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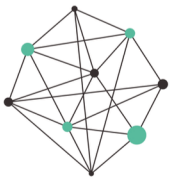

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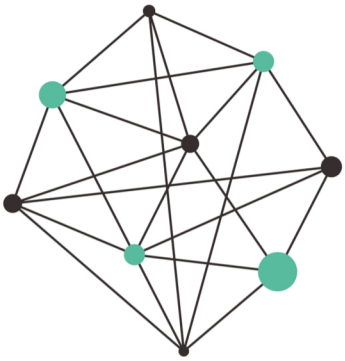

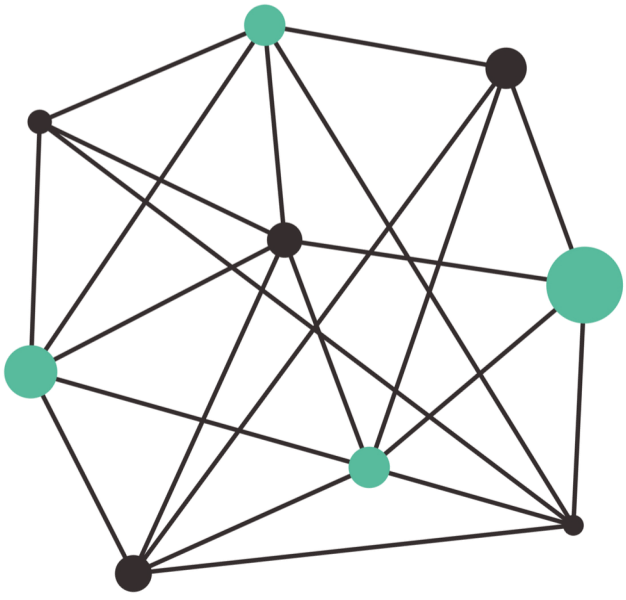

Content

Addressing the confusion in language within the literature of trauma: A reflective account and conceptual synthesis

Michael Guilding

Abstract

There is much confusion in the literature concerned with our biological responses to threat particularly as regards the states of "Freeze" and "Tonic Immobility". The term "Freeze" is used by various authors to describe three quite different biological states, while an unchallenged decades-old hypothesis concerning Tonic Immobility may have obscured our understanding of parasympathetic shutdown in response to a seemingly inescapable threat to life. This confusion can prevent therapists from clearly understanding trauma responses and thus limits our ability to help our clients. This article examines some contradictions in the literature and proposes a clearer terminology for describing human fear responses.

This reflective account, that synthesizes selected literature with clinical and personal observations, is an extract from Michael Guilding's forthcoming book "Fear in the Therapy Room: A survival guide for working with complex trauma", due to be published in June 2026 by Hammersmith Books, who have given permission for its inclusion in the Journal.

Article type: **Reflective account**

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Outlining the problem

In the course of trying to understand our fear-system there have been many occasions where I hit a "roadblock" and just couldn't make sense of what I was reading. Over time, the problem resolved into two main issues.

1. I could not understand why there was such confusion over the use of the word "Freeze". It is used with great frequency throughout the literature of threat-response, but it means different things for different writers. Some use it to describe the Orienting Response where we evaluate a threat and prepare to respond to it, some use it to describe a rigid "locked-muscle" state of hyper-arousal where the fight-flight response is active but "put on hold"[1], while many others use it to describe the state of metabolic shutdown when death seems imminent.

2. I struggled to get my head around the concept of "Tonic Immobility" and whether this refers to a rigid or a weak muscle tone. Tonic Immobility is a phrase used by scientists who study animals in their natural environment, to describe the physical collapse of prey animals when caught by a predator. Stephen Porges' Polyvagal Theory[2] explains the evolution of this physical collapse as a parasympathetic shutdown with weak muscle tone triggered by the dorsal vagus nerve. This appeared to conflict with many authors who describe Tonic Immobility as a state of sympathetic nervous system arousal characterised by rigid muscle tone.

Why does this matter?

Each of the three fear-system responses, which I characterise as Fear-Alert (the Orienting Response), Fear-Arousal (Fight, Flight, Freeze and Fright) and Fear-Collapse (Tonic Immobility)[3], is a distinct set of biological processes, so applying the same word, "Freeze", to these different responses is a recipe for confusion. Lack of clarity around Tonic Immobility limits our ability to help our clients recognize and understand the biological processes related to trauma. This confusion cost me a lot of time as I struggled to make sense of the biology of trauma and delayed my efforts to fully integrate it into my work with clients. A number of therapists attending my workshops reported experiencing similar difficulties.

My first struggles to understand

I first hit this confusion reading Peter Levine's book, In an Unspoken Voice[4]. I found it eye-opening and exciting, but on second reading I had some problems with understanding, starting with this passage:

[1] Kozlowska et al. (2015), p.267.
[2] Porges (2011).
[3] Guilding (2020).
[4] Levine (2010).

"When an organism perceives overwhelming mortal danger (with little or no chance for escape) the biological response is a global one of paralysis and shutdown. Ethologists[1] call this innate response Tonic Immobility (TI). Humans experience this frozen state as helpless terror and panic"[2].

This last sentence seemed to contradict both my own experience of an immobility collapse, and what I had been reading of Stephen Porges:

"In humans we observe a behavioural shutdown, frequently accompanied by very weak muscle tone. We also observe physiological changes: heart rate and breathing slow, and blood pressure drops." [3]

Both my experience and Porges' observations related to parasympathetic nervous system collapse, while Levine's description of Tonic Immobility in humans places it clearly in sympathetic nervous system arousal, matching Le Doux's definition of "Freeze"[4]. It also seemed to contradict much of what Levine himself had written. For example, Levine gives an example of an experience of "overwhelming mortal danger" using the explorer David Livingstone's account of being attacked by a lion which seized him by the shoulder, and shook him like a rat:

"It caused a sort of dreaminess in which there was no sense of pain nor feeling of terror, though quite conscious of all that was happening…. The shake annihilated fear, and allowed no sense of horror in looking round at the beast"[5]

As I examined sources to try to make sense of this confusion, it gradually dawned on me that, taken as a whole, the literature relating to our biological threat responses was a mess. Before reaching this conclusion however, I struggled with a sense that something had gone wrong with my brain because I couldn't arrive at a coherent understanding of what I was reading.

[1] Scientists who study animal behaviour in the wild.
[2] Levine (2010), pp.23-24.
[3] Porges (2011), p.14.
[4] Le Doux (1998), pp. 141-142. He describes a rat, subjected to a fear conditioning experiment which "…stops dead in its tracks and adopts the characteristic freezing position – crouching down and remaining motionless, except for the rhythmic chest movements required for breathing. In addition, the rat's fur stands on end, its blood pressure and heart rate rise, and stress hormones are released into its bloodstream".
[5] Levine (2010), p.50.

An overview of different frameworks

I found it helpful to draw up a chart which reflects my understanding of the terminology used by the key authors I examined in trying to resolve this issue. (Fig.1).

	Orienting	Mobilising			S	
	Sympathetic Nervous System				Parasympathe	
	Body preparing for action	Body active		Body locked	**Tipping-Point**	Mild shut-down	Mc shu
Cannon 1915		Flight	Fight				
Le Doux 1997		Flight	Fight	Freeze			
Bracha 2004	Freeze	Flight	Fight	Fright & Tonic Immobility		Colla	
Levine 2003, 2010	Arrest	Flight	Fight	Freeze & Tonic Immobility		Fold & (but often	
Schauer & Elbert 2010	Freeze	Flight	Fight	?	Fright & Tonic Immobility		
Baldwin 2013	Freeze-alert	Flight	Fight	Freeze-Fright & Tonic Immobility		Flac	
Kozlowska et al. 2015	Arousal	Flight	Fight	Freeze	Tonic Immobility	Co	
Guilding 2020	Fear-Alert	Fear-Arousal				F	
		Flight	Fight	Freeze	Fright		
Symptoms	Anxiety		Anger & Rage	Panic		Low Mood	D

Fig. 1 Terminology used for fear-system respons

More than a century ago Cannon[1] wrote of the Fight or Flight response, which later became very well known, and dominated our understanding of fear responses until relatively recently. By the time I first came across the concept of a "fear-system", Cannon's Fight and Flight had already been supplemented by the Freeze response, a hyper-aroused but "locked" rigid-muscle sympathetic nervous system response adopted when there was no obvious escape route from danger[2].

Bracha[3] expanded Cannon's work and included the Orienting Response (the body's preparatory response to danger at a distance) in the fear-system, but he named it "Freeze", while describing the state Le Doux had called Freeze as "Fright". Bracha also described Fright as Tonic Immobility. Having therefore characterised Tonic Immobility as a rigid-muscle hyper-aroused state, he then proposed the term "Collapsed Immobility" to cover the parasympathetic state of loss of muscle tone.

Levine[4] also included the Orienting Response in the fear-system but used the term "Arrest" for this stage, instead of Freeze. He reserved the word "Freeze" for hyper-arousal (consistent with Le Doux's use of the word) and proposed the term "Fold" for parasympathetic collapse. He used the term Tonic Immobility for both Freeze and Fold, (though he often also referred to both as Freeze).

Schauer and Elbert[5] in their "Fear-Cascade" followed Bracha's terminology (Freeze) for the Orienting Response but described Fright (which they also described as Tonic Immobility) as a tipping point into a parasympathetic collapse. They divided this collapse into "Flag" and "Faint". Their model does not appear to cover a state which is aroused but locked but does not necessarily tip into collapse – hence my question mark in fig.1.

Baldwin[6] named the Orienting Response "Freeze-Alert" and called the state of locked hyper-arousal both "Freeze-Fright" and "Tonic Immobility". He described parasympathetic collapse as "Flaccid Immobility".

Kozlowska and others[7] termed the Orienting Response "Arousal". They posited a Freeze state which was separate from Fright, and agreed with Schauer and Elbert in seeing Fright (which they also described as Tonic Immobility) as a tipping point into parasympathetic collapse, which, in agreement with Bracha they termed "Collapsed Immobility"

[1] Cannon (1915).
[2] Le Doux (1998).
[3] Bracha (2004).
[4] Levine (2003).
[5] Schauer and Elbert (2010).
[6] Baldwin (2013).
[7] Kozlowska et al. (2015).

Examining the evidence

Apart from the confusion of terminology, what I found difficult to understand in all this was why the term "Tonic Immobility", taken from the sudden collapse of animals in the wild in the context of predation, was being used to refer to hyper-aroused states of Freeze and Fright, and not to parasympathetic collapse, (apart from in Levine's 2003 article). It seemed clear to me from the work of Porges[1] on the evolution of the dorsal vagus, that animal and human Tonic Immobility was a form of parasympathetic collapse.

Case illustrations in the literature, supposedly describing Tonic Immobility, simply reinforced this view. For example, Kozlowska and others[2] gave a couple of vignettes of Tonic Immobility which seemed to describe a parasympathetic collapse, not a hyper-aroused state. One vignette described a 9 year old girl suffering from dissociative states, with no evidence of rigid muscle tone presented, and including an observation that her father "used gentle touch" to shift her out of these episodes, (exactly as the female doctor did for Levine himself when he was dipping in and out of parasympathetic collapse after his car accident.[3])

Their second "Tonic Immobility" vignette presented an account of a soldier, who experienced shutdown during a firefight, describing him as:

"feeling strangely detached from the situation. He was unable to lift his head, move his limbs or aim his rifle. He recalled a sensation of being drawn to the ground, a heavy sensation that he could not resist."[4]

He recovered from this collapse only when joined by another soldier, and not until he returned to his base did he realise he had been incontinent of both urine and faeces.

This account with the emphasis on the sensation of "heaviness" combined with complete physical collapse and the loss of bladder and bowel control would appear to indicate a powerful dorsal vagal response with flaccid rather than stiff muscle tone.[5]

[1] Porges (2011).
[2] Kozlowska et al. (2015).
[3] Levine (2010).
[4] Kozlowska et al. (2015), p.272
[5] Defecation during flight appears to be common in the animal world, involving a co-activation of dorsal vagal and sympathetic nervous system responses, but this example described a collapse rather than a flight, with no evidence presented of high muscle tone.

The origin of the confusion?

As I followed sources to try to understand how Tonic Immobility came to be associated with the (hyper-aroused) Freeze response, the evidence pointed back to Gordon Gallup[1] who worked on inducing states of Tonic Immobility in animals, by restraining them (or turning them upside down). The immobility states could last from a few seconds to hours, and Gallup noted that the higher the level of fear immediately before the restraint, the longer the animal remained immobile. Gallup proposed the hypothesis that Tonic Immobility may be "the evolutionary precursor to catatonic schizophrenia in man."

He described the chickens he experimented on in words that clearly convey his hypothetical perspective. He claimed that the restrained chicken

"...assumes an almost catatonic-like state" and also that in this state, "the legs may be flexed or extended, (often exhibiting signs of catatonic-like waxy flexibility)."[2]

"Waxy flexibility" refers to "a condition in which a patient's limbs retain any position into which they are manipulated by another person, and which occurs especially in catatonic schizophrenia."[3] In other words, there is a degree of muscular rigidity which can defy gravity.

I would suggest that doubts might be raised about the scientific objectivity of Gallup's observations. I suspect that his observations may have influenced subsequent researchers, and that this may be the chief reason that so many describe Tonic Immobility as a state of hyper-arousal, which then gets confused with the state of Freeze as described by Le Doux. Indeed, this approach is now built into a psychological measurement tool for evaluating Tonic Immobility[4] which precedes each question with "When I Freeze…", or "After unfreezing…". These are leading questions which will preclude experiences of Fear-Collapse that don't feel like a rigid-muscle "Freeze" state.

[1] Gallup (1977).
[2] Gallup (1977), pp.41-43.
[3] Merriam-Webster.com Medical Dictionary
[4] Lloyd et al. (2019).

The inclusion of such questions as “When I Freeze I take short quick breaths”, alongside “When I Freeze my muscles go limp” shows that two opposing biological states are being shoehorned into the “Tonic Immobility Response” which in my mind deprives it of any value as a scientific or clinical concept. If we are to understand our fear responses and their underlying biological processes, the language we use in describing our observations needs to be precise, the metaphors accurate. If I translate the sentence “When I Freeze my muscles go limp” into plain English, it conveys the meaning “when my muscles go rigid, my muscles are not rigid”. I think this neatly sums up the mess we have got into with the concept of Tonic Immobility.

For me, the key question at the centre of this confusion is whether there is tension or not in the muscles when an animal or human goes into a collapsed state when there is an imminent threat to their life. I would invite the reader to refer to https://www.youtube.com/watch?v=lAtW7nJUcRA, available on YouTube[1] This video shows an antelope in a state of Tonic Immobility, having been caught by a leopard. The antelope’s nose is being held in the leopard’s jaws, but when the leopard is distracted and loosens its grip, the antelope’s head simply flops to the ground. Its muscles appear to show no sign of “waxy flexibility”, but rather the flaccidity associated with “Collapsed Immobility”.

Gallup, in describing his experimental subjects observed “Parkinsonian tremors of the limbs”[2]. This makes me wonder whether, in his understanding of Tonic Immobility, he is conflating an immobile collapse (without muscle tone) with the subsequent transition out of immobility, (where muscle tone is recovered and tremoring often follows).

Conclusion

As a layperson examining this literature I am unconvinced that Tonic Immobility and Collapsed Immobility are separate biological states and would suggest that the introduction of the term Collapsed Immobility only became necessary because Gallup, in pursuing his dubious catatonia hypothesis, had hijacked the term “Tonic Immobility” as belonging to a rigid-muscle state.

[1] YouTube (100100 channel),
[2] Gallup (1977), p.41. He does appear to have a tendency to view his animal observations through the lens of human mental or neurological illness.

My own conclusion is that there is a rigid “locked” muscle state that can be properly termed “Freeze”, which indicates sympathetic nervous system hyper-arousal, (Fear-Arousal in my terminology), and a limp muscle state which could be termed Tonic Immobility, which involves a metabolic shutdown triggered by the parasympathetic nervous system, (which I call Fear-Collapse). Some of the confusion around this term may arise from the fact that the adjective “tonic” indicates muscle tone without specifying whether this is stiff or flaccid. However, as ethologists have used this term for many years for the collapse of animals in the face of an extreme threat to life, I think it should be retained for human collapse in similar circumstances. I would therefore discard the term Collapsed Immobility as being redundant.

The state of “Fright”, the peak of hyper-arousal, then straddles these two opposing systems as a tipping point, as Schauer and Elbert proposed. I have found this theoretical framework works well in clinical practice, describing my clients’ experiences with an accuracy that often evoked in them feelings of considerable relief.

It is easy to see how confusion arises in trying to describe fear responses, as they can shift so quickly from one state to another, and there are three types of “stillness” - Fear-Alert, Freeze (an aspect of Fear-Arousal) and Fear-Collapse - that might possibly be confused.

I understand the stillness of Fear-Alert as being underpinned by a moderate muscular tension which could switch into powerful action, but also quickly relax into rest. I see the Freeze state as involving a stronger, more rigid muscular tension which is holding in check the powerful energy of hyper-arousal and which cannot calm quickly.

As for using the term Freeze to describe Tonic Immobility (Fear-Collapse), this makes no sense to me at all. The word Freeze is associated in our minds with the rigid state of water at 0° centigrade, so it is an accurate metaphor for the “locked” or rigid-muscle state of Fear-Arousal (Fight-Flight “put on hold”) and creates confusion if applied to Fear-Collapse where the muscles are limp and without energy.

Postscript – Explaining my own terminology

The confusion of language in the threat-response literature compelled me to use my own descriptive terms – Fear-Alert, Fear-Arousal and Fear-Collapse - in order to reach a clear understand of the biology of our fear-system responses.

I chose the word “Alert” (used by Baldwin and, at times, by Levine) for the Orienting Response, as it seemed to most accurately convey the heightened attention in this “preparation for action” stage.

I chose “Arousal” for the Fight, Flight, Freeze and Fright responses, as this reflects the heightened metabolic state of hyper-arousal underpinning these responses.

I chose “Collapse” for the metabolic shutdown of last resort as this accurately reflects our experience of the continuum of energy loss from slight postural collapse to full physical prostration.

I then prefixed these words with “Fear-” to distinguish each response to external, social or imagined dangers from a range of other autonomic nervous system responses which use the same biological processes.

- The body’s “Alert” state appears to be activated when we give focused attention to a task such as mental problem-solving.
- The sympathetic nervous system’s “Arousal” response is activated in sports and many forms of manual work.
- The parasympathetic nervous system’s “Collapse” response is used by the body as a survival strategy in the event of major fluid loss, and as an energy-conservation response to allow the body to fight viral and bacterial infection, process toxins, recover from exhaustion and also assist the process of conception[1].

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[1] Levine (2010) who notes that the post-orgasm state of dreaminess is a dorsal vagus shutdown which increases the chances of conception.

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Biosuggestive Therapy in the Correction of Mental Trauma

Dr Tetiana Ivanitska-Diachun, Yuliia Kharkhalis

Abstract

Biosuggestive Therapy (BST) is an innovative Ukrainian psychotherapeutic method specifically developed in wartime conditions for the rapid correction of the consequences of psychological trauma. The approach integrates verbal and non-verbal suggestion techniques, including the therapist's modulated voice and either imagined or gentle real touch, to induce a therapeutic state of relaxation and perceived safety.

BST is adapted to the specific needs of individuals who have experienced traumatic events and can be used both individually and in group formats, including online. The current evidence base for the method is based primarily on expert opinion, clinical observations, and preliminary studies, as randomised controlled trials have not been conducted due to the ongoing crisis conditions.

Preliminary findings indicate a prompt reduction in psychosomatic symptoms (such as anxiety, pain, and sleep disorders) following only a few sessions. However, the method is still regarded as a conceptual hypothesis that requires further scientific investigation.

The article deals with the theoretical foundations of BST (including suggestive therapy, polyvagal theory, somatic approaches, and the neurobiology of trauma), provides a detailed description of the session methodology, presents available empirical data and clinical observations, and discusses ethical considerations related to the application of the method.

In conclusion, the authors emphasise the limitations of the current evidence, advocate for the ethical use of BST, and invite the international community to collaborate in further research and development of this promising approach to trauma treatment.

Article type: **Research Article**

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Introduction

The ongoing Russian military aggression has placed an unprecedented strain on the psyche of the Ukrainian population. Citizens are continuously exposed to war-related stressors, leading to elevated levels of stress hormones, dysregulation of the nervous system, and disruption of homeostasis. As a result, there has been a sharp increase in the demand for rapid and accessible methods of recovery from both acute and chronic psychological trauma among both military personnel and civilians (Sayed et al., 2011).

Recently, Ukrainian mental health professionals have benefited from the trauma expertise of colleagues in the US, UK, Israel, Austria, and elsewhere. However, many Western therapy models have not been fully adapted to the extreme conditions and realities of the war in Ukraine. In a context of persistent danger, limited resources, and widespread traumatisation, traditional long-term therapeutic approaches are often impractical or inaccessible.

In response to these challenges, and building on international experience, Ukrainian psychotherapists have developed their own adaptive trauma-informed interventions. One such novel domestic approach is **Biosuggestive Therapy (BST)** – a method specifically designed to accelerate recovery from combat stress and psychological trauma. Although certain elements of BST have been evolving over the past decades, it is during the recent years of full-scale war that the method has undergone intensive refinement and demonstrated practical effectiveness with both Ukrainian military personnel and civilians (Gubska et al., 2023).

BST has already gained recognition at the national level: it is recommended for implementation by leading professional organisations (such as the Ukrainian Institute of Psychology and the League of Psychiatrists and Psychotherapists) and has been included by the Ministry of Veterans Affairs in the list of essential psychotherapeutic rehabilitation interventions.

However, BST remains largely unknown internationally, as it has only recently begun to be presented outside of Ukraine. The aim of this article is to present a conceptual model of Biosuggestive Therapy and its theoretical basis, describe the protocol and features of the method's application, and summarise the available clinical data regarding its effectiveness. Given the current absence of randomised controlled trials, BST is not presented as a standardised treatment modality but rather as a promising hypothesis requiring further scientific substantiation. The authors also discuss the ethical dimensions of applying this method in the context of humanitarian crises and emphasise the need for international collaboration to strengthen the evidence base for BST.

Theoretical Background

Biosuggestive Therapy (BST) conceptually integrates approaches from suggestive (i.e., hypnotic or persuasive) psychotherapy with contemporary insights from trauma neurobiology and autonomic nervous system regulation. The author of the method is Aleksandr Strashny (Strashny, 2024). As the name implies, the method is based on suggestion, i.e. psychotherapeutic influence achieved through the process of suggestion. Unlike traditional hypnosis or autogenic training, where suggestion is usually purely verbal, in BST it is carried out simultaneously verbally and non-verbally. Specifically, during a session, the therapist utilises a special intonational modulation technique involving overtone-rich vocal patterns, and – subject to the client's consent – applies light rhythmic touches to specific areas of the body. This multi-sensory engagement, involving auditory and tactile stimuli, facilitates deeper integration of the therapeutic effect (Lucas et al., 2015).

BST is rooted in classical principles of suggestive therapy but introduces several critical modifications: it does not require the induction of a deep trance (a light trance or relaxed state is sufficient), and the content of the suggestions is carefully standardised and tailored to trauma-related symptomatology. Moreover, the addition of touch to verbal suggestions brings BST closer to body-oriented approaches and takes into account the role of the body in experiencing and healing trauma.

The main hypothesis of the mechanism of action of BST is the activation of physiological processes of relaxation and recovery through stimulation of the parasympathetic nervous system. During a session, when the client enters a light trance-like state of relaxation, parasympathetic activity predominates – this is neurophysiologically antagonistic to the "fight or flight" response. Such activation facilitates the inhibition of maladaptive neural patterns associated with trauma and enhances connectivity in neural circuits related to a sense of safety and well-being. In essence, this leads to repatterning of the nervous system: instead of entrenched stress responses, new associations of calm and security are formed.

The verbal suggestions delivered during relaxation are specifically designed to reduce psychophysiological hypersensitivity to pain and anxiety. Studies show that trance suggestions can reduce hyperalgesia, or excessive sensitivity to pain. As a result, the pain threshold and emotional distress tolerance are increased, leading to an improved balance in the autonomic nervous system (Oliveira et al., 2023). These effects are consistent with the principles of Stephen Porges' Polyvagal Theory, according to which creating a sense of safety and social interaction activates the ventral vagal complex and inhibits fear responses (Porges, 2011).

BST explicitly incorporates such “safety signals” – including the therapist’s gentle, modulated voice, the supportive presence of a group, and reassuring physical touch – to soothe the client’s autonomic nervous system.

Figure 1 schematically illustrates the three primary autonomic states described in Polyvagal Theory (Porges, 2011):

- The Safe State (social engagement under ventral vagal dominance),
- The Mobilised State (stress-related sympathetic activation), and
- The Immobilised State (freeze response under dorsal vagal dominance).

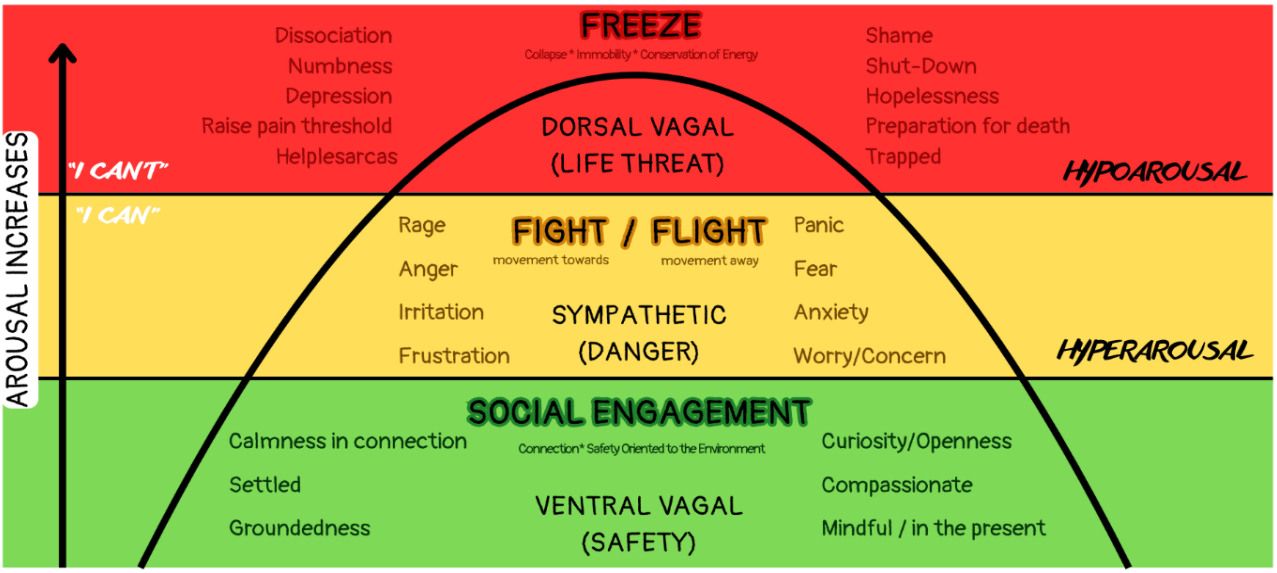

Figure 1: The Polyvagal Concept of Three Autonomic Nervous System States, adapted from Stephen Porges’ theory. In the safe state (green), the individual feels relaxed and open to social engagement (ventral vagal activation); in the mobilised state yellow, the person is prepared for fight or flight in response to threat (sympathetic system activation); in the immobilised state red, the person enters a state of shutdown or dissociation in the face of extreme threat (dorsal vagal activation). BST is aimed at guiding the client's nervous system back to a safe green state.

BST is designed to guide the client from mobilised or immobilised states toward the state of safety, utilising a strategic combination of verbal and non-verbal therapeutic techniques.

In addition to its neurophysiological foundations, BST relies on an understanding of the psychological mechanisms of trauma and healing. Contemporary theories of traumatic stress emphasise the importance of integrating traumatic experiences into a narrative and bodily sensations into a holistic experience (B. van der Kolk, 2015). Methods that combine work with the body and mind have gained momentum in recent decades as a complement to traditional cognitive therapy. In particular, somatic methods – such as Peter Levine's Somatic Experiencing, Sensorimotor Psychotherapy, and various mindfulness-based body practices – demonstrate that focusing on bodily sensations and movements can facilitate the discharge of "frozen" traumatic energy and restore autonomic regulation (Payne et al., 2015).

BST resonates with these frameworks by utilising therapeutic touch and relaxation to process the psychosomatic manifestations of trauma. In terms of its components, the method occupies a conceptual middle ground between hypnotherapy and somatic therapy. Similar integrative attempts to combine suggestion and sensory input can be found in other innovative trauma interventions. For example, the Havening Technique (developed by Ronald Ruden after 2001) uses gentle skin stroking combined with positive visualisation to reduce fear and reprocess traumatic memories (Ruden, 2018) – an approach that shares foundational similarities with BST.

BST differs from classical hypnosis through its group-based induction format and the active engagement of the body, while it stands apart from most body-oriented practices through the use of structured verbal suggestion. In this regard, BST can be considered a unique integrative conceptual model that combines the strengths of different approaches: the power of suggestion, somatic resource therapy, and social support of the group.

It is important to emphasise that this model is currently a hypothetical construct that requires thorough validation. The theoretical framework of BST outlines plausible pathways of therapeutic influence, supported in part by neuroscience and psychology data, but final conclusions about the effectiveness of the mechanisms should be drawn on the basis of future research.

Methodology

Design and General Principles.

Biosuggestive Therapy (BST) has been developed as a short-term intervention, suitable for implementation in contexts characterised by limited resources and widespread traumatisation. The method is designed to produce rapid therapeutic effects and is relatively easy to implement: only a few days of specialised training are required for a practising psychologist to acquire the basic skills necessary for conducting BST sessions. This expedited training of specialists was critical during the war, when the demand for help far exceeded the number of experienced trauma therapists.

BST can be conducted individually or in a group format, depending on the capabilities and needs - the method is equally applicable to both forms of work. At the same time, practice has shown that the group form has certain advantages: the effect of therapy is enhanced by the phenomenon of group dynamics and mutual support of participants. In particular, newcomers are positively affected by the presence in the group of other clients who have already experienced improvement in previous sessions - this increases their trust in the process and motivation to recover.

Structure of the Therapeutic Session

The classical BST protocol is built on a clearly defined structure and consists of three main phases:

Individual Therapeutic Conversation (Pre-therapeutic Phase). Each session begins with a brief one-on-one conversation between the therapist and the client – even in cases where a group session will follow. The purpose of this exchange is to assess the client's current condition, establish therapeutic rapport, and prepare the individual for suggestion. The structure of an individual conversation is designed to gradually shift the client's focus from distress to resources: positive changes since the previous session are discussed, the current emotional state is explored, and specific complaints are clarified. The therapist gently corrects the patient's dysfunctional thoughts or fears, creating expectations of recovery. This phase initiates a transformation process even before the suggestive work begins, moving the client from a neurotic pattern of distress toward a pattern of well-being. This phase typically lasts no more than 10–15 minutes.

Group Induction (Preparatory Phase of Suggestive Relaxation). In group settings, the next step is a collective induction into a light trance state. Participants sit comfortably in a circle, and an atmosphere of calm and mutual trust is fostered. The therapist addresses the group in a soothing, evenly modulated voice, guiding them through simple synchronised breathing and muscle relaxation exercises. This brief meditative segment helps equalise the group's emotional tone, reduce initial anxiety, and prepare participants for the suggestion process. The group setting facilitates faster relaxation due to the phenomenon of emotional contagion – when several participants begin to calm down, their state influences others in the group. In individual sessions, this induction phase is replaced by a continuation of the earlier conversation, now shifting toward relaxation-oriented suggestions delivered in a calm, rhythmical tone. Group induction is a feature of BST: it not only allows for time-efficient delivery of therapy to multiple clients simultaneously but also amplifies therapeutic effectiveness through the group's supportive presence.

Biosuggestive Relaxation-Meditation (Core Therapeutic Phase). Following induction, the core part of the session begins – a scripted therapeutic meditation incorporating elements of suggestion. The suggestion script is either pre-recorded as an audio track. Often, an audio recording featuring the therapist's voice over calming background music is used, ensuring standardisation and precision of phrasing.

The relaxation meditation typically lasts ~18 minutes. During this phase, participants sit with eyes closed (or lie down if preferred), focusing on their bodily sensations. The therapeutic script includes a series of positive, suggestive images and affirmations targeting symptom relief: reduction of muscle tension, pain, and anxiety; restoration of calm, safety, and a sense of control over one's state.

The key element is a light rhythmic touch of the therapist to the client (or self-hypnosis touch), which occurs in synchronisation with the words of suggestion. The therapist touches certain points (on the patient's shoulder, back, or arms) with the palm of his hand in a predetermined rhythm, which enhances the perception of the images being suggested. If necessary, assistants are present in the group to provide such tactile contact with each participant.

Touch is used only with the client's explicit consent; prior to starting the therapy course, each participant is informed about the method and decides whether physical contact is acceptable.

Experience has shown that most traumatised people respond positively to supportive touch, as it adds a sense of security. However, an alternative option (and the only one possible in the online format) is imaginary touch - when the patient visualises the therapist touching the specified

points during meditation. This technique is based on neuropsychological data: the human brain activates sensory areas almost as much with an imaginary touch as with a real one. (Lucas et al., 2015; Chan & Baker, 2015).

In particular, studies have shown that self-touching the body gives a minimal reaction (about 10% of the possible), the touch of another person gives the maximum reaction (about 100%), and an imaginary touch of another person gives an intermediate reaction (~60-70%).

Thus, during an online BST session, where real contact is not possible, the effect of virtual touch is achieved by the client simply imagining the therapist's touch - this is enough for ~70% of the impact, similar to an offline session.

Session Duration and Treatment Course

The total duration of one BST session is about 30-40 minutes. The recommended therapeutic course is eight sessions (with a frequency of about 1-2 per week). Such a relatively small number of sessions is usually sufficient to achieve a lasting improvement. Moreover, patients often feel significant relief after 1-2 sessions. According to clinical observations by Ukrainian BST practitioners, after completing a full eight-session course, roughly 30–60% of clients (depending on initial symptom severity and other factors) experience a near-complete resolution of their primary complaints. These figures are drawn from preliminary clinical reports in Ukraine (Osokina et al., 2017; Koshyrets & Shkarlatiuk, 2022; Venger & Ivanitska, 2023) and demonstrate the potential of BST as a short-term intervention. It should be emphasised, however, that these outcomes are from uncontrolled case series; controlled studies are needed to confirm the efficacy and clarify what proportion of improvement is specifically attributable to BST techniques.

It is important to note that BST does not lead to dependence – neither psychological attachment of the patient to the therapist nor “addiction” to the method itself. It is important that CBT does not cause dependence, neither psychological attachment of the patient to the therapist nor "addiction" to the technique itself. This means that clients, having felt relief, do not need constant repeated support sessions and can continue to maintain their improved state on their own, using the relaxation skills acquired during therapy. The method also has no side effects and is easily tolerated by clients. If anything, the main caution is to ensure proper consent and comfort with touch, as discussed, and to integrate BST appropriately with other treatments when needed (see Ethical Considerations below).

Adaptation to the Client's Condition

The therapeutic relaxation scenario may vary slightly depending on the client's main symptoms. For example, if the patient has manifestations of sympathetic system hyperactivity (anxiety, tension, insomnia), the suggestions emphasise calming and relaxation. And vice versa, if apathy and depressive "freezing" are observed, then the text contains more images of activation, of returning to life. These adaptations are consistent with the polyvagal model, which seeks to balance sympathetic and parasympathetic system activity.

Several standard scripts have been developed for different clinical presentations; however, when dealing with complex or comorbid states, a universal BST relaxation-meditation protocol is applied. This script includes general formulations for stress recovery and well-being enhancement and is effective across a wide spectrum of conditions. It is the most commonly used version in practice, serving as a baseline intervention when individual customisation is not feasible or necessary.

Indications and Contraindications

BST is indicated for dealing with the consequences of acute and chronic traumatic events, especially when the trauma manifests itself at the psychosomatic level. The method is most often used among patients with the following symptoms of post-stress disorders:

- Anxiety
- Hyperarousal
- Inner tension
- Fear
- Sleep disorders (insomnia, nightmares)
- Psychosomatic pain (headaches, migraines, muscular pain, unexplained neurological symptoms)
- Functional somatic disorders (e.g., stress-induced digestive issues, palpitations)

Practical experience and early studies have shown the effectiveness of BST in correcting a wide range of conditions, including:

- Anxiety and depressive disorders
- Adjustment disorders
- Psychosomatic illnesses
- Combat stress relief
- Prevention of PTSD in military personnel

The method has been successfully used for adults (including the elderly), as well as for children and adolescents with behavioural problems due to trauma.

However, there are specific contraindications where the use of BST is either inadvisable or requires postponement:

1. Lack of prior medical evaluation – Therapy is deferred until a physician confirms that somatic complaints do not require urgent medical intervention.
2. Acute psychotic or paranoid symptoms, or severe behavioural disorganisation – Suggestive techniques are contraindicated due to the risk of unpredictable responses.
3. Alcohol or drug intoxication – Sessions are postponed until the client is sober.
4. Somatic conditions that interfere with group work – For example, febrile states or infectious illnesses (e.g., flu) preclude participation for safety reasons.
5. Situations where deep relaxation is inappropriate – For instance, it is not advisable to conduct relaxation sessions for military personnel immediately prior to active combat operations, as it may reduce operational readiness.
6. Lack of informed consent – As previously noted, participation in BST requires explicit client consent for each component (suggestion, touch). If the client does not consent, therapy is not administered.

These restrictions are intended to ensure the most ethical and safe application of BST in clinical practice. Therapists using the method are obligated to act in accordance with professional standards: assessing client suitability, explaining the intervention, obtaining consent for each component, and avoiding any form of manipulative influence.

BST is considered a complementary method – it supplements rather than replaces other necessary forms of treatment. If indicated, patients are encouraged to continue prescribed pharmacological treatments or other psychotherapeutic interventions concurrently with BST.

Online Format

A significant achievement is the successful adaptation of BST Therapy to the online mode, which has become relevant both during the COVID-19 pandemic and in wartime (when many clients or therapists are displaced, at the front line, etc.).

The main question was: how to replace the component of real touch through the screen? The solution was the aforementioned imaginary biosuggestion when the client puts his hand to a certain part of his body (or simply imagines touching it) when he hears the therapist's corresponding suggestive command.

Experience with this approach has demonstrated that the effectiveness of online BST sessions is comparable to in-person delivery. Patients report experiencing a felt sense of the therapist’s presence and group connection, even via video conferencing, and imagined touch often elicits tactile and thermal sensations similar in intensity to real physical contact.

The scientific basis for this phenomenon is the research of neuropsychologists who have proven the brain's ability to distinguish between its own and someone else's touch, suppressing the sensations of self-touch and enhancing the sensations of external influence. According to these data, when a person touches himself or herself, the activation of the sensory cortex is minimal, but when he or she is touched by someone else, it is much higher (Boehme et al., 2019). It is interesting that the imaginary touch of another person occupies an intermediate place, activating about two-thirds of the full reaction. This confirms that virtual tactile contact can be sufficient for therapeutic purposes (Chivukula et al., 2021).

Thus, the online BST algorithm includes all the same stages, namely:

- Individual therapeutic dialogue,
- Group induction,
- Audio-guided relaxation, with the role of physical touch replaced by verbal suggestion, instructs the client to touch themselves or imagine being touched.

This approach appears to have proven to be both effective and safe, enabling therapists to provide support even to those in remote or hard-to-reach locations.

It is important to note that the therapist in an online session is particularly careful about safety: he makes sure that the client is in a quiet, private place (not driving, not in a war zone, etc.) and has the ability to immediately interrupt the session in case of discomfort.

Thus, the remote format has expanded the availability of BST without significantly losing the quality of the impact.

Evidence and Observations

Since BST Therapy emerged as an emergency response to the challenges of war, its systematic scientific evaluation has just begun. Currently, conclusions about the effectiveness of the method are based mainly on clinical observations and pilot studies conducted by Ukrainian specialists. Formal randomised controlled trials of BST have not yet been published, due to the objective difficulties of conducting research in wartime. Nevertheless, the initial empirical data obtained in hospitals and rehabilitation centres across Ukraine are encouraging.

BST has undergone clinical testing at leading Ukrainian medical universities, resulting in a total of 16 studies and 24 publications in Ukrainian and international academic journals. Below is a summary of the key findings from these studies (most of which were open-label clinical trials, without control groups or based on pre–post comparisons):

Reduction of Chronic Pain in Psychoneurological and Dental Patients.

BST was shown to reduce pain intensity in patients suffering from chronic psychogenic and dental-related pain syndromes. The most pronounced changes occurred in the emotional dimension of pain–i.e., the subjective suffering decreased, even if some physical sensations remained. This aligns with the hypothesis that suggestions of well-being reduce anxiety and catastrophising associated with pain perception (Osokina et al., 2017; Prudka, 2025).

Reduction of Dental Phobia and Anxiety Prior to Medical Procedures.

Applying BST before dental appointments helped stabilise the emotional state of patients with panic-level fear of dental treatment. In a short study (Osokina et al., 2017), even a single session of biosuggestive relaxation prior to a dental procedure significantly reduced patients' anxiety levels compared to their baseline state.

Improved Psychological Well-Being in Anxiety and Depressive Disorders.

Several studies have demonstrated a positive effect of BST on the subjective well-being and emotional state of patients with neurotic disorders. Specifically, among patients diagnosed with generalised anxiety disorder and mixed anxiety-depressive disorder, the addition of BST to standard treatment led to statistically significant reductions in anxiety and depression levels, along with improved psychological well-being (Zelenska & Kraskovska, 2020).

Recovery from Post-COVID Syndrome.

An intriguing application of BST was its use in the rehabilitation of post-COVID patients experiencing lingering psychosomatic symptoms (e.g., chronic fatigue, anxiety, unexplained physical complaints). In these cases, a course of BST facilitated the regulation of psychosomatic stress responses, resulting in improved physical markers (e.g., sleep, appetite, energy) and emotional indicators (reduced anxiety, elevated mood) (Reutskyi & Karepova, 2021).

Correction of Emotional Disturbances in Diabetic Patients.

Another study (Sinaiko et al., 2021) demonstrated the effectiveness of BST as part of the complex treatment of patients with type 2 diabetes mellitus who had concomitant emotional disorders. After BST Therapy, these patients experienced significant improvements in mood and a reduction in stress and anxiety, which ultimately contributed to better control of diabetes. These findings suggest that BST may enhance psychosomatic well-being even in the context of chronic endocrine conditions, where stress is a critical contributing factor.

Support for Internally Displaced Persons (IDPs) from Conflict Zones.

Several publications from 2022-2023 describe the results of work with IDPs who experienced hostilities and were forced to leave their homes. In these groups, BST has proven to be an effective means of overcoming symptoms of depression and anxiety, reducing post-traumatic stress and normalising sleep. According to Venger and Ivanitska (2022), after a course of several sessions, IDPs significantly improved their quality of life and psychological well-being compared to the initial data. Another study (Gubska et al., 2023) concluded that the BST method is a universal tool that can be successfully used to correct a variety of psychosomatic and stress disorders - from functional gastrointestinal disorders to behavioural problems in children - that often accompany trauma.

This study emphasises the wide possibilities of adapting biosuggestive techniques to different clinical situations. While further rigorous research is needed, early results position BST as a promising and flexible approach to trauma-informed care in both acute and long-term settings.

Qualitative Feedback and Practitioner Observations

The qualitative feedback from practitioners and patients who participated in the first sessions of BST during the war is particularly revealing. For example, psychologists who conduct biosuggestive groups for the military note the unique property of the method to quickly establish trust even among an audience that has a sceptical attitude toward “talk” therapy. BST is attractive to soldiers because they are not required to talk in detail about their experiences or “open up” to others.

Soldiers can achieve relief by minimising the verbalisation of traumatic events, which reduces psychological discomfort from therapy. Many combatants have reported that, following BST sessions, they were able to sleep properly for the first time in months and experienced a reduction in phantom pain or muscular tension.

Civilian participants–those who survived shelling, occupation, or displacement–also shared similar impressions: even after the first group session, most reported improved mood and general well-being, and expressed a desire to continue the full course.

These subjective improvements are corroborated by objective clinical data. In particular, one study with the participation of residents of de-occupied settlements in the Kyiv region provides the following data:

- After five sessions of BST, the average level of anxiety (according to the HADS scale) decreased from 24 to 18 points.
- 68% of patients had a significant improvement in sleep quality, and 21% had a complete normalisation of sleep.
- According to a visual analogue scale, the intensity of chronic abdominal pain (a selected psychosomatic complaint) decreased from 6.67 ± 1.0 to 4.22 ± 1.48 after 4–5 sessions; some individuals even reported complete disappearance of pain during the relaxation phase.

Participants reported that during meditation, their attention seemed to be redirected from disturbing thoughts to the "therapeutic" images offered by the therapist's voice, which reduced the feeling of internal tension and visceral anxiety. These observations are consistent with the assumption that BST acts as a kind of "safety anchor" for the nervous system, which allows even severely traumatised individuals to find a point of calm within themselves.

It is also important that no complications or negative reactions have been recorded during the implementation of the method. On the contrary, therapists note an interesting phenomenon: conducting BST sessions has a positive effect on their own mental state. Working with a group in a trance mode, the psychologist personally reaches a state of calm, resonates with positive suggestions, and thus reduces the risk of professional burnout.

This “bidirectional” therapeutic effect–benefiting both client and therapist–contributes to the high professional acceptability of the method. Many practitioners have praised BST for its simplicity, conceptual clarity, and practical effectiveness, which has led to the rapid dissemination of the approach within the Ukrainian psychological community.

The above data, although preliminary, demonstrate the significant potential of Biosuggestive Therapy in overcoming psychological trauma and related psychosomatic disorders. However, these results should be interpreted with caution. Most of the studies had open designs and small samples, and did not include control groups, so the placebo effect or the influence of nonspecific factors cannot be ruled out.

Nevertheless, the coincidence of observations in different independent projects - from pain relief to sleep normalisation - suggests the presence of a real therapeutic effect. At this stage, BST has the status of an experimental technique with an accumulated collection of clinical cases and a series of pilot trials. To become an evidence-based practice, it is necessary to conduct more rigorous research projects, including:

- Randomised controlled trials,
- Long-term follow-up of patients after therapy, etc.
- And continued development of validated measurement protocols.

Discussion

The development of Biosuggestive Therapy fits into the broader context of finding new solutions to overcome trauma in extreme conditions. International experience shows that during wars and humanitarian crises, there is a need for short-term interventions that can be quickly scaled up to a large number of victims. Historically, many psychotherapeutic innovations have arisen in response to wartime challenges – from frontline crisis counselling in World War I, to modern group techniques for refugees.

For instance, in the 1990s, psychologists working with survivors of organised violence in East Africa developed Narrative Exposure Therapy (NET) as a concise PTSD treatment model. NET's creators, Dr. Maggie Schauer, Dr. Frank Neuner, and Dr. Thomas Elbert, designed the approach to be delivered in as few as 4–6 sessions, focusing on constructing a chronological narrative of the patient's life to contextualise traumatic memories (Schauer et al., 2011). Studies found that even this brief intervention was effective for war-affected refugee children – yielding significant symptom reduction immediately post-treatment, with benefits maintained at 9-month follow-up (Neuner et al., 2008). Notably, NET proved feasible even in refugee camp settings, which are comparable in many ways to the current realities in Ukraine (minimal infrastructure, high trauma exposure).

Another example is the integration of physical practices into trauma therapy. A recent paper by Swiss experts described group therapy with martial arts elements for refugee adolescents: combining karate-do with psychotherapeutic techniques increased concentration and emotional regulation in children who attended such classes (Montenegro et al., 2024). Although this approach needs further evaluation, preliminary feedback from teachers is positive. While still experimental, such an approach illustrates the creative blending of physical activity and group support to address trauma in extreme situations. Early feedback from that project has been positive, though formal evaluation is ongoing.

These cases illustrate how hybrid therapeutic models often emerge in extreme contexts–blending, for example, narrative and exposure elements (as in NET) or physical movement and group therapy (as in the karate-based intervention). In this context, BST is a logical and timely innovation: it synthesises suggestion and bodily relaxation in a group format, which allows for quick results without complicated equipment or lengthy preparatory stages. BST's design reflects practicality and cultural adaptability, much like the other war-born methods mentioned.

Despite the encouraging evidence, BST cannot yet be considered a fully proven method in terms of evidence-based medicine. The limitations of the available evidence base are obvious. First of all, there are no randomised controlled trials, so we do not know for sure whether the effect of BST is superior to placebo or other interventions. Secondly, the studies conducted in Ukraine were mostly descriptive in nature and had small samples, which reduces the statistical significance of the results. It cannot be ruled out that some part of the success of BST is due to nonspecific factors, such as therapist attention, group support, the effect of expectation of improvement, etc. Such factors are inherent in any psychotherapy, but without control groups, it is difficult to separate them from the specific effects of suggestion and touch.

In addition, there is still a lack of data on long-term results: does the relief achieved persist for several months to a year after the course is completed? This question requires special study through follow-up observation.

It is also worth considering the possibility of subjective bias in positive reviews - both therapists and patients, knowing about the novelty of the method, could unwittingly exaggerate its effects out of enthusiasm. To counteract such biases, future evaluations of BST should incorporate more objective outcome measures and study designs that include: independent blinded assessors (to evaluate patient symptoms without knowing if BST was administered), and comparison groups receiving either treatment-as-usual or an alternative intervention.

It is important to put the current lack of "hard" evidence in context. Many therapeutic methods go through an initial stage where anecdotal success outpaces scientific documentation, especially when developed under crisis conditions. In an ongoing war, it can be ethically acceptable to use interventions with limited empirical support, provided they appear safe and show practical effectiveness, because the alternative may be no treatment at all for people in acute distress. In Ukraine, BST was implemented widely because preliminary benefits seemed to outweigh potential risks, and there was an urgent need for accessible help. For many traumatised individuals during the war, the only real alternative would have been the absence of any psychological support.

The accumulated clinical experience to date – hundreds of patients treated across various regions of Ukraine – indicates that BST merits further development and scientific exploration. The method's apparent flexibility and ease of dissemination are attractive features in disaster mental health contexts. Now, the onus is on the professional community to rigorously test and refine BST so that its place in trauma therapy can be properly understood.

Ethical Considerations

From an ethical standpoint, the developers of Biosuggestive Therapy (BST) place particular emphasis on safety and voluntariness as fundamental principles of the method. As outlined in the methodology section, no client is subjected to any unwanted influence. All suggestions in BST are supportive and positively framed, with strict avoidance of any content that could conflict with the client's values or personal will.

Therapists practising BST undergo training not only in the technical aspects of the method but also in the ethics of suggestion. For instance, they are taught to formulate instructions in a non-categorical, soft form to leave space for the patient's autonomy (instead of the imperative "'You relax', constructions such as 'You can let yourself relax' are used, etc.) Thus, avoidance of manipulativeness is a conscious principle of the method.

The second critical ethical aspect is physical contact. In many cultures and situations, touch in psychotherapy is a sensitive issue. In BST, its use is strictly regulated:

- Therapists obtain written informed consent from the client prior to any use of touch.
- The client can opt out of the technique at any time or limit the form of contact (e.g., consenting only to a light touch on the shoulder).
- Touch is explicitly framed as a therapeutic tool, not a personal interaction, and this is clearly communicated beforehand.

Respect for personal boundaries is non-negotiable: if a client displays even the slightest sign of discomfort during a session, the tactile component is immediately discontinued. Fortunately, as clinical feedback indicates, the majority of BST participants respond positively to biosuggestive touch. Many describe the rhythmic tapping or gentle contact as something that "brings them back to reality" in a grounding and reassuring way, providing a felt sense of support and presence.

In groups where some of the participants are victims of violence, therapists sometimes immediately choose the format of imaginary touch in order to avoid triggering memories. Thus, flexibility and sensitivity in the application of the technique help to successfully avoid ethical problems.

Another ethical issue is the limits of applying BST. The authors consistently emphasise that this method does not claim universality and is not a panacea. There are cases where other types of therapy would be more appropriate. For example:

- Cognitive Behavioural Therapy (CBT) for addressing cognitive distortions,
- Pharmacotherapy for managing severe depression,
- or trauma-focused exposure therapies (e.g., EMDR) for in-depth trauma resolution.

BST has proven to be particularly effective as a first-line intervention in acute stress situations and as a stabilising tool. It often serves as a gateway that helps clients regain equilibrium, after which they may be referred for more in-depth psychotherapeutic work (e.g., psychoanalysis, trauma exposure therapy, or EMDR). From an ethical standpoint, the most responsible approach is integrative – embedding BST within a broader treatment plan, rather than allowing it to displace other necessary interventions.

It is also significant that BST is being disseminated through official, professional channels – via certified training programs conducted under the auspices of recognised professional organisations. This ensures that therapists using the method are part of a professional supervisory community and remain accountable for the quality of care provided.

In this way, BST is not introduced as a fringe or quasi-spiritual practice, but as a professionally grounded psychotherapeutic method, subject to ongoing monitoring, supervision, and training. This ethical infrastructure contributes to the credibility of BST as a legitimate and responsible therapeutic approach.

Future Directions and Scientific Collaboration

It should also be noted that at the current stage of BST development, the authors are open to cooperation with the scientific community to test and improve the method. The Institute of Biosuggestive Therapy is looking for opportunities for larger-scale studies, including partnerships with international researchers, to enhance methodological rigour and broaden the diversity of participant samples.

A substantial body of case reports and observational series has already been collected, which may serve as a foundation for generating hypotheses and research questions. The next logical step involves the organisation of controlled trials–for example, comparing BST with standard relaxation techniques or placebo conditions (such as pseudomeditation) in clinically similar populations.

Another interesting area is the neurophysiological study of the effect of BST (recording changes in heart rate variability, EEG during the session, etc.) to objectively confirm the activation of the parasympathetic system. The authors anticipate that findings from these studies will be available soon and look forward to the opportunity to validate the method on a wider scientific stage.

The invitation to collaborate is extended at international conferences and through publications; there is interest in collaborating with trauma therapists from other countries to conduct independent evaluations of the effectiveness of BST in different cultural contexts. Such an exchange would not only test the universality of the approach but also identify possible improvements or alternative explanations for its effectiveness.

Ultimately, the goal is not to promote BST as a “brand,” but rather to provide scientifically grounded support to individuals suffering from trauma. If future research confirms even part of the current clinical observations, BST could earn a place among recognised evidence-based practices, alongside established modalities.

Otherwise, negative or ambiguous results will also be a valuable contribution, allowing for adjustments or determining under what conditions the method works and under what conditions it does not. This scientific honesty and openness to verification are a cornerstone of the ethics of the method's authors.

Conclusions

Biosuggestive Therapy (BST) is a new integrative method of psychotherapy developed in response to the challenges of wartime in Ukraine. By combining the power of verbal suggestion and therapeutic touch, BST aims to quickly and gently alleviate the suffering of people who have experienced psychological trauma. Theoretically, the method is based on the classical principles of suggestive hypnotherapy, enriched by knowledge of the polyvagal regulation of the nervous system and the somatic nature of trauma.

Clinical practice and early studies show promising results. Various samples of patients have reported a reduction in anxiety, normalisation of sleep, reduction in the intensity of chronic pain, and improvement in mood and quality of life after a course of BST. The method has proven particularly well in working with military and civilian victims of combat operations, as well as in the correction of stress-related psychosomatic disorders.

At the same time, the current level of empirical evidence for BST must be regarded as preliminary. Due to the constraints of wartime, large-scale controlled studies have not yet been conducted, and existing data are primarily based on expert evaluations and open-label pilot research. Confirming the efficacy of BST will require continued efforts by the scientific community. The authors of the method clearly recognise these limitations and emphasise the need for further research, both in Ukraine and abroad.

Nowadays, Biosuggestive Therapy can be seen as a valuable complement to the range of trauma therapy methods, especially in times of crisis, when the speed and accessibility of care are crucial. The method may be integrated into comprehensive rehabilitation programs alongside other evidence-based approaches. Its application should always adhere to ethical standards, including informed consent, respect for patient autonomy, and careful consideration of medical indications and contraindications.

Preliminary experience offers hope that BST may benefit many trauma survivors, yet definitive conclusions about its effectiveness must be evidence-based. Therefore, we call upon researchers, clinicians, and organisations involved in trauma care to join efforts in further investigating BST. International collaboration will not only serve to validate the method, but – if its efficacy is confirmed – will allow it to be adapted and disseminated for the benefit of trauma-affected individuals worldwide.

Collaborative efforts to build an evidence base will contribute to the advancement of trauma recovery science and the improvement of treatment approaches, ultimately ensuring the best possible support for those in need.

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Psychological well-being in therapists who are members of the UK Complex Trauma Institute

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Abstract

Therapists working within the role of professional care-giving for survivors of trauma can experience an impact to their health and well-being. The emotionally demanding nature of the role can lead to implications on professional quality of life and the manifestation of body-centred countertransference (BCT). These implications may be exacerbated when the therapist has personal experiences of childhood trauma and an insecure attachment style. The aim of the present study was to examine the relationship between childhood trauma and therapist outcomes of burnout and BCT. A cross-sectional survey of 192 trauma therapists was carried out online wherein participants completed a number of self-report measures. Hierarchical regression analyses were conducted. Results indicated that psychological distress and insecure attachment styles predicted trauma therapists' reported scores of burnout as measured by the Professional Quality of Life Questionnaire. BCT was significantly predicted by anxiety, psychoform and somatoform dissociation, and childhood emotional abuse. The study findings and clinical implications are discussed, and suggestions for future research are indicated.

Keywords: body-centred countertransference, attachment, childhood trauma, burnout

Article type: **Research Article**

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Introduction

Working therapeutically with survivors of trauma can have an adverse impact on the professional and personal lives of the therapists engaging in these professional care-giving roles (Piedfort-Marin, 2019), significantly impacting the therapist's emotional well-being. Due to the emotionally demanding nature of this work, therapists are likely to experience burnout (Cohen & Collens, 2013), resulting from work related stress (Bell et al., 2024) and exposure to another individual's trauma narrative. The complexity of trauma work may also lead to the therapist experiencing challenging countertransference reactions (Tlali, 2022), wherein the therapist responds at a somatic level, a phenomenon known as body-centred countertransference (BCT). Understanding what factors contribute to these aspects of therapists' emotional well-being will be the focus of this study.

Body-centred Countertransference

Countertransference is experienced in different forms, with much research evidencing therapists' experiences at a cognitive and emotional level (Gubb, 2014). However, less research has focused on experiences of physical or somatic reactions within the countertransference (Egan & Carr, 2008; Gubb, 2014; Athanasiadou & Halewood, 2011). BCT is a form of countertransference that is experienced by the therapist at a physical level (Stone, 2006). As described by Pearlman and Saakvitne (1995), our affects are held physically, and therapists often respond to their clients through their bodies. BCT manifests as an unconscious bodily reaction in response to, or as a defence to, the presence of the client and their unconscious internal world, or a shared experience within the therapeutic work (Athanasiadou & Halewood, 2011).

Although experiences of countertransference were once understood to be problematic, recent views suggest it can have a positive impact within the therapeutic process, but only when the therapist is aware of its presence (Forester, 2007). Working therapeutically, BCT may serve as a tool for the therapist, allowing them to intuitively connect to the client and their internal world, as well as understand and manage the intersubjective space between them and their client (Athanasiadou & Halewood, 2011; Shaw, 2006). BCT provides the therapist with valuable information (Booth et al., 2010), and when this is channelled effectively, it can positively influence the therapeutic process. However, if the therapist is not consciously attuned to their somatic experiences, it may result in detrimental consequences, such as an absent therapist for the client (Athanasiadou & Halewood, 2011; Blackburn & Price, 2007; Heard et al., 2018; Shaw, 2006), or negative health implications for the therapist (Egan & Carr, 2005). Thus, it is important for therapists to be vigilant to this phenomenon and engage in reflective awareness (Forester, 2007).

The literature on countertransference suggests it is the therapists' own life experiences that determines how the concept manifests during therapy (Gabbard, 1995; 2001; Jacobs, 1973). It is the result of particular aspects within the client's presentation that elicit emotional and somatic reactions within the therapist (Gubb, 2014; Sandler et al., 1992). Research also indicates that BCT may be a result of the client and therapist having similar experiences, suggesting the idea of a 'shared psychological wound' (Athanasiadou & Halewood, 2011; Margarian, 2014). Thus, understanding the factors that may contribute to BCT are crucial (Hamilton et al., 2020).

Childhood Trauma

The therapist's life experiences are important in understanding the processes that occur as a result of their clinical work, particularly given that many therapists are attracted to this type of work due to their own experiences of emotional distress (Cuseglio, 2019; Stone, 2006). One factor that may contribute to BCT, is the therapist's experiences of trauma (Jacobs, 1973; Piedfort-Marin, 2019), particularly childhood trauma (CT) (Athanasiadou & Halewood, 2011). CT encompasses physical, sexual and emotional abuse, and physical and emotional neglect, as measured by the Childhood Trauma Questionnaire (Bernstein et al., 2003). These experiences interrupt cognitive, emotional and interpersonal development (Herman, 1992), and have been suggested to predispose individuals to psychological distress and greater risk of using defence mechanisms such as dissociation and depersonalisation as a way of coping (Ó Laoide et al., 2017; Sar et al., 2009; Vonderlin et al., 2018), which remain present throughout the individuals' lifetime (Katzman & Papouchis, 2023). Individuals who experience CT are vulnerable to poor emotional development, often engaging in avoidant coping to suppress the emotional needs that were not met in childhood (McCluskey, 2011), and research has indicated therapists who have experienced CT may make sense of bodily experiences through defences, such as disconnection and resistance (Athanasiadou & Halewood, 2011).

Therapists who have personal trauma experiences exhibit greater emotional and physical countertransference reactions (Cavanagh et al., 2015). Listening to clients' traumatic narratives may result in the therapists own experiences becoming activated, which may have been suppressed until meeting and experiencing a client (Cavanagh et al., 2015), leading to manifestation of BCT (Piedfort-Marin, 2019). Clients that present with similar traumatic childhood experiences to the therapist are also more likely to evoke such countertransference reactions (Cuseglio, 2019), and therapists may engage in defences such as dissociation to numb themselves against the emotional trauma and somatic experiences (Athanasiadou & Halewood, 2011; Cavanagh et al., 2015).

Attachment Style

Bowlby's (1969/1982) work on attachment theory hypothesises that one's earliest life experiences significantly shapes development, and form one's mental representations of the self and others, known as internal working models. Through early interactions with a caregiver, one learns how to navigate and manage in times of distress, through engaging in comfort seeking and emotional regulation (Ainsworth, 1989; Bowlby 1988). These consistent and reciprocal interactions between the child and caregiver lead to secure attachment relationships (Grossmann & Grossmann, 2019), wherein the individual feels worthy and deserving of affection (Kong et al., 2018). However, individuals who experience childhood trauma are more vulnerable to having experienced disruptions within their attachment bond, negatively impacting on their development (Briere, 2002), which leads to the development of insecure attachments (Zayde et al., 2019). Insecure attachments leave individuals vulnerable to poor adjustment later in life (Oliveira & Fearon, 2019), lacking in confidence, with a reduced likelihood of engaging in comfort seeking and utilising social supports when distressed (Howe, 2011; Mikulincer & Shaver, 2007). Mary Ainsworth discovered patterns of insecure attachment styles, which include insecure-anxious and insecure-avoidant (Gillath et al., 2016), influencing how one behaves and copes under stress (West, 2015). Those with anxious attachment styles are likely to worry they will be rejected or abandoned by others, hold a strong desire for connection and engage in excessive care-seeking, but experience others as unlikely to respond to their needs. Those with avoidant attachment styles are likely to deny their own emotional needs, limit closeness and interdependence, perceiving others as untrustworthy and unreliable (Kong et al., 2018; Zorzella et al., 2020).

Research on attachment styles suggests one's early attachment history later determines their ability to manage and cope with distressing emotions in adulthood (Heard et al., 2018), and guides their behaviour and ability to initiate and maintain relationships, including caregiving behaviours and helping relationships within a professional capacity (West, 2015). Insecure attachment has been evidenced as a risk factor for poor regulation of emotion in intra- and interpersonal relationships, as well as coping through dissociation (Mikulincer & Shaver, 2008). Research on those with insecure attachment styles in the caregiving profession has indicated higher levels of negative affect than those of secure attachment (Cassidy & Shaver, 2008). As one's internal working model is likely to be activated in times of stress, determining their cognitions and behaviour (Pines, 2004), and given attachment style itself can be considered a strategy for emotion regulation (Kong et al., 2018), this suggests that an insecurely attached caregiving professional's attachment style will influence how they cope and respond to stressful situations within their work (West, 2015).

Given this, it is possible that when therapists are listening to the traumatic narratives of their clients, their interpersonal attachment style may become activated, impacting how they process and respond to their own internal reaction, as well as their relationship with the client. Anxiously attached individuals may find it difficult to manage boundaries and separate their own pain from that of their clients (Bartholomew & Horowitz, 1991; West, 2015), while avoidant attachment individuals tend not to seek out disclosures in their work (Mikulincer & Shaver, 2007).

Therapist Quality of Life

Therapists are not immune to, or exempt from experiencing traumatic events in their life (Piedfort-Marin, 2019). In fact, much research states therapists often chose the role of professional caregiving due to their own experiences of trauma and emotional distress (Adams, 2013; Chu, 1988; Pines, 2004), with literature stating psychotherapists, compared to that of the general population, originate from homes that are unstable and emotionally withdrawn (Groesbeck, 1975; Racusin et al., 1981). Similar to Carl Jung's concept of the 'wounded healer' which suggests the healer's own pain may cure clients' pain (Cuseglio, 2019), trauma therapists, who had their own experiences of trauma, believed this to benefit their work due to a greater ability to express empathy and sympathy towards the client (Cavanagh et al., 2015). However, working with survivors of trauma may impact their personal and professional lives (Piedfort-Marin, 2019) as they are exposed to stories of horrific events which may have a significant emotional impact on them (Piedfort-Marin, 2019). Research has shown therapists working with victims of abuse are at greater risk of experiencing burnout (Brockhouse et al., 2011; Cohen & Collens, 2013; Egan & Carr, 2005; Reddi, 2021). It has also been suggested that due to the challenging nature of the work, this may elicit difficult countertransference reactions (Tlali, 2022).

Research has demonstrated that therapists who have experienced severe trauma in early childhood or have had similar physical experiences to that of their client are more likely to experience BCT (Jacobs 1973; Stone, 2006). Although this can be utilised as a way to learn about the client (Dosamantes-Beaudry, 1997; Pearlman & Saakvitne, 1995; Piedfort-Marin, 2019), if the therapist does not have the self-awareness to attune to this, it can impact on the therapy (Sharma & Fowler, 2016) and on the therapists health, with research evidencing a positive relationship between countertransference and sick leave in a sample of female trauma therapists (Egan & Carr, 2005). In considering this from the model of Affect Phobia (McCullough, 2003), if the client activates the therapist's unmet needs or difficult past relationships, and the therapist is unable to sit with their own emotional state, this may result in the therapist engaging in an inhibitory response or defensive caregiving, as it elicits emotional conflict from past trauma for the therapist.

Aims & Objectives

As outlined in the above literature, and reported by Lee (2017), therapists' experiences of trauma and attachment greatly influence what occurs within the therapeutic process. Thus, the aim of the present study is to explore the relationship between CT and therapist outcomes of professional quality of life and BCT, and the role of attachment style in these relationships.

Method

Participants and Procedures

Participants were qualified therapists (n = 192) working with survivors of trauma, and were recruited from the Complex Trauma Institute (CTI). An online survey was implemented via Microsoft Forms. All members of the CTI received an email invitation from the institute director to participate in the study, including the research information sheet and a direct link to complete the questionnaires. All participants provided consent prior to their participation and submission of their data.

Measures

Demographic Information

Participants provided relevant demographic and work related information including gender, age, employment status, therapist type, client population, years working with survivors of trauma, and frequency of clinical supervision.

Dissociative Experiences Scale (DES-II)

The DES-II is a 28-item self-report questionnaire that assesses psychological dissociative experiences, ranging from mild to more severe symptoms, including amnesia, derealisation and depersonalisation (Bernstein & Putnam, 1986), and can be used amongst clinical and normal populations (Saggino et al., 2020). The DES-II has three subscales for amnesia, depersonalisation/derealisation and absorption symptoms, and has demonstrated high internal reliability with a Cronbach's alpha (α) of above .90 for this version of the scale (Wright & Loftus, 1999). Cronbach's alpha values ranged from .81 to .92 in the current study.

Somatoform Dissociation Questionnaire (SDQ-20)

The SDQ-20 is a 20-item self-report questionnaire that assesses the physical and somatic experiences of dissociation, including sensory symptoms, pain and loss of motor function (Nijenhuis, 2001; Nijenhuis et al., 1996). The SDQ-20 has a high internal consistency, with a Cronbach's alpha (α) of .95 (Nijenhuis et al., 1996). Cronbach's alpha was .90 in the current study.

Body Centred Countertransference Scale (BCTS)

The BCTS is a 16-item list of bodily or somatic symptoms that therapists may experience in response to their clients (Egan & Carr, 2005). The frequency of these symptoms is captured through a likert scale type questionnaire. The scale has demonstrated acceptable internal reliability with a Cronbach's alpha (α) of .74 (Egan & Carr, 2008). Cronbach's alpha was .83 in the current study.

Experiences in Close Relationships – Relationship Structures Questionnaire (ECR-RS)

The ECR-RS is a 9-item self-report questionnaire that assesses attachment style, through assessing attachment related avoidance and anxiety in close relationships. Responses are provided through a likert scale type questionnaire (da Rocha et al., 2017; Fraley et al., 2011). The scale has good internal consistency with Cronbach's alpha (α) ranging from .78 to .91 (da Rocha et al., 2017). Cronbach's alpha values ranged from .85 to .86 in the current study.

Childhood Trauma Questionnaire – Short Form (CTQ-SF)

The CTQ-SF is a 28-item self-administered questionnaire that assesses physical and emotional abuse, physical and emotional neglect, and sexual abuse, experienced during childhood (Bernstein et al., 2003). The CTQ-SF has a good internal consistency, with Cronbach's alpha (α) ranging from .63 to .95 across the scales (Thombs et al., 2009). Cronbach's alpha values ranged from .76 to .90 in the current study.

Professional Quality of Life Scale (ProQOL-5)

The ProQOL-5 is a scale designed to assess the affect of working with survivors of trauma (Stamm, 2005), through measuring compassion satisfaction, burnout and secondary traumatic stress (Hemsworth et al., 2018). The scale has good internal consistency with Cronbach's alpha (α) ranging from .75 to .88 across the scales (Stamm, 2010). Cronbach's alpha values ranged from .75 to .85 in the current study.

Patient Health Questionnaire (PHQ-4)

The PHQ-4 is an ultra-brief 4-item self-report screening measure for anxiety and depression (Kroenke et al., 2009). There was good internal reliability for all subscales, with Cronbach's alpha (α) > . 80 (Kroenke et al., 2009). Cronbach's alpha values ranged from .74 to .76 in the current study.

Design and Analysis

A cross-sectional study design was implemented. Hierarchical multiple regression analyses were then conducted to examine the relationship between childhood trauma, attachment style and dissociation, both psychoform and somatoform, in relation to BCT and burnout. Due to the large number of predictor variables, only variables with a correlation of above .25 and an alpha level of .05 or lower were entered into the regression models. All analyses were completed using IBM SPSS version 27.0 (IBM Corp., 2020).

Results

Data Screening

Given the reasonably large sample size, significance in the distribution of skewness and kurtosis was expected, however this was not expected to 'make a substantive difference in the analysis' or underestimate the variance (Tabachnick et al., 2013). Collinearity statistics revealed that variance inflation factor (VIF) and tolerance values indicated there was no significant multicollinearity between the predictor variables for multiple regression analysis (Field, 2013).

Descriptive Statistics

Demographic information captured about the study participants are presented in Table 1, participant scores on the study variables are presented in Table 2 and the descriptive and frequencies of BCT symptoms are presented in Table 3. In the present study, the most common reported experiences of BCT within the previous six months are: muscle tension (84.8%), sleepiness (82.9%), tearfulness (80.7%) and yawning (78.6%). This finding replicates that of previous research conducted by Egan and Carr (2008), Booth and colleagues (2010) and Hamilton and colleagues (2020) who also found muscle tension (83%, 79%, 80.6%), sleepiness (92%, 76%, 72%), tearfulness (71%, 61%, 77.7%) and yawning (77%, 65%, 69.15%) to be of the most commonly reported experiences of BCT, with their findings reported respectively. A correlation matrix presents the bivariate correlational relationships between the predictor and outcome variables in Table 4.

Table 1. Demographic Information

Variable	Frequency (%) or M(*SD*)	Variable	Frequency (%) or M(*SD*)
Age	52.52 (12.56)	**Therapist Type**	
Gender		Psychotherapist	83 (41.9%)
Male	28 (14.1%)	Counsellor	41 (20.7%)
Female	163 (82.3%)	Clinical Psychologist	20 (10.1%)
Non-binary	1 (0.5%)	Counselling Psychologist	24 (12.1%)
Marital Status		Forensic Psychologist	2 (1%)
Single	25 (12.6%)	Counsellor & Psychotherapist	1 (0.5%)
Married	108 (54.5%)	Energy Healing & Light Counselling	1 (0.5%)
Co-habiting/In a relationship	33 (16.7%)		
Separated	3 (1.5%)	Craniosacral Therapist	1 (0.5%)
Divorced	18 (9.1%)	Support Worker	1 (0.5%)
Widowed	5 (2.5%)	Therapeutic Coach	1 (0.5%)
Ethnicity		In Training	4 (2%)
White/Caucasian	163 (82.3%)	Health Psychologist	1 (0.5%)
Black/African	1 (0.5%)	Psychoanalyst	1 (0.5%)
Latino	2 (1%)	Psychosexual & Relationship Therapist	2 (1%)
Asian	6 (3%)		
Mixed Race	7 (3.5%)	Marriage Family Therapist	1 (0.5%)
Other	13 (6.5%)	Recovery Coach	1 (0.5%)
Employment Type		Gestalt Psychotherapeutic Counsellor	1 (0.5%)
Full-time	67 (33.8%)		
Part-time	70 (35.4%)	Art Psychotherapist	3 (1.5%)
Self-Employed/ Private Practice	42 (21.2%)	Eye Movement & Desensitisation Trauma Therapist	1 (0.5%)
Studying	1 (0.5%)	Hypnotherapist	1 (0.5%)
Currently not working/ On sabbatical	2 (1%)	**Clinical Supervision**	
		Weekly	26 (13.1%)
Freelance	2 (1%)	Fortnightly	54 (27.3%)
Retired	4 (2%)	Once a month	105 (53%)
Voluntary	1 (0.5%)	Every six weeks	2 (1%)
By appointment	1 (0.5%)	As needed/Ad Hoc	3 (1.5%)
Client Population		Annually	1 (0.5%)
Children & Adolescents	6 (3%)	None	1 (0.5%)
		Years working with survivors of trauma	12.16 (9.15)
Adults	124 (62.6%)		
Children, Adolescents & Adults	62 (31.3%)	**Number of clients each week**	12.46 (7.00)

Table 2. Study Variables

Variable	M(*SD*)
DES-II	
Amnesia	5.02 (9.00)
Depersonalisation/Derealisation	5.11 (12.03)
Absorption	13.71 (13.50)
SDQ-20	25.97 (7.69)
BCTS	13.13 (7.69)
ECR-RS	
Avoidant	2.86 (1.34)
Anxious	1.96 (1.26)
CTQ-SF	
Emotional abuse	12.18 (5.54)
Physical abuse	7.76 (4.04)
Sexual abuse	7.97 (4.91)
Emotional neglect	13.77 (4.87)
Physical neglect	8.35 (3.56)
ProQoL-5	
Compassion satisfaction	40.81 (5.04)
Burnout	20.20 (4.77)
Secondary traumatic stress	19.98 (4.83)
PHQ-4	
Anxiety	0.99 (1.22)
Depression	0.87 (1.24)

Table 3. Frequency of Occurrences of body-centred countertransference symptoms

BCT Symptom	M (SD)	"never happened to me within the last six months" %	"happened to me at least once in the last six months" %	"happened a few times in the last six months" %	"has happened often in the last six months" %	Happened at some point during the last six months %
Muscle Tension	2.52 (0.96)	15.1	35.9	30.7	18.2	84.8
Sleepiness	2.46 (0.97)	17.2	36.5	29.2	17.2	82.9
Tearfulness	2.31 (0.92)	19.3	42.7	25.5	12.5	80.7
Yawning	2.38 (1.00)	21.4	35.9	26	16.7	78.6
Aches in Joints	2.06 (1.06)	38	32.8	14.1	15.1	62
Headache	1.94 (0.97)	40.1	34.9	15.6	9.4	59.9
Unexpectedly shifting your body	1.99 (1.01)	41.1	28.6	20.3	9.9	58.8
Stomach Disturbance	1.81 (0.94)	46.9	34.4	9.9	8.9	53.2
Dizziness	1.62 (0.88)	59.4	26	8.3	6.3	40.6
Throat Constriction	1.57 (0.81)	60.4	25.5	10.9	3.1	39.5
Sexual Arousal	1.66 (1.12)	60.4	23.4	9.9	5.7	39
Nausea	1.50 (0.72)	62.5	26.6	9.9	1	37.5
Raised Voice	1.48 (0.74)	64.6	24.5	8.9	2.1	35.5
Numbness	1.47 (0.82)	69.3	18.2	8.3	4.2	30.7
Genital Pain	1.19 (0.51)	84.9	12	2.1	1	15.1
Loss of Voice	1.15 (0.48)	89.6	7.3	2.1	1	10.4

Table 4. Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. BCTS																
2. ProQoL – CS	-.04															
3. ProQoL – B	.26**	-.63**														
4. ProQoL – STS	.33**	-.25**	.57**													
5. DES-II Amnesia	.46**	-.08	.24**	.28**												
6. DES-II Dep	.06	.05	.02	.08	.07											
7. DES-II Abs	.46**	-.04	.25**	.35**	.72**	.12										
8. SDQ-20	.51**	-.10	.27**	.35**	.72**	.05	.75**									
9. ECR-RS Avoidant	.16*	-.31**	.27**	.17*	.20*	-.04	.23**	.22**								
10. ECR-RS Anxious	.15*	-.27**	.37**	.33**	.13*	.04	.15*	.22**	.30**							
11. CTQ – EA	.28**	.00	.11	.09	.11	.10	.18**	.26**	.17*	.30**						
12. CTQ – PA	.28**	.02	.10	.10	.29**	.06	.30**	.42**	.23**	.23**	.64**					
13. CTQ – SA	.19*	.04	-.08	-.02	.22**	.04	.30**	.31**	.14*	.13*	.44**	.41**				
14. CTQ – EN	.23**	-.19*	.23**	.16*	.21*	.03	.20*	.34**	.31**	.27**	.66**	.42**	.34**			
15. CTQ – PN	.26**	-.12*	.22**	.10	.25**	.04	.29**	.39**	.32**	.23**	.62**	.57**	.40**	.67**		
16. PHQ-4 Anxiety	.33**	-.15*	.35**	.43**	.09	.11	.18*	.21**	-.02	.29**	.17**	.14**	.10	.17*	.16*	
17. PHQ-4 Depression	.18*	-.26**	.42**	.36**	.17*	.01	.22**	.22**	.09	.29**	.12	.09	.06	.11	.14*	.54**

Note. ** $p \leq 0.001$, * $p < 0.05$

Multiple Regression Analysis

Hierarchical multiple regression analyses were conducted to examine the predictive relationship to determine which variables predicted the likelihood of trauma therapists experiencing burnout and BCT.

The first regression model examined variables that predicted the presence of burnout, as measured by the ProQoL-5. Participant age, gender, anxiety and depression scores were entered in block one as control variables. Attachment anxiety and attachment avoidance were then entered in block two. The somatoform dissociation questionnaire score was then entered in block three. Step one of the model with gender, age, anxiety and depression significantly predicted the presence of burnout, $F(4,187) = 12.16$, $p < .001$, explaining 20.6% of the variance. With the addition of anxious and avoidant attachment styles in step two of the model, it added an additional 9.7% of variance in explaining burnout scores, F change $(2,185) = 12.83$, $p < .001$, with anxiety and depression remaining as significant predictors, with their beta weights .16 and .25 respectively. Both anxious and avoidant attachment styles appeared to contribute the same beta weights to the model, adding more than anxiety, but less than depression, as presented in Table 5 below. The final step did not add to the model in accounting for variance of burnout scores, F change $(1,184) = 3.13$, $p = .079$.

Table 5. Multiple regression model for prediction of burnout

Variable	β	S.E.	*p*	R^2	R^2 change
Block 1:				.206	-
Gender	-.08	.86	.21		
Age	-.04	.03	.53		
PHQ-4 Anxiety	.18	.30	.03		
PHQ-4 Depression	.32	.31	<.001		
Block 2:				.303	.097
Gender	-.10	.82	.10		
Age	-.07	.03	.26		
PHQ-4 Anxiety	.16	.29	.04		
PHQ-4 Depression	.25	.30	.002		
ECR-Avoidant	.20	.23	.002		
ECR-Anxious	.20	.26	.004		
Block 3:				.315	.012
Gender	-.11	.81	.08		
Age	-.08	.03	.23		
PHQ-4 Anxiety	.14	.29	.06		
PHQ-4 Depression	.24	.30	.003		
ECR-Avoidant	.18	.24	.006		
ECR-Anxious	.19	.26	.007		
SDQ-20	.12	.04	.08		

The second regression model examined the variables that predicted the presence of BCT in trauma therapists. Participant age, gender, anxiety and depression scores were entered in block one as control variables. Emotional abuse, physical abuse and physical neglect as measured by the childhood trauma questionnaire were then entered in block two. The dissociative experiences amnesia and absorption subscale scores, and the somatoform dissociation questionnaire score were then entered in block three. Step one of the model with gender, age, anxiety and depression significantly predicted the presence of BCT, $F(4,187) = 5.65$, $p < .001$, explaining 10.8% of the variance. With the addition of childhood trauma subscales in step two of the model, it added an additional 6.9% of variance in explaining BCT scores, F change $(3,184) = 5.11$, $p = .002$, with anxiety remaining as the only significant, $\beta = .28$. The final step of the model, with the addition of psychoform and somatoform dissociation scores, added an additional 18.8% of variance in explaining BCT scores, $F(3,183) = 17.81$, $p < .001$, accounting for a total of 36.4% of variance, with anxiety remaining as a significant predictor, $\beta = .27$. Childhood emotional abuse emerged as a significant predictor in the third step of the model, $\beta = .20$. Both amnesia and somatoform symptoms contributed beta weights of .23 and .22 respectively, adding more than emotional abuse, but less than anxiety as presented in Table 6 below.

Table 6. Multiple regression model for prediction of body-centred countertransference

Variable	β	S.E.	*p*	R^2	R^2 change
Block 1:				.108	-
Gender	.02	1.48	.82		
Age	.05	.04	.53		
PHQ-4 Anxiety	.33	.52	<.001		
PHQ-4 Depression	.01	.53	.88		
Block 2:				.176	.069
Gender	.02	1.44	.75		
Age	.03	.04	.64		
PHQ-4 Anxiety	.28	.51	<.001		
PHQ-4 Depression	-.002	.51	.98		
CTQ Emotional Abuse	.09	.13	.35		
CTQ Physical Abuse	.14	.18	.14		
CTQ Physical Neglect	.08	.19	.38		
Block 3:				.364	.188
Gender	-.008	1.29	.90		
Age	.006	.04	.93		
PHQ-4 Anxiety	.27	.46	<.001		
PHQ-4 Depression	-.09	.46	.24		
CTQ Emotional Abuse	.20	.12	.03		
CTQ Physical Abuse	-.04	.16	.61		
CTQ Physical Neglect	-.04	.18	.65		
DES-II Amnesia	.23	.08	.02		
DES-II Absorption	.10	.06	.35		
SDQ-20	.22	.10	.03		

Discussion

Research exploring countertransference experienced by therapists, has greatly focused on the cognitive and emotional aspects of the phenomenon, leaving a paucity of research exploring countertransference that is experienced at a bodily level. BCT is widely experienced by therapists (Booth et al., 2010; Hamilton et al., 2020; Margarian, 2014), with experiences varying from mild symptoms of headache to more severe or startling symptoms such as numbing of the body (Booth et al., 2010; Cuseglio, 2019; Hamilton et al., 2020; Margarian, 2014; Pearlman & Saakvitne, 1995; Stone, 2006). This study provides evidence that early life experiences, insecure attachment styles and coping styles developed, greatly shape how therapists approach and engage with professional care-giving, manage and cope with the emotionally demanding nature of the profession, and the undesireable consequences that may occur as a result of a combination of these factors. To the best of our knowledge, this study is of the first to examine the impact of these factors on the presence of BCT in trauma therapists. The study has generated findings of significance within this phenomenon, which have important clinical implications for therapists working with survivors of trauma.

In the present study, there were no reported high levels of burnout, with 64.6% of participants reporting low burnout scores. This differs from Brugnera and colleagues (2023) finding which identified up to 50% of psychotherapists experience high levels of burnout, and a recent systematic review which revealed approximately 60% of psychologists experience moderate to high levels of stress from their work (Bell et al., 2024). Hierarchical multiple regression analysis revealed burnout was significantly predicted by anxiety, depression, and both anxious and avoidant attachment style. This suggests individuals who experience mental distress, have difficulties regulating emotions, and experience interpersonal challenges, are at greater risk of burnout.

Well-being and mental distress have previously been associated with burnout (Brugnera et al., 2023; Hardiman & Simmonds, 2013; Morse et al., 2012). Brugnera and colleagues (2023) also found anxious attachment to predict burnout in psychotherapists, however avoidant attachment was not found to predict burnout, differing from the present findings. It is possible that for anxiously attached therapists who experience psychological distress, given their high fear of rejection, over-exaggerate the negative affect that arises in their work (Strauss & Petrowski, 2017), and as result over invest in their care-giving towards the client (Hazan & Shaver, 1990), ultimately emotionally over-extending themselves. Whereas therapists with an avoidant attachment experiencing psychological distress, whom are uncomfortable with closeness (Kong et al., 2018), may try limit the presence of, or engagement with, emotional material (Haroush & Koslowsky, 2020), depleting their energy. Thus, insecure attachment styles impact on therapists' response to their work (West, 2015), leaving them at greater risk of burnout. It is therefore crucial that trauma therapists consider interventions to reduce stress (Bell et al., 2024) or engage in self-care behaviours to lower their risk of reaching burnout (Di Benedetto & Swadling, 2014).

BCT manifests within the therapist in response to the interaction between the client's unfolding narrative within therapy, and the therapists own unmet needs and unresolved conflicts (Sharma & Fowler, 2016). Hierarchical multiple regression analysis revealed BCT was significantly predicted by anxiety, dissociative amnesia, somatoform dissociation, and childhood emotional abuse. This suggests that therapists who experience BCT are more likely to have experienced childhood emotional abuse, engage in psychoform and somatoform dissociative behaviours as a defensive form of coping, and experience symptoms of anxiety.

Bowlby's (1973) work on attachment theory suggested that, in the presence of childhood emotional abuse, when a child is not met with positive care-seeking interactions with their primary caregiver, they will engage in dissociative behaviours. The child does not learn how to engage in adaptive emotion regulation due to the absence of positive modelling of emotional expression (Besharat, 2010). This can result in emotion processing remaining 'stuck' at a bodily level (McHugh & Egan, 2023), which is a risk factor for somatoform dissociation (Nijenhuis et a., 2004). Childhood emotional trauma has previously been associated with psychoform dissociation (McHugh & Egan, 2023), and dissociative amnesia is assumed to be a natural way of coping in response to childhood trauma (Mangiulli et al., 2022). These dissociative ways of coping remain separated from conscious until the individual is faced with stressful situations in life (Bowlby, 1973), and become an automatic coping response over time (Zorzella et al., 2020). Somatic dissociation is believed to become reactivated when the individual is faced with reminders of their trauma later in life (McHugh & Egan, 2023).

Thus, in understanding this finding from the model of Affect Phobia (McCullough, 2003), when the therapist is actively tuned in to their client's traumatic narrative in session, trauma therapists with a history of emotional abuse are likely being triggered and in the absence of connecting to their feelings, grounding their bodies or acknowledging how their client's narrative is triggering them, this then increases their anxiety. This leads to further negative emotional and physical reactions, and in the absence of learned adaptive coping (Besharat, 2010), and in an effort to avoid these feelings the therapist then engages in defence behaviours (McCullough, 2003). These behaviours manifest both psychologically, in the form of dissociative amnesia, with therapists having an inability to recall their emotional trauma (American Psychiatric Association [APA], 2013) and physically, in the form of somatoform dissociation, where trauma related memories are stuck physically (McHugh & Egan, 2023; van der Boom et al., 2010). Somatic dissociation was moderately associated with BCT in the present study, suggesting these therapists are more likely to experience BCT.

This finding has significant implications for therapists working with survivors of trauma and have their own experiences of childhood trauma. It is important that when therapists are engaging in supervision or personal therapy, they are reflecting on what is happening within their bodies in response to their client, to identify whether they are integrating memories or they are going in to defence (Athanasiadou & Halewood, 2011), through engaging in one or both forms of dissociation. If the therapist is in defence, and unaware of their BCT reaction, as previously highlighted from past research, this may have detrimental implications for both the therapist and their client (Athanasiadou & Halewood, 2011; Blackburn & Price, 2007; Heard et al., 2018; Shaw, 2006).

Although the findings of the present study have generated new information in our understanding of BCT, they should be interpreted with the consideration of study limitations. As the study employed a cross-sectional design, it is important to note, that the research took place during the time of Russia-Ukraine war, and shortly after the Hamas-led attack on Israel that led to the Israel-Hamas war. This was reflected by a few participants in the commentary feedback section of the study questionnaires. Thus, given the nature and significance of these events, this may have contributed to greater psychological distress in those directly impacted (Khrushch et al., 2023; Xu et al., 2023), and future research may benefit from a longitudinal study design to examine these relationships over time.

Given the reported consequences for therapists and their clients as a result of therapists being unaware of their BCT, it would be beneficial to understand what factors or strategies may be able to prevent such outcomes. Future research may benefit from examining the impact of attendance at supervision or participation in personal therapy on BCT, as well as therapist quality of life outcomes. This may provide valuable information on how therapists can manage and potentially reduce the negative outcomes that can arise from engaging in an emotionally demanding profession.

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Pseudologia Fantastica (i.e. Pathological Lying) as a Possible Outcome of Complex Trauma

Kyd Shepherd

Abstract

Pseudologia Fantastica is an interesting syndrome as it is commonly talked about yet remains elusive in many regards. Thus, this presentation will aim to shed light on its purpose within the mind of the pathological Liar as well as the potential unconscious ramifications of complex PTSD and psychotherapeutic treatment. In order to explore these topics, we will first define pseudologia fantastica and explore the interpersonal dynamics of this syndrome, after which we will draw a direct link between pathological lies and the traumatic truth. Next, we will present four different phases of psychotherapy. Lastly, we will conclude with a discussion of the inherent limitations of this paper. In this essay, pseudologia fantastica will be analysed as a standalone disorder and in light of psychoanalytic theories, namely those of Bion, Lacan, Klein, Kernberg, Fairbairn and Kohut, as well as my observations and ideas based on my clinical experience with pathological liars.

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What is Pseudologia Fantastica?

Pseudologia Fantastica is a relatively rare syndrome in which the individual lies by wildly exaggerating or creating events, presenting their fantasies as reality, thereby aggrandising their sense of Self.

This disorder is known by many names in the mental health community: *Compulsive lying, pathological lying, mythomania and pseudologia fantastica*. All these names regroup the same clinical reality. Interestingly enough, this syndrome is not recognised by the DSM-5 nor the ICD-11 as a standalone disorder but as a symptom of a larger personality organisation (ex, borderline personality disorder, narcissistic personality disorder, factitious disorder, histrionic personality disorder, antisocial personality disorder). I believe this lack of an 'official' nosological delineation has contributed to the vagueness of its definition and absence in our professional discourse.

So, for the sake of clarity, I am going to provide a list of ten features partially inspired by the perspectives of psychoanalysts such as Kernberg (1992), Kohut (1971) and Bollas (1987), as well as my own clinical experiences, encounters, and observations of people experiencing pseudologia fantastica:

● Pseudologia fantastica is compulsive, meaning that the person cannot control themselves as if lying were stronger than them, despite all the negative impacts of this behaviour on themselves and others.

● The content of pathological lying can vary, but its purpose is to attract the attention/sympathy and admiration (or, in some cases, anguish) of others, at least in part.

● On a psychological level, pathological lying is a fantasy (=imaginary thought) presented to others as reality.

● The person does not feel guilt, remorse or distress about lying/deceiving others.

● If the lie is exposed as false, the person can either retreat into denial or experience deep shame, but this shame cannot be mobilised as a transformative element.

● Lying does not inherently have as its objective material or financial gain, identity theft, an increase in the standard of living, etc. Unlike the con man, who seeks material gain,

● The content of the lie is often grandiose, incredible, exceptional and easily refuted by an outsider.

● The content of the lie is not impossible in itself, but it seems unrealistic, unlikely and very theatrical/dramatic.

●The person resorting to pseudologia fantastica is aware in his inner Self that his lies do not coincide with reality, even if he can refuse to admit it to others. In this sense, reality testing is not lost, unlike psychosis.

● Pseudologia fantastica is intrinsically connected to a feeling of enjoyment (jouissance in French) in the person who suffers from it. That is, they take pleasure in creating and sharing their lies.

Please note:

Although I can attest to the clinical usefulness of these criteria, as they have helped me navigate the disorder, I am not implying that they are an exhaustive listing or that they constitute the absolute definition of pseudologia fantastica. There very well might be symptoms or manifestations that are missing from the list. So please keep this in mind during the lecture on this essay.

In this paper, I will be working with three Apriori:

● Firstly, pseudologia fantastica is a separate (standalone) nosological entity. As such, I will leave out co-occurrences and comorbidities to focus on the topic at hand.

● Secondly, pathological lying has an unconscious meaning, aetiology and purpose for the individual suffering from it. It is a creation of the mind that is made manifest; hence, it is akin to a positive symptom (in the psychiatric sense) as it adds rather than withdraws from the person's experience of the world.

● Thirdly, I believe pseudologia fantastica to be on a spectrum from limited to a specific area of life in the mildest cases and all-encompassing in the more severe ones.

Lastly, I would like to emphasise that my intention is not to reduce or override the variety of manifestations and hypotheses linked to pseudologia fantastica but only to add my own understanding based on clinical experience and the literature I have read.

Key takeaway:

A lie always implies a truth, and pseudologia fantastica is no exception. In the case of pathological lying, it is buried as deeply as possible but still retains its intensity, as often this truth is intertwined

The interpersonal dynamics of Pathological lying

In her 1921 article "On the Pathological Lie (Pseudologia Fantastica)", psychiatrist and psychoanalyst Helen Deutsch (1884-1982) argued that this syndrome isn't directed towards others but only towards the Self. Thus, the relationship is incidental, and the lie is created solely for the Liar's sake and to aggrandise their sense of Self.

Although I agree with the narcissistic aspect of her theory, I do take issue with the relationship being incidental. My clinical experience has led me to the opposite conclusion. The pathological lie is addressed to the other(s), those receiving the lies. I believe the Receiver is as important as the Emitter[1]

This dynamic is based on the feeling of excitement. Indeed, the Liar creates a fictional narrative that they share with others. The Emitter will often put considerable effort into their 'storytelling,' steering the tall tales to elicit the desired reaction from the Receiver. The aim is often to stimulate suspense and excitement while maintaining and controlling the relationship with the lie.

These thrilling lies tend to fascinate the receivers and lower their critical reasoning skills and scepticism, at least at the beginning of the process.

From a psychoanalytic perspective, we could argue that the Emitter uses a form of projective identification, an archaic defence mechanism theorised by psychoanalyst Melanie Klein (1946). This mechanism involves projecting into the psyche the aspects of oneself that cannot be integrated.

In the case of the Emitter, we could speculate that he is unconsciously replaying an infantile pattern in which the lie not only eclipses the truth but also stimulates the other and controls them with the presented narrative. Thus, the Emitter is splitting between an idealised, grandiose false ego he incarnates and a vulnerable, gullible yet genuine true self he projects into others. Thus, this creates a loop in which the Emitter gains a temporary boost to their pride and sense of Self by manipulating the gaze of others.

If we were to consider this dynamic from the perspective of Fairbairn’s Endopsychic structure (1944), we could argue that the Emitter plays the role of an Exciting Object (i.e. a relationship that creates an unconscious hope of perfect love and fascination) and through projective identification triggers the Receiver's libidinal Ego (=the part of the mind that seeks an perfect relationship that is flawless).

[1] Throughout this section, I will name the pathological Liar, the Emitter (of the lies) and the person experiencing the lies, the Receiver.

This interaction gives the Emitter relational control and maintains the splitting process.

Please note that this dynamic can also be based on anxiety. The Emitter might lie about an illness, a traumatic event, or a loss to create unrest (like excitement) in the Receiver and prevent them from being too critical of this behaviour or enjoying the anguish it causes. In these cases, the projective identification aim is to reduce the Receiver to a state of powerlessness that the Emitter experienced as a child.

However, when the lie is discovered, the Receiver often shifts from excitement/anguish to hate, bitterness, rejection and suspicion for the Emitter. In this state, the presented narrative collapses. The relationship enters a dynamic in which the Receiver sees the Emitter as a Rejecting Object (= a terrible relation that aims to destroy them), which sparks the Antilibidinal Ego of the Receiver (= a part of the mind that seeks to defend against the rejecting Object by all means).

In this phase, the splitting is still present but inverted. The Emitter becomes a feared enemy, and the Receiver a potential victim. This can also create a narcissistic gain for the Emitter, as they are perceived as all-powerful and thus become the ruthless parent they feared as a child. Nevertheless, it will most likely destroy the relationship between both parties, as the Emitter no longer controls the bond.

The reader might wonder what happens when the Emitter is deprived of a Receiver (i.e., someone who will engage in this interpersonal dynamic). Often, the Pathological Liars will try their utmost to reach out to 'new' people, whether in person or on the internet. However, if this no longer works for them, they might try to repeat this dynamic with former Receivers. When this fails, they will attempt to become both the Emitter and Receiver. This tentativeness is made in front of other people. In these cases, the pathological Liar doesn't engage others and can only project and not use projective identification (which makes the dynamic incomplete and unfulfilling).

Moreover, if they run out of options, they might regress to a more archaic state of mind by attacking their own body to draw attention (substituting words with actions, i.e. Acting Out). In these cases, they might deploy fictitious disorders or attempt suicide to get medical attention and recreate the interpersonal dynamic with medical staff members.

An important question we might ask is why the pathological Liar constantly tries to repeat this dynamic.

● The first and most manifest reason is to supply their narcissism and reinforce their feeling of omnipotence, grandiosity and control over the Object (i.e. the other, as we call them in psychoanalysis).

● Secondly, this dynamic strengthens the lie by making it masquerade as reality. Indeed, having one or more people believe the falsehood reinforces the obfuscation of the truth and makes it even harder to reach or hold the Emitter accountable.

● Thirdly, on an unconscious level, this dynamic allows the Emitter to externalise internal tensions and conflict. Tensions and conflicts that cannot be integrated into the conscious mind are expelled onto another person.

Finally, I will mention that pseudologia fantastica constitutes a form of societal transgression. This attack is a result of the distrust and suspicion caused by lies, as our entire society is built on trust and confidence, from our daily interactions to the macro level, encompassing the global economy and international relations. Furthermore, repeated falsehoods undermine the integrity of global systems.

Key takeaway:

Pseudologia Fantastica is fundamentally an interpersonal phenomenon. In it, the pathological Liar seeks to create an emotional state of excitement and/or anguish within the person listening to the falsehood. Thus, the pathological lie is always addressed to another person in addition to oneself

Pseudologia Fantastica and the Traumatic Truth.

Before diving into the notion of trauma and its connections to pseudologia fantastica. I would like to take the time to develop the following question:

What is a lie?

This may seem futile to ask at this point, but it is nevertheless necessary. A lie is a false statement, a falseness that implies that there is a truth, something genuine. The lie cannot exist without the truth, as a shadow cannot exist without the casting of the light.

To further this point, the philosopher Martin Heidegger (1927), in his book *Being and Time*, ties the notion of truth to the ancient Greek word *ἀλήθεια* (Aletheia). This means etymologically what is 'unhidden' or 'unconcealed', i.e., what is obvious. So, in this perspective, the lie obfuscates and hides the truth, as there is no need for a lie if there is no truth, just as there is no need for a forgery if there is no genuine object to copy.

In the ‘classical’ sense, also known as the everyday lie, this obfuscation is relatively easily explained by the desire to avoid negative consequences or to gain a certain advantage. However, in the cases of pseudologia fantastica, this obfuscation is not as straightforward.

In my clinical experience, it is quite common for the pathological Liar to deny any meaning or truth behind the lie (at least in the first months of psychotherapy) as if the lie was 'pointless' or merely a form of enjoyment. This posture casts the truth even further away, with the lie being a way of burying the truth and the excitement/ anxiety a tactic to generate in others a distraction that aims to mislead.

They operated under the axiom 'Any lies are better than the truth'.

A position that goes against the collective values of society and inverts them.

A second question now arises:

Why does the pathological Liar need to conceal the truth to such an extent?

I believe this phenomenon occurs because the truth is experienced as inherently destructive by the compulsive Liar.

A destructiveness that is felt on both an unconscious and preconscious level. The truth is experienced as a powerful force to rupture the continuity of the Self and break it down (i.e., the fear of losing the sense of Self). A breakdown that must be avoided at all costs. The question now is, what are the roots of this force?

At the core, I believe the trauma to be a fundamental truth that cannot be detoxified or integrated into the conscious mind, so the only option left is to cover it.

It is important to note that the pathological Liar has often undergone highly traumatic experiences in childhood (sexual assault, rape, violence, neglect, extreme humiliation, belittlement, utter rejection, hate). The nature of the trauma can vary, but it is often severe and repeated throughout the psychological and physical development of the individual. Making it impossible to avoid or escape the situation. Thus, we can postulate that the pseudologue has a form of C-PTSD.

The inescapable nature of trauma pushes the pathological Liar further and further into falsehood as an ultimate way of creating a new reality that is not just manageable but fantastic and flamboyant, rewriting the lived terror. If we were to use a metaphor, it is as if the pseudologue were constantly burying a corpse that continuously resurfaced.

From a psychoanalytic perspective, there would be two ways of explaining this phenomenon:

- The first would be to use Bion's (1962) ideas of Beta-elements (β) and the Alpha function (α).
- The second would be that of the three orders as defined by Jacques Lacan (1953).

In the early sixties, British psychiatrist and psychoanalyst Wilfred Ruprecht Bion developed a theory of the mind in which traumatic and unbearable events, sensations and effects are slowly processed and transformed by the caregiver during the first years of life into bearable and integrable elements within the mind. In addition, with time and repetition, the infant can identify and copy the caregiver's ability to transmute the displeasure events. He called this transformational capacity the Alpha function and the destructive elements the Beta elements (β).

Thus, for Bion, trauma can be conceptualised as an accumulation in quantity and intensity of Beta-elements that override the ability of the Alpha function to contain and process them. From this perspective, our psychotherapist role is to help the patient process and digest those beta-elements by leading them to our alpha function through interpretation, the setting, and our positive regard.

In the best-case scenario, the Alpha function should drive clinician and patient into a reverie in which the Beta elements are contained and transformed into thinking, hoping, loving, etc.

In regard to the syndrome of pseudologia fantastica, we can postulate that the traumatic truth has never been processed or digested by the pseudologue. It has remained in the mind as a beta element capable of destroying the individual's psyche as if it were a foreign object in the body, something that does not belong there. Thus, the mind tries to contain it through the lie as the body tries to contain the effect of the foreign Object through inflammation and antibodies. However, this defence of the mind is limited, as the traumatic truth does not diminish in intensity or force. The ability to detoxify the beta elements is lost and replaced by the lie instead of the reverie. As such, this process is not an alpha function, but a pseudo-alpha function that only limits, but does not process, the traumatic truth.

The Alpha functions often don't fully develop or even regress because, during childhood, the individual was neglected, left alone with this destructive event, not knowing what to make of it. In some other cases, the child might have been mystified[1] by adults around him. Caregivers who would deny the trauma called the child a liar, an idiot, or an attention seeker.

In such cases, the child has nowhere to turn but to a lie to save their identity. The fantastical falsehood becomes a refuge from the unbearable truth as the environment never processed or acknowledged it.

In time, the survival mechanism becomes pleasurable for the individual as they witness the control and admiration it grants them to others, pushing them further and further away from integrating the traumatic truth.

In the early fifties, Jacques Lacan, a French psychoanalyst and psychiatrist, conceptualised three orders that organise the human subjective experience:

- *The Symbolic*

The symbolic order is the realm of rules, laws, and meaning. It represents the Other on a radical level, as we must inscribe ourselves into a collective set of symbols and understanding (including language). These symbols and laws aren't 'us', but we must abide by them. By doing so, we gain structure and develop the reality principle and a Superego (i.e., a limit to the pleasure principle and moral compass).

[1] A process that is now commonly known as gaslighting

● *The Imaginary*

In the Lacanian conception, the imaginary is the order of identification and alienation, as the Ego is forced to identify with others and become aware of itself in a social setting (through the mirror stage). Thus, a gap is created between one's self-image and what one presents to others. However, this gap implies losing a part of ourselves in the process. This is also the root of deception, allure, and masquerading, among other things.

● *The Real*

Finally, the Real is a phenomenon that the mind cannot assimilate, as it cannot be symbolised or played with. The Real is beyond understanding, and it does break down the Ego as it cannot be assimilated into meaning. It remains meaningless and even dissolves the narrative of one's life. In many ways, the mind is built against the experience of the Real. This order is inherently traumatic, but it isn't just the trauma. It encompasses the effects of trauma on the identity of the person themselves.

Tying it back to the question of pathological lying, we can speculate that the truth, because of its highly traumatic nature, fragments the narrative the pseudologue tries to build. Hence, the truth becomes part of the Real and must be fought against. In this perspective, the pathological lie is like a *neo-reality* that aims to maintain the sense of Self of the individual, as discontinuous and bizarre as it may seem. Moreover, without the lie as an ultimate safeguard, the individual might fall at risk of collapsing into psychosis.

However, the fight against the Real would be unconscious as the pathological Liar, on a conscious level, experiences feelings of elation, pleasure and power through his lies, what Lacan (1958) calls *Jouissance* or Surplus enjoyment in English. A pleasure is intertwined with the action of transgression, meaning the lie isn't part of the symbolic order but the imaginary, in which deception is central, and what matters is the masquerade and the image.

In a way, it was as if the pseudologue clung to the Imaginary order to push back the Real and resist the integration into the Symbolic realm. The laws and rules fell meaningless as they were not enforced, operative, or disavowed when the pathological Liar was a child, preventing the pseudologue from building and maintaining a proper Superego.

In both cases, the truth, due to its intensity, becomes an unbearable part of the mind (Beta-elements or the Real) that cannot be integrated, as the individual lacks the necessary processes to do so (absence of the Alpha function or the symbolic order). Thus, the pathological Liar is stuck in a constant struggle to prevent the truth from resurfacing and, by doing so, prevent it from being forgotten.

Please note:

● That even though both theories can be complementary, these ideas are part of very different schools of thought, and they might be issues if one tries to merge them.

● In this essay, I have tried to make Bion's and Lacan's models more accessible to a layperson in psychoanalysis. However, by doing so, I have omitted many of the complexities, intricacies, nuances, and depth that these two authors are renowned for. I can only invite the reader to further their understanding of these brilliant thinkers.

● Although I have found these intellectual constructs to be valuable in explaining pseudologia fantastica, I am by no means implying that these are the only meaningful ways of explaining this syndrome.

Key takeaway:

A lie always implies a truth, and pseudologia fantastica is no exception. In the case of pathological lying, it is buried as deeply as possible but still retains its intensity, as often this truth is intertwinedPsychotherapy and its effects on Pseudologia Fantastica.

Psychotherapy and its effects on Pseudologia Fantstica

Pathological liars are seldom interested in psychotherapy. Despite the negative consequences, they do not tend to suffer consciously from the falsehoods they create and share. More often than not, they come for another reason (a relative threatens to cut ties, an impending divorce, or social isolation). If this alternative is often presented as 'the only one', an astute clinician will quickly spot the pseudologia fantastica and how it impacts the patient's life. However, this syndrome is rarely treatable in a direct fashion, as would be the case with anxiety or depression, as pathological Liar would often vehemently deny the presence of lies in their discourse. As such, the process of psychotherapy can be quite challenging and complicated with the pseudologue, but it remains possible in some cases.

These specific instances are what I will be exploring in the next paragraphs. I am now going to present the four phases of psychotherapy I have identified through my clinical work with pathological liars.[1]

I. The centrality of the lies

This is the first phase of psychotherapeutic treatment. At this stage, the pseudologue will try to recreate the emitter-receiver dynamic with the therapist. The patient will often show disinterest when the clinician asks about information that isn't tied to the lie, putting the discussion back on track. During this period, the pseudologue blocks all attempts to avoid or go beyond the falsehood, and the lie(s) take centre stage in treatment.

If the therapist attempts to interpret, confront or expose the lie(s) of the patient. They can show signs of withdrawal or aggression towards the professional as if they were going to be ripped apart and destroyed. At this stage, the truth is unbearable and a threat to their sense of Self and being in the world.

Thus, they might see the therapist as a malevolent individual who is out to harm them and doesn't care about their well-being. In these moments, they developed what psychiatrist and psychoanalyst Otto Kernberg (1992) calls a paranoid transference towards the professional.

[1] The four phases are a construct of mine, but they provide a heuristic framework that I want to share because I find it valuable.

In this early stage, the clinician should refrain from directly interpreting the lie or drawing attention to it as a defence mechanism. However, this doesn't mean the clinician should take everything the pseudologue says at face value; the professional can also 'reframe' the information to subtly indicate that the lie doesn't fool him. This reframing can be achieved through formulations such as: 'This is your perspective', ' How do you feel when you share this information?' and' It seems important for you to share this information with me'. This reframing aims to show the patient that the psychologist is not tricked while respecting the necessity of recourse to pseudologia fantastica.

This space given to the lie is essential in developing the therapeutic alliance (what we call transference in psychoanalysis). Without this 'respect ' given to the lie, the pseudologue is at risk of leaving therapy prematurely, as it is experienced as deeply dangerous, as it seeks the destructive truth. The tolerance and patience shown toward the lies (without the feelings of excitement or anxiety) are also what will differentiate the therapeutic relationship from other relations. The pathological Liar will slowly feel less interested in recreating the interpersonal dynamic and more open to another type of interaction. In this phase, the therapist might feel profound boredom or aggression. These states of mind indicate a form of countertransference, an impossible connection, and a lack of genuineness on the part of the patient, as the truth remains hidden.

Side Note:

The clinician may not be able to detect pseudologia fantastica in the patient for a few reasons:

- Because of a high level of masking by the patient.
- Because of the coherence of the lies being presented.
- Because the interpersonal dynamics of the syndrome sway the clinician.

Whatever the case may be, if pseudologia fantastica remains undetected, it will most likely go unaddressed, and the following consequences will not occur.

II. The rewriting of the lies

The lies are still very present in this phase, but their nature seems to have somewhat changed. They are more flexible, and the pseudologue can ‘rewrite’ them to fit his current state of mind or external events in front of the clinician. The patient frames this change as: ’I was joking’, which Kohut (1971) called a ‘half-joke’ or ‘I have remembered a new aspect’. In the best-case scenario, he will even explicitly state the falsehood of the information: 'I lied about the first version. The one I am giving now is the real one.' 'No, that was a lie. This is what truly happened.' In this phase, the lie is exposed for both the therapist and the pseudologue, creating a sort of 'game' between them.

This game can be extended to aspects of the setting, such as the patient trying to guess the dates of the therapist's next holidays or counting the number of sessions before the end of the year. The lie loses its centrality in this phase, and other topics become available for conversation. At this stage, the patient will not be as strongly denied the traumatic truth, and he may even show glimpses of it.

The aim of the pseudologue through the lie now becomes to maintain the ‘good enough’ relationship as it evolves beyond the interpersonal dynamics. In many ways, it is as if the patient has started playing again, similar to the young child who plays to experience the world and its relationships.

From a psychoanalytic perspective, we could interpret this phrase as a regression to an earlier stage of life that involves making beliefs rather than overt falsehood. This regression also reduces the need for pseudologia fantastica as a defence mechanism for the individual, as the pseudologue enters a positive transference towards the therapist and starts to trust them.

At the tail end of this stage, the individual may even admit and apologise for the lies he has told the clinician. I believe that these moments are critical in the therapeutic process as they show that the pseudologue expresses gratitude for maintaining the relationship and a form of reparation toward the other and trusts them enough not to fear repercussions in the therapy.

Although the lie has decreased in both intensity and frequency, the clinician should not directly confront it as it could weaken the therapeutic 'game'. However, the therapist can now gently question the validity of what the patient is saying through formulations such as: ‘Is that really so?’, ‘Are you sure?’, ‘Is this the full picture?', and ' What you are saying seems quite extreme'.

However, this soft redirection by the clinician feeds the playfulness of the interaction and thus transforms the lie into a more flexible defence mechanism for the patient. At this stage, the traumatic truth remains destructive and cannot be brought into the therapeutic space; it can only be pointed to and denied.

Regarding countertransference, the therapist might start to feel sympathy towards the patient and a sense of playfulness as the therapeutic relationship opens up to something real, as the truth emerges.

III. From lies to reverie

At this stage, the lies become infrequent, and the patient starts to present his constructs as fantasies, i.e., something that could have been or could have the potential to be. In this phase, the sharing of information is closer to a daydream than anything else but presented as such through words like: ' If only it had gone this way…', ' I could have been so much better…', ‘ I would have loved to have done this…', ‘ If I were like this I would…’.

This stage shows a transition from lies to reverie in which the patient can allow themselves to investigate their subjective experience while recognising and sharing it as such, and no longer presenting it as facts. In addition, the interpersonal dynamic at this point is less about excitement/anxiety and more about potentiality and introspection.

In regards to the traumatic truth, the patient can now talk about it to the therapist in a prolonged manner, explaining the events and their repercussions for them (both psychologically and physically) and their family.

Although the traumatic truth is now exposed, it is not yet accepted by the patient. As such, the lies might come back at any point to try to cover up the trauma. Tentatives might still be made to divert the clinician's attention to lies. However, the step from consistent lying to reverie is as important as the pseudologue becomes increasingly capable of distinguishing the delimitations between their inner world (made up of fantasies and daydreams) and the external world. Thus, the internal world does not 'leak' out into the external one.

From a psychoanalytic perspective, we could interpret this subjective change as the patient becoming able to process beta-elements with their own mental apparatus without feeling the need to expel them. We could argue that the pseudologue has internalised a good internal therapist with an operational Alpha function that can detoxify the suffering they experienced (what Fairbairn would call an Ideal Object). In addition, we could think that enough detoxification has occurred that the trauma isn't threatening their existence, a diminished menace that consequently frees mental resources that can now be used to daydream about a potential past or future.

At this point, the patient can acknowledge the trauma and talk about it, but he may resist it if the clinician brings it up too frequently or too directly. However, the clinician can now encourage introspection in this direction and even offer interpretations that would 'normally' be rejected by the patient. Through their interpretations, the therapist is helping the patient make sense of his traumatic experiences and slowly developing an intrapsychic space in which reverie slowly replaces the lies. By doing so, the truth starts to lose its destructive nature and is reintegrated into the mental life of the patient.

The clinician might also start developing a deep and interesting reverie when the patient talks about what they wish for or how they would do things differently. This form of countertransference is a type of co-thinking (Widlöcher, 2012) in which the clinician unconsciously shapes the patient's fantasies, thus reinforcing their subjectivity.

Side Note:

At this point, the astute reader might wonder how the clinician can tell if the events mentioned are real or just another lie.

It seems to me that if the patient shares the information to worry or excite the therapist, it is most likely a falsehood. The truth, however, is not a matter of excitement or a way of triggering anxiety; it is a painful experience that the pseudologue is reluctant to talk about, contrary to the lies that they enjoy spreading. So, I would postulate that the resistance to communicating the information and exploring its impacts is a sign of genuineness.

IV. Boredom and the acceptable truth

In this final phase, the patient begins to experience a state of boredom, characterised by the absence of excitement and/or anxiety. The lies become rare and seem more procedural than stimulating. Other topics take centre stage, such as grief, regret, fear of the future…

At this point, the pseudologue has developed what I would call a healthy state of boredom in which he can tolerate the mundanity of life and day-to-day issues. These struggles are more frequently talked about in therapy.

This ennui shows that the patient has developed a stronger reality principle that can postpone the instant gratification of the lie or reverie to focus on harder yet more important aspects of human existence. In a sense, it is as if the fantastical elements have resorbed into the inner subjectivity of the individual, leaving them to deal with current problems or existential questions (such as death, freedom, etc.).

At this stage, the truth is no longer destructive, and it becomes acceptable to openly talk about it. Feelings of sadness, vulnerability, loss, and grief become prevalent, and the patient can let go of the pseudologia fantastica as a defence mechanism. The truth cannot erase their identity as it once did.

In terms of psychoanalysis, we would interpret the following improvements as the transition from a paranoid-schizoid (Klein, 1928) position in which the individual feels complete, all-powerful, merged with the others and persecuted to a depressive position (Klein, 1928) in which the individual experience themselves as limited and others as separate. The pseudologue goes from fantasies of absolute excitement and control over others, themselves and the truth to a position of boredom and renunciation of the defence mechanism. The renunciation is also more fundamental because omnipotence is given up.

The corollary of this renunciation is the addressing of the repressed feelings of powerlessness, despair and terror linked to the trauma that, up until then, was unbearable for the patient. The trauma becomes an accepted part of the patient's subjective experience.

In this final stage, both the patient and the therapist can openly discuss the trauma. Even though the patient might still find it difficult or painful, he will go there.

Regarding countertransference, the clinician might start to truly feel connected to the patient even if the content of the sessions is more mundane. This is because the interpersonal exchange is now genuine in both parties. In addition, the clinician might even feel hopeful.

Please note:

Although I have chosen to present the four phases separately, there are many intersections between them, and some aspects of one phase may be present simultaneously in another. Therapy is a dynamic process in which rigid categories are only provided as a general 'map' rather than rails to follow.

There might also be other hurdles in the psychotherapeutic treatment of pseudologia fantastica, among which:

● *In and out relationships.*

It is frequent for pseudologues to quit therapy only to come back a few months later. This difficulty is because some of them resist transference, and they might be afraid of truly trusting the therapist. As such, they might present a form of 'In and Out relationship' as defined by Harry Guntrip (1969).

● *Subversion of therapy*

Some pseudologues might present a perverse personality or what psychiatrist Otto Kernberg (2009) called malignant narcissism, and they might try to pervert therapy by making it a destructive process rather than a healing one. In these cases, the pseudologue will try to triumph over the therapist, and the lies will be weaponised against the professional in a sadistic manner to enjoy the distress that they might cause. Needless to say, the prognosis for such individuals is not good.

● *It is easier to treat pseudologia fantastica in institutions than in private practice.*

I would also add that the treatment of pseudologia fantastica might be easier in an institutional setting. The patient may have more professionals to consult and review their scenarios, making the process more contained and manageable than in a private practice. In addition, the patient may be able to trust the clinician more, as the transferential investment is in the entire institution rather than in one individual therapist.

● *Comorbidities*

Lastly, there might be comorbidities such as borderline personality disorder or histrionic personality disorder that necessitate specific treatment. In addition, it might be, depending on circumstances, better to prioritise the treatment of the personality disorder rather than the pseudologia.

Key takeaway

In this section, I outlined four phases for the psychotherapeutic treatment of pseudologia fantastica. These phases provide a theoretical 'map' for the clinician working with pathological liars and demonstrate that psychotherapy is possible and valuable for these individuals.

Discussion of the main ideas and their limitations.

This paper presents my perspective on the pseudologia fantastica syndrome, its possible origins, and psychotherapeutic treatment. Although I strongly believe in the value of my work, I must also acknowledge its limitations. I will now be addressing the following points:

- *The Neurological atypicality of the pathological liars.*

In a study headed by Yaling Yang, titled "Localisation of increased prefrontal white matter in pathological liars," scientists found an increase between 23% and 36% in white matter in multiple brain parts compared to the standard population.

According to Yang and his team, this difference in brain matter could indicate a potential cause for pseudopodia, or, conversely, be the neurological result of consistent lying. This is a biological chicken-and-egg situation in which I cannot contribute, as my knowledge of neuroscience is quite limited and beyond the scope of this article.

- *The lies are part of the family system.*

Some French psychologists like Simone Korff-Sausse have argued that the root causes of pathological lying could be found in the family dynamics and that it is often the parent who lies to the child. A lie that is allowed and even encouraged in order to escape/ survive the perceived wrath of the outside world/ society. Although I agree with this hypothesis, my work centred more on the intrapsychic and interpersonal processes of the pseudologue rather than the family interactions. That said, I do not think these two perspectives are mutually exclusive; rather, I believe they are complementary. I just think that the issues are not approached from the same angle.

● *The limitations of my clinical data*

To be fully transparent with the reader, I have only encountered ten patients who would fit the criteria listed at the beginning of the essay. Out of these ten individuals, I only met four of them once. Two of them came for five sessions or fewer. For the remaining four, I provided psychotherapy ranging from six months (for the shortest) to six years (for the longest). Although the sample size could be considered statistically negligible, I believe the insights we (both I and the patients) have gained are relevant and important in treating pseudologia fantastica as a syndrome.

● *This model is psychoanalytically incomplete*

In this paper, I described both interpersonal and subjective dynamics. However, I haven't inscribed my theory within a global metapsychological framework (e.g., drive theory, the endopsychic structure, etc.). This means that the explanations provided are insufficient to understand the psychodynamic process implicated in pathological lying.

Conclusion

In this essay, I have presented pseudologia fantastica as a standalone syndrome (without the comorbidities). Although this distinction may seem artificial, I believe it is valuable and necessary to better understand the processes at work. I have also tried to demonstrate that the pathological lie is not meaningless. Quite the opposite, it makes sense as a defence mechanism against an unacceptable truth based on a deeply traumatic experience. Thus, the truth becomes associated with the experience of trauma and disavowal, which makes it destructive. Destruction the individual avoids at all costs on an unconscious level. This defence becomes a source of surplus enjoyment, and the lies bury the truth. Lastly, psychotherapy can help the pseudologue to manage and work on the lies. I defined the process of therapy in four stages that I have observed:

I. The centrality of the lies

II. The rewriting of the lies

III. From lies to reverie

IV. Boredom and the acceptable truth

My aim with this paper is to open the conversation and share new insights on this unusual and relatively rare disorder. A syndrome that is still often dismissed or relegated to a mere symptom of a wider personality disorder by many professionals.

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Key takeaway:

Although this paper aims to gain a deeper understanding of pseudologia fantastica, it remains a contribution to a broader understanding of the syndrome, as limitations in neurology, family dynamics, and metapsychology persist.

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In closing, I would like to thank the Complex Trauma Institute for allowing me to participate in the 7th International Trauma Conference, and you, the reader, for taking the time to read this paper.

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

Adela Stockton

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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