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Introducing an integrated SHIP® trauma-spectrum model on the etiology, characteristics and natural disposition of trauma-spectrum manifestations (TSM)

Johan O Steenkamp, BA, BA Hons, MAPsych, DLitt et Phil[*]
Private Practice, Brooklyn, South Africa

Abstract

An integrated SHIP® (spontaneous healing intra-systemic process) trauma-spectrum model is introduced as a theoretical exposition of the etiology, characteristics and natural disposition of the proposed trauma-spectrum manifestations (TSM) diagnosis. The model proposes an interactive and interdependent developmental process of complementary factors for all types of trauma (complex PTSD and PTSD) and incorporates genetic, environmental and neural influences that effect the eventual selected coping configuration. Innate self-regulation towards people's natural healthy blueprint disposition reflects the SHIP® point of reference and incorporates the psycho-biodynamic healing script, consisting of psycho-biodynamic translators, that stimulates awareness of the need for internal reconnection. Distracters that support a distressed coping style are discussed, as well as the discrepancy between the Integrated SHIP® Trauma-spectrum Model and current pathology diagnostics.

Keywords: Complex PTSD, coping configuration, distracters, individual specific field, intra- and inter-translators, psycho-biodynamic, psycho-biodynamic healing script, psychology, PTSD, self-regulation, SHIP®, spontaneous healing reactions, trauma, trauma-spectrum manifestation

Introduction

The outdated pathology point of reference for psycho-biodynamic trauma translators and spontaneous healing reactions caused by trauma obscures healing possibilities. Pathology-oriented treatments categorise these manifestations as separate diseases/disorders that should be controlled through medication, shock therapy and/or behaviour management. The aim is to obscure the patient's experience of the misunderstood trauma ramifications (1). Therapeutic effects are based on a false premise and simply suppress and

[*] *Correspondence:* JO Steenkamp, Private Practice, PO Box 35077, Menlo Park, 0102, South Africa. E-mail: jos@intekom.co.za

mask the "symptoms" (2), while the underlying brain rhythms and wave-frequency imbalances are not addressed (3). Many of the techniques sustain existing trauma, while occasionally creating new treatment-induced trauma and overriding psycho-biodynamic healing messages (1). There is often no indication of an understanding of the functionality of self-regulatory patterns (4).

When chronic dis-ease/dis-orders, as seen from a SHIP® perspective, are defined as psycho-biodynamic trauma translators and spontaneous healing reactions, then the scope of trauma becomes much wider than is currently acknowledged. A considerable amount of research has been noted on the high rate of comorbidity between PTSD and other chronic diseases/disorders (1,2,5). Common stress-induced neurological deficits/changes in the brain caused by trauma, especially childhood abuse, seems to be a central core disorder that underlies all the related manifestations (6). An argument has been put forward that the current diagnostic schema of a splitters approach to diagnosis (separate distinct disorders) in the absence of any theoretical foundation is based on error and should be replaced by a single inclusive "trauma-spectrum disorders" category (6). The author of this article agrees that many of the chronic dis-eases and pain people are struggling with as a result of trauma should be sorted into a singular defined concept. One of the doctrines of the SHIP® philosophy is that clients are in a continuous process of spontaneous healing rather than pathology (7), therefore the "trauma-spectrum *disorders*" category (that supports pathology and a problem) is redefined in this article as "trauma-spectrum *manifestations*" (TSM) (that support a process of spontaneous healing as a natural disposition towards a solution).

The function of this article is to present an Integrated SHIP® Trauma-spectrum Model that will help to create a platform for spontaneous healing facilitation of clients with trauma.

The research questions that this article will focus on are:

- How can the Integrated SHIP® Trauma-spectrum Model be formalised to create a better understanding of TSM?
- What are the sequential complementary etiological constituents within the proposed Integrated SHIP® Trauma-spectrum Model?
- What are the characteristics and natural disposition of the interactive constituents of the proposed Integrated SHIP® Trauma-spectrum Model?

The key concepts of this article will be defined in the following paragraphs, after which the constituents of the Integrated SHIP® Trauma-spectrum Model will be introduced and further described. This will incorporate other authors' views. For the sake of brevity and in deference to the journal parameters the focus where possible will be on concise explanations.

Explanations of the key concepts

- Psycho-biodynamic – a SHIP® concept that encompasses the following complementary areas of interconnectedness (4):
  - *psycho* – current psychological experiences (e.g. emotional dis-ease, such as sadness, anger and anxiety, in relation to all encounters)
  - *bio* – *involuntary* sensory experiences and/or physical reactions (e.g. physical dis-ease, such as smells, palpitations, nausea, spasms in the body)
  - *dynamic* – uncompleted past experiences (traumas) projected onto and colouring perceptions and experiences of the present (e.g. unresolved childhood abuse projected into an adult intimate relationship)
- Individual specific field (ISF) – a SHIP® concept that translates the human electromagnetic energy field that harbours our being as a holographic unified psycho-biodynamic network of all experiences both intra- and inter-systemically (1,2,4,8,9):
  - *intra-systemically* – refers to the subatomic electrical impulses and neuropeptide information

molecules of emotion within the person (2) that transmit information messages back and forth through the vibrating cell-membrane receptors and thereby link all the major internal systems into a multidirectional body-mind communication

inter-systemically – between the person and the environment where it represents the active and proactive dynamic translation of the individual in all situations

SHIP® philosophy interprets the quality of the ISF as a manifestation that is similar to the Arabic concept *fitrah:* an innate natural disposition and constitution with which the child is created in his or her mother's womb and which exists at birth in all human beings (10). The innate natural disposition, constitution and pre-destined path of the ISF is to manifest its inherent potential (4). This manifestation takes place through energy vibrations that form potentialities that manifest in an infinite set of possibilities, out of which probabilities emerge (11). In this way the ISF continuously interacts with the external world in order to experience itself through the configuration of its potentialities. In so doing the archetypal hero's journey towards the discovery of his or her internal divine nature and resultant maturity (12) automatically contributes to shaping the evolution of humankind (7).

Healthy blueprint manifestation, self-regulation and spontaneous healing reactions are constituents of the ISF that serve its natural disposition.

- Healthy blueprint manifestation - a SHIP® concept that defines the innate potential and drive within the ISF that carries the possibility for all humans to reach and maintain an integrated, evolving state without compromising their integrity (7). The healthy blueprint personality and relational potential are based on the free flow of energy within the ISF.
- Self-regulation – a complex interaction of nerve centres, glands and chemicals (13) that form the multiple self-correction interactive feedback systems within the ISF. Through their "non-conceptual knowing" or internal wisdom (15) they continuously and "spontaneously reshuffle" (14), correct, integrate and move the system towards its optimal healthy blueprint for most effective intra- and inter-systemic functioning.
- Spontaneous healing reactions (SHRs) – a SHIP® concept for the normal inherent ceaseless involuntary, psycho-biodynamic, interconnected intra- and inter-cellular energy fluctuations that form part of the heartbeat of the self-regulatory process in people's daily experiences and responses to external demands (1,4,7). External demands activate the person's internal psychobiological being. Through the process of free-flowing self-regulation, or "completion tendency" (16), the SHRs move through their energy activation (the activated vibrations within a potentiality) and return to their normal energy flow throughout the system, aligning it to its natural disposition.
- Point of reference – A client is in a state of intentionality to receive and his or her commitment to the meaning attributed by the facilitator to the client's dis-ease will influence the client's psycho-biodynamic responses and, accordingly, the outcome of treatment and the health of the client (1,4,7,9). Pathology orientated professionals can keep clients imprisoned in dis-ease (1). Through intentional observation a reality brought into the psychotherapeutic space, namely that the client is in a process of spontaneous healing rather than pathology, can extract a healing quanta state from the DNA sea of possibilities and routinely collapse space-time possibilities into genetic expression of healing responses (4,7,9,17).
- Trauma – The natural disposition of the human system is characterized by free-flowing energy through different evolving and self-regulatory processes (1). A trauma-activating event (the external events that eventually lead to trauma within the human system) affects the sequence of internal events: Overwhelming SHRs result from a

perceived external threat to the internal integrity. A sense of helplessness in the face of the external trauma-activating event causes the person to experience an inability to successfully express and integrate the activated SHRs (1). The information overload cannot be reconciled with current schemata and the alerted self-regulatory system sets the stage for the following (2,4,7,8,16,18-21): The internal activation moves into an inhibited, on-hold state where there is no energetic discharge and completion of the hyper-aroused response. The longer the experience of the trauma-activating event, the more likely it is that the on-hold response will occur. Compromised neural communication may be so restricted that the on-hold SHRs freeze/disconnect as an involuntary self-preservation mechanism. Receptor inhibition has closed off affected potentialities (potentiality freeze/unconscious) within the ISF, with no apparent further psycho-biodynamic recall of the experience of the trauma-activating event passing through the synapses. SHIPⓇ defines the disconnected SHRs as trauma, implying that the person still needs to complete the psycho-biodynamic experience.

A trauma-chain forms when different traumas (multiple traumas) within the ISF relate to a particular trauma theme. SHIPⓇ theory holds that developmental and acute trauma may be part of the trauma-chain. The trauma-induced non-alignment with the natural healthy blueprint disposition of free flowing energy within the ISF will put the client at risk of TSM. TSM includes both current Complex PTSD and PTSD diagnostic categories:

- Complex PTSD (also referred to as DESNOS – Disorders of Extreme Stress Not Otherwise Specified) (19) – consists of and is the result of developmental trauma. Developmental trauma stems from childhood where people were traumatised by psycho-biological victimisation such as neglect due to lack of safe and secure caregivers (abandonment, maltreatment). Other forms would include sexual molestation/abuse, experiencing and witnessing domestic and community violence/cruelty/assault, major illness or disability, social humiliation, and involvement in actual or potential accidents (4,22). Subtle trauma such as guilt manipulation forms part of developmental trauma. Characteristics associated with Complex PTSD are listed as (1,4,19,23): abnormal startle responses, hyper-arousal, hyper-vigilance, flashbacks/intrusive memories of the traumatic experience(s), feeling worse when reminded of the trauma, amnesia, fatigue, somatisation and physical complaints, eating problems, affect dysregulation (anxiety, panic, depression, irritability, angry outbursts towards self and others), distrust, shame, and sleep disturbances. Other signs include avoidance of reminders of the trauma (numbing, detachment, emotional blunting), memory and concentration problems, difficulty in planning effective action, changes in character and personality, trauma re-enactment in interpersonal relationships, and alterations in systems of meaning.

Complex PTSD manifests mainly in adulthood and signifies that the person suffered years of chronic "wear and tear" as a result of developmental trauma. Earlier trauma of a longer duration creates a greater likelihood that a high level of symptoms will be present, giving rise to a diagnosis of Complex PTSD (19). Extensive research evidence on the long-standing neuro-physiological consequences of developmental trauma points to the following (1,4,5,8,23,24): Trauma suspended in the cell membrane dramatically interferes with and alters the natural free flow of energy. Peptides that are vital for effective, healthy functioning are denied cellular access. Activated stress hormones cannot be neutralised and the natural spontaneous healing process is hindered from moving through its sequence. The chronic autonomic psychobiological entrapment of the initial freeze response, with no discharge of the hyper-aroused energy, can increase manifestation of most chronic debilitating psycho-biodynamically driven dis-eases in later life.

Examples are higher risks and rates of infections and some autoimmune disorders (e.g. systemic lupus erythematosus and cancer), cerebrovascular diseases (e.g. stroke), cardiovascular diseases, liver diseases, skin diseases, chronic lung diseases, irritable bowel syndrome, chronic pain, syndromes like fibromyalgia, chronic fatigue syndrome, preterm labour, ovarian dysfunction and early menopause, ADHD, diabetes, somatisation disorder and psychosis. An adult client with TSM described his experience as, "I feel constantly unwell."

The author of this article has found that many clients manifesting with complex PTSD (suffering from chronic dis-ease manifestations in the body) do not recall and do not have conscious access to some of their developmental trauma such as sexual molestation. It is not uncommon for them to end up with a diagnosis such as fibromyalgia. Many of the symptoms seem to have no biological basis and the victims are seen as hypochondriacs.

- PTSD – consists of and is the result of acute trauma. Acute trauma can exacerbate existing developmental trauma by linking onto its trauma-chain (4), or it can stand on its own, especially in the absence of developmental trauma. Acute trauma manifests when potentially "in the face of death" life-threatening and dangerous experiences, such as motor vehicle accidents, war, terrorist attacks and natural disasters, occur in current (adult) life. Events such as divorce and separation, loss of employment, physical or sexual assault, and transgression of one's moral code are included (25).

PTSD manifestations would include potential chronic problems with all of the above as stated under Complex PTSD, although the severity and chronicity of the problems might well be of a lower order. Acute trauma does not usually exert the same debilitating effect on an established personality configuration. Hyperarousal and startle responses are usually more prominent with PTSD, indicating that the SHRs to the trauma-activating event are not completely disconnected/frozen and the person has easier access to the psycho-biodynamic memory. Unlike with Complex PTSD, the treatment of PTSD is usually of brief duration.

The characteristics of Complex PTSD and PTSD will be dealt with under the different complementary constituents of the proposed Integrated SHIP® Trauma-spectrum Model, which will now be introduced and discussed. The model is based on the author's naturalistic research on trauma sufferers over a period of 29 years in private practice (covering more than 60,000 psychotherapy sessions).

Explanations and discussions of the sequential and interactive complementary constituents of the Integrated SHIP® Trauma-spectrum Model

The Integrated SHIP® Trauma-spectrum Model comprises the constituents outlined below that cause, indicate and attempt to rectify the miss-alignment of the free flow of energy of a person's *fitrah*. Although the constituents are discussed in a particular sequence, a systemic interplay and cross-pollination between these complementary interactive and inter-dependent constituents should be allowed for (see figure 1).

- *Genetic constitution and environmental influences*. Genetic susceptibility, or pre-trauma biologically based variables (ancient-to-current space-time information coded in the DNA) are viewed by some as the determinants causing a particular event to produce trauma and eventual PTSD (26). The field of Epigenetics states, however, that the quality of external activators or signals from outside the cell will set in motion a set of chemical or electromagnetic instructions – certain genes within the human DNA will be turned on and expressed because of the nature of the external activation and others will be turned off or suppressed (9,27). The implication is that although research has discovered that there is a genetic vulnerability that can make a substantial contribution to the development of PTSD (6), it remains dependent on the quality of the

environment (27) whether the genetic predisposition will become reactive and develop into chronic dis-ease.

- *Stress-induced environmental influences causing neural deficits*. Pre- and post-natal (maternal/infant bonding) and infant attunement periods are characterised by naturally occurring brain plasticity in key neural systems. Rapid brain development and formation of dendrite connections through attachment to caregivers and others create layered and relatively permanent individual connections on the inherited genetic template of the infant. These will influence and mould the eventual behaviour and lifelong capacity of the person to self-regulate positive and negative stimuli (6,13,28).

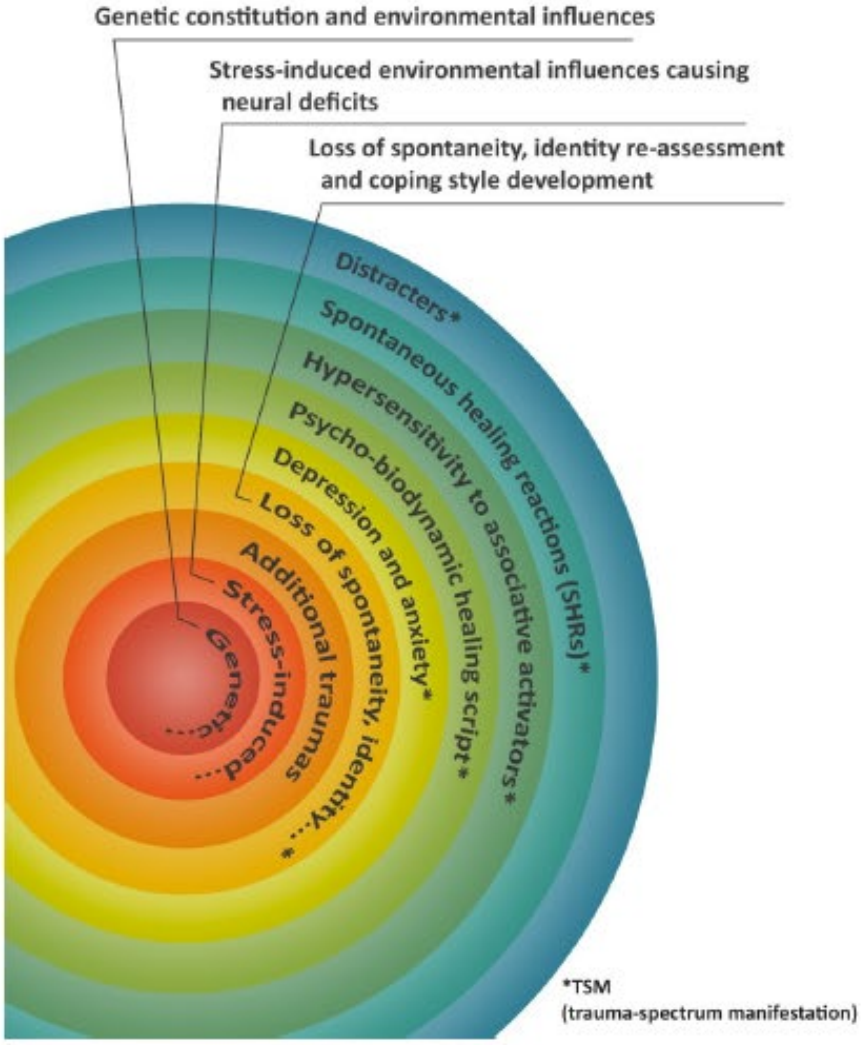

Figure 1. The sequential and interactive complementary constituents of the Integrated SHIP® Trauma-spectrum Model.

Developmental trauma causes enduring structural physiological alterations/impairment (neural programming) to the integrative neurons of specific areas in the child's vulnerable developing brain. Examples are fetal stress (significantly increases susceptibility to future disease development, especially diabetes and heart disease), the absence of breast milk (inherent chemicals necessary for certain neurotransmitter formation), the lack of repetitive facial and gaze-based interaction between mother and infant (necessary for stimulation of the right orbitofrontal cortex that modulates autonomic regulation and homeostasis) especially during the first eight months of life, the absence of adequate

somatosensory stimulation (especially necessary for the cerebral cortex and the cerebellum), such as rocking of the infant by the mother and other sensory experiences (29,30).

When caregivers are unable to meet significant portions of their babies' needs, when owing to deprivation and abandonment there is not a healthy and secure parent-child attachment, caregivers create the space of psychological neglect. Mental health is affected and children and adults end up lacking resilience and find it difficult to adapt to life's ebbs and flows (8,26).

Developmental trauma not only fertilises the potentialities of genetic susceptibility, it also compromises the dynamics of the ceaseless fluctuations within the ISF that can act to modify genetic material (6). Other research on the effects of trauma on the neural system highlights the following (1,4,19,23): Internal chronic stress levels increase the levels of the body-damaging stress hormone cortisol (beneficial for short-term survival), and the dysregulation and excessively high levels of cortisol and adrenaline make the brain more inefficient. Consistent excessively high levels of cortisol kill brain cells. The brain areas affected by trauma include the limbic system (hippocampus – affecting memory and learning), corpus callosum, cerebeller vermis, putamen and lateral ventricles, anterior cingulate gyrus, media prefrontal cortex, visual and parietal cortex, spinal fluid and cerebellum.

- *Additional traumas*. The inclusion of this category is due to the fact that developmental trauma lies on a continuum. Any additional trauma accumulated after the original developmental trauma (whether it is more developmental trauma or much later acute trauma) can add to the internal arsenal of the trauma-chain. Research indicates that acute trauma also compromises neural integrity, especially in the hippocampus (6).

The remaining constituents of the Integrated SHIP® Trauma-spectrum Model make up the manifested characteristics and natural disposition of TSM.

Trauma-spectrum manifestation (TSM)

Psychobiological trauma results in compromised neural integrity (the ability of different brain areas to self-regulate, co-operate and integrate), which stimulates TSM (19,23,26). SHIP® theory defines the following characteristics and natural disposition of TSM:

- *Loss of spontaneity, identity reassessment and coping style development*. Integrated people have a state of free access to their potentialities and reactive coping configurations (1). Relatedness is dependent on space-time and the shaping of sense of self is built on a collection of memories related to, and thoughts and feelings about, events in one's life (31). People are their memories. Fragmentation of memory (loss in neural integrity – the immobile space-time memory gaps of frozen SHRs) related to the context of trauma-activating events leads to a disintegration of sense of self, and problems which affect regulation and relatedness (21,26). Neglect or abuse shape personality (13).

Empty memory (loss) can also be trauma: a 43-year-old client with TSM tells of her youth when her father, with whom she had a special bond, was killed when she was eight years old, and her life from then on was empty of the memories that could have been.

When the system becomes stifled by the debris of past entropy production, it mutates towards a new regime of dynamic interaction (32). The person needs to sustain a state of survival and a sense a belonging, and experience value added. A breakdown of the sense of self, when the "I" becomes "dented", stimulates the search for, and a shaping of, a redefined "I-dent-ity". To compensate for the disconnected relational possibilities (memory gaps) the self-regulatory process follows a trial and error strategy – life energy is directed into that which succeeds (7). This identity reassessment and readjustment to a coping style that takes place mainly during the first ten years of life is a process of classical conditioning that incorporates both mechanisms of procedural

(unconscious) and explicit or declarative (conscious) memory (7,13).

The more severe and rigid the chronic coping style that is carved out, the likelier it is that trauma-chain disconnection will result in the equivalent experience of loss of spontaneity. With excessive disconnection the coping style, based on the energy shift and compromise in the personality structure, becomes an obsessive drive resulting in a chronic, blinkered identity (such as rescuer, pleaser, performer, director, explorer, spectator, borderline, fragmented, etc) (7). This type of coping style can be likened to the Hebrew word *mitzrayim*, "the narrow place" (12), an imprisoned ingrained place of habit that arrests the remainder of the person's spontaneous expression.

The coping style guards against further developmental trauma and uncomfortable activation of existing developmental trauma. At the outer limits of the coping style possibilities, when the internal trauma is so intense that it continually floods the system, the coping style becomes more and more removed from exposed relational possibilities, and the parts of the personality that would be accessed are those that can be categorised as borderline and fragmented. This differs from the pathology-oriented diagnostic labels in that SHIP® theory views these extremes as still being on the continuum of coping configurations in an effort to maintain life. It becomes the safest avenue and most effective lifeline and coping strategy for a relationship with the external world. These individuals have a need for order and experience an inability and a lack of energy to create and maintain order. Experiences of fragmentation of the personality along with the alteration of memories are common phenomena in TSM sufferers.

There is also the coping style of no-identity, where the environment the children came into was so foreign to their *fitrah* that they could never manage to "fit into their own skin". The author has seen this phenomenon, especially where parents adhere to a dogma of too much judgement – in adult life the search for the self has to start in the uterus and then gradually proceed into current life. Such people have a constant inner loneliness and find it difficult to connect. Their self-regulatory process has not moved into re-arranging potentialities and the person hovers in an in-between state.

The more intense the disconnection, the more prevalent the compensating internal fantasy coping style through which the personality potential that has been denied expression is lived out. Unfortunately, fantasy can never replace reality. Projection means fighting an external war that is not there, and the loss of self-expression and free flow of energy manifest themselves in a life burdened by depression and anxiety.

- *Depression and anxiety*. According to SHIP® philosophy, depression and anxiety go hand in hand. Depression is the result of being denied the space to live and express freely. When self-assertion is "de-pressed" the sense of loss of control feeds anxiety and spells the loss of living a full life in which there is access to complete potential. The existential anxiety that is projected onto the external world, when failure to fit into the self is projected as failure to fit into the world, is present in all resulting coping configurations. Early trauma victims tend to develop depression symptoms that stay with them for life (6).

The larger and more intricate the trauma-chain, the more severe the experiences of depression and anxiety, and the more vicarious the potential chaos of the ISF-induced psycho-biodynamic healing script (1).

- *Psycho-biodynamic healing script.* Trauma causes a narrowing of consciousness and the function of the ISF's induced psycho-biodynamic healing script is to stimulate internal re-connection so that the human system has access to its full potential. The script is written in the typical repetitive, chronic dis-ease manifestations of Complex PTSD and PTSD that SHIP® refers to as psycho-biodynamic trauma translators.

Excessive compensation is kept alive through a trauma-chain: Trauma causes a recession in areas within the ISF (the holding of disconnected information) with a resulting compensating overflow in other parts of the systemic landscape (1). When the

ISF judges that the overflow is disturbing the natural *fitrah* disposition, internal resources are utilised (3,7). A pre-requisite for defining trauma is the manifestation of dis-ease in the aftermath of trauma-activating events (20). Psycho-biodynamic trauma translators are dis-ease invasive healing sites in the present for the narrowed consciousness. They are part of ISF self-regulation that exposes the reason and existence of frozen historical receptor baggage and indicates that psycho-biodynamic validation of the trauma-chain is long overdue. Posing as illuminating mediators, they symbolise the right to, and importance of, a freedom of expression of all the inherent personality potentialities (1,4) and herald a metamorphosis for a healthy mind change that enables a more coherent sense of self (21). Psycho-biodynamic trauma translators can be likened to the old *imuksuit* sculptural communication monuments found in the Arctic landscape that were erected for purposes of survival and navigation. Conceived through evolutionary wisdom, these monuments indicate potential danger and signify that the traveller requires a shift in energy on the road forward (4).

Prominent theorists and practitioners in psychology acknowledge that dissociation can result in somatisation and projection dis-eases (1,4). SHIP® theory defines somatisation and projection as intra- and inter- psycho-biodynamic trauma translators:

- *Intra-translator* – here the psycho-biodynamic translation is through a person's internal ISF. The trauma induced non-alignment with the natural healthy blueprint disposition of free flowing energy may show up within the ISF quite some time before it manifests somatically. Eventually disconnected compacted energy information, or molecules of emotion, translate through cellular signals into chronic explosive manifestations in locations such as lower back pain, stomach ulcers, headaches, discomfort in the chest, etc. The common characteristic of these TSMs is an exaggerated autonomic cycling – somatisation becomes the represented metaphor for the retained procedural memory of the trauma (2,7,13,24).
- *Inter-translator* – The inter-translator is the shadow opposite of the excessive coping style and carries an emotional weight of core habitual negative programmed beliefs on inter-relational schemas (26,33). (The shadow consists of two dimensions: that which has been denied through trauma and that which from an individual evolutionary perspective has not yet developed into awareness and maturity.) Trauma induction of the molecules of emotion into the biological (damage to the limbic system – space-time memory gaps) causes perceptual "trauma-colouring" (projection). This time perception corruption as a state of imprisonment results from the fact that the brain has lost its ability to distinguish past from present – stored procedural memory of the trauma-activating event continues to operate as if the danger is still imminent, resulting in an inability to move into the future free of issues (13). On the extreme end of disconnection the inter-translators reflect paranoia and potential psychosis, where the person hallucinates his/her shadow (14).

Whereas the intra-translator is the represented metaphor for the trauma, the inter-translator is the route to the childhood trauma–activating event. SHIP® theory states that projection always follows its owner: That which the person fears lives near, and replays as fate through different associative props (1,7,34,35). Current chronic dis-ease experiences in relational schemas become time-travel mirror-windows exposing a traumatised past through an unconscious repetitive projected re-enactment script in the present (4,36). The inter-translator expresses and exposes the frozen space-time memory through the person's external ISF in the medium of projection issue statements in specific interpersonal locations such as activated feelings experienced in relation to a spouse or people at work, e.g., "Nobody ever hears me," or "I'm always on the losing end" or "People always hate me". Judgements incorporated as a child (the initial feelings of despondency at being a victim and failing to make life work successfully) become the projected judgements in adult life (1). The focus of the inter-translator is to enable the person to come

face to face with and experience and integrate frozen SHRs related to the trauma-activating event, the underlying trauma (shadow) which the coping style has been trying so hard to avoid (7,21). It has become a journey characterised by a systemic *fitrah* obsession in its quest to transcribe and send the message to live a full life. The projected issue results in a self-fulfilling prophecy of destruction in order to open the authentic path. It is one of the most creative paradoxical dramas: people set themselves up for failure so that they can succeed. Its aim is to push the limits in order to open potentialities, expose the internal power to prepare for redistribution, and live an uncompromised, conscious and TSM-free life (1).

Psycho-biodynamic trauma translators are interdependent-complementary opposites and occur in unison (4). The initial sequence is as follows (1): Trauma in the ISF that elicits the manifestation of the intra-translator is a prerequisite for inter-translators which in turn have a reciprocal activating effect on somatic functioning. When assertiveness is suppressed, the over-exposed space-time memory of "My world does not allow me to be assertive", which is being projected outwards through the inter-translator, manifests alongside the "opposite" psycho-biodynamic dis-ease such as chronic arthritis that unconsciously tries to compensate for suppressed assertiveness by retaliating through noncompliance in the form of, "I cannot submit to a denigration activity if I am ill". The translators thus co-conspire by establishing the environment for one another and in this way maintaining a healing site function by consistently exposing the existence of trauma.

Hypersensitivity to associative activators carries the potential to facilitate the unravelling of the mystery concealed within the psycho-biodynamic trauma translators.

- *Hypersensitivity to associative activators.* When there is trauma in the system the person will be subjected to potential reactivation through futuristic (usually adulthood) external associative activators that are cues reminiscent of previous trauma-activating events. These activators are energetic vehicle catalysts that prompts healing of certain deep emotions and feelings within the cortical, limbic and brainstem centres that will not reveal themselves unless provoked (1,7,24,37). They are also referred to as "abuse-reminiscent stimuli, trauma reminders, cue specific stimuli, trauma-related cues, and situationally appropriate cues" (6,13,24,26,38), and can be anything (e.g. particular dates, ages, children, sensory experiences, movie scenes, illness) that is linked in some way to the original psycho-biodynamic trauma-activating event. As an example, the author of this article has found that all the clients in his practice diagnosed by others with "seasonal affective disorder" (SAD) had in fact been activated through a seasonal associative activator that opened the old trauma memories induced during/or related to that season. As with all associatively activated "syndromes" (TSM), once the clients diagnosed with SAD detoxed their psycho-biodynamic trauma through SHIP®, the emotional distress classically conditioned to the stimuli present at that time was healed.

When an adult is activated into the exposure of childhood trauma, he or she regresses to a psychological structure that was traumatised during its construction (14). Although the laying bare of thoughts and feelings might seem excessive in the immediate context, they are appropriate in the context of an abused or neglected child (26).

SHIP® has developed over 200 activators to activate and expose frozen SHRs. These are in addition to the client's historical trauma-activating events presented through the narrative medium of images, thoughts, dream contents, psycho-biodynamic trauma translators and other information (7).

Associative activators that flood the coping style, rendering it incompetent, expose and initiate unfreezing of the original frozen SHRs – the person has entered spontaneous healing.

- *Spontaneous healing reactions (SHRs).* Post-traumatic responses are an inherent self-healing tendency that keeps banging against the internal locked door, sending out particular below-the-radar messages through the autonomic nervous system, exposing the

client to small "chunks" of flashbacks, nightmares and intrusive cognitions (36,39). SHIP® theory states that migration to a state of connectedness depends on SHRs, or "freeze discharge" (13). Selected regulatory release by the limbic system converts chemical communication into sensations that are read by the conscious mind as emotions (27). Neuropeptide receptors assist in mediating trauma to rise into SHRs and awareness (2).

SHRs, as is the case with the psycho-biodynamic healing script, may find expression in typical Complex PTSD and PTSD manifestations such as experiences of hyper-arousal, startle responses, anxiety, irritability, flashbacks, nightmares, depersonalisation (sense of body distortion) and de-realisation (distortions in visual perception). SHRs can be categorised as visual, auditory and those related to other somatic senses such as taste, touch, smell, proprioception (sense of the body's spatial and internal states) and vestibular responses (8). Sensorimotor, non-narrative experiences are related to traumas that occurred prior to the child's acquisition of language (26). The author of this article has noted 1860 varieties of SHRs. It is quite common in SHIP® for a chain reaction of SHRs to follow initial activation, signifying energy release of the trauma-chain.

Experiences of depersonalisation and de-realisation are not classified in SHIP® theory as personality disorders. Unfreezing SHRs typically move through these distortions during the process of re-aligning with the healthy blueprint boundary. When a 49-year-old client with TSM mentioned during a SHIP® session, "I feel my right side, my face and my body disintegrating', the SHIP® facilitator asked her to remain in that spontaneous healing experience that was previously disallowed to complete.

If the point of reference of psycho-biodynamic psychotherapy focuses on healing rather than pathology, clients will gain consciousness of previously unconscious developmental trauma in their own time. Some procedural memory may not become conscious and the SHRs will be experienced psycho-biodynamically, with resulting relief of TSM.

The fact that the hippocampus demonstrates an unusual capacity in adult life for neural regeneration (neurogenesis) (6) suggests that neural damage in TSM may be reversible through successful unfreezing of frozen SHRs.

To some the world at large is often a constant flooding associative activator, resulting in continuously activated SHRs; with depleted internal coping resources, avoidance becomes their chosen alternative.

- *Distracters*. The aim of defenses is to reduce the threat (40). Distracters play a similar role in that they buy time/control when an established coping style is flooded by stress. The distracter is a short-term focus that tries to avoid and shut off the activated, exposed trauma. Distracters can be classified as any too muchness avoidance behaviour such as substance abuse (e.g. alcohol, tobacco, drugs, food), intense physical activity (e.g. working out at the gym, sexual aggression), tics, and angry outbursts (e.g. projection, self-injury). Distracters create the bi-polar pattern of opposites (activity vs. non-activity) to distract the person's attention until the coping style has again settled into handling the external demands (7). Whereas coping styles oscillate between unconscious and conscious processes, the use of a distracter is a conscious act. Unfortunately the distracter has the potential to re-traumatise the system (e.g. the body's helplessness when it is stuffed full of food or drugs, or trauma "counsellors" denying the trauma translators their value), since denial is precisely the reason for TSM. It will therefore simply exacerbate the healing messages owing to the experience of impaired self-capacities, leading to further need for distraction and the development of more serious addictions (26).

The value of distraction is seen in instances where psychiatric medication might serve a purpose in supporting a flooded/failing coping style; at the same time, however, all distracters keep the person remote from healing and integrating his or her personality potentials.

Paradoxically, intra- and inter-translators can also serve a defensive function until such time as the person can assume responsibility for self-healing: intra-translators hold the trauma in an implicit imploded/disconnected space, and inter-translators hold the trauma-activating event in an explicit projected/dissociated space.

Conclusion

The author of this article has presented a theoretical exposition on a proposed Integrated SHIP® Trauma-spectrum Model; different constituents of the model have been discussed. A SHIP® point of reference was advanced, namely that trauma-spectrum manifestation (TSM) is a continuous process of self-regulation. This contrast to the old school of pathology has implications for treatment: Practitioners should create a healing space for SHRs that were unable to complete their sequences at the time of trauma-activating events. With appropriate facilitation, alignment with the inherent healthy blueprint will take place spontaneously and TSM will reciprocally diminish and cease to exist in the face of complete integration. Neuropsychologically oriented research on the correlates between coping styles, intra- and inter-translators, SHRs and developmental phases will contribute to more effective psycho-biodynamic psychotherapy in less time, allowing clients to travel the inevitable journey towards becoming the people they are destined to be.

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