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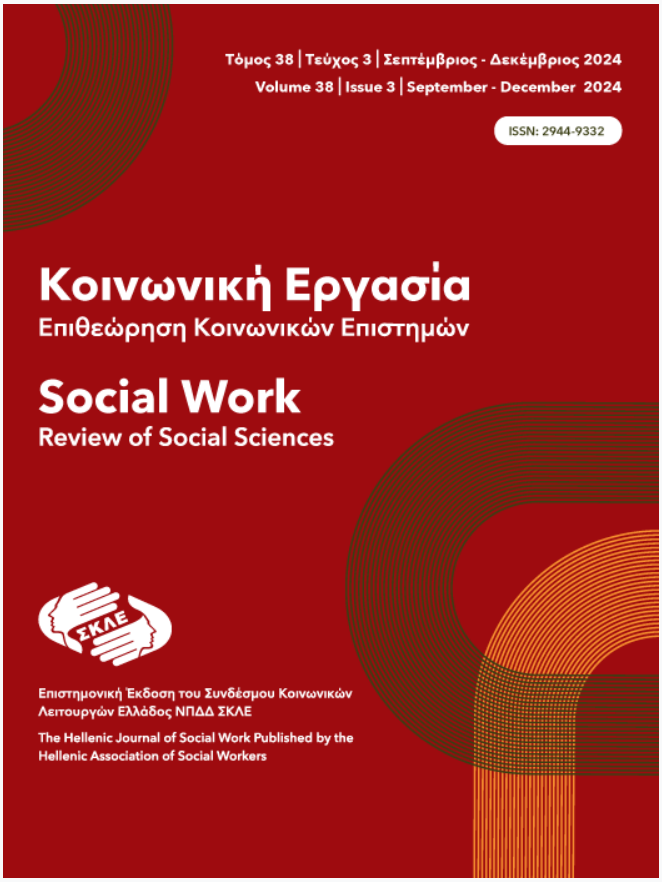

Η τεχνική ήρεμος/ασφαλής τόπος σε πλαίσια ιδρυματικής φροντίδας

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The calm/safe place technique in residential care

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ABSTRACT

Calm/safe place is an imagery stabilization exercise, an important resource the child can use during trauma processing when emotions become too distressing. Safe place can be viewed as a form of controlled dissociation. However, children in residential care, due to their developmental and complex traumas, may not have developed secure foundations for attachments and, therefore, face difficulties in identifying a safe place in therapy. This article aims at presenting 12 drawings of safe places of children that have been referred for EMDR therapy at the Mental Health Unit the “House of the Child” andlive in host houses of the association “the Smile of the Child”. The analysis of drawings indicated the need for privacy and particular patterns that will be discussed. The second aim of this article is to present the conclusions of a pilot focus group in which three EMDR therapists participated (two clinical psychologists and a child psychiatrist). The EMDR therapists work therapeutically with children in residential care and discuss the obstacles to establishing a safe place and other therapeutic considerations. The output of the focus group is presented through a SWOT analysis. Our findings could have implications on the conceptualization of the stabilization phase in the therapeutic work with children in residential care.

Key-words: Safe place technique, Stabilization, Residential care, Controlled dissociation, Relaxation technique

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Introduction

Calm/Safe place technique

Calm/safe place is an imagery stabilisation exercise, and an important resource the child can use during trauma processing when emotions become too distressing. Safe place can be viewed as a form of controlled dissociation (Morris-Smith & Silvestre, 2014).

According to Leeds (2009), the first EMDR procedure intended to strengthen self-capacities was the safe place exercise. The safe place imagery exercise (Korn & Johnson, 1983) was first combined with bilateral eye movements by Neal Daniels and added to EMDR training in 1991 (Shapiro, 1998). Since then, the technique has constituted a standard part of the preparation phase of EMDR (Gomez, 2013; Shapiro, 2001; Struik, 2014). The safe place exercise is intended to provide a positive introduction to alternating bilateral stimulation (BLS), clinical assessment information, and resource building as a self-control exercise. As suggested by Leeds (2009), a small portion of clients, however, report negative associations to frightening, shaming, or distressing images during the safe place exercise; many of these patients go on to demonstrate more complex or ineffective responses to standard EMDR reprocessing of their traumatic memories. These early negative responses to the safe place, together with other clinical factors (Korn & Leeds, 2002; Shapiro, 2001), suggest the potential need to extend the preparation phase with additional resource-focused and skill-building interventions.

Safe place is a resource the child can use during trauma processing when emotions become too distressing, in order to end incomplete sessions and at home and in other contexts when they feel distressed. Children need to feel safe in the real world before EMDR therapy is started (Morris-Smith & Silvestre, 2014). Every time the child is able to utilize the calm/safe place, his or her ability to change affective states and regulate internal states is enhanced. In order to assist the child in using the calm/safe place when needed, we could start by identifying the triggers in the child's life (Gomez, 2013). This will help us determine the best way to help the child remember to use the calm/safe place. The child is asked to choose a place where they feel good and completely safe and imagine they are there (Struik, 2014). They are asked to describe what they see, hear, smell, taste and where in their body feel the connection with the safe place. Afterwards, they are instructed to imagine they feel good and completely safe. The child is encouraged to create a key word or phrase (cue word) as a reminder for the safe place (Gomez, 2013). Then they draw the safe place. Alternatively, as suggested by Morris-Smith and Silvestre (2014), this could be done through different ways, talking and imaging, drawing or creating it in other ways by using toys and materials. Gomez (2013) proposes that a series of creative activities and the use of transitional objects aim to facilitate the finding of a calm/safe place.

Regarding bilateral stimulation, the number of repetitions is generally limited to 6 to 12 complete movements to lessen the potential for association to other disturbing memories (Kuiken et al., 2001). According to the instruction of Greenwald (2012), 6 (round trips) are proposed for adults, 5 for teens and 4 four children. Our goal is the visualization to click-in. As suggested by Morris-Smith and Silvestre (2014), even with a small amount of bilateral stimulation, a child’s safe place is disrupted and connected to negative material, or becomes neutral, or the child reports feeling numbed and/or less happy, then child may be not ready yet to begin the work of desensitization and further stabilisation is required.

Drawings of safe places

In many of the drawings, the need for privacy emerged. The need for privacy was most pronounced in adolescents living in residential care. Children with multiple experiences of victimization, neglect, or developmental trauma needed more time to develop a safe place and demonstrated greater need for gradual familiarization with pleasant sensations and positive engaging experiences through

flash technique and calm-safe-happy protocol. In children with complex trauma, there was a greater need for stabilisation with grounding techniques (Shapiro, 2007: four elements and breaths). When the safe place was contaminated, the need for resourcing inside the safe place (Schwarz et al. 2017: power animal) and caring of dissociative parts emerged. The drawing would be stored safely in the therapy room but a copy could be also kept in the children's room, as suggested by Gomez (2013) and Struik (2014). In some cases, where children exhibited resistance to engage with the safe place exercise, bilateral music was used as suggested by Schwarz et al. (2017). If this was enjoyable for the child, it was suggested they practice it at home with music. Through bilateral music, some children could relax and concentrate better on the instructions, experiencing less interference from dissociative parts. Some children, after the desensitization of a traumatic memory, asked to change their initial safe place as it did not feel suitable anymore and built a more cohesive and stable place for them.

Safe place in the residential care

The safe place installation often presents problems in severely traumatised children and adolescents (Gonzalez & Mosquera, 2012). Children having experienced developmental and complex traumas may not have developed secure foundations for attachments and face more difficulties to identify a stable safe place in therapy (Gomez, 2013).

Severely traumatised children and adolescents in residential care have difficulty with this safety task. For survivors of chronic abuse or neglect, establishing safety can be complex and time-consuming and difficult task (Tripp et al., 2019). For survivors of early trauma, the word “safe” can be a trigger in itself (Gonzalez & Mosquera, 2012). Children who have experienced ongoing childhood neglect or abuse often have coupled the word “safe” (used and associated via reinforcement by perpetrators) with subsequent betrayal and/ or danger. Thus, the word “safe” means quite the opposite and can trigger survival terror. Many perpetrators tell their victims that they provide safety, whereas in reality the client experiences with them danger, harm, injury and survival terror (Schwarz et al., 2017). Alternatively, Schwarz et al. (2017) suggest the term “special” place instead of safe place.

As suggested by Struik (2014), for severely traumatised children, using an imaginary private island may be a better option than asking them to choose a real place. These children have never felt really safe in daily life and, therefore, have trouble describing a real safe place. The idea is to create an island for them full of positive sensations and associations and ask them to expand on that. The description of the island should include elements and sensations, which are opposite to what they have experienced as traumatic These can encompass animals, a safe person, a feeling of being strong together, feeling good/safe, feeling free, having control, feeling warm, enjoying good food, a full stomach, a good smell, being allowed to drink. Children with a dissociative disorder have parts that may feel very frightened and/or alone. They can be assured that all the parts are allowed to go to the island.

In addition, Gomez (2013) suggests the use of here and now activities and moments of joy, safety, or calmness as a way to overcome the obstacles to finding a safe place. The calm-safe-happy protocol is appropriate for children who cannot find a safe place or find safe places that rapidly become contaminated (Gomez, 2013). In some cases, we also used the Flash technique (Manfield et al., 2017) both as a resource and as a way of getting children familiarized with bilateral stimulation.

The House of the Child

The House of the Child is a Mental Health Unit for the provision of individualized Mental Health Services to children and adolescents victims of abuse, neglect, domestic violence, victimized minors, children

involved in bullying incidents and generally children who have recently or in the past been exposed to severe psycho-traumatic experiences and suffering resulting to mental health, adaptation or behavioral problems (Tsouvelas et al., 2019). “The House of the Child” is operated by the domestic child protection civil society Association “The Smile of the Child” and constitutes a specialized service, unique in Greece and innovative both in Europe and internationally.

Methods

Participants

Fourteen children (comprising 6 girls and 8 boys) referred to the day center for Eye Movement Desensitization and Reprocessing (EMDR) therapy participated in the intervention. The participants ranged in age from 9 to 17 years. In most instances, the technique was applied within a single therapeutic hour; however, in some cases, multiple sessions were required to complete the process. Once the association with the calm/safe place was established, the child proceeded to draw the calm place.

Analysis of the children’s drawings and SWOT analysis on the implementation of the technique

The authors, who were the children's therapists, conducted a thematic analysis of the children's drawings following the application of the technique. Additionally, four illustrative examples demonstrating each child's connection with the calm/safe place are provided.

Following the implementation of the technique and the data collection, a SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats) (Gürel, 2017) was conducted on the results of a focus group, in which all the authors participated. This analysis was utilized to synthesize the information and facilitate a discussion on the limitations of the technique and the integration of the technique into therapeutic interventions with children in residential care.

Procedure and Ethical Statement

This was an interventional and qualitative study. The implementation of the technique and the data collection took place from January 2017 to December 2019. The questionnaires completed by the children, the caregivers and psychotherapists were part of the diagnostic assessment process that took place at the Day Center "The House of the Child". They were administered during the phase of stabilization and preparation for EMDR. Written informed consent was obtained by the person who had the legal custody of the minor at the point of the assessment process (before the minor was assessed). Recognising the need for ethical clearance for such a retrospective analysis, the researchers were concerned with whether there was more than minimal risk for harm to the participants. No risk was identified and the authors/ researchers decided to obtain approval from the President of the “Smile of the Child” who has the legal custody for all of the participants.

Results

Analysis of children’s drawings and connection to calm/safe place

The collection of the children's drawings offers diverse representations of what they perceive as a "calm" or "safe" place, revealing various themes and elements that contribute to their sense of security. Figures 1 and 2 show the children's drawings.

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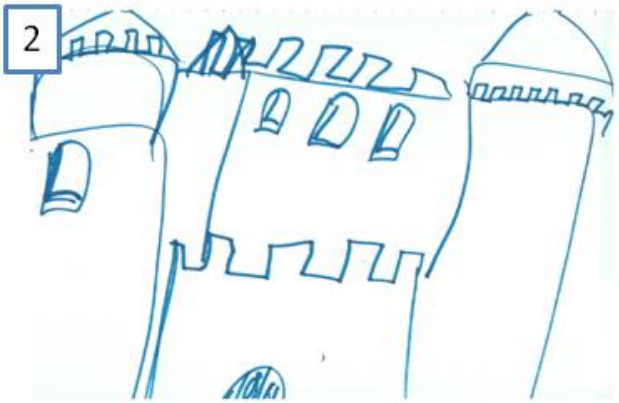

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Nature and Outdoor Settings are prominent in many drawings, which feature landscapes such as beaches, fields, or gardens. The inclusion of natural elements like trees, grass, water, and sunlight indicates that children often associate feelings of safety and comfort with being in nature. Images depicting open spaces, blue skies, or calm waters convey tranquility and freedom, suggesting that these children perceive wide, peaceful environments as reassuring and protective. However, the inclusion of specific natural elements, such as turbulent sea and wilderness, may also indicate underlying feelings of fear, anxiety, tension or loneliness.

Homes and Buildings are also commonly depicted, with some drawings illustrating houses or castles. These structures symbolize enclosed and protected spaces, indicating that children may equate safety with familiar surroundings and the security of being sheltered or near family. The depiction of castles, in particular, might suggest a desire for heightened protection or a sense of being safeguarded from external threats, with walls and towers. Magical or Fantasy Elements appear in several drawings, incorporating features such as rainbows, stars, or dream-like imagery. These fantastical components introduce a sense of magic and whimsy, indicating that some children perceive safety as intertwined with imagination, external powers, idealized qualities and escapism. This suggests that a child's sense of security may extend beyond the physical realm to include the comforting power of their own fantasies. Water Settings is another recurring theme, with scenes portraying oceans, rivers, or lakes. Water can evoke a calming influence and may represent emotional safety or a state of ease for the child. Water may also represent life energy, renewal or the maternal figure. In some instances, the presence of boats or people in the water scenes implies a controlled adventure or exploration, where the child feels protected even while engaging in activities that take them away from the familiarity of home. It may also suggest a sense of hope for change, movement or transition. Social Interaction and Solitude are represented in varying ways. While some drawings depict children in solitude, others include figures such as family members, friends, or animals. The inclusion of other individuals suggests that relationships play a significant role in fostering a child’s sense of safety. On the other hand, scenes featuring solitude may indicate that the child feels safe in being alone, possibly in a setting that allows for peace, introspection and protection from potential threats. Light and Colors are frequently used to convey emotions, with bright colors, sunshine, and rainbows signifying positivity and happiness. These elements may suggest that children associate safety with warmth, joy, and positivity. Conversely, darker or more subdued colors are sometimes used in conjunction with enclosed environments, such as inside a house, which may reflect a sense of protection or shelter. Overall, the drawings exhibit a range of conceptualizations of safety, blending elements of nature, family, fantasy, and different spatial contexts—both open and enclosed. This diversity of themes highlights how children's representations of safety are shaped by their experiences, environments, cognitive complexity and imaginative capabilities.

Presented below are representative narratives describing the children's connection to the calm/safe place for the first four drawings. The children tried to connect with their senses in this place and gave a title for their calm/safe place.

In drawing 1 a 13-year-old girl reported the following: Image: I am on the clouds, lying down and looking at the stars. And there is a colourful rainbow above me. Sound: I hear a very soft melody. Feel: I feel the warmth on my skin. I feel joy, peace, and security. Body location: In the heart Cue/Title: The stars

In drawing 2, an 11-year-old girl from a war zone reported the following: Image: I'm in my castle which is built in a remoted area. I can look outside but no one can see me. No one can hurt me. It is well sheltered. Sound: I hear the sound of birds. Smell: I smell the scents of the trees, of the nature

around. Feel: I feel the sun warming my skin. I feel safe inside the castle, because no one can harm me. Body location: All over my body but more on my arms and legs. Cue/Title: My castle

In drawing 3 a 17-year-old boy reported the following: Image: I am on a hill near the house (residential house) where I can see the sea, boats and houses. It is summer, at noontime, it has a pleasant warm atmosphere Smell: I can smell the flowers and the grass. I feel: I feel a gentle breeze that cools me. I hear: I hear the sound of the wind flowing through the branches of the trees. Connection with the body: Chest. Cue/Title: The view of the sea

In drawing 4, an 11-year-old girl reported the following: Image: It is a summer morning and I am alone on a sandy beach. I am lying on a sun lounger, looking at the sky and relaxing. Smell: The sea and the smell of fresh air Hearing: I listen to calm music and also the sound of the sea. Taste: Ice cream. Body location: Chest. Cue/Title: Beautiful beach

Results of the focus group in a SWOT analysis

The second aim of this article is to present the conclusions of a pilot focus group in which three EMDR therapists participated (two clinical psychologists and a child psychiatrist). The EMDR therapists have worked psychotherapeutically with children in residential care and discuss both the obstacles to establishing a safe place working with this population and therapeutic considerations based on developmental aspects of Perry's Neurosequential Model (NM) (2008). According to the NM, the brain is organized and should be responded to in a hierarchical manner from the bottom-up: safety (brainstem-survival state), connection (limbic system- emotional state), and problem solving (prefrontal lobes-executive state) (Perry, 2008, 2009). To this end, in order to help children in an acute state of distress, we need to first help them regulate their behaviors, then relate to us or others, and then reflect upon or make meaning of their experience (De Luna & Wang, 2021). Following the principles of the Neurosequential Model, cognitive scaffolding was used to find sensations associated with a sense of security when there were difficulties with the safe place.

Data from the focus group were analyzed using SWOT analysis. The SWOT analysis of the therapeutic intervention for children in residential care reveals several key strengths, weaknesses, opportunities, and threats that influence the implementation of the technique in corresponding samples of children from institutional care contexts.

Strengths of the intervention lie in its ability to provide a source of empowerment and stabilization for children. The therapy room, being located outside of their residential home, served as a private sanctuary, offering a sense of safety that was often new and unprecedented for many of the children. This "corrective emotional experience" allowed them to permit and explore feelings of security that they may not have experienced before. Additionally, the therapy approach was flexible, alllowing children to change or modify their designated safe place as needed during the sessions, which further personalized the process. The introduction to pleasant sensations before installing the concept of a safe place helped to build a foundation of stabilization that was beneficial even for those who did not continue with trauma processing. Furthermore, the provision of two color copies of the safe place drawing—one for the therapy room and one for the child's home—helped to reinforce the therapeutic intervention.

However, there are notable weaknesses that hindered the program's effectiveness. A significant challenge was the absence of parents and stable caregivers due to frequent staff turnover and shift work, which disrupted the continuity of care. The fact that the therapy unit and the residential setting were part of the same organization could act as a trigger for the children, as it was associated with feelings of abandonment and separation trauma. Another issue was the lack of involvement from the primary caregivers during therapy sessions, coupled with insufficient feedback mechanisms for

therapists, who only received updates from caregivers via Child Psychiatrists on a monthly basis. Moreover, the residential care environment's lack of privacy made it difficult for children to practice the safe place technique at home. Additionally, some children were reluctant to engage in the activity of drawing their safe place due to low self-esteem, negative self-evaluations, or fear of judgment.

There are several opportunities from which the intervention could benefit to improve outcomes. For instance, finding a calm, pleasant, or soothing place could be used as a more accessible alternative to a "safe" place for those who had never felt safe in real life. The therapy room itself could be used as a surrogate safe place to help children develop grounding skills before they were able to visualize one independently. The program could also focus on better management of intrusions, dissociative symptoms, and motivation at various stages of therapy to help children engage more fully with the technique. Additionally, some children connected to safe places that reflected nurturing, positive, or mastery experiences, suggesting that the therapy could be tailored to incorporate these aspects more intentionally.

Nevertheless, there were critical threats that posed risks to the intervention's success. The assignment of primary caregivers without consideration of the child's attachment history sometimes undermined the therapeutic process and could exacerbate trauma symptoms. The inability to find or connect to a safe place may have served as a trigger for feelings of abandonment and safety-related traumas, leading to dissociative symptoms. The environment's lack of privacy further restricted the children from practicing the techniques outside of therapy sessions, limiting the generalization of therapeutic benefits to their daily lives. Moreover, when children struggled to connect with their safe place, it could result in feelings of failure and frustration, potentially reinforcing negative self-perceptions.

In conclusion, while the therapeutic intervention offered significant strengths in creating a structured and empowering environment for children in residential care, there were several areas that needed attention. Addressing the weaknesses related to caregiver involvement and privacy, as well as utilizing opportunities to make the safe place technique more accessible, could enhance the intervention's effectiveness. Simultaneously, mitigating threats associated with trauma triggers and dissociation would be crucial for fostering a stable and supportive therapeutic process.

Discussion

Our findings could have implications on the conceptualization of stabilisation in therapeutic work with children in residential care. The analysis of the implementation of the "calm/safe place" technique for children in residential care reveals significant insights into the intervention's effectiveness, limitations, and potential improvements. The children's drawings provide a diverse representation of what constitutes a "safe" or "calm" place, illustrating how safety is perceived through various elements such as nature, familiar structures, fantasy, social connections, and sensory experiences. These findings highlight that children often associate feelings of safety with both physical and emotional aspects, including natural settings, enclosed spaces like homes or castles, and imaginative scenarios that offer a sense of escape or protection. (Gordon, 2010). The strengths of the intervention lie in its ability to create a corrective emotional experience by introducing children to previously unknown sensations of safety and stabilization. The flexibility of the approach, which allows children to modify their designated safe place during therapy sessions, personalizes the experience and facilitates engagement. Additionally, integrating positive sensory experiences before working with the safe place concept provides a foundation of stabilization, even for those who are not ready to process trauma. The dual

reinforcement of providing a copy of the drawing for the therapy room and the child's home further strengthens the intervention's impact (Struik, 2014).

However, several weaknesses hinder the effectiveness of the intervention. The instability of caregiver relationships due to staff turnover, lack of caregiver involvement, and limited privacy in residential settings restrict the generalization of therapeutic benefits beyond the therapy room. Additionally, some children face challenges in connecting with a safe place due to past traumas, low self-esteem, or the absence of real-life experiences of safety. This difficulty can trigger dissociation or reinforce negative self-perceptions, posing risks to the child's therapeutic progress. The findings also identify opportunities for enhancing the intervention by adapting the approach to meet the unique needs of children who struggle to connect with a typical "safe" place. For example, using the therapy room as a surrogate safe place or focusing on pleasant or calming experiences as an alternative to safety could improve accessibility and engagement (Morris-Smith & Silvestre, 2014). Tailoring the therapy to incorporate nurturing or mastery experiences that resonate with the child's personal history may also strengthen the intervention's effectiveness. Critical threats to the success of the intervention include triggers related to trauma, attachment issues, and environmental factors like lack of privacy, which can limit the technique's effectiveness outside therapy sessions. Addressing these threats will require strategies to better manage dissociative symptoms, ensure appropriate caregiver assignments, and create environments conducive to practicing grounding techniques.

In summary, while the "calm/safe place" technique offers a promising approach for fostering a sense of safety and stabilization in children living in residential care, addressing challenges related to caregiver involvement, privacy, and trauma triggers is crucial. By refining the intervention to accommodate individual needs and creating opportunities to make the technique more accessible, the therapeutic process can be enhanced, leading to improved outcomes for children in institutional care settings. Based on our data, it would be helpful to view stabilisation and trauma processing as a circular process, rather than distinct stages, as they may be inextricably interwoven in therapy (Schwarz et al., 2016).

The present study / intervention has several limitations that should be considered. Firstly, the sample size was relatively small, which may limit the generalizability of the findings across different residential care settings. The reliance on qualitative data, such as children's drawings and self-reported experiences, introduces subjectivity in the analysis and may affect the consistency of the results. The study's setting, with the therapy room and residential facility being part of the same organization, could have inadvertently influenced the children's perceptions, as it may trigger associations with previous trauma or feelings of abandonment. Environmental factors, such as the lack of privacy in residential settings, may have influenced the children’s ability to engage fully with the calm/safe place technique. Longitudinal studies could provide deeper insights into the long-term effects of the intervention. In recent years, the significance of therapeutic stabilization has gained attention. According to Eichfeld et al. (2019), trauma stabilization, when employed as a standalone treatment intervention, has been demonstrated to be a safe, effective, efficient, and sufficient approach for the treatment of PTSD. Including more structured feedback mechanisms involving caregivers, therapists, and children themselves would also be beneficial. Lastly, investigating alternative grounding techniques for children who struggle to visualize a safe place, as well as exploring ways to integrate the intervention into daily life, would help to refine and improve therapeutic outcomes.

References

De Luna, J. E., & Wang, D. C. (2021). Child Traumatic Stress and the Sacred: Neurobiologically Informed Interventions for Therapists and Parents. Religions, 12 (3), 163. https://doi.org/10.3390/rel12030163

Gomez, A. M. (2012). EMDR therapy and adjunct approaches with children: Complex trauma, attachment, and dissociation. Springer Publishing Company.

Gonzalez, A., & Mosquera, D. (2012). EMDR and Dissocation: The Progressive Approach. AI.

Gordon, J. (2010). Place matters: The significance of place attachments for children's well-being. British Journal of Social Work, 40(3), 755–771. https://doi.org/10.1093/bjsw/bcn142

Gürel E. (2017). Swot analysis: a theoretical review. Journal of International Social Research, 10 (51), 994–1006. https://doi.org/10.17719/jisr.2017.1832

Greenwald, R. (2012). EMDR within a phase model of trauma-informed treatment. Routledge.

Eichfeld, C., Farrell, D., Mattheß, M., Bumke, P., Sodemann, U., Ean, N., ... & Mattheß, H. (2019). Trauma stabilisation as a sole treatment intervention for post-traumatic stress disorder in Southeast Asia. Psychiatric Quarterly, 90, 63–88. https://doi.org/10.1007/s11126-018-9598-z

Korn, D. L., & Leeds, A.M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilisation phase of treatment of complex posttraumatic stress disorder. Journal of Clinical Psychology, 58 (12), 1465–1487. https://doi.org/10.1002/jclp.10099

Korn, E. R., & Johnson, K. (1983). Visualization: The uses of imagery in the health professions. Irwin Professional.

Kuiken, D., Bears, M., Miall, D., & Smith, L. (2001). Eye movement desensitization reprocessing facilitates attentional orienting. Imagination, Cognition and Personality, 21 (1), 3–20. https://doi.org/10.2190/L8JX-PGLC-B72R-KD

Leeds, A. M. (2009). Resources in EMDR and other trauma-focused psychotherapy: A review. Journal of EMDR Practice and Research, 3 (3), 152–160. https://doi.org/10.1891/1933-3196.3.3.152

Manfield, P., Lovett, J., Engel, L., & Manfield, D. (2017). Use of the Flash technique in EMDR therapy: Four case examples. Journal of EMDR Practice and Research, 11, 195–205. http://dx.doi.org/10.1891/1933-3196.11.4.195

Morris-Smith, J., & Silvestre, M. (2014). EMDR for the Next Generation-Healing Children and Families (2nd ed.). Academic Conferences and Publishing Limited.

Perry, B.D. (2006). Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics. In In N. B. Webb (Eds.), Working with Traumatized Youth in Child Welfare. Social Work Practice with Children and Families (pp. 27–52). The Guilford Press.

Perry, B.D. (2008). Child maltreatment: A neurodevelopmental perspective on the role of trauma and neglect in psychopathology. In T. P. Beauchaine & S. P. Hinshaw (Eds.) Child and Adolescent Psychopathology (pp. 93–129). Springer Publishing Company.

Schwarz, L., Corrigan, F., Hull, A., & Raju, R. (2016). The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma. Taylor & Francis.

Shapiro, E. (2007). 4 Elements Exercise. Journal of EMDR Practice and Research, 2, 113–115

Shapiro, F. (1998). Eye movement desensitization and reprocessing (EMDR): Accelerated information processing and affect-driven constructions. Crisis Intervention & Time-Limited Treatment, 4 (2-3), 145–157.

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (2nd ed.). Guilford Press.

Struik, A. (2014). Treating Chronically Traumatized Children: Don't let sleeping dogs lie!. Routledge.

Tripp, T., Potash, J. S., & Brancheau, D. (2019). Safe Place collage protocol: Art making for managing traumatic stress. Journal of Trauma & Dissociation, 20 (5), 511–525. https://doi.org/10.1080/15299732.2019.1597813

Tsouvelas, G., Chondrokouki, M., Nikolaidis, G., & Shapiro, E. (2019). A vicarious trauma preventive approach. The Group Traumatic Episode Protocol EMDR and workplace affect in professionals who work with child abuse and neglect. Dialogues in Clinical Neuroscience & Mental Health, 2 (3), 130–138. https://doi.org/10.26386/obrela.v2i3.123

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Η τεχνική ήρεμος/ασφαλής τόπος σε πλαίσια ιδρυματικής φροντίδας

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ΠΕΡΙΛΗΨΗ

Η τεχνική του «ήρεμου/ασφαλούς τόπου» αποτελεί μια άσκηση νοερής απεικόνισης που χρησιμοποιείται στο στάδιο της σταθεροποίησης κατά τη θεραπεία τραύματος, προσφέροντας στα παιδιά έναν χρήσιμο πόρο για την αντιμετώπιση έντονων συναισθημάτων κατά την επεξεργασία του τραύματος. Η τεχνική αυτή παρέχει μια μορφή ελεγχόμενης αποσύνδεσης, η οποία μπορεί να είναι ιδιαίτερα λειτουργική. Ωστόσο, τα παιδιά που ζουν σε πλαίσια ιδρυματικής φροντίδας έχουν συχνά βιώσει αναπτυξιακά και πολλαπλά τραύματα, με αποτέλεσμα να μην έχουν αναπτύξει ασφαλείς δεσμούς προσκόλλησης, γεγονός που δυσχεραίνει τη διαδικασία σύνδεσης με έναν ήρεμο και ασφαλή εσωτερικό τόπο. Οι ανήλικοι που έχουν βιώσει σοβαρά ψυχικά τραύματα σε ιδρυματικά περιβάλλοντα παρουσιάζουν συχνά δυσκολίες στην κατανόηση και την αξιοποίηση αυτής της τεχνικής. Το παρόν άρθρο παρουσιάζει τη συγκεκριμένη μέθοδο, συνοδευόμενη από ανάλυση 14 ζωγραφιών παιδιών που είχαν παραπεμφθεί για θεραπεία EMDR στη μονάδα «Σπίτι του Παιδιού» και διαμένουν σε διαμερίσματα του συλλόγου «Το Χαμόγελο του Παιδιού». Σε ορισμένες από τις εικόνες υπήρξε ανάγκη προστασίας της ιδιωτικότητας, ενώ παράλληλα αναλύονται τα μοτίβα που εντοπίστηκαν στις δημιουργίες των παιδιών. Επιπλέον, το άρθρο στοχεύει να παρουσιάσει τα ευρήματα μιας εστιασμένης συζήτησης (focus group) με τη συμμετοχή τριών θεραπευτών EMDR (δύο κλινικών ψυχολόγων και ενός παιδοψυχίατρου). Οι συμμετέχοντες ψυχοθεραπευτές, που είχαν εφαρμόσει τη μέθοδο και συνεργάζονταν θεραπευτικά με τα παιδιά, συζήτησαν τόσο τα εμπόδια στη δημιουργία ενός ασφαλούς χώρου εργασίας όσο και τις θεραπευτικές προτάσεις για την αποτελεσματική εφαρμογή της τεχνικής σε αυτόν τον πληθυσμό. Τα αποτελέσματα της συζήτησης παρουσιάζονται μέσω ανάλυσης SWOT, παρέχοντας προτάσεις για την προσαρμογή της τεχνικής σε ιδρυματικά πλαίσια φροντίδας..

Λέξεις-κλειδιά: Ήρεμος/ασφαλής τόπος, Σταθεροποίηση, Πλαίσιο ιδρυματικής φροντίδας, Λειτουργική αποσύνδεση, Τεχνική χαλάρωσης

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