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Working with Complex Trauma Integrating a Phased Stage Approach with Psychodynamic Therapy: Assessment and Formulation

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Abstract

This paper aims to explore the theoretical and clinical development of working with Complex Trauma (CT) through the integration of a phased-stage structure with the psychodynamic approach. The focus will be on Assessment and Formulation.

While reputed for its non-directional method, it could be suggested that the psychodynamic model might not lend itself well to incorporating a therapeutic structure, such as a phased-stage system, with its clearly directive requirements. The use of transference and countertransference, which are fundamental to psychodynamic work, is however inherently body-focused; this may provide a framework for integrating a phased-stage approach and Embodied Reprocessing (ER) practices when working with CT. Furthermore, the boundaries that are firmly held in psychodynamic practice support the establishment of psychological safety (Jacobs, 2024; Bridges, 1999). The recognised need for client stabilisation while working with CT is paramount and physiologically necessary in order that the therapeutic process may proceed safely and, therefore, ethically (Rothschild, 2021; Steele et al., 2005; Fisher, 1999). Indeed, a recent study by Foreman et al. (2024) supports the theory that stabilisation can be useful in the reduction of CT symptoms.

Trauma specialised psychodynamic therapist, Adela Stockton, discusses the compatibilities and challenges of incorporating directed bodywork and additional support resources into her clinical practice during Assessment and Formulation, while remaining fundamentally true to psychodynamic thinking.

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Introduction

Complex Trauma (CT) or Complex Post Traumatic Stress Disorder (CPTSD) is categorised as the sequelae of having experienced repeated multiple traumatic events over long periods of time, where the survivor held neither power nor any real hope of release from the experience (WHOa, 2025; Herman, 1992). Recovery can be a long process, often resulting in, at best, symptoms feeling more manageable than cured. This is in contrast to Post Traumatic Stress Disorder (PTSD), which is usually caused by a single life-threatening traumatic event, where recovery may feel more sustained (WHOb, 2025).

A principal challenge to working therapeutically with CT is the risk of causing re-traumatisation through re-visiting the traumatic event through narrative (SAMHSA, 2014). Trauma is memorised at a cellular and, therefore, deeply visceral level and any thought process that involves recalling the traumatic event carries the potential to trigger not only an emotional but also a powerful body response (van der Kolk, 2014). Without the ability to effectively self-regulate or feel safe in a relationship, the client is at risk of dissociating and being further damaged rather than supported by the therapeutic process. Indeed, psychotherapist and author Babette Rothschild recently stated that the ‘biggest mistake in trauma therapy work’ has been to skip an initial period of stabilisation, before any processing work begins. She claims that this can be integrated into any therapeutic approach since it is a 'structure rather than a method' (Rothschild, 2022).

Fundamentally aligned with the psychodynamic approach since qualifying in 2013, six years ago, I was employed by a third-sector agency supporting survivors of torture, where therapists were required to implement psychiatrist and author Judith Herman’s Three Stage Trauma Recovery model (Herman, 1998). I had previously undertaken CPD training in Embodied Reprocessing (ER) (Karpuk & Dawson, 2012; Karpuk, Stoneham, & Davies, 2019; Karpuk & Dawson, 2024), similar to psychotherapist and author Peter Levine’s Somatic Experience work (Somatic Experiencing International, 2025), and this post offered me the opportunity to practice an integration of the phased-stage approach within psychodynamic principles. Supported by an experienced ER clinical supervisor, I quickly understood that it was indeed neither safe nor ethical to work therapeutically with such traumatised individuals without the initial baseline framework of the stabilisation stage (Willis et al., 2023; Courtois, 2008). Safety and accountability were paramount, starting with (Risk) Assessment and Formulation, although the directive nature of utilising these in a more structured way aroused some considerable resistance from my psychodynamic perspective on free association.

The aim of this paper is to examine the intersection between psychodynamic and ER practice when working with CT, with a focus on Assessment and Formulation. Areas of potential for clinical collaboration without necessary compromise and areas where it could be proposed that ethical negotiation on theoretic rationale effectively becomes essential in light of client safety, will be explored.

Psychodynamic Approach

Psychodynamic counselling/therapy has a reputation, among others, for its firmly held boundaries and non-directional approach. These are considered essential to supporting the provision of a safe thinking space or therapeutic frame wherein the client may themselves bring the unconscious into conscious awareness without due influence from the therapist or the environment. With its focus on early years relationships and attachment dynamics formulating potential links between the past and present, the therapy can evoke painful emotions in the client as part of the healing process (Jacobs, 2024; Bridges, 1999).

It could be surmised that where the psychodynamic therapeutic relationship proposes such an opportunity to 'think together' about the issues arising for the client, the physical body experience might be considered secondary to the psychological. However, it is, in fact, the very focus on feelings experienced in the client's body (which includes the brain) that provides the vehicle for therapeutic processing through emotional expression and, ultimately, mind-body integration. This, in addition to the use of transference and countertransference, the felt sense that guides the psychodynamic therapist in offering potentially useful interventions, is fundamental to the strengths of this modality (Moneta & Kaechele, 2023; Rayska, 2017).

The ability to safely emotionally process in this way, however, can depend on the degree to which a client is able to feel safe in their body. Often found to be rooted in early human years and repeated through adult life, the resulting symptoms of CT include dissociation (feeling disconnected from oneself and others), persistent intrusive thoughts, sleep disturbance and nightmares. While also present in PTSD, CT additionally acknowledges a diminished sense of self with a heightened sense of guilt and shame, difficulties maintaining a sustained connection in relationships and a severely reduced ability for affect regulation (WHOa, 2025). This means that it may be a challenge for a client suffering from CT to remain within or have the ability to return to the Window of Tolerance during the therapy session, where benefits from process work can be optimised (NICABM, 2025; Seigel, 2020).

Phased-Stage approach

Embracing Judith Herman's 3 Stage Trauma Recovery model (Herman, 1998), which incorporates interchangeable stages of 1. Stabilisation, 2. Remembering & Understanding, 3. Integration, a phased-stage approach such as ER, initially focuses almost entirely on the body (Moneta & Kaechele, 2023). Establishing a sense of physical safety (Stage 1) is key to the client being able to manage the feelings arising from starting to think about what has happened to them (Stage 2). Reconnection with others and community (Stage 3) is only possible further to reconnection with self through Stages 1 & 2.

Understanding how learning to regulate the body supports the ability to regulate emotions, and that only when able to access the Window of Tolerance is it safe to start psychological processing, can take time. Meantime however, the Therapeutic Alliance has the opportunity to develop. Once therapy starts, feelings may well be triggered, but with the groundwork of Stage 1 in place, the client (with the therapist) can draw on stabilisation strategies at any point to help maintain affect regulation (Levine, 1997).

A client can, therefore, learn and understand how stress is held in the muscles and that through practising simple repetitive physical movements on a regular daily basis, the stress can be released from the body. This is not necessarily through high-velocity gym workouts, long-distance running or joining a yoga class, although if these are activities a client already enjoys, they may be the movement of choice. Rather, it can be a walk in the park or countryside, which includes the benefits of spending time in nature, also known for calming the Vagal System (Shuda et al., 2020), simple arm, leg, and body stretches while standing, sitting in a chair or lying on the bed or throwing a ball back and forth with another person, even a pet or a child (CTI, 2025).

Breathwork can be practised together in the therapy room, using longer out breaths to reduce hyper-arousal (anxiety) and shorter out breaths to raise hypo-arousal (depression). Some clients like to start or end sessions with a five-breath exercise, which helps to build their skills and confidence to utilise this strategy outside the room when feeling triggered, for example. ER further utilises visualisation techniques that support the client in managing uncomfortable sensations in the body aroused by CT to establish good enough stabilisation for the work of processing trauma to commence safely. ER also maintains the essential benefits of systemic thinking, which could entail referring to other agencies for simultaneous physiological and/or social support (CTI, 2025).

While it is possible to work on these grounding practices for stabilisation through psychoeducation without straying from psychodynamic principles, working any more directionally and/or in tandem with resources outside the room would not be usual practice. However, it is perhaps useful to reflect on every single aspect of the therapist's interaction with the client, from the first point of contact to the way the client enters, sits in and exits the room to their response to the end of therapy is psychodynamically relevant. While maintaining a clear awareness of the boundaries of the therapeutic frame, elements outside those boundaries can still be incorporated into the work and underpinned by psychodynamic principles—for example, when working within multidisciplinary statutory organisations or conducting sessions outdoors (Kotze, 2023; Hardie, 2021).

Assessment & Formulation

Clients living with CT inherently experience a sense of lack of internal safety, which can impact their ability to self-regulate and engage in stable relationships and may include periods of suicidality (MIND, 2025). The rationale for undertaking a structured assessment and formulation of the client's risk factors and individual needs in terms of initial stabilisation and capacity to make use of therapy and/or requirements for additional or alternative support (Fisher, 2023), makes sense, although this may seem more formal than that to which the psychodynamic therapist is accustomed. Working in an agency setting may provide more support for the therapist in terms of risk management than in private practice, but clinical accountability nonetheless lies with the individual practitioner. Additionally, working to a contract can support this and, indeed, is most times required in an agency setting.

Informing the client, in the same way as arrangements are always clearly agreed upon, that an initial number of sessions will be for assessment (including formulation) before it is agreed to proceed to stabilisation work and eventually, therapeutic processing still maintains the boundaries of psychodynamic practice. It also upholds a more clearly defined space for the client or therapist to withdraw should they feel they are not a useful match before therapy formally starts. Such as when the therapist assesses the risk to be too high for their scope of practice or the client does not feel the therapist is well aligned with them.

Where a potentially suicidal or self-harming client has no social support and/or no contact with their GP, is it appropriate to work with them in private practice, for example? Where such a client does have social support, contact with a GP and perhaps Community Mental Health support, private therapy may be suitable on the agreement that the therapist can contact these services on the client's behalf should they disclose a suicide plan, for example. In terms of confidentiality, a signed contract stating the therapist's duty of care in view of the 'risk of causing serious harm to self' and that this can be acted upon, even without consent, also maintains clear boundaries.

Using a short assessment tool such as CORE-10 (Barkham et al., 2012), PHQ9 (Kroenke et al., 2001) or GAD7 (Spitzer et al., 2006) can be useful in assessing risk (McShane, 2018), although asking direct questions may be seen as a box-ticking and out of keeping with the free association that is aligned to the psychodynamic approach (Rigby, 2015). However, undertaking these tools in a psychodynamic way is still possible, utilising the benefits of psychodynamic language. For example, questions may be expanded to wonder about daily habits such as sleep and eating or self-awareness around feelings of anger and can be used in tandem with the perhaps more usual approach of inviting the client initially to say something about themselves, their life and aims for therapy.

Psychoeducation and thinking time regarding what might be possible for the client in terms of bodywork, the social dynamic (including potential additional agency support) and self-care support the premise of meeting each person with acceptance and respect and minimise the risk of setting expectations, the latter of which would not be psychodynamic. Rather than being directive, however, psychodynamic formulation can be collaborative and supportive of autonomy. CT clients have the opportunity to understand how engaging in stabilisation is an essential part of their therapeutic process, while the therapist gains awareness of what might be possible in terms of the client’s capacity to benefit from an integrated therapeutic experience (Garrett et al., 2022).

Repetitive movement, muscle stretches, guided breathing, and visualisation techniques may be new and possibly challenging for some clients. Asking them what they would usually do can be a helpful platform upon which to build additional potential strategies. Many clients are able to agree to gently stretch their limbs and bodies in tandem with a breath in to stretch and a longer breath out to relax. Clients already familiar with meditation or internal visualisation, may be able to start creating a virtual ‘comfortable space’ to hold in mind as a resource for internal safety (CTI, 2025; Lampe et al., 2024).

In terms of self-care, for some, a relaxing bath may not be a pleasant experience or therapeutic massage may feel too intrusive; however, walking in nature, spending time with pets or applying touch to accessible parts of the client's own body may feel acceptable. For clients who use high-impact self-soothing methods, however, such as extreme sports or sexual practices, muscle stretches that involve more weight or pressure behind the movement may be appropriate. These might include pressing the hands against a wall with the full body weight behind or lifting the body with the arms while seated in a chair (CTI, 2025).

Maintaining, even promoting, meaningful contact and connection with others need not be limited to friends and family; they may be colleagues, teammates (sport), or support group communities (Matheson, 2016). The latter may require a referral by the therapist, although psychodynamically, the potential for this to be received (consciously or unconsciously) by the client as rejection can present a challenge (Counselling Tutor, 2025). Hence, the usefulness of psychodynamic language is always tentative and careful to avoid any suggestion of undermining client integrity. Alternatively, additional support may be initiated by the client outside. Building a regular working relationship with a gym coach or massage therapist, for example, can help to replace previously unhealthy interpersonal dynamics in a healthier way.

While psychodynamically, everything is relevant and would still fall under the umbrella of 'the work', a clearly defined assessment of risk when working with CT not only protects the safety of the client but also the integrity of the practitioner. Formulation duly supports the clinical rationale for potentially signposting or referral to an additional agency, such as for addictions or physical support, that may be undertaken in tandem with attending psychological therapy (Lampe et al., 2024).

Conclusion

Ways in which psychodynamic practice and the ER approach may be integrated, with reference to working with CT, have been examined, with a particular focus on undertaking Assessment and Formulation. While it is clear that supporting a client through the stabilisation stage of trauma recovery is directional, perhaps raising resistance for the psychodynamic practitioner, potential ways of navigating this so that the work remains underpinned by psychodynamic thinking have been identified.

With its integral body orientated aspect as outlined above, it could be argued that the psychodynamic approach might lend itself well towards integration with ER in this context. Equally, that holding clear boundaries and the adherence to the therapeutic frame would fit in terms of containment and holding, while using psychodynamic thinking and language to navigate the management of directions.

As rising numbers of clients suffering from CT attend therapy, the proposal of integrating ER with the psychodynamic modality, with a view to supporting an initial stabilisation stage of the work, is perhaps an opportunity to be usefully embraced.

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