IT WASN'T ME!
DEFINING COMPLEX TRAUMA AND DISSOCIATION
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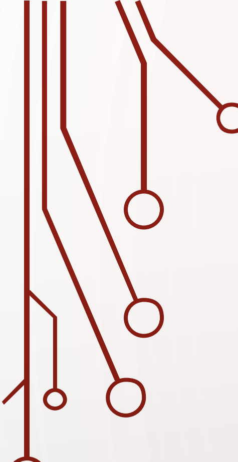
OBJECTIVES:

1. Be able to define complex trauma
2. Be able to define dissociation
3. Recognize the symptoms of dissociation
4. Know ways to assess dissociation
5. Identify best practices in working with complex trauma and dissociation

GABBY

BESSEL VAN DER KOLK



COMPLEX TRAUMA

multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of functioning

COMPLEX TRAUMA

These experiences include:

1) intense emotional reactions such as rage, betrayal, fear, resignation, defeat and shame.

2) efforts to avoid those emotions, including the avoidance of experiences that precipitate them or engaging in behaviors that allow them a sense of control in the face of potential threats

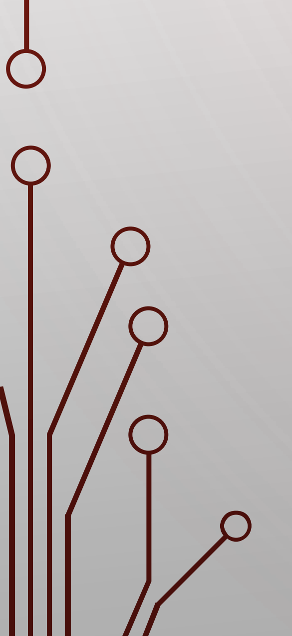
COMPLEX TRAUMA

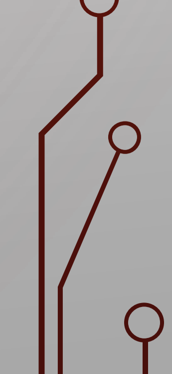
- Physical complaints: headaches and stomachaches
- fearful, enraged, or avoidant emotional reactions to minor stimuli
- difficulty restoring homeostasis and returning to baseline
- they tend to become confused, dissociated and disoriented when faced with stressful stimuli
- constantly on guard, frightened and over- reactive

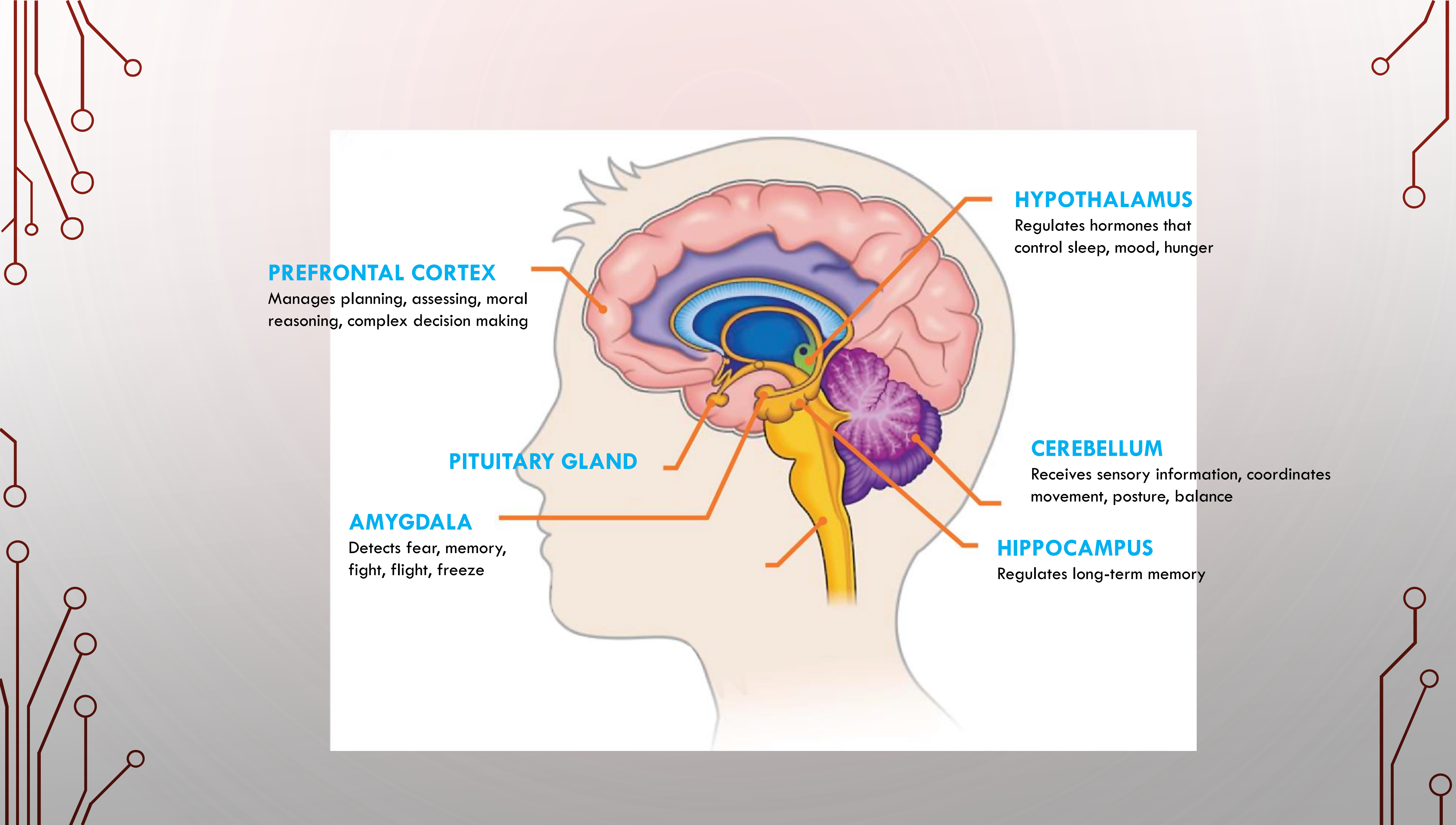
COMPLEX TRAUMA

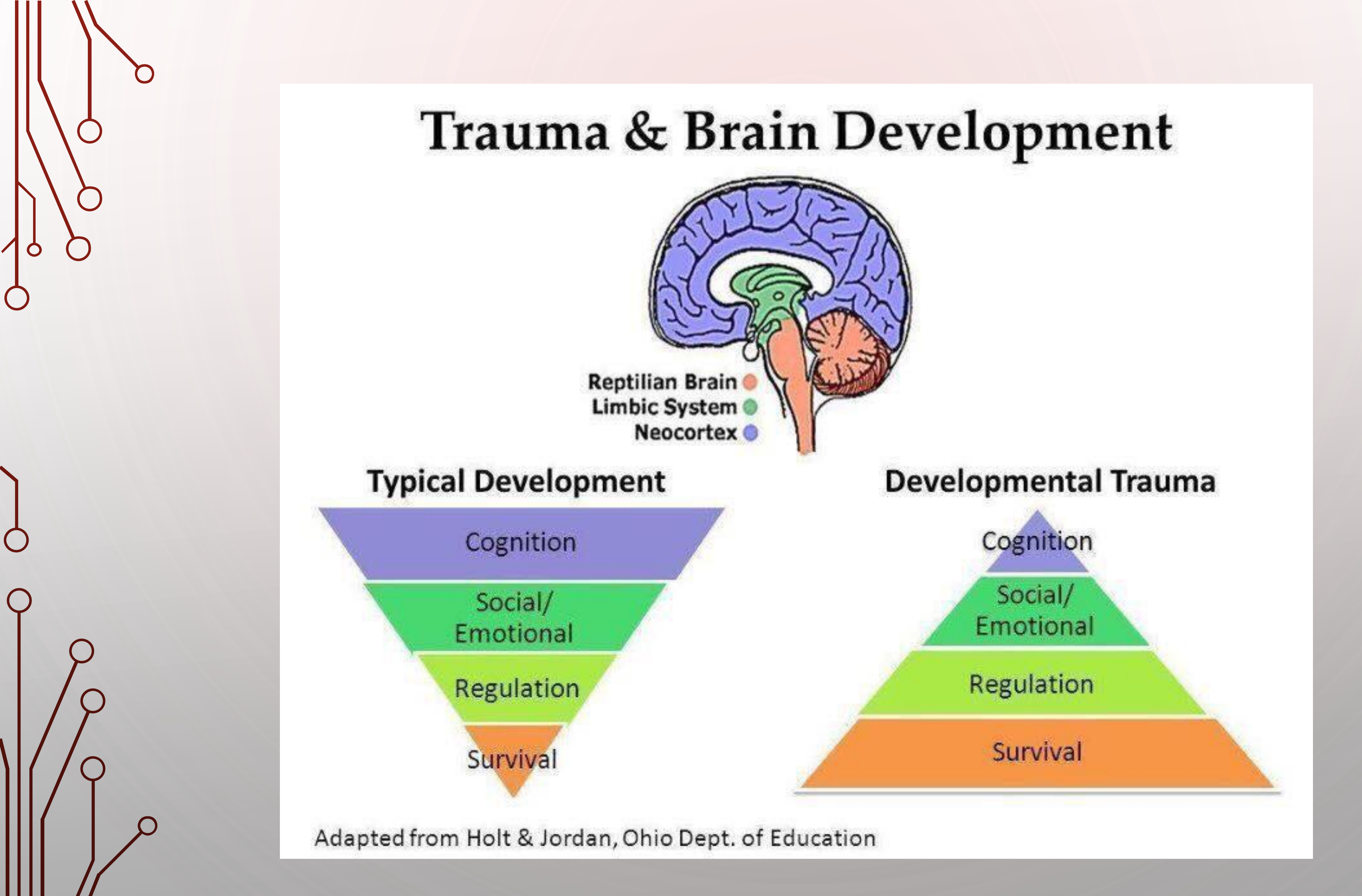
- lose the expectation that they will be protected
- excessive clinging, compliance, oppositional defiance and distrustful behavior
- preoccupied with retribution and revenge
- suffer from distinct alterations in states of consciousness, with amnesia, hypermnesia, dissociation, depersonalization and derealization, flashbacks and nightmares of specific events
- “out of touch” with their feelings, and often have no language to describe internal states

BRAIN DEVELOPMENT



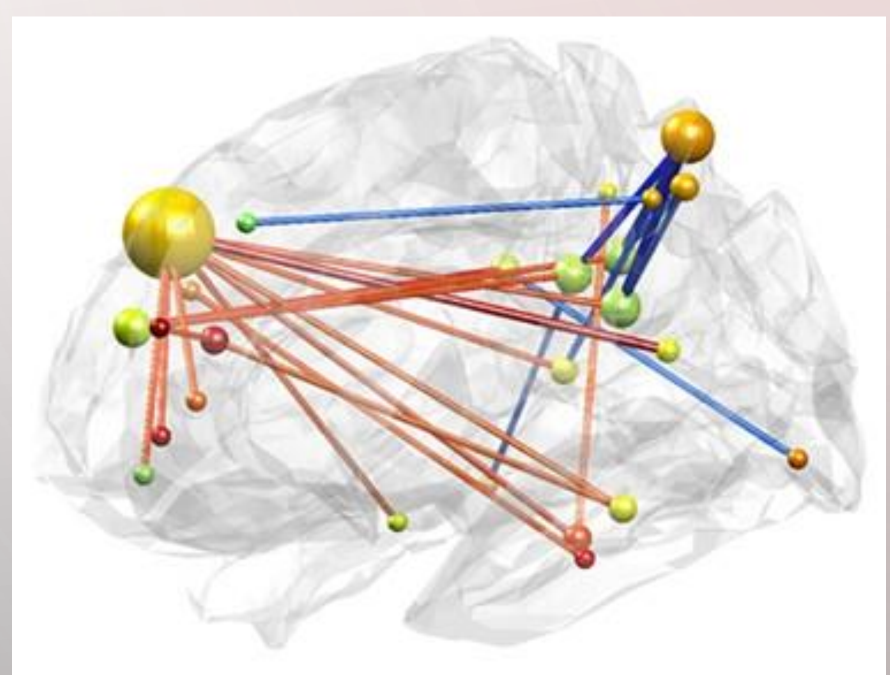



HYPOTHALAMUS
Regulates hormones that control sleep, mood, hunger
PREFRONTAL CORTEX
Manages planning, assessing, moral reasoning, complex decision making
PITUITARY GLAND
CEREBELLUM
Receives sensory information, coordinates movement, posture, balance
AMYGDALA
Detects fear, memory, fight, flight, freeze
HIPPOCAMPUS
Regulates long-term memory



Trauma & Brain Development
Reptilian Brain
Limbic System
Neocortex
Typical Development
Cognition
Social/
Emotional
Regulation
Survival
Developmental Trauma
Cognition
Social/
Emotional
Regulation
Survival
Adapted from Holt & Jordan, Ohio Dept. of Education

MEMORY NETWORKS



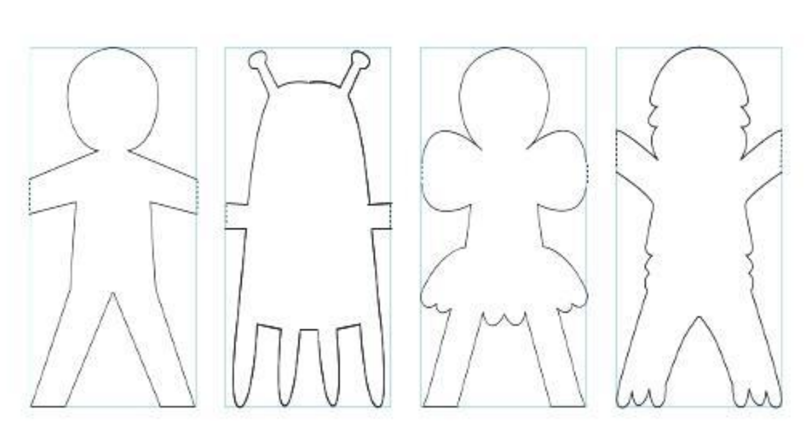
VERBAL

- Involve the hippocampus and the prefrontal cortex
- Linear
- Coherent
- Complete

MEMORY NETWORKS

NONVERBAL

- Primitive
- Emotion driven
- Highly charged
- Traumatic Memories are stored here
- Not ‘realized’

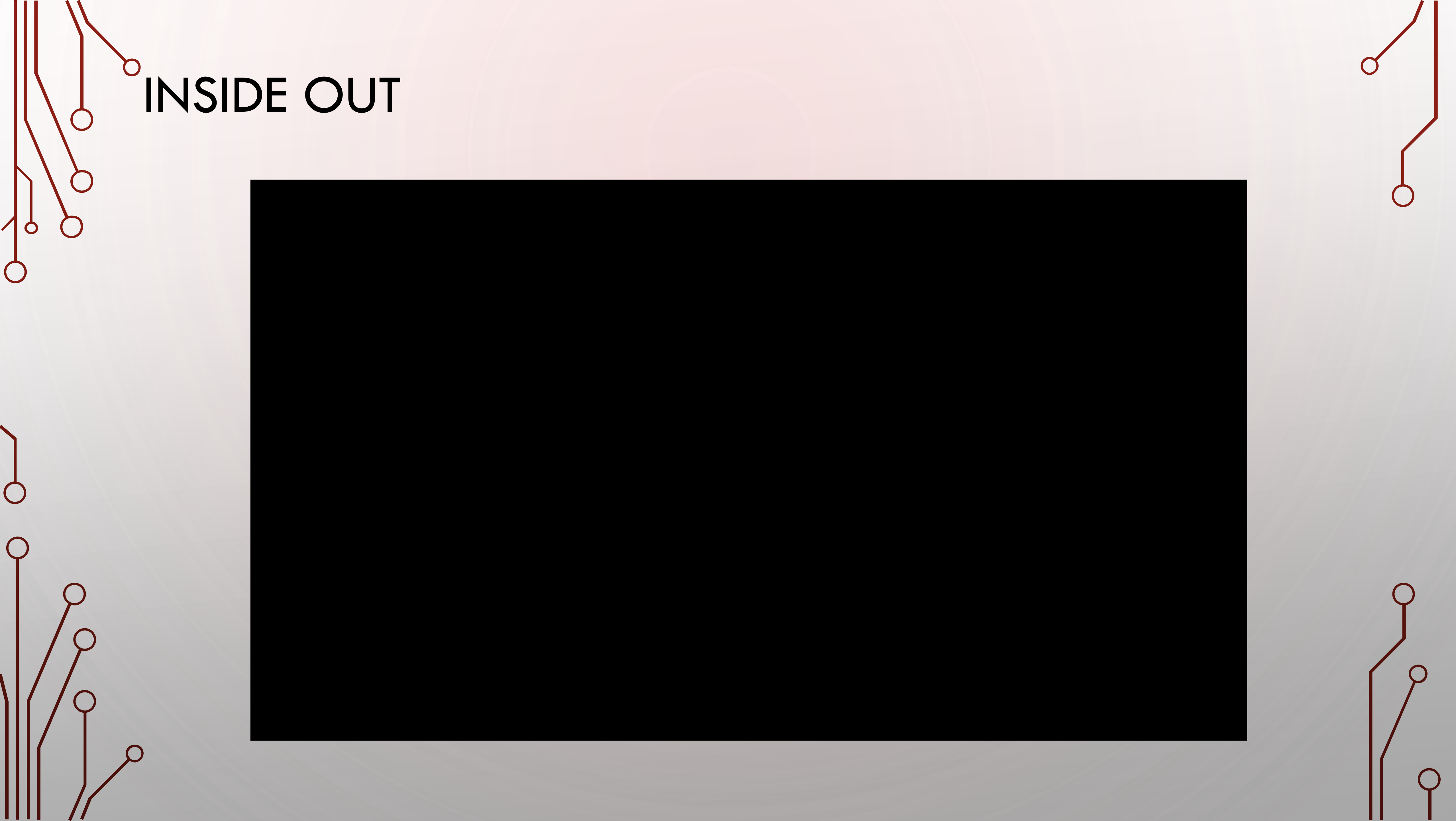


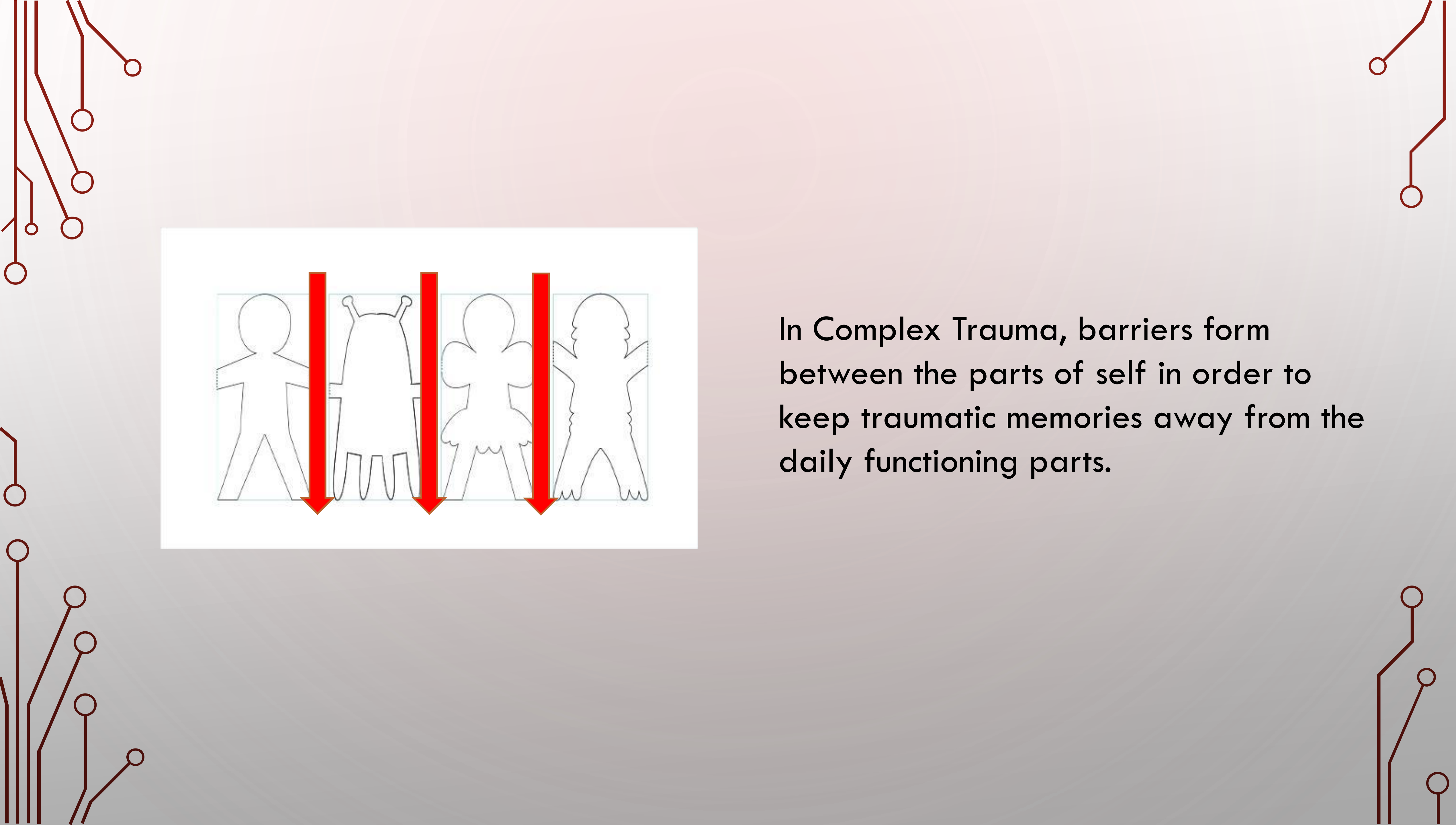
We're all born with different self-states and not one unified personality

These self-states merge during normal personality development

INTEGRATION

- The organization of all the different aspects of personality in a unified whole that functions in a cohesive manner.
- The development of lasting ways of thinking, feeling, acting, and perceiving.


INSIDE OUT

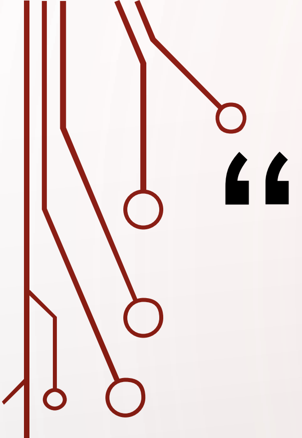

In Complex Trauma, barriers form between the parts of self in order to keep traumatic memories away from the daily functioning parts.

DEFINITION OF DISSOCIATION

- A psychological experience in which people feel disconnected from their sensory experience, sense of self, or personal history.
- A lack of connection in a person's thoughts, memories, feelings, action, or sense of identity.
- A major failure of integration that interferes with and changes our sense of self and our personality

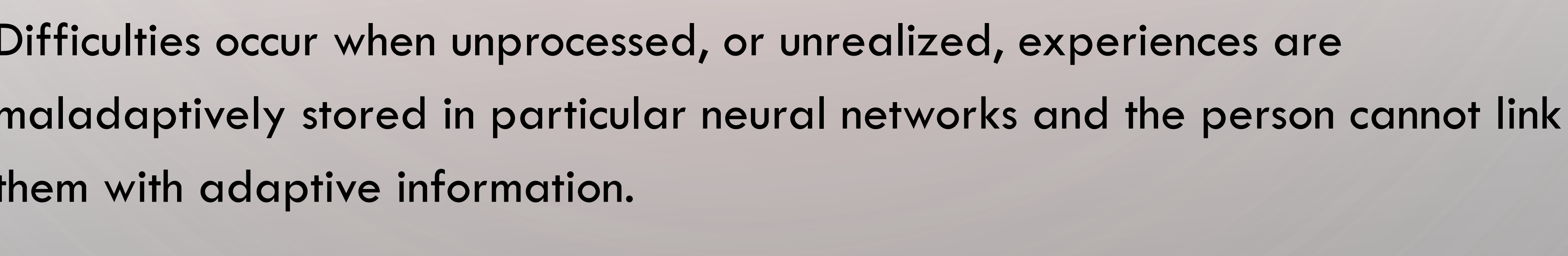
DEFINITION OF DISSOCIATION

- a process that provides protective psychological containment, detachment from, and even physical numbing for overwhelming experiences, usually of a traumatic or stressful nature
- the “animal defensive reaction”: freezing in the face of a predator, when fight/flight is impossible



“DISSOCIATION IS THE ESSENCE OF TRAUMA”

Bessel Van Der Kolk

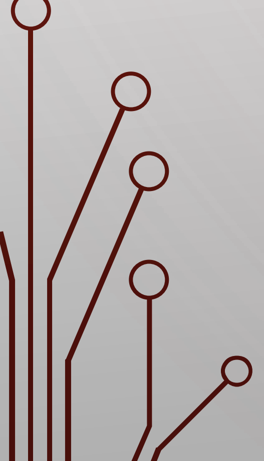


Difficulties occur when unprocessed, or unrealized, experiences are maladaptively stored in particular neural networks and the person cannot link them with adaptive information.

DISSOCIATION

- Trauma destroys the ability to integrate
- Life narrative is compartmentalized
- One part of a person owns the traumatic experiences, one part does not
- Thoughts, memories, feelings, and behaviors do not belong to them.
- Sense of self and patterns of response change from experience to experience.

Symptoms of Dissociation



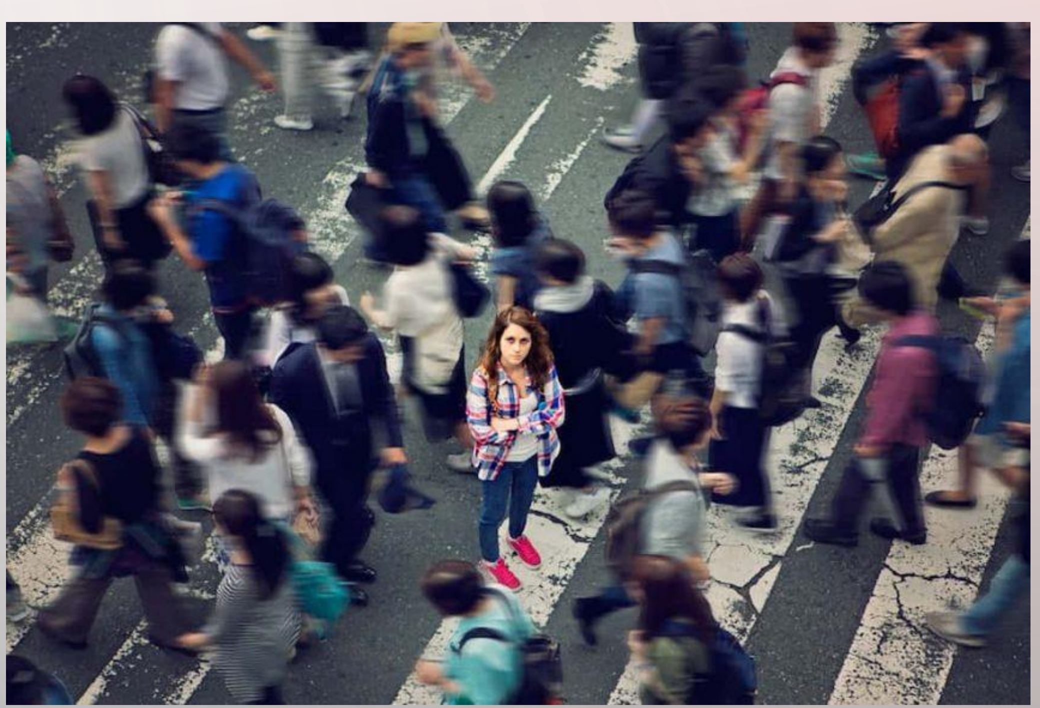
EXPERIENCING TOO LITTLE

- Symptoms that involve apparent loss of functions or experiences
- The loss of important events
- Loss of a skill or knowledge
- Suddenly unable to feel emotions or sensations in the body
- Become emotionally or physically numb
- Losses are not permanent

DEPERSONALIZATION

- the sense of being detached from, or “not in” one’s body
- Not recognizing oneself in the mirror, not recognizing their face, or simply not feeling connected to their body

DEREALIZATION



- sense of the world not being real
- seeing the world as if they are detached, or as if they were watching a movie

TIME DISTORTIONS

- Experience time passing by too fast
- Experience time passing by too slow
- Feel more time has passed than they think
- Feel like an hour is an entire day
- Confused about space and time and believe they are still in the past.

AMNESIA

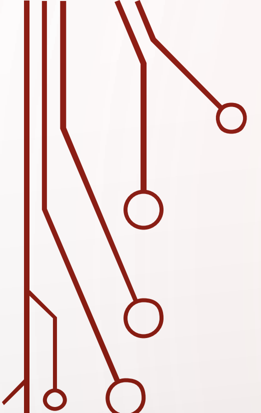
- inability to recall important personal information that is so extensive that it is not due to ordinary forgetfulness
- Large gaps in memory of the past
- micro-amnesias where the discussion engaged in is not remembered, or the content of a conversation is forgotten from one moment to the next
- Evidence of behaviors in the present that patients do not remember doing
- Finding themselves in strange places and not remembering how they got there

EXPERIENCING TOO MUCH

- Dissociative symptoms that involve intrusions
- Flashbacks
- Intrusive thoughts
- Sudden feelings, thought, impulses, or behaviors that ‘come out of the blue’
- A sense of being physically controlled by someone else or forces beyond control

SOMATIC SYMPTOMS

- Unexplained pain, or sensations
- Cannot feel pain
- Physical numbness
- Paralysis without medical cause
- Loss of physical function without medical cause
- pseudoseizures



SCHIZOPHRENIA SYMPTOMS

Dissociative Voices: auditory hallucinations that comment on the patient and include crying, screaming, and berating.

- Usually begin in early childhood
- Include voices of children and adults
- Voices of people from the past
- Heard regularly or constantly
- Have conversations about the patient

SYMPTOMS OF SCHIZOPHRENIA

- Strange thoughts popping up
- Mind suddenly feeling blank
- Feelings, impulsivities, and actions seem as though created by someone else
- Sense of body being controlled
- Hallucinations related to trauma—aware they are not real
- Delusions related to trauma

DISSOCIATION VS. PSYCHOSIS

- People often have great difficulty describing their symptoms and may fear or believe that they are going crazy
- people always remain aware that their experiences of detachment are not real but rather are just the way that they feel
- People with a psychotic disorder always lack such insight

SYMPTOMS RELATED TO OTHER DISORDERS

Behavior

- Fluctuations in skills and abilities
- Told by others they act very differently in situations and seem like different people

Affect

- Report unexplained and rapid fluctuations in mood and emotions
- Feel as though they are not in control of their emotions and they come out of the blue

SYMPTOMS RELATED TO OTHER DISORDERS

Verbal

- Disorganized/disoriented attachment narrative that is not cohesive or coherent and involves lapses in attention and confusion of past and present

Depersonalization and Derealization across psychiatric disorders

- Report feeling like they are in a dream or actor on the stage
- Feel unreal or like a robot
- Feel alienated or disconnected from their bodies
- Feel underwater
- Experience tunnel vision
- Report difficulty hearing, as though they are down a long tunnel

SYMPTOMS COMMON TO GENERAL POPULATION

- Not feeling present
- Spacing out
- Being very forgetful and losing track of time
- Inability to concentrate or pay attention
- Being so absorbed in an activity that you do not notice what is going on around you
- Day dreaming
- Imaginative involvement
- Trance like behaviors—not recalling part of a normal every day activity
- Time distortions
- Low mental energy

IDENTITY CONFUSION

- a sense of confusion about who a person is

IDENTITY ALTERATION

- the sense of being markedly different from another part of oneself

DISSOCIATIVE IDENTITY DISORDER

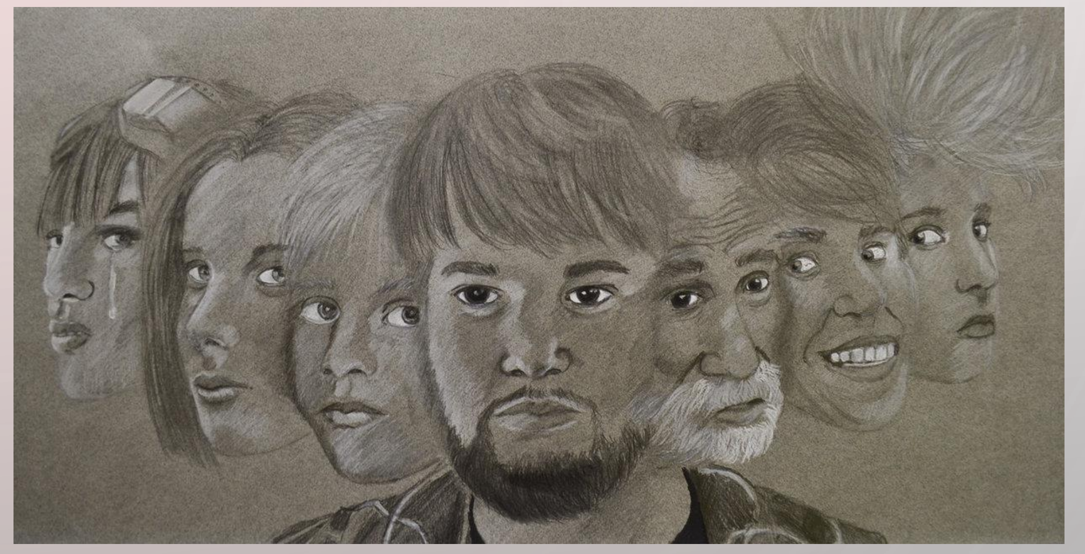
SPLIT

DISSOCIATIVE IDENTITY DISORDER: DSM-V

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiological effects of a substance(e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

DISSOCIATIVE IDENTITY DISORDER

- Each part has their own sense of identity, self-representation, autobiographical memory, and personal experiences.
- Each part has their own thoughts, feelings, memories, fantasies, perceptions, predictions, moods, sensations, decision making, and behaviors.



FALSE POSITIVES

- Only report symptoms described in media
- Defensive when asked for more examples
- Clear chronological history
- Use first person across range of emotions and experiences related to trauma
- Dramatically switch in the first session
- Bring ‘proof’ or maps of part to session
- Report abuse and diagnosis without fear and shame

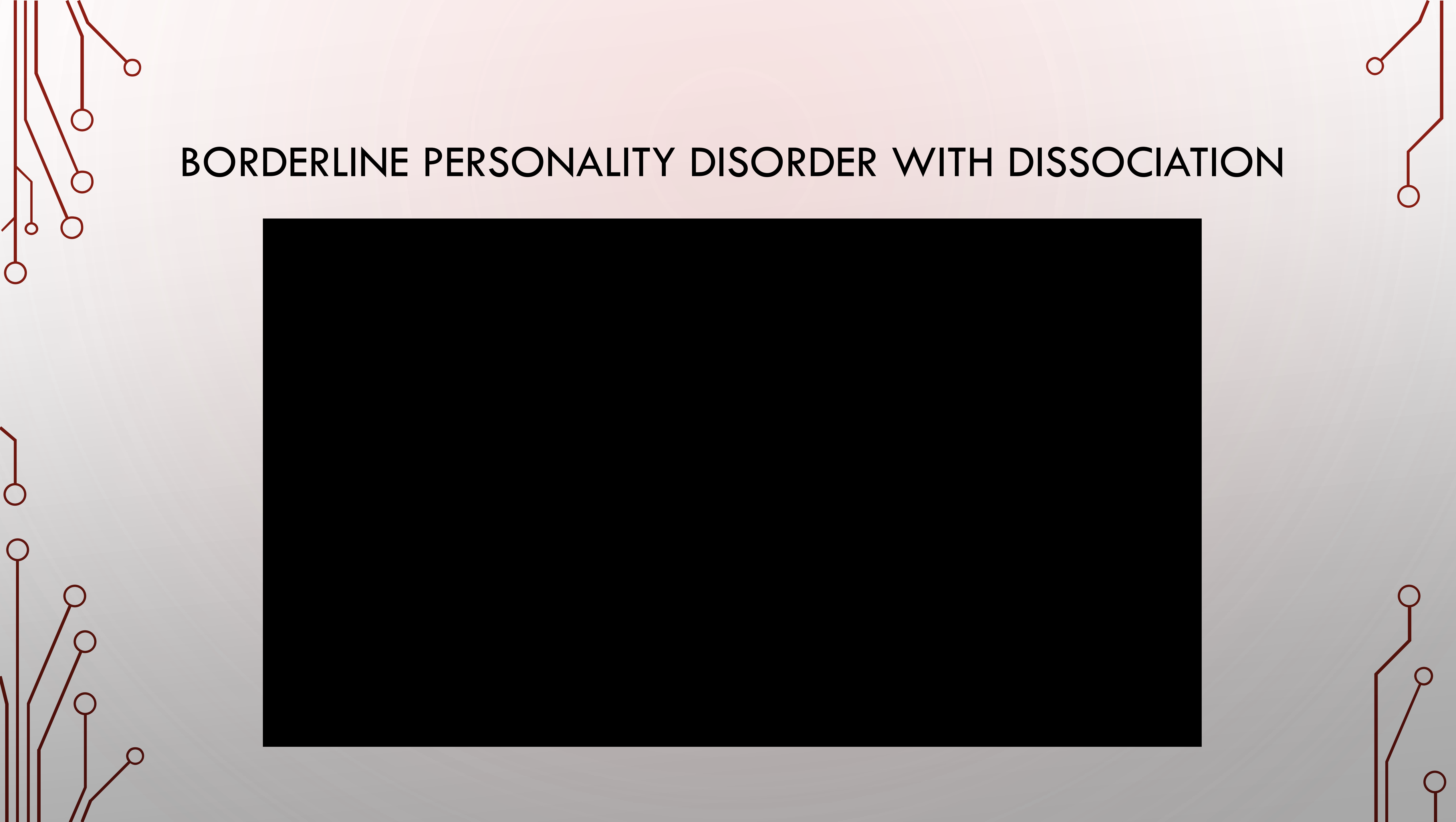
COMMON MYTH

- dissociation involves blatant switching between parts that are vastly different from each other
  - Only in about 5-6% of DID Cases
  - May also have Histrionic Personality Disorder
  - These are the severe cases
  - Indicators the patient is under severe duress and highly conflicted internally

COMMON PRESENTATION

- Patients are usually avoidant of their dissociative parts
- Not likely to present them in public
- Ashamed of their switching
- Dissociation is experienced as a frightening loss of control

BORDERLINE PERSONALITY DISORDER


BORDERLINE PERSONALITY DISORDER WITH DISSOCIATION

BORDERLINE PERSONALITY DISORDER WITH DISSOCIATION

- Only DID clients report higher dissociation scores than BPD clients
- BPD clients report severe dissociation during severe stress

In a 2009 study of dissociation and BPD

- Almost all clients report identity confusion, unexplained mood changes, and depersonalization.
- BPD patients with mild DD reported derealization, depersonalization, and dissociative amnesia.
- BPD patients with DDNOS reported frequent depersonalization, frequent amnesia, and notable experiences of identity alteration.
- BPD patients with dissociative identity disorder endorsed severe dissociative symptoms in all categories.

ASSESSING FOR DISSOCIATION

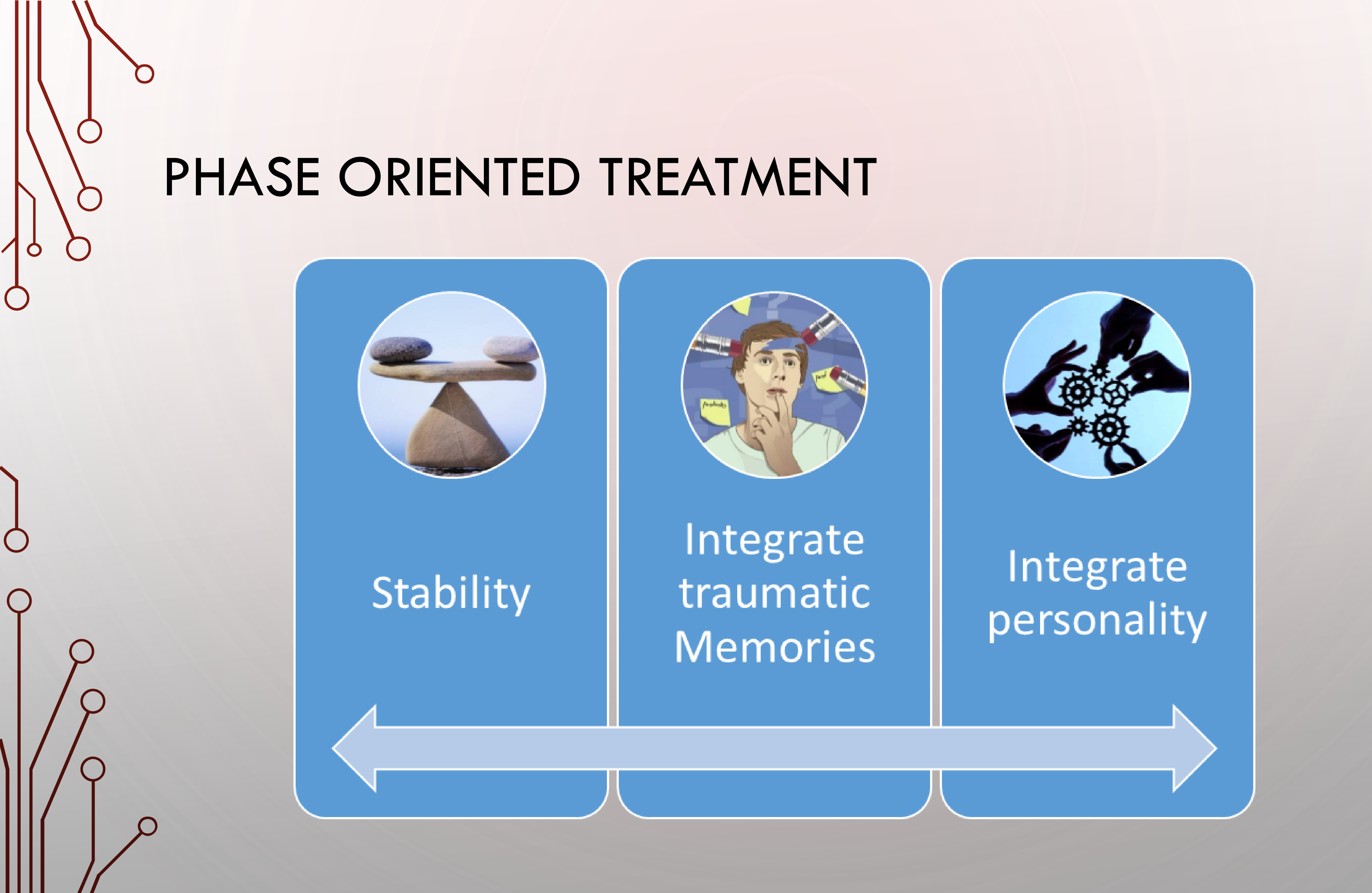
ASSESSMENT

- All patients with complex trauma should be screened for dissociation
- Conducting a thorough assessment of children with complex trauma does not occur in a single session—it is an ongoing process
- Always ask for several examples of endorsed symptoms
- Determine how often symptom occur, when they began, what helps, and what makes them worse
- Do not assume that a high score on a self-report measure of dissociation means the person has a dissociative disorder
- Diagnosis should be based on a constellation of symptoms that can be described over time.

COMMON ASSESSMENTS

- DES- Dissociative Experiences Scale (adult, adolescent, and child)
- Child Dissociative Checklists
- Children's Dissociative Experiences Scale and PTSD Symptom Inventory
- MID
- Interviewing

TREATMENT OVERVIEW


PHASE ORIENTED TREATMENT
Stability
Integrate traumatic Memories
Integrate personality

PHASE 1: STABILITY

- Focus is on safety, stabilization, symptom reduction, and skills building
- Create inner and external safety
- Traumatic memories are contained to the degree possible until the patient can develop the capacity to remain in the window of tolerance
- Relational approach: take into account chronically traumatized patients have been injured in the attachment arena.
- Consistent relational repair is essential

PHASE 1: STABILITY

A guiding principle is to prevent further reactivation of traumatic memories in Phase 1 while compassionately hearing the patient and keeping treatment within the window of tolerance.

emotional distress
can't think clearly
overreact
unproductive problem solving

deep breathing
mindfulness
grounding exercises

Can't calm down

window of tolerance

optimal problem solving
alert
engaged
accessing both emotion and reasoning

Shutting down

depressed
lethargic
unmotivated
numb

mindfulness
physical exercise
deep breathing

GREENWOOD COUNSELING CENTER

STAYING PRESENT EXERCISE EXAMPLES

1. Learning to be Present
2. Finding your own anchors to the present

PHASE 2: INTEGRATING TRAUMATIC MEMORIES

- Interventions are directed towards exposure and processing of traumatic memories.
- Remember that dissociative can become more easily dysregulated than others
- EMDR (reprocessing) is possible at this point

PHASE 3: INTEGRATION OF THE PERSONALITY AND REHABILITATION

- Accept and grieve losses of the past, present, and future
- Adjust to a more normal daily life and routine, learning to live more fully in the present
- Take risks to improve life and relationships
- Accept change as inevitable and adapt to the degree possible
- Establish enduring, healthy relationships

RESOURCES

1. Assessing and Diagnosis Dissociation in Children: Beginning the Recovery- Frances S. Waters
2. “Coping with Trauma-Related Dissociation: Skills Training for Patiens and Therapists” Suzette Boon, Kathy Steele, Onno Van Der Hart
3. “Treating Trauma-Related Dissociation: A Practical, Integrative Approach” Kathy Steele, Suzette Boon, Onno Van Der Hart
4. “A Closer Look at Dissociative Identity Disorder” Anastasia Pollock
5. https://www.isst-d.org/resources/dissociation-faqs/
6. “Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories” Bessel A. van der Kolk, MD.
7. DSM V: Diagnostic and Statistical Manual of Mental Disorders