CAROLYN SPRING
reversing adversity

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PowerPoint handouts
(with space for notes)

Working with Dissociative Disorders in Clinical Practice
online training

SESSION 1

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- Today we will distil the complex into the simple to give you a useful roadmap for the work
- I didn't start therapy knowing I had a dissociative disorder
- I assumed my difficulties were because I hadn't talked about the trauma – NOT because I was traumatised

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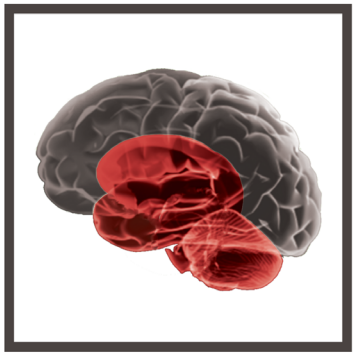
- Most people think of trauma as a distressing or upsetting event
- It is an adaptation to life-threatening powerlessness
- Trauma resides more in the 'back brain' than the 'front brain'
- Trauma conceals itself from awareness



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- Most clients start therapy for a reason other than 'a dissociative disorder'
- Often a disconnection between their symptoms and their past experiences
- The focus of a DID survivor will more likely be on their parts than on their trauma

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- My symptoms:
  - Fear of insanity
  - 'Blind' flashbacks of abuse
  - Disruption of sleeping, eating, life tasks
  - Suicidality and self-harm
  - Distress, shame, self-hatred

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- My symptoms:
  - Powerlessness
  - 'Carousel' of alters/parts (with/ without co-consciousness)
  - Abandonment and aloneness
- Found it hard to do daily life; focused on danger

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- Beliefs and expectations upon entering therapy:
  - Being 'understood' as a miracle cure
  - Dependent on others
  - The therapist would 'fix' me
  - I would unburden myself of dark secrets
  - All would be well!

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- Beliefs and expectations can derail the therapy
- Often the goal is to tell the 'story' to be cured
- That doesn't work for trauma
- The therapist is not just a super-attentive 'professional friend'

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- Far deeper process than I imagined, of a relationship that was:
  - mutual
  - collaborative
  - boundaried
  - empowering
- Process of painful loss and grieving, not instant relief

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- Reframing of myself as resilient rather than weak and mad
- 'I have already survived the worst'
- Confidence in my ability to survive anything in the future
- Feeling safe and 'at home' within myself

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- My recovery was built on someone else's belief in me ...
- ... teaching me to believe in myself
- So much of recovery is about building skills
- ... telling myself a different story about myself
- I am not my symptoms

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- Main focus on this course won't be on the symptoms (multiplicity)
- Focus will be on relieving the suffering of unhealed trauma
- Resolving the processes which maintain the dissociation
- 'Working with' ... to effect change
- Not just sympathy and understanding

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What do you think the purpose of therapy is? Listening ear? Brain surgery? How would you describe it?

When you think of someone with DID, what do you think the key issues to resolve will be?

In what way is a dissociative disorder an 'adaptation to a threatening environment'?

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- Professionals often want tips, techniques and tools
- These are like felt-tip pens
- Need to grasp the big picture so you know what you're drawing
- Different ways to draw beautiful things – not 'painting by numbers'
- Just be 'good enough'

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- DID is not a random 'mental illness' which can happen to anyone
- Post-traumatic and developmental condition
- It's not a 'thing'
- It's a set of responses and adaptations to trauma

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- DID helps us survive a life-threatening environment
- It stops being effective once our environment is no longer dangerous
- We are 'injured' by trauma, stuck at a certain point
- Right conditions = healing

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- Don't focus on the parts!
- Multiplicity is one half of the diagnostic criteria (the other is memory disturbance)
- The focus for diagnosis is not the focus for treatment
- Focus on dealing with the underlying trauma

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- Focus on integrating the trauma, not the parts!
- The root issues:
  - The adaptations to a life-threatening environment
  - Allowing the natural defensive sequence to complete

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- Focus on recovery (via neuroception) and integration (front brain processing)
- Clear roadmap for the work
- DID is treated like a freak show when the symptoms are divorced from the cause

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Do you think you need to be an expert to work with dissociative disorders?

Are you naturally more confident in your toolkit (your felt-tips) or in your knowledge of the big picture?

Is your focus naturally on the 'cough' or the 'infection'?

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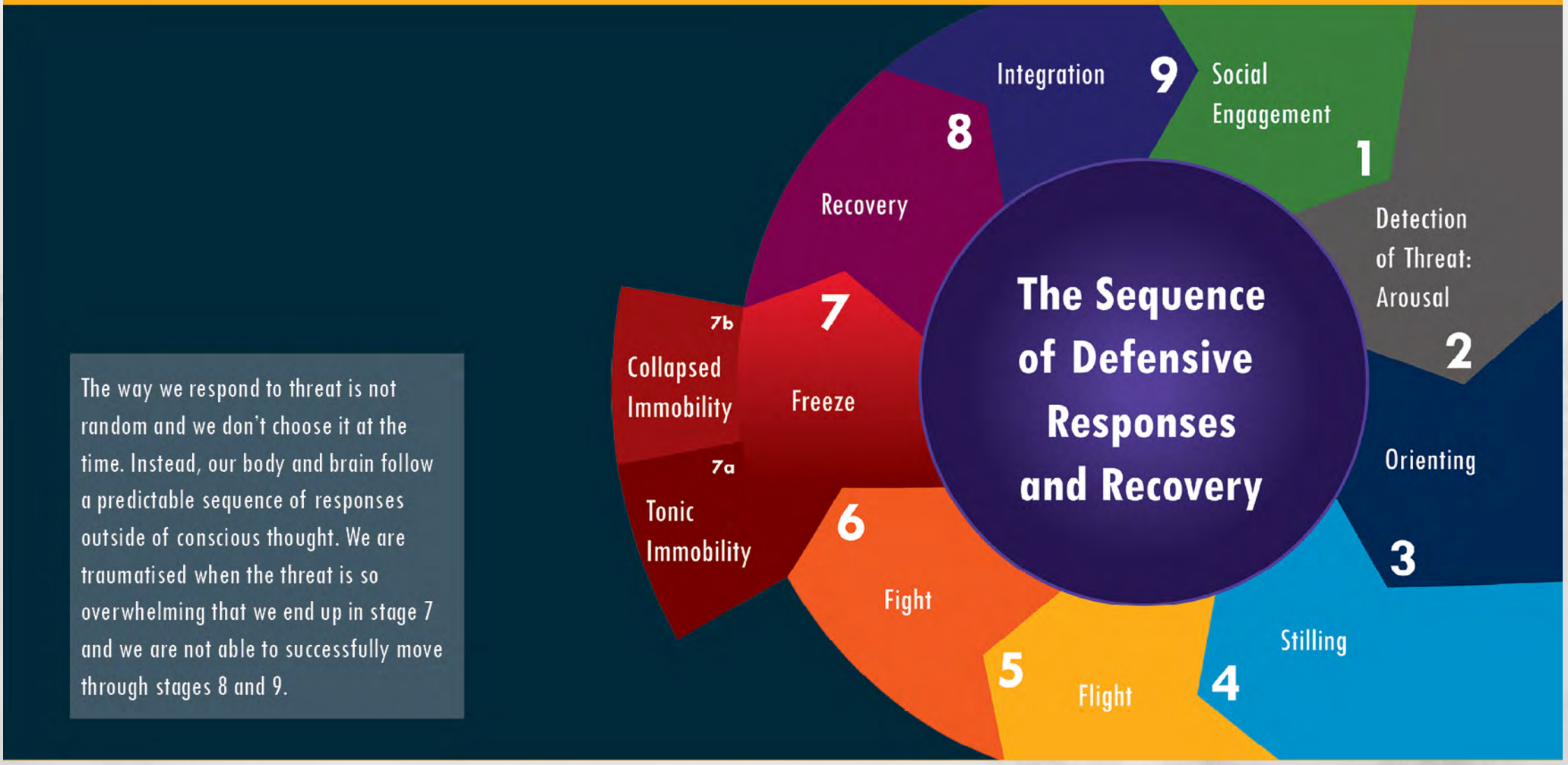
- General, 'lay' view of trauma is that it is a deeply upsetting or distressing event
- Not everyone who experiences a distressing event develops a post-traumatic condition, let alone DID
- Being 'traumatised' is different to a 'traumatic' event

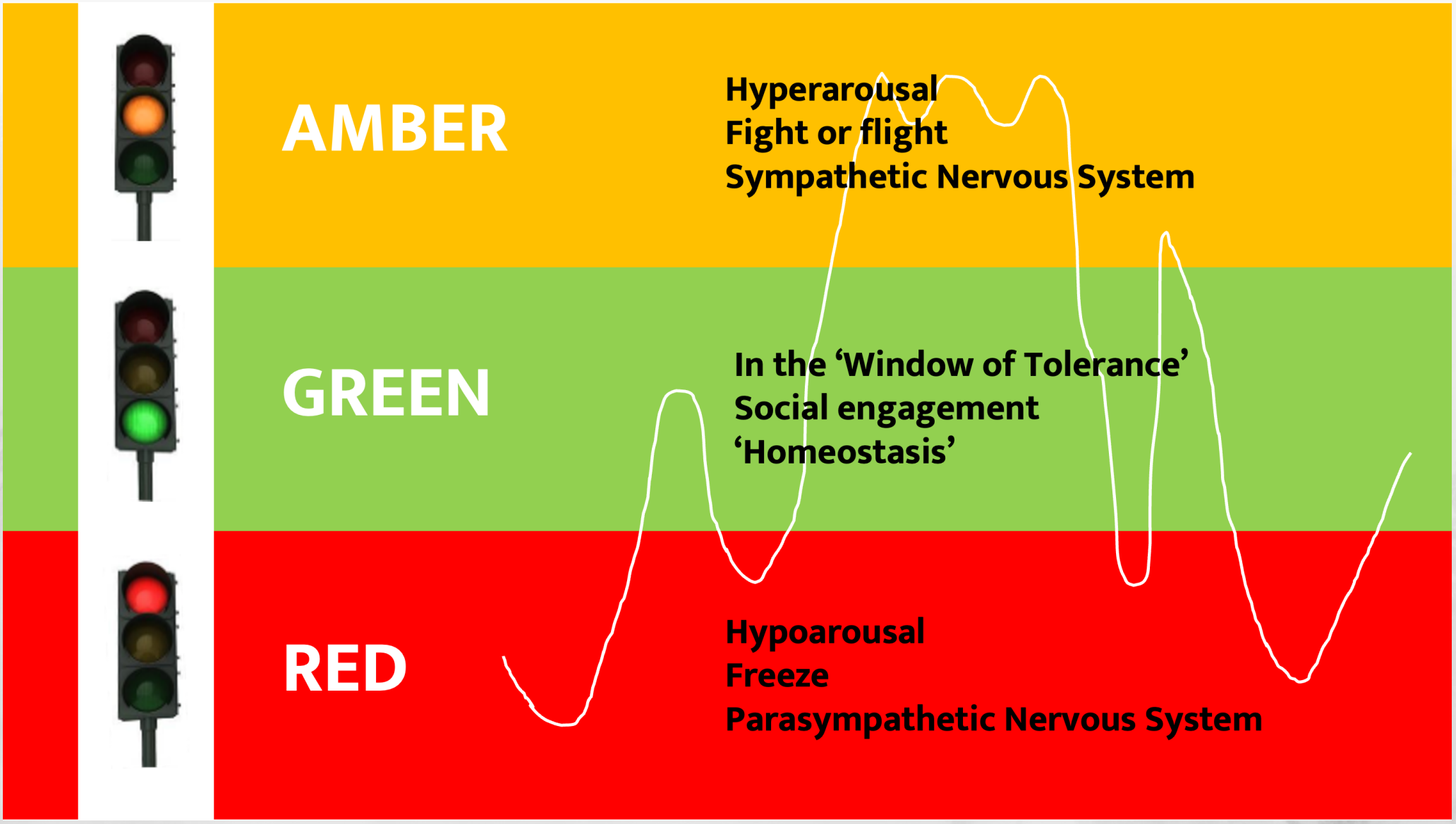
- APA: trauma involves 'intense fear, helplessness, or horror'
- That just describes a potentially traumatising event
- Core essence of trauma: 'life-threatening powerlessness'
- Neurophysiological responses to threat are very predictable: defensive sequence

DEFENSIVE RESPONSE CYCLE

DEFENSIVE RESPONSE CYCLE



The way we respond to threat is not random and we don't choose it at the time. Instead, our body and brain follow a predictable sequence of responses outside of conscious thought. We are traumatised when the threat is so overwhelming that we end up in stage 7 and we are not able to successfully move through stages 8 and 9.



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- First line of defence – 'social engagement' (green zone)
  - Safety through relationships
  - 'Feed and breed', 'rest and digest'
  - Ventral vagal complex (parasympathetic)
  - Feeds the social/relational muscles (head, face, larynx)

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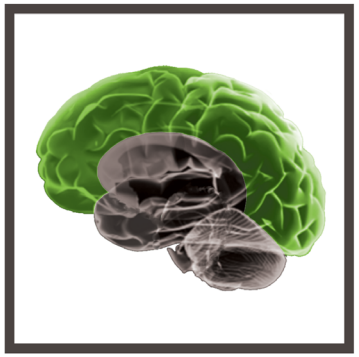
- In the green zone:
  - We can form social bonds when we feel safe
  - Front brain is online
  - Facilitates higher processing (planning, imagination reflecting, mentalising, empathising etc)



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- Threat:
  - Detection and arousal
  - Orienting
  - Stilling (aka freeze) – sympathetic nervous system prepares to act
  - Amber zone: mobilise for action to defend against threat (flight, then fight)

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- Overwhelming threat:
  - Next best attempt at survival: freeze
  - Red zone of immobilisation
  - Dorsal vagal part of parasympathetic system
  - Feigned death, shutdown
  - Conservation of energy
  - Release of endogenous opioids

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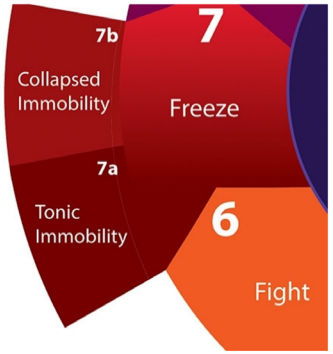
- Overwhelming threat:
  - Dissociation = freeze
  - Tonic immobility (frozen with high muscle tone)
  - Collapsed immobility (floppy muscles, submit)
  - Not a conscious choice (front brain off)



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- Next stages should be recovery and integration
- Recovery:
  - Resetting the nervous system (returning to green)
  - Processing emotions
  - Feeling safe in your body

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- Integration:
  - Making meaning
  - Reconnecting front and back brain
  - Restoring choice, planning and control (as opposed to automatic responses of the back brain)

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- In chronic childhood trauma, no opportunity for recovery and integration
- We didn't leave the 'war zone'
- We stayed 'on duty' ready for another attack
- Body and brain adapts to this environment of ongoing terror

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- 'Being traumatised' represents adaptations of the brain and body to survive future life-threatening events
- Increasingly defensive (sensing and responding to threat)
- Reduced ability to process information from our environment with our front brain

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- 'Double-consciousness' = beginnings of a dissociative disorder
- One part: consumed with the threat and defence
- Other part: cannot hold the threat in mind (no capacity to process it)

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- Structural dissociation:
  - ANPs (apparently normal personalities) – daily life
  - EPs (emotional personalities) – danger
- DID: multiple parts of the personality operating independently of one another (no integration)

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- Recovery
  - Accurate 'neuroception' (feeling safe in the body)
  - Tagging the threat as 'over'
- Integration
  - Engaging the front brain in higher processing (making connections)
- Resolve need for dissociation

HOW TRAUMA LEADS TO DID

Trauma is caused by one-off or repeated experiences which involve intense fear, helplessness or horror: life-threatening powerlessness.

During these events, the body and brain instinctively follow a defensive sequence, resulting in freeze (dissociation). As the brain and body are shut down and overwhelmed, the sequence is halted and recovery and integration do not take place.

The trauma is not in the event. Trauma lies in the changes in the body and brain as a result of the event. These adaptations are attempts to survive future life-threatening events, which feel imminent due to the absence of recovery and integration.

These changes include an increased defensiveness against threat and a reduced ability to process information from the environment.

The brain experiences double consciousness: a part which is consumed with the threat and defends against it, and a part which cannot process and integrate awareness of the trauma.

BACK BRAIN AND BODY

One self-state (part of us) can hold in mind only the trauma, because it was so severe. Without the front brain online to mark the threat as over (to integrate it), this part stays stuck in 'trauma-time', forever on guard and ready to respond to the next threat: hypervigilant and with an altered nervous system.

DANGER (THREAT)
EPs (Emotional Personalities)

disconnected
unintegrated
dissociated

Another self-state (part of us) can't hold in mind the trauma at all. During the event, our integrative front brain shut down before completing its job. We experience amnesia, denial and avoidance. We are disconnected (dissociated) from the emotions of the back brain and the sensations of the body.

DAILY LIFE (SAFETY)
ANPs (Apparently Normal Personalities)

FRONT BRAIN

connected
integrated
associated

The focus should be on RECOVERY: accurate neuroception (feeling safe in the body) and tagging the threat as over (processing traumatic memory).

The focus should be on INTEGRATION: bringing the front brain online (higher processing) to integrate the trauma into the mind and body as a whole.

After the trauma is processed and integrated and the nervous system has recovered its sense of safety (returning to the green zone of social engagement) there will be no more need for the self-states to be separate.

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Can you see a difference between 'a traumatic event' and 'being traumatised'? What implications does this have for your work?

Thinking about either yourself or your clients, when faced with stress or challenge, do you tend to go into 'amber' or 'red'? How do you know – what are the signs of this?

'We focus on integrating the trauma, not the parts' – how might this change your approach to recovery?

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- The 'syndrome' of trauma work:
  - Lack of confidence
  - Difficulties holding the therapeutic frame
    - Boundaries
    - Uncontrolled switching
    - Pacing
    - 'Stuck' issues
- This is the nature of the work

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- Three aspects to the work:
  - The therapist
  - The client
  - The work that evolves between you
- All you can control is you
- The powerlessness of trauma will be re-evoked within the therapy

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- This work can undermine your confidence and leave you feeling deskilled
- All you can do is provide a healing environment
- You cannot control the outcome of your client's choices

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- Three questions to consider:
  - Should you be doing this work in the first place?
  - What qualifies you to do it?
  - What do you need to do it effectively?

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- You cannot do this work if your own trauma is unresolved
- You do not have to have been in a pit to help someone out of one
- If you need to do this work, don't do it

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- You don't need to be an 'expert'
- The real measure of your value is the impact on the lives of your clients
- Foundational therapy training – do the basics well
- Working with the complex does not qualify you to ignore the simple

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- Some knowledge and understanding of trauma, dissociation and attachment
- Humility, lack of ego, closing the power differential
- A deep respect for the autonomy and dignity of every person you work with
- Don't forget the human

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- What do you need to do this work?
  1. A sufficient self-life
  2. Sufficient safety
  3. Sufficient financial security
  4. Sufficient autonomy balanced with sufficient accountability

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What do you think qualifies you (or disqualifies you) to do this work?

What are your self-care practices and where is your sense of self grounded?

What do YOU need to do this work successfully?

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- The fundamental issue to work on in therapy is the inability to feel safe (neuroception)
- Our platitudes:
  - 'It's okay, you're safe now'
  - 'There's nothing to worry about'
  - 'It's not happening now!'

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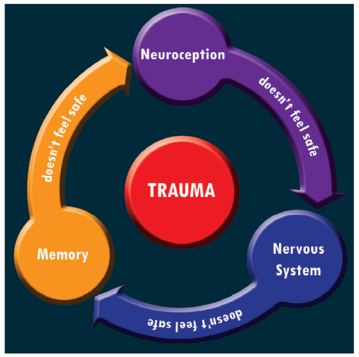
- These translate into the three hubs of the vicious cycle of trauma:
  - Faulty neuroception
  - An altered nervous system
  - Corrupted memory system
- They become a self-reinforcing feedback loop



THE TRAUMA VICIOUS CYCLE

NEUROCEPTION

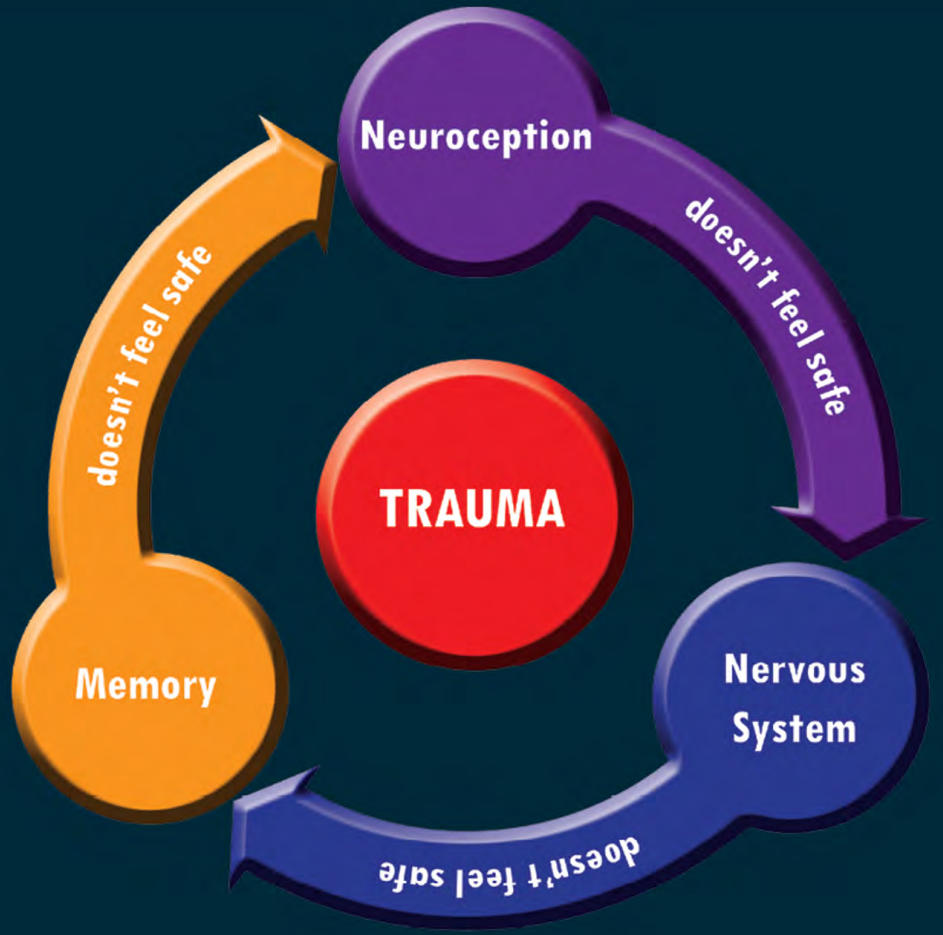
Faulty neuroception in the body cannot sense safety

NERVOUS SYSTEM

The nervous system remains on high alert to respond to imminent threat

MEMORY

A corrupted memory system doesn't tag the threat as 'over'



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- Faulty neuroception:
  - Feeling unsafe when you're safe
  - Feeling safe when you're unsafe
- Our body defaults to an alarm state after trauma
- We think we're still at war because we're still dressed in combats
- Chicken-and-egg

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- Two prerequisites for the work:
  - The war needs to be actually over (safe environment)
  - Psychoeducation for clients
- We do not engage in therapy under general anaesthetic!
- We have to be active in the process

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- Psychoeducation essentials:
  - The false alarm
  - Default to danger
  - Reactive nervous system
  - Lower to higher processing
- Three aspects of 'recovery':
  - Notice
  - Soothe
  - Assess

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- 'Noticing'
- We automatically jump to interpretation
- We need to disrupt this automatic response through engaging the medial pre-frontal cortex (front middle brain)
- Focus isn't on the narrative (why or when)

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- Focus is on the building blocks of experience:
  - Thoughts
  - Emotions
  - Sensory perceptions
  - Movements
  - Sensations
- 'Noticing' is counter-intuitive to start with

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- To feel safe, need to have the experience of actually feeling safe
- Not just talk about the reasons why we don't feel safe or its causes (narrative)
- Draw attention to the reaction in the body of feeling unsafe
- Notice the experience, don't just experience the experience

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- Notice the feeling of unsafety
- And simultaneously draw attention to cues in the environment which suggest safety
- Break the habit of automatic meaning-making
- In slowing down the experience, it can change

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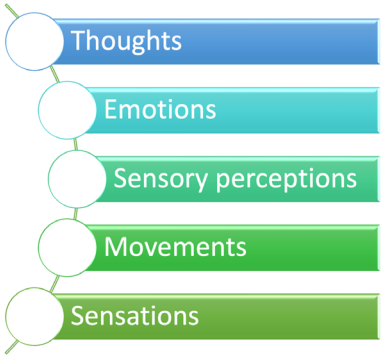
- Experience the body beginning to settle as we notice the building-blocks
- If we stay with the experience long enough, it will change
- Start being able to feel safe while talking about unsafe things from the past
- They're not still unsafe now



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- Soothing
- If the client is going out of green into amber or red, pause the narrative
- Soothe: come back into green
- Catharsis is the realm of retraumatisation
- We only metabolise trauma when we're in the green zone

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- Effective works takes place at the edges of our window of tolerance (edge of green)
- Retraumatisation happens when we're way into amber or red
- Then it's not a memory from the past, but is being relived in the present

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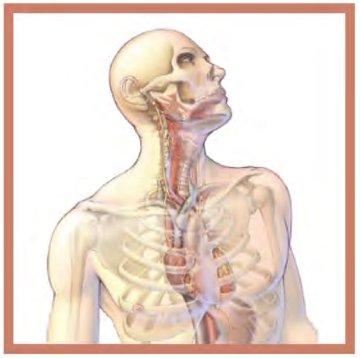
- Outside the green zone, without the proper influence of the vagus nerve:
  - Facial and vocal expression (of all parts) change significantly
- Soothing is more body-based than brain-based



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- Soothing with:
  - Breathing
  - Posture and movement
  - Vagal stimulation with hands on heart and belly
  - Attention
  - Attunement
- Repeated practice

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- Assessing:
  - Green zone, front brain, higher processing
  - 'Are you actually in danger?'
  - 'I feel unsafe ... but that's just a feeling'
- Mantra cards for practice and repetition

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Have you ever struggled to help clients 'feel safe' even though they are actually safe in the therapy room with you?

What strategies have you developed to bring clients back into the green zone?

What physical strategies do you have to soothe yourself when you are feeling anxious or unsafe?

'I have dissociative identity disorder. I have many separate, distinct and unique 'parts' of my personality. My 'parts' or 'alters' collectively add up to the total person that is me. I am the sum of all my parts. They are each a letter, and I am a sentence.

At times, different parts take 'control' of my body, mind and behaviour—this is switching and it can be obvious or subtle. The part who comes out, who takes over, may be known by a different name, may perceive themselves to be a different gender or age, and most usually will view the world very differently to the way that I do.'

Carolyn Spring: 'Parts are only part of the problem'

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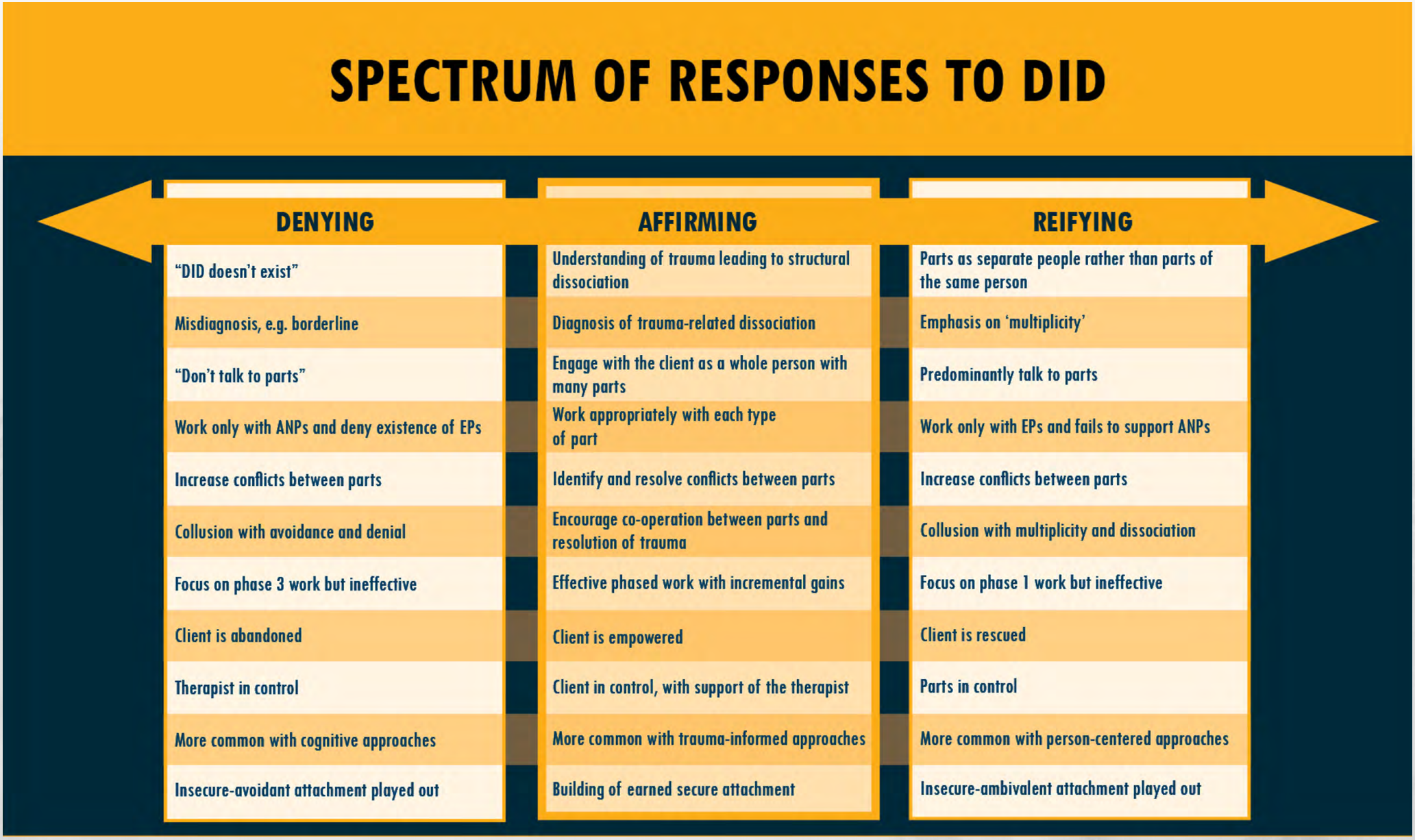
- Focusing on parts can leave you sidetracked from the core work
- 'Parts', 'alters', 'self-states' – whatever your client is comfortable with
- Richard Kluft: 94% of people with DID are private about it
- 'Split' in approach to parts

SPECTRUM OF RESPONSES TO DID



DENYING	AFFIRMING	REIFYING
"DID doesn't exist"	Understanding of trauma leading to structural dissociation	Parts as separate people rather than parts of the same person
Misdiagnosis, e.g. borderline	Diagnosis of trauma-related dissociation	Emphasis on 'multiplicity'
"Don't talk to parts"	Engage with the client as a whole person with many parts	Predominantly talk to parts
Work only with ANPs and deny existence of EPs	Work appropriately with each type of part	Work only with EPs and fails to support ANPs
Increase conflicts between parts	Identify and resolve conflicts between parts	Increase conflicts between parts
Collusion with avoidance and denial	Encourage co-operation between parts and resolution of trauma	Collusion with multiplicity and dissociation
Focus on phase 3 work but ineffective	Effective phased work with incremental gains	Focus on phase 1 work but ineffective
Client is abandoned	Client is empowered	Client is rescued
Therapist in control	Client in control, with support of the therapist	Parts in control
More common with cognitive approaches	More common with trauma-informed approaches	More common with person-centered approaches
Insecure-avoidant attachment played out	Building of earned secure attachment	Insecure-ambivalent attachment played out

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- Denial position:
  - DID isn't real
  - Misdiagnosis
  - 'Don't talk to parts'
  - Work only with the ANPs and deny existence of EPs
  - Increase conflicts between parts

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- Collusion with avoidance and denial
- Focus on phase 3 work but ineffective
- Client is abandoned
- Therapist in control
- More common with cognitive approaches
- Insecure-avoidant attachment played out

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- Reifying position:
  - Parts as separate people rather than parts of the same person
  - Emphasis on 'multiplicity'
  - Predominantly talk to parts
  - Work only with EPs and fails to support ANPs
  - Increase conflict between parts

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- Collusion with multiplicity and dissociation
- Focus on phase 1 work but ineffective
- Client is rescued
- Parts in control
- More common with person-centered approaches
- Insecure-ambivalent attachment played out

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- Affirming position:
  - Understanding of trauma leading to structural dissociation
  - Diagnosis of trauma-related dissociation
  - Engage with the client as a whole person with many parts

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- Work appropriately with each type of part
- Identify and resolve conflicts between parts
- Encourage co-operation between parts and resolution of trauma
- Effective phased work with incremental gains

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- Client is empowered
- Client in control, with support of the therapist
- More common with trauma-informed approaches
- Building earned secure attachment

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- In engaging with parts, hold the goal in mind
- Having DID is a time of transition like being at University
- Own dialect and culture
- Right to be in that place at that time
- There will be a time to graduate

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In what ways do you deny the reality of your client's parts?

In what ways do you reify your client's parts (make them more real than they are)?

In what ways can you affirm your client's current multiplicity whilst leading them towards a life after trauma?

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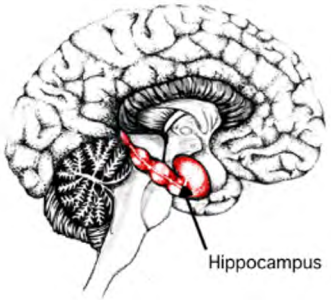
- The work of recovery (feeling safe, resetting the nervous system back to green) is first
- Then we can focus on process and integration of the trauma
- During trauma the front brain switches off and the back brain switches on
- The hippocampus goes offline



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- With the hippocampus offline, the traumatic memory isn't tagged as 'over'
- The vicious cycle of trauma
- We've believed historically that the trauma is in the event
- Therefore we've believed that narrating the event is the answer

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- The narrative can just 'retraumatise'
- This word can be overused
- Clients **can** recover if the session goes pear-shaped!
- The narrative can be a way into the trauma, but it is rarely a way out
- Remembering is not recovering

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- The narrative gives us a sense of personal history and context
- It can direct our future actions (e.g. staying safe)
- But we can also listen to the narrative from our body
- Feeling safe in the body, and being able to really think

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- After trauma we don't process information from our environment well
- Our thinking becomes rigid as we focus on survival
- We operate mainly on lower-level processing
- Our learning can be impeded
- Or we may still be good at acquiring facts

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- We often have developmental deficits for higher-processing, e.g.:
  - Mentalising
  - Imagination
  - Cause and effect thinking
  - Reflective function
- Because of:
  - Lack of safety growing up
  - Traumatic events

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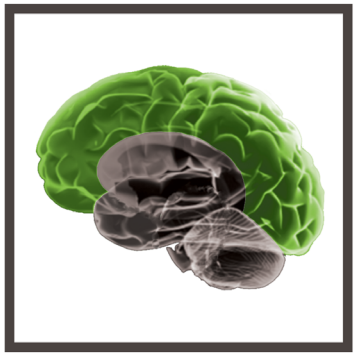
- We need to change the way our brain works by default, from back to front
- From lower to higher processing
- Lower processing can be very evident and relevant when working with parts
- EPs in particular have been cut-off from front-brain higher processing



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- Lower-level processing examples:
  - Jumping to conclusions
  - Fixed and rigid thinking
  - Generalisations
  - Catastrophising
  - Despair and helplessness

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- Lower-level processing examples:
  - Personalisation
  - Magnification
  - Mindreading
  - Persistent core beliefs

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- Lower-level processing examples:
  - Psychic equivalence
  - Pretend mode
  - Paranoia
- These cognitive developmental deficits play a huge part in dissociative disorders
- Move vertically and horizontally

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- After trauma there is a disrupted flow of information across parts of the personality
- ... and for that information to be processed with higher, front brain strategies
- This process has to take place at multiple levels
- It is most effective after establishing a sense of safety

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- The narrative provides a way into this processing
- Stay in the window of tolerance while processing
- Focus on process, not content
- Back/lower often feels safer
- Switching to parts is a lower-processing strategy

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Take a look at the table around higher and lower processing (page 9 of Course Notebook).

How does this play out in your own life and in the lives of your clients?

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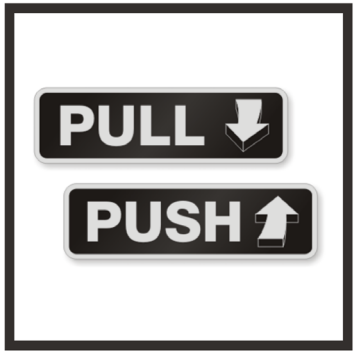
- Difficulties holding the frame
- Multiple and conflicting (incompatible) survival strategies:
  - Danger / daily life
  - Approach / avoid
- How do I elicit help from someone who is the source of danger?



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- Feeling safe through exerting control (rather than neuroception)
- Need to manage the terror of you:
  - Not helping them
  - Hurting them

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- Disorganised attachment:
  - Controlling-caregiving
  - Controlling-punitive
- Two crash barriers on either side of the road (therapeutic frame):
  - Rigidity
  - Chaos

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- Chaos (controlling-caregiving):
  - Usually child or attachment-based parts seeking help
  - Approach
  - 'Don't leave me!'

- Rigidity (controlling-punitive)
  - Hostile, challenging parts sabotaging the relationship
  - Avoid
  - 'Stay away!'

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- Keep your boundaries:
  - Don't rescue the approach parts
  - Don't take abuse from the avoid parts
- For every action, expect an equal and opposite reaction
- 'Is this okay with ALL of you?'
- Clues from the building-blocks, e.g. body movements, posture

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- 'How do you know you want this?'
- Gain consensus
- We shouldn't be coercive towards our parts
- We shouldn't view ourselves as victims of our parts
- We need to develop self-leadership if we want to stay safe
- We **can** develop co-consciousness

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- Integrity is the courage to face reality as it actually is
- I would never be free of my symptoms while I wanted to stay dissociated
- Commitment to communication
- Commitment to self-compassion
- 'Parts can come but they also have to go'

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- You get what you tolerate
- The freeze response of immobilisation is expressed in learned helplessness
- If we believe we are powerless, we will try to get others to look after us (child parts)
- Attachment-cry behaviours are understandable
- We believe we can't but you can

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- But we are resourceful, resilient human beings to have survived what we did
- We have to punch through our belief in our powerlessness
- Or we will live in constant crisis and dependency
- Don't collude with our powerlessness

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How can you help your client to identify and resolve the conflicts between the various parts of their personality?

How can you affirm the reality and necessity of your client's multiplicity without encouraging them to be a victim of it?

How can you manage the inherent sense of powerlessness of a dissociative client, and instead empower them?

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- Common issue for therapists is feeling overwhelmed
- Are you resourcing yourself sufficiently?
- Action to combat freeze
- Is the trauma being re-evoked in you, rather than resolved in the room?

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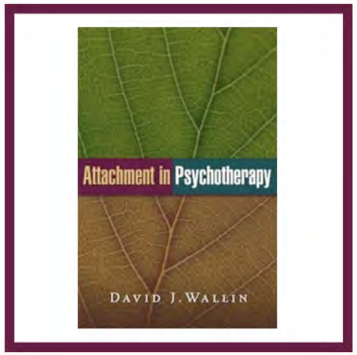
- David Wallin ('Attachment in Psychotherapy') – dissociative material can be:
  - Evoked
  - Enacted
  - Embodied
- Are you carrying their trauma for them?
- Hand it back – it's not yours



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- Is the client abdicating self-leadership?
- Continual crisis is very common
- Be more worried if they're NOT talking to you about suicide than if they are
- But also take it seriously and spell out cause and effect

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- Develop a scale and a vocabulary for suicidal ideation
- Is the work moving too quickly?
  - Sufficient neuroception?
  - Consensus?
- Slow down and focus on safety, not the narrative

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- A 'no pain no gain' approach is not helpful
- Does the client want to be in crisis?
- Keeping the status quo of suffering
- Is crisis negotiating currency for proximity?
- If so, reduce contact?

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- Teach skills for stabilisation
- We are not victims of our own distress – we are not powerless to help ourselves in crisis
- Do not collude with the distress by palliating it

- Stuckness
  - Beliefs of powerlessness
  - Lack of consensus
- Shame and self-blame
- Paradoxical intervention: 'Well done for being ashamed'
- 'How shame saved my life'

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- Shame was our best attempt at survival at the time
- Letting go of shame therefore feels life-threatening
- Reframing it as positive
- Break the habitual shame posture
- Get parts to experiment with posture

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- Shame had helped me survive
- But it hadn't kept me safe
- I needed a more active defence
- The shame posture was a signal that I could be abused
- Change the habitual posture before (and in order to) change the mind

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- Pacing sessions is a challenge
- Difficulties ending a session due to attachment
- Transitional objects can help
- Consider longer sessions
- Won't work if attachment issues are at the root
- Client needs to hit the ground running

SESSION 9

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- Therapy is more than just dealing with trauma
- Becoming the best version of ourselves
- Going from -10 to +10 not 0
- I regained a sense of identity that I had lost
- This work is one human being sitting alongside another