Dissociation in Play Therapy

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Schedule Today

- 9:00-10:30 Theory of Dissociation
- 10:30-10:45 Break
- 10:45-12:15 Stabilization Skills
- 12:15-12:45 Lunch
- 12:45-2:15 Assessment for Dissociation
- 2:15-2:30 Break
- 2:30-4:00 Working with Parts

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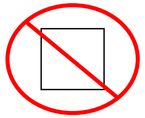
About Me: Nikolaus Johnson
MS, LPC, RPT, EMDR Consultant

- Since 2017, I have worked at the Center for Counseling and Family Relationships in North Fort Worth.
- Previously worked at an agency providing play therapy to children in the foster care system
- Population: 60% children under the age of 12, 40% adolescents and adults
- My focus is in developmental trauma, adoption issues, and dissociative disorders.
- I get a lot of clients that don't fit in a diagnostic box.



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Who are you?

Your name

Agency or setting

What would you like to get out of this training today?

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OBJECTIVES

1. Explain how to assess for dissociation in children, both in parent sessions and the playroom
2. Describe the major theories of dissociation and how they apply to the playroom
3. Discuss how to speak to children about parts of self in play therapy, and how to speak to parents about parts of self in parent sessions
4. Identify coping skills for children experiencing dissociation in the playroom
5. Demonstrate grounding skills for children experiencing dissociation in the playroom
6. Demonstrate basic parts work interventions in play therapy during training breakout session

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A playful way of engaging individuals in therapy at a developmentally appropriate level

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What is dissociation?

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Dissociation

- The mental process of being disconnected from one's thoughts, feelings, body sensations, identity, or memories
- We all experience dissociation to some extent
  - Healthy dissociation
  - Unhealthy dissociation
- Can look like ADHD
- Dissociation is a spectrum

(Gonzalas & Mosquera, 2012)

Common Dissociative Symptoms

- You dislike your client
- Client presents with flat or incongruent affect
- Client argues with him/herself
- Client takes a long time answering questions
- Client mood changes rapidly
- Client denies saying something the previous session
- No memory or few memories from childhood
- No or few body sensations
- Passing out for no reason
- Headaches in odd places of the head
- Trouble swallowing
- Visual or audible hallucinations

Common Dissociative Symptoms in Children

- **Common dissociative symptoms in children include**
  - Imaginary friends
  - Explosive behavior
  - Coping skills work for a time, then they just don’t
  - Client has a long list of diagnoses (i.e. ADHD, DMDD, bipolar, schizophrenia, ODD, autism)
  - Child is “odd”
  - Child acts emotionally inappropriate (i.e. laughing when someone dies in car accident)

Why Is This Important?

- You all likely have current clients and people in your personal life that meet the criteria for DID or another dissociative disorder.

- It is estimated that 1% of the population are “multiples”. Up to 10% of the population experiences a pathological level of disassociation. This number is similar to the level of the population experiencing MDD or GAD.

- It is a myth that DID and other dissociative disorders are untreatable. Many clients have no longer met the criteria for DID after 3-5 years of weekly therapy.

(Steinberg and Schnall, 2001)

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What Causes Dissociation?

- **Dissociation occurs for 3 primary reasons:**
  - **Automate behavior**
  - **Compartmentalize emotions and memories**
  - **Estrange from self in the face of death**

(Putnam, 1997)

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Automatic Behavior

- **Riding your bike**
- **Doing something boring**
- **Doing an activity you don’t like**
  - i.e. chores, schoolwork
- **Often described as autopilot**

Compartmentalize Emotions or Memories

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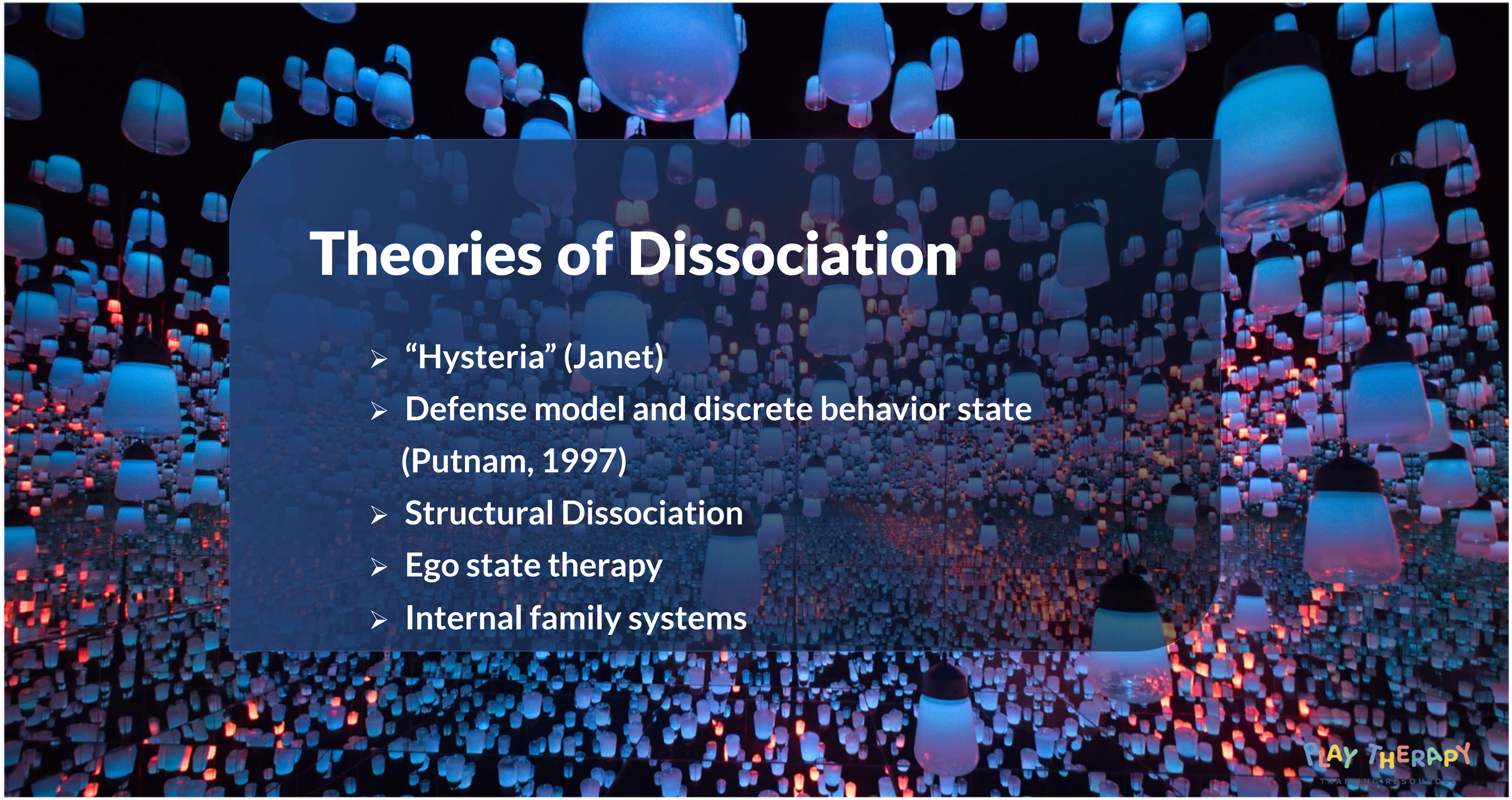
To Estrange from Self in the Face of Death

DISSOCIATION STRATEGIES

- A person's nervous system is tuned to his or her environment.
- If the childhood home is unsafe, the client will likely not have a felt sense of safety.
- The person's neuroception is affected by his or her history.
- A person's felt sense is affected by the nervous system's response to trauma.

Your Client

- Think about the client you have who inspired you to sign up for this training.
- Write down some demographic information.
- Reflect on how you feel that client experiences dissociation.


Theories of Dissociation
“Hysteria” (Janet)
Defense model and discrete behavior state (Putnam, 1997)
Structural Dissociation
Ego state therapy
Internal family systems
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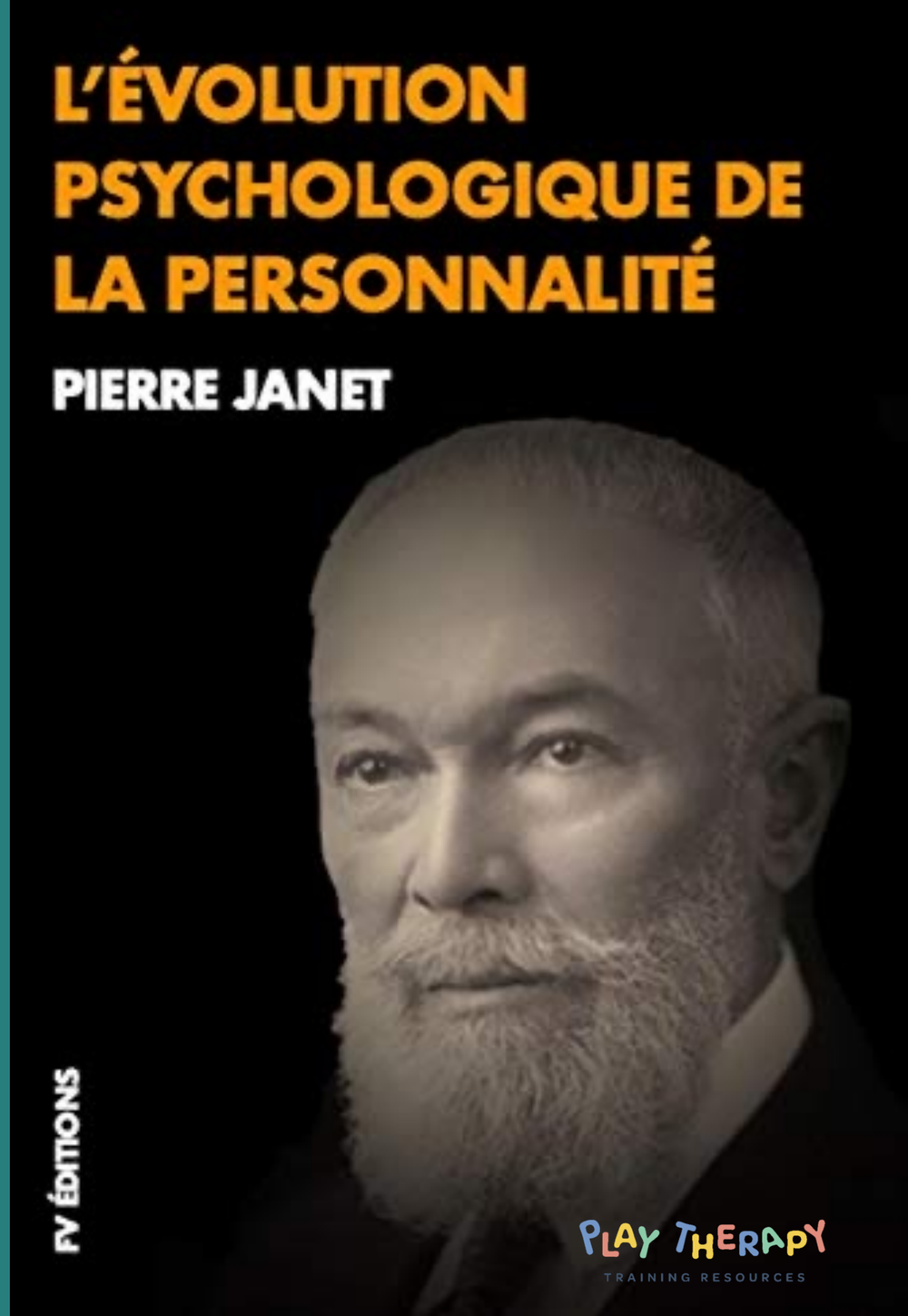
Hysteria

- Janet observed that trauma victims would retract into consciousness into unique internal states with their own senses of self.
- He referred to this as “hysteria”.
- Janet developed a phase model of therapy.



Defense Model and Discrete Behavioral States

- **Developed by Putnam (1997)**
- **Highly complex theory**
- **States that dissociation is a defense mechanism in order to**
  - Automate behavior
  - Compartmentalize emotions and memories
  - And to estrange from self in face of death

Structural Dissociation Theory

- **Van der Hart, 2006**
- **The internal system is divided between**
  - Apparently Normal Parts (ANP)
  - Emotional Parts (EP)
- **ANP's moderate normal daily tasks and avoid the thoughts of traumatic incidences.**
- **EP's hold traumatic material and arise when "triggered".**

Ego State Therapy

- The theory that ego states are normal and exist on a spectrum.
- The ego states are considered unhealthy if they include “impermeable” barriers such as amnesia.
- Ego states often take on roles such as an emotion (happy, angry sad), jobs (student, spouse, worker), or as a person (abuser, mother, superhero).

Internal Family Systems

- Developed by Schwartz, 1995
- The idea that there are many parts inside of us that have different roles
- In the healthiest internal family systems, all the parts work together in harmony.
- In an unhealthy system, parts struggle to work together and often cause conflict. This is due to a lack of cooperation.

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Dissociation Theories

- It is my belief that all these theories are useful.
- I use different explanations for dissociation according to what I believe the client needs.
- In my experience, the client's brain does not follow the rules anyway.

Common Terms

- **Structural Dissociation Theory**
  - Apparently Normal Part (ANP)
  - Emotional Part (EP)
- **Ego states**
- **Parts of self**

- **IFS**
  - Self (not technically a part, but a healing “self energy”)
  - Protective parts, i.e. firefighters, managers
  - Exiles
  - Introjects

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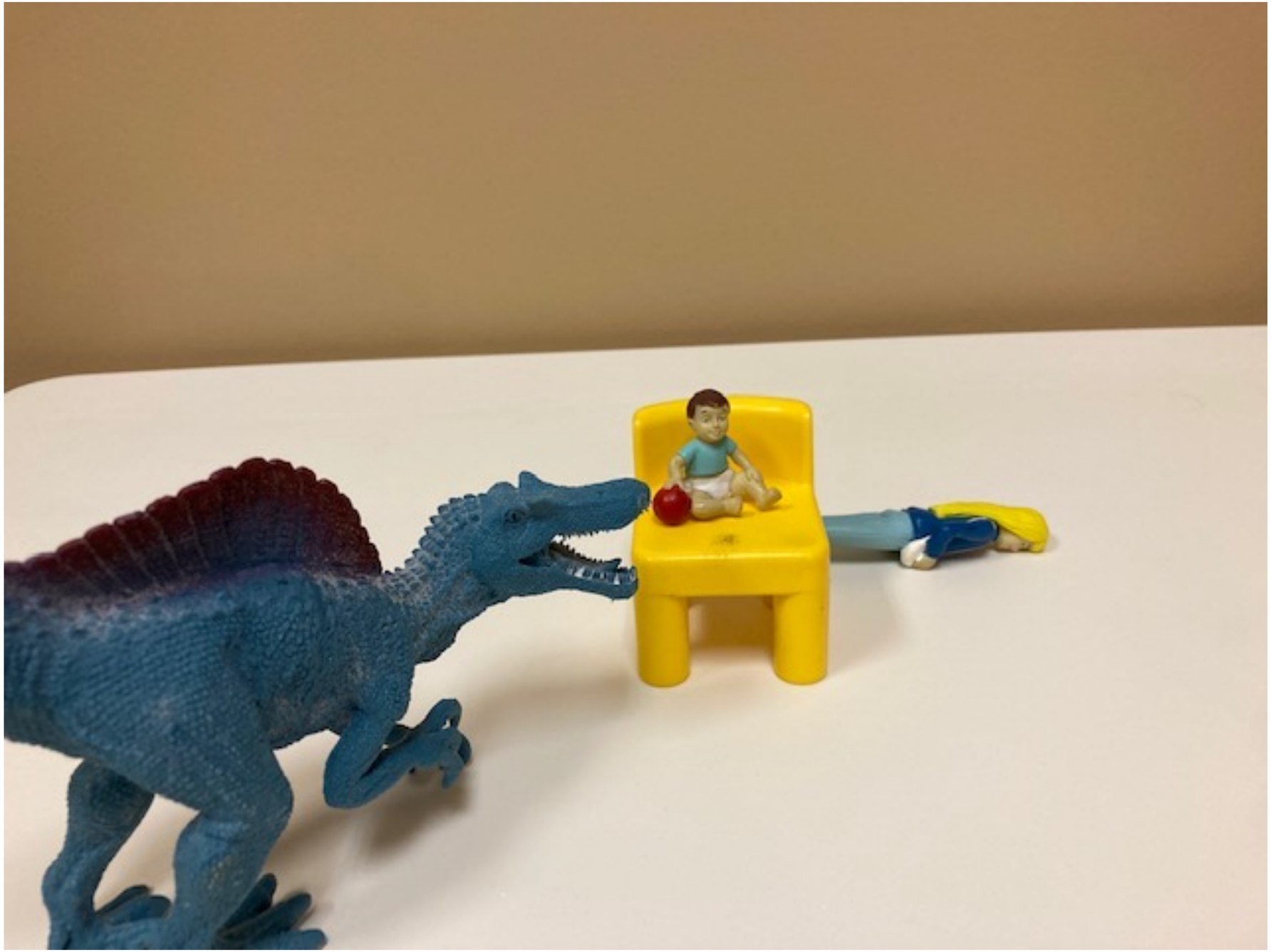

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Treatment Model

- **Build rapport**
  - Create a sense of safety
- **Assessment**
- **Stabilize**
  - Attic and Basement
- **Work with parts as needed**
- **Reprocess traumatic material**
- **Re-integrate**

Reflect on Client

- After discussing theory relating to dissociation, think about the client you wrote about earlier.
- Where has your brain been taking you over these last few minutes?

BREAK

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Questions So Far

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Your Client

- **After this morning's presentation**
  - How do you see dissociative symptoms in your practice with children?
  - How do you see these symptoms in yourself?

SO WHAT DO WE DO ABOUT IT?

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Treatment Model

- **Build rapport**
  - Create a sense of safety
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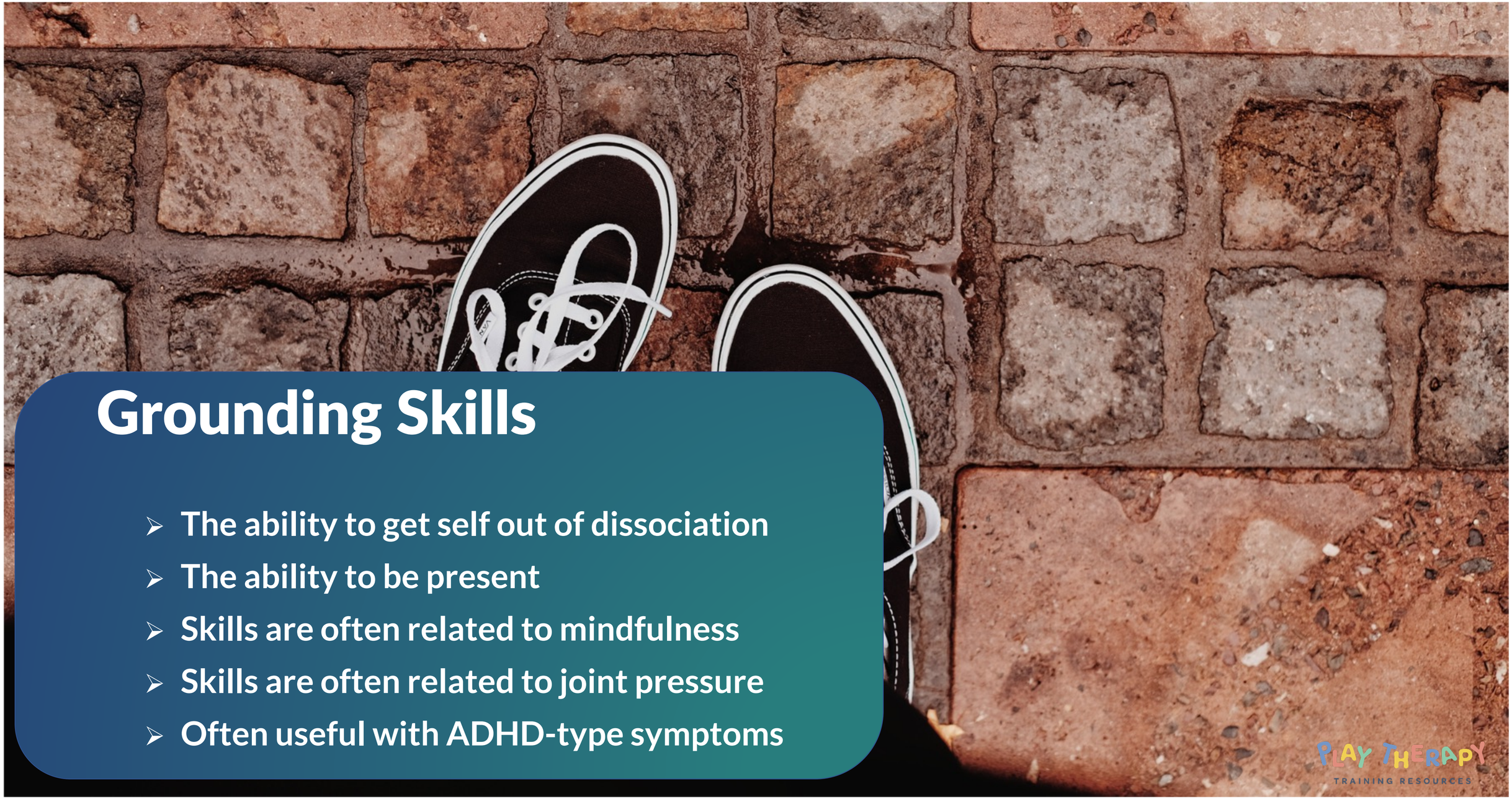
STRESS RESPONSE AND TRIGGERS

- Managing stress response and triggers is the first step in treating dissociation.
- Step 1: Your room must feel safe.
  - If parts exist, they emerge when they feel safe.
- Step 2: Assist the client in grounding and coping skills.
- Step 3: Parts work , if applicable

Self Regulation Skills

- The ability to manage your affect
  - Especially in relation to emotions relating to adrenaline



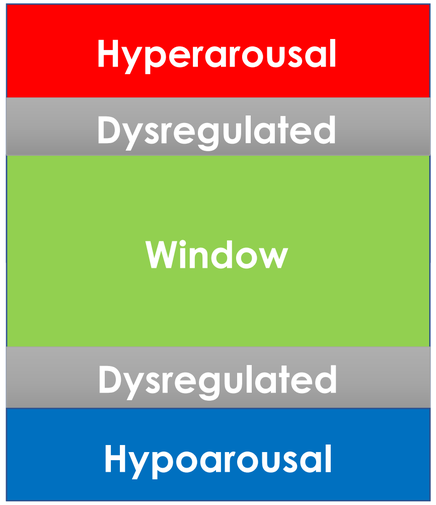
Grounding Skills

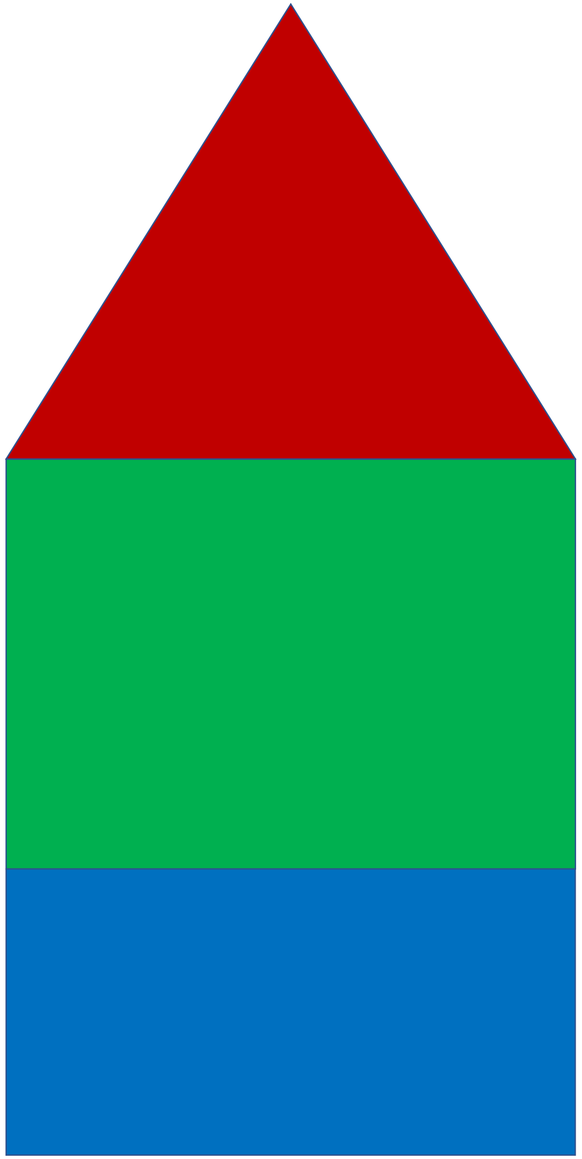
- The ability to get self out of dissociation
- The ability to be present
- Skills are often related to mindfulness
- Skills are often related to joint pressure
- Often useful with ADHD-type symptoms

The Window of Tolerance

- Developed by Dan Siegel (1999)
- A way to describe an individual's level of arousal

  Hyperarousal
  - More defiance, more energy
  - Think "fight or flight"
- The Window
  - The larger the window, the more an individual can handle
- Hypoarousal
  - Less energy, more spaced out or distracted
  - Think "freeze"
- Dysregulation
  - State of loss of control
  - Occurs when leaving the window on either side
  - Child loses brain function during dysregulation





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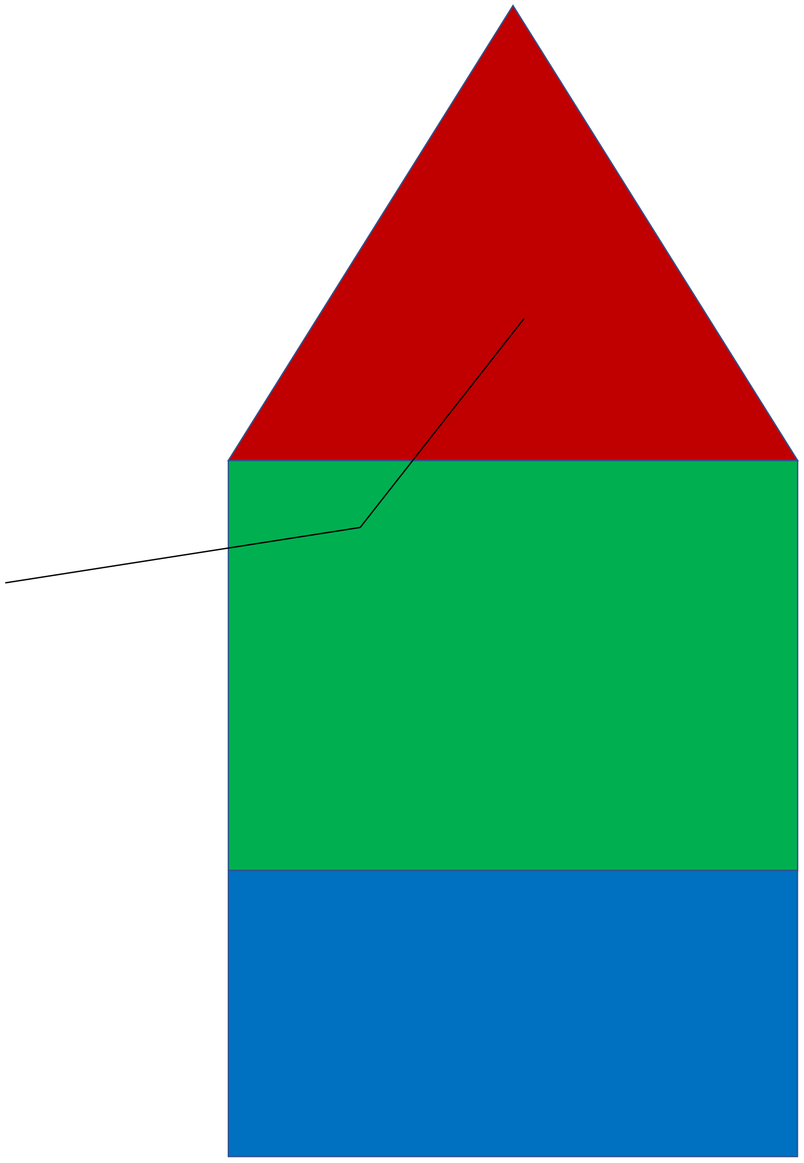

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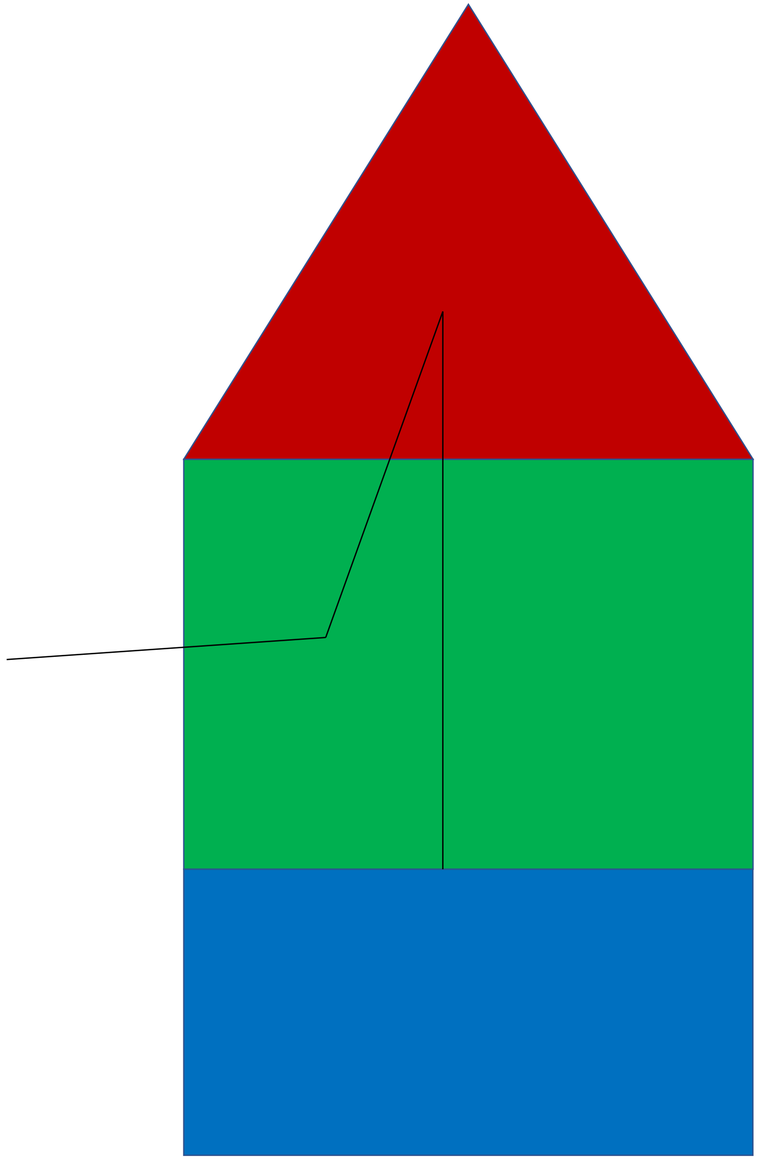

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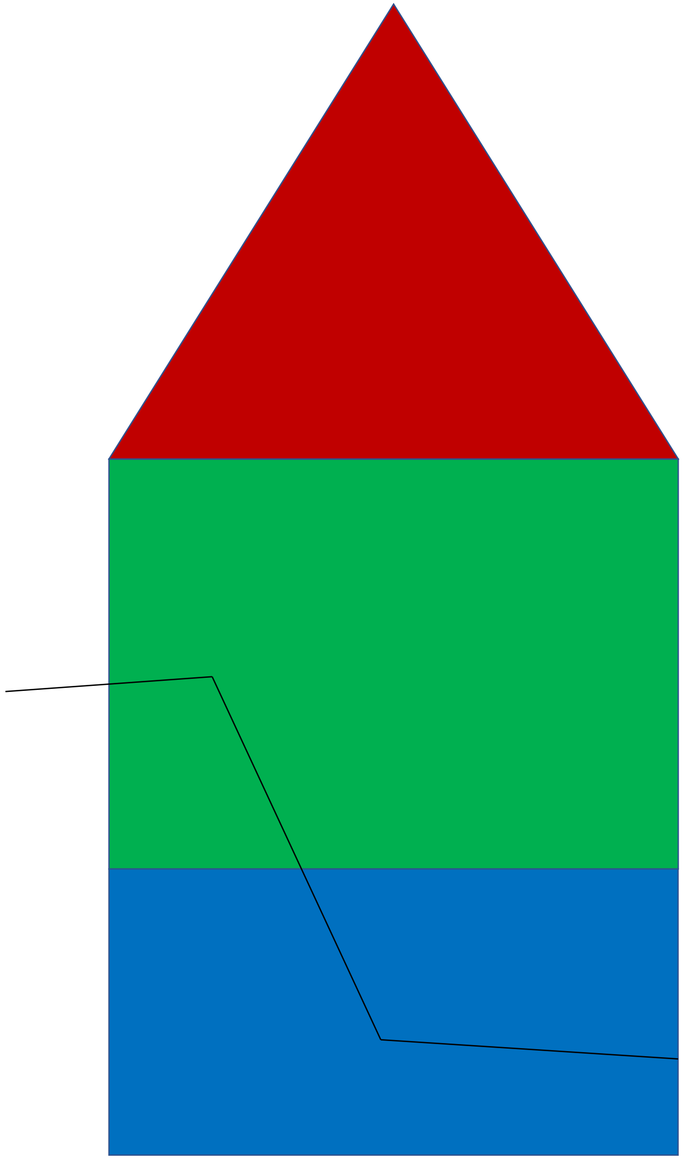

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Teach Window of Tolerance in the Sand

(Beckley-Forest, Monaco, 2020)

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Window of Tolerance (Jot it Down)

- What emotions do you feel when you are in the “house”?
- What emotions do you feel in the “attic”?
- What emotions do you feel while in the “basement”?

Window of Tolerance (Jot it Down)

- What body sensations do you feel when you are in the “house”?
- What body sensations do you feel in the “attic”?
- What body sensations do you feel while in the “basement”?

Let’s Physicalize It!

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Why Self-Regulate?

- Defensive dissociation

Skills to Teach

- **Breathing**
  - Make sure client is breathing correctly
    - Make sure it is from the gut and that the rib cage expands
  - Use 4.4.8 breathing (or whatever numbers you use)
  - Square breathing
  - Circle breathing
  - Rainbow breathing

Skills to Teach (2)

- **Tactile grounding: for when we can't take a breath**
  - Feet on the floor!
  - Weighted object
  - Metal object
  - Joint pressure
- **Once successful, return to breathing exercise**

Skills to Teach (3)

- Grounding skills
  - Feet on the floor
  - Muscle tension exercises
  - Hold ice in your hands
  - Splash face with water
  - Bilateral drawing

Skills to Teach (4)

- **Safe, calm place**
  - Let's imagine a safer, calmer place. It can be a place you have been to, would like to go, or a place you imagine.
  - What do you see/smell/taste/hear/feel there? Engage in five senses.
  - What emotions do you feel when there?
  - What body sensations go with those emotions?
  - Take slow deep breaths to install the place.
  - Can be done in the sand tray

Shiver Like a Snowman

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Case Study: Dudley

- Teen boy
- Diagnosis: Bipolar I
- Did not want to attend therapy
- Client presented with nausea before school
- Grief/loss
- His “Jedi mind trick”

Skills to Teach (5)

- **Safe, calm state (when a safe, calm place cannot be established)**
  - What do you think it would feel like to feel safe and calm when it is okay to feel safe and calm?
  - What emotions would you feel?
  - Where would you feel this in your body?
  - Install with deep breathing

Importance of Non-Directive Play Therapy

- Non-directive play therapy is a stabilization activity
- Non-directive play therapy can be a trauma processing activity
- Non-directive play therapy can be parts work!

(Parker, Hergenrathe, Smelser, 2021)
(Parker, Glickman, Smelser, and DeRaedt, 2021)
(Haas and Ray, 2020)

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Container Exercise

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STABILIZATION SKILLS

- The stabilization skills for managing dissociation are not too different than the skills you already know.
- What skills can you think of that would help your dissociative clients that we have not yet talked about?

Pre-Lunch Questions

- What's confusing?
- What's making sense?
- What seems applicable to your clients on Monday?

Lunch

Questions So Far

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DIAGNOSIS AND ASSESSMENT

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Dissociative Disorders

- Dissociative Identify Disorder
- Dissociative Amnesia
- Depersonalization/Derealization Disorder
- Dissociative disorder not otherwise specified

Dissociative Identity Disorder

- The existence of two or more distinct identities (or “personality states”)

  The distinct identities are accompanied by changes in behavior, memory and thinking. The signs and symptoms may be observed by others or reported by the individual.
- Ongoing gaps in memory about everyday events, personal information and/or past traumatic events.
- The symptoms cause significant distress or problems in social, occupational, or other areas of functioning.

(American Psychiatric Association, 2013)

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Dissociative Amnesia

- Unable to recall autobiographical memory associated with a traumatic event. The recall of traumatic events is usually unconscious.
- The inability to recall traumatic events creates distress.
- The memory dysfunction does not have a physiological cause.
- The memory dysfunction is not Dissociative Identity Disorder.
- The memory loss is not a result of substance abuse or other substances.

(American Psychiatric Association, 2013)

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Depersonalization/Derealization Disorder

- **The presence of persistent or recurrent experiences of depersonalization, derealization, or both**
  - Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing)
  - Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted)
- During the depersonalization or derealization experiences, reality testing remains intact.

(American Psychiatric Association, 2013)

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DDNOS and Other Diagnoses

- **There has been a change from the DSM IV to 5**
- **OSDD 1a**
  - Like DID, however less distinct parts/no alters
- **OSDD 1b**
  - Like DID, however parts can take control of the body, but without amnesia
- **DDNOS2**
  - An old diagnosis referring to derealization without depersonalization
    - Now all Derealization/Depersonalization Disorder

(American Psychiatric Association, 2013)

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Fugue State

- In DSM 5, part of dissociative amnesia
- Sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past
- Confusion about personal identity, or the assumption of a new identity
- Significant distress or impairment

(American Psychiatric Association, 2013)

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Your Client

- What symptoms of dissociation is your client experiencing?
- What questions are you needing to ask to get further diagnostic information?

Case Study: Thomas

- Age 9
- Presenting problem: dissociative fugues and hallucinations
- Diagnosis: DID
- Treatment

Assessment for Dissociation

- Basic assessments
  - Dissociative Experience Scale (DES)
  - Dissociative Experience Scale Adolescents
  - Child Dissociation Checklist
- More involved assessments
  - Multidimensional Inventory of Dissociation (MID)
  - There is also an adolescent version.

Child Dissociation Checklist

- To be used in a parent meeting after client dissociation is observed in play sessions
- Great for helping parents gain insight into the client's symptomology

Child Dissociative Checklist (CDC), Version 3

Frank W. Putnam, MD

Date: _____ Age: _____ Sex: M F Identification: _____

Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST 12 MONTHS, please circle 2 if the item is VERY TRUE of your child. Circle 1 if the item is SOMEWHAT or SOMETIMES TRUE of your child. If the item is NOT TRUE of your child, circle 0.

0 1 2 1. Child does not remember of denies traumatic or painful experiences that are know to have occurred.

0 1 2 2. Child goes into a daze or trance-like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school

0 1 2 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.

0 1 2 4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.

0 1 2 5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.

0 1 2 6. Child shows marked day-to-day or even hour-to-hour variations in his or

Your Client

- What dissociative symptoms have you been seeing in your client?
- Do you have any provisional diagnoses based on our discussion today?

Talking to Clients and Parents about Dissociation and Parts

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WITH CLIENTS

- Normalize it
- Use common language
- Use examples about how you, the clinician, experience dissociation
- Provide a rationale for why it matters

With Children

Introduce the Doll

With Parents of Clients

- Again, normalize it
- Give examples of how the client displays it
- Provide hope

Case Study: Victoria and Mom

- Client referred to me for family therapy with client, bio dad, and step-mother
- Client presented with parts
- I was given permission by primary therapy to assess the client for dissociation
- I diagnosed the client with DID
- Client’s bio mother attended the next session with client angry with the diagnosis

Adapting to Teens

- I'd argue to use less clinical language with all clients, but especially with teens.
- Use terms like "space out".
- Often trouble focusing in school is a good "in" with teens for discussing dissociation strategies.
- Also focusing on reality testing and self harm can be a good way to open the conversation.
- If you can show them that the skills work, they will be bought in.
- Use inner active cards


Old lady
Emily
Exiles
WELCOME
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Case Study: Derrick

- Another teen boy who did not want to attend therapy
- Derrick’s experience with the inner active cards

STUMP SPEECH

- Briefly write down your “Stump Speech” in describing dissociation to your clients.

Malingering

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Malingering

- **Questions to ask**
  - What does the client have to gain from having this diagnosis?
  - What unmet needs does the client have?
  - Why is DID the cover story?

Treatments for Malingering

- **In children**
  - Non-directive play therapy
  - Parts work
  - EMDR
- **In adults**
  - DBT
  - Parts work
  - EMDR

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Adaptations for Malingering

- Have you ever had a client that you suspected was malingering?
- How did you handle it?
- Whether or not you have been faced with this situation, how would you like to handle it in the future?

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How I Handle Malingering

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BREAK

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Working with Parts of Self

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Questions So Far

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Dissociation and Blocked Processing

- Goal of therapy with a dissociative client is to get all the parts working together towards the same goal
- Therapy—regardless of the modality—will not work without completing this task
- How: the therapist's job is to identify the parts, build rapport with parts and provide intervention only when parts are ready
- Working with the self
- Working with emotional parts
- Working with introjects
- Note: Standard EMDR resourcing will not work without some form of integration first

RESOURCES FOR DISSOCIATIVE CLIENTS

- Parts will not emerge with you unless they feel safe enough, or they have something to gain from coming out.
- Respect parts that do not want to speak. They may not trust you yet, even though the ANP does.
- Be ready for “Memory Dumps”.

Memory Dumps

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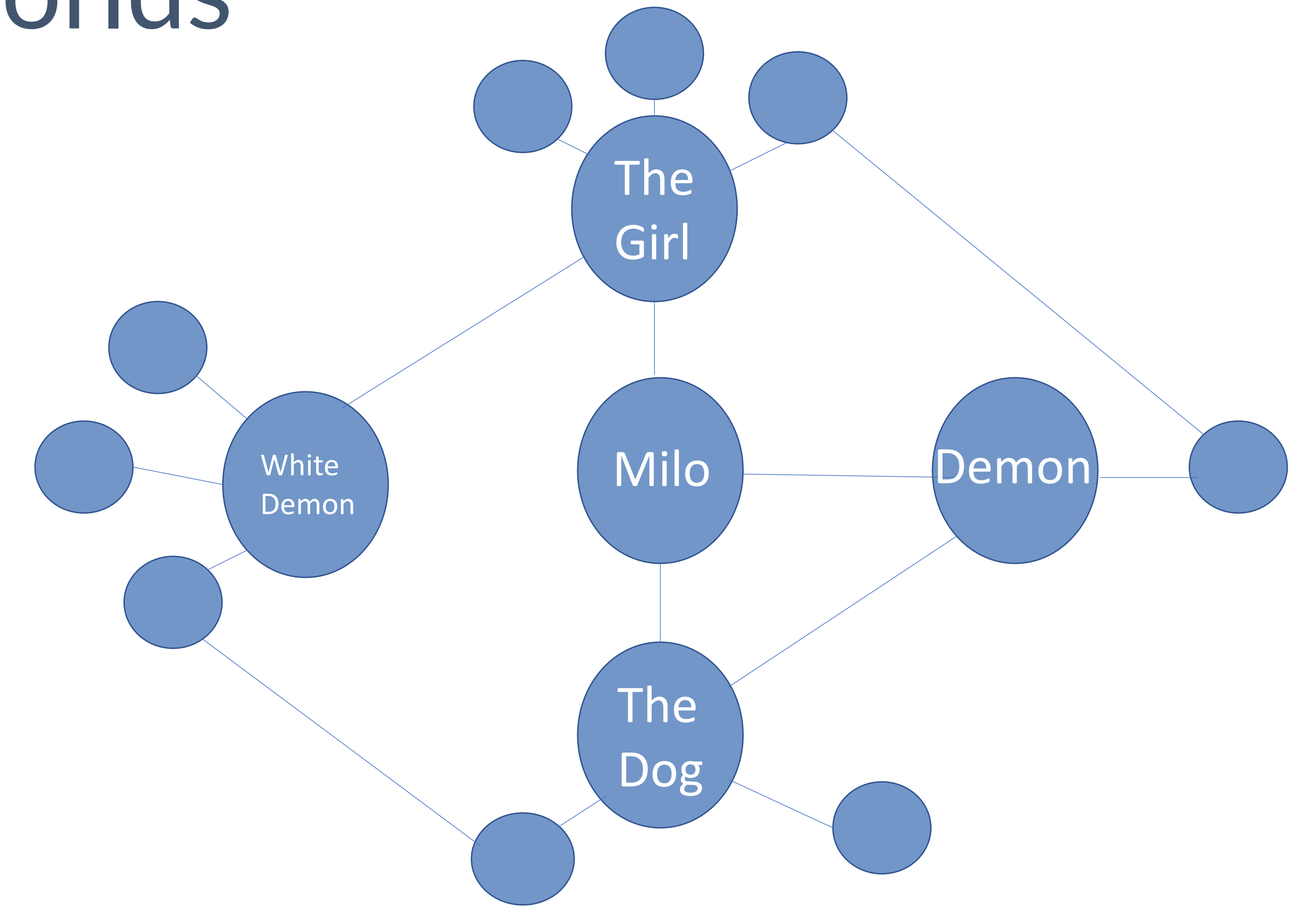
Frasier's Table

Case Study: Milo

- Age 10
- Presenting problem: client described as “strange” and anxious
- Diagnosis: DID
- Memory dumps
- Vast internal system

Milo’s Inner Worlds



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Witnessing a Part

Loving Eyes

- **Have client pull up his/her safer, calmer place**
  - Have the client imagine him/herself as a child in this place.
  - Ask how old the child is and ask what he/she looks like.
  - Allow the child to interact with the ANP.
  - Have the ANP look in the child's eyes.
  - Have the client remind the child "I will never leave you." This is an acceptable promise because the client literally cannot let the part down!
  - Assess client for emotions felt and body sensations felt.
  - You can install with eye movements if you are trained to do so.

(Shapiro, 2016)

Case Study: Raquel

- Age 11
- Presenting problem: processing adoption issues, emotional dysregulation
- Diagnosis: DDNOS (likely DID)
- Client denies parts
- Dissociative trances
- “Manic-like” behavior
- Loving Eyes with Raquel

Two-Handed Interweave

- Have your client place a different ego state in each hand.
- Delineate the differences with physical, emotional, and other state-specific traits.
- Facilitate an interaction between the two while continually assessing for emotions and body sensations.

(Shapiro, 2016)

Let’s Practice the Two-Handed Interweave

- Think about your favorite ice cream…

Principles for Working with Parts

- Work with the person who shows up that day.
- Don’t force exercises; there is always a “why” and we need to respect them saying no.
- The combination of the relationship, safety, self-regulation skills, and parts work for unblocking helps the client heal.

When Parts Don’t "Behave"

- Different parts work systems conceptualize wayward parts in several ways.
- Never place a part in the container unless it is a risk to the self.

WHEN PARTS PRESENT AS THE PERPETRATOR

- **Introject (Swartz, 1995)**

- **Unzipping**
  - For use with introjects
  - “Imagine the part or the figure in front of you in your safe place.”
  - Allow the client to experience control of the situation by allowing parts to change size, color, freeze the frame, or any other adjustment.
  - Have the client imagine walking behind the figure and finding a zipper on its back. Have the client unzip the figure like it’s a costume and have the client look inside.
  - Move to loving eyes script if appropriate.

(Shapiro, 2016)

Case Study: Carlos

- Age 4
- Presenting problem: controlling behavior, anxiety
- Diagnosis: OCD, DDNOS
- Introjects “Blood Carlos”
- Vast internal system

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When Client Presentation Does Not Include Parts of Self (1)

- This may be due to a phobia of parts
- Client may not have insight into parts
- Client may not have parts

When Client Presentation Does Not Include Parts of Self (2)

- **Treatment goal is still to reduce dissociation and process traumatic material**
- **Goals include**
  - Widening the Window of Tolerance
  - Grounding
  - Helping the client feel a felt sense of safety
  - Processing of developmental trauma material
- **One of the therapist's strongest tools is coregulation**

Processing the Negative Material

- **I use EMDR adapted for parts work to process the negative material as it arises. I suggest consultation if this is what you are needing to do.**
- **IFS has its own process called “unburdening parts”.**
- **There are many good therapies for processing the negative material.**
  - EMDR
  - IFS (Unburdening)
  - Coherence
  - EFT
  - Somatic Experiencing
- **Experiential therapies**

When Nothing Else Works

- Go back to coregulation and non-directive play therapy
- Ask yourself: How can I make my space feel safer for my client?
- How can I help my client feel safe or calm when it is okay to feel safe and calm?

Remember the Three Rules

1. Don’t make it weird.
2. The client’s systems are there for a reason; respect them.
3. All parts share the nervous system.

Summary

- Approach dissociation with curiosity.
- Their brains don’t follow the rules!
- Use stabilization skills for both the basement and the attic.
- Use a mix of instruments and clinical judgement to diagnose.
- Approach the client where he/she is that day. Don’t force anything.
- Take advantage of consultation.

Questions

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Your Client

- What from today is applicable to your practice?
- What do you believe are the next steps in therapy with the client you were thinking of today?

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ANY QUESTIONS?

THANKS FOR LISTENING!

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