Foreword

I and we are very proud to present this research; it is the culmination of many years of work and thinking within SAFE Ireland. It is part of our programme to “centre stage” women and children in our work and to learn about domestic and sexual violence at a deeper level. We believe that it is only by doing this that we will find new solutions to the soul-destroying reality of domestic violence in our communities and lives. The very essence of this work is social change, not therapy. It is about enabling women to understand what has happened to them in a social change context. It is about creating “voice” on the issue of domestic violence in Ireland, working with the advocates of the future.

As a biodynamic practitioner, I had the privilege of being present throughout the whole programme and I witnessed our wonderful capacity to heal, to engage and to trust in the wisdom of our bodies to enable this to happen. I met the most extraordinary women, I heard their stories, I witnessed their healing and I was deeply moved by their humanity and beauty, their capacity to overcome harrowing experiences and their belief in their right to flourish and know joy. All of these women have changed and influenced the work of SAFE Ireland; their journeys have made a difference and their courage gives us all hope.

Sharon O’Halloran
CEO, SAFE Ireland

Acknowledgements

The research in this report was made possible by the lead coordination and expertise of the staff and board of SAFE Ireland. The project had the cooperation of the Gerda Boyesen International Institute of Biodynamic Psychology and Psychotherapy (GBII) who provided expertise, support and the critical biodynamic services. Mayo Women’s Support Service and Teach Tearmainn DV Service worked alongside the project providing support and valuable insights, these services supported the women’s participation throughout the research programme. The women participants made it happen; they turned up and the team was able to work, and they were amazing. As the principal investigator, my role was to work with the research team, design the studies, manage the human subjects training and protection, as well as gather, analyse and protect the integrity of the data. The research team carried out dissemination of this data collaboratively. We disseminated the data to the women who participated in the study, as well as to the members of SAFE Ireland, presented our work at international conferences, and also have it in publication. These projects were made possible by funding provided by SAFE Ireland, Michigan State University Gender Centre and the University of Michigan School of Nursing in the US.
Preface

Domestic violence (DV) is a serious and pervasive social problem, disproportionately affecting women around the world, regardless of their socioeconomic conditions or ethnicity. Women who have experienced DV are at an increased risk of depression and suicide attempts; physical injuries; psychosomatic disorders; unwanted pregnancies; HIV and other STDs; and are at risk of being killed by a partner (World Health Organisation, 2009). The experience of DV has been found to relate to post traumatic stress disorder (PTSD), depression, and suicidal ideation (Carlson, McNutt, Choi, & Rose, 2002; Coker et al., 2002; Zlotnick, Johnson, & Kohn, 2006). While people can heal after the experience of trauma, the road to healing can be challenging for many of those affected. It is difficult to clearly estimate the proportion of people who are likely to struggle with recovery from trauma. This difficulty is because the response to trauma depends on so many factors, including: the type of trauma; the levels of uncertainty; repetition of the trauma; the age and dependency of the person at the time of the trauma; emotional factors such as shame and betrayal; and a host of other variables. Because DV involves repetitive aggression by people who should be trusted, and occurs in a context that should be loving and safe, these situations can be experienced as “inescapable shock”, necessitating a psychological response of dissociation (or psychically removing oneself from the unbearable situation). Unfortunately, while this response is adaptive at the time, research has suggested that these people are at higher risk of PTSD and other health complications (van der Hart, Nijenhuis, Steele, & Brown, 2004; van der Kolk, McFarlane, & Weisaeth, 1996; van der Kolk, Pelcovitz, & Roth, 1996).

This report examines the experience of trauma recovery for groups of women who have found that, while traditional therapies and mental health support helped them “move on” and resume functioning, struggled to achieve the quality of life, fulfilling social relationships and meaning in their lives that they needed in order to thrive. The women in these research studies recognised that they were “stuck”, and wanted to move from survival to joy. In this report, I will help our readers understand theories that can explain why recovery from trauma may be resistant to some traditional psychotherapy, and lead people to seek alternative therapies to address them. In this report, I will explain the research studies carried out by me (University of Michigan), the Gerda Boyesen International Institute for Biodynamic Psychology and Psychotherapy (GBII), SAFE Ireland (SI), and the staff and clients from the Mayo Women’s Support Services (MWSS) and Teach Tearmainn DV service in Kildare. These research studies aimed to examine the effectiveness of one type of integrative healing approach called biodynamic psychotherapy. Finally, I will explore and integrate the complexities surrounding trauma recovery faced by these women, with the literature, ending with recommendations for treatment, research and service delivery based on this literature and these findings.

The women who participated in these studies approached this research with enthusiasm and open-hearts, generously sharing with us their healing experiences. Through this work, they have gained and shared their understanding of healing and recovery, and, what’s more, they have shared these in the hope that it will enable many more women who struggle with healing to find this kind of clarity and meaning. This empowers all of us, and moves us closer to real social change. This report is written for them.
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Introduction and background

A surprisingly large percentage of traumatised individuals meet criteria for an array of mental and physical conditions, including mood and anxiety disorders, substance abuse and dependence disorders, eating disorders, somatoform disorders, and medically unexplained symptoms (Crowne et al., 2010; Pico-Alfonso et al., 2006). Insight-oriented psychological treatments, in general, rely on the patient’s conscious thought processes, and assist clients to re-experience traumatic events within a therapeutic climate in order to gain insight, and to resolve problematic emotions, behaviours, and cognitions (Courtois, 2004; Courtois & Ford, 2009; van der Kolk et al., 1996). Three limitations of this approach for the treatment of chronic, complex trauma have been proposed. First, traditional psychotherapeutic models problematise the emotions, behaviours, and cognitions, and may fail to provide for the immediate needs of security, personal strength, and self-confidence. Second, from a feminist empowerment perspective, women need help feeling whole and well. Exploration of these “problems” may leave women feeling depleted and confused, rather than retaining the strength they need to create a new life for themselves and their families (Hill & Ballou, 2005). Third, evoking trauma memories can reinforce survival-related neural pathways, prompting the body toward autonomic nervous system activation, which fosters muscular tension, intrusive sensory experiences, and involuntary movements (Ogden, Pain, & Fisher, 2006; Schore, 2002; van der Kolk et al., 1996). Cognitive and emotion-oriented therapists that do not apply neurobiological theories may not have the clinical experience and tools to recognise and resolve these physiological states.

These limitations to standard psychotherapeutic practice suggest that short-term interventions that promote personal strength, and that can mitigate autonomic nervous system excitement, may be valuable to improve mental, physical health and quality of life for women recovering from trauma. The research studies included here were designed to respond to international, national and SAFE Ireland’s priorities and goals to provide effective therapies that promote quality of life for women who have experienced DV and other interpersonal trauma.

The research questions addressed in these studies are:

1. Can short-term, body-oriented interventions help women in the recovery phase of DV reduce physical and psychological sequelae, and promote health and wellbeing?
2. What are the stages of trauma recovery from an integrated mind-body perspective?
3. What are the training and support implications of these findings?
Neurobiological and psychophysiological understanding of trauma

While research has examined treatment for PTSD, much less is known about how complex trauma affects the behavioural, emotional and cognitive healing journey. Complex trauma can be defined as multiple occurrences of interpersonal abuse, often beginning early in life (Courtois & Ford, 2009; Herman, 1997). While the concept of complex trauma has focused on childhood trauma; many experiences of DV could be defined as such. Here, I will use the concept of complex trauma to refer to trauma that is experienced as inescapable; and that involves repeated instances characterised by numerous layers of emotional, physical and sexual control and violation. These experiences may be compounded by: a history of either direct experience of childhood trauma; or by witnessing violence within the family or origin; and/or the experience(s) of rape.

Theories about the impacts of complex trauma on brain development, brain processing, the perception of safety, emotional regulation, behavioural patterns, and social engagement after trauma are available. However, there is substantial disagreement in the neurobiological field about how the psychological, hormonal and neurochemical systems interact. This state of the science is even more problematic because of a variety of overlapping factors, including: the overwhelming incidence of anxiety and depressive disorders within the trauma population; the diversity of the types, frequency and intensity of traumas; the fact that many trauma survivors have also had trauma as children; and the co-morbidities with other illnesses such as substance misuse, heart disease, chronic pain disorders, chronic bowel disorders and obesity. All of these conditions affect the biomarkers that scientists would use to confirm their theories, making conclusions difficult.

In this report, I will examine two theories that can help make sense of the importance of integrative approaches to trauma recovery, as well as the findings of the studies reported here. The first is the Polyvagal Theory developed by Porges (Porges, 2007). The Polyvagal Theory includes a neurobiological perspective that can explain how people ascertain whether they are safe or in danger, and how this assessment translates into engagement with, or withdrawal from, the social world. The second body of work we will examine here is a new perspective on the construct of dissociation proposed by van der Hart, Nijenhaus and others (van der Hart et al., 2004). These authors suggest that our conventional notion that dissociation is a pathological psychological defense is too narrow, and that we should embrace the view that dissociation is a common and protective response to “inescapable” danger. This perspective can explain why patterns of psychological and social withdrawal may persist long after the danger has passed.

The autonomic nervous system

There are several partitions of the nervous systems of the human body. One partition is the central nervous system, which includes the brain and spinal cord. A second partition includes the peripheral nervous system, which regulates pain, reflexes, and coordinated muscle activity. Within the peripheral nervous system, some researchers are suggesting that there is an enteric nervous system that regulates nutrient assimilation and elimination processes (Mayer, 2011). This enteric nervous system may also be involved in complex systems such as spatial awareness, balance and perhaps the presence of threat in the environment. However, the partition of the peripheral nervous system that has received

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the most attention in trauma recovery research is the autonomic nervous system (ANS), which regulates “automatic” functions that connect the human being with their environment. The ANS acts “behind the scenes”, automatically and unconsciously, to coordinate complex responses to the environment.

The ANS uses innumerable sources of data—sights, sounds, smells, sensations, emotions, and memories—and then releases hormones and neurochemicals to regulate instantaneous, coordinated and efficient emotional and behavioural responses to the environment. The ANS also has complementary mechanisms that use hormones and neurochemicals that restore the mind and body back to routine daily movement and interactions. Research has only begun to understand these complexities, with most research focused on the fear and anxiety responses. Less research has been carried out on the neural pathways that regulate normal, healthy, peaceful and joyful physiological states of wellbeing. However, since our goal is to help women heal from trauma, we not only want to help women resolve symptoms of anxiety and fear, but also restore their ability to engage and thrive. Therefore, our inquiry examines both abnormal symptoms as well as healthy and ideal mental and bodily states.

It is generally known that the ANS includes a sympathetic nervous system (SNS) branch, which provides the body with chemicals that allow us to effectively fight or flee when we are in danger. Most people also have a general understanding that the SNS is balanced by another system, the parasympathetic nervous system, which calms us and brings our bodies back to normal. Another name for the parasympathetic nervous system is the vagal nervous system. In the Polyvagal Theory, Porges has proposed that the ANS is not a dual system, as we once thought, but contains a three-fold system (hence, the “poly” vagal theory). He proposes that a critical aspect of the vagal nervous system is the social mobilisation system. Porges theorises that the social mobilisation system (or the ventral vagal complex (VVC), or what I will call the “explore and engage” system) regulates our ability to “move toward”—toward people, toward newness, toward information, and toward growth. According to Porges, this social mobilisation system allows us to engage in the world, gives us the ability to communicate, and allows us to send and receive social information. The WS releases neurochemicals that regulate eye contact, hearing, speech, eating, singing, nursing, kissing and smiling. Porges theorises that the WS uses the mechanisms of sending and receiving social information as a way of achieving personal safety or assessing when we are in danger. Because humans may need to quickly solve problems or respond in case of brief necessity, WS activation also allows for brief increases in emergency action with short bursts of energy required in the context of day-to-day life, such as handling a quick need or dealing with brief issues as they come about (such as grabbing the child who is running away), without activating the SNS.

In the face of danger, such as crisis or trauma, those bursts of mobilisation are inadequate. Porges theorises that the vagal system can “lift the brake” and allow the sympathetic nervous system (the “fight or flight” system) to take over. When the SNS is activated, the person is tense and ready for action, and their thoughts and emotions are restricted to those aims. In this SNS activation state, hearing and visual perception are acute and hyper-alert, and the heart rate and blood flow are increased and moved out to the muscles to enable quick and strong responses.

In cases when a person is faced with an “inescapable” threat (the body and mind have determined that fleeing is impossible, and fighting will increase the risk of death), an older aspect of the vagal system (referred to as the immobilisation system, the dorsal vagal complex (DVC), or what I will call the “freeze to protect” system) may be activated. In this case, the person becomes, disengaged, quieted, and numbed from emotional and physical pain.

The system that determines when danger is present, and when the situation is inescapable, is referred to in the Polyvagal Theory as neuroception (Porges, 2009). Neuroception is not the same as perception. Perception is a conscious, meaning-making, cognitive activity based on social and cultural development.
However, neuroception is proposed to be the biological and unconscious nervous system mechanism that regulates the sympathetic and vagal systems, and related hormonal activity.

Neuroception represents a neural process that enables humans and other mammals to engage in social behaviours by distinguishing safe from dangerous contexts. Neuroception is proposed as a plausible mechanism mediating both the expression and the disruption of positive social behavior, emotion regulation, and visceral homeostasis...Neuroception might be triggered by (voice, face, and hand movement) feature detectors...Thus, the neuroception of familiar individuals and individuals with appropriate...voices and warm, expressive faces translates into a social interaction promoting a sense of safety (Porges, 2009, p.S89).

We propose here that people who have experienced complex trauma may have faulty neuroception, and cannot reliably and accurately determine whether a situation is dangerous or safe; therefore, their bodies may not appropriately activate vagal or sympathetic nervous systems. However, research is only beginning to explore these mechanisms.

From this theoretical perspective, all of these scenarios are adaptive, protective and appropriate. However, we can see that it is only within the vagal social mobilisation system activation that the person can interact with others, receive support and information, and communicate their needs most effectively (Porges, 2001, 2007) (see figure 1). Theoretically, then, a clinical aim is to increase the ability of the person to regain and maintain this “explore and engage” system activation for maximum health, wellbeing and growth.

Figure 1: The triune autonomic nervous system

- **Ventral Vagal Complex** (Social Mobilisation)
  - Regulates love, affiliation, language, empathy, curiosity and exploration.
  - Activates eyes, ears, mouth and throat.
  - “Explore and Engage”

- **Sympathetic Nervous System**
  - Mobilises readiness for action in the face of danger.
  - Moves blood to muscles; sharpens and focuses hearing and cognition.
  - Acts on emotional brain, heart and adrenal glands.
  - “Fight or Flight”

- **Dorsal Vagal Complex** (Immobilisation)
  - Disengages from external experiences.
  - Acts to decrease pain; numbs sensation; decreases cognition.
  - Acts on “primitive” brain, heart and gut.
  - “Freeze to Protect”
Clinical literature has attempted to explain why some people who experience trauma fully recover and some are beset with symptoms (van der Kolk et al., 1996). As described earlier, it is difficult to estimate the proportion of those who are likely to struggle because any trauma can create neurobiological vulnerabilities, including everything from accidents to the sudden death of loved ones. As we have seen, traumatic experiences vary widely by type, level of uncertainty, repetition, the age and dependency at the time of the trauma, the significance of the event and the actors involved. Research suggests that when traumatic experiences are cumulative, emotionally and socially complex, and/or chronic (Courtois, 2004; Courtois & Ford, 2009; van der Kolk et al., 1996), the body may not be able to remain in the ideal social mobilisation “explore and engage” system because of the chronic recurrent nature of their situation. This would be true in hostage situations and in DV situations (for children and adults), who experience being under siege, never knowing when events might occur, and feeling that they cannot escape. In these situations, the physiology of a person is required to regularly go back into the sympathetic “fight or flight” state, into the immobilisation “freeze to protect” state, or to vacillate between these states.

The wellbeing of a person who is affected by chronic activation of the sympathetic or the immobilisation system is ravaged on several levels. Cognitively, the sympathetic state creates a hypersensitivity to stimuli, and a tendency to ‘zero in’ on only threat-related signals from the environment. In the immobilisation state, the person can be confused and lethargic. Emotionally, the sympathetic state provokes feelings of alarm, anxiety, fear, and rage. The immobilisation state may feel like numbness, emptiness, depression and despair. Physically, the sympathetic state causes pounding heart, physical tension, high blood pressure, stomach tightness and inability to sleep. In the immobilisation state, the person may have palpitations, difficulty breathing, may feel achy, have abdominal pain and diarrhoea, and may have difficulty moving. Behaviourally, in the sympathetic state, a person can be highly reactive, agitated, aggressive, intense and self-protective. In the immobilisation state, the person may behave with acquiescence, passivity, apathy, hesitancy or even catatonia (Ogden, Minton, & Pain, 2006; Ogden et al., 2006; van der Kolk et al., 1996).

Table 1: Symptoms of sympathetic and immobilisation system activation

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<th></th>
<th>Sympathetic activation</th>
<th>Immobilisation state</th>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Hypersensitivity to stimuli, and a tendency to ‘zero in’ on only threat-related signals from the environment</td>
<td>Confused and lethargic</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td>Feelings of alarm, anxiety, fear, and rage</td>
<td>Numbness, emptiness, depression and despair</td>
</tr>
<tr>
<td><strong>Behavioural</strong></td>
<td>Overly reactive, agitated, aggressive, intense and self-protective</td>
<td>Acquiescence, passivity, apathy, hesitancy or even catatonia</td>
</tr>
<tr>
<td><strong>Physical</strong></td>
<td>Pounding heart, physical tension, high blood pressure, stomach tightness and inability to sleep</td>
<td>Palpitations, difficulty breathing, the body may feel achy, with diarrhoea, abdominal pain, and difficulty moving</td>
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Dissociation

Another theory that can help us understand how the experiences of trauma can interrupt the routine activation of adaptive neurobiological systems comes from psychodynamic work. Humans have the capacity to protect the “self” by compartmentalising memories of traumatic experiences in such a way that they can go on living and functioning. From a psychodynamic perspective, this is referred to as dissociation. Dissociation allows memories of life’s tragedies to remain in the mind, but conscious awareness of them is available only when the person is psychologically able to process them without losing their capacity to function. In cases where trauma is extreme, repetitive, chronic, inescapable, or has interrupted normal development, this psychological ability to compartmentalise is called upon all too often. In these cases, dissociation, however adaptive it was at the time of the trauma, can decrease healthy social engagement, increase maladaptive social engagement, inhibit help-seeking and impede personal growth.

Some researchers have suggested that these compartments of the mind hold not only memories, but all of the cognitive, emotional, behavioural and physical responses related to the traumatic experience (Nijenhuis, van der Hart, & Steele, 2010; van der Kolk et al., 1996). These emotional and behavioural patterns are sometimes referred to as neuropathways or integrated neural networks, “response patterns” or “action tendencies”. Researchers have theorised that it is especially critical to understand the response patterns that were developed at the time of the original trauma, because those are the responses or actions that are held in the mind as incomplete. This theory has been espoused nearly a century ago by the French psychiatrist Janet, who wrote:

(Traumatised) patients…are continuing the action, or rather the attempt at action, which began when the (traumatising event) happened; and they exhaust themselves in these everlasting recommencements (Janet, 1919, p. 663).

In cases where there have been numerous traumatic events, there may be several of these response pattern compartments in the personality. In the course of daily life, situations, smells, sounds, or other environmental or internal sensations can activate this compartmentalised memory set, along with its attached cognitive, emotional and behavioural response patterns. Psychophysiological, it is efficient for the mind to store these response patterns together as “clumps” because it increases the efficiency of action. However, experientially trauma survivors know these as “triggers” that set off cascades of memories, feelings, behaviours and neurochemicals that are not necessarily related to current needs or conscious desires. This theory can help explain how traumatised people can function very well some of the time, but can become incapacitated in other areas of their lives. In these cases, sympathetic or immobilisation systems are activated in some areas of day-to-day life, while dissociation allows them to function in other aspects of their lives (van der Hart et al., 2004).
Some authors have overlaid these concepts, referring to the “freeze” mechanism as “tonic immobility” and contrasting that with a kind of “flaccid immobility” or what is sometimes referred to as submission. In tonic immobility, the body is immobilised, yet there is muscular tension; however, with flaccid immobility, the person is limp and unable to respond. An example of an attempt to show how these related processes may overlap is shown in figure 3. Here, we can see that the response type may be based on conscious (or unconscious and bodily) assessment of escapability.

Figure 3: The five Fs: ANS responses to threat

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3 Adapted from Bracha, 2004.
Many people who seek treatment for trauma-related problems have had histories of multiple traumas. However, most of the PTSD treatment available was developed and tested with single trauma populations (Courtois, 2004; Courtois & Ford, 2009; van der Kolk et al., 1996). Authors are now suggesting that some people who have experienced complex trauma may be unable to utilise the treatment approaches developed for PTSD. It is possible that PTSD treatment approaches may address only part of the multifaceted syndrome seen by survivors of complex trauma, which includes interrelated emotional, physical, behavioural and social difficulties, as well as dissociation outlined above (Kezelman & Stavropoulos, 2012). Most traditional psychotherapies, including cognitive-behavioural therapy (CBT), depend on what researchers are now referring to as “top-down processing”, in which clients use cognitive strategies to manage or inhibit problematic feelings, thoughts, and behaviours. CBT helps clients understand how traumatic experiences have affected their beliefs, and how these beliefs have fostered maladaptive ways of feeling and behaving. Clients learn how to identify stimuli that trigger them, understand their responses, and learn how to manage disturbing emotions and reactions (Courtois, 2004; Courtois & Ford, 2009; Ogden et al., 2006; van der Kolk et al., 1996). Top-down approaches, however, may not resolve physiological hyper-arousal in the short-term, and clients may still be triggered by stimuli that their unconscious systems determine are dangerous, therefore continuing to respond to these stimuli in maladaptive ways (Courtois and Ford, 2009; Putnam and Trickett, 1997). This reflexive neurological responsiveness, which lies outside of consciousness, affects affective regulation (Wilson, 2008); is maintained by dissociation (DePrince & Freyd, 2007; Price, 2007; Zelikovsky & Lynn, 2002); and may also cause physical hyper-vigilance, pain and disease (Nijenhuis et al., 2010; Ogden et al., 2006). Many authors are now suggesting that effective treatment of complex trauma must be directed towards integration of the mind and the body, as well as the impact of dissociation on functioning. Some have suggested that engaging the body and the action tendencies that are held in the mind and body, are required treatment strategies for complex trauma. Van der Kolk has said that we need to “pay… attention to the experience and interpretation of physical sensations and preprogrammed physical action patterns” (van der Kolk in Ogden, et al, 2006, p. xxii).

Body-psychotherapy is a cluster of diverse body-oriented treatment approaches that focus on the interrelationships among bodily experiences, emotional content and neurobiological processes that regulate affective and sensory stimulation. Body-oriented approaches to treating trauma survivors are referred to as “bottom-up” treatments, which focus on the physiological, automatic processing, and aim to address the physiological effects of trauma directly within the body itself, without the primary reliance on conscious recall of painful memories. These techniques focus on the physiological arousal processes described above, and use interventions to interrupt the reflexive responses to trigger stimuli. Body psychotherapeutic approaches aim to foster the body’s natural healing processes, which in turn affect cognition, emotion and behaviour (Allmer, Ventegodt, Kandel, & Merrick, 2009; Boyesen, 1980; Koemed-Lutz et al., 2003; Koemed-Lutz, Kaschke, Revenstor, Schermann, Weiss, & Soeder, 2006; Ogden et al., 2006; Price, 2005; Solomon, Solomon, & Heide, 2009).

The most empirically tested body-oriented treatment for trauma is the Eye Movement Desensitisation and Reprocessing (EMDR) method (Servan-Schreiber, 2000; Solomon et al., 2009). EMDR is a combination of body-focused (bottom-up processing) and cognitive-behavioural (top-down processing) treatment, and is used primarily for PTSD. EMDR uses structured protocols that invite clients to identify a disturbing image that represents the worst part of a traumatic event, and then to identify the negative self-beliefs that have arisen from that experience. The client holds the disturbing images in their mind, as well as their associated negative beliefs, feelings, and physical sensations while focusing on an external
stimulus. Theoretically, this EMDR technique allows the mind to adaptively reprocess and resolve the stored memories of the traumatic experience, and is used after crisis stabilisation (Courtois et al., 2009). However, for women who have experienced repeated interpersonal violence within their living situations, processing of some traumatic memories can open a cascade of multiple memories that compete for attention and psychic resources, which can be overwhelming and destabilising for them. Clients with long histories of abuse, compromised ego-strength, limited support systems, or those who are unable to commit to long-term therapy may not have the psychological resources to engage in this kind of therapeutic work. In addition, women who have survived DV often remain continually exposed to the perpetrator because of: custody and visitation; the need to negotiate for maintenance payments and other legal arrangements; or exposure because of situations where they see each other in small communities, church affiliations or other family configurations. The implications of re-exposure on the course of treatment is unknown.

In this present research, we examine whether neurological and cognitive–emotional effects of trauma might be mitigated without the exclusive focus on trauma recall and conscious processing of traumatic events.

The biodynamic understanding of healing from trauma

Biodynamic psychology (BP) is a unique type of therapy (Allmer et al., 2009; Boyesen, 1980; Koemeda-Lutz, et al, 2006; Southwell, 1988; Ventling, 2002; Ventling, Bertschi, & Gerhard, 2008). Norwegian-born Gerda Boyesen developed these theories and therapies in Europe in the early 1940s and continued to develop her thinking and techniques throughout her life. Biodynamic therapy (BDT) is a system of psychotherapy that combines psychodrama, specialised massage techniques, and bodywork to dislodge trapped fluids in the tissues, which can enable natural biological processes to complete emotional healing and restore homeostasis and organic equilibrium. Because BDT uses both psychological and physical methods to complete healing processes after trauma, we believe this method merits exploration as a potentially useful intervention to promote healing for women recovering from the effects of violence.

The theories and the practice of biodynamic psychology are complex and are inadequately summarised here. Therapists receive training in schools throughout Europe, and there are major centres in Ireland, England, France, Germany and the Netherlands. Training usually takes four to five years, and involves countless hours of clinical practice and personal therapy.

BP theorises that in order for thorough and lasting healing to take place, the emotional affects and biochemical effects of trauma must be resolved and dissolved and then discharged through a biological mechanism known as “vegetative discharge” (Boyesen, 1980; Saint Arnault, Mary Molloy, O’Halloran, & Bell, 2013; Saint Arnault, Molloy, & O’Halloran, 2012a; Saint Arnault, Molloy, & O’Halloran, 2012b; Southwell, 1988). The human organism is capable of repressing painful emotions and conflicts by muscular tension and by chronic contraction of the diaphragm, referred to as “armouring”. Armouring keeps the psychic and physical energy static, or prompts recirculation without resolution. In either case, the body is held in a chronic, “freeze” or permanent startle reflex. This muscular contraction prevents tensions and emotions from being released. Armouring is understood to occur in layers, from superficial to deep. In addition to storing tension and emotional pain, armouring traps bodily fluids and restricts blood and lymph circulation that normally would have drained and removed biochemical
deposits at the time of the trauma. This is referred to as “tissue armour”, or a concentration of metabolic residues in the body, such as adrenaline and lactic acid. The chronic storage of tension and fluid by the body repeatedly engages the sympathetic nervous system, keeping the person in a chronic state of hypervigilence or shock. This chronic state of sympathetic nervous system excitement can exhaust adrenal glands and other feedback mechanisms that would normally engage to restore a state of neurological quiet and equilibrium.

Theoretically, BDT releases this fluid and tension encapsulation by gradually undoing the muscular defenses, enabling the body to use its healthy biological mechanisms to complete the emotional and bodily cycles that were interrupted, thereby releasing the fluids that were stored in the tissues at the time of trauma or shock. BP theorises that the bio-emotional processing of toxins, and restoration of healthy biochemical processes, is carried out in the gut, and is called “psycho-peristalsis”. The BDT practitioner monitors psycho-peristalsis by listening to the ‘borborygmii’ (or tummy rumblings) via a loudspeaker or normal stethoscope (with an elongated tube for walking around the body) placed on the abdomen throughout a session (Saint Arnault et al., 2013; Saint Arnault et al., 2012a; Saint Arnault et al., 2012b).

Biodynamic psychotherapy uses a variety of methods to help the participant to release blocked energy in the mind and body. One technique used in the workshop was psychodrama, including role-playing, role reversal, mirroring and doubling. BP theorises that by completing the reaction or response that was already activated but not expressed in the original situation (referred to as “therapeutic ab-reaction”), the autonomy, dignity, strength and spontaneity of the “primary personality” is restored (Saint Arnault et al., 2013; Saint Arnault et al., 2012b). While other members of the group might become part of the psychodrama, most of the work is done with the therapist in a one-on-one, witnessed by the group. Other methods within the biodynamic approach may have included biodynamic massage and bodywork. Using specialised touch techniques, the BDT practitioner locates areas of tension in the muscles. This produces audible sounds from the gut of the client to indicate trapped emotional content, and this feedback is used by the biodynamic practitioner as a guide to where the armouring is stored, as well as an evaluation of the completion of bio-emotional cycles. Another technique is vegetotherapy, which aims to encourage the emergence of unconscious material and to facilitate safe expression. BP acknowledges that when the healthy bio-emotional processes are engaged and restored, painful memories may surface into consciousness. During a session, the therapist works with the body and the psychological content that comes to the surface to promote energy discharge and resolution. BP theorises that when the body becomes engaged in healthy bio-emotional release, the usual hypervigilance and threat can be resolved and dissolved (Saint Arnault et al., 2013; Saint Arnault et al., 2012a; Saint Arnault et al., 2012b). This report examines two research studies that evaluated the usefulness of this approach to help women heal from the effects of trauma.
Research methodology

This research used qualitative and quantitative approaches to gather data about how women responded to the biodynamic therapies. All of the staff involved with the participants received Human Subjects Protection training, and the Institutional Review Boards at Michigan State University and University of Michigan approved all research.

Recruitment, retention and procedures

Women receiving DV services were recruited for this study. We believed it was critical for refuge staff to assist in the selection of research candidates for biodynamic interventions, and to understand their treatment experiences. Because many of the staff and managers of the Mayo and Kildare Women’s Support Services had experienced biodynamic treatments themselves, we selected these as the recruitment sites. All participants were in the recovery phase of their survivorship, were at risk for somatic and psychological symptoms and disorders related to their trauma experience, desired healing from the effects of that trauma to promote or restore wellbeing and optimal functioning, and were deemed by the refuge staff to be ready and able to participate in a group intervention. Inclusion criteria included women over-21 who were receiving services and had a case manager, spoke and read English, and who agreed to the treatment. Exclusion criteria included a score over-20 on the Kessler 6 screening tool (described below), and those who were actively psychotic.

Participants received written and telephone communication from the SAFE Ireland office. If the women qualified and agreed to enter the study, they received an online or paper survey and returned it within one week to the SAFE Ireland office. For the Randomised Controlled Trial (RCT), after the receipt of the surveys, participants were randomised into the intervention or the waitlisted group. Both groups also completed a post survey at six weeks (the waitlist control completed their before they received their intervention). I interviewed all women with support from Sharon O’Halloran (CEO SAFE Ireland and a biodynamic psychotherapist). Interviews were completed either at the Mayo Women’s Support Services or at the intervention venue. All but one of the interviews was tape-recorded with consent of the women. The longitudinal cohort group received their interventions between May 2011 and May 2012. The intervention group of the RCT received their treatment in March 2013, and the waitlisted control group received their treatment in May 2013.

Data management, safety and monitoring procedures were included in the IRB application and carried out by the Principal Investigator (PI). In case of adverse events, women were instructed to call their case manager, the SAFE Ireland office, or the PI. The SAFE Ireland CEO coordinated any follow up needed. Mayo and Kildare staff monitored women regularly and coordinated closely with the SAFE Ireland staff to create what we termed “wrap-around” services. These “wrap around” services were critical in ensuring women’s safety throughout the research.
We recorded recruitment and retention for our study, including: the number of women invited to our study; the responses received; the resolution of these responses (ineligible, refused, eligible and included, other); the number of participants assigned to the BDT intervention group who were actually treated; the number of participants providing follow-up data by group at each follow-up; the number of participants completing the trial; and the number of withdrawals due to ineffective treatment, adverse experiences, loss to follow-up, or other causes. In the cohort study, we had 100% follow-up on all procedures. For the RCT, four women enrolled and withdrew prior to commencement of the intervention. One withdrew because her life was “too stressful”, two gave no reason, and one withdrew because she feared she would know women in the group. One woman participated in the intervention, but subsequently moved to the United States. There were eight women in the cohort study over one year, seven women who comprised the experimental group (six sets of useable data) and seven women who comprised the control group of the RCT (one of the women in the experimental group did not complete her follow-up survey despite repeated requests and unfortunately we had to exclude her from the analysis).

**Instruments and measures**

Demographic data included age, education, employment and use of psychological and medical services (RCT only). The survey measures were assessed at baseline and six weeks before and after interventions. Psychological distress measures included depression, anxiety, physical and emotional distress measures. Quality of life was measured with the vitality, bodily pain, social functioning and role functioning subscales of the SF-36. Use of social support, perception of social conflict and sense of coherence were also measured to gain a full understanding of women’s wellbeing. Because we used both quantitative and qualitative measures of all of the constructs in this study, the corollary interview questions are shown in appendix A.

**Psychological measures**

We screened women with the Kessler 6, which is a six-item screening tool designed to detect individuals who are likely to be suffering from non-specific psychological distress (Kessler et al., 2002). While the cut-off for indication of distress is 13, we expected high levels of distress, so we set our threshold for entry into the study at 20. All depression, anxiety and physical and emotional symptoms were measured using the same Likert scale with “1” indicating little or no times per week to “4” indicating most or all of the time. Depression was measured by the Center for Epidemiologic Studies-Depression scale (CES-D), developed at a division of the National Institutes of Mental Health, in 1971 (Radloff, 1977). The CES-D is a self-report scale that is an amalgamation of previously devised depressive inventories. Anxiety was assessed using the Zung Anxiety Self Report (Zung, 1971). Physical and emotional symptoms were measured with the 45-item Composite Symptom Checklist, which included 22 physical items and 23 emotional items (Saint Arnault & Fetters, 2011; Saint Arnault & Kim, 2008; Saint Arnault, Sakamoto, & Moriwaki, 2006). Use of social support was measured with the Social Support Questionnaire for Transactions (SSQT), developed by Suurmeijer and colleagues (Suurmeijer et al., 1995) that measures satisfaction with social support in five domains: emotional support, problem-oriented emotional support, social companionship, instrumental support and problem-oriented instrumental support. Sense of coherence was measured with the Sense of Coherence Scale (SOC) consisting of three dimensions: comprehensibility, manageability, and meaningfulness (Albertsen, Nielsen, & Borg, 2001) and is comprised of 13 statements. The Medical Outcomes Study Short Form-36 Health Survey (SF-36) was used to evaluate quality of life. The SF-36 was developed in the USA and has been used in a number of countries (Ware et al., 1998; Ware, Kosinski, & Keller, 1994; Ware & Sherbourne, 1992). We selected the sub-scales representing bodily pain, vitality, social functioning and role functioning.
Qualitative measures

We evaluated pre and post-intervention distress, functioning and wellbeing with a semi-structured interview that examined psychological and social functioning and wellbeing. Interviews were conducted with all women in the study at baseline, and at six months in the cohort group. We asked women to speak about their social situation and their physical and psychological condition, and their overall wellbeing. At the follow-up interviews, women were also asked to speak about their healing journey.

Treatment approach

Before embarking on these research studies, I participated in one of the Nurturing the Soul (NTS) intervention programs (November 2011) run by GBII. These workshops were re-designed with SAFE Ireland to meet the needs of frontline DV support workers and to understand the effects of vicarious trauma in the work. My clinical specialty as a psychiatric nursing practitioner throughout the 1980s and 90s was focused on women who had been traumatised. I participated in the NTS workshop from the authentic position of a practitioner and researcher at risk of secondary trauma related to working in this field. However, my co-participants knew that I was also researching the biodynamic perspective of trauma and recovery. As an outcome of this interaction, I developed a document entitled the “Eight Healing Principles” of biodynamic healing for trauma. This material was presented in Washington DC and disseminated to the GBII membership (Saint Arnault et al., 2012a) (see appendix B). The workshop that we developed for the studies reported here was based on that research.

The intervention was a two-and-a-half day group-oriented intervention, and a follow-up individual session about three weeks later. The individual sessions ranged from three to five hours. Sometimes, the needs of the participant necessitated alterations to the individual sessions. For example, two of the participants had concerns about their children that were addressed with both the participant and the child. The individual treatment was developed according to the needs of the women, and at least two members of the research team were present. The treatment team members, by their presence, gave witness to the healing of the women, and thereby represented a compassionate community.

Biodynamic therapists who had at least ten years of experience and agreed to follow the treatment protocols performed all group and individual treatments. The GBII treatment team has been providing theory-based biodynamic therapy for decades.

The intervention employed a “biodynamic environment”, which is understood as a space that affirms the integrity of each person, and supports honest self-expression without judgment. This is a conscious creation of a safe and structured environment that allows self-discovery, release of trapped energy, and the re-integration of the mind and body. In addition, the biodynamic therapists employ a system of “holding”. Holding may be of the therapeutic space, which involves supporting the participant to take time, with focused support and encouragement to express feelings or thoughts arising from the intervention; or, if bodywork is being used, holding may be of a muscle or a part of the body that has been weakened, in order to allow the complete circulation of energy. The therapist assists the participant to complete their thoughts, feelings and the interrupted impulses without judgment or disruption. In doing so, the therapist allows the participant to discover psychological and bodily places where energy has been stored, and hold attention there while the participant completes the action, speaks the unspoken or gives expression to the energy that needs to be discharged.
An important focus of BDT is “listening to the body”, whereby the therapist assists the participant to gain awareness of habitual movements and to discover their source. The practitioner may use observation, mirroring, or may encourage the participant to consciously alter or exaggerate movements or bodily sensations to facilitate self-discovery and the discharge of trapped energy. The biodynamic therapist may call attention to areas of the body, and/or the participant may use idioms or direct references to areas of the body that are involved in the psychological matter.

The BDT uses specialised biodynamic massage techniques or precise manipulation monitored by the stethoscope feedback to facilitate release of trapped energy and toxins. The goal in the BDT session is to “complete emotional cycles” and to “facilitate the vegetative discharge and release of trapped energy”. Repressed feelings and incomplete or interrupted impulses can be a source of trapped energy that can cause a person to short-circuit thoughts or expression and to repeat non-productive patterns in an effort to meet needs. The therapist uses holding and attention to the body to help the participant identify incomplete or interrupted impulses, and facilitates their completion, which can discharge trapped energy. Trapped energy can be a source of pain, disability, anxiety, depression and problematic social behaviours. Therapists work with participants to discover the sources of trapped energies, and use a variety of methods to facilitate release, including massage, manipulation, holding, emotional catharsis and/or psychodrama exercises that allow the safe completion of impulses in a contained and structured way (Saint Arnault et al., 2012a).

**Follow-up monitoring**

This intervention included a critical “wrap-around” philosophy that encouraged women to keep in close contact with their support worker, and were informed that if they needed additional support, that they or their support worker could contact SAFE Ireland.
This study was a yearlong longitudinal study to examine the feasibility of the intervention, as well as to examine the healing trajectory of the women. Three interventions were carried out, each separated by six months. Eight women volunteered for this study, attended all workshops, completed the interviews, and participated in the individual sessions. The average age of the women was 44 years. The range of time the women were with their abuser was five to 20 years. At least half of the women had experienced and/or witnessed abuse as children and several had experienced sexual abuse or rape either as children or in the abusive relationship. All of the women had been out of the violence over four years, and two of the women were in new relationships. All of the women had been in DV support services at the time of the interventions, and all but one had been in these services for years. Most of the women had vocational training and one had a graduate degree. All of the women were residing in rural areas of Ireland.

Severity of distress at baseline

One of the findings from this study is a detailed picture of how trauma devastates the quality of life for women, even after years away from the abuse. The mean Kessler score of the women was 13.4 (SD=4.9), with a range from seven to 20 on intake. The CESD scores ranged from 18 to 56 and the mean was 36.2 (SD=13.8) (cut-off for indicating clinically significant depression is 16). The Zung Anxiety Scale scores ranged from 18 to 46 with a mean of 31.3 (SD=10.7) (cut-off for moderate to severe anxiety is 45-59). Physical and emotional symptoms were also very high. On the physical symptom checklist (22 physical symptoms including sleep, intestinal pain, muscle or joint pain, cardiac and neurological symptoms), women’s sum of symptom scores ranged from 19 to 54 with a mean of 34.4 (SD=10.9). On the emotional symptom checklist (23 physical symptoms including depression, sadness, anxiety, fear, anger, loneliness, and out of body feelings), women’s sum of symptom scores ranged from 27 to 68 with a mean of 47.2 (SD=15.5). Although I did not carry out psychiatric evaluations of the women in my intake interviews, there were several noteworthy findings related to the level of distress among these eight women. Three of the women had current major depression disorder, one had an anxiety disorder, most had hopelessness either in their past or currently, most were on psychiatric medication, and two had a history of panic attacks.

Qualitative findings: living without healing

Qualitative analysis reveals how most of the women had sought healing many times but that their symptoms were resistant to traditional interventions including psychotherapy and medications. Related to this, women reported feeling “stuck”. Women reported that their relationships were severely impacted, both because they isolated themselves from others, and because of the ways that others in their life judged them and cut them off. Finally, women were searching for meaning and hope.

Persistence of symptoms

Most of the women were on medications and all of them had been to counselling. Despite these attempts to get help, it seemed that the effects of trauma had been resistant to the therapies that were provided for them. This was true also for the three women who were using alternative therapies (Hakomi, meditation and yoga). One woman put it this way:

... going to counselling... I have used...(for) post-traumatic stress since 1997. I got counselling then and they told me to ‘get up, get dressed, and do your hair nice’. And I feel like that’s my coat of armour every morning.
Another woman said:

I really fight it every day. I fight the fear and the loneliness...I get up, usually ’cause they tell me to in counselling. But it’s more like retail therapy. But I have to get up ’cause of the depression and everything.

One woman was seeing a counsellor, a psychiatrist, was on medication and had a support worker. Despite this support, she says:

A lot of times or someone might just say something and I will have a lot of flashbacks. Just certain things and I didn’t realise how much it would happen. I hold my breath a lot and that’s a big thing. And at night time I hold my ears and try to keep the nightmares away.

The women carried on with surprisingly high symptom burden. The physical and the emotional symptoms were intertwined. Physical pain and digestive problems were the most common. One woman said:

I have shoulder pain, and a bad back. ...I would have had a huge amount of anxiety...it’s a huge overwhelming feeling that just takes over, you are kind of paralysed. ...I have been on my meds for five or six years...I get palpitations in my body but other than my back no other problems. Down in my tummy, I would have like heartburn. A few days ago I had the stomach pains. They happen a lot...I deal with exhaustion and tiredness.

Another woman reports:

I have headaches a lot of the time, but it’s just in one spot. It’s kind of like I have been used to it. It’s always there...(before, it was) all down my face and back...I find coming down the stairs in the morning hard. My ankles and knees will hurt. ...My hands go numb a lot, even just talking on the phone...I (have to) sleep on my stomach with hands under the pillow, and I still wake up at night time just to get things going sometimes (to get the numbness to go away).

This woman also has chronic pain:

Primarily (pain in my)...back, but my whole body feels like a large weight. At the moment my walking is disabled some. I swap and change pain meds all the time. If I am having a really, really bad week, I take half of a sleeping pill. I’m taking so many painkillers I need to take something for my stomach.

Feeling “stuck”

Women used words like “stuck”, “freeze” or “frozen”, “on edge”, “not moving” and “trapped” to describe their healing trajectory. One woman, who had been out of the relationship for years, states: “I have nightmares when I am stressed or when he comes near me. I go into that freeze mode where nothing works.” Another says: “You think it’s over and done but it’s just something that knocks you back.” Another puts it this way: “I suppose for the last few months I have felt stuck like I am not moving forward. I’m not moving backwards. I’m just in this place where I am stuck.” One woman says: “...you’re moving on all the time but you’re still kind of stuck in the same hole.” This woman said: “At times I sit with the kids and you feel trapped.”

Some women are not so much frozen as they are hyper-vigilant. This woman is always on the alert, saying: “It’s like he’s not there but he is always there.” Another woman reports: “I just live in fear. I lock my doors and don’t open my windows. I did this past weekend. I had a great weekend and my friend came to stay with me...when there is someone around I feel more secure.”
Social isolation

A third finding was the complex interactions among stigma, social isolation and interactions with family and community after leaving the relationship. In some cases, interpersonal relationships, even with children, were strained. This woman said:

I find keeping busy, but when I get too busy I just get overwhelmed...I just shut off towards the kids, and sit in my room. They leave me alone when I shut down.

The social isolation of women was profound. This woman said: “Several people have come into my life since and I just cut them off.” Another said “(I realised) how isolated I have become and how much of a recluse and how cut off I have become from everyone because that’s the easy option.”

Many women received pressure to stay in the abusive relationships from family, and some lost family when they left their abuser. This one said:

My relationship was so bad with my mom, and after the first time he went to my dad and my dad made me take him back, and that’s just so embarrassing.

Another couldn’t believe the response, saying: “So I find that difficult ‘cause I don’t feel like they can accept ‘the me’ that I am now.” Another explained: “I suppose my sisters couldn’t cope when I fell apart.”

One woman made the startling comment:

The funny thing about family is when I was in the relationship they were the most supportive, but once I left it was just like I had done the unthinkable, I had left. Mother, she said ‘you made your bed and you lie in it.’

Searching for meaning

When we constructed the interview, we were very aware that women were healthy, as well as needing additional healing. Moreover, because of my previous work, I also knew that sense of coherence is an important aspect of health and healing. Therefore, I asked the women what they would say was “the meaning of their lives”. In almost every case, the question generated anxiety, sadness and confusion. One woman said:

I suppose the meaning of life for me would just be able to love and be loved, and love yourself. I suppose just to love everything. I used to really think that life was meaningless. That life was shit and then you die. I don’t believe that anymore though. It’s much more important than that. It’s good to be alive. I suppose having energy. I don’t have a lot of energy. I am tired all of the time. I suppose just light heartedness.

Another said:

My life would have meaning if I knew what my life path was. Not have to rely on other people, trust myself more than I have been. If I could just like myself a bit more. I just find it hard. But if I could do that the rest would come. It is just so hard. But it’s just how do you do that?
Qualitative findings: healing from the effects of DV

The findings from the qualitative analysis included the hypothesis that women's healing may progress through predictable stages, and that this healing trajectory can help focus sessions for women. We also learned that women gained the ability to manage life, the ability to open up to others, and an awareness of their body.

Phases of recovery

One of the major findings in this study was the discovery of the healing trajectory for the women. The first phase seemed to be the need for the women to get “unfrozen”. That is, they needed to complete some of the actions that were repeating in their bodies, perhaps causing their symptoms, and preventing them from fully healing from the effects of the trauma. The second phase seemed to be around getting close to others, trusting, keeping safe, and establishing boundaries when they were close, as well as giving and receiving love. The third phase seemed to relate to the need to take on the larger institutional structures of the society, whether they be the extended family and community in some cases, the ability to manage money and banking or taking on the legal system.

Understanding the effects of trauma

Most of the women said that a pivotal awareness in their healing was the understanding that they had been suffering from the residual effects of the trauma. This awareness gave them confidence in their capacity, strength and competency. Women used phrases like: “Learning and understanding the affects and effects of trauma and the lineage of our families and understanding about charge and discharge;” and “It has made me stronger and better able to mind myself in all this mess.” Another woman contrasts this strength with just coping, saying “…And just knowing that I dealt with things. It’s not just a case of coming to terms with it... (now) it’s just not an issue.”

Another woman sums it up this way: “And that I just feel an awful lot stronger. And whatever comes up I can handle it. Like when I (tried to) handle stuff in the past (but) I could just handle it now.” Another said: “I suppose it validated for me my pain. It’s only now I can look at the marriage for what it was. And it wasn’t nice at all. I don’t know why I stayed for so long. I stayed for 20 years.” One woman commented that she felt in charge, saying: “I have this new life starting. I know he will never be able to control me again. And my life is whatever I make it out to be.”

One woman reported:

I feel honoured to have been part of the weekend, learned a lot about myself. I believe now that I reacted normally to some very unusual situations. Time to stop beating myself up about everything and move on with life.

Opening up to others

A second primary change for the women was their ability to open up to others, either in the group, or because of being in the group. One woman said: “To think you could bring eight people into a room that didn’t know each other and they could spit out their emotions.” Another woman elaborates:

Not just the work with Mary but also being with others. I learned a lot from them and how they coped with different things. And how they worked through things. And you just realise you are not alone. Even though you knew beforehand. It was just such an intimate setting. You know other people have all these things to deal with. And it’s just a huge respect for people and them. And how they all shared things.
In addition, women described how they had cut themselves off from others before. For one woman, it was explicitly because of her shame: “The shame was huge, at the moment I don’t feel that awful shame that use to be there. I use to relate that to the others that it’s not their shame.” Another stated: “I am … not concerned (now) about what people think of me.” For another, the openness to others increased her confidence and capacity:

…it was like ‘good’ and ‘having all my needs met as much as I want’. That was something that struck me. I would be inclined to isolate myself. But (now) I feel more comfortable with people. I feel like an adult. I don’t feel like the child.

**Body awareness**

Another healing element included body awareness. Comments included “I feel more in my body now than I did before,” and “I think with the eating it was to fill a gap. I noticed I am not doing that now.” One woman explains:

I think that was because it was still in my body. I (would) deal with it but I wasn’t out with the system...Now the trauma is) not just out with the head its out with the whole of me.

**Quantitative change in health indicators**

In order to measure whether the intervention had an effect on key indicators, we used paired t tests to examine the difference between the means for each indicator between baseline, and before and after each intervention. However, the sample size is so small; these only provide an indication of a trend.

**Table 2: Cohort health indicators changes over time (\*p \leq 0.05)**

<table>
<thead>
<tr>
<th>Health Measure</th>
<th>T1 M (SD)</th>
<th>T2 M (SD) sig.</th>
<th>T3 M (SD) sig.</th>
<th>T4 M (SD) sig.</th>
<th>T5 M (SD) sig.</th>
<th>T6 M (SD) sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>47.3 (15.6)</td>
<td>24.9 (17.2)*</td>
<td>23.9 (18.8)*</td>
<td>20.4 (21.1)*</td>
<td>20.5 (21.0)*</td>
<td>18.0 (19.2)*</td>
</tr>
<tr>
<td>Physical</td>
<td>34.4 (11.0)</td>
<td>16.9 (9.8)*</td>
<td>17.8 (9.9)*</td>
<td>16.8 (10.1)*</td>
<td>17.3 (9.7)*</td>
<td>13.8 (9.9)*</td>
</tr>
<tr>
<td>Depression</td>
<td>36.3 (13.8)</td>
<td>18.0 (14.5)*</td>
<td>20.5 (13.3)*</td>
<td>17.6 (15.2)*</td>
<td>18.3 (14.5)*</td>
<td>14.5 (14.6)*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>31.3 (10.8)</td>
<td>15.9 (8.6)*</td>
<td>18.4 (10.6)*</td>
<td>21.4 (7.8)*</td>
<td>19.6 (9.9)*</td>
<td>17.9 (11.7)*</td>
</tr>
<tr>
<td>Social Support</td>
<td>47.8 (11.3)</td>
<td>53.4 (14.4)</td>
<td>57.0 (13.0)*</td>
<td>59.6 (14.9)*</td>
<td>59.9 (15.2)*</td>
<td>61.3 (16.2)*</td>
</tr>
<tr>
<td>Conflict</td>
<td>17.8 (3.4)</td>
<td>13.1 (6.0)</td>
<td>13.4 (3.2)*</td>
<td>14.6 (2.9)</td>
<td>14.8 (2.8)</td>
<td>13.1 (2.9)*</td>
</tr>
<tr>
<td>Vitality</td>
<td>25.0 (18.9)</td>
<td>46.9 (16.7)</td>
<td>42.5 (19.6)*</td>
<td>35.0 (26.3)</td>
<td>35.0 (26.3)</td>
<td>43.8 (17.7)*</td>
</tr>
<tr>
<td>Bodily Pain</td>
<td>42.8 (29.7)</td>
<td>55.9 (31.0)</td>
<td>59.1 (22.6)*</td>
<td>55.9 (22.5)</td>
<td>57.5 (24.6)</td>
<td>59.1 (58.7)</td>
</tr>
<tr>
<td>Social Functioning</td>
<td>48.4 (30.9)</td>
<td>62.5 (30.6)</td>
<td>59.4 (18.6)</td>
<td>53.1 (19.8)</td>
<td>56.3 (24.1)</td>
<td>56.3 (20.0)</td>
</tr>
<tr>
<td>Role</td>
<td>25.0 (38.8)</td>
<td>45.9 (39.6)</td>
<td>46.1 (32.2)</td>
<td>45.8 (35.4)</td>
<td>50.0 (39.8)</td>
<td>45.8 (46.9)</td>
</tr>
<tr>
<td>Coherence</td>
<td>38.9 (10.9)</td>
<td>50.1 (9.4)*</td>
<td>50.4 (7.9)*</td>
<td>54.0 (6.9)*</td>
<td>52.6 (6.3)*</td>
<td>56.9 (12.3)*</td>
</tr>
</tbody>
</table>
Distress

The distress indicators in this study were emotional symptoms, physical symptoms, depression scores and anxiety scores (see chart 1 for a depiction of these score changes over time). The women in the longitudinal study had statistically significant and sustained improvements in all of their distress indicators. There was a dramatic reduction of emotional symptoms after the first workshop (baseline M=47.3, SD=15.6) compared with six weeks (M=24.9, SD=17.2) (t=3.7, df=7, p=.01). These means remained lowered, with statistically significant mean differences across all time points (mean range was from 18.2-23.9, p>.01) compared with the baseline. Physical symptoms reduced after the first workshop (baseline M=34.4, SD=11.0) compared with six weeks (M=16.9, SD=9.8) (t=8.8, df=7, p=.00). These means remained lowered, with statistically significant mean differences across all time points (mean range was from 13.8-17.8, p>.01) compared with the baseline. Depression symptoms reduced after the first workshop (baseline M=36.3, SD=13.8) compared with six weeks (M=18.0, SD=14.5) (t=5.8, df=7, p=.00). These means remained lowered with statistically significant mean differences across all time points (mean range was from 14.5-20.5, p>.01) compared with the baseline. Finally, anxiety symptoms reduced after the first workshop (baseline M=31.3, SD=10.8) compared with six weeks (M=15.9, SD=8.6) (t=5.4, df=7, p=.01). These means remained lowered with statistically significant mean differences across all time points (mean range was from 17.9-21.4, p>.03) compared with the baseline.

Chart 1: Cohort distress changes

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5 It should be noted that these depression means still exceed the standard screening cut-off of 16, which indicates likelihood of continuing clinically significant symptomology.
Quality of life

The quality of life indicators used in this study were vitality, bodily pain, social functioning and role functioning (see chart 2 for a depiction of these score changes over time). The women in the longitudinal study had some statistically significant changes, in some time points, in vitality, bodily pain and role functioning. There were no statistically significant changes in social functioning at any time point; however a trend toward improvement is evident. Vitality means were statistically increased from baseline (baseline M=25.0, SD=18.9) compared with six month time point (M=42.5, SD=19.6) (t=-2.6, df=7, p=.04); and at the one year time point (M=43.8, SD=17.7)(t=-2.5, df=7, p=.04). Bodily pain means were statistically different from baseline (baseline M=42.8, SD=29.7) only at the six month time point (M=59.1, SD=22.6)(t=3.6, df=7, p=.01).

Chart 2: Cohort quality of life changes

Social measures

The social indicators in this study were use of social support and social conflict (see chart 3 for a depiction of these score changes over time). The women in the longitudinal study had statistically significant and sustained improvements in their use of social support at six months and for the rest of the time points. Social conflict scores were statistically reduced at the six months and after the year out intervention. There was an improvement in use of social support (baseline M=47.8, SD=11.3) at the six months (M=57.0, SD=13.0 (t=-4.1, df=7, p<.01). These means remained improved with statistically significant mean differences across all remaining time points (mean range was from 59.6-61.3 p>.01) compared with the baseline. Social conflict scores reduced (baseline M=178, SD=3.4) at the six months (M=13.4, SD=3.2) (t=4.6, df=7, p<.00). These means were statistically lowered again after the year out intervention (M=13.1, SD=2.9 (t=3.2, df=7, p<.01).
Sense of coherence

The sense of coherence score is the sum of three interrelated subscales, which are meaning, insight and manageability. While the authors warn that these scores should not be examined apart from one another, looking at the trend lines for them in chart 4 shows that these may operate independently and improve at different rates. However, for statistical purposes, only the sense of coherence sum score is reported here. The sense of coherence score improved (baseline M=38.9, SD=10.9) compared with six weeks (M=50.1, SD=9.4) ($t=-2.9$, $df=7$, $p=.03$). These means remained improved with statistically significant mean differences across all remaining time points (mean range was from 50.4-56.9, $p>.02$) compared with the baseline.

Chart 4: Cohort sense of coherence changes
Study two: A randomised controlled trial of a biodynamic intervention

This study used a randomised sample to carry a controlled trial of the effect of the two-and-a-half day group-oriented workshop and follow-on individual session (three to five hours) on standardised psychological, physical and wellbeing instruments. The aim of this study was to discover whether the intervention had an impact of health indicators for a randomly assigned group of women when compared with women who were receiving support services but who had not had the intervention. We gathered baseline and six-week measures for both groups, and the waitlisted control group received their intervention after the six-week measures were completed.

Most of the women in both groups had either secondary or technical educational preparation. All of the women were receiving DV support services. The range of time in the abusive relationship ranged from three years to 20 years. The range of time out of the relationship varied from two to ten years. Independent sample t tests revealed that the experimental group had statistically higher depression scores ($M=52.0$, $SD=5.7$) ($t=2.4, df=11, p=.04$) at baseline compared with control group ($M=40.6$, $SD=9.8$). In addition, the control group had higher social support scores ($M=55.7$, $SD=14.9$) ($t=2.1, df=11, p=.04$) compared with the experimental group ($M=40.1$, $SD=6.6$). There were no statistical differences in the age; current use of general practitioners, accident and emergency use; psychiatrist, psychologists or use of medication. However, more women in the experimental group were seeing a counsellor at the time of the baseline survey (all of the seven in the experimental group were seeing counsellors, while only three of the waitlisted control group were) ($p=.02$). There are no statistically significant differences between six-week scores for the experimental and the control group on any measures.

For this analysis, we compared the six-week scores for the women in both groups; the scores for the women in the experimental group who had had the intervention were compared with the scores for the women at six weeks who have had standard support services. The means, standard deviations and effect sizes are in table 3.

Table 3: RCT effect sizes (**control group higher at baseline)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Experimental Mean (SD) *p&lt;.05</th>
<th>Control Mean (SD)</th>
<th>Cohen’s d (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Point</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>56.3 (18.9)</td>
<td>52.6 (19.8)</td>
<td>-.58 (-.28)</td>
</tr>
<tr>
<td>6 weeks</td>
<td>39.2 (20.2)</td>
<td>50 (16.7)</td>
<td></td>
</tr>
<tr>
<td>Physical Symptoms</td>
<td>38.1 (11.4)</td>
<td>33.0 (10.6)</td>
<td>.05 (.03)</td>
</tr>
<tr>
<td>Depression Score</td>
<td>52.0 (5.7)</td>
<td>40.6 (9.8)</td>
<td>.21 (-.10)</td>
</tr>
<tr>
<td>Anxiety Score</td>
<td>47.0 (8.0)</td>
<td>42.1 (11.0)</td>
<td>-.47 (-.23)</td>
</tr>
<tr>
<td>Social Support**</td>
<td>40.9 (6.3)</td>
<td>52.7 (13.0)</td>
<td></td>
</tr>
<tr>
<td>Social Conflict</td>
<td>16.7 (4.5)</td>
<td>11.0 (4.2)</td>
<td>-.03 (-.01)</td>
</tr>
<tr>
<td>Vitality Score</td>
<td>45.7 (9.8)</td>
<td>45.7 (19.0)</td>
<td>.68 (32)</td>
</tr>
<tr>
<td>Bodily Pain</td>
<td>75.0 (28.9)</td>
<td>71.4 (22.5)</td>
<td>-.16 (-.08)</td>
</tr>
<tr>
<td>Social Functioning</td>
<td>33.3 (20.4)</td>
<td>53.6 (26.7)</td>
<td>.31 (15)</td>
</tr>
<tr>
<td>Role Functioning</td>
<td>7.1 (18.9)</td>
<td>28.6 (39.3)</td>
<td>.27 (13)</td>
</tr>
<tr>
<td>Sense of Coherence</td>
<td>38.1 (16.5)</td>
<td>50.6 (19.8)</td>
<td>.06 (03)</td>
</tr>
</tbody>
</table>
We calculated Cohen’s $d$ to estimate the effect sizes for the biodynamic intervention for the experimental group. Cohen (1988) proposed rules of thumb for interpreting effect sizes: an effect size less than .32 would be difficult to see but not trivial (small), an effect size .33 -.55 would be visible to the “naked eye” (medium), and effect sizes over .55 are substantial (large) (Cohen, 1988).

The means for the distress indicators for the women are depicted in chart 5; the analysis shows large effect size for emotional symptoms ($d=-.58$); medium effect size for anxiety ($d=-.47$); and small effect size on depression ($d=-.21$). For quality of life indicators (depicted in chart 6), the analysis showed large effect size for vitality ($d=-.68$); small effect sizes for social functioning ($d=-.31$), role functioning ($d=-.27$) and bodily pain ($d=-.16$). We found no effects for physical symptoms, social conflict or sense of coherence after the first session.

Chart 5: RCT distress at six weeks
Effect size is about the magnitude of the differences between the mean scores, but does not examine what caused that effect. We might hypothesise that the intervention relates to the difference between the scores but there are a host of other variables that may also influence those differences, even when we randomise the sample. For example, more of the women in the experimental group were in counselling. Cohen and others warn that effect sizes should be evaluated when compared with other similar studies. Unfortunately, there are very few studies reporting effects sizes for similar interventions for comparison. One study reported an effect size of .32-.46 on PTSD scores for a ten-week community-based intervention for mother-child dyads (Graham-Bermann & Miller, 2013). Another study examining the effect of a community based referral and outreach intervention found effect sizes between of .30-.40 on PTSD symptoms (DePrince, Labus, Belknap, Buckingham, & Gover, 2012). A third study reported medium effect sizes of cognitive behavioural therapy on depression and PTSD scores at six weeks (using a partial regression coefficient squared).
Lesson learned one: New insights in trauma recovery

We saw stages of recovery in the women that were somewhat different from those reported in the literature (Herman, 1997; van der Kolk et al., 1996; van der Kolk et al., 1996). Herman recognised the establishment of safety, remembrance and mourning, and reconnection with ordinary life as critical stages in the recovery from DV trauma. The women in the longitudinal group had been out of their relationships for over five years, and had established relative physical safety. However, we found that feelings of safety, security and emotional safety remained an on-going struggle. In light of the number of symptoms and our earlier discussion of the nature of chronic activation of the sympathetic or immobilisation systems, women were often not feeling safe. Our findings also indicated that reconnection with ordinary life involves numerous processes, and that it was often difficult. For example, since women were grappling with numerous physical and emotional symptoms, meeting the challenges of day-to-day life was a struggle. In general, women also found that while their life should have been joyful and filled with meaning, there were areas they needed to heal. They were searching for the zest, vigour, vitality and social engagement that had been here-to-fore elusive.

Our longitudinal study of a longitudinal of women is important, and demonstrates that these women were able to gain significant reductions in their symptom burden. Reduction in symptoms may have translated into an improvement in their quality of life, especially in the areas of bodily pain and vitality.

In the first workshop, the clinical focus was working with the neurobiological freeze or immobilisation mechanism. The aim seemed to be to get the women re-activated, and re-engaged in their lives, to complete actions they needed to complete, and to release the trapped energy so that it was available to them for other important uses.

We saw that, at baseline, issues with the use of social support were important concerns. This is consistent with earlier work (Herman, 1997; van der Kolk, 1996). We found that after the first session, women gained significant improvements in their ability to use social support. However, the trend in the social support was illuminating. While there was a dramatic improvement in satisfaction with social support, it was one indicator that might be sensitive to time. It may be that the improvement in symptoms may have helped women initially in making improvements in their use of social support, but they may have still been struggling with issues of trust. Therefore, emphasis of the second workshop was focused on relationships, boundaries and trust. In addition, we found that women struggled with stigma and shame, which were important barriers to engaging socially. In light of the need for activation of the social mobilisation system, this is an important question for future research to examine. It may be that the women had the capacity to engage, but psychological barriers or stigma and shame, as well as the characteristics of their social system, made meaningful engagement difficult.

The trends in sense of coherence are useful in understanding the spiritual aspects of healing from the effects of trauma. Personal insight was the most steadily improving aspect of the sense of coherence in their lives. It seems that the women simply continued to learn about who they were in the world, what they could achieve, and how they could feel happy. In the quantitative measures, we saw that manageability got a boost after each intervention, then dropped a little, then rose again, with an overall improvement, however unsteady. This is an interesting measure because since the women’s symptoms reduced and stayed better, it is likely that the manageability was not, therefore, only about symptoms, but an overall assessment about how they could manage all of the aspects of their lives, which included functioning as well as social aspects. For example, we know that in the second session,
the women were struggling with closeness, boundaries, trust, stigma and shame. It is possible that in the first six months, women who are healing from the effects of trauma are learning to manage relationships in life after DV. In the third intervention, the therapeutic focus was around the larger social, cultural, community, political and legal context of their lives. Women focused on how they struggled with banking and finance and asking for what they needed from the courts. It is possible that the women were struggling with the manageability of these larger institutional aspects of their lives in the last six months. Finally, meaning in life improved initially but then levelled off. It may be that meaning takes a long time to develop, and that until the women took on the institutional systems, they were still struggling to find meaning. It is possible that this is still improving for them now that they are getting on with their lives more fully.

Evaluation of effect sizes inherently requires a personal value judgment regarding the practical or clinical importance of the effects. The effect on any given variable doesn’t explain the importance of the impact of that change in women’s lives. As we have seen in the qualitative data, there were numerous, interacting effects in this sample that may have profound clinical impact. In addition, we do not know how each variable relates to the others, and many of the variables, such as depression, anxiety and emotional symptoms, vary together. The effect of the intervention on anxiety, for example, may make a major difference in a person’s ability to sleep, make decisions, go to work, have meaningful interactions with others, and a host of other life tasks.

We found that it was essential to work with women who were currently embedded in the services network. As awareness or needs came up for the women, they were able to work with SAFE Ireland and their local DV support services to mobilise additional supports. In addition, as their health improved, women were easily able then to make use of the support available to them. We also saw that in many cases, as women’s health improved, they were also able to make increased use of supports for their family, and/or more fully engage with their therapists or use their medications more effectively. While not fully captured in the interviews, we heard in the group that their involvement in the services also took on a new significance, with many of them seeing their increasing involvement as a way of “giving back” or making meaning of their lives.
This research used symptom measures that gave us an indirect view of the theoretical neurobiological effects of trauma for women who had experienced complex trauma, and “inescapable” shock. Since most research to date on this topic has focused on child abuse, military trauma, or single event trauma, we had little to draw on to understand how neurobiological mechanisms affect women recovering from DV. In this data, we saw that the women’s symptoms were consistent with theories about chronic activation of sympathetic and immobilisation systems, even years after escape from the violence. We found that many of their symptoms were resistant to traditional psychological and psychiatric interventions alone, and that they interacted with other aspects of quality of life.

Most of the neurobiological literature emphasises the brain. However, we believe that the appropriate understanding of trauma requires us to know about how our “brain” (our central operating unit, as it were), our “mind” (our experience of ourselves in the world) and our “body” (our feelings, sensations and actions in the world) interact. Our trauma therapies must address them all. Much of the alternative work being done in trauma (i.e. somatic experiencing, Radix and sensory-motor integration) have emphasised that, from a neurobiological perspective, the mind/body needs to resolve the trauma by completing the actions and emotions that were begun at the time that the person “froze” in the face of “inescapable” shock. This work is consistent with the biodynamic approach. However, we have seen that it might be very important to do this healing in the context of a group. This is because experiences of shock are intertwined with shame, social stigma and social isolation. Indeed, it may be that the social aspects of trauma can serve to maintain some of the residual physical and psychological effects of trauma. We suspect that the completion of cycles in the context of a group lends the additional healing power of emotional and behavioural processes being contained, witnessed and supported by others who are on the same journey. The team felt so strongly about this need that we developed the protocol that at least two other members of the team (with permission from the women) be present even during the individual sessions.

An alternative hypothesis is that it is the act of completing cycles that is the healing mechanism, and that the social healing can only occur after this has taken place. One way to test this would be to determine whether women who have received biodynamic therapy in individual sessions only would receive these benefits, or have the same healing trajectories. Indeed, there are many women for whom the intensity of the group healing format would be unbearable. It may be that this group-oriented healing approach is not for everyone. If, for example, these effects could be achieved in a few individual sessions, this would be important to know. Also it is critical to understand what individual treatment is needed, and whether it is the “completion of the action” or the resolution of the trapped or armoured energy and fluids, or some combination that provides the necessary healing. It is likely that this might be different for every woman.

The finding that healing trajectories may have a predictable pattern, and that these patterns may relate to opening up their neurobiological system, has implications for staging interventions for women at different points in their service use. Perhaps, for example, if women could have treatment aimed at “unfreezing” them and activating their self-regulation system (psycho-peristalsis), this might reduce the chances that they would return to the abuser, reduce the length of time that they used the service, decrease their need for mental health services, and improve empowerment outcomes. Research is needed to determine what kind of biodynamic, holistic and/or psychological interventions would mitigate this “freeze to protect” response, thereby allowing women to make full use of services and social supports available to them.
The theoretical neurobiological processes and the healing we saw in these studies suggest an inability of the person who is in shock or freeze to reach out. This finding may explain why only a fraction of women who need support for violence ever reach out to services. In addition, it may also explain why, for those who access services (like the women we have encountered here), they cannot achieve the full benefits of psychological and social support available to them even after years of therapeutic engagement. It may be that traditional psychotherapy and medication would be more useful for women who have had a course of therapy that “unfreezes” their neurobiology. Alternatively, we do not know if their history of use of support and medication helped them make use of this complementary approach.

Summary and looking to the future

We were astonished that the women in our samples were actively engaged in help-seeking and service use, yet they continued to feel “stuck”, suffer with a high emotional and physical burden symptom, social isolation and social stigma, and that despite years of time out of the abuse, they struggled to find meaning and healing. We found that biodynamic treatment may be useful as a short-term mind/body intervention that promotes health, reduces symptoms, and can improve quality of life. While these findings are preliminary, and our samples are small, we believe that biodynamic healing techniques warrant larger trials. These trials should include both group and individual work, and should be carried out with groups in different phases in the healing process. While these studies were not designed to discern the specific mechanisms of healing, because we used mixed methods, we can point to the words of the women to begin to get a clue. The women report that understanding the effects of trauma in their bodies and their lives, opening up to others, and increased bodily awareness were healing factors for them.

The findings in these studies were consistent with the work of Porges and others who cite the persistence of the “freeze” mechanism long after the crisis of abuse is over. We believe that while not everyone may generate PTSD after the tragedies of living with abuse, the residual effects of that trauma live on in our bodies, hearts and minds.

Research is sorely needed to understand how neurobiological theories can help us understand help-seeking, and to develop strategic interventions for women who are “frozen” after complex cumulative trauma. This is consistent with the findings of research that interviewed 42,000 women from the 27 EU Member States and Croatia (FRA, 2013), and found that four out of five women did not turn to any service following the most serious incidents of violence. Research, including my own, has found that the help-seeking process begins with an awareness or recognition by the woman that she is in distress, and that the distress signifies that her situation is abnormal and significant (Saint Arnault, 2009). This research has shown that there are situations in which women: are in a “frozen” or immobilised state; are in a sympathetic nervous system activation state; have underactivated social engagement; or are unaware of their needs because of dissociation. In any of these cases, they are unlikely to recognise their feelings, to label them as abnormal or significant, and seek help for services. In any of these cases, women may not recognise their needs, or respond appropriately to access or utilise all of the help they need. In the interviews, we found that some women “had seen the flyers” about support services, but either did not think they applied to them, or didn’t think that they could actually escape. Some women had been in therapy for years, and had never talked about the extent of the types of trauma they had experienced, and were therefore unlikely to heal from the therapy.
The implications of these phenomena for help-seeking are critical. Research is needed about how help-seeking is impacted by these mechanisms, including the trajectories of help-seeking for women who have had complex trauma histories that include DV. For example, we need to know much more about whether women can receive or relate to communication about support for their situation. If women do not think that these flyers relate to them, then we may need to alter how we reach out to and communicate to women. Since most research is carried out with women who have accessed services, we can begin by evaluating the conditions or communication that finally mobilised them to act. We can also reach out to women who seek help from non-DV supports, such as health care services, to discern how they perceive their help-seeking options.

We need to know more about how women who are receiving services make use of the array of healing options available to them. If dissociation remains long after leaving the abuse, women may be unable to fully use existing supports. Perhaps agencies can develop help-seeking and complex trauma-assessment protocols so that they can provide information and intervention targeted at making full use of available services. For example, recognising that women are experiencing dissociation can alert service providers that cognitions, emotions and behaviours may come forward in certain settings or when certain trigger topics activate action pathways in the brain. In these cases, the provider and the woman can partner to process her feelings in the situation, and work toward consciousness and choice rather than reflexive avoidance or impulsive actions. Understanding the patterns of action and reaction in a woman’s life can empower the service provider to help where help is needed, and empower the women to move toward conscious choice and service utilisation. In addition, this kind of complex trauma-informed service provision can increase the effectiveness of all service provision. Reports and guidelines are available to guide this transition at an organisational level (See Kezelman & Stavropoulos, 2012 for a recent Australian example). Finally, women can be taught these concepts and how to recognise them within her mind and body. Alone, or in partnership with trauma-informed service providers, women can learn to identify triggers, the action pathways that are habitually triggered in her, and begin to move toward conscious integration of aspects of herself that she had needed to avoid in the past to remain functional.

It is our hope that those engaged with women who are experiencing violence, and women themselves, are inspired by these results. These results show that we can heal from the effects of trauma, and that we can thrive with vitality and meaning. We believe that treatment and support may or may not result in healing. However, treatment and support that is aimed at the complex and holistic interactions among the brain, heart, mind and body may be more effective than psychosocial intervention alone. Surely, our purpose for treatment and support is not only symptom reduction, but full, thriving and engaged living. When we are attentive to the goal of “healthy” women, children, families and communities, we can recognise that we all need and deserve to heal the effects of violence, not only in ourselves but in our women, our families and our world.

Summary and looking to the future

Healing from domestic violence and trauma – Lessons learned from research on the biodynamic approach
# Appendix A: Instruments and measures

<table>
<thead>
<tr>
<th>Concept</th>
<th>Survey</th>
<th>Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellbeing</strong></td>
<td><strong>Sf-36 subscales</strong> (14 items)</td>
<td>Overview: Tell us how you have been in the last month or so? What is going well? What isn’t going so well?</td>
</tr>
<tr>
<td></td>
<td><strong>Social functioning</strong></td>
<td>Tell us about your social life. Who do you see regularly? Who do you wish you could spend more time with? Who do you feel you have to be with, but wish you didn’t?</td>
</tr>
<tr>
<td></td>
<td><strong>Role emotional</strong></td>
<td>Talk about your ability to do the things you need to do. What kinds of things are helping you do well with that? What kinds of things are holding you back?</td>
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<tr>
<td></td>
<td><strong>General health and bodily pain</strong></td>
<td>How have you been feeling overall? Are you bothered by any physical or emotional concerns or problems?</td>
</tr>
<tr>
<td></td>
<td><strong>Vitality</strong></td>
<td>Talk about your ability to do the things you want to do. What kinds of things are helping you do well with that? What kinds of things are holding you back?</td>
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<td></td>
<td><strong>SSTS (22 items)</strong></td>
<td>Satisfaction and use of social support and social conflict: (See social functioning)</td>
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<td><strong>SSCS (5 items)</strong></td>
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<td></td>
<td><strong>SOC (12 items)</strong></td>
<td>Sense of coherence: Talk about how your life has meaning for you right now. Do you feel able to understand what is happening? How do you feel you are able to manage your life right now?</td>
</tr>
<tr>
<td><strong>Distress</strong></td>
<td><strong>CESD (20 items)</strong></td>
<td>Depression: (See general health) If symptoms were brought forward, these were discussed at length for medical treatments and effectiveness.</td>
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<td></td>
<td><strong>Zung Anxiety Scale (20 items)</strong></td>
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<tr>
<td></td>
<td><strong>Symptom Checklist (40-50 items)</strong></td>
<td>Social, physical and dissociative symptoms</td>
</tr>
</tbody>
</table>
Appendix B: Eight healing elements of Nurturing the Soul – The Biodynamic Approach

1. Biodynamic environment. Creating a space that affirms the integrity and dignity of each person, the importance of each person, supports honest self-expression without judgment, honours the needs of each individual and the needs of the group.

2. Listening to the body. The group leader may encourage the participant to consciously alter or exaggerate any movements or bodily sensations to facilitate self-discovery and the spontaneous discharge of trapped energy.

3. Holding. The group leader trains the participants to hold ‘space’ and have ‘time’ for the person who is speaking so that they can complete their thoughts, feelings and impulses without judgment or interruption. Where energy is trapped in a particular muscle or joint in the body, the group leader can ‘hold’ or support that muscle so that the energy that is trapped there can become free and continue along the original pathway to reach its final destination.

4. Armouring. Energy is the fundamental source of health and life. If we suppress feelings that seem too difficult, energy can become trapped in the body, also after traumatic experiences, or when impulses cannot be completed in a normal, safe and healthy manner. Trapped energy can be a source of pain, disability, anxiety, depression and problematic social behaviours. Energy can be stored in rigid and chronically contracted muscles, referred to as armouring. Armouring keeps the psychic and physical energy static, and the body is held in a chronic, permanent startle reflex. This muscular contraction prevents tensions and emotions from being released. Armouring is understood to occur in layers, from superficial to deep. In addition to storing tension and emotional pain, armouring traps bodily fluids and restricts blood circulation that would remove biochemical deposits. This concentration of metabolic residues in the body, such as adrenaline and lactic acid, repeatedly engages the sympathetic nervous system, keeping the person in a chronic state of hypervigilence or shock.

5. Discharging trapped energy. The group leader works with participants to discover the sources of trapped energies, and uses a variety of methods to help the participant build the charge to a point that it has sufficient strength to break through the armouring, to get it all out, and bring vegetative discharge and release.

6. Completion of cycles. Incomplete or interrupted impulses can be a source of trapped energy that can cause a person to repeat non-productive patterns in an effort to meet needs. The group leader uses holding – of a muscle, a joint - and by paying attention to the body helps the participant to identify blocks – which can be considered to be holding incomplete or interrupted impulses. Participants can talk about, re-experience and heal (and not just work with or understand) any incomplete cycles or events arising from experiences in the present or in the past.

7. Self-care. Participants discover ways that they have and have not cared for the needs of their minds, bodies and souls, and witness these patterns in other participants. They discover ways that they can care for the needs of their minds, bodies and souls, and have the opportunity to witness the process of self-care in other participants.

8. Recuperation and integration. Following the expression of strong emotions, or following any kind of working through on the physical (massage or bodywork), mental or emotional level, time is given for the establishment of the vegetative discharge which leads to recuperation and integration, for a person to “normalise” or return to homeostasis. In this phase, the group leader may gently stay near the participant, or direct the assistant to be near, for support and as confirmation that they have indeed “got through” and that everything is alright.

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Condensed from the original 12 principles discussed by the research team (Boyesen, 1980; Saint Arnault et al., 2012; Saint Arnault et al., 2012).


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