 1996). However, while normal memory can be described as “the action of telling a story” (Herman, 2001, p. 175), “traumatic memory differs fundamentally from other types of memory impacting on the effective functioning and wellbeing of clients” (Levine, 2015; MacNaughton, 2004). Van der Kolk (2001) explains that teaching individuals to safely experience their sensations and emotions has not yet received sufficient attention during psychological trauma treatment.

Specific body-oriented treatment techniques have been introduced to deal with trauma. The first of these treatments was articulated by Wilhelm Reich in 1937 (MacNaughton, 2004) and expanded in modern times to trauma-specific body-oriented work, such as Somatic Experiencing (SE) (Levine, 1997; Levine, 2005; 2015), Trauma and Tension Release Exercises (TRE) (Berceli, 2008), and Somatic motoric approach (Ogden et al., 2006), which focus on experiencing, tolerating and transforming trauma-related physical sensations.

In South Africa, the SHIP® Foundation was one of the first training schools in body-oriented treatment for registered psychologists. SHIP® is an assimilation of techniques from different modalities, including psychoanalysis, existential phenomenology, client-centred psychotherapy, behaviour therapy, biopsychosocial and psychoneuroimmunology, and Gestalt therapy. SHIP® was developed as a psychotherapeutic model for clients who have been exposed to trauma (Steenkamp et al., 2012) and focuses on the underlying emotional causes of somatic symptoms and dis-ease. Although not all medical conditions can be attributed to an underlying emotional cause, a great deal of research points to the fact that many bodily symptoms and diseases have a psychological undertone and meaning (e.g., stomach ulcers, a spastic colon, chronic pain, excessive sweating, chronic fatigue, a chronic urinary tract infection) (Scaer, 2005; Steenkamp et al., 2012).

The basic premise underpinning SHIP® is that traumatised clients are in a continuous process of spontaneous healing and self-regulation.

> Spontaneous healing reactions (SHRs) are part and parcel of this process within the individual specific field (ISF) and when this self-regulatory state is interfered with, trauma is defined. The subsequent chronic internal dysregulation results in a chronic dis-ease that manifests through intra- and inter translators. These translators' main function is to point out that the person is living at the expense of free-flowing energy within the ISF. The innate movement of the ISF is therefore towards releasing on-hold and disconnected SHRs so that the person may live an uncompromised life (Steenkamp et al., 2012, p. 210).

1.4 AGEING PEOPLE AND TRAUMA

Trauma is not limited to a specific age group, but ageing individuals may be particularly vulnerable. Over the course of a lifespan, individuals are exposed to trauma-activating events and when they reach old age, many have to deal with the impact of accumulated trauma (Van der Kolk et al., 1996). From a developmental perspective, ageing individuals are also challenged to adapt to declining abilities (a loss of hearing, eyesight, mobility and cognitive functions) and multiple death-related losses and other losses (Louw & Louw, 2009) – all impacting on the synchronic interaction of various systems of individuals (Johnson, 2005). As individuals age, they adjust to ageing and they deal with developmental trauma and/or adverse events. The flexibility of this adjustment is called plasticity (Van der Kolk, 2007). Plasticity tends to reduce over time

and individuals become more rigid as they age. It is, therefore, not uncommon for adult patients who experienced traumatic events to suffer minimal effects from those events until their later years (Van der Kolk, 2007). As individuals age, their defensive structure starts breaking down (Herman, 2001). Consequently, a large proportion of the population with a history of trauma function by maintaining a rigid problem-solving focused stance (Ladson & Bienefeld, 2007).

1.5 PROBLEM STATEMENT

By 2030, the world's ageing population is expected to have grown to over 998.7 million (He, Goodkind & Kowal, 2016). Very little research has been done on treatment methods for ageing clients who exhibit trauma symptom clusters (Foa, Keane, & Friedman, 2009). Psychotherapy for ageing individuals mainly focuses on cognitive-behavioural, interpersonal and problem-solving psychotherapy approaches (Dinnen, Simiola, & Cook, 2015; Foa et al., 2009; Thakur, 2015).

These approaches tend to miss important clues that can unveil the trauma history of clients (Herman, 2001). A study done on the treatment of PTSD in ageing adults found that clinical literature on the topic often implies that cognitive-behavioural treatments may be ineffective or inappropriate for ageing adults in view of their physical and cognitive vulnerabilities (Clapp & Beck, 2012).

There is also little support for the claim that interventions are ineffective when PTSD is treated among ageing people (Clapp & Beck, 2012). Numerous studies suggest that psychotherapy is more effective in the treatment of mental health issues in ageing adults than treatment with medication (Alecopoulos & Kelly, 2009; Clapp & Beck, 2012). However, studies have revealed that even though ageing individuals prefer psychotherapy to medication, they are rarely offered psychotherapy as a treatment option (Giverns et al., 2006; Gum et al., 2010). Very little research has been done on an integrated psychobiological treatment model for ageing clients who exhibit C-PTSD symptom clusters (Foa et al., 2009). According to Ebert and Dyck (2004), individuals presenting with C-PTSD do not respond well to standard exposure treatments for PTSD. Although cognitive behavioural therapy is used as an evidence-based therapy (Levine, 2015), it is effective in resolving PTSD and related symptoms among victims of chronic and prolonged trauma, including those whose trauma occurred in early life. However, it is not known whether this type of therapy provides an optimal outcome in dealing with the prolonged and repeated nature of trauma and with problems in self-regulation (Cloitre, 2012; Cloitre et al., 2011). Studies, have, however, demonstrated the effectiveness of a combined phase-based approach in which the sequenced addressing of stabilisation skills with regard to repeated trauma was found to be of value. Limited studies have explored the effectiveness of alternatives for individuals with complex trauma histories, focusing primarily instead on C-PTSD symptoms (Cloitre, 2012; Cloitre et al., 2011).

For the purpose of this research, SHIP® is proposed as a treatment method. The research question that guided this research was: What shifts towards healing take place in an ageing individual who presents with C-PTSD who volunteered for an integrated psychobiological treatment model, SHIP®?

1.6 PURPOSE OF THE STUDY

The aim of the research was to explore an ageing individual's experience of C-PTSD and spontaneous healing shifts during SHIP® therapy. A focus on the biopsychosocial model and its application in psychotherapeutic approaches was, therefore, proposed, because research has shown that psychosocial factors affect the onset and course of almost all chronic physical disorders (Dogar, 2007; Suls & Rothman, 2004).

1.7 A BIOPSYCHOSOCIAL PERSPECTIVE

A link between accumulated trauma and mind-body dis-ease is well documented (Coates, 2010). Across a lifespan, trauma impacts on the social, psychological and biological domains of individuals with complex consequences. It is now universally acknowledged that illness and health are the outcomes of a connection between biological, psychological and social factors (Alonso, 2004; Jacovlejevic et.al, 2012). Symptoms associated with trauma fuse with the biopsychosocial development of individuals and keep repeating in relationships and experiences throughout life (Coates, 2010). A biopsychosocial perspective explains complex trauma manifestations experienced by individuals as a multisystem dis-ease (Jacovlejevic et al., 2012).

A biopsychosocial perspective specifically promotes the idea that illness and health are the result of an interaction between biological, psychological and social factors (Dogar, 2007; Engel, 1980; Suls & Rothman, 2004) as illustrated in Figure 1:

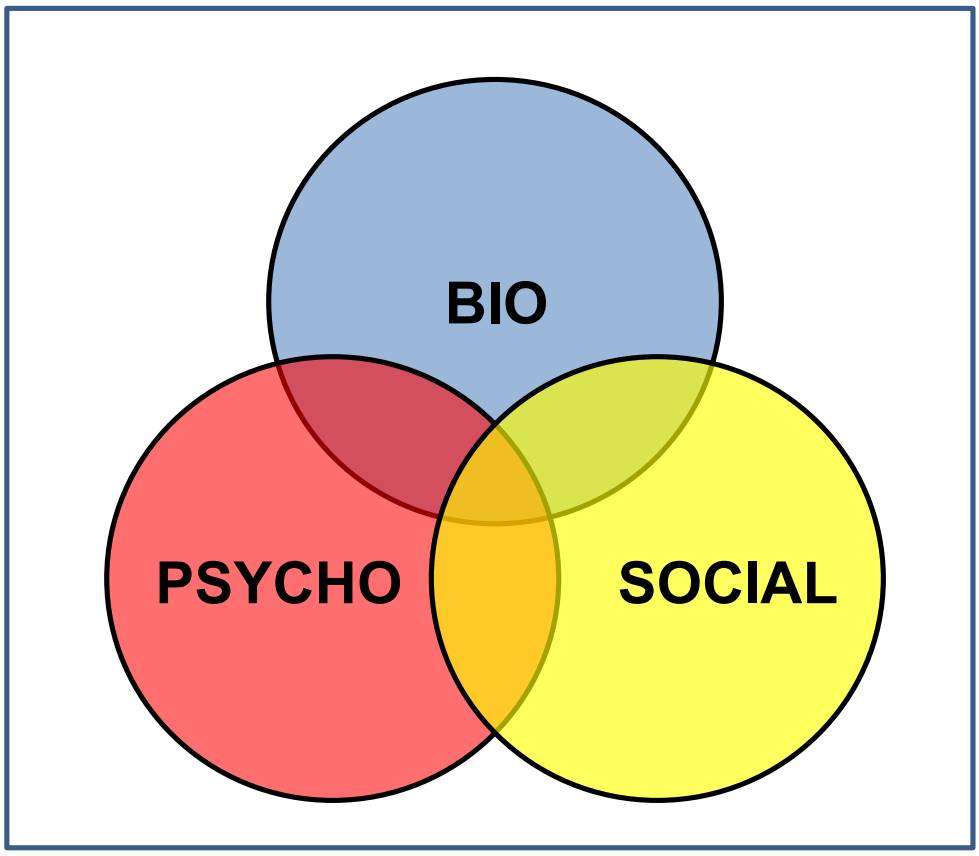

Figure 1: Biopsychosocial interconnectedness (Dogar, 2007).

The biological system embraces the anatomical, structural and molecular substrate of diseases and the reciprocal effects on the biological functioning of individuals. The social system weighs the cultural, environmental and familial impacts on the experience of dis-ease or illnesses. The psychological system

describes the effect on the psychodynamic aspects of individuals, such as motivation and personality, and the experience of and emotional reactions to the biological and social systems (Alonso, 2004; Dogar, 2007). The psychological system also encompasses emotional aspects, such as anxiety, worry, phobias, feelings of hopelessness and helplessness, guilt, shame, feelings of emptiness, powerlessness or inadequacy, and relational dimensions, such as patterns of withdrawal, isolation, boundary difficulties or control issues, and cognitive functioning, such as attention, concentration, memory function and decision-making faculties (Cloitre, 2012; Courtois & Ford, 2009; Heller & LaPierre, 2012; Herman, 2001; Van der Kolk et al., 1996). Most importantly, trauma affects memory function, which interferes with "all other experiences, spoiling an appreciation of the present moment" (Levine, 2015, p. 2).

A biopsychosocial perspective is a broader and more integrated approach to trauma-spectrum manifestations than the biomedical model, which is based on the pure linear biological aspects of medicine (Dogar, 2007). A biopsychosocial perspective was constructed to take into account the missing dimensions (psychological and social) of the biomedical model (Engel, 1980) and is now the conceptual base used by many psychologists (Suls & Rothman, 2004). Biopsychosocial thinking has created a cognitive shift from seeing parts of a system to seeing the whole system (Jacovlejevic et al., 2012).

A biopsychosocial perspective can be linked to a science of wholeness, and is a means of explaining progressively complex systems (Friedman & Allen, 2011). In complex systems, each level in the hierarchy represents an organised dynamic whole. A biopsychosocial perspective embodies a conceptual framework within which both organised wholes and component parts can be studied − each system is a component of a higher system (Engel, 1980). As illustrated in Figure 2, life is systematically arranged on a hierarchical continuum with more complex and larger units superior to less complex and smaller units (Engel, 1980). Bronfenbrenner (1979) explained that the levels of a system appear to be arranged hierarchically: Each successive level is more intricate than the preceding one and encompasses all the subsystems that form the foundation. The hierarchy is depicted as nested structures (Figure 2), which are inextricably linked to one another. Von Bertalanffy (as cited in Friedman & Allen, 2011) endorses the organismic conception found in biology in which an organism is considered to be a whole system. This leads to the basic assumption that “the whole is more than the sum of its parts” (p. 9). Nothing exists in isolation (Engel, 1980): The cell organelles operate within the context of a cell, the cell within the context of a body, the body within the context of an individual, the individual within the context of humanity, and humanity within the context of the cosmos (Friedman & Allen, 2011; Jacovlejevic et al., 2012).

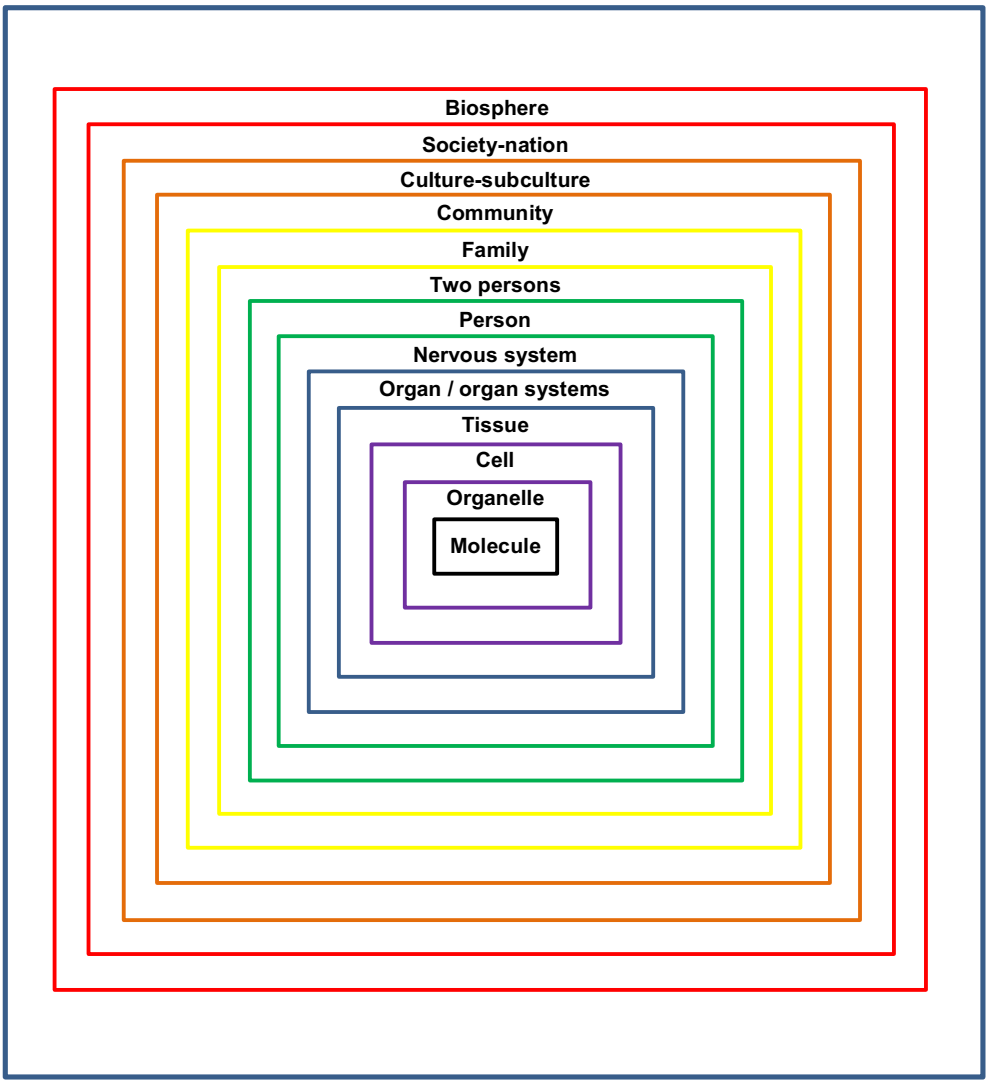

Figure 2: Continuum of Natural Systems (Bronfenbrenner, 1979).

Becvar and Becvar (2012) describe the organisation of levels in a hierarchy of systems as consisting of two parts, namely the social hierarchy (e.g., society, culture-subculture, a community, a family) and the organismic hierarchy (nervous system, organ system, tissues, cells, organelles, molecules, atoms and subatomic particles). The experiences and behaviour of individuals may be the link between these two aspects of the whole. Figure 3 illustrates the hierarchy of natural systems. All of the systems interact and serve as both

causes and effects of a particular condition. It is important for psychotherapists to understand the dynamic nature of this interaction between systems (Friedman & Allen, 2011). Change depends on and is possible because of interaction taking place between all of the bodily systems. Each individual is an independent, self-regulating system – a change in a particular system level causes a reactive change in higher or lower level systems (Friedman & Allen, 2011).

The above-mentioned perspective suggests that biological, psychological and social processes are interactively involved in physical and emotional dis-ease (Suls & Rothman, 2004). Initially, the controversial premise that the psychological experiences and social behaviours of individuals are mutually related to biological processes has fuelled dramatic advances in psychology over the past 25 years (Engel, 1980; Friedman & Allen, 2011; Suls & Rothman, 2004). Moreover, the premise that these subsystems are nested and inextricably connected has stimulated innovation in the design and implementation of interventions to promote health (Suls & Rothman, 2004). The biopsychosocial perspective as a guiding framework has proved remarkably successful (Friedman & Allen, 2011). This perspective has placed psychologists at the forefront of undertakings to develop a multilevel, multisystem approach to human functioning (Suls & Rothman, 2004). As a meta-theory for understanding (Engel, 1980), a biopsychosocial perspective introduces order into the complexity of human diseases. The development of appropriate intervention strategies for a particular client requires consideration of the client in relation to the broader context.

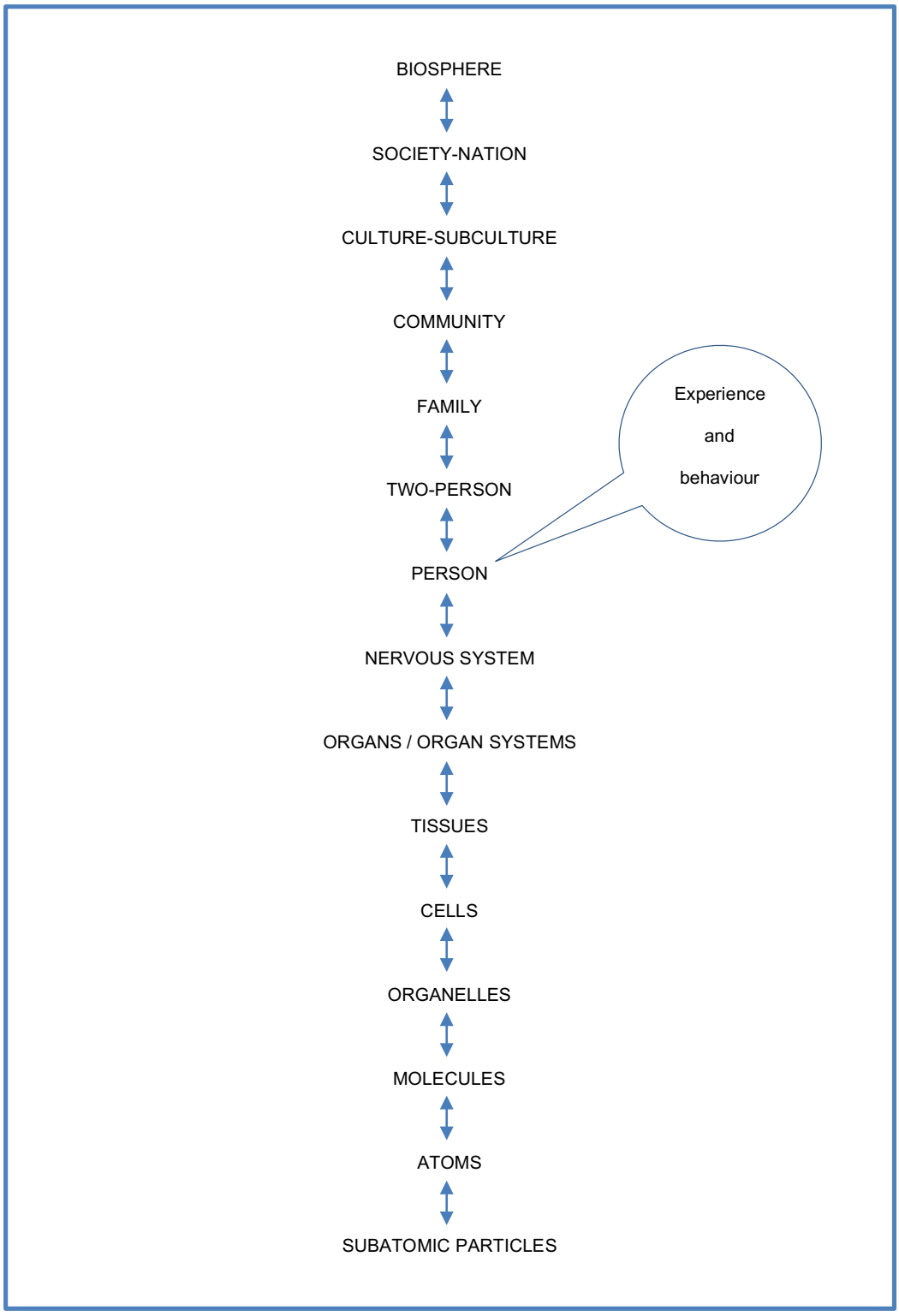

Figure 3: Hierarchy of Natural Systems (Levels of Organisation) (Friedman & Allen, 2011)

Psychotherapists should keep the hierarchy and continuum of natural systems (illustrated in Figures 1, 2 and 3) in mind as a guide to ensure interrelatedness between systems (Engel, 1980).

A biopsychosocial perspective is a means of organising information rather than explaining observations. An important distinction between this perspective and psychotherapy is the way psychotherapists use psychological theories to aid them in the practical application of this perspective when treating individuals with C-PTSD (Friedman & Allen, 2011). Friedman and Allen (2011) are of the opinion that substantial contemporary treatment models that connect the biological, psychological and social systems are needed when direct psychotherapeutic intervention is used (Friedman & Allen, 2011). SHIP® is such an approach.

1.8 STRUCTURING THE RESEARCH

This study contains a narrative literature review, including a theoretical and practical component. The content of each chapter is summarised as follows:

Research done on trauma, the theory of trauma interventions and C-PTSD are discussed in Chapter 2 and indicates that C-PTSD has a multifaceted and far-reaching systemic effect on individuals. Chapter 3 focuses on the frame of reference of psychotherapists, starting with biopsychosocial theory as meta-theory and concluding with the integrated SHIP® trauma-spectrum model for the treatment of C-PTSD. This chapter contains an explanation of the theoretical framework of the SHIP® trauma-spectrum model. Lastly, the basic

concepts and theoretical constructs are described. Chapter 4 describes the research method used in this study. Reasons are provided for why qualitative research was chosen as the preferred method of inquiry. The research context and participant are described. Data gathering and the analysis of data are discussed and the legitimisation and validity of qualitative research are highlighted and placed in the context of this study. Chapter 5 contains the findings of the study. The experiences of the research participant concerning C-PTSD and the shifts that took place during the course of SHIP® are described and literature is used to critically discuss the findings. Chapter 6 concludes the research study. A critical reflection is provided, contributions to theory are discussed while recommendations for future research are made.

CHAPTER 2: THE CLASSIFICATION, ETIOLOGY, CHARACTERISTICS AND IMPLICATIONS OF TRAUMA

Trauma is a psychophysical experience − even in the absence of physical harm − and is experienced when individuals feel overwhelming helplessness (Scaer, 2005). In recent years, trauma has become a familiar part of the lives of individuals, irrespective of where they live (Norris & Slone, 2013). Research in the United States of America indicates that traumatic event exposure is high (89.7%) and exposure to multiple traumatic events during a lifespan is the norm (Kilpatrick et al., 2013). In South Africa, one may infer that the exposure to traumatic events is probably much higher as a result of the high crime rate, violence and history of political instability. In addition, individuals in South Africa are bombarded with continuous personal or indirect exposure to incidents of violence, such as rape, hijacking, murder, armed robbery and abuse (Williams et al., 2007; Herman et al., 2009). These traumatic events do not even include the continuous subtle traumas to which individuals are exposed. Despite the nature of traumatic incidents, individuals are differently affected by the impact of trauma. Their personal predisposition (including age), subjective assessment and resources (personal, social and environmental) determines how they deal with the impact of trauma (Cloitre et al., 2009; Follette et al., 1996; Van der Kolk et al., 1996).

The purpose of this chapter is to provide a literature overview of the development and implications of trauma; a discussion of trauma-activating events; the impact of different trauma-activating events; and the development of trauma from a systemic perspective.

2.1 TRAUMA-ACTIVATING EVENTS

Trauma-activating events are any events with the potential to overwhelm the psychobiological resources of individuals (JOS, 2002; Scaer, 2005; Steenkamp et al., 2012). Our understanding of what is considered a traumatic life or trauma-activating events (Steenkamp, 2014) has evolved considerably over the past century (Scaer, 2005). The nature of traumatic events that act as catalysts in evoking trauma ranges from acute/shock trauma to subtle (soft/“little”) traumas (Levine, 1997).

2.1.1 Acute/shock trauma

Acute trauma, also referred to as shock trauma, is defined as trauma that manifests when a potentially life-threatening and dangerous experiences occur and the capacity of individuals to respond effectively to a threat(s) is overwhelmed (Heller & LaPierre, 2012). This type of trauma can be caused by blatant, single traumatic incident events known as intense trauma-activating events (Steenkamp, 2014) and can include natural disasters, sexual abuse, assault, rape, serious motor vehicle accidents, illness or medical procedures (Herman, 2001; Levine, 1997; Van der Kolk et al., 1996). Acute trauma can also be caused by being a victim or witnessing a traumatic incident happening to someone else (Scaer, 2005; Van der Kolk et al., 1996).

2.1.2 Subtle trauma

Subtle trauma-activating events are ongoing, hidden and intangible trauma-activating stimuli (Courtois & Ford, 2009; Heller & LaPierre, 2012). Societal and culturally endorsed trauma through male initiation schools and rituals and the involuntary female circumcision of young girls are examples of subtle trauma. Another potential source is governmentally instilled fear to justify a war or restrictions placed on personal freedom, as illustrated by the military conscription of white South African males in former years. Exposure to violence though the media (especially if individuals are not warned about the sensitive nature of the reports/images); domination; verbal assaults; abusive expectations; emotional blackmail and unpredictable responses are other examples of potential sources of subtle trauma (Cloitre, 2012; Heller & LaPierre, 2012; Levine, 1997; Scaer, 2005; Solomon & Siegel, 2003; Steenkamp, 2014).

2.2 IMPACT OF TRAUMA-ACTIVATING EVENTS

Trauma − whether in the form of an overwhelming impact caused by an acute, devastating incident or subtle, trauma-activating events − activates both body and mind, because individuals feel trapped compounded by a consequent overwhelming feeling of helplessness (Cloitre, 2012; Heller & LaPierre, 2012; Porges, 2011). The perception of loss of control, emotional dependency or emotional wounds produces the same effects as actual physical wounds (Kooker, 2004; MacNaughton, 2004).

When individuals are confronted with a perceived threat, complex integrated feedback responses are activated, which involve both physiological (body) and psychological (psyche) responses (Herman, 2001; Kooker, 2004). Physical responses comprise three potential neurochemical responses that may occur when individuals are threatened with danger, namely fight, flight or freeze. However, fight or flight responses are automatic arousal reactions whereas the freeze response is a reaction of suppression (Johnson, 2009; MacNaughton, 2004). In terms of a psychological reaction, the choice between fight or flight and immobility/freezing is not consciously made; it is an instinctive physiological reaction to promote safety and survival (Porges, 2011). Porges (2011) uses the term “neuroception” to describe this instinctive reaction.

2.2.1 Fight or flight response

The development of trauma can be understood from the perspective of successful or unsuccessful fight or flight responses. The fight or flight stress response begins with an actual or perceived threat, activating sensory centres in the cerebral cortex (Johnson, 2009). The amygdala houses the emotional memory and is instantly activated when danger is sensed (Juhan, 2003; LeDoux, 1998; Rothschild, 2000). The amygdala functions independently and instantaneously on instinctive triggers of a perceived threat or danger when the freedom of choice of

individuals is negated. The amygdala overrides the neocortex, the thinking sector of the brain (LeDoux, 1998).

Exposure to an overwhelming experience triggers an emergency response, launching a biochemical cascade of hormones. The hypothalamus is activated and produces corticotrophin-releasing factor (CRF). CRF is a hormone that sends signals to the pituitary and adrenal glands. In response, these two glands flood the bloodstream with stress hormones: adrenaline, noradrenaline and cortisol (Johnson, 2009). These stress hormones prepare individuals for the intense neuromuscular activity needed for mobilisation during a fight or flight response (Rothschild, 2000; Van der Kolk et al., 1996).

The hippocampus simultaneously evaluates the situation by comparing new information with past memory associations (Rothschild, 2000). If the situation is perceived as dangerous or life-threatening, a full-blown fight or flight response is initiated. The same stress hormones instantaneously halt any body functions that are not essential for survival, such as digestion, immunity, hunger and libido (Juhan, 2003).

The body is then activated into mobilisation: blood pressure rises and the heart rate increases. Internal blood vessels are constricted to force oxygen-rich blood to the muscles of the extremities

(Porges, 2011). Breathing also quickens in response to an urgent need to sustain the increased oxygen supply. A vast amount of energy is generated in preparation for a fight or flight response (Porges, 2011). The liver contributes by blasting muscle tissue with high dosages of glucose. While all this is happening, the brain also releases endogenous opioids − pain-killing neurotransmitters. This self-protective response ensures that individuals are not distracted by pain while trying to fight or flee from danger. During a fight or flight manifestation, a huge amount of energy and tension is released (Ogden et al., 2006; Van der Kolk et al., 1996). As a result, action occurs even before individuals think about why they are reacting (Rothschild, 2000; Levine, 2015). Levine (1997, p. 96) states that on a biological level, survival is paramount regardless of how one gets there: “The objective is to stay alive until the danger has passed and deal with the consequences later.”

The equilibrium of a body is returned once the threat has passed and the parasympathetic nervous system has been activated (Porges, 2011). Acetylcholine is the neurotransmitter responsible for modulating the “coming down” process after the intense energy discharge phase. The heart rate slows, the blood pressure normalises and blood flow is stabilised throughout an individual. Digestion is reactivated and sexual interests are normalised (Rothschild, 2000).

2.2.2 Freeze response

When a fight or flight response is unsuccessful, the immobility response (also known as the freeze response) is activated (Levine, 1997). Scaer (2005) describes this response as an unsuccessful attempt to fight or flee and leads to the shutting down or immobilisation of the psychobiological system. Herman (2001, p. 34) defines the freeze response as follows:

> Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defence becomes overwhelmed and disorganised. This causes the psychobiological system to resort to the most basic level of survival, the freeze response.

Freezing is an instinctive and unconscious reaction (Fogel, 2013; Levine, 1997). Levine (1997) explains that the helplessness experienced during a freeze response is so intense that the sense of being of individuals (feeling/experiencing/reacting) is completely immobilised. A freeze response cannot be imagined, perceived or reasoned as an option. It is a real physical reaction activated by a body − a sort of paralysis – and individuals cannot react by screaming, moving or feeling (Rothschild, 2000). This immobilisation forms part of the defence system, which is employed while under threat. Individuals are rendered helpless and are unable to defend themselves or to flee from danger (Van

der Kolk, 2001). This primitive response is wired into almost every organism and plays a key role in the development and shift of trauma symptoms (Herman, 2001).

Scaer (2005) explains that dissociation is a perceptual experience and physiologically the same as freezing. The focused and super-alert mind becomes stunned or anaesthetised with an impairment of access to memory storage, resulting in amnesia for some or all of the distressing experiences during trauma-activating events (Porges, 2011). Freezing or dissociation is a common primitive biologically driven immobilisation response that involves a sense of unrealness, a feeling of detachment from what is happening, a dulling of bodily pain, emotional aloofness and an altered sense of time and place (Solomon & Siegel, 2003). When freezing, a body undergoes enormous biochemical extremes. During a state of on-hold energy, additional doses of endorphins are released. In this on-hold state, responses recoil from extreme tension to near paralysis or debilitation. The body enters a biologically enforced vegetative state while still containing huge amounts of undischarged biochemical residual energy (MacNaughton, 2004; Rothschild, 2000).

A freeze response is characterised by dissociation due to a neurological disconnection and this process keeps the incomplete past in the present (Van der Kolk, 2001). The on-hold residual

energy (energy that would have been expended during a fight or flight response) does not disappear but remains in the body (Levine, 1997). The uncompleted psychobiological experiences of an incident of trauma are stored as unconscious memories until these memories can be processed and integrated (felt and experienced). The process of sorting out, saving and discarding memories is achieved through a very important physiological process, called a freeze discharge (Rothschild, 2000).

There are many variations of a freeze discharge response − from movements as vigorous as patterns resembling a grand mal seizure or as subtle as slight twitching (Levine, 1997; Ogden et al., 2006). The difference between animal and human reactions provides a benchmark for health and vitality. According to Levine's (1997) insight into the instinctual biological healing process of wild animals, reactions after being confronted with real or perceived threats are helpful. Wild animals instinctively discharge the activated energy through an energy discharge sequence once the environment has been found to be safe. While animals continue to suffer from lingering trauma symptoms, there is, however, a return to a natural, self-regulating equilibrium (Levine, 1997; MacNaughton, 2004; Payne, Levine, & Crane-Godreau, 2015). Animals tremble and show signs of reorientation to their surroundings. In contrast, humans have learned to override this self-regulating response with their highly evolved neo-cortex (the

> neo-cortex is synonymous with the brain hemispheres responsible for cognitive functioning, perception, observation and reasoning), because of the fear to experience powerful sensations (Levine, 1997; Ogden et al., 2006). The unwillingness of humans to go through the discharge response of shuddering, perspiring and breathing deeply can be attributed to the assigned negative stigma associated with these responses. Such responses are often viewed as cowardly, weak and incompetent (Levine, 1997). Helplessness and immobility may also be experienced as character flaws (Scaer, 2005).
>
> The inhibition associated with a freeze discharge appears to be related to a sustained state of helplessness, entrapment or disempowerment (Scaer, 2005). Individuals tend to spend a lot of time narrating their experiences, expressing pent-up emotions of anger, fear and frustration “but without passing through the primitive immobility responses and releasing the residual energy. They will often remain stuck in the traumatic maze and continue to experience distress” (Levine, 1997, p. 21).

The impact of trauma-activating events is more intense if these events are human-made incidents. Human-made incidents are perceived to be a deliberate attempt to target fellow human beings (Van der Kolk et al., 1996).

2.3 THE PSYCHOBIOLOGICAL INTERPLAY IN TRAUMA

Psychobiological systems are characterised by self-regulation (Juhan, 2003). Self-regulation is an essential process that is needed for optimum effective functioning and may be either intentional or autonomic (Courtois & Ford, 2009; Solomon & Siegel, 2003; Steenkamp, 2014). Intentional self-regulation refers to the conscious capacity of individuals to alter their behaviour in order to achieve goals (Botha, 2013; Ogden et al., 2006; Porges, 2011). Autonomic self-regulation involves innate psychobiological processes consisting of feedback that aims to achieve homeostasis (Ogden et al., 2006; Porges, 2011). This optimal functional range is obtained through physiological or behavioural shifts (Ogden et al., 2006; Porges, 2011). Steenkamp (2014) explains that through the system's drive to maintain balance, it spontaneously and constantly rearranges itself, makes corrections and shifts towards its optimal healthy blueprint. Overwhelming experiences contribute to psychobiological dysfunction and can set up a cascade of potential disorders (MacNaughton, 2004; Ogden et al., 2006). Biological dysregulation takes place when autonomic self-regulation affects how individuals think, feel and behave (Van der Kolk, 1987). Ford and Courtois (2009, p. 31) states that "self-regulation serves as the organising framework" for understanding the implications of complex traumatic stress.

When the on-hold activated energy does not move through the freeze discharge process, it leads to a constant state of alarm. The more activated individuals are, the more susceptible they are to activation. The capacity of

activators with declining potency to produce the same response over time is referred to as kindling or chronic neurosensitisation (Solomon & Siegel, 2003).

The kindling feedback loop, if not stopped, continues to run automatically. The amygdala is continuously being triggered into an alarm state by external and internal activators/triggers (LeDoux, 1998). Over time, the excitability threshold lowers, leaving the system more sensitive to activation (Van der Kolk et al., 1996). Activated psychobiological experiences may be overt, for example flashbacks or nightmares, and may be activated by a remembered odour, the movement of a shadow or the form of a familiar landscape. These activators are not only activated by external triggers, but also by internally activated sensations, which can trigger arousal (Scaer, 2005; Van der Kolk et al., 1996). Every time the amygdala is activated, more adrenaline, noradrenalin and cortisol are produced − activating the same muscle and nerve fibres as before. Activation energy is, therefore, continuously being released and repeatedly being put on hold (Miller, 2000).

Miller (2000) explains that individuals will continue to move backwards and forwards between sympathetic adrenalized stimulations and parasympathetic analgesic freezes. This movement can become a vicious cycle of entrapment (Johnson, 2009) if all of the on-hold activation energy is not processed. Shortly after trauma has taken place − and even years afterwards − when there is accumulated trauma as well, individuals can easily be activated into an alarm state again.

Over time, the system tips over to the other side, however, and individuals spend more and more time in a parasympathetic state of shutdown, dissociation and numbness with occasional spikes of hyper-arousal and periods spent in an alarmed state (Miller, 2000; Scaer, 2005). This progressive sensitisation or kindling explains why there is a spiralling tendency towards a cumulative collection of chronic somatic dis-ease. The undischarged energy accumulates in the nervous system and forms the foundation for the manifestation of trauma-spectrum symptoms (Scaer, 2005), including symptoms referred to as trauma-spectrum manifestations (Steenkamp, 2014).

A compromised capacity for self-regulation can have an adverse impact on individuals across their lifespan. Contemporary trauma literature indicates that one of the most significant after-effects of developmental and shock trauma is the resulting lack of autonomic self-regulation (Heller & LaPierre, 2012).

In the last 20 years, considerable advances in the field of neuroscience have established and documented the biological foundation and psychological importance of affect regulation along with interpersonal and social connection (Solomon & Siegel, 2003). Significant developments in affective neuroscience consist of Siegel's interpersonal neurobiology, which explains the role of the neural substrate of relationship (Solomon & Siegel, 2003), Schore's regulation theory, which documents the critical function of the right orbitofrontal cortex in supporting resonant content and the repair of attachment wounds (Schore, 2009; Heller & LaPierre, 2012), and Porges's, Polyvagal Theory together with his focus on the role of the social engagement system (SES) (Porges, 2011).

The Polyvagal Theory widens our comprehension of the autonomic nervous system by explaining how the evolutionary, layered development of our brain and nervous system influence our capacity to alter between defence strategies or a socially engaged sense of safety and connection (Porges, 2011). 'Neuroception' is a term used by Porges (2011) to describe how this neural circuits differentiate whether conditions and/or individuals are safe, dangerous or life threatening (Fosha, Siegel, & Solomon. 2009). Furthermore, Porges (2011) highlights the development of two vagal systems. The two aspects of a polyvagal system are respectively referred to as the dorsal vagus (the more primitive structure that oversees primitive defensive survival strategies and initiates the freeze response) and the ventral vagus (a limbic-based system, which controls sympatric arousal through social engagement), because individually they support different adaptive functions. The ventral vagus aids the ability of individuals to communicate though social engagement (eye contact, facial expressions, tone of voice, the ability to listen). The ventral vagus also calms the heart − as the heartbeat slows, individuals feel calmer and become more open for connection. The goal of social engagement is the diffusion of aggression and tension to provide safety through connection (Porges, 2011).

The two branches of a vagal system are depicted as hierarchical. If social engagement is a feasible choice, the newer ventral vagus guides the responses of individuals. If, however, safety through social engagement and connection is not possible, the system falls back on the dorsal vagus and the

system prepares for survival. Consequently, the ventral vagus fails to mature fully and social development is impaired with lifelong implications (Porges, 2011). The Polyvagal Theory explains how social engagement (the ventral vagal) is a more developed way of managing sympatric arousal states than a dorsal vagal freeze. With developmental trauma, the only option is to go into a freeze or dissociation (Heller & LaPierre, 2012; Nijenhuis et al., 1998). This is important for C-PTSD clients whose capacity for interpersonal connection, social engagement and self-regulation have been compromised who can be assisted during psychotherapy with nervous system regulation (Courtois & Ford, 2009).

Trauma interventions theory emphasises the need for nervous system regulation (Courtois & Ford, 2009; Levine, 2005; Solomon & Siegel, 2003). The principle techniques used to support nervous system regulation are containment, grounding, orienting, titration and pendulation (Levine, 2015).

Working within the range of resilience of clients − also referred to as a ‘window of tolerance’ by Levine (2005) − supports **containment**. It is important that clients are able to work in psychotherapy with their difficulties while at the same time they stay grounded in their bodies and in the here-and-now moment. This can be facilitated by regularly asking questions where the answers clarify the various internal states, both visceral (interoception) and musculoskeletal (proprioception and kinesthesis) together with cognitive and emotional experiences (Heller & LaPierre, 2012; Payne et al., 2015).

Grounding is a basic technique commonly used in body-centred psychotherapies (Berceli, 2008; Levine, 2015). Grounding functions as an antidote to disconnection, helping to literally bring awareness back into the body, supporting reconnection by being mindfully present in the here-and-now together with nervous system regulation (Berceli, 2008; Levine 2015). Grounding should not be forced, it needs to be done gradually in a way that is manageable and should not overwhelm clients. Dissociated clients can find it difficult, if not impossible, to ground themselves during the early stages of psychotherapy. Grounding and orienting are seemingly simplistic but valuable tools, because − as clients ground them in and orient themselves to their surroundings − they come into the here-and-now and at the same time they begin to surface from disconnection (Berceli, 2008; Levine 2005).

Trauma interventions theory advises not to focus on trauma-activating experiences until clients have gained some capacity to settle, ground and self-regulate (Courtois & Ford, 2009; Levine, 2005; Solomon & Siegel, 2003). When some capacity for self-regulation is obtained through containment, traumatic experiences should be approached slowly and gently. Levine (2005) describes a technique called **titration**. He borrowed this concept from chemistry. The analogy communicates the importance of taking highly charged on-hold activation energy − one manageable fragment at a time, which ensures that the discharge is gradually − and to facilitate the integration of highly-charged affect to help avoid catharsis. Trauma histories that are not titrated effectively, can be overwhelming and disorganising (Levine, 2005). Knowing when and how to titrate effectively, is an art that requires continual

adjustment according to the growing healing capacity and rhythm of clients (Levine, 2005; Heller & LaPierre, 2012).

2.4 DEVELOPMENTAL TRAUMA AND TRAUMA OVER A LIFESPAN

2.4.1 Developmental trauma

Developmental trauma stems from childhood (Heller & LaPierre, 2012) and can include acute traumas suffered at an early age (Courtois & Ford, 2009; Heller & LaPierre, 2012) and repetitive encounters of subtle and/or intense trauma-activating events (Heller & LaPierre, 2012; Steenkamp, 2014). Traumas experienced by children include, but are not limited to, on-going cruelty, neglect and abuse due to a lack of safe and secure primary caregivers (Lanius, Vermetten, & Pain, 2010).

The ability of self-regulation is firstly learned by infants through an intimate relationship with their primary caregivers, also referred to as attachment (Schore, 2009; Solomon & Siegel, 2003). When the connection between infants and their mother/primary caregiver is disrupted, the impact is traumatic for infants (Solomon & Siegel, 2003). The connection can be disrupted by chronic depression, anxiety, anger or dissociation of mothers or primary caregivers. A sense of self of individuals develops primarily during the childhood developmental phase. When one of the basic needs of children is not met, autonomic self-regulation, a sense of self and self-esteem

are compromised (Ogden et al., 2006; Schore, 2009). During this development, disruptions to the spontaneous rhythm prevent children from achieving maturation and individuals continue to view the world from the perspective of a child. The implications of trauma experienced during the developmental stage are taken up by recurring experiences and trauma is frozen.

When children do not receive the connection they need, they grow up both seeking and fearing connections (Heller & LaPierre, 2012). The more the biologically-based core needs of individuals are met early in life, the more likely they are to develop abilities within themselves that allow them to identify and meet their needs as adults (Solomon & Siegel, 2003; Van der Kolk et al., 1996).

Contemporary findings in studies on developmental traumatology confirm that the cumulative effects of developmental trauma have an adverse effect on neurological development and the endocrine system (Lanius et al., 2010; Van der Kolk et al., 1996). The impact of the ‘too-muchness’ of developmental trauma overloads the capacity of individuals to self-regulate in the face of on-going autonomic activation (Ogden et al., 2006). The chronicity of developmental trauma is a leading cause of dysregulation and associated symptoms that lead to numerous psychological and physiological dis-eases (Courtois & Ford, 2009).

Over time, these subtle stimuli can change brain function and resultant behaviours in elusive ways (Cloitre, 2012). Consequently, a foundation is laid for restricted coping styles and responses to threats, resulting in a loss of resiliency (Scaer, 2005; Steenkamp, 2014). A loss of resiliency in the psychobiological system leads to an increased deterioration in social functioning and the health of individuals (Cloitre, 2012; Steenkamp, 2014).

Multiple trauma-activating events are the rule rather than the exception (Green et al, 2000). Individuals with a trauma history are likely to have experienced more than one episode of trauma-activating events (Cloitre et al., 2009).

Developmental trauma is a strong predictor of future exposure to activating events (Green et al., 2000). Putnam et al. (2013) found that as the number of different types of activating events increases across a lifespan, so does the risk of a range of negative outcomes later in life increases as well. Research indicates that the potential for complex symptoms increases threefold when individuals experience three to four trauma-activating events. According to Steenkamp (2014), this suggests that there may be a threshold effect − a personal critical limit or window of tolerance (Levine, 2015) − for coping with unresolved trauma (Green et al., 2000). The cumulative effect of a multitude of trauma-activating events on the system of individuals is consistent with findings on combat-

related PTSD and rape (Follette et al., 1996). Several studies have shown that multiple exposure to traumatic events is associated with increased levels of symptoms (Green et al., 2000), indicating a significant relationship between cumulative trauma and symptom complexity (Cloitre et al., 2009).

Epidemiological studies have documented the impact of developmental trauma on health and emotional well-being (Anda et al., 2005). These studies suggest that exposure to multiple or repeated forms of acute and developmental trauma can result in symptoms that are not simply more intense than the sequelae of a single incident of trauma but are qualitatively different in their effect on multiple biological and interpersonal systems (Cloitre et al., 2009). Research has also revealed that the consequences of developmental trauma persist throughout adulthood (Feeney, Kamiya, Robertson, & Kenny, 2013; Lanius et al., 2010).

2.4.2 Trauma over a lifespan

Scaer (2005, p. 2) emphasises that trauma can no longer be defined in terms of the horrific extremes of human experience but needs to be redefined “as a continuum of variable negative life events occurring over the lifespan”. These events are often accepted as ‘normal’ in everyday life within the context of society and culture. The traumatic nature of everyday life experiences can be determined by the way they are experienced by individuals and

the meaning individuals attach to them. The meaning is grounded in earlier life exposure and has a cumulative effect on all facets of the life of individuals over time. JOS (2002) sees the beginning of trauma as the consequence of a rupture in the psychological, biological and sociological boundaries of individuals that may eventually lead to disturbances on multiple levels of functioning. The progressive loss of resilience is felt as accumulated negative life experiences built up over years of freeze/dissociation incidents (Porges, 2011; Scaer, 2005).

Van der Kolk (1987; 2001) states that a body keeps score − it continues to carry the burden of unresolved, unfelt, unprocessed and disconnected feelings. These feelings are imprinted in every cell of a body, resulting in alterations to the autonomic physiological balance of individuals.

Over a lifetime, individuals can be exposed to multiple acute trauma incidents (Solomon & Siegel, 2003). Acute trauma can also aggravate existing developmental trauma by reactivating old on-hold/frozen energy in the system of individuals (Heller & LaPierre, 2012). Green et al. (2000) found that individuals with both lifespan developmental and adult trauma exposure present with more dis-ease than those with either exposure alone. The absence of developmental trauma significantly decreases the risk of dis-ease across the lifespan of individuals, as an increase in developmental

trauma exposure is associated with more complex adult dis-ease symptomatology (Putnam et al., 2013). Across a lifespan, symptoms resulting from recent trauma may not only be distressing, but they may also serve to aggravate latent symptoms related to preceding unresolved trauma (Follette et al., 1996).

2.5 TRAUMA-SPECTRUM MANIFESTATIONS (TSMs)

Levine (1997) argues that trauma can be defined by the debilitating symptoms experienced after a trauma-activating event. Steenkamp (2014) refers to these symptoms as trauma-spectrum manifestations. Trauma produces profound and sometimes lasting changes in the psychobiological system of individuals (Bremmer, 2005; Myss, 1996), which can cause extensive diseases (Miller, 2000; Natalie & Middelbrooks, 2011). The DSM-5 contains a major category devoted to persistent symptoms of an increased arousal in the autonomic nervous system. The diagnostic symptom list for PTSD falls into this category.

According to Herman (2001), trauma can result in a variety of potentially different symptoms. The manifestations of symptoms often take on a life of their own. Multi-systemic changes, such as body pain, neurological impairments, emotional complaints and atypical behaviour, are physical manifestations resulting from unresolved trauma (Herman, 2001; Levine, 1997; Scaer, 2005; Solomon & Siegel, 2003). TSMs can be classified as PTSD or C-PTSD (Steenkamp, 2014).

2.5.1 Post-Traumatic Stress Disorder (PTSD)

Rothschild (2000, p. 6) states that “PTSD is a complex psychobiological condition”. Psychobiology examines the dynamic interrelationship between current and past experiences (the “psycho” element) and the relationship between the biological makeup of individuals and the way in which they ascribe meaning to the world.

PTSD is a clinical manifestation of the failure to integrate traumatic memories (Ogden et al., 2006). The chronic symptoms of re-experiencing, avoidance and hyper-arousal appear after individuals have been exposed to or witnessed a potentially life-threatening event or an event that involved serious injuries where individuals experienced intense fear, helplessness or horror (Van der Kolk, 2003). These symptoms can be caused by a single event (shock trauma) or intensified by existing developmental trauma that lies dormant in the system. Symptoms may have been present for a long time − even years − before individuals seek help.

Generally, people who are exposed to intense trauma-activating incidents immediately display a marked stress reaction (distress) (Friedman, 2003). Such a reaction is a normal, temporary response to an overwhelming situation. The most usual somatic complaints that immediately follow a traumatic experience are restlessness, hypervigilance, difficulty in falling and staying asleep,

generalised anxiety, inability to relax, shallow breathing, fatigue and an exaggerated startle response (Greenspan, 2003; Courtois & Ford, 2009).

The diagnosis of PTSD incorporates the above-mentioned symptoms that occur when individuals experience a short-lived trauma. Firstly, there is a re-experiencing or repeated “reliving” of the event, which disturbs day-to-day activities though flashback episodes in which the event seems to be happening again and again. There may also be recurrent distressing memories of the event or repeated dreams of the event. Re-experiencing also includes physical reactions to situations that call to mind the traumatic event. Secondly, avoidance occurs in the form of apathy, lethargy, indifference, amnesia or a disconnection from the self and others. Avoidance also manifests as avoiding places, people or objects that serve as reminders of the event. Lastly, hyper-arousal is experienced in any of the following forms: having difficulty concentrating, an exaggerated startle response, hypervigilance, irritability, anger outbursts, sleeping difficulties, agitation, excitability, dizziness, fainting, palpitations, bouts of fever and headaches (Van der Kolk, 1996, 2001, 2003; Herman, 2001; Johnson, 2009).

Clinicians and researchers have found that the current PTSD diagnosis often fails to capture the severe psychological harm that

occurs with prolonged and repeated trauma together with the impact of exposure to a range of different traumatic events over a lifespan (Follette et al., 1996; Natalie & Middelbrooks, 2011; Van der Kolk,1987). For this reason, the diagnosis of Complex-PTSD has been incorporated.

2.5.2 Complex-PTSD (C-PTSD)

Complex psychological trauma results from exposure to severe stressors that are repetitive or prolonged or involve harm or abandonment by primary caregivers or occur at developmentally vulnerable times in the life of victims, such as early childhood and during adolescence (Courtois & Ford, 2009). Exposure to accumulated trauma and extreme stress affects individuals on many levels of functioning (Van der Kolk et al.,1996). Research has shown that developmental trauma can contribute significantly to the susceptibility of adults to many of the diseases attributed to stress (Heller & LaPierre, 2012; Nijenhuis et al., 1998; Scaer, 2005). Research has shown that individuals with a trauma history seem to direct much of their lives around being caught up in repetitive patterns or reliving trauma incidents. Chronic trauma symptoms continue or repeat for months or years (Cloitre et al., 2009). Energy and time are spent in dodging traumatic memories, reminders and effects (Nijenhuis et al., 1998). When unrelated stress reaches a certain degree of intensity or continues long

enough, the psychobiological system of affected individuals begins to manifest diseases.

Herman (2001) explains that C-PTSD is characteristically the consequence of exposure to repeated or prolonged occurrences or multiple forms of trauma. It often occurs under circumstances where escape is not possible due to physical, psychological, maturational, family, environmental or social constraints (Cloitre, 2012; Nijenhuis et al., 1998). C-PTSD manifests as problems of affect dysregulation, structural dissociation, somatic dysregulation, impaired self-development and disorganised attachment patterns.

With accumulated trauma, individuals may typically manifest a surprising number of health-related diseases (Cloitre et al., 2009). This can result in numerous visits to physicians in search of a diagnosis for the widespread and often debilitating symptoms (Scaer, 2005). Diseases often include cardiac and arterial problems, difficulties in the lower gastrointestinal tract, various dermatological and musculoskeletal complaints, chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, alopecia, multiple chemical sensitivities, reflex sympathetic dystrophy, interstitial cystitis and myofascial, lower back and pelvic pain (Scaer, 2005). Puzzling chronic dis-eases are manifesting in disproportionate numbers. These dis-eases are often categorised as functional dis-eases, because there is no clear and evident

physical basis that explains these diseases according to standard medical tests (Cloitre et al., 2009). Dis-eases can include hypertension, heart diseases, kidney diseases and alterations of the intestinal and immune systems.

Trauma at any age − especially trauma caused by primary caregivers during the early developmental years − generally has a profound effect on the personality configuration development (Cloitre et al., 2009; Feeney et al., 2013). After traumatic events, perceptions of the self and the world are compromised and tend to become filtered by these experiences. Kardiner (as cited in Van der Kolk et al., 1996) notes that once traumatised, the nervous system of individuals “acts as if the original traumatic situation is still in existence and engages in protective devices” (Van der Kolk et al., 1996, p. 196). Protective devices compromise, therefore, a natural free-flowing personality configuration (Steenkamp, 2014) on two levels:

a) Individuals experience disruptions of their sense of self and they incorporate a belief of being helpless, damaged and hopeless with disturbances of their body image.
b) The compromised personality configuration distorts the view and experience of individuals with regard to the world, often leading to difficulties with trust, intimacy, self-assertion and a feeling of separateness.

This implies that the conception of themselves and of the external world has been permanently altered.

C-PTSD involves multifaceted interactions between multiple biopsychosocial systems (Herman, 2001). Herman (2001) explains C-PTSD can be viewed as a psychological wound − the consequence of extended or protracted social and/or interpersonal trauma. C-PTSD is different from − but related to − PTSD, somatisation disorders, dissociative identity disorders and borderline personality disorders. According to Herman (2001, p. 121), C-PTSD sufferers have:

> A history of subjection to totalitarian control over a long period (months to years). Examples include hostages, prisoners of war, concentration camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organised sexual exploitation.

In 2008, the International Society for Traumatic and Stress Studies (ISTSS) acknowledged that the PTSD framework does not cover the significant symptoms and problems of individuals who were exposed to prolonged and repeated trauma, commonly referred to

as C-PTSD (Cloitre, 2012). The ISTSS's definition of C-PTSD includes the core symptoms of PTSD (re-experiencing, avoidance/numbing and hyperarousal) in conjunction with a range of disturbances in self-regulatory capacities. The latter are grouped into five broad domains*:*

a) Emotional regulation difficulties (e.g., depression, anxiety, worry, phobias, feelings of hopelessness, feelings of helplessness, excessive guilt, shame, feelings of emptiness, powerlessness or inadequacy).

b) Disturbances in relational capacities (e.g., continual repetition of unhealthy relationship patterns, withdrawal, isolation, lack of trust, fear of abandonment, boundary problems, inability to see relationships clearly, control issues).

c) Alterations in attention and consciousness (e.g., dissociation, problems with concentration, memory function, decision-making and distraction).

d) Adversely affected belief systems (e.g., negative thinking patterns and beliefs about the self).

e) Somatic distress or disorganisation (e.g., physical symptoms/somatisation, a racing heart, high blood pressure, exaggerated startle responses, sleep problems, headaches/migraines, low energy, appetite changes, sexual dysfunction, gastrointestinal distress, muscle tension, constant hyper-vigilance, chronic pain) (Cloitre, 2012;

Courtois & Ford, 2009; Heller & LaPierre, 2012; Herman, 2001; Van der Kolk et al., 1996).

C-PTSD is a diagnosis that includes an extensive disruption of self-regulation (Courtois & Ford, 2009; Heller & LaPierre, 2012). These disruption experiences interfere with and alter developing biological and emotional systems, especially during early childhood. C-PTSD has enduring biological, emotional, interpersonal and social facets that must all be attended to during treatment (Courtois & Ford, 2009; Heller & LaPierre, 2012).

Comprehension of how the brain and body process, remember and preserve traumatic experiences holds the key to the potential treatment of a traumatised system (Rothschild, 2000). There are various treatment modalities that were developed to address the sequelae of trauma, such as e.g. CranioSacral Therapy (CST) (Upledger, 2001); BodyTalk therapy; Trauma and Tension Release exercises (TRE) (Berceli, 2008), Somatic Experiencing (SE) (Levine,2005); and for this purpose SHIP®. In September 2001, the SHIP® Foundation was established as a training school for psychologists who are registered with the Health Professions Council of South Africa (HPCSA).

2.6 CONCLUSION

The definition of trauma has changed over the past few decades. This redefining of the trauma spectrum has a profound impact on our understanding of what trauma is and provides insight into its rippling sequelae. The scientific grounding of the psycho-biodynamic trauma spectrum ripple changes the psycho-therapeutic stance on complex trauma cases. An understanding of both complex trauma and the impact of accumulated trauma over a lifespan is essential in today's psycho-therapeutic environment.

CHAPTER 3: THEORETICAL FRAMEWORK OF SPONTANEOUS HEALING INTRA-SYSTEMIC PROCESS (SHIP®)

In this chapter, the focus is on the frame of reference used by psychotherapists. The chapter deals with the ISTSS treatment guidelines followed by an explanation of the researcher's frame of reference: the integrated the SHIP® trauma-spectrum model for the treatment of C-PTSD. This chapter concludes with the limitations and contraindications of SHIP® as a therapy method.

3.1 ISTSS EXPERT CONSENSUS GUIDELINES FOR THE TREATMENT OF ACCUMULATED TRAUMA

The expert consensus guidelines provided by the ISTSS recommend a phase-oriented or sequential treatment model for clients with C-PTSD (Cloitre, 2012). A phase-oriented model consists of the following three phases:

Phase 1 entails the stabilisation of clients and the strengthening of their skills. In this phase, the focus is on providing psycho-education information regarding the effects of trauma. Interventions in this phase must be matched to the individual needs of clients with the emphasis on developing emotional regulation skills, stress management, building social and relational skills and cognitive restructuring. Meditation and mindfulness interventions are often used, although they are not sufficient by themselves. In Phase 1, the development of a psychotherapeutic relationship through support, validation and encouragement is important.

In **Phase 2**, attention is focused directly on the reflection and review of specific traumatic memories. The process involves some form of reflection on or re-

experiencing of the events of the trauma within a safe and controlled environment. The purpose is to enable the restructuring and integration of traumas into an autobiographical memory − resulting in a more positive, compassionate and coherent sense of self and connection to others. In the course of individual psychotherapy during this treatment phase, the specific focus is on trauma memory processing. There are numerous trauma memory processing approaches that have proved successful and they usually entail an organised recounting of the traumatic events − primarily through language − although other mediums of expression are becoming increasingly popular, such as visual art, music, drama and therapy with animals (horses). It is recommended that during a trauma memory processing session, treatment should include a continued review and interventions relating to emotional management, self-efficacy and relationship skills (Cloitre, 2012; Cloitre et al., 2011).

Phase 3 indicates a shift from psychotherapy into greater engagement in community life. During this treatment phase, emotional, social and relational competencies are consolidated. Planning for education, employment, recreation and social activities or hobbies should be carefully considered. This phase is quite effective as a plan for follow-up care (Cloitre, 2012; Cloitre et al., 2011).

Throughout the above three phases, psychotherapy should be carefully paced in accordance with the tolerance of clients (Cloitre, 2012; Cloitre et al., 2011). In their expert consensus guidelines for C-PTSD, the ISTSS confirms that

additional research is required to evaluate phase-based treatment approaches in relevant populations − including different age groups (Cloitre, 2012). The ISTSS also states that to enrich the outcomes, novel treatment approaches, such as complementary medicine strategies that focus on somatosensory experiences and the mind-body relationship, should be investigated (Cloitre, 2012; Cloitre et al., 2011).

3.2 SPONTANEOUS HEALING INTRASYSTEMIC PROCESS (SHIP®)

This section discusses the SHIP® treatment model, beginning with its history. Attention is given to the assumptions underlying SHIP® and SHIP®-specific constructs are explained. A concise explanation of SHIP® as a psychotherapeutic strategy is also presented.

An intrasystemic perspective focuses primarily on the experiences and behaviour of individuals along with an internal sequel on the systemic levels (Lee & Martin, 2013; Pinsof, 1994). The intrasystemic perspective proposed by the SHIP® provides a framework for psychotherapists that reflects the interrelationship between symptoms and context (JOS, 2002; Steenkamp et al., 2012).

Theoretical relativity is an attribute of this view. According to this concept (theoretical relativity), acceptance of one theory does not require or imply the rejection of other theories. Each theory provides meaning to the other and each theory has its place relative to a given context (Becvar & Becvar, 2012).

By accepting a systemic perspective, individual psychology perspectives are, therefore, not rejected (Pinsof, 1994). Individual psychology and a systems theory are intricately connected − each providing meaning to each other (Becvar & Becvar, 2012).

Through an intrasystemic perspective, individuals are viewed as a whole, a complete unit with internal system levels. The same systemic principles can be applied to enable us to understand the behaviour of individuals by tracking changes in the intrapsychic systems of individuals (Pinsof, 1994).

3.3 The history of SHIP®

SHIP® started with Dr JO Steenkamp's conceptualisation of his treatment of clients presenting with chronic physical and emotional dis-ease. Dr Steenkamp was originally drawn to and experimented with autogenic training as a psychophysiological method. In 1969, Shultz and Luthe developed autogenic training by incorporating the idea of internal self-regulating and self-normalising processes (Steenkamp et al., 2012). This development was pivotal to Steenkamp's discovery of SH in 1986. Steenkamp (1991) decided not to prompt clients to self-learn autogenic relaxation in preparation for unfolding internal phenomena, but rather to accept their current uncomfortable internal awareness as a sign of need for expression. Steenkamp (1991) then assessed the use of selective individual-specific activators or triggers (a SHIP® construct that is explained later in this chapter under "constructs") to expose incomplete and painful memories that appear to be the source of chronic dis-ease. Methods from other modalities were assimilated, such as free

association (psychoanalysis), the here-and–now experience (phenomenology), unconditional regard (client-centred psychotherapy), flooding (behaviour therapy), imagery (gestalt therapy), and the process of abreacting (autogenic training) (Steenkamp, 1991). This assimilation was done in order to create a psychotherapeutic space in which autonomic self-regulation, as explained in Chapter 2, can run its normal course (Steenkamp et al., 2012). This eventually resulted in a gradual unfolding of a psychotherapeutic procedure for the facilitation of autonomic self-regulation in order to complete mostly unexpressed psychobiological experiences that have resulted in developmental trauma (Steenkamp, 2013; Steenkamp et al., 2012). Once the on-hold energy has been discharged and integrated, chronic dis-ease should lose relevance and disappear (JOS, 2002).

According to Steenkamp (2014), SHIP® is effective in addressing physical and emotional symptoms found in C-PTSD. Sevenster (2009) confirms that SHIP® validates and facilitates the owning of gastrointestinal symptoms and emotions not previously permitted. In their SHIP® psychotherapy with different clients (covering in excess of 100 000 SHIP® sessions), Steenkamp, Van der Walt, Schoeman-Steenkamp and Strydom (2012) found that clients manifesting with C-PTSD generally experience developmental trauma from which they had dissociated when they were younger than ten years old.

3.3.1 Assumptions underlying SHIP®

Similarities exist between SHIP® principles and other bottom-up healing spaces, such as Somatic Experiencing® and sensorimotor

psychotherapy (JOS, 2002; Levine, 1997; Ogden et al., 2006). These interventions also address the more primitive, repetitive and unbidden physical sensations, movement inhibitions and somatosensory intrusions of trauma (Levine, 2005; Ogden et al., 2006).

The basic premise of SHIP® is that when the autonomic self-regulatory state is interfered with, trauma is defined. The ensuing chronic internal dysregulation results in a chronic disease − C-PTSD (Steenkamp et al., 2012). Traumatised clients are in a continuous process of spontaneous healing and self-regulation, and if the processes of these clients are properly facilitated, built-up and on-hold disconnected energy is unclogged. The freeing of on-hold energy completes the lifelong search of clients for a sense of identity, acceptance, to fit in and to live a purposeful life (JOS, 2002).

3.3.2 SHIP® constructs

The following SHIP® constructs are explained in greater detail to obtain clarity concerning SHIP® as a theoretical model: psycho-biodynamic domain, spontaneous healing reactions (SHRs), individual specific fields (ISFs), psycho-biodynamic translators, coping style, distractors, healing space and activators.

3.3.2.1 Psycho-biodynamic domain

According to the SHIP® theory, the psycho-biodynamic domain refers to current psychological experiences together with involunatry sensory reactions and continuously suppressed trauma projected onto perceptions of the present (Steenkamp, 2014; Steenkamp et al., 2012).

Steenkamp et al. (2012, p. 203) define the psycho-biodynamic concept as follows:

> **Psycho-** refers to current psychological experiences (e.g. emotional dis-ease, such as anger, sadness, anxiety, in relation to all encounters);
> **Bio-** refers to involuntary sensory experiences and/or physical reactions (e.g. palpitations, dizziness, physical dis-ease and spasms in the body); and
> **Dynamic-** refers to the continuously suppressed, unresolved/ uncompleted past experiences (trauma) projected onto and contaminating perceptions of the present (e.g. the experience of childhood sexual molestation).

The above-mentioned unresolved or uncompleted past experiences are lodged in the system of individuals due to the process of dissociation (Steenkamp, 2013, 2014; Steenkamp et al., 2012).

Dissociation is a concept that refers to the actual activation of experiences that are too painful or unacceptable to release as energy. These experiences are not expressed through the normal channel of SHRs, and are then encoded and concealed (Briere & Spinnazzola, 2009; Coates, 2010). SHIP® postulates that initially, when the too intense trauma-activated energy information becomes suppressed, the suppression process takes place involuntarily as a self-preservation mechanism, which corresponds to the dissociation and unintentional freeze response discussed and defined in Chapter 2 (Steenkamp, 1991).

3.3.2.2 Spontaneous healing reactions (SHRs)

The psychobiological release of trauma is referred to in SHIP® as SHRs (JOS, 2002; Steenkamp, 2013, 2014; Steenkamp et al., 2012). SHRs are viewed as interactive physical, emotional, cognitive/mental and spiritual interconnected energy patterns. These patterns form part of our daily internal responses to external demands (Steenkamp, 2013, 2014; Steenkamp et al., 2012). SHIP® defines SHRs as self-regulating psycho-biodynamic interconnected energy patterns within individuals through which activated trauma memories are released involuntarily (JOS, 2002).

Developmental trauma significantly impedes the capacity of a body to self-regulate physically and emotionally (Fisher, 2006; Fisher &

Ogden, 2009). In the late 1900s, Pierre Janet was the first clinician to explicitly pronounce that traumatic memory consisted of non-integrated sensory experiences, emotional states, intrusive recollections and behavioural re-enactments (Levine, 2015; Van der Kolk, 2015). Pert (1997) refers to trauma information messengers within the body as molecules of emotion. These neuropeptides and their receptors tie the major systems (neural, immune and endocrine) into a multidirectional body-mind system of interaction and communication. The molecules of emotion are literally converting mind into matter (Pert, 1997). Memories are explicitly accumulated and stored in nerve bundles, called ganglia (Pert, 1997). The disconnection of emotional and physical trauma information can – when receptors are blocked − be stored perpetually at cellular level (Pert, 1997). Upledger (2001) states that during its release, on-hold activated energy is not limited to physical phenomena but is often accompanied by the re-experiencing of emotions related to an original trauma-activating event(s). In a research study done with 46 participants with PTSD, Van der Kolk and Fisler (1995, p. 505) found that the traumatic memories of the participants presented "… in the form of dissociated mental imprints of sensory and affective elements of the traumatic experience: as visual, olfactory, affective, auditory and kinaesthetic experiences". Damasio termed this phenomenon 'somatic markers' (Damasio, Everitt, & Bishop, 1996).

In a period of over 30 years in clinical practice, Steenkamp identified over 2000 different variations and combinations of these SHRs in clients during SHIP® treatments (Steenkamp, 2015). Manifestations can be perceived in any part of the system and include experiences, such as distortions, spinning, palpitations, headaches, nausea, pain sensations, scary images, smells, sounds, and emotions, such as sadness and anger (Levine, 2005; Scaer, 2005; Steenkamp, 2015; Steenkamp et al., 2012). Levine (2005) and Church (2007) found in the course of their research that a bona fide psychological shift is always subject to and accompanied by physical signs of emotional discharge, such as tears, sweating, moaning or shuddering. Although further research on SHRs is recommended, types of SHRs seem to be predetermined by the experience value of the trauma and the subsequent accumulated information unable to discharge through the innate self-regulatory process (JOS, 2002; Levine, 2005; Scaer, 2005; Steenkamp, 2015).

When the significance of the experience and value of SHRs is misjudged during youth, clients are denied inherent and spontaneous self-regulation while the energy released is put on hold (Steenkamp, 1991). According to SHIP®, trauma is, therefore, the pausing of SHRs. If spontaneous release is repeatedly disallowed from childhood onwards, the on-hold energy later develops into TSMs (Steenkamp, 2014) and related to C-PTSD

symptoms. When SHRs are allowed to unfold and to follow their natural energy release process, the system of individuals will simultaneously self-regulate towards balance. This internal unfolding and release of SHRs is a psycho-biodynamic process that take place within the ISF of individuals (Steenkamp, 2013, 2014; Steenkamp et al., 2012)

3.3.2.3 Individual Specific Field (ISF)

The psycho-biodynamic system or an ISF differs from one individual to another although there is a human commonality (Steenkamp, 2013, 2014; Steenkamp et al., 2012). An ISF is a personal three-dimensional energy field that connects and links everything, both intra-systemically (within individuals) and inter-systemically (between individuals and their environment). It embodies all the dimensions of the experiences of individuals, and is defined as a unified network of past, present and potential future happenings and relations (Steenkamp, 2013, 2014; Steenkamp et al., 2012). An ISF as an information network is fluid, interactive and expressive, acting like a grid of pathways employed by a body and its senses are the medium of expression. Dissociation and freeze have a negative impact on the free-flowing energy of an ISF. When individuals store too much trauma-activated energy over time, the compacted and blocked SHRs eventually exceed the critical mass, leading to implosion. Implosions can present themselves in internal explosions (dis-ease) and projections onto

the external environment of individuals (Steenkamp, 2013, 2014; Steenkamp et al., 2012). Subsequent explosions are defined as psycho-biodynamic translators.

3.3.2.4 Psycho-biodynamic translators

Individuals follow a psycho-biodynamic path to keep reconstructing and translating on-hold, unresolved trauma manifestations and events through the medium of selected psycho-biodynamic translators or metaphors. This implies the chronic repetition of the same psychobiological feelings (Steenkamp, 2013, 2014; Steenkamp et al., 2012).

The process of re-enactment is framed in SHIP® as a healing script: what you chronically try to avoid, is what you recreate. Through repetition, individuals continuously and selectively bring themselves face-to-face with the fact that internal on-hold trauma activation energy requires awareness and a psycho-biodynamic discharge (JOS, 2002; Steenkamp, 1991; Steenkamp et al., 2012).

SHIP® distinguishes between intra-translators and inter-translators as the two subcategories of psycho-biodynamic translators in relation to the locations where the psycho-biodynamic healing script is translated and re-enacted (Steenkamp, 2013, 2014; Steenkamp et al., 2012).

Intra-translators (intra-psycho-biodynamic trauma translators): Intra-translators psycho-biodynamically translate trauma through the internal ISF of individuals (Steenkamp, 2013, 2014; Steenkamp et al., 2012). These repetitive explosive somatic manifestations are expressed through symptoms, such as chronic pains in the lower back, stomach or head and feelings, such as sadness, are experienced. Intra-translators may become metaphors for hidden on-hold, unresolved and uncompleted experiences, such as powerlessness, anger and physical trauma (JOS, 2002; Steenkamp et al., 2012).

Inter-translators (inter-psycho-biodynamic trauma translators): Steenkamp et al. (2012) explain that inter-translators are expressions that work through the external ISF of individuals by means of projection issue statements, such as: “I always have to prove myself”; “Relationships do not work for me”; and “People make me feel I am never good enough”.

According to the SHIP® theory, individuals experience their external world as a mere projection of their internal world (JOS, 2002; Steenkamp, 1991). On-hold activation energy from uncompleted experiences cloud the view of individuals with regard to the world – individuals can only view the world though that which is on hold in the inside.

The SHIP® theory states that the different varieties of developmental trauma link into a trauma chain that eventually presents itself through the above-mentioned psycho-biodynamic translators (Steenkamp, 2013, 2014; Steenkamp et al., 2012). Intra-translators and inter-translators indicate that an internal trauma chain has formed, and that psycho-biodynamic validation of its existence is needed (Steenkamp, 2013, 2014; Steenkamp et al., 2012). Psycho-biodynamic intra-translators and inter-translators are symbiotic and usually occur together. Translators reveal information about buried trauma through present day events and new events are activated. Although these trauma incidents no longer exist, psycho-biodynamic translators indicate that their disconnected energy is still on hold in the system of individuals. Psycho-biodynamic translators are a constant reminder that the process of autonomic self-regulation is incomplete or has been blocked – indicating trapped energy in need of expression (Levine, 1997; Steenkamp, 2013, 2014; Steenkamp et al., 2012; Scaer, 2005).

The natural ISF of individuals is, therefore, compromised in proportion to the amount of frozen energy present in their system. Consequently, the more on-hold energy is present, the more intensely the psycho-biodynamic translators display and the more they initiate a need for healing, integration and balance (Steenkamp, 2013, 2014; Steenkamp et al., 2012).

3.3.2.5 Coping style

A coping style develops in response to the environment of developing children. Steenkamp (JOS, 2002) maintains that a coping style develops before children reach the age of ten years. During this time, one or more parts of a personality are favoured and become more dominant through trial and error: That which is accepted and encouraged by the environment is kept and developed at the expense of the rest, which remain as undeveloped potentialities (Heller & LaPierre, 2012; Steenkamp, 2013). The direction of energy can result in an imbalance, because the various areas of the self are not equally expressed (JOS, 2002).

Trauma-activating events during childhood give rise to disconnection − resulting in an exclusive coping style. When a coping style is flooded by stress, individuals may use a variety of distractors to divert their attention for a short period of time until their coping style has again stabilised into managing external demands (Heller & LaPierre, 2012; Steenkamp, 2013).

3.3.2.6 Distractors

Distractors take the form of any type of behaviour in overload, such as excessive drinking, smoking, working, exercising or sleeping (JOS, 2002). Distractors function as conscious short term

survival strategies. When the frantic attempts of individuals to distract themselves fail, professional distractors may often be sought, such as painkillers or psychiatric medication, which might serve the purpose of supporting individuals who are suffering from a sense of being flooded or overloaded. While distractors support flooded systems, they also prevent healing and an integration of disconnected on-hold trauma activation energy.

It has been found after work done with clients suffering from trauma, that medications prescribed to clients by their medical providers do not resolve trauma (Steenkamp, 2013; Steenkamp et al., 2012). Oschman (cited in Steenkamp 2013) reports on research stating that pharmaceuticals do not affect the underlying brain rhythms and wave frequency imbalances of traumatised victims, which indicates that medication only suppresses and masks TSMs. Generally, in the field of psychiatric medicine, many TSMs are viewed as incurable (Steenkamp, 2013; Steenkamp et al., 2012). Medication or behavioural management therapies are administered mainly to marginally control or suppress symptoms (Levine, 2005) and focus mainly on changing the experience of victims to less threatening − serving as a distractor. In contrast, the SHIP® focuses on not changing the experience of clients or to distract them from internally activated SHRs, but rather allows clients to discharge on-hold activation energy and in the process allows autonomic self-regulation to move the system of clients

towards balance. SHIP® theory states that by creating a space conducive to healing and by allowing the SH process to unfold, change happens by itself (JOS, 2002; Steenkamp, 2013).

3.3.2.7 Healing space and activators

A healing space is qualitatively different and detached from the surrounding cosmic milieu. It is a place where the opening up of what is sacred is encouraged and a shift in the consciousness of clients is facilitated by psychotherapists. A healing space refers to the “be with” and the wisdom of the ISF. SHIP® facilitators (psychotherapists) create the most suitable setting for a psycho-biodynamic awareness of internal processes of disconnection in order to surface to connection. “The qualities of a suitable SHIP® healing space is an environment of ‘non-judgement, respect, trust, validation and patience’” (Steenkamp, 2013, p. 185). Clients are usually already activated when they consult a psychologist but as Steenkamp (2013, p. 186) explains: “most deep emotions and feelings won’t reveal themselves when not provoked”.

In a healing space, the psycho-biodynamic translators and other metaphoric or associative images or words are used as SHIP® activators to ignite and steer the healing process towards integration (JOS, 2002; Steenkamp, 1991, 2013). Activators can be the historical trauma experiences of clients presented through the narrative medium of images, thoughts, dream contents and

other metaphors to evoke distant glimpses of developmental traumas and to quicken and unmask a healing response (JOS, 2002; Steenkamp, 1991). Activators are used to release emotions and to set in motion the process of SH. When permitted to, SH happens by itself, because “the healing is in the feeling” (Steenkamp, 2013, p. 186).

Activated feelings, such as sadness, habitually causes clients to want make use of distractions. Within a healing space, the attempt of clients to distract themselves is neutralised by discouraging clients from taking any voluntary actions. One of the requirements of SH is passivity to allow for involuntary SH reactions where clients do not try to heal. When clients remain inactive and they do not make use of distractions from activated discomfort, trauma imprints are exposed and the on-hold energy is allowed to discharge through the SHRs (Steenkamp, 2013).

During SHIP®, the focus is not on attempting to alter or correct the uncomfortable experiences of clients − that constitutes distracting (JOS, 2002; Van der Kolk, 2014). This focus differs from cognitive processing therapy (CPT), which assists clients to challenge and modify their “erroneous beliefs” (inter-translators), which have been generated through trauma (Friedman, 2003). Within SHIP®, clients are continuously reassured in their healing space in order for them to remain inactive within their involuntary physical and

emotional experiences and to keep their focus on the SHRs as they surface (JOS, 2002). Van der Kolk (2014) and Levine (2005) refer to this reassurance as self-awareness and within a healing space clients are brought into contact with their ability to heal (Steenkamp, 2013).

Prolonged exposure (PE) therapy corresponds to SHIP® in that clients are asked to visualise their trauma-activating event. Subsequently, the “in-the-moment” experiences are added – narratives can be repeated several times during a single session (JOS, 2002). SHIP® resembles an immersion technique − clients immerse themselves in their feelings and symptoms. Immersion can be described as going on a journey experiencing symptom sensations − sinking into and merging with discomforts (Steenkamp, 2013). This technique relates to the practice of mindfulness, a tradition stemming from Buddhism where individuals intentionally pay attention to everything (physical sensations, perceptions, moods, thoughts and images) during present moment experiences (Hayes & Feldman, 2004). Paying attention is done in a non-judgemental manner. Moment-to-moment changes are described comprehensively that were subjectively experienced by clients – a stable non-reactive awareness is thereby cultivated (JOS, 2002; Steenkamp, 1991, 2013). In a healing space, clients stay in control by being fully conscious. By sustaining a state of awareness, clients direct the

SH process and on-hold energy is able to release and integrate into the ISF while balance is restored (JOS, 2002; Steenkamp, 2014).

The integration of traumatic experiences − in both body and mind − is the goal of trauma psychotherapy (Rothschild, 2000). SHIP® creates a space in which this integration can happen. Clients can experience what they need to experience “for the issue is to move through the tissue” (Steenkamp, 2013, p. 188). Trust is placed in SHIP® to achieve autonomic self-regulation − the process of spontaneous movement and distribution of energy throughout the ISF. SHIP® clients need to integrate a sense of time lost, of living a compromised life, of time that can never be retrieved. Steenkamp (2013, p. 188) states that “although history cannot be changed through any psychotherapy, SHIP® creates the space in which historical issues of contention may become resolved”.

Within a healing space, psycho-biodynamic translators (e.g., chronic pain) are followed to their source and on-hold energy is converted into kinetic energy released in the form of SHRs. When all of the links in a trauma chain have gone through SHRs, there is no more on-hold energy to sustain intra-translators and inter-translators and they disappear. The previous limited coping style configuration becomes more extensive as on-hold coping style potentialities open up. This new position of clarity in perception

happens spontaneously; it is the natural outflow of the process of connectedness and integration (Steenkamp, 1991, 2014).

3.3.3 The function of psychotherapists

The primary function of SHIP® psychotherapists is facilitating. SHIP® psychotherapists should create a healing space where clients can come into contact with themselves in order to heal disconnected information (Steenkamp, 1991, 2013). SHIP® psychotherapists should be a reassuring presence so that clients can feel safe. When clients feel safe, they are enabled to continue with their healing process (JOS, 2002; Steenkamp, 1991). The perceptions and well-being of clients must always be considered. Empathy towards clients is important. Without empathy, the healing process is not optimal. Moreover, a non-judgemental approach with no voiced expectations should be used – it is imperative that clients must be allowed to create and experience their own subjective reality (Steenkamp, 1991). SHIP® psychotherapists keep clients experiencing internal connectedness – this allows energy release through involuntary autonomic SHRs (JOS, 2002; Steenkamp, 2013).

SHIP® psychotherapists should view cases where chronic symptoms present as SH in action – energy movements towards balance (JOS, 2002; Panksepp, 2009; Steenkamp, 2013). This approach differs from a psychopathological point of reference,

which focuses on “what is wrong with a person”. Levine (2005) refers to this point of reference as reminding clients that they are experiencing only a memory of trauma and this memory is not happening in the here-and-now. This approach is referred to as the reframing of that which presents itself.

According to Fourie (2002), reframing is the purposeful attempt to guide the ideas of clients by presenting them with a convincing explanation of the problem followed by a consistent treatment procedure, which brings about transformation (JOS, 2002; Steenkamp, 2013, 2014; Steenkamp et al., 2012). Reframing forms part of the continuous psycho-education that takes place during SHIP® and reinforces the healing process. The focus is on the reframing of activators as healing sites and their effects on the body as SH messages, indicating a need for self-restoring and rebalancing (Steenkamp, 2013, 2014; Steenkamp et al., 2012).

The more SHIP® psychotherapists stay focused on the facilitation of SH (this process is outlined later in this chapter) and refrains from projecting pathology (by continuously referring back to or reminding clients of SH, autonomic self-regulating potential, the point of reference) into the chronic dis-ease patterns of clients, the more will the healing of clients manifest in untainted forms. Primary fundamental reframed healing messages that are verbally conveyed to prospective clients are: “I trust your system’s ability to

communicate its spontaneous healing messages to us during the SHIP®." The assumption and point of reference of SHIP® is that individuals are in a continuous spontaneous healing process and they possess internal knowledge about their SH processes (Steenkamp, 2013, 2014; Steenkamp et al., 2012). Psycho-education is also often used to reassure clients that what they are experiencing is part of the healing process and to assure them of the presence of a psychotherapist.

3.3.4 SHIP® as a therapeutic strategy

In this section, the general course of applying SHIP® as a therapeutic strategy is explained. Although a rigid procedure is not followed due to the individuality of clients, the following phases are an indication of the general course of SHIP®, as described by Steenkamp (JOS, 2002; Steenkamp, 1991). SHIP® makes use of a framework that follows a particular sequence of phases, called "The Frame". The different phases of SHIP® can be explained graphically in the form of a funnel consisting of five phases, as illustrated by the following figure:

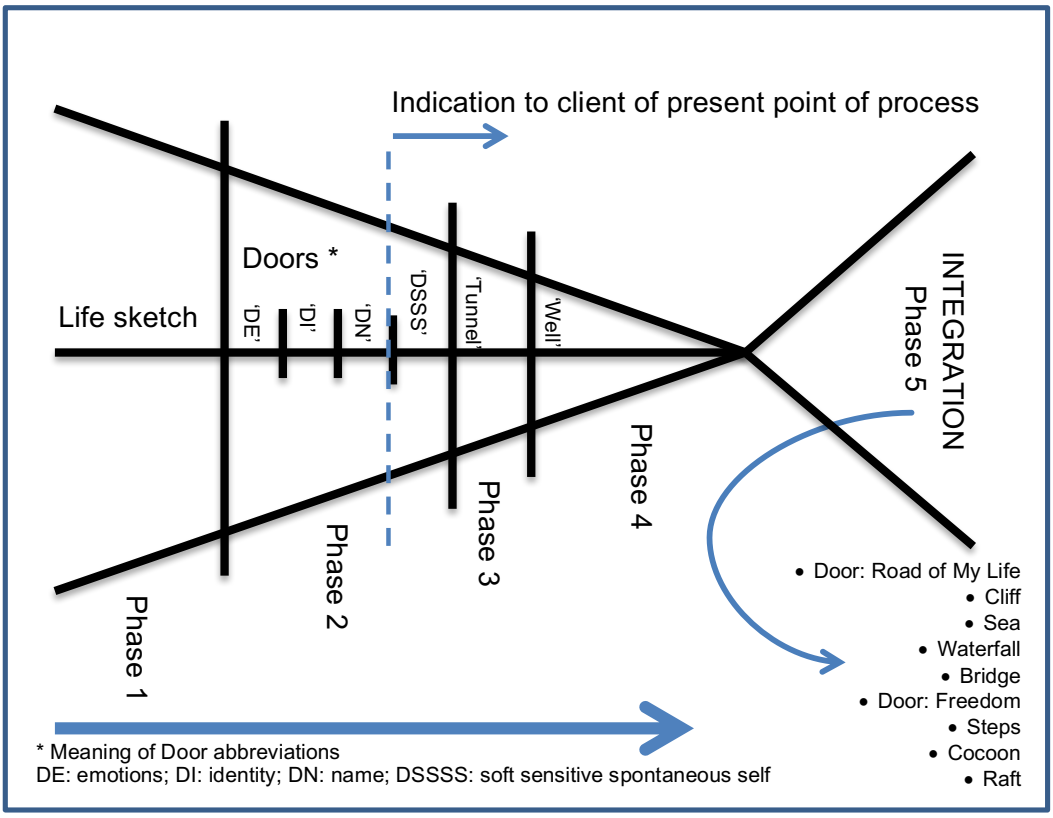

Figure 4: The Frame of the SHIP® (JOS, 2002, p. 209)

3.3.4.1 Phase 1: The history of clients

During a first session, clients discuss their reasons for consulting a SHIP® psychotherapist. Relevant information is continuously noted by psychotherapists. During the second half of a first appointment, psychotherapists should explain the rationale of SHIP® to clients. Different constructs are explained in broader terms according to the need of clients for a more detailed description.

Psychotherapists should make sure that clients have a reasonable understanding of the process of integration.

When clients accept the rationale of SHIP® and agree to undergo this process, they are asked to bring a life sketch to the next therapy session. A life sketch should include all of the life experiences that clients can remember as distressing, traumatic or embarrassing. A life sketch should cover all of the life phases from as far back as clients can remember to the present. The reason for the life sketch is that as clients remember and write about themselves, forgotten incidents resurface and this is a valuable data source regarding themes or trauma chains in the lives of clients. Information in the form of a life sketch enables psychotherapists to identify the psycho-biodynamic patterns of clients that expedites the therapy process. Some clients experience a secondary benefit – in writing down something that they have never told anyone brings a sense of relief. It is necessary to emphasise to clients that nobody except them and their psychotherapist read the life sketch.

In the next session, clients are introduced to SHIP® and told what to expect according to the SHIP® protocol:

> You will be lying on the bed with your eyes closed. The reason for the bed is that it allows for passivity, which is what we need in this psychotherapy. The clients' eyes are closed during the different phases of SHIP® to avoid distraction by objects in the

> psychotherapist's office. In the later stages of SHIP®, where images are used, the clients are used to lying with their eyes closed (Steenkamp, 1991). You will not be under a process such as hypnosis, but as awake as you are now, since you need to connect with the disconnected information while you are fully awake. Your eyes are closed so that you can see the images we will be using (JOS, 2002, p. 210).

During this session, the possibility of different SHRs is described to clients:

> You may experience smell and sound, you may also experience a range of emotions, like anger, sadness, guilt, frustration, irritation, and the like. You may experience different physical sensations in your body. Everything you experience is relevant and useful, so don't be alarmed by what you may experience. The different sensations can vary in intensity and can be singular or mixed. Of course you might not experience everything I have described; these are just examples. The point is that it is OK to

> experience whatever arises, and you should just feel it and follow the process as it unfolds (JOS, 2002, p. 211).

During the initiation of SHIP®, there are a few important things clients should take note of:

a) Psychotherapists tell their clients what to do as they progress through the process.

b) Clients must tell their psychotherapist everything they experience − physically and emotionally: They may feel anxious and short of breath or feel that something is squeezing their chest.

c) It is important that clients do not do anything to distract themselves from the healing process by falling back on old patterns and habits, for example fidgeting. Inactivity allows disconnected material to surface and be integrated into the present. “I’ll remind you throughout the process not to do anything with your feelings, but to experience what the feelings are doing to you” (JOS, 2002, p. 211). Clients may ask questions, blow their nose, scratch an itch or open their eyes briefly when needs arise during a session, but for the most part of a session they need to remain still on their backs, on the bed with their arms comfortably at their sides.

A consulting room should be equipped with a recliner chair or a bed for clients to lie on with a psychotherapist positioned next to a client − close enough to note physiological reactions but not too close. Psychotherapists should avoid encroaching on the personal space of clients. Once everything has been explained, clients are asked to lie on the bed. Clients may take their shoes off or leave them on – they should feel comfortable. Spectacles should be left on the desk. Clients should also be advised to remove their contact lenses, because their lenses can move during a session caused by tears. A blanket should be available on the bed for clients if they like to be covered. Lights should be dimmed as soon as a client is lying on the bed. A session starts when a psychotherapist saying the following to a client:

> This is a new and unfamiliar experience for you, so I want you to focus on being in the position for the first time. Focus on your feelings about lying on the bed with your eyes closed, and not really knowing what to expect. Go through your whole body and tell me exactly what you are feeling, however difficult that may be (JOS, 2002, p. 212).

Normal everyday tension is likely to dissipate if focused on during the initial part of a session. If, for example, a headache persists,

and the psychobiological discomfort increases, it should receive priority. Clients are asked to stay with the discomfort and to verbalise whether the discomfort is intensifying (an indicator of disconnected, on-hold activation energy starting to discharge), fading away (at which point another activator is given) or simply remaining constant (in which case the reaction should stay the same).

SH can be qualitatively described as follows: Clients heal if an SHR occurs. Healing is accompanied by a highlighting of physical experiences and emotions together with an unforced letting go (Berceli, 2008; Levine, 2005; Ogden et al., 2006; Steenkamp, 2015). Clients experience intense physical and emotional discomfort and see disturbing images and experiences. It is important for clients to allow their system to react spontaneously with minimum interference and without taking control in any way. Clients must allow their system to react to the activators. At times, reactions can take the form of a spontaneous surge of emotions or a physical and sensory awareness, but it can also be accompanied by the reliving of a specific trauma incident.

When clients have been sufficiently exposed to experiences and discomfort and the correct activators do not have any further effect on them, clients become emotionally and physically calmer – breathing becomes more even, facial expressions are more

relaxed, the rest of the body is more at ease, their tone of voice is calmer and no other sensory experiences are felt. Their visual images are less distressing or even completely absent. Before and during healing, these images contain disconnected material. Afterwards, images contain connected material. These images are not a threat to clients and they do not want to change them.

As soon as a neutral feeling is experienced, SHIP® psychotherapists can move to the next activator. They should again allow all the feelings of clients to unfold and run their course. No specific timeframe is allocated to each activated issue; the important thing is to follow each process as it unfolds whether it takes up the remainder of the session or stretches over several sessions.

When painful or uncomfortable experiences have been worked through − completed and integrated − the same activators no longer cause the activation of SHRs. Clients can listen to activators provided by psychotherapists or even talk about trauma-activating experiences without experiencing any psychobiological discomfort. SHIP® psychotherapists will note that themes and patterns no longer appear as often in the images, words, sensory or emotional experiences of clients. When the same chain events are addressed at a later stage, these experiences will still be non-threatening and no dis-ease will manifest. Qualitatively, clients

show a greater degree of tranquillity concerning specific incidents or experiences and they may sometimes report that certain incidents and experiences are no longer a point of contention and they feel much more at ease.

3.3.4.2 Phase 2: Doors

In Phase 2, doors are visualised as activators of symbolic projections. Symbolic projections, such as doors, tunnels and wells, are also used during symbolic visualisations (Sheikh, 1984). In SHIP®, four different doors are used and described by JOS (2002) as follows:

1) A door with the word 'Emotions' inscribed on it. This door allows for contact with projections related to emotions clients have disconnected from.
2) A door with the word 'Identity' inscribed on it. There is a natural tendency in the system of clients to search for those parts of the self that have been denied identity due to disconnected emotions.
3) A door with the client's 'Name' inscribed on it. This door projects an overall connectedness with the self − how clients project themselves.
4) A door with the words 'My soft sensitive spontaneous self' inscribed on it. The conditioned acceptance and chronic feelings of helplessness during childhood have caused a

disconnection from internal vulnerability. The words on the door create an opportunity to venture into that sacred area.

5) Any other name can be used on this door, depending on where clients are.

Steenkamp (JOS, 2002; Steenkamp, 1991) explains that with all images, clients should ‘feel’ these images as they express themselves. Clients are asked to pass through a door once a neutral feeling is experienced in front of a specific door. Once on the other side, clients should describe the total image as it unfolds and all the feelings activated by this image. After this, clients should walk towards the middle of the image and sit down with closed eyes to neutralise any form of control. Clients are then asked to focus on the word on a door and to experience the effect if other individuals enter that area of the self. Next, the focus should be on individuals entering the personal space of clients − this implies exposure, which in turn return clients to the vulnerability of possible initial imprints of not being good enough, being isolated and helpless. Once this procedure culminates in a neutral feeling – indicating that spontaneous healing has taken place − further exploration of the total image, associations with the present and past occurrences or interactions should take place. As long as the interference projected into an image is felt completely while clients remain totally passive and they feel secure about verbalising this process, the image will rectify itself (SH) and

clients can then experience this image positively. A dark, uncomfortable room can change, for example, into a peaceful, illuminated space.

3.3.4.3 Phase 3: A tunnel

In this phase, a natural tunnel is visualised. It is an archetypal symbol of the birth canal and signifies a journey towards life (Grof, 1988). Clients are asked to visualise a naturally formed tunnel. Before the clients are asked to step into the tunnel, all uncomfortable feelings should be allowed to connect. Once again clients must describe everything they see and experience as they step into and walk towards the centre. Once standing in the centre, clients are asked to sit down with their eyes closed and to experience all potential discomforts. While in that central space, clients are asked to focus on and connect with the effect of the following activators: isolation; experiencing the tunnel as if it was the birth canal; emotions within the self that block the self from moving forward spontaneously; all other activators with substantial psychological effects on them during the previous phases of SHIP®. Clients are then asked to stand up and walk towards the other side of the tunnel. Once on the other side, general feelings are expressed and experienced.

3.3.4.4 Phase 4: A well

The image of a well is used as a symbolic activator of the prenatal period and illustrates bonding with your mother and other significant others (Grof, 1988). During this phase, clients are asked to visualise a well. After explaining what they are experiencing, clients are asked to look into the well − again verbalising their experience. After this, clients are asked to imagine that they are floating down into the well and to describe this journey. Clients are asked to sit down at the bottom of the well with their eyes closed and again to stay with their experience. If the water is deep, clients should be reassured that they can breathe under water. Once all of the discomfort has been experienced, the following activators are given while clients remain seated at the bottom of the well:

- Prenatal phase – as if in a womb and surrounded by their mother. Psychotherapists should further enquire whether their mother is experienced as near or far.
- All of the previous activators that caused intense discomfort when presented initially in previous phases.

3.3.4.5 Phase 5: Integration

During the final integration phase, the previous four phases are integrated into a whole with the focus on the connection of clients with their future. Selected activator images deal with closure and the testing of issues that may still be disconnected and serve as activators of potential discomfort regarding the future of clients.

The following image can be used during this phase:

A door with the inscription 'The road of my life': Clients are asked to visualise a door with the above-mentioned inscription. All of the activated feelings are allowed until neutrality is achieved. Clients are asked to look at their past and the road they have travelled and to focus on the concept of "emotions within myself concerning the past that may still inhibit me from being spontaneous". When all of these feelings have been experienced, the focus should be on the road ahead and a similar instruction is given: "Emotions within myself that may still inhibit me from continuing into the future unrestrained".

The following images deal with relinquishing control:

Cliff: Clients are asked to visualise themselves standing at the edge of a cliff while looking straight down. They should describe all of the sensations they experience. Once neutrality is reached, clients are asked to fall forward by letting go completely.

Sea: Clients should visualise themselves descending to the middle of the sea where they are able to breathe naturally. They should describe the journey while experiencing all activators. Once standing on the seabed, they should sit down with their eyes closed and then experience being at the mercy of their surroundings.

Waterfall: Clients are told that they can breathe under water and that they are floating down a river towards a waterfall. As they float, their complete journey should be verbally described without clients taking control in any way. When the waterfall is reached, all forms of control should be neutralised until clients pass down the waterfall − activated feelings are allowed. Clients usually describe a deep tranquil pool waiting for them beneath the waterfall.

Bridge: Clients are asked to visualise a bridge. Once they visualise this image, clients should walk to the centre of this bridge and look straight down. Then they have to sit in the middle of the bridge with their eyes closed – relinquishing control – and once a neutral feeling has been established, they should look back to the side of the bridge where they started from and symbolically view that side of the bridge as their past. Clients are then asked to focus on "emotions within myself that may still hold me back". Afterwards clients are asked to focus on the side of the bridge they are walking towards – symbolising their future. Clients are then asked to get up and walk to the other side. They should describe all of their images and feelings on the way.

A door with the inscription 'Freedom': Freedom means being in full contact with internal potentialities and the absence of trauma. Clients are asked to visualise and experience the scene as it

unfolds in front of them – especially on the other side of the door. Clients should connect with all of the feelings that may arise.

Stairs leading down with an inscription at the top: 'My disconnected self': In order to check for any residual disconnected information, clients are asked to go down the stairs and enter the space that represents their disconnected self.

Cocoon: The cocoon is an archetypal projection of a metamorphosis. Clients in SHIP® have gone through a lot of changes − from being disconnected to being connected with potentialities within. A new definition of the self is the result of this intense psycho-biodynamic journey. Clients are asked to experience themselves cocooned with all the associated feelings until neutrality is reached. As clients emerge from their cocoon, they should describe everything they feel.

Raft: At this point in time, clients have opened themselves to the world, and can begin to explore and utilise their released energy. Clients are asked to visualise themselves on a raft in the middle of the ocean, and to describe their journey. Physical and emotional feelings should be experienced without taking control.

Once all of the images have been completed, and there are no more recurring dis-ease, the images used during SHIP® are interpreted for clients and SHIP® is terminated. The five phases do not necessarily take place in chronological

order, because each client has a unique healing rhythm. The Frame is, therefore, only used as an indication to guide SHIP®-guided therapy.

3.4 LIMITATIONS OF SHIP® AND CONTRAINDICATIONS USING SHIP®

There are always limitations to any form of psychotherapy or models. SHIP® was developed from the insights of Dr Steenkamp, a clinical psychologist who combined his knowledge of heuristic constructs of psychotherapeutic models, such as autogenic training, free association, the importance of the here-and-now, unconditional regard, flooding, imagery and the process of abreacting. These insights were combined with his experiences in practice – and can be, therefore, described as a top-down approach.

SHIP® coined terms for concepts that have not yet been formulated, locally or internationally. This unique language can confuse readers and psychotherapists who are not familiar with developed SHIP® terms. The challenge today for SHIP®, is to avoid developing further in isolation from other international frontrunners in trauma research.

SHIP® is psychotherapy in the long term and has financial implications for clients. Unfortunately, SHIP® is not a quick fix, because autonomic self-regulation needs time for rebalancing and integration and follows the spontaneous healing rhythm of individual clients. However, given the scarcity of resources in a South African context, this kind of psychotherapy may be reserved for a select few who can afford it.

A limitation of the initial development of SHIP® is that it did not include neurophysiology in its conceptualisation and application. This aspect was, however, addressed in recent publications (Steenkamp, 2013, 2014, 2015; Steenkamp et al., 2012). How contemporary theory informs SHIP® practice remains unclear. Safety in SHIP® seems to refer to the traditional psychotherapeutic approach to safety with regard to the presence, containment and empathy of psychotherapists for their clients. However, recent trauma literature proposes that a safe space is not enough to address the specific needs of acutely or chronic PTSD patients (Levine, 2005; Ogden et al., 2006; Van der Kolk, 2007). Trauma influences brain structure that causes traumatised individuals to neurophysiologically experience the self, the world and therapists in a fundamentally different way.

Also, SHIP® makes use of a bed on which a client lies and encourages passive needs to be reconsidered. Safety of the nervous system is compromised when exposure to activation is combined with passivity (called a biological completion model) and this approach is particularly prone to re-traumatise the nervous system (Payne et al., 2015). It is suggested that other safety measures should be incorporated in the SHIP® healing process, for example sitting in a chair, grounded body formation, using the eyes of clients for security − described by the Polyvagal Theory (Porges, 2011) − and to continue with activation (in a SHIP® way) by using the smallest activation possible called titration (Levine, 2005) until discharge and integration have taken place.

By requesting clients to visualise a traumatic event, should also be introduced with caution. Even though healing discharges are normally not overwhelming in nature, if the principle of titration is not applied it can re-traumatise clients, because it forces them out of the window of tolerance (Levine, 2015). A bottom-up approach should be followed by grounding clients and by introducing small amounts of activation (titration) to enable the nervous system to self-regulate and to ensure that clients are not overwhelmed by on-hold trauma energy. This recommendation also aligns with Phase 1 of the ISTSS that emphasises that clients should be stabilised and their skills strengthened − the first and foremost important starting point of psychotherapy.

In applying SHIP®, clients are encouraged to stay in a healing space through 'psycho-education' that can be experienced as a double bind/loose-loose interaction and contributes to potential conflict experienced by clients. SHIP® psychotherapists need to adapt to the needs of the nervous system of clients and should be careful not to apply the SHIP® framework mechanistically. SHIP® psychotherapists need to be aware of the difference between a sympathetic and a parasympathetic nervous system over arousal or flooding. An integration with the Polyvagal Theory will, therefore, ripen SHIP® theory.

An associated challenge for SHIP® psychotherapists and other trauma models exists in the psychotherapeutic relationship, namely traumatic countertransference, which is the same as vicarious or secondary trauma

(Herman, 2001). Psychologists must always be alert to the dangers of countertransference and should seek their own supervision if necessary.

SHIP® is contraindicated for clients presenting with the following: organic mental problems and disorders due to a difficulty in visualising images; clients lacking motivation and focus; clients who are subjected to chronic substance abuse/intoxication; and clients who are in a psychotic state (JOS, 2002; Steenkamp, 1991).

3.5 CONCLUSION

An integrated SHIP® trauma-spectrum model for the treatment of C-PTSD was discussed and are coherent with the qualitative research paradigm and case study methodology described in Chapter 4. The next chapter describes the motivation for this study and the research method used.

CHAPTER 4: RESEARCH METHOD

This chapter provides an overview of the research method used and the way it was implemented. The choice of a case study design is theoretically contextualised and described. Salient points relating to the sampling method data collection and analysis of the data are discussed. Aspects that were considered to ensure research quality and uncompromised ethical standards are expanded upon, and the way in which the research project was implemented is described.

4.1 RESEARCH PARADIGM

In line with critical realism, this chapter deals with obtaining the subjective experiences (relativism) of an ageing individual who was exposed to acute and developmental trauma. An interpretivist perspective accommodates the subjective experiences of individuals (Creswell, 2013; Denzin & Lincoln, 2011). This study was approached from a descriptive and explanatory perspective to describe the experiences and shifts of a participant. A descriptive and explanatory approach aims to produce an in-depth understanding of the healing experiences of an ageing individual who presented with C-PTSD, as a result of was SHIP® applied as a therapeutic intervention.

Qualitative research is an appropriate means of exploring phenomena in depth and does not arrive at conclusions by means of statistical procedures or other processes of quantification (Clarke & Braun, 2013). Qualitative research is used to develop theory and to conduct research when limited or insufficient literature exists (Brinkmann & Kvale, 2008). It is also used when present

literature or theory does not adequately portray the complexity of a research problem (Creswell, 2013). In this instance, literature on C-PTSD, developmental trauma and mild/subtle trauma regarding ageing individuals is very limited.

Furthermore, qualitative research enables researchers to explore research topics in context and report findings are obtained from participants in such a way that the views of participant are not decontextualised (Marshall & Rossman, 1985; Struwig & Stead, 2001). The experience of participants of C-PTSD and their shifts acquire meaning within the psychotherapeutic context of SHIP®. Furthermore, the experience of trauma is subjective and needs to be explored within a context where participants do not feel overwhelmed (Levine, 1997; Scaer, 2005). Creswell (2013) views qualitative research as an evolving process. All or some of the phases of the process may by modified or adjusted after researchers have entered the field and data are collected (Creswell, 2013). In planning this research, the initial aim was to make use of multiple case studies. However, in view of the extent and depth of each SHIP® session over the course of psychotherapy, it was decided to change the research design to a single case study.

Qualitative research is, therefore, appropriate for this study, because it aims to achieve the following: to understand phenomena from the viewpoint of participants; to describe the context of participants in such a way that their views are not seen out of context; to understand the thoughts, feelings and behaviours of participants.

Captured data are not presented in a static, reductionist and decontextualised manner (Struwig & Stead, 2001). In order to conduct an in-depth investigation of the experiences of a participant suffering from C-PTSD and the shifts that took place during the course of SHIP® psychotherapy, a case study design was chosen.

4.2 RESEARCH DESIGN

Since 1984, case study research has been increasingly recognised as a valuable research method (Yin, 2014). A case study approach is appropriate when inquirers have a clearly identifiable case with boundaries and seek to provide an in-depth understanding of a case (Creswell, 2013). Yin (2014) affirms that case study research is the preferred research method compared to others (experiments, surveys, archival analyses) in situations where the main research question is a ‘how’ or ‘why’ question; researchers have little or no control over the behavioural events of a case, and the focus of a study is a contemporary phenomenon.

The motivation for using a case study design for this study is twofold: Firstly, a case study investigates a contemporary phenomenon − C-PTSD − in a real world context. Secondly, in a case study design, researchers rely on multiple sources of data and the prior development of theoretical propositions to guide data collection and analysis (Yin, 2014).

Case studies are distinguished in terms of the intention that prompted a case analysis: an instrumental case study and an intrinsic case study. An intrinsic

case study is undertaken when the primary purpose and focus are to gain a better understanding of a particular case (Yin, 2014). It is not undertaken, because a case represents other cases or to illustrates a particular trait or problems − the case is in itself of interest. An instrumental case study is used to provide insight into an issue or to redraw a generalisation (Yin, 2014).

A case is chosen to obtain a better understanding of a problem. In an individual instrumental case study, researchers focus on an issue or concern and then select a single bounded case to illustrate a particular issue (Yin, 2014). This study employed an instrumental case study. A single case was used and a single issue or concern was addressed, namely an ageing individual who presented with C-PTSD and not SHIP® in itself.

Case study research is unique in that data sources are used that are not usually available when other research methods are used: direct observations of an event being studied and contact with an individual involved in an event (Yin, 2014). In this case, the multiple data sources included: the verbatim psychotherapy process notes, the life sketch of the participant and feedback upon conclusion of the therapy.

4.3 RESEARCH CONTEXT AND THE PARTICIPANT

Although a rigid procedure is not followed, SHIP® is underpinned by a conceptual framework. SHIP® uses the interrelationships between intra-trauma and inter-trauma translators and SHRs to facilitate healing. Intra-trauma translators refer to repetitive somatic dis-ease and inter-trauma translators

refer to projection issue statements. SHIP® can be applied through a combination of its five phases, not necessarily in a linear manner. Each phase represents a different level of SHIP® − working towards integration in Phase 5. In Phase 1 to Phase 5, The Frame represents a gradual phasing out of on-hold activation energy lodged in the system of clients. The Frame is like a road map − keeping therapy on course, because the individuality of clients must be accommodated. The phases are an indication of the general course of integration of unresolved trauma. It is the responsibility of SHIP® psychotherapists to keep track of the process of clients and to note what still needs to be integrated. The Frame and its constituent phases are described in detail in Chapter 3.

In selecting a participant, the suggestion of Creswell (2013) was followed: no set number of cases is required. Furthermore, no social, cultural, ethnic or gender parameters were laid down for a participant in this study. A participant should have certain characteristics researchers are interested in (Neuman, 1997). In this study, the following inclusion criteria were used: a middle-aged (40+/50+) or an older (60+) individual who presented with C-PTSD symptoms (as described in Chapter 2) as a result of earlier multiple traumas that occurred over the lifespan of this individual who underwent SHIP® psychotherapy (as described in Chapter 3) over a period of time. Criteria used to select a case from case files were that the data source had to include the following information: 1) trauma-activating events (incidents experienced by an individual overwhelmed by psychobiological resources); 2) intra-translators

and inter-translators; 3) SHRs; 4) shifts; and 5) an individual who was involved in SHIP® psychotherapy over a period of time.

4.4 RESEARCH PROCEDURE

The process of selecting a participant suitable for this study included that the sample criteria were chosen and presented to the SHIP® Foundation. A pool of possible participants (12) diagnosed with C-PTSD by their psychotherapists and who completed their psychotherapeutic process was provided by members of the SHIP® Foundation. The participant was selected from this pool. The screening of potential participants was done by systematically searching through client case files – made anonymous by psychotherapists − for possible cases of an ageing individual who presented with C-PTSD and who completed the SHIP® process over a period of time. All of the potential selected cases were then sifted for information-rich data that complied with the selection criteria (Creswell, 2013). This was followed by checking for a complete life sketch done by the potential participant.

Lastly, the potential participant was asked to give permission for her process to be used for research (see ethical considerations). The participant used in this study completed her process over a period of seven years. The process notes were written during the psychotherapy period.

The research only commenced after the participant had completed her SHIP® treatment and agreed that her psychotherapy process notes and life sketch can be used for research purposes. The researcher had no professional

consultation with the SHIP® psychotherapist who diagnosed and treated the research participant.

4.5 DATA COLLECTION

Data collection in case study research is typically extensive − drawing on several sources of information (Yin, 2014). The ability to deal with the full variety of data sources is a unique strength of case study research (Creswell, 2013; Yin, 2014). The three data sources used in this research are described in the following section.

Firstly, the 127 SHIP® **psychotherapy sessions** lasting 60-120 minutes each were used. Each session consisted of process notes (approximately 190 pages of shorthand, written, verbatim descriptions of what exactly was said during each session) (Creswell, 2013; Yin, 2014). Textual data were, therefore, obtained.

Secondly, the **life sketch** of the participant was obtained as part of the case file of the participant. A life sketch is a narrative that the participant wrote of all her life experiences that she can remember as having been distressing, traumatic or embarrassing. A request for a life sketch is usually made to participants before they start with psychotherapy: Please write a story of your life, which contain everything that you can remember as having been distressing, traumatic or embarrassing from as far back as you can remember until today. A life sketch is a valuable data source and is used to identify trauma-activating events (incidents experienced by individuals that

overwhelmed her psychobiological resources) and to identify intra-translators and inter-translators.

Thirdly, a **narrative** written by the participant as a reflection on her process upon conclusion of SHIP® psychotherapy was also used. The following request was given to the participant: Please contemplate over your SHIP® psychotherapy and write a reflection on your experience thereof.

4.6 DATA ANALYSIS

Data were analysed in two phases. In Phase 1, the method of analysis as outlined by Kohlbacher (2006) was followed:

a) **Summary**: Reading and familiarisation with data (the life sketch, process notes and client feedback). Identifying and extracting the "instances"/occurrences for the purpose of reducing data. The researcher read through the life sketch, process notes and client feedback to familiarise her with the content of the data and identified occurrences of trauma-activating events; intra-translators and inter-translators, SHRs and shifts.

b) **Explication**: Coding for defining themes was done by making use of *a priori* coding application (Creswell, 2013; Yin, 2014) or a deductive category application (Kohlbacher, 2006). The researcher analysed the life sketch, process notes and client feedback by making use of a deductive category application by systematically extracting themes from SHIP® constructs: inter-translators and intra-translators and the SHRs (concepts are explained in Chapter 3) along with shifts experienced by

the participant. A theory-guided analysis is one of the strengths of a thematic analysis, which ensures the quality and validity of a analysis (Kohlbacher, 2006).

c) **Structuring**: During this phase, the data was structured according to content, form and scaling. A table was used to group inter-translators, intra-translators and shifts. After the data analysis phase was completed, an interpretation process followed − beginning with a description of the context of the case study and the identification of key examples. In the final stage, the findings were processed and are presented in Chapter 5.

The analysis completed by the researcher was, however, not a linear process of merely moving from one phase to another; the researcher had to go back and forth as needed (Ely, Vinz, Downing, & Anzul, 2005).

Phase 2 entailed an inductive thematic analysis, which was used to explore the underlying themes (experiences and shifts) within the data (Clarke & Braun, 2013). A thematic analysis is appropriate for processing qualitative data as rich, detailed and complex accounts of data are produced (Frankfort-Nachmias & Nachmias, 2014). A thematic analysis is an inductive and iterative way of looking at data from different angles with the aim of identifying keys in the text that can facilitate understanding and an interpretation of the raw data (Niewenhuis, 2007). A thematic analysis is, therefore, “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79).

The following guidelines are proposed by Braun and Clarke (2006) and Clarke and Braun (2013) and were used during an analysis of the textual data obtained from the three sources previously identified:

Step 1: Familiarisation with the data by reading and re-reading the data.

Step 2: Generating initial codes by using in-vivo coding or by generating codes from the data.

Step 3: Searching for themes by arranging codes into potential themes and gathering all of the relevant information for each potential theme that emerged.

Step 4: Reviewing themes by verifying these themes in relation to the coded subject groups and generating a thematic table of the analysis.

Step 5: Defining and naming themes.

4.7 RESEARCHERS IN RELATION TO QUALITATIVE RESEARCH

Case study research is a form of inquiry in which researchers try to gain an understanding of what they see, hear and understand (Brinkmann & Kvale, 2008; Yin, 2014). The interpretations of researchers cannot be separated from their own personal history and preceding knowledge (Creswell, 2013), as this study was done from a SHIP® perspective.

The researcher is a middle-aged Afrikaans-speaking woman who began her professional career as a town and regional planner, but she soon realised that the psycho-biosocial dynamics within a system have a direct impact on the overall well-being of individuals and that there are very often underlying emotional problems that need to be addressed before a lasting improvement

in the quality of life of individuals can take place. This prompted the researcher to further her studies in psychology and she obtained a Master's degree in Counselling Psychology. She completed her internship at 1 Military Hospital, a psychiatric hospital dealing with Defence Force personnel (soldiers) and their families. The researcher was exposed to various aspects of psycho-biodynamic imbalances and trauma-activating events within a diverse demographic and cultural client base. In 2005, she started a private practice where she focuses on the facilitation of the process of achieving a balance between the mental, emotional and physical dimensions of clients. In 2003, the researcher began her training as a SHIP® psychotherapist and registered as a SHIP® psychotherapist (SHIP® for Adults Facilitator) in October 2006.

During the past decade − while working with adults in private practice − the researcher has continued her search for a better integrated understanding of what she has seen, heard, and experienced of the psycho-biodynamic field by attending SHIP® workshops, continuing supervision with a SHIP® trainer, attending weekly meetings with other SHIP® psychotherapists, reading extensively in the field of mind-body medicine and completing various courses related to trauma-spectrum manifestation, such as craniosacral therapy (Level 1); trauma and tension release exercises (Level 2), life energy (Advanced Level). This search culminated in the undertaking of this study.

4.8 INTEGRITY OF THE RESEARCH

Yin (2014) identified three traditional concerns about or prejudices against case study strategies. The first concern is the lack of rigour in case study

research. Yin acknowledges that in the past, biased views were allowed to influence conclusions but explains that there is a need to differentiate between case study research and case study teaching and that bias may also have been prevalent in experiments and quantitative analyses. Another concern is that case studies are not a basis for scientific generalisations. The same argument can be applied to single experiments that, like a single case study, aim to present a case for theoretical generalisation and not statistical generalisation (Yin, 2014). Thirdly, a common limitation of case studies is that they are too time-consuming and result in massive documentation. Yin (2014) acknowledges this but maintains that with a better design this can hopefully be avoided in future. The following guidelines were, therefore, used to contribute to the trustworthiness of the research study and findings:

Credibility was achieved by making use of specific inclusion criteria to select a participant who presented with C-PTSD (Denzin & Lincoln, 2011). Furthermore, following the suggestion made by Morse, Barrett, Mayan, Olson and Spies (2002), verification procedures were applied during the research to make sure that the data ensure the rigour of the study, according to SHIP® theory.

Credibility may have been compromised by having the originator of SHIP® as the co-promotor of this study. As the co-promoter, he was involved in supervising Chapter 3. The researcher was first introduced to SHIP® as a psychology student. After completing her SHIP® training programme under Dr Steenkamp's supervision, she participated in collegial group discussions of

case studies. In the past 13 years, the researcher attended numerous SHIP® workshops and conferences where a variety of SHIP® trainers, SHIP® facilitators and specialised guest lecturers were presenters. The researcher also completed various other courses during these past years as part of the continuous professional development requirements: A short course in Spontaneous Healing Facilitation presented by the University of South Africa (UNISA); Craniosacral therapy (Level 1) through the Upledger Institute; and Trauma and tension release exercise (Level 1 and Level 2) presented by Dr Berceli. These short courses informed and shaped her understanding of trauma and psychotherapy.

"Research is only as good as the investigator" (Morse et al., 2002, p. 17). The researcher is also a registered SHIP® psychotherapist and has an extensive background in providing SHIP® therapy to a variety of clients. She was, therefore, able to demonstrate the complexities and connections amongst psycho-biodynamic translators, SHRs and shifts that took place during the course of therapy.

In qualitative research, parameters should be stated adequately − the boundaries of a study should be set (Marshall & Rossman, 1985; Yin, 2014). In this study, the participant had to be an individual who presented with C-PTSD and opted for SHIP® therapy and who was in psychotherapy over a period of time. SHIP® theory also guided the first phase of the data analysis process.

The choice of a case study in relation to the research question together with the choice of participant, data sources and the method of analysis ensured methodological coherence, as suggested by Mayan (2009). The participant was selected, because she best represented known facts about C-PTSD and have experienced shifts during the course of her SHIP® psychotherapy (Morse et al., 2002).

Transferability refers to the question whether findings can be transferred to another case or context. Transferability is enhanced by designing studies to make use of multiple methods of data collection (Lincoln & Guba, 1985). In this study, process notes were used and a life sketch was provided by the participant together with a reflective account of the participant after she has concluded her SHIP® psychotherapy. The theoretical parameters of the research are specified and anyone reading the research report can see how the research ties into a body of theory, as described in Chapter 3 (Marshall & Rossman, 1985; Yin, 2014).

Marshal and Rossman (1985) describe an additional strategy to boost generalisability: The crystallisation of multiple sources of data. **Crystallisation** is the act of bringing more than one data source to bear on a single point to provide a deepened, complex and thoroughly impartial understanding of a topic (Ellingson, 2009). Data from different sources can be used to support, enrich or illuminate the research in question. A study design in which multiple informants or several data gathering methods are used can greatly strengthen the transferability and generalisability of a study (Ellingson, 2009). The data

were obtained from extensive process notes (including observations), reflective notes, a life sketch and a reflective account of the psychotherapy − provided by the participant. The use of direct quotes accommodates the ideas and thoughts of the participant. An analysis of other case studies confirmed the assumption that multiple case studies would simply produce more of the same themes and would not necessarily provide an in-depth description of the shifts that are linked to the subjective interpretation of trauma from an individual perspective.

Dependability is the fourth construct necessary to obtain trustworthiness. The researcher attempted to account for changing conditions concerning the phenomenon investigated in this study and changes in the design created by a refined understanding of the setting (Lincoln & Guba, 1985; Denzin & Lincoln, 2011). Dependability is increased by a precise description of the methods of data gathering together with the analysis and interpretation of data. A dense description of the methods used in this study yielded important information as to how unique the setting is and how repeatable the study is. The research process in this study followed a logical sequence and is well documented; an audit trail is available on request.

Confirmability in qualitative research is the degree to which other people are able to confirm the results and findings of a particular study (Marshall & Rossman, 1985; Yin, 2014). The researcher continuously reflected on the data analysis in collaboration with her supervisor. The researcher embraced the outlines of the code of professional ethics of the HPCSA as her personal

credo throughout the study regarding the integrity of the data analysis performed. Lastly, sincerity was demonstrated through an introspection on the question of personal bias by having regular peer-reviewed discussions.

4.9 ETHICAL CONSIDERATIONS

Ethical approval was obtained from the Human Research Ethics Committee of the North-West University, Potchefstroom Campus, under the number: NWU-00053-10-A1 and with the project title: “An exploration of enabling contexts”. The researcher further adhered to the general ethical guidelines for health researchers outlined by the HPCSA (2008). These core ethical guidelines are:

The **principle of best interest or well-being**: Harm to participants must be minimised and the benefits of the research must outweigh the risks to participants (HPCSA, 2008). Brinkmann and Kvale (2008) explain that the healing processes of clients are the sole responsibility of psychotherapists. The healing rhythm of participants should be respected and participants should not be pressured into completing their processes within a certain time frame. The role of psychotherapists is of the utmost importance and the role of researchers second to that. Questions asked during a session must be conducive to the process of participants and should not hinder it in any way. During sessions, the focus should always remain on participants and not on potential research information (Brinkmann & Kvale, 2008).

In this study, the participant has completed her SHIP® process and was no longer in psychotherapy. The psychotherapy process was, therefore, not

contaminated by the subjective influences of the researcher. The manipulation of information obtained from observations of participants is one of the limitations of case study research (Yin, 2014) but has been addressed by using data from a participant who has completed the SHIP® process.

Secondly, the **principle of respect**: Participants must be treated with respect and afforded the opportunity to make an informed decision regarding participation in a study. In addition, participants have the right to privacy and confidentiality (HPCSA, 2008). The participant who participated in this research study was selected based on her willingness to participate and she provided consent to conduct the study. The purpose of the study was discussed with the participant. The voluntary nature of her involvement was also explained and emphasised. Permission to make use of the participant's process notes on her psychotherapy sessions in the research study was obtained. Confidentiality was addressed by assuring the participant that she would remain anonymous in any reports associated with the study by using an alias.

Lastly, the **principle of justice**: Justice entails treating everyone in accordance with what is right and proper − meaning that the research must not violate the rights of participants by causing harm. The choice of research questions must be justified to ensure that these questions do not result in an exploitation of participants (HPCSA, 2008). The transcripts and their interpretation in the form of a final report were made available to the participant before the final documents were submitted.

4.10 CONCLUSION

This chapter described the research method applied in this research. Qualitative research and a case study design were chosen, because the objectives of the research could be reached. The research was also consistent with the systemic perspective described in Chapter 3. Data collection and analysis were described in detail and ethical issues regarding the research were examined. The next chapter provides the findings obtained during the research study.

CHAPTER 5: FINDINGS

This chapter discusses the experiences and shifts of an ageing individual who presented with C-PTSD. She participated in a SHIP® psychotherapeutic intervention over a period of time. This chapter provides background information about the participant and the experiences and shifts in SHIP® are discussed.

5.1 BACKGROUND INFORMATION ON THE PARTICIPANT

Gender:	Female
Age:	46 years old when she started with psychotherapy and completed psychotherapy at the age of 53
Language:	Afrikaans
Marital status:	Married
Occupation:	Stay-at-home mother and wife residing
with her	husband and two sons
Previous psychological treatments:	None

5.2 DIFFERENT TYPES OF TRAUMA-ACTIVATING EVENTS

Table 1 provides a summary of acute trauma-activating events after an analysis of the life sketch of the participant was done.

Table 1

Different types of acute trauma-activating events

Birth: breech baby – right hip was dislocated in the process.

At the age of 18 months the participant had her first hip surgery. She was in the theatre without her mother − crying, feeling scared, alone and cold.
The participant had to undergo surgery for about four to five times and after each operation she was for approximately six weeks in a cast.
The participant was cut several times by accident when the cast was removed.
The cast was put on too tightly. As a result, her feet turned blue and the cast had to be taken off to try again.
She once fell against the coffee table at home and cut her cheek. Her father (a medical doctor) gave her stitches.
During a surgery, the anaesthesiologist worked so roughly with her that when the mask was pushed onto her face the whole cut burst open.
At the age of four and a half, she had to undergo two additional surgeries to repair the damage done to her hip by previous surgeries.
A smash-and-grab incident one evening three nights prior to making an appointment with a psychotherapist.
Two years previously, an armed robbery at their house.

5.3 EXPERIENCES BEFORE PSYCHOTHERAPY COMMENCED

Different intra-translators and inter-translators were identified before the participant commenced with psychotherapy. Intra-translators manifest in the ISF of individuals as repetitive and/or intense somatic sensations or feelings. Inter-translators are projection issue statements (the verbalisation of repetitive psychobiological dis-ease concerning a specific issue) of the external ISF of individuals (in relation to individuals and their environment).

5.3.1 Intra-translators

Somatic sensations result from an interacting pattern formed by the physical, emotional, cognitive and spiritual issues in the life of persons. In this case, several intra-translators manifested in the life of the participant, such as fibroids; chronic lower back pain; clenching of jaw, gritting of teeth; discomfort in solar plexus; difficulty concentrating/maintaining focus; exaggerated startle response; nightmares; muscle tension; pain in left ankle; left eye continuously teary; headaches; nausea; chronically tired; liver under stress; heartburn; and painful coccyx.

Levine (2015) stresses the fact that the felt sense of bodies allows physiological access to memories. These are the crucial unspoken memories that cognitive approaches do not engage with and cathartic approaches frequently overwhelm these memories (Fogel, 2013). The Polyvagal Theory further explains that on a physiological level, because the vagus nerve innervates the larynx, pharynx, heart, lungs and the enteric nervous system (gut), the impact of trauma on these organ systems leads to a variety of physical symptoms (Porges, 2011) affecting the cognitive, affective, immune, endocrine, muscular and visceral systems (Scaer, 2005). This elucidates why from a psycho-biosocial perspective, illness and health are both the consequence of connections between biological, psychological and social factors (Alonso, 2004; Jacovlejevic et al., 2012).

Depending on the unique makeup of individuals, these sensations may manifest differently. The participant, for example, experienced nightmares,

anxiety attacks and increased aggressiveness combined with an exaggerated startle response. The following additional intra-translators also emerged: feelings of helplessness, anxiety, unworthiness, loneliness, isolation and anger.

Helplessness is an experience of not being protected: *There is nothing to protect you in this country* (from sessions 2 and 3; hereafter only the number of a session is noted) or felt as defencelessness: *You are just so defenceless* (43), vulnerability or being exposed is highlighted: *I could never fight* (4) and the feeling of not having the ability to influence circumstances: *I feel stuck!* (89). Helplessness is experienced when individuals are unable to do something to make a situation better or easier together with a feeling of not being in control: *I want to be in control again* (1, 4); *As a small, small child, I never had any control* (4); *They always decided for me, I was unable to crawl or walk where I wanted to* (6); *I want to do it myself, but I can't* (19). Helplessness can also be linked to a feeling of powerlessness – a feeling of losing power that was part of the existence of individuals: *I want to scream, but I can't* (55). Powerlessness can be described by words such as "paralysed" or "weak": *It drains me* (2).

Anxiety can be identified as fearfulness, worry or nervousness: *There is always that damn anxiety* (52); *It is a feeling which I always had, I never liked it, I always had to be on guard* (8). It is apprehensiveness experienced regarding impending or anticipated events: *I'm afraid I'll be abandoned* (70) Apprehensiveness is marked by doubt concerning the reality and nature of

threats: *I expect the worst* (54) Individuals experience self-doubt about their capacity to cope with threats: *I was always afraid that I can't, scared that I will fail* (11). Anxiety is frequently associated with physiological signs, such as sweating, tension and/or heart palpitations: *I feel closed in, almost shocked, frightened* (61) Usually, anxiety goes hand in hand with agitation, anxiousness, concern, nervousness and/or general dis-ease: *Feels as if I leopard crawled my whole life* (11) and *I'm afraid to be* (66).

Unworthiness can be described as feelings of not being good enough: *I'm not at ease with myself* (62); and when individuals experience shame: *I don't like myself* (124), which imprints when they feel humiliated: *I feel useless* (77) or shamed: *I just wanted to believe that I'm normal* (4), embarrassed: *Embarrassment made me freeze* (99) or they experience themselves negatively: *I feel worthless* (77). Unworthiness often initiates feelings of not being deserving of someone: *I always had the feeling that I'm not worthy of his attention* (38); *I feel rejected by my father* (39) or not being deserving of something: *I wish I could expressively live my life* (10). Unworthiness leads to feelings of loneliness and isolation: *I feel not good enough* (11, 39, 77. 93, 101).

Loneliness can be expressed as feeling alone: Alone … *I remember that well* (39); or feeling isolated: *It feels like I fit nowhere* (124) or being set apart from other individuals: *You feel orphaned* (52); and *You need to do it yourself, alone* (52). Loneliness can cause feelings of sadness from being apart from

other individuals: *I struggle to connect with anybody* (43) or not included: *I'm in a hole and out there is stuff, and I am missing out, not being part of it* (63).

Anger can be caused by strong feelings of dislike and offence and can turn into antagonism, bitterness and resentment. Anger is an intense emotional state induced by wrongdoing and often results in active opposition, such as insults or injuries. The feeling masked by anger is usually pain. The following are quotes from the participant as she expressed her experiences of anger even from early childhood: *It feels like a storm inside me* (33); *I'm angry at everyone* (43); *I am furious!* (121); *I want to throw a tantrum, but I can't* (70); *I always had to pretend that everything was ok, but it wasn't* (8); and lastly, *I bear grudges* (10).

5.3.2 Inter-translators

Inter-translators indicate the presence of unresolved on-hold activation energy (disconnected trauma energy) still present in a freeze response (Steenkamp, 2013, 2014; Steenkamp et al., 2012). Levine (2005) explains that the debilitating after effects can also be referred to as long-term symptoms of trauma and can take many negative and destructive forms. The effects of unresolved trauma can affect various dimensions of the system of individuals. As explained by a biopsychosocial perspective, complex trauma manifestations are a multisystem dis-ease (Jacovlejevic et al., 2012) and a biopsychosocial perspective specifically maintains the idea that illness and health are both the result of an interaction between biological, psychological and social factors (Dogar, 2007; Engel, 1980; Suls & Rothman, 2004).

SHIP® describes inter-translators as expressions that work through the external ISF of individuals by means of projection issue statements, such as: *I never feel good enough*. Within such a statement there is a recurring feeling that links back to the residual on-hold activation energy of unresolved trauma experiences. Different trauma-activating events link into a trauma chain that eventually present themselves through inter-translators. When inter-translators are followed to their origin, initial trauma-activating events are exposed. This is very useful as clients do not always know why they feel the way they do (Levine, 2015). If an internal trauma chain is systematically exposed, the on-hold activation energy can be discharged and integrated through the autonomic self-regulation system of clients.

From the data, the following inter-translator themes were identified:
Now I have another (repetitive) *scar to remind me of my childhood surgeries* (issue).
I was always (repetitive) *self-conscious* (issue) *about my scars and as I got older the more self-conscious about them I became.*
I always (repetitive) *wondered how my life would have been if the doctor had not dislocated my hip. – would I have had more confidence* (issue)*? Would I have achieved more? Would I believe more in myself?*
I never (repetitive) *liked it when someone asked me about it and then felt sorry for me. Then they reminded me that I was different* (issue) *– not normal – weaker* (issue).

I always (repetitive) *wondered whether if it had not been for my hip I would have excelled* (issue) *in athletics/gymnastics?*
I still (repetitive) *struggle to write about my father* (issue).

Repetitive projection issue statements are the result of trauma fused with the **biopsychosocial development** of individuals that keep on repeating in relationships and experiences throughout life (Coates, 2010). This is visible in the compulsion to repeat actions or experiences that replicate the original trauma in obvious and less obvious ways (Levine, 2015). This replication may occur through physical symptoms or through interactions with the external environment (Levine 2005; Scaer, 2005; Steenkamp, 2014).

In this study, the participant experienced a combination of chronic difficulties in her external ISF, such as re-experiencing, avoidance, numbing and hyper-arousal − PTSD symptoms. In addition, the participant experienced a complex mixture of emotional regulation difficulties, disturbances in relational capacities, alterations in attention and consciousness, and an adversely affected belief system.

5.4 SHIFTS DURING PSYCHOTHERAPY

Shifts in SHIP® refer to a dynamic healing process that does not follow a linear approach (Steenkamp, 2015). Shifts are the organising principle of healing, which relates to an increased capacity for connection with the self and others, feeling the ‘right to be’, and the intrinsic right to a meaningful place in life and in the world (Heller & LaPierre, 2012; Steenkamp, 2013). Early in the process

of the participant only a few shifts were noted, but these shifts increased over time.

5.4.1 From acute trauma-activating events to developmental trauma

The smash-and-grab shock trauma-activating incident activated old unresolved residual trauma energy still lodged in the system of the participant. The inter-translator of *I want to be in control* indicated a link to unprocessed developmental trauma. It is also evident from the participant's response:

> *When I was very young, I had no control. I was always in plaster bandages, always different from the other normal kids. I don't want to be different. I always wished it could be different. I feel the fear when they would take me into the operating theatre. I'm cold and afraid. My mother was only allowed to be with me until we reached the doors. Then I would scream! And they would put a mask on me, I would still scream for my mother. I would scream, see the lights and then I would be gone. When I came to, it was always that wet, heavy plaster bandages. They cut me several times by accident when they put the plaster on or as they removed it. I have a lot of scars from that time.*

Apart from this particular acute trauma-activating event for which the participant sought help, other acute trauma-activating events also occurred over an extended period of time in the participant's life beginning from birth to

the age of 43/44. The participant remembered numerous times when she experienced immobilisation and fear (trauma) while growing up (developmental trauma). As a young child, she was subjected to multiple surgeries in an attempt to correct her hip. Her natural defence mechanism of fight or flight could not be used and the energy was captured in a freeze response. Other projection issue statements (inter-trauma translators) also showed that the participant has experienced and was still carrying residual on-hold activation energy as a result of the developmental trauma within her system, which was reactivated by shock trauma incidents:

> *I wish ... with everything that had happened to me, I wish that I had been able to turn around and fight and not flee. I always said to myself that I could have been better … My neck and my jaw are stiff now. I also feel anxious and rushed.*

The word "*everything*" describes the repetitive nature of the issue that indicates the development of a pattern as a result of the on-hold activation energy that was still in her system. Clients often express a wish that they or the world can be different. Inter-translators are, therefore, links to a trauma chain that can be followed to all of the trauma-activating events that have occurred over the lifespan of individuals.

Developmental trauma − due to shock or subtle trauma activating events – is implied when one of the basic needs of children is not met – when autonomic self-regulation, a sense of self and self-esteem are compromised (Ogden et al., 2006). Trauma sympoms fuse with the psycho-biosocial development of

individuals and continuously echo across their lifespan (Coates, 2010). Although not every stressful event is experienced as trauma, Levine (2005) stresses that individuals and especially children can be overwhelmed by what we usually think of as everyday events, such as automobile accidents, routine invasive medical procedures or even falling from a bicycle. Trauma during the developmental phase can lead to disruptions of the spontaneous rhythm that can prevent children from achieving maturation and these adults continue to experience the world from the perspective of children (Scaer, 2005).

Levine (2005) stresses that it is important to understand that individuals can be traumatised by any event which they perceive − consciously or unconsciously – as life-threatening. We become traumatised when our ability to respond to a perceived threat is in some way overwhelmed (Levine, 2005; Scaer, 2005; Steenkamp, 2014).

Disconnected trauma energy often presents in a trauma chain that is formed by linking different types of trauma-activating events (e.g., shock trauma and developmental trauma) over the course of the life span of individuals. In the case of the participant, the shock trauma of the smash-and-grab incident was linked to her developmental trauma of being subjected to multiple immobilising and inescapable medical procedures (hip operations) and to the relationship with her father (not in his role as medical doctor).

To systematically discharge on-hold activation energy when working with developmental trauma, is like peeling off the layers of an onion – as the

presenting layer is worked through and discharged, the layer underneath is exposed and surfaces and after the second layer has been worked though the next layer surfaces. This process continues by working deeper and deeper to discharge and integrate disconnected and on-hold activation energy of previous trauma incidents.

5.4.2 Shifts in the here-and-now

By focusing on incomplete trauma experienced in the past but discharged in the here-and-now, makes it possible to integrate on-hold activation energy. By simultaneously going back to the past while staying in the here-and-now, clients are able to follow a link to the origin of their trauma and to uncover the original trauma-activating incident. If this process is complete, an integration of the rippling effect of the trauma-activating event into past memories can take place.

Shifts can take place by focusing on the present moment and asking clients to verbalise any discomfort (physical and/or emotional) that they are aware of at that moment. Levine (2005) describes this as the felt sense. A felt sense encompasses a complex array of ever-shifting nuances of very subtle, complex and intricate feelings and sensations, which make it sometimes difficult to convey through language (Fogel, 2013). By becoming aware of inner sensations, allow clients to access direct experiences of our system along a spectrum that ranges from pleasure to pain (Levine, 2015; Gendlin 1997). Furthermore, these feelings originate from the deepest levels of the brain stem and not the cerebral cortex. This is significant, because to avoid over arousal or flooding, clients need to be grounded first (Levine, 2015).

The developmental trauma of the participant consisted of subtle and acute trauma-activating events. The on-hold activation energy from that time was activated by past traumatic experiences expressed as hyperarousal, constriction, dissociation and feelings of helplessness and freezing, which were activated into a healing discharge response in the present. The participant was encouraged to mindfully explore trauma-activating events in the moment:

> *I feel it in my chest ... I can't remember much. I remember that I could not play around. Freeze, not fight or flight. I remember the heavy, wet plaster of Paris. I was unable to move ... I remember now that a lot of the time I felt anger towards the doctor, but I always accepted everything amiably*.

In the here-and-now, disconnected material emerged and the participant was able to connect with her disconnected feelings of anger towards the doctor, as she was unable to do this as a young child. At that time, she experienced feelings of being overwhelmed by her powerlessness but in the here-and-now the on-hold activation energy could be discharged in a contained therapeutic space. The autonomic self-regulating mechanism completed its natural cycle of activation and deactivation in order to return to homeostasis, which is the natural inclination of a body to heal itself.

SHIP® is a psycho-biodynamic systemic approach that works in the present moment with the felt sense (Fogel, 2013; Levine, 2005) by making use of

somatic mindfulness (Heller & LaPierre, 2012) in assisting the nervous system to self-regulate and to support the increasing capacity for connection and aliveness (Porges, 2011).

In the present, SHRs (JOS, 2002; Steenkamp, 2013, 2014; Steenkamp et al., 2012) are self-regulating psycho-biodynamic interconnected energy patterns within individuals and release activated trauma memories involuntarily (JOS, 2002). This was observed in the reported stiffness, anxiousness and rushed feelings that are indicators of a freeze discharge that has been activated (Levine, 2005).

5.4.3 Shifts in relation to activators

Shifts in a therapeutic process is noted when clients can listen to activators (described in Chapter 3) without any reported psychological discomfort. When the participant was asked to visualise an image of her father's face, the participant noted a felt sense of dis-ease in her abdomen: *My abdomen is pulling in*. From the perspective of psychotherapists, psychological discomfort is noted when inter-translator themes no longer appear in images, words, sensations, emotional experiences or physical reactions of clients.

In this case, the participant reported that she does not feel the need to react immediately – she can sit back, think about something before she responds to a situation. The overreaction to and exaggeration of incidents are significantly reduced and she feels that things have happened to her to learn from and to bring her in contact with herself in order to heal and grow. At present, the

participant has a better perspective of the world, she feels she is able to live in the present − not in the past or future as usual − without experiencing any anxiety. She described this realisation as a very fundamental shift for her.

5.4.4 Re-connecting the disconnected

Trauma is about a loss of connection (Levine, 2005). A loss of connection between and within the different levels of the biopsychosocial system (Coates, 2010). This loss of connection is often difficult to recognise as a disconnection does not happen all at once (Levine, 2005). Trauma across the lifespan of individuals impacts on the social, psychological and biological domains of individuals (Alonso, 2004; Jacovlejevic et al., 2012).

When the participant's developmental trauma occurred, it was too much for the psychobiological system to deal with and the overwhelming nature of the trauma resulted in a disconnection of experiencing (emotions and physical reactions) trauma incidents. By being **disconnected**, the participant was protected from overwhelming fear and immobilisation. As the participant connected with these disconnected experiences, she became aware of sensory and emotional memories:

> *I remember the smell, and the clinking of all the hospital stuff and that I always had to sit on a bedpan. And all the endless injections and drips. I feel so helpless. I had about five operations. Always in that damn plaster bandages. I'm a normal child which they made abnormal. All I wanted to be was to be normal. I*

> *always thought that if it was not for my hip I could have done this and that. Why could the doctor not just do a C-section, why did he have to dislocate my hip trying to turn me?*

Healing from trauma is, therefore, the establishment of connectedness and can often be viewed as a cyclical nature when trauma-activating events activate dormant developmental trauma. During the course of psychotherapy, traumatic experiences are uncovered.

It is vital to comprehend the dynamic nature of interaction between systems as depicted by a psycho-biosocial paradigm (Friedman & Allen, 2011). Change depends on and is possible due to the interactional connectedness between psycho-biosocial systems. Changes in a particular system level cause reactive changes in a higher or lower level systems due to an independent self-regulating system of individuals (Friedman & Allen, 2011). These changes have a rippling effect on all of the psycho-biosocial systems. This perspective indicates that biological, psychological and social processes are interactively involved in physical and emotional dis-ease (Suls & Rothman, 2004). In SHIP®, we see that it is in the re-connection to the self, the body and relationships that we experience integrational shifts.

The participant's past can be linked to her present in terms of her psychobiological experiences of disconnected developmental trauma and she was gently encouraged to connect with her disconnected experiences. In the

safety of a psychotherapeutic relationship, the participant was able to express her shame and anger towards her father – she was unable to express her feelings as a child. The participant expressed emotions of anxiety, uncertainty and insecurity. After identifying her own emotions, she expressed her disappointment with regard to her father. In her words: *It was such a disappointment to come home and see he had been drinking again!*; *Actually, he only disappointed me* and *Now, I feel anger towards him*.

Negative emotions overshadow any pleasant childhood memories. The participant described incidents that caused concern for the well-being of her mother and in relation to herself she experienced fear and humiliation. The participant recalled in her own words:

> *He really hurt my mom. I was always concerned for her. Especially when I had to, in Standard 6, leave to go to high school and live in a hostel. I really had difficulty adjusting. I can remember once I came home with friends, and at the back door, he was sitting on my mother strangling her! I felt so ashamed. There I learned to just keep your head high and carry on.*

A trauma chain formed during her lifespan and as the deeper layers of trauma were resolved, the participant discharged her anger − something that she was unable to do as a child. The participant accessed these disconnected experiences as she allowed the physical reaction (felt sense) in her stomach

and she experienced an emotional awareness of various disconnected feelings that surfaced. The participant described her felt sense as follows:

> *It sits here. It is a heaviness on my stomach. It goes so far back; I don't know where to start. It feels like a darkness coming over me. I feel guilty … he is dead … my thoughts are jumbled. When I think of him I feel angry, disappointed and … sorry for him*.

The cyclical nature of trauma can be compared with movement in a spiral or as Levine (2005) describes it − a vortex that keeps on spiralling deeper and deeper. With this image in mind, the participant encountered the same issue time and again – her relationship with her father. Her first recollection of an image of her father is linked with tension in her abdomen and manifested in feelings of fear, insecurity, disappointment and shame. The participant was able to express her anger in the here-and-now – she was unable to express her anger as a young child. She was able to discharge her disempowerment as anger − Levine (2015) identifies this as 'healthy aggression' − and she claimed her own sense of self.

A summary of biopsychosocial shifts is provided in Table 2:

Table 2

Summary of biopsychosocial shifts facilitated by a SHIP® psychotherapeutic process

(Bio) Somatic distress	Distress symptoms are absent. Physical discomfort drastically diminished. She no longer has an exaggerated startle response.
(Psycho) Emotional regulation	She is no longer dependent on psychiatric medication for emotional regulation. Feelings of connectedness to self. An acceptance regarding past experiences. She no longer has chronic emotional dis-ease manifesting in anxiety, worry, feelings of hopelessness and helplessness, shame, feelings of unworthiness, powerlessness or inadequacy.
Attention and consciousness	Improved focus, concentration and memory function.

	She is more at ease with regard to decision-making − she has taken on a new business challenge. An increase in pleasant childhood memories. More connected to self − physically and emotionally – she does not experience dissociation anymore. She is now more connected to her own needs, desires, wants and preferences.
Belief system	She experiences a transformation of her sense of self as negative thinking patterns and beliefs shifted to an increase in self-esteem and creativity.
(Social) Relational capacities	No continual repetition of unhealthy relationship patterns. She is now at ease with family issues. Healthy boundaries are set. She is more assertive, she can voice her needs and preferences.

	A change in her social circle took place. No more feelings of withdrawal and isolation due to a lack of trust or fear of abandonment.

In reflecting back on her psychotherapy, the participant reported the following psycho-biosocial shifts facilitated by her SHIP® therapy: Her distress symptoms have dispersed and she feels more connected to herself − physically and emotionally. She experienced a transformation within herself and she is becoming more connected to her own needs, desires, wants and preferences. This transformation has led to an increase in her self-esteem and dormant on-hold potential creativity within her system was opened up. Physically, most of her dis-ease has diminished − the majority have cleared altogether.

She recalled that she has always expected the worst, always seeing the glass as half empty. She was always worrying about something and whenever something happened, she viewed it as the worst thing that could have happened. At present, she feels different, she is more objective concerning things close to her. Her perspective is clearer, she is more positive in situations and she has lost her appetite for negative things. A connection with the self includes the capacity to comprehend what is felt physically and emotionally while a connection with others means having the capacity for consistent relationships and intimacy (Heller & LaPierre, 2012; JOS, 2002).

Levine (2015) explains that with every healing cycle completed, clients can begin to experience an inner sensation of flow and a growing sense of allowance for being. With this sense of inner movement, freedom and flow, the participant gradually eased out of the grip of trauma and dis-ease. The healing process enhanced the capacity of the participant for self-reflection and self-compassion (Levine 2015; Steenkamp, 2015).

The participant's relationship with her brothers improved drastically and they now visit her from time to time. She can now calmly set boundaries without experiencing anxiety or dis-ease. She is enjoying the dynamic shift that has taken place between her and her brothers. Her irritation with regard to opinionated people, especially the opinions of individuals about religion, has diminished. A change took place in her circle of friends. She can now relate to her friends and she can set healthy boundaries. She is more aware of her feelings − physically and emotionally.

She experienced shifts in her social circle. She is now at ease with issues pertaining to her family and is able to establish healthy boundaries. She is more assertive and can voice her needs, preferences and dislikes. She took on a new entrepreneurial business challenge and stopped taking psychiatric medication for anxiety and depression.

Throughout her whole psychotherapeutic process the participant experienced a spontaneous increase in remembering pleasant childhood memories. These pleasant memories flowed into an experience of being more herself, of being

more connected to herself and of reaching an acceptance of what had happened and what is: *I now fit into myself*.

5.5 CONCLUSION

In this chapter, the experiences and shifts of the participant who presented with C-PTSD and who underwent SHIP® therapy were discussed. As is evident in the life of the participant, trauma is a psycho-biodynamic experience. This discussion of the case study of an ageing client has demonstrated that accumulated trauma has no expiry date. Individuals of all ages experience trauma. However, through a body-oriented psychological therapeutic approach, relief of discomfort can be achieved and ineffective coping patterns can be revised.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

This concluding chapter presents a general review of the study. Inferences regarding SHIP® are drawn. Possible limitations of the study are noted, the contribution of this study is highlighted and recommendations for future research conclude this chapter.

Chapter 1 introduces the research and concludes with biopsychosocial theory as meta-theory. Research done on trauma and C-PTSD is discussed in Chapter 2 and indicates that C-PTSD has a multifaceted and far-reaching systemic effect on individuals. Chapter 3 focuses on the frame of reference of psychotherapists and the integrated SHIP® trauma-spectrum model for the treatment of C-PTSD. Chapter 4 provides an overview of the research method followed and describes how the research method was implemented. Key points relating to the sampling method, data collection and the analysis of the material are discussed. The findings of the study are encapsulated in Chapter 5. By making use of an analysis of the therapeutic journey of an older individual who presented with C-PTSD, thematic prominent themes were extracted, described and illustrated in the words of the participant.

6.1 SHIP® and C-PTSD

Trauma does not lie in events themselves but in 'the neurobiology of the beholder' (Ogden et al., 2006; Payne et al., 2015). The participant's loss of control, emotional and physical dependency and the emotional wounds she suffered produced the same traumatic effects as tangible physical wounds and overwhelming helplessness (Porges, 2011). The case study selected for this research was of a client who was exposed to developmental trauma and a

variety of shock trauma-activating events. Shock trauma-activating events started during her pre-natal developmental phase with the dislocation of her hip by a doctor who attempted to turn her from a breech position. Throughout her life, the participant was continually exposed to other shock traumas, such as surgeries, armed robberies and the final incident for which she sought professional help, a smash-and-grab. An acute trauma incident, such as the smash-and-grab the participant was subjected to, aggravated latent symptoms related to existing preceding unresolved developmental trauma by re-activating old, on-hold/frozen energy in the system of the participant (Heller & LaPierre, 2012).

The development of trauma can be understood from the point of view of a successful or unsuccessful fight or flight response. The choice between fight or flight and freezing or dissociation is an instinctive physiological reaction to promote safety and survival and not a conscious process (Porges, 2011). With a freezing or dissociation response, the energy that would have been used during a fight or flight response does not disappear but remains in the body of individuals as on-hold residual energy (Levine, 1997) until discharged and integrated into the system of individuals. The incomplete psychobiological experiences of trauma incidents are stored as unconscious memories until these memories can be processed and integrated through a freeze discharge. The freeze discharge is a very important psychobiological process as the inhibition of a freeze discharge appears to be related to a sustained state of helplessness, entrapment or disempowerment (Scaer, 2005).

This imbalance eventually results in chronic dis-ease with a complex blend of symptoms. The participant described her experiences as a combination of chronic difficulties, such as re-experiencing, numbing and hyper-arousal, which are PTSD symptoms. In addition, she experienced a mix of C-PTSD symptoms, such as *difficulties pertaining to the regulation of emotions* (e.g., depression, anxiety, worry, phobias, feelings of hopelessness, feelings of helplessness, excessive guilt, shame, feelings of emptiness, powerlessness or inadequacy), *difficulties in relational capacities* (e.g., continual repetition of unhealthy relationship patterns, withdrawal, isolation, lack of trust, fear of abandonment, boundary problems), *alterations in attention and consciousness* (e.g., dissociation, problems with concentration, memory function, decision-making or distraction), and experienced an *adversely affected belief system* (e.g., negative thinking patterns and beliefs about the self).

Trauma often has a cyclical nature when trauma-activating events activate dormant developmental trauma. During the course of psychotherapy, dormant traumatic experiences are uncovered and on-hold activation energy is systematically discharged. As the presenting layer of trauma is worked through, the layer beneath is exposed and worked on. This is a continuous process, proceeding to deeper and deeper levels to discharge and integrate the disconnected, on-hold activation energy of earlier trauma experiences. This case study illustrates the outer layer of trauma and a developmental trauma chain, which developed as a consequence. The deeper layers of trauma were resolved and the participant was finally able to discharge her anger − something that she was unable to do previously.

Through SHIP®, the developmental trauma of the participant, consisting of subtle and acute trauma-activating events, emerged and the on-hold activation energy from that time was activated by past traumatic experiences expressed as hyperarousal, constriction, dissociation and feelings of helplessness and freezing, which were activated into a healing discharge response in the present. The system of the participant presented with intra-translators, repetitive and explosive somatic manifestations expressed through symptoms, such as chronic pain in the lower back, fibroids, headaches, anxiety affecting the stomach or a lump in the throat. Emotions underpin physical dis-ease and needed to be acknowledged and felt by the participant. The intra-translators are often viewed as metaphors for hidden and uncompleted experiences, such as powerlessness, anger and physical trauma (JOS, 2002; Steenkamp et al., 2012).

The inter-translators or projection issue statements of the participant (for example, *I want to be in control*) are the connecting link to previously unprocessed developmental trauma. As the participant focused on incomplete trauma experienced in her past and processed trauma in the here-and-now, it was made possible for her system to discharge and integrate the on-hold activation energy. When the participant simultaneously went back to the past while in the present, it enabled her to follow the link to the origin of her trauma. Her trauma chain containing all of the trauma-activating events was, therefore, uncovered. Prominent themes within the intra-translators and inter-translators of the participant were experiences of helplessness and hopelessness, anxiety, unworthiness, loneliness or isolation and anger.

SHIP® facilitates the process of SH by utilising activators from the historical trauma experiences of clients presented through the narrative medium of images, thoughts, their life history and psycho-biodynamic translators. Clients come into contact with trauma stored within their system and this trauma are exposed. A healing response can then be stimulated. A freeze discharge consists of SHRs, which are essential in the process of SH. In this case study, an example of a SHR was when the participant described her neck and later her whole body as being tense. She explained that it was as if her whole body went into defence mode when she was confronted with anything concerning her hip surgeries. As the on-hold energy was allowed to move through her system (sensations and emotions), she became aware that she cal lie down comfortably and straight − in contrast to the way she used to feel in situations where she had to lie down during a beauty treatment, for example.

Through an integration of the physical and psychological on-hold activation energy created by trauma-activating events, the psychobiological balance of the participant was restored − evident from the dispersal of her distress symptoms and the fact that she feels more connected to herself, physically and emotionally. These feelings are accompanied by a transformation within herself. She became more connected to her own needs, desires, wants and preferences with an increase in her self-esteem and dormant, on-hold, potential creativity was opened up in her system. Physically, most of her dis-ease diminished and the majority cleared altogether.

During SHIP® psychotherapy, the participant learnt how to trust and tap into her inner strengths and inner wisdom by listening to the feedback of healing messages of her own system: to stay with, to pay attention to, to explore, to identify and to reprocess the reactions of her system to trauma-activating events. This leads to autonomic self-regulation, which involve her innate psychobiological processes, consisting of feedback aimed at achieving homeostasis.

Spontaneous healing processes through SHIP® facilitate intra-systemic shifts and produce positive inter-systemic ripples. SHIP® can accommodate and respect the unique meandering style of each client to achieve integration and growth by focusing on the facilitation of the unique SH journey of each client. This makes SHIP® a suitable psychotherapeutic modal for assisting clients across their lifespan on their healing journey.

6.2 LIMITATIONS OF THE STUDY

The following aspects have been identified as limitations of the research. Because SHIP® has a unique language and publications on SHIP® are limited, finding additional references were a challenge and it was, therefore, necessary to consult additional sources that were not necessarily linked to SHIP® but were applicable to traumatology. Sources available on developmental trauma and soft/subtle trauma are also very limited in this recently discovered and contemporary field of traumatology. There seems to be a gap in current literature regarding subtle trauma. An in-depth study encompassing the subtle side of the trauma spectrum is recommended.

In line with the ethical principles of the HPCSA, to conduct research on one's own clients after therapy has been completed can produce a deeper understanding of the experiences and shifts that took place during SHIP®.

This is a retrospective study. It is possible, however, to plan a prospective study on different levels, such as a longitudinal study over time. The advantage of doing such a study is that it is fundamentally an observational study of people over time. With data collection at regular intervals, potential recall error can be greatly reduced.

6.3 CONTRIBUTION

This research highlights the important notion of symptoms as healing messages by reframing chronic dis-ease or the "pathology" of traumatised clients as activated healing messages. Instead of focusing on what is wrong with traumatised clients, SHIP® supports the destigmatisation of normal reactions and expressions of the psycho-biodynamic system of individuals to trauma.

Furthermore, SHIP® is a psychotherapeutic approach with the aim to achieve psycho-biodynamic integration. SHIP® is based on the assumption that traumatised clients are in a continuous process of SH and self-regulation and facilitates a process − the discharge of accumulated, on-hold, disconnected trauma energy that permits the integration of mind and body responses to previously traumatic experiences. The discharging of on-hold energy completes the lifelong search of individuals for an identity, acceptance and the

ability to fit in and live a purposeful and uncompromised life. This process provides another avenue for clients and psychotherapists to deal with the management of C-PTSD symptoms.

6.4 CONCLUSION

Deeper integration does not take place when working from a purely classical psychological paradigm but when all of the psycho-biodynamic systems are combined, trauma symptoms can be healed. SHIP® has much to offer in providing a treatment alternative that incorporates the complexities of C-PTSD and the expression of these traumatic experiences − provided that SHIP® incorporates recent research in neurobiology to create neuropsychological safety; use small amounts of activation; and support the active involvement of all of the senses of traumatised clients to restore natural defence mechanisms to deal with trauma.

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