Essential Skills for the Successful Treatment of Complex Trauma and Dissociation

November 2014
Presented by Sherrad Barton, LCSW
sherrad.barton.lcsw@gmail.com

Goals of Presentation

- Provide an overview for recognizing, understanding, and treating the broad spectrum of trauma-based disorders: PTSD, Complex PTSD, DDNOS, and DID
- Provide a way to think about the process of dissociation as distinct from the manifestation of dissociative disorders
- Provide a framework for understanding the concept of “multiplicity of the mind” and teach a basic “parts model” for working with the sequelae of trauma
- Dispel common myths about dissociation, DDNOS, and DID - appreciate that “dissociation is not a dirty word”
- Provide an overview of a 3-stage model for trauma work
- Introduce an essential “skill set” for working with Complex PTSD and dissociative disorders

WHAT IS TRAUMA?

Wikipedia defines trauma as “damage to the psyche that occurs as a result of a severely distressing event” which can be either physical or psychological in origin.

Trauma that occurs in the course of development can overwhelm the child’s capacity to cope, leave her helpless and powerless, and cause disruptions in all areas of life: biological, psychological/emotional, social/relational, and spiritual.

“Psychological trauma is an affliction of the powerless … traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning … they overwhelm the ordinary human adaptations to life, [and] confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe.” ~ Judith Herman, 1992
WHAT DOES IT MEAN TO BE A TRAUMA-INFORMED THERAPIST? (1)

- Always assess for the potential impact of a trauma history when patients present with:
  - Long-standing untreatable depression and bipolar disorders
  - Chronic pain
  - Confusing undiagnosed medical or somatic symptoms
  - Substance abuse
  - Eating disorders
  - History of turbulent relationships
  - Patterns of emotional ability
  - Symptoms of “character disorder”

What It Means to be a Trauma-Informed Therapist – the “A” list (2)

- Accept the logic of your patients’ symptoms as having roots in their traumatic experiences
- Appreciate the adaptive survival function of symptoms
- Acknowledge and validate that their victimization, whether physical or psychological, was real and that they were not responsible for their abuse or their symptom development
- Allow for a well-bounded but honest, warm, connected therapeutic relationship that includes deep compassion for what your patient experienced, for how embedded their symptoms are, and for how difficult it is to change.
- Attend to both the psychological and the biological impact of traumatization
- Anticipate working with your patient’s extreme and often conflicting emotional states
- Always assess for dissociation and dissociative disorders

POTENTIAL SEQUELAE OF TRAUMATIZATION

- PTSD SYMPTOMS
- COMPLEX PTSD SYMPTOMS, INCLUDING:
  - Abuse-related personality disordered
  - Attachment Challenges
  - Alterations in the way people view themselves and the world
- DISSOCIATION AND DISSOCIATIVE DISORDERS
- THE FULL RANGE OF PSYCHOLOGICAL AND PSYCHIATRIC SYMPTOMS
Symptoms of PTSD (1)

- **Intrusion Symptoms** (feeling too much):
  - Flashbacks
  - Nightmares
  - Hallucinations and delusions
  - Severe recurring anxiety or panic
  - Feeling paralyzed with fear and/or wanting to run away

- **Avoidance Symptoms** (feeling too little):
  - Efforts to avoid thoughts, feelings, or situations that might evoke traumatic memory; amnesia of traumatic events
  - Emotional numbness
  - Inability to enjoy life, other love
  - Feeling like you’re on automatic pilot
  - Isolation and avoidance of other people
  - Reluctance to talk about traumatic experience

Citation Information: 2011

Symptoms of PTSD (2): The Biological Impact

- **Hyperarousal Symptoms**
  - Persistent physical symptoms of tension
  - “On Alert” : hyper vigilant symptoms
  - Jumpy, easily startled, hypersensitive to noise, smells, air temperature, other environmental stimuli
  - Irritability with outbursts of anger and rage
  - Emotional outbursts
  - Sleep difficulties

- **Hypoarousal Symptoms**
  - Emotional and/or physical numbness
  - Blank mind, unable to think or speak
  - Profound detachment
  - Inability to move or respond
  - Extreme drowsiness or temporary loss of consciousness

Citation Information (Adapted from J. Chu, 1998)

- Classically, PTSD is a biphasic disorder with alternating phases of intrusion ("feeling too much") and numbing ("feeling too little"), accompanied by hyperarousal and/or hypoarousal symptoms (sympathetic nervous system "fight or flight" responses)
- This biphasic pattern is the result of dissociation: traumatic events are distanced and dissociated from usual conscious awareness in the numbing phase, only to return in the intrusive phase

PTSD Symptoms (3): The Biological Impact (Adapted from J. Chu, 1998)
Modulation Model (Ogden and Minton, 2000)

- Hyperarousal: Over-activated & Over-stimulated
- Optional Arousal Zone/Window of Tolerance: Sufficient ANS activation to be calm, curious, engaged, and able to respond to danger without reactivity or numbing
- Hyperarousal: Insufficient activation to integrate

COMPLEX PTSD

THE DEVELOPMENTAL IMPACT OF CHRONIC ABUSE AND NEGLECT

Complex PTSD

- First described by Judith Herman in 1992 to differentiate between the symptoms of single incident trauma and prolonged multiple and chronic childhood trauma within an intrafamilial context – and this includes emotional and physical neglect as well as abuse.
- C-PTSD symptoms result from stressors that:
  - Involve repetitive or prolonged exposure from which there is no escape
  - Involve direct harm and/or neglect or abandonments by caregivers or other significant/neglected adults
  - Occur at developmentally vulnerable times in the victim’s life
  - Have the potential to severely compromise a child’s development
- (Courtois and Ford, 2009)
Symptoms of Complex PTSD

C-PTSD Impacts:
- Ability to regulate affect and impulses
- Attention and Consciousness resulting in dissociative symptoms – amnesia, lapses, disorganization, not fully present and aware of the present moment
- Self Perception resulting in shame, guilt, helplessness, negative beliefs about self as unworthy and unlovable
- Relationships with Others, e.g., isolation, distrust, avoid/passive patterns, fear of experience/forbidding for merger, living as a victim or becoming a victim
- Somatic Symptoms including chronic pain, conversion disorders, medical or sexual symptoms
- Meaning-Making, especially around beliefs in others as potentially trustworthy and in the capacity for hope
- Fear and judgment of one's own inner experiences (feelings, thoughts, needs, wishes, sensations)

Complex PTSD and Borderline Personality Disorder (BPD)

“The Beginning of Wisdom is Never to Call a Patient Borderline” (Vaillant, 1992)

- Severe childhood trauma and attachment disruptions DO lead to enduring personality changes and relational difficulties – and to the symptoms associated with BPD
- Chu (2011) reports that:
  - Not the broad smart with severe PTSD and DD seen at McLean Hospital, the vast majority had BPD characteristics
  - 60-75% of adolescents and adults with BPD experienced trauma
- Courtois (2008) proposes
  - Reconceptualizing BPD as a post traumatic adaptation
  - Recognizing that personality symptoms are not “pathology” but adaptions will lead to less pathologizing and shaming of …………..

Complex PTSD and Borderline Personality Disorder (2)

- Lack of trust makes sense when caretakers were not trustworthy
- Fear of abandonment makes sense when you were abandoned
- Intense relationships make sense when family life in childhood was unpredictable and dangerous
- Difficulty with affect tolerance and impulse control make sense when you grew up with people who did not soothe and nurture you
- Confusion about self and identity make sense when you grew up with people who did not see you
- Self-abuse makes sense when you had no alternative to abusive parent, when you needed to blame yourself in order to preserve some semblance of a connection to that parent
- Hopelessness and helplessness make sense when you really did have no way out
- Isolating and “disappearing” make sense when it was the only way to survive being alone with overwhelming emotions
How do we know what healthy attachment looks like?!
Disorganized attachment patterns are seen at the root of both complex trauma and dissociative disorders.

"...when caregivers are a source of terror in a young child's life...there is no solution to such fear – one part of the child's brain has the drive to escape the source of terror, the parent; while another circuit drives the child to seek comfort and security - but from the same person, the parent who is terrifying...there is no resolution to the biological paradox, and the child fragments." (Daniel Siegel, 2010, p.69).

"The child faced with continuing helpless victimization must learn to somehow achieve a sense of power and control. They cannot safely conceptualize that a parent might be ruthless and self-serving; such a conclusion is tantamount to abandonment and annihilation. The only acceptable alternative for the child is to believe that they have provoked the painful encounter and to hope that by learning to be good they can earn love and acceptance. The desperate assumption of responsibility and the inevitable failure to earn relief set the foundation for self-hate..." (Roland Summit, 1983, p. 184)
Common Myths about Dissociative Disorders (1)

- Dissociative disorders are rare disorders
  - In fact, dissociative symptoms occur in most, if not all survivors of early trauma, whether physical, sexual or relational trauma
- People with DID present in a florid, Sybil-like fashion and they live chaotic, marginal lives with a lot of disorganization and acting out
  - In fact, people with DID look pretty much like everyone else and can be highly accomplished in their lives

Common Myths about Dissociative Disorders (2)

- The best way to treat dissociative symptoms is to ignore alters/parts and just treat the “whole person”
  - Treating the whole person means developing internal communication and cooperation between parts
- The best treatment for patients with dissociative disorders always involves memory retrieval and abreaction of the traumatic material
  - In fact, premature or over-focus on memory work is one of the biggest contributors to destabilization and treatment failure
- It’s okay to say “I treat trauma but not dissociation.”
  - In fact, if you’re treating trauma, you are treating dissociation.
What Exactly is Dissociation (1)?

- Both a verb and a noun
- Dictionary definition of the verb: “to dissociate is to break the association of, to disconnect, to separate”
- As a verb, dissociation refers to a process of putting experience outside of conscious awareness “not me”.
- This can happen:
  - Internally: parts are unaware of the beliefs memories, feelings or body sensations of other parts
  - Externally: disconnected from experience, in a trance, spacey, fogged out, detached from self and others, from the environment, from parts of the body
- The result of this process is that “the process” is not present. Your patient may be talking and interacting with you, even telling you about what upset her during the week or about her memories of child abuse. But “she” is not there.

What Exactly is Dissociation (2)?

What about dissociation as a noun? Here we can see that dissociation is:

- A lack of integrative functioning: “A disruption in the usually integrated functions of consciousness, memory, identity, or perception” (DSM-IV).
- A compartmentalization of experiences: Elements of experience – and/or parts of the personality – are not integrated into a whole, but are stored in isolated, well walled off fragments of the mind. The fragmentation serves to protect against extreme disorganization.
- A survival strategy, a way that children learn to cope when there is not enough adult support to help them make sense of and integrate overwhelming experiences.

What Exactly is Dissociation (3)

- A skill that children develop to deal with something horrible that is happening “right now” – better to “go away”, disappear, become someone else, to hang out on the ceiling than to have to experience what is happening to me in this moment. Over time, the skill becomes both an incredible resource and also a huge handicap – and, at the extreme end, results in severe amnesia and time loss.
- Dissociation is also what Karla Lyons-Ruth (2001) refers to as “flight without solution”, a psychological and physiological response to danger when there is no available adult support.
- A psychological disorder: DID and DDNOS
How Does the Compartmentalization Work?

Miss America by Day
- "Without realizing it, I fought to keep my two worlds separated. Without ever knowing why, I made sure, whenever possible, that nothing passed between the compartmentalization I had created between the day and the night child." Marilyn Van Derbur (2003, p.26)
- I don't know who that girl was who slept with all those men, but I assure you that it wasn't me. (my patient who was dressed like a hooker and repeatedly "offered up" to father's friends from an early age)
- I remember nothing. Things that happened to me are just not there... If I hadn't been able to put them away, I'd have gone crazy. (my extremely well-functioning patient with a history of multiple sexual traumas from early childhood through college)

Here and Now

"Parallel Lives"

"Now feels just like there and then"

Dissociative Barrier

There and then: past/childhood memories

"Arrggh!"

Something Happens

Parts and Triggers

- Something happens in the present
- It evokes a somatic or mental memory of something from the past
- Parts automatically respond to the trigger as though it was the same as the original situation – with hyperarousal and/or numbing. Reactions are rarely appropriate to current situation.
- The patient may or may not "know" that she's been triggered – and not every part is triggered by the same thing
- Triggers can be related to: time (seasons, holidays, time of day); place; relationship; sensory experiences; internal stimuli

Therapeutic Challenge: Help the patient re-orient to 2014, realize that she's been triggered and that nothing bad is happening "now"
What is it that Gets Dissociated?

The Bask Model:
- Behavior
- Affect
- Sensation
- Knowledge

When Behavior is Dissociated:
- More than simple forgetting; one part of the system behaves in ways totally unknown to other parts of the system — the essence of amnesia.
- "What are those sexy clothes doing in my closet? I’d never wear anything like that?"
- I don’t know why I always end up in the basement when I get scared because that’s where she hid from her father as a child, something “she” forgot.

Therapeutic Task: Do not confront the inconsistency; it will only lead to further disorganization. Create space and safety for the part who “knows” what happened to come forward and be understood and, eventually, introduce dissociated parts to the rest of the system.

When Affect is Dissociated:
- Can describe the most frightening experiences in a monotonous, sing-song voice without any accompanying emotion — because the part holding the emotion is not really present.
- "I don’t do feelings."
- "I was gang-raped when I was 6 but it was no big deal."
- "I am NOT angry!" (as they rage at you).

Therapeutic Task: Bring all parts into the room and into the present century. It is not useful to tell these stories without affect; it is re-traumatizing. That’s what happened the first time — to survive the traumatic experience, they had to do it alone and without the emotion.
What Gets Dissociated? The BASK Model

Behavior – Affect – Sensation – Knowledge (3)

- When Sensation is Dissociated:
  - Not feeling things in the body – so can endure pain at a potentially unsafe level.
  - The physical sensation the person felt during the traumatic event are “relived” through somatic symptoms in adulthood.
  - Somatoform symptoms and Conversion Disorders: Intermittent loss of vision, hearing, experiences of paralysis.
  - “I don’t feel things in my body, it’s just numb.”
  - “I’ve got to find a doctor who can figure out why I have constant sense of choking and coughing” – until she remembers she was orally raped as a child.
  - “I hate when the dentist touches my face that way.”
  - **Therapeutic Task**: “The body keeps the score” (van der Kolk). Reconnect them.

- When Knowledge is Dissociated:
  - The result is amnesia, both present day experiences and for large parts of childhood.
  - Time loss, blackouts, blank spells of staring into space, memory loss.
  - May be amnestic for large parts of childhood – or knowing that something happened but not wanting to or being able to get that it really happened “to me”.
  - “I don’t really remember my childhood, but I know it was happy.”
  - “I forgot what happened in the last session” (or in period between getting out of her car on time and then arriving 15 minutes late for your session).
  - **Therapeutic Task**: Reconnecting the behavior, affect, sensation, and knowledge that have, to survival, been compartmentalized.

The Development of Dissociative Symptoms (1)

- The best predictors for the later development of dissociative symptoms is not the traumatic event itself, but rather:
  - Neglect in infancy.
  - Physical unavailability of the primary caretaker in the first two years of life.
  - The quality of parental communications, particularly around affective involvement and recognition of the child’s needs and attachment signals.
  - Disorganized attachment patterns characterized by a relationship with a caretaker who is both “frightened” (anxious, depressed, dissociative withdrawn) and simultaneously “frightening” (emotional, explosive, abusive, unpredictable).

Barlow, 1995; Quinlan et al., 2009; Leilani, 1992
The Development of Dissociative Symptoms (2)

- "...when a frightened child needs his mother, but ultimately finds that he is abandoned and alone he protects himself from further suffering by detaching himself from any awareness of his feelings and needs...[he] detaches from the affect...and learn(s) to expect no help from the mother." (Barach, 1991)
- And, neglectful or detached caretakers may not be alert, aware, or connected enough to their child to detect signs that something is wrong, to prevent trauma from occurring or to protect the child from further trauma once it has occurred.

The Development of Dissociative Symptoms (3)

Thus, overwhelming, traumatic experiences in the absence of a safe connection alter the child’s brain chemistry and her capacity for self-regulation and leave her with the physical sensation of helplessness in the face of terror. This solidifies the dissociative “shut-down” and leads to the creation of even stronger protective walls around the parts carrying memory, affect, belief, sensation – as the child tries to cope with going to school and being in the world.

Let’s Talk about Parts

- We all have parts and, in essence, we all have “multiply” parts that are more or less connected to one another.
- The difference between the experiences of people with and without significant dissociation is how separate, fragmented or split off their parts are from their conscious minds and from one another.
- When someone has a dissociative disorder, in order for them to function day-to-day and avoid becoming totally overwhelmed, certain parts that carry the feelings, beliefs, memories, and body sensations of early trauma need to be split off, isolated, and exiled awareness.
Some of the Parts

- Parts taking care of day-to-day life (who are too busy to want anything to do with parts holding affect and memory)
- Parts stuck in “trauma-time” for whom today feels exactly the same as it fell at the time of trauma, often terrified and vigilant, reactive, and can easily dysregulate the system
- Young child and adolescent parts who are often extremely lonely and needy (and who feel abandoned or rejected by the ones who get you through the day)
- Helper parts who attempt to soothe others in the system, often through unhealthy ways (sleeping, eating, suicide)
- Internal Perpetrator parts who mimic the original offender and who often hold the anger and rage but tend to act it out against other parts of the system, especially vulnerable parts
- “Fight” parts—tough kids who want nothing to do with vulnerability and often nothing to do with therapy
- Ashamed parts

PARTS EXERCISE

………OR, WHO’S IN CHARGE HERE?!

How Do You Know?
Diagnosis of DID/DDNOS
The Dissociative Continuum

- Normal lapses in consciousness: daydreaming, "highway hypnosis" dissociation.
- Ability to be "in the zone" to peak performance.
- Ability to stay "calm, cool, and collected" in responding to crisis, e.g., emergency "front responders".
- Dissociation "at the moment of impact". Adaptive response to stress.
- PTSD Avoidance Symptoms: amnesia for traumatic events; operates "on automatic pilot": detached/can't feel.
- Dissociation as a symptom of C-PTSD.

Dissociative Disorder NOS
Dissociative Identify Disorder

Dissociation in C-PTSD, DDNOS and DID

- Only 20% of people with clinically significant dissociation are DID.
- Neither you nor the patient may know the extent of the dissociation and dissociative barriers at the onset of therapy.
- With C-PTSD and DDNOS, people tend to be aware of their parts and of when they are dissociating. They can be brought back into the present with a gentle "are you here? where did you go? did a part take over" and can usually tell you what was going on inside when they were "gone".
- With DID, there is:
  - greater compartmentalization, thicker boundaries, and other serious and intense conflicts between the parts; as the part who takes care of the children may know nothing of the part who goes out and is promiscuous at night.
  - significant time loss and amnesia; parts can take over for minutes, hours, days and the rest of the system can be amnestic for where the time went.

Detecting Dissociative Processes

- BASK Symptoms:
  - Your client is just "not there" every momentarily. Consciousness has fluctuated, client appears preoccupied with a lot of inner distraction.
  - Client jumps from topic to topic, cannot sustain continuity in telling a story — as gets lost in the story and the details and forgets what they are telling you about this. "How?"
  - Client loses connection with you, glasses over, eyes flutter, forgets what you’ve been talking about, spaces out.
  - Client gets "lost in the past" when telling you their history—and/or tells you a horrible history with no corresponding affect.
  - Long gaps between sentences. You ask them a question and it seems like hours before they answer — and their answer is often appear (though may not be) forgetful.
  - You, the therapist, get sleepy, foggy, floaty, confused, irritable, feel helpless and as though nothing is working. Why: because "your client" is not there.
When to Suspect the Possibility of DID/DDNOS (1)

- When you see a cluster of any of the following symptoms, it is a good idea to stay open to the possibility that your patient has a dissociative disorder:
  - Complex trauma history in childhood
  - Traumatic medical history in childhood
  - History of multiple therapists, prior treatment failures
  - Fluctuating symptoms and levels of functioning, with inconsistent and unpredictable patterns

When to Suspect the Possibility of DID/DDNOS (2)

- Serious somatic symptoms, often with no apparent medical cause, unexplained injuries, eating disorders
- Very high pain tolerance, the ability to block out pain
- Hearing voices/hallucinatory experiences
  - Voices mostly come from inside the head, often lots of elaborate conversations going on at the same time
  - Voices experienced as separate/not mine, “as if”
  - Disorganizing competing voices, e.g. trust the therapist, no DON'T, have unprotected sex with that cute guy over there/never look at a man again
  - Lots of voices telling person they are bad, unlovable, deserve to be punished
  - When this is occurring, patient may look distressed and preoccupied, may get quiet and withdrawn

When to Suspect the Possibility of DID/DDNOS (3)

- Amnesia:
  - Gaps in memory, small and large, that cannot be attributed to simple forgetfulness
  - Losing time, having blank spells when hours or days cannot be accounted for
- Depersonalisation:
  - The sense of not being oneself, feeling detached from who you are, from feelings, from parts of your body
  - Feeling unreal, that you are going through the motions of living, but the “real you” is far away
- Derealisation
  - The sense of feeling disconnected from the environment and from your surroundings—the world feels “far away,” or people’s voices seem at a distance, unreal
When to Suspect the Possibility of DID/DDNOS (4)

- Mood swings and switches in states, sometimes from moment to moment in your session
- Inexplicable behaviors, e.g., sometimes comes in dressed as a student in jeans, sometimes as a hooker ready for a night on the town
- Discovering objects, drawings or handwriting in one’s possession that one cannot account for
- Disremembering, e.g., being caught shoplifting but not remember taking/hiding an item
- An adult suddenly talking in a childlike voice
- The frequent use of “we” in referring to self
- When therapist talks about “parts”, client overreacts, sure you’re calling her Sybil

When to Suspect the Possibility of DID/DDNOS (5)

- These patients almost always start therapy thinking they are “crazy” because of their symptoms

  **Therapeutic Task:** Help them appreciate the adaptive function of their symptoms and how, no matter how strange the symptom, it made sense that it developed just as it did. Dissociation was a survival strategy when there was not enough adult support to help the child integrate overwhelming experience.

  **Ongoing Diagnostic Challenge:** To assess the level or extent of the dissociation. How much compartmentalization and fragmentation exists? How thick are the boundaries between parts/different feeling states? How difficult is it for the person to shift from one feeling state to another? How much do feeling and behavioral states associated with child parts slip into the present moment?

Diagnostic Tests (1)

- **Dissociative Experiences Scale (DES)** [Benjamin and Putnam] (you can Google this and find the questions) is a fairly reliable screening instrument. If you decide to use the DES with clients, do it in a face-to-face interview and watch how the client answers—pauses, confusion, eyelids rolling up can indicate internal impact of parts commenting or disagreeing on what, if any, response to give.

  **DES Scoring:**
  - Values over 30 suggest the likelihood of a dissociative disorder
  - Values over 45 suggest the likelihood of DID
  - Scores are NOT diagnostic
  - Scores less than 30 do not exclude the presence of DID
Diagnostic Tests (2)

- DES Taxon (questions with high significance):
  - Finding oneself in some place but unaware of how one got there
  - Finding new things among belongings, don't remember buying them
  - Seeing oneself as if looking at another person
  - Do not recognize friends for family members
  - Feeling that other people, objects, and the world are not real
  - Feeling that one’s body is not one’s own
  - Feeling as though one were two different people
  - Hearing voices inside one’s head

Diagnostic Tests (3)

- SCID-D: Steinberg Clinical Interview for DSM-IV developed by Marlene Steinberg – “the gold standard”
- Office Mental Status Examination for Complex Chronic Dissociative Symptoms and Multiple Personality Disorder. See RJ Loewenstein, Psychiatric Clinics of North America, 14 (3).
- Multidimensional Inventory of Dissociation (MID), developed by Paul Dell, Ph.D.
- SDQ 20/5: Somatoform Dissociation Questionnaire, developed by Ellert Nijenhuis

What to Do?!?!?!?

Effective Treatment of Trauma and Dissociation
Effective Treatment of Trauma and Dissociation

Step #1: Buy this book!!


Effective Treatment of Trauma and Dissociation

Step #2: Join other trauma therapists for networking and support

- ISSTD (International Society for the Study of Trauma and Dissociation)
- Educational events
  - Excellent website with resources, bibliographies, treatment guidelines
  - www.isst-d.org
  - Annual Conference
  - Great student rates
- See references for books and online resources

What’s the Goal of Trauma Treatment?
What's the Goal of Trauma Treatment?

Contrary to many people’s beliefs, the goal of trauma treatment is not to process every single traumatic event and relational failure. Rather, it is to help people get to the place where they are able to say, “It happened, it happened to me, and it’s over,” to mourn their losses, let go, and move on – and, thus, to be able to live with more safety, freedom, and hope in the present and the future.

The SAFER Model for Treatment of Dissociative Disorders

- Understanding the Symptoms and learning how to manage them
- Acknowledging that they are symptoms and they have been caused by Trauma
- Finding ways to Function in the present and to achieve some degree of internal cooperation and communication
- Experiencing the self as one whole with multiple perspectives, learning how to Express those multiple perspectives without having to dissociate, and achieving the capacity for internal Empathy
- Reconnecting the parts into a coherent Self capable of developing healthy, collaborative, supportive Relationships

Adapted from Chu, J. (1998)

Helpful Techniques for Effective Treatment of Trauma and Dissociation

- Having many skills will prepare you for the wide assortment of cases you will see. Helpful skills include:
  - Hypnosis and Projective Technique
  - Sensorimotor Psychotherapy and Mindfulness Techniques
  - EMDR
  - Internal Family Systems Therapy
  - Solid foundation in psychodynamic and relational approaches, including AEDP
  - Energy Techniques, including SRT, EFT, Acupressure, Feldenkrais
  - Relaxed or supervised work with physical therapists or other body workers familiar with gentle somatic release for trauma/based pain.

Therapist’s Self Care

- "...think carefully about whom you’re going to treat and why" [Ross]. It’s okay to say no if this is not the right time in your life to take on a complex and difficult case.
- Be aware of secondary PTSD, Cumulative Trauma
- Do you own work
- Notice when you’re dissociating and take action
- Create “energy boundaries”, send projections back
- You are part of the solution
- If a child got through her/his childhood alone, then you and the client should be able to get through the healing! [James Twombly]

Three-Stage Model of Trauma Treatment

- Stage 1: Symptom Reduction of Stabilization
- Stage 2: Processing of Traumatic Memory
- Stage 3: Integration and Self Development

Herman, J.L. (1992), Trauma and Recovery

Goals of Phase 1 Treatment

- Get to know the parts – who is there, what is their function, how do they help the system
- Develop internal communication and cooperation among parts
- Develop capacity to stay in the present moment and to develop coping skills to regulate numbing and intrusive symptoms
- Develop capacity to recognize and work with the triggers
- Help client maintain dissociative defenses, use them with intention to regulate affect
- Ongoing psycho-education about dissociation and about the treatment process
Goals of Phase 2: Treatment of Traumatic Memory

- Desensitization of the traumatic scenes and associated affects
- Integration of the traumatic material into the fabric of the client's life history, putting the past in the past so the client can live in the present and future (this happened, it happened to me, it happened a long time ago, it's over and I have control now to make sure it never happens again)
- New awareness of how the trauma impacted all of the parts of the self

Goals of Phase 3 Treatment: Integration

- Integration – resolution of the trauma
- Learning new coping skills
- Work on character issues
- Work on relationship issues
- Solidification of gains and working through
- Continuing to focus on co-consciousness, removing dissociative barriers
- Enjoying Life

Basic Principles in the Treatment of Trauma and Dissociation

#1: Stay in the Present – slower if faster, Mindfulness is the key
#2: Work within the Window of Tolerance
#3: Develop internal communication and collaboration between parts
#4: Develop capacity to recognize and work with triggers
#5: Attunement to the therapeutic relationship
#6: Principles in the processing of memory
#7: On-going psychoeducation about trauma and dissociation: Your symptoms make sense in the context of how you grew up
Basic Principles #1: Stay in the Present (1)

- Change and healing can only occur in the present, not by getting lost in the past.
- Pay attention to parts that believe they still are in the past, that want to go back and fix the past, or who are driven to repeat and re-live the past (often in the hopes of gaining better understanding and mastery of what was tolerable).
- Learning to stay in the present and to develop "dual attention" (the ability to witness and speak about what happened without becoming physiologically dysregulated) is the essence of good trauma treatment.

Basic Principle #1: Stay in the Present (2)

ORIENTING PARTS TO THE PRESENT:

- How do you know it's 2014? What are the facts? Do parts know how tall you are, how many children you have, where you live now? That your father is no longer alive?
- How do you know you're not being abused now? Does the part know the ways you've learned to keep yourself safe?
- Dissociation messes with people's sense of time; find ways to help people keep track of time: calendars, watches, &/or alarms that go off at particular times.

Basic Principle #1: Stay in the Present (3)

SLOWER IS FASTER, MINDFULNESS IS THE KEY

Developing mindfulness of thoughts, feelings, body sensations, the five senses is the key to learning to experience safety in the moment. Grounding people in the present moment and helping them achieve some stability there will ultimately facilitate processing and integration of past trauma.

GROUNDING IN THE BODY: WHAT IS HAPPENING RIGHT NOW?

- Simple breath, body, sound, or eating meditations
- Door handle meditation
- Mountain pose, other yoga poses
- Progressive muscle relaxation
TRY THIS: SIMPLE GROUNDING INSTRUCTIONS

Sit up with both feet on the floor... and bring your attention to your feet... notice the temperature of your feet, the way your toes touch... any tingling or numbness. Just noticing, without trying to change a thing. Don’t feel you can feel the soles of your feet touching your socks... notice the texture of your socks... and then noticing your shoes under your socks, firm or soft... and can you feel through your socks and your shoes to the rug under your shoes... right here, right now, fully present... and then feeling the floor below the rug... and now seeing if you can imagine spreading the energy through your feet, the rug, the floor; all the way into the ground and just noticing as roots spread from your feet into the ground... feeling more and more connected, rooted. And when you are ready, seeing if you can pull some of that earth energy up from the ground into your body... Back through the floor, rug, shoes, socks... noticing all the sensations as the body becomes more and more grounded and more and more connected.

MINDFULNESS OF THE FIVE SENSES: BRINGING PEOPLE BACK TO THE PRESENT

- **Sight:** Look around the room and find five red objects—or find something comforting, or something that reminds you it’s 2014—in the midst of overwhelming affect. Name out loud, describe.
- **Touch:** Holding a stone, touching the chair—is it hot or cold, hard or soft, rough or smooth? Feel the sensations, describe.
- **Taste:** Hold a raisin in your mouth, describe its texture, taste, temperature, etc.
- **Sound:** What’s the sound closest to you, the one farthest away? Loud or soft? Constant or intermittent? Pleasant or unpleasant?
- **Smell:** A bottle of vanilla or lavender in your office can help someone out of a flashback.

EXPERIENCES OF TRAUMA ALTER THE CAPACITY FOR SELF-REGULATION AND TRAUMA SURVIVORS TEND TO GET SOMATICALLY DYSREGULATED QUITE EASILY.

- The autonomic nervous system responds to present day triggers “as though” they were occurring in the past—and react to both internal and external triggers with hyperarousal, freezing, and/or hypoarousal/hunstuning.
- Effective treatment needs to take this autonomic reactivity into account—real transformation and processing of trauma can only occur when the biological systems is in an “optimal state of arousal” (Ogden and Minton).
Basic Principle #2: Work Within the Window of Tolerance (2)

- Hyperarousal: Overactivated & Overstimulated
- Optional Arousal Zone/Window of Tolerance: Sufficient ANS activation to be calm, curious, engaged, and able to respond to danger without reactivity or numbing

Basic Principle #2: Work Within the Window of Tolerance (3)

Working with Hyperarousal (feeling too much flooding):
- Intentional use of compartmentalization: containers (bank vaults, a drawer in your filing cabinet) to hold intense affect, body sensations, and traumatic memory
- Safe Space Imagery for parts who are upset to retreat to
- Self Soothing Practices: yoga stances, guided meditations, "waves of relaxation"
- Grounding Strategies: Using the five senses: Orienting to the present
- EMDR Butterfly Hug, Tapping
- Distraction: change the subject, go for a walk, play music
- Listen to all the parts: try to find the reactive parts and learn what has triggered them

Basic Principle #2: Work Within the Window of Tolerance (4)

Working with Hyperarousal (feeling too little, avoidance, detachment, numbness):
- Shutting down, avoiding feelings or going into trance is a form of dealing with overwhelm: respect the part that shuts down, appreciate its survival function - and realize that it is probably a very young part who is living in the past
- Try to make eye contact, remind them it is 2014
- Try to help the person move, even if only the tip of the finger
- Open the window
- Ice cubes, smelling salts, loud (but not threatening) noises/music
- Invite them to draw or write
- IF AND ONLY IF your on-going relationship involves acceptance of safe touch, take their hand or put your hand on their knee, cover of the head: do some gentle bilateral tapping
Basic Principle #3: Develop Internal Communication and Collaboration Between Parts (1)

ALWAYS REMEMBER:

- THERE ARE NO BAD PARTS, JUST PARTS STUCK IN EXTREME ROLES
- EVERY PART, NO MATTER HOW PROBLEMATIC, IS TRYING TO HELP THE SYSTEM FUNCTION IN SOME WAY
- MOST IF NOT ALL OF THE SYMPTOMS YOU SEE RESULT FROM PARTS IN INTERNAL CONFLICT AND/OR FROM PARTS STUCK IN THE PAST TRYING TO MAKE SENSE OF THE PRESENT

(Schwartz 2001)

Basic Principle #3: Develop Internal Communication and Collaboration Between Parts (2)

- Address the who person. The part who shows up for therapy and seems like the “whole person” may not be.
- Look for/think about conflict between dissociated parts. DON’T TAKE SIDES!
- Be active in making sure all parts are hearing. Don’t assume, when there are long silences, that there is work going on inside; it may be that one or more parts has shut down the system.
- Ask permission from the whole system to proceed. Trauma survivors often have very compliant, harsh protectors (life-savers they were) who may not want to tell you that parts are screaming at them to stop the process.

Basic Principle #3: Develop Internal Communication and Collaboration Between Parts (3)

- Negotiating with parts: who is going to participate in what activities in the person’s daily life, e.g., children don’t drive or have sex/abusive and/or self-hating parts do not do childcare
- Externalizing the parts as a way of getting to know who is in the system and what the relational dynamics between the parts—who is aligned with whom and who is in opposition to whom, who is protecting whom

- A basket of pebbles or little animal figures are good ways of representing the parts that are currently active in the system and of getting some distance from and perspective on the intense affect that they hold
Basic Principle #3: Develop Internal Communication and Collaboration Between Parts (4)

- **Dissociative Table Technique** (Frazer, 2003) for developing internal communication and negotiation
  - Ask host and parts to visualize a room with a big table
  - Invite all to take a seat at the conference table (ok if some don’t want to, but it would be nice if you would watch or listen)
  - Can be used for internal communication for negotiating between parts and for mapping parts’ relationships
- **Computer Screen**: parts can be in different windows that can be opened and closed. But they can still see that they are part of the whole. Many parts don’t know that they share a body with parts they hate

Basic Principle #4: Develop Capacity to Recognize and Work With Triggers (1)

Many if not all people with complex trauma histories and dissociative symptoms are in the habit of looking reflectively at their emotions and behaviors. **Why am I in such a bad mood?** Why did I just blow up at my 10 year old? How come I haven’t been able to get out of bed for the past week? I don’t know why I quit my job. I like it.

Instead of being able to reflect, they see moods come upon them out of the blue, behavior “just happening”, and they come into your offices confused and in despair, highly reactive but without the capacity to look at what has triggered their current state.

The worst triggering is when some situation in the present biologically activates traumatic memory from the past and parts automatically respond to the present **AS THOUGH** it was the past

- Suspect someone has been triggered when their reactivity is higher than usual
  - When they are stuck in their reaction and cannot step back and reflect
  - When parts are switching back and forth rapidly and/or when you notice what appears to be a lot of internal dialogue
  - When they tell you they are or were in a flashback
  - When they seemed lost in “trauma-time”
  - Help them “go back in time” to figure out what triggered them
  - Help them anticipate how to work with this trigger in the future
Basic Principle #4: Develop Capacity to Recognize and Work With Triggers (3)

Reducing the Impact of Triggers:
- Work on developing dual awareness and the capacity to distinguish the past from the present:
  - "I am afraid of closets because something bad happened to me in a closet when I was a child. I can open closet doors and see that there is nothing dangerous inside. I have choices now that I did not have before."
  - "I hear anger in my husband's voice, he sounds like my father and I am afraid. I can remember that my husband is not my father and is not going to harm me. I can speak to him."
  - "I am feeling afraid (experiencing self) but when I look around me I see that I am safe right now (observing self)."

- Grounding: carry a small talisman in your pocket to remind you of the present, of the therapist, therapist's office
- Remember that it is a PART that is reacting to the trigger. Try to identify the part and recognize the "wise adult self" who is able to soothe the part and make adult decisions.

Basic Principle #5: Attunement to the Therapeutic Relationship (1)

- Pay attention to attachment issues, especially to the conflict between parts that have longings and the parts that are terrified about their relationship with you. Remember, you are the therapist for the whole system and take care not to get too identified with any one part.
- It is also essential to pay attention to your own parts in working with people who have many parts needing to push you away and whose internal disorganization often makes it hard to map the therapy and to hold the frame.
- Pay attention to boundaries around time, money, cancellations, touch. These people by and large grew up in families with dysfunctional boundaries, you need to be a model.
- AND you simultaneously need to be human and flexible, preserving boundaries while also being warm and active.

Basic Principle #5: Attunement to the Therapeutic Relationship (2)

The Most Common Countertransference Errors in Working with Patients with Dissociative Disorders:
- Enmeshment Errors: poor boundaries and limits; excessive outside contact with the patient; forgetting to view the patient as a competent adult; failure to empathize with and simultaneously contain dependency longings; attempting to provide re-parenting.
- Distancing Errors: setting arbitrary or punitive limits; refusal to allow patient to express needs or shame the expression of needs (belief that patient's "dependency" is unhealthy); intellectualization of the therapy process; failure to process the internal conflicts around the fear and wish for rescue.

Kathy Steele, NESTTD presentation, 2002
Basic Principle #5: Attunement to the Therapeutic Relationship (3)

- Therapeutic neutrality isn’t therapeutic!
- Be human, show a wide range of affects, to a moderate degree
- Be honest. Realize your client may pick up on your feelings before you do
- Have options.
- Humility helps. Apologize if you get or do something wrong
- Admit if you don’t know when you don’t know
- Admit it when your buttons are being pushed, carefully
- Try to understand, don’t say “I understand” because you probably often can’t

Joanne Twombly 2008

Basic Principles #6: Principles in the Processing of Traumatic Memory (1)

- Processing traumatic material is NOT the same thing as re-experiencing and “abreacting” the trauma
- Client must be grounded in the present in order to witness what happened in the past
- Pace processing of traumatic memories so client can remain at the highest level of functioning possible
- Return to Phase 1 stabilization and coping skills if things get out of control or the client gets overwhelmed in or between sessions
- Work within the window of tolerance
- Key: Make the work, chunk it down
- Client didn’t have control as a child, must have control of the processing of the memory

Basic Principles #6: Principles in the Processing of Traumatic Memory (2)

The Dynamics of Memory (Courteous, 1999)

- The therapist strives to practice from a neutral perspective regarding memory.
- The therapist understands the malleability of human memory and the differences between historical and narrative truth. We can never validate “the truth” of a memory, but we can validate the truth of the client’s experience.
- The therapist’s goal in attending to traumatic memories is to facilitate mastery and resolution.
A Note About Self-Harm

Self-harm is generally a protective and caring gesture by a part trying to re-regulate a dysregulated system. It is only occasionally a suicidal statement; more often a statement of extreme suffering. Motivations for self-harm include:
- To feel real/alive when one is numb
- To evoke numbness when feeling too much
- To focus emotional pain “outside” in order to localize it
- As a substitute for hurting others
- To cope with abandonment, rejection, loneliness
- A traumatic re-enactment, a way to tell what happened
- The expression of a self-hating part
- As punishment for telling secrets, talking about the trauma
- An addictive release of endorphins

(Adapted from Boon, et al., 2008)

Principles in Working with Self-Harming Parts

Informed by Internal Family Systems Model (Schwartz, 2001)

- Honor them, take them seriously, appreciate their good intentions (even if you don’t agree with them)
- Self-harming parts are usually very isolated in the system. Understand that. Help them connect and collaborate with other parts of the system that may have other ideas about how to help the situation
- Help them recognize what triggers their behavior; work with the triggered parts
- Re-orient them to safety in the present
- Work with the parts of YOU, the therapist, who get triggered by threats or acts of self-harm

...You are Now a Trauma-Informed Therapist!
“Who” Will Show Up for Therapy?

Wise, Resourceful Adult Going on with Life

Traumatized Child Self or Selves

A Protector

A Distancer

Terrified Child

Depressed Child

Needy Child

Angry Self-destructive, Suicidal, Hyper vigilant, Addictive

Distance, Retreat, Avoid, Disinhibit, Anxious

Riveted, Terrified, Wary, Scared, Abandoned, Does not want to be seen

Depressed, Anhedonic, Self-hating, “Dissociative”, Catatonic

Desperate, Codependent, Connection, Dependent, Childlike

The Continuum of Dissociation

Normal Dissociation

Pathological Dissociation

Daydreaming

Driving

Listening to Music

Typing

Creative/Artistic Process

The “Absent Minded Professor Going to the Bathroom in the Middle of The Night” (Normal Organic Dissociation)

Excessive Daydreaming

Amnesia After Brain Trauma (Abnormal Organic Dissociation)

Hysterical Blindness, NOS

Depression

Dissociative Disorder NOS

MPD (Dissociative Identity Disorder)

Eating Disorders

OCD

Panic Disorder

Normal Dissociation

Pathological Dissociation