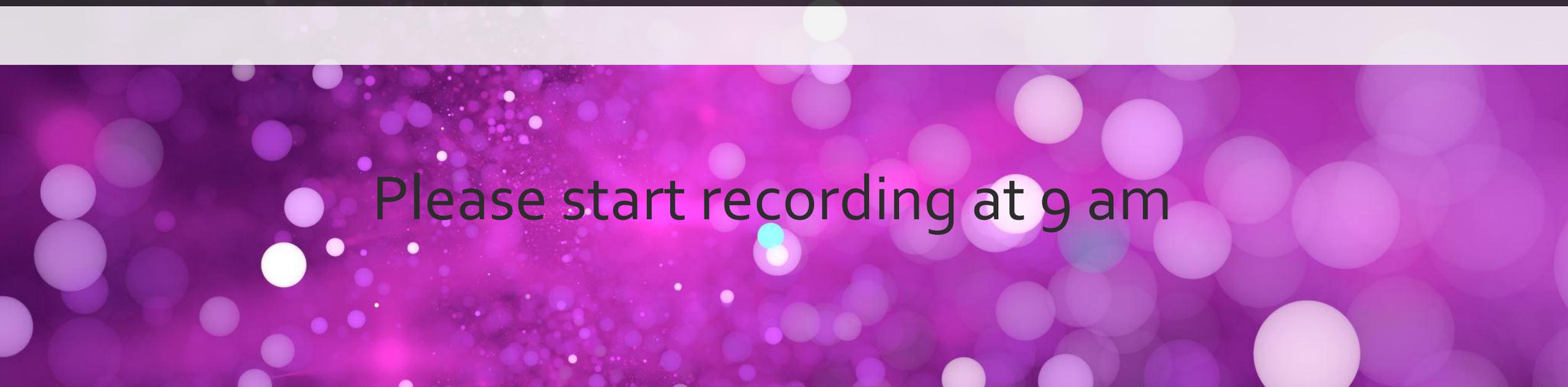


The background features a purple bokeh effect with various sized circles in shades of purple, pink, and white. A dark grey horizontal band is positioned in the upper middle section, containing the main title text.

WELCOME TO SIMPLE WEEK 19  
DISSOCIATION AND THE TREATMENT OF THE  
TRAUMATIC SPECTRUM DISORDERS

The background continues with the purple bokeh effect. A light grey horizontal band is positioned in the lower middle section, containing the recording instruction text.

Please start recording at 9 am

week 17- the stress and trauma related disorders-session 20 of manual.

week 18- emotional regulation skills p.148-206 of dbt workbook. our fifth practice session-the goals diary card procedure- session 21 of manual

**week 19- dissociation and the treatment of the traumatic spectrum disorders- session 22 of manual.**

week 20- introducing interpersonal skills p.207-241 of dbt workbook. Review of all the skills

week 21-introducing internal family systems (ifs)-session 24 of manual.

introducing the ifs workbook and ifs workbook guided ai assisted self therapy

week 22- Spirituality, religion, and health- session 26 of manual.

week 23-interpersonal skills and putting it all together p.242-265 of dbt workbook.

states of activation as essential trailheads and the four pillars of recovery from trauma-session 27 of manual.

# SIMPLE COURSE SCHEDULE 2025-26

Week 1- October 1

Week 2- October 8

Week 3- October 15

Week 4- October 22

Week 5- October 29

Week 6- November 5

Week 7- November 12

Week 8- November 19

Week 9- November 26

Week 10- December 3

Week 11- December 10

Week 12- December 17

December 24 and 31

Week 13- January 7

Week 14- January 14

Week 15- January 21

Week 16- January 28

Week 17- February 4

Week 18- February 11

Week 19- February 18

Week 20- February 25

Week 21- March 4

March 11 and 18 no course

Week 22- March 25

Week 23- April 1

Week 24- April 8

Week 25- April 15

Week 26- April 22

Week 27- April 29

Week 28- May 6

Week 29- May 13

Week 30- May 20

Week 31- May 27

Week 32- June 3

# WARNING ABOUT MEDITATION

FEEL FREE TO SKIP IT. FOLLOWED BY A MOMENT OF SILENCE





# 5-Minute Mindfulness Meditation for Dissociation

## Opening (30–45 seconds)

Before we begin, I want to remind you that this is an invitation, not a requirement.

You're welcome to keep your eyes open or closed, to shift position, or to stop at any point.

If at any time this feels like too much, you can orient to the room—look around, feel your feet, or gently move.

Dissociation is not a failure. It's a protective response—the nervous system doing its best to keep us safe.

Today, we're not trying to force ourselves to be present.

We're simply practicing coming back a little, in a way that feels tolerable.

## Grounding Through the Senses (1½ minutes)

Let's begin by orienting to the room.

Gently look around or imagine the room if your eyes are closed.

Notice three things you can see—shapes, colors, light, shadow.

Now notice two things you can hear—near or far, inside or outside the room.

No need to label them as good or bad.

And notice one physical sensation that feels neutral or mildly pleasant—

perhaps the weight of your body on the chair, your feet on the floor, or your hands resting.

# 5-Minute Mindfulness Meditation for Dissociation

If you feel distant, foggy, or unreal, that's okay.  
Simply noticing that is already a form of presence.

## Gentle Embodiment (1½ minutes)

Now, we'll bring awareness to the body in a very light, respectful way.  
See if you can notice the outline of your body—  
where you end and the chair, floor, or clothing begins.

Without trying to change anything, notice:  
Is there more sensation in the upper body or lower body?  
More inside or on the surface?

If at any point the body feels too far away or too intense,  
you can return to the room, open your eyes, or press your feet gently into the floor.

Just staying within what feels manageable.

# 5-Minute Mindfulness Meditation for Dissociation

## Breath as an Anchor (1 minute)

We'll now bring in the breath—not to control it, but to use it as a soft reference point.

See if you can notice where the breath is easiest to feel—the nose, chest, or belly—or simply the sense of air moving in and out.

There's no right depth or rhythm.

If the breath disappears from awareness, that's okay.

Just gently come back when you notice.

If dissociation shows up as numbness, distance, or blankness, you might silently say to yourself:

'Something in me is protecting me right now.'

## Choiceful Re-Engagement (45 seconds)

Before we close, notice:

Is there one small way you can signal safety to your nervous system?

Maybe that's pressing your feet into the floor, stretching your fingers,

or gently naming where you are and what day it is.

You're practicing the skill of returning, not forcing, not fixing.

# 5-Minute Mindfulness Meditation for Dissociation

Closing (30 seconds)

As we come back, take a moment to notice:

What feels slightly more present, even by one percent?

When you're ready, gently re-orient—open your eyes, move, look around.

Thank your system for what it's learned over time.

Dissociation helped you survive.

Now you're slowly teaching your nervous system that return is possible, and safe.



# PRACTICE SESSIONS SCHEDULE

practice	preparation		
6. Week 25 April 15	April 8, 1:30	IFS workbook 1	Elaine S.
7. Week 26 April 22	April 15	IFS workbook 2	Dinko T.
8. Week 27 April 29	April 22	IFS workbook 3	Barb H.
9. Week 28 May 6	April 29	IFS workbook 4	Meaghan
10. Week 29 May 13*	April 22 3 pm	Wise mind remediation	Rob T.

We now have a full slate of volunteers but if anyone would like on a “substitute list” in case someone can’t make it, as happened last week, please let us know.

## HOMework FROM LAST WEEK

Submit	Submit questions or comments to <a href="mailto:itssimple2023@gmail.com">itssimple2023@gmail.com</a>
Read	Simple manual session 22.
Continue	Continue reviewing and practicing your crisis plans, diary cards, chain analysis, rational mind remediations and goals diary cards.
Continue	Continue tracking all the skills you've learned using the skills lists. Practice them.

# HOMEWORK FOR NEXT WEEK

Submit	Submit questions or comments to <a href="mailto:itssimple2023@gmail.com">itssimple2023@gmail.com</a>
Read	Skills training workbook p.207-241 (double skills training session)
Continue	Continue reviewing and practicing your crisis plans, diary cards, chain analysis, rational mind remediations, and goals diary cards.
Use	Use templates to start becoming acquainted with your part selves, doing wise mind chain analysis, fostering your wise mind, and soothing your parts.
Continue	Continue tracking all the skills you've learned using your skills lists. Practice them.

# FOR THOSE WHO DON'T HAVE THE SECOND EDITION OF THE DBT SKILLS TRAINING WORKBOOK HERE'S WHAT WE'LL COVER NEXT WEEK

## P. 207-241 INTERPERSONAL SKILLS



- This section of the workbook covers seven topics
- 1. Mindful attention
- 2. Compassion for others
- 3. Passive vs. aggressive behavior
- 4. I want-they want ratio
- 5. I want-I should ratio
- 6. Key interpersonal skills
- 7. Blocks to using interpersonal skills
- 8. Knowing what you want
- 9. Modulating the intensity of a request
- 10. Making a simple request
- 11. Designing basic assertiveness scripts and
- 12. Assertive listening

# HOMESCHOOL HABITS CHECKLIST

Circle or check what you will try this week.

## 1. Preparation habits

- I schedule a specific time for homework.
- I choose a consistent location with minimal distractions.
- I gather what I need ahead of time (notebook, worksheet, pen).

## 2. Focus & pacing habits

- I start with a tiny step (2–5 minutes).
- I use a timer (10–15 minutes).
- I remove distractions (phone away / Do Not Disturb).

# HOMework HABITS CHECKLIST

## 3. Tracking & organization habits

- I keep materials in one place (binder / folder / notebook).
- I write down insights right after doing the homework.

## 4. Self-compassion habits

- I aim for progress, not perfection.
- I notice resistance without judgment.

## 5. Accountability habits

- I review my week: What worked? What didn't?
- I share honestly with my buddy — even when I didn't do it.

Micro commitment:

This week I will focus on: ■ Time ■ Place ■ Tiny step ■ Timer ■ Other please specify:



# REMINDER PARTICIPANT AGREEMENTS

- If you have questions, comments, or feedback, please save them for the two question periods. You can put them in the chat box or raise your real/virtual hand.
- Keep comments, questions, and feedback relatively brief so everyone has a chance to participate.(one breath sharing)
- If you're on zoom, make sure no one can overhear what is being said
- For reasons that will become clear later in the course please avoid giving advice to other participants about what they should or should not do. Validation, encouragement , and understanding are however very much appreciated.

<p><b>BE ON TIME</b></p> <p>Late entries to the video conference interrupt the lesson.</p> 	<p><b>MUTE YOUR MICROPHONE</b></p> <p>This helps reduce background noise and allows everyone to hear the speaker.</p> 
<p><b>TURN ON YOUR VIDEO</b></p> <p>Please make sure you are dressed appropriately.</p> 	<p><b>JOIN FROM A QUIET PLACE</b></p> <p>Try to avoid places with a lot of activity and distractions.</p> 
<p><b>BE PREPARED</b></p> <p>It is difficult to participate or ask for help if you are behind with your work.</p> 	<p><b>RAISE YOUR HAND</b></p> <p>Let your teacher know if you have a question or want to comment.</p> 
<p><b>USE THE CHAT FEATURE RESPONSIBLY</b></p> <p>Remember – a record is kept of everything you post in the chat.</p> 	<p><b>BE RESPECTFUL</b></p> <p>Everyone deserves to have a safe learning environment. Be kind in everything you say, post, and do online.</p> 
<p><b>USE YOUR FIRST AND LAST NAME</b></p> <p>Please rename yourself in Zoom with your first and last name.</p>	

## WEEKLY ANNOUNCEMENTS



We think we my have fixed the zooming in and out problem. Please let us know.

# THANK YOU

- On February 9's boing group we had a great discussion about what some people are struggling with in the course.
- Our personality is what it is because what it is has helped us to survive in the world. To ask us to change something which has helped us survive is akin to asking us to jump off a tall building while reassuring us that we'll be alright. Emotionally it's extremely difficult to believe and to do it we need a lot of "handholding" or coaching.
- This brings us to the main problem with this course. It gives us theory and provides us with tools and skills, but it falls short on coaching us individually on how to practically use that theory, tools and skills. It's as if were learning the theory of carpentry but never applied our tools and skills to a real woodworking project.
- We also talked about how the course can be quite activating. From an IFS perspective it may activate parts of us that feel shame, are anxious, procrastinate or are perfectionistic. When such parts are activated, we may be inadvertently repeating patterns from our past.
- One of the suggestions that came out of that boing group is for the co-leaders to summarize both at the beginning and at the end of the session the key points to retain from the session.
- We agreed that it's so very important to be able to put our thoughts and feelings such as these into words and feel safe doing it. We concluded that what is most important is to be kind and compassionate with ourselves and with each other.
- Thank you to all those who contributed to this important discussion and to everyone who continues to attend the course.

A photograph of a desert landscape featuring numerous saguaro cacti of various sizes. The scene is set against a bright blue sky with scattered white clouds. In the foreground, a large, prominent saguaro cactus stands with two arms. The background shows rolling hills and more cacti, creating a sense of a vast, arid environment. The lighting suggests a clear, sunny day.

# E-MAILED QUESTIONS, COMMENTS, FEEDBACK

As always, we've had some very good questions this week. We try to address most questions that are asked. These question may interest one person or many people.

Until we find a better way, we'll post answers that we think may be of interest to most people but unfortunately because of time we cannot read all of them in the sessions. We will therefor arbitrarily read out only a few of the many excellent questions you've asked.

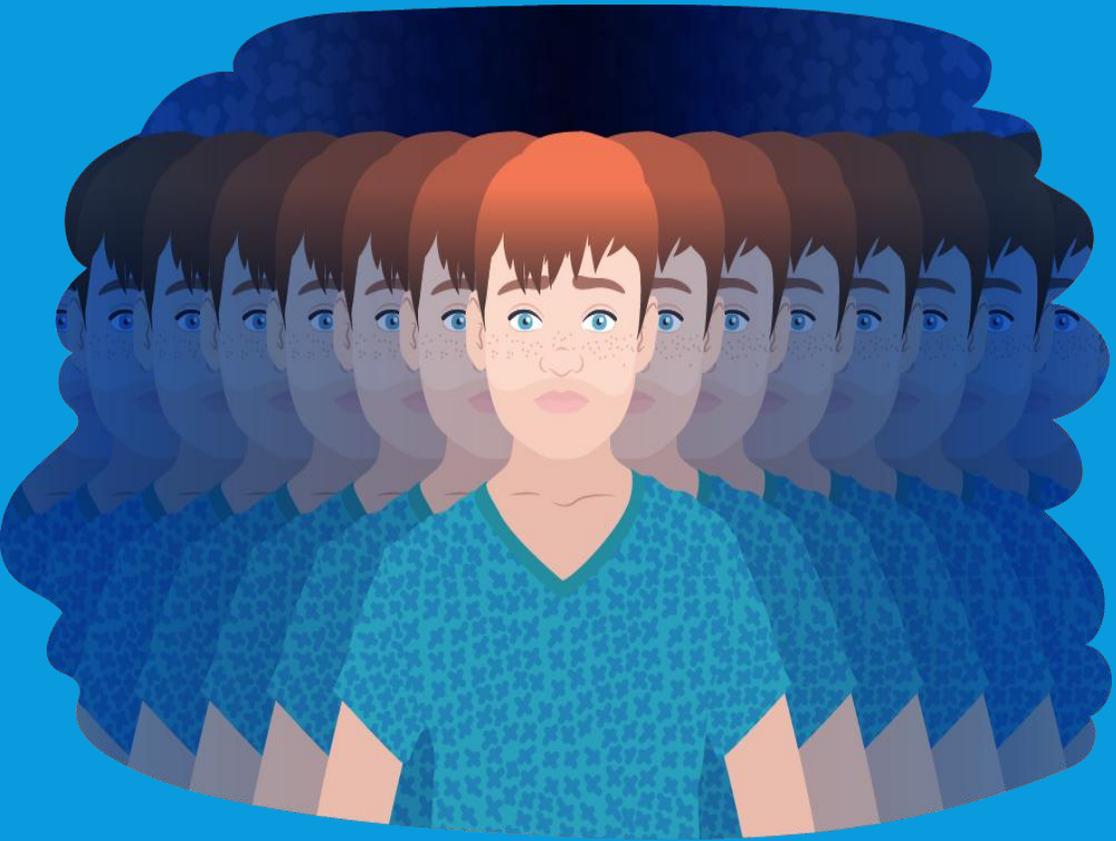
We'll however read out all the questions and invite everyone to go to the website's PowerPoint presentations and go over the answers with more time.

Question whose answer we will read out today

# O V E R V I E W



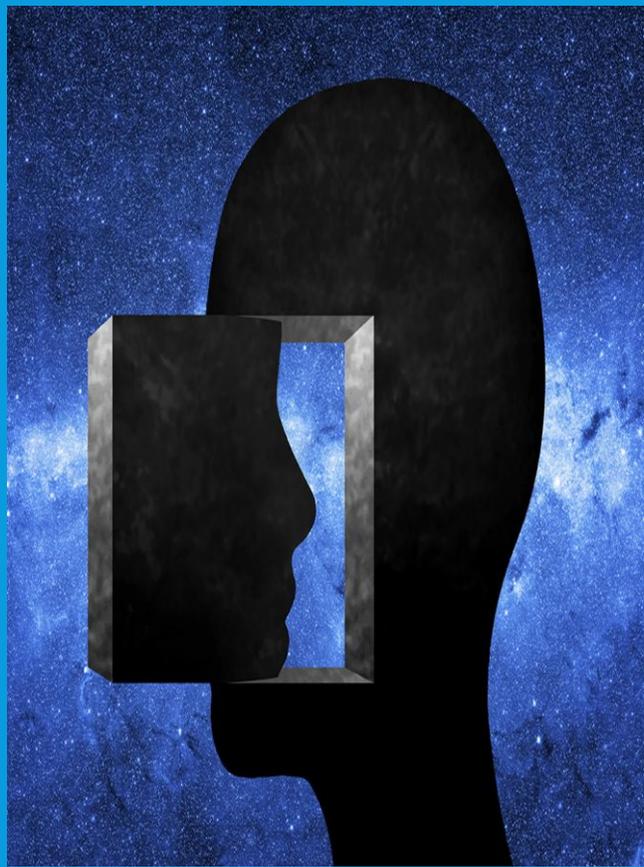
# IN OUR EXPLORATION OF TRAUMA, WE HAVE SO FAR DISCUSSED



- Stress and the stress response
- Adult, developmental, and attachment trauma
- How to assess trauma
- The consequences of trauma
- The Adverse Childhood Events studies
- Trauma as a disorder of implicit memory
- How understanding the states of autonomic activation is key to understanding the trauma related disorders
- Psychiatry's blind spot for trauma
- Trauma informed care

“Talking about your trauma doesn't make you a victim. Making your trauma your identity does.”

# WHY ARE WE TALKING ABOUT DISSOCIATION TODAY?



- It's been said that trauma spectrum disorders are a disorder of time. Part of you knows it's 2026. You go to work. You function. You try to live your life. But another part of you is still reacting as if it's the moment of danger. That part isn't just remembering the trauma, it's reliving it.
- In our minds trauma creates a time dissociation. One part of us tries to move forward, another part remains behind frozen in the moments of the trauma.
- The treatment of the trauma spectrum disorders isn't about erasing the past. It's about helping the part that's stuck in trauma time learn that the danger is over.
- Treatment of trauma is typically divided into three phases:
- Phase one helps us feel safe enough in the present. That's the goal of DBT, expanding the window of tolerance.
- Phase two helps the stuck part update its clock, moving the memory from 'happening now' to 'something that happened. That's the goal of IFS.
- Phase three helps all parts of resume a full life.
- Healing happens when no part of you is left alone in the past.
- Structural dissociation theory explains the fragmentation of the self. The three stages of treatment describe the pathway back toward integration.

# TODAY



- What is dissociation?
- Neodissociation theory
- Structural dissociation theory
- How dissociation arises from trauma
- Primary structural dissociation
- Types of flashbacks
- Features of PTSD
- Secondary structural dissociation
- Tertiary structural dissociation
- Neodissociation vs. structural dissociation theories
- Controversies in the diagnosis of dissociative identity disorder
- Treatment of the trauma spectrum disorders
- How simple addresses the three stages of trauma therapy
- Special considerations in the treatment of trauma

# PART 1 WHAT DISSOCIATION FEELS LIKE AND WHY IT HAPPENS

# WHAT IS DISSOCIATION?

# DISSOCIATION AS A DEFENSE AGAINST OVERWHEMING STRESSORS

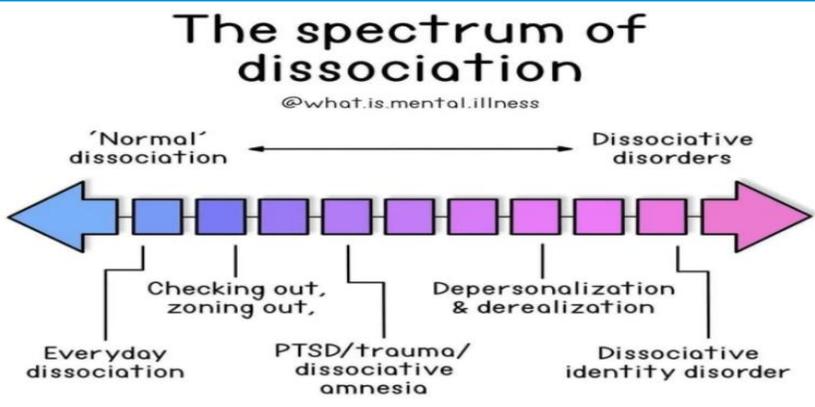
- Dissociation is a psychological defense mechanism. Defense mechanisms are automatic psychological strategies the mind uses to reduce the stress or anxiety created by internal or external stressors. They protect us from feeling overwhelmed, ashamed, frightened, or conflicted.

Level	Examples	Function
Mature defenses	Sublimation, humor, suppression	Regulate while staying integrated
Neurotic defenses	Repression, intellectualization	Keep conflict out of awareness
Immature defenses	Projection, splitting, denial	Distort reality to reduce anxiety
Dissociative defenses		Disconnect from experience itself

- Most defenses distort experience. Dissociation removes experience from awareness. It is the nervous system's last-ditch protection when other defenses fail.

# WHAT IS DISSOCIATION?

- **Definition:** in its common usage, the term “dissociation” refers to a disconnection between things usually associated with each other.
- In psychology, dissociation refers to a wide array of psychological experiences, ranging from a mild emotional detachment from our immediate surroundings, such as happens when we’re driving long distances, to a more severe disconnection from our physical and emotional experiences.



- **Spectrum:** Individual instances of dissociation are best understood as lying on a spectrum. In **mild** cases, dissociation can, in the presence of stress, be a healthy coping mechanism or defense. Daydreaming is a benign example of mild dissociation. Towards the **pathological** end of the dissociative spectrum are the DSM dissociative disorders.



- **Metaphor:** As do Humans, trees adapt to the **stress** of wind by bending. Every tree has a breaking point (traumatic stress) at which rather than bending branches will break.

- After a windstorm, a few or many, small or large tree branches may break.(spectrum of dissociative disorders)

- The degree of damage a tree sustains depends on the severity of the wind, the resilience of the tree and other resources or protective factors such as other trees sheltering each other from the wind.



# DISSOCIATION RELATED DIAGNOSIS

ICD-11	DSM-5
Dissociative neurological symptom disorder	DID
Dissociative amnesia	Dissociative amnesia including dissociative fugue
Depersonalization-derealization disorder	Depersonalization/derealization disorder
Trance disorder	Depersonalization/derealization disorder
Possession trance disorder	Other specified dissociative disorder
Complex dissociative intrusion disorder	Other specified dissociative disorder
Dissociative identity disorder	Unspecified dissociative disorder
Other dissociative disorder	Unspecified dissociative disorder

DSM=Diagnostic and Statistical Manual, ICD=International Classification of Diseases, DID=Dissociative identity disorder

- The major characteristic of all dissociative phenomena is a detachment from reality, rather than a loss of reality as is the case in psychosis. (sometimes it's difficult to tell dissociation and psychosis apart and sometimes the two merge)
- The DSM 5 lists five dissociative disorders:
  - 1. dissociative identity disorder,
  - 2. dissociative amnesia including dissociative fugue
  - 3. depersonalization derealization disorder.
  - 4. other specified dissociative disorder and
  - 5. unspecified dissociative disorder.
- The DSM doesn't make an explicit link between dissociation and the trauma spectrum disorders.

- = I'm not going to go through this slide in the session, I encourage you to go to the website if you want to explore it further.

# DISSOCIATION RELATED DIAGNOSIS

ICD-11	DSM-5
Dissociative neurological symptom disorder	DID
Dissociative amnesia	Dissociative amnesia including dissociative fugue
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Other dissociative disorder	Unspecified dissociative disorder

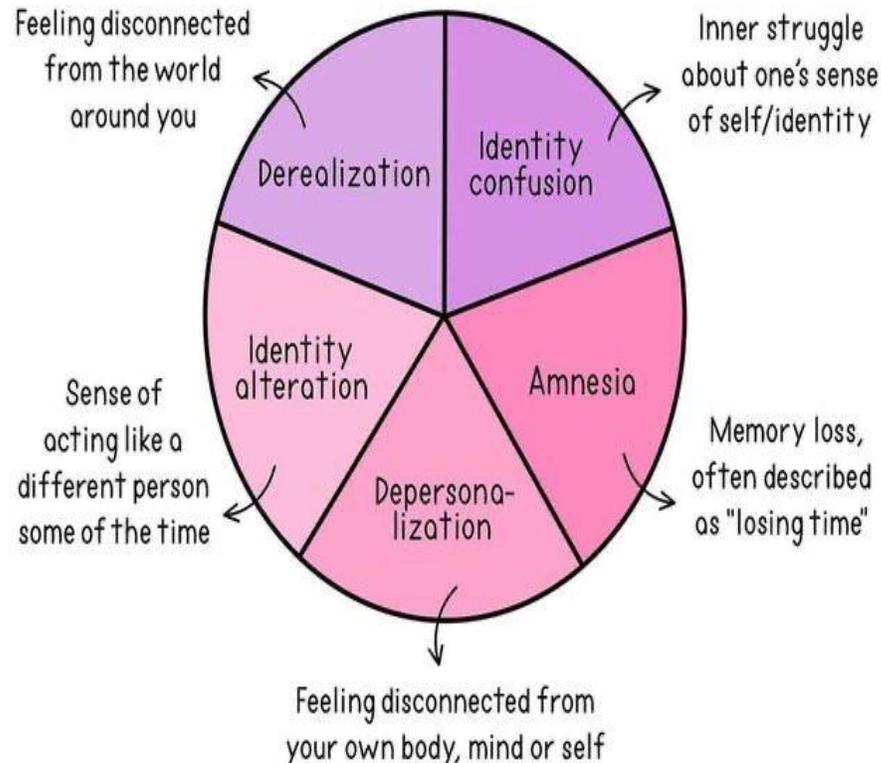
DSM=Diagnostic and Statistical Manual, ICD=International Classification of Diseases, DID=Dissociative identity disorder

- ICD-10, the International classification of disease 11th edition, also lists, in addition to the five DSM's dissociative disorders described above:
- 6. dissociative neurological symptom disorder which includes psychogenic paralysis, unexplained pain and other sensations, and pseudo seizures.
- 7. trance disorder
- 8. possession trance disorder and
- 9. complex dissociative intrusion disorder
- As we will see when we consider dissociative identity disorder, dissociative experiences are sometimes not integrated into the usual sense of self resulting, for people experiencing them, in discontinuities of conscious awareness and memory.

# THE 5 CORE FEATURES OF DISSOCIATION

## The many faces of Dissociation

@what.is.mental.illness

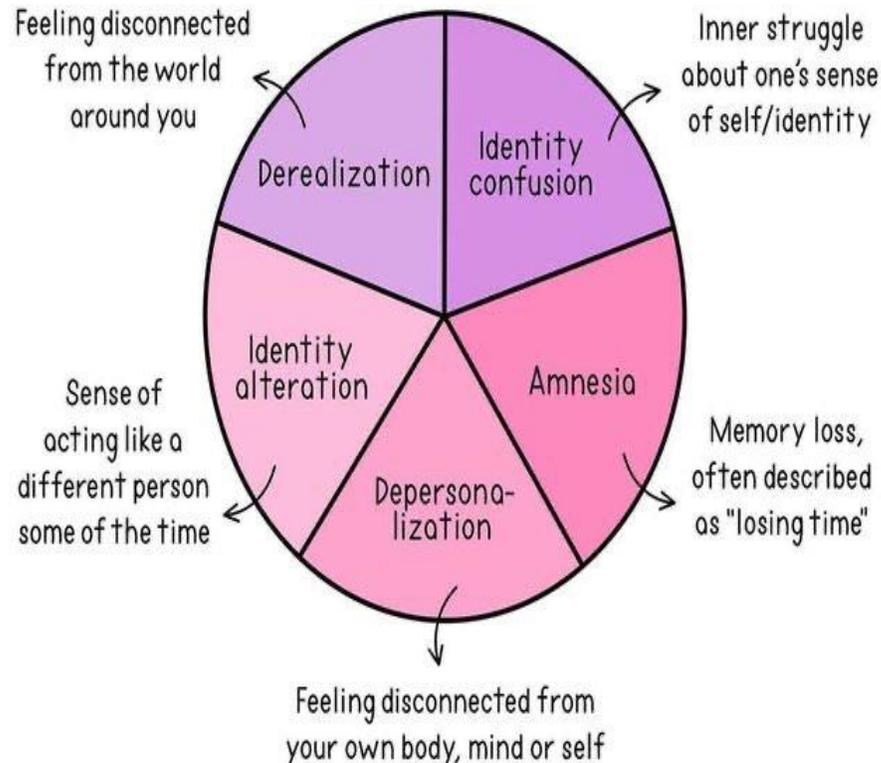


- 1. Derealization (feeling disconnected from the world around you) is an alteration in the perception of the external world, causing those with the condition to perceive it as unreal, distant, distorted or falsified. Other symptoms include feeling as if one's environment is lacking in spontaneity, emotional coloring, and depth.
- 2. Depersonalization (feeling disconnected from your own body, mind or self) can consist of a detachment within the self, regarding one's mind or body or being a detached observer of oneself. It can be described as feeling like one is on "autopilot" and that the person's sense of individuality or selfhood has been hindered or suppressed

# THE 5 CORE FEATURES OF DISSOCIATION

## The many faces of Dissociation

@what.is.mental.illness



- 3. Identity confusion (inner struggle about one's sense of identity or self) is a pronounced difficulty achieving a cohesive sense of self. Someone with identity confusion may constantly wrestle with separate often adversarial identities that are engaged in a battle for control of the person's mind and body.
- 4. Dissociative amnesia (memory loss often described as losing time) is characterized by retrospectively reported memory gaps. These gaps involve an inability to recall personal information, usually of a traumatic or stressful nature.
- 5. Identity alteration (sense of acting like a different person some of the time) involves pronounced changes in behavior, memory and thinking over periods of time.

In this session we'll present two theories that seek to explain dissociation and then we'll compare and contrast them:

1. Neodissociation theory
2. Structural dissociation theory

# 1. NEODISSOCIATION THEORY

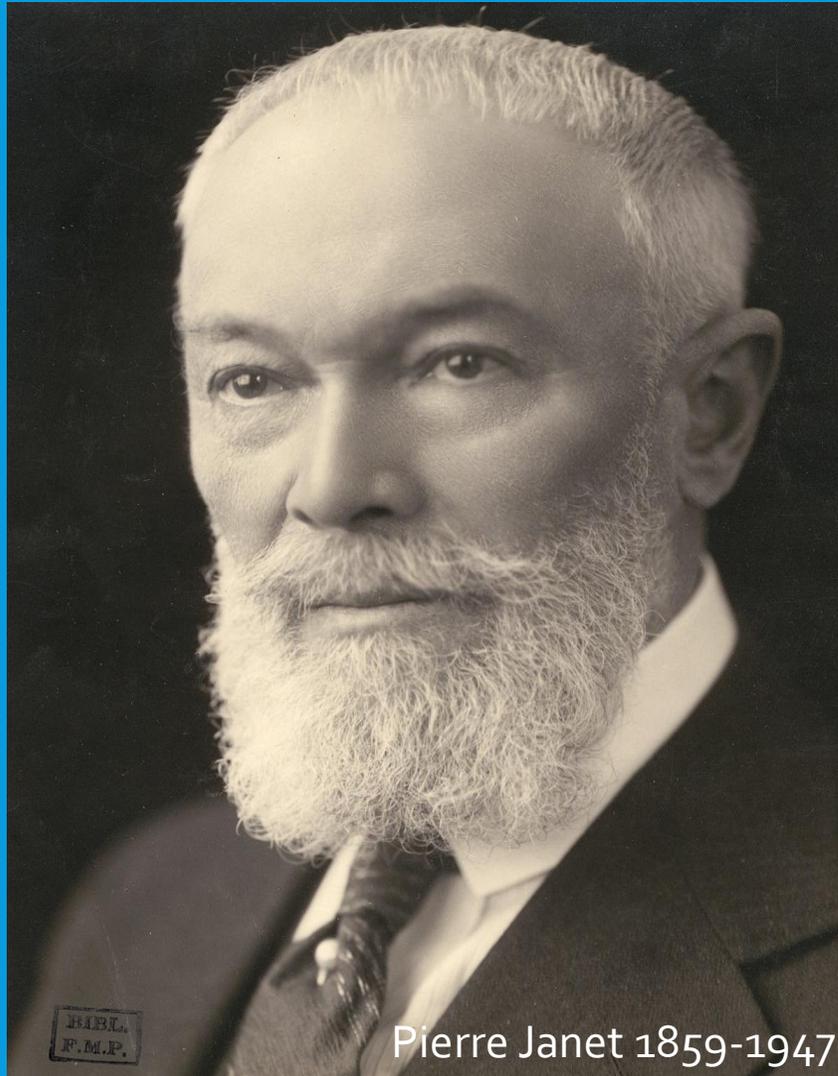
# NEODISSOCIATION THEORY

- Neodissociation theory proposes that consciousness is made up of semi-independent mental systems such as attention, memory, perception, and self-monitoring that usually work together. Under certain conditions these mental systems can become functionally disconnected.
- Neodissociation theory comes out of experimental psychology and hypnosis research.
- It proposes that:
  - ✓ The mind is modular.
  - ✓ Dissociation is a state-based separation of mind functions.
  - ✓ Dissociated processes can continue operating outside awareness.
  - ✓ There is still one person, one self, just poor internal communication.
- Examples of such disconnection of mental functions include:
  - ✓ Hypnotic analgesia where pain processing occurs, but awareness of it is blocked and
  - ✓ Automatic behaviors (“I don’t know why I did that”)
- The emphasis in Neodissociation theory research is on determining which functions are offline, what triggers this and how can integration be restored.

## 2. STRUCTURAL DISSOCIATION THEORY

What is structural dissociation theory?

# THE ORIGINS OF STRUCTURAL DISSOCIATION THEORY



Pierre Janet 1859-1947

- Pierre Marie Felix Janet was a pioneering French psychologist, physician, philosopher and psychotherapist who coined the term dissociation and described its importance in mental health by postulating a theory called “structural dissociation”.
- Pierre Janet was 3 years younger than Freud.
- He studied under Jean-Martin Charcot at Paris’s Hospital La Salpetriere where in 1885 Freud also spent 3 months learning about “hysteria”.
- Janet was one of the first psychologists to draw a clear connection between a person’s past trauma and symptoms presenting later in life. Unlike Freud he never abandoned this idea.
- Freud acknowledged his debt to Janet. Janet doesn’t have as high a profile in modern psychology as Freud possibly because unlike the later he was humble and avoided the spotlight .
- In the late 1980’s Ellert, Nijenhuis, Onno van der Hart, and Kathy Steele built on Janet’s work and expanded structural dissociation theory into its present-day form

# WHAT IS STRUCTURAL DISSOCIATION THEORY?



- Structural dissociation theory describes three types of psychopathological dissociation:
- primary, secondary and tertiary structural dissociation.
- Structural dissociation theory proposes that people with these trauma related disorders experience a dissociation of their personality into separate parts, each part having its own psychobiological characteristics.
- Although the theory describes three types of dissociation, there is no clear demarcation between the three and they are thought to be on a continuum or spectrum of severity.

# WHAT IS STRUCTURAL DISSOCIATION THEORY?



- These three types of dissociation correspond to traditional diagnostic categories:
- 1. Primary structural dissociation = PTSD
- 2. Secondary structural dissociation = Complex PTSD
- 3. Tertiary structural dissociation = dissociative identity disorder
- A person with a trauma related disorder can experience a combination of symptoms from any of these three. Ex. Someone with predominantly PTSD can present with some DID symptoms.
- The type of dissociation a person develops depends on the balance between the duration and severity of the trauma and the person's coping resources.

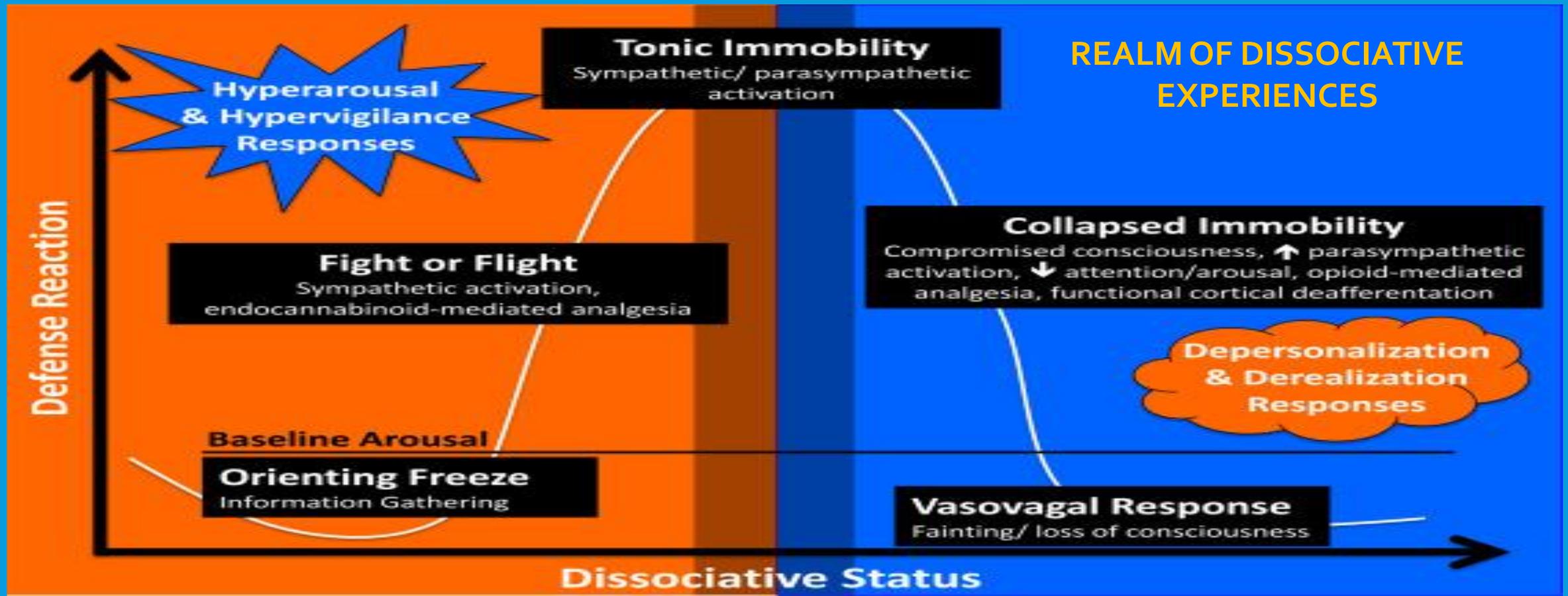
# HOW DISSOCIATION ARISES FROM TRAUMA

Can we review how dissociation results from trauma?

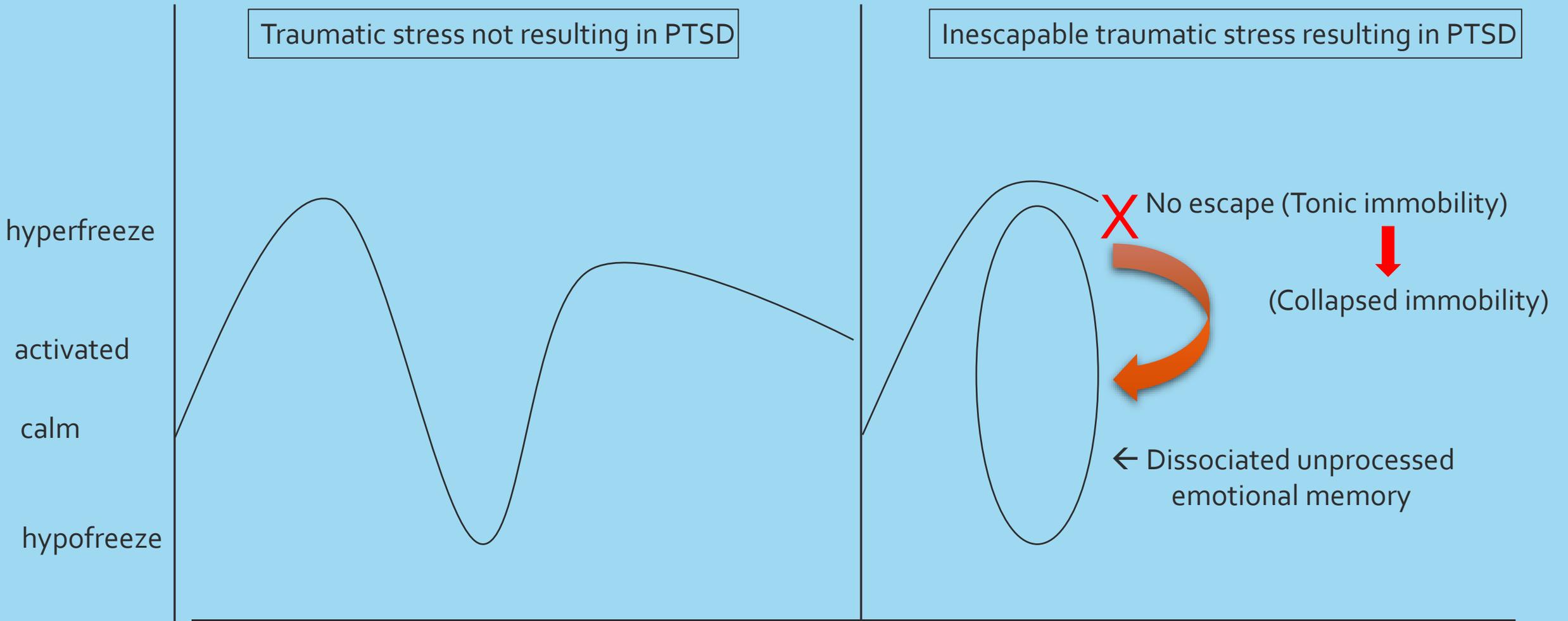
# THE ORIGINS OF DISSOCIATION IN 3 STEPS

Step 1) When faced with a life-threatening danger, an organism first goes into a fight or flight state of activation.

Step 2) When the organism perceives that life-threatening danger as physically inescapable, it leaves or psychologically dissociates from the situation by going into a freeze state of activation. (Tonic to collapsed immobility is when the branch of the metaphorical tree breaks. Dorsal parasympathetic brake)



# Activation curves



Step 3) The unprocessed dissociated memory of the traumatic situation is then encoded in its original form with accompanying activation states, physical sensations, emotions, and visual images in the somatic, emotional, and rational memory systems. To use a computer metaphor, a traumatic dissociated experience is like a document or file that is saved into the computer memory and no longer present as an open window. Triggers however reopen the document or file.

HOW IS DISSOCIATION DIAGNOSED?

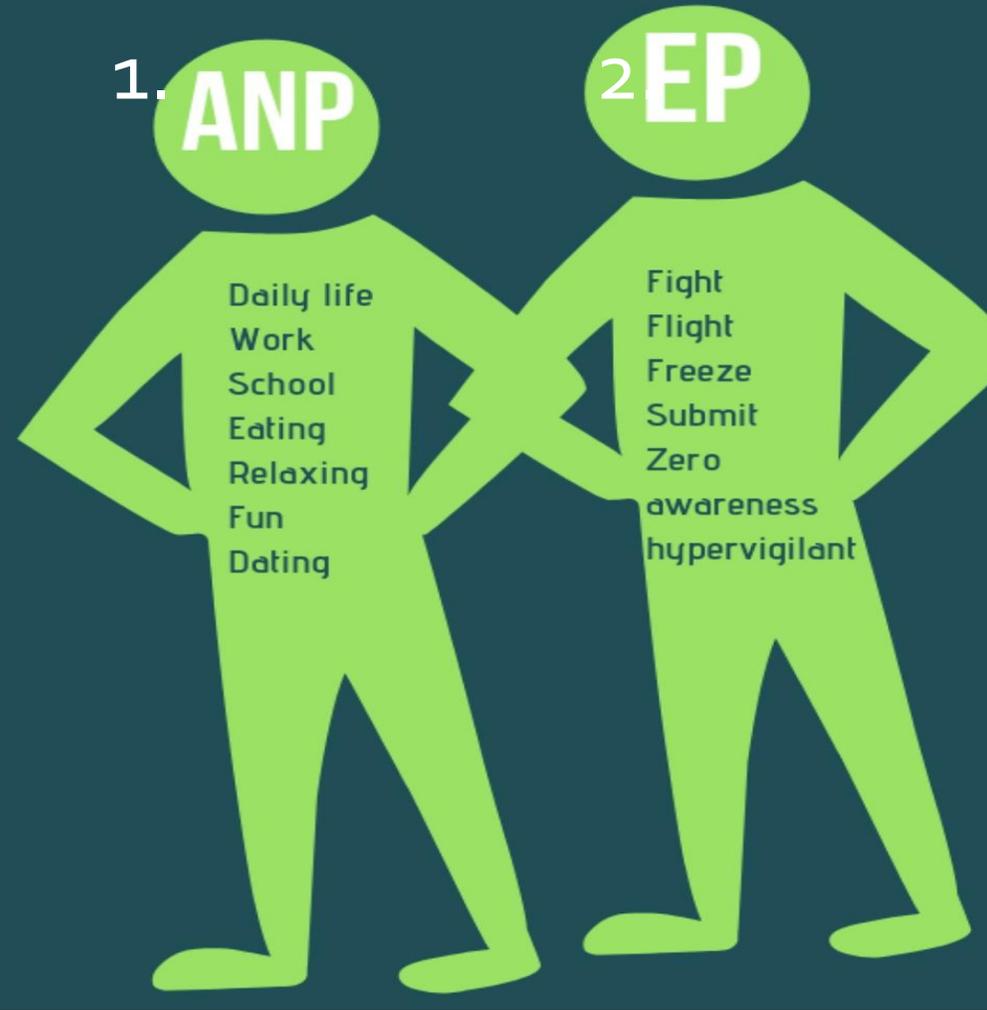
# ASSESSMENT OF DISSOCIATIVE DISORDERS

- The assessment and diagnosis of dissociative disorders typically involves a combination of clinical interviews, structured diagnostic instruments, and self-report questionnaires. These tools help clinicians identify the presence and severity of dissociative symptoms, distinguish between different types of dissociative disorders (e.g., DID, dissociative amnesia, depersonalization/derealization disorder), and differentiate dissociation from other conditions such as psychosis or PTSD. The most commonly used and validated assessment tools and scales are:
  - **Structured Interviews**
    1. **Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D)**: Gold standard for diagnosing dissociative disorders. Assesses five core dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Requires trained clinicians.
    2. **Dissociative Disorders Interview Schedule (DDIS)**: Semi-structured interview developed by Dr. Colin Ross. Assesses dissociative symptoms, trauma history, and comorbidities (e.g., somatization, borderline traits). Suitable for research and clinical use.
  - **Self-Report Measures**
    3. **Dissociative Experiences Scale (DES)**: 28-item self-report screening tool. Measures a wide range of dissociative symptoms (e.g., absorption, amnesia, depersonalization). A DES score >30 is suggestive of a dissociative disorder, though not diagnostic on its own.
    4. **Multidimensional Inventory of Dissociation (MID)**: Comprehensive 218-item self-report instrument developed by Paul Dell. Assesses 23 dissociative symptom clusters and provides detailed profiles. Used in clinical and research settings, often for complex dissociative presentations.
    5. **Somatoform Dissociation Questionnaire (SDQ-20)**: 20-item self-report questionnaire. Focuses on somatoform dissociation, such as pain, paralysis, or anesthesia without organic cause. Particularly useful in evaluating dissociation in trauma survivors with physical symptoms.

# THE 3 TYPES OF DISSOCIATION

# PRIMARY STRUCTURAL DISSOCIATION

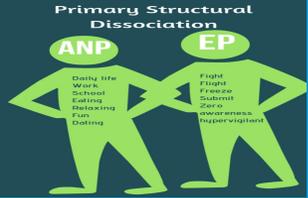
## Primary Structural Dissociation



A.K.A. PTSD

- Structural dissociation (SDT) theory considers that humans have a rational and an emotional mind/brain which normally function in an integrated fashion. (recall DMM's three information centers and the triune brain)
- It then postulates that in PTSD or primary structural dissociation the mind dis-integrates or splits into two parts:
  - 1. An apparently normal part or **ANP** that tries to carry on with the usual business of life... and
  - 2. A dissociated emotional part or **EP**, whose primary concern is defence and survival. This part carries the unprocessed dissociated traumatic memories that occasionally resurface and manifest as flashbacks, dysregulated emotions, and the physiological arousal states of fight, flight, freeze, and fawn.
- At times, the person with PTSD functions mostly in their apparently normal part **ANP**, while at other times the traumatized dissociated emotional part **EP** is triggered and takes over.

How are the apparently normal part or ANP and the emotional part or EP different?



# FUNCTIONS OF THE ANP AND EP IN PTSD

## APPARENTLY NORMAL PART

Is also known as the daily life action system. It carries on actions that are concerned with the survival of the species:

- ✓ exploration (work, study)
- ✓ play
- ✓ energy management: sleep, eating, preparing food, housecleaning etc.
- ✓ attachment
- ✓ Socializing
- ✓ Reproduction
- ✓ Caretaking

## EMOTIONAL PART

Is also known as the defensive action system. It carries on actions that are concerned with the survival of the individual.

- ✓ Fight
- ✓ flight
- ✓ freeze
- ✓ total submission/collapse
- ✓ social submission
- ✓ attachment cry
- ✓ Recuperation following the threat: rest, isolation, wound care, and gradual return to daily activities.

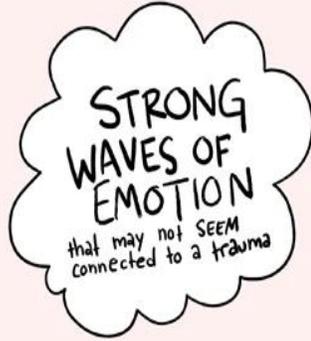
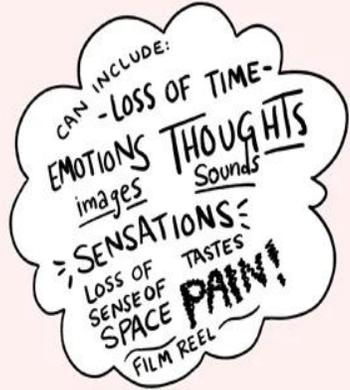
Structural dissociation theory's emotional part is the "computer file or document" that's created by the trauma and stored in the somatic and emotional memory systems. It occasionally, and sometimes unpredictably, resurfaces into the computer "window" of everyday life as a flashback

When you feel suddenly hijacked that may be your EP

# TYPES OF FLASHBACKS

How does structural dissociation explain PTSD flashbacks ?

# TYPES OF FLASHBACKS



what  
**FLASHBACKS**  
often feel like.

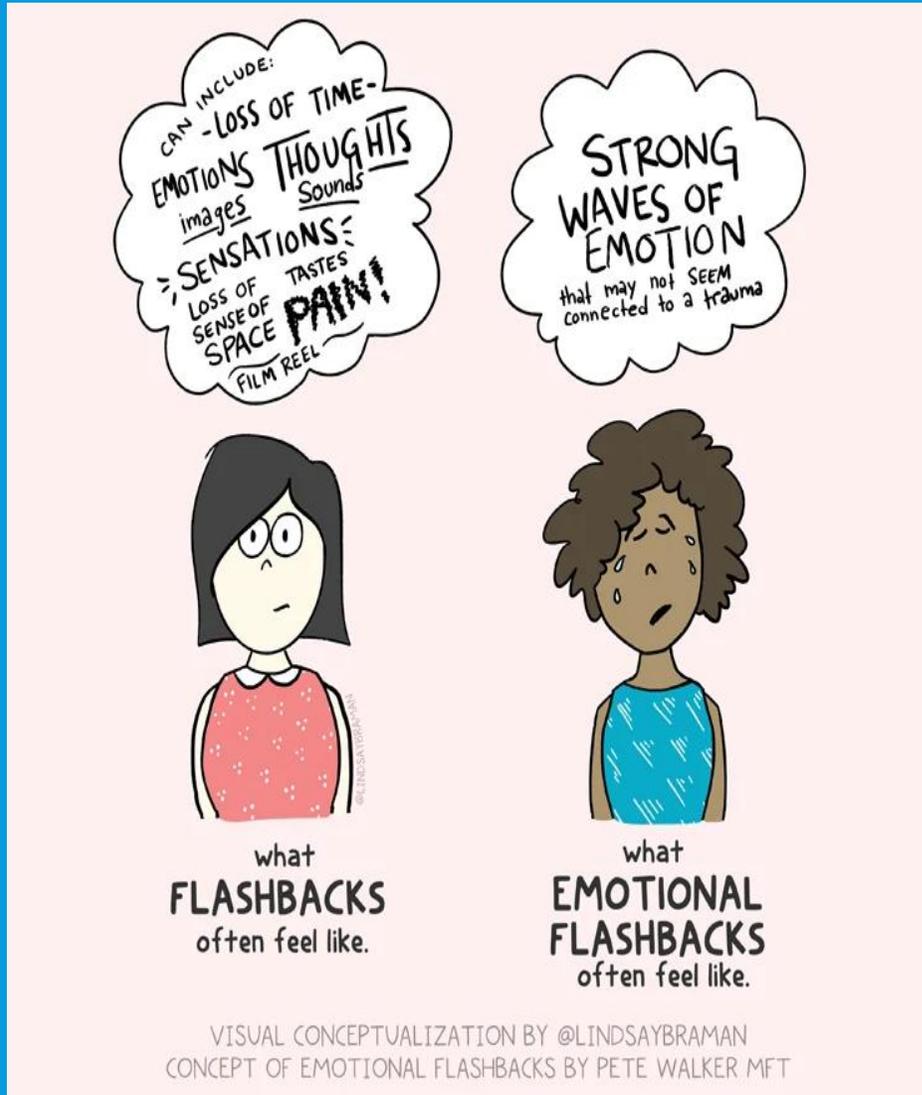


what  
**EMOTIONAL  
FLASHBACKS**  
often feel like.

VISUAL CONCEPTUALIZATION BY @LINDSAYBRAMAN  
CONCEPT OF EMOTIONAL FLASHBACKS BY PETE WALKER MFT

- Flashbacks are a common experience in people with trauma related disorders and can be thought of as the surfacing of the EP
- The pop psychology understanding of a flashback is that it is the reexperiencing of the trauma as a visual image with an auditory component.
- Such images and sounds are however only the conscious or rational mind memory of the trauma.
- There are at least three distinct types of flashbacks each associated with one of the three information processing centers we talked about when we discussed Patricia Crittenden's DMM.

# 3 TYPES OF FLASHBACKS

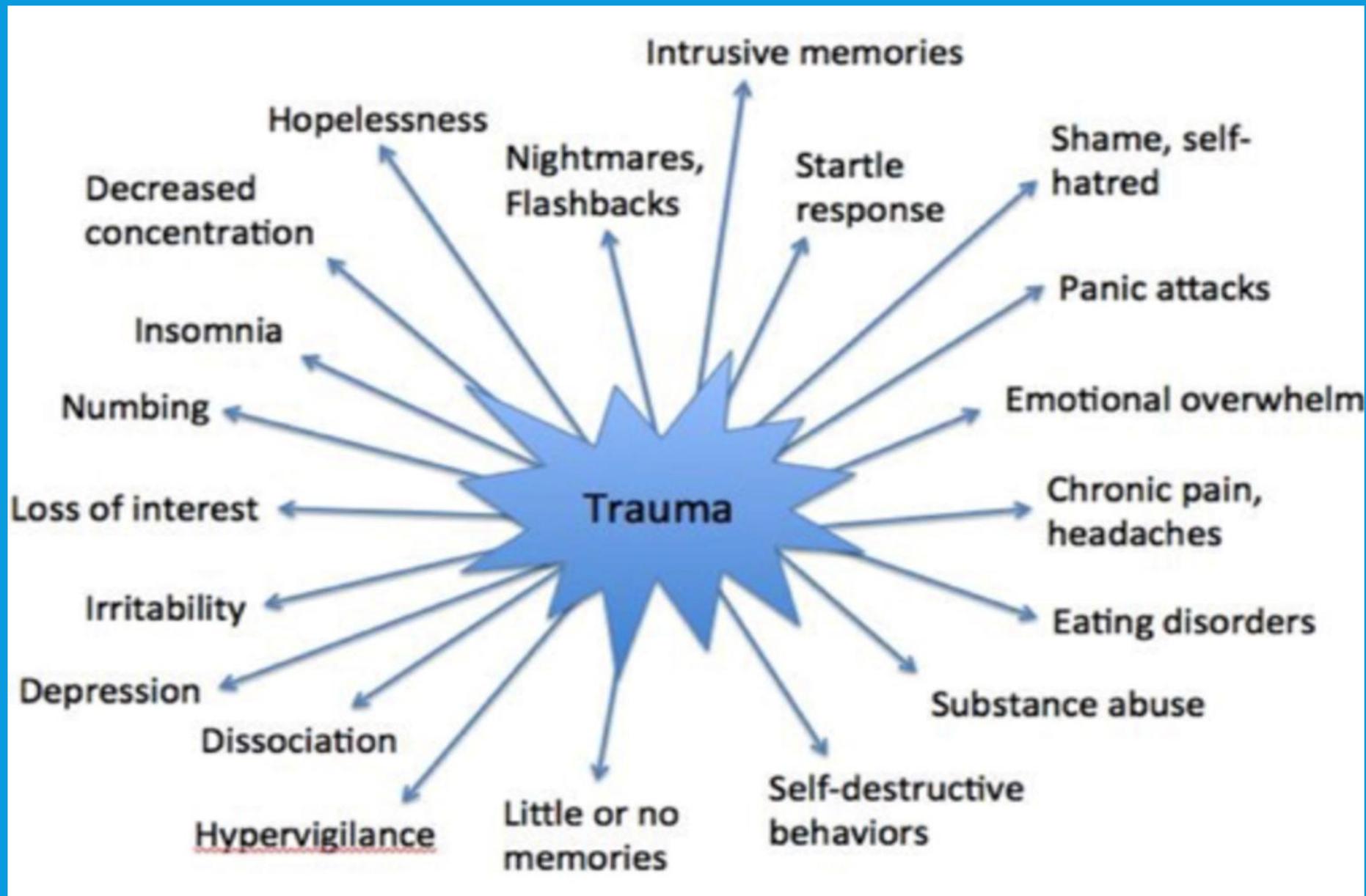


- 1) cognitive flashbacks in which the traumatic memory is reexperienced as a visual or auditory experience. The pop psychology version.
- 2) emotional flashbacks in which the intense emotions felt during the trauma are reexperienced and
- 3) somatic flashbacks in which the pain and bodily sensations felt during the trauma are reexperienced
- While people with trauma related disorders readily associate their visual and auditory flashbacks with their trauma, they may not as readily associate somatic or emotional flashbacks with the trauma.
- In fact, people are often at a loss as to how to explain somatic and emotional flashbacks when they occur independent of cognitive memories of the trauma.
- They often attribute the somatic sensations and emotional reactions to something happening in the present rather than to their trauma.

# FEATURES OF PTSD

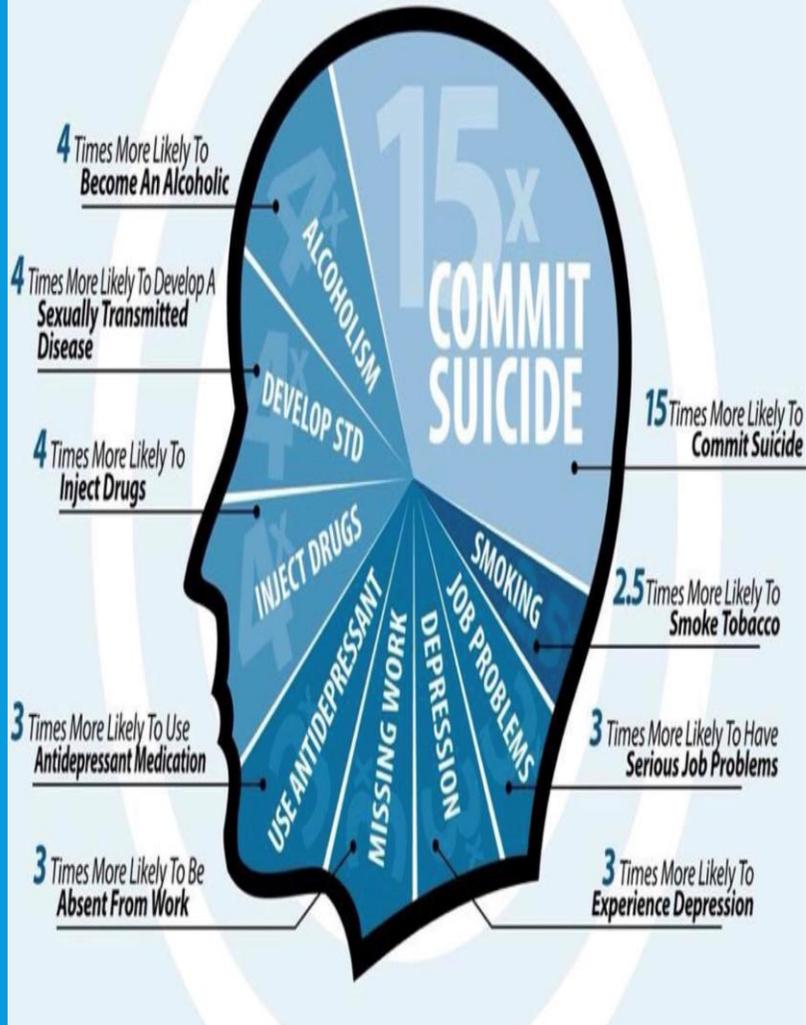
I know we already covered this on our session on trauma, but can we quickly review the symptoms that people with primary structural dissociation or PTSD experience?

# REVIEW OF SYMPTOMS IN PTSD



# SOME FEATURES OF PTSD A REVIEW

## PEOPLE WHO HAVE EXPERIENCED TRAUMA ARE:



- People who have experienced trauma are at a much greater risk for other issues such as substance abuse, suicide, depression, sexually transmitted diseases, and unemployment.
- In some ways PTSD presents differently in men and women.
- 10% of all women develop diagnosable PTSD compared to only 4% of all men.
- Women are at a much greater risk of sexual assault or abuse, child abuse, and domestic violence.
- Risk factors for developing PTSD include genetic predispositions, lack of social support, neurological impairments, previous trauma, pre-existing mental health conditions, and significant life stressors.
- The posttraumatic stress disorders are often misdiagnosed as mood, anxiety and personality disorders.
- There is a significant overlap between symptoms of the posttraumatic stress disorders and of ADHD. Both can present with easy distractibility, difficulty listening, disorganization, hyperactivity, restlessness and difficulty sleeping.



## PTSD: AVOIDANCE, DEPRESSION, AND VULNERABILITY



- For people suffering from trauma related disorders, reminders of the trauma can trigger the EP to surface. They try to avoid this surfacing by avoiding triggers.
- Eventually the person avoids more and more things and becomes more agoraphobic to the point that many people with trauma related disorders become housebound
- As their life becomes more restricted, they become more disconnected from others, a meaningful occupation, engagement with the world, nature, and a meaningful cosmic story. This is in part why people with PTSD are also often depressed.
- The avoidance of potential triggers and memories perpetuates PTSD since the processing of the traumatic memories requires some degree of controlled exposure to triggers . By not facing their fears people with PTSD remain victims of the trauma rather than becoming survivors.
- The more avoidance there is, the less the ANP is able to maintain a semblance of apparent normality
- How trauma impacts people depends on their resources : at one end of the resource's spectrum are people with secure attachment, who had normal psychosocial development prior to a single event trauma. They have more resources and are less likely to develop PTSD. If they do, their prognosis is better.
- At the other of the resource's spectrum are people with insecure forms of attachment, and developmental trauma who likely have psychosocial developmental issues. They often have fewer resources and are more likely to be retraumatized and to experience the more severe types of the post traumatic disorders.

# FEATURES OF PTSD

Can you review how the type of parenting a person receives plays a role in their predisposition to developing PTSD?

# MULTIGENERATIONAL TRAUMA

## HOW A CAREGIVER'S TRAUMA CAN IMPACT A CHILD'S DEVELOPMENT

### EARLY DEVELOPMENT

#### Caregiver With Traumatic Experience

Mother releases cortisol

Baby absorbs cortisol through placenta

Can impact baby's:

- HPA axis
- Central nervous system
- Limbic system
- Autonomic nervous system



Caregiver struggles to regulate

Attachment relationship between caregiver and child may be strained

Can impact child's:

- Development of a core sense of self
- Ability to integrate experiences
- Epigenetic expressions

### ADULTHOOD

#### A Person Who Has Had a Caregiver With Untreated Trauma May:

Be more prone to PTSD after trauma

Struggle to repair after conflict

Struggle with relationships



Unintentionally bring out negative behaviors in others

Be emotionally detached

Be more prone to dissociate

### BREAKING THE CYCLE OF TRAUMA

This can become a cycle, impacting future generations.



The good news is that healing trauma can break this loop. Seek help from a licensed health or mental health practitioner.

Parenting is a hard job, and this isn't meant to add to the stress of raising children. But it's critical to provide practitioners with information that can help them work more skillfully with patients who've experienced trauma and help them resolve their trauma. Trauma is not a life sentence - it's never too late to heal.

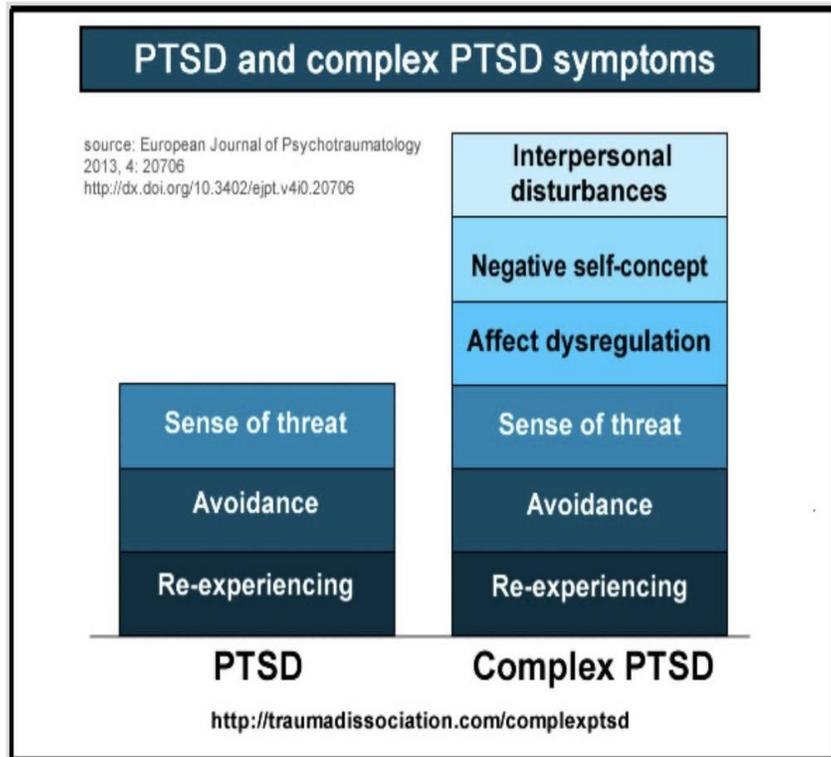
- There are several ways in which trauma can be passed from one generation to another
- Epigenetically – trauma alters the expression of the parents' genes, and this is passed on to the child
- Intra-uterine environment – a mother who has a trauma spectrum disorder has elevated stress hormones which cross the placenta and impact the fetus's development
- Attachment issues – parents with trauma spectrum disorders tend to have insecure attachment types. Insecure attachment styles are often passed on from generation to generation
- Caregiver difficulties with emotional regulation – emotional regulation is learned via modelling. Parents who struggle with emotional regulation may have difficulty teaching their children to emotionally regulate
- Lack of psychosocial resources – Trauma spectrum disorders correlate with economic insecurity and fewer social supports. A child growing up in such an environment will also have fewer psychosocial resources and be more vulnerable to trauma.
- People who have trauma spectrum disorders often feel guilty that they may pass some of their struggles on to their children. They often ask what can I do to help my children? The consensus answer seems to be "do what you can to heal and grow yourself that healing and growth will also be passed on to your children."

# SECONDARY STRUCTURAL DISSOCIATION

What is secondary structural dissociation or complex PTSD and how is it different from primary structural dissociation or PTSD?

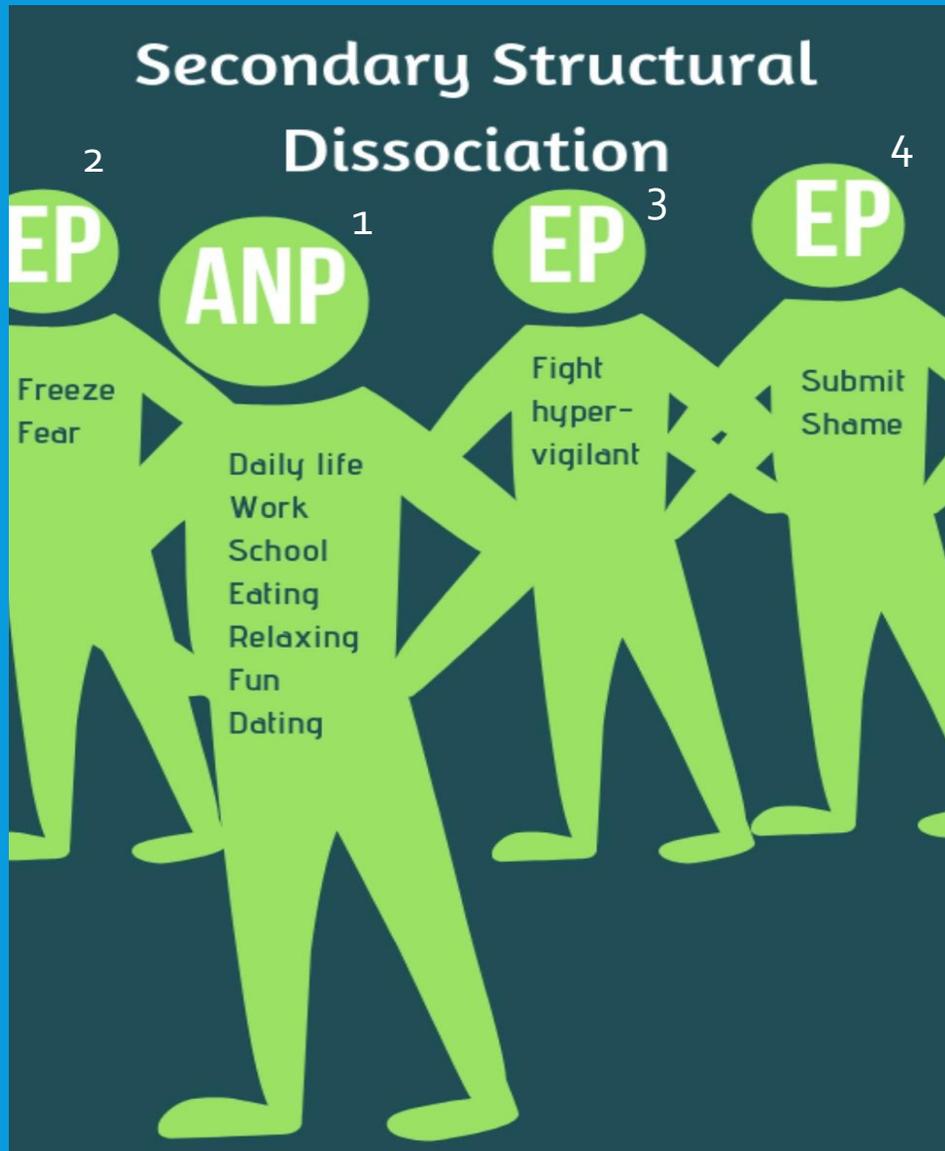
# HOW C-PTSD/SECONDARY STRUCTURAL DISSOCIATION MANIFEST ?

## Differences between PTSD and Complex PTSD



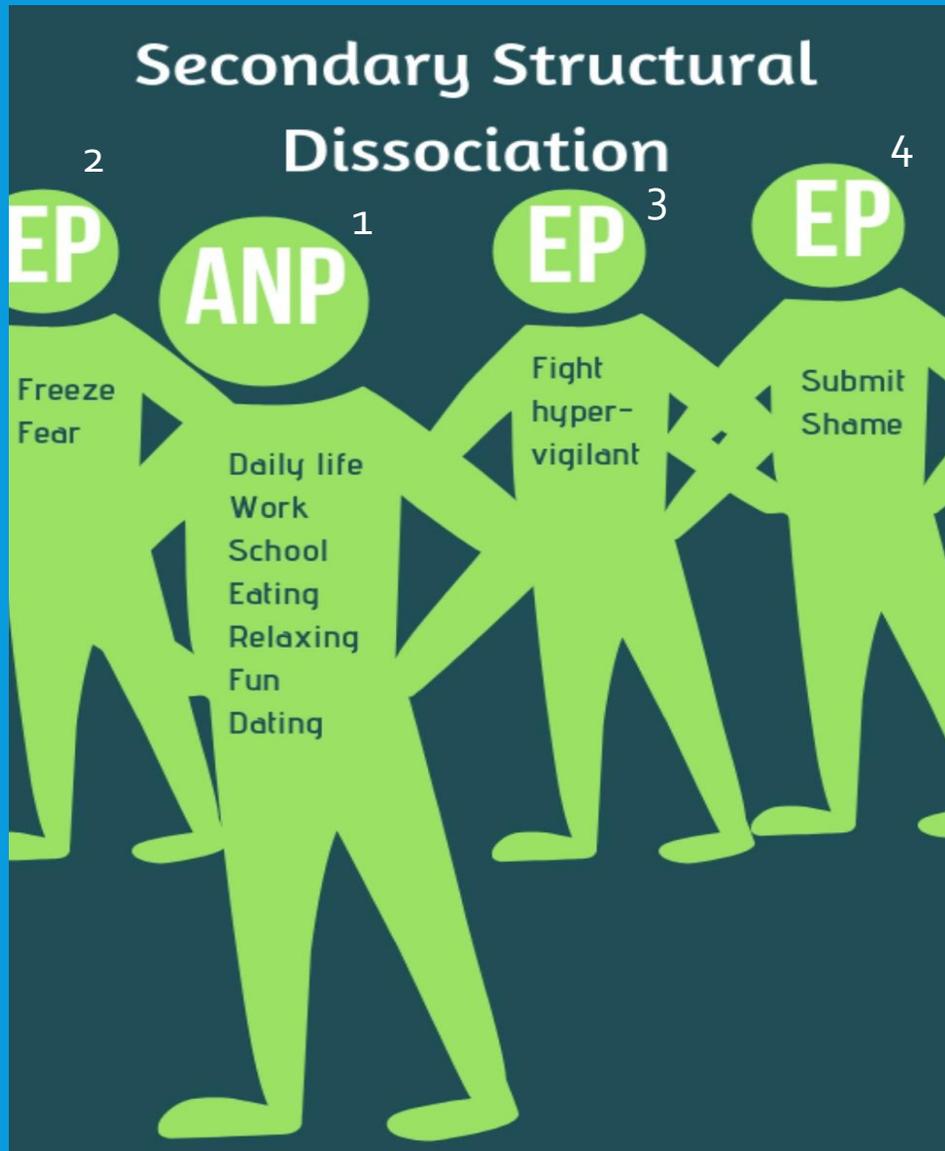
Complex PTSD causes a broader range of symptoms compared to PTSD. The additional symptoms of Complex PTSD are known as **Disturbances in self-organization** (DSO). [6]

- Complex PTSD often results from exposure to severe stressors that are 1) repetitive or prolonged 2) in children involve harm or abandonment by caregivers or other ostensibly responsible adults and 3) occur at developmentally vulnerable times in the victim's life.
- Like PTSD, people with complex PTSD feel 1) a sense of threat, 2) reexperience the trauma in the form of flashbacks, and 3) avoid potential triggers.
- In addition, people with complex PTSD also experience 4) affect dysregulation, 5) negative self-concept, and 6) interpersonal disturbances all of which are not typically present in PTSD.



A.K.A. COMPLEX PTSD

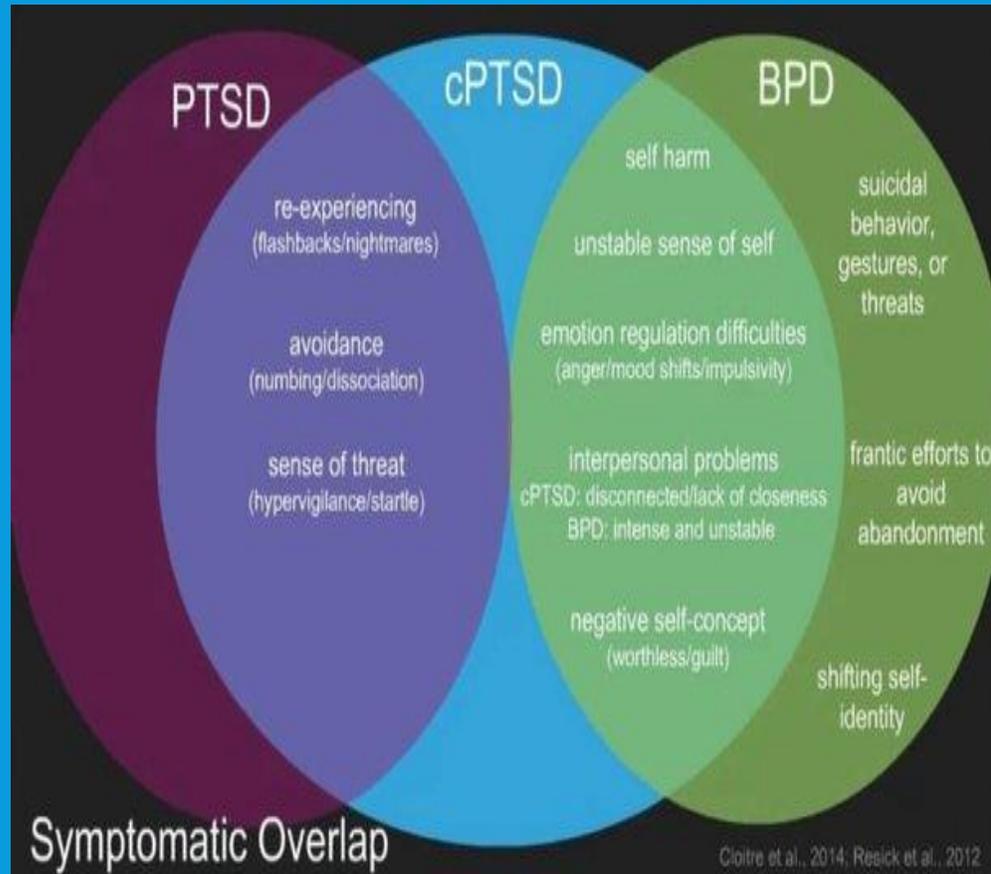
- Secondary structural dissociation is a more severe form of dissociation. It is often associated with disorganized attachment, and attachment/developmental trauma.
- Children and adults with insecure attachment are more vulnerable to trauma and more likely to experience multiple traumatic events
- As with primary structural dissociation/PTSD, in secondary structural dissociation, after traumatic experiences, an apparently normal part (ANP) tries to carry on with normal everyday life.
- But, in secondary structural dissociation, because there may have been multiple traumas and/or an increased vulnerability, there are multiple split off emotional parts, (EP's) each arising from a different trauma and each carrying different implicit memories.



- These traumas may have happened at different ages and stages of development, and the trauma that gave rise to them may not be a discreet one-time event but ongoing over a significant period. (as in ongoing child or partner abuse)
- As we will see when we talk about internal family systems, it's useful to think of these EP's as having distinct personalities, ages, ways of thinking, feeling, behaving, and distinct states of activation (fight, flight, freeze, or fawn)
- In secondary Structural dissociation, while the person **consciously** experiences themselves as a single individual, **emotionally**, they feel they are different people. (Dr. Jekyll and Mr. Hyde)

A.K.A. COMPLEX PTSD

## SYMPTOM OVERLAP BETWEEN PTSD, C-PTSD, AND Borderline PD

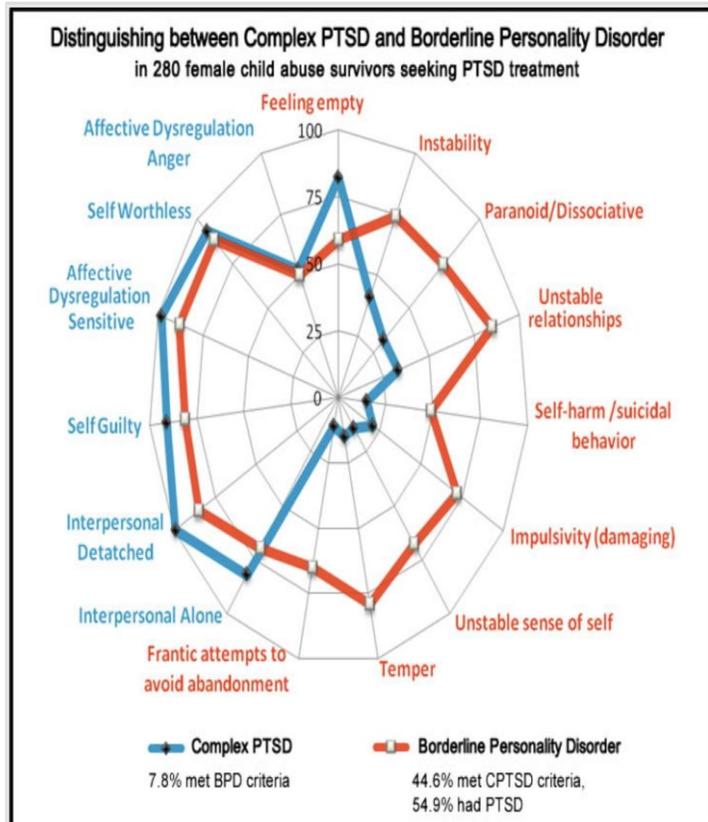


- Remember that these are general categories arrived at by consensus of select experts. Each person's experience is unique. Don't get bogged down self diagnosing
- While they are distinct concepts, posttraumatic stress disorder, complex posttraumatic stress disorder and borderline personality disorder overlap
- PTSD and c PTSD share flashbacks/nightmares, numbing/dissociation and hypervigilance/startle
- c PTSD and BPD share self-harm, an unstable sense of self, emotional regulation difficulties, interpersonal problems, and a negative self-concept
- BPD Overlaps significantly with disorganized attachment style and features suicidal behavior, frantic efforts to avoid abandonment, and shifting self-identity

# C-PTSD, AND BPD

## Complex PTSD, BPD and Personality Disorders

A history of childhood trauma is also common in people with [Borderline Personality Disorder](#) (BPD), and emotional regulation difficulties is a symptom of both BPD and Complex PTSD. [1], [3], [5], [6] A significant proportion people with BPD also have either PTSD or Complex PTSD.



Four BPD symptoms greatly increased the odds of being in the BPD compared to the Complex PTSD class: frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, and impulsiveness. *European Journal of Psychotraumatology* 2014, 5: 25097. doi: 10.3402/ejpt.v5.25097

<http://traumadissociation.com/other>

- A history of childhood trauma is common but not always present in people diagnosed with BPD.
- A history of trauma is always present in people diagnosed with cPTSD.
- A person can be diagnosed with both BPD and PTSD or cPTSD. 8% of people diagnosed with cPTSD also met criteria for BPD. 45% of people with BPD met cPTSD criteria. 55% of people diagnosed with BPD also met criteria for PTSD
- Most people diagnosed with BPD have a disorganized attachment style
- BPD and cPTSD overlap in 1) low self-worth 2) feelings of guilt 3) feeling detached and alone 4) sensitivity to slights 5) feels of anger
- The symptoms that are found more frequently in BPD than in cPTSD are: 1) frantic efforts to avoid abandonment 2) unstable sense of self 3) unstable and intense interpersonal relationships and 4) impulsiveness
- In my opinion psychiatry is not doing a good job in trying to classify emotional dysregulation. Take all these labels with a huge grain of salt
- While there is a lot of interest in these distinctions keep in mind that humans are complex and that psychiatric labels are imperfect, limited, political, evolving ways of trying to understand this complexity

# TERTIARY STRUCTURAL DISSOCIATION

What is tertiary structural dissociation?



- Dissociative identity disorder or tertiary structural dissociation used to be called “multiple personality disorder”. It is the most severe form of dissociation.
- According to structural dissociation theory, in tertiary structural dissociation, there is such an imbalance between the severity and duration of the trauma and the person’s coping resources, that the emotional mind’s dissociative coping mechanisms are insufficient to protect the self from the trauma and the apparently normal and conscious self also splits or fragments. This creates two or more conscious mind parts or alters that have distinct personalities and states of activation.
- Each “alter” of the apparently normal part ANP ( I and II) may have a function in the overall personality system. Ex. One goes to work, another socializes, others protect the person...

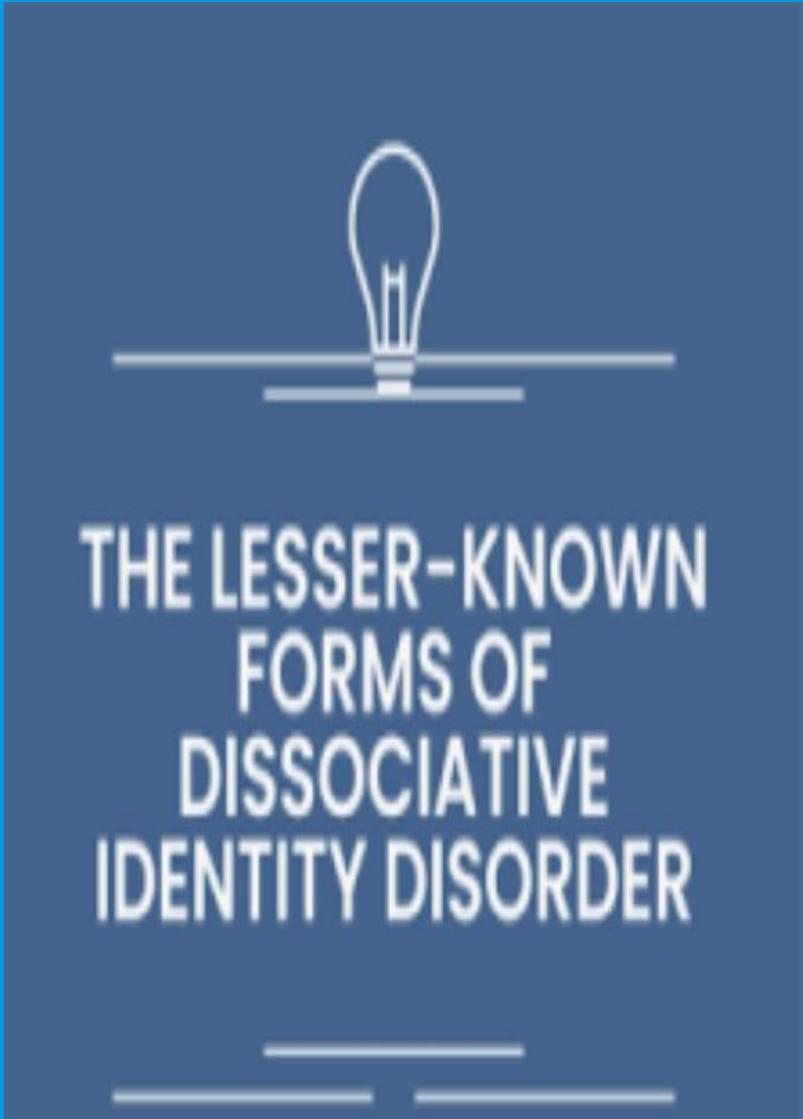
A.K.A. Dissociative identity disorder



A.K.A. Dissociative identity disorder

- In only 5% of people experiencing DID is there blatant switching of parts. DID is difficult to diagnose because in 95% of people behavior changes are subtle.
- Dissociative identity disorder is at the frontier of our understanding of the trauma related disorders, and perhaps because of that, is a subject around which there much debate and controversy.
- Imaging studies have compared DID individuals to actors and studied alters who are blind while the main personality is not.
- While some experts consider all parts present in primary, secondary, and tertiary structural dissociation as being on a dissociative spectrum, others differentiate “ego states” in which parts retain a shared sense of belonging to a person as a whole and are less distinct, autonomous, and amnesic and “dissociative states” in which each part has its own sense of identity with discreet self-representations, autobiographical memory and personal experiences or a sense of I, me, and mine.

## OVERT AND COVERT DID



- Overt and covert DID refer to different manifestations of DID.
- Overt DID, the 5%, is when the presence of different identities is clearly visible to observers. Individuals with overt DID may experience noticeable switches between identities, which can result in changes in behavior, voice, or demeanor that others can observe. People around them usually notice these sudden changes, making overt DID more recognizable.
- Covert DID, the 95%, on the other hand, is less apparent to others. The identity switches may be more subtle, and individuals might not outwardly show distinct changes when transitioning between identities. Instead, they might feel these shifts internally, experiencing changes in thoughts, emotions, or attitudes. Because of these intricacies, covert DID can be more challenging to diagnose and may often remain hidden from those around the individual.

# MISDIAGNOSING COVERT DID

- Covert Dissociative Identity Disorder (DID) can sometimes be misdiagnosed as other mental health conditions. Because the symptoms of covert DID are less apparent and more subtle than overt DID, it can lead clinicians to consider other diagnoses. Common misdiagnoses for covert DID include:
  - **Major Depressive Disorder:** Due to mood fluctuations and feelings of hopelessness that can accompany DID.
  - **Bipolar Disorder:** Because of the shifts in mood and behavior, which might resemble the manic and depressive episodes in bipolar disorder.
  - **Schizophrenia:** Some individuals with DID may report hearing voices (from their alternate identities), which can be confused with the auditory hallucinations seen in schizophrenia.
  - **Borderline Personality Disorder:** Overlaps can occur with emotional instability and identity confusion, common in both conditions.
  - **Post-Traumatic Stress Disorder (PTSD):** Since DID often develops as a response to severe trauma, the two conditions can share symptoms like flashbacks and dissociation.

Pg. 2/3

## DID Myths Vs. Facts

### Myth

- Therapists create DID, and acknowledging alters makes symptoms worse.
- DID is overt, you can easily tell when a person has it.
- DID is incredibly rare.
- DID is a dubious condition.
- Integration is the only proper treatment for DID.

### Fact

- DID is formed from trauma and can only be successfully treated by acknowledging alters (DSM-5, 2013; Brand et al, 2014).
- DID is primarily covert, which is why the DSM-V criteria was expanded to include self-reported identity states (DSM-5, 2013).
- DID affects approx. 1.5% of the population, or ~5 million Americans (DSM-5, 2013).
- DID is well-established in research and can't be replicated fictitiously (Brand & Chasson, 2015).
- Integration can be beneficial but not practical or possible in all cases (Ringrose, 2011).

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40%

40% of clinicians were unable to identify DID from a clinical vignette. This directly correlated with their skepticism of the disorder (Perniciaro, 2014). It's no surprise that there are considerable delays in diagnosis and treatment.

### The Iatrogenic/Sociocognitive Model is Harmful and Demonstrably False

The false belief of DID as an iatrogenic condition has led to under-diagnosis, rampant misinformation, and lack of research. There are no excuses for clinicians or educators to assert this belief still, considering the extensive literature supporting the trauma model and disproving the socio-cognitive (APA, 2013; Brand et al, 2014; Loewenstein, 2018).

# COMMON DID SYMPTOMS

## Dissociative Identity Disorder Symptoms



Passive Influence



Internal Voices



Intrusive Thoughts, Feelings, Urges



Changing Memories, Skills, Preferences



Identity Confusion



Amnesia



Flashbacks



Feeling Like Different People



Dissociation



# COMMON DID ALTERS

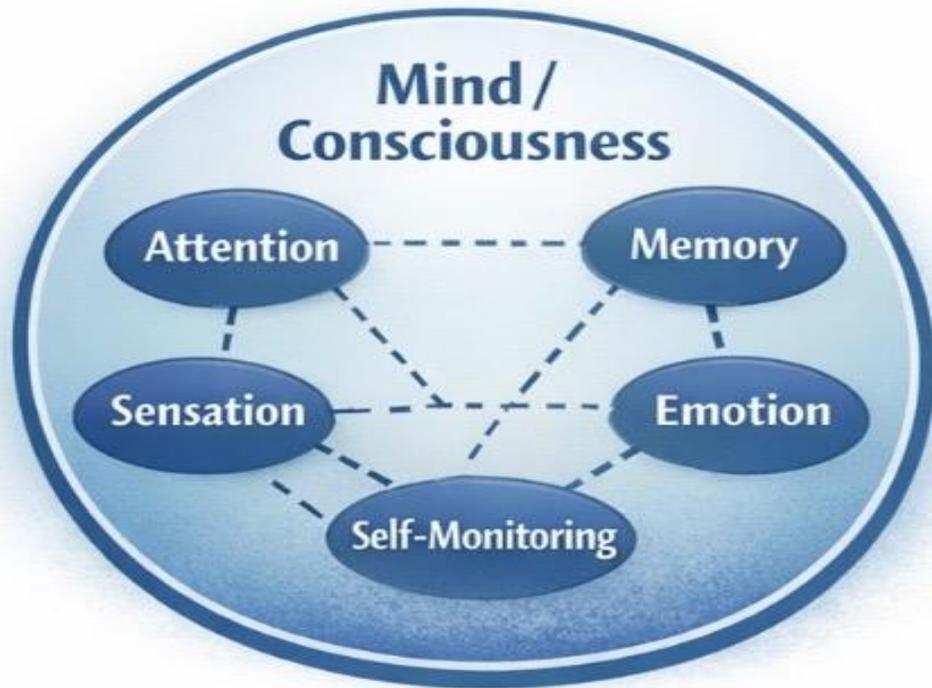


- Common types of alters in dissociative identity disorder include: the host, child alters, internal self-helper, opposite sex alters, persecutor, protector, sexual alters, suicidal altar, teen alter.
- Less common alters include animal alter, baby and infant, caretaker, demonic, military or political, non-human, robot or machinelike, and supernatural alters

# NEODISSOCIATION VS. STRUCTURAL DISSOCIATION THEORIES

# Two Levels of Dissociation

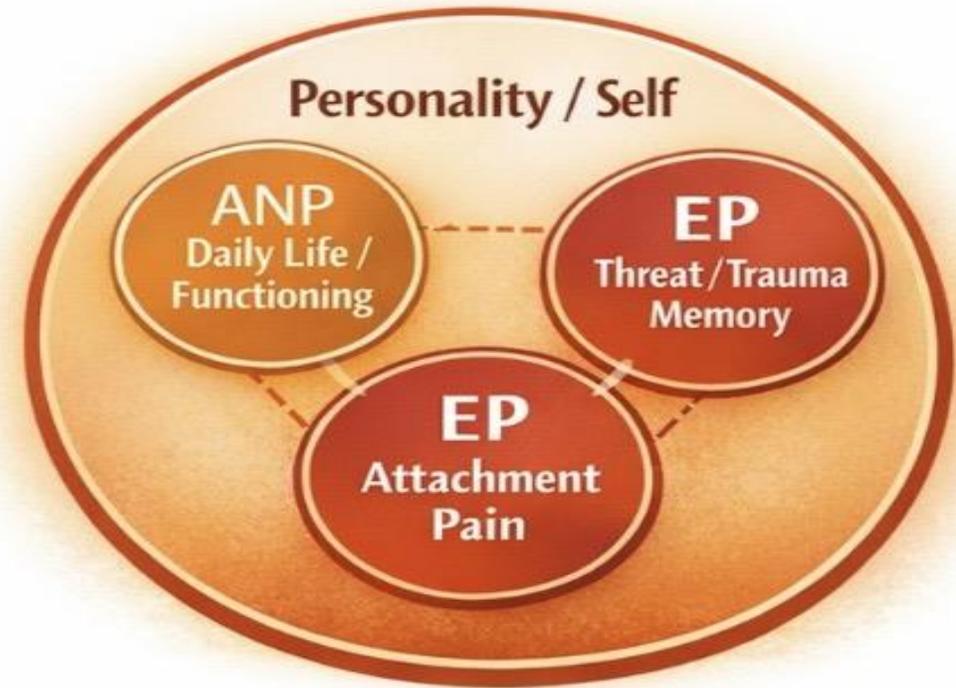
## Neodissociation (Functions Separate)



Temporary loss of communication between mental functions

State-based

## Structural Dissociation (Parts Separate)



Enduring organization of self around survival

Developmental

Repeated **state dissociation** during development → **Structural organization**

# TWO WAYS OF UNDERSTANDING DISSOCIATION

- Psychiatry uses two complementary models to describe dissociation.
- **Neodissociation theory** sees dissociation as a temporary disconnection between mental functions. Awareness, memory, sensation, emotion can uncouple. It sees this as temporary and reversible. The mind's semi-independent systems under stress stop communicating well resulting in numbing or shutdown, autopilot functioning, depersonalization / derealization or dissociative amnesia. Dissociation is a capacity, not a disorder and is often adaptive in the short term. Treatment focuses on restoring connection, awareness, and regulation
- **Structural dissociation theory** sees dissociation as a developmental organization of the personality where different self-states carry different survival roles. It sees this as long-term and integration requires work. Chronic trauma disrupts integration during development. The personality organizes into parts with different jobs ANPs manage daily life and avoid trauma. EPs carry fear, pain, and survival responses. Healing requires insight, safety, pacing, and cooperation between parts. Integration is gradual, not forced.
- Neodissociation explains how dissociation happens. Structural dissociation explains what the self becomes when dissociation repeatedly happens during development.
- Neodissociation helps you understand shutdown, numbing, autopilot and the sense that "I wasn't really there". Structural dissociation helps you understand inner conflicts, parts that sabotage or protect you and rapid shifts in identity, emotion, or behavior.

Where do you see yourself on this dissociation map?

# ZOOM POLL

- Please launch poll (dissociation symptom scale)
- Then share zoom results

## 1. How useful was this meeting? (Multiple choice)

Extremely useful (10/10) 100%



Somewhat useful (0/0) 0%



Not useful at all (0/0) 0%



## 2. How useful was this course?

Extremely useful (10/10) 100%



Somewhat useful (0) 0%



Not useful at all (0) 0%



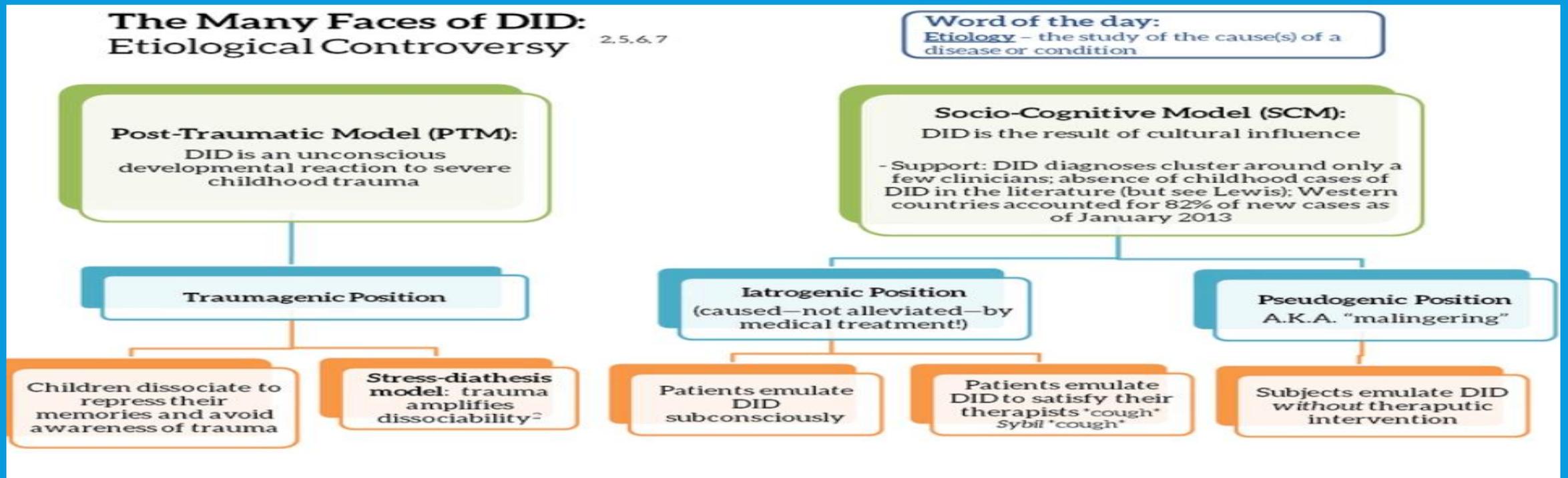
# HOW TO THINK ABOUT YOUR DSS-B SCORE

- Remember that dissociation is not a disorder. It's a capacity of the nervous system, a way the system creates distance, numbness, or automatic functioning when things feel overwhelming, unsafe, or too much to process all at once.
- This scale helps us notice how often our system has been using this strategy lately.
- 0–4: Minimal dissociative symptoms: This suggests our nervous system has mostly been able to stay present and integrated over the past week. That doesn't mean we never dissociate, everyone does sometimes, but it hasn't been a prominent coping strategy recently.
- 5–12: Mild to moderate dissociation: This range is very common, especially during stress, fatigue, illness, emotional load, or relational strain. It suggests our system occasionally uses spacing out, emotional numbing, or autopilot to manage demands. This isn't a problem to fix, just a pattern to notice with curiosity.
- 13 and above: Elevated dissociation: This suggests dissociation has been a frequent or relied-upon strategy recently. Often this reflects a nervous system that learned, at some earlier point, that distance was the safest or most efficient way to cope. This doesn't mean something is "wrong," but it may be worth gentle exploration, especially around safety, overwhelm, boundaries, and support.
- Note that scores can change week to week depending on stress, sleep, health, and life events. Please don't use these scores to label yourself, instead think of them as a way your nervous system protects itself.

# CONTROVERSIES IN THE DIAGNOSIS OF DISSOCIATIVE IDENTITY DISORDER

Is the diagnosis of dissociative identity disorder controversial ?

- There is some controversy surrounding DID and its causes. In the simple course we follow and have presented the 1) post-traumatic model of DID. There is however also the...
- 2) Socio-cognitive model which proposes two alternative explanations for DID A) the iatrogenic- which suggests that DID is in part induced by therapists, and B) the pseudogenic position which suggests that some individuals feign DID for “secondary” gain. Many experts in the field now hold that these models are compatible. Click [link](#) which explores this controversy



# PART 2 HOW HEALING HAPPENS

# TREATMENT OF THE TRAUMA SPECTRUM DISORDERS

If PTSD, complex PTSD, and DID or primary, secondary and tertiary dissociation are all on the dissociative spectrum, are they treated following similar principles?

# TREATMENT OF TRAUMA SPECTRUM DISORDERS

- Today there is more scientific knowledge, public awareness, and peer initiatives in the fields of trauma and its treatment than there's ever been, but there is also a great lack of well-trained trauma treatment providers, programs and resources.

- We are in a situation akin to that which the treatment of acute lymphocytic leukemia, the most common type of childhood cancer, was in in the 1970's when it had a 90% mortality rate. Today the mortality rate of ALL has dropped to 10%. This is not because we have any new treatments. We are still using all the same ones as we did 50 years ago. What has changed is that we're much better at using those treatments in a uniform systematic way.

- Similarly with dissociative/trauma spectrum disorders, if we were better at using the treatments we've known about for 100 years effectively, we'd have much better treatment outcomes.
- The body keeps the score by Bessel van der Kolk describes several evidence based effective treatments for the trauma spectrum disorders

## The Three Phases of Trauma Therapy



# TREATMENT OF TRAUMA SPECTRUM DISORDERS

- In this segment of today's session, we will explore the three phases of treatment for dissociative trauma spectrum disorders which are the common denominator of all trauma treatment approaches. Keep in mind that treatment needs, of course, to be individualized for each person. For instance, people with single event PTSD who have good resources may not need to spend a lot of time in phase I of treatment and may be able to proceed directly to phase II.

- On the other hand, people who have fewer "resources" may need to spend considerable time in phase I stabilization whereas those with significant psychosocial developmental issues may need to spend considerable time in phase III
- We will also explore how specific treatment issues arise in each of the three types of structural dissociation. For example, shame is an important consideration in secondary structural dissociation/complex PTSD. We'll explore why.

- In week 23 we'll talk about the four pillars of trauma therapy which are psychoeducation, mindfulness, body movement and trauma informed therapies.

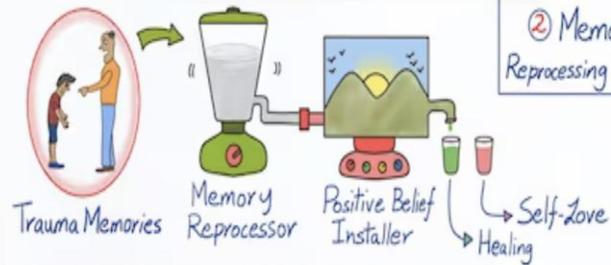
- Soon we will start discussing Wise mind remediation and Internal family systems which are both phase II trauma processing approaches.

## The Three Phases of Trauma Therapy

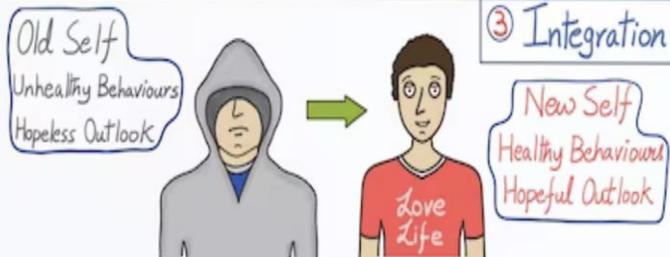
### ① Stabilization Phase



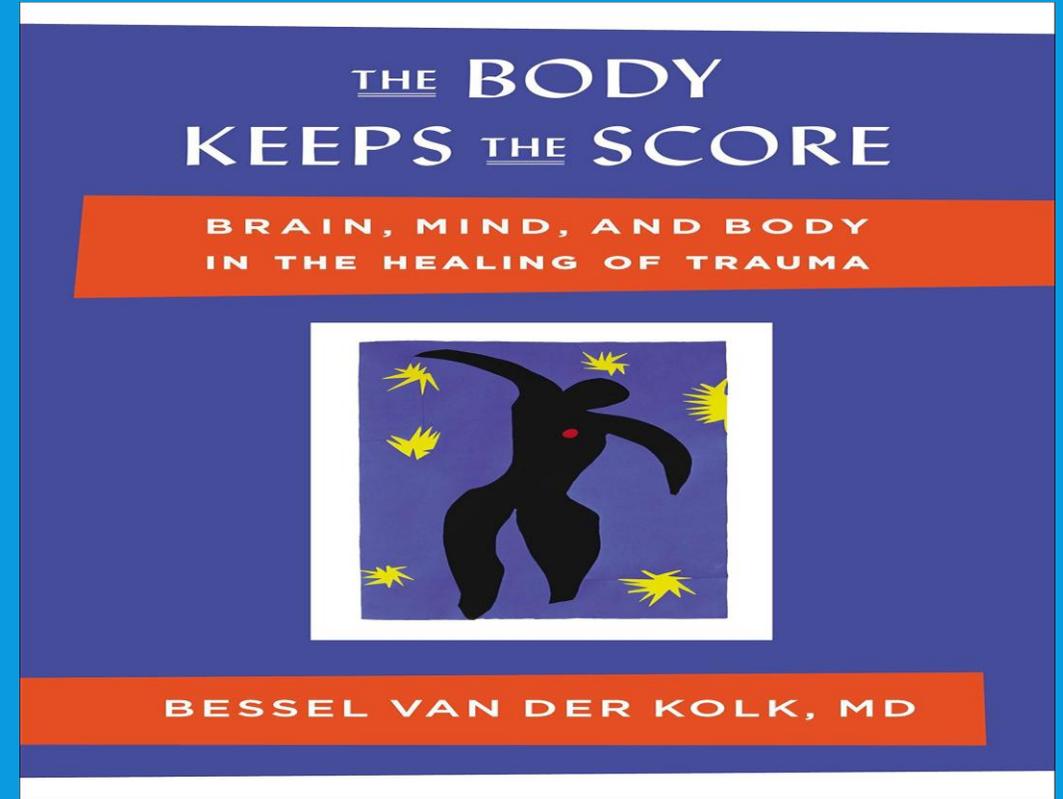
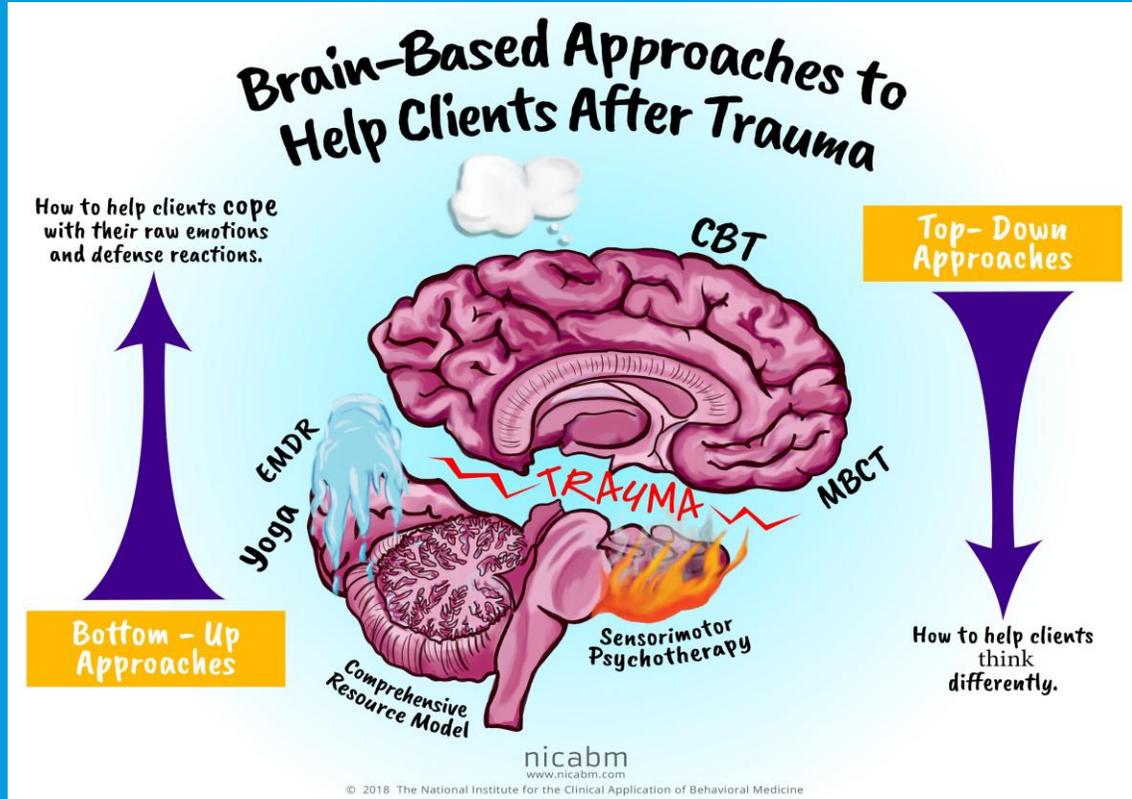
### ② Memory Reprocessing Phase



### ③ Integration



# BOTTOM UP VS. TOP-DOWN APPROACHES



- Trauma treatment approaches are commonly grouped into “top down” or “bottom up” categories. “Top” refers to the rational brain, thinking, or cognition, “bottom” to the body or somatic information center. Trauma affects all three information processing centers, but specific treatment approaches tend to target primarily the body or thinking.
- Top-down approaches help people think differently, bottom-up help people cope with their sensations, emotions, and action urges.
- For example, CBT and MBCT are top-down approaches, Yoga, EMDR, and the sensorimotor therapies bottom up.

# GENERAL PRINCIPLES OF THERAPY OF DISSOCIATIVE AND TRAUMA SPECTRUM DISORDERS

## Phases of Complex Trauma Treatment



After Herman, 1992

- The foundations underlying the treatment approaches for the dissociative and trauma spectrum disorders have not changed much since the time of Pierre Janet.
- There are three phases (or stages) to the active stage treatment of trauma spectrum dissociative disorders be they primary, secondary, or tertiary dissociation.
- **Phase 1** deals with the person's safety and aims to stabilize them. DBT does this.
- **phase 2** deals with remembrance and mourning of past trauma. IFS does this.
- **phase 3** deals with reconnecting with the world of other people, nature, the universe and a meaningful occupation. The goals diary card procedure addresses this.

# STAGES OF COMPLEX TRAUMA RECOVERY

Based on Judith Herman's model

Recovery is not linear. Your journey will likely not follow a straight line, but instead might be circular moving in and out of stages until you feel you are ready to move forward and reconnect with your goals and dreams.

## STAGE 1: Education, Stabilization & Safety

Education helps normalize doubts. Your nervous system and brain are responding exactly the way it was designed to respond after having survived repeated traumatic experiences.

Two sets of goals that are typically worked on in this stage with the help of a counselor, case worker, or other helping professional are:

- Basic Health Needs  
*Regulation of Sleep, Eating, Exercise, Drugs & Alcohol, Destructive Behavior*
- Basic Environment Needs  
*Physical Self Protection, Work and Money, Secure Living Situation*

**Therapeutic Task:** Safety  
**Time Orientation:** Present  
**Focus:** Self-Care  
**Time Limit:** Limited, Repeating  
**Boundaries:** Flexible, Inclusive  
**Conflict Tolerance:** Low

## STAGE 2: Processing – Remembering & Mourning

Inner healing practitioner or counselor works on going through all the traumatic memories and taking the incoherent pieces and working it into a more coherent whole.

Cognitive based approaches associated with Somatic are best to release body memories and make it less triggering

- Uncovering proceeds in small steps
- Memories evoke intense grief
- Goal is integration, not catharsis

Memories of several representative traumatic events and periods are processed but not every single memory as the emotional content is often the same.

**Therapeutic Task:** Integration  
**Time Orientation:** Past  
**Focus:** Trauma  
**Time Limit:** Fixed Limit  
**Boundaries:** Closed  
**Conflict Tolerance:** Low

## STAGE 3: Meaning & Reconnection

This stage is where inner healing is especially helpful in identifying faulty coping mechanisms and lies that were believed and dealing with existential questions like "Why did God allow this to happen to me? Why am I here? And What does it all mean for me?"

- Expanded peer relationships
- Intimate relationships
- Family relationships
- Reintegration at successive stages
- Social action and survivor mission

**Therapeutic Task:** Reconnection  
**Time Orientation:** Present & Future  
**Focus:** Interpersonal  
**Time Limit:** Ongoing  
**Boundaries:** Slow Turnover  
**Conflict Tolerance:** High

"Trust people in support network. Lead a full life at a reasonably high level of functioning"

"No new traumatic memories to process"

"Have authority over traumatic memories, be able to control traumatic symptoms, and have a coherent system of meaning and belief that integrates the trauma"

**Duration & Continuity:** Each of these stages can last months to years depending on the severity, duration, and age of onset of the trauma. The stages also may not follow one another directly, with breaks taken between the stages, and sometimes relapses occur to previous stages of recovery. People may be done with recovery after stage one or after stage two based on personal comfort level and goals.

**Support after trauma is critical for recovery.** "Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connection with other people, the survivor re-creates the psychological facilities that were damaged or deformed by the traumatic experience. The first principle of recovery is empowerment of the survivor. She must be the author and arbiter of her own recovery." – Judith Herman

# THE GOALS OF EACH OF THE STAGES OF TREATMENT

## Stages of Trauma Recovery: Treatment Aims

- Stage One: ESTABLISHING SAFETY
  - Securing safety
  - Stabilizing symptoms
  - Fostering self-care
- Stage Two: REMEMBRANCE & MOURNING
  - Reconstructing the trauma
  - Transforming traumatic memory
- Stage Three: RECONNECTION
  - Reconciliation with self
  - Reconnection with others
  - Resolving the trauma

(Herman, *Trauma and Recovery*)

# Phase I Complex Trauma Treatment: Safety and Stabilization

- Stage I in the healing of trauma spectrum disorders involves:
- 1) developing a personal roadmap for the healing process.
- 2) developing realistic and attainable goals and setting up a plan of action for achieving those goals in a practical timeframe
- 3) establishing a sense of stability and safety in interpersonal relationships, one's own body, and all other areas of life
- 4) learning how to regulate emotions, and how to manage psychological and behavioral symptoms that may contribute to a sense of instability and overall personal suffering
- 5) beginning to recognize and tap into resources and inner strength.
- 6) developing crucial coping mechanisms and life skills, geared towards effectively managing painful experiences and regulating emotional, mental, and physical responses.

# Phase I Complex Trauma Treatment: Safety and Stabilization

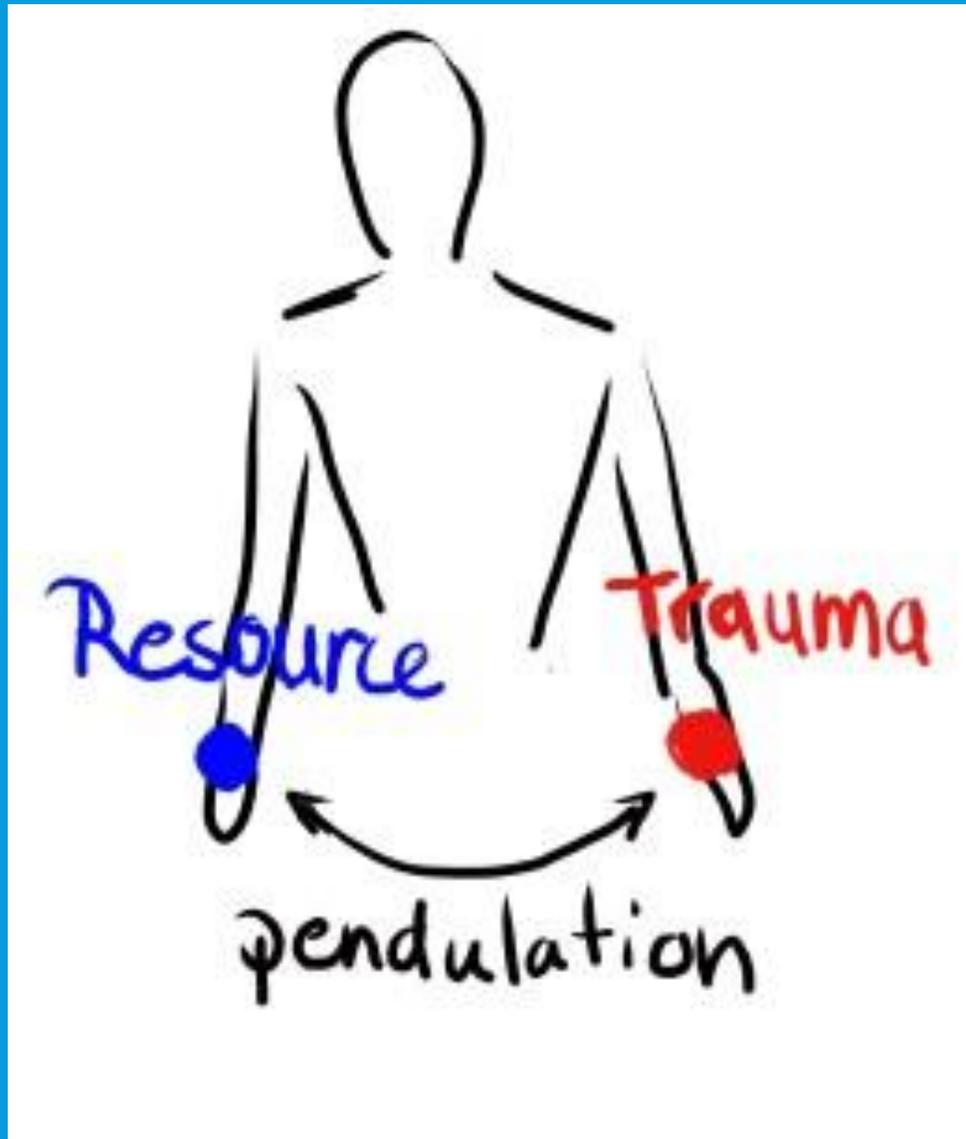
- Practically, Stage I stabilization goals include reduction and elimination of drug and alcohol abuse, promotion of good health, safe housing, adequate income, adequate transportation and setting and keeping a healthy schedule.
- The main goals of stage I are developing a sense of personal safety, cultivating a healthy self-care routine and learning to regulate emotions and behaviors appropriately.
- Once these basic necessities and skills become fully integrated into our lives, we will be able to do the stage II working through painful memories with far less mental and emotional repercussions. It is, however, not always necessary for everyone to do the stage II work of processing traumatic memories.

## Empirically-Supported Treatments for Stage I

- ◆ Dialectical Behavior Therapy (DBT)
- ◆ Seeking Safety
- ◆ Mindfulness-Based Stress Reduction
- ◆ Therapies for specific problems
  - Imagery Rehearsal Therapy
  - Cognitive-Behavioral Therapy
  - Motivational Interviewing
  - SAMHSA's Anger Management workbook

- Phase I treatment (stabilization) can be lengthy in people who have prominent dissociative features.
- When people start working on phase II or processing trauma, which can trigger dysregulation, they need phase I stabilization skills to pendulate back to the window of tolerance.
- Stabilization skills include:
  - 1) learning to observe somatic sensations. This is a somatic experiencing technique
  - 2) developing and installing “resources”. This is done in approaches such as EMDR through resourcing which refers to identifying and instilling coping resources that help us to deal with difficult situations. It is also part of DBT skills.
  - 3) developing spiritual resources
  - 4) building social supports
  - 5) engaging in pleasant activities
  - 6) healing the brain using neurofeedback
- Empirically supported stage I treatments include DBT, mindfulness-based stress reduction, cognitive behavioral therapy, imagery rehearsal therapy, and motivational interviewing.

## THE IMPORTANCE OF STAGE I "RESOURCES" FOR STAGE II WORK



- In trauma therapy a "resource" is anything that helps the therapeutic process. Resources can be supportive friends, therapists, therapy animals, learnt skills etc. Resources help bring people back to the window of tolerance.
- When processing trauma, it is critical that the person stay in the window of tolerance
- All trauma processing strategies involve some kind of imaginal, real life, or virtual exposure to implicit and/or explicit traumatic memories with pendulation to resources when the person is leaving the therapeutic window. Thus, pendulation between trauma and resources.
- "Dual focus", or the shifting of focus between trauma and resources, is the common factor of many phase 2 approaches including EMDR.
- This is why phase I work which fosters resources is so important before embarking on processing trauma
- If you try to do phase II work but don't have resources to help bring you back to the window of tolerance, exploration of dissociated traumatic memories will only further traumatize you.



## Phase II Complex Trauma Treatment: Remembrance and Mourning

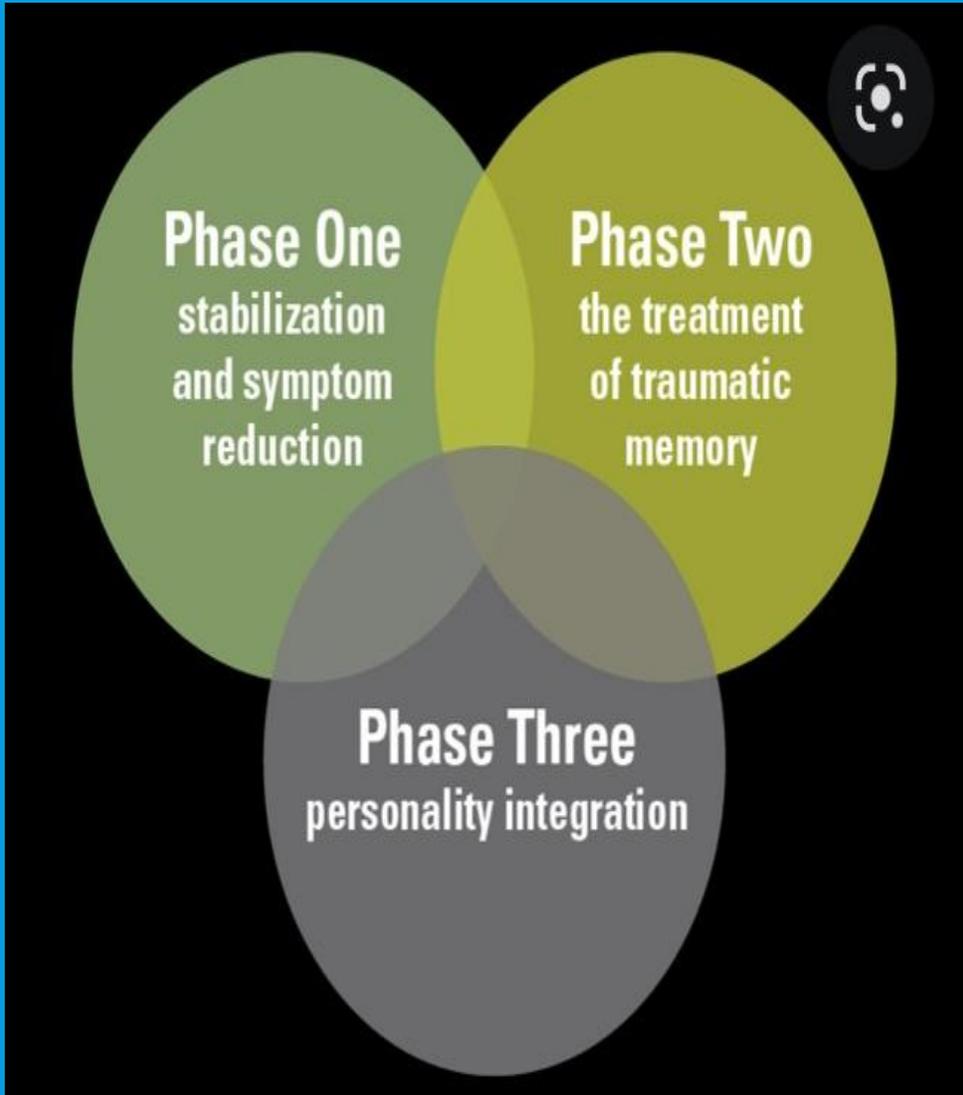
- Stage II of trauma recovery is frequently referred to as "remembrance and mourning". Once an individual has developed a strong and functional set of coping skills and feels reasonably safe and secure in their surroundings, it becomes possible to address long buried memories.
- The main work the second stage of trauma recovery involves:
  - 1) discussing and evaluating painful and traumatic memories with the intention of restructuring the role they play in people's lives.
  - 2) Working through trauma -related grief brought about by unwanted or abusive experiences, and the impact they had and continue to have on people's lives.
  - 3) mourning the loss of good experiences that have not yet occurred, or did not have the chance to occur, because of persistent, trauma -related symptoms.



## Phase II Complex Trauma Treatment: Remembrance and Mourning

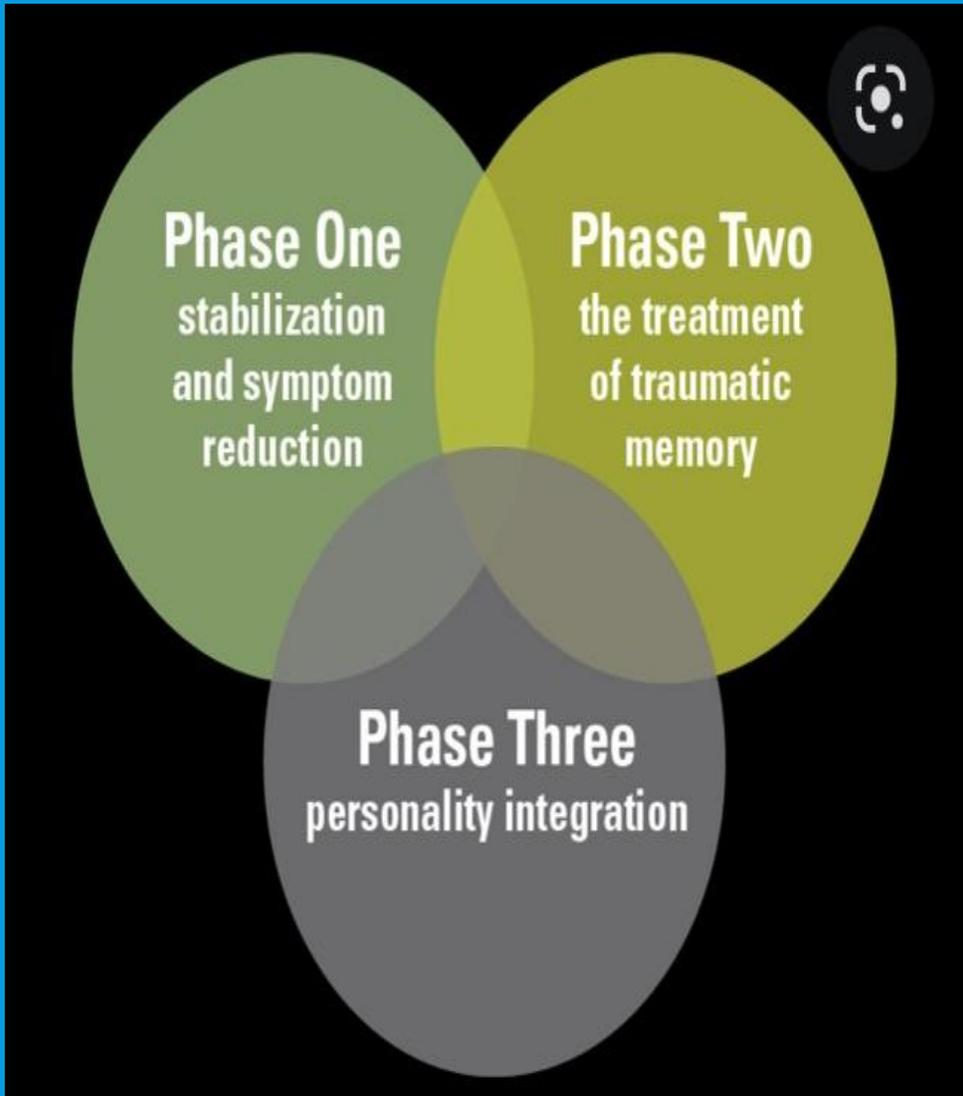
- 4) discussing painful memories is not always necessary to achieve the personal goals established in the first stage of trauma recovery. Remember stages will vary depending on personal history and personality. Some people may find that memories that were once perceived as too painful to examine are no longer causing any grief or inner turmoil.
- 5) if memories are still disruptive and have been found to continuously pose a threat to long-term recovery from related issues, there are several "memory processing" methods that can be employed during this stage of recovery such as EMDR or sensorimotor therapies.

# STAGE III WORK



- **Stage III** the third and final stage of trauma recovery focuses largely on reconnecting with people, personally meaningful activities, and all other aspects of a meaningful, fulfilling and healthy life.
- In this stage, we need to develop a new sense of self. Traumatic experiences will no longer play a defining role in our lives, and we will be mentally and emotionally set free from the painful and limiting chains of the past. Steps toward self-actualization and empowerment will be taken, and the human spirit, in all its awe-inspiring resilience, will begin truly and thoroughly recovering from the devastating effects of traumatic experiences.

# STAGE III WORK



- It is important to keep in mind that recovery is a highly individualized process, and it will look quite different for every individual. It is common for those who have suffered trauma to want to feel better as quickly as possible. However, recovering from trauma is a process that requires consistency, commitment, and self compassion.
- Recovering from trauma does not mean we will be completely free of intrusive thoughts or feelings, rather, we will reclaim our life, love, and authentic self.

# Three Phases of Treatment

- . Stabilize
- . Process
- . Reconnect

# TREATMENT OF THE TRAUMA SPECTRUM DISORDERS

The previous slides described the general type of work to be done at each of the stages of treatment. Can you tell us more about the specific therapeutic modalities that are offered by therapists ?

# SPECIFIC TRAUMATIC SPECTRUM TREATMENTS

## PTSD Treatments and Therapies



**Psychotherapy**



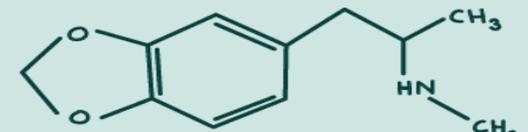
**Alternative treatments  
(yoga and acupuncture)**



**Virtual reality exposure**



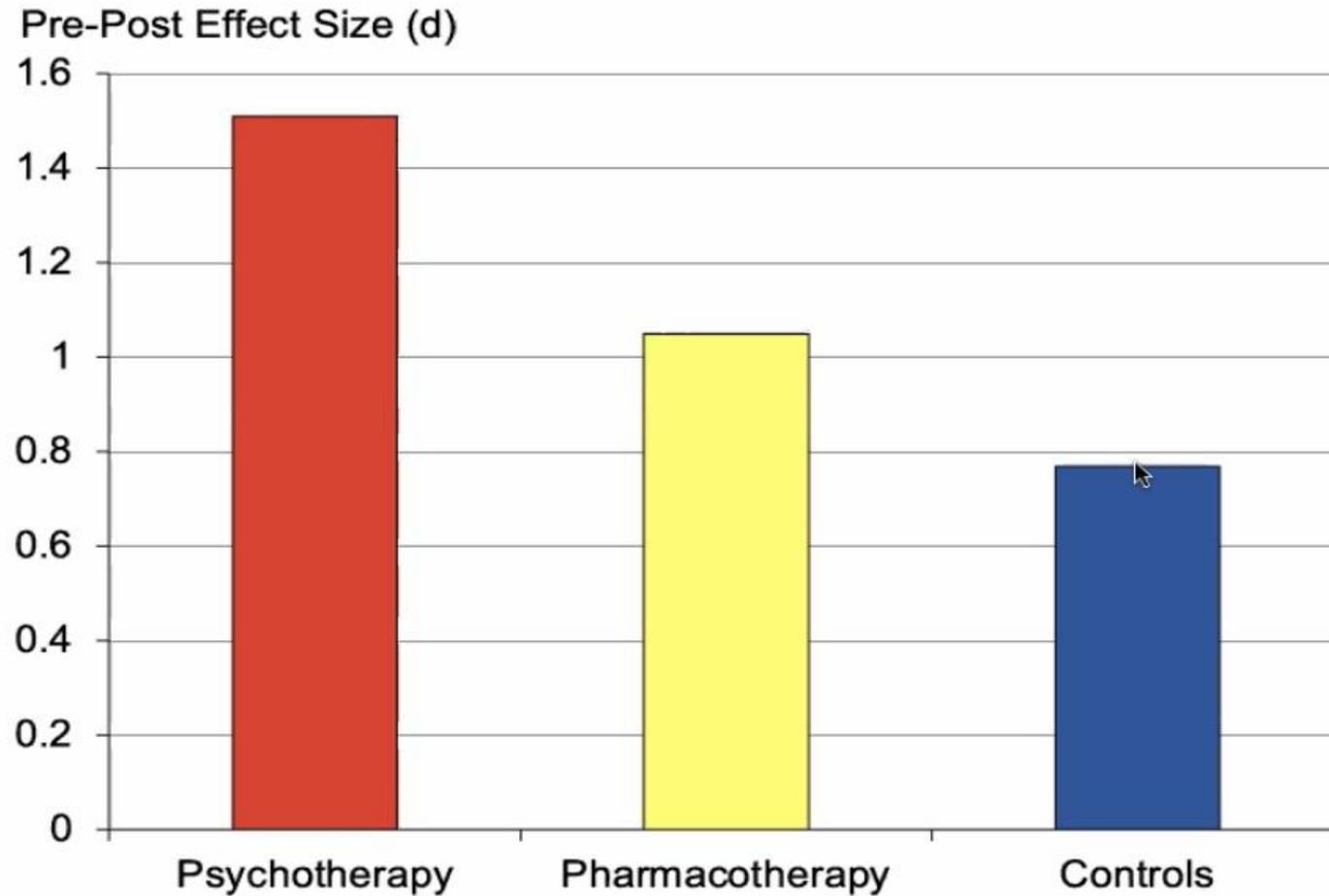
**Medication**



**MDMA-assisted therapy**

# Psychotherapy versus drug treatment for PTSD

*van Etten & Taylor, 1998*



# Rx OF PTSD

**TABLE. PTSD treatment options based on evidence**

Recommendation	Psychotherapies	Psychopharmacology
First-line treatments	Prolonged exposure (PE) Cognitive processing therapy Eye movement desensitization and reprocessing	Sertraline <sup>a</sup> Paroxetine <sup>a</sup> Fluoxetine
Demonstrated benefit	CBT specific for PTSD Narrative exposure therapy Brief eclectic psychotherapy	Venlafaxine Imipramine Prazosin <sup>b</sup>
Some benefit, use cautiously	Meditation-based interventions	Nefazodone
Recommend against using		Monotherapy with antipsychotics, benzodiazepines; medical marijuana
Experimental		MDMA-assisted psychotherapy

CBT, cognitive behavioral therapy; MDMA, methylenedioxymethamphetamine; VA/DoD, Veterans Affairs/Department of Defense.

<sup>a</sup> Sertraline and paroxetine are approved for PTSD.

<sup>b</sup> Prazosin has demonstrated efficacy for nightmares, flashbacks (re-experiencing symptoms), and sleep disorder in PTSD in small trials, although the VA/DoD clinical practice guidelines state that there is insufficient evidence either for or against using prazosin (based on an unpublished VA Cooperative Studies Program trial).

**Table 52.1 Pharmacotherapy Steps for Post Traumatic Stress Disorder**

Step 1
<p>Selective serotonin reuptake inhibitor (SSRI)</p> <p>Adjunctive medications:</p> <p>If prominent hyperarousal: benzodiazepine or buspirone</p> <p>If prominent mood lability or explosiveness: anticonvulsant or lithium</p> <p>If prominent dissociation: valproic acid</p> <p>If persistent insomnia: trazodone</p> <p>If psychotic: atypical antipsychotic</p>
Step 2
<p>If no response or intolerance to SSRI:</p> <p>Dual action antidepressant, e.g., mirtazapine, venlafaxine</p> <p>Adjunctive medications as above</p>
Step 3
<p>If no response to Step 1 or 2:</p> <p>Monoamine oxidase inhibitor</p> <p>Adjunctive medications as above</p>
Step 4
<p>Other useful drugs:</p> <p>Propranolol – hyperarousal</p> <p>Clonidine – startle response</p> <p>Neuroleptics – psychosis, poor impulse control</p>

# Evidence based psychotherapies for PTSD

(in authors' alphabetical order)

- Marylène Cloitre      Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy
- Anke Ehlers            Cognitive Therapy for PTSD
- Thomas Elbert        Narrative Exposure Therapy (NET)
- Edna Foa                Prolonged Exposure Therapy (PE)
- Berthold Gersons     Brief Eclectic Psychotherapy for PTSD (BEPP)
- Patricia Resick        Cognitive Processing Therapy (CPT)
- Francine Shapiro      Eye Movement Desensitization and Reprocessing Therapy (EMDR)

## Prolonged Exposure (PE): Theory

- Fear is a normal response to trauma
- Fear, anxiety, and social conventions lead to avoidance
- Avoidance tends to get reinforced
- Avoidance prohibits emotional processing
- Emotional processing requires
  - Activation of the traumatic memory
  - Corrective information

# PROLONGED EXPOSURE (PE) THERAPY

- PE is a well-established, evidence-based treatment for post-traumatic stress disorder (PTSD) that helps people recover by systematically confronting trauma-related memories and avoided situations in a safe, therapeutic way.
- PE's Core idea is that PTSD persists in part because traumatic memories and reminders are avoided. Avoidance reduces distress short-term but prevents emotional processing and keeps fear responses alive. PE works by helping the nervous system *relearn* that these memories and cues are not dangerous in the present.
- PE involves:
  1. Psychoeducation: Clients learn how PTSD works and why avoidance maintains symptoms.
  2. Imaginal exposure: The person repeatedly revisits and narrates the traumatic memory in session, in detail and in the present tense, allowing fear, grief, or shame to rise and naturally settle.
  3. In-vivo exposure: Between sessions, clients gradually approach safe but avoided situations (e.g., driving, crowds, certain places), using a planned hierarchy.
  4. Processing: After exposure, therapist and client reflect on what was learned—often correcting beliefs such as *“I can’t tolerate this”* or *“I’m still in danger.”*
- Mechanisms of change: Habituation and inhibitory learning (fear diminishes without avoidance). Increased distress tolerance. Updating trauma-related beliefs about safety, control, and self-efficacy
- Format: Typically, 8–15 weekly sessions. Highly structured and collaborative. Requires active engagement and homework
- Strengths: One of the most empirically supported PTSD treatments. Especially effective for fear-based trauma symptoms
- Limitations / cautions: Can feel emotionally demanding early on. Requires careful pacing for complex PTSD, dissociation, or unstable safety

# EMDR treatment - 8 stages

## 1. Treatment planning



- Treatment history.
- Create a list of traumatic events.
- Categorize trauma's.

## 2. Preparation



- Pick a safe place.
- Discuss possible side-effects.
- Learn self-control techniques.

## 3. Assessment



- Select traumatic memory.
- Select best representing image.
- Select best fitting negative cognition.
- Select positive cognition.

## 4. Desensitization



- Follow the fingers/dot.
- Neutralize image.

## 5. Installation



- Install positive cognition.
- Follow the finger/dot.

## 6. Body scan



- Identify residual tension in the body.
- Reprocess residual tension.

## 7. Closure



- Return to a state of equilibrium.
- Apply self-control techniques.
- Know what to expect in between sessions.
- Keep a journal.

## 8. Reevaluation



- Check if the previous memory is still upsetting.
- If yes, continue EMDR from step 4.

„EMDR minus eye movements equals good psychotherapy“

*Hyer L, Brandsma JM (1997) Journal of Traumatic Stress 10: 515-522*

“Exposure in combination with an explicit external focus of attention leads to larger PTSD symptom reduction than exposure alone. Eye movements have no advantage compared to visually fixating on a nonmoving hand.”

*Sack M et al. (2016) Psychotherapy and Psychosomatics 85: 357-365 (DOI: 10.1159/000447671)*

# ● EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

- EMDR is an evidence-based psychotherapy for PTSD that helps people process traumatic memories, so they become less emotionally distressing and less intrusive.
- The Core idea in EMDR is that Traumatic experiences can become “stuck” in the brain in an unprocessed form, maintaining vivid memories, strong emotions, and negative beliefs. EMDR aims to help the brain reprocess these memories so they are integrated into normal autobiographical memory rather than relived as present danger.
- EMDR involves:
  - Targeting a traumatic memory (image, emotion, body sensation, and negative belief such as “*I am unsafe*” or “*I am powerless*”)
  - Bilateral stimulation (most commonly guided eye movements, but also tapping or tones) while the client briefly attends to the memory
  - Spontaneous associative processing, allowing thoughts, emotions, and sensations to shift without detailed verbal recounting
  - Mechanisms of change (theories): Facilitates adaptive memory reprocessing. Reduces emotional intensity and physiological arousal. Updates negative core beliefs to more adaptive ones (e.g., “*I survived,*” “*I am safe now*”)
  - Structure: Follows a standardized 8-phase protocol (history, preparation, assessment, desensitization, installation, body scan, closure, reevaluation). Typically 6–12 sessions, though complex trauma may take longer. Less homework and less prolonged verbal exposure than PE
  - Strengths: Strong evidence base for PTSD. Often well tolerated by patients who struggle with prolonged verbal exposure
  - Cautions: Requires careful preparation for dissociation or complex trauma. Effectiveness depends on adequate stabilization and therapist training
- In short, EMDR helps trauma memories move from being relived to being remembered, reducing their emotional and physiological charge.

# Cognitive Therapy for PTSD

- Developing an individualized case formulation
- Updating trauma memories:
  - accessing memories of the worst moments (“hot spots”) during the trauma and their currently threatening meanings
  - identifying information that updates these meanings
  - linking the new meanings to the worst moments in the memory
- Discrimination training with triggers of reexperiencing
- Behavioral experiments to help dropping unhelpful behaviours and cognitive processes
- Reclaiming your life

# Brief Eclectic Psychotherapy for PTSD (BEPP)

Manualized, multimodal, 16 sessions, combination of psycho-education, cognitive-behavioral and psychodynamic elements:

- Psychoeducation
- Exposure (guided imagery)
- Writing tasks, working with mementos
- Finding meaning and integration
- Farewell ritual

- 
- Gersons BPR, Carlier IVE, Lamberts RD, van der Kolk BA (2000) Randomized clinical trial of brief eclectic psychotherapy for police officers with posttraumatic stress disorder. *Journal of Traumatic Stress* 13: 333-348
  - Schnyder U, Müller J, Maercker A, Wittmann L (2011) Brief Eclectic Psychotherapy for PTSD: a randomized controlled trial. *Journal of Clinical Psychiatry* 72: 564-566

# Narrative Exposure Therapy (NET)

- Psychoeducation (fear network)
- Written documentation of patient's biography
- **Detailed account** of traumatic experiences
- Using the document for political and social purposes
- From fragmented biographical memories, a **coherent narrative** is created
- Integration and habituation of past fears
- The unspeakable terror in the „here and now“ is transformed into a past that can be put into words, that was experienced at a different time and in a different place

## Cognitive Processing Therapy (CPT)

- 12 sessions, individual or group format
- Trauma-focused cognitive therapy: Socratic questioning of assumptions and beliefs arising as a result of traumatic events
- Focus focusing first on the trauma itself (assimilation) and then on disruptions in beliefs on a range of topics (over-accommodation)
- Between sessions patients write a detailed account of their worst traumatic event and read it to themselves daily
- Cognitive restructuring using work sheets and other written materials

### Cognitive Processing Therapy for PTSD



The illustration shows a therapist with blonde hair in a light blue shirt and green pants sitting on a purple chair, holding a clipboard and talking to a patient with dark skin in a yellow shirt and patterned pants sitting on a purple chair. The background is a textured yellow. Four icons are placed around the central scene: a head with lightning bolts (top left), a brain with lightning bolts (bottom left), a question mark with a sad face (top right), and a thought bubble with two arrows (bottom right).

Become aware of your feelings

Learn about your PTSD symptoms

Learn skills to challenge thoughts

Learn how to change post-traumatic beliefs

**verywell**

# EXPOSURE : IMAGINATION, REAL LIFE, VIRTUAL

## Virtual Reality Exposure: Hardware



A head-mounted display



A handheld sensor or joystick



A computer and monitor



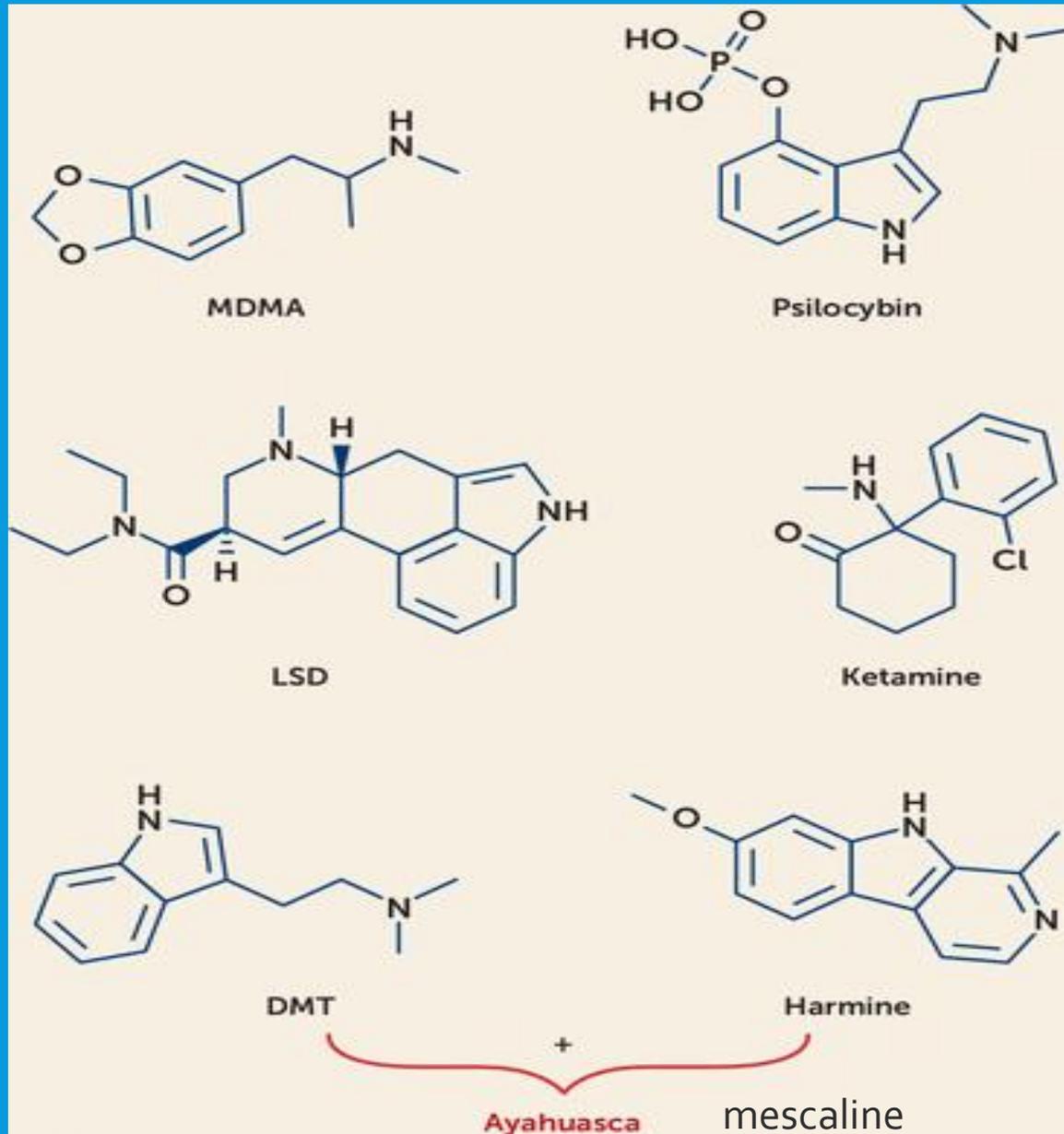
A thunder chair

- Rothbaum, B. O., Price, M., Jovanovic, T., Norrholm, S. D., Gerardi, M., Dunlap, B., Davis, M., Bradley, B., Duncan, E. J., Rizzo, A., & Resnik, K. J. (2014). A randomized, double-blind evaluation of D-cycloserine or alprazolam combined with virtual reality exposure therapy for posttraumatic stress disorder in Iraq and Afghanistan war veterans. *American Journal of Psychiatry*, 171(6), 640-648. <https://doi.org/10.1176/appi.ajp.2014.13121825>
- Rothbaum, B. O., Hodges, L., Smith, S., Lee, J.H., & Price, L. (2000). A controlled study of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology*, 68(6), 1025-1029. <https://doi.org/10.1037/0022-006X.68.6.1025>
- Rothbaum, B. O., Anderson, P., Zimand, E., Hodges, L., Lang, O., & Wilson, J. (2008). Virtual reality exposure therapy and standard (in vivo) exposure therapy in the treatment of fear of flying. *Behavior Therapy*, 37(1), 80-90. <https://doi.org/10.1016/j.beth.2008.04.004>
- Resnik, K. J., Rothbaum, B. O., Tannarbaum, L., Anderson, P., Green, K., Zimand, E., Hodges, L., & Davis, M. (2004). Cognitive enhancers as adjuncts to psychotherapy: use of D-cycloserine in phobic individuals to facilitate extinction of fear. *Archives of General Psychiatry*, 61(11), 1135-1144. <https://doi.org/10.1001/archpsyc.61.11.1135>

# PSYCHEDELIC ASSISTED PSYCHOTHERAPY

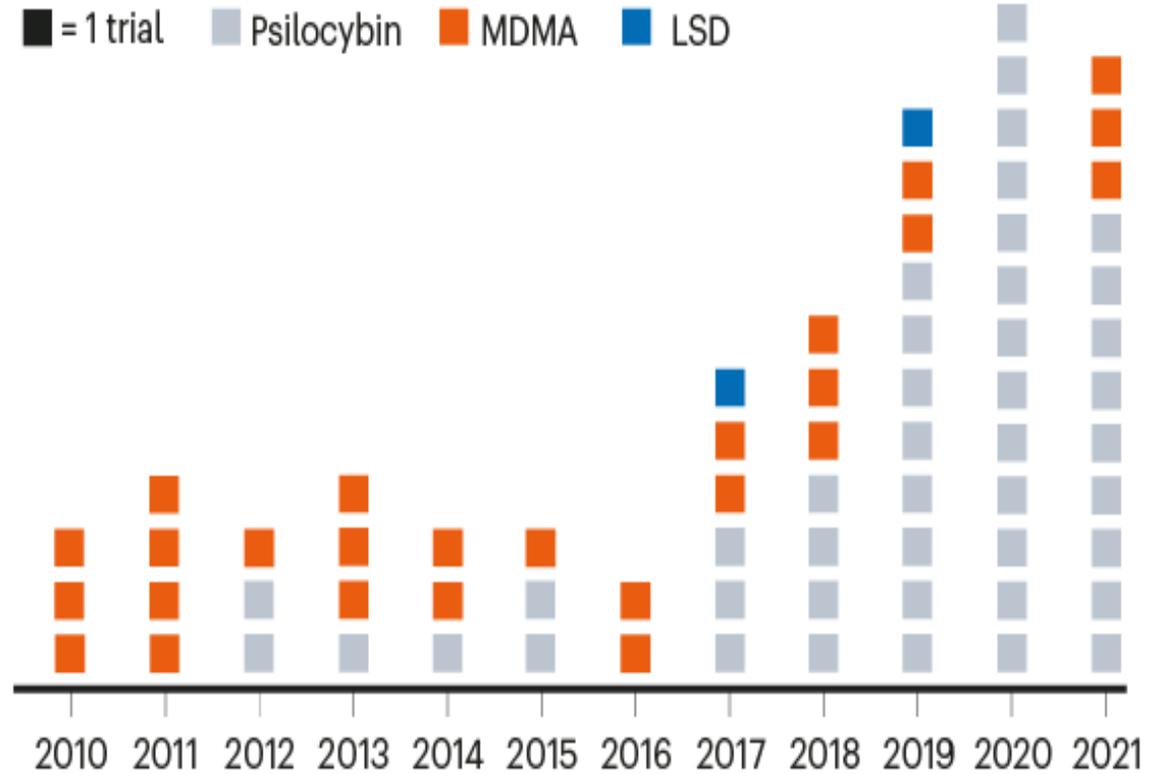


# AGENTS USED IN PSYCHEDELIC ASSISTED PSYCHOTHERAPY

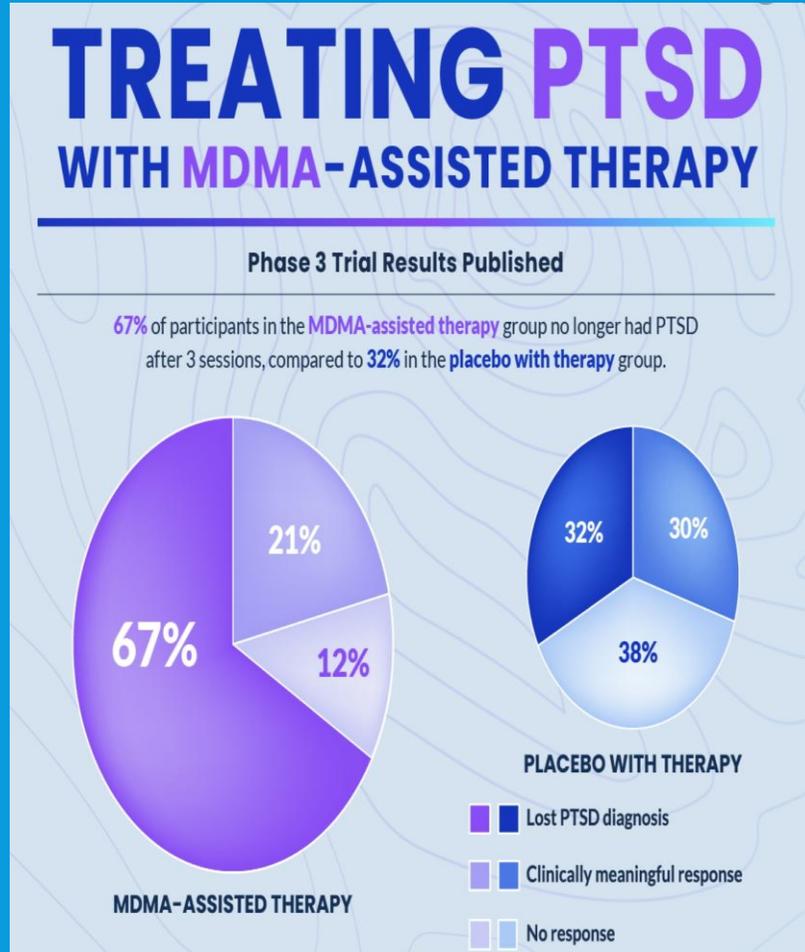


## PSYCHEDELICS TAKE FLIGHT

Over the past decade, there has been an increase in clinical trials testing psilocybin, MDMA and LSD for use in psychiatric conditions, including depression, drug dependency and anorexia nervosa.



# WHY PSYCHEDELICS IN TRAUMA TREATMENT?



- Trauma spectrum disorders, especially complex trauma, often involve nervous systems that cannot access traumatic memory without either flooding or shutting down. Psychedelics are being revisited because they appear to temporarily soften defensive rigidity, increasing emotional openness, trust, and flexibility in a controlled setting.
- In trauma, the brain wants to fight or run away, psychedelics may temporarily reduce the intensity of these protective parts so the system can safely process the trauma.
- Studies show that MDMA (most relevant for PTSD) significantly reduced trauma symptoms. After treatment many participants no longer met PTSD criteria. In these studies MDMA was administered in structured psychotherapy, not recreationally
- Psilocybin studies show strong evidence for depression. Early data also suggests benefit in trauma-related disorders.
- These medicines are regulated and availability for treatment is very limited (basically you have to be in a study)
- These are not substances people take on their own and heal. The therapeutic effect appears to come from careful guided preparation followed by the medicine session and then integration. The integration phase is often more important than the medicine.

# TREATING PTSD WITH MDMA-ASSISTED THERAPY

## Phase 3 Trial Results Published

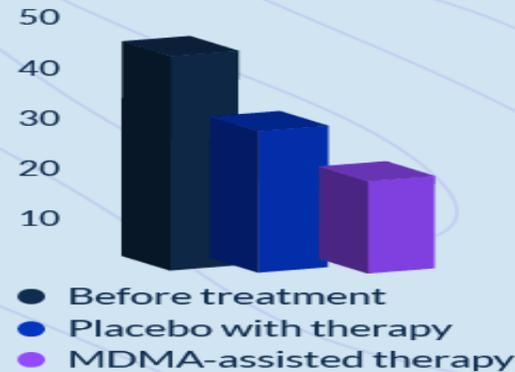


67% of participants in the **MDMA-assisted therapy group** no longer had a PTSD diagnosis after 3 sessions.

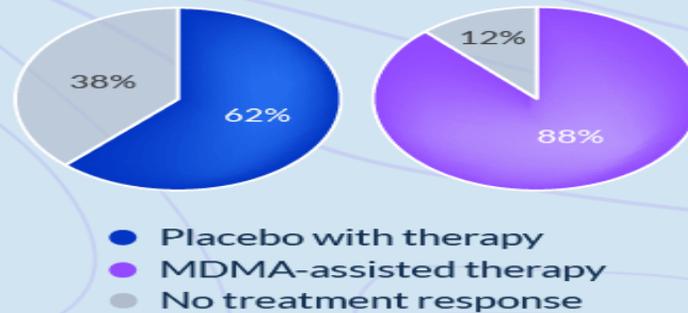


32% of participants in the **placebo with therapy group** no longer had a PTSD diagnosis after 3 sessions.

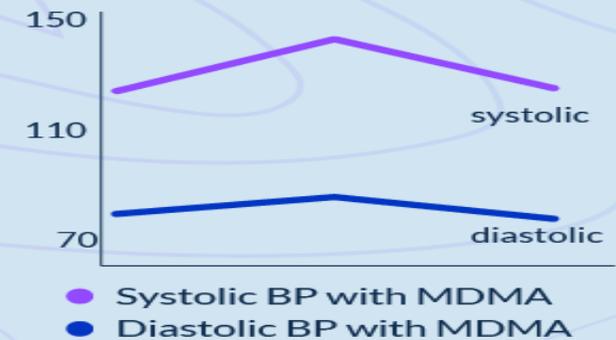
### Average Severity of PTSD Symptoms (CAPS-5 Score)



### Participants with Clinically Meaningful Response



### Temporary Blood Pressure Increase with MDMA



# COMPARING MDMA PSILOCYBIN AND KETAMINE

- **MDMA** appears particularly suited to trauma because it reduces fear while increasing trust and emotional openness. People can revisit traumatic memories without the same level of threat activation. It is probably the most trauma-specific of the three. Illegal, but accessible for select patients via special access.
- **Psilocybin** tends to soften rigid identity structures. For some trauma survivors, especially those whose identity is fused with shame, this can allow a profound shift in self-perception. May increase destabilization in fragile structures. illegal; clinical trials and special access possible.
- **Ketamine** works differently. It's not a classic psychedelic. It can rapidly reduce depressive symptoms and suicidality, sometimes within hours. It is often administered medically, as an anesthetic, rather than psychotherapeutically. It has less consistent trauma processing evidence. Dissociation can be therapeutic or destabilizing. Approved for medical/therapeutic use under regulated conditions.
- LSD, DMT, Mescaline illegal available for research only.
- MDMA seems to help people feel safe enough to revisit trauma. Psilocybin may help them reinterpret their story. Ketamine may help them get unstuck from severe depressive collapse.

# PSYCHADELICS PROMISE AND CAUTION

## Potential Benefits

- ✓ Reduced avoidance
- ✓ Increased emotional access
- ✓ Improved connection
- ✓ Breakthrough experiences

## Risks

- ✓ Psychological destabilization
- ✓ Worsening anxiety
- ✓ Dissociation

## Not appropriate for

- ✓ Active psychosis
- ✓ Bipolar I disorder
- ✓ Unstable personality structure
- ✓ Certain cardiac conditions

## HYPE

- ✓ It cures trauma
- ✓ One breakthrough session can fix years of suffering.
- ✓ It's a shortcut to healing
- ✓ It dissolves the ego permanently
- ✓ It's spiritual awakening in a pill.

## REALITY

- ✓ It can create a temporary therapeutic window
- ✓ It may reduce fear and rigidity long enough to process trauma
- ✓ It requires careful screening, preparation, and integration
- ✓ It can destabilize vulnerable nervous systems
- ✓ Healing still depends on relational safety and long-term integration

Trauma healing is not about erasing the past. It's about increasing our capacity to stay present with it. Psychedelics may be one emerging tool, but they are not a shortcut around the work of integration, relationship, and meaning.

# BESSEL VAN DER KOLK RESEARCH ON PSYCHEDELICS

- Bessel van der Kolk, has in the last 10 years turned significant attention to the potential of psychedelic-assisted therapy, particularly with MDMA and psilocybin, in treating trauma and PTSD. His conclusions are grounded in his participation in clinical research, especially through collaboration with MAPS (Multidisciplinary Association for Psychedelic Studies).

1. MDMA-assisted therapy is highly effective for complex PTSD: MDMA when combined with psychotherapy, allows trauma survivors to revisit painful memories without being overwhelmed by fear or shame. In the Phase 3 trials led by MAPS, which van der Kolk was involved in, two-thirds of participants no longer met the criteria for PTSD after treatment. MDMA helps patients access and process traumatic material with greater empathy, self-compassion, and emotional safety.

2. Talk Therapy Alone Often Falls Short. Van der Kolk has long argued that conventional therapies (like CBT) often do not adequately reach the deep, embodied impact of trauma. Psychedelics offer a powerful means of bypassing the limitations of verbal therapy, allowing access to nonverbal, experiential processing and neurobiological reset.

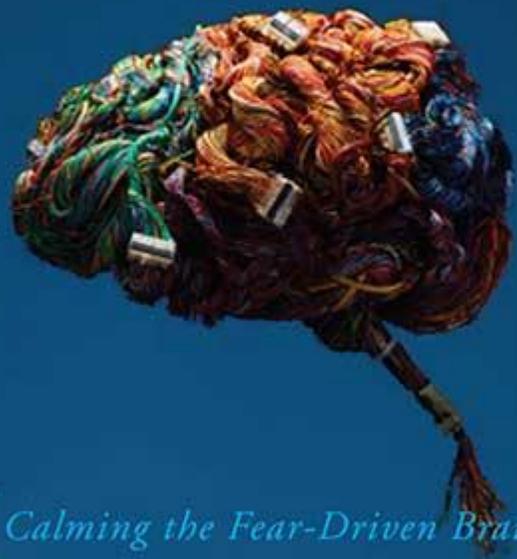
3. Psychedelics Work on the Brain in Profound Ways. MDMA and psilocybin can decrease activity in the amygdala (fear center) and increase connectivity in the default mode network, supporting self-reflection and emotional integration. He sees this as aligned with his belief that trauma lives not just in memory, but in the body and brain's threat systems.

# BESSEL VAN DER KOLK RESEARCH ON PSYCHEDELICS

4. **Psychedelics Facilitate Relational Healing and Self-Compassion:** A key trauma outcome is alienation from self and others. Under MDMA, patients often experience empathy, forgiveness, and connection, even toward perpetrators, themselves, or dissociated parts of themselves. This allows for a reconnection of fragmented inner experience, similar to what van der Kolk has long emphasized as crucial to healing.
5. **Clinical Use Must Be Structured, Supportive, and Ethical.** Van der Kolk stresses that psychedelics are not magic bullets. Their benefits emerge only in the context of skilled, supportive psychotherapy, proper preparation, and integration. He advocates for rigorous training and ethical standards to prevent harm and misuse as these therapies expand.
6. **The Future of Trauma Treatment Must Include Expanded Consciousness Work.** He believes altered states of consciousness, including those induced by psychedelics, yoga, EMDR, and bodywork, are essential for accessing and resolving trauma. Psychedelics, in particular, offer a new paradigm for healing that aligns with his holistic view of trauma: not just a disorder of memory, but of body, brain, and soul.

No medicine replaces phase I safety or phase III meaning.

NEUROFEEDBACK  
IN THE TREATMENT OF  
DEVELOPMENTAL TRAUMA



*Calming the Fear-Driven Brain*

SEBERN F. FISHER



# NEUROFEEDBACK

- Neurofeedback is a non-invasive, brain-based intervention used in trauma treatment to help people regulate dysregulated neural patterns associated with chronic stress and PTSD.
- The Core idea in neurofeedback is that Trauma can leave the brain stuck in patterns of hyperarousal (fight/flight), hypoarousal (shutdown), or unstable switching between the two. Neurofeedback provides real-time feedback on brain activity (via EEG), allowing the brain to gradually learn more stable and regulated states.
- Neurofeedback involves:
  - EEG sensors monitor brainwave activity
  - The client receives immediate feedback (e.g., visual or auditory cues)
  - When the brain shifts toward healthier patterns, it is “rewarded”
  - Over repeated sessions, the nervous system learns improved self-regulation
- It targets: Hypervigilance and startle response. Emotional reactivity and mood instability. Sleep disturbance. Dissociation or shutdown. Impaired affect regulation
- In trauma treatment it is often used as a bottom-up approach. Can be especially helpful for clients who are overwhelmed by verbal or exposure-based therapies. Frequently used as a stabilization or adjunct to trauma therapies such as PE, EMDR, or IFS
- Evidence: Growing but mixed evidence base. Strong clinical support for improving arousal regulation. Less robust evidence than PE or EMDR for core PTSD symptom resolution
- Strengths: Nonverbal and experiential. Can increase emotional tolerance and window of affect. Helpful for complex trauma and developmental trauma
- Limitations: Requires many sessions. Access, cost, and protocol variability
- Best viewed as complementary, not standalone, trauma treatment
- In short: neurofeedback helps trauma survivors by training the nervous system to feel safe again, making deeper psychological work more possible.

# The “three core elements” in treating PTSD

	Marylène Cloitre	Anke Ehlers	Thomas Elbert	Edna Foa	Berthold Gersons	Patricia Resick	Francine Shapiro
					Trustful therapeutic relationship	Nonspecific effects	
							Stabilization
	Psycho-education					Psycho-education	
	Emotion regulation					Emotion regulation	Skills training
			Exposure	• Exposure • Emotional engagement	Exposure		
	Meaning making	• Meaning making • Discrimination	Meaning making	Reducing negative cognitions	Learning that life is dangerous		
		Memory changes					Processing memories
			Mobilizing resources				

- Therapeutic alliance
- Stabilization
- Psychoeducation
- Emotional regulation
- Exposure
- Finding meaning
- Processing memories
- Mobilizing resources

# Treatment of Trauma

There are no Evidence-Based  
Psychotherapies for Phase III  
trauma treatment\*

\*but couples and/or family therapy may be helpful, including Cognitive Behavioral Conjoint Therapy for PTSD (Monson, 2012)

# THE TREATMENT OF DISSOCIATIVE IDENTITY DISORDER

- The treatment of Dissociative Identity Disorder (DID) is typically long-term, psychotherapy-based, and guided by a phase-oriented model rather than rapid trauma exposure.
- The Core principles of DID therapy: Treatment focuses less on eliminating “parts” and more on improving cooperation, safety, and integration of experience. It follows The three phases of treatment model 1. Stabilization and safety (often the longest phase) 2. Trauma processing 3. Integration and rehabilitation
- Goals: Greater continuity of identity, memory, and affect. Increased flexibility and shared functioning. Improved relational, occupational, and life functioning
- Integration may mean: Full fusion into one identity *or* Stable, cooperative multiplicity with minimal dissociation
- Role of medication: No medication treats DID itself. Medications may help comorbid conditions (PTSD, depression, anxiety, sleep disturbance) Careful monitoring is essential due to dissociative sensitivity
- What distinguishes DID treatment: Avoids early exposure-based therapy. Emphasizes safety, pacing, and relational containment. Accepts dissociation as adaptive before helping it soften. Requires therapist consistency and long-term commitment
- In short Treatment of DID is about helping a severely traumatized system move from fragmentation toward coherence, from internal fear toward internal cooperation, and from survival toward living—slowly, safely, and relationally.

# Dissociative Identity Disorder - Treatment Routes

*Integrated functioning* is the goal of treatment for DID.

"A desirable treatment outcome is a workable form of integration or harmony among alternate identities."

## Treatment Phase 1

Establishing safety, stabilization, and symptom reduction

## Treatment Phase 2

Confronting, working through, and integrating traumatic memories, returning to Phase 1 when needed

## Treatment Phase 3

Integration and Rehabilitation

### Cooperative arrangement between alters/parts

Sufficiently integrated and coordinated functioning among alternate identities to promote optimal functioning.

### Partial integration

Fusion plus cooperative functioning

Fusion - some alters/parts join together, no sense of separateness between them. All alters/parts function in a cooperative & coordinated way.

### Final Fusion

(complete integration)

- Complete merger and loss of separateness of all alters/parts
- Most stable treatment outcome
- Many DID patients won't achieve this and/or won't find it desirable

The terms Integration and Fusion can be used in confusing ways.

Integration is a broad process referring to ALL work on dissociated processes during treatment.

Fusion refers to a point in time when two or more alters/parts join together with a complete loss of subjective separateness.

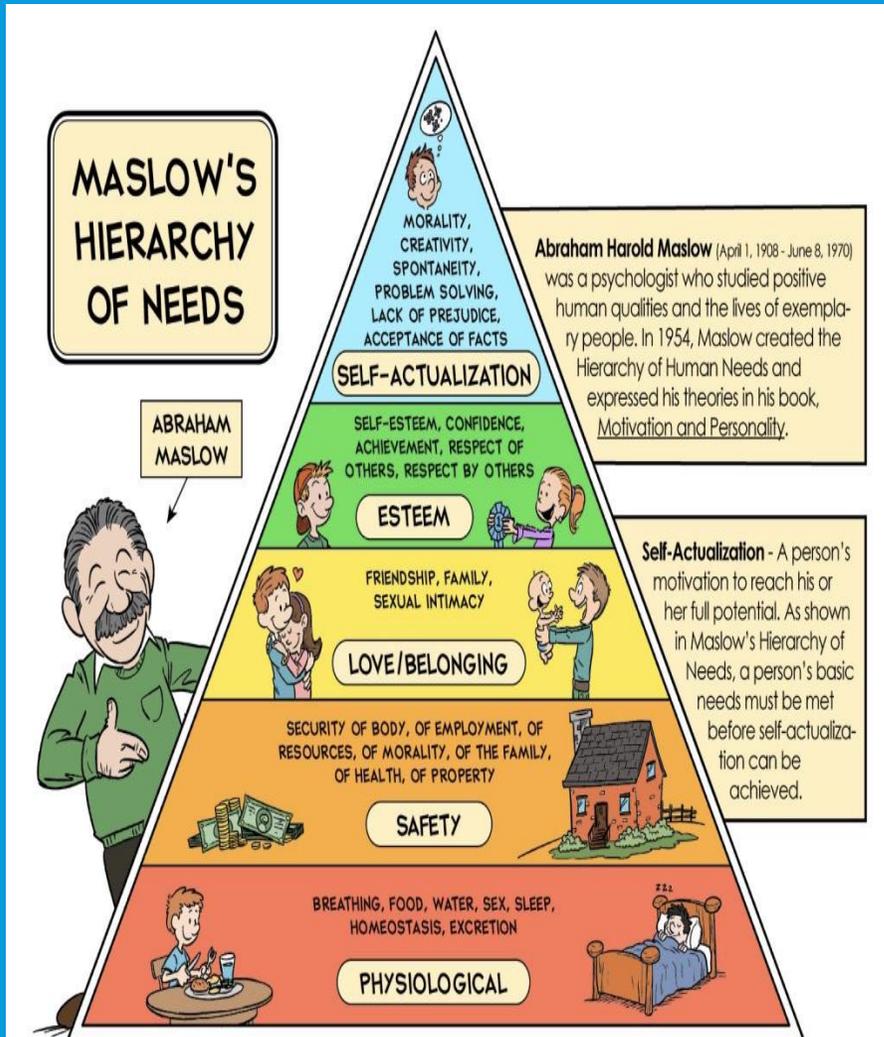
Final fusion refers to the point in time when the patient's sense of self shifts from that of having multiple identities to that of being a unified self.



# HOW SIMPLE ADDRESSES THE THREE STAGES OF TRAUMA THERAPY

Is simple a stage I, II, and III therapy?

# SIMPLE ADDRESSES ALL THREE STAGES OF TRAUMA THERAPY



- Stage I and II work focus on the bottom half of Maslow's pyramid : meeting physiological and safety needs and staying safely in the window of tolerance. In simple we spend a lot of time discussing emotional regulation and building resources.
- Stage III work focuses on top half of pyramid : Developing connections, self-esteem and a sense of meaning.
- The goals diary card procedure outlines our various needs, helps us assess which are and aren't met, and sets out a systematic approach to pursuing our need for connection.
- Stage three work pursues establishing a meaningful life through connections. It focuses on the upper half of Maslow's pyramid or love and belonging, self-esteem, and self-actualization
- Stage three fosters psychosocial growth through Erikson's stages of achieving a healthy identity, the capacity for true intimacy, the desire to give back to the world, and to find meaning in life.
- This requires stages I and II work first.



# SPECIAL CONSIDERATIONS IN THE TREATMENT OF TRAUMA

Clearly the treatment of the trauma related disorders is complex. Is there anything else we might have left out that you think is important for us to know?

# SHAME AND GUILT

## SHAME vs. GUILT

Understanding the difference

### SHAME

Shame is feeling bad about yourself as a person.



I AM BAD.

### GUILT

Guilt is feeling bad about what you did.



I DID SOMETHING BAD.

### WHY DO WE EXPERIENCE SHAME?

Shame is a defense mechanism. It is a way we learned to keep ourselves safe from harm in the past.

It served an important purpose in the past – it kept us safe. But now it may cause problems in our lives and relationships when we no longer need that shame to keep us safe.

Shame can be a way we blame ourselves for something that happened to us that wasn't our fault.

When we feel ashamed, we may feel we can control our safety by controlling our actions and beliefs.



### WHY IT MATTERS

When we understand the differences between these powerful feelings, we begin to understand and eliminate negative self-judgments and self-talk.

### WHAT TO DO WHEN YOU EXPERIENCE ...

#### SHAME

- Exercise self-compassion.
- Recognize shame as a survival tactic.
- Seek healthy connections with others.
- Talk to your therapist.



#### GUILT

- Admit you are wrong.
- Take responsibility.
- Seek forgiveness.
- Change your behavior.



- Guilt is the feeling that we have done something wrong
- Shame, in contrast, is the feeling we have when we evaluate our actions, feelings, and behaviors and conclude that we are inadequate or deficient. Shame encompasses the whole of ourselves; it generates a wish to hide, to disappear or even to die. Shame is the feeling of inferiority.
- Shame is the belief in one's inferior status or the feeling that one does not conform to social norms and expectations.
- Shame is frequently associated with complex PTSD. Enduring prolonged abuse, whether it be by a caregiver, partner, relative, or coworker, leaves the person with a false internalized belief that they are innately bad, defective, and not good enough.
- Shame is associated with trust issues, being a people pleaser, self sabotage, feeling undeserving of love, never feeling safe, feeling as if you must be perfect, constantly feeling like you've done something wrong, and a chronic sense of worthlessness and not being good enough.
- People experience external shame in the form of thoughts and feelings about how they exist in the mind of others and internal shame or self-directed evaluations, thoughts and feelings about inadequacies and flaws.

# SHAME: A FEATURE OF ATTACHMENT ISSUES AND CAREGIVER TRAUMA



- When most of us think of an abused child, we rationally know the child does not deserve the abuse. We consider the abuser to be entirely at fault for the abuse.
- If, however, as adults, we are in an abusive relationship, over time, we often come to believe that the problem is with us. (gaslighting-Stockholm syndrome.)
- That is because we come to feel the situation from emotional mind and emotional mind dominates rational mind.
- The emotional mind is fully developed at birth, the rational mind isn't, it starts to develop at age 3-4 and is only fully developed by our mid 20's.
- The abused child doesn't have the capacity to think rationally about their situation. They can only "feel" the situation. The model that forms in their mind is that of 1) an all-knowing, all-powerful adult who is angry at them and repeatedly holds them at fault, and 2) their frightened, or despairing/abandoned selves .
- Shame, the feeling that there is something fundamentally wrong, evil, unlovable, not good enough, or different and that I will be abandoned, in danger, unhappy and that it is my fault is born in this caregiver child dynamic. This deep-rooted feeling is resistant to change by rational mind re-framing.
- This kind of shame is extremely common in people with attachment and developmental trauma issues.

# SHAME IN THERAPY



- Shame often result in people stopping or never engaging in treatment.
- Shame impedes social connection and cuts the individual off from the support and soothing that may come from others including therapists.
- The power imbalance between patient and therapist, and the unilateral exposure of the patients most intimate thoughts and feelings can further contribute to a feeling of shame in therapy.
- The lack of trust present in complex PTSD starts with early attachment issues and the failure to negotiate Erickson's stage of trust versus mistrust.
- The development of a trusting and secure relationship whether it be with a mentor, friend, partner, or therapist is key in the repair of shame.

# RE-TRAUMATIZATION



## Retraumatization

### WHAT HURTS?

SYSTEM (POLICIES, PROCEDURES, "THE WAY THINGS ARE DONE")	RELATIONSHIP (POWER, CONTROL, SUBVERSIVENESS)
 HAVING TO CONTINUALLY RETELL THEIR STORY	 NOT BEING SEEN / HEARD
 BEING TREATED AS A NUMBER	 VIOLATING TRUST
 PROCEDURES THAT REQUIRED DISROBING	 FAILURE TO ENSURE EMOTIONAL SAFETY
 BEING SEEN AS THEIR LABEL (I.E. ADDICT, SCHIZOPHRENIC)	 NON-COLLABORATIVE
 NO CHOICE IN SERVICE OR TREATMENT	 DOES THINGS FOR RATHER THAN WITH
 NO OPPORTUNITY TO GIVE FEEDBACK ABOUT THEIR EXPERIENCE WITH THE SERVICE DELIVERY	 USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE

- Re-traumatization happens when a person suffering from a trauma related disorder is exposed to people, incidents, or environments that cause them to relive the previous trauma, almost as if it were occurring again.
- Because we are drawn not to relationships that are good for us but to those that are familiar, re-traumatization is common.
- In a therapeutic setting transference and countertransference can result in re-traumatization.
- Re-traumatization often affects vulnerable people in contact with healthcare settings.
- Re-traumatization can be prevented through trauma informed care.

# TRAUMA INFORMED CARE: WHAT HELPS

## Safety



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Ensuring physical and emotional safety

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Common areas are welcoming and privacy is respected

## Choice



Individual has choice and control

Individuals are provided a clear and appropriate message about their rights and responsibilities

## Collaboration



### Definitions

Making decisions with the individual and sharing power

### Principles in Practice

Individuals are provided a significant role in planning and evaluating services

## Trustworthiness



Task clarity, consistency, and Interpersonal Boundaries

Respectful and professional boundaries are maintained

## Empowerment



Prioritizing empowerment and skill building

Providing an atmosphere that allows individuals to feel validated and affirmed with each and every contact at the agency

# COMPLEX PTSD: From Surviving to Thriving



"Pete Walker's new book is an invaluable, comprehensive resource for anyone with a childhood history of trauma. This book is certain to benefit clients and clinicians alike."

- Julie Scheinman, M.A., MFT

**Pete Walker**  
Author of *The Tao of Fully Feeling*

READ BY PAUL BRION

# The COMPLEX PTSD WORKBOOK

A Mind-Body Approach to Regaining  
Emotional Control & Becoming Whole

ARIELLE SCHWARTZ, PhD

Foreword by Jim Knipe, PhD

# THE BODY KEEPS THE SCORE

BRAIN, MIND, AND BODY  
IN THE HEALING OF TRAUMA



BESSEL VAN DER KOLK, MD



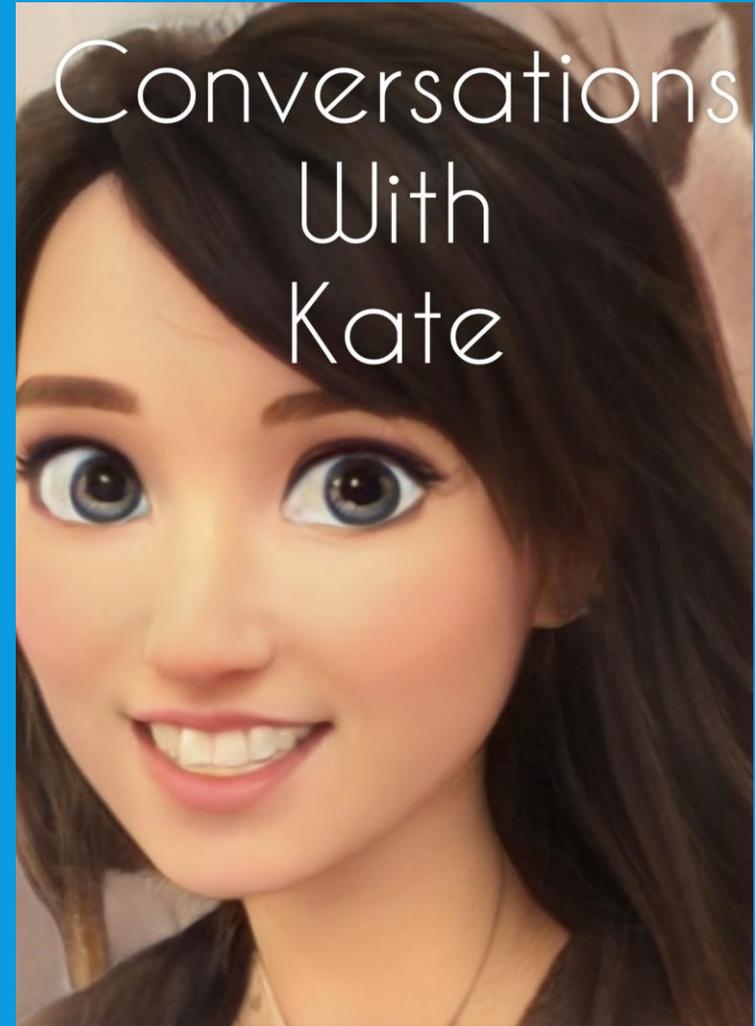
## 5 TAKEAWAYS

1. Dissociation is adaptive before it becomes problematic.
2. Trauma dissociates or splits survival parts EP's from daily life parts ANP's across time.
3. Avoidance keeps trauma alive.
4. Healing happens in phases.
5. No shortcut replaces safety and integration.

SUMMARY



Conversations  
With  
Kate



VIDEO Week 19 of simple

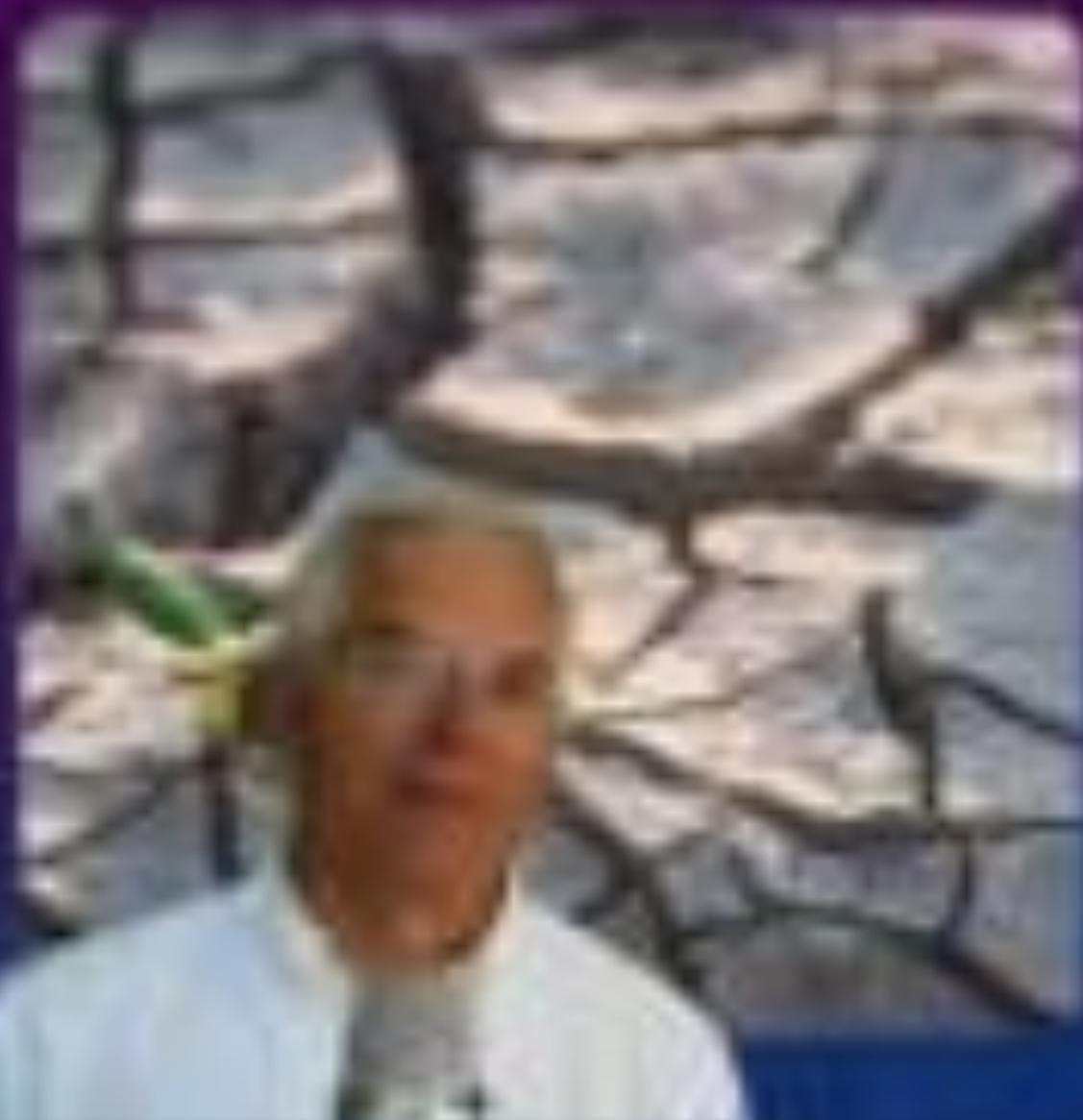




THE BREATHING  
SPACE WITH  
KINDNESS

NO MUSIC  
FEMALE VOICE ONLY

# STRUCTURAL DISSOCIATION AND THE TRAUMA SPECTRUM



- According to structural dissociation theory, people with stress disorders, complex post-traumatic stress disorder and dissociation, like PTSD, have an explicit part of the mind that is not at the point of awareness (Schwartz)
- Structural dissociation theory proposes that people with these complex trauma-related disorders are experiencing more than a disarray of their personality, with different parts, with each with having its own psychological organization (Schwartz)
- According to structural dissociation theory, there is one type of dissociation at work, but it combines with any other coping strategies for stress (e.g., hypnosis, fear, the different parts cannot speak to each other.)
- 1. Primary structural dissociation = PTSD
- 2. Secondary structural dissociation = Complex PTSD
- 3. Tertiary structural dissociation = Dissociation due to PTSD
- This part of parts is to help develop and protect structure on the trauma between the explicit and implicit self for trauma and the person, making the world





# WHAT IS DISSOCIATION



Authentic Mental Health



9 Signs  
You Have  
Unhealed  
Trauma

THE TRUTH ABOUT  
TRAUMA AND  
DISSOCIATION





Signs you have

**C-PTSD**

(Complex Post-Traumatic Stress Disorder)

and not PTSD



A Mindfulness-Based  
Stress Reduction Workbook  
(Coming March, 2010)

An hourglass with white sand is positioned in the center, with the top bulb containing a frothy, golden liquid. To the right, a calendar is visible, showing dates 22, 23, 24, 29, 30, and 31. The scene is set on a light-colored wooden surface. A dark grey rectangular box is overlaid across the middle of the image, containing the text 'SEE YOU NEXT SESSION' in white, bold, sans-serif font.

**SEE YOU NEXT SESSION**

# what if life gets so busy you don't have time to use the tools ?

- I have a rational mind and a wise mind response to this very important and common question.
- The rational mind has to do with the back-end vs. the front-end time commitment.
- Using the skills tools and strategies would be a good goal in that it can help with physiological, safety, psychological and spiritual needs. Every goal you set will require that you use skills and tools. If you are struggling to find goals start with setting time aside to use skills and tools every week. Even 15 minutes twice weekly will make big difference. The important thing is being accountable.
- Doing something inefficiently (or if you keep falling into holes) takes so much more time than doing it efficiently.
- The wise mind response has to do with our unconscious resists change. How much time do we spend on social media or watching TV each day? It takes wise mind to do the hard thing when the hard thing is the right thing to do.
- We live in an attention economy, and our attention is drawn to certain things and not to others. It is drawn to things that providing us immediate gratification and high emotional intensity.
- People are also drawn to chaos as its familiar its repetition compulsion, it distracts us from our pain, and it validates our view of the world.
- Our parts resist change.

(1) Structural dissociation theory is a psychological theory that was developed by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele. It is based on the idea that the mind is structured into different parts or self-states, each with its own thoughts, feelings, and memories. According to this theory, dissociation is a normal and adaptive response to trauma, where the mind separates different parts of the self in order to cope with overwhelming experiences.

In structural dissociation theory, there are two main parts of the self: the apparently normal part (ANP) and the emotional part (EP). The ANP is responsible for day-to-day functioning and is often unaware of traumatic memories, while the EP holds the emotional and traumatic memories. When a person experiences trauma, these parts of the self can become fragmented and disconnected, leading to symptoms of dissociation and other psychological disorders. Therapy based on structural dissociation theory aims to help individuals integrate these different parts of the self, so that they can process and heal from traumatic experiences. By understanding and working with these different self-states, individuals can develop a more cohesive sense of self and reduce symptoms of dissociation.

(2) Flashbacks are a common symptom of post-traumatic stress disorder (PTSD) and can be distressing experiences where a person feels as though they are reliving a traumatic event. There are several different types of flashbacks that individuals may experience:

1. **Visual flashbacks:** These involve vivid images or scenes from the traumatic event that play out in the person's mind as if they are happening in the present moment.
2. **Emotional flashbacks:** These involve intense emotions or feelings related to the traumatic event, such as fear, sadness, or anger, that can be triggered by certain stimuli or reminders.
3. **Sensory flashbacks:** These involve sensations or physical feelings associated with the traumatic event, such as pain, smells, sounds, or tastes, that can be triggered by sensory cues in the environment.
4. **Dissociative flashbacks:** These involve a sense of detachment or disconnection from reality, where the person may feel like they are outside of their body or watching themselves from a distance.

It's important to note that flashbacks can vary in intensity and duration, and may be triggered by specific cues or reminders of the traumatic event. It's also important for individuals experiencing flashbacks to seek support from mental health professionals to learn coping strategies and techniques to manage and reduce the impact of these distressing experiences.