THE SPECTRUM OF PSYCHOLOGICAL TRAUMA

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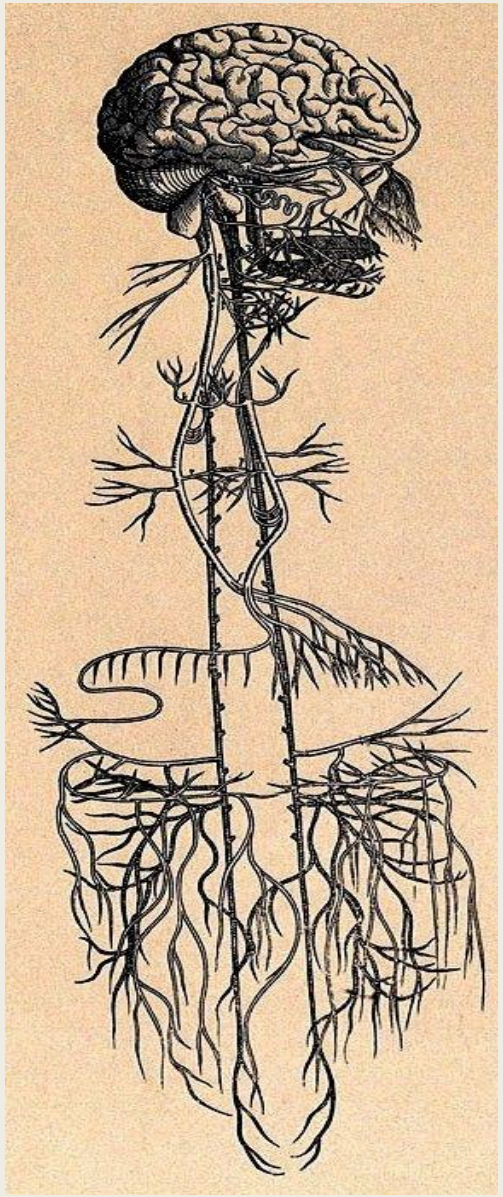


INTRODUCTION

A Wound to the Psyche

- Psychological trauma is frequently defined in terms of dissociation
  - *“Dissociation is the essence of trauma.” (van der Kolk 2014)*
  - *“An experience is traumatic if it is overwhelming enough to cause a break in the linkage and meaning of experience, in narrative memory, and even in body processing.” (Howell 2020)*
- A major goal of the first phase of much trauma therapy is stopping the client’s automatic use of dissociation as a defense

A Wound to the Psyche (2)

- Bonding Psychotherapy (Stauss and Ellis 2007) conceives of emotional disorders as resulting from cumulative relationship trauma, but does not focus on or treat dissociation
- This presentation will outline an understanding of psychological trauma that offers a way to integrate those two perspectives
- I will also share some of my clinical work, which is informed by that understanding

The Spectrum of Trauma

- We use the metaphor of a “spectrum” to suggest that something can be classified in terms of its position on a scale between two extreme points
- I will suggest that the manifestations of psychological trauma can be viewed as falling on a spectrum that includes
  - *A continuum of automatic stress reactions*
  - *A continuum of dissociative processes and dissociated self-states*

CONCEPTUAL FOUNDATIONS

Overview

- Actions systems
- The Polyvagal Theory
- The defense system
- The window of tolerance of arousal
- Self-states
- Dissociative processes and structure
- OPD-2 axes of assessment

Action Systems

- Foundational systems
  - *Physiological arousal/energy regulation*
  - *Social engagement*
  - *Attachment*
  - *Defense*
- Others
  - *Exploration*
  - *Caregiving*
  - *Sociability*
  - *Play*
  - *Sexuality*

The Polyvagal Theory

- Key concepts
  - *Neuroception*
  - *Safety, danger, and life threat*
  - *Three parts of the autonomic nervous system*
  - *The social engagement system*
- Five autonomic states
  - *Hyper-arousal*
  - *Play*
  - *Social engagement*
  - *Intimacy*
  - *Hypo-arousal*

The Polyvagal Theory (2)

- The ventral part of the vagus nerve, which regulates heart rate, and four other cranial nerves form a social engagement system that enables our bodies to
  - *Detect the autonomic state of others from their faces, voices, and movements and*
  - *Automatically coordinate our autonomic state with theirs*
- We automatically, unconsciously calm down and feel safer when others we hear and see feel safe, and we become aroused to defend ourselves when they do not feel safe

The Polyvagal Theory (3)

- There are five possible autonomic states, each of which
  - *Reflects a specific pattern of activation of the three parts of the autonomic nervous system*
  - *Is evoked by neuroception (unconscious detection) of safety, danger, or life threat*
  - *Constrains an individual's psychological experience and behavior*
- In addition to the ventral part of the vagus nerve, there is also the dorsal part, which is connected to organs below the diaphragm

The Polyvagal Theory (4)

		Parts of the Autonomic Nervous System		
Neuroception	Autonomic State	Sympathetic Nervous System	Social Engagement System	Dorsal Vagal Complex
Danger	Hyper-Arousal	Activated to Extremely Activated	Functionally contained	Functionally contained
Safety	Play	Activated	Activated	Functionally contained
Safety	Social Engagement	Functionally contained	Activated	Functionally contained
Safety	Intimacy	Functionally contained	Activated	Activated
Life Threat	Hypo-Arousal	Functionally contained	Functionally contained	Activated to Extremely Activated

The Defense System

- In response to neuroception of danger or life threat, a person's defense system automatically activates
  - *Sympathetic arousal increases*
  - *The person orients toward the stimulus*
- The person responds with three types of behavioral strategies in a specific sequence
- Those strategies form a continuum that is part of the spectrum of psychological trauma

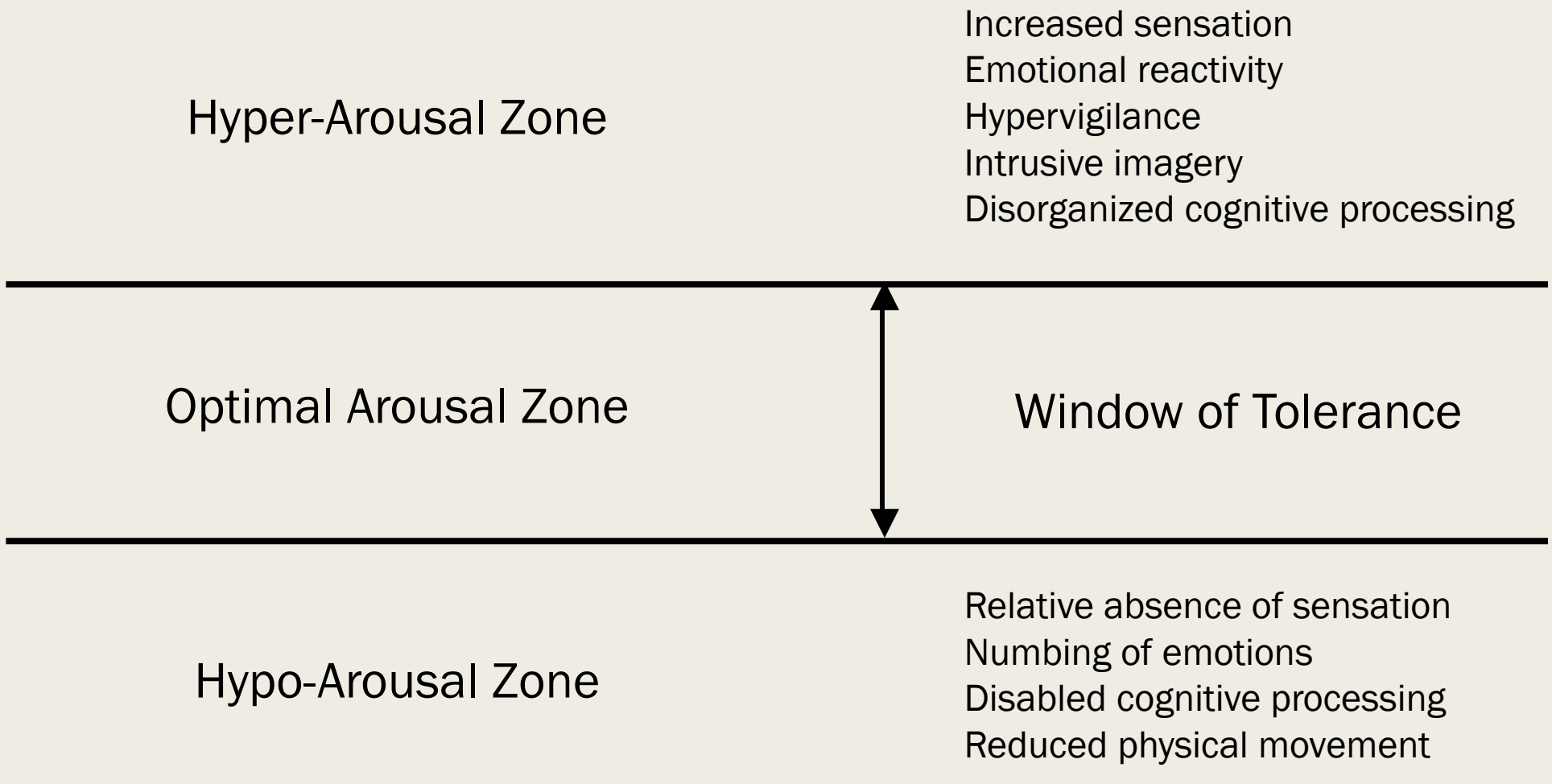
The Defense System (2)

- Relational strategies
  - *Social engagement behavior*
  - *Attachment behavior*
- Mobilization strategies
  - *Flight*
  - *Fight*

The Defense System (3)

- Immobilization strategies
  - *Freeze (2 types)*
    - Motionless, panic stricken, silent, but energized and ready and able to act
    - Paralyzed, incapable of moving, and unable to breathe
  - *Fawning/submissive behaviors (crouching down, ducking the head, avoiding eye contact, bowing the back, shrinking physically, robotic compliance)*
  - *Total submission/shutdown (feigning death, limp passivity, behavioral shutdown, fainting)*

The Window of Tolerance of Arousal



Source: Ogden, Minton, Main (2006)

Self-States

- "Different ways of being me"
- Include "internal working models" of self interacting with others
- Are formed and maintained by associative and dissociative processes
- Healthy psychological functioning
  - *Smooth linkages and continual shifting among self-states in a relatively unimpeded way*
  - *Relatively unrestricted flow among self states of information, emotion, and behavioral and relational capacities*

Dissociative Processes and Structure

- **Everyday dissociative processes** separate aspects of experience that are normally linked
  - *We choose what to attend to*
  - *We tune some things out to focus on others*
- Such processes often do not have a defensive purpose, but they may
- **Severe dissociative processes** manifest in self-states that contain hyper- or hypo-arousal or defend us from experiencing other self-states

Dissociative Processes and Structure (2)

- Dissociative processes contribute to the formation of **dissociative structure**, self-states that contain aspects of experience—sensorimotor, emotional, and cognitive—that are not voluntarily accessible to the rest of the self without support from others
- I view dissociative processes and dissociated self-states as falling on a continuum that is also part of the spectrum of psychological trauma

OPD-2 Axes of Assessments

I. Experience of illness and prerequisites for treatment
II. Interpersonal relations
III. Conflict
IV. Structure
V. Symptoms according to the DSM-V or ICD-11

MANIFESTATIONS OF PSYCHOLOGICAL TRAUMA

Overview

- Core manifestations
  - *Dissociated self-states*
  - *Deficits in structural abilities*
  - *Emergency coping behaviors*
  - *Totalizing shame*
- Countertransference to dissociation
- Severe trauma and mental disorders

Dissociated Self-States

1. Self-states that contain arousal and are formed through everyday dissociative processes and the decay of explicit memory
   - *We do our best not to focus on or think about an event in which we do not get our emotional needs met that evokes sensorimotor and emotional arousal, and we do our best not to recall it later*
   - *Our explicit memory of the event fades over time*
   - *Our sensorimotor and emotional arousal is recorded in implicit memory and lives on in a dissociated self-state*

Dissociated Self-States (2)

- *When environmental cues trigger implicit memory, we experience the self-state—in dreams, more or less vivid "flashbacks," and dysfunctional emotional schemas related to our basic emotional needs---until our sensorimotor and emotional arousal is processed and the experience becomes an explicit memory*
- *Through our nonverbal behavior, we may pass the implicit memory on to our children and grandchildren, who may also experience the self-state in similar ways*

2. Self-states that contain hypo-arousal and timeless sensorimotor and emotional fragments

Dissociated Self-States (3)

- *When emotional arousal becomes unbearable, the brain shifts from hyper-arousal toward hypo-arousal, and defensive activity shifts from mobilization toward immobilization strategies*
- *At the same time, the integrative function of the hippocampus and the storage of experience in explicit memory deteriorate*
- *A dissociated self-state is formed that contains implicit memory of the experience in the form of timeless sensorimotor and emotional fragments*
- *It becomes more difficult to use explicit, declarative memory to recall the experience*

Dissociated Self-States (4)

- *Sensorimotor and emotional fragments of the experience may intrude into consciousness as vivid "flashbacks" when environmental cues activate implicit memory*

3. Self-states in which experience is distorted and fragmented in severe ways, such as through
   - ***Amnesia:*** *lack of explicit recall of important personal information and events, including behavior of self or others*
   - ***Depersonalization:*** *disconnection from oneself or one's body*

Dissociated Self-States (5)

- ***Derealization:*** *sensing the external world as not real or changed*
- ***Identity alteration:*** *creation of one or more dissociated self-states that feel very different from one's usual self-state*
- ***Identity fragmentation:*** *creation of multiple dissociated self-states that are "personified"*

4. Self-states that enact behaviors that defend against the conscious experience of other dissociated self-states

Deficits in Structural Abilities

- Stauss and Ellis (2007): the inability to be emotionally open reflects deficits in seven structural abilities
- Clients with insecurities and motivational conflicts: generally moderate deficits
- Clients with personality disorders: moderate to severe deficits
- Clients with PTSD, complex PTSD, and dissociative disorders: severe deficits

Emergency Coping Behaviors

- Deficits in structural abilities manifest in self-states in which we engage in automatic behaviors to defend against the conscious experience of other dissociated self-states. Examples:
  - *Clinging to, withdrawing from others*
  - *Criticizing, blaming, shaming others*
  - *Obsessional behavior*
  - *Promiscuous behavior*
  - *Addictive behavior*
  - *Binge eating*
  - *Self-harming behavior*

Totalizing Shame

- Shame is the social emotion that signals loss of connection between self and others or between self in the present and in the past
- The fragmentation of experience resulting from absence of social engagement, hypo-arousal, and dissociation destroys those connections without possibility of repair
- The result is “totalizing” shame, the pervasive affective tone that accompanies hypo-arousal

Countertransference to Dissociation

- Feeling sleepy or “spaced out”
- Being unable to think
- Feeling like one is falling or like one’s insides are dropping or being sucked into a black hole
- Not having a felt sense of one’s wholeness, continuity, and connection to the client
- No subtle energy in one’s body
- Joint behavioral enactments of dissociated self-states with the client

Severe Trauma and Mental Disorders

- Chronic Depressive Disorders
  - *Chronically depressed clients often report clinically significant histories of childhood trauma*
  - *Emotional abuse, sexual abuse, and multiple childhood traumas are associated with higher levels of chronic depressive symptoms*
  - *Chronic depressive symptoms reflect dissociated self-states that contain hypo-arousal*
  - *There is significant comorbidity between depressive disorders and other disorders associated with childhood trauma, including BPD, PTSD, chronic PTSD, and dissociative disorders*

Severe Trauma and Mental Disorders (2)

- Borderline Personality Disorder (BPD)
  - *There is a strong association between BPD and various forms of abuse in childhood, including physical abuse, sexual abuse, and witnessing domestic violence*
  - *BPD symptoms include fragmentation of the self into two distinct self-states (or groups of self-states), one attachment-oriented and the other aggressive.*
  - *Symptoms include alternation between these self-states, which have the same identity but are affectively dissociated.*
  - *Clients generally have severe deficits in structural abilities and may engage in multiple emergency coping behaviors.*

Severe Trauma and Mental Disorders (3)

- Post-Traumatic Stress Disorder (PTSD)
  - *Develops after exposure to actual or threatened death, serious injury, or sexual violence related to traumatic event(s)*
  - *Intrusion symptoms and increased arousal and reactivity reflect self-states involving hyper-arousal and mobilization reactions*
  - *Persistence of avoidance of stimuli associated with traumatic event(s) defends against the intrusions*
  - *Negative alterations in cognitions and mood reflect cognitive distortions associated with hypo-arousal and immobilization as well as dissociative processes*

Severe Trauma and Mental Disorders (4)

- Complex PTSD
  - *History of repetitive, prolonged, pervasive, and sometimes ongoing attack, harm, or neglect and abandonment, with great potential to compromise, often severely, a child's development or to undermine or reverse important developmental attainments*
  - *In addition to all the symptoms of PTSD, symptoms often include chronic, extensive emotional, interpersonal, and self-dysregulation*
  - *Clients generally have severe deficits in structural abilities and may engage in multiple emergency coping behaviors*

Severe Trauma and Mental Disorders (5)

- Dissociative Identity Disorder (DID)
  - *Develops as a result of early, frequent, sustained, violent trauma, often sexual abuse, and severe neglect*
  - *Personified self-states and depersonalization reflect severe dissociative processes that both manifest and defend against acute hyper- and hypo-arousal*
  - *Flashbacks reflect hyper-arousal of personified self-states formed at the ages when trauma occurred*
  - *Self-states range from less than ten to hundreds*
  - *Many clients do not present with easily discernible "switching" between self-states*
  - *Co-consciousness of and cooperation among self-states often limited early in therapy*

TREATMENT OF PSYCHOLOGICAL TRAUMA

Overview

- What to be curious about
- Phases of treatment
- Key clinical processes
  - *In work with all traumatized clients*
  - *In work with complex trauma and dissociative disorders*
  - *In work with Dissociative Identity Disorder (DID)*
- Treatment modalities

What to Be Curious About

- What is the client's typical autonomic state?
- What dissociative processes are manifesting in the client's experience?
- Is the client grounded in their body in the present?
- How severe are the client's structural deficits?
- What are the client's intrapsychic conflicts?
- Where are we in the treatment process?
- What can be accomplished in this session?

Phases of Treatment

- Treatment of complex PTSD and dissociative disorders is comprised of three phases
  - *Phase 1: Stabilization and symptom reduction*
  - *Phase 2: Treatment of traumatic memories*
  - *Phase 3: Integration and rehabilitation*
- The term “phase” does not imply a linear sequence
- In practice, treatment proceeds in spiral fashion, with frequent return to “earlier” stages to prepare for further work

Key Clinical Processes

- In work with all traumatized clients
  - *Helping the client describe sensorimotor experience*
  - *Tracking the client's arousal and autonomic state*
  - *Helping the client regulate arousal and stop any emergency coping behaviors in which they engage*
  - *Enhancing the client's structural abilities*
  - *Processing emotions while regulating arousal*
  - *Helping the client practice expressing emotional needs and new beliefs ("attitude work") and new interactional patterns*
  - *Exploring autonomic states of play and intimacy and a felt sense of oneness and heart connection*

Key Clinical Processes (2)

- In work with clients with complex PTSD and dissociative disorders
  - *Tracking the client's dissociative processes*
  - *Teaching and supporting the client to be sensorily grounded in their body in the present and to tolerate arousal without going into hypo-arousal*
  - *Helping the client remain grounded and regulate their arousal while describing sensorimotor fragments and feeling the emotions contained in the memories and evoked by remembering in the present*
  - *Helping clients observe, explore the motivations for, and let go of severe dissociative processes*
  - *Helping clients create a detailed narrative of the history of their abuse and its meanings*

Key Clinical Processes (3)

- In work with clients with DID/identity fragmentation
  - *Serving as a "relational bridge" between clients' personified dissociated self-states to promote co-consciousness and collaboration*
  - *Teaching the client to use self-hypnosis to help self-states feel safer, control the intensity of their experience, and practice self-soothing and nurturing*
  - *Helping the client reflect about self-states as containers of fragments of memories and current experience*
  - *Guiding and accompanying the client as they use self-hypnosis and other techniques to access, process, and integrate the memory fragments of abuse contained in self-states*

Therapeutic Modalities

- Trauma-informed psychodynamic therapy
- Sensorimotor Psychotherapy
- Somatic Experiencing
- Trauma-informed Internal Family Systems (IFS)
- Trauma-informed group therapy
- Bonding Psychotherapy
- Structural work
- Hypnosis

Therapeutic Modalities (2)

- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Brainspotting
- Deep Brain Reorienting
- Stanley Rosenberg's Polyvagal-informed exercises to stimulate the ventral vagus
- Therapeutic yoga and movement therapies
- Neurofeedback

CASE STUDIES

Case #1: Mild Dissociative Symptoms

- **History:** Apparently limited sexual abuse by a male relative when he was a boy
- **Symptoms:** Frequent hypo-arousal, porn addiction
- **Modalities:** Psychodynamic therapy, Rosenberg exercises, IFS
- **Results:** Greater tolerance of arousal and emotions, reduction in hypo-arousal and porn addiction

Case #2: Complex PTSD

- **History:** Emotional, physical, and sexual abuse by family members
- **Symptoms:** Anxiety, depersonalization, flashbacks, emotional numbing, emergency coping behaviors, dysfunctional relationship patterns
- **Modalities:** Psychodynamic therapy, EMDR, IFS
- **Results:** Stronger structural abilities, no dissociation, lower anxiety and numbing, more functional behaviors and relationship patterns

Case #3: Complex PTSD

- **History:** Neglect, emotional abuse by mother, parents' divorce at age 5, recent physically and sexually abusive relationship
- **Symptoms:** Anxiety, depression, ADHD, nightmares, flashbacks, emergency coping behaviors, dysfunctional relationship patterns
- **Modalities:** Psychodynamic therapy, IFS, EMDR, medication
- **Results:** Stronger structural abilities, stable mood, no flashbacks, better executive functions, more functional behavior and relationship patterns

Case #4: Relationship Problems

- **History:** Emotional neglect and abuse
- **Symptoms:** Anxiety, unstable self-esteem and moods, emergency coping behaviors, dysfunctional relationship patterns
- **Modalities:** Psychodynamic therapy, Rosenberg exercises, structural work, IFS
- **Results:** Stronger structural abilities, stable mood, no flashbacks, more functional behavior and relationship patterns

Case #5: DID

- **History:** Repeated violent sexual abuse by a neighbor between the ages of 5 and 7
- **Symptoms:** Anxiety, depression, nightmares, discontinuities of experience, flashbacks, depersonalization, somatization
- **Modalities:** Psychodynamic therapy, Sensorimotor Psychotherapy, IFS, hypnosis, medication
- **Result:** Over three years of stabilization work before processing of memories could begin

CONCLUSION

Key Takeaways

- Psychological trauma as a spectrum
  - *A continuum of automatic stress reactions*
  - *A continuum of dissociative processes and self-states*
- Important clinical tasks
  - *Tracking autonomic state and dissociative processes*
  - *Helping clients who go into hypo-arousal and dissociate to ground, learn to tolerate arousal and emotions, build structural abilities, and develop more functional behaviors and relationships*
- Careful structure required to process emotions
- The diversity of therapeutic modalities

The Human Condition

- Two recent books
  - *Galit Atlas,* ***Emotional Inheritances*** *(2022)*
  - *Manfred Henningsen,* ***Regimes of Terror and Memory*** *(2023)*
- Common themes
  - *Intergenerational transmission of trauma and dissociative processes*
  - *Symptoms and a need for healing at multiple levels: the person, the family system, and society*
- Psychoeducation and the availability of treatment are social and political issues (Herman 2022)

Training Resources

- American Society of Clinical Hypnosis (https://asch.net)
- European Society of Hypnosis (https://esh-hypnosis.eu/)
- European Society for Trauma and Dissociation (https://estd.org)
- European Society for Traumatic Stress Studies (https://estss.org)
- International Society for the Study of Trauma and Dissociation (https://isst-d.org)
- International Society for Traumatic Stress Studies (https://istss.org)

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