**What is dissociation?**

- A disruption and/or discontinuity in the normal, subjective integration of one or more aspects of psychological functioning:
  - Memory
  - Identity
  - Consciousness
  - Perception
  - Motor control

(DSM-5)

http://www.rachelelise.org/

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**Emotion Dysregulation in PTSD**

- **Emotional Undermodulation**
  - Reexperiencing

- **Emotional Overmodulation**
  - Dissociation

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**Dissociative symptoms are caused by trauma**

- Rigorous prospective, longitudinal studies with corroborated abuse show that trauma is linked to dissociation
- Dissociation decreases over time
  - after trauma exposure (for all but a small subset of people who retain high dissociation)
  - in response to trauma treatment

Dissociative symptoms are caused by trauma

- Dissociation is not highly related to suggestibility or fantasy (predicts on 1–3% of variance in suggestibility)
- Dissociation had moderate correlations with trauma in a meta-analysis of 38 controlled studies
- More severe trauma is often associated with step-wise increases in the size of correlation with dissociation


Informed by:

- Assessment results
- Patient’s stage in treatment, degree of motivation, degree of insight, capacity for affect/impulse regulation and self-soothing
- Developed collaboratively with patient

Empirically Supported Treatments for Classic PTSD

- Prolonged exposure therapy (Foai and others)
- Cognitive processing therapy (Resick and others)
- Eye movement desensitization and reprocessing (EMDR; Shapiro and others)
Empirically Supported Treatments for Classic PTSD

Problems with empirical basis of support for PTSD:
- Many exclusion criteria
- Rarely include severe childhood abuse survivors
- Results have limited generalizability to the most severely dissociative patients

Cloitre’s STAIR-NST Treatment
- Staged treatment: skills training in managing emotions and healthy relationships, followed by adapted narrative story telling

Ford’s TARGET treatment model
- Explains in basic language the stress response reactions and how to manage them
- No detailed discussion of trauma

Treatments for Complex Trauma

Staged Model
- Stage One - Stabilization and Safety
- Stage Two – Processing and Mourning Trauma
- Stage Three – Integration and Moving Forward

Examples:
1. Chaotic patient living “crisis-to-crisis”
2. Affectively restricted patient living numbed and isolated
3. Self-harming patient with substance abuse and denial of dissociative states

Treatment Goals & Planning

(Herman; Courtois & Ford; Cloitre; Kluft)
**PRESENTING PROBLEM**

1. Chaotic patient living “crisis-to-crisis”

**GOALS & PLAN**

1. Educate about replicating childhood patterns — “Is this chaos familiar?”
2. Affect regulation skills
   a) Identify & tolerate feelings
   b) Mindfulness
   c) Increase distress tolerance
3. If doesn’t stabilize, explore whether there are conflicts underlying chaos (e.g., avoidance of trauma due to fear of facing feelings and memories)

**PRESENTING PROBLEM**

1. Affectively restricted patient living numbed and isolated

**GOALS & PLAN**

1. Educate about dissociation and the importance of learning to deal with affect
2. Teach grounding
3. Explore reluctance to feel; conflicts about emotions
4. Assess social skills and reasons for isolation; explore fears of relationships

**PRESENTING PROBLEM**

1. Self-harming severe DD patient with serious substance abuse and denial of dissociative self-states

**GOALS & PLAN**

1. Educate about importance of not replicating childhood patterns; body not being taken care of; neglect of healthy needs
2. Teach affect and impulse regulation; grounding skills
3. Assist patient in getting clean & sober
4. Explore reasons for lack of acceptance of parts — fear of loss of control; fear of dealing with past traumas, etc.

**First Stage of Treatment for Complex PTSD**

- Traumatic material and affect are contained rather than “opened up”
- Clients taught techniques to help manage strong feelings and impulses
- Clients taught techniques to manage symptoms of PTSD
- Therapeutic alliance built
- Psychotropic medications tried and adjusted
Suicide
Which patients are most at risk?

Severe depression
- approximately 20% attempt suicide
- approximately 4% complete suicide

Borderline Personality Disorder
- approximately 75% attempt suicide
- approximately 5% - 10% complete suicide

Dissociative disorders patients
- 66% - 80% attempt suicide

(Brand, 2001; Foote et al., 2008; Foote, 2013; Gunderson, 2001)

Self-Injurious Behavior
Which patients are most at risk?

Recurrent SIB is linked with severe and chronic child maltreatment

(e.g., Briere & Gil, 1998; Fliege et al., 2009; Kisel & Lyons, 2001; Paivio & McCutcheon, 2004; van der Kolk et al., 1991; Wachter, Murphy, Kennerley, & Wachter 2009; Yates, Carlson, & Egeland, 2008)

Severe dissociation predicted SIB among mixed psychiatric patients, even after controlling for CM, BPD, and demographic variables

(Zlotnick, Mattia, & Zimmerman, 1999)

Dissociation mediates the relationship between CSA and recurrent SIB

(Yates et al., 2008)

Self-Injurious Behavior
Which patients are most at risk?

SIB is very high in patients with DID, ranging from 24-77.5%

(Coons & Miletion, 1990; Foote et al., 2008; Ross et al., 1990; Putnam et al., 1986; Yargiç et al., 1998)
What predicts SIB and Suicide Attempts in DD Patients?

TOP DD Study

Only variable that predicted suicide attempts as reported by clinicians:

- Dissociation
- Not PTSD or depression

(Webermann, et al., under review)

What predicts SIB and Suicide Attempts in DD Patients?

TOP DD Study

- 61% of patients had self-harmed in last 6 months
- Variables that predicted self-harm as reported by clinicians:
  - Dissociation and depression
  - Not PTSD

(Webermann, et al., under review)
TOP DD clinicians generally utilized expert recommended treatment techniques.
But less strongly emphasized targeting:
- dissociative symptoms,
- safety,
- daily stressors,
- self-care,
- affect tolerance,
- impulse control
(Myrick, Chasson, Lanius, Leventhal, & Brand, in press)

(Levine, 1997; Siegel, 1999; Ogden, Minton, & Pain, 2006; Porges, 2005)

Stabilizing Dissociative Client’s Impulsivity and Safety Struggles
Steps to Stabilizing Impulsivity & Safety

1st: Assess the conflict or situation creating destructive urges.

2nd: Negotiate a safety agreement and develop a safety plan.

3rd: Build alliance with patient around the need to establish safety.

4th: Resolve conflict and/or teach adaptive coping.

The Cycle of Unsafe Behavior

Warning Signs

Results: I felt relief for a while then ashamed. My friends and therapist were mad. I hurt myself more. The voices started yelling again.

Unsafe Behavior: I started drinking. I finally gave up and cut myself.

Warning Signs: I felt no one likes me. I was isolating and dissociating.

The Last Straw: The voices were yelling at me. I had an upsetting talk with someone.

Results: I felt relief for a while then ashamed. My friends and therapist were mad. I hurt myself more. The voices started yelling again.

Unsafe Behavior: I started drinking. I finally gave up and cut myself.

The Last Straw: The voices were yelling at me. I had an upsetting talk with someone.

2nd: Negotiate safety agreement. Sometimes it is helpful to be concrete:

If I find myself having difficulty maintaining this, I will use my safety plan. If I have used every aspect of my safety plan and am still feeling I may do something that is life threatening, I will call you and wait safely while I wait for your call. If I can't wait, I will call 911 or go to the ER.

2nd: Negotiate a safety agreement.

Discuss the spirit of the agreement:
- it's about being honest
- working with you collaboratively
- treating themselves protectively and with compassion
- Learning to talk about urges to enact, rather than enacting, relationship themes of danger, life or death, coercion with you
Discuss the spirit of the agreement:
 It’s not about punishing them or them being bad.
 It’s not about you being controlling.
 It’s not about them controlling you.
 Having grown up with manipulative people, they may use their body as a pawn to get what they need from you and others.

Have client write 10 – 20 things that help when s/he is feeling self-destructive, suicidal, aggressive, overwhelmed

Ideas:
• Use grounding techniques (list)
• Distinguish past from present (list)
• Use relaxation techniques (list: breathe!)
• Call a supportive person (list)
• Use healthy distraction (list: play with a pet)
• Exercise

More Ideas:
• Get outdoors
• Think about what you would say to them
• Take a soothing bath
• Pray
• Listen to upbeat or soothing music
• Watch funny or light TV or video
• Review a list of consequences
• Review a list of reasons to live
• Remember that the feelings are temporary “storms”
• Call to listen to your voice on your machine
• Call a crisis hotline
• Call you

During a crisis:
 Not using logical thinking and planning
 Hazy or no recall of safety planning
 If severely dissociative, may switch to a self-state that does not recall work in therapy and/or that has little alliance with you
3rd: Build alliance with patient around the need to establish safety.

Understanding and empathizing with their discomfort; Not by condoning destructiveness.

Must challenge impulsivity and destructiveness, or else you're falling into transference pattern of unprotective/neglectful parent.

(Courtois, 1988; Messler Davies & Frawley, 1994)

Help make self-destructiveness ego dystonic.

For trauma survivors, interpret as a repetition of trauma:

- Stuffing food into mouth (penis), then throwing up (getting rid of semen)
- Identifying with both abuser (penetrating), abused (being wounded or stuffed), and detached parent (cool detachment from destructiveness)

(Farber, 2006)

Repetition of trauma:

When understand what this communicates (via countertransference or the enactment on the body), what has been dissociated becomes integrated, thought about, and shared within relationship

(Farber, 2006)
4th Step: Resolve conflict and/or teach adaptive coping

- Therapist will help with co-regulation of affect
- Therapist’s mirror neurons may signal alarm
- Consultations: Kluft and Loewenstein

Ineffective Affect Management

Review of 18 studies:

**#1 reason for SIB is relief of negative emotion:**

- Intense negative emotion precedes SIB and decreased negative emotion and sense of relief follow SIB

(Klonsky, 2007, Clinical Psychology Review)

Ineffective Affect Management

Self-harm changes affective and physical state:

- calming
- provides distraction from emotions
- provide “rush” (thrill seeking)
- end deadened state of depersonalization
- way of client relieving sense of shame by providing “punishment”
- antidote to helplessness
- “anti-suicide”

(Levine, 1997; Siegel, 1999; Ogden, Minton, & Pain, 2006; Porges, 2005)
Determine what client accomplishes with SIB and try substitution (e.g., other ways of feeling real or calming).

Therapist:
1. Empathize with how overwhelming and dangerous the feelings seem.
2. By therapist listening, witnessing the feelings in session, helps develop patient's capacity to sit with feelings.
3. Teach adaptive ways of dealing with feelings.
4. "How long does the rush last? So it's only a quick fix. Are you satisfied with being addicted?"

Self-harm often used to handle the more difficult feelings of shame, anger, terror, emptiness, loneliness and fear of abandonment.

Teach ways of tolerating affect and physical sensations.
- Reframe destructive behaviors as an attempt to calm and take care of themselves; normalize it.
- Label the feeling or sensation.
- Feelings can't hurt or kill you. They are temporary.
- Metaphors: hurricane; stormy ocean
- Teach client about the impact of stress on the brain and body

Teach ways of tolerating affect and physical sensations.
- Zone yourself to a chair or being outside your home until urge is tolerable
- Journal or draw but not graphically
- Relaxation exercises, imagery, hypnosis: safe places; healing stream; feelings dial
- Distraction (e.g., hold a pet, do something creative, garden, exercise)
Ineffective Affect Management

Teach ways of tolerating affect and physical sensations.

- Being with someone
- Reviewing consequences of acting on urges
- Reviewing reasons for staying alive
- Reviewing list of things that give them hope

Teach how to motivate self to change and praise self

- May have learned to control via criticism and punishment
- Give self credit when they follow through on safety plan
- Learn to tolerate you praising their hard work

4th: Resolve conflict and/or teach adaptive coping.

Ineffective Affect Management

Teach ways of tolerating affect and physical sensations.

- Reviewing list of good things about themselves and the world
- Remind self that they don’t want to keep stuck in a cycle of treating self as poorly as they were treated as a child
- Remind self they don’t want to teach unhealthy coping to their own children
- Exercise

4th: Resolve conflict and/or teach adaptive coping.

- May involve working through trauma and/or trauma based cognitive distortions.
- Example: self-punishment may not totally stop until has examined and re-examined shame and self-blame about having been abused, hatred towards body.
Internalized Rage

- Enraged about past trauma with no way to manage it safely.
- Often as enraged with unprotective parent as with overtly abusive parent.
- Expressed it as client saw adults express anger destructively.
- Can indirectly express anger towards abuser by internalizing it. Rather than symbolically or literally jeopardize relationship with abuser, turn rage on self.
- Can keep attachment and idealized image of abuser intact but with tremendous cost.

Externalize rage by holding others “hostage” by threatening suicide/homicide.
- Or less directly: express rage at abusers by “making them pay” by keeping stuck in chronic pattern of low-functioning.
- “If I got well, then it means they didn’t hurt me and they got off without paying.” “I’ll show them how much they damaged me.”

Magical beliefs blend with masochism and sadism.

Treatment:

- Normalize intense anger/rage as related to past.
- Encourage verbal, behavioral (e.g., exercise) and artistic expression.
- If dumping anger, may be re-enactment. Way to finally have power.
- Communication of their past experience: “You are helping me understand how it must have felt to always be in trouble, getting yelled at, seen as no good.”
- Challenge distortions and ask whether this gets them what they want in long-term.
  - Ex: “How does your continual self-harm effect your dead abuser?”
Ineffective Affect Management: Shame

- Blame themselves for the abuse, for having a body, for needing the attention, for feeling special or powerful or aroused
- Ashamed for feeling vulnerable and out of control
- Fuels wanting to disappear and/or attack “the body”

Treatment:
- Internalize therapist’s compassion
- Explore if feel guilt or shame as a way to avoid anger and grief
- Cognitive interventions:
  - Would you blame your best friend?
  - Were the 25% of women who experience CSA awful children who deserved it?
  - Observe kids – do they deserve abuse?
- Imagery: Healing stream
- Develop sense of pride in their body via exercise, yoga

May fuel the wish to die
- Annihilate self rather than feel anguish and recognize how unloved and unprotected they were

Treatment:
- Connection with therapist and friends
- Finding purpose, a way to make the world better
- Make amends
- Don’t make this decision when depressed
Don't make me come over there.

Control others rather than be controlled
- Feels endangering self is the one thing s/he controls.
- Example: Bring up safety problem at end of session to keep you engaged
  - only way they know you care is if you are furious
  - way to tell you how angry they are with you
  - way to compete with your other clients for your attention

Misdirected Attempt to Communicate and Manage Relationships

Avoidance – Become unsafe so don't have to deal with difficult interpersonal task/issue.
- Example: Pt required hospitalization repeatedly at holidays.
- Example: Repeated lengthy hospitalizations to distance herself from her husband.

Only way they know to get noticed
Systematic Education about Improving DD Patients’ Safety

Online Study: TOP DD Network
Stage 1 psychoeducational intervention
1. decreasing dissociation
2. improving emotion-regulation
3. enhancing safety

- Web-based intervention globally available free of charge to patients and therapists
- Adjunct to individual therapy

TOP DD Network study

Example:

- Video: reasons traumatized people hurt themselves
- Written: make a list of reasons why you self-harm; make a safe coping list (healthy alternatives)
- Practice: use safe coping list this week

I experience my emotions as overwhelming and out of control.

- Almost Never (0 - 10%) 27
- Sometimes (11 - 35%) 9
- About Half of the Time (36 - 65%) 35
- Most of the Time (66 - 90%) 27
- Almost Always (91 - 100%) 8

Example:

- Video: reasons traumatized people hurt themselves
- Written: make a list of reasons why you self-harm; make a safe coping list (healthy alternatives)
- Practice: use safe coping list this week
I have no idea how I am feeling.

Therapists’ View: Shows Good Awareness of Emotions and Body Sensations

When I’m upset, I feel like I can remain in control of my behaviors.

Able to Deal with Stressful Situations Without Dissociating
I noticed while watching the video that I felt hope to heal, and motivation to do the work. With the videos I can watch it over and over again when I need it.

This program is helping me because I am part of a Network. There are many other people that suffer in the same way as I do. I am not alone as I once was.

I know there are many therapists in the Network, too. It is important for me to know that many therapists pull together with me, with all of us who are patients. We pull together.

When I wrote my safety list I realized some of my safety techniques are on a slippery slope to dissociative states. It led to an excellent conversation with my therapist.

It was astonishing for me how personal and encouraging this video was. Its like you wrote the script based on my life!
The TOP DD internet-based program has the potential to reach patients who live in isolated places without available dissociation-focused treatment. For some people it may be the only way to have treatment that addresses their core problems.

Many dissociative patients live in isolation. With the possibility to watch the videos at home, the patients avoid the exposure to triggers outside their home. At home, some will find it easier to “stay present” within their “window of tolerance” and avoid some dissociative episodes. This will increase the effect of the techniques.

I think this program is “the future”!

Further information:
- APA Division 56 (Trauma Division) apatraumadivision.org
- ISST-D.org
- NCPTSD.va.gov
- ISTSS.org
- NCTSN.org
- Sidran.org
- PILOTS database (largest international database on PTSD) http://www.ncptsd.va.gov/norman/publications/pilots/
Resources

Books:


Contact

bbrand@towson.edu
topddstudy.org