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National Centre of Excellence
for Complex Trauma

Practice Guidelines for Clinical Treatment of Complex Trauma

BLUE KNOT FOUNDATION

Dr Cathy Kezelman AM
Pam Stavropoulos PhD

empowering recovery from complex trauma

Practice Guidelines for Clinical Treatment of Complex Trauma

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Blue Knot Foundation 2019 *Practice Guidelines for Clinical
Treatment of Complex Trauma: Authors Kezelman C.A &
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www.blueknot.org.au

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AUDIENCE: These guidelines are intended for *clinicians* (i.e. counsellors, psychologists, mental health social workers and other mental health professionals) who work in one-to-one therapeutic contexts with clients/patients who experience the impacts of complex trauma. This includes therapists who specialise in this work as well as those who see complex trauma clients as part of their general work.

Disclaimer

This document is a general guide to appropriate practice. The guidelines are designed to provide information to assist decision-making and are based on the best available evidence at the time of development of this publication.

It is a privilege to endorse these guidelines, which are ground-breaking in addressing the major public health problem of childhood/interpersonal abuse and its long-term impact on the health and welfare of the survivors. These guidelines are the foundation of not only trauma-informed care and treatment, but address the vital issue of prevention. These are complex issues, which all of us in mental health, institutions, and societal/political systems need to address. The guidelines show us the way!

Joan A. Turkus, M.D.

Medical Director, TraumaSci: Complex Trauma Disorders Program

Dominion/HCA Hospital, Falls Church, VA, USA

Past President and Lifetime Achievement Award

International Society for the Study of Trauma and Dissociation

The Board of Directors of the International Society for the Study of Trauma and Dissociation is pleased to endorse Blue Knot's *Practice Guidelines for Clinical Treatment of Complex Trauma*. Blue Knot has provided the complex trauma field with an invaluable and accessible resource that synthesizes the rapidly expanding evidence base for the efficacious treatment of trauma and dissociation.

International Society for the Study of Trauma and Dissociation (ISSTD)
Washington, DC

Blue Knot's Practice Guidelines for the Clinical Treatment of Complex Trauma is a truly remarkable and sorely needed document. In concise, clear language it accurately summarizes the now considerable and empirically supported literature on complex trauma, dissociation, and their treatment. It is a sad and poignant irony that countless people around the world struggle to overcome the impact of complex trauma but are denied effective therapy because so few mental health professionals are familiar with this staggeringly prevalent phenomenon. Hopefully these guidelines will garner sufficient attention to make complex trauma more visible across the helping professions.

Steven N. Gold, PhD

Director, Trauma Resolution & Integration Program (TRIP)

Professor, Center for Psychological Studies

Nova Southeastern University

Editor, *APA Handbook of Trauma Psychology* (American Psychological Association)

Author, *Not Trauma Alone* (Routledge)

Blue Knot has done a masterful job of presenting treatment approaches for individuals who suffer from the enduring impact of complex trauma. These updated treatment guidelines recognize that randomized controlled trials (RCT) should not be the only source of evidence about treating traumatized individuals. While information gleaned from RCTs is crucial, RCT studies typically exclude the most severely traumatized and symptomatic clients, which means that the mental health field needs additional guidance to successfully treat the most complex trauma reactions. Thankfully, Blue Knot has taken the international lead in providing such guidance. Clinicians, clients, and researchers should read these guidelines!

Bethany Brand, Ph.D.

Professor of Psychology and Director, Clinical Focus Program

Towson University, USA

Treatment of Patients with Dissociative Disorders (TOP DD) Studies

As evidenced by these revised and updated guidelines, Australia has taken an international leadership role in developing clinical guidance for the treatment of complex trauma. The authors have consolidated a vast amount of research and clinical literature to arrive at an updated and state-of-the art treatment formulation. Significantly, this document does not stop with those treatments that carry the evidence-based designation but extends beyond them to consider other approaches and strategies for the myriad of developmental aftereffects that make up complex traumatic stress disorders. It places particular emphasis on dissociation as a process by which repeatedly traumatized children and adults protect themselves, a process that needs recognition and attention. Other recommended approaches include an emphasis on the body-mind and the use of treatments long considered complimentary (and alternative) to mainstream talk therapy. In line with recent research findings from the neurosciences and attachment studies, the case is made here to offer treatment that is holistic and oriented towards the client's identity development, self-management, relationship ability, and other life skills, and an emphasis on life quality rather than only on the trauma. This model emphasizes the necessity for individualized assessment and treatment formulation, with interventions offered sequentially across three main phases. I repeat what I wrote in my endorsement of the earlier guideline: "This document is a singular and pioneering achievement in its depth and scope... Bravo to all involved in its development!"

Christine A. Courtois, PhD, ABPP

Licensed Psychologist, Private Practice, Washington, DC (retired)

Consultant and Trainer, Trauma Psychology and Treatment, Bethany Beach, DE

Chair, American Psychological Association Clinical Practice Guidelines for the Treatment of PTSD in Adults.

Co-Chair, International Society for Traumatic Stress Studies Complex Trauma Task Force.

Chair, Joint Complex Trauma Treatment Guidelines Committee, Division 56 (Psychological Trauma), American Psychological Association and the International Society for the Study of Trauma and Dissociation

Author: *Healing the Incest Wound: Adult survivors in therapy* (revised edition)

Recollections of Sexual Abuse: Treatment Principles and Guidelines

Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide (co-edited with Julian Ford, PhD; revised and updated version forthcoming)

The Treatment of Complex Trauma: A Sequenced, Relationship-based Approach (co-authored with Julian Ford)

Treating Complex Traumatic Stress Disorder in Children and Adolescents (co-edited with Julian Ford)

My deepest congratulations and thanks to Blue Knot for your inspirational guidelines. They are an Esperanto that brings honour to Australia and hope to survivors and clinicians all over the world.

Dr Valerie Sinason PhD MACP MInstPsychoanal

Consultant Child Psychotherapist Psychoanalyst

Founder and former Director, Clinic for Dissociative Studies UK

I am delighted to endorse these practice guidelines, which will be a milestone in readable and usable heuristics for those clinicians discovering these helpful Blue Knot recommendations. They are balanced with traditional wisdom and leading edge findings. They draw on the collective creations of many contributors in the field, recent and past. Importantly, they avoid the usual stodgy feeling of academic texts in favor of something approachable, engaging and digestible.

Sandra Paulsen, Ph.D.

Paulsen Integrative Psychology, Bainbridge Island WA, USA

Fellow, International Society for Study of Trauma and Dissociation

Co-Author *Neurobiology and Treatment of Traumatic Dissociation: Toward an Embodied Self*

Author, *Looking Through the Eyes of Trauma & Dissociation: An Illustrated Guide for EMDR Therapists and Clients*

Author, *When There Are No Words: Repairing Early Trauma and Neglect from the Attachment Period with EMDR Therapy*

These updated practice guidelines are an extraordinary integrative feat melding clinical wisdom with cutting edge neuroscience inside a thoughtful and well-crafted psychotherapeutic frame. It's actually a pleasure to read and soak in. Unusual in its breadth and depth it will provide a lovely guide for doing quality work informed by the best standards of practice we have to offer our patients. Bravo!

Richard A. Chefetz, M.D., Private Practice

Institute of Contemporary Psychotherapy & Psychoanalysis
Washington, D.C.

*I am honored and privileged to endorse the 2019 'Practice Guidelines for the Treatment of Complex Trauma.' Distinctly different from the quasi-manualization found in many Guidelines, these address the therapist's **existence** in a complex human relationship in which the patient's traumatization began in early childhood, as well as addressing the specifics of **what to do** as a therapist that characterizes both the humanity and the unique complexity of the therapy itself.*

Philip M. Bromberg, Ph.D.

Faculty, Training and Supervising Analyst: William Alanson White Institute, NYC
Adjunct Clinical Professor of Psychology: New York University Postdoctoral Program in
Psychotherapy and Psychoanalysis

Author: *Standing in the Spaces: Essays on Clinical Process, Trauma, and Dissociation* (Routledge, 1998);
Awakening the Dreamer: Clinical Journeys (Routledge, 2006);

The Shadow of the Tsunami: and the Growth of the Relational Mind (Routledge, 2011)

With its updated clinical guidelines, the Blue Knot Foundation continues to display national and international leadership in the promotion of effective and compassionate care for survivors of complex trauma. The guidelines have synthesised a tremendous amount of research and clinical literature into an accessible resource that will drive this field of practice forward for years to come.

Michael Salter, PhD

Associate Professor

Scientia Fellow and Associate Professor of Criminology, University of New South Wales

Board of Directors, International Society for the Study of Trauma and Dissociation

Any clinician involved in the treatment of individuals who suffered from severe childhood adversities might be interested in reading these guidelines. In fact, these guidelines represent a wise and rare combination of clinical wisdom and erudite knowledge on the origins and treatment of complex trauma, and they might be of great help for clinicians who deal with the effects of child abuse, neglect and failures of care on the mind, body, and relationships of their clients.

Prof. Adriano Schimmenti, DCLinPsych

Full Professor of Psychodynamic Psychotherapy, UKE – Kore University of Enna (Italy);

Deputy Director, SIPDC – Italian Society of Psychological Assessment;

Research Director, IIPP – Italian Institute of Psychoanalytic Psychotherapy.

This publication is a major achievement by the Blue Knot Foundation who, with their earlier 2012 guidelines, have already had an important influence on Mental Health Care in Australia. It is a practical guide that will be widely used and has great potential for humanizing mental health care through the recognition of trauma that is so often behind clinical presentations. Blue Knot give an effective voice to all those who have suffered as a result of trauma. They point towards healing possibilities for individuals, with many paths to recovery. It will give hope to many and stimulate further research in the field. It has an implied vision of a more humane society.

Dr Anthony Korner

Director, Westmead Psychotherapy Program
Master of Medicine / Science in Medicine
University of Sydney

The 2019 Practice Guidelines for the Treatment of Complex Trauma is the result of extensive and painstaking revision of the earlier guidelines, combined with new learning to make these guidelines comprehensive, easy to follow, and most importantly to convey through the use of language, the complexities of trauma and its effects on human existence. It has achieved all of these and thoughtfully reminds those working in the field, that establishing relatedness through developing a shared understanding of the humanity of the sufferer, is the first step towards healing. Thank you for providing us with these very helpful guidelines.

Joan Haliburn

Consultant child and adolescent psychiatrist and psychotherapist Consultant
Complex Trauma Unit, University of Sydney, Australia

Updated treatment guidelines have been sorely needed for contemporary practice. This requires not only an understanding of the latest research, but also compassion for the survivor community and comprehension of its rights as a culture. Rather than being a managed care manual, these guidelines are more appropriately a description of the relational process between survivors with complex trauma and those who treat them. Survivors are empowered through attunement that heals shame, connection that resolves isolation, and competency that focuses on their adaptive skills and strengths used to endure so much already and maintain functioning both prior to and during treatment. This approach respects the survivor as they are, and focuses instead on what the clinician can do to support, assist, and join with the survivor in both defining and creating their own experience of healing – rather than previous models which labeled the client and therapeutically objectified them as someone who needed fixing. These new guidelines are both powerful and empowering, while offering hope for a new era in treatment.

Emily Christensen, PhD, LCPC

Survivor and Clinician

System Speak: A Podcast about Dissociative Identity Disorder

The Blue Knot Practice Guidelines aren't just treatment guidelines. They acknowledge that our institutions—families, churches, schools, coaching and scouting programs—enable child molesters. As we've seen, these institutions typically respond to abuse reports by assuring us they are what we trust them to be—places where child molesters cannot gain access to our children. If a child molester has already gained access to children, the institution promises it has already taken measures to ensure this will never happen again. I see this acknowledgement of the role played by institutions in tolerating child molesters as a huge step forward! Thank you!

Lynn Crook

'Deconstructing the Lost in the Mall study' (2019)

As a trauma-focused youth work team the guidelines validate how we help young people. They also lead us in sharpening our practice and identify areas that we need to work upon. We were excited to see the significant emphasis on dissociation in the updated guidelines as that reflects what we are seeing amongst young people... as an adventure therapy organisation, the guidelines suit group work and ecological dynamics practice. The Guidelines are not just for clinicians – Youth Workers use them too!

Graham Pringle, PhD Candidate, MA (Outdoor Education)

BA, GDip Soc Sci (Psych), Dip Ed, CIV Adventure Based Youth Work

Chair, Youth Flourish Outdoors

I was very pleased to endorse the 2012 Guidelines published by (then ASCA) the Blue Knot Foundation as the groundbreaking endeavor they represented. At that time, I was the clinical supervisor at a rape crisis agency, and the Guidelines accurately represented and validated the work we had been doing for decades with severely traumatized clients. I am now in private practice and consultation, and it is my further privilege to enthusiastically endorse the Foundation's 2019 updated Guidelines, which reflect the momentous changes in the visibility of complex trauma and its sequelae. Clinicians around the world are faced with ever-increasing caseloads of individuals coming forward in the wake of the #MeToo movement, and the accountability to which public figures are now being held relative to charges of sexual abuse. The new Guidelines are a comprehensive resource that I will use in my consultation work with other therapists who are learning about trauma and dissociation. It is my hope that this unique set of guidelines, acknowledging the interweave of trauma and dissociation, will be adopted worldwide.

Nancy Fair, PhD
Pittsburgh, PA

As an international clinician who works with pregnant moms and at risk multicultural families in Southern California, USA, I would like to endorse your new written guidelines....I am honored to be able to support such grand and complex work. Thank you for all you and your organization do for Australia and those suffering around the globe!

Rosita Cortizo, Psy.D, LMFT, MA
EMDRIA Certified & Approved EMDR Consultant
Pre-Perinatal High Risk Psychologist
Equine Assisted Psychotherapy Certified
Panama, Pma / San Diego, CA

The Blue Knot Guidelines is a masterpiece document that lays a firm foundation in describing complex trauma and dissociation, and an analysis of research and efficacy of a variety of treatment approaches for those with complex trauma. These guidelines advance the field in providing a comprehensive and integrative approach to treating dissociation.

Frances S. Waters, DCSW, LMSW, LMFT

Past President of International Society for the Study of Trauma and Dissociation

Author, *Healing the Fractured Child: Diagnosing and Treating Youth with Dissociation*

The Practice Guidelines for Clinical Treatment of Complex Trauma by Blue Knot Foundation generates hope in me that a new era of healing has truly dawned, where the focus is on fine-tuning clinician's skills, while embracing the knowledge, research and wisdom from various treatment approaches and healing systems of the world into the care.

Adithy, Counseling Psychologist

Pune, India



Contents

Foreword	14
Acknowledgements	16
Blue Knot Foundation	17
Executive Summary	19
Introduction: <i>Where are we now in understanding, treatment, and service responses to complex trauma?</i>	21
Summary of key developments since publication of the 2012 <i>Guidelines</i>	25
<hr/>	
PART I GUIDELINES	33
<i>Practice Guidelines for Clinical Treatment of Complex Trauma</i>	34
<hr/>	
PART 2 RESEARCH BASE	55
Contents of Part 2	56
Summary of Key Research Themes	60
1. Understanding Complex Trauma and the Implications for Treatment	80
2. What is Dissociation and Why do we Need to Know about It?	101
3. Revisiting Phased Treatment for Complex Trauma	121
4. 'New' and Emerging Treatments	140
5. 'Evidence-based': the challenge of and for complex trauma	177
<hr/>	
REFERENCES	197
<hr/>	
APPENDICES	229
1. Resources	230
2. Self-care for therapists who work with complex trauma	233
<hr/>	
GLOSSARY	237



Foreword by Professor Warwick Middleton

The Blue Knot Foundation, its President, Dr Cathy Kezelman AM and its Head of Research, Dr Pam Stavropoulos, are to be highly commended for their vision and the enormous amount of hard work that has resulted in this excellent, relevant, and readily accessible set of *Practice Guidelines For Clinical Treatment Of Complex Trauma*. The Blue Knot Foundation has for years been at the forefront of initiatives in Australia on behalf of those who were abused as children, and/or experienced different forms of repeated interpersonal trauma.

When Dr Kezelman and Dr Stavropoulos in 2012 produced “*The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*”, nothing like it had been published anywhere in the world. The International Society for the Study of Trauma and Dissociation (ISSTD), which is the world’s oldest international trauma society, was so impressed with it, that for the first time in its history it endorsed a set of treatment guidelines that had been written by another organisation.

A lot has happened in the seven years between the first set of Blue Knot treatment guidelines for complex trauma and this up-to-date offering. In November 2012, then Australian Prime Minister, Julia Gillard announced the establishment of a national Royal Commission into Institutional Responses to Child Sexual Abuse. On 15th December 2017, the Hon Justice Peter McClellan AM, head of the Royal Commission handed over his final report to Sir Peter Cosgrove, the Australian governor general. The inquiry ran for five years and it held 444 days of public hearings. It conducted private sessions with nearly 8,000 witnesses and it heard evidence relating to 3,489 institutions. The six commissioners who had started out were all there at the end. In reality the world had never seen anything quite like it.

There have been multiple other attempts at inquiries into institutions and their abuses of children and/or their failure to protect children from abusers. Some inquiries never start out with credible leaders, others have poorly formulated terms of reference, or lack a clear plan on how to deliver findings in a timely fashion. Some give little emphasis to prosecuting anyone or have a succession of leaders, or meander on for years, as they lose the confidence of victims that they can deliver meaningful outcomes. This Australian Royal Commission succeeded because it maintained an unwavering central focus on victims. It treated them with total respect and it emphasised their dignity.

On the day the Commission’s findings were delivered, journalist David Marr, writing for *The Guardian*, observed, “The royal commission was one of those rare things in Australia: an idea we didn’t fudge. It was executed beautifully. It never lost its overwhelming public backing. Somehow it managed to traverse extraordinarily difficult terrain with little – not none, but the minimum controversy.

In 2012 when Blue Knot wrote their first set of guidelines, we may not have seriously contemplated that seven years later we would have a world in which a senior Australian Catholic cardinal was serving jail time, having been convicted of sexually abusing minors, that an organic phenomena, the #MeToo movement would be redistributing shame to the abusers on a large scale, that an enormous number of individuals would have been exposed as leading double lives, and that multiple community institutions from mainstream churches to the Boy Scouts, were experiencing a loss of faith in their leadership. This was directly related to their demonstrated inability to protect children from the many abusers who had sheltered within them. As confronting as the findings of the Australian Royal Commission were, no one was under any illusions that an even bigger source of childhood abuse is the family.

Blue Knot and the ISSTD have been strong supporters of the Australian Royal Commission, and are aware of how very frequently it met individuals who carried the symptomatology that characterises complex trauma. Royal commissioners on many occasions saw firsthand the dissociative switching and amnesias that have their origins in childhood abuses.

The Royal Commission represented a coming of age in respect to the validation of severe childhood abuse. In a sense it was book-ended by two Blue Knot Guidelines concerning complex trauma. This 2019 version has much more focussed information on dissociation and on Dissociative Identity Disorder than the original. It integrates much that has been added to the literature in the past seven years. It will be an influential document in the field of complex trauma and dissociative disorders.

Professor Warwick Middleton MB BS, FRANZCP, MD

Past President, ISSTD

Director, Trauma & Dissociation Unit, Belmont Hospital

Chair, the Cannan Institute



Acknowledgements

Special thanks to Dr Sylvia Solinski MB, BS, MPM, FRANZCP, consultant psychiatrist in private practice, Melbourne, and Prof Martin Dorahy DClínPsych, PhD, School of Psychology, Speech and Hearing, University of Canterbury, Christchurch, New Zealand, who provided feedback on the whole manuscript. Also to Assoc. Prof. Loyola McLean, Consultation-Liaison Psychiatrist, Psychotherapist and Psychotherapy Educator, Brain and Mind Centre, Discipline of Psychiatry, Faculty of Medicine and Health, The University of Sydney; Sydney West and Greater Southern Psychiatry Training Network and Westmead Psychotherapy Program for Complex Traumatic Disorders, WSLHD, who gave comments.

Prof. Warwick Middleton MB, BS, FRANZCP, MD, Past President, International Society for the Study of Trauma and Dissociation, Director, Trauma and Dissociation Unit, Belmont Hospital, Chair of the Cannan Institute, Brisbane, has been generous in his support and advice as always. We are grateful to the many people who provided direct and indirect support which has assisted the preparation of these guidelines.



Blue Knot Foundation

Blue Knot Foundation is the Australian National Centre of Excellence for Complex Trauma. It empowers recovery and builds resilience for the more than five million (1 in 4) adult Australians with a lived experience of complex trauma. This includes those experiencing repeated ongoing interpersonal trauma and abuse, often from childhood, as an adult, or both as well as their families and communities.

Formed in 1995, Blue Knot Foundation provides a range of services. These include:

- specialist trauma phone counselling, information, support and referrals including around redress
- educational workshops for survivors and their family members, partners and loved ones
- professional development training for workers, professionals and organisations from diverse sectors
- group supervision
- consultancy
- resources including fact sheets, videos and website information at www.blueknot.org.au
- advocacy
- research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it.

In 2012, Blue Knot Foundation released *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* www.blueknot.org.au/guidelines. These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice. In 2015, Blue Knot Foundation released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by *Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts*, and in 2018 the paper *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance of Trauma* was launched and released. In 2018-19 Blue Knot Foundation released its *Talking about Trauma* series.

In 2019-20 Blue Knot Foundation will additionally release:

- An additional publication on trauma-related dissociation
- Two complementary sets of guidelines in a single publication
 - Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches
 - Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation
- Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma

For more information, visit www.blueknot.org.au. If you need help, information, support or referral, call Blue Knot Helpline on 1300 657 380 or email helpline@blueknot.org.au between 9am-5pm Monday to Sunday AEST/ADST.



Executive Summary

The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery were published by Blue Knot Foundation (then ASCA) in 2012. They elaborated and recommended embedding the core components of effective complex trauma treatment into all psychotherapeutic modalities. This recommendation stands and will remain valid into the future.

Prior to the 2012 *Practice Guidelines*, there were almost no guidelines for the treatment of complex trauma. A notable exception was the pioneering work of Christine Courtois;¹ trauma guidelines were addressed to treating 'single-incident' Post-Traumatic Stress Disorder (PTSD). The *Practice Guidelines* - and the *ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*² published in the same year - rectified that anomaly.

Evolving research and clinical insights, as well as the continuing challenges of treating the multifaceted syndrome described as 'complex' trauma, mean that the original 2012 Blue Knot guidelines require updating. The following updated and expanded clinical guidelines include substantial additions to the underpinning research base in a number of areas:

- the nature of complex trauma
- dissociation and the related clinical challenges
- phased therapy in the context of current debates
- 'new' and emerging treatment approaches
- issues with respect to 'evidence-based' treatment

Now more than ever it is important for clinicians to be aware of ways to assist complex trauma treatment. A wealth of relevant and potentially valuable material is now available. But the diversity of this material, and the diversity of forums and formats in which it appears, means that it can be hard for clinicians to navigate. The updated *Practice Guidelines* provide a means of doing so.

As in the first edition, Part 1 presents the actual guidelines, and Part 2 comprises the research chapters – all of them new - on which the guidelines are based. To further assist clinicians who work in the challenging terrain of complex trauma and dissociation, additional sets of guidelines and publications are also being released.³

Dr Cathy Kezelman AM
President

-
- 1 Christine A. Courtois, *Recollections of Sexual Abuse: Treatment, Principles and Guidelines* (Norton, New York, 1999); *Healing the Incest Wound* (Norton, New York, 2010); also see Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', ch.3 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders* (The Guilford Press, New York, 2009, pp.82-103) the Foreword for which is by psychiatrist, researcher and author Judith Herman who spearheaded recognition of the nature and impacts of complex trauma.
 - 2 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* (2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf
 - 3 These include *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*, *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* (i.e. two complementary sets of recommendations in a single publication), *Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma*, and an additional publication on trauma-related dissociation.



Introduction

Where are we now in understanding, treatment, and service responses to complex trauma?

In 2012, Blue Knot Foundation (then ASCA) released *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. These guidelines were hailed as a significant contribution to both the effective clinical treatment of complex trauma and a trauma-informed approach to service delivery for people with past and current traumas.⁴

The 2012 *Practice Guidelines* were widely acclaimed and extensively endorsed nationally and internationally.⁵ In October 2012 they were launched at Parliament House in Canberra by the then Federal Minister for Health. The peak international body, the International Society for the Study of Trauma and Dissociation (ISSTD) endorsed them unanimously and they were presented by invitation at the 29th Annual ISSTD Conference in Long Beach, California. In 2014 the Royal Australian College of General Practitioners (RACGP) adopted them as an 'Accepted clinical resource'.

At the time of publication of the following updated (2019) guidelines, the first edition has been downloaded over 25,000 times and purchased by many. Extensive, ongoing referencing and acknowledgement of them shows the deep need for enhanced recognition of, and informed clinical and non-clinical responses to, the large numbers of people impacted by complex trauma.

Survivors, clinicians and researchers welcomed the integrationist approach of the 2012 guidelines. We received many endorsements from complex trauma survivors including the following:

'As a complex trauma patient, who has had a long involvement with the Australian mental health system, I am all too aware of its shortcomings and pitfalls that specifically affect someone with my condition at so many professional and institutional levels... I fully endorse the guidelines and hope that they are put into place to help so many other people, both the consumers and the professionals as well as the country.'

Tamara Stillwell, Foreword to *Practice Guidelines...*, 2012, *ibid*.

The 2012 Guidelines collated and distilled current research insights from diverse relevant fields. International trauma expert Janina Fisher praised their integration of '*neuroscience, social policy, and a therapeutic understanding of trauma*'.⁶ So, too, did other expert complex trauma clinicians and researchers, as the following endorsements attest: '*A wonderful summation of the important insights that have emerged from neuroscience and psychotherapy*', '*comprehensive*', '*thorough, grounded in the latest knowledge of the field of trauma, complex trauma, and dissociation*', and '*a marvellous resource*'.⁷

4 'The world map on countries that provide understanding and treatment for the most traumatised people with dissociative disorders has now expanded as Australia rigorously, compassionately and robustly provides us with clinical guidelines' (Dr Valerie Sinason, PhD, MACP, Minst Psychoanal, FIPD Director, Clinic for Dissociative Studies, London). See endorsements cited in *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Blue Knot Foundation (then ASCA): 2012).

5 An ISSTD director, Lynette S. Danylchuk, PhD, regarded the Guidelines as 'stunningly well done' and was 'honoured to endorse' them. The following endorsement is also noteworthy: 'Each time any of us takes a significant step, the field benefits, and your step is remarkable' (Adah Sachs, Psychoanalytic Psychotherapist, Consultant Psychotherapist Forensic Clinical Lead Clinic for Dissociative Studies, London); all endorsements cited in *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, *ibid*.

6 Accompanying published endorsement around the release of the 2012 Practice Guidelines, *ibid*.

7 Endorsements of *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, *ibid*.

The integration of research insights additionally addressed the contexts of policy and infrastructure:

'This is a very important initiative which is much needed. The morbidity associated with complex trauma is vast and a great burden not only on these sufferers but on the health system. There are, at the moment, only the most inadequate forms of service delivery available to these people. The guidelines approach an urgent health service delivery requirement.'

Professor Russell Meares, Emeritus Professor, Psychiatry, University of Sydney. Endorsement of the *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, *ibid.*

The updated guidelines reflect the continuing and rapidly evolving terrain of research and clinical treatment in relation to complex trauma and dissociation. As more clinicians develop expertise in working with complex trauma clients, it becomes increasingly important to provide credible information about the diverse approaches and interventions available. It is also increasingly clear that '[t]raditional methods employed in psychotherapy have limited effectiveness when it comes to healing the psychological effects of trauma, in particular, complex trauma'.⁸

Integrating diverse treatments

The dissemination of cutting-edge podcasts, transcripts, and interactive learnings means that relevant material in multimedia formats is increasingly accessible.⁹ The 'neurobiology of healing', which once lagged behind interdisciplinary research insights,¹⁰ is catching up. Well-known clinicians and researchers including Dan Siegel, Bessel van der Kolk, Pat Ogden, Janina Fisher, Babette Rothschild, Peter Levine and others now educate a large and increasingly receptive international audience on how to operationalise relevant concepts, strategies and techniques at 'the clinical coalface'.

At the same time, and increasingly in recent years, diverse health professionals from 'outside' the trauma field are contributing intriguing insights, strategies and recommendations: *'More and more therapists, energy workers and body-based psychotherapists are opening themselves to new and different healing modalities that are based in the integration of mind-body-spirit.'*¹¹ This is not an 'either-or' situation. Some respected complex trauma pioneers are receptive to what were previously perceived as 'alternative treatment/s'.¹² Indeed, many experts have become conduits for a range of healing practices traditionally regarded as outside the domain of 'standard' psychotherapies.¹³

8 Lisa Schwarz, Frank Corrigan, et al, citing Corrigan & Hull, 2015, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (Routledge, New York, 2017) and see points made in the Introduction.

9 See, for example, the *Healing Trauma Summit* by Sounds True <https://www.soundstrue.com/store/healing-trauma-summit/free-access-c> and the *Treating Trauma Master Series* by the (US) National Institute for the Clinical Application of Behavioral Medicine (NICABM) <https://www.nicabm.com/program/treating-trauma-master/>

10 The challenge of translating burgeoning research insights into widespread clinical practice is ongoing. See, for example, Marion F. Solomon & Daniel J. Siegel, *Healing Trauma* (Norton, New York, 2003).

11 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*, p.3.

12 The term 'alternative' is relative to an existing status quo. In Western societies 'alternative health treatments' has been over-inclusive and describes a diverse range of 'Eastern' practices.

13 The writings and many publicised comments of Bessel van der Kolk are a case in point; also see subsequent discussion.

While complex trauma clinicians should not necessarily embrace all such practices,¹⁴ neither can they simply ignore them. The possibility of integrating diverse techniques – a process already underway – also requires increased attention.

Expanding access to diverse and potentially valuable treatment approaches has exponentially increased the nature and range of interventions to consider regarding complex trauma treatment.

The revised Blue Knot Guidelines cannot fully address the range of treatment approaches available (as no single set of guidelines could do). Rather they attempt to distil and convey the parameters and variety of the relevant material, and to delineate the current state of a very dynamic field with appropriate qualification where necessary.¹⁵

In considering evolving research and relevant developments since 2012, it is also important to ask what and how much has changed in the interim. For this reason, a summary of key developments since publication of the 2012 Practice Guidelines follows.

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Head of Research

¹⁴ See Chapter 4 for discussion of some of the many issues in relation to this point.

¹⁵ As noted in the Executive Summary, Blue Knot is also releasing two sets of short guidelines under separate cover (*Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*, and *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*) as well as *Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma* and an additional publication on trauma-related dissociation.

'All of us have experienced work with patients we come to view as difficult to treat or, as they are sometimes called, 'treatment resistant'...but that which is difficult often resides not in them, but in us, and in the limitations of our treatments.'

Eric M. Plakun, MD, 'Biopsychodynamic Psychiatry, the Biopsychosocial Model, and the Difficult Patient', *Psychiatric Clinics of North America* (41, 2, 2018), p.237.

'The client labelled 'difficult' is almost always the person who has survived the most difficult experiences.'

Danylchuk & Connors, *Treating Complex Trauma and Dissociation* (Routledge, New York, 2017).

Summary of Key Developments since Publication of the 2012 Practice Guidelines

(1) A formal diagnosis of Complex PTSD

A major development is the announcement that the diagnostic classification of Complex PTSD will be added to the upcoming *International Classification of Diseases* (ICD-11). This has been a long time coming. In 2009, Bessel van der Kolk underlined the anomaly that what is widely called complex trauma officially did 'not exist'.¹⁶ This was despite the 'vast amounts of knowledge' in relation to it, and that it possibly comprised 'the most common set of psychological problems to drive human beings into psychiatric care'.¹⁷

On 18th June 2018, nearly a decade after that statement, the World Health Organisation (WHO) released the ICD-11. For the first time, a diagnosis of Complex PTSD (CPTSD) exists and will come into effect on 1st January 2022.¹⁸

Yet just as '[t]here is more to trauma than PTSD'¹⁹, there is also more to complex trauma than Complex PTSD.²⁰ The breadth of complex trauma requires a sufficiently inclusive diagnosis to fully encapsulate it. Additionally, diagnosis is also only one of several lenses through which to view complex trauma.

In contrast to the ICD-11, the *Diagnostic and Statistical Manual of Mental Disorders* does not yet include the diagnosis of Complex PTSD. The 2013 DSM-5 does, however, include a new 'dissociative subtype' of PTSD. This expands the range of impacts with which PTSD is associated,²¹ thereby acknowledging the need to expand the prior PTSD classification.²² But the current DSM-5 criteria for the diagnosis of PTSD does not recognise the range and depth of impacts of complex trauma.²³ Inclusion of the diagnosis of Complex PTSD in the new ICD-11, on the other hand, makes recognition and more appropriate treatment of Complex PTSD more likely. This is an important advance since the original guidelines were published.

16 Bessel A. van der Kolk, 'Afterword', Christine A. Courtois & Julian D. Ford, *Treating Complex Traumatic Stress Disorders* (The Guilford Press, New York), 2009, p.455.

17 Van der Kolk, 'Afterword', *ibid*.

18 WHO releases new International Classification of Diseases (ICD 11) 18 June 2018 News Release Geneva [http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-\(icd-11\)](http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11))

19 Shapiro, *The Trauma Treatment Handbook* (Norton, New York, 2010), p.11.

20 'Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders...increasingly becomes a risk the more prolonged and severe the traumatic events' (Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors*, Routledge, New York, 2017, p.67).

21 The current 'dissociative' subtype of PTSD in DSM-5 specifically addresses the dimensions of depersonalisation (sense of self-estrangement) and derealisation (perception of the external world as strange or unreal). For more detailed consideration of diagnosis in relation to complex trauma, see Chapter 1.

22 It is ironic that the ICD-11 2013 working group for stress-related mental disorders found sufficient empirical evidence for a Complex PTSD diagnosis (Maercker et al, 2013) and a DSM-IV working group decided that the diagnosis of Complex PTSD should go ahead. See Chapter 1 for more detailed discussion of the diagnostic issues.

23 'To date, the dissociative subtype of PTSD has been defined specifically in relation to symptoms of depersonalization and derealization' (Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (New York: Norton, 2015), p.166.

(2) 'Then and now': the Royal Commission into Institutional Responses to Child Sexual Abuse

Childhood trauma is an insidious variety of complex trauma which comes in many forms. If not resolved, it can impair psychological and physical health in adulthood.²⁴ Child sexual abuse, a form of complex childhood trauma, has long been 'taboo'. Its prevalence has been doubted, denied, and whispered about behind closed doors when acknowledged at all. In November 2012, shortly after the launch of the *Practice Guidelines*, then Prime Minister Julia Gillard announced an Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

This momentous undertaking led to widespread recognition of child sexual abuse and the need for appropriate responses to those affected.²⁵ In 2017, the Commission closed its doors and handed down its final report and wide-ranging recommendations to government.

The 2013-17 Royal Commission systematically and comprehensively exposed *the prevalence of child sexual abuse by and within the full spectrum of mainstream societal institutions*. In so doing, it exploded the myth that the crime of child sexual abuse is perpetrated by 'a few bad apples' or 'errant individuals' in isolation. Rather it is *systemic*; enabled, harboured and overlooked by the very institutions in which the public is expected to trust.

In the early 1990's, American psychiatrist and complex trauma pioneer Judith Herman said that without a political movement, 'it has never been possible to advance the study of psychological trauma.'²⁶ This is because strong alliances are needed to overcome the powerful societal mechanisms which impede discussion of disquieting and incriminating truths. Three times over the past century, Herman contended, 'a particular form of psychological trauma has surfaced into public consciousness' together with a political movement.²⁷ The Australian Royal Commission into Institutional Responses to Child Sexual Abuse arguably represents a fourth such movement.²⁸

In his Foreword to the 2012 Guidelines, Professor Warwick Middleton noted that many reputable studies had long substantiated the negative impacts of childhood trauma.²⁹ The Royal Commission has ensured that denying and minimising the prevalence and devastating impacts of child sexual abuse is no longer tenable. In 2018, the Australian Human Rights Medal for services to the Royal Commission was presented jointly to longstanding Blue Knot Ambassador Chrissie Foster and former Chair of the Royal Commission, The Hon. Justice Peter McClellan AM.³⁰

24 'The malformation of ...interdependent systems results in many disorders that spring from extreme early stress' (Louis Cozolino, *The Neuroscience of Psychotherapy* (New York, Norton, 2002); '[A]daptation to trauma, especially early in life, becomes a 'state of mind, brain and body' around which all subsequent experience organizes' (ibid: 258-259).

Yet this can also be hard to recognise: 'Because most chronic disease builds slowly and does not manifest until later, diagnoses are typically disconnected from their early developmental roots' (Robin Karr-Morse, *Scared Sick: The Role of Childhood Trauma in Adult Disease* (Basic Books, New York, 2012, ix-x).

25 The 2013-2017 Royal Commission examined educational institutions, religious groups, sporting organisations, state institutions, youth organisations and charities. It received more than 40,000 phone calls, 25,000 letters and emails and held approximately 8000 private sessions which led to 2575 referrals to authorities including the police.

26 Judith Herman, *Trauma and Recovery: From Domestic Abuse to Political Terror* (New York, Basic Books, 1992, 1997), p.32.

27 i.e. *Hysteria* (in the context of the republican movement of late nineteenth century France), *shell shock* or *combat neurosis* (in relation to the anti-war protests which culminated around the Vietnam War) and opposition to *sexual and domestic violence* (in the context of second-wave feminism). Herman, ibid, p.9.

28 See Warwick Middleton et al, 'The Australian Royal Commission into Institutional Responses to Child Sexual Abuse', *Australian and New Zealand Journal of Psychiatry* Vol.48 (1) 2014, pp.17-21, and 'Child Abuse and the Dynamics of Silence', *ANZJP*, 48 (6) 2014, pp.581-583.

29 'The issue is much more about society's willingness to know, and our at times extraordinary need to believe something other than the unsettling truth'. Warwick Middleton, 'Foreword', *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, ibid, p. xiii.

30 'Chrissie Foster, Peter McClellan awarded top human rights medal' (on 14th Dec 2018) SBS online news 15th December 2018 <https://www.sbs.com.au/news/chrissie-foster-peter-mcclellan-awarded-top-human-rights-medal>
For the Blue Knot tribute to Chrissie, Justice Peter McClellan and the late Anthony Foster, see <https://www.blueknot.org.au/ABOUT-US/Blog/ID/204/Congratulations-to-to-Chrissie-Foster-and-Justice-Peter-McClellan-on-their-joint-receipt-of-the-2018-Human-Rights-Medal>

The *societal recognition of a crime so long denied has been ground breaking*. This was highlighted by the title of the newspaper article 'No longer OK: how public attitudes turned against a culture that ignored children's pain'.³¹

It is time to implement tangible measures around prevention and to assist and compensate survivors. This includes implementation of the many recommendations of the Royal Commission. Important in this context is the National Redress Scheme, which commenced on 1st July 2018, and which all relevant institutions must join to expedite redress to survivors.³²

The Royal Commission has compelled society to confront the 'unsettling truth' of child sexual abuse. This is a considerable advance from 2012, and we are now working from a higher base of awareness and understanding. However concerted efforts around prevention, support, treatment and justice are still needed in relation to child sexual abuse, and childhood trauma more broadly.

(3) A changing treatment landscape

Since 2012, the already wide range of treatment possibilities has expanded further to include many 'new' approaches and practices which may have much to contribute. Some are not familiar to many within the 'psy' professions, and lack official status and endorsement. But this does not mean they should be ignored. For example, Bessel van der Kolk highlights the extent to which the principles of Polyvagal Theory,³³ which is now being applied clinically,³⁴ seem to support 'disparate, unconventional techniques' from a range of 'age-old, nonpharmacological approaches that have long been practised outside Western medicine'.³⁵

There is an urgent need for new effective complex trauma treatments. This is also because treatment for 'standard' PTSD has often been prioritised over that for complex trauma and widely endorsed treatment approaches are not effective for everyone. As a 2018 paper underlines,

*'Currently existing treatment methods are ineffective for 25–50% of patients enrolled in clinical trials...the economic costs of PTSD and trauma- and stressor-related disorders are estimated to amount to 43.2 billion dollars annually... The necessity for more effective treatments efficiently reducing current treatment failure rates thus becomes apparent.'*³⁶

Despite some conflicting claims and findings,³⁷ current 'evidence-based' psychotherapeutic trauma treatments - specifically 'first line', 'trauma-focused', short-term and exposure-based - may be problematic for people who experience complex trauma and dissociative disorders (see Chapters 3 and 5 in Part 2 of this document). This has disturbing implications for 'on the ground' clinical practice:

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- 31 Kathy Evans, 'No Longer Ok: how public attitudes turned against a culture that ignored children's pain', *Sydney Morning Herald*, 29 September 2013.
 - 32 Robert Llewellyn-Jones, 'The survivors of child sexual abuse deserve compensation before they die', *The Guardian* (20 December 2018) <https://www.theguardian.com/commentisfree/2018/dec/20/the-survivors-of-child-sexual-abuse-deserve-compensation-before-they-die>
 - 33 Stephen Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* (Norton, New York, 2011).
 - 34 Stephen Porges and Deb Dana, *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies* (Norton, New York, 2018); Dana, *The Polyvagal Theory in Therapy* (Norton, New York, 2018).
 - 35 Bessel van der Kolk, MD, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* (New York: Penguin, 2015), p.88.
 - 36 S.B. Thal and M.J. Lommen, ref Foa et al. 2009; Stein et al. 2009; Mithoefer et al. 2011; Greenberg 1999, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *Journal of Contemporary Psychotherapy* (48, 2, 2018), 99–108. doi: <https://link.springer.com/article/10.1007/s10879-017-9379-2>
 - 37 See, for example, M. A. Hagenaars, A. van Minnen, et al 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy* (48, 1, 2010, pp.19-27) and the detailed discussion in Chapter 5 of this document.

*'Psychotherapists in many services are required to restrict their approaches to those therapies recommended in guidelines or expert consensus irrespective of the oversimplified misrepresentation of the evidence base that result in service constraints such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. Psychotherapy therefore is often protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control. Patients unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance.'*³⁸

Calls for 'evidence-based' treatments can sound 'common-sense' as well as authoritative and scientific. But it is important to understand the many ways in which such treatments may not be optimal, and especially for complex trauma clients. *This does not mean abandoning the need for evidence to support particular treatments and claims of their effectiveness.* On the contrary, it underlines the need to carefully scrutinise the basis and criteria for assessing treatment effectiveness.

Many current treatments increasingly command an evidence base, as distinct from being 'evidence-based' (see Chapters 4 and 5). It is important to understand the challenges and restrictions generated by sole use of 'evidence-based' treatments - especially for complex trauma.

It is 'well known that clinical innovations come from clinicians, not researchers.'³⁹ It is also the case that 'logical fallacies and lapses in critical thinking are not only used to promote new, innovative or alternative methods and techniques, they also serve to denounce them.'⁴⁰ Given the challenges of effective complex trauma treatment, clinicians and researchers need to remain receptive to possible 'new' treatment options for complex trauma and dissociation (see Chapter 4). They should also note the circular logic which can stymie reviews of potentially promising treatments (e.g. 'it is paradoxically difficult to obtain funding for a novel treatment approach as '...there is no evidence that it works so why would we study it?')'⁴¹

It is critical to consider the limits of 'evidence-based' treatment approaches:

*'the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities... The over-optimistic claims for the effectiveness of cognitive-behavioural therapy (CBT) and misrepresentation of other approaches do not best serve a group of patients greatly in need of help; excluding individuals with such disorders as untreatable or treatment-resistant when viable alternatives exist is not acceptable.'*⁴²

38 Lisa Schwarz, Frank Corrigan, et al, citing Corrigan & Hull, 2015, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (Routledge, New York, 2017), p.140.

39 Suzette Boon, Kathy Steele, & Onno van der Hart, ref Westen, Novotny, & Thompson-Brenner, 2004, *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* (Norton New York, 2011), p. xiii.

40 And 'many of these criteria may apply to established forms of psychotherapy as well' (J.A. Rydberg, 'Research and Clinical Issues in Trauma and Dissociation: Ethical and logical fallacies, myths, misreports, and misrepresentations', *European Journal of Trauma and Dissociation* 1, 2017, p.92). As is 'evident from psychotherapy's recent embrace of mindfulness meditation, psychotherapists do embrace unconventional procedures having roots in ancient traditions that do not yet have explanatory models within the prevailing psychological paradigm, as long as sufficient empirical evidence demonstrates the approach's effectiveness in treating psychological issues' (David Gruder, PhD 'Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support', *Psychotherapy: Official Publication of Division 29 of the American Psychological Association*, (Vol.47, No.3, 2012), p.39.

41 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.6.

42 Frank M. Corrigan & Alastair M. Hull, 'Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions', *BJPsych Bull.* (39, 2, 2015), pp.79-86. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478907/>

Rapidly expanding research and new insights into the brain, body, and memory also raise new issues which challenge traditional research methods. For example, Porges notes that '[l]imited research has been conducted on the influence of sensory feedback from bodily organs (i.e. visceral afferents) in the neural regulation of the autonomic nervous system' and ways in which these influences manifest 'in the heart and other visceral organs'.⁴³ This, he says, is in part due 'to a top-down bias in medical education that limits the conceptualization of the neural regulation of the heart and other bodily organs by emphasizing the role of motor fibres and minimizing the role of sensory fibres'.⁴⁴

This raises the key question of 'what kind of evidence?' Indeed, evolving neurobiological and other research necessitates reviewing *the way in which research of psychological treatment/s is conceptualised*.

Growing recognition that physiological and somatic processes and experiences are integral to wellbeing also challenges unqualified reference to 'mental' health. The inextricable interrelationship of body and brain is potentially game changing for the design and validation of studies of 'psychological' treatments.⁴⁵

(4) Dissociation and its clinical implications

The updated Guidelines include more information regarding the clinical challenges of *dissociation*. Dissociation is a common feature of complex trauma and many therapists have not been adequately trained to identify it.⁴⁶

Described as the 'partial or complete disruption of the normal integration of a person's psychological functioning',⁴⁷ dissociation is not as easy to detect as the usually more overt signs of hyperarousal. When a therapist doesn't recognise dissociation when it occurs, this can substantially reduce the benefits of therapy because the client may 'zone out' or not pay attention to what is occurring. People dissociate to protect themselves from the challenges of interpersonal contact, *including in the therapy relationship*.

Research in the area of dissociation has grown in recent years, and therapists need to be aware of the key points it reveals. For this reason, we have included dedicated discussion of dissociation in a new chapter of the updated guidelines (see Chapter 2 of Part 2, *'What is Dissociation and Why Do We Need to Know about It?'*).

Yet an understanding of dissociation is so critical for clinicians that it merits more detailed consideration than can be included in these updated Guidelines. The area of 'structural' dissociation⁴⁸ - which describes divisions of the personality generated by early life trauma - has an increasingly rich research base. The 'development of increasingly severe trauma-related disorders...increasingly

43 Stephen Porges, 'Polyvagal Theory: A Primer', in Porges & Dane, ed. *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), p.59.

44 Porges, 'Polyvagal Theory: A Primer', *ibid*, p.59. Porges also notes that 'this bias is rapidly changing due to research on the applications of vagal nerve stimulation' ('a bottom-up model that focuses on the vagus as a sensory nerve'); note that 'approximately 80% of the vagal fibres are sensory' (Porges, *ibid*).

45 This point is elaborated further in Chapter 5.

46 'Most mental health practitioners are not trained to identify complex trauma and dissociation in their clients. If they do know about dissociation, they may only think of the most extreme form of that, Dissociative Identity Disorder, perceive that to be rare, and miss any signs of...milder forms of dissociation in the clients they see' (Lynette Danylchuck & Kevin Connors, *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges* (Routledge, New York, 2017), p.7.

47 Paul F. Dell & John A. O'Neill, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, New York, Routledge, 2011), p.xxi).

48 See Onno van der Hart, Ellert Nijenhuis, and Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).

becomes a risk the more prolonged and severe the traumatic events.⁴⁹ This extends beyond the new diagnosis of Complex PTSD. Structural dissociation occurs, often chronically, within 'increasingly severe trauma-related disorders'. But dissociation per se (i.e. not necessarily 'structural') is a feature of less severe clinical presentations of trauma which is why all clinicians need to know about it (see discussion in Chapter 2).

(5) A landmark legal case validating the diagnosis of Dissociative Identity Disorder (DID)

On Friday 6 September 2019, a Sydney District Court Judge sentenced Richard Haynes to 45 years in prison, with a non-parole period of 33 years, for his repeated 'depraved and abhorrent'⁵⁰ sexual abuse of his daughter Jeni over a long period. The abuse led Jeni to develop Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD). In handing down this sentence, Judge Sarah Huggett said that she was required to put aside her emotional response to what she described as the 'profoundly disturbing and perverted'⁵¹ way in which Richard Haynes had (mis)treated his daughter.

In recognising and punishing the egregious violations to which the courageous Jeni Haynes – who testified in court against her father – was subjected by him, this legal ruling is ground-breaking in recognising the diagnosis of DID and its aetiology in severe childhood trauma and abuse. This paves the way for the many people who have DID (1.5% of the general population)⁵² to have confidence that this disorder which is in the first instance protective⁵³ will increasingly be treated seriously by the legal system as well as by the mental health sector.

Notwithstanding the large evidence base which supports it,⁵⁴ the DID diagnosis is often described as controversial even within the mental health sector. That a District Court judge of New South Wales – avowedly putting aside an emotional response to the nature of the crimes committed by Richard Haynes - has validated the reality of what led Jeni to develop DID is powerful testament to the reality of this disorder and to the factual basis on which the DID diagnosis rests. The legal finding in this instance is also a precedent which is likely to have many ripple effects in challenging the misrepresentation and stigma with which people with DID have long had to contend.⁵⁵ Hopefully it will also encourage increased recognition and appropriate treatment of a disorder which can indeed be successfully treated. DID is the most severe of the dissociative disorders; see chapter 2.

49 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors* (Routledge, New York, 2017), p.67.

50 Jamie McKinnell, 'Depraved and abhorrent' father Richard Haynes, who raped daughter, sentenced to 45 years in prison, ABC News (6 September 2019) <https://www.abc.net.au/news/2019-09-06/richard-haynes-sentenced-to-45-years-in-jail-for-rapes/11484760>

51 McKinnell, *ibid*.

52 I.e. the official figure cited in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edit; DSM 5 (American Psychological Association, Washington DC, 2013), p.294.

53 See discussion in ch.2.

54 See, for example, Martin Dorahy, Bethany Brand, et al 'Dissociative Identity Disorder: An empirical overview', *Australian and New Zealand Journal of Psychiatry* (48, 5, 2014), pp. 402 - 417. https://www.researchgate.net/publication/262025048_Dissociative_identity_disorder_An_empirical_overview

55 In large part because of the myths and misconceptions about DID which continue to circulate. For an open access article which identifies and decisively refutes several such myths in light of the substantial evidence base which attests to the reality of DID, see Bethany Brand, Vedat Sar et al, 'Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry* (24, 4, 2016), pp. 257-270. https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx

(6) Increased awareness of the need for trauma-informed care

While clinical treatment is important, so too is ‘treatment’ in terms of the way in which people are engaged with and responded to (i.e. treatment in the broad, non-clinical sense). The paradigm of trauma-informed care and practice has major implications for *the way in which* treatment is offered and service is provided; i.e. it is attentive not just to *what* the service comprises but to the contextual dimensions of *how* it is offered. If this is not understood and prioritised, clinical treatment will be less effective: ‘[w]ithout such a shift [towards trauma-informed care] ...even the most ‘evidence-based’ treatment approaches may be compromised’⁵⁶

A major text on trauma-informed approaches to mental health care in Australia was published in 2019. Two of its editors are Australian psychiatrists and the other is an Australian clinical psychologist.⁵⁷ As well as chapters by Australian contributors, including the authors of the 2012 (and now updated) guidelines, this landmark text includes contributions from international complex trauma experts. It brings awareness of the paradigm of trauma-informed care to a wide range of service providers.

The 2012 Guidelines included a set of non-clinical recommendations for *organisations* across diverse sectors. They detailed the organisational changes which are needed ‘bottom-up’ as well as ‘top-down’. This includes formally and informally at the level of service culture as well as policy, and by all staff at all levels. ‘Bottom- up’ and ‘top-down’ change *within organisations* attends to all aspects of the person and is the institutional parallel to optimal *clinical* treatment.

The 2012 organisational guidelines have not been included and updated here but can be downloaded or purchased at www.blueknot.org.au/guidelines.

Since 2012, Blue Knot has developed and delivers comprehensive trauma-informed trainings for a diverse range of personnel, services and sectors. This is in addition to separate and specific trainings for clinicians and health professionals. See <https://www.blueknot.org.au/Training-Services>

In the years since 2012, clinicians have become more aware of the prevalence of complex trauma and the needs of complex trauma clients. Many are seeking to further develop their knowledge and skills in this area. The need for aspiring and practising therapists to understand the ways in which working with complex trauma clients requires adaptation of standard counselling principles is also increasingly apparent.

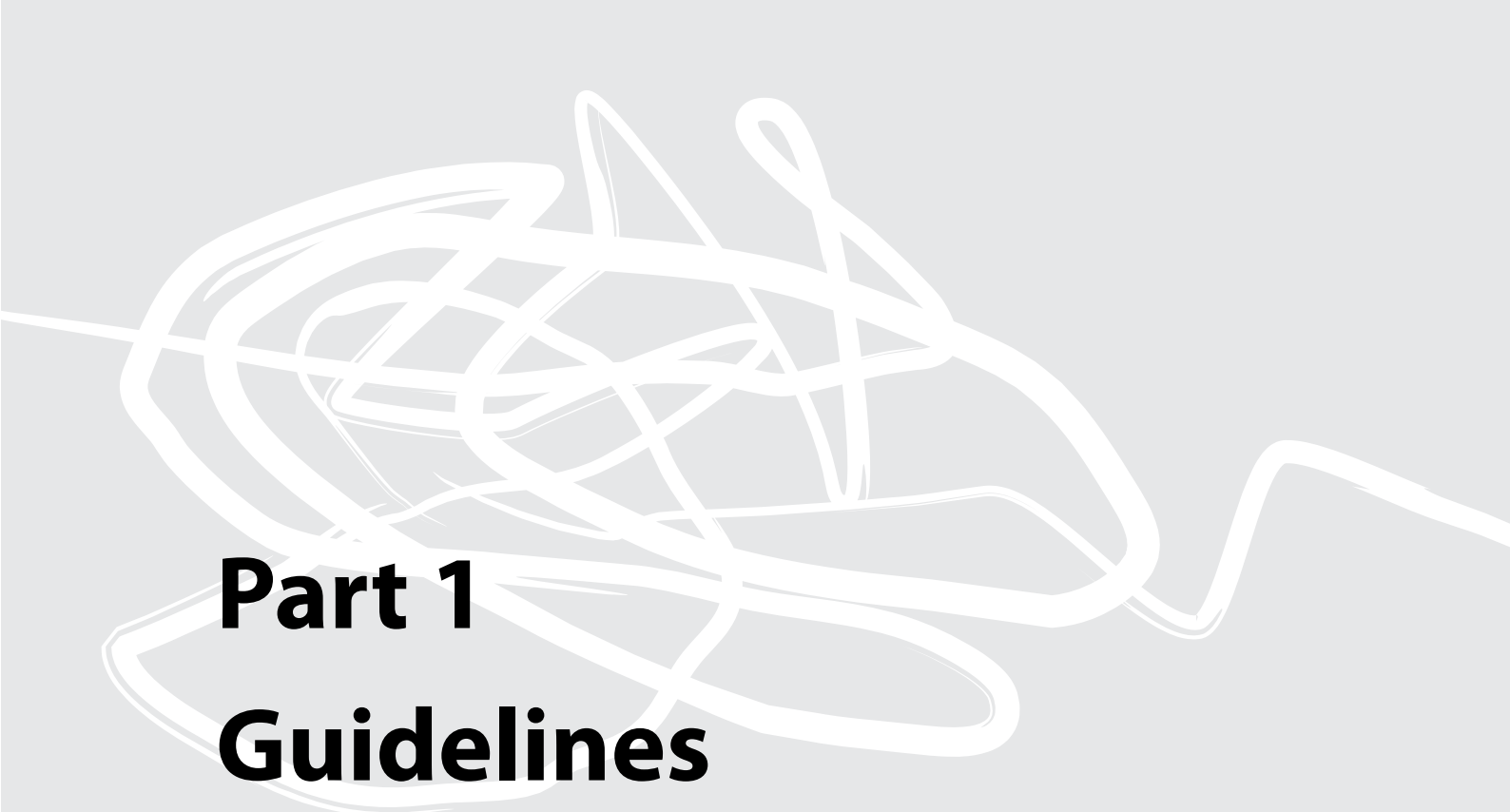
This includes not only the need for all modalities to be trauma-informed, but for understanding of how complex trauma challenges the ‘taken-for-granted’ of what ‘good’ therapy is considered to comprise. Also necessary is awareness of the competencies a therapist needs to work effectively in the complex trauma ‘space’. Blue Knot has produced additional and complementary sets of guidelines,⁵⁸ together with guidelines for clinical supervisors,⁵⁹ to assist in meeting these needs.

56 Ann Jennings, ‘Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services’, Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004. On the paradigm shift from traditional biomedical approaches, see Andrew Moskowitz, ‘Schizophrenia, Trauma, Dissociation, and Scientific Revolutions’, *Journal of Trauma and Dissociation* 12, 2011, pp.347-357.

57 Richard Benjamin, Joan Haliburn, & Serena King, *Humanising Mental Health Care in Australia: A Guide to Trauma-Informed Approaches* (Routledge, London, 2019).

58 I.e. *Guidelines to Differences between Therapy for Complex trauma and Standard Counselling Approaches* and *Guidelines to Therapist Competencies for Working with Complex Trauma* respectively. These complementary guidelines will be released separately in a single Blue Knot publication.

59 *Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma and Dissociation*.



Part 1

Guidelines

Practice Guidelines for Clinical Treatment of Complex Trauma (Updated)

Prior to the 2012 release of the Practice Guidelines for Treatment of Complex Trauma by Blue Knot Foundation, then ASCA, there were no guidelines for treatment of complex trauma. Trauma guidelines were aimed at treating 'single-incident' Post-Traumatic Stress Disorder (PTSD). This was despite research findings that '[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas' (Jennings, 2004) and that people who experience complex trauma 'may react adversely to current, standard PTSD treatments' (van der Kolk, 2003: 173). The 2012 Practice Guidelines spoke to both of these findings and their clinical implications.

Evolving research and clinical insights, as well as the continuing challenges of treating the multifaceted syndrome described as 'complex' trauma, require and account for the following updating of the 2012 guidelines. The formal recognition of the diagnosis of Complex PTSD in the International Classification of Diseases (ICD-11), announced in June 2018, is a major, much awaited and welcome development. The current edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, unfortunately does not contain this diagnosis although it does now include a dissociative subtype of PTSD.

Neither the diagnosis of Complex PTSD, nor that of a dissociative subtype of PTSD, fully encompass the breadth of complex trauma. Diagnosis is also not the only lens through which complex trauma can be viewed and conceptualised. Just as '[t]here is more to trauma than PTSD' (Shapiro, 2010: 11), so there is more to complex trauma than Complex PTSD: 'Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders...increasingly becomes a risk the more prolonged and severe the traumatic events' (Fisher, 2017: 67). The new diagnosis of Complex PTSD also requires criteria for 'standard' PTSD to be met, which is problematic in that 'many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms' (Schwarz, Corrigan et al, 2017: 21).

The following updated Guidelines rest on a diverse research base which continues to evolve (see Part 2). While the key themes of this research are reflected in the following recommendations, the wealth of pertinent material now available, for example in relation to trauma-related dissociation, is also now addressed in other Blue Knot publications. See the additional Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches, Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation (i.e. complementary sets of guidelines which appear in a separate and single publication), Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma and Dissociation, and the separate publication on trauma-related dissociation which expands on the material presented in Chapter 2 (Part 2) of this document. www.blueknot.org.au

(1) Facilitate client safety at all times

Establishing and maintaining safety at all times is critical: '[A] first order of treatment is to establish conditions of safety to the fullest extent possible. The client cannot progress if a relative degree of safety is not available or attainable.'⁶⁰ Note that a felt sense of safety may be alien to many complex trauma clients. For this reason, therapists should take care regarding all resources and interventions, including choice of language, used to promote them.

⁶⁰ Christine A. Courtois, Julian D. Ford & Marylene Cloitre, 'Best Practices in Psychotherapy for Adults', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (The Guilford Press, New York, 2009), p. 91.

(2) Understand how experience shapes the brain, the impacts of trauma on the brain (particularly the developing brain) and body

Psychoeducation about the effects of trauma on the brain and body is a component of effective trauma therapy.⁶¹ Communicating this information to the client at an appropriate time helps to normalise distressing/problematic experience and responses for which they may otherwise hold themselves solely responsible. While psychoeducation alone is unlikely to dissolve self-blame, conveying current insights into the psychology and physiology of trauma and its effects to clients is important.

(3) Acknowledge the extensive impacts of childhood trauma and their treatment implications

Complex trauma, particularly if it occurs in childhood, can entail developmental deficits which do not apply to 'single-incident' PTSD: *'As a group, clients with complex trauma disorders have developmental/attachment deficits that require additional treatment focus... treatment goals are more extensive than those directed at PTSD symptoms alone.'*⁶² While clients with single-incident PTSD need to *restore* their capacity to self-regulate, clients with complex trauma often need to *learn* to do this as they have not previously acquired this capacity.

(4) Expect a variety of client responses including shame which is frequently intense

A client's inability to self-regulate and to draw upon relationships to regain self-integrity⁶³ engenders deep shame. Shame can present 'not only as an acute emotional state', but also as 'a more fundamental and enduring aspect of an individual's personality structure' ('in many traumatized persons the experience of shame essentially *defines who they are*').⁶⁴ Attentiveness to shame 'also expands the clinician's focus from fear or anxiety to the sense of a *damaged self*'.⁶⁵

Therapists need to attune to the clinical implications of the pervasiveness of shame. This is because 'when a person's past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice'.⁶⁶ Also see Guideline 21.

61 John Briere & C. Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment* (Sage, London, 2006).

62 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', *ibid*, pp. 89-90; see for the many priority areas which need to be addressed.

63 Julian D. Ford & Christine A. Courtois, 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.17.

64 Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (Norton, New York, 2015), p.206; original emphasis.

65 Ford & Courtois, citing Feiring, Taska & Lewis, 2002, 'Defining and Understanding Complex Trauma...', p.17; emphasis added.

66 'Instead, clients are perhaps better served by psychotherapies aimed at lowering self-judgemental tendencies and fostering greater self-compassion' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.207; ref. Gilbert, 2011; Greenberg & Iwakabe, 2011).

(5) Attune to dissociation and the treatment implications

Attune to, identify, and address dissociation to assist self-regulation and to enable therapy to progress. Dissociation, i.e. disconnection from the moment, has been defined as ‘partial or complete disruption of the normal integration of a person’s psychological functioning.’⁶⁷ While occurring in benign everyday forms,⁶⁸ persistent activation of dissociation for defensive purposes erodes health and wellbeing:

‘The most important distinction...to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe.’⁶⁹

Problematic dissociation is frequent in complex trauma⁷⁰ ([m]ost people with complex PTSD have experienced chronic interpersonal traumatization as children’ and ‘have severe dissociative symptoms’).⁷¹ ‘Structural’ dissociation, i.e. dissociative division of the personality which is a frequent feature of complex trauma in early childhood,⁷² is an extreme defence in the face of extreme (inescapable) threat. Yet trauma-related dissociation may be hard to recognise, including for clinicians, even when it is severe.⁷³ This is because dissociation is often not addressed in the training of health professionals.⁷⁴ Attuning to the frequently subtle signs of dissociation is essential, because when clients ‘zone out’ they are unable to pay attention which limits the benefits of therapy (and where inability to ‘stay present’ is often a key if unrecognised reason why many clients seek therapy in the first place).

(6) Become aware of the core dissociative symptoms of *depersonalisation* (estrangement from self), *derealisation* (estrangement from environment), *amnesia*, *identity confusion*, and *identity alteration* which occur in varied combinations

Dissociative symptoms can be treated when recognised and addressed. In attuning to mental processes, Chu notes that clinicians often fail to consider experiential state changes, gaps in memory, and distortions in perceptions.⁷⁵ Yet *‘[t]he questions needed to elicit evidence of dissociative symptoms are simple’⁷⁶* - ‘at a minimum’ clients should be asked about experiences of amnesia, depersonalisation, and derealisation.⁷⁷

67 Paul F. Dell & John A. O’Neil, ed., *Dissociation and the Dissociative Disorders: DSM-V and Beyond* (Routledge, New York, 2011), p.xxi.

68 ‘Associative process alerts our awareness that something is worth noticing. Dissociation tells us we need not pay any attention. The healthy result of this sorting is a coherent mind’ (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes* (Norton, New York, 2015), p.1; also see Vedat Sar, ‘The Many Faces of Dissociation’, *Clinical Psychopharmacology and Neuroscience* (12, 3, 2014), pp.171-179. Also note that not all accept a continuum model of dissociation.

69 Marlene Steinberg, & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2003), p. 33.

70 ‘[i]t is not uncommon for people with multiple traumas to have dissociative issues of varying kinds’ (Lynette Danylchuk & Kevin Connors, *Treating Complex Trauma and Dissociation*, Routledge, New York, 2017, p.7).

71 Onno Van der Hart, Ellert Nijenhuis, & Kathy Steele, *The Haunted Self* (Norton, New York, 2006), p.112.

72 Van der Hart, Nijenhuis & Steele, *The Haunted Self*, *ibid.*

73 ‘Many Complex PTSD presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected by clinicians’ (Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma*, Routledge, New York, 2017, p.23).

74 ‘Most mental health practitioners are not trained to identify complex trauma and dissociation in their clients. If they do know about dissociation, they may only think of the most extreme form of that, Dissociative Identity Disorder, perceive that to be rare, and miss any signs of...milder forms of dissociation in the clients they see’ (Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid.*, p.7).

75 James A. Chu, MD *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders* (John Wiley & Sons, New Jersey, 2011), p.62.

76 Chu, *Rebuilding Shattered Lives*, *ibid.*

77 ‘For depersonalisation and derealisation, one might ask: ‘Do you ever have the experience of feeling as if your body or emotions are unreal? ...feeling detached from your body or that you are outside your body observing yourself? ...feeling as though your surroundings are foggy or unreal?’ (Chu, *Rebuilding Shattered Lives*, *ibid.* pp.62-63) If these are present, the clinician should proceed to ‘inquire about identity confusion and identity alteration’ (Chu, *Rebuilding Shattered Lives*, *ibid.* p.210).

It is important to be aware that '[p]eople with dissociative experience come to us hoping clinicians can help them understand what subjectively plagues them';⁷⁸ '[w]e must speak up because our [clients] are unlikely to do so'.⁷⁹

(7) Understand that complex trauma-related dissociation underlies diverse presentations and remains widely undetected

*'Most mental health practitioners are not trained to identify complex trauma and dissociation in their clients. If they do know about dissociation, they may only think of the most extreme form of that, Dissociative Identity Disorder, perceive that to be rare, and miss any signs of... milder forms of dissociation in the clients they see.'*⁸⁰

It is also the case that '[m]any Complex PTSD presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected by clinicians'.⁸¹

The new diagnosis of Complex PTSD in the *International Classification of Diseases* (ICD-11) does not encompass the range of forms of structural dissociation.⁸² Nor does the dissociative subtype of PTSD in DSM-5 adequately describe the range and severity of the impacts of complex trauma⁸³ to which therapists should attune.

(8) Attune to arousal levels and assist clients to stay within 'the window of tolerance'

Hyperarousal, characterised by agitation, is a response to extreme anxiety, while hypoarousal generally manifests as passivity, 'shut-down' and withdrawal.⁸⁴ As noted in Guideline 5, therapists need to be aware that dissociative responses can occur along a continuum from mild to severe.⁸⁵ Therapy should remain within the 'window of tolerance'; i.e. the threshold of sensation the client can tolerate without becoming either hyper or hypoaroused.⁸⁶

78 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p. 59.

79 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p.94.

80 Danylchuck & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.7.

81 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p 23.

82 'Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders... increasingly becomes a risk the more prolonged and severe the traumatic events' (Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors*, Routledge, New York, 2017, p.67).

83 'To date, the dissociative subtype of PTSD has been defined specifically in relation to symptoms of depersonalization and derealization' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.166). Thus it is regarded as a problematic conceptualisation by some; e.g. the contention of Ross that '[t]here does not appear to be any sound conceptual reason for excluding amnesia and flashbacks from the criteria for dissociative PTSD' (Colin Ross, 'Problems with the Dissociative Subtype of Posttraumatic Stress Disorder in DSM-5', *European Journal of Trauma and Dissociation* August 2018) <https://doi.org/10.1016/j.ejtd.2018.08.005>

84 While widely described as the 'shut-down' response, dissociation can also occur when a person is behaviourally active. As Rothschild highlights, there is a frequent misconception that clients in 'the freeze state' are underaroused. This can become dangerous if the therapist attempts to provoke an overt response – 'Every trauma client, whether frozen, dissociated, or hypervigilant, is suffering with a nervous system that is in overdrive, already provoked to the highest level' (Babette Rothschild, *Trauma Essentials*, Norton, New York, 2011, p.15; emphasis added). Thus '[r]educing pressure by removing provocation will relieve the nervous system and make mobility, calmness, and clear thinking more possible' (Rothschild, *ibid*).

85 'The more you know about dissociation, the more you automatically watch for its markers'. Robin Shapiro, *The Trauma Treatment Handbook* (Norton, New York, 2010), p.36. To help therapists attune to dissociative responses, Shapiro provides an informal 'Dissociation Assessment' tool (*ibid*); note that there are several formal dissociation assessment scales, some of which require formal training to administer. For orienting discussion on this topic see Colin Ross & Naomi Halpern, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* (Manitou Communications, TX, 2009), pp.227-272.

86 Daniel J. Siegel, *The Developing Mind* (The Guilford Press, New York 1999); *Mindsight* (Random House, New York, 2009).

(9) Understand that trauma can lead to physical as well as psychological symptoms

Activation of unresolved overwhelming experience ('triggering') leads to major dysregulation at a somatic as well as psychological level. Reduced capacity to integrate and cognitively represent bodily states can lead to '*distressing somatic complaints, concerns and symptoms*' as well as to distressing feelings and thoughts.⁸⁷

The phenomenon of 'medically unexplained symptoms' (MUS) is illustrative: '*Somatization is a dissociative process... and we pay a steep price when this possibility is overlooked in the medical investigation of chronic pain.*'⁸⁸ Many clients who experience the impacts of complex trauma consult a 'psy' practitioner when medical tests are inconclusive and their 'physical' pain has no apparent organic cause.

(10) Foster client resources from the first contact point

The ability to access both internal and external resources is central to wellbeing and is radically impeded by unresolved trauma. Self-regulation depends upon the capacity to access internal resources and is also the pre-condition for trauma processing (see Guideline 32). Supporting the client to develop the capacity to self-regulate involves teaching strategies to self-monitor and self-soothe. Acquiring and cultivating client resources is a key therapeutic goal regardless of the duration of therapy and whether or not trauma is processed: '*It is almost impossible to overstate the importance of traumatized patients maintaining an appropriate level of functioning in their lives.*'⁸⁹

(11) Regard symptoms as adaptive and work from a strengths-based approach

Viewing symptoms as 'expectable and adaptive' reactions to traumatic childhood experiences,⁹⁰ i.e. the outgrowth of normal protective responses to abnormal conditions, should inform clinical work. A strengths-based response empowers a client's existing resources. Care should be taken, however, to attend to ongoing difficulties while focussing on strengths. This can be challenging when surface presentations mask underlying trauma; e.g. the client may appear to be resilient and 'high functioning' in some regards but lack any sense of quality of life.

(12) Utilise coping strategies as potential resources

Many counselling modalities assume that the client already possesses the internal resources they need, and that therapy is primarily about enabling the *accessing* of resources. But complex trauma and dissociation, particularly if generated by childhood experience, disrupt the internal structures needed to build the *capacity* to self-regulate. At the same time, reconceptualization of symptoms as the outgrowth of *initially* protective strategies to defend against overwhelm⁹¹ underlines that all clients are resourceful.

87 Adriano Schimmenti & Vincent Caretti, V. 'Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1, 2016), p.109.

88 Chefetz (citing (Nijenhuis, 2000) *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p. 27.

89 James Chu, *Rebuilding Shattered Lives*, *ibid*, p.117.

90 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', *ibid*, p. 93. As Ross and Halpern point out, '[n]egative, undesirable symptoms and behaviours often do not seem to serve any purpose. On closer inspection, however, they do' (Ross & Halpern, *Trauma Model Therapy*, *ibid*, p. 107).

91 I.e. '*the problem is the solution*'; Vincent J. Felitti & Robert F. Anda, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine* (14, 4, 1998), pp.245-258.

It also paves the way to utilise symptoms therapeutically instead of seeking to eradicate them. The latter may not work because 'symptom-generating emotional learnings'⁹² may initially have been adaptive: '*for many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously*'.⁹³ This makes 'targeting' symptoms difficult and potentially problematic and illustrates the benefits of utilising them therapeutically where possible.

For example, while effective treatment entails reducing trauma-related dissociation, the framework of 'symptoms as potential resources' requires re-evaluation of the view that dissociation is 'the problem to be solved': '*the more germane questions are, from where is the person dissociating and to where is she associating?*'⁹⁴ The challenge is to recognise 'the dissociation/association mechanism as a dynamic process' whereby '[t]he therapist works to create and maintain resourceful [states]'.⁹⁵

(13) Foster support networks

The impaired relational capacity common to complex trauma clients often means they have limited and less than optimal external supports. The therapeutic relationship itself fosters the client's relational capacity as a step towards building healthy support networks. Also see *Guidelines 42 & 43*.

(14) Attune to attachment issues and to non-verbal communication

The interpersonal violations typically sustained by complex trauma clients impair their ability to connect with themselves and others. Hence the need - from the first point of contact - for the therapist to be sensitive to the relational style of the client and attentive to non-verbal communication. Attuning to attachment issues is vital to the therapeutic alliance and to working effectively within it.⁹⁶ Non-verbal communication is central as clients are often reluctant or unable to express difficult experience in words.⁹⁷ Clients typically cannot narrate unresolved trauma coherently, even when words are available.⁹⁸ This means that *how* – not just *what* – the client communicates can be very significant.⁹⁹

92 Bruce Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (Vol.6, Issue 1, 2018, p.6).

93 Sandra Bloom & Brian Farragher, *Destroying Sanctuary* (OUP, Oxford, 2011), p.16.

94 Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002), p.42; emphasis added.

95 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.43.

96 Robin Shapiro's 'Attachment Assessment' and 'Affect Tolerance Assessment' (Shapiro, *The Trauma Treatment Handbook*, *ibid*, pp.33-35) combine observational questions for the clinician with questions that can be asked of the client (i.e. as appropriate). These informal 'tools' do not require training to administer and are helpful in orienting the clinician to attachment issues in the early stages of client contact and in sensitising to the ability of the client to tolerate affect (which will need to be consistently gauged in all subsequent contact).

97 '*The words...may or may not convey significant meaning. The implicit, nonverbal subtext almost always does*'. (David Wallin, *Attachment in Psychotherapy*, The Guilford Press, New York, 2007, p.259).

98 'Groundbreaking studies by van der Kolk and Fisler (1995) and Foa and her colleagues (Foa, Molnar et al, 1995) established objectively that the retelling of traumatic memories by traumatised persons with PTSD often fails to exhibit a coherent narrative structure' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.140).

99 As per the Adult Attachment Interview (AAI) developed by American psychologist Mary Main; see discussion of the AAI in Daniel J. Siegel & Mary Hartzell, *Parenting from the Inside Out* (Penguin, New York: 2004).

(15) Establish appropriate boundaries

Most varieties of psychotherapy require attention to boundaries. But boundaries are invariably more challenging for the therapist who works with complex trauma as well of course for the client.¹⁰⁰ Many complex trauma clients need considerable assistance, which necessitates a more flexible attitude to boundaries on the part of the therapist than is the case for clients who do not experience the impacts of complex trauma.

This is particularly but not exclusively in the ‘first phase’ of therapy when self-regulatory capacity may be lacking (*‘therapists may find themselves having to spend additional time on communication with the client between sessions in order to facilitate emotional regulation and support in navigating any life-interfering activation that occurs as a result of therapeutic processing’*).¹⁰¹ Therapists should mutually negotiate boundaries and ensure that clients understand their significance and do not experience them as punitive. Maintaining appropriate boundaries is also central to therapist self-care, especially when working with complex trauma-related issues.

(16) Select and apply all tools and interventions with care

‘[T]he first step is to help the client feel safe to accept and participate in the intervention, and the second step is the intervention itself.’ (Robert Schwarz, 2002: 20)

A distinction is sometimes made between a ‘technique’ as a more specialised skill and a ‘tool’ which is more basic and ‘down to earth’.¹⁰² In any case, a wide range of tools is *‘essential in treating severely traumatised people, many of whom have highly idiosyncratic manners of coping.’*¹⁰³ Tools can often be customised and combined to good therapeutic effect, and the greater the diversity of tools the more flexibility for selecting and individualising them for the client.¹⁰⁴

Use of tools is compatible with working relationally (*‘the very act of questioning oneself is a specific type of tool, is it not?’*).¹⁰⁵ Tools used in a relational context are also most likely to be effective, and this is particularly the case in treatment of complex trauma. Tools assist active skills of ‘mastery, competence, and resourcefulness.’¹⁰⁶ They can be learned by therapists and often potentially taught to clients to enhance resourcing and empowerment. *Note that ‘standard’ tools, interventions and strategies often need to be adapted for complex trauma clients* (also see Guideline 34).

(17) Ensure the therapeutic approach promotes integrated functioning and is informed by research in the neurobiology of attachment

Core features of complex trauma therapy include engaging with right-brain processes, attending to the role of implicit memory (see Guideline 30) and engaging with physical as well as cognitive and emotional processes – *‘we must attend to all three levels: cognitive processing... emotional processing...*

100 See ‘Revisiting the ‘over-functioning’ therapist’ and ‘Revisiting boundaries’ in *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*; also see *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*.

101 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.203. (*‘Trauma clients need more...The ability to tolerate emotional distress, while offering authentic reassurances and yet still setting necessary limits becomes easier with experience of how and how much that actually helps the person’*; Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.169).

102 Robert Schwarz, *Tools for Transforming*, *ibid*, p.51.

103 Schwarz, *Tools for Transforming Trauma*, *ibid*.

104 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.63.

105 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.63.

106 Schwarz, *Tools for Transforming Trauma*, *ibid*. 217.

and sensorimotor processing (physical and sensory responses, sensations and movement).¹⁰⁷ While there are different ways of attending to these dimensions, current research confirms the need to address all three therapeutically ('it is important to be able to engage the relevant neurobiological processes').¹⁰⁸

(18) Recognise that promoting integrated functioning requires adaptation of, and supplements to, 'traditional' psychotherapeutic approaches (i.e. insight-based and cognitive behavioural)

Research in the neurobiology of attachment establishes the limits, as well as benefits, of 'talk'. This requires active addressing of physical and experiential processes as well as cognitions and the verbal expression of emotion ('bottom-up' and 'top-down').¹⁰⁹

*'It is not possible to shift emotional and psychological states without shifting physiological states.'*¹¹⁰

(19) Attune to and integrate diverse interventions and treatment approaches within the phased treatment model where appropriate (also see Guideline 21)

'There is no one perfect trauma therapy' (Shapiro, 2010)

The current treatment landscape is diverse and dynamic and offers a wide range of modalities and methods which may potentially be incorporated. It is important to be receptive to approaches for which credible evidence exists including when the approach may be unfamiliar (see Chapter 4). Application of Polyvagal Theory to the field of psychotherapy underlines that '*[c]ues of safety are the treatment*'.¹¹¹ It also provides a rationale for integration of diverse 'non-traditional' strategies and methods (i.e. non-traditional within the majority of 'psy' professions) to assist physiological, and thereby psychological, regulation.¹¹² *'When we consciously and deliberately engage in practices that produce physical calmness, we signal the limbic brain that we're safe at a physiological level'*.¹¹³

Many 'alternative' treatment approaches from outside the field of psychotherapy command an evidence base (as distinct from being 'evidence-based'; see ch.5) and may be integrated into the recommended phased approach to treatment of complex trauma¹¹⁴ (see Guideline 21 and research Chapters in Part 2 of this document).

NOTE THAT CARE WITH APPLICATION AND INTEGRATION OF ALL TECHNIQUES IS ESSENTIAL; SEE GUIDELINE 16

¹⁰⁷ Pat Ogden, Kekuni Minton & Clare Pain, *Trauma and the Body* (Norton, New York, 2006), p.140.

¹⁰⁸ Diana Fosha, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma* (Norton, New York, 2003), p.229.

¹⁰⁹ Bessel A. van der Kolk, 'Foreword', Ogden et al, *Trauma and the Body*, p.xxiv; Fosha, 'Dyadic Regulation and Experiential Work...', *ibid*, pp.229-230. Note that of the several foci which 'must' comprise therapy for complex trauma, Courtois, Ford & Cloitre include '[b]odily as well as mental functioning, including both sensorimotor integration and neuro-chemical and psychophysiological integrity' ('Best Practices in Psychotherapy for Adults', p.90).

¹¹⁰ Amber Gray, in Stephen Porges & Deb Dana, ed *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), p. 221.

¹¹¹ Stephen Porges & Deb Dana, *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies*, *ibid*, p.61.

¹¹² Bessel van der Kolk, *The Body Keeps the Score* (Penguin, New York, 2015), p.88.

¹¹³ Dawson Church, *Psychological Trauma: Healing its Roots in Brain, Body, and Mind* (Energy Psychology Press, CA, 2015), p.49.

¹¹⁴ For example, in his eclectic but also integrative text *Tools for Transforming Trauma*, Schwarz describes how, within a neo-Ericksonian framework, the principles of certain short-term psychotherapies which 'are active and involve the direct or indirect alteration of perception, sensation, and meaning' can be applied at various points in the treatment of trauma including its more complex varieties in the phased treatment approach (Schwarz, *Tools for Transforming Trauma*, *ibid*, p.24; also see Guideline 20).

(20) Ensure that all treatment modalities are ‘dissociation-informed’ as well as trauma-informed

This includes therapeutic approaches which may be otherwise well evidenced according to standard criteria. For example, Eye Movement Desensitisation Reprocessing (EMDR) is a well evidenced trauma treatment which has also been adapted for dissociative clients.¹¹⁵ Yet as is the case with clinicians of contrasting modalities, not all EMDR practitioners are ‘dissociation savvy’.¹¹⁶ If using EMDR with clients with trauma histories, the modified protocol which prioritises resource installation prior to trauma processing¹¹⁷ is strongly advised.

(21) Phased treatment remains the ‘gold standard’ for complex trauma therapy

In phased treatment, Phase I is *safety/stabilisation*, Phase 2 is *processing* and Phase 3 is *integration*.

The ability to tolerate emotion (i.e. self-soothe; regulate affect) is a primary task of treatment, and accounts for the importance of Phase I. Attempts to ‘process’ trauma without the ability to self-regulate can precipitate overwhelm and re-traumatisation. ‘Processing’ complex trauma is a Stage 2 task and should not be encouraged without the foundational self-regulatory work of Phase I: *‘Overstatement of the importance of this step is not possible; it is vital if trauma recovery is to be realised’*.¹¹⁸

In recent years there has been criticism of the phased treatment approach¹¹⁹ by exponents of ‘first-line’, ‘evidence-based’ and ‘trauma focused’ psychotherapies which are mainly short-term and exposure-based (see Chapters 3 and 5 in Part 2). Therapists should be aware, however, that phased treatment - as per the 2012 ISTSS *Expert Consensus Guidelines for Complex PTSD in Adults*¹²⁰ - remains the recommended approach by experts in the complex trauma field. This is especially when high levels of dissociation are apparent. Clients *‘with significant dissociative symptoms... respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well’*;¹²¹ *‘What one does not do in early recovery is any form of exposure therapy’*.¹²²

115 Deborah L. Korn, ‘EMDR and the Treatment of Complex PTSD: A Review’, *Journal of EMDR Practice and Research* (3, 4, 2009, pp.264-278); also see Anabel Gonzalez, ‘Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures’, *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2, 2018, pp. 192-211).

116 ‘No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population... The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously’ (Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, 3rd edition, The Guilford Press, Washington, DC, 2018, pp. 342-343).

117 See Korn, ‘EMDR and the Treatment of Complex PTSD: A Review’, *ibid*; Gonzalez, ‘Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation’, *ibid*; also Sandra Paulsen, *When There Are No Words: Repairing Early Trauma and Neglect From the Attachment Period With EMDR Therapy* (Bainbridge Island, WA: Bainbridge Institute for Integrative Psychology Publication, 2017); Carol Forgash, & Margaret Copeley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (Springer, New York, 2007), and Laurel Parnell, *Attachment Focused EMDR: Healing Relational Trauma* (Norton, New York, 2013).

118 Babette Rothschild, *Trauma Essentials* (Norton, New York, 2011), p. p.57.

119 De Jongh, Resick et al, ‘Critical analysis of the current treatment guidelines for complex PTSD in adults, *Depression and Anxiety* (33, 5, 2016), pp.359-369.

120 Marylene Cloitre, Christine A. Courtois, et al *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* (2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

121 David Spiegel, ‘Integrating Dissociation’, *American Journal of Psychiatry* (175:1, 2018), p.4.

122 Judith Herman, ‘Foreword’, Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, p.xvi. Also see Guide-line 4.

(22) Promote dual awareness

Dual awareness, i.e. mindful noticing, is the ability to attend to two experiences simultaneously and to observe internal sensations while retaining awareness of surroundings. It is central to self-regulation and an important skill to cultivate in therapy as early as possible.¹²³

Dual awareness is also essential for trauma processing (see Guideline 32). The challenge is that paying attention to sensations is initially profoundly unsettling for trauma survivors and is difficult to do because of dissociation. Hence client resourcing and 'befriending sensations' is critical (see Guideline 26).

(23) Recognise that mindfulness and dissociation are rival brain activities (Forner, 2017)

Unless clinicians are dissociation-informed, the rival activities of mindfulness and dissociation can challenge the therapy (as per Guideline 5). Dissociation is described as 'the deficiency of internal and external awareness' while 'mindfulness is internal and external awareness in abundance': *'One is a basic function that is designed to know; the other is a brain function that is designed to not know.'*¹²⁴

While clients need to move to mindful awareness (and 'mindfulness is one of the interventions that helps put the human back on track')¹²⁵ doing so is especially challenging when dissociation is the client's 'default' coping response. Resourcing is critical because initial attempts to 'notice' body responses and sensations can be distressing for clients who dissociate as the 'go to' reaction.

(24) Proactively support your client to stay within the 'window of tolerance'

While standard counselling training advises counsellors to 'take their lead from the client', the complex trauma therapist may need to proactively intervene in order to help the client stay within the 'window of tolerance'. This is because the therapist needs to act as 'psychobiological regulator' until the client can *self-regulate*.¹²⁶

Clinicians may need to be directive and also at times interrupt a client in the interests of safety (which may seem difficult to do in the knowledge that complex trauma clients may have been interpersonally 'cut off' many times). While a collaborative approach which respects client choices is a principle of trauma-informed treatment, the concurrent need to be proactive in the interests of client safety is primary.

123 'Noticing' as in mindful awareness allows the client to achieve 'dual awareness', the ability to stay connected to the emotional or somatic experience while also observing it from a very slight mindful distance'. (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.44).

124 Christine Forner, *Dissociation, Mindfulness and Creative Meditations* (Routledge, New York, 2017), p. xii.

125 Forner, *Dissociation, Mindfulness and Creative Meditations*, ibid, p. xv.

126 See Ogden, Minton & Pain (ref Diamond et al, 1963), *Trauma and the Body*, ibid, p.206; van der Hart et al, *The Haunted Self*, ibid, and Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.51. Also see *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*.

(25) Distinguish between *acknowledging* and *focusing on* traumatic material

While *focusing* on traumatic material relates to trauma processing (and requires adequate client resourcing) *acknowledging* the trauma is a different matter. Acknowledging overwhelming experience erodes the silence of secrecy and validates client distress. Judicious alluding to difficult material is thus different from talking 'about' it:

'Acknowledging the trauma or implicit triggered memories is never unsafe, especially when we allude to 'bad things that happened' in a more general way without vivifying the details of them or using triggering language such as 'rape', 'incest', or 'penetration'.¹²⁷

(26) Assist the client to 'befriend' sensations (van der Kolk, 2015)

Appropriate methods vary according to the client and the nature and level of arousal (e.g. hyper- and/or hypo).¹²⁸ There are now a range of strategies and tools which may assist in this regard (see the resources in Appendix 1 of this document). Special care is needed to select the strategy, technique, exercise etc. to help clients soothe and stabilise. It is also important to note that the client may respond differently to particular methods at different times.

(27) Contain distressing material

Particularly in the early stages of therapy, before the client can consistently self-regulate, the risk of destabilisation is high. For this reason, distressing material needs to be contained rather than attempting to 'process' it prematurely (i.e. the rationale of phased treatment; see Guideline 21).

There are many strategies to foster containment and assist client resourcing (e.g. creating symbolic 'containers' and 'places'). These can vary enormously and are most effective when constructed and tailored according to the client's preferences. A therapist's choice of language is also important. For example, reference to a 'safe' place may destabilise clients for whom the concept and experience of safety is alien or triggering. And while a 'sacred' place may be consoling for some, it could have disturbing implications for others. Note that containing distress is also a form of boundary creation and maintenance.

(28) Help the client to distinguish between current triggers and past threat

'The ability to differentiate between being triggered and being threatened is key to trauma treatment. We have to know we are safe now in order to effectively process how unsafe it was then.'¹²⁹

There are a number of ways therapists can help their clients distinguish between past danger and current triggers. They include simply encouraging the client to say '*I'm triggered*' when distressed, rather than expressing global statements about lack of safety (i.e. subject to knowing the client's living context and circumstances).

¹²⁷ Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.47.

¹²⁸ 'When a client is numb and hypoaroused, active strategies are indicated', while '[i]f the client is hyperaroused 'containment' strategies may be helpful' (Courtois, 1991, cited in Ogden et al, *Trauma and the Body*, *ibid*, p.198).

¹²⁹ Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.49.

(29) Utilise the now empirically confirmed power of imagination

Use of imagination in the therapy room (e.g. to soothe, encourage, and potentially inspire) and fostering the client's use of imagination outside therapy can be a valuable resource: 'it is *often extremely useful to take advantage of the fact that the emotional brain hardly distinguishes between imagined and physically enacted experiences*'.¹³⁰

Note, however, that the power of imagination 'goes both ways' in that it may be a source of distress as well as comfort. Actively enlisting imagination for therapeutic purposes also risks further destabilisation. This underlines the need for care regarding both the nature of all imagery chosen and the way in which interventions involving imagery and symbols are used. Images should usually be selected by the client; i.e. individualised rather than generic.

(30) Ensure an updated understanding of the nature of memory and traumatic memory

Current neuroscientific research confirms that memory is not a single entity. Rather it comprises *different types and subsystems which are stored in different areas of the brain*. The key distinction is between *explicit* (conscious, verbal) and *implicit* (non-conscious, non-verbal) memory. Implicit memory is encoded in the body as procedural movements and tendencies,¹³¹ and/or situationally elicited via diverse triggers (visual, auditory, olfactory, anniversaries, and other stimuli/cues).

Traumatic memory is a particularly potent variety of implicit memory which is remembered via non-verbal reliving (i.e. what is consciously 'forgotten' because it is overwhelming is remembered implicitly via sensation, movement and behaviour at an unconscious level).¹³² For a summary of current research in relation to traumatic memory, see the 2018 Blue Knot publication *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma* at <https://www.blueknot.org.au/resources/publications/trauma-and-memory>

Delayed conscious recall ('recovered') memory¹³³ is common in diverse forms of trauma:¹³⁴ '*Contrary to the widespread myth that traumatic events are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind*,'¹³⁵ '*Research during the past two decades has firmly established the reliability of the phenomenon of recovered memory*'.¹³⁶

Studies show that neither explicit nor implicit memory is infallible, and that '*[m]emories that are recovered – those that were forgotten and subsequently recalled- can often be corroborated and are no more likely to be confabulated than are continuous memories*'.¹³⁷ It is important for clinicians to be aware of these findings and for an updated understanding of memory to inform the entire mental health field.¹³⁸

130 Bruce Ecker, Robin Ticic & Laurel Hulley, citing Kreiman, Koch, & Fried, 2000, *Unlocking the Emotional Brain* (Routledge, New York, 2012), p.27.

131 Peter Levine, *Trauma and Memory* (North Atlantic Books, CA: 2015).

132 Babette Rothschild, *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment* (Norton, New York, 2000); Bessel A. van der Kolk, *The Body Keeps the Score*, *ibid*.

133 C.R. Brewin, 'A Theoretical Framework for Understanding Recovered Memory Experiences' Nebraska Symposium on Motivation, in Belli, R.F. ed. *True and False Recovered Memories, Toward a Reconciliation of the Debate*. (Springer, New York, 2012), p.165.

134 Onno Van der Hart, Brown & Graafland, 'Trauma-induced Dissociative Amnesia in World War 1 Combat Soldiers', *Australian and New Zealand Journal of Psychiatry* (33, 1, 1999 pp.37-46); D. M. Elliott, 'Traumatic Events: Prevalence and Delayed Recall in the General Population', *Journal of Counselling and Clinical Psychology* (65, 1999, pp.811-820).

135 Brewin, 'A Theoretical Framework for Understanding Recovered Memory Experiences', *ibid*, p.165.

136 Constance Dalenberg, 'Recovered memory and the Daubert criteria: recovered memory as professionally tested, peer reviewed, and accepted in the relevant scientific community', *Trauma, Violence & Abuse* (7, 4, 2006), p.274.

137 James Chu, *Rebuilding Shattered Lives* (John Wiley & Sons, NJ, 2011, p.80, citing Dalenberg, 1996; Kluft, 1995; Lewis, Yeager, Swiza, Pincus & Lewis, 1997) [also see Dalenberg et al, 2012]; '[s]ubstantial research examining both naturalistic and laboratory situations has demonstrated that recovered memories are equally likely to be accurate as are continuous, never-forgotten memories' (M. Rose Barlow, Kathy Pezdek et al., citing multiple sources, 'Trauma and Memory', Chapter 16 in Gold, S.N., ed. *APA Handbook of Trauma Psychology: Foundations in Knowledge* (American Psychological Association, 2017, pp.307-331).

138 Levine, *Trauma and Memory*, *ibid*.

(31) Apply understanding of implicit memory to the processing of traumatic memory (i.e. 'Phase 2' in the phased treatment model)

Increased understanding of the role of implicit traumatic memories in generating 'symptoms' (see Guideline 11) indicates that 'past' traumatic experience can be credibly and more readily discerned *in present time*.¹³⁹ This means that attempts to 'retrieve' traumatic memories are unnecessary and inappropriate: *'[G]uided by the neuroscience and attachment research, treatments have moved away from an emphasis on event memory retrieval to focus on the legacy of implicit memory, and on mindful witnessing in lieu of narrative expression'*.¹⁴⁰

Implicit traumatic memory registers *in the present unfolding moments* (which *'depending on past experiences, produces experiences of ventral vagal flow, sympathetic mobilization, or dorsal vagal immobilization'*).¹⁴¹ Thus *'[a] trauma-informed treatment...focuses on recognising and working in present time with the spontaneous evoking of implicit memory and animal defense survival responses rather than in creating a verbal narrative of past experiences'*.¹⁴²

The principles of Polyvagal Theory,¹⁴³ which is now being applied clinically,¹⁴⁴ explain how verbal expression follows rather than precedes autonomic state (also see Guideline 18). This has major implications for 'talk therapy' in general and for processing traumatic memory in particular.

(32) Dual awareness supports the processing of traumatic memory

Just as the capacity for dual awareness is foundational to self-regulation and daily functioning, it is also critical for trauma processing:¹⁴⁵

'Using 'dual awareness', we have the capacity to fully inhabit the moment: to feel our feet on the ground through awareness of body sensation while our visual perception takes in details of the room in which we are sitting – while, in the same moment, we can evoke an image from an earlier time in our lives that takes us 'back there' to a state-specific memory'.¹⁴⁶

Client resourcing and ability to tolerate sensations is critical to this process; see Guideline 26.

139 'The root cause of the client's difficulty, we now know, is not just the original event but the reactivation of implicit memories by trauma-related stimuli that mobilise the emergency stress response as if the individual were in danger again' (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.43; ref van der Kolk, 2014).

140 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, pp.154-155.

141 Deb Dana & Deb Grant, 'The Polyvagal PlayLab: Helping Therapists Bring Polyvagal Theory to their Clients', Chapter 11 in Porges & Dana, *Clinical Applications of the Polyvagal Theory*, *ibid*, p.203; emphasis added.

142 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.43.

143 Stephen Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, Self-Regulation* (Norton, New York, 2011).

144 Porges & Dana, *Clinical Applications of the Polyvagal Theory*, *ibid*.

145 In 'allowing us to explore the past without risk of retraumatization by keeping one 'foot' in the present and one 'foot' in the past' (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p. 78; ref Ogden et al, 2006; also Rothschild, *ibid*, 2000, 2011, 2018; [Robin] Shapiro, *ibid*).

146 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.45.

(33) Recognise that misconceptions about Dissociative Identity Disorder (DID) continue to circulate

Notwithstanding frequent reference to DID as 'controversial', research confirms that DID is not uncommon.¹⁴⁷ Although widely undiagnosed and despite ongoing disbelief, it is a recognised psychiatric classification and stems from severe trauma in early childhood: *'Scepticism about numbers of self-states is a potential intellectualization and deflection of the sad reality...an intolerance of the reality of severe abuse.'*¹⁴⁸

An open access paper published in the *Harvard Review of Psychiatry* identifies and refutes common and recurrent myths about DID and is accessible at the following link: https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx

(34) Therapy should be tailored, individualised, and attuned to the client's internal diversity

'One size does not fit all' (not even for the same client all of the time).¹⁴⁹ Complex trauma clients can present in different states even within a single session. Tailoring interventions is particularly challenging when the client experiences significant internal diversity of parts which 'hold' different feelings and thoughts without conscious awareness. This often occurs due to trauma and disrupted attachment.

As van der Kolk observes *'The mind is a mosaic'* and *'[w]e all have parts.'*¹⁵⁰ Trauma and dissociation engender rigidity and loss of flexibility between parts of the self. This means that what may be tolerated by one part of the client's internal 'system' may not be tolerated by another. While DID is the most 'extreme' illustration of this, clients with trauma histories commonly experience disabling forms of dissociation which are less severe. Even where the client has conscious access to the majority of their 'parts', the clinician may struggle to assist and even recognise 'the whole person' in light of activated trauma responses and the significant lack of integration.¹⁵¹

All aspects of therapy and all proposed interventions should consider the internal diversity of the client (which in the case of complex trauma is potentially high). This is as well as attuning to the visible non-verbal indicators of expression, behaviour, and movement, and the fluctuating dynamic of hypo as compared to hyperarousal.

147 See, for example, Martin Dorahy, Bethany Brand et al, 'Dissociative Identity Disorder: An empirical overview', *Australian and New Zealand Journal of Psychiatry* (48, 5, 2014, pp. 402 – 417) and Bethany Brand, Vedat Sar et al, 'Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry*, (24, 4, 2016), pp. pp. 257-270.

148 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p.116.

149 Most therapists are aware of the need to *'[a]dapt the therapy to the client rather than expecting the client to adapt to the therapy'* (Rothschild, *Trauma Essentials*, *ibid*, p. 15).

150 van der Kolk, *The Body Keeps the Score*, *ibid*, p.282. Note that reference to 'parts', multiple states of consciousness, and 'self-states' is a common feature of many varieties of psychotherapy, although different terms are used to describe this phenomenon. See *Glossary*.

151 For elaboration of the significance and stakes of this point, see Fisher *Healing the Fragmented Selves of Trauma Survivors*, *ibid*. Also see *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches* and *Guidelines to Therapist Competencies for Working with Complex Trauma*.

(35) Understand that self-harm can serve as a coping strategy

It is often wrongly believed that the challenging behaviour of self-harm – in the sense of direct and intentional injury to body tissue – indicates suicidal intent. On the contrary, self-injury has been defined as deliberate infliction of harm to body tissue *in the absence of* suicidal intent.¹⁵² Research indicates that self-injury 'is most often performed with intent to alleviate negative affect'.¹⁵³ The coping strategy of self-harm is not uncommon among people who experience the impacts of complex trauma. Thus clinicians need to understand the functions it performs and work to address these (*also see the following guideline*).

(36) Recognise that the risk of suicide 'is a very real threat with many patients with complex PTSD' (Chu, 2011)

It is well established that '[a] heightened level of suicidal behaviour has been correlated with childhood trauma'.¹⁵⁴ All clinicians who work with complex trauma clients should be attuned to the level of risk and take appropriate steps to manage it.¹⁵⁵

Therapists should be aware, however, that suicidal thoughts are common among complex trauma survivors and can paradoxically serve as stabilising and soothing (i.e. the possibility of 'the final escape'). Hence immediate counteractive measures by the clinician (such as calling the crisis team) in the absence of clear suicidal intent can be counterproductive, erode the therapeutic alliance, and discourage disclosure by the client of their feelings and thoughts. This is clearly a therapeutic 'dance' in which the practitioner needs to maintain high attunement.

Some self-harming behaviours can also entail a high level of risk, and the client's goals and motivations should be directly explored with them. Clients 'are often able to be quite clear that there is no suicidal intent in certain self-harming activities'.¹⁵⁶ But 'there are often areas of ambiguity, such as patients who hurt themselves in ways that might or might not be lethal, or in behaviour that is not intended to be suicidal but might well result in serious injury or death': *'[b]ecause of the extreme consequences of this kind of ambivalent behaviour, therapists should clearly err on the side of acting to safeguard patients' wellbeing if there is any substantial question of personal safety'*.¹⁵⁷

(37) Distinguish between 'getting better and feeling better' (Kluft, 2013)

The important distinction between getting better and feeling better (which Kluft describes as '*two different processes*')¹⁵⁸ may at first seem counterintuitive. While it makes sense on reflection, this awareness can also be hard to sustain in the face of increased client distress.

152 E. David Klonsky, 'The Functions of Deliberate Self-Injury: A Review of the Evidence', *Clinical Psychology Review* (27, 2, 2007), p.226.

153 Klonsky, 'The Functions of Deliberate Self-Injury', *ibid*.

154 Chu, citing many sources, *Rebuilding Shattered Lives*, *ibid*, p.136.

155 See 'The Management of Suicide Risk', in Chu, *Rebuilding Shattered Lives*, *ibid*, pp.136-141.

156 Chu, *Rebuilding Shattered Lives*, *ibid*, p.137.

157 Chu, *Rebuilding Shattered Lives*, *ibid*.

158 Richard P. Kluft, *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* (CreateSpace, South Carolina, 2013), pp.79-80.

A client's increased capacity to experience emotion – i.e. as they dissociate less – includes painful feelings which may be very distressing if the person was previously insulated from them: 'as dissociation is reduced, its power as a defence is diminished. Things can hurt more...' and there are 'more painful things in awareness'.¹⁵⁹

This can precipitate a crisis in the therapy – not, paradoxically, because the therapy 'isn't working' but because it *is*. As clients begin to *get* better, they may not *experience* it as progress because decreased dissociation means increased capacity to feel pain.¹⁶⁰

Subject to reflective practice regarding the progress of the therapy (i.e. tracking to ensure that it remains 'on course') it is important that the clinician does not experience the client's distress as a crisis of *the therapy*. If this occurs it could derail the therapy itself. Note that Kluft advises that the increased pain the client feels as emotional capacity increases may be partially offset by a decreased sense of internal constriction.¹⁶¹ It may be valuable to communicate this to the client and to 'check it out' with them.

(38) Therapists should be culturally competent and sensitive to all dimensions of diversity

Awareness of, and attunement to, the potential impacts of diversity in its various forms (e.g. age, ethnicity, gender, sexual orientation, socio-economic status) is important for all therapeutic work. This is including and especially with complex trauma clients who are often highly attuned to therapist ambivalence.¹⁶² Clinicians need to be highly attuned to their own responses to perceptions of culture, gender and other 'differences' in relation to their clients, and to be conversant with resources which can help with this.¹⁶³

(39) End all sessions safely

*'[I]t is imperative that the client leaves the session in an embodied adult state, with a sense of orientation to time, place and person and specific plans to regulate themselves in the face of potential day-to-day triggers'.*¹⁶⁴

This may seem difficult to achieve at times, especially given the challenges of 'grounding' for dissociative clients and/or clients with high internal diversity (see Guideline 34). But it is critical for therapists to ensure that all sessions end appropriately. This includes implementing suitable strategies for client resourcing, and methods for managing 'hand on the doorknob' disclosures that can derail and destabilise the client.

159 Kluft, *Shelter from the Storm*, *ibid*, p.79.

160 Kluft, *Shelter from the Storm*, *ibid*

161 Kluft, *Shelter from the Storm*, *ibid*

162 Recall that what is not spoken and consciously articulated tends to be evoked, embodied and enacted (David J. Wallin, *Attachment in Psychotherapy*, The Guilford Press, New York, 2007, p.131).

163 For an excellent discussion of this multifaceted topic, see Laura S. Brown, 'Cultural Competence', Chapter 8 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, pp.166-182; and her book *Cultural Competence in Trauma Therapy* (American Psychological Association, Washington, DC, 2009).

164 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p. 202.

(40) Engage in regular professional supervision and attend to self-care

*'The intensity and complexity of transference-countertransference dynamics in complex trauma relationships are such that working without clinical consultation, at any level of helper experience, can pose great hazards for both clients and therapists.'*¹⁶⁵

There are many reasons why ongoing trauma-informed clinical supervision for complex trauma therapists is essential. Regular trauma-informed supervision is not only professionally necessary and a safeguard for clients. It is also a vital component of therapist well-being and self-care.¹⁶⁶ Also see 'Self-Care for Therapists who Work with Complex Trauma' (Appendix 2 of this document).

(41) Attend to duration and frequency of sessions

Therapists should recognise that complex trauma treatment is generally longer than for many other presentations, and that while varying significantly according to the client, is *'rarely...meaningful if completed in less than 10-20 sessions'*.¹⁶⁷ If economic or other constraints severely limit the number of available sessions, there may be grounds to confine therapy to the 'stabilisation' (Phase I) stage.¹⁶⁸

Therapy is recommended to occur on a once or twice-weekly basis, with sessions ranging between 50 and 75 minutes for individual therapy and between 75 and 120 minutes for group therapy.¹⁶⁹ Therapy should not exceed these recommended standards of frequency in the absence of compelling grounds for doing so, or destabilisation and excessive dependence may result.

(42) Engage in collaborative care as appropriate

This entails collaboration not only with the client, but also with other professionals and services with whom the client may be in contact in relation to their care.¹⁷⁰ While clinicians are not case workers, the extensive impacts of complex trauma, particularly in the early stages of therapy but often for prolonged periods, mean that many clients may need extra-therapeutic support to remain in therapy at all. Within obvious limits, therapists should liaise with appropriate support services where necessary, i.e. additional to formal provision of the therapy, to optimise the context and conditions in which therapy is undertaken by clients who may require this support. Also note availability of the Blue Knot Helpline database of trauma-informed practitioners and services accessible via the Blue Knot helpline on 1300 657 380 from 9-5 Mon-Sun AEST.

¹⁶⁵ Laura Anne Pearlman & James Caringi, 'Living and Working Self-Reflectively to Address Vicarious Trauma', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, p.214 (emphasis added).

¹⁶⁶ For a helpful paper which addresses the breadth of the dimensions involved, see Anne Marie Coleman, Zoe Chouliara, & Kay Currie, 'Working in the Field of Complex Psychological Trauma: A Framework for Personal and Professional Growth, Training, and Supervision' *Journal of Interpersonal Violence* (2018), pp.1–25 <https://rke.abertay.ac.uk/en/publications/working-in-the-field-of-complex-psychological-trauma-a-framework->

¹⁶⁷ Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.96. Here it should be noted that the pervasiveness and depth of the impacts of complex trauma sometimes require the duration of therapy to be extensive: "For some clients, treatment may last for decades, whether provided continuously or episodically" (*Ibid*).

¹⁶⁸ As recommended by Rothschild, *Trauma Essentials*, p.62.

¹⁶⁹ Note the qualification of Courtois, Cloitre & Ford that 'when multiple modalities are required (i.e. group and individual; substance abuse treatment in addition to psychotherapy; couple and/or family work plus individual therapy; partial hospitalization in addition to or instead of individual therapy) more sessions per week are obviously needed' ('Best Practices in Psychotherapy for Adults', *ibid*, pp.96-97).

¹⁷⁰ This should also include receptivity to quality innovative collaboration to treatment. For example a US study of an eight-week multimodal phase-oriented inpatient treatment program for complex trauma and dissociation from which patients were found to benefit incorporated a mix of components including art therapy, music, and movement therapy along with 'traditional' cognitive treatment and pharmacotherapy (Yolanda Schlumpf, Ellert Nijenhuis et al, 'Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', *Neuroimage: Clinical* (23, 2019), Also see discussion in Chapter 5.

(43) Facilitate continuity of care as appropriate

Histories of betrayal and abandonment render complex trauma clients vulnerable to feelings of rejection. Ending therapy (for whatever reason) is itself a process which represents *'a critical opportunity to support and sustain the client's gains in relational, emotional, and behavioural self-regulation'*.¹⁷¹ Courtois, Ford and Cloitre note that when a client is engaging with a new therapist or treatment provider, interventions which encourage a sense of continuity should be integrated into the client's transition process.¹⁷²

'Continuity of care' also applies in the sense of optimal conditions under which the therapy is conducted and experienced. For some clients, particularly those who lack healthy interpersonal relationships and social connection and participation, this may involve accessing extra-therapeutic supports, contact with which therapists may in the first instance directly or indirectly assist. Clinicians should be aware of the range of services which may support clients in diverse and appropriate ways and take reasonable steps to assist clients to engage with them where necessary.

(44) Diversity of clients means that recovery, too, is diverse

*'Therapists must be aware of differences in clients' capacities to engage in therapy and to resolve their symptoms and distress. There are as many degrees of self- and relational impairment as there are of healing capacities and resources, resulting in different degrees and types of resolution and recovery.'*¹⁷³

171 Courtois & Ford, 'Best Practices in Psychotherapy for Adults', *ibid*, p.98.

172 Courtois & Ford, 'Best Practices in Psychotherapy for Adults', *ibid*.

173 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', *ibid*.



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Part 2

Research Base

Contents

Part 2: Research Base

SUMMARY OF KEY RESEARCH THEMES 60

(1) 'The neurobiological revolution in psychotherapy' ¹⁷⁴ continues: Implicit memory, the impact of experience, and the implications for trauma treatment/s	60
(2) 'Bottom-up' and 'top-down'	61
(3) The salience of the body	62
(4) Updating our understanding of memory	63
(5) Dissociation and complex trauma: 'the fear of feeling real' ¹⁷⁵	67
(6) 'New' approaches to trauma treatment	69
(7) Is brief necessarily bad? Rapid interventions and brief therapies	70
(8) Reconsidering 'the relational'	74
(9) Strategies, techniques and 'the net'	77
(10) Evidence base or 'evidence-based'? Validating how we work and what we do	78

CHAPTER 1 80

Understanding Complex Trauma and the Implications for Treatment

1.1 A new diagnosis: Complex PTSD	81
1.2 Complex PTSD differs from standard PTSD	82
1.3 Updating diagnoses and continuing dilemmas	83
1.4 Beyond diagnosis: the importance of relational context	84
1.5 Betrayal of trust and 'soul murder'	84
1.6 Complex trauma and the dissolution of self	85
1.7 Flight from the body	86
1.8 Complex childhood trauma and its adult impacts	88
1.9 Complex trauma and dissociation: 'the fear of feeling real' ¹⁶⁸	89
1.10 Revisiting 'resilience'	91
1.11 Sociocultural/political contexts: insidious trauma and micro-aggressions	93
1.12 The centrality of experience: limits of 'symptom-based' approaches to treatment	96
Summary of key findings and themes	99

¹⁷⁴ Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (Routledge, New York, 2017), p. xi.

¹⁷⁵ Subtitle of Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real* (Norton, New York, 2015).

CHAPTER 2	101
What is dissociation and why do we need to know about it?	

2.1	Association and dissociation: a constant interplay	101
2.2	What is dissociation?	102
2.3	An alternative model of mind: integration and coherence are developments not givens	104
2.4	The emergent self: dissociation, relationality, and development of emotional coherence	104
2.5	Impediments to linkage: 'when things go wrong'	106
2.6	Both the norm and forerunner of disorder	108
2.7	When experience is overwhelming: trauma-related dissociation	109
2.8	Dissociation is not the same as repression and why the differences matter	110
2.9	Dissociation is transdiagnostic and implicated in diverse forms of disorder	114
2.10	Revisiting disorder: the role and challenge of dissociation	116
	Summary of key findings and themes	119

CHAPTER 3	121
Revisiting Phased Treatment for Complex Trauma	

3.1	Challenge to the phased treatment approach	123
3.2	Exposure therapy/ies: questions to arise	124
3.3	Emerging therapies and 'multiple resource' models	128
3.4	The Comprehensive Resource Model (CRM)	129
3.5	Challenging implementation	132
3.6	Fine tuning of phasing	133
3.7	Finding at this time	135
	Summary of key findings and themes	137

CHAPTER 4	140
'New' and Emerging Treatments	
4.1 New therapies, old therapies, and clinical integration	141
4.2 'Cues of safety are the treatment': ¹⁷⁶ Polyvagal Theory and the advent of polyvagal therapy/ies	142
4.3 Right brain and somatically attuned: 'analytic' yields to 'experiential'	144
4.4 Emerging 'short-term' psychotherapies and the implications for healing	145
4.5 Treatment challenges in the context of complex trauma	146
4.6 Energy Psychology	148
4.7 Emotional Freedom Techniques (EFT) and Thought Field therapy (TFT)	149
4.8 Complications in the context/s of complex trauma	151
4.9 Potential benefits	152
4.10 Eye Movement Desensitization and Reprocessing therapy (EMDR)	154
4.11 Attachment-Focused EMDR and resource tapping	157
4.12 Brainspotting: 'Where you look affects how you feel'	160
4.13 Clinical hypnosis (hypnotherapy)	162
4.14 MDMA assisted psychotherapy: back to the future and towards a changed treatment landscape?	164
4.15 MDMA, psychotherapy and complex trauma	168
4.16 'There is no turf when it comes to healing'	170
4.17 Integrating short-term 'alternative' approaches in the context of phase-based treatment for complex trauma	171
Summary of key findings and themes	173

176 Stephen W. Porges, 'Polyvagal Theory: A Primer', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, p.61.

CHAPTER 5	177
'Evidence-based': the challenge of and for complex trauma	
5.1 Questioning 'evidence-based' in the context/s of psychological treatment	177
5.2 Trauma treatment research	180
5.3 'Laboratory measures': what is being studied?	181
5.4 'First-line', 'trauma focused' and 'evidence-based': grounds for scepticism as treatments for complex trauma (and see the detailed discussion in Chapter 3)	183
5.5 Emotion-Focused Therapy for Complex Trauma (EFTT) Redressing 'affect phobic' treatment?	184
5.6 Revisiting the dominance of the RCT	186
5.7 The Treatment of Patients with Dissociative Disorders (TOP DD) Study	187
5.8 Practice-based evidence, common factors research and Feedback Informed Treatment (FIT)	189
5.9 Widening our purview: complex trauma and diverse treatment types	190
5.10 Evidence base rather than 'evidence-based'?	192
Summary of key findings and themes	195



Summary of Key Research Themes

The following is a summary of the key research themes of the updated *Practice Guidelines for Clinical Treatment of Complex Trauma*. While some clinicians may not want to focus on the underpinning research, we recommend that you read the substantiating detail in the chapters which follow.

Please note that any references to the need for diverse disciplines to be receptive to trauma-informed interventions are offered as professional development. They do not represent an endorsement of any particular approach, modality, or technique.

(1) The ‘neurobiological revolution in psychotherapy’¹⁷⁷ continues: implicit memory, the impact of experience, and the implications for trauma treatment/s

In the early 2000s, clinicians and researchers such as Bessel van der Kolk, Dan Siegel and Louis Cozolino introduced neuroscientific findings to psychotherapy which heralded a revolution in more effective complex trauma treatment. This ongoing revolution reflects advances in understanding the nature of memory which spearheaded ‘the reorientation of psychotherapy in terms of emotional implicit memories and its associated brain science’.¹⁷⁸

Recognising the different regions and subsystems of the brain, the pervasive influence of *implicit* memory, that neuroplasticity is life-long,¹⁷⁹ and that ‘[e]arly life experiences within primary attachment relationships create potent emotional learnings in implicit memory’¹⁸⁰ continues to transform the psychotherapy field.

This paradigm shift has also ignited new interest in possible treatments within psychotherapy. The driving quest for effective treatment/s is bringing new possibilities for more effective clinical practice.

‘[G]uided by the neuroscience and attachment research, treatments have moved away from an emphasis on event memory retrieval to focus on the legacy of implicit memory, and on mindful witnessing in lieu of narrative expression’.¹⁸¹

Paying attention to the *legacy*, rather than the *content*, of traumatic experience means moving away from ‘an emphasis on event memory’ (i.e. in favour of present-centred focus). This has a number of major implications.¹⁸² Prominent clinician and educator Janina Fisher invites therapists ‘to make a paradigm shift from a focus on traumatic *events* to prioritizing attention to the role of implicit memory in trauma treatment’¹⁸³:

177 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (Routledge, New York, 2017), p. xi.

178 Bruce Ecker et al. *Unlocking the Emotional Brain* (Routledge, New York, 2012), p. xviii.

179 See, for example, Louis Cozolino, *The Neuroscience of Psychotherapy* (Norton, New York, 2002) and Norman Doidge, *The Brain that Changes Itself* (Penguin, New York, 2007).

180 Ecker et al, *Unlocking the Emotional Brain*, *ibid*, p.32.

181 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, pp.154-155.

182 ‘Rather than remembering what happened, once thought to be the goal of trauma treatment, we know now that resolution of the past requires *transforming* the memories’ (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.40; original emphasis).

183 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.10; emphasis added.

*'Rather than focusing on desensitizing the event memories, experts now advise prioritizing transformation or repair of trauma-related states through the cultivation of new experiences.'*¹⁸⁴

This single sentence encapsulates the scope and challenges of this contrasting approach. The contrast between current and prior perspectives on effective trauma treatment is stark and is still being assimilated.¹⁸⁵ The capacity of *new experiences* to challenge, unsettle and resolve prior implicit traumatic memory challenges traditional trauma treatments; i.e. 'talk therapy'.

(2) 'Bottom-up' and 'top-down'

Psychotherapy ('talk therapy') has traditionally emphasised 'cognitive, critical functioning – a 'top-down' process primarily engaging the pre-frontal cortex.'¹⁸⁶ But it is increasingly recognised that

*'there is a problem when it comes to using such methods to heal the effects of trauma. The cognitive part of the brain has limited input to the subcortical areas where blocked emotional and defence responses are activated, driven and stored.'*¹⁸⁷

This means that 'a client may seem to make significant breakthroughs in understanding their feelings on a rational level by talking with a therapist, *but this may make no difference to their post-traumatic symptoms if the midbrain is unable to modulate its activity in response*'.¹⁸⁸

While this limitation of 'talk therapy' is increasingly recognised, 'top-down' interventions *at the expense of 'bottom-up'* remain common. Many therapists still focus on a client's thoughts, feelings and beliefs without paying sufficient attention to their *experience*. This is not logical as *physiological* experience precedes reflection and subjectivity (see below comments) and failure to acknowledge this in treatment can have destabilising effects. Destabilisation can also stem from a therapist's basic well-meaning invitation to invoke a 'safe place':

*'[A]sking a client to imagine a safe place inside when there has never been a safe place in his or her life is a top-down approach that often fails with survivors of severe trauma.'*¹⁸⁹

184 Fisher, Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*; emphasis added.

185 The range of issues pertaining to perspectives on treatment/s is discussed in Chapters 3-5. The extent to which single-incident PTSD and complex trauma require different treatment paths is a key continuing issue for some, despite studies which have advised this (see Bessel van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Marion F. Solomon & Daniel J. Siegel, *Healing Trauma*, Norton, New York, 2003, p.173). It is also despite the subsequent research which attests to this need. The merits of desensitization and exposure - based therapies for the respective cohorts need to be considered and are addressed in Chapter 3.

186 Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma* (Routledge, New York, 2017), p.2.

187 Schwarz, Corrigan et al. *The Comprehensive Resource Model*, *ibid*, p.2 ('largely in the brainstem, hypothalamus, thalamus and basal ganglia structures' (Corrigan, 2014, in Schwarz & Corrigan, *ibid*).

188 Schwarz, Corrigan et al. *The Comprehensive Resource Model*, *ibid*, p.2; emphasis added.

189 Lynette Danylchuk & Kevin Connors, *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges* (Routledge, New York, 2017), p.77.

Detecting threat, as Stephen Porges elaborates, is not voluntary or conscious.¹⁹⁰ Porges has introduced the term ‘neuroception’ to describe this process.¹⁹¹ His celebrated Polyvagal Theory contends ‘that physiological state is a fundamental part, and not a correlate, of emotion or mood’.¹⁹² The meanings we make of our experience follow - rather than drive - our physiological responses even as there is a bi-directional relationship between them:

*‘Polyvagal Theory challenges therapists to change their customary way of thinking about trauma and adopt a core concept from Polyvagal Theory: neuroception precedes perception, story follows state’.*¹⁹³

Greater recognition of the limitation of the ‘body blindness’ of traditional psychotherapeutic practice¹⁹⁴ continues to bring greater attention to the primacy of the body and its physiological processes.¹⁹⁵ The resulting ‘reorientation’ of standard psychotherapeutic practice has major implications for treatment approaches and modalities in general and for effective trauma treatment in particular.

(3) The salience of the body

There is a burgeoning interest in somatic psychotherapies, of which Peter Levine’s Somatic Experiencing (SE) and Pat Ogden’s Sensorimotor Psychotherapy (SP)¹⁹⁶ are well-known and respected variants. Many therapists are now enrolling in these trainings, including in Australia, where the numbers of graduates of each are growing.

*‘Over the last 15 years, the leading edge of trauma work has been focusing on the importance of the body and ‘bottom-up’ factors that contribute to the creation of post-traumatic stress on the one hand and post-traumatic healing on the other’.*¹⁹⁷

The 2012 Guidelines stressed the need to attune to somatic processes in effective complex trauma therapy. Many clinicians are upskilling accordingly.

‘Brain-based’ psychotherapy has its correlate in ‘body-based’ therapies although the legacy of the ‘mind-body’ dichotomy remains. The general public is also more aware of the relationship between physiology and psychology, especially in relation to trauma. Van der Kolk’s 2015 text *The Body Keeps the Score*¹⁹⁸ quickly became a bestseller, and joins Rothschild’s *The Body Remembers*¹⁹⁹ as a ‘trauma classic’.

190 Stephen Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* (Norton, New York, 2011).

191 Neuroception is described as ‘the nervous system’s capacity to evaluate risk without awareness’ (Lindaman & Makela, in Stephen Porges & Deb Dana, ed. *Clinical Applications of the Polyvagal Theory*, Norton, New York, 2018, p.229); ‘The vagus knows before cognition, and this means that neuroception precedes cognition’ (Theede in Porges & Dana, *Clinical Applications of the Polyvagal Theory*, ibid, p.160; emphasis added).

192 Stephen W. Porges, ‘Polyvagal Theory: A Primer’, in Porges & Deb Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, p.59.

193 Dana & Grant in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, p.198; emphasis added.

194 ‘The body, for a host of reasons, has been left out of the ‘talking cure’ (Pat Ogden, Kekuni Minton & Clare Pain, *Trauma and the Body*, Norton, New York, 2006), p. xxvii.

195 ‘Modern neural science clearly points to the central role of the body in the creation of emotions and meaning’ Daniel J. Siegel, M.D. ‘Senior Editor’s Foreword’, in Ogden et al, *Trauma and the Body*, ibid, p. xv.

196 See Somatic Experiencing Australia <http://www.seaustralia.com.au/> and detailed information on training in Sensorimotor Psychotherapy at <https://www.sensorimotorpsychotherapy.org/psychotherapists.html>

197 Robert Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, ref Van der Kolk, 2014, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, p.282.

198 Bessel A. van der Kolk, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* (Penguin, New York, 2015).

199 Babette Rothschild, *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment* (Norton, New York, 2000),

Somatic processes are central to both psychological and physical healing. Effective psychotherapy for complex trauma must attune to and access physiological responses. This relates to a *sense of safety* which must be established before ‘processing’ trauma, and is an underpinning principle of the ‘phased’ approach to complex trauma treatment recommended by the expert consensus guidelines.²⁰⁰

Stephen Porges highlights the anomaly of saying that we ‘know’ what safety is, when sense of safety is not cognitive but rather about feeling and experiencing.²⁰¹ Since the 2012 guidelines, the ‘*Polyvagal Theory*’ has become a ‘polyvagal therapy’; i.e. the theory is now being applied clinically.²⁰²

‘It is not possible to shift emotional and psychological states without shifting physiological states’

Gray, 2018, p.221

‘When we consciously and deliberately engage in practices that produce physical calmness, we signal the limbic brain that we’re safe at a physiological level’

Church, 2015: 49

Few trauma therapists now dispute the importance of ‘attuning to the body’ to supplement and at times reorient traditional psychotherapeutic practice (see below comments and Chapter 4).

(4) Updating our understanding of memory

Memory is not a single entity, but rather consists of different types which relate to different areas of the brain. This has significant clinical implications. As Peter Levine explains, ‘[b]roadly speaking, there are two types of memory: those that are explicit and those that are implicit, the former being conscious and the latter relatively unconscious.’²⁰³ It is also the case that ‘conscious explicit memory is only the tip of a very deep and mighty iceberg.’²⁰⁴

Enhanced understanding of the role of *implicit* memory, and its differences from conscious explicit memory, is revolutionary for psychotherapy and more broadly. As Siegel relates, ‘*recent discoveries in the field of brain science allow us...to grasp how implicit memory can influence our present without our awareness that something from the past is affecting us*’.²⁰⁵

In relation to trauma treatment, this means that ‘careful clinical recognition of, and *ability to distinguish between and work with*, memory that is declarative or explicitly held in a conscious, narrative verbal format and nonverbal, implicit memory that is evoked by traumatic reminders is vital’.²⁰⁶

200 M. Cloitre, C.A. Courtois, J.D. Ford, B.L. Green, P. Alexander, J. Briere, J.L. Herman, R. Lanius, B.C. Stolbach, J. Spinazzola, B.A. van der Kolk, & O. Van der Hart (2012) *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf Note that the ‘phased’ approach to complex trauma treatment has since been criticised; for consideration of the nature and validity of these more recent criticisms see Chapter 3.

201 Stephen Porges, ‘Mistakes Made, Lessons Learned’ Bonus material, EMDR Bonus material, PESI 2018).

202 Stephen Porges & Deb Dana, *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies*, *ibid*; also see Deb Dana, *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation* (Norton, New York, 2018).

203 Peter Levine, *Trauma and Memory: Brain and Body in a Search for the Living Past* (North Atlantic Books, CA), p.15.

204 Levine, *Trauma and Memory*, *ibid*, p. xxii.

205 Daniel J. Siegel, *Mindsight* (Random House, New York, 2010), p.149; emphasis added.

206 Ogden et al, *Trauma and the Body*, *ibid*, p.236; emphasis added.

Neuroscientific research regarding the nature of traumatic memory validates the insights of pioneers in the trauma field more than a century ago.²⁰⁷ It also has profound implications for our ability to understand human functioning.

Yet *updated information on the nature of memory is rarely reflected in current commentary*. This includes in purportedly contemporary research on memory in the professional literature - including that of the 'psy' professions²⁰⁸ - as well as in journalism, the law, and public discussion.

Both popular and academic/professional use of the word 'memory' generally still refers only to conscious, explicit memory (Levine, 2015).

This ignores the ongoing power of implicit memories which *'are primarily organized around emotions and/or skills or 'procedures' – things that the body does automatically'* (Levine, 2015: 21)

The emphasis placed on cognition (i.e. 'top-down') at the expense of *subcortical* ('bottom-up') functioning has deep roots in our culture.²⁰⁹ It is also apparent in the 'psy' professions in which Cognitive Behavioural Therapy (CBT) remains a dominant modality. As noted previously, privileging cognition in trauma treatment is often not sufficient or helpful when the client's level of arousal blocks their ability to think and reflect;²¹⁰ i.e. if they have exceeded their 'window of tolerance'.²¹¹

There has been a longstanding focus on cognitive function at the expense of subcortical processes. This partially accounts for the narrow focus on conscious (explicit) recall, at the expense of implicit, non-conscious, and procedural memory (which includes traumatic memory).

In contrast to consciously recalled explicit memory, implicit traumatic memories *'tend to arise as fragmented splinters of inchoate and indigestible sensations, emotions, images, smells, tastes, thoughts'* (Levine, 2015: 7) and in '[f]lashbacks, intrusive bodily sensations... and images of traumatic events that 'seem to come out of nowhere' (Siegel, 2012: 30-5)

207 'Over a century ago, [Pierre Janet] recognized that traumatized people are unable to tell their stories in words, as we conventionally understand memory, but are often compelled to re-enact them, often remaining unaware of what their behaviour is saying' (Elizabeth Howell, *The Dissociative Mind*, Routledge, New York, 2005), pp.56-57. The current neuroscientific research confirms 'the century old finding' that trauma is experienced in the body and is often remembered via behavioural re-enactment (van der Kolk, in Levine, *Trauma and Memory*, *ibid*, p xiii).

208 Levine, *Trauma and Memory*, *ibid*, and see subsequent comments. For example '[i]t is crucial to appreciate that emotional memories [a form of implicit memory] are experienced in the body as physical sensations' (Levine, *Trauma and Memory*, *ibid*, p. 22). This is crucial to understanding the nature of traumatic memory but is not apparent in much contemporary, including professional, literature. For further discussion of these points also see *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma* (Blue Knot Foundation: Sydney, 2018) <https://www.blueknot.org.au/resources/publications/trauma-and-memory>

209 Indeed it is at the heart of the Western philosophical tradition, as the dictum of seventeenth century philosopher Rene Descartes *cogito ergo sum* ('I think, therefore I am') encapsulates.

210 'Generally, interventions that are primarily cognitive in nature do not work as well with dissociative clients as they usually do with others. When the connection to the cognition is present, they work. However, if the person is in a dissociative state, that cognitive skill is not available, and so, it doesn't help' (Danylchuck & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.19).

211 I.e. the now widely utilised term coined by Dan Siegel (1999) to describe the zone/threshold at which arousal can be tolerated.

An understanding of the complexity of memory (the question should always be 'what type of memory?') is crucial for professionals and the public alike.

The stakes are high in relation to trauma, because misconceptions about the nature of memory remain common.

Failure to differentiate between explicit and implicit memory also limits understanding of the phenomenon of 'recovered' (delayed onset recall) memory. While common to diverse types of trauma,²¹² recovered memory is still often not recognised and misperceived as illegitimate.²¹³

'If recovered memory experiences appear counter-intuitive, this is in part due to misconceptions about trauma and memory'

(Brewin, 2012: 149)

Memory is not just about neurology and this point is especially relevant to 'recovered' memory. Secrecy and power inequities and dynamics are characteristic of recovered memory in particular, in which '[b]oth internal and external processes operate to keep us unaware'²¹⁴ ('[t]o the extent that it is not safe to disclose externally, it is not safe to know, or disclose internally, to oneself').²¹⁵

The social, political, and survival functions of 'forgetting' need to inform any discussion of traumatic memory, and specifically of recovered memory.

This often doesn't happen, which further illustrates both the urgent need to update professional and public understanding of memory and the importance of the context/s in which different types of memory are 'forgotten' and recalled.²¹⁶

As well as the context of recollection, the state of the person at the time is also highly significant:

*'A considerable body of research points to state dependence in learning, memory, and recall. That is, when a person is in one emotional and physiologic state, it is more difficult to access memories and experience of a different state.'*²¹⁷

The survival value of (consciously) 'forgetting', the ongoing legacy of concerns about physical/emotional safety in unequal power relationships, and the availability of safe contexts in which to disclose prior traumatic experience are routinely ignored when questions about the reliability of 'recovered' memory are raised.

212 'Post traumatic amnesia extends beyond the experience of sexual and combat trauma and is a protean symptom, which reflects responses to the gamut of traumatic events' (Onno van der Hart et al, 'Trauma-induced Dissociative Amnesia in World War 1 Combat Soldiers', *Australian and New Zealand Journal of Psychiatry* (33, 1, 1999), pp.37-46.

213 'Substantial research examining both naturalistic and laboratory situations has demonstrated that recovered memories are equally likely to be accurate as are continuous, never-forgotten memories' (M.R. Barlow, K. Pezdek et al, 'Trauma and Memory' [ref. Chu et al, 1999; Williams, 1995; Dalenberg, 2006] 'Trauma and Memory', Chapter 16 in S. Gold, ed. *APA Handbook of Trauma Psychology*, American Psychological Association, 2017, pp.322).

214 Jennifer Freyd & Pamela Birrell, *Blind to Betrayal* (Wiley & Sons, New Jersey, 2013), p. 95.

215 Freyd & Birrell, *Blind to Betrayal*, *ibid*, p.116.

216 '[T]he social context in which people disclose affects the process itself... a process that is highly dependent on the reactions of others' (Freyd & Birrell, *Blind to Betrayal*, *ibid*, p.126)

217 James Chu, ref Eich & Metcalfe, 1989; Tobias et al, 1992; van der Kolk, 1994, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders*, 2nd edit. (John Wiley and Sons, New Jersey, 2011), p.101.

The relationship between context and memory also raises the issue of the *context of therapy*. Particularly in relation to recovered memory of childhood sexual abuse, therapy has been criticised as a vehicle for actively promoting retrieval of early life memories.²¹⁸ Clearly not every memory that is recovered – whether within or outside therapy – is necessarily accurate, just as recall of explicit continuous memory is not always reliable either (see subsequent discussion). But it is important for clinicians and the public alike to be aware that ‘[r]esearch during the past two decades has firmly established the reliability of the phenomenon of recovered memory’.²¹⁹ Critics of recovered memory also frequently overlook the fact that traumatic memories are often the catalyst to seeking therapy rather than a product of it.²²⁰

Additionally, recovery of traumatic memory is itself traumatic and rarely welcomed by those who experience it. Rather than embracing traumatic memories, many survivors consciously try to forget them and struggle to believe *themselves*.²²¹ This reflects the recurring dynamics of power and dependency in that ‘[n]ondisclosure, delayed disclosure, and retraction are particularly likely in cases in which the perpetrator is close to the victim’.²²²

Current research consistently confirms that *memory is malleable*. This means that not all recovered (i.e. formerly implicit) memories are necessarily reliable. But studies also show that *explicit memory is not always reliable either*.²²³ In fact autobiographical ‘narrative’ memory may be no more or less reliable than recovered memory.²²⁴

‘Memories that are recovered – those that were forgotten and subsequently recalled – can often be corroborated and are no more likely to be confabulated than are continuous memories.’²²⁵

Current research does not endorse memory ‘excavation’²²⁶ in therapy (as noted in Pt 1 above). It is not the content and details of client memories which are salient to healing, but rather *the impacts of the memories* on current functioning (‘and that’s the focus of the therapy’).²²⁷

Emphasis on the *impacts*, rather than *content*, of traumatic memories represents a shift in treatment orientation. It reflects current neuroscience and attachment theory (as noted in Pt 1). The relevance of implicit memory, and growing awareness that the natural emergence of traumatic memory rather

218 A major impetus to this critique were the so-called ‘Memory Wars’ of the 1990s; see ‘The Memory Wars: The Nature of Traumatic Memories of Childhood Abuse’, Chapter 5 in Chu, *Rebuilding Shattered Lives*, *ibid*, pp.78-106.

219 Constance Dalenberg, ‘Recovered memory and the Daubert criteria: recovered memory as professionally tested, peer reviewed, and accepted in the relevant scientific community’, *Trauma, Violence & Abuse* (7,4, 2006), p.274.

220 ‘[M]emory recall occurs both within and outside of therapy sessions’; ‘[n]ewly recalled trauma memories frequently precede a patient’s entry into psychotherapy’ (Chu, *Rebuilding Shattered Lives*, *ibid*, p.80).

221 Hence what Danylchuk & Connors call ‘[m]emory and denial playing tag’, in which there may be repeated denials (‘[f]or some clients the shift is the only way they know to take a break from facing the reality of their lives’) where denial may be replication and continuation of ‘*the same strategy that was used on them*’ (Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.48; emphasis added).

222 Freyd & Birrell, citing multiple sources, *Blind to Betrayal*, *ibid*, p.123; emphasis added. Also note that ‘[r]epeated research findings have shown that memory for abusive events is impaired when the victim was emotionally or otherwise dependent on the perpetrator’ (Barlow et al [ref. Schultz, Passmore, & Yoder, 2002], ‘Trauma and Memory’, *ibid*, p.321).

223 Barlow, Pezdek et al, ‘Trauma and Memory’, *ibid*.

224 Here it is also pertinent to note a documented case from the Australian Royal Commission in which a survivor of clergy institutional sexual abuse did not recover memory of his abuse *even though his abuser had confessed to it*. For details of this cases Jenny Ann Rydberg, ‘Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations’, *European Journal of Trauma and Dissociation* (1, 2017), p.96.

225 Chu, *Rebuilding Shattered Lives*, *ibid*, p.80, citing Dalenberg, 1996; Kluft, 1995; Lewis, Yeager, Swica, Pincus & Lewis, 1997 [also Dalenberg et al, 2012]; & see Barlow et al 2017).

226 Conversely, ‘research studies on memory implantation routinely warn against suggestive techniques that could lead to a belief in false memories of abuse, but do not consider the possibility that, with such suggestive techniques, victims may begin to falsely believe that they were not abused, perpetrators may falsely remember that they are innocent, and other family members may falsely remember information supposedly proving that the abuse never happened’ (Rydberg, [ref Pope, 1996, 1997, Spiegel, 1997], ‘Research and Clinical Issues in Trauma and Dissociation’, *ibid*, p.94).

227 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p 68; Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*.

than focussing on the content and details (which can destabilise clients) heralds a changing treatment trajectory.²²⁸ In terms of *trauma recovery*, it is 'not necessary for the memory to be complete for the person to heal'.²²⁹

Regarding the content of traumatic memories, clearly '[t]herapists cannot validate what they have no means of authenticating'.²³⁰ Validation of *the person and their experience*, however, is a different matter. In the clinical context, '[i]t's not the details of the memory that are important; it's the effect of whatever happened on the person'.²³¹ By contrast, the legal context prioritises fact finding and corroboration and serves a different purpose. The legal and judicial context often does not well accommodate clinical material and the nature of traumatic memory. This highlights the importance of educating the legal profession as a whole in this area.²³²

(5) Dissociation and complex trauma: 'the fear of feeling real'²³³

'Our mental life is full of discontinuities...For some, the cracks in identity are marked'

Spiegel, 2018: 4.

A major inclusion of the updated Guidelines relates to the clinical challenges of *dissociation* (see Chapter 2).

In simple terms, dissociation is 'the deficiency of internal and external awareness' that is the correlate of 'a brain function that is designed to not know'.²³⁴ It means not paying attention and 'not being present'. As Forner relates, dissociation is the 'opposite' of mindfulness, where mindfulness is 'internal and external awareness in abundance'.²³⁵

Expressed in this way, the clinical challenges posed by dissociation are obvious. This is because mindful noticing and awareness are important to healthy functioning. Mindfulness based approaches are now a shared feature of diverse varieties of psychotherapy, and mindfulness is widely regarded as a capacity to be cultivated outside of the therapy context as well. But dissociation cuts across this capacity. 'Paying attention' (*mindsight*)²³⁶ and 'not paying attention' (*mindflight*)²³⁷ are different and seemingly incompatible processes.

228 As Fisher points out, 'the memory retrieval and disclosure approach of the 1980s and 1990s' has yielded to a different orientation which better serves clients (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.155); 'The neurobiological research and a better understanding of the somatic legacy of trauma advises us to take a new and different course in treatment' (Fisher *ibid*, p.31). For current 'state of play' with respect to contrasting perspectives on complex trauma treatment, see Chapter 3 (also Chapters 4 and 5) in Part 2 of this document.

229 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, pp. 67. Understanding traumatic memory is pivotal to appropriate and effective trauma treatment, as well as to broader issues of identity and wellbeing. The relevant contextual issues also need to be considered. Research on the subsystems of memory is advancing and has many implications for the practice of psychotherapy (see, for example, Richard Lane, Lee Ryan, et al, 'Memory reconsolidation, emotional arousal, and the process of change in psychotherapy', *Behavioral and Brain Sciences*, 2015, pp.1-64). For discussion which includes consideration of some of the many pertinent contextual dimensions see *The Truth of Memory and the Memory of Truth* <https://www.blueknot.org.au/resources/publications/trauma-and-memory>

230 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.68.

231 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, pp. 67-8; emphasis added.

232 See Kezelman & Stavropoulos, 'Dealing with Trauma', *Law Institute Journal* (October, 2016), pp.36-39. <https://www.liv.asn.au/Staying-Informed/LIJ/LIJ/October-2016/Dealing-with-trauma>

233 Subtitle of Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real* (Norton, New York, 2015).

234 Christine A. Forner, *Dissociation, Mindfulness and Creative Meditations: Trauma Informed Practice to Facilitate Growth* (Routledge, New York, 2017), p.xii.

235 Forner, *Dissociation, Mindfulness and Creative Meditations*: *ibid*.

236 Daniel J. Siegel, *Mindsight* (New York: Random House, New York, 2009).

237 As per the seminar description of complex trauma clinician and researcher Kathy Steele, MN, CS, 'From MindFlight to MindSight: Overcoming the Phobia of Inner Experience', April 14 - 15, 2011, Trauma Center, http://www.traumacenter.org/training/Workshops.2010-11/Workshop_From_MindFlight_to_MindSight.php

Dissociation ‘interrupts’ mindfulness and ‘being present in the moment’ and this challenges how a client can engage in the ‘here and now’ of therapy. Yet it is often not recognised by clinicians:

‘One characteristic of dissociative phenomena is how frequently they are misdiagnosed or not accounted for at all. Many people in the mental health profession do not know what dissociation looks like or how to assess for it.’ (Danylchuk & Connors, 2017: 39).

This situation needs to be redressed, because dissociative disorders have serious adverse impacts including ‘substantial risk for suicidal and self-destructive behavior.’²³⁸ As noted in the first edition of the Guidelines, the *hyperarousal* of visible agitation is routinely easier to detect than the ‘shut-down,’ ‘withdrawal’ response of *hypoarousal* which is a marker of dissociation.²³⁹ It is important to enhance therapists’ knowledge about the nature, process, and state of dissociation because misconceptions and misunderstanding about it abound.²⁴⁰ This also requires updated information about the nature of memory; see Pt 4.

‘Multiple lines of evidence support a powerful relationship between dissociation/DD [i.e. dissociative disorders] and psychological trauma, especially cumulative and/or early life trauma. Skeptics counter that dissociation produces fantasies of trauma, and that DD are artefactual conditions produced by iatrogenesis and/or socio-cultural factors. Almost no research or clinical data support this view. DD are common in general and clinical populations and represent a major underserved population with a substantial risk for suicidal and self-destructive behavior.’²⁴¹

The above comments of Richard J. Loewenstein, MD encapsulate the urgent need to focus on dissociation in mental health in general and complex trauma in particular. Consistent high-level research findings which substantiate the reality, serious health risks,²⁴² and effective treatment of dissociation in clinical presentations continue to emerge.

Yet as reference to ‘skeptics’ in the above quotation also indicates, the urgency of the need to address dissociation continues to be contested, including within the mental health sector.²⁴³ The equation of trauma-related dissociation with notions of ‘fantasy’ further decreases the likelihood that dissociative disorders will be detected, despite their pervasiveness and health risks.

As with the need to update information on the nature of memory, dispelling myths and misinformation about dissociation is critical for public health.

(‘[e]ven among professionals, beliefs about dissociation... often are not based on the scientific literature’; Loewenstein, 2018: 229)

For this reason, key information on the topic of dissociation comprises a new chapter (Chapter 2) in these updated Guidelines, the research base of which is informed by studies which confirm dissociation to be transdiagnostic. As David Spiegel noted in a recent editorial of the *American Journal of Psychiatry*, the integration of dissociation into the field of mental health is long overdue.²⁴⁴

238 Richard Loewenstein, ‘Dissociation Debates: everything you know is wrong’, *Dialogues in Clinical Neuroscience* (20, 3, 2018), p.229.

239 In fact it is also possible for dissociation to underlie actions which a person is not aware of performing. For consideration of the many faces of dissociation, see Chapter 2.

240 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.39; Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.69.

241 Richard J. Loewenstein, ‘Dissociation Debates: everything you know is wrong’, *Dialogues in Clinical Neuroscience* (20, 3, 2018), pp.229; underline added.

242 See, for example, Brad Foote, Yvette Smolin et al, ‘Dissociative Disorders and Suicidality in Psychiatric Outpatients’, *The Journal of Nervous Diseases* (Vol.196, Issue 1, 2008), pp.29-36.

243 As Loewenstein also notes, ‘[c]ontroversy about dissociation and the dissociative disorders... has existed since the beginning of modern psychiatry and psychology’ (Loewenstein, ‘Dissociation Debates: everything you know is wrong’, *Dialogues in Clinical Neuroscience* (20, 3, 2018), pp.229.

244 David Spiegel, ‘Integrating Dissociation’, *American Journal of Psychiatry* (175:1, 2018). pp. 4-5. Also see the Blue Knot publication *Understanding and Identifying Dissociation*.

(6) 'New' approaches to trauma treatment

Greater awareness of the role of physiological processes, emotional learning, implicit memory, and 'consilience' (i.e. converging findings of diverse disciplines) about the impacts of overwhelming stress on the body and brain are informing psychotherapy practice. The field is also increasingly receptive. Even when overwhelming experience can be articulated in words, 'talking about the trauma' is often profoundly destabilising. Therapists need to consider approaches and methods which can attune to this reality, even though some lie outside traditional psychotherapeutic training.

'The success of therapy, especially with patients who have been traumatized, hinges on our ability to accurately read and effectively modulate their levels of physiological arousal as well as their needs for (and fears of) relational engagement'

(Wallin, 2007:71).

A recent text which addresses the particular challenges of treating complex trauma observes that 'the climate of the therapy world is changing':

*'More and more therapists, energy workers and body-based psychotherapists are opening themselves to new and different healing modalities that are based in the integration of mind-body-spirit.'*²⁴⁵

'New evidence from emerging fields such as epigenetics, neural plasticity, psychoimmunology, and evolutionary biology confirms the central link between emotion and physiology, and points to somatic stimulation as the element common to emerging psychotherapeutic methods'

(Church, 2013: 645).

This also includes, as van der Kolk affirms, increased receptivity to 'age-old, nonpharmacological approaches that have long been practised outside Western medicine'.²⁴⁶ These range 'from breath exercises (pranayama) and chanting to martial arts like qigong to drumming and group singing and dancing'.²⁴⁷

*'All rely on interpersonal rhythms, visceral awareness, and vocal and facial communication, which help shift people out of fight/flight states, reorganize their perception of danger, and increase their capacity to manage relationships.'*²⁴⁸

Applying 'mind-body' approaches brings rich possibilities to the current treatment landscape for healing and resolving trauma, including complex trauma.²⁴⁹ Despite the widely conceded limits of standard 'evidence-based' treatments,²⁵⁰ particular approaches and orientations should not be rejected because they are unfamiliar or unusual.

245 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.3.

246 Van der Kolk, *The Body Keeps the Score*, ibid, p.88.

247 Van der Kolk, *The Body Keeps the Score*, ibid, p.88.

248 Van der Kolk, *The Body Keeps the Score*, ibid, p.88.

249 See, for example, Arielle Schwartz, PhD *The Complex PTSD Workbook: A Mind Body Approach to Regaining Emotional Control and Becoming Whole* (Althea Press, CA, 2016).

250 See Corrigan & Hull, 'Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions', *BJPsych Bull.* (39, 2, 2015, pp.79-86); Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *Journal of Contemporary Psychotherapy* (48, 2, 2018, pp. 99–108; Schwarz, Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma*, ibid, p.140, and discussion in Chapters 4 and 5 of this document.

Van der Kolk highlights how the Polyvagal Theory helps us understand why *'disparate, unconventional techniques'* may be highly effective. It has *'enabled us to become more conscious of combining top-down approaches (to activate social engagement) with bottom-up methods (to calm the physical tensions in the body).'*

(van der Kolk, 2015: 88; emphasis added)

Diverse tools and methods from contrasting sources can also 'help patients generate new action that will lead to new information and new experience.'²⁵¹ This is exactly what research in the neurobiology of attachment requires trauma-informed psychotherapy to do.

Different tools foster *'active skills that therapists can learn and can even teach their patients to use for themselves'*, as these are *'based on mastery, competence, and resourcefulness.'*²⁵² The client may feel they lack these attributes. Yet imparting ways to acquire such skills is empowering, and utilisation of appropriate tools is trauma-informed.

'An important caveat – specialized techniques, specific schools of thought or treatment methodologies are tools, not panaceas. They must all be used with wisdom and caution reflecting the therapist's best clinical judgement based on the unique and individualised needs of the person sitting before them'.

(Danylchuk & Connors, 2017: 66).

Because of the particular challenges of *complex* trauma, it is not possible to simply apply unfamiliar or even standard tools (which should always be carefully tailored to the person). Some tools may be effective for clients who are not significantly dissociated. But caution is needed at all times because even familiar therapeutic techniques may be destabilising for a traumatised person.²⁵³

This caution is critically important when the client's inner world comprises many 'parts' to which there is little or no conscious access and which may reflect different experiences, attitudes and memories:

*'Many specialised techniques can work well with severely traumatised people, but they must be used with the awareness and cooperation of the client's 'system.'*²⁵⁴

(7) Is brief necessarily bad? Rapid interventions and brief therapies

Increasing interest in the proliferation of non-standard approaches to clinical treatment suggest that some aspects of psychological distress, including in relation to trauma, may respond better to rapid interventions than previously thought.

As Schwarz, Corrigan et al. contend, '[c]linically it is striking how frequently symptoms in the present are sourced in past experiences that have not been assimilated, and clearing the residues of these

251 Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002), p.48.

252 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.217.

253 As Danylchuk & Connors also underline, '[s]everely traumatised people are avoiding their pain for good reasons. The desire to be 'fixed' quickly and without pain or discomfort can cause therapists and clients to use a technique too often or too soon with tragic results' (Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.66). See discussion in Chapter 4.

254 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*, p.66; also see 'self-states', 'self-system', 'parts' and related terms in the *Glossary*.

brings immediate symptomatic relief'.²⁵⁵ Treatment of complex trauma is known to be of longer duration than that for 'less complex clinical presentations'.²⁵⁶ This makes it more difficult (as Schwarz, Corrigan et al. acknowledge)²⁵⁷ to achieve rapid relief in complex cases. In contrast to the biomedical paradigm, 'symptoms' are regarded as the outgrowth of attempted coping strategies (i.e. rather than as the 'problem').²⁵⁸ This means that relief from symptoms is also only part of effective complex trauma treatment.²⁵⁹

For clients with complex trauma in contrast to 'single-incident' PTSD, we are not talking about a 'quick fix' or attempts to 'fast track' psychotherapy.²⁶⁰ Expert consensus guidelines for the treatment of complex trauma endorse the 'phased' treatment model with a period of stabilisation and resource building before attempts to 'process' the trauma²⁶¹ (see Part 2, Chapter 3).

At the same time, many existing psychotherapeutic and 'extra therapeutic' approaches and resources which are supported by evidence promote rapid healing (see Chapters 4 and 5). Some of these are 'stand-alone' and/or can be and/or are being integrated into the various stages of effective complex trauma treatment (see Chapter 4).

In *Tools for Transforming Trauma*, Robert Schwartz frequently references dissociation as a therapeutic resource.²⁶² He situates short-term strategic psychotherapies within an Ericksonian hypnotherapeutic framework which offers many techniques that don't necessarily require specialist training.²⁶³

Energy Psychology is described as 'a family of brief, focused approaches to releasing stuck energy and unprocessed information in the mind-body system that is the result of unresolved trauma'.²⁶⁴ The most well-known method within this approach, Emotional Freedom Techniques (EFT) is well supported by research studies.²⁶⁵ In the past two decades it has moved 'from a fringe therapy to widespread professional acceptance'.²⁶⁶ Significantly, Schwarz contends that when the Polyvagal

255 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.60.

256 Christine Courtois, Julian Ford & Marylene Cloitre, 'Best Practices in Psychotherapy for Adults', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (The Guilford Press, New York, 2009, p.96) and as the expert consensus guidelines endorsement of the 'phased treatment' approach for treatment of complex trauma clearly conveys (Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, *ibid*).

257 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.60.

258 As encapsulated in the phrase 'the problem is the solution', coined by the principal investigators of the Adverse Childhood Experiences (ACE) Study (Vincent J. Felitti, Robert F. Anda et. al. 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine*, 14, 4, 1998 pp.245-258. For more recent elaboration of this concept and term in the ACE Study, see Felitti & Anda, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare'. Chapter 8 in Lanius. R.A., Eric Vermetten & Clare Pain, ed. *The Impact of Early Life Trauma on Health and Disease* (Cambridge University Press, 2010), pp.77-87.

259 And 'if symptom management is all that is being done in therapy, true healing may never happen' (Lynette Danylchuk & Kevin Connors, *Treating Complex Trauma and Dissociation* (Routledge, New York, 2017), p.6.

260 As van der Kolk highlighted in 2003, and as complex trauma experts have since endorsed (see footnote below) studies show 'that these patients may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma' (van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Solomon & Siegel, ed. *Healing Trauma*, Norton, New York, 2003, p.173).

261 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, *ibid*.

262 'One of the chief aspects of the response to trauma is dissociation. Following the utilization principle, dissociation becomes one of our chief resources' (Schwarz, *Tools for Transforming Trauma*, *ibid*, p. 40).

263 Distinction is also drawn in this text between methods, strategies and techniques which do not require specialist training and those which do.

264 Robert Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', Chapter 15 in Porges & Dana, *Clinical Applications of the Polyvagal Theory*, *ibid*, pp. 271.

265 See Dawson Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *Psychology* (4, 8, 2013), pp.645-654; James Lane, 'The Neurochemistry of Counterconditioning: Acupressure Desensitization in Psychotherapy', *Energy Psychology: Theory, Research, and Treatment* (1, 1, 2009), pp.31-44; David Gruder, 'Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support', *Psychotherapy: Official Publication of Division 29 of the American Psychological Association*, (47, 3), pp.39-42; and Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*.

266 Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *ibid*, p.645.

Theory of Stephen Porges is integrated with the interpersonal neurobiology of Dan Siegel, 'a theoretical foundation for energy psychology (EP) emerges' in which the latter need no longer be framed 'as a strange alternative treatment'.²⁶⁷

From this (Polyvagal) perspective, 'the clinically rapid results' ('supported by many outcome studies')²⁶⁸ mean that Energy Psychology is not necessarily contraindicated for complex trauma (which is generally not 'rapid' to treat). And while a rapid response - if/when this occurs - may generate particular challenges for complex trauma clients,²⁶⁹ use of the 'Gentle Techniques' such as 'Tearless Trauma' in the EFT manual may mitigate possible adverse effects.²⁷⁰

Church concurs that the EFT approach makes 'deliberate and systematic use of dissociation in the healing process',²⁷¹ recognizing 'that dissociation can perform a protective function'.²⁷² The three Gentle Techniques are designed to assist 'working on *events so traumatic they cannot be approached in ordinary states of consciousness*'.²⁷³ The description of the method and rationale behind this technique illustrates that some 'short term' approaches to treatment are conversant with the nature and challenges of complex trauma.²⁷⁴

The potential for client destabilisation - particularly with developmental trauma, particularly in the early stages of therapy, and particularly if utilising a potent modality - is high.

For this reason, it is important to support the client with resourcing, ability to self-soothe, and self-regulatory capacity prior to trauma processing.

Specific techniques from outside 'traditional' psychotherapy can also assist trauma processing. Hypnotherapy, about which there are many misconceptions (see Chapter 4), also uses dissociation therapeutically in some of its methods. In its rapid but gentle capacity to enhance diverse therapeutic modalities, hypnotherapy may itself be described as a 'gentle technique' although not in the EP sense described above.

Describing hypnosis as 'the redistribution of attention', Kluft advises that most dissociative disorders 'involve the redistribution of attention toward certain things and away from others' and 'have many hypnotic elements'.²⁷⁵ Thus it '*is only natural to enlist the redistribution of attention that we call hypnosis in the service of treating dissociative disorders*'.²⁷⁶ If using hypnotherapy when working with complex trauma, formal training in this approach as well as understanding of dissociative disorders is required. But 'the hypnotically oriented therapist' can also be guided by the principles of hypnosis 'whether or not formal trance is used'.²⁷⁷

267 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.271 (and see above citations).

268 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*; multiple references and see previous citations.

269 This is one of the grounds for the 'Phase 3' (integration) stage of phased treatment.

270 Dawson Church, *The EFT Manual*, 3rd edit Energy Psychology Press, CA, 2013.

271 Dawson Church, *Psychological Trauma: Healing its Roots in Brain, Body, and Mind* (Energy Psychology Press, CA, 2015), p.42. Note that Church's contention that EFT is 'unique among therapeutic approaches' in using dissociation in the healing process is not accurate (see subsequent comments on the approach of hypnotherapy and discussion in Chapter 4).

272 Church, *Psychological Trauma*, *ibid*.

273 Church, *Psychological Trauma*, *ibid*, p. 42; ref. Church, 2013.

274 In *Psychological Trauma*, *ibid*, Church distinguishes single-incident trauma from Complex PTSD and references the extensive impacts of childhood trauma in particular.

275 Richard P. Kluft, ref Bliss, 1986; Braun, 1983; *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* (CreateSpace, South Carolina, 2013), p.276. Note that this does not apply to all forms of Depersonalization Disorder.

276 Kluft, *Shelter from the Storm*, *ibid*, p.276; emphasis added.

277 Robert Schwarz, *Tools for Transforming Trauma*, *ibid*.39. This valuable and integrative text presents a range of such tools, the majority of which 'do not require formal training in hypnosis' (Schwarz, *ibid*, p.ix). Kluft also elsewhere presents a number of techniques inspired by hypnotherapeutic methods for which formal training in hypnosis is not necessary; see discussion in Chapter 4.

Chapter 4 of this document considers a range of diverse ‘short-term’ methods and strategies which may assist a therapist to treat complex trauma. These include EMDR, MDMA Assisted Psychotherapy²⁷⁸ and Brainspotting.²⁷⁹

If ‘short-term’ and ‘rapid’ interventions are utilised (see Chapters 3 and 5) it must be with the understanding that complex trauma memories are not merely ‘upsetting’ or ‘unpleasant’ but are often *unbearable*²⁸⁰ (and have been dissociated for this reason). Given that dissociation can be hard to detect,²⁸¹ knowledge of the nature of complex trauma and dissociation is critical when applying ‘non-traditional’ and ‘alternative’ techniques. But the same also applies to traditional evidence-based strategies and methods.

When processing traumatic memory, clients may be advised by practitioners to ‘start with’ a less distressing memory. But this advice, even when followed, may not protect the client from becoming overwhelmed. This is because even seemingly less intense ‘single’ recollections often elicit a cascade of memories which can quickly become disorienting.²⁸² This has necessitated reappraisal and adaptation of some ‘rapid effect’ techniques and treatments, including the well evidenced Eye Movement Desensitization and Reprocessing Therapy (EMDR).

In fact the initial practice of EMDR was so effective that it became apparent it was problematic if trauma is cumulative (which is not necessarily known in advance). This is because EMDR quickly brought unsuspected prior trauma (i.e. as well as the particular memory ‘targeted’ for processing) to the surface. The result was destabilisation of both clients and therapists who were unprepared for this. This prompted a 1996 meeting of a Dissociative Disorders Task Force and subsequent position paper which presented guidelines for EMDR in relation to dissociative disorders.²⁸³ These emphasised the importance of prior client resourcing and a phased approach to treatment.²⁸⁴

In the 2018 third edition of *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, Shapiro is explicit that

*‘No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population... The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously.’*²⁸⁵

278 ‘There were no drug-related serious adverse events, and the treatment was well-tolerated’ (Marcela Ot’alora, Jim Grigsby et al, ‘3,4-Methylenedioxymethamphetamine-assisted psychotherapy for treatment of chronic posttraumatic stress disorder: A randomized phase 2 controlled trial’, *Journal of Psychopharmacology* (32, 12, 2018), 1295); ‘Our findings support previous investigations of MDMA-assisted psychotherapy as an innovative, efficacious treatment for posttraumatic stress disorder’ (Ot’alora, Grigsby et al, *ibid*; emphasis added). Indeed, it is suggested in one study that ‘MDMA may provide a bridge to effectively overcome the gap between psychotherapy and psychopharmacology, thereby facilitating the integration of a more holistic approach to psychopathology’ (Sascha B. Thal & Miriam Lommen, ref Schuldt 2015, ‘Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder’, *Journal of Contemporary Psychotherapy* (48, 2, 2018), p.108; emphasis added).

279 David Grand, *Brainspotting: The Revolutionary New Therapy for Rapid and Effective Change* (Boulder, CO: Sounds True, 2013) <https://brainspotting.com/>

280 Philip Bromberg, *Awakening the Dreamer*, Routledge: New York, 2011); *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* (Psychology Press, New York, 2001).

281 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*.

282 I.e. due to the phenomenon of ‘kindling’ as per Scaer (2005) which is high-risk in relation to complex trauma in particular where ‘what started out as a single-event trauma requiring minimal resourcing’ catalyses underlying childhood trauma and major attachment issues (Schwarz, Corrigan et al, *The Comprehensive Resource Model* (Routledge, New York, 2017), p.132-3).

283 Francine Shapiro, *Dissociative Disorders Task Force Position Paper*, Presentation at the International Society for the Study of Dissociation 13th Annual Conference (San Francisco, CA, 1996) doi:10.1037/e609292012-016

284 Deborah L. Korn ‘EMDR and the Treatment of Complex PTSD: A Review’ *Journal of EMDR Practice and Research* (3, 4, 2009), pp.264-278.

285 Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd edition (The Guilford Press, Washington, DC, 2018), pp.342-343; emphasis added. While some EMDR practitioners have adapted EMDR with specific reference to the challenges of dissociation (see discussion in Chapter 4) this is not typical of the EMDR field as a whole.

Interest in 'brief therapy' (itself a broad category) is increasing, including among relational psychotherapists.²⁸⁶ This is in addition to integration of aspects of diverse 'short-term' approaches alongside and within contrasting psychotherapeutic orientations, including within the 'phased treatment' model (see Chapter 4). Integration of disrupted neural networks is key to resolving trauma.²⁸⁷ A range of often brief interventions and strategies (i.e. whether part of or separate from a systematised practice) may promote integration.

Chapter 4 addresses some of the many 'new' 'non-traditional' psychotherapies and approaches to healing which offer many possibilities for complex trauma treatment/s. While an 'ad hoc', unintegrated approach is inappropriate, and training is necessary where applicable, there are now many options to explore in the current terrain of psychotherapy and healing practices outside it.

(8) Reconsidering 'the relational'

'Embedded in most methods of psychotherapy is the belief that 'healing' is the outcome of a relational process: that if we are wounded in an unsafe relationship, the wounds must heal in a context of relational safety... But...[w]hat if being witnessed as we recall painful events does not heal the injuries caused by those experiences?'

(Fisher, 2017: 78)

'[W]e want to address the ability to use interactive regulation – to reach out, to call a friend – and we want to address how to auto relate, independent of relational contexts'

(Ogden, 2018: 5).

The centrality of safe, supportive relationships to recovery from interpersonal trauma is foundational to psychotherapy.²⁸⁸ It also accounts for some of the longstanding reservations many clinicians have about the effectiveness of 'techniques' applied outside of a relational context.²⁸⁹

Safe relationships counter the isolation many survivors of interpersonal trauma experience. As Judith Herman contended well over two decades ago, '[r]ecovery can take place only within the context of relationships; it cannot occur in isolation.'²⁹⁰

286 Joan Haliburn, *An Integrated Approach to Short-Term Dynamic Interpersonal Psychotherapy*, *ibid*; also note the model of Accelerated Experiential Dynamic Psychotherapy (AEDP) founded by Diana Fosher; see Fosha, *The Transforming Power of Affect: A Model for Accelerated Change* (Perseus, New York, 2000).

287 Louis Cozolino, *The Neuroscience of Psychotherapy*, *ibid*; Siegel, 'An Interpersonal Neurobiology of Psychotherapy', *ibid*.

288 See, for example, Philip Kinsler, *Complex Psychological Trauma: The Centrality of Relationship* (Routledge, New York, 2017).

289 The following comments are emblematic in this regard - *'The most influential part of the therapy will be the relationship between the therapist and the client. It is within the relationship that the therapist gets to know the client at a level deep enough to determine which therapeutic tools may be helpful. It is also the presence and reality of the relationship that gives the client an experience of being seen and attuned so that facilitates healing beyond techniques and tools'* (Danylchuk & Connors, *Treating Complex Trauma and Dissociation*: *ibid*, p.77).

290 Judith Herman, *Trauma and Recovery: The Aftermath of Violence, From Domestic Abuse to Political Terror*. (Perseus, New York [1992] 1997), p.133. This is a view widely shared among psychotherapists, particularly those who work with complex trauma: 'it's all about the relationship, in the first place and all the way through' (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real*, Norton, New York, 2015, p. ix).

We know the importance of early childhood attachment to caregivers. This is not only for initial survival but to foster the capacity to *self-regulate* later on.²⁹¹ Stephen Porges has described connectedness as ‘a biological imperative’, because ‘we cannot regulate our body as an isolate – we need another’.²⁹² This challenges the concept of ‘self’ regulation; indeed Porges has described a well-regulated person as ‘someone who can co-regulate with another’.²⁹³

As the above indented quotes from Pat Ogden and Janina Fisher indicate, the importance of the *therapeutic* relationship is a consistent theme in current research. Therapists play a vital role which includes their very presence in enabling and actively assisting a client to develop the capacity to self-regulate. At the same time, it is important not to detract from a client’s ability to manage their own internal states.²⁹⁴ Complex trauma clients in particular may experience the therapy relationship as *unsafe*, especially but not only in the initial ‘rapport building’ stages.

As Peter Levine and others identify, clients who are unfamiliar with being shown empathy may not be able to process it for a long time.²⁹⁵ An empathic therapeutic relationship can also unintentionally shame a complex trauma client (as in ‘*my therapist is so warm and compassionate; why can’t I feel and respond to that?*’).

The importance of a ‘safe therapeutic relationship’ can readily become a mantra for therapists. It can blind us not only to the possibility but also the likelihood that ‘*safety*’ *may itself be an unfamiliar and threatening concept and experience for a client who has been traumatised in interpersonal contexts*. This is because despite their best intentions, therapists - and the context of therapy itself - can trigger attachment anxiety.

‘[C]omplex trauma absolutely requires attachment resources other than the therapist-client attunement’

(Schwarz, Corrigan et al, 2017: 130).

‘While it is true that the therapeutic relationship is an important resource in itself, the degree of resourcefulness can be significantly increased by accessing the patient’s own resourceful states’

(Schwarz, 2002: 37)

In the NICABM Treating Trauma Master Series, all the ‘master therapists’ of complex trauma emphasised the importance of imparting simple *self-regulatory* tools to clients as soon as possible, including from the first session.²⁹⁶

291 Here it is also important to note that it is possible for early suboptimal attachment to be reworked (‘earned security’) in adulthood. This occurs when the underlying trauma is recovered from and resolved (Siegel, ‘An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma’, in Solomon & Siegel, ed. *Healing Trauma*, *ibid*, pp.1-56.

292 Stephen Porges, ‘Connectedness as a Biological Imperative: Understanding Trauma through the Lens of the Polyvagal Theory’, *Healing Trauma Summit*, *ibid*. This perspective is also repeatedly elaborated in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*.

293 Porges, ‘Connectedness as a Biological Imperative’, *ibid*.

294 As Schwarz, Corrigan et al. note, ‘[t]he idea that the therapeutic relationship between the client and therapist is one of healthy corrective attachment is of course necessary. However, it is helpful to create this connection and secure relationship internally, within the client’s ‘system’, because ultimately the personal objective is to develop the relationship with Self as an adult’ (Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.114.

295 Peter Levine, *In an Unspoken Voice* (North Atlantic Books, Berkeley, 2010), p. xi.

296 Ruth Buczynski, PhD, Bessel van der Kolk, MD, Pat Ogden, PhD, Stephen Porges, PhD & Ruth Lanius, MD, PhD, ‘How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal’, Transcript, *Treating Trauma Master Series*, *ibid*. This includes implementable ‘take aways’ designed to intercept the high levels of overwhelm complex interpersonal trauma generates: ‘*I would give them tools that they could potentially use to self-soothe, because the tools would be relatively simple. And I would demonstrate to them the effects of these simple tools [such as comparing the calming effect when breathing and exhaling more slowly] And you can actually walk them through these different stages*’ (Stephen Porges, ‘How to Help Traumatized Clients Expand

The way in which this is done is clearly important, and need not be at the expense of relational context and connection. This will be reassuring to therapists who may be ambivalent about the role of strategies and techniques (and *'the very act of questioning oneself is a specific tool, is it not?'*)²⁹⁷

Points 2 and 3 above noted the stakes and risks of privileging 'the [clinical] relationship'. This includes the importance of the therapist attuning to their clients' 'bottom-up' as well as 'top-down' responses. Janina Fisher and others note that even seemingly benign encouragement of a traumatised client to access support may evoke unbearable feelings of vulnerability. In this situation a client's 'fight' and 'flight' (as well as 'attachment') parts may galvanise in response:²⁹⁸

*'Attunement may be necessary for treatment to be successful but it is not sufficient as a regulator when it is itself triggering.'*²⁹⁹

This also underlines 'the complexity of the complex trauma client' (particularly if structurally dissociated), the need for the therapist to know how to work with complex trauma-related presentations, and the limits of equating the 'standard' anxieties of all clients with the more challenging dynamics of complex trauma cohorts. 'Self-help' strategies and measures, turbo-charged by accessible globalised technology (see below) are here to stay. Some are actively recommended even by 'master' complex trauma specialists.³⁰⁰

Rothschild consistently attests to the importance of 'Phase 1' stabilisation. This corrects the myth that 'you only work with trauma when you're working with memories'.³⁰¹ Indeed, Rothschild contends that an improved quality of life may not involve trauma processing at all, and that *'for a good portion of our clients Phase 1 will be their therapy.'*³⁰²

Significantly, Stephen Porges applauded Francine Shapiro's self-help book *Getting Past Your Past*,³⁰³ saying it 'provides readers with powerful new insights to understand how traumas and disturbances of all kinds disrupt human potential and how they can deal with their own distress'.³⁰⁴ Past President of the American Psychological Association Division of Trauma Psychology Laura S. Brown also described it as 'a valuable resource for therapists and clients alike, as well as for the many individuals who struggle with the effects of painful life experiences but who do not seek formal treatment'.³⁰⁵

their Window of Tolerance', in 'How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal', Transcript, *ibid*, p.11); *'I may spend the first hour with a new patient helping them to just open up their rib cage and to breathe, because as long as that primitive part of someone's brain is all uptight, it's no use to do psychotherapy with them'* (van der Kolk, 'How to Help Traumatized Clients Expand their Window of Tolerance', *ibid*).

297 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.63.

298 'It might not occur to us that a 'felt sense' of safety is likely to be unattainable if the client is habitually blended with child parts who still feel unwelcome, frightened, ashamed or suicidal' (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.91).

299 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.74.

300 See 'Resources' at the conclusion of this document.

301 Babette Rothschild, 'Mistakes Made, Lessons Learned' Bonus material, EMDR Bonus material, PESI 2018).

302 Babette Rothschild, 'Mistakes Made, Lessons Learned', *ibid* [emphasis added]. This may be for various reasons, ranging from client reluctance to financial and time constraints; also see Babette Rothschild, *Trauma Essentials* (Norton, New York, 2011), pp.57-58.

303 Francine Shapiro, *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (Rodale: New York, 2012).

304 Stephen Porges, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

305 Laura S. Brown, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

Formal treatment is also inaccessible to many. For this reason, we must be receptive to the many styles and modes of helpful interventions, including those which are self-accessed and self-administered. It is important, however, to recognise the risks of approaches which are not reputable (and which fall well short of Jeff Zeig's description of Shapiro's 2012 text as 'self-help at its finest').³⁰⁶ There are also many types of relationship outside the context of formal therapy which can serve as therapeutic in different ways.

(9) Strategies, techniques and 'the net'

A wide range of diverse healing practices offer helpful strategies and techniques outside of formal therapy. The ever-growing smorgasbord of online psychological tools means that 'self-help' approaches and strategies are now highly accessible. Clearly, however, much that is *unhelpful* is also accessible.

Dan Siegel's 'hand model of the brain'³⁰⁷ is a shining example of the healing potential of online tools and strategies 'direct to the public'. This is notwithstanding his commitment to the importance of relationship/s and their healing potential in psychotherapy. Yet this is not an 'either'/'or' phenomenon. And as noted above, complex trauma experts question the assumption that a safe relationship with the therapist (i.e. even when it is experienced as safe) is sufficient to bring about the necessary change.³⁰⁸

A distinction needs to be made between potentially helpful online strategies and the need for clinical treatment. Yet the potential of online support as an adjunct to formal therapy - even in relation to complex trauma - is significant and indeed is already occurring.

The Treatment of Patients with Dissociative Disorders (TOP DD) Network study is a web-based international program which teaches patients and therapists how to stabilise self-destructive, including suicidal, behaviour. It 'provides education about DD and healthy coping skills (including managing dissociation, unsafe urges and emotions) with a focus on the enhancement of DD patients' safety'.³⁰⁹

The TOP DD treatment team are preparing a book based on the web program to allow non-participants in the study to access the material; i.e. the formal publication, envisaged as an adjunctive treatment manual, will follow the web-based offering. A paper detailing this innovative online program appears in the January 2019 issue of *Journal of Traumatic Stress* <https://onlinelibrary.wiley.com/doi/full/10.1002/jts.22370>

A distinction needs to be made between 'one-off' tools and an integrated online educational program which is an adjunct to formal therapy (as in the case of TOP DD online which is specifically designed for clients with dissociative disorders).³¹⁰ Rapidly evolving technology may assist, rather than compete with, formal therapy. If offered as a supplement to, rather than substitute for, ongoing clinical work, this potential is as yet untapped.

³⁰⁶ Jeff Zeig, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

³⁰⁷ Dr Daniel Siegel, presentation of the hand model of the brain <https://www.youtube.com/watch?v=gm9CIJ74Oxw>

³⁰⁸ In this context, Bessel van der Kolk has said that the therapeutic relationship can be too safe, whereby therapists become akin to 'refuelling stations' while the internal world of the client remains tumultuous 'Mistakes Made, Lessons Learned' *ibid*.

³⁰⁹ <https://topddstudy.com/>

³¹⁰ I.e. Professor Bethany Brand and associated colleagues. A sample of her many publications is included in the reference list.

Currently there exists a vast and potentially confusing mix of 'psychological healing assists'. As noted in the previous point, these include 'stand-alone' strategies which may or may not be supported by credible evidence. Some might be fruitfully integrated into existing treatment approaches, but many are clearly (and sometimes not so clearly) contraindicated. The internet is a conduit for both highly credentialed and dubious entities, as well as a portal for diverse advice and suggestions. In relation to complex trauma, it is always important to maintain caution.

(10) Evidence base or 'evidence-based'? Validating how we work and what we do

As noted in the Introduction and above, there are a number of grounds on which the nature and status of evidence for effective psychotherapy treatment/s is more problematic than the imprimatur of 'evidence-based' can address.³¹¹ These include the longstanding restrictive entry criteria for participation in outcome studies (which have traditionally precluded people with multiple comorbidities), funding issues regarding modalities being formally assessed, and that the active ingredients of psychotherapy are not necessarily correctly identified.³¹²

Manualised, short-term psychotherapies such as those routinely considered in RCTs raise a number of questions, and there are 'many reasons why outcome studies may fail to show differences between treatments even if important differences really exist'.³¹³ Pharmaceutical corporations also influence many aspects of trial construction, data, and ensuing publications.³¹⁴ These factors challenge claims to objectivity.³¹⁵

Even outside of complex trauma presentations, 'major problems' have been identified regarding the clinical utility of 'evidence-based' practice on the ground that '*evidence-based treatments too often are ineffective*'.³¹⁶

311 See D'Andrea & Pole, 'A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma', *Psychological Trauma: Theory, Research, Practice and Policy* (4, 4), 2011), p.439 and discussion in Chapter 5 of this document.

312 Shedler, 'The Efficacy of Psychodynamic Psychotherapy', *American Psychologist* Feb-March, 2010, p.103.

313 Shedler, 'The Efficacy of Psychodynamic Psychotherapy', *ibid.* p.105.

314 See, for example, David Healy, *Pharmageddon* (University of California Press, CA, 2012) and Chapter 7 of this document.

315 So much so that the term 'evidence DEbased medicine' has been coined to describe the distortion, suppression, data massaging, and innumerable other problematic practices deployed in the name of 'science', and in relation to which no less an institution than the prestigious Cochrane has been impugned in criticisms which many consider to have foundation. See Dr David Healy, 'The Goetzsche Affair' (5 November 2018) <https://davidhealy.org/the-goetzsche-affair/>. Simon Sobo M.D., former Chief of Psychiatry at New Milford Hospital, Connecticut, charges that EBM (i.e. evidence-based medicine) 'is being touted for its scientific prestige, precisely as the process has forsaken the true spirit of science', when '[c]onsidering how much we still don't understand, our steps forward should be exploratory, investigative, and not closed off by the chilling effects of authority' (Simon Sobo, 'Does Evidence-Based Medicine Discourage Richer Assessment of Psychopathology and Treatment?' *Psychiatric Times*, 5 April, 2012).

316 Simon Sobo, 'Does Evidence-Based Medicine Discourage Richer Assessment of Psychopathology and Treatment?', *ibid.* 'EBM eschews the anecdotal in the name of generalised conclusions, based on the odds that the patient's ailments are typical for their group...[this] can miss important particulars brought by the patient' where '[k]nowing a patient well can be the difference between effective and ineffective treatment' (Sobo, *ibid.*). Sobo continues that while it is 'a given for researchers' that exact numbers and statistics are the yardstick of what is determined to be factual, this is 'not as relevant for clinicians who may need answers for their patients that cannot be organized into questions answered with numbers' (Sobo, 'Does Evidence-Based Medicine Discourage Richer Assessment of Psychopathology and Treatment?', *ibid.*)

In light of evolving research which attests to the importance of 'bottom-up' as well as 'top' down processes, and recalling Porges' comments regarding the 'top-down' bias of traditional study methodology,³¹⁷ questions also now arise about the authority of 'psychological' research which fails to address the pervasive impacts of somatic regulatory functions.

Bruce Ecker contends that we have reached a point at which, due to 'a fortunate convergence of clinical observations and brain research', clinical findings are advancing 'at an accelerated pace unexplicated by and unknown by neuroscience researchers'³¹⁸ who lack access to – and often interest in – unfolding 'real time' subjective experience.³¹⁹ Subjective experience is critical to accurate assessment of treatment effectiveness. It provides additional impetus for revising the imprimatur of 'evidence-based' as sole guarantor of treatment effectiveness. These and other relevant considerations are discussed in Chapter 5.

317 Porges, 'Polyvagal Theory: A Primer', *ibid*, p.59; note that 'approximately 80% of the vagal fibres are sensory' (*ibid*).

318 Bruce Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (Vol.6, Issue 1, 2018), p.80.

319 Bruce Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *ibid*.



Chapter 1

Understanding Complex Trauma and the Implications for Treatment

'It is clear from many studies that interpersonal violence is more likely to have long-term consequences than natural disasters or accidents.'

(Bloom & Farragher, 2011: 67)

All trauma is overwhelming in that it exceeds coping mechanisms and all trauma can be devastating. But there are important differences between 'complex' trauma and 'single-incident' Post-Traumatic Stress Disorder (PTSD). PTSD is a well-known and accepted diagnosis. In contrast, for a long period and notwithstanding its prevalence and devastating impacts, *complex* trauma was not classified in its own right. The new diagnosis of Complex PTSD (CPTSD) in ICD-11 acknowledges the significant differences. While complex trauma is broader than the diagnosis of CPTSD (see below) this new and more refined classification is a welcome development.

Complex trauma is *cumulative, underlying, and often interpersonally generated*.³²⁰ This contrasts with 'single-incident' trauma which carries a standard PTSD diagnosis. The new ICD-11 diagnosis of CPTSD shows the limitations of confining the definition and diagnosis of trauma to exposure to 'single-incident' events.³²¹ Complex trauma, especially if interpersonally generated, is well documented to have more extensive impacts than 'one-off', 'out-of-the-blue' events (i.e. 'single-incident' PTSD).³²²

But diagnosis is only one lens through which to view the extensive impacts of complex trauma. There is also more to complex trauma than is included in the diagnosis of CPTSD: *'Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders... increasingly becomes a risk the more prolonged and severe the traumatic events.'*³²³

It is important to be aware of the dynamics of complex trauma in order to optimise treatment and the possibility of recovery for clients. Significant subtleties have long been subsumed within diagnostic discourse and by the umbrella term 'trauma'. But these subtleties are not confined to semantics and diagnosis. They translate into 'real world' health effects. And as elaborated in the 2012 Blue Knot Guidelines, they also have treatment implications.³²⁴

320 For an authoritative account of the nature of complex trauma, see 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', Chapter 1 in Christine A. Courtois & Julian D. Ford, ed. *Treating Complex Traumatic Stress Disorders: Scientific Foundations and Therapeutic Models* (New York: The Guilford Press, 2013), pp.13-30.

321 For example, it risks deemphasising the role of perception as to what the 'events' actually comprise (i.e. trauma is not necessarily the product of the 'size' of the event/s). Note that there is also often confusion about the definition of trauma itself, as the term is variously used to describe events, the individual's experience of events, and/or response to the event/s.

322 '[I]t is clear from many studies that interpersonal violence is more likely to have long-term consequences than natural disasters or accidents' (Sandra Bloom & Brian Farragher, *Destroying Sanctuary*, OUP: New York, 2011, p.67) and see subsequent discussion.

323 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (Routledge, New York, 2017), p.67.

324 In 2003, citing relevant studies, Bessel van der Kolk contended that patients who have experienced interpersonal trauma, especially but not limited to child abuse, 'may react adversely to current, standard PTSD treatments' (van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma*, Norton, New York, p.173); an observation recently affirmed by psychiatrist David Spiegel (see 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4).

1.1 A new diagnosis: Complex PTSD

The announcement of a formal diagnosis of Complex PTSD (CPTSD) was a long time coming.³²⁵ The breakthrough came in 2018 when the World Health Organisation (WHO) announced its new iteration of the International Classification of Diseases (ICD-11), which will come into effect on 1st January 2022.³²⁶

‘Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).’³²⁷

A formal diagnosis of complex PTSD will help differentiate complex trauma from standard PTSD and thereby improve detection, recognition and treatment. Given that complex trauma is broader than the diagnosis of CPTSD, the new CPTSD diagnosis does not, however, encapsulate or exhaust all the dimensions and impacts of challenging complex trauma presentations.³²⁸

The current iteration of the American-based *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* does not include a Complex PTSD diagnosis or reference to complex trauma.³²⁹ It does, however, include a new dissociative subtype of PTSD which has expanded the range of impacts with which trauma is associated.³³⁰ But the current DSM criteria for diagnosis of PTSD still falls short of recognising the range and depth of impacts associated with complex trauma.³³¹ By contrast, and notwithstanding its own limitations, the new ICD-11 diagnosis increases the likelihood of better recognition and more appropriate treatment of complex trauma-related issues.

325 Attempts to gain official recognition of Complex PTSD (as of complex trauma more broadly) have been protracted. For an authoritative account of the pre-history of the CPTSD diagnosis, see Judith Herman, ‘Foreword’ to Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*.

326 WHO releases new International Classification of Diseases (ICD-11) 18 June 2018 News Release Geneva [http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-\(icd-11\)](http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11))

327 Cloitre, D.W. Garvert, C.R. Brewin et al ‘Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis’, *European Journal of Psychotraumatology*, 4, 2013 <https://www.tandfonline.com/doi/full/10.3402/ejpt.v4i0.20706>

328 See, for example, Giourou, Skokou et al. ‘Complex Posttraumatic Stress Disorder: The need to consolidate a distinct clinical syndrome or to reevaluate features of psychiatric disorders following interpersonal trauma?’ *World Journal of Psychiatry* (8. 1, 2018, pp.12-19) and subsequent discussion.

329 As Rydberg notes, the respective DSM and ICD workgroups arrived at quite different (indeed ‘diametrically opposed’) conclusions, ‘with the workgroup for DSM-5 producing the most complex definition of PTSD to date (20 symptoms and 4 clusters) and the workgroup for the ICD-11 proposing the simplest (6 symptoms and 3 clusters) (Hoge et al, 2016)’ Jenny Ann Rydberg, ‘Research and clinical Issues in Trauma and Dissociation: Ethical and logical fallacies, myths, misreports, and misrepresentations’, *European Journal of Trauma and Dissociation* (1), 2017, p.93. For account of reasons for the DSM rejection, see Patricia Resick, Michelle Bovin, et al, ‘A Critical Evaluation of the Complex PTSD Literature: Implications for DSM-5’ *Journal of Traumatic Stress* 25(3) 2012, pp. 41-51.

330 The current ‘dissociative’ subtype of PTSD in DSM-5 specifically addresses the dimensions of depersonalisation (sense of self-estrangement) and derealisation (perception of the external world as strange or unreal).

331 ‘To date, the dissociative subtype of PTSD has been defined specifically in relation to symptoms of depersonalization and derealization’ (Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (New York: Norton, 2015), p.166. It is also regarded by some as a problematic conceptualisation. For example, while noting its emphasis on ‘the presence of depersonalization or derealization’, Ross highlights that diagnostic criteria for PTSD similarly include dissociative flashbacks and dissociative amnesia, and that ‘[i]f these symptoms were included in the definition of the dissociative type of PTSD in future editions of the manual, then most cases of PTSD would be dissociative in nature, and non-dissociative cases would be a minority subtype’ (Colin Ross, ‘Problems with the Dissociative Subtype of Posttraumatic Stress Disorder in DSM-5’, *European Journal of Trauma and Dissociation*) <https://doi.org/10.1016/j.ejtd.2018.08.005> Hence, he says, ‘[t]here does not appear to be any sound conceptual reason for excluding amnesia and flashbacks from the criteria for dissociative PTSD’ (Ross, *ibid*).

1.2 Complex PTSD differs from standard PTSD

As well as the standard markers of PTSD (i.e. hyperarousal, intrusion, and avoidance) the new diagnosis of Complex PTSD in the ICD-11 sets out the key additional domains of complex trauma impacts:

ADDITIONAL IMPACTS OF COMPLEX PTSD TO THOSE OF STANDARD PTSD (as listed in ICD-11)

- (1) *severe and pervasive problems in affect regulation;*
- (2) *persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor; and*
- (3) *persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning*

Cloitre, D.W. Garvert, C.R. Brewin et al 'Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis', *European Journal of Psychotraumatology*, 4, 2013.

The contrasting impacts of complex trauma and standard PTSD, known for many years by those who work with complex trauma-related presentations,³³² are eloquently conveyed in the following comments:

'...[identifying complex trauma as a distinct subset of psychological traumas provides the clinician and researcher with a basis for identifying individuals who have experienced not only the shock of extreme fear, helplessness, and horror, but also disruption of the emergent capacity for psychobiological self-regulation and secure attachment.

In addition to hyperarousal and hypervigilance in relation to *external* danger, complex trauma poses for the person the *internal* threat of being unable to self-regulate, self-organise, or draw upon relationships to regain self-integrity.³³³

The above comments clarify the more comprehensive and devastating impacts of complex trauma across the full spectrum of human functioning. They also clearly convey why *trauma in early life* (i.e. developmental trauma; complex childhood trauma) is particularly damaging.

Complex PTSD affects *self*-conception and processes as well as perceptions of the external world.³³⁴ Because the self is literally 'under construction' in childhood, it is especially vulnerable to influence.³³⁵

³³² As per the longstanding attempts to achieve a 'stand-alone' diagnosis; see Herman, 'Foreword' to Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*.

³³³ Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, p.17.

³³⁴ 'Complex PTSD is described as involving alternations in views of the self and other' (Elizabeth Howell & Sheldon Itzkowitz, *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* (New York: Routledge, 2016), p.37.

³³⁵ As Cozolino states, 'It stands to reason that the most devastating types of trauma are those that occur at the hands of caretakers'; (Louis Cozolino, *The Neuroscience of Psychotherapy*, New York: Norton, 2002, p.258) and see subsequent discussion.

'Complex' trauma impedes *self-conception and development* and other domains of functioning:

'As a result of compromising self-regulation, self-integrity, and attachment security, complex trauma constitutes *objective threats not only to physical survival - but also to the development and survival of the self*.'³³⁶

As Frewen and Lanius confirm 'whereas...diagnostic practices in psychiatry emphasize traumatic events as causes of harm or threat to the physical integrity of the self or others, symptoms of negative self-referential processing (SRP) may develop not only when the integrity of the physical bodily self is threatened or harmed but also when the adaptive content of the self-schema³³⁷ is equally wounded'.³³⁸

This means that 'the cost of survival often includes a far more complex array of medical and psychiatric conditions and impediments' than for PTSD alone (the latter of which may be 'merely the tip of the iceberg').³³⁹

1.3 Updating diagnoses and continuing dilemmas

Inclusion of the diagnosis of Complex PTSD in the ICD-11 addresses the limits of the 'standard' PTSD diagnosis.³⁴⁰ Yet the continuing requirement for the core familiar criteria of PTSD; i.e. intrusion, avoidance and hyperarousal, to be met is an anomaly of the CPTSD diagnosis:

'The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder'.³⁴¹

As Schwarz, Corrigan et al. point out, '[c]linicians will readily see the potential Achilles heel; i.e. many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms'.³⁴² This is a potentially disabling limitation of the new diagnosis of Complex PTSD which may deny diagnosis and treatment to some of the people who need it most.

Clinical expertise and evidence do not always converge with official categorisation, recognition and external authorisation.³⁴³ The reality is that the 'symptom-based' orientation of diagnostic categories and biomedical approaches³⁴⁴ can also be problematic (see subsequent discussion).

336 Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, p.16; emphasis added.

337 As Frewen and Lanius explain, "[a]n increasingly voluminous literature has investigated the neurophysiological processes that mediate one's sense of oneself as comprising a listing of characteristics or attributes, typically referred to in clinical psychology as the 'self-schema' and what we earlier called 'first-person self-contents' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.108).

338 Frewen & Lanius, *Healing the Traumatized Self* (ref. Ebert & Dyck, 2004; Jobson, 2009), 2015, p.106.

339 David Emerson & Elizabeth Hopper, *Overcoming Trauma through Yoga* (CA: North Atlantic Books, 2011), p.4.

340 And which account for the longstanding criticism that 'the PTSD diagnosis does not begin to describe the complexity of how people react to overwhelming experiences...Focusing solely on PTSD to describe what victims suffer from does not do justice to the complexity of what actually ails them' (van der Kolk & McFarlane, 1996: 15-16), in Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.239).

341 Cited in Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (New York: Routledge, 2017), p. 21. Also see Chris Brewin, 'NICE and the PTSD revolution', *BMJ Opinion* (1 October, 2018).

342 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p. 21.

343 Clinical experience comprises an important, valuable and necessary evidence base. Indeed, Bruce Ecker has recently contended that it can now inform neuroscience rather than solely the other way around (Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy*, Vol.6, Issue 1, 2018, pp.1-92). Prof Sir Dennis Hill's contention that 'there is no such thing as the scientific mind, but many sorts of scientific mind; there is no such thing as the scientific method, but many sorts of method' remains relevant ('On the contribution of psychoanalysis to psychiatry: mechanisms and meaning', *International Journal of Psychoanalysis*, 52, 1971, pp.1-10). Also see discussion in Chapter 5 of this report.

344 See Judith Herman, 'Foreword' to Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*, pp. xiii-xvii.

Inclusion of Complex PTSD in the ICD-11 is largely welcome notwithstanding the above limitations and complications. Acknowledging the differences between Complex and 'standard' PTSD and the potential treatment implications (whilst also noting that various presentations of complex trauma, particularly in relation to dissociation,³⁴⁵ are not included in the CPTSD diagnosis) is important. As Schwarz, Corrigan et al. underline, inclusion of Complex PTSD in ICD-11 'may also help the organisation of clinical services as the interventions and their duration, and the therapeutic skills required of the clinician, are markedly different for Complex PTSD'.³⁴⁶

1.4 Beyond diagnosis: the importance of relational context

There are many lenses through which to view trauma in general and complex trauma in particular. These contrasting perspectives challenge diagnostic discourse and have treatment implications. The role of *experience* is critical but is often at odds with biomedical frameworks. For example, Judith Herman has described the different experiences of standard and complex trauma as the difference between a sense of loss of 'mind' (PTSD) and loss of 'self' (complex trauma).³⁴⁷

People who experience complex and 'single-incident' trauma also vary in their initial attitudes to treatment. While all trauma is dysregulating, people experiencing single-incident PTSD often recall prior good health and want to 'get back to the way [they were] before'. People who experience complex trauma, however, rarely say this. Particularly if their self-disruption dates from childhood, they may have no sense of having functioned well or of ever feeling healthy or happy.³⁴⁸ These differences have treatment implications which a diagnostic lens, however refined, does not address.

Many forms of complex trauma are interpersonal and relational. Complex trauma comprises violations of trust and breaches of care in interpersonal and often intimate relationships in which care and protection should be expected. Violation of this expectation generates wide-ranging impacts on a person's experience of self and others as well as multiple psychological and physical impacts.³⁴⁹

The impacts of interpersonal trauma speak to relationship and meaning beyond formal 'treatment' in the standard clinical sense. The role of trust, and the trauma which can stem from betrayal, is significant and merits specific reference. Indeed, 'betrayal trauma' is a particularly insidious form of complex trauma.

1.5 Betrayal of trust and 'soul murder'

Any betrayal of trust can be deeply traumatic, especially if it occurs in contexts in which it should be *safe* to trust. This underlines the important point that '[t]rauma is not limited to surviving life-threatening experiences'.³⁵⁰

American researcher Jennifer Freyd developed the concept of 'betrayal trauma' over two decades ago. Significantly, 'betrayal trauma' involves social, as well as psychological, factors. Freyd's research led to 'a new scientific model of what constitutes trauma'.³⁵¹

345 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, *ibid*, p.67.

346 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p. 22 and see *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*.

347 Herman, *Trauma and Recovery*, *ibid*, p. 158.

348 'In contrast to the traumatized person who has experienced a sense of safety and wellbeing prior to onset of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage' (Shapiro, *The Trauma Treatment Handbook*, *ibid*).

349 Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*.

350 Louis Cozolino, *The Neuroscience of Psychotherapy*, p.259.

351 Laura S. Brown, *Cultural Competence in Trauma Therapy* (Washington, DC: American Psychological Association, 2009), p. 107.

'Betrayal trauma theory has caused us to re-evaluate the concept of psychological trauma. Traditionally, psychological trauma was understood to be the result of terrorizing, life threatening events that cause extreme fear...Yet...an equally traumatizing aspect of the events is social betrayal'

(Freyd & Birrell, 2013: 56-57).

Attention to the social, as well as psychological, dimensions of betrayal trauma reveals the many contexts in which it is not 'safe to tell' or to speak about personal experience. This, in turn, relates to the role of *politics* and inequalities of power. A sole focus on the 'psychology' of trauma misses these important dimensions.

Prior to Freyd's elaboration of 'betrayal trauma' Edward Shengold MD described the betrayal of trust as a form of 'soul murder'.³⁵² He subsequently updated the concept,³⁵³ noting that Scandinavian playwrights August Strindberg and Henrik Ibsen used the term in the nineteenth century.³⁵⁴ Revealingly, Ibsen described 'soul murder' as *'the destruction of the love of life in another human being'*.³⁵⁵

'Soul murder' is a form of interpersonal trauma that causes damage to self, identity, and relationships. This is because survival can come at the cost of subjugation of the spirit.

Once again, these dimensions transcend the domains of diagnosis and clinical 'treatment'. *Complex interpersonal trauma also has to do with wounds of the 'soul' and spirit*. As such, it calls for healed connections, relationships, and restored *meaning* - dimensions not addressed in many clinical and particularly medical 'treatments'.

1.6 Complex trauma and the dissolution of self

'...negative SRP [i.e. self-referential processing] in the form of guilt and shame may be a more principal outcome than are even anxiety and fear'

Frewen & Lanius, *Healing the Traumatized Self*

(ref. Ebert & Dyck, 2004; Jobson, 2009), 2015, p.106.

Psychological shock, including in the absence of physical threat, massively disrupts experience of self and sense of identity. While physical scars are easier to detect, the cumulative impact of psychological overwhelm in interpersonal relationships can erode both self-esteem and *sense of self per se*. In complex trauma this can be so extreme that the person may not believe they have a self (i.e. as a relatively stable, coherent, and continuous identity) at all.³⁵⁶

352 Leonard Shengold, MD *Soul Murder: The Effects of Childhood Abuse and Deprivation* (New Haven: Yale University Press, 1989).

353 Shengold, *Soul Murder Revisited* (New Haven: Yale University Press, 1999; 2000).

354 Shengold, *Soul Murder Revisited*, *ibid*.

355 Cited in Shengold, *Soul Murder Revisited*, *ibid*.

356 As noted above, the contrasting experience of complex, as distinct from single-incident, trauma has been described as the difference between the feeling of losing one's *mind* (single-incident trauma) and losing *oneself* (complex trauma). (Herman, *Trauma and Recovery*, *ibid*). Thus in addition to the disabling impacts of PTSD, complex trauma entails the devastating experience of self-impairment and/or self-annihilation. The extent to which self and identity can be regarded as stable and continuous is contestable; hence the reference to 'relative' stability and coherence.

Complex trauma clients can also experience intense and often unremitting self-criticism. *Shame* is one of the most pervasive and debilitating of the negative emotions experienced.³⁵⁷ Frewen and Lanius emphasise the importance of understanding that in severely traumatised people, shame can present ‘not only as an acute emotional state’, but as ‘a more fundamental and enduring aspect of an individual’s personality structure. For many traumatized persons the experience of shame essentially *defines who they are*’.³⁵⁸

Many complex trauma survivors experience shame as a deep-seated and inherent sense of defectiveness.³⁵⁹ Judith Herman identified the clinical significance of shame:

*‘most of our patients do not cite their PTSD symptoms as their reason for seeking treatment. Rather, it is most commonly some breach in a relationship that acutely aggravates a profoundly damaged sense of self. In treatment, we find repeatedly that the core issue is shame’.*³⁶⁰

Frewen and Lanius regard shame as ‘the core affective counterpart to extreme negative self-referential cognitions (e.g. beliefs that one is ‘dirty’, ‘ruined’, ‘damaged’, ‘no longer human’, and the like’).³⁶¹ Note that such beliefs can stem not only from experiences within interpersonal and familial relationships but from the wider social, cultural, and political contexts in which interaction takes place (see subsequent discussion).

Deep-seated beliefs of lack of self-worth and inherent defectiveness are of a different order than the fear and anxiety that characterise standard PTSD.

They also raise particular challenges including for decisions around effective treatment/s. Experts in the research and treatment of complex trauma³⁶² claim that ‘when a person’s past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, *exposure-based therapies may not be the treatment of choice*’.³⁶³

1.7 Flight from the body

Many people with complex trauma histories experience a problematic relationship to their bodies. A person who has been sexually abused, in particular, can view their body as alien, treacherous, contaminated, and/or as detached from the self:

357 Note that ‘[r]ecent psychoanalytic studies of shame generally distinguish clearly between guilt for transgressions creating debt and/or feelings of guiltiness...and shame over one’s very being in the eyes of others or one’s own eyes’ (Donna Orange, *Nourishing the Inner Life of Clinicians and Humanitarians*, Routledge, New York, 2016, p.96).

358 Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.206 (original emphasis)

359 ‘The feeling of shame is about our very selves – not about some bad thing we did or said but about what we are’ (Lewis B. Smedes, *Shame and Grace*, HarperCollins, New York, 1993, p.6).

360 Herman (2011: 262), as cited in Frewen and Lanius, *Healing the Traumatized Self*, *ibid*, p.201.

361 Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.106, ref. Neufeld, Densmore et al, 2011.

362 As per endorsement of a phased approach to complex trauma treatment trauma; see Courtois, Ford, & Cloitre, ‘Best Practices in Psychotherapy for Adults’, Chapter 4 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, pp.82-103. For detailed discussion of the phased approach to treatment of complex trauma, including some of the criticisms of it, see Chapter 5.

363 ‘Instead, clients are perhaps better served by psychotherapies aimed at lowering self-judgemental tendencies and fostering greater self-compassion’ (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.207, ref. Gilbert, 2011; Greenberg & Iwakabe; emphasis added).

*'Severe interpersonal trauma...often teaches people that their bodies are not safe, are not their own, or are a place of disgust and defilement of which to be ashamed. As a result, people often seek to flee from, or reject and abandon their bodies...the incest survivor may no longer wish to take ownership over his or her bodily self... Accordingly, consciously or unconsciously he or she rejects the bodily core, the most basic nature of him or herself.'*³⁶⁴

Rejection and 'separation' of self from body sounds, and is, extreme.³⁶⁵ But the physical body can serve as a constant and visible reminder of the trauma (i.e. as literally the site of the trauma).

A perceived dichotomy between subjective/experiential and objective/physical reality is not uncommon outside the experience of trauma. Indeed, it might be regarded as characteristic of the Western political and philosophical tradition.³⁶⁶ In the context of interpersonal trauma, it is also challenging for health professionals and society as a whole to confront the fact that apparently 'extreme' responses are often the product of extreme trauma.³⁶⁷

Bessel van der Kolk notes that '[t]he most profound legacy of trauma' may be '[the] timeless feeling of being battered by unbearable physical sensations'.³⁶⁸ In this he echoes the earlier findings of Judith Herman that '[s]urvivors feel unsafe in their bodies'.³⁶⁹ When viewed in this light, it is challenging although less surprising that:

*'If it is too painful to experience the world from inside one's body, self-identity can become organized outside the physical self.'*³⁷⁰

Inability to identify with, and feel comfortable within, one's body is associated with a range of psychological and physical health problems. It can also challenge self-care,³⁷¹ and increase the risk of self-harm as well as suicide³⁷² (because inhabiting the body; i.e. the physical self, can literally feel unbearable).

364 Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.168.

365 Here it needs to be noted that notwithstanding its untenability, the 'mind/body' dichotomy has been a foundational feature of the Western philosophical tradition (i.e. Descartes's seventeenth century cogito ergo sum) the legacy of which is still apparent.

366 Where the most (in)famous is the mind/body dualism of the Western philosophical tradition (see previous footnote).

367 Which can thus serve 'as deflection from the sad reality...an intolerance of the reality of severe abuse' (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real*; New York: Norton, 2015, p.116). In this context, Chefetz suggests that radical compartmentalisation of, for example, 'day' and 'night' time by an abused child may be a literal and accurate internal representation of external reality. This is consistent with the account of her sexual abuse at the hands of her father by survivor, prominent advocate and former Miss America Marilyn Van Derbur in her memoir *Miss America By Day* (Denver, CO: Oak Hill Ridge Press, 2003).

368 Bessel van der Kolk, 'Introduction' to Emerson & Hopper, *Overcoming Trauma through Yoga*, *ibid*, p.xix.

369 Herman, *Trauma and Recovery*, *ibid*, p.160.

370 Louis Cozolino, *The Neuroscience of Psychotherapy* (Norton, New York, 2002), p.267.

371 See James Chu, 'Staying Safe: the Paradox of Self Care', Chapter 7 in Chu, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders* (NJ: John Wiley & Sons, 2011), pp.129-146, and Herman, *ibid*.

372 The distinction needs to be made between self-harm and suicidality as they are often conflated. Self-harm – in the sense of direct and intentional injury to body tissue – does not necessarily indicate suicidal intent. On the contrary, self-injury has been defined as 'deliberate infliction of harm to body tissue in the absence of suicidal intent' (E. David Klonsky, 'The Functions of Deliberate Self-Injury: A Review of the Evidence', *Clinical Psychology Review* (27), 2, 2007, p.226, emphasis added). Research indicates that self-injury 'is most often performed with intent to alleviate negative affect'; while acute negative affect precedes self-injury, decreased negative affect and relief are present after self-injury (Klonsky, *ibid*: 226; emphasis added). Results from 18 studies of self-harm 'provide converging evidence for an affect-regulation function' (*ibid*).

1.8 Complex childhood trauma and its adult impacts

'Although both adults and children experiencing complex trauma are more likely to have symptom complexity, the much stronger predictor was found to be cumulative complex trauma in childhood'

(Cloitre et al, 2009; in Schwarz, Corrigan et al, 2017, p.19.

Childhood trauma, in all its forms, is complex trauma at its most insidious. It disrupts a child's normal developmental trajectory and continues to have wide-ranging impacts into adult life unless the trauma is resolved.³⁷³

The multiple impacts of childhood trauma have been extensively documented and have a large evidence base.³⁷⁴ The 2012 Blue Knot Guidelines delineated the costs and damaging effects of childhood trauma on children, the adults they become, and the families they create. A subsequent Blue Knot publication³⁷⁵ established the enormous financial costs of not adequately addressing complex childhood trauma, and the potential cost *savings* of recognition, resources, and appropriate services. This was flagged as an urgent national priority and public health challenge; i.e. commensurate with the enormity of the public health challenge of childhood trauma.

As Cozolino observed nearly two decades ago, '[i]t stands to reason that the most devastating types of trauma are those that occur at the hands of caretakers.'³⁷⁶ When caretakers are primary and the victims are children, the impacts are often substantial. As Schwarz, Corrigan et al. wrote more recently,

*'If major reactions to one traumatic event can occur in adults with fully developed cortical centres for emotion regulation, there should be no surprise that chronic, invasive, life-threatening, dignity-defiling abuse in early life leads to a wide spectrum of clinical presentations and long-term consequences including self-mutilation and/or suicidal thoughts.'*³⁷⁷

The terms 'chronic', 'invasive', 'life-threatening' (including the perception thereof), and 'dignity-defiling' describe the onslaughts and violations which traumatised children experience. Indeed 'there should be no surprise' that such trauma not only radically disrupts the normal developmental trajectory but adult health as well.³⁷⁸ As van der Hart et al. note, '[m]ost people with complex PTSD have experienced chronic interpersonal traumatization as children.'³⁷⁹

373 See, for example, Daniel J. Siegel, 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma* (New York: Norton, 2003), pp.1-56. Also see Erik Hesse, Mary Main et al, 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation Effects: Disorganisation, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', Chapter 2 in Solomon & Siegel, *Healing Trauma*, ibid, pp.57-106.

374 See, for example, Charles H. Zeanah & Edmund J.S. Sonuga-Barke, 'Editorial: The Effects of Early Trauma and Deprivation on Human Development – From Measuring Cumulative Risk to Characterizing Specific Mechanisms', *Journal of Child Psychology and Psychiatry* (57:10, 2016), pp.1099-1102, Adam Schickedanz, Neal Halfon, Narayan Sastry, Paul J. Chung, 'Parents' Adverse Childhood Experiences and Their Children's Behavioral Health Problems', *Pediatrics*, 2018; e20180023 DOI: [10.1542/peds.2018-0023](https://doi.org/10.1542/peds.2018-0023) and DS. Busso, K.A. McLaughlin et al, 'Child Abuse, Neural Structure, and Adolescent Psychopathology: A Longitudinal Study', *Journal of the American Academy of Child and Adolescent Psychiatry*, 56(4), 2017, pp.321-328 <https://www.ncbi.nlm.nih.gov/pubmed/28335876>

375 Dr Cathy Kezelman, Nick Hossack et al, *The Cost of Unresolved Childhood Trauma and Abuse on Adults in Australia* (Sydney, NSW: 2015).

376 Cozolino, *The Neuroscience of Psychotherapy*, ibid, p.258.

377 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid. p.19.

378 See V. J. Felitti, & R.F. Anda, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare'. Chapter 8 in Lanius. R.A., Vermetten, E. & C. Pain, *The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press, 2010, pp.77-87.

379 Van der Hart et al, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (New York: Norton, 2006), p.112. Also see the upcoming Blue Knot publication on trauma-related dissociation.

1.9 Complex trauma and dissociation: 'the fear of feeling real'³⁸⁰

Children who experience 'chronic interpersonal traumatization as children' - who represent the majority of people with complex PTSD³⁸¹ - need to protect themselves from being overwhelmed. Such trauma generates the need for *dissociative* responses which are commonly linked to the survival responses of 'freeze' and 'shut-down'.³⁸² Indeed, as van der Hart et al. confirm, most people with complex trauma 'have severe dissociative symptoms'.³⁸³

Trauma-related dissociation causes many challenges for clients and also their clinicians. These are addressed in more detail in the following chapters. The key point is that:

A consistent research theme relates not only to the clinical challenges of *treating* trauma-related dissociation, but also to *detecting* it.

Health professionals can also easily miss complex trauma. As Schwarz, Corrigan et al. note, '[m]any complex trauma presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected'.³⁸⁴ The prominence of familiar and 'ostensibly non-trauma-related symptoms' such as anxiety and depression often leads to diagnosis of 'only these comorbid conditions'.³⁸⁵

Attuning to and detecting dissociative disorders remains a particular clinical challenge for many clinicians.

Research shows that dissociative disorders are prevalent in the general population (9.1%),³⁸⁶ disproportionately so within clinical populations,³⁸⁷ and that dissociation 'more often than not has psychopathological implications'.³⁸⁸

Yet despite this - and '[e]ven when dissociative disorders are of significant severity'³⁸⁹ the relevant diagnoses are often not made. Indeed, Schwarz, Corrigan et al. contend, as do other researchers and clinicians of trauma-related dissociation,³⁹⁰ that 'only those believing that the diagnosis is of utility [are] likely to diagnose'.³⁹¹ Hence widespread education around the prevalence of dissociative disorders is much needed.

Underlying trauma in general and dissociative disorders more particularly often go undetected. The frequent clinical failure to detect the effects of underlying trauma in general and of undiagnosed dissociative disorders in particular is of great concern. Research shows that clients with sub-clinical, as well as diagnosed, PTSD have higher suicide risk³⁹² 'with or without major depression', and when there is child sexual abuse 'the earlier the onset of childhood sexual abuse, the greater the suicidal intent'.³⁹³

380 Subtitle of Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid.*

381 Van der Hart et al, *The Haunted Self*, *ibid.*, p.112.

382 In fact trauma-related dissociation is more complex than commonly conceptualised; it is possible to be behaviourally active while dissociative; see the more detailed discussion of dissociation in the following chapter.

383 Van der Hart et al, *The Haunted Self*, *ibid.*

384 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*: 23.

385 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*: 23.

386 J.G. Johnson, P. Cohen et al, 'Dissociative disorders among adults in the community, impaired functioning, and axis I and II comorbidity', *Journal of Psychiatric Research* (40, 2, 2006), pp.131-40. Also note that a higher prevalence rate has been found; see Kate, Hopwood & Jamieson, 'The prevalence and antecedents of Dissociative Disorders and dissociative experiences in college populations: a meta-analysis of 98 studies. *Journal of Trauma & Dissociation*, 2019.

387 David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4.

388 Spiegel, 'Integrating Dissociation', *ibid.*

389 Schwarz, Corrigan et al, *ibid.*, p.23.

390 Martin Dorahy et al, 'The Role of Clinical Experience, Diagnosis and Theoretical Orientation in the Treatment of Post-traumatic and Dissociative Disorders: A Vignette and Survey Investigation', *Journal of Trauma and Dissociation* (Vol.18, Issue 2, 2017), pp.206-222.

391 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*, p.23.

392 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*, referencing Kessler, 2000

393 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*, ref. Lopez-Castro et al, 2015; emphasis added.

The risks of missed diagnosis are also especially high in relation to Dissociative Identity Disorder (DID).³⁹⁴ Failure to diagnose and appropriately treat DID has major repercussions.³⁹⁵ As ‘the most extreme complex trauma disorder’,³⁹⁶ DID will ‘frequently fail to be recognized as such’, and ‘even the most highly motivated patient’ will often ‘struggle to access appropriate services’

The DID Treatment Guidelines of the International Society for the Study of Trauma and Dissociation (ISSTD)³⁹⁷ note that DID presentations are frequently ‘a mix of dissociative and PTSD symptoms with a number of apparently ‘non-trauma’ co-morbidities such as depression, anxiety, somatoform, substance abuse and eating disorders’:³⁹⁸

‘Treatment of these conditions with no recognition of the relevance of the underlying trauma history and its genesis of, for example, a major dissociative disorder will fail to promote recovery, and the patient will be seen as treatment-resistant or suffering from a personality disorder.’^[399] Individuals will likely be treated with pharmacological cocktails that fail to provide more than intermittent symptomatic relief’.⁴⁰⁰

If clinicians miss the harder to detect signs of dissociation, complex trauma-related presentations are likely not only to be inappropriately treated, but also completely bypassed: ‘Clearly without targeting the effects of childhood experience of trauma, no matter how low-grade it may appear to the therapist,⁴⁰¹ treatment will not result in the full resolution of the negative affect state or the restoration of the capacity for joy and happiness’.⁴⁰²

394 For helpful and authoritative papers on DID, see Martin Dorahy et al, ‘Dissociative Identity Disorder: An empirical overview’, *Australian and New Zealand Journal of Psychiatry* (48, 5, 2014), pp. 402 – 417, and Bethany Brand et al, ‘Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder’ *Harvard Review of Psychiatry* (24, 4, 2016), pp. 257-270. https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx

395 For helpful and authoritative papers on DID, see Martin Dorahy et al, ‘Dissociative Identity Disorder: An empirical overview’, *Australian and New Zealand Journal of Psychiatry*, Vol. 48 (5) 2014, pp. 402 – 417, and Bethany Brand et al, ‘Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder’ *Harvard Review of Psychiatry*, Vol.24, Issue 4, July-August 2016, pp. 257-270. https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx

396 Schwarz, Corrigan et al., *The Comprehensive Resource Model*, *ibid*, p.19; recall, however, that trauma, which may be extreme, generates apparently ‘extreme’ responses. DID is routinely correlated with the most severe early life trauma. This illustrates the appropriateness and even ingenuity of this ‘extreme’ response to severe child abuse.

397 *Guidelines for Treating Dissociative Identity Disorder in Adults* (third revision) ISSTD http://www.isst-d.org/downloads/guidelines_revised2011.pdf

398 Cited in Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.19.

399 Note that some regard personality disorders as dissociation-based; see, for example, Philip Bromberg, *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* (Psychology Press, New York, 198, 2001); also see Russell Meares, *A Dissociation Model of Borderline Personality Disorder* (Norton, New York, 2012).

400 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, pp.19-20.

401 And where ‘[r]esearch has shown that it is the perception of the individual that determines if the PTE [potentially traumatic event] was traumatic or not – not a witness or a clinician’ (Schwarz, Corrigan et al, *ibid*, p.18).

402 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid*, p.20.

1.10 Revisiting ‘resilience’

The prevalence and nature of complex trauma and trauma-related dissociation necessitate a more nuanced understanding of the concept of *resilience*; a term which is widely referenced in the mental health field. Relevant contextual and individual factors pertaining to resilience are increasingly understood.⁴⁰³ But ‘resilience’ is even more complex in the context/s of complex trauma.

That our primary care-giving experience significantly influences our capacity for resilience⁴⁰⁴ makes intuitive sense. But when resilience is equated with ostensibly ‘productive’ activity, the fact that *an apparently resilient person may also be a victim of trauma* is often missed.

Privileging ‘positive’ functioning as a sign of resilience risks mistaking the appearance of healthy functioning for a person’s *subjective experience*.

This increases the possibility that any underlying trauma will be unrecognised. It also reveals the limits of diagnosis and categorisations which are ‘less useful when we try to understand the patient’s subjective (that is, actual) experience’.⁴⁰⁵

It is vital to understand that apparently ‘high functioning’ people can experience the impacts of complex trauma.

It is also important to reflect on particular characteristics or activities associated with the term ‘resilience’ rather than simply applying it across the board.

In considering what is regarded as ‘high functioning’, we need to consider how we *subjectively experience* ourselves. People can also be high functioning in some registers and not in others. In which respects and domains are we ‘high functioning’? As the concepts and activities of ‘compensation’ and ‘overcompensation’ imply, a person can be high functioning in some areas *because* they are less so in others.

The role of *coping strategies*, both in basic functioning/activity and on subjective experience, is particularly relevant here. Seemingly ‘high functioning’ and ‘resilient’ people can struggle with unresolved overwhelming stress and impaired quality of life. For example, overwork can serve as an unconscious coping strategy which, because it is often well remunerated and socially sanctioned, may not be regarded as a problem. While the health impacts which present as personal stress may be seen as a *consequence* of overwork, the possibility that overwork is a coping strategy *to distract from prior internal stress or underlying trauma* is less frequently considered.⁴⁰⁶

403 ‘Two streams of thought now dominate the field of resilience: the emergence of individual resiliency skills (emotional regulation, social skills, empathy, and optimistic thinking) and the ecological and protective factors that influence a child’s development (community, family, parents, school and peers). The past two decades have seen a stronger shift towards researching strengths and protective factors that build resilience in children, young people and adults in diverse situations’ Resilience Report, The Resilience Centre, The Research Doughnut, UK <https://www.resiliencedoughnutuk.com/resilience-report>

404 See ‘The Interpersonal Sculpting of the Social Brain’, Chapter 9 in Cozolino, *The Neuroscience of Psychotherapy*, ibid, pp.172-214. The process by which this takes place is explicated in detail by Allan Schore; see, for example, *Affect Dysregulation and Disorders of the Self* (New York: Norton, 2003).

405 D. Kalogjera-Sackellares, *Psychodynamics and Psychotherapy of Pseudoseizures* (Wales: Crown House, 2004), p.15 (emphasis added)

406 While theorists of resilience are not guilty of this view, such misperceptions occur readily in a fast-paced society, including in busy health service settings.

It is important to pay adequate attention to the role and function of compensatory activity in regard to complex trauma. This is because for many people who struggle with its impacts, *'resilient strategies and maladaptive coping skills are interlaced and occur simultaneously.'*⁴⁰⁷

'One method of adapting.... is to seek effortfully to develop a solid structure in one's own life, and to be conscientious, dutiful, productive, and most importantly to focus on solving problems, and not on interpreting feelings. This line of adaptation can lead to substantial, even superior, achievement'

(Kalogjera-Sackellares, 2004:12; note that this can also apply more broadly than to complex trauma per se).

The dynamics of dissociation are relevant here, in that intellectual capacity, creativity, and will-power may be unimpaired. To this extent, dissociation enables *compartmentalisations* which permit, and can even facilitate, 'achievement'. But this comes at the cost of healthy access to emotion.⁴⁰⁸

'Along with the child's desire to be very dutiful and to control things in very careful ways, there is also a parallel fear of emotional experience. This does not include only negative feelings, but any emotional experience as such. Feelings are feared intrinsically because they can mobilise frightening memories...'

(Kalogjera-Sackellares, 2004: 12)

The adult child of a parent with, for example, substance abuse issues 'may find it virtually impossible to separate emotions from chaos'.⁴⁰⁹

Being estranged from one's experience can also make a person more vulnerable to somatization (i.e. psychological distress manifesting in physical symptoms) 'for the simple reason that the person has never learned how to express feelings in words or has been actively discouraged from doing so'.⁴¹⁰

'In spite of their traumatic lives and many losses, [some patients] tend to be, or can be, very strong and resilient. In a word, they are survivors, rather than the reverse. They learned to cope with external circumstances and stressors, but may neglect (or have never learned to attend to) their feelings, and do not process the impact of all the adverse events on their lives. Then, a substantial lag develops between coping with external problems and coping with emotions. The latter lags significantly behind.'

(Kalogjera-Sackellares, 2004: 18)

Thus *'[v]ulnerability in one domain may be offset by resilience in another.'*⁴¹¹

407 Bloom & Farragher, *Destroying Sanctuary*, ibid, p. 16.

408 'What is typical about my patients clinically is that they have extraordinary capacities to lead highly productive lives in very compartmentalised ways' (Chefet, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid: 116). This contemporary clinical observation reproduces the observations of the first generation of psychotherapists: '[A]mong hysterics may be found people of the clearest intellect, strongest will, greatest character and highest critical power' (Breuer [re his view & Freud's] 1895:232, in Elizabeth Howell, *The Dissociative Mind* (New York: Routledge, 2005:62).

409 Kalogjera-Sackellares, *Psychodynamics and Psychotherapy of Pseudoseizures*, ibid, pp.12-13. Here it is also significant that traumatic memory is implicit, generally non-conscious, and severely disrupts coherence, a sense of self-continuity and identity. It also entails a 'blurring of the boundaries between cognitive and emotional phenomena, which '[i]n the patient's actual experience...are typically blended, as indeed they are in non-injured people' (Kalogjera-Sackellares, *Psychodynamics and Psychotherapy of Pseudoseizures*, ibid, pp.14- 15; emphasis added).

410 Kalogjera-Sackellares, *Psychodynamics and Psychotherapy of Pseudoseizures*, ibid, p 12.

411 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid. p.27; emphasis added.

In compartmentalised ways, unresolved trauma may not necessarily impede - and through dissociation and coping strategies may even enable - 'high functioning' in some areas at the same time as there are deficits in other domains and reduced quality of life overall.

This is 'resilience' of an extraordinary kind. But it is also double-edged. This is because the underlying trauma may remain unrecognised, including by the person affected, making them 'less likely to present for treatment'.⁴¹²

An often uneasy 'mix' of 'high-functioning' and apparent resilience at some levels, with less visible internal disruption at others, complicates familiar notions of 'resilience'.

The problematics of 'resilience' in the context of complex trauma also requires more nuanced understanding and application of 'strengths-based' orientations to recovery.

'Strengths-based' approaches are clearly important in that existing competencies need to be harnessed and celebrated. But such approaches *can also minimise concurrent difficulties and fail to recognise 'hidden' suffering*. This means that care needs to be taken to attune both to ongoing strengths *and* the nature and extent of ongoing challenges. The risks are especially high and the consequences potentially dire when multiple compartmentalised self-states co-exist (as in Dissociative Identity Disorder; DID).

1.11 Sociocultural/political contexts: insidious trauma and micro-aggressions

'In the lives of many individuals who are members of target groups, daily existence is replete with reminders of the potential for traumatization and the absence of safety'
(Brown, 2009: 103)

'[B]etrayal...operates[s] in a larger context beyond interpersonal relationships'
(Freyd, 2013: 35)

Complex trauma can stem from many sources. This highlights the limits of an 'individualist' lens. As Freyd's concept of betrayal trauma elaborates, and as the Royal Commission into Institutional Responses to Child Sexual Abuse documented in detail, breaches of duty of care are not confined to the realm of the interpersonal. They also occur at a 'whole of society' level.

The phenomenon of intergenerational transmission of trauma,⁴¹³ as evidenced by the continuing health impacts on Aboriginal Australians,⁴¹⁴ also attests that complex trauma is not only 'individual', physical and psychological. It is social, cultural, collective and political.

412 '[T]he very resilience which allowed a young person to survive developmental trauma...may mean they are less likely to present for treatment'; Schwarz, Corrigan et al., *The Comprehensive Resource Model*, *ibid.* p.27.

413 See Ariel J. Lang & Maria A. Gartstein, 'Intergenerational Transmission of Traumatization: Theoretical Framework and Implications for Prevention', *Journal of Trauma and Dissociation* (19, 2, 2018), pp.162-175. Also see 'How Trauma and Resilience Cross Generations' Interview with Rachel Yehuda (updated 2017) <https://onbeing.org/programs/rachel-yehuda-how-trauma-and-resilience-cross-generations-nov2017/> ; and Thomas L. Hodge, *Intergenerational Trauma* (CreateSpace, 2016).

414 Judy Atkinson, 'Aboriginal Australia – trauma stories can become healing stories if we work with healing intent', Chapter 10 in Richard Benjamin et al, *Humanising Mental Health Care in Australia* (Routledge, London, 2019), pp.133-142.

The politics of trauma was highlighted by Judith Herman in her classic text *Trauma and Recovery*.⁴¹⁵ More recently, Bessel van der Kolk has emphasised the inextricable relationship between trauma and politics in *The Body Keeps the Score*.⁴¹⁶ While the power imbalance in interpersonal relationships enables complex trauma, wider structural factors also incubate and facilitate it.

Yet many residents of Western liberal societies struggle to recognise the collective, as well as interpersonal, contexts of relational trauma. This is because the ideology of individualism is so strong,⁴¹⁷ including within mental health services.⁴¹⁸ Western liberal democracies which privilege individualist 'norms' often fail to acknowledge that whole *groups* of people may be oppressed by 'the everyday attitudes of a well-intentioned liberal society'.⁴¹⁹ The concept of oppression tends to be regarded as alien and as external to liberal democracy.⁴²⁰

For many people, trauma is neither solely a 'one-off' single-incident nor purely the product of interpersonal (e.g. intrafamilial) processes. Rather it is '*a frequent component of social and emotional environments in which daily life can become a series of encounters with threat*'.⁴²¹ In fact the contemporary cultural socio-political landscape is conducive to many varieties of trauma, including systemic discrimination which affects some people and not others.⁴²²

American trauma therapist Laura Brown draws attention to the concepts of 'insidious trauma' and 'micro-aggressions'.⁴²³ These terms describe experiences which are not necessarily traumatic in themselves but which can accumulate and are 'traumatic in a subtle way'.⁴²⁴ Because they occur 'in apparently banal ways',⁴²⁵ insidious trauma and micro-aggressions are often invisible to those who do not experience them.

415 Herman, *Trauma and Recovery*, *ibid*.

416 'When I give presentations on trauma and trauma treatment, participants sometimes ask me to leave out the politics and confine myself to talking about neuroscience and therapy. I wish I could separate trauma from politics, but as long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail' (van der Kolk, *The Body Keeps the Score*, *ibid*, p.350).

417 For a powerful account of the dominance and impacts of the ideology of individualism in Western democratic societies, see Iris Marion Young, *Justice and the Politics of Difference* (Princeton, NJ: University of Princeton Press, 1991).

418 While the individual is rightly prioritised in treatment settings, this can be at the expense of adequate recognition of the contexts which shape them. This is despite concurrent emphasis on relationality and on social models of health. It has been argued that the 'default setting' of otherwise diverse counselling approaches remains that of the bounded individual - 'Many pressures incline us towards drafting an outline of the client as a private being, as someone who... has more or less stable boundaries, has a more or less internal locus of control...' (Mark Furlong, 'Calling the client as a relational being', *Psychotherapy in Australia*, Vol.19, No.3, 2013, p.69). As Furlong goes on to remark, '[c]ertain therapeutic traditions acknowledge an explicit relational aspect as a core principle, mindful that the established approaches (CBT, humanistic/third force, psychoanalytic traditions) recognise an autonomous, well-bordered self as the ideal...even if the practitioner has a relational, feminist or post-structural allegiance, the materiality and context of the therapeutic project invites the practitioner to act as if the client is bounded by their skin' (Furlong, *ibid*).

419 Young, *Justice and the Politics of Difference*, *ibid*.

420 Young, *Justice and the Politics of Difference*, *ibid*. In Western liberal societies, 'violence' is often viewed as specific acts carried out by identified perpetrators (i.e. rather than as ongoing systemic violations which are generally less overt but increasingly destructive for large numbers of people). Slovenian psychoanalyst Slavoj Žižek outlines three forms of violence of which, he proposes, only the first is widely recognised within Western 'liberal democratic' societies: *subjective* (the most visible, 'performed by a clearly identifiable agent'), *symbolic* ('embodied in language and its forms') and *systemic* ('the often catastrophic consequences of the smooth functioning of our economic and political systems') (Slavoj Žižek, *Violence*, New York: Picador, 2008, pp.1-2).

421 Laura S. Brown, *Cultural Competence in Trauma Therapy* (American Psychological Association, Washington, DC, 2009), p.111.

422 Discrimination on the basis of social, political and/or religious difference is frequent. A recent horrific illustration is the massacre of Muslims at prayer in Christchurch, New Zealand, by an Australian white supremacist in March 2019. Also note that there are forms of social, cultural and political trauma which are not targeted towards particular groups or individuals but rather directed at the general public (e.g. terrorism in a more general sense).

423 Brown, *ref Root*, 1992, and Sue, 2000, *Cultural Competence in Trauma Therapy*, *ibid*. See Sue, Capodilupo et al 'Racial Microaggressions in Everyday Life Implications for Clinical Practice', *American Psychologist* (62, 4, 2007), pp. 271–286 DOI: 10.1037/0003-066X.62.4.271

424 Brown, *Cultural Competence in Trauma Therapy*, *ibid*, p.103.

425 Brown, *Cultural Competence in Trauma Therapy*, *ibid*.

Insidious trauma and micro-aggressions are often *group based* rather than 'individual' traumas. Those outside the target, 'non-norm' or 'not mainstream' group/s often fail to comprehend the discrimination which can stem from the ideology of individualism. While positive in many ways, focus on 'the individual' can limit our ability to recognise the *social* injustices experienced by whole *groups* of people who don't fit the 'norm'. In ostensibly democratic societies, some people are more welcome than others:

'Everyday racism, sexism, homophobia, classism, ableism, and so on...are the small but ever-present pulls of energy toward a survival level of consciousness, the reminders that someone somewhere is trying to make you and people like you less welcome on the planet'
(Brown, ref. Essed. 1991. 2009: 103)

Discrimination as part of a group is often portrayed as 'individual' perception with objections being a matter of 'personal choice'.⁴²⁶ This is despite the extensive documentation of successive government-sponsored reports of systemic rights violations in Western societies. Frequent powerful personal accounts attest to the harm of group prejudice in so-called liberal democratic societies.⁴²⁷

Trauma occurs socially as well as interpersonally. Oppression exists within as well as outside Western societies and can be highly traumatic to those who experience it. It can also lead to dissociative responses: *'where oppression resides, dissociation is by necessity a constant companion'*
(Sar, Middleton & Dorahy, 2013: 126)

*The ideology of liberal individualism which underpins Western societies obscures the reality of systemic and structural oppression within, as well as outside, Western societies.*⁴²⁸

Discrimination and rights violations within Western societies is often rationalised as aberrant, the actions of 'bad apples', and/or as the product of 'the values of the time'. Paradoxically, the people involved are often seen to have 'meant well' and to have 'good intentions'. Yet a number of Australian inquiries which include Royal Commissions have revealed the systemic rights violations perpetrated against diverse groups. Many such violations have been officially authorised, culturally sanctioned, and routinely perpetrated by and within the key institutions of 'mainstream' liberal 'democratic' society.⁴²⁹

426 Young, *Justice and the Politics of Difference*, ibid. In contemporary Australia, the 2016 controversy around Section 18C of the Australian Racial Discrimination Act serves as an example. Section 18C defines it as unlawful to engage in offensive behaviour on the ground of race, colour, or national or ethnic origin if the act (a) 'is reasonably likely...to offend, insult, humiliate or intimidate another person or group of people' and (b) 'the act is done because of the race, colour or national or ethnic origin of the other person or of some or all of the people in the group'. Under the former conservative Prime Ministership of Tony Abbott, it was proposed to repeal this section of the Act on the grounds that it contravenes free speech. While the proposal was subsequently dropped, it was revived and championed by many on the grounds that refusal to take offence to insults and humiliation is a personal decision and a matter of individual choice.

427 For a powerful first-person account of ongoing experience of racism in Australian society, see Maxine Beneba Clarke, *The Hate Race: A Memoir* (Hachette, 2016).

428 Young argues that the ideology of liberalism has never dealt well with the reality of group life, and that a bias against collective forms of identity (apparent at the inception of the 'Universal' Declaration of Human Rights) continues to discriminate against the many who lack recourse to the status of 'individual' (Young, *Justice and the Politics of Difference*, ibid, pp.59-60). Note that the idea of the 'individual' dates to the particular context of eighteenth century Europe in which 'individual' rights could only be accessed by white middle class males.

429 Previous inquiries and Royal Commissions have exposed the extent of the violations perpetrated against particular groups of people in Australia, including children, with respect to Aboriginal and Torres Strait Islander people ('Bringing them Home' Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families', Australian Human Rights Commission, 1997; Royal Commission into Aboriginal Deaths in Custody (1987-1991); note that the rate of Aboriginal deaths in custody is now higher than when this RC completed its findings, and Inquiry into Child Migrants from the United Kingdom, 2001; among others. Also see the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse <https://www.childabuseroyalcommission.gov.au/final-report>

A key point is the frequent ‘invisibility’ of bias, discrimination and prejudice to those who do not experience it.⁴³⁰ While universal equality is a core principle of liberal ideology, relatively privileged residents of Western societies often discriminate unconsciously because of ‘aversive’ bias.⁴³¹

1.12 The centrality of experience: limits of ‘symptom based’ approaches to treatment

Diagnostic categories do not adequately delineate and address the subjective, qualitative experience of complex trauma. The focus has been on *symptoms* and symptomatology and this has implications for treatment. ‘Targeting symptoms’ is a common focus and priority in the treatment of many conditions and disorders. But while a legitimate path for clinicians, and often the primary treatment aim, it can be particularly problematic with complex trauma presentations.

There are several reasons why a ‘symptoms-based’ approach to the treatment of complex trauma is not optimal. Firstly, complex trauma is associated with extensive impairments. This makes it difficult for the clinician to know what and where to target. ‘Targeting’ implies that the symptoms are localised. But complex trauma clients traditionally meet diagnostic criteria for a raft of diagnoses (i.e. ‘high comorbidity’).⁴³²

Herman identified the ‘bewildering array’⁴³³ of complex trauma presentations nearly two decades ago, many of which ‘are so enmeshed in co-morbid factors (that) the traumatic antecedents can be readily neglected by clinicians’.⁴³⁴

A further powerful challenge to traditional ‘symptom-based’ approaches to complex trauma treatment comes from the paradigm of ‘trauma-informed’ care and practice.⁴³⁵

The philosophy of trauma-informed practice, spurred by reports of the lived experience of trauma survivors, began to emerge in the 1990s, continues to develop, and presents a major challenge to the biomedical paradigm (Moskovitz, 2011). Among its core tenets is a different understanding and reading of ‘symptoms’ which has different treatment implications to that of ‘the medical model.’

430 I.e. in the particular context in which it occurs. Note that the diversity of grounds on which discrimination can take place (e.g. ethnicity, gender, sexual orientation, age etc.) means that it is possible to be privileged in some respects but not others.

431 For discussion of this concept, see Brown, *Cultural Competence in Trauma Therapy*, *ibid.*

432 Hence the longstanding aim to arrive at what Judith Herman described in 2009 as ‘the integrative nature’ of the CPSTD diagnosis, in that ‘[r]ather than a simple set of symptoms, it is a coherent formulation of the consequences of prolonged and repeated trauma’ (Herman, ‘Foreword’ to Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid.*, p.xiii).

433 Herman, ‘Foreword’, *ibid.*

434 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, *ibid.*, p.23.

435 See C. Wilson, M. Pence et al. ‘Trauma-Informed Care’, *Encyclopedia of Social Work*. National Association of Social Workers and Oxford University Press, 2013, pp. 1-26, and A. Moskovitz, ‘Schizophrenia, Trauma, Dissociation, and Scientific Revolutions’, *Journal of Trauma and Dissociation* 12, 2011, pp.347-357.

A 'trauma-informed' approach views symptoms as *the outgrowth of self-protective strategies to deal with traumatic overwhelm which have lost their protective function because the trauma remains unresolved*. This underlines the need to address the underlying trauma, not only to 'remediate symptoms' but to resolve the need for defensive strategies (i.e. it is important to identify their source to resolve the underlying trauma and aid recovery).

This contrasting understanding of 'symptoms' reflects the pioneering insights of the Adverse Childhood Experiences (ACE) Study that 'the problem is the solution'.⁴³⁶ Rather than being intrinsically problematic, the identified 'problem' (i.e. symptom) represents the attempted solution (coping strategy) for the unresolved trauma. This 'trauma-informed' understanding also supports the previously discussed reconceptualization of 'resilience', where strength and deficit may coexist and where 'resilient strategies and maladaptive coping skills are interlaced and may occur simultaneously'.⁴³⁷

Complex trauma, which is often interpersonally generated, is *relational* and needs to be healed *in relationships*.⁴³⁸ This further challenges focussing solely on symptoms which are detached from the context which gave rise to them. It also suggests the limits of 'techniques' applied outside of a relational context.⁴³⁹

Given the severe interpersonal violations within intimate relationships, and egregious violations of duty of care experienced by many survivors, repairing relational wounds, developing the ability to trust, and building the capacity to connect safely within relationships are central to healing.⁴⁴⁰ These dimensions go far beyond an exclusive focus on 'symptoms'. They also highlight the advantages of experiential and 'whole person' orientations which see clients within their whole experience and as 'more than their symptoms'. An increasingly robust and scientific evidence base criticises treatment approaches which deny the role and importance of attuning to clients and of the therapist's experience in the shared clinical context.⁴⁴¹

A philosophical and treatment approach which critiques and transcends 'symptom-based' orientations is the Power Threat Meaning Framework.⁴⁴² This comprehensive integrated approach provides 'an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification'.⁴⁴³

436 V. J. Felitti, R.F. Anda et. al. 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine*, 14 (4), 1998, pp.245-258.

437 Bloom & Farragher, *Destroying Sanctuary*, *ibid*, p.16.

438 Herman, *Trauma and Recovery*, *ibid*, and where the therapeutic relationship is an agent of healing (see subsequent discussion).

439 This does not deny the role of judiciously applied techniques but contends that they are optimally administered and more likely to be effective within a relational therapeutic context.

440 Herman, *Trauma and Recovery*, *ibid*.

441 See, for example, Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *ibid*.

442 Lucy Johnstone, Mary Boyle et al, *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis* British Psychological Society Leicester:2018 https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Framework%20%28January%202018%29_0.pdf

443 Johnstone, Boyle et al, *The Power Threat Meaning Framework*, *ibid*, p.5.

The Power Threat Meaning Framework was developed by services users and senior psychologists under the auspices of the Division of Clinical Psychology of the British Psychological Society over a period of five years. It prioritises lived experience and is not limited to any specific theoretical model or practice modality. It was introduced to Australian audiences in 2019 in workshops sponsored by Blue Knot Foundation in collaboration with the International Society for Psychological and Social Approaches to Psychosis (ISPS).

For many clients, particularly those with complex trauma, diagnostic classifications and the privileging of symptomatology often problematically bypass subjective, qualitative, and experiential domains (as showcased in the Power Threat Meaning Framework). The challenges of comorbidity, and a reductionist reading of 'symptoms' which is often detrimental to a client, are additionally compounding.

Chapter 1

Summary of Key Findings and Themes

- A formal diagnosis of Complex PTSD on 18 June 2018 (i.e. in contrast to 'single-incident' PTSD) in the *International Classification of Diseases* (ICD-11) of the World Health Organisation (WHO) will come into effect on 1st January 2022.
- The new WHO diagnosis defines Complex post-traumatic stress disorder (Complex PTSD) as '*a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse)*'. It is characterised by persistent beliefs about oneself as diminished or worthless, deep and pervasive feelings of shame, difficulty in feeling close to others, 'significant impairment in personal, family, social, educational, occupational or other important areas of functioning' and severe and pervasive problems in affect regulation'.
- While welcome, formal diagnosis of Complex PTSD does not encompass the range of challenging presentations of complex trauma, especially its dissociative features: '*Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders...increasingly becomes a risk the more prolonged and severe the traumatic events*' (Fisher, 2017: 67).
- The new CPTSD diagnosis still requires the core criteria of PTSD - i.e. intrusion, avoidance and hyperarousal in addition to the new and differentiating domains. ('*[c]linicians will readily see the potential Achilles heel; i.e. many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms*' (Schwarz, Corrigan et al, 2017: 21).
- In contrast to the ICD-11, the most recent edition of the American *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, which is widely used in Australia) does not include Complex PTSD. It does, however, feature a dissociative subtype of PTSD, which captures the features of *depersonalisation* (sense of self-estrangement) and *derealisation* (*perception of the external world as strange or unreal*) which are more characteristic of complex than single-incident PTSD.
- The diagnostic lens is not adequate to fully address the many dimensions of complex trauma and implications for treatment. For example, many people with complex trauma experience a problematic relationship to their bodies: ('*[s]evere interpersonal trauma...often teaches people that their bodies are not safe, are not their own, or are a place of disgust and defilement of which to be ashamed*' (Frewen & Lanius, 2015: 168)
- Inability to identify with, and feel comfortable within, the body can lead to a range of psychological and physical health problems, including the risk of suicide (because inhabiting the body; i.e. the physical self, can literally feel unbearable).
- The impacts of childhood trauma are extensive and '[m]ost people with complex PTSD have experienced chronic interpersonal traumatization as children' (Van der Hart et al., 2006; 112).
- A consistent theme of complex trauma research relates not only to the clinical challenges of *treating* trauma-related dissociation, but to the more fundamental challenge of *detecting* it. It is important for all clinicians to become aware of and be able to address dissociation in trauma treatment (also the following Chapter).

- Privileging 'positive' functioning as a sign of resilience risks mistaking the surface criteria of healthy functioning for *a person's subjective experience*.
- Betrayal can be deeply traumatic as the term 'soul murder' (Shengold, 1989; 2000) implies. It occurs both interpersonally and 'in a larger context beyond interpersonal relationships' (Freyd, 2013: 35).
- In Western liberal democracies based on individualist 'norms', many people fail to acknowledge that *groups* of people may be oppressed by '*the everyday attitudes of a well-intentioned liberal society*' (Young, 1991). The concept of oppression is alien to the principles of liberal democracy and is regarded as external to Western liberal societies (ibid).
- The individualist 'norms' of Western liberal democratic societies make it difficult to recognise *systemic* and *structural* oppression and the accompanying trauma. Discrimination is often 'invisible' to those who do not experience it and can be perpetrated unconsciously ('aversive bias', Brown, ibid)
- At a sociocultural level, *insidious trauma* and *micro-aggression* occur in everyday contexts 'in apparently banal ways': '*[E]veryday racism, homophobia, classism, ableism, and so on...are the small but ever-present pulls of energy toward a survival level of consciousness*'; Brown, 2009; ref. Root, 1992; Sue, 2000 & Essed, 1991)
- A range of coping strategies for complex trauma exist. Apparently 'high functioning' people can continue to experience complex trauma impacts. Trauma-related dissociation leads to compartmentalisation and people may be '*high functioning in some domains (resilient strategies and maladaptive coping skills are interlaced and occur simultaneously*'; Bloom & Farragher, 2011:16).
- A 'trauma-informed' approach regards 'symptoms' as the outgrowth of self-protective strategies to deal with traumatic overwhelm which, when the trauma is unresolved, have lost their protective function. The underlying trauma needs to be addressed not only for 'remediation of symptoms' but for the trauma to be resolved. This contrasts to the understanding of symptoms within the biomedical model.
- 'Symptom-based' approaches to treatment often fail to recognise 'the whole person'. The Power Threat Meaning Framework, a philosophical and treatment approach developed in the UK prioritises lived experience and provides an alternative to the traditional psychiatric approach to diagnosis.
- As complex trauma is often interpersonally generated, it is *relational* and needs to be healed *in relationship*. A sole focus on symptoms detaches them from the context which gave rise to them. This also suggests the limits of 'techniques' which are administered outside of a relational context.



Chapter 2

What is Dissociation and Why do we Need to Know about It?

'The occurrence of compartmentalized function in human beings is normal. The central issue is not whether it occurs but the extent to which the compartments share information, emotion, worldview, and so on'
(Chefet, 2015: 129).

'Even though dissociation can arise from other sources as well, problematic or maladaptive dissociation is often a chronic, rigidified outcome of trauma'
(Howell, 2005:23).

The topic of dissociation is challenging. Until recently it was mainly only specialists who knew about it. But a wealth of information about the prevalence and significance of dissociation has been released in recent years. This information is critical for everyone who works with and relates to people impacted by trauma.

Information about dissociation also needs to be integrated throughout the entire mental health sector. This will foster better recognition and treatment of trauma. It is important because trauma-related dissociation remains the least recognised response to the experience of being overwhelmed. Information about dissociation will also help to educate clinicians about the relationship of dissociation to mental health and the misconception that dissociation only relates to trauma. There are 'many faces of dissociation'.⁴⁴⁴ Acknowledging its 'normal' and problematic 'faces' is a good start.

2.1 Association and dissociation: a constant interplay

'Associative process alerts our awareness that something is worth noticing. Dissociation tells us we need not pay any attention. The healthy result of this sorting is a coherent mind'
(Chefet, 2015:1)

Dissociation, in the context of mental health, is often paired with the term 'disorder'. This implies that dissociation occurs when something 'goes wrong'. It is *a particular reading* of dissociation. Dissociation can certainly be (come) problematic. However it is also a part of normal adaptive psychological processes. This is even in the context of trauma (i.e. trauma-related dissociation).

Dissociation - i.e. 'not paying any attention' - can be powerfully protective at the time of the initial trauma when other responses (e.g. 'fight' or 'flight') are ineffective or unavailable. The problem arises when the underlying trauma has not been resolved and trauma-related dissociation *remains* a coping mechanism.

⁴⁴⁴ Vedat Sar, 'The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience* (12, 3, 2014), pp.171-179. On the normative expressions of dissociation, see Lisa Butler, 'The Dissociations of Everyday Life', *Journal of Trauma and Dissociation* (Vol.5, No.2, 2004), pp.61-88. Note that there are differing views on how to conceptualise dissociation; see subsequent discussion.

Dissociation is a complex capacity which works in a number of ways. It relates to healthy 'everyday' processes as well as to the development of disorder/s (i.e. both when there is no cause for concern and when things 'go wrong').

2.2 What is dissociation?

Dissociation is commonly described as '*partial or complete disruption of the normal integration of a person's psychological functioning*'.⁴⁴⁵ The terms 'disruption', 'normal' and 'integration' can imply that dissociation is always problematic (i.e. where 'integration' is the norm and the 'disruption' of dissociation is a brake on the smooth functioning of psychological processes). In fact indicators of dissociation are common and do not necessarily signify disorder.⁴⁴⁶

An ongoing challenge is that definitions of dissociation differ. There is agreement, however, that dissociation *occurs beyond conscious awareness and control, varies in intensity, and impedes linkage between different registers of functioning*:

*'In essence, aspects of psychobiological functioning that should be associated, coordinated, and/or linked are not.'*⁴⁴⁷

A disconnection between different domains which 'should' be linked means that a person can't access the registers of functioning we all need for daily life (i.e. rather than the 'normal' interplay between association and dissociation described by Chefetz above). Dissociation is an inherent capacity of the mind which also occurs in healthy and 'normal' people.⁴⁴⁸ When it persists and there is an ongoing inability to connect, access, and move between different ranges of functioning, it impedes health and wellbeing. If severe, unrecognised and untreated, it can erode quality of life and pose a serious health threat.⁴⁴⁹

Dissociation is multifaceted, and this makes it challenging. For example, it is widely regarded to display distinct forms and mechanisms.⁴⁵⁰ It is also conceptualised both as a *continuum* (from normative to pathological) and as a *taxon* model (which differentiates the two and emphasises symptoms):⁴⁵¹

*'...dissociation has been used to describe a range of dimensional, adaptive processes not just categorical disorders. There is a tendency to conflate the [different conceptualizations]...leading to confusion about what is being described.'*⁴⁵²

445 Paul Dell & John O'Neill, ed. *Dissociation and the Dissociative Disorders* (Routledge, New York, 2011), p. xxi; also James A. Chu, *Rebuilding Shattered Lives* (John Wiley & Sons, New Jersey). 2011, p.41.

446 J. Stone, 'Dissociation: What is it and Why is it Important?' *Practical Neurology* (6, 2006), pp.308-313.

447 David Spiegel, Richard Loewenstein et al., 'Dissociative Disorders in DSM-5', *Depression and Anxiety* (28, 2011), p.826). As Chefetz also describes '[w]hen there is active dissociative process, ordinarily expectable linkage may not occur' between *behaviour, affect, sensation, and knowledge* as per the 'BASK' model developed by Bennett Braun in 1988 (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, (Norton, New York, 2015), p.25.

448 Stone, 'Dissociation: What is it and Why is it Important?', *ibid*, p.310; Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*.

449 Note that the most severe dissociative disorder is Dissociative Identity Disorder (DID).

450 The differences between *compartmentalisation* and *detachment* are commonly accepted. See, for example, Richard Brown, 'Different Types of 'Dissociation' Have Different Psychological Mechanisms', *Journal of Trauma and Dissociation* (7:4, 2006), pp.7-28, E. Holmes, R. Brown, et al 'Are there two qualitatively distinct forms of dissociation? A review and some clinical implications', *Clinical Psychology Review* (25: 1, 2005), pp.1-23, and Martin Dorahy et al. 'The Detachment and Compartmentalization Inventory (DCI): An assessment tool for two qualitatively distinct forms of dissociation' <https://osf.io/kgfyv/>

451 Spiegel, Loewenstein et al., 'Dissociative Disorders in DSM-5', *ibid*, p.827; Elizabeth Howell, *The Dissociative Mind* (Routledge, New York, 2005) pp.18-19.

452 Spiegel, Loewenstein et al, 'Dissociative Disorders in DSM-5', *ibid*, p.826.

Dissociation can be understood in several ways – e.g. as *a lack of integration of the mind and mental systems, as an altered state of consciousness, as a defence mechanism and structure, and as a 'normal' psychological process*. The diversity of these forms also highlights the limits of a purely 'symptom-based' perspective.

As two prominent contemporary researchers and clinicians of trauma-related dissociation point out, '[d]epending on how it is understood, the construct of dissociation describes many psychological phenomena or few'.⁴⁵³ The initial understanding of dissociation (which 'has been reintroduced in modern times') described 'divisions or dissociations in the personality or consciousness... that resulted from a dissociative personality structure'.⁴⁵⁴

Terming this 'the narrow conceptualization of dissociation', Dorahy and van der Hart note that the concept has now widened to a 'diffuse' understanding 'which presumes multiple origins for dissociative experiences [and] can account for many and various clinical and nonclinical psychological phenomena'.⁴⁵⁵ This view is also now more common in the contemporary conceptualization of dissociation.⁴⁵⁶

Current research into the nature of unconscious processes is leading to increasing attention to the phenomenon of dissociation ('[t]oday the mental health field is paying more and more attention to dissociation and dissociative experiences').⁴⁵⁷ For some, dissociation is not only undergoing reappraisal but is increasingly regarded as central to psychological functioning.⁴⁵⁸

Research in the neurobiology of dissociation shows that dissociation 'is accompanied by altered activation of brain structures...involved in regulating awareness of bodily states, arousal, and emotions'.⁴⁵⁹

'Exciting strides have begun to reveal the neurobiology of dissociation' (Brand, 2012:394)

'[N]euroimaging studies provide concrete, theoretically consistent evidence that dissociation exists' (Brand, *ibid*: 395).

While attention to the phenomenon of dissociation is now more sustained, insight into its nature and processes is not new. The pioneer of understanding of dissociation was Pierre Janet, a French clinician and researcher whose ideas and concepts 'predate and anticipate current views of dissociative processes'⁴⁶⁰ (see subsequent discussion). Significantly, Janet's ideas correlate with current 'bottom-up' models of mental processing.⁴⁶¹

453 Martin Dorahy & Onno van der Hart, 'Relationship between Trauma and Dissociation: An Historical Analysis', Chapter 1 in Eric Vermetten, Martin Dorahy & David Spiegel, ed. *Traumatic Dissociation: Neurobiology and Treatment* (American Psychiatric Publishing, Washington DC, 2007), p.6.

454 Dorahy & van der Hart, 'Relationship between Trauma and Dissociation: An Historical Analysis', *ibid*, p.6.

455 Dorahy & van der Hart, *ibid*, pp.6-7.

456 Dorahy & van der Hart, *ibid*, p.7.

457 Elizabeth Howell, *The Dissociative Mind* (Routledge, New York, 2005), p. vii.

458 'Today, our concept of the unconscious is expanding, with dissociation taking at least an equal role to repression.... Many of these new theoretical perspectives rest on dissociation as central' (Howell, *The Dissociative Mind*, *ibid*, p.2).

459 Bethany Brand, 'What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation* (13:4, 2012), p.395. Functional neuroimaging also shows 'that trauma survivors with more dissociative symptoms had a pattern of hyperfrontality and limbic inhibition that was the opposite of that seen among those with the more common hyperarousal type of PTSD, who had limbic hyperactivation and hypofrontality' (David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018), p.4. Increased recognition of the role of dissociation also accounts for inclusion of the dissociative subtype of PTSD In DSM-5.

460 Howell, *The Dissociative Mind*, *ibid*, p.51.

461 Spiegel, Loewenstein et al, 'Dissociative Disorders in DSM-5', *ibid*, p.827.

2.3 An alternative model of mind: integration and coherence are developments not givens

'[Janet] believed that we begin life with the elements of consciousness relatively disconnected. Maturation is the process of integration'

Russell Meares, *A Dissociation Model of Borderline Personality Disorder*
(Norton, New York, 2012), p. 19.

'Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given'

David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4.

Having 'a mind of our own' is widely taken for granted.⁴⁶² But people with persistent dissociative processes - i.e. frequent and ongoing rather than the daily 'disconnects' of not paying attention to everything - *'don't and can't make that assumption'*.⁴⁶³ When dissociation is persistent it is often, although not always, trauma-related.

It is first helpful to consider a common view of the human mind as coherent and integrated. Inner life fluctuates. Most people believe there is a 'division' between conscious and unconscious processes. Yet a foundational and innate coherence is also widely assumed. So, too, is an early dependence on primary caregivers for psychological and physical development. It appears, however, that the mind may be inherently dissociative (because inherently dependent and relational). This would mean that integration, coherence, and self-continuity are products of *experience* rather than conferred at the outset.⁴⁶⁴ To seriously engage with the topic of dissociation we need to consider this and its implications.

'[U]nlinked dissociated states are at the root of all self-experience'

(Goldman, 2016: 98).

'Self-states are what the mind comprises. Dissociation is what the mind does. The relationship between self-states is what the mind is'

(Bromberg, 2011, p.2).

2.4 The emergent self: dissociation, relationality, and development of emotional coherence

'In the process of being brought up by humans, and as a result of experiencing anxiety and learning how to avoid it, dissociative gaps in consciousness inevitably form'

(Howell, 2005: 93, ref. Sullivan, 1953).

462 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders*, *ibid*, p.2.

463 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p.2.

464 Not least because the privileging of consciousness and cognitive capacity, and the concepts of autonomy, choice, responsibility, and 'authoring our own destiny' are intrinsic to the Western political and philosophical tradition and the mind more broadly (as the 17th century proclamation of Rene Descartes 'I think therefore I am' underlines).

How do we become our 'selves'? This is another way of asking how our minds cohere. Citing Dan Siegel and Frank Putnam, Elizabeth Howell notes that '*[d]evelopmentally, lack of integration characterizes our beginnings... and facilitative maturational environments enable disconnected sets of experiences to be linked*'.⁴⁶⁵

Interpersonal connections foster links between mental states ('intrapsychic') while states are the building blocks of consciousness and behaviour.⁴⁶⁶ Thus development involves *linkage* of and between self-states ('parts') and different ways of being:

'The self is characterized by a complex multiplicity of subunits and subselves (Erdelyi, 1994), and even the multiple parts themselves have parts'

'...the important issue is not how many parts there are, but how they hang together'
(Howell, 2005:48)

In normal development, 'we are usually able to integrate our ongoing interaction... with our social surroundings into a coherent sense of self'.⁴⁶⁷ 'Good enough' caregiving allows us to internalise positive relational interactions and healthy socialisation. This means that we can repair ruptures and learn to self-regulate. But developmental trajectories can be disrupted. This occurs most obviously when primary care-giving is not adequate, although as the term 'socialisation' implies, child rearing occurs within the wider socio-political context which also influences development.⁴⁶⁸

'[T]he organization of the self [is] based on the interactive patterns of [early caregiving] relationships, on characteristic patterns of avoiding or diminishing anxiety that have developed in the course of these relationships, and on the degree to which severe anxiety has prevented experience from being remembered, codified, elaborated, and linked with other experience'

(Howell, 2005:93, ref Sullivan, 1953).

In the above reading, dissociation is central to the development of the self (where *the extent of the need to dissociate* varies rather than the need itself). 'Self' is viewed as 'an organization of evasions and detours, constituted to avoid anxiety and preserve a feeling of interpersonal security'.⁴⁶⁹ Thus '[t]he internalization of the processes belonging to the human relationships of upbringing, as it is organized by anxiety, is the basis of what constitutes the psyche'.⁴⁷⁰

Clearly this conceptualisation and pathway to development of the self differs from the traditional more familiar view of the assertive and self-actualising individual. It also evokes a contrasting notion of what constitutes 'I'. The 'I', in this reading, is not about agency and/or a rational ego which seeks to tame instincts. Rather it is a view of self as fragile and avoidant of anxiety, '*protected only by dissociation and those security operations that undergird it. The self is organized around dissociative gaps*'.⁴⁷¹

465 Howell, *The Dissociative Mind*, *ibid*, p. 17, ref Siegel (1999) and Putnam (1997).

466 Howell, *The Dissociative Mind*, *ibid*, p.170, ref. Putnam, 1992, 1997.

467 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2001), p.103.

468 See Erdinck Ozturk & Vedat Sar, 'The 'Apparently Normal Family: A Contemporary Agent of Transgenerational Trauma and Dissociation', *Journal of Trauma Practice* (4, 3, 2006), pp.287-303.

469 Howell, *The Dissociative Mind*, *ibid*, p. 95, ref. Sullivan, 1953.

470 Howell, *The Dissociative Mind*, *ibid*, p.93, ref. Sullivan, 1953 ('This self is often highly distorted, like the trees growing in the Grand Canyon; structured around the constraints, requirements, needs, anxieties, and forbidding gestures of significant others'). As Howell discusses 'this psychic prohibition was not codified or symbolized anywhere in the mind. Rather, the personality was structured around it, the way a painting can be structured around unpainted spaces on the canvas' (*ibid*: 95)

471 Howell, *The Dissociative Mind*, [ref. Sullivan, 1953] *ibid*, p.95.

2.5 Impediments to linkage: ‘when things go wrong’

‘People who have suffered more interruption of state linkage have more difficulty understanding their emotions and tend to feel buffeted by circumstances. As a result, they tend to rely on dissociation, and dissociation of self-states will be more frequent and severe’

(Howell, 2005: 170)

Dissociation, according to the above, is the corollary of attempts to evade anxiety (which stems from ‘internalization of the processes belonging to the human relationships of upbringing’).⁴⁷² As such, it is a constituent of the emergent self and not simply an outcome.

The process of development and socialisation via the mechanism of dissociation aligns with Bowlby’s account of ‘defensive exclusion’.⁴⁷³ We all use defensive exclusion to preserve the primary care-giving relationships on which we depend. What threatens the care-giving relationship is ‘defensively excluded’; i.e. dissociated to preserve the primary attachment.⁴⁷⁴

For some people, however, the need to dissociate (‘defensively exclude’) is more extreme. In ‘good enough’ caregiving relationships, ruptures are repaired and there is no need to decisively compartmentalise to preserve the relationship. Sadly, this is not the case for all children, including those in abusive or otherwise traumatic caregiving relationships.⁴⁷⁵

Although childhood trauma is a pathway to developing isolated self-states (see below) early relationships which don’t foster a linkage between self-states may not necessarily be traumatic. However, they will be ‘somehow unresponsive to the particular needs of the child’.⁴⁷⁶ Research has also shown that ‘[t]he best predictor of adult dissociation is emotionally unresponsive parenting’.⁴⁷⁷

Frequent severe dissociation in childhood has a high cost. This is because even though dissociation allows the child to maintain their attachment to their caregiver, it makes it difficult for them to subsequently attach to others:

472 Howell, *The Dissociative Mind*, *ibid*, p.93, ref. Sullivan, 1953.

473 John Bowlby, ‘The Origins of Attachment Theory’ [1981] in Bowlby, *A Secure Base* (New York: Routledge 2006, p.39).

Despite the fact that the nature and significance of dissociation and trauma were long ignored by the traditional psychoanalytic community (which dates to Freud’s ‘abandonment of the seduction theory’; see subsequent discussion) dissociation was infrequently referenced by earlier generations of psychotherapists. This does not mean, however, that pioneers, then seen as dissidents, did not appreciate its significance. Note, for example, the following comments regarding eminent psychoanalyst D.W. Winnicott – ‘At the very end of his life, Winnicott was poised once again to *destroy and thereby bring psychoanalysis to life* by placing his ideas about dissociation front and centre. The Notes for the Vienna Congress continue... One can hear Winnicott’s plea as an attempt to more fully integrate into psychoanalytic theory a view of dissociation that had always been important to him. Despite operating within an *espoused* theory privileging repression as an explanatory construct, *in practice* Winnicott demonstrates a keen awareness of dissociation – both as a healthy natural capacity and as a defensive response to trauma. For Winnicott, *it makes a vast difference how and in what context dissociation is used*’ (Dodi Goldman, ‘A queer kind of truth’: Winnicott and the uses of dissociation’ in Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis*, Routledge, New York, 2016, pp.97-8).

474 Clearly this concept and the phenomenon of dissociation also shed valuable light on the phenomenon of ‘attachment to the perpetrator’, whereby a child remains psychologically loyal even, and especially, to an abusive caregiver. See Joyanna Silberg, *The Child Survivor: Healing Developmental Trauma and Dissociation* (New York: Routledge, 2013).

475 This includes the transmission of disrupted attachment to the offspring of parents whose own trauma is not resolved. See Erik Hesse, Mary Main et al. ‘Unresolved States Regarding Loss or Abuse Can Have ‘Second Generation Effects’: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents’, Chapter 2 in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma* (Norton, New York, 2003), pp.57-106.

476 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders*, *ibid*, p.90. Also see Steven Gold, *Not Trauma Alone* (Routledge: Philadelphia, 2000).

477 Lyons-Ruth et al, 2006, cited in Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders*, *ibid*, p.89.

*'The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others.'*⁴⁷⁸

Recognition of the pathways by which deficits in early childhood relationships can lead to problematic (as distinct from normative) dissociation in adulthood is not new. But as will be discussed below in relation to trauma, there are reasons why this understanding has not been widespread in the mental health sector. In the current period the phenomenon of dissociation is beginning to receive increased attention, and the implications for understanding of wellbeing, as well as 'disorder', are major.⁴⁷⁹

Drawing on the prior concepts of American psychiatrist and psychoanalyst Harry Stack Sullivan (1892-1949), Elizabeth Howell summarises some of his key themes and their significance:

`GOOD ME', `BAD ME' & `NOT ME'

(Sullivan, 1953 in Howell, 2005:95)

Self is organised around 'the requirements of anxiety' (Howell, 2005:95) according to 3 conceptions:

- **`Good me'** (*ordinary conception of self; stems from affects and activities that have met with early approval*)
 - **`Bad me'** (*stems from early behaviours which were not welcomed; `associated with the increasing gradient of anxiety'*)
-
- **`Not me'** (*`out of conscious and dissociated'; the product of severe anxiety*)
'In Sullivan's terms, it is the partition between the `me' and the `not-me' that is the dissociative organization of the psyche' (Howell, 2005: 96.).

Shaming involves not being seen, or having an aspect of oneself not seen, by a significant other.⁴⁸⁰ As previously discussed, shame is 'a core affect' of complex trauma. A child's need to preserve attachment to caregivers via dissociation can threaten *self*-connection, as well as the ability to attach to others as an adult.

But trauma is not the only reason to dissociate in childhood:

*'Many of our [clients]...have suffered in childhood precisely the sorts of severe loss that research associates with an unresolved state of mind with respect to attachment. Yet loss of a different, less disorganizing kind is a feature of the history of most of our patients.'*⁴⁸¹

478 Philip Bromberg, *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* (Psychology Press, New York, 2001), p.6.

479 Also see upcoming publication on trauma-related dissociation.

480 Bromberg, *Standing in the Spaces*, *ibid.*

481 David Wallin, *Attachment in Psychotherapy* (The Guilford Press, New York, 2007), p.204.

2.6 Both the norm and forerunner of disorder

'The dissociative concept of multiple self-states is enormously helpful in understanding both normal experience and pathological conditions'
(Chu, 2011:46).

The way 'normal' dissociation operates in psychological wellbeing obscures the key role it plays. Dissociation helps us maintain a sense of continuity and integration 'by systematically and routinely invoking processes that enable [us] to ignore the glaring gaps, inconsistencies, and lack of continuity in [our] experiences and behaviour'.⁴⁸² This means we are unaware of being unaware. The 'everyday' interplay of associative and dissociative processes in managing diverse psychological stimuli is 'second nature'. This partly explains why the phenomenon of dissociation is often ignored.

Yet as Bromberg elaborates, 'even in the most well-functioning individual, normal personality structure is shaped by dissociation' as well as by other psychological processes.⁴⁸³ In his numerous pioneering publications, Bromberg elaborates why the phenomenon of dissociation (*'in all its forms – healthy and adaptive, pathological and self-protective'*) is '[c]entral to any understanding of therapeutic growth'.⁴⁸⁴

If 'unlinked dissociated states are at the root of all self-experience',⁴⁸⁵ and if self develops from childhood via the linking (or not) of self-states which were not continuous to start with, this model of the mind and psychological functioning has non-clinical, as well as clinical, implications. As Howell suggests, '[a] model of the dissociative mind is potentially transformative of the way we conceptualize mental processes'.⁴⁸⁶

A continuum model of dissociation helps us understand the different expressions of dissociation (i.e. from 'normal' and healthy to problematic and pathological; also see subsequent discussion). Yet there are also contrasting readings of dissociation. As with longstanding debates regarding continuum/dimensional vis a vis categorical/taxon models more broadly, it needs to be noted that some researchers and clinicians reject what are regarded as overly inclusive conceptualisations of dissociation in favour of more specific understanding/s.

A respected example of the taxon model is the theory of structural dissociation presented by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele.⁴⁸⁷ Yet the range and breadth of experiences arguably encompassed by dissociation remains the subject of debate. As one clinician contends, 'it makes a vast difference how and in what context dissociation is used'.⁴⁸⁸ If, as Bromberg contends, dissociation 'in all its forms' is '[c]entral to any understanding of therapeutic growth',⁴⁸⁹ this clearly has many implications for clinicians.

482 Gold, 2004; in Howell, *The Dissociative Mind*, ibid, p.36.

483 Bromberg, *Standing in the Spaces*, ibid, p.270.

484 Bromberg, *Standing in the Spaces*, ibid, p.310.

485 Goldman, 'A queer kind of truth', ibid, p.98.

486 Howell, *The Dissociative Mind*, ibid, p.8. Hence, she says, 'we need to reformulate our psychological theory accordingly' (Howell, ibid: xi).

487 Onno van der Hart, Ellert Nijenhuis, & Kathy Steele, *Structural Dissociation and the Treatment of Chronic Traumatization* (Norton: New York: 2006). Additional discussion of chronic trauma-related dissociation is presented in the upcoming publication on trauma-related dissociation.

488 Goldman, 'A queer kind of truth'; ibid, p.98 (original emphasis).

489 Bromberg, *Standing in the Spaces*, ibid: 310.

2.7 When experience is overwhelming: trauma-related dissociation

'the escape when there is no escape'

(Putnam, 1992:104)

The developmental process critically shapes coherence and self-continuity which are relational. This means that integration is not a natural state or 'given', and dissociative self-states, rather than coherence, are inherent. The experiences of our formative years initially foster (or not) linkage between self-states.⁴⁹⁰ Individual wellbeing, itself inherently relational, is not static. Rather it derives from the ease with which diverse self-states can be accessed and moved between.⁴⁹¹

Yet while dissociative gaps in consciousness are 'part and parcel' of the developmental process and the need to avoid anxiety,⁴⁹² trauma-related dissociation – i.e. *dissociation as a defence against overwhelming experience* – is of a different order.

Mild and even moderate experiences of stress are common. But stress that is *overwhelming* substantially impedes the ability to segue between self-states. This means that 'associative capacity – access to thoughts, feelings, normal abilities, and judgement – is lost or becomes limited'.⁴⁹³

There are various reasons why the ability to move between self-states may be disrupted, and these are not always trauma-related. But as Bromberg relates, *when utilised as a defence in the face of overwhelm*, dissociation 'is a defence unlike any other...It functions because conflict is unbearable to the mind, not because it is unpleasant'.⁴⁹⁴ Putnam's much quoted description of dissociation as 'the escape when there is no escape' is significant.

'If the overwhelming traumatic event could not be taken in...it is dissociated. There is a split in experience. Experience that is too overwhelming to be assimilated will cause a division of experiencing and knowledge. Part of self-experience will be separated or split off from one another, and one part of ourselves will not know of other parts of ourselves...the result of trauma is dissociation'

(Howell & Itzowitz, 2016: 35).

In any trauma, the resulting 'split in experience' is dissociative⁴⁹⁵ (*'the person surrenders self-state coherence to protect self-continuity'*).⁴⁹⁶

Dissociative disorders are frequently correlated with a history of significant trauma.⁴⁹⁷ Inclusion of the dissociative subtype of PTSD in DSM-5 reflects the evidence which substantiates this.⁴⁹⁸ Significantly, functional neuroimaging reveals that trauma survivors with more dissociative symptoms (such as depersonalization and derealisation) show a pattern of brain activation that is 'the opposite of that seen among those with the more common hyperarousal type of PTSD'.⁴⁹⁹

490 Note that this does not mean that the impacts of overwhelming early life stress cannot be resolved (i.e. moving to the attachment status of 'earned secure'; see Daniel J. Siegel, 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Siegel & Solomon, *Healing Trauma*, *ibid*, p.16).

491 Hence the title of Bromberg's text *Standing in the Spaces*, *ibid*.

492 Howell, *The Dissociative Mind*, *ibid*, p.93, ref. Sullivan, 1953.

493 Chu, *Rebuilding Shattered Lives*, *ibid*, p.41 (original emphasis).

494 Philip Bromberg, *Awakening the Dreamer: Clinical Journeys* (Routledge, New York, 2011), p.7.

495 '[A]ll of these [different] kinds of trauma, seemingly massive, or ordinary, large, small, occurring in childhood or adulthood, while different and having different effects, cause some degree of dissociation' (Howell & Itzowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p.35).

496 Bromberg, *Awakening the Dreamer*, *ibid*, p.68 (emphasis added)

497 David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018), p.4.

498 'The inclusion of the dissociative subtype in DSM-5 was based on evidence that a substantial minority (about 14%) of a large sample (25, 018) of individuals with PTSD also suffer significant depersonalization and/or derealization and are characterized by a history of more severe and earlier trauma, suicidal ideation, and more functional impairment' ('Spiegel, 'Integrating Dissociation', *ibid*, p.4).

499 Other studies, too, have 'employed latent class analysis and related techniques to look at the clustering of symptoms among trauma survivors and identified a distinct subgroup with dissociation' (Spiegel, 'Integrating Dissociation', *ibid*, p.4).

'[A] substantial subgroup of those with PTSD have significant dissociative symptoms, and indeed, they respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well...'

So identifying and understanding dissociative symptoms in PTSD beyond the standard flashbacks, numbing and amnesia improves treatment outcome as well as our understanding of the disorder'

(Spiegel, 2018, p.4).

2.8 Dissociation is not the same as repression and why the differences matter

In the context of its function as a response to overwhelming stress, it is important to understand the differences between dissociation and repression. The two are often conflated⁵⁰⁰ because both are unconscious processes.⁵⁰¹

Repression occurs when 'single or a few memories, perceptions, affects, thoughts, and/or images are thought to become relatively unavailable to full conscious awareness'.⁵⁰² It relates to instances of conflict which do not need to involve traumatic experience and does not manifest in nightmares, intrusive images, flashbacks, and somatoform symptoms ('large blocks of ordinary experience do not become unavailable to consciousness along with the psychologically conflictual information').⁵⁰³

Dissociation, in contrast, relates not only to *content* but also to *state* of mind. In the context of trauma it is generally associated with distinct gaps and deletions in continuous memory for life history and/or experience.⁵⁰⁴ This is much less common in repression, where 'the material that is unavailable is so limited in scope'.⁵⁰⁵ As a response to trauma,⁵⁰⁶ dissociation is extensive in its impacts: '*Not only is their amnesia for the trauma, but the person frequently has dissociated that certain basic assumptions about the self, relationships, other people, and the nature of the world have been altered*'.⁵⁰⁷

How can these differences between repression and trauma-related dissociation be explained? It is suggested that the unconscious motivation for dissociation is different than that for repression.⁵⁰⁸ While the motivation for repression has been conceptualised as avoidance of *certain kinds of experience*, the motivation for dissociation is seen as avoidance of *a certain kind of identity* and the state of being which accompanies it: '*One must not be the person to whom that thing happened, the person who has the feelings, memories and experiences that come with being that person*'.⁵⁰⁹

With trauma-related dissociation, in contrast to repression, we are in the realm of the 'not me' (i.e. the state of being which is unbearable, not just unpleasant, which cannot be tolerated, and which must be defended against at all costs).⁵¹⁰

500 See Richard J. Loewenstein, 'Dissociative Amnesia and Dissociative Fugue', in Larry K. Michelson & William J. Ray, ed. *Handbook of Dissociation* (Plenum Press, New York, 1996). p.311.

501 For helpful discussion of these challenges of conceptualisation, see Elizabeth Howell, 'Models of Dissociation in Freud's Work: outcomes of dissociation of trauma in theory and practice', Chapter 6 in Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* (Routledge, New York, 2016), pp.73-84.

502 Loewenstein, *ibid*, following Rapaport, 1942.

503 Loewenstein *ibid*, p.311.

504 Loewenstein *ibid*, ref. Steinberg, 1994.

505 Loewenstein *ibid*, p.311.

506 Dissociation is 'a basic part of the psychobiology of the human trauma response: a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma' (Loewenstein, *ibid*, p.312, citing Putnam, 1991).

507 Loewenstein, *ibid*, p. 312, citing multiple references.

508 Donnel B. Stern, *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment* (Routledge, New York, 2010), p.13.

509 Stern, *Partners in Thought*, *ibid*, p.13.

510 Stern, *Partners in Thought*, *ibid*, p.13, referencing Sullivan (1954), and Bromberg (1998, 2006).

A related difference with significant clinical implications is that the motive for repression is avoidance of conflict. In dissociation, however, internal conflict is not experienced because the experience which would give rise to it has not been formulated: *'It is not that [conflict] is 'moved' to a hidden location in the mind or changed in such a way that it is unrecognizable - it is simply not allowed to come into being.'*⁵¹¹

REPRESSION	DISSOCIATION
<i>Assumes:</i>	<i>Assumes:</i>
<i>PRE-FORMULATED</i> experience	<i>UN-FORMULATED</i> experience
Conflict <i>unpleasant</i>	Conflict <i>unbearable</i> (Bromberg, 2011:7)
'In repression, the contents were once known and then forgotten'	'[C]annot be disavowed because it was never known'
<i>[because unpleasant]</i>	<i>[because unbearable]</i> (Bromberg, 2001)
(Stern, 2004, in Howell, 2005:208)	(in Howell, 2005:208)

It is argued that '[r]epression is always something that one *does*, but dissociation can happen to one.'⁵¹²

Both dissociation and repression 'serve to divide conscious from unconscious.'⁵¹³ But the highlighted differences are significant and need to be better recognised. Repression has traditionally been seen as a central defence in the theory and practice of psychotherapy.⁵¹⁴ Yet repression 'is a subcategory of dissociation'⁵¹⁵ and refers to 'a particular kind of dissociation.'⁵¹⁶

Repression, like all unconscious processes, displaces reason. It was the form of defence about which Freud had most to say⁵¹⁷ after his changed thinking which defined the classical, as distinct from pre-analytic, period in psychoanalysis (see below). But repression is also more specific than trauma-related dissociation, and to the extent that what is repressed was once known 'suggests that we mostly know the basic content of the unconscious mind.'⁵¹⁸ In this sense, '[r]epression is an active defence that connotes mastery.'⁵¹⁹

By contrast, dissociation is a state of mind (i.e. beyond specific content) which attests 'to our utter helplessness and lack of agency at times of trauma.'⁵²⁰ Repression, as Freud came to elaborate, relates to forbidden wishes, fantasies, and impulses, where '[m]uch of the unconscious content involves sexual and aggressive impulses...that connote agency and power.'⁵²¹ This contrasts with dissociation in the sense of the protective warding off of *overwhelming* experience. For Freud, defence in general and repression in particular were active, whereas for Janet, dissociation 'encompassed both the active and the passive.'⁵²²

511 Stern, *Partners in Thought*, ibid, p.92.

512 Howell, *The Dissociative Mind*, ibid, p.199; original emphasis.

513 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.75.

514 'Freud's most relied-upon defence was repression' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.38).

515 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.75.

516 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.75.

517 'Freud chose to build his edifice on the cornerstone of repression' (Howell & Itzkowitz, ibid), p. 81; see subsequent discussion.

518 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p. 38.

519 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p. 38.

520 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p. 38.

521 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p. 38.

522 Howell, *The Dissociative Mind*, ibid, p.64.

Freud's ambivalence on this topic – and his famous 'turning away' from his initial thoughts on it – shaped subsequent understanding of trauma in the fields of psychoanalysis and psychodynamic psychotherapy. This is in ways which have only recently begun to be redressed. In fact it is ironic that psychoanalysis, and other areas of psychotherapy which followed, said little about trauma at all for a long period.⁵²³

It is well known that Freud's initial 1896 conceptualisation of 'the seduction theory' (which regarded premature sexual experience, i.e. incest, as the cause of adult psychopathology in the form of 'hysteria')⁵²⁴ was replaced less than two years later. The theory of infantile sexuality and the Oedipus complex was introduced instead, 'which primarily emphasized the child's sexual fantasies, rather than real events (seductions/child abuse) as the root cause of neurosis.'⁵²⁵

Perhaps less well known is that Freud's 'abandonment of the seduction theory' signalled a shift of emphasis to internal, intrapsychic processes *at the expense of* real-world occurrences.⁵²⁶

*'The importance of reality as a determining factor in the patient's behaviour faded into the background... The focus of analytic interest turned to the mechanisms by which fantasies were created.'*⁵²⁷

The costs have been enormous: 'the result of Freud's disavowal was the subsequent denial of the reality of abuse by generations of psychiatrists, psychologists, and other mental health professionals.'⁵²⁸

This is because *the emphasis on fantasy entailed a corresponding move away from the reality of trauma and the nature of the dissociative processes it generates.*⁵²⁹ Replacement of the seduction theory with the theory of infantile sexuality and the Oedipus complex '*became the cornerstone of the psychoanalytic understanding of mind, and exogenous trauma took a back seat to fantasy.*'⁵³⁰

Conceptually and clinically Freud's 'U-turn' has had serious practical impacts up to the present period. As Chu notes, the view that 'fantasies derived from Oedipal wishes' implied 'that adult women were often unable to distinguish between fantasy and reality, and essentially blamed the patient for her own victimisation.'⁵³¹ Both adult women and children were disbelieved and inappropriately treated.⁵³²

523 For recent, accessible, and valuable accounts of the reasons for this omission in the history of psychoanalysis, see Elizabeth Howell & Sheldon Itzkowitz, 'Is trauma-analysis psycho-analysis?' and 'From trauma-analysis to psycho-analysis and back again', Chapters 1 and 2 in Part 1 'History of complex trauma and dissociative problems in living', in Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, pp.7-19 & 20-32 respectively.

524 Freud, 'The Aetiology of Hysteria', 1896; in Howell & Itzkowitz, p.26.

525 Howell & Itzkowitz, *ibid*: 26; as Howell & Itzkowitz note, notwithstanding this major shift 'he did not deny that child sexual abuse did sometimes occur' (*ibid*).

526 James Chu makes this point strongly and starkly. He cites Zetzel and Meissner (1973) that abandonment of the seduction theory and belief 'that the patient's reports of infantile seduction were not based on real memories but fantasies *marked the beginning of psychoanalysis as such*' (James Chu, *Rebuilding Shattered Lives*, 2011, *ibid*, p.4; referencing Zetzel & Meissner, 1973:72-73; emphasis added).

527 Zetzel & Meissner, *ibid*, in Chu, *ibid*.

528 Chu, *Rebuilding Shattered Lives*, *ibid*, p.4 (emphasis added); also see Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p.81.

529 '[T]he differentiation of what is real from what is fantasy becomes obscured by the inability to notice or know what has been dissociated' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p.81).

530 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p. 26; emphasis added. As these authors underline (and as the work of Chu *ibid* and many others attests), 'the classical, Freudian model filters out, or minimizes, the contributory factor of reality in general' (Howell & Itzkowitz, *ibid*: 7); they further note '[t]he repudiation of real experience as relevant data in the classical model of psychoanalysis' (*ibid*, p.9).

531 Chu, *Rebuilding Shattered Lives*, *ibid*, p.4.

532 As Chu elaborates, well into the late twentieth century, 'psychodynamic psychiatry was still dominated by classic psychoanalytic thinking, where conflicts about sexual drives, instincts, and fantasies were considered more important than the possible reality of occurrence of sexual abuse' (Chu, *Rebuilding Shattered Lives*, p.4). Arguably it is only since the 2013-17 Australian Royal Commission into Institutional Responses to Child Sexual Abuse that the extent of the reality of child sexual abuse in institutions has finally become widely apparent and acknowledged.

As Chu underlines, 'even when professionals believed that sexual abuse had occurred, the major emphasis was the resulting intrapsychic conflicts and not on the actual experience and aftereffects of the molestation.'⁵³³

Trauma researchers and clinicians found psychoanalytic approaches inhospitable for a long period (a situation which has now changed) - '*Freud chose to build his edifice on the cornerstone of repression... which is an agentic defense. Dissociation, which connotes greater helplessness, was largely left by the wayside*'.⁵³⁴ As Freud's views and influence grew, Janet's ideas were eclipsed. But Janet was 'the first to explain the link between trauma and dissociation.'⁵³⁵ His pioneering understanding of the complex ways in which dissociated memories ('such as in sensory perceptions, affect states, intrusive thoughts, and behavioural re-enactments')⁵³⁶ can become encoded in the body also anticipated current understanding of how this occurs.⁵³⁷

The post-Freudian 'relational turn' (sometimes described as the movement from 'one-person psychology' to 'two-person psychology')⁵³⁸ assisted reappraisal of trauma-related dissociation within the field of psychoanalysis. It is neither possible nor necessary to detail the nature of this shift here.⁵³⁹ The key point is the way this conceptual and clinical shift expanded the psychodynamic purview from emphasis on the *intrapsychic* (the inner world of the client at the expense of their relationships with others) to the *interpersonal* (which allows more scope to consider these relationships).

This shift has major implications for the understanding and treatment of trauma:

*'This one-person psychology involving erotogenic stages, in which the child is the sole guilty one with respect to unsocialized impulses, does not leave room for the existence of a perpetrator.'
'In contrast, accepting relational trauma requires accepting the possibility of an aggressor, abuser, or perpetrator'*
(Howell & Itzkowitz, *ibid*: 28)

Clearly this seismic shift has clinical, conceptual and philosophical implications. *We are irrevocably relational beings*. Prioritising the intrapsychic over the interpersonal is untenable. In contesting '[t]he repudiation of real experience as relevant data in the classical model of psychoanalysis',⁵⁴⁰ Howell and Itzkowitz underline that '*meaning emerges from interpersonal-relational experience and not from intrapsychic drives and fantasies*'.⁵⁴¹

Appreciating the centrality of relationality also paves the way for acknowledging *relational and interpersonal trauma*. The role of dissociation as a defence against being overwhelmed ('the escape when there is no escape') is central.⁵⁴²

533 Chu, *Rebuilding Shattered Lives*, *ibid*, p.4.

534 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p.81.

535 Howell, *The Dissociative Mind*, *ibid*, p.51.

536 Howell, *The Dissociative Mind*, *ibid*, p.51.

537 As van der Hart explains, 'Janet observed that patients suffering from trauma-related dissociative disorders tend to initially be hindered in the integration of their traumatic memories by a host of other 'unfinished business'; (Ellenberger, 1970). Thus, his therapy, presaging most current approaches to complex trauma, was characterized by a phase-oriented approach, consisting of (1) stabilization, symptom reduction, and preparation for the resolution of traumatic memories; (2) treatment of traumatic memories; and (3) personality (re)integration, rehabilitation, and relapse prevention (Van der Hart, Brown, and Van der Kolk, 1989)'. (Onno van der Hart, 'Pierre Janet, Sigmund Freud, and Dissociation of the Personality', Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, pp.50-51).

538 Lewis Aron, 'One-person and two-person psychologies and the method of psychoanalysis', *Psychoanalytic Psychology* 7(4), 1990, pp.475-485.

539 The shift within psychoanalysis towards emphasising and exploring the relational and interpersonal has been widely discussed. It led to a reappraisal of method and of what is appropriate data for the field; e.g. therapist as *participant* as well as *observer*, 'the centrality of the analytic relationship', and of 'what we listen for and what we validate' (Howell & Itzkowitz, *ibid*, p.14).

540 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, p.9.

541 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*: 13 (emphasis added).

542 I.e. both as a response to trauma as contrasted with repression ('*dissociation is the primary unconscious defensive process, replacing repression*' (Stern, *ibid*, p.13) and conceptualization of the mind per se (i.e. that '*the unconscious structure of mind is fundamentally dissociative rather than repressive in nature*' (Davies, 1996:564 in Howell, *The Dissociative Mind*, *ibid*, p.2).

2.9 Dissociation is transdiagnostic

Although they are less familiar than diagnoses such as PTSD, anxiety, and depression,⁵⁴³ a number of dissociative disorders feature in diagnostic manuals. The core symptoms of dissociation are *depersonalization, derealisation, amnesia, identity confusion, and identity alteration*: '[d]ifferent constellations' of which define 'the particular dissociative disorder a person ha[s]'.⁵⁴⁴

*'Dissociative amnesia, depersonalization, derealization, identity confusion, and identity alterations are core phenomena of dissociative psychopathology characterized by a spectrum of severity.'*⁵⁴⁵

In this 'spectrum' model, Dissociative Identity Disorder (DID) is at the extreme end and other disorders sit along the continuum. Yet a comprehensive meta-analysis of studies of dissociative experiences⁵⁴⁶ reveals that these feature in many disorders beyond those designated as dissociative. As Spiegel highlights, the meta-analysis (using the Dissociative Experiences Scale; DES) identified dissociative experiences as present 'among a wide variety of psychiatric populations'.⁵⁴⁷

Patients diagnosed with DID had the highest DES scores.⁵⁴⁸ Those diagnosed with PTSD had the next highest scores.⁵⁴⁹ The group with the third highest DES scores was those with Borderline Personality Disorder (a disorder for which there is 'growing evidence of trauma history as an etiological factor').⁵⁵⁰ Lower 'but still substantial' DES scores were identified among patients with schizophrenia, eating disorders, somatic symptom disorders and anxiety disorders, followed by those with depression and bipolar disorder.⁵⁵¹

Significantly, '*all of the clinical samples had higher dissociation scores than those found in healthy samples.*'⁵⁵² As Spiegel discusses, while in some cases this may be attributable to comorbidity with disorders more associated with dissociation, dissociation itself tends to be a marker of psychopathology.⁵⁵³

Dissociation is prevalent in a wide range of mental disorders, is associated with a high burden of illness, and has detrimental effects if it is untreated.

Similarly, psychiatrist Vedat Sar notes that as well as being disorders in their own right, '*dissociation may accompany almost every psychiatric disorder and operate as a confounding factor in general psychiatry.*'⁵⁵⁴ This is consistent with neurobiological and psycho-pharmacological research findings.⁵⁵⁵

543 Hence the subtitle of Marlene Steinberg and Maxine Schnall's, *The Stranger in the Mirror: Dissociation, The Hidden Epidemic* (HarperCollins, New York [2001] 2003).

544 Steinberg, *The Stranger in the Mirror*, *ibid*, p.32.

545 Vedat Sar, 'The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience*, 2014, p. 171.

546 Lyssenkov, Schmahl et al. 'Dissociation in Psychiatric Disorders: A Meta-Analysis of Studies Using the Dissociative Experiences Scale', *American Journal of Psychiatry* (175, 2018), pp.37-46.

As Spiegel discusses, the authors 'thorough search of electronic databases led them to 216 articles involving 15,219 people', and 'employed sophisticated meta-analytic techniques to compare findings across these studies' (David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4).

547 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

548 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

549 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

550 *Ibid*. Also see Russell Meares, *A Dissociation Model of Borderline Personality Disorder* (Norton, New York, 2012).

551 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

552 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

553 Spiegel, 'Integrating Dissociation', *ibid*, p.4.

554 Vedat Sar, 'The Many Faces of Dissociation', *ibid*, p.171; emphasis added.

555 Vedat Sar, 'The Many Faces of Dissociation', *ibid*, p.171.

Dissociative disorders, suicide attempts and non-suicidal self-injury also commonly co-exist. A meta-analysis found that dissociative disorder (DD) patients 'were more likely to report SA and NSSI [suicide attempts and non-suicidal self-injury] in comparison to non DD psychiatric ones'

Calati, Bensassi & Courtet, 'The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', *Psychiatry Research* (Vol 251, 2017), p.103.

Dissociation was found to be a predictor of suicide attempts and self-harm independent of other concurrent diagnoses.⁵⁵⁶

The transdiagnostic significance of dissociation has implications not only for diagnosis, health risk and effective treatment/s but also for receptivity to treatment/s. For example, a comparison of bipolar patients with and without comorbid dissociative disorder (where comorbidity of dissociative disorder with bipolar disorder is 'especially common')⁵⁵⁷ found that '[d]issociative psychopathology seems to be an important predictor for poor treatment response and high relapse rates, at least with panic and obsessive-compulsive disorders'.⁵⁵⁸

A subsequent study⁵⁵⁹ extends this finding. Noting that recent data supports use of an early exposure intervention to reduce acute stress and PTSD symptoms after trauma exposure, it explored 'a comprehensive predictive model that included history of trauma exposure, dissociation at the time of the trauma and early intervention, physiological responses (cortisol and heart rate) to determine which variables were most indicative of reduced PTSD symptoms for an early intervention or treatment as usual'.⁵⁶⁰ The findings suggested 'that dissociation at the time of the 1st treatment session was associated with reduced response to the early intervention' (where '[n]o other predictors were associated with treatment response').⁵⁶¹

The above meta-analysis and studies provide a strong argument for screening for dissociation in relation to all psychological disorders and issues as a matter of course and not just in particular cases.

A number of studies have found that dissociative disorders are often misdiagnosed as psychotic disorders ('and such patients may suffer iatrogenic worsening of their disorders due to years of misdiagnosis and mistreatment').⁵⁶² This is even though the appropriate screening tools 'show that DDs [i.e. dissociative disorders] can be distinguished from psychotic disorders (and other disorders) with excellent discriminant validity'.⁵⁶³

556 Raffaella Calati, Ismail Bensassi & Philippe Courtet, et al, 'The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', *Psychiatry Research* (Vol 251, 2017), p.103. Also see Brad Foote, Yvette Smolin et al al, 'Dissociative Disorders and Suicidality in Psychiatric Outpatients', *The Journal of Nervous Diseases* (Vol.196 Issue 1, pp.29-36) and J. Tanner, D. Wyss et al (2017) 'Frequency and Characteristics of Suicide Attempts in Dissociative Identity Disorders: A 12-month follow-up study in psychiatric outpatients in Switzerland', *European Journal of Trauma and Dissociation* (1, 2017, pp.235-239).

557 Bahadir, Karamustafalioglu & Ozer, 'Comparison of Bipolar patients with and Without Comorbid Dissociative Disorder', *European Neuropsychopharmacology* (Vol 22, Supplement 2, 2012), p.S299.

558 Bahadir et al, 'Comparison of Bipolar patients with and Without Comorbid Dissociative Disorder', *ibid*.

559 M. Price, M. Kearns et al. 'Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *Journal of Clinical Psychology* (82, 2, 2014), pp.336-341.

560 Price, Kearns et al. 'Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *ibid*, p.336.

561 Price, Kearns et al, 'Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *ibid*.

562 David Spiegel, Richard Loewenstein et al (2011) 'Dissociative Disorders in DSM-5', *Depression and Anxiety* 28, 2011, p.829. As Howell notes, '[t]he hallmark of psychosis is not only poor reality-testing, but also the inability to distinguish the internal from the external. It is exactly this distinction that trauma disrupts' (Howell, *The Dissociative Mind*, *ibid*, p.x). Also note that '[t]here is now a well-established link between childhood maltreatment and psychosis' (Barker, Gumley et al. 'An Integrated Biopsychosocial Model of Childhood Maltreatment and Psychosis', *The British Journal of Psychiatry* (Vol 206, Issue 3, 2015, p.177). (a3) School of Clinical Sciences, University of Edinburgh, Royal Edinburgh Hospital, Edinburgh, UK

563 Spiegel, Loewenstein et al, *ibid*. Also see Ellason & Ross, 'Positive and negative symptoms in dissociative identity disorder and schizophrenia: a comparative analysis', *Journal of Nervous and Mental Disease* (183, 1995, pp. 236-247); Kluft, 'First-rank symptoms as a diagnostic clue to multiple personality disorder', *American Journal of Psychiatry* (144:1997, pp.293-298); Boon and Draijer, *Multiple personality disorder in the Netherlands* (Swets and Zeitlinger, Lisse, 1993).

The frequent coexistence of bipolar disorder with dissociative disorders has prompted the suggestion that for people with bipolar, 'DD comorbidity should be investigated'.⁵⁶⁴ But the above meta-analysis and studies confirm the need for wider-ranging investigation. Indeed, Philip Bromberg suggests that all personality disorders, which are often regarded as untreatable, are dissociation-based.⁵⁶⁵

*'[T]he concept of personality 'disorder' might usefully be defined as the characterological outcome of the inordinate use of dissociation and that independent of type (narcissistic, schizoid, borderline, paranoid, etc.) it constitutes a personality structure organized as a proactive, defensive response to the potential repetition of childhood trauma.'*⁵⁶⁶

This conceptualisation of personality disorders as *dissociation-based*⁵⁶⁷ provides valuable insights into their possible aetiology as well as treatment. It also reconceptualises 'disorder' as arising when normal childhood development is thwarted. This reading assists understanding of dissociation '*in all its forms – healthy and adaptive, pathological and self-protective*'.⁵⁶⁸

2.10 Revisiting disorder: the role and challenge of dissociation

'The most important distinction...to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe'
(Steinberg, 2003: 33)

'Dissociation is mostly not about dissociative disorders. It is about how a mind struggles to cope with the intolerable and unbearable'
(Chefet, 2015: 23).

While attempts to explain dissociation can be confusing, the continuum model is helpful. A continuum, spectrum, or dimensional model of dissociation, while not accepted by all, has a number of benefits. It demystifies a phenomenon which, given its more severe and 'extreme' expressions, remains widely misrepresented, misunderstood, and in the case of DID, controversial and stigmatised.⁵⁶⁹

564 Bahadir Bakim, Elif Baran et al. 'Comparison of the Patient Groups with and Without Dissociative Disorder Comorbidity among the Inpatients with Bipolar Disorder', *Family Practice and Palliative Care* (1, 2, 2016), p.35).

565 As Howell has discussed, '[o]ne of Bromberg's insights involves his view that dissociation is the underlying condition of all personality disorders. Personality disorders are based on characterological structures organized as proactive, defensive responses to the potential repetition of childhood trauma. Conceptualizing personality disorders in this way allows defences to be understood in terms of dissociative processes resulting from their traumatic etiology. Bromberg (1995) sees DID as providing a 'touchstone' for understanding personality disorders' (Howell, *The Dissociative Mind*, *ibid*, p.104).

566 Philip Bromberg, 'Psychoanalysis, Dissociation, and Personality Organization' in *Standing in the Spaces*, *ibid*, p.200. Bromberg continues: 'If, early in life, the developmentally normal illusion of self-unity cannot safely be maintained when the psychosoma is flooded by input that the child is unable to process symbolically, a configuration of "on-call" self-states is gradually constructed in which a 'personality disorder' represents ego-syntonic dissociation no matter what personality style it embodies. Each type of personality disorder is a dynamically 'on-alert' configuration of dissociated states of consciousness that regulates psychological survival in terms of its own concretized blend of characteristics. In each type, certain self-states hold the traumatic experiences and the multiplicity of raw affective responses to them, and others hold whichever ego resources (pathological and nonpathological) have proven effective in dealing with the original trauma and making sure the pain would never again be repeated (e.g., vigilance, acquiescence, paranoid suspiciousness, manipulateness, deceptiveness, seductiveness, psychopathy, intimidation, guilt-induction, self-sufficiency, insularity, withdrawal into fantasy, pseudomaturity, conformity, amnesia, depersonalization, out-of-body experiences, trance states, compulsivity, substance abuse). Bromberg, *Standing in the Spaces*, *ibid*, pp.200.

567 Also see Meares, *A Dissociation Model of Borderline Personality Disorder*, *ibid*.

568 Bromberg, *Standing in the Spaces*, *ibid*, p.310.

569 See Bethany Brand, Vedat Sar et al, 'Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry*, Vol.24, Issue 4, July-August 2016, pp. 257-270. https://journals.lww.com/hrjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx

Conceptualising dissociation as a continuum, and as a normal psychological capacity and process which can *become* problematic in particular circumstances, can also help us understand the contexts which contribute to maladaptive coping in managing stress.

This can help people with problematic forms of dissociation (as in dissociative disorders) feel less stigma and self-blame. It can also assist health professionals understand better and be more empathic in attuning to dissociation when it occurs, whether of itself or when 'comorbid' with other presentations.

'As I kept hearing about these symptoms from patients, I realised what a hidden epidemic dissociation is. I saw that the psychiatric community and the public were labouring under the misperception that dissociation was an all-or-nothing matter - either you were a 'Sybil' or you were free and clear. What was missing from the equation was the continuum of dissociation, the same mild to moderate to severe range that occurs in depression or anxiety'
(Steinberg, 2001: xiv).

The description of problematic dissociation and its progression to disorder as 'a healthy defence gone wrong'⁵⁷⁰ is valuable in the context of a continuum. Put simply, dissociation can be regarded as an inherent capacity of the mind, where 'mind' is comprised of various self-states which are linked and moved between, smoothly or not, depending on the nature of our relationships. Wellbeing derives from the interplay of associative and dissociative processes; we cannot notice and pay attention to everything - dissociation is normal and healthy.⁵⁷¹ But dissociation can also serve as a defence. The greater the need to defend against overwhelming experience, the greater the need to dissociate (and the more likely that psychological functioning will be compromised).

Psychotherapist and author Elizabeth Howell contends that '[t]he rising tide of trauma and dissociation studies has created a sea change in the way we think about psychopathology'.⁵⁷² This is because many prevalent psychological problems 'seem to be about keeping dissociated experience out of awareness'.⁵⁷³ The lens of dissociation sheds light on 'much of what used to be seen as neurosis'; and '[m]ore and more problems in living are being understood as being trauma-generated'.⁵⁷⁴

Dissociation and disruption to developmental pathways can also be generated outside of trauma (and '*[t]he best predictor of adult dissociation is emotionally unresponsive parenting*').⁵⁷⁵ This underlines the prevalence and need for broader recognition and understanding of problematic, as well as 'normal', dissociation in the general population as well as in clinical contexts.

Dissociation can be hard to detect and the risk of not detecting it is high when there is little understanding of what to look for.⁵⁷⁶ Thus it has been easy for dissociation itself to become dissociated from an understanding of mental health.⁵⁷⁷ This also accounts for Spiegel's contention that dissociation needs to be better integrated within the field of psychiatry: *'Just as we identify and treat uncontrolled extremes of mood and defects in cognition, we can help many of our patients more if we identify problems with integration of identity, memory, perception, and consciousness.'*⁵⁷⁸

570 Steinberg & Schnall, *The Stranger in the Mirror*, *ibid*, p.8.

571 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p.1.

572 Howell, *The Dissociative Mind*, *ibid*, p.ix.

573 Howell, *The Dissociative Mind*, *ibid*, p.ix.

574 Howell, *The Dissociative Mind*, *ibid*.

575 Lyons-Ruth et al, 2006 in Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, *ibid*, p.89 (emphasis added).

576 There are misconceptions about this complex set of responses; for e.g. while equated with passivity and 'shut-down', it is possible to be behaviourally active while in a dissociated state.

577 The aetiology of the severe dissociation of DID in childhood trauma remains confronting and difficult for many to accept. Also note Spiegel's contention that 'dissociative disorders have themselves been dissociated from psychiatric nosology' (Spiegel, 'Integrating Dissociation', *ibid*, p.4) and Margaret Hainer, 'The Ferenczi Paradox: His importance in understanding dissociation and the dissociation of his importance in psychoanalysis', Chapter 5 in Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, *ibid*, pp.57-69..

578 Spiegel, 'Integrating Dissociation', *ibid*, p.5.

Identification and appropriate treatment of such problems, which are common features of diverse psychological disorders,⁵⁷⁹ is critical. A dissociative disorder 'is no different from any other physical or psychiatric illness' in that it is treatable and has 'a good prognosis for recovery'.⁵⁸⁰ But in the absence of screening for dissociation - i.e. for '*the same mild to moderate to severe range that occurs in depression or anxiety*'⁵⁸¹ - problematic dissociation will remain poorly detected. This will come at enormous cost in many regards.

In short, 'even in the most well-functioning individual, normal personality structure is shaped by dissociation'.⁵⁸² This means that dissociation is not only pathological. Indeed it is time to integrate dissociation into mainstream understanding and treatment, both clinical and non-clinical. Conceptualising it as a continuum is arguably the best way to do this.

579 Spiegel, 'Integrating Dissociation', *ibid.*

580 Steinberg & Schnall, *The Stranger in the Mirror*, *ibid.*, p.113.

581 Steinberg & Schnall, *The Stranger in the Mirror*, *ibid.*, p.xiv.

582 Bromberg, *Standing in the Spaces*, *ibid.*, p. 270 ('[c]entral to any understanding of therapeutic growth is the phenomenon of dissociation in all its forms – healthy and adaptive, pathological and self-protective...' (*ibid.*, p. 310))

Chapter 2

Summary of Key Findings and Themes

- The importance of the phenomenon of dissociation is increasingly but not sufficiently recognised within and outside the mental health field.
- While often associated with disorder, dissociation occurs in many forms (*'healthy and adaptive, pathological and self-protective...'* Bromberg, 2001: 310); *'it makes a vast difference how and in what context dissociation is used'* (Goldman, 2016:98).
- Neuroimaging reveals that dissociation 'is accompanied by altered activation of brain structures... involved in regulating awareness of bodily states, arousal and emotions' (Brand, 2012).
- Dissociation can be understood in several ways – as a lack of integration of the mind and mental states, as an altered state of consciousness, as a defence mechanism and structure, and as a 'normal' process (*'even in the most well-functioning individual, normal personality structure is shaped by dissociation'*; Bromberg, 2001).
- When dissociation is persistent it is often, although not always, trauma-related. Persistent inability to connect, access, and move between different registers of functioning impedes health and wellbeing. If severe, unrecognised and untreated, dissociation can erode quality of life and pose serious health risks.
- Repression occurs when 'single or a few memories, perceptions, affects, thoughts, and/or images are thought to become relatively unavailable to full conscious awareness' (Loewenstein, 1996). Dissociation, in contrast, relates not only to content but also to state of mind. In trauma it is generally associated with distinct gaps and deletions in continuous memory for life history and/or experience. This is much less common in repression, where 'the material that is unavailable is so limited in scope' (Loewenstein, *ibid*: 311).
- The motive for repression is avoidance of conflict. In dissociation, however, internal conflict is not experienced because the experience which would give rise to it is not formulated: *'It is not that [conflict] is 'moved' to a hidden location in the mind... it is simply not allowed to come into being'* (Stern, 2010:92).
- Repression relates to experience which was pre-formulated and unpleasant while dissociation relates to experience which was unformulated because it was unbearable ('not me'; Sullivan, 1953 in Howell, 2005; '[r]epression is always something that one *does*, but dissociation can happen to one'; Howell, *ibid*: 199).
- Pierre Janet (1859-1947) pioneered understanding of trauma-related dissociation; his ideas predate current understanding.
- Rather than being inherent, integration, coherence, and self-continuity stem from developmental and relational experience (*'Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given'*; Spiegel, 2018:4).
- *Interpersonal connections* foster links between mental states. States are the building blocks of consciousness and behaviour; self, identity and wellbeing depend on *linkage between self-states* (Howell, 2005, ref. Putnam, 1992, 1997).

- In normal development 'we are usually able to integrate our ongoing interaction...with our social surroundings into a coherent sense of self' (Steinberg & Schnall, 2001, 2003:103). 'Good enough' care-giving allows us to internalise positive relational interactions and fosters healthy socialisation in which ruptures are repaired and the capacity to self-regulate is acquired. Less than 'good enough' primary caregiving can disrupt developmental trajectories.
- Impediments to linking of self-states can occur in different ways. Research shows that '[t]he best predictor of adult dissociation is emotionally unresponsive parenting' (Lyons-Ruth et al, 2006, in Chefetz, 2015: 89).
- The process by which development and socialisation of self occurs via dissociation is akin to Bowlby's account of 'defensive exclusion' (Bowlby, 1981; 2006). What threatens the care-giving relationship is 'defensively excluded'- i.e. dissociated to preserve the primary attachment. For some people, notably with trauma, the need to dissociate ('defensively exclude') is extreme.
- Chronic dissociation in childhood is costly. This is because the coping strategy that allows ongoing attachment to caregivers impedes the ability to attach securely later on: *'The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others'* (Bromberg, 2001:6).
- Childhood trauma and other developmental deficits can be resolved, and secure attachment can be achieved (Siegel, 2003).
- Overwhelming stress (i.e. trauma) impedes the ability to move flexibly between self-states (*'the person surrenders self-state coherence to protect self-continuity'*; Bromberg, 2011:68). The capacity to access thoughts, feelings, and important registers of functioning is limited or lost (Chu, 2011:41).
- Dissociative disorders are frequently correlated with a history of trauma (Spiegel, 2018:4) as inclusion of the dissociative subtype of PTSD in DSM-5 reflects.
- Studies show that dissociation features in many disorders: *'dissociation may accompany almost every psychiatric disorder and operate as a confounding factor in general psychiatry'* (Sar, 2014:171).
- The significance of dissociation as a transdiagnostic presence, including in suicide attempts and non-suicidal self-injury (Calati, Bensassi et al, 2017) has implications for diagnosis, health risk, effective treatment/s and receptivity to treatment/s (Price, Kearns et al, M. Price, M. Kearns et al. 2014).
- A continuum model of dissociation, while not subscribed to by all, has a number of benefits. When dissociation is conceptualised as a continuum, and as a normal psychological capacity and process which can *become* problematic in certain circumstances, we can begin to understand the contexts which contribute to maladaptive coping in managing stress.
- Describing problematic dissociation and its progression to disorder as 'a healthy defence gone wrong' (Steinberg & Schnall, *ibid*: 8) is helpful.
- Dissociation can be regarded as an inherent capacity of the mind, in which 'mind' comprises various self-states which are linked and moved between smoothly or not depending on our relationships.
- Wellbeing derives from the interplay of associative and dissociative processes; we cannot notice and pay attention to everything and dissociation can be normal and healthy (Chefetz, 2015). But dissociation can also serve defensive as well as benign 'everyday' purposes.
- The greater the need to defend against overwhelming experience, and the greater the need to dissociate, the more likely it is that psychological functioning is compromised.
- An understanding of dissociation in its various forms, clinical and non-clinical, needs to be integrated into public understanding in general and within and across health sectors and services in particular.

Chapter 3

Revisiting Phased Treatment for Complex Trauma

'The emphasis on making sure that in the first part of treatment patients are stable and sufficiently safe... has been, in part, an outgrowth of learning from mistakes that were made previously'

(Schwarz, 2002: 18)

Phase-based treatment – what Herman calls 'a tripartite model of recovery stages'⁵⁸³ - has long been endorsed by clinicians of complex, as distinct from standard ('single-incident'), PTSD.⁵⁸⁴ While variously named, the stages of the phased model correspond to (1) *stabilisation and resource-building*, (2) *processing of traumatic memory*, and (3) *integration*.⁵⁸⁵

The phased treatment model is based on clinical experience that various forms of complex trauma, including severe childhood trauma,

*require an initial (sometimes lengthy) period of developing fundamental skills, including maintaining supportive relationships, developing self-care strategies, coping with symptomatology, improving functioning, and establishing some basic positive self-identity as a prerequisite for active work on memories of traumatic events.*⁵⁸⁶

The rationale for the phased approach is that '[b]y the time patients have done the arduous work of the early phase of treatment, they are much more stable.'⁵⁸⁷ This means that they are better equipped to address the painful task of processing traumatic memories with less risk of being retraumatised in the process.

583 Judith L. Herman, 'Foreword', in Christine A. Courtois & Julian D. Ford, ed. *Treating Complex Traumatic Stress Disorders* (The Guilford Press, New York, 2009; 2014, p.xv); ref. Herman *Trauma and Recovery* (Perseus, New York: [1992], 1997).

584 As Chu points out (with reference to Van der Hart, Brown, & van der Kolk, 1989), '[a]lthough this has been a new approach in the modern study of trauma treatment, as early as the late 19th century, Pierre Janet advocated a phase-oriented treatment for dissociative disorders' (James Chu, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders*, 2nd ed, John Wiley & Sons, NJ, 2011, p.109). In her landmark text *Trauma and Recovery* (ibid) Herman likewise traces the staged approach to treatment of complex trauma to Pierre Janet's 1889 approach to treatment of (what was then called) hysteria. More recent proponents of the phased treatment approach include Chu, 1992; 2011; Courtois, 1999; Courtois & Ford, 2009; 2014; Herman, 1992; Lebowitz et al, 1993; Steele, Van der Hart and Nijenhuis, 2005.

585 The language used to describe the various stages may differ (eg Herman [1992] 1997) describes 'Safety', 'Remembrance and Mourning' and 'Reconnection', while Chu (2011) speaks of 'Early', 'Middle' and 'Late' phases). As Chu notes, however, '[m]ost phase-oriented treatment models consist of three phases or stages' comprising (1) safety, stabilisation, symptom reduction and improvement in overall functioning, (2) '[c]onfronting, working through, and integrating traumatic memories', and (3) '[c]ontinued integration, rehabilitation, and personal growth' (Chu, ibid: 112; also see Onno van der Hart, Ellert Nijenhuis, and Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).

586 Chu, 'The Therapeutic Roller Coaster: Phase-Oriented Treatment for Complex PTSD', in *Rebuilding the Shattered Self*, ibid, p.109.

587 Chu, 'The Therapeutic Roller Coaster: Phase-Oriented Treatment for Complex PTSD', ibid, p.112.

It is important to understand that:

‘The division of the course of treatment is somewhat arbitrary, because *patients generally move back and forth between phases rather than progressing in a neat linear fashion*’
(Chu, 2011: 112; emphasis added).

Delineating the various stages is considered useful, however, ‘in specifying the components and sequence of treatment.’⁵⁸⁸

The phased model for complex trauma treatment⁵⁸⁹ is endorsed by the ISTSS *Expert Consensus Treatment Guidelines for Complex PTSD in Adults*.⁵⁹⁰ The investigatory research for these guidelines found that 85% of consulted experts reported that they would use a phase-based approach as their first line of treatment.⁵⁹¹

Yet the phased (also called ‘staged’) approach in general and the need for and usefulness of the initial ‘stabilisation’ phase in particular has been criticised since publication of the 2012 Blue Knot Foundation Guidelines. Indeed, the inaugural 2017 issue of the *European Journal of Trauma and Dissociation* included a paper which specifically considered the ‘stabilisation controversy’.⁵⁹²

588 Chu, ‘The Therapeutic Roller Coaster: Phase-Oriented Treatment for Complex PTSD’; *ibid*, p.112.

589 Detailed description of the various phases will not be included here as it is included in the first iteration of the Blue Knot Guidelines. The material addressed here supplements that, and updates the discussion of phased treatment in light of interim developments which include the challenges to it.[ie necessary to clarify ‘it’]

590 M. Cloitre, C.A. Courtois, et al *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* (2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf The introduction to these guidelines noted that Complex PTSD has also been named Disorders of Extreme Stress Not Otherwise Specified (DESNOS), PTSD and its associated features (ie in DSM-IV and note subsequent iteration of DSM 5), and Enduring personality change after catastrophic events in the WHO 1992 iteration of the ICD (i.e.prior to the ICD-11). As Rydberg relates, ‘[t]he ISTSS task force selected a definition of cPTSD [CPTSD] that covers a range of symptoms derived from these diagnostic descriptions and includes the core symptoms of PTSD (re-experiencing, avoidance/numbing, and hyperarousal) in conjunction with a range of disturbances in self-regulatory capacities’; emphasis was on ‘not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources’ (J.A. Rydberg, ‘Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations’, *ref. Cloitre et al, 2012, European Journal of Trauma and Dissociation*, 1, 2017, p.92).

591 Noortje van Vliet, Rafaele Huntjens et al, ‘Phase-based treatment versus immediate trauma-focused treatment in patients with childhood trauma-related posttraumatic stress disorder: study protocol for a randomized controlled trial’, *BioMed Central (BMC)*, 19: 138, 2018. To date there have been two studies of the safety and efficacy of the phase-based approach to treatment of complex trauma: M. Cloitre, K.C. Slovall-McClough et al, ‘Treatment for PTSD related to child abuse: a randomized controlled trial’, *American Journal of Psychiatry*, 167, 2010, pp.915-24; M. Cloitre, K.C. Koenen et al, ‘Skills Training in Affective and Interpersonal Regulation followed by Exposure: a phase-based treatment for PTSD related to childhood abuse’, *J Consult Clin Psych*, 70 (Supplement 5), 2002, pp.1067-74. It also continues to be widely endorsed. Writing in 2006, van der Hart et al stated that there was no research to support the adequacy for complex trauma treatment of relatively short-term treatment approaches recommended for standard PTSD ‘if they are applied outside of a phase-oriented treatment...In fact, severe comorbid psychopathology, a common feature of trauma survivors, emerged as the predominant reason for exclusion of participants across PTSD treatment efficacy studies’ (van der Hart et al, *The Haunted Self*, *ibid*, citing Spinazzola, Blaustein, & van der Kolk, 2005).

592 Jenny Ann Rydberg, ‘Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations’ (*European Journal of Trauma and Dissociation*, 1, 2017), pp.89-99; the ‘stabilisation controversy’ is discussed on pp.92-4.

3.1 Challenge to the phased treatment approach

The premise underlying much of the criticism of the phased approach to treatment of complex trauma⁵⁹³ is straightforward. Authorised evidence-based ‘first line’ therapies for treatment of PTSD⁵⁹⁴ are relatively short term ‘intensive trauma-focused’ psychotherapies which do not include a staged approach.⁵⁹⁵ As van Vliet, Huntjens et al. point out, those who favour immediate application of evidence-based treatments ‘argue that a stabilization phase could delay or restrict access to trauma-focused treatments, thereby preventing immediate benefit from the treatments.’⁵⁹⁶

‘...the core question is still whether the addition of a stabilization phase is a necessary condition for, and/or has added value over, immediate trauma-focused treatment’

(Van Vliet, Huntjens et al, 2018).

A number of papers which critique the phase-based approach, the majority of which endorse exposure treatment/s and Cognitive Behaviour Therapy (CBT), contend that complex - as distinct from ‘simple’ - PTSD is no impediment to immediate and effective application of standard evidence-based treatment approaches.

For example, Wagenmans, Van Minnen et al. take issue with the ‘assumption’ that ‘PTSD patients with a history of childhood sexual abuse benefit less from trauma-focused treatment than those without such a history.’⁵⁹⁷ Their own study found that ‘[t]he results do not support the hypothesis that the presence of a history of childhood sexual abuse has a detrimental impact on the outcome of first-line (intensive) trauma-focused treatments for PTSD.’⁵⁹⁸ Similarly, Hagedaars, Van Minnen et al. found ‘that PTSD patients with serious comorbid dissociative or depressive symptoms are just as likely to profit from effective treatment programs like exposure as those with low dissociative and depressive symptom levels.’⁵⁹⁹

593 See, for example, Anouk Wagenmans, Agnes Van Minnen et al, ‘The Impact of Childhood Sexual Abuse on the Outcome of Intensive Trauma-Focused Treatment for PTSD’, *European Journal of Psychotraumatology*, 9 (1) 2018; Muriel A. Hagedaars, Agnes van Minnen et al, ‘The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD’, *Behavior Research and Therapy*, 48, 2010, pp.19-27;

H. Bongaerts, A. Van Minnen & A. De Jongh, ‘Intensive EMDR to treat PTSD patients with severe comorbidity: A case series’, *Journal of EMDR Practice and Research*, 11, 2, 2017, pp.84-95, and A. Van Minnen, M.S. Harned et al ‘Examining Potential Contraindications for Prolonged Exposure Therapy for PTSD’, *European Journal of Psychotraumatology*, 3, 2012.

594 Namely Cognitive Behavioural Therapy (CBT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) and Eye Movement Desensitization and Reprocessing (EMDR) Note, however, that while EMDR is widely referenced as an ‘evidence’ rather than ‘phased’ approach to treatment (including by its critics), more recent iterations of EMDR incorporate phases and attentiveness to stabilization (Gonzalez & Mosquera, 2012; also see Chapter 4). And see David Blankenship, ‘Five Efficacious Treatments for Posttraumatic Stress Disorder: An Empirical Review’, *Journal of Mental Health Counseling* (Vol 39, No.4, 2017), pp.275-288.

595 See discussion in Chapter 5.

596 Van Vliet, Huntjens et al, ‘Phase-based treatment versus immediate trauma-focused treatment in patients with childhood trauma-related posttraumatic stress disorder: study protocol for a randomized controlled trial’, *ibid*; also Rydberg, ‘Research and Clinical Issues in Trauma and Dissociation’, *ibid*, p.92.

597 Wagenmans, Van Minnen et al, ‘The Impact of Childhood Sexual Abuse on the Outcome of Intensive Trauma-Focused Treatment for PTSD’, *European Journal of Psychotraumatology*, 9 (1) 2018, *ibid*.

598 Wagenmans, Van Minnen et al, ‘The Impact of Childhood Sexual Abuse on the Outcome of Intensive Trauma-Focused Treatment for PTSD’, *ibid*.

599 Hagedaars, van Minnen et al, ‘The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD’, *Behavior Research and Therapy*, *ibid*, p.26.

In their 2016 review of the ISTSS Expert Consensus Guidelines (i.e. for Complex PTSD in adults which endorse the phased approach)⁶⁰⁰ De Jongh et al. contended that evidence in favour of 'special stabilisation procedures prior to trauma-focused treatment' for patients described as having complex PTSD was weak.⁶⁰¹ They also conceded, however, that at time of writing, there were no studies which directly examine whether or not trauma-focused treatments are superior to phase-oriented approaches for more complex PTSD.⁶⁰²

How can the contrasting perspectives on the effectiveness of the phased approach compared to the 'non-phased' treatment approaches to complex trauma be adjudicated? A number of points need to be considered in this context. While advocates of exposure-based therapy have generated the most criticism, it also needs to be noted that there are other sources of direct and indirect critiques of the phase-based approach as well (see subsequent comments). These include approaches which promote new shorter-term psychotherapies and/or combine some of the growing range of available resourcing techniques which can potentially dissolve the need for a formal 'stabilisation' phase (and/or other specific stages).⁶⁰³

3.2 Exposure therapy/ies and questions which arise

*'What one does **not** do in early recovery is any form of 'exposure' therapy'*

(Herman, 2014: xvi; original emphasis)

'[P]rolonged exposure types of therapies miss the mark. And though they undoubtedly do help some, they harm others'

(Levine, 2015: 116)

Exposure therapy exists in various forms and is widely referenced, evidenced, and recommended.⁶⁰⁴ It is used for a wide range of psychological disorders as well as for standard PTSD. This means that the above quotes by pioneering trauma clinicians and researchers Judith Herman and Peter Levine may seem to 'go against the tide'. But they encapsulate grounds for serious reservations about applying exposure-based treatment to clients who experience complex trauma, especially if, as van der Hart et al. caution, 'they are applied outside of a phase-oriented treatment'.⁶⁰⁵

Exposure-based treatment is generally conducted within Cognitive Behaviour Therapy (CBT) which addresses the thoughts and beliefs associated with feared stimuli. The foundational premise of exposure therapies is that facing anxiety-inducing stimuli decreases the presenting symptoms and distress. The rationale is that avoiding what is distressing fuels further evasion and increases the aversion which in turn reduces quality of life.

600 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, *ibid*.

601 A. De Jongh, P.A. Resick et al, 'Critical analysis of the current treatment guidelines for complex PTSD in adults', *Depression and Anxiety*, 33, 2016, pp.359-369.

602 De Jongh et al, 'Critical analysis of the current treatment guidelines for complex PTSD in adults', *ibid*.

Clearly a major reason for this is that 'severe comorbid psychopathology, a common feature of trauma survivors [has] emerged as the predominant reason for exclusion of participants across PTSD treatment efficacy studies' (van der Hart et al, *The Haunted Self*, *ibid*, citing Spinazzola, Blaustein, & van der Kolk, 2005).

603 See, for example, Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (New York: Routledge, 2017) and subsequent discussion.

604 Forms of exposure therapy, developed since the 1950s, include graded, prolonged (PE), imaginal, in vivo, and systematic desensitisation. On evidence for exposure therapy in relation to the treatment of anxiety, see Christian Otte, MD, 'Cognitive behavioral therapy in anxiety disorders: current state of the evidence', *Dialogues in Clinical Neuroscience* (13, 4, 2011), pp. 413-421.

605 Van der Hart et al, *The Haunted Self*, *ibid*, p.ix.

Diverse therapeutic modalities are mindful of this reality. Indeed, psychoanalysis introduced concepts such as 'catharsis' and 'abreaction' which reflect the need to confront aversive experience.⁶⁰⁶ Why, then, might exposure therapies be problematic, and even cause harm?⁶⁰⁷ And why, despite assertions and evidence to the contrary, might this particularly apply in relation to complex trauma?

The most obvious answer relates to *the capacity of the person exposed to aversive stimuli to tolerate the affect the stimuli elicit*. No one enjoys the experience of distress. But it is not only the magnitude of the stress level experienced which is significant. Of critical importance is *the ability to manage* the ensuing responses. In addition, if exposure to aversive stimuli elicits a *dissociative* response, the treating clinician may not detect it.

While all varieties of trauma feature dissociation,⁶⁰⁸ most people with complex trauma 'have severe dissociative symptoms'.⁶⁰⁹ The previously cited finding 'that PTSD patients with serious comorbid dissociative or depressive symptoms are just as likely to profit from effective treatment programs like exposure as those with low dissociative and depressive symptom levels'⁶¹⁰ raises questions. This is because it *presupposes that the therapist will appropriately intervene when aversive stimuli elicit dissociative responses*. It also presumes that the therapist is able to *identify* dissociative responses, many of which are not overt. The relevant research does not support this assumption.⁶¹¹

In the context(s) of trauma, the distinction between 'unpleasant' and 'unbearable' sensations is salient (Bromberg, 1998, 2002). Clients who experience trauma-related dissociation while undergoing exposure therapy may be re-traumatised by the process of the treatment.

Exposure which is *graded* ostensibly provides a safeguard to reduce the possibility of overwhelm, destabilisation, and thus retraumatisation. Graded exposure, if appropriately paced, also increases the possibility that the clinician may attune to signs of impending dissociation. Yet this presumes that therapists are competent to detect and manage trauma-related dissociation. It also presupposes that graded exposure is an appropriate approach to *complex* trauma-related presentations.

606 Hence Levine's equation of Prolonged Exposure (PE) with 'other cathartic therapies' (Levine, *Trauma and Memory*, Berkeley, North Atlantic Books, 2015, p.116 and 117; also see his 'brief history of abreaction and trauma'; *ibid*, pp.116-118.

607 Levine, *Trauma and Memory*, *ibid*, p.116. This is not only in relation to complex trauma in contrast to more straightforward, presentations of trauma. See, for example, David J. Morris, 'After PTSD, More Trauma' (*Opinionater*, *New York Times*, 17 January 2015) and Levine's discussion (Levine, *ibid*, pp.115-116). Also see J. Jaeger, A. Echiverri et al, 'Factors Associated with Choice of Exposure Therapy for PTSD', *International Journal of Behavioral Consultation and Therapy* (5, 2, 2009), pp.294-310.

608 Elizabeth Howell & Sheldon Itzkowitz, *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* (Routledge, New York, 2016).p.35.

609 Van der Hart et al, *The Haunted Self*, *ibid*.

610 Hagenaars, van Minnen et al, 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy*, *ibid*, p.26.

611 Note, for example, the observation by researchers of one complex trauma treatment study of 'a trend toward increased dissociation over the course of treatment, which may have been mobilized to cope with the emotional demands of psychotherapy' (D'Andrea & Pole, 'A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma', *Psychological Trauma: Theory, Research, Practice and Policy*, 4 (4), 2012, p.443. Also see Martin Dorahy et al, 'The Role of Clinical Experience, Diagnosis and Theoretical Orientation in the Treatment of Posttraumatic and Dissociative Disorders: A Vignette and Survey Investigation', *Journal of Trauma and Dissociation* (Vol.18, Issue 2, 2017), pp.206-222. For the anecdotal evidence of one account of a concerning patient experience see the comments of former marine David J. Morris in Levine, *Trauma and Memory*, *ibid*, pp.115-116.

A graded form of exposure therapy was introduced by psychiatrist Joseph Wolpe in the mid-1950s.⁶¹² Systematic desensitization (in which anxiety inducing triggers are 'graded' from most to least) followed later that decade.⁶¹³

As Levine notes,

*'This type of therapy was originally designed for the treatment of simple phobias, such as the fear of heights, snakes, or insects....Prolonged exposure therapy, as developed by Edna Foa and her colleagues at the University of Pennsylvania in the 1980s, was built on Wolpe's prototypic method for eliminating simple phobias.'*⁶¹⁴

Extrapolating from 'simple phobias' to the very different terrain of trauma raises a number of issues. As Levine points out, 'in aiming to treat PTSD and other diverse traumas, PE took on a very complex and fundamentally different phenomenon than evidenced in simple phobias'.⁶¹⁵ For this reason, he believes that 'the repurposing of a therapy originally designed for simple phobias to treating trauma, which is much more complex, may be a disturbing misapplication of these early methods'.⁶¹⁶

In the view of Levine, prolonged exposure (PE) whereby patients are encouraged to repetitively retell 'the story of their trauma' to their therapists (in order to 'unlearn' their traumatic responses to the associated memories)⁶¹⁷ operates 'with the implied belief that each traumatic memory is an isolated island, a very specific 'tumour' that needs to be cut out, excised':

*'This reified, illusory view of traumatic memory, as a thing to be repetitively relived and thus resected, dismisses the organic gestalt of body, mind, and brain in integrating the entirety of an individual's encounters with stress and trauma ...within the full developmental arc of one's entire life.'*⁶¹⁸

The 'full developmental arc of one's entire life' is also impacted and experienced differently if the trauma is cumulative and underlying (as distinct from event-based and adult-onset). This is particularly if it dates to experiences in childhood. Significantly, the above critique of prolonged exposure is discussed in the context of adult combat⁶¹⁹ as distinct from childhood trauma (with which it may have coexisted).⁶²⁰

Thus this particular critique of prolonged exposure – i.e. as an extension of treatment for 'simple' phobias to the more complex entity of trauma - potentially raises even more disturbing questions about the utility of PE. Particular concern is warranted when it is applied to varieties of trauma which are recognised - or, even more problematically, which remain undiagnosed and undetected - as complex trauma to begin with.

612 Joseph Wolpe, 'Reciprocal Inhibition as the Main Basis of Psychotherapeutic Effects', *Archives of Neurology and Psychiatry* (72, 2, 1954), pp.205-226.

613 Wolpe was one of the first psychiatrists to ignite interest in the behavioural treatment of psychiatric problems.

614 Levine, *Trauma and Memory*, *ibid*, p.117.

615 Levine, *Trauma and Memory*, *ibid*, p.117-118.

616 Levine, *Trauma and Memory*, *ibid*, p.118; emphasis added.

617 Levine, *Trauma and Memory*, *ibid*, p.115.

618 Levine, *Trauma and Memory*, *ibid*, p.116.

619 The veteran involved, former Marine David J. Morris, apparently hoped that 'over time, with enough repetitions of the story, he would rid himself of his terror. Instead, after a month of therapy, he began to have more acute problems' (See Levine, *Trauma and Memory*, *ibid*, p.115).

620 To the extent that childhood trauma can be dissociated and 'forgotten' at a conscious level (Chu, *Rebuilding Shattered Lives*, *ibid* and many corroborating references) and is difficult to disclose even when consciously recalled, many ostensibly 'single-incident' traumas may also be preceded by complex underlying trauma.

If a widely endorsed treatment (i.e. PE) is problematic for treatment of trauma, it is potentially more so for clients who experience *complex* trauma (in which the associated phobias, particularly if interpersonally generated, are correspondingly complex). By definition, and as belated diagnostic acknowledgement of the contrasting impacts of Complex vis a vis standard PTSD now attest, the impacts of complex trauma are commensurately less 'simple'.

The characteristic relational phobias of complex trauma (e.g. phobia of attachment and phobia of inner experience; van der Hart et al, 2006, 2011) are less comparable to phobias pertaining to natural phenomena, external structures, simple life forms, and inanimate objects, and also to the phobias associated with standard PTSD.

To what, specifically, is the survivor of complex, cumulative, interpersonally generated trauma to be 'exposed'?

This additional question is important:

*If clinical and ostensibly therapeutic exposure to memory of adult-onset 'event' trauma can be so disabling, what are the potential risks for a client who has experienced ongoing interpersonal violation and betrayal from childhood? That is, when pervasive, deep-seated, and dissociated feelings of pain and lack of self-worth have been generated by relationships with the family members who are widely assumed to have loved and protected them?*⁶²¹

Exponents of exposure therapy do not address this particular critique of prolonged exposure. This is a serious omission. Also because as De Jongh et al. concede, 'it is well-established that a substantial minority of PTSD patients, with cPTSD [Complex PTSD] or not, remain symptomatic despite receiving empirically supported treatments for this disorder'.⁶²²

The possibility that trauma clients may 'remain symptomatic' *because* of, rather than *despite*, the empirically supported treatment received (i.e. Levine's point about potential misapplication of PE to trauma treatment) or that the treatment may be especially damaging to clients whose self-concept is impaired *due to complex childhood trauma* is not considered at all.

Critics of phased treatment for complex trauma, such as de Jongh et al., imply that the apparent effectiveness of empirically supported treatments in *some* cases is sufficient for *all* cases. Clients who do not improve (who are known to comprise 'a substantial minority') are seen as refractory rather than the problem as relating to the therapy. This ensures that the evidence base for the effectiveness of empirically supported treatments remains impervious to criticism, even by renowned trauma clinicians and researchers. It also has the effect that clinicians are less likely to consult and apply the phase oriented model endorsed by the *Expert Consensus Treatment Guidelines for Complex PTSD in Adults*.⁴¹

Further grounds for concern about exposure-based therapies for treatment of complex trauma relate to the salience of *shame* as 'a core affect', such that exposure to aversive stimuli may result in rapid and severe decompensation. As noted in Chapter 1 and as Frewen and Lanius underline, 'when a person's past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice'.⁶²³

621 Claims of some trauma treatment providers of the need 'to step fully into the darkness of our experiences' (Schwarz, Corrigan et al, 2017, p.134) are problematic in a number of ways with respect to complex trauma. They also stand in contradistinction to the views of Levine, who in common with many other practitioners and researchers, expounds the need for trauma to be approached *indirectly* (Levine, 2010, 2015 and see subsequent discussion).

622 De Jongh, Resick et al, 'Critical analysis of the current treatment guidelines for complex PTSD in adults', *ibid*.

623 'Instead, clients are perhaps better served by psychotherapies aimed at lowering self-judgemental tendencies and fostering greater self-compassion' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.207, ref. Gilbert, 2011; Greenberg & Iwakabe).

Clinician, researcher, and trauma expert Ellert Nijenhuis underlines that exposure 'is not something 'done' to an individual'.⁶²⁴ He contends that '[i]n itself exposure is nothing, and 'one subject cannot 'expose' another subject to anything inasmuch as this other individual does not engage in some kind of action'.⁶²⁵ Nijenhuis notes that integration 'is not the result of a single action', and that 'engagement in one action does not imply engagement in all others'.⁶²⁶ He further notes that '[e]xposure is exposure inasmuch as individuals or dissociative parts of individuals engage in particular actions'.⁶²⁷ To the extent that dissociative parts of a client (i.e. as distinct from the presenting self) may not engage in the therapy, this is clearly problematic in terms of its potential benefits.

Nijenhuis cites comments of a former client which provide strong grounds for criticism of exposure therapies in this regard ('[h]er objections are also my objections').⁶²⁸ For these and other reasons, criticism of the phased treatment approach is problematic: 'Phase-oriented enactive trauma therapy does not constitute a waste of time and effort'.⁶²⁹

The several grounds on which unqualified endorsements of 'evidence-based' treatment can be problematic in general and specifically in relation to complex trauma are discussed in Chapter 5. The apparently strong evidence base of 'evidence-based' treatment for effective treatment of complex trauma is far less authoritative than it might seem. Note for example, the finding of D'Andrea and Pole,⁶³⁰ that prolonged exposure was far less efficacious than anticipated - *"It is arguable the most surprising result in our study was the poor performance of prolonged exposure therapy process....PE is often touted as the first-line treatment for distressed trauma survivors (Foa, 2009), but we found little evidence that PE was helpful for these clients, and some evidence of adverse effects."*⁶³¹

3.3 Emerging therapies and 'multiple resource' models

The emergence of new formal treatment approaches and shorter psychotherapies also challenge the phased approach of complex trauma treatment,⁶³² although not necessarily directly. An exponentially expanding plethora of resource tools and methods - some offered separately and in their own right - also has implications for discussion of the phased treatment model. The current treatment landscape is very dynamic and potentially confusing.⁶³³

624 Ellert Nijenhuis, *The Trinity of Trauma*, Vol. 3 (Vandenhoeck & Ruprecht GmbH & Co, Goettingen, 2017), p.401.

625 Nijenhuis, *The Trinity of Trauma*, Vol. 3, *ibid*.

626 Nijenhuis, *The Trinity of Trauma*, Vol.3, *ibid*, p.402.

627 Nijenhuis, *The Trinity of Trauma*, Vol.3, *ibid*, emphasis added.

628 Nijenhuis, *The Trinity of Trauma*, *ibid*, p.403

629 Nijenhuis, *ibid*.

630 Wendy D'Andrea & Nnamdi Pole. 'A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma', *Psychological Trauma: Theory, Research, Practice and Policy*, 4 (4), 2012, pp.438-446.

631 'Though PE aims to reduce hyper-reactivity to trauma reminders, we found no evidence of reduced sympathetic reactivity and trend-level evidence of reduced parasympathetic activity (RSA), which would increase arousal' (D'Andrea & Pole, *ibid*, p.444). Indeed, D'Andrea and Pole note '[w]e observed a trend toward increased dissociation over the course of treatment' (*ibid*, p.443). For further comment on the limits of exposure therapy for treatment of complex trauma, see Jaeger, Echiverri et al, 'Factors Associated with Choice of Exposure Therapy for PTSD', *ibid*, and Emerson & Hopper, *Overcoming Trauma through Yoga* (Berkeley, CAS: North Atlantic Books, 2011), pp.15-16 and accompanying footnotes and references.

632 For discussion of these see Chapter 4.

633 As noted in the introduction to this report, a large range of psychological resources and diverse modes of delivery of these is now available.

Treatment for complex trauma is generally of longer duration than that for other client presentations.⁶³⁴ At the same time, the importance of client 'resourcing' for a wide range of issues is increasingly recognised, and there is now no shortage of psychological 'resources' readily available.⁶³⁵

In the context of formal treatment for complex trauma which draws upon and attempts to integrate a wide range of disparate resources, a new approach is 'the Comprehensive Resource Model' ('CRM').⁶³⁶ Indeed, the conception, methods of implementation, and the sources on which CRM draws are so broad that its status as a 'particular' treatment modality might reasonably be contested. It might alternatively be described as a richly suggestive orientation to comprehensive treatment of complex trauma more broadly. Yet precisely because of its breadth and diversity, and its somewhat problematic challenge to the 'phased treatment' approach, CRM merits specific attention.

3.4 The Comprehensive Resource Model (CRM)

CRM is conceptualised 'as a nested hierarchy of resources'⁶³⁷ in the manner of the 'Russian doll' model of layers. These are discussed in the 2017 text which presents the CRM model as a whole.⁶³⁸ The scope and eclecticism of this model partly account for its somewhat idiosyncratic conceptualisation of phases, which although endorsed by the model itself, take issue with the phased treatment approach as such:

*'CRM creates a neurobiologically resourced state that allows for three phases of trauma treatment – stabilisation, 're-processing' and integration – to be done simultaneously; therefore distress work is not separate from the resourcing, nor is resourcing regarded as a separate 'phase' of treatment. CRM has its foundation in resourcing but it is not conceptualised primarily as strategies to prepare a client for trauma work; rather its concurrent use during trauma processing invites the state of distress itself to be utilised as a resource from which healing unfolds.'*⁶³⁹

Conceptualisation of distress as 'a resource' conveys the contrasting nature of this wide-ranging approach. Exponents of CRM want to differentiate this model 'from many other trauma-focused modalities'⁶⁴⁰ in terms of 'the way it targets the primary origins of distress'⁶⁴¹ (as distinct from targeting distress per se):

*'It is the identification and processing of that split-second moment of intense, intolerable threat and/or affect that occurs immediately before dissociation or fight-flight-freeze responses; that micro-second of intense, often visceral pain that catalyses the dissociation or fight-flight-freeze which is the imperative target in healing through CRM.'*⁶⁴²

634 See 'Duration of Treatment', in Courtois and Ford, ed, *Treating Complex Traumatic Stress Disorders*, ibid. pp.96-98 and Guideline 17 of the 2012 Blue Knot *Practice Guidelines*, ibid. On the issue of 'presenting symptoms', also note that complex trauma may underlie a wide range of diverse health problems (Herman, ibid, *Blue Knot Practice Guidelines*, 2012, ibid).

635 While care clearly needs to be exercised in relation to these, some free online resources can be valuable, including for complex trauma-related conditions. In the latter category is Dan Siegel's 'hand model of the brain' <https://www.youtube.com/watch?v=gm9CIJ74Oxw> which, while not a substitute for psychotherapy, is easily taught and learned (also with basic linguistic adaptation for children) which is why Siegel elected to offer it 'direct to the public'.

636 Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma* (Routledge, New York, 2017),

637 Lisa Schwarz, Frank Corrigan et al, *The Comprehensive Resource Model*, ibid, p.131.

638 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid.

639 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.131; original emphasis.

640 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.131.

641 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.131.

642 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.131-132; original bolding and emphasis.

*'Many modalities will focus on the secondary and tertiary responses without ever getting back to the initial impact of the traumatic experience, the moment that life changes forever. To do that safely, it is necessary to intertwine and interweave the relational and neurobiological resources.'*⁶⁴³

Neurobiological resources comprise 'a neural platform' to underpin work with 'the sources of survival terror' and lived experience, 'rather than the symptomatic implications of these origins which have unfolded throughout the client's life and present-day events'.⁶⁴⁴

These contentions raise several questions. For example, complex trauma clients may not have experienced a single 'moment that life changes forever'. Cumulative ongoing complex trauma, particularly from childhood, often stems from ongoing repeated experience. Additionally, while 'many modalities' may focus on the subsequent, rather than initial, impacts of traumatic experience, this is certainly not true of all.⁶⁴⁵

The 'intertwining' and 'interweaving' of relational and neurobiological resources is also not peculiar to CRM. Indeed, it is a key feature of the phase-based approach to complex trauma treatment that CRM purports to contest.⁶⁴⁶

CRM rightly prioritises client safety in the treatment of complex trauma. It claims that 'full brain - and body-based safety' needs to be 'in place from the start as well as throughout the distress work in order for the client to experience healing in a way that is not re-traumatising and that does not lead to dissociation'.⁶⁴⁷ Based on extensive clinical experience, however, ensuring that there is complete brain- and body-based safety 'from the start' is an enormous and potentially unachievable task.

Certainly it is actively worked towards by phased-treatment approaches, in which safety and stabilisation comprise the first, essential (and 'sometimes lengthy')⁶⁴⁸ phase. While it is legitimate to ask whether resourcing for safety can be safely accelerated - and while CRM promotes condensing of the familiar three stages of the traditional phased approach via its own (i.e. CRM) syncretic model of treatment - the risks of doing so invite obvious questions.

The risks of 'condensing' the familiar stages of the phased model are noted by CRM exponents and also explicitly addressed. The potential for 'kindling' - whereby distress is triggered and rapidly escalates - is one such risk.⁶⁴⁹ It also applies to many clients, not only those who experience *complex* trauma.⁶⁵⁰ Thus 'what started out as a single-event trauma requiring minimal resourcing'⁶⁵¹ spirals into underlying childhood trauma issues in which problematic attachment dynamics emerge.

643 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.132.

644 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.132.

645 A surprising omission in this context (and in an otherwise widely researched text) is the work of Bruce Ecker, who clearly endorses targeting of the source of the original distress (as also experienced in the present; i.e. 'at the roots') and who also discusses the range of therapies that accord with the principles of 'memory reconsolidation' even if such therapies do not specify or are unaware of this process. See Ecker et al. *Unlocking the Emotional Brain: Eliminating Symptoms at Their Roots Using Memory Reconsolidation* (Routledge, New York, 2012).

646 'Phase oriented therapy may be applied in a simple, straightforward way in less complicated cases... However, in most cases ... the phase-oriented model takes the form of a spiral (Courtois, 2010; Steele et al., 2005; Van der Hart et al., 1998). This implies that as needed, Phase 2 ... will periodically alternate with Phase 1; and later... be alternated with Phase 3' (van der Hart et al, *The Haunted Self*, ibid, p.217). Also note Herman's contention that treatment must not only be appropriate to each stage, but be tailored to each client: '[a]t each stage of recovery, comprehensive treatment must address the characteristic biological, psychological, and social components of the disorder' (Herman, *Trauma and Recovery*, ibid, p.156).

647 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.132.

648 Chu, *Rebuilding Shattered Lives*, ibid, p.109.

649 Schwarz, Corrigan et al, referencing Scaer, 2005, *The Comprehensive Resource Model*, ibid, p.132

650 This is because '[e]ven high-functioning people who appear initially to be within the window of tolerance can easily flip into flooding and dissociation if the original survival terror event is triggered by processing a present-day single event' (Schwarz, Corrigan et al, ibid, p.132).

651 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

Acknowledgment of such risks, however, is no guarantee that they will be averted. Schwarz, Corrigan et al. contend that '[p]art of the conceptualisation of CRM is the use of nested resources to modify the physiological activation so that trauma processing work can proceed dynamically, without dissociation, within a session depending on the issue being addressed'.⁶⁵² But given the speed and unexpectedness with which distress can escalate (e.g. the 'kindling' effect) this attempted reassurance may fail to convince. The caveat of '*depending on the issue being addressed*' (emphasis added) also adds ground for concern. Affect can fluctuate rapidly in the face of distress, particularly if affect-regulation difficulties are long-standing.

The developers and exponents of CRM state that '[p]ractitioners who are new to the CRM work' frequently report that a particular resource 'didn't work' in a session with a client.⁶⁵³ Unsurprisingly, a noted concern is that a client has gone 'immediately into intense processing of the traumatic material, appearing to the therapist to be un-resourced'.⁶⁵⁴ 'In fact', Schwarz, Corrigan et al. respond, 'one of two contrasting processes may be occurring': either the client is so efficiently resourced that deeper layers of experience have quickly become accessible ('[i]n effect...because the safety is there')⁶⁵⁵ or the same dynamic occurs ('meaning the resourcing has created the safety necessary for more to unfold') but the client is unable to tolerate the level of intensity (in which case there is need 'for further therapist intervention, quickly and from a place of full attunement',⁶⁵⁶ drawing on additional CRM resources as indicated).

This response fails to consider that rapid precipitating of the client 'into intense processing' may be an inherent risk of the model itself. Also clear from the above comments are the very high demands placed on the therapist.

Schwarz, Corrigan et al. repeatedly emphasise that therapists also need to have 'done their own work'. But the potential need to intervene rapidly if clients are rapidly galvanised into 'intense processing' (and where the authors have already conceded that '*even high-functioning people who appear initially to be within the window of tolerance can easily flip into flooding and dissociation*')⁶⁵⁷ merits more sustained consideration than it is given.

Failure to consider that in condensing the traditional phases of staged treatment CRM may carry an inherently higher risk of the client going 'immediately into intense processing of the traumatic material' is concerning. Rather than just 'appearing', the client may actually *be* under-resourced to cope with this. This is a gap within the model that is not acknowledged and which needs to be systematically addressed.

In fact the description and explanation of CRM frequently expresses the language of, as well as need for, 'stages' in complex trauma treatment. Thus it is conceded that 'it can be quite challenging for the client to have to navigate powerful trauma release in the early stages of treatment'.⁶⁵⁸ Direct reference to 'the early stages of treatment' and to the challenges the client faces during this period is striking. It also undercuts the assurance that while 'it may look scary' to the under-resourced therapist, rapid entry into intense trauma processing is experienced by the client 'as totally doable'.⁶⁵⁹

652 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.132.

653 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

654 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

655 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133; original emphasis.

656 And drawing on additional CRM resources as indicated. Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

657 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.132; emphasis added.

658 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.214.

659 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

Given the speed with which apparent tolerance for strong emotion can dissolve under stress, the rapidity of dissociative overwhelm which can be subtle as well as overt, and the conceded potential need 'for further therapist intervention, quickly and from a place of full attunement'⁶⁶⁰ (a hard call in the best of circumstances) can this authoritative and also appropriative assertion about client experience be justified?⁶⁶¹ In light of the depth and duration of complex trauma experienced by many clients – and thus the potentially greater likelihood of triggering by rapid entry into 'intense processing' in the absence of a dedicated and preliminary stage of stabilisation – the extent to which these factors constitute a risk which is disabling needs to be considered with great care.

3.5 Challenging implementation

Exponents of 'first-line', 'trauma-focused' treatments (whose objections are direct and unequivocal) and the otherwise contrasting CRM are not the only critics of the phased approach. Less explicit criticisms have been made from other quarters and likewise need to be acknowledged. For example, Janina Fisher points out that 'for clients with chronic multi-layered trauma histories and severe dissociative symptoms, dysregulated unsafe behaviour, or chronic stuckness, the goal of stabilization can be elusive'.⁶⁶² This can mean that '[y]ears of treatment focused on self-regulation and avoidance of traumatic content sometimes leads only to small steps forward – or bigger steps forward followed by setback after setback'.⁶⁶³

Fisher also highlights a 'quandary' posed by phased treatment related to the relationship between preparation and processing. On the one hand, it may not feel right to discourage clients from 'telling their stories' (where 'the prioritising of stabilisation requires focusing away from traumatic events').⁶⁶⁴ Yet 'on the other hand, meeting the client's need to 'get it out' is also risky': *'The former risks empathic failure; the latter risks destabilization. What does the therapist do when caught between 'a rock and a hard place?'*⁶⁶⁵

Interestingly, the above critique also highlights the extent to which 'affect phobia' *on the part of the therapist and/or treatment modality* may delay trauma processing (also see below comments). This in turn underlines the need for treatments to be able to assist, rather than circumvent, engagement with intense emotion.

Emotion-Focused Therapy for Complex Trauma (EFTT) is an approach attuned to this need⁶⁶⁶ (see discussion in Chapter 5). Interestingly, ironically - and in this respect like the Comprehensive Resource Model from which it otherwise differs - EFTT eschews a 'stage or linear model' even as the language and utilisation of phases is also invoked.⁶⁶⁷ This also reveals *the difficulty of circumventing the need for phases*, albeit variously conceptualised and applied, in the treatment of complex trauma.

660 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.133.

661 The accompanying claim of the need 'to step fully into the darkness of our experiences' (Schwarz, Corrigan et al, ibid, p.134) is problematic on a number of grounds in relation to complex trauma; see forthcoming reference to the widely endorsed need for careful titration and *indirect* engagement of traumatic memory and experience.

662 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors* (Routledge, New York, 2017), p.44.

663 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid.

664 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, p.47.

665 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid.

666 Sandra Paivio & Antonio Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach* (American Psychological Association, Washington DC, 2017); see Chapter 5 of this document.

667 'EFTT is not a stage or linear model, but particular processes typically are dominant during particular phases of therapy' (Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, ibid p.44). See pp.44-48, ibid, for enumeration of the principles of what are specifically described as *four* phases in this treatment.

A very different integrative treatment approach – comprising multiple resources drawn from short-term psychotherapies within a neo-Ericksonian framework⁶⁶⁸ – also considers issues regarding the phased treatment approach. Significantly, however, Robert Schwarz, who developed this approach, contends that he has ‘no disagreement with a phase-oriented model’ but rather wants to highlight issues to arise in relation to it.⁶⁶⁹ Indeed, he specifically correlates interventions from the techniques he describes to the phased treatment model.⁶⁷⁰ In his subsequent contribution to *Clinical Applications of the Polyvagal Theory*⁶⁷¹ (which presents the benefits of non-abreactive techniques from Energy Psychology) Schwarz contends that there have long been strong grounds to locate contributions from Energy Psychology ‘within the triphasic model of trauma treatment’.⁶⁷²

3.6 Fine tuning of phasing

To ‘critique the critiques’ of phased treatment is not to imply that it is beyond criticism. Nor is it to contend that problematic issues in relation to phased treatment do not arise. One obvious criticism (as contended by its critics, albeit a preferable scenario to clients being precipitated into trauma processing too soon) is that clients may be kept unnecessarily in phase 1 (i.e. safety and stabilisation for too long).⁶⁷³

This can occur when the *therapist or treatment* may be over-cautious about the client’s (and implicitly the therapist’s) ability to cope with strong emotion. It may also be despite adequate and even extensive client preparation and apparent signs of the acquisition or restoration of self-regulatory capacity (i.e. the opposite situation to that of the therapist who may be over-confident and/or wants to go ‘straight to processing’). Conversely, *the client* may insist that they are ‘ready to process’ their trauma while the therapist has legitimate misgivings about their capacity to do so.⁶⁷⁴ Clearly critics of the phased approach would be less likely to advise a client to ‘hasten slowly’, with the attendant risk that some clients could be inadvertently ‘fast tracked’ to re-traumatisation.⁶⁷⁵

Critics of the phased approach contend that time may be lost and processing unwarrantedly delayed by ‘over caution’. It is true that therapists can directly or indirectly discourage trauma processing when their clients are ready to do so. But rather than upholding criticism of the phased approach, this underlines the need for clinicians working with complex trauma clients to have sufficient training and competencies.⁶⁷⁶

668 Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002). See Chapter 4. Schwarz also has a skill base in Energy Psychology and hypnotherapy.

669 See Schwarz, *Tools for Transforming Trauma*, *ibid*, p.20.

670 As per the various chapters of Schwarz, *Tools for Transforming Trauma*, *ibid*, and see the chart included on p.19 (*ibid*).

671 Robert Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, in Stephen Porges & Deb Dana, *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), pp. 270-284. Also see discussion in Chapter 4 of this document.

672 Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, *ibid*, p.275, and see Chapter 4 of this document.

673 ‘There may, however, exist therapists who do offer stabilization techniques to their patients unnecessarily or for too long’ (Rydberg, ‘Research and clinical issues in trauma and dissociation...’ *European Journal of Trauma and Dissociation*, 1), p.93, also Robin Shapiro, *The Trauma Treatment Handbook* (Norton, New York, 2010).

674 As Shapiro has discussed, if assessment does not reveal prior attachment and self-regulatory challenges trauma processing can begin earlier and therapy can be more straightforward (Shapiro, *The Trauma Treatment Handbook*, *ibid*). However this requires therapist attunement and competence to detect differences which, without sensitively administered trauma screening, may not be readily apparent until the therapy is well underway.

675 As Shapiro (2010, *ibid*) underlines, ‘[i]n contrast to the traumatized person who has experienced a sense of safety and wellbeing prior to onset of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage’.

676 See *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*.

It is important to clarify what 'exposure' to traumatic memories and experiences means and comprises. As noted previously, avoiding distressing life experience is not a viable course, much less therapeutic treatment. The limits of avoidance often drive traumatised (as well as other) people *into* treatment. Accordingly, some degree of exposure to traumatic memory is indeed necessary (as per phase 2 'processing' in the phased approach). The issue is not *whether* some degree of exposure is needed (as processes such as 'dual attention'/presence⁶⁷⁷ and 'memory reconsolidation'⁶⁷⁸ attest). Rather it is *the way in which* engagement with, rather than avoidance of, traumatic experience is facilitated.

Exponents of exposure therapy imply that adherents of the phased approach unnecessarily delay their client's engagement with traumatic memory. However, pacing and the way in which traumatic life experience is engaged is key. As Herman explains: *'[i]n early recovery...issues of safety and self-care always take priority, but this does not mean that the subject of trauma should be avoided'*.⁶⁷⁹

Rydberg notes that some critics may have 'a lack of comprehension of stabilisation and phase-oriented treatment'.⁶⁸⁰ It cannot be over-emphasised that proponents of phased treatment do not regard the phases as strictly linear (*'[o]f course, these stages are not meant to be applied rigidly'*).⁶⁸¹ Rather, the clinician *'incorporates interventions for each of the three phases of treatment as the need arises'*.⁶⁸²

*'Although the phases have been described in linear fashion, in reality they are flexible and recursive, involving a periodic need to return to previous phases... Each phase involves a problem-solving and skills-building approach within the broader context of a relational approach...'*⁶⁸³

Paying attention to problem-solving, skill-building, and flexibility *within as well as between* stages (where are all embedded *'within the broader context of a relational approach'*) facilitates honed and comprehensive healing. It also distinguishes the phased approach to complex trauma treatment from 'first-line', trauma-focused treatments which, whatever their merits, are not necessarily delivered within a paced and *relational* context.

Complex trauma clinicians and researchers consistently attest to the need for *careful titration of traumatic material*⁶⁸⁴ (i.e. the opposite of prolonged exposure) and the *importance of the relational context* in which healing occurs. Complex, interpersonally generated trauma is relational and relationships are critical to recovery.⁶⁸⁵

677 As Shapiro notes in her reference to 'dual attention', '[i]n good trauma therapy, clients must be in two places at once: they must hold the trauma in mind (exposure), while maintaining focus in the current time and place' (Shapiro, *The Trauma Treatment Handbook*, *ibid*, p.2).

678 See Ecker, *Unlocking the Emotional Brain*, *ibid*.

679 Herman, 'Foreword', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, *ibid*, p.xvi.

680 Rydberg, 'Research and clinical issues in trauma and dissociation...', *ibid*, p.93.

681 Herman, 'Foreword', Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*, p. xvi.

682 Pat Ogden et al, *Trauma and the Body* (Norton, New York, 2006), p.269.

683 Van der Hart et al, *The Haunted Self*, *ibid* (ref. Courtois, 1999, Steele et al, 2005, and D. Brown, Schefflin & Hammond, 1998; original emphasis). Also see Julian Ford, Christine Courtois et al. 'Treatment of Complex Posttraumatic Self-Dysregulation', *Journal of Traumatic Stress* (18, 5, 2005), p.437.

684 A wide range of clinicians and researchers underline the centrality of this point. Note, for example, Levine's analogy of the shield used by Perseus in Greek mythology to protect him from direct sight of the Gorgon Medusa (Levine, *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness* (Berkeley, CA: North Atlantic books, 2010) and Richard Kluft's method of 'fractionated abreaction' in Kluft, *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* (South Carolina, CreateSpace Independent Publishing 2013). Also note development in 2016 of the 'flash' technique within EMDR in recognition of the extent to which direct engagement with traumatic memory can impede rather than assist its processing.

685 'Recovery can take place only within the context of relationships; it cannot occur in isolation' (Herman, *Trauma and Recovery*, *ibid*, p.133; this is a reading endorsed by many subsequent clinicians and researchers of complex trauma).

'Front-line' intensive trauma-focused therapies almost completely bypass the centrality of this contextual dimension which is a precondition for healing. Together with the previous points about pacing, this omission reveals a disabling limitation of the criticism of the phased approach by 'first-line', 'trauma-focused' treatments which has not as yet been satisfactorily addressed.

Manualised and decontextualised treatment modalities do not, by definition, consider the needs of the individual client and the need to tailor treatment. Nor do they consider the way in which treatment is administered. The growing call for care and practice to be 'trauma-informed' organisationally as well as clinically also highlights that '[w]ithout such a shift [towards trauma-informed care] ...even the most 'evidence-based' treatment approaches may be compromised'.⁶⁸⁶

3.7 Finding at this time

In 2014, it was noted that while the effectiveness of 'first-line' treatments for standard PTSD is 'well established', nevertheless 'their generalizability to child abuse (CA)-related Complex PTSD is largely unknown'.⁶⁸⁷ The conclusion of a recent quantitative review of evidence-based treatment for women with child abuse-related Complex PTSD found that the evidence suggesting the effectiveness of predominantly CBT treatments is 'limited'.⁶⁸⁸ It found 'no superior effect size' for exposure, that affect management 'resulted in more favourable recovery and improvement rates and less drop-out, as compared to exposure', and that CBT treatments 'do not suffice to achieve satisfactory end states, especially in Complex PTSD populations'.⁶⁸⁹

The extensive well-documented impacts of complex trauma provide ample ground for the ISTSS Expert Consensus Guidelines⁶⁹⁰ to propose caution and for continued endorsement of a phased treatment approach. In 2018, an editorial of the *American Journal of Psychiatry* noted that patients 'with significant dissociative symptoms'⁶⁹¹ 'respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well'.⁶⁹² Indeed, some treatment modalities which did not previously incorporate a phased approach are now explicitly doing so.⁶⁹³

Note that the relative weight apportioned to the therapeutic relationship per se is an area on which there is also discussion.

686 Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004.

687 Ethy Dorrepaal, Kathleen Thomas et al, 'Evidence-based Treatment for Adult Women with Child Abuse-related Complex PTSD: a Quantitative Review', *European Journal of Psychotraumatology* (Vol,5, 2014) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4199330/>

688 Dorrepaal, Thomas et al, 'Evidence-based Treatment for Adult Women with Child Abuse-related Complex PTSD', *ibid.*

689 Dorrepaal et al, *ibid.*

690 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, *ibid.*

691 Van der Hart et al, *The Haunted Self*, *ibid.*

692 David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4.

693 As Rydberg points out, '[t]he field of EMDR therapy, for example, shows examples of adaptations to the processing of traumatic memories that include many aspects of stabilisation...in these cases, phases one and two follow a parallel path' (Rydberg, 'Research and clinical issues in trauma and dissociation...', *ibid.*, pp.93-4; ref. Gonzalez & Mosquera, 2012; Van der Hart et al, 2013, 2014). Also see Chapter 5.

Consideration of the criticisms of phased treatment confirms Rydberg's contention that '[i]f the evidence in support of phase-oriented treatment for cPTSD is not entirely conclusive but the research in favour of strictly trauma-focused therapy for the same population is even weaker or inexistent, then there appears to be no solid logical reason to modify current guidelines.'⁶⁹⁴

At the same time, evolving and potentially valuable short-term psychotherapies, some of which incorporate variants of phases, and the growing plethora of techniques to potentially integrate within the phased model (see Chapter 4) may offer means by which complex trauma treatment may be accelerated without sacrificing safety.

⁶⁹⁴ Rydberg, 'Research and clinical issues in trauma and dissociation...', *ibid*, p.93.

Chapter 3

Summary of Key Findings and Themes

- Recent and current criticism of the 'phased approach' to complex trauma treatment (recommended by the *ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, 2012) needs to be considered.
- Authorised 'evidence-based', 'first-line' therapies for treatment of PTSD (the majority of which endorse exposure treatment/s and CBT) are relatively short-term 'intensive trauma-focused' psychotherapies which do not include a staged approach.
- '[T]he core question is still whether the addition of a stabilization phase is a necessary condition for, and/or has added value over, immediate trauma-focused treatment' (Van Vliet, Huntjens et al, 2018).
- Exposure therapy, in its various forms, is widely referenced, evidenced, and recommended. Despite this, many respected trauma clinicians and researchers question its utility. (*'What one does not do in early recovery is any form of 'exposure' therapy'* (Herman, 2014: xvi); *'[P]rolonged exposure types of therapiesthough they undoubtedly do help some... harm others'* (Levine, 2015: 116)
- Exposure therapy was initially designed to treat simple phobias and may be less well suited to and appropriate for treating trauma (*'the repurposing of a therapy originally designed for simple phobias to treating trauma, which is much more complex, may be a disturbing misapplication of these early methods'* Levine, 2015: 118).
- The *relational* phobias of complex trauma (e.g. phobia of attachment and phobia of inner experience; van der Hart et al, 2006, 2011) are more complex than the phobias of natural phenomena, basic life forms and inanimate objects, and those associated with standard PTSD. This suggests that applying exposure therapies to complex trauma treatment is even more questionable than applying them to treatment of standard PTSD.
- The claim 'that PTSD patients with serious comorbid dissociative or depressive symptoms are just as likely to profit from effective treatment programs like exposure as those with low dissociative and depressive symptom levels' (Hagenaars, Van Minnen et al, 2010) is concerning. This is because it assumes that the therapist can discern and appropriately intercept trauma-related dissociation.
- Manualised and de-contextualised treatment modalities, while they may seem valid, do not consider the needs of the individual client, the need to tailor treatment, or the contextual dimensions of the way treatment is administered.
- A range of new modalities and resources implicitly and sometimes explicitly contest the necessity for a phase-based approach to treatment of complex trauma.
- The Comprehensive Resource Model (CRM) claims to create *'a neurobiologically resourced state that allows for three phases of trauma treatment – stabilisation, 're-processing' and integration – to be done simultaneously; therefore distress work is not separate from the resourcing, nor is resourcing regarded as a separate 'phase' of treatment'* (Schwarz, Corrigan et al., 2017: 131).

- While CRM emphasises the importance of safety, examination of this model suggests that rapid movement of the client into 'intense processing' (i.e. without a specific stabilisation phase) could increase the risk of the client being overwhelmed. This is especially given the authors' acknowledgement that '*[e]ven high-functioning people who appear initially to be within the window of tolerance can easily flip into flooding and dissociation*' (ibid: 132)
- The emergence of multiple resource treatment models (i.e. other than the officially endorsed 'first-line', 'trauma-focused' psychotherapies) raises issues in the context of the phased treatment approach. This does not necessarily mean that all such models are incompatible with it (Schwarz, 2002, 2018) or that diverse strategies and techniques cannot be integrated into it (also see discussion in Chapter 4).
- The prevalence of shame as a 'core affect' in complex trauma-related conditions has led to the view of some clinicians that 'when a person's past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice' (Frewen & Lanius, 2015:207).
- While phase-based treatment of complex trauma is not beyond criticism, some criticisms suggest 'a lack of comprehension of stabilisation and phase-oriented treatment'⁶⁹⁵ (Rydberg, 2017: 93). For example, proponents of the phased approach have never contended that adherence to the three stages should be linear and inflexible (Herman, 1992, 2014; van der Hart et al, 2006; Ogden et al, 2006; Chu, 2011).
- 'First-line' and exposure-based treatments do not account for or address the importance of *relationship* and *context* in complex trauma treatment ('*Recovery can take place only within the context of relationships; it cannot occur in isolation*'; Herman, 1992, 1997: 133).
- Many trauma clinicians and researchers advocate the need for careful *titration* in processing traumatic memory/ies (Levine, 2010, 2015; Ogden et al, 2006; Courtois & Ford, 2014). This contrasts starkly to the principles of prolonged exposure therapy (PE).
- Several studies of the effectiveness of PE for complex trauma treatment (i.e. as well as standard PTSD), find it far less efficacious than anticipated: '*It is arguable the most surprising result in our study was the poor performance of prolonged exposure therapy process....PE is often touted as the first-line treatment for distressed trauma survivors (Foa, 2009), but we found little evidence that PE was helpful for these clients, and some evidence of adverse effects*' (D'Andrea & Pole, 2012: 444; also see Emerson & Hopper, 2011:15-16).
- While the effectiveness of 'first-line' treatments for standard PTSD is 'well established', nevertheless 'their generalizability to child abuse (CA)-related Complex PTSD is largely unknown' (Dorrepal et al., 2014).
- While the review of the *ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* found that evidence in favour of 'special stabilisation procedures prior to trauma-focused treatment' was weak, it also conceded that studies which directly examine the superiority or otherwise of trauma-focused treatments to phase-oriented approaches for more complex PTSD did not exist (de Jongh et al., 2012).
- Evidence for overturning the 'phased treatment' recommendation does not stand up to scrutiny. Thus Rydberg's contention (2017:93) that '*[i]f the evidence in support of phase-oriented treatment for cPTSD is not entirely conclusive but the research in favour of strictly trauma-focused therapy for the same population is even weaker or inexistent, then there appears to be no solid logical reason to modify current guidelines*' is persuasive.

695 Rydberg, 'Research and clinical issues in trauma and dissociation...', ibid, p.93.

- At the same time, evolving and potentially valuable short-term psychotherapies - some of which incorporate variants of phases - and techniques which can potentially be integrated within the phased model should be noted and evaluated (see Chapter 4). Any means by which treatment of complex trauma might be accelerated should not compromise the safety of the client.

Chapter 4

'New' and Emerging Treatments

'One may wonder whether scientific validation is necessary or sufficient before adopting a certain therapeutic approach. Several authors...have questioned the usefulness and relevance of current psychotherapy research. Although research studies may guide our choice of one method over another for the treatment of a specific client and lead to the improvement of our techniques, new approaches are developed because a number of therapists have been creative and 'strayed' from conventional and validated techniques. Furthermore, the quality of methodology and design vary greatly between studies, rendering the results difficult to interpret. The simple number of extant published papers can therefore not be considered sufficient to select a specific form of psychotherapy.'

Rydberg, 'Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations', *European Journal of Trauma and Dissociation* (1), 2017, p.91; citing Persons & Silberschatz, 1998; Ruth & Fonagy, 2013; Coyne & Kok, 2014.

The field of psychotherapy, which encompasses a wide range of treatment approaches, is currently very dynamic. It is now clear that 'beyond...recognised theoretical and therapeutical approaches, be they general, or specific to trauma and dissociation, there is a growing trend of integrating alternative techniques and belief systems with traditional psychology-based therapies.'⁶⁹⁶

The exciting ongoing evolution within psychotherapy has potentially highly significant implications for treatment of trauma and dissociation. As noted in the introduction, Bessel van der Kolk is one of several high profile trauma specialists who welcomes and indeed promotes 'non-traditional' (i.e. non-traditional in the field of psychotherapy) treatment approaches.⁶⁹⁷

Notably, these include 'age-old, nonpharmacological approaches that have long been practised outside Western medicine, ranging from breath exercises (pranayama) and chanting to martial arts like qigong to drumming and group singing and dancing.'⁶⁹⁸ These do not exhaust the diverse practices, strategies, and tools which are potentially available to clinicians and which may be especially helpful in the treatment of trauma.⁶⁹⁹

This also raises questions about how to assess the array of diverse 'new' approaches, lineages, and treatment sources. This is no easy matter. But it is important to note at the outset that 'logical fallacies and lapses in critical thinking are not only used to promote new, innovative or alternative methods and techniques, they also serve to denounce them' and that many of the criteria used 'may apply to established forms of psychotherapy as well'.⁷⁰⁰

696 Jenny Ann Rydberg 'Research and Clinical Issues in Trauma and Dissociation', *ibid.* p.90; emphasis added.

697 See Bessel van der Kolk, 'New Approaches to Treatment' in van der Kolk, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* (New York: Penguin, 2015), pp.87-88 and his current commentary.

698 Van der Kolk, *The Body Keeps the Score*, *ibid.*, p.88.

699 Van der Kolk, *The Body Keeps the Score*, *ibid.*, p.88.

700 Rydberg, 'Research and Clinical Issues in Trauma and Dissociation...', *ibid.*, p.92, citing Lilienfeld, Lynn & Lohr, 2015; Mollon, 2007.

The wider issues in relation to evidence, and the grounds on which psychotherapies may be endorsed, legitimised and regarded as effective, are addressed in chapter 5. The aim of the current chapter is to provide a broad orientation to some of the diverse treatment approaches traditionally 'outside' the field of psychotherapy which might be useful and/or integrated within it to assist complex trauma treatment.

Although diverse treatment approaches have been integrated within and alongside familiar psychotherapeutic modalities for some time, the pace of this is rapidly accelerating. As van der Kolk affirms,⁷⁰¹ and as discussed below, the now clinically applied⁷⁰² principles of the widely respected Polyvagal Theory⁷⁰³ would seem to support several 'non-traditional' treatment modes.

4.1 New therapies, old therapies, and clinical integration

'Traditional methods employed in psychotherapy have limited effectiveness when it comes to healing the psychological effects of trauma, in particular, complex trauma.'

Schwarz, Corrigan et al, 2017.

'New evidence from emerging fields such as epigenetics, neural plasticity, psychoimmunology, and evolutionary biology confirms the central link between emotion and physiology, and points to somatic stimulation as the element common to emerging psychotherapeutic methods.'

Church, 2013: 645.

The limitations of standard 'talk therapy' for treatment of trauma are increasingly acknowledged. The majority of psychotherapies have traditionally emphasised 'cognitive, critical functioning – a 'top-down' process primarily engaging the pre-frontal cortex.'⁷⁰⁴ This does not address subcortical areas of the brain in which trauma is located, activated, and stored.⁷⁰⁵ Trying to 'talk about trauma', even when words are available, can profoundly destabilise clients. For this reason, the 'neurobiological revolution', 'bottom-up' (as well as 'top-down') reorientation and attention to somatic processes continues to define the evolving treatment landscape.⁷⁰⁶

701 As noted in the summary of the research in this report, Van der Kolk directs our attention to Polyvagal Theory to help us understand why '*disparate, unconventional techniques*' may be highly effective. This is because it has 'enabled us to become more conscious of combining top-down approaches (to activate social engagement) with bottom-up methods (to calm the physical tensions in the body)' van der Kolk, *The Body Keeps the Score*, ibid, p.88; emphasis added.

702 See Stephen Porges & Deb Dana, ed. *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies* (Norton, New York, 2018); also Deb Dana, *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation* (Norton, New York, 2018).

703 Stephen Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* (Norton, New York, 2011).

704 Schwarz, Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma*, 2017, p.2.

705 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.2; ref Corrigan, 2014.

706 As noted in the initial summary comments, '[o]ver the last 15 years, the leading edge of trauma work has been focusing on the importance of the body and 'bottom-up' factors that contribute to the creation of post-traumatic stress on the one hand and post-traumatic healing on the other' (Robert Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', ref Van der Kolk, 2014, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, p.282.

‘Trauma treatment as a professional field is fairly young. As our understanding of the impact of trauma on human experience grows through neuroscience with conceptualizations such as Polyvagal Theory... and research on the brain and memory... the essential role that somatic and movement-based therapies play in the restorative process is now widely accepted...

To remain connected to our embodied experience, we must relearn to work through trauma with movement, the primary language of the body.’

(Gray, 2018: 209; ref Porges, 2011; Perry 2017; Siegel, 1999, 2012 & van der Kolk, 2001, 2014); (Johnson, Lahan, & Leray, 2009; Gray, 2015, & Gray, 2016).

Spoken words alone cannot easily create the experience of safety which is foundational to effective trauma treatment. It is postulated that physical movement *‘may be the most direct pathway to promote brain plasticity and therefore promote learning capacities, healing, and a sense of wellbeing.’*⁷⁰⁷ Also that *‘[w]hen we consciously and deliberately engage in practices that produce physical calmness, we signal the limbic brain that we’re safe at a physiological level.’*⁷⁰⁸

4.2 ‘Cues of safety are the treatment’:⁷⁰⁹ Polyvagal Theory and the advent of Polyvagal therapy/ies

In 2011 the pioneering text *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* by Stephen Porges⁷¹⁰ presented the neurophysiological underpinnings of the experience of safety and the emotions and cognitions which support and erode it. Polyvagal Theory explains why *‘[i]t is not language, it is our biology that communicates safety’*⁷¹¹ and why *‘[i]t is not possible to shift emotional and psychological states without shifting physiological states’*.⁷¹²

The Polyvagal Theory illuminates the processes involved. It also explains why thoughts, feelings, and verbalisations are actually ‘epiphenomena, all driven by body-based, nonverbal data’ (*‘the story arises from the autonomic state first, and then the top-down cognitions and narrative helps to solidify the experiential state’*).⁷¹³ To enable us to feel safe, sympathetic or dorsal vagal reactivity is reduced via ventral vagal regulation.⁷¹⁴ Movement from the former to the latter – and thus the importance of methods which can assist this – is key.

This challenges sole reliance on ‘the talking cure’. A range of diverse psychotherapies are increasingly attuning to and incorporating the ‘bottom-up’ approaches which are essential to working with trauma. For example, Robert Schwarz discusses how, with Energy Psychology approaches, clients often ‘report self-generated cognitive shifts about the meaning of the traumatic events’:

707 Amber Gray, ref Perry, 2017, ‘Roots, Rhythm, Reciprocity: Polyvagal-Informed Dance Movement Therapy for Survivors of Trauma’, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.209; emphasis added.

708 Dawson Church, *Psychological Trauma: Healing its Roots in Brain, Body, and Memory*, Energy Psychology: Theory, Research, and Treatment Monograph 7(3), Energy Psychology Press, California, p.49.

709 Stephen W. Porges, ‘Polyvagal Theory: A Primer’, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.61.

710 Porges, *The Polyvagal Theory*, *ibid*.

711 Gray, ‘Roots, Rhythm, Reciprocity: Polyvagal-Informed Dance Movement Therapy for Survivors of Trauma’, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.212.

712 Gray, ‘Roots, Rhythm, Reciprocity: Polyvagal-Informed Dance Movement Therapy for Survivors of Trauma’, *ibid*, p.221.

713 Robert Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, *ibid*, p.275.

714 Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, *ibid*.

'One could suggest that it is the change in meaning that is creating the new sense of safety. While conceivable, it is more likely the other way around. Because the mind is no longer hijacked by intense affect dysregulation, the information can be processed in a new way'.⁷¹⁵

In contrast to, for example, Cognitive Behavioral Therapy (CBT), Energy Psychology approaches 'do not attempt to actively change cognitions of clients'.⁷¹⁶ Nor do they interpret and symbolise as do insight-based psychodynamic psychotherapies. Rather in EP, '[t]he narrative shifts as the autonomic state shifts and as the neuroception [i.e. the subcortical process of threat detection]⁷¹⁷ becomes one of safety'.⁷¹⁸

'The obvious question is, Does the mind drive the body, or does the body drive the mind? The answer is both. However, Polyvagal Theory suggests that the body-to-mind side of the road (i.e. sensory pathways from the body to the brain) has four lanes of traffic, compared to only one lane on the mind-to-body side (i.e. motor pathways from the brain to the body). It is a lot easier to have a quiet and calm mind when the body says, 'You are safe and secure' (Schwarz, 2018: 274).

The Polyvagal Theory is both exciting and challenging for the practice of psychotherapy in affording a sound rationale from which to explore and potentially integrate the somatic based interventions that 'talk therapy' has traditionally lacked.

Extending the Polyvagal Theory to clinical practice (i.e. 'from theory to therapy') is an exciting current development. It means that '[f]unctionally, therapy becomes a platform to exercise the capacity to shift state by recruiting features of the social engagement system to keep the autonomic nervous system out of prolonged states of defense...through co-regulation between the client and the therapist'.⁷¹⁹

Two texts designed to further this goal help us understand how this might be done.²⁵ Note that while potentially highly complementary to a trauma-informed orientation (with which it overlaps in significant ways) a trauma-informed approach is not the same as clinical application of the Polyvagal Theory and does not necessarily guarantee polyvagal awareness and attunement. In fact one Polyvagal exponent contends that it is possible to be trauma-informed while being 'polyvagal blind'.⁷²⁰ This, in turn, suggests the need for training and other opportunities by which trauma-informed clinicians can begin to rectify any (prior training induced) myopia.⁷²¹

715 Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', *ibid*, p.275.

716 Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', *ibid*.

717 Porges' concept of 'neuroception' (i.e. the subcortical process of threat detection in our environments/s) is described as 'the nervous system's capacity to evaluate risk without awareness' (Lindaman & Makela, in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.229; 'The vagus knows before cognition, and this means neuroception precedes cognition' (Moir Theede in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.160). Neuroception and autonomic responses 'range from adaptive protection to social connection'; registering implicit memory which 'depending on past experiences, produces experiences of ventral vagal flow, sympathetic mobilization, or dorsal vagal immobilization' (Dana & Grant, in Porges & Dana, *ibid*, p.203).

718 Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', *ibid*, p.275; emphasis added.

719 Porges, 'Polyvagal Theory: A Primer', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.62.

720 George Thompson, 'Brain-Empowered Collaborators: Polyvagal Perspectives on the Doctor-Patient Relationship', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.133.

721 See, for example, Deb Dana & Deb Grant, 'The Polyvagal PlayLab: Helping Therapists Bring Polyvagal Theory to their Clients', Chapter 11 in Porges & Dana ed., *Clinical Applications of the Polyvagal Theory*, *ibid*, pp.185-206.

4.3 Right brain and somatically attuned: 'analytic' yields to 'experiential'

The availability and growing popularity in Australia (as elsewhere) of the somatic trainings of Peter Levine (Somatic Experiencing [SE])⁷²² and Pat Ogden (Sensorimotor Psychotherapy [SP])⁷²³ attest to the increasing priority accorded the body and the experiential for 'talk therapists' who previously did not work with body based therapies. Training in trauma-sensitive yoga is also gaining momentum in Australia.⁷²⁴

The 'neurobiological revolution in psychotherapy' (Fisher, 2017: xi) and enhanced understanding of the role of implicit memory continue to underscore that both desired change in general and trauma resolution more specifically are optimised 'not through analytical insight, but using experiential methods developed for that purpose' (Ecker, 2018: 5; citing multiple sources)

'Experiential methods' vary considerably. Attention to the body and physiological processes has not displaced talk-based psychotherapies. Rather, standard trainings are supplemented with body-based professional development and concurrent focused attunement to somatic regulation/dysregulation at all times.⁷²⁵

'Right-brain' oriented psychotherapies such as art therapy, sandplay,⁷²⁶ creative dance, equine therapy,⁷²⁷ and drumming⁷²⁸ are gaining ground. Heart math, Heart Rate Variability and neurofeedback are contrasting yet complementary and widely utilised therapeutic approaches and tools.⁷²⁹

Bringing mindful awareness to breathing and physical processes (i.e. combining 'mind and body' in a basic fundamental way) and incorporating mindfulness within otherwise contrasting approaches is increasingly becoming standard in diverse psychotherapeutic modalities.

722 See Somatic Experiencing Australia <http://www.seaustralia.com.au/>

723 Sensorimotor Psychotherapy at <https://www.sensorimotorpsychotherapy.org/psychotherapists.html>

724 'Trauma sensitive yoga' developed from recognising the many potentially beneficial effects of yoga while noting that standard forms of yoga practice can be triggering for people with trauma histories. See David Emerson & Elizabeth Hopper, *Overcoming Trauma through Yoga* (North Atlantic Books, CA, 2011). Note that staff of Trauma Centre Trauma Sensitive Yoga Australia (TCTSY Australia) have trained at the Trauma Center in Brookline, Massachusetts. Described as 'an adjunctive treatment for PTSD and Developmental and Complex Trauma', TCTSY is empirically validated and grounded in trauma theory, attachment theory, and Hatha yoga practice. For these reasons, it is specifically recommended for people with complex trauma histories. See <http://www.tctsyaustralia.com/>

725 Relational trauma-informed psychodynamic psychotherapies are well placed to address the challenges of structural dissociation and the complexity of the client's inner world.

726 See, for example, ANZ Sandplay Therapy Institute <http://stanza.asn.au/sandplay-therapy-institute/> and Sandplay Australia <http://www.sandplayaustralia.com.au/>

727 See Equine Therapies Association of Australia <https://equinetherapies.net.au/#ETAA>

728 See DRUMBEAT <https://www.holyoake.org.au/drumbeat/about-us/>

729 Neurofeedback has been described as 'a specific application of biofeedback [visualising and training of physiological activity in real time] for visualizing and training the electrical activity of the brain, the electroencephalography (EEG)' ('What is Neurofeedback?'). Via 'visualization of the EEG' people learn to better self-regulate their brain activity' Non-pharmacological and non-invasive, it 'focuses on optimizing the brain, rather than suppressing symptoms' both of itself and when combined with other therapies: 'To get a full physiological view and insight into mind-body interaction, true power lies in combining neurofeedback with other physiological signals, such as Heart Rate Variability (HRV) and Skin Conductance (SC/GSR)'; 'What is Neurofeedback?' https://www.mindmedia.com/en/solutions/neurofeedback/?gclid=EAlaIqobChMI1ojU58iR3wIVECQrCh25hw7IEAAYAiAAEgLRVvD_BwE For presentation of the research base of neurofeedback, see D. Corydon Hammond & D. Allen Novian, 'The ISNR Comprehensive Bibliography of Neurofeedback Research', International Society for Neurofeedback and Research (ISNR) <https://www.isnr.org/isnr-comprehensive-bibliography>

Approaches to healing from diverse sources can be either 'stand-alone' or systematised. Brief interventions which claim to have rapid therapeutic effects can be separate from but may also intersect with other approaches.

There is now increased optimism about the capacity of people to heal not only from mild but also deep and longstanding distress. This includes even severe developmental and childhood trauma. An understanding of neuroplasticity fuels optimism in this regard and was a key theme of the 2012 Guidelines. The potential of shorter term therapies to play a key role in this regard – and for profound healing from severe psychological distress, including trauma, to occur in relatively brief periods of time – is increasingly raised and clearly needs to be considered.

4.4 Emerging 'short-term' psychotherapies and the implications for healing

The 'growing trend of integrating alternative techniques and belief systems with traditional psychology-based therapies'⁷³⁰ is now well underway. Development of diverse, often relatively brief, therapies is also proceeding parallel to the field of psychotherapy, both outside and within the trauma field. The claim that not only mild but deep and longstanding distress (i.e. underlying and of long duration) may be rapidly alleviated even to the point of resolution now has diverse advocates.⁷³¹

Interest in 'brief therapy' (itself a broad category) is increasing, including among relational psychotherapists.⁷³² This is as well as incorporation of aspects of diverse 'short-term' approaches alongside and within contrasting psychotherapeutic orientations. Integration of disrupted neural networks is central to resolution of trauma,⁷³³ and a range of often brief interventions and strategies (i.e. whether part of or separate from a systematised practice) may promote integration.

To what extent are these effective for complex in contrast to single-incident trauma?⁷³⁴ This question needs to be considered before focus on some of the 'alternative' healing practices which may benefit complex trauma therapy.

4.5 Treatment challenges of complex trauma

While it may not be immediately obvious, clients who experience the impacts of complex trauma start from a very different position to those who do not:

730 Rydberg 'Research and Clinical Issues in Trauma and Dissociation...', *ibid*, p.90.

731 Note, for example, the contention of Bruce Ecker et al that '[c]ore, non-conscious, disturbing emotional themes of a lifetime can be deeply resolved and dispelled in a highly time-effective manner' (Ecker, Ticic & Hulley, in the context of discussing the process of memory 'reconsolidation', *Unlocking the Emotional Brain*, Routledge, New York, 2012, p. 149); also the claim that the approach of Emotional Freedom Techniques (i.e. EFT; see subsequent discussion) 'is a short and efficient therapy...even in extreme trauma cases' (Dawson Church, *Psychological Trauma*, Energy Psychology Press, Fulton, CA, 2015, p.64).

732 Joan Haliburn, *An Integrated Approach to Short-Term Dynamic Interpersonal Psychotherapy*, *ibid*; also note the model of Accelerated Experiential Dynamic Psychotherapy (AEDP) founded by Diana Fosha; see Fosha, *The Transforming Power of Affect: A Model for Accelerated Change* (Perseus, New York, 2000).

733 Cozolino, *The Neuroscience of Psychotherapy*, *ibid*; Siegel, 'An Interpersonal Neurobiology of Psychotherapy', *ibid*.

734 Cloitre, Courtois, et al *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, *ibid*, and see Chapter 3.

'In contrast to the traumatized person who has experienced a sense of safety and wellbeing prior to onset of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage.'

(Shapiro, 2010)

All clinicians - regardless of their treatment orientation and skill set - need to be aware of this. This is because many psychotherapies - particularly short-term 'strengths-based' approaches - assume that clients can access existing untapped resources. This may not be the case, however, for many survivors of complex childhood trauma who may lack the necessary foundational scaffolding.

Impaired capacity to access internal resources is one of several impacts and 'signature features' of complex trauma of which all exponents of short-term interventions, strategies and techniques need to be aware.

There are many differences between early life trauma and adult onset trauma which may not be readily apparent.

Understanding of this is important for all therapy types and timeframes. It is especially salient when brief interventions are applied outside of a relational context.

There are many pitfalls regarding treatments which are not grounded in this understanding. For example, decontextualized strategies and techniques which may rapidly assist clients who do not experience the impacts of complex trauma may be risky for those who do. This applies in the case of practitioners who are otherwise competent, credentialed and experienced ('many patients have been retraumatized by [clinicians] who had inadequate understanding and skills to treat complex trauma-related problems').⁷³⁵

It is common for people to present to health practitioners with 'here and now' issues which affect their quality of life. 'Targeting' symptoms is not confined to short-term and/or adjunctive therapies; it characterises the biomedical paradigm which responds in different ways than those of 'alternative therapies' so-called. But as Ecker,⁷³⁶ exponents of the Power Threat Meaning framework⁷³⁷ and others highlight, 'symptoms' can represent deep emotional learnings.⁷³⁸ Hence 'attempting to prevent or reduce a symptom with counteractive methods that leave the underlying memory material intact positions a therapy client to be prone to relapses'.⁷³⁹

Even the language of 'relapse' – with its connotation of illness – is problematic in the context of complex trauma. This is because it fails to recognise that symptoms which may be currently disabling (even severely) may stem from behaviours and strategies that initially enhanced survival. Indeed, '[f]or many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously'.⁷⁴⁰ This means that it can be problematic not only to attempt to 'counteract' symptoms; it may also be hard to 'target' them.

FEATURES OF COMPLEX TRAUMA IMPORTANT FOR ALL HEALTH AND HEALING INTERVENTIONS:

Lack of a 'felt sense' of safety prior to presenting issue

(impaired capacity to self-regulate is a hallmark of childhood trauma in particular; Courtois

⁷³⁵ Van der Hart et al, *The Haunted Self*, ibid, p. 224.

⁷³⁶ Ecker, Ticic & Hulley, *Unlocking the Emotional Brain*, ibid; Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (Vol.6, Issue 1, 2018), pp.1-92. Also Felitti & Anda, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare', ibid.

⁷³⁷ Johnstone & Boyle, *The Power Threat Meaning Framework*, ibid.

⁷³⁸ Also Felitti & Anda, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare', ibid.

⁷³⁹ Ecker, 'Clinical Translation of Memory Reconsolidation Research...', ibid, p. 7

⁷⁴⁰ Bloom & Farragher, *Destroying Sanctuary* (OUP, Oxford, 2011), p.16; emphasis added.

& Ford, 2009) Advice to focus on a safe/calming image or feeling may be destabilising (and the ability to 'focus' may itself be impeded; see final point).

Pervasive sense of shame

(a 'core affect' of complex trauma which presents 'not only as an acute emotional state' but as 'a more fundamental and enduring aspect of...personality structure'; Frewen & Lanius, 2015:206) Thus 'exposure-based therapies may not be the treatment of choice' (ibid: 207).

'Symptoms' are the outgrowth of coping strategies which were initially protective

(i.e. 'adaptive yet symptom-generating emotional learnings'; Ecker, 2018: 6; 'the problem is the solution'; ACE Study, 1998; 2010: 83). Thus 'targeting symptoms' - as is common in many short-term interventions - may be problematic.

High levels of dissociation

('Most people with complex PTSD have experienced chronic interpersonal traumatization as children' and 'have severe dissociative symptoms'; Van der Hart et al, 2006: 112).

Often undetected by clinicians, dissociation impedes client ability to focus and increases the risk of destabilisation.

An understanding of the core common features of complex trauma summarised in the above box can optimise short-term strategies, tools, and practices (as all treatment modalities and timeframes). *Without this foundational understanding, interventions which are not comprehensively integrated within a phased treatment approach⁷⁴¹ are contraindicated* (also see discussion regarding integration of a phased approach *within* short term psychotherapies below).

Knowledge of the differences between complex trauma and single-incident PTSD does inform some short-term 'non-traditional' treatment approaches. For example, drawing on Ecker, Ticic, & Hulley's work⁷⁴² on the impacts of subconscious (implicit) memory, EFT exponent Dawson Church notes that 'emotional learning' takes place at a somatic level, well before cognitive capacity and spoken language develop ('this type of learning is occurring at the level of the cells, in the deepest layers of the body').⁷⁴³ Hence less than 'good enough' attachment to primary caregivers can lead to chronic lack of attunement to one's own body, 'with reduced neural volume in the parts of the brain that govern awareness of the body's location in space'.⁷⁴⁴

The most disabling type of 'disorganised' attachment; i.e. '[t]he type of PTSD resulting from abuse by a caregiver [recall that disorganised attachment can also stem from childhood trauma which is not 'abuse'] is a very different matter from PTSD resulting from a single traumatic event in adulthood such as an auto accident'.⁷⁴⁵ For this reason, Church contends that it 'belongs in its own unique diagnostic category, complex PTSD or C-PTSD'⁷⁴⁶ (as in the ICD-11). In short, '[t]rauma that results from early childhood experience with caregivers is harder to treat than trauma acquired in adulthood'.⁷⁴⁷

4.6 Energy Psychology

'Energy Psychology (EP) is a family of brief, focused approaches to releasing stuck energy and unprocessed information in the mind-body system that is the result of unresolved trauma.'

⁷⁴¹ Cloitre, Courtois, et al *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, ibid, and see Chapter 3.

⁷⁴² Ecker, Ticic, & Hulley, *Unlocking the Emotional Brain*, ibid.

⁷⁴³ Church, *Psychological Trauma*, ibid, p.15; emphasis added.

⁷⁴⁴ Church, ibid, p.15; ref. Anderson, Teicher, Polcari, & Renshaw, 2002; emphasis added.

⁷⁴⁵ Church, *Psychological Trauma*, ibid, p.15

⁷⁴⁶ Church, *Psychological Trauma*, ibid.

⁷⁴⁷ Church, *Psychological Trauma*, ibid, p.42; citing van der Kolk, 2014:210,

'the clinically rapid results, supported by many outcome studies, may be due to the restoration of ventral vagal regulation of the flow of information and energy in the mind-body system. Polyvagal Theory helps explain phenomenological experience of clients during EP treatment.'

(Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', 2018: 270).

The field of Energy Psychology (EP) has been burgeoning for some time. It integrates methods from non-Western healing traditions into contemporary clinical practice. Energy Psychology regards psychological problems as the result of disruption of the body's energy system. While many still regard EP as controversial, it is increasingly recognised to have a scientific basis.⁷⁴⁸

Robert Schwarz, Executive Director of the Association for Comprehensive Energy Psychology, describes various attempts to explain mechanisms for the apparent rapid effectiveness of EP⁷⁴⁹ (see discussion of its most well-known varieties below). The initial explanation was that 'the treatment was engaging the energy system of the body' (hence the coinage 'energy psychology').⁷⁵⁰ Attempts have since been made to illuminate the neurological mechanisms involved. The advent of Polyvagal Theory may now account for the 'missing links': *'energy psychology protocols may be mediated by the vagal systems, and superbly effective at creating conditions that allow for natural healing to occur.'*⁷⁵¹

When the Polyvagal Theory of Stephen Porges (2011) is integrated with the interpersonal neurobiology of Dan Siegel (2015) 'a theoretical foundation for energy psychology (EP) emerges', in which the latter need no longer be framed 'as a strange alternative treatment' (Schwarz, 2018: 271).

In her foreword to David Feinstein's 2005 text *The Promise of Energy Psychology*⁷⁵² American neuroscientist and pharmacologist Candace Pert noted that Energy Psychology approaches 'can look quite odd'.⁷⁵³ Pert, a recognised researcher, lent her name to this work several years before Porges's elaboration of Polyvagal Theory. Feinstein is a respected psychologist who has laboured successfully for many years to bring EP's 'revolutionary tools for dramatic personal change' to professional and public consciousness.⁷⁵⁴

The field of *Energy Medicine* preceded that of *Energy Psychology*. The pioneering text *Energy Psychology* - 'the first academic book to introduce professionals to the field' - was written by Fred Gallo, PhD, published in 1998, and released in second edition in 2005.⁷⁵⁵ In 2004,

748 See, for example, David Gruder, PhD 'Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support', *Psychotherapy*: Official Publication of Division 29 of the American Psychological Association, (Vol.47, No.3, 2012), pp.39-42. Psychologist and Executive Director of the Association for Comprehensive Energy Psychology Robert Schwarz says '[t]he fact of the matter is that the research shows these approaches are remarkably fast and effective, and actually meet the criteria of evidence-based approaches, especially for PTSD and trauma', Robert Schwarz (citing Feinstein, 2010, 2012; Nelms, 2017), 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*; p.272. ; see Schwarz's summary of the published research findings, *ibid*; p.272. Also see the prior paper by Dawson Church, founder of the National Institute for Integrative Healthcare, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *Psychology* (Vol.4, No.8, 2013), pp.645-654 and information at 'What is Energy Psychology?' <https://www.energypsych.org/general/custom.asp?page=AboutEPv2>

749 See Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, *ibid*, p.273, for description of some of these proposals and studies over the previous fifteen years.

750 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.273.

751 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.273-4; emphasis added.

752 Candace Pert, 'Foreword', David Feinstein, Donna Eden & Gary Craig, *The Promise of Energy Psychology* (Penguin, New York, 2005), p. xiii

753 Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid*.

754 Note that 'revolutionary tools for dramatic personal change' is the subtitle of *The Promise of Energy Psychology*, significant sections of which discuss the research on which the presented 'tools' are based.

755 Fred P. Gallo, PhD, *Energy Psychology: Explorations at the Interface of Energy, Cognition, Behavior and Health*, 2nd edit. (Taylor & Francis, Boca Raton, Florida, 2005).

Feinstein (partner of prominent Energy Medicine practitioner Donna Eden)⁷⁵⁶ released a 40-hour computer-based training program *Energy Psychology Interactive*. Subsequently the journal *Clinical Psychology* called EP 'an exciting and rapidly developing realm', with research suggesting its methods to be 'very effective indeed, extremely rapid, and thoroughly gentle'.⁷⁵⁷ The research base and application of EP has developed exponentially since then and continues to do so.

In her introduction to *The Promise of Energy Psychology*, Pert described EP as 'a synthesis of practices designed to deliberately shift the molecules of emotion'.⁷⁵⁸ These practices, she said, 'have three distinct advantages over psychiatric medications': they are '*non-invasive, highly specific, and have no side effects*'.⁷⁵⁹

Current accounts of EP affirm these benefits in light of the principles of Polyvagal Theory. The characteristic 'acupoint tapping' of EP (*i.e.* '*a way of stimulating acupuncture points without the use of needles*')⁷⁶⁰ prompts 'cessation of subcortical messages of danger' in favour of 'an autonomic message of safety' in which '[s]ympathetic or dorsal vagal reactivity [is] replaced by ventral vagal regulation'.⁷⁶¹

4.7 Emotional Freedom Techniques (EFT) and Thought Field Therapy (TFT)

The two most well-known approaches of Energy Psychology are Emotional Freedom Techniques (EFT) and Thought Field Therapy (TFT), for which '[a] basic procedure, shared by both approaches, involves tapping on a prescribed set of acupuncture points'.⁷⁶²

Research shows that the pressure applied (*i.e.* 'acupressure') to the acupuncture points ('acupoints') 'can be as effective as acupuncture itself'.⁷⁶³ '*Acupuncture theory teaches that energy flows through our body through pathways called meridians. Disease can be caused by a blockage or interruption of that flow, and acupuncture or acupressure can be used to remove those blockages*'.⁷⁶⁴

The potential of stimulating the physical body ('somatic stimulation') to foster psychological healing was increasingly recognised in the second half of the twentieth century. It thus predates the field now known as Energy Psychology. As Church reminds us, psychiatrist Wilhelm Reich coined the term 'muscular armour' in the 1920s 'based on his observations that emotional trauma can result in rigidity in certain regions of the body'.⁷⁶⁵

'In the 1970s, clinical psychologist Roger Callahan found that clients made rapid shifts in psychological trauma when psychotherapy was combined with tapping on acupressure points...'

In the 1990s Callahan's method was simplified as EFT and published in a manual.'

756 With whom Feinstein has co-authored and presented, furnishing the academic and research base for Eden's deeply intuitive experiential approach. Also see Donna Eden with David Feinstein, PhD *Energy Medicine* (Pergamon, New York, 2008).

757 See Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid*, p.9.

758 Pert, 'Foreword', *The Promise of Energy Psychology*, *ibid*, p. xii.

759 Pert, 'Foreword', *ibid*; emphasis added.

760 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.270; emphasis added.

761 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.275.

762 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.271. For further on EFT, see 'Emotional Freedom Techniques (EFT)' <https://www.eftdownunder.com/energy-techniques/what-is-emotional-free-dom-techniques-eft/> and on TFT see John Diepold, Jr, Victoria Britt, & Sheila Bender, *Evolving Thought Field Therapy: The Clinician's Handbook of Diagnoses, Treatment, and Theory* (Norton, New York, 2004).

763 Dawson Church, ref Cherkin et al, 2009, *Psychological Trauma*, *ibid*, p.10.

764 Church, *Psychological Trauma*, *ibid*, p.10.

765 Church, *Psychological Trauma*, re Reich, 1927, *ibid*, p.11.

(Church, 2015: 11, ref Callahan, 2000; Craig & Fowlie, 1995; Church, 2013).

Subsequent research and studies have upheld the effectiveness of EFT for a range of mental health problems.⁷⁶⁶ In the past two decades it has moved 'from a fringe therapy to widespread professional acceptance.'⁷⁶⁷ The 'basic procedure' of both EFT and TFT – i.e. the application of 'acupressure' via the tapping of acupoints⁷⁶⁸ – is as follows:

*'Relative to most other forms of treatment, these 'tapping' approaches are quite similar. At the most basic level, they involve having the client focus on a 'target' thought, memory, sensation, or feeling that is associated with distress. At the same time, the client taps on selected acupoints. Clients report changes in their unfolding experience, including their sense of distress. The process is repeated until the distress levels are eliminated or vastly reduced.'*⁷⁶⁹

EFT, TFT and the Energy Psychology 'family' to which they belong are *experiential, non-verbal, 'bottom-up'* techniques and therapies:

'It is very important to note that in TFT and in many forms of EFT, there is little to no attempt to actively and consciously change the cognitions and meaning-making activity of the clients with regard to what happened in the memory. There is no attempt to help the clients see that they are now safe or to provide an alternative explanation or interpretation for what happened. However, the meaning making of the clients often spontaneously changes.'

(Schwarz, 2018:272).

It is also important to note that:

'There is an exception to [the above] comment. In EFT, the client is asked at the beginning of each round of treatment to tap on a meridian point and use the 'set up' phrase that includes the statement, 'Even though _____ [the client inserts the aversive aspect of the memory being targeted], I deeply and completely accept myself'. This type of statement can be regarded as facilitating self-compassion. It is important to note that there is no attempt to change any other attribution.'

(Schwarz, *ibid*)

766 See Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *ibid*; also James Lane, 'The Neurochemistry of Counterconditioning: Acupressure Desensitization in Psychotherapy', *Energy Psychology: Theory, Research, and Treatment* (1, 1, 2009), pp.31-44; Gruder, 'Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support', *ibid*, and Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*.

767 Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *ibid*, p.645.

768 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, p.271.

769 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, pp.271-2.

Schwarz states that when a client is requested to think about the original distressing memory after 'a few rounds of tapping', they often have 'a quizzical facial expression' and say something like: *'This is strange. I can think of the event, but it doesn't bother me anymore. It's just kind of gone'*.⁷⁷⁰

Follow up questions often reveal 'that the client actually remembers the event, but no longer experiences body-based feelings of danger'.⁷⁷¹ This process and effect illustrate, Schwarz says, that consistent with the principles of the Polyvagal Theory, '[s]ympathetic or dorsal vagal reactivity has been replaced by ventral vagal regulation'.⁷⁷²

To what extent might this process be as effective for clients who experience complex, as distinct from 'single-incident', trauma? Additional issues may arise in relation to the potentially very contrasting context/s of complex trauma. For example, the above account describes a soldier who may have 'frozen' in a combat situation⁷⁷³ (i.e. rather than a survivor of childhood trauma who may experience the cumulative impacts of interpersonal betrayal).

4.8 Complications in the context/s of complex trauma

'Targeting' a symptom or memory may be difficult in complex *cumulative* trauma as discussed. This raises questions about the applicability of Energy Psychology techniques with complex trauma clients.

Inviting a complex trauma client to focus on a particular memory, especially early in treatment as in brief short-term therapy approaches, may be destabilising.

This applies even if the client can 'target' a memory in the first place (hence the emphasis by complex trauma clinicians on phased treatment so a client can stabilise and self-soothe).

As with the risks of precipitate exposure treatments/s (see Chapters 3 and 5) complex trauma does not relate to memories which are merely 'upsetting' or 'unpleasant'. Rather the memories of cumulative complex trauma, especially from early childhood, are often unbearable, implicit, and have been dissociated for this reason (also noting that clinicians may fail to recognise dissociation when it occurs in session).

A practitioner's reassurance to 'start with' a less distressing memory will not necessarily prevent a client from being overwhelmed. This is because even seemingly less intense 'single' recollections often elicit a cascade of memories which can quickly become disorienting.⁷⁷⁴

The role of prior overwhelming experience in generating initially adaptive coping strategies, the subsequent generation of symptoms via triggering of implicit memory, and the frequent 'interlacing' of maladaptive and resilient coping skills (Bloom & Farragher, 2011: 16) raise treatment challenges. These may not be apparent to a practitioner who is unaware of the nature and impacts of complex trauma (and may remain challenging for the practitioner who is aware).

770 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*, pp.275; emphasis added.

771 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*.

772 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*.

773 Schwarz, 'Energy Psychology, Polyvagal Theory and the Treatment of Trauma', *ibid*.p.272.

774 I.e. due to the phenomenon of 'kindling' as per Scaer (2005) which is high-risk in relation to complex trauma in particular [i.e. applies to single-incident trauma as well] where 'what started out as a single-event trauma requiring minimal resourcing' catalyses underlying childhood trauma and major attachment issues (Schwarz, Corrigan et al, *The Comprehensive Resource Model* (Routledge, New York, 2017), p.132-3)

Incorporation of the EFT set-up phrase *'Even though...'* (see above illustration) can also be questioned in contexts of complex trauma. While clearly intended to promote self-compassion, the deep and pervasive shame which is a signature feature of complex trauma⁷⁷⁵ suggests that articulation of the characteristic words *'I deeply and completely accept myself'* may be 'a bridge too far' for many survivors.

The frequent excoriating self-criticism, and the difficulty many complex trauma clients have in responding to and processing compassion from others as well as applying it to themselves, means that the 'standard' EFT statement is somewhat problematic.

It is, of course, possible to substitute a less comprehensively affirming declaration than *'deep and complete acceptance of self'* (at least in the early stages of therapy and possibly longer). This 'standard' EFT phrase may need to be adapted for complex trauma. EP practitioners already adapt it for other contexts and contingencies of client situation, preference and need.⁷⁷⁶

Issues surrounding the apparent 'rapid' resolution of distressing memories for a complex trauma client are substantial. Clients are apparently frequently surprised by the speed with which previous distress around 'target' memories often resolves following brief rounds of tapping (Schwarz, 2018: 275). Even if this is the case for complex trauma clients, rapid resolution could itself unsettle a client who has little experience of positive change.

What does resolution of previously distressing memory/ies constitute for the client who has experienced ongoing, cumulative interpersonal trauma from an early age? That is, as compared to a client with single-incident 'adult onset' trauma who can resume healthy functioning when the presenting issue resolves?

These two situations are not comparable. This also explains why the 'third phase' of phased therapy for complex trauma can take a significant amount of time. Considerable time may be needed to assimilate and integrate the residue and legacy of trauma 'processing'.⁷⁷⁷

4.9 Potential benefits

The caveats in the previous section do not necessarily preclude the potential benefits of EFT and of EP interventions/approaches in treating complex trauma. Indeed many EP practitioners are well aware of some of these points and are taking appropriate steps to address them. Rather the cited qualifications highlight the need for adaptation of and particular care around EP protocols as all methods and modalities (see upcoming discussion).

Interestingly, Church distinguishes EFT among therapeutic approaches in making 'deliberate and systematic use of dissociation in the healing process'.⁷⁷⁸ EFT recognizes, he says, 'that dissociation can perform a protective function', and '[t]he EFT Manual...describes three 'Gentle Techniques' for working on events so traumatic they cannot be approached in ordinary states of consciousness'.⁷⁷⁹

775 As noted in the initial chapters of this report, and as now recognised in the new CPTSD diagnosis, shame is increasingly acknowledged to be 'a core affect' of complex trauma; presenting 'not only as an acute emotional state', but as 'a more fundamental and enduring aspect of... personality structure; in many traumatized persons the experience of shame essentially *defines who they are*' (Frewen & Lanius, *Healing the Traumatized Self*, *ibid*, p.206; original emphasis)

776 As per Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid*.

777 For discussion of the nature and tasks of the third phase of staged treatment for complex trauma, see Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, *ibid*, Chu, *Rebuilding Shattered Lives*, *ibid*, and Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, *ibid*.

778 Church, *Psychological Trauma*, *ibid*, p.42.

779 Church, *Psychological Trauma*, *ibid*, ref. Church, 2013.

Reference to events 'so traumatic they cannot be approached in ordinary states of consciousness' clearly evokes the realms of complex trauma and dissociation (to which, Church believes, EFT may be particularly suited). While it is not the case that EFT is 'unique among therapeutic approaches' in utilising dissociative processes to activate healing (clinical hypnotherapy certainly does this)⁷⁸⁰ the techniques to which he refers merit consideration.

One of the three 'Gentle Techniques' in the EFT toolbox is that of 'Tearless Trauma'. As Church describes, it 'allows clients to introduce as many layers of dissociation between themselves and the event [memory of which is causing distress] as they desire'.⁷⁸¹ For example, he describes a client so unnerved by the possibility of recalling traumatic memories of child sexual abuse that she placed them in a metaphorical 'box' sealed shut with eight padlocks, inside a safe which she relegated to outer space.⁷⁸²

Using the Subjective Units of Distress scale ('SUDS') of 0 - 10, a widely used tool in diverse forms of psychological practice, the memory/ies were tapped on until the box could be removed from the vault, opened, its contents registered, 'turned into sea sand, and then [blown] away in the wind'.⁷⁸³ The 'Tearless Trauma' technique deliberately utilised dissociation to allow the client 'enough distance from the trauma to begin to work on it'.⁷⁸⁴

'The three Gentle Techniques allow the client to dissociate just enough to feel safe, while also tapping. This creates enough psychological distance from the event to allow the client to begin the healing process. The felt sense of safety engendered by the Gentle Techniques quickly demonstrates to the client that it may be possible to reduce the degree of emotional triggering around the event. With this encouragement, the client then approaches the event at his or her own pace, dissociating less and less until he or she is able to tap on the memory itself without dissociation'

(Church, 2015: 42).

Externalising experiences too traumatic on which to focus - i.e. whereby the client does not direct attention to but rather distances *from* them - is a common technique of diverse trauma therapies. It is also often deployed for memories of experiences which are distressing but not necessarily traumatic. 'Dissociation' from the distress is indeed utilised therapeutically although not necessarily used and conceptualised in the same way. The difference between these interventions and Church's gentle 'Tearless Trauma' technique is that in EFT, dissociation is paired with tapping which provides somatic stimulation at the same time.

The above example illustrates way/s in which contrasting techniques, interventions, and methods can potentially combine to optimise the therapeutic effect. Effective therapy for complex trauma should entail safe methods by which dissociation may be reduced. As illustrated above, this may include partial utilisation of dissociation - the very mechanism in need of remediation - *in combination with* a 'bottom-up' approach.

The application and extension of EFT and 'tapping' (also see below) to diverse issues and contexts (i.e. professional and non-professional; by trained practitioners but also in the domain of self-help) raises familiar questions about safety as well as credibility. Church contends that EFT appears to be safe whether administered by therapist, life coach, or self.⁷⁸⁵

780 See, for example, Herbert Spiegel & David Spiegel, *Trance and Treatment: Clinical Uses of Hypnosis*, second edit. (American Psychiatric Publishing, Inc, Washington DC, 2004). Also see subsequent discussion.

781 Church, *Psychological Trauma*, *ibid*, p.42.

782 Church, *Psychological Trauma*, *ibid*, pp.42-3.

783 Church, *Psychological Trauma*, *ibid*, p.43.

784 Church, *Psychological Trauma*, *ibid*, pp.43-4.

785 Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *ibid*, p.650.

Writing in 2013 (with more research studies conducted since) he noted that over 1000 subjects had participated in EFT trials 'without a single adverse event being reported'.⁷⁸⁶ Feinstein likewise extols the research base for the 'powerful tools for personal development' he presents in *The Promise of Energy Psychology*.⁷⁸⁷

Feinstein does, however, caution that a proportion of the population may experience issues so severe that 'they should not attempt *any* potent healing intervention without the presence and guidance of a skilled professional'.⁷⁸⁸ Notably, dissociative disorders and severe trauma are conditions for which his co-written book 'is not presented as an independent 'self-help' resource'.⁷⁸⁹ In this respect *The Promise of Energy Psychology* is similar to the otherwise different 'self-help' text *Healing Trauma* by Peter Levine.⁷⁹⁰ In this text (and accompanying CD) Levine likewise offers a range of healing strategies for the general public while advising the importance of therapist assistance as needed.⁷⁹¹

Energy Psychology approaches may have much to contribute to complex trauma treatment. Depending on the nature and timing of their use, the 'rapidity' of EP may not necessarily be problematic. Church cites therapists treating survivors of childhood sexual abuse who '*preferred energy psychology treatments such as EFT over talk therapy because they found the risk of abreaction low with the former*'.⁷⁹² Schulz's 2009 study 'Integrating Energy Psychology into Treatment for Adult Survivors of Childhood Sexual Abuse'⁷⁹³ evaluates the experiences of twelve therapists who integrated EP interventions for this cohort. It also presents recommendations for clinicians who are interested to pursue these possibilities.

4.10 Eye Movement Desensitization and Reprocessing therapy (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) therapy is an innovative but now well established and well evidenced treatment approach. It was developed by psychologist Francine Shapiro in the late 1980s. Described as a 'powerful, well-researched treatment for trauma that incorporates alternating bilateral stimulation into a structured therapy',⁷⁹⁴ Shapiro found 'that people could process a trauma memory at an accelerated rate when it was paired with bilateral stimulation'.⁷⁹⁵

Bilateral stimulation is defined as '[t]he use of eye movements, tactile sensations, sounds or physical movements to stimulate the left and right hemispheres...of the brain'.⁷⁹⁶ In activating and integrating information from these two brain hemispheres, the therapeutic aim is to access latent resources which can be strengthened and utilised to therapeutic benefit.⁷⁹⁷

786 Church, 'Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions', *ibid.*

787 Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid.*, p.26.

788 Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid.*

789 Feinstein, Eden & Craig, *The Promise of Energy Psychology*, *ibid.*

790 Peter Levine, *Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body* (Sounds True, Colorado, 2008).

791 Levine, *Healing Trauma*, *ibid.*

792 Church 2013, p.650, citing Schulz, 2009. He further notes that 'Mollon (2007) reports a general reduction of client distress during acupoint tapping, while Flint, Lammers, and Mitnick (2005) remark on the absence of abreactions during energy psychology treatments' (*ibid.*).

793 Kirsten Schulz, PsyD, 'Integrating Energy Psychology into Treatment for Adult Survivors of Childhood Sexual Abuse' *Energy Psychology: Theory, Research, & Treatment* (1, 1, 2009), pp. 15-22.

794 Laurel Parnell, PhD, *Tapping In* (Sounds True, Boulder, Colorado, 2008), p.14; emphasis added.

795 Parnell, *Tapping In*, *ibid.*, p.14.

796 Parnell, *Tapping In*, *ibid.*, p.30.

797 Where 'activation' is defined as '[b]ringing a resource into consciousness through your imagination so that all of your senses are alive, and its qualities are available to you' (LP, TI, p.31).

In 2018, three decades after its initial formulation, the third edition of Shapiro's *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*⁷⁹⁸ became available. In her prefatory comments, Shapiro noted that '[s]ince the early days of controversy' over thirty randomised studies have verified the approach, and 'hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations.'⁷⁹⁹

Certification in EMDR, i.e. to practice this modality as a health professional, requires formal training and qualification. Institutes and associations around the world provide opportunities to undertake approved programs (the EMDR Association of Australia was founded in 1998). As with Energy Psychology, which likewise requires formal qualifications for practice,⁸⁰⁰ EMDR has also generated self-help techniques which are widely practised and which are promoted by Shapiro herself in her 2012 publication *Getting Past Your Past*.⁸⁰¹

This text for the general public has been widely endorsed by key researchers and clinicians from outside the EMDR field. Norman Doidge describes EMDR as '*one of the most important breakthroughs in the history of psychotherapy*', declaring that he and his patients '*still marvel at the depth and speed with which it can help heal and change the mind and brain, and even body symptoms of people who have been locked in suffering from trauma for decades*'.⁸⁰² Dan Siegel describes it as 'a life-transforming gift to the world' supported by 'rigorous development of a science-validated approach to soothing the suffering of our small and large life traumas'.⁸⁰³

Bessel van der Kolk is similarly effusive ('a lucid and practical book for transforming people's lives').⁸⁰⁴ And Stephen Porges contends that *Getting Past Your Past* 'provides readers with powerful new insights to understand how traumas and disturbances of all kinds disrupt human potential and how they can deal with their own distress'.⁸⁰⁵ While shown to be efficacious for treatment of standard PTSD, how effective is EMDR for treatment of the particular challenges of complex trauma?

In fact the effectiveness of initial practice of EMDR was what rendered it problematic in cases of cumulative trauma. This is because unsuspected prior trauma (i.e. which preceded the particular memory 'targeted' for processing) was rapidly activated and brought to the surface. This destabilised clients and therapists alike who were unprepared (as distinct from unwilling) to deal with this.

This unexpected outcome prompted a 1996 Dissociative Disorders' Task Force meeting and subsequent position paper. The paper presented guidelines for applying EMDR in the context of dissociative disorders.⁸⁰⁶ In 2009, a review of EMDR in the treatment of complex PTSD⁸⁰⁷ presented 'a phase oriented EMDR model' which emphasised 'the role of resource development and installation (RDI) and other strategies that address the needs of patients with compromised affect tolerance and self-regulation'.⁸⁰⁸

798 Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd edit (The Guilford Press, Washington, DC, 2018).

799 Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, *ibid*, p.vii.

800 See <https://energypsychologytraining.com/>

801 Francine Shapiro, *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (Rodale, New York, 2012).

802 Norman Doidge, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

803 Dan Siegel, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

804 Bessel van der Kolk, Shapiro, *Getting Past Your Past*, *ibid*.

805 Stephen Porges, endorsement of Shapiro, *Getting Past Your Past*, *ibid*.

806 Francine Shapiro, *Dissociative Disorders Task Force Position Paper*, Presentation at the International Society for the Study of Dissociation 13th Annual Conference (San Francisco, CA, 1996) doi:10.1037/e609292012-016

807 Deborah L. Korn 'EMDR and the Treatment of Complex PTSD: A Review' *Journal of EMDR Practice and Research* (3, 4, 2009), pp.264-278.

808 Korn, 'EMDR and the Treatment of Complex PTSD: A Review', *ibid*, p.264.

The 2009 review noted the ‘strong arguments that the patient characteristics associated with childhood abuse survivors and complex PTSD patients (e.g., difficulty tolerating distress and certain emotional states, vulnerability to dissociation, difficulty maintaining a stable therapeutic relationship) *require a phase-oriented, multicomponent approach, emphasizing initial skill development and stabilization*’.⁸⁰⁹

The review also considered ‘EMDR treatment goals, procedures, and adaptations for each of the various treatment phases (stabilization, trauma processing, reconnection/development of self-identity)’ and what were claimed to be ‘the strengths and unique advantages of EMDR in treating complex PTSD’.⁸¹⁰

In the 2018 third edition of *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, Shapiro is explicit that with respect to complex trauma ‘the preparation phase needs to be carefully implemented, potentially over a longer period of time than usual, to ensure stability during processing and between sessions’.⁸¹¹

‘No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population... The clinician should also have a clear understanding regarding strategies for assisting the client in managing intense affect during EMDR processing, the client’s dissociated system, and the client’s defensiveness and resistance. The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously’

(Shapiro, 2018: 342-343; emphasis added).

An EMDR practitioner experienced in treating dissociative disorders notes that:

‘When working with EMDR in simple trauma, we directly search for the memories that are connected to present symptoms, and access and process them following an eight-phase protocol. In complex trauma and dissociation, we may find many difficulties in memory access and in maintaining dual attention, as well as blockages during processing; we may even find that establishing a therapeutic relationship is challenging.’

(Gonzalez, 2018: 201; emphasis added).

A subgroup of clinicians within the EMDR field are now attuned to the many challenges of utilising this modality in the context of complex trauma and dissociation, and have adapted and refined the ‘standard protocol’ to address these. They include Anabel Gonzalez,⁸¹² Sandra Paulsen,⁸¹³ Carol

809 Korn, ‘EMDR and the Treatment of Complex PTSD’, *ibid*, p.275; emphasis added,

810 Korn, ‘EMDR and the Treatment of Complex PTSD’, *ibid*, p.264.

811 Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy*, *ibid*, p.289.

812 Anabel Gonzalez & Dolores Mosquera, *EMDR and Dissociation: The Progressive Approach* (Createspace, CA, 2012). Also see Gonzalez, ‘Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures’, *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2, 2018, pp.192-211); Gonzalez, Del Rio-Casanova & Justo-Alonso, ‘Integrating Neurobiology of Emotion Regulation and Trauma Therapy: Reflections on EMDR Therapy’, *Reviews in the Neurosciences* (28, 4, 2017), pp.431-440.

813 Sandra L. Paulsen, ‘Neuroaffective Embodied Self Therapy (NEST): An Integrative Approach to Case Formulation and EMDR Treatment Planning for Complex Cases’ *Frontiers in the Psychotherapy of Trauma and Dissociation*, (1, 2, 2018); also see Paulsen’s 6-part Youtube videos ‘When EMDR is Not Enough’ <https://www.youtube.com/watch?v=MHzBYXzCRgI>

Forgash,⁸¹⁴ Shirley Jean Schmidt,⁸¹⁵ and Jim Knipe.⁸¹⁶ Onno van der Hart has also made significant contributions in this regard.⁸¹⁷

It needs to be noted, however, that such adaptation is not typical of the EMDR field overall. Some EMDR clinicians also find Shapiro's comments about amending the modality for work with dissociative clients unclear.⁸¹⁸ The role of EMDR therapy 'as an alternative for the treatment of dissociative disorders' is also disputed.⁸¹⁹ This is notwithstanding a recent systematic review which 'suggests that there is growing evidence to support the clinical efficacy of EMDR in treating CT in both children and adults'.⁸²⁰

Note that skill in working with clients with complex trauma-related dissociation is currently the exception rather than the norm among EMDR practitioners.

4.11 Attachment-Focused EMDR and resource tapping

Significant adaptations continue to develop within the EMDR field. Increased attunement to the challenges of trauma-related dissociation is apparent in the Attachment-Focused EMDR of Laurel Parnell.⁸²¹ This adaptation emphasises the need for client resource-building prior to trauma processing when working with complex trauma. It aligns to the 2009 review which recommended 'resource installation' [RDI]⁸²² and is particularly suited to working with adult survivors of childhood trauma with disrupted attachment and self-regulatory deficits.

Parnell's development of an attachment-based form of EMDR provides a framework for fostering internal client resources from the ground up (Parnell, 2013).

It is specifically attuned to the dynamics of working with relational trauma, in which *'the structural foundations of this integrative framework are adapted to further catalyze integration for individuals who have experienced non-secure attachment and developmental trauma'*

(Parnell, *ibid*).

814 Carol Forgash, 'Healing the Heart of Trauma and Dissociation with EMDR and EGO State Therapy', <https://www.youtube.com/watch?v=5Myz2DnjrlA>

815 Shirley Jean Schmidt, 'Internal Conference Room Ego-State Therapy and the Resolution of Double Binds: Preparing clients for EMDR trauma processing' EMDIR Newsletter reprint at <https://www.dnmsinstitute.com/doc/db-prep.pdf> 1998 ; Schmidt, *The Developmental Needs Meeting Strategy (DNMS): An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* (DNMS Institute, Texas, 2009).

816 Jim Knipe, 'Loving Eyes: Procedures to therapeutically reverse dissociative processes while preserving emotional safety', in Carol Forgash & Margaret Copeley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (Springer, New York, 2007), pp.181-225.

817 Onno Van der Hart, Mariette Groenendijk, et al al. 'Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in the Stabilisation Phase', *Journal of EMDR Practice and Research* (7, 2, 2013) pp.81-94; Onno Van der Hart, Mariette Groenendijk, et al al. 'Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in Phases 2 and 3 Treatment', *Journal of EMDR Practice and Research* (8, 1, 2014), pp.33-48.

818 In the view of Gonzalez, '[a]lthough Shapiro's (2018) proposals stress the importance of working with the dissociative structure, some of her statements may be somewhat confusing' (Gonzalez, 'Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures', *ibid*, pp.194-195.

819 Gonzalez, 'Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures', *ibid*, p.192.

820 Runsen Chen, Amy Gillespie et al, 'The Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adults Who Have Experienced Complex Childhood Trauma: A Systematic Review of Randomized Controlled Trials', *Front. Psychol.*, 11 April 2018 <https://doi.org/10.3389/fpsyg.2018.00534>

821 Laurel Parnell, *Attachment Focused EMDR: Healing Relational Trauma* (Norton, New York, 2013). Parnell is also the author of *A Therapist's Guide to EMDR: Tools and Techniques for Successful Treatment* (Norton, New York, 2007).

822 Korn, 'EMDR and the Treatment of Complex PTSD', *ibid*.

The work of Parnell conveys the importance of RDI in working with adult survivors. Parnell is also the author of *Tapping In: A Step-by-Step Guide to Activating Your Healing Resources through Bilateral Stimulation*.⁸²³ Affirming the value of tapping (defined as use of the hands 'to alternately tap (right-left, right-left) on the knees, legs or shoulders in order to achieve bilateral stimulation' (as well as via other methods such as alternatively tapping the feet on the floor 'or simply tapping any surface with your fingers')⁸²⁴ Parnell distinguishes 'resource tapping' which is related to but also different from EMDR.⁸²⁵

*Resource tapping is 'a technique that pairs an activated resource with alternating bilateral stimulation via tapping to strengthen and integrate the resource.'*⁸²⁶

Described as 'a modern psycho-spiritual method that echoes the spiritual technology of Tibetan and other meditative traditions, and is also influenced by hypnotherapy, guided imagery, positive psychology, and EMDR,' these diverse influences 'combine to provide a powerful and effective method for harnessing the power of the resources latent within us.'⁸²⁷

As Parnell explains,

*'In the early days of EMDR we discovered that bilateral stimulation could also be used in a focused way to activate and strengthen certain resources within our clients. The first resource to be tapped in was the safe place... This practice, called 'installing a safe place', helped traumatized people feel safer and was used by therapists prior to beginning EMDR sessions.'*⁸²⁸

Subsequent to this discovery, practitioners became increasingly aware of the diversity of resources which could be 'tapped' to assist work with trauma survivors:

*'Later we found that we could tap in many different kinds of resources – such as images of nurturing figures, protector figures, and inner wisdom figures – to help strengthen and stabilize clients who had been severely traumatized in childhood. Resource tapping became an important tool in helping to prepare clients for the difficult EMDR trauma processing work.'*⁸²⁹

The 'discoveries' described above highlight some of the evolving insights derived from working with complex trauma survivors (and their inclusion in some, though not all, applications of EMDR).

They also underline that many new and established psychotherapeutic modalities are benefitting from and incorporating some of the learnings of accumulated clinical experience (*where all modalities that are not trauma and also dissociation-informed need to be adapted for working with trauma in general and complex trauma in particular*).

Tapping of client 'resources' (whether literally or figuratively) is problematic in the context of complex trauma, which especially if relating to childhood experience, disrupts internal development. As

823 *Tapping In: A Step-by-Step Guide to Activating Your Healing Resources through Bilateral Stimulation* (Sounds True, Boulder, Colorado, 2008),

824 Laurel Parnell, *Tapping In*: ibid, p.31.

825 Parnell, *Tapping In*, ibid, p.18.

826 Parnell, *Tapping In*, ibid, p.31.

827 Parnell, *Tapping In*, ibid, p.7.

828 Parnell, *Tapping In*, ibid: 16-17.

829 Parnell, *Tapping In*, ibid, p.17. For a demonstration of resource tapping, see Laurel Parnell 'Installing Resources: An Attachment-Focused EMDR™ In-session Demonstration [PESImentalhealth](https://www.youtube.com/watch?v=MH3tKSbkje0) Published May 2, 2017 <https://www.youtube.com/watch?v=MH3tKSbkje0>

noted previously, while the premise of latent inner resources within all of us is potentially highly therapeutic, the situation is different for survivors of complex childhood trauma whose early life experience did not assist and may have actively impeded development of foundational resources.⁸³⁰

This means that the very concept of safety may be alien, a subliminal reminder of manipulation by perpetrators, or otherwise triggering.⁸³¹ A therapist's presumption that a client has had a prior felt sense of safety may not only be incorrect but counterproductive and destabilising.

Resource installation - while not necessarily described by this term or encouraged by 'tapping' - is key to diverse approaches to treatment of complex trauma. The number and nature of potential resources, particularly at a symbolic level, is potentially infinite.

Resource tapping in the literal sense described above, although 'related to EMDR, is essentially a different model.⁸³² In EMDR, focus is on the trauma memory, bilateral stimulation is engaged, and a protocol is administered 'that allows the unfolding of a free-associative processing':⁸³³

'In contrast, when we tap in resources we focus on the positive resource and only allow a short amount of bilateral stimulation. We keep the work focused exclusively on the positive, healing resources and do not allow a free flow of processing....I do not allow myself to tap for too long. If I do, I risk activating anxiety-producing information.'⁸³⁴

As the above caution reveals, Parnell's 'Attachment-focused EMDR' for relational trauma is expressly designed to minimise the potential for harm and the risks of inadvertent retraumatisation.⁸³⁵ So, too, are other adaptations of EMDR in order to better meet the needs of dissociative clients with complex trauma histories.⁸³⁶ *In the absence of such adaptations, the risks of 'standard' EMDR protocols in the context of complex trauma are high.*⁸³⁷

The potential for client destabilisation - particularly with developmental trauma, particularly in the early stages of therapy, and particularly if utilising a potent modality - is high. Attention to client resourcing, ability to self-soothe, and acquisition/restoration of self-regulatory capacity is an essential prelude to trauma processing.

830 Resources are defined by Parnell in this context as '[i]nherent qualities such as love, wisdom, strength and joy, as well as memories, experiences, mental images, or people to whom we connect. Resources reside within us' (Parnell, *Tapping In*, *ibid*, p.30).

831 As Parnell also points out, '[f]or some people the word 'safe' immediately evokes associations to its opposite, 'unsafe'. People who experienced being unsafe repeatedly may think about those experiences when the word 'safe' is used' (Parnell, *Tapping In*, *ibid*: 47). In such instances Parnell suggests reference to a 'peaceful' or 'comfortable' place instead (Parnell *ibid*: 48). Although potentially unfamiliar too, these terms may be less problematic than safety which is more overarching, and its presumption by the therapist could itself be destabilising.

832 Parnell, *Tapping In*, *ibid*, p.18. Nor is it a model that is confined to working with trauma - 'Over the years resource tapping has expanded and developed considerably...Moreover, tapping in has expanded beyond EMDR and trauma work' (Parnell, *ibid*, p.17).

833 Parnell, *Tapping In*, *ibid*, p.18.

834 Parnell, *Tapping In*, *ibid*.

835 Also see Debra Wesselmann, Stefanie Armstrong et al, 'An Integrative EMDR and Family Therapy Model for Treating Attachment Trauma in Children: A Case Series', Research Article, *Journal of EMDR Practice and Research* (12, 4, 2018) DOI: 10.1891/1933-3196.12.4.196

836 As per the work of Gonzalez & Mosquera (2012), Paulsen (2018), Schmidt (2009), Forgash & Copeley (2007) and see previous discussion.

837 As per Shapiro's explicit advice that '[n]o clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population...The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously' (Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, third edition, *ibid*, pp. 342-343; emphasis added).

In their text *Freedom from Pain*,⁸³⁸ which includes a summary of resources and which notes that much chronic pain is trauma-related, Maggie Phillips and Peter Levine are salutary in their comments regarding EMDR. Noting the more recent developments within the EMDR field which emphasise the development of resources prior to trauma processing, Phillips and Levine ‘strongly recommend’ that if using EMDR, and ‘especially if you have significant trauma in your history... you work with an EMDR therapist who is skilled with resource installation as well as trauma processing’.⁸³⁹

4.12 Brainspotting

‘Where you look affects how you feel’
(Grand, 2013)

Brainspotting is a ‘new’ and current psychotherapy for trauma treatment and other issues which has been compared to but also differs significantly from EMDR. David Grand, its founder, says ‘where you look affects how you feel’.⁸⁴⁰ This applies quite literally in Brainspotting, in that we feel different according to where our eyes focus.

Less than two decades old, Brainspotting (BSP) is a psychotherapy now practised by over 12,000 therapists around the world with fifty trainers on seven continents. Significantly, it has been found to be the most efficacious therapy for the people impacted by the mass shooting at Sandy Hook Elementary School, Newtown Connecticut in 2012.⁸⁴¹ A recent multicentre longitudinal study which compared it to EMDR as a trauma treatment suggests that BSP is ‘an effective alternative therapeutic approach’.⁸⁴²

Differing from EMDR in its emphasis on fixed, rather than moving, eye position as well as in other respects, Brainspotting was ‘discovered’ by Grand in his work with a client in 2003.⁸⁴³ It has since developed into a distinctive psychotherapy which rapidly locates the ‘spot’ at which trauma or any negative experience is located in the brain, which in turn facilitates its processing when the corresponding feelings and sensations are focused upon.⁸⁴⁴

The point at which our eyes fix is where we are held to be the most activated. Lingering at this exact point and observing the accompanying internal experience is a ‘fast track’ to where trauma or other negative experience is held in the brain, thus precipitating its rapid processing
(Grand, 2013; Corrigan, Grand & Raju, 2015).

838 Maggie Phillips & Peter Levine, *Freedom from Pain* (Sounds True, Boulder, CA, 2012)

839 Phillips & Levine, *Freedom from Pain*, *ibid*, p.167.

840 David Grand, ‘What is Brainspotting?’ Published Dec 23, 2014 <https://www.youtube.com/watch?v=lm3Plvaf3UE> And see <https://brainspotting.com/>

841 ‘Report of Findings from the Community Survey, September 2016’, Newtown-Sandy Hook Community Inc <http://www.emdrandpsychotherapy.com/wp-content/uploads/delightful-downloads/2016/09/2016-NSHCF-Community-Assessment-Report.pdf>

842 Anja Hildebrand, David Grand & Mark Stemmler, ‘Brainspotting – the efficacy of a new therapy approach for the treatment of Posttraumatic Stress Disorder in comparison to Eye Movement Desensitization and Reprocessing’ *Mediterranean Journal of Clinical Psychology* (15, 1, 2017). For further research on BSP, see Frank Corrigan & David Grand, ‘Brainspotting: Recruiting the midbrain for accessing and healing sensorimotor memories of traumatic activation’, *Medical Hypotheses* (80, 6, 2013, p759-766) and Corrigan, Grand & Raju, *Brainspotting: Sustained attention, spinothalamic tracts, thalamocortical processing, and the healing of adaptive orientation truncated by traumatic experience*, *Medical Hypotheses* (84, 4, 2015), pp.384-394

843 David Grand, *Brainspotting: The Revolutionary New Therapy for Rapid and Effective Change* (Sounds True, Boulder, CO, 2013); ‘What is Brainspotting?’ <https://brainspotting.com/>

844 Grand, *Brainspotting*, *ibid*.

Brainspotting is thus very precise, as well as rapid, in its harnessing of the ability of the brain to process negative experience efficiently when the exact source ('spot') of the disturbance is located and thereby activated. The subcortical brain is pivotal in generating the trauma response (which in this therapy is regarded as organised around eye position). The potential of BSP as a 'bottom-up' therapy capable of circumventing the limitations of 'talk therapy' is clear.

BSP is also explicitly attuned to complex developmental trauma and the challenges of dissociation. Grand specifically addresses issues in relation to early life trauma and the ensuing challenges around attachment and dissociation.⁸⁴⁵ He also notes the adaptive, survival enhancing function of dissociation, in which overwhelming experience becomes encapsulated in parts of the brain to which the person lacks conscious access,⁸⁴⁶ which does not necessarily preclude high functioning in some regards, but which serves as an impediment to healing⁸⁴⁷ and potentially to engagement in treatment.

The attunement of BSP to the dimensions of brain, body, mindfulness and relationship has significant implications for complex trauma treatment. Brainspotting is described by its founder David Grand as '*a brain-body mindfulness based relational therapy*' (Grand, 2018).

The apparent rapidity of BSP in accessing and processing of traumatic experience raises the question of whether it could potentially destabilise clients with complex trauma. Yet the combining of all four dimensions of *brain, body, mindfulness* and *relationship* serves as a protective safeguard.

It is widely acknowledged that therapy for complex trauma is generally longer than that for single-event trauma. Grand contends that while a single-event trauma may be processed quickly (e.g. 'in a few sessions') early life trauma can take much longer.⁸⁴⁸ He makes the point that BSP work is more focused and efficient, and can also enable previously worked on material to be processed at a deeper level.⁸⁴⁹ In BSP, the brain is viewed as an extraordinary scanning mechanism. When the precise spot at which the trauma or other adverse experience is elicited, the brain can start processing it as it is wired to do.⁸⁵⁰

Brainspotting is also highly attuned to the integral connections between the physical and the emotional (which, in complex trauma, pose treatment challenges in the form of 'medically unexplained' symptoms and pain). Due to 'the integrated circuit that is known as the nervous system',⁸⁵¹ physical experience affects emotional experience and vice versa. Early life trauma becomes encapsulated in areas of the brain and can manifest in somatic disturbances.⁸⁵²

Brainspotting is foundationally informed by the workings of the brain and is 'well developed within the psychotherapy relationship' (Grand, 2014).

The signature BSP metaphor is of clinicians following 'the tail of the comet'. The comet is the client and clinicians are the tail which always follows; this is a highly client-centred modality. The emphasis is placed on Heisenberg's 'uncertainty principle', where, in the context of BSP, uncertainty on the part of the therapist ensures consistent attunement to client experience.

(Grand, *ibid*).

845 Grand, 'What is Brainspotting?' <https://www.youtube.com/watch?v=lm3Plvaf3UE>

846 In this context he references the work of Robert Scaer, *The Body Bears the Burden: Trauma, Dissociation, and Disease*, 3rd edit. (Routledge, New York, 2014).

847 Grand, 'What is Brainspotting?' <https://www.youtube.com/watch?v=lm3Plvaf3UE>

848 Grand, 'What is Brainspotting?' *ibid*

849 Grand, 'What is Brainspotting?' *ibid*

850 Grand, 'What is Brainspotting?' *ibid*

851 Grand, 'What is Brainspotting?' <https://www.youtube.com/watch?v=lm3Plvaf3UE>

852 Grand, 'What is Brainspotting?' *ibid*

While BSP is a potent psychotherapy in its own right, it can also enhance and augment other approaches. Described as ‘an open creative tool’, it is tailored to the particular client and also involves a variety of techniques (*‘we don’t approach anything in just one way’*).⁸⁵³

BSP can be modified for widespread use and integrated with other psychotherapeutic approaches.⁸⁵⁴ For example, while considered to be more precise than EMDR in being organised around a focused, rather than moving, eye position, Brainspotting differs from EMDR in being less structured in its approach and less bound by protocols.⁸⁵⁵ Additionally, unlike hetero-hypnosis, BSP does not require induction by the therapist because the trance state which correlates with the eye position is self-generated by the client.⁸⁵⁶

4.13 Clinical hypnosis (hypnotherapy)

‘There seems to be a tendency for people using hypnosis therapeutically to be surprisingly uninformed about the science behind the process’

(Naish, 2015: 3)

While regarded by many as controversial, in part due to misconceptions about how it operates, clinical application of hypnosis has a legitimate place within psychological and psychotherapeutic practice.⁸⁵⁷ Unfortunately the perception of hypnosis as the imparting of directive suggestions by an external authority figure continues to impede understanding of the potential of *clinical* use of hypnosis and to marginalise its practice.

Richard Kluft, complex trauma clinician and an expert in clinical hypnosis, acknowledges that in the time of Freud hypnosis was used in quite an authoritarian way.⁸⁵⁸ Yet ‘[t]o this very day, many tend to connect hypnosis with an archaic authoritarian approach to the treatment of mental and physical problems that in no way resembles the methods and interventions that hypnosis has been used to facilitate in the last half-century or so’.⁸⁵⁹

The research which supports many therapeutic applications of clinical hypnosis is now considerable and is more advanced than many would be aware.⁸⁶⁰ This includes within the professions of medicine

853 Grand, ‘What is Brainspotting?’ *ibid*

854 Grand, ‘What is Brainspotting?’ *ibid*

855 Grand contends Brainspotting is both more precise and more flexible than EMDR, in that an ongoing process of tracking allows the choice of which approaches to use at particular times. Grand, ‘What is Brainspotting?’ *ibid*

856 Grand, ‘What is Brainspotting?’ <https://www.youtube.com/watch?v=lm3Plvaf3UE>

857 See, for example, Herbert Spiegel & David Spiegel, *Trance and Treatment: Clinical Uses of Hypnosis* 2nd Edit (American Psychiatric Publishing, Inc, Washington DC, 2004); Steven Jay Lynn PhD, Judith W. Rhue PhD & Prof Irving Kirsch, ed *Handbook of Clinical Hypnosis* 2nd Revised Edition (2010); Les Brann, Michael D. Yapko, *Trancework: An Introduction to the Practice of Clinical Hypnosis* 4th Edition (Routledge New York 2012); Les Brann, Jacky Owens & Ann Williamson, ed. *The Handbook of Contemporary Clinical Hypnosis: Theory and Practice* 1st Edition (John Wiley & Sons, Oxford 2015); Prof Ursula James, Foreword by Ernest L. Rossi, *Clinical Hypnosis Textbook: A Guide for Practical Intervention*, third edit (2015); Robin A. Chapman PsyD, ABPP, *Integrating Clinical Hypnosis and CBT: Treating Depression, Anxiety, and Fears* (Springer, New York, 2014).

858 Richard P. Kluft, *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* (CreateSpace, South Carolina, 2013), p.275.

859 Kluft, *Shelter from the Storm*, *ibid*.

860 See Dr Leon Cowen, ‘Literature Review into the Effectiveness of Hypnotherapy’, *Australian Counselling Journal* (10, 1, 2016, pp.1-55) <http://www.acrjournal.com.au/resources/assets/journals/Volume-10-Issue-1-2016/Volume-10-Issue-1-2016-FULL.pdf> Dr Cowen, an Australian practitioner and long-standing teacher of hypnotherapy, made a submission in 2013 to the Department of Health and Ageing for the Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies and has authored several articles on clinical hypnotherapy; see References at the end of this document.

and dentistry.⁸⁶¹ The efficacy of clinical hypnosis is also championed by internationally recognised psychologist Ernest Rossi, who has played a key role in ensuring the legacy of hypnosis pioneer Milton H. Erickson.⁸⁶² Rossi publishes widely, and integrates research insights from the fields of neuroscience, medicine, biology, and psychology.⁸⁶³

While the clinical application of hypnosis requires formal training,⁸⁶⁴ certain principles of hypnotic practice can be utilised more broadly to therapeutic effect. As Naish notes in his discussion of 'the theory behind the therapy', it is advisable that '[a]nyone intending to use hypnosis in a therapeutic setting should understand something of the science behind it'.⁸⁶⁵ But what Schwarz refers to as 'the hypnotically oriented therapist' can also be guided by the principles of hypnosis 'whether or not formal trance is used'.⁸⁶⁶

Hypnosis is 'a facilitator of treatment interventions, not a therapy or treatment in itself' (Kluft, 2017:27).

Judicious use of hypnosis can be applied in clinical settings to psychotherapeutic benefit in general and for clients who experience the impacts of complex trauma in particular.

Drawing on diverse strategic psychotherapies, Robert Schwarz has presented a neo-Ericksonian framework for trauma treatment which is attuned to diverse states of consciousness and which specifically engages with and utilises dissociative responses.⁸⁶⁷ In fact hypnosis has a respected and ongoing place in treatment of the dissociative disorders: '*The study of dissociation begins in hypnosis*'.⁸⁶⁸

Describing hypnosis as 'the redistribution of attention', Kluft (2013) advises that most dissociative disorders 'involve the redistribution of attention toward certain things and away from others' and 'have many hypnotic elements' (Kluft, *ibid*: 276, ref Bliss, 1986; Braun, 1983; the exception is Depersonalization Disorder to which this applies only in some forms).

861 See, for example, Gary Elkins, PhD, ABPP ABPH *Handbook of Medical and Psychological Hypnosis: Foundations, Applications, and Professional Issues* (Springer, New York, 2017), and Donald C. Brown, MD, *Advances in the Use of Hypnosis for Medicine, Dentistry, and Pain Prevention/Management* (Crown, Wales, 2009). Also note that a survey of General Practitioners in Victoria conducted in 1997 revealed that as many as 20% had trained in hypnosis (RACGP, QI&CPD e-bulletin, May 2013, p.1); presumably that figure is now significantly higher.

862 Ernest Rossi, Roxanna Erickson-Klein, & Kathryn Rossi, *The Collected Works of Milton H. Erickson, M.D.* Collector Edition; also see Milton H. Erickson and Ernest L. Rossi, *Hypnotherapy, An Exploratory Casebook* (Irvington, New York, 1979) and podcasts in which Rossi explains the nature of Erickson's work to new and contemporary audiences. 'Knowing Milton Erickson by Dr Ernest Rossi PhD' Published Jan 30, 2015 <https://www.youtube.com/watch?v=4xZTrhp03I> Also see Stephen Lankton & Carol Hicks Lankton, *The Power Within: A Clinical Framework of Ericksonian Hypnotherapy* (Crown, CT, 2008).

863 In a recent publication Rossi explores 'how the interplay between *behavioural state-related gene expression* (nature) and *experience- or activity-dependent gene expression* (nurture) generates the interconnections between biology and psychology that are now open for experimental investigation and therapeutic application in psychotherapy and the healing arts' (Ernest L. Rossi, *The Psychobiology of Gene Expression: Neuroscience and Neurogenesis in Hypnosis and the Healing Arts*, 1st edit (Norton, New York, 2002, p.3). The recipient of lifetime achievement awards in clinical hypnosis and psychotherapy, Rossi is the author of many publications which seek to introduce research insights in the mind-body relationship to a wide audience.

864 So, too, is more specific training in relation to clinical application of hypnosis for the treatment of trauma and dissociative disorders (see below).

865 Dr Peter Naish, 'Hypnosis: The Theory behind the Therapy', in Brann, Owen & Williamson, ed. *The Handbook of Contemporary Clinical Hypnosis: Theory and Practice* *ibid*, p.4.

866 Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002), p.39. This valuable and integrative text presents a range of such tools, the majority of which 'do not require formal training in hypnosis' (Schwarz, *ibid*, p.ix).

867 Robert Schwarz, 'A Neo-Ericksonian Framework for Treating Trauma', Chapter 2 in Schwarz, *Tools for Transforming Trauma*, *ibid*, pp.21-50.

868 Elizabeth Howell & Sheldon Itzkowitz, *The Dissociative Mind in Psychoanalysis* (Routledge, New York, 2016, p.21) and see Richard Kluft, 'Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States: An Overview and Case Study', *South African Journal of Psychology* (42, 2, 2012, pp.146-155); and Frischholz, Lipman et al, 'Psychopathology, hypnotisability, and dissociation', *American Journal of Psychiatry*, (149: 1992) 1521-1525.

Thus it `is only natural to enlist the redistribution of attention that we call hypnosis in the service of treating dissociative disorders'

(Kluft, 2013: 276; emphasis added).

It is not possible to delineate the nature, principles and practice of clinical hypnosis here. But given its potential to enhance the treatment of dissociative disorders,⁸⁶⁹ it clearly needs to be noted. Information on the clinical utility of hypnosis is also readily available (see supporting footnotes of this discussion and the reference list).

In its demonstrated capacity to gain access to the subconscious mind, there are numerous ways in which understanding and application of clinical hypnosis may be valuable in psychotherapy for complex trauma. There are also numerous points at which hypnotherapy might fruitfully be applied to, and tailored for, the various phases of complex trauma treatment.⁸⁷⁰

4.14 MDMA assisted psychotherapy: back to the future and towards a changed treatment landscape?

'It works. It's safe....I'm not controversial. I'm a very boring conservative doctor...I like evidence-based data that helps my patients. I'll tell you what's controversial. It's...[the number of suicides that stem from unresolved trauma]'

Sessa, 'Is MDMA psychiatry's antibiotic?' 2016.

'The results seem to support MDMA's safe and effective use as an adjunct to psychotherapy'

Thal & Lommen, 2018: 99.

In 2017, the psychoactive agent MDMA⁸⁷¹ was designated a 'breakthrough therapy' by the United States Food and Drug Administration (FDA). Increased therapeutic access to this substance in the absence of comparable or satisfactory therapy alternatives is also possible in the US via the 'compassionate use' category.⁸⁷² Participant screening in Phase 3 Clinical Trials of MDMA-Assisted Psychotherapy for PTSD became open for enrolment in November 2018, and FDA approval of therapeutic use of MDMA assisted psychotherapy is anticipated in 2021.⁸⁷³

869 See Maggie Phillips & Claire Frederick, *Healing the Divided Self: Clinical and Ericksonian Hypnotherapy for Post-Traumatic and Dissociative Conditions* (Norton, New York, 1995); Marcia Degun-Mather, *Hypnosis, Dissociation and Survivors of Child Abuse* (John Wiley and Sons, West Sussex, 2006).

870 Note that Phillips & Frederick elaborate a phase-based approach; see *Healing the Divided Self*, *ibid*. In noting that '[t]he overlap between hypnotherapy and counselling can be extensive', Australian hypnotherapist Leon Cowen (who obtained his doctorate in clinical hypnotherapy in the School of Medicine, University of Western Sydney) explains that '[t]he structure of the consultation incorporates four phases: the greeting phase, counselling phase, hypnotherapy phase, and the wrap-up', where '[a]reas of difference... occur in the counselling and hypnotherapy phases of hypnotherapy' (Leon Cowen, 'Clinical Hypnotherapy', *Modality Profile, The CAPA Quarterly*, 2, 5, 2013) As he further elaborates, '[w]hilst the techniques used in the counselling phase overlap significantly with standard counselling techniques, the intended outcomes are appreciably different. The counselling phase outcomes provide the information that forms the basis for the techniques, which will later be used in the hypnotherapy phase. This latter phase is radically different and uses non-standard counselling and psychotherapeutic techniques' (Cowen, 'Clinical Hypnotherapy', *ibid*). The potential of hypnotherapy to assist treatment of complex trauma and dissociation in Australia is as great as it currently remains underexplored. A pioneering initiative in this regard was the workshop 'Introduction to hypnosis and its use in the dissociative disorders' presented by Melbourne psychiatrist Dr Sylvia Solinski in July 2018.

871 Full name of MDMA 3,4-methylenedioxymethamphetamine.

872 See 'Expanded Access', US Department of Health and Human Services website <https://www.fda.gov/NewsEvents/PublicHealthFocus/ExpandedAccessCompassionateUse/default.htm>

873 For full details of the steps in this trajectory see the website of the Multidisciplinary Association for Psychedelic Studies (MAPS) www.maps.org

These current and evolving developments underline the extraordinary trajectory of the history of MDMA and the (re)emergence of 'psychedelic psychotherapy'. Initial and accidental discovery of MDMA by the pharmaceutical corporation Merck in 1912 (which patented it in 1914 and on which it conducted two animal studies), experimentation in its use as a 'non-lethal incapacitant' for mind control by the US Army, and application in therapeutic contexts and personal growth communities in the 1960s and 1970s highlight the diverse environments in which MDMA has been used and studied.⁸⁷⁴

Increased use of MDMA in the 1970s also increased the likelihood of its criminalisation. This concerned advocates of its therapeutic benefits. Thus American biochemist Alexander Shulgin resynthesised MDMA in the 1970s to try to obviate the properties which could be criminalised.⁸⁷⁵ When satisfied with his work, Shulgin shared the information with psychologist and psychotherapist Leo Zeff, who came out of retirement to help promote the therapeutic benefits of MDMA to professional colleagues.⁸⁷⁶

Large numbers of people in early 1980s America were using MDMA for diverse purposes (recreational, personal growth, spiritual) without intervention from the Drug Enforcement Administration (DEA). But its conversion into 'ecstasy' and ready availability at the famous Starck Club in Texas presaged the subsequent crack-down and the 'war on drugs' of the Reagan years. It also galvanised efforts to protect the therapeutic use of MDMA via a lawsuit against the DEA (which announced imminent criminalisation of the substance in 1984).⁸⁷⁷

In fact this lawsuit,⁸⁷⁸ which had been long in the planning and for which advocates of therapeutic use of MDMA were well prepared, was successful. But the judicial recommendation was not binding and was stymied by bureaucratic bodies. This ensured years of illegal status which is only now beginning to change in the US and some European countries, although not elsewhere, including Australia.⁸⁷⁹

MDMA operates differently than a 'classic' psychedelic like LSD or psilocybin. Rick Doblin, founder and executive director of the Multidisciplinary Association for Psychedelic Studies (MAPS) places it 'in the middle' between mescaline at one end and methamphetamine at the other. The effect, he says, is of being less jittery and more peaceful than with methamphetamine, and more embodied than with mescaline.⁸⁸⁰

MDMA is also 'not the same as 'Ecstasy' or 'molly'.⁸⁸¹ While substances sold on the street under these names may contain MDMA, they can also contain unknown and/or dangerous ingredients. But '[i]n laboratory studies, pure MDMA has been proven sufficiently safe for human consumption when taken a limited number of times in moderate doses'.⁸⁸²

874 Information drawn from the 'brief history of MDMA' conveyed by MAPS founder and Executive Director Rick Doblin, 'Healing Trauma with MDMA- Assisted Psychotherapy: An FDA-Designated Breakthrough Therapy' Healing Trauma Summit, June 2018 <https://www.soundstrue.com/store/healing-trauma-summit?sq=1>

875 Doblin, 'Healing Trauma with MDMA-Assisted Psychotherapy: An FDA-Designated Breakthrough Therapy', *ibid*. The now difficult to obtain book is Alexander Shulgin & D. Nichols, *Characterization of three new psychotomimetics: The Pharmacology of Hallucinogens* (Pergamon, New York, 1978).

876 Doblin, 'Healing Trauma with MDMA-Assisted Psychotherapy', *ibid*, also see the section 'Leo Zeff – The Secret Chief' in Torsten Passie, 'The Early Use of MDMA ('Ecstasy') in Psychotherapy (1977-1985)', *Drug Science, Policy and Law* (4, 2018), pp.1–19.

877 To take effect for all suppliers within 30 days; a subsequent declaration of an emergency in relation to MDMA was announced in 1985. Doblin relates that the DEA was unnerved by the apparently widespread and diverse use of MDMA, including by Catholic monks and Jewish rabbis! (Doblin, 'Healing Trauma with MDMA-Assisted Psychotherapy', *ibid*).

878 The aim of which was inclusion of MDMA in Schedule 3 which would allow its use as a therapeutic tool otherwise illegal outside of therapeutic contexts.

879 This has led the Australian non-profit research association Psychedelic Research in Science and Medicine (PRISM) and others to question whether Australia is being 'left behind'. <https://www.prism.org.au/australia-is-missing-out/>; <https://www.prism.org.au/renewed-interest-in-psychedelics/> Also see subsequent discussion.

880 Doblin, 'Healing Trauma with MDMA-Assisted Psychotherapy', *ibid*.

881 MDMA-Assisted Psychotherapy <https://maps.org/research/mdma>

882 MDMA-Assisted Psychotherapy, *ibid* <https://maps.org/research/mdma>

A number of studies and trials have upheld the safety and beneficial effects of the clinical use of MDMA (Ot'abora, Grigsby et al, 2018; Thal & Lommen, 2018).

Advocates in mental health for the therapeutic, as distinct from recreational, use of MDMA believe it should comprise 'a potential new treatment in medicine' (Sessa, 2016).

'Positive cognitive effects of MDMA in a controlled clinical setting were described to include enhanced mood and wellbeing, happiness, relaxation (physical and mental), increased emotional sensitivity and responsiveness, heightened openness, extroversion and sociability, the feeling of closeness to other people, sight (visual, auditory, and tactile) changes in perception and exceptional anxiolysis...

...Most importantly, aforementioned pharmacological and subjective effects of MDMA have been consistently established across clinical settings'

(Thal & Lommen, 2018, ref Harris et al, 2002; Vollenweider et al, 1998, 2002, 2005; Kirkpatrick et al, 2014; Schuldt 2015; emphasis added).

The benefits of clinical use of MDMA for trauma treatment are of particular interest. This is because, as is now well known and widely acknowledged in research studies, trauma 'often does not resolve after conventional psychotherapies or pharmacotherapies'.⁸⁸³ While biomedical approaches are about management of symptoms, and 'talk therapy' can be destabilising, MDMA assisted psychotherapy can 'go to the roots' and thereby enable resolution and healing.⁸⁸⁴

British psychiatrist Ben Sessa says that 'psychiatry is in need of this innovative approach because current treatments are failing patients'.⁸⁸⁵ Indeed, one study suggests that '*MDMA may provide a bridge to effectively overcome the gap between psychotherapy and psychopharmacology*, thereby facilitating the integration of a more holistic approach to psychopathology'.⁸⁸⁶

'Positive cognitive effects of MDMA in a controlled clinical setting were described to include enhanced mood and wellbeing, happiness, relaxation (physical and mental), increased emotional sensitivity and responsiveness, heightened openness, extroversion and sociability, the feeling of closeness to other people, sight (visual, auditory, and tactile) changes in perception and exceptional anxiolysis...

...Most importantly, aforementioned pharmacological and subjective effects of MDMA have been consistently established across clinical settings'

(Thal & Lommen, 2018, ref Harris et al, 2002; Vollenweider et al, 1998, 2002, 2005; Kirkpatrick et al, 2014; Schuldt 2015; emphasis added).

883 Marcela Ot'abora, Jim Grigsby et al, '3,4-Methylenedioxymethamphetamine-assisted psychotherapy for treatment of chronic posttraumatic stress disorder: A randomized phase 2 controlled trial', *Journal of Psychopharmacology* (32, 12, 2018), 1295.

884 Ben Sessa, 'Is MDMA Psychiatry's Antibiotic?' TEDxUniversity of Bristol, posted 5 July 2016 <https://www.youtube.com/watch?v=UygZnBTWWOM>

885 Sessa, 'Is MDMA Psychiatry's Antibiotic?' *ibid*.

886 Sascha B. Thal & Miriam Lommen, ref Schuldt 2015, 'Current Perspective on MDMA-Assisted Psychotherapy for Post-traumatic Stress Disorder', *Journal of Contemporary Psychotherapy* (48, 2, 2018), p.108; emphasis added.

EFFECTS OF MDMA ASSISTED PSYCHOTHERAPY

- Reduces activation of the amygdala (*e.g. fear*)
- Enhances activity in prefrontal cortex (*stimulates nurturing hormones; increases release of oxytocin; assists sense of attachment and bonding*)
- Increases connectivity between the amygdala and hippocampus
- Assists emergence/movement of implicit memory to consciousness
- Reduction of fear helps reflection and the ability to articulate (*'puts the patient into the optimal arousal zone'* Sessa, 2016)
- Enhances the mind-body connection

(Schuldt 2015; Thal & Lommen 2018).

MDMA, when administered clinically, increases the client's ability to gain both distance from, and connection to, previously overwhelming experience. It also enhances a client's capacity to engage both in therapy and with themselves (including with previously exiled and abandoned parts of self).⁸⁸⁷

Revisiting trauma 'is often associated with intolerable negative feelings making confrontation extremely difficult'.⁸⁸⁸ In MDMA- assisted therapy, however, traumatic memories are experienced as less threatening which assists their processing and reconsolidation.⁸⁸⁹ This, it is suggested, 'may be explained by the positive correlation between decreased blood flow in the right amygdala and right hippocampus and the intensity of subjective effects of the experience'.⁸⁹⁰ Further, 'favorable autobiographical memories are perceived as more vivid and intense, while unfavorable memories are regarded as less negative and less distressing'.⁸⁹¹

In addition, reduction in activation of the amygdala may help explain 'MDMA's positive effects on social behavior and anxiety', at the same time as there is heightened activity in the ventral striatum (which is important 'for the processing of (socially) rewarding stimuli').⁸⁹² These processes and effects suggest 'further evidence for MDMA's potential to improve the therapeutic relationship'.⁸⁹³

887 Interestingly, Doblin describes MDMA as 'very much like Internal Family Systems' (therapy) in this regard (Doblin, 'Healing Trauma with MDMA-Assisted Psychotherapy', *ibid*).

888 Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*, p.101.

889 Doblin 2002 in Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*. Also see Lane, Ryan, et al 'Memory reconsolidation, emotional arousal, and the process of change in psychotherapy', *Behavioral and Brain Sciences*, 2015, pp.1-64.

890 Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*, ref Carhart-Harris et al 2015.

891 Thal & Lommen, *ibid*, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*, ref Carhart-Harris et al. *ibid*.

892 Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*, ref Haber 2011.

893 Thal & Lommen, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *ibid*, ref Schuldt 2015. Also see Alli Feduccia, 'MDMA Breakthrough Therapy Designation Results Published', *Research* (7 May, 2019).

The interest and paradox (as well as now established benefits) of clinical use of MDMA is that we are not talking about a 'drug of addiction' in this context. Rather – and as its title conveys – we are talking about MDMA *assisted* psychotherapy in which limited controlled use of this substance facilitates deep healing and thus erodes the need for subsequent use of chemical stimulants.⁸⁹⁴ When used clinically, MDMA is thus fundamentally different from 'street drugs' as well as from many commonly used pharmaceuticals.

'There were no drug-related serious adverse events, and the treatment was well-tolerated'.

(Ot'alora, Grigsby et al, 2018: 1295).

'Our findings support previous investigations of MDMA-assisted psychotherapy as an innovative, efficacious treatment for posttraumatic stress disorder' (ibid; emphasis added).

(Ot'alora, Grigsby et al, ibid; emphasis added).

4.15 MDMA, psychotherapy and complex trauma

What of the potential for MDMA assisted psychotherapy for complex trauma clients? Ben Sessa, a child and adolescent psychiatrist who has worked with adults in recent years, publishes on this topic.⁸⁹⁵ *Significantly*, he declares that witnessing and treating distressed clients across the developmental trajectory 'has brought [him] to the door of MDMA'.⁸⁹⁶

Psychiatry, Sessa says, is good in areas such as epidemiology but its treatments are seriously deficient and particularly for adult survivors of childhood trauma.⁸⁹⁷ This is despite overwhelming epidemiological and other evidence that a majority of adult psychological problems and disorders have their aetiology in early life trauma.⁸⁹⁸ MDMA, he suggests, is to psychiatry what discovery of antibiotics was to general medicine a century ago; namely a means of facilitating resolution of trauma - including complex early life trauma - at its source.⁸⁹⁹

In his TED address of July 2016,⁹⁰⁰ Sessa referenced a fictional client ('Clare') who was a composite of complex trauma clients he had struggled to treat. 'Clare', he tells us, grew up in a frightening and chaotic home from which she was removed. She was placed in foster homes in which she was sexually, physically, and emotionally abused again. As an adult, 'Clare' was self-harming, anxious, addictive and intermittently suicidal.

Fifty per cent of traumatised adults, says Sessa, do not respond to traditional treatments (partly because, like 'Clare', they 'freeze' with any reminder of traumatic experience).⁹⁰¹ This condemns many people to indefinite, sometimes life-long pharmacological and/or psychological treatment.

894 Doblin relates that a postulated breakdown of MDMA assisted psychotherapy corresponds to sixty per cent from the MDMA and forty per cent from the therapy per se (a 'combination breakthrough therapy' which would seem to be promising indeed). Doblin, 'Healing Trauma with MDMA- Assisted Psychotherapy: An FDA-Designated Breakthrough Therapy' ibid. For detailed analysis of the impacts of MDMA in clinical settings, see Felix Schuldt, 'MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder' Diplomarbeit, Fakultät für Psychologie Universität Wien, 2015.

895 See Ben Sessa, 'Could MDMA be useful in the treatment of post-traumatic stress disorder?' *Progress in Neurology and Psychiatry* (15, 6 2011), pp.4–7; Sessa & Nutt, 'MDMA, politics and medical research: Have we thrown the baby out with the bathwater?' *Journal of Psychopharmacology* (21, 8, 2007), pp. 767-791.

896 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

897 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

898 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

899 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

900 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

901 Sessa, 'Is MDMA Psychiatry's Antibiotic?' ibid.

Sometimes people stop accessing treatment even when it is available. Often treatment is of limited use, and only addresses some of the symptoms.⁹⁰²

Sessa is also concerned about attitudes to adult survivors which turn off ‘the empathy switch’. He believes that concern for the welfare of distressed children is not matched by concern for distressed adult survivors who could be substantively assisted by MDMA assisted psychotherapy.⁹⁰³ We need, he says, to reject the sociopolitics that a drug which is used recreationally can’t also be used for trauma treatment (*‘we need scientists to drive this’*).⁹⁰⁴

Increasingly, scientists, including neuroscientists, are driving the quest to introduce MDMA assisted psychotherapy.⁹⁰⁵ Ironically, it is politics and social attitudes, rather than scientific evidence, which is slowing progress on this issue. Institutional reticence, in the academy as well as in government and bureaucracies, is also delaying development of policy and provision of mental health services which reflect scientific MDMA research.⁹⁰⁶

Australian psychiatrist and MDMA assisted psychotherapy advocate Nigel Strauss⁹⁰⁷ is critical of the timidity and lack of support for MDMA research in this country. So, too, is Dr Stephen Bright, psychologist and vice-president of the Australian not-for-profit organisation Psychedelic Research in Science and Medicine (PRISM).⁹⁰⁸ Bright has co-authored a paper on this topic which was published in *Australian Psychologist*.⁹⁰⁹ He likewise criticises the ‘academic conservatism’ and ‘vested interest in maintaining the current paradigm’⁹¹⁰ which opposes support for research on psychedelics in Australia while ignoring the growing science in relation to this topic. A similar case is made in a paper published in the *Australian and New Zealand Journal of Psychiatry*.⁹¹¹ Indeed, in September 2019 Johns Hopkins University in the US announced the opening of a new center dedicated to research of psychedelics.⁹¹²

902 In Sessa’s view, we owe ‘Clare’ and all who experience the effects of childhood trauma the benefits that MDMA assisted psychotherapy could provide (Sessa, ‘Is MDMA Psychiatry’s Antibiotic?’ *ibid*).

903 Sessa, ‘Is MDMA Psychiatry’s Antibiotic?’ *ibid*.

904 Sessa, ‘Is MDMA Psychiatry’s Antibiotic?’ *ibid*.

905 In addition to the previously cited papers, also note that many neuroscientists promote the benefits of MDMA. See, for example, Boris D. Heifets and Robert C. Malenka, ‘MDMA as a Probe and Treatment for Social Behaviors’, *Cell* (166, July 14, 2016), pp.269-272. This paper explicitly advocates that exploring the ‘mechanism of action’ of MDMA ‘could lead to new treatments for psychiatric conditions characterized by impairments in social behavior’ (Heifets & Malenka, *ibid*, p.269).

906 The concluding comments of the previously cited 2016 paper in the journal *Cell* are particularly striking: ‘More and more results are accumulating to support the proposition that listing MDMA as a schedule I drug with no accepted medical use is no longer a rational societal policy. By no means would we suggest that its recreational use is appropriate. But, its use as an object of rigorous scientific study should be encouraged and perhaps facilitated. As a probe of brain function, it is a remarkably simple but powerful tool that can be used to advance our understanding of the neural basis of empathy, social reward, and related prosocial behaviors. Such understanding can only benefit individuals and the human interactions in which they engage. The world’s populations need more compassion and empathy for one another. The study of MDMA provides one small but potentially important step toward reaching that goal’ (Heifets & Malenka, ‘MDMA as a Probe and Treatment for Social Behaviors’, *ibid*, pp. 271-2).

907 Melbourne-based Strauss counsels recognition that all drugs can be harmful, and believes Australian ethics committees are too fearful of being seen to promote controversial treatment, notwithstanding the research strides made overseas (‘Psychedelic psychiatry with Nigel Strauss’ The MindStew podcast, published 16 Nov 2018 https://www.youtube.com/watch?v=vY_IcwULPV4) He argues that MDMA research is so promising that it needs to be developed in Australia, and that ‘in this particular area we’re getting left behind’. Contending that many people do not benefit from standard trauma treatments, he also expresses frustration that institutional bodies are not encouraging a treatment which is likely to be approved in the future and says that ‘many people are not getting the treatment that might help them’ (‘Psychedelic psychiatry with Nigel Strauss’, *ibid*).

908 Psychedelic Research in Science and Medicine (PRISM) <https://www.prism.org.au/>; <https://www.prism.org.au/australia-is-missing-out/>; <https://www.prism.org.au/renewed-interest-in-psychedelics/>

909 Stephen Bright and Martin Williams, ‘Should Australian Psychology Consider Enhancing Psychotherapeutic Interventions with Psychedelic Drugs? A Call for Research’, *Australian Psychologist* (53, 6, 2018), pp.467-476.

910 Dr Stephen Bright, quoted in Megan Gorrey, ‘Australia missing psychedelic drug ‘renaissance’ for mental health’, *The Sydney Morning Herald* (8 April 2018) <https://www.smh.com.au/national/australia-missing-psychedelic-drug-renaissance-for-mental-health-20180408-p4z8f8.html>

911 Antonio Insera, ‘Current status of psychedelic therapy in Australia and New Zealand: Are we falling behind?’ *Australian & New Zealand Journal of Psychiatry* (53, 3, 2019), pp.190 –192.

912 Benedict Carey, ‘Johns Hopkins Opens New Center for Psychedelic Research’, *The New York Times* (4 September 2019). <https://www.nytimes.com/2019/09/04/science/psychedelic-drugs-hopkins-depression.html>

The case of MDMA assisted psychotherapy evokes the assertions of Judith Herman and Bessel van der Kolk that trauma and politics cannot be compartmentalised.⁹¹³ It also further underlines that gaps can exist between research findings and evidence base and translation into practice.

4.16 ‘There is no turf when it comes to healing’ (Grand: 2018)

Even cursory appraisal of some of the many ‘new’ and ‘non-traditional’ psychotherapies and approaches to healing suggest fertile ground from which complex trauma treatment might be enhanced. The limits of an ‘ad hoc’, unintegrated approach, and the need for appropriate training where necessary, of course need to be acknowledged. With this in mind, the current terrain of psychotherapy and healing practices outside of it is rich and replete with possibilities.

The ‘integration’ of diverse approaches and methods is already occurring, as noted at the outset of this chapter. For example, in relation to Emotion-Focused Therapy for Complex Trauma (i.e. EFTT; not to be confused with EFT), Paivio and Pascual-Leone note that ‘brief treatments aside’, aspects of this modality have already ‘been integrated into longer term treatments.’⁹¹⁴ As this chapter has discussed, subject to the requisite care (and recalling that what is ‘traditional’ and established for some practitioners and fields may be unfamiliar and innovative for others) there is no reason not to pursue and integrate less traditional approaches into treatment which might help complex trauma survivors.

For practitioners of standard (‘talk based’) psychotherapies, some of the approaches discussed in this chapter may seem unusual. Yet each has a growing evidence-base, and respected and credentialed advocates can be cited for all the modalities and interventions presented. While this account has been brief, sufficient evidence has been adduced to substantiate that initially ‘controversial’ treatment approaches may indeed rest on scientific principles⁹¹⁵ and attain subsequent scientific status. It is also the case that the terms ‘controversy’ and ‘science’ can themselves be deployed in political and problematic ways.

Increased recognition of the centrality of somatic and subcortical processes to the resolution of trauma requires attention to treatment approaches which do not privilege spoken language. Different ways of attuning to non-verbal registers can also activate and accelerate healing. Extreme care is needed in treating complex trauma and dissociation, which has already required revision and adaptation of standard protocols of some of the ‘newer’ and short-term approaches.⁹¹⁶

The attendant risks of any treatment for complex trauma - whether novel or traditional, short or long term - need to be recognised.

Practitioners of brief approaches offered outside of a relational context may be especially vulnerable to inadvertent client re-traumatisation. But this does not mean that practices, strategies and techniques which may be novel to some therapists should be dismissed and marginalised without due consideration. As this chapter has indicated, some may effectively accelerate healing.

913 Herman, *Trauma and Recovery*, *ibid*; van der Kolk, *The Body Keeps the Score*, *ibid*, p.350.

914 Sandra C. Paivio & Antonio Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach* (American Psychological Association Washington DC, 2017), p.6 and see discussion in Chapter 7 of this report.

915 Recall the comment of Schwarz that ‘[w]hen we integrate Polyvagal Theory with interpersonal neurobiology (Siegel, 2015), a theoretical foundation for energy psychology (EP) emerges’ and EP is no longer ‘framed as a strange alternative treatment’ (Schwarz, ‘Energy Psychology, Polyvagal Theory, and the Treatment of Trauma’, *ibid*, p. 271).

916 E.g. EMDR as per its 2009 review for the treatment of complex trauma and dissociation (Korn, ‘EMDR and the Treatment of Complex PTSD: A Review’, *ibid*, and Shapiro’s 2018 reinforcing cautions around working with dissociation in her updated third edition of *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, 3rd edition, *ibid*).

The need for openness to innovative treatment approaches is also powerfully underlined by the recognised limits of ‘first-line’ ‘evidence-based’ trauma treatments and the manifest need for improved, safe, and effective methods of trauma resolution: *‘Currently existing treatment methods are ineffective for 25–50% of patients enrolled in clinical trials... The necessity for more effective treatments efficiently reducing current treatment failure rates thus becomes apparent.’*⁹¹⁷

4.17 Integrating short-term ‘alternative’ approaches in the context of phase-based treatment for complex trauma

The relationship between the recommended ‘phased treatment’ model for complex trauma (also see Chapter 3) and short-term ‘rapid’ therapies, approaches and techniques may still seem anomalous. This raises the interesting and potentially highly fruitful possibility of *tailored interventions and strategies for the particular phases of phased therapy*.

It also requires attention to the promising phenomenon of introducing and integrating particular phases *within* short-term therapy approaches. As discussed in the review ‘EMDR and the Treatment of Complex PTSD’,⁹¹⁸ while formal controlled studies are fewer for this cohort,⁹¹⁹ a recognised consensus is that *‘work with survivors of childhood abuse and other forms of chronic traumatization should be phase-oriented, multi-modal, and titrated’*.⁹²⁰ As we have seen, the standard EMDR protocol has been adapted for this reason.⁹²¹

Energy Psychology, too, is amenable to dedicated adaptation for the needs of complex trauma clients (although in common with EMDR not all practitioners of either field are attuned to and practice in this way). For Robert Schwarz, PsyD, DCEP, and Executive Director of the Association for Comprehensive Energy Psychology, this *includes and even requires adherence to a phase-based approach*:

‘[W]e want to place energy psychology treatment within the triphasic model of trauma treatment...

Tapping approaches themselves can be used as part of Phase 1 or stabilisation. However, they are generally used as a non abreactive approach to treating memories of trauma (Phase 2).

Phase 3 focuses on helping clients reconnect with social systems. For years, I have suggested that it also includes helping clients reconnect to a more resourceful identity.’

(Schwarz, 2018: 275-6).

917 Thal & Lommen, ref Foa et al. 2009; Stein et al, 2009; Mithoefer et al. 2011; ‘Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress, *ibid.*

918 Korn, ‘EMDR and the Treatment of Complex PTSD: A Review’, *ibid.*

919 See ch. 5 for discussion of the reasons for this.

920 Korn, ‘EMDR and the Treatment of Complex PTSD: A Review’, *ibid.*, p.264; emphasis added.

921 ‘The field of EMDR therapy... shows examples of adaptations to the processing of traumatic memories that include many aspects of stabilisation... in these cases, phases one and two follow a parallel path’ (Rydberg, ‘Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations’, *ibid.*, pp.93-94).

When clients report positive shifts (which in relation to Energy Psychology may be rapid; see previous discussion) Schwarz contends that 'it is good clinical practice to stabilise these new beliefs and to connect them with other aspects of a client's social system and self-narrative.'⁹²² This 'can be done in many ways', and is especially conducive to a phased treatment approach.⁹²³

Some exponents of 'short-term', 'rapid response' treatments such as EMDR and Energy Psychology (EP) actively advocate the need for their modalities to incorporate a phase-based approach.

Hypnotherapy, as noted in the preceding discussion, is also highly conducive to a phase-based approach, and can be very useful in treating dissociative disorders.⁹²⁴ In his eclectic and integrative text *Tools for Transforming Trauma*, Schwarz describes how, within a neo-Ericksonian framework, the principles of certain short-term psychotherapies (which 'are active and involve the direct or indirect alteration of perception, sensation, and meaning')⁹²⁵ can be applied at various points in the treatment of trauma. This includes its more complex varieties according to the phased treatment approach.

Clearly there are differences within, as well as between, the modalities discussed. But incorporation of strategies and techniques can be 'mapped' to different stages and treatment tasks and can indeed be done 'in many ways'. This is exciting not only in terms of parallel developments in short-term approaches 'outside' the field of talk-based psychotherapies. It is also promising for the possibilities of integrating currently unfamiliar but potentially highly effective interventions within it.

922 Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', *ibid*, p.275.

923 'Once we have helped the client completely resolve a traumatic event during a session, we want to spread the neuroception of safety back through the client's consciousness. This can be done in many ways' (Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', *ibid*, p.276. For discussion of how the various tools can be used in the context of the different phases of treatment, see Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002), p.20 and throughout.

924 See Phillips & Frederick, *Healing the Divided Self*, *ibid*, Kluft, *ibid*.

925 Schwarz, *Tools for Transforming Trauma*, *ibid*, p.24.

Chapter 4

Summary of Key Points and Themes

- Integrating diverse treatment approaches within and alongside familiar psychotherapeutic modalities has been occurring for some time and is increasing.
- The limitations of standard 'talk therapy' and cognitive based approaches to trauma treatment are increasingly recognised.
- '*Cues of safety are the treatment*' (Porges, 2018: 61). Polyvagal Theory (2011) accounts for why psychotherapy needs to be both 'bottom-up' and 'top-down' is now being applied clinically (Porges & Dana, 2018; Dana, 2018).
- The principles of Polyvagal Theory seem to support some 'non-traditional' treatment modalities. This helps us understand why '*disparate, unconventional techniques*' may be highly effective (van der Kolk, 2016: 88).
- '*It is not language, it is our biology that communicates safety*' (Gray in Porges & Dana, 2018: 212) and '[i]t is not possible to shift emotional and psychological states without shifting physiological states' (Gray, *ibid*: 221).
- Attention to the body and physiological processes does not displace talk-based psychotherapies. But standard psychotherapy trainings need to be supplemented with appropriate professional development and concurrent focused attunement to somatic regulation/dysregulation at all times.
- Bringing mindful awareness to breathing and physical processes (i.e. combining 'mind and body' in a basic, fundamental way) and incorporating mindfulness within otherwise contrasting approaches is increasingly a 'staple' of diverse psychotherapeutic modalities.
- 'Right-brain' oriented psychotherapies, which evolving clinical and research findings support, include art therapy, sandplay, creative dance, equine therapy, and drumming. Heart math, Heart Rate Variability (HRT) and neurofeedback are also now widely used therapeutic tools.
- Short-term strategies, tools, interventions and approaches/practices (as all treatment modalities and time frames) are optimised when predicated on an understanding of the core common features of complex trauma. These include *lack of a 'felt sense' of safety, pervasive shame, symptoms which are the outgrowth of initially protective coping strategies, and high levels of dissociation.*
- Short-term strategies and techniques are contraindicated unless comprehensively integrated within a phased treatment approach as per the expert consensus treatment guidelines for complex trauma (Cloitre, (Cloitre, Courtois et al, 2012). Also see final point below regarding integration of a phased approach *within* short term psychotherapies.
- 'Targeting' symptoms can be problematic as some of the behaviours and strategies that initially enhanced a person's survival may underpin disabling symptoms: '*[f]or many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously*' (Bloom & Farragher, 2011:16)

- *'[A]ttempting to prevent or reduce a symptom with counteractive methods that leave the underlying memory material intact positions a therapy client to be prone to relapses'* (Ecker, 2018: 7).
- 'Energy Psychology (EP) is a family of brief, focused approaches to releasing stuck energy and unprocessed information in the mind-body system as the result of unresolved trauma' (Schwarz, 2018: 270)
- While still regarded by many as controversial, Energy Psychology is increasingly recognised to have a scientific basis (Schwarz, 2018; Feinstein 2012; Nelms, 2017; Church 2013).
- The two most well-known Energy Psychology approaches are Emotional Freedom Techniques (EFT) and Thought Field Therapy (TFT), for which '[a] basic procedure, shared by both approaches, involves tapping on a prescribed set of acupuncture points' (Schwarz, 2018: 271).
- Studies have upheld the effectiveness of EFT techniques for a range of mental health problems (Schwarz, 2018; Gruder, 2012; Church, 2013). In the past two decades it has moved 'from a fringe therapy to widespread professional acceptance' (Church, 2013: 645).
- Practitioners and exponents of Emotional Freedom Techniques (EFT) report that clients are frequently surprised by the speed with which previous distress around 'target' memories can resolve following brief rounds of tapping (Schwarz, 2018: 275). Yet even if this is the case for clients who experience complex trauma and high levels of dissociation (which impede ability to focus and which may be undetected by the clinician) rapid resolution could itself be unsettling for a client who has little experience of positive change
- 'Starting with' a less distressing memory does not necessarily prevent a client from becoming overwhelmed as apparently less intense recollections can elicit a cascade of disorientating memories (a response which has necessitated reappraisal and adaptation of 'rapid effect' treatments and techniques)
- While some EFT practitioners are aware of trauma-related dissociation and incorporate relevant techniques (e.g. the Gentle 'Tearless Trauma' technique; Church 2015) this is not true of all.
- Depending on the nature and timing of applying a particular practice or intervention, its 'rapidity' may not necessarily be problematic. Church references therapists treating survivors of childhood sexual abuse who 'preferred energy psychology treatments such as EFT over talk therapy because they found the risk of abreaction low with the former' (Church, 2013: 650, ref Schulz, 2009).
- The study 'Integrating Energy Psychology into Treatment for Adult Survivors of Childhood Sexual Abuse' (Schulz, 2009) evaluated the experiences of twelve therapists who integrated EP interventions for this cohort. It presents recommendations for clinicians who are interested to do this.
- EMDR is an innovative well-evidenced treatment approach which has established that trauma memories may be processed more rapidly when paired with alternating bilateral stimulation. In 2018, three decades after its formulation, 'hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations' (Shapiro, 2018: vii).
- Rapid eliciting of multiple traumatic memories while attempting to focus on a 'single' event destabilises many people. This learning led to modification of the EMDR protocol for clients with complex trauma histories. A 2009 review noted the 'strong arguments that the patient characteristics associated with childhood abuse survivors and complex PTSD patients require a phase-oriented, multicomponent approach, emphasizing initial skill development and stabilization' (Korn, 2009: 275).

- A subgroup of EMDR practitioners is attuned to working with clients who experience complex trauma-related dissociation but this is not true of all (Gonzalez, 2018).
- *'No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population...The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously'* (Shapiro, 2018: 342-343).
- Attachment Focused EMDR (Parnell, 2013) is specifically addressed to the attachment deficits of relational trauma.
- 'Resource installation' is an EMDR-related technique to promote internal resources. 'Resource tapping' is a technique which 'pairs an activated resource with alternating bilateral stimulation via tapping to strengthen and integrate the resource' (Parnell, 2008: 31).
- Complex trauma clients who access EMDR are advised to work with a practitioner 'who is skilled with resource installation as well as trauma processing' (Phillips & Levine, 2012: 167).
- Brainspotting (BSP) is a new treatment approach which dates to 2003 and which is presented as 'an effective alternative therapeutic approach' to EMDR (Hildebrand, Grand & Stemmler, 2017). It is a 'brain-body mindfulness based relational therapy' (Grand, 2018) which utilises focused rather than moving eye position to locate the 'spot' at which trauma is located in the brain. BSP facilitates processing when the corresponding feelings and sensations are focused upon.
- While the apparent rapidity of Brainspotting might seem to be destabilising, BSP is explicitly attuned to complex developmental trauma and the challenges of dissociation (Grand, 2018). It combines all four dimensions of *brain, body, mindfulness* and *relationship* which serves as a safeguard.
- Clinical hypnosis, i.e. hypnotherapy, is the application of hypnosis for therapeutic purposes in a clinical context. The (mis)perception of hypnosis as the imparting of directive suggestions by an external authority figure continues to impede understanding of its many clinical applications.
- Hypnosis has been defined as 'the redistribution of attention' (Kluft, 2013). Accordingly, it is greatly applicable to the treatment of dissociative disorders (*'The study of dissociation begins in hypnosis'*; Howell & Itzkowitz, 2016: 21).
- As most dissociative disorders 'involve the redistribution of attention toward certain things and away from others' (and 'have many hypnotic elements') it is only natural to enlist the redistribution of attention that we call hypnosis in the service of treating dissociative disorders' (Kluft, *ibid*: 276).
- In 2017 MDMA-assisted psychotherapy was designated a breakthrough therapy by the United States Food and Drug Administration (FDA) and is anticipated to receive FDA approval in the US in 2021.
- A number of studies and trials uphold the safety and benefits of the clinical use of MDMA (Ot'alora, Grigsby et al, 2018; Thal & Lommen, 2018).
- Its advocates in the area of mental health believe that therapeutic, as distinct from recreational, use of MDMA should comprise 'a potential new treatment in medicine' (Sessa, 2016).

- In MDMA-assisted psychotherapy 'favorable autobiographical memories are perceived as more vivid and intense, while unfavorable memories are regarded as less negative and less distressing' (Thal & Lommen, 2018, ref Carhart-Harris et al 2015). This markedly aids processing of traumatic memories and 'may be explained by the positive correlation between decreased blood flow in the right amygdala and right hippocampus' (Thal & Lommen, *ibid*).
- Political and social factors, rather than the evidence base which is now strong, constrain funding for research into MDMA assisted psychotherapy in Australia ('*There were no drug-related serious adverse events, and the treatment was well-tolerated*'; Ot'alora, Grigsby et al, 2018; '*Our findings support previous investigations of MDMA-assisted psychotherapy as an innovative, efficacious treatment for posttraumatic stress disorder*' (Ot'alora, Grigsby et al, *ibid*).
- The potential of MDMA-assisted psychotherapy to assist the treatment of adult survivors of childhood trauma, as well as those with 'single-incident' trauma, is strong (Sessa, 2016, 2011, 2007).
- The current terrain of psychotherapy as well as healing practices outside of it is replete with possibilities. It is also important to note the limits of an 'ad hoc', unintegrated approach, and the need for appropriate training where required.
- It is possible to integrate diverse interventions, approaches, and techniques at appropriate points in the recommended 'phased treatment' model for complex trauma. Some short term and 'rapid' treatments and approaches are now introducing and incorporating particular phases or are amenable to doing so.



Chapter 5

'Evidence-Based': the Challenge of and for Complex Trauma

'Currently existing treatment methods are ineffective for 25–50% of patients enrolled in clinical trials... the economic costs of PTSD and trauma- and stressor-related disorders are estimated to amount to 43.2 billion dollars annually... The necessity for more effective treatments efficiently reducing current treatment failure rates thus becomes apparent.'

Thal & Lommen, 2018; ref Foa et al. 2009;
Stein et al. 2009; Mithoefer et al. 2011;
Greenberg 1999

Calls for all treatment/s to be 'evidence-based' are problematic in general and particularly in relation to complex trauma. This point was made in the 2012 *Practice Guidelines* and is validated by the above 2018 reference. It also needs to be reiterated in light of escalating demands on health budgets which favour short consultation times.

The claim that treatments should be 'evidence-based' can seem so 'common-sense', as well as authoritative and scientific, that the ways in which it is problematic need to be emphasised. *This does not mean abandoning the need for evidence to support particular treatments and claims of their effectiveness.* On the contrary, it underlines the need for careful scrutiny of the criteria by which treatment effectiveness is assessed.

5.1 Questioning 'evidence-based' in the context/s of psychological treatment

'Evidence-based therapy' has become a marketing buzzword. The term 'evidence-based' comes from medicine....But [it] has come to mean something very different for psychotherapy. It has been appropriated to promote a specific ideology and agenda. It is now used as code word for manualized therapy – most often brief, one-size-fits-all forms of Cognitive Behaviour Therapy (CBT). 'Manualized' means the therapy is conducted by following an instruction manual.'

Jonathan Shedler, 'Where is the Evidence for 'Evidence-Based' Therapy?' *Psychiatric Clinics of North America* (41, 2, 2018), p.319.

'[L]ogical fallacies and lapses in critical thinking are not only used to promote new, innovative or alternative methods and techniques, they also serve to denounce them... many of these criteria may apply to established forms of psychotherapy as well.'

Rydberg, 'Research and Clinical Issues in Trauma and Dissociation: Ethical and logical fallacies, myths, misreports, and misrepresentations', *European Journal of Trauma and Dissociation* (1, 2017:92).

Some of the several grounds on which unqualified endorsement of ‘evidence-based’ treatment is problematic, particularly for psychotherapeutic as distinct from medical treatment, are conveyed by the above quotes. The concept of evidence-based treatment emerged from the medical context, which is very different from that of psychotherapy and counselling. This raises fundamental questions.

Such is the presumed authority of the ‘evidence-based’ marketing ‘buzzword’, however, that this key misconception is routinely unchallenged and indeed widely misunderstood. As well as appropriating the term ‘evidence-based’ in order ‘to promote a specific ideology and agenda’⁹²⁶ (namely brief, manualised, ‘one-size-fits-all’ therapies often in the form of CBT)⁹²⁷ major misconceptions regarding the need for psychotherapeutic treatment/s to be ‘evidence-based’ – *as distinct from the need for their effectiveness to be assessed via appropriate and context-attuned mechanisms* – continue to proliferate.

The ‘buzzword’ of ‘evidence-based’ engenders the status of authority. This can mean that misconceptions are not challenged, and relevant issues are misunderstood. The term seems to have been appropriated ‘to promote a specific ideology and agenda’⁹²⁸ (i.e. of brief, manualised, ‘one-size-fits-all’ therapies often in the form of CBT).⁹²⁹ This conceptualisation has contributed to major misconceptions about the need for all psychotherapeutic treatment/s to be ‘evidence-based’ – *as distinct from the need to assess treatment effectiveness via appropriate context-attuned mechanisms*.

The question which consistently needs to be asked is: what *kind* of evidence? There are clearly many types. When applied to treatments which are endorsed, extreme care is needed regarding assumptions about how evidence is defined, exactly what it comprises, and the methods by which it is determined.

A number of issues arise with respect to psychological treatments in general. One relates to the nature of the diagnosis on which treatment is based (which is only one method to define the presenting issue/s of the client).⁹³⁰ If a particular diagnosis is problematic, the recommended treatment can also be problematic. Using an externally determined ‘evidence-based’ treatment may be unhelpful and/or inappropriate in these circumstances.

Despite its culturally, as well as scientifically, endorsed status, the nature of diagnosis and diagnostic practice is also criticised. Emergence of the Power Threat Meaning Framework is a comprehensive and cogent illustration.⁹³¹ Such critique necessarily has implications for the treatments diagnosis prescribes: ‘[e]ven mainstream medical authorities have begun to question the creeping medicalization of normal life and criticise *the poor reliability, validity, utility and humanity of conventional psychiatric diagnosis*’.⁹³²

926 Shedler, ‘Where is the Evidence for ‘Evidence-Based’ Therapy?’ *ibid*.

927 Shedler, ‘Where is the Evidence for ‘Evidence-Based’ Therapy?’ *ibid*.

928 Shedler, ‘Where is the Evidence for ‘Evidence-Based’ Therapy?’ *ibid*.

929 Shedler, ‘Where is the Evidence for ‘Evidence-Based’ Therapy?’ *ibid*.

930 Clinical assessment based on knowledge and client experience is widely regarded as a legitimate, and many would contend superior, mode of understanding people’s issues (and see subsequent discussion).

931 Lisa Johnstone, Mary Boyle et al *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis* (British Psychological Society, Leicester, 2018) https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Framework%20%28January%202018%29_0.pdf

932 Peter Kinderman, ‘Why We Need to Abandon the Disease-Model of Mental Health Care’, *Scientific American* (17 November 2014), emphasis added. Indeed, Kinderman references former director of the (American) National Institute of Mental Health Thomas Insel that ‘traditional psychiatric diagnoses ha[ve] outlived their usefulness’ (Kinderman, *ibid*). Also see subsequent discussion and footnotes.

The requirement of 'evidence-based' treatment is not attuned to the particularities of individual clients (much less the 'whole person'). Rather, reflecting its biomedical origins, evidence-based treatment is targeted at *symptoms*. It describes decontextualized and manualised treatments, and rejects 'the anecdotal' for 'generalised conclusions, based on the odds that the patient's ailments are typical for their group'.⁹³³

The generalised and decontextualized nature of 'evidence-based' psychological treatments highlights a major anomaly regarding this prevailing philosophical and cultural - as much as scientific⁹³⁴ - standard to which diverse psychological treatments are exhorted to adhere. *It does not necessarily translate to clinical practice.*

Notwithstanding its scientific claims and status, evidence-based treatments can be ineffective:

'The paradigm for modern psychiatry is evidence-based medicine (EBM) – it represents proven treatments for defined diagnoses. But there are major problems with this position... evidence-based treatments too often are ineffective.... Sensible approaches based on what we know about a particular patient, not limited to statistically validated treatments, are often more fruitful'
(Sobo, 2012)

The above observation relates to 'evidence-based' psychological treatments in general, beyond the widely referenced and endorsed Cognitive Behaviour Therapy, 'CBT' (the relative effectiveness of which is also questioned vis a vis other treatment modalities notwithstanding its routinely extolled merits).⁹³⁵ It also applies to the several treatment types with which 'evidence-based' psychological treatment is associated.⁹³⁶

Space does not permit comprehensive consideration of the challenges to calls for psychological treatments to be 'evidence-based' (i.e. as distinct from the need for appropriate criteria by which to gauge treatment effectiveness). Such discussion would need to include, among other things, consideration of the wider cultural, political, and socio-economic contexts which shape health policy and practice. Powerful financial and stakeholder investments and corporate and pharmacological interests wield disproportionate influence in indirect as well as overt ways.⁹³⁷

933 Sobo, 'Does Evidence-Based Medicine Discourage Richer Assessment of Psychopathology and Treatment?' *ibid*.

934 Significantly, Kinderman contends that the grounds for scepticism about traditional psychiatric diagnosis are not only ethical and humanitarian, but scientific as well. This is not only because '[i]t is difficult reliably to distinguish different 'disorders', but also difficult to identify specific biological and etiological risk factors' (*ibid*). Nor is this an isolated view: '*Unfortunately, the search for the 'real' diagnosis in psychiatry is often unfruitful therapeutically; 'It cannot be assumed that doing a better job clarifying psychopathology diagnostically is the best way to move forward. Established diagnostic entities are as much wish as reality'*' (Sobo, 'Does Evidence-Based Medicine Discourage Richer Assessment of Psychopathology and Treatment?' *ibid*).

935 'A critical review...shows that the available evidence for the theoretical foundations of CBT, assumed mechanisms of change, quality of studies, and efficacy is not as robust as some researchers claim. Most important, there is no consistent evidence that CBT is more efficacious than other evidence-based approaches' (Falk Leichsenring, Allan Abbas et al. 'Gold Standards', Plurality and Monocultures: The Need for Diversity in Psychotherapy', *Frontiers in Psychiatry*, 2018).

936 I.e. cognitive processing therapy (CPT), prolonged exposure therapy (PE) and Eye Movement Desensitization and Reprocessing (EMDR); also see Chapter 3.

937 In the view of psychiatrist and cultural critic David Healy, the capacity of corporate interests and culture to *market*, as much as *treat* 'disorder' has now grown to the extent of displacing the authority of medical discourse itself (Healy, *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression*, New York University Press, 2004; *Pharmageddon*, CA: University of California Press, 2012). This, he contends, represents a striking new development in which the 'old' authority of science and medicine must compete in new ways within a substantially different environment. The advent of 'a new corporate psychiatry', paralleling the rise of corporate capitalism, raises new and disturbing questions which include implications for what it means to be 'well' in our society and indeed for what 'mental health' comprises: '*Galbraith has argued we no longer have free markets; corporations work out what they have to sell and then prepare the market so that we will want those products...It works for cars, oil, and everything else. Why would it not work for psychiatry?*' (David Healy, 'Psychopharmacology and the Government of the Self', Lecture delivered at the University of Toronto, 30 November 2000) <https://www.pharmapolitics.com/feb2healy.html>

They influence not only the science⁹³⁸ but the politics and economics of health more broadly, and thus significantly affect the landscape of psychological as well as medical treatment/s.⁹³⁹

5.2 Trauma treatment research

If the nature and status of evidence for effective psychotherapy treatment/s is more complex than the imprimatur of 'evidence-based', assessing effective treatment/s for complex trauma is even more challenging.

'The trauma psychotherapy research literature is limited in at least three ways. First, most studies have excluded patients with 'complex trauma'... because these patients tend to suffer from a wider variety of more chronic problems than their circumscribed trauma counterparts....

Second...trauma psychotherapy studies rarely involve laboratory measures of cognitive and physiological functioning as indicators of trauma-related change... Third, the current literature overvalues randomized controlled trials (RCTs), which...make causal inferences about the efficacy of treatment packages, but often lack generalizability to independent practice...'

D'Andrea & Pole, 'A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma', *Psychological Trauma: Theory, Research, Practice and Policy*, 4 (4), 2011, p.439.

As several years have passed since the above observation, it is instructive to consider the extent to which it still applies. The first point – exclusion of clients with complex trauma from treatment studies – has been a longstanding issue. Clients with complex trauma have long been excluded from treatment outcome studies. Restrictive entry criteria, which preclude clients with comorbidities from participation, have limited research into effective complex trauma treatment/s over a long period. As Rothschild noted, in the 'vast majority' of trauma method outcome studies, subjects are not random but 'carefully chosen': *'People with multiple traumas, especially with complex issues or complicating personality disorders, are rarely accepted in outcome studies.'*⁹⁴⁰

This is rarely made explicit, and the frequent conflation of complex with standard PTSD compounds the issues. Assertions that complex trauma treatment lacks an adequate research base can imply that effective treatments don't exist. This is different to understanding that exclusion criteria perpetuate

⁹³⁸ Bioethicist Leemon McHenry notes that while '[m]ost people trust that medical and scientific journals are reliable sources of knowledge', in fact most 'are owned by large publishing corporations and there is growing evidence that those corporations serve the private interests of their client corporations rather than the medical and scientific community': 'Instead of demanding rigorous peer review of submissions and an independent analysis of the data, editors submit to pressures to publish favourable articles of industry-sponsored titles and rarely publish critical deconstructions of ghostwritten clinical trials' (Leemon McHenry, 'Villains and Heroes: Academic Thuggery', <https://davidhealy.org/villains-and-heroes-academic-thuggery>). Also see Healy *ibid*, Allen Frances, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (HarperCollins, New York, 2013); Robert Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (Random House, New York, 2010); *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (Perseus, PA, 2002); Ray Moynihan & Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Corporations are Turning us all into Patients* (Allen & Unwin, Sydney, 2005).

⁹³⁹ But the insidiousness and sophistication of its marketing can be subtle and hard to recognise; see Healy, *Pharmageddon*, *ibid*, Frances, *Saving Normal*, *ibid*, Whitaker, *Anatomy of an Epidemic*, *ibid*. Indeed, the term 'evidence DEbased medicine' has been coined by Tim Moss to describe the distortion, suppression, data massaging, and innumerable other problematic practices which can be deployed in the name of 'science' (and to which respected institutions are not immune) <https://davidhealy.org/the-goetzsche-affair/>

⁹⁴⁰ Babette Rothschild, *Trauma Essentials* (Norton, New York, 2011). P. 71 (emphasis added).

a situation in which the number of studies that assess complex trauma treatment is relatively low.⁹⁴¹ Conflation of standard with complex PTSD also strengthens the expectation that what works for the former will work for the latter. This claim has long been contested by many complex trauma specialists.⁹⁴²

To what extent are complex trauma clients still excluded from outcome studies? To a limited extent this is starting to change. As discussed in the chapter on phased treatment, some treatment studies now include and actively recruit complex trauma participants. Mostly, however, this is to compare how complex trauma patients respond to 'first-line', intensive 'trauma-focused' psychotherapies as compared to people with standard PTSD.⁹⁴³ Such studies only assess the short-term treatments defined as 'evidence-based' (see above comments and discussion in ch.3). Nevertheless, the contention that patients who experience the impacts of complex trauma are excluded from outcome studies now needs to be qualified somewhat.⁹⁴⁴

It is also important to note that *'[t]rauma treatment as a professional field is fairly young,'⁹⁴⁵ and that '[a]s our understanding of the impact of trauma on human experience grows through neuroscience with conceptualizations such as Polyvagal Theory... and research on the brain and memory... the essential role that somatic and movement-based therapies play in the restorative process is now widely accepted.'*⁹⁴⁶

5.3 'Laboratory measures': what is being studied?

The second observation in the previous indented quote that ('with some exceptions') psychotherapy studies in relation to trauma 'rarely involve laboratory measures of cognitive and physiological functioning as indicators of trauma-related change'⁹⁴⁷ also requires examination. This is particularly in light of the current interest in somatic psychotherapies and the role of the body. 'Laboratory measures', like the phrase 'evidence-based', connotes authority and objectivity.

Yet bias in conceptualisation of *what* is measured is a feature of the 'hard' as well as so-called 'soft' sciences. Stephen Porges notes that '[l]imited research has been conducted on the influence of sensory feedback from bodily organs (i.e. visceral afferents) in the neural regulation of the autonomic nervous system' and ways in which these influences manifest 'in the heart and other visceral organs'.⁹⁴⁸

942 Namely van der Kolk's reference years ago to studies which show that complex trauma patients 'may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma' (Bessel A. van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Solomon & Siegel, *Healing Trauma*, ibid, p.173).

943 See, for example, Wagenmans, Van Minnen, et al, 'The Impact of Childhood Sexual Abuse on the Outcome of Intensive Trauma-Focused Treatment for PTSD', *European Journal of Psychotraumatology* (9, 1, 2018) and Hagenaars, van Minnen, et al, 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy* (48, 1, 2010), pp.19-27.

944 The legitimacy of naturalistic studies, case histories and other means by which to assess treatment effectiveness also needs to be reiterated. See, for example, Colin Ross et al, 'Treatment Outcomes across Ten Months of Combined Inpatient and Outpatient Treatment in a Traumatized and Dissociative Patient Group', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2, 2018), pp.87-100. Also see Ulrich Schnyder, & Marylene Cloitre, ed *Evidence-Based Treatments for Trauma-Related Psychological Disorders* (Springer International Publishing, Switzerland, 2015).

945 Amber Gray, in Stephen W. Porges & Deb Dana, eds. *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), p.209. Key developments of recent years include Dan Siegel's Interpersonal Neurobiology (IPN; 1999,2015), Stephen Porges' Polyvagal Theory (2011) which is now being applied clinically (Porges & Dana,2018, ibid) and clinical implications of the work of Iain McGilchrist (2009) on the hemispheres of the brain.

946 Gray, in Porges & Dana, *Clinical Applications of the Polyvagal Theory* ibid, citing multiple references.

947 D'Andrea & Pole, 'A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma', ibid, p.439.

948 Stephen Porges, 'Polyvagal Theory: A Primer', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), p.59.

*'This is, in part, due to a top-down bias in medical education that limits the conceptualization of the neural regulation of the heart and other bodily organs by emphasizing the role of motor fibres and minimizing the role of sensory fibres.'*⁹⁴⁹

Porges also notes that 'this bias is rapidly changing due to research on the applications of vagal nerve stimulation' ('a bottom-up model that focuses on the vagus as a sensory nerve').⁹⁵⁰ Increased awareness of the centrality of somatic impacts of trauma (where '*[m]odern neural science points to the central role of the body*'⁹⁵¹ and '*[t]he body, for a host of reasons, has been left out of the 'talking cure'*'⁹⁵² is starting to redress the bias Porges describes. Increased technological capacity to attune to these impacts is significant. But utilisation of advances in technology is not a routine component of standard 'laboratory' measures.

The issue of 'what kind of evidence?' underlines a more fundamental question in light of evolving neurobiological and other research, but which at this point remains insufficiently addressed and even recognised. This is *the way in which research of psychological treatment/s is conceptualised*. Physiological and somatic processes and experience are increasingly regarded as integral to wellbeing. This means that unqualified reference to 'mental' health is itself increasingly problematic. Growing awareness of the interrelationship of body and brain may be game changing in terms of how future studies for effective 'psychological' treatments are designed and authenticated.

Significantly, this is also an area in which at this point clinicians may have more to contribute than neuroscientists. With reference to the phenomenon of memory reconsolidation,⁹⁵³ and due to 'a fortunate convergence of clinical observations and brain research', Bruce Ecker contends that '*the translation of reconsolidation research findings into effective psychotherapeutic use appears to have advanced at an accelerated pace unexplicated by and still largely unknown to neuroscience researchers*'.⁹⁵⁴

*'The rigor of the clinical observations ... is of a different type from that of the quantitative measurements made in laboratory controlled studies by neuroscientists... the aim is phenomenological rigor that capitalizes on the unique ability of human subjects (therapy clients) to direct attention to their own mental and emotional states and to describe the moment-to-moment effects.'*⁹⁵⁵

Neuroscientists, says Ecker, 'have barely begun to utilize such articulation of subjective experience for gaining access to the memory reconsolidation process' (even as 'their first forays in that direction' have been fruitful).⁹⁵⁶

Similarly, David Grand, founder of Brainspotting⁹⁵⁷ (see Chapter 4) contends that *clinical* scientists can contribute to necessary research in ways neuroscientists cannot ('*they just don't have that exposure and access*').⁹⁵⁸ He also affirms that research is not just about psychometric measures and hypothesis testing.⁹⁵⁹

949 Porges, 'Polyvagal Theory: A Primer', *ibid*, p.59.

950 Porges, 'Polyvagal Theory: *ibid*; note that 'approximately 80% of the vagal fibres are sensory' (*ibid*).

951 Daniel J. Siegel, 'Senior Editor's Foreword', in Pat Ogden et al, *Trauma and the Body* (New York: Norton, 2006), p.xv. For detailed discussion of the '[n]eurological foundations of emotions, attachment, communication, and self-regulation', see Stephen Porges, *The Polyvagal Theory* (Norton, New York, 2011).

952 Ogden, *Trauma and the Body*, *ibid*, p.xxvii.

953 See Bruce Ecker, Robin Ticic, & Laurel Hulley, *Unlocking the Emotional Brain* (Routledge, New York, 2012).

954 Bruce Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (Vol.6, Issue 1, 2018), p.80.

955 Ecker, 'Clinical Translation of Memory Reconsolidation Research', *ibid*, p.4.

956 Ecker, 'Clinical Translation of Memory Reconsolidation Research', *ibid*, citing Sevenster et al., 2013, 2014.

957 David Grand, *Brainspotting: The Revolutionary New Therapy for Rapid and Effective Change* Boulder, Sounds True, Boulder, CO, 2013 <https://brainspotting.com/> (and see discussion in ch.4 of this document).

958 David Grand, 'What is Brainspotting?' <https://www.youtube.com/watch?v=lm3Plvaf3UE> Published Dec 23, 2014, and the interview screened in June 2018 in the Healing Trauma Summit by Sounds True <https://www.soundstrue.com/store/healing-trauma-summit?sq=1>

959 See previous footnote.

5.4 'First-line', 'trauma-focused' and 'evidence-based': Grounds for scepticism as treatments for complex trauma (detail in ch.3)

The limitations of 'first-line', 'trauma-focused' and 'evidence-based' psychotherapies as treatments for complex trauma, and especially for clients who are severely dissociative, are discussed in ch.3. They will not be repeated here. The majority of people with complex trauma and Complex PTSD 'have severe dissociative symptoms'.⁹⁶⁰ Contrary to the findings of Haaenars, Van Minnen et al. that such clients 'are just as likely to profit from effective treatment programs like exposure as those with low dissociative and depressive symptom levels',⁹⁶¹ experienced complex trauma researchers and clinicians do not endorse this view (patients with significant dissociative symptoms... respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well';⁹⁶² 'What one does not do in early recovery is any form of 'exposure' therapy').⁹⁶³

The privileging of 'evidence-based' trauma treatments (particularly in light of the reality described in the quote which prefaces this chapter) is concerning on a number of grounds. As a recent text on a comprehensive treatment approach for complex trauma articulates,

*'Psychotherapists in many services are required to restrict their approaches to those therapies recommended in guidelines or expert consensus irrespective of the oversimplified misrepresentation of the evidence base that result in service constraints such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. Psychotherapy therefore is often protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control. Patients unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance.'*⁹⁶⁴

Officially endorsed approaches to treating traumatic memory also show little understanding of the distinction between explicit (conscious, verbal) and implicit (largely non-conscious somatic; of which traumatic memory is a particular and particularly potent type).⁹⁶⁵ Delayed onset recall (or 'recovered' memory) is frequently regarded with scepticism despite its established prevalence in diverse types of trauma.⁹⁶⁶ The reality is that no form of memory is infallible; many studies confirm that subsequently

960 Van der Hart, Nijenhuis & Steele, *The Haunted Self* (2006) *ibid*, p.112

961 M. A. Haaenars, A. Van Minnen et al, 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy*, (48, 1, 2010), p. 26.

962 David Spiegel, 'Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4. Similarly, Paul Frewen & Ruth Lanius contend that 'when a person's past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice' (Frewen & Lanius, *Healing the Traumatized Self* (Norton, New York), p.207.

963 Judith L. Herman, 'Foreword', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (The Guilford Press, New York, 2009), p.: xvi; original emphasis). Peter Levine is likewise explicit in his concern about extending exposure treatment for 'simple phobias' to the ['evidence-based'] treatment of trauma via 'prolonged exposure' ('the repurposing of a therapy originally designed for simple phobias to treating trauma, which is much more complex, may be a disturbing misapplication of these early methods'; Levine, *Trauma and Memory* (North Atlantic Books, Berkeley, CA), pp.117-118). For further critique of exposure therapies for treatment of chronic traumatisation, see Ellert Nijenhuis, 'Therapeutic Exposure from an Enactive Perspective', *The Trinity of Trauma*, Vol. 3 (Vandenhoeck & Ruprecht GmbH & Co, Goettingen, 2017), pp.400-404.

964 Lisa Schwarz, Frank Corrigan, et al, citing Corrigan & Hull, 2015, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (Routledge, New York, 2017), p.140.

965 Levine, *Trauma and Memory*, *ibid*; also see *The Truth of Memory and the Memory of Truth*, Blue Knot Foundation, 2018 <https://www.blueknot.org.au/resources/publications/trauma-and-memory>

966 See Van der Hart, Brown, & Graafland, 'Trauma-induced Dissociative Amnesia in World War 1 Combat Soldiers', *Australian and New Zealand Journal of Psychiatry* (33, 1, 1999, pp.37-46); Wagenaar & Groeneweg, 'The Memory of Concentration Camp Survivors', *Applied Cognitive Psychology* (4, 1990, pp.77-87), and Elliott, 'Traumatic Events: Prevalence and Delayed Recall in the General Population', *Journal of Counselling and Clinical Psychology* (65, 1999, pp.811-820).

recalled ('recovered') memory is no more likely to be reliable or unreliable than explicit memory.⁹⁶⁷ These factors, in combination, paint a sorry picture of the officially authorised psychotherapies for trauma treatment. Also concerning, and correspondingly, is the limited capacity of millions of people with complex trauma to access other treatment possibilities which may indeed have an evidence base (see Chapter 4) although lack the status of 'evidence-based'. Many respected complex trauma clinicians are increasingly speaking out about this situation:

*'the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities...The over-optimistic claims for the effectiveness of Cognitive Behavioural Therapy (CBT) and misrepresentation of other approaches do not best serve a group of patients greatly in need of help; excluding individuals with such disorders as untreatable or treatment-resistant when viable alternatives exist is not acceptable.'*⁹⁶⁸

5.5 Emotion-Focused Therapy for Complex Trauma (EFTT) *Redressing 'affect phobic' treatments?*

In their specific focus on treatment which is appropriate for complex trauma, Schwarz, Corrigan et al. characterise much evidence-based treatment as 'protocolised and affect-phobic' (whereby strong emotion is 'regulated by top-down control').⁹⁶⁹ It is ironic to consider that the containing of emotion in complex trauma may be perpetuated by the very therapies which aim to treat it.

Emotion-Focused Therapy for Complex Trauma (EFTT) is another complex trauma treatment which implicitly aims to redress this inadequacy. Exponents of EFTT describe it as 'the only evidence-based ...individual therapy for both men and women who are dealing with different types of childhood maltreatment'.⁹⁷⁰

*'The characteristics of client suitability are consistent with best practices for most trauma therapies...In general, EFTT is designed for clients who are suitable for short-term trauma-focused therapy who have the capacity to form a therapeutic relationship over a few sessions and to focus on a circumscribed issue from the past – in this case childhood trauma.'*⁹⁷¹

967 'Substantial research examining both naturalistic and laboratory situations has demonstrated that recovered memories are equally likely to be accurate as are continuous, never-forgotten memories' (Barlow et al, 'Trauma and Memory', ref. Chu et al, 1999; Williams, 1995; Dalenberg, 2006, Chapter 16 in Gold, ed. *APA Handbook of Trauma Psychology*, American Psychological Association, 2017 p.322; 'Memories that are recovered – those that were forgotten and subsequently recalled – can often be corroborated and are no more likely to be confabulated than are continuous memories' Chu, *Rebuilding Shattered Lives*, John Wiley & Sons, NJ, 2011, p.80 (ref Dalenberg, 1996; Kluff, 1995; Lewis, Yeager, Swiza, Pincus & Lewis, 1997 [and see Dalenberg et al, 2012].

968 Frank M. Corrigan & Alastair M. Hull, 'Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions' *BJPsych Bull.* (39, 2, 2015), pp.79–86.doi: [10.1192/pb.bp.114.047134] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478907/>

969 Schwarz, Corrigan, et al, *The Comprehensive Resource Model*: ibid, p.140.

970 Sandra C. Paivio & Antonio Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach* (American Psychological Association, Washington, DC .2017), p.4; ref Paivio, Jarry et al, 2001.

971 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, ibid, p.6, ref Courtois & Ford, 2009; Foa, Keane, Friedman & Cohen, 2009; note that the latter citations pertain only to the first part of the quotation (re 'best practices').

Whether childhood trauma is appropriately described as an 'issue' (and a 'circumscribed' one at that) is contestable. EFTT is also described as unsuitable for clients who exhibit severe affect regulation and a risk of harm to themselves or others, 'whose current problems take precedence over a focus on past issues (e.g. domestic violence, substance dependence) or who wish to focus primarily on current rather than past relationships'.⁹⁷²

The latter group comprises a significant proportion of people with complex trauma. Indeed, strictly delineating current and past relationships is problematic, as trauma re-enactment is a well-evidenced reality of the interplay between implicit memory and symptoms as recognised by complex trauma clinicians and researchers.⁹⁷³ It is also problematic that EFTT is not described as a 'staged or linear model'⁹⁷⁴ despite the fact that specific phases of the approach (which comprise four; i.e. an additional stage to the widely endorsed three-phased model for treatment of complex trauma)⁹⁷⁵ are delineated and discussed.⁹⁷⁶

EFTT does, however, speak to the reality and treatment challenges of shame and impaired self-conception. Paivio and Pascual-Leone also note that apart from the research which supports EFTT, 'almost all other studies of individual therapy for complex trauma have included only female sexual abuse survivors diagnosed with PTSD'⁹⁷⁷ while 'only one additional study included female sexual and physical abuse survivors'.⁹⁷⁸ As they go on to note, 'the negative effects of child abuse are not exclusive to this subgroup', and 'a diagnosis of PTSD is not necessarily a defining feature of complex PTSDs'.⁹⁷⁹

Described as 'among a growing group of psychological treatments identified as emotion-focused approaches for particular disturbances or disorders',⁹⁸⁰ EFTT represents adaptation of 'the general emotion-focused therapy model' of Greenberg and Paivio (1997),⁹⁸¹ 'modifying its interventions' and 'tailoring its structure and emphasis to the specific needs of trauma victims'.⁹⁸² It is a 'semi-structured approach that typically consists of 16 to 20 weekly 1-hr sessions' (although in cases of greater severity and duration of trauma 'therapy likely will be more long term').⁹⁸³

EFTT is also described as 'a manualised treatment that on one hand is sufficiently specific to be used in research and, on the other hand, is sufficiently flexible to be used by clinicians in their daily practice'⁹⁸⁴ ('The text also can be used in graduate training programs and is consistent with the American Psychological Association's recommendations to provide training in evidence-based approaches').⁹⁸⁵

While not 'affect phobic' by definition (and thus different from standard evidence-based trauma treatments as per the critique of Schwarz, Corrigan et al)⁹⁸⁶ EFTT is nevertheless not unproblematic.

972 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.6.

973 As per 'adaptive yet symptom-generating emotional learnings'; Ecker, 'Clinical Translation of Memory Reconsolidation Research', *ibid*, p. 6; 'the problem is the solution'; The Adverse Childhood Experiences (ACE) Study, 1998; 2010.

974 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.44.

975 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* (2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

976 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, pp.44-47.

977 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.4, ref Chard, 2005, Resick, Nisbith & Griffin, 2003).

978 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, ref Cloitre, Koenen, Dohen & Han, 2002.

979 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, pp.4- 5; ref van der Kolk, 2003.

980 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.5

981 Greenberg & Paivio, *Working with Emotions in Psychotherapy* (The Guilford Press, New York, 1997).

982 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.5.

983 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.44.

984 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.8.

985 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, pp. 8-9.

986 Schwarz, Corrigan, et al, *The Comprehensive Resource Model*: *ibid*, p.140.

To reiterate, this is due to its conceptualisation of childhood trauma as a ‘circumscribed issue’,⁹⁸⁷ its acknowledged unsuitability as a treatment for severely addictive and self-harming clients,⁹⁸⁸ its ambivalent embrace of a phased approach that it also disavows,⁹⁸⁹ and its counterposing of ‘past’ and ‘present’ client relationships⁹⁹⁰ (which is problematic in that re-enactment of prior trauma, previously widely referenced as ‘repetition compulsion’, is a familiar and characteristic feature in the lives of complex trauma survivors).

5.6 Revisiting the dominance of randomised control trials (RCTs)

‘The [US APA] guidelines are supposed to reflect the best scientific evidence. In fact, they ignore all scientific evidence except one kind of study, called randomized controlled trials (RCTs).’

(Schedler, 2017)

It is contended that randomised controlled trials (RCTs) are ‘overvalued’ as they ‘make causal inferences about the efficacy of treatment packages, but often lack generalizability to independent practice...’⁹⁹¹ (i.e. the third claim regarding the status of trauma research; see the previous indented quote of D’Andrea and Pole). Yet this is only one of several disabling limitations of RCTs.

Gold standard or old standard? The randomised controlled trial is traditionally seen as the ‘gold’ standard of evidence in ‘evidence-based’ therapy research. This model of research randomly assigns participants with a particular diagnosis to either a treatment or control group and compares the two groups. Yet as Shedler discusses, the RCTs which informed the most recent trauma treatment guidelines of the American Psychological Association (APA) studied only therapies of 16 sessions or less and ‘[m]any were eight sessions or less’ (‘[i]n other words the guidelines considered only therapies that are inadequate’).⁹⁹²

Lack of consideration of therapies other than those which are short-term is a concerning criticism of RCTs. This is along with the other criticisms which can be made of this research method (and which relate to the types of therapies assessed, pharmacological influence, restrictive exclusion criteria, and issues in relation to control groups):⁹⁹³ *‘It was a foregone conclusion that the guidelines would recommend only brief, standardized forms of CBT which are conducted by following step-by-step instruction manuals. They are the only therapies that are expedient to study with RCTs.’*⁹⁹⁴

987 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.6.

988 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*.

989 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.44.

990 Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*, p.6.

991 D’Andrea & Pole, ‘A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma’, *ibid*, p.439.

992 Jonathan Shedler, ‘Selling Bad Therapy to Trauma Victims’, *Psychology Today* 2017.

993 Also suppression of data; Shedler, ‘Where is the Evidence for ‘Evidence-Based’ Therapy?’ *ibid*; also see McGauran, Wiessler, et al. (2010) ‘Reporting Bias in Medical Research – A Narrative Review’, *Trials* 11-37, 2010 <http://www.trialsjournal.com/content/11/1/37>

994 Shedler, ‘Selling Bad Therapy to Trauma Victims’, *ibid*.

5.7 The Treatment of Patients with Dissociative Disorders (TOP DD) Study

An exception to the exclusion of complex trauma clients from treatment outcome studies, as well as to the short-term trauma treatments endorsed as 'evidence-based', is the Treatment of Patients with Dissociative Disorders Study (TOP DD).⁹⁹⁵ Significantly, the TOP DD is also now in the process of preparing to convene an RCT.

The TOP DD is a prospective, longitudinal international study which addresses the paucity of research for the treatment of complex trauma and dissociative disorders. It does this by a systematic assessment of the effectiveness of phased treatment for this client group (also see Chapter 3 of this document). Led by Professor Bethany Brand of Towson University, Maryland, the TOP DD study is the largest and sole international study of dissociative disorders (DD) and has involved patients and therapists from 19 countries.

The research team of the TOP DD has conducted two studies to date. The first is a prospective, naturalistic study of treatment outcome for DD patients from a range of countries, and the second is a survey of DD experts which canvasses their recommendations for specific treatment interventions that are effective at various stages of treatment for DD. Data was collected at four points across 30 months of treatment, several papers pertaining to it have been published or are in press,⁹⁹⁶ and additional papers, as well as the 'in process' RCT preparation, are planned. A paper on the TOP DD's web-based educational program has also been published in the *Journal of Traumatic Stress*.⁹⁹⁷

995 For full details of the Treatment of Patients with Dissociative Disorders (TOP DD) Study see the information contained on its website <https://www.towson.edu/cla/departments/psychology/topdd/>

996 Bethany L. Brand, Catherine C. Classen et al. 'A naturalistic study of dissociative identity disorder and dissociative disorder not otherwise specified patients treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, & Policy*, 1(2) 2009, 153-171; Bethany Brand, & Richard Loewenstein, 'Does phasic trauma treatment make patients with dissociative identity disorder treatment more dissociative? *Journal of Trauma & Dissociation*, 15, 2014, 52-65; Bethany Brand, S.W. McNary et al. S.W., Myrick, A.C., Loewenstein, R.J., Classen, C.C., Lanius, R.A., Pain, C. & Putnam, F.W. 'A longitudinal, naturalistic study of dissociative disorder patients treated by community clinicians', *Psychological Trauma: Theory, Research, Practice, & Policy*, 5(4) 2013, 301-308; Brand, Myrick, et al., 'A survey of practices and recommended treatment interventions among expert therapists treating patients with dissociative identity disorder and dissociative disorder not otherwise specified', *Psychological Trauma: Theory, Research, Practice, & Policy*, 4, 2011 490-500; Brand, & Stadnik, 'What contributes to predicting change in treatment of dissociation: Initial levels of dissociation, PTSD, or overall distress?' *Journal of Trauma & Dissociation*, 14, 2013 328-341; Cronin, Brand et al, B.L., (2014). The impact of the therapeutic alliance on treatment outcome in patients with dissociative disorders. *European Journal of Psychotraumatology*, 2014, Engelberg, J.C., & Brand, B.L. 'The effect of depression on self-harm and treatment outcome in patients with severe dissociative disorders. *Psi Chi Journal of Psychological Research*, 17, 2012, 115-124; Myrick, Brand et al. 'An exploration of young adults' progress in treatment for dissociative disorder', *Journal of Trauma & Dissociation*, 13, (2012). 582-595; Myrick, Brand, & Putnam, 'For better or worse: The role of revictimization and stress in the course of treatment for dissociative disorders', *Journal of Trauma & Dissociation*, 14 (4) 2013, 375-389; Myrick, Chasson, et al. 'Treatment of complex dissociative disorders: A comparison of interventions reported by community therapists versus those recommended by experts', *Journal of Trauma & Dissociation*, 16 (1), 2015, 51-67; Webermann, Brand, et al, 'Childhood maltreatment and intimate partner violence in dissociative disorder patients', *European Journal of Psychotraumatology*, (2014).

997 Bethany L. Brand, Hugo J. Schielke, et al, 'An Online Educational Program for Individuals With Dissociative Disorders and Their Clinicians: 1-Year and 2-Year Follow-Up', *Journal of Traumatic Stress* (January 2019) <https://onlinelibrary.wiley.com/doi/full/10.1002/jts.22370>

The TOP DD found that patients with dissociative disorders show less depression, dissociation, PTSD, and general distress over 30 months of treatment, together with decreases in suicide attempts, self-injurious behaviors, and hospitalizations. Further, therapists rated patients as having higher adaptive functioning over time:

'[t]he consistent reports of both the patients and the therapists in the TOP DD study demonstrated that DD treatment is associated with decreased symptoms and improved functioning'

'What is the TOP DD Study?'

<https://www.towson.edu/cla/departments/psychology/topdd/>

The TOP DD study is also providing information about how DD patients respond to treatment, and 'the variables that are associated with different treatment outcomes such as age, revictimization, and stressors.'⁹⁹⁸

This pioneering study is starting to redress a major research gap: *'The study has important implications for the mental health field because DD are prevalent and associated with severe symptoms and dysfunction, as well as high treatment costs.'*⁹⁹⁹

'Several medical economics studies find that dissociative disorders are among the most costly of all psychiatric disorders in terms of their rates of treatment utilization (Brand, Classen, McNary, & Zaveri, 2009; Brand et al, 2013; in Putnam, 2016; 247).

The TOP DD is also a major achievement in being conducted at all. Lack of government funding means that it relies on private and alternative funding sources. Compared to other mental health conditions and disorders, treatment studies for dissociative disorders are not encouraged, and indeed are actively *discouraged*, from being conducted and even conceived.¹⁰⁰⁰

Few areas have received as little support for understanding and treatment as that of the dissociative disorders. Pioneering clinician and researcher Frank Putnam underlines that funding continues to be blocked at the grant review level of the US National Institute of Mental Health.¹⁰⁰¹ As Putnam points out, the NIMH 'unofficially discourages dissociative disorder treatment research at the program level such that preliminary inquiries about NIMH's interest in potential dissociative disorders treatment studies are quickly nipped in the bud.'¹⁰⁰²

Once again this evokes the politics of health and funding, which at least as much as disinterested inquiry, shapes the agenda and priorities of 'scientific' research. It also relates to the challenges posed to governments, funding bodies and society as a whole in confronting the extent of severe childhood abuse which correlates with the most severe complex dissociative disorders.¹⁰⁰³ Studies of effective treatment/s for this extremely under-served cohort labour under enormous constraints. Despite this continuing inequity, and against considerable odds, studies of treatment for complex trauma and dissociative disorders – of which the TOP DD is the largest and most authoritative – are starting to appear.¹⁰⁰⁴

998 'What is the TOP DD Study?' <https://www.towson.edu/cla/departments/psychology/topdd/>

999 What is the TOP DD Study?' <https://www.towson.edu/cla/departments/psychology/topdd/>

1000 See Frank W. Putnam, *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* (International Psychoanalytic Books [IP Books], New York, 2016), p.245 and subsequent discussion.

1001 Putnam, *The Way We Are*, *ibid*.

1002 Putnam, *The Way We Are*, *ibid*, p.245.

1003 'Dissociation is the ultimate form of human response to chronic developmental stress, because patients with dissociative disorders report the highest frequency of childhood abuse and/or neglect among all psychiatric disorders' (Vedat Sar, 'The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience*, 12, 3, 2014, p.171).

1004 See, for example, Colin Ross et al, 'Treatment Outcomes across Ten Months of Combined Inpatient and Outpatient Treatment in a Traumatized and Dissociative Patient Group', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2, 2018), pp.87-100.

The TOP DD has also led to the TOP DD Network Study; a pioneering internet-based program which 'enables DD patients around the world to participate in a web-based educational program informed by the results of [the] previous [TOP DD] studies'.¹⁰⁰⁵

5.8 Practice based evidence, common factors research, and Feedback Informed Treatment (FIT)

Actively enlisting practitioner recommendations at various stages of treatment, as in the TOPP DD research, also again draws attention to the limits of standard 'evidence-based' treatment. The latter generally lacks reference to, and does not take account of, client and practitioner experience. The absence of input from those who administer and those who receive treatments raises a number of issues.

The alternative paradigm of 'practice-based evidence'¹⁰⁰⁶ (which prioritises client and practitioner feedback in assessing treatment effectiveness) and the associated but also distinctive approach of 'common factors' research¹⁰⁰⁷ (which shows that the particular treatment modality is less significant to the effectiveness of the therapy than are other factors involved in the treatment process) were noted in the first edition of the Blue Knot Guidelines. The research in relation to both highlights additional considerations unaddressed by the imprimatur of 'evidence-based' regarding 'what works' in psychotherapy.¹⁰⁰⁸

Another related but also distinctive approach to gauging the effectiveness of psychological treatments is Feedback Informed Treatment (FIT).¹⁰⁰⁹ FIT 'involves routinely and...formally soliciting feedback from clients about the process of therapy, working relationship [with the therapist] and overall wellbeing'.¹⁰¹⁰ To access this information,

'Two simple scales that have proven useful for monitoring the status of the relationship and progress in care are the Session Rating Scale (SRS [Miller, Duncan, & Johnson, 2000]) and the Outcome Rating Scale (ORS, [Miller & Duncan, 2000]). The SRS and ORS measure alliance and outcome, respectively. Both scales are short, 4-item, self-report instruments that have been

1005 The TOP DD Network Study <https://topddstudy.com/networkstudy.php>

1006 See Alice Ammerman, Tosha Woods et al, 'Practice-Based Evidence in Public Health: Improving Reach, Relevance, and Results', *Annual Review of Public Health* (US) Vol.35, 2014, pp.47-63 <https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182458>; Padraig Collins & Sarah Crowe, 'Recovery and practice-based evidence: reconnecting the diverging discourses in mental health', *Mental Health and Social Inclusion* (Vol. 21, Issue: 1, 2017), pp.34-42

<https://www.emeraldinsight.com/doi/abs/10.1108/MHSI-09-2016-0028?journalCode=mhsi> Also see Bruce Duncan, S. Miller & M. Hubble, ed. *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd edit. (American Psychological Association, Washington, DC, 2010); Duncan, Miller & Sparks, *The Heroic Client* 2nd edit. (Jossey-Bass, SF, CA, 2004), and David J. Hellerstein, 'Practice-Based Evidence Rather Than Evidence-Based Practice in Psychiatry', *The Medscape Journal of Medicine* (10, 6, 2008), p.141 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2491680/>

1007 James Drisko, 'Common Factors in Psychotherapy Outcome: Meta-Analytic Findings and Their Implications for Practice and Research', *Families in Society, the Journal of Contemporary Human Services* (85, 1, 2004), pp. 81-90. Also see Bruce Wampold, 'How Important are the Common Factors in Psychotherapy? An Update', *World Psychiatry* (14, 3, 2015), pp.270-277.

1008 It also continues to grow; see Scott. D. Miller, 'Practice-Based Evidence Goes Mainstream', 5 September 2009 <https://www.scottdmiller.com/practice-based-evidence-goes-mainstream/> The question of 'what works' in psychotherapy continues to generate diverse and valuable research; see for example Per Høglend and Knut Hagtvet, 'Change Mechanisms in Psychotherapy: Both Improved Insight and Improved Affective Awareness Are Necessary', *Journal of Consulting and Clinical Psychology* (Vol. 87, No. 4, 2019), pp. 332-344 <http://dx.doi.org/10.1037/ccp0000381>

1009 Scott D. Miller, Mark A. Hubble et al, 'Feedback Informed Treatment (FIT): Achieving Clinical Excellence One Person at a Time', *Independent Practitioner* (Summer 2014), pp.78-85.

1010 Jason Seidel, PsyD, founder and director of The Colorado Center for Clinical Excellence, Denver, cited in Margarita Tartakovsky, 'Feedback-Informed Treatment: Empowering Clients to Use their Voices', PsychCentral 8 October 2018 <https://psychcentral.com/lib/feedback-informed-treatment-empowering-clients-to-use-their-voices/>

tested in numerous studies and shown to have solid reliability and validity (Miller, 2010). Most importantly perhaps, the brevity of the two measures insures they are also feasible for use in everyday clinical practice'.¹⁰¹¹

The nature of client feedback, and ways in which practitioners can become aware of it, is a large topic. This is especially in the context of complex trauma therapy, in which non-verbal communication is critical and where formalized input from the client may not be possible at various times.¹⁰¹² However, the client's sense of how treatment is affecting them, and the practitioner's sense of this in interacting with the client, is important. It also raises considerations beyond the recommendation that confines psychological treatments to those which are 'evidence-based'.

5.9 Widening our purview: complex trauma and diverse treatment types

To what extent does restricting the variety of psychotherapies to those which have been formally assessed limit the claimed generalisability of RCT findings about short-term therapies? For Jonathan Shedler, '[r]elevant scientific evidence' no longer matters, because proponents of so-called evidence-based therapies ignore evidence for therapy that is not pre-scripted, manualised therapy'.¹⁰¹³

Psychodynamic psychotherapies have long been excluded from RCTs (the parameters of which do not easily accommodate them). For this reason there is little evidence of their effectiveness as compared to short-term 'evidence-based' psychotherapies. This situation is anomalous and concerning.

It is not only Shedler, a vocal credentialed critic of RCTs, who finds this situation perturbing. In his paper 'The Scientific Standing of Psychoanalysis', Mark Solms summarises 'the core scientific claims of psychoanalysis', and effectively rebuts 'the prejudice that it is not 'evidence-based''.¹⁰¹⁴ Others make similar cases.¹⁰¹⁵

Some qualification of this critique is warranted to the extent that there are many reasons why dynamic psychotherapies have not been evaluated extensively relative to treatments more amenable to the strictures and structure of the RCT. Reference to short-term psychotherapies also needs to be

1011 Miller, Hubble et al, 'Feedback Informed Treatment (FIT): Achieving Clinical Excellence One Person at a Time', *ibid*, p.79.

1012 See Guideline 14.

1013 Shedler, 'Where is the Evidence for 'Evidence-Based' Therapy?', *ibid*. Also note McHenry's highlighting that '[p]ublished reports of unfavourable outcomes or serious events have been directly linked to sharp fluctuations in stock prices' (McHenry, 'Villains and Heroes: Academic Thuggery', *ibid*). Nor is this the undermining of 'pure' scientific research by 'external' commercial pressures (i.e. 'good' science as distinct from representation of it), because 'the corruption of science and the corruption of the journals are parts of the same phenomena' (*ibid*).

1014 Mark Solms, 'The Scientific Standing of Psychoanalysis', *British Journal of Psychiatry* (15, 1, 2018), pp.5-8. Solms makes his case by addressing the nature of the emotional mind (how it operates in health and disease), what psychoanalytic treatment aims to achieve, and its effectiveness (*ibid*)

1015 See, for example, Christiane Steinert, Thomas Munder et al. 'Psychodynamic Therapy: As Efficacious as Other Empirically Supported Treatments? A Meta-Analysis Testing Equivalence of Outcomes', *The American Journal of Psychiatry* (25 May 2017) and Leichsenring & Raburg, 'The Effectiveness of Long-Term Psychodynamic Psychotherapy in Complex Mental Disorders: Update of a Meta Analysis', *The British Journal of Psychiatry* (99, 1, 2011), pp.15-22. Also see the *Psychiatric Clinics of North America* issue on psychodynamic psychiatry (Volume 41, Issue 2, June 2018) described by Thomas N. Franklin MD as 'an example of what twenty-first century medicine is aspiring to be: patient centered, evidence-based, and concerned with the root causes of suffering and disability rather than simply treating symptoms as they arise' (*ibid*, pp. xv-xvi).

qualified to the extent that some psychodynamic approaches are themselves short-term¹⁰¹⁶ and have been assessed¹⁰¹⁷ (i.e. 'short-term' therapies and treatment approaches are very diverse; see the previous chapter for consideration of evidence in specific instances). Also notable is that research around experiential psychotherapies is increasing as well.¹⁰¹⁸

It is not only omission of acknowledgement of the evidence base for psychoanalytic psychotherapy that limits claims about the generalisability of RCT findings regarding 'evidence-based' psychological treatments. A wide and growing range of psychotherapies is consistently expanding (see Chapter 4) and there are many legitimate methods by which to assess treatment effectiveness. Particular psychotherapies cannot be dismissed as lacking evidence because they were not included in RCTs (the nature of which, by definition, means that the majority won't be).

Evidence is always important and particularly in relation to health services offered to the public. But the absence of evidence does not necessarily mean that treatment is ineffective. There are many examples of effective treatments that are not 'evidence-based' in the familiar sense.¹⁰¹⁹ Most clinicians are not researchers, and, as practitioners, we would not expect them to be. As previously stated, it is also 'well known that clinical innovations come from clinicians, not researchers.'¹⁰²⁰

In this context, the comments of Daniel Siegel in his Foreword to the 2010 text *The Trauma Treatment Handbook* by Robin Shapiro (which is avowedly not research-based)¹⁰²¹ are significant. At first, says Siegel, he thought 'the lack of scientific studies supporting many of the various individual approaches' in this text 'would lead [him] to call the author and say that he could not write [the] foreword.'¹⁰²² But reflecting on his own development as a therapist, and bearing in mind the need for 'a spectrum of interventions at our disposal to create the most effective and individually sculpted therapeutic experiences' he decided otherwise.¹⁰²³

1016 See, for example, Joan Haliburn, *An Integrated Approach to Short-Term Dynamic Interpersonal Dynamic Interpersonal Psychotherapy* (Karnac, London, 2017); Diana Fosha, *The Transforming Power Of Affect: A Model for Accelerated Change* (Perseus, New York, 2000) and as discussed above, Paivio & Pascual-Leone, *Emotion-Focused Therapy for Complex Trauma*, *ibid*.

1017 See, for example, Andrew Lewis, Michelle Dennerstein et al. 'Short-Term Psychodynamic Psychotherapy: Review of Recent Process and Outcome Studies', *Australian and New Zealand Journal of Psychiatry* (42, 6, 2008), pp. 445-55; Barkham, Guthrie, et al, *Psychotherapeutic-Interpersonal Therapy: A Conversational Model* (Sage: London, 2017). Also see Knekt, Lindfors et al 'Randomized trial on the effectiveness of long and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up', *Psychological Medicine* (38, 2008), pp. 689-703.

1018 See, for example, Robert Elliott, Leslie Greenberg et al, 'Research on Humanistic-Experiential Psychotherapies, Chapter 13 in Michael J. Lambert, ed. *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change*, 6th edition (John Wiley & Sons, New Jersey, 2013), pp.495-538.

1019 An example is clinical application of EFT ('Emotional Freedom Techniques') which, as Church has discussed, 'attracted the attention of researchers' as it became popular in therapy and coaching contexts (Dawson Church, PhD, *Psychological Trauma*, Energy Psychology Press, CA, 2015, p.11). Studies of EFT have been conducted and it has been found to be 'extremely effective for mental health problems such as phobias, depression, anxiety, and PTSD' (Church, *ibid*: 10-11, ref. Lane, 2009). For more detailed discussion of EFT in the context of treatment of trauma see Chapter 4 of this document.

1020 Boon, Steele, & van der Hart, ref Westen, Novotny, & Thompson-Brenner, 2004, *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* (Norton New York, 2011), p. xiii.

1021 Robin Shapiro, *The Trauma Treatment Handbook: Protocols Across the Spectrum* (Norton, New York, 2010), pp.3-4.

1022 Daniel J. Siegel, MD, 'Foreword' to Shapiro, *The Trauma Treatment Handbook*, *ibid*, xiii-xiv.

1023 'I realised that this compilation was indeed a very helpful compendium of useful – even if mostly not scientifically proven – approaches that would help any clinician working with traumatized individuals' Siegel, 'Foreword', *The Trauma Treatment Handbook*, *ibid*.

It would be a serious mistake to dismiss the evidence of clinical practice which is now considerable. Bearing in mind the comments of earlier in this chapter, and the previously cited comments of Bruce Ecker,¹⁰²⁴ it would also be a mistake to regard it as necessarily inferior to, rather than different from, 'laboratory measures'.

5.10 Evidence base rather than 'evidence-based'?

A diverse range of evidence suggests the limits of RCTs and the generalisability of their findings regarding short-term 'evidence-based' psychological treatments. As Wampold et al. noted in their review of the psychotherapy research literature in relation to RCTs for anxiety and depression, there was 'insufficient evidence to suggest that transporting an evidence-based therapy to routine care that already involves psychotherapy will improve the quality of services'.¹⁰²⁵

The *context* of treatment is important as is the need for treatment contexts to be 'trauma-informed'. Jennings's contention that '[w]ithout such a shift [towards trauma-informed care] ...even the most 'evidence-based' treatment approaches may be compromised'¹⁰²⁶ remains apposite.

*'Our current emphasis on evidence-based practice implemented by various interventions, protocols, treatment plans, and expected outcomes is both a creation of our culture's left-centric bias and the means by which we remain confined to that viewpoint and separated from the living reality of our patients' unfolding experience.'*¹⁰²⁷

'As is evident from psychotherapy's recent embrace of mindfulness meditation, psychotherapists do embrace unconventional procedures having roots in ancient traditions that do not yet have explanatory models within the prevailing psychological paradigm, as long as sufficient empirical evidence demonstrates the approach's effectiveness in treating psychological issues'.

David Gruder, PhD (2012: 39).

David Gruder, author of the above comments, notes that 'research findings coming from independent investigations in more than a dozen countries' suggest that 'controversy notwithstanding', Energy Psychology 'is not only durably effective, but unusually rapid'.¹⁰²⁸ While the apparent rapidity of EP techniques may suggest their use might be

1024 Ecker, 'Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *ibid*.

1025 Wampold, Budge et al, 'Evidence-based treatments for depression and anxiety versus treatment-as-usual: a meta-analysis of direct comparisons', *Clinical Psychology Review*, 31, 2011, p.1311.

1026 Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) US, 2004.

1027 Bonnie Badenoch, 'Safety is the Treatment', in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory* (Norton, New York, 2018), p.81.

1028 David Gruder, PhD 'Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support', *Psychotherapy*: Official Publication of Division 29 of the American Psychological Association, (Vol.47, No.3, 2012), p.42. Also see Church, 2013, 2015, footnote 79 and Chapter 4 of this report.

contraindicated for treatment of complex trauma, this is not necessarily the case. Indeed, EP approaches can be and are integrated into the phased trauma treatment model.¹⁰²⁹ Sufficient has been said about some of the many grounds on which calls for psychological treatment/s to be 'evidence-based' can be challenged. Unfortunately, however, the term 'evidence-based' has become a buzzword. This necessitates repeated reiteration of the serious limits of this form of evidence.

The politics of health and public policy can also significantly stall the official endorsement of treatment modalities which are subsequently endorsed in the interest of public health and made widely available¹⁰³⁰ (*'It is paradoxically difficult to obtain funding for a novel treatment approach as ...there is no evidence that it works so why would we study it?'*)¹⁰³¹

The *phase-based* treatment model of complex trauma is widely considered to be effective. It is recommended by a majority of complex trauma clinicians and endorsed by the ISTSS *Expert Consensus Treatment Guidelines for Complex PTSD in Adults*.¹⁰³² This approach is critiqued by exponents of short-term, intensive, 'evidence-based' and 'trauma-focused' psychotherapies and is considered in detail in ch.3 which should be read in conjunction with this one. The question 'what *kind* of 'evidence?' should consistently be asked and perennially borne in mind.

Studies to gauge the effectiveness of time-limited phased therapy for complex trauma which incorporates expressive and somatic components are needed. Judicious combinations of 'standard' and 'alternative' treatment approaches within a phased treatment approach may begin to be conducted and would be very valuable.

For example, a recent study of an eight-week multimodal phase-oriented inpatient treatment program for complex trauma and dissociation¹⁰³³ incorporated an innovative mix of components including art therapy, music, and movement therapy along with 'traditional' cognitive treatment and pharmacotherapy. In this mixed-model approach, most of the patients in this study received an amalgam of treatment components and showed appreciable benefits, including a reduction of negative dissociative symptoms.¹⁰³⁴

1029 See Robert Schwarz, 'Energy Psychology, Polyvagal Theory, and the Treatment of Trauma', Chapter 15 in Porges & Dana, ed. *Clinical Applications of the Polyvagal Theory*, ibid, pp. 270-284, in which Schwarz specifically recommends integration of Energy Psychology within the 'triphasic' treatment model. Also see his prior text *Tools for Transforming Trauma* (Routledge, New York, 2002) in which he maps a number of 'short term' and strategic psychotherapeutic approaches to the phased treatment model. Also see Chapters 3 and 4 of this document.

1030 See discussion of MDMA assisted psychotherapy in Chapter 4.

1031 Schwarz et al, *The Comprehensive Resource Model*, 2017, p.6.

1032 M. Cloitre, C.A. Courtois, et al *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* (2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf The introduction to these guidelines noted that Complex PTSD has also and alternately been named Disorders of Extreme Stress Not Otherwise Specified (DESNOS), PTSD and its associated features (ie in DSM-IV and note subsequent iteration of DSM 5), and Enduring personality change after catastrophic events in the WHO 1992 iteration of the ICD (note that the ICD-11 was likewise unavailable at the time). As Rydberg relates, '[t]he ISTSS task force selected a definition of cPTSD [CPTSD] that covers a range of symptoms derived from these diagnostic descriptions and includes the core symptoms of PTSD (re-experiencing, avoidance/numbing, and hyperarousal) in conjunction with a range of disturbances in self-regulatory capacities'; emphasis was on 'not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources' (J.A. Rydberg, 'Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations', ref. Cloitre et al, 2012, *European Journal of Trauma and Dissociation*, 1, 2017, p.92).

1033 Yolanda Schlumpf, Ellert Nijenhuis et al (2019) 'Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', *Neuroimage: Clinical* (23, 2019), 101807.

1034 Schlumpf, Nijenhuis et al 'Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', ibid.

The above study noted that effective phased treatment of complex trauma is invariably much longer than eight weeks.¹⁰³⁵ This means that its benefits need to be considered in this context and the study does not endorse or promote 'fast track' treatment. At the same time, studies such as this are important in showing that a diverse 'mix' of treatment approaches can benefit complex trauma clients, including when the treatment is time-limited, if the principles of the phased treatment approach are adhered to. Thus while not sufficient in itself, and while conducted in an inpatient setting to which the majority of complex trauma clients lack access, 'brief therapy' of this innovative kind may indeed be beneficial for complex trauma clients (also see Chapter 4).

1035 Schlumpf, Nijenhuis et al 'Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', *ibid*.

Chapter 5

Summary of Key Findings and Themes

- Calls for all psychological treatment/s to be 'evidence-based' are more problematic than they may appear. This is not to dispute the need for evidence to support the range of psychotherapies available. Rather it is to recognise that there are various forms of 'evidence'. Care is needed to scrutinise the basis upon, and criteria by which, treatment effectiveness is assessed.
- The imprimatur of 'evidence-based' favours *particular kinds* of psychological treatment (largely short-term, intensive, and CBT oriented). A key reason for this is that such psychotherapies are most amenable to assessment by randomised controlled trials (RCTs).
- A diverse range of evidence suggests the limits of RCTs and the generalisability of their findings regarding short-term 'evidence-based' psychological treatments (Shedler, 2015, 2018): *'Sensible approaches based on what we know about a particular patient, not limited to statistically validated treatments, are often more fruitful'* (Sobo, 2012).
- Research into trauma treatment in general, and complex trauma treatment in particular, faces a number of challenges (D'Andrea & Pole, 2011). With respect to complex trauma, restrictive entry criteria to clinical trials for participants with multiple comorbidities has long impeded the availability of outcome studies (Rothschild, 2011; Ross & Halpern, 2009).
- Conflating standard with complex PTSD can imply that treatment which may be effective for the former is likewise effective for the latter. The legitimacy of this claim has long been contested by many complex trauma specialists who cite studies which show that clients with complex trauma-related conditions *'may react adversely to current, standard PTSD treatments'* (van der Kolk, 2003).
- Some recent studies have included both complex trauma patients and participants with standard PTSD in order to test the claim that treatment of these cohorts should be different (e.g. Wagenmans, Van Minnen et al., 2018). While the results of some studies do not conclude that a childhood trauma history 'has a detrimental impact on the outcome of first-line (intensive) trauma-focused treatments for PTSD' (ibid), the use of short-term 'evidence-based' psychotherapies for such clients remains contra-indicated in the view of a majority of complex trauma clinicians and researchers who endorse the more gentle and phased treatment approach long favoured for this client population (Cloitre, Courtois et al, 2012; *see Chapter 3 'Revisiting Phased Treatment for Complex Trauma' for detailed discussion of this topic*).
- The Treatment of Patients with Dissociative Disorders Study (TOP DD), for which an RCT is now planned, is a pioneering international study in an area from which government research funding continues to be withheld (Putnam, 2018). This is despite the enormous costs of untreated and inappropriately treated complex trauma-related dissociative disorders and thus the urgent need for studies of effective treatment.
- The TOP DD involves 19 countries and has conducted two studies; a prospective, naturalistic study of treatment outcome for patients with dissociative disorders and a survey of dissociative disorder experts for their recommendations of specific treatment interventions effective at various stages in DD treatment. Data was collected at four points across 30 months of treatment.

- Findings of the TOP DD study reveal that patients with dissociative disorders show less depression, dissociation, PTSD, and general distress over 30 months of treatment, together with decreases in suicide attempts, self-injurious behaviors, and hospitalizations <https://www.towson.edu/cla/departments/psychology/topdd/>
- That TOP DD followed a treatment period of 30 months and used ‘phased’ (rather than short-term, intensive ‘evidence-based’) treatment approaches challenges the claim ‘that PTSD patients with serious comorbid dissociative or depressive symptoms are just as likely to profit from effective treatment programs like exposure as those with low dissociative and depressive symptom levels’ (Hagenaars, van Minnen et al., 2010). The latter reading is not shared by experts in complex trauma and dissociation (e.g. Spiegel, 2018 and see Chapter 3).
- The importance of the *context* of treatment, the centrality of *relationship/s* to healing (especially for complex trauma which is interpersonally generated), and the limits of decontextualised, externally determined, short-term and ‘manualised’ psychotherapies needs to be emphasised.
- Practice-based evidence, ‘common factors’ research and Feedback Informed Treatment (FIT) highlight major omissions of sole focus on the ‘evidence-based’ paradigm. They also challenge calls for all psychological treatments to be ‘evidence-based’.
- The need for treatment contexts to be ‘trauma-informed’, and the contention that in the absence of this shift ‘even the most ‘evidence-based’ treatment approaches may be compromised’ (Jennings, 2004) remains apposite.
- A recent study of an eight-week multimodal phase-oriented inpatient treatment program for complex trauma and dissociation incorporated an innovative mix of components including art therapy, music, and movement therapy along with ‘traditional’ cognitive treatment and pharmacotherapy (Schlumpf, Nijenhuis et al, 2019). Participants were found to benefit from this treatment. Similar studies are necessary and the potential for enhanced treatment options of this kind should be explored.



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Appendix 1

Resources

Appendix 1: Resources

Blue Knot Foundation (*resources, helpline, trainings*):

www.blueknot.org.au

International Society for the Study of Trauma and Dissociation, ISSTD

<https://www.isst-d.org/>

The Academy on Violence and Abuse (AVA; *US based*)

http://www.avahealth.org/who_we_are/

<http://www.teachtrauma.com/>

(by an expert US clinician and researcher of complex trauma and dissociation)

Healing Trauma Summit

Sounds True

<https://www.soundstrue.com/store/healing-trauma-summit?sq=1>

Treating Trauma Master Series

US National Institute for the Clinical Application of Behavioral Medicine (NICABM)

<https://www.nicabm.com/program/treating-trauma-master/>

CPTSD: Four Discoveries That Are Revolutionizing Treatment

<https://www.youtube.com/watch?v=8N6tbUS5EYU>

‘How Childhood Trauma affects Health across a Lifetime’ Nadine Burke Harris, MD

<https://www.youtube.com/watch?v=95ovIJ3dsNk>

How Childhood Sexual Abuse Affects Interpersonal Relationships

<http://ritualabuse.us/research/sexual-abuse/how-childhood-sexual-abuse-affects-interpersonal-relationships/>

‘The Bomb in the Brain: The Aftermaths of Child Abuse’

<https://www.youtube.com/playlist?list=PLB3F2CF45EEB95C80>

(4 part series by a Canadian broadcaster on the extensive impacts of childhood trauma; draws on the pioneering research of Vincent Felitti MD who is interviewed)

Reflections on the Adverse Childhood Experiences (ACE) Study Dr Vincent Felitti

<https://www.youtube.com/watch?v=-ns8ko9-ljU>

‘The Enduring Effects of Child Abuse’ (Updated March 2018)

<https://network.crcna.org/safe-church/enduring-effects-child-abuse>

On betrayal trauma and disclosure:

<https://dynamic.uoregon.edu/jjf/defineBT.html>

‘Why Therapy Works’ Louis Cozolino

<https://www.thescienceofpsychotherapy.com/why-therapy-works/>

Why Therapy Works: a talk by Robin Shapiro (*focuses on complex interpersonal trauma*) https://www.youtube.com/watch?v=1C5s3z48_Qw

Expressive and 'non-traditional' therapies

Art Therapy

https://my.uq.edu.au/programs-courses/plan.html?acad_plan=ARTTHX5151

Brainspotting

<https://brainspotting.com/> (*additional links and research papers in References*)

'What is Brainspotting?' Interview with David Grand, 2014 <https://www.youtube.com/watch?v=Im3Plvaf3UE>

Dream Network Australia

<http://www.dreamnetworkaustralia.com.au/home>

(*general programs for those interested in working with their dreams; also offers resources and learning experiences '[f]or practitioners wanting to develop their professional skills in dreamwork'*)

Drumbeat

<https://www.holyoake.org.au/drumbeat/about-us/>

<https://www.holyoake.org.au/drumbeat/about-us/>

(*'incorporates hand drumming, behavioural therapeutic principles and cognitive and dialectical elements' in an award-winning program*)

Energy Psychology

<https://www.energypsych.org/general/custom.asp?page=AboutEPv2>

Equine Therapies Association of Australia

<https://equinetherapies.net.au/#ETAA>

Hypnotherapy

The Australian Hypnotherapists Association

<https://www.ahahypnotherapy.org.au/>

Academy of Applied Hypnosis (AAH)

<https://aahypnosis.com.au/>

MDMA-Assisted Psychotherapy

<https://maps.org/research/mdma>

'Healing Trauma with MDMA-Assisted Psychotherapy: An FDA-Designated Breakthrough Therapy'

Rick Doblin, Healing Trauma Summit, Sounds True, June 2018

<https://www.soundstrue.com/store/healing-trauma-summit?sq=1>

Psychedelic Research in Science and Medicine (PRISM)

<https://www.prism.org.au/> ;

<https://www.prism.org.au/australia-is-missing-out/> ;

<https://www.prism.org.au/renewed-interest-in-psychedelics/>

Neurofeedback

https://www.mindmedia.com/en/solutions/neurofeedback/?gclid=EAlaIQobChMI1ojU58iR3wIVEC-QrCh25hw7IEAAYAAAEgLRVvD_BwE

For the research base of neurofeedback, see D. Corydon Hammond & D. Allen Novian, 'The ISNR Comprehensive Bibliography of Neurofeedback Research', International Society for Neurofeedback and Research (ISNR) <https://www.isnr.org/isnr-comprehensive-bibliography>

Polyvagal Therapy training

https://catalog.psychotherapy.com.au/sales/pz_c_001280_applyingpolyvagaltheory_email-36249

Sandplay therapy

ANZ Sandplay Therapy Institute

<http://stanza.asn.au/sandplay-therapy-institute/>

Sandplay Australia

<http://www.sandplayaustralia.com.au/>

Sensorimotor Psychotherapy

<https://www.sensorimotorpsychotherapy.org/psychotherapists.html>

Sensoriprocessing Disorder Australia

<https://spdaustralia.com.au/>

(directly addresses sensoriprocessing disorder in children but sensory integration interventions can also assist the somatic disruptions sustained by adult survivors).

Somatic Experiencing Australia

<http://www.seaustralia.com.au/>


Trauma-Sensitive Yoga

<https://www.traumasensitiveyogaaustralia.com/>

Trauma Center Trauma-Sensitive Yoga Australia, An Adjunctive Treatment for PTSD and Developmental and Complex Trauma

<http://www.tctsyaustralia.com/>

(an empirically validated, adjunctive treatment for youth and adults with complex trauma or chronic, treatment-resistant PTSD, developed at the Trauma Center at JRI in Brookline, Massachusetts, USA, by David Emerson [Founder and Director of Yoga Services] in clinical consultation with Dr Bessel van der Kolk)



Appendix 2

Self Care for Therapists who Work with Complex Trauma

Appendix 2: Self Care for Therapists who Work with Complex Trauma

'[T]he first line of care should be for the caregivers'
(Rothschild, 2011:134)

*'...self-care is an ethical imperative for all therapists but especially
for those working with complex trauma'*
(Pearlman & Caringi, 2009:216; original emphasis)

The above quotes highlight the importance of practitioner wellbeing. *The risk of vicarious traumatization is especially high in complex trauma treatment* (Coleman, Chouliara & Currie, 2018, who also highlight *'[t]he need for good practice guidelines on self-care internationally'*).

It is important to look after and maintain your own wellness and energy levels for you as well as your clients. The following basic points, questions, and tips can help safeguard your wellbeing:

DIMENSIONS OF WELL BEING:

- Physical
- Emotional
- Organisational (*policies and health of the service in which you work if not in private practice*)
- Consultation with colleagues
- Regular trauma-informed clinical supervision
- Structural and systemic support
- R&R (*is time for rest and relaxation factored into your weekly schedule?*)
- Ability to track your responses (*attune to your body and to somatic cues which may challenge the rationalisation that you 'feel fine' and can 'carry on' without regular breaks*)
- Your capacity to find meaning (*important when ministering to human distress*)

QUESTIONS TO CONSIDER:

- How do you currently care for yourself in light of the work that you do?
- Do you have a 'wellness plan' to which you regularly refer?
- Are there dimensions of self-care that remain in need of addressing?
- To what extent do you track your own (as well as client) responses? (*does consultation with colleagues help you with aspects of this?*)
- Are your attitudes and assumptions to your work and life protective of your own health? (*if not, how can you begin to address this?*)
- From where do you derive your sense of meaning? (which is critical both to your own wellbeing and to effective practice)

For training to help safeguard you against the risks of Vicarious Trauma see
<https://www.blueknot.org.au/Training-Services/Training-for-your-organisation/Vicarious-Trauma>



Glossary



Glossary

acupoints – In traditional Chinese medicine, acupoints are ‘specifically chosen sites of acupuncture manipulation, and also the basis for studying the mechanism of acupuncture’ (Li, 2015). In Energy Psychology, the term describes acupuncture points to which pressure is applied (‘acupressure’) which may be ‘as effective as acupuncture itself’: ‘Acupuncture theory teaches that energy flows through our body through pathways called meridians. Disease can be caused by a blockage or interruption of that flow, and acupuncture or acupressure can be used to remove those blockages’ (Church, 2010, ref Cherkin et al, 2009). See ‘Emotional Freedom Techniques’ (EFT), Energy Psychology (EP), ‘Thought Field Therapy’ (TFT).

adaptation to trauma – Responses to overwhelming experience include physiological, psychological and behavioural shifts; adaptation to trauma, particularly at an early and vulnerable developmental stage, becomes a ‘state of mind, brain and body’ around which all subsequent experience organises’ (Cozolino, 2002). This means that a range of diverse symptoms and conditions can be viewed as adaptations (‘PTSD, borderline personality disorder, and self-harm can all reflect complex adaptation to early trauma’; *ibid*). In the context of trauma, ‘symptoms’ can be viewed as ‘adaptive coping mechanisms’ rather than seen as pathology. This recognises that the person is responding, often resourcefully, to damaging events or situations. The Adverse Childhood Experiences (ACE) Study charts the longstanding connections between ‘personal solutions’ (coping strategies to deal with adverse childhood experiences) and ‘public health problems’ (which stem from coping strategies which have ceased to protect). Ecker (2018) refers to ‘adaptive yet symptom-generating emotional learnings’. It is also the case that ‘[f]or many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously’ (Bloom & Farragher, 2011).

‘Trauma-informed’ care approaches are non-pathologising as they consider what ‘happened to’ a person rather than what is ‘wrong’ with a person. They emphasise acquisition of skills rather than ‘symptom management’ (Jennings, 2004). See ‘Adverse Childhood Experiences Study’, ‘coping strategies’, ‘strengths-based’, ‘trauma-informed’.

adult onset trauma – Trauma that is experienced in adulthood rather than in childhood. The pathways to trauma and implications for treatment can be very different according to whether the trauma is of adult or early onset. Prior attachment difficulties are a frequent early indicator of complex childhood trauma, for which graduated (‘phased’) treatment is recommended. By contrast, in treating single-incident adult onset trauma there is generally less need for extensive repair of the capacity to regulate affect (Shapiro, 2010). See ‘affect regulation’, ‘early onset trauma’, ‘trauma treatment’, ‘phased treatment’.

Adult Attachment Interview (AAI) – A widely used questionnaire developed by psychologist Mary Main which accurately predicts the effects of adult attachment styles on parenting. Siegel & Hartzell (2004) discuss the proven correlations between childhood attachment style and particular parenting styles. Note that even longstanding attachment styles can be modified (Siegel, 2003). This means that less than optimal adult attachment styles can be reworked and their negative effects on the next generation intercepted. See ‘attachment’, ‘attachment styles’, ‘the Strange Situation’, ‘earned security’.

Adverse Childhood Experiences (ACE) Study – A pioneering longitudinal study in the United States which establishes the relationship between potentially overwhelming ('adverse') experiences in childhood and emotional and physical ill health in adulthood. The ACE study included over 17000 participants, the majority of whom were white middle-class. Its major findings are that adverse childhood experiences are 'vastly more common than recognised or acknowledged', and that such experiences negatively impact both physical and emotional adult health up to fifty years later (Felitti, Anda et al, 1998; Felitti & Anda, 2010). The study also found that childhood coping strategies developed to defend against adversity stop being protective over time and can negatively impact health (i.e. conversion of 'personal solutions' into 'public health problems'). See 'adaptation to trauma', 'affect regulation', 'symptoms', 'coping strategies'.

affective neuroscience – Study of the neurobiological processes which form and mediate emotion, focusing on the role of the right-brain hemisphere. See 'interpersonal neurobiology', 'neurobiology of attachment', 'right brain', 'social brain'.

affect regulation – Management of emotion, also described as 'self-soothing'. The capacity to tolerate and regulate emotion, and is central to wellbeing and the ability to deal with life challenges. The right brain hemisphere mediates affect regulation and early attachment experience with primary caregivers crucially shapes this process (Schoore, 1994; Siegel, 1999). Complex trauma disrupts affect regulation. This accounts for the emphasis on 'phased' treatment recommended for complex trauma treatment. Phase 1 focuses on safety and stabilisation, which fosters the capacity to regulate affect and is the vital precondition for ability to process and integrate trauma (Phases II and III respectively). Trauma cannot be processed, much less 'confronted' without the ability to tolerate and regulate affect. See 'attachment', 'complex trauma', 'early onset trauma', 'phased treatment'.

alter – A particular kind of ego state; the term is commonly used to describe the inner world of people diagnosed with Dissociative Identity Disorder (DID). Reference to 'ego states' helps describe the chronic internal divisions, including structural dissociation of the personality, which can be generated by developmental disruption and early life trauma. But the ego states of structural dissociation ('alters') differ from the ego-states which characterise health and wellbeing: 'All alters necessarily fall under the broad rubric of ego states, but most ego states are not alters' (Kluft, 2006). Kluft (2006) describes characteristics of ego states which are also alters but which 'are not intrinsic to the ego state phenomenon per se' (Kluft, 2006). See 'ego state', 'dissociation', 'dissociative disorder', 'Dissociative Identity Disorder', 'parts', 'self state', 'self system'.

attachment – Originally conceptualised by British psychiatrist John Bowlby, attachment relates to the emotional bonds forged between infant and primary caregiver/s. Attachment is described as 'a fundamental form of behaviour with its own internal motivation, distinct from feeding and sex, and of no less importance for survival' (Bowlby [1981] 2006). Attachment to caregivers is protective for the developing infant as affective neuroscience supports. Bowlby argued that attachment behaviour is seen in all human beings in different ways, as well as in other species, and is wrongly regarded as 'dependence' (which has a pejorative connotation). While most obvious in early childhood, attachment behaviour is apparent throughout the life cycle. See 'attachment theory', 'attachment styles', 'The Strange Situation'.

Attachment-Focused EMDR – An adaptation of Eye Movement Desensitisation and Reprocessing (EMDR) therapy which emphasises the need for client resource-building prior to trauma processing when working with complex trauma. It follows the emphasis on 'resource installation' (RDI) recommended for complex trauma clients in the 2009 review of EMDR (Korn, 2009). Attachment-Focused EMDR is particularly suited to adult survivors of childhood trauma who have self-regulatory defects as a result of disrupted attachment. See 'attachment', 'Eye Movement Desensitisation and Reprocessing', 'resources'.

attachment style/s – Modes of relating to others which stem from our early experience of relating to primary caregivers. The concept of 'attachment style' dates to the 'Strange Situation' study of the 1970s, which drew on the original research of John Bowlby and which identified three distinct styles of infant reunion behaviour with their mothers after short periods of separation. The initially identified attachment styles were labelled 'secure', 'avoidant' and 'ambivalent' (i.e. one secure and two varieties of insecure attachment style). A fourth attachment style – 'disorganised' – was added in the 1990s.

Attachment styles have been shown to be longstanding, and to be transmitted intergenerationally via parental interaction with their infants. Yet studies also show that it is possible for attachment styles to be modified (i.e. for insecure attachment styles to be converted to secure ones); a process known as 'earned security'. See 'attachment', 'The Strange Situation', 'disorganised attachment' and 'earned security'.

attachment theory – This large growing body of research builds on the original work of John Bowlby, Mary Ainsworth and Mary Main and explores the pivotal role of emotional connection and relationship to human development and wellbeing. Attachment theory, along with affective neuroscience, is described as 'probably the fastest-growing area of study in the psychotherapy branch of psychology' (Rothschild, 2011).

Research in attachment has 'objectively demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's wellbeing' (Siegel, 2003). It has further established 'that the parents' own subjective internal experience... is the most robust predictor of the security of the child's attachment to them' (Ibid) and that the effects are transgenerational. See 'attachment', 'attachment styles', 'The Strange Situation', 'transgenerational trauma'.

aversive bias – unconscious prejudice which stigmatises whole groups of people and which constitutes a form of micro-aggression within Western liberal democratic societies. Often taking the form of aversive racism (Gaertner & Dovidio, 1986) aversive bias targets 'non norm' groups and can constitute a form of insidious trauma (Brown, 2009). See 'micro-aggression', 'individualism', 'politics of trauma'.

betrayal trauma – This term describes complex trauma in which a caregiver, someone known to the victim, or someone expected to be protective substantially violates a person's trust. First elaborated by Freyd (1998, 2008) the term captures the depth of the psychological violation which can occur in complex trauma. Betrayal trauma also operates 'in a larger context beyond interpersonal relationships' (Freyd, 2013)

bilateral stimulation – '[t]he use of eye movements, tactile sensations, sounds or physical movements to stimulate the left and right hemispheres...of the brain' (Parnell, 2008). This is significant in light of the recognised limits of 'talk therapy' for the resolution of trauma (Schwarz, Corrigan et al, 2017) and growing evidence from diverse fields which confirms 'the central link between emotion and physiology, and points to somatic stimulation as the element common to emerging psychotherapeutic methods' (Church, 2013). See 'expressive therapies', 'right brain', 'Energy Psychology', 'Eye Movement Desensitisation and Reprocessing', 'resources', 'tapping'.

blaming the victim – A defensive psychological response which holds the wronged party responsible for the injury they have received. The prevalence and diversity of interpersonal sources of complex trauma pose individual as well as collective challenges. 'Blaming the victim' is a psychological protection from acknowledging the level of violence society tolerates. Neuroscientific research reveals that trauma is encoded in the brain, thereby precipitating responses for which the person cannot be held responsible. See 'adaptation to trauma', 'coping strategies', 'endogenous opioids', 'Adverse Childhood Experiences Study', 'social defence mechanisms'.

body – Neuroscientific research is illuminating the inextricable relationship between physiological and psychological processes, with major implications for understanding and treatment of trauma ('Modern neural science clearly points to the central role of the body'; Siegel, 2007). Current research suggests that traditional psychotherapeutic approaches need to attune more closely to physical experience and expression (van der Kolk, 2003; Ogden, 2006). See 'sensorimotor psychotherapy', 'somatisation', 'traditional psychotherapy', 'expressive therapies'.

Borderline Personality Disorder (BPD) – A diagnostic category in which the person has great difficulty integrating emotional states, and in which seemingly extreme feelings of anger, emptiness and abandonment frequently coexist with volatile and self-harming behaviours. This diagnosis masks underlying trauma, and the term 'borderline' is often applied in a derogatory way due to the person's relational difficulties. Many people contest both the diagnosis and the label. Ross & Halpern (2009) note that '[t]oo often, the mental health field inflicts more abuse, neglect, devaluation, and rejection on top of the life experience that gave rise to the borderline criteria to start with'. Also see 'blaming the victim', 'complex trauma', 'coping strategies', 'Dialectical Behaviour Therapy', 'trauma informed'.

Brainspotting (BSP) – A psychotherapy developed by David Grand based on the principle that we feel different according to where our eyes focus ('where you look affects how you feel'; Grand, 2013). Differing from EMDR in its emphasis on fixed, rather than moving, eye position, Grand 'discovered' Brainspotting in his work with a client in 2003. This distinctive psychotherapy rapidly locates the 'spot' of the trauma or any negative experience in the brain, which facilitates processing of the experience when the corresponding feelings and sensations are focused on. The effectiveness of BSP has a growing evidence base (see Hildebrand, Grand & Stemmler, 2017; Corrigan, Grand & Raju, 2015).

BSP – See 'Brainspotting'

burnout – '[A] collection of symptoms associated with emotional exhaustion and generally attributed to increased workload and institutional stress' (Bloom, 2011). Burnout is not the same as vicarious trauma - which stems from repeated exposure to traumatic material in the context of attempts to assist- although the two may coexist. See 'secondary trauma', 'vicarious trauma', 'supervision', 'trauma-informed'.

CBT – See Cognitive Behavioural Therapy

child abuse – There are many forms of child mistreatment. The typical forms of child abuse are neglect, physical abuse, emotional abuse and sexual abuse, and witnessing interpersonal violence. Note that the data on the incidence of child abuse is conservative as it relates only to the number of children who come to the attention of child protection authorities. Also note that adverse childhood experiences are both highly prevalent and have longstanding effects on subsequent emotional and physical health in adulthood (ACE Study, 1998; Shonkoff & Garner, 2012). Current neuroscientific research on early caregiving ('attachment') relationships reveals the often profound effects of child abuse on the developing brain. See 'Adverse Childhood Experiences Study', 'early onset trauma', 'survival brain', 'child sexual abuse'.

child sexual abuse (CSA) – A pernicious form of child maltreatment which involves sexual violation and which is correlated with pervasive negative impacts including and especially on mental health (Canton-Cortes, Cortes, et al, 2012; Mullen et al, 2000; Everett & Gallop, 2001). Repeated episodes of child sexual abuse comprise severe childhood trauma which, if occurring at critical periods of neural vulnerability, can impair the development of the self as well as impede functioning in a range of domains. See 'early onset trauma', 'survival brain', 'developmental trauma', 'Developmental Trauma Disorder' (DTD).

clinical hypnosis – see ‘hypnotherapy’

clinical supervision – A key component of ethical and professional practice in diverse health disciplines, including counselling, psychotherapy and psychology, in which clinicians regularly consult about their client work with a (usually) more experienced practitioner. Clinical supervision differs from ‘de-briefing’ as it involves facilitated self-reflection, support, psychoeducation, and fosters self-care. Also see ‘ethical practice’, ‘supervision’, ‘self-care’, ‘risk management’.

Cognitive Behavioural Therapy (CBT) – A form of psychotherapy which is explicitly directed to intercepting and challenging negative thinking and thought patterns and which is commonly used in treating depression. As a widely promoted ‘evidence-based’ treatment, Cognitive Behavioural Therapy is generally short-term, its principles and techniques are relatively easy to learn, and in Australia it attracts the Medicare rebate. Note, however, that as CBT emphasises cognition and ‘faulty thinking’, it is less suited to early stage therapy of deep emotional issues and childhood trauma. Thus it is less indicated as the ‘therapy of choice’ for a client who is dysregulated and whose cognitive capacity is correspondingly impaired.

Current research shows the centrality of sensorimotor processes to unresolved trauma and suggests the limits of CBT without attention to physicality and the body (van der Kolk, 2007). This also relates to the wider limits of ‘evidence-based’ treatment approaches: ‘the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities....The over-optimistic claims for the effectiveness of cognitive-behavioural therapy (CBT) and misrepresentation of other approaches do not best serve a group of patients greatly in need of help; excluding individuals with [complex comorbid] disorders as untreatable or treatment-resistant when viable alternatives exist is not acceptable’ (Corrigan & Hull, 2015). See ‘evidence-based treatment’, ‘practice-based evidence’, ‘traditional psychotherapy’, ‘common factors research’, ‘right brain’, ‘expressive therapies’.

common factors research – This considerable body of research shows that the particular type of psychotherapy is less significant to the effectiveness of the therapy than are other factors (Duncan, Miller et al, 2010; Barkham, Hardy et al. 2010; Collins & Crowe, 2017). In ‘common factors’ research, client dimensions and the quality of the therapeutic alliance are more reliable determinants of effective therapy than the approach or technique itself. This is in contrast to ‘evidence-based’ treatment and practice, in which such variables are regarded as irrelevant to treatment effectiveness. See ‘evidence-based practice’, ‘practice-based evidence’.

comorbidity – A medical term for coexistence of more than a single disorder or disabling condition. Because of its comprehensive effects, complex trauma often has high comorbidity (Ross & Halpern, 2009); ‘Many Complex PTSD presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected by clinicians’ (Schwarz, Corrigan et al, 2017).

compassion fatigue – Formerly known as secondary traumatic stress disorder (Figley, 1995); refers to the negative though predictable and treatable psychological consequences of working with, and alongside, suffering people (Bloom, 2011).

complex trauma – ‘[A] subset of the full range of psychological trauma which has as its unique trademark a compromise of the individual’s self-development’ (Ford & Courtois, 2009). In contrast to ‘single-incident’ trauma, complex trauma is cumulative, repetitive and largely interpersonally generated, and occurs in the context of the family and intimate relationships as well as within organisations.

Complex trauma ‘usually involves a fundamental betrayal of trust in primary relationships, because it is often perpetrated by someone known to the victim’; Courtois & Ford, 2009). Unlike a one-off event, the cumulative impact of relational trauma involves compounded dynamics and entails pervasive effects. Complex trauma places the person at risk ‘for not only recurrent anxiety...but also interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development’ (Ibid). Note that complex trauma is broader than the new diagnosis of Complex PTSD (CPTSD) in ICD-11: ‘[w]hereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders...increasingly becomes a risk the more prolonged and severe the traumatic events’ (Fisher, 2017). See ‘Complex Post-Traumatic Stress Disorder’

Complex Post-Traumatic Stress Disorder – Diagnosis first proposed in 1992 by psychiatrist Judith Herman to describe the range of clinical presentations of survivors of long periods of interpersonal violation. Complex traumatic stress reactions ‘are those that are most associated with histories of multiple traumatic stressor exposures and experiences, along with severe disturbances in primary caregiving relationships’ (Courtois & Ford, 2009). The advantage of the concept ‘complex post-traumatic stress disorder’ (CPTSD) is that it integrates in a single and coherent formulation ‘the consequences of prolonged and repeated trauma’ (Herman, 2009). Note that ‘PTSD alone is insufficient to describe the symptoms and impairments that follow exposure to complex trauma’ (Courtois & Ford, 2009; van der Kolk, 2003).

Achievement of a formal diagnosis of Complex PTSD (CPTSD) occurred in 2018 with release by the World Health Organisation (WHO) of the 11th revision of the International Classification of Diseases (ICD-11) effective January 2022: ‘Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse’ (Cloitre, Garvert, 2013; <https://icd.who.int/en/>).

While problematic in requiring all diagnostic criteria for single-incident PTSD to be met (note that ‘many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms’; Schwarz, Corrigan et al, 2017) achievement of the formal diagnosis of CPTSD is a welcome and long overdue development. In contrast to ICD-11, the current edition of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) does not include the diagnosis of CPTSD. It does, however, now include a dissociative subtype of PTSD. See ‘dissociative subtype of PTSD’, ‘complex trauma’.

complex trauma treatment – In contrast to single-incident trauma (PTSD) in which the traumatised person has generally experienced a sense of safety prior to the onset of trauma, the survivor of complex trauma does not start with this advantage. The radical impairments in self-regulatory capacity associated with complex trauma, particularly when it is early onset as in child abuse, present a different treatment starting point. This is important to recognise because complex trauma is commonly mistaken for, and conflated with, PTSD. Phased treatment is recommended for complex trauma. See ‘affect regulation’, ‘complex trauma’, ‘Complex Post-Traumatic Stress Disorder’, ‘phased treatment’, ‘trauma treatment’.

consilience – Convergence of diverse findings, ideas and approaches. According to research in the neurobiology of attachment, consilience is now apparent in understanding of the interrelationship between brain, body and mind (‘Independent findings from a variety of scientific endeavours are converging in an interdisciplinary view of the mind and mental wellbeing’; Solomon & Siegel:2003). This has major implications for understanding trauma and mental health. See ‘trauma’, ‘body’, ‘right brain’, ‘sensorimotor psychotherapy’.

coping strategies – methods for dealing with adverse experience/s. As the Adverse Childhood Experiences (ACE) Study establishes (Felitti, Anda et al, 1998) traumatic childhood experiences are highly prevalent even in the absence of overt markers of social disadvantage. As it also shows, there is a direct relationship between the coping strategies which initially serve a protective function and their conversion over time into active risks to emotional and physical health. Thus ‘personal solutions’ in the form of coping strategies become both individual health problems in adulthood and public health problems. See ‘adaptation to trauma’, ‘Adverse Childhood Experiences (ACE) Study’, ‘symptoms’, ‘pathology’, ‘trauma-informed’.

countertransference – The largely unconscious responses of a therapist to their client based on prior relationships and associations. Because psychotherapy involves power differentials which the therapist needs to manage, clinical supervision is a necessary and valuable forum in which to explore therapist countertransference to their clients. Some evidence suggests that therapists with trauma histories may have stronger countertransference responses than those who do not (Cavanagh, Wiese-Batista et al 2015). Briere (1992) elaborated the phenomenon of abuse-related countertransference in the early 1990s. As childhood trauma is prevalent, a therapist may often have a trauma history as well. Subject to having addressed their own histories, personal experience of trauma does not preclude clinicians from conducting effective trauma therapy. See ‘implicit memory’, ‘supervision’.

developmental trauma – A form of complex trauma which, because it occurs at early critical periods of development, can radically compromise psychobiological, social and emotional development. It comprises threats not only to physical survival but to survival of the self (see ‘complex trauma’). Such threats are especially damaging to young children for whom the self is fragile because it is still developing. Also described as ‘developmentally adverse interpersonal trauma’ (Ford, 2005) See ‘Developmental Trauma Disorder’ (DTD), ‘early onset trauma’

Developmental Trauma Disorder (DTD) – A diagnosis proposed by van der Kolk (2005) for children who experience complex trauma. Criteria for DTD, which has not been included in diagnostic manuals, stem from exposure to ‘developmentally adverse interpersonal trauma’. See ‘developmental trauma’.

diagnosis of trauma – The delay in identifying complex trauma as a distinct entity within standard classificatory and diagnostic systems delayed recognition that trauma can underlie otherwise diverse client presentations (and can therefore receive multiple and contrasting diagnoses). Inclusion of the diagnosis of Complex PTSD in the 11th revision of the International Classification of Diseases, ICD-11, partially rectifies this anomaly.

The diagnosis of Complex PTSD goes beyond the criteria of 'standard' single-incident PTSD, and comes closer to acknowledging that trauma in its more complex forms represents 'a defining and ongoing experience that forms the core of an individual's identity rather than a single discrete event' (Jennings, 2004). As Courtois & Ford (2009) highlight, 'in the absence of a formal diagnosis for complex traumatic stress disorders, there is the potential for mis- or overdiagnosis of severe disorders (e.g. bipolar or schizophrenia spectrum disorders, BPD, conduct disorder): As they further underline, experts on complex traumatic stress disorders argue that 'a sophisticated trauma-based approach to conceptualizing and classifying these disorders is essential to prevent complexly traumatised clients from being burdened with stigmatizing diagnoses and to provide these clients with treatment that is informed by current scientific and clinical knowledge bases' (ibid).

'Trauma-informed' care and practice implicitly challenge formal diagnostic categories which fail to recognise the complex trauma that underlies a plethora of symptoms, health problems and conditions and which are 'rarely captured by traditional diagnostic models' (Fisher, 2017). See 'complex trauma,' 'post-traumatic stress disorder,' 'complex post-traumatic stress disorder,' 'Diagnostic and Statistical Manual of Mental Disorders,' 'International Classification of Diseases,' 'Power Threat Meaning Framework,' 'trauma-informed'.

Diagnostic and Statistical Manual of Mental Disorders (DSM) – Widely cited publication of the American Psychiatric Association for classification and diagnosis of psychological problems and conditions. The current (fifth) edition is the DSM-5 (2013). Despite the proliferating number and nature of DSM diagnoses, complex trauma is not included in its own right. This contrasts with the International Classification of Diseases (ICD-11) which now includes the diagnosis of Complex Posttraumatic Stress Disorder (CPTSD). While the DSM-5 includes a dissociative subtype of PTSD which addresses the dimensions of depersonalisation and derealisation, the dissociative subtype is much less inclusive than the diagnosis of CPTSD. See 'dissociative subtype,' 'diagnosis of trauma,' 'Complex Post-Traumatic Stress Disorder').

Dialectical Behaviour Therapy (DBT) – A form of psychotherapy developed by American psychologist Marsha Linehan (1993, 2015) that is primarily used to treat Borderline Personality Disorder (BPD). Dialectical Behaviour Therapy involves various stages of treatment, focuses on development of self-regulatory capacity and skills acquisition and training, and DBT groups are common. Note that an American psychiatrist and clinical psychologist have suggested ways in which DBT may be adapted for treatment of Dissociative Identity Disorder; DID (Foote & Van Orden, 2016).

disorganised attachment – A form of attachment which occurs when the primary attachment figure on whom the child depends also engenders fear, meaning that the child cannot effectively connect with them. Disorganised attachment stems from 'a collapse in coping ability' (Siegel, 2010). Note that a primary caregiver who is not actively abusive, but who cannot manage their own responses (the frequent legacy of their own unresolved trauma) can engender this response in a child (Hesse, Main, et al, 2003). Disorganised attachment is closely correlated with childhood trauma (Carlson et al, 1989; Siegel, 2010). Also see 'attachment styles,' 'borderline personality disorder,' 'early onset trauma,' 'the Strange Situation'.

dissociation – Separation or disconnection from immediate experience: 'In essence, aspects of psychobiological functioning that should be associated, coordinated, and/or linked are not' (Spiegel, Loewenstein et al, 2011). Dissociation varies in type and intensity and many believe it operates along a continuum. As such, it may occur in unremarkable forms such as daydreaming and mild trancing. As a defensive response to overwhelming threat ('the escape when there is no escape'; Putnam, 1992) dissociation is commonly a dimension of trauma, and people who have experienced chronic interpersonal traumatization as children 'have severe dissociative symptoms' (van der Hart et al, 2006).

Dissociation occurs beyond conscious awareness and control. As a protective response to the risk of being overwhelmed, it can also occur subsequent to the original trauma in the absence of apparent threat (i.e. it can be activated by seemingly innocuous cues which 'trigger' the original trauma). Because it is a common feature of trauma (particularly in sexual abuse and complex trauma varieties) effective trauma treatment requires knowledge of and the ability to work with dissociative responses. Also see 'dissociative disorder', 'implicit memory', 'right brain'.

dissociative disorder - Persistent activation of dissociation for defensive purposes erodes health and wellbeing: 'The most important distinction...to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe' (Steinberg & Schnall, 2003). The core symptoms of dissociation are depersonalisation (sense of detachment from self), derealisation (sense of estrangement from surroundings), amnesia, identity confusion and identity alteration, and 'different constellations of these five core symptoms define the particular dissociative disorder a person ha[s]' (Steinberg & Schnall, *ibid*). It is important for health professionals to be aware that '[m]ultiple lines of evidence support a powerful relationship between dissociation/DD [i.e. dissociative disorders] and psychological trauma, especially cumulative and/or early life trauma...DD are common in general and clinical populations and represent a major underserved population with a substantial risk for suicidal and self-destructive behavior' (Loewenstein, 2018).

Dissociative Identity Disorder (DID) – Diagnosis for the most serious form of dissociative disorder which stems from early childhood trauma and in which, commensurate with the severity of the trauma, the person exhibits separate and distinct identity states. In DID, alternate identity states are dominant at different times, and a degree of amnesia occurs between the different self-states which 'cannot be explained by imaginary companions, alcohol blackouts or medical conditions' (Ross & Halpern, 2009). Neuropsychological data confirms different brain activity between individuals with DID and simulating controls (Schlumpf, Reinders et al, 2014; Reinders, Willemsen et al, 2016). These findings are consistent with the theory of structural dissociation of the personality 'and inconsistent with the idea that DID is caused by suggestion, fantasy-proneness and role-playing' (Schlumpf, Reinders et al. *ibid*). Recurrent myths about DID are addressed in an Open Access paper published in the Harvard Review of Psychiatry (Brand, Sar et al, 2016) accessible at the following link: https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction_An_Empirical.2.aspx See 'structural dissociation', 'alters', 'parts', 'self-state', 'self-system', 'implicit memory', 'Trauma Model'.

dissociative subtype of PTSD – subtype of PTSD introduced in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) which addresses depersonalisation (sense of self-estrangement) and derealisation (perception of the external world as strange or unreal). In so doing, it comes closer to addressing characteristic features of complex trauma but is insufficiently inclusive. In contrast to the International Classification of Diseases (ICD-11), the DSM-5 does not yet include the diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD). The dissociative subtype of PTSD is also regarded by some as a problematic conceptualisation. For example, Ross argues that '[t]here does not appear to be any sound conceptual reason for excluding amnesia and flashbacks from the criteria for dissociative PTSD', in which case 'most cases of PTSD would be dissociative in nature, and non-dissociative cases would be a minority subtype' (Ross, 2018).

DSM – See Diagnostic and Statistical Manual of Mental Disorders

dual awareness – the ability to attend to two experiences simultaneously and to observe internal sensations while retaining awareness of surroundings ('Noticing' as in mindful awareness allows the client to achieve 'dual awareness', the ability to stay connected to the emotional or somatic experience while also observing it from a very slight mindful distance'; Fisher, 2017). Also known as dual presence, dual awareness is central to self-regulation and a skill which therapy needs to foster as early as possible. It is also essential for trauma processing, 'allowing us to explore the past without risk of retraumatization by keeping one 'foot' in the present and one 'foot' in the past' (Fisher, 2017). See 'mindfulness', 'affect regulation', 'implicit memory'.

early onset trauma – Trauma which is experienced in childhood. Current research on the developing brain in the context of early attachment relationships substantiates that early onset trauma – particularly when prolonged, repetitive, and unrepaired – is highly damaging. Given the centrality of the right brain hemisphere to social connectedness, self-regulatory capacity, and development, parental attunement to the emotional needs of the infant is no less vital than attending to their physical needs (i.e. in fostering the ability to manage emotion which is crucial to healthy development). See 'affect regulation', 'developmental trauma', 'Developmental Trauma Disorder'.

earned autonomy – See 'earned security'

earned security – The conversion of 'insecure' attachment to 'secure' attachment via the working through, processing, and resolution of adverse childhood experience. When a person achieves earned security (by developing a coherent perspective on their childhood experience) this helps to modify parenting style and so can benefit the next generation ('These are adults who appear to have had difficult childhoods, but... have made sense of their lives. The children attached to these adults have secure attachments and do well! History is not destiny – if you've come to make sense of your life'; Siegel, 2003). The possibility and many positive effects of earned security (sometimes called 'earned autonomy') reflect the importance of brain neuroplasticity. See 'attachment styles', 'attachment theory', 'neuroplasticity', 'psychotherapy'.

EFT – See 'Emotional Freedom Techniques'

EFTT – (not to be confused with EFT!) See 'Emotion-Focused Therapy for Complex Trauma'

ego state – 'one of a group of personality states that is relatively stable across time' and which 'is distinguished by a specific role, emotion, behavioral, memory, and/or cognitive function' (Phillips & Frederick, 2010). An ego state is an 'organized system of behaviour and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable' (Watkins & Watkins, 1997). While described in different ways (e.g. parts, self-states; see relevant listings) ego states are widely regarded to characterise the internal world of all individuals: 'Ego states exist as a normal aspect of personality development. Every individual has a number of different ego states, each of which is designed to assist the personality in important ways. Ego states evolve as creative ways of coping with the demands of external environments, allowing us to master developmental challenges such as distinguishing between acceptable responses in social, home, and school situations' (Phillips & Frederick, 2010).

Ego state therapy – ‘a psychodynamic approach in which techniques of group and family therapy are employed to resolve conflicts between various ‘ego states’ that constitute a ‘family of self’ within a single individual’ (Watkins, 1993). In the current period Internal Family Systems (IFS) developed by Richard C. Schwartz (1995) is the most well-known and popular variety of ego state therapy. Many clinicians draw on IFS when working with complex trauma clients (e.g. Fisher, 2017). Note, however, that regardless of the approach and nomenclature, recognising diverse inner states (‘ego states’) is common across diverse psychotherapeutic modalities: ‘Every major school of psychology recognizes that people have subpersonalities and gives them different names’ (van der Kolk, 2015). See ‘ego state’, ‘self’, ‘self-states’, ‘self-system’, ‘parts’, ‘alters’.

EEMDR – See ‘Eye Movement Desensitization and Reprocessing’

Emotion-Focused Therapy for Complex Trauma (EFTT; not to be confused with EFT!)

A semi-structured evidence-based treatment for complex trauma that characteristically comprises 16–20 weekly sessions of 1 hour each (note that in cases of greater severity and duration of trauma ‘therapy likely will be more long term’; Paivio & Pascual-Leone, 2017). In engaging directly with emotion, EFTT avoids the ‘affect phobia’ for which protocolised and evidence-based treatments have been criticised (e.g. by Schwarz, Corrigan, et al, 2017). Note, however, the acknowledged unsuitability of EFTT as a treatment for severely addictive and self-harming clients (who comprise a significant proportion of people who suffer the impacts of complex trauma). See ‘complex trauma’, ‘trauma treatments’.

Emotional Freedom Techniques (EFT) – One of the two most well-known approaches of Energy Psychology which ‘involves tapping on a prescribed set of acupuncture points’ (Schwarz, 2018).

Practitioners and exponents of EFT report that clients are frequently surprised by the speed with which previous distress around ‘target’ memories can resolve following brief rounds of tapping (Schwarz, 2018: 275). Studies have upheld the effectiveness of EFT for a range of mental health problems (Schwarz, 2018; Gruder, 2012; Church, 2013). In the past two decades EFT has moved ‘from a fringe therapy to widespread professional acceptance’ (Church, 2013: 645). See ‘Energy Psychology’, ‘Thought Field Therapy’, ‘acupoints’.

endogenous opioids – Neurochemicals which relieve pain in ‘fight or flight’ situations, and which are also implicated in maladaptive coping strategies in post-traumatic reactions. Endogenous opioids are now recognised to be potentially operative in dissociative responses (Cozolino, 2002), the self-harm often enacted by adults who have experienced child abuse (van der Kolk, 1994) and in relation to eating disorders (Middleton, 2007). Enhanced understanding of the operation and function of endogenous opioids strengthens the case for a revised understanding of post-traumatic ‘symptoms’ as post-traumatic ‘coping strategies’. See ‘symptoms’, ‘coping strategies’, ‘somatisation’, ‘unexplained medical symptoms’, ‘Adverse Childhood Experiences (ACE) Study’.

Energy Psychology (EP) – ‘a family of brief, focused approaches to releasing stuck energy and unprocessed information in the mind-body system that is the result of unresolved trauma’ (Schwarz, 2018). While still regarded by many as controversial, EP is increasingly recognised to have a scientific basis (Schwarz, 2018; Feinstein 2012; Nelms, 2017; Church 2013). It is also argued that the principles of the Polyvagal Theory (Porges, 2011) provide grounds for why EP need no longer be framed ‘as a strange alternative treatment’ (Schwarz, 2018). EP may also be integrated into therapy for complex trauma including for adult survivors of child sexual abuse (Schulz, 2009). See ‘bilateral stimulation’, ‘Energy Psychology’, ‘Polyvagal Theory’, ‘Polyvagal Therapy’.

EP – See ‘Energy Psychology’

epigenesis – *The process by which early experiences can alter genetic functioning– ‘If early experiences are positive... chemical controls over how genes are expressed in specific areas of the brain can alter the regulation of our nervous system in such a way as to reinforce the quality of emotional resilience. If early experiences are negative, however, it has been shown that alterations in the control of genes influencing the stress response may diminish resilience in children and compromise their ability to adjust to stressful events in the future’ (Siegel, 2010). Also see ‘affect regulation’, ‘attachment theory’, ‘attachment styles’.*

ethical practice – *the code of conduct, both implicit and explicit, for responsible and professional practice. Ethical practice in psychotherapy has several dimensions, including clinical supervision, self-care and adhering to principles such as client confidentiality (subject to some exceptions) and informed consent. Ethical practice can also be considered a component of effective risk-management. See ‘risk-management’, ‘self-care’, ‘supervision’.*

evidence-based treatment and practice – *A description and endorsement of treatments and therapies which have undergone scientific testing and research. While seemingly straightforward, the requirement for all treatments to be ‘evidence-based’ is problematic in several ways. For example, privileging a scientific paradigm over a particular treatment for which there is little or no research does not of itself mean that this therapy ‘doesn’t work’. Rather, research into it may not have been conducted. This is important to underline in a culture in which ‘lack of evidence’ (which routinely equates to scientific evidence) can wrongly imply that a treatment approach is ineffective. By contrast, ‘practice-based evidence’ provides a different view of ‘evidence’.*

Existing treatment methods are known to be ineffective for 25-50% of patients enrolled in clinical trials (Thal & Lommen, 2018, citing many sources). Officially authorised evidence-based treatments have also been criticised as ‘protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control’ (Schwarz, Corrigan et al, 2017). Thus people ‘unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance’ (Schwarz, Corrigan et al, ibid). In fact ‘the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities’ (Corrigan & Hull, 2015).

Requiring all treatments to be ‘evidence-based’ is ill-advised and unrealistic in light of the many problems associated with this ‘standard’, and its more specific limitations with complex trauma. For example, restrictive entry criteria continue to preclude people who experience complex trauma from participation in outcome studies (Rothschild, 2011). Calls for ‘trauma-informed’ care and practice also highlight the limits of the imprimatur of ‘evidence-based’ as a necessary and sufficient measure of treatment effectiveness: ‘Without such a shift [towards trauma-informed care]... even the most ‘evidence-based’ treatment approaches may be compromised’ (Jennings, 2004). Note that the neurobiology of attachment now comprises a strong evidence base. See ‘exposure therapies’, ‘common factors research’, ‘neurobiology of attachment’, ‘practice-based evidence’.

explicit memory – *Conscious memory which is linked to development of the left brain hemisphere. This contrasts with ‘implicit’ memory, which is pre-verbal, linked to the right brain hemisphere, and largely inaccessible to conscious awareness. See ‘implicit memory’, ‘re-enactment’.*

exposure therapies – Psychotherapies, generally short-term and cognitive-based, which eschew the ‘stabilisation’ phase recommended by the phased treatment approach to complex trauma in favour of early confronting of the client with the distressing material being avoided. Notwithstanding the imprimatur of ‘evidence-based’ and some studies which suggest otherwise, exposure therapies are problematic for complex trauma clients and especially in relation to the risks of dissociation (Spiegel, 2018, Herman, 2009; and see Chapter 3 in Part 2 of these guidelines). See ‘trauma treatment,’ ‘evidence-based treatment and practice,’ ‘prolonged exposure,’ ‘phased treatment.’

expressive therapies – Treatment approaches which engage right-brain processes and physicality, in contrast to both cognitive and insight-based orientations. Neuroscientific research which shows the centrality of physiological processes to emotional experience also suggests the limits of psychotherapeutic approaches which privilege ‘talk’ and the spoken word (‘To make meaning of the traumatic experience usually is not enough. Traumatized individuals need to have experiences that directly contradict the emotional helplessness and physical paralysis that accompany traumatic experiences’; van der Kolk, 2003). For this reason, ‘expressive’ therapies which can engage right-brain processes and physicality may be highly beneficial and particularly in relation to trauma. Expressive therapies are numerous and varied, and include bodywork, art therapy, and sandplay. See ‘affective neuroscience,’ ‘body,’ ‘right brain,’ ‘sensorimotor psychotherapy.’

exteroception – attunement to stimuli originating outside of the body

Eye Movement Desensitization and Reprocessing (EMDR) – A therapeutic form of bilateral stimulation which can be effective in treating a broad range of trauma, and which, subject to a client’s ability to tolerate affect, can achieve dramatic results in a single session (Shapiro, 2010). Note that while directed to the eyes, other forms of bilateral stimulation (e.g. alternating hand taps or headsets playing alternating tones or music) are also found to be effective (ibid). In 2018, the third edition of Shapiro’s *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures* became available. Shapiro notes that ‘[s]ince the early days of controversy’ over thirty randomised studies have verified the approach, and ‘hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations’ (Shapiro, 2018).

In relation to complex trauma and dissociation, a 2009 review recommended ‘a phase oriented EMDR model’ which emphasises ‘the role of resource development and installation (RDI) and other strategies that address the needs of patients with compromised affect tolerance and self-regulation’ (Korn, 2009). Shapiro is explicit in the 2018 reiteration of her landmark text that ‘[n]o clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population...The clinician should also have a clear understanding regarding strategies for assisting the client in managing intense affect during EMDR processing, the client’s dissociated system, and the client’s defensiveness and resistance. The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously’ (Shapiro, 2018). See ‘bilateral stimulation,’ ‘resources,’ ‘resource tapping,’ ‘Attachment Focused EMDR.’

Fantasy Model – Also known as the sociocognitive, iatrogenic or non trauma-related model, the ‘Fantasy Model’ contests that Dissociative Identity Disorder (DID) has its aetiology in childhood trauma. This is in contrast to proponents of the ‘Trauma Model’: ‘Skeptics counter that dissociation produces fantasies of trauma, and that DD [i.e. dissociative disorders] are artefactual conditions produced by iatrogenesis and/or socio-cultural factors’ (Loewenstein, 2018). This is notwithstanding that ‘[a]most no research or clinical data support this view’ (Loewenstein, 2018).

Evolving psychobiological, psychophysiological, and other data supports the Trauma Model rather than the Fantasy Model: '[c]omparisons of neural activity for individuals with DID and non-DID simulating controls suggest that the resting-state features...in DID are not due to imagination' (Schlumpf, Reinders et al, 2014). These findings are 'inconsistent with the idea that DID is caused by suggestion, fantasy-proneness and role-playing', and correspondingly are 'inconsistent with the sociocognitive model of DID' (Schlumpf, Reinders et al ibid). Yet while confirmed to have little empirical support (Dalenberg et al, 2014; Reinders, Willemsen et al, 2016; Schimmenti, 2017) the claims of the Fantasy Model, like the many myths about DID, continue to circulate. See 'Trauma Model', 'dissociative disorder', 'Dissociative Identity Disorder', 'implicit memory' 'recovered memory'.

Feedback Informed Treatment (FIT) – *Method for gauging the effectiveness of psychological treatments which falls within the paradigm of Practice-Based Evidence rather than Evidence-Based Practice: FIT 'involves routinely and...formally soliciting feedback from clients about the process of therapy, working relationship [with the therapist] and overall wellbeing' (Seidel in Tartakovsky, 2018).*

first-line trauma treatments – *treatments deemed to be evidence-based which are recommended as front line and as immediately applicable to trauma treatment. 'First-line' trauma treatments are part of the suite of generally short-term, cognitive, and exposure-based psychotherapies which are arguably less applicable to treatment of complex trauma. While the effectiveness of 'first-line' treatments for standard PTSD is 'well established', 'their generalizability to child abuse (CA)-related Complex PTSD is largely unknown' (Dorrepaal et al, 2014). See 'evidence-based treatment and practice', 'exposure therapies', 'complex trauma', 'phased treatment'.*

flashbacks – *Intrusive and disturbing memories in the form of images and/or sensory inputs which are indicators of unprocessed traumatic experience. Experience too overwhelming to be processed at the time of the trauma is stored as fragments of implicit, non-conscious memory which is activated ('triggered') by situational cues such as sounds, smells, or anniversaries which serve as reminders of the trauma. See 'post-traumatic stress disorder' (PTSD), 'implicit memory'.*

gender – *While trauma is not gender-specific, the crime of child sexual abuse and adult sexual assault is often gendered. Courtois (2010) attests that in the 1970s, and prior to the contributions of feminism, there was little in the professional journals on the subject of sexual assault: 'We searched the literature for guidance and found articles highly biased against women – they were blamed or treated as though they were irreparably damaged, and their experiences were minimised' (Courtois, ibid).*

Transgender, gay, lesbian, bisexual, and intersex people face many barriers within the health system and society more broadly. Efforts to address systemic bias around gender diversity are underway and increasing (Victoria, 2014) but have a long way to go in terms of widespread translation to practice (Hughto, Reisner et al, 2015). See 'social defence mechanisms', 'microaggressions', 'politics of trauma'.

hyperarousal – *Physiological and psychological agitation which stems from over-activation of the central nervous system and which can be a key indicator of trauma. See 'trauma treatment', 'window of tolerance'.*

hypnotherapy – the clinical application of hypnosis for therapeutic purposes. As an inclusive, facilitative orientation to health and wellbeing, hypnotherapy is very different from ‘stage’ hypnosis and the imparting of authoritarian directives. It also has an evidence base in relation to a range of psychological issues (Spiegel & Spiegel, 2004; Brann, Owens et al, 2015; Lynn, Rhue & Kirsch, 2010). Hypnosis is ‘a facilitator of treatment interventions, not a therapy or treatment in itself’ (Kluft, 2017). In its demonstrated capacity to access the subconscious, there are many ways in which it may facilitate complex trauma treatment and can be integrated into a phased treatment approach (Phillips & Frederick, 1995; Schwarz, 2002). See ‘phased treatment’, ‘self-state’, ‘dissociation’, ‘complex trauma’.

hypoarousal – Emotional numbing or ‘shut-down’. In contrast to the generally visible signs of hyperarousal, hypoarousal is also an indicator of trauma (‘Emotional numbing alternating with periods of high arousal is characteristic of PTSD’; Bloom, 2011). It is extremely important that hypoarousal is identified as a trauma response. This is because it can be misperceived as a lack of expressiveness which risks challenging the client to elicit a visible reaction (a major error which can lead to re-traumatisation; also note that it is possible for a person to be behaviourally active while dissociated). See ‘trauma treatment’, ‘window of tolerance’.

implicit memory – Non-verbal and largely non-conscious recollection which relates to neural networks central to the organisation of sensation, emotion and behaviour (Levine, 2015). Much implicit memory derives from early attachment experience with caregivers (Cozolino, 2002; Schore, 2003). Because early life experience occurs when the right brain hemisphere is dominant, it is remembered implicitly as ‘schemas’ rather than explicitly (i.e. in contrast to conscious memory which is linked to subsequent development of the left brain hemisphere). Since it is ‘stored’ as implicit rather than conscious memory, early attachment experience tends to be enacted and embodied rather than expressed in words. Also note the role of autonomic responses and the subcortical process of detecting threat in the environment (i.e. neuroception; evaluation of risk without awareness) which ‘range from adaptive protection to social connection’ and which register as implicit memory which, ‘depending on past experiences, produces experiences of ventral vagal flow, sympathetic mobilization, or dorsal vagal immobilization’ (Dana & Grant, in Porges & Dana, 2018). See ‘neuroception’, ‘Polyvagal Theory’, ‘affect regulation’, ‘attachment theory’, ‘re-enactment’, ‘recovered memory’.

individualism – A conceptual framework by which individuals are privileged at the expense of the social context in which they are embedded and by which they are profoundly shaped. Individualism is a central tenet of ‘Western’ liberal societies and can obscure systemic and structural oppression within, as well as outside, Western societies. While individual rights are to be celebrated, they are not enjoyed by or accessible to vast numbers of people. Young argues that the ideology of liberalism has never dealt well with the reality of group life, and that a bias against collective forms of identity (apparent at the inception of the ‘Universal’ Declaration of Human Rights) continues to discriminate against the many who lack recourse to the status of ‘individual’ (Young, 1991). Note that the idea of the individual dates to the particular context of eighteenth century Europe in which ‘individual’ rights could only be accessed by white middle class males (origins which many argue have continuing implications). See ‘aversive bias’, ‘blaming the victim’, ‘social defence mechanism’, ‘violence’, ‘politics of trauma’.

integration – Coherence between different levels of functioning, which requires the linked operation of neural pathways in the brain. Neuroscientific research is revealing that integration is the hallmark of wellbeing (Siegel, 1999, 2010; Cozolino, 2002). Basic requirements of integration are linked activity between the brain stem, limbic region and cortex (‘vertical integration’) and between the left and right brain hemispheres (‘horizontal integration’). Trauma profoundly disrupts integration. In neuroscientific terms, effective trauma therapy entails repair and realignment of disrupted neural pathways (Cozolino, 2002). Note that the term ‘integration’ has more specific connotations in the context of treatment for DID, and that the extent to which full integration of the diverse self-states or alters of the internal world of DID clients is necessary (i.e. as distinct from increased communication and cooperation between them) is now somewhat contested.

intergenerational trauma – See transgenerational trauma

International Classification of Diseases (ICD) – The international diagnostic compendium for classification of health and disease. Unlike the American Diagnostic and Statistical Manual of Mental Disorders (DSM; current edition DSM-5, 2013) the current edition of the ICD (ICD-11) now includes a diagnosis of Complex Posttraumatic Stress Disorder (CPTSD). See ‘Complex Posttraumatic Stress Disorder’, ‘complex trauma’, ‘Diagnostic and Statistical Manual of Mental Disorders’.

interoception – sensitivity to stimuli from within the body

interpersonal neurobiology The processes by which experience activates neural mechanisms in the formation of mind and self (‘the structure and functioning of the mind and brain are shaped by experiences, especially those involving emotional relationships’; Siegel, 2003). Also see ‘affective neuroscience’, ‘neurobiology of attachment’, ‘social brain’.

learning brain – Development of neural networks in infancy fosters what has been called the ‘learning brain’ (Ford 2009). This is necessary for developing self-awareness, and requires sufficient support from caregivers and the external environment to sustain it. Without such support, there is a shift to a ‘survival’ brain, which impedes learning and development. See ‘affect regulation’, ‘survival brain’.

MDMA-Assisted Psychotherapy – Clinical use of the psychoactive drug MDMA (i.e. in stark contrast to its street use) to assist the processing and resolution of psychological trauma. In 2017 the United States Food and Drug Administration (FDA) designated MDMA a ‘breakthrough therapy’. Late stage clinical trials are currently being conducted before the anticipated FDA approval of therapeutic use of MDMA assisted psychotherapy in the US in 2021. The markedly beneficial effects of clinical use of MDMA are upheld by a number of studies and trials (Ot’alora, Grigsby et al, 2018; Thal & Lommen, 2018).

MDMA-Assisted Psychotherapy may also be a ‘break through’ therapy for adult survivors of complex trauma (‘psychiatry is in need of this innovative approach because current treatments are failing patients’; Sessa, 2016). It is suggested that ‘MDMA may provide a bridge to effectively overcome the gap between psychotherapy and psychopharmacology, thereby facilitating the integration of a more holistic approach to psychopathology’ (Thal & Lommen, 2018). MDMA-Assisted Psychotherapy research remains unfunded in Australia.

Medically Unexplained Symptoms (MUS) – Symptoms for which there is no apparent organic cause. The dysregulation of unresolved trauma has physical as well as psychological impacts. An impaired capacity to integrate and cognitively represent bodily states can lead to ‘distressing somatic complaints, concerns and symptoms’ as well as to distressing feelings and thoughts (Schimmenti & Caretti, 2016). Many complex trauma clients consult a ‘psy’ practitioner when medical tests are inconclusive and the sources of ‘physical’ pain are unclear (‘every physician will see several patients with high ACE scores each day’; Felitti, 2010). ‘Somatization is a dissociative process... and we pay a steep price when this possibility is overlooked in the medical investigation of chronic pain’ (Chefet, 2015; ref Nijenhuis, 2000). See ‘somatisation’, ‘symptoms’, ‘endogenous opioids’, ‘trauma screening’, ‘Adverse Childhood Experiences [ACE] Study’.

micro-aggressions – forms of sociocultural bias and discrimination often enacted unconsciously at a group level within ‘individualist’ Western democratic societies, which can cumulatively lead to complex trauma for the people at whom they are directed: ‘Everyday racism, sexism, homophobia, classism, ableism, and so on...are the small but ever-present pulls of energy toward a survival level of consciousness’; ‘In the lives of many individuals who are members of target groups, daily existence is replete with reminders of the potential for traumatization and the absence of safety’ (Brown, 2009; Sue, Capodilupo, et al, 2007). See ‘aversive bias’, ‘individualism’, ‘politics of trauma’.

mindfulness – A state of focused attention. Inspired by Buddhist and other spiritual traditions, the benefits of cultivating attuned awareness are now widely endorsed not only for spiritual practice but for general health and wellbeing. Diverse schools of psychotherapy encourage a mindful approach to experience in order to foster inner coherence and integration. The challenge for complex trauma clients is that mindful awareness and dissociation are rival brain activities (Forner, 2017) and dysregulated people are often destabilised by attempts to notice their physical sensations. Hence the importance of appropriate resourcing and ‘Phase 1’ of complex trauma treatment. Also note that mindfulness in the sense of non-judgmental ‘noticing’ is different from mindful meditation. Clients should not be encouraged to meditate unless or until they have acquired the ability to self-regulate. See ‘affect regulation’, ‘attachment theory’, ‘dual awareness’, ‘phased treatment’.

mirror neurons – Neurons which are activated through observation of the goal-directed behaviour of others (‘Our brains use sensory information to create representations of others’ minds, just as they use sensory input to create images of the physical world’; Siegel, 2010). Initially identified in relation to monkeys, the ‘mirror neuron system’ operates in human beings, and is regarded as ‘the root of empathy’ (Ibid) Also see ‘affective neuroscience’, ‘attachment’, ‘attachment theory’, ‘attachment styles’.

MUS – See ‘Medically Unexplained Symptoms’

neurobiology of attachment – Convergent findings from the fields of affective neuroscience and attachment theory which show ‘how the developing mind is shaped by the interaction of interpersonal experience and neurobiological processes in the creation of the human mind’ (Siegel, 2003). See ‘affective neuroscience’, ‘interpersonal neurobiology’.

neuroception – A term coined by Stephen Porges to describe the subcortical process of detecting threat in the environment; i.e. ‘the nervous system’s capacity to evaluate risk without awareness’ (Lindaman & Makela in Porges & Dana, 2018). Consistent with the principles of Polyvagal Theory, ‘[t]he vagus knows before cognition, and this means neuroception precedes cognition’ (Theede, 2018). See ‘Polyvagal Theory’, ‘Polyvagal Therapy’, ‘implicit memory’.

neuroplasticity – The capacity of the brain to reorganise and form new neural connections related to environmental stimuli. Contrary to the long-standing belief that the brain is ‘hard-wired’ or ‘fixed’, neuroscientific findings reveal that it is malleable, and changes both structurally and functionally in relation to social experience (Siegel, 1999; Cozolino, 2002; Doidge, 2007). This ground-breaking recognition has implications for a wide range of fields and practices, especially mental health. Neuroplasticity means that experience changes the brain in both directions – just as damaging experiences change the brain in ways that impair subsequent functioning, positive experiences change it in ways that are conducive to health. Studies now show that it is possible for trauma to be resolved, and that ‘experience in later relationships can actually change the future development of the mind’ (Siegel, 2003).

organisational trauma – Trauma which occurs in the context of institutions and organisations. With respect to ‘parallel process’, Bloom (2011) applies concepts from trauma theory to organisational systems as well as to individual functioning. She argues that trauma-specific treatment of individuals correlates with the organisational shifts required for health systems to become trauma-informed (ibid) Research in the neurobiology of attachment highlights that positive experiences have healing potential, which in turn underlines the need for services to facilitate healing at operational and organisational levels. See ‘parallel process’, ‘trauma-informed’

OSDD – see ‘Other Specified Dissociative Disorder’

Other Specified Dissociative Disorder (OSDD) – Diagnostic category which in DSM-5 has replaced the previous classification of Dissociative Disorders Not Otherwise Specified (DDNOS), and ‘applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class’ <http://traumadissociation.com/osdd> See ‘Diagnostic and Statistical Manual of Mental Disorders’ (DSM), ‘International Classification of Diseases’ (ICD), ‘Complex Posttraumatic Stress Disorder’.

oxytocin – A hormone which plays a significant role in childbirth, and which is important in the physiology of early attachment with respect to the experience of safety and the development of empathy and trust (Carter & Ahnert, 2005; Churchland, 2011)

parallel process – A psychoanalytic concept which has traditionally been applied to the psychotherapy supervisory relationship when it mirrors what is occurring in the relationship between therapist and client. Bloom (2011) extrapolates this concept to the context of organisations, which she argues can become dysfunctionally ‘trauma-organised’ in relation to the trauma experienced by their clients. See ‘organisational trauma’, ‘trauma-informed’

part/s – That what we call ‘self’ is not fixed or unified but rather consists of fluctuating states is now widely accepted: ‘The self is characterized by a complex multiplicity of subunits and subelves and even the multiple parts themselves have parts’ (Howell, 2005; ref Erdelyi, 1994); ‘It is the nature of the human mind to be subdivided... Parts exist from birth... multiplicity is inherent in the nature of the mind’ (Schwartz, 1995); ‘Modern neuroscience has confirmed this notion of the mind as a kind of society’ (van der Kolk, 2015); ‘The mind is a mosaic; ‘We all have parts’ (van der Kolk, ibid). Yet standard theories of personality continue to emphasise ‘fixed, persistent, and globally defining traits’ (Putnam, 2016).

It is important to be aware that ‘[p]arts are not just feelings but distinct ways of being, with their own beliefs, agendas, and roles in the overall ecology of our lives’ (van der Kolk, ibid). Healthy functioning is when we can move flexibly between states and parts of the self, where ‘the important issue is not how many parts there are, but how they hang together’ (Howell, 2005). Trauma and problematically unintegrated self-states impede internal flexibility, and can lead to internal configurations in which ‘a part of... psychic functioning... seems to operate independently from the other parts’ (Schimmenti & Caretti, 2016; ref Steele, Van der Hart & Nijenhuis, 2006).

To the extent that ‘we all have parts’ (van der Kolk, ibid) using the language of parts in therapy is realistic for all clients. It is also non-stigmatising for traumatised clients (‘traumatized patients generally find ‘parts of the personality’ or ‘parts of yourself’ an apt description of their subjective experience’; van der Hart, et al, 2006). Utilisation of the language of parts is also helpful in reflecting ‘how the mental and behavioural actions of survivors shift with the type of dissociative part that exerts executive control’ (van der Hart et al, 2006) See ‘self’, ‘self-state/s’, ‘self-system’, ‘ego state/therapy’, ‘alter’.

pathology – Commonly defined as the opposite state to health, the notion of pathology is intrinsic to biomedical frameworks of understanding, which notwithstanding acknowledgment of ‘biopsychosocial’ factors tend to locate pathology within the individual. In establishing the unequivocal relationality of human growth and development, neuroscientific findings about ‘the social brain’ challenge individualist readings of health and pathology. See ‘neurobiology of attachment,’ ‘Adverse Childhood Experiences (ACE) Study,’ ‘symptoms,’ ‘trauma-informed.’

phased treatment – Effective trauma treatment cannot proceed in the absence of the client’s ability to tolerate affect. Since impaired capacity to regulate affect is a hallmark of complex trauma, graduated or ‘phased’ treatment is recommended for treatment of trauma in its complex forms (The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults, 2012) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf These guidelines remain the standard for complex trauma treatment notwithstanding some critiques of the phased based approach. See ‘Revisiting Phased Treatment for Complex Trauma,’ ch.3 in Part 2 of this document). Also see ‘affect regulation,’ ‘complex trauma treatment,’ ‘early onset trauma.’

politics of trauma – The relationship between trauma and politics was noted by Judith Herman in her classic text *Trauma and Recovery* (1992, 1997). It was restated more recently by Bessel van der Kolk in *The Body Keeps the Score* (2015). The politics of trauma comes in many forms, e.g. failure to recognise and respond to the prevalence of trauma and to prioritise it as a public health problem. Middleton (2012) criticises the ‘rebadging’ of a range of psychiatric problems to effectively conceal the trauma which underlies them.

‘Inability to see’ the prevalence of trauma can be unconscious (as the concept of ‘social defence mechanisms’ conveys; Bloom, 2011). But it is also the case that some diverse and powerful interests are safeguarded by failure to confront the pervasiveness of trauma, and that vested interests which may themselves operate unconsciously are protected by such myopia. Neuroscientific findings have major implications for a range of areas, and notably for the field of mental health. They also go far beyond the ‘social model of health’ frameworks which have challenged the individualist paradigm since the 1970s. If subjectivity is inherently relational – and the brain itself is ‘social’ – we need to reconceptualise the very categories by which we structure our perceptions. We also need to recognise the extent to which problems traditionally described as ‘personal’ and ‘individual’ are also social and political. This has major implications for the ways in which social policy is constructed and funding is allocated. See ‘social brain,’ ‘social defence mechanisms,’ ‘individualism,’ ‘adaptation to trauma,’ ‘blaming the victim,’ ‘organisational trauma,’ ‘violence,’ ‘trauma-informed.’

Polyvagal Theory – Account of the neurophysiological underpinnings of the experience of safety, and the emotions and cognitions which support and erode it. Developed by American psychiatrist Stephen Porges, *The Polyvagal Theory* (2011) was hailed as ground-breaking and its implications continue to reverberate. For example, it explains why ‘[i]t is not language, it is our biology that communicates safety’ (Gray, 2018) and why thoughts, feelings, and verbalisations are actually ‘epiphenomena, all driven by body-based, nonverbal data’ (‘the story arises from the autonomic state first, and then the top-down cognitions and narrative helps to solidify the experiential state’; Schwarz, 2018). The implications for effective trauma treatment are major. See ‘Polyvagal Therapy.’

Polyvagal therapy – Application of the principles of the Polyvagal Theory (2011) to psychotherapeutic practice. Publication of *Clinical Applications of the Polyvagal Theory* (2018) builds on the recognition that ‘[i]t is not possible to shift emotional and psychological states without shifting physiological states’ (Gray, 2018). This understanding has major implications for psychotherapy in general and for trauma treatment in particular. In order to feel safe, sympathetic or dorsal vagal reactivity needs to be reduced via ventral vagal regulation (Porges, 2011). Methods which can assist this process become critical; indeed ‘[c]ues of safety are the treatment’ (Porges, 2018).

Extension of the Polyvagal Theory to the realm of clinical practice introduces the notion of polyvagal therapies. It also offers a sound rationale from which to potentially integrate the somatic based interventions that 'talk therapy' has traditionally lacked. For example, Bessel van der Kolk highlights the extent to which the principles of Polyvagal Theory seem to support 'disparate, unconventional techniques' from a range of 'age-old, nonpharmacological approaches that have long been practised outside Western medicine' (van der Kolk, 2015). See 'bilateral stimulation', 'Energy Psychology'.

Post-traumatic growth (PTG) – Concept introduced in the 1990s to describe the positive changes some people experience, including a greater appreciation of life, spiritual growth and new possibilities 'as a direct result of experiencing a traumatic event' (Boals, Bedford et al, 2019; Tedeschi & Calhoun, 1996). While PTG has generated a number of research studies and considerable enthusiasm, it has also attracted criticism (Mancini, 2016). For example, it can reinforce individualistic assumptions and implicitly shame people 'for whom simply functioning adequately remains a struggle' (Brown, 2009:241). Others contend that 'adequate functioning' is itself 'a triumphant transcendence of fragmentation [and that] those survivors have evidenced PTG as well' (Brown, *ibid*). To the extent that the concept of PTG can reinforce simplistic and over-optimistic conceptions of resilience it is problematic in many ways. It does, however, speak to the possibility and reality that 'life after trauma' can indeed be transformative in the sense of new or regained quality of experience following resolution of trauma, and that this possibility can be sustaining during the challenging process of recovery. See 'strengths based', 'resilience', 'neuroplasticity', 'earned security'.

Post-traumatic Stress Disorder (PTSD) – A disabling condition of unresolved trauma which can follow experience or witnessing of an event or events involving actual or threatened death or serious injury to oneself or others, or threat to the physical integrity of oneself or others. Symptoms need to have been present for at least one month and include persistent hyperarousal, avoidance of reminders of the traumatic event, involuntary recall of the incident (e.g. via intrusive images or flashbacks) and compromised quality of life. It is estimated that approximately 20-25% of people who experience traumatic events go on to develop PTSD (Rothschild, 2011).

'Standard' or 'single-incident' PTSD might follow a motor vehicle accident, natural disaster, combat experience or single-incident of assault. This is in contrast to 'complex' trauma, which is multiple, cumulative and interpersonally generated (such as recurrent abuse). People who experience complex trauma are at higher risk for developing 'standard', 'single-incident' PTSD (and note that not everyone who experiences a single-incident trauma goes on to develop PTSD). The current iteration of the International Classification of Diseases includes a diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD) but the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not (although does include a dissociative subtype of PTSD). See 'Complex Post-Traumatic Stress Disorder', 'complex trauma', 'diagnosis of trauma', 'Diagnostic and Statistical Manual of Mental Disorders', 'dissociative subtype of PTSD'.

Power Threat Meaning Framework – A philosophical conceptualisation which critiques and transcends 'symptom-based' orientations in favour of a 'whole person' approach to health and wellbeing. This understanding has treatment implications. Developed by service users and senior psychologists in the UK under the auspices of the Clinical Division of the British Psychological Society over a period of five years, this comprehensive and integrated approach provides 'an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification' (Johnstone, Boyle et al, 2018). The Power Threat Meaning Framework accords high priority to lived experience, was co-designed with a group of service users and carers, and is not limited to any specific theoretical model or practice modality. See 'symptoms', 'adaptation to trauma', 'coping strategies'.

practice-based evidence – An inversion of, and alternative to, the paradigm of ‘evidence-based practice’. In contrast to the latter, ‘practice-based evidence’ gauges treatment effectiveness with reference to client feedback which in turn guides the treatment (Miller, 2005). Correspondingly, it recognises the input of the clinician to the therapies being applied. Practice based evidence converges with the view that the most valuable measure of treatment effectiveness is client outcomes (on which there is comparatively much less emphasis when evidence-based practice is regarded as definitive). See ‘common factors research’, ‘evidence-based practice’, ‘Feedback Informed Treatment (FIT)’.

prolonged exposure (PE) – an evidence-based psychotherapy in which the client is encouraged to repetitively retell their trauma experience with a view to systematic desensitisation to its distressing impact. Notwithstanding its adherents and its status as an evidence-based treatment, the benefits of this approach in relation to complex trauma which involves interpersonal violation and betrayal have been questioned (i.e. complex trauma is unlike simple phobias; to what, in the context of relational trauma, should clients be ‘exposed’?) Questions also arise about the benefits of PE for severely dissociative clients. A study of the effectiveness of PE for complex trauma treatment (i.e. as well as of standard PTSD) found that it was less efficacious than anticipated: ‘It is arguable the most surprising result in our study was the poor performance of prolonged exposure therapy process....PE is often touted as the first-line treatment for distressed trauma survivors (Foa, 2009), but we found little evidence that PE was helpful for these clients, and some evidence of adverse effects’ (D’Andrea & Pole, 2012: 444; also see Emerson & Hopper, 2011:15-16). Peter Levine is explicit that ‘prolonged exposure types of therapiesthough they undoubtedly do help some... harm others’ (Levine, 2015). See ‘exposure therapies’, ‘complex trauma treatment’, ‘evidence-based treatment and practice’, ‘phased treatment’.

psychotherapy – The practice by which a trained health professional assists clients to address emotional and psychological problems. Following the initial dominance of psychoanalysis (the original ‘talking cure’ pioneered by Freud in the late nineteenth century) psychotherapy has become a diverse field with an expanding range of approaches and modalities. It is also undergoing reappraisal and renaissance as its central tenets have been found to correlate with neuroscientific principles (Cozolino, 2002; Doidge, 2007; the latter describes psychotherapy as ‘a neuroplastic therapy’).

Psychotherapy is now regarded as ‘an enriched environment that promotes the development of cognitive, emotional and behavioural abilities’ (Cozolino, 2002). Cozolino argues that ‘all forms of psychotherapy – from psychoanalysis to behavioural interventions – are successful to the extent to which they enhance change in relevant neural circuits’ (Ibid).

Note, however, that current research in the physiology and psychobiology of trauma also suggests ‘the limits of talk’ in relation to the resolution of trauma (Ogden et al, 2006; van der Kolk, 2003; Porges, 2011). This in turn suggests the need to supplement traditional psychotherapeutic orientations with approaches which can directly engage somatic and ‘right brain’ processes. See ‘body’, ‘expressive therapies’, ‘right brain’, ‘traditional psychotherapy’, ‘Sensorimotor Psychotherapy (SP)’, ‘Somatic Experiencing (SE)’, ‘trauma sensitive yoga’.

psychodynamic psychotherapy – An interpretive and insight-based variety of psychotherapy which is directly traceable to Freudian psychoanalysis. Psychodynamic psychotherapies (which differ from the classical Freudian period of psychoanalysis and following ‘the relational turn’) can be very valuable in working with the unconscious processes and self-states of complex trauma. Yet neuroscientific research also suggests the limits of psychotherapies which do not attend to bodily experience, and a range of therapeutic approaches now focus in other ways (‘It is possible that some of the newer body-oriented therapies, dialectical behaviour therapy, or EMDR may yield benefits that traditional insight-oriented therapies may lack’; van der Kolk, 2003). See ‘self-state’, ‘parts’, ‘self-system’, ‘body’, ‘expressive therapies’, ‘traditional psychotherapy’, ‘body’, ‘expressive therapies’, ‘traditional psychotherapy’.

recovered memory – Delayed conscious recall of experience too overwhelming to be assimilated at the time of the original trauma. Trauma impedes functioning of the hippocampus, which is central to the encoding of memory and to conscious recall. Fragments of memory of the traumatic experience are stored somatically, and reactivated – sometimes years later – by sensory stimuli which serve as ‘triggers’ to conscious recall (‘Contrary to the widespread myth that traumatic events are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind’; Brewin, 2012).

Traumatic memory relates to implicit (non-conscious) rather than explicit (conscious) memory, and is expressed in ‘physical sensations, automatic responses and involuntary movements’ (Ogden et al, 2006) rather than spoken language. The book titles ‘The Body Remembers’ (Rothschild, 2000) and ‘The Body Keeps the Score’ (van der Kolk, 2015) are illustrative. Recovered memory occurs in relation to diverse types of trauma (van der Hart et al, 1999) but its reliability is usually only contested in relation to child sexual abuse. It is important to be aware that research ‘has firmly established the reliability of the phenomenon of recovered memory’ (Dalenberg, 2006). It is also important to be aware that studies show that recovered memories ‘can often be corroborated and are no more likely to be confabulated than are continuous memories’ (Chu, 2011: 80; Barlow et al, 2017). See ‘implicit memory’, ‘explicit memory’, ‘re-enactment’.

recovery – As applied to mental health, the belief that impaired psychological functioning ‘is based on more than diagnosed pathology or the intensity of symptoms, [and] is the product of interactions between the individual and the environment’ (Anthony, Cohen & Farkas, 1990, in Jacobson & Curtis, 2000). In contrast to the domain of physical illness (also recognising the interconnections) application of the term ‘recovery’ to psychological conditions is more recent. It also contains an implicit critique both of longstanding assumptions that recovery from mental illness is not possible and of the systems and institutions organised around this belief.

In the language of psychiatric rehabilitation, ‘recovery’ refers primarily to functional ability. But for those with lived experience of emotional and psychological challenges, the concept has both personal and political implications – ‘to recover is to reclaim one’s life, to validate one’s self in order that one may be validated as an autonomous, competent individual in the world’ (ibid). Thus recovery is centrally related to the concept of empowerment, which is also an underpinning principle of trauma-informed care. See ‘resilience’, ‘strengths based’, ‘Power Threat Meaning Framework’, ‘trauma-informed care’.

re-enactment – The repetition of prior experience which is an expression of implicit memory and which is particularly marked in the context of trauma. Traumatic re-enactment was described by Freud (1920) as ‘the compulsion to repeat’. It is also increasingly recognised to have strong biological foundations, and to be ‘part of the innate and programmed behavioral repertoire of the traumatised person’ (Bloom, 2011). For this reason contemporary research suggests the need for traditional psychotherapy to take more direct account of physical movement and the body, as in sensorimotor approaches (van der Kolk, 2003, 2007).

The relationship between traumatic re-enactment and unresolved grief has also been highlighted – ‘The person continually re-enacts what he or she has not been able to resolve... unresolved loss becomes another dynamic that keeps an individual stuck in time, unable to move ahead, and unable to go back. Compounded and unresolved grief is frequently in the background of lives based on traumatic reenactment’ (Bloom, 2011). See ‘trauma’, ‘complex trauma’, ‘recovered memory’, ‘body’, ‘sensorimotor psychotherapy’.

relational trauma – Interpersonally generated trauma which is not necessarily the product of experience within the family or with people to whom one is interpersonally attached (Shapiro, 2010). Examples of relational trauma include bullying, humiliation and shaming, rejection by a love object, having to keep a secret which sets one apart, and having one’s needs ignored at any age – ‘All of these situations can create trauma. Any of them, chronically experienced, can root deeply into human neurology, creating a distorted view of the self (‘I’m not worth caring about’, ‘I’m bad’, ‘Anything I try to do is futile...’ (Ibid) See ‘complex trauma’, ‘micro-aggressions’, ‘organisational trauma’.

resilience – The capacity to sustain and respond positively to life stress, setback and difficulty. While initially conceptualised in individualistic terms, recent research emphasises the importance of social, cultural and environmental processes in fostering and supporting this capacity (Liebenberg & Ungar, 2009). While a focus on resilience is strengths-based rather than deficit-based, celebrating resilience should not be at the expense of recognition of difficulties. For example, compartmentalised functioning may mean that a client seems to ‘tick all the boxes’ of health according to external criteria (e.g. in employment, relationships etc) but their quality of life may be compromised. See ‘adaptation to trauma’, ‘coping strategies’, ‘dissociation’, ‘medically unexplained symptoms’.

resolution of trauma – The processing, coming to terms with, and ‘working through’ of traumatic experience so that it ceases to be disabling. Clinical and neuroscientific research show that it is possible for trauma to be resolved, and its negative effects on the next generation (via transmission of unresolved parental trauma) to be intercepted (Siegel, 2010). See ‘attachment style/s’, ‘Adult Attachment Interview’ (AAI), ‘earned security’, ‘trauma treatment’, ‘recovery’.

resources – assets and strategies, both internal and external, which can be drawn upon to support wellbeing. Unresolved trauma radically impedes the ability to access supportive resources which are central to self-regulation and healthy functioning. Complex trauma, particularly from childhood, can also damage the capacity to access resources. This means that ‘resourcing’ the complex trauma client is itself more complex than for clients who do not have trauma histories. See ‘affect regulation’, ‘complex trauma’, ‘bilateral stimulation’, ‘expressive therapies’, ‘resource tapping’, ‘implicit memory’.

resource tapping – ‘a technique that pairs an activated resource with alternating bilateral stimulation via tapping to strengthen and integrate the resource’ (Parnell, 2008). It is described as ‘a modern psychospiritual method that echoes the spiritual technology of Tibetan and other meditative traditions, and is also influenced by hypnotherapy, guided imagery, positive psychology, and EMDR’ (ibid). These diverse influences are held to ‘combine to provide a powerful and effective method for harnessing the power of the resources latent within us’ (Parnell, ibid). See ‘tapping’, ‘bilateral stimulation’, ‘Energy Psychology’, ‘Emotional Freedom Techniques’, ‘Thought Field Therapy’.

re-traumatisation – Recurrence and re-experience of trauma. Research shows that many clients are re-traumatised within the mental health system itself (Jennings, 2004; Fallot & Harris, 2009). It further shows that service practices which contribute to re-traumatisation rather than recovery are pervasive and deeply entrenched. This underlines both the limits of individualist frameworks, and the need to introduce care and practice which is ‘trauma-informed’. See ‘re-enactment’, ‘trauma-informed’.

right brain – The right brain hemisphere, also known as the ‘emotional’ brain, is critical to processing emotion and regulating affect. In contrast to the left or ‘cognitive’ brain, the right brain is dominant in infancy, ‘indicating the essentially affective nature of mental functioning in the first years of life’ (Fosha, 2003). See ‘affect regulation’, ‘early onset trauma’.

risk management – The suite of policies, strategies and methods to safeguard and maintain professional practice. Effective risk management in psychotherapy entails several components, including respect for and implementation of boundaries, professional indemnity insurance, regular clinical supervision, and attentiveness to self (i.e. as well as client) care. Compliance with the relevant ethics codes and ethical practice are also part of risk management. In organisational settings, risk management entails maintenance of a context which is conducive to ethical practice at all times. See ‘ethical practice’, ‘self-care’, ‘supervision’.

safety – The foundational principle in complex trauma treatment, which may need to be actively facilitated as many complex trauma clients have not previously experienced it. A sense of safety is a prerequisite to the ability to regulate affect, which is critical to the capacity to process and integrate trauma. Safety is also a key concept of trauma-informed care and practice (the others being trustworthiness, choice, collaboration and empowerment; Falloot & Harris, 2009). See 'trauma-informed', 'phased treatment', 'affect regulation'.

screening for trauma – The process of posing spoken or written questions to gain a sense of whether a client is experiencing unresolved trauma. Health services and settings do not commonly screen for trauma; Bloom (2011) argues that trauma is not only not screened FOR but is actively screened OUT. Trauma is prevalent and needs to be detected early. However screening without the appropriate safeguards and sensitivity can also precipitate re-traumatisation, and re-traumatisation may occur even when these are in place. To minimise this risk, all trauma screening should be conducted in a context which is trauma-informed. See 'trauma-informed'.

secondary trauma – A variety of 'indirect' overwhelming experience which can stem from proximity to trauma, and which includes 'the parallel trauma symptoms that helpers may develop in working with traumatised clients' (Pearlman & Caringi, 2009). Also previously known as secondary traumatic stress disorder (Figley, 1995) it is commonly now known as compassion fatigue. See 'compassion fatigue', 'burnout', 'risk-management'.

self – the concept of 'self' has long been difficult to define. It is increasingly clear that mental life is 'full of discontinuities' (Spiegel, 2018). Neuroscientific research reveals that '[t]he concept of a single, unitary 'self' is as misleading as the concept of a single unitary 'brain' (Schoore, 2011). Research in the neurobiology of attachment also confirms that 'self' is not a 'given'. Rather it is constructed over time in the context of interpersonal relationships. This makes it easier to understand how disturbances of self can occur in interactions with others, that traumatic interpersonal experiences can disrupt self-coherence, continuity and identity (especially if trauma occurs early in life) and that resolution of trauma is necessary for self-regulation, self-development and healthy functioning. See 'self-state/s', 'ego state/s', 'affect regulation', 'complex trauma', 'social brain'.

self-care – Attentiveness to one's own needs, especially for rest and relaxation, and generally 'looking after' self. The ability for self-care is an indicator of healthy self-respect, and is very different from 'selfishness'. Self-care is a key component of professional and ethical therapeutic practice, both in fostering the therapist's wellbeing given the intensity of psychotherapeutic work, and in modelling this ability for clients. See 'affect regulation', 'ethical practice', 'risk management' and 'supervision'.

self-harm – Harm inflicted on the self which can take a number of forms but which frequently describes direct and intentional injury to body tissue. Self-harm is a frequent response to trauma, particularly when the trauma is sexual and early onset. Rather than indicating suicidal intent, self-harm more often serves a self-regulatory function and 'is most often performed with intent to alleviate negative affect' (Klonsky, 2007). See 'adaptation to trauma', 'blaming the victim', 'coping strategies', 'early onset trauma', 'endogenous opioids', 'trauma-informed'.

self-soothing – Management of emotion; particularly the ability to establish or restore inner calm when experience is stressful. The capacity to self-soothe is a vital precondition to processing and integrating trauma. See 'affect regulation', 'attachment theory', 'phased treatment', 'right brain', 'safety'.

self-state/s – What we call ‘self’ is not unitary (see listing for ‘self’) but comprises diverse states. These are variously described as self-states, ego states, and/or ‘parts’ (see listings for these terms). We are all subject to state change/s and fluctuations. In this sense multiplicity is the norm and ‘[w]e are all multiple to some degree’ (Putnam, 2016). Standard theories of personality, in their emphasis on ‘fixed, persistent, and globally defining traits’, do not assist us to comprehend this (Putnam, 2016). By contrast, the ‘state model’ defines self and personality as ‘the collective dynamics of a person’s set of identity, emotional and behavioural states’ (Putnam, 2016). See ‘self’, ‘self-system’, ‘ego states’, ‘parts’.

self-system – The configuration of self-states which comprises the multiplicity of the mind: ‘The left and right [brain] hemispheres process information in their own unique fashion and represent a conscious left brain self system and an unconscious right brain self system’ (Schoore, 2011). Severe traumatic disruption in early life can generate many diverse self-states and an extremely complex self-system of which Dissociative Identity Disorder (DID) is the most severe: ‘Scepticism about numbers of self-states is a potential intellectualization and deflection of the sad reality... an intolerance of the reality of severe abuse’ (Chefet, 2015). See ‘self’, ‘self-state/s’, ‘ego states’, ‘parts’.

Sensorimotor Psychotherapy (SP) – A school of psychotherapy which emphasises the role of the body and in which resourcing is based in integrating somatic interventions at all stages of treatment (Ogden, 2006). Neuroscientific research has established the inextricable relationship between physiological and psychological processes, as well as the centrality of movement and the body in relation to trauma. This in turn suggests that traditional psychotherapeutic approaches need to incorporate awareness of sensorimotor processes (Ogden, 2006; van der Kolk, 2003, 2006). See ‘body’, ‘expressive therapies’.

shame – While guilt relates to feelings of culpability for actions, shame applies to feelings about the self. In complex trauma, an inability to self-regulate and regain self-integrity in relationships (Courtois & Ford, 2009) means that shame frequently assumes an extreme or ‘toxic’ form. It can present ‘not only as an acute emotional state’, but also as ‘a more fundamental and enduring aspect of an individual’s personality structure; in many traumatized persons the experience of shame essentially defines who they are’ (Frewen & Lanius, 2015). Deep-seated beliefs of lack of self-worth and inherent defectiveness are of a different order than the fear and anxiety that characterise standard PTSD. This can also have treatment implications: ‘when a person’s past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice’ (Frewen & Lanius, *ibid*).

single-incident trauma – See post-traumatic stress disorder (PTSD)

social brain – Term which reflects neuroscientific findings that social and environmental factors impact brain development and functioning. In illuminating the constitutive role of social experience in activating neural mechanisms and processes, findings from affective neuroscience transcend longstanding debates about ‘nature’ and ‘nurture’. Humans are inherently relational. From the moment of birth, experience not only influences the self (which implies the effects of ‘external’ environment on already intact subjectivity) but actively shapes and formulates it. Experience has ‘psychobiological correlates’ in the organisation of our brains (Castillo, 1997; Cozolino, 2002; Doidge, 2007).

social defence mechanisms – While defence mechanisms are widely regarded as the preserve of individuals (i.e. in protecting from the recognition of an unpalatable reality) they serve a similar function collectively (Herman, 1992). Bloom (2011:11) argues that basic assumptions underlie and reassure groups and organisations as much as the individuals within them. Thus ‘challenges to these basic assumptions... are likely to give way to anxiety and to ‘social defense mechanisms’ (Bloom, Ibid). A powerful illustration of a ‘social defence mechanism’ is the medicalisation of what are actually social problems (Ibid) See ‘blaming the victim’, ‘politics of trauma’, trauma-informed’.

Somatic Experiencing (SE) – a body-based psychotherapeutic approach to treatment developed by American researcher and clinician Peter Levine.

somatisation – Expression of psychological states and processes as physical symptoms. Implicit memories of trauma can emerge as bodily ailments and pain (Cozolino, 2002; Siegel, 2010). In some cases, surgery is sought or recommended because the emotional and psychological sources of somatic symptoms are not recognised. See ‘symptoms’, ‘coping strategies’, ‘screening for trauma’, ‘Medically Unexplained Symptoms’.

soul murder – A form of interpersonal trauma which entails damage to self, identity, and relationships with others, and in which survival comes at the cost of subjugation of the spirit. Prior to Freyd’s elaboration of ‘betrayal trauma’ in the late 1990’s, Edward Shengold MD described betrayal of trust as a form of ‘soul murder’ in relation to child sexual abuse (Shengold, 1989, 2000). The term was first used in the nineteenth century by Scandinavian playwrights August Strindberg and Henrik Ibsen; the latter described ‘soul murder’ as ‘the destruction of the love of life in another human being’ (Shengold, ibid). See ‘betrayal trauma’.

The Strange Situation – A study of reunion behaviour between infants and their caregivers which yields multiple insights into primary emotional bonds (‘attachment’) and their different forms. First conducted in the 1970s by developmental psychologist Mary Ainsworth in relation to the research of John Bowlby, the Strange Situation has been consistently replicated and validated. Research in affective neuroscience is further clarifying and extending its findings. The study delineated contrasting ‘attachment styles’ – ‘secure’, ‘avoidant’ and ‘ambivalent’ – with a fourth variety (‘disorganised’) added in the 1990s by psychologist Mary Main. The Strange Situation establishes the critical role of parental attachment for child wellbeing, and for subsequent adult health and parental capacity (i.e. transgenerational effects). Note that it is possible to rework attachment styles, resolve childhood trauma, and achieve ‘earned security’ (Siegel, 2003). See ‘attachment theory’, ‘attachment style/s’, ‘Adult Attachment Interview’, ‘earned security’.

strengths-based – An approach to treatment which emphasises the client’s existing resources, which fosters client options and empowerment, and which is explicitly non-pathologising. Also note that a strengths-based treatment approach should not forgo attuning to the client’s struggles which may be concealed and not readily apparent. See ‘adaptation to trauma’, ‘coping strategies’, ‘resilience’, ‘trauma-informed’.

structural dissociation – ‘[A] division of the personality as a biopsychosocial system into two or more subsystems of personality that should normally be integrated’ (Steele & van der Hart, 2009). Also see ‘Dissociative Identity Disorder’ (DID) and ‘dissociation’.

supervision – A process of oversight and monitoring which takes different forms depending on the context. In counselling and psychotherapy, it takes the form of ‘clinical supervision’, does not function in an authoritarian way, and generally assumes the form of a conversation. Supervisees also generally select their own supervisor.

Clinical supervision is a key component of professional and ethical practice, in which (usually) less experienced practitioners consult a more senior clinician about their work with clients on a formal but also democratic basis. Ethical psychotherapeutic practice requires all practising therapists to undertake regular clinical supervision, regardless of their level of experience. Therapists who work with complex trauma clients face particular challenges to which their supervision needs to be attuned (Coleman, Chouliara et al, 2018). See ‘clinical supervision’, ‘ethical practice’, ‘trauma-informed’, ‘self-care’, ‘risk management’.

See ‘clinical supervision’, ‘ethical practice’, ‘self-care’, ‘risk management’.

survival brain – In contrast to the ‘learning’ brain (which develops naturally with adequate caregiving and environmental support) the ‘survival’ brain is suboptimal. Rather than being open to experience and new learning, it becomes ‘fixated on automatic, nonconscious scanning for and escape from threats’ (Ford, 2009). The shift from a ‘learning’ to a ‘survival’ brain radically impedes the developmental task of self-awareness, and is particularly prevalent in contexts of child abuse (Ibid). See ‘early onset trauma’, ‘developmental trauma’, ‘Developmental Trauma Disorder’.

symptoms – Physical or mental indicators of unwellness according to which health problems are classified and diagnosed. A ‘trauma-informed’ approach challenges the conventional understanding of symptoms as linked to a medical model which is implicitly pathologising. By contrast, a trauma-informed perspective is strengths-based, and regards symptoms as the outgrowth of coping mechanisms which are adaptations to trauma and which can be utilised as resources in the process of recovery. See ‘adaptation to trauma’, ‘coping strategies’, ‘Adverse Childhood Experiences (ACE) Study’, ‘pathology’, ‘strengths-based’, ‘Power Threat Meaning Framework’, ‘trauma-informed’.

tapping – a method of light somatic stimulation common in Energy Psychology. Alternate right-left tapping is applied to achieve bilateral stimulation. When tapping is accompanied by focusing the mind on an unwanted emotional response, it can send electrochemical signals to the brain to produce rapid relief (Feinstein et al, 2005). Tapping is a characteristic feature of Emotional Freedom Techniques (EFT) and is widely utilised for a range of psychological issues. While regarded as unconventional by some, it draws on healing practices of traditional Chinese medicine, is widely subscribed to, and has a growing evidence base. See ‘acupoints’, ‘bilateral stimulation’, ‘resource tapping’, ‘Energy Psychology’, (EP), ‘Emotional Freedom Techniques’ (EFT), ‘Thought Field Therapy’ (TFT).

TFT – see ‘Thought Field Therapy’

The Treatment of Patients with Dissociative Disorders (TOP DD) Study – Prospective, naturalistic study of treatment outcome for patients with dissociative disorders. The TOP DD involves 19 countries and data was collected at four points across 30 months of treatment. Findings which were informed by participating therapists were that the phased treatment delivered led to reduced depression, dissociation, PTSD, and general distress, as well as fewer suicide attempts, self-harm behaviors and hospitalizations over the 30 months of treatment <https://www.towson.edu/cla/departments/psychology/topdd/>. The TOP DD has generated a number of publications, including a paper on its web-based educational program in the Journal of Traumatic Stress (Brand, Schielke, et al, 2019).

Thought Field Therapy (TFT) – an approach of Energy Psychology which, in common with Emotional Freedom Techniques (EFT), involves applying light pressure by tapping on a prescribed set of acupuncture points: ‘Relative to most other forms of treatment, these ‘tapping’ approaches are quite similar. At the most basic level, they involve having the client focus on a ‘target’ thought, memory, sensation, or feeling that is associated with distress. At the same time, the client taps on selected acupoints. Clients report changes in their unfolding experience, including their sense of distress. The process is repeated until the distress levels are eliminated or vastly reduced’ (Schwarz, 2018). See ‘Emotional Freedom Techniques’, ‘Energy Psychology’, ‘acupoints’, ‘tapping’.

TOP DD – See ‘The Treatment of Patients with Dissociative Disorders (TOP DD) Study’

traditional psychotherapy – As the original ‘talking cure’, psychoanalysis bequeathed a legacy of emphasis on verbal articulation to the many psychotherapeutic modalities which followed. To this extent, approaches as diverse as psychodynamic psychotherapy and Cognitive Behavioural Therapy privilege spoken language over a focus on the body (‘[n]either CBT nor psychodynamic therapeutic techniques pay much attention to the experience and interpretation of physical sensations and pre-programmed physical action patterns’; van der Kolk, 2007). Current neuroscientific research suggests the need to ‘put the body back’ in the practice of psychotherapy, that optimal trauma treatment needs to engage right-brain processes, and that physical as well as cognitive and emotional experience needs to be attended to (Ogden et al, 2006). See ‘body’, ‘right brain’, ‘sensorimotor psychotherapy’, ‘somatisation’, ‘expressive therapies’.

transference – The unconscious responses of a client to their therapist, based on past relationships and associations which are evoked in therapy. Because complex trauma clients have often experienced betrayal and abuse from their caregivers, their transference to therapists can be strong (e.g. negative, idealising, or a combination of the two). This means that therapy can be particularly intense for both parties, and therapists need regular clinical supervision to ventilate and explore their responses to their clients (i.e. the ‘countertransference’) See ‘complex trauma’, ‘countertransference’, ‘supervision’.

transgenerational trauma – The process by which trauma is transmitted to the next generation via an attachment style which is associated with unresolved parental trauma. Studies now show that it is possible for traumatic childhood experience to be resolved, and for the negative effects on parenting and the next generation to be positively intercepted. See ‘epigenesis’, ‘Adult Attachment Interview’ (AAI), ‘attachment style/s’, ‘disorganised attachment’, ‘earned security’.

trauma – ‘[A] state of high arousal that impairs integration across many domains of learning and memory’ (Cozolino, 2002). Trauma stems from activation of the instinctive ‘fight-flight’ response to an overwhelming threat. Mobilisation of this biological ‘survival’ response leads to a ‘freeze’ response when the danger cannot be escaped and the normal impulse for action is arrested. An experience doesn’t need not to be life-threatening to be traumatic. Neuroscientific research also establishes the vulnerability of the developing brain to early experience of caregivers. Repeated and unrepaired parental misattunement can be traumatic to infants, and can lead to significant developmental compromise. See ‘attachment’, ‘complex trauma’ ‘developmental trauma’.

trauma diagnosis – See ‘diagnosis of trauma’

trauma-focused treatment – like ‘first-line’ trauma treatments (see entry under that heading) trauma-focused treatments are evidence-based and generally short-term, exposure, and/or cognitive-oriented. This more particular use of the term is not obvious when the ‘trauma-focused’ descriptor is assumed to apply to psychotherapies which address trauma differently than ‘evidence-based’ approaches (but which may be effective, and potentially more effective, for complex trauma treatment than ‘evidence-based’ psychotherapies). See ‘complex trauma treatment’, ‘evidence-based treatment and practice’, ‘phased treatment’.

trauma-informed – A re-conceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised around the prevalence of trauma in society. Services which are ‘trauma-informed’ are attuned to the dynamics of trauma and all facets of service delivery, formal and informal, and ‘do no harm’. This is as distinct from directly treating trauma which is the role of clinicians (the appropriate term in the latter case is ‘trauma-specific’; note that the two can also overlap).

Trauma-informed services are alert to the possibility of trauma in the lives of all clients/ patients/ consumers regardless of whether it is known to exist in individual cases. The contrast with ‘traditional’ health and welfare settings is profound: ‘Changes to a trauma-informed organizational service system environment will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently’ (Jennings, 2004). Key principles of trauma-informed care include safety, trustworthiness, choice, collaboration and empowerment (Fallot & Harris, 2009).

Trauma Model – The perspective of trauma clinicians and researchers regarding trauma-related dissociation who see DID as ‘at the far end of the spectrum of trauma-related psychiatric disorders and related to a combination of factors such as chronic emotional and physical abuse and neglect and/or sexual abuse from early childhood, insufficient integrative capacity, and lack of affect regulation by caretakers’ (Rydberg, 2017). This reading is contested by proponents of the ‘Fantasy Model’: ‘Supporters of the opposed trauma and fantasy models...of DID are engaged in a debate regarding the validity of DID as a mental disorder and its causes (i.e. traumatization or fantasy proneness, suggestibility, suggestion, and simulation’ (Reinders, Willemsen et al, 2016). Research consistently supports the ‘Trauma’ rather than ‘Fantasy’ model of DID (Schlumpf, Reinders et al, 2014; Brand, Vissia et al, 2016). See ‘dissociative disorder’, ‘Dissociative Identity Disorder’, ‘complex trauma’, ‘Fantasy Model’).

Trauma sensitive yoga – As the name implies, ‘trauma sensitive yoga’ developed in recognition both of the potentially beneficial effects of yoga and that standard forms of yoga practice may be triggering for people with trauma histories. Hence the need for trauma-informed adaptations (Emerson & Hopper, 2011). A well-developed variety of trauma sensitive yoga is Trauma Center Trauma Sensitive Yoga (TCTSY) which derives from the program pioneered at the Trauma Center in Brookline, Massachusetts. Staff of Trauma Centre Trauma Sensitive Yoga Australia (TCTSY Australia) have trained at the Trauma Center. Described as ‘an adjunctive treatment for PTSD and Developmental and Complex Trauma’, TCTSY is empirically validated and grounded in trauma theory, attachment theory, and Hatha yoga practice. For these reasons, it is specifically recommended for people with complex trauma histories. See <http://www.tctsyaustralia.com/>

trauma-specific – Treatment approaches and services which are directly addressed to the clinical treatment of trauma in its various forms.

trauma treatment – Effective trauma therapy entails facilitation of neural integration (Solomon & Siegel, 2003; van der Kolk, 2003). The importance of the capacity to manage emotion (affect regulation) is a precondition to the capacity to process and integrate trauma. In contrast to standard (single-incident) PTSD, the cumulative impact of complex trauma severely disrupts self-regulatory capacity which has implications for appropriate trauma treatment.

Studies show that people who experience complex trauma ‘may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than ‘processing the trauma’ (van der Kolk, 2003). This is why the recommended treatment for complex trauma is phased treatment. See ‘complex trauma treatment’, ‘exposure therapies’, ‘phased treatment’, ‘evidence-based’.

treatment of complex trauma – See ‘complex trauma treatment’; ‘phased treatment’

treatment of trauma – See ‘trauma treatment’

vicarious trauma (VT) – ‘[T]he negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them’ (Pearlman & Caringi, 2009). Vicarious trauma is situationally inherent in exposure to traumatic material over time and does not reflect weakness or fault on the part of the helper (‘VT goes with the territory’; Ross & Halpern, 2009). Thus the challenge is one of recognition and appropriate addressing, where both ongoing clinical supervision and ongoing therapist self-care are protective factors. The role of institutional factors and workplaces in mitigating the risks and impacts of VT (i.e. in contrast to worker exposure ‘that is unrecognised and unsupported by the organisational setting’; Bloom, 2011) is also increasingly recognised. See ‘supervision’, ‘self-care’.

violence – In liberal Western societies ‘violence’ is often viewed as specific acts carried out by identified perpetrators. However it also entails ongoing less overt systemic violations which are increasingly destructive for large numbers of people. Slovenian psychoanalyst Slavoj Žižek outlines three forms of violence of which only the first is widely recognised within Western ‘liberal democratic’ societies: subjective (the most visible, ‘performed by a clearly identifiable agent’), symbolic (‘embodied in language and its forms’) and systemic (‘the often catastrophic consequences of the smooth functioning of our economic and political systems’; Žižek, 2008). Recognising the extent of structural and systemic violence allows a broader perspective which implicates a range of social practices and institutions. Bloom (2011) argues for violence to be seen as ‘a public health problem, instead of simply an individual problem’. See ‘individualism’, ‘organisational trauma’, ‘politics of trauma’, ‘micro-aggression’, ‘social defence mechanisms’.

window of tolerance – The threshold at which emotion can be tolerated without the person becoming either agitated and anxious (hyperaroused) or ‘shut-down’ and numb (hypoaroused) [Siegel, 1999]. It is essential that trauma therapy is conducted within ‘the window of tolerance’, which, if exceeded, can precipitate re-traumatisation. See ‘affect regulation’, ‘complex trauma’, ‘phased treatment’.

As evidenced by these revised and updated guidelines, Australia has taken an international leadership role in developing clinical guidance for the treatment of complex trauma. The authors have consolidated a vast amount of research and clinical literature to arrive at an updated and state-of-the-art treatment formulation..... I repeat what I wrote in my endorsement of the earlier guideline: `This document is a singular and pioneering achievement in its depth and scope...Bravo to all involved in its development!

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Author of many publications in complex trauma (*details and full endorsement on p. 5*)

This is a remarkable document that reflects the state of the art in the treatment of complex trauma as well as an incisive critique of research on trauma treatments. It is a great service to the trauma field. These guidelines validate what clinicians who treat complex trauma have long known --- the gold standard treatments for simple PTSD are, to put it mildly, less than optimal for complex trauma. It affirms and explains why evidence for effective treatments of complex trauma cannot be limited to RCT's.

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These updated Practice Guidelines for Treatment of Complex Trauma represent a description of state-of-the-art trauma treatment as it has developed over the past thirty years. No therapist or client can fare badly if these guidelines are followed. They are compassionate, reflect expert knowledge, and yet eminently practical. They should be recommended reading for all therapists who treat complex trauma—i.e., most of us.

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