The Battle Within:

A Parts Framework to Heal internal wounds and conflicts

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3 CPD Hours

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TRAINING AND CONSULTING

Contents

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1

Overview

- The Battle
- Parts from a structural dissociation theory approach
- The problem is not the problem
- Locus of control shift and ambivalent attachment
- Parts and shame
- Healing internal wounds and conflicts

2

Chronically Traumatised Individuals

Are too rigid and closed instead of flexible: fixed in particular and narrow ways of being, defense and avoidance; overly closed to learning from the present; respond with conditioned reactions

Are too unstable and open: overly open to the influence of internal experiences and perceptual distortions, sometimes to other people; overly open to the influence of the past

Are reflexive instead of reflective: difficulty being reflective or staying in a reflective mode; are impulsive and reactive

Kathy Steele, 2009

3

Treatment challenges

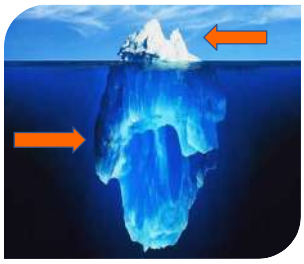
- Self-regulation based on **dissociation** & **hypervigilance** ***Survival defenses***
- Relatedness based on **enmeshment** & **detachment** ***Attachment defenses***
- Expectation of validation of **self as damaged, future as hopeless** ***Shame defenses***

Courtois & Ford, 2013 *italics Halpern 2021*

4

Presenting issues

- Relationship
- Domestic abuse
- Parenting
- Acute and chronic health conditions
- Financial distress
- Housing instability / homelessness
- Work or study problems



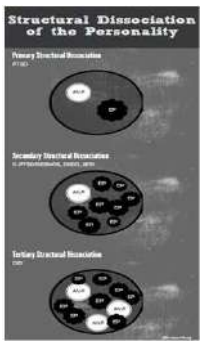
5

PARTS FRAMEWORK

6

Structural Dissociation

The Haunted Self, Onno van der Hart, Ellert Nijenhuis, Kathy Steele, 2006



- Primary: one trauma or series of connected traumas
  Post Traumatic Stress Disorder
- Secondary: Multiple EP's separate from one ANP
  Complex-PTSD/BPD/OSDD
- Tertiary: Multiple EP's separate from multiple ANP's
  Dissociative Identity Disorder

7

ANP's: Going on with normal life part/s

- Not impacted by the trauma
- Varying degrees of knowledge and awareness of the trauma / other parts
- Function in the 'outside' world, develop and maintain relationships / socialize, go to school, university, work etc.
- **Primary** and **Secondary** SD there is **one ANP**
- **Tertiary SD** there can be **many ANP's** that have different roles and functions in the outside world (and many Emotional Parts).

8

Structural Dissociation adapted from Fisher, 2012

Variation on Traumatized Parts Halpern, 2019

Left brain: ANP

Right brain: EP

Fight	Flight	Hyper & Hypo Freeze	Collapse	Attach
				
'Bodyguards' watch and wait for opportunity to defend		Autonomic alarm	Compliant, non-threatening avoids rocking the boat	Takes any 'crumbs' fallen from the table

9

Relational and complex trauma

"Early bonding experiences are remembered in the form of implicit or emotional memories

and procedurally learned autonomic, motoric, visceral and behavioural responses"

Fisher, 2017

10

11

Freeze – Hyper		Difficulty making decisions, stuck, can't think, can't move – followed by another survival response or an ANP.
Freeze - Hypo		Numb, shut down, dissociate.
Flight		Workaholic, perfectionistic, anxiety, panic, OCD, over-thinker, difficulty sitting still, comfort eating, substance misuse, joke, change subject, minimises.
Fight		Critical, sarcastic, defensive, find Achilles heel, angry outbursts, controlling, bullying, physically aggressive – humiliated fury.
Collapse		People pleaser, keep the peace, "I'm not a threat", don't notice me, lose identity, agrees, goes along with, says you're a great therapist, boundary difficulties.
Attach		Young part desperate for any connection. Attachments replicate earlier relational dynamics that never meet a chasm of needs.

12

Tend and befriend parts

Taylor. S. et al , 2000

Ambivalent attachment to perpetrator

Ross and Halpern, 2009

Instinctual response associated with a need to avoid conflict and trauma via appeasing behaviors.

Walker, P. 2003

Individual desperately clings abuser.

Bentzen, 2014

Traumatic bonding

Dutton; Painter, 1981

13

Survival responses are not static

- Each part has its own survival response
- Some parts may have more than one survival response
- Survival responses look slightly different in different parts
- Survival responses will be activated in different parts by different triggers
- Rapid switching from one part to another when survival response activated

14

Functions of Parts

Commonly present	Less common
• Baby / infant / child / teens	• Animals
• Adults	• Robots
• Inner self helpers / caretakers	• Demons
• Introjects	• Spirits / supernatural beings
• Different gender identities	• Angels
• Protectors	• Psychotic presentations
• Persecutor imitators	
• Sexualised parts	
• Substance misusers / ED's	
• Self-harming	
• Suicidal / homicidal	
• Same part at different ages	

http://traumadissociation.com/alters

15

The problem is not the problem

but a solution to another problem

Ross & Halpern, 2009

16

The attachment dilemma

- Biological drive to **attach** or **seek proximity**
- Biological **withdrawal reflex** from danger
- Drive to attach and withdraw from danger creates a **double-bind**
- One drive may **override** the other or the child may **oscillate** from one to other.
- Seeds for **disorganized attachment**

Ross and Halpern, 2009

17

Disorganized attachment

- 80% of traumatized children have disorganized attachment patterns.

Carlson & Cicchetti, (1994), cited van der Kolk (2003)

- **Has anxious and dismissive tendencies**
- **Feels exploited and used in relationships**
- **Terror of intimacy & autonomy**
- **Craves emotional intimacy but deeply mistrustful**
- **High anxiety when depends on someone**
- **Pulls away when feels rejected or overwhelmed**

18

Anxious preoccupied

- Sensitive nervous system
- Clingy, needy, demanding
- Other oriented
- Excessive compliance or crying
- Impulsive - acting out
- Fears separation & autonomy

19

Dismissive Avoidant

Downplays importance of relationships	Excessively self-reliant	Difficulty expressing emotions
Conflict averse	Difficulty being vulnerable and intimate	Focus on others flaws to maintain distance

20

Ambivalent attachment to perpetrator

- Unable to hold contradictory feelings e.g. love and hate – stuck in black and white thinking.
- Identifies with the aggressor = self blame and treats self badly as did the perpetrator e.g., self-harm.
- Identifies with passive victim = projects on to others to fix it.
- Splitting: "I hate you - don't leave me"!

Approach – Avoid = disorganized attachment

Ross & Halpern, 2009

21

Locus of control shift

"I am bad" = compensates for feelings of helplessness, powerlessness

"I am bad" = attempts to manage pain, grief and anger

It's my fault because I am bad. Therefore,

I can change and be good – then I will be lovable and the abuse will stop =

illusion of power

Enables maintenance of attachment bond

Ross & Halpern, 2009

22

Shame

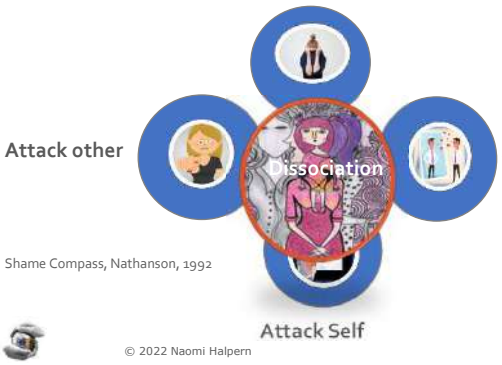
Evolutionary purpose to shame – to remain connected and accepted in social groups.
Logan, 2016

By 3 years old, children are conscious of shameful and shaming behaviours.

Shame is an emotion in it's own right and also can be a defence against other emotions

23

Interpersonal trauma and shame



Shame Compass, Nathanson, 1992

24

What is the problem?

Memory, meaning, emotions, sensations, attachment needs

Depression	Anger - rage
Substance/ ED	Pain - emptiness
Cutting	Distress reduction - numbness
Flashbacks / fire season	Memorial / omens
Rage/shame	Powerlessness - grief
Dissociation	All of the above!

Ross & Halpern 2009

25

External or internal triggers give rise to implicit memories and conflict between parts in an attempt to manage

26

Countertransference

Therapists' **attachment needs, countertransference, vicarious trauma, trauma history** and **Parts** will be triggered in relationship with the client.

Awareness of our triggers

Support our Parts!!!

27

Traumatic grief often is defended against with aggression, impulsivity, guilt, shame, or dissociation

Courtois & Ford 2014

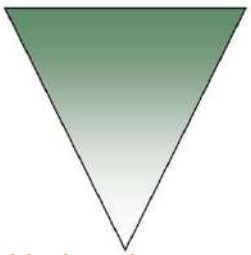
28

Internal Karpman's triangle

Bad things happen because I am bad
Victim

I am bad because I do bad things
Persecutor

I can fix it
Rescuer



All parts have a positive intention

Anderson 2021

29

Positive Intention

Survival is the primary driver

- Don't tell secrets
- Don't let anyone close
- Don't lose this person
- Don't take risks
- Don't cry or be angry

30

Healing internal wounding

31

32

Shame-filled parts

- rendered powerless
- what was done to the person
- what a person did to survive
- defending against other emotions
- being blamed by other parts

33

Rage-filled parts

Sometimes the **most wounded** OR they **protect a more wounded part** OR they use rage to **defend from other feelings** such as shame, vulnerability or grief.

34

Grief filled parts

- What happened
- What didn't happen
- What has been lost in the past
- What may never be able to be
- Abandonment

35

Attach parts

Attach parts can have different presentations or rather, their attachment hunger can be disguised and sophisticated.

Very young part desperate for any attention and connection.

Seemingly more mature part that appears to be grounded and balanced but seek out attachments with people that reenact earlier relational dynamics and never meet a chasm of needs.

Client that seems quite composed and functional until you announce leave dates.

36

37

Spectrum of emotions

Hypoarousal Past	Grounded Present	Hyperarousal Past
Numb	Rejected	Abandoned / betrayed
Numb	Afraid/Fear	Terror/Panic
Numb	Anger	Rage
Numb	Vulnerable	Helpless
Numb	Hurt	Despair
Numb	Guilt	Shame / self loathing
Numb	Grief/loss/sad	Depression

38

Window of tolerance for each part

Hyperarousal Zone

Flight Attach Hyper-Freeze Fight

WINDOW OF TOLERANCE

Hypoarousal Zone

Hypo-Freeze

Collapse

39

Parts supporting Parts

Who inside knows something about this?

Who can help with this?

40

Meeting place (talking through to parts)

41

Verbal and written communication

Talking through to parts

- Assists with co-consciousness, identifying parts and their function, and relationships between parts
- Does another part have another point of view, think, feel differently?
- Is anyone else listening / do they have a point of view?
- Are you aware of any other thoughts, feelings, sensations?
- Who inside knows something about this, can help with this?

Written communication

- Parts worksheet
- Round table discussion – agree on 'rules of engagement'
- Written dialogues (alternate between dominant and non-dominant hand)

42

Communication through artwork
"Telling without talking" (Cohen & Cox, 1995)

- **Inner landscape**:
  "can you show me what it look like inside"
  "where does that part of you live inside – can you draw it?"
- Can X draw "something" about that experience?
- Can Y draw "something" in reply to X's experience?
- Ask questions – let the client interpret

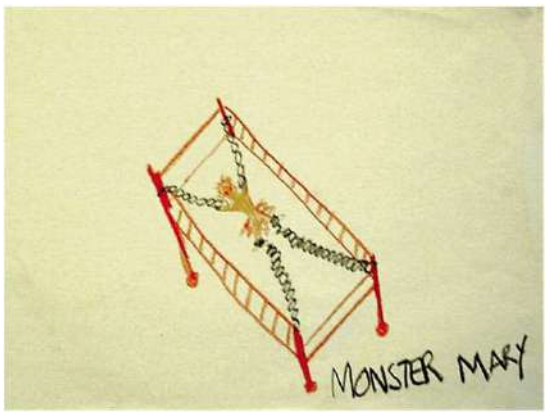
43

44

45

46

47



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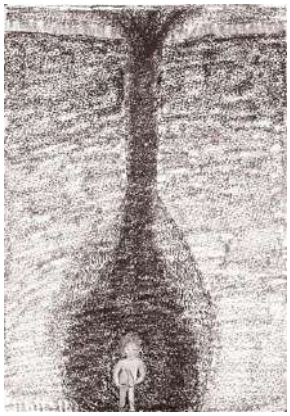

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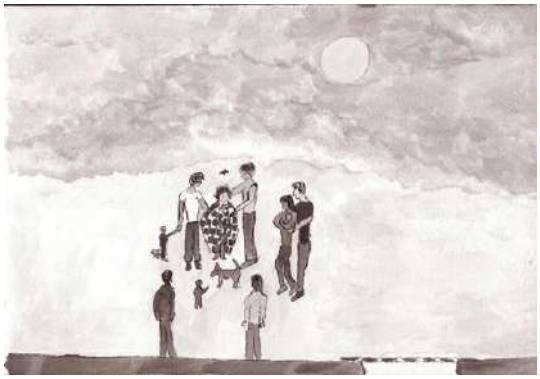
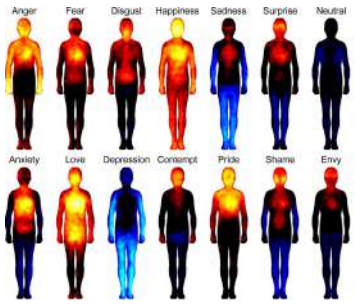
51



52

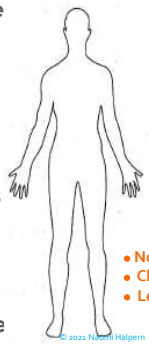
Mind-Body Connection
Emotions in the body



Nummenmaa, Hari, Glerean, Hietanen (2014)

53

Communication through the body
(parts holding physical symptoms)



headache
flushing
fatigue
palpitations
sore neck
hyperventilation
sore back
constipation
diarrhea
sore hips
aching fee

- Notice posture and movements
- Change posture – how does it feel?
- Let parts of the body speak

54

Trauma can be held in the body and lead to dysfunction in the nervous symptom, and manifest as physical symptoms. **Somatic Experiencing** (Levine, 1997) correlates this to being stuck in the **fear response**.

- head
- eyes
- throat
- heart
- solar plexus
- stomach
- genitals

55

Pacing

Reframe resistance as communication

Don't get caught in the narrative!

56

Earned secure attachment

- Cultivated through **apparently normal parts** and **emotional parts** developing compassion for, attunement with, and witnessing other parts experiences.
- All parts noticing what it's like to have the other(s) respond to their needs (developing mentalization).
- *"How do you feel toward that part now?"*

Fisher, 2017

- Rescripting traumatic experiences or a "Do-Over"

Anderson 2021

57

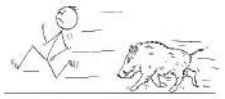
Complex trauma therapy objective

"…the creation of safe places *(autonomic)* for sharing where the unspeakable can be given voice *(pre-frontal cortex)*, where feelings can be felt *(limbic)*, and where sense can be made out of what seemed previously senseless *(pre-frontal cortex)*".

Atkinson, J. Trauma Trails 2000 - *Italics* Halpern, 2018

58

My survival response(s) and experiences reflections

My Survival Response	Self-reflection: negative experience	Self-reflection: positive experience
Flight  ☐		
Fight  ☐		
Hyper-Freeze  ☐		
Hypo-Freeze  ☐		
Collapse  ☐		

Reflections about shame responses

Our shame response is shaped by early attachment relationships, events and personality characteristics. We may have a 'go to' shame response but other response(s) may be activated depending on circumstances and triggers. For example, we may have one shame response with our partner or family and another response(s) with clients or colleagues. This is not an assessment but a tool to reflect on your shame response(s). Think about different situations where shame has been activated and reflect on your response(s). Which response is predominant and in what settings? Make a note of thoughts, feelings and observations. ***Be compassionate with yourself.***

Withdrawal		Avoidance		Attack Self		Attack Other	
Wish I could be invisible	☐	Others fault or problem	☐	"I'm an idiot"	☐	Put down – blame others	☐
Avert eye contact	☐	Brazen it out – don't care	☐	Self-deprecating humour	☐	Fly into a rage	☐
Embarrassed - humiliated	☐	Puff yourself up	☐	Negative commentary	☐	Retaliation - revenge	☐
Withdraw from others	☐	Distract - risky activity	☐	Self-punishing behaviour	☐	Lash out verbally	☐
Difficulty speaking	☐	Substance misuse	☐	Self harm	☐	Lash out physically	☐
Other:	☐	Other:	☐	Other:	☐	Other:	☐
Score:		**Score:**		**Score:**		**Score:**	

Reflection: _____

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SPECTRUM OF EMOTIONS						
Somatic Complaints	**Internalize**	**Stuck in Past Ungrounded Extreme**	**Present Grounded Fluid Balanced**	**Stuck in Past Ungrounded Extreme**	**Externalize**	**Actions & Behaviours**
Aches/Pains						Alcohol/Drugs
Headaches		Numb	Anger	Rage		Hurt Self / Other
Nausea		Numb	Cautious	Paranoia		Suicidal Ideation
Dizziness		Numb	Hurt	Despair		Panic Attacks
Stomach Aches		Numb	Vulnerable	Helpless		Eating Disorders
Irritable Bowel		Numb	Sad	Depression		Psychosis
		Numb	Happy	Mania		
AVOID CONFLICT						**AVOID CONFLICT**

SPECTRUM OF EMOTIONS						
Somatic Complaints	**Internalize**	**Stuck in Past Ungrounded Extreme**	**Present Grounded Fluid Balanced**	**Stuck in Past Ungrounded Extreme**	**Externalize**	**Actions & Behaviours**
Aches/Pains						Alcohol/Drugs
Headaches		Numb	Afraid/Fear	Panic/Terror		Hurt Self / Other
Nausea		Numb	Frustration	Overwhelmed		Suicidal Ideation
Dizziness		Numb	Concern	Anxiety		Panic Attacks
Stomach Aches		Numb	Conflicted	Confused		Eating Disorders
Irritable Bowel		Numb	Remorse	Shame of Self		Psychosis
		Numb	Rejected	Abandoned		
AVOID CONFLICT						**AVOID CONFLICT**

[Adapted from "Spectrum of Emotions", M. Caldwell-Engle, presented at ISSD 21st International Fall Conference, New Orleans, USA 2004]

The "What If" Cascade

The *"what if"* cascade is a series of hypothetical *"what if"* questions. It is a *cognitive cascade*. The purpose of the technique is to move behind defenses to the core issue being defended. Defenses can be best understood as '*the problem is not the problem but a solution to another problem*.' This is true even when a defense creates other problems, such as self-harming behaviour or substance abuse.

The repeated *"what if"* questions allow the client and therapist to identify underlying feelings and conflicts. The *"what if"* cascade won't stop the defense but it can be a springboard to understanding the function of a defense and safely stepping toward the underlying issue.

The cascade might be short, only a few sentences or it may take longer. The questions can be direct or more nuanced. The cascade may naturally progress into exploring the underlying defense or it might lead to a broader discussion about how therapy might best progress with a structured plan about to how to proceed.

The "What If" Cascade example

Therapist: At the end of our last session, you mentioned that sometimes you harm yourself and we agreed we would talk about that some more today.

Client: Yeah, I know I really do need to deal with my cutting. I want to stop but I can't.

Therapist: I've worked with a lot of people who have cut or hurt themselves in some way and what I have learned is that people hurt themselves for lots of different reasons. Why do you think you cut – how does it help you?

Client: It calms me down and makes me feel better. I feel relief after I've cut myself.

Therapist: What do you think would happen if you stopped cutting?

Client: I wish I could - that would be great.

Therapist: What's standing in the way of stopping?

Client: I don't know how to stop. I get overwhelmed and I have to do it. I have tried to stop you know.

Therapist: Don't get me wrong – I know it isn't easy; it's very hard. It's not a simple questions of willpower. But let's take a step back for a moment. You say you don't know 'how to' stop cutting, but that's the second step in the process. The first step is deciding whether you're ready to make a commitment to stop. That's where you're at, the deciding step.

Client: Oh OK. Well yes. I want to stop but I don't think I can. I have tried so many times to stop. I feel like a failure and I am very ashamed of all the scars.

Therapist: Then what happens when you feel you have failed and are ashamed?

Client: I cut again because I feel ashamed, and I need to punish myself.

Therapist: So, it seems there is more than one reason you cut? You cut to feel better, it brings some relief and then you also cut yourself because you feel you've failed and are ashamed about cutting.

Client: Actually yeah. I hadn't really thought about all the different reasons because it can blur into one overwhelming urge to cut myself.

Therapist: So, maybe the first step is to understand more about the reasons why you cut. I'm going to suggest I ask a series of hypothetical questions to try to get there. Speaking hypothetically, what would happen if you didn't cut anymore, starting right now?

Client: You mean I just stopped now and never did it again - I'd feel great. I'd have hope then.

Therapist: It would be great to feel hope. But if it felt so great to quit, you would have quit already - right? You said that cutting makes you feel better. If you didn't cut, what would happen to the feelings you get rid of temporarily by cutting?

Client: They'd build up and eventually become unbearable.

Therapist: Then what would happen?

Client: Then I'd have to cut.

Therapist: Right, but what if you didn't cut? Remember, this is a hypothetical.

Client: Then I'd feel really bad and it wouldn't go away.

Therapist: And if you felt really bad and it didn't go away, what would happen then?

Client: I'd have to get drunk.

Therapist: What if you said "No" to alcohol and drugs, and didn't use anything?

Client: I'd have to kill myself.

Therapist: OK, so cutting is actually a suicide prevention technique?

Client: I guess so, yeah, if you put it that way.

Therapist: Well, that's a positive, isn't it? Cutting prevents you from a much more serious harm. But let's take this hypothetical further. What if you didn't cut, drink, kill yourself, or use any other harmful behaviour?

Client: I don't know. I can't imagine. I'd get lost in the feelings forever.

Therapist: And if you got lost in the feelings forever, then what would happen?

Client: What do you mean?

Therapist: Well, for instance, would you ever eat again, or go to the park with your dog? What would you do for the rest of your life if you got lost in the feelings forever?

Client: I'd probably be locked up in a psychiatric hospital forever.

Therapist: OK, so you're frightened you'd become catatonic or psychotic? What if in this hypothetical, we define catatonia and psychosis like cutting, another drug, another addiction? What if you said "No" to catatonia and psychosis?

Client: You make it sound so easy. Just say "No" and like magic — I'm cured.

Therapist: No, please don't misunderstand, I get that none of this is easy. I'm not making light of it at all. This hypothetical is to try and get to the root of cutting yourself.

Client: Well, then I'd feel really bad forever and I couldn't stand it.

Therapist: And if you couldn't stand it, what would happen?

Client: I'd kill myself.

Therapist: But we agreed that in this hypothetical you wouldn't do anything harmful.

Client: Well, if there was no other way out, I'd have to feel the feelings wouldn't I?

Therapist: Right, so the worst thing that would happen if you stopped all the addictions and all the self-harming, is you would feel your feelings.

Client: I guess so. But I can't bear to feel my feelings. They are terrifying and overwhelming.

Therapist: What if I were to suggest that your terror of feeling is causing you to over-estimate how big a catastrophe that would be. You've got *feeling your feelings* defined as an absolutely intolerable catastrophe.

Client: I know, but they hurt too much.

Therapist: Well, if that's true, if you really can't stand your feelings, then you can choose to keep cutting to manage them.

Client: So, you're telling me that cutting is OK?

Therapist: It depends. It's OK if you say it's OK. But you also talk about feeling a failure and being ashamed of cutting. You don't like the scars. So if you want a different life, then you need to make a different choice. What's blocking you at the moment is your belief that to stop cutting is impossible because the feelings are intolerable.

You're giving your feelings too much power and you're not giving yourself enough credit for courage, and survival skills. Think about it. It must take a lot of courage to take a blade and cut yourself. Imagine if you could learn to channel that courage into facing and feeling your feelings and learn to be safe with your feelings and yourself?

Client: I never thought about it that way before. I want to try but I'm terrified.

Therapist: I know you are and that's OK. We'll take it really slowly. We'll explore your triggers to cutting and slowly begin to tolerate your feelings. I'll be right alongside you. This is a journey. There may be times when you feel stuck and take one step forward and two backwards. But that's OK. We can plan for that and you will be in charge and set the pace.

The therapist would then explain how the feelings in fact won't last forever but will peak in intensity and then ease off over a limited, tolerable period of time. The *"what if"* cascade can be pursued with a variety of wordings, and the therapist can divert to other matters before picking up the thread later in the same session, or in a subsequent session.

The '*what if*' cascade can be applied to working with any issue that is causing conflict and can be adapted to all Parts of self. As we saw in the above example, there was more than one reason the client cut herself. Often this reflects different parts managing different internal conflicts and issues. All Parts need to be supported and invited to come on board with decisions as to how best to proceed. (see Dialoguing with Parts worksheet)

Adapted from Ross & Halpern (2009) *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity*, Manitou

Visit: https://delphicentre.com.au/ ABN: 62 406 997 428

Dialogue with 'Parts' Work Sheet

We all have Parts. We may be aware of, and in touch, with some of our Parts and be unaware and not in touch with others. Our Parts, as in our external relationships, don't always agree. They may appear to have opposing needs, desires and motivations. Yet, all of our Parts have developed to assist us to navigate our world. In essence, each Part has a positive drive or motivation, even when a behaviour or attitude is also harmful or destructive. Learning to connect with, relate to and develop communication between our Parts leads to greater inner strength, wisdom, resilience and compassion for self and others.

Think about a current issue that is causing some degree of internal conflict i.e. you are experiencing conflicting thoughts, feelings, ideas, beliefs or needs around the matter.

Step 1: Summarize the issue: _____

_____

_____

_____

Step 2: Using your dominant hand, ask yourself a question about the issue:

_____

_____

_____

Step 3: Put the pen in your non-dominant hand and write down whatever answer, thought, feeling comes to mind – don't censor!:

_____

_____

_____

_____

Step 4: Based on the above response, ask a further question or reply to the response:

Continue the dialogue in this way, asking questions, responding to answers and seeking input from other Parts, until it feels like a solution or agreement has been reached, you feel greater clarity or understanding between the conflicted Parts of yourself or you have done as much as you can for the time being (and may come back to it another time).

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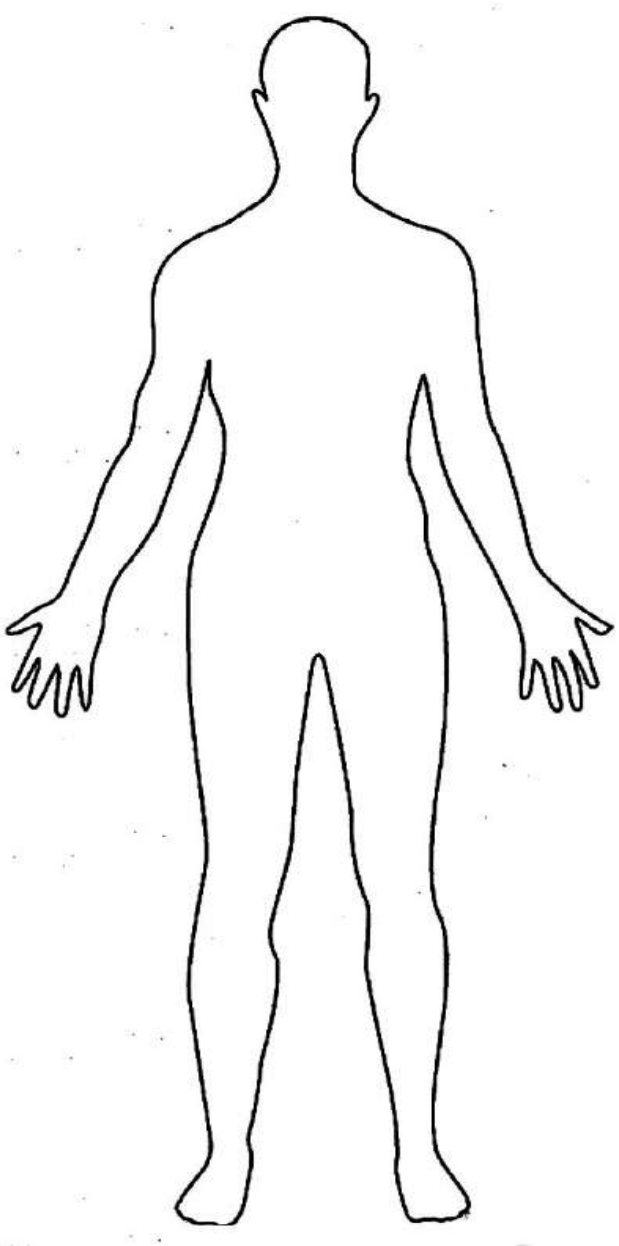
Let your body do the talking



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