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EMBER-T: An Integrative Trauma Formulation Framework for Ongoing Threat Contexts

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ABSTRACT

Many dominant trauma models assume that safety can be established before trauma processing begins. This assumption is often invalid in contexts marked by displacement, chronic violence, and persistent threat. For many individuals, trauma is not a past event but an ongoing physical, relational, and existential reality. Existing stage-based and event-focused frameworks frequently fail to account for the state-dependent nature of trauma presentations, where individuals may demonstrate regulation and competence in some contexts while remaining significantly dysregulated in others, sometimes within the same session. This paper presents EMBER-T, an integrative trauma formulation framework designed to support ethical clinical decision-making when trauma persists rather than resolves. EMBER-T conceptualises trauma presentation across five dynamic, interrelated domains: Embodied Activation, Meaning Making, Breaks in Connection, Endurance-Oriented Identity Work, and Reclamation and Re-Patterning. Central to the framework is the concept of Trauma Endurance, the capacity to maintain functioning, dignity, and relational connection despite unresolved and ongoing threat. EMBER-T is not a treatment protocol or a replacement for evidence-based interventions. It functions as a meta-framework that assists clinicians in evaluating readiness, pacing, and the ethical sequencing of interventions when standard readiness conditions cannot be assured. Drawing on polyvagal theory, attachment theory, narrative approaches, existential psychology, and Ubuntu-informed relational perspectives, the framework addresses a critical gap in trauma care for humanitarian, displacement, and ongoing-threat contexts. Clinical illustrations and identity mapping tools are included to support practical application.

Keywords: trauma formulation, complex trauma, trauma endurance, ethical sequencing, ongoing threat.

Contribution/Originality: This study contributes to the existing literature by introducing EMBER-T, a meta-framework for trauma formulation in ongoing-threat contexts. It offers novel insights into ethical intervention sequencing and Trauma Endurance, addressing a critical gap where existing evidence-based models assume safety conditions that are unavailable for many trauma-affected populations.

INTRODUCTION

Trauma is not always confined to past events. For many individuals, trauma persists as an ongoing physical, relational, and existential challenge. Although current trauma models have significantly improved clinical care, many are based on assumptions of environmental safety, distance from danger, and simple recovery paths. In cases of chronic violence, displacement, or systemic chaos, these assumptions often don't hold.

Clinical work in such settings shows that individuals can demonstrate competence and resilience in some areas while remaining dysregulated in others, often shifting between states within the same day or session. These presentations are not adequately explained by stage-based or event-focused models of trauma recovery.

EMBER-T was created to fill this gap. It is intentionally designed as a framework for formulation, not as a treatment model, to support ethical clinical decisions about when, how, and if trauma interventions are appropriate during ongoing threats.

EMBER-T did not begin as a framework. It began as a problem the author could not solve with the current tools. This paper presents the result of more than two decades of clinical observation, across private practice, crisis intervention, and anti-trafficking work, that consistently revealed the same gap: existing trauma models assumed conditions that many clients simply did not have. What follows is a clinically derived conceptual contribution in the tradition of framework development in clinical psychology (cf. Herman, 1992; Cloitre et al., 2011), rather than an empirical outcome study. The aim is to offer clinicians a coherent way of thinking about trauma in ongoing-threat contexts, rather than a new protocol to rigidly apply.

This methodology is consistent with established traditions of theoretical model development in clinical psychology (cf. Herman, 1992; Cloitre et al., 2011), and is appropriate where the aim is to generate new conceptual tools rather than to test specific hypotheses. The acronym EMBER-T reflects the framework's five core clinical domains: E - Embodied Activation; M - Meaning Making; B - Breaks in Connection; E - Endurance-Oriented Identity Work; R - Reclamation and Re-Patterning. The suffix –T denotes Trauma Endurance - the framework's foundational philosophical concept. Trauma Endurance is not merely a clinical domain; it is the orienting principle that distinguishes EMBER-T from recovery-focused frameworks. It holds that for many individuals, the clinical goal is not the resolution of trauma but the sustained capacity to function, maintain dignity, and remain relationally connected despite ongoing or unresolved threat. The five EMBER-T domains describe how that endurance is assessed, supported, and built.

NATURE OF THIS CONTRIBUTION

EMBER-T is presented as a clinically derived conceptual framework grounded in longitudinal observation across trauma-focused practice, crisis intervention, and ongoing-threat contexts. It is not proposed as a manualized intervention or empirically validated treatment model. Rather, the framework is intended as a formulation aid to support ethical sequencing, pacing, and readiness assessment in situations where conventional assumptions of safety may not apply.

The contribution of EMBER-T lies in its attempt to integrate state-responsiveness, relational context, identity formation, and endurance under unresolved threat into a clinically usable framework. Its purpose is not to replace evidence-based interventions, but to assist clinicians in determining when and how those interventions can be ethically and safely implemented.

THEORETICAL FOUNDATIONS

EMBER-T integrates established trauma theories, including:

- Polyvagal theory (Porges, 2011; Dana, 2018)
- Attachment theory (Bowlby, 1988; Schore, 2012)
- Narrative and meaning-making approaches
- Existential psychology (Frankl, 1959)
- Ubuntu-informed relational perspectives

Rather than synthesizing these into a unified intervention, EMBER-T uses them to inform state-responsive formulation.

DEVELOPMENT OF THE EMBER-T FRAMEWORK

EMBER-T evolved from over twenty years of trauma-focused clinical work in crisis intervention, anti-trafficking environments, and private practice. In these settings, three consistent patterns were identified:

1. **Functioning was state-dependent rather than trait-based**
2. **Traditional interventions were effective only when correctly timed**
3. **Premature trauma processing often caused iatrogenic harm**

Clients living under continuous threat were not failing treatment; more often, treatment frameworks were failing to adequately account for their reality.

Clinical Origins

The clinician approaches this work as a trauma specialist trained in G-TEP (Group Traumatic Episode Protocol) based on EMDR, TIR (Traumatic Incident Reduction), somatic methods, and attachment-based therapies, among others.

Two cases fundamentally influenced EMBER-T's development.

Lindiwe (not her real name) came in 2019 after a violent assault in her Soweto neighborhood. The clinician started with the regular recommended starting points: establish safety, build resources, and stabilize before processing. Lindiwe had a haunting question. "When will it be safe enough?" She couldn't walk away. The men who attacked her were seen in her neighborhood. Her environment was always unsafe.

Yet Lindiwe was also remarkably functional, raising three children, maintaining employment, and staying deeply connected to her church community. Traditional formulations emphasized symptom reduction rather than state-dependent capacity. However, her presentation did not align with static or stage-bound conceptualizations. She moved fluidly between different states depending on the situation, regulated and relational at home, in survival mode on the way to work, engaging in meaning-making, and spiritually grounded in church. Herman's (1992) stages failed to account for this state-dependent presentation.

Around the same time, the clinician worked with Thabo, a client battling long-term addiction. When the clinician asked about his childhood and who he was before substances, he could not answer.

His identity was shaped by addiction, not interrupted by it. There was no "pre-addiction self" to recover. They examined what was present in his childhood: chaos, unpredictability, and adult responsibilities at age 10 (the parentified child), in which he saw what was missing: safety, play, consistent caregiving, and the substances that provided numbing, belonging, structure, and predictability. The substances served more than symptom management; they provided identity scaffolding.

This speaks to the Endurance-Oriented Identity Work domain and the Identity Mapping process of the EMBER-T framework.

Model Development

EMBER-T is noted when clients are observed for their capacity rather than feeling overwhelmed, for how regulation and meaning-making change during sessions, and for what happens when interventions are timed to their state instead of following general trauma models. The patterns remained consistent across settings.

Clients who "would not talk"? They weren't avoiding; they were in states where narrative processing was unavailable, and their nervous systems couldn't handle it.

Clients "stuck in resourcing"? They showed the clinician that regulation alone wasn't enough. They also needed meaning, connection, and identity work.

This was not unique to the clinician's private practice clients with their relative privilege and resources. The clinician had seen similar patterns on trauma hotlines with callers in crisis, during volunteer work with trafficking survivors, and displaced populations. The patterns were consistent.

Theoretical integration happened gradually, not all at once. Polyvagal theory (Porges, 2011) explained why clients could not "just talk" when dysregulated; different nervous system states allow for different interventions. Attachment theory (Bowlby, 1988; Schore, 2012) explains why trauma processing without relational safety leads to ruptures. Narrative approaches focused on meaning-making. Frankl (1959) discussed existential psychology, which emphasizes finding meaning in the face of suffering. Ubuntu philosophy, the South African idea that personhood is fundamentally relational, influenced how the clinician understood connection ruptures in this context.

The five domains that emerged are Embodied Activation, Meaning Making, Breaks in Connection, Endurance-Oriented Identity Work, and Reclamation and Re-Patterning.

They were not predefined categories imposed by the clinician on the data. Instead, they are what consistently emerged when the clinician ceased trying to force clients into existing frameworks.

The ethical sequencing principles arose from repeated clinical observations where premature trauma processing led to destabilization and therapeutic rupture.

Three principals have been reinforced through these painful lessons: regulation must come before reflection (you truly cannot think your way out of dysregulation), relational safety should precede vulnerability (exposure without a strong alliance not only fails but also damages relationships), and integration needs to come before sustainable endurance (trying to endure without processing leads to fragile, exhausting coping mechanisms that eventually break down).

Reflexivity

The author of this paper is trained in Western psychology and practices within a context that naturally influences their framework. Notably, the private practice clients of the clinician, despite facing significant adversity, have some resources; they can afford therapy, have transportation, and keep housing. This means EMBER-T was developed with clients who had some stability despite ongoing threats.

The framework might need adjustments for populations with fewer resources, but the clinician's past trauma work and volunteer experience indicate that the core principles (state-responsiveness, ethical sequencing, endurance focus) remain applicable across different resource levels.

The clinician clarified: Endurance should not be conflated with complacency or passive acceptance of unjust conditions. It does not mean telling people to accept unjust conditions. It recognizes that systemic change is slow and that people must maintain their dignity and ability to function while fighting for it. Individuals who sustain functioning while simultaneously engaging in acts of resistance illustrate that endurance reflects adaptive persistence rather than resignation. EMBER-T supports the first option without undermining the second.

The framework requires cultural adaptation and cannot substitute for social justice. Its broader usefulness will only be evident when clinicians from various backgrounds, working in different environments with diverse populations, use it.

EMBER-T COMPARED TO EXISTING TRAUMA MODELS

Table 1: EMBER-T Compared to Existing Trauma Frameworks - Please refer to Appendix A. EMBER-T does not replace any specific approaches. It addresses what they do not.

Firstly, clients often shift between different states. They might function well one day and then become dysregulated the next. This isn't "regression" or a sign that treatment is failing. Instead, it's a normal response to changing circumstances, different threat levels, variations in support, and increasing stressors. However, stage-based models tend to pathologize this fluctuation, labelling it as backsliding or resistance.

Secondly, some traumas will never fully heal. The refugee who cannot return home. The trafficking survivor whose perpetrator still lives in her community. The woman whose assault happened on a route she must take every day. They need frameworks for living with trauma, not just recovering from it.

Most models assume that resolution is both achievable and desirable. But what if it isn't? This forms the foundation of Trauma Endurance, yet it's missing from any conceptual vocabulary.

Thirdly, timing is crucial both ethically and clinically. Pushing trauma processing too soon not only fails to help but also causes harm, including iatrogenic harm or worsening caused by the therapist. When the clinician asked Lindiwe to process her assault memories before she had enough regulation capacity, the clinician did not support her healing. Instead, she re-traumatized her during the session. Ethical sequencing extends beyond clinical preference and carries significant ethical implications for preventing iatrogenic harm.

THE EMBER-T FRAMEWORK: FIVE INTERRELATED DOMAINS

Please refer to Appendix B.

EMBER-T conceptualizes trauma presentation across five domains that operate dynamically rather than sequentially (E - Embodied Activation; M - Meaning Making; B - Breaks in Connection; E - Endurance-Oriented Identity Work; R - Reclamation and Re-Patterning; –T - Trauma/ongoing Threat context). Clients move between these domains based on nervous system state, relational context, and environmental conditions.

Domain 1: Embodied Activation

This domain reflects physiological threat responses, including hyperarousal, dissociation, and shutdown. Rooted in autonomic nervous system functioning, it highlights that reflective or cognitive interventions are not accessible during survival states. Regulation is necessary before further work. The Flame Profiles (Appendix B) give clinical texture to this domain: a client in the Flickering Flame state (hypervigilant, scanning) or Wild Flame state (reactive, dysregulated) is in active Embodied Activation and requires regulation before any other intervention. A Smothered Flame presentation (collapsed, dissociated) signals a different physiological survival state but carries the same clinical implication: narrative, cognitive, or relational work is premature.

Domain 2: Meaning Making

Once regulation stabilizes, individuals can engage in cognitive and narrative processes that structure traumatic experiences. Trauma-shaped meanings are seen as adaptive efforts to restore coherence, not distortions needing correction.

Domain 3: Breaks in Connection

Trauma often disrupts relational safety and attachment. This area focuses on relational withdrawal, hypervigilance, and challenges with vulnerability. Therapy emphasizes pacing and repairing relationships before engaging in deep trauma processing.

Domain 4: Endurance-Oriented Identity Work

Trauma Endurance - the framework's foundational concept - is most directly operationalised here, at the level of identity. This domain addresses Trauma Endurance the capacity to maintain roles, dignity, and meaning under ongoing threat. Crucially, Trauma Endurance is not avoidance or resignation; it is active, adaptive persistence. While the concept of Trauma Endurance underpins the entire framework, this domain is where it is explicitly named, assessed, and supported at the level of selfhood and identity.

Domain 5: Reclamation and Re-Patterning

When ample regulation, relational safety, and endurance exist, individuals can reconnect with previously inaccessible parts of life. This includes agency, relational risk-taking, and expanding identity beyond mere survival.

A note on Trauma Endurance across the framework: While Trauma Endurance is explicitly named within Domain 4 (Endurance-Oriented Identity Work) and designated by the –T suffix in the acronym, it functions at two levels simultaneously. At the domain level, it describes clinical work with identity, meaning, and adaptive persistence. At the framework level, it is the philosophical orientation that makes EMBER-T distinct: the recognition that for many individuals in ongoing-threat contexts, enduring with dignity is both a realistic goal and a legitimate clinical aim. All five domains serve this larger purpose.

It is worth pausing here to name something that can get lost in domain-by-domain descriptions. Trauma Endurance is not the fourth domain, or even the fifth. It is the reason the framework exists. Every clinical decision EMBER-T supports, when to regulate, when to make meaning, when to repair a rupture, when to begin identity work, when to support reclamation, is oriented toward a single underlying question: can this person continue to function with dignity while their situation remains unresolved? The five domains are five ways of approaching that question. They are not a sequence to be completed; they are lenses to be used.

EMOTIONAL STATES AND NERVOUS SYSTEM PROFILES

One of the most consistent barriers the author of this paper encountered in applying state-responsive formulation was language. Clients could not always say 'I am dysregulated.' Clinicians sometimes struggled to name what they were observing in a way that was clinically useful without being pathologising to the client. The Flame Profiles emerged from that practical problem. They are a shared vocabulary, a way for therapist and client to locate where someone is, without the weight of a diagnosis. A client who can say 'I'm in a Wild Flame today' has already done something clinically significant: they have observed their own state from a small step outside it. The profiles are described in full in Appendix B. What matters here is how they connect to the sequencing decisions at the heart of EMBER-T.

These profiles view emotional and physiological states as temporary nervous-system states rather than diagnoses, emphasizing the framework's focus on movement, flexibility, and responsiveness.

The profiles include:

- The Flickering Flame (anxious/hypervigilant)
- The Wild Flame (reactive/dysregulated)
- The Smothered Flame (collapsed/shut down)
- The Divided Flame (fragmented/parts-dominant)
- The Contained Flame (armoured/high functioning)
- The Rekindling Flame (integrating/healing)

The connection to ethical sequencing is straightforward once you are looking for it. A client who arrives Wild or Flickering is not ready to process. A client who is Smothered needs gentle activation before anything else can happen. The Contained Flame is perhaps the most clinically tricky: these clients look ready, they are articulate, functional, often high-achieving, but their containment is doing significant protective work. Pushing toward trauma processing before the relational alliance can hold that vulnerability is where ruptures happen. The Rekindling Flame is the signal that the conditions for deeper work are beginning to emerge. The profiles do not replace clinical judgment; they structure it.

Clients' express agency narratives: "I chose." "I can." These show growing confidence and acknowledgment of progress, along with a willingness to try behaviors that were once impossible. They take calculated risks, reclaim hobbies or roles, and set goals beyond just surviving.

Relationally, they initiate connection despite fear, communicate needs, set boundaries, and repair ruptures. Interventions promote gradual exposure, foster agency, support trying new behaviors, and provide scaffolding for manageable risk-taking.

Pushing clients too soon to reclaim or engage in activities they are not ready for can cause re-traumatization. Success relies on a comprehensive assessment of their readiness in all areas.

ETHICAL SEQUENCING PRINCIPLES

EMBER-T stresses that timing is an ethical obligation, not just a clinical preference. Three guiding principles shape intervention sequencing:

1. Regulation precedes reflection
2. Relational safety precedes vulnerability
3. Integration precedes sustainable endurance

Incorrect timing in trauma processing risks re-traumatization and therapy disruption. EMBER-T offers a framework to prevent such harm.

1. Regulation comes before reflection.

Cognitive interventions, challenging thoughts, narrative restructuring, and exposure depend on prefrontal cortex function, which is unavailable during survival states. Asking clients to "examine their thinking" while dysregulated is futile and potentially harmful.

2. Relational safety comes before vulnerability.

Deep trauma processing depends on a strong therapeutic alliance. Premature vulnerability, especially in attachment-injured clients, risks causing rupture and reinforcing the belief that connection is unsafe.

3. Integration comes before sustainable endurance.

EMBER-T does not replace established trauma treatments like CPT, EMDR, or PE. Instead, it serves as a decision-making framework to help determine when these therapies are safe and appropriate.

In ongoing threat situations, the readiness conditions outlined by standard protocols might not be available. EMBER-T helps clinicians adjust pacing and sequencing while maintaining treatment integrity.

INTEGRATING EMBER-T WITH EVIDENCE-BASED TREATMENT

A key question for practitioners trained in evidence-based treatments: How does EMBER-T compare to established interventions like Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), or Prolonged Exposure (PE)?

EMBER-T is not intended to replace these interventions. It functions as an integrative meta-framework that guides clinicians in determining when, why, and for whom specific interventions are appropriate and safe.

EMBER-T as a Meta-Framework for Intervention Sequencing

Evidence-based trauma treatments were primarily developed and validated with populations where trauma was straightforward, limited in duration, and occurred in safe settings. Their effectiveness is well-supported under these conditions. However, these treatments assume readiness conditions that might not be present in ongoing threat situations: enough physiological regulation to support cognitive processing, sufficient relational safety to handle vulnerability, and environmental stability to maintain between-session practice.

EMBER-T offers a framework to assess if these readiness conditions are met. Instead of recommending a specific intervention, it clarifies when the intervention is safe and outlines necessary preparatory steps.

For example, a client presenting for CPT with active Embodied Activation-hyperarousal, dissociation, and an inability to sustain attention may need somatic stabilization before engaging in stuck point analysis. The treatment is not contraindicated; it's just mistimed.

Clinical Application Examples
Cognitive Processing Therapy (CPT):

CPT requires clients to identify and challenge maladaptive thoughts about trauma. The EMBER-T framework assesses whether the client is in a sufficiently regulated state (Embodied Activation managed) to engage in prefrontal cortex-mediated cognitive work.

If Embodied Activation is dominant, the clinician might begin sessions with grounding or somatic regulation, assess readiness before progressing to cognitive work, and adjust the session structure based on the client's state rather than strictly adhering to a specific model. This approach does not abandon CPT; it tailors delivery to the client's capacity.

EMDR (Shapiro, 2018; de Jongh et al., 2019):

EMDR involves bilateral stimulation and memory reprocessing that require clients to tolerate moderate distress while maintaining dual attention. The EMBER-T formulation assesses whether the client has sufficient affect regulation capacity (Embodied Activation and Endurance domains) to engage in reprocessing without decompensating. It also evaluates if relational safety (Breaks in Connection domain) is adequate for the client to tolerate the vulnerability inherent in memory work.

If the assessment indicates limited capacity, the clinician might focus on the resourcing phases of EMDR (Shapiro, 2018; de Jongh et al., 2019), extend the preparation phase, or delay reprocessing until regulation improves. EMDR (Shapiro, 2018; de Jongh et al., 2019) remains the primary treatment approach. EMBER-T dictates the timing and pacing.

Prolonged Exposure (PE):

PE involves repeatedly confronting trauma memories and avoiding situations. EMBER-T helps assess if exposure is safe or premature.

A client facing an ongoing threat or perpetrator in the community, unstable housing, and active safety concerns faces different risks compared to someone with resolved trauma. If the Endurance domain is fragile, meaning the client is barely maintaining their functioning, exposure-induced distress can lead to destabilization.

EMBER-T does not prevent exposure but may sequence it differently: build endurance first (support networks, practical problem-solving, pacing strategies), then gradually introduce exposure when the client is ready to handle more distress.

Treatment Fidelity Considerations

Clinicians may appropriately question whether EMBER-T-guided adaptation compromises treatment fidelity. This concern emphasizes the important tension between protocol adherence (which research shows to be effective) and clinical responsiveness (which often requires flexibility in real-world practice).

EMBER-T does not support abandoning evidence-based protocols. It recognizes that strict adherence to session-by-session planned protocols can cause iatrogenic harm when the client's state does not match protocol assumptions.

Research on treatment fidelity differentiates between adherence (following prescribed procedures) and competence (delivering treatment skillfully with clinical judgment). Providing competent delivery in complex cases may require flexibility during sessions while still maintaining treatment integrity.

EMBER-T ensures effective delivery by providing guidance on when and how to adapt. Importantly, EMBER-T aligns with the core principles of evidence-based treatments. CPT focuses on cognitive restructuring; EMDR (Shapiro, 2018; de Jongh et al., 2019) involves reconsolidation of memory; and PE is based on extinction learning. These mechanisms remain valid.

EMBER-T outlines the conditions necessary for these mechanisms to operate safely. Asking clients to restructure cognitions while dysregulated does not support the CPT's mechanisms; it undermines them. Regulating first allows cognitive work to be more effective.

When EMBER-T Indicates Deviation from Protocol

There are cases where the EMBER-T formulation deviates significantly from the standard protocol.
Ongoing threat situations: If a client's trauma is still current, such as domestic violence by a partner, ongoing community violence, or persistent displacement, exposure-based treatments intended for resolved trauma may be inappropriate. EMBER-T would emphasize work in the Endurance domain, including safety planning, stabilization, and maintaining functional stability, rather than processing ongoing trauma memories.
Severe attachment injury: When a client exhibits deep Breaks in Connection (severe relational trauma and attachment injuries that hinder therapeutic alliance formation), rushing into trauma work can cause ruptures. EMBER-T would prioritize relational repair first, even if manuals recommend starting trauma processing earlier.
Identity Shaped by Adversity: For clients like Thabo, whose identity was formed within trauma rather than disrupted by it, traditional trauma processing relies on a pre-trauma baseline to restore. This assumption is flawed. EMBER-T is an Identity Mapping approach that handles identity reconstruction differently from standard protocols. In these cases, deviating from protocol is not a technical failure; it is an ethical obligation. The alternative can cause harm through mistimed or inappropriate intervention.
Integration in Practice: A Decision-Making Framework
Clinicians can integrate EMBER-T into evidence-based treatments through this process:

Perform an EMBER-T domain assessment: Which domain(s) are most active? What is the client's current state?
Assess treatment readiness: Does the evidence-based protocol assume conditions that are not present, such as safety, regulatory capacity, or relational trust?
Sequence interventions accordingly: If readiness conditions are met, proceed with the standard protocol. If readiness conditions are only partially met, adjust the session structure (e.g., start with regulation, then move to protocol). If readiness conditions are absent, prioritize establishing them before proceeding with the protocol.
Monitor state changes: Client state is fluid. A client regulated at session start may become dysregulated during trauma processing. EMBER-T guides within-session adaptation.
Return to the protocol when appropriate: Once readiness conditions are satisfied, resume the evidence-based protocol. EMBER-T does not replace the protocol; it assesses when it is safe to implement.
This approach respects both the research supporting evidence-based treatments and the clinical reality that complex presentations require judgment beyond manual adherence.

Collaborative Treatment Planning

The EMBER-T framework can be shared with clients to support collaborative treatment planning.
Instead of a clinician unilaterally deciding "you are not ready for trauma processing," EMBER-T offers language for shared understanding: "Right now, your nervous system is in survival mode most of the time (Embodied Activation). Trauma processing requires being able to stay present with difficult memories, which is hard when your body is in fight-or-flight. Let's work on regulation first, and the author and clinical literature will know you are ready when you notice [specific markers]. Does this make sense?"
This approach maintains client agency, clarifies the rationale for sequencing choices, and establishes shared treatment goals. It also helps prevent delays in trauma processing caused by failure or clinician gatekeeping.

Conclusion: Complementary, Not Contradictory

EMBER-T and evidence-based treatments are complementary, not conflicting. Evidence-based treatments provide specific techniques with proven effectiveness, while EMBER-T offers a framework for determining when it is safe to use those techniques.
Together, they help clinicians deliver effective, ethical, and contextually appropriate trauma care, especially in the complex, ongoing threat environments for which EMBER-T was designed.

IDENTITY MAPPING: A CLINICAL TOOL FOR THE ENDURANCE DOMAIN

Within the Endurance-Oriented Identity Work domain, a key clinical tool derived from the Thabo case described earlier is Identity Mapping.
When Thabo could not answer, "Who were you before addiction?" the clinician realized that traditional methods assumed a pre-trauma identity for recovery. But for clients whose identity developed through adversity, whether from addiction, trafficking, ongoing conflict, or chronic threat, we needed a different approach.

Identity Mapping addresses this clinical reality. Within EMBER-T, Identity Mapping is a structured yet flexible process that helps clinicians and clients explore how selfhood is formed, limited, and maintained under ongoing threat conditions. Traditional trauma models often view identity disruption as a deviation from a pre-trauma baseline. In contrast, EMBER-T recognizes that for many individuals, identity is shaped by instability rather than being disrupted by it.

Identity Mapping, therefore, focuses on understanding the adaptive, relational, and existential aspects of selfhood that develop in environments where trauma is a condition rather than an isolated event.

Identity Mapping is not a diagnostic tool or a narrative excavation exercise. It is a state-responsive, dignity-preserving inquiry that helps clients articulate who they are, how they endure, and what internal and relational capacities remain available to them.

The process is intentionally slow to avoid overwhelming the client or forcing coherence where it isn't feasible or safe.

The Three Interconnected Layers

The mapping process examines three interconnected layers:

1. The Survival Self

This layer represents the strategies, postures, and identities that help functioning under threat. It includes adaptive vigilance, emotional containment, guardedness in relationships, and the ability to endure. The Survival Self is not a disorder. It is a form of intelligence shaped by the situation.

2. The Restricted Self

This layer captures parts of identity that have been suppressed, silenced, or hidden due to instability. These may include relational needs, creative impulses, emotional expression, or aspects of self that require safety to emerge. The Restricted Self isn't a flaw; it's a delayed potential.

3. The Enduring Self

This layer represents the client's core values, relational needs, and identity aspects that persist despite challenges. It includes dignity, agency, meaning, and the quiet internal commitments that help individuals remain human under pressure. The Enduring Self serves as the foundation of Trauma Endurance.

Distinction from Parts-Based Therapies

Unlike parts-based therapies (e.g., Internal Family Systems, Ego State Therapy), which conceptualize separate personality parts with their own agendas or voices, Identity Mapping explores dimensions of a unified self-influenced by ongoing threats.

The three layers are not independent entities; they interact with each other. Instead, they are interconnected parts of identity that shift in importance depending on context and safety.

This distinction is clinically relevant, as parts-based approaches such as IFS typically assume sufficient internal and environmental safety for intra-psychic negotiation. In contrast, Identity Mapping assumes a constant threat, where such negotiation might be impossible, premature, or unsafe.

The goal is not to integrate parts but to articulate the complexity of identity without imposing forced coherence.

Clinical Application

Identity Mapping is typically introduced when clients demonstrate sufficient regulation to engage in reflective processes (Making Meaning domain accessible) but struggle with coherent identity narratives or experience significant identity confusion.

As already discussed, timing is crucial. Exploring identity too early, when clients are in survival states (Embodied Activation dominant), risks dysregulation or dissociation.

Clinicians might begin the process by asking questions like:

- What parts of yourself have needed to be very strong, vigilant, or protective to help you survive?
- Which parts of yourself have had to wait, stay quiet, or be put aside because circumstances weren't safe enough? (Restricted Self)
- "What matters to you that hasn't changed, even through all of this? What have you held onto?" (Enduring Self)

The process is collaborative, with clinicians following the client's language, metaphors, and pacing. Some clients think visually (drawing concentric circles, creating diagrams), others tell stories (storytelling, listing), and others focus on bodily sensations (noticing body sensations or movements associated with each layer).

There is no one right way to map. The goal is for clients to guide how they express their identity complexity and collaborate on final identified parts.
Identity Mapping helps clinicians recognize which layer is active at a specific moment and adjust interventions accordingly. It also assists clients in distinguishing between who they are because of trauma, who they are despite trauma, and who they are beyond trauma, without forcing integration or resolution.
For clients like Thabo, whose addiction served as his identity scaffold, mapping helped identify what substances provided (Survival Self function), what development was missed (Restricted Self), and which values persisted despite the addiction (Enduring Self).
The process is continuous, not a one-time task. It's a dynamic, relational journey that evolves as the client's situation and abilities change.
As threats lessen or safety improves, parts of the Restricted Self may become accessible. As clients develop sustainable endurance, their relationship with the Survival Self may shift from shame ("I should not need these protective strategies") to appreciation ("These kept the clinician alive").
The Enduring Self often becomes clearer through the mapping process as clients discover continuity they hadn't recognized before.
Please refer to Appendix D.

CASE ILLUSTRATIONS

Three composite case examples illustrate the application of EMBER-T across adult, adolescent, and transnational trauma contexts. Each demonstrates how state-responsive formulation prevented iatrogenic harm and supported ethical intervention timing under unresolved threat conditions.

(Please see details in supplementary material.)

POTENTIAL ETHICAL RISKS AND MISAPPLICATIONS

As with any conceptual framework, EMBER-T carries risks if applied without sufficient clinical judgment. The language of endurance could be misunderstood as encouraging passive adaptation to unsafe or unjust conditions. That is not the intention of the framework. Trauma Endurance does not advocate resignation, suppression, or indefinite tolerance of harm. Rather, it recognizes that many individuals must continue functioning psychologically and relationally while broader systems, environments, or circumstances remain unresolved.
There is also a risk that clinicians may overextend stabilization and unintentionally delay trauma processing indefinitely. EMBER-T is not intended to justify avoidance of difficult therapeutic work. Ethical pacing should not become therapeutic paralysis. Instead, the framework emphasizes continual reassessment of readiness, capacity, relational safety, and environmental conditions.
Finally, EMBER-T cannot substitute for structural intervention or social justice responses. Psychological endurance should never be used to obscure the need for safety, advocacy, protection, or systemic change. The framework is intended to support human functioning under ongoing threat, not normalize the conditions that create that threat.

LIMITATIONS AND FUTURE DIRECTIONS

EMBER-T is derived from longitudinal clinical observation rather than empirical trials. Formal validation, operationalized domain measures, and outcome research are required. Until such data are available, EMBER-T should be applied as a conceptual formulation aid, not as a validated intervention.

CONCLUSION

EMBER-T offers a state-responsive framework for trauma formulation in environments where safety cannot be assumed, and recovery cannot be defined as resolution. By introducing Trauma Endurance and framing ethical sequencing as a moral responsibility, the framework addresses a critical gap in trauma care.
EMBER-T shifts clinical decision-making from focusing on technique selection to considering the context of what a given moment needs.

SUPPLEMENTARY MATERIAL

Case 1: State Transitions in Ongoing Threat

Thandi (pseudonym), a 34-year-old woman, reported six months after a workplace assault. She lived in a community where she frequently encountered people connected to her assailant.

Initial assessment: showed state-dependent functioning: at home with her children, she displayed relational skills, problem-solving, and calmness (Endurance domain). Near her workplace or in crowded public spaces, she experienced hypervigilance, dissociation, and panic (Embodied Activation domain).

Traditional phase models suggested an exclusive focus on stabilization. However, EMBER-T formulation acknowledged her existing endurance capacity within safe contexts.

Treatment: involved parallel work: in-session somatic regulation when she arrived activated, ongoing support for workplace accommodations and childcare arrangements (Endurance domain), and periodic meaning-making when she spontaneously accessed questions about why the assault happened.

Critical moment: Thandi said she couldn't afford transportation for the weekly session. Instead of seeing this as "resistance," EMBER-T formulation identified it as an Endurance domain constraint that needed immediate attention. We shifted to biweekly sessions with phone check-ins and connected her with transportation support. This Endurance intervention enhanced her trauma work. Removing one ongoing stressor freed up capacity for processing the assault.

By three months, Thandi had successfully returned to work with accommodations, her children's behavior had stabilized, and she had started volunteering in workplace safety advocacy (Reclamation domain).

PCL-5 scores decreased from 54 (severe) to 32 (moderate). Most notably, she expressed a clear identity beyond trauma: "I'm a survivor, yes, but I'm also a mother, a sister, someone who is learning to dream again."

The PCL-5 (PTSD Checklist for DSM-5- Diagnostic and Statistical Manual of Mental Disorders, 5th edition) is a 20-item self-report questionnaire used to screen for Post-Traumatic Stress Disorder (PTSD) and measure symptom severity.

Scoring

Each item is rated on a scale from 0 to 4:

- 0 = Not at all
- 1 = A little bit
- 2 = Moderately
- 3 = Quite a bit
- 4 = Extremely

Total scores range from 0-80, with higher scores indicating greater symptom severity.

Interpretation

- Screening cutoff: A score of 31-33 or higher is commonly used to suggest a probable PTSD diagnosis (though the exact cutoff can vary depending on the population and clinical setting)
- Symptom severity levels (general guidelines):
  - 0-10: Minimal symptoms
  - 11-20: Mild symptoms
  - 21-30: Moderate symptoms
  - 31-40: Severe symptoms
  - 41+: Very severe symptoms

Important: The PCL-5 is a validated screening instrument and should be interpreted within the context of a comprehensive clinical assessment conducted by a qualified mental health professional.

Case 2: Ethical Sequencing in Adolescent Trauma

Mandla (pseudonym), a 16-year-old male, was referred after witnessing a fatal shooting. The shooter stayed in his community. The referral requested "EMDR for PTSD."

Initial assessment: significant Embodied Activation.

Breaks in Connection: Mandla had withdrawn from school, peers, and family. His relationship with his mother, previously close, had become marked by irritability and distance. Premature trauma processing would have been ethically problematic.

Firstly, the threat was ongoing as the shooter was seen weekly.

Secondly, his ability to form and maintain relationships was greatly limited. Starting intensive work without a solid relational foundation risked overwhelming his self-regulation capacity.

Thirdly, extended school withdrawal jeopardized developmental trajectories.

EMBER-T- prioritized Endurance and Breaks in Connection domains before trauma processing: safety planning for community encounters, psychoeducation with his mother, gradual school re-entry, reconnection with his soccer team, and development of portable regulation skills.
Only after four months, when Mandla had returned to school, rebuilt peer connections, and demonstrated reliable self-regulation, did the author and clinical literature begin careful trauma processing.
This sequencing prevented iatrogenic harm. If the clinician had followed the referral request for immediate EMDR (Shapiro, 2018; de Jongh et al., 2019), they would have violated ethical sequencing principles.
Mandla required endurance scaffolding and relational repair before he could safely confront trauma memories.

Case 3: Transnational Trauma and Ambiguous Loss
Sarah (pseudonym), a 42-year-old attorney in Johannesburg, sought therapy three months after her brother's friend was kidnapped.
Presenting problem: Insomnia, obsessive news checking, difficulty concentrating at work, and deep guilt about living normally while her brother's friends' status remained unknown. She described feeling "split in two"- physically safe in, but psychologically in the zone where her brother's friend was held.

EMBER-T formulation revealed:
Primary domains: Meaning Making (focused on unanswerable questions about suffering and moral injury related to continuing normal life) and Breaks in Connection (where isolated friends avoided the topic or made insensitive comments, and there was an inability to share deep anguish even with a supportive husband).
Secondary domains: Embodied activation present but manageable; endurance already strong (maintaining work and parenting) but creating additional guilt. Traditional models provided no guidance.
There was no distinct traumatic memory to process, no safety to build (ongoing threat to attachment figure), and no clear temporal boundaries to the trauma.
Labelling this as "secondary" or "vicarious" trauma dismissed its severity. Sarah's nervous system did not differentiate between a threat to her own body and a threat to her brother, and what his friend was enduring.

EMBER-T-guided treatment:
Months 1-2: Confirmed transnational trauma as primary. Addressed moral injury through meaning-making work ("It is not wrong to eat dinner; starving yourself does not help him the friend you see as a brother too") and supported holding contradictions without forcing resolution. Breaks in Connection work identified who could witness her experience without politicizing it.
Months 3-4: Identity Mapping helped distinguish: Survival Self (viewing compulsive news checking as adaptive rather than pathological), Restricted Self (aspects on hold-joy, lightness, full engagement with life), Enduring Self (values, fierce love, capacity for complexity).
Months 4-6: Focused on trauma endurance work to maintain functional stability without seeking closure. Managed news intake carefully, conserved energy for work and parenting, and established rituals in honor of her brother's friend while allowing herself to take breaks.
This was not about acceptance or forced resolution. It was about learning how to live while carrying an open wound.
Critical moment: When another hostage's body was recovered, Sarah faced increased ambiguous loss, not knowing if her brother's friend was alive or dead. EMBER-T supported her ability to hold both grief and hope simultaneously without forcing an early resolution.
Outcome (6 months): Sarah's brother's friends' status remained unknown. She was not "recovered" - trauma was ongoing.
However, there were noticeable functional improvements: work capacity increased from 40% to 80%, sleep improved from 3 to 5-6 hours, and news checking decreased from constant to scheduled times. PCL-5 scores fell from 48 (severe) to 38 (moderate) - still elevated, which is appropriate given the ongoing threat.
Most notably, she developed a clear identity despite an unresolved crisis.
"I am living with an open wound. I am not broken. I am enduring something ongoing. I am a mother who reads bedtime stories and grieves at the same time. These contradictions don't need resolution."
Clinical insight: This case shows that EMBER-T applies to transnational trauma-diaspora communities affected by conflicts in their homelands, families of refugees in danger, and immigrant families with loved ones in war zones.
Geographic distance does not reduce psychological closeness when the threat is directed at attachment figures.

Traditional models, designed for geographically limited events, struggle to address this increasingly common reality in our interconnected world.

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Conflicts of Interest: The author has developed EMBER-T and intends to provide training in the framework. Independent researchers are encouraged to rigorously test EMBER-T.

Ethics Statement: Case illustrations are composite and de-identified. Informed consent for the de-identified publication of cases was obtained from clients whose clinical work informed the development of the cases.

Data Availability: This manuscript is based on theoretical and practical insights. No empirical datasets are linked to this work beyond the clinical observations described.

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APPENDICES

Appendix A

Model	Key Contribution	Gap EMBER-T Addresses
Herman's 3 Stages (1992)	Safety-first principle; relational healing focus	Assumes linear progression; doesn't account for state-dependent functioning or contexts where safety is unavailable.
Phase-Based (Cloitre et al., 2011)	Structured pathway for complex PTSD	May pathologize oscillation between states as "regression" rather than adaptive flexibility.
Polyvagal-Informed (Porges, 2011)	Nervous system state understanding	Focused primarily on physiology; less emphasis on meaning, identity, and endurance.
Attachment-Based (Bowlby, 1988)	Relational trauma and repair	May not address contexts where safe relationships are systematically unavailable.
EMDR/CPT/PE	Evidence-based efficacy for PTSD	Designed for resolved, discrete trauma; less applicable to ongoing threat contexts.

Appendix B: The EMBER-T Model - Core Domains of Trauma Response

Figure B1. The EMBER-T Model

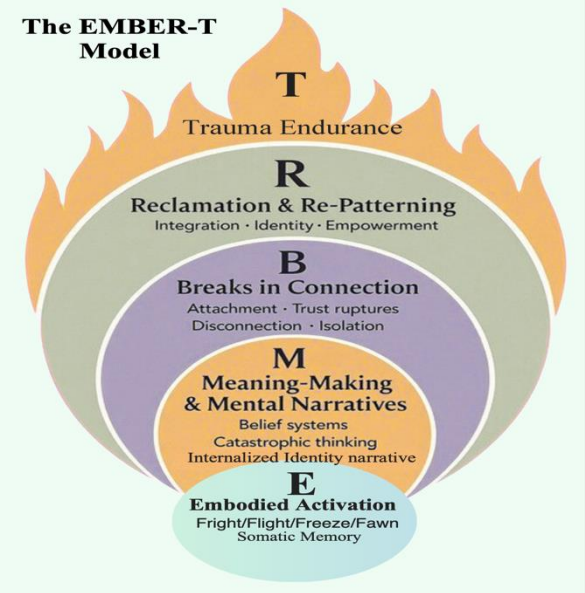
The EMBER-T model visually depicts the five interconnected domains of trauma response that underpin the EMBER-T framework. The model is arranged vertically to illustrate different levels of function rather than a straight line, highlighting that trauma responses depend on state and change over time, not in consecutive recovery stages.

The domains consist of:

- **Embodied Activation (E)**
  This core domain includes physiological survival responses like fight, flight, freeze, and fawn. It signals activation of the autonomic nervous system, somatic memory, and limited access to reflective or cognitive processes. When this domain takes precedence, intervention should focus on regulationand stabilization rather than on meaning-making or narrative work.
- **Meaning Making and Mental Narratives (M)**
  This domain includes belief systems, trauma-influenced interpretations, catastrophic thinking, and internalized identity narratives. These meanings are seen as adaptive efforts to regain coherence after overwhelming experiences, rather than cognitive distortions to be corrected too early.

- **Breaks in Connection (B)**
  This domain addresses relational disruptions caused by trauma, such as attachment injuries, trust breaks, withdrawal, and isolation. It highlights challenges related to safety, intimacy, and co-regulation, emphasizing the need for relational pacing and repair before engaging in deep trauma processing.
- **Reclamation and Re-Patterning (R)**
  This domain describes the gradual process of reclaiming agency, shaping identity, and gaining empowerment. It involves recovering roles, values, and relational skills that were limited during survival. Progress in this domain relies on proper regulation and relational safety.
- **Trauma Endurance (T)**
  This reflects the highest level of resilience, showing the ability to sustain functioning, dignity, and identity despite ongoing or unresolved threats. It doesn't mean symptoms are resolved or gone, but rather that a person can adapt sustainably amid continuous adversity.

The flame imagery shows that these domains are active states, not fixed traits. People can move between domains easily depending on the situation, perceived threat, internal capacity, and environmental stability. The model emphasizes EMBER-T's main clinical question: 'What does this moment require?"
As a formulation framework, the EMBER-T model aims to guide ethical sequencing and clinical decision-making instead of prescribing intervention techniques or treatment stages.



EMBER-T Flame Profiles - Nervous System States

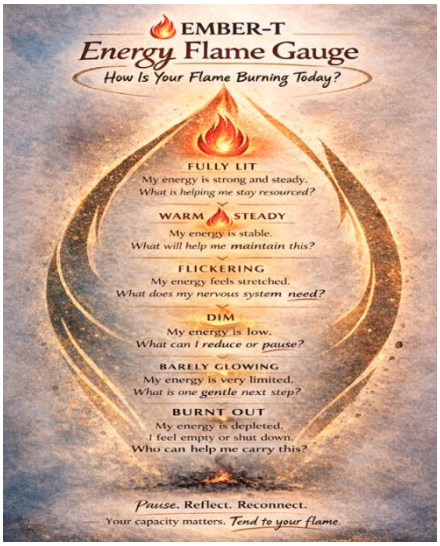
Figures B2 and 3. EMBER-T Flame Profiles

The EMBER-T Flame Profiles represent patterns of nervous system adaptation rather than fixed personality traits or diagnostic categories. They recognise that trauma responses are fluid, changing as the nervous system responds to shifting experiences of safety, connection, and threat. This reflects current neurophysiological thinking that understands autonomic regulation as dynamic and responsive to changing environmental conditions. In particular, Polyvagal Theory (Porges, 2011, 2025) provides a framework for understanding how the nervous system responds to perceived safety and threat, while the Window of Tolerance model (Siegel, 1999; Beutler et al., 2022) describes the optimal range within which emotional and physiological regulation can be maintained.
Within this framework, regulatory states are understood as adaptive responses to environmental and internal demands. The seven EMBER-T configurations include states of integration (Rekindling), over-control (Contained), relational depletion (Overextended), hypervigilant activation (Flickering), reactive dysregulation (Wild), internal fragmentation (Divided), and collapse/shut-down (Smothered). Within the EMBER-T framework, these patterns are understood as reflecting different states of nervous system regulation rather than fixed characteristics. As autonomic regulation changes, so too can emotional regulation, cognitive flexibility, and behavioural responses. This interpretation is supported by contemporary research on trauma-related autonomic dysregulation (Costa et al., 2025).
Integral to the model is the Energy Flame Gauge, which differentiates regulatory pattern (structure of state) from regulatory capacity (moment-to-moment energetic availability). While Profiles describe qualitative organization of

nervous system states, the Gauge reflects current energetic resources within those states, recognizing that the same configuration may be experienced with differing degrees of capacity or depletion. This distinction aligns with the window of tolerance's mapping of physiologically tolerable arousal ranges and supports clinical sequencing by informing whether interventions should target stabilization, resource enhancement, or experiential processing. Clinically, the model externalizes regulatory states, reducing stigma and supporting collaborative formulation and pacing. The therapeutic aim is not static regulation but increased flexibility and capacity to recover integrative functioning following autonomic disruption.

The profiles include:

- **The Flickering Flame -** An anxious, hypervigilant state marked by heightened alertness, over-reading of cues, and persistent scanning for threat.
- **The Wild Flame -** A dysregulated, explosive state characterized by intense affect, reactivity, and reduced impulse control.
- **The Smothered Flame -** A collapsed or shutdown state involving numbness, withdrawal, dissociation, and reduced engagement.
- **The Divided Flame -** A fragmented state in which conflicting internal parts or survival strategies dominate awareness.
- **The Contained Flame -** A high-functioning, armored state marked by control, competence, and emotional suppression.
- **The Rekindling Flame -** An integrating state associated with increased flexibility, self-trust, and adaptive regulation**.**
- **Overextended Flame -** Over-Responsible state led associated with drive and Relational depletion.



Appendix C: EMBER-T Quick Reference Guide for Clinical Formulation

Figure C1. EMBER-T Quick Reference Guide

The EMBER-T Quick Reference Guide provides a concise overview of the framework's five domains of trauma response, associated clinical markers, and corresponding intervention priorities. It is designed as a formulation aid, not a treatment protocol.

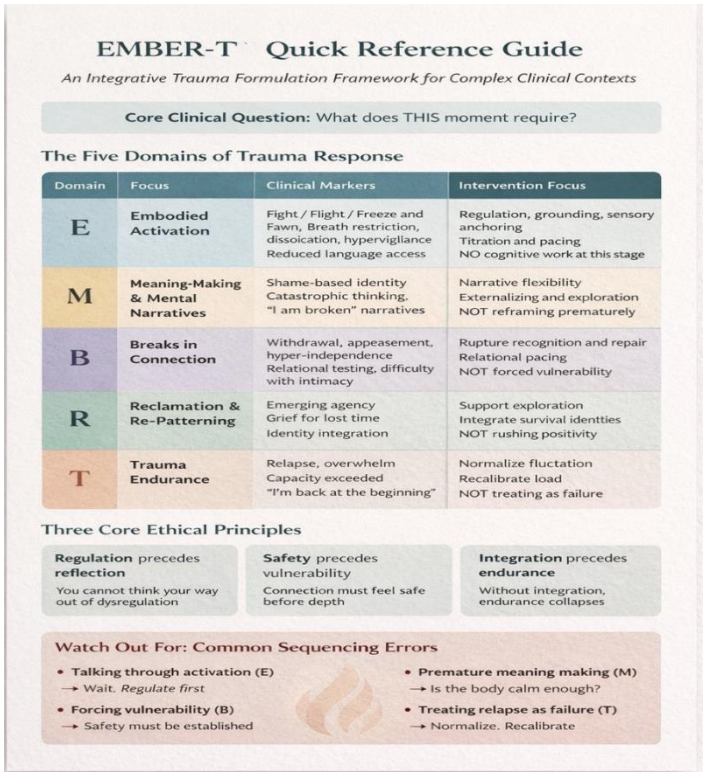
The guide is organized around the core clinical question of EMBER-T: "What does this moment require?"

The five domains include:

- **Embodied Activation (E) -** Physiological survival responses such as fight, flight, freeze, or fawn. Intervention focus prioritizes regulation and grounding, with cognitive work explicitly contraindicated at this stage.
- **Meaning-Making and Mental Narratives (M) -** Trauma-shaped beliefs, shame-based identity narratives, and catastrophic interpretations. Interventions emphasize narrative flexibility rather than disputation or reframing.

- **Breaks in Connection (B) -** Relational withdrawal, hyper-independence, or boundary instability. Clinical work focuses on relational pacing, rupture recognition, and safety-based connection.
- **Reclamation and Re-Patterning (R) -** Emerging agency, grief for lost time, and identity integration. Interventions support gradual experimentation and reclaimed engagement without rushing toward positivity.
- **Trauma Endurance (T) -** Sustainability challenges, relapse, and load exceeding capacity. Interventions normalize fluctuation, recalibrate expectations, and support rest and pacing rather than framing setbacks as failure.

The guide also highlights common sequencing errors, such as engaging in cognitive processing during high activation or interpreting relapse as regression. By making sequencing explicit, the guide reinforces EMBER-T's ethical emphasis on timing and state-responsiveness in complex clinical contexts.



Appendix D: EMBER-T Identity Parts Overlay

Figure D1. EMBER-T Identity Parts Overlay

The EMBER-T Identity Parts Overlay demonstrates how identity organization and survival strategies can develop and coexist amid ongoing threats. Unlike parts-based therapies that see internal parts as separate entities, this overlay shows interconnected identity functions within a unified self-shaped by trauma and resilience.

At the core is the Performer-Protector, which represents adaptive strategies formed to sustain functioning, approval, or safety in the face of threat. Surrounding identity components include both protective adaptations and restricted or emerging aspects of selfhood, such as:

- **Unchosen Child -** Early relational wounds involving abandonment, loss, or unmet attachment needs.
- **Trauma Echo -** Ongoing reverberations of sudden loss, abandonment, or threat that continue to influence present-day responses.
- **Outsider -** Experiences of exclusion, not belonging, or chronic otherness.
- **Escaper -** Strategies of avoidance, numbing, or relief-seeking used to manage overwhelm.
- **Endurer -** The capacity to persist, pace, and sustain functioning under prolonged stress.
- **Choosing Self -** Emerging agency, intentionality, and self-directed decision-making.
- **Creative Self** - Expression, imagination, and vitality that may be limited during survival but remain as potential. The overlay is used within the Endurance-Oriented Identity Work domain of EMBER-T to help clients articulate how adversity has shaped their identity without pathologizing adaptation. It

supports dignity-preserving exploration of survival intelligence, restricted potential, and enduring values, while avoiding premature integration or forced coherence.