



International Society for the Study of Trauma and Dissociation
Professional Training Program:
Level III

Advanced topics in Complex Trauma and Dissociative Disorders

Curriculum for 2024

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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.

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 available immediately upon registration.

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 sessions. Each session is “free-standing” in that it encompasses an entire topic to be covered in a single class.

Session One - 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)

Session 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 as 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 session 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 - optional)
- 30 minutes: Discussion of Readings 1 and 4
- 30 minutes: Discussion of Readings 1,3, and 4
- 30 minutes: Discussion of Reading 2
- 30 minutes: Discussion of Reading 4
- 30 minutes: Discussion of student's disguised cases, or further discussion of readings A, B, C and D if no case material available.

Session Two - Depersonalization and Derealization

Content Level: Advanced

Contributors:

Su Baker, MEd and Joan Turkus, MD

Session 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 session will 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, its 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. Simeon, D. (2014). Depersonalization/Derealization Disorder. Chapter 5 in Gabbard, G., *Gabbard's Treatments of Psychiatric Disorders, Fifth Edition*, pp. 459-469. Washington, DC: American Psychiatric Press.
3. 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 1 and 2– defining depersonalization and derealization
30 minutes: Discussion of Readings 1 and 2– etiology, prevalence and differential diagnoses in Depersonalization/derealization disorder
30 minutes: Discussion of Reading 3 – research on depersonalization and affect
30 minutes: Discussion of Reading 2 – some treatment paradigms, including pharmacological, for working with Depersonalization/derealization disorder
30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, and 3 if no case material available.

Session Three - 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

Session Description

In this session, 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 1 and 2

30 minutes: Discussion of Reading 2

30 minutes: Discussion of Reading 3 and 4

30 minutes: Discussion of Reading 1 and 5

30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3, 4 and 5 if no case material available.

Session Four - 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

Session 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 session 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

1. 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).
2. 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*.
3. 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.
4. Oral, R., Rameriz, M., Coohy, 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 1

60 minutes: Discussion of Readings 2 and 3

30 minutes: Discussion of Reading 4

30 minutes: Discussion of student's disguised cases, or further discussion of webinar and readings 1, 2, 3 and 4 if no case material available.

Session Five - Neurobiology of complex trauma and dissociative disorders and research update

Content Level: Advanced

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

Session Description

This session 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 Psychiatry* 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 6
 30 minutes: Discussion of Reading 2
 30 minutes: Discussion of Readings 3 and 4
 30 minutes: Discussion of Readings 1 and 5
 30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3, 4, 5 and 6 if no case material available.

Session Six - 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)

Session Description

This session 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 four 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 session 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.)

2. 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.
3. Jinkerton, J.D. (2016) Defining and assessing moral injury: A syndrome perspective. *Traumatology*, 22(2), 122-130.
4. Kluff, 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)
5. 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 1

30 minutes: Discussion of Reading 2 and 5

30 minutes: Discussion of Webinar 4

30 minutes: Discussion of Reading 3

30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3, 4 and 5 if no case material available

Session Six - Addictions and Eating Disorders

Content Level: Advanced

Contributors: Su Baker, MEd and Joan Turkus, MD

Session 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 session, 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 1 and 2

30 minutes: Discussion of Reading 5

45 minutes: Discussion of Readings 3 and 4

30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3, 4 and 5 if no case material available.

Session Eight - Sexual victimization of men and boys and its outcomes

Content Level: Advanced

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

Session 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 session 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 2

30 minutes: Discussion of Reading 1

30 minutes: Discussion of Readings 3 and 4

60 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3 and 4 if no case material available.

Session Nine - Suicidality and non-suicidal self-injury

Content Level: Advanced

Contributor: Su Baker, MEd

Session Description

Suicidality and non-suicidal self-injury (NSII) are very prevalent in those with complex trauma and dissociative disorders. This session 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 & Dissociation*, 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 1 and 2

30 minutes: Discussion of Reading 3

30 minutes: Discussion of Readings 1, 2 and 4

30 minutes: Discussion of Readings 1, 2, 3 and 4

30 minutes: Discussion of student's disguised cases, or further discussion of readings 1, 2, 3 and 4 if no case material available.