Dissociation & complex trauma

Esen Uygun (WestCASA)

In this paper I will focus on the work of Van der Hart, Nijenhuis and Steele's (2006) The Theory of Structural Dissociation of the Personality (TSDP) in primary, secondary and tertiary level and how to work with these kind of presentation holding the 3-phase trauma in mind.

PTSD is currently diagnosis that sits within the Anxiety Axis of DSMIV and DSMV. However, victims of sexual abuse trauma almost always experience a degree of dissociation, making this a more typical impact of childhood trauma rather than anxiety. Therefore, a useful question of therapeutic inquiry is not whether the client has any dissociation, but rather the level of dissociation they experience, and how to treat it. This presentation considers the work of Van der Hart, Nijenhuis and Steele (2006), and the Theory of Structural Dissociation of the Personality (TSDP), including the construct of Emotional Parts (EP) and Apparently Normal Part/s (ANP) following on from dissociated trauma(s).

Rather than labeling of Borderline Personality Disorder as we have seen in the past, the term 'complex psychological trauma' has been recognized in the DSMV and used more often these days to refer to the impacts of chronic, and/or childhood attachment abuse. "… patients with BPD reported the highest rate of traumatic exposure (particularly to sexual assault trauma, including childhood sexual abuse), the highest rate of PTSD, and the youngest age of first traumatic events." (Van der Hart, Nijenhuis and Steele 2006; p.113)

The complex psychological trauma defined as;

1. "repetitive or prolonged,
2. involve harm or abandonment by caregivers or other ostensibly responsible adults, and
3. occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence" (Ford & Courtious, 2009, p.13)

Complex Trauma and psychological-emotional injury intertwine and come together as a package in many clients with sexual abuse histories. Research suggests the degree of dissociation is closely connected to the intensity, as well as the longevity of trauma and the betrayal of attachment figure. (Cortois, Ford, & Cloitre; 2009)

The majority of the clients counsellors at WestCASA see therapeutically have long-term and/or repetitive trauma with attachment injuries from a young age to adulthood, which impacts on their brain development, perceptions of their sense of self and the world. It is evident that complex psychological trauma is precursor for developing trauma related disorders such as Post Traumatic Stress Disorder (PTSD), Complex PTSD, DDNOS (Dissociative Disorder Not Otherwise Specified). (Van Der Hart, Nijenhuis, Steele, 2006)

Dissociation is one of the byproducts of complex trauma.

> "….the term **dissociation** describes a wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience. The major characteristic of all dissociative phenomena involves a detachment from reality, rather than a loss of reality as in psychosis. http://en.wikipedia.org/wiki/Dissociation_(psychology).

This self defense mechanism –dissociation- is likely to be to a higher degree when there is prolonged trauma where we are more likely to encounter overwhelming trauma material and a more complex form of Structural Dissociation of the personality takes place. Van Der Hart, Nijenhuis, & Solomon theorise that Structural dissociation of the Personality (SDP) is where:

> "….the personality of traumatized individuals is unduly divided in two basic types of dissociative subsystems or parts. One type involves dissociative parts primarily mediated by daily life action systems or motivational systems. The other type involves dissociative parts, fixated in traumatic memories, primarily mediated by the defense action system. The more severe and chronic the traumatization, the more dissociative parts can be expected to exist." (Van Der Hart, Nijenhuis, & Solomon, 2010, p.76)

These two subsystems are called Emotional Parts and Apparently Normal Part/s as first described by Charles Samuel Myers. The Emotional Parts (EP) is believed to be created because it cannot be absorbed/processed by the system/human mind and body. So the EP holds the trauma material separate from ordinary consciousness. The Apparently Normal Part (ANP) will go on with life and continue functioning as it used to until the EP is triggered. The ANP, for instance, is the part that will take us to the work, to a birthday party or to see friends. "When individuals have the (very high) mental level needed to integrate shocking events, they do not develop structural dissociation. (Van Der Hart, Nijenhuis, Steele, 2006; p.133)

Two mechanisms of human evolution referred to by Van der Hart, Nijenhuis, Steele are those outlined in the work of Jaak Pansepp (2006, 2011) as action system for defense (fight, flight and freeze/collapse/submit) and action systems of day-to-day life. When we are not in our defense system, which holds the Emotional Part (EP)s of the personality, we switch off to daily living system, which is the Apparently Normal Part (ANP).

When trauma overwhelms the human's adaptive system, the integration of the trauma materials becomes unsuccessful. Trauma is processed in three level;

1. Cognitive
2. Emotional
3. Sensorimotor (Body sensations) (Ogden, Minton & Pain, 2006)

Thus, when the trauma is overwhelming it can be split into each of these different parts such as a sensory trauma, a cognitive trauma, or vehement emotions, which this paper will look at in more depth.

When the integration of trauma material is not an option because , for instance, the

person is too young, their neurological system are too immature, they are not sufficiently resourced to cope with threats, or the threats and danger are overwhelming to the nervous system, then the disintegration or, splitting of the personality, becomes the next best or only viable/practical option. Therefore the explicit and implicit memory aspects of the traumatic memory will be stored differently; EP's will hold the trauma material, which makes many of my clients to say things like "it does not feel like it happened to me, it feels like it happened to someone else".

After trauma the Apparently Normal Part (ANP) will be fixated on moving on and living the life as if the traumatic experience did not happen at all while the Emotional Part (EP) of the personality will hold the trauma material. In this way, Van der hart, Nijenhuis, and Steele suggest the

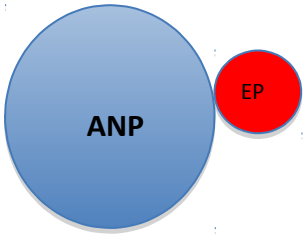
> "ANP "uses" EPs as mental protection, in that these EPs contain emotions, thoughts, fantasies, wishes, needs, and sensation that ANP believes to be unbearable or unacceptable" (Van Der Hart, Nijenhuis, Steele, 2006; p. 66)

Structural Dissociation is therefore a mechanism to adapt or help the person to live a relatively problem free life and the majority of the time the ANP will do anything to avoid EP's from surfacing. For instance, clients say things like: "I keep so busy that I am exhausted so I don't have time to think about anything", "I don't go to city, because it reminds me the sexual assault". (Van Der Hart, Nijenhuis, Steele, 2006) When ANP pushes down the EP it will create inner conflict, which will played out in person's life such as through exhaustion, lack of spontaneity or restricted behavior. For example one of my clients who was sexually assaulted when she went out with friends, lost the majority of her friends because she was regularly declining any outings that had been suggested by them.

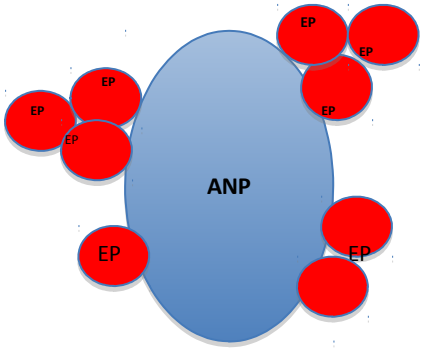
In their work, Van der Hart, Nijenhuis and Steele (2006) suggest there are three different levels in structural dissociation of the personality: Primary, Secondary, and Tertiary Structural Dissociation. Briefly, they are described as:

Primary Structural Dissociation (PSD)

In PSD there is one ANP and one EP, which, in my experience as a counsellor working with clients who are sexually assaulted, is a rare presentation. PSD indicates a traumatic experience with small "t" such as one sexual assault with no further trauma. (Van Der Hart, Nijenhuis, Steele, 2006)



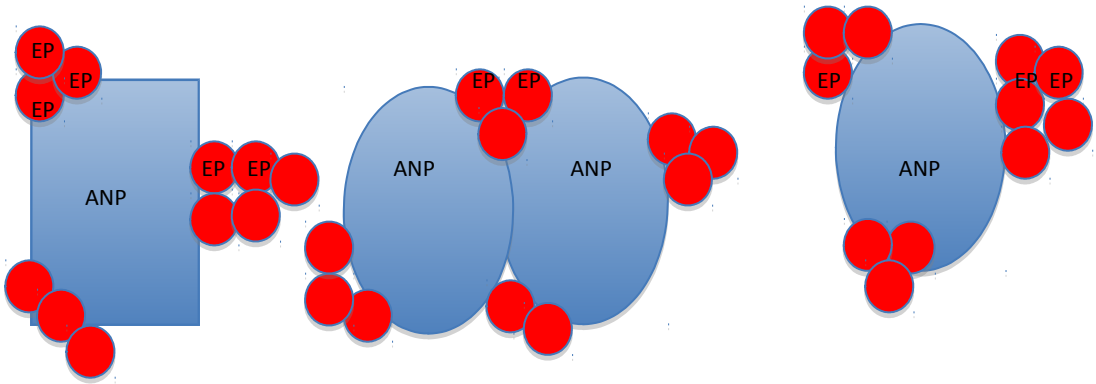
Secondary Structural Dissociation (SSD)



Clients who present with SSD will have one ANP and more than one EP. These clients will have a prolonged trauma history. It is common that EP's may not be aware of each other's existence. Different EP's might hold different defense action eg:fight or flight or freeze, therefore people can act differently at different times. For example when the person is freezing in the presence of their father, the same person can attack and have massive fight with a brother. (Van Der Hart, Nijenhuis, Steele, 2006) I once had a client who stated she would freeze when she saw the perpetrator who sexually assaulted her, however she would get into rage against her father whenever he was violent against her mother.

ANP usually have the sense or knowledge about some of their EP's existence, however ANP may not be aware of the existence of all EPs (Van Der Hart, Nijenhuis, Steele, 2006). An example of this I have found with my clients is the client who describes being exposed to a single sexual assault incident but they report having a major breakdown and within counselling I note inconsistency between their reason for attending counselling and their affect, for instance feeling suicidal and not being able to attend any of their personal needs.

<u>Tertiary Structural Dissociation (TSD)</u>



Clients who are presenting with TSD will have more than one ANP and more than one EP. When ANP cannot function at the desired level, new ANP's may develop to be able to manage day-to-day life. For example one of the ANP's holds the caretaking (mother), another ANPs hold connecting (work, friendship). It is good to be mindful that each ANP will be limited with their functions; each ANP will have different job descriptions, which will be strictly followed. Critically, when there is more than one

ANP, then there is what we commonly know as Dissociative Identity Disorder (DID). (Van Der Hart, Nijenhuis, Steele, 2006) People with DID create new ANP as the need arise in adulthood. (Van Der Hart, Nijenhuis, & Solomon, 2010) Clients recognized as having DID do not form the majority of WestCASA clients. However the number is way higher than ten years ago and I have experienced greater numbers of these type of clients in recent years. This might be related to our increase knowledge about DID and therefore an increased capacity to recognize DID clients.

In my practice across the past ten years I have not met with one single person who fits under primary structural dissociation yet. I believe the majority of WetsCASA clients fit under the Secondary Structural Dissociation category and small number of clients with Tertiary Structural Dissociation, DID. Given the biggest group of clients fit under the Secondary Structural Dissociation this paper will focus in depth on how Secondary Structural Dissociation manifest during the counselling sessions and how we can work with these presentation in line with the theory of Structural Dissociation of the Personality.

According to Van der Hart, Nijenheus and Steele

> "Individuals who grow up with chronic abuse and neglect often have profound deficiencies in the ability to regulate affect, physiology, sense of self, and other aspects of functioning that require regular modulation, coordination, and cohesiveness." (Van Der Hart, Nijenhuis, Steele, 2006: p 87)

Children with an abuse history often did not have the safe place or safe person necessary to support their development, so they had to find their own safe place/safe person. As practitioners we are all aware that secure attachments in early life are the basis of affect regulations capacity, which the majority of our clients lack. On top of this, some of our adult clients have lived as children in social structures where trauma is entrenched and abuse is permitted, which then becomes an intergenerational issue. (Ford & Courtious, 2009; Van Der Hart, Nijenhuis, Steele, 2006) Herman points out that there is enormous pressure from perpetrator and the families to continue with life as if nothing happen; victim/survivor are left with no option other than dissociating from the fact that they have been sexually assaulted. (Herman, 1993) So it's not surprising we see such high levels of dissociation in our adult clients who were abused as children within a family context.

People with long term childhood sexual assault and/or neglect may develop more EPs, which will be more complex and autonomous. This autonomy may lead them to take over and dominate consciousness and behavior. (Van Der Hart, Nijenhuis, Steele, 2006) When this happens, as counsellors we may hear "It was not me, I don't do these kind of things; I don't understand the way I behaved" or cases where the client is not able to connect with their own achievements or pain when they are harming themselves. EP's almost holds their own identity, which is connected to the trauma memory. For instance, this identity focus will be on specific stimuli. An example could be the belief that all red cars are dangerous because rape happens in red cars. Because the EP's is created at a certain time and place which is separate to the

present moment, the trauma material becomes the current reality even though it had happened in the past. Therefore the external reality, for instance even where an offender is no longer alive and the ANP registers. “He is dead and I am safe from his abuse” will not be registered by the EP who continues to exist at the time where the abuse was happening. (Van Der Hart, Nijenhuis, Steele, 2006)

People with long-term trauma have different experience of time; their present moment has a lot of past in it. EP lives in the time of the trauma and believes the past is current and very real. On the other hand the ANP believes that past/trauma is not real enough, or did not happened to them and they have no emotional connection to it “it does not feel like it happened to me”. Yet , the ANP also cannot live in present moment fully because they need to constantly watch EP to stop them surfacing or entirely avoiding them (Van Der Hart, Nijenhuis, Steele, 2006), hence we frequently have clients who live in a tortured stated of not being present to their life, self, relationship, needs and interest. Instead, we frequently see clients who are escaping the present moment through numbing, drug use, other addictions, cycles of crisis, overworking, negative relationships or manic states of business.

According to the theory of Structural Dissociation of the Personality the ANP is phobic of the EPs and so too EPs of each other. This is the foremost reason obstructing the integration of the trauma material and recovery. As a result of not being able to integrate the trauma material the victim/survivor instead alters his or her behavior to manage the trauma material (from the top down), for instance through restricting their behavior: “I am bad so I don’t deserve to have good things”. If and when the trauma memory gets triggered and the EP surfaces and start behaving, reasoning and emoting like at the time when trauma happened, it will result in the ANP getting confused ,disoriented, scared and the ANP will do anything to stop this happening again, for example through self medicating, or keeping busy. When the EPs surface the defense action system (fight, flight, freeze) will be activated so that our clients will often attend sessions in a state of anger, rage restlessness, agitation, or depression and feeling frozen stuck. For example a male client of mine was unable to focus on any other objects in our counselling room because he was fixated on the danger: me, a person who had activated his EP with its natural defensive reactions when we were talking about his trauma material.

How we can work with these different presentations in line with the theory of Structural Dissociation of the Personality.

Once again I come to the conclusion that “All roads leads to Rome” in the sense that the most important aspects of our work is building a therapeutic relationship which will enable us to do this work.

“Patients with trauma–related structural dissociation have not been able to engage

> adequately in the integrative actions that generate and maintain one cohesive sense of self and a cohesive personality." (Van Der Hart, Nijenhuis, Steele, 2006; p 143)

Importantly, when we are working with clients who have experienced sexual abuse and structural dissociation as a result, we need to provide a therapeutic container for our clients. This is done through a three-phased trauma-model, including:

1. Stabilization and symptoms reduction
2. Treatment of trauma material
3. Personality (re)integration and rehabilitation

When there is a long-term trauma, the focus needs to be on skills building around affect regulation such as increasing the resilience of the ANP and EP mental functioning. When we create safety for all parts EPs and ANPs we can work more effectively because the phobia will be reduced between these parts. (Van Der Hart, Nijenhuis, & Solomon, 2010). Being here and now; staying in the Window of tolerance is a critical first step within therapy with dissociated clients.

Secondly, while we are skilling up our clients it is imperative to attend the attachment that is played out in the counselling room. For example: one client who was highly avoidant that I established rapport and connection with very quickly never came back after that session. I believe I activated her attachment injury and/or belief system of "getting close and trusting others is dangerous". If I had a better understanding of her attachment needs at the time I would have a guide to my level of engagement with her during our counselling sessions. Considering the majority of our clients have attachment injuries which is one of the contributing factors of structural dissociation of the personality; it is essential to gauge victim/survivor's phobia is around the attachment figure. Due to attachment injuries I find that majority of my clients are avoidant to any attachment figure but also phobic to the loss of the attachment figure. In practice with the client this can look like "I hate you but I don't want you to leave me", or "Don't get too close to me". In trauma counselling the therapeutic relationship is the heart of trauma work. (Van Der Hart, Nijenhuis, Steele, 2006)

The third point when working with dissociation within counselling is to introduce the language of different parts of the person, or rather, "parts work", to the victim/survivor is vital parts of this work. According to Schawartz (1995, p.4) "The Italian psychiatrist Roberto Assagioli is credited by some as the first Western thinker to discover the multiplicity of the mind." Considering trauma can cause disintegration in the system, we need to work with these disintegrated parts in order to integrate them to the system. In my experience the majority of people are very cautious when it comes to talk about different parts of themselves, or aspects of the self that hold different wished, desires and even voices. This can lead people to feel "Am I crazy?". Nevertheless, this is a very useful strategy within counselling with highly dissociated clients because it recognize the splitting and it aids emotional parts to be integrated into the system.

In addition to working with different parts of the self, I also find that being aware of

the client's body movements is very useful because the client's body holds a lot of information and symptoms of the trauma material. This also becomes a solution to the problem that we are working with. (Ogden, Minton & Pain, 2006 & Damasio, 1994) For instance when I was working with a client who looked extremely tense and immobilized, when I enquired about it she reported that she feels she cannot move any parts of her body. I then asked her to try to move only her little finger then we moved onto her legs. In coming session she reported that there was an incident, which made her feel scared, yet she did not freeze and managed to get herself out of the scary situation.

A further way of working with dissociation within counselling is through Psycho-education: This will normalize their symptoms and reduce the symptoms. For example, talking about Window of Tolerance is a regular practice when I am working with the sexual assault trauma victim/survivor. Every time I talked about the window of tolerance my clients reported feeling relieved and now they know that they are normal.

A critical aspect of therapy where there is high dissociation is a focus on working with shame: when there is sexual assault then there is shame. The therapeutic relationship is one of the antidotes to the shame; compassion between parts is another antidote. In view of our clients, who had major relationship injuries – attachment injury/ies and/or sexual assault trauma- providing respectful, empowering and empathic therapeutic relationship will work like healing balm to those injuries.

In my work with clients who show high levels of secondary structural dissociation I place a lot of emphasis on working with phobic ANP's and EPs and trying to improve communications and co-operations between them. I believe this practice helps increase the integration of the trauma memory and thus aids towards recovery. For instance, one of my clients who was very angry with her young part (seven years old), because this young part continuously went back to perpetrator's home, which meant further abuse. I invited the adult loving grandmother part to see how the seven year old self looked like, and asked her to remember and hold in mind the seven years old child's reasons – the care and love she received from perpetrator and his wife - to keep going back where perpetrator lived. My client started crying and saying that it was not seven years old girl's fault. She was just a child but the perpetrator was an adult and he chosen to abuse her.

When it comes to Tertiary Structural Dissociation our job is to help parts to be less separate and more connected to one another through more communication, more empathy and cooperation working together rather than against each other (Van der Hart, Nijenhuis, & Steele, 2006) Encouraging the knowledge that they share the same body helps to bring unity and integration. I have found there can be parts that will sabotage the work that we are trying to do. In this instance I find it useful to remember that the different parts are there for a reason: namely they are trying to

help. When working with a client with structural dissociation of the personality it is good to hold the image that I am working with a family (systemic work). When we work with a family; we won't blame any individual but try to increase the communication between them and unfold the belief system and the logic of that behavior or belief system. Empathy and curiosity are the key word. When we do the parts work; it is good to look at which parts is going to be present, when you have family therapy you will not have children at all times, there will be topics that you will ask parents to come alone because these topics are only for adults. At these times the children are left at home in a safe environment with an adult. I have found the same principle applied in this work. Not every aspects of the therapeutic work are suitable for every part. It is good to check with different parts if there is any objection to anything and where there is then you can clear it up. Usually the phobic parts will object to the work. Then we need to work with these phobic parts first and understand what they are concerned about, so these concerns can be eliminated. Our clients will have higher consciousness/wisdom and it's useful to engage with this part when possible.

A central element of working with structural dissociation is learning about the client's avoidance strategies. Avoidance can come in different forms like feeling dizzy, obsessive involvement with an activity, or constant joking. Knowing the client's avoidance strategies can work like an alarm bell for the counsellor. Every time the alarm bell goes off, we will have a chance to work on those avoidance strategies. Sometimes it may be hard for our clients to even talk about these avoidance strategies because if they learn and lived these strategies in silence; it may be very difficult to voice them during the counselling sessions. These maladaptive ways of avoiding strategies are strong and hard to overcome. It is well practice pathway in the brain. We also need to be mindful of the victim/survivor's immediate social network and how this too supports the client's avoidance, for instance through suggested and encouraged avoidance "it was long time ago, forget about it, move on". (Herman, 1993)

As counsellors sometimes we may feel like we are hearing the same issue that we have addressed 10 sessions ago, which may be disheartening. Bearing in mind that there are many layers in trauma work and different EP's hold the different aspects of the trauma; therefore we may need to go back to the same trauma material while we are working with different EPs . Each EPs/part needs to be brought on the same page; namely that the trauma happened to me, it happened in the past and I experienced these thoughts, feelings, sensations in connection with the experience. These bring about a coherency of the trauma event.

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