mission: empowerment!

WORKSHOPS AND EVENTS THAT EDUCATE, INSPIRE AND EMPOWER

presents

Treating Complex Trauma: An Integrated Approach

With Sheri Van Dijk, MSW, RSW

March 26, 2026

Instructor Biography

Sheri Van Dijk, MSW, RSW, is a social worker, psychotherapist, author, consultant, and international trainer who has been supporting individuals with severe and complex mental health problems since 2000. She currently maintains a private practice while offering consultation and training to clinicians worldwide., drawing on more than two decades of clinical experience in both hospital and community settings.

Sheri is widely recognized for her expertise in trauma-informed care and evidence-based modalities such as Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Deep Brain Reorienting (DBR), and the Safe and Sound Protocol (SSP). She has been providing DBT-informed therapy since 2004, became a certified EMDR therapist in 2018, and serves as an EMDRIA-Approved Consultant. Sheri was awarded the R.O. Jones award for her research on using DBT with bipolar disorder, presented at the Canadian Psychiatric Association Conference.

An accomplished author, Sheri has written several widely used books that translate DBT skills into accessible tools for managing emotional dysregulation, trauma, and mood disorders, including The Dialectical Behavior Therapy Skills Workbook for C-PTSD, The DBT Workbook for Emotional Relief, and the best-selling Don't Let Your Emotions Run Your Life for Teens.

For more information about Sheri Van Dijk and her work, visit **https://www.sherivandijk.com/**.


An Integrated Approach to Treating Complex Trauma
Sheri Van Dijk, MSW, RSW
EMDR Certified & EMDRIA Approved Consultant

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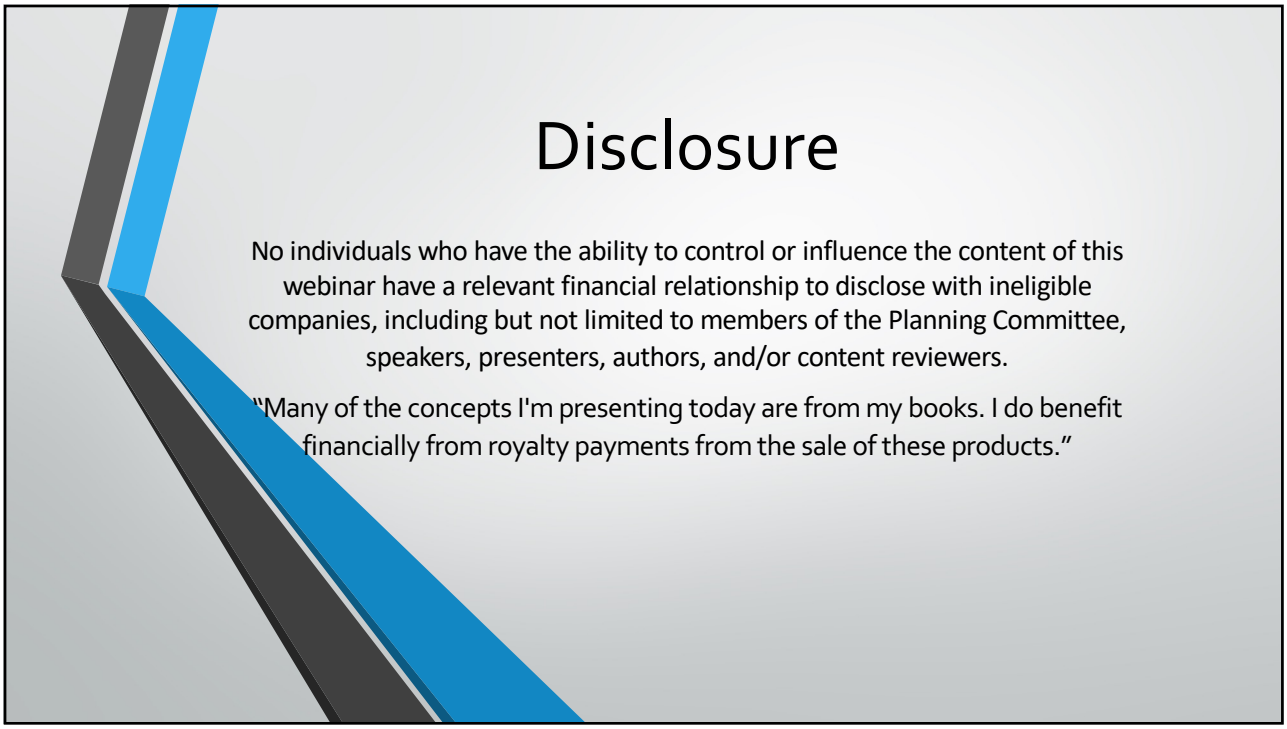
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No individuals who have the ability to control or influence the content of this webinar have a relevant financial relationship to disclose with ineligible companies, including but not limited to members of the Planning Committee, speakers, presenters, authors, and/or content reviewers.
"Many of the concepts I'm presenting today are from my books. I do benefit financially from royalty payments from the sale of these products."

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Objectives

By the end of this workshop, participants will understand:

- The difference between PTSD and C-PTSD
- The Triphasic approach to trauma treatment
- The basics of Polyvagal Theory and the Theory of Structural Dissociation of the Personality
- Dissociation and its implications for therapy
- The basics of how to use a Parts approach in therapy
- How to help ground and re-regulate clients using skills, as well as resources to help prepare clients for trauma processing therapy

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Post-Traumatic Stress Disorder (PTSD)

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in one (or more) of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

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Post-Traumatic Stress Disorder (PTSD)

C-PTSD is not a diagnosis in the DSM-V-TR but has been included in the most recent edition of the WHO's ICD-11.

The ICD-11 formulation of PTSD requires exposure to an extremely threatening or horrific event or series of events; and the experience of symptoms in each of the following clusters:

1. **Re-experiencing symptoms** such as intrusive thoughts, flashbacks, or nightmares.
2. **Avoidance symptoms**, such as avoiding places or situations that trigger memories of the traumatic event.
3. **Sense of threat**, such as hypervigilance and being easily startled.

To be diagnosed with PTSD, symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

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Complex PTSD

In 1988, Dr. Judith Herman of Harvard University suggested that a new diagnosis, "Complex PTSD" (C-PTSD), was needed to describe the symptoms of long-term trauma.

To receive a diagnosis of CPTSD all the features of PTSD must be present; in addition, there must be evidence of Disturbances of Self Organization (DSO) in three additional domains:

1. Problems of affect regulation (e.g. emotional reactivity such as explosive anger and violent outbursts, difficulties calming or soothing oneself after a stressor)

2. Persistent negative beliefs about oneself (e.g. beliefs about self as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event)

3. Difficulties in sustaining relationships and feeling close to others (Relationships often suffer due to difficulties trusting others and the negative self-view; the individual may avoid relationships or develop unhealthy relationships similar to what they knew in the past)

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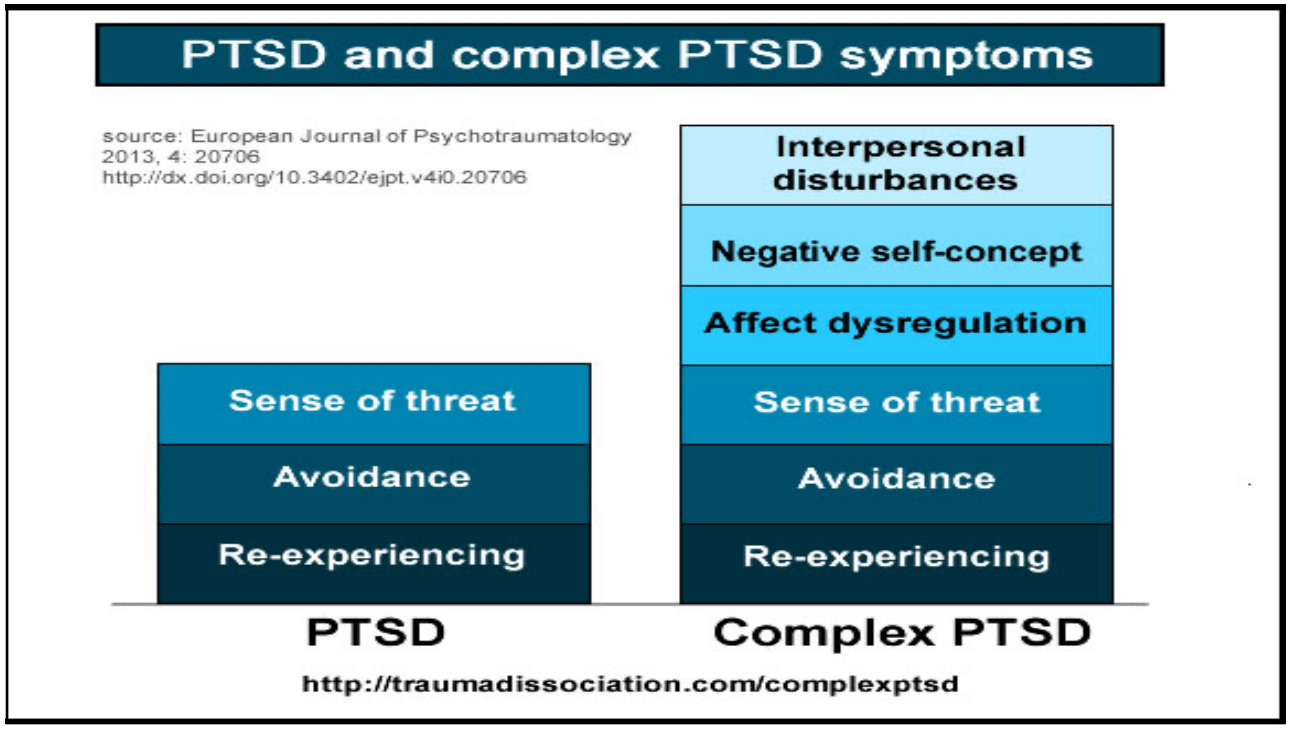

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Complex PTSD

In terms of the trauma itself:

- C-PTSD usually results from multiple traumatic events, or when the exposure to trauma is prolonged (although chronic or repeated trauma is a risk factor, not a requirement, for CPTSD; and it can be diagnosed after a single traumatic event (although this will be less likely);
- And the stressors are typically of an interpersonal nature – that is, resulting from human mistreatment rather than acts of nature or accidents (e.g. childhood abuse, domestic violence, human trafficking, torture, kidnapping, racism, etc.)

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Complex PTSD: Sorting out the Language

Developmental Trauma – proposed as a new diagnosis by van der Kolk & colleagues; this refers to trauma that takes place in childhood and/or adolescence, while the brain is still developing – essentially, C-PTSD for children; often involves attachment trauma.

- currently this is often being mis-diagnosed as pediatric Bipolar Disorder, Oppositional Defiance Disorder, Conduct Disorder, and ADD/ADHD, and therefore treated with medications rather than addressing the trauma

Relational Trauma – refers to trauma that happens within a close relationship; this can happen in relationships in children or adults; when this occurs in developmental years it's also referred to as Attachment Trauma

- Relational Trauma may lead to C-PTSD

Traumatic Invalidation – can also lead to C-PTSD. When our internal experiences are regularly invalidated by people in our environment; invalidation can be traumatic when it is severe, long lasting, and negatively affects your understanding of yourself and the world (Linehan, 2014). Examples of traumatic invalidation include emotional or verbal abuse, neglect, discrimination, being blamed or disbelieved when telling someone about a trauma you experienced

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Complex PTSD	Versus	BPD
Reactive anger; problems calming self when distressed; chronic emotional numbing; substance use; often over-regulated (emotional numbing, avoidance, dissociation)	- Emotion Dysregulation -	Recurrent suicidal behaviors, gestures, threats, and self-harming; emotional lability; extreme, uncontrolled anger; profound emotional dyscontrol; typically underregulated
Stable, deeply negative; chronic sense of guilt, shame, worthlessness	- Sense of Self -	Highly unstable, polarized positive and negative perceptions of self Chronic sense of emptiness
Avoidance and detachment based on a fear of closeness	- Relationships -	Intense, volatile, oscillating between idealizing and disparaging; intense fear of abandonment and behaviors to avoid this
**Required	- Traumatic Event -	**Not required; and some studies are showing that emotional abuse & neglect are more likely in BPD (Ford & Courtois, 2021)

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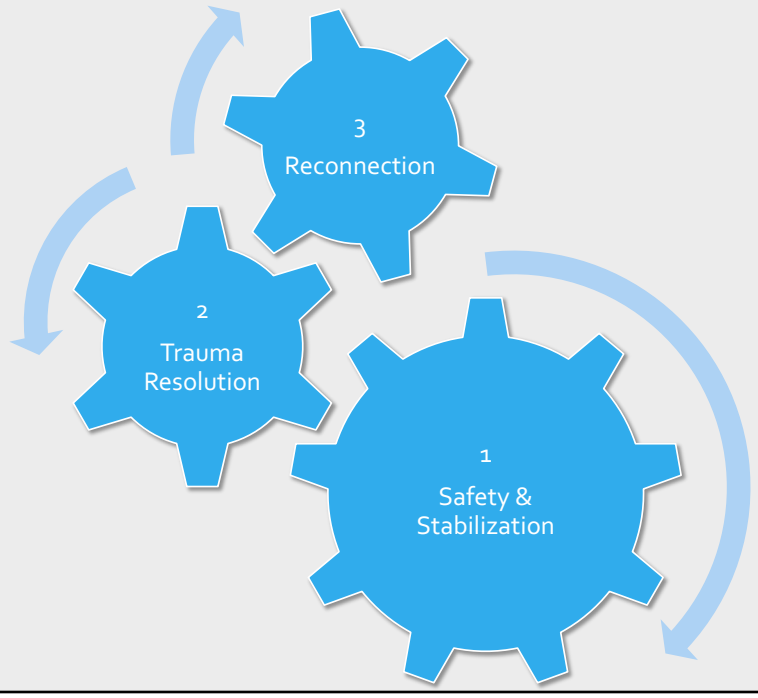
Triphasic Model of Treatment (Herman, 1992)



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The Triphasic Approach to Treating Complex Trauma (based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization: Focus is on helping clients identify the issues that brought them to therapy, learn to manage dysregulation, develop resources, and resolve any major internal conflicts in preparation for Stage 2 (trauma resolution)

- Developing and building the therapeutic alliance
- Identify presenting issues and concerns, including risk factors, and medical or trauma-related symptoms that may interfere with successful treatment or contraindicate the use of certain interventions (such as EMDR)
- Take a thorough history, (depending on the client's ability to tolerate affect; not delving into details of trauma!), and identify current and past sources of resilience
- Develop an initial plan for the subsequent treatment stages
- Provide psychoeducation about trauma and its effects
- Teach skills to increase stability (externally – e.g. housing, finances, relationships; as well as internally - emotion regulation, dissociation, self-care)
- For clients who are highly dissociative, Stage 1 will also include understanding how the client's self-system is organized, obtaining on-going consent from all parts, orienting parts to present, and working on resolving conflicts between parts

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The Triphasic Approach to Treating Trauma

Stage Two: Trauma Resolution: focuses on coming to terms with and resolving past, painful experiences and present triggers for that pain (e.g. through EMDR, Ego-State Therapy or IFS, PE, CPT, SE, etc.). Tasks include:

- Overcoming fears of the memory, triggers, and cognitions
- Accessing and resolving old, painful experiences
- Accessing and resolving present triggers that connect to the painful experience
- Depending on the treatment, an additional task in this stage may be restructuring trauma-based personal schemas (in EMDR therapy this results naturally through reprocessing dysfunctionally stored material)

**Not all clients will be willing or able to engage in Stage 2 work

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The Triphasic Approach to Treating Trauma

Stage Three: Reconnection: focuses on integrating the changes within the self and in day-to-day life, consolidating gains, and (re-)connecting to a meaningful life.

- Addressing any existential, identity, and attachment-related issues (e.g. "Who am I, now that I'm no longer defined or held back by my trauma?")
- Developing a more consistent sense of mastery in life and self-sufficiency through learning skills for handling "ordinary" life difficulties
- Considering longer-term goals
- Achieving relief of any residual symptoms
- Concluding the therapeutic relationship ("what does it mean that we won't be working together any longer?", "will you be here if I need you in future?")

It's important to recognize that these stages of treatment do not exist separately from one another – clients will shift back and forth between stages at times

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Polyvagal Theory (Stephen Porges, 1994)

Polyvagal Theory (PVT) is a popular approach to explaining how neurophysiology impacts our emotional states.

- The Autonomic Nervous System (ANS) is a system that involves various organs from the brain to the colon; the Vagus Nerve links them all together.
- The job of the ANS is to keep us alive; it plays a central role in regulating emotions, behaviors, and the body's automatic reactions to social and environmental challenges, acting ***outside of our conscious awareness.***
- Historically we've known the ANS to have two distinct branches: the sympathetic (SNS - "fight or flight") and the parasympathetic (PNS - "rest and digest").
- PVT postulates that there are **two** branches (SNS and PNS), but **three pathways**: with the PNS being split between the Dorsal Vagal and the Ventral Vagal

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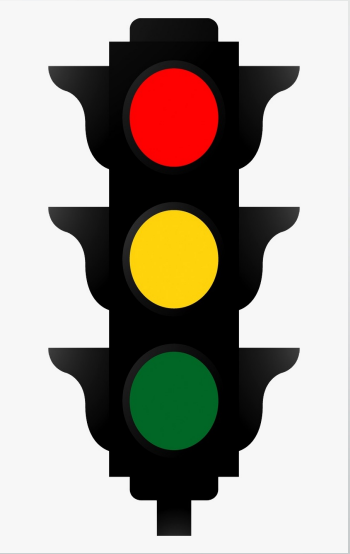
Ventral Vagal (Green Zone; WoT)

- Supports social engagement
- Heart rate slows (65-70bpm resting)
- Saliva & digestion are stimulated
- Facial muscles are activated
- Increased vocal prosody (versus monotone) and eye contact
- Middle ear muscles are turned on, allowing us to better hear sounds in the mid-range, including the human voice
- "Safety is a necessary prerequisite for strong social connections":

  Everything isn't necessarily peaches and roses here, but we have access to our PFC!



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Green Zone

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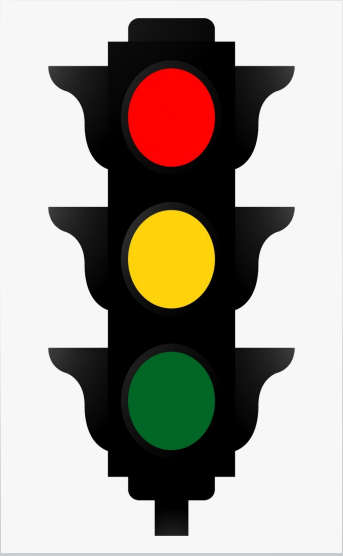
Sympathetic (Yellow Zone)

- Heart rate increases (110bmp = amygdala hijack)
- Pain tolerance increases
- Middle ear muscles turn off: better to hear extreme low and higher frequency sounds (predator sounds)
- Healthy individuals can bounce between Green & Yellow with ease (playfulness; healthy stress)



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Yellow Zone

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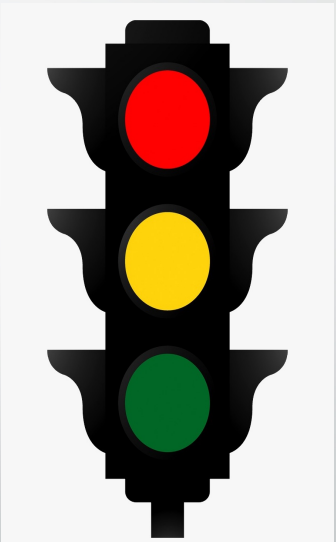
Dorsal Vagal (Red Zone):

- Associated with reptilian brain; path of last resort!
- Supports defensive immobilization and "shutdown" behaviours
- Heart rate decreases (60 and below)
- Death feigning - DISSOCIATION



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Red Zone

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Polyvagal Theory (Stephen Porges, 1994)

Neuroception:

- The term coined by Stephen Porges to refer to our unconscious perception (based on our senses) of safety or danger in the environment.
- The ANS constantly scans (6 times per second) inside your body, the environment outside your body, and what's happening between you and the people around you; it's the filter through which we experience the world
- Neuroception occurs deep underneath the conscious level of awareness – it is instant and automatic.
- How we neurocept is also influenced by what autonomic state we are in; our ANS is shaped by experiences, habitual responses, and patterns; and what we neurocept leads our ANS to respond in a certain way (active or dissociative defenses)
- "Are we in Connection, or Protection?"

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Polyvagal Theory (Stephen Porges, 1994)

Co-Regulation:

- The process by which a nervous system is reciprocally regulated (brought back to "safety") in the presence of a safe "other" (caregiver, parent, etc).
- Co-regulation is imperative to a person's ability to move into safe relationships and meaningful connections, and therefore to survival.
- We influence others around us through their neurocepting the signals we send.

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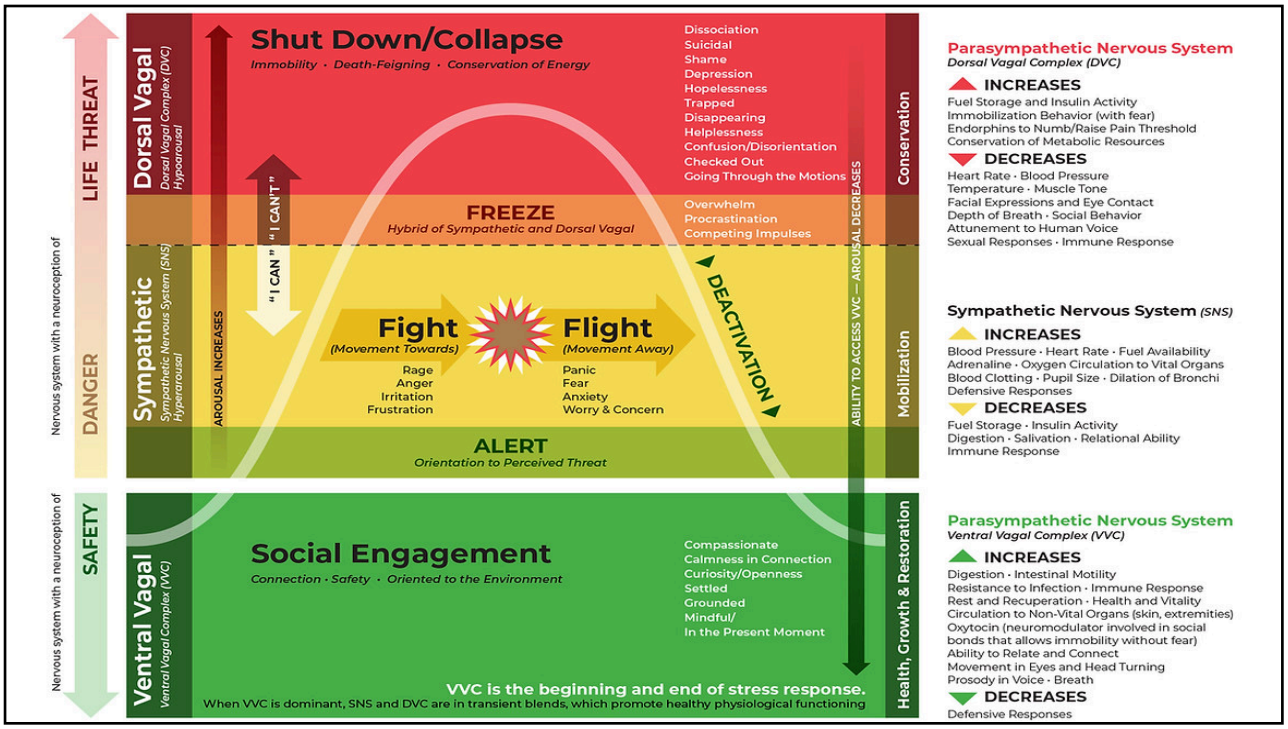

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Polyvagal Theory (Stephen Porges, 1994)

Ways of stimulating the Vagus Nerve:

1. Forward Bend
2. Paced Breathing
3. Stimulate the salivary glands
4. Mindfulness meditation
5. Physical exercise
6. Cold water immersion
7. Hum, sing, chant, talk or shout, laugh, gargle (the vagus nerve is connected to the vocal chords)
8. Massage

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Personal Profile (Deb Dana)

For each of the three zones:

- I am…(e.g. at peace; cautious; shut-down)
- The World is…(e.g. calm; overwhelming; terrifying)
- What word best describes the state for you? (e.g. Chill; Defcon 1; Gone)
- What are things you can do to help you stay in Green on your own? And with others?
- What things can you do on your own and with others to help move you out of Yellow and Red? (it takes 20 minutes for us to move back into Green when in full fight/flight)
- Name (the state) to tame it…Understanding the state reduces the shame!
- Trauma isn't psychological, it's physiological
- Anxiety is an overactive neuroceptive system

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Polyvagal Theory (Stephen Porges, 1994)

Criticisms of PVT:

- The model contains vague concepts that can't be tested as a scientific theory
- It over-simplifies the complexities of human emotions and reactions, ignoring the heterogeneity of internal experiences and discounting individual temperament and personality
- The evolutionary ideas are also disputed
- PVT at the very least, provides a way of understanding what's happening in the stress system, even when the precise underlying mechanisms remain under debate (the debate is about specific anatomical claims, not about whether the clinical work has merit)

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Polyvagal Theory (Stephen Porges, 1994)

Resources:

- https://www.youtube.com/watch?v=ZdlQRxwT1lo&t=2s
- https://www.bing.com/videos/search?q=seth+porges+polyvagal+theory+on+youtube&view=detail&mid=BC9D971A7BED21C47BCFBC9D971A7BED21C47BCF&FORM=VIRE

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Dissociation: What is it?

"Dissociation is the essence of trauma" *(Van der Kolk, 2014)*

Not all dissociation is problematic, or a sign that trauma has occurred! - e.g. daydreaming, highway hypnosis, absorption in a book or movie

Dissociation: we still lack consensus on a definition!

- ***Involves the total or partial loss of awareness or knowledge, inner body sensation, five-sense perception, emotions, thoughts, perceptions, memories, impulses, and/or sense of self*** *(ISSTD)*
  - Examples: a client reports loss of feeling in her hands after she mentioned to me in session that her hands had been badly injured when she was a child; during assessment a client mentions they have "no memory" of their life before age 10; a client starts describing how she worries she's going to find her son dead from suicide, but expresses no emotion; a client informed me that her brother, who had sexually abused her when they were growing up, was supposed to come for a visit at Christmas-time, but when I asked about this two weeks later she had no memory of the visit.

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Dissociation: What is it?

- The immediate purpose of *peritraumatic* dissociation (dissociation that takes place at or around the time of a distressing event) is *survival*: a reflexive, instinctual distancing from unbearable pain, or a way of maintaining attachments. The end result is overwhelming experiences being split off from and held outside of conscious awareness.
- According to Simeon & Putnam (2022), 4.3% of the US population experiences problematic dissociation

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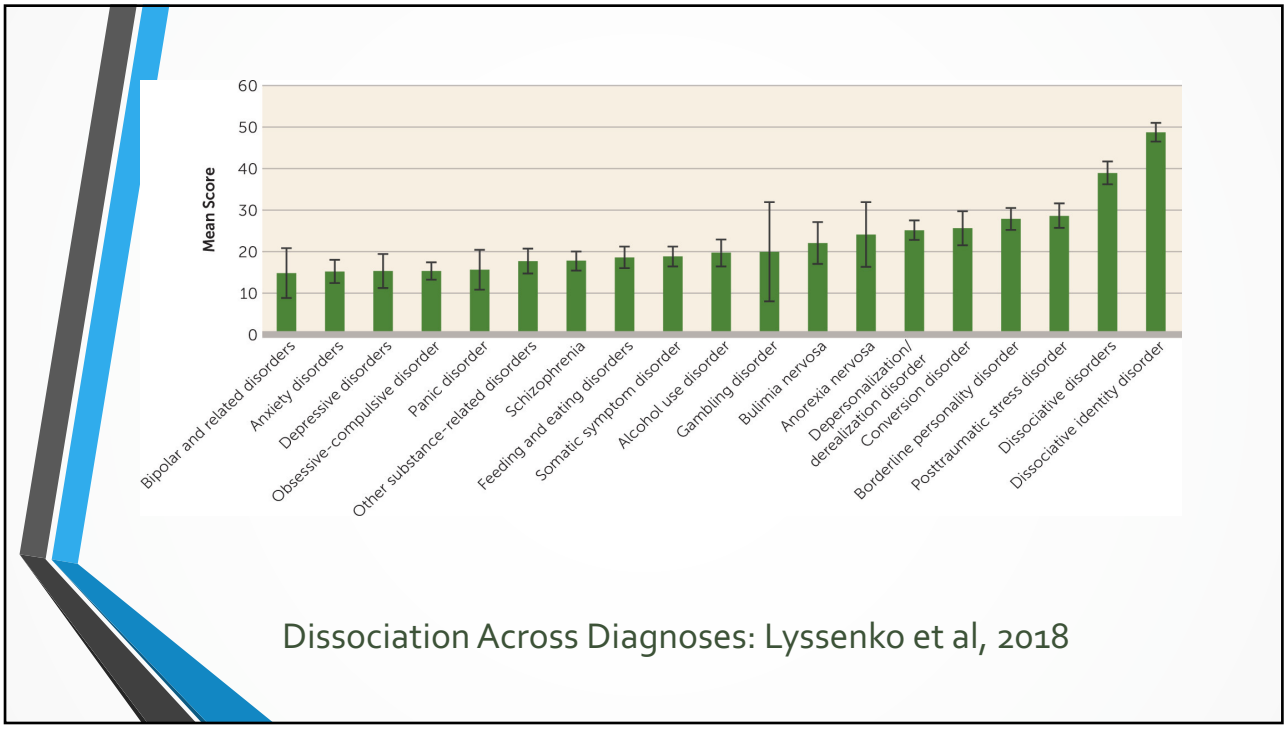

Dissociation Across Diagnoses: Lyssenko et al, 2018

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Types of Dissociation

Dissociative symptoms commonly occur in many disorders, including dissociative disorders, PTSD, eating disorders, panic disorder, major depressive disorder, and borderline personality disorder

- **General memory problems:** can include day to day forgetfulness (working memory issues that can be caused by chronic distress) and difficulties with remote memory (e.g. inability to recall childhood, or important life events)
- **Depersonalization:** the experience of feeling detached from, and as if one is an outside observer of, one's mental processes, body, or actions
- **Derealization:** Persistent or recurrent experiences of unreality of the world around you; there may be the sense of the world being distorted, blurred vision, as feeling as though you're in a dream or simulation, or as though time has sped up or slowed down

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Flashbacks: Sudden, intrusive memories, pictures, tastes or body sensations, emotions, or nightmares of traumatic events; during a flashback the individual may lose contact with the present moment
Somatoform (Conversion) Symptoms: bodily experiences and symptoms that have no medical basis; these may affect vision, hearing, sight, smell taste, body sensations and functions, or physical abilities, and are often a partial re-experiencing of the traumatic event
Trance: an altered state of consciousness that occurs spontaneously. The person loses conscious contact with what is going on around them and may not respond to attempts to gain their attention (e.g. staring into space, thinking of "nothing", or "going away" in their own mind)
Types of Dissociation

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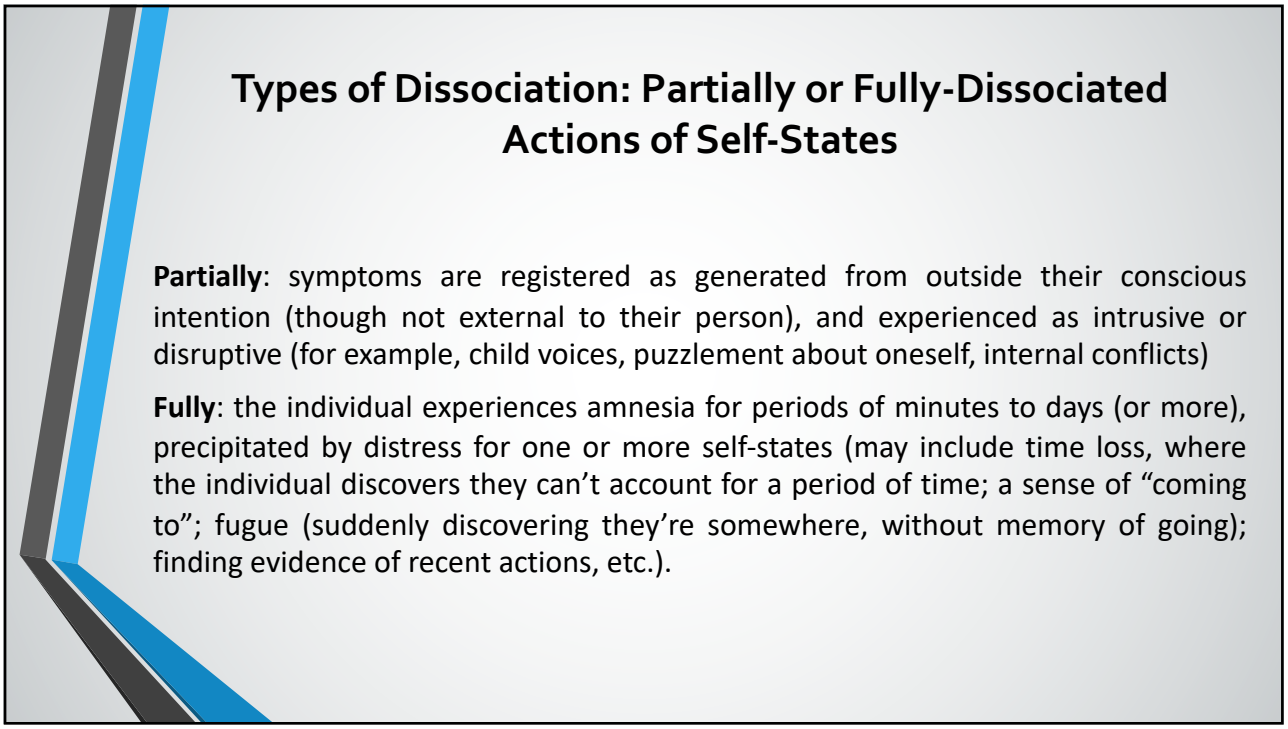
Types of Dissociation: Partially or Fully-Dissociated Actions of Self-States
Partially: symptoms are registered as generated from outside their conscious intention (though not external to their person), and experienced as intrusive or disruptive (for example, child voices, puzzlement about oneself, internal conflicts)
Fully: the individual experiences amnesia for periods of minutes to days (or more), precipitated by distress for one or more self-states (may include time loss, where the individual discovers they can't account for a period of time; a sense of "coming to"; fugue (suddenly discovering they're somewhere, without memory of going); finding evidence of recent actions, etc.).

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The Dissociative Disorders

According to the DSM-V-TR there are five dissociative disorders:

1. Dissociative Identity Disorder (DID)
2. Depersonalization/Derealization Disorder (DPDR)
3. Dissociative Amnesia (difficulty recalling important information about yourself and your life)
4. Unspecified Dissociative Disorder (with dissociative symptoms or symptoms consistent with a dissociative disorder are present, but the individual does not meet the full criteria for a dissociative disorder)
5. Other Specified Dissociative Disorder (OSDD) – where a person experiences dissociative symptoms but does not meet the full criteria for any other dissociative disorder; may be diagnosed when there is an identifiable cause that is not typical of other dissociative disorders.

- There are four common presentations of OSDD:
- **mixed dissociative symptoms**: disturbances of identity without amnesia
- **identity disturbances due to chronic and extreme persuasion**: disturbances of identity due to brainwashing, being involved with a cult, or being subjected to torture
- **dissociative reactions to stress**: dissociation as a result of stressful events that last a few hours to less than one month
- **dissociative trance:** an uncontrollable loss of awareness of their surroundings

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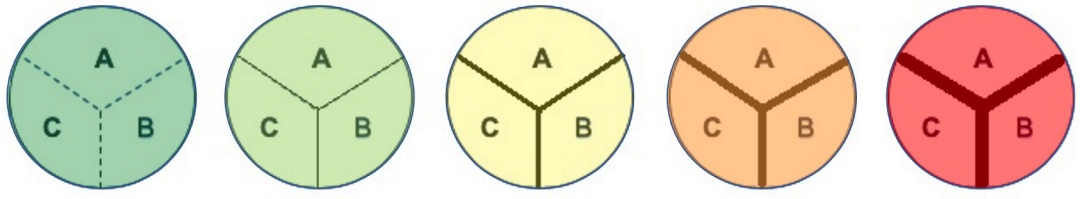
The Ego State Differentiation -Dissociation Continuum



Adaptive Differentiation → Maladaptive Defenses → 'Pathological' Dissociation

Healthy, Well-adjusted Ego States (Limited Internal Conflict)

Traumatized Ego States (Greater Internal Conflict)

Dissociative Parts (Severe Internal Conflict)

Watkins & Watkins, 1997

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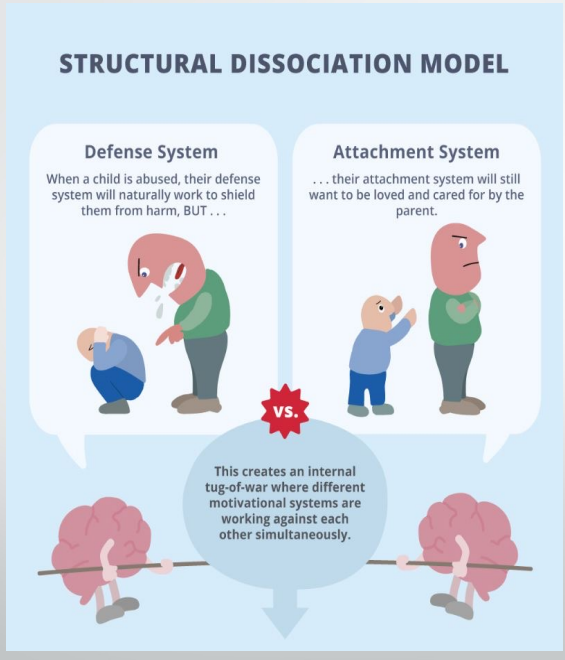

(From NICABM)

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Theory of Structural Dissociation of the Personality (SDP) (van der Hart O., Nijenhuis E., and Steele, K., 2006).

- No single model of dissociation has yet to be established as "fact".
- According to SDP, self-states (Parts) develop as a means of adapting to extreme or chronic stress, such as childhood abuse or neglect
- The "Apparently Normal Part" (ANP) of the personality is focused on going on with normal life (PFC)
- "Emotional Parts" (EP's) are triggered by implicit or explicit reminders of traumatic events and are often characterized by intense painful emotions (Limbic System);
  - It's important to understand that the focus of the EP's is to protect, even if that's not readily apparent (e.g. a 30 year-old client has suicidal thoughts related to a 12 year-old part that started as a means of feeling in control when he lived at home with his controlling father)
- The ANP and EP's can interact in complex and conflicting ways, leading to difficulties with self-identity, emotion regulation, and relationships.

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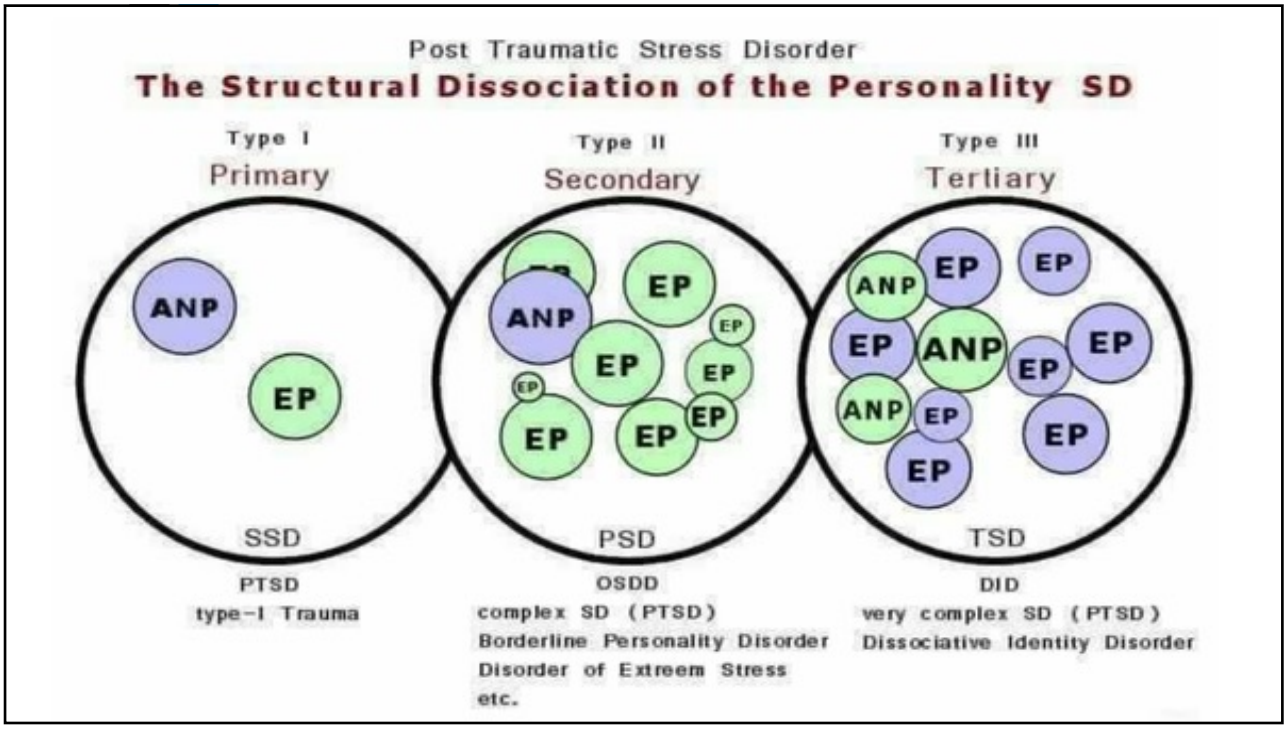
Post Traumatic Stress Disorder
The Structural Dissociation of the Personality SD
Type I
Primary
Type II
Secondary
Type III
Tertiary
ANP
EP
SSD
PSD
TSD
PTSD
type-I Trauma
OSDD
complex SD (PTSD)
Borderline Personality Disorder
Disorder of Extreem Stress
etc.
DID
very complex SD (PTSD)
Dissociative Identity Disorder

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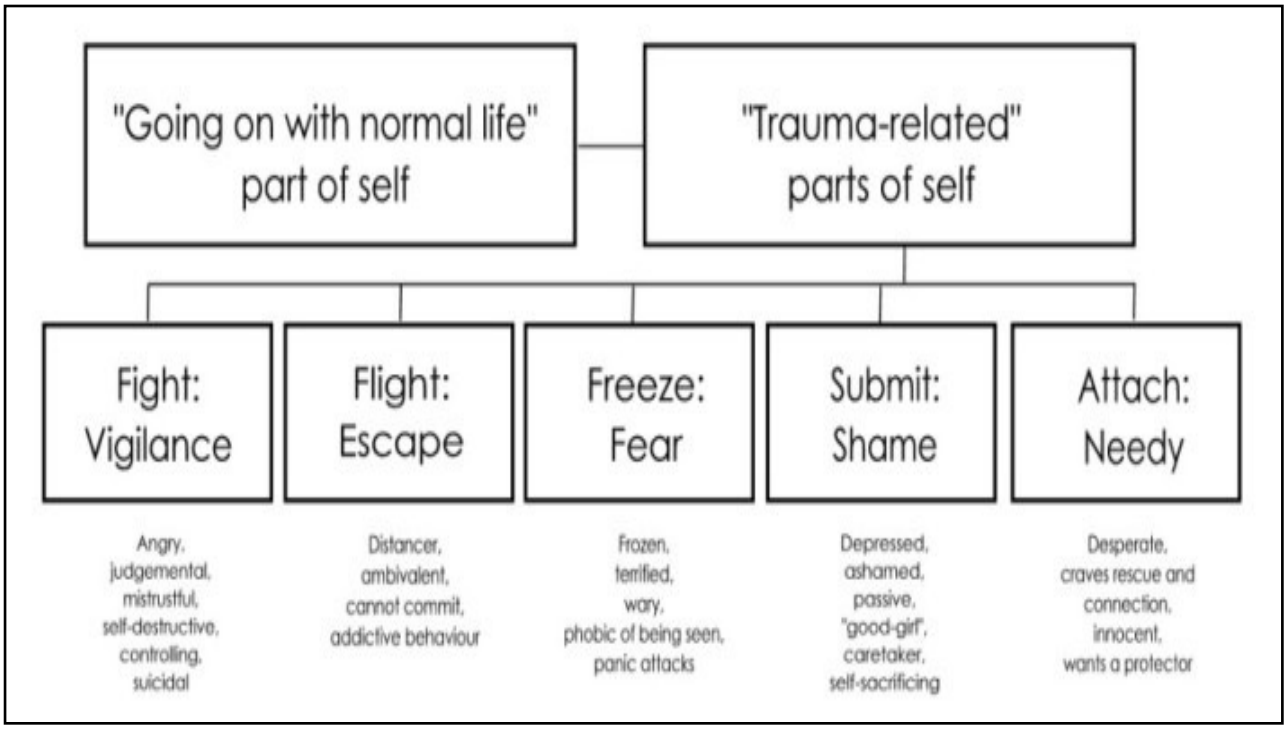
"Going on with normal life" part of self
"Trauma-related" parts of self
Fight: Vigilance
Flight: Escape
Freeze: Fear
Submit: Shame
Attach: Needy
Angry, judgemental, mistrustful, self-destructive, controlling, suicidal
Distancer, ambivalent, cannot commit, addictive behaviour
Frozen, terrified, wary, phobic of being seen, panic attacks
Depressed, ashamed, passive, "good-girl", caretaker, self-sacrificing
Desperate, craves rescue and connection, innocent, wants a protector

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Structural Dissociation: What to Look For In Adults

(From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

1. Signs of internal conflict: e.g. functioning well at work but struggling in personal relationships; acting out a disorganized attachment—a desperate attach part fearing abandonment followed by a fight part pushing away those who try to get close.
2. Treatment History: Often multiple previous treatments with little progress; past treatment may be described as "rocky" or ending badly.
3. Somatic symptoms: e.g. high tolerance for pain, or an unusual pain sensitivity, headaches, eye blinking or drooping, narcoleptic symptoms, other physical symptoms with no diagnosable medical cause

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Structural Dissociation: What to Look For In Adults (From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

4. Atypical or non-responsiveness to psychopharmacological medications
5. Regressive behavior or thinking: e.g. body language or voice of a young child, shorter sentences, themes relating to separation, caring, and fairness; client is more likely to feel empathically failed when not well understood.
6. Patterns of indecision or "self-sabotage": Ambivalence = conflict between parts with different objectives.
7. Memory gaps and time loss: Difficulty remembering therapy sessions, how time was spent in a day, conversations, getting lost while driving someplace familiar.
8. Patterns of self-destructive and addictive behavior: Fight and flight parts seeking to avoid pain from traumatic past.

**It's the Going On With Normal Life part that's seeking therapy

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Ego-State Therapy/Parts Work

Ways of conceptualizing Self-States/Ego States/Parts: **yes, they are PART of YOU!

- Parts are "disconnected containers of implicit memory, driven by instinctive subcortical animal defense responses…a part is the child you once were at a certain age, or the child you had to be in certain situations…it's the little You" (Fisher, 2017)
- Parts are memory networks - bundles of neuronal connections that hold consistent patterns of information that belong to specific ages or situations from childhood
- They're autonomic states (e.g. "my freeze part", or "my fight part")
- Parts are neural networks that know what to expect about the world, and therefore how to respond

Working with Parts:

- ***It's important for parts to know that we're not trying to get rid of them!!!***
- Instead, focus is on helping the client get to know their internal system and helping the system work together more effectively (Stage One of Herman's Model)
- Brain scan research on clients with DID has demonstrated an association between the ANP and the PFC; while none of the trauma-related parts' brain scans show cortical activity (Fisher, 2017)
- Therapies: Ego-State Therapy, Internal Family Systems, Trauma-Informed Stabilization Treatment

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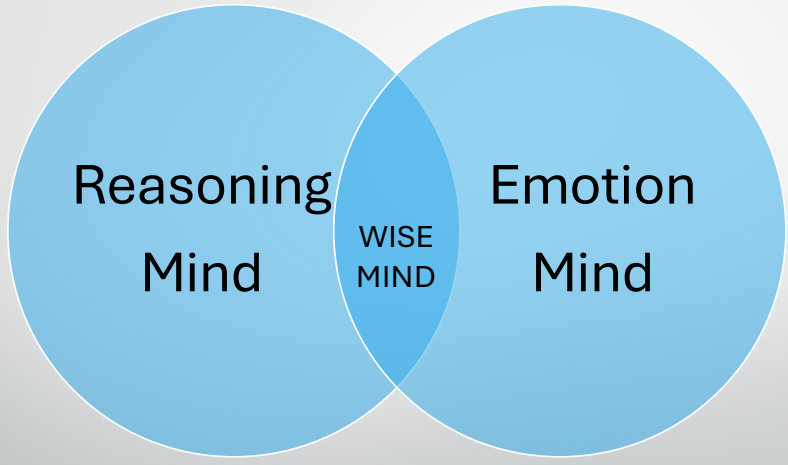
Core Mindfulness Skills: States of Mind



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Core Mindfulness Skills: States of Mind

Reasoning Mind (may be EP or ANP):

- Logical, practical, intellectual, rational, straight-forward thinking
- No emotions involved (or very minimal)
- E.g. making a grocery list; following instructions to bake a cake; balancing your chequebook (as long as there's no anxiety involved!)

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Core Mindfulness Skills: States of Mind

Emotion Mind (EP):

- You know you're in emotion mind when your *emotions* are controlling your *behaviors*
- E.g. you're feeling anxious so you avoid; your mood is depressed so you withdraw and isolate yourself; you feel angry and you lash out at the people around you
- Emotion mind also includes pleasant emotions

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Core Mindfulness Skills: States of Mind

Wise Mind:

- It's not that RM and EM are *bad*, and we want to get rid of them; rather, we want to be able to find a balance more often: this is Wise Mind
- Wise Mind = RM + EM + Intuition
- You're in WM when you're thinking about the consequences of your behavior and *choosing* how you want to act rather than reacting.

**WM is fully integrated, having access to all information in the system

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Strategies: The Meeting Place

- The client chooses a place they'll be meeting with their parts; this can be based in reality, or fictional, and can be an indoor or outdoor space; have the client close their eyes if possible and imagine this place in as much detail as possible (client describes their meeting place; elicit as much details using as many senses as possible)
- Have the client create a door in their meeting place
- Instruct the client: "When you're ready, unlock the door, open it up, and invite in any parts that would like to join us".
  - Attending the Meeting Place is voluntary for parts; parts may come in but not want to participate in any way, which is fine.
  - Let the client know that parts may appear as other versions of themselves; but they may also appear as unfamiliar: they may be a gender different from the gender the client identifies with; they might be animals or inanimate objects; they may be insubstantial and so are more "felt" than "seen"
  - When the client indicates that parts have come in: "Before we start, I want to let all parts know that this is a safe place, where no one is allowed to hurt anyone else. The meeting place is a place where we're working on getting to know one another, and increasing communication between everyone. Is everyone in agreement?"
- You can then open up dialogue (e.g. do any of the parts have anything they'd like to share, or questions they'd like to ask?)
- Closing down the meeting place

Other ways of encouraging communication with parts: collage, drawing, non-dominant hand drawing, Sand Tray

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Blending With Parts

- When a part takes over and is controlling thoughts, emotions, physical sensations, and body functions, the client has become blended with the part (Schwartz, 1995); they can't tell the difference between their experience and that of the part.
- Blending with a part isn't inherently "bad" – it can be helpful when a part takes over to navigate a specific situation where that parts' skills are required.
  - e.g. a parent who's a doctor – isn't it better for the Doctor part to take over when their child is injured, to deal with the immediate crisis, rather than having the worried Parent part in charge?
- In a healthy system the part will unblend, stepping aside for the wise self to take the wheel again once that need is resolved; when this doesn't happen in a natural and fluid way – as is often the case for individuals with CPTSD – it becomes problematic.

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How to Unblend

Step One: Assume that any painful or overwhelming thoughts and emotions are communications from parts (Fisher, 2017).

Step Two: Rather than referring to parts' experiences as *yours*, refer to them as belonging to the part (*There's a part of me that feels angry*). Notice what happens when you describe *the parts'* experience – often people note a calmness, reduction in tension, or sense of relief as the part feels validated.

Step Three: See if you can create some space between yourself and the part, so you still feel the parts' feelings, but less intensely, and you're able to feel yourself at the same time. A change in your body position (like a forward bend!), paced breathing, or looking at your hands to remind yourself of your current age can help; and continue to use parts language: *That part of me is feeling…* or *that part of me is thinking*.

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How to Unblend

Step Four: From your wise mind, consider what the part needs:

- if this was your child, your friend, or your partner, what would you say or do for them?
- depending on the age of the part, you might ask, *What do you need to help you feel less (angry, afraid, ashamed, etc.) right now?*
- if this is a young part, asking might not be appropriate – a 5 year-old can't usually articulate what they need! So, ask yourself, *If this was a 5 year-old child with me right now, feeling afraid, what would I do or say?*
- then, try it: imagine yourself having that conversation with your 16 year-old self; or feel yourself hugging that 5 year-old child.
- notice if the part responds: if you don't get a positive response, you can try again – maybe the part hears your words but doesn't feel them; or perhaps this part struggles to trust and it will take time to build a relationship with them. If the part is responsive, notice how it feels for you that the part feels soothed, reassured, a little calmer, or whatever their experience was.

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Strategies: Mindful Noticing & Internal Dialogue

- What do you notice happening inside right now?
- If you turn inward right now, are you able to identify what part is responding?
- Parts often need ***validation***, reassurance, orienting to time and place
- If client really struggles: imagine you have a 5 year old sitting with you right now; would it be okay to tell them they should just get over this? What would you want to say or do for them instead?
- "How do you feel towards (that part, that physical sensation, etc.)?" – activates PFC "witnessing mind" and encourages a perspective of "separate from and in relationship with" (Taylor-Shore)

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Strategies: Grounding & Orienting Parts

Grounding:

- Ice pack
- Tell me 3 things you see that are… (red, round, etc.)
- "Big Toes Little Toes"
- Look at your hands; are these 5 year-old hands, or are they 40 year-old hands?
- Having the client stand up and face the door: reach for the door handle; are you the height of a 5 year-old, or of a 40 year-old?
- Can that part of you feel how long your body is? Are they able to sense that this isn't a 5 year-old body, but a 40 year-old body?
- Tell me where you live now? And who do you live with? And where did you live when the (abuse/bad things) were happening?

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Assessment Tools for Dissociation

- Dissociative Experiences Scale (DES)

http://traumadissociation.com/downloads/information/dissociativeexperiencesscale-ii.pdf

- Cambridge DPDR Scale https://www.wspce.org/couples/Cambridge%20Depersonalization%20Scale-chart-scoring%20version.pdf
- Multidimensional Inventory of Dissociation (MID)

https://www.mid-assessment.com/

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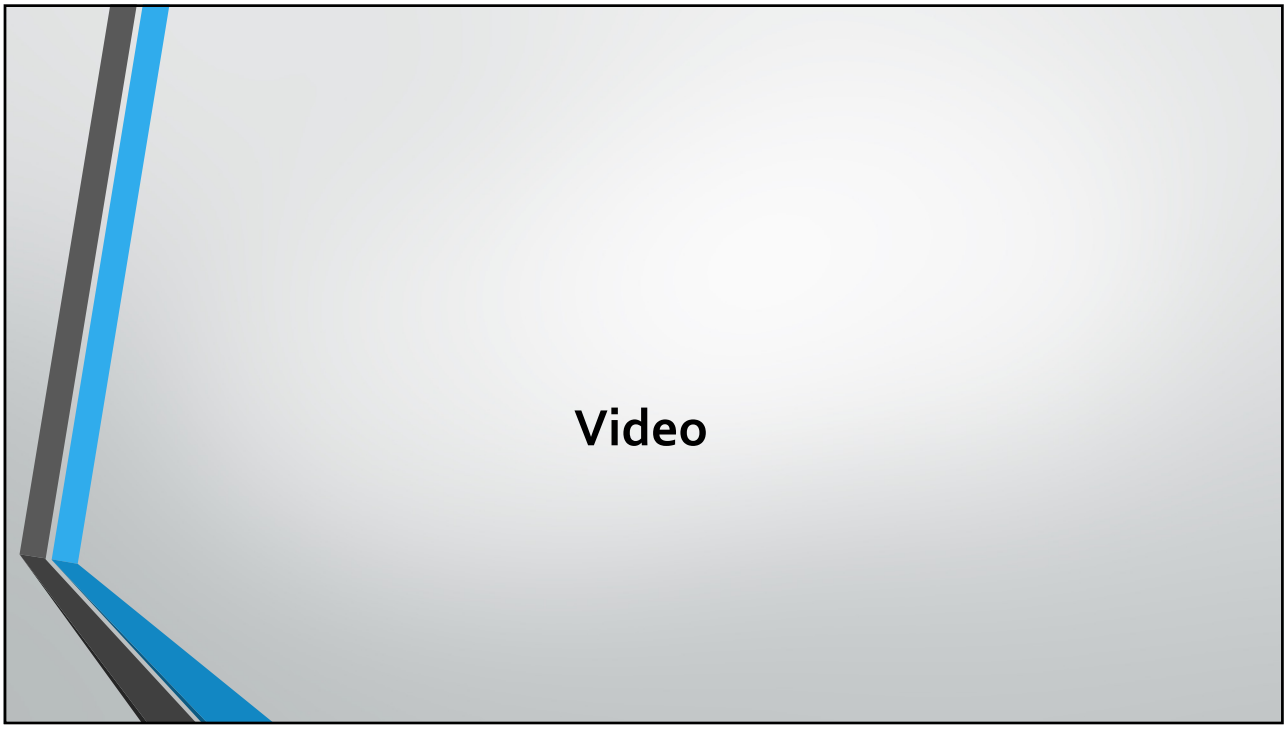
Video

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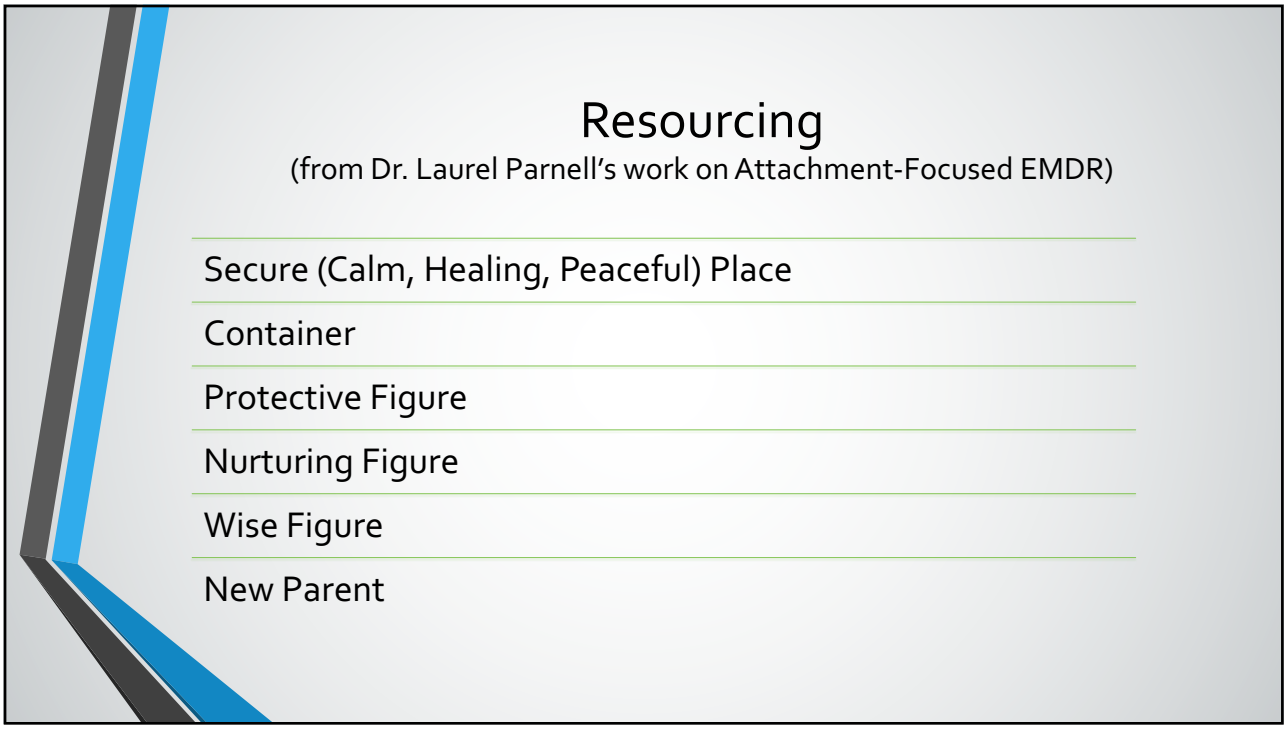
Resourcing
(from Dr. Laurel Parnell's work on Attachment-Focused EMDR)
Secure (Calm, Healing, Peaceful) Place
Container
Protective Figure
Nurturing Figure
Wise Figure
New Parent

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Ending In Safety

Be sure to always end the session in safety, with your client grounded in the present.

Kluft's "Rule of Thirds" for therapy with clients with C-PTSD:

1. Checking in, catching up, reviewing any homework, making a plan for the session
2. Doing the deeper healing work
3. Closing the session: closure, stabilization, homework and planning for the upcoming time between sessions

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Thank You!

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