The ALIVE National Centre for Mental Health Research Translation

THE ALIVE NATIONAL **WRITER-IN-RESIDENCE** PROGRAM

About the writer

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Issue 1

Sensing as a whole person: is sensation more than anecdotal evidence?

An invitation to see the interconnected embodied whole.

As I write the first of a series of articles for the ALIVE Writer-in-Residence program I am wrestling with where to start and how to talk in a series of separate articles about the interconnected wonderfulness of being a whole complex person. My solution is to plan a series that reflects on the interconnections of facets of being whole. Over this set of essays, we will reflect together on being whole people who sense, feel, experience, connect, comfort, defend, encourage, and heal. These themes are intentionally verbs, not nouns. They describe active processes that we can all be part of for our own wholeness and to help us see the wholeness of others.

As some of you may know, I am an Australian General Practitioner (GP) who became a GP psychotherapist so I could care for people that the mental health services in my community dismissed, ignored, or pathologised. I have become fascinated and passionate about making sure that whole person care becomes normal care in health, education, and the social services sector. This has led me on a journey of learning about trauma, grief, attachment, and the biology of stress (and so much more across the disciplines). At one point (2009- 2013) it led me to create a transdisciplinary clinic

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called Integrate Place that offered generalist care, art therapy, trauma-informed yoga, mental health nursing, and attachment based social work care to adults who had survived trauma and neglect in their community.

This passion for whole person care also led me to research. It led me to reflect on the philosophy of how we know about people and how people change and grow. It also made me search for shared language and goals that might unify how the disciplines see and care for whole complex people This search led me to see how biotechnical approaches that highly value precision and prediction have an inbuilt narrowed gaze that blinds them to the rich complexity of how culture, relationships, meaning and context impact health. It also made me fall back in love with generalism – a way of seeing, listening, questioning, discerning, and caring that integrates both the biography and biology of each person as part of a complex whole. [1p.5,2-5]

In this series of essays, we will reflect on ways of seeing and being and knowing that help us to see whole people. We will start with the verb *sensing*. What do you think of when you think of the word *sensing*?

For me as a clinician indoctrinated in the value of a certain kind of 'evidence', the word *sensing* used to imply something unreliable, not precise or predictive enough to be useful for medical decision making, and perhaps the worst accusation: 'anecdotal' which was code for 'unscientific'. This suspicion was applied to both the patient's sensations and the clinician's own invisible internal praxis wisdom and intuition. Sensing was often described in medical settings as 'subjective' - a kind of dismissive reductionist code for 'not objective' or even 'not real'. We sometimes see this in descriptions of symptoms as 'psychological' or the slightly less offensive 'functional' (implying subjective, internal, invisible but impacting someone's capacity to function) compared to 'organic' (implying observable, objective, or real to the clinician). But is it reliable and scientific to only value as 'real' what can be observed from outside?

Meanwhile, over the years, I have been learning from the brave honesty of the people I cared for as they described their life stories, inner experiences, memories, yearning, pains, and joys. Their insightful and reasoned reflections on their lived experience have changed me. Miranda Fricker says it is unjust to not value knowledge from inside the knower.[6] Inner subjective knowledge requires different ways of understanding that are not focussed on precision and prediction. To see internal

processes, we need to value knowledge that is experiential, authentic, culturally grounded, meaning making, and created with other people in relationship. This way of knowing adds so much to how we understand the world.

In a world obsessed by 'science' as 'reality', it is perhaps important to notice that subjective information is also 'scientific' - if we agree with Iain McGilchrist's definition of science as: "neither more nor less than patient detailed attention to the world". [7p.5] Sensing is not just 'anecdote'; it is a complex experiential way of knowing.

It is also important to critique the archaic assumptions of those who overvalue objectivity and assume that the body is an object that is 'completely explorable'.[8p.2] Assumptions that the disembodied observer's ('objective') mind is more reasonable and reliable than their own subjective experience (or that of the person they are caring for) are not aligned with the current science of a complex interconnected person.[9]

This brings us back to *sensing*. I have become completely fascinated by how sensing is an interconnected continuous oscillatory feedback process between inner and outer knowing.[10,11] Sensing is not just a simple linear process of perceiving, thinking and acting. For example, the sensors in the microbiome unconsciously influence mood, and past experience can alter our perception. Each time we sense something in our inner or outer worlds, our conscious and unconscious awareness links to our life story, beliefs, reasoning, and intuition as we 'make-sense' of the world.

Sensing is so complex and interconnected that it completely blows apart any artificial distinctions between objective and subjective, body and mind, inner and outer, and even past and present.

I have come to love sensation as a kind of moment-by-moment way of knowing about the world that integrates and connects the whole, and is owned by the knower. Only they can know what they sense, it cannot be defined from outside. Sensing and sense-making are so intertwined.[12,13] Sensing is a kind of unity, a perception of the whole, not just a bodily reaction to environment.

Along with new understanding of the multilayered whole person, there is a growing literature that explores the role of a part of the brain called the insula. The insula organises, connects,[14] interprets[14,15] and integrates sensation, perception, emotion,

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thoughts and plans. Florian Kurth says this creates "one subjective image of 'our world'."[16p.519] Although this image is not always accurate, or complete, or conscious, it matters.

Interestingly, when people are asked to rate their own health, their sense is more accurate than medical assessments of their wellbeing. Marja Jylha calls self-rated health a "cross-road between the social world and psychological experiences on the one hand and the biological world on the other."[17p.308] This cross-road is where those who offer whole person care need to sit, listen, learn, and care. Respect for sensing could help us all, in Bradley Lewis's words, to develop "better, truer, richer, and more generous stories … in the service of healing and coping.[18p.196]

Sensation is also responsive to small changes, tuned in to relationships, context, inner values and history. Our cells sense danger, and temperature change and oxygen levels (and so much more!). We sense ourselves in relationship to gravity and movement (proprioception), and the circadian rhythms of the sun. We even sense what is behind us. We use our senses to relate to others – to tune into their facial expressions and tone of voice (known as prosody). When we are fearful, we find it harder to hear the human voice as our ear drum changes to hear low sounds. We sense our emotions, and we sense threat (what Stephen Porges has called 'neuroception'[19]), and we sense our capacity to cope. We sense when we belong, and whether we have existential or spiritual peace or despair. We even sense our relationship to place (connection to country) and to the future (sense of hope).

As you are reading this – I am wondering if you could reflect on your current 'sense of' yourself? Where are you and who is nearby? How do you sense yourself and your spirit? When you tune into it are you aware of interconnections and how you know about your whole person?

When all these layers of sensation work seamlessly together, they often go unnoticed, and yet they have a purpose: to help us to enjoy and be safe in our world. In my doctoral research exploring threat and sense of safety,[3] it emerged that sensation protects our:

- *Integrity* – both physical and moral
- *Coherence* - that the world makes sense –
- *Connection* – to other people

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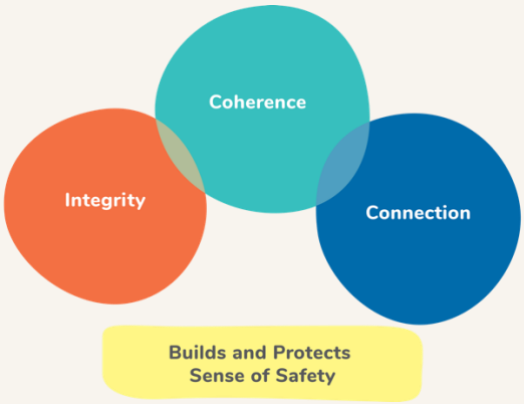

Figure 1: What senses protect: From the cellular to the communal (Used with permission Figure 5.1 Lynch, J.M. (2021) A whole person approach to wellbeing: Sense of safety. Routledge: UK (p.78)

In complex systems, reality is probed, sensed and responded to.[20] So if we want to know about complex whole people, we need to value and respect sensation. We also need to understand its limitations, the way it can be numbed, or dissociated, or hyperaware and hypervigilant, or distorted, altered, and confusing.

Awareness of sensation and sense-making can transform clinical practice. In my work with adult survivors of childhood maltreatment, I had to learn to be very aware of sensation - my own and those of the person I was caring for. Sensation became a friend as it prioritised the voice of the person who was sensing, and reduced the focus on what Paul Verhaeghe critiques as the 'ascendant medical observer'.[21] Sensing was also a gift through grounding techniques, attuned therapeutic connection, and learning to trust my own intuitions. It became a guide when trying to understand something embodied that had no words in assessment and in my own selfcare. It also helped me to make sense of coping mechanisms: how disconnection, numbness, distraction (for example using obsessions and addictions), or creative flow and activity helped people to alter their sensations to a dose they could tolerate.

Sensing became a way to understand whole people. Rather than being dismissed as anecdotal evidence, it is now central to both assessment and treatment. Sensing can help both people in the therapeutic relationship to tune into their own needs. Highlighting a person's 'sense of...' is an amazing combination of subjective and objective knowing that normalises caring for the many layers of being a whole person. Understanding the beautiful complexity of *sensing* could transform care.

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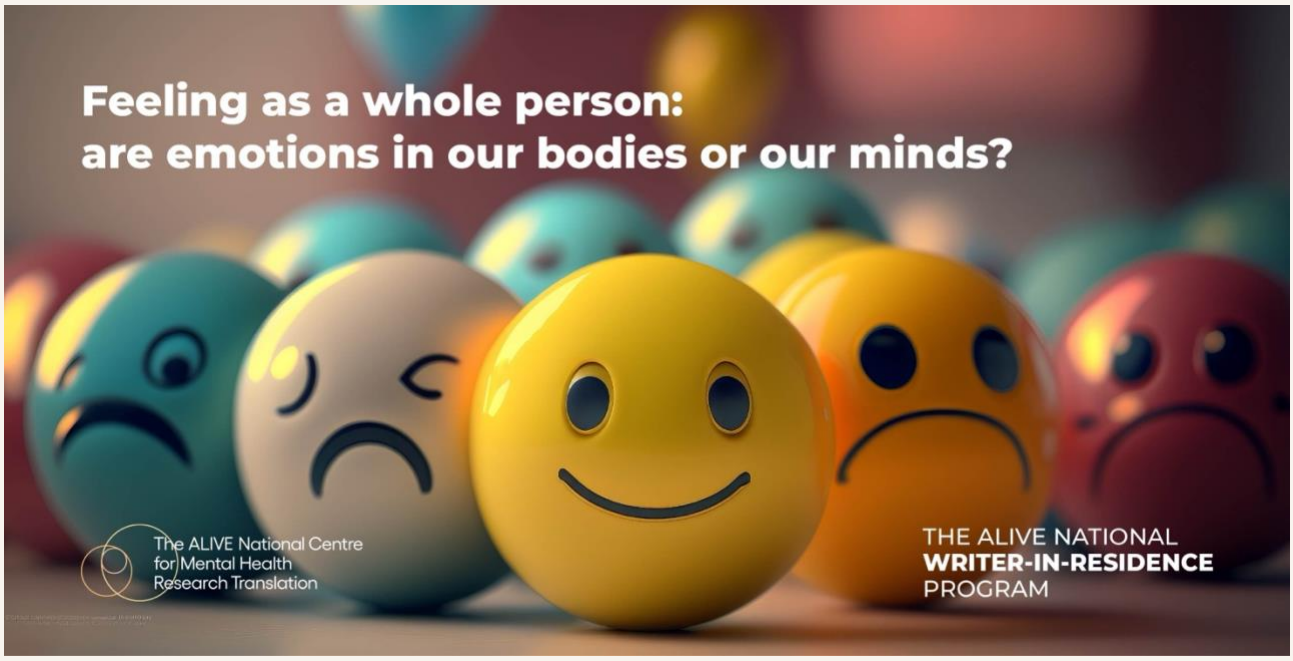
Issue 2

Feeling as a whole person: are emotions in our bodies or our minds?

An invitation to critique current understanding of mood as disorder.



Continuing the exploration of the interconnected wonderfulness of being a whole complex person, this issue will explore the multiple meanings and layers of the word 'feeling'.

I am not an expert in the area of emotion – but I bring it up for a topic of discussion as we think about the whole person. Just like sensation, I think it is another area that has become a narrowed concept. I am concerned that the categorical way the medical and lay community often use the words 'mood', 'emotion' or 'feeling' does not help us see whole complex people, and often pathologises something that is completely reasonable and understandable into a 'mood disorder'.

It seems that a beautiful interconnected meaningful experience of 'feeling' has been turned into a noun of disorder – a passive one dimensional thing.[1] When I first started writing about 'feeling' – I genuinely thought it was a verb – a process – a way of knowing or communicating to ourselves. But would you believe it – the Cambridge dictionary declares it as only a noun with multiple meanings (including 'sense', 'emotion', 'opinion', 'experience'). I have since learnt that you can 'have', and 'express'

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feelings and can express past sensation as a verb 'I sensed/felt x'. But there is no verb for the actual present emotive feeling process.

'Feeling' or 'emotion' or 'mood' or 'affect' being nouns, not verbs, doesn't seem to match reality where so much activity and change happens in our bodies, minds, and intersubjectively in relationships with others when we are experiencing a 'feeling'.

As a younger Australian general practitioner (GP) I can distinctly remember a moment when I felt a moral dilemma where my GP training called me to see the whole person, but mental health frameworks around depression saw it as a discrete thing – like a body part that can be treated. This narrowed assessment to a checklist independent of the personhood and experience of the patient. In those days drug company representatives used to book appointments, come into our consulting room, and give out pens and other paraphernalia to help embed their drug name into our consciousness. Those selling 'anti-depressants' used to leave 'helpful' little pads of questionnaires that would determine (quite often) that people needed that particular script. These questions were about mood over the last two weeks. As a new GP, the decision to prescribe an anti-depressant was difficult – but this tick box made it look straightforward. So – even though I knew that list didn't ask about a person's loss of a close pet, or existential distress as a widow, or childhood adversity, or work strain, or menopause – I still wrote that prescription – and it didn't feel right.

Categorising feeling or mood as a noun is not benign. It has completely altered how we relate to sorrow or fear in ourselves and other people.[2-6] It has led to a cookie cutter view of complexity that can make healing and community comforting harder. Rather than complex words like ennui (thanks Inside Out 2!), lethargy, regret, despair, lament, sorrow, or disappointment we now have the bland pathologizing word 'depression'. I think the tiny word depression has professionalised care, disenfranchised community from knowing how to help, and created an industry designed to offer narrow impersonal technological or pharmaceutical solutions.

This way of narrowing emotion to a noun has deep roots in trying to objectify something complex. Those who critique the concept of 'depression' call this 'reifying' – making something abstract into a noun and thereby creating something that is now more concrete but may not be quite as true or complex as it was before.[7,8] Some say our fascination with nouns in medicine is that we crave certainty or that our original

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science came from dissecting immobile cadavers. Others say it may come from a dated view of a silent body that is just observed from outside by a mind (usually that of an medical observer) that speaks: "the silent body and the speaking mind."[9p.1097] What if that body could speak? And the person who is experiencing it could speak for themselves?

There is good quality research that shows that emotion is embodied in an inseparable kind of way.[10,11] Some researchers describe a constant flow of communication between sensation and cognition – including what they call 'hot thought', or 'cognitive emotion' (links between emotion and thinking influenced by social, cognitive, neural and molecular processes).[12] Others link interpretations of emotion (emotional cognition or emotional thought) to "somatic states" that include musculoskeletal and visceral inner aspects of the body (especially cardiac, lung and gastrointestinal viscera).[13,14] Researchers have also named the ways that emotion is not passive – but can be manage through attention, soothing, and regulation- through what they call 'effortful control.[15,16] and both adaptive and maladaptive emotion regulation.[17] Some theories of emotion and sensation – such as Dabrowski's theory of positive disintegration, really highlight the interconnected purpose and development of emotion.[18]

Feeling and emotion are also closely linked with how we sense ourselves internally and respond to our external environment. Antonio Damasio in his essay 'Feelings of emotion and the self' describes exteroceptive senses (like sight, sound, touch, smell, and taste) alongside interoceptive senses (like proprioception that senses movement and gravity, vestibular sensation for balance, the internal sense of our organs, and environment that sense pain and temperature, and changes in chemistry such as pH, oxygen, lactic acid, glucose, histamine, hormones etc).[19] He claims that this sensing is part of how we know who we are – our bodily self as part of an integrated nervous system[20] that links 'factual knowledge and bioregulatory states'.[13p.296] Somatic markers or signals, for example heart rate, heart rate variability and skin conductance [21] can also reveal these inner processes. Stephen Porges would add 'neuroception' as an unconscious awareness of danger we sense all the time at multiple layers of our being.[22]

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Each of our main emotions have different physical markers. So much so, that one of the early researchers into emotion was Jaak Panksepp, a veterinarian turned researcher, who named what he called core emotions based on physical markers. He named emotions of 'seeking, fear, rage, lust, care, panic/grief, and play/joy' as the basis of a neuroscience of emotion.[23] Other researchers name core emotions of disgust, contempt, surprise, and happiness in their lists and describe 'seeking' as a type of focussed attention.[24] Cross-cultural research into bodily maps of emotion is also really helpful to understand the intersection of body and emotion exploring "bodily fingerprints" of anger, fear, disgust, happiness, sadness, surprise, anxiety, love, depression, contempt, pride, shame and jealousy.[25]

So, a 'feeling', that is often simplified into a noun (like 'fear') is actually a complex interconnected embodied experience that helps us know who we are, and connect to our own and others' experiences. It is a kind of inner connector, communicator and regulator: from our embodied self to our whole selves, and to others.

When understood this way – as a form of knowing or communicating – then we can learn so much from the array of emotions in our world. Emotion can help us to understand deep things that have no words, it can connect past and present experience, and help us to unravel the riddles of some presentations. One of my Norwegian mentors, Professor Anna Luise Kirkengen describes the "complex bodily logic" or "logic of the lived body" (personal communication) that is inside symptoms. This points to a deeper kind of knowing inside a person that has deep reason and meaning. Feeling is a way of knowing that we sometimes cannot interpret (if we are numb and cannot name a feeling - alexithymia), or can misinterpret (if we experience fear but interpret that bodily experience to be anger). Feeling is a way of knowing that can be linked to forgotten or ignored history that our body still remembers[26] (for example chronic pelvic pain after sexual assault). It can warn us about other people or places with gut feelings, and it can help us enjoy the world around us.

If you reflect on the last time you felt angry. Can you remember the thoughts you were having? Can you remember what it felt like in your body to feel angry? Can you remember how you calmed yourself down from that state? Can you sense that being angry involves all of you? The reason or meaning for the feeling, the bodily experience of your heart rate and stress hormones changing, the inter and intrapersonal context of the feeling? The way our voices get harsher and it becomes more difficult to sense

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or care about other people? We do not feel in just one part of ourselves – the whole of us experiences it.

I would also add that feelings usually make sense. They are rarely disordered. They usually have a reasonable cause somewhere within the whole person. Of course, feelings can be experienced in ways that are not helpful – for example rumination, rigidity, obsession, intrusions. And perception can be distorted. But if we took the time to understand the whole story and translate the meaning of that 'feeling', we would find the inner logic that Anna Luise Kirkengen describes above. This is something that I have encountered often.

With permission I share this story: I once had a patient who came asking for help because whenever she had unpleasant clients she found herself trying to give them more freebies than usual. As we talked, she realised that she recognised the feeling just before she was generous. She suddenly remembered being six years old and leaving a posy of flowers for her father on the front door steps when her mother took her away from the family home. The same (now wilted) posy was there two weeks later when she came to visit –her gift was unacknowledged, unreceived. Perhaps the logic of the feeling of needing to give to difficult clients was a kind of flashback – to a little girl trying to give a gift searching for acknowledgment from someone who did not notice her gifts. This feeling led us towards the healing logic.

If something meaningful is simplified to a discrete noun – we miss something important. We can miss the bigger story of harm or joy within the noun. In some ways this is why I think the professional psychiatric community is often late to the party about the importance of trauma-informed and strengths-based care. One writer that I think has captured this is Prentice Hemphill who notices how trying to suppress a feeling might actually mean we miss a chance to intervene and respond appropriately:

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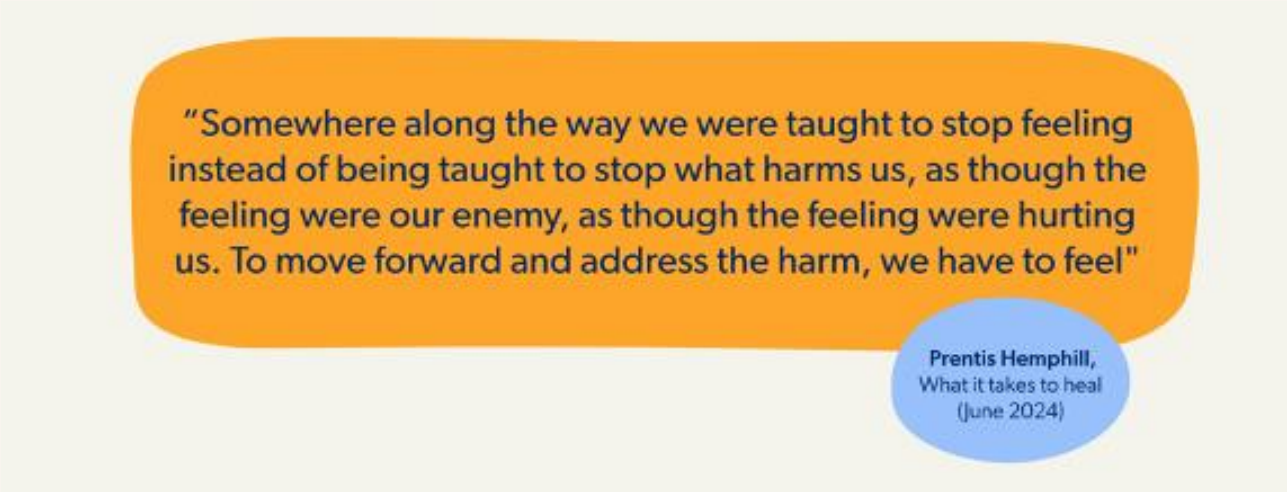

Image credit from Sense of Safety for Practitioners Foundation training course.

So – is feeling in our mind or in our body?

This vexed and important question changes how we understand, care for and manage emotion. Perhaps even the implied dichotomy in the question narrows our attention and makes us miss the amazing interconnections within a whole person. Perhaps this is so important that we need to resist simplistic answers that give simplistic (and perhaps therefore ineffective) solutions. Transdisciplinary researcher Sue McGregor says: "Simplifying reality to simplify our work is irresponsible". [27p.7]

I really think it is better to have an unanswered question than an incomplete answer. So, if we stay close to a person having or expressing a feeling, can we notice the bigger story, the interconnected sensory and cognitive meanings and regulation across the whole? Perhaps that is enough to critique the concept of mood as disorder?

I wrote a little poem to capture how much I think it matters if complex whole experiences become things:

Nouns of Disorder

If a feeling is a noun
then it becomes a thing
to be treated or categorised
with other impersonal things
it becomes disconnected
from me and you

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it loses its nuance
and its meaning to me
it gets bleached of
its body memory
and history
its story

If feeling loses story
and connections to me
and to you
then what does it mean?
what can we do to help?
where do we go next?

Johanna Lynch 2024

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The ALIVE National Centre for Mental Health Research Translation

Issue 3

Experiencing as a whole person: how does lived experience impact biology?

An invitation to see social determinants of health in a new light.

In this issue on experiencing as a whole person we will reflect on dynamic impacts of life story on health that are relevant to clinical care. This process will be like flying over a landscape (macro population-based studies) and examining each house plan in detail (micro biological studies). It will still not be able to tell us what is going for each person inside their home (the clinical needs) as in many areas, further clinical studies are needed to help us understand the whole person in their context. I hope these thoughts inspire your curiosity about how relationships, context, meaning, story, hope, and justice impact biological health of the whole person.

Patterns of whole person interconnections relevant across the disciplines can be seen across both macro and micro perspectives. Population and public health researchers and those who study social determinants of health (at a macro level), alongside molecular biologists, psychophysiologists, interpersonal neurobiologists, and those who study psycho-neuro-endocrine-immunology (at the micro level) explore the impact of lived experience and relationships on health. Drawn together these studies give insights that could transform healthcare priorities.

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Interconnectedness is so difficult to study in a world focussed on siloed disciplines. Insights that change how we understand whole person health usually come from those working on the borders[1] – rarely from within the mainstream of an established and powerful discipline. This work done outside established disciplines often does not have funding, knowledge translation pathways, or champions who are respected or valued by the mainstream, and so there can be decades of ignorance between discovery and any changes to practice. [2] Learning from cross-disciplinary research can inspire us to see and care in new ways.

Firstly, a few random insights into interconnections to start - about biological impacts of tickling rats, and kangaroo cuddles for neonates; the ways that stressful marriage and unregulated anger delay wound healing; and the way that the immune threat of COVID-19 impacted those experiencing structural racism. Tickling rats (a proxy for relational touch) is associated with lower stress hormone, lower anxiety measures, and more positive vocalisation and approach behaviours.[3] Neonatal units now prioritise 'kangaroo' (skin-to-skin) cuddling for preterm infants as it was found to reduce stress hormones, improve oxygen levels, blood pressure, and heart and breathing rates.[4] Wounds heal slower (a functional measure of health), and blood levels of the bonding hormone oxytocin are lower if a person is in a stressful marriage[5] or if they have difficulty regulating their anger.[6] Finally, USA research showed there were more deaths from COVID-19 in communities without household internet and with lower attainment of a high-school diploma, (which, due to structural racism, equated to neighbourhoods with higher percentages of Black residents).[7] These snap shots show how tuning into the molecular biology or the population experience can reveal patterns that matter.

Now let us focus on a few patterns within the macro and micro research worlds:

Three insights from population-based research, will show the impact of lived experience on our bodies from a macro angle:

One prospective study, done by Robert Anda's team, from the USA Centre for Diseases Control, studied the impact of hopelessness on cardiac death in a cohort with no cardiac risk factors or other serious illness.[8] He studied 2832 USA adults aged 45-77 and asked them about hope - asking them: *In the past month have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything*

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was worthwhile? Participants were asked to rate themselves on a six-point scale from "*not at all*" to "*extremely so – to the point that I have just about given up*". After adjusting for demographic and risk factors, this work showed that people with hopelessness were at increased risk of both fatal and nonfatal ischaemic heart disease. This risk was dose dependent – the more hopeless, the more cardiac death and nonfatal heart attacks. This trend was more marked in people of colour, the least educated women, and those who were unmarried. This research was published in 1993 and yet monitoring hope as an important outcome of therapeutic care is still not usual practice.

The second area of population-based research that helps us to notice the impact of lived experience on the body is from those who study social determinants of health.[9] Social determinants of health are defined as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life".[10] It includes structural inequities in power, money and resources as well as practical things like crowding, noise, poverty, food insecurity, low education, unemployment and job insecurity, social exclusion, racism, sexism, discrimination, and war. In our own community, colonisation and dehumanising public policy have changed health outcomes of First Nations people. Those who study the biology of the social determinants of health 'exposome' would contend that exposure to social inequity has more impact on health than healthcare.[11] They mention increased chronic inflammation, neurodegeneration, infection, cancers, cardiometabolic and autoimmune diseases.[11] Health disparities in communities that endure inequity are patterns that should change clinical assessment and policy priorities across sectors.[12-14]

The third body of research is the Adverse Childhood Experiences (ACE's) research that started with Vincent Felliti (an American physician) and Robert Anda (a population scientist). They studied 9503 Californian adults who reported childhood experiences of maltreatment and followed them forward for decades to monitor risk behaviour, health status, disease, or death.[15-18] They were interested in the prevalence and impact of a history of childhood psychological, physical, and sexual abuse; violence against the mother, or living with household members who were substance users, mentally ill, or suicidal, or ever imprisoned. They were also interested in the links to health risk factors and health outcomes. They found a dose-relationship between number of

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childhood adversities and prevalence of health risk behaviours (including smoking, severe obesity, physical inactivity, depressed mood, suicide attempt, alcoholism, drug use, > 50 lifetime sexual partners, and history of a sexually transmitted disease).[15] Independent of these risk factors, their publication in 1998 also showed a direct impact on health – they showed a dose-dependent relationship between the number of ACE's and ischaemic heart disease, cancer, chronic bronchitis, emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health.[15] More associations have been documented since – including FMRI studies showing changes to the brain associated with ACEs.[19] In their original paper, Felitti and Anda also predicted that medicine would have difficulty attributing physical disease to psychological wounding and adult disease to childhood experiences.[15]

In 2002, Vincent Felitti expanded on this in a paper detailing how the health of a child can deteriorate into adult sickness, saying "we have shown that adverse childhood experiences are both common and destructive. This makes them one of the most important, if not the most important determinants of health and well-being of the nation." [17p.46] He also added: "Unfortunately, these problems are both painful to recognise and difficult to cope with. Most physicians would far rather deal with traditional organic disease...comfortably focussed on tertiary consequences far downstream... the primary issues are well protected by social convention and taboo ... we have limited ourselves to the smallest part of the problem: the part where we are comfortable as mere prescribers of medication." [17p.46]

The recent Australian Childhood Maltreatment Study has confirmed many of Felitti and Anda's findings. It has confirmed through telephone interviews with 8500 representative adult Australians who report that before the age of 18 years old they have experienced physical (32%), sexual (39%), emotional (31%) abuse, and exposure to domestic violence (40%).[20] This study also confirmed the link to increased physical and mental illness and increased use of the health system.[20]

Inequities and maltreatment impact life expectancy – they are inscribed on the body,[21] and yet we do not routinely integrate social determinants of health into clinical understanding of disease. We rarely understand the importance of justice, community development and empowerment to health.

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The other area of research that can help us to see new patterns, is those who study molecular, cellular, or structural systems of the body. A key embodied form of research is the stress research that started with Hans Selye describing 'eustress' (tension that can lead to growth), and 'stress' (physical changes in the body in response to internal or external 'stressors').[22] He originally noticed that people in hospital with different diseases seemed to be trying to adapt in similar ways – with fatigue, loss of appetite, fever, and weakness – which he called 'stress'. This body of research has developed over the years into those who describe 'positive', 'tolerable', and 'toxic stress' (described as "a physiologic memory or biological signature that confers lifelong risk well beyond its time of origin"[23p. E238]).

There is now an exploding body of research trying to work out how life experience impacts the body. We all know that life stresses impact a person's health. We have seen people's tired worn-out faces and know they have had a 'hard life'. This is now being confirmed at a cellular level as we learn how stressors impact our body. Psycho-neuro-endocrine-immunology research clarifies that all forms of threat have an impact: "the disparity between physical and psychological stressors is an illusion. Host defence mechanisms respond in adaptive and meaningful ways to both."[24p.114]

The stress research includes explorations into molecular changes in cellular energy and sugar management (linked to diabetes, fatigue, DNA changes, aging and cell death)[25-29], changes in brain connectivity and neurodevelopment[30] (linked to capacity to self-soothe, learn, and perceive accurately), autonomic nervous system reactivity (connected to cardiac risk[31], and irritable bowel[32]), cranial nerves (linked to hearing, learning, and social connectedness[33]), and the immune system[34,35] (connected to asthma[36], dermatitis[37,38], infection and cancer[39] risk). Importantly, toxic stress becomes tolerable stress if another safe person is able to buffer the effect of the stressor.[40]

Allostatic load was named by Bruce McEwen's team – to describe a theory of how stressors changed the body.[41] He theorised that the body started in homeostasis where it could keep the body stable in its context, but then when the stressors started to impact, the body moved into 'allostasis' where it was trying to adapt, and then final into 'allostatic overload' when it couldn't adapt anymore and permanent changes started to lead to disorder and disease.

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A way to explain this is to think about our knees – when we are young our knees can jump and run and twist (and shout!) (*homeostasis*), if we put on weight (*the stressor*), the muscles around our knees adapt – they become stronger and ready to protect and move the knee (*allostasis*). If we continue to gain weight the muscles around our knees will not be able to adapt enough – and predispose us to injury to the cartilage and knee arthritis (*allostatic overload*).

This very ordinary process in our knees is played out in the molecular complexity of every cell in our bodies as we age or are overloaded by stressors. Allostatic overload due to stressors causes multisystem physiological dysregulation that impacts metabolic, cardiac, immune and neuroendocrine systems.[42] It is especially important in disadvantaged communities with a known health gap where there are daily stressors, including racism.[43]

Another key growing area of research has come from a psychophysiologist who started out studying low heart rate in premature infants – Stephen Porges.[44] This work led to an understanding of heart rate variability[45] that is how stress is measured in smart watches! His work has become very important in the trauma treatment community. He now studies the autonomic nervous system that organises our bodily temperature, oxygen levels, blood flow, thirst, hunger, and so much more - all while we are barely aware of it. You may have heard talk of the vagus nerve's role in mental health? The vagus nerve is a cranial nerve that originates in the brainstem – it receives (afferent fibres) and sends (efferent fibres) messages to the face, larynx, ear, oesophagus, heart, lungs, spleen, kidneys, adrenals, pancreas, and gastrointestinal system. Part of its impact on wellbeing is that it has been implicated in effects of the microbiome on mental health. [46]

Stephen Porges' work into the structure of the vagus nerve has shown that our body automatically monitors for threat all the time even when we are not aware (he calls that 'neuroception'[47]), it activates for fight or flight, or it shuts down ('freezes') if life threatening danger occurs. He has also shown that when we feel safe, our body can have needed restful restorative sleep, and we can also feel relaxed and sociable with other people. He has called this the Social Engagement System[48] that may help us understand the important way that relationships impact health.

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A final word from modern stress researcher Robert Sapolsky – from his great book – Why Zebras Don't Get Ulcers:

"Something akin to love is needed for proper biological development and its absence is among the most aching, distorting stressors that we can suffer. Scientist and physicians and other caregiver have often been dim at recognising its importance in the mundane biological processes by which organs and tissues grow and develop."[49p.98]

So – as we come to the end of this flight over the landscape (macro view), and exploration of each house plan (micro view), can we end with a reflection on the life of each person in their home? Let's reflect on how magnificently life experience and adaptive responses of our biology are woven together and how important love and connection are to health. [49,50] We can be more aware of how our bodies are impacted by injustice, fear, life experience, maltreatment and adversity, hope, relationships, and by the absence of 'something akin to love'[49]. I want to also remember with thankfulness all the places my knees have taken me - all the kneeling with children in grass, all the joyful dancing, and stunning mountains they have climbed. What are you thankful for in your body and the experiences it has weathered?

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Issue 4

Connecting as a whole person: what do shame and loneliness have in common?

An invitation to consider the biology of belonging.

In this issue we will reflect on the central role that relationships have on our wellbeing as humans: 'being human is a team sport'. We cannot thrive without safe, tuned in, and available relationships in the places we live, work, learn, and play. We need safe, connected relationships for quality sleep, relaxed creativity, language acquisition, biological regulation, neurodevelopment and connectivity, and social capacity.[1]

We can relax and eat, tell and digest stories, let our guard down, laugh, play, create, dance, express ourselves, concentrate, and listen well when we are in the company of safe people. This is the Social Engagement System that Stephen Porges has described as being a balance of sympathetic and parasympathetic nervous systems engaging and connecting.[2] Although originally ridiculed by the medical establishment, the attachment research of William Blatz, Mary Ainsworth, and John Bowlby is now foundational learning for anyone seeking to understand patterns in relationships and their impact on child development and wellbeing.[3-6] Daniel Siegel describes safe attachment that includes experiencing safety, 'feeling felt' and responded to, and being soothed.[7] Feeling able to seek comfort when hurt, unwell,

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and upset is strong predictor of later wellbeing.[8] There are some 'sensitive periods' of our life (e.g., before the age of three and adolescence)[9,10] where our human connections are especially important to development of our sense of self and neural connectedness to our world.

Perhaps you remember the feeling of joy at being 'found' and 'seen' when playing 'peek a boo' with a child? This moment epitomises the physical delight of being socially connected. This is a biology of belonging – a complex whole person experience.

Our relationships with other people are so important that we have refined sensory systems and meaning-making processes designed to monitor and protect our connection to other people. Human beings are social mammals – we need each other, and we have complex ways of sensing if a person is safe to interact with that include gaze, touch, tone of voice (prosody), proximity, and cultural ways of knowing. We tune in moment by moment to people around us, and our bodies run a background check in our memories for any alarming shapes, colours, movements, sounds, smells, words, and so much more.

Connectedness is so hard wired into us that early infant reflexes to hold onto a finger, reach out, or turn to nurse are all designed to reconnect us with our caregiver.[11] Donald Winnicott even went so far as to describe an early child-parent bond as an essential dyad where the parent's brain is a tuned-in adapting and nurturing 'scaffold' [11p. 196] for normal neurodevelopment and social growth. Stephen Porges summarises this in his phrase: "the goal of civilisation is to be safe in another's arms".[12] Those who have a whole person (not narrow psychiatric) understanding of trauma as a relational wound describe trauma as "repeatedly being left psychologically alone in unbearable emotional pain"[13p.xxii] or a "violation of an expectancy to be safe with another".[12] This kind of terrible aloneness can happen in the presence of people.

Feeling alone in the world is highly threatening for humans. Social rejection has some shared neural pathways to physical pain.[14,15] Loneliness has well documented impacts on health including increased mortality and higher risk of cardiovascular, metabolic, and neurological disorders.[16-19] Emotional neglect – although rarely studied alone and still not well understood - has been linked to decreased physical and mental health.[20-22] Those who study social belonging link loneliness, marital distress, and lack of

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perceived social support as blocks to the basic human need to "form caring social bonds and be loved by others" [23p.90] and see these experiences as public health concerns. The multilayered experience of belonging matters. [23-25]

Safe belonging with others (and to ourselves in solitude) is so important to lifelong health and moment by moment comfort that our bodies have an early warning signal if connectedness is threatened in any way. Safe connection can be threatened by invasion of our physical and moral integrity, confusion of our sense that we know our place in our social world, and various forms of ostracism or dehumanising exclusion.[1] This is especially so in cultures that have more of a sense of transgression of collectivist values.[26]

Do you remember the tense uncomfortable feeling in our stomach and throat when our caregivers used a sharp tone of voice to stop us hurting ourselves before we could understand words? Their 'Uhh-ahh' sound in our preverbal years, and sharp urgent 'no' later, could guide us towards safety and connection. The feeling of potential disconnection in that tone of voice is so important to our physical and social survival it will stop us in our tracks. Being out of attunement with our caregiver triggers a social signal and physiological reflex we can't ignore that makes us blush, turns our gaze to the floor, makes us go still, and causes our shoulders to droop.[11] It is "a relatively wordless … [and]… acutely self-conscious state" that alerts our caregiver to tune in and reconnect.[27p.60] Judith Herman notes that these postural changes, facial signals, and hiding behaviours are similar to appeasement displays in other social animals and are recognisable across cultures.[27]

This tense misattuned feeling is hard wired into us as an alarm when we are at risk of losing our social connections. It can happen when we experience disapproval, bullying, rejection, racism, and ostracism. It can happen when we hurt someone else, and they withdraw from us. It can also happen when we are neglected, ignored, treated as invisible, and given the silent treatment (including when the caregiver is unwell, preoccupied by other needs, or absent – what Judith Hermans calls 'psychologically unavailable'[27]). I even get a dose of it when I am about to do something that exposes me to potential exclusion – like giving a speech. It is a social emotion.

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I was first given cause to reflect on the alarm of disconnection reading the work of Louis Cozolino in his book The Neuroscience of Psychotherapy. In his chapter on the 'interpersonal sculpting of the brain', he describes a bodily experience when we experience social misattunement – where we expected positive tuned in connection (what Allan Shore calls 'sparkling-eyed pleasure'[28p.65]) and instead our caregiver is not tuned in (preoccupied, disconnected or disapproving). This is a sudden neurological shift from sympathetic engaging tone to parasympathetic switch off. This bodily reaction is an early warning signal of social risk and a potential need to repair connection. If left without a timely attuned social response it becomes a chronic experience of hopelessness and helplessness.[28]

The tense 'I'm at risk of being disconnected' feeling has many causes and unfortunately can be misinterpreted as shame. Some describe this as toxic shame where we can feel "irreparably flawed, unworthy and unlovable, and that our social position and social bonds are under threat".[29p.4] When disconnection is misunderstood as shame it can have far reaching impacts that often increase disconnection from others and from self – what some call self-stigma[30] or self-alienation.[31,32] One of my patients (with permission) described this as *"I am in prison with the worst cellmate in the world – me"*. Donald Nathanson described a 'compass of shame' that named shame responses that often exacerbate disconnection: *avoidance*, *attacking self, withdrawing socially*, and *attacking others.*[33] So many of these responses to feeling shame in response to disconnection are contributors to mental distress including addictions and compulsions. In fact, recent studies of internet gaming disorder for example, name 'compensatory internet use' [34] as a response to emptiness, an identity void, or "unfulfilled" attachment needs.[35] Although the links between attachment needs and addiction[36,37] and loneliness and mental illness are well studied, enquiring about relationships, loneliness, and fear of disconnection is not routine healthcare practice.

Brene Brown has described shame as 'fear of being disconnected'.[38] Instead – I would describe a fear of disconnection that is often misinterpreted as shame. Misinterpreting (and misdiagnosing) disconnection as shame can lead to well-meaning but misguided treatments aimed at building self-esteem and increasing self-compassion without addressing the aching loneliness of the person's heart. Conflating shame with 'trauma' can also distract us from potential pathways to

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healing the grief of disconnection. Although linked or braided together,[39] trauma, dissociation, disorganised attachment, and shame[27] are distinct processes requiring tailored and personalised care.

Years ago, I had some trauma-informed training on shame that I have refined into my clinical approach to shame. People who experience neglect or trauma as children have three strong reasons to interpret their disconnection as shame and three different potential pathways to healing:

1. Shame feels less overwhelming than powerlessness. If a child is neglected or abused by their caregiver, they have no money, nowhere to go, and no power to change it. But, if they believe they could have or will be able to change it, then they are protected from the unbearable knowledge that they cannot stop the pain. *Facing and grieving powerlessness is part of healing shame*.
2. Shame allows you to protect connection with your caregiver – if you take the blame you can still emotionally connect to your caregiver. You can blame yourself for not noticing and predicting that someone was about to have a rage, or you can have a long list of 'what ifs' that you could have done to prevent the neglect or abuse. Without taking that blame, you will have to face the unbearable knowledge that your caregiver has hurt you. Taking blame allows you to still sleep in their home or eat at their table, to seek them out for comfort. *Grieving the loss of a safe caregiver and facing any ambivalence and confusion about the mixture of kindness and harm that came from them is part of the healing for shame.*[40]
3. Children are designed to respond to their environment with magical thinking that makes them the centre of their world. When they are loved they get a message that they are lovable. When they are neglected – they get a message that they are not lovable. As Bessel van der Kolk says: "If you feel loved, your brain becomes specialised in exploration, play and cooperation. If you are frightened and unwanted, it specialises in managing feelings of fear and abandonment"[41] *Embodied experiences of feeling safe and connected are part of the healing of shame*.

There is an extensive literature around shame that has become disconnected from the natural and purposeful physiological tension that humans feel when they feel

socially isolated. Those who have survived childhood trauma and neglect often have a constant experience of that tension. They experience it if they do anything that other people might disapprove of (including asking for things they need or challenging the status quo). They experience it if someone ignores or ghosts them or if there are any traces of disapproval or disconnection (or even micro-expressions of disgust) in someone's facial expressions or movements. They are exquisitely tuned into disconnection. Sometimes, when they have done nothing wrong – they describe feeling 'guilty' and other times this tension about being disconnected is misnamed 'shame' and interpreted to be a sign of personal (not a relational) inadequacy. If it is a constant experience, it can lead to inner experiences of emptiness, self-alienation, self-loathing, and suicidal ideation.[32,42] The tension of imminent social exclusion can also trigger amnesia, numbing, and other depersonalising dissociative experiences if associated with overwhelming memories of aloneness.[8,43] This shame reaction has direct impacts on physiology and health[44-48] and is the reason that there are calls for 'shame-sensitive' trauma informed practice.[29]

It is important to understand that the tense embodied 'fear of disconnection' feeling that is often misnamed 'shame' is a purposeful warning sign with a social goal – to help us reconnect:

This tension can be caused by a fear of *exposing* ourselves to rejection (a risk of disconnection) that modulates our self-expression to be socially acceptable and can be an invitation to courageously practice being ourselves (something Brene Brown calls 'shame resilience'). This is often an ordinary growing-up feeling that comes with new tasks of disagreeing with others or asking for our own needs to be met. It also enables pro-social respect and attunement towards others.

The tension of fear of disconnection can be caused by someone withdrawing from us or our own internal conscience alerting us to *when we have hurt someone else*. This is what is often called *guilt*. It is specific, about something we have done or not done or said or not said. It has a specific date, time, and place, and is never about who we are as a person. This tension of disconnection is a prompt or invitation to repair the relationship through the doorway of apology and restitution.[27]

Finally, the fear of disconnection can be because *other people have harmed us* with disconnection, invasion or confusion.[1] Pulling away from unsafe people is a natural

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response to pain caused by the adults in our life when we were powerless and dependent on them for connection. It is not our defects that caused the disconnection. It is not shame. This disconnection leads towards mourning our loss of safe connection, and needing comforting present day sensory and social experiences of belonging. As Frank Putnam said in an interview: "First and foremost, the client must be safe and feel safe, or no treatment will be effective"

In all of these experiences, the core relational need for a sense of safety is fundamental. The natural biology of alarm at disconnection helps us to understand and discern whether courage, apology, or felt security and love are needed on the pathway to healing. Rather than the "shame of unrequited love"[27p.4] in the game of peek- a-boo we need to be feel seen and heard, we need a safe person to ask for comfort. The biology of belonging offers a whole person, strengths-based, embodied, relational, and healing-oriented approach that tunes into and cares for the lonely pain inside shame and trauma.

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Issue 5

Comforting a whole person: does it matter if we miss a part?

An invitation to consider the links between wholeness and healing.

A few years ago – a mentor encouraged me to read a fantastic little book by John Allen called *Restoring mentalising in attachment relationships: Treating trauma with plain old therapy*. There was a question in this book from mentalising expert Peter Fonaghy that has stuck with me, haunted me, and inspired some of my research and writing. It is even in the first paragraph of my book on whole person care[1]:

> *What happens to states of mind, when terror or grief is not met by reasonably attuned comforting?*[2p.xiii]

As a General Practitioner, I have also added questions to this: What happens to… *bodily states, behaviours, hearts, relationships, and communities*… when they are not met by reasonably attuned comforting? Within this question is a deeper question – what is 'reasonably attuned comforting?'

People are complex and layered. Sometimes we are only shown a small part of a person while they work out whether to trust us. Often there are other hidden parts of the person that they feel are 'unpresentable' or hold a risk if exposed. Sometimes the person has very reasonable fear associated with terrifying or overwhelming memories

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that they have pushed to the side and instinctively know they are not yet ready to touch. Other times they need encouragement to face something and discover they are now able to encounter their childhood distress with adult resources. Sometimes, we are only invited to care for a part of a person at first, and over time, inside a reliable and consistent relationship more layers of the person appear.

So – what is attuned comforting? This question is at the heart of all relationships. It is an essential part of relationships between an infant and their carer, between friends, and lovers, or even between colleagues and leaders in safe working and learning environments. It is a sophisticated dyadic and embodied kind of attention that paces connection, regulates experience, and builds sense of safety across the whole person.

The Oxford English Dictionary describes the word attuned as a verb and an adjective that means 'to bring into harmony or accord'. In practice, tuning in to one another requires sophisticated sensing and responding between people. Daniel Seigel describes a "mutually resonant form of interpersonal communication" or aligned "states of mind" that contribute to safe attachment.[3] This complex task requires careful observation and sending words and tone of voice or touch as probes into the space between people, and then sensing that response in a moment by moment way. It can include sensing that someone only wants to reveal a part of themselves and aligning with that. At other times it can involve tuning in to see hidden parts of a person and responding with signals that they are seen, welcome and included too. Sometimes, especially in a therapeutic or close relationships it may involve intentionally reaching out towards parts of a person that feel unlovable or threatened. It can be a way of 'being with' that sometimes has no words, with subtle changes in our posture, tone of voice, and movements. It does require that we are aware of the many layers of the whole person.

And who decides if something is comforting? How do we know that our attempts to care have been helpful? These are deep and important questions for anyone who seeks to be a healer in their community.

The Merriam-Webster dictionary defines comfort as: 'to give strength and hope to (to cheer); and 'to ease the grief or trouble of' (to console). That word 'console' is defined by the Oxford Dictionary as 'to alleviate the sorrow of a person, to free from the sense of misery'. This mixture of easing, alleviating and relieving AND giving freedom,

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strength, and hope are at the heart of comforting. Comforting is not just being made comfortable. It is not the same as withdrawing from life or avoiding tension or struggle. Strangely, bringing comfort is almost the opposite of avoidance: it involves bravely going towards pain and sorrow, for the sake of facing and knowing and growing. It is also paced in a way that facilitates calm – using humour, distraction, music, and even silence to communicate safe care of the whole person. It is a proactive building of sense of safety that enables growth.

When we teach parenting using the Circle of Security Model there are two aspects of normal development – *running home* to welcoming arms, that help us organise and understand our experience *AND* being delighted in while *stepping outwards* to explore the world. Courage to explore and engage with life is the natural result of attuned comforting. Those who study grief report a natural oscillation between attending to what we have lost and keeping on living.[4] This flow of connection between loss and restoration can only occur if someone is safe enough to grieve.[1] Attuned comforting sees and hears and walks alongside (and even mourns with us sometimes) as we face life and grow in confidence to be our real selves in the world. This is being safe enough to grow.

My doctoral work explored a strengths-based and healing-oriented approach to trauma-informed whole person care: Sense of Safety. Sense of Safety is a whole person experience that is a foundation for normal physiology, social and neurodevelopment, learning, existential ease, and bodily calm. The Sense of Safety approach is a way to deliver care and a goal of care. In this framework, Sense of Safety builds both a sense of comfort and of courage.

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Figure 2: Reprinted with permission from Lynch, J.M. (2021) A whole person approach to wellbeing: building sense of safety. Routledge. London.

The goal of building Sense of Safety aligns with the stages of trauma-informed care first described by Judith Herman[5] as 'establishing safety, remembrance and mourning, and reconnecting with ordinary life'. This was later described in Blueknot Foundation's guidelines[6] as 'stabilisation, processing, and integration'. The Sense of Safety Approach names these steps as: 'building sense of safety, safe enough to grieve reality, and safe enough to grow'.[1]

So – back to the opening question – when we are trying to comfort a person, does it matter if we miss a part?

Knowing how wide and deep to look and sensing how welcome our attempts to reach out are, is part of the art of healing. It is also a practical question. One physician, Robert Centor suggests that we… must 'understand the whole story… gather the history at appropriate depth'.[7p.59] What is appropriate depth?

In my doctoral work on Sense of Safety I came to realise that whole person care requires at the very least, an awareness of the various ways that humans can be threatened and can sense safety. There are many ways that sense of safety can be built and lost.

My doctoral research asked the questions 'what causes threat?' and 'how do you sense that you are safe?' to participants (people with a lived experience of mental illness, First Nations academics, rural and urban GPs, and multidisciplinary mental health clinicians).[1,8] Analysis initially looked at the content – what people described – and themes emerged that are called the Sense of Safety Whole Person Domains. These domains are a kind of map or overview that define the breadth of layers that might be affecting how safe someone feels:

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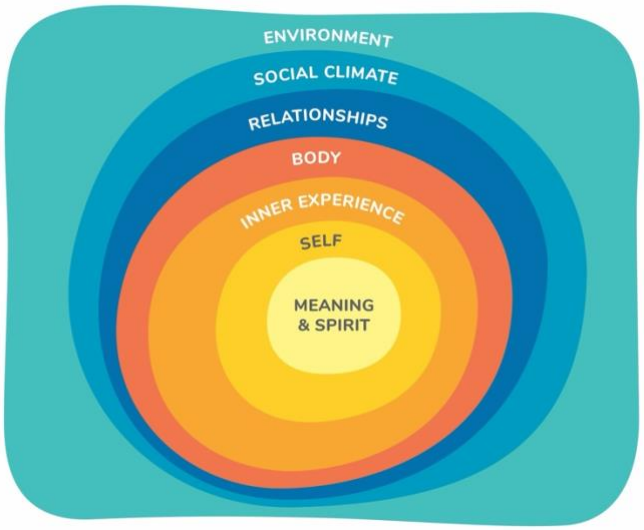

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Environment: including the presence or absence of justice, housing, finances, policing and political security, and food and water security.

Social climate: experiences of respectful and hope-filled community relationships and stories, in places where people live, work, and learn (or of bullying, aggression, addiction, hopelessness, frightening community stories, poverty, and witnessing harm to others).

Relationships: presence of respectful connections in personal relationships – who is there, who is missing, and are they available, tuned in, and on your side?

Body: experiences of calm, rest, and regulation of emotion, or of overwhelming embodied emotion, pain, insomnia, or illness.

Inner Experience: settled, ordered, and unified (or chaotic, rigid, or fragmented) internal thoughts, visions, perceptions, attention and dreams or nightmares.

Sense of Self: A settled sense of relationship with self – connected and internally compassionate, or experiences of self-stigma, internal ignoring, hatred or betrayal.

Spirit/Meaning: existential sense of meaning and knowing place in the world, or beliefs or experiences of existential unease, ostracism, shame or guilt.

Each of these Whole Person Domains are outlined in the image above – as a kind of map to guide clinicians to notice the breadth and depth of ways that a person can be sensing safety or harm. Being aware of both sense of safety and threat can make us tune in to the reality of where the person is at. These layers of the person can guide us to notice the whole, including hidden, shameful parts as well as gifts and strengths even the person themselves might not be aware of. Even though there are times we have to wait for the person to feel able to show us all parts of them, it is really important that we stay aware of the whole person. These seven domains of a whole

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person can help us to stay aware of any parts that have not yet been revealed. We can then actively wait for them to become part of healing care.

Unfortunately, some scientific approaches to distress have not remained aware of what they are leaving out of their assessment of the person. Although social determinants of health are the key drivers of mental distress – they are often ignored in psychiatric frameworks of mental illness.[9] Similarly, culture, spirituality, and sense of self are often not included in psychiatric or mental health formulations.[10,11] Relationships and life story are also often left out of mental health assessments. A key neurobiologist has called into question many psychiatric diagnoses that have not included any information on the participants' experiences of childhood adversity – he says these diagnoses need to be "re-evaluated to take into account the possible prepotent confounding influence of maltreatment".[12p.664] Some studies of behaviour do not attend to the rest of the body, or to the inner experiences that are part of that behaviour. As behavioural approaches to assessment have increased, awareness of inner experience or consciousness has become a less valued part of care[13] – this has had far reaching impacts on conceptualisations of mental health and adequate healthcare. Diagnoses that claim certainty but take an interest in only a part of a person offer spurious precision. Not seeing a whole person causes harm – a kind of ignoring of their inner and outer connections. We should therefore critique research, diagnoses, or treatment that only cares for a part of a person without care for the whole.

Abraham Maslow reminded that threat impacts "a whole human being … never a part of a human being'.[14p.75] He also noted that overwhelming experiences cause people to 'disintegrate'.[14p.11] If one part of a person hurts, the whole hurts – so if we miss something, it matters.

Balfour Mount and colleagues who wrote on suffering and wholeness remind: 'Suffering occurs with perceived threat of destruction and ends when the threat has passed or a sense of integrity is otherwise restored'.[15p.372] This confirms the underlying research into threat that underpins the Whole Person Domains.

Tuning in to the whole and restoring someone to wholeness is the central task of healing. Creating a place that is safe for all parts or layers of the person to be seen is the particular gift of a healer. Let's ask a new question: what happens when terror or

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grief is met by reasonably attuned comforting? Peace, inner kindness, steady sense of self, capacity to regulate emotion, respectful connected relationships, and communities filled with spaces for belonging. Let's all offer the healing art of seeing and caring for the whole person!

The author would like to thank Rubayyat Hashmi for their review of an earlier draft.

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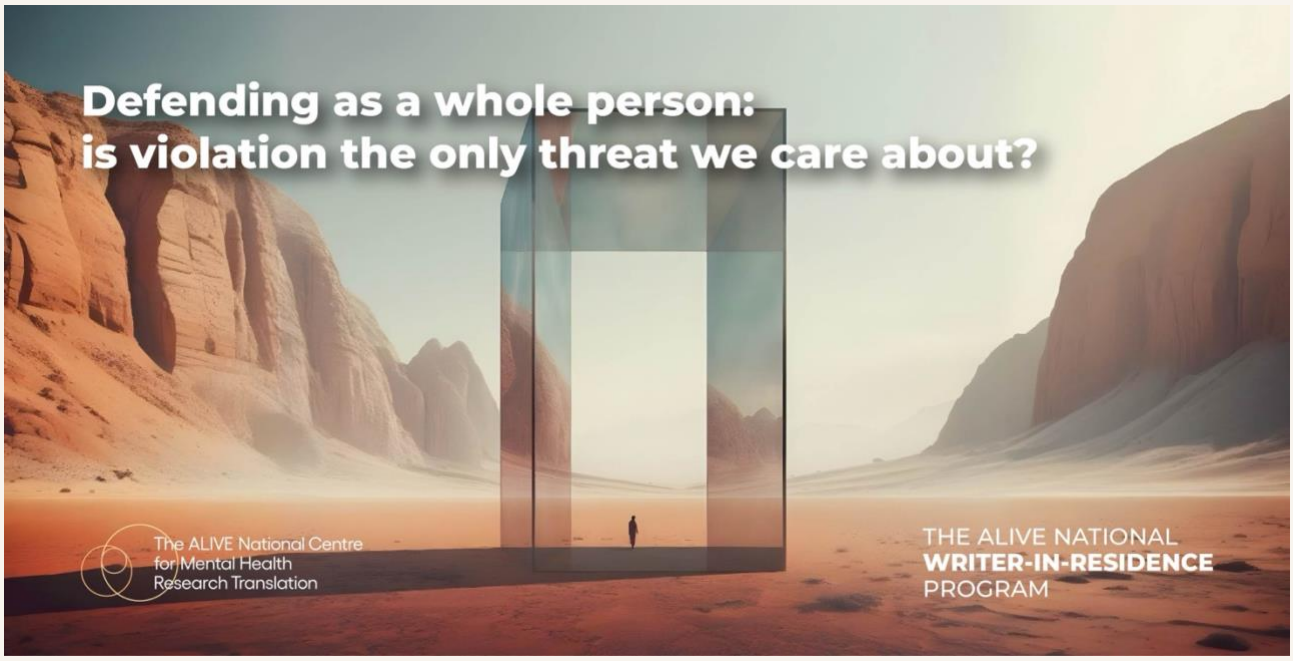
Issue 6

Defending as a whole person: is violation the only threat we care about?

An invitation to resist ignoring invisible causes of suffering and strength.



Our culture is cued into violence and action. Action heroes (and their medical counterparts in the emergency department) are highly visible and valued. Quieter things like patience and attention to detail or kindness to marginalised people are rarely featured in our entertainment. In the news, violence and fear are often on the front page while deep good things are ignored. In healthcare we see these attitudes in the funding models that gives millions to places of action (the hospital) and new ideas (like shiny new clinics) and the leftovers to parts of the health system that care for the poor and prioritise prevention. In general practice we see this in higher Medicare funding for procedures and fast consultations and lower funding for longer consultations and processes that take time to listen deeply, understand and care (like complex distress). This can also be seen in the reductive way that First Nations people are depicted in mainstream medica with a focus on violence and harm, and not on the deep gifts they have given our culture. I draw attention here to the First Nations values of 'Dadirri': 'inner deep listening and quiet still awareness'- in the

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Ngan'gikurunggurr and Ngen'giwumirri languages[1p.14], and 'Ngarraanga Giinganay ' – thinking peacefully in the language of Gumbaynggirr country.[2]

As well as action, our culture is wedded to measuring things. Our healthcare policy funding is cued into 'evidence' and 'outcomes' – which often is code for 'easily measurable'. Being able to measure something easily has always been something that politicians need – tied into election cycles that need quick results that become easy sound bites. Turns out that this same attitude influences funding of research – in cycles needing evidence of public funding well spent. Louise Stone says this causes disease prestige – where care and research into easily measured diseases are more easily funded and prioritised.[3] This means that diseases that can be seen (like cancer) or diseases that lead to procedures (eg. hip replacements or gastroscopies) or formulaic responses (like CBT), are prioritised (and made more commercially valuable) compared to complex psychosocial distress with quiet relational therapies that impact wellbeing across generations like community development, healing from trauma, or learning how to regulate emotion or parent well. Even more worrying – the word 'evidence' has schooled a generation of scientists and clinicians to search for measurements rather than a broader view of science, healing and health. A commonly used hierarchy of evidence has overvalued reductionist knowledge that can promise precise repeatable knowledge that predicts outcomes, and undervalued wisdom[4] and healing that are often imprecise and difficult to measure, and yet deeply valuable.

This focus on action and measurement is not benign. Mixed with tight funding cycles, it skews clinical assessment processes and public funding models away from whole person wellbeing, early intervention, and prevention and towards easily identifiable disease and organ failure. It skews treatment away from whole of society prevention, invisible human kindness and comfort, and towards action in hospitalisation, procedures or pill-taking. It skews public attention away from invisible processes that harm (like emotional neglect) and towards overt actions that harm (like the many forms of assault). It also skews attention away from inner experiences and towards visible behaviours or physical impacts on a person. This is part of why the voice of people with lived experience in public policy is so important. Listening to and integrating the viewpoint of lived experience into public policy can help to reduce the

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focus on action and measurement and widen attention to the complexity of caring for a whole community.

The quieter more invisible processes that impact wellbeing can be written out of a story defined by narrow measurable events and actions. This includes an overvaluing of numbers compared with words – as though numbers are more real. Searching only for what can be measured impoverishes our understanding, makes our research unscientific, blinds us to subtle and complex strengths, and even reduces our capacity to innovate new ways to respond and care.

Those who study the impact of stressors on the physical body declare boldly that both unseen and seen harms have impacts we need to care about. Our human defenses are activated by both. Psychoneuroimmunologists Monika Fleshner and Mark Laudenslager assert:

> *"The disparity between physical and psychological stressors is only an illusion. Host defense mechanisms respond in adaptive and meaningful ways to both."*[5p.114]

So, those of us who are healers need to always remember that humans respond as an interconnected whole when defending against threat. Healers need to stay actively aware of the links between what is invisible and what is seen, what is loud and what is quiet, what is active and what is still, what is invasive and what is dismissive or disconnecting. We need to resist the draw towards only noticing action and what can be easily seen and measured.

I was reflecting on how the recent Olympics and Paralympics, could be seen as the ultimate place where action is measured! They also have a strong focus on outcomes in the form of world records and medals. Is that why we watch and cheer? Or is there something deeper and less visible going on when the world gathers to watch? Something that is perhaps even more visible at the Paralympics? Something about human dignity, passion, dedication, patience, respect, friendship, teamwork, spirit? The original values of Olympism were to "*encourage effort*", "*preserve human dignity*" and "*develop harmony*".[6] Perhaps these are a beautiful immeasurable description of healthy community – perhaps that is why we cheer?

There are many drivers towards only searching for what is easily measurable. One of these is a misunderstanding about the nature of reality: a kind of materialistic

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philosophy where only what is observable is considered real. This narrows our conception of what it is to be human. It blinkers our attention and blinds us to other forms of reality that are not so visible. It lets us see shapes and colours while missing beauty and awe. It causes us to focus on observing the individual and so we miss their sense of self, hope, and connections to community and country. During the COVID-19 pandemic – it led to public policy that prioritised masks, without tuning in to the needs for children to learn to speak seeing human faces. It prioritised distance without addressing the deep importance of human longing for touch and connection. This focus on what can be measured elevates psychiatric conceptualisations of reality that focus on observable symptoms while having minimal conceptualisation of the role of lived experience, relationships, and even morality, including the hidden sicknesses of hatred, bitterness, envy, and fear. In the current social pandemics of hopelessness, loneliness, and interpersonal cruelty, it contributes to 'trauma' (the Greek word for 'wound') being narrowed through a psychiatric lens to only mean threatened physical life. This narrowed attention to action is part of why the complex invisible pain and harm inside families has been termed 'domestic violence', reducing attention to neglect, and the soul-crushing and invisible ways that humans can hurt each other without action or words.

Perhaps this is also why those who advocate for suicide prevention find it difficult to shift attention to invisible and complex contributors to suicide that require whole-of-government changes in attitude.[7,8] It is perhaps why invisible drivers that thwart suicide prevention remain resistant to change, such as "commercial determinants" where unseen profit incentives damage community health,[9] or stuck blocks to collaboration across university faculties or governmental departments that prevent unified innovation. For example, we have known that gambling is linked to suicide since 1790[7], but the way it tortures families and individuals, and the way its powerful lobby impacts public policy are largely invisible in psychiatric or health responses to suicidality.

In the words of one person with a lived experience of suicide: "*To create a genuinely effective, sustainable approach to suicide prevention, we need to [...] look at how we love, how we communicate, and how we treat others, especially those who are vulnerable, and our various systems – health, social, welfare, economic, education,*

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and others – exacerbate or contribute to suicide."[10p.20] Even though it is invisible: how we love matters.

While I was designing my doctoral research methodology, I came across a division between objective understanding of reality (positivism)- the '*what's*' of life, and the subjective relational kind of knowledge that sees reality in culture, spirit, relationship and context (post-positivism) – the '*who's*', '*how's*', and '*why's*' of life.[11,12] As a GP, I was searching for a way to see both kinds of knowledge that related to how I made clinical decisions in everyday practice. I discovered a kind of reciprocity or complementary match between positivist and post-positivist knowledge, which became the Whole Person Knowledge Map outlined below:

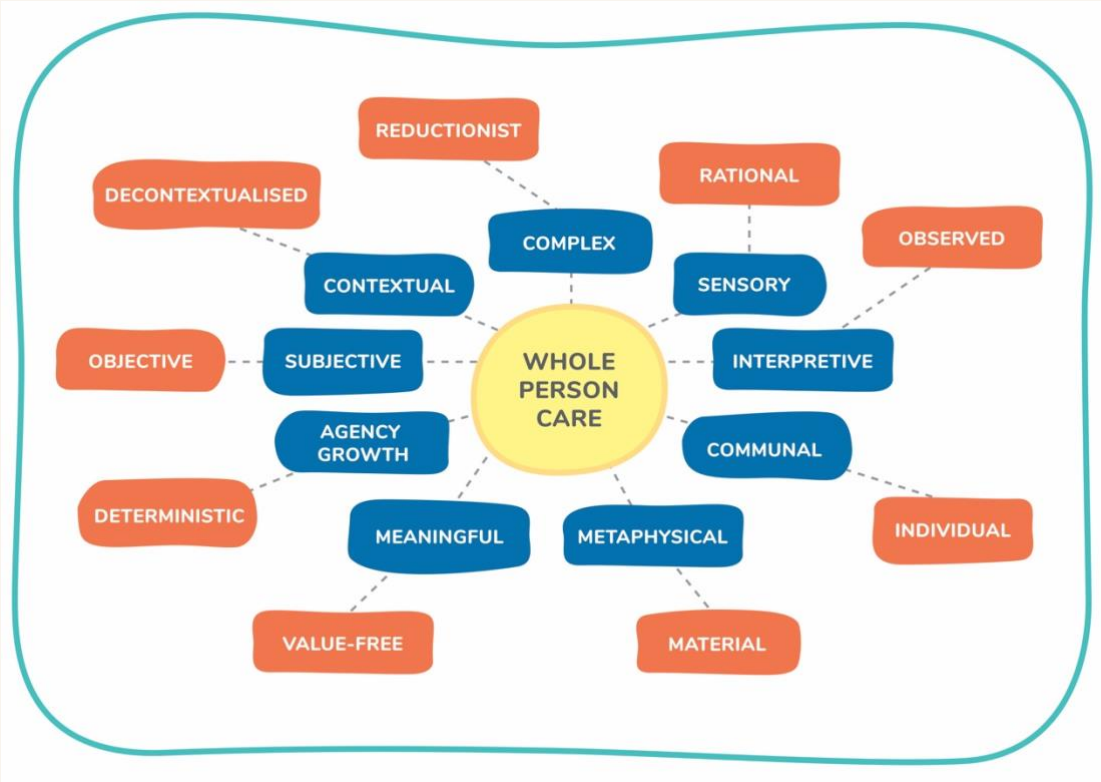

Figure 4: Whole Person Knowledge Map. Used with permission from Lynch, J.M. (2021) A Whole Person Approach to Wellbeing: Building Sense of Safety. Routledge: London (orange = positivist; blue = post-positivist)

This map helps us to see that both kinds of knowledge matter when we want to see a whole. Both are a kind of science – both see reality from different angles. Good quality care should bring them together so we can see the whole person. This map also helps us to see the limitations of positivist/reductionist knowledge – it is decontextualised, it is deterministic (this is why it is hard for the recovery movement to gain traction in psychiatry, and it is why a psychiatric diagnosis often sticks for a

lifetime), and it is very individualised. It also shows the gifts of positivist knowledge – (links to objectivity, observation, and reason) and pos-positivist knowledge (awareness of context, sensation, relationships, movement, and meaning-making).

Measurement and action. These are visible and hard to ignore. Subjective relational and meaningful kinds of knowledge that are also part of health are more invisible and easier to ignore. It takes an act of resistance against dominant ways of seeing reality to notice all parts of the whole.

First Nations elders have been saying this for decades built on thousands of years of wisdom about the interconnectedness of place, people, spirit, and health.[13,14] They invite us to listen deeply with a quiet still awareness (Dadirri). They remind us about country, community and spirit as part of health. In the words of elder Puggy Hunter:

> *"There is an urgent need to shift the paradigm of Aboriginal health service delivery away from the current maze of programs and specialists dealing with specific conditions, to a holistic approach that looks at the health of the whole person, family, and the community.*
>
> *The 'body parts' approach has been a complete failure in Aboriginal health. There is no use treating the heart or the ears alone, when the whole person is in danger of breaking down... This means a new way of thinking."*[15]

General practitioners also call for a way of seeing people that cares for both their objective biology and their subjective biography.[16] This generalist way of seeing highly values an expertise in whole person care that sees the unseen alongside the seen, the unpresentable alongside the presented concerns, the person inside their community.[11,17-20] It even dares to question the ascendancy of the 'evidence-based medicine' that overvalues observation and undervalues the unseen, tacit, intuitive, spiritual and cultural ways of knowing.[4,21,22] Generalism is a valued approach within family medicine, paediatrics, geriatrics, palliative care, social work, occupational therapy, and mental health nursing. Generalism is good at seeing all forms of suffering so that it can offer healing.

Valuing this kind of generalist and First Nations wisdom about the whole person could enrich clinical care and public policy.[23]

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When we think about defending ourselves – of course people are cued into the invisible and the visible causes of threat. Of course, we have to defend the whole of ourselves. Of course, any strengths or suffering in our inner and outer worlds impacts the whole. Again, as Abraham Maslow reminds: threat impacts "a whole human being … never a part of a human being'.[24p.75]

In these essays we have reflected together on the whole ways that we sense, feel, experience, connect, and comfort one another. And here is another – the whole way that we defend ourselves. In each of these important human experiences, it is possible to ignore parts of a person that are essential for their healing. It is possible to fragment a whole just because it is easier to see the parts.

Noticing the wounds, threats, suffering, defences, sensations, strengths, and gifts of each person within their community and context is a way of resisting fragmentation. This is the active pattern recognition work of whole person care. Learning ways of being from First Nation's wisdom about Dadirri (inner deep listening and quiet still awareness) and Ngarrangag Giinganay (thinking peacefully) could help us to see people and their strengths with our whole hearts.

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Issue 7

Is feeling safe a platform for courage? Building Sense of Safety for whole person wellbeing.

An invitation to be fascinated with what builds enough courage to engage with our world.

I have an issue with the term 'resilient'. It seems like just another way to objectify a person. In some ways it is similar to the word 'vulnerable' when used to describe someone else from the outside– rather than the whole human condition. These describing words seem judgemental to me: one praising a version of 'normal', one a polite putdown when used in particular ways. Both are very thin descriptions of complex people from the point of view of other people. Both lay responsibility on the individual for very complex communal processes. Both imply something about weakness, effort, and moral fortitude. Both miss the whole picture.

The word resilience has snuck into healthcare in a similar way to depression. They describe abstract processes and complex social phenomena as nouns that supposedly reside inside people.[1] They individualise and simplify in a way that is irresponsible and not evidence based. [2,3]. According to the Merriam-Webster Dictionary, resilience now means: "the capability of a strained body to recover its size and shape after deformation caused especially by compressive stress" and "an ability

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to recover from or adjust easily to misfortune or change". Wright et al describe it as "positive adaptation in the face of risk or adversity". They also describe it in a less individualised and more systemic way as a "capacity of a dynamic system to withstand or recover from disturbance".[4]

I can see a positive intention in using the word 'resilient' to notice the strengths of a person and their innate capacity to heal or recover despite hardships. So, it seems counter-intuitive to not support the move towards 'resilience-training' and 'developing a resilience mindset' that are now part of many mental health settings. It seems a strong and worthy goal of care. Doesn't it?

Except it leaves out so many parts of the whole person. It leaves out their context and history; their relationships and culture; what suffering and injustice they and their community have endured; what gives them meaning; and it can mask the potential paradox of inner distress coexisting with the outer appearance of function. While championing growth, it leaves out community and it continues the isolationary individualising of care that is part of the legacy of psychiatry and cultures that overvalue individuality and personal agency. [3]

This focus on the individual and their capacity to 'bounce back' seems especially harmful in the context of communities who have experienced generations of 'compounded trauma' after colonisation or other forms of injustice (thank you to Uncle Richard Fejo from Larrakia Country for this wording, communicated by Phillip Orcher). It seems a callous cruelty for a privileged observer to dare to assess an individual's 'resilience' in those settings. I would say that some of my most distressed patients never get called 'resilient' and yet they have overcome so much – more than I think I could face and still be standing. This group of patients also sometimes have their personality and families over generations critiqued from outside, completely ignoring that impact of what they have had to endure. As trauma therapist and author of My Grandmother's Hands, Resmaa Menaken says:

> *"Trauma in a person, decontextualised over time, looks like personality. Trauma in a family, decontextualised over time looks like family traits. Trauma in a people decontextualised over time, looks like culture."*

When we review literature about resilience, so many of the correlates to resilience are to do with the community around a person. As you can see in this 'short list of

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resilience correlates' in Table 1, even the list of 'child characteristics' are mostly dependent on the list of family, community, and cultural or societal characteristics.[4] A quick glance at this list confirms that 'resilience' is a communal process we don't get to choose. It is not an individual act of agency. If we instead notice what this list builds around a person – I would suggest this list outlines communal processes that build a sense of safety for all the members of that community.

Short list of resilience correlates Table adapted from Wright et al (2012)
Child characteristics
Social and adaptable temperament in infancy
Good cognitive abilities, problem solving skills, and executive functions
Ability to form and maintain positive peer relationships
Effective emotional and behavioural regulation strategies
Positive view of self (self-confidence, high self-esteem, self-efficacy)
Positive outlook on life (hopefulness)
Faith and a sense of meaning in life
Characteristics valued by society and self (talents, sense of humour, attractiveness to others)
Family characteristics
Stable and supportive home environment (harmonious parental relationship, close relationship to sensitive and responsive caregiver, authoritative parenting style (high on warmth, structure/monitoring, and expectations), positive sibling relationships, supportive connections with extended family)
Parents involved in child's education
Parents have individual qualities listed above as protective for child
Socioeconomic advantages
Post-secondary education of parent
Faith and religious affiliations
Community Characteristics
High neighbourhood quality (safe neighbourhood, low level of community violence, affordable housing, access to recreational centres, clean air and water)
Effective schools (well-trained and well-compensated teachers, after-school programs, school recreational resources (e.g., sports, music, art)
Employment opportunities for parents and teens
Good public health care
Access to emergency services (police, fire, medical)
Connection to caring adult mentors and prosocial peers
Cultural or societal characteristics
Protective child policies (child labour, child health, and welfare)
Value and resources directed at education
Prevention of and protection from oppression or political violence
Low acceptance of physical violence

Table 1: "Short-list" of correlates of resilience as per Wright et al (2012)[4]

And yet – so often 'resilience' is used to describe individual capacity or competence. Some thinkers critique this as a kind of neo-liberal social policy that highly values "individual attributes that are integral to autonomy, self-invention, and choice"[5] Resilient people, the logic goes, are good contributors and customers, good wheels in our economy. Although autonomy and opportunity to choose are part of health, they seem to be words that only the privileged think of as always accessible. Seen through

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this lens, the word resilience could perhaps be closely aligned with socioeconomic and social and emotional privilege.

Perhaps it would be better for us to measure the community capacity to comfort and encourage its own members. Perhaps individualising distress as personal psychopathology has let us ignore the need to prevent harm or pursue justice. Perhaps there are communal processes that heal. These are not about individual choice, autonomy or 'resilience'. They are about relationships, beliefs, behaviours, cultures and contexts that build our sense of safety in the world.

Dr Nicole LePera describes this saying:

> *"The New Generational Wealth is growing up in a home where people apologise and repair after conflict... It's witnessing respect between your parents, even if they are no longer together... [It's] knowing that love doesn't leave when things get hard. It's the quiet understanding that that your worth isn't tied to productivity, perfection, or performance. It's growing up knowing that softness and strength can coexist, and that the foundation of a home isn't built on silence and submission, but on honesty, repair, and respect..."*[6]

As a family doctor, I sometimes think that public policy is designed by people who have never been sick. People who have never needed others to lift them up, never needed to ask for help, never felt so tired or ill they couldn't make a choice, never needed to repair relationships with people who they continue to live with in community, or never had to manage complex layers of distress. Many public policies assume internet access; enough money to buy food that follows health advice; enough nurturing to not need addictive substances to cope; enough workplace support to take maternity leave; enough community safety to go outdoors for exercise; enough financial freedom to 'move on' and make a new beginning; enough emotion regulation to navigate the frustrations of learning with a growth mindset; even enough safety in their bed to be able to sleep.

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I have spent the last 15 years researching the idea that building Sense of Safety is a more inclusive, active, and communal way to describe health.[1,7] [1] This has become the Sense of Safety Theoretical Framework for whole person care.[8] Sensing we are safe is personal, and it is dependent on the people and context we are in. Sensing we are safe is relevant for our biology, our sense of self, and our relationships.[1,9-12] Sensing we are safe is a life raft above the stormy seas of life. It is a whole person and communal experience. When we lose our sense of safety it is a communal responsibility.

Dr Judith Herman, who first identified trauma in the home, has recently published a book where she reminds us not to individualise 'trauma' as within a person – and instead to search for ways to make our communities more just, more mutual, more accountable, less tyrannical, and less patriarchal.[13] She calls us towards healing, repair, restitution, rehabilitation, and prevention.[13] This is a communal vision of what heals individuals within their communities.

Unlike the word resilience, the ordinary English phrase 'sense of safety' embeds the internal and embodied experience of the person who senses within their community. It places them as the one who names their experience. It brings together appraisal of internal and external threat, appraisal of capacity to cope with that threat, perception of social support, and capacity to make meaning out of a situation.[8] It is a strength-based and healing oriented goal of care. Focussing on building sense of safety naturally draws attention to personal, communal, contextual, and meaning-making strengths and resources for coping and growth.[1]

In my doctoral research[14,15] I asked people with a lived experience of mental illness (n=9), rural and urban Australian General Practitioners (n=11), multidisciplinary mental health clinicians (n=18) and Indigenous academics (n=2) a question: *"what does the phrase 'sense of safety' mean to you?"* Their responses were very integrated-describing concurrent awareness of themselves, other people and their context. They said things like:

> *"Feeling secure withing myself, my community, and the wider world"*
> (mental health clinician)

[1] The University of Queensland School of Medicine Low Risk Ethical Review Committee (2017-SOMILRE-0191) with an amendment in 2018 (2018000392) to allow inclusion of iterative feedback from international consultation that year. Phase Two ethical approval was provided by the University of Queensland School of Medicine Low Risk Ethical Review Committee (2021/HE002268)

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> *"Feeling safe for my culture, spirit, identity"* (indigenous academic)
>
> *"Being safe, and feeling that in all aspects of my being" (indigenous academic)*
>
> *"Feeling safe in all aspects of life: being respected for your mind, body, spirit"* (lived experience)

Participants in this study also mentioned relationships ("*Feeling of having supportive people around me*" – mental health clinician), their body ("*Being physically and emotionally comfortable"* – mental health clinician), inner experiences ("*feeling secure within myself"* – mental health clinician), context ("*feel safe in this space*" – general practitioner), culture ("*secure in my culture, identity, environment, and femininity without persecution"* – indigenous academic) and community ("*to have others to reach out to when I am overwhelmed"* – mental health clinician).

Participants also described the nature of the connections between self, other, and context – describing connections to other people that were respectful, available, tuned in, and "*with you*" and "*on your side*" and helped them to feel free to be themselves and express their needs. Participants noticed the culture of how others interacted with their context and described their engagement with their context with phrases like:

> *"It means an individual feels comfortable in their environment and in turn within themselves to step outside their comfort zone and try something new"* (mental health clinician)
>
> *"feel free to try something risky"* (lived experience)
>
> *"I have the resources needed to deal with the demands of my environment"* (mental health clinician)

Sense of Safety is depicted in the image below as an integrated personal experience at the centre of community, context and self. Every part of that whole contributes to a person's Sense of Safety. This is so much more than the thin description of function - 'resilience,' and it turns attention towards deep strengths and resources (unlike the word vulnerable).

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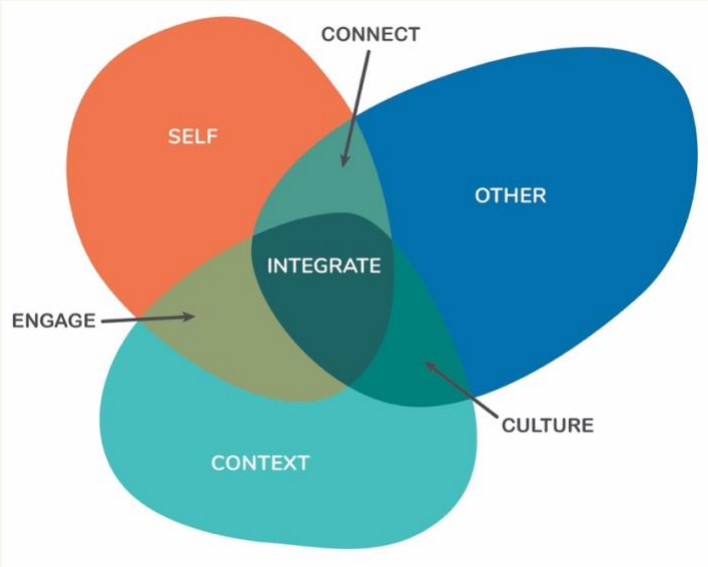

Figure 5: Broad concurrent awareness: mapping responses to "what does the phrase "sense of safety" mean to you? Reprinted with permission from Lynch (2021) A whole person approach to wellbeing: Building Sense of Safety. (Available on Audible now)

Sensed safety changes our physiology, it protects us from chronic inflammation and stress hormones, it enables us to concentrate and learn, and accurately sense other people and assess whether they are trustworthy.[1] It holds within in it an implicit sense of our own value, our dignity, our place in the world. It also helps us engage with our world. The Sense of Safety Theoretical Framework is not just about feeling comforted and safe.[8] It is not just about getting comfortable away from stress or threat. It is feeling safe enough to face reality. Safe enough to grieve our losses and pain. Safe enough to reach out towards others, to ask for help, to express our needs, and to engage with life. Safe enough to grow. Safe enough to give.[1]

Judith Herman, who first described the key aspects of trauma informed care, described "establishing safety" before people could face the tasks of "remembrance and mourning", and "reconnecting with ordinary life". These tasks of mourning and reconnecting are built on a foundation of feeling safe. As I mentioned in an earlier essay, the Circle of Security parenting training describes two aspects to safe caregivers – safe haven to help someone by welcoming and comforting them, and secure base to step out from them into the world.[16] Sensing we are safe is a platform for courage – and there are endless possibilities for how courage changes how we live our lives.

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Staying aware of what builds Sense of Safety in our community and in a whole person is a way of paying attention that does not individualise responsibility to get well or 'bounce back'. Rather than describing people as 'resilient' maybe we could focus more on whether their community is just and kind enough to build sensed safety. This kind of community offers the dual gifts of comfort to heal and courage to live. Will you join me in staying fascinated about how communities build enough courage to engage with the world?

The author would like to thank Rebecca Moran for her review and comments on an earlier draft.

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The ALIVE National Centre for Mental Health Research Translation

Issue 8

Healing as a whole person: what dynamics move us towards wellbeing?

An invitation to see healing orientation as the new normal

Well, as I start my final Writer in Residence essay for the ALIVE National Centre for Mental Health Research Translation, I reflect on the privilege of writing, as I set out to do, on the "interconnected wonderfulness of being a whole person". [1] I have chosen to use each of these essays to address an aspect of being whole. We have reflected together on sensing our inner and outer worlds as whole people[1]; feeling emotion in our bodies, minds, and communities[2]; how our biology is impacted by our life story and how sensing we belong can ease the deep embodied experience of shame[3]; how comforting and healing impact the whole person[4]; how holistically we defend ourselves against threat[5]; and how our community impacts our personal sense of capacity to engage with our world[6]. I have invited readers to see the interconnected embodied whole; to critique current understanding of mood as disorder; to see social determinants of health in a new light; to consider the biology of belonging; to consider the links between wholeness and healing; to resist ignoring the invisible causes of suffering; to be fascinated about what helps us engage with our world; and finally in this essay, to see healing orientation as the new normal.

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In this last essay I will be focussing on healing as a whole person dynamic – a movement towards wellbeing that all of us need – practitioners, patients, clients, students, leaders, researchers, and anyone with a lived experience of distress. I will argue for policy and practice that orient towards healing and point towards the importance of caring for the heart of each healing practitioner.

If I could leave one lasting impression from this series – it would be that healing requires movement. Without movement we are stuck. Healing requires a way of seeing that does not diagnose people, personalities, families, or communities with fixed nouns, denotations,[7] classifications,[8] or deterministic labelling [9] – but rather is tuned into the interconnected verbs that move us forward to engage with life. For those who are carers and leaders – this is a movement towards 'therapeutic action'.[7p.419] **Healing is always about movement.**

So – let's start with some definitions of healing. Looking up the history of the word 'heal' – we find the verb Hǣlan which is Old English for 'to heal, cure, save, greet, salute'. We also find the Proto-Germanic word Hailijaną that means 'to heal, make whole, save' and the Proto-Indo-European word Koil that means 'safe, unharmed'. [10] Deep truths can be found within language and its development. Healing is also described in modern dictionaries as a verb - *'to make free from injury or disease; to make sound or whole; to make well again; to restore to health; to patch up or correct (a breach or division); to restore to original purity or integrity; to become free from injury or disease; to return to a sound state.'* As we seek to learn how to counter the stretching apart that is distress - I think it is important to see the links between wholeness, safety, and the active verbs that move us towards healing.[11]

Interestingly, at the end of my PhD exploring sense of safety as a whole person approach to wellbeing, I discovered that the word safety came from a Proto-European word that means whole: Solwos. As well as reminders of the interconnected whole, I hope these series of essays remind us all of the importance to human beings of the interconnected active presence of sensing we are safe. My doctoral work has become the 'Sense of Safety Theoretical Framework' which highlights the importance of the verbs 'to save', 'to build safety' and 'to make whole' in our understanding of healing.[11,12]

Healing also has embedded within it an assumption of change – an acceptance of need to adapt to imperfection, challenge, and adjusting relationships, unlike cure

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which often focusses on resisting change and surviving as we have always seen ourselves.[13] This is a mindset shift for healthcare. It involves messy changing verbs rather than certain output nouns.[11] It is a subjective internal meaning-making process that is difficult to define. Lets consider together the ways that highly valuing verbs can make healing-orientation usual care in our community!

First Nations academic Emeritus Professor Judy Atkinson defines healing in community in stages that include: *awakening to unmet needs; experiencing safety; community support; deepening self-knowledge; meaning-making story in ceremony; personal cultural/spiritual identity; transformation and transcendence; and integration.*[14] The first steps in her definition are poignant. They remind us that some communities and individuals have experienced so much oppression and injustice that they are often unaware of what healing could be like, or what needs could be met. Her definition is also full of communal and spiritual connections reminding us of the important interconnected impact of healing movement within all communities. This First Nations wisdom can teach us so much.

General practitioners who work on the frontline of our community, can also add to our understanding of what healing is. I recently asked a group of Australian General Practitioners from the Australian Society for Psychological Medicine to write down what they thought healing was. Here are some of their anonymous answers, shared with consent:

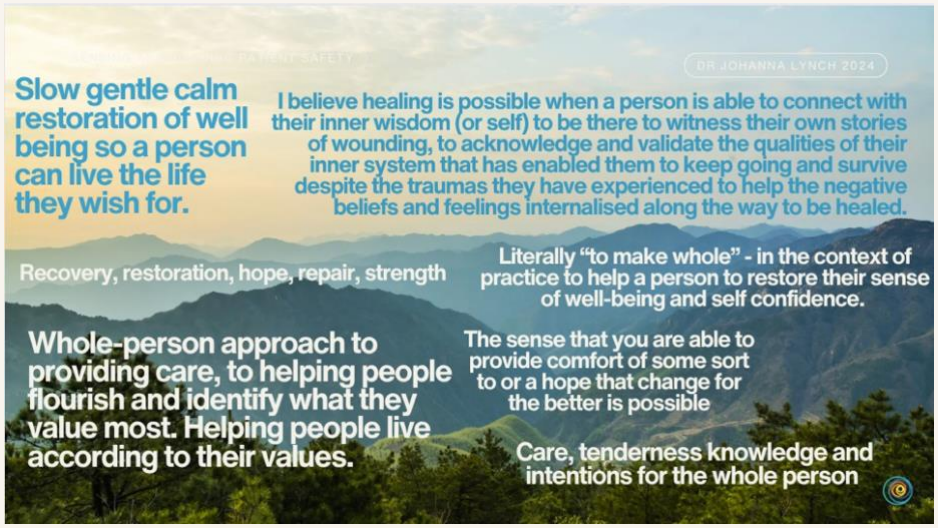

Figure 6: Anonymous quotes from Australian family doctors when asked to define healing Australian Society for Psychological Medicine Annual Conference 2024.

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Figure 7: More anonymous quotes from Australian family doctors when asked to define healing at the Australian Society for Psychological Medicine Annual Conference 2024

What do you think of these answers?

I am struck by how relational and human they are, and how many verbs are embedded in these descriptions.

General practitioner researchers also describe the healing purpose of their work in these active phrases: *"rehabilitate a person's sense of self"*[15p.6]; *"avoid diagnoses that imply a layer of dismissal"*[16p.104]; and *"restore or improve the individual's health related capacity for living"*.[17p.390] In my very first published paper entitled *'Beyond symptoms: defining primary care mental health clinical assessment priorities, content, and process'*, I wrote about how priorities of primary care focus on building strengths to enable coping, and do not align with psychiatric goals of naming diagnoses that often become fixed labels.[18]

Another paper describing the nature of healing relationships in primary care names healing processes that include '*valuing'* each person through a connecting presence and nonjudgemental stance; managing power and control in healing relationships through partnering and education in what they called '*appreciating power'* ; and *abiding* through not giving up on each person – a "promise to not abandon the patient even if the pills and technology have little left to offer".[19p.315] They also name relational verbs that are part of healing that include to *trust* (willingness to be vulnerable within healing relationships, feeling cared for, and knowing that promises

will be kept), to *hope* (belief that some positive future beyond present suffering is possible), and *being known* (sense that the physician knows the patient as a person).

Wise American physician, Ron Epstein also wrote a beautiful paper entitled 'Responding to suffering' in which he wrote about 'turning towards' (that includes *recognising suffering*, *becoming curious* about the patient's experience, and intentionally *becoming more present* and engaged) and 'refocussing and reclaiming' (*enabling patients* to connect to what they see as important, meaningful, and generative despite adversity).[20] He highlights the skills of listening deeply, and recognising ambiguity, incompleteness, and contradictions. Listening deeply is also an active part of healing that Australian First Nations elder Miriam Rose Ungunmer teaches as a part of First Nations ways of being – 'Dadirri' - in the language of the Ngan'gikurungurr and Ngen'gwiumirri peoples.[21] The actions and movements of turning towards and listening deeply to people matter. They enable healing.

Movement is also central to the descriptions of healing described by those with a lived experience of mental distress who have recovered. They describe movement from passive to *active sense of self*, from disconnection towards *connection,* and hopelessness towards *hope*.[22] Their descriptions of recovery are summarised in the mnemonic 'CHIME': Connectedness, Hope, Identity, Meaning, and Empowerment.[23] Recovery is active, individual, unique, gradual, non-linear, and multidimensional. It is also a journey of struggle and life-changing trial and error. This movement towards healing is part of ordinary living and is something that can occur without professional intervention.[23]

Wouldn't it be great if a focus on this kind of healing was the new normal??

In my doctoral work developing the Sense of Safety Theoretical Framework for whole person care, I analysed the data for verbs and found patterns that could help practitioners, individuals, communities, and workplaces to orient towards healing.[11] These processes build sensed safety. They emerged from clinical experience, transdisciplinary literature, and multidisciplinary and lived experience participatory conversations.[24] These dynamics are designed to offer an alternative to psychiatric categorising and prescribing. They describe not what is wrong with a person, but what could become their pathway to wellbeing. They are focussed not on 'what happened?' but on 'what next to help you feel safer?' They are ordinary processes that

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every person needs in life. In other places I have described these dynamics in more detail[11,24-26] – in this essay I will point out their ordinary goodness. These dynamics can be offered by anyone seeking to comfort another person – not just by professionals.

The five Sense of Safety Dynamics that are part of the Sense of Safety Theoretical Framework are *Broad Awareness, Calm Sense Making, Respectful Connection, Capable Engagement*, and *Owning Yourself*. These dynamics underpin processes that facilitate the deep human need for safety.[27] They are more important than symptom control and diagnostic certainty. They are relevant for every part of a whole person – their environment, social climate, relationships, body, inner experience, sense of self, and spirit/meaning. These Sense of Safety Dynamics are implicit priorities of anyone who is a healer. Naming them makes these implicit skills explicit. In Figure 3, each of these dynamics are depicted as flow across the whole person across self, other and context – including directional arrows that depict the internal movement of attention and action.

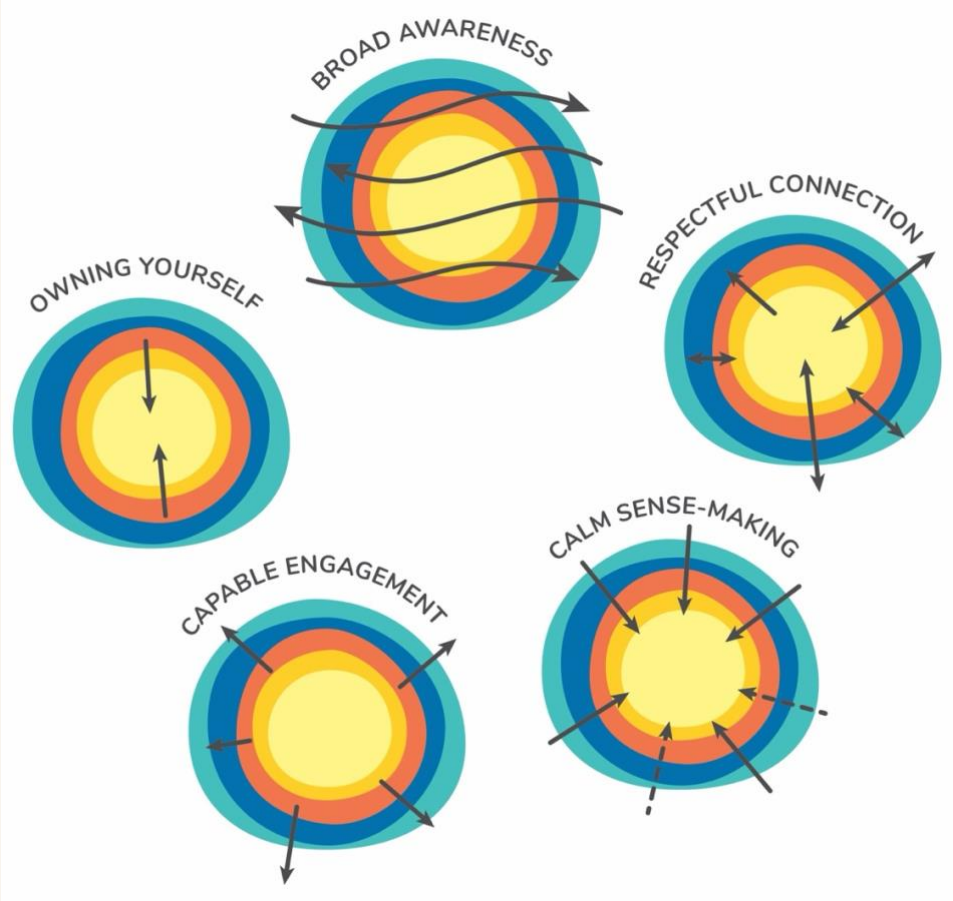

Figure 8: Sense of Safety Dynamics. Reproduced with permission Lynch, J.M (2021) A whole person approach to wellbeing: Building sense of safety. Routledge. London

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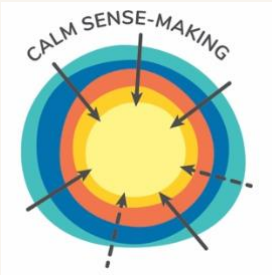
Broad awareness is an active intuitive awareness of multiple aspects of self, other, and context – all at once. It is the experience we have when we go on a bush walk and we are aware of the sounds, the smells, what we are looking forward and who we are with. It is a wide noticing that includes your peripheral vision and sense of what is behind you. It includes an awareness of past, present, and future. It includes a capacity to sense what other people experience. It is the opposite of feeling 'triggered', 'freaked out', 'numb', 'flooded', 'switched off' or having your attention narrowed by fear. Ordinary words to describe broad awareness are: 'seeing the big picture' and 'being present'.[11] This is a neurological and social process that involves attention, reflective capacity, empathy, attunement, resonance, and awareness. It happens when we enjoy a view, connect in a conversation, understand something, take a wide perspective on something or see it from a different point of view. It can be learned and practiced and therapeutic techniques like mindfulness, mentalising and dialectic behaviour therapy can build it. It is involved in humour and music and lying in the grass. It is a whole curious observant way to see ourselves, our community, and our world.



Calm Sense Making is clear headed embodied inner and communal organisation. It occurs within the self through inner reflection, emotion regulation, and body feedback systems that produce calm. It occurs between people in co-regulation, dialogue and storytelling, and within communities through ceremony, rituals, tradition, history keeping, and culture. It occurs between people and the natural and spiritual world in awe, creating, meaning-making, worship, prayer, and scientific enquiry that seeks to understand. It is the opposite of feeling confused, disconnected, disorganised, reactive, fragmented, overwhelmed, and incoherent. It has ordinary words to describe it: 'gathering ourselves together', 'grounded', 'insightful', 'reflective', discerning', 'wise', and 'having it in perspective'.[11] This is relational and neurological, it involves making sense of ourselves and our world, it involves insight, revelation, pattern recognition and perspective. It is wide and deep and clear. It is hidden inside routines and predictable rhythms, and in ordinary debriefs after big days. It is in tears and stories and deeply inside culture. Even the process of creating a sentence requires fragmented ideas and feelings to become words and then become orderly

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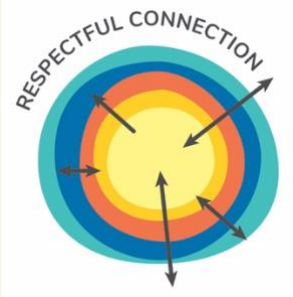
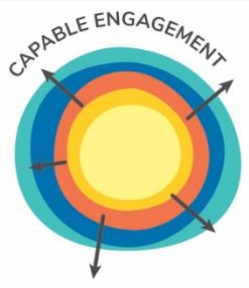
grammatical sentences that help us to understand ourselves. It is also in biological calming and self-regulatory feedback cycles. It can be in creating a meal, planning a party, painting, acting, dancing, writing, and singing – where both shapes, colours, movement, lyrics and melody help us to make sense of our world.



Respectful connection is a kind of connection received and given within ourselves, and between us and other people, and our environment. It is attuned, trusting, and respectful. It is the kind of relationship that is in safe attachment relationships and talked about as part of the Duluth Equality Wheel (respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, economic partnership, negotiation and fairness, and non-threatening behaviour).[28] And it is in tenderness and gentle tone of voice. It is apologies and repair and reconciliation. It is a giving and receiving of love towards ourselves, and others, and our world. It is the opposite of rejection, loneliness, abandonment, disconnection, being 'ghosted', marginalisation, racism, deceit, exploitation, self-hatred, betrayal, disharmony, suicidal ideation, estrangement and so many other painful relational experiences. Ordinary words to describe it are 'seen', 'heard', 'valued', 'welcomed', 'cared for', 'supported', 'respected', 'belonging', 'trust', 'self-acceptance', and 'loved'.[11] At the heart of respectful connection are ordinary kindnesses, communal etiquette, heartfelt apologies, and reconciliation..



Capable Engagement is a dynamic movement towards the world. It involves self-expression, growth, and purposeful engagement with self, others, and the wider world. It also involves an environment that offers access, opportunity and encouragement to enable you to have your say and be free to move and grow and learn. It is the opposite of being stuck, out of control, insecure, fragile, trapped, constrained, controlled, manipulated, voiceless, or passive. Ordinary words for this dynamic include being curious, creative, confident, and able. It includes being able to influence, negotiate, take appropriate risks, move, express, advocate, and be effective.[11] The two sides of building capable engagement include being in a community that helps you to give it a go and being willing to try something new.

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Owning yourself is a journey towards feeling comfortable, capable and aligned with your whole self. It includes a physical sense of comfort in your body, and with all parts of who you are. It is also experiencing yourself being acknowledged by others. This theme came from someone with a lived experience of mental illness saying that sense of safety is "owning yourself and your experiences." It includes a sense of autonomy, self-trust, self-control, inner reflective attention and affection, inner unity, feeling 'good enough' and "ok to make mistakes", feeling 'in control of my life', having 'confidence to be able to cope with adversity', and having 'agency to address threat...[and] agency to make your world safer.[11] The opposite of this dynamic is disconnection, being exposed, powerless, or intoxicated, overwhelmed by expectations, bullied, feeling stupid, shamed, disowned, inner neglect or attack, and loss of autonomy. Ordinary words for this dynamic are integrity, backing yourself, taking responsibility for yourself, owning up, being boundaried, differentiated, having inner alignment, and self-control.[11] Especially in health, this dynamic needs to be taught and retaught – so that both clinician and patient remember to enable a person to be charge of their own pathways forward.

Each of these dynamics are ordinary and they are essential to wellbeing. They bring together movements of attention, affection, and connection between people, self, and the wider world. They involve sensing and sense-making, and they include movement towards tuning in, understanding, respecting, engaging, and owning. They are neurological, relational, meaningful, and contextual. These dynamics can be guidelines for family life, for classrooms, workrooms, waiting rooms, clinic rooms, and boardrooms. They can be built in small everyday interactions as well as be the underpinning of complex therapeutic techniques. They can guide public policy and private practice. They involve community as well as the inner private life of each person. They are a kind of description of what it is like to be comforted, encouraged and loved. They assume a shared responsibility for building sense of safety as we are all community members and citizens of our own meaningful lives.

I reflect now on three ordinary processes that brought healing for people I have cared for over the years – shared with consent. One was a woman who later thanked me for giving her children back their mother. Her healing came when she reconnected to an early childhood dream to do deep sea kayaking. She saved up and had a kayak made

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that she could enjoy, then became healthier by catching and eating her own fish and enjoying the outdoor adventures. This was a story of owning herself and growin in capacity for calm sense making about what matters to her. Another was a patient who took on the cooking for her son's wedding as a way of reengaging with life as mother, away from the trapped experience of her abusive childhood. This was a movement towards capable engagement and respectful connection. Lastly – a patient who started writing poems and music to help her remember who she was and what she had faced and overcome. This was a practical way for her to make sense of her life and increase her own respectful connection towards herself.

In my postdoctoral research, physiotherapists (n=6), Australian, USA, and Norwegian family doctors (n=42), occupational therapists (n=3), domestic violence social workers (n=9), teachers (n=6), mental health clinicians with a lived experience of mental illness (n=3) and a small multidisciplinary rural health team (n=7) were asked to reflect on how they already build sense of safety. Themes that aligned with the Sense of Safety Dynamics emerged and practitioner skills and attitudes, as outlined in Table 1.[12]

Table 2: Practitioner Skills and Dynamics that facilitate Sense of Safety Dynamics

Practitioner Skill and Attitude	Sense of Safety Dynamic
Valuing the whole picture (includes a generalist gaze, seeing the system, tuning into both bodies, and including paradox)	Broad Awareness
Holding Story Safely (includes inviting the story, holding and containing, soothing and co-regulating, joining a dance and integrating wisely)	Calm Sense Making
Being with you (includes being comfortable with not knowing, being present, having their back, repairing ruptures, and taking care)	Respectful Connection
Learning together (includes holding space for collaboration, rebuilding boundaries together, envisioning and future, seeing safely, and believing in them)	Capable Engagement

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Protecting dignity (includes welcome and invitation, seeing and protecting the person's dignity, reminding them of their capacity, and drawing inwards to centre myself too)	Owning Yourself

As I come to the end of this last essay. Can I also remind all those readers who are healers or carers to care for themselves too. Here are a few quotes chosen to encourage you that your own healing matters.

My favourite quote about this is from Henri Nouwen. His link between hospitality and healing is so helpful – those of us who heal need to feel at home in the free and fearless spaces (that have a sense of safety ☺)that we hold for others to heal:

> "What does hospitality as a healing power require? It requires first of all that the host feel at home in their own house, and secondly, that they create a free and fearless place for the unexpected visitor." [29p.89]

Another reminder of our humanity:

> "Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of the other. Compassion becomes real when we recognise our shared humanity." [30p.235]

And a reminder not to take on all the pain of the world – because when we do it can make us helpless and drive overwhelming demands on ourselves:

> "the therapist's defence against feelings of helplessness leads to a stance of grandiose specialness or omnipotence...[leading to] aspirations to heal all, know all, and love all."[31p.143]

And finally a reminder to hold the healer's task lightly – that meaningful life is inspired not given:

> "a meaning must be found and cannot be given... Meaning is like laughter... you cannot forces someone to laugh – you must tell him a joke! The same applies to faith, hope, and love – they cannot be brought forth by an act of the will, our own or someone else's."[32p.112]

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These series of essays have been a reminder to see the movement across the whole wonderfulness that is part of being a person. These are the verbs we have considered: sensing[1], feeling[6], experiencing[33], comforting[4], defending[5], connecting[3], belonging[3], engaging, and healing. Each of these verbs is part of the beautiful journey towards healing. They are vibrant and active and so much more helpful than categorising nouns originally designed for research. They are verbs of wellbeing.[11] Seeing them across the whole person could be the new normal for how we see and celebrate healing in our community.

The writer would like to thank Dr Rubayyat Hashmi for their review of an earlier draft.

1. Sensing as a whole person: is sensation more than anecdotal evidence? An invitation to see the interconnected embodied whole.

2. Feeling as a whole person: are emotions in our bodies or our minds? An invitation to critique current understanding of mood as disorder.

3. Connecting as a whole person: what do shame and loneliness have in common? An invitation to consider the biology of belonging.

4. Comforting as a whole person: does it matter if we miss a part? An invitation to consider the links between wholeness and healing.

5. Defending as a whole person: is violation the only threat we care about? An invitation to resist ignoring invisible causes of suffering.

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