Phobia of Vulnerability:

Working with Dissociation and Avoidance in Trauma Treatment

Janina Fisher, PhD

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Delphi Centre
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"Stuckness" = the therapist is stuck, too

- **When the client is stuck, it means that we too are stuck!** When clients are in their heads and avoidant of feeling or insight, we feel stymied. The therapy is stuck
- **The "Eeyore effect:"** every time we try to go in a different direction, the client keeps returning to the same dead-end
- **Blocks and deadlocks:** some immovable obstacle prevents forward momentum. The client begins to open up a little and then shuts down or is intellectualized again
- **"Avoidance:"** the client consciously or unconsciously backs away from every emotion, memory, connection to self or to the body. We feel helpless to help

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"Avoidance" = so many styles

- **The "help-rejecting complainer:"** the client's pleas for help alternate with rejection of any intervention we offer
- **"I'm fine:"** though the client comes to therapy, the message is: "I don't need help." What do we do with that?
- **"I didn't want to come and I have nothing to say:"** Sometimes the client is unable to participate at all!
- **"It's my [husband/child/boss]."** The client's weekly story is that all the problems stem from someone or something else
- **"Doing the same thing over and over and expecting different results:"** the client doesn't see that it will end the same way it always does

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We do not 'remember' trauma in words. . .

*"**Under conditions of extreme stress, there is failure of . . . memory processing**, which results in an inability to integrate incoming input into a coherent . . . narrative, **leaving the sensory elements of the experience unintegrated and unattached**."*

Van der Kolk, Hopper & Osterman, 2001

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Sensory elements without words = 'implicit memory'

- All experiences are remembered implicitly but not all are encoded explicitly. Traumatic experiences typically fail to be encoded as **autobiographical memories** because the prefrontal cortex shuts down under threat
- **The victim is left instead with easily activated implicit memories:** automatic emotional, physical, and cognitive responses disconnected from the events
- **The implicit or nonverbal memory system is a more powerful influence on our behavior than verbal memory** because implicit memories are not recognizable as 'memory:' **they are states, not narratives**.

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Sensory elements without words = 'implicit memory,' cont.

- **Implicit memories cannot be recalled voluntarily.** They are evoked by stimuli directly or indirectly related to events
- **"[I]mplicit-only memories continue to shape the subjective feeling we have of our here-and-now realities**. . ." *(Siegel, 2010, p. 154)* The past is not something that happened long ago. **We feel 'in danger' right here, right NOW.**
- **Verbal recall re-activates implicit memory networks** rather than processing them, causing clients to become phobic of remembering, but implicit memories are still evoked by everyday stimuli

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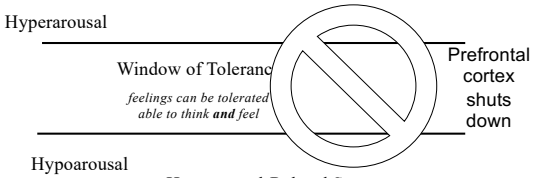
Dysregulation Gets Worse, Not Better, Over Time

Hyperarousal-Related Symptoms:

Interpretations of danger fuel activation, impulsivity, risk-taking, poor judgment
Hypervigilance increases, leading to post-traumatic paranoia or frozen terror
Clients experience an increase in intrusive images, sensations, emotions; racing thoughts
Self-destructive and addictive behavior are used to regulate the intense reactivity



Hypoarousal-Related Symptoms:

'Danger' cues cause disconnection, numbing, shutting down
Patient interprets responses as evidence to support self-loathing
Defensive responses are disabled by shame, collapse, victim identity

Ogden and Minton (2000); Fisher, 2006
*Siegel (1999)

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Stuckness = stuck in Autonomic Arousal patterns

Hyperarousal
Chronically anxious, impulsive, angry, desperate, and/or self-destructive
Active avoidance of feelings

Sympathetic Arousal

A very narrow Window of Tolerance

"Window of Tolerance"*

Parasympathetic Arousal

Hypoarousal
Chronically numb, depressed, hopeless, ashamed, disconnected
Low energy: no energy for change
No ability to feel or sense the body

Ogden and Minton (2000)
*Siegel, D. (1999)

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The problem with therapy. . .

- **Every type of trauma is associated with some form of human interaction.** Therapists are human beings who want to interact—and therefore potentially dangerous
- **Therapy requires activities highly associated with danger:** self-disclosure, verbalizing personal experience and emotion, internal awareness, connection to emotion and/or the body, and **vulnerability**
- **Therapy requires a willingness to trust enough to try something new:** neither is safe in a dangerous world
- Therapy requires **the ability to be vulnerable AND the ability to be independent. Not all clients can do both**

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Phobia of emotion

- **In abusive families, emotions are dangerous:** they can be used to humiliate or as a pretext for more violence
- "I'll give you something to cry about" is a common response to children's tears. **Anger is also punished; shame or fear result in more humiliation. Even positive emotions are often punished or shamed.**
- **To survive, the body becomes organized to prevent access to anger and sadness or any other 'dangerous' emotion. Basic needs may also evoke numbing or tensing.** Tears come up; the throat constricts to hold back speech; the chest tightens: "I don't cry," the client says.

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"Deepening" and the therapist

- **Therapist and client often have different agendas.**
- **The client wants to "feel better,"** while the therapist wants to "deepen" into emotion—**but** "deepening" entails the client's willingness to feel vulnerable
- **The client may feel threatened by the therapist's 'unsafe' agenda** to explore emotional responses AND traumatic memories. **The therapist is threatened by the client's reluctance or resistance to "deepen"**
- **A struggle ensues:** we push to deepen, while the client passively resists the 'deepening' agenda

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"Deepening" and the therapist, cont.

- **The therapist begins to feel threatening to clients,** leading to increased tension and guardedness. **They have even less access to emotion, are more resistant**
- **The more we push clients to deepen, the harder they must fight against that agenda.** But, because the process is so unconscious, neither party realizes what is happening. They are defending; we feel them resisting
- **To clients, "deepening" does not feel like a path to healing.** Because emotions feel 'threatening' and because 'not feeling' is a body response to threat, the client cannot comply with our wishes to deepen

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Feeling better before you feel worse. . .

- "Feeling worse before you feel better" is an adage that fit well with Freud's neurotic patients. In trauma work, "feeling worse" is a sign that our pacing is too fast
- **It is more important for traumatized clients to gain confidence that they can feel better**. Before asking them to 'feel worse,' we have to help them learn how to manage and regulate their reactions so they will not be overwhelmed and dysregulated by intense emotions
- **Befriending 'easy' feelings must always come first before asking clients to 'sit with' intense emotions**

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"Help" can feel dangerous

- The lows of hypoarousal and the tension of hyperarousal states usually motivate our clients to seek help
- But **the need to "maintain a state of vigilance and suspiciousness" complicates the simple act of seeking therapy**
- Therapists are triggering because we offer care. Self-disclosure is triggering, dependency is triggering, and asking for help is triggering
- What if we ask them, "Tell me about what happened to you. . ."? What if we abandon the client once we've learned their terrible secrets? What if we take advantage of them?

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"Attachment-related traumatic experiences . . . seriously impede the capacity to reflect on one's own and the other's state of mind. This happens because of ***automatic construing [of] the mind of the other as containing destructive intentions against one's own mind,*** *a deeply negative interpersonal schema . . . activated by a [trauma-related internal working model]."*

Liotti, 2011, p. 244

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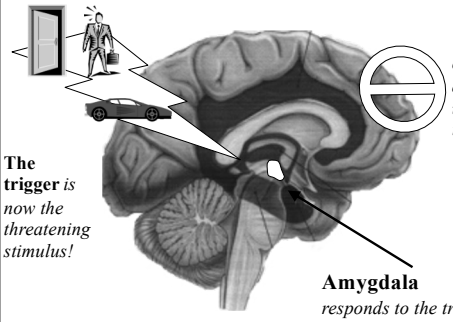
Triggering supports a sense of threat



The prefrontal cortex shuts down to allow us to respond instinctively

The trigger *is now the threatening stimulus!*

Amygdala
responds to the trigger by activating emergency stress response

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Trauma-related patterns of avoidance represents adaptation to danger

- **Phobia of emotion is an effective adaptation in a world in which emotions are punished:** it is not safe to be angry, sad, afraid, or unsure in an abusive environment
- **Phobia of the body is also a good adaptation** when the body is used and abused, violated and humiliated
- **Avoidance of thinking about 'it'** is a good adaptation when abuse is a secret and the child has to act 'normal'
- **Mistrust of new information** makes sense when one has been lied to. **Mistrust of other human beings** makes sense when those you love the most are abusive

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Children don't get abused for thinking, but they do for feeling

- **It is much safer to be the child whose head is in reading, in the imagination, or focused on school work.** Rarely do children get punished for being in their heads
- **Intellectualization can be a survival strategy** when there are family secrets and lies or chaos and confusion. Many children try to think their way through childhood
- **Thinking about ideas is much safer than thinking about what is happening.** That protects children from disclosing their dangerous secrets. It can help them to appear 'normal' when they feel overwhelmed or ashamed

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Do clients avoid? Or do their bodies avoid??

- **Most therapists assume that avoidance is conscious and intentional,** but when that is the case, the client usually voices it: "I can't think about it," "I don't want to feel those feelings again…"
- **Avoidance is more often related to survival patterns:**
  - The client is parasympathetically hypoaroused: numb, disconnected, unable to feel emotions other than shame or hopelessness, unable to remember yesterday, not just the past
  - The client's body automatically shuts down when certain feelings or memories surface. The client dissociates, the throat cuts off sadness, anger arises momentarily and then is gone. The body only allows feelings that were safe to feel in the past

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"The concept of a single unitary 'self' is as misleading as the idea of a single unitary 'brain.' *The left and right hemispheres process information in their own unique fashion and represent a conscious left brain self system and [a nonverbal] right brain self system."*

Schore, A. N. (2011). The right brain implicit self lies at the core of psychoanalysis. *Psychoanalytic dialogues*, 21:75-100. p. 76-77.

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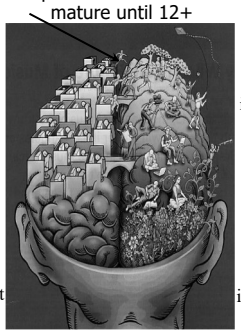
How does the brain dissociate?

Left Brain

Slow to develop, the left brain is verbal, can reason, plan and organize. It can learn from experience and anticipate problems. The left brain is the verbal, analytical, information-gathering brain that manages right brain emotions/impulses. It assesses danger but does not sense it.



Right Brain

Dominant for the few five years of life, the right brain is the survival brain. With no verbal language, it speaks through emotion, and impulse and reads nonverbal cues. It is intuitive and emotional: it senses danger instead of evaluating it.

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Theory of Structural Dissociation

Prior to any trauma, we have a brain that is inherently compartmentalized and capable of 'splitting'

Apparently Normal Part of the Personality

Emotional Part of the Personality

A split now occurs between the Left Brain part of the Self that "carries on" with normal life and adaptation during and after the trauma

And the Right Brain part of the Self that holds the implicit memories of trauma and the survival responses needed to survive it

Van der Hart, Nijenhuis & Steele, 2006

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What do we mean by a "part of the personality"??

"Neurons that fire together wire together" (Hebb, 1958)

"In the developing brain, [autonomic, affective, somatic and cognitive] states organize [into] neural systems, resulting in enduring traits." (Schore, 2001)

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Patient-Friendly Language

Pre-traumatic Personality

"Going On with Normal Life" Part

"Traumatized Part" of the Personality

This Left Brain part of the self "carries on" with normal life and adaptation during and after the trauma

This Right Brain part of self holds both the traumatic memories and the survival responses employed

Van der Hart, Nijenhuis & Steele, 1999

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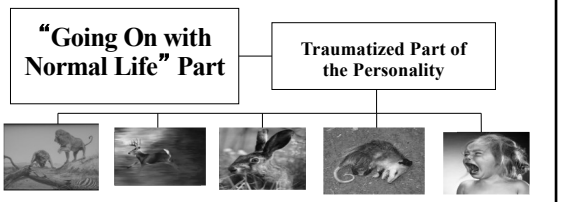
The more traumatic exposure, the more fragmented and split the patient becomes



Although on the outside, we see one whole body with one name, the chronic activation of survival responses results in split-off states defending against danger in different ways, each associated with shifts in mood, perspective, and even memory.

Fisher, 2019

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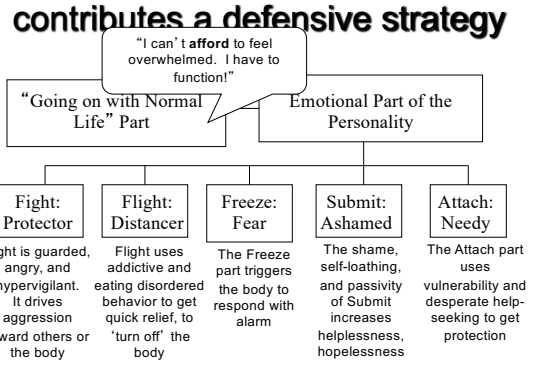
Each part of the personality contributes a defensive strategy



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The Basis of Crisis and Stuckness

- Flooding and blending: Intense feelings and sensations triggered by trauma-related stimuli are automatically interpreted as reflections of 'how I feel'
- Failure of acceptance: The parts are not "owned" as "parts of **ME**" but instead are denied and disowned: e.g., *'I'm never angry,' 'I'm so ashamed & afraid"*
- Lack of accountability: the feeling is either 'It's all my fault' or 'It has nothing to do with me'
- Loss of control: Traumatized parts come to exert more and more control over the individual's daily life, resulting in chaos and confusion

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And we too may contribute to stuckness !

- Our wish to offer relief may cause us to push against the stuckness, necessitating more resistance. **We may encourage hope, trust, self-esteem, believing those to be "good things," without realizing the fear we trigger**
- Anxiety about the pace of change may lead us into direct discussion or confrontation of the stuckness
- **Our frustration may alienate us from the patient:** we begin to dread the visit, give up hope, resign ourselves to the stuckness—gradually detaching emotional investment
- **We may add intervention on top of intervention, hoping that "something will work"**

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"I've got different minds at different times—and they are not working together. . ."

"Annie"

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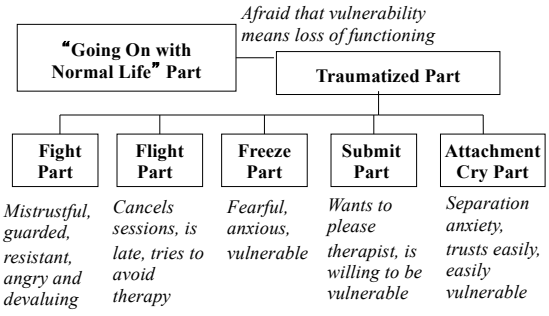
Parts have conflicting responses to therapy and therapists



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Protectors and vulnerability

•**Fight and Flight parts had little physical power when the client was young. All they could do was to protect the child by internal silencing and blocking** that prevented showing emotion or noncompliance.

•These protector parts are activated by even the **idea** of empathy for the young parts, connection to their emotions, or listening to their distress

•**We should expect interference from protectors when clients make a caring connection to young parts.** Interference includes hostility toward the young parts, blaming them for the trauma, sleepiness in therapy, hopelessness or distraction, missing appointments

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What overwhelms patients are. . .

•**Struggles between vulnerable and protector parts:**

- Vulnerable parts try to get the client's attention by intruding implicit memories, nightmares, or 'flashes' of the trauma
- The intrusions often dysregulate and overwhelm the client, activating the protectors' impulses to cut, burn, head-bang, or plan suicide—which in turn makes the child parts more desperate to be heard
- The memories or flashes often increase in number and intensity, further triggering the protectors and straining the client's ability to tolerate the feelings

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What overwhelms patients, p. 2

•**Both sides must be heard in order to settle the increasing chaos:**

- Protectors must be acknowledged and reassured that the client can tolerate the emotions
- The young parts must also be acknowledged along with their wish to be heard and helped. If they are not heard, their intensity and frequency will increase
- The client has to make a commitment to both sides: a commitment to respect the concerns of the protectors and a commitment to caring for the wounded parts

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Responding to vulnerable parts

•The experience of young parts is usually that no one was there, no one understood, and no one helped. What the patient must understand is that **failure to respond to these parts now is a repetition of the abusive past**

• Most traumatized clients and even their protectors understand abandonment and injustice: **the argument that it is unfair to the wounded parts to fail to hear them is usually a powerful and persuasive one**

•**Even if the client simply acknowledges what the parts need and deserve, some healing occurs.** Don't push for a repair—acknowledgement is a good first step

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Responding to vulnerable parts, p. 2

•**A felt relationship to the protectors usually is enough to allow for negotiation with wounded parts, too**

• When clients are too overwhelmed by the images or memories or emotions, they can ask their wounded parts to give them more time to take it all in:

- **Therapist:** *"Explain to the young parts that you want to stay with them but the images are overwhelming you. . . Ask them if they would slow the pictures down a little so you can stay connected."*

•**It also helps if the client can apologize to the parts or acknowledge they deserve more. That is also a repair.**

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"Rolling out the red carpet" [Deirdre Fay]

- **"Rolling out the red carpet" means making it as easy as possible for clients** to enter into the therapy
- Asking easy questions, staying attuned to the client's ease or difficulty with emotion and memory or the body, **pacing the treatment so that it is comfortable for the client and parts** (even if a little slow for the therapist!)
- Normalizing the symptoms, offering "psychoeducational reassurance," **creating an atmosphere of "fun and play rather than work**, curiosity rather than fear"
- **Working with simply acknowledging the parts**—with the awareness that getting close to them feels threatening

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Increasing the Client's Capacity to "Feel," p. 1

- **Work with the parts first rather than the emotions:** "Can you listen to their feelings?" "Can you understand why this part is so ashamed?"
- The vulnerability is easier to tolerate if it is the vulnerability of a part rather than the vulnerability of the whole person: "This part is sad. . . She wants to cry."
- **Use mindfulness techniques to regulate**: "Just notice the sadness as **her** feeling and notice you noticing her." "It wasn't safe for her to be sad then, but it is perfectly safe now. . ."

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Increasing the Client's Capacity to "Feel," p. 2

- **Avoid asking, "How do you feel?"**

•Instead, ask easier questions: "How is that young part feeling now?" "Ask her if she likes it when you listen. . ."

•Assume that all distress and all resistance represents communication from vulnerable parts or protectors. The vulnerable parts will push to be heard, the protectors will fight to inhibit their show of vulnerability

•Validate both sides of the struggle. Without the protectors, the client may not have survived. Without the vulnerable parts, the client would have no empathy

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Countertransference: the client may be stuck, but we don't have to be!

•Avoid being "inducted into the system:" I.e. avoid being seduced into anger, guilt, feelings of responsibility for the client's choices, or promising more than you can deliver

•Avoid becoming clients' "external locus of control:" no matter how self-destructive they become, no matter how depleted and helpless or angry

•Learn to use the language of parts: the client is stuck because the parts are in conflict. Change the conversation and re-interpret the problem

•Work in mindfulness: when the session bogs down or you feel stuck, become more curious and observant: what is the "stuck" part accomplishing?

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Mark your diary!

Dr Janina Fisher | 14 June | 3 hours| Phobia of Vulnerability | Online

Hana Assafiri, OAM | 4 July| 1 hour | The Audacity to be free | FREE EVENT Online

Naomi Halpern | 20 & 27 July | 2x 4 hours (Total 8 hours) | Befriending the Tiger: Vicarious Trauma, Resilience and Self-Care on the Frontline | Online

Dr Jennifer Freyd | 2 August | 1.5 hours | Moving from Institutional Betrayal to Institutional Courage | Online

Dr Janina Fisher | 16 August | 3 hours| Grieving the Losses of Childhood | Online

Naomi Halpern | 7 – 8 Sept | 12 hours | The Snow White 'Parts' Metaphor: Working with Complex and Attachment Trauma | Christchurch, New Zealand

Dr Mary-Anne Kate & Dr Colin Ross | 5 October | 3 hours | Expert Guidance in Screening for Dissociative Disorders and Differential Diagnosis | Online

Dr John Briere | 18 & 19 October | 18 hours | Four Clinical Dilemmas: Maintaining Resilience, Mindfulness & Compassion in Work with Complex Trauma & Challenging Presentations | Melbourne, Australia