Healing from domestic violence and trauma

Lessons learned from research on the biodynamic approach

Executive summary

2014

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Creating safety for women and children

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 Organization, 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. 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). 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. This report explains the research studies carried out by me (University of Michigan), the Gerda Boyesen International Institute of Biodynamic Psychology and Psychotherapy (GBII), SAFE Ireland (SI), and the staff and clients from the Mayo Women's DV Support Service (MWSS) and Teach Tearmainn DV service Kildare 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 the literature and these findings.

The research in this report was made possible by the diligent and complex coordination of SAFE Ireland, with cooperation of the Gerda Boyesen International Institute of Biodynamic Psychology and Psychotherapy, Mayo Women's Support Service and Teach Tearmainn Kildare and the amazing women who participated in these projects. These projects were made possible by funding provided by SAFE Ireland, Michigan State University Gender Center and the University of Michigan School of Nursing. The women who participated in these studies approached this research with enthusiasm and open-hearts, generously sharing with us their healing experiences. This empowers all of us, and moves us closer to real social change. This report is written for them.

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). However, traditional psychotherapeutic models problematise the emotions, behaviours, and cognitions; may fail to provide for the immediate needs of security, personal strength, and self-confidence; may leave women feeling depleted and confused, rather than retaining the strength they need to create a new life for themselves and their families; and evoke trauma memories that can reinforce survival-related neural pathways, prompting the body toward autonomic nervous system activation. 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). Theories about the impacts of complex trauma on brain development, brain processing, perception of safety, emotional regulation, behavioural patterns, and social engagement after trauma are available. Despite the substantial disagreement in the neurobiological field about how the psychological, hormonal and neurochemical systems interact, I 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), that can explain how people ascertain whether they are safe or in danger, and engage with or withdraw from the social world. I also examine new perspectives on the construct of dissociation proposed by van der Hart, Nijenhaus and others who espouse the view that dissociation is a common and protective response to "inescapable" danger, helping us understand why patterns of psychological and social withdrawal may persist long after the danger has passed.

The autonomic nervous system

The autonomic nervous system (ANS) regulates "automatic" functions that connect the human being with their environment, acting "behind the scenes", to coordinate complex responses to the environment. 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. It also includes the vagal nervous system. The social mobilisation system (or what I call the "explore and engage" system) regulates our ability to "move *toward*"- toward people, toward newness, toward information, and toward growth, allowing us to engage in the world, communicate, and send and receive social information. In the face of danger, the sympathetic nervous system (the "fight or flight" system) takes over, hearing and visual perception are acute and hyper-alert, and the heart rate and blood flow are increased enabling 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), the immobilisation system, (or what I call the "freeze to protect" system) may be activated. In this case, the person becomes, disengaged, quieted, and numbed from emotional and physical pain. From this theoretical perspective, all of these scenarios are adaptive, protective and appropriate. However, 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 so it follows that helping the person regain and maintain this "explore and engage" system activation

is necessary for maximum health, wellbeing and growth. This report provides a profile that support workers can use to help them to recognise these states and intervene appropriately.

Dissociation

Humans have the capacity to protect the "self" by compartmentalising (or dissociating) memories of traumatic experiences in such a way that they can carry on functioning. However adaptive it was at the time of the trauma, dissociation can decrease healthy social engagement, increase maladaptive social engagement, inhibit help-seeking and impede personal growth because 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). When dissociated or compartmentalised unconscious material is activated by triggers in the course of daily life, it sets off cascades of memories, feelings, behaviours and neurochemicals that are not necessarily related to current needs or conscious desires.

Integrative approaches to trauma recovery

Even though many people who seek treatment for trauma-related problems have had histories of multiple traumas, most PTSD treatment has been developed and tested with single trauma populations (Courtois, 2004; Courtois & Ford, 2009; van der Kolk et al., 1996). Many authors are now suggesting that some people who have experienced complex trauma may be unable to utilise the treatment approaches developed for PTSD, because they 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 (Kezelman & Stavropoulos, 2012). Traditional psychotherapies are referred to as "top-down processing" because they emphasise cognition and behaviour. However, top-down approaches may not resolve physiological hyper-arousal in the short-term, and clients may still be triggered by stimuli that their unconscious systems perceive as dangerous, therefore continuing to respond to these stimuli in maladaptive ways. Therefore, some authors are suggesting that effective treatment of complex trauma must be directed towards integration of the mind and the body. One such example is body-psychotherapy, which 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 are referred to as "bottom-up" treatments because they emphasise the bodily experience that related to mental and emotional processes. . These techniques focus on the physiological arousal processes described above, and use these interventions to interrupt the reflexive responses to trigger stimuli.

The biodynamic understanding of healing from trauma

Biodynamic psychology (BP) is a unique type of body-psychotherapy developed by Norwegian born Gerda Boyesen. Biodynamic therapy (BDT) is a system of psychotherapy that combines psychodrama, specialised massage techniques, and body work to dislodge trapped fluids in the tissues, which can enable natural biological processes to complete emotional healing and restore homeostasis and organic equilibrium. Therapists receive training in schools throughout Europe, and there are major centres in Ireland, England, France, Germany and the Netherlands.

BP aims to resolve and dissolve trapped, painful emotions and conflicts stored within the muscles and within the mind. This 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. BDT releases this fluid and tension encapsulation enabling the body to complete the emotional and bodily cycles that were interrupted, and restore healthy biochemical processes, including those carried out in the gut called "psycho-peristalsis". The practitioner uses a variety of methods to help the participant to release blocked energy in the mind and body, including psychodrama, specialised massage and bodywork.

Research methodology

This research used qualitative and quantitative approaches to gather data about how women responded to the biodynamic therapies. Women receiving DV services were recruited for this study. 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. Women with a score over 20 on the Kessler 6 screening tool and those who were actively psychotic were excluded. For the Randomised Control 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 survey before they received their intervention). I interviewed all women with support from Sharon O'Halloran (CEO SAFE Ireland and a biodynamic psychotherapist). 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. In the longitudinal cohort study, we had 100%

follow-up on all procedures. 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 intervention did not complete her follow-up survey).

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. The interview included questions about the same distress and wellbeing domains.

Intervention

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. 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. The treatment team members, by their presence, gave witness to the healing of the women, and thereby represented a compassionate community. All group and individual treatments were performed by biodynamic therapists who had at least ten years of experience and agreed to follow the treatment protocols.

Study one: The feasibility of a biodynamic intervention to promote healing from trauma

This study was a year-long 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 participated. 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. 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: mean Kessler score was 13.4 (SD=4.9); CESD mean was 36.2 (SD=13.8); anxiety mean was 31.3 (SD=10.7); physical symptom sum mean was 34.4 (SD=10.9); and emotional symptom sum mean was 47.2 (SD=15.5). 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 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.

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, to open up to others, and gained an awareness of their bodies.

Quantitative change in health 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 small sample size limits generalisability. The women in the cohort study had statistically significant and sustained improvements in all of their distress indicators over all time points. The women in the cohort 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. The women in the cohort 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. The sense of coherence score also remained statistically improved across all time points.

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 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. Independent samples *t* tests revealed that the experimental group had statistically higher depression scores at baseline compared with the control group and the control group had higher social support scores. There were no statistical differences in any other measure at baseline. 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 had had standard support services. We calculated Cohen's *d* to estimate the effect sizes for the BD 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 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, 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.

Lesson learned one: New insights in trauma recovery

Herman (1997) recognised the establishment of safety, remembrance and mourning and reconnection with ordinary life as critical stages in the recovery from DV trauma. However, while the women in the cohort group had been out of their relationships for over five years, and had established relative physical safety, they were often *not* feeling safe. We found that reconnection with ordinary life was often difficult. Women in our samples were searching for the zest, vigour, vitality and social engagement that had been heretofore elusive.

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. We saw that issues with the use of social support were an important concern. However, despite significant improvements in use of social support, women struggled with issues of trust, closeness, boundaries, stigma and shame. 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.

Personal insight was the most steadily improving aspect of the sense of coherence. However, it took more time to learn to manage relationships and the larger social and institutional world after DV. 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.

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 local 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.

Lesson learned two:
The importance of the body in trauma recovery

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. 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 neurobiological literature emphasises the brain, but we believe that the appropriate understanding has to be 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) must be understood as interacting, and that therapies should address them all. Much of the alternative work being done in trauma 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.

We found that healing in the context of a group can address the intertwined nature of shock, shame, social stigma and social isolation. Perhaps 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. Also, it is critical to understand when and 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. 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, 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), 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 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. 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:

1. Understand how neurobiological theories can help us understand help seeking, and to develop strategic interventions for women who are "frozen" after complex cumulative trauma.
2. Determine how help seeking trajectories are impacted by the freeze mechanism and dissociation.
3. Know much more about whether women can receive or relate to communication about support for their situation.
4. Know more about how women who are receiving services make use of the array of healing options available to them.

Our conclusion is that 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.

Notes

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SAFE Ireland would like to thank the Department of Environment, Community and Local Government and the School of Nursing, University of Michigan, US for their financial support towards this research

Comhshaol, Pobal agus Rialtas Áitiúil
Environment, Community and Local Government

School of NURSING UNIVERSITY OF MICHIGAN

 Published by **SAFE IRELAND** 2014

National Network of Women's Refuges & Support Services Ltd, trading as SAFE IRELAND, is a company limited by guarantee not having a share capital, registered in Dublin, Ireland with registered company number 291205. NNWRSS Ltd is a registered charity with CHY number 13064.

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