Restoring the Shattered Self: The Treatment of Complex Trauma

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My Background in this Specialization
- Sexual abuse survivors
- Dissociative disorders
- Other trauma survivors (see Gingrich, 2002)
- Research on dissociation and trauma in the Philippines
- Recognition of overlap in treatment techniques

Trauma Field
- Posttraumatic Stress Disorder
  - even single exposure
    - natural disasters
    - rape incident
    - witnessing violence
    - combat veterans
  - primarily cognitive-behavioral treatments
  - International Society for Traumatic Stress Studies (ISTSS)
- Complex Traumatic Stress Disorder
  (Disorders of Extreme Stress)
  - multiple exposures
    - incest survivors
    - child abuse and rape
  - multi-faceted treatment approaches
  - International Society for the Study of Trauma and Dissociation (ISSTD)

Trauma Psychology, Division 56, APA

Posttraumatic Stress Disorder: DSM-IV Criteria
- Exposure to traumatic event
- Reexperiencing
  - Memories, thoughts, mental images, dreams, flashbacks
- Avoidance/Numbing
  - thought stopping, social withdrawal, amnesia for the trauma, constriction of affect
- Hyperarousal
  - Irritability, explosive anger, hypervigilance, problems with concentration, difficulty falling and staying asleep
- Symptom duration of more than 1 month
- Clinically significant distress/impairment in functioning

American Psychiatric Association, 2000

DSM-5 – Change in Criteria A
- Sexual assault listed as a possible traumatic event
- Response of fear, helplessness, or horror no longer included

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DSM-5 – Additional Symptom Cluster

- Negative thoughts and mood or feelings
  - a persistent and distorted sense of blame of self or others
  - estrangement from others or markedly diminished interest in activities
  - an inability to remember key aspects of the event.

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DSM-5 PTSD Dissociative Subtype

- chosen when PTSD is seen with prominent dissociative symptoms
  - depersonalization
    - experiences of feeling detached from one’s own mind or body
  - derealization
    - experiences in which the world seems unreal, dreamlike or distorted.

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Why Talk about Dissociation?

- Used by victims of all kinds of trauma
- There is a well-documented association between trauma and posttraumatic dissociation
- DSM-5 now lists a dissociative subtype

DSM-V-Definition of Dissociation

Disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior.

Simply put: Dissociation is compartmentalization, or disconnection among aspects of self and experience

Normal versus Pathological Dissociation

CONTINUUM OF DISSOCIATION

Developing the Capacity to Dissociate

- We are born unintegrated (i.e., dissociated)
- Healthy attachment leads to integration of behavioral states
- Impact of child abuse
- Dissociation as a defense
- Mental disorder
  - dissociative disorder/other disorder with dissociative symptoms

Putnam, 1995
Attachment Style and Dissociation

- Attuned, “good enough” parenting
  - Secure attachment style
  - Integration of self-states
- Inattentive/neglectful/abusive parenting
  - Insecure (Ambivalent/Disorganized) attachment style
  - Dissociated self-states

(D Gingrich, 2013)

Dissociation as a Defense Mechanism

- Used by victims of all kinds of trauma
- In addition to the link between peritraumatic dissociation and PTSD, there is a well-documented association between trauma and posttraumatic dissociation (see Gingrich, 2005)
- Explanation for why treatment techniques for dissociative disorders can also be helpful for other trauma survivors

Dissociative Symptoms

- **Amnesia:** A specific and significant block of time that has passed but that cannot be accounted for by memory
- **Depersonalization:** Sense of detachment from one’s self, e.g., a sense of looking at one’s self as if one is an outsider
- **Derealization:** A feeling that one’s surroundings are strange or unreal.
- **Identity confusion:** Subjective feelings of uncertainty, puzzlement, or conflict about one’s identity
- **Identity alteration:** Objective behavior indicating the assumption of different identities or ego states, much more distinct than different roles

(Steinberg, 1994)

DSM-V Diagnoses Related to Dissociation

- Dissociative disorders
  - Dissociative amnesia
  - Depersonalization/derealization disorder
  - Dissociative identity disorder (DID)
  - Dissociative disorder not otherwise specified
- Selected other disorders with significant dissociative symptoms
  - Post-traumatic stress disorder (PTSD)
  - Somatic symptom and related disorders
  - Schizophrenia
  - Borderline personality disorder (BPD)
  - Others (e.g., eating and feeding, anxiety)

BASK MODEL OF DISSOCIATION

- **Behavior**
- **Affect** (emotions)
- **Sensation** (physical)
- **Knowledge**
  - Full, integrated memory includes all four re-associated components.

(Braun, 1980)

BASK - KNOWLEDGE

- Trauma survivor has full or partial cognitive knowledge of traumatic event
- Cognitive knowledge of the trauma is dissociated from behavior, affect and sensation
- Generally what people mean when they say “I remember”
**BASK - Behavior**
- Behavior is dissociated from other aspects of memory
- Individual acts in a certain manner without knowing why
- Examples:
  - avoiding intimate relationships
  - vomiting after sexual intercourse
  - dislike of particular foods

**BASK - Affect**
- Affect is dissociated from other aspects of memory
- Example: feeling of fear for no apparent reason

**BASK - Affect (continued)**
- There are no feelings attached to the cognitive knowledge of the memory
  - flat affect
  - matter-of-fact tone of voice
  - e.g., can talk about being raped as though discussing the heat of the coming summer

**BASK - Sensation**
- Physical sensation is dissociated from other aspects of memory
- Individual may have cognitive knowledge of the traumatic event, be aware of related affect, and understand some behavior, but not remember the pain or pleasure associated with the trauma
- Examples:
  - body memories – physical symptoms such as bleeding or severe pain occur in the present but are unexplained
  - sexual excitement

**BASK Model**

**Three-Phase Treatment Process**

Gingrich, H. D., 2013, p. 107
Rationale for Phase-Oriented Model

- Premature trauma processing can lead to destabilization
  - Hospitalization
  - Inability to function in job
  - Difficulty parenting
  - Basic coping capacities can be overwhelmed

Three Phases

- Phase I – Safety and Stabilization
- Phase II – Processing of Traumatic Memories
- Phase III – Consolidation and Restoration

Phase I – Safety and Stabilization

- Safety within the Therapeutic Relationship
  - Developing rapport
    - Facilitative conditions
  - Becoming a safe person
    - Remember that every client is unique
    - Know your limitations
    - Give advance warning
  - Remaining a safe person
    - Keep appropriate therapeutic boundaries
    - Consult
    - Protect confidentiality

- Safety from Others
  - Identifying healthy vs. unhealthy relationships
  - Helping clients find physical safety

Safety from Self and Symptoms

- Making sense of symptoms
  - Symptoms as attempts at coping
  - Warning signals
- Therapeutic use of dissociation
  - Potentially assess use of dissociation
    - Somatiform Dissociation Questionnaire (SDQ-5 or SDQ-20)
    - Dissociative Experiences Scale-II (DES-II) (Nijenhuis, 1999)
    - Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) (Steinberg, 1993)
  - Use of parts of self language
  - Contracting
    - symptom management
    - day to day activities
    - suicide
  - Ideomotor signaling

Phase II - Processing of Traumatic Memories

- Readiness for Phase II Work
- Memory Work
  - Nature of memory
  - Accessing dissociated memories
    - Deciding where to start
    - When specific memories do not surface
  - Is memory recovery the goal?
  - Facilitating the integration of experience
    - The importance of details
    - Titrating the process
    - Extent to which reexperiencing is necessary
    - Grounding techniques
    - Checking in
    - Memory containment
    - Structuring the session and counseling relationship
**BASK Model**

Gingrich, H. D., 2013, p. 107

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**Phase II - Processing of Traumatic Memories (cont’d)**

- Facilitating Integration of Self and Identity
- Working through Intense Emotions
  - General principles
  - Understanding and dealing with specific emotions
    - Mourning: Denial, anger, and depression
    - Guilt, shame, and self-hatred
    - Fear of abandonment
    - Anxiety, terror, and fear
- Roadblocks for counselors
- Keeping Perspective

Gingrich, H. D., 2013, p. 107

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**Levels of Integration of Self**

Gingrich, H. D., 2013, p. 121

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**Integration of Self and Experience**

Gingrich, H. D., 2013, p. 122

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**Dealing with Spiritual Issues (1)**

- All phases, but particularly Phases II and III
- Gradual, often difficult process
- Allow client to set pace
- Often are questions re: why God did not protect from the trauma
- In time clients can often see that God was there, and is currently involved in their healing process
- In highly dissociative clients, some parts of self may have a relationship with Christ, while others may not
  - E.g., internal Bible study

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**Is the Goal Full Integration?**

- Immediate goal is better functioning
- Some highly dissociative clients never fully integrate
  - May be afraid to (i.e., fear of death of parts of self)
  - Too much work and time
- The process of integration can begin to happen from the beginning of therapy

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**Is the Goal Full Integration?**

Gingrich, H. D., 2013, p. 122

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**Dealing with Spiritual Issues (1)**

Gingrich, H. D., 2013, p. 122
Dealing with Spiritual Issues

- Distinguish between parts of self and demonic
  - Ultimately gift of discernment necessary
  - Potentially VERY destructive to attempt deliverance ministry
- If any kind of deliverance/exorcism ritual is decided upon make sure that the following factors are incorporated (Bull, Ellason, & Ross, 1998):
  - Permission of the individual
  - Noncoercion
  - Active participation by the individual
  - Understanding of DID dynamics by those in charge
  - Implementation of the procedure within the context of psychotherapy
- See my article “Not all voices are demonic” (Gingrich, 2005b)

Phase III – Consolidation and Resolution

- Consolidating changes
- Development of new coping strategies
- Learning to live as an integrated whole
- Navigating changing relationships
  - Marriage and parenting
  - Friendships
  - Relationship to God and church congregations
  - Community
  - Family of origin
- Employment
- Confronting the perpetrator
- Forgiveness

How the Church Can Help

- Educating about CTSD
- Providing emotional and spiritual support
  - Formal care
  - Groups
  - Lay counseling
  - Mentoring, spiritual direction and life coaching
  - Assigned helpers
  - Informal care
- Churches and Christian mental health professionals in partnership

References