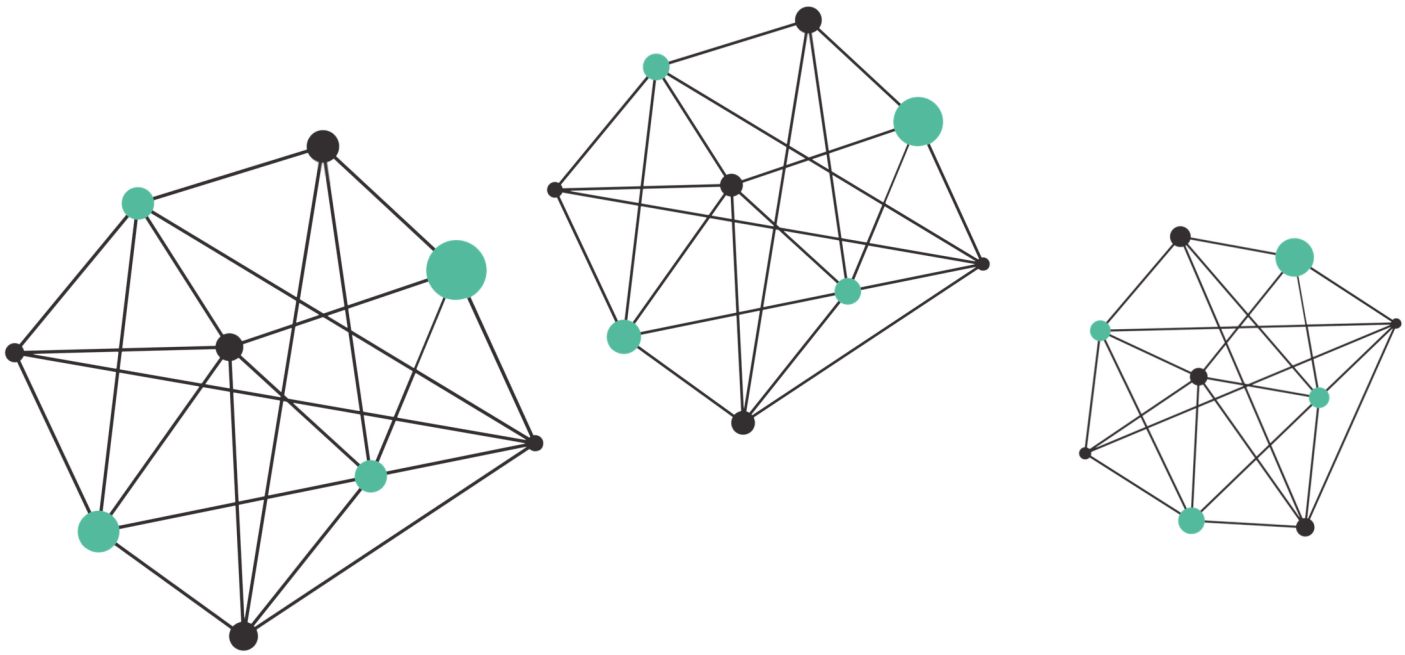
ISSN: 2635-0807

Perspectives on Trauma

The Journal of the Complex Trauma Institute



Volume 2 Issue 3 July 2022

Content

What is complex trauma? Part 3: Reflections on complexity

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Abstract

This paper follows from my previous articles 'What is complex trauma?' which outlined a theory of complex trauma as a chronic condition in which the biological fear system is unable to deactivate, and 'What is complex trauma? Part 2: Working with the body', which examined the implications of this theory for working directly with the physical reactions of the body, in addition to traditional 'talking therapy' approaches. This current paper reflects further on the issue of complexity and its practical implications for our work as therapists, examining among other things the nature of the organic change which underpins therapy and setbacks and limitations involved in working with complex trauma. It also reflects on the variety of approaches that may be required by this complexity, and the issue of our competence in undertaking this work.

Introduction

When there is no place of safety in the aftermath of a shock or a threat to the self the biological 'fear system'[1] which was activated by the threat is unable to deactivate. Where the fear system remains continually active over time, this affects other biological systems (expressing themselves in physical and psychological symptoms) and these become dysfunctional and further disrupt a whole range of other interlinked systems (behavioural, cognitive, relational and environmental) creating a complicated tangle of dysfunctionality which becomes harder to alleviate over time.

At the core of the problem is the fact that the very mechanisms the body relies on to deactivate the fear system become disabled by prolonged fear system activation. This leaves the fear system stuck in fear-alert and highly susceptible to states of fear-arousal and fear-collapse. We experience this emotional volatility as states of anxiety, panic, rage, low mood, depression and dissociation.

The prolonged activation of the fear system can also damage the cardiovascular, digestive and immune systems creating chronic physical illness, and it can disrupt pain signalling and energy production in the body causing chronic pain and chronic fatigue (Guilding, 2020). These physical conditions create ongoing problems with personal autonomy, financial survival and social relationships and these problems can contribute to maintaining fear activation.

Prolonged fear system activation with roots in early childhood can shut down cognitive systems and destroy educational opportunities. It can also lead to the development of destructive defensive behaviours and paralyse the social engagement system shutting down the ability to receive help and support from others which is normally our most effective way of regulating our fear system responses. All the above is discussed in greater detail in my article 'What is complex trauma?' (Guilding, 2020).

Much of the above can be illustrated in the story of one of my clients:

1 My definition of the 'fear system' (Guilding 2020) covers fear-alert (the orienting response), fear arousal (fight, flight, freeze and fright) and fear collapse (immobility or metabolic collapse).

My client's biological father left before she was born, and her mother was self-absorbed and neglectful. She felt there was no point trying to seek care, so she became self-reliant at a very young age. Dyslexic and emotionally troubled, she was dismissed by her schools as a failure despite being highly intelligent. Her stepfather sexually abused her resulting in a traumatic abortion in her teens.

In adult life her partners were dominant and violent, and she found herself as a single mother of four children struggling to make ends meet. She suffered flashbacks that could leave her physically collapsed for hours, anxiety, panic, depression, agoraphobia, chronic back pain and low energy. Many of the people she thought of as friends were caretakers not caregivers. They relied on her support, but when she needed help, they disappointed her, leading to friendship rifts.

She is currently unable to work because of the level of her anxiety, so she is trapped in a hostile benefits system that intermittently pulls the rug out from under her. She finds herself having to live in substandard housing with bullying neighbours which causes her great distress.

In the past she was very easily triggered by disappointment and would reject those who were in a position to help her at the first sign that they would let her down, leading to fallouts with police, advocates, support workers and doctors.

Throughout all this she tried to bring her stepfather to justice and was further traumatised by insensitivity, inconsistency, bungling and bureaucratic delays on the part of both police and Crown Prosecution Service. This strung the process out for well over a decade until her stepfather died, slowing any therapeutic progress and leaving her search for justice unresolved.

This is complex work, which is very hard to undertake, but I think there will be few therapists who have not experienced working with clients with similar difficulties. The theory of complex trauma which I outlined in my 2020 article describes the wide-ranging impact of the fear system failing to switch off after a threat has passed. This means that therapists have to work with biological reactions, emotional states, thinking processes, patterns of behaviour, relationship dynamics and social and environmental contexts. These aspects cannot be worked with in isolation as they are constantly interacting, with problems in one system often undermining progress in another. What I have learned over a number of years working with this level of complexity is that:

- we have to work at the speed of organic change
- there are limits to the changes that can be made
- we work with constant setbacks
- we have to work on many fronts and
- we have to work within our own competence and try to avoid becoming discouraged

We work at the speed of organic change

Each physical sensation, feeling, behaviour or thought arises from neurons (brain cells) firing in a particular pattern of connection (Lewis, Amini & Lannon, 2000). In the case of complex trauma our fear reactions reflect patterns of powerful connections that are not easy to change.

This means that working with complex trauma is a bit like trying to change the direction of a river which has been flowing in its bed for hundreds of years. Physical reactions, feelings, thoughts, and behaviours become engrained over the years when there has been no place of safety following threats.

When we work in therapy, we are starting to calm our clients' physical reactions and to help them to explore new ways of thinking, feeling, and behaving. It is as if, working from the 'old river', we are together digging out an alternative channel for the water to flow along, but the new channel is not very deep and not much water will flow that way at first.

If we keep on with this work, repeating our efforts to calm the fear system, helping our clients to manage their feelings, to do different things and to think differently, the channel deepens a bit more, and more water flows this way. Over time, the channel widens and deepens further and more water flows in a new direction.

So, in the brain, as we work in therapy, new pathways are created between neurons and these connections are strengthened with repetition and these new ways of thinking and feeling and doing gradually become slightly easier. However, the old riverbed is still there, and a lot of water still flows in the old direction.

My understanding of the way change works in the brain as we process traumatic memories is as follows:

- Trauma memories are held in the brain in networks of brain cells (neurons) which 'fire' between each other in a particular pattern of connection when they are activated (Lewis, Amini & Lannon, 2000).
- It is possible to make changes to these trauma networks, but they can only be changed when this pattern of connections between the neurons is activated, and the memory is 'unlocked' (Nader, Schafe & Le Doux, 2000). This can happen when the memories are triggered by external cues, or when there is a deliberate attempt to recall them.
- When activated and unlocked, new experiences which *contradict or disconfirm* the survival-based learnings of the original trauma(s) can change these trauma networks. For example, the experiences within therapy of feeling safe or having competence affirmed or gaining a new perspective on the initial trauma can be 'added' to these networks as an extension to the memories, gradually changing them.
- Networks remain active for about 5 hours then deactivate and cannot change until activated again (Ecker, Ticic & Hulley, 2012).
- Over time, when repeated activations are processed in safe contexts, traumatic memories are 'softened' with the addition of more benign associations.
- These changes to the trauma networks dampen their emotional charge and at a certain point the activation of these networks will no longer trigger the activation of the fear system. Once the fear system can regulate, trauma symptoms disappear.[2]

I have tried to put this into a diagram which might make it more digestible. Fig. 1 is a crude attempt to picture the development in therapy of the neural networks (the pattern of firing between different

2 Ecker, Ticic and Hulley, (2012) refer to trauma memories being erased' on the grounds that the process of unlocking trauma memories and then disconfirming them while they are active leads to the disappearance of trauma symptoms such as panic and depression. They then contrast their own therapeutic method (Coherence Therapy) based on this process with "counteractive methods", such as aversion therapy, which they claim set up separate neural networks which conflict with the original trauma networks but do not erase them. They claim that this ability to erase trauma memories undermines the theory of the indelibility of emotional learnings (van der Kolk, 1994). While I am grateful to Ecker, Ticic and Hulley for introducing me to the research underpinning the notion of trauma memories being unlocked and then changed before being locked again, I am unpersuaded that this is an erasure of the trauma memory. I think this is sloppy use of language which confuses what happens in the human brain, when trauma memories are activated in therapy, with what happened in animal brains in the research upon which they relied. (In this research when memory networks were activated, synaptic connections were destroyed by chemical means which would be toxic to humans). I think that Ecker, Ticic and Hulley have set up a false dichotomy between the erasure and indelibility of emotional (traumatic) learnings. The perspective on complex trauma I have outlined provides another way of understanding what may be happening in trauma therapy. In my view what leads to the cessation of trauma symptoms is not an erasure of the original network, but the addition to that network of more benign associations which dampens the capacity of that network to trigger the activation of the fear system. By thus allowing the fear system to deactivate, it results in a cessation of trauma symptoms such as panic and depression, but I do not think this is the 'permanent cessation' that Ecker, Ticic and Hulley suggest, and the data at their disposal could not substantiate such a claim. My ideas on the 'shadow of the trauma' (see below) are one way of understanding the possibilities of relapse into further unregulated fear system activation after recovery from trauma. This view matches both my own experience and the experiences of many of my clients far more closely that the over-optimistic conclusions of Ecker, Ticic and Hulley.

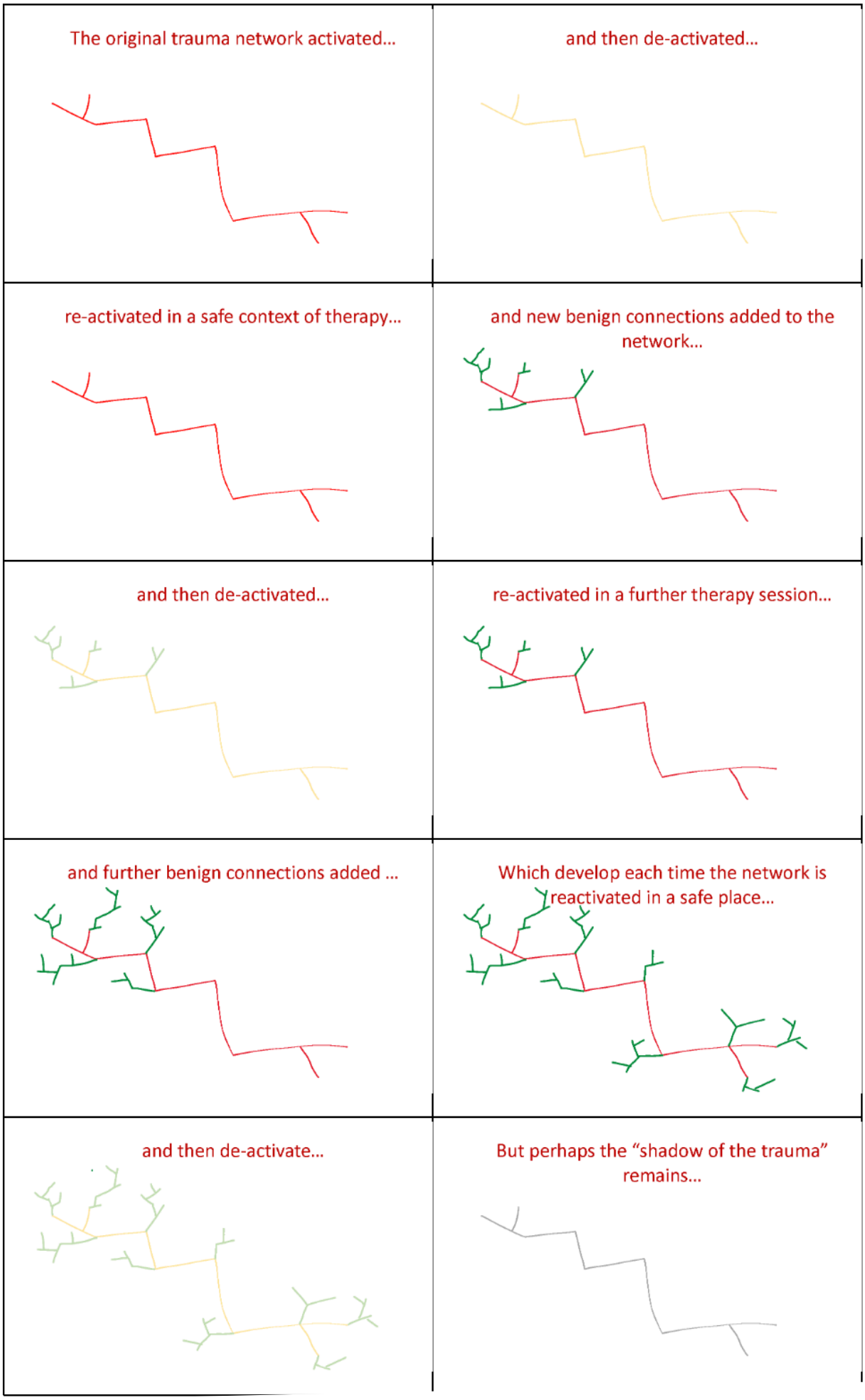

Fig. 1 - The development of the trauma network during therapy (a pictorial representation).

neurons) in which the traumatic experience was encoded.

It starts with a representation of the pattern of the original trauma which is then deactivated as a stored memory. When reactivated in a safe context in therapy this safe experience and any resultant changes become part of the original network, which then deactivates after a few hours. The repeating of this process over time profoundly changes the trauma memory and the impact of its reactivation on our fear system. However, we are biological organisms, and we must work at the pace of organic change. We may well see sudden change when a trauma network is no longer able to trigger a fear system response, but with complex trauma it can sometimes take a long time to get to that point.

There are limits to the changes that can be made

However much we manage to change traumatic memories, 'coating' them in more benign associations, diminishing their power to the extent that they are no longer able to keep the fear system on permanent alert, there are limits to the changes that can be made because, at the core of that altered memory is the original memory, the original pattern of neural firing.

A client of mine had seen a spiritualist before coming to work with me, who told her that a malevolent spirit had been persuaded to leave her, but that it had left a space, which would continue to resonate throughout her life. My client had found this a useful metaphor and had called this space (the ongoing impact on her of her deeply envious and destructive mother) the 'shadow' of the spirit.

The concept of the shadow came back to my mind as I played with my drawings trying to describe the process of change during trauma therapy. It seemed to me the perfect word for describing that original memory pattern at the centre of the altered memory - the shadow of the trauma.

This then started to make sense of an idea that had been growing on me, based on my experience of working with many clients, and on my experience of my own long (and still incomplete) journey out of unnecessary fear. The idea is that once we have had a traumatic experience and, for a time, our fear system has been unable to switch off, when we do manage to reach a place in our life where our fear system switches off, this may be a temporary victory. I suspect that once our fear system has failed to switch off properly for a time, we may have a tendency to get stuck again in chronically active fear mode when we encounter serious threats and blows to the self in the future. I now think about this tendency as 'the shadow of the trauma' and present this idea as a hypothesis to balance what I see as over-optimism in Ecker, Ticic and Hulley's (2012) theory of the permanent erasure of trauma memories. As I see it, there is never a complete cure. However, there is the possibility that over time the impact of past trauma diminishes, and we become able to live our lives more and more fully.

We work with constant setbacks

We looked previously at the metaphor of an old river to try to understand organic change, but in our work with complex trauma we are working with a number of these old river systems, not just one. We are working to change bodily and emotional responses, defensive patterns of behaving and relating to others, old ways of thinking about ourselves and others, and to encourage changes in our client's external environments.

Each part of each aspect of these patterns is like a separate 'old river' requiring persistent work to change the direction of flow, but with complex trauma, progress in one area can so easily be derailed by problems in another.

Working with the client I referred to at the beginning, we encountered many setbacks. Over a number of years, she made impressive progress in being able to regulate her fear responses, but time and again adverse events from many areas of her life triggered old defensive responses of rage or

collapse making it feel for a time as if all progress was wiped out.

For example, she would get a letter out of the blue telling her she was no longer entitled to the benefits she relied on. This has happened on several occasions in the time I have worked with her. On each occasion she has appealed, and she has won all her appeals, but the cost in stress and emotional exhaustion has been huge. Other setbacks were triggered by a bullying neighbour trying to turn her whole street against her, her son falling out with her and refusing to let her see her grandchildren and the Crown Prosecution Service suddenly deciding to drop the case against her stepfather (she got it reinstated on appeal).

The greatest source of setbacks in our work has been the constant mishandling of her case by the police with long periods of bureaucratic inaction interspersed with demands for more evidence and further statements which seriously retraumatised my client.

What I have described here are only the *external* setbacks - the adverse life events which can be multiplied by the effects of complex trauma. In addition to these setbacks are those created by *internal* defences against intolerable experiences built up over the years. Our fear systems are finely tuned from past experiences to react to threats in the present as if we were still in the context of the past. Any therapeutic change will upset the balance of these defences, opening up vulnerabilities which can then trigger old fear system reactions. Where these reactions are powerful, as they are with complex trauma, this creates a 'pendulum effect' in trauma work as any significant progress triggers old fears.

This is illustrated in Fig. 2. We start with our client's old defences and old feelings and by helping them to feel safe and thus calming their fear system, we are able to do some work. Our client manages to take a new step and to experience new feelings. We work a bit more and this strengthens and consolidates. But in doing this, our client has moved out of the comfort zone of their old defence and their fear system activates, triggering this old fear system reaction, and this makes them feel as if they are back to square one (the old river bed of our previous metaphor), and they have got nowhere. Our clients' feelings will affect us powerfully, triggering our own fears of being ineffective and our own sense of despair in the work. So, we go slow and regulate ourselves. We can then try to help our client not to get alarmed at what seems a failure, and we help them to regulate their emotions, going back to Stage 1 of the work (Herman, 1998), and gradually the fear system calms down a bit, and we do a bit more work and this new work strengthens a bit more.

However this new work leaves the client further out of their comfort zone and the fear system kicks in again and they swing back to square one, and it looks like another failure, but if we slow down, and regulate the fear system (back to Stage 1 again[3]) and help our client to get used to this pattern and not to be too afraid of it, the fear system calms again and they can move back to the new steps and the new feelings and consolidate and strengthen them still further.

For an example of this we might consider a client with an inconsistent parent who could sometimes give care but sometimes completely neglected her. Over the years the experience of bitter disappointment at being let down would lead to a powerful defence against trusting a caregiver which would increase the risk of re-experiencing this pain. In such a case the development of an emotional attachment to the therapist can become a dangerous new feeling that is likely to trigger defensive reactions - the therapist may be pushed away, and the work rubbished, and all sense of progress lost.

In another example, if a two-year-old expresses anger in a temper tantrum and their parent hits them and shames them, an internal defence can develop against the feeling of anger which has come to

3 This illustrates the fact that Herman's (1998) three stages of trauma therapy are not separate steps which have to be completed before moving from one to the next but are part of the backwards and forwards "weave" of the work where, with each of the many aspects of the work we manage a "good enough" attempt at each stage and move backwards and forwards between the stages in attunement with our clients' needs.

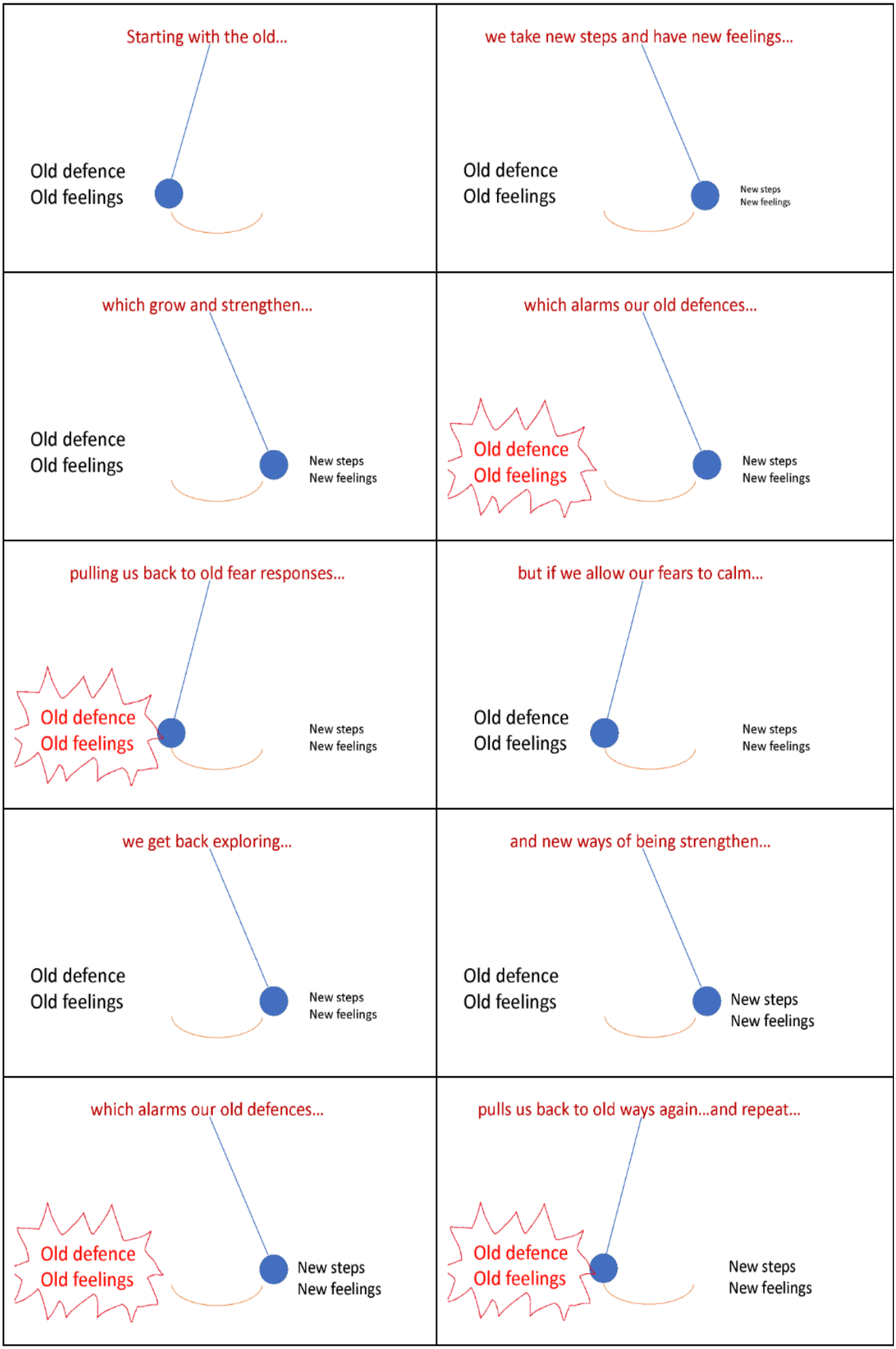

Fig. 2 - The pendulum of complex trauma work.

be experienced as a danger. Where this has happened in the past, then in the present the physical sensations of the arousal of anger can constitute a trauma trigger, alarming the fear system and most likely activating the old dissociative collapse which disables the anger response. As a result, work in therapy which helps a client to start to get in touch with the physical sensations of the arousal of anger is likely to trigger the old defence which then appears to wipe out all the new work. However, despite such apparent setbacks, the new neural wiring from the therapeutic work remains in place and can be returned to and consolidated once the fear reaction has been calmed.

We work on many fronts

For me one of the big implications of a clearer understanding of complex trauma is the need to consider a number of different approaches to working with clients. Before we can use skills of relational attunement, empathic listening and the facilitation of exploration we may need to be able to help clients regulate metabolic arousal and collapse in order to access the window of tolerance (Siegel, 2012) in which thinking and exploration become possible.

We may also need to help clients relax physical tensions and take up practices which reverse a chronic weakening of the signal on the ventral vagus nerve (Guilding, 2021). We will often need to work with patterns of negative and anxious thoughts to reduce their ability to feed back into a spiral of fear arousal.

When we think of the metaphor of the river, the back and forward pendulum of trauma work, the slow organic process of neurological change and the limitations that there might be to the work because of the 'shadow of the trauma', it is also very helpful if we prepare our clients for the journey they are undertaking and explain all of this to them.

This will make it less likely that they abandon the work because of quite normal setbacks, and once they have completed a piece of work they may be more alert to the impact of negative life events which could throw them back into chronic fear system activation, and be more ready to take steps to self-care, to seek care from others, and perhaps to periodically return to a familiar therapist for further help in regulating their fear system.

Much of the above refers to working at Herman's (1998) Stage 1, creating the emotional stabilisation which is the necessary foundation for direct trauma work.

We may also need to work with addictions, and we might have to consider referring clients on for specialist work if we don't have expertise in this area or encouraging them to use support groups particularly if we work in private practice disconnected from other services. We may have to help our clients negotiate difficult relationships and consider whether couple work or family work may be helpful, referring on again if this is not part of our training, but perhaps leaving open the invitation to return for individual work.

When we directly address traumatic experiences in our work at Herman's (1998) Stage 2 there are a number of really useful methods that work with the body-based core of the problem such as EMDR (Shapiro, 1995), Sensorimotor psychotherapy (Ogden, Minton & Pain 2006) and Focusing-oriented therapy (Gendlin, 1996), and ways of integrating the fragmentation of the internal world, such as Internal Family Systems (Schwartz, 1995) and other ways of working with parts of the self or child selves.

There is then the perhaps less examined area, Herman's (1998) Stage 3, of helping the client to reconnect back to the world in a different way when the fear system is again able to switch off. Here it might be necessary to tackle existential issues (Who am I now? Where do I now fit into the world?) for clients whose 'assumptive world' (Dolinsky, 2020) was shattered by trauma, and who have to rebuild themselves and their connections to the world in the aftermath of trauma recovery.

At this stage, where old social systems and relationships may have been part of the problem and can trip the client back into chronic fear activation, it may be helpful to support any move away from existing fear-dominated relationships and towards seeking out relationships with people whose fear systems are better regulated. Where possible, finding supportive sustained contacts with fellow-travellers who are at the same stage on the road to recovery from trauma, may be really important.

For myself, I have found Una McCluskey's method of working in groups (Heard, Lake & McCluskey, 2009) to be by far the most helpful way of working for this final stage of trauma work. Her method, which she calls Exploratory Goal-Corrected Psychotherapy, is strongly focused on safety, stabilisation and awareness of the activation of the fear system. The intervention of each member is supported in dialogue with the facilitator, with other members encouraged to work on their own process alongside. Personal attacks, probing of other members and unregulated acting out is stopped with members invited to focus back on their own work instead of projecting onto others. This method also uses a framework of exploring a range of systems which may have been disturbed by an overactive fear system, making it a rich resource for Stage 3 of trauma recovery.[4]

We need to work within our own competence

Working with complex trauma can be overwhelming and if we do not work within our own competence, we can block our clients' progress and risk physical and mental burnout and a collapse of confidence in ourselves and our training. It is not always easy to know what our competence is, but we can stay better grounded in it if we know what aspects of our knowledge are rooted in our own experience and what are based in theory, and if we are not too afraid of what we don't know and understand that developing our capacity for this work is a life-long task. We are also more likely to stay working within our competence if we can resist the pull to take too much responsibility for our clients by assuming that we are the only person who can help them or who is helping them.

In understanding my work as a therapist I find it helpful to use the metaphor of a guide who helps others to travel through uncharted territory. The territory represents the lived experience of the whole of humanity. We are qualified to be guides because our life experience lies in one patch of this territory, and in our own therapeutic journey we ourselves have hired a guide or guides who have helped us to make sense of that part of the territory. Our life-experience and the work we have undertaken processing it are the core of our competence. I have noticed in myself and in many other therapists a tendency to be drawn to work in the area of our own trauma and at the level of our own trauma. On the whole I think that this is a healthy thing and illustrates an instinctive knowledge of what we know and where we can be most useful to others. However, it can carry a real danger if we do not fully undertake our own therapeutic journey. I believe that for most of us, our own emotional problems are the driving force that brings us into helping others with their emotional problems. If we do not devote a significant amount of time to addressing our own issues in the independent space of individual or group therapy, we run the risk of using our clients as guinea-pigs in our own experiment, tangling them in our own issues and blocking them by our own defensiveness.

From the competence we acquire through our life experience and our own therapeutic exploration, we can gradually expand our ability to act as a guide over a wider area of the territory, with our capacity increased over time with each therapist, tutor, supervisor or supportive colleague we work with, and each client we learn from further increases our knowledge and competence.

4 Because of their focus on fear system activation and its regulation, these groups can also be very effective for working at Stages 1 and 2 where the trauma is not so severe that group-working is intolerable. I think these groups are far safer that the chaotic and unregulated processes that passed for 'personal development groups' in so many counselling trainings which, in my experience, have left many counsellors with a fear of working in groups. (See Heard, Lake & McCluskey, 2009, Chapter 9 for an example of this group work).

To stay safe in ourselves and be safe for our clients, we need at each stage of our professional journey to be able to evaluate our competence and know which part of the territory to work in and which to avoid.[5]

I think that however much we increase our competence, it helps to accept that in the field of complex trauma we cannot be a skilled guide in all areas. It also helps (to continue the metaphor of the guide) to know that we walk with our clients for just one part of their path through life, and we are only responsible for guiding them on that part of the path. Others may have helped them in the past and others may help them in the future. We are neither rescuers nor saviours and if we try to be, we are at risk of overwhelm and burn out.

On not being discouraged

The complexity of complex trauma means that our work is difficult, often deeply frustrating, many faceted, often long term or requiring many episodes of work, rarely complete and requiring enormous learning and the development of many diverse skills. For a therapist not long out of training this probably seems really daunting, but each of us starts from our own life experience which is the core of our map of this territory, and our knowledge of this map is hugely enhanced by our own therapeutic journey. Each of us also starts from a solid training base, whichever approach we begin with, and from that point the addition of a biologically based theory of trauma can illuminate many aspects of the map which might not previously have made sense. Our supervisors, therapists, colleagues and clients further enhance our knowledge and skills, and we integrate the knowledge and experience of others with that of our own. Over time, if we stop comparing ourselves with others but ground ourselves in what we know, stay curious and follow our interests, keep reading, take short courses to acquire skills in different ways of working[6], meet and talk with our colleagues and avoid those who tell us that their approach is the only correct way to work, we will gradually integrate all we need to build our own individual way of working with complex trauma. In this way, over time, we can become the best therapist that we have it in us to be.

Overview

I started this exploration of complex trauma in my first paper by looking at it from the perspective of a dysfunction of the goal-correction[7] of the fear system, and, as the fear system is chiefly a set of bodily reactions to threat, this led to my second paper in which I noted our need to work directly with the body as one of the key implications of this approach. This current paper has continued to examine these implications, focusing on the complexity of the systems disrupted by chronic fear system activation and the difficulties and frustrations this creates for therapeutic work.

In my next paper I intend to examine why safety is such a crucial issue in working with complex trauma and what this means for us as therapists. A fifth paper will offer some brief reflections on the prevalence of complex trauma. I believe it is a far more common problem than we might have assumed, which leads me to think that a trauma-focused approach is of relevance to the entire range of work we do as therapists regardless of its level of severity. I hope then to conclude this series of articles by looking in more depth at the fear system as it affects the therapist. For me the two main implications for therapists of this perspective on complex trauma are the importance of being able to regulate our own fear system responses and the huge level of support we need in order to achieve this.

5 I think this task has been made much harder for many counsellors by the many training courses that have approved unsuitable placements for their students meaning that the experience of working beyond their competence has been built into their training and normalised thus desensitising the evaluation of competence.

6 I think it is unhelpful that so many practical ways of working directly with trauma are chiefly taught via lengthy and expensive courses when the essence of their particular contribution could be conveyed in brief courses which experienced therapists can then gradually integrate into their own ways of working.

7 The ability of the fear system to deactivate once the threat that caused its activation has passed.

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