Understanding and Working with Complex Trauma and Dissociation

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Presented at:
Mid-Valley Behavioral Care Network
9 April 2013
Abstract
Every clinician has at least one; the difficult, demanding client. This client lives in chaos, complicating treatment with frequent calls, constant crisis, unremitting self-mutilation, and repeated threats of suicide. They come to you labeled problematic, oppositional, manipulative, or worse – Borderline. They present with a history of diagnoses including depression, bi-polar disorder, generalized anxiety disorder, schizoaffective disorder, eating disorders, as well as multiple addictions. With such a complex array of emotional and behavioral difficulties, there are no simple solutions; only a maelstrom of intra-psychic dynamics, overwhelming emotions and distorted beliefs generating internal storms and external anguish.

This workshop synthesizes state of the art knowledge about complex post-traumatic stress disorder, attachment theory, and dissociative defenses as well as often overlooked but equally critical issues of power, control and shame. Empathic attunement to this complex interplay empowers therapists to formulate effective and nuanced treatment plans. Client reactions are reframed, shifting from oppositional or manipulative to an appreciation of the nature of their defenses, the history of their abuse and the direction of their healing.

This seminar will focus on clinical concerns and conflicts, common in the first two stages of treatment, which derail the therapy process. This is a practical workshop, emphasizing skills, techniques and perspectives that help the therapist connect with the client and help the client move beyond therapeutic impasses and acting out behaviors.

The workshop will also address the common reactions of therapists in situations where the client’s behavior leaves the therapist feeling lost, frustrated and confused. The practicum will include opportunities for participants to discuss their own clinical cases and apply the ideas of the workshop to them.

The therapist is challenged to identify the trauma in a way that advances the therapy by exploring what is being expressed through the therapeutic relationship. The therapist is challenged to be and empathic engaged and sensitive to the dynamics within the client and within the transference. The therapist is challenged to communicate in ways and on levels where language often fails. The therapist is challenged to guide the client through new ways of thinking and perceiving.

Objectives
Participants will be able to:
- Evaluate clients for complex trauma histories and dissociation defenses
- Delineate how complex trauma and dissociation complicate treatment and describe appropriate & effective treatment strategies
- Describe treatment interventions to increase client safety and stability
INTRODUCTION
Overview
Co-Morbidity of Complex Trauma & Dissociation
Impact of Complex Trauma & Dissociation
  On Client's Lives
  In Clinical Practice
Take Home Message:
  By having an expanded and comprehensive understanding of trauma based disorders and dissociative defenses more clients will get better treatment.
Definitions
Complex Trauma
  PTSD
Relational Trauma
  Developmental Trauma
Dissociation
  Dissociation is little understood, and Dissociative Identity Disorder is mistakenly considered rare.
  Clients with complex relational trauma exacerbated by dissociative defenses remain stuck in inappropriate treatment paradigms. They are labeled as difficult, oppositional and manipulative. Uninformed clinicians treat symptoms of depression or anxiety without addressing critical underlying issues. Therapists may never even ask about the person’s history, treating the symptoms as if they arose out of nothing.

THEORITICAL FRAME
Phenomenological Presentation – What does it look like?
  PTSD Symptoms – Siegel’s Window of Tolerance
    Hyper-arousal
    Hypo-arousal
    Intrusive Flashbacks
Dissociative Symptoms
  Conceptualizations of dissociation
    Disruption of self-awareness
    Disruption of relatedness
  Dissociative symptomology
    Dissociative amnesia
    Depersonalization & Derealization
    Somatoform dissociation
    Dissociative Identity Disorder
Relational Symptoms
  Borderline features
  Paranoid features
  Narcissistic features
  Asocial features
Diagnosis – How do we find out if someone is dissociative?

**Dissociation**

Screening Devices: DES Dissociative Experience Scale

Formal Diagnostic Tests: MID 6.0 Multidimensional Inventory of Dissociation

Clinical Interviews: SCID-D

**PTSD**

Los Angeles Symptom Checklist (Foy)

PTSD Check List (VA)

Trauma Symptom Checklist- 40 (Elliot & Briere)

**Differential Diagnosis Considerations**

- Schizophrenia
- Bi-Polar Disorder
- Paranoid Disorder
- Major Depression
- Borderline Personality Disorder

Prevalence – How many people have it?

**General Population**

Waller & Ross suggest 3% of the general population has pathological dissociation

**Substance Abuse**

Data:

<table>
<thead>
<tr>
<th>Authors</th>
<th>Population</th>
<th>N</th>
<th>Tests</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benishek &amp; Wichowki</td>
<td>Substance Abusers</td>
<td>51</td>
<td>DES</td>
<td>25 % &gt; 15</td>
</tr>
<tr>
<td>Tamar-Gurol, Sar, Karadag, Evren &amp; Karagoz</td>
<td>Substance Abusers</td>
<td>104</td>
<td>DES, DDIS &amp; SCID-D</td>
<td>46% &gt; 30</td>
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</table>

**Historical antecedents**

Alcohol or substance abuse in families increases likelihood of interpersonal violence, including, intimate partner violence, children exposed to physical or emotional abuse, neglect and other forms of childhood maltreatment.

**Intimate Partner Violence**

Data:

<table>
<thead>
<tr>
<th>Authors</th>
<th>Population</th>
<th>N</th>
<th>Tests</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connors, Kemper, Hamel &amp; Ensign</td>
<td>Intimate Partner Violence – Victims</td>
<td>95</td>
<td>DES, CTS, CAT Trauma History</td>
<td>31.6 % &gt; 20 18.9% &gt; Taxon Score of .55</td>
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</table>
Intimate Partner Violence

**Historical Antecedents:**

IPV is itself a form of relational trauma and involves aspects of betrayal trauma similar to what many child abuse victims experience.

Clients who dissociate may have deontic reasoning deficits and be at greater risk of re-victimization. (DePrince)

Female victims of child sexual abuse are more likely to experience abuse at younger ages, and to be abused by family members, than are male victims of child sexual abuse.

Connors et al (2008) found that participants that reported pathological levels of dissociation reported that they use isolation & jealously and general control in their relationships and engaged in higher levels of physical conflict with their battering partners.

Simonetti, Scott and Murphy (2000) suggested that dissociative coping mechanisms among batterers play a role in severe intimate partner violence.

Mantakos (2008) in attempting to develop the Dissociative Partners Violence Scale sought to establish a correlation between the DPVS and pathological dissociation. She found a significant correlation between the 9 items of the DVPS and the DES-T.

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**Eating Disorders**

**Data:**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Population Studied</th>
<th>N</th>
<th>Tests</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beato, Cano, &amp; Belmonte</td>
<td>Eating Disorders</td>
<td>118</td>
<td>DES, Rosenberg Self-esteem Scale, Body Shape Questionaire, Eating Attitudes Test-40</td>
<td>30.5 % &gt; 25</td>
</tr>
<tr>
<td>Dalle, Grave, Tosico, Bartocci</td>
<td>Eating Disorders</td>
<td>106</td>
<td>DIS-Q</td>
<td>22.6% had severe dissociative symptoms,</td>
</tr>
<tr>
<td>Vanderlinden, Van der Hart, Varga</td>
<td>Eating Disorders</td>
<td>98</td>
<td>DIS-Q</td>
<td>12% pathological dissociative experiences</td>
</tr>
</tbody>
</table>

**Historical Antecedents:**

Reports of sexual abuse are similar to those in general psychiatric disorders, and may be a factor in the development of eating disordered behaviors.
However, traumatic experiences appear to be more prevalent among clients diagnosed with bulimia and clients with anorexia nervosa/binge eating-purging subtype.

**Etiology – What causes it?**
- Response to Physical/ Sexual Trauma
- Response to Relational Trauma
- Response to Dysfunctional Family Dynamics

**Conceptual Models – How do we think about it?**
- Ego State Model (Watkins)
- Component Model
  - BASK (Braun)
  - Sequential Model
- Structural Model (Van der Hart, et al)
  - Self as Process
  - ANP
  - EP

**TREATMENT – DID/DDNOS confirmed – Now What?**
ISSTD Treatment Guidelines available at: [www.ISST-D.org](http://www.ISST-D.org)

**Complicating Factors – Heads up – the person you will be treating comes with:**
- Impact of Abuse on Attachment and Relationships
  - Disorganized attachment leads to multiple models of attachment
  - Attachment and avoidance become enmeshed
  - Inability to transcend “Good Parent/Bad Parent” paradigm
  - Disconnection from normal relationships
- Stockholm Syndrome (Graham & Rawlings, 91)
  - Victim feels threatened and fearful for survival
  - Victim feels isolated
  - Victim feels dependent upon perpetrator for safety
  - Perpetrator shows limited kindness
  - Victim bonds to perpetrator
  - Victim adopts beliefs/rhetoric & perceptions of perpetrator
- Externalized Locus of Control – ‘Just tell me what to do…’
  - Client Symptomology
    - Lack internal control
    - Attempt to control others
    - Assume responsibility for others
    - Alternately seeks and rejects external control
  - Perpetrator dynamics (Sgroi, 82  Mey, 82 )
    - Dysfunctional boundaries
    - Displacement of responsibility
    - Isolation
    - Discounted/distorted feelings
    - Non-validation of reality
Shame – ‘I’m a worthless piece of shit who’s not worthy of the air I breathe.’

Conceptualizations of shame
Inherent sense of flawed self
Shame is about the self; guilt is about an act (Lewis, 71)
Shame as a significant basis for defense mechanisms (Wurmser, 81)
Shame as an attenuator of affect (Nathanson, 92)

Denial of abuse maintains shame
Perpetrator denial
Familial /societal denial
Self-denial
Therapist denial (C. Dalenberg, 2000)
  Fears of counter transference
  Fears of legal liability
  Fear of the overwhelming pain
  Silence and the failure of language

Shame and powerlessness
E. Erickson: Autonomy vs. Shame
  If not able to make change then no autonomy (powerless)
  If powerless to make changes (lacking autonomy), then shame filled
Nathanson: Shame vs. Pride
  Shame inhibits experiencing the positive affects
  Purposeful goal directed, intentional behavior
  Success leads to affect: enjoyment-joy
  Competence & pleasure antidotes to shame

Paradoxical relationship between shame and powerlessness
  Powerlessness leads to shame
  Shame is held to avoid powerlessness
  Accepting powerlessness to relieve shame

Addiction to Chaos (van der Kolk, 87)
Examples of chaos
  Eating disorders
  Chemical dependency
  Self-injurious behavior
  Dysfunctional relationships
  Identification with aggressor - Addiction to anger

Alexithymia
  Difficulty identifying feelings
  Difficulty expressing feelings
  Affect storm
  Connection to somatoform dissociation (Clayton, 04)
General Treatment Considerations

Three Stage Trauma Model
1. Safety & Stabilization
2. Remembrance & Mourning
3. Reconnection

Trauma Treatment Triggers Trauma
- Treatment frame should be safe but not too safe
- There will be complications
- Therapists will step in it
- Rupture repair process is rich and necessary

Underlying Themes/Guiding Lights
- Transference and Countertransference
- Non-linear Nature of Trauma Therapy
- Replication of Dysfunctional Trauma Dynamics
  - Addictive Patterns of Arousal
  - Power, Powerlessness, Choices and Shame
  - Shift from Ordeal to Recovery

Therapeutic Relationship
- Secure Attachment
  - Consistent Caring Presence
  - Sustained Connection

Boundaries
- Predictable
  - Not too rigid, not too loose
- Negotiable
  - Create safe environment within which to meet

Stage One: Safety and Stabilization

Intrusive Flashbacks
- Container Imagery
- Divide & Put Away (Controlled Dissociation)
- Manipulating Memories

Lack of Internal Cooperation
- Honor the Resistance/Honor the Fear
- Seeing the Whole Person as Conflicted

Alexithymia- ‘I don’t know what to say’
- Development of affective language
  - Modulating an titrating affective experiences
  - Use of journaling and art exercises
- Development of somatic awareness
  - Distinguish between hyper & hypo arousal
  - Attention to somatic state changes

Grounding: (See list at end)
Stage 2: Remembrance & Mourning

General Considerations
They were traumatized, they are not the trauma
They are not the problem
Integration not Exorcism
Growing awareness that what feels bad or scary may be necessary and helpful
Self as Process

Remembrance
Sometimes the Bad Guys are the Best
The Navy Seals of the system,
The parts that took the worst abuse & showed up for the most difficult experiences,
They saved the innocence and protected the rest
Value the need to identify with the perpetrator

Not Changing History
Dealing with what was, and grieving what was not.
Connecting with the past yields two important fields of information:
What was learned and
What was missing
What was learned may (or may not) be useful in different ways in the present.
What was missed needs to be learned – earned attachment, relational skills,
Healthy habits – self-care, food, employment, finances, and self-expression.

Do Not Need All the Memories
Pivotal points that are paradigmatic memories that speaks for all
Using present to tap into what’s relevant from past
Identify the repetitive patterns of behavior and attendant emotional responses
Highlight how the person learned to adapt
Demonstrates what life in the “warzone” was like.

Critical mass – Consciousness raising
Shift the psyche from inside to outside the trauma vortex.
The need to do every bit of memory work is based on fears
Of not getting it right,
Of the beliefs based about trauma,
Of avoiding making a mistake and being punished

Need to Understand the Meaning of the Trauma Event
Unbridled expression of emotion (without attached meaning) is unhealthy and re-traumatizing
Recounting without affect remains disconnected & dissociated
Assembling all the components of the trauma includes the meaning assigned at the time of the trauma. (Think BASK)

Pacing
Resist the urge to turn therapy into another ordeal
The slower you go, the faster you get there
Trauma is not a paced experience
Trauma is subjectively felt as if there is no beginning, middle, and end
Learning to pace one’s self heals of the effects of trauma
Trauma Treatment Triggers Trauma
- Stage II work elicits Stage I issues
- Intense affect inhibits cognitive functioning
- Decreasing dissociative defenses increases PTSD symptomology

Safety
- Finding other ways to deal with overwhelming emotions
  - Grounding exercises,
  - The power of relationship
  - Learning about the body and mind
  - How to calm the self,
  - Become more present

Affect regulation
- Name the fear/affect
- Identify where in your body you are experiencing the fear/affect,
- Identify where in your body you are NOT experiencing the fear/affect,
- Shift your focus between the two

Differentiating past from present

Critical Therapeutic Issues
- You’re supposed to be able to get over it yourself
  - We all need each other far more than we are willing to admit.
    - What was it like to be you, disconnected from the rest of human kind?
    - What does it means to be a person and live in the human condition?

Role of Therapist and Therapeutic Alliance
- Cannot be the blank screen
- Healing can only occur within the context of a healthy relationship

Therapists Will Make Mistakes
- Be mindful of when & how
- Be able to say, “I’m sorry.”
- Repair of therapeutic ruptures is as important as any other piece of good therapy
- A golden opportunity to strengthen the therapeutic alliance

Methods
Assembling Dissociative Components
- Non-leading Questions
  - If you weren’t there, you don’t know,
  - Dealing with the client’s need to be believed
    - Believing their experience while not getting stuck in validating what you have no way of validating
    - Not getting caught up in who, what, where, and when
    - Those basics become a way to avoid loss, abandonment, betrayal

When to talk about ‘why’
- The question may be a distraction, moving from emotional to intellectual
- It can be a different question, helping to understand others and themselves
Exploring the recalled event
Empowering the person to work with the beliefs about self, others and the world
Recognizing and responding to the traumatized body & mind
Enumerating and acknowledging the missed chances and lost opportunities
Developing the client’s ability to question and to view experiences and events from alternate perspectives
None of these core issues require absolute knowledge of exactly what happened.

Moving Forward & Backward to Complete Beginning, Middle & End
Allowing non-linear processing
Develop a coherent narrative
Trauma memories tend to be a repeating loop of a portion of the event
Identify the context and finding the frame of reference
Asking either:
  What happened next? or
  What happened before that?
All along the way, existential issues arise and need to be dealt with
  Accept the vulnerability of being human
  We need each other in order to survive
  Independence is an illusion

  We do have the ability to be separate, independent, but not disconnected from others.
  We are interdependent, and that makes us all vulnerable to each other.

Stage II will often activate Stage I needs
  Practice re-stabilization

Sharing Across Alter Personalities
Metaphors for helping
  Taking spoonfuls of pain,
  Letting feeling be carried out by the breath,
  Joining hands,
  Giving wisdom, knowledge to others in the system,
  Pushing strength into the part that needs it.
When appropriate, ask for spiritual help in the form accessible to the client, which may mean they create something for themselves that you would never have thought of.
Metaphors to create a sense of oneness out of many and value all within
  Team,
  Village,
  Orchestra,
  Tribe
Specialized Techniques

Caveat: Tools, not panaceas, use with wisdom and caution.
Many new specialized techniques can work well with severely traumatized people, but they must be used with the awareness and cooperation of the client’s system.
Severely traumatized people are avoiding their pain, etc. for a good reason.
The desire to be fixed, quickly, without pain can cause therapists and clients to use a technique too much or too soon.

Hypnosis
Extremely useful,
Hypnosis with DID clients is often not the usual preparation, induction, etc.
DID people are already in trance,
Help guide their process in healthy directions

EMDR
Can be very useful in specific applications
Be very well trained and careful with DID people
Level 3 training is recommended for anyone with a dissociative client

Somatic Therapies
Very useful
Very powerful
Be careful - Do you want to activate or calm?

Prolonged Exposure
Least useful,
Can be re-traumatizing,
The client may suppress more, looking better while feeling worse

Mourning
Grief
The intensity of grief
Affect comes in waves
Look for relief between the waves
Assurance that the grieving will not go on forever
Learn to accept support and give it to self
Self-soothing
Holding and comforting that should have happened can happen in visualization with the voice and presence of the therapist to guide it

Key questions
What did you want?
What was done to you?
What didn’t you get because of that?

Therapist’s ability to stay present
Determines how far the client can go
Clients are highly attuned to the reactions and responses of the therapist
Will stop themselves rather than push the therapist too far
Why Me?
Perpetrators and Narcissism
   No I and Thou
   Other as prop or audience
Karpman's Triangle:
   Roles in a subculture
   Therapeutic Exercise
      Have client identify roles in family,
      How they may have shifted between family members,
      Look at own internal system to see how it had to adapt to those roles,
      Explore how internal system reflects those roles to deal with family
      To escape the Triangle and allow for growth and freedom
      Mindfulness,
      Curiosity,
      The ability to observe self and other
What Does It All Mean?
   Normalize the reactions and learned behaviors.
      Those worked for that original situation
      Now the person needs to learn new things.
Developmental process happening within therapy
   Who am I?
   Letting go of the false self/selves
   Allow the authentic self to emerge.
   Explore key therapeutic questions
      About Self,
      About Others
      About Relationships
      About Life
Finding Strength
   Buried treasure: Finding the self amidst the ruins
   Identifying the strengths derived from survival
   Keen observational skills
   Adaptability
   Compassion
   Wisdom
   An increasing ability to see the truth of the world and remain in it
Control
   Locus of Control Issues
      Attachment to Perpetrator – often a necessary survival tactic
      Stockholm Syndrome – seeing how best to connect with perpetrator to live
      Control paradigm in dysfunctional families
   Explore what can and can’t be controlled
   Shifting shame to another areas of life give the illusion of control
Shame
Perpetrators displace blame & shame
Shame as inhibitor: stifles joy, happiness, any kind of vulnerability.
Nathanson’s shame diagram – act out, act in, blame others, blame self.
Keeps the trauma stuck.
Shame avoids Powerlessness
    Holding onto shame is an attempt to avoid the feeling of being out of control and powerless.
    Ironically, facing shame pulls the person out of the abyss of powerlessness
Therapist needs to be able to sit with the shame
Explore culpability – where responsibility truly resides
Explore reality of choices

Stage 3: Integration –
Not the end of therapy, but the stage that most resembles therapy with non-dissociative people.
Loneliness, mourning the loss of ‘others’ inside.
‘who am I?’ questions, learning to relate as a whole person, from the inside out, finding meaning and purpose, working on relationships.

CONCLUDING REMARKS
The Impact of Chronic Interpersonal Trauma
Strips the ability to be in community
    No attachment = No connection
    In the natural world, this would mean certain death
    To the trauma survivor this is felt as complete annihilation
    People exclude others who are seen as excluded in order to avoid the reality of our own personal human needs and frailties.
Abandonment, Shame, and Powerlessness are the key elements
    Abandonment: Not wanted, not included
    Shame: Not worthy
    Powerlessness: Not able to build a bridge back

Therapy Builds the Bridge - The Therapeutic Alliance Creates Community
Bibliography


*D.C.: APA. The most useful and readable book on the countertransferential experience of the therapists who work with clients suffering from severe trauma. Dalenberg writes with wisdom and warmth. All trauma therapists should read this book for their own well-being and for the benefit of anyone they counsel.*


Erikson, E. H. (1950) *Childhood and Society* Norton


Freyd, J., Klest, B., & Allard, C., (2005) Betrayal trauma: Relationship to physical health, psychological distress and a written disclosure interview. *Journal of Trauma and Dissociation* 6 (3) 83 - 104


Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books. A classic – a great book to start with, and one that won’t fully be appreciated until re-read years later.


One of the first somatic books.

Good for clients.


Siegel, D. J. (1999). *The developing mind: how relationships and the brain interact to shape who we are*. New York: Guilford.


Stein, P. and Kendall, J. (2004). *Psychological Trauma and the Developing Brain*.


Van der Hart, O., Nijenhuis, E., Steele, K. (2006). The haunted self: structural dissociation and the treatment of chronic traumatization. New York: W. W. Norton & Company. This book has very helpful tables in the midst of the writing, with do’s and don’ts that help therapists set the therapy frame and guide the client through the process.


van der Kolk, et. al. (1997). *Psychobiology of Post-Traumatic Stress Disorder.*


**Internet Links:**

http://www.isst-d.org/
http://www.isst-d.org/training/Training-index.htm
http://www.trauma-pages.com/
http://www.sidran.org/
http://www.istss.org/Home.htm
http://www.firstpersonplural.org.uk/dvd