Dissociation and the traumatic experience from a psychotherapeutic perspective

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Declaration

I hereby certify that this thesis is entirely my own work and has not been submitted as an exercise for a degree at any other university. I agree that the library may lend or copy the thesis request.

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Abstract

This study sets out to examine dissociation as a marker of trauma in the psychotherapeutic environment. It offers some definitions of trauma, post-traumatic stress disorder and dissociation. It examines the neuroscience involved in the body’s stress response. It distinguishes between the hyperarousal response of the sympathetic nervous system and the hypoarousal of the parasympathetic response to a traumatic event. It identifies the hypoaroused response as the cause of dissociation as an ongoing disorder. It identifies poor infant attachment and early abuse and neglect as a primary factor in developing dissociation and dissociative identity disorder. It examines three leading theorist/practitioners approaches to the treatment of post-traumatic stress disorder and dissociation. Concluding that dissociation is primarily a marker for hypoaroused post-traumatic stress disorder in the psychotherapeutic environment.
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Chapter One
Introduction

1.1 Overview

Stress and Trauma are part and parcel of the human experience, and for the most part in the healthy individual is processed satisfactorily by the body’s stress response. In many cases individuals are able to experience traumatic events and process them without any long-lasting consequences (Rothschild, 2000, p.15). The difficulty occurs when the body and mind is unable to process or discharge the natural stress protecting system of fight-flight-freeze. The stress response remains stuck and un-discharged. It is an “…incomplete physiological response suspended in fear” (Levine & Frederick, 1997, p. 34), which then results in Posttraumatic Stress Disorder (PTSD).

In addressing the debilitating symptoms of PTSD (of which dissociation is a prime symptom (van der Kolk, 2015, p.66)) from a psychotherapeutic perspective, an understanding of the physiological and psychic impact of PTSD is essential. From that physiological perspective this study will examine the neuroscientific understanding of PTSD with a focus on the symptom of dissociation.

In order for sufferers to heal and move on with their lives, a combination of top down, and bottom up approaches in the treatment of PTSD is crucial in affecting long lasting change and healing (van der Kolk, 2015, p.3). Top down involves the talking with another in the therapeutic alliance, and in doing so, finding an understanding to what is going on, as the trauma is processed. Bottom up entails working with the body and understanding the neurobiology of PTSD. “Shut-down and dissociated people are not in their bodies” (Levine, 2010, p. 112).
1:2 Aim and objectives

The aim in this study is to explore dissociation as one of the markers of PTSD in the psychotherapeutic setting. This exploration will focus on two main objectives.

The first objective will focus on the aetiology of PTSD and dissociation from a neuroscientific perspective. It will examine how the brain and nervous system function in response to stress and life threatening situations. It will examine the role dissociation plays within the parameters of autonomic arousal, with specific attention on dysregulated autonomic arousal (Schore, 2012, p. 78-79). It will examine how dissociation comes about, and how infant neglect and abuse can create a pre-disposition for dissociation.

The body’s natural response to stress and life threatening situations is the activation of the Autonomic Nervous System (ANS) - in the fight, flight or freeze response. For dissociation to occur the person who has experienced the traumatic event must be unable to physiologically and psychically process the experience, in other words, the individual is unable to “discharge” the physiological effects of the freeze traumatic response – then as a result, PTSD will occur - and dissociation will be an ongoing indicator of the traumatic experience (Levine, 2010, p. 47 - 49).

In terms of susceptibility to dissociation in later life, this study will examine links that have been drawn to severe neglect and abuse in the first two years of an infant’s life. In the last trimester of pregnancy up to age two there is a significant growth spurt of the infant brain and if neglect and or abuse occurs during this critical period dissociative tendencies can be hard wired into the ANS (Schore, 2012, p. 77).
The second objective will review what the leading trauma theorists, and psychotherapeutic practitioners have to say with regard to the treatment of PTSD. It will outline the symptoms associated with PTSD. It will examine talk-therapy and body-awareness approaches in the psychotherapeutic environment. It will consider why talk-therapy alone is problematic, and can in a worst-case scenario, re-traumatise the client.

1:3 Definitions
As an introduction to the topic, and in an effort to contextualise the aim and objectives, this study will outline some definitions of trauma, PTSD, and dissociation.

Trauma can be defined a psychophysical experience in that the traumatic event has a damaging impact on the mind and the body whether or not there has been bodily injury. The individual can be said to be in fear of annihilation (Rothschild, 2000, p. 5).

PTSD can be defined as the re-experiencing in the present moment of the physical sensations of past traumatic events whilst experiencing intense feelings without being able to control them (van der Kolk, 1998. as cited in Rothschild, 2000, p. 3). The body’s Autonomic Nervous System (ANS) can suddenly and unexpectedly go into a state of hyperarousal (Rothschild, 2000, p. 13). Symptoms of PTSD are “hyperarousal, intrusive reliving, numbing and dissociation get in the way of separating current reality from past trauma” (van der Kolk, 1994).

Dissociation consists of an altered sense of time, with reduced sensations of pain, and absence of terror or horror in the face of imminent death. It can be described as a split, or a sense of leaving the body while observing from a disconnected perspective
(Rothschild, 2000, p. 13). The devastating traumatic experience causes a splitting or fragmentation, where physical sensations, thoughts, sounds, images, smells, and emotions of the traumatic event assume a life of their own (van der Kolk, 2015, p. 66).

‘What is dissociation?’ an article published on the website Positive Outcomes for Dissociation (PODS) (Spring, 2012). The question ‘Dissociation – State or Structure?’ is asked. The author suggests dissociation is something that a person does, and is. It can refer to an experience, and also to a state and structure of the mind (Spring, 2012). In an effort to explain this, the author offers a long list of descriptions, or definitions of dissociation. A selection of which speak to the complexity of understanding the concept:

- “A fairly common and normal response to trauma,
- A creative survival mechanism, a way of mentally blocking out unbearable thoughts or feelings
- An instinctive, biologically-driven reaction
- A splitting-off of mental functions which normally operate together or in tandem
- A normal process which starts out as a defence mechanism to handle trauma, but which over time becomes problematic
- A way of distancing or disconnecting ourselves from the awfulness of trauma
- A failure to integrate or join up information about the environment and our self
- An automatic and reflexive response based around survival from extreme threat
- A way to cope with irreconcilable conflicts in our mind (such as being abused by someone we love)
- A way of escaping psychologically when we cannot escape physically”

(Spring, C. 2012).
The splitting that occurs in a dissociated state can have a wide variation from individual to individual, from simply forgetting what you went into the kitchen for to the extreme of dissociative personality disorder (Rothschild, 2000, p. 13).

If as Levine states “The roots of trauma lie in our instinctual physiologies” (1997, p. 34) then in order to understand dissociation in the context of the therapeutic environment it is necessary to understand the neurophysiological terrain where dissociation finds its genesis.
Chapter 2
PTSD and dissociation from a neuroscientific perspective

In order to understand dissociation from a neurophysiological perspective it is necessary to understand how the body deals with stress. The human organism responds to perceived stress or danger using the ANS. This is peripheral to the Central Nervous System (CNS) and is controlled by the emotional centres of the brain, the limbic system (the thalamus and amygdala). The ANS governs primary somatic functions such as heart rate, digestion, body temperature, circulation, and to some degree the immune system. It works independently of the conscious control of the brain. (van der Kolk, 2015, p. 77). The ANS … “generates the somatic aspects of emotion” (Schore, 2012, p. 265).

2.1 The Brain

The brain is divided into three areas. The primitive or reptilian brain (amygdala) is the part of the brain that develops in the womb; its primary function is survival. The amygdala controls arousal, homeostasis, and the drive for reproduction it filters and interprets sensorimotor information from the thalamus, an area in the limbic brain (Ogden, Minton, Pain, & Siegel, van der Kolk, 2007, p. 5), (van der Kolk, 2015, p. 59).

Next the limbic brain, which surrounds the amygdala. It controls the relevance of emotions and filters information from the senses. It is also concerned with learning and situating the individual in their surroundings. The last part of the brain to develop is the neocortex or prefrontal cortex; it receives filtered information from the limbic brain, and amygdala. It governs self-awareness and it is where our conscious thinking
occurs, it deals with time and context and the regulation of inappropriate behaviours, it is the lookout tower where risk, threat and danger are appraised consciously (Ogden, et al., 2007, p. 5), (van der Kolk, 2015, p. 59).

The amygdala is constantly scanning for danger or threats. Its primary function is survival. It will trigger the body’s stress response when it perceives danger or risk to life - it is … “the brains smoke detector” (van der Kolk, 2015, p. 60). It is an intrinsic part of the ANS, moderating the amygdala’s primitive survival fight or flight response (van der Kolk, 2015, p. 60 - 62).

In the case of PTSD, the capacity of the prefrontal cortex to moderate the danger signals of the amygdala is dramatically affected. When the individual experiences extreme fear, anger or sorrow or perceives themselves to be in grave danger, the balance between the smoke detector (amygdala), and the lookout tower (prefrontal cortex), shifts to the amygdala. The ability of the prefrontal cortex to mediate breaks down. A loud bang may cause them to startle, a touch cause them to freeze, or they may fly into a rage from a small irritation. Trauma causes the prefrontal cortex to go offline leaving the primitive response of the amygdala in charge (van der Kolk, 2015, p. 62 - 63).

2.2 Sympathetic and parasympathetic nervous systems

This unconscious defence system is divided into two distinct responses: sympathetic and parasympathetic. When the amygdala perceives imminent danger, the sympathetic system is triggered, bypassing the prefrontal cortex. This is known as fight or flight response, it is …“energy mobilization” (Levine, 2010, p. 354) in the body to facilitate combat or escape. If there is no imminent threat to life the
parasympathetic response will reset and bring the body into homeostasis the parasympathetic response encourages rest, relaxation and recuperation.

The Sympathetic Nervous System (SNS) triggers the release of hormones, which increase the heart rate, and breathing, which sends fresh blood and oxygen to the main muscle groups associated with fight or flight. If the individual is unable to run away or fight the danger then the Parasympathetic Nervous System (PNS) is triggered causing the freeze response. In these circumstances if the individual is unable to discharge the enormous energy that is mobilised they will suffer from PTSD and in the case of the freeze response they will dissociate (Rothschild, 2000, p.46 - 47).

PTSD and dissociation are most likely to occur when an individual is intensely frightened, restrained or feels confined. The individual freezes in paralysis and/or collapses in overwhelming helplessness (Levine, 2010, p. 48).

In ordinary everyday life these two responses are in constant flux but not causing any lasting distress (Levine, 2010, p. 354). The individual’s ability to moderate the stress response will help them develop resilience and a …“window of tolerance” (Ogden, et al., 2007, p. 26) to day-to-day stress.

Within this window of tolerance there is an optimal arousal zone, which exists between a state of hyperarousal (fight/flight) - where the individual is in danger – and hypoarousal (freeze) - where the threat of annihilation is immanent. In this hyperarousal state, the sympathetic system is aroused and the individual is in fight or flight mode, there is amplified sensation, emotional volatility, hypervigilance, and dissociated rage or panic. In the hypoarousal state the parasympathetic system is
aroused, there is a relative lack of physical sensation; cognition is immobilized, emotions are numbed, they are in dissociative collapse, in a state of freeze. When the individual is within these parameters they are said to have a regulated nervous system and when in either extreme they are said to have a dysregulated nervous system (Ogden, et al., 2007, p. 27), (Schore, 2012, p. 79).

The difference between these two poles of hyperarousal and hypoarousal is the “window of tolerance” (Ogden, et al., 2007, p. 27) Individuals with PTSD and dissociation will be vulnerable to both hyperarousal (too much activation) and/or hypoarousal (very little activation) or they may swing between the two extremes. And will have virtually no window of tolerance. When in a state of hyperarousal the individual will experience an overload of information, disturbing images, affects, and body sensations. On the other hand the individual in hypoarousal will experience a lack of feeling and sensation and a total deadness and numbness. These individuals will have little if any resilience (Ogden, et al., 2007, p. 26).

2.3 Attachment and dissociation

Where does this window of tolerance or resilience come from? Alan Schore (2012) posits that it is connected to the early secure attachment of the infant with the primary caregiver. He makes the point that the psychobiological attunement of the mother to ups and downs of the infant’s internal bodily states of arousal develops through visual, auditory and bodily contact cues (p. 263).

The infant and primary caregiver develop a method of synchronised communication, through which the caregiver is able to regulate the infant’s arousal states. However there are times in this early process where the caregiver is unavailable to regulate the
infant’s autonomic response due to day-to-day distractions. This disruption in the attachment causes the infant's autonomic response to go out of homeostasis. When the caregiver returns and repairs the situation, the infant learns to cope with stressful situations in a self-regulatory fashion. This is referred to as good-enough caregiving. This good-enough caregiving facilitates the development of resilience or a healthy Window of Tolerance. So that as the infant develops and grows it is able to accommodate the day-to-day stresses that occur in its new life thereby regulating its autonomic response to perceived threat and stress (Schore, 2012, p. 263 - 265).

Thus, the good-enough caregiver facilitates the optimal development of the stress response in the maturing infant. This is achieved when the caregiver helps the infant to reduce, and mend stressful negative arousal and strengthens positive arousal (Schore, 2012, p. 265).

Where the primary caregiver is not emotionally available and does not react appropriately to the infant’s expression of stress or emotion, or moreover rejects the infant and shows little, or unpredictable responses to the arousal. The infant experiences prolonged negative states, as no interactive repair happens. Schore posits that the infant’s psychobiological response to the traumatic experience is comprised of hyperarousal and dissociation (2012, p. 265).

In the first two years of the infant’s life, there is a great spurt of brain development. In the case of the good-enough caregiver - the infant, as we have seen already - develops resilience. The vast majority of brain development at this time occurs in the right side or emotional side of the brain as a result of the synchronised communication system developed between infant and caregiver (Schore, 2012, p. 77).
In contrast, if the caregiver is unavailable or causes stress and neglects the developing infant, the infant reacts to this traumatic stress in two ways: hyperarousal of the SNS and dissociation in the PNS. Hyperarousal response is triggered in the infant’s right brain hemisphere, the location of the attachment system and the fear motivational system. It creates a bodily expression of fear-terror (Schore, 2012, p. 78).

Dissociation occurs as the infant withdraws from the external environment exhibiting a dazed and disconnected look. This parasympathetic response is an effort to not be seen or noticed thereby reducing the risk of further abuse or trauma. This dissociative response of the parasympathetic system becomes hardwired in the infants developing brain and as such this metabolic shutdown state will become the primary response to stress or threat throughout the ensuing lifetime (Schore, 2012, p. 78 - 81).
Chapter 3
Theorists and treatment

3.1 Brief history

In the late nineteenth century, Jean-Martin Charcot, Pierre Janet, and Sigmund Freud, in their work on the treatment of hysteria, discovered that the trauma of childhood sexual abuse was at the root of many of their patients’ hysteria (van der Kolk, 2015, p. 177). In 1887 Janet further explored the concept of dissociation in his article “Systematised Anaesthesia and the Psychological Phenomenon of Dissociation” from which he is credited with initiating the groundwork for current theories of dissociation and PTSD (Rothschild, 2000, p.66).

In the 1980’s, PTSD became a medical disorder, mainly as a result of the effects of the Vietnam War on American soldiers. These soldiers’ nervous systems had been strained to breaking point, leaving them shattered in mind body and spirit (Levine, 2010, p. 33).

Also in America in the early 1980’s clinicians became aware that they were dealing with significant numbers of patients presenting with PTSD and dissociation from childhood sexual abuse and neglect. The role of these past traumatic childhood events became recognised for initiating PTSD and dissociative disorders in the presenting adult clients (Chu, 2011, p. 15).
3.2 Symptoms and Treatment

Some of the leading theorists and practitioners in the understanding and treatment of trauma and PTSD are James Chu, Peter Levine, Pat Ogden, Babette Rothschild and Bessel van der Kolk. Their clinical work and treatment approaches are largely rooted in psychodynamic, humanistic, somatic-orientated psychotherapy.

This study will focus on; Chu, Levine, and Rothschild. Their styles of treatment fall into two general categories. *Top down* which focuses on talk therapy with some emphasis on working with the body and *bottom up* which primarily focuses on working with the body.

3.3 Top down treatment

**James Chu**

In his book “*Shattered Lives*” (2011) Chu focuses on the treatment of adult complex PTSD and Dissociative Identity Disorder (DID). Both of which he posits are the result of either/or severe childhood sexual abuse, physical abuse or neglect. They have a number of secondary comorbid conditions such as depression, anxiety, self-destructive behaviour, substance abuse, and eating disorders. These secondary conditions are developed in an effort to deal with the distress from the original traumatic events (Chu, 2011, p. 20 - 21).

Chu explains that dissociation occurs in everyday life. Someone can have the experience of driving the same route to work every day and on occasion have no recollection of the journey. The individual had made the journey safely, without incident, but the memory has split off (Chu, 2011, p. 48).
DID on the other hand is a severe condition. It is the polar opposite to the driver who doesn’t recall his journey to work. The individual with DID is split off from thoughts, memories feelings, actions and possibly their sense of identity. The dissociation is the brains way of protecting the person from the memories of the traumatic experience Chu maintains that DID is for the most part a response to severe childhood sexual abuse (Chu, 2011, p. 50 - 52).

With regards to the treatment of Complex PTSD and DID, Chu refers to disordered attachment as a prime contributing factor in the aetiology of the conditions. He asserts that psychotherapeutic treatment for these conditions should focus on relationship capacity in order to effect lasting change (2011, p. 75). He proposes a three-phased approach to therapy.

**Early Phase Treatment**

**Self-care** - the focus is to develop self-care behaviours to counter the self-destructive coping behaviours (substance abuse, self-harm and dysfunctional behaviours that re-victimise). …“survivors must create an environment of personal safety before they are able to make progress in therapy” (Chu, 2011, p. 114).

**Symptom control** - this entails the stabilisation of the disturbing symptoms (flashbacks, nightmares, intrusive thoughts, and states of hyperarousal) by using grounding techniques based on the five senses, sight (making eye contact, and having a well-lit environment), hearing (using a calm tone of voice with client, listening to relaxing music), touch (the use of transitional objects), smell and taste (2011, p. 153). He also recommends the development of safe places through guided imagery, the goal being to promote a relaxation response. He also recommends developing a crisis plan
for the client so that they have a list of things they can do in the event of unexpected symptom activation (Chu, 2011, p. 151 - 159).

**Acknowledgment** - the therapist should acknowledge the traumatic experiences of the client, without going into detail at this phase, so as not to re-traumatise them. While assuring the client that they are responsible for their recovery, they are not in any way responsible for the cause of the trauma (Chu, 2011, p. 116).

**Functioning** – the therapist should encourage the client to develop regular occupational habits, exercise regimes, work or regular occupational therapy or if relevant the attendance at AA/NA meetings. These activities help the client to function in the here and now and provide an anchor when symptoms are activated (Chu, 2011, p. 117 - 118).

**Expression** – the client can be encouraged to express the effects of the PTSD and dissociative symptoms without exploring the actual events at this phase of the treatment. The objective here is for the client to be able to put words to some of the intense feelings they are experiencing without them being re-traumatised (Chu, 2011, p. 118 - 120).

**Relationships** – In the therapeutic alliance the client will bring their … “abuse related interpersonal assumptions” (Chu, 2011, p. 120), and this will have implications for the therapy relationship. The building of trust will require seemingly interminable withdrawals and reconnections in the building of the relationship. The therapist role is to assist in the client developing a new way to relate. This may take months or years but is essential before moving on to the next phase (Chu, 2011, p. 120 - 122).
Middle Phase Treatment
This phase of treatment focuses on working with the clients memories of their traumatic experiences. Abreaction is used in this phase - the client releases the strong emotions related to their past traumatic experience. The therapist role is to bear witness as the client finds the words to express the traumatic experience. This work should only commence when the client and therapist are happy that the first phase has been negotiated. Great care should be taken not to re-traumatise the client in this phase. The objective is to release the repressed traumatic experience so that the client can see it in perspective – from a slight remove as it were. The therapist may have to take a step or two back with the client as this phase progresses, returning to the work of phase one. As the work progresses the client should begin to experience relief from the debilitating symptoms of PTSD and dissociation.

Late Phase Treatment
This phase is one of consolidation of the work done in the previous phases, continuing to promote the skills developed in the first phase. The client will more than likely deal with “normal” non-traumatic issues. As the client progresses in this phase they may unearth further unresolved traumas. Their previous successful experience in phase two will assist them greatly and will shorten subsequent treatment. This phase allows for the patient to fully own their process of recovery (Chu, 2011, p. 128).

3.4 Bottom up treatment
Peter Levine Somatic Experiencing®
Levine’s primary thesis is that when an animal - or in our case a human being - is unable to discharge the effects of the stress response, due to a traumatic experience, the memory of that experience becomes imprinted in the primitive brain (amygdala),
making the ANS unable to return to homeostasis, and PTSD ensues. This means in effect, that the client is unable to be present in the here and now, and is dissociated (2010).

**Symptoms**

Levine proposes that the first symptoms of trauma surface quite soon after the traumatic event. These first symptoms generally consist of hyperarousal, constriction, dissociation, and feelings of powerlessness (Levine & Frederick 1997, p. 147).

The next phase of symptoms follow soon after and can include; hypervigilance, flashbacks, intense sensitivity to light and sound, hyperactivity, exaggerated startle response, nightmares, sudden mood swings, stressed easily and difficulty sleeping (Levine & Frederick, 1997, p. 147).

The following phase of symptom development can incorporate; panic attacks, phobias, and anxiety, “spaced-outedness” (dissociation), drawn to dangerous situations and behaviours, uncontrollable crying, exaggerated or reduced sexual behaviour, feelings of shame, forgetfulness (dissociation), morbid fear of death and a sense of going mad (Levine, & Frederick 1997, p. 148).

The final phase of symptoms takes much longer to develop and includes; exaggerated shyness, reduced or impaired emotional responses, reneging on commitments, chronic tiredness, difficulties with the immune system and thyroid problems, psychosomatic illnesses, feeling isolated and anti-social, and showing little or no interest in life. There is a degree of fluidity with these symptoms across the last two phases it’s not one size fits all (Levine, & Frederick 1997, p. 149).
Treatment

Levine’s therapeutic model Somatic Experiencing® (SE) can be used immediately after a traumatic event or many years later to help a client recover. This therapeutic approach unlike that of Chu’s is body focused – bottom up as opposed to top down.

The goal of SE therapy is to help the client return to a state of homeostasis after a traumatic experience by helping them connect with their instinctual nature (Levine, 2010, p. 137). The objective is to build up the client’s resilience so that they can function within a strong ‘window of tolerance’ (Ogden, et al., 2007, p. 27).

In the treatment of trauma, Levine suggests that firstly the therapist “…needs to cultivate a deep and enduring relationship with his or her own body”, and have “…a capacity to perceive the subtle behaviours of others”… (2010, p. 138).

His therapeutic process incorporates a series of steps for renegotiating and transforming trauma. The objective of these steps is to bring the three parts of the brain (the amygdala, limbic, and pre-frontal cortex) back online so that the traumatic experience or experiences can be made sense of in the client’s conscious.

The therapeutic process he uses involves the therapist and client talking together, this facilitates the client’s awareness and experience of his/her various bodily sensations and perceptions. Levine uses the acronym SIBAM to describe the gestalt of the client’s experience in the therapy process – Sensations, Images, Behaviours, Affect, and Meaning (Levine, 2010, p. 133 – 152). The core of this process utilises what he calls “pendulation” … “the innate organismic rhythm of contraction and expansion” (ibid). The therapist works back and forth sensitively between activation and
deactivation. This is all undertaken at the client’s pace and with an acute awareness by the therapist of the client’s ability. Resilience is developed as the clients ANS goes back online and he/she is able to make sense of their traumatic experience (Levine, 2010, p. 78).

**Babette Rothschild**

Rothschild In *The Body Remembers* divides the book into two parts, theory and practice. In the theory section she gives an overview of PTSD, discussing the impact of trauma on the mind and body, distinguishing between stress, traumatic stress and posttraumatic stress disorder. She examines the ANS fight or flight response and compares the normal response to that of the PTSD response. She concludes … “that the most severe consequences of PTSD result from dissociation.” Dissociation is a very effective primal response to avoid immediate suffering, but it comes at a high price. She maintains that dissociation during a traumatic incident is a strong indicator for future PTSD (Rothschild, 2000, p. 13).

With reference to somatic memory, she explains how the body remembers trauma, detailing the ANS and the somatic nervous system and kinaesthetic memory. Rothschild posits that dissociation and flashbacks are the most noticeable symptoms of PTSD (Rothschild, 2000, p. 65).

**Treatment**

Rothschild’s therapeutic approaches to PTSD are through the body. She states that the guiding principle in trauma therapy is not to re-traumatise the client …“first do no harm” (Rothschild, 2000, p. 77). She makes the point that this is not an easy task and requires good practice, and awareness of the client’s triggers. Creating ways for the
client to stop, slow down, or break the process is essential if re-traumatisation is to be avoided.

Recognising the type of trauma the client has is essential in deciding what treatment approach to take. With reference to the therapeutic alliance, Rothschild recommends not starting trauma therapy until the relationship is well established (Rothschild, 2000, p. 77-82). Like Levine’s model she proposes creating safety and body awareness - the ability to be aware of the sensations within and outside the body. She outlines techniques for safe therapy- building the client’s awareness of body sensations in the here and now can provide an anchor for them. The therapist should be quick to gauge the client’s limits and teach them how to utilise their body as a break.

**The goals of trauma therapy**

- That the client can integrate the implicit and explicit memories into an all-inclusive account that makes sense of the mental and physical experience.
- That the hyper-aroused symptoms of the ANS, which relate to the trauma, are purged.
- And for the client to place the traumatic event in the past knowing that they have survived (Rothschild, 2000, p. 150).
Chapter 4  
Conclusion

This study set out to explore dissociation as one of the markers of posttraumatic stress disorder in the psychotherapeutic arena with two objectives. To do this it had two objectives. Firstly it examined the role of the body and nervous system in the development of PTSD. The second reviewed what three of the leading theorists and practitioners in the field of trauma had to say with regard to symptoms and treatment of PTSD and dissociation.

It found all PTSD does not necessarily entail the development of dissociation. As it is primarily associated with the hypoaroused state of the stress response rather than the hyperaroused.

In examining the aetiology of dissociation from a neuroscientific perspective it found that it is the body’s way of protecting the psyche from the awfulness of a traumatic situation. It is caused by the parasympathetic nervous systems freeze response. It found that dissociation is primarily a marker for PTSD from the hypoarousal of the ANS. It has the capacity to cause long lasting difficulties for the individual as they will have a lower resilience to stress and trauma if left untreated. They will be unable to be present to a greater or lesser extent in their lives depending on the severity and prolonged exposure to trauma.

It found that early childhood abuse and severe neglect impacted the attachment system. This in turn affected the infant/child right brain development hard-wiring a predisposition in the child for dissociation or in very severe cases DID for life. It found that dissociation as a marker of PTSD is primarily linked to the freeze response.
The freeze response being the body’s last ditch attempt to protect itself from annihilation.

From the perspective of the psychotherapeutic environment and the treatment of PTSD and dissociation it found two types of therapeutic approach: Top down (primarily talking) and bottom up (working with physical symptoms).

Chu advocates a top down approach with some reference to body work for symptom relief. He recognises dissociation as a distinct post traumatic condition separate from what he refers to as Complex PTSD. He stresses the importance of building a strong therapeutic alliance and cautions against early work on the traumatic event as it will re-traumatise or cause the client to dissociate. He proposes abreaction as the catharsis for recovery.

Levine on the other hand takes a bottom up approach. He primarily focuses on the body and developing skills with the client that will eventually return the stuck autonomic response to homeostasis. He is very clear about the importance of the therapeutic alliance. For Levine dissociation is a marker of hypoarousal.

Rothschild like Levine takes a bottom up approach and is insistent on the slow building of body skills with the client. She differs from Levine in that she recommends talking about the therapeutic event but only after the client has developed breaking skills. Her approach is a combination of both Chu’s and Levine’s.

In conclusion it is clear from the literature that dissociation is a marker for hypoaroused PTSD in the psychotherapeutic arena. It is distinct from hyperaroused
PTSD in spite of the fact that some dissociative behaviour may be experienced during the traumatic event in hyperaroused PTSD.

It is also evident that for a practising psychotherapist working with a client with PTSD, awareness of the physiological processes and the emotional impact on the client is essential in order to support them safely through the treatment process.

Following this study some questions arose that might benefit from further exploration: First what does the research say about the effectiveness between *top down* and *bottom up* treatment approaches to PTSD. Secondly what treatment approaches are psychotherapists in Ireland using and to what effect?
Bibliography


