International Society for the Study of Trauma and Dissociation

Professional Training Program:

Level III
Advanced topics in Complex Trauma and Dissociative Disorders

Curriculum for 2020

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Course Directors:

Su Baker, MEd Joan A. Turkus, MD

subaker@videotron.ca joan.turkus@verizon.net

**Intended Participants:** Licensed mental health professionals (psychiatrists, psychologists, clinical social workers, mental health counselors, accredited psychotherapists, etc.) who are interested in developing their skills in treating clients with complex trauma related disorders. Students must have successfully completed From Complex Trauma to Dissociative Disorders, parts 1 and 2 to register for this course. Students who have completed the previous “Standard course” before 2012 must have permission from the course instructor and one of the course directors.

**Course Format:** Nine, two and a half hour sessions of literature discussion, lecture, and discussion of your cases. For the first session, the class will be three hours to allow for introductions and review of the course syllabus.

**Course Materials:** There are no required textbooks. All Materials will be provided at no cost via the online course portal. **Please note that time spent completing required readings is not eligible for continuing education credit.** Access to the course portal is sent to registered participants two weeks in advance of the first class.

**Recommendation:** We recommend that you join ISSTD. Membership in ISSTD gives you free access to every past issue of the Journal of Trauma & Dissociation and a wealth of clinical articles and discussions from past issues of The ISSTD Newsletter.

**Advanced Topics in Complex Trauma and Dissociative Disorders**

Advanced topics in complex trauma and dissociative disorders consists of nine modules – six required modules that make up the core of the course, and three elective modules chosen by the instructor. Each module is “free-standing” in that it encompasses an entire topic to be covered in a single class. The required modules will be presented in the first six classes, with the three electives left to the last three classes of the course.

**Required Modules – all six must be covered in the course**

**R1**

An Introduction to complex trauma and dissociation in children and adolescent

Content Level: Advanced

Contributors:
Fran Waters, DCSW, Su Baker, MEd, Joan Turkus, MD (edited by John O’Neil, MD)

Module Description

The diagnosis of complex posttraumatic and dissociative disorders is often neglected in

children and adolescents as clinicians tend to be unacquainted with their signs and

symptoms. Commonly recognized symptoms, such and anxiety and depression, overlap

with other diagnoses and may mask dissociation. Children already have limited ability to

put their experiences into words. Traumatized and dissociative children may also have

speech and language deficits, along with fluctuations in consciousness and memory,

further limiting their capacity to disclose their symptoms.

This module will explore the genesis of signs and symptoms of complex trauma and

dissociation in children and adolescents and how to arrive at a diagnosis. Often, more

subtle signs and symptoms arising from developmental adversity, including trauma, abuse,

neglect and disorganized attachment are inadequately represented. Clinicians need to

approach signs and symptoms as clues about what is going on within the child, to explore

the underlying meaning of mercurial and contradictory symptoms, which may appear

abruptly with force and then recede in a flash! This requires going beyond the diagnostic

criteria in order to focus on the child who has the symptoms, and not just on the symptoms

the child has.

Finally, some models of treating children with complex trauma and dissociation will be

discussed and explored.

As this is a brief introduction, students are encouraged to obtain further training before

treating dissociative children and adolescents. ISSTD has training in treating

complex trauma and dissociation in children and adolescents.

Objectives: After the completion of this class, participants will be able to:

1. Identify signs and symptoms that suggest a dissociative process may be taking place within the child or adolescent, and distinguish between dissociative disorder and psychosis
2. Discuss the origin of symptoms of complex trauma and dissociation in children and adolescents
3. Discuss the need to go beyond the DSM criteria to adequately diagnosis complex trauma and dissociation in children
4. Describe some models of working with children with complex trauma and dissociation

Readings

1. Silberg, J.L and Dallam, S. (2009) Dissociation in children and adolescents: At the crossroads. Chapter 5 in Dell, P.F. and O’Neil, J.A. Dissociation and the dissociative disorders: DSM-V and beyond. New York, NY: Routledge.
2. D’Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., and van der Kolk, B. (2012). Understanding interpersonal trauma in children: why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, 82(2), 187–200.
3. Bernier, M.J., Hébert, M, and Collin-Vézina, D. (2013) Dissociative symptoms over a year in a sample of sexually abused children, *Journal of Trauma and Dissociation,* 14(4), 455-472.
4. ISSTD, Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents (2003), *Journal of Trauma and Dissociation* 5(3), 119-150.

Timed Outline

30 minutes: Introduction of students and instructors (not eligible for CEs)

30 minutes: Discussion of Readings A and D

30 minutes: Discussion of Readings A, C and D

30 minutes: Discussion of Reading B

30 minutes: Discussion of Reading D

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A, B, C and D if no case material available.

**R2**

Depersonalization and Derealization

Content Level: Advanced

Contributors:
Su Baker, MEd and Joan Turkus, MD

Module Description
Depersonalization/Derealization Disorder, one of the DSM-5 Dissociative Disorders, is a generally underdiagnosed and misunderstood disorder, whose lifetime prevalence is about 2% of the population. While depersonalization and derealization symptoms are found in a variety of other psychiatric diagnoses, depersonalization (the sense of detachment from one’s own self) and derealization (the sense of detachment from the world around, making it seem unreal) as diagnoses attest to the persistence and distressing symptoms, which color the experiences of the sufferer. Generally starting in the teens and often persisting over the lifespan, this disorder is difficult to treat. This module with explore the diagnosis, etiology, symptoms, affects and treatment of Depersonalization/Derealization Disorder

Objectives: After the completion of this class, participants will be able to:

1. Define Depersonalization/Derealization Disorder
2. Describe and discuss the etiology of Depersonalization/Derealization Disorder, it prevalence, and differential diagnosis
3. Discuss the research findings on depersonalization and affect
4. Discuss various treatment paradigms, including psychotherapeutic interventions and psychopharmacology, and their limitations

Readings

1. Michal, M. et al. (2016). A case series of 223 patients with depersonalization-derealization syndrome. *BMC psychiatry*, 16, 203.
2. Gentile, J. P., et al. (2014). Stress and trauma: psychotherapy and pharmacotherapy for Depersonalization/Derealization Disorder. *Innovations in Clinical Neuroscience.* 11(7-8), 37-41
3. Spiegel, D. (2017). Depersonalization/Derealization Disorder. *Merck Manual: Professional Version.*
4. Simeon, D. , Riggio-Rosen, A., Guralnik, O., Knutelska, M. & Nelson, D. (2003) Depersonalization Disorder: Dissociation and Affect, *Journal of Trauma & Dissociation*, 4:4, 63-76.

Timed Outline

30 minutes: Discussion of Reading A, C and D

30 minutes: Discussion of Readings A, C and D

30 minutes: Discussion of Reading D

30 minutes: Discussion of Reading B

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A, B, C and D if no case material available.

**R3**

Institutional Betrayal

Content Level: Advanced

Contributors: Jennifer Freyd, PhD; Warwick Middleton, MB BS, FRANZCP, MD; Bridget Klest, PhD; Carly Smith, PhD; Su Baker, MEd, edited by John O’Neil, MD

Module Description

In this module, institutional betrayal will be explored in a variety of settings with broad implications for abused victims.

Institutional betrayal occurs when an institution (academic, military, religious, commercial, legal, healthcare, etc.) fails to protect an individual against harm, or to respond effectively when harm occurs, when protection is a reasonable expectation. Victims, perpetrators, witnesses, and treaters may display betrayal blindness (denial) so as to preserve relationships, institutions, and social systems upon which they depend.

Institutional betrayal exacerbates the symptoms of traumatic stress, and the clinician ought to be sensitive to this interplay. Victims tend to leave institutions that have betrayed them, compromising their social supports. The treating healthcare system may itself constitute another institutional barrier facing the client, and the clinician ought to understand their own position within that context.

The betrayal of victims is documented as occurring in a wide range of institutions including churches, schools, scouting bodies, orphanages, universities, political organizations, police forces, sporting bodies etc. Credible evidence in multiple countries points to the existence at times of groupings of senior societal figures including politicians, involved in the sexual abuse of children. The large numbers involved in documented international web-based pedophile groupings points to the capacity of humans to organize around common interest, and how embedded organized abuse is in a society where the public image of such abusers is frequently one of total respectability. The findings of the globally unprecedented Australian Royal Commission into institutional aspects of child sexual abuse are enormously instructive in documenting the enormous resistance major institutions have to investigating child sexual abuse occurring within their structures.

Objectives: After the completion of this class, participants will be able to:

1. Define institutional betrayal, betrayal blindness and organized ongoing abuse
2. Examine and describe historical examples of organized abuse
3. Discuss how institutional betrayal complicates traumatic experiences.
4. Discuss the impact of institutional betrayal on the treatment of the trauma survivor

Readings

1. Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. *American Psychologist*, 69(6), 575. doi: 10.1037/a0037564.
2. Middleton, W. (2013). Parent-child incest that extends into adulthood: A survey of international press reports 2007-2011. *Journal of Trauma and Dissociation*, 14:2, 184-197.
3. Gómez, J. M. (2015). Microaggressions and the enduring mental health disparity: black Americans at risk for institutional betrayal. *Journal of Black Psychology*, 41(2), 121–143.
4. Gomez, J. M., Smith, C. P, Gobin, R. L., Tang, S. S., & Freyd, J. J. (2016). Collusion, torture, and inequality: understanding the actions of the American Psychological Association as institutional betrayal [editorial]. *Journal of Trauma & Dissociation,* 17, 527–544.
5. Smith, C. P. (2017). First, do no harm: institutional betrayal and trust in healthcare organizations. *Multidisciplinary Healthcare*, 10, 133-144.

Timed Outline

30 minutes: Discussion of Readings A and B

30 minutes: Discussion of Reading B

30 minutes: Discussion of Reading C and D

30 minutes: Discussion of Reading A and E

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A, B, C, D and E if no case material available.

**R4**

Psychopharmacology and medical consequences of complex trauma and dissociative disorders

Content Level: Advanced

Contributors: Richard Loewenstein, MD, Su Baker, MEd, Joan Turkus, MD; John O’Neil, editor

Module Description

The psychopharmacology is by webinar; the medical consequences are by published text.

Psychopharmacology: Many patients with complex trauma and dissociative disorders seek

relief of symptoms (including depression, intrusive and hyperarousal symptoms, sleep

disorders, etc.) with medications, not necessarily prescribed by physicians with knowledge

of the field. Dr Loewenstein bases this webinar on 35 years of experience in the

medication management of severely traumatized dissociative individuals. The webinar

addresses the role of psychopharmacology and somatic treatments such as

electroconvulsive therapy (ECT) in the treatment of patients with complex trauma and

dissociative disorders, in particular dissociative identity disorder (DID).

Medical consequences: For close to 25 years, the ACE studies have been collecting and

analyzing data on the outcomes of trauma, abuse and neglect in childhood and its impact

on health and illness in the adult population. Many of our patients have co-morbid chronic

health issues which complicate their lives, threaten their livelihoods, and impact their

families. Most do not recognize that their illnesses may be related to their childhood

traumas. Educating these patients in the medical outcomes of trauma, abuse and neglect,

as discussed in the ACE studies, can have a powerful effect on patients and their doctors.

This part of the module gives an overview of the ACE studies and some ideas for

educating others, including patients, doctors and other health and educational

professionals.

Objectives: After the completion of this class, participants will be able to:

1. Identify and discuss the use of medication in the treatment of complex trauma and dissociative disorders
2. Discuss the effects of childhood trauma and neglect on physical and mental health across the lifespan
3. Discuss the impact of understanding the role of trauma on medical sequelæ shared with clients with complex trauma and dissociative disorders

Readings and Webinars

# Lowenstein, R (2016). Rational and irrational psychopharmacology for complex trauma and dissociative disorders​. *ISSTD webinar 102204*. (to be viewed on one’s own, before the class, not during class time).

1. Middlebrooks, J. S., Audage, N. C. (2008). The effects of childhood stress on health across the lifespan. *Centers for Disease Control and Prevention, National Center for Injury Prevention and Control,* Atlanta GA.
2. Kendall-Tackett, K., Klest, B. (2009). Causal mechanisms and multidirectional pathways between trauma, dissociation and health (editorial). *Journal of Trauma and Dissociation*, 10, 129–134.
3. Oral, R., Rameriz, M., Coohey, C., Nakada, S., Walz, A. Kuntz, A., Benoît, J., Peek-Asa, C. (2016). Adverse childhood experiences and trauma-informed care: the future of health care. *Pediatric Research*, 79(1), 227-233.

Timed Outline

30 minutes: Discussion of Webinar A

60 minutes: Discussion of Readings B and C

30 minutes: Discussion of Reading D

30 minutes: Discussion of student’s disguised cases, or further discussion of webinar and readings A, B, C and D if no case material available.

**R5**

Neurobiology of complex trauma and dissociative disorders and research update

Content Level: Advanced

Contributors: Su Baker, MEd, Joan Turkus, MD, John O’Neil, MD

Module Description

This module explores research on the neurobiology of trauma and dissociation, the validity

of the diagnosis, as well as ongoing research into treatment of those with complex trauma

and dissociative disorders. The high correlation between early and severe trauma and

neglect in the developmental histories of people with complex posttraumatic and

dissociative disorders has inspired much research into the underlying neurobiology. How

do trauma and neglect during development affect normal neurobiology? How do genetics,

developmental adversity, and their interaction (genetic expression – epigenetics) lead to

different neurobiological pathways that ultimately give rise to various clinical expressions,

such as complex posttraumatic pathology with and without significant dissociation, and the

various dissociative disorders themselves? Research into treatment will focus especially

on the TOP DD (Treatment of Patients with Dissociative Disorders) study, now past its 6th

year of ongoing research. Specialized phasic, dissociation-focused treatment in this

population has shown significant reductions in stressors, sexual revictimization, and

psychiatric hospitalizations, and improved global functioning, safety, and quality of life.

Objectives: After the completion of this class, participants will be able to:

1. Describe how difference patterns of trauma and neglect give rise to different sets of neurodevelopmental effects
2. Examine and discuss the research that underlines the validity of the diagnosis of DID
3. Describe different neurobiological substrates of different categories of mental functioning across different diagnoses
4. Discuss how treatment approaches to complex posttraumatic and dissociative pathologies may be statistically researched and tested

Readings

1. Brand, B. L., McNary, S. W., Myrick, A. C., Classen, C., Lanius, R., Loewenstein, R. J., . . . Putnam, F. W. (2013). A longitudinal naturalistic study of patients with dissociative disorders treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(4), 301–308. doi:10.1037/a0027654
2. Dorahy, M.J., Brand, B.L., Sar, V., Kruger, C., Stavropoulos, P., Martinez-Taboas, A., Lewis-Fernandez, R. and Middleton, W. (2014) Dissociative identity disorder: An empirical overview. *Aust NZ J P*sychiatry 48: 402-417.
3. Frewen, P.A. and Lanius, R.A. (2014). Trauma-Related Altered States of Consciousness: Exploring the 4-D Model. *Journal of Trauma & Dissociation*, 15, 436–456.
4. Lanius, R.A. (2015). Trauma-related dissociation and altered states of consciousness: a call for clinical, treatment, and neuroscience research. European Journal of Psychotraumatology, 6(1) 1-9
5. Myrick, A.C., Webermann, A.R., Loewenstein, R.J., Lanius, R.A., Putnam, F.W. and Brand, B.L. (2017). Six-year follow-up of the treatment of patients with dissociative disorders study. *European Journal of Psychotraumatology*, 8, 1-7.
6. Sar, V., Dorahy, M.J. and Kruger, C. (2017) Revisiting the etiological aspects of dissociative identity disorder: A biopsychosocial perspective. *Psychology Research and Behavior Management* 2017:10 137–146.

Timed Outline

30 minutes: Discussion of Reading F

30 minutes: Discussion of Reading B ­

30 minutes: Discussion of Readings C and D

30 minutes: Discussion of Readings A and E

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A,B,C, D, E and F if no case material available.

**R6**

Shame and moral injury and their roles in complex trauma and dissociative disorders

Content Level: Advanced

Contributors: Martin Dorahy, PhD; Su Baker, MEd and Joan Turkus, MD, (edited by John O’Neil)

Module Description

This module focuses on the effect of shame in the understanding and treatment of

Complex trauma and dissociative disorders. To understand shame clinically and

theoretically it needs to be well differentiated from other closely related affects and

emotions, such as guilt. For example, the cognitive elements of shame pertain to

appraisals about the self, while for guilt, appraisals are associated with one’s actions. Like

guilt, shame can manifest in healthy ways (e.g., the threat of shame arising helps us

conform to social norms) and unhealthy ways (e.g., eroding self-esteem, as well as

relationships). More pathological manifestations of shame have been shown to be

particularly common in complex trauma and dissociative disorders, and have routinely

been shown to disrupt therapy if not worked through. Part of the therapeutic understanding

is to recognize different behavioral responses to experiencing shame or having it begin to

rise. Nathanson (1992) has proposed fours scripted responses: withdrawing, avoiding,

attacking oneself and attacking another. In DID for example, these different behavioral

scripts may be dominant in the psychological make-up of different identities (Kluft, 2007).

This module will look for how shame is related to complex trauma and dissociation, and

readings will allow a further understanding of the treatment process and related theoretical

foundations. In addition, the newer concept of moral injury is introduced as a subset of

shame and guilt, which impacts on spiritual and/or ethical beliefs.

Objectives: After the completion of this class, participants will be able to:

1. Define the effect of shame and differentiate it from related but distinct emotions
2. Discuss the importance of shame for understanding the clinical presentation of complex posttraumatic and dissociative disorders
3. Discuss treatment issues associated with working through shame in the therapy of those with complex posttraumatic and dissociative disorders
4. Define and discuss the concept of moral injury and its effect on the traumatized person

Readings and Webinars

1. Dorahy, M. (2015). Shame and Dissociation in Complex Trauma Disorder. ISSTD webinar. (To be watched on student’s own time, before the class.)

# Dorahy, M. J. (2017). Shame as a compromise for humiliation and rage in the internal representation of abuse by loved ones: Processes, motivations and the role of dissociation. Journal of Trauma and Dissociation, 18(3), 383-396.

# Jinkerton, J.D. (2016) Defining and assessing moral injury: A syndrome perspective. Traumatology, 22(2), 122-130.

1. Kluft, R. (2008). The use of Tomkins' innate affect theory and Nathanson's compass of shame in facilitating the understanding and treatment of DID and DDNOS. ISSTD Webinar. (To be watched on student’s own time, before the class)
2. Platt, M. & Freyd, J. (2011). Trauma and negative underlying assumptions in feelings of shame: an exploratory study. Psychological Trauma: Theory, Research, Practice, and Policy, 4(4), 370–378

Timed Outline

30 minutes: Discussion of Webinar A

30 minutes: Discussion of Reading B and E

30 minutes: Discussion of Webinar D

30 minutes: Discussion of Reading C

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A, B, C, D and E if no case material available

**Elective modules (Instructors choose three of the following modules to cover in the course. Modules selected are offered in order. Please note that if the instructor chooses to offer Elective Module 6 the course will not be eligible for ASWB ACE continuing education credit.)**

**E1**

Addictions and Eating Disorders

Content Level: Advanced

Contributors: Su Baker, MEd and Joan Turkus, MD

Module Description

Of the many co-morbid conditions that pose enormous challenges in treating clients with complex posttraumatic and dissociative disorders, addictions and eating disorders are among the most common, and the most difficult to treat. Understanding the role of childhood trauma, abuse and neglect in the etiology of addictions and eating disorders is of paramount importance.

In this module, we examine research into the childhood antecedents of addictions, as well as what posttraumatic symptoms are significant in the development of addictions and substance abuse in our patients. Treatment needs of dissociative patients with substance abuse problems will be discussed as well as outcomes of those in residential treatment facilities whose trauma histories are addressed. Equally important are the significant determinants of eating disorders in samples of women with histories of trauma and abuse, and the implications for treatment. The need for strategies for self-regulation is highlighted in the survivor’s use of substances and eating behaviours. The relationship of dissociation and eating disorders is explored, especially its relevance to binge eating.

Objectives: After the completion of this class, participants will be able to:

1. Discuss the role of early childhood trauma on the etiology of substance abuse and eating disorders
2. Discuss the role of dissociation in eating disorders, and in particular binge eating and/or bulimia
3. Address the need to develop trauma-informed programs and methods of treatment of patients with addictions and eating disorders

Readings

1. Brewerton, T.D. and Brady, K (2014). The role of stress, trauma, and PTSD in the etiology and treatment of eating disorders, addictions, and substance use disorders. In T. D. Brewerton and A. B. Dennis (eds.), *Eating Disorders, Addictions and Substance Use Disorders*, pp. 379-404, Berlin, Heidelberg: Springer-Verlag.
2. Najavits, L.N, Hyman, S.M, Ruglass, L.M, Hien, D.A and Read, J.P. (2017) Substance Use Disorder and trauma. In Gold, S.N. (ed) APA *Handbook of Trauma Psychology, Vol. 1: Foundations in Knowledge.* pp. 195-213, Washington, DC: American Psychological Association.
3. Sacks, J. Y., McKendrick, K., Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment,* 34, 90–100.
4. Covington, S. S. (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs*, 40, 377-385.
5. Palmisano, G. L., Innamorati, M., Susca, G., Traetta, D., Sarracino, D., & Vanderlinden, J. (2018). Childhood traumatic experiences and dissociative phenomena in eating disorders: level and association with the severity of binge eating symptoms. *Journal of Trauma & Dissociation*, 19(1), 88-107.

Timed outline

45 minutes: Discussion of Readings A and B

30 minutes: Discussion of Reading E ­

45 minutes: Discussion of Readings C and D

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A, B, C, D and E if no case material available.

**E2**

Couples Therapy

Content Level: Advanced

Module Description

Relational (betrayal) trauma and its posttraumatic and dissociative sequelæ typically complicate relational functioning with difficulties in communication, pair-bonding, desire and sexual arousal. The fearful-avoidant attachment style typical of relational trauma survivors features an alternation between fluctuating and competing needs for closeness, and overt avoidance. Partner responses to trauma survivors may maintain or even exacerbate posttraumatic symptoms or else such partners may suffer vicarious traumatization and adopt maladaptive coping.

One third of couples presenting for couple therapy will have one or both partners a relational trauma survivor; such couples have a higher divorce rate and are challenging to treat.

Childhood trauma survivors have difficulty listening and not becoming defensive and overwhelmed with emotion, especially shame, when negotiating unmet needs and perceived hurts. Their partners have difficulty acknowledging their role in the conflict and repairing the relationship ([MacIntosh, 2013](#_ENREF_10); [MacIntosh & Johnson, 2008](#_ENREF_11)). In couple therapy, there is a need for enhanced safety, affect regulation skills as well as psychoeducation regarding the difference between re-enactments of past trauma and here-and-now relational challenges and facilitation of secure bonding interactions. The therapist as a new attachment figure may be an added challenge for survivors with attachment insecurity, complicating emotion regulation, and perspective taking.

This module will explore the role of trauma and dissociation in various treatment paradigms with couples.

Objectives: After the completion of this class, participants will be able to:

1. Outline the symptomatology and attachment patterns engendered by relational trauma, and their repetition in couple relationships
2. Define the challenges unique to childhood sexual trauma survivors in couple therapy
3. Describe the process of reenactment and its effect on relational conflict, on both the childhood sexual trauma survivor and also on his/her partner

Readings

1. Dalton, E.J., Greenman, P.S., Classen, C. & Johnson, S.M. (2013) Nurturing Connections in the Aftermath of Childhood Trauma: A Randomized Controlled Trial of Emotionally Focused Couple Therapy for Female Survivors of Childhood Abuse, *Couple and Family Psychology: Research and Practice*, Vol. 2, No. 3, 209–221.
2. MacIntosh, Heather B. (2017). Working with male survivor couples, In Richard Gartner, ed.: *Healing Sexually Betrayed Men and Boys: Treatment for Sexual Abuse, Assault, and* *Trauma*. Chapter 12, pp.233-260, Routledge.
3. MacIntosh, Heather B. (2012). Dissociative Identity Disorder and the process of couple therapy. *Journal of Trauma and Dissociation*, 14( 1), 84-96.
4. Weinberg, M., Besser, A., Ataria, Y., & Neria, Y. (2016). Survivor-spouse dissociation and posttraumatic stress disorder: Personal and dyad relationships. *Journal of Trauma and Dissociation*, 17(4), 448-459.

Timed outline

30 minutes: Discussion of Reading A

45 minutes: Discussion of Readings B and C

30 minutes: Discussion of Reading D

45 minutes: Discussion of student’s disguised cases, or further discussion of readings A,B,C and D if no case material available.

**E3**

EMDR

Content Level: Advanced

Contributors: Joanne Twombly, MSW, LICSW & Su Baker, MEd, edited by John O’Neil, MD

Module Description

Eye Movement Desensitization and Reprocessing (EMDR), as developed by Francine Shapiro for the treatment of trauma, has been used in clinical practice for more than three decades. The use of EMDR with clients with DID and other dissociative disorders has been something that has required careful adaptation (Shapiro, 2001) to allow the unique benefits of EMDR to be used productively, without the risk of unleashing a flood of traumatic material and destabilizing the client. The EMDR Dissociative Disorders Task Force Recommended Guidelines (Shapiro, 2001) recommends that clinicians using EMDR with DD clients have solid EMDR skills, and prior training and experience in working with DD clients.

The required readings in this module are basic to using EMDR with complex trauma and dissociative disorder clients. They outline the research into the use of EMDR as an effective treatment in all stages of therapy. Various adaptations of the standard protocol are covered for Stages 1, 2 and 3. This is compared to other forms of treatment protocols, some of which can be used together with EMDR. Care in using EMDR with dissociative clients is discussed, especially the use of titration of abreactive work in the second stage of treatment.

The recommended readings will provide further options, and information about the use of EMDR with this population. **It is necessary to receive further training to utilize EMDR in the treatment of complex trauma and dissociative disorders.**

Objectives: After the completion of this class, participants will be able to:

1. Discuss the development of EMDR as a tool for treating complex trauma and dissociative disorders
2. Develop an understanding of how to incorporate EMDR adaptations to facilitate stabilization, orient DD clients to the present, and decrease negative transferences
3. Discuss how to prepare a client for trauma processing and how to process traumatic material using a protective EMDR protocol, and to appreciate the need for further training in this process
4. Describe and discuss the complexities of dissociative disorders and approaches to treating them with EMDR

Readings

1. Twombly, J.H. (2000). Incorporating EMDR and EMDR Adaptations into the Treatment of Clients with DID.  *Journal of Trauma and Dissociation*, Vol. 1(2), pp. 61-81
2. Paulsen, S. (2018) Neuroaffective Embodied Self Therapy (NEST): An Integrative Approach to Case Formulation and EMDR Treatment Planning for Complex Cases. *Frontiers in the Psychotherapy of Trauma and Dissociation*, 1(2):135–159
3. Knipe, J.(2015). The CIPOS procedure. Chapter 13 in *EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation.* New York, NY: Springer.
4. Gelinas, D. (2003). Integrating EMDR into phase-oriented treatment for trauma. *Journal of Trauma and Dissociation*, 3(3), 91-135.
5. Gonzales A., (2018) Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures, *Frontiers in the Psychotherapy of Trauma and Dissociation,* 1(2):192–211.

Additional material

Knipe, Jim (2016). The Method of Constant Installation of Present Orientation and Safety

Timed outline:

30 minutes: Discussion of Readings A and D

30 minutes: Discussion of Reading C

30 minutes: Discussion of Readings A and D

30 minutes: Discussion of Reading E

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A,B,C, D and E if no case material available.

**E4**

Clinical Hypnosis

Content Level: Advanced

Contributors: Richard Kluft, MD; Su Baker, MEd; edited by John O’Neil, MD

Module Description

Hypnosis-facilitated treatments of Dissociative Identity Disorder (DID) have provided the most successful series reported to date, making the study of clinical hypnosis a subject of profound importance to the dissociative disorders field. This module will review the history, theoretical understanding, and current definitions of hypnosis. It will explore the connection between hypnotizability and the dissociative disorders, and discuss the implications of high hypnotizability for their treatment. Finally, it will demonstrate the many techniques associated with hypnosis that have proven useful in the treatment of DID, and encourage students to take formal training in hypnosis. The specialized use of hypnosis-based Ego State Therapy will also be explored. **Those untrained in hypnosis should not make use of hypnotic techniques in practice.**

Objectives: After the completion of this class, participants will be able to:

1. List 8 or more hypnotic techniques useful in the treatment of DID

2. Discuss the importance of de-hypnosis in the treatment of DID

3. List techniques appropriate for use in beginning, containing, and terminating abreactions

4. Discuss ego-state therapy and its relevance to treating complex trauma and dissociative disorders, especially DID

Readings

1. Elkins, G., Barabasz, A., Council, J., & Spiegel, D. (2015). Advancing research and practice: the revised APA Division 30 definition of hypnosis. International *Journal of Clinical and Experimental Hypnosis*, 60, 1-9.
2. Kluft, R.P. (2012). Issues in the detection of those suffering adverse effects in hypnosis training workshops. *American Journal of Clinical Hypnosis*, 54(3), 213-232.
3. Kluft, R.P. (2012). Hypnosis in the treatment of Dissociative Identity Disorder and allied states: An overview and case study. *South African Journal of Psychology,* 42, 146-155.
4. Watkins, H.H. (1993). *Ego-State Therapy: an overview. American Journal of Clinical Hypnosis*, 35(4), 232-240.

Timed outline:

45 minutes: Discussion of Reading A

15 minutes: Discussion of Reading B

30 minutes: Discussion of Readings C

30 minutes: Discussion of Reading D

30 minutes: Discussion of student’s disguised cases, or further discussion of readings

A,B,C and D if no case material available

**E5**

Sexual victimization of men and boys and its outcomes

Content Level: Advanced

Contributor: Su Baker, MEd (edited by John O’Neil, MD)

Module Description

Most research in the area of childhood sexual abuse, its phenomenology and long-term psychological, social and medical outcome focusses on women, given their prevalence in clinical practice. However, there is now a growing body of literature focusing on the sexual victimization of boys and men. This module explores some of the similarities and differences in disclosure, presentation and psychotherapy of men who were sexually abused as boys and adolescents.

Because of various factors, including feelings of shame and guilt, masculine stereotypes, fear of being blamed for the abuse, denial, etc., men in therapy often do not report sexual abuse histories to their therapists. Thus, it is important that therapists be aware of possible indicators of childhood sexual abuse (CSA) so that appropriate questions about CSA history be included in assessment and interventions. As well, since some male CSA survivors have not recognized that their early sexual history constitutes sexual abuse, despite their deeply ambivalent feelings about their experiences, understanding the role of betrayal by trusted adults in their lives, and the circumstances around them, is paramount. Finally, working therapeutically with men entails some differences when it comes to treating the complex posttraumatic and dissociative disorders that result from male CSA.

Objectives: After the completion of this class, participants will be able to:

1. Discuss the social and psychological obstacles that men face in disclosing a history of CSA
2. Discuss the impact of betrayal on boys and men and its impact on psychotherapy
3. Describe and discuss the psychological outcome of male CSA, especially in those who had never disclosed until later in life

Readings

1. Alaggia, R., Millington, G. (2008). Male child sexual abuse: a phenomenology of betrayal. *Clinical Social Work Journal*, 36, 265–275. DOI 10.1007/s10615-007-0144-y.
2. Easton, S.D. (2013). Disclosure of child sexual abuse among adult male survivors. *Clinical Social Work Journal*, 41, 344–355. DOI 10.1007/s10615-012-0420-3.
3. Dorahy, M.J., Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: a qualitative investigation. *Journal of Child Sexual Abuse*, 21, 155–175. DOI 10.1080/10538712.2012.659803.
4. Sigurdardottir, S., Halldorsdottir, S., Bender, S. (2012). Deep and almost unbearable suffering: consequences of childhood sexual abuse for men’s health and well-being. *Scandinavian Journal of Caring Sciences*, 26, 1-10.

Timed Outline

30 minutes: Discussion of Reading B

30 minutes: Discussion of Reading A

30 minutes: Discussion of Readings C and D

60 minutes: Discussion of student’s disguised cases, or further discussion of readings A,B,C, D and E if no case material available.

**E6**

Sensorimotor therapy and yoga

Content Level: Advanced

Contributors: Pat Ogden, PhD & Lisa Danylchuk, LMFT; edited by John O’Neil, MD

Module Description

This module clarifies the relationship between dissociative parts of the self and discrete

psychobiological behavioral or “action” systems that are aroused in response to conflicting

demands of defense and avoidance. Physical actions of diverse parts of the personality

can vary widely, depending on the action systems that influence the part. Since action

systems are inherently physical in nature, the lack of integration among parts can be

clearly perceived in the lack of integration in the patient’s movements, and thus, work with

the body can be a powerful avenue of integration, through sensorimotor therapy and yoga.

Sensorimotor therapy

In this section of the module, students will learn interventions from Sensorimotor

Psychotherapy that highlight the use of controlled actions to help overcome traumatic

repetitions, integrate defensive action systems with those of daily life and support

integration of both body and mind.

Yoga

This section of the module addresses how mental health therapists can bring the body into

treatment in a manner that is both trauma-informed and responsive to the specific needs of

each client. The common roots of yoga philosophy and trauma treatment will be explored,

including how posture, movement, yoga shapes, and breathing techniques can positively

impact clients, providers, and the therapeutic relationship. While students will learn the

basics of yoga philosophy and practice, they should receive additional training prior to

teaching yoga postures or sequences to clients.

Objectives: After the completion of this class, participants will be able to:

1. Describe three somatic resources to promote stabilization (Phase 1 goals).
2. Explain the importance of completing truncated mobilizing defensive actions (Phase 2 work with traumatic memory).
3. Discuss potential risks and benefits of integrating yoga into trauma treatment.
4. Define philosophical roots of yoga and apply them to current best practices in trauma treatment.

Readings:

1. Ogden, P & Fisher, J. (2014). Integrating body and mind: Sensorimotor psychotherapy and treatment of dissociation, defense, and dysregulation. In U. Lanius, S. Paulsen, & F. Corrigan (eds.), *Neurobiology and treatment of traumatic dissociation: Towards an embodied self* (pp. 399-422). New York, NY:  Springer Publishing Company.
2. Gene-Cos, N., Fisher, J., Ogden, P., Cantrell, A. (2016). Sensorimotor psychotherapy group therapy in the treatment of complex PTSD*. Ann. Psychiatry* *Ment. Health*, 4(6), 1080.
3. Maggi Price, M., Spinazzola, J., Musicaro, R.,Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017) Effectiveness of an Extended Yoga Treatment for Women with Chronic Posttraumatic Stress Disorder. *The Journal of Alternative and Complementary Medicine,* 23(4), 300-309.
4. Telles, S., Singh, N., & Balkrishna, A. (2012). Managing mental health disorders resulting from trauma through yoga: a review. *Depression Research and Treatment*, vol. 2012, Article ID 401513.

Timed outline:

30 minutes: Discussion of Readings A and B

30 minutes: Discussion of Readings A and B

30 minutes: Discussion of Reading C

30 minutes: Discussion of Reading D

30 minutes: Discussion of student’s disguised cases, or further discussion of readings

A,B,C and D if no case material available

**E7**

Suicidality and non-suicidal self-injury

Content Level: Advanced

Contributor: Su Baker, MEd

Short description of content

Suicidality and non-suicidal self-injury (NSII) are very prevalent in those with complex

trauma and dissociative disorders. This module explores research into the role of complex

trauma and dissociative disorder in both suicide and non-suicidal self-injury and whether

dissociation in and of itself is a mediator in non-suicidal self-injury. As an outcome of the

research, methods of assessing and treating suicidal acts and non-suicidal self-injury is

discussed. Students are encouraged to consider their responses to their clients’ suicidal

acts as well as client’s non-suicidal self-injury in light of the research.

Objectives: After the completion of this class, participants will be able to:

1. Discuss differences between suicidal ideation and attempts and non-suicidal self-injury in trauma survivors
2. Discuss the role of dissociation in suicidal acts and non-suicidal self-injury
3. Discuss the impact of the research in the assessment and treatment of suicidal acts and non-suicidal self-injury.
4. Discuss countertransference responses to clients’ suicidal acts and NSSI.

Readings

1. Ford, J.D. & Gómez, J.M. (2015) The Relationship of Psychological Trauma and Dissociative and Posttraumatic Stress Disorders to Nonsuicidal Self-Injury and Suicidality: A Review, *Journal of Trauma & Dissocia*tion, 16:3, 232-271.
2. Ford, J.D. & Gómez, J.M. (2015) Self-Injury and Suicidality: The Impact of Trauma and Dissociation, *Journal of Trauma & Dissociation*, 16:3, 225-231
3. Franzke, I, Wabnitz, P & Claudia Catani, C (2015) Dissociation as a Mediator of the Relationship Between Childhood Trauma and Nonsuicidal Self-Injury in Females: A Path Analytic Approach, *Journal of Trauma & Dissociation*, 16:3, 286-302
4. Webermann, A.R., Myrick, A.C., Taylor, C.L., Chasson, G.S. & Brand, B.L. (2016) Dissociative, depressive, and PTSD symptom severity as correlates of nonsuicidal self-injury and suicidality in dissociative disorder patients, *Journal of Trauma & Dissociation*, 17:1, 67-80.

Timed Outline

30 minutes: Discussion of Readings A and B

30 minutes: Discussion of Reading C

30 minutes: Discussion of Readings A, B and D

30 minutes: Discussion of Readings A, B, C and D

30 minutes: Discussion of student’s disguised cases, or further discussion of readings A,B,C and D if no case material available.