An Integrated Approach to Treating Complex Trauma
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1

Disclosure

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"Many of the concepts I'm presenting today are from my books. I do benefit financially from royalty payments from the sale of these products."

2

Objectives

By the end of this workshop participants will learn:

- Some differences between PTSD, C-PTSD, and BPD
- The Triphasic approach to trauma treatment
- The basics of Polyvagal Theory and how to use this with clients
- Some skills to help ground and regulate clients, and to help prepare clients for trauma processing therapy
- How to screen for dissociation and understand its implications for therapy
- The Theory of Structural Dissociation of the Personality
- The basics of how to use a Parts approach in therapy

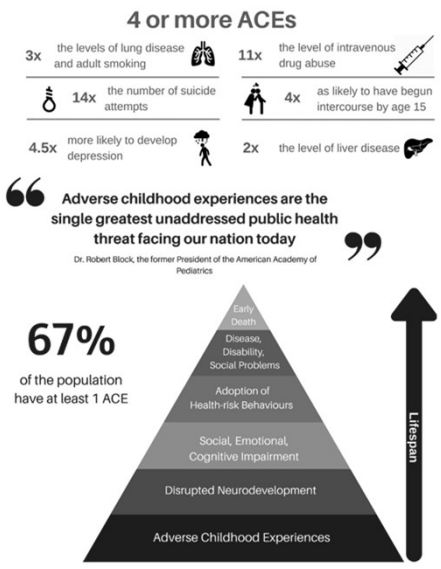
3

What is Trauma?

- Life-threatening trauma meeting the DSM-5 Criterion A definition for PTSD requires exposure (first-hand or vicariously) to actual or threatened death, serious injury, or sexual violence (often referred to as "Big T trauma").
- Experiences that don't meet this strict definition – such as emotional or verbal abuse, or neglect – (sometimes referred to as "small t trauma") may be perceived by an individual as equally or more life threatening than the Big T traumas.
- In EMDR's Adaptive Information Processing model, it's clear that if an experience undermines an individual's sense of self-worth or safety, inhibits their capacity to attribute or accept proper responsibility, or limits one's sense of control or choices in the here-and-now, then it is a trauma (Shapiro, 1997).
- "Trauma is in the eye of the beholder"!

4

The Adverse Childhood Experiences (ACE) study looked at the health and social consequences of seven traumatic childhood experiences in over 17,000 adults in the US (Felitti et al, 1995)



ACEs Measured:
- Parental separation, divorce, addiction, or incarceration
- Household mental illness or domestic violence
- Experiencing physical, sexual, or emotional abuse or neglect

5

Adverse Childhood Experiences (ACES)

- Green et al (2010) study findings suggest that early childhood adverse experiences could be related to up to 32% of psychopathology in adults, and up to 44% in children
- ACEs also increase the risk of early mortality; individuals with six or more ACEs:
  - Were found to have died 20 years earlier than those with no ACEs;
  - Were at a 1.7 times higher risk of death by age 75, and 2.4 times higher risk of death by age 65.

6

ACE Score Increases Suicide Attempt

1 of 100 people with 0 ACEs attempt suicide

10 of 100 people with 3 ACEs attempt suicide

20 of 100 people with 7 ACEs attempt suicide

7

Adverse Childhood Experiences (ACES)

- We need to remember that ACE scores don't account for positive experiences in early life that can help build resilience and protect a child from the effects of trauma (e.g. having a grandparent who loves you, a teacher or coach who understands and believes in you, a trusted friend you can confide in), which may mitigate the long-term effects of early trauma
- AND the initial ACEs study was composed of respondents who were predominantly white, middle-class, and well-educated. The Philadelphia ACEs (2012) project expanded on the original ACEs to look at an urban location with a racially and socio-economically diverse population, adding several events to capture a broader range of experiences…

(the response rate was small, at 1784 adults, or 67%)

8

Philadelphia Expanded ACE Questions look at Community-Level Adversity

Witness Violence	How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life?
Felt Discrimination	While you were growing up...How often did you feel that you were treated badly or unfairly because of your race or ethnicity?
Adverse Neighborhood Experience	Did you feel safe in your neighborhood? Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted?
Bullied	How often were you bullied by a peer or classmate?
Lived in Foster Care	Were you ever in foster care?

9

Post-Traumatic Stress Disorder (PTSD): DSM-5 vs. ICD-11

- C-PTSD is not a diagnosis in the DSM-V-TR but has been included in the most recent edition of the WHO's ICD-11 (published in 2019, in-use as of 2022).
- DSM's "criterion A" for a **PTSD** diagnosis: ***The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence,*** either first-hand or vicariously:
  - Directly experiencing the traumatic event(s)
  - Witnessing, in person, the event(s) as it occurred to others
  - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

*DSM criterion A may exclude a diagnosis of PTSD in many individuals

10

Post-Traumatic Stress Disorder (PTSD)

The ICD-11 formulation of PTSD requires ***exposure to an extremely threatening or horrific event or series of events***; and the experience of symptoms in each of the following clusters:

1. **Re-experiencing symptoms** such as intrusive thoughts, flashbacks, or nightmares.
2. **Avoidance symptoms**, such as avoiding places or situations that trigger memories of the traumatic event.
3. **Sense of threat**, such as hypervigilance and being easily startled.

To be diagnosed with PTSD, the symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

11

Complex PTSD

In 1988, Dr. Judith Herman of Harvard University suggested that a new diagnosis, "Complex PTSD" (CPTSD), was needed to describe the symptoms of long-term trauma.

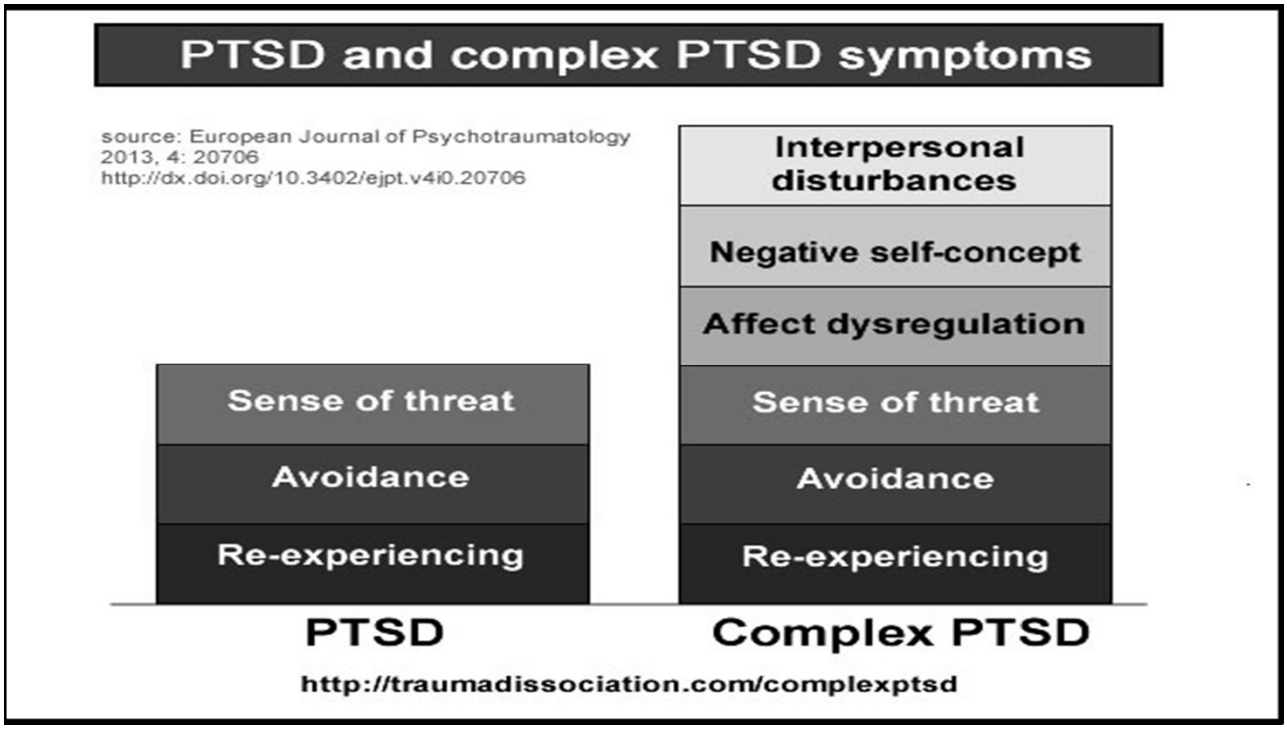
To receive a diagnosis of CPTSD all the features of PTSD must be present; in addition, there must be evidence of Disturbances of Self Organization (DSO) in three additional domains:

1. Problems of affect regulation (e.g. emotional reactivity such as explosive anger and violent outbursts, difficulties calming or soothing oneself after a stressor)

2. Persistent negative beliefs about oneself (e.g. beliefs about self as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event)

3. Difficulties in sustaining relationships and feeling close to others (Relationships often suffer due to difficulties trusting others and the negative self-view; the individual may avoid relationships or develop unhealthy relationships similar to what they knew in the past)

12



13

Complex PTSD

In terms of the trauma itself:

- CPTSD usually results from multiple traumatic events, or when the exposure to trauma is prolonged (although chronic or repeated trauma is a risk factor, not a requirement, for CPTSD; and while it can be diagnosed after a single traumatic event, this is less likely);
- The stressors are typically of an interpersonal nature – that is, resulting from human mistreatment rather than acts of nature or accidents (e.g. childhood abuse, domestic violence, human trafficking, torture, kidnapping, racism, etc.)

14

PTSD, CPTSD and BPD as Different Disorders

- Evidence suggests that PTSD and CPTSD are distinct from, but often co-occur with BPD (Ford & Courtois, 2021; Cloitre et al, 2014; Frost et al, 2018; Knefel et al, 2016).
- Consistent with the idea that chronic or multiple trauma is a risk factor for CPTSD, studies have shown that childhood physical or sexual abuse, particularly within the family, is more strongly related to CPTSD than PTSD (Cloitre et al 2019); CPTSD is also associated with higher levels of psychiatric burden than PTSD, including greater depression and dissociation, and this burden increases when there is co-morbid BPD (Hyland et al, 2018; Cloitre et al, 2019)

15

Complex PTSD	Versus	BPD
Problems calming self & finding comfort when distressed; chronic emotional numbing; substance use; often over-regulated (emotional numbing, avoidance, dissociation). Anger, suicidal and self-injurious behavior occur occasionally.	- Emotion Dysregulation -	Recurrent suicidal behaviors, gestures, threats, and self-harming are more frequent; emotional lability; extreme, uncontrolled anger; profound emotional dyscontrol; typically underregulated
Stable, deeply negative; chronic sense of guilt, shame, worthlessness	- Sense of Self -	Highly unstable, polarized positive and negative perceptions of self Chronic sense of emptiness
Avoidance and detachment based on a fear of closeness; they may desire a relationship, but fear and shame prevents them from pursuing one.	- Relationships -	Pronounced reactive hostility in relationships; oscillating between idealizing and disparaging; intense fear of abandonment and behaviors to avoid this. Often an overwhelming need for closeness and demanding behaviors to fulfill this need.
**Required	- Traumatic Event -	**Not required; and some studies are showing that emotional abuse & neglect are more likely in BPD (Ford & Courtois, 2021)

16

Complex PTSD: Sorting out the Language

Developmental Trauma – proposed as a new diagnosis by van der Kolk & colleagues; this refers to trauma that takes place in childhood and/or adolescence, while the brain is still developing – essentially, C-PTSD for children; often involves attachment trauma.

- currently this is often mis-diagnosed as pediatric Bipolar Disorder, Oppositional Defiance Disorder, Conduct Disorder, and ADD/ADHD, and therefore treated with medications rather than addressing the trauma

Relational Trauma – refers to trauma that happens within a close relationship; this can happen in relationships in children or adults; when this occurs in developmental years it's also referred to as Attachment Trauma

Relational Trauma may lead to C-PTSD: for children, attachment is survival! So when attachment is damaged, lost, or inadequate, the child may experience the world as unsafe, without explicit memory or experiences of "trauma"

Traumatic Invalidation – can also lead to C-PTSD. When internal experiences are regularly invalidated by people in the environment; invalidation can be traumatic when it is severe, long lasting, and negatively affects your understanding of yourself and the world (Linehan, 2014). Examples of traumatic invalidation include emotional or verbal abuse, neglect, discrimination, being blamed or disbelieved when telling someone about a trauma you experienced

17

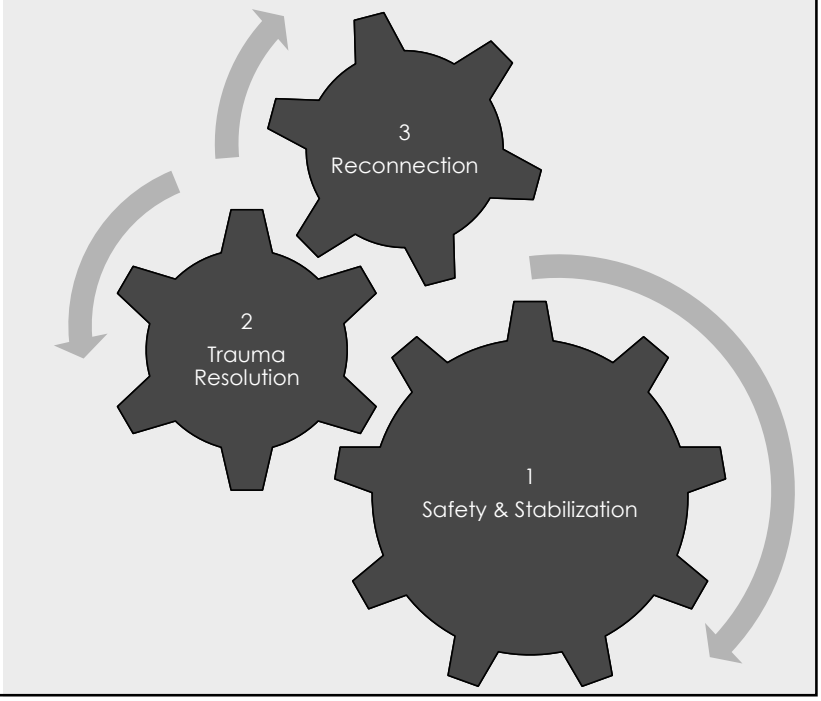
International Trauma Questionnaire

At present only one instrument is available that specifically assesses ICD-11 CPTSD, the International Trauma Questionnaire (Cloitre et al, 2018):

International Trauma Questionnaire: ITQ (traumameasuresglobal.com)

18

Triphasic Model of Treatment (Herman, 1992)



19

The Triphasic Approach to Treating Complex Trauma

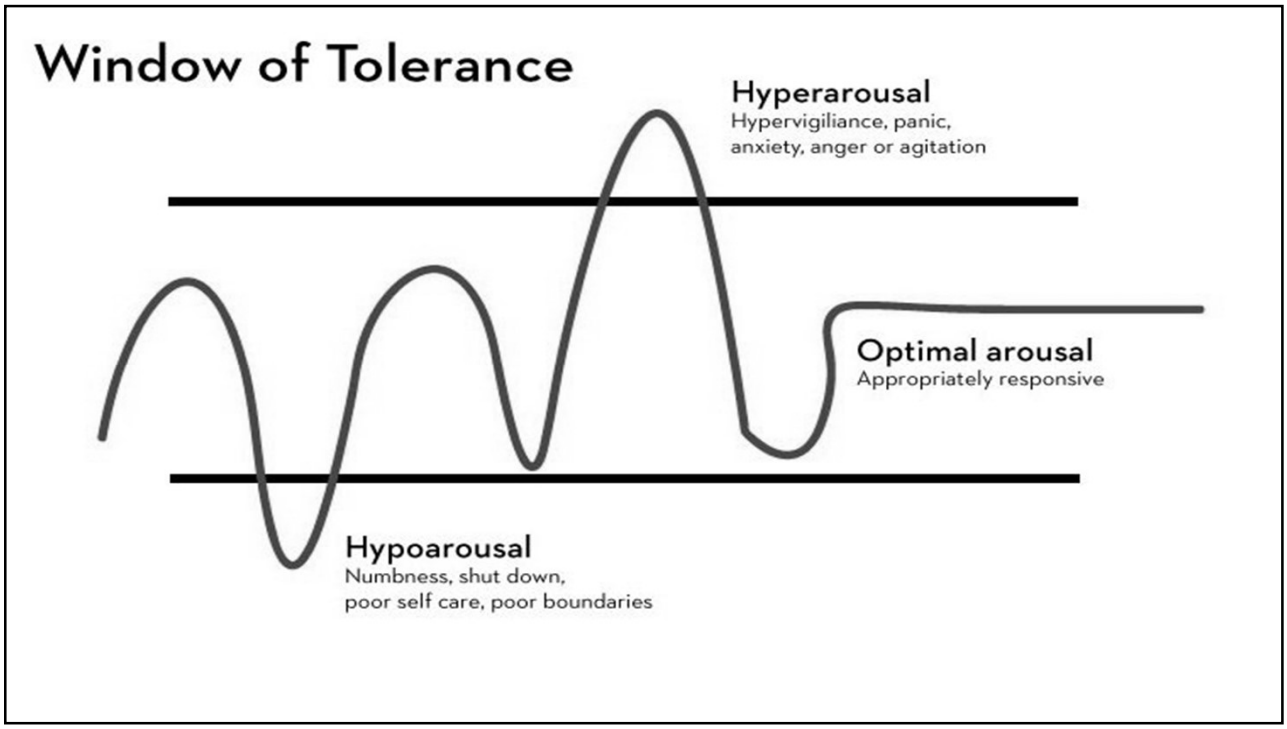
(based on Janet, 1907 & Judith Herman, 1992)

(Keeping in mind that CPTSD is a newer diagnosis and so research is on-going regarding how best to treat it…)

Stage One: Safety and Stabilization: Focus is on helping clients identify the issues that brought them to therapy, learn to manage dysregulation, develop resources, and resolve any major internal conflicts in preparation for Stage 2 (trauma resolution)

- Develop and build the therapeutic alliance (expect this to take longer for a client with relational trauma!)
- Identify presenting issues and concerns, including risk factors, and medical or trauma-related symptoms that may interfere with successful treatment or contraindicate the use of particular interventions (such as EMDR), and that may need immediate attention (e.g. disordered eating)
- Take a thorough history, (not delving into details of trauma and keeping the client within their window of tolerance), and identify current and past sources of resilience

20



21

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

History Taking:

- Remembering that there may not be an explicit memory of the trauma, but that *the body keeps the score*!
  - What were/are relationships like in the family of origin?
  - What's NOT being said? (e.g. a client who notes their parent was an alcoholic but then reports "childhood was great"; client might not know to report "no one was home at dinnertime so I had to make myself a sandwich when I was six"; new client)
  - e.g. From a Biosocial Theory perspective
  - e.g. From an Adaptive Information Processing (AIP) perspective
  - ***This should include screening for dissociation!*** e.g. The Dissociative Experiences Scale (DES and DES-T)

22

The Biosocial Theory
(Linehan, 1993)

Pervasive emotional dysregulation is the result of two main factors:

1. A biological predisposition to emotional vulnerability (high sensitivity) AND
2. A pervasively invalidating environment (e.g. the abusive home, the poor fit, the chaotic home)
   - Where the individual's internal experiences are regularly judged, punished, minimized, ignored, etc.

23

The Biosocial Theory
(Linehan, 1993)

Consequences of the emotionally vulnerable child growing up in the invalidating environment:

- The child doesn't learn to label or trust private experiences, including emotions; instead, they learn to search their environment for cues on how to think, feel, and act
- They therefore don't learn to modulate emotional arousal; or how to respond appropriately to distress
- "Problem Behaviors" are the result of unhealthy attempts to regulate emotions

24

The Adaptive Information Processing (AIP) Model

(Shapiro, 1995)

- Usually, we're able to heal from disturbing events we encounter; but sometimes things happen that overwhelm our ability to cope, resulting in the trauma becoming "stuck", or remaining "unprocessed" – unable to link up with more adaptive information
- From this perspective, we conceptualize the client's current symptoms based on the maladaptively stored information

25

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- Develop an initial plan for the subsequent treatment stages
- Provide psychoeducation about trauma and its effects (including the fact that talking about the trauma prematurely isn't typically helpful and sometimes causes more harm) – we'll come back to this with Polyvagal theory as well!

26

The Triphasic Approach to Treating Complex Trauma

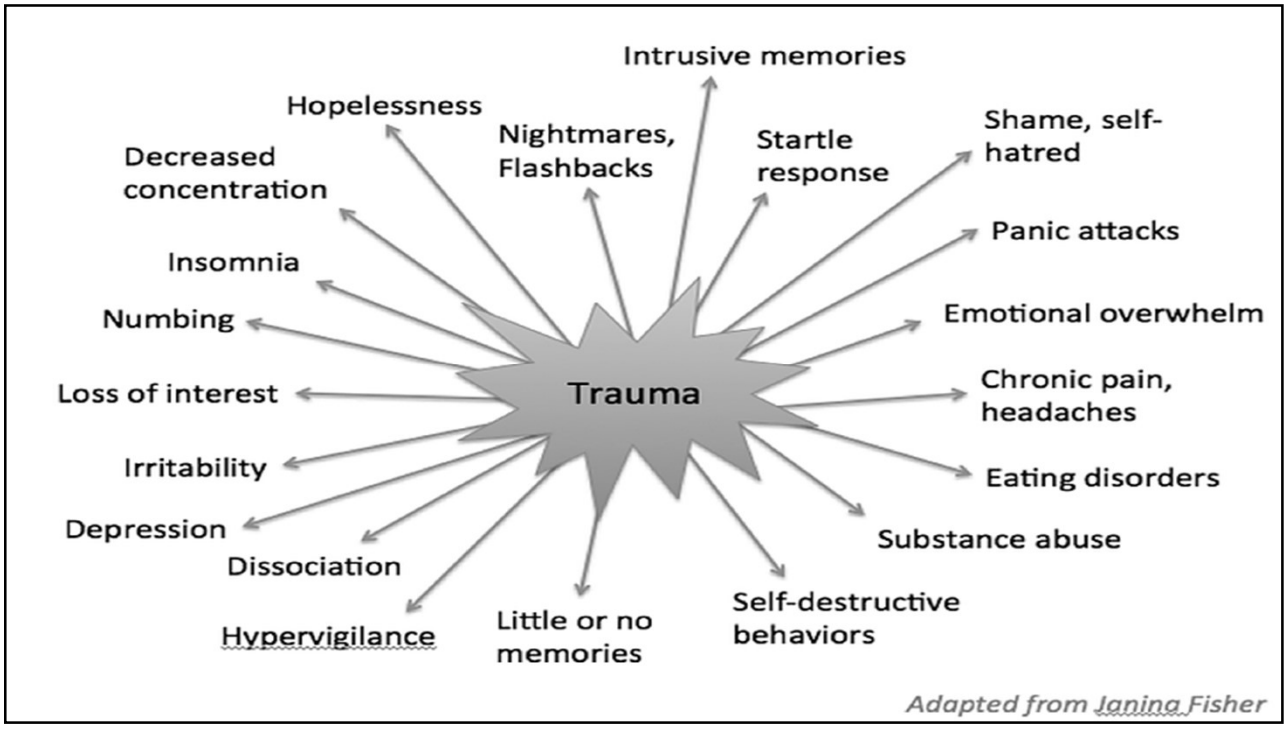
(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization: Identifying Triggers

"When we remember a traumatic event or are triggered by some small cue in the here and now, our bodies automatically begin to mobilize for danger, not knowing that we're *remembering* threat rather than being threatened now" (Fisher, 2021, p. 96).

- This is because the amygdala - the part of the brain that responds to stress and triggers our active defenses – can't differentiate between past and present, so we feel as though the danger is happening *now*.
- Flashbacks and dissociation are obvious signs of being triggered, but signs can also be subtler, such as:
  - Feeling like you're not in control of your reaction
  - Having a reaction that seems more intense than what's warranted by the situation
  - Having a reaction different from how you would usually react
  - Becoming stuck in your reaction, unable to step back and access your internal wisdom
  - Feeling as though you're "not yourself", as though another part of you has taken over

27



28

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- Teach skills to increase stability (externally – e.g. housing, finances, relationships; as well as internally - emotion regulation, dissociation, self-care)
- "Bottom-Up" skills to re-regulate quickly (F-TIP Skills):
  - Forward Bend (PNS)
  - "TIP" the temperature of your face (mammalian dive reflex)

*****clients with anorexia and/or bulimia, who have low bp or take beta blockers cannot do this skill without first checking with their doctor!**

  - Intense exercise
  - Paced Breathing (PNS)
  - Paired Breathing: Progressive Muscle Relaxation + Paced Breathing
  - (Hyperventilation technique)

29

Mindfulness for CPTSD ("top-down")

Stage One: Safety and Stabilization:

- One study of an online mindfulness-based intervention demonstrated reduced CPTSD DSO symptoms, particularly negative self-concept and disturbances in relationships; reduced the PTSD symptom of sense of threat, and promoted positive mental health (Dumarkaite et al, 2021)
- Another study on mindfulness for PTSD: "findings suggest the mindfulness facet most relevant to PTSD may be nonjudging of inner experience" (Reffi et al, 2019)
- Aliche et al (2021) found that mindfulness reduced PTSD symptoms associated with experiential avoidance
- I believe everyone can benefit from mindfulness, AND we want to be cautious about how we're introducing mindfulness to someone with a trauma history – e.g. informal versus formal mindfulness; caution re: focus on body or breath; eyes open versus closed

30

Resourcing (Top-Down & Bottom-Up)

Stage One: Safety and Stabilization:

Secure (Calm, Healing, Peaceful) Place

Container

Protective Figure

Nurturing Figure

Wise Figure

New Parent

31

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- For clients who are highly dissociative, Stage 1 will also include understanding how the client's self-system is organized, obtaining on-going consent from all parts, orienting parts, and working on resolving conflicts between parts
- Psychoeducation (we all have parts!); for clients with very complicated internal systems, this may be a problem itself (red flag!)

32

The Triphasic Approach to Treating Trauma

Stage Two: Trauma Resolution: focuses on coming to terms with and resolving past, painful experiences and present triggers for that pain. Tasks include:

- Overcoming fears of the memory, triggers, and cognitions
- Accessing and resolving old, painful experiences
- Accessing and resolving present triggers that connect to the painful experience
- Depending on the treatment, an additional task in this stage may be restructuring trauma-based personal schemas (in EMDR therapy this happens naturally as a result of reprocessing dysfunctionally stored material)

**Not all clients will choose or be able to engage in Stage 2 work

33

Stage Two Treatments

- Eye Movement Desensitization and Reprocessing (EMDR)
- Deep Brain Reorienting (DBR)
- Ego-State Therapy
- **"Four Blinks":** Four Blinks Version of Flash: An Open Approach To Trauma Reprocessing – Rapid Memory Reconsolidation Resources (video)
- Internal Family Systems
- Prolonged Exposure/DBT-PE
- DBT-PTSD
- Cognitive Processing Therapy
- Somatic Experiencing
- Sensorimotor Therapy
- Trauma-Informed Stabilization Therapy

** again, research is on-going for CPTSD

34

The Triphasic Approach to Treating Trauma

Stage Three: Reconnection: focuses on integrating the changes within the self and in day-to-day life, consolidating gains, and (re-)connecting to a meaningful life.

- Addressing any existential, identity, and attachment-related issues (e.g. "Who am I, now that I'm no longer defined or held back by my trauma?")
- Developing a more consistent sense of mastery in life and self-sufficiency through learning skills for handling "ordinary" life difficulties
- Considering longer-term goals
- Achieving relief of any residual symptoms
- Concluding the therapeutic relationship ("what does it mean that we won't be working together any longer?", "will you be here if I need you in future?")
- (DBT Skills that I often use here: assertiveness, limit-setting, acceptance)

It's important to recognize that these stages of treatment don't exist separately from one another – clients will shift back and forth between stages at times

35

Polyvagal Theory (Stephen Porges, 1994)

Polyvagal Theory (PVT) is a popular approach to explaining how neurophysiology impacts our emotional states. It is evidence-based, but there is still debate about it.

- The Autonomic Nervous System (ANS) is a system that involves various organs from the brain to the colon; the Vagus Nerve links them all together.
- The job of the ANS is to keep us alive; it plays a central role in regulating emotions, behaviours, and the body's automatic reactions to social and environmental challenges, acting ***outside of our conscious awareness.***
- Historically we've known the ANS to have two distinct branches: the sympathetic (SNS - "fight or flight") and the parasympathetic (PNS - "rest and digest").
- PVT postulates that there are **two** branches (SNS and PNS), but **three pathways**: with the PNS being split between the Dorsal Vagal and the Ventral Vagal

36

Polyvagal Theory (Stephen Porges, 1994)

Neuroception:

- The term coined by Stephen Porges to refer to our unconscious perception (based on our senses) of safety or danger in the environment.
- The ANS constantly scans (6 times per second) inside your body, the environment outside your body, and what's happening between you and the people around you; it's the filter between us and the world
- Neuroception occurs deep underneath the conscious level of awareness – it's instant and automatic.
- How we neurocept is also influenced by what autonomic state we're in; our ANS is shaped by experiences, habitual responses, and patterns; and what we neurocept leads our ANS to respond in a certain way (active or dissociative defenses)

37

Polyvagal Theory (Stephen Porges, 1994)

- When a human neurocepts an unfamiliar or possibly dangerous stimulus, our brain orients to the stimulus; if it's determined to be safe or non-life-threatening, we return to a state of calm. If the stimulus is perceived to be harmful or dangerous, a defensive response from the ANS follows (**unconsciously**!)
- **Active** defenses are primitive, reflexive actions that include:
  - Crying for help
  - Flight
  - Or, if escape is not possible, Fight
- When active defenses are not possible, the next line of defense is **immobility**:
  - the hyper-aroused *freeze* response ("deer in the headlights"); or
  - the hypo-aroused response of *collapse/submit ("playing possum");* this submit response is the last mammalian defense prior to the onset of death, reducing ability to feel pain. In the context of day-to-day life, this shut-down can include dissociation, or collapsing into paralyzing experiences of depression, shame, or emotional and physical numbness

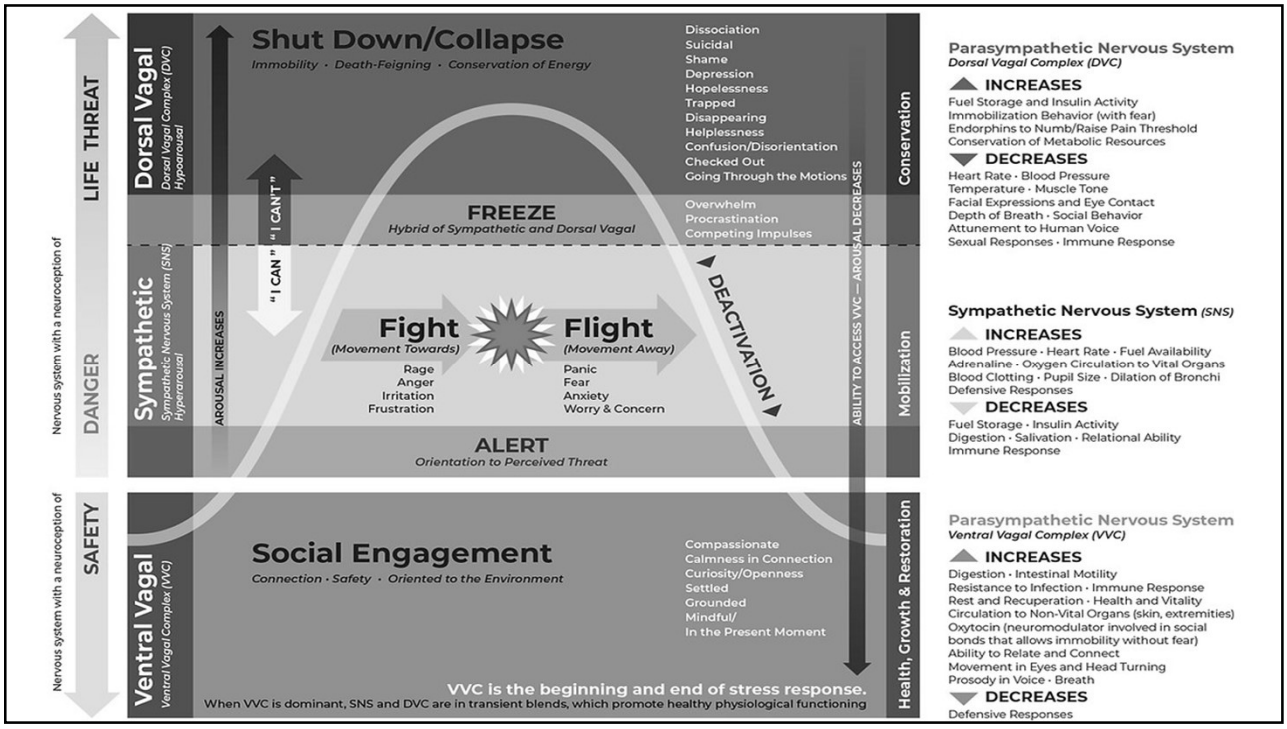
38

Polyvagal Theory (Stephen Porges, 1994)

Co-Regulation:

- The process by which a nervous system is reciprocally regulated (brought back to "safety") in the presence of a safe "other" (caregiver, parent, etc).
- Co-regulation is imperative to a person's ability to move into safe relationships and meaningful connections, and therefore to survival.
- We influence others around us through their neurocepting the signals we send.

39

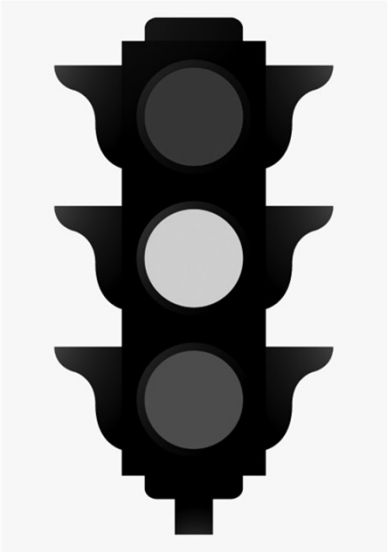


40

Ventral Vagal (Green Zone; WoT)

- Most recent in terms of evolutionary development
- Supports social engagement
- Heart rate slows (65-70bpm resting)
- Saliva & digestion are stimulated
- Facial muscles are activated
- Increased vocal prosody (versus monotone) and eye contact
- **Middle ear muscles are turned on, allowing us to better hear sounds in the mid-range, including the human voice**
- "Safety is a necessary prerequisite for strong social connections":

  Safety => Proximity => Contact => Bonds
- Everything isn't necessarily peaches and roses here, but we have access to our PFC!



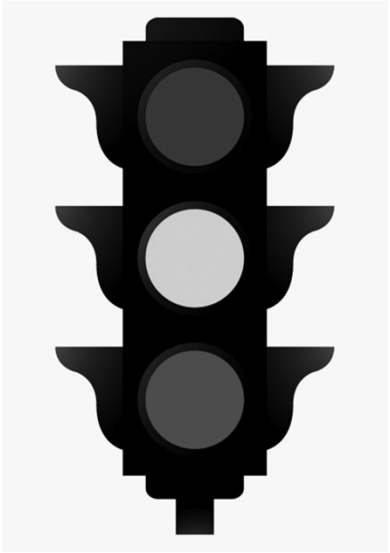
41

Green Zone

42

Sympathetic (Yellow Zone)

- Heart rate increases (110bmp = amygdala hijack)
- Pain tolerance increases
- Middle ear muscles turn off: better to hear extreme low and higher frequency sounds (predator sounds)
- Healthy individuals can bounce between Green & Yellow with ease (playfulness; healthy stress)
- Clinically: client with PTSD related to her husband's death; she's able to recall the events of his death within her WoT (tearful, anxious), but is able to stay in or return to the present and reconnect with me.



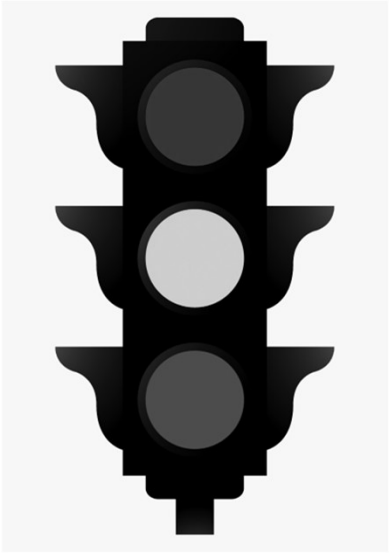
43

Yellow Zone

44

Dorsal Vagal (Red Zone):

- Oldest system, associated with reptilian brain; path of last resort!
- Supports defensive immobilization and "shutdown" behaviours
- Heart rate decreases (60 and below)
- Death feigning - DISSOCIATION
- Understanding the Red Zone helps us to better understand Trauma
- Clinically: client gets highjacked by a memory and dissociates into trance



45

Red Zone

46

PVT: The Story of Trauma Survivors

- Individuals stuck in the dorsal vagal state may carry a story of loneliness, shame, depression, suicidal and self-harming thoughts and behaviors, and dissociation.
- Stuck in the sympathetic state, individuals with unhealed trauma may carry a story of anxiety, mistrust, and difficulties managing emotions
- When survivors are in the ventral vagal state, they're able to let go of these stories and become more connected with and attuned to others.

47

Personal Profile (Deb Dana)

For each of the three zones:

1. I am…(e.g. at peace; cautious; shut-down)
2. The World is…(e.g. calm; overwhelming; terrifying)
3. What word best describes the state for you? (e.g. Chill; Defcon 1; Gone)
4. What are things you can do to help you stay in Green on your own? And with others?
5. What things can you do on your own and with others to help move you out of Yellow and Red? (it takes 20 minutes for us to move back into Green when in full fight/flight)

- Name (the state) to tame it…Understanding the state reduces the shame!
- Trauma isn't psychological, it's physiological

48

Polyvagal Theory (Stephen Porges, 1994)

Ways of stimulating the Vagus Nerve:

1. (Forward Bend)
2. (Paced Breathing)
3. Stimulate the salivary glands
4. Mindfulness meditation
5. Physical exercise
6. Cold water immersion (with caution)
7. Hum, sing, chant, talk or shout, laugh, gargle (the vagus nerve is connected to the vocal chords)
8. Massage

(Safe and Sound Protocol (SSP))

49

Polyvagal Theory (Stephen Porges, 1994)

Criticisms of PVT:

- The model contains vague concepts that can't be tested as a scientific theory
- It over-simplifies the complexities of human emotions and reactions, ignoring the heterogeneity of internal experiences and discounting individual temperament and personality
- The evolutionary ideas are also disputed

50

Diagnoses from a PVT Perspective (Ford & Courtois, 2021)

- PTSD = ***freeze*** response (Yellow Zone): orienting response to scan the environment for stressors and for ways to avoid harm or signs of potential threat (i.e. avoidance based on intrusive re-experiencing of trauma memories)
- CPTSD DSO Symptoms = ***flight*** response (Yellow/Red Zone): unmodulated distress (i.e. difficulty in self-calming, guilt, and sense of worthlessness); and conscious and unconscious attempts to avoid further harm (i.e. emotional numbing and relational detachment). Therefore, CPTSD might be understood as the maladaptive persistence of an initially adaptive stress response that progresses from hypervigilance (i.e., PTSD) to shut-down (i.e., DSO).
- BPD = ***fight*** response (Yellow Zone) when executive control capabilities aren't sufficient to sustain PTSD's freeze/hypervigilance or CPTSD's flight/detachment

51

Polyvagal Theory (Stephen Porges, 1994)

Resources:

- https://www.youtube.com/watch?v=ZdIQRxwT1I0&t=2s
- https://www.bing.com/videos/search?q=seth+porges+polyvagal+theory+on+youtube&view=detail&mid=BC9D971A7BED21C47BCFBC9D971A7BED21C47BCF&FORM=VIRE

52

Dissociation: What is it?

"Dissociation is the essence of trauma" *(Van der Kolk, 2014)*

- We still lack consensus on a definition! ISSTD Definition: ***Involves the total or partial loss of awareness or knowledge, inner body sensation, five-sense perception, emotions, thoughts, perceptions, memories, impulses, and/or sense of self***

Examples:

- a client reports loss of feeling in her hands after she mentioned to me in session that her hands had been badly injured when she was a child;
- during assessment a client mentions they have "no memory" of their life before age 10;
- a client starts describing how she worries she's going to find her son dead from suicide, but expresses no emotion;
- a client informed me that her brother, who had sexually abused her when they were growing up, was supposed to come for a visit at Christmas-time, but when I asked about this two weeks later, she had no memory of the visit.

53

Dissociation: What is it?

- **Not all dissociation is problematic, or a sign that trauma has occurred! -** e.g. daydreaming, highway hypnosis, absorption in a book or movie
- Dissociation becomes problematic when it occurs frequently, is activated in inappropriate circumstances, interferes with daily life functioning, or involves the symptom of identify alteration (and we need to consider the client's perspective of this experience – culture, spiritual/religious beliefs, etc.).

54

Dissociation: What is it?

- Peritraumatic dissociation (PD) is dissociation that takes place at or around the time of a distressing event; it helps us to survive ("the escape when there is no escape" – Putnam, 1997)
  - It's an instinctive, automatic distancing from unbearable pain; or a way of maintaining attachments
  - It allows overwhelming experiences to be split off from and held outside of conscious awareness
- A history of attachment trauma and/or neglect appears to increase the likelihood of PD in the face of traumatic experience; and PD predicts pathological response to trauma (Lanius et al, 2014)
- Dissociation is greater with "betrayal trauma", when a caregiver is an abuser, fails to protect a child from an abuser and/or has an alliance with the abuser (Courtois & Ford, 2009)

55

Key Dissociative Symptoms

Dissociative symptoms commonly occur in many disorders other than dissociative disorders, including PTSD/CPTSD, eating disorders, panic disorder, major depressive disorder, and borderline personality disorder

1. **Depersonalization** – the sense of being disconnected from, or "not in" your body, feeling as though you're an outside observer of your own mental processes, body, or actions
2. **Derealization** – persistent or recurrent experiences of the world seeming unreal or dreamlike, foggy, or distant

(DP/DR are more general symptoms of posttraumatic symptoms, but can also be present in more severe forms – such as dissociative disorders)

56

Key Dissociative Symptoms

3. **Identity Confusion** – feeling as though you don't have a good sense of who you are, what your values are, what you like and dislike, and so on.

4. **Identity Alteration** – At its extreme, this is where a person has DID, and shifts to a different part (or self-state) that may not know where they are, how old they are, and so on. But this can also happen in less extreme ways: like feeling as though there's a different part of you acting at times, and that part doesn't feel like the real you.

(these are the result of more fully-formed self-states resulting from traumatic experiences)

5. **Amnesia** – an inability to recall autobiographical information of various kinds

(amnesia is highly disruptive to an individual's sense of continuity, and ability to be present, aware, and in control; amnesia is therefore recognized as the fullest expression of pathological dissociation, and a defining characteristic of DID).

57

Dissociative Symptoms

Paul Dell notes that, "the phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive (cognitive) functioning and sense of self" (2009); and developed a taxonomy of dissociative symptoms organized into three sets of criteria:

1. General posttraumatic dissociative symptoms – occur not only in dissociative disorders, but in other disorders as well, such as PTSD, panic disorder, conversion disorder, major depression, BPD:
    1. General memory problems – may include day to day experiences like forgetfulness; as well as difficulties with remote memory
    2. Depersonalization
    3. Derealization

58

Dissociative Symptoms

4. Somatoform (conversion) symptoms - bodily experiences and symptoms that have no medical basis; these may affect vision, hearing, sight, smell taste, body sensations and functions, or physical abilities, and are often a partial re-experiencing of the traumatic event

5. Trance - an altered state of consciousness that occurs spontaneously. The person loses conscious contact with what is going on around them and may not respond to attempts to gain their attention (e.g. staring into space, thinking of "nothing", or "going away" in their own mind)

6. Flashbacks - sudden, intrusive memories, pictures, tastes or body sensations, emotions, or nightmares of traumatic events; during a flashback the individual may lose contact with the present moment

59

Flashbacks

- DSM-5 and ICD-11 both recognize flashbacks as existing on a continuum:
  - at one end is total absorption in the traumatic memory, with a complete loss of awareness of the current environment;
  - at the other end of the continuum is a vivid, intrusive memory of the traumatic event in which the person doesn't lose contact with their current surroundings but has a sense that the event is happening again in the here and now.
- This helps differentiate PTSD from other conditions (e.g. major depression) in which there may be intrusive memories of distressing events, but these are experienced as belonging to the past.

60

Dissociative Symptoms

2. Partially-Dissociated intrusions of another self-state into executive functioning and sense of self: symptoms are registered as generated from outside of conscious intention (though not external to the person), and experienced as intrusive or disruptive (for example, hearing child voices, puzzlement about oneself, internal conflicts)

3. Fully-Dissociated Actions of another self-state: the individual experiences amnesia for periods of minutes to days (or more), precipitated by distress for one or more self-states (may include time loss, where the individual discovers they can't account for a period of time; a sense of "coming to"; fugue (suddenly discovering they're somewhere, without memory of going); finding evidence of recent actions, etc.).

61

You Might Not See It!

- Dissociation can be difficult to observe
- Clients might not be aware of the problems – the nature of dissociation is that it is protective!
- Western medicine has "dissociated dissociation!" – clinicians often haven't been trained in dissociation, what to look for, and how to screen
- Other, "more important" treatment targets (e.g. suicidality, self-harming, eating disorders, substance abuse) might distract us from seeing dissociation or inquiring further

62

The Dissociative Disorders

There are five dissociative disorders in the DSM-V-TR:

1. Dissociative Identity Disorder (DID)

2. Depersonalization/Derealization Disorder (DPDR)

3. Dissociative Amnesia (difficulty recalling important information about yourself and your life)

4. Unspecified Dissociative Disorder (used when the symptoms fit the general category of a dissociative disorder but are not specific enough or there's not enough information yet to be classified as a dissociative disorder)

5. Other Specified Dissociative Disorder (OSDD) – where a person experiences dissociative symptoms but does not meet the full criteria for any other dissociative disorder; may be diagnosed when there is an identifiable cause that is not typical of other dissociative disorders.

- There are four common presentations of OSDD:
- **mixed dissociative symptoms**: disturbances of identity without amnesia
- **identity disturbances due to chronic and extreme persuasion**: disturbances of identity due to brainwashing, being involved with a cult, or being subjected to torture
- **dissociative reactions to stress**: dissociation as a result of stressful events that last a few hours to less than one month
- **dissociative trance:** an uncontrollable loss of awareness of their surroundings

63

Ego-State Therapy/Parts Work

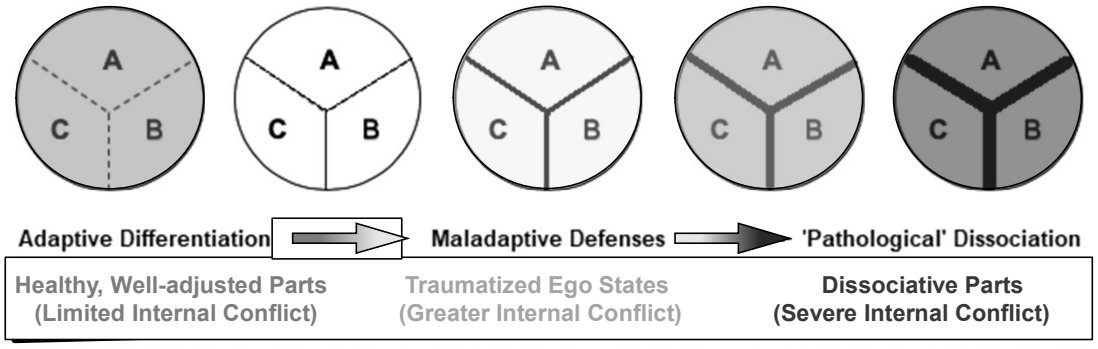
Ways of conceptualizing Self-States/Ego States/Parts:

(yes, they are PART of YOU!)

- Parts are "disconnected containers of implicit memory, driven by instinctive subcortical animal defense responses…a part is the child you once were at a certain age, or the child you had to be in certain situations…it's the little You" (Fisher, 2017)
- Parts are memory networks - bundles of neuronal connections that hold consistent patterns of information that belong to specific ages or situations from childhood
- They're autonomic states (e.g. "my freeze part", or "my fight part")
- Parts are neural networks that know what to expect about the world, and therefore how to respond

64

The Ego State Continuum: From Differentiation to Dissociation
(based on Watkins & Watkins, 1997)



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65

Ego-State Therapy/Parts Work

Ego states can develop in three ways (Watkins & Watkins, 1997):

1. Through normative, healthy differentiation (for example, as I learned and trained to be a psychotherapist, I developed my Therapist part).
2. By unconsciously internalizing certain qualities of others, such as beliefs, values, and behaviors ("**Introjects**"). This commonly happens with children and parents – for example, if your parents always ensured you said *please* and *thank you* as a child, as an adult you may judge people who don't say *please* and *thank you* as impolite. Your parents' value has been internalized as your own.

66

Ego-State Therapy/Parts Work

Ego states can develop in three ways (Watkins & Watkins, 1997):

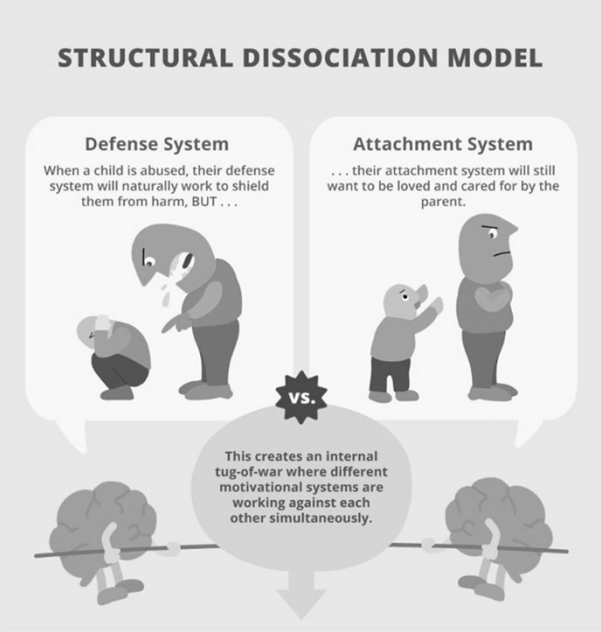
3. As a reaction to trauma: experiencing a traumatic event can lead to the formation of parts associated with those events: Peritraumatic Dissociation is associated with the release of endogenous opioids and endo-cannabinoids that alter communication between lower and higher brain structures (Lanius et al, 2014), creating isolated ego states

- e.g.: a child who is verbally and emotionally abused by a male caregiver develops a part that's triggered when they interact with male authority figures. When a trauma part is activated, you may re-experience emotions, thoughts, and physical sensations associated with the original trauma.

67

Theory of Structural Dissociation of the Personality

When an infant/child (who has not yet developed an integrated personality) is traumatized and receives insufficient soothing, calming, and modeling of emotion regulation, the child may not develop a healthy, integrated personality system of ego-states; instead, the personality divides on "fault-lines" – it becomes structurally dissociated.



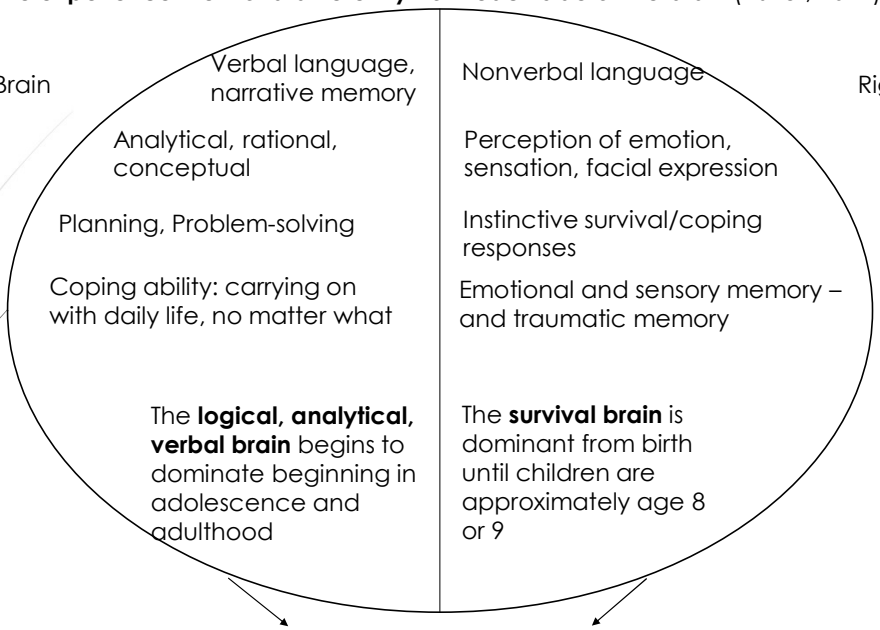
68

Theory of Structural Dissociation of the Personality

Video

69

We experience the world differently from each side of the brain (Fisher, 2022)



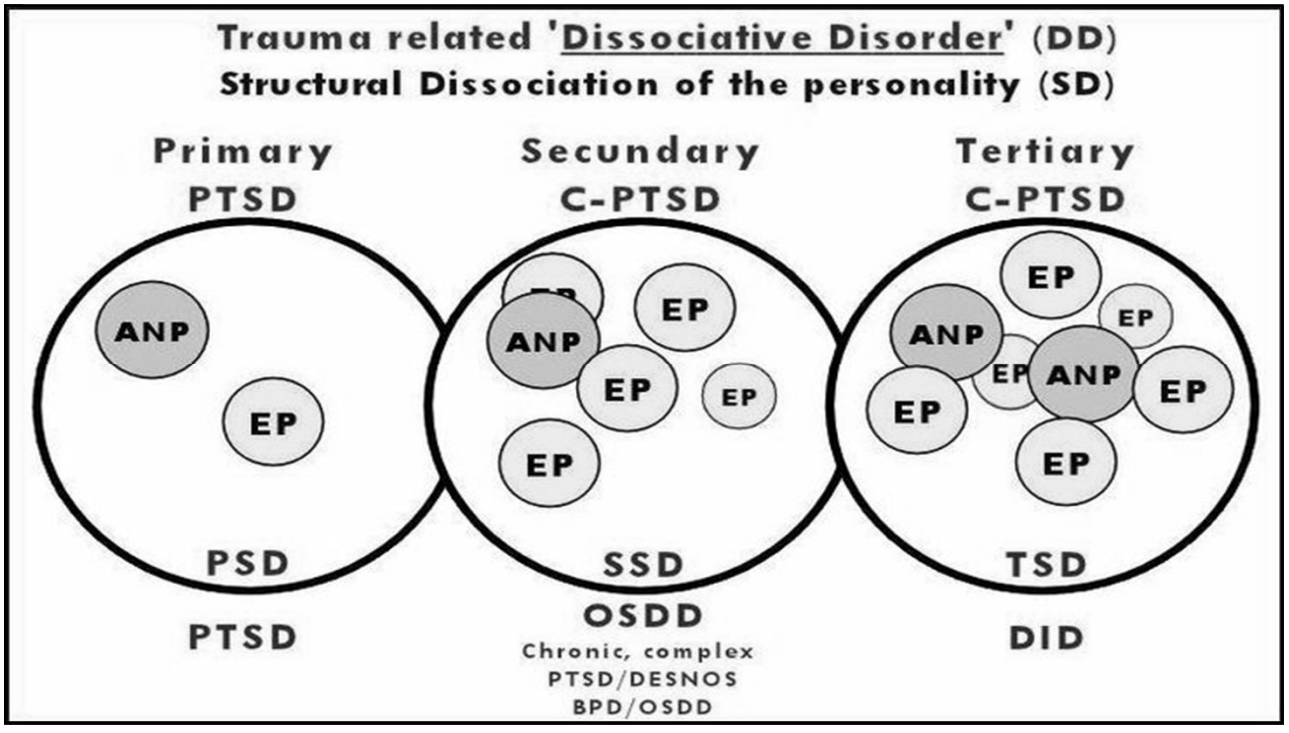
70

Theory of Structural Dissociation of the Personality (SDP)

(van der Hart O., Nijenhuis E., and Steele, K., 2006).

- No single model of dissociation has yet to be established as "fact".
- According to SDP, self-states (Parts) develop as a means of adapting to extreme or chronic stress, such as childhood abuse or neglect; these dissociative structures are based on action systems
- The "Apparently Normal Part" (ANP) of the personality is focused on going on with normal life (PFC)
- "Emotional Parts" (EP's) are triggered by implicit or explicit reminders of traumatic events and are often characterized by intense painful emotions (Limbic System);
  - It's important to understand that the job of the EP is to protect, even if that's not readily apparent (e.g. a 30 year-old client has suicidal thoughts related to a 12 year-old part that started as a means of feeling in control when he lived at home with his controlling father)
- The ANP and EP's can interact in complex and conflicting ways, leading to difficulties with self-identity, emotion regulation, and relationships.

71



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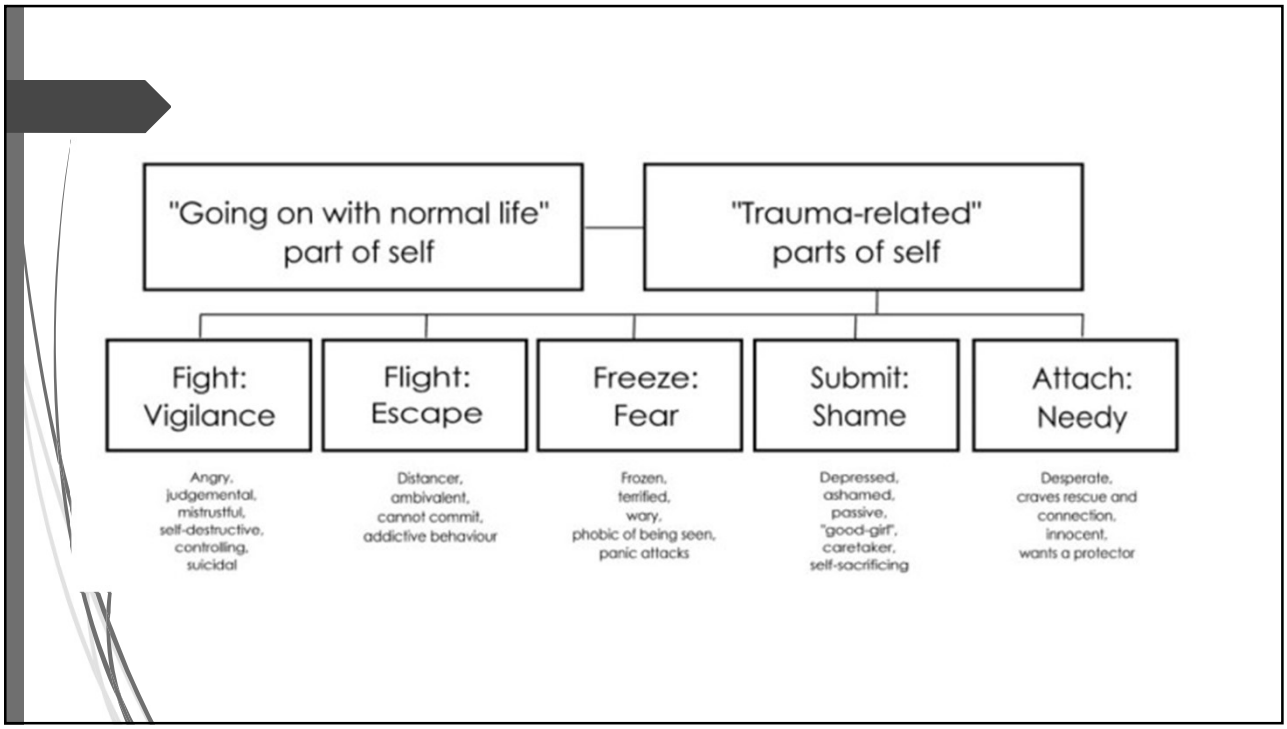


73

SDP: Examples of Parts

Fight: Cory recalls first thinking of suicide when he was 12 years old. He had a very controlling father who didn't understand his depression, and who pushed Cory to do better in school, play more sports, take on more responsibilities, and so on, until Cory finally found escape through fantasizing about taking his life. Now Cory is 30 years old and finds himself thinking about suicide when he feels like he has no control, even though he knows he's an adult and has choices he didn't have as a child.

Flight: Karmen recently left her marriage to an abusive and controlling partner. She had been using drugs for a long time to manage her emotions; but having finally gotten clean from these, she now finds herself alternating between restricting food and bingeing. She doesn't want to do these things but feels like she has no control over herself.

Freeze: Jhavid reports constant feelings of anxiety, and daily panic attacks. Bullied in school for being the only person of color, and growing up with three older brothers who teased him relentlessly for being more sensitive, Jhavid still feels like nowhere is safe.

74

SDP: Examples of Parts

Submit: Marval recalled her mother always yelling at her when she was a child, and even at age 55, she constantly feels like she's doing something wrong. She goes out of her way to try to please others and make them like her, even when that means regularly putting aside her own needs and wants. She also has a habit of over-apologizing, constantly feeling ashamed and not good enough.

Attach: Sam was seeing their new therapist, Shayne, once a week and felt very connected to him, but Sam found they had a strong need to reach out to Shayne between sessions. Sam was reaching out multiple times a day by email or text, and when Shayne told Sam he would only respond to them once a day moving forward, Sam felt very hurt and alone.

75

Structural Dissociation: What to Look For In Adults

(From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

1. Signs of internal conflict: e.g. functioning well at work but struggling in personal relationships; acting out a disorganized attachment—a desperate attach part fearing abandonment followed by a fight part pushing away those who try to get close; a client who reconnected with me to return to therapy but keeps missing or being late for appointments.
2. Treatment History: Often multiple previous treatments with little progress; past treatment may be described as "rocky" or ending badly
3. Somatic symptoms: e.g. high tolerance for pain, or an unusual pain sensitivity, headaches, eye blinking or drooping, narcoleptic symptoms, other physical symptoms with no diagnosable medical cause
4. Atypical or non-responsiveness to psychopharmacological medications

76

Structural Dissociation: What to Look For In Adults

(From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

5. Regressive behavior or thinking: e.g. body language or voice of a young child, shorter sentences, themes relating to separation, caring, and fairness; client is more likely to feel empathically failed when not well understood.

6. Patterns of indecision or "self-sabotage": Ambivalence = conflict between parts with different objectives.

7. Memory gaps and time loss: Difficulty remembering therapy sessions, how time was spent in a day, conversations, getting lost while driving someplace familiar.

8. Patterns of self-destructive and addictive behavior: Fight and flight parts seeking to avoid pain from traumatic past.

**It's the Going On With Normal Life part that's seeking therapy

77

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if they:

- Report a childhood history of abuse or neglect
- Provide vague, inconsistent, contradictory, or poor chronological history
- Notice times where they experience loss of well-rehearsed skills and knowledge

78

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if they have had times when:

- They acted as if they were a child, or like a completely different person
- They found objects in their possession that they don't recall acquiring and that don't make sense for them
- They referred to themselves by a different name
- They noticed distinct changes in their hand-writing
- They experience rapid mood changes without apparent reason
- They heard voices or "loud thoughts" (usually inside the head)

79

Hearing Voices

- Although now recognized as a feature of PTSD (in the DSM-5 and ICD-11), the symptom of hearing thoughts as voices is rarely acknowledged; but hearing voices isn't uncommon in PTSD and especially CPTSD (Anketell et al, 2010). In this study, hearing voices was correlated with increased dissociative symptoms.
- A study by Shinn et al, 2020 concluded that hearing voices is not equivalent to having a psychotic disorder; and that "the experience of voice hearing may potentially be the rule rather than the exception in trauma spectrum disorders" (p. 14).

80

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if in session you observe your client:

- "Switching" – distinct changes in voice, speech, behavior, movement, or appearance
- Referring to self as "we", or in third person ("he/she/they")
- Answering basic questions with puzzled, ambivalent, or conflicting responses
- Reacting strongly to questions about dissociation
- Blinking repeatedly, keeping eyes closed for no apparent reason, or exhibiting "eye rolling"
- Struggling to track from one session to the next

81

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if in session you observe in YOURSELF:

- Feeling confused, or ungrounded: as dissociation disrupts your client's linear thinking and emotional congruity, they may move from one topic to another, or from one emotional state to another, and you find yourself struggling to follow what's happening for them
- Feeling sleepy – your mirror neurons may be picking up on your client being partially absent
- Having a sense of not knowing the client; wondering "who came to therapy last week?" – if your client presents quite differently, with different clothing/hair style, mannerisms, vocabulary, attitude, manner of relating to you, goals for therapy, etc.
- Questioning your memory – the client may have gaps in their memory for previous sessions, and may deny or be unaware of this, suggesting or leaving you questioning if you're mis-remembering

82

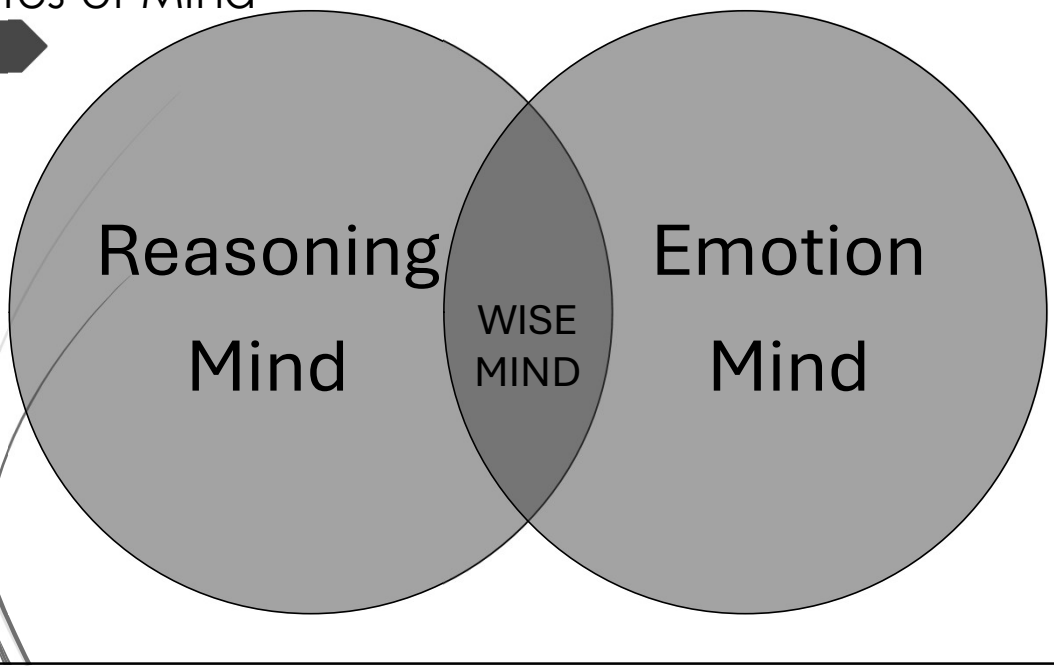
Ego-State Therapy/Parts Work

The Adult Wise Self

- Neither the *going on with normal life part* nor the *trauma parts* are fully integrated, so we want to help our client learn to access their Adult Wise Self/Wise Mind (in IFS this is known as Self or Self Energy)
- I draw on DBT's States of Mind for this:
  - Emotion Mind & Reasoning Mind = Trauma Parts and going on with normal life parts
  - Wise Mind: Emotions + Logic + Intuition (which includes values)

83

States of Mind



84

Core Mindfulness Skills: States of Mind

Reasoning Mind (might be EP or ANP):

- Logical, practical, intellectual, rational, straight-forward thinking
- No emotions involved (or very minimal)
- E.g. making a grocery list; following instructions to bake a cake; balancing your chequebook (as long as there's no anxiety involved!)

85

Core Mindfulness Skills: States of Mind

Emotion Mind (EP):

- You know you're in emotion mind when your *emotions* are controlling your *behaviors*
- E.g. you're feeling anxious so you avoid; your mood is depressed so you withdraw and isolate yourself; you feel angry and you lash out at the people around you
- Emotion mind also includes pleasant emotions

86

Core Mindfulness Skills: States of Mind

Wise Mind:

- It's not that RM and EM are *bad,* and we want to get rid of them; rather, we want to be able to find a balance more often: this is Wise Mind
- Wise Mind = RM + EM + Intuition
- You're in WM when you're thinking about the consequences of your behavior and *choosing* how you want to act rather than reacting.

**WM is fully integrated, having access to all information in the system

87

Core Mindfulness Skills: States of Mind

Differences between EM and WM:

- Both involve an element of emotion, so clients often confuse the two
- In EM, the feelings are more intense, and are *controlling behavior*; there's usually an uncertainty and going back and forth between two choices
- In WM, there's a feeling of peace or calmness ("rightness") about a decision
- EM can often "trick" us into thinking it's WM – we have to *go within*; this usually takes practice

88

Core Mindfulness Skills: States of Mind

Exercises to help clients get to Wise Mind:

- "What does your Wise Mind tell you?"
- Turning inward exercises – e.g. Stone flake on a lake; going down a spiral staircase within yourself
- Breathing exercise: breathing in "Wise", out "Mind"

89

Core Mindfulness Skills: States of Mind

Often just identifying what state of mind is there can help someone take a step back if they're in EM or RM

Help increase awareness of these states by having clients notice regularly ("short cut")

Mindfulness and many of the DBT skills will help people access WM

90

Ego-State Therapy/Parts Work

Working with Parts:

- ***It's important for parts to know that we're not trying to get rid of them!!!***
- Instead, the focus is on helping the client get to know their internal system and helping the system work together more effectively (Stage One of Herman's Model)
- Brain scan research on clients with DID has demonstrated an association between the ANP and the PFC; while none of the trauma-related parts' brain scans show cortical activity (Fisher, 2017)
- Therapies: Ego-State Therapy, Internal Family Systems, Trauma-Informed Stabilization Treatment

91

Strategies: The Meeting Place (Video)

- The client chooses a place they'll be meeting with their parts; this can be based in reality, or fictional, and can be an indoor or outdoor space; have the client close their eyes if possible and imagine this place in as much detail as possible (client describes their meeting place; elicit as much details using as many senses as possible)
- Have the client create a door in their meeting place
- Instruct the client: "When you're ready, unlock the door, open it up, and invite in any parts that would like to join us".
  - Attending the Meeting Place is voluntary for parts; parts may come in but not want to participate in any way, which is fine.
  - Let the client know that parts may appear as other versions of themselves; but they may also appear as unfamiliar: they may be a gender different from the gender the client identifies with; they might be animals or inanimate objects; they may be insubstantial and so are more "felt" than "seen"
  - When the client indicates that parts have come in: "Before we start, I want to let all parts know that this is a safe place, where no one is allowed to hurt anyone else. The meeting place is a place where we're working on getting to know one another, and increasing communication between everyone. Is everyone in agreement?"
- You can then open up dialogue (e.g. do any of the parts have anything they'd like to share, or questions they'd like to ask?)
- Other ways of encouraging communication with parts: collage, drawing, non-dominant hand drawing, Sand Tray

92

Blending With Parts

- When a part takes over and is controlling thoughts, emotions, physical sensations, and body functions, the client has become blended with the part (Schwartz, 1995); they can't tell the difference between their experience and that of the part.
- Blending with a part isn't inherently "bad" – it can be helpful when a part takes over to navigate a specific situation where that parts' skills are required.
  - e.g. a parent who's a doctor – isn't it better for the Doctor part to take over when their child is injured, to deal with the immediate crisis, rather than having the worried Parent part in charge?
- In a healthy system the part will unblend, stepping aside for the wise self to take the wheel again once that need is resolved; when this doesn't happen in a natural and fluid way – as is often the case for individuals with CPTSD – it becomes problematic.

93

How to Unblend

Step One: Assume that any painful or overwhelming thoughts and emotions are communications from parts (Fisher, 2017).

Step Two: Rather than referring to parts' experiences as *yours*, refer to them as belonging to the part (*There's a part of me that feels angry*). Notice what happens when you describe *the parts'* experience – often people note a calmness, reduction in tension, or sense of relief as the part feels validated.

Step Three: See if you can create some space between yourself and the part, so you still feel the parts' feelings, but less intensely, and you're able to feel yourself at the same time. A change in your body position (like a forward bend!), paced breathing, or looking at your hands to remind yourself of your current age can help; and continue to use parts language: *That part of me is feeling…* or *that part of me is thinking*.

94

How to Unblend

Step Four: From your wise mind, consider what the part needs:

- if this was your child, your friend, or your partner, what would you say or do for them?
- depending on the age of the part, you might ask, *What do you need to help you feel less (angry, afraid, ashamed, etc.) right now?*
- if this is a young part, asking might not be appropriate – a 5 year-old can't usually articulate what they need! So, ask yourself, *If this was a 5 year-old child with me right now, feeling afraid, what would I do or say?*
- then, try it: imagine yourself having that conversation with your 16 year-old self; or feel yourself hugging that 5 year-old child.
- notice if the part responds: if you don't get a positive response, you can try again – maybe the part hears your words but doesn't feel them; or perhaps this part struggles to trust and it will take time to build a relationship with them. If the part is responsive, notice how it feels for you that the part feels soothed, reassured, a little calmer, or whatever their experience was.

95

Strategies: Mindful Noticing & Internal Dialogue

- What do you notice happening inside right now?
- If you turn inward right now, are you able to identify what part is responding?
- What does that part need? Can you check in with that part (if appropriate)? Based on what you know about_____, can you think of something that part might find helpful? (e.g. "Based on what you know about 5 year old kids, what do you think would help that young part right now?")
- Parts often need ***validation***, reassurance, orienting to time and place
- As you (validate that part, hug that part, assure that part you're going to continue to check in with them…) How is that part responding?
- What's it like to sense that part feeling… (e.g. reassured by your words)?
- If client really struggles: imagine you have a 5 year old sitting with you right now; would it be okay to tell them they should just get over this? What would you want to say or do for them instead? Some clients may need even more distancing (e.g. The Bonnyville Intervention)
- "How do you feel towards (that part, that physical sensation, etc)?" – activates PFC "witnessing mind" and encourages a perspective of "separate from and in relationship with" (Taylor-Shore)

96

Strategies: Grounding & Orienting Strategies

Grounding:

- Ice pack
- "Big Toes Little Toes"
- Tell me 3 things you see that are… (red, round, etc.)
- Look at your hands; are these 5 year-old hands, or are they 40 year-old hands?
- Having the client stand up and face the door: reach for the door handle; are you the height of a 5 year-old, or of a 40 year-old?
- Can that part of you feel how long your body is? Are they able to sense that this isn't a 5 year-old body, but a 40 year-old body?
- Tell me where you live now? And who do you live with? And where did you live when the (abuse/bad things) were happening?

97

Resourcing (Top-Down & Bottom-Up)

Secure (Calm, Healing, Peaceful) Place

Container

Protective Figure

Nurturing Figure

Wise Figure

New Parent

98

Dissociative Experiences Scale (DES)

Average DES Scores in research	
General Adult Population	5.4
Anxiety Disorders	7.0
Affective Disorders	9.35
Eating Disorders	15.8
Late Adolescence	16.6
Schizophrenia	15.4
Borderline Personality Disorder	19.2
Posttraumatic Stress Disorder	31
Dissociative Disorder Not Otherwise Specified	36
Dissociative Identity Disorder (MPD)	48

http://traumadissociation.com/downloads/information/dissociativeexperiencesscale-ii.pdf

99

Assessment Tools for Dissociation

- Cambridge DPDR Scale
  https://www.wspce.org/couples/Cambridge%20Depersonalization%20Scale-chart-scoring%20version.pdf
- Multidimensional Inventory of Dissociation (MID)
  https://www.mid-assessment.com/

100

Client Story: Gabrielle (DES & MID Example)

101

Ending In Safety

Be sure to always end the session in safety, with your client grounded in the present.

Kluft's "Rule of Thirds" for therapy with clients with C-PTSD:

1. Checking in, catching up, reviewing any homework, making a plan for the session
2. Doing the deeper healing work
3. Closing the session: closure, stabilization, homework and planning for the upcoming time between sessions

102

103

The Complexities of Complex PTSD: References

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