WORKING WITH PATIENTS WITH COMPLEX DISSOCIATIVE PRESENTATIONS
DAY TWO

Dr Melanie Temple MBChB MRCPsych
Consultant Psychiatrist & Psychotherapist

MoD Military Mental Health Services
Previously
Complex Trauma & Dissociation Services,
Kemp Unit, Schoen Clinic York.

Karen
Expert By Experience

Recap of Day 1……

- What dissociation is & spectrum of presentations
- Theories to why it happens and thoughts on why it becomes a problem
- Structural model of dissociation & linked diagnoses
- Presentations in clinic
- Assessment & diagnosis approaches
- Comorbidity
- Intro to treatment
  - General points
  - Resourcing incl grounding, triggers
  - Role of shame, invisibility & guilt in triggering & impacts in treatment behaviours
  - Challenges

Working with Complex Dissociative Presentations Day 2 - Plan for the Day

- 10.00- 10.15 Intro & small group discussion ‘what do I want from the day’ with feedback
- 10.15 - 12.00 The ‘basics’ & general guidelines of management
- 12.00 – 13.00 Lunch
- Please put questions not answered within the session in the chat over lunch
- 13.00 – 13.15 Group feedback & answers
- 13.15 – 15.00 Strategies for working on the ‘intrapersonal’ in dissociative disorders incl. DID
- Questions into chat function as going along & will endeavour to pause review & answer as going along ☺

Dissociative Presentations & Disorders - General Treatment Goals

'Desired Future'

What does recovery look like?

- **Safety** – personal responsibility & agency, all aspects of risk from "self" & 'to self' from others
- **Acceptance & Accountability**
- **Stability** –psychological skills & resilience
- **Improved functioning** – "system & symptoms" based, tackling avoidance, social & occupational based in the "real world"
- **Positive relational experience** to encourage continued engagement with positive relationships of whatever sort
  - TEDx – Harvard 75 year Study "what makes a good life?"
- **Instillation of self understanding & compassion, hope & agency**
- **Provision of safe opportunities to explore and start the "new path of recovery" to their desired future**

HOPE

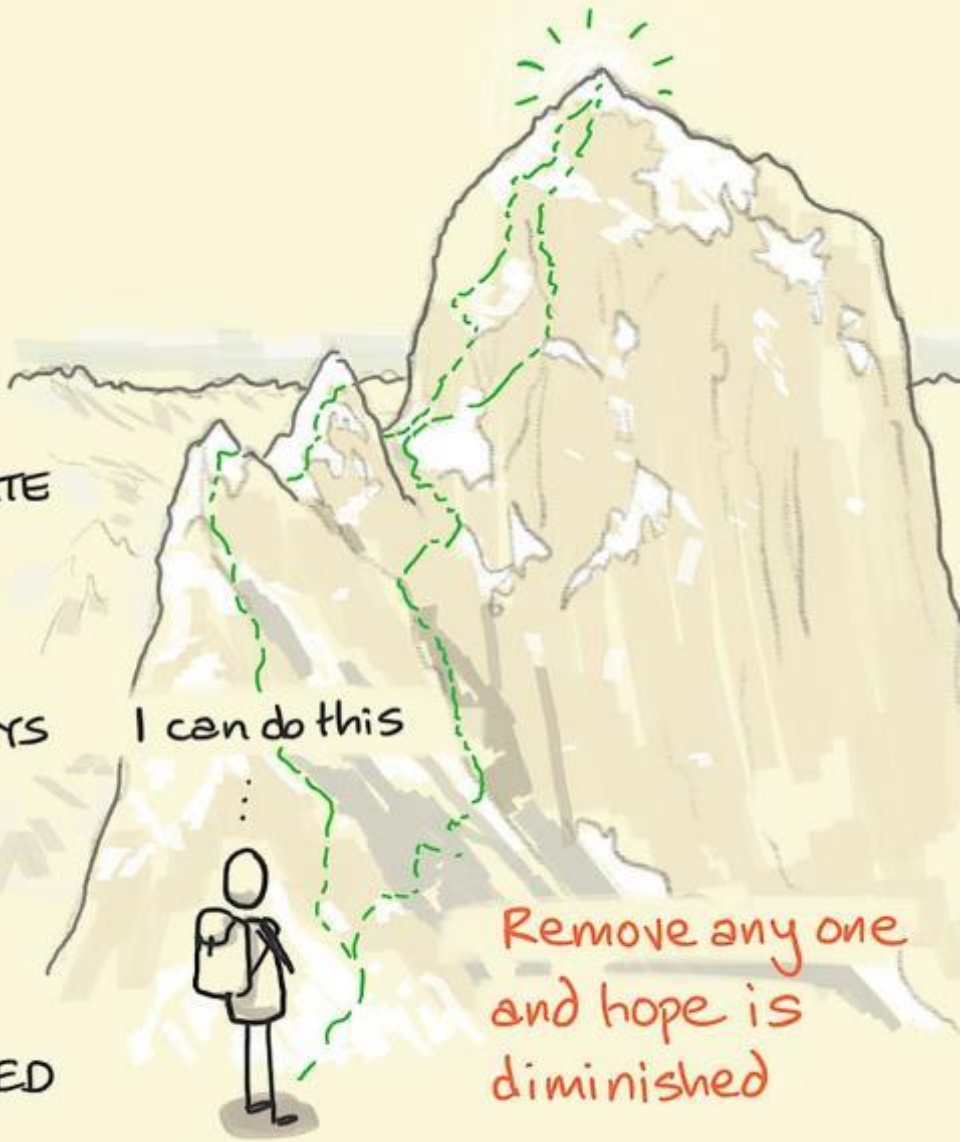
MORE THAN A FEELING

To feel hopeful you need

1. GOALS
   A DESIRED FUTURE STATE
   TO AIM FOR

2. PATHWAYS
   SEEING DIFFERENT WAYS
   TO YOUR GOALS

3. WILLPOWER
   BELIEF IN YOUR AGENCY
   AND ABILITY TO SUCCEED

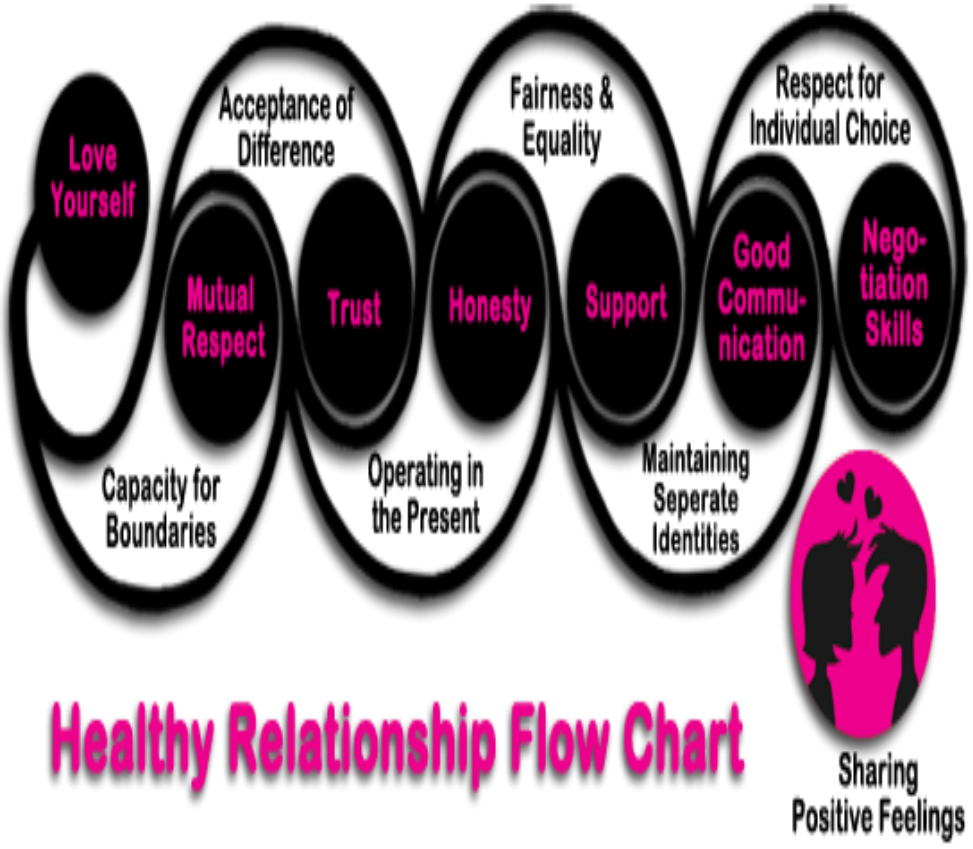


FRAMEWORK: CR SNYDER

sketchplanations

Complex Dissociative Presentations Treatment – General Points

- **Relationships are fundamental to and at the core of recovery**
  - Key harms occur in the interpersonal context
  - This in-turn impacts on our interpersonal functioning and so directly impacts on our ability to meet interpersonal needs / access support
  - Healing is achieved through relationships



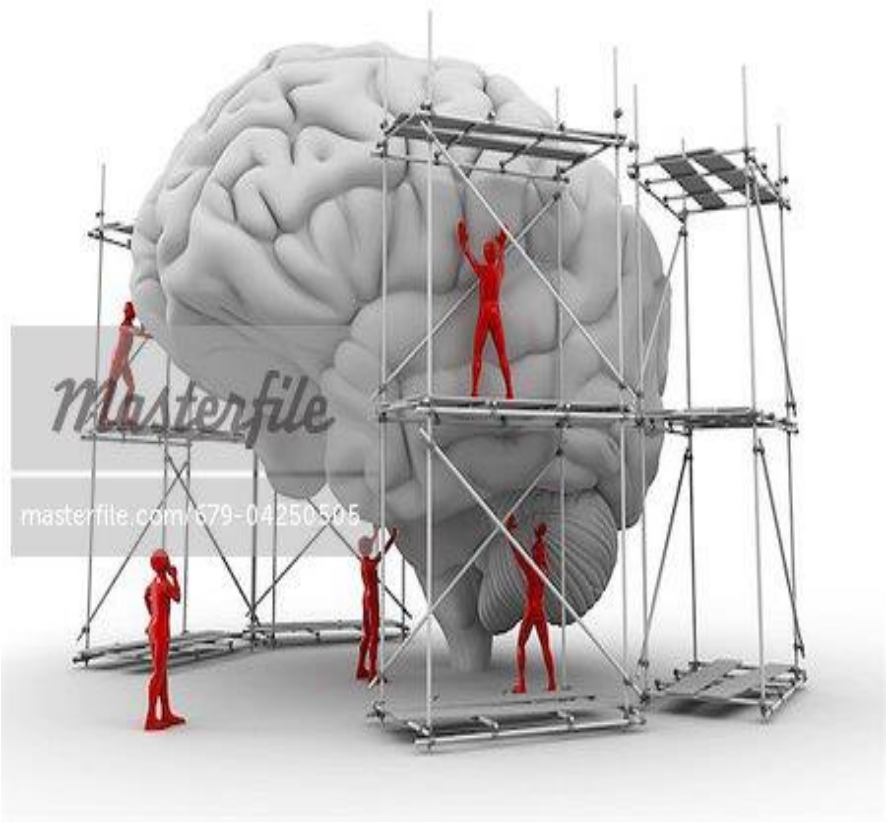
Complex Dissociative Presentations Treatment – General Points

- Consistency
- Appropriately boundaried
- Responsive
- Modelling positive relational functioning
- Compassionate, curious, non judgmental, understanding and empathic… truthful

Complex Dissociative Presentations Treatment – General Points

- 'Treatment' duration average **5-10 years** but….. **the composition & content of this should vary**
- Interpersonal & Socio-occupational recovery BIG part – needs as much (if more) focus as therapy
- 'Episodes of therapy' approach
- Community & inpatients may be part of the pathway depending on need / risk
- Importance of crisis planning

Important to remember timeframes when we are considering what changes we should see in the patients



Complex Dissociative Presentations
"The Basics" - Factors for consideration

- Relational & Attachment Framework needs to underpin all
  - Training delivery where needed
- Support general points delivery approach in **all staff**
- "Team working" –avoid replicating the disconnect
- Risk Assessment & Management Plans needs to be informed by all aspects of the patients interventions & care plan
  - Use of risk formulation key
- Skills Development – Group programme, therapy work, OT, key nurse & staff interventions
- Use of Physical, Green & Animal interventions
  - Sensory & physical integration OT assessments
- Socio-occupational recovery interventions – purpose & opportunities for relational development

Complex Dissociative Presentations

Helicopter Trauma Timeline Outline:

"I want us to just have an idea as if a view from a helicopter – can be as far up a needed"

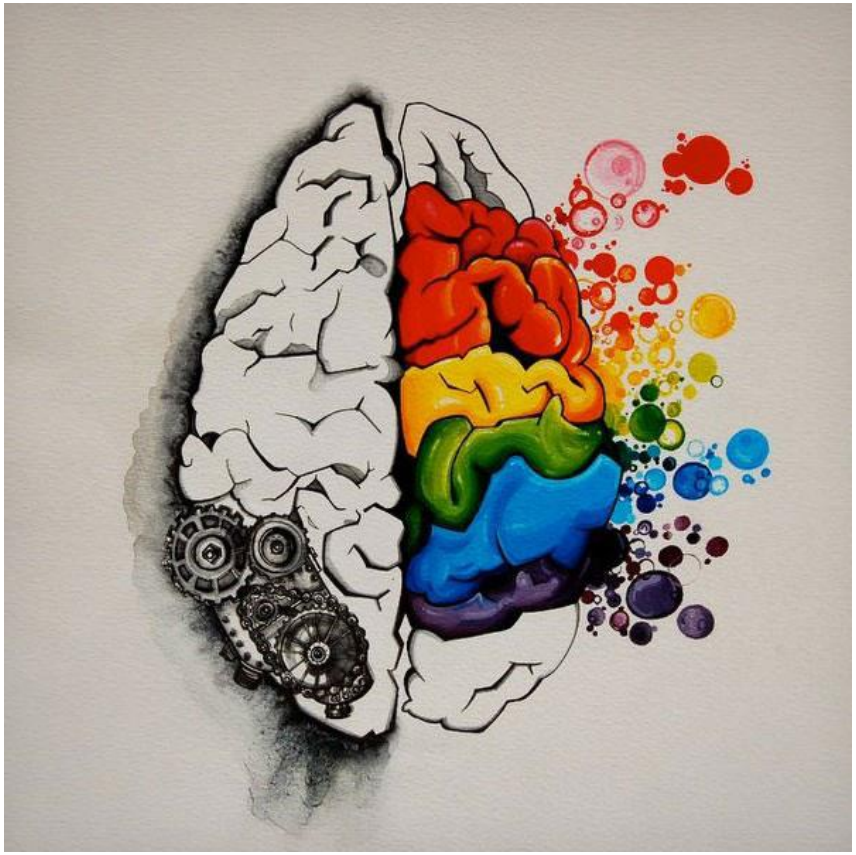
Yes or No (tick or X) or Don't know

Different trauma types – interpersonal / medical / environmental

- Age band: 0-5, 5-10, 10-15, 15-20, 20-25, 25 onwards
- Single event / multiple events
- Known / Unknown perpetrator
- Single / multiple perpetrator
- Inside home / outside home
- Help sought? – if Yes response Good / bad / ignored

Complex Dissociative Presentations
The patients experience of the clinical space should be……

- A safe, containing & validating place to explore and develop understanding of the "whole" of themselves
- A safe space to be vulnerable & practice new skills
- A space in which to learn that others can be ok & that 'I' matter (as much as others)



Complex Dissociative Presentations
Triggers need to inform care plans & interventions
BUT not promoting avoidance looking to find strategies

Dissociation

Interpersonal interactions incl. abandonment

Experience of need / vulnerability incl attachment

Emotions – esp anger & shame

Complex Dissociative Presentations Consideration for services in care delivery

- Ability to deliver multi-clinician assessments with access to appropriate therapy
- Relational approach with consideration to triggering and informed by internal / external impacts
  - Use of regular case formulation discussion
- Staff to require specific skill sets to support such as grounding, symptoms monitoring, behavioural & communication analysis, solutions development & review
- High weighted focus on interpersonal & socio-occupational recovery
- Regular team case supervision
- Groupwork adapted to potential for dissociation and presence of DID
- Therapy approaches 'Integrated' - Drawing from psychological approaches to specific areas of dysfunction
  - Collaborative identification, discussion and documentation
  - Agreements around work with regular reviews
  - Specialist supervision

Joined up working with care plans informed by all staff

Skills base for all staff around dissociation & complex trauma with co-production

Team Roles & Responsibilities

Helpful to identify to assist joined up working (clinical family around the patient)

- Psychiatrist (Dad)
  - Diagnosis
  - Case overview
  - Risk – MHA / MCA
  - Medication
- Psychologist (Mum)
  - Formulation
  - Relational & attachment work
  - Promotion of self care
- Therapists (Coach & guide)
  - Specific DID & Trauma work
- Care Co / Key Nurse/ OT (Big Sib / Mentor)
  - Symptom monitoring
  - Skills coaching
  - Supporting communication / work directed by therapist
  - Care & intervention planning
  - Risk
- Support workers (Sibs)
  - Relational work
  - Symptom monitoring
  - Skills coaching

Roles – ‘Ship, Captain & Crew’ Metaphor

The Journey destination - Recovery
The Ship – The body
The Captain – The patient
The Crew

- Therapist is the navigator
- Psychiatrist is the medic & safety officer
- Care co / key nurse / OT / SW are the first mates
- The rest of the team make up the support crew

The captain decides the destination and the rest of the crew assist them to get there.

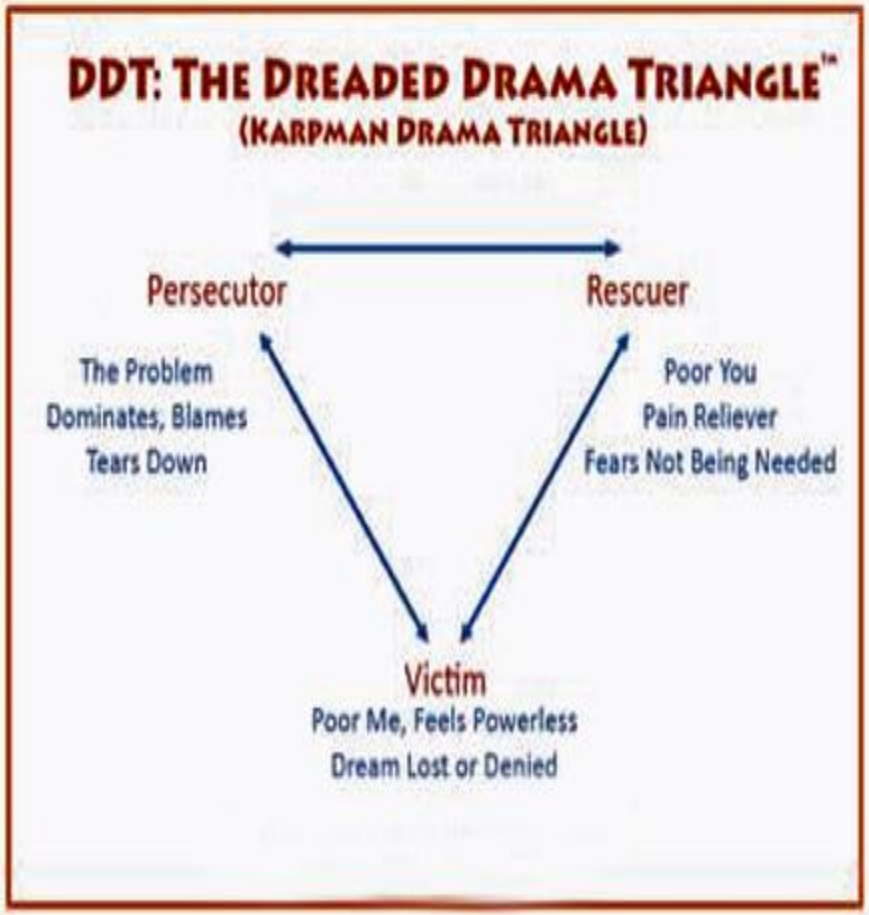
The captain has a responsibility to look after the ship and achieve the safe arrival to their destination

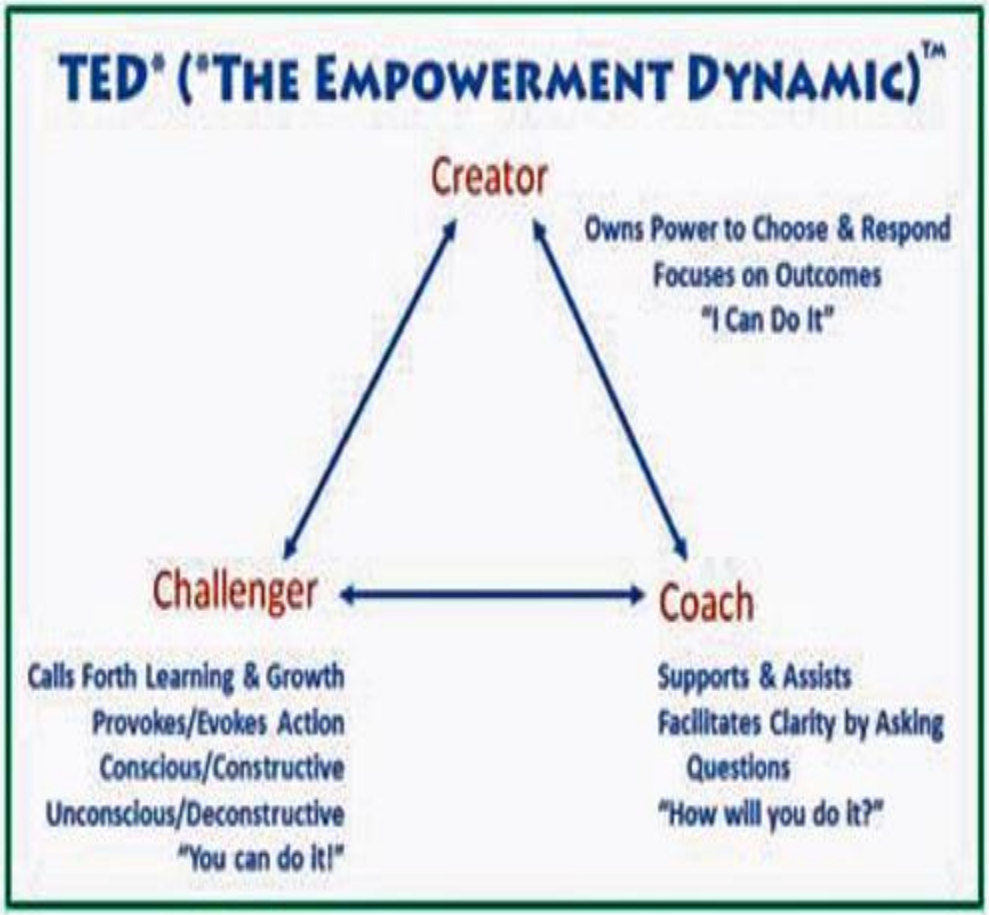
The crew are responsible to inform the captain of possible pitfalls / issues & support in finding the remedy

The crew can mutiny & temporarily take control to assist if absolutely needed to protect life but can’t productively remain this way for long

The crew have the option to ‘step off’ if they feel despite best advice & support the Captain still makes the choice to put in the face of harm (treatment breaks)

How to make bad relationships good





Complex Dissociative Presentations

So how do we think about what we are seeing?

Setting dependent

- **Specialist Therapy**

  Look to detailed understanding & direct engagement

- **Non-'therapy' settings**

  Compassionate validation of presence but focus on noticing what this reflects - "need" or situation being represented by the dissociation

Complex Dissociative Presentations Settings & Approaches in them…..

General Clinical Settings

Learning to function
Practicing skills

Positive relational experiences

Experiencing being visible

Experiencing “I matter”

Promotion of self care (including inside) & self efficacy

NOT for

- Trauma disclosures
- Active interventions engagement with dissociative presentations
  - Unless at risk at the time e.g. re-experiencing

1:1 should not be occurring with dissociative presentations

Acknowledgement of any presentations but not looking to complete active work.

Complex Dissociative Presentations Settings & Approaches

Therapy Space (incl.in 'interventional psychiatry')

- Active exploration & understanding of the system and the various roles, responsibilities to understand presentations
- Engagement & relational building with the system
- Development of communication and collaborative approaches
- Supporting compassion, ownership and internal skills
- Understanding the trauma
- Specific pieces of trauma processing as needed affecting the here & now

Balance of validation & acknowledgement of the inner world that allowed survival to the reality of functioning in the "real singular world" in the here & now

Developing understanding to inform care planning & support the wider teams interventions

Complex Dissociative Presentations Settings & Approaches

Avoiding……

- Promotion of dissociative responses
- Promotion of age inappropriate or unsafe dissociative presence for place or task
- Promotion of continued disconnection
- Re-traumatisation
- Re-playing roles and patterns of past abusive relationships

Complex Dissociative Presentations Clinical Language…..

- The patient or “passport” holder – the legally responsible “original”
- Parts, States, alters, presentations, ANP, EP…….**Be guided by the patient as to what they prefer**
- Where there are internal parts with linked behaviours / ‘ways of being’ and functional dissociative self states refer to ‘internal part-self’ and ‘functional part-self or state’

Clinical notes legal standards:

Only use the registered patient / passport holder name any other presentation should be referenced as “dissociative presentation xxxx” or “presented apparently dissociated with associated behaviour xxxx”

Complex Dissociative Presentations Capacity

Lacking Capacity- Incompetence

- The MCA defines this as,

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

Dissociation = Disconnect

Disconnect = disturbance of functioning of the brain= lack of capacity

Only the fully grounded patient has capacity – this excludes all adult 'parts'

Does this matter?

Depends on the situation and whether and intervention is needed

E.G. Only the patient can drive – dissociative functional presentations should not & would be reason to remove licence. Patient must be fully aware at all times.

So how do we handle in-clinic in-vivo complex dissociative presentations?

- During non-trauma therapy 1:1

Validate presence / what's happened and be curious as to why they have presented / are present at that time

If functional self state – compassionately explain (using what you know) whilst ok for them to be co-present / listen needs to be the patient present. If this cant occur, be curious why, ensure safety & consider early ending, follow-up call with situation analysis.

If internal part – assist to ground and complete situation analysis identifying plans to overcome.

If repeated – support to take to therapy session to understand further & plan to overcome

- During / Part of incidents

Acknowledge the presence of dissociative parts if evident & emotions / event appears to be happening

Explain / remind who you are / where they are

Ask what might help – if known from therapy use specific care plan intervention for the part

Use here & now grounding aspects & language appropriate to the developmental presentation

Consider your position relative to the patient, body language etc

If needing consent e.g. for medical intervention **with compassion to the part presenting** (normally young part) explain need adult due to consent & could they or someone else inside get the patient

If unable to get the able consider the need for treatment and explain to the part why with continued encouragement to get the adult – complete the treatment with trauma informed & age appropriate approach

DOCUMENT –

- Any interventions where lacking capacity - urgent care needs identified, best interest / necessity intervention & how completed
- Provide de-brief of incident to patient verbally and in writing following and arrange to complete situation analysis
- Document in detail situation analysis as you understood it & the presentation, responses etc.
- Update care & risk plans

So how do we manage complex dissociative presentations in vivo in clinic? - Inpatients

- If noticed on Obs
  - If no risk apparent, note on the sheet, increase checks, feedback to the patient to assist in symptom monitoring
  - If uncertain as to risk

    notice “xxxx doesn’t seem to be is there any reason for that?”

    “Does xxx know you are here? Are they ok with that?”

    Can you or someone else let them know?”

    “Do you need any support to manage so xxx is ok?”

- During check in’s for leave

Assessment should be guided by joint plan by key nurse & therapist with patient. Use of advanced statements

Assessment is with grounded patient, ask simple direct Yes / No

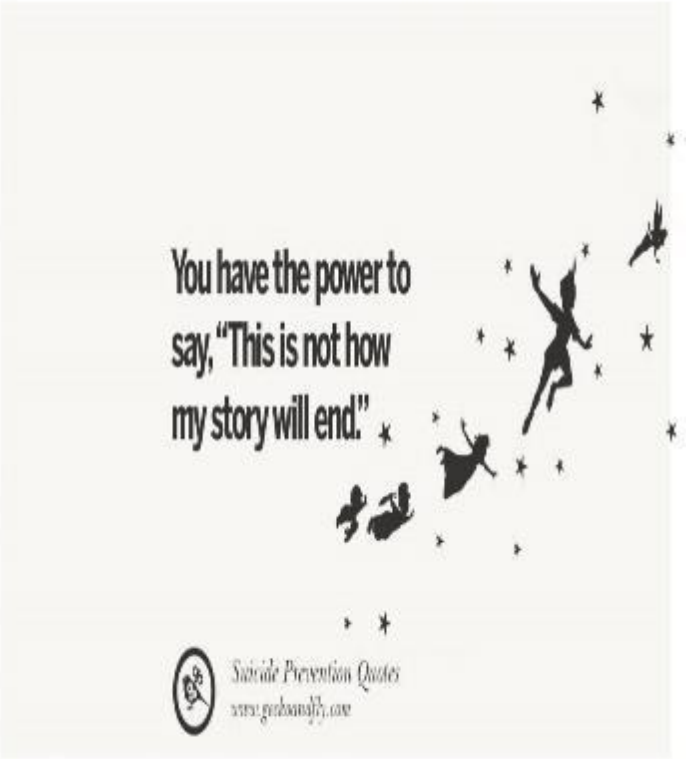
If not truthful to be addressed in therapy & plan adjusted

How do we support the patient to understand & manage dissociative presentations

- Identifying & managing
  - Use of symptom monitoring charts & situation analysis / BCA – take to therapy & 1:1
  - Encourage their use of communication books with parts
  - Identifying & trialing solutions – Self / others / environment, use of grading / planning / preparation, proactive noticing & management of avoidance
  - Skills development – mood, emotions, shame responses
  - Be honest with themselves about reality
- Handling & supporting the amnesia
  - Provide written information on interactions
  - Check in with patient several times to ensure understanding
  - Option of recording sessions audio or video for their record
  - Inpatients / Homecare - Use of white boards

A few words on Risk…..

Must be owned & responsibility taken for it by the patient



- Can be a very complex picture – Non-Dissociative, Partial & Dissociative
  - Direct work with non dissociative & partial at all levels as per any other patient
  - Partial may need some more therapy-based understanding
  - Work with dissociative in therapy / interventional psychiatry and then informs care plans
  - Always has a purpose which needs to be understood
- Assessment & plan informed by all aspects of work
  - Risk formulation outlining for all 3 the different risk presentations, understanding of why they present, their purpose, triggers with likelihood, approaches to management (incl which situations effective)
- Understanding of risk develops over time so has to be an ongoing & regularly updated piece of work
- Use of MCA & Advanced statements in support of capacitious decision making by the patient
- Use of MHA – ideally collaboratively with the patient identifying the ownership / responsibility.
- MDT approach BUT Psychiatrist responsibility & primary intervention

Interventional Psychiatry – Risk Assessment & Management in Complex Dissociative Presentations

- Informed by own assessment, MDT & feedback from therapy work
- Active exploration & understanding of the system and the various roles, responsibilities to understand risk presentations
- Specific engagement & relational building with the system with the patient to manage risk
- Development of communication and collaborative approaches
- Supporting compassion, ownership and internal skills
- Feedback into therapy for specific pieces of work
- Collaborative use of MCA / MHA as needed to manage risk

Lunch

Basics for Trauma Treatment

- “4 legged stool” to sit on for successful trauma processing
  - Self Compassion (leg)
  - Attachment (Leg)
  - Emotional experience and tolerance – fear, anger, sadness (Leg)
  - Body connection (leg)
  - Arousal Management (seat)
- SIBAM model for successful event processing (Paul Levine)
  - Sensations (Body)
  - Image (picture / observations)
  - Behaviours (what were they doing)
  - Affect (What emotions were felt / experienced)
  - Meaning (how did they make sense of it / what did they believe)

What's the problem with Dissociation?

The Impact on Application of therapy in these cases?

- Poor internal resources – little / no compassion
- Difficulties with emotional tolerance and arousal levels even phobia of the same
- Difficulties incl. complete phobia of body connection
- Where there are different parts they may have different SIBAM for events and disconnection of the same from the adult
- Looping related to activated beliefs and blocking by different parts
- Poor if possibly absent attachment
- Poor intersession containment with associated unhelpful and risky coping behaviours by parts if not included / accounted for in stabilisation work
- Shame responses – connected & internally held

Treating complex dissociative presentations
Therapy – General Points

- **No one-size fits -** Integrated approach using the principles of the phased approach and pulling in "tools" from various psychotherapies to address key target areas in RDI
- Recovery goals are those set by the patient – note this may not align with scores reductions
- Focus Areas – Risk & Functioning in daily life. Formal trauma processing of what aspects you need to do support this!
- Active integrated use of creative therapies alongside as an integral part of the treatment
- Approaches / language adapted as age appropriate within the session

Adapted EMDR 'AiCE'

- **RDI Frameworks**

Attachment & interpersonal

Compassion

Ego State based

- **Regular Use of Bilateral (BLS)**

Multiple ways across all phases of the work, patient & phase dependent

- **Specific Processing approaches**

Specific elements in phase I with the system and potentially stepped approaches in phase II of the phased trauma model

Complex Dissociative Presentations Therapy Treatment – General Points

The Therapeutic Relationships is fundamental to and at the core of recovery

The relationship needs to hold to the core principles of a positive supportive relationship within clearly stated & held boundaries of clinical relationship

Understanding the trust takes times (Brene Brown TEDx & marbles jar metaphor)

Where there are dissociative presentations the relationships need to be developed with all impacting on / important to functioning holding to the core concepts.

You need to mirror in your work how you would wish the patient to relate to themselves and support them to develop the capacity to do so

Where there is a dissociative system you need to support parts to develop relationships and understanding with each other as well as the patient

Role of interpersonal skills training (& diplomacy / mediation for the therapist!)

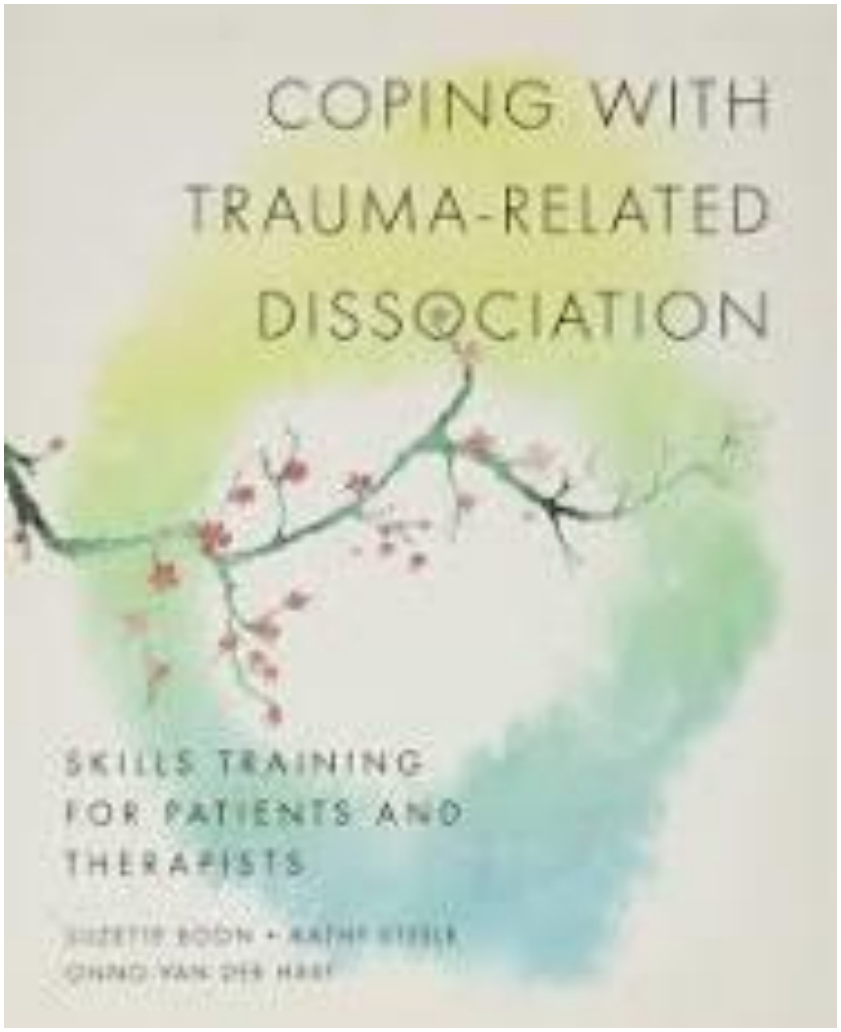
INTRA-PERSONAL WORK - ‘EGO STATE’ WORK

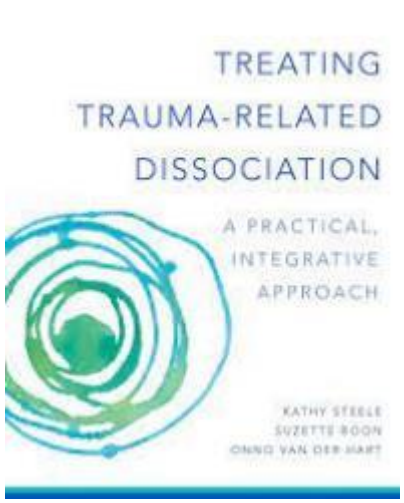
Twombly, Phillips, Forgash, Copley, Patterson, Mosquera

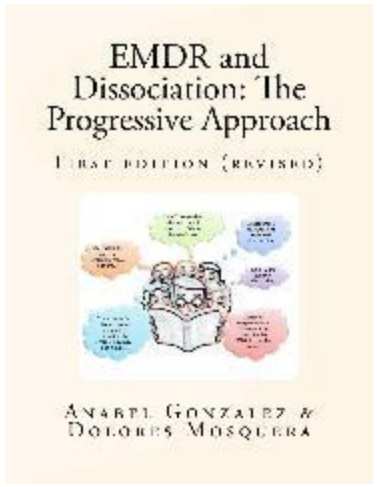
Different author models for the same thing – find the one that makes sense to you and you can explain to & use with the patient!

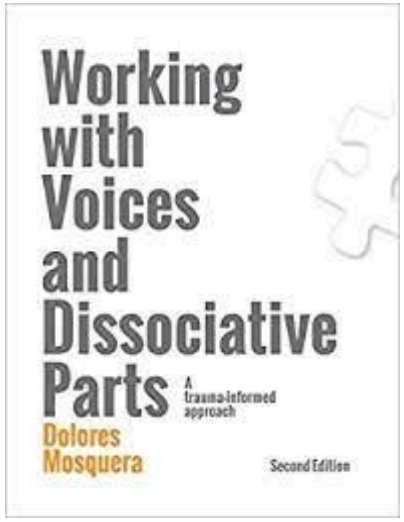
Importance of addressing this from the beginning within Stage I due to the impact on achieving processing and risk if not

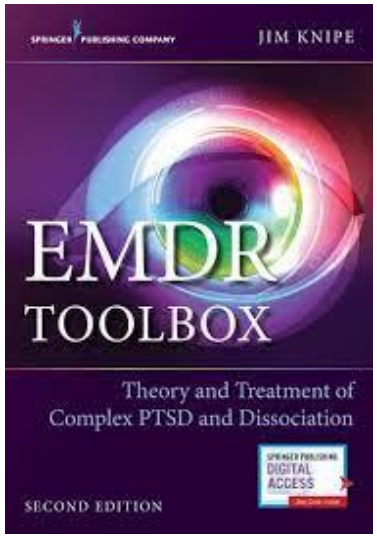
Useful ‘handbooks’











Complex Dissociative Presentations Intra-personal work

Key Elements

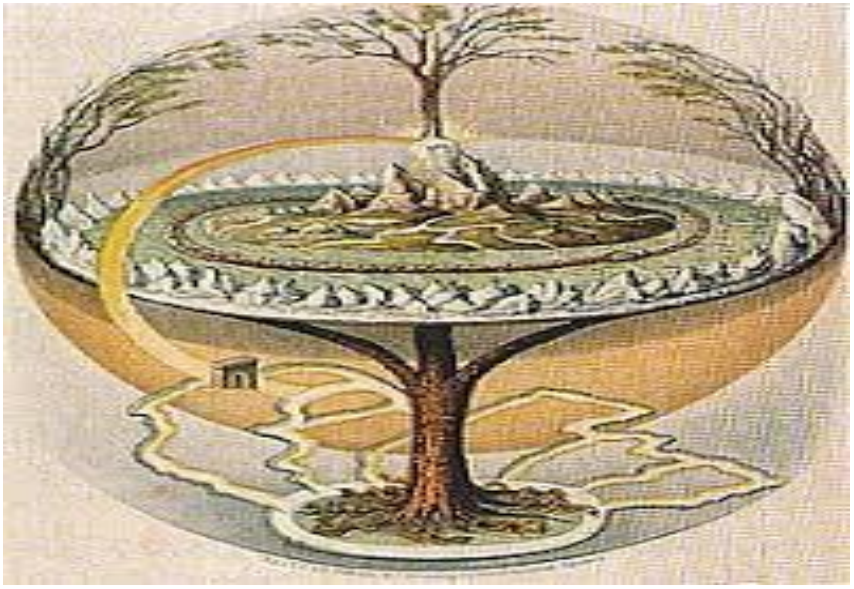
- Managing patients fears / phobias of the internal world
- Understanding origins / roles / purpose
- Ensuring Orientation to the present
- Developing resources & compassion to parts
- Developing shared purpose, agreements around functioning in the present.
- Specific targeted trauma processing incl the system as identified with safety measures
- Work to an agreed future template

Integrated use of imagery as means of contact & working with parts

Positive impact of integrating creative approaches

Always be open and ready for further parts to emerge and allow contact in complex cases

Complex Dissociative Disorders Intrapersonal Work



Specific goals - DID

- Acceptance of internal world & responses, developing understanding, compassion & self care along with accountability
- Identifying phobias & working on them
- Developing internal connection and communication & Team working
- Working to agreed “functional multiplicity” within their inner world in the outside world

Intra-personal work

Sessions Boundaries

- Always grounded at beginning and the end of sessions
- No harm
- Respect – listen, take turns
- Feedback agreements

- Use of technology to assist with feeling in control e.g. recording sessions(CAREFUL!)
- Curious stance as to why, when the patient is not present & keep record to assist understanding
- Agreed use of grounding approaches & ‘toolkit’ which they are responsible for
- Provision of written summaries of sessions

Intra-personal Work

- **The Key to functioning – The importance of the four C's**
  - Connection
  - Communication
  - Compassion
  - Collaboration
- **Communication approaches & setting**
  - Try to work through the adult patient but flexibly work with what presents. Check for amnesia & feedback

Remember they are always listening, watching and have the potential to respond……

Intra-personal Work

- **Engagement**
  - Noticing & using opportunity
  - What does the patient know already
  - Direct opportunities & approaches
  - Where high phobia may need to use imagery
- **Introductions & Orientation**
  - do they have a name, age, what they look like, who they know in the system & in real world
  - Present state orientation – time, place, person
  - Flexibility in means of communicating – cant speak may write, draw, use characters
- **Understanding their origins with the patient -** linking to time line
- **Understanding possible roles / purpose in the past & in present functioning**
- **Understanding & Managing how relates to Risk** – Ownership by parts & ownership of overall responsibility by patient

Intra-personal work – creativity

- Imagery & connection
  - Internal “safe” house (Jim Knipe)
  - Meeting room
  - Individual rooms for patient & parts
  - Internal resources in the house
  - Use imagination to create safety
  - Rules of the house!

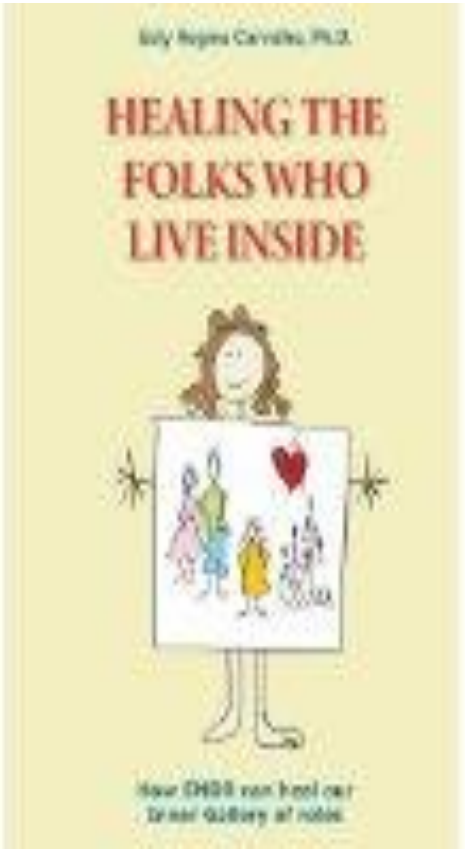
Intrapersonal Work

- Dealing with the phobia's of the internal world
  - Trauma
  - System
  - Parts of the system incl. parts to parts
  - Behaviours

- Psychoeducation is key
- Pace is directed by the patient & the system

Use of "NEW RULES for life now" can help with behaviours

- Integrate Creative approaches
- Use of Literature



Impact of Creative work

Creative “Drama” figurine approaches for Ego states / parts can be extremely helpful with connection & compassion

Resource Development & Installation

- Deliberate interventions, including psychoeducational to achieve
  - Feeling safer & understanding
  - Ability to be grounded in the present
  - Experience & Tolerate affect / emotion
  - Connect bodily & manage arousal
  - Connect & understand the internal world, their roles & experiences
  - Compassion –self & internal world
  - Attachment – inter & intrapersonal relationships

Positive templates of having these and connecting to this

If EMDR - Using BLS (tapping) in positive experiences both in session & between sessions of having the same.

From these the patients develops the ability to tolerate day to day and increases their window of tolerance to work with trauma experiences for the processing.

Complex Dissociative Presentations

Phase I - Resourced Resilience

- **Inner Resilience**
  - Resource figures
  - Positive mastery strengths
  - Positive Mastery of Trigger to behaviours
  - Peaceful, individual rooms & Container imagery
  - Managing Re-experiencing skills
  - Body Connection & Management
  - Emotions Experience & Management
  - CPOS – arousal / here & now

  Looking at how the patient and system can support themselves – who can do what with whom etc.

- **External Resources**
  - Interpersonal Inventories & IPT skills work
  - Use of Animals
  - Roles & mastery in adult life – OT / MHSW /STR interventions

Complex Dissociative Presentations - Resourcing

- **Attachment Figures – Parnell & others**
  - Nurturing / comforting Figure (person or animal ie animate)
  - Strength Figure
  - Wise Figure
  - Magical Figure
  - +/- Spiritual figure if appropriate to the patient

"*Think of a figure that represents this key ability, it can be real or imaginary (book / movie). Think of an image that represents them displaying this at their best, allow a connection to that image and just be aware of how it makes you feel (emotions / body*)"
- When a connection is felt - add BLS (tapping given attachment context)

"*Now imagine that figure with you at a time you need / needed that ability and allow a sense of connection to the same and just be aware (emotions / body)"* - When a connection is felt - add BLS

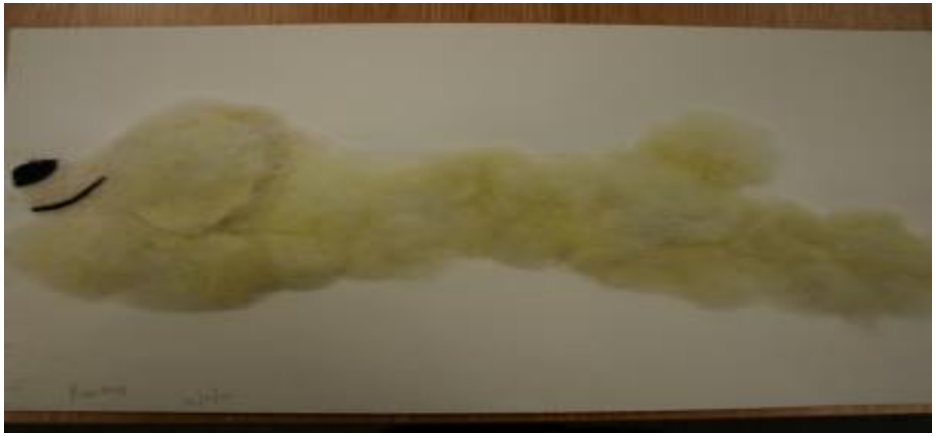
"*Now think of a word that goes with that person / feeling and when bringing up that image add the word*" - if connection still present add BLS

Once created – "team" image

Working with parts you will need to do this across the system as you develop connection with them

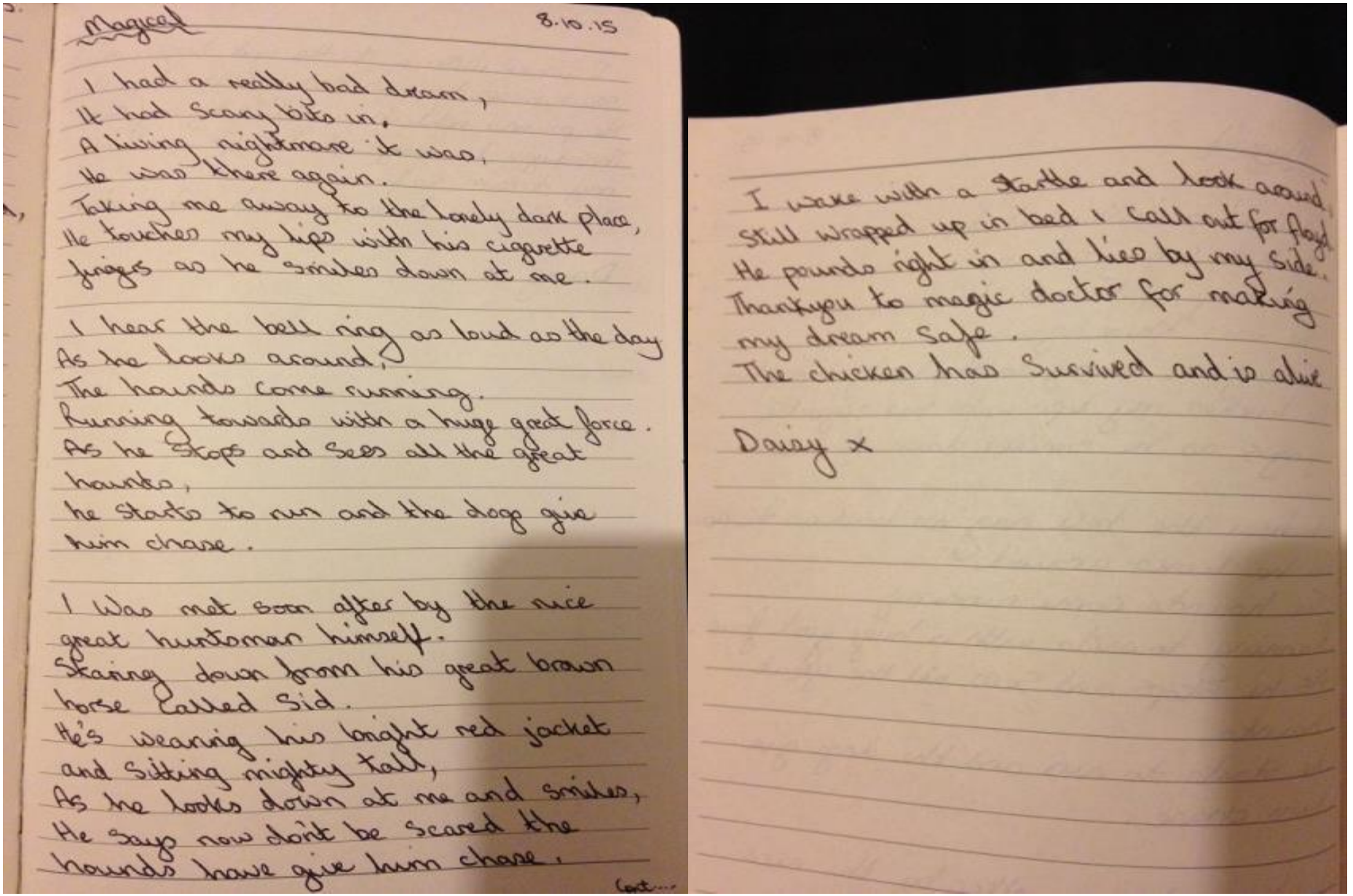
Resourcing

- Increase the impact with art & creative approaches –very useful for young parts
- Use of real representative objects to support
- Use of music, videos
- Use of animals
- Use of visits
- Transitional objects for between sessions



Complex Dissociative presentations - Impact of Resourcing ‘Think outside the box’

EMDR-ACE Impact of Resourcing



Magical 8.10.15

I had a really bad dream,
It had Scary bits in.
A living nightmare it was,
He was there again.
Taking me away to the lonely dark place,
He touches my lips with his cigarette
fingers as he smiles down at me.

I hear the bell ring as loud as the day
As he looks around,
The hounds come running.
Running towards with a huge great force.
As he stops and sees all the great
hounds,
he starts to run and the dogs give
him chase.

I Was met soon after by the nice
great huntsman himself.
Staring down from his great brown
horse called Sid.
He's wearing his bright red jacket
and sitting mighty tall,
As he looks down at me and smiles,
He says now don't be scared the
hounds have give him chase.

(cont...

I woke with a startle and look around
still wrapped up in bed I call out for floss
He pounds right in and lies by my side.
Thankyou to magic doctor for making
my dream safe.
The chicken has Survived and is alive

Daisy x

Integrating creative work

Resourcing

- **Emotion**
  - Dealing with phobia of emotion / dissociated emotion
    - Identify the fear and then set some experiments
    - Safe experiencing with outline of components of emotion – energy / cognition
  - DBT Skills work
  - Shame based work – use of imagery / creative approaches
- **Arousal Levels**
  - Thermometer of arousal
    - Note of emotion, body feelings, functioning different levels
    - Triggers to movement
    - Management – What can I do, what in the environment can help, how could others help
    - Body approaches – biofeedback, breathing, meditation etc
- **Grounding**
  - Use of the body & how the body works
  - Jim Knipe CPOS

Risk Reduction & Functioning

- **Interventional Psychiatry (or same approach if no psychiatrist!)**

- **Specific Processing in Phase 1 –**

EMDR “Lite” / “Finger Tip” & “Freckle” (Mosquera)

Processing Work with specific targeted pieces in the here and now that are causing specific issues e.g. specific triggers to risk & impact functioning

- Just with those parts who own that aspects of the trauma and if possible with the patient

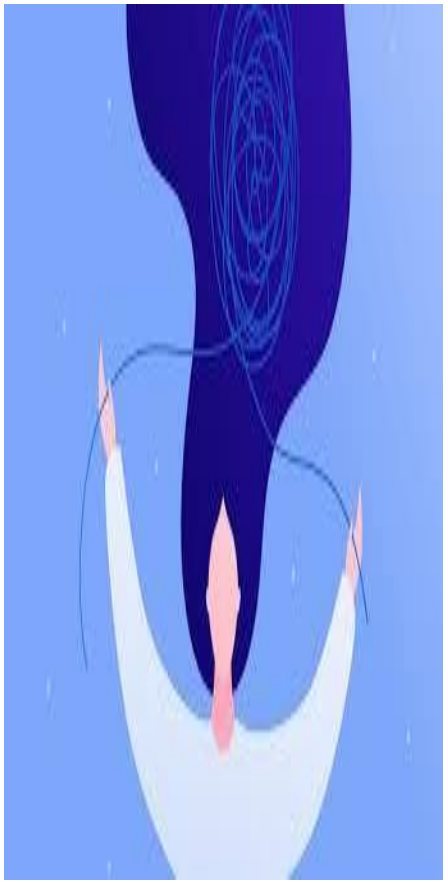
Others made safe

- "where did they learnt this?"
- "Where did they first learn they needed to do this?"

Then apply normal standard protocol but... hold to just that memory. Told to stop if moves away from it and come back to target and re-start.

Can use "blind to therapist approaches"

Considerations for Phase II Processing work



There is an absolute need to have relationships across the system to do this successfully

Focus areas – Risk & Functioning, then other aspects of trauma at patients direction

Needs full understanding SIBAM for each, agreeing who will be present, support each other etc

Grade exposure to different elements in processing

Processing is completed with adult patient & parts of the system to an agreed plan

Sometimes may need to do with parts first & then together with the patient

Co-conscious if that's possible

Parts not engaging in processing need to be made "safe"

- Use of other parts of the system to support this

Notice where there is looping / blocking and enquire who might not be there / not happy and look to engage

Eventually need to complete processing across all the parts involved with the adult patient to fully process if that is what's wished / needed

- Carefully consider the impact on the adult patient of something coming into their full conscious awareness

Be ready and prepared for potential escalation in risk….

Be ready for development of co-morbid illness e.g. depression

A word from my Clinical Experience:

It is possible to achieve recovery without processing all of the trauma… and for some this may be better.

Be guided by the patient…

EMDR- AiCE for complex cases

- **Phase II Reprocessing**
  - Attunement to the patient is key
  - Use of modified approaches only if needed such as in attachment & compassion focused languages
  - Child approaches dependant on presentation
  - Pace and selection related to current functional symptoms
  - Use of distancing & stepped elements of SIBAM
  - Consider tapping as BLS to assist connection and grounding where appropriate
  - **Working with Ego-states and be prepared for others to appear!**
  - **Consider high frequency sessions of 90 mins duration**

- **Phase III Focused Recovery Work**
- Continued ego state work to a new agreed framework
- Positive future template development and mastery resourcing
- Continued use & building on internal & external resources
- Interpersonal / relational work
- Occupational aspects - leisure, work, education
- Life skills - eating, sleeping, self care, budgeting
- Housing
- Creative & Spiritual aspects

Phase II Processing – non formal TF based

- IPT – PTSD (intra & inter)

Nature of work completed supports forward movement, change of behaviours

- Modified & adapted ‘active’ ego-state based dynamic therapy with specialist supervision

Relational based ‘active’ therapy incorporating ego-state work with supervision can be as effective

Working with complex dissociative presentations

Thank You

Melanie.temple103@mod.gov.uk