

EEK, There's Dissociation in My Office! The Art of Mentoring Therapists in Working With Dissociation



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Why Be Conscious About Supervision and Consultation?

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- Frequency of supervision / consultation as primary or sole teaching tool for therapists who are new to complex trauma and dissociation
- Correcting thinking errors about what makes for good supervision/consultation
- Risk management issues for supervisor/consultant as well as the therapist seeking assistance
- Responsibility to the field of complex trauma and dissociation

Criteria for Consulting/Supervising

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- Familiarity with the current research and scholarly clinical literature on trauma and dissociation
- Familiarity with treatment guidelines for PTSD, Complex PTSD, Dissociative Disorders
- Familiarity with current assessments for trauma and dissociation
- Familiarity with basic trauma-informed, attachment-based phase-oriented therapy
- Experience in assessing and treating a wide range of trauma-related disorders: PTSD, Complex PTSD, DDNOS, DID, and others, such as Depersonalization Disorder, as well as Personality Disorders
- Training in supervision
- Supervision of supervision

Fostering Clinical Competence

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- Offering behavioral (didactic) skills (what to do)
 - “Let me feed you a line”
- Helping therapist to understand and focus on process instead of content (what is happening in the moment in the therapeutic relationship, in the therapist, and in the client)
- Attitudinal changes of the therapist via understanding and insight about dissociation and trauma, and other clinical issues (e.g., Borderline personality, resistance)
- Normalizing experiences of the client and the therapist
- Strong supervisor / supervisee alliance
- Non-stigmatizing and non-critical approach
- Using adult learning principles

The Principle of Minimal Change

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- Help therapist deconstruct desired actions into manageable steps, no matter how small
 - ✦ “What’s the one small powerful/empowering thing that you and/or your client can do right now?”
- One step at a time, e.g., move one millimeter, cry for a second, cry from one eye, cut a little less deep, drink a drop less, make a weak fist, whisper “stop;” whisper one word of anger, eat one bite
- Mindfully initiate, execute, complete the new action that involves a minimal change
- Evaluate the consequences of the new actions, compare these to the fear of taking the action

Helping the Therapist Overcome Fear and Shame

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- Small steps toward mastery
- Role play
- Working through fears: “What are you afraid or concerned will happen?”
 - Confronting therapist’s fear that client will act out, bolt or kill herself
- Working to maintain window of tolerance in general and recognizing when client is become activated.
- Making plans for when things go wrong.
 - What “going wrong” looks like (not always obvious with complex trauma and dissociation)

Important Issues

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- Teaching through our own mistakes
 - Keep your list of things you wish you'd known not to do, and use them- de-shames and validates
- Not imposing theories, but insisting that therapists have theories of their work
- Walking the fine line between therapy and supervision of countertransference
- Informed consent of therapist (Forms)
- Informed consent of client
- Avoiding a dissociative consultative relationship

Important Issues

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- When and how to recommend therapy for a consultee
- When to directly intervene with the therapist
 - Therapist impairment, vicarious traumatization
 - Therapist's trauma material triggered by client material
- The therapist with a personal trauma history and the therapist without such a history- values and challenges of each
- Helping the therapist be him or herself when the client is being many selves – avoiding D-attachment



**Client as the agent of change
(Takes responsibility for the work)**



**Cooperative therapeutic relationship and
clear therapeutic contract**



Collaborative skills building and learning



**Self and relational regulation /
Positive affects and experiences**



**Focus on intersubjectivity – implicit and
explicit, moment to moment experience
in relationship, rather than on content**

Common Stuck Places for Consultees

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- Feeling overwhelmed
 - Own trauma material evoked
- Not knowing what to do (more than usual)
- Boundary crossings and violations
- Difficulty setting and maintaining the treatment frame
- Unable to manage acting out of client
- Not understanding how to effectively treat dissociation
- Being drawn into trance of helplessness, despair, and passivity
- Failure to recognize a toxic enactment
- Premature memory work
- Transference / Countertransference
- Recognizing and working with resistance and counter-resistance

Common Stuck Places for Consultees

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- Inadequate assessment, especially of Axis II, general prognostic factors, and ego strength capacities
- Failure to identify key conflicts (“I want to get better – I don’t want to get better”)
- Problems with pacing
- Fostering secure attachment versus dependency
- Systemic work with dissociation
- Rescue and (re)action rather than reflection
- Recognizing trance logic and urgency
- Shame

Common Stuck Places for Consultees

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- Ignoring or failing to set limits with the rage and sadism of client
- Failure to set limits on abuse of the therapist by the client
- Unresolved defensiveness of the therapist
- Failure to manage the client's demands/entitlement
- Failure to work with certain parts (e.g., perpetrator-imitating parts), or premature work with parts
- Dealing with safety (internal and external) and ongoing abuse
- Failure to address client's difficulties with using positive affects and experiences
- Not attending to process / fascination with content

Common Stuck Places for Consultees

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- Not knowing how to work with specific types of parts, especially child parts, perpetrator-imitating and hostile parts, non-verbal parts, etc.
- Not understanding the dissociative system as a whole, how to hold the whole system of the client responsible, and keep the adult self of the client actively engaged in treatment
- Not knowing how to empathically phrase limits and boundaries and confrontations
- Ongoing and current victimization or perpetration by the client

Assessment Measures

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- CAPS
- SIDES
- MDI
- TSI 2
- IASC
- MID
- DDIS
- SCID-D
- Loewenstein's Office Mental Status Exam for Dissociation and PTSD

Prognostic Factors

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- Able to share personal thoughts and feelings
- Ability to experience and tolerate painful affects/thoughts/wishes/sensations
- Able to have positive affects and experiences (pleasure, enjoyment, joy, exuberance)
- Motivation for change
- Psychological mindedness, capacity for mentalizing and reflection
- Degree and rigidity of defenses
- Positive response to therapeutic relationship, empathic attunement, and interpretation
- Willingness to be an active participant in therapy
- Some degree of empathy for self and others

Therapeutic Contract and Goals

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- The explicit therapeutic contract is that the therapist and client will work collaboratively, with the client taking responsibility for engaging in treatment and making change.
- When the implicit contract differs from the explicit one, e.g., the client expects the therapist to magically fix the past, or to comfort and never confront, a therapeutic impasse occurs, or the therapist feels the need to take care of the client.
- Return to original goals: Why did the client come to therapy? Does the therapist need to revisit the goals of therapy with the client?
- Are the therapist and client working toward the same goals?

A Systemic Approach to Dissociation

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- ALL interventions should be geared toward increasing integration and decreasing dissociation
- Always use interventions at the highest level of integration
- When possible, use interventions that address the whole person at once: e.g., talking through; having all parts listen; meeting place
- Use integrative language. “Parts” language is OK, but emphasize “Parts of you” or “different ways of being you” (Chefetz).
- Understand the relationships between parts. These include conflicts, defenses, resistances
 - Remember- non-dissociated people have parts, too; you know how to respond to this kind of conflict when it’s less dissociated.
- Always ask yourself, “What is this part avoiding or protecting right now?”

A Systemic Approach to Dissociation

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- Begin work with the adult self of the client so there is a stable foundation for working with parts fixed in trauma and parts avoidant of treatment.
- If it is not possible to work with all parts simultaneously, then work with two or more parts to increase cooperation among them.
- For example, have an adult part soothe a child part; a functional part support a nonfunctional one; build cooperation among parts that function in daily life
- Avoid working with child parts too soon, or without an adult part present (no “drop-off daycare!”)

A Systemic Approach to Dissociation

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- If it is not possible to work with two or more parts simultaneously, work with one part to the point of stabilization and immediately bring in other parts as possible.
- For example, engage an angry part that is destructive and help with regulation before connecting with other parts.
 - This is very similar to what you would do with non-dissociative folks; stabilization and regulation first
- Avoid letting one part dominate therapy, tell you “secrets,” or suppress other parts.

A Few Types of “Impossible” Therapy

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- **Drop-off Daycare Therapy:** Client “drops off” disowned parts to be taken care of by therapist
- **Drive-By Therapy:** Angry or persecutor parts “drive by” internally and “attack” the client or therapist in session and disappear
- **Do Me Therapy:** Client expects the therapist to fix him or her
- **DOA (dead on arrival) Therapy:** Client is completely hopeless and waiting to suicide; rebuffs all efforts to help
- **Dumb Therapy:** Client’s typical response, other than complete silence, is “*I don’t know.*”
- **Denial Therapy:** Client denies s/he has problems, diagnoses, feelings, needs
- **Destructo Therapy:** Client is continuously chaotic and destructive to self and/or others
- **Desire Therapy:** Client has an aggressive entitlement to receive from therapist whatever he or she wants and demands

Rule of Thirds

(from Richard Kluft)

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- 1. Prepare in first third of session
- 2. Intensive work in second third
- 3. Ground, orient, and cognitive focus in the present in last third
- Make sure to leave enough time at the end of the session for the client to get grounded, talk a little about what happened, and discuss safety and plans after the session.
- Do not run the session over beyond the end time.
- Always start and end on time.

How Often and Long Should the Client Be Seen?

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- Treatment Guidelines: 1 – 2 times per week
- More is not better; seek quality over quantity
- Often clients ask for more/longer sessions because they are not able to take in what is already being offered
- and because they are experiencing increased dependency yearning
- Ask about client's experience of sessions. Does s/he remember sessions? Does h/she work on material at home?
- Begin with less
- Time-limited increase of sessions for a week or two for acute crisis management
- Avoid prolonged or unlimited sessions – integrative capacity is limited
- “*The proof is in the pudding.*” Change in number of sessions should result in an increase daily life functioning, improve symptoms, decrease crisis, and increased productive activity in therapy

Managing Self-Harm & Suicidality

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- Withdrawing, rescuing, helpless, or aggressive stance of the therapist
- Focus on process (“how is the behavior helping you?”) versus content of behavior
- Willingness to set firm limits in outpatient therapy with referral to higher level of care
- Countertransference of hopelessness and helplessness
- Work with suicidal and self-harming parts
- Alertness to relational triggers in therapeutic alliance for self harm and suicidality
- Pacing

Reliving versus Remembering

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Reliving

- Go from present to past
- Not grounded or oriented
- Outside window of tolerance
- Not connected to therapist
- Dissociated
- Unable to meta-observe [mentalize] experience (speaks and feels as though event is happening now)

Remembering

- Bring the past to the present (dual attention)
- Grounded and oriented
- Within window of tolerance
- Connected to therapist
- Not dissociated
- Able to meta-observe [mentalize] experience (“I am feeling intensely sad, but I am OK and here in the present with you.”)

Attachment versus Dependency

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Secure Attachment

- Clear, consistent boundaries and treatment frame
- Boundaries supported by processing of transference and countertransference
- Support client to do for self
- Process painful emotions and wishes with matching and words
- Predictable but limited availability outside of sessions
- Focus on intersubjective experience
- Decreases insecurity

Maladaptive Dependency

- Unclear, reactive boundaries
- Boundaries depend on what the client wants or demands from the therapist
- Do for the client
- Relieve painful emotions and wishes with actions
- Unlimited or greatly extended availability
- Focus on client's experience only
- Actually increases insecurity

Tips to Prevent Dependency Impasses

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- Weekly or twice weekly sessions, not more, except during very brief periods of crisis, prevents unhealthy dependency
- Limit contact outside sessions; otherwise dependency can develop and client will not bring material into session
- Stay with the intersubjective experience in the moment.
- Ensure adult parts are responsible for child parts
- Avoid working with child parts too much before working with shame and rage about dependency needs (often in perpetrator-imitating parts)
- Your best guide is how the client is functioning in daily life – if the same or better, you are likely on track in therapy

Attachment and Flashbacks

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- Be alert to the possibilities of flashbacks (also) being a meta-communication about, and the vehicle for, the client's attachment needs, wishes, and conflicts in the therapeutic relationship.
- Frame flashbacks as non-integrated, dissociative ways of remembering and knowing, with the message clear; you can know and remember, and our job is to empower you to do that non-dissociatively
 - Emphasis on radical acceptance of the realities of the past, disrupting avoidance while titrating exposure

How to Work with “Parts”

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- Always keep adult (more functional) parts engaged in treatment and mostly co-present.
- Think in terms of how a part fits into the whole system
- Why does a part need to remain separate? That is the entrée for therapeutic interventions.
- Always try to include “all parts” in sessions as possible.
- Do not treat parts as people, but rather as aspects of one person
- Do not ignore parts and hope they will go away.
- Accept the client’s belief of separateness without agreeing yourself

Parts Within A Whole System

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- All parts are connected by many substrates of experience, even when they do not recognize it
- Do not let parts blame other parts for trouble in the client's life: there is always implicit systemic collusion
- *“If you are not part of the solution, you are part of the problem”*
- Do not favor parts, or try to “get rid” of parts
- Do not agree that a part is a problem; emphasize that each part has an important function in the system as a whole
- Don't try to force change or integration

Systemic Resistance

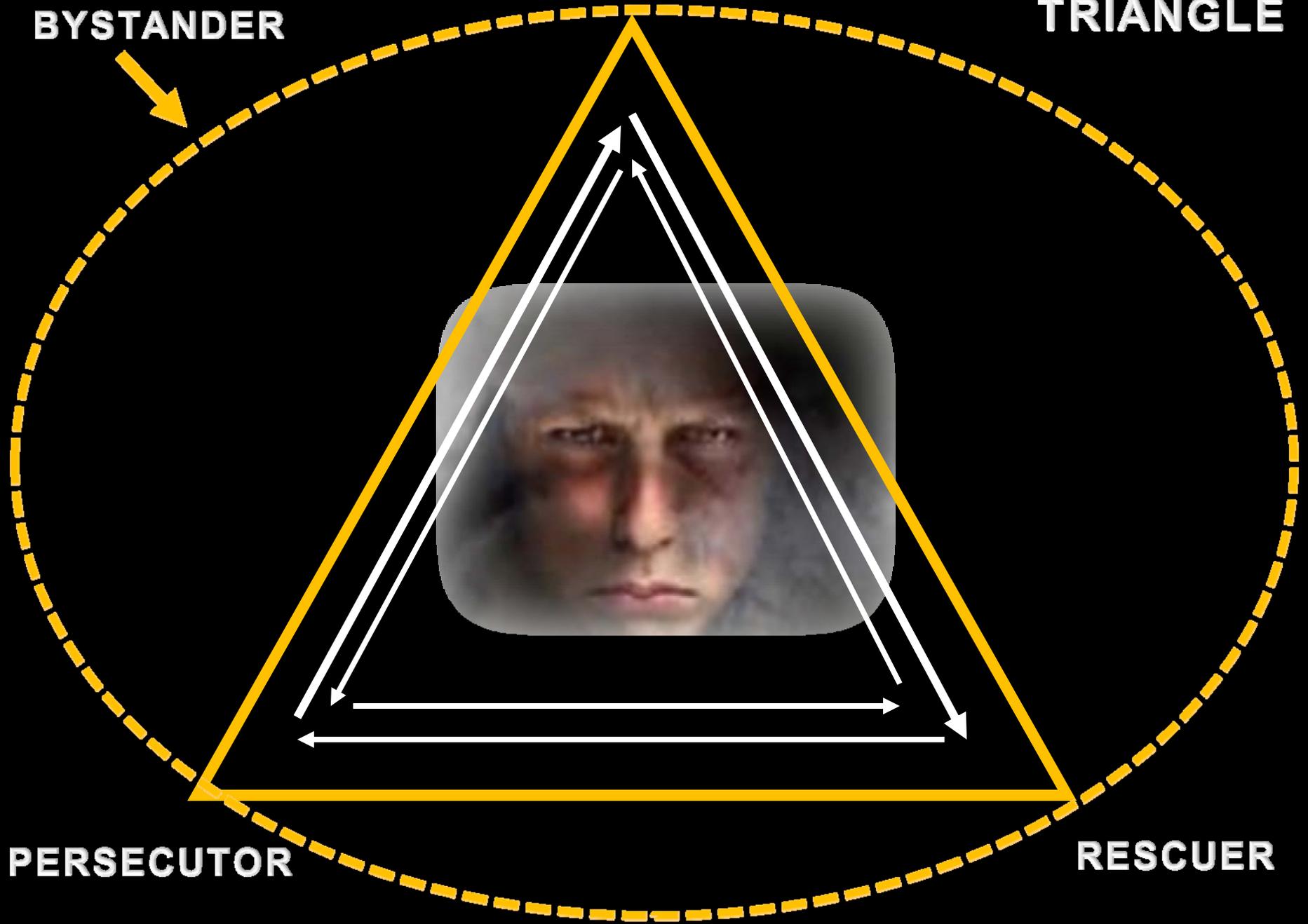
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- Resistance always involves the entire system, not just the “identified problem” part.
- The client as a whole is implicitly colluding with the resistance of a part.
 - Don't get into the blame game with the client!
- Resistance is the manifestation of the conflicts and phobic avoidance of the client as a whole
 - Countertransference challenges: What are you afraid that you will hear/learn; What are you afraid will emerge that will increase acuity or difficulties in safety management? How are you preparing yourself and client for this?

**NEGLECTFUL
BYSTANDER**

VICTIM

**KARPMAN'S
TRIANGLE**



PERSECUTOR

RESCUER

Enactments

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- Between dissociative parts internally in the client
- Between the client and others in his or her life
- Between the client and the therapist
- Between the therapist and the consultant/supervisor

Noticing the Therapist's Process in Consultation/Supervision

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- Seems rushed, jumps over important issues too quickly, tries to cram it all in, doesn't seem mindful or reflective
- Anxiety, fear, avoidance, anger, control, hopelessness
- HOW the therapist talks about the client
- HOW the therapist talks about self
- HOW the therapist and consultant relate to each other
- Emphasis on content or process
- Enmeshed, appeasing, or dismissive stance
- Burned out, vicariously traumatized
- Defensiveness: "You don't understand my client."

Noticing Your Process as Consultant / Supervisor

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- Need to be helpful, need to intervene
- Feel urgent, frustrated, dismissive, anxious, fearful, hesitant to set limits on therapist or let therapist take the reins
- Feelings about therapist
- Willingness to sit with uncertainty and not knowing what to do
- HOW do you tolerate risk?
- HOW do you talk about the client?
- HOW and when do you self disclose?

Basic Principles in Working with Impasses

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- Help the therapist recognize his/her defensiveness in session and work with it, own it, and engage in re-attunement and repair.
- Types of defense fit with various types of attachment style in the therapist
 - Avoidant
 - Dismissing
 - Ambivalent
 - Unresolved

Beware Trance Logic in Dissociation

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- A state in which logical processing is altered
 - words are taken more literally (i.e., concrete thinking)
 - decrease in critical judgment
 - increase in tolerance for incongruity or illogical thoughts or situations
- Indicative of lower levels of integrative capacity and of nonrealization

Examples of Trance Logic

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- By definition, the belief that one is separate “people” involves trance logic, e.g., “That little girl is not me.”
- A 5 year old “child” part drives the car and goes to work
- Part says, “I don’t keep my house clean so that my mother can’t come to visit”
- The therapist asks if a perpetrator-imitating parts is listening, and the part says, “No!”

Examples of Trance Logic

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- A part cuts herself to “let out the bad stuff.”
- The client is reluctant to talk about distressing subjects because, “If I don’t talk about it, it doesn’t exist.”
- Therapist: “Focusing on the present is a key that opens the door to feeling better.”
Child part (crying): “But I lose the keys and get in trouble; only the grownup parts get to have keys!”

Trance Logic in the Therapist

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- If I don't see this client 4x a week the client will kill herself
- If I don't have sex.....the client will die.
- If I terminate
- If I don't respond immediately 24/7 the client will hurt herself
- Treating parts like separate people
- Different therapy agreements with parts

Slippery Slopes

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- Avoiding talking about a client with colleagues
- Ongoing feelings of guilt or shame about your work
- Feeling no one understands you or the client well enough to help
- Not following supervisory advice or directives
- Feeling pressured by client to do something you would not typically do
- Feeling the client is special

Slippery Slopes

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- Feeling you are the only therapist who understands the client
- Spending more time with the client than other clients
- Seeing client outside your typical work hours
- Dual relationships (going to AA together, serving on a committee, working together, etc.)
- Socializing with client (different from natural social role overlap)
- Talking more about yourself in session than usual

Trauma and Countertransference

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- Whether or not your theoretical model formally acknowledges the presence of countertransference, all psychotherapies acknowledge human emotions and dynamics occurring in the therapist-client dyad.
- Therapist feelings about trauma survivors are more present, more powerful, and more challenging than may be the case with other clients because of the nature of the material and the dynamics of post-trauma responses

The Painful Affects of Trauma-Related Countertransference

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- All of our clients are likely to evoke some kind of strong emotions from us at some points, clients with a history of trauma are more likely than most to do so
- Everything about trauma has the potential to evoke some kind of powerful response in other human beings
 - Turning away, becoming numb, getting emotionally activated or sexually aroused, rescuing, judging or blaming a victim – all common

Trauma as a Risk Factor for Therapists to Violate Boundaries

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- “Trauma victims figure prominently in virtually every well-known therapeutic dilemma or disaster associated with strong countertransference reactions.” (Dalenberg, 2000, p. 12)
- She goes on to say, “psychotherapists often have countertransferential reactions to the *fact* of trauma...the psychotherapist’s pre-existing thoughts and beliefs about the trauma may affect the course of therapy greatly.”
- “I’m not a trauma expert, what are you doing here in my office? I work with chronic pain/couples and families/eating disorders...” ignoring the ubiquitous nature of trauma exposure as a risk factor.

Common Countertransference Response to Trauma and their Ethical Implications

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- **Numbing and avoidance**
 - **Common countertransference response that therapists have to their clients' material is the desire not to hear or know the details**
 - **How therapists respond to this inner need—**
 - ✦ repeatedly fail to listen, forgot that they had been told painful details by the client, or in some instances discouraged the client from telling their stories (Dalenberg, 2000)
 - ✦ Violates beneficence and fidelity principles of ethics
 - **Emotional abandonment of the client**
 - **Silencing (unfaithful to client's welfare)**
 - ✦ Demonstrates a failure of emotional competence

Disbelief of Survivor's Trauma Narrative

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- A sub-theme of avoidance
- Fueled by
 - Bizarre nature of real trauma
 - So-called “false memory” movement of the 1990’s
 - Fears of litigation by third parties
 - Loss of distance from trauma for therapist
- “He hacked into my computer and bugged my car...”
- Narratives that are not factual, but are emotionally true

The “Believing Game”

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- “It is crucial during this negotiation (between belief and doubt) that the clinician respect the bravery of the client as she or she breaks silence and asks to be believed.” (Dalenberg, 2000, p. 113).
- Emotional competence in trauma therapy requires willingness to believe in the client, not ascribe to every fact of the narrative
 - Dalenberg’s research on bizarre details in trauma narrative of children whose CSA has been strongly corroborated.

Prurient Interest

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- A secret of trauma work -some psychotherapists find the details of our clients' traumas exciting, titillating, or even arousing – all of which is just fine
- Ethical issue arises when the therapist abuses position of power and authority to require client to go into more detail about the trauma than is truly therapeutic in order to gratify therapist's fascination.
 - "A fascinoma" not a human being
 - Risks for violation of confidentiality

Attack and Victim-Blame

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- Therapists are (humanly) threatened by trauma stories
 - Victim blame serves to enhance distance from client/story, soothe therapist's distressed affects
- Risk for trauma reenactments in which therapist first takes on role of rescuer, then defaults to perpetrator or helpless bystander
 - Ethical issue – abandonment, real or emotional, can occur
 - “I’m not the best person to be working with you” (hiding behind the competency rule)

Therapist Guilt and Shame as Risk Factors for Boundary Violations

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- Guilt and shame are normal affects when relating to trauma survivors
 - However, if disowned, guilt breeds resentment
 - Shame leads to blame, distancing, and avoidance
 - Both affects, if disowned, raise the risk of boundary violations in work with trauma survivors

Common Patterns of Trauma Reenactment Boundary Violations in Therapy

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- Therapist rescues client
 - Infantilizes, encourages unnecessary dependency, then resents
 - Hiring client to work
 - Bartering for unwanted/unneeded services or objects
- Therapist becomes identified with perpetrator/persecutes
 - Sexual misconduct
 - “She said she’ll kill herself if I didn’t have sex with her”

More Common Trauma-Related Boundary Violations

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- Therapist takes role of helpless bystander
 - Therapist's subjective experience is of being overwhelmed by client or by details of trauma narrative
 - "There's nothing I can do to help" – condemnation in the guise of validation
 - Failure to make necessary safety plans
 - Neglecting to complete paperwork leading to drops or termination of services

Reducing Risk of Boundary Violations

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- Accept reality that you will be invited into trauma reenactments
 - Be attuned to when these occur, and use them therapeutically rather than feeling guilt and or shame, which will perpetuate and worsen the violations
- Have boundaries for your work that are clear and yet flexible in response to real needs of clients
 - Considering how to flex; cui bono?

Reducing Risk, continued

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- Integrate functions of boundaries into treatment
 - Boundaries not simply an external set of rules with which to comply
 - Rather, aspects of the frame that create:
 - ✦ Stability
 - ✦ Predictability
 - ✦ Evidence of therapist fidelity (I will do what I say and be honest in my relationship with you, even if it is sometimes painful)

Interventions for the Therapist

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- Mentalizing: “I am feeling so angry. What information is that giving me? Does this client evoke something from my history?”
- Understand and utilize projective identification
- Learning to react and respond differently, e.g., “If my pattern is to withdraw and avoid conflict, how can I be more aware of that and change it in sessions?”
- Rest and breaks; scheduling issues
- Stepping aside from what is being directed at you in session
- Self care

When Should a Therapist Refer a Client to an Expert?

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- Mostly, because of the relationship, the therapist should not transfer the client
- Special cases
 - For assessment only
 - When the therapist isn't interested or can't learn adequate treatment approaches
 - When the therapist can't or won't help the client regulate and improve function in daily life
 - When the therapist is too overwhelmed or afraid
 - When the therapist is too skeptical
 - When the therapist's own unresolved history is too triggered

Online Video-Chat Consultation Issues

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- Useful for long distance consultation
- Do not use a free public network (e.g., Starbucks)
- Use a highly password protect network whose SSID is not broadcast, or a VPN if possible
- Skype
- Google Hangouts
- Apple Facetime
- Others?
- HIPAA Compliance issues

Supervisor/Consultant Self-Care

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- Supervising/consulting entails increased exposure to client material
- Monitor your carrying capacity for this kind of supervision/consultation, just as you would your capacity for seeing complex trauma/dissociation clients
- Know how to protect yourself if the person you're working with puts you or his/her client at risk
- Have consultation for yourself!