The Problem is not the Problem:

What works for whom in trauma therapy

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delphi
TRAINING AND CONSULTING

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The problem is not the problem:

What works for whom in trauma therapy

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&
Colin Ross, MD

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Outline

Part 1

- Principles of Trauma Model Therapy
- Ambivalent attachment to the perpetrator
- The Locus of control shift
- The problem is not the problem
- The victim-rescuer-perpetrator triangle
- Case discussion / Q&A
- Activation of trauma-based shame
- Relational conflicts: attachment struggles
- Internal victim-rescuer-perpetrator triangle
- Trigger loop
- Case discussion / Q&A

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Four Meanings of "Dissociation"

- General systems meaning
- Technical term in cognitive psychology
- Phenomenological meaning
- Postulated intrapsychic defense mechanism repression versus dissociation

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Dissociation Measures

Dissociative Experiences Scale (DES)
Eve Bernstein Carlson, PhD & Frank Putnam, MD

Multidimensional Inventory of Dissociation (MID)
Paul Dell, PhD

Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D)
Marlene Steinberg, MD

Dissociative Disorders Interview Schedule (DDIS)
Colin A. Ross, M.D.

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The Dissociative Structural Model

Intrusions and withdrawals

Apparently normal personality (ANP)

Emotional personality (EP)

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The Dissociative Structural Model

Dissociative identity disorder

Posttraumatic stress disorder

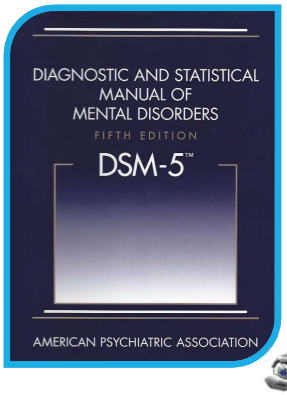
Obsessive compulsive disorder

Impulse control disorder

Borderline personality disorder

Dissociative schizophrenia

Somatization disorder



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Diagnostic Criteria For Maladaptive Daydreaming Disorder

A. Persistent and recurrent fantasy activity that is vivid and fanciful as indicated by the individual **exhibiting 2 (or more)** of the following in a 6-month period.
At least one of these should include criterion (1):

1. While daydreaming, experiences an intense sense of absorption/immersion that includes visual, auditory or affective properties.

2. Daydreaming is triggered, maintained or enhanced with exposure to music.

3. Daydreaming is triggered maintained or enhanced with exposure to stereotypical movement (e.g., pacing, rocking, hand movements).

4. Often daydreams when feels distressed, or bored.

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Diagnostic Criteria For Maladaptive Daydreaming Disorder

5. Daydreaming length or intensity intensify in the absence of others (e.g., daydreams more when alone).

6. Is annoyed when unable to daydream or when daydreaming is interrupted or curbed.

7. Would rather daydream than engage in daily chores, social, academic or professional activities.

8. Has made repeated unsuccessful efforts to control, cut back, or stop daydreaming

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Diagnostic Criteria For Maladaptive Daydreaming Disorder

B. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., dementia) and is not better explained by Autism Spectrum Disorders, Attention-Deficit/Hyperactivity Disorder, Schizophrenia Spectrum Disorders, Bi-Polar I Disorder, Obsessive-Compulsive and Related Disorders, Dissociative Identity Disorder, Substance related and Addictive Disorders, an Organic Disorder or Medical Condition.

Specify current severity:

Mild: Experiences mainly distress, no obvious functional impairment.
Moderate: One area of functioning is affected (e.g., work)
Severe: More than area of functioning is affected (e.g., work, school or social life).

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Trauma Model Therapy

- The Problem of Attachment to the Perpetrator
- The Locus of Control Shift
- The Problem is Not the Problem
- Just Say 'No' to Drugs
- Addiction is the Opposite of Desensitization
- The Victim-Rescuer-Perpetrator Triangle

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The Problem Of Attachment To The Perpetrator

Mammalian attachment

Dissociate to protect attachment systems

I loved the people who hurt me

I was hurt by the people I loved

Approach/avoid, love/hate

The borderline dance

Underlying grief – errors of omission
- errors of commission

Mourning the loss of the childhood you never actually had

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The Locus Of Control Shift

Child

Perpetrator

Power
Control
Mastery
Badness

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The Locus Of Control Shift

- Feeling helpless is intolerable. Shifting to an internal LOC compensates for feelings of powerlessness and loss of control
- Can lead to entrenched self-blame but also serves a protective function

"It happened because I'm bad"

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The Problem Is Not The Problem

- There is a story behind the symptoms and behaviors – they have a function and a purpose
- The presenting problems is a solution to a problem in the background

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Just Say 'No' To Drugs

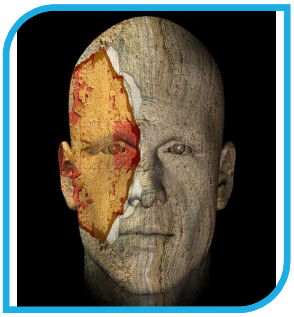
12 Steps
- step 0.5

Commitment to doing the work

'Failing' at sobriety vs succeeding at continuing to drink

Commitment fluctuates

Abstinence vs harm reduction



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Addiction Is The Opposite Of Desensitization

- Above or below the window of tolerance
- Experiential groups
- Different groups for different feelings
- Flooding vs systematic desensitization
- Somatic experiencing aspect

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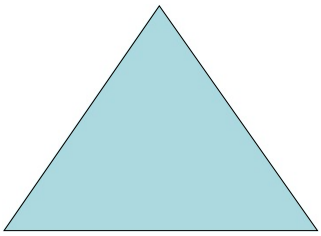
The Victim-rescuer-perpetrator Triangle

Victim



Rescuer

Perpetrator

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The Victim-rescuer-perpetrator Triangle

- A systems model
- A trauma model
- Plain English
- Transference and counter-transference
- Staying off the triangle

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Challenges in complex trauma and dissociation

Self-regulation based on **dissociation** & **hypervigilance**
Survival protections

Expectation of validation of **self as damaged, future as hopeless**
Shame protections

Relatedness based on **enmeshment** & **detachment**
Attachment protections

Courtois & Ford, 2013 *italics Halpern 2018*

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Shame functions (Scheff, 2003)

Shame is **master emotion** because it has **more functions** than most other emotions

- Key component of **conscience** (moral sense)
- Arise in **threat to a bond** (signals trouble in a relationship)
- **Regulates expression of other emotions,** and also awareness of other emotions
- **Increase social bonds**
  - Acknowledgement of shame increases social bonds
  - Lack of acknowledgement (e.g., anger), increases alienation.

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Shame and trauma

- Shame **intimately linked to traumatic events,** especially those of a **relational nature** (Andrews, Brewin, Rose & Kirk, 2000; Dorahy, 2010; Dorahy & Clearwater, 2012; Harvey, Dorahy, Vertue, & Duthie, 2012; Feiring & Taska, 2005).
- Relational trauma characterised by **dominance, subordination** and **control** evokes a strong shame response
- The caregiver's shaming/humiliating attacks (overt or subtle) on child, evoke in the child the perception that they were **unable to fulfil the needs of the parents**.
- The child is **humiliated for being a child** and not living up to the (unconscious) expectations/needs of the caregiver.
- Child own need for care is not seen Garfinkle, 2012. (M. Dorahy, 2023)

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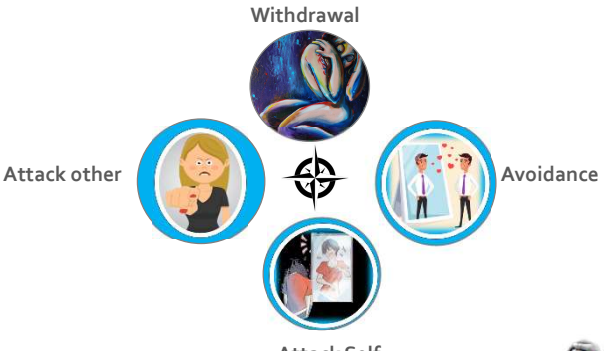
Shame compass

Nathanson, 1992



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Withdrawal

- Distress and fear
- Avert eye contact
- Blushing to flushing
- Difficulty speaking
- Withdrawal and isolation
- Sexual abstinence or psychological sexual difficulties

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Attack Self

- Self-disgust
- Self-deprecating humour
- Self-harm
- Suicide ideation and attempts
- Sexual masochism
- Somatization

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Avoidance

"It's not me it's you"!

Risk taking, notoriety, excessive seductive behaviour (not necessarily sexual).

Avoids shame through excitement, fear and pleasure.

Substance abuse or other hedonistic distractions.

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Attack Other

"Someone must be made to feel lower than I feel"

Put-down, ridicule, contempt, character assassination

Bullying - physical aggression

Rage - *humiliated fury*

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5th possible response: Dissociation

Freeze (can't think or move)

Space or zone out

Can't hear, speak, respond

Difficulty with recall

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Acute and chronic shame in relational trauma

"**Acute shame** is arguably the **most painful of affects** as there is an instant deflation of rewarding affects, usually **attachment-based**."

"**Chronic shame** attempts to **limit the re-experiencing of the relational trauma,** i.e. the massive affective deflation of **attachment failure**."

Hohfeler, 2018

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Even the word 'shame' can be too much

- Naming shame is important — Lewis, 1971
- But, in some cases using the word 'shame' can be too strong — Herman, 2011
- Thus start with ***'mortified'***, ***'embarrassed'***, ***'lowest of the low'*** — Herman, 2011
- "It can be deeply shaming just to admit to feeling shame" — DeYoung, 2015, p. 3

M. Dorahy 2023

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Regulating arousal and attachment

The **primary function** of parents is to support the child in **regulating arousal** and engaging in **affective attunement processes**.

Lack of self-regulating competency is probably the **most serious consequence of insecure attachment and psychological trauma** in both children and adults.

Hart, 2017

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Anxious - Ambivalent

- Sensitive nervous system (somatisation)
- Clingy, needy, demanding
- Other oriented
- Excessive compliance/crying
- Impulsive - acts out
- Fear separation & autonomy: Push-Pull

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Avoidant - Dismissive

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

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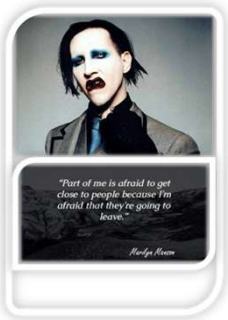
80% of traumatized children have disorganized attachment patterns.

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

"A child neglected early in life will exhibit profound attachment problems which are extremely insensitive to any replacement experiences later, including therapy"

Perry, 1995, p. 277



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Fearful-avoidant attachment style

Extreme inconsistency of behaviour (romantic relationships).

Shame easily activated: four faces – can rotate quickly.

Poor emotion regulation – fear of emotional intimacy.

Suspicious of intentions - extreme **fear of abandonment** = difficulty connecting to and trusting.

Seeks **extreme closeness** or **distance with no in-between** - pushes away and shuts down (I hate you – don't leave me".

Feels exploited - used in relationships.

Emotionally aggressive behaviour toward partners.

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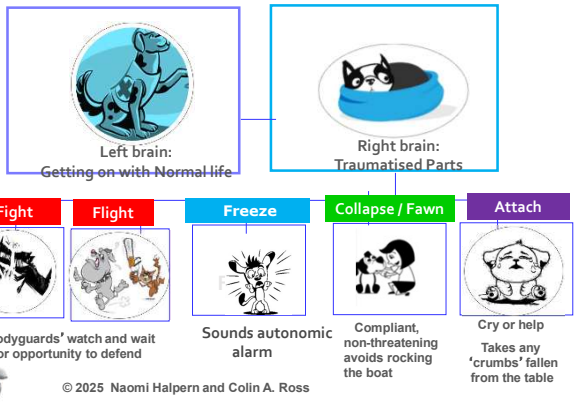
Structural Dissociation adapted from Fisher, 2012



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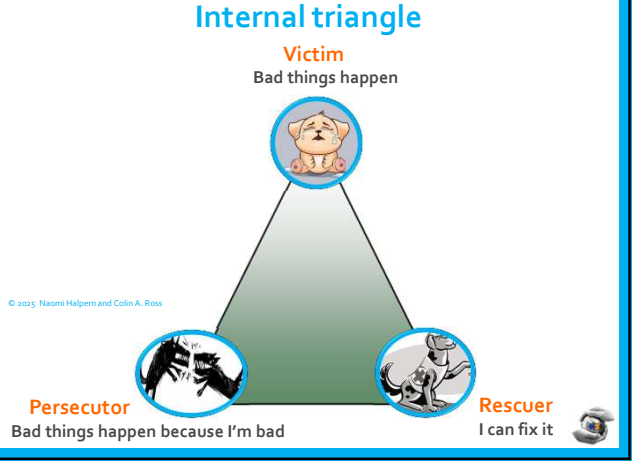
Internal triangle



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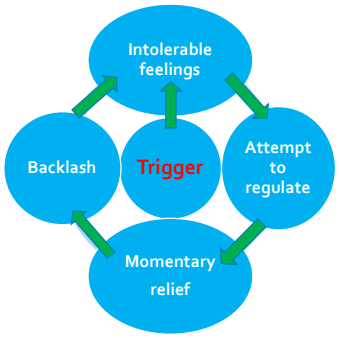
Trigger loop activation 1



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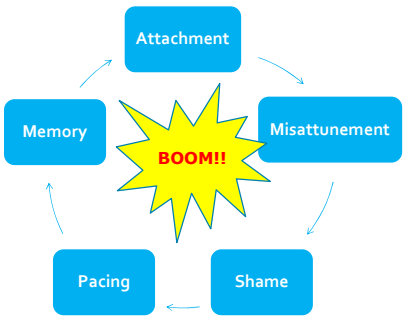
Trigger loop activation 2



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Trigger loop activation 3

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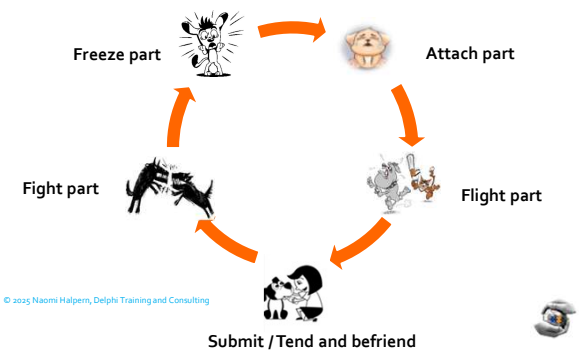
Trigger loop activation 4



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Outline

Part 2

- Cognitive strategies and techniques
- Demonstration of the "What if Cascade"
- Role play in breakout rooms
- Feedback / Q&A
- What works for whom?
- When words are not enough: art, music, journaling and creative writing
- 'Let your body do the talking': demonstration of working with the body
- Role play in breakout rooms
- Feedback / Q&A

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The Problem is not the problem: it's a solution to another problem

Dissociating / Switching in / out of session
Overwhelmed with grief, anger, shame depression, anxiety
Drug and / or Alcohol abuse
Flashbacks
Self harm and / or Suicidality
Risky Sex / Relationships
Eating Disorders
Workaholic / Over-exercising
Gaming / Binge watching
Gambling / Overspending

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The importance of Psychoeducation

- How the brain works in survival mode: fight . flight . freeze . collapse . attach
- Flashbacks
- Attachment styles
- Problem not problem
- Attachment to perpetrator
- Locus of control shift
- Karpman's Triangle
- Trigger loop
- Parts approach

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Insight and reflection

- **Challenge cognitive distortions *(What if cascade)*** Ross and Halpern, 2009
- **Internal communication** Ross and Halpern, 2009
- **Journaling - Dream work**

- **Rescripting: helplessness to empowerment – bringing adult parts on board to take care, soothe younger or more distressed parts etc.**

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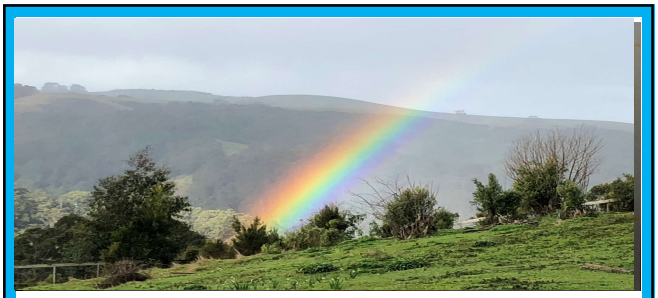

Meeting place (talking through to parts)

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Verbal and written communication

Talking through to parts

- Assists with co-consciousness, identifying parts, function, 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?

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The 'What If' Cascade

Why do you cut on yourself?

What if you didn't cut on yourself?

What if you didn't act out in any way?

What if you didn't kill yourself?

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Working with Parts

- Facilitate skills to develop **internal communication** and

Ross and Halpern, 2009

- an **attachment** to **Emotional parts *(traumatised parts)*** that are **disowned** and **disconnected** from each other and the **Apparently Normal parts (Getting on with norm**

Fisher 2017

- Develop **empathy, compassion** between parts and foster **internal earned secure attachment, healing of wounds** and new ways to support **internal** and **external** stress and conflict.

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" ……seriously **disrupted attachment without repair** or intervention for the child can, in and of itself, be traumatic, as the child is left **psychologically alone** to cope with their **heightened** and **dysregulated emotional states**, thus creating additional trauma."

Pearlman and Courtois, 2005 (p. 451).

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- In infants **threat** is related to the **caregiver's signals, interactions and availability** rather than to **the actual degree of physical or survival threat** in the event itself.

Lyons et al, 2006

- Early bonding experiences are remembered in the form of **implicit or emotional memories** and **procedurally learned autonomic, motoric, visceral** and **behavioural** responses.

Fisher, 2017

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Stuck in survival responses

Don't have the capacity to **mentalise**, to interpret and understand one's own and/or others **mental states** or the ability to **empathize** with Self or others.

The first step is to learn skills to **self-regulate**, learnt through **co-regulation**

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The Window of Tolerance

STIMULI

INTOLERABLE AROUSAL

TRAUMATIC HYPERAROUSAL
fight, flight, manic thrill-seeking, exercise addictions etc

CO-REGULATION

OPTIMAL AROUSAL

SELF REGULATION

CO-REGULATION

INTOLERABLE LACK OF AROUSAL

TRAUMATIC HYPO-AROUSAL
collapse, numbness, freeze, tend and befriend, spaced-out, narcolepsy, tv-addictions etc

Hart, 2017 (Adapted from Dr. Jukka Mäkelä)

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Approaching feelings and emotions

- Careful approaching of triggers: be present to feelings – sensations – memory to allow processing and integration
- Approach and move away
- Stay within the "therapeutic window"
- Therapist's support & empathy (being mindful of attachment style)

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Sympathetic nervous system
Freeze ♦ Flight ♦ Fight

reduce arousal

- soothing voice: *"that seems like it was difficult, challenging, scary, can we come back to here and now and slow things down?"*
- synchronize e.g. breathing /activity
- focus on senses
- push feet into ground
- client hug self / stroke arm

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Parasympathetic nervous system
Collapse ♦ Fawning

increase arousal: not too much

- movement - change posture
- create boundaries with arms
- push against pillows - wall
- find their voice - make noises
- play with ball or other games

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Exploration for Fawn and Attach Parts

ALIGN

"It must be tiring / feel like a lot of pressure trying to keep everyone happy / calm a situation down / try and stop things from happening?"

"It feels pretty scary right now - are you feeling alone?"

CURIOSITY

"I wonder what thoughts / feelings are around about this job – seems like a huge responsibility."

"I wonder what might help you feel less alone or frightened right now?"

EXPLORATION

"Do you notice anything about those thoughts / feelings?" (e.g. sensations in body – other thoughts)

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Survival responses in the transferential relationship

Attach: needs for closeness and care

"I know it feels scary when I go on leave, let's make a plan on what you can do that will help while I'm away."

Flight: needs space – don't try to get too close

"So how about we experiment with different ways you can let me know if what we're doing feels too much."

Fight: boundary testing, prove reliability

"You've had so many people let you down, let's work out what we both can agree on about how we will work together."

Fawn: compliant, pleasing, burdened and submissive

"Your mum could get really angry if you didn't do what she said. What do you think about experimenting with me, saying no to something I suggest?" (make it fun)

Freeze parts: Don't hurt me

First work with the freeze response – then, *"Something got really stirred up inside then. Do you think we can explore that a little or do you think it's enough for today?"*

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Therapy is relational

- Our brains are constantly rewiring themselves - being reshaped by new relationships.

(Schore & Siegel)

- Therapeutic relationship can assist rewiring brain through co-regulation, attunement, "present moments"

(Hart)

- When the ANS is soothed and settled there is space to make connection with another.
- Shared tasks, conversation, moving toward and away from difficult content, empathy, appropriate use of humour and fun

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Collaborative approach that ....

has **less focus on attachment** with its capacity for re-enactments, Brown, Elliot, 2016

and triggering of '**attach**' and '**fight**' parts. Fisher, 2017

Moments of meeting: client and therapist engage in shared activities ***'synchronized regulation'.***

Louis Sandler, 1950's

Bring **arousal up but not overstimulated** and then bring **arousal down with calming activities**. Co-regulation teaches the client to learn how to self regulate.

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

- Inner landscape:
  "can you show me what it looks 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

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Shame-filled parts

- I am inherently bad
- Rendered powerless
- What was done to the person
- What they did to survive
- Blamed by other parts
- Avoidance of anger and grief

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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.

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Grief filled parts

- What happened
- What didn't happen
- What has been lost in the past
- What may never be able to be
- Abandonment
- Avoidance of rage and anger

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Developing internal 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

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Developing M & M (mentalisation & mindfulness)

Mentalization: see ourselves as others see us and others as they see themselves *(can't if in survival mode)*

Mindfulness: paying attention to present moment *(counter-intuitive)*

Becoming curious about internal experience, thoughts, feelings and sensations

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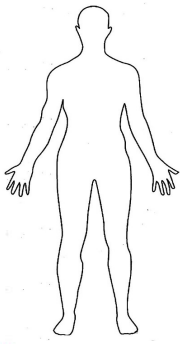
Trauma can be held in the body and lead to dysfunction in the nervous symptom, and manifest as physical symptoms. **Somatic Experiencing** (Levine, 1997) correlates this to being stuck in the fear response.

"Trauma is not what Happens to you. Trauma is what happens inside you as a result of what happens to you." Gabor Maté, 2021



- Notice posture and movements
- Change posture – how does it feel?
- Yoga, Pilates, martial arts, swimming, massage

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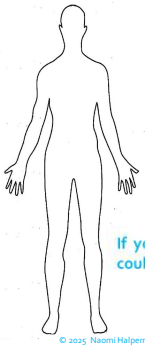
Communication through the body

headache
flushing
fatigue
palpitations
constipation
sore hips
aching feet



sore neck
hyperventilation
sore back
diarrhea

If your sore neck, headache, sick feeling could talk – what would it want to say?

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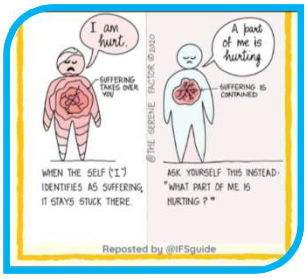
Parts Supporting Parts: Curiosity



Who inside knows something about this?

Who can help with this?

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Move toward and away

Pacing

Don't get caught in the narrative!

Reframe resistance as communication

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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

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Don't be frightened to try new things

"Anyone who has never made mistakes has never tried anything new!"

Albert Einstein

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Common dissociative experiences in children and adults

DSM-5-R Dissociative Disorders

- **Dissociative amnesia**
- **Depersonalisation-Derealisation disorder**
- **Dissociative Identity Disorder**
- **Other Specified Dissociative Disorder**

- ❖ gaps in memory
- ❖ finding self in a strange place without knowing how you got there
- ❖ out-of-body experiences
- ❖ loss of feeling in parts of your body
- ❖ distorted view of your body *
- ❖ forgetting important personal information (that you would be expected to remember)
- ❖ being unable to recognise your image in the mirror
- ❖ detachment from your emotions
- ❖ impression of watching yourself as if in a film
- ❖ feeling unreal
- ❖ hearing voices and dialogue (inside or outside your head)
- ❖ feeling detached from the world
- ❖ forgetting appointments (adults and older teens)
- ❖ feeling that a known environment is unfamiliar
- ❖ sense that what is happening is unreal

- ❖ forgetting a talent or learned skill
- ❖ sense that people known to you are strangers
- ❖ perception of objects changing shape, colour or size
- ❖ feeling you don't know who you are
- ❖ being told your behaviour is out of character (and not remembering it)
- ❖ behaving in a manner not congruent with your age e.g. speech, understanding, mannerisms or skills or behaviour
- ❖ showing opposite gender characteristics in how you behave *
- ❖ being unsure of (age appropriate) boundaries between yourself and others
- ❖ feeling like a stranger to yourself
- ❖ being confused about sexuality or gender *
- ❖ feeling like there are different people inside
- ❖ confused about pronouns e.g. referring to self as 'we' / 'they' instead of 'I' / 'me' *
- ❖ finding items in your possession that don't remember buying or receiving
- ❖ having different styles of handwriting
- ❖ having knowledge of a subject but you don't recall studying

*Points marked with * **may not be related to dissociation**. Any of the listed experiences need to be ruled out as **not due to alcohol / substance use, head injury or illness** that may produce any of these symptoms or behaviours.*

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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: No-one ever said it helps before - but it does! 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. It helps but it also makes me feel out of control. And I'm ashamed of all the scars.

I have to keep my arms covered.

Therapist: So it both helps and is a problem? What do you think is 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 so ashamed about it. I feel judged and like I must be crazy.

Therapist: I'm not judging you and I don't think you're crazy. You do it helps because in the moment it helps with how you're feeling. I'm curious to understand a bit more about it. 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.

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

DISSOCIATED EMOTIONS						
Somatic Complaints	**Internalize**	**Stuck in Past Ungrounded Extreme**	**Present Grounded Fluid Balanced**	**Stuck in Past Ungrounded Extreme**	**Externalize**	**Actions & Behaviours**
Aches/pains		Numb	Anger	Rage		Alcohol/drugs
Headaches		Numb	Cautious	Paranoia		Hurt Self / Other
Nausea		Numb	Hurt	Despair		Suicidal ideation
Dizziness		Numb	Vulnerable	Helpless		Panic attacks
Stomach aches		Numb	Sad	Depression		Eating Disorders
Irritable bowel		Numb	Happy	Mania		Psychosis
Pseudo seizures						
Self protection through avoiding conflict and internalizing					**Self protection through avoiding conflict and externalizing**	

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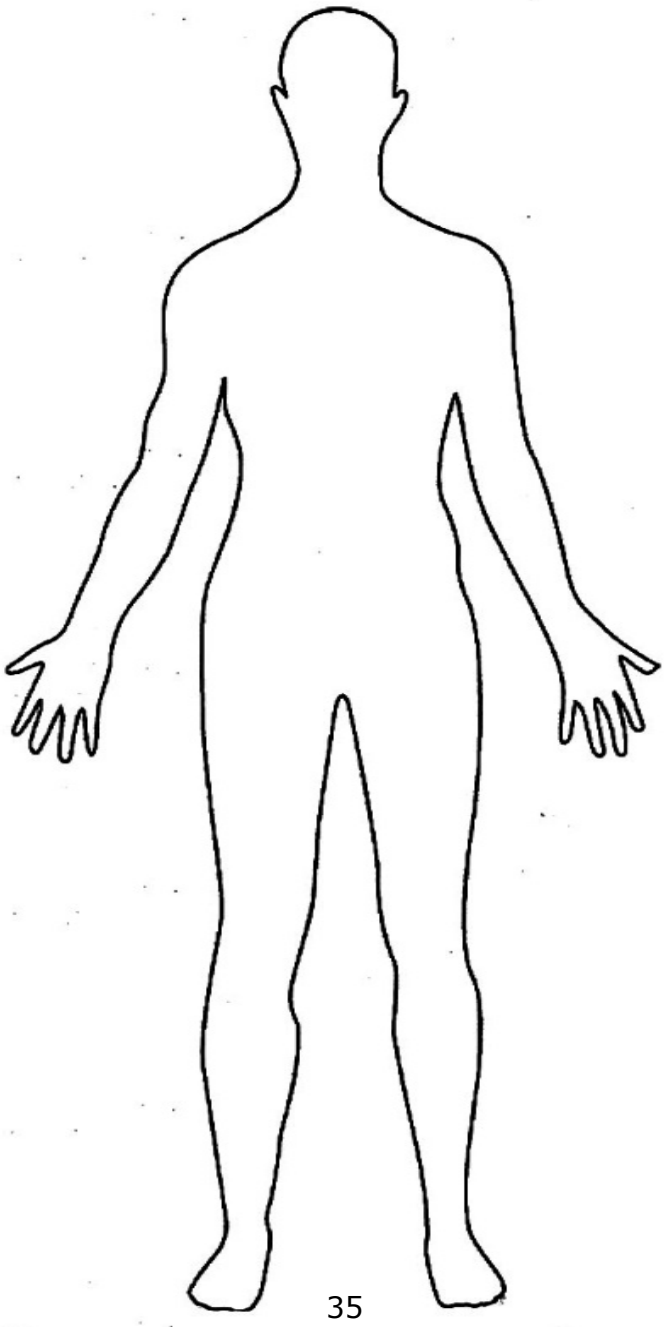
Aches/Pains						
Headaches		**Numb**	**Afraid/Fear**	**Panic/Terror**		Alcohol/drugs
Nausea		**Numb**	**Frustration**	**Overwhelmed**		Hurt Self /Other
Dizziness		**Numb**	**Concern**	**Anxiety**		Suicidal ideation
Stomach aches		**Numb**	**Conflicted**	**Confused**		Panic attacks
Irritable bowel		**Numb**	**Remorse**	**Shame of Self**		Eating disorders
Pseudo seizures		**Numb**	**Rejected**	**Abandoned**		Psychosis
Self protection through avoiding conflict and internalizing					**Self protection through avoiding conflict and externalizing**	

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

Let your body do the talking

Sometimes our emotions and memories can be stored and held in the body and expressed through physical symptoms. Scan your body in your mind and listen to what it may be communicating to you. Do you notice a sensation, symptom or feeling in a particular part of your body? Pay attention and be curious. Use colour or symbols to let your body do the talking.



Reflection: _____

Roleplay Guidelines

In-person workshop: Pair-up with another participant

Live online workshop: You will be randomly placed in a breakout room

Each pair will have an opportunity to play client and therapist.

The role plays will be for **15 minutes** each which will include the client briefing the therapist about the issue – the roleplay – each participant offering feedback and debriefing.

Client: Choose a client or a composite of clients / issues you would like to roleplay. Give your therapist a summary of the client and issue/s e.g. age – gender – how long you have been working with the client - brief outline of issue you will roleplay.

Get into the role. The roleplay does not have to end with the issue having progressed or being resolved!

Therapist: From the outline you have been provided, choose an approach to work with the issue presented taking into consideration where the client is at right now, what has previously been tried (successfully or unsuccessfully), ***What works for whom and when?.***

Psychoeducation: (remember, we need to go over these principles many times). Ask the client what they understand about their thoughts, feelings, experiences, behaviour etc. Depending on the client's age, cognitive capacity and emotional state at the time, offer a trauma informed explanation, reframing any misunderstandings or cognitive distortions.

Talking through to parts: Ask if there is a part inside who knows something about this issue, has a different perspective, can assist in some way? Encourage parts to talk to each other. If parts are unreasonable to each other, gently challenge this behaviour without taking sides, ***"I'm just wondering right now, how does it feel for you X when Y speaks to you in that way?"***

"Y can you help X understand why you're speaking like that and what you need right now?"

What if Cascade: Present a hypothetical to your client. ***"What if"*** they just stopped behaving in the way they do when they are feeling overwhelmed / triggered (cut, binge eat, use substances, seek sex etc.) Explore what would happen if any alternative behaviour that may also 'help' but be harmful is taken off the table, until the underlying fear or concern is revealed.

Regulating the sympathetic or parasympathetic nervous system: Join with the client to assist in regulating the ANS using strategies for hyper or hypo arousal, seeking feedback from the client, ***"Do you feel any different?" "Are you feeling better or worse?"***

Artwork: Invite the client to draw ***'something'*** about the issue they are struggling with – or something to show what it looks / feels like inside. If the roleplay is online, ask the client if they can show you their picture on the screen. Ask, ***"can you tell me 'something' about what you have drawn."*** Notice the client's posture, facial expressions, breathing while they are drawing. Explore the feedback the client gives about their drawing.

Let the body do the talking: As your client talks about the issue troubling them, notice their posture, facial expressions, breathing. Invite the client to be curious about what they notice / don't notice about their body. Invite the client to change their posture – move it in and out of postures, ***"I noticed when you were talking about your mum your body slumped a little in the chair – did you notice that?"***

"What do you notice when you change the way you hold your head / shoulders etc.? Does it feel better or worse?"

OR if the client is experiencing a pain or sensation, invite that part of the body to talk, ***"I know it might sound a little unusual but what if we imagine your neck / stomach / genitals could talk, what would they like to say right now – what do they need you to know?"***

Remember: The purpose of the roleplay is **not to try and resolve the issue** but to **experiment** with an approach, explore how that approach **felt for the client** and **for you**. What did you learn or understand more about this way of working?

Email: events@delphicentre.com.au
Visit: https://delphicentre.com.au/

Complex Trauma and Dissociation Recommended Reading

Anderson, F. (2021) Transcending Trauma: Healing Complex PTSD with Internal Family Systems Therapy, PESI

Arden, J.B., (2015) Brain 2 Brain: Enacting Client Change Through the Persuasive Power of Neuroscience, Wiley

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