**ISSTD – Standard Part 1, Class 7**

**Objectives:**

# Discuss the relational dilemmas in treating complex trauma and dissociative disorders. Chu Chapter 9

## Basic Trust

### Client sees relationship as unequal partners, could be powerful potential rescuers who may become abusers

### Relationships provide little gratification and perpetuate only uncertainty, conflict and fear.

### Watch for therapist assumptions, “trust me”.

## The therapeutic stance

### Traditional psychoanalytic distance (therapists as blank screen) is contraindicated with complex trauma and dissociative disorders

### Client may interrupt silence as a sign of disapproval, hostility or repugnance.

### Can’t maintain strict neutrality. ie) clients accept blame or responsibility for abuse, therapist must challenge this belief.

### Therapist can over identify/over involve, therapist may see self as reparenting patients, so used to empowering client, could lose objectivity.

## Therapist’s Dual role

### Actively participate in therapy and empathize with patience experience with patience

### Maintain a sense of therapeutic perspective and direction

1. Even when feeling overwhelmed, clients can achieve mastery over their feelings
2. Therapist must empathetically confront patient’s demands that external world adapt to their disabilities and ask patient to make efforts to change in order to deal with this world.

# Explore the outcomes of chronic disempowerment as they are played out in therapy with dissociative disorder and complex trauma patients

## Disempowerment – intense psychological distress and entrenched/unchanging despair, hopelessness, and helplessness

## Disempowerment creates dissonance in the therapy when therapists assume clients share their own assumption about the world and relationships

## The client, caught in disempowered world views change as impossible

### The client and the therapist are caught in a conundrum

### The therapist tries to promote change while the client cannot conceive of positive change and resists any change at all

## Enmeshment

### Reenactment of past abusive relationships frequently involve interpersonal enmeshment

### The counselor needs to act in a way that fosters trust and attachment, however this involvement has the tendency for dependency and enmeshment

### The therapeutic relationship becomes an arena for acting out hostile dependency – hence clients are often “testing” clinicians to see if they can be trusted

### It is helpful for the clinician to reiterate the therapy must be progressing in a helpful way and it is not helpful to engage in way that recapitulates the enmeshed and abusive relationships from childhood

### Remind the client – he/she has control over the relationship and can ensure an ongoing relationship by taking care of him/herself

### Paying attention to both the content and process of the therapeutic process helps

1. Content – what the client says
2. Process – reflected by the manner in the way the client interacts
3. Most of the time content is what the counselor is reacting to most, with enmeshment, it is important to focus on the process

### Rather than change patterns of relating – disempowered clients’ primary goals are to: hold onto important nurturing relationships, discharge intolerable feelings such as anger, and obtain comfort

### At times when working disempowered clients, it is difficult to maintain therapeutic boundaries. It is very important to keep the boundaries as strong as possible. Significant alteration of the normal structure of therapy should be made with great caution since it almost always results in recapitulation of the lack of boundaries and limits in the client’s original family of origin

## Control and Manipulation

### Since disempowered clients feel it is impossible to trust enough to do things “with” others, the only alternative is to do things “to” others

### Counselor needs to remember the client has no other experience in getting their needs met, while maintaining a goal in therapy to increase self-esteem and self-efficacy

## **Working with chronically disempowered clients take tremendous patience it is necessary to empathically sets limits over and over, regression to old behaviors and minor violations of therapeutic contract should be tolerated if there is progress over time toward agreed upon treatment goals**

# Describe and discuss the need for good boundaries in treating dissociative disorder patients.

## Especially early in treatment, clients have frequent crisis situations with panic and despair

## Establishing the treatment frame

### Incorporating ground rules of therapy (frequency, length of session, availability outside the office, role of client and counselor)

### A strong treatment frame allows client to feel safe, where rules are mutually understood and respected

### A certain amount of availability of the counselor is helpful – 3 reasons constant/extraordinary availability is problematic

1. Escalating demands of therapist ignores the human limitations of the therapist
2. Constant availability leads to increased dependence on therapist to provide reassurance vs. client learning to self-sooth
3. The expectation that therapist can always provide soothing reassurance is unrealistic – the client may encounter pain that is overwhelming and needs to find non-harming ways to manage it
4. It is not so much EXACTLY where the boundaries are set, but there are clear boundaries and limits that create a workable and reasonable treatment frame

### *It is important to seek consultation if you would not want a colleague to know the type of therapy you are pursuing with a particular client*

**Article: Through the lens of Attachment Relationship**

1. Emphasizes 3 phases of treatment with emphasis on secure attachment modeled in phase 1 as well as psychoeducation
2. Sachs proposes there are 2 distinct presentation of DID
   1. Stable – are able to go through phases of treatment and potentially integrate
   2. Active – in ongoing abusive relationships, although they gain insight from treatment, overall they do not improve in symptoms, especially as it relates to safety
3. Since the injuries are ongoing it can bring up an ethical question for the counselor
4. Clients with active DID presentation do not respond to phase 3 treatment
5. Attachment Modes – behavior patterns that succeed in engaging the attachment figure most fully
   1. Type – distress signal that elicits response from caregiver and equals safety and closeness in the child’s mind
   2. Intensity – the degree of fear, pain, or emotional devastation the child experiences in the attachment relationship determines the intensity of attachment needs
   3. Frequency – the number and length of gaps between the high intensity, high dependency traumatic episodes.
      1. The gaps create windows of opportunity the child has to develop relationships with people other than attachment figure and experience independence.
      2. The longer the gas are, the more opportunities for development and learning a person has
      3. Those with very short gaps are least able to establish therapeutic relationships which enable them to heal from trauma
6. Attachment Types
   1. Secure – babies engage their attachment figures predictably and consistently through their natural reactions to pain or fear
      1. Both frequency and intensity of distress are low
      2. Degree of baby’s security determines the extent of baby’s ability to increase physical distance from attachment figure and explore environment
   2. Insecure (ambivalent and avoidant) – have to modify natural behavior to attract attachment figure’s attention
      1. Since type of behavior to engage attachment figure did not match true self, may have long-term negative consequences
      2. Intensity as well as frequency of distress is moderate (vs. low)
   3. Disorganized attachment – baby’s attachment calls are not responded to reliably
      1. Response is unpredictable – sometimes a hug, sometimes a beating, sometimes no response at all
      2. Leaves baby constant alert (hypervigilant)
      3. Intensity and frequency of the distress is high and distress episodes often go unresolved.
      4. Since there is a constant focus on the attachment figure, there is little space to learn about the environment or focus on self
7. Types of disorganized attachment proposed
   1. Erotizing – engaged through sexual communication
   2. Agonistic – headed conflict or violence
   3. Care-giving – to a needy parent
   4. Infanticidal – attachment figure is preoccupied with death, especially of the child; child is compelled to brush against death (self-harm, high risk behavior, eating disorders, suicide attempts..)
   5. Symbolic infanticidal – caregiver is extremely anxious to ‘save’ the child, child engages caregiver through grief, illness or death = high risk behaviors. Child’s depression, illness, or looming death engages caregiver more than child’s life
   6. Concrete infanticidal – move toward pain or near death abuse because these are the only moments where they feel truly held in the mind of the attachment figure safety and loved
   7. Major correlation between attachment and trauma-born mental disorders
   8. TYPE of attachment – determines behaviors, i.e. erotizing = promiscuity
   9. SEVERITY of trauma – determines intensity of attachment needs/dependency
   10. FREQUECY of trauma – high frequency means little time for freedom from attachment needs and development of self