Dissociation
(*dissociatio (latin)*: separation)

Post Graduate Student: Marjolein van Belle
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Supervisor: Tanja Konig

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I am willing to share this paper, so people can benefit from it. I would appreciate it if you cite the source when using (parts of) my paper. I would love to have contact and I am open for remarks and questions, so feel free to e-mail me at marjolein@bellein.nl.

If you want to learn more about Core Energetics, the way I work in my practice and the workshops I offer, please feel free to visit the website www.bellein.nl

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Introduction

Container concept

In the Netherlands we have the saying 'container concept'. It means that sometimes words are used in so many situations and for so many experiences that it loses its real definition. It becomes a concept that everybody seems to know about and one uses it in many different situations. But what the original definition is, nobody really knows anymore. I had this 'container-concept feeling' with the word dissociation. In my experience within the land of therapy one uses the word dissociation many times in so many different situations that I got lost and started wondering what the origin of the term dissociation is.

Theoretical and personal journey

I want this paper to be both a theoretical disquisition and a personal journey. Theoretically I will present information of what dissociation is, about what kinds of dissociation we know, the continuum of dissociation and if every experience in this 'area' is called dissociation or actually called something else, according to the scientific knowledge that is available. I will write about how you can recognize dissociation (signs) and overall what you can do as a therapist (treatment). I will *not* write about the types of dissociative identity disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

I also want to share practical knowledge about how it is to feel dissociation, how people experience it and handle it. Stories about their dissociation and 'where they go to', how does the place look like for them? During my four-year training of Core Energetics at NICE I experienced a deep form of dissociation myself that could have lead up to a psychosis, but fortunately didn't occur. It was one of my deepest moments in my life and I will share what happened to me in the next chapter.

Research

To write this paper I have asked all the people of the school of NICE. All students of the 2- and 4-year training, the post graduates and teachers to participate in this research. I have send them my questions and asked them to write from their own experience. I realized the questions I asked where very personal and vulnerable. Unfortunately only five persons responded so I won't be able to use this, except some quotes.

The way I wrote this paper

The concept dissociation is much more comprehensive than expected. I liked it a lot, there was so much to be found and there is so much to learn and write about it. As you will see when reading this paper many other theories and concepts are related to the concept of dissociation. Due to the format that has been decided by the school I had to restrict myself and observe the maximum of 25 pages. Therefor at moments my paper may feel a bit like a staccato written paper. I've tried to keep it flowing, but sometimes I will just mention a theory or concept in short and then refer to a book, article or to YouTube. This way you can get more information if you want to. So, in this paper I had to focus and I choose to elaborate on those parts of the concept of dissociation that I think are the most interesting for the readers who work as or want to become a core energetic therapist (body-oriented therapist). I hope reading about this topic helps you in your work with clients that experience dissociation.

1. My personal story

As I walked away from the classroom, I could feel myself falling into a big black whole and although I was still aware of my surroundings the world disappeared bit by bit. I wasn't there anymore. It was like I had entered another world, a world I've never been before. I immediately felt deep quietness, a silence that was soothing and warm. For the first time I could hear my heart beating although I was deaf for all the sounds around me. I could feel my own body, the sensations and emotions within. I never knew how it felt before, I didn't know how it was to feel *me*, to feel my emotions and impulses. I didn't know who I was on the inside of me. And it felt so calm, I felt so at ease. For me I felt at home for the very first time of my life.

I also knew I never wanted to leave this place ever again. So, I stayed and let myself even fall deeper, I allowed myself to let go of everything and let myself fall into the deep black space that was there. Although I've always been afraid of falling into that abyss and losing control, I wasn't scared anymore. I found myself in that emptiness and it turned my life upside down in a way that I could never had imagined.

This all happened in a split second, and for me it felt like eternity. It all started when we, our group of the fourth-year training of Core Energetics, did an exercise during class. We were halfway our third year. I took the role of therapist and my classmate was in the role of client. I was always so nervous being in the therapist role (now I understand why, I worked from my head because I had absolutely no clue how to work with my body, I couldn't feel the bloody thing!) So, I didn't do so well during that exercise and the criticisms was quite strong. Because it wasn't the first time I got myself in a pickle (to my feeling I messed up a lot of exercises as a therapist) I couldn't handle the feedback anymore. And it wasn't even the feedback, it was the feedback that wired up my image that I didn't belong. By always working so hard, I hoped I might get permission to belong to someone, a group or a family. I had a strong image I didn't have the right to belong in this world, to belong in a family and definitely not in the core community. So, by getting that feedback my right to exist disappeared.

With the criticism I received, I lost every hope that I might be allowed to belong in the core family. Everything fell apart and I fell into a deep fear of not belonging and I had to disappear forever. That fear was immense, and I couldn't stay with it anymore. That was the moment I walked away and started to fall. I could hear my ears whizzing, my heart pounding, I got nauseous and it felt I had to run, run as fast as I could to get out of this pain. I ran away into the hallway, and some people stopped me and started to talk to me. I couldn't hear them, and I got even more scared, It felt I had to answer the questions but my mouth wasn't working anymore. I felt more panic coming up and the only thing I could hear in myself was 'get out, get out, get out!!!!'. I couldn't, they took me into the dining room, but it only got worse. I was so scared everybody looking at me, that I had to disappear even more. It didn't get paranoid, I just got scared even more. Unconsciously I did by shutting down my system even more, I couldn't hear, I couldn't see, I couldn't speak. I had to GET OUT!! At one point someone came up to me, started talking again and that was the moment I fled. I ran into the hallway, looking for a safe place. I ended up in a dark room and hid myself on a couch in a corner. Unfortunately (and also fortunately) a senior teacher came into the room, he put on the light (which I really hated because it made me visible again) and he sat right next to me on the couch. He started to call me by my name, he kept on talking in a loving way and he stayed even though I didn't react. I felt my system ease

down a bit. He stayed there with me, being with me without judgements, without punishment, without pushing me. He stayed and after a while I was able to slowly make contact with him. He looked at me in a loving way and he stayed with me without wanting me to do anything. I was allowed to cry, to be scared and not be alone in this. Eventually I was able to get up and he helped me to find my room, he said he would send a loving friend to me to put me to bed. She came and stayed for a while, not talking so much, just being there, stroking my hair and cheeks until I fell asleep.

The next day I got up and all felt so surrealistic, as if it was a bad dream. Still I had to get up, go to bodywork and get back into class. I was scared of all the judgements that might come towards me from my classmates, actually from all the community. But they didn't. Most of them gave me a loving look or gentle touch. I didn't have to talk about it, as if they knew I wasn't able to and needed time to come back into reality. When I got into my classroom, the teacher just looked at me and welcomed me in a soft and gentle way. He didn't put me in the spotlight, he didn't mention anything to put me on the spot. And he also didn't ignore what happened. He mentioned in the group how brave it was to experience deep process and then get up in the morning and be there, not fleeing but staying. It touched my heart and I had to cry softly. I was able to slowly come back into the classroom, into my group, into life. It took me four months to find my balance, this time a new balance. Not back to the old one. I never wanted to leave myself again. So, I had to sort out some more stuff within myself and with the guidance of my therapist I was able to meet me.

2. Continuum of awareness

Before I go into the concept op dissociation, I want to share about the continuum of awareness. According to Bennett G. Braun (1988) dissociation can be displayed on a continuum of awareness. We alter our level of awareness in situations in which we feel we are being pushed out of our window of tolerance and can't handle the pain or fear at that present moment. To cope with this kind of stress we are able to alter our level of awareness/consciousness.

As you can see in figure 1 the continuum of awareness runs from full awareness through suppression, which is a conscious putting-out-of-mind of something we don't want to think about. From there the level of awareness can go up denial, which is a mechanism we use not to feel the fear or pain until we have the capacity to cope with it in other ways. For example, absorption, daydreaming, imaginative involvement, altered time sense, trance-like behaviour and temporary loss of concentration. From denial the level continues to repression, to normal dissociation and finally it can end up in structural dissociation (as you will read in the next chapters three types of structural dissociation can be distinguished). In the next chapter I will explain the difference between normal dissociation and structural dissociation. Note: All of the mentioned levels of awareness above are about detachment of reality, not about loss of reality what occurs during psychoses amongst others.

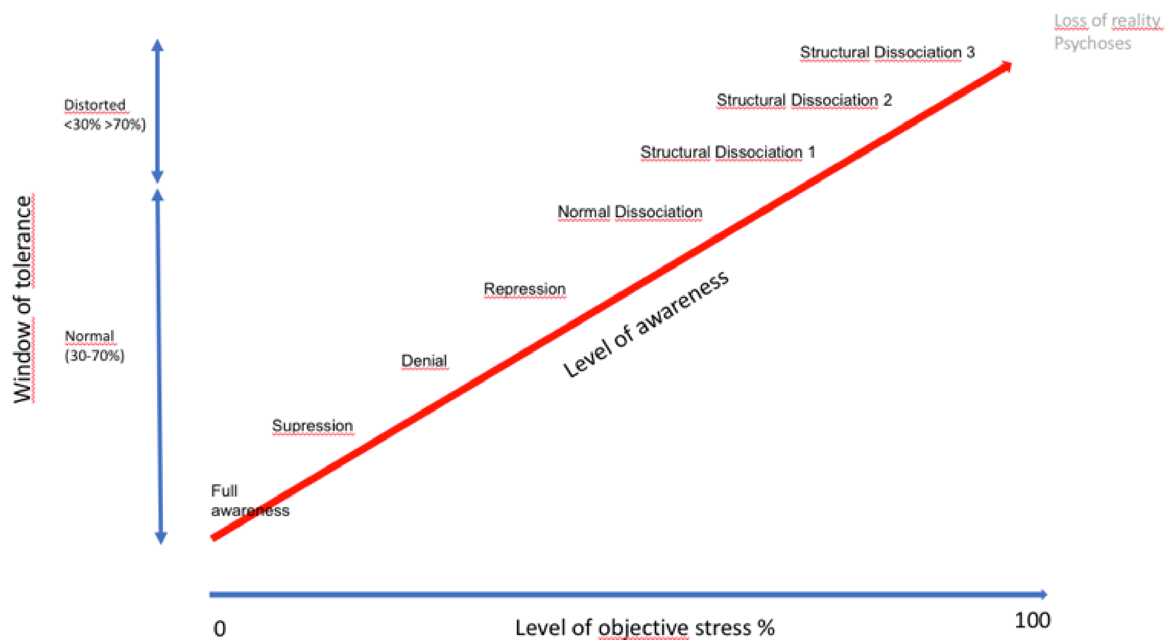

Fig.1 levels of awareness

3. Concepts of dissociation

Janet, Freud and Jung about dissociation in short

The French philosopher and psychologist Pierre Janet (1859–1947) is considered to be the author of the concept of dissociation (1889). Janet claimed that dissociation occurred only in persons who had a constitutional weakness of mental functioning that led to hysteria when they were stressed. Although it is true that many of Janet's case histories described traumatic experiences, he never considered dissociation to be a defence against those experiences. Quite the opposite: Janet insisted that dissociation was a mental or cognitive deficit. Accordingly, he considered trauma to be ‘one of many stressors that could worsen the already-impaired mental efficiency of a hysteric, thereby generating a cascade of hysterical (in today's language, dissociative) symptoms’. Contrary to some conceptions of dissociation, Janet did not believe that dissociation was a psychological defence.

Psychological defence mechanisms belong to Freud's theory of psychoanalysis, not to Janetian psychology. Sigmund Freud rejected dissociation in favour of repression as a central mechanism of the mind’s defensive organization. And in 1881-82 Breuer had concluded that a splitting of consciousness is the basic phenomenon of hysteria. Carl Jung described pathological manifestations of dissociation as ‘special or extreme cases of the normal operation of the psyche’. This structural dissociation, opposing tension, and hierarchy of basic attitudes and functions in normal individual consciousness is the basis of Jung's Psychological Types. He theorized that dissociation is ‘a natural necessity for consciousness to operate in one faculty unhampered by the demands of its opposite’.

Nowadays we say that dissociation is the separation of ideas or thought process from the main stream of consciousness. Or even more commonly said: dissociation is an experience of having one’s attention and emotions detached from the environment. Bennet G. Braun (1988) states that ‘the essential feature of the dissociative disorders is a disturbance or alteration in the normally integrated functions of identity, memory or consciousness. This disturbance or alteration may be sudden or gradual, and transient or chronic’.

Attention to dissociation as a clinical feature has been growing in recent years as knowledge of post-traumatic stress disorder increased, due to interest in dissociative identity disorder and the multiple personality controversy, and as neuroimaging research and population studies show its relevance. (source: Wikipedia)

Dissociation according to Onno van der Hart et al.

"Over the past several decades the original meaning of dissociation has been quite extended by the addition of other phenomena not typically considered to be dissociative. These include alterations in consciousness such as absorption, daydreaming, imaginative involvement, altered time sense, trance-like behaviour, and "highway hypnosis (e.g., Bernstein & Putnam, 1986)." (Onno van der Hart)

If you google the word dissociation, you can find many definitions of dissociation and they can be quite inconsistent. Some people tend to qualify symptoms of ordinary changes of awareness (e.g. daydreaming or intensively watching a movie) as dissociative symptoms. Psycho-traumatologist Onno van der Hart stresses this is a misconception. 'The term dissociation is used not only to indicate 'true' dissociative symptoms, such as dissociative amnesia, but also used for non-dissociative phenomena, such as absorption, imaginative involvement and daydreaming. Moreover, some important categories of dissociative symptoms are generally not recognized'.

After reading and thinking about all the presented definitions, ideas and theories around the phenomena dissociation the conceptual clarity regarding trauma-related dissociation as described by Onno van der Hart et al spoke to me the most. When Hart talks about trauma-related structural dissociation of the personality he places dissociation as the central concept of traumatization. Hart et al. describes trauma-related structural dissociation of the personality as the division of parts of the self. It occurs when the parts of the self that know and feel traumatic experience no longer communicate with the rest of the self. He proposes that the search for conceptual clarity around dissociation begins by revisiting Pierre Janet's view of dissociation. Together with Charles Myers' observations of traumatized soldiers in WW I this resulted in a specific delineation of trauma-related dissociation. Namely that trauma-related dissociation involves a division into two parts, that is, the 'apparently normal part of the personality' (ANP) and a so called 'emotional part of the personality' (EP). These systems do not exist in a vacuum but hold a sense of self, no matter how rudimentary or vastly developed. I will write about is this more in chapter 5.

Dissociation and trauma-related dissociation

As a process, dissociation has been described in short as a failure to synthesize and personify terrifying experiences, i.e. they don't get integrated within the personality.

Dissociation is something we all do, and it is a vital part of our survival system. It is a part of the system that helps us to cope with painful and stressful situations, which may otherwise feel overwhelming (Steinberg and Schnall, 2001). It is built in and is not pathological (Ross and Halpern, 2011).

> *'The cause of dissociation for me is being extremely afraid. This happens when I lose control over the situation by being confronted with unknow/dangerous situations (real or from images), extreme pain or from stress. I dissociate by freezing. Physically al my muscles in my body get stiff and hurtful. I can't move anymore. Emotionally I first do not feel anything anymore and then my anger comes up. In that state my muscles get full of energy and get ready to fight'.*
> (Quote NICE student)

However, when a trauma occurs, sometimes this built-in system disconnects to a greater degree in an effort to protect the individual from traumatic material, such as body sensations, emotions or memories that may be overwhelming. We then talk about trauma related dissociation which at first can be peri-traumatic but can even grow into structural dissociation.

The essence of the theory of structural dissociation of the personality is
1. traumatic experiences, especially when they occur early in life and involve severe threat to the integrity of the body, may activate psychobiological action systems that have been developed by evolution
2. due to extreme stress levels and classical as well as evaluative conditioning to traumatic memories these systems may remain unintegrated

> *‘I can go in other realms very quickly, especially when some judgment or danger is present in the room or if a lot of stress is in my body. I have also problems with my hearing (I'm wearing a hearing aid). When there is a lot of different voices or chaotic talking (especially in big group) I need a lot of mental power to stay in contact with myself. A big trigger is also different, ‘unsafe’ media news about politics, economics and nature. I feel the world is not safe anymore. Then I am not in fear because of me, but because of my children.’*
> (Quote NICE student)

Manifestations of dissociation

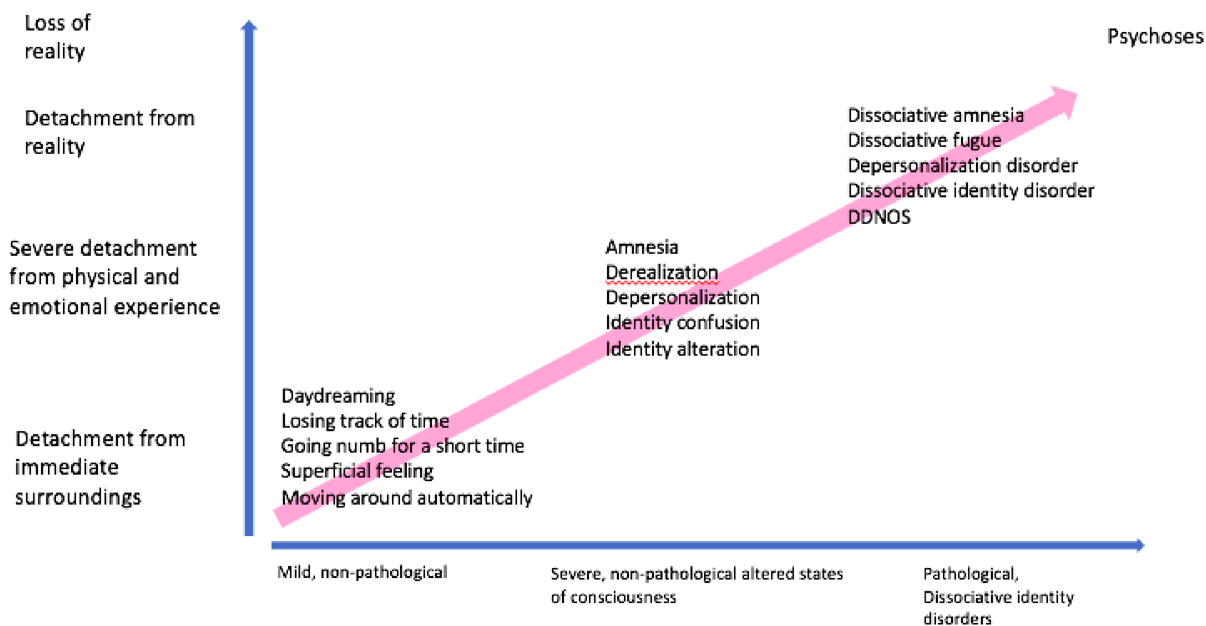

Fig. 2: manifestations of alterations in consciousness

Dissociation can be displayed within the continuum of awareness. At the non-pathological end of the continuum, alterations of awareness describe common events such as spaciness, daydreaming, altered time sense and temporary loss of concentration (e.g. while driving daydreaming while driving a vehicle).

> *Daydreaming or being lost in thoughts, yes, of course!* (Quote NICE community)

No, I don't experience dissociation and yes all the time.
*No, because it does not trouble me as such, I come back when need be; and all the time because I am a "distracted" person and live much in my own world. A dream can linger strongly in my system, so it is as if I live for a while with one foot in reality and one foot in the dream. (*Quote NICE community)

Normal dissociation can be regarded as a coping mechanism or defence mechanism in seeking to master, minimize or tolerate stress – including boredom or conflict. As you want to stay within the window of tolerance. Further along the continuum are pathological altered states of consciousness that can end in loss of reality, for example during psychoses.

In the continuum you see the severe, non-pathological altered states of consciousness mentioned, also called trauma related dissociative disorders. These kinds of dissociations are typically experienced as startling, autonomous intrusions into the person's usual ways of responding or functioning. Due to their unexpected and largely inexplicable nature, they tend to be quite unsettling. In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. There are five main manifestations in which the trauma-related dissociation of psychological processes changes the way a person experiences living. Important to say that forms of dissociation can also be triggered by using hallucinogens and drugs.

1. Depersonalization

This is the sense of being detached from or "not in" one's body. This is what is often referred to as an "out-of-body" experience. It is in a way that some people report rather profound alienation from their bodies, a sense that they do not recognize themselves in the mirror, recognize their face, or simply feel not "connected" to their bodies.

*'I was seven years old and very ill, I had a high fever. Suddenly I could see the situations from the outside. When I was out there, I felt totally calm. There was no fight or pain. I saw the whole situation from above. I saw my mother on my bed, holding my hand and crying. I decided to be with her, so I went into my body again. Later I realized that there I had made a choice between staying or going away'. (*Quote NICE teacher)

2. Derealization

This is the sense of the world not being real. Some people say the world looks phony, foggy, far away, or as if seen through a veil. Some people describe seeing the world as if they are detached, or as if they were watching a movie (Steinberg, 1995).

3. Amnesia

It refers to the inability to recall important personal information that is so extensive that it is not due to ordinary forgetfulness. Not the classic fugue variety, where people travel long distances, and suddenly become alert, disoriented as to where they are and how they got there. But the amnesias are often an important event that is forgotten, such as abuse, a troubling incident, or a block of time, from minutes to years. More typically, there are micro-amnesias where the discussion engaged in is not remembered, or the content of a conversation is forgotten from one moment to the next.

'For me memorizing what happened and still happens in live is difficult. Although all memories are stored, it is nearly impossible for me to recall them. It is like the story is there, but the titles and time stamps are missing completely. Only when other people start telling parts of the story or are telling about the

> *circumstances, then slowly pictures come back in my mind. Memories that come up are fragmented, the synchronicity and correlations are missing. For me this means that without checking externally, I never know for sure what is and isn't true, if something really happened or not. (*Quote NICE student)

4. Identity confusion

It is a sense of confusion about who a person is. An example of identity confusion is when a person sometimes feels a thrill while engaged in an activity (e.g., reckless driving, drug use) which at other times would be repugnant.

5. Identity alteration.

This is the sense of being markedly different from another part of oneself. The person may experience distortions in time, place, and situation. For example, when a person uses different voice tones, range of language, or facial expressions. These may be associated with a change in the patient's world view. For example, during a discussion about fear, a client may initially feel young, vulnerable, and frightened, followed by a sudden shift to feeling hostile and callous (e.g., Fine, 1999; Maldonado et al., 2002; Spiegel & Cardeña, 1991; Steinberg, 1995).

At the other end of the continuum there are the pathological altered states of consciousness (DID, MPS). There are four main categories of dissociative identity disorders as defined in the standard catalogue of psychological diagnoses (DSM-V). The four DID's are: Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, and Depersonalization Disorder. As DID is not within the scope of this paper I want to refer to the DSM-V if you want to learn more about these disorders.

4. Developing a personality

Let's start at the beginning. When a child gets born in the years that come it will start developing a personality. A child's personality has several components: temperament, environment, and character. Temperament is the set of genetically determined traits that determine the child's approach to the world and how the child learns about the world. There are no genes that specify personality traits, but some genes do control the development of the nervous system, which in turn controls behaviour. A second component of personality comes from adaptive patterns related to a child's specific environment. Most psychologists agree that these two factors—temperament and environment—influence the development of a person's personality the most. Temperament, with its dependence on genetic factors, is sometimes referred to as "nature," while the environmental factors are called "nurture." Finally, the third component of personality is character—the set of emotional, cognitive, and behavioural patterns learned from experience that determines how a person thinks, feels, and behaves.

Attachment

Looking at factor nurture it is not so difficult to understand that attachment is the crucial part in it. The quality of attachment determines for a great deal the way our personality develops. As Bowlby explains, a child has an inborn need to attach to one main attachment figure and it should receive the continuous care of this single most important attachment figure for approximately the first two years of his life. Separation from an attachment figure leads to distress and can lead to 3 progressive stages of distress: protest, despair and detachment. Also Bowlby (1969) said that the child's attachment relationship with their primary caregiver leads to the development of an internal working model. This internal working model is a cognitive framework comprising mental representations for understanding the world, self and others. A person's interaction with others is guided by

memories and expectations from their internal model which influence and help evaluate their contact with others (Bretherton, & Munholland, 1999).
It was Ainsworth (1970) who identified four main attachment styles, namely the secure attachment style, the insecure avoidant, the insecure ambivalent/resistant and later the disorganized attachment style was added by Main, & Solomon(1990).

Abuse and dissociation

Repetitive childhood physical and/or sexual abuse and other forms of trauma are associated with the development of dissociative disorders (Putnam, 1985). Dissociation may occur when there has been severe neglect or emotional abuse, even when there has been no overt physical or sexual abuse. Children may also become dissociative in families in which the parents are frightening, unpredictable, are dissociative themselves, or make highly contradictory communications. In all situations as mentioned above one can state that there wasn't a safe environment at all for the child to grow up. In this environment the child will develop an insecure or disorganised attachment style which will have a negative effect on the capability to integrate experiences.

Integration

A healthy personality is characterized by a strong capacity to integrate experience (Janet, 1889). Integration is an adaptive process involving ongoing mental actions that help both to differentiate and link experiences over time into a flexible and stable personality that promotes the best functioning possible in the present (Jackson, 1931/32; Janet, 1889; Meares, 1999; Nijenhuis et al., 2004a, 2004b). The capacity to be open and flexible allows us to change when required, whereas the capacity to stay closed allows us to remain stable. In structural dissociation, although parts are not completely static or closed, there is insufficient linking and coordination among the parts. Thus, the entire personality of the traumatized individual is too closed and rigid in fundamental ways, leading to proliferation of relatively stereotypical and poorly coordinated actions within and among various dissociative parts.

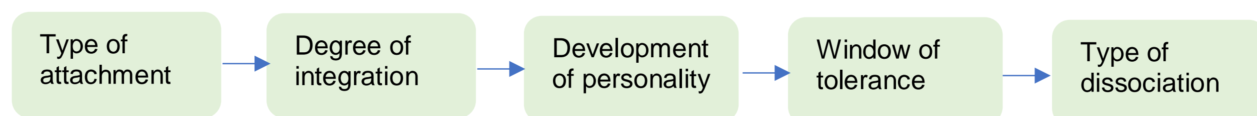

Fig. 3: realms that lead up to different types of dissociation

5. Trauma-related structural dissociation of the personality

"Attachment is central to the context in which all other action systems mature. If attachment is disrupted early in life, it may lead to maladaptive functioning in various areas of life because the most basic action systems do not function well. Attachment relationships assist individuals in regulating their emotions and physiology, providing basic internal and relational stability."
(Onno van der Hart, The haunted self)

Action systems and their action tendencies

If we want to understand the process of dissociation, we have to look at the way our psychobiological systems, which compose our personality, have being organised. These psychobiological systems consist of two main action systems. These action systems help

us to distinguish the useful from the harmful experiences in order to react adequately to daily situations and therefor stay alive. The first system is focused on positive stimuli. It contains action tendencies. For example, when we are still a child, in normal situations the action tendencies to attach, explore, play, and develop social engagement and collaborate skills. When we get older we also learn to regulate our bodily needs, mate and reproduce, and care for the next generation. The second action system concerns avoiding or escape all stimuli we fear. As a child we know action tendencies like mobilizing hypervigilance, crying for help, fight and flight, freezing, collapsing and submission to responses to quickly inhibit exploration, social engagement, and regulating functions in order to ensure automatic self-protective behaviour.

The psychoanalytic therapists among us will recognize the drive theory of Freud in this, where the first action system would be named the life drive or libido or Eros. The second action system got the term death drive or Thanatos.

Anyway, to put in short: the first action system helps us through the day as pleasant as possible by adapting to our environment (to live, play and develop). The second system protects us against great danger and it helps us to recover when necessary (to survive). Although our nature is awesome, we are still not capable to run these two systems at the same time. Sometimes, when children or grown-ups are at great threat they are forced to use the two systems at the same time. As you can imagine this puts a great force on a person. When such a situation occurs, a rigid split within the personality arises (especially in situations when the threat lasts for a longer period). It is the only solution they know for dealing with such great threats.

> *‘At times my mother was violent. I had to be prepared when she got home. When I heard her footsteps coming up the stairs, I felt panic and froze. Most of the time I crawled under the bed, sometimes I tried to lift her irritable mood and tried to make her laugh and happy.’*

Now you understand that when a trauma occurs the personality gets split and a lack of integration between parts of the personality that are mediated by daily life action systems and defensive action systems has become a fact. Once the action systems are strongly evoked, the action tendencies involved in these two action systems tend to inhibit each other, hence they are not easily integrated in circumstances of major threat, particularly chronic threat. There is insufficient cohesion and flexibility within the structure of the personality. If this is the case, we use the term structural trauma-related dissociation of the personality.

ANP and EP

As Hart et al. writes, the personality is being divided into at least two parts as the result of an unbearable emotional state that has a powerful and paralyzing effect on one’s capacity to act. One of the two parts of the personality is called the EP (the emotional part of personality) and it consists of a defensive reaction triggered by a life-threatening situation and traumatic memories of it. The EP is stuck in the traumatic experience that constantly fails to become a narrative memory of the trauma. EP is dedicated to responding to (perceived) threat while being fixated in past traumatic experiences.
The other part is characterized by an effort to continue living as if the damaging experience had never occurred; the ANP (the apparently normal part of personality). It is associated with avoidance of the traumatic memories, detachment, numbing, and partial or complete amnesia. The ANP is dedicated to functioning in daily life in the wake of trauma. Realize that ANP does have emotions, but not the overwhelming emotions that are present in EP.

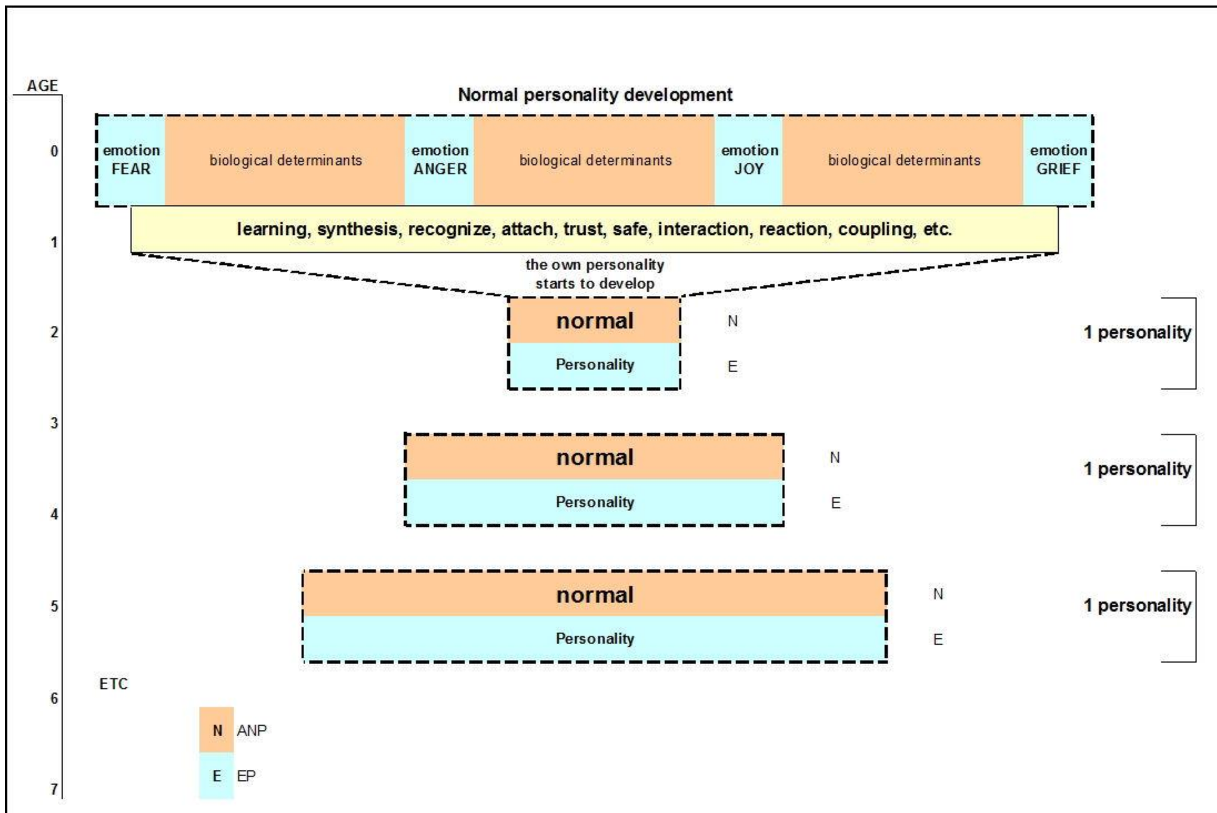

Fig. 4: Normal' personality development

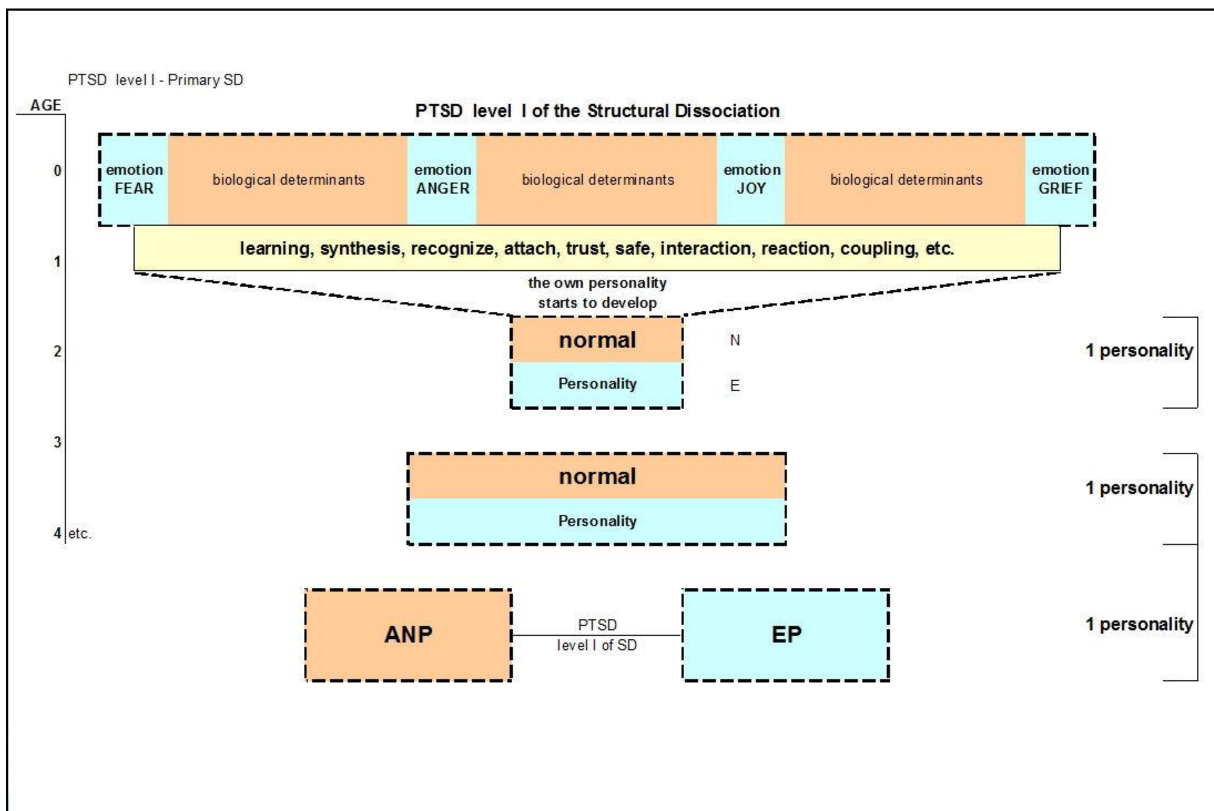

Fig. 5: PTSD level I of the structural dissociation

Peri-traumatic dissociation

As a process dissociation has been described as a failure to synthesize and personify terrifying experiences. In the acute phase, this failure manifests in psychoform (mental) and somatoform (body) peri-traumatic dissociative symptoms. Psychoform dissociation means dissociation of mental functions related to memory, consciousness and identity, for example amnesia and hearing voices. Somatoform dissociation contains symptoms relates to functions of movement, sensation, and perception, for example loss of motor or perceptual functions, pain, panic and tics. Psychoform and somatoform symptoms are dissociative reactions during or immediately after a potentially traumatizing event, and in the aftermath of trauma. Peri-traumatic dissociation increases the risk of general psychopathology and, in particular, posttraumatic stress disorder (PTSD) over time. Dissociation related to trauma occurs in varying degrees as you will read below.

Primary structural dissociation

Primary structural dissociation is a basic division of the personality into a single ANP and a single EP. It appears to characterize simple trauma-related disorders, including PTSD. The single ANP is the ‘main shareholder’ of the personality and it represents more closely the personality that existed before the trauma then EP. The ANP even has emotions but these aren’t as overwhelming as the emotions that exist within the EP. The ANP is associated with detachment, numbing and partial or complete amnesia of the trauma. The single EP (usually rather limited in scope) is associated with hyper amnesia and re-experiencing of the trauma. Because the single EP is rather limited it is little autonomous and is stuck within the traumatic experience. Still the EP can force his way into the consciousness of the ANP by reactivating traumatic memories (for example through intrusive flashbacks).

More complex forms of structural dissociation are described below in terms of secondary and tertiary structural dissociation and involve wider ranges of dissociative parts. They are variations on this primary structural dissociation of the personality.

Secondary structural dissociation

When a trauma is more severe and holds for a longer time, the EP part can get divided into more EPs, while keeping a single ANP. A default in integrating the different defence systems causes the division into more EPs. These defensive subsystems are hypervigilance, flight, freeze, fight and total submission, as well as the ‘attachment cry’ and recuperation. Each of these EPs is characterized by an even more extreme retraction of the field of consciousness than a single EP.

Secondary structural dissociation manifests in more complex trauma-related disorders, such as complex forms of acute stress disorder, complex PTSD (also known as disorders of extreme stress (DES)), trauma-related personality disorder, dissociative disorder not otherwise specified (DDNOS), complex dissociative amnesia and complex somatoform dissociative disorders.

> *Brenda, a patient diagnosed with DDNOS had one single ANP and several EPs. In her early childhood she was both physically and sexually abused by her stepfather, who was an alcoholic. She also witnessed her mother and brother being beaten by him. Her ability to function within the society was inconsistent. When her ANP was in control she functioned reasonably stable, but once the EPs forced their way into the consciousness of the ANP her functioning became chaotic. She experienced flashbacks and showed disorganised attachment patterns. One could distinguish her EPs quite clearly: one EP handled the fighting, so she could become violent (action subsystem fighting). Once she*

physically threatened a colleague. When Brenda was in her ANP she hardly remembered these episodes. Another EP, a child, got terrified for her husband while they made love to each other. She screamed and fled into the bathroom, locked the door and screamed in a childlike voice that 'the bad man had to go away' (action subsystem fleeing). She also couldn't recall this episode once she returned to her ANP. There was also a third EP, this one had the voice of her stepfather who said horrible things like 'slut' and 'the world is better of without you'. When she lived in this EP so tried to commit suicide several times. When she returned to her ANP she did remember her taking an overdose, but it felt like she didn't have any control over it. 'It was like somebody forced me to take those pills.' She said, 'I could see myself from a distance taking the overdose'.
(source: The haunted Self, Hart et al.)

Tertiary structural dissociation

Division of ANP in addition to dissociation among EPs is termed tertiary structural dissociation. It is limited to dissociative identity disorder (DID), which is often comorbid with complex PTSD or personality disorders. Early and chronic traumatization may prevent the development of a relatively cohesive pre-traumatic personality. Thus, childhood trauma may interfere with the normal developmental pathway toward integration of action systems dedicated to functions in daily life, promoting the emergence of more than one ANP.

The field of consciousness of various ANPs is more restricted than in a single ANP. Each of these ANPs selectively attends to cues that are pertinent to their limited range of action systems (e.g. caretaking, work). Some ANPs are high-functioning and consciously aware of many issues. Still their field of consciousness can be quite restricted in that they fail to appreciate the importance of other issues. Some dissociative parts of the personality in DID may have characteristics of both ANP and EP, making distinctions among them much more difficult.

<table>
<tr><td>(relatively) Integrated action systems</td><td colspan="6">The personality at large</td><td></td></tr>
<tr><td>Primary structural dissociation (PTSD)</td><td colspan="6">Emotional part of the personality (EP)</td><td>Apparently normal part of the personality</td></tr>
<tr><td>Action systems</td><td colspan="6">The system dedicated to survival of the severely threatened individual: the defensive system</td><td>Systems dedicated to survival of the species and to managing daily life</td></tr>
<tr><td>Secondary structural dissociation (C-PTSD, DES, DDNOS)</td><td colspan="6">Dividedness of the emotional part of the personality (EP, EP, EP)</td><td rowspan="4">Apparently normal part of the personality</td></tr>
<tr><td>Action systems: sequential dissociations (1)</td><td>Appreh ension</td><td>Flight</td><td>Freeze</td><td>Fight</td><td>Total submis sion</td><td>Recupe-ration, return of pain, sensitivit y</td></tr>
<tr><td rowspan="2">Action systems: parallel dissociation (2)</td><td colspan="6">Observing part of the personality</td></tr>
<tr><td colspan="6">Experiencing part of the personality</td></tr>
</table>

Table 1: structural dissociation of the personality
(1) Combinations of sequential and parallel secondary structural dissociation may occur;
(2) Sequential dissociation may also include an EP that remains attached, in a regressive way, to abusive and/or neglectful caretakers. This may be a separate EP or an EP that also has a defensive function. One or more ANPs may also remain attached to these perpetrators.

6. What happens in brain and body?

About the window of tolerance

Window of tolerance is a term used to describe the zone of arousal in which a person is able to function most effectively. When people are within this zone, they are able to readily receive, process, and integrate information and respond to the demands of everyday life without much difficulty. This optimal window was first named as such by Dan Siegel. A psychiatrist specialized in interpersonal neurobiology.
(Flipping your Lid by Dan Siegel: https://www.youtube.com/watch?v=G0T_2NNoC68)

When you are within your window of tolerance, generally the brain is functioning well and can process stimuli effectively. You are be able to reflect, think rationally, and make decisions calmly without feeling either overwhelmed or withdrawn. During times of extreme stress, you can experience periods of either hyper- or hypo-arousal. Hyper-arousal, otherwise known as the fight/flight response, is often characterized by hypervigilance, feelings of anxiety and/or panic, and racing thoughts. Hypo-arousal, or a freeze response, may cause feelings of emotional numbness, emptiness, or paralysis. In either of these states, you may become unable to process stimuli effectively. The prefrontal cortex region of the brain shuts down, in a manner of speaking, affecting the ability to think rationally and often leading to the development of feelings of dysregulation, which may take the form of chaotic responses or overly rigid ones. In these periods, you are outside the window of tolerance.

The window of tolerance is different for everyone. Those who have a narrow window of tolerance may often feel as if their emotions are intense and difficult to manage. Others with a wider window of tolerance may be able to handle intense emotions or situations without feeling like their ability to function has been significantly impacted. The window of tolerance can also be affected by environment: people are generally more able to remain within the window when they feel safe and supported. Trauma and extreme stress often make it more likely a person will become either hyper- or hypo-aroused.

The Window of Tolerance in relation to trauma

The stress of a traumatic event may have the effect of “pushing” a person out of their window of tolerance. People who have experienced a traumatic event may respond to stressors, even minor ones, with extreme hyper- or hypo-arousal. As a result of their experiences, they may come to believe the world is unsafe and may operate with a window of tolerance that has become more narrow or inflexible as a result. A narrowed window of tolerance may cause people to perceive danger more readily and react to real and imagined threats with either a fight/flight response or a freeze response. People who frequently operate outside of their window of tolerance can experience mental health issues, such as depression and anxiety. A person who is often in a state of hyper-arousal can develop symptoms of posttraumatic stress, such as flashbacks, nightmares, and derealisation. For a person who is often in a state of hyper- or hypo-arousal the awareness can alter, and he can start to dissociate, have memory issues, and experience feelings of depersonalization.

Hypo- and hyperarousal

We tend to get stuck in one of two different ways: hyperarousal and hypo-arousal.
When the nervous system is stuck in hyper-arousal the sympathetic branch of the nervous system is stuck. This is the sub-system that directs fight and flight kinds of behaviours when we’re threatened. When this hyperarousal happens, the frontal lobe shuts down which leads to impulsivity, risk-taking behaviours, poor judgment, hyper-vigilance, mind

racing, states of frozen terror, and of course self-destructive and addictive behaviours. Most of that is because the nervous system is "on" and it's as if everything inside is racing, racing, racing, seemingly without end.

When the nervous system is stuck in hypo-arousal the parasympathetic branch of the nervous system is on. That's the sub-system that will make us freeze or go immobile if our life is threatened in a way that makes us feel that the situation is such that we can't do anything at all about it or that we might die. When this gets stuck it can hold down our energy making us feel flat, numb, dead or empty. It can often feel inside like "nobody's there" and it's a major force behind depression and the victim identity where the feeling is that "I can't do anything." Thinking can be slow and even "zombie like." When individuals are extremely hypo aroused they may not encode much of what is happening, may feel the event is not real, and may experience emotional and bodily anaesthesia. To the extent that individuals nonetheless recall the events, all of these experiences make it more difficult for them to eventually fully integrate the experience. When stuck in immobility people often become preoccupied with shame, despair and self-loathing. One extra challenge that comes along with freeze/immobility is that it can look calm on the outside but inside there is actually a lot of turbulence and noise. People stuck here often have a hard time explaining that inside it actually feels like the accelerator is on at the same time as the brake. So, sympathic system is active but the mind and muscles are frozen.

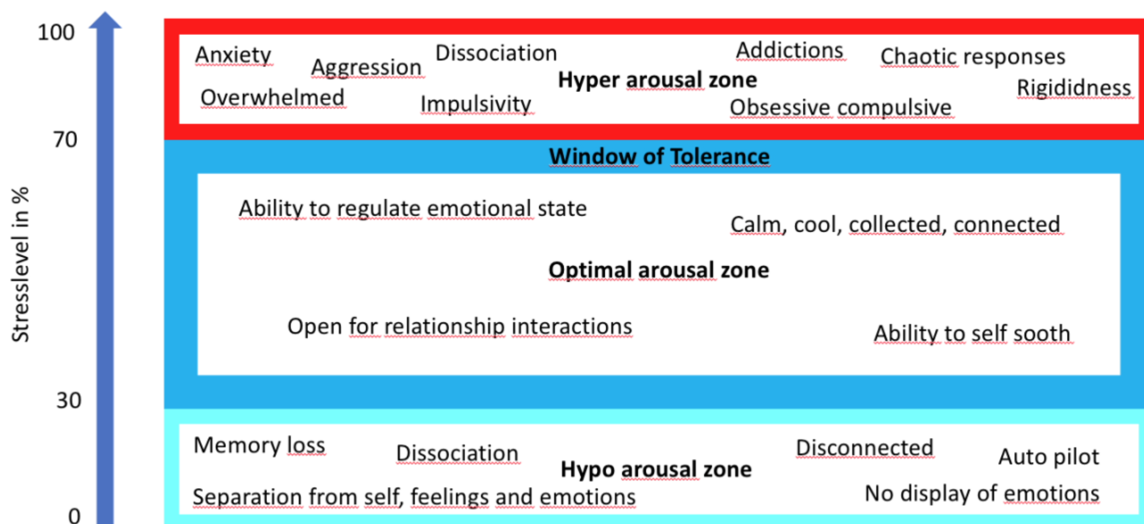

Fig.6 Zones of arousal

Since these responses like fight/flight and freeze are generated in the most primitive part of our brain ("the reptilian brain"), symptoms of trauma tend to be related to the functions regulated by that part of our brain. This area governs physical balance, arousal, movement, and all basic vital bodily functions such as breathing, digestion, circulation, heartbeat, sexuality and action. Understanding this allows us to see trauma symptoms as the result of this highly activated and incomplete biological response to threat, frozen in time. The very structure of trauma, including these two physiological states, is based on the evolution of the predator/prey survival behaviours. They include this process which humans have a tendency not to complete. But fortunately, we can complete the process. And we do when we have the right information and the right kind of support to do it.

The polyvagal theory of dr. Stephen Porges.

Porges explains that in safe contexts, when our mammalian vagal circuits are active, the function of our nervous system is optimized to support processes related to health, growth,

and restoration as well as feeling connected and intimate. But when we no longer feel safe, the newer circuits go off-line, and we are more prone to get defensive and disconnected. We fall prey to sympathetic nervous system stress—the fight or flight reflex—which shuts down much of our higher social brain and many of its health benefits. In more threatening situations, when even sympathetic fight or flight doesn't get us out of danger, our bodies may reflexively dissociate and disappear, using the older uninsulated vagal circuit that controls the faint or freeze reflex, effectively shutting down our body and higher social brain. You can learn more about it from Stephen Porges himself, look the video at https://www.youtube.com/watch?v=ec3AUMDjtKQ

7. Trauma related dissociation in relation to Core Energetics

Vertical and horizontal plane of trauma

Nearly all my clients that come into my practice have experienced trauma, which varies in degree and plane. Most of these traumas occurred during their childhood and can be mild to severe. The traumas affect their development on the vertical plane and/or on the horizontal plane. Within the vertical plane I look at the various forms of environmental trauma and the arising character defences, i.e. the energetic and bodily consequences of the trauma and the associated arrest in development. Hence, the child's ego gets translated in his body and energy. In essence it is about the basic needs of the child that are not being met. This has core affective consequences, i.e. the child's behaviour that is being motivated by affect and emotion becomes compromised. This results in a pattern of perceptible behaviour, bodily structures and certain flow of energy by which a subjective feeling is being expressed. Note: All of the character defences are formed energetically by the age of five or six, although they don't take form in the body until puberty. This means you cannot see character defences in children. (Stuart Black – Core Energetics, a way of life)

I also look at any kind of wounding in the natural evolution of ego development and the Self and the effect of the trauma on the ego functioning. We call this the horizontal plane as it has everything to do with attachment, ergo it is about the relationship between the child and his caretaker (often the mother). Amongst others the borderline and the narcissistic wound (pre-oedipal) and psychopathic and rigid traits (oedipal) can be placed within this horizontal plane

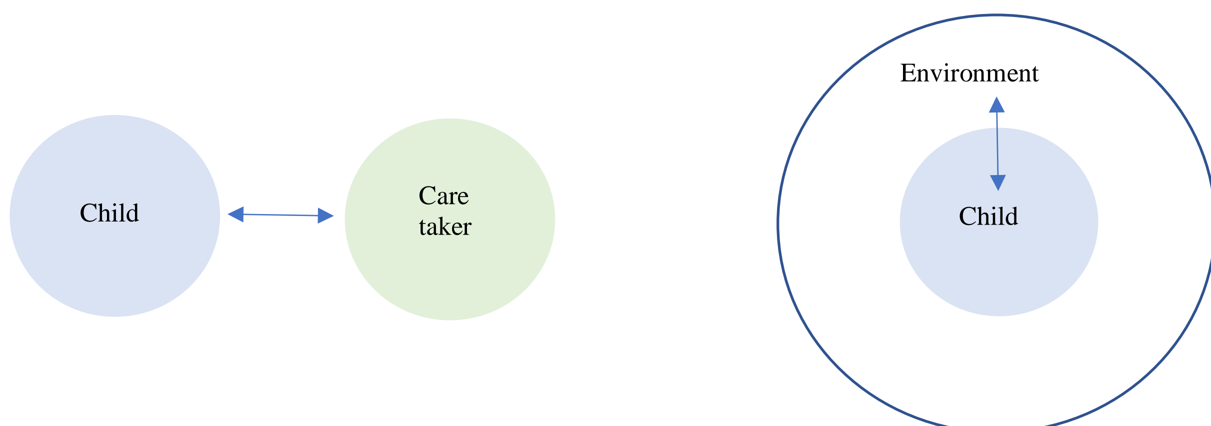

Fig. 7: horizontal and vertical plane

Ego

Freud writes about the id, ego, and super-ego which are three distinct, yet interacting agents in the psychic apparatus. The id is the set of uncoordinated instinctual trends; the super-ego plays the critical and moralizing role; and the ego is the organized, realistic part that mediates between the desires of the id and the super-ego. When growing up you move from id to ego, a process of realizing you are a human being and consciousness of Self is growing. The caretaker is crucial and helps the child regulate emotions and control uncoordinated impulses, this way a child can develop a healthy ego and therefor ego strength. As mentioned before, insecure and disorganised attachment leads to distortions in ego and in the ability to integrate experiences which causes a lack of integration etc..

According to the object-relation theory (amongst others Klein, Fairbairn, Winnicott, Mahler) the way people relate to others and situations in their adult lives is shaped by family experiences during infancy. For example, an adult who experienced neglect or abuse in infancy would expect similar behaviour from others who remind them of the neglectful or abusive parent from their past. These images of people and events turn into objects in the unconscious that the "Self" carries into adulthood, and they are used by the unconscious to predict people's behaviour in their social relationships and interactions. A healthy ego helps developing a strong sense of Self.

True (real) Self – False Self by Winnicott

"Only the true self can be creative and only the true self can feel real”. For Winnicott, the true self is a sense of being alive and real in one's mind and body, having feelings that are spontaneous and unforced. This experience of aliveness is what allows people to be genuinely close to others, and to be creative. The false self is a defence, a kind of mask of behaviour that complies with others' expectations. Winnicott states that a False Self begins to develop in infancy, as a defence against an environment that feels unsafe or overwhelming because of a lack of reasonably attuned caregiving. He sees developing a false self as an unconscious process. Consequently, not only others but also the person himself starts to mistake his False Self for his real personality. But even with the appearance of success he would feel unreal and lack the sense of really being alive or happy. According to Winnicott, in every person the extent of division between True and False Self can be placed on a continuum between the healthy and the pathological. The true self, which in health gives the person a sense of being alive, real, and creative, will always be in part or in whole hidden. The false self is a compliant adaptation to the environment, but in health it does not dominate the person's internal life or block him from feeling spontaneous feelings, even if he chooses not to express them. The healthy false Self feels that it is still being true to the true Self. It can be compliant to expectations but without feeling that it has betrayed its true Self.

Working as a core therapist

When working with clients it is important to know and understand which trauma(s) is (are) present within the client. Although as a core energetic therapist I work with the theme that is present at that moment for the client, I am always aware of the wounds the client is dealing with and in which plane these wounds belong. It determines the way I work with whatever the client brings into the session. For example, when working with a character structure I can work with the three levels of consciousness (mask, lower self, higher self). When the client experiences a trauma in attachment, I can work on building on a healthy ego development, ergo a healthy Self development.

As a therapist, I appreciate dissociation as a valuable gift our brains give us when we endure trauma. When I work with clients I emphasize that dissociation amongst others has helped them to survive, and we can acknowledge that this is a defence that has perhaps worked for longer than it was intended. It is important to remember that experiencing more than a regular level or type of dissociation as a result of trauma does not make a person defective. Rather, it shows that he or she has been able to live through and survive extraordinary circumstances that no one would be able to endure without the brain's ability to dissociate.

For me the goal in therapy is not to eliminate dissociation completely, but rather to help the brain and body to update to the current circumstances. Specifically, this would include helping a client to integrate current information about the present circumstances in which they live. If no danger currently exists, helping the brain and body to learn how to be safe would be one part of treatment. The body of the client need cues of safety. They come from social engagement. They come from the friendly face, from the soothing voice and gracious gestures. They come from our ability to feel safe in the proximity with one another. Without these cues, the clients' body falls back into a hypervigilant state. If he is in a hypervigilant physiologic state, he will react to the world as if it's dangerous, whether it is or not. If he is in a state of social safety and connection, he is in another physiological mindset, and we'll be welcoming even in the face of challenge.

Working with the body means I work with the client towards being able to maintain awareness of the present moment and develop awareness of self and of others. This includes that the client becomes more conscious of his own body, his body sensations and emotions. When working with clients who have dissociative behaviour I start working with the enlargement of the grounding. I can do this not only with breathing exercises but as a therapist I also have to work on amplifying the bodily awareness, the sense of self and others. Soft techniques like somatic experience and sensorimotor exercises can help the clients to look at their non-integrated parts whilst staying within the window of tolerance. You can read more about sensorimotor psychotherapy in the book Pat Ogden wrote.

When working with a client with trauma-related structural dissociation of the personality I have to realize I am working with ANP and EP. To be clear I don't work with clients who are diagnosed with secondary and tertiary structural dissociation. Maybe in the late future I might consider working with the secondary realm, but for now I leave it at the primary one at most. Searching within the terminology of structural dissociation I realized links can be formed with the idiom of Core Energetics and the psycho-analytic view. For example, ANP and EP can be equated with the pathological false self and living from the mask. BUT this doesn't mean that the way we work with the mask should be the same as working with ANP and EP! I strongly advice against working with those techniques of penetrating the mask that will push the client out of his window of tolerance, for example hitting the block. It can be a great technique for clients that are less severely traumatized. However when working with structural dissociation, there are more subtle ways of bringing consciousness to the unconscious behavioural patterns and somatic responses. I find it of at most importance that when working with clients with structural dissociation you, as a therapist, realize you are working with deep traumas related to attachment issues. It demands a different way of working with your client.

8. Signs and symptoms of Dissociation

Being able to recognize and diagnosing symptoms as trauma-related structural dissociation is important. As a therapist you should see and understand that structural dissociation has a profound division of the personality. It is important to understand how this manifests and how it can be treated. You should know the psycho-dynamic, relational and physical

aspects of treatment as well as being able to work with mental energy and mental efficiency of the client. All of this is to enlarge the level of action tendencies in every part of their personality. Being able to recognize and diagnose symptoms as (structural) dissociation is not easy at all. Symptoms of structural trauma-related dissociation resemble symptoms of other pathological disorders for example borderline. So you need to test and be aware of the possibility. As a core therapist I am not fully equipped diagnosing according to the DSM V, so in doubt I would refer the client to a specialist.

In the list below, I have written the signs and symptoms that might indicate structural dissociation. Together with another diagnose that also might explain these signs, just to show you how difficult it is to see and confirm that the client is suffering from structural dissociation.

Signs and symptoms of structural dissociation

- Treatment history: a number of previous treaters and diagnoses without much progress or clarity, treatments that have been rocky, tumultuous, or have ended in some unusually dramatic way. (or borderline behaviour)
- Manifestations of internal splitting: i.e., functioning highly at work while regressing in therapy, alternately idealizing and devaluing significant others or the even his therapist, high intelligence coupled with poor judgment. (or narcissistic wound)
- Somatic symptoms: unusual pain tolerance, stress-related headaches, eye scanning, blinking, or drooping; narcoleptic symptoms; atypical or non-responsiveness to psychopharmacological medications. (or blocked energy in segments)
- Regressive behaviour: body postures, cognition, verbal or body language more typical of young children; inability to make eye contact, running away, becoming mute, fear of abandonment, clinging emotionally (schizoid character structure)
- Patterns of indecision or self-sabotage reflecting internal struggles between parts: inability to make small everyday decisions, difficulty committing to significant others; frequent job or career changes, success in life alternating with failure or disability, high-functioning alternating with decompensation, hard-working in therapy but self-destructive outside of it (bipolar disorder)
- Memory symptoms: difficulty remembering how time was spent in a day, difficulty maintaining continuity from therapy session to therapy session, “black outs,” getting lost while driving somewhere familiar (such as going home from work), forgetting conversations, forgetting well-learned skills (such as how to drive), engaging in behaviour they do not recall (burn-out)
- Patterns of self-destructive and addictive behaviour reflecting internal conflicts. (oral structure or personality disorder)

9. Treatment of dissociation

General conditions needed in a therapeutic setting

First of all always rule out any neurological and/or medical causes. And make sure the client doesn’t use hallucinogens and/or drugs that can lead up to dissociations. Then create conditions that will support the client to work on his trauma and his tendency to dissociate. Hence, create a safe therapeutic environment. As already mentioned the polyvagal theory explains how the autonomic nervous system works and how people defend themselves when threatened. A sense of security is the most important condition for healing, and I dare to say that the autonomic nervous system is vitally important in producing a sense of security. The capacity of the autonomic nervous system to act is shaped by experiences, which explains why the creation of a strong therapeutic alliance and the identification of triggers associated with fugue onset is also important. And finally, it

is necessary to set appropriate boundaries as traumatized clients often are dependent during the first phases of therapy. Be available but abstinent in a way that during sessions transfer and counter transfer can still happen.

Treatment for structural dissociation

According to Janina Fischer 'when working with traumatized clients, the therapist must focus on the 'going on with normal life self' (ANP), while simultaneously holding in mind that the client is being influenced moment by moment by emotional and physiological input from the trauma-related parts (EP). The most important goals of treatment are to increase meta awareness of the whole system of parts, promote acquisition of new, healthy self-regulatory skills for soothing, calming or energizing them, and foster a greater capacity for internal connectedness, for "association" instead of dissociation.'

The steps of treatment that Fischer proposes are quite mental. So I went along with the sequel but did add core energetic (body oriented) ways of working with clients who experience structural dissociation. The steps to follow are:

- Increase the activity in the prefrontal cortex: psychoeducation about the structural dissociation model, about how we develop parts, and how trauma affects the mind and body can serve to strengthen the adult Self by increasing his or her curiosity and therefore activating the frontal lobes
- Learning how to differentiate an adult Self from traumatized parts. Letting clients do self-observation to differentiate the moment-by-moment input from child versus adult parts and helping clients develop techniques for regulating autonomic arousal, staying present, and better managing the symptoms so they do not interfere with having a life in the here-and-now
- Speaking the "language of parts": techniques require the more complex ability for internal awareness, while using parts language simplifies the task of noticing moment-to-moment responses and eliciting curiosity. Parts language also facilitates increased self-compassion: if an angry or lonely or ashamed feeling is re-framed as a communication from a young part, the adult often softens toward it or feels more empathy
- Learning to identify triggered responses and differentiate past from present so that post-traumatic symptoms are not confused with current reality. Intrusive emotions, thoughts, and impulses can be felt and put into the right perspective. The client experiences trauma-related parts, such as autonomic hyperarousal or numbing and loss of energy. They can be framed as symptoms characteristic of a particular part rather than labelled more generally as "my" acting out, rage, shame, depression or passive-aggressive behaviour.
- Teaching an array of cognitive-behavioural and somatic techniques to help the ANP learn to manage the overwhelming number of symptoms and autonomic dysregulation associated with PTSD, Complex PTSD, borderline personality disorder, bipolar disorder, and dissociative disorders
- Learning how to use "therapeutic dissociation," taking positive advantage of clients' dissociative abilities: teaching them how to hold multiple parts in awareness simultaneously, engage in internal dialogue, and create safe places inside
- Learning how to foster internal communication and cooperation: helping the ANP to develop increased trust, empathy, and compassion, increasing the capacity to soothe the parts, developing ways to resolve internal conflict
- Learning how "to be here now:" for trauma to feel like 'past' experience requires that we have gained the ability to stay conscious and present even in the face of triggering, to tolerate the ups and downs of a normal life, and to help all parts feel safe in the body

10. Conclusion

Learning about the concept of dissociation more, I realized what happened to me that day at school. My stress level went up sky-high and far out of my window of tolerance, I couldn't handle the amount of stress and fear anymore. It was too much. As a result of the fear I felt my body freeze (hypo-arousal), I could feel my heart freezing and the inside of my body turning cold. I then drifted away from reality. I didn't lose contact with reality, but I dissociated from it (*I could feel myself falling into a big black whole and although I was still aware of my surroundings the world disappeared bit by bit*). My anxiety got bigger and I felt I had to flee (hyper-arousal). I got numb and got separated from myself, my feelings and emotions, I got disconnected from the world. So, what happened is I dissociated and got into a non-pathological state of consciousness. In the beginning I got into deep contact with my body and then I got detached from my body and emotions and experienced derealization, hence I experienced the world as far away and I was detached from it (*I could feel myself falling into a big black whole and although I was still aware of my surroundings the world disappeared bit by bit. I wasn't there anymore*). The trigger was trauma related (*it was the feedback that wired up my image that I didn't belong*). One could have thought it was an anxiety attack or psychosis, but the experienced derealization and the detachment from reality are clear signs of dissociation.

I was so pleased to discover the research and book of Onno van der Hart et al. He does a lot of research and a lot of challenging questions are being put out there, open for discussion. His vision and the way he approaches the concept of dissociation is illuminating for me, he brings the concept back to its origin (Janet) and from there he adds more nuances to the theory. That is why I followed his view on how to treat dissociation and I tried to link this knowledge to the way we work as a core energetic therapist.

I enjoyed writing this paper. The feeling that I might add something to the work of a core energetic therapist makes me happy. I feel that it is important to recognize dissociation within the client. And to see and understand with what kind of dissociative part we as a therapist are dealing with. The tertiary structural dissociation for example is a kind of dissociation I don't feel comfortable working with. I will refer them to other specialists who can help them integrate more. I love to elaborate more about this concept of dissociation and write about it on a deeper level. Because I think it can add something to the way we work with (severely) traumatized clients. To do so, I need more time. Not only to read more and more in depth but also to fully integrate what I am reading. To feel what I am talking about. Also I want to work and experience how it helps my clients, or not. So, I have a longing to write about this subject more, like writing about what techniques we specifically can use and I will take my time with it. I hope with this paper I brought some clarity around the concept of dissociation.

I am willing to share this paper, so people can benefit from it. I would appreciate it if you cite the source when using (parts of) my paper. I would love to have contact and I am open for remarks and questions, so feel free to e-mail me at marjolein@bellein.nl.

If you want to learn more about Core Energetics, the way I work in my practice and the workshops I offer, please feel free to visit the website www.bellein.nl

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