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Content

Complex Trauma and Cancer. A Case Study.

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Abstract

In this article, I describe an intervention with a cancer patient who developed C-PTSD whilst experiencing an onset of trauma related to dissociation. The therapeutic approach focuses on trauma-focused therapy used in my clinical practice as a person-centred counsellor. The case study describes therapeutic intervention, illustrating a creative and embodied way of working with trauma.

The therapeutic process has consisted of mindfulness techniques, embodied reprocessing exercises, sleep hygiene exercises, identification of healthy coping strategies, task planning, working with the inner child and using regulated exposure for anxiety management.

Introduction - Case Presentation

This presentation outlines the integration of my trauma-informed training into my clinical practice through a case study of a 26-year-old woman who is a cancer patient experiencing trauma and related dissociation. She presented with significant stress in the workplace, a feeling of being separated from her emotions, a certain confused sense within her identity, anxiety and a feeling of continuous sadness. She had been experiencing flashbacks that had been taking her back to a childhood that she described as traumatic due to a violent and abusive father who almost killed her twice. At a professional level, she was a successful woman who satisfied her professional goals very early in life. Although she felt delighted and fulfilled for some time, she had begun to question whether she wanted to continue in her current workplace, and this made her doubt her professional worth. When we began our work together, the client stated being engaged and that she would be married within the year. She described this as her first healthy relationship where she felt safe and secure. Prior to this relationship, most of her affective relationships were described as toxic and abusive, and her physical integrity was in danger on more than one occasion.

Her goal in therapy was to get to know herself and how to live her life fully since she did not know what that meant for her. During our first consultation, the client detailed that all her life, she had felt in danger. She related that since her childhood, she had had to protect herself from an abusive father who physically abused her to the point of almost killing her. She always felt her mother was weak and absent and did not feel protected by anyone else.

This feeling of being constantly in danger was derived not only from the abuse suffered at the hands of her father but from the affective relationships she maintained with men who did not treat her well, and one of them almost killed her. Her whole life felt inadequate and insufficient. For that reason, she worked very hard studying even things that did not motivate her or that she liked, but that could guarantee her a successful career, proving her worth in front of others.

In her present relationship, she felt safe, loved, respected and secure. She described her partner as a kind and caring man who loved her, took care of her and gave her space.

For a while, she felt valued, accepted, sufficient and safe, and suddenly, the cancer appeared, and all the feelings of danger and inadequacy resurfaced. And with them: sleep disturbances, muscle tension, anxiety, intense sadness, physical discomfort, affective dullness, not enjoying most everyday things, lack of energy and certain problems of concentration at work.

Safety and stabilisation - Using grounding techniques

The goal at this stage in the therapeutic intervention is to create a safe and stable life in the here and now, allowing the client to remember the trauma safely rather than continue to relive it.

In this case, it was observed that the client needed to tell her story, having given enough details about her childhood and in order to avoid a possible re-traumatisation through the telling of her own story, it was suggested to the client to focus on the practice of some grounding techniques to focus on the present moment, creating a space of security in which she felt safe when it comes to working on her emotions.

These grounding techniques aimed to give the client sensory stimulation. By focusing on this stimulation, the client could focus on the present moment and away from distressing memories, thoughts, or fears (Clark et al., 2014).

The techniques used both in the first session and throughout the therapeutic process when required were:

- Sitting upright on a chair placing hands on the knees and then pushing equally (hands push down against the knees, knees push up into the hands).

- Progressive muscle relaxation.

- Mindfulness. Using the 5-4-3-2-1 mindfulness technique. FIVE things you see around you. FOUR things you can touch around you. THREE things you hear. TWO things you can smell. ONE thing you can taste.

- Breathing. Taking three breaths and slowly exhaling after each breath.

The client did not feel completely at ease and confident in the process since, through practicing these techniques, she felt a somewhat overwhelming sadness in her chest.

The therapist invited her to focus on this physical sensation translated into emotion in her chest, and initially, the sensation was diluted. Throughout the therapeutic work, the sensation in the chest occurred on several occasions, and the client was invited to perform embodied reprocessing exercises (Karpuk & Dawson, 2021).

Assessment

Identification of strengths and personal resources to face the therapeutic process

Once the individual felt sufficiently safe, an evaluation of the case was carried out, first identifying the strengths and personal resources that would support the client during the therapeutic process to continue and move forward. In this case, we identified three strengths and personal resources:

- The ability to introspect, this skill would be very useful when exploring her process using mindfulness techniques.

- The ability to strive for personal growth and continue in the therapeutic process when it feels stuck.

- Empathy to have a wider view of some of the traumatic events and the people involved in them.

Self-care

We reviewed habits, routines and possible addictions, and observed that levels of tea and coffee intake were quite high. She slept irregularly and not too deeply, used electronic devices frequently even when she was already in bed, exercised almost compulsively and defined herself as a workaholic.

A reduction of coffee and tea was proposed, replaced by infusions and non-caffeinated beverages.

Since she worked from home, it was suggested to take breaks and go outside for walks to get some fresh air and establish regular work schedules that did not make her work until late. It was advised to not use devices two hours before going to bed and replace them with a book or a gratitude journal. She also started combining the gym with yoga, which she had practiced before and had found very useful, as well as the practice of mindfulness of the body as a whole (Kabat-Zinn, 2016).

Network: Social factors

Social support system: The main support of this client was her fiancé; she said she had full confidence in him. He knew about the abuse and difficulties she had had in her childhood, as well as the past abusive relationships. He had been her main support during cancer treatment and encouraged her to start therapy. She also had some friends who supported her and met occasionally. The relationship with her family was not very good, especially with her mother and her brothers. The relationship was somewhat better with her sisters.

Housing and finances: The client was in a stable economic situation. She and her fiancé occupied positions of responsibility whose economic income allowed them to have a good life, a nice house and frequent holidays.

Systemic or social oppression: At her job, she had begun to feel uncomfortable. She affirmed that for a long time, she had been masking herself to integrate into a deeply patriarchal and quite oppressive environment where women were not visible and where there was no room for listening, compassion and space for emotions. She claimed to be in an inhumane space, where she did not allow herself to be herself for fear of being judged by her male peers. She affirmed that to be accepted and valued for many years, she has been very competitive to progress in her career. She had even been promoting this behaviour within her work environment. However, she began to feel deeply distant from it and would prefer to be part of a company that made women and feminine values more visible.

Intervention - Normalise, validate and educate

The therapeutic relationship with the client was built on the person-centred model by Carl Rogers (1902-1987), fundamentally based on the “actualising tendency”, referred to by Rogers. It is essential to recognise that the individual has an innate capacity to decide their own best directions in life. Alternatively, Levitt (2005) refers to the “universal need to drive or self-maintain, flourish, self-enhance and self-protect”.

“(…)the individual can constructively handle all aspects of his life that can be recognised in the consciousness” (Rogers,1972,1978). Based on this and applying the person-centred core conditions of empathy, congruence, and unconditional regard (Rogers, 1980), clients allow themselves to discuss their fears openly.

In this case study, the focus was on the survivor’s experience, normalising and validating that experience by the therapist to reprocess traumatic memories so they could be integrated. In order to metabolise (not just verbalise), we started to work toward those memories using embodied reprocessing exercises (Karpuk & Dawson, 2021).

The individual expressed her curiosity and, at the same time, her confusion about the physical sensation, somewhat overwhelming, experienced in her chest during the first session.

First, the individual was invited to continue to learn to focus and stay in the “here and now”, and we identified their safe container or comfortable, relaxing place. To do this, we would begin with a brief breathing exercise while inviting the individual to enter their safe place gradually. We continued with a body scan (Kabat-Zin, 2005) to stay present and avoid wandering thoughts and possible flashbacks during the exercise.

Afterwards, the client was invited to connect with a physical sensation. This time, the pressure previously noticed in her chest shifted to the pit of her stomach. Continuing with the exercise, we established a dialogue with that physical sensation that connected her with a deep sense of sadness.

Sadness was perceived as a very heavy white cloud within her, but one that was helping her and protecting her. The feeling did not want to leave; it wanted to stay and continue to protect itself. The individual could show gratitude for that feeling, which also invited her to look at and connect with her inner child.

After the exercise, the client was quite surprised and tried to rationalise what happened. The client was invited to stay in the sensation and embrace it. It is advised that the goal is to come to terms with the traumatic past, not necessarily trying to find logic in it. She expressed curiosity about the 'recommendation' by the physical sensation of connecting with her inner child and verbalised that she would like to explore that possibility. Therefore, throughout the subsequent three sessions, we focused the intervention on her inner child.

Before starting this joint work, it was suggested that she look for photos of her childhood and identify one in which she could see her inner child.
She was first invited to introduce/describe that child. She defined this girl as someone somewhat shy and fearful who did not trust the adult but who, nevertheless, within herself, was eager to dance. A twenty-minute visualisation was carried out where the individual was invited to connect and be present with that child, letting her know that she is there for her as an adult.
In this first session, the inner child remained absent, so it was recommended that in the coming days, the client make a collage with the images that had come to her mind in the visualisation and put the previously chosen photo in the centre. Moreover, it was recommended to also begin a dialogue with this girl through daily meditations letting her know that she is there for her, treating her with kindness and respect. She was invited to connect and listen to her inner child from here daily (Thich, et al., 2010).

As she connected and healed her relationship with her inner child, she was invited to gradually introduce activities that gradually exposed her to those situations that not only connected her with her inner child, such as dancing, going to an amusement park, playing or painting and colouring, but also those that produced anxiety such as not having a plan, having everything under control, working too much, etc. She was invited to introduce more improvisation and spontaneity, to feel safe flowing with what is there, to take breaks from work, to take days off, etc.

Moving On

In parallel to the work with the inner child, she was invited to be very present in her body, in the emotions and physical sensations that emerged every time she connected with that child in meditation. As this work continued with gradual exposure to avoided situations, she felt that her shame diminished as she became more and more connected to herself. She began to set new personal and professional goals and developed healthy coping mechanisms, such as going for walks in the park when she felt fatigued instead of forcing herself to finish work.

She began to establish a healthier relationship with herself, her environment, and her work. She started to change her approach to daily life; she felt a more vital feeling and the difficulties that brought her to therapy became distant. She began to elaborate and develop commitments to herself, to feel what has come to be called a "survivor mission" (Courtois, 2008).
In this way, she began to look for a job with a more human approach, one in which she could develop as a professional woman in a more empathetic, flexible and diverse environment. Furthermore, at the same time, she became involved in forums and campaigns for the prevention of breast cancer.

At the end of the intervention, the individual had a firm job offer in a company that met the requirements of flexibility, diversity and visibility of women required for the client. She continued to support cancer prevention campaigns. She married and carried out the celebration as she wanted without giving up on family pressures. She and her husband decided to buy another house and move to

another place where she could create new present and future memories. The client continued to meditate daily and exercise regularly but not compulsively. She reduced her working days and enjoyed her leisure time more. She is dancing again.

Conclusion

In this case, it has been proven that the implementation of Karpuk and Dawson's (2021) trauma-informed method, together with the practice of mindfulness, provides a sense of safety for the client that facilitates the exploration of emotions through bodily sensations and does not mediate the narrative that would invite the client to relive traumatic events.

Through this method, where creativity is prioritised, emphasising the connection and work with the body, the individual can rechannel, rework and observe emotions from a more holistic plane.

Through the use of this method, I have learned that the body serves as an anchor and antenna at the same time. The anchor is to remain present in the here and the now, and the antenna is to explore from a focused connection what happens without giving free rein to the narrative that can distort or avoid what is really happening.

Combining this method with my training as a person-centered counsellor has given me a more complete breadth of therapeutic interventions.

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How Fairbairn's model of the endopsychic structure can help clinicians understand and treat Complex-PTSD

Kyd Shepherd

Abstract
In the 1940s, Scottish psychiatrist and psychoanalyst William Ronald Fairbairn developed a model to understand the impacts on the mind of abuse, neglect, violence, etc. This model was largely overlooked by the psychoanalytic institutions of the time. But it reveals itself to be still incredibly relevant in our day and age to understand, treat and help people suffering from Complex-PTSD. In this paper, I will explain the endopsychic structure and show how beneficial it can be for the clinician and the patient.

What is the endopsychic structure?
Endopsychic structure is a theoretical model developed by Scottish psychiatrist and psychoanalyst Ronald Fairbairn to explain trauma and its effects on the psyche and human interactions (Celani, 2010 and Fairbairn, 1944).

This theory is based on the principle that a human never develops alone. We rely on others to meet our needs. Thus, the mind (and, by extension, the person) is fundamentally built on relationships with others. Therefore, one cannot separate one's individuality from one's experiences with others.

In other words, the identity of a person (which we call the Ego in psychoanalysis) is attached to their experience with others (others who we call Object in psychology); therefore, the Ego and the Object go hand in hand and influence each other in the mind of the individual.

In this model, the mind is divided into three pairs:

- The Central Ego and the Ideal Object
- The Libidinal Ego and the Exciting Object
- The Antilibidinal Ego and the Rejecting Object

At the historical level, Fairbairn developed this theory from his experience with veterans of the First and Second World Wars suffering from 'war neurosis' (former name for Post-Traumatic Stress Disorder), beaten, neglected and mistreated children as well as his traumatised patients in private practice.

Key takeaway:
The basic idea of this theoretical model is that the human mind is divided into several parts. These parts have been deeply impacted by our relationships with others in both good and bad interactions.

The Central Ego and Ideal Object
The Central Ego in Fairbairn's theory is the seat of consciousness. It represents the identity of the

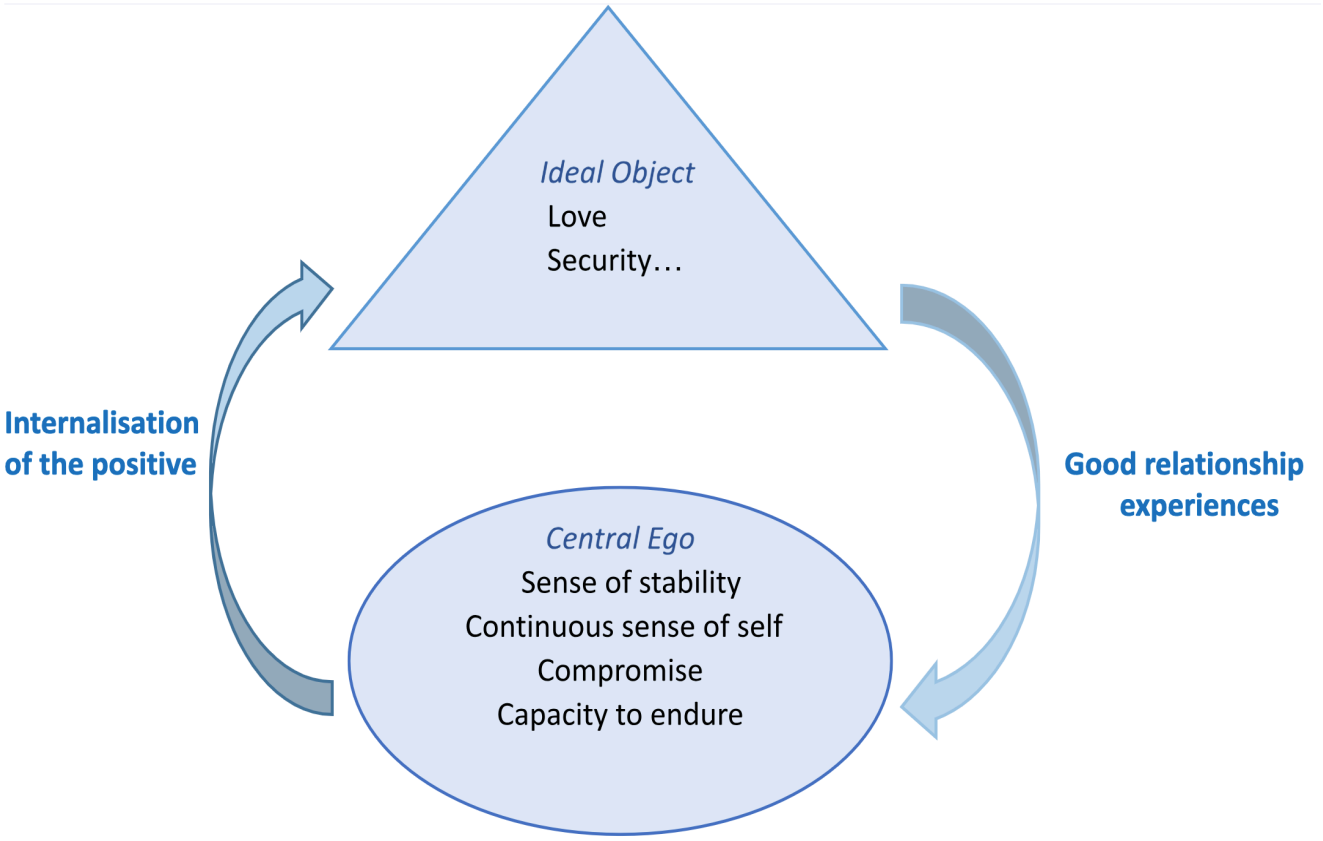
person, and it guarantees psychological stability, continuity, contentment and hope. Initially, the Central Self develops in early childhood thanks to the caregiver and the care, attention and love they give to the infant.

The child internalises these good interactions. An internalisation will provide the basis for self-reassurance, a continued feeling of love, self-esteem, etc. By repeating these good things, the child will construct an Ideal Object, namely a benevolent, fair and conciliatory psychological image of others.

Please note: If Fairbairn called this positive and caring image the Ideal Object, it is not the image of a 'perfect' person but that of a person who hears and responds to the infant's needs while putting a clear limit on interaction and setting prohibitions when necessary.

This duo between Central Ego and Ideal Object guarantees internal security and an ability to 'endure' and 'overcome' relational and emotional difficulties and unpleasant or painful moments.

Here is a schematic illustration of how this psychic pair works:



Key takeaway:
The Central Ego is the guarantor of emotional stability and self-image; it comprises positive experiences and difficulties that have been overcome. It is supported by the Ideal Object, who is not a perfect person but a good enough (to borrow from Winnicott's vocabulary) person who provides both love and a framework. A love that will become a source of internal security.

The Libidinal Ego and Exciting Object
The Libidinal Ego in Fairbairn's theory is an unconscious part of the mind, which is the seat of all the hopes, expectations, and demands for love and care that have not been fulfilled or even recognised by the other. Initially, the Libidinal Ego was a part of the Central Ego, but following experiences of frustration (e.g. not considering the need for love), feelings of incompleteness and lack, the Libidinal Ego was separated from the conscious mind and rejected into the unconscious mind.

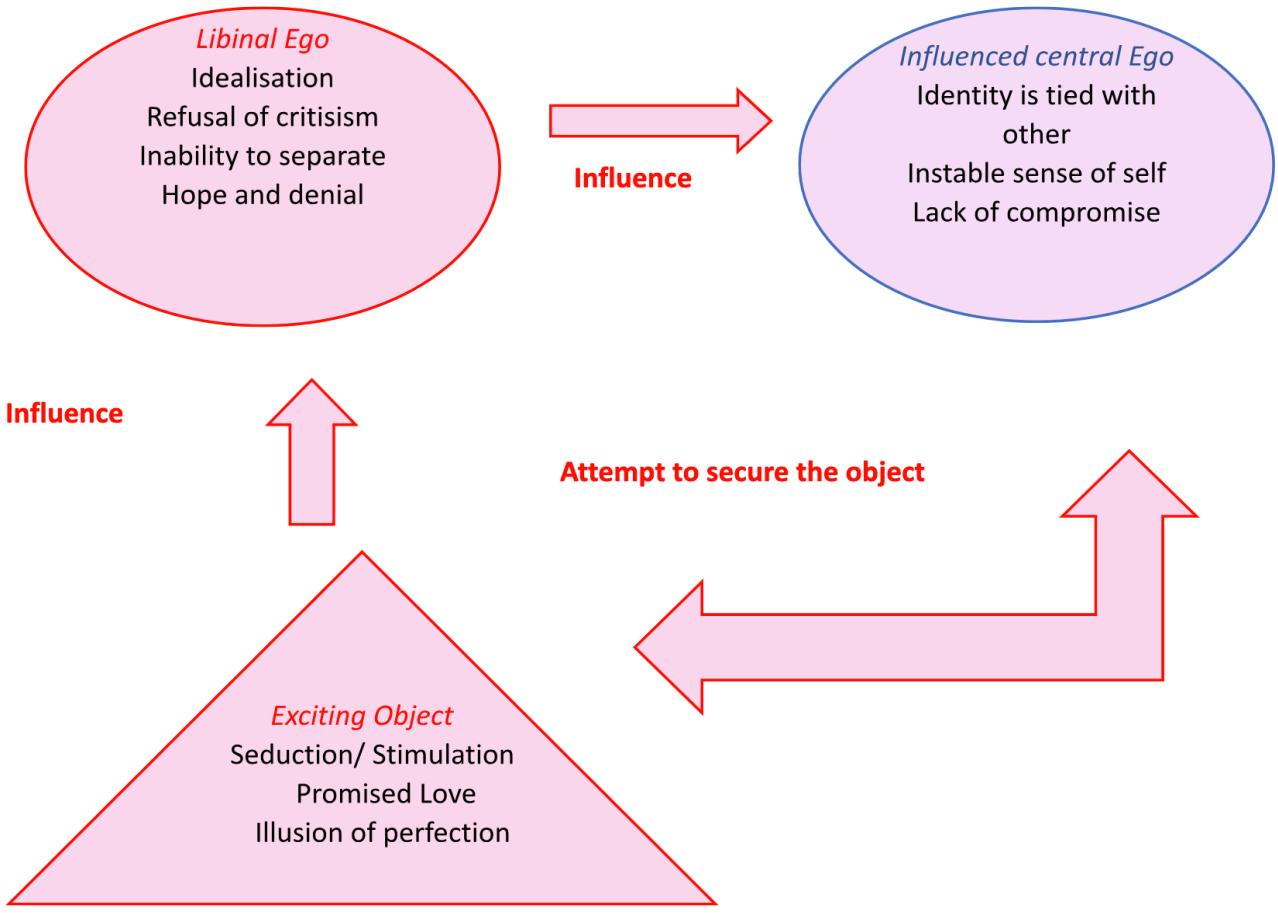
However, the hope that someone can meet all the needs remains very strong in the mind, and it will

have an important influence on the individual. This hope will reactivate when a person shows the 'signs' of potential interest. This excessive hope in the other will create what Fairbairn calls the *Exciting Object.*

The Exciting Object will stir up the Libidinal Ego, which will do everything to maintain the relationship with the other. This includes suffering, sacrificing and mistreatment because the hope is so intense that it gives the illusion that everything can go well if only the Exciting Object makes itself available. When the Libidinal Ego is tantalised, it will invade or even overwhelm the person's Central Ego and prevent it from playing its role as an internal stabiliser.

Please note: While Fairbairn uses the words "libidinal and exciting" in his theory, this is not limited to the relationship and/or sexual activity. Indeed, this dynamic extends to the person's entire mental and relational life. Fairbairn selected these words because they partly reflect Freud's ideas and theory (which served as a starting point). Thus, the duo Libidinal Ego and Exciting Object maintains a strong hope of a 'perfect relationship'. A hope which is illusory but undermines the person's emotional stability and prevents them from separating and from being critical of others.

Here is a schematic illustration of how this psychic pair works:



Key takeaway:
The Libidinal Ego is an unconscious part of oneself which hopes against all odds to find and secure a relationship with the other. Relationship, which is experienced as potentially perfect and which will fully satisfy the person. A relational illusion caused by the Exciting Object. Indeed, the Exciting Object will stir up attachment with promises of love, reward and happiness. But will inevitably lead to disappointment.

The Antilibidinal Ego and Rejecting Object

The Antilibidinal Ego (formerly the *internal saboteur)* in Fairbairn's theory is an unconscious part of the mind, which is the seat of all disappointments, bitterness, resentment, betrayals, hatred, etc.

Initially, the Antilibidinal Ego was a part of the Central Ego. Still, following experiences of rejection, humiliation, abandonment, and injustice, the Antilibidinal Ego developed against human relationships to protect itself from them. An unconscious defence is independent of the conscious mind.

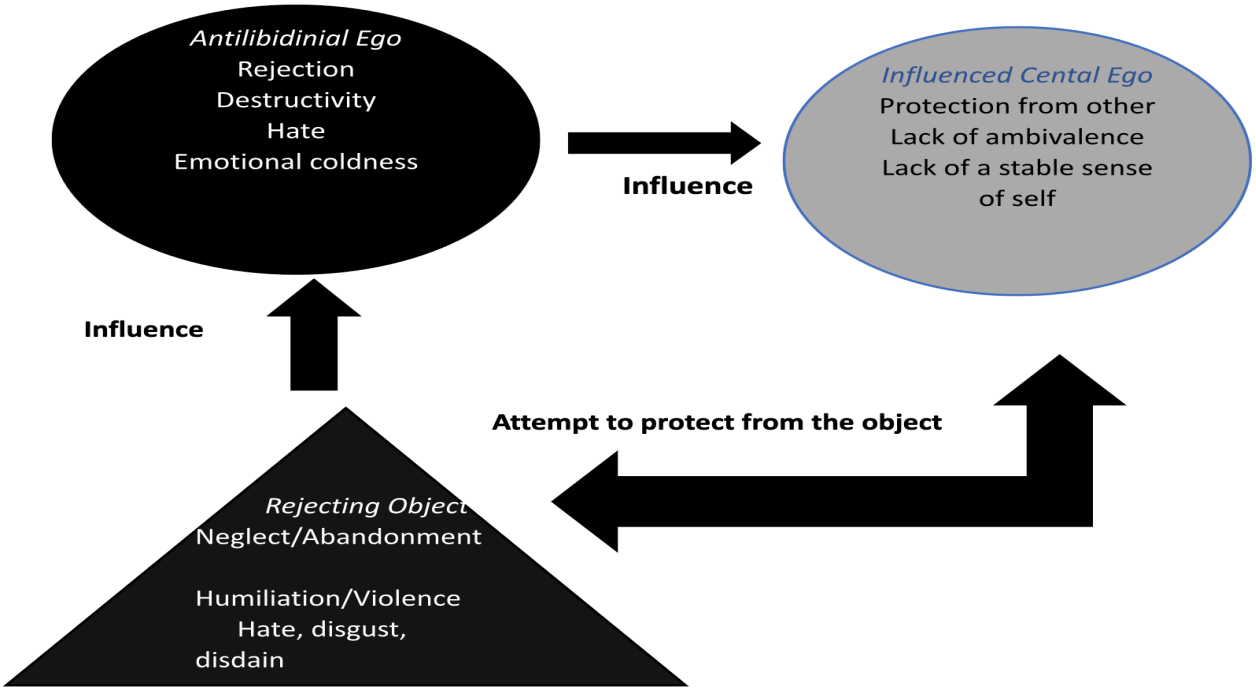
Let us specify that the fear of being humiliated again, hurt, neglected, mistreated or abandoned remains very strong in the mind and will influence the person. An anxiety that will reactivate when the other person shows 'signs' of potential rejection. This fear will create in the person what Fairbairn calls the Rejecting Object.

The Rejecting Object will provoke rage, dismay and hatred of the Antilibidinal Ego, which will attack (verbally or physically), reject and flee the relationship with the other. The emotions that emerge in this way are intense and challenging to channel because the person who experiences them has the impression that they are fighting for their life and that the Rejecting Object has the power to destroy them. Therefore, when the Antilibidinal Ego is activated, it will also invade and overwhelm the person's Central Ego and thus prevent any inner stability.

Please note: At first glance, one might think that the Antilibidinal Ego counterbalances the Libidinal Ego, cancels the latter's effects and that the presence of both provides a certain balance. However, this is not the case; these two egos do not communicate with each other and are separated by divide (splitting). They follow one another but do not cancel each other. In this system, only the Central Ego can provide mental stability.

Let us note that if the Antilibidinal Ego can facilitate separation from the other, it remains unstable and connected with the other (but a connection in hatred).
Thus, the duo Antilibidinal Ego and the Rejecting Object aim to protect the person from the emotional and physical suffering inflicted by others. A protection that turns out to be extreme, and very often, it can end up harming the individual due to the uncontrolled and uncontrollable nature of the reactions.

Here is a schematic illustration of how this psychic pair works:



Key takeaway:
The Antilibidinal Ego is an unconscious part of oneself that fears human interactions for fear of being mistreated (an anxiety that is often linked to complex trauma). Consequently, the Antilibidinal Ego will protect itself from the other by attacking and fleeing. This defence was erected against the Rejecting Object, which was experienced as a completely bad and harmful person.

Understanding C-PTSD through the endopsychic structure
Now that we have explained and detailed the endopsychic model, let us see how to integrate C-Post Traumatic Stress Disorder (C-PTSD) into this theory and its clinical applications. C-PTSD is (concisely) defined by the World Health Organisation (WHO, 2024) as follows:

● Repeated, prolonged, and unavoidable exposure to physical violence, sexual abuse, torture...

● Re-experiencing the traumatic events (flashbacks, intrusive memories, nightmares, etc.), which may cause emotional overwhelm.

● Attempts to avoid triggering the re-experience or repeating the trauma both internally and externally.

● Intense vigilance towards perceived threats (hypervigilance) and diminished vigilance or startleness.

● Severe and chronic issues of emotional regulation, i.e. intense emotional reactions to minor stress (e.g. self-destructive behaviour, outbursts…) or, on the contrary, emotional detachment and/or dissociation.

● A diminished sense of self-worth consisting of beliefs of being incapable, useless, and powerless… it is often associated with feelings of guilt and/or shame.

● Struggle to maintain relationships and feel close to others. The individual might avoid or withdraw from social interactions or have intense but unstable relationships.

● These symptoms impact the person's social, personal, family (…) life. If the person's life is maintained 'normally', it is at the cost of a massive effort.

Now let us envisage these symptoms through the lens of Fairbairn's endopsychic structure:

● In Fairnbairn's model, it is the intensity and repetition of traumatic events that is going to weaken the Central Ego and amplify the sub-egos[1]. In the case of C-PTSD, the impact of trauma on the psyche is massive, and the endopsychic structure is deeply shaken.

● The re-experiencing the traumatic events, hypervigilance and attempts to avoid triggering the re-experience could be interpreted as an unconscious way for the Central Ego to gain a semblance of stability[2] without the ability to use the backing of the Ideal Object (as the trauma has broken or prevented the link between the Central Ego and the Ideal Object).

● The diminished sense of self-worth and subsequent guilt, shame, and powerlessness result from a moral defence. The moral defence is a defence mechanism developed by Fairbairn (1943) in which the individual shoulders the blame and shame instead of attributing it to an external aggress-

1 Both Libidinal and Antilibidinal egos.
2 Re-experiencing here could be interpreted as way for the mind to try to overcome the experience itself as if repetition would help digest what happened by integrating it into the inner world.

or (like parents, peer groups, spouse, etc.). This results from the unconscious belief that by absorbing all the 'badness' of others, they will become good and help heal the person. The manifestation and impact of emotional dysregulation (be it self-destructive or detached) and the struggle of maintaining relationships (be it because of the high intensity or the withdrawal) can be explained as the effects of the Libidinal and Antilibinal egos overwhelming the Central Ego.

Please note:

● The endopsychic model is not the only way of conceptualising C-PTSD. It does not invalidate other models or methods (like EMDR, CBT, Schema Therapy, Gestalt, etc.). I believe all methods are helpful and add something to the understanding and treatment of C-PTSD.

● C-PTSD can be a comorbidity with other disorders such as substance abuse, personality disorders (borderline, narcissistic, schizoid, avoidant and dependent…), generalised anxiety, depression… This paper exists as an introduction of sorts; as such, it does not answer every question or detail regarding the effects of C-PTSD on the endopsychic structure, but it aims to establish a connection between the two.

Key takeaway:

C-PTSD, by its sheer intensity and repetition of trauma, creates effects on the mind that are intense. Those effects like withdrawal, guilt, shame, hypervigilance… It can be partly understood with the endopsychic model and the splitting between distinct parts of the psyche. Symptoms that benefit from being conceptualised as the result of the sub-egos and their relationship with the bad objects (exciting and rejecting).

Therapeutic strategies for the Libidinal Ego and Exciting Object as it manifests in C-PTSD

In the following parts, we will be presenting the clinical applications of the endopsychic structure in psychotherapy[3]. Let us begin with the Libidinal Ego and Exciting Object.

The Exciting Object and Libidinal Ego dynamic in this context can be 'reactivated' by a spouse, a parent, a sibling, a mentor, an employer… What matters is that the other (knowingly or not) triggers an unconscious hope within the patient.

This 'reactivation' is going to lead to the rise of intense emotions and behaviours within the patient suffering from C-PTSD, such as:

● Tolerating abusive situations (verbal, physical, blackmail, sexual…) towards them or a relative.

● Seeking the 'love', 'attention' and 'care' of the other regardless of how bad he is acting.

● Idealising the other or fantasising about the 'potential' of the relationship.

● Blaming themselves and internalising the guilt and shame of the aggressor.

● Rejecting or minimising any criticism of the relationship.

● The mental inability or the unwillingness to separate or protect from the other.

● Denying all the pain and suffering experienced at the 'hands' of the other.

3 David Celani's excellent books inspired the next chapters:

Celani D. P. (2010) *Fairbairn's object relations theory in the clinical setting.* Columbia University Press.
Celani D. P. (1994) *The Illusion of Love: Why the battered women returns to her abuser.* Columbia University Press.
I highly recommend both books for a more in-depth understanding.

● Going back to the aggressor despite everything that has been experienced.

The intensity of these symptoms reflects the measure of the unconscious hope of finding/maintaining the relationship. It seems to me that in the person suffering from C-PTSD, the underlying fantasy is that this human bond will come and 'fix' the trauma and abusive experiences as if the other, by his perceived 'exceptionalism' could prevent future relational trauma and make the person 'whole again'. A hope that is bound to fail as the 'exceptionalism' of the Exciting Object is but a lure, a *façade* that always holds the risk of reactivating these patterns of behaviour.

So, given the potential gravity of the situation, how can the clinician handle it?

● The deconstruction of this internalised pattern is often relatively slow, and the clinician must be prepared to take the time to unbuild it with the patient. The professional must be willing to tolerate regressions of negative feelings in themselves (e.g. hopelessness, stagnation, frustration, etc.).

● Confronting the patient outright to the flaws of an 'Exciting Object' is risky as it can damage the therapeutic alliance and increase resistance to psychotherapeutic work. Sometimes, the patient might even quit therapy to preserve this dynamic.

● Paying close attention to countertransference[4] as this pattern might create annoyance, dread, frustration, hopelessness… These feelings are important, common and not 'meaningless' as they might reveal aspects of the patient's mind or relational (un)abilities. They could even be used to guide the therapy.

● The feelings within the clinician, once understood and analysed, can be restituted to the patient when they have regained psychic stability.

● It is also important to memorise (not necessarily verbatim) what the patient says when engulfed by the Libidinal Ego and what you have analysed. Because even if the patient cannot hear or come to terms with idealisation immediately, they might be capable of it later and, at some point, even be receptive to the interpretations of the clinician.

● When engulfed in this pattern, the clinician can try to name the patient's current experience, e.g., "This relationship makes you feel alive again, perhaps you feel understood or question the patient: how does this relationship make you feel? Do you feel that he gets you?" In my experience, these affect naming methods strengthen the therapeutic alliance and are not an endorsement of the 'Exciting Object' but a way of refocusing on the Libidinal Ego of the patient.

● If the clinician has a good or strong therapeutic alliance, they may ask the patient more challenging questions, e.g., "How long do you think this honeymoon phase will last? Do you truly feel he has changed, or is it a *façade*? Do you remember the last time this happened?" These questions are a 'soft' way of considering the relationships and the patterns the patient is experiencing. It is also a first step in the process of separation.

● If the clinician is assigned to be the Exciting Object. It is essential not to confuse oneself with this projection. As this dynamic is still a hindrance to psychotherapy, the patient becomes less interested in introspection and more fueled by the idea of a relationship. In these cases, it is essential to take a step back and analyse what is helping the patient decrease the force of the pattern and what might be inadvertently feeding into it.

4 I am using the idea of countertransference as a way of drawing attention to the feelings, moods and thoughts the clinician is experiencing towards the patient.

A certain 'tolerance' towards being idealised is necessary without, however, being engulfed by it. When this dynamic occurs, the trauma might not be accessible to consciousness; the patient might be in deep denial of the past suffering they have experienced. While it is important to point out the connection to the trauma and its impact on the mind and the triggering of the unconscious illusion of finding a relationship that overcomes all forms of suffering. Insight should not be 'forced' onto the patient. If tolerance is an important part of the clinician's work with the Libidinal Ego/Exciting Object. It does not mean that everything should be 'accepted' if the patient is at risk; actions might be necessary to protect them from themselves or others (e.g. reporting to local authorities, hospitalisation, warning a trusted relative…)[5].

Please note:
In the previous section, I have discussed therapeutic strategies; this is by no means a 'dogmatic truth'. As such, I would like you to consider it more like recommendations that I found helpful and helped me with C-PTSD patients.

Key takeaway:
The dynamic between the Libidinal Ego and the Exciting Object in C-PTSD can be challenging. As an open critic or confronter on behalf of the clinician can lead to increased resistance and suspiciousness within the patient. In some instances, it can even lead the patient to end therapy to 'protect' the dyad. To help the client, the therapist must be patient and tolerant towards these dynamics while trying to deconstruct them slowly.

Therapeutic strategies for the Antilibidinal Ego and Rejecting Object as it manifests in C-PTSD
Like the Libidinal Ego/Exciting Object dynamic, the Antilibidinal Ego/Rejecting Object pattern will be 'reactivated' by the others. However, these phenomena (Antilibidinal Ego/Rejecting Object) is not going to trigger an unconscious hope but a deep fear of re-experiencing the traumatic events of the past at the hands of others (be it in childhood, or in the current relationship, the previous one…). I think this reaction as the opposite side of the spectrum to the Libidinal Ego/Exciting Object process.

The Antilibidinal Ego/Rejecting Object dynamic is going to lead to the rise of intense feelings and behaviours within the patient suffering from C-PTSD, such as:

● The influx of traumatic and painful memories to the conscious mind (including those during childhood).

● The reawakening of a deep hatred towards the other and even humanity.

● Heightened suspiciousness towards others, including people that have not hurt them.

● Fantasies and/or acting out of revenge and destruction for the person's pain.

● Intense feelings of betrayal, lack of trust, despair, resentment, hopelessness…

● Emotional and/or physical withdrawal from human interactions (including positive ones).

● Potential feelings of aggression, persecution…

● An inability to nuance takes a step back from one's experience (loss of ambivalence) even if the event is considered minor by the individual in other circumstances.

● Potential acts of self-harm or destruction of one's property (or that of others)[6]. In some cases,

5 These situations are to be examined on a case-by-case basis and protocols might vary from country to country.
6 What is called a *crise clastique* in French.

hospitalisation might be necessary to protect the person from self-destructive tendencies.

The intensity of these symptoms reflects the measure of the unconscious fear of being exploited, abused and destroyed by the relationship. It seems to me that in a person suffering from C-PTSD, the underlying anxiety is that this human bond will inevitably lead to intense suffering, rejection and the ultimate feeling of loneliness and loss of self. An emotion that is bound to trigger a deep need to 'survive' and a need to escape or to protect oneself against the Rejecting Object. A Rejecting Object that comes to represent every traumatic interaction the person has ever experienced.

So, given the potential gravity of the situation, how can the clinician handle it?

● When the dynamic Antilibidinal Ego/Rejecting Object is reactivated, all the past relational trauma might come back in full force in the patient's conscious mind. It can easily overwhelm the individual and provoke a moment of identity diffusion in which delusional thinking and even hallucinations might occur. In these moments, the therapist must contain the trauma. How I operate in these circumstances (please note that many valuable techniques can be used) is that I name the present experience as being traumatic and part of a chain of events (cumulative trauma) in the person's life and underline how they have adapted to a traumatic environment.

● Given the high level of intensity, the clinician might feel as if they were 'walking on eggshells' with the patient during the antilibidinal phase. In certain situations, verbalising one's countertransference (e.g. "I have the feeling that I am walking in a land mine and that one wrong move, and we are done for.") This verbalisation may help the patient realise the therapist is not almighty and not seeking to control them or their emotional reactions. Sometimes, this can even help them relate to the therapist, as those feelings of unease can be similar to the experiences the patient endured in childhood.

● Please remember that however intense the Antilibidinal Ego/Rejecting Object dynamic might be, it is not a 'sign' of separation or individuation. The relationship with the other still exists and is fueled by hatred instead of love. So, the patient is still attached to the relationship but in a negative way.

● Even if I have separated these dynamics, it might be worth noting that the Libidinal/Exciting and the Antilibidinal/Rejecting can quickly shift from one to the other. Both mental processes are unstable and volatile by essence (especially if the person presents a dissociative disorder). Therefore, it is safe to say the clinician should be ready to deal with both in the same session.

● During this phase, the clinician's empathy or concern might be met with scepticism, suspiciousness or outright aggressiveness by the patient. It is interesting to note that in these moments, the patient is incarnating the Rejecting Object, and the professional is denied his realness. However, verbalising these concerns is not 'lost' on the patient. Even if they cannot or are afraid of connecting with these concerns, they will still be useful later.

● Nuance and ambivalence might be unattainable when the patient is engulfed in this dynamic. Trying to 'push' nuance too early could result in the patient withdrawing from the interaction or becoming highly confrontational.

● When patients go into a state of relational withdrawal because of the emotional re-experience of the trauma. States that can occur in autistic patients (shut down) and schizoid patients… it is essential to give them some space and verbalise it, e.g.," I can see you are withdrawing. I am here whenever you feel ready to speak again". This will allow the patient to focus on their emotions and internal state without feeling abandoned. A benevolent silent moment can help the patient develop emotional regulation and ask for help if necessary.

● If the clinician is assigned to be the Rejecting Object. It is essential to tolerate the criticism of the patient and even acknowledge when mistakes were made (i.e. being late, forgetting an important

life event…). This acknowledgement without retribution will help the patient change their internal dynamics and strengthen the therapeutic alliance.

● Tolerating criticism, even if it is unfair, also helps the patient realise that his internalised bad elements are not enough to destroy the therapeutic relationship or alter the clinician. This can reassure the patient and lead them to be more tolerant of their 'bad side'.

● Please remember that if ever these phenomena go too far, you can use the setting of the therapy to uphold limits and boundaries (e.g. refusing to provide a session to an intoxicated patient, ending the session at the right time, etc.). These limitations have a containing effect and establish a clear set of possibilities and interactions that can become a basis for patient interaction and self-regulation.

Key takeaway:
The dynamic between the Antilibidinal Ego and the Rejecting Object in C-PTSD can be very intense. An intensity that is due to the emotional reactivation of past trauma. A reactivation that might cause feelings of nervousness in the clinician and suspiciousness or aggression in the patient. In certain cases, the patient may be overwhelmed by the trauma and the fear of repetition. To help the client, the therapist must contain and work with the traumatic elements and acknowledge mistakes and errors.

Fostering the Central Ego
Fostering the Central Ego is the primary therapeutic goal when working with C-PTSD. A strong Central Ego can inhibit the triggering of the sub-egos and bad object dynamics. And provide the patient with a stable sense of self and of others.

So, how does the clinician strengthen this stabilising part of the mind?
● The first and most important aspect, like in all forms of psychotherapy, is a solid therapeutic alliance. The building of such a working relationship is a long-term endeavour, but if successful, it will allow both patient and clinician to work through negative reactions, hate and anxiety...

● By bringing into consciousness the endopsychic structure and its dynamics through interpretations like:
"I feel there is a deep dive in you; a part of yourself wants to be with others, whatever the cost might be, and another side doesn't want anything from others and doesn't trust them."

Verbalising the patterns such as:
"See, it is interesting you had a lot of affection for her/him, and now you seem to harbour deep resentment for them, and it reminds me of a previous relationship you talked about"

By giving a frame to these phenomena, the awareness of the patient increases ever so slightly, and the splitting becomes lesser.

● I also found that the careful deconstruction of the expectations and idealisation (both of the relationship and oneself) helps the Central Ego grow as both sub-egos are based on highly invested mental and emotional representations (representation we would call *Imagos* in classical psychoanalysis). By 'shrinking' the perfect image of oneself and others, the strength of the unconscious is diminished as it has less to draw on.

● During sessions in which the patient is not engulfed by their sub-egos, the clinician can focus attention on past sessions in which these dynamics were present and try to understand the

phenomenology[7] of the patient and what he was experiencing (something that is not entirely possible when the sub-egos take over). This close look at the inner subjectivity of the individual might help the clinician realise the full extent of these dynamics' impact on the patient's psyche. This can unearth the sub-egos in a stable state of mind, making them observable for both client and clinician. Eventually, they may become a phenomenon the patient can recognise and take a step back from.

● When working with these unconscious dynamics, the therapist must be prepared to face setbacks and failures. Sub-egos have a powerful grasp on the patient's mind and cannot be underestimated. So, I believe it is essential to integrate into the treatment plan and verbalise explicitly to the patient that there will be moments of relapse and stagnation, and it is manageable as both parties are not losing sight of the main objective, i.e. healing the relational trauma.

Remember, the battle might be lost, but not the war is not.

● The therapist's consistency, stability and benevolence are necessary for the patient to start or continue the integration of the 'Ideal Object', i.e. the relationship that will give them the confidence and trust needed to expand their self-esteem and agency.

● The therapist might, at certain moments, leave the position of 'benevolent neutrality' to congratulate or notify the patient of their progress or to reinforce their decision-making. By doing so, the clinician builds a therapeutic alliance and gives the patient the blueprints for a caring relationship. By doing so, the therapist is rebuilding the trust in humanity that the patient has lost due to C-PTSD.

● At specific points in the therapeutic process, the patient might leave therapy to try to safeguard the 'bad objects' or to evaluate the ability of the clinician to maintain consistency even if the client 'attacks' the setting.

● It is also important to verbalise and work on the moral defence by redistributing responsibility, guilt, and shame to the aggressor (feelings they have often projected onto the patient and given the full responsibility to). By 'giving back' the guilt to the abuser, the therapist is creating the conditions for the patient to hold others accountable for their actions or inactions.

● When the patient's 'inner critic' (Superego) runs wild and holds the patient accountable for everything. A technique I have found helpful is to ask the patient to imagine a metaphor for this 'inner critic' (ex, a judge, a rainy cloud, an elephant…) and then ask them to critique these inner critics. By doing so, the patient might be able to turn the tables on the superego and use a part of its power against it; thus, the ego might be reinforced.

● Working to alleviate C-PTSD is a long and slow process with many ups and downs. As such, it is important to conceptualise therapy as a long-lasting, step-by-step process that backward steps might impede. However, these regressions are not signs of failure but a necessary path towards the process, and if navigated successfully, they can lead to a true leap in the outcome of the treatment.

Please note:
Even if I have given specific guidelines in this presentation, I think it is essential for the clinician to remain creative when treating patients regardless of their disorder. As such, I invite you to consider my developed topics but remain open to variations and other methods. I firmly believe that our multiplicity of perspectives allows us to explore and even alleviate the human mind. So please feel free to expand, play and create with these theories!

Key takeaway:
The work with patients presenting Complex-PTSD is a long and delicate process. One in which there

7 The study of lived experience and subjectivity.

is not a decisive moment but continual progress as the patient learns new ways of exploring the trauma and managing its effects on the relationship, as well as reinforcing their sense of self. This process necessitates a benevolent and adaptive therapist for the patient to internalise a feeling of security and stability.

I thank the Complex Trauma Institute for inviting me to participate in the 6th International Trauma Conference. I would also like to thank you, the reader, for taking the time to read this paper.

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Cancer, Trauma and Mentalisation

Dr Daniel Anderson and Dr Victoria Jones

Abstract

This paper explores the role of mentalisation theory to aid the recovery of patients experiencing cancer-related post-traumatic stress disorder (CR-PTSD). While existing research highlights the significance of this condition, the paper especially emphasises the often-overlooked subgroup with a history of adverse adulthood or childhood experiences and complex PTSD. Approximately 14% of oncology patients meet diagnostic criteria for CR-PTSD. Consideration of sub-threshold post-traumatic stress symptoms reveals that a third of all cancer patients encounter some degree of post-traumatic stress. Notably, those with AAEs/ACEs face unique challenges, as traumatic memories may resurface during cancer care, impacting overall well-being.

The paper introduces a mentalisation-based framework to engage patients with cancer-related PTSD, offering a holistic approach grounded in psychoeducation, emotion-focused techniques, and transparent communication. By interrogating mentalisation theory regarding this patient group, the framework advocates for therapeutic relationships, multidisciplinary collaboration, and regular supervision to comprehensively address the psychological consequences of living with cancer-related post-traumatic stress. The significance of this framework lies in its potential to enhance patient outcomes, including improved engagement with cancer treatment. The paper calls for further research and evaluation to assess the framework's efficacy to improve morbidity and mortality outcomes.

Introduction

The prevalence of mental illnesses such as anxiety and depression in oncology has been extensively researched, with approximately 10-20% of all oncology patients meeting the diagnostic criteria (Chaturvedi and Uchitomi, 2012). In addition, the estimated prevalence rate of cancer-related PTSD (CR-PTSD) is around 14% (Abbey et al., 2015). Although this rate is comparable to more widely recognised mental disorders, it is far less acknowledged. If sub-threshold post-traumatic stress symptoms (PTSS) are also considered, an additional 20% of patients, roughly a third of all cancer patients, experience some degree of post-traumatic stress (Andrykowski et al., 1998; Shelby et al., 2008). Additionally, within cancer services, there is a notable group of patients who present with a history of trauma and meet the criteria for complex PTSD (Anderson and Jones, 2024). These individuals may have endured challenging experiences during both adulthood and childhood, commonly referred to as adverse adulthood or childhood experiences (AAEs/ACEs) (Brown et al., 2013) (see Felitti et al., 1998 (Felitti et al., 1998) for their definition and measurement). Cancer patients can currently access non-cancer specific support for trauma-related symptoms through primary care or specialist psycho-oncology services and, in the UK, this may include eye movement and desensitisation and reprocessing therapy, medication, or other talking therapies (NICE, 2018).

As a relatively small specialty of clinical work, the research in this field in lacking. However, we work in a tertiary care UK cancer centre and, as such, our forthcoming comments in this paragraph are based on our collective clinical experience using our specific population. In our experience, it is not uncommon for patients with a history of trauma to find that memories of past traumatic events re surface during their cancer care and treatment, even after years of resolution or prior management

(Anderson and Jones, 2024). Within cancer services, patients with AAEs/ACEs may disclose instances of childhood abuse, including sexual abuse, for the first time (Brown et al., 2013). In our experience, these disclosures can be triggered by the specific anatomical location of their cancer and the subsequent examinations and interventions required in those areas. The coexistence of these traumatic memories and their associated attachment patterns with the already challenging process of cancer care can render the experience more complicated and distressing than necessary.

Again, in our experience, this patient group tends to be under-recognised and inadequately considered within cancer care, despite their heightened psychiatric and psychological needs (Anderson and Jones, 2024). PTSD reduces quality of life in people living with cancer and also affects concordance with cancer care, including drug concordance; this in turn negatively impacts morbidity and mortality (Cavalcanti-Ribeiro et al., 2012; Neigh and Ali, 2016; Shand et al., 2015). Furthermore, when patients have mental health problems, it is known that their physical health outcomes are generally worse (Ashworth et al., 2017; Grassi and Riba, 2020; Osborn, 2001).

This paper aims to introduce a framework for engaging patients with a history of cancer-related PTSD and which is grounded in a mentalising perspective. It is an experiential discussion primarily based on the authors' experience of clinically working in this field for several years using various techniques related to mentalisation and trauma-informed psychological therapies as adapted for patients with cancer. It is hoped this framework can be used by mental health clinicians and oncology teams to better engage with patients living with PTSD/PTSS symptoms who are going through cancer care.

The case for change

Trauma-focused cognitive-behavioural therapy (CBT) is an evidence-based psychological therapy for trauma but may not specifically address the cancer experience (Capezzani et al., 2013). Mentalisation extends CBT by incorporating specific relational and attachment-based approaches, which are particularly relevant for cancer patients who may already be hyperaroused due to PTSD and are disengaging from their oncology clinicians (Fonagy and Campbell, 2016). In the context of cancer care, where there is a limited window of opportunity for engagement, mentalisation and the proposed framework provide a flexible and time-efficient approach that focuses on establishing a therapeutic relationship, providing education, and adapting to the patient's needs. Several other authors have examined the role of mentalisation-based treatment in cancer patients but have not yet provided a specific adapted rationale and framework for such an approach (Hales et al., 2015; Lombardo et al., 2024).

After the initial stage of education and grounding, in our experience mentalisation techniques can help maintain engagement and build trust. At this point, primary PTSD symptoms may be relatively managed, but secondary symptoms related to negative self-perceptions, guilt, and shame may become problematic. Again, in our expeerience, patients emphasise the importance of recognising individual communication needs and adjusting consultations accordingly. A critical literature review by Li et al. (Li et al., 2020) highlighted the positive effects of acknowledging individual needs, including feelings of empowerment. For patients who have experienced trauma, which often leads to a sense of loss of control and powerlessness, addressing individual communication needs becomes particularly important (Schnur et al., 2018). The awareness of previous trauma by healthcare professionals was mentioned as an ongoing area of improvement, especially considering the higher prevalence of PTSD among cancer patients compared to the general population (Swartzman et al., 2017). Furthermore, a survey conducted by Mehnert et al. (2010) highlighted the significance of positive doctor-patient consultations in managing mental health symptoms, while detrimental interactions were linked to psychological co-morbidity (Mehnert et al., 2010).

The interactions between healthcare professionals and patients throughout the cancer journey hold great importance, and inadequate communication can have devastating effects on patients' wellbe-

ing. Regarding perceived loss of dignity, these situations are particularly distressing for individuals with a history of trauma, which may include instances of sexual abuse. Sensitivity in communication and obtaining consent becomes crucial in preserving patient dignity (Avestan et al., 2019). Traumatic experiences in healthcare settings can retraumatise or trigger patients and furthermore, patients who have experienced trauma may reach their "threshold" for further traumatic experiences due to the challenges of living with cancer (Anderson and Jones, 2024). Healthcare professionals working in cancer care should be mindful of these associations and their potential impacts on patients' wellbeing and cancer care. The comments regarding bodily identity highlight the need for healthcare providers to consider the impact of cancer treatment on the wellbeing of sexual and gender minority patients. Previous research has shown that these patient groups are more likely to experience trauma and distress in cancer care (McCarthy et al., 2016; McKinnish et al., 2019), and to provide optimal support, clinicians need to be educated about trauma and its implications for cancer care. There is also a need for education regarding trauma and its impact for those affected by cancer or childhood trauma (Anderson et al., 2024). Stigma surrounding mental illness, which is not visibly apparent in the physical body, further emphasises the importance of educating patients about trauma-related conditions.

Our experience suggests that information provided is not always relevant or personalised. Clinicians should be aware of how to deliver information effectively to meet individual patient needs (Lu and Zhang, 2019). Furthermore, there is a need for a specific trauma-informed approach in cancer care, though there is a lack of strong evidence-based recommendations due to paucity of literature available (Davidson et al., 2022). One scoping review identified trauma-informed care in cancer could include universal or targeted trauma screening, a dedicated interprofessional team including psychologists, or drawing attention to how certain behaviours could be linked to psychological distress (Davidson et al., 2022). Another paper looking at trauma-informed care in cervical cancer called for an emphasis on safety and shared decision-making, and tailoring education and counselling to patient needs; however, it was non-specific in how to achieve these aims (Kohler et al., 2021). Generally, recommendations regarding trauma-informed care in cancer are not routinely quantified or detailed in the description of tools used and how they were applied, and this is an area for further research.

The PsyCLOPSS framework

The development of the psychological consequences of living with oncological post-traumatic stress (PsyCLOPSS) framework is wholly based on our experience of working with both traumatised cancer patients and non-cancer patients with a history of complex PTSD. Using our experience of patients living with cancer, alongside existing theoretical knowledge of PTSD in general, cancer-related PTSD, and mentalization, the framework has been developed to aid patient engagement in cancer care. PsyCLOPSS is a framework designed to facilitate therapeutic engagement between clinicians and cancer patients with a history of traumatic experiences. The underlying concept of this approach is that such patients may re-experience their original trauma within the context of cancer investigations and treatments, leading to disengagement from cancer care and subsequent negative impacts on disease prognosis. The primary objective of the PsyCLOPSS approach is to ensure that patients living with post-traumatic stress and cancer can effectively participate in their cancer treatment while addressing their mental health needs. This model provides clinicians with a systematic framework and tools to guide therapeutic interventions on a moment-by-moment basis.

The PsyCLOPSS approach is not a structured psychological therapy but is instead a framework for using within consultations with patients. It reflects the ad hoc and at times unplanned presentation of patients with mental health problems in oncology. It requires a flexible approach that is tailored according to individual needs such as the stage of cancer treatment and illness. The key ideas encompassed within this approach include:

- Recognition of the fundamental human need for stable and meaningful relational attachments a

a basic level.

- Drawing from attachment theory, the PsyCLOPSS model emphasises the establishment of trust as a foundational element. The notion of a secure base encompasses both physical and relational aspects.

- Encouraging clinicians to engage in congruent self-reflection of their own emotions and thoughts, both professionally and personally, without fear of exploring the range of human feelings associated with cancer care, such as shame, existential anxiety, anger, hatred, and erotic feelings.

- Emphasising the development of effective communication as a fundamental task, where the clinician acknowledges and validates the patient's attempts to communicate, while demonstrating a genuine willingness to understand and explore the meaning behind that communication.

- Despite the anxieties inherent in cancer, the clinician plays a crucial role in fostering interpersonal meaning and creating a sense of hope. By consistently valuing and prioritising the quality of communication between the clinician and the patient, a sense of hope can be sustained.

- Cultivating a sense of belonging by recognising and respecting the diverse identities of individuals living with and beyond cancer.

In our experience, educating patients about trauma, PTSD, and its effects on the brain can be beneficial (Anderson and Jones, 2024). Recognising symptoms, providing a diagnosis, and explaining the impact of trauma on the brain can help patients understand and manage their experiences. Teaching grounding techniques and self-regulation strategies is also valuable. These early conversations shift the focus from thoughts and emotions to the present moment and body awareness. Simple models that distinguish between the "old brain" (limbic system) and the "new brain" (neocortex) based on their preferred sensory inputs can be helpful. The "old brain" prioritises bodily awareness and the fight/flight mode, while the "new brain" prefers thoughts and words. In times of overwhelming panic, the new brain shuts down, and accessing the old brain becomes necessary (Schorr, 2016).

The management of complex PTSD in cancer patients often begins with educating both clinicians and patients about polyvagal theory (Porges, 2009). Establishing a basic understanding of this theory is essential for effective treatment. Initially, the focus is on keeping the patient engaged and present in the treatment room. The activation of the sympathetic nervous system leads to hyperarousal and panic symptoms, which are associated with the "fight or flight" response. However, it is equally important to address the activation of the parasympathetic nervous system, which can result in dissociation. In this state, patients may experience freezing, shutting down, and numbness.

To engage patients who are dissociating, attention is directed towards their relational security and body awareness. Attachment theory plays a crucial role in facilitating this process of co-regulation (Porges, 2009). It involves finding a balance between survival instincts and the need for connection, as these drives coexist within the autonomic nervous system. The autonomic nervous system is shaped and regulated through interactions with others. These interactions can either invite new possibilities and promote co-regulation or increase reactivity and reinforce survival patterns. Neuroception, which operates outside of conscious awareness, plays a vital role in determining whether an individual perceives safety or danger in a given moment (Porges, 2009).

The interaction between a patient and an oncology clinician is particularly relevant in the context of mentalization and cancer-related PTSD. When there is a neuroceptive mismatch, the "fight or flight" response, and in severe cases, freeze and dissociation, may occur. In the case of complex PTSD, such mismatches are not uncommon due to historic attachment patterns that involve neglectful or hurtful care (Schorr, 2016; Van der Kolk, 2015). It is important to avoid triggering a neuroceptive

mismatch, as it can lead to disengagement from cancer care.

The experiences of cancer and trauma can lead to a fragmented sense of self and environment, where emotions become extreme and individuals struggle to maintain a coherent understanding of their feelings and their causes. Expressing these experiences verbally can be challenging. This changeability applies not only to individuals with cancer but also to those around them. Individuals often seek connection and meaning with others, but they may also engage in avoidance behaviours towards caregivers. Evaluating effective care in this context requires an ongoing assessment of each moment.

In cases of complex cancer-related post-traumatic stress disorder, clinicians may sometimes validate the patient's feelings by acknowledging or suggesting a specific emotional state (Fonagy and Campbell, 2016). The process of making sense of these experiences, even if not explicitly verbalised, can help stabilise moments of fragmentation. It is important to note that patients with cancer should not be blamed for behaviours such as non-engagement with investigations or treatment. By maintaining a state of awareness without acting upon such feelings, clinicians can pause and reflect on questions related to their own emotional state and understanding of the patient's experience.

Adapted mentalisation

Mentalisation is closely linked to attachment theory and helps to explain neuroceptive mismatches (Bateman and Fonagy, 2004, 2006; Fonagy and Adshead, 2012; Fonagy and Campbell, 2016). Although mentalisation as described by Anthony Bateman and Peter Fonagy was originally envisaged as a treatment for borderline personality disorder, the ideas have been adapted for patients with cancer-related PTSD who in our experience can also present with complex PTSD difficulties related to interpersonal dynamics. As such, the mentalisation framework for borderline personality disorder has been helpful but adapted using a more general trauma-informed approach relying on grounding techniques, psychoeducation, and attachment theory.

Attachment theory, originally developed by John Bowlby, describes how infants and children develop and understand relationships with their caregivers, such as parents (Holmes, 1993). Attachment patterns are crucial for survival and play a role in the transition from an integrated sense of self to a disintegrated one, which may be comparable to the experiences of a child or infant. Attachment depends on developing basic trust in caregivers and oneself. In infants, attachment serves as a motivational and behavioural system that directs the child to seek proximity to a familiar caregiver during moments of distress, with the expectation of protection and emotional support. A secure base is provided by the caregiver, allowing the child to explore their environment. The main principle of attachment theory is that, with a sensitive and responsive caregiver present, the infant will utilise them as a secure base for exploration (Holmes, 1993). The primary objective of mentalisation for individuals with cancer-related post-traumatic stress is to enhance their understanding of emotions, thoughts, and behaviours by providing a secure base, thereby enabling them to continue with their cancer care. In our experience, mentalisation can improve communication with those around them and fosters a better understanding of the patient's emotional and cognitive experiences by the entire care team, including clinicians, family members, and the broader systemic care team beyond the hospital.

The concept of "not knowing" (as in not assuming knowledge) is also vital for clinicians to develop adequate mentalizing capacity, both for themselves and subsequently for the cancer patient (Bateman and Fonagy, 2006; Fonagy and Campbell, 2016). To truly understand the nature of communication, direct enquiry with the patient is necessary. Clinicians should avoid preconceptions or assumptions, despite the pull towards a disintegrated state triggered by the severity of the patient's traumatic feelings. A willingness to communicate and develop mutual understanding on a moment-to-moment basis is essential. Clinicians should maintain curiosity about the patient's internal world, which may influence their specific presentation or communication. Additionally, clinicians

should be willing to disclose their own emotional states when appropriate. Emotional openness and curiosity are expected from all parties involved. Regular supervision also serves as a platform to openly discuss the challenges of mentalisation and find ways to regain focus as soon as possible (Jordet and Kjølbye, 2023). The following theoretical ideas, adapted from mentalisation practice using our experience, are proposed as interventions in the cancer population (Bateman and Fonagy, 2006; Fonagy and Campbell, 2016).

Attachment and epistemic trust

Understanding historic trauma: Acknowledging past traumatic experiences and associated affective and sensory elements that resonate with the current experience of threat or trauma in cancer care. Exploring these experiences should be approached cautiously to avoid re-triggering hyperarousal and impairing affect and bodily response reflection. The emphasis is on understanding the emotional and physical experiences and the meaning derived from them rather than focusing on the details of the actual events.

Attachment: Recognising the patient's relationship history, which may include childhood abuse, neglect, and current abusive or neglectful relationships. Patients with post-traumatic stress receiving cancer care often have experiences of neglect or hostility from caregivers, perpetuated through ongoing problems and traumas in adult relationships and exacerbated by the experience of cancer, regardless of its severity. Mentalisation requires a careful understanding of the circumstances surrounding actions, prior behavioural patterns, and the individual's exposure to experiences. Mentalisation theory intersects with cancer and clinical realities in this model. Unconscious re-experiencing of these patterns within the care system and therapeutic relationship is possible. To manage this unconscious re-experiencing, clinicians should avoid becoming defensive and instead maintain a curious stance, acknowledging the automatic and learned nature of these behaviours while remaining attuned to the patient's mind.

Epistemic trust: By disclosing thoughts and promoting mentalisation, clinicians uncover underlying mistrust of others (Fonagy and Campbell, 2016). This mistrust may stem from early childhood experiences of neglect and abuse, resulting in a vigilance that distrusts care. While it is essential to acknowledge such experiences, the primary goal is to enable patients to continue with their cancer care rather than extensively exploring these issues. Mapping attachment patterns may provide additional insight, but the focus should remain on present relationships, including those with the cancer care team. Empathic validation of the patient's current experience fosters trust in the therapeutic relationship (Bateman and Fonagy, 2006). Adopting a not-knowing stance and nurturing curiosity are vital. Due to childhood neglect, patients may be sensitive to shame, making non-verbal communication (for example, tone of voice or eye contact) particularly important, as verbal communication alone may be insufficient. However, excessive eye contact can also be perceived as threatening and shaming.

The body

Affect focus and body focus: Recognising trauma and threat responses, particularly focusing on emotions and bodily sensations (Fonagy and Campbell, 2016). Cancer care is perceived as a threat to bodily integrity and life, leading to heightened arousal and potentially dissociative states. Aiming for a cognitive focus is likely to be ineffective until patients become aware of their hyperarousal from affects and bodily sensations and learn to pause and reflect.

Explaining neurobiology: As described earlier, explaining the threat responses and stress reactions originating from the "old brain" or limbic system, contrasting them with the cognitive processes associated with the "new brain" or neocortex (Schorr, 2016).

Mindfulness and alien self: The task is to distinguish between "old brain" responses and "new brain" responses. Techniques such as grounding, mindfulness, and controlled breathing can help patients

recognise their hyperarousal and allow the "new brain" to resume its functioning (Jarero et al., 2018). This process may unveil multiple self-concepts rooted in distorted guilt, shame, hopelessness, and loss of control. Patients are encouraged to discontinue unproductive thinking and shift their focus to different subjects. The concept of the "alien self" is employed to represent aspects that tend to result in self-sabotage of their cancer care through behaviours and thoughts that disengage, reflecting the unconscious attempt to repeat past traumatic experiences (Bateman and Fonagy, 2006). It is crucial to bear in mind that this repetition is not intentional but stems from attempts to undo past learning.

Modes of mentalising

As patients develop mentalisation skills, the focus shifts between self-perception and other-perception, automatic and controlled processes, affective and cognitive aspects, and internal and external stimuli (Bateman and Fonagy, 2006; Fonagy and Campbell, 2016). Encouraging patients to consider the minds of others involved in their cancer care, as well as the clinician's mind, promotes mentalization. Clinicians revealing their thoughts to patients can challenge the patients' assumptions. Each mode of mentalising has been adapted according to the experience of the authors working with a cancer population.

Automatic versus controlled mentalising: The brain responds rapidly and unconsciously to stress, enabling a fight or flight reaction. However, complex human relationships often provoke intense emotions, leading to automatic mentalisation. While useful in immediate threats, this automatic mechanism can complicate situations requiring a nuanced understanding such as during procedures involving complex cancer interventions or during consent to chemotherapy. Controlled mentalisation becomes essential in such instances, demanding conscious effort. This deliberate mentalisation allows individuals to consider consequences, fostering more thoughtful and effective responses. It provides a means to navigate emotional complexities with increased empathy. It is usually enabled through slowing down using grounding techniques.

Self versus others: An essential part of mentalising is being able to weigh up one's own feelings, thoughts, and perspectives alongside those of others at the same time. The difficulty lies in distinguishing between the two without neglecting oneself or the other party. Navigating these boundaries and achieving a balance between self- and other-focused mentalising can be especially challenging in emotionally intense situations such a receiving bad news or when past traumatic memories are being triggered in the here and now of current treatment experiences.

External versus internal focus: Mentalising, which relies on external features like facial expressions and non-verbal cues, is often quicker and more automatic, allowing for adaptive responses to potential threats. However, mentalising focused on internal features, involving the representation and contemplation of one's and others' internal mental states, demands slower, more intricate processes. In the context of cancer patients where there are multiple and threatening internal changes happening in the body, recognising these distinct modes of mentalising becomes essential. While the automatic mode aids in swift responses to visible distress, the slower, internal-focused mentalising is crucial for understanding the nuanced emotional experiences of cancer patients.

Affective versus cognitive mentalising: Mentalisation requires the integration of both affective and cognitive processes. Affective empathy operates automatically and is embodied, while cognitive empathy involves controlled elements like belief–desire reasoning and perspective-taking. Affective mentalising is needed during moments such as distress when receiving bad news or moment of joy if there is good news. The body in intrinsically connected to such moments through touch, for example. Cognitive mentalising is vital for comprehending complex situations, including understanding cancer treatment process. It requires awareness and therefore resources.

Pre-mentalising modes

Finally, the following pre-mentalising modes (or non-mentalising modes) are also described as adapt

ed for the cancer population using the authors' experience (Bateman and Fonagy, 2006; Fonagy and Campbell, 2016).

Psychic equivalence: Recognising how past and present bodily sensations, feelings, behaviours, and thoughts may appear similar but, through reflective thinking, acknowledging that the past and present experiences are distinct. This involves disrupting the perceived traumatic equivalence between past events (traumas) and the present event (cancer care) by noticing the conflation of ideas.

Teleological stance: By pausing and noting the similarities in bodily and affective experiences between the past and present, clinicians can disrupt the teleological stance that drives avoidance. Avoidance can have significant implications in cancer care, as patients may avoid investigations and treatments that evoke historic feelings of abuse or neglect. Disrupting repetitive behavioural patterns helps re-engage patients with their cancer care.

Pseudo-mentalisation: When patients living with cancer become too focused on factual clinical details such as clinical trials, research data and treatments side effects, it can appear as if affective and cognitive processing is occurring that appears helpful. However, it is often the case that the patient is really becoming increasingly non-mentalising and therefore anxious and mistrustful of care. While it is important to allow patients autonomy and control, such clinical details are likely to lead to hyperarousal and disengagement that will likely worsen trauma symptoms and outcomes generally.

These proposed interventions based on mentalisation theory can aid individuals with cancer-related post-traumatic stress in understanding their emotions, thoughts, and behaviours, enabling them to continue with their cancer care. Through mentalisation, patients can improve their communication with those around them, while clinicians and other members of the care team gain a deeper understanding of the patient's emotional and cognitive experiences to maintain their patients' engagement with cancer care.

Practical suggestions for framework delivery

To operationalise and deliver the framework based on mentalisation theory in clinical practice for individuals with cancer-related post-traumatic stress, here are some practical suggestions base on our previous research (Anderson et al., 2024):

Training and Education: Clinicians and healthcare professionals involved in cancer care should receive training and education on mentalization theory and its application in working with patients experiencing trauma. This training can help them understand the key concepts, interventions, and techniques involved in mentalization-based practice.

Assessment: Develop a systematic approach to assess the mentalizing capacity of patients with cancer-related post-traumatic stress. This assessment can include evaluating their ability to reflect on emotions, thoughts, and behaviours, as well as their capacity to consider the minds of others. Use standardised measures or clinical interviews to gather this information.

Establishing a Therapeutic Relationship: Focus on building a strong and trusting therapeutic relationship with the patient. This involves creating a safe and non-judgmental space where patients feel comfortable expressing their emotions and thoughts. Establish clear boundaries, empathic communication, and active listening to foster trust and openness.

Psychoeducation: Provide psychoeducation to patients about the impact of trauma on their emotional and cognitive experiences. Explain the concept of mentalisation, the role of the "old brain" and "new brain" in stress responses, and the importance of recognising bodily sensations and affective states. Help patients understand how trauma may influence their perceptions and behaviours in the context of cancer care.

Emotion and Body-Focused Techniques: Teach patients techniques to focus on emotions and bodily sensations. This may involve mindfulness exercises, grounding techniques, and controlled breathing to help patients become more aware of their internal experiences. Encourage patients to pause, reflect, and notice their affective and sensory responses before reacting automatically.

Reflective Enquiry: Engage in reflective enquiry with the patient to explore their internal world and experiences related to trauma and cancer care. Use open-ended questions to encourage patients to share their thoughts and emotions. Avoid assumptions and preconceptions, and genuinely seek to understand each patient's perspective.

Validating and Normalising Experiences: Validate the patients' emotions, thoughts, and reactions to trauma and cancer care. Help them understand that their experiences are understandable given their history and the challenges they are facing. Normalise their responses, reducing self-blame or shame associated with their reactions.

Transparent Communication: Be transparent in your own communication with the patient. Share your thoughts and emotions when appropriate to promote mutual understanding and trust. This can help challenge the patients' assumptions and encourage open dialogue.

Collaborative Treatment Planning: Involve the patient in collaborative treatment planning, where their preferences, goals, and concerns are taken into account. This collaborative approach empowers patients and enhances their sense of agency in their own care.

Regular Supervision and Reflective Practice: Provide regular supervision and opportunities for clinicians to reflect on their own mentalising capacity and challenges in working with patients with cancer-related post-traumatic stress. Supervision can help clinicians maintain their own mentalising stance and explore strategies for effectively supporting patients.

Multidisciplinary Collaboration: Foster multidisciplinary collaboration among healthcare professionals involved in patients' care, including oncologists, psychologists, nurses, and social workers. This collaborative approach ensures that mentalisation-based interventions are integrated into the broader cancer care plan and that all team members work together to support the patient's mentalising capacity.

Conclusion

In conclusion, we have identified a clear role and value for a framework based on mentalisation theory for clinicians and healthcare professionals working with individuals experiencing cancer-related post-traumatic stress. This framework emphasises the importance of a strong therapeutic relationship in addition to incorporating key elements such as psychoeducation, emotion and body-focused techniques, reflective inquiry, and transparent communication. The framework also highlights the significant of multidisciplinary collaboration and regular supervision to ensure comprehensive and effective care for patients. By operationalising and delivering this framework in clinical practice, professionals can effectively engage patients in therapeutic work, while contributing to patients' overall wellbeing and help them navigate the complex psychological consequences of living with cancer-related post-traumatic stress. This holds the potential to enhance patient outcomes, including improved engagement with cancer treatment, better communication, and increased understanding of emotions and behaviours.

Further research and evaluation are warranted to assess the efficacy and long-term impact of this framework in clinical settings. It is anticipated that patient engagement into cancer care will improve in this group of patients, thereby improving morbidity and mortality. By building on the existing evidence and refining the operationalisation of the framework, healthcare professionals can continue to advance their understanding and practice in supporting individuals with cancer-related

post-traumatic stress. Ultimately, the application of the mentalisation-based framework has the potential to make a significant contribution to the field of psycho-oncology and improve the overall quality of care for patients with cancer-related post-traumatic stress.

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A Theoretical Introduction to Working with Nightmares using Embodied Reprocessing™

Dzmitry Karpuk and Celia Dawson

Abstract

This article introduces the Embodied Reprocessing™ method, a unique contribution and structured framework for therapists to manage and process nightmares (Karpuk & Dawson, 2012; Karpuk, Stoneham & Davies, 2019). This article provides a theoretical introduction to the method. These are excerpts from the manual outlining an up-to-8-session framework that has been regularly taught in the UK and worldwide since 2012. This framework offers therapists a unique contribution by combining embodied, experiential and systemic interventions and tools and understanding for managing and processing nightmares by using proactive techniques and experiential learning to promote healing and reduce re-traumatisation.

1. Introduction to the Embodied Reprocessing™ Framework for Working with Nightmares

1.1. Overview of the Embodied Reprocessing™ Framework for Working with Nightmares

The Embodied Reprocessing™ framework has embedded within it the Cultural-Social Model (CSM) of dreams. This is a novel perspective regarding the nature of dreaming. Also contained with the framework are concepts taken from Hermann/Piaget's three stage model as well as elements from Porges's Polyvagal theory. The net result is a safe and stable model for working with nightmares effectively. The Embodied Reprocessing is a process that helps the body to reprocess the traumatic reactions that it went through and had to adjust. Unlike the body's first experience this time there are supports, understanding, care and attention that help the body to allow the difficulties experienced to be reprocessed.

We will be using an array of systemic, experiential and embodied tools which help facilitate the re-evaluation and reprocessing of problematic sleep disorders – including nightmares. Re-evaluation (or re-authoring) of problematic issues and meaning is specifically aimed at avoiding re-traumatisation and is achieved by anchoring the client in the here and now of experience during the processing stage. Clients are encouraged to shift their attention away from the dream content (report) to the bodily process of dreaming, during which they are supported to manage any distressing embodied memories in the here and now. Essentially the process is to go from a narrative dream interpretation – causing re-enactment of trauma – to the alienated experiences and bodily sensations in the present moment being supported safely. The combination of the Cultural – Social model and the Embodied reprocessing method are a coherent theory and practice system which is delivered throughout the UK in a series of CPD training events.

The Embodied reprocessing framework is suitable for clients with high intrusion and hyperarousal scores, as well as those with high avoidance scores. However, it is also useful for any client interested in exploring their usual dreams. As a member of the gradual exposure methods family, it stands out as a method which addresses traumatic experiences in a very gentle way, working at the level of embodied experiences.

Client Needs	Applicability of Embodied Reprocessing™
1. High Intrusion and Hyperarousal	Suitable for clients with high intrusion and hyperarousal scores.
2. High Avoidance	Suitable for clients with high avoidance scores.
3. Interest in Dream Exploration	Suitable for any client interested in dreamwork.

1.2. The Importance of Addressing Nightmares

There is a significant amount of research reporting that up to 90% of patients with PTSD experience insomnia symptoms, and 50-70% experience nightmares (Koffel, Khawaja, & Germain, 2016; Spoormaker & Montgomery, 2008). A diagnosis of PTSD or CPTSD tends to have nightmares as a core symptom, which contributes to the functional impairment and distress of the individuals involved. Addressing nightmares effectively alleviates significant sources of anxiety whilst also improving sleep quality and enhancing overall therapeutic outcomes (Walker, 2009; Lanius et al., 2001; Mellman et al., 2001). Nightmares are part of the six criteria used to diagnose PTSD and CPTSD (Emmerich, 2017):

1. Intrusion Symptoms: Distressing memories, flashbacks and nightmares.
2. Avoidance: Avoiding reminders of the traumatic event.
3. Negative Alterations in Cognition and Mood: Prevalence of negative thoughts and emotions
4. Alterations in Arousal and Reactivity: Irritability, hypervigilance, and sleep disturbances.
5. Affective Dysregulation: Intense emotions and mood swings (CPTSD-specific).
6. Interpersonal Difficulties: Problems in relationships and social functioning (CPTSD-specific).

PTSD

1. Intrusion Symptoms: Distressing memories, flashbacks, and nightmares.

2. Avoidance: Avoiding reminders of the traumatic event.

3. Negative Alterations in Cognition and Mood: Persistent negative emotions and beliefs.

4. Alterations in Arousal and Reactivity: Symptoms such as irritability, hypervigilance, and sleep disturbances.
PTSD often involves symptoms that occur after some traumatic events.

CPTSD

1. Intrusion Symptoms: Same as PTSD, including distressing memories, flashbacks, and nightmares.
2. Avoidance: Same as PTSD, avoiding reminders of the traumatic event.

3.Negative Alterations in Cognition and Mood: *Persistent and pervasive negative emotions and beliefs.*

4. Alterations in Arousal and Reactivity: Same as PTSD, with symptoms like irritability, hypervigilance, and sleep disturbances.

5. Affective Dysregulation: Difficulty in controlling emotions such as persistent sadness, suicidal thoughts, explosive anger, or inhibited anger.

6. Disturbances in Relationships and Self-Perception: Issues with relationships and a negative self-concept, which are distinctive to CPTSD and not typically part of PTSD criteria. CPTSD includes the core symptoms of PTSD along with additional symptoms that reflect more pervasive and persistent difficulties in affect regulation, self-concept, and relationships. These often stem from prolonged or repetitive traumatic exposure rather than a single event.

Trauma affects the whole human system and is a key indicator of disruptive sleep patterns (Lavie and Kaminer, 1991). A traumatic event inevitably stimulates (but usually over-stimulates) the body, and the brain gets flooded with neurochemicals involved within the survival mechanism. These neurochemicals may keep you alive at the moment of a traumatic event, but there can be a price to pay in terms of the impact of after-effects both on the mind and body. Nightmares can seem like replays of (or re-experiences of) traumatic events, and the body's responses are closely linked to the reactions during the traumatic event.

Trauma is a whole-body phenomenon and the complex system involved generally gets over- stimulated by the release of various neurochemicals involved in the survival process. The cost in terms of after-effects is generally considered the price to pay for survival, and nightmares and negative bodily reactions long after the events are what we are left with to try and restore balance to the system.

We know that many sleep-related movement disorders often accompany other sleep disorders and only sometimes require primary therapy (Silber, 2013). There is a negative somatic effect within sleep-related movement disorders (e.g., Bruxism (teeth grinding), leg cramps, etc.), and research is currently being carried out into the bodily effects of those disorders.

Sleeping and dreaming are vital to good health. Difficulties arise when sleeping is disrupted, and dreams are unwanted. Therapeutic solutions are many and varied and changing all the time, especially with the advent of neuroscience and body-oriented therapy modalities. The key is finding a solution for each individual who seeks help from therapy. Every human being has a different threshold for pain, stress, trauma, or simply coping with life, and there is no one size fits all in the history of the therapeutic process as we are humans and as such unique. The therapeutic end result is generally a compromise. By addressing nightmares, mental health professionals can provide crucial support that is tailored to each individual's unique needs, ultimately promoting better health and wellbeing for their clients.

Sleeping and dreaming are effective indicators of good health, and problems arise when sleep is disrupted, or dreams are unwanted. Neuroscience has pointed the way to more effective solutions in the modern world, and these revolve around the idea that every human is unique and has different thresholds or tolerances for pain or stress. Addressing nightmares is considered one of the key components of a trauma recovery model (Lee et al., 1995).

2. Theoretical Foundations of Embodied Reprocessing for Nightmare Treatment

2.1. Background and Development of the Method & the Evidence Base and Research Support

This framework was developed by a clinical team led by Systemic Family Psychotherapist Dzmitry Karpuk (Complex Trauma Therapists Network in the UK; Karpuk & Dawson, 2012), with contributions from the academic team led by Professor Tom Stoneham (University of York; Karpuk, Stoneham, & Davies, 2019). Karpuk and Dawson developed a novel method for reprocessing trauma-related nightmares and other sleep disturbances called Embodied Reprocessing (ER, previously known as Systemic Experiential Embodied Reprocessing, or SEER). Stoneham, on the other hand, formulated a new theory (the Cultural–Social model) of dreams which explained how the ER method could work.

This collaboration started as a response to a shortage of clinical interventions with Nightmares (Escamilla et al., 2012; Aurora et al., 2010; Foa et al., 2009) and included many other researchers and clinicians, with key collaborators being Dr Robert Davies (University of York), whose research encompasses memory and related phenomena, and Celia Dawson, a psychotherapist specialising in body-focused interventions. Since 2017, the team has worked on numerous projects, including co-designing and co-delivering CPD training workshops, conducting original research (case studies and collecting expected experiences on the application of this method), and producing resources

for therapists. Notably, the Embodied Reprocessing method, which has been regularly taught since 2012.

2.2 The Cultural-Social Model (CSM)

The Cultural-Social Model (CSM) of dreams has provided an alternative view of the nature of dreaming, positing that dream reports are triggered by memories of the nocturnal experience of bodily and environmental changes, including cultural influences and social expectations (Stoneham, 2019). Embodied Reprocessing embraces a series of systemic, embodied and experiential tools which facilitate re-evaluation and subsequent reprocessing of problematic sleep disorders such as nightmares. This works at the level of embodied experience. The combination of CSM with Embodied Reprocessing provides a coherent merging of theory with practice, which is delivered through CPD training events held throughout the UK.

The Cultural-Social model of dreams, developed by Professor Tom Stoneham (Stoneham, 2019), offers a departure from traditional Freudian theories (Freud, 1900/1955). It challenges and rejects three of Freud's fundamental theses:

1. The dreaming process does not influence Dream Content:
According to the Cultural-Social model, the process of dreaming itself shapes or influences the content of dreams. The model posits that dream content is not a product of the unconscious Mind's efforts to fulfil wishes or desires.

2. Dreams Are Encoded into the Memory During Sleep:
This model asserts that dreams are not stored in memory during sleep. Therefore, the dream content is not something that can be retrieved or recalled accurately upon waking.

3. Dreams Are Not Recalled from the Memory During Waking:
Since dreams are not encoded in memory, they are not retrieved or recalled in a traditional sense when a person wakes up. What we remember as dreams are mainly confabulations that we keep reconstructing.

Implications of Confabulation
If dreams are indeed confabulations, this has significant implications:
- The 'retelling or dream deconstruction' of the dream provides no access to the causes of the dream (Rosen, 2013)
- The process of retelling a dream does not offer insights into its origins or underlying causes.

Meaning and Informativeness
Despite rejecting Freud's first three theses, the Cultural-Social model acknowledges that dreams can still be meaningful and informative, albeit in a different way:
- According to CSM, dreams can hold significance or provide information, but not in a manner that directly aids in reprocessing traumatic experiences. The meaning derived from dreams is shaped by cultural and social contexts rather than subconscious drives or memories.

Relevance to Embodied Reprocessing
The Cultural-Social model (Stoneham, 2019) supports the use of Embodied Reprocessing in treating trauma-related sleep disturbances. Focusing on the embodied experiences during dreaming is more beneficial than interpreting the content of dreams (Loftus, 1996). By shifting the focus from dream content, which is shaped by cultural and social contexts, to the bodily processes and managing distressing embodied memories, this process reduces retraumatisation, supporting clients to stay present as much as possible while attending to past memory contents.

2.3. Insights for Treating Nightmares

Stephen Porges' Polyvagal Theory (Porges, 2011) offers significant insights that can be particularly useful for Embodied Reprocessing™, especially when dealing with nightmares associated with trauma. For clients experiencing nightmares, understanding and identifying which state they are in can help them learn to shift from a state of high alert (fight or flight) to a state of safety and social engagement (rest and digest).

1. Regulation of arousal and parasympathetic response: Embodied Reprocessing™ can utilise techniques derived from Polyvagal Theory to help clients manage their physiological arousal. Working with the body using techniques such as breathing and grounding exercises can reduce the intensity of nightmares by modulating the nervous system's response and promoting a state of calm and safety.

2. Teaching clients how to use the Polyvagal Ladder to build their resilience is crucial for clients who experience frequent nightmares. It empowers them with tools to self-soothe and manage distress in healthier ways.

3. The Polyvagal Theory highlights the importance of perceived safety and social connection in regulating emotional and physiological states. Embodied Reprocessing™ involves using therapeutic techniques that strengthen the client's capacity to engage with others and feel safe, which can be pivotal in processing traumatic dreams.

4. Trauma Release: Nightmares often serve as a replay of traumatic events or as a manifestation of unresolved trauma. The Polyvagal Theory suggests that through the physical state of safety, the body is more likely to access states conducive to healing trauma (example working with embodied experiences here and now).

In summary, The Polyvagal Theory offers a framework for comprehending and addressing the physiological mechanisms underlying trauma-related nightmares. By incorporating these principles, Embodied Reprocessing™ furnishes therapists with clear guidelines for initial sessions, planning, and contracting work, starting with a focus on managing insomnia.
When processing nightmares in passive versus active survival modes, different approaches can be used to address the underlying trauma response associated with each state. Here's a breakdown of the differences in processing nightmares in these two survival modes:

1.Nightmares in Passive Survival (PTSD/CPTSD) Characteristics:
In passive survival, nightmares are often a chronic manifestation of past trauma. The client may feel overwhelmed, frozen, or disconnected, and their body is in a state of hypo-arousal.

Managing and Processing Approach:

- Grounding and Stabilisation: Prioritise techniques that help clients reconnect with their bodies gently, such as grounding exercises or sensory anchors (e.g., tactile or proprioceptive cues) to counteract the sense of dissociation.
- Slow Sensory Integration: Since sensory processing is often disrupted, reprocessing is introduced slowly. Encourage clients to explore sensations connected to safety, such as warmth or supportive pressure, helping them associate bodily sensations with security.
- Embodied Processing of Chronic Stress: For chronic stressors, help clients process specific sensory details linked to the nightmare (e.g., sounds or images) in a controlled way. Practising embodied safety responses - like gentle movement or orienting - can help shift the system out of freeze and mitigate the chronic stress response.
- Body Awareness in a Non-Intensive Manner: Help clients track sensations in a neutral part of the body (e.g., hands or feet) to avoid triggering intense memories. Passive survival states often require gentle reconnection to avoid overwhelming the client's system.

2. Nightmares in Active Survival (Recent or Acute Stress)
Characteristics: In active survival, nightmares are often related to recent stressful events and reflect a hyper-arousal state. Here, clients might feel more agitated, hypervigilant, and energized.

Managing and Processing Approach:
- Discharge and Release: Encourage movement or expressive exercises, like shaking or stretching, to release built-up tension. Active survival modes can benefit from exercises that allow the client to let go of excess energy safely.
- Calming Sensory Reprocessing: Hyper-arousal from recent stressors can make clients more sensitive to external stimuli. Use calming sensory inputs, such as rhythmic breathing or sounds, to counterbalance the body's heightened arousal.
- Embodied Processing of Immediate Stress: For recent stressors, help clients process specific sensory details linked to the nightmare (e.g., sounds or images) in a controlled way. Practising embodied safety responses—like softening the body or exhaling slowly—can mitigate the acute stress response.
- Grounding Through Present-Moment Awareness: Use grounding techniques that emphasise the connection to the present to shift focus away from the recent stressful events of the nightmare.

2.4. Understanding Nightmare Recovery: Herman/Piaget's Three-Stage Model
Herman/Piaget's three-stage model (Herman, 1992) of trauma recovery is another valuable concept that was integrated by Embodied Reprocessing™ when addressing nightmares. Each stage of the model offers distinct therapeutic goals, interventions and considerations tailored to treating trauma-related nightmares:

1. **Stage 1: Safety and Stabilisation**
Objective: To make clients feel safe in their life environment and within themselves. The aim of this stage is to help clients develop coping skills to manage their emotional and physical responses. Clients are helped to establish a routine in their daily lives, which helps them feel able to engage in deeper work. This will reduce the impact of nightmares.

2. **Stage 2: Remembrance and Mourning**
Objective: Process the traumatic memories through compassionate acceptance. In this stage, the focus shifts to actively working through the traumatic content of nightmares. Through the controlled and safe re-processing of traumatic events (often the content of nightmares), clients can begin to integrate these experiences into their narrative in a healthier way (Athena, 2011)

3. **Stage 3: Reconnection and Integration**
Objective: Rebuild the clients' connection with themselves and in their personal and professional contexts and integrate their new post-trauma identity.

This final stage helps clients re-establish trust in themselves and others, which is essential for those whose nightmares have isolated them or distorted their view of reality. Working with embodied experiences foster positive relationships, enhance self-esteem, and encourage healthy lifestyle changes. Therapists support clients to transfer their learnings to their social interactions and reduce the recurrence of nightmares by resolving psychosocial conflicts.

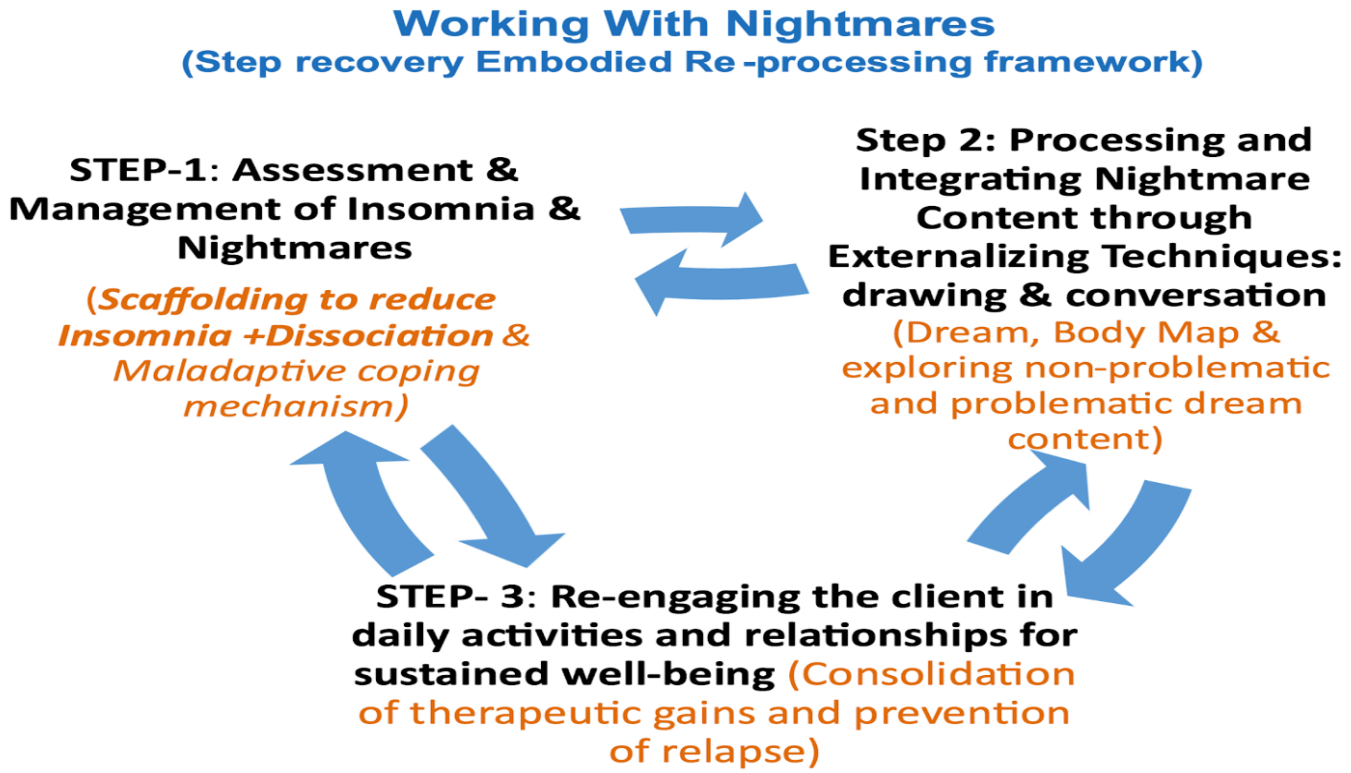
2.5. The Embodied Mind theory
Embodied Mind philosophical ideas, notably those developed by Varela and other scholars (Varela, Thompson & Rosch, 1991), are incorporated into the clinical method known as Embodied Reprocessing. These ideas stress the importance of the interconnectedness of mind, body and the environment. Consciousness and perception are deeply rooted in physical and experiential experiences. Embodied Reprocessing incorporates these ideas into a structured manualised treatment specifical-

ly designed to address and alleviate the distress caused by nightmares.

This method leverages the understanding that nightmares, as embodied experiences, can be re-processed through techniques that engage both the cognitive and physical aspects of the individual's experience. Trauma can also impact an implicit memory stored within the body – which is also unconscious and generally operates when you are exposed to certain triggers in the environment. Explicit memory is the kind of memory that you must consciously think about, like remembering someone's name or address or an exam question. It does not operate automatically and can be searched for in a conscious way.

Now, if you can change the implicit memory into an explicit memory – by using body sensation and felt senses, you can gain a bit more control over the unconscious aspect of it (Van der Kolk et al. I 1984, 2006). Once the implicit has become explicit, you become aware of where the unconscious aspect came from, and this gives you awareness and choices of what to do next. Working with the body and the sensations and feelings that emerge can eventually help remove or make the hidden unconscious body memories easier. Embodied reprocessing is essentially reshaping or altering the implicit body memories and creating a way of transforming them by bringing them into conscious awareness.

3. A short introduction to a clinical Implementation of Embodied Reprocessing™



Step 1: Initial Assessment, management of insomnia and Nightmares and intervention for internal and external safety (Herman, 1992; Schauer & Elbert, 2010; Miller & McIntosh, 2006; Pagel & Kwiatkowski, 2010).

Step 2: Integration of nightmare content by facilitating externalising interventions (drawing and conversation). This step also involves assessing the client's readiness to confront and process distressing episodes through the externalisation process (Herman, 1992; Agarkov, 2011; Gendlin, 1986; Garfield, 1974; Hartmann, 2001).

Step 3: Consolidate therapeutic gains and prevent relapse while re-engaging the client in daily activities and relationships for sustained wellbeing (Herman, 1992; Tedeschi & Calhoun, 1996; Wilmer, 1996).

People who suffer from nightmares often have difficulty in engaging in everyday life and become isolated. Their roles within their community and their personal relationships often break down. This is, therefore a crucial stage, where clients can be supported to reconnect with themselves, establishing a sense of self-worth. From this stage, the therapist can help them gradually to reintegrate into their community settings and into their family and work life.

It is important that this process engages clients in community-based recovery. The goal of therapy is not only personal but the ability to engage in meaningful relationships. They will have learned coping strategies for use in their daily social interactions which will help with their emotional stability and their connection with the world around them. The resolution of deeper psychosocial conflicts will strengthen their ability to engage in supportive relationships, which is a key to long-term healing. These interactions will reduce the recurrence of nightmares.

Conclusion

Embodied Reprocessing (Karpuk & Dawson, 2012; Karpuk, Stoneham, & Davies, 2019, 2021), a clinical short-term therapy method for treating nightmares, is grounded in several key theoretical concepts where the Cultural-Social Model (CSM) was most influenced and helpful in manualising this method. Other concepts include Embodied Mind Theory, Herman/Piaget's Three-Stage Model and Polyvagal Theory. These concepts provide the theoretical underpinnings that inform and shape the Embodied Reprocessing approach, offering a comprehensive framework for understanding and addressing nightmares in clinical practice.

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