Dissociation and Complex Trauma

Christine A. Courtois, PhD, ABPP
Psychologist, Private Practice
Courtois & Associates, PC
Washington, DC
202-362-2776
CACourtoisPhD@aol.com
www.drchriscourtois.com
The Study of Trauma and the Development of Treatment Models

- Trauma studies
  - 25 years

- Trauma treatment
  - begun in the late 1800s then disappeared
  - treatment for combat veterans
  - adapted with growing awareness of rape, child abuse, domestic violence
  - now attention to acute stress and the aftermath of terrorism and other disasters
  - several “generations” of treatment
Types of Trauma

- **Impersonal**—cause is impersonal
  - accidents, natural disasters

- **Interpersonal**
  - assault, rape, sexual harassment, stalking, war and political violence

- **Combined impersonal and interpersonal**
  - transportation accidents, human-made disasters

- **Attachment**
  - occurs in attachment relationships: can be experienced and/or witnessed
  - abuse of all types, neglect, abandonment and non-protection, domestic violence
Complex Trauma

- Associated with childhood trauma that is chronic, pervasive, cumulative
  - all forms of abuse and neglect: physical, sexual, emotional
  - severely impacts the developing child
    - psychophysiology
    - psychosexual development, including attachment capacity/style

- Also associated with other forms of chronic trauma
  - DV, POW, refugee status, civilian/combat trauma, chronic illness w/ invasive treatment
Trauma Responses and Disorders

- Complex Posttraumatic Stress Disorder (DESNOS) “PTSD plus”
  - related to severe chronic abuse, usually in childhood
  - usually highly comorbid
  - may involve a high degree of dissociation

- Dissociative Disorders
  - associated with disorganized attachment and/or abuse in childhood
  - can develop in the aftermath of trauma that occurs any time in the lifespan
  - DDNOS may be the most common DD
PTSD: Diagnostic Criteria
(DSM-IV, American Psychiatric Association, 1994)

- A. Exposure to a traumatic event
  - 1. objective seriousness
  - 2. subjective response
- B. Traumatic event is persistently reexperienced
- C. Persistent avoidance of stimuli associated with the trauma
- D. Persistent symptoms of increased arousal
- E. Duration of B, C, & D > 1month
- F. Clinically significant distress or impairment
PTSD

- A complex **dynamic** entity
  - fluctuating, not static
  - **variable** in form, presentation, course, degree of disruption

- A multimemensional **bio-psycho-social** stress response syndrome
  - often co-morbid

- An **allostatic** condition
Allostasis: “refers to the body’s effort to maintain stability through change when loads or stressors of various types place demands on the normal levels of adaptive biological functioning…The failure to “switch off” allostatic mechanisms once the threat or requirement to respond has terminated, however, begins a complex process of “wear and tear” on the nervous and hormonal systems”.

( Wilson, Friedman, & Lindy, 2002, p. 9)
## Attachment Organization

(Ainsworth, 1978; Liotti, 1992; Main, 1986, Siegel, 1999)

<table>
<thead>
<tr>
<th>Child style</th>
<th>Adult style</th>
</tr>
</thead>
<tbody>
<tr>
<td>secure</td>
<td>autonomous</td>
</tr>
<tr>
<td>insecure-avoidant</td>
<td>dismissing (“teflon”)</td>
</tr>
<tr>
<td>insecure-dismissing/resistant/ambivalent</td>
<td>preoccupied (“velcro”)</td>
</tr>
<tr>
<td>insecure-disorganized/disoriented</td>
<td>unresolved/dissociative</td>
</tr>
</tbody>
</table>
Severe Childhood Trauma Is Associated With At Least Three Major Areas of Psychological Disturbance (Chu, 1992)

- 1. Dissociative symptoms (up to and including DID)
- 2. Posttraumatic stress symptoms
- 3. Disruption of personality development (often labeled BPD)
  
  …plus other comorbidity
Complex PTSD/DESNOS (Disorders of Extreme Stress Not Otherwise Specified)

- Designed to account for developmental issues, co-morbidity, memory variability and to reduce stigma
- Co-morbid/co-occurring diagnoses:
  - *distinct from or co-morbid with PTSD*
  - other Axis I, mainly:
    - depressive and anxiety disorders
    - substance abuse/other addictions
    - impulse control/compulsive disorders
  - Axes II and III
Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS
(Spitzer, 1990)

1. Alterations in regulation of affect and impulses
   - a. Affect regulation
   - b. Modulation of anger
   - c. Self-destructiveness
   - d. Suicidal preoccupation
   - e. Difficulty modulating sexual involvement
   - f. Excessive risk taking

2. Alterations in attention or consciousness
   - a. Amnesia
   - b. Transient dissociative episodes and depersonalization
Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS (cont’d)

3. Alterations in self-perception
   - a. Ineffectiveness
   - b. Permanent damage
   - c. Guilt and responsibility
   - d. Shame
   - e. Nobody can understand
   - f. Minimizing

4. Alterations in perception of the perpetrator
   - a. Adopting distorted beliefs
   - b. Idealization of the perpetrator
   - c. Preoccupation with hurting the perpetrator
5. Alterations in relations with others
   - a. Inability to trust
   - b. Revictimization
   - c. Victimizing others

6. Somatization
   - a. Digestive system
   - b. Chronic pain
   - c. Cardiopulmonary symptoms
   - d. Conversion symptoms
   - e. Sexual symptoms

7. Alterations in systems of meaning
   - a. Despair and hopelessness
   - b. Loss of previously sustaining beliefs
Defining Dissociation

Dissociation is a psychophysiological process with psychodynamic triggers which produces an alteration in ongoing consciousness.

Putnam, 1985
Defining Dissociation

- A state of fragmented consciousness involving amnesia, a sense of unreality, and feelings of being disconnected from oneself or one’s environment

- A standard human response to trauma, a near universal reaction to a life-threatening event

(Steinberg & Schnall, 2000)
Defining Dissociation

- Dissociation not invariably linked to overt trauma
  - recent studies of attachment, family dynamics
- Yet, it often develops in dire circumstances
- This mechanism is not available to all
  - a predisposition to dissociate is a necessity
- Can be considered a skill and a defense
- It covers a broad spectrum of experience
- The skill can become crippling and dangerous

(Allen, 1995)
Defining Dissociation

- Two types have been identified:
  - psychoform
  - somatoform
    - has been less readily recognized, studied
- Can include **positive or negative dimensions**
  - positive: added capacities, qualities
  - negative: diminished, absent capacities, qualities
The Relationship between Dissociation and Attachment

- An intergenerational transmission of attachment patterns has been identified.
- Theory: disorganized/disoriented attachment in infants in the presence of the caregiver is related to the caregiver’s attachment style and history of unresolved trauma or loss.
  - Caregiver may be frightening to and frightened of the child and therefore inconsistent/disorganized in relating to the child.
Implication

■ Emotional abuse including neglect and failure to respond and soothe a child is implicated in the development of the DD’s
  − a wider base beyond overt physical and sexual abuse from which to understand DD’s

■ The emphasis in treatment is shifted back toward the interpersonal patterns started early in life and away from solely working through the trauma
Attachment Styles

- Secure
  - can have sub-categories
- Insecure: Preoccupied
- Insecure: Dismissing
- Insecure: fearful/unresolved/ dissociative
  - an organized relational strategy even though it doesn’t seem to be
- Attachment style may be important in predicting trauma symptoms

(Roche, Runtz, & Hunter, 1999)
Fearful/Unresolved/Dissociative Style

- Long history of betrayal and abuse
- **Often dissociative in appearance**
  - frozen, glazed, apprehensive, dazed
- Therapist as source of both *comfort* & *anxiety*
- **Approach/avoid relational strategies**
  - *not predictable*
- Meets criteria for Simple & Complex PTSD
  - Axis II: avoidant, BPD, mixed styles
Essential Feature and Types of Dissociative Disorders (DSM-IV, APA, 1994)

Essential Feature: Disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment

- *in consciousness*: important personal events cannot be remembered
- *in memory*: important personal events cannot be remembered
- *in identity*: the customary identity is temporarily forgotten and a new identity assumed or imposed
Types of Dissociative Disorders

(DSM-IV, 1994)

- Dissociative Amnesia
- Dissociative Fugue
- Depersonalization Disorder
- Dissociative Identity Disorder (DID)
  - the result of pervasive *childhood* trauma (including attachment trauma)
- Dissociative Disorder Not Otherwise Specified (DDNOS)
  - likely most common
Phenomenology & Characteristics of Dissociation

- **Subjective elements**
  - negative symptoms:
    - loss of continuity
      - self, identity, memory, consciousness
    - loss of time
      - blank spells
  - positive symptoms:
    - reexperiencing phenomena
  - Schneiderian symptoms:
    - voices inside (“3rd reality”), passive influence
  - somatic symptoms/manifestations
Phenomenology & Characteristics of Dissociation

- Objective elements and behaviors
  - affect
  - facial
    - musculature
    - eyes
  - behavioral
  - postural
  - linguistic
    - vocal
    - writing
  - somatic
  - skills and knowledge
III. Treatment: The New Consensus Model

- Developed from consensus among clinicians and researchers
- Evolving
- Empirical investigation ongoing
  - outcome research underway
- This model applies to complex PTSD with or without DD’s
  - same approach for both, tailored to the individual
The Standard of Care

- **Evolving**
  - *Expert Consensus Guidelines available*
    - “simple” PTSD
    - Dissociative Disorders
      - Adult (ISSD, 1994, 1997, under revision)
      - Children (ISSD, 2001)
    - Delayed memory issues
    - Complex trauma (under development)
PTSD Treatment: Empirical Base

- Empirical support for some treatments for “simple” PTSD
  - particularly CBT & psychopharmacology
  - *not all CBT approaches are applicable to complex trauma*
    - questions about sampling inclusion and exclusion and applicability of findings from current studies
- Empirical support under development for complex trauma
  - current model based on clinical observation and modifications
  - empirical data base is building
PTSD Treatment

Like PTSD
Comprehensive treatment must be BIO-PSYCHO-SOCIAL
Complex PTSD in Treatment

- PTSD symptoms
- Depression & anxiety
- Negative self-concept
- Problems with affect regulation
  - may rely on maladaptive behaviors, substances
  - problems with safety
- Problems with trust and relationships
  - revictimization/reenactments
  - needy but mistrustful
- Physical/medical concerns
- Other...
Fearful/Unresolved/Dissociative Style in Treatment

- Inconsistent/unpredictable/paradoxical
  - fearful, mistrustful yet needy
  - approach-avoid
  - idealizing/denigrating of caregivers
- Negative self-concept
- Crisis lifestyle
- Overwhelmed by history
- Interpersonal avoidance
- Major problems with affect regulation
Treatment Approach: Sequenced, Progressive, & Organized

- Sequencing of treatment/goals with emphasis on:
  - safety
  - therapeutic relationship
  - ego-strengthening, maintenance of function
  - skill-building for emotional regulation, self-management, daily living
  - matching patient’s capacity to intensity and pace of treatment
    - titration and individual treatment trajectories
  - work with traumatic material as necessary
Early Stage: Alliance-building, Safety, Skill-building, Self-management

Stage measured in mastery of skills and healing tasks, not time!

Therefore, often a problem for patient and for managed care; however, good stage 1 work often saves time in the long run
Early Stage: Psychological Components of Treatment

- Therapeutic alliance as essential but takes time
  - mistrust issues

- Safety as essential, not to be ignored
  - safety planning: collaborative problem-solving vs. time-limited contracting
    - involves a hierarchy of interventions and actions, internal and external and the agree-upon use of supports including voluntary hospitalization, if indicated
  - trauma work cannot be conducted without safety

- *expect and plan for relapses*
Early Stage: Psychological Components of Treatment

- Affect processing and change
- Attachment style/personality and related issues
- Identifying/undoing cognitive errors & distortions
- Grounding and stabilization skills for numbing and/or reexperiencing symptoms
- Life skills
  - assertiveness, problem-solving, decision-making, organization
Work With The Dissociative Process

- Be actively engaged and observant
  - recognize it, don’t ignore
  - ask about, comment on
  - watch for subtle “soft” signs

- Teach recognition of dissociative process/triggers
  - strategic avoidance

- Teach grounding

- Differentiate past from present

- Strengthen ego functions
  - “childmind/childthink” vs. adult self
  - adult self in charge
  - self-nurturing
  - reality testing
Work With The Dissociative Process

- Teach affect identification/modulation
- Separate feeling from taking action
- Teach alternative behaviors/ways to cope
- Utilize dissociation and “trance logic” in the interest of the patient
- “Nudge” patient to face what has been/is being avoided
  - interpretation and empathic confrontation
  - graduated exposure and processing
- Encourage unfreezing, becoming more real
  - physical and emotional
- Have limits, model being real
Grounding Skills

- Remove triggers
- Reorient to the present
  - directive voice, bring patient back
  - stress safety, soothing, comfort, what is known
- Self-awareness
  - ask for adult self-state (in DID/DDNOS)
  - talk to the whole person
- Body awareness:
  - eyes open and focused, increase brightness
  - tactile sensations, use of touch
  - breathing
Treatment of DID/DDNOS

- Sequenced
- Whole person, non-regressive treatment
  - identification of internal self-aspects
  - “you are all in this together”
  - “you are all responsible for function and safety”
  - adults in charge of adult functions
    - internal self-nurturance
- Reframe all self-aspects as important
  - all are protectors in their own way
  - do not develop favorites; give all equal time/attention
  - work against cognitive distortions/trance logic
Treatment of DID/DDNOS

- Facilitate internal communication
- Interpret roles, dynamics, Karpman triangle
- Working with part-selves
  - learning roles, responsibilities, cognitive processes
  - shifting roles and cognitive restructuring
  - internal dialogue and cooperation
  - increasing awareness/developing co-consciousness
- processing of trauma
- blending/unification over time
- Post-blending/unification treatment
  - “single personality disorder” (Kluft)
Middle stage: Trauma processing, de-conditioning, resolution

- Revisiting and reworking the trauma
  - in the interest of resolution, not to retraumatize
  - only after stabilization skills have been learned--even with careful pacing, work is destabilizing
  - plan for possible relapse

- Graduated exposure and deconditioning
  - careful processing of traumatic memories and emotions to decondition them, allow integration
  - work from least to the most painful of the traumas
  - gradual, approach-avoid, controlled uncovering
  - geared to the “therapeutic window” or “affect edge”
  - with therapist’s support & empathy
Middle stage: Trauma processing, de-conditioning, resolution

- Expression of emotion and resolution of core issues/affect/cognitive distortions/schema
  - guilt, shame
  - responsibility, self-blame
  - fear, terror
  - mistrust, ambivalent attachment, and individuation
  - rage: safe expression and channeling
- Griefwork and mourning
  - past and present issues
  - foster self-compassion and self-forgiveness
- Careful attention to body reactions/responses as part of the processing
Middle stage: Trauma processing, de-conditioning, resolution

- Creating a narrative over time
  - increased understanding and resolution
  - new meaning
- Behavioral changes indicative of resolution
- When processing is complete and memory is deconditioned, symptoms often cease and anguish fades as trauma is integrated with other aspects of life
  - increased control & authority over memories, self
  - greater affect range and tolerance
  - improved self-esteem and capacity for attachment
  - lessening or cessation of symptoms
  - new meaning
Middle stage: Trauma processing, de-conditioning, resolution

- Special techniques (empirically supported)
  - cognitive-behavioral protocols
    - exposure, stress inoculation, anxiety management, etc.
  - hypnotherapy
    - for ego strengthening and pacing, not for memory retrieval
  - EMDR (Eye Movement Desensitization and Reprocessing)
    - for resource installation and for memory processing
- special treatment programs and protocols
  - STAIR, ATRIUM
Middle stage: Trauma processing, de-conditioning, resolution

- **Collateral work**
  - w/ cautions, preparation, training
    - with current family/significant others: often desirable at different stages of the treatment process
    - with family of origin/abusive others
      - mediation model: third reality (Barrett)
      - re-connection in some cases
      - alienation in others
      - the issue of forgiveness
Late stage: Self and relational development

- Development and connection with new sense of self
- Existential crisis and spirituality
- Ongoing meaning-making
  - may involve a survivor mission
- Current life stage issues
- Career/vocational issues, as applicable
- Continued development of a support network and restitutive relationships with others
  - intimacy
  - sexuality
  - family
  - friendships
Not a member yet?

- Join to receive our division journal, newsletter, access to the Division 56 listserve, discounts and more!
- Join through APA’s on-line system at www.apa.org
- Or visit us at www.apatraumadivision.org to fill out a brochure

Welcomes New Members!