Survivor#led relational psychotherapy and embodied trauma: A qualitative inquiry

Survivor-led Relational Psychotherapy and Embodied Trauma: A Qualitative Inquiry

Abstract

Background: Childhood sexual abuse has complex and multifarious consequences for one's physical and mental health, including injuries and psychological illnesses such as depression (Browne & Finkelhor, 1986; McGee et al, 2002; Hornor 2010). In contrast to traditional psychotherapeutic approaches that focus on the treatment of disorders, Humanistic integrative frameworks address the relational and neurobiological roots, and cumulative impact, of trauma (WHO 2007; Rothschild, 2000). Quantitative research investigating the efficacy of these various therapies is gaining momentum (Regehr et al 2013; Ehring et al, 2014; Chen et al, 2015), yet qualitative evidence on individuals' experiences, and analyses of a Humanistic approach, are lacking.

Aim: This study sought to address these gaps by examining the role of Rape Crisis Centre (RCC) specialist psychotherapy in addressing the psychophysiological impact of child sexual abuse in Ireland.

Method: Semi-structured, in-depth interviews were conducted with a purposive sample of 11 adult survivors of childhood sexual abuse accessing RCC therapy and 12 RCC psychotherapists. Interview questions focused on their experiences and perspectives of RCC therapy and recovery. Interview data was analysed using qualitative thematic analysis.

Findings: The analysis showed that working with embodied trauma is integral to the recovery process, while providing salient insights into the complexity of the empowerment approach in trauma work. Recovery is survivor-led, but it is the individual's somatic experience that guides the process, monitored by the psychotherapist.

Conclusions: This study makes an important contribution to trauma treatment research by detailing the lived experience of the recovery process. The findings enhance our understanding of the dynamics involved in processing the biological, psychological and social components of sexual abuse trauma. They also underscore the importance of a non-directive relational approach. Implications for practice are discussed.

Keywords: child sexual abuse, adult survivor, trauma, integrative approach, qualitative

1 Introduction

Sexual abuse is a pervasive problem worldwide and Ireland is no exception. In the only national prevalence study to date, 30.4% of women and 23.6% of men reported sexual abuse in childhood (McGee, Garavan, de Barra, Byrne, & Conroy, 2002). Anxiety, depression, and confusion of sex with love may characterise the profound impact of sexual abuse on the physical and mental health of survivors (Browne & Finkelhor, 1986; McGee et al, 2002; Hornor 2010). Indeed, a wide variety of post-traumatic response and recovery patterns have been identified, Post Traumatic Stress Disorder (PTSD) the most recognised among them (Rothschild, 2000). Dissociative symptoms, such as flashbacks, are associated with PTSD. Dissociation appears to be an available psychological defence and protective process for abused children whose limited coping capacities are overwhelmed by exceptionally traumatic events (Chu, 2011; Davies & Frawley-O'Dea, 1994).

1.1 Dissociation and PTSD

Encompassing both body and mind, the natural human response to danger is a complex, integrated system of reactions (Rothschild, 2000). When faced with a traumatic threat, an individual's limbic system releases hormones that prepare the body for defensive action. If neither resistance (fight) nor escape (flight) is possible, the body will freeze. The freeze response

shares a number of characteristics with dissociation: an altered sense of time, reduced sensations of pain and an absence of terror/ horror (Rothschild, 2000). As children generally cannot resist or escape sexual abuse and have not had the chance to develop adaptive coping mechanisms, they tend to dissociate when subjected to such abuse (Chu, 2011; Davies & Frawley-O'Dea, 1994). This strategy protects them from physical pain and psychological distress in the moment, yet it has complex negative ramifications.

Traumatic dissociation results in profound and lasting changes in physiological arousal, emotion, cognition and memory, often severing their interconnections. 'When PTSD splits mind and body, implicitly remembered images, emotions, somatic sensations, and behaviors become disengaged from explicitly stored facts and meanings about the traumatic event(s)-whether they are consciously remembered or not' (Rothschild, 2000, p. 160-161). Such fragmentation may involve intense emotion experienced without a clear memory of the event or the memory may be detailed yet recalled without emotion. Trauma thus continues to intrude with visual, auditory and/or other somatic reality on victims' lives without drawing meaningful associations to past or present precipitants (Rothschild, 2000). In other words, these somatic symptoms are the expressions of embodied trauma, namely trauma that is stored in the body as an implicit memory. Grief, fear, anger and shame are among several complex emotions that can result.

1.2 Psychotherapeutic approaches

Traditional psychotherapeutic approaches employ cognitive techniques, such as exposure treatment, aimed at systematically managing the trauma memory and reinterpreting it to reduce the immediate symptoms of fear and anxiety (WHO 2007). Dialectical Behavior Therapy, one such approach, is underpinned by a psychosocial model, but it seeks to address difficult memories and emotions by focusing on acceptance, tolerance and regulation (Görg, Priebe, Böhnke, Steil, Dye, & Kleindienst, 2017). Integrative frameworks, by contrast, emphasise a body-mind approach to addressing the multi-layered impact of trauma (Rothschild, 2000). For instance, the Eye Movement Desensitisation and Reprocessing (EMDR) method combines body-focused and cognitive-behavioural techniques aimed at helping individuals to access, process and resolve traumatic memories (Shapiro, 2014).

Other integrative approaches that are body-centred, such as somatic experiencing (Levine, 2010) and somatic trauma therapy (Rothschild, 2000), focus on releasing trapped emotions or blocked energy, which in turn, affects emotion, cognition and behaviour. Further recognising the importance of social context, Humanistic integrative frameworks conceptualise recovery in terms of addressing the cumulative biological, psychological and social components of the trauma response

(Rogers, 1961). For example, Rothschild's (2000) approach involves facilitating survivors to regain a sense of power and control over their bodies by emphasising safety and working at their own pace. The body remembers traumatic events through the brain's encoding of sensations, movements, and emotions associated with the trauma (Rothschild, 2000).

Recovery thus involves the integration of memory and effect by uniting implicit and explicit memories into a comprehensive narrative (Rothschild, 2000). As a result, past experiences are recalled with emotion that does not elicit defensive numbing or dissociation. 'Making sense of implicitly encoded sensations, emotions, and behaviors in the context of the traumatic memory is a crucial part of the process' (Rothschild, 2000, p. 161). Therapists facilitate survivors to feel and identify these sensations, and then to name and describe them in order to understand their meaning for the individual in the present moment (Rothschild, 2000). Body awareness enables one to gauge, slow down and halt traumatic hyperarousal, as well as separate past from present.

1.3 Study Rationale

Seeking support is an important pathway to recovery (WHO 2007). Emphasising growth, Irish Rape Crisis Centre (RCC) therapy offers individuals a safe space to examine their feelings, with empowerment as the guiding principle and goal of their therapeutic work (RCNI, 2006). The psychotherapeutic relationship is conceptualised as the focal point of the healing process, in which trust, boundaries and self-worth can be re-learned. Placing the focus on coping mechanisms, rather than the recurrence of symptoms, RCC therapy comprises three stages (RCNI, 2006). Stage one builds the deep, transformative work to come on the solid foundations of Humanistic principles (Rogers, 1961), with a primary focus on establishing safety. The next stage involves accessing and deepening to get in touch with the experience beneath the story. Drawing on the work of Rothschild (2000), this entails working with the memories, sensations, feelings and emotions that arise. The final stage involves integration and completion, building resources the survivor can transfer into their daily life.

Research investigating the efficacy of various therapeutic approaches is gaining momentum in the area of gender-based violence. However, data regarding survivors' experiences and the relationship between the underlying dynamics of psychotherapy and the process of recovery is lacking. This study contributes to addressing these gaps by exploring RCCs Humanistic integrative psychotherapeutic approach to addressing the psycho-physiological and relational impacts of child sexual abuse in Ireland. Centralising the perspectives of adult survivors and RCC practitioners, the analysis provides an

understanding of the role of RCC specialist therapy in facilitating the healing process. It further positions integrative non-directive and relational psychotherapy as an important option for therapists treating child sexual abuse survivors and embodied trauma, conceptualised as trauma that is stored/trapped in the body as a result of dissociation (Rothschild 2000).

2 Methods

In line with Tong, Sainsbury and Craig's (2007) criteria for reporting qualitative research, the following sections detail the methodology employed and the meaningfulness of the study's findings. The steps taken to ensure rigor throughout the research process, from design to analysis of the raw data, ensure quality, trustworthiness and dependability (Morrow, 2005).

2.1 Overview and Design

A qualitative methodology was employed to understand the role of RCC therapy in the recovery process[1] as it provides rich insights into participants' understandings and experiences (Rubin & Rubin, 2005). Eleven survivors of child sexual abuse, 8 women and 3 men, and 12 RCC psychotherapists, 10 women and 2 men, participated in semi-structured, in-depth interviews

[1] This paper draws on the qualitative findings of a larger study aimed at investigating the nature and effectiveness of RCC therapy using a mixed-methods approach.

across six RCCs located in the west, east and south of Ireland. Employing a purposive sampling strategy (Ritchie, Lewis, & Elam, 2003), the researchers determined the number of individuals selected for interviews by careful consideration of the sample required for valid and meaningful analysis within a qualitative framework. To ensure diversity, the sample of survivors was stratified by gender, age group, type of sexual violence experienced, time period when the trauma took place and duration in therapy.

For the sample of psychotherapists, the key stratifying variables identified were gender, size of RCC and range of psychotherapeutic methods provided. Psychotherapists facilitated recruitment of survivors, who initially completed a questionnaire and had been accessing therapy for a period of at least 3 months. This timeframe was chosen to ensure individuals' emotional readiness and that the duration was of a suitable length for investigation. Psychotherapists were recruited by the primary researcher through the Rape Crisis Network Ireland (RCNI). As it was not a factor under consideration, psychotherapists and survivors from the same service did not necessarily have a therapeutic relationship.

To minimise harm, protocol was put in place (Ellsberg & Heise, 2005) and ethical approval was granted by the university Research Ethics Committee. Participant names in this paper are pseudonyms.

2.2 Sample

The sample of survivors primarily consisted of women who have experienced childhood sexual abuse and had been participating in therapy for over a year at the time of study participation (Table 1). Five of the participants are survivors of both child sexual abuse and sexual violence in adulthood. Most survivors indicated a lengthy delay in seeking specialised support. Eight individuals had accessed other services, such as general therapy, prior to participating in RCC therapy and this influenced their decision to seek treatment with a qualified trauma specialist. The psychotherapists are women and men representing small, medium-sized and large RCCs, providing a variety of psychotherapeutic approaches compatible with an overarching humanistic framework. All participants are Caucasian.

2.3 Reflexivity and analysis

Given the researcher's role in the construction and interpretation of qualitative data, reflexivity is of paramount importance (Charmaz, 2014). The primary researcher's interest in RCC psychotherapy stems from learning acquired though a policy internship with the RCNI. Subsequently, while analysing interview data from the study to understand the role of RCC therapy in the recovery process, the importance of working with embodied trauma and the benefits of a non-directive relational approach emerged. To avoid the influence of bias, a strict protocol was followed.

First, interviews were digitally recorded and transcribed verbatim. As the aim of the analysis was to interpret the meaning of the participants' experiences and perceptions within the context of existing theory, rather than the generation of theory (grounded theory, Glaser & Strauss, 1967), qualitative thematic analysis was employed (Rubin & Rubin, 2005). Thematic analysis shares important elements with interpretative phenomenological analysis (IPA) in terms of developing a hermeneutic account of participants' relatedness to the topic under investigation as a 'person-in-context' (Larkin, Watts & Clifton, 2008). However, while IPA may be informed by existing theoretical constructs, it does not engage with a predefined theoretical framework, as is the case with thematic analysis and the current study (Larkin, Watts & Clifton, 2008). Guided by an iterative framework, involving a 'repetitive interplay' between the collection and analysis of data, initial themes were noted as the interviews were transcribed. This was followed by systematic coding of passages of text on individual reading of each transcript. Rather than excluding anticipated categories, as is the case with grounded theory (Glaser & Strauss, 1967), the coding categories were both concept and data-driven, drawn from the theoretical framework underpinning the research, in addition to what emerged in the data. By applying a theory-driven approach, while remaining open to the discovery of themes not previously considered, the researchers ensured reliability and credibility (Guest & MacQueen, 2008). *Trauma*, the *therapeutic process,* the *recovery process*, and *factors influencing the recovery process* were among the main coding

categories devised relevant to this paper. To accurately reflect the complexity of the data, these categories were further divided into sub-codes based on sub-themes that emerged from the data (Table 2). In reviewing the data in each coding category, themes, patterns and contradictions were elicited. A summary of elaborated themes was then produced and the relationships between these themes explored to develop a narrative that captures meaningful aspects of the data concerning the research question (Braun & Clarke, 2013). The inclusion of participant quotes demonstrates credibility of interpretation by supporting the core themes and findings.

Several additional steps were taken to ensure rigor. A combination of open-ended and clarifying questions was employed in the interviews to elicit rich narratives, while ensuring clarity of meaning. The coding framework and preliminary findings were then presented to a review panel for peer debriefing (Graneheim & Lundman, 2004). In addition to regular peer review, an analytic memo was recorded to facilitate continuous and reflexive refinement of interpretations. Complementarity (inclusion of RCC psychotherapists' perspectives) and anecdotal counting were also employed to enhance the credibility of the findings. Finally, due consideration was given to the use of respondent validation. As the need for rigor must be balanced with striving not to make unfair demands on participants, it was deemed inappropriate.

3 Findings

The personal accounts shared by the survivors are interwoven with the views of the psychotherapists, thus producing a synthesised narrative. There were no discernible patterns based on: 1) type of sexual violence, 2) size and location of RCC. The themes that emerged from the psychotherapist interviews broadly echo those from the survivor interviews and, together, they enhance our understanding of Rothschild's integrative approach to addressing child sexual abuse trauma. The findings are presented under the following themes that emerged: *Coping with the traumatic impact of sexual abuse*; *Here and now*; *Holding the space*; *Releasing trapped emotions*.

3.1 Theme 1: Coping with traumatic impact of sexual abuse

Survivors identified several emotions they had in the past, and in some cases, continued to struggle with, including shame, fear, grief and anger. The psychotherapists confirmed that these are the most common emotions they work with. Owing to the difficulty of accepting abuse has occurred, minimisation and denial emerged as typical responses. Many survivors described the pain of having a secret they could not tell and hiding from the reality of their situation. Some of these participants discussed burying their memories of the abuse and how their retrieval has taken time. In Sam's case, it was empowering to retrieve these memories, 'sketchy' as they were, but he had no emotional connection to them.

For Megan (survivor of sexual violence in both childhood and adulthood), survival involved 'splitting off' from the abuse she experienced as a child, a process described by the psychotherapists as commonplace among victims. In the following quote, she discusses her confusion, illustrating the emotional turmoil that victims of child sexual abuse face:

> When you're going through this as a child, you have a skewed perception and you're questioning when you're being abused, you know, 'did I do something? Did I bring this on? I don't understand because I love this person. Is this a demonstration of love? I don't like it. Why are they pretending everything is normal this morning? Why are they looking at me with contempt when I should be feeling that way?' It's such a confusing range of emotions you go through but you don't have the life experience to be able to decipher and answer all of those questions, so you just proceed and you go along.

Survivors therefore discussed how, for a long time, they held their painful emotions inside. Rachel recognised how this prevented her from feeling joy, while Megan felt consumed or overwhelmed by the internal pain, the containment of which eventually led to physical exhaustion. Stephanie also described how she felt detached and numb due to banishing the memories from her mind. However, the emotions dissociated from at the time of the traumatic experience became trapped and

subsequently began to intrude on the survivors' lives, leaving them feeling confused and overwhelmed as, for example, shame manifested in anxiety and maladaptive coping mechanisms. As noted by Helen:

> I'd always struggled with flashbacks and nightmares. It was actually the next door neighbour who abused me so growing up next door to him…it was very difficult and obviously keeping it from my mum and stuff because she was worried about me and her finding out…I went from eating disorders to over-eating, drinking, self-harm and depression…there were a lot of issues before I came here [RCC].

Though anxiety and depression persisted for some survivors, it was less frequent and with the help of therapy they have learned how to cope better when such problems arise. The psychotherapists discussed how the therapeutic process involves working with trauma held in the body to release it.

3.2 Theme 2: Here and now

Survivors are either stuck in the past or are fearful of the future, according to the psychotherapists. As such, the therapeutic process involves working in the present. The focus is placed on the impact of the trauma and how survivors are

currently coping, rather than the story content. Working from an understanding developed over many years, the psychotherapists maintained that survivors do not necessarily need to recount the trauma narrative, which can be re-traumatising, to heal. Rather, survivors tell as much of their story as they feel comfortable with. For example, Mark, who participated in an interview on his last day of therapy, has worked with the emotions that arose, but he had not discussed his memories.

As noted by some psychotherapists, the full details of the trauma might never be told verbally, yet the story is always told psychologically, via the emotions that arise. If a survivor's present coping strategies are destructive, the psychotherapists help them to explore alternative and more constructive ways of expressing their pain and developing self-caring routines. The following passage captures the connection between nature and coping for Miriam, who invokes the nurturing of a plant as a symbol of her healing journey in the context of therapy:

> I rescue, not that I rescue, I get little plants for ten cent that look decrepit…it's still alive in there somewhere and I have this little patch at the side of my garden…they come with no name and I plant them wherever and I leave it up to whoever that is or whatever that is to…I just sit back and watch and that helps me cope because when I come out of

> the door everyday…especially now in the Spring, you sort of see them begin to come, 'oh, yeah, that's the guy that was up last year'…and I suppose I resonate with that plant when I buy it for ten cent, whereas somebody else could have spent €4 on it or something, you know, and it was in its full bloom.

3.3: Holding the space

Given the vulnerability of survivors at the outset, in addition to the difficulties associated with the healing process, the psychotherapists stated that safety must be established before deep therapeutic work can begin. The trust built within the therapeutic relationship is central to survivors feeling comfortable to express their vulnerability and emotions. According to some psychotherapists, survivors often find it too painful to 'be in their bodies' and do not know what they are feeling.

Advising that therapy has really helped them in their healing process, many survivors highlighted the value of being given the space in the therapeutic session to feel the emotions that come to the surface and to work through them at their own pace. Indeed, they discussed readiness in terms of the evolving nature of dealing with the impact the trauma has had on their lives. The psychotherapists shared that they facilitate survivors to take control of this process by 'holding the space'. The following passage from Martin (medium-sized RCC) poignantly captures its essence:

> There's a lovely little saying about a man watching a butterfly struggling to break out of a cocoon for hours and all of a sudden the butterfly stops struggling so the man gets a scissors and he cuts the cocoon open. He thought the butterfly was dying so when the butterfly came out, its wings were small and he just walked around. What the man didn't know was in that struggle, right, this is what for me is the hard part for a therapist is to sit there and watch someone struggling and not cut them out of it. The butterfly needed to struggle because what it does is it pushes the fluid from its body into its wings so it can fly but the butterfly never flew, because he was cut out of the cocoon. There's a great message in that for therapists.

Psychotherapists described working with body awareness in terms of checking how survivors are feeling and then continuing at the appropriate pace, using the 'break' when necessary. They also teach survivors to recognise their sensations so they can learn this technique. The following quote illustrates the difficulty of connecting to painful emotions:

> It's a process and it's a human response…If they're going through something, 'slow down'. You're speeding away on me and you're going too fast and can you just come back here to me for a minute and let the emotion come in…'. They might get very mad at ya and say, 'I don't want to do that' or they might feel it and start crying so it's being able to

> contain it, em, and lovingly meet them in it and go ‘it’s okay, you know, I’m here, I’m not going anywhere’, you know, ‘I believe you’, em, all the things they possibly haven’t felt before or received (Cathy, psychotherapist, large RCC).

According to some psychotherapists, discrepancies between an individual’s physical and verbal communication are important indicators of dissociation. Asking a survivor how they are feeling can help them to connect to something deeper they have possibly been completely unaware of. These participants nonetheless highlighted the importance of gauging if the individual is ready to feel that level of emotion.

The psychotherapists described how they facilitate survivors to process and integrate trauma by helping them to become attuned to the emotions that arise, slowing things down and guiding them to understand how trauma manifests in their bodies. Integration also involves naming these emotions and understanding how they relate to the trauma and any memories discussed. Given the focus on the present, if survivors discuss their memories, they work with the associated emotions. Once an individual has touched into these emotions, the psychotherapists help to ground them.

Psychotherapists help survivors to release or let go of the embodied trauma, while imparting breathing and visualising techniques to help them manage panic attacks, intrusive thoughts and flashbacks. Shame, grief and anger were the most common emotions that the psychotherapists and survivors discussed. In the following quote, Cathy describes the intricacies of this work:

> It could take weeks to process the pain and allowing them to do that…It's a powerful phenomenon, that feeling of allowing it to penetrate through you to respond because that's what didn't happen during the child sex abuse so sitting back and allowing them, even though you want to at times explain what's happening. It's far, far more important to stay back, you know, and every so often in those few moments when it's happening, allow it, contain it, hold it, em, and you do all of this without talking as well…You don't fall into it with them. You're standing back with the tools, when they're ready, when it's processed through.

3.4: Theme 4: Releasing trapped emotions

Mark described how he was finally able to let go of the shame that had become deeply entrenched by imagining his son in the same position he was in as a child. As stated by several psychotherapists, this technique helps survivors to recognise

that they are viewing the abuse based on an adult's understanding of the world. Once Rachel was able to let go of the shame she felt, she found that the 'old anger inside that wants to manifest itself' began to surface. While Thomas struggled to connect with his anger in his therapy sessions, he credited his psychotherapist's help:

> Once in a while when I'm feeling that it needs to be done, I'll kind of get more in touch with the emotions and maybe ask [psychotherapist] to help me ta get in touch with the emotions that are still trapped because that's the key. It's about trapped emotions, if you like, so, you know, to actually really feel, to really remember and, and to be safe with those feelings and release them, yeah, and I suppose it's all about me feeling that I'm in charge and it's my decision and he's not pushing me to.

Many psychotherapists described working with anger as helping survivors to learn how to recognise when it builds in their bodies to manage and physically release it in a way that is not destructive to them or those around them. For Sam, a combination of therapy and intense holotropic breath-work has enabled him to get in touch with his deeply buried anger. He also reported valuing the fact that his therapy sessions have facilitated a discussion of the resulting shift in his worldview. Megan, by contrast, reported feeling rage only when she has touched something that belonged to her adoptive mother

(perpetrator). Linking this to her high functioning autism, she questioned the suitability of RCC therapeutic work for individuals with autism or Asperger's syndrome.

Some psychotherapists described how anger almost becomes like a friend to individuals who have been carrying it for many years. Questioning who they would be without it, some survivors hold onto this anger as it protected them. For example, Rachel described her anger as 'armour' and, once she let it go, the hurt and pain hidden underneath surfaced. She credited RCC therapy with helping her to let go of a lot of emotions. The following quote from Catriona (medium-sized RCC) further highlights the layered nature of survivors' emotions:

> So people might go through a period of deep grief and move on from that to looking at how they're going to cope with a particular situation in their life and then might begin to feel huge anger towards the person who abused them because they very often have come with huge anger but they can't direct it at the person who actually really caused it so they tend to lash out at lots of people and they maybe work their way through that and find ways of expressing it and venting it that are safe, em, and then they might come back to the grief again because it's just not done with.

Miriam discussed the extreme sadness she felt in the past and its connection to the anger she reported feeling towards her father since coming to the realisation that he failed to protect her. Describing it as if something had opened, she reported feeling angry at her inability to stop crying for a period of time and not knowing why. Grief was characterised by some psychotherapists as a bereavement of the childhood/parent/ life that one could have had. Some psychotherapists discussed how they allow survivors the space to feel their grief and to cry, as this is a good way of releasing this emotion. In the following quote, Rachel discusses the onset of her overwhelming grief:

> I woke up one morning and just couldn't stop crying, didn't know what was wrong with me. It was like, just, you know, like I'd hit the, the wall as they say, em, went to my GP, she said you're depressed and I said ‘great (laughs), what do I do?’ and she said ‘well I can give you medication or, you know, have you considered therapy?’ So that was the first time I'd heard the magic word therapy.

Some survivors also noted the importance of their psychotherapists’ help with grounding techniques when panic has arisen, as well as self-care following therapy sessions. The following quote is indicative of the positive feelings expressed by survivors towards the complex, yet liberating, nature of the recovery process facilitated by integrative psychotherapy:

> So, there's times when it's very tough and it's very challenging, em, but it's always so worth it, you know. You come out the other side of something and the bright sunny day is there and you know you've let go of something else that you were carrying and you're lighter and brighter (Rachel, survivor of sexual violence in both childhood and adulthood).

4. Discussion

This study examined the role of a Humanistic integrative therapeutic approach to addressing the psycho-physiological impact of sexual abuse trauma. The participants' experiences not only address the dearth of qualitative data on working with embodied trauma of this nature, they provide salient insights into the benefits of non-directive relational psychotherapy as a sexual violence intervention. According to Chen et al (2015), CBT and EMDR are the most frequently studied treatments for PTSD. Focusing on efficacy as determined by reduction in symptoms, cumulative findings from a series of studies suggest that these trauma-focused treatments may accelerate recovery for survivors of sexual violence experiencing PTSD (Vickerman & Margolin 2009, Regehr et al 2013, Chen et al 2015). By contrast, a recent review of early posttraumatic interventions reveals modest and inconsistent effects for CBT (Guay et al 2019), which may not resolve the physiological aspects of trauma (Holtzhausen et al, 2016). In-keeping with important developments in the field, the current findings indicate that working with

embodied trauma is an integral aspect of the recovery process for childhood abuse survivors (Levine, 2010; van der Kolk 2015; Payne et al, 2015).

Integrative exposure treatments, such as EMDR, that focus on the intrusive symptoms characteristic of PTSD provide specific foci regarding symptom relief (Shapiro, 2001). However, complex PTSD stemming from childhood abuse presents specific challenges (Korn, 2009) and individuals who have experienced this type of trauma have traditionally been underrepresented in treatment outcome research (Ehring et al, 2014). EMDR's emphasis on reducing the immediate symptoms of fear and anxiety may neglect survivors' more long-term feelings of guilt, shame, self-blame, isolation and mistrust. Also, treatment outcome research involving EMDR overlooks two central components of healing: integration of the self, which reduces dissociation (Bowlby, 1988), and periods of symptom intensification inherent in psychotherapy (Bazzano, 2011). As recovery is a non-linear process, measuring changes in symptomatology alone may distort an understanding of the outcomes achieved (Sullivan & Coats 2000). It is crucial that psychotherapists assess the appropriateness of EMDR for survivors of sexual abuse, as well as their readiness (Shapiro, 2001). The deliberate recalling of painful memories may be re-traumatising, take away their autonomy and prevent them from recovering at their own pace (Cook et al, 2004; Saint Arnault,

2014; Boterhoven de Hann et al, 2017). Given the nature of abuse, restoring power and control to survivors is a central tenet of recovery (Herman, 1997).

The current study focuses on the role of RCC therapy in the recovery process, rather than an evaluation of its outcomes. These findings highlight the benefits of the non-directive and relational psychophysiological approach advocated by Rothschild (2000). Indeed, they expand our knowledge of this approach by providing salient insights into the intricate nature of empowerment in the context of trauma work. The accounts shared by participants indicate that dissociation, denial and minimisation are commonplace among survivors, leading to the suppression of emotions such as fear and anger, and resulting in fragmentation (Rothschild, 2000). Though it can seem easier to avoid the traumatic impact, doing so leads to greater problems; the mind may choose to forget, but 'the body keeps the score' (van der Kolk, 2015). Rather than working directly with the trauma story, RCC therapy places the focus on the current impact of the trauma, as related by the survivor in their own time (RCNI, 2006).

The findings indicate that the RCC therapist's role involves facilitating survivors to become attuned to the emotions that arise, while gauging readiness and guiding them through body awareness. As such, the survivors' pace is dictated by their somatic sensations, rather than their cognitive consciousness. Awareness of current sensory stimuli is our primary link to the 'here and now', enabling determination of an individual's state of arousal (Rothschild, 2000). The psychotherapists discussed how they then help survivors to relate the emotions that emerge to their traumatic past, and any memories discussed, to understand and integrate the experience. Described by Rothschild (2000) as uniting implicit and explicit memories into a comprehensive narrative of events that is relegated to the past, this process addresses dissociation and the mind/body split.

Survivors confirmed the importance of the empowerment, relational and meaning-focused aspects of the RCC approach. The salience of this approach is further revealed when the 'retelling' of the trauma story is explored in greater depth. According to Herman (1997) and Rothschild (2000), verbally recounting the details of the trauma narrative is an important aspect of the recovery process in the context of therapy. Given how survivors are silenced, narrating one's story while the therapist bears witness can be powerful. However, based on extensive experience, the psychotherapists in the current study asserted that such memory work is not a prerequisite for integration, as what really matters is the 'here and now'. They highlighted the importance of enabling survivors to recount only what they feel comfortable with, while the full story is told via

the emotions that surface. This finding echoes Rafaeli and Markowitz's (2011) conclusion that Interpersonal Psychotherapy may relieve PTSD symptoms without the use of exposure treatment. It is also borne out in Mark's account, detailing his completion of therapy by working through the psycho-physiological impact of the trauma without discussing the narrative in its entirety.

The current study found that the distinct relationship between the RCC empowerment approach and their psycho-physiological work is exemplified by the process of 'holding the space'. Recent research presents contradictory evidence regarding the need for a stabilization phase prior to providing trauma-focused treatment to individuals with complex PTSD (Korn, 2009; Cloitre, 2011; de Jongh et al, 2016). Echoing Parry and Simpson (2016) and Flückiger et al (2018), the current findings indicate that readiness and the trust built in the therapeutic alliance are central to survivors feeling comfortable to explore and express their emotions. The need for establishing safety before deep therapeutic work can be undertaken was discussed in terms of survivors' vulnerability and difficulties with developing secure attachments (Bowlby, 1988). Therapy that is non-directive, relational and meaning-focused provides a safe space for integration of the traumatic experience and integration of the self.

Discussion of the ways in which survivors are then enabled to release or let go of trapped emotions yielded several significant insights. Anger, a natural part of the healing process (Rothschild, 2000), emerged as a dynamic and frightening emotion. Highlighting its familiar and self-protective aspect, the findings indicate that some survivors who have been carrying their anger for many years can experience difficulty letting it go. Most psychotherapists described their role in terms of helping survivors learn how to recognise when anger is building in their bodies and to find safe ways of physically releasing it. While Sam's need to practice holotropic breath work indicates that psycho-physiological psychotherapy may be insufficient for survivors whose anger is buried deep, he has found it complements his therapy work. Indeed, recent research highlights the efficacy of yoga as a body-oriented adjunctive treatment for PTSD (van der Kolk et al, 2014; West, Liang & Spinazzola, 2017). Dance therapy, massage and body awareness exercises are also beneficial for survivors with embodied trauma (Field et al, 1997; Price, 2005; Cristobal, 2018).

The narratives shared by Miriam and Rachel draw attention to the difficult, interconnected and multi-layered nature of survivors' emotions. Grief generally emerges at various times in trauma (Rothschild 2000), with the findings illuminating the importance of having the time to feel this emotion and to release it by crying (Davies & Frawley-O'Dea, 2014). Highlighting how an individual can become overwhelmed by the process of finally allowing themselves to feel the deep well of sadness

long kept hidden, Miriam evoked the image of floodgates opening. She also discussed the relationship between this sadness and her anger. Rachel described how the process of letting go of one emotion allowed another emotion to surface, revealing the depth of feelings underneath. The findings also indicate that Rothschild's relational approach is particularly useful for tackling shame. Megan's questioning of the applicability of Rothchild's approach to individuals with autism or Asperger's syndrome further signifies the salience of non-directive trauma treatment, while highlighting the need for trauma therapists who specialise in these conditions.

4.1: Implications for practice

This study makes an important contribution to trauma treatment research by detailing the lived experience of the recovery process from the perspectives of survivors and psychotherapists. Underscoring the benefits of Rothschild's (2000) non-directive relational approach, the findings indicate that addressing embodied trauma is an integral aspect of the recovery process. Rothschild's approach is an important alternative to exposure treatment, in this regard, as the latter may prove inadequate to the task of safely addressing the profound, multidimensional and long-term nature of sexual abuse trauma. Establishing safety and allowing survivors the time and space to process suppressed emotions emerged as a salient theme. For healing to begin, one must face the difficult emotions deeply buried, breaking not only the silence but the very defences

put in place to survive. Rothschild's approach honours an individual's unique recovery process and prevents re-traumatisation, as well as ensuring their wellbeing following a therapeutic session.

The study also enhances our understanding of the ways in which the relational framework underpinning this psycho-physiological treatment creates a safe space for survivors to explore, understand and integrate trauma. In keeping with the understanding of recovery as both a process and an outcome (Liberman & Kopelowitz, 2005), survivors are enabled to repair the natural systems of care that provide individuals with a sense of control, connection and meaning (Herman, 1997). The findings indicate that successful integration also depends upon psychotherapists employing their specialist knowledge to monitor an individual's level of arousal. They further establish the salience of focusing on the impact of the trauma, as opposed to the content of the story, as well as raising important questions regarding psychological conditions and deep therapeutic work. This learning has the potential to inform psychotherapeutic practice and policy in Ireland and further afield.

4.2: Limitations

The findings should be considered in the context of the limitations inherent to the study. As only individuals who stayed in RCC therapy for at least three months were involved, the sample excludes those who left therapy after one or a few sessions. However, there was no ethical or reasonable way of accessing such clients.

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References

Bazzano, M. (2011). Reclaiming diagnosis. *Therapy Today*, Nov. 22(9), 21-23.

Bowlby J. (1988). *A secure base: Parent-child attachment and healthy human development*. London: Basic Books.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: a review of the research. *Psychological Bulletin*, 99 (1), 66-77. doi: 10.1037/0033-2909.99.1.66.

Charmaz, K. (2014). *Constructing grounded theory*, 2nd ed. London: Sage.

Chen, L., Zhang, G., Hu, M. & Liang, X. (2015). Eye movement desensitization and reprocessing versus cognitive-behavioral therapy for adult posttraumatic stress disorder: Systematic review and meta-analysis. *Journal of Nervous and Mental Disease*, 203(6), 443-451. doi: 10.1097/NMD.0000000000000306.

Cloitre, M., Courtois, C.A., Charuvastra, A., Carapezza, R., Stolbach, B.C., & Green, B.L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey onbest practices. *Journal of Traumatic Stress*, 24, 615–627. http://dx.doi.org/10.1002/jts.20697.

Cook, J.M., Schnurr, P.P. &Foa, E.B. (2004). Bridging the gap between post-traumatic stress disorder research and clinical practice: the example of exposure therapy. *Psychotherapy: Theory, Research Practice, Training*, 41(4), 374-387.doi: 10.1037/0033-3204.41.4.374.

Cristobal, K.A. (2018). Power of touch: Working with survivors of sexual abuse within dance/movement therapy. *American Journal of Dance Therapy,* 40, 68–86*.* doi: 10.1007/s10465-018-9275-7.

Davies, J.M. & Frawley-O'Dea, M.G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective.* New York: Basic Books.

de Jongh, A. et al (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety,* 33(5), p. 359-369.doi: 10.1002/da.22469.

Ehring, T, Welboren, R., Morina, N., Wicherts, J.M., Freitag, J., Emmelkamp, P.M.G. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review,* 34, 645-657.

Ellsberg, M. &Heise, L. (2005). *Researching violence against women: A practical guide for researchers and activists*. Washington, DC: World Health Organization.

Field, T., Hernandez-Reif, M., Hart, S., Quintino, O., Drose, L.A., Field, T., Kuhn, C. & Schanberg, S. (1997). Effects of sexual abuse are lessened by massage therapy. *Journal of Bodywork and Movement Therapies,* 1(2), 65-69. doi: 10.1016/S1360-8592(97)80002-2.

Flückiger, C., Del Re, A.C., Wampold, B.E &Horvath, A.O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55 (4), 316–340.

Görg, N., Priebe, K., Böhnke, J.R., Steil, R., Dyer, A.S., & Kleindienst, N. (2017).Trauma-related emotions and radical acceptance in dialectical behavior therapy for posttraumatic stress disorder after childhood sexual abuse. *Borderline Personality Disorder and Emotion Dysregulation*, 4(15), 1-12. doi: 10.1186/s40479-017-0065-5.

Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New Brunswick: Transaction Publishers.

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 5-112. doi: 10.1016/j.nedt.2003.10.001.

Guay, S., Beaulieu-Prévost, D., Sader, J. & Marchand, A. (2019). A systematic literature review of early posttraumatic Interventions for victims of violent crime. *Aggression and Violent Behavior,* 46, 15-24.

Guest, G., & MacQueen, K. (2008). *Handbook for team-based qualitative research*. New York: Altamira Press.

Boterhoven de Haan, K.L., Lee, C.W. et al. (2017). Imagery rescripting and eye movement desensitisation and reprocessing for treatment of adults with childhood trauma-related post-traumatic stress disorder: IREM study design. *BMC Psychiatry,* 17(165), 17-165. doi: 10.1186/s12888-017-1330-2.

Herman, J.L. (1997). *Trauma and recovery: the aftermath of violence – from domestic abuse to political terror* (2nd Ed.). New York: Basic Books.

Hornor, G. (2010). Child sexual abuse: Consequences and implications. *Journal of Paediatric Health Care*, 24(6), 358-364.

Korn, D. L. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research*, 3 (4), 264-278. doi: 10.1891/1933-3196.3.4.264.

Larkin, M., Watts, S. and Clifton, E. (2008) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3 (2), 102-120. doi: 10.1191/1478088706qp062oa.

Levine, P.A. (2010). *In an unspoken voice: how the body releases trauma and restores goodness*. Berkeley, California: North Atlantic Books.

Liberman, D.P. & Kopelowitz, A. (2005). Recovery from schizophrenia: a concept in search of research. *Psychiatric Services*, 56(6), 735-742.doi: 10.1177/0020764006075018.

McGee, H., Garavan, R., De Barra, M., Byrne, J. & Conroy, R. (2002). *The SAVI report. Sexual abuse and violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence*. Dublin: Liffey Press.

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250-260. doi: 10.1037/0022-0167.52.2.250.

Parry, S. & Simpson, J. (2016). How do adult survivors of childhood sexual abuse experience formally delivered talking therapy? A systematic review. *Journal of Child Sexual Abuse*, 25(7), 793-812.doi: 10.1080/10538712.2016.1208704.

Payne, P., Levine, P.A. & Crane-Godreau, M.A. (2015). Somatic experiencing: Using interception and proprioception as core elements of trauma therapy. *Frontiers in Psychology,* 6(93), 1-18.doi: 10.3389/fpsyg.

Price, C. (2005). Body-oriented therapy in recovery from child sexual abuse: An efficacy study. Price C. (2005). Body-oriented therapy in recovery from child sexual abuse: an efficacy study. *Alternative Therapies in Health and Medicine*, 11(5), 46–57.11(5), 46–57. PMID: 16189948.

Rafaeli, A.K. & Markowitz, J.C. (2011). Interpersonal psychotherapy (IPT) for PTSD: A case study. *American Journal of Psychotherapy,* 65(3), 205-223.

RCNI (2006). *Basic training manual*. Galway: Rape Crisis Network Ireland.

Regehr, C., Alaggia, R., Dennis, J., Pitts, A. & Saini, M. (2013). Interventions to reduce distress in adult victims of sexual violence and rape: A systematic review. *Campbell Systematic Reviews,* 9(1), 3-134. doi: 10.4073/csr.2013.3.

Ritchie, J., Lewis, J. & Elam, G. (2003). Designing and Selecting Samples. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers*. London: Sage Publications Ltd., 77-108.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: W.W. Norton and Company.

Rubin, H.J, & Rubin, I.S. (2005). *Qualitative interviewing: The art of hearing data* (2nd Ed.). Thousand Oaks, CA: Sage.

Saint Arnault, D. (2014). *Healing from domestic violence and trauma: Lessons learned from research on the biodynamic approach*. Athlone: Safe Ireland.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing* (2nd Ed.). New York: Guilford Press.

Shapiro, F. (2014). The role of Eye Movement Desensitization and Reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experiences. *Permanente Journal,* 18(1), 71-77.

Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal of Qualitative Health Care,* 19(6), 349-357.

van der Kolk, B. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. London: Penguin Books.

van der Kolk, B.A., Stone, L., et al. (2014). Yoga as an adjunctive treatment for Posttraumatic Stress Disorder: A randomized controlled trial. *Journal of Clinical Psychiatry*, 75(6), 559-565.doi: 10.4088/JCP.13m08561.

Vickerman, K.A. & Margolin, G. (2009). Rape treatment outcome research: Empirical findings and state of the literature. *Clinical psychology Review,* 29(5), 431-448. doi:10.1016/j.cpr.2009.04.004.

West, J., Liang, B.& Spinazzola, J. (2017). Trauma Sensitive Yoga as a complementary treatment for Posttraumatic Stress Disorder: A qualitative descriptive analysis. *International Journal of Stress Management,* 24(2), 173-195.doi: 10.1037/str0000040.

WHO (2007). *Rape: How women, the community and the health sector respond*. Geneva: World Health Organization.

Table 1: Survivors

	Age	Type of Sexual Violence	Length in Counselling	Country of Origin
Miriam	40	Childhood	< year	Ireland
Thomas	49	Childhood	1-2 years	England
Claire	21	Childhood	3-5 years	Ireland
Rachel	44	Childhood & Adulthood	1-2 years	Ireland
Sam	56	Childhood	3-5 years	Ireland
Megan	46	Childhood & Adulthood	3-5 years	Canada
Mark	44	Childhood & Adulthood	1-2 years	Ireland
Stephanie	43	Childhood & Adulthood	3-5 years	Ireland
Ruth	47	Childhood	3-5 years	Ireland
Helen	23	Childhood	1-2 year	England
Louise	31	Childhood & Adulthood	3-5 years	Ireland

Table 2: Coding Schedule

Codes	**Sub-codes**	**Sub-codes**	**Sub-codes**
Recovery Process	personal journey	struggle	growth
Trauma	consequences	trauma held in the body	overcoming consequences
Coping Strategies	denial	minimisation	
Counselling Process	safe space	holding the space	here and now
Factors Influencing Recovery Process	readiness	femininity	masculinity
RCC Approach	relationship non-clinical	empowerment specialist	holistic