WORKING WITH DISSOCIATIVE DISORDERS IN CLINICAL PRACTICE
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PODS (Positive Outcomes for Dissociative Survivors) works to make recovery from dissociative disorders a reality through training, informing and supporting.

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Dissociative identity disorder is a post-traumatic condition which results, amongst many other symptoms, in ‘multiple parts of the personality’. One of the most common questions we are asked at PODS, by both professionals and supporters, is: ‘Should I talk to parts?’ What most people mean is this: when a person with DID ‘switches’ from their main adult personality state into a different ‘part’, ‘self-state’ or ‘alter’, should they engage with this ‘part’ or not? When someone switches in this way, is this attention-seeking behaviour? And is talking to a ‘part’ in some way dangerous—does it reinforce pathological behaviour? What should you do?

Often people are looking for a definitive ‘yes’ or ‘no’ response; I believe the answer lies, like so many things, in the context. We therefore need to be aware of some guiding principles, rather than setting black-or-white ‘rules’. To shed some light on this complex topic, let’s look at some of the reasons that have been proposed for why we shouldn’t talk to parts, and the arguments why we should.

There is a school of thought, led by researchers such as Spanos (1994), called the ‘sociocognitive model of dissociative identity disorder’. This proposes that DID is not a valid psychiatric disorder, and that it does not result from trauma. Instead, the model suggests that it results both from psychotherapy (it is iatrogenic—created mainly by suggestion and reinforcement from the therapist) and from the influence of the media (through films such as The Three Faces of Eve and Sybil). In other words, people act like they have multiple personalities for personal gain (usually to elicit attention or care), encouraged by their well-meaning but misguided therapist. But is this really so?

David Gleaves (1996) argued coherently against this model in his paper, The Sociocognitive Model of Dissociative Identity Disorder: A Reexamination of the Evidence. However, many of the ideas put forward by Spanos and his colleagues, despite being robustly rebuffed, have caught hold in many sections of the psychiatric world, leading to an orthodoxy which contends that DID is not real and that ‘parts’ are a ‘multiple identity enactment’ encouraged and reinforced by the therapist. Consequently, given the little training that many professionals have had regarding dissociative disorders, the prevailing belief seems to be that talking to parts will make things worse, and that the therapist or other professional should insist on talking only to the adult self. This causes a great deal of frustration for people with genuine DID—in many cases they feel that they have to stop having the disorder for which they are
seeking in treatment, in order to access that treatment.

The sociocognitive model suggests that ‘people who receive the diagnosis of multiple personality disorder (MPD) behave as if they have two or more distinct identities’ (Spanos, 1994, p.143)—not that they do have two or more distinct identities. The ISSTD Guidelines refute this comprehensively:

Severe and prolonged traumatic experiences can lead to the development of discrete, personified behavioural states (i.e. rudimentary alternate identities) in the child, which has the effect of encapsulating intolerable traumatic memories, affects, sensations, beliefs, or behaviours and mitigating their effects on the child’s overall development. Secondary structuring of these discrete behavioural states occurs over time through a variety of developmental and symbolic mechanisms, resulting in the characteristics of the specific alternate identities. The identities may develop in number, complexity, and sense of separateness as the child proceeds through latency, adolescence, and adulthood (R P Kluft, 1984; Putnam, 1997).

Furthermore, the sociocognitive model posits that individuals with DID are generally attention-seeking (histrionic) and this is the main motivating factor for pretending to have ‘parts’. However, Gleaves and many other researchers (e.g. Kluft) insist that the vast majority of people with DID hide their symptoms rather than seek attention for them. The orthodoxy of not talking to parts is based on this misconception that alternate identities are a manipulative form of attention- and care-seeking: engaging with them would therefore encourage and maintain the pathological behaviour. But if they are understood instead—as the ISSTD Treatment Guidelines do—as products of a combination of trauma and developmental deficits, then it is easier to see that the work of therapy is to help the client come to terms with the existence of their parts, and ‘to foster the idea that all alternate identities represent adaptive attempts to cope or to master problems that the patient has faced.’ The Guidelines go on to say: ‘It is countertherapeutic to tell patients to ignore or ‘get rid’ of identities’ (ISSTD, 2011)—and so surely it is also countertherapeutic for the therapist also to do so.

The ISSTD Guidelines warn against the elaboration of distinct identity states, saying:

It is countertherapeutic to suggest that the patient create additional alternate identities, to name identities when they have no names (although the patient may choose names if he or she wishes), or suggest that identities function in a more elaborated and autonomous way than they already are functioning.

In other words, the function of therapy is not to try to uncover increasing numbers...
of ‘alters’ or to encourage them to operate independently from one another: the goal of therapy is increased well-being and functioning across the entire spectrum of personality. Engaging with parts who present spontaneously in the course of therapy does not in and of itself encourage either elaboration or increased disconnection. The reality is that the client has a dissociated sense of self, and refusing to speak to parts when they appear—in essence as a form of attempted behavioral modification—is most likely to disrupt the therapeutic alliance, provoke shame, and actually increase a sense of separateness.

Many parts represent disowned aspects of the self (such as vulnerability, emotional expression, attachment, etc) or disavowed experiences—especially traumatic ones. In refusing to engage with parts, their function, role and experiences are in fact kept segregated from the person as a whole, rather than being integrated into it. The sense of shame, alienation and rejection that many dissociative clients experience when professionals refuse to engage with or acknowledge their parts can cause further dissociative distancing.

Dissociation is a strategy of avoidance, but one that results from life-threatening and traumatic circumstances, and one which carries significant cost. Dissociation is what has allowed the person to survive both the original trauma, and the effects of it up until this point. To insist on abandoning this defence at the outset...
of therapy—before having developed alternative tools for managing intense distress, amongst other things—is countertherapeutic and could result in serious decompensation.

Instead I believe that therapy is the place that the client, with all their dissociated parts, can begin to learn to manage their feelings, to acknowledge and own the segregated aspects of themselves, and build a secure base that provides the platform for exploration of traumatic material. That is only going to happen if the client feels that they are welcome and accepted—that all of them is welcome and accepted. By welcoming and working with parts, the therapist builds trust and a sense of safety. By rejecting them, the therapist reinforces the belief that these parts of the self are unacceptable, that the experiences they had are unspeakable, and that using dissociation as a survival mechanism was in some way ‘wrong’.

It is certainly true that recovery requires an increasing willingness to take responsibility for one’s actions, beliefs, feelings, choices and behaviours. It is also true that many people feel out of control and unable to take responsibility for the actions of their ‘alters’ due to a lack of co-consciousness or memory afterwards. They can feel in a double-bind where they are told that they need to be responsible for their parts, but they have no conscious awareness of them. It is a Catch-22 situation if a therapist says that they won’t engage with parts, and yet the client has to take responsibility for them. In my opinion, the best way for people with dissociated identities to begin to take responsibility for their parts is to get to know them. The therapist can facilitate this process by beginning to engage with the parts directly, and then acting as a ‘relational hub’, gently and carefully feeding back to the client their experience of their parts, to increase awareness of each other, and encourage communication, cooperation and collaboration.

The ideal—and in many respects the end-goal—of therapy is needed for the client to be able to keep online their thinking, ‘front brain’ (principally the neo-cortex) during a therapy session in order to be able to both ‘think and feel’ simultaneously whilst processing traumatic material. But you have to start somewhere, and if the trauma is so overwhelming or shameful...
that the client in their adult self cannot face it, then initially it may be parts who are able to start to articulate their experiences and to begin to come to terms with them.

The ultimate aim is to integrate the memories and feelings into the person as a whole, but as a step towards that it can be helpful to first start working with the parts who hold those memories and feelings. Research shows that many memories are ‘state-dependent’ and are only accessible to certain identity states (the parts who experienced the trauma, for example). If these memories are only accessible via these parts, there will be stalemate if the therapist insists on talking only to the adult part, whose role to date has been to avoid all knowledge and awareness of that trauma. A better solution would be for the therapist to help the client to become more co-conscious of their traumatised parts and able to reflect upon what they are remembering and experiencing, as a first step towards owning that material for themselves.

Some people say no, because parts are stuck in trauma and talking to them just reactivates the trauma

**FACT CHECK: Engaging with parts helps to contain the trauma in the therapy room**

It is true that many parts hold memories and emotions connected with the trauma, and at a structural dissociation level are stuck in a defensive action system which
is focused on the trauma (and defending against it) rather than on daily living. But that is how the person as a whole has survived. Can you imagine carrying the weight of trauma such as sexual abuse, rape, prolonged neglect, or emotional abuse—all alone, and never being allowed to talk about it or disclose it? This is what drives so much of the survivor’s desperate behaviours and distress. Providing a safe place in therapy to begin to talk about the unspeakable is like letting the steam out of a pressure cooker. That is not to say that the lid should be taken off quickly or carelessly—it is important to build strategies for staying, relatively speaking, within a ‘window of tolerance’ and to manage the distress that disclosure inevitably leads to. But if there is no safe space within therapy for dissociative survivors to do this, the reality is that they are likely to leak out their trauma with less well-trained and less boundaried people. It is surely preferable to do this within the therapy session, and to work hard at maintaining a balance of disclosure with stabilisation for the client as a whole.

Some people say no, because parts are different people and only the main ‘host’ is my client

FACT CHECK: Engaging with parts helps to model collaboration and encourages integration

I believe that one of the pitfalls in working with dissociative identity disorder is a ‘black or white’ approach that either takes the multiplicity of parts of the personality as literal, or disregards it as delusional. The reality lies, I believe, in understanding that parts are and feel real, but that they are not actual, separate people with no connection to one another. There is one person, one client, with many parts, and in a lot of respects this is no different to non-DID people: we all have parts. The difference for people with DID is that there is often amnesia between parts, and ‘alters’ have a different way of perceiving the world and relating to it. There is little or no overlap, and no sense of unitary connection.

The answer to this disconnection is not to disconnect further by refusing to talk to anyone other than the main person (called by some the ‘host’). The answer is engaging all the parts, and starting to help them make connections with each other, by becoming aware of one another and working cooperatively together. Keeping ‘secrets’ between the parts is countertherapeutic and simply re-enacts the secrecy of the abuse environment. To a large degree, the person has survived by blocking awareness of his or her parts; the therapist needs to gently reintroduce him or her to them, not so fast that it floods and overwhelms, but not so slow that the segregation remains unchallenged. The client is the person as a whole, including all their parts—both those that have made themselves known and those that are yet to—and the therapist should model to the client collaboration with all of his or her parts.
WORKING WITH A DISSOCIATIVE DISORDER DIAGNOSIS

by Sue McAteer

I have worked with a number of dissociative clients over the years, several of whom have had full-blown dissociative identity disorder along with a significant number who have struggled to get a satisfactory diagnosis but whom we might label dissociative disorder not otherwise specified (DDNOS), now called other specified dissociative disorder (OSDD). I think the best preparation for working with dissociative clients is working with any clients—they are not a different species of being, but just the same as me and you and anyone else. They’ve simply experienced worse things (the worst things), and their brains have had to make greater adaptations to that.

Once we understand dissociation as a logical response to overwhelming trauma, it stops being so dramatic and different, and the person suffering dissociation stops being ‘complex’ and ‘bizarre’ too. There is nothing bizarre about dissociative disorders—what is bizarre is how some people can be so badly mistreated that they end up with a dissociative disorder. It seems that as a society we pay very little attention to that, and focus instead, with morbid curiosity, upon ‘mental illness’ which in so many cases would be so much better understand as ‘mental distress’. ‘Mental illness’ sounds as if they have been afflicted by something, as if their brain has gone wrong, but ‘mental distress’ is really all we’re talking about. I firmly believe that we shouldn’t pathologise suffering, and call people ‘ill’ when they are simply experiencing the natural fallout of trauma.

I think it’s something that has been instilled into our consciousness, with an emphasis from the medical model, that everything we suffer should have a name and be called a syndrome or a disorder. It’s as if we can only cope with our suffering if we alienate it and call it names. For some people, a diagnosis is a relief—what they have really been battling with is a terrible fear of going mad, and being told instead that their symptoms represent ‘unhealed suffering’ (as Carolyn Spring puts it) comes as a massive relief. To others, a diagnosis makes them feel validated, that it’s words on a bit of a paper that tells the world that there really is something wrong with them, and they’re not making it all up.

Many people expect a diagnosis to usher in the right treatment—most of them are disappointed and can actually find that it excludes them from treatment. So I have found that a diagnosis is a double-edged sword, and for all its benefits it also comes with a long list of disadvantages—difficulties in obtaining insurance, the possibility of losing a driving licence, other people’s prejudices and ignorance, employment difficulties, to name but a few. I think it’s always worth weighing up the whole concept of a diagnosis and thinking, ‘Do I really need this? Is it going to make a difference?’ For some it does and so it’s a good thing, but many
people seem to think that they need a diagnosis in order to recover, which is simply not true.

The best response to a diagnosis of dissociative identity disorder, in my experience, is to use it to validate your symptoms and your experiences, but to hold it lightly. It describes your experiences (and you could say that within that it points to a likely cause) but it doesn’t define you. The worst response to a diagnosis is to ‘become the label’—to think, ‘This is who and what I am, so I need to find out what people with DID are like and then become like them.’ That may not be said or done at a conscious level, but it’s a very real possibility for people who have grown up with a sense of identity confusion. The pull to fit in, to belong to a group (especially in the absence of a nurturing family environment), can mean that people twist themselves out of shape and become what they think people believe they are, rather than having an ‘internal locus of evaluation’ and being who they really, truly are and having sufficient ego strength to stand firm against peer pressures. It’s the same thing as goes on during adolescence, although delayed due to trauma for many with a dissociative disorder.

A diagnosis to me is a map of the territory rather than the destination. It tells me as a therapist what to look out for. It suggests quickest routes, and warns me of dangers. But I must never believe the map over and above my experience of the person in front of me. It’s a form of prejudice, and perhaps even discrimination, if I look at people through the lens of their diagnosis. Who’s to say that that diagnosis is correct, anyway? How many people have been given a diagnosis, for example, of borderline personality disorder (or emotionally unstable personality disorder) by a psychiatrist that they have only met for 10 minutes? That diagnosis, so quickly given by an ‘expert’, can haunt them for the rest of their lives, follow them on their medical history, and cause professionals to treat them with wariness and suspicion. That’s a huge responsibility therefore to dish out diagnoses so quickly and to rubberstamp them as ‘facts’. I think it’s much safer to think of a diagnosis in terms of a theory, a hypothesis, and to weigh up its suitability as things develop, but always be open to changing it if it doesn’t fit, or if it doesn’t help.

A diagnosis can be helpful, but most of the time—at least for me personally—I see it as something that just gets in the way. This person, who has been brave enough and determined enough to make the effort to come and see me, despite their shame, their fear and often their physical or logistical problems—is a person, first and foremost: a person just like me. They may have suffered extensive trauma as a child, which may be affecting the way their brain operates now because they’re still trying to keep themselves safe, but that doesn’t affect who they are as a person. Given the abuse of power that so many survivors have experienced, I think it’s essential that I don’t infer a power
imbalance between me and this other person by treating them as ‘other’—by thinking of them in terms of a broad brushstroke label. I am not the ‘expert’—they are the expert on them. I can guide them, and help them to navigate their way through their difficulties, but they’re in the driving seat and the moment I think I know them because I know their diagnosis, I am not just a useless guide, but I’m exerting power over them too. It’s the power to determine someone’s identity, and I believe that each individual person alone has the right to determine that, and that we shouldn’t be imposing that on other people for them.

I work with the person in front of me at the time—I don’t work with their label. I want to show them that I respect them, that I value them, that they have worth and dignity, and that I’m not better than them or more powerful than them. I won’t always achieve that, but I can try, and it’s always my intention. I want the person in front of me to know that I’m not ‘better’ than them just because I don’t have flashbacks, or don’t switch between parts of my personality, or don’t self-harm. If I had had their experiences, I would probably have their symptoms too! I’ve just been lucky enough to have avoided the kinds of trauma that they had no choice but to endure. I’ve been lucky enough to have grown up in a family where I was loved, and I knew it. That is a massive privilege and blessing, but it doesn’t make me a better person. And yet every single client I have ever worked with has felt that I’m better than them, at least at the beginning, by default. That’s part of the legacy of trauma and abuse—people feel worthless and ashamed and undeserving, and they come to therapy feeling bad for taking up our time, for ‘making a fuss’. I have to work hard at levelling the playing field between us.

When I was first a therapist, I used to think that I had to inspire and encourage my clients to think and feel what I was thinking and feeling. After all, I’m happy, life is good, I feel blessed—and I want to pass that on. Eventually I realised how arrogant and wrong that was of me. It’s not about me, and it’s certainly not about me pulling someone else up to my level, or getting them to think like I think. That’s a throwback to our colonial history, where as the whites ruling the world we went to educate the savages who became our slaves. That kind of ‘racism’ still goes on between professionals and their clients nowadays, far far too much.

I should be focused on understanding what my clients think, and why they think it—because there will be a good reason for it, a reason usually based on survival or adaptation to their environment. It will help me understand them, and then I can help them understand themselves. Once people understand that the way they are makes sense—that it’s logical in the light of their past experience—they tend to be able to be much more compassionate towards themselves. I often find that survivors’ biggest battle is to stop perpetuating the abuse. They’ve
grown up with neglect or abuse, and they
think that that’s the only way to be, so
even when in adulthood they are free from
their abusers (to one extent or another),
they take up the role of abuser towards
themselves. It maintains the status quo,
fits their expectations, and feels right,
even though they hate it.
To start with I used to try to argue this out
with my clients, to help them see that they
don’t need to continue to abuse themselves,
that they can have good things now, but I
was surprised at how ineffective it was. In
more frustrated moments I would blame
the client for this (not necessarily to their
face!) and talk in terms of them being
‘resistant’. But now I understand much
more that what I am asking of them is
ridiculous, and even a little bit arrogant
of me. Why on earth should they trust
me or believe that I’m right when I say
that they are lovable and worthy of care
and attention, and that they deserve good
things? Nothing in their experience has
ever suggested that that could be the
case, and I sit there with them for an
hour or two a week and tell them in effect
how wrong they are to believe what they
believe and that they should believe what
I do!—and then I’m surprised when we
don’t get anywhere. So often as therapists
we blame this on ‘resistance’ when really
it’s our own lack of empathy: we fail to see
the world from their viewpoint.
Attachment theory teaches us that exploration comes from a secure base, but many of our mental health services are not geared up to provide that secure base. Working in private practice I can give my clients the time to work at their own pace, and I’ve found that when people aren’t shamed or told that they’re wrong and urged to change, they can learn to stop beating themselves up for being ‘defective’. The basis for all change, I believe, is a profound respect for them as people, that they have survived the most awful things in the past, and they’re doing the best to survive now. When they realise that I’m not looking down on them, that I’m not patronising them, but that I do actually deeply respect them, that often sparks a change in their attitude towards themselves. They begin to believe that they’re not stupid. They begin to think that things can change, and that they have the power and the capabilities to effect that change. But change doesn’t come by me shaming them and inferring that they’re not good enough because they don’t think and feel like I do!

That’s why I resist a ‘diagnosis’. If people believe that they are their label, it’s hard to come out of it. If instead we could give people diagnoses of ‘extraordinary resilience in the face of adversity syndrome’ or ‘coped with too much trauma in childhood syndrome’ then they might see themselves in a more positive light. Telling them that they are defective and disordered as people because they were chronically abused or neglected just isn’t fair on them. It blames them, rather than celebrating their strengths and what they have survived. When I hear my clients’ accounts, I’m not sure I could have managed in the way that so many of them have—I don’t know if I would have kept on battling to stay alive and get treatment in the face of so much prejudice, apathy and blame.

A diagnosis remains useful as an explanation, and I have no hesitation in using it to help people understand why they act and react why they do. But it still seems to me that dissociative identity disorder is the diagnosis that no one wants to give, while some psychiatrists are all too quick to misdiagnose with schizophrenia or borderline personality disorder—the diagnoses that no one wants to receive. The real benefit of being a counsellor or psychotherapist in private practice is that we can work with the person in front of us, rather than being constrained by labels and controlled by the system that imposes them.
All I did was walk into the kitchen and pick up a cloth. But the sudden waft of bleach flung me far, far back into some childhood memory. I switched to a traumatised part of myself. I had been ‘triggered’.

Physically, I revved up into the panic and distress of the fight/flight response, everything in me taut and straining to protect me from some unseen danger. My heart lurched inside me. It’s just bleach, I tried saying to myself, desperately. Just bleach. And I strained with everything I had to feel real again, to stop this mad descent into terror and shame and darkest, deepest dread.

I wonder sometimes how any of us manage to work, or parent, or socialise, or go shopping, or even sleep, when this is happening all the time. And for me there was a period of 3 or 4 years when it was constant. I made several suicide attempts during that period of my life, because it was so bewildering, so overwhelming, so exhausting. I never want to go back to that kind of misery again. Being on the other side of it now, I feel strongly that we need a solution to triggers—it’s not enough just to sympathise.

I struggled too with the shame of being triggered. I didn’t want to be like this. I hated people noticing. I wanted to shout and scream that I hadn’t caused the abuse, so it was unfair to have to deal with the consequences. I railed against the unfairness, wanting everyone to listen. Why should I have to do the heavy lifting of dealing with triggers? I didn’t cause them! But eventually I realised that no amount of anger or resentment would change the fact that I was being triggered, and that no one else was going to do anything about it—that no one else could do anything about it. Only me. So I had to learn how to deal with triggers better.

THE SHAME OF TRIGGERS

I struggled too with the shame of being triggered. I didn’t want to be like this. I hated people noticing. I wanted to shout and scream that I hadn’t caused the abuse, so it was unfair to have to deal with
powerlessness at the moment of trauma, and they whisper to you that you are still powerless now. It makes recovery from trauma seem impossible.

Many people, believing that triggers are uncontrollable, immutable and inevitable, assume that we must avoid them, and ask others to avoid them too; hence the rise of the trigger warning. Certainly when we’re assaulted day and night by them, logic suggests that our reactions cannot be controlled. After all, none of us choose to be triggered—so how we can choose not to be triggered?

**The Cost of Avoidance**

But there’s a cost to coping with triggers through avoidance alone. Our world narrows to the point of imprisonment: if open spaces are triggering, we can’t go outside; if small rooms are triggering, we can’t stay inside; if things in our mouth are triggering, we can’t eat; if our bed is triggering, we can’t sleep. Hence why life with unresolved trauma is so debilitating, when there are so many situations to avoid. Avoidance is a smart survival strategy, but it comes at a price.

So what if there’s a way to neutralise triggers, rather than just avoid them? Can you even imagine that?! What if we didn’t have to avoid life, but could enjoy it? Wouldn’t that be life-changing?

And it is, and I know this—again from personal experience. It is possible to live a life where triggers no longer hold sway, where most of the time I can stay in the ‘green zone’, in my ‘window of tolerance’. And what a transformation it has been—it makes life liveable again.

**Why Are We Triggered?**

So in order to learn how to neutralise triggers, we need to go back to basics and figure out what triggers are and why they exist. Let’s stop and consider: how do we manage to stay alive? What stops us from walking off cliffs, playing with fire, jumping into traffic, sitting down on a dual carriageway?

*Fear.*

Fear is an emotion, a feeling we have, which helps us avoid danger. It can be based on reality—it’s right to fear a man with a gun—or it can be a natural fear ramped up to an extreme: we can’t reconcile hurtling through the air in a tin can at 30,000 feet, so we develop a fear of flying. To ensure our safety, fear exists in anticipation, before the event, so with a fear of flying we might start reacting physically even just thinking about planes.

That feeling of fear is an awful one. It’s very visceral—you feel it in your guts. It starts with an uneasy, anxious sense of dread. Your tummy is queasy and your muscles are taut. As it increases, you might feel shaky; your throat might go dry; your heart begins to thud in your chest; you might feel like you can’t breathe, or you start hyperventilating. It’s a really aversive experience. Everything in you is screaming to run away, to make it stop. And of course it does—how would we
know to avoid dangerous situations if we didn’t have so strong a physical reaction? Our fear response is intended to keep us safe, to ensure we survive.

When we encounter a dangerous situation—a near miss on the motorway, a gunman, a fall near a cliff—our body reacts instantly to ensure we do something to deal with this danger. We swerve; we duck; we grab onto something. So our internal alarm sets off a chain reaction in our body of physical responses—mainly adrenaline, causing our breathing and heart rate to increase so that energy is available for us to deal with the threat. The feeling we feel is of fear, and panic.

When we suffer some harm from this threat—when our efforts to defend ourselves aren’t sufficiently effective—then our body does the next best thing it can to survive. It goes into a submissive freeze response. It might curl into a ball to shield itself and to hide from view; it might play dead; it won’t resist. It’s a clever survival strategy that might be the only thing that actually saves our life, but it leaves us with an enduring sense of powerlessness and helplessness, that there was nothing we could do. The survival brain, seeing what has happened, marks this event as ‘extremely aversive’ and plans from that moment on to avoid it happening ever again. If you can’t beat it, avoid it. Forever. It becomes both a physical and psychological imperative.

So to avoid it, we need some clues that it might be happening again. Was it raining when it was happening? Was it a man? Was there a smell of alcohol? Was he wearing a red jumper? The basic, survival brain adds all of these elements to a threat list. So the next time it’s raining, or there’s a smell of alcohol, the alarm goes off again: look out, threat coming! It’s as aversive as the original event. The brain doesn’t check that it’s right. It prefers to have the earliest possible warning, even at the risk of a false alarm. A delay could mean death, rather than life. React first, ask questions later…

That’s a trigger in action. A trigger is a reminder, conscious or unconscious, of a traumatic event. It’s something that sets off the alarm system in the body and brain to prepare us for a threat. The problem with triggers is that they elicit such a powerful response in the body, but they’re not always accurate. The amygdala,
the brain’s smoke alarm, is a basic piece of kit and it generalises and jumps to conclusions—better safe than sorry. So after trauma it goes off at the slightest hint of smoke, telling us that burnt toast is as dangerous as the house on fire.

So a trigger in the strictest sense is something which activates the smoke alarm. It all happens in the blink of an eye, within 7 milliseconds. The survival-based back brain, which houses the smoke alarm, makes the decision before our conscious, thinking front brain gets to take a look. It all happens unconsciously, before we’ve had a chance to choose. In that sense, we are not choosing to react to a trigger. It’s all beyond our conscious processing.

So if a trigger is something which activates the body’s autonomic nervous system (with fight, flight or freeze—into the amber or red zones), then do we use the word accurately? Or do we use the word ‘trigger’ to mean other things as well? Do we use it to mean ‘anything which causes an unpleasant feeling’?

THREE TYPES OF TRIGGER

Instead, I think there are three things that we tend to lump together and call a ‘trigger’, in decreasing order of severity: true triggers, distressing reminders and uncomfortable associations.

TRUE TRIGGERS

True triggers occur when our smoke alarm is activated by something in our environment—it’s usually a felt sense, a real re-experience. Rather than just a picture of a tree, it’s finding yourself under a tree, with the smell of undergrowth, the dappled sunlight, the crunch of twigs underfoot. The information comes in through the senses and sets off the smoke alarm to full alert. The front brain goes offline; the back brain comes online; and it is very difficult to manage our response as we have such reduced mental functioning. Our response occurs within 7 milliseconds, before conscious thought has had a chance to be engaged—it is, as Judith Lewis Herman described it, ‘wordless terror’. It is principally a body-based response, directed almost entirely by the back brain and is mediated solely by the amygdala. The key to dealing with them is the magic phrase ‘just notice’, engaging the front middle brain (the medial prefrontal cortex), although to start with we might only begin to address them afterwards. But, as the saying goes, better late than never!

DISTRESSING REMINDERS

Distressing reminders evoke memories of a traumatic event, and cause negative, aversive feelings, but our front brain remains mostly online. They occur within conscious thought (we know why we’re triggered) but there may be some unconscious elements to them as well: we can describe them, but not always explain them. It is a reaction partly in our body, and partly in our brain; partly in our front brain, and partly in our back brain. Technically, the process is mediated both
by our amygdala (our smoke alarm) and our hippocampus (our context stamp). As we’ll see, the key to dealing with them is via soothing, specifically activating our front right brain, the right orbitofrontal cortex, and we can learn to deal with them while they’re happening.

UNCOMFORTABLE ASSOCIATIONS

Uncomfortable associations are links we have made in our mind with our trauma. They occur consciously and we can explain verbally what is going on for us, for example: ‘I don’t like pictures of trees, because they remind me of where the abuse took place.’ It’s a reaction that occurs within our brains rather than bodies; our front brain is still engaged and online; and the process is mediated by the hippocampus as it draws on explicit memory. We deal with these associations through reframing, specifically via our front left brain or the dorsolateral prefrontal cortex, and we can work on this subset of triggers even before they occur.

The table on the page 19 shows a summary of these three types of trigger.

MANAGING TRIGGERS

So if we break down the super-category of ‘trigger’ into these three sub-categories, it can help to make them less overwhelming, and we can figure out different strategies for the three types, based on three parts of our front brain. And we can also prioritise our efforts as we see which types of trigger can be worked on even before we’re triggered; which we learn to manage as they happen; and which we can look at and begin to deal with after they’ve happened.

A PERSONAL STORY

I used to find dogs a huge trigger. And in the midst of my breakdown, I sat in a seminar at a survivors’ event, and in came another delegate with a guide dog. She sat on the front row, diagonally opposite me, unintentionally blocking my exit. I was triggered. I felt irrationally upset, like I wanted to burst into tears, but I didn’t even know what at. I had a strong flight reaction—I just needed to get out of there. My heart was pounding and I could hardly breathe. But I couldn’t move—at least I felt I couldn’t, because the dog was in the way. In reality, if my front brain had been working, I could have figured out a route around the back of the room, or I could even have asked the owner if she could move to let me past. I could have asked someone else to ask the owner to move. In reality, there were a number of options open to me, but I couldn’t see them in my terror and freeze.

If I’d had some scripts or mantras, I could have grounded myself. I could have said to myself, ‘Okay, I’m being triggered by the presence of this dog. It’s bringing up feelings, sensations and memories from the there-and-then. But what’s going on in the here-and-now? Am I in danger from this dog? Or is it in fact just sitting there, completely uninterested in me? What is the actual risk, right here and right now? Can I just notice that this is ‘a’ dog, but it is not ‘the’ dog?’

The distinction between ‘a’ dog and ‘the’ dog was a breakthrough for me. As I walked down the street and was approached by walkers and their dogs, I began to say, over and over to myself, ‘It’s okay. This is ‘a’ dog, but it’s not ‘the’ dog.’ I forced my brain to make the distinction between the actual, specific trigger at the time of the trauma, and the way I have generalised out from that. I got my front brain to start ‘just noticing’ and to play spot the difference: ‘This is ‘a’ dog, but it’s not ‘the’ dog.' The dog’ was a Border Collie. This dog is a Staffie. The dog’ was alive during the 1980s and must have been dead for over twenty years. ‘This dog’ is safe.'
MANAGING UNCOMFORTABLE ASSOCIATIONS

Let’s start with associations first, as the easiest type to deal with. We may have been abused as a child in a wood, and so we associate trees with abuse. We therefore see a picture of trees in our therapist’s office, and our nose curls up in disgust. There’s a sense that this isn’t right—this isn’t good. ‘Could you take that picture down?’ we might ask. ‘It’s triggering us,’ we explain. We feel uncomfortable, and it would be so much easier for us if we didn’t have to feel that discomfort.

The problem with this approach is that there are a lot of trees in the world, and there are a lot of pictures of trees in the world. We can’t remove them all. And this is actually the best level to start at, as it can help us to build confidence in our ability to manage the greater levels of trigger.

The problem here is to with our thoughts. We have made a negative association between the trauma and something that would otherwise be neutral, maybe even positive. So the key here is to engage the front left brain, which is based around words, facts and knowledge. We need to reframe.

So we can start to unpick the associations we have made and replace them with new ones:

Oh look! I am making an association between this picture of a tree and my abuse. I was abused near trees, and so that’s why I’ve made this association. But it’s not a helpful one, because it’s not actually doing anything to keep me safe.

The truth is that trees aren’t dangerous; abusers are. It wasn’t the location that was dangerous; it was the person. And this isn’t even a tree; it’s just a picture of one. So, it is an association I’ve made, but I’m going to break that association and I’m going to create a new one instead.

I’m going to imagine beautiful fruit trees in an orchard. I’m sitting under the tree and everything is peaceful and safe. I pick the fruit from the trees—apples, pears, plums—and it all tastes delicious. The branches and leaves shade me from the hot sun. It’s nice sitting here by the trees. Trees are lovely. Trees are safe.

It can be helpful to create your own ‘frame’ for your previous trigger and write it down, and then repeat it to yourself several times daily until—as in my example—every time you think of trees, you think of the orchard. That way I can remind myself that every time I see a tree, or a picture of a tree, I can direct myself towards the positive rather than allowing my mind to chase after the negative. It might take a lot of repetition, but it is highly effective in the long run.

If we don’t do this, our life narrows and everything becomes a source of misery. If we want to be free from the effects of trauma, we have to start to learn to take control of the thoughts in our head. It’s not that we can necessarily stop the thoughts coming; but when they do, we can choose to ‘flip’ them from something negative to something positive. Learning that we can start to direct some of our
thoughts—guiding them from negative to positive—is a fundamental step in recovery: instead of being powerless victims of our thoughts, we can learn to take charge of them.

Worst still, if every time we see a tree, or a picture of a tree, we replay the negative association, it will grow and strengthen in our mind. And it allows the trauma to infect all the good things in life. Certainly for me, I had to learn to impose a boundary on the trauma—to be able to say, at times, ‘No, you’re not ruining THAT for me as well!’ It takes time, with lots of repetition and perseverance, to change the associations, but if we keep on keeping on, it can massively improve the quality of our life.

**MANAGING DISTRESSING REMINDERS**

Distressing reminders are more powerful than associations, but not as powerful as triggers. There is an emotional reaction, rather than just a mental one, but it’s not at the level of a full somatic response. It’s upsetting, but it’s still at the edges of my window of tolerance. My front
brain is still online a little and so there is some conscious choice over what happens next. The key to distressing reminders is soothing.

Soothing is about letting both our body and our brain know that we’re safe and that nothing bad is going to happen now, so that we can go back into the ‘green zone’ of our window of tolerance. The distress we’re feeling is in our body so it’s important that we address this, not just cognitively, but somatically too. Breathing is absolutely key. It might sound simplistic—of course we need to breathe!—but breathing is a secret super-weapon in our fight against trauma. Breathing sits on the interface between what is conscious and unconscious: after all, you breathe all the time, even when you’re not conscious of doing so, and yet you can also consciously take control of your breathing and speed it up or slow it down.

When we breathe in, it activates our sympathetic nervous system, the amber of fight and flight—our accelerator. So even just one in-breath can make our heart beat slightly faster. Breathing out, however, activates the parasympathetic nervous system of the ‘green zone’—our brakes. So when we’re activated in our bodies by a distressing reminder of trauma, we can override our body’s automatic response by consciously slowing our breathing. It can be useful to breathe in to the count of five, and then breathe out deeply, to the count of five or even longer. For full effect, we can do this mindfully, with our attention on the breath, for a minute or even longer. It’s the most effective response to being triggered, and our breath is available to us everywhere, no matter what we’re doing.

There are other ways to soothe our body’s alarm response too. Many of us trauma survivors find it difficult to actively relax our bodies, and this is because the amygdala is telling us that there’s a fire, so why would we want to relax? Relaxation and fire don’t mix! But when we do relax our bodies, it sends an overriding message to the smoke alarm to say, ‘This is okay! I’ve got this! I’m not concerned!’ The smoke alarm is a two-way device: it sounds the alarm, but we can also tell it to mute the alarm, and we do this by actively relaxing our bodies. How? One of the easiest ways is actually to tense the body. Pick a muscle group—say your quadriceps (front of the upper leg)—and clench them really really tight for as long as you can, say 5 or 10 seconds. Then just let them go. This automatically relaxes the muscles and is far easier than trying to figure out how to make a muscle go floppy which is rigid and tense and ready for action!

The front right brain has the best connections to our body, and is calmed when we calm our bodies. It’s also the part of the brain that is most active in ‘attachment moments’, times when we reach out to a significant person, another human being who is attuned to us and can provide a safe haven for us when we’re distressed. It’s not always appropriate or possible to get help from people—people aren’t always available—but sometimes
they are and just a little cry for help at these moments can help pull us back into our green zone. Who can you reach out to? And even if they're not available, can you imagine a conversation with them in which they are telling you that you're okay?

In addition, we can send mental messages to our smoke alarm to calm down, with reassuring mantras. For example:

*It’s okay. It’s just my smoke alarm sounding. But it’s a false alarm—just burnt toast, not the house on fire. I’m safe now. My body and brain have noticed something that reminds them of the trauma, and they’re trying to protect me. But that danger was then; this is now, and I’m safe. No need for the smoke alarm. I can breathe, and relax.*

**MANAGING TRUE TRIGGERS**

If we can become proficient at reframing our uncomfortable associations, and soothing our distressing reminders, then we can move on to tackling the most difficult level of trigger, the ‘true trigger’. This is the full-blown, all-out emergency that can at first be almost impossible to deal with. We go either into the amber zone, with fight or flight, manifesting even in a panic attack, or we tip even further into the red zone and we shut down with freeze. How on earth can we manage when this is happening?

To start with, we can’t. We can only work on ‘repairing’ the brain after the event. It is very common, after being triggered like this, to feel shame and frustration.
‘What happened? Oh no! I can’t believe I was triggered again!’ We unleash a verbal torrent of abuse on ourselves for having reacted the way we did, or we feel helpless and overwhelmed at our inability to prevent it. Either way, our attack on ourselves sends a new message to the amygdala that we are under attack. It can’t distinguish between a real attack from an outside source, and an internal attack from ourselves: it just sounds the alarm! So we end up in a vicious cycle: we get triggered, and then afterwards we attack ourselves for having been triggered, which triggers us further.

So we may not be able—at least to start with—to stop the initial trigger, but we can do something afterwards. We can be kind to ourselves, and we can just notice the fact that we were triggered, without judgment or criticism. We can say, ‘Aah! I was triggered! How interesting!’ If we can take all the blame out of it, it will at the very least prevent us from being triggered again. It’s like stubbing our toe and then whacking ourselves on the head for being clumsy—we end up not just with one pain, but two!

Self-compassion turns down the sensitivity of the smoke alarm. Staying calm after the event gets the smoke alarm to see a trigger as just ‘one of those things’, but not as representing real danger. Because afterwards, nothing bad happens. I’m walking through the woods, a dog runs up to me, I get triggered… and I may even lose time as I switch to a traumatised part of myself. But afterwards, as my front brain comes back online, I can look back at what happened and I can say, ‘I was just triggered—that’s all it was. Nothing bad happened. I’m safe.’

I like the word ‘just’. It helps defuse situations. It gives a shrug of the shoulders to something that otherwise is clamouring to shout ‘DANGER!’ It’s an important part of overcoming trauma. Because all of these reminders of trauma feel like they’re an emergency; it feels like we’re going to die. And we can validate these feelings, because yes—we really do feel this. But we mustn’t believe them, because it’s okay now and we’re safe.

If we keep telling ourselves we’re unsafe, we’ll keep on being triggered. The key to recovery from triggers and flashbacks is to work towards feeling safe. And so we have to start telling ourselves that we’re safe even before we feel we are. We have to base what we tell ourselves on external reality, rather than internal feelings. Are we actually safe? Even if we don’t feel it, we need to be saying it, and the word ‘just’ can help us to tune things down a little. ‘I’m just triggered… It’s just a tree… It’s just a dog… It’s just my smoke alarm sounding… It’s just trying to keep me safe.’

So to manage true triggers better, our first step is to ‘just notice’ that they’ve happened, and be compassionate and reassure ourselves that we’re safe now. We learn to calm down quickly after having been triggered, so that at the very least we are minimising the harm.
The next step is to build reassuring mantras into our everyday thinking, to train the conscious mind so that our unconscious mind can start to do things habitually. These are the kinds of mantras I mentioned above for ‘distressing reminders’. It’s utilising the same concept as training for paramedics or people in the military—people who absolutely have to stay calm even in the midst of a crisis or a full-blown attack. They are drilled, over and over again, to keep their front brains online even while bullets are flying overhead, or a patient is in cardiac arrest. And many of them have simple mantras: ‘ABC: airways, breathing, circulation.’ Rather than freaking out and not knowing what to do, the emergency responder can fall back on doing the basics: the ABC. In the military, the most basic is ‘ready, aim, fire!’ You don’t want someone to fire a gun until they’ve readied themselves in position and taken aim. You train the conscious mind so that it becomes a habit even under difficult conditions. And that’s the same process that we can use to learn to manage triggers.

Making your own mantras, which make most sense to you, is most effective. They must be short and simple—able to be repeated easily, maybe using rhyme or alliteration to plug them into memory. Write them down, so that you can keep practising them at all times of day or night, and carry them around as ‘mantra cards’ so that when you are triggered and your front brain is going offline, you don’t have to remember them—you just have to...
remember where they are. It can also be helpful to let professionals and significant others know about them, so that they can use them if you are too triggered to be able to use them for yourself.

WE CAN RECOVER!

When daily life is consumed with a battle with triggers, it can feel that nothing will ever change and that triggers are impossible to manage. But if we narrow down the problem—if we take the general and make it specific—then we can split the problem up into three types of trigger, and work out a strategy for each. We need to stop and ask: is this an association, a reminder, or a trigger?

• If it’s an uncomfortable association, what can I replace the negative association with? How can I reframe it?
• If it’s a distressing reminder, how can I soothe my body, get support and calm myself down?
• If it’s a true trigger, can I just notice and be compassionate towards myself? Can I practice some mantras that remind me that I’m safe?

The bad news is that this process is hard work and requires dedication and lots of repetition. Our brains are plastic and do change—but not in response to a one-off. If you want to learn a musical instrument, a foreign language or how to drive a car, you have to practice and practice and then practice some more. The same is true for changing the way our brains respond to trauma cues. We can change them, but we need to work hard at it. The rewards, however, are truly phenomenal. I cannot begin to describe how different my life is now from when I was beset with hourly, daily triggers. I’m so glad that I put the time and effort into retraining my brain, and I’m so grateful that I had the support to do it. And I hope you do too.

Mantra cards are available from https://shop.pods-online.org.uk/mantra-cards
I came to be a therapist quite late in life after a successful but ultimately unrewarding career in business. I always felt that there should be something more to life than making money, and it struck me repeatedly how mental health difficulties disrupted the lives of so many of my staff. Within my department, which consisted of over 200 people, I promoted a strong ethos of being a supportive employer and we provided time off for and access to counselling to anyone who needed it. It fell under the remit of ‘flexible working’ so that colleagues wouldn’t need to know why someone didn’t come in on a Thursday morning until 11.00 am. But being the manager, I knew how many people accessed this kind of support, and it eventually occurred to me that, rather than retiring to a lifestyle of golf and DIY, this was maybe something that I could invest the later years of my life into. So I took early retirement and retrained as a therapist.

I assumed from my background that I would work at the supposedly ‘higher’ end of things, maybe business coaching, helping people to set and achieve goals, that sort of thing. But I did my placement at a local Mind office where we provided short-term (6 sessions) counselling for people referred via their GP. Suddenly I was working with lots of people with depression, relational difficulties, and low self-esteem. I was surprised at how much I enjoyed the work, but I found it frustrating to have such little time with them. For my next placement, my aim was to be able to work longer term and coincidentally it ended up being for a sexual abuse counselling service. I’d never given much thought to the topic before, and had very simplistic attitudes—I really had no idea at all about the dynamics of abuse, how in grooming the victim takes on the responsibility that should be the perpetrator’s, and how insidious the impacts of abuse are. I was also completely unaware at just how prevalent abuse is. That alone shocked me to my core, and made me feel that I’d been living in an alternative universe all my life.

I feel quite ashamed when I realise how ignorant I was. The first year was a steep learning curve but I was surprised at how rewarding I found the work. The counselling manager felt that it would be a good idea to send all the male clients my way, and in particular those who could most closely relate to my business background. It really struck me how different they were to many of my previous clients. Most of them were externally very successful: driven, high-achieving workaholics. They didn’t fit my existing schema of ‘mental health’ at all, and caused me to reassess a lot of my preconceptions. I realised that I had unconsciously assumed that most people seeking counselling, especially after sexual abuse, would be female; unemployed; depressed; and lacking in life skills. I felt deeply ashamed of such prejudice. All but one of the men I worked with over the first five years was employed,
and probably over two thirds of them at a management level. They were people that I would have considered to be colleagues. And it hit me like a missile that I had been assuming that abuse survivors would be ‘other’—different to me—in the same way that we think that the perpetrators are ‘other’. We assume that they are monsters and don’t see that they are just normal people with normal jobs living in normal neighbourhoods. And we stigmatise the survivors by assuming that their abuse will be written on their foreheads. I came to realise, albeit slowly, how much energy survivors invest in covering the abuse they have suffered, because they feel so ashamed. It began to stir in me a deep, deep passion to see these people free of the shame that didn’t belong to them, and as I worked more closely with them I increasingly came to feel deeply in awe of the resilience of these men who had survived such atrocities with such little support. I began to feel a little ashamed of my sheltered life and of how much I had moaned about really quite minor inconveniences. Rather than looking down on these survivors, as I might have done when in my previous career, I began to look up to them.

Over the five years I worked for that counselling service, I was struck by the commonalities between many of the survivors I worked with. All expressed some level of chronic disempowerment in their lives, a logical consequence of the powerlessness of trauma. But males in our culture are not expected to...
It was so difficult to get these men to open up emotionally. They were all or nothing— together, competent, brave, or sobbing and distraught. It was hard to work in the middle, and for them to be able to identify and verbalise what they were feeling. So their emotions were either suppressed or just burst out of them. Even after crying, many of them wouldn't be able to put into words what they had been so upset about. The language of emotions was foreign to most of them.

I was also struck by how difficult they found it to mentalise, to really step back from their experience and think about it. In the workplace, this was by no means an impediment to their success: they had a way of operating, they followed the rules of business, and they didn't need to understand things from other people’s point of view. Some ran into difficulties as a result in their man-management, but mostly business operates—at least in my experience—according to fairly rigid protocols and rules, and you don't always need a high degree of emotional intelligence to be successful. This was
CONTINUED: THE BUSINESSMAN, THE THERAPIST AND THE BRILLIANT CEO

perhaps why so many of the men I worked with found such safety in their work—it was predictable, it didn’t demand too much of them emotionally, and within the business world it’s perfectly acceptable to be cold-blooded and to rely on rationality and logic.

But when I tried to get these men to mentalise about their own experiences of abuse, they really struggled. In some ways they had a very immature psychological outlook: if they felt it was their fault, it was their fault; no point discussing it. If they felt they had been cowards because they hadn’t fought back or run away, they were cowards. There was a real sense of it being black-and-white, and the grayscales were for wimps. It took a long time to break through this with many of my clients, and to help them to be able to see the abuse from the perspective of the frightened 4-year-old boy, or the entrapped 12-year-old. Many seemed to think that the answer lay in them proving themselves as fathers, husbands, breadwinners, managers—that their outward success in terms of salary, car, house and golf handicap would wipe away their sense of intrinsic shame. There was a real terror in terms of coming to terms with their vulnerability and the fact that they were abused and that that abuse was wrong. They preferred to see that they were wrong for having allowed themselves to be abused. It took a lot of work to get them to view it any differently.

The challenge for me personally in working with these men was in not colluding with them. Unconsciously, they invited me to blame them. I found myself more easily triggered into feeling irritated with them, a sort of evoked ‘fight’ response in me. I found myself drawn into wanting to relate to them as a business mentor rather than as a therapist, to tell them to get a grip and set goals and put emotions to one side. Time and again, I realised that I was drawn into this approach. It took a long time for me to realise that I, too, was scared of what might happen if they let their guard down. I realised that I too was expecting them to be strong and to hold it together. Our cultural models have such a strong impact on us, even unconsciously.

The first male DID client I worked with was the CEO of a very successful tech start-up that had grown up out of ‘Silicon Fen’. At work, he was brilliant. At home, he was a mess and it was his impending divorce that drove him into therapy. He thought he could get ‘fixed’ in six sessions—in fact, he was a little surprised that we would need so many. He was as shocked as I was that the third session was ‘hijacked’ by another part of his personality. I had worked with female DID clients previously, and with one in particular it had been extremely slow work, building up trust before any of the parts manifested. But with this male client, we were straight in there. It was as if he couldn’t wait any longer. The narrative—disjointed, mostly unintelligible—of atrocious abuse poured out of him session after session; try as I might, nothing worked to slow him down.
or keep him in a window of tolerance. His abuse had been particularly severe, and also, in some ways, particularly bizarre—he had been hung over a motorway bridge and warned that if he ever told anyone, they would drop him. He was taken to ‘parties’ at stately homes and abused by both men and women, and forced to abuse other children. If it hadn’t all exploded out of him in the dissociated, fragmented way it did, it would have been unbelievable. And then, in the blink of an eye, the businessman was back in front of me again, with no memory whatsoever for what had just passed.

I worked long-term with this particular client, and all along he held it together at work. His business went from strength to strength. It never failed to impress me that dissociation is such a gift, in that it enables the person to carry on with daily life, even while the trauma is causing such distress internally. I trod very carefully in my work with him, to ensure that he was able to remain functioning at work—it was his ‘island of ability’, his source of resilience. Never in a million years would he have been willing to access mental health services through the NHS, or be seen as a ‘mental health patient’; his business reputation depended on his dissociation. And he really confirmed to me that we need to tailor our services to our clients. I smile when I look back now and think about how I assumed that I would be a business coach, maybe helping the occasional CEO through a divorce or some inter-personal conflict within their organisation. The reality is that people with even the most extreme backgrounds of abuse will walk through our doors, and we have to be open to the possibility that even the CEO of a technology start-up might have DID, and that it’s the dissociation that is facilitating their business brilliance. Above all, this work has taught me never to make assumptions about people and not to put them in boxes. We are all unique.
**Caring for Yourself**

**Aspects to Consider from the Mental Health Act and the Mental Capacity Act**

by Carolyn Spring

Having experienced a lack of control in childhood, many of us continue to fear a lack of control in adult life, especially when we are plagued by the symptoms of traumatisation and conditions such as PTSD or DID. Rather than engaging with mental health services because we trust that they will be helpful, many of us—rightly or wrongly—fear any involvement with them partly because we fear losing further control by being ‘sectioned’. We fear losing our liberty, losing the right to make decisions about our life, and losing the right to choose the kind of treatment we receive. In this article we will provide a brief overview of the Mental Health Act, the most relevant sections from it, and then look at how it differs from the Mental Capacity Act. We will then look at various tools and legal structures that we can use to plan for a future where we might encounter either the MHA or the MCA, including the Lasting Power of Attorney, Displacement of Nearest Relative, and Advance Statements.

**The Mental Health Act**

The Mental Health Act is a law in England and Wales about detaining and treating people with a ‘mental disorder’. Under the MHA, people can be made to stay in hospital (‘being sectioned’) and can receive treatment against their wishes. They may also be given a Community Treatment Order which specifies that, although living at home, they must do certain things, such as take their medication. The MHA has 5 guiding principles, which are summarised as follows:

1. Give treatment in the least restrictive way and help people to be as independent as possible
2. Involve patients
3. Respect patients, families, carers and friends
4. Help people get well
5. Make fair and efficient decisions.

In order to be admitted to hospital against your wishes, certain people must agree that you have a mental disorder and that you are putting your own safety or someone else’s at risk. You will be assessed and can be given treatment—even if you don’t want it. You have certain rights under the Mental Health Act, including the right to appeal and the right to get help from an advocate. The MHA also provides for free aftercare (section 117) once you leave hospital under certain sections.

The MHA applies to England and Wales and contains two parts: ‘civil’ sections (for people who have not committed a crime) and ‘forensic’ sections (for people who have, or who are suspected of having done so).

A ‘mental disorder’ is defined as ‘any disorder or disability of the mind’ and includes mental health conditions including schizophrenia, depression, bipolar, OCD, anxiety disorders, eating disorders, and personality disorders. Although rarely recognised
by psychiatrists, DID would also classify as a disorder, even if misdiagnosed as another condition. ‘Mental disorder’ also refers to dementia, behaviour changes following traumatic brain injury and autistic spectrum disorders. Learning disability is only included where it is associated with abnormally aggressive or seriously irresponsible behaviour, and drug and alcohol misuse is not counted as a mental disorder on its own—the MHA would only apply if the person has a dual diagnosis.

It normally requires three people to agree to someone being detained in hospital (sectioned), but this can differ depending on the circumstances and how urgent it is. In general, the three people would be:

- an Approved Mental Health Professional (AMHP), such as a psychologist, social worker, occupational therapist or nurse; or the ‘nearest relative’
- a section 12 doctor (a doctor who has received specialist training)
- a registered medical practitioner (such as a GP).

The table on pages 40–41 shows the most important sections of the MHA and the purpose and parameters of each. Of particular relevance to many people with dissociative disorders are sections 135 and 136 which allow the police to come into your home or remove you from a public place to take you to a ‘place of safety’. The police do not need medical evidence before removing you—they just need to reasonably think that you are mentally ill and that they need to move you to keep you and other people safe. A ‘place of safety’ can be an A&E department or a ‘place of safety suite’ at a psychiatric hospital. It could also be the home of a relative or friend, which may pose particular dangers if relatives are abusive. However, most commonly the police will take you to a police station and you will be detained in a cell until you can be assessed. You can be held for up to 72 hours until an Approved Mental Health Professional and/or doctor sees you. Once assessed you will be released, taken to an inpatient hospital as a voluntary patient, or detained under another section of the Mental Health Act.

**DISPLACEMENT OF NEAREST RELATIVE**

The ‘nearest relative’ is a legal term under the Mental Health Act 1983 and is not the same as the ‘next of kin’. Under the MHA, the ‘nearest relative’ has certain rights and responsibilities if you are detained in hospital under sections 2, 3, 4 or 37, whereas the ‘next of kin’ has none. The box on page 32 shows the list for determining who your nearest relative is, which is strictly adhered to as part of the law. The ‘nearest relative’ only applies to the Mental Health Act 1983 and not in other situations.

The nearest relative:

- can ask for an assessment to decide if their relative should be sectioned under the Mental Health Act;
• must be consulted by the Approved Mental Health Practitioner before their relative can be detained under a Section 3, unless this is impractical or would cause delay; but if the nearest relative objects, it makes being sectioned much more difficult;
• must be told within a reasonable timeframe if their relative is going to be detained under Section 2 unless it would cause emotional distress, physical harm or other exploitation to their relative;
• can be consulted about treatment decisions;
• can request for their relative to be discharged from hospital (but this may be overruled by the Responsible Clinician);
• can apply for a discharge from a Community Treatment Order;
• can delegate their rights to another person by writing to the chosen person and to the Hospital Managers.

People from abusive families or difficult situations may wish to ‘displace’ the nearest relative and appoint someone else instead. For example, it may not be appropriate for a spouse or civil partner to be the nearest relative if you are in a domestic violence situation, and neither would it be helpful (for unmarried people without children over the age of 18) to have an abusive parent take that role. In these situations, you can make an application to the County Court to ‘displace’ your nearest relative on the grounds that the nearest relative ‘is otherwise not a suitable person to act as such’. You can represent yourself in Court if you cannot afford a Solicitor, although you may in some circumstances be entitled to Legal Aid. At the time of writing, the correct form to use is N1 which can currently be downloaded at http://hmctsformfinder.justice.gov.uk/courtfinder/forms/n001-eng.pdf. This should be sent along with

Who is your nearest relative?
A nearest relative must be over the age of 18 (except for spouses, civil partners and parents), and the oldest in each category takes precedence. Half-blood relatives are counted as equivalent to full-blood, and the nearest relative must be resident in the UK, Channel Islands or Isle of Man. They are appointed in the following order:
1. Husband, wife or civil partner (including cohabitee for more than 6 months; none of these apply if separated)
2. Son or daughter
3. Father or mother (an unmarried father must have parental responsibility in order to be nearest relative)
4. Brother or sister
5. Grandparent
6. Grandchild
7. Uncle or aunt
8. Nephew or niece
the Court fee (search for form EX50 for a list of fees) to your nearest County Court—go to https://courttribunalfinder.service.gov.uk/search/.

If someone does not have a nearest relative, the local County Court will, under Section 29, appoint a nearest relative. The person involved may nominate their choice of nearest relative, but the Court will have the final say. If a nearest relative objects to a Section 3 without good cause, the Approved Mental Health Practitioner can also apply to the Court to have them displaced.

Mental health act and mental capacity act: what’s the difference?

Mental capacity is different to mental illness. Someone may be mentally ill and yet still have mental capacity, and someone may be mentally well but lack mental capacity. In addition, someone can both lack mental capacity and be mentally ill, and in ideal circumstances people will both have mental capacity and be mentally well, as this quadrant shows:

<table>
<thead>
<tr>
<th>Has mental capacity</th>
<th>Has mental capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is mentally ill</td>
<td>Is not mentally ill</td>
</tr>
<tr>
<td>MHA</td>
<td>Neither</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does not have mental capacity</th>
<th>Does not have mental capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is mentally ill</td>
<td>Is not mentally ill</td>
</tr>
<tr>
<td>MHA/MCA</td>
<td>MCA</td>
</tr>
</tbody>
</table>

WHAT IS MENTAL CAPACITY?

Mental capacity is the ability to make your own decisions. When you make a decision you need to be able to:

- understand the information relevant to making that decision
- use or weigh up that information
- keep or remember that information
- have the means to communicate your decision to someone else.

You may lose capacity because of a mental illness, brain injury, stroke, severe learning disability or if you have used alcohol or drugs.

HOW IS MENTAL CAPACITY ASSESSED?

The Mental Capacity Act has a specific test for assessing if you have capacity to make a decision at a particular time. The test is not based on your symptoms or diagnosis alone—for example, a diagnosis of schizophrenia will not by itself indicate a lack of mental capacity. The test has to be done for each decision that you are making, because you might be able to decide what you want for lunch but be unable to make a decision about long-term financial investments.

There are two parts to the test of capacity under the MCA:

1. Medical professionals must decide if you have an injury or illness which affects the way your brain or mind works, and whether the
effects are so severe that you cannot make a particular decision.
2. You will be tested to see if you have capacity by assessing if you can:
   a. understand the information needed to make the decision
   b. remember and recall that information
   c. understand the result or outcome of the choice you are making
   d. tell people your decision, for example by talking, using sign language or squeezing someone’s hand.

You cannot be deemed to lack mental capacity if you are just making an unwise decision, and nor can you be deemed to lack mental capacity just because you have a particular diagnosis.

WHAT CAN I DO IF I AM WORRIED ABOUT LOSING CAPACITY?

Whilst you still have mental capacity, you can register a Lasting Power of Attorney (LPA). This will pass decision-making powers to certain people whom you specify (your ‘attorneys’). You can choose for them to be able to make decisions on your behalf straightaway (for example, financial decisions while you are abroad) or you can stipulate that they can only step in once you lose mental capacity.

WHAT IS A LASTING POWER OF ATTORNEY (LPA)?

A Lasting Power of Attorney is a legal document that is sealed by the Court of Protection. It allows you to appoint one or more people (your ‘attorneys’) to make certain decisions on your behalf if you lose mental capacity.

WHO IS A LASTING POWER OF ATTORNEY FOR?

To make an LPA you must:
- be over the age of 18
- have the mental capacity to make the decision to have an LPA
- have someone sign to say that you have the mental capacity to make an LPA—this can be a professional such as a doctor, social worker or solicitor, or someone who has known you for more than 2 years and is independent and will not benefit from the LPA
- have one or more people who are willing to act as your ‘attorney’
- have one or more people who are willing to be informed of your decision to register a LPA and can object or raise concerns to the Office of the Public Guardian—this is a safeguard to ensure that you are not being coerced into it.

WHAT MIGHT HAPPEN IF I DON’T HAVE AN LPA?

If you don’t have an LPA, many decisions will be taken on your behalf either by...
medical professionals or your next of kin or relatives. In situations where you have a domestically violent partner or spouse, or abusive parents, this could put you in a very worrying situation. A Lasting Power of Attorney gives you security in this kind of scenario, for example if you have a stroke or enter a coma following a car crash. It would mean that your ‘attorneys’ are entitled to make decisions about you regarding your care (such as ongoing life support) and can receive information about you, and abusive family members or partners will be prevented from doing so. Your ‘attorneys’ can only make the kinds of decisions that you stipulate in your LPA.

WHY MAKE AN LPA?
• it ensures that the people you have chosen can make decisions on your behalf, rather than strangers or abusive family members
• it allows you to stipulate the kind of care and treatment that you wish to receive, so your wishes are more likely to be followed
• it makes it easier for the people around you to be able to act on your behalf and know what decisions you would want them to make.

WHAT DOES AN LPA COVER?
There are two types of LPA:
1. Health and Welfare
   This covers areas such as your daily routine, for example washing, dressing and eating, your medical care, and life-sustaining treatment. This will only come into effect once you lose mental capacity.
2. Property and Financial Affairs
   This covers areas such as managing a bank account, paying bills, collecting benefits and selling property. This can come into effect while you still have mental capacity if you so desire.

WHAT WOULD MY ATTORNEYS DO?
• they must follow your instructions as written on the LPA, but you cannot instruct them to do anything illegal
• they must follow the Mental Capacity Act Code of Practice
• they must make sure that you are allowed to make as many decisions for yourself as you can
• they must make sure that any decisions they make are in your best interests
• they must not take advantage of their position, and only make decisions which benefit you
• they must not let other people make decisions, unless they have the right to do so, such as a doctor
• they must respect your privacy
• they must follow any directions given by the Court of Protection
• they must not give up the role without first telling you and the Court.
CONTINUED: MENTAL HEALTH ACT AND MENTAL CAPACITY ACT

HOW DO I MAKE AN LPA?
1. Choose your attorney(s).
2. Fill in the forms to appoint your attorneys and specify your instructions. The forms can be currently found at https://www.gov.uk/power-of-attorney. You can also instruct a solicitor to do it for you, but this is more expensive.
3. Register your LPA with the Office of the Public Guardian, which can take up to 10 weeks and costs £110 per LPA, unless you are entitled to a reduction due to low income.

ADVANCE STATEMENTS

According to the NHS, an Advance Statement is:

a written statement that sets down your preferences, wishes, beliefs and values regarding your future care. The aim is to provide a guide to anyone who might have to make decisions in your best interest if you have lost the capacity to make decisions or to communicate them.

Advance Statements are also known as Advance Requests and are becoming increasingly common within many NHS Trusts and some provide a specific form to fill in to register your Advance Statement with them, which is then attached to your medical records. You can also write your own (see www.pods-online.org.uk/advance-statement for a template), including information such as who to contact in an emergency (and who NOT to contact), and clear statements about your preferences for treatment, as well as perhaps practical arrangements for caring for children and pets etc. It is important to be realistic when writing an advance statement, focusing on the main priorities and what is practicable.

Having signed and dated your Advance Statement in front of a witness, who also signs and dates it, you then need to make sure that professionals are aware that your advance statement exists and where to locate a copy. You could for example give a copy to your GP, your mental health team, your therapist and a person of your choice (for example, a close friend, relative or an ‘attorney’ if you have a LPA). You could also include details of where to locate it on your crisis card.

If you change your mind about what you have put on your advance statement, it is important to update it as soon as possible and have your signature witnessed again. Even without making changes, it is a good idea to review it regularly and provide updated copies so that it is as clear as possible that your wishes are still current. You can also revoke your statement, which should involve destroying the original copies to avoid confusion, and informing people who had access to it.

An advance statement is not legally binding, but increasingly medical professionals are becoming aware of them and taking them more seriously. However, there are times when health professionals will overrule your wishes, including:
WHAT IS AN ADVANCE DECISION?

Advance Decisions, also known as Advance Directives, are part of the Mental Capacity Act 2005 and allow people a legal right to refuse medical procedures in advance. For example, you may wish to make an Advance Decision that you do not want electroconvulsive therapy (ECT) if you become unwell. Unlike Advance Statements, they are legally binding. You need to have mental capacity when you make the Advance Decision, and it must be clear and definite. But as long as it has been made properly, a medical professional who goes against your Advance Decision is breaching your rights and may be committing a criminal offence. You may be able to sue them for assault and/or negligence if they are aware of your Advance Decision and act contrary to it. However, if you are detained under the Mental Health Act, doctors can in most cases ignore your Advance Decision.

- when a health professional judges that the treatment you have requested or refused is not in your best interests
- if the treatment you ask for is illegal—for example, asking a doctor to end your life
- if it is an emergency and there is not sufficient time to consult the advance statement
- if you are detained under the Mental Health Act
- if the treatment you request is not available in your area
- if a health professional believes that you did not have mental capacity when you made the advance statement.

If health professionals do not follow your advance statement, you could ask for their reasons and if necessary make a complaint.
# Mental Capacity Act or Mental Health Act?

**Mental Capacity Act** (MCA 2005)

<table>
<thead>
<tr>
<th><strong>When does it apply?</strong></th>
<th>If you lose mental capacity, e.g. coma, stroke, persistent vegetative state. Also relevant for example in a manic phase of bipolar for specific decisions, e.g. financial.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When is it used?</strong></td>
<td>When you lack the mental capacity to make decisions about yourself because you cannot understand, remember or weigh up information to make a decision, or if you can’t communicate that decision.</td>
</tr>
<tr>
<td><strong>Who can assess it?</strong></td>
<td>In most cases a medical doctor.</td>
</tr>
<tr>
<td><strong>Who acts on your behalf if you are under the Act?</strong></td>
<td>If you have made a Lasting Power of Attorney your attorneys will act on your behalf. If you haven’t, the Office of the Public Guardian (OPG) will appoint someone as a ‘deputy’. Family or friends can apply to the OPG to be the ‘deputy’. In the meantime the NHS or social services may appoint an Independent Mental Capacity Advocate (IMCA) to support you if you do not have any family or friends.</td>
</tr>
<tr>
<td><strong>What areas does it apply to?</strong></td>
<td>Medical treatment, care needs, housing and financial matters.</td>
</tr>
<tr>
<td><strong>Can I be treated without my consent?</strong></td>
<td>If healthcare professionals think you need care or treatment and you lack capacity, they have a legal right to treat you without your consent, unless prevented from doing so by your attorney from a legal LPA.</td>
</tr>
<tr>
<td><strong>What can I do to plan ahead?</strong></td>
<td>Set up an LPA for Health and Welfare and/or an LPA for Finance and Property. This is legally binding.</td>
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</tbody>
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When does it apply? if you lose mental capacity, e.g. coma, stroke, persistent vegetative state. also relevant for example in a manic phase of bipolar for specific decisions, e.g. financial.

When is it used? When you lack the mental capacity to make decisions about yourself because you cannot understand, remember or weigh up information to make a decision, or if you can't communicate that decision.

When, despite having mental capacity, you refuse assessment or treatment for a mental health disorder and you pose a risk of harm to yourself or others. you will then be ‘sectioned’, i.e. detained in hospital under a section of the Mental Health Act.

Who can assess it? in most cases a medical doctor.

Who acts on your behalf if you are under the act?

if you have made a lasting power of attorney your attorneys will act on your behalf. if you haven't, the office of the public guardian (opg) will appoint someone as a ‘deputy’. Family or friends can apply to the opg to be the ‘deputy’. in the meantime the nhs or social services may appoint an independent Mental capacity advocate (iMca) to support you if you do not have any family or friends. your ‘nearest relative’. If you are under a section you are also entitled to an Independent Mental Health Advocate (IMHA).

What areas does it apply to? Medical treatment, care needs, housing and financial matters. treatment for mental disorders.

Can I be treated without my consent?

if healthcare professionals think you need care or treatment and you lack capacity, they have a legal right to treat you without your consent, unless prevented from doing so by your attorney from a legal lpa. you can be assessed and treated for a mental health disorder without your consent, but you cannot be given treatment for a physical illness without your consent, unless it is emergency treatment in a life-threatening situation.

What can I do to plan ahead?

set up an lpa for health and Welfare and/or an lpa for Finance and property. this is legally binding. Write an advance statement. although not legally binding, doctors and nurses should take into consideration what you have requested in your Advance Statement. Write an Advance Directive, also known as an Advance Decision. This is a legally binding document which says which treatments you do not want. In most cases, doctors can overrule an Advance Directive if you are sectioned under the MHA. However, if you have a valid Advance Directive refusing electroconvulsive therapy (ECT), a doctor cannot override this.

Mental Health Act (MHA 1983)

<table>
<thead>
<tr>
<th>When you need to be assessed or treated for a mental health disorder.</th>
<th>When, despite having mental capacity, you refuse assessment or treatment for a mental health disorder and you pose a risk of harm to yourself or others. You will then be ‘sectioned’, i.e. detained in hospital under a section of the Mental Health Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In most cases, three people must agree to you being detained in hospital, including an Approved Mental Health Professional, a specially trained doctor, and a further doctor.</td>
<td>Your ‘nearest relative’. If you are under a section you are also entitled to an Independent Mental Health Advocate (IMHA).</td>
</tr>
<tr>
<td>Treatment for mental disorders.</td>
<td>You can be assessed and treated for a mental health disorder without your consent, but you cannot be given treatment for a physical illness without your consent, unless it is emergency treatment in a life-threatening situation.</td>
</tr>
<tr>
<td>Write an Advance Statement. Although NOT legally binding, doctors and nurses should take into consideration what you have requested in your Advance Statement. Write an Advance Directive, also known as an Advance Decision. This is a legally binding document which says which treatments you do not want. In most cases, doctors can overrule an Advance Directive if you are sectioned under the MHA. However, if you have a valid Advance Directive refusing electroconvulsive therapy (ECT), a doctor cannot override this.</td>
<td></td>
</tr>
<tr>
<td>SECTION OF MHA</td>
<td>PURPOSE</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>S2</td>
<td>Detained in hospital for an assessment of your mental health and to get any treatment you may need</td>
</tr>
<tr>
<td></td>
<td>Used if you have not been assessed in hospital previously or for a long time</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>Detained in hospital for treatment</td>
</tr>
<tr>
<td></td>
<td>For your health, or to protect you or other people</td>
</tr>
<tr>
<td></td>
<td>Used after an admission under S2 or if you are well known to mental health services</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td>Stops you leaving hospital as a voluntary or informal patient</td>
</tr>
<tr>
<td></td>
<td>Can also be used if you are having treatment in a general hospital for a physical condition</td>
</tr>
<tr>
<td></td>
<td>Can only be used when it is not possible or safe to use a S2, S3 or S4</td>
</tr>
<tr>
<td></td>
<td>Known as ‘the doctor’s holding power’</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>S135/136</td>
<td>To enable you to be taken by the police to a ‘place of safety’ for a mental health assessment if they think you have a mental illness and are in immediate need of care and control</td>
</tr>
<tr>
<td></td>
<td>You can either be removed from your home (S135) or from a public place (S136)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
### HOW LONG CAN I BE DETAINED FOR?
- Up to 28 days
- May be discharged before this
- The S2 cannot be renewed but can be transferred to a S3
- Up to 6 months
- May be discharged before this
- Can be renewed for a further 6 months
- After that, can be renewed for 12 months at a time
- Can only be renewed following an assessment by the Responsible Clinician during the 2 months before the S3 is due to expire
- Under S5(2), up to 72 hours and cannot be renewed
- Under S5(4), up to 6 hours and cannot be renewed; holding power ends as soon as a doctor arrives, who may transfer you onto a S5(2)
- Up to 72 hours until an AMHP and/or doctor sees you

### WHAT ARE MY RIGHTS?
- Right to appeal to a Tribunal during the first 14 days that you are detained
- Right to appeal to the Mental Health Act managers
- Can ask for the help of an Independent Mental Health Advocate
- Should receive a Patient Rights Leaflet
- Right to appeal to a Tribunal once during the first 6 months of detention
- Right to appeal once during the second 6 month period
- Right to appeal once during each subsequent one year period
- Right to apply for discharge to the Mental Health Act managers at any time
- Can ask for the help of an Independent Mental Health Advocate
- Should receive a Patient Rights Leaflet
- Should receive a Patient Rights Leaflet

### CAN I BE TREATED AGAINST MY WILL?
- Yes, but some treatments including ECT (electroconvulsive therapy) cannot be given unless certain criteria are met
- Yes, for up to 3 months
- After this, you will need to be assessed by a Second Opinion Appointed Doctor (SOAD)
- Some treatments including ECT (electroconvulsive therapy) cannot be given unless certain criteria are met
- No, unless you lack capacity, or treatment must be given in an emergency to prevent serious harm to yourself or others
- No, unless you lack capacity, or treatment must be given in an emergency to prevent serious harm to yourself or others

### WHO CAN DISCHARGE ME?
- The Responsible Clinician
- The Mental Health Act managers
- The ‘nearest relative’ (can be overruled by the Responsible Clinician)
- The Tribunal
- The Responsible Clinician
- The Mental Health Act managers
- The ‘nearest relative’ (can be overruled by the Responsible Clinician)
- The Tribunal
- You will automatically be discharged from S5 once the detention time ends and if you have not been transferred onto another section
- You will automatically be discharged once the detention time ends and if you have not been transferred onto another section
EMDR IN THE TREATMENT OF DISSOCIATIVE DISORDERS

by Helena Garner

WHAT IS EMDR?

EMDR stands for Eye Movement Desensitisation and Reprocessing and was developed in 1989 by Dr Francine Shapiro, an American Psychologist and Educator. It is a comprehensive, integrative psychotherapy approach which has been recognised as an effective treatment for trauma in many countries and by different organisations. In the UK, the NICE (National Institute for Clinical Excellence) guidelines for PSTD (post traumatic stress disorder) specify EMDR as a suitable treatment option. The EMDR Institute (www.emdr.com) says:

EMDR psychotherapy is an information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviours and mental health.

HOW DOES IT WORK?

It is not entirely clear why EMDR is effective in treating trauma, although some people theorise that it may help the hippocampus (part of the brain involved in memory storage and retrieval) to process distressing memories and flashbacks. The alternating left-right stimulation of the brain with eye movements, sounds or taps during EMDR seems to help the brain to integrate and process information.

CAN IT BE USED TO TREAT DISSOCIATIVE DISORDERS?

The ISSTD (International Society for the Study of Trauma and Dissociation) endorses EMDR as an adjunctive treatment in their Guidelines for Treating Dissociative Identity Disorder in Adults (2011). They recommend that EMDR is not used as a standalone treatment but as part of an overall treatment plan.

Early use of EMDR with dissociative clients, however, resulted in a number of difficulties, including ‘unintended breaches of dissociative barriers, flooding, abrupt emergence of undiagnosed alternate personalities, and rapid destabilisation’ (ISSTD, 2011). The ISSTD therefore recommend that adjustments be made to the standard EMDR protocols when working with dissociative survivors, and various safeguards put in place.

WHEN CAN EMDR BE USED WITH DISSOCIATIVE CLIENTS?

These guidelines suggest the following considerations:

- the therapist needs to be experienced in working with dissociative disorders, and using EMDR with non-dissociative clients
- the client needs to be assessed for their readiness, for example:
  - being generally stable, with good ego strength and social support
  - having sufficient coping strategies
  - having sufficient internal cooperation between parts
  - having a history of engaging successfully in treatment
  - being able to maintain a ‘dual focus of awareness’ (i.e. on the traumatic memory and on the therapist)
  - having low levels of self-harm or suicidality
  - having low levels of uncontrolled flashbacks and involuntary switching
  - being of sufficiently good physical health
  - having no serious dual diagnoses such as non-dissociative psychosis or serious substance abuse
  - having a positive relationship with the therapist
- the therapist also needs to consider their own readiness and suitability, for example:
  - being sufficiently trained and experienced in working with dissociative disorders
  - being able to work with a range of alternate personalities, e.g. child parts, angry and hostile parts, perpetrator-loyal parts
  - being able to manage crises and therapeutic ruptures
  - being able to recognise hypnotic and dissociative symptoms and phenomena
  - being experienced in using EMDR with non-dissociative clients.

WHAT ARE THE MAIN RISKS OF USING EMDR WITH DISSOCIATIVE CLIENTS?

Onno van der Hart, quoted in the ISSTD Guidelines, states that: ‘The risk inherent with the use of EMDR with chronically traumatised individuals is that it often reactivates too much traumatic memory too quickly.’ Francine Shapiro states: ‘The use of eye movements too early in treatment risks premature penetration of dissociative barriers. This could produce such results as flooding of the system, uncontrolled destabilisation, and increased suicidal or homicidal risk. For crisis intervention, the therapist should attempt eye movements only if the risks of failing to intervene are as high without as with the intervention.’

The risks can be reduced with the following considerations:

- working only with clients who are already reasonably stable (see above)
- keeping the quantity and intensity of traumatic material at a manageable level
• isolating one target memory as much as possible
• developing a sound relationship with the client before attempting to begin work with EMDR, and knowing the client well enough to become aware of subtle signs that might indicate that the pace is too fast or there is a risk of flooding
• adjusting the pacing and type of alternating bilateral stimulation, for example using shorter sets or using audio or tactile stimulation rather than eye movements
• increasing the length of a session to allow a slower pace to process and integrate material and reground afterwards
• repeating protocols, as processing is usually incomplete after the first attempt
• using EMDR in the first instance to reduce and contain symptoms, build ego strength, develop cooperation between parts, increasing a felt sense of current day safety, and increasing distress tolerance—rather than working specifically on traumatic memories.

WHERE CAN I FIND OUT MORE?
EMDR Association: www.emdrassociation.org.uk
EMDR Institute: www.emdr.com

WHAT IS EMDR USEFUL FOR IN THE TREATMENT OF DISSOCIATIVE DISORDERS?
Shapiro states the following uses for EMDR:
• neutralising trauma through abreaction
• improving internal dialogue between parts using ego state therapy
• restructuring cognitive distortions
PODS Positive Outcomes for Dissociative Survivors

making recovery from dissociative disorders a reality through training, informing and supporting

www.pods-online.org.uk · 01480 878409