

NARRATIVES OF DISSOCIATION: INSIGHTS INTO THE EXPERIENCE AND  
TREATMENT OF DISSOCIATION IN INDIVIDUALS WHO HAVE BEEN  
SEXUALLY ABUSED IN CHILDHOOD

by

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## ABSTRACT

A narrative research design was used to obtain an in-depth understanding of the experience and treatment of dissociation in seven individuals who had a history of childhood sexual abuse and engaged in moderate to high levels of dissociation. Through a holistic-content analysis (Lieblich, 1998), seven major themes emerged--disconnection to self, others, and the world; gaps in time, space, and memory; the dissociative process; personal meaning and insight; tools and techniques; challenging the dominant paradigm; and the therapeutic relationship. Significant contributions include: (a) redefining dissociation from the perspective of those who dissociate; (b) challenging the dominant discourse that views dissociation through a lens of pathology; and (c) highlighting the critical role of the therapeutic relationship in the treatment of dissociation.

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Forever in my heart.

## CHAPTER ONE INTRODUCTION

As she sits across from me, I wonder where she has gone. In the chair where she once was, I can see the physical presence of her body--but the vacant look in her eyes tell me that she is no longer there. It's taken me awhile but over time I have learned to recognize her subtle moments of departure. Sometimes I can tell by the rapidness of her speech and the monologue she engages in as she jumps from topic to topic in a logic that only she can follow. Other times, our conversations end mid-stream--her voice trailing off into silence.

Moments ago I had been listening to her story--a story that she struggles between wanting to tell and wanting never to reveal. Deep inside I share a similar struggle for as much as I want to listen and support her in her journey, there are times when I sense my own need to escape from a story that I often wish wasn't real. As I sit with her, a series of questions flow through my mind. What was it that prompted her to leave? Where has she gone and is she even aware that she is no longer here? More importantly, I wonder how to reconnect with her and bring her back to the presence of the here-and-now. I engage her in some dialogue, ask her to focus on her breathing, and move through a list of all the things I learned from workshops, seminars, and people that I've spoken to about this complex, and often puzzling, experience called dissociation.

Originally identified by Janet in 1907, dissociation is defined as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception [and can be experienced as either] sudden or gradual, transient or chronic" (Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR], 2000, p. 519). Signs of dissociation include a shallowness in breathing, a loss of eye contact, an inability to

experience physical and emotional sensations, and an overall sense of distance and disconnection (e.g., Brown, 2006; Dell, 2006; Herman, 1992; Hunter, 2004; McEvoy & Ziegler, 2006; Nijenhuis, 2004; Putnam, 1997; Scaer, 2005). Researchers (e.g., Briere, 2002; Freyd, 2002; Howell, 2005; Levine, 1996; Rothschild, 2000; Ogden & van der Kolk, 2002; Waites, 1997) have acknowledged that dissociation is especially prevalent in individuals with a history of trauma and abuse. For many, it is the only means of survival.

Several theorists (e.g., Brown, 2006; Courtois & Pearlman, 2006; Dell, 2006; Perry, 1999; Putnam, 1997; Steinberg & Schnall, 2001; van der Kolk, 1996) have recognized that dissociation exists along a continuum depending upon the type of trauma experienced (i.e., single incident versus multiple incidences, nature versus human-made, known versus unknown perpetrator) and the developmental age at which the trauma occurred. In general, multiple traumas intentionally perpetrated by a known and trusted caregiver result in the greatest tendency to dissociate for the threat to one's self is often severe. For a child, sexual abuse is one of the most devastating forms of violation and betrayal. A child's basic sense of trust and safety is shattered and the developmental line that separates self from other is significantly blurred. In order to cope with the terrifying events taking place, a child must rely on an innate capacity to dissociate and in doing so, create a much needed barrier that psychologically insulates the child from harm. Although dissociation initially develops from a desperate need for survival, over time it can become a highly established way of being that interferes with a person's capacity to fully experience life and living.

According to researchers (Briere, 2002; Fosha, 2003; Howell, 2005; Hunter, 2004; Porges, 2004a), dissociation can also act as a barrier to the therapeutic process by

interfering with an individual's ability to remain present and integrate the reparative experiences that can occur. Briere and Ogden (2006) state that one of the more significant challenges of working with individuals who experienced sexual abuse is being able to manage levels of dissociation and maintain a therapeutic balance that enables clients to access traumatic material without becoming too overwhelmed or re-traumatized. Therapists working within the area of trauma and abuse are therefore required to continuously monitor and regulate their client's capacity to process the traumatic events and navigate within an often limited therapeutic window in order for reparation to occur.

What is the experience of dissociation in individuals who have been sexually abused in childhood? How do therapists work with dissociation? And what factors positively and negatively influence the therapeutic process of reparation? The purpose of this study was to explore the experience and treatment of dissociation from the perspective of individuals who have been sexually abused and engage in moderate to high levels of dissociative behavior. Although much research has examined the role of dissociation in forgetting incidences of abuse (e.g., Freyd, 1996; Herman & Harvey, 1997; Perry, 1999; Polusny & Follette, 1996; Spiegel, 1997; Williams, 1994; Wilsnack, Wonderlich, Kristjanson, Vogeltanz-Holm, & Wilsnack, 2002), the implications of dissociation on disclosure (e.g., Alpert, 2001; Bonanno, Noll, Putnam, O'Neill, & Trickett, 2003; Herman, 2003; Nijenhuis, van der Hart, & Steele, 2004; Pasquini, Liotti, Mazzotti, Fassone, & Picardi, 2002; Schultz, Passmore, & Yoder, 2003), the neurobiological basis of dissociation (eg., McFarlane, 2004; Nijenhuis, 2004., Perry; Williams, Haines, & Sale, 2003; Porges, 2004a; Scaer, 2007; van der Kolk, 1996), and the experience of dissociation as interpreted by clinicians and theorists (e.g., Bromberg,

2003; Brown, 2006; Hall, 2000; Putnam, 1997), little research has been done on how therapists can work with dissociation and to date, few studies have explored this experience from the perspective of clients.

**What is the experience and treatment of dissociation among individuals who have been sexually abused in childhood?** This research sought to examine the experience and treatment of dissociation among individuals who have been sexually abused with the purpose of providing insight into how therapists can better understand and support clients in their process of therapy. To explore this experience, a narrative research design was used. According to Lieblich, Tuval-Mashiach, and Zilber (1998), stories shape our lives. Stories provide us with a sense of coherence and continuity and offer a unique window into our inner worlds. Through a narrative methodology, I was provided a window into the inner lives of those who engage in moderate to high levels of dissociation in order to cope with a history of childhood sexual abuse. Through story and narrative, an in-depth understanding of the experience and treatment of dissociation was obtained.

Within the trauma literature, dissociation remains an area in which very little is known and unfortunately, what we do not know, we tend to fear. As a society, we pathologize, medicalize, and stigmatize the experience of dissociation and in doing so, establish an arbitrary divide between normal and abnormal and create an unnecessary chasm between us and them. By examining the experience and treatment of dissociation, I address a significant gap in the current trauma literature and contribute to the field of counselling psychology by (a) providing insight into the experience and treatment of dissociation from the perspective of clients who dissociate; (b) offering therapists information on how to work with individuals who engage in moderate to high levels of

dissociative behavior; (c) giving voice to the client's experience of what positively and negatively influences the therapeutic process of reparation; and (d) de-pathologizing and demystifying our societal concept of what dissociation is.

## CHAPTER TWO LITERATURE REVIEW

The purpose of this chapter is to provide a comprehensive review of the literature in the areas of childhood sexual abuse and dissociation and offer readers a knowledge base that will facilitate a clearer understanding of the rationale for this study. Each of these areas is discussed individually. Together, they combine to form the foundational basis of this research.

### Childhood Sexual Abuse

Recent statistics have revealed that in North America, one in every three girls and one in every six boys experience some form of sexual abuse before the age of 18 (National Clearinghouse on Family Violence [NCFV], 2005; National Center for Victims of Crime [NCVC], 2005). This data however, represents only those incidences of abuse that were reported and it is therefore believed that these statistics are an underestimation of the actual number of cases that occur. Childhood sexual abuse, as defined by Courtois (1999), refers to any sexual act imposed upon a child by a person or persons who are in a powerful and dominant position and implicitly or explicitly coerce the child into sexual compliance. Childhood sexual abuse can involve intra-familial or extra-familial relationships and can vary in terms of frequency, duration, and severity. Statistics have also indicated that individuals with a history of childhood sexual abuse are at a higher risk for future victimization where two out of every three individuals who have been sexually abused in childhood are sexually revictimized as adults (e.g., Classen, Gronskeya-Palesh, & Aggarwal, 2005; Marx, Heidt, & Gold, 2005; Roodman & Clum, 2001). Researchers (Briere, 2002; Chu, 1998; Courtois & Perlman, 2006; Fosha, 2003; Herman, 1992; Schwartz, 2000; Waites, 1997) have stated that individuals

who endured acts of childhood sexual abuse represent a vulnerable population.

Consequently, it is imperative for therapists to obtain a level of competency that will enable them to fully support the reparative journey of those whose lives have been affected by abuse.

In this section, I discuss two areas of research that are critical to our understanding of those who have been sexually abused in childhood. First, I discuss the impact sexual abuse has on a person's cognitive, emotional, behavioral, and relational functioning and highlight recent studies that demonstrate the long-term consequences of childhood sexual abuse. Second, I draw attention to what is known as the third wave of research. In this portion, I identify mediating factors that influence a person's ability to overcome the negative affects of abuse. By discussing the impact of abuse and the factors that contribute to levels of resiliency, I acknowledge both the pain and the strength of those whose lives have been affected by early sexual trauma.

### Childhood Sexual Abuse and Its Impact

#### Assumptions, Beliefs, and Schemas

Researchers (e.g., Hirakata & Arvay-Buchanan, 2005; Janoff-Bulman, 1992; McCann, Sakheim, & Abrahamson, 1988; Porter & Long, 1999; Swartz, 2000; Ullman, 1997; Wenninger & Ehlers, 1998) have identified that childhood sexual abuse has a profound impact on a person's fundamental assumptions about the world where core beliefs, such as those related to trust, safety, power, esteem, and intimacy are seriously altered. According to Janoff-Bulman, sexual abuse is a direct attack on a child's inner world. As human beings, we build our lives on assumptions that enable us to feel safe both within our selves and with others and efficiently organize our experiences around certain fundamental structures of knowledge. The world is a safe place, people are

inherently trustworthy and good, events that happen are meaningful, and I am a worthy person are some of the foundational beliefs that we, as humans, hold. When sexual violations occur to a young child however, these core structures of knowledge are shattered and a child's "inner world is suddenly pervaded by thoughts and images representing malevolence, meaninglessness, and self-abasement" (Janoff-Bulman, p. 63). The world becomes a frightening place and a sense of trust and safety is lost.

A study by Owens and Chard (2001) examined the relationship between the severity of posttraumatic stress disorder (PTSD) symptoms and levels of cognitive distortions among 79 women with a history of childhood sexual abuse. Participants ranged in age from 18 to 55 years and were recruited through flyers posted at local counselling centers. Each participant was asked to complete a battery of assessments: the Personal Beliefs and Reactions Scale ([PBRs] Mechanic & Resick, 1993), the World Assumptions Scale ([WAS] Janoff-Bulman, 1989), and the Clinician Administered PTSD Scale ([CAPS-SX] Blake, Weathers, Nagy, Kaloupek, Klauminzer, Charney, & Keane, 1990). The results of these assessments were then calculated using Pearson correlation coefficient to determine the relationship between cognitive schemas (i.e., benevolence, self-worth, safety, trust, self-blame, and meaningfulness) and levels of PTSD.

The findings of this study revealed that cognitive disruptions were positively correlated with the severity of PTSD symptoms and that disruption to personal power, trust, and self-worth were particularly apparent. The researchers of this study concluded that individuals who endured acts of childhood sexual abuse "appear to focus more on self-attributions in the processing of the abuse. [Consequently, it would be] of greater benefit to focus more of therapy on the survivor's disruptive cognitions related to the

self and self-blame and less on disruptive schemas about the world and others” (Owens & Chard, p. 188).

The results of another study by Leahy, Pretty, and Tenenbaum (2003) produced similar findings. In this qualitative study, 20 individuals (10 men; 10 women) who had a history of childhood sexual abuse were interviewed to obtain insight into their core schemas and beliefs. Participants ranged in age from 21 to 47 years and consisted of individuals who were identified by the researchers as high functioning. For example, most of the participants were well-educated (i.e., 70% obtained university degrees), held high-achieving occupations (i.e., 75% worked in professional or managerial positions), and were considered personally and physically competitive (i.e., 45% competed in athletic competitions at either a regional or international level).

A thematic-content analysis revealed four dominant schemas: confusion (e.g., “I just didn’t really know what was going on”); negative valence referring to the assignment of negative thoughts about the abuse (e.g., “It was, like, the worst feeling”); entrapment (e.g., “I didn’t realize there was another way out”); and internal locus of control (e.g., “Well, I didn’t resist him”). These results reflected a clear sense of self-blame as well as a general lack of trust and safety in both themselves and others. Implications included cautioning therapists from prematurely challenging their client’s belief system and attributing blame to the abuser. Instead, the researchers suggested working with the often confusing and ambivalent feelings of attachment that clients might have with their perpetrator and provide a corrective experience that typically occurs when the therapist is able to empathically enter into the client’s frightening and confusing world.

With researchers (e.g., Hall, 2000; Leahy et al., 2003; Owen & Chard, 2001; Romano & De Luca, 2005) identifying self-blame as one of the primary beliefs that develops in a child who has been sexually abused, it is important to understand the specific abuse-related factors that influence self-blaming tendencies. A study by Quas, Goodman, and Jones (2003) examined attributions of self-blame in 218 children (51 boys; 167 girls) ranging in age from 4 to 17 years in an effort to understand what characteristics of abuse resulted in a greater tendency towards self-blame. Recruitment for the study occurred through referrals from various district attorneys' offices across the United States and consisted of a select group of children whose testimonies possessed sufficient evidence to either begin criminal prosecution or had already resulted in a criminal conviction. All of the participants were at various stages of pursuing criminal charges against their perpetrator of sexual abuse.

Data were gathered through individual interviews with both the child and the non-offending parent and through a series of assessments that included the Sexual Assault Profile ([SAP] Conte & Berliner, 1984), the Child Behavior Checklist ([CBCL] Achenback, 1991), and the Social Adjustment Scale-Revised ([SAS-R] Weissman & Bothwell, 1976). A hierarchical linear regression revealed four key factors that were particularly influential in determining the children's attributions of self-blame. Factors that were likely to increase a child's tendency towards self-blame were: (a) a close relationship with the perpetrator; (b) a greater severity of abuse in terms of duration and use of force; (c) a perception that the abuse was scary, painful, or bad; and (d) an ability to cope with the abuse by disconnecting and pretending that it was not happening. Contrary to the researchers' prior assumptions however, the level of support by the non-

offending caregiver was not a factor in either raising or lowering the children's personal attributions of blame.

### Trauma-Related Dimensions

Childhood sexual abuse impacts an individual's core beliefs about one's self and the world however, what is it specifically that disrupts a child's fundamental belief system? Herman (1992), Janoff-Bulman (1992), and Waites (1997) have stated that there are four significant trauma-related dimensions that influence a person's core assumptions. First, traumas that are perpetrated by another human being typically result in greater alterations to cognitive schemas. Intentional acts of torture, abuse, and violence that are human-induced bring forth the existence of evil and lead to beliefs that the world is malevolent because it is made up of horribly bad people (e.g. Courtois & Pearlman, 2006; Freyd, 1996; Janoff-Bulman, 1989; Pearlman, 2003; Schwartz, 2000). In contrast, traumas that are the result of natural forces (e.g., floods, hurricanes, earthquakes) lead to an increase in an individual's sense of benevolence as communities of people come together and offer, at times, unprecedented support through an extremely difficult period (e.g., Briere & Elliot, 2000; Bodvarsdottir & Elklit, 2004; Gilbert, 2005). The trauma becomes a shared experience as groups of people work together to acknowledge, validate, and bear witness to each other's pain. While nature-perpetrated traumas affirm our belief in the goodness of people, human-perpetrated traumas can seriously challenge our basic faith in humankind. For a child being sexually abused, there is no one to validate or recognize the pain because perpetrators rarely acknowledge the violations that occur and instead, promote an atmosphere of secrecy and silence. In the isolated world of a child being sexually abused, people are seen as

neither safe nor benevolent (e.g., Briere, 2002; Courtois, 1999; Hall, 2000; Hirakata & Arvay-Buchanan, 2005; Janoff-Bulman; Pearlman).

The second dimension that influences a person's basic assumptions is dependent upon whether the trauma occurred as a single isolated incident (e.g., a motor vehicle accident, a single assault, a one time act of terrorism) or a series of traumatic events that occurred over a period of time (e.g., war, peace keeping missions, multiple incidences of domestic or childhood abuse). In general, multiple incidences result in a greater disruption to core beliefs and particularly play a role in challenging assumptions related to self-worth and blame (e.g., Herman, 2003; Leahy et al., 2003; Owen & Chard, 2001; Quas et al., 2003; Pearlman; Romano & De Luca, 2005; Waites, 1997).

When a single traumatic incident occurs, people are more able to dismiss it as bad luck or a case of being in the wrong place at the wrong time. In situations where traumatic events are repeated however, there is a greater tendency to internalize the events and attribute what is happening to acts of punishment for having done something wrong or for simply being a bad person. In multiple incidences of childhood sexual abuse, a child's inner belief in his or her inherent goodness is disrupted in several ways (e.g., Hall, 2000; Janoff-Bulman, 1992; Freyd, 1996; Pearlman, 2003). First, a child is frequently blamed, either directly or indirectly, for the abuse through statements such as You wanted me to touch you or If you weren't so pretty, I wouldn't have had to do this. Second, highly warranted feelings of anger and rage can be experienced by a child as a sign of inherent badness, particularly if the child has fantasies of seriously harming or killing the perpetrator. Third, a child is often aware that the events taking place are wrong and as a result, attributes blame to him or herself for simply being involved. Finally, a child typically experiences a surrendering to the powerlessness of the situation

and will interpret this compliancy as proof that he or she is bad for allowing the abuse to happen. "In the environment of chronic abuse . . . neither time nor experience provide any correction for this tendency toward self-blame [but rather] it is continually reinforced" (Herman, 1992, p. 103). All of these factors communicate to a child that he or she is worthless and erode a child's self-esteem. Unfortunately, diminished self-esteem sets the stage for numerous social, emotional, and intellectual difficulties and can increase the potential for future abuse and re-victimization (e.g., Briere, 2002; Chu, 1998; Classen et al., 2005; Hall; Marx et al., 2005; Pearlman; Roodman & Clum, 2001).

The third trauma-related dimension that influences a person's core beliefs is dependent upon whether the trauma occurred in childhood or adulthood (e.g., Courtois, 1999; Herman, 1992, Janoff-Bulman, 1992; Waites, 1997). In general, traumas committed to a child result in greater disruptions to cognitive schemas for a child's core belief system is still in the process of developing and is therefore more susceptible to external influences. According to Herman and Janoff-Bulman, childhood traumas that involve the experience of being left alone or abandoned can be particularly traumatic since the very essence of a child's existence is dependent upon the closeness and care of another. For a child, personal connections are strongly "associated with security, safety, and self-preservation [and the threat of being left alone] will strike fundamental fears of survival" (Janoff-Bulman, p. 59).

In situations of childhood sexual abuse, abandonment can occur either by the non-offending caregiver who leaves the child unprotected with an abuser or by the perpetrator who leaves the child terrified and alone after the abuse has occurred. Several core assumptions are shattered as the child quickly realizes that he or she is powerless to the situation and not important enough to be protected during moments when he or she

is in the greatest need of care and comfort (e.g. Hall, 2000; Janoff-Bulman, 1992; Pearlman, 2003). A disrupted sense of trust and safety follows from experiences of abandonment and in the mind of a child, this quickly translates into a belief that he or she is insignificant (e.g. Freyd, 1996; Herman, 1992; Pearlman).

The final trauma-related dimension that influences the degree to which core assumptions are altered relates to whether or not the perpetrator was known or unknown to the victim. Typically, traumas perpetrated by a known and trusted caregiver result in the greatest disruptions to a person's fundamental belief system for the degree of violation and betrayal is often severe. According to Courtois (1988), Janoff-Bulman (1992), and Pearlman (2003), traumatic events perpetrated by a complete stranger often disrupts an individual's trust in others however, traumatic events perpetrated by a known and trusted caregiver disrupts, not only a basic trust in others, but also a fundamental trust in oneself.

Children are inherently dependent upon others for their basic needs and when a trusted caregiver is the perpetrator of abuse, the child is placed in a highly conflicting situation where the caregiver is the source of both love and pain. According to researchers (e.g., Briere, 2002; Courtois, 1988; Freyd, 1996; Neborsky, 2003; Rothschild, 2000; Waites 1997), the closer the relationship, the greater the conflict. When sexual abuse occurs at the hands of a parent, the potential for harm is severe for "it involves the betrayal of the parent's role as nurturer and protector [and shatters the child's trust in self and others] when the parent meets his or her own needs through sexual contact with the child" (Courtois, 1988, p. 47). In the dichotomous world of a child whose cognitive and developmental levels dictate that people are either good or bad, the confusion that occurs when a caregiver exists in both realms is highly

distressing. As a result, a child begins to question his or her perception of others and a basic trust in one's own judgment is lost (e.g., Courtois, 1999; Hirakata & Arvay-Buchanan, 2005; Janoff-Bulman, 1992; Pearlman, 2003).

### Conclusion

In incidences of sexual abuse, a child is faced with the enormous task of trying “to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable [and] power in a situation of helplessness” (Herman, 1992, p. 96). In the above stated dimensions, childhood sexual abuse falls within the trauma-related categories (i.e., multiple incidences of human-perpetrated traumas that occurred in childhood by a known and trusted caregiver) where the greatest disruptions to cognitive schemas occur. For therapists working with individuals who have been sexually abused in childhood, the ongoing task is to re-build the shattered assumptions of trust, safety, power, esteem, and intimacy and re-establish the client's basic belief in him or her self (e.g., Briere, 2002; Courtois, 1999; Hall, 2000; Herman).

### Feelings and Emotions

Childhood sexual abuse has a profound emotional impact on a person's life and the link between early sexual trauma and symptoms of depression, anxiety, and posttraumatic stress have been well documented (e.g., Kendler, Kuhn, & Prescott, 2004; Peleikis, Mykletun, & Dahl, 2005; Walker, Carey, Mohr, Stein, & Seedat, 2004). Emotional distress resulting from childhood sexual abuse has been identified at all levels of development and although most studies (e.g., MacMillian, Fleming, Steiner, Lin, Boyle, Jamieson, Duku, Walsh, Wong, & Beardslee, 2001; Sofka, 1999) have

recognized elevated levels of depression and anxiety in adults, recent studies have also noted increased levels of depression and PTSD in children and adolescents.

Grover (2004) compared levels of PTSD and depression in 110 adolescents who had been sexually abused to 478 adolescents who reported no known history of abuse. All of the participants (380 boys; 202 girls) were interviewed individually and completed a series of questionnaires designed to determine: (a) the presence and severity of childhood sexual abuse and (b) the presence and severity of PTSD and depression. The results were consistent with findings from previous studies and revealed that adolescents with a history of sexual abuse had significantly higher levels of PTSD and depression and that these levels were positively correlated with abuse severity. The researcher of this study also found that parents and professionals (e.g., physicians, teachers, and therapists) failed to recognize signs of emotional distress and tended to dismiss trauma-related symptoms (e.g., being emotionally withdrawn, agitated, or anxious) as typical teen behavior.

Adolescents who have been sexually abused “are at an increased risk for a variety of developmental, emotional, and behavioral consequences” (Grover, 2004, p. 692). Therapists working with this population must therefore be aware of the potentially hidden symptoms of PTSD and depression and offer caregivers information on the emotional impact sexual abuse can have on an adolescent’s life.

A meta-analysis of 19 studies conducted by Walker et al. (2004) examined the role of gender in the subsequent development of PTSD in children who had been sexually abused. Results from these studies revealed that rates of pediatric PTSD ranged from 36% to 90% and that the likelihood of a child demonstrating symptoms of PTSD was largely dependent upon gender. In general, girls exhibited a heightened

vulnerability to PTSD with rates being two to six times higher in girls than boys. Furthermore, the presentation of PTSD symptoms was also found to be gender-specific. Although avoidant-related behaviors were equally demonstrated in both girls and boys, symptoms of intrusive thoughts and hyperarousal were significantly more prevalent in girls.

This gender-specific pattern has also been reported in adult populations. MacMillian et al. (2001) examined the prevalence of DSM-IV-TR disorders (e.g., depression, anxiety, substance use, and personality disorders) in a sample of men and women who experienced childhood sexual abuse. All of the participants, ranging in age from 25 to 64 years, were interviewed individually and assessed for DSM-IV-TR disorders. The results of this study supported findings from other studies and revealed a distinct gender difference with regards to the emotional impact of childhood sexual abuse. Although all of the participants experienced early sexual trauma, incidences of depression, anxiety, and PTSD were more commonly reported in women whereas substance abuse and disorders involving inappropriate anger or aggression were more commonly reported in men.

To explain these differences, several researchers (e.g., Friedman, Wang, Jalowiec, McHugo, & McDonagh-Coyle, 2005; MacMillian et al., 2001; Peirce, Newton, Buckley, & Keane, 2002) have postulated ideas related to gender role stereotyping and socialization. Theorists have stated that women are generally conditioned to exhibit internalizing symptoms, such as depression, anxiety, and posttraumatic stress while men are generally conditioned to exhibit externalizing symptoms, such as anger, hyperactivity, and aggression. These societal messages are

internalized at an early age and greatly contribute to the gender-specific expression of early sexual trauma.

Gender role stereotyping has serious implications for practice (e.g., Friedman et al., 2005; Grover, 2004; MacMillian et al., 2001; Peirce et al., 2002; Softa, 1999). In therapy, clients will typically present those emotions that have been deemed socially acceptable. For men, this will often result in a presentation of substance abuse, anger, and aggression and a general lack of emotional expression related to sadness, hurt, and fear. For women, the opposite occurs. Women will typically present stronger feelings of sadness and fear and a general lack of emotional expression related to anger.

Implications for practice include acknowledging the powerful role society has in dictating an individual's style of expression and recognizing that "differences in emotional experience [are most likely] due to socialization factors rather than innate biological differences" (Peirce et al., p. 191). Therapeutic environments must therefore support clients in breaking the restraints of gender role stereotyping and work towards accepting and encouraging a full range of emotional expression regardless of gender.

#### Conclusion

The relationship between childhood sexual abuse and emotional distress has been firmly established and strongly "associated with elevated lifetime rates of adjustment, mood, anxiety, attention deficit hyperactivity . . . and somatization disorders" (Walker et al., 2004, p. 114). The primary task of therapists is to recognize the hidden emotions that may exist in clients who have been sexually abused and acknowledge the various barriers to emotional expression. For some individuals, trauma-related symptoms can be well camouflaged and as a result, therapists must

remain acutely aware of the varying styles of emotional presentation (e.g., MacMillian et al., 2001; Peirce et al., 2002; Softa, 1999).

#### Actions and Behaviors

Similar to the cognitive and emotional disruptions that develop in response to early childhood trauma, researchers (e.g., Bailey & McCloskey, 2005; Farley, Lynne, & Cotton, 2005; Levenkron, 1998; Paivio & McCulloch, 2004; Potter, Martin, & Romans, 1999; Smith, Cox, & Saradjian, 1999) have also identified specific behaviors that are common amongst those with a history of sexual abuse. In particular, three behaviors--self-harm, addiction, and sexual risk-taking--dominate the current literature and represent those actions that have been found to be both harmful, yet soothing, to those who engage in them.

Self-harm. Researchers (e.g., Brown, Houck, Hadley, & Lescano, 2005; Gladstone, Parker, Mitchell, Malhi, Wilhelm, & Austin, 2004; Jeffreys, 2000; Romans, Martin, Anderson, Herbison, & Mullin, 1995; Strong, 1998; Weinberg, 2007) have explored the relationship between self-harm and childhood sexual abuse and have consistently found that those who have been sexually abused as children have a significantly greater tendency to engage in self-harming behaviors. Defined as a conscious attempt to harm oneself through the repetitive, non-suicidal pattern of socially unacceptable behavior that results in physical alterations to the body, self-harm primarily involves behaviors, such as the cutting and burning of one's skin (e.g., Favazza & Conterio, 1988; Nijenhuis, 2004; Paivio & McCulloch, 2004; Selekman, 2005; Suyemoto, 1998). Although statistics regarding the prevalence of self-injurious behavior varies, it is most commonly cited as occurring in approximately 0.4% of the general population, 12% in populations of adolescent girls and college students, and

significantly rising as high as 79% in populations of those who have been sexually abused as children (e.g, Brown et al., 2005; Favazza & Conterio; van der Kolk, Perry, & Herman, 1991; Selekman; Weaver, Chard, Mechanic, & Etzel, 2004).

Although the link between early sexual trauma and self-harm has been widely acknowledged, it is important to note that not all individuals who have been sexually abused engage in self-injurious behavior. What factors therefore distinguish those who intentionally harm themselves and those who do not? A study by Turell and Armsworth (2003) examined the differentiating variables that determine self-harming behaviors in 84 women (42 engaged in self-harming behaviors; 42 did not) ranging in age from 18 to 67 years. All of the participants had a history of childhood sexual abuse and were recruited through flyers distributed to local universities and counselling agencies. Each participant completed a series of assessments: the Sexual Attitudes Survey (Finkelhor, 1980); the Diagnostic Inventory of Personality and Symptoms ([DIPS] Vincent, 1985); the Dissociative Experiences Scale ([DES] Bernstein & Putnam, 1986); and the Beck Depression Inventory ([BDI] Beck & Steer, 1984).

The results of this study indicated that individuals who engaged in self-injurious behaviors were more likely to have had: (a) early psychological and physical abuse in addition to the sexual abuse; (b) a history of eating disorders; (c) deeper levels of depression; and (d) higher levels of dissociation characterized by a greater tendency to forget significant periods of time. In addition, five other variables in this study neared significance and were considered by the researchers as representing those factors that required closer exploration. These variables were identified in individuals who: (a) experienced longer durations of abuse (i.e., those who engaged in self-harm had been abused for almost twice as long as those who did not); (b) had a parent who was the

perpetrator; (c) developed an addiction to drugs or alcohol; and (d) reported feeling abandoned or rejected, primarily by their mother, in childhood.

The researchers of this study concluded that self-harming behavior was significantly more likely in those who experienced a lack of safety and protection in a childhood filled with danger and despair. Although additional factors such as the age of the perpetrator, frequency of abuse, incidences of penetration, and being diagnosed with a personality disorder were included in the analysis, none of these factors produced significant results and were therefore interpreted by the researchers as being non-determining factors in relation to self-harm. The results of this study suggested that self-harm appeared to be one of many “adaptive methods developed to survive and accommodate the secrecy, helplessness, and entrapment of abuse” (Turell & Armsworth, p. 489). Additional studies conducted by Gladstone et al. (2004) and Weaver et al. (2004) produced similar findings.

Although acts of self-harm are clearly differentiated from acts of suicide, individuals who have been sexually abused in childhood and engage in self-harming behavior are more likely to have suicidal ideations and are at a greater risk for suicide attempts (e.g., Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Oquendo, Brent, Birmaher, Greenhill, Kolko, Stanley, Zelazny, Burke, Firinciogullari, Ellis, & Mann, 2005; Suyemoto, 1998). A study by Ystgaard, Hestetun, Loeb, and Mehlum (2004) examined the relationship between various forms of childhood trauma (i.e., physical abuse, sexual abuse, emotional neglect, the loss of a caregiver, and exposure to family violence) and chronic attempts of suicide in 74 individuals (48 women; 26 men) who had been admitted to a local hospital in Norway for suicidal behavior. Participants ranged from 16 to 82 years of age and voluntarily agreed to individual interviews that

included the Childhood Experience of Care and Abuse interview schedule ([CECA] Bifulco, Brown, & Harris, 1994) and a series of open-ended questions related to suicide and self-harm. A logistic regression analysis was conducted and the results revealed that those individuals who experienced physical or sexual abuse in childhood were significantly more likely to exhibit higher levels of suicidal ideation and experience a greater number of suicide attempts. The results further revealed that those individuals who have been physically or sexually abused as children and engaged in intentional self-harming behavior represented an extremely vulnerable population and were at an even higher risk for suicidal action.

Previous researchers (e.g., Caprara & Rutter, 1995; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Wiederman, Sansone, & Sansone, 1998) have argued that suicidal behavior was not dependent upon the type of childhood trauma experienced but rather an accumulation of early negative events that may, or may not, have involved sexual abuse. The researchers of this study however, disputed those arguments and suggested that therapists need to be aware of specific factors (i.e., a client's history of physical or sexual abuse combined with self-harming tendencies) and recognize that this combination of variables can play a significant role in increasing the likelihood of suicide.

Why self-harm? There are numerous theories (e.g., psychoanalytic perspective, behavioral model, anti-suicide theory, interpersonal boundaries model) exploring the rationale behind intentional acts of self-harm. The dominant theory however, that exists in the current literature has suggested that self-harm serves a self-regulatory function where "individuals report feeling anxious, angry, tense, or fearful prior to harming themselves [and] a relief from mounting tension as a motivating factor for engaging in

self-injurious behavior” (Weaver et al., 2004, p. 560).

Built upon the assumptions of early attachment theory, the self-regulation model states that children develop an ability to monitor and express a full range of feelings through the physical and emotional attunement with their primary caregivers (e.g., Fosha, 2003; Porges, 2004a; Rothschild, 2000; Scaer, 2001; Schore, 2003). A caregiver’s ability to effectively respond to a child’s needs and feelings is critical for it helps children learn to regulate their emotions and communicate them appropriately to others (e.g., Dench, Murray, & Waller, 2005; Paivio & McCulloch, 2004; Neborsky, 2003; van der Kolk et al., 1991). In incidences of early sexual trauma, a child’s emotional world is often ignored. The skills needed to monitor and regulate the overwhelming array of feelings that arise from the abuse are therefore not acquired. As a result, a child is left alone with a flood of emotions and is forced to find alternate ways to soothe and release the often negative bombardment of fear, anger, pain, and confusion (e.g., Rothschild, 2000; Neborsky, 2003; Schore, 2003; Suyemoto, 1998).

Support for this theory exists in the research that identified a strong correlation between self-harm and dissociation (e.g., Dench et al., 2005; Low, Jones, MacLeod, Power, & Duggan, 2000; Paivio & McCulloch, 2004; van der Kolk et al., 2001). Low et al. (2000) examined levels of dissociation in 50 women ranging from 17 to 62 years of age who had a history of childhood sexual abuse and engaged in self-harming behavior. All of the participants were recruited through referrals from psychiatrists working at a local hospital in Wales and data were gathered through individual interviews designed to elicit information regarding levels of self-injurious and dissociative behaviors.

A one-way ANOVA analysis revealed that dissociation played a critical role in regulating self-harming tendencies. Participants reported that self-injury was used to

escape overwhelming feelings by prompting a dissociative episode and creating a state of emotional numbness. Although a causal relationship between these two variables could not be established, the results of this study supported findings from previous studies that consistently demonstrated “a positively strong association between higher levels of dissociation and an increased frequency of self-harming behaviour” (Low et al., 2000, p. 269).

A similar study by Dench et al. (2005) tested the hypothesis that dissociation plays a mediating role in the relationship between core beliefs of abandonment and intentional acts of self-harm. Fifty individuals (16 men; 34 women) admitted to a local hospital in England for symptoms of depression or anxiety voluntarily agreed to participate in this study. Although only half of the participants disclosed a history of sexual abuse, all engaged in some form of self-injurious behavior.

Each participant was asked to complete a series of self-report questionnaires: the Young Schema Questionnaire-Short form ([YSQ-S], Young, 1998); the DES-II (Carlson & Putnam, 1993); and the Impulsive Behaviours Scale-Revised ([IBS-R], Penas, Lledo, Vaz, Ramos, & Waller, 2002). The researchers of this study concluded that dissociation played a strong role in mediating the relationship between core beliefs of abandonment and intentional acts of self-harm. “Abandonment beliefs significantly predicted DES-II dissociation scores [and] DES-II dissociation was significantly and positively associated with self-harming behavior” (Dench, et al., p. 113). Interestingly however, this relationship was only found in the sub-population of women participants. Suggestions for future research included conducting studies to explore a possible gender-specific link among variables related to beliefs of abandonment, dissociation, and self-harm.

## Conclusion

A growing body of literature has indicated that dissociation is a mediating factor in the relationship between childhood sexual abuse and self-harm where higher levels of dissociation are positively correlated with an increased frequency in self-injurious behavior. Currently however, it is not known whether self-harm serves to end, or initiate, a dissociative episode. Some theorists (e.g., Favazza & Rosenthal, 1993; Russ, Campbell, Kakuma, Harrison, & Zanine, 1999; Selekman, 2005) have stated that self-harm acts in a regulatory manner to end unwanted feelings of dissociation by drawing a person's attention to his or her body and creating a sense of being real. Other theorists (e.g., Dench et al., 2005; Low et al., 2000; Suyemoto, 1998) have argued that self-injurious behavior is used to promote dissociation and serves as part of a self-regulatory defensive mechanism used to reduce, or distract, a person's awareness away from distressing feelings and memories. Regardless, Suyemoto (1998) has stated that one of the most therapeutically relevant issues related to self-harm is the difficulty individuals have in verbalizing their needs and feelings. Effective therapy must therefore focus on developing a client's ability to articulate his or her needs and assign words to those experiences that are difficult to communicate verbally. Suggestions for practice included educating clients about the often confusing role self-harm plays in regulating emotions, helping them build an effective repertoire of grounding skills, and developing their ability to identify and express emotions, particularly those related to anger, loss, rejection, and abandonment (e.g., Dench et al., 2005; Paivio & McCulloch, 2004; Schore, 2003; Selekman). Further discussion on the experience of dissociation and the role it plays in helping individuals cope with overwhelming feelings and emotions is discussed in the literature review section entitled Dissociation.

It is important to note that within this growing body of literature supporting a self-regulatory model of self-harm, researchers (e.g., Brodsky, Oquiendo, Ellis, Haas, Malone, & Mann, 2001; Gallop, 2002; Schore, 2003; Scaer, 2001; Yates, 2004) have also begun exploring possible neurobiological factors that might play a role in increasing a person's tendency towards self-injurious behavior. More specifically, studies (e.g., Favazza & Rosenthal, 1993; U. Lanius, personal communication, June 25, 2007; Russ et al., 1999; Selekman, 2005) have suggested a link between intentional acts of self-harm and a dysregulated opioid system where levels of beta-endorphins become elevated during moments of self-injury. It is hypothesized that self-harm triggers a cascade of beta-endorphins, which in turn, decreases a person's perception of pain while at the same time increasing a pleasurable sense of euphoria (e.g., Brodsky et al.; Russ et al.; Schore). Studies in this area however, are minimal and require further research before any definitive conclusions can be made.

Addiction. There are considerable studies (e.g., Bailey & McCloskey, 2005; Fleming, Mullen, Sibthorpe, Attewell, & Bammer, 1998; Kilpatrick, Acierno, Saunders, Resnick, Best, & Schnurr, 2000; Picard, Sharon, Kang, Angarita, & Gastfriend, 2005; Simpson, 2002) citing the relationship between early sexual trauma and addictive behavior with statistics stating that individuals who have been sexually abused in childhood are 1.6 times more likely to misuse marijuana, 2.4 times more likely to abuse alcohol, and 2.6 times more likely to develop an addiction to drugs, such as heroin and cocaine. Although not all individuals with a history of sexual abuse become addicted, it is estimated that between 6% to 25% of all men and 60% to 84% of all women entering treatment programs have experienced some form of sexual abuse in childhood (e.g.,

Bailey & McCloskey; Freeman, Collier, & Parillo, 2002; Johnson, Ross, Taylor, Williams, Carvajal, & Peters, 2005).

Many theorists have agreed that the link between substance abuse and early sexual trauma involves a person's attempt to self-medicate where "sustained drug or alcohol misuse allows the abuse survivor to separate psychologically from the environment, anesthetize painful internal states, and blur distressing memories" (Johnson et al., 2005, p. 212). However, what factors of sexual abuse distinguish those individuals who engage, and do not engage, in addictive behavior?

Freeman et al. (2002) compared the differences related to the age of onset of abuse (i.e., sexual abuse perpetrated in childhood before the age of 12 versus sexual abuse perpetrated in adolescence between the ages of 12 to 18) and the use of crack cocaine in adulthood. A large sample of 1,478 women was recruited from a list of participants involved in the National Institute on Drug Abuse (NIDA) and the Women Helping to Empower and Enhance Lives (WHEEL) projects. Consent was granted by each participant for the researchers of this study to access data collected during intake procedures from the above stated projects and data collected offered information regarding past and current drug use, history of sexual abuse, and abuse-related details, such as the age of onset, relationship to the perpetrator, duration, and severity.

A controlled multivariate analysis revealed that sexual abuse perpetrated by a close family member in childhood was strongly associated with the use of crack cocaine in adulthood. Sexual abuse perpetrated in adolescence however, fell short of statistical significance and failed to suggest a relationship between sexual abuse beginning after the age of 12 and future addiction. The researchers of this study hypothesized that sexual abuse initiated before the age of 12 may "adversely affect a child's developing

sexual identity . . . and set the stage for a vulnerability to later life problems that might be palliated by substance use” (Freeman et al., p. 124). The results of this study offered support regarding the seriousness of abuse perpetrated on younger children and were consistent with theories stating that children who are sexually abused at a younger age are at a greater risk for future drug-related difficulties.

Another study by Bailey and McCloskey (2005) explored the link between childhood sexual abuse and substance use amongst adolescent girls and examined this link in relation to two variables: low self-worth and levels of aggression and impulsivity. Participants (n = 150) for this study were recruited from a list of individuals who took part in a longitudinal project designed to explore the impact of family violence on the lives of adolescent girls. As part of this study on family violence, information was obtained about the type of violence each adolescent experienced and those who disclosed a history sexual abuse were contacted regarding their interest in further research. Upon consent, each participant was interviewed individually. Open-ended questions were asked to explore past and current substance use and levels of self-worth and aggression and impulsivity were assessed using the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and the Child Behavior Checklist (Achenbach, 1991).

Contrary to the researchers’ expectations, a chi-square analysis revealed that scores related to low self-worth were not a significant factor in mediating the relationship between childhood sexual abuse and future substance use however, levels of aggression and impulsivity were. In fact, impulsivity and aggression displayed through acts of violence and risk-taking behavior “emerged as a unitary factor that mediated the relationship between childhood sexual victimization and adolescent substance use” (Bailey & McClosky, 2005, p. 51). Implications for practice included strengthening a

client's ability to regulate his or her behaviors and incorporating programs designed to address issues related to impulse control and anger management.

### Conclusion

In situations where individuals present concerns involving both substance use and a history of childhood trauma, therapists have questioned whether it might be more effective to treat the addiction before the trauma or treat the trauma with the belief that the addiction, held in place by the trauma, will automatically subside. A review of the current literature however, indicated that addiction and trauma should be addressed simultaneously for interventions that target both trauma-related symptoms and substance use problems tend to yield significantly better outcomes (e.g., Freeman et al., 2002; Johnson et al., 2005; Pirard et al., 2005; Simpson, 2002). According to Johnson et al., "it is not possible to successfully treat the chemical addiction without addressing the related historical trauma" (Johnson et al., p. 221). Therapists must therefore acknowledge the interconnected nature of trauma and addictions and develop programs that can effectively attend to the tightly woven needs and concerns of both issues.

Sexual risk-taking. Researchers (e.g., Benoit & Millar, 2001; Campbell, Ahrens, Sefi, & Clark, 2003; El-Bassel, Cooper, Simoni, Gilbert, & Schilling, 2001) have examined the relationship between childhood sexual abuse and sexual risk-taking behavior and have reported that behaviors tend to exist along a continuum with some individuals completely withdrawing from any form of sexual activity and others repeatedly engaging in unprotected sex with multiple partners. To date, there have been no consistent findings that identify a specific link or pattern between the two experiences.

Several researchers (e.g., Farley, Lynne, & Cotton, 2005; Napoli, Gerdes, & DeSouza-Rowland, 2001; Simpson, 2002) have focused their studies on the sexual risk-taking that occurs in prostitution where incidences of violence and the potential for contracting sexually transmitted diseases are extremely high. Recent statistics estimate that 82% to 90% of North American sex trade workers experienced some form of sexual abuse in childhood and that more than two thirds enter the sex trade before the age of 15 (e.g., Farley et al., Napoli et al., Nixon, Tutty, Downe, Gorkoff, & Ursel, 2002; Simpson). Although not all individuals who have been sexually abused engage in prostitution, researchers have questioned why some individuals enter a world that is so reminiscent of the power imbalance and abuse they experienced as children. Several connections have been made with regards to low self-esteem and the practicality of supporting a costly addiction to numb the emotional pain and memories of the abuse (e.g., Potter, Martin, & Romans, 1999; Simpson; Suporn-Koetsawang, 1997). Recent theorists (e.g., Campbell et al.; Farley et al.; Nixon et al., 2001) however, have postulated the idea that prostitution may play a role in providing sex trade workers with an illusionary sense of power and control over their past.

A case study by Napoli et al. (2001) examined the life experience of a 25 year old woman who had been involved in the North American sex trade since the age of 16. In an in-depth interview with the researchers, the woman revealed personal aspects of her life and provided insight into how she believed sexual abuse led her to a life of prostitution. The woman described how her father began sexually abusing her at the age of four and in the following statement reflected upon how the abuse created a belief system that set the stage for her entry into the sex trade:

I had developed the erroneous belief that the world was a jungle that only consisted of two types of people; those who got eaten and those who ate. Abuse, unfortunately, is a dance that women don't realize they can sit out of. It would take me a long time to learn there was a third group that neither abused nor were abused . . . the ones who just didn't dance. (p.75)

Rather than place herself in the role of victim, the woman identified herself as a sexual predator who preyed upon her customers and controlled them through their sexual desires. "This type of behavior is virtually identical to the behavior of a, usually male, sex offender who . . . grows up a prisoner of his own rage, shame and helplessness, then turns his aggression on other children in a repetition compulsion" (Napoli et al., p. 75). Arising from early abuse and a sense of utter fear and helplessness, repetition compulsion has been defined as a need to continuously re-create childhood traumas in an unconscious effort to regain a sense of power and control over the past (e.g., Courtois, 1999; Herman, 1992; Napoli et al.; van der Kolk, 1996). A common form of repetition compulsion exists when individuals who have been abused as children find themselves in situations where further victimization occurs. For members of the sex trade, the sexual exploitation experienced on the streets is a direct representation of the sexual exploitation they endured as children.

The results of this study indicated that prostitution allowed individuals to create an illusion of power by establishing themselves in the role of perpetrator rather than victim. "Prostitution worked for me like drugs worked for other people; it kept me from feeling my feelings. As long as I was perpetrating against someone else it meant they weren't perpetrating against me--or so I believed" (Napoli et al., p. 75). Researchers concluded that a crucial element of this woman's story was her need to regain power

over her past and that her life as a prostitute offered her some semblance of control and authority over another.

Nixon et al. (2002) reported similar findings through a qualitative study that examined the narratives of 47 women involved in the Western Canadian sex trade. All of the women, ranging in age from 18 to 36, had a reported history of childhood sexual abuse and were recruited through flyers posted at agencies that specialized in providing services for individuals who engaged in prostitution. Semi-structured interviews were conducted and open-ended questions (e.g., How did you become involved in prostitution? What factors do you believe contributed to the start of you working on the streets?) were asked to elicit dialogue about each participant's entry into the sex trade.

Through a thematic-content analysis, the researchers of this study concluded that many of the women became involved in prostitution as a way to gain control over the powerlessness they experienced as children. According to one woman:

When you're sexually abused, I always thought I had control over men. I never thought about it as they're using me. I always thought I had the power. The more money I made, the more wanted and loved I felt because I always associated love with sex. (p. 1024)

Although some women in the study sought to exit the sex trade, others did not and stated that working in the sex trade was simply a comfortable and familiar part of their childhood identity. One woman recalled how her uncle paid her as a child to perform numerous sexual acts and stated that her life as a prostitute was simply a natural continuation of that earlier experience: "No customer after that really seemed to matter. It never really made a difference. I just made sure that I got paid" (Nixon et al., p. 1024). Another women expressed similar sentiments: "I started when I was so young. It's just

been a part of my life. It's not something that's like out of the ordinary" (Nixon et al., p. 1036).

### Conclusion

Although prostitution is widely recognized as being associated with a high risk of physical assaults, sexual violence, and possibly even death, some individuals who have been sexually abused as children entered the sex trade with an illusionary belief that they were regaining control of their lives. Members of the sex trade have often been met with multiple barriers in their attempts to access therapy and it is therefore important for therapists to acknowledge the intense fear, suspicion, and mistrust that may exist in those who have been repeatedly violated as both children and adults. For many sex trade workers who have a history of sexual abuse, there is "a profound distrust of authority figures [and of] the social structures that did not protect them as children" (Napoli et al., 2001, p. 85). Implications for practice included: (a) remaining open and flexible to the specific needs and issues of those working in the sex trade; (b) recognizing how the added barriers, such as a severe lack of trust and safety, may impede the therapeutic process; and (c) acknowledging the role prostitution may play in reenacting earlier sexual abuse (e.g., Courtois, 1999; Napoli et al.; Nixon et al., 2002; van der Kolk, 1996).

### Relational Impact on Self and Partners

Childhood sexual abuse occurs within the context of an intimate relationship and the impact of such an experience will undoubtedly affect an individual's ability to fully enter into the closeness of an interpersonal relationship (e.g., Anderson-Jacob, & McCarthy-Veach, 2005; Hooper & Koprowska, 2004; Nelson & Wampler, 2000; Noll, 2005; Wiersma, 2003). A study by Larsen and Lamont (2005) examined the marital

attitudes of 622 newly engaged women with a history of childhood sexual abuse to explore how early sexual trauma impacts an individual's attitude towards marriage. Participants ranged in age from 18 to 25 years and were recruited through marriage preparation courses across the United States. Each participant was asked to complete two self-report questionnaires: the Severity of Abuse Scale ([SAS] Wyatt & Mickey, 1987) and the Marital Attitude Scale (Greenberg & Nay, 1982).

A multiple regression analysis revealed that childhood sexual abuse was significantly related to women having less confidence in the success of their upcoming marriage and a belief that marriage would be "more frustrating than satisfying, more demanding than easy, and more tense than happy" (Larson & LaMont, p. 425). Adjustment to married life was also expected to be more difficult and interpersonal conflict with their partner was identified as an overwhelming fear they experienced. Researchers suggested that therapists involved in premarital counselling thoroughly assess both partners for a history of childhood trauma and openly discuss the effect past trauma may have on their upcoming union. Conflict resolution and communication skills were also recommended.

Researchers (e.g., Anderson-Jacob & McCarthy-Veach, 2005; Nelson & Wampler, 2000; Swanson & Mallinckrodt, 2001; Wiersma, 2003) have also questioned how childhood trauma affects the spouses and partners of those who have been abused. Nelson and Wampler compared levels of family adjustment and relationship satisfaction in 96 couples, in which one member of the couple had a history of physical or sexual abuse to 65 demographically matched couples, in which no history of abuse was reported. All of the participants were in heterosexual relationships, married for an average of 6.9 years, and recruited through referrals from various marriage and family

therapists across the United States. To examine the relational impact of childhood trauma, each participant was asked to independently complete a series of questionnaires: the Dyadic Adjustment Scale ([DAS] Spanier, 1976); the Brief Symptom Inventory ([BSI] Derogatis, 1993); and the Family Adaptability and Cohesion Scale ([FACES III] Olson, Portner, & Lavee, 1985).

The results of a multivariate analysis revealed that in couples where one individual had a history of abuse, the partner, who had no history of abuse, obtained BSI scores that were strikingly similar to the BSI scores of the individual who had been abused. These results suggested that vicarious traumatization occurs in the partners of those who experienced physical or sexual abuse and that trauma-related symptoms, such as those measured by the BSI (i.e., depression, anxiety, interpersonal sensitivity) were a shared experience amongst couples. Implications for practice included engaging both partners in the therapeutic process for typically, “the primary survivor is the only family member who receives therapeutic services [and] therapy is left an enigma to others in the family, particularly spouses” (Nelson & Wampler, p. 178). The researchers of this study suggested that therapists seek to involve the partners and spouses of those who have been abused and recommended the use of systemic interventions, such as couples or conjoint family therapy.

A study by Wiersma (2003) explored the relational impact of individuals disclosing a history of childhood sexual abuse to their partner and examined this experience in the lives of six couples recruited through referrals from therapists working at a university counselling center in the United States. All the couples were in heterosexual relationships and accepted for participation based on the following criteria: (a) one member of the couple (i.e., identified by the researchers as the primary survivor)

had been sexually abused in childhood and the other (i.e., identified as the secondary survivor) had no history of abuse; (b) the secondary survivor was recently disclosed of the primary survivor's abuse history; and (c) the couple had been in an intimate relationship with each other for at least 6 months. Four of the primary survivors were women and two were men.

Each member of the couple was interviewed individually and open-ended questioned were asked to elicit information regarding the process of disclosure and how each participant perceived the disclosure to impact his or her life. A thematic content analysis revealed several significant themes. For primary survivors, there was a hesitation to disclose the abuse to their partner primarily because there was a perceived lack of their own ability to talk about what happened. One participant stated:

I thought if I tried to sit down and talk to her about it . . . it would be o.k., and I think it would have been something we could probably work on, but . . . I didn't think I could actually do it at that point. (p. 155)

Another participant stated: "I couldn't really tell him . . . what I wanted because I didn't know. I didn't know what was wrong with me" (Wiersma, p. 155).

Primary survivors also experienced a reluctance to talk about the abuse with their partner for fear of him or her becoming distressed, judgmental, impatient, or disinterested. "It's not something I felt we could really talk about. I think it's because it's so touchy" (Wiersma, p. 155). For others, there were regrets about disclosing the abuse:

I've never really liked him knowing. There's a part of me . . . that's always thought to myself, you made a big mistake. You should have just kept it to yourself. You should have shut up . . . like I shouldn't have told him [tearful]. I

think it's just because it's made me feel really insecure to know that he knows."

(p. 155)

For secondary survivors, there was a perceived lack of ability to properly support their partner. "If it would help her to talk to me about it, then that would be great, but . . . at the same time [breaks off] . . . 'cause I don't know how much I could help her . . . I don't know how to respond to that" (Wiersma, p. 158). Another participant stated: "Everything I say to her, I'll think about before I say it, just to make sure that I don't say something wrong or in a bad way to where she could get more upset about it" (Wiersma, p. 158).

Secondary survivors also expressed some ambivalence about whether they wanted to know about the abuse:

If that would help her, again that would be fine. I guess. But I think that would . . . I don't know. It's kind of horrifying and . . . creepy . . . I just don't know if I want to hear about that in that great of detail. It would just make me uncomfortable. (p. 158)

One participant simply stated: "It's probably better that I didn't know" (Wiersma, p. 159).

The results of this study demonstrated that both partners experienced similar concerns regarding: (a) whether or not they wanted to disclose, or receive, information about the abuse and (b) their ability to effectively express, or properly support, the disclosure. In essence, individuals whose partners have been sexually abused are secondary victims to the trauma and in fact, experienced similar thoughts, feelings, and fears with regards to discussing the abuse. Although the researcher suggested that both partners work together to recognize and resolve any relational issues that may arise as a

result of past trauma, the researcher cautioned therapists from involving partners too quickly. "Premature attempts to share abuse-related responses may be unfruitful, or even damaging" (Wiersma, p. 161) and it was recommended that therapists thoroughly assess both partners before engaging in joint therapeutic sessions. Assessment of primary survivors should include whether they are able to openly discuss the abuse and have an awareness of how the abuse impacts their relationship. Secondary survivors should demonstrate a desire to learn about their partner's needs and feelings and more importantly, have an awareness of their own needs and issues so that they can be fully present in their support of their partner's reparative process.

#### Conclusion

Shattered trust, intimate betrayals, and broken attachments are core experiences of those who have been sexually abused as children and the impact of such experiences can have implications that extend well beyond the individual who had been abused. Researchers (e.g., Anderson-Jacob & McCarthy-Veach, 2005; Hooper & Koprowska, 2004; Nelson & Wampler, 2000; Noll, 2005; Schreiber & Lyddon, 1998; Swanson & Mallinckrodt, 2001; Wiersma, 2003) have stated that childhood sexual abuse is a shared trauma amongst couples and that symptoms of posttraumatic stress, depression, and anxiety have been identified in partners who have no reported abuse history. Not all couples are aware of the degree to which childhood trauma is jointly experienced and unknown triggers that spark interpersonal tension can lead to further discord. For therapists working with individuals whose partner had been sexually abused, "it is critical to understand how secondary trauma may be a factor in the relational problems they present" (Nelson & Wampler, p. 178). Therapists must therefore acknowledge the vicarious nature of childhood sexual abuse, assess the readiness of both the client and

his or her partner for conjoint family or couples therapy, and when appropriate, incorporate systemic treatment plans that can help educate and support both partners in their parallel journey of reparation (e.g., Anderson-Jacob & McCarthy-Veach; Hooper & Koprowska; Wiersma).

### Strength, Resiliency, and Mediating Factors

Research in the area of childhood sexual abuse has shifted its focus over the years and according to theorists (e.g., Leahy, Pretty, & Tenenbaum, 2004; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Steel, Sanna, Hammond, Whipple, & Cross, 2004), studies have developed into what has become known as the three waves of research. Studies (e.g., Briere & Runtz, 1993; Conte, 1985; Courtois, 1988; Elliot & Briere, 1992; Finklehor & Browne, 1985) conducted during the first wave have focused on the range of psychological, behavioral, emotional, and interpersonal challenges that arise in individuals who have been sexually abused and has brought awareness to the common effects (e.g., depression, anxiety, posttraumatic stress) of early sexual trauma. The second wave of research, characterized by studies (e.g., Gold, Hill, Swingle, & Elfant, 1999; Freyd, 1996; Valentine & Feinauer, 1993; Williams, 1993) that recognize the variability amongst individuals, have highlighted specific abuse-related factors (i.e., age of abuse onset, relationship with the perpetrator, abuse severity, levels of threat) that influence the degree to which sexual trauma impacts a person's life. Currently, studies in the area of childhood sexual abuse have entered its third wave. Theorists (e.g., Owen & Chard, 2001; Katerndahl, Burge, & Kellogg, 2005; Pickering, Farmer, McGuffin, 2004; Wilcox, Richards, & O'Keeffe, 2004) in this area have focused on the subjective experiences of individuals who have been abused and have begun exploring mediating factors that influence levels of resiliency. Thus far, four areas--the experience of

disclosure, styles of attribution, and perpetrator manipulation--have emerged as being critical mediators in protecting individuals from the negative consequences of childhood sexual abuse.

#### The Process of Disclosure

Researchers (e.g., Feiring, Taska, & Chen, 2002; Jonzon & Lindblad, 2005; Palmer, Brown, Rae-Grant, & Loughlin, 1999; Ullman, 2003) have recognized that disclosing childhood sexual abuse is neither a predictable nor linear process but instead involves a backward and forward motion of wanting to tell and wanting no one to know at all. For a child, there are several barriers to disclosure. First, disclosures made by children are often complicated by what Palmer et al. have identified as veiled disclosures where disclosures are made in an indirect and somewhat subtle manner through statements such as I just don't like him or through symbolic acts of play, somatic symptoms, and re-enactive behaviors. As a result, adults fail to recognize the hidden messages of abuse and children, believing that they have told someone, begin to question why no one cares enough to listen. Second, children are frequently told by their perpetrator not to tell (e.g., Courtois, 1999; Lovett, 2004; Sjoberg & Lindblad, 2002; Ullman). Threats of harm are made both directly and indirectly and the immense fear placed upon a child can act as a powerful silencer. Third, when the perpetrator is a member of the family, children typically feel an extreme responsibility to keep the family together and recognize that by disclosing the abuse, they could destroy the only family that they have known (e.g., Freyd, 1996; Jonzon & Lindblad; Lundqvist, Hansson, & Svedin, 2004). Finally, researchers (e.g., McFarlane, 2004; Ogden & van der Kolk, 2002; Perry, 1999; Schore, 2003; van der Kolk, 1996) have identified numerous physiological barriers to verbally disclosing a traumatic experience. The age

of the child, the highly sensory nature of the abuse, and the innate biological processes that occur in the presence of real or perceived danger all trigger a physiological response that momentarily deactivates the center of the brain associated with verbal language. All of the above-stated barriers have been found to be equally present in adults with a history of childhood sexual abuse. Additional fears of societal and peer rejection, judgment, and blame further contribute to the lack of disclosures in adulthood (e.g., Briere, 2002; Bolen & Lamb, 2004; Courtois & Pearlman, 2006; Howell, 2005; Lovett; Pearlman, 2003; Schwartz, 2000).

Researchers (e.g., Jonzon & Lindblad, 2005; Lovett, 2004; Lundqvist et al., 2004; Merrill et al., 2001; Ullman, 2003) have estimated that approximately 52% to 72% of all individuals who have been sexually abused eventually tell someone about the abuse and that most tellings occur an average of eight years after the abuse has ended. Although disclosures made in a safe and supportive environment can be highly reparative, not all disclosures are met with the same degree of support and understanding (e.g., Bolen & Lamb; Feiring et al., 2002; Hobfoll, Bansal, Schurg, Young, Pierce, Hobfoll, & Johnson, 2002; Whiffen & MacIntosh, 2005).

A study by Jonzon and Lindblad (2005) examined two disclosure-related factors --the timing of first disclosure (i.e., disclosures made in childhood versus disclosures made in adulthood) and the reaction of the person being told--in 123 women ranging from 20 to 60 years of age. Each participant was interviewed individually and completed a variety of questionnaires designed to determine: (a) levels of abuse severity; (b) the timing of the first disclosure; (c) reactions of those who were told; and (d) any past and/or current psychological or psychosomatic symptoms.

Two significant findings emerged from this study. First, a positive disclosure was identified as the single most significant factor in predicting future psychological and psychosomatic functioning. Responses that conveyed a sense of support, understanding, and validation were most strongly correlated with fewer symptoms of posttraumatic stress, depression, and anxiety. Furthermore, in situations of severe abuse, a positive disclosure was powerful enough to minimize the negative consequences of abuse and influence a person's subjective level of emotional and physical well-being. Second, a positive first disclosure made in childhood was more strongly correlated with physical and psychological health than a positive first disclosure made in adulthood. These findings were especially prevalent in situations where the disclosure was positively received by the child's non-offending caregiver. Implications for practice included recognizing the importance of providing the necessary support during sexual abuse disclosures and acknowledging the power a therapist holds in building a client's internal sense of strength and resiliency when responding to an initial disclosure.

#### Styles of Attribution

Studies (e.g., Merrill et al., 2001; Steel, Samma, Hammond, Whipple & Cross, 2004; Whiffen & MacIntosh, 2005; Wilcox, Richards, & O'Keeffe, 2004) have identified that attribution styles and locus of control are significant predictors of future emotional adjustment and that resiliency is positively correlated with an external locus of control in which blame is assigned to the perpetrator. A study by Porter and Long (1999) compared locus of control and abuse severity in 84 women who had been sexually abused in childhood in order to examine how these variables influenced later life adjustment. All of the participants completed a series of questionnaires and the results revealed a strong relationship between external locus of control and lower levels

of posttraumatic stress, depression, and anxiety. Interestingly however, in situations of severe abuse an internal locus of control and self-blame were more strongly associated with emotional health and well-being. In cases of extreme abuse, “women who maintained an internal locus of control experienced limited psychological difficulties in adulthood [whereas women] who perceived that they were not in control of their lives and maintained an external locus of control were vulnerable to greater difficulties” (Porter & Long, p. 18-19).

The researchers concluded that “locus of control moderates the relationship between childhood sexual abuse and later psychological functioning [and that this factor] plays the most important role for women with a history of severe abuse” (Porter & Long, p. 15). Given that personal control has been identified as a critical factor in maintaining power in a situation where one is powerless, the researchers suggested that a certain degree of self-blame provided victims of severe abuse with a sense of being in charge of their lives and therefore the belief that they could protect themselves from future harm. The results of this study were replicated in research conducted by Feinauer, Middleton, and Hilton (2003) and Leahy, Pretty, and Tenenbaum (2003).

#### Perpetrator Methodology

Several studies (e.g., Leahy et al., 2003; Leahy, Pretty, & Tenenbaum, 2004; Mollen, 2002; Sullivan & Beech 2004) explored the differences in perpetrator methodology and the relationship between the strategies perpetrators used and the degree to which an individual is affected by abuse. A study by Leahy et al. (2004) examined the style of perpetrator manipulation in 39 adults (18 men; 21 women) who demonstrated high levels of posttraumatic stress and dissociative symptoms. Individual

interviews were conducted and a thematic-content analysis revealed three dominant themes.

First, higher trauma-related symptoms were positively associated with the perpetrator's use of deception. One man stated that deception on the part of his abuser played a significant role in making him feel responsible for what had happened:

He said he was doing a survey, and uhm, it started off with stuff like that . . . and he asked me to describe things, what turned me on and that kind of stuff . . . I guess I felt partly that I'd been conned and was therefore somewhat responsible.  
(p. 532)

Similar comments were made by another participant: "He played us off together as well so (pause) . . . it never entered my mind that others could possibly be experiencing the same thing (pause)" (Leahy et al., 2004, p. 532).

Second, elevated levels of dissociation and posttraumatic stress were found to be especially prevalent in those who described being emotionally manipulated through a cycle of reward and punishment. One woman who was sexually abused by her coach stated:

It was more emotional, everything he did, like he used to build (pause) like he'd put me down . . . he'd really put me down . . . like as an athlete and then build me up with his affection and uhm, then it got really confusing. (p. 533)

A man who was also abused by his coach made a similar comment:

I mean, I, this guy had done a lot of things for us, for me, had helped me out, you know, had bought me new training boots (long pause) and all sorts of bits and pieces (pause) and given us good jobs, and I mean there was some sort of relationship there. (p. 533)

Finally, participants with higher levels of trauma-related symptoms reported a style of perpetrator manipulation that involved the abuser communicating a sense of omnipotence. One woman whose perpetrator was well liked and held a prominent position in the community stated:

I still remember how I used to brag to my friends and my parents about how great this guy was, how lucky I was. He was just absolutely brilliant . . . people kept saying how fortunate I was that he was taking such a special interest in me.  
(p. 536)

Another woman described how the deep stare of her perpetrator's eyes mesmerized her into believing that he was all-powerful. "He wouldn't actually physically abuse me or whatever. You know, he'd do, not even ask, just (pause) . . . I'd just freeze and . . ."  
(Leahy et al., 2004, p. 532).

The results of this study suggested that perpetrator methodology was an influential factor in increasing the likelihood of posttraumatic stress, dissociation, depression, and anxiety. Recommendations were made to further this study by expanding upon the different aspects of perpetrator methodology and gaining insight into how therapists can build inner strength and resiliency through the safe and trusting interactions that occur in the therapeutic relationship.

A study by Sullivan and Beech (2004) examined the manipulation strategies from the perspective of 41 perpetrators of childhood sexual abuse to gain insight into the strategies they used to convey a sense of power over their victims. Participants, recruited through a treatment center for sex offenders in the United States, were individually interviewed and a thematic content analysis revealed three dominant themes. First, most perpetrators were aware of their attraction to children and intentionally placed

themselves in positions of high regard where regular contact with children was an expected part of their job description. Participants stated that these positions gave them easy access to children and that their role was such that children typically wanted to please them. Furthermore, participants acknowledged that by placing themselves in well-respected positions of authority, parents were less likely to question their involvement with children and in fact, were more likely to unwittingly support the abuse by encouraging such relationships to exist.

Second, participants stated that emotional manipulation was far more effective than physical force in creating a sense of self-doubt and self-blame in a child. A common strategy involved the use of grooming where abuse began with subtle gestures that gradually progressed until the abuse became more direct and severe. Sixty-seven percent of the participants admitted to initially involving a child in gentle embraces before eventually advancing to discussions of sexually explicit fantasies, viewing pornographic material, and then finally engaging in direct sexual abuse and exploitation. This process left a child questioning the reality of what was happening and often evoked intense feelings of shame, guilt, and confusion.

Third, participants stated that by instilling fear and severing a child's ability to form attachments, a child was more likely to be compliant and develop a form of traumatic bonding or dependency upon the perpetrator. One participant who was the perpetrator of more severe forms of abuse stated:

First you take a child and confine it in a box. Then you add worms, bugs, and snakes and place a lid on the box. The child will kick and scream in terror. You ignore the child until no noise comes from the box, at which time you remove the top of the box. You check the muscle tone of the child. If the tone is relaxed

... you can train this child to be who you want and to do what you want. The child will obey without question. (p. 239)

Another participant described how he deliberately encouraged children to become attached to an animal before killing it or taking it away: "The intention attributed to this was that of breaking any tendency to make attachments. That's how you teach a child not to risk feeling anything for anyone" (Sullivan & Beech, 2004, p. 242).

### Conclusion

Studies on the mediating factors of early sexual trauma have greatly assisted both theorists and practitioners in understanding the differing degrees to which an individual is affected by abuse. Although some researchers (e.g., Katernadahl, Burge, & Kellogg, 2005; Pickering, Farmer, & McGuffin, 2004; Wilcox, Richards, & O'Keeffe, 2004) have explored factors such as genetic predisposition and the influence of spirituality and religion as contributing factors in the development of personal strength and resiliency, the results from these studies have remained inconclusive. More research in these areas is therefore needed.

### Dissociation

Although the topic of childhood sexual abuse is an area of study that has been well researched over the years, research on dissociation has only recently resurfaced and as a result, our understanding of this complex phenomenon is just beginning. Studies on dissociation began over a century ago when French psychiatrist, Moreau de Tours first used the term in 1845. However, it was the work and multiple publications of Pierre Janet (e.g., 1882; 1885; 1898; 1907; 1947) that drew widespread attention to what he described as a "retraction in the field of personal consciousness and [a disruption of the normal synthesis between] systems of ideas and functions that constitute personality"

(Janet, 1907, cited in Putnam, 1997, p. 7). Following the death of Janet in 1947, interest in dissociation became lost in a zeitgeist that focused on conscious thought, concrete beliefs, and modes of therapy that revolved around challenging irrational thought patterns. Advancements to the understanding of dissociation were virtually at a standstill. In the late 1980's however, trauma theorists (e.g., Briere & Runtz, 1988; Carlson-Bernstein & Putnam, 1986; Conte, 1985; Courtois, 1988; van der Hart & Friedman, 1989) sparked a renewed interest in a person's ability to psychologically escape the dangers of real or perceived harm and thus began the current movement towards developing a deeper understanding of dissociative behavior.

In this section, I discuss some of the core developments that have emerged on the topic of dissociation. First, I describe symptoms of dissociation and identify the range of behaviors that exist along a continuum that spans what theorists have referred to as normal versus pathological behavior. Second, I discuss the cultural aspects of dissociation and highlight the culturally specific context in which dissociation occurs. Third, I outline the neurobiology of dissociation and draw attention to what Janet recognized as an experience that affects both the psychological mind and the physiological body. Finally, I discuss how dissociation is currently treated in therapy and identify the role this research plays in developing a deeper understanding of how therapists can better support individuals who dissociate.

#### Signs and Symptoms of Dissociation

There are two types of dissociative symptoms--negative and positive. Negative dissociative symptoms refer to a wide range of mental and functional losses that include: anesthesia (i.e., loss of pain sensation); amnesia (i.e., loss of memory); abulia (i.e., loss of will or ability to maintain conscious attention); changes to motor control (i.e., loss of

voice or movement); and changes in character traits (i.e., shifts in personality or identity). Positive dissociative symptoms refer to a range of actions and thoughts that occur beyond what is considered normal. These symptoms include: hyperesthesia (i.e., heightened sensations of pain); audition (i.e., auditory hallucinations frequently perceived as voices); motor disturbances (i.e., changes in voice or the occurrence of physical tremors); nutritional alterations (i.e., temporary shifts in eating habits); and flashbacks (i.e., intrusive images and sensations often related to traumatic remembering). Negative dissociative symptoms are found to be more fixed than transient while positive symptoms appear intermittently and are experienced as highly distressing. Appendix A includes a list of observable signs and symptoms characteristic of dissociative behavior.

#### The Dissociative Continuum

Although there has been some debate as to whether dissociation exists as a typology or as a continuum that spans normal versus pathological dissociation, most theorists support the latter. According to Shirar (1996), "dissociation is not good or bad per se [but] it is something that can be adaptive and helpful--or just the opposite" (Shirar, p. 3 - 4). The continuum of dissociation (see Appendix B) includes nine levels of dissociative behavior that fall within three larger categories entitled Normal Dissociation, Disorders with Dissociative Symptoms, and Dissociative Disorders.

#### Normal Dissociation: Mild Levels of Dissociation

Fantasy, daydreaming, automatic behaviors, and highway hypnosis. Take a moment to imagine the following: You are driving along a familiar highway route and suddenly realize that you have missed your desired exit; as you sit in a long and somewhat tedious business meeting, you find yourself staring out the window and

daydreaming; in the midst of reading a captivating novel, you look up at the clock and realize that you have lost track of time. All of these scenarios represent examples of normal dissociation and chances are you can recall moments when such incidences occurred.

Theorists (e.g., Butler, 2004; Dell, 2006; Nijenhuis, 2004; Putnam, 1997; Scaer, 2005) have stated that “one of the everyday benefits of normal dissociation is the capacity of the mind to divide attention into two or more streams of consciousness [thus allowing] an individual to perform more than one mental task at a time” (Putnam, p. 68). Although individuals of all ages engage in some form of dissociation, children and adolescents are especially adept for they possess a natural capacity to fully immerse themselves in moments of play, fantasy, and imagination. For example, younger children are able to bring inanimate objects, such as teddy bears and toys to life while adolescents are able to immerse themselves in videogames for hours at a time or entertain elaborate fantasies of glamour, stardom, and fame. This form of dissociation is a normal part of child development and typically peaks by the age of ten before steadily declining into adulthood (e.g., Butler; Howell, 2005; Kisiel & Lyons, 2001; Steinberg & Schnall, 2001).

Denial. From this point forward, dissociation acts as a defense mechanism and serves a self-protective function. Existing within the range of normal dissociative behavior, denial is commonly used to momentarily escape an emotionally or physically uncomfortable experience. These experiences can involve the avoidance of having done something wrong or being in disbelief that an event, such as winning the lottery or receiving news of a terminal illness, has occurred. Although denial provides temporary

relief from situations of mild shock or anxiety; individuals are conscious of the events that took place and do not lose touch with reality.

#### Disorders with Dissociative Symptoms: Moderate Levels of Dissociation

Repression. Commonly occurring in disorders such as posttraumatic stress, depression, and anxiety, repression involves the pressing down of unwanted thoughts, feelings, and experiences for the purpose of removing painful stimuli from memory. Unlike denial, repression occurs in the absence of a person's conscious awareness and involves the actual forgetting of distressing information. Repressed material is state dependent and as a result, typically reappears in conscious memory when triggered by reminders of the unwanted events or manifests itself in forms of unknown physical ailments or psychological symptoms.

Derealization and depersonalization. At this point in the continuum, dissociation begins to involve entire aspects of a person's life since perceptions of reality are significantly confused or altered. Derealization refers to a change in the perception of one's external world where objects in the environment appear to shrink or expand. Sights, sounds, smells, tastes, and tactile sensations become exaggerated or diminished and create a temporary sense of disconnection from one's surroundings. Depersonalization however, refers to a change in the perception or experience of one's self and is "the third most common psychiatric symptom [with] prevalence rates of up to 70%" (Putnam, 1997, p. 99). Depersonalization is often described as being robot-like, feeling in a dazed or dream-like state, or experiencing a sense of detachment from one's body.

Symptoms of derealization and depersonalization often co-exist and although distressing, do not impair an individual's basic cognitive functioning. In milder forms,

depersonalization and derealization occur during moments of initial awakening, sleep deprivation, or lack of proper food and nutrition while moderate levels emerge in eating disorders, drug use, panic attacks, and depression. Elevated and more persistent levels of depersonalization are primarily the result of trauma and are classified in the later section of dissociative disorders.

Traumatic reenactment, psychic numbing, hyperarousal, and flashbacks. These forms of dissociation are primarily linked to traumatic experiences and are typically triggered by reminders of a trauma resulting in an overwhelming sense of disorientation, helplessness, and fear. During these moments, individuals enter an altered state of consciousness and experience events from the past as if they were vividly happening in the present. Although these forms of dissociation are hallmark symptoms of posttraumatic stress, they can also appear independently in disorders of acute panic attacks, depression, and anxiety.

#### Dissociative Disorders: High Levels of Dissociation

From this point along the continuum, dissociation is considered pathological in that perceptions to memory and self-identity are considerably altered. Typically, dissociative disorders begin as a much needed defense mechanism that develops in response to trauma but remains highly persistent long after the need for psychological protection has ended (e.g., DePrince & Freyd, 2004; Kisiel & Lyons, 2001; Thomas, 2005; van den Bosch, Verheul, Langeland, & van dem Brink, 2002). Classified in the DSM-IV-TR, dissociative disorders are not the result of any organically created medical condition (e.g., dementia, Alzheimer's disease). Cumulative estimates of the prevalence of dissociative disorders range from 3.1% to 15 % of the general North American

population and 4.3% to 35.7% of clinical populations (e.g., Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Hunter, 2004; Nijenhuis, 2004; Putnam, 1997; Scaer, 2005).

**Dissociative Amnesia Disorder.** Dissociative amnesia refers to an acute yet time-limited disorder characterized by a person's inability to recall important aspects of his or her life. The five forms of dissociative amnesia are: localized (i.e., a failure to recall events that occurred during a closed time period, such as time served in a war); selective (i.e., inability to remember information from a specific aspect of life, such as a motor vehicle accident); generalized (i.e., loss of all memory); continuous (i.e., ongoing failure to encode and remember events as they occur); and systematized (i.e., memory loss related to specific classifications of information, such as being unable to remember all of one's family members).

**Dissociative Fugue.** Dissociative fugue is characterized by a sudden and unexpected traveling away from one's usual place of work or residence and being unable to recall some or all aspects of one's life. Similar to dissociative amnesia, fugue states emerge following a traumatic event and have been particularly associated with traumatic losses, such as the sudden or tragic death of a loved one. During fugue states, individuals are often confused about their identity and typically assume a new identity that may, or may not, retain some elements of their life prior to dissociation. Secondary identities are frequently "at odds with the primary identity, supporting dynamic interpretations that fugues [serve as a barrier to trauma and are] a psychological defense against overwhelming experiences" (Putnam, 1997, p. 99).

**Depersonalization Disorder.** Depersonalization disorder exists in 2.4% of the general population and is especially linked to childhood abuse (e.g., Baker, Hunter, Lawrence, Medford, Patel, Senior, Sierra, Lambert, Phillips, & David, 2003; Simeon &

Knutelska, 2005; Simeon, 2004; Steinberg et al., 2001). Depersonalization disorder refers to chronic and severe alterations in one's perception or experience of self and is extremely distressing as individuals "deeply question the meaning of being alive when they do not feel alive or real" (Simeon, p. 345). Although depersonalization is a highly persistent disorder, approximately one third of individuals with this diagnosis have episodic incidences where a series of depersonalized episodes occur intermittently over an extended a period of time.

Dissociative Disorder Not Otherwise Specified (DDNOS). DDNOS refers to a category of dissociative disorders that involves symptoms of dissociation that do not fit the specific criteria of other diagnostic classifications. Three common forms of DDNOS include: (a) dissociative symptoms that resemble dissociative identity disorder but lack the presence of distinct and separate personality states; (b) severe forms of derealization but without depersonalization; and (c) severe and prolonged states of dissociation specifically related to extensive torture, interrogation, or indoctrination.

Dissociative Identity Disorder (DID). DID, formally referred to as Multiple Personality Disorder, refers to the presence of two or more distinct identities that recurrently take control of the person's thoughts and behaviors. Each personality state, or alter, possesses its own consistent pattern of viewing, relating to, and thinking about the self and the world. For individuals diagnosed with DID, both memory and identity are significantly affected yet "unlike the previous disorders, dissociation at this level is more highly organized" (Shirar, 1996, p. 9). It is estimated that the prevalence of DID in the general population is between 1% to 3%, 2% to 6% in clinical populations, and that 85% to 100% of individuals diagnosed with DID have a history of severe childhood sexual abuse (e.g., Brenner, 1999; Dell, 2006; Foote et al., 2006; Haddock, 2001;

Leonard et al., 2005; Sar, 2006; Sar, Akyuz, & Dogan, 2007; Schwartz, 2000). Although an extensive body of research exists on this topic, the intent of this study is to focus on the general nature of dissociation and as a result, will not include an in-depth review of the literature on DID.

### Conclusion

“The significant advances made over the last decade in understanding dissociation result primarily from our increased ability to define and measure dissociative behaviors and symptoms” (Putnam, 1997, p. 59). The dissociative continuum, DSM-IV-TR criteria, and diagnostic assessment tools (e.g., Dissociative Experiences Scale, Child Dissociative Checklist, and Multidimensional Inventory for Dissociation 6.0) have been instrumental in assisting both researchers and practitioners in recognizing and identifying a wide range of dissociative behavior. Despite these advancements however, researchers (e.g., Castillo, 2003; Leonard, Brann, & Tiller, 2005; Simeon, 2004; Sutton, 2004) have estimated that proper diagnoses of dissociative disorders take an average of six to seven years and that during this time, 57% of individuals are inappropriately medicated and treated for other disorders that include episodes of mania, psychosis, and schizophrenia. Further research is therefore warranted in order to improve the ethical care and treatment of dissociation.

### Cultural Variations of Dissociative Behavior

While the developmental model of dissociation captures a view of pathology that exists within westernized cultures, it is important to note that the dissociative continuum is not a perspective held universally around the world. In many countries, different forms of meditation, healing rituals, and ceremonial cleansings evoke varying levels of dissociative behavior where altered states of consciousness are a welcomed, if not

celebrated, experience (e.g., Becker-Blease, 2004; Butler, 2004; Castillo, 2003; Davediuk Gingrich, 2005; Haddock, 2001; Rosik, 2004; Luhrmann, 2004; Somer, 2004). Given this diagnostic diversity, how are DSM-IV-TR dissociative disorders perceived in other parts of the world?

A study by van Duijl, Cardena, & DeJong (2005) compared the North American DSM-IV-TR dissociative categories with the local concepts and experiences of similar symptoms in southwestern Uganda. Two focus groups comprising of 48 individuals were held in accordance to the Ugandan traditions and included a variety of religious leaders, traditional healers, counsellors, and community members. A thematic content analysis revealed four distinct forms of dissociation.

1. Okukangarana: “A 14-year old girl was abducted and tortured by rebels. She had to carry heavy loads. She could not remember part of what she had gone through . . . her mind disappeared during fear” (Duijl et al., 2005, p. 228). Okukangarana was identified by the participants as an experience of shock that occurs in such a way that a person is unable to remember what had happened and was closely matched to the westernized version of dissociative amnesia. Similar to the DSM-IV-TR category, the cause of okukangarana was attributed to trauma and warranted the support of traditional healers and counsellors to help individuals recover from the experience.

2. Okusharara and eibugane:

Something is running down the back, pushing on the head, the blood is being pulled out of the body. Something keeps the mouth closed so that one cannot talk . . . your mind is away and you don't hear what is going on . . . something steals your mind. (p. 230)

Both okusharara and eibugane were described as afflictions resulting from forces that

cause unusual behavior and draw blood from parts of the body that result in the person being unable to feel that his or her body is there. These experiences were closely associated with the DSM-IV-TR diagnosis of depersonalization and were identified as being the result of a deep shock that occurs through the loss of a loved one or important pieces of land or property. Counsellors and traditional healers were frequently summoned to help those with these afflictions.

### 3. Emizimu and emandwa:

A man in Entebbe left his family for 4 years and was not aware he had a family.

After praying for about an hour, he started asking what was going on. He packed his things and went back to his family. (p. 229)

Emizimu and emandwa closely matched the DSM-IV-TR diagnosis of dissociative fugue and was described as a person traveling to a different place without knowing where he or she had come from. Unlike westernized interpretations however, emizimu and emandwa were not caused by traumatic events and instead, were the result of people being called away by the spirits. To have an experience of emizimu or emandwa was considered an honor.

4. Okutembwa: “There was a lady, two times a week she would talk with a small voice. It was another person: I am so and so, I’m your mother, bring my grandchildren” (van Duijl et al., 2005, p. 231). Okutembwa was strikingly similar to the DSM-IV-TR diagnosis of DID and was described by the participants as a person’s ability to spontaneously speak in another voice and change one’s self as if he or she was another person. Unlike the western view however, okutembwa was believed to be caused by a possession or attack of evil spirits. Individuals with such abilities were

considered bewitched and required the specialized knowledge and skill of religious leaders to make the evil spirits go away.

### Conclusion

Researchers (e.g., Castillo, 2003; Corrigan, 2002; Luhrmann, 2004; Rosik, 2004; Sar, 2006; Somer, 2004; Uchinuma & Sekine, 2000; Waelde, 2004; Xiao, Yan, Wang, Zou, Xu, Chen, Zhang, Ross, & Keyes, 2006) have identified several forms of dissociative behavior in various countries around the world and found that trance-induced sensations played a key role in 89% of the world's ceremonial activities. Different cultures have different interpretations of what dissociation is.

According to Sar (2006), dissociative disorders are "culture bound syndromes; somewhat paradoxically, either as a merely North American disorder or a premodern phenomenon seen in exotic cultures, primitive societies, or mystic-religious communities" (Sar, 2006, p. 227). Butler (2004) further identified the need for dissociative disorders to be divided into the content and context of dissociation and emphasized the importance of incorporating a cultural component into the mental health diagnoses. As stated by Hilgard, "daily life is full of many small dissociations if we look for them" (cited in Butler, p. 1). It is therefore essential that both researchers and practitioners acknowledge the powerful role culture plays in identifying, diagnosing, and treating dissociation and understand its influence in shaping what constitutes normal versus pathological behavior.

### The Neurobiology of Dissociation

Dissociation was originally introduced by Janet as a disorder that involved both the psyche and soma however, many theorists (e.g., Baker et al., 2003; DePrince & Freyd, 2004; Putnam, 1997; Simeon, 2004) have focused primarily on dissociation as an

experience of the mind. Consequently, its physiological basis has been largely ignored. Recent studies (e.g., Bob, 2003; Lanius, Bluhm, Lanius, & Pain, 2006; Lanius, Williamson, Boksman, Densmore, Gupta, Neufeld, Gati, and Menon, 2002; Lanius, Hopper, & Menon, 2003; Nijenhuis, 2004; Nijenhuis, van der Hart, Kruger, & Steele, 2004; Phillips & Sierra, 2003; Porges, 2004a; Porges, 2004b; Scaer, 2007) have begun investigating the neurobiology of dissociation and thus far, three specific areas have been identified.

Physiological alterations. In contrast to the experience of PTSD where physiological arousal is elevated during reminders of a traumatic event, studies on dissociation have suggested the opposite. Koopman, Carrion, Butler, Sudhakar, Palmer, and Steiner (2004) examined the relationship between high levels of dissociation and heart rate in 25 women and 16 men with a history of childhood sexual abuse. All of the participants were recruited through flyers posted at local counselling centres across the United States and were screened for levels of dissociation through the use of the DES (Bernstein & Putnam, 1986). Individual interviews were conducted and each participant was asked to verbally recall a traumatic childhood event while being monitored for physiological changes. An analysis of variance revealed that during high levels of dissociation, heart rate and skin conductance were significantly lowered and that these levels were particularly evident during moments of derealization and DID identity alterations. The researchers concluded that severe forms of dissociation served a self-protective function and as a result, created a physiological state that prevented individuals from being physiologically overwhelmed by traumatic stimuli.

Another study by Williams, Haines, and Sale (2003) examined the physiological and psychological effects of dissociation in a 25-year-old woman diagnosed with DID.

During a four-stage personalized guided imagery, researchers monitored her heart rate and blood pressure while at the same time, obtaining subjective reports of her psychological response to the traumatic imagery. Results revealed a significant reduction in both physiological and psychological arousal and this pattern of responding was particularly evident as the guided images became more distressing. During these times, levels of dissociation were high. Subjective reports however, were characterized by remarkably low levels of personal fear and anxiety and included statements of feeling calm, detached, and less afraid. According to the researchers, dissociation was linked “with a range of psychological responses that were not negative for the individual [and instead] provided her with a sense of being in charge of the situation” (Williams et al., p. 113). Implications for practice included recognizing the positive aspects of dissociation and carefully monitoring any attempts to therapeutically dismantle this highly valuable and much needed form of protection.

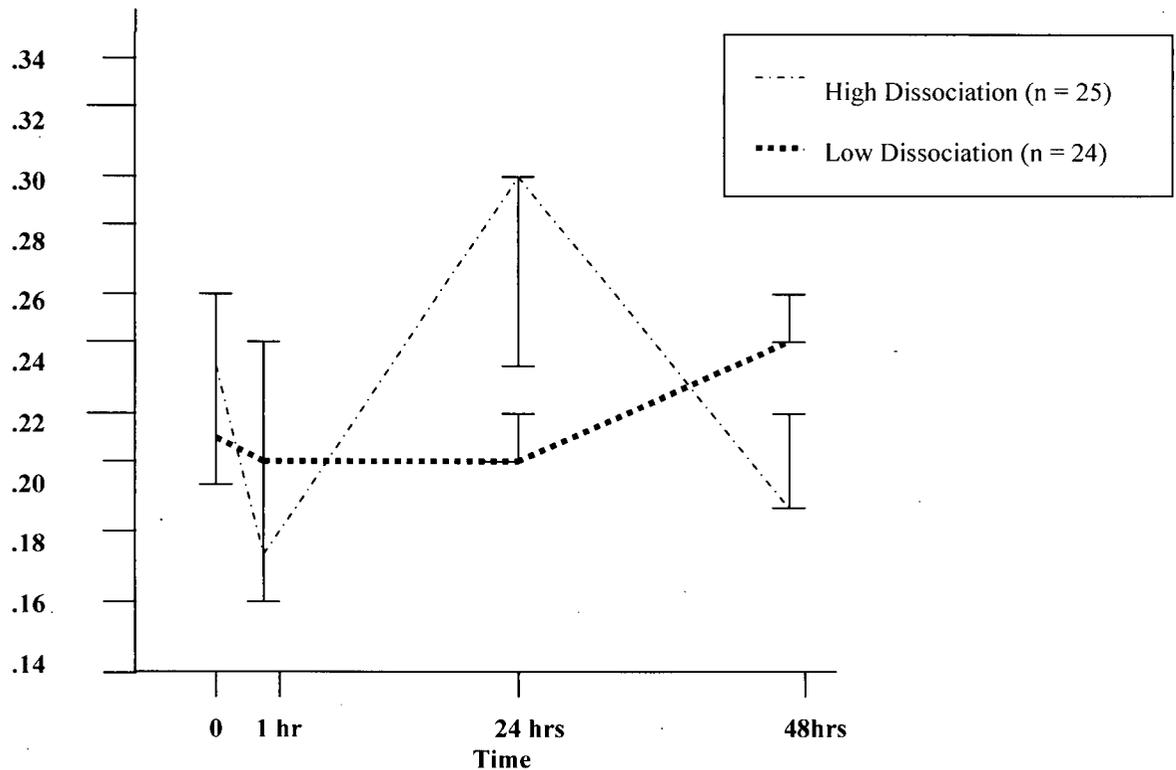
Noradrenergic dysregulation. Simeon, Guralnik, Knutelska, Yehuda, and Schmeidler (2003) compared plasma norepinephrine levels in nine individuals who had been diagnosed with depersonalisation disorder with nine demographically matched individuals who demonstrated minimal to low levels of dissociative behavior. Participants, recruited through referrals from psychiatrists and mental health workers across the United States, were regularly monitored over a 48 hour period and assessed for changes in dissociation and norepinephrine. Studies have identified that norepinephrine plays a critical role in eliciting feelings of hyperarousal, panic, and fear. Given that dissociation is characterized by a numbing of affect, it was hypothesized that norepinephrine levels would significantly decrease during dissociative episodes. The results of this study supported this hypothesis and noted a “very strong association

between increasing dissociative severity and declining levels of norepinephrine” (Simeon et al., p. 96). The researchers concluded that autonomic responses to traumatic stimuli resulted in lower norepinephrine, which in turn, created the blunting, or shutting-down, of sensations experienced by those who dissociate.

A study by Koopman, Sephton, Abercrombie, Classen, Butler, Gore-Fenton, Borggrefe, and Spiegel (2003) measured changes in cortisol levels, a hormone released during times of extreme stress, in 49 women with severe levels of dissociation. Participants were asked to engage in a single one hour interview to discuss a traumatic childhood event as changes in cortisol levels were measured one hour, 24 hours, and 48 hours after the interview. The results revealed that although cortisol levels decreased during the interview, they significantly increased 24 hours later and then returned to near baseline levels within a 48 hour period (see Figure 2.1).

The researchers concluded that although dissociation dampened an individual’s physiological response to a stressful situation, its protective function was limited and this was significantly demonstrated in the surge to above average cortisol levels in the 24 hour period following the emotionally distressing event. “A highly dissociating individual may appear to be functioning quite well immediately following a stressful event, but may need assistance to cope in the aftermath of the trauma, when dissociative defences are unable to adequately quell the stress reaction to traumatic memories” (Koopman et al., 2003, p. 41). Implications for practice therefore included carefully monitoring the discussion of traumatic material and recognizing the potential need for therapeutic support in the 24 hour period following an intensely emotional therapeutic session.

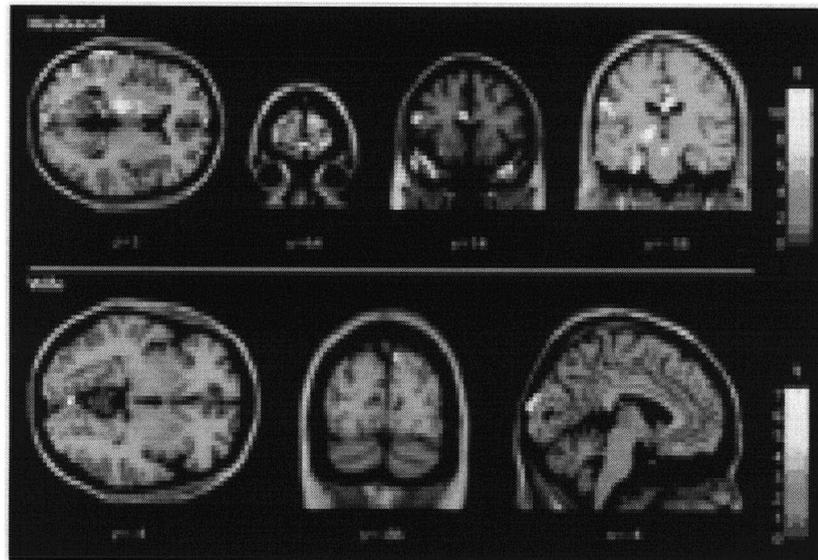
Figure 2.1 Changes in cortisol levels measured from trauma interviews one hour, 24 hours, and 48 hours later in women diagnosed with low versus high dissociative symptoms ( $p = .05$ ).



Neuroanatomical activation. A study by Lanius, Hopper, and Menon (2003) compared the neuronal circuitry associated with dissociative behavior in a husband and wife who were involved in a motor vehicle accident, in which the husband was able to free himself from the wreckage while the wife, unable to move, was left physically trapped in the vehicle. In an interview three months after the accident, the husband described the actions he took to free himself and the attempts he made to rescue his wife in a manner that the researchers described as displaying an appropriate amount of emotion given the traumatic nature of his experience. The wife however, who reported high levels of dissociation, described the accident in a flat and detached manner and

identified feelings of being numb and disconnected from the entire experience. As the husband and wife independently recounted details of the accident, fMRI scans monitored neural activation and the results revealed two distinctly different patterns of activity (see Figure 2.2).

Figure 2.2. FMRI scans of a husband and wife who were in a motor vehicle accident.



The husband displayed high activation in the anterior frontal, thalamic, and amygdala regions of the brain. These results were consistent with findings in studies of PTSD and revealed elevated emotional arousal and cognitive activity that possibly accounted for his ability to process the traumatic incident at a comparatively faster rate. The wife however, displayed only slight activation in the occipital region. The researchers concluded that this lack of neuronal activity offered possible explanations for the woman's subjective reports of emotional and psychological numbness and likely contributed to her difficulty in cognitively and emotionally processing the trauma.

Studies by Porges (2004a, 2004b) explored the neurobiological factors involved in a child's ability to experience safety and comfort and the shifts that occurred when

confronted with a highly fearful and traumatic event. Physiological changes included a slowing of heart rate, shallowness in breathing, a significant drop in blood pressure, and a dysregulation to the spinal motor pathways. During moments of intense fear, changes were noted in the corticobulbar (i.e., cranial nerves that regulate the muscles of the face and head) and corticospinal pathways (i.e., spinal nerves that regulate the muscles that control the trunk and limbs) and were directly linked to the child's inability to control the muscles needed to maintain eye contact, engage in voice inflection, and differentiate the sound of human voice from background noise. These findings offered possible explanations for a child's observed disconnection from the environment during moments of dissociation. Implications for practice included acknowledging the degree to which dissociation suppresses an individual's ability to interact with his or her environment and recognizing that visual, auditory, and tactile engagement with others may be physiologically limited.

### Conclusion

Although there have been significant advances made towards understanding the neurobiological factors involved in dissociative behavior, there is still "relatively little known about its biological correlates . . . particularly when occurring in the absence of PTSD" (Simeon et al., 2003, p. 93). Although PTSD and dissociation share many trauma-related similarities, it is important to recognize that they are two distinctly separate phenomena and that their underlying physiological basis may in fact be completely different.

### Current Treatment of Dissociation

Current treatment of dissociation has been limited to the administration of psychotropic medication and individual psychotherapy (e.g., Cohen, Mannarino, &

Knudsen, 2005; Everest, 1999; International Study for the Society of Trauma and Dissociation [ISSTD], 2005; U. Lanius, personal communication, April 30, 2007; Middleton, 2005; Fosha, 2004; Fosha, 2006; Ogden, 2006; Simeon, 2004; Thomas, 2005). Although research in this area is still in its infancy, some studies have revealed significant findings.

**Psychopharmacology.** Researchers (e.g., Ginsberg, 2005; Phillips, Hunter, Baker, Medford, Sierra-Siebert, & David, 2003; Philipsen, Schmahl, & Klaus, 2004; Simeon & Knutelska, 2005) have revealed promising findings in the treatment of dissociation through the use of naltrexone, an opioid antagonist found to decrease symptoms of depersonalization. Simeon and Knutelska (2005) examined the effects of naltrexone in 14 individuals (12 men; 2 women) diagnosed with depersonalization disorder by administering increasing doses of naltrexone for a period of 10 weeks to a maximum daily dosage of 250mg. Clinician administered and self-reported scales measured changes in dissociative behavior and the results revealed that “33% of the participants showed a marked improvement with a 50% to 90% reduction in dissociative symptoms” (Simeon & Knutelska, p. 269). Thus far, naltrexone has been the only psychotropic medication found to significantly reduce dissociative behavior. Despite this however, researchers (e.g., Ginsberg; Phillips et al.; Simeon, 2004) have found that psychiatrists and physicians continue to prescribe benzodiazepines, SSRIs, and fluoxetine for dissociative symptoms. Repeated studies of these psychotropic medications have shown very little evidence of treatment efficacy.

**Psychotherapy.** A study by Leonard et al. (2005) examined the experience of treatment for dissociation in 250 practitioners and 55 clients in an effort to gain insight into the subjective experience of treatment for dissociation. Recruitment occurred

through a mail survey distributed to therapists who in turn, distributed these surveys to clients matching the required criteria for dissociative behavior. The results revealed that over the course of their career, 21% of therapists reported having an average of six clients diagnosed with a dissociative disorder, 38% reported having less than six, and 42% reported having no clients with a dissociative diagnosis. Of those practitioners working with dissociative clients, only 21% believed they had the experience to effectively work with this population and commented on the lack of proper resources and training to work in this area.

Results from the client surveys revealed that 67% of clients reported significant delays in being appropriately diagnosed with a dissociative disorder and that 57% were misdiagnosed and consequently, mistreated for schizophrenia. Although clients tried a variety of treatments (e.g., medication, in-depth individual therapy, electroconvulsive therapy, group therapy, EMDR, and alternative practices such as spiritual healing), 90% reported that individual therapy was the most helpful. Sixty percent also identified medication, such as antidepressants, to be useful when used in conjunction with individual therapy.

The researchers of this study concluded that individual psychotherapy conducted in combination with medication resulted in the most effective form of support for individuals who engaged in moderate to high levels of dissociation. These results were based on the subjective reports of clients who dissociate and warranted further research in order to specify the therapeutic factors that were viewed as most beneficial.

#### Conclusion

Research on the treatment of dissociation is seriously lacking and barriers to effective care exist, not only in the lack of research and training, but also in our current

societal perceptions of dissociative behavior (e.g., Chefetz, 2004; Kisiel & Lyons, 2001; Sutton, 2004; Thomas, 2005; van den Bosch, Verheul, Langeland, & Brink, 2003).

Historically, dissociation was believed to be either therapist-induced or due to client malingering and as a result, dissociation was regarded as an invalid disorder that did not deserve the time nor the attention to properly diagnose, treat, or understand its underlying affliction. For some, this belief still exists and recent studies have estimated that approximately 35% to 45% of clinicians in westernized countries continue to question the veracity of dissociative disorders (e.g., Butler, 2004; Leonard et al., 2005; Thomas, 2004).

Theorists (Butler, 2005; Butler & Palesh, 2004; Chefetz; Goldsmith & Satterlee, 2004; Putnam, 1997) have suggested that social biases, misrepresentations in media presentations, and personal fears are the primary reasons for a societal disowning of dissociative behavior. This disowning results in the development of multiple barriers to treatment for individuals who engage in moderate to high levels of dissociation and although significant advancements have been made to remove these barriers, cultural fears and social stigmas continue to persist. Consequently, "one must wonder what it is that the critics fear most. [Dissociation] per se, or what it says about the [fragility of the] human condition" (Putnam, p. 102).

### Summary

In situations of childhood sexual abuse, dissociation arises from a desperate need to cope with severe violations to a child's mind and body and our discomfort with the fact that such violations occur is compounded by the knowledge that the perpetrators of such violations are individuals who exist amongst ourselves as a part of the human race. For individuals who have been sexually abused in childhood, dissociation becomes a

place of refuge--a sanctuary where the threats and dangers of the outside world are unable to enter. For many, it is the only means of survival. As researchers and practitioners, it is essential for dissociation to be recognized and valued as such in order to truly understand and support the reparative journey of those whose lives have been affected by childhood sexual abuse.

With this review of the literature, several key points emerged as the rationale for this study. First, given the high prevalence of childhood sexual abuse and the strong link between dissociation and early sexual trauma, there is an ethical need to educate and train counsellors in the area of dissociation and provide them with the necessary skills and abilities to work with individuals who engage in moderate to high levels of dissociation.

Second, although significant advancements have been made in our understanding of dissociative behavior, a large portion of this understanding has been obtained through the clinical observations of therapists and theorists. As a result, there is a general lack of knowledge regarding the experience of dissociation from the perspective of clients. This insight into the clients' personal experiences of dissociation is critical and would provide a means through which previous studies could be validated.

Third, societal views continue to situate dissociation within a dominant medical paradigm that defines dissociation as a mental disorder and implies a significant departure from normalcy. These views fuel a sense of othering and consequently, serve to further stigmatize and isolate individuals seeking treatment for dissociative behaviors.

Fourth, researchers (e.g., Ginsberg, 2005; ISSTD, 2005; Leonard et al., 2005; Nijenhuis, 2004; Phillips et al., 2003; Scaer, 2005; Simeon, 2004) have agreed that although our knowledge of dissociation has increased, "there continues to be a need to

explore the phenomenology and treatment of other forms of pathological dissociation” (ISSTD, p. 70). Research on a range of moderate to high levels of dissociative behavior is therefore essential.

Finally, dissociation is an experience that is unfortunately misrepresented and sensationalized in popular North American culture. Films, movies, and novels often depict dissociation in its most severe forms and thus, contribute to a cultural fear and misunderstanding surrounding dissociative behavior. With these fears, individuals who engage in moderate to high levels of dissociation are more likely to be stigmatized and isolated, not only from society, but also from therapists whose personal fears lead them to deny or dismiss the experience of dissociation. Consequently, further research in this area is needed.

The purpose of this research is therefore to explore the experience and treatment of dissociation among individuals who have been sexually abused in childhood with the intent of providing therapists a clearer understanding of how they can better support clients who dissociate. Contributions of this study include: (a) providing insight into how clients experience dissociation, (b) offering a deeper understanding of how therapists can best support those who engage in a mid to high range of dissociative behaviors, (c) giving voice to the client’s experience of what positively and negatively influences the therapeutic process of reparation, and (d) de-pathologizing and demystifying the current societal view of what dissociation is.

### CHAPTER THREE METHODOLOGY

We are born into a narrative world, live our lives through narrative and afterwards are described in terms of narrative ~ Michael Murray, 2003

To examine the experience and treatment of dissociation among individuals who have been sexually abused in childhood, a narrative research design was used. Existing within a postmodern framework, narrative inquiry offers insight into an experience by engaging both you as the reader and I as the researcher toward a deeper understanding of the experience of dissociation and the factors that positively and negatively influence the treatment of dissociative behaviors.

According to Kohler-Reissman (1993), stories are an essential part of who we are. We tell stories as a way of inviting people into our inner world and it is through the process of storytelling that we intimately share, exchange, and bear witness to each other's lives. Captured within every story is a wealth of data. Stories provide a window into our personal identities and reveal the social, historical, and political culture in which we live. It is this aspect of story that is particularly relevant to the topic of dissociation for the experience of dissociation exists within a culture of trauma and abuse and is firmly held within a climate that has shaped, and continues to shape, the stories that can be told.

Some experiences are extremely difficult to talk about. Stories embedded within an atmosphere of trauma are particularly difficult to tell for not only do they lack verbal description, but they also lack the much needed acceptance and understanding from society (e.g., Courtois, 1999; Herman, 1992; Waites, 1997). As a society, we tend to dismiss and deny those events that we ourselves cannot bear and in doing so, silence

those experiences that only we as a society can alter. Unfortunately, dissociation is one such experience where the very root of its existence lies within the horrific and often unspeakable acts that occur and when dissociation arises in response to the sexual crimes committed against an innocent child, our collective need to dismiss and deny is even greater.

According to Lieblich, Tuval-Mashiach, and Zilber (1998), narrative inquiry offers a forum through which stories of sorrow and pain can be told. Narrative inquiry brings order to disorder, gives meaning to the meaningless, and allows for a new creation of reality that challenges the cultural restraints that prevent stories from being told in the first place (Kohler-Reissman, 1993; Murray, 2003). Through a narrative methodology, the stories and experiences of those who use dissociation to cope with a history of sexual abuse can finally be heard.

This chapter is divided into five sections. First, I discuss the methodology I have chosen and introduce the concept of narrative inquiry as a research design. Second, I offer my personal biases and assumptions as the researcher. I discuss my thoughts on how narrative inquiry corresponds with my own epistemological beliefs and in doing so, create an argument as to why this approach is most appropriate. Third, I discuss my research procedure. I introduce my participants and provide a brief summary of the participants' history of abuse (e.g., age of onset and number of perpetrators). I further describe how data was collected, analyzed, and represented within the text of this study and also identify criteria of rigor and worth. Fourth, I discuss issues of representation. I identify the voices heard and the voices missing in this study and bring attention to the inherent limitations that exist within these representations. Finally, I conclude this

chapter by briefly highlighting the significance of my research and outline the contributions I make to the field of counselling psychology.

What is Narrative Research?

Arising in response to a post positivistic paradigm, narrative research has become increasingly popular in the past twenty years. Classical texts, such as those written by Theodore Sarbin (1986), Donald Polkinghorne (1988), Jerome Bruner (1990), and Elliot Mishler (1991) mark a societal turn towards narrative research by stating that stories are essential to the human experience for they provide a shared forum for making sense of the world. Particularly in the area of social sciences, narrative inquiry has added to our understanding of individual lives. Through story, we provide a link between ourselves and others and reveal aspects of our identities, our histories, and our worlds (Lieblich et al., 1998). Narratives are essential to our self-definition and it is through the stories that we selectively tell that we engage in a process of co-constructing ourselves and the narrative identity of who we are (Murray, 2003).

Defined as research that uses or analyzes material to represent an organized interpretation of events, narrative inquiry brings order to a succession of happenings, infers causal links to the things that occur, and offers meaning to help us understand our ever-changing world. The material obtained through narrative inquiry varies. Material can range from literary works to personal letters, orated life histories to informal conversations, and physical artifacts that can take the form of artwork, sculpture, and film (Lieblich et al., 1998).

Narrative research challenges the post positivistic views of knowledge and knowing by advocating pluralism, relativism, and subjectivity. A narrative methodology breaks the traditional barrier that categorically separates the psychological from the

social and creates a more holistic psycho-socio-cultural view of the world (Murray, 2003). Through the narrative turn that occurred in the mid-1980's, researchers are now able to stand upon a process of analysis and interpretation that is neither fixed nor terminal and instead, experience the process of knowing as being forever emerging, unpredictable, and unfinished (Lieblich et al., 1998).

#### Researcher's Subjectivity

Narrative inquiry exists within a postmodern paradigm and it is within this paradigm that I situated myself as the researcher. As the sole researcher and writer of this study, my epistemological beliefs were inherently woven throughout this text and as a result, several of my core assumptions are worth noting. First, it is my belief that there is no single truth but instead multiple truths that are contextually and relationally defined. Within this assumption, meaning is co-constructed--between the researcher and the participant as well as the reader and writer--and differ depending upon each person's own unique history and experience. Based upon my assumption of multiple realities, the meanings assigned to this study differ as each story is filtered through my subjective lens of knowledge and knowing. What I bring to this study is therefore different from what you bring to this study even if we were simultaneously experiencing the same events at the exact same time. In narrative research, differences are expected to exist. Different perspectives and experiences however, do not reduce validity nor does it indicate that one representation is more valid than another (Clandinin & Connelly, 2000).

Consequently, the meanings constructed from this research represent a truth as identified by those involved in its co-creation even though these personal truths may shift or change over time. Each participant contributes to an understanding of the

experience and treatment of dissociation by sharing his or her own personal narrative. In situations of childhood sexual abuse where events occur in a shroud of shame, secrecy, and silence, a narrative form of inquiry is most appropriate for it honors the unique truth of each person's experience and evokes a power that occurs when stories are told and the silence is broken.

Second, it is my belief that knowledge is an on-going process of exploration that involves a co-constructed experience shared amongst the reader, the writer, and the teller of a story. Unlike knowledge obtained in quantitative research where a stated hypothesis is carefully examined, tested, and either confirmed or denied, narrative inquiry is analogous to traveling on a mysterious journey that takes a person into the inner workings of one's self and one's world (Denzin, 1989). As a reader of this study, you will not be a passive traveler on this journey. Each narrative will evoke within you thoughts, feelings, and sensations that bring you face to face with your own moment-to-moment responses to the stories being told. Through this process, a new story is created and with each creation, a cultural shift begins to occur. A narrative form of inquiry therefore allows both you as the reader and I as the writer to become intimately aware of our own personal biases and assumptions and as a result, assists us in eliminating some of the barriers that restrict us from fully entering the world of those who dissociate.

Third, stories are purposeful (Clandinin & Connelly, 2000; Murray, 2003). The words I write are written in a particular style with the hopes of communicating to you my personal thoughts, feelings, and experiences. Similarly, the narratives told by each participant were told in a particular manner and spoken with a sense of purpose. According to Murray, each teller of a story is empowered for he or she dictates which stories are told and the language in which they are communicated. For individuals

whose violations involved a loss of personal voice and power, this sense of empowerment is critical.

Fourth, it is my belief that there is no 1-1 correspondence between words and their meaning (Manning & Cullum-Swan, 1998; Murray, 2003). As I write this text, I string together a series of symbols made up of letters, spaces, and punctuation and present them to you in the form of a sentence. Congruent with my assumption of multiple realities, I believe that you as the reader will assign your own meaning to these symbols based upon your own unique history and experience. Personal meaning is attached to each story and it is through this personal connection to each participant's narrative that the greatest changes can occur.

Fifth, we are all born into cultural tales (M. Buchanan, personal communication, April 2005). Stories are situated within a cultural discourse that dictates what can be told, to whom, and under what circumstances. This assumption is particularly relevant to the topic of dissociation for many who use dissociation to cope with a history of trauma and abuse exist behind a cloak of secrecy and silence that limits what stories can be told. Through narrative inquiry, I acknowledge the cultural tales that exist within each participant's story and recognize the inherent power society has in giving voice to, and silencing, a person's experience.

Finally, stories live us (Wittgenstein as cited by M. Buchanan, personal communication, April 2005). As you read these words, my thoughts as a person and researcher come to life. My ideas live through you as you discuss, challenge, contemplate, or simply consider the things that I say. Similarly, as you read each narrative, you breathe life into each participant's story for his or her experience will live within you and become integrated into a part of your own personal knowledge and

experience. As the life of each participant's story grows, a movement is created that challenges some of the misunderstandings and misconceptions surrounding dissociation. Through narrative inquiry, each teller, writer, and reader of a story possesses the power to make a difference.

#### Research Procedures

**Participants.** This research study includes the stories and narratives of seven participants who (a) experienced sexual abuse in childhood, (b) engaged in some form of therapeutic intervention, such as talk therapy, therapeutic enactment, EMDR, and/or art therapy, and (c) demonstrated a mid to high range of dissociative behavior (i.e., scores equal to or greater than 30) as measured by the Dissociative Experiences Scale II ([DES-II], Bernstein-Carlson & Putnam, 1993). Reliability of the DES II includes a Cronbach's alpha value of 0.95 and split half reliabilities of 0.83 and 0.93. The DES-II shows good construct and convergent validity and shows a sensitivity and specificity rate of 74% and 80% respectively. Recruitment involved the posting of flyers (see Appendix C) at local counselling offices outlining the purpose of this research and asking potential participants to contact the researcher if they were interested in participating in this study.

The participants (one male; six females) ranged from 34 to 53 years of age. Three of the participants were abused by at least one family member, two by non-family members, and two others by both family members as well as trusted individuals from their community. The abuse began when the participants were between the ages of three and nine and continued for 3 to 16 years. Two of the participants were abused by a single perpetrator, one by two perpetrators, and four by three or more perpetrators. At

the time of the interviews, five had no contact with their abusers while two maintained minimal contact.

Involvement in the study was completely voluntary and informed consent (see Appendix D) was obtained. Given that this research sought to understand a coping mechanism that developed in response to trauma, each participant was also informed that participation in the study could result in the emergence of unexpected emotions that may require additional debriefing. A list of qualified therapists knowledgeable in the area of trauma and abuse was therefore available for participants to access in the event that they needed to discuss any emotions that unexpectedly emerged from this study.

Data collection. According to Briere (2002) and van der Kolk (1996), dissociation is a multifaceted experience that includes aspects of verbal as well as non-verbal thoughts, feelings, and sensations. In order to adequately capture the complexity of this experience, data was collected from four sources. First, data was obtained through personal interviews. Each participant engaged in a single two to three hour interview designed to facilitate dialogue around each person's experience of dissociation and the factors that he or she found to positively or negatively influence the process of reparation. Interviews were semi-structured and included open-ended questions (see Appendix E) such as "What is your experience of dissociation?" "How was dissociation addressed in therapy?" "What did you find helpful?" And "What did you find not helpful or even harmful?" These interviews offered a verbal account of each participant's experience and highlighted the conscious thoughts, feelings, and insights each individual had.

Second, given the non-verbal nature of dissociation, participants were invited during the course of the interview to creatively express their story through art. Although

verbal interviews provide a rich source of data, much information is lost when interviews are only conducted through the use of verbal dialogue (Harrison, 2002). In order to provide a forum through which participants could share those thoughts, feelings, and experiences that words simply cannot describe, art materials (e.g., paint, clay, pastels, and collage material) were available and another layer of understanding into the experience and treatment of dissociation was obtained.

Third, for the reasons stated above, data was also gathered from physical artifacts such as dreams, journal entries, and drawings that were previously created by the participants during their process of therapy. As stated by Harrison (2002), research tends to privilege the written word over visual stimuli and as a result, neglect those critical pieces of information that can only be encountered through the experience of sensing and seeing. In this study, each artifact speaks for itself. The sensory information each artifact holds provides unique insight into how individuals experience dissociation and the manner in which dissociation was addressed during their process of reparation.

Finally, data was collected through my own observations as the researcher. As the researcher, I bring to this study my own subjective experiences as I traveled with each individual on a parallel journey towards a deeper awareness into the experience and treatment of dissociation. This experience was further facilitated by my professional background as a counsellor working in the field of trauma and abuse. My skills in this area provided me with the necessary insight to conduct research on this topic and greatly contributed to the trust and safety that was established in the interviews. My observations as the researcher included the gestures, expressions, and behaviors of each participant as well as my own reflexive thoughts and experiences that developed from hearing their stories. This source of data was recorded in a personal research journal and

offered yet another perspective into this complex and multifaceted experience of dissociation.

With written permission, all interviews were audio taped and transcribed and any physical artifacts, such as journal entries and artwork were photographed. As the researcher, I obtained ethical consent through the ethics review committee at the University of British Columbia (see Appendix F) and consent forms signed by the participants included information advising them of their right to withdraw from the study at any time. All information was kept confidential through the use of pseudonyms and will remain locked in a secured filing cabinet until the information is destroyed five years after the completion of my dissertation defense.

Data analysis. Data were analyzed according to a holistic-content approach identified by Lieblich et al. (1998). Within this approach, I read each participant's story for its content in a holistic manner and moved through the following steps:

1. Data were read until patterns, typically recognized as the foci of the story, began to emerge. At this stage, it was important for me to trust my own ability to detect the meaning behind each story for according to Lieblich et al., stories speak to us with a sense of power and emotion and communicate a depth of knowledge that can otherwise be left unheard.
2. I documented my initial and global impressions, noted any exceptions, and was aware of unusual or contradictory features to the stories. As stated by Lieblich et al., issues that produce disharmony are equally as important as those that appear consistent. Both sources of data were noted and recorded.
3. I decided upon the various themes that appeared in the context of each story. These themes were identified by the space dedicated to a certain issue, its

repetitive nature, and the amount of detail each teller provided. As stated above, omissions and brief comments about a particular subject were also considered significant and required further discussion with each participant.

4. Colored markers were used to mark the various themes that emerged as each story was read separately and repeatedly over a period of time.
5. Finally, the results of this study were documented according to the themes that emerged both within and across narratives. Each theme was carefully identified and recorded in my research journal.

In addition to a holistic-content approach, a critical reading of the study occurred through my own reflexive voice as the researcher. As the researcher, I critically examined my influence on this study and brought attention to the dominant discourse that currently surrounds dissociation and childhood sexual abuse. Through a careful look at the inherent differences that exist on a relational, societal, and cultural level, I added to this study a critical reading that arose as I looked reflexively at my self in this process of research.

Representation of the research text. According to Josselson (1995) and Kohler-Reissman (1993), it is difficult to truly capture an experience through a single voice or perspective for it fails to embrace the complex and intricate nature of what has occurred. A greater and deeper understanding is therefore obtained when “a kaleidoscope of contrasting or complementary perspectives is provided” (Atkinson, 1992, p. 24). This research therefore consists of an orchestra of voices--three voices that come together to provide a more holistic sense of the experience and treatment of dissociation in those who have been sexually abused in childhood.

First, data transcribed from each interview is represented as voices with various fonts used to express voice tones, such as **loudness**, softness, and/or ~ silences ~.

Lieblich et al. (1998) state that no story speaks from a single voice and that every narrative has a unique melody and pitch that communicates a wealth of information. This visual representation of voices offers a more complete sense of each participant's experience and thus a deeper understanding into their inner world is revealed.

The second voice that appears in this study is that of knowledgeable researchers in the area of trauma and abuse. This voice is used to highlight portions of each participant's story in order to provide an informative explanation that is based in the current literature. This voice of the researchers or theorists appear in The Shared Story and Discussion chapters and offer an additional perspective of the participants' experiences.

The final voice that appears in the text of this study is my voice of the researcher-observer. With this voice, I offer my personal thoughts and reflections as the stories and narratives of each participant unfold. My voice, appearing in the chapter entitled The Researcher's Voice, brings transparency to my thoughts and feelings as the researcher and includes excerpts from my own research journal as well as personal artwork and writing. My voice as the researcher-observer therefore provides yet another layer of insight into the complex and multifaceted experience of dissociation.

Through this orchestra of voices that intertwines and weaves together, a narrative of our inner experiences is created. Individually, each voice allows a unique perspective to be heard. Together, they combine to form a more complete understanding of the experience and treatment of dissociation in those sexually abused in childhood.

Criteria of worth and rigor. In order to evaluate this research, three criteria were used: coherence (i.e., Does my research convey a sense of clarity? Is it easy to read? Does it make sense?); (b) resonance (i.e., Are you as the reader able to emotionally relate to this research? Are you provided with a vicarious experience?); and (c) verisimilitude (i.e., Does the research reflect the personal truth of each participant's experience?).

To meet these criteria, this study was piloted with one individual who met the three conditions (i.e., experienced sexual abuse in childhood; demonstrated a mid to high range of dissociation as measured by the DES-II; and engaged in some form of therapeutic intervention) required for participation in this study. The data collected and the analysis provided were also member checked through a process of having each participant read, validate, and affirm that the above stated criteria have been met. This study was also peer reviewed by three individuals independent of this study who validated the coherence, resonance, and verisimilitude of the data. Furthermore, my own assumptions as the researcher were clearly stated and owned.

#### Issues of Representation

Voices heard. In this study, several voices are heard. First, my reflexive voice as the researcher is clearly identified and represented in the text of this study. Second, the voice of society is heard through a review of the literature as well as within the stories and narratives of each participant. This voice speaks of the societal views and values placed upon the experience and treatment of dissociation and highlight the social and political context in which each participant lives. Third, the cultural voice of childhood sexual abuse is also heard. Again, this voice is represented within each participant's narrative as well as within the information obtained from the literature. This voice

brings forth the historical underpinnings of dissociation and the journey that generations of childhood sexual abuse survivors have traveled over time. Finally, and perhaps most importantly, is the voice of the client. Each participant's voice is represented in the form of a story and is comprised of verbal (e.g., interviews), non-verbal (e.g., researcher observations), written (e.g., journal entries and poems), and/or symbolic (e.g., artwork and dreams) texts.

Voices missing. In this study, two voices are missing. The first is that of the therapist for although this voice is indirectly heard within the stories of the participants, it is not directly represented in this study. Given that previous research has focused on the perspectives of therapists, I have chosen to exclude this voice in order to maintain a clear and direct focus on the voice of the client. The second voice that is missing is that of the perpetrator. Again, although this voice is indirectly represented within the stories of the participants, the voice of the perpetrator is absent. Although this representation would make an interesting contribution to the literature, I believe that it would be best presented in a separate study.

Limits of representation. As stated by Kohler-Riessman (1993), all forms of representation are limited portraits of an experience. As researchers:

we are interpreting and creating texts at every juncture, letting symbols stand for or take the place of the primary experience, to which we have no direct access.

Although the goal may be to tell the whole truth, our narratives about others' narratives are our worldly creations . . . all we have is talk and texts that represent reality partially, selectively, and imperfectly. (p. 15)

Lieblich et al. (1998) identify that it is impossible to be neutral and objective when conducting research. Each researcher does not have direct access to another

person's experience but rather comes in contact with the ambiguous representations of talk, text, interaction, and interpretation. Consequently, it is important to note that what follows is my own subjective interpretation of each participant's story.

#### Significance and Contributions of the Research

**What is the experience and treatment of dissociation in individuals who have been sexually abused in childhood?** This study aims to provide a deeper understanding of dissociation and offer insight into how therapists can better support clients who use dissociation as a primary way of coping. According to researchers (Briere, 2002; Fosha, 2003; Howell, 2005; Nijenhuis, 2004; Putnam, 1997; Scaer, 2005), acts of sexual abuse upon an innocent child can trigger an automatic response that enables the child to momentarily escape the horrors of the events taking place and as a result, provide the child with a much needed psychological buffer from harm. Currently dissociation exists as a mental disorder in the DSM-IV-TR (2000) and involves the use of language that implies a significant departure from normalcy.

Although much research has examined the experience and treatment of dissociation from the perspective of theorists and clinicians, to date few have explored this from the perspective of clients. This research therefore addresses a significant gap in the current trauma literature by: (a) providing therapists with insight into the experience and treatment of dissociation from the perspective of clients who engage in moderate to high levels of dissociative behavior; (b) challenging the dominant discourse that presently surrounds dissociative behavior; and (c) giving voice to those whose experiences of dissociation have been primarily silenced and shamed. Through a narrative methodology, an in-depth exploration into the lives and experiences of individuals who use dissociation as a primary method of coping is obtained.

## CHAPTER FOUR STORIES & NARRATIVES

Behind every symptom is a story waiting to be told.

~ L.A. Pearlman,  
personal communication, June 24, 2006

The purpose of this section is to provide the stories and narratives of the seven individuals who participated in this study. Each participant was screened for levels of dissociation through the use of the DES-II (Bernstein-Carlson & Putnam, 1993) and scored within a moderate to high range of dissociative tendencies (i.e., scores equal to or above 30). All except one participant identified distinct memories of being sexually abused as a child.

To highlight both within and across narrative themes, I first introduce each participant individually by presenting his or her own unique narrative of how he or she experienced dissociation and the factors that positively and negatively influenced reparation. In a following chapter entitled *The Shared Story*, I present the commonalities that emerged from the participants' stories and draw attention to the themes that appear across narratives. Each story is written in the first person and woven together from multiple sources of data that include personal interviews, artwork, dreams, poems, and journal entries. Through story and narrative, each participant's experience comes to life. A deeper exploration into the experience and treatment of dissociation is obtained.

### **"Sara"**

I'm 47 years old and a twin. I was the second one out five minutes after my twin so I'm technically the baby I suppose ~ laughs ~ we have an older brother. He's five years older and both parents are living. My father is a closeted gay man still living with

my mother and . . . and all of my family lives in another province. I'm very close to them and we still keep in touch but I definitely needed to get away and out of the family dynamics. I never would have straightened out my mind if I hadn't moved here. No children. Never been married. Right now I'm in a long distance relationship with a fellow that lives in another province. We've been together for two and a half years now and . . . and I think there's a big part of me that enjoys the distance we have in the relationship ~ laughs ~

I've questioned sexual abuse because of certain behaviors of my own that . . . I'm very hung up on not getting suggestive stuff but I do find it a bit odd just by various behaviors of my own like--ummm--not having . . . not having a lot of connection to myself as a child. When I look at photos of me as a child I see that little girl as being someone else. She looks desperately sad and I don't feel . . . I don't feel I can connect with the child that I'm looking at ~ silence ~ I really hate looking at those pictures. I just hate it! I actually find them quite painful.

I also had a morbid, morbid fear of going to school. I would run away from school in Grade 1 which is pretty little to be running away on the streets alone but I did that a lot and I had a terrible, terrible fear of leaving my mother. There's a lot of sexual secrecy in my family and there's definitely some sexual inappropriateness with the brothers to the girls on my mom's side. My mother had an experience where she was taken to an abandoned house where her much older brother grabbed her breasts and tried to neck with her. It took me awhile to get that information out of her ~ silence ~ there's lots of secrecy ~ silence ~ its pandemic on my mother's side and of course, my father led an entire double life that none of us ever knew. He used to bring his lovers home for

supper without any of us knowing and we even vacationed with one of them. I discovered it . . . his homosexuality . . . in 1986 and my mother has only chosen to tell my brother about it just before Christmas . . . 20 years later!

I don't know if living in that kind of dysfunction can lead to dissociation but I know that the traumatic events I've had as an adult have contributed to that response. I witnessed the death of my best friend, her sister, her mom, another friend, and a guy in a car explosion when I was 19 ~silence~ I very much dissociated at the time ~ silence ~ and I had a near rape when I was 25 and then two years ago . . . my former boyfriend . . . his sister was murdered by her husband who then killed himself in the presence of their twelve year old child. It was the murder that did me in.

I remember my therapist saying to me, "You know, you don't learn to dissociate as an adult." I can't believe I'm saying this but I've wondered about one of my parents. I know I was quite fused with that parent growing up and I replaced the relationship that parent didn't have in the marriage ~ silence ~ it's just a gut feeling and . . . and as I say, I don't want to suggest what isn't there but I've done so much personal work that if suddenly I came up with this revelation that I was sexually abused ~ silence ~ I don't think nothing would shock me at this point.

#### Experience of Dissociation

It's very foggy ~ silence ~ ummmm--it's like . . . it's like I can see the world in front of me but . . . but I feel really no connection to it. My entire world shifts on an axis so everything looks crooked and I'm extremely dizzy. When I used to finish seeing my therapist, I couldn't drive home . . . in fact for the longest time, I couldn't drive at all. Sometimes I would drive somewhere and have no recognition of how I got there. We all do that from time to time but not even noticing traffic lights?! I miss parts of

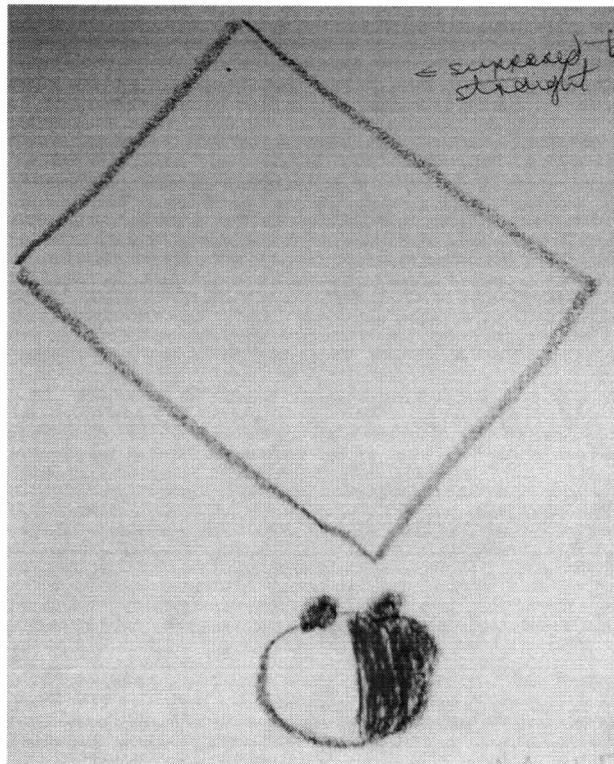
conversations . . . like in group discussions I get very confused because there is too much stimuli and I'm not able to . . . I'm not able to separate them out so there is just a blob that makes no sense at all. I remember my best friend's accident. People were speaking to me and I could see their lips move but I had no idea what they were saying. I just watched their mouths but I couldn't hear their words and . . . and the near rape thing ~ silence ~ everything was reduced to morbid slow motion . . . like whoop! suddenly everything around me was a slow motion event.

I remember being so completely out of it when I was seeing my first therapist that I fixated so much on an image in her carpet. Sadly, that's all I can remember of her. I couldn't control myself from not getting lost in her carpet . . . I think that was a way of dissociating. I also struggle constantly with recognizing myself in the mirror. I know intellectually that it's supposed to be me because I'm the one that lives at that address but . . . but it doesn't look like me. It doesn't look familiar. There's a big part of me that really wants to connect with that person in the mirror ~ tears ~ sometimes I can but I find it really hard ~ tears ~ it's really hard.

Often we hear dissociation described as watching a situation from above but I only remember doing that a bit at my friends' deaths in the car accident. For me, dissociation is much more than that. It's not a disconnection from the body because to feel disconnected from one's body is to know that you actually possess one. For me, it's more like the body is not in my understanding at all. To detach from it I have to recognize and acknowledge that I have a body and . . . and that is not always in my level of awareness. When I dissociate, I have no sense of my body and for some reason, I don't question how I can walk without a body to move me.

This is me and the world and my eyes are like this and the world is completely slanted on its side (see Figure 4.1). I won't give myself a body ~ laughs ~ because for me, everything happens from the eyeballs up. Not really much of me exists below my eyes. So this is dissociation and . . . and my eyes are foggy and . . . how do I keep my feet on the ground if my body wants to follow the angle of the world? ~ tears ~ Sometimes I wonder if my eyes look as glassy as they feel. I wonder if people notice that I'm not as alert or as sparky as I should be.

Figure 4.1. Sara's Drawing



I used to always say that I'm just not with the program. I am SO not with the program. I'm blanking out, I'm a nutbar, and at times I feel quite insane. There's nothing good about dissociation. During the near rape, I was frozen stiff and dissociation made me unable to protect myself. It also makes me a walking target. Once I was walking home from my therapist's office and . . . and I'm always seriously out of

it for a long time after and . . . and some guy came up to me and asked me for the time. He told me he was visiting from Brazil or something and then he shook my hand, went to kiss my cheek, and put his lips on mine. It wasn't until I got home that I realized that some perfect stranger's lips were on mine and I had no idea how they got there!

Dissociation is . . . it's isolating . . . it feels chronic . . . it feels repetitive. It feels narcissistic and ~ silence ~ and it feels self-absorbed because I can't . . . I can't truly be present to those around me if I can't ~ silence ~ how can I have truly connected relationships if I'm not really connected to the world? ~ tears ~

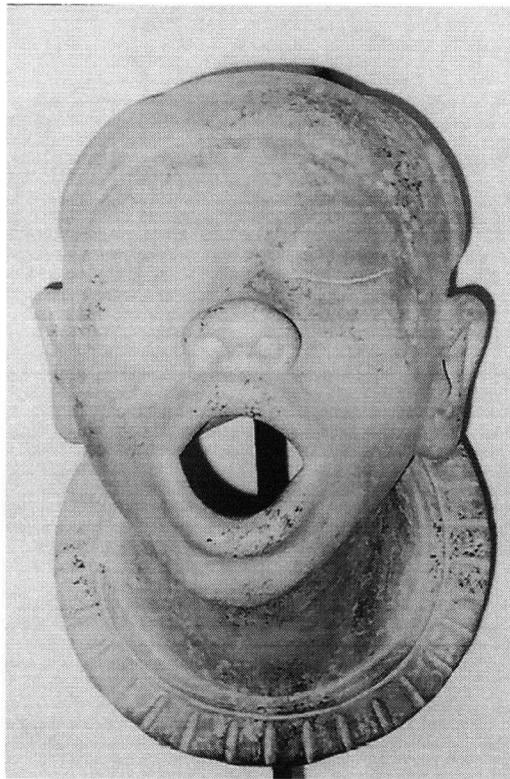
I dissociate when . . . it's about anxiety. I quit breathing and it happens most if you ask me how I feel. Right before I dissociate I'm aware that I feel out of control. It can be triggered by physical pain but mostly it's triggered by the need to mentally escape entering any sort of emotional field. For me, it's related to the shame of showing emotion. I fear that people will see how I really feel or . . . or that I might cry and die of embarrassment. I have a lot of sculptures in my house and I realize that all of them have big gaping mouths with no arms and legs. Their mouths are wide open because they're screaming but . . . but no sound comes out so you can't hear them. I don't like violence but I love violent art. Somehow the art speaks the emotions I can't (see Figure 4.2).

#### Treatment of Dissociation

I did a three year program at a place which uses . . . it's transpersonal psychology and takes a very spiritual bent. It had a cognitive behavioral approach and involved a ton of group work. As much as I hate groups, they have become very important to me ~ laughs ~ because somehow they have been a very safe place for me to test my ability to stay present. I've seen a few therapists and my current therapist . . . I've been seeing him for a few years now . . . we do EMDR and that has been helpful in

clearing my brain. There's something critical about instilling confidence in me. In the program that I'm in I have to be a mentor to others and that really helps build confidence. Both EMDR and the groups have helped me understand that I'm normal . . . that I'm not the crazy one and that life around me is. I'm also on Naltrexone and for me that has been critical.

Figure 4.2. Sara's Sculpture



My therapist tells me that I'm dissociating and . . . and he will usually get the lavender out or make me do things like pull my hands together or stomp my feet. The lavender helps. Somehow it snaps me back to the present and gives me a little dose of reality. It's funny though because sometimes just mentioning that I'm not present helps me realize that I'm not here and that in itself can bring me back. Sometimes my therapist asks me to write. He says that my hands move a lot and seem quite busy and

. . . and that it looks like my hands are trying to say something. He would give me a pen and my hands would speak:

I do feel sad because I know I will never be normal. I will never show feeling. I will always be out to lunch. I will never be truly connected. I will always be alone in my head with no one understanding me.

It's strange because by writing I can often communicate the things that I cannot say. I feel very secure with a pen in my hand. Writing seems to access my subconscious stuff and it feels much safer ~ silence ~ especially in those sessions when speaking does not come easy. Somehow having a pen in my hand helps me think and makes me feel kind of grounded. I realized the other day that my fingers naturally flick the pen that I'm holding and that makes a noise alerting me to my hands and the rest of my body. I also jump into freezing cold water and that helps a lot! I did that last October when I was near the ocean and I love that feeling because that's when I feel most alive. It's like putting on a pair of new glasses. The colors around me are more vivid and the world looks clearer and more alive! It alerts me to my body. It grounds me and connects me back to the present.

For the most part, my therapist believes in me. That's critical. He . . . he ~ tears ~ assures me that I'm not the crazy one and that life around me is crazy ~ silence ~ he treats me saner than I think I am and . . . and that is a very kind thing to do ~ tears ~ I figured something out the other week that helps me come back when I'm dissociating. I figured out that if I can extend love or care to someone . . . it's like a ribbon that joins us together. It's an extension of love that happens when I am able to take a sincere interest in someone else. It's about connection. My therapist has a real quirky sense of humor and he discloses things about himself and his crazy family that I find extremely helpful because I can see this high functioning individual and realize that it could be me. That's part of the ribbon.

It's about removing the wall or barrier and taking away the isolation. It gives me hope and helps me feel connected.

I told my therapist that I was coming to talk with you and he said, "Oh, you're too high functioning for that!" That wasn't helpful. I need for him to acknowledge that this is a problem for me and that I'm struggling. I was in a program once and had to do an exercise where I needed to be quite emotive and totally immerse myself in the act of a character. At the end, people in the group asked me how I felt and . . . and I don't recall anything after that but the exercise was videotaped and when I watched myself on the video I saw myself give a perfectly clear cognitive answer. That's when I realized wow! I can be completely out of it but look totally with it! That's scary! I can really fool a lot of people including myself and I need my therapist to recognize that on the outside I may look like I'm holding it together but on the inside A and B just aren't matching up.

For the longest time, my therapist would ask, "What do you feel in your body?" That would just . . . I don't know what to say to that except that I don't know what you're talking about. Then he'd say, "Well, what are you feeling? What are those tears about?" And I still couldn't understand. Even if I'm emoting, I can't make the link between the feeling and the tears. I mean, I might be bawling my eyes out but I couldn't tell you what feeling matches it. My therapist seemed frustrated by that and that wasn't helpful because I can't access what I can't access. Connecting to my body and my feelings . . . I don't know how to do that and it's just a source of frustration. I don't like that physical connection to myself. I don't like deep breathing. I don't want to be in my body so why are you asking me to go there? For me, it's a bit like speaking Greek to

someone that doesn't understand Greek. I don't have a clue as to what you're talking about.

I need to have things explained to me intellectually first because intellectually is the only way I can function. Remember it's from the eyeballs up. You're going to have to get to me through my intellect for me to feel safe. It's been a relief to know that I dissociate. If I had known that the first day of therapy I wouldn't have been sitting around thinking that I'm a lunatic or that I'm lazy or that I'm not paying attention or that I'm not trying hard enough. In some ways, not pointing out dissociation and educating people about it is harmful because . . . because it's very lonely in here and I would have been constantly beating myself up. It's taken me five years to even begin to talk about my body . . . five years for me to even want to go there . . . so don't jump too far ahead. Don't take me to the end before I'm ready.

### **"Kate"**

I'm 34 and I have a father, a mother, and two sisters. I'm in the middle. Relationship with my family? Don't have one. I haven't spoken to my mom for . . . for two years now and I haven't talked to my dad for about four or five. I don't speak to them because one, they don't get it and two, they will never get it and I couldn't move forward with my life if I kept a relationship with them. It's a family that's very dead to me inside.

I'm not in an intimate relationship at the moment but I have a really great circle of women friends elsewhere in the province. I'm a musician and ~ laughs ~ and I'm

going to say that first because that's what I love to do but I also work as a teacher. For me, my friends and my music are my family.

My abuse was mainly when I was really young and I don't think the overt stuff happened much past the age of five ~ silence ~ it's still a bit foggy around that stuff but . . . but it was my grandfather and my father who sexually abused me. My dad thinks I'm mentally ill and when I told my mom, she didn't believe me. She actually said that to me and that's like the ultimate rejection! My mom wasn't in my life too much. I mean sure, she was there physically but emotionally . . . there was just nothing from her in that way. You know, my father for all the stuff he did there was another side of him that ~ silence ~ we had a really great connection when I was growing up and . . . and ~ tears ~ I don't know why I'm getting so emotional ~ tears ~ he was the guy that . . . he was the guy that taught me how to love music. All the things that I do in my life I got from my father. My interest in the outdoors. My love for music ~ tears ~ I mean those are my two great passions and I got them from him. We shared a lot of that stuff when I was young . . . we shared it together. He was passionate about me playing music ~ silence ~ he was proud of me.

#### Experience of Dissociation

Gone. That would be the word I would use to describe it. Gone. Not present. I sort of see myself as . . . as ghost-like with no real form and it's like being in a dream but not being in a dream and it's weird. It's not an out-of-body experience because it happens in your head. Sometimes I would go out of my body, see myself through someone else's perception, and actually watch myself through their eyes. Other times I would hear my voice but it wouldn't sound like it's me talking. You know, I could be driving and end up somewhere but not realize how I got there and it's amazing how you

can do something so important like drive a car and . . . and it's like suddenly you disappear and you're on auto pilot!

When I'm dissociating I don't have any feelings and from my neck down there's nothing. I'm just not there. I think that's what I mean when I say that I'm out of my body. Everything below my neck disappears and my feelings are gone. One way I can tell that I'm dissociating is when I find myself having a hard time writing my music. I write all my own songs and I need to be in the right space to do that. I need to be feeling at least some emotion but when I dissociate everything shuts down. It's empty and . . . and when that happens the words don't come, the guitar playing doesn't happen, and my voice doesn't sound as good.

I did a lot of things that were harmful in my life and they were all forms of dissociation because they would stop me from feeling and being in my body. Drugs, alcohol, smoking cigarettes, sleeping with as many people as possible . . . you know, I was doing heroin when I first started teaching and I used to drink like a fish when I was in university. I was a good happy drunk. I did fun stuff and I was fun to be around. I didn't feel anxious or embarrassed because I simply didn't feel. I wasn't even there. I had sex with people because that's what I knew how to do and I knew how to do it well. It was all about making someone else happy just so I could be happy ~ silence ~ I learned how to do that really early on.

I don't know how to be intimate with people. When people are interested in me I immediately go to that place of being shut down and floaty and I think it's the same as the sexual abuse thing. I mean, the attention I got from my father . . . somehow I dissociated with him when he was sexually interested in me and so I do it with everyone

else in my life that's interested. That makes me angry. I mean, how can I have a relationship with anyone if I keep doing that?

My mother . . . that's another real trigger. Talking about my mom. She gave me a Christmas card a few years ago and I was so angry that I burned it. You know, sometimes I wonder when am I going to stop feeling guilty? When am I going to stop missing my mother? I had to let her go because . . . it's hard ~ tears ~ the fact that she doesn't believe . . . sometimes I think she just kind of fed me to my father because she didn't want to be with him herself. Subconsciously she knew stuff was going on . . . and she didn't ~ silence ~ (5 seconds) she didn't ~ silence ~ (14 seconds) I think I just dissociated ~ silence ~ (12 seconds) I'm gone. What was I supposed to be talking about right now?

#### Unmothered Daughters

Why is it when mothers  
Who have been dead their whole lives  
Who have never chosen to come alive  
Finally die  
And still daughters feel sorrow  
That tears the ground out from beneath them?

Why is it when daughters  
Break free of mothers' grip  
And begin to move into their lives  
Strong, on their feet, holding their power  
Loving with hearts and souls and bodies that are healing  
And are still overcome with tears?

What else is there?

There is rage  
The deep, dark, blood-red rage  
Being unmothered  
Left alone to mother ourselves  
And to hold the very mothers who abandoned us.

And there is sadness  
Uncoiling and heavy, like thick, braided rope  
Sadness for the loss of a bond that never was

And now will never be.

There are memories that flood through  
 Our bodies like tsunamis  
 Powerful and destructive  
 And there is the weight of memories still hiding away  
 In the dark, soft corners of our flesh  
 And we weep for our own soul's loss  
 Again and again  
 Over and over  
 Until our bones cry out in pain  
 And we weep for the end of possibility  
 And for finality

And then we take a breath of  
 Clean, mountain, autumn air

And then we weep  
 With relief.

~ written by Kate

I don't think I'm aware of anything when I dissociate. I just know that I'm gone and sometimes I lose all thought of what I'm supposed to be saying. It's like I'm in the middle of a conversation and someone's talking and . . . and it's like I'm not listening or something. Sometimes my throat starts to close up and I can't speak or I can be really hyper . . . like nervous . . . and talk really quick and jump to different topics. Other times I focus in on certain objects . . . like right now I'm focusing in on the title of that book over there. I lose my train of thought and . . . and I'm gone . . . then suddenly I come to and it's like I wake up and can feel my emotions and my body again.

#### Treatment of Dissociation

I've seen a number of therapists and the first therapist I saw was probably when I was 17 or 18. My mom and dad were going through this huge rift in their relationship and I was angry at my father so my mom said I should go see someone. I thought it was a good idea at the time but the guy I saw . . . I think I only saw him once or twice. He

was a guy and that didn't work for me. I saw someone else when I was in university and she was a student doing her degree but there just wasn't a connection. I met my current therapist about five years ago and I have been seeing her ever since.

I remember the first time I met my therapist. She sat like really close and our knees were almost touching. I was terrified of her so I sat way on the other side of the couch ~ laughs ~ I couldn't face her. I was way too scared ~ silence ~ I was ashamed. We started off doing imagery work and I went to a couple of her workshops where we did things like danced to music and went on shamanic journeys. Shamanism is a really ancient and spiritual way of life and there is a belief in the animals and the spirits of animals and the spirits of trees. That really worked for me because I've always been really connected to nature. We went on these journeys and I could feel things happening to me in my body on a visceral level and we worked through whatever came up. We did EMDR and that was the best. I found that it made a huge difference in how I am in the world and I think EMDR and the shamanic journeys worked because of the imagery. Imagery is really powerful for me. My therapist would always get me to imagine myself with a guitar in my hand because that's when I feel most powerful. When she sees that I'm dissociating she asks me to feel my feet on the floor or . . . or she would get me to go to my place in nature and connect with my power animals. By doing that, I'm put in a stronger place. I feel more adult in my body and somehow that brings me back.

When we work through memories of the abuse she would always go with whatever I brought up. There have been times where I've stopped myself because this weird image would come into my head but . . . but she would just remind me to go with whatever was happening. Even if I dismissed something she didn't and that was so

reaffirming and validating because I've always felt very crazy in my life. My older sister is mentally ill so being crazy has been a real fear for me.

Writing helps. I write poems and that's been good but I think the connection I have with my therapist has been crucial. I don't know how to describe her because she's unlike anyone I've ever met before. She saw who I was right from the very beginning and she knew me and believed in me long before I did. My therapist has gotten really good at reading me and it's awful sometimes because I can't do anything without her seeing ~ laughs ~ she's very good at what she does. She's got good boundaries. She's really smart and she clearly does her own work. I think that's vitally important because you can't do this kind of soul level work unless you've done your own work too. I don't know how to say this in a way that doesn't sound unethical but she mothered me in a way that I needed to be mothered. She gives me unconditional acceptance and love and that's just what I needed. All of that makes for a deeper connection and that's when healing really happens.

#### Crone Women

I was born in a valley of blood  
 And it stained the skin of my soul  
 My body was shamed and trained to believe  
 That I wasn't in control.

And the very first thing that I witnessed  
 My mother's own lack of control  
 I learned to push back pain, like she did  
 Right from birth.

Throughout my growing up years  
 I watched my mother live out her life  
 She weathered the storm called my father  
 Till one day her shelter gave way.

And she opened her eyes to the damage  
 The ruins of her life at her feet

And I moved on knowing my mother's faults and fears  
And my father's choices were imprinted on me.

And sometimes when I am feeling disconnected  
There's a rock in a place on a hill  
A woman's name has been engraved there  
And her spirit floats on the wind all around  
And I go and sit with her and I feel her  
Wrap her windy arms around me  
She wraps her windy arms around me.

The other day, I saw my mother on a beach  
She was bleeding into the ground  
And the tears rolled down her cheeks  
Back into the sea.

And I wonder how many mothers have  
Given up their daughters, like seeds on the wind  
And I wonder how long those mothers wonder  
When those seeds will meet the soil  
And how far those roots will travel  
To anchor those daughters down  
To anchor those daughters down.

I know a silver woman in the mountains  
There's a raven perched on top of her head  
And she carves out her life all around her  
With fingernails caked in black earth.  
And she tells me to hold fast to my truth  
And to lay myself down in the grass  
And she tells me to live in my body  
And worship it too.

I can't wait to be an old crone woman  
Cuz then I'll know who I really am  
I'll hoist my animals onto my shoulders  
With hands that are calloused and worn.

And I'll carry crystals in my pockets  
And the moon will rise in my eyes  
And I'll walk barefoot on strong old muddy feet  
And sing stories of a well-aged life.

And I won't feel disconnected anymore  
And on a rock in a place on a hill  
I'll carve my own name into the stone there  
And my spirit will float on the wind

And young women will sit with me there  
And I'll wrap my windy arms around them  
I'll be a windy old crone woman.

~ written by Kate

For the longest time I couldn't sing that song without crying. It's so hard not to cry ~ tears ~ so hard. The fifth verse is about my therapist and how I want to be like her. You know, I have this great image for that song where I'm standing on this cliff at one of my favorite places in nature and I'm standing there with my therapist. We're both holding large staffs in our hands and . . . you know, we're just facing the world ~ tears ~ I couldn't have gotten through what I did . . . not without her. She is such a hugely different role model than my parents were and I love her dearly. I feel extreme gratitude towards her. I mean, she's in her sixties and I worry that ~ tears ~ my music, it's a tribute to her. It saved my life. It makes me feel alive and she honed in on it and knew that was what I wanted to do ~ tears ~ she always says that it makes her heart sing when she sees me perform. She comes to all my shows and she's so excited about how far I've come. She tells me that she's proud of me ~ tears ~

Generally speaking I have a much better grasp on how to stay grounded, how to calm myself down when I feel agitated, and a much better understanding of my triggers. I think it's important for therapists to always go with the client. One of the things my therapist does is she just goes with whatever I bring up. She lets me come to what I need to come to in my own time and wherever I'm going in my process she follows. She holds a mirror up to me so I can hear what I'm saying because sometimes I'm not even aware of what I'm saying until she repeats it. She's real and that's important because if you're not real and transparent, a client is going to pick that up.

The only thing I can think of is that sometimes I wish my therapist was a little more forceful. I mean, I can talk up a storm and she knows that and sometimes she

doesn't challenge me on it. I mean, she's really good at letting me come to my own realizations but there have been a couple of times where I could hear myself say stuff and I'd be wishing that she would stop me and say "What are you talking about?!" Obviously she chooses carefully when she challenges me and when she doesn't.

If I were to give advice to someone first starting out in this process I would tell them that it will be really hard for a long time but to stick with it. It's going to be okay. When I started all of this, I couldn't see the end and that was really hard ~ silence ~ I think dissociation definitely helped when I was younger and even now . . . well, I guess it still helps because there are times when it's just not appropriate to have certain feelings because I can't manage them so . . . so in that way dissociation can be good. It shuts you off and gives you a bit of a breather. It can also be bad because it stops you from being present in your life ~ tears ~ and that's sad because . . . because it's about survival.

#### Survival Gear

I wear survival gear.  
 I started making it  
 In infancy.  
 Back then.  
 I sewed and hammered  
 Into the night.  
 I had a lot of time.  
 I sewed and hammered out a lot of gear.  
 During the nights when my father wasn't in my room  
 And the times when I wasn't in the care of my grandfather or my father's crazy family  
 And the days when my mother wasn't paying attention (like I said, I had a lot of time)  
 I worked on my survival gear.  
 I added patches  
 For each new, gaping wound  
 That needed covering  
 And healing.  
 And then, I took down hems  
 And pounded out metal  
 And pulled out stitches

For every inch I grew.  
 This survival gear is wrapped around me  
 Like a fortress of stone  
 Like a protective suit of amour  
 It saved me  
 Held me  
 Gave me comfort.

Sometimes I feel  
 My armour weaken.  
 There are broken seams  
 That predator men  
 Try to pry open  
 And stick me with daggers.  
 There are fraying patches  
 That twisted women  
 Want to unravel  
 And expose my insides.  
 There are transparent pieces  
 Where the fabric has worn thin  
 Where the metal has been pounded through.  
 Straightjacket made of fear, control, grief, anger, mistrust and shame  
 Sometimes I gasp for breath  
 Sometimes I forget to breathe  
 Sometimes my friends can't see me in here  
 Sometimes I cannot find myself in the darkness of this suit  
 Sometimes I cannot move with ease.

And sometimes,  
 I can take out my can of oil  
 And a soft, old cloth  
 I rub oil into the seams of my suit  
 I polish my suit and make it gleam  
 I grease and work the joints lovingly so that they move freely  
 So that I can move with ease.

That suit ain't so bad  
 When I take care of it, I decide  
 When I don't ignore it, I realize  
 I love my suit of armour, I declare  
 As I wipe off the excess oil  
 Seeing my reflection looking back at me.  
 It has gotten me this far, I say aloud.  
 It has helped me  
 Survive.

~ written by Kate

## “Catherine”

I have two cats and a common law husband. I'll be 34 on July 10<sup>th</sup> and my husband and I have been together for 13 years. I work during the day as a full time veterinarian assistant . . . receptionist, groomer . . . and my husband works nights so we do not have a lot of time together. My parents were married but got divorced. My dad is dead now. He died in 1988. He was very domineering and abusive. My mom is still alive but I'm not as close to her as I would like be. She's an alcoholic. My brother is one year younger. He's a heroin user and my sister is one year older. She's an alcoholic too. My sister and I live in the same city yet we feel like we're a hundred miles apart. To even approach her about what I'm going through ~ silence ~ she's not interested. She called me today and I said I was seeing you about disassociation research and she wanted nothing to do with it. She didn't even hear what I had to say ~ silence ~ I like plants. Plants are always good. I know that plants aren't going to hurt me.

My first memory of abuse is with my babysitter. She would have these parties and bring her boyfriends over and . . . and I don't know exactly how it all came about but I remember her sitting on the couch and making me do things. I remember crying for my mom. All of this happened before we got sent to the foster home so it must have been five or under ~ silence ~ so that was the babysitter. There were others. I was attacked by a stranger when I was about 16 and then I was . . . this is the one I have the most problems with . . . my dad's girlfriend . . . she had three children and the oldest son ~ silence ~ he used to molest me when I was sleeping. My sister told me that he used to repeatedly rape her too and . . . and that he repeatedly raped my brother. My sister and brother are alike in that they remember too much. I don't remember a lot. My brother

keeps telling me that I should not try to remember because nothing very good is going to come out of it. **Nothing!** I can't understand why he would say something like that. He says he remembers everything and that is the reason why he wants to forget. It's been years of not knowing . . . years of not remembering. It's horrible to not know ~ silence ~

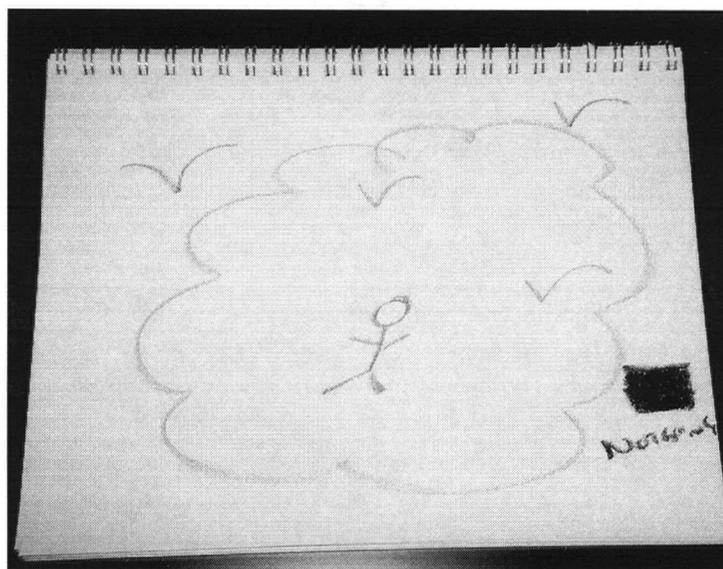
#### Experience of Dissociation

Being forgetful. **Very, very forgetful!** That's how I would describe it and it's to the point where it's very annoying and frustrating! It's a memory thing and I often think if I could just concentrate harder or pay more attention. It's . . . it's spacing out. I see that in my sister. She sits there and just stares at nothing and my husband says I do that too. Sometimes disassociation is like looking at a movie or a screen . . . it's all fuzzy and something's going on but it's not very clear. Sometimes things move slower. Sometimes it's like somebody cut the movie in half and there are long periods of absolutely nothing before you jump back in again . . . into a different scene . . . and the person has changed and you're trying to figure out where the lost part of the movie went. Sometimes I read things and the words do not stick in my brain. I can see words like the, and . . . you know, words that aren't threatening but the other stuff, it just does not compute. Sometimes when people talk, it's like they're speaking in a different language so nothing makes sense . . . other times, it's like somebody just turned off the sound.

Disassociation feels like . . . it is literally not me. It's **NOT** like I'm floating above my head or anything. It's different characters and these characters are other people . . . a different person . . . and they are trying to relay to me what this different person's life is like. So it's **her** life not mine and there's no ownership whatsoever. I have no

connection to them. They're not me because if they were me it would be too real. When disassociation happens it's like birds coming in and out. They dart away and when they're in, I'm not there. Sometimes I go to a dark room in my head . . . behind everything. Sometimes I can see what the characters are doing but it depends on whether or not I'm paying attention. It's very difficult to pay attention. The dark room in my head . . . it's a place of nothing. It has no feelings. It's blank. When I'm there, I'm as small as possible and nobody can see me so that's where I know it's totally safe ~ silence ~ it's way better to be in there than out here (see Figure 4.3).

Figure 4.3. Catherine's Drawing I



Stress is a trigger for me. I was molested at night so one thing that's stressful is going to sleep. I have a lot of issues with sleep . . . not sleeping through the night, grinding my teeth, and . . . and feelings. That's another trigger. I try not to feel. I try not to feel anything. I was reading *The Courage to Heal*, a book for people who were sexually abused and there was a sentence in there that brought up a very dark, dense emotion. The emotion was big and black. It was huge! I'm not exactly sure how it was

worded but the sentence asked people to think about something positive that might have come out of being sexually abused. What the hell is positive about being sexually abused?! To even suggest that . . . it's mean, insensitive! That brought up an emotion that scared me to death. It was . . . it was anger. Anger. And that is a very scary feeling for me.

So I try not to feel any emotion and I try not to feel my body. I hate this body! Hate it! One of my therapists said that I have disgust for my body. I looked it up and yes, I do. Disgust! I punish my body by eating. I just eat and eat and eat. One time, I ate an entire box of crackers all at once and my mouth was so dry that I almost choked. My doctor says I'm supposed to exercise but when I do I can feel the body. I can feel the muscles. I can feel the body moving and that's when it gets freaky so I stop. The body is a big trigger for me. Usually I only exist from the head up. Most of the time the rest of me just isn't there.

I don't think I'm aware of anything before I disassociate. When I'm disassociating, there's nothing and when I'm not disassociating, I try not to notice anything. I try not to notice thoughts. And feelings? Like I said, I try not to notice them either. I usually hold my breath but that's getting better because now when I hold my breath, it's not to the point where I'm going to pass out. Sometimes when things get really bad, I can feel palpitations in my heart. Like right now, I can feel my jaw clenching and . . . and when that happens, it's like the muscles have their own way of doing things and I have no control. I can ~ silence ~ (7 seconds) right now I can see my mouth moving but I don't really know what I'm saying ~ silence ~ (12 seconds) what was your question again?

Disassociation is safe. Very safe! I like it because it helps me go ahead and do a lot of things. I am a lot more productive when I disassociate. I can go out, get my job, be in a relationship with my husband, and just do things that are different.

Disassociation creates the appearance of being normal. I can watch how normal people act, go through their actions, and fit into the world even though I'm not really in it. I'm not in the world at all ~ silence ~ disassociation helps because it hides the fact that I am living a lie. When you're disassociating, you shut down instantly yet you're walking and talking and seem like everyone else. My first therapist said that disassociation saved my life and that it's probably the only reason why I'm not into any drugs or alcohol. I believe that but . . . but in some ways, disassociation is really no different than being an addict. I like it. I want to be in it and for me it's comforting. It's nice, warm, fuzzy . . . it's a perfect place to be.

I often wonder if I'm crazy. I wonder if I'm crazy because none of this makes sense . . . my memory . . . my life. I want to rely on disassociation yet at the same time, I know that I can't. It's one of those catch 22's. I want to be in that state but I don't want to use it as a crutch. As much as disassociation keeps me safe, it interferes with my life because . . . because it's a band-aid. It covers up a wound but it isn't really going to make anything better ~ silence ~

#### Treatment of Dissociation

I just started with a new counsellor but I've seen a few in the past and it was my past counsellor that pointed out the fact that I have disassociation. She also said that I have posttraumatic stress and depression too. When she told me that I thought she was crazy. I'm thinking, "This lady is nuts! I don't have any of these things and I must be pretty wacko to pick a stupid counsellor like her!" Now I think she hit the nail on the

head. I think it was good that she told me what she did but at the same time, you have to be careful. It's very important for therapists to convey that you are not crazy, that this is natural, and that we are NOT stupid but . . . but now that I'm becoming more aware I ~ silence ~ having knowledge does not always make it easier. Once you have awareness of disassociation, it's hard to go back and actually do it. I want to get back into that state because now the world is just bombarding me with too much feeling . . . too much everything ~ silence ~ I have to figure out a way to get it back.

I was in a car accident two years ago and that made my disassociation crumble too. The pain in my body . . . I could not get rid of it. I could not ignore it. I could not make the feelings in my body go away. So when people tell you that you have disassociation it's . . . it's kind of like having a safety blanket and all of a sudden that safety blanket that you have had your whole life is being pulled away. I want to go back to the point where I don't have to think and feel and notice anything. To not be able to rely on it anymore ~ silence ~ that's the scary part. You are literally taking somebody's safety away. It's their lifeline, I guess.

The counsellor who told me that I have disassociation then proceeded to tell me that in her professional opinion it is not unusual for people in my circumstances to experience one or more of these problems. For me to just remember all of the conditions she said I had . . . disassociation, posttraumatic stress, depression . . . it was difficult. She said that she could tell just by looking at someone that they were in disassociation. I don't think so. I don't know how she can feel what I'm feeling or think that she knows what my mind is doing. In my mind, I just twisted it all around, thought she was the crazy one, and left.

With this disassociation thing . . . it's not an easy subject to approach. I don't know how a therapist can tell someone about it but I know that you have to go slow ~ silence ~ trust is a big thing. The world is very scary and you just can't trust anybody ~ silence ~ like when I was waiting for you, I was pacing back and forth. I was trying to pretend that nothing was going on but I was watching everybody. Everybody! For the majority of time, I don't let anybody into my space. If someone tries to enter my space, I always have to assess . . . is this someone going to harm me? It's that hypervigilance of always watching and being on guard. So for a therapist to tell someone about disassociation . . . I think ultimately it's a good thing. It's one of those things that you have to do but I don't think I was ready and now I have to deal with the awareness. Disassociation helped me keep my job but now . . . not having my disassociation . . . it's interfering. I've been at my work for 15 years and apparently now my tone is not correct. My attitude is wrong and I've been told that I rub people the wrong way. I've had a few complaints and my boss does not want to hear anymore. He told me that if he hears one more complaint he's not sure what to do with me. So to say that disassociation is natural is not enough. I need tools on how to deal without it . . . tools on how to cope and continue my life so that it does not crumble apart.

My husband . . . he tries to understand but then again he says stupid things like "I know you're not stupid so why do you always forget?" He says that I use disassociation as an excuse but it's not an excuse. He tries to be supportive but at the same time, he blames himself. He says he never treated me badly so I should not have to be that way with him. That of course, doesn't help at all. It makes it worse because it's not about him ~ silence ~ we joke about my forgetfulness and disassociation. We have

to laugh about these things because it makes it more livable and that's where my husband is very good. He tries so hard on a daily basis to make me laugh. He's very patient ~ laughs ~ and I give him credit for that.

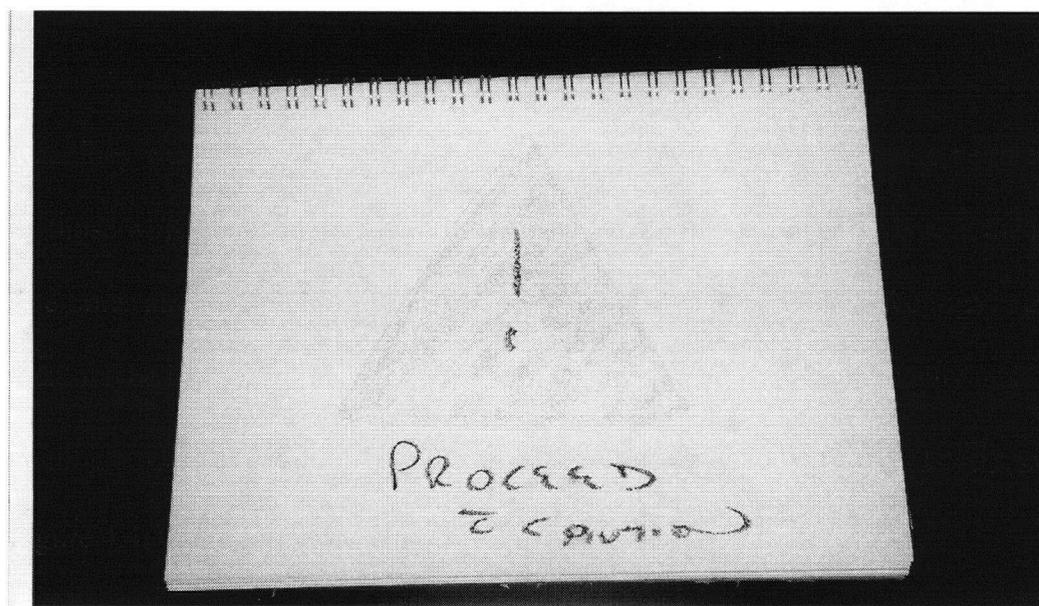
For me, it's a lot easier to see disassociation in my sister and with her, I help by giving her encouraging words. I tell her what I'm doing . . . what's going on in my life. I tell her that I'm thinking of her. I try connecting with her and I think that helps because learning how to connect with people is important ~ silence ~ I want to do that but my fear gets in the way. It's difficult reaching out. It's difficult to hug someone because . . . because I know that nobody stays forever.

Talking is helpful because I'm not always aware of what I say or do and the more I talk, the more it starts to make sense. Awareness is massive but it needs to come from me because when it does, that's when I start to understand. Awareness takes away disassociation and that's both good and bad. When I was told about my disassociation it . . . it was probably one of the better things that happened but you have to go slow. You have to go slow because . . . well, it's scary. Very scary! We develop disassociation for a reason and we don't know what we have until it's gone. It is really important for therapists to proceed with caution (see Figure 4.4).

Right now, I'm trying to learn a new way of being . . . to live with the awareness and not rely on disassociation. I guess I need to rely more on my mental strength . . . more on myself. It's important for me to know that the mess I went through can be of help to somebody else. Who knows, maybe there will be better therapists out there. I know I need to feel more comfortable with myself and . . . and to figure out what feelings are ~ silence ~ I saw a movie a few weeks ago and for the first time I was able to see what feelings like love, passion, anguish, and shame actually were. I could see

what they were by the way the actors portrayed it on the screen. I used to be threatened by those words but I'm not anymore. Maybe I'm getting stronger. I've seen the movie five times already and it is absolutely gorgeous! If I could see those feelings in a movie then maybe I can start to apply those feelings to myself. That would be my next step. If I could learn to feel those feelings for myself then that would be really, really good!

Figure 4.4. Catherine's Drawing II



### **“Lauren”**

I'm 48 and right now I'm single with an extended family from my ex-partner and two grown up sons that my ex-partner and I fostered together. Both of my parents are dead. When I was eleven, my mom committed suicide and I found her body and after that my four brothers and I were split up and sent to foster care. My older brother lives in Alberta and I don't have any contact with him. A younger brother lives on Vancouver Island. He has a brain injury and lives in an institutional facility. Another brother lives

in the United States and the other elsewhere in Lower Mainland. Three years ago I quit my job in mental health and now I'm a fulltime student. I also do some respite for a little boy in foster care.

I think I was quite damaged prior to my sexual abuse. My mom was emotionally absent and to some degree, abusive and my dad was physically abusive to everyone. I had a drug abuse habit that started at the age of nine and that was very much connected to being able to use drugs and alcohol at the home of my sexual offender. The sexual abuse began when I was ten and ended when I was 26. Money had always been a part of the sexual abuse so I often confused the relationship between my abuse and money as meaning I was involved in prostitution. I wasn't but I didn't recognize this distortion until later when I was in therapy. The long term perpetrator who abused me for 16 years lived in the neighborhood and the other perpetrators were my mom's boyfriend and a family friend.

#### Experience of Dissociation

Zoned. Hollowed. I think for me it's quite metaphorical because when I dissociate I always have this feeling that is akin to being scooped out and that's accompanied by a numbed out feeling of being hollow from the top of my chest down to my abdomen. I've heard of dissociation being described as floating above and watching things happen but I don't know if I would describe that in myself. For me, it's a chronic sense of being numb where everything inside of me seems removed. Dissociation is dream-like and I don't experience much emotion. When I think about finding my mom's body after she committed suicide I . . . even now when I think about it I have this completely derealized feeling. I can recall it in perfect detail ~ silence ~ I remember

everything . . . the room, the light . . . it's really intense but there are no emotions at all  
~ silence ~ I remember it as if I wasn't there.

Dissociation started as a coping skill. My offender was the type who wanted you to talk and . . . and that was one aspect of the abuse so I always associate dissociation with chanting. I think that was the root of me starting to dissociate. I'd go into my head and chant or say things repeatedly ~ silence ~ angry things directed at my offender and that would be accompanied by holding my breath which allowed me to ward off whatever was happening to me physically. I've been told that when I dissociate I can look really passive and my eyes usually go off in one direction. I have almost no facial expression and can speak about really difficult things quite matter-of-factly. In my life I've had numerous suicide attempts and other things happen where dissociation was quite positive as it blunted the feelings. I used my addiction to drugs in the same way. It was a maladaptive way to suppress feelings and . . . and dissociation was positive because it gave me control. If I held my breath I knew that I could displace any feeling I was having and I had absolute choice about that. Even though people suggested that I not hold my breath no one could force me but ~ silence ~ but it's a double edged sword. As much as dissociation blunts the feelings, it also blunts my capacity in terms of relationships and connection to others and any feeling of embodiment within myself. Maybe it would be good to have feelings about certain events. I don't know but when I began looking at my sexual abuse in therapy, I know I really learned to appreciate my ability to dissociate and get away from it.

Any activity that is uncomfortable . . . sexual activity, most kinds of stress . . . are triggers where I will eventually start to leave myself if I don't pay attention. It starts by me holding my breath and I do that as a way to control the anxiety which is quite

physical and manifests as a pressure that is localized in my chest. I feel the anxiety creeping up my body and when that happens I have secondary anxiety about losing control. I generally zone myself out by finding something to fixate on like a picture or the weave of the carpet. The carpet is a really easy one for me ~ silence ~ I can just look at it and eventually it starts to undulate and then I feel calm.

I don't have any thoughts that precede dissociation and I think that's the problem because I assume dissociation is triggered by thoughts which in turn are triggered by something that I'm feeling or . . . or that's what I've been told. When I dissociate I don't experience much. I have a problem separating out basic emotions and that's frustrating because I don't have enough of that internal prompting that tells me what it is that I'm feeling. I tend to think what I feel rather than feel what I feel and that's problematic. I'm most aware of anxiety so I tend to describe everything as anxiety and then if I have tears, I describe it as sadness ~ laughs ~ I guess it's pretty limited right now.

It has been suggested that dissociation had a very protective function when I was young and I believe that but . . . but now I see it as a total negative because I'm not successful at learning how to undo it. Dissociation is very familiar for me. It's comfortable. I'm drawn to it and it's as if I want it to happen. It has become automatic and that's hard because it doesn't allow people to get in there and intervene. It's hard to undo something that seems so lodged in my body. The fact that I dissociate means that I'm carrying around the legacy of my abuse all the time and ~ tears ~ and I hate that because it's a chronic reminder of what happened.

#### Treatment of Dissociation

I've done various forms of counselling since I started therapy in 1984. Most of it was talk therapy but I've also done some body work and EMDR. I didn't find EMDR

particularly helpful. For one, it was based on recalling a feeling sense and I didn't have a feeling sense so I found it really hard to think of things that were in any way real. I also didn't like the eye movement or tapping thing ~ silence ~ I think the proximity of that was too close for me. The therapist that I'm currently seeing is someone that I have been seeing for eight years. She's been the most helpful and has made me more aware that I use dissociation as a technique. Initially, I didn't even know dissociation was going on and for me, a valuable part of therapy has been helping me develop more of an awareness of the things that I do.

When my therapist notices that I'm dissociating, she prompts me to breathe. Sometimes she will ask me what I'm feeling and that's helpful but it's also frustrating because like I said, I still can't sort out what basic feelings are. Sometimes she will ask what I'm noticing in my body. I usually say that I feel anxiety and that makes me pay more attention. She also does that orientation thing where I tell her two things that I can see in the room but overall most of her techniques involve some sort of reminder to breathe. One counsellor that I saw in the past had me put up dots on the walls around my house and when I saw the dots I was prompted to stop, take a breath, and center into what I was feeling. At that point, I was pretty chronically dissociated so it was helpful in trying to get me to identify feelings and counter the dissociation.

It's also useful when there's some kind of education process that is a precursor to the deeper therapeutic work because when you've only lived in your own experience, you're not able to stand outside of it and have any understanding of what it really is. One counsellor that I saw in the past brought out a flip chart and we did things at a cognitive level because initially that was a really safe way for me to work. She never came near me and we didn't talk about feelings and that was helpful especially in the

beginning. It's also useful to educate clients by identifying a commonality to other people's situations. I have a hard time applying the things I learn about others to myself but once I began to understand that my abuse wasn't an isolated experience, I could reframe it and talk about it and that helped break the secrecy.

My current therapist does well at challenging me. She points things out and my sense is that any information or observations that are made by a person I trust are going to be things that I pay attention to. I didn't always trust her though ~ silence ~ it has taken me quite a long time but . . . but somehow she's created a relationship where I eventually could. There are a few things that facilitated that trust. For one, she allowed me to challenge her and I think that's the only reason I've been able to work with her for so long. I was quite rude to her in the beginning. I have a larger vocabulary than her and I'd say things like, "Well, I'm a hedonic personality and if you don't know what that means then that's a problem" ~ laughs ~ I would also do things like use sarcasm to fend her off completely or I would roll my eyes or be critical and start to sneer.

Another reason is the longevity of the relationship. I've queried her numerous times, "Is this therapeutically okay that you've been seeing me for this long? Shouldn't you be retired by now?" ~ laughs ~ She's quite candid in that yes, she has seen me longer than most and reminds me that the initial part of our therapy was getting me into treatment. I tested her by working on the practical things in my life first. The initial part of therapy was taken up by family crises and during that time, I was going through treatment for a pretty active addiction problem. We've only started working on the more emotive part in the last year and a half and . . . and it's really hard some days ~ silence ~ for the first three or four years of seeing her, I probably didn't cry at all. I was so disdainful of crying because I characterized it as something pathetic. I mean, what's the point

of crying about something when it isn't going to change it? To some degree, I've ventilated my feelings to her and now those feelings aren't as overwhelming. Now I can actually appreciate sitting through a session without being hostile.

Over time I started to understand how smart my therapist is in terms of basic counselling. One of my issues is that I would only choose to answer people's questions if they told me why they were asking them because I didn't want someone to ask me something for the purpose of manipulating a feeling. I mean, why are you asking me that question right now? What are you thinking? My counsellor and I got into a dialogue about it and after that she got into the habit of explaining to me therapeutically why she asks the questions she does. I found that really helpful and it made me think more highly of her because I realized that she was keeping a reference map in her head about me and that nothing she was asking me was capricious.

Sometimes I wouldn't be able to say a lot but she would see and hear what I wasn't saying verbally. I'm quite smart and I'm also a control freak so it dismayed me when she noticed something about me that I didn't know about myself. It's taken her awhile to have that capacity but she's really in tune with me. That's another way in which she scored points and gained my trust.

Another factor is that I've been able to depend on her and ask her for help. I didn't always feel I could but . . . but it's kind of grown over the last couple of years. I had some significant stuff happen two years ago where I had a violent reaction to something and partially smashed up a house. I was completely dismayed by it and could have potentially gotten into quite a bit of legal trouble. My therapist was the first person I called. She gave me her home number and I only used it once but the fact that I could was ~ silence ~ I never had a sense of how to depend on anyone before. None of that

stuff was ever modeled for me in my family and . . . and I feel as if I've been re-parented to a certain degree. I was pathologically independent for a long time and that was a real impediment in terms of my relationship to others. I learned from my therapist that I could depend on her ~ silence ~ I asked her to help me out and I knew that she'd be there.

Anything that I see as provocative where I think I'm being manipulated or confronted to have some kind of feeling isn't helpful. Role playing or dialoguing with my dead mother hasn't worked well for me and I find those techniques quite manipulative. I also detest people just sitting there in silence and using it as a therapeutic strategy. A counsellor that I saw in the past used to do that and I found it torturous. That same counsellor also moved too quickly into emotions and asked questions like, "Why are you here? What do you want to get out of seeing me?" For me, it was enough to just get myself into her office and I think it's unrealistic for someone with my degree of trauma to have a counsellor ask questions like that.

It also doesn't help when therapists follow some prescribed track from a textbook and aren't willing to switch modalities to suit the client and . . . and it's unhelpful when they don't challenge me on what I'm doing. I was in a treatment group for people with addictions and I got through the entire group by getting everyone else to talk and I avoided saying anything at all about myself. I'm really good at deflecting attention away from myself and what I'm feeling and I have learned to present in such a dissociative way that . . . the facilitators of the group didn't do anything about it and I really needed someone to challenge me about what I was feeling right there in that moment. I don't know what they could have done ~ silence ~ to be honest, I probably would have defended myself against anything they said.

I was diagnosed as borderline several years ago and that wasn't helpful. I'm not borderline and . . . and it really angered me that someone would say that because when you look at anyone with my history of course they would show up that way. I was also sent to a therapist who specializes in the area of multiple personality disorder and was assessed as someone who should be on a positive watch for multiplicity. For awhile I thought, can this be true? And then I thought of course it can't be true! I've had numerous suicide attempts, problems with relationships and addictions, and maladaptive and highly entrenched ways of meeting the world but all of that is about my abuse history and none of it makes me borderline or multiple. I felt quite sad about how that therapist diagnosed me because we had done some valuable work and those diagnoses really accelerated my sarcasm towards her. It was just so wrong and I thought it was ridiculous!

If I could give advice to the person I was at the beginning of my journey from where I am today, I would tell myself to seek help earlier. I was in a maladaptive coping style for a very long time and I stayed there a lot longer than I needed to. I didn't have any reference point to the fact that the problems I was having were things that could be described and it never occurred to me that they were things I could be helped with. I would tell myself that not every therapist is going to be a good fit and if you don't connect with someone it doesn't mean you're a failure. I made the mistake of doing that with a counsellor who was quite well known and everyone said was really good. My assumption was that if I didn't connect with her then it was about the degree to which I was damaged and if she couldn't help me I was never going to get better. I now have the frame of reference to say, "This counsellor might be great for some but she isn't good

for me.” I would advise myself and anyone who experienced something similar to not embody whatever pathology or label they receive ~ silence ~ that can be too damaging.

In my life I have gone through a lot and I can’t negate the fact that my struggles have given me knowledge and strength but . . . but at the same time, I also feel that I’ve lost a huge part of my life. I’ve lived with this chronically numbed out feeling for a long time and now at 48 I’m finally in the process of recovering from it. I’m better at cluing myself into the fact that I could be dissociating or zoning out and I recognize my patterns of doing that.

My work with my therapist has helped me dissociate less because now there’s less of a need to dissociate. I have a bigger capacity to tolerate feelings. I can breathe without having to hold my breath and I don’t have that cement block in my chest all the time. In some ways, your research is looking for techniques that therapists can use to help a person who dissociates but it’s really not about techniques. It’s about the therapeutic relationship. The therapist I see is very warm yet at the same time, very matter-of-fact. She has a good sense of humor and she shows me that I can laugh at my own experiences. She acknowledges my resiliency and that’s important because anyone who doesn’t is being disrespectful and disempowering and right away, I would dismiss that person’s ability to be of any value to me. My therapist is genuine in our relationship and I think that’s critical because survivors of trauma know. We know how to recognize whether a person is being real or not and she needed to be genuine with me in order to be successful. I use my relationship with her as a model for other relationships that I’m in because . . . because in a way, it’s like having a surrogate relationship with a person who teaches you how to be in the world. I . . . I feel really lucky to have met up with her

~ silence ~ I've learned a lot from just being able to trust and depend on the fact that she'll be there.

### **“Teresa”**

Earlier this year, my biological father died ~ silence ~ I was estranged from him for a really long time but I have a brother, a sister, and a mother who are still living. They all live in Europe and given that we didn't grow up in the greatest of circumstances, it's surprising that my relationship with them has never been conflictual. I'm 49 years old, work full time, and have two children whom I raise as a single parent. When I was seven or eight, my mother left my father and immediately re-married and when I was 15, she left that father and again re-married soon after. My stepfather was diagnosed as a psychopath and sexually abused me until I was 15 but prior to that I was involved in ritual abuse with my biological father ~ silence ~ the ritual abuse began when I was three and lasted for about five years.

Unconsciously, my mother must have known but . . . but in a lot of ways, she was psychologically deaf and blind because she was in survival mode herself. One time my father stabbed her and she nearly died and she was completely controlled by her husbands. None of my fathers worked so my mother always had minimum wage jobs to support us all. It was hard for her yet I never saw her cry. When I told my mother that I was sexually abused, she shut down and didn't want to talk about it ~ silence ~ a week later, she broke down, started crying, and said she was really sorry.

#### Experience of Dissociation

For me, there are two levels of dissociation. At one level, your emotions shut down and you feel spaced out. Empty. You're on automatic so you carry on and

function but the body is phased out so part of your entire make up is gone. I don't remember having any emotions until I started theatre school at the age of 32 and it was like nothing was there and you learn how to be in life by following what other people do. You're supposed to be happy when that happens so okay, I'll act happy but you're not connected to anyone ~ silence ~ you're not even connected to the world. Dissociation is like talking through a fog and trying to think through molasses. It's . . . it's hollow ~ silence ~ I really was a shell that had no center.

The other level of dissociation is when you're gone . . . gone to the lost parts and when that happens, you're not aware of it until something tugs at you and brings you back. These lost parts . . . there are about four of them for me . . . four little people and they are all very different. Little T. She's three and she's very afraid. She stayed on the stairs that led down to the place where the abuse happened and never got off. She just stayed there . . . third stair down . . . pushed in the corner ~ silence ~ it's like she was frozen there . . . frozen in time.

Wild Girl. She's three as well and she split off during part of the abuse where a curse was performed and got banished to a different dimension . . . banished to a hell world . . . and when that happened she felt complete loss and hopelessness. For Wild Girl there was no option. She's very self-sufficient. If you can imagine a three year old surviving on her own with no parents . . . that's what she looks like . . . totally disheveled with cuts and bleeding all over. She's very wary . . . very, very wary . . . like an animal would be . . . always on alert (see Figure 4.5).

Faint Girl is also three but ~ tears ~ but I don't think I can draw her. I remember the split completely. It was because of the pain . . . total physical pain . . . and I needed to go because I couldn't stay any longer ~ tears ~

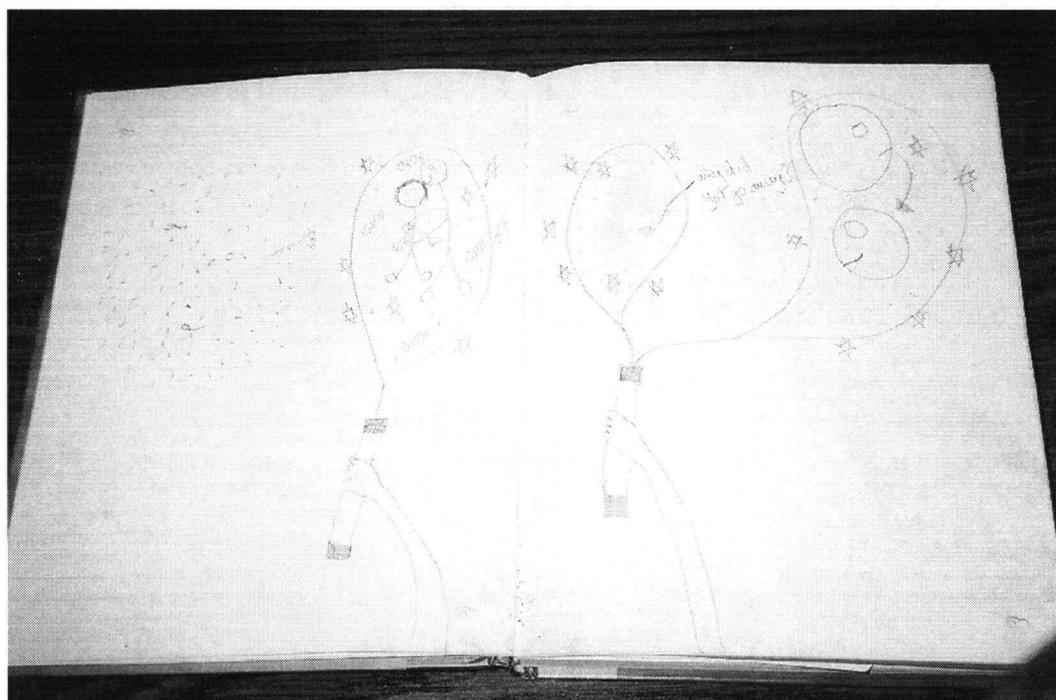
8 . . . she's eight years old and she began when I started passing out at school. We used to have these assemblies and sing hymns every morning and that triggered something in me because I used to pass out and even though it was investigated, no one could ever find a physical or organic reason as to why ~ silence ~ 8 and Faint Girl are connected. They're connected but I'm not sure how.

Figure 4.5. Teresa's Drawing I



The three year olds . . . they're the little ones and . . . and they split off when the abuse started ~ tears ~ they can't speak ~ silence ~ my therapist asked me once, "If a clown could wave a magic wand, what would I want to happen?" I used to think that God was this big presence that turned away from me and the magic wand would have God turn around and face me ~ tears ~ Little T drew this. These are her eyes . . . no body . . . and her hand is reaching out ~ silence ~ this is dissociation. I'm rubbed out . . . erased . . . gone (see Figure 4.6).

Figure 4.6. Teresa's Drawing II



Dissociation is both bad and good. It's bad because when I dissociate I feel half dead. It's like everyone else is carrying on in the world but I'm not here. It stops me from connecting to myself and others and that feels very empty but . . . but it's also good because without it I honestly believe I would have ended up in the psych ward. It enabled me to function in everyday life . . . it still does . . . because if I get in trouble, I can be on auto mode and still go to work and look after my daughter. Dissociation makes it so that the little ones aren't able to speak and that's a good thing because if

they could speak and told someone the bizarre things that were happening, no one would have believed me ~ silence ~ if those parts hadn't gotten lost, I really don't know where I would be.

#### Journal Entry: Going Into "The Faint"

Inside the blackness was silence, nothing, a thoughtlessness that stretched to eternity. I just "existed" there with nothing to feel, nothing to do, no thoughts to promote any action or being of any kind. I guess I don't really know why or how I existed, I just did . . . I then "felt" a presence, an awareness of something that slipped into my "tummy", something that suggested I needed this blackness to protect "the core". To protect the core from dying.

#### Treatment of Dissociation

I really resisted the therapy process completely ~ laughs ~ I had the attitude that no therapy would work and that all I needed to do was pull up my socks and get on with it. I'm used to dealing with things on my own and I don't tell anyone I'm in trouble until after I've figured it all out. I started counselling when I was in theatre school but I only went for a couple of months. A few years later I joined a residential therapy program and then when I was having my daughter, I went to some workshops to tie up loose ends and make sure I wasn't going to pass anything from my childhood onto her.

The counsellor I see now is very helpful. She never pushes me and is completely non-threatening. When I dissociate, she talks to me and when I hear her voice I'm pulled back to the present. I don't think it matters what she says although at one point, I remember her telling me that my children needed me and it was time to come back. When my therapist and I first started she was a student and that was a plus because it made her more open. She also uses a lot of non-traditional methods and that has been incredibly valuable. One of the first things she did was take me on a journey to find my

power animals and I know that sounds crazy but I can't tell you how much that has affected my everyday life. Right now, I have several power animals and each one serves a very specific purpose.

Lion. Lion has been amazing in teaching me how to stand up for myself . . . to have a voice . . . and to stay present with my feelings. Lion helps me in my relationship with others and teaches me that I don't have to sacrifice myself or put up with anyone treating me badly.

#### Journal Entry: The Lions' Den

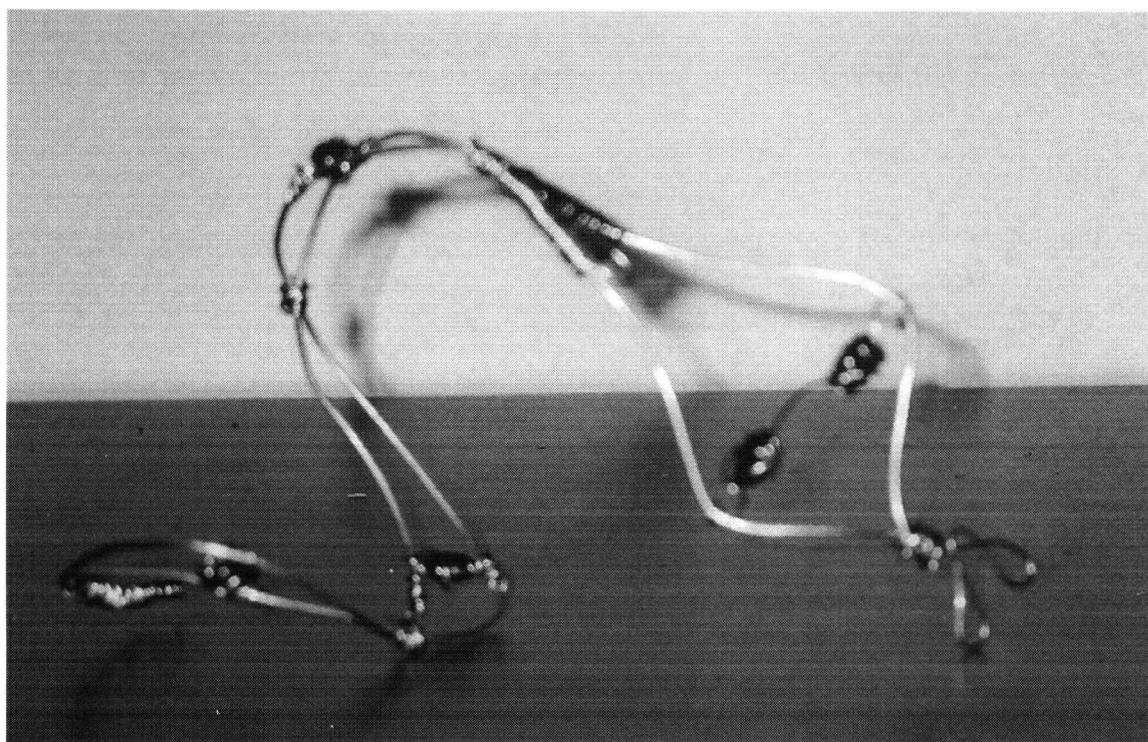
At that moment a huge lion emerged from the scene and stood beside me . . . the lion told me he would help me to reach into myself to find a way out, but it was me who had to do the reaching . . . then a picture emerged of somehow the lion instilling in me the confidence to go out there with a stance and a "roaring ability" that matched that of the lions. Matched being the main important word. Not a lion's roar, still human. Not louder than them or in a way that was more aggressive but which carried an "authority", an ability to "stop them in their tracks".

Rabbit is also very prevalent and . . . and he comforts the little ones. Rabbit is always there whenever they're afraid ~ silence ~ snake. Symbolically, snake represents turning something very bad into something good. When snake first appeared, he scared me but eventually I realized that he was there to keep me safe. I made this to wear around my leg. It's one of my protectors . . . snake is my safety (see Figure 4.7).

In some ways, visualizing these power animals can seem like dissociation but it's not because when I visualize these animals, it totally brings me back to the present.

The ritual abuse I experienced was very bizarre but somehow all of this imagery and symbology gives me the roots to understand it. For the first time in my life, my world makes sense! For me, these animals hold a language that everyday language doesn't hold because if you think about it, I was three when the abuse started. I didn't have a lot of language and like all children, I saw things in images. Children relate to animals so these visualizations give the little ones a way to communicate. It . . . it offers them a way to heal ~ silence ~ these animals have given me back my life.

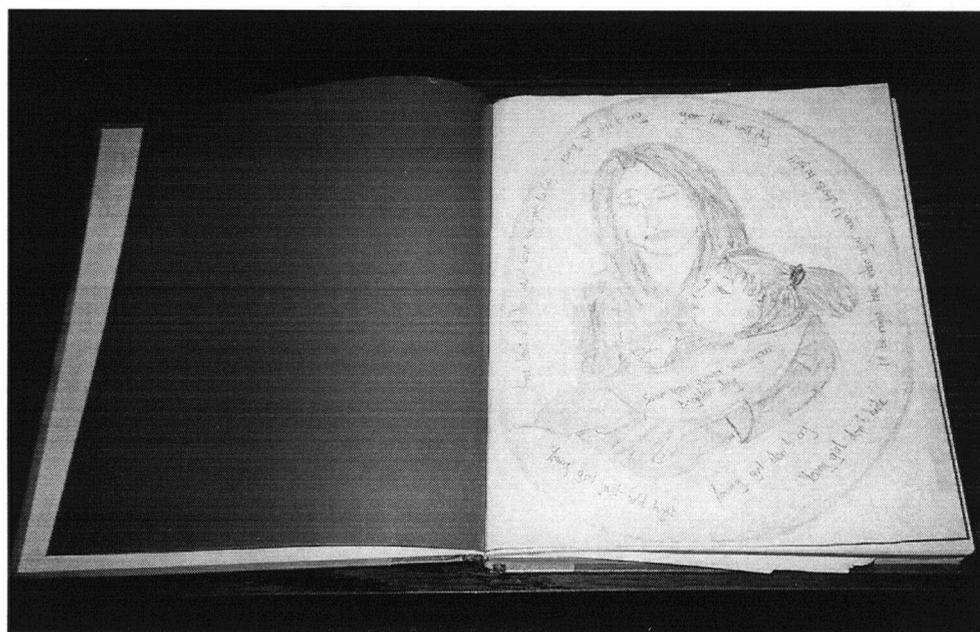
Figure 4.7. Teresa's Protector



My therapist also uses an experiential process . . . a re-enactment . . . that allows me to connect with those lost parts that split away when the abuse happened. A few years ago my therapist led me through an enactment to help me go back and get the little girl . . . Little T . . . who was left frozen on the stairs. We re-created a scene where I became that little girl and enacted it from the perspective of what might have happened

if my mom came home and found out what was happening. In a sense, we changed the ending and . . . and even though I know that ending didn't really happen the enactment gave the little girl a corrective experience and allowed her to heal and be embraced by her mother ~ silence ~ for the longest time, I always felt that pieces of me were missing . . . pieces of me that were lost and I didn't have access to but . . . but the enactment gave me an embodied experience that helped me get those pieces back. When I re-connected with Little T, I felt something change at a really deep and cellular level. Somehow it enabled me to go back and get Little T off of those stairs (see Figure 4.8).

Figure 4.8. Teresa's Drawing III



As a person, my therapist is very genuine and she truly cares but . . . but I didn't always believe that. I tend to think that if you're paying someone to be there for you then of course, they're going to say nice things ~ laughs ~ my therapist shows she genuinely cares by knowing me and knowing me beyond words. I often have a hard time using words to communicate and I feel stupid and think I should just snap out of it and speak but . . . but my therapist can hear what it is that I'm not saying and that helps me

trust her. Also for awhile my therapist and I were in regular email contact but at one point her emails just stopped. I didn't know it at the time but I later found out that she was in a situation where she needed to pack up and move away. She didn't have to do this but after some time, she sought me out. She sought me out and said how sorry she was for losing touch and I could hear in her voice that she was feeling some emotion. That was a real pivotal moment and I knew at that point that her care for me was genuine.

I'm probably my own worst enemy when it comes to things that aren't helpful ~ laughs ~ I often beat myself up by telling myself "I should be over this!" or "I shouldn't be having trouble because anyone else would be fixed by now!" All of the labels I put onto myself . . . not seeing myself as normal . . . and believing that if people really knew me, they would run away and leave. I had a bad experience where I told a counsellor about a blood ritual I experienced and she told me that was really bad and when things like that happen, a person can be scarred for life and never get better. That was really damaging so I tend to not reach out. There aren't many people who know my story ~ silence ~ I certainly choose very carefully where and with who I share it.

For therapists, it's important to know that talking alone isn't going to help. Traditional talk therapy gave me an awareness as to why I was messed up but it didn't change the fact that I was messed up. Therapists need to use something that goes beyond talking . . . something experiential because . . . because when abuse happens, there really are no words for it ~ silence ~ an experiential process goes beyond words . . . beyond cognition and intellect . . . and takes a person deeper into the experience where healing can occur. Therapists also need to find a way to communicate with those young parts because it

was the child parts, not the adult parts that were abused. Little T, Faint Girl, and Wild Girl can't speak and they don't write very well but . . . but they can draw and their pictures are their way of speaking ~ silence ~

There will never be an exact same route of healing for everyone. Clients need to decide for themselves what route is best and therapists need to facilitate that process and use what clients connect with to do something experiential. For me, it was movement or drama but it may not be that for everyone. Therapists should encourage clients to follow their intuition and trust that they know what they need even though they may not be consciously be aware of it. **We need to find our own answers!** The answers will come in their own time but it can't be rushed because if it is and we feel pressured, we're no longer safe. Dissociation happens so fast and it takes a real conscious effort to come back. If it's not safe, we'll dissociate and be gone.

I used to feel that there was something wrong with me . . . that I was different than everyone else . . . but now I realize that I'm being guided on a special journey ~ silence ~ during the abuse I used to focus on this light . . . a light that came and took me into its presence . . . and when that light was there I knew that everything was going to be okay. That light was my lifeline but . . . but one day that light disappeared. It never came back and that was the most painful thing. I was devastated ~ silence ~ with my therapist, we were able to get that light back and even though it's not back to the same degree I experienced as a child, it's there and by reconnecting with it, I re-connected to a spirit world. Today, I'm a lot more present than I used to be and when I'm not dissociating, I can actually feel! I feel more solid . . . more present . . . and it's as if someone turned on the light and something is radiating

from within me. The world is brighter, colors are stronger . . . more vivid . . . and everything just feels more alive!

### **“Christopher”**

I’m the youngest of eight children . . . six older brothers and a sister . . . and my family fled the Soviet Union as refugees right after the Second World War. My father was a decent man but very unhappy. I mean, he had eight kids, was a prisoner of war, and he and my mother first fled to South America where they absolutely hated it! As the youngest, I think I was sheltered from my father’s unhappiness to a certain degree and my oldest brothers bore the brunt of his stress but as the saying goes, shit rolls downhill  
~ laughs ~

The sexual abuse started when I was ~ sigh ~ it’s amazing how hard it is to remember all of this ~ silence ~ it started when I was around six and stopped when I was eleven and it was my sister who sexually abused me. In 1986, I confronted my sister and then ten years later she called me back to . . . not to confess . . . but to put it into context by telling me that she too had been sexually abused by our older brother and that he was sort of coached by another brother. That just blew me out of the water! My older brothers were my heroes yet . . . yet at the same time, they were they ones that made my life miserable. To a child, abusers are all-powerful and . . . and I looked up to them. To know that my brothers did that ~ silence ~ it was a very painful realization.

Dream (Recurring):

Someone is with me and there is a promise of something good . . . something wonderful . . . but when I look around I see that there are dead babies

everywhere. Dismembered. Disjointed. Bloody. I wake up screaming. I'm afraid. Too afraid to turn on the lights. I'm afraid that if I turn on the lights I will see that there is blood everywhere.

For me, there is a real loss of childhood . . . a childhood that was very much taken away . . . dismembered . . . stolen ~ silence ~ I'm close to one brother but I don't have much to do with the rest of them and to be honest, I try not to think about those people at all ~ silence ~ I'm 45 years old, married with two boys, and I'm a self-employed family physician. My brothers live elsewhere in Canada and . . . and I think for me, moving to Vancouver was a bit of a geographical cure ~ laughs ~

#### Experience of Dissociation

When my therapist told me that I would be a good candidate for your research I was surprised because . . . well, because I don't dissociate! ~laughs ~ but obviously I do because when I said that to my wife she just laughed and rolled her eyes! I'm not sure what my wife notices but she sees it in me and can tell that sometimes I'm just not there. For example, I'll spend a lot of time reading and even though the books I read aren't that great when I read, I'll be completely gone. I also used to cycle a lot . . . I'd cycle for hours at a time . . . and I'd end up in places without knowing how I got there. I mean, I know I got there by bicycling but I'd have no idea what route I took or what towns I cycled through to get to where I was. Also, for various surgical procedures, I'll refuse anesthetic. The other doctors think I'm nuts but I don't need anesthetic because I know how to go away on my own. Actually when I have anesthetic that really screws me up because then I'm forced to be present when I don't want to be and I lose control of my ability to go where I want to go.

There are times when I dissociate and I'm in complete control. I choose when I leave and where I go and in those moments I usually find myself flying. I'm not really flying but I'm flying in my mind and . . . and it's not an out-of-body experience but it's a sense of floating in the air. I do the same with an image of sailing but again it's a feeling of floating and when I do that I very easily escape to a state of ungroundedness. It's interesting because when that happens I'm not aware of any physical sensations but I experience a sense of mastery . . . not mastery over my body but over a skill or . . . or a machine ~ silence ~ at other times when my need to escape is triggered by stress, worry, or anxiety ~ sigh ~ then I don't know where I go ~ silence ~ I'm just gone. It's a nothingness and I float off into nowhere.

In a lot of ways, I seek out these experiences of escape because some of my most real feelings of peace occur when I dissociate. I've worked really hard at learning how to induce myself into a trance-like state. For example, if I have to go through a medical procedure that's painful, I have specific inductions that I practice where I think about where I want to go and then I see myself going deeper and deeper into that place until the painful experience is over. I don't worry about being able to dissociate but unfortunately, I don't have a very smooth or ritualized way of coming back ~ laughs ~ I mean, why would I want to be here when it's so much better over there?

Dissociation has been positive because I think I've been able to find a good place within myself and be comfortable there. It has also allowed me to withstand some otherwise uncomfortable situations but . . . but at the same time, I feel sad about my escapes because even though they're peaceful, I'm always alone. I guess that's another way in which I experience dissociation. For me, it's an experience of being an other . . . an other on the outside looking in and . . . and I've experienced that my entire life.

Whenever I escape I never imagine myself with anyone else and my experience of dissociation is always solitary. It's a disconnection from myself and others and that's really hard because . . . well, because I'm the disconnected male and the sacrifices of that are huge! For example, when guys talk in the locker room or when they tell each other "Nice shot!" or "Good show!" or when they somehow know how to trust each other without showing any feelings . . . I just don't get it! I mean, I can relate but not really and that's difficult because I feel apart from everything yet at the same time I have an intense desire to fit in. So it's like wanting to fit in but not being able to and knowing that I have something to offer but not knowing what that something is. In some ways, that feeling of being an other is less with women than men but . . . but it's hard ~ silence ~ maybe that's why I don't have many friends.

Anxiety. Stress. Worry. Those are all things that will lead me to dissociate but I think one of my biggest triggers is having to face certain messages I got in childhood . . . messages that say I'll never be good enough and that I was born less than. I mean, **Who do I think I am? I can't be big. I'm small. I'll never amount to anything!** It's strange because there is a part of me that really craves rewards yet at the same time, I can't seem to accept them. If I do accept them then I'm forced to confront those early messages and I'll dissociate or sabotage my involvement in anything that will lead to success or recognition. I mean, maybe I do have the skills to further some larger project. I've actually been asked to be involved in various things but if I get involved that would mean I might succeed and . . . and I'm really not good enough for that! Lately, I've been seeing dissociation as becoming more problematic all the time. For example, I have a really good job and I'm very proud of what I do but I could be mediocre for the

rest of my career because instead of confronting something I'd like to accomplish, I'll retreat and disappear. When I'm stressed or triggered, I seek my escape and in that way, dissociation is a weakness because it prevents me from connecting with who I am and seeing myself as successful or good in any way ~silence ~ I guess it's an issue I'm going to have to deal with.

#### Treatment of Dissociation

I started my therapy process by just muddling through . . . doing some reading and trying to figure things out on my own . . . but I don't think I really got anywhere. I remember reading books like *Victims No Longer* about men who had been sexually abused and getting connected with a group of male survivors through the internet. I educated myself and connected with others who shared a similar experience and that was helpful because I think there's a real lack of understanding about men who have been sexually abused by women. The typical stereotype is that of a male perpetrator having power over a female victim and that's a real narrow understanding of sexual abuse. Abuse comes in many different forms and it's not just about power and force. There can also be some highly manipulative components and I think that's really important to recognize.

For me, formal therapy has been intermittent and it started after I confronted my sister and realized that my brothers weren't the superheroes I thought they were. I saw two therapists but the one I see right now has been quite helpful. There are several things that my therapist does but the most important is probably the fact that he challenges me. For example, when I go away in therapy my therapist will bring me back to the here-and-now and explore why it is that I went away in the first place. I mean, when I'm in escapist mode I'm comfortable but I'm in that mode for a reason and if I'm

escaping then what is it that I'm escaping from? My therapist will ask questions like, "You seem to be in another place right now. Are you okay? Can you tell me where you are?" And if I say I don't know, he'll say, "What do you mean you don't know? Let's stop and look at that for a second." I might not be able to talk about it in that moment and . . . and it's good that my therapist doesn't stop me from zoning out because I would not want him to do that . . . but later he'll say, "You know something really powerful happened and at the time you didn't want to talk about it but this is what I noticed. When we talked about this, you seemed to go away and I'm wondering if that was a trigger for you." By helping me explore what's happening in the moment I can become more aware of what it is that I'm escaping from and somehow find new ways of dealing with things without needing to dissociate ~ sigh ~ somehow I need to learn how to protect myself and not disappear.

It also helps when my therapist explores how dissociating helps me and challenges me to understand how it might hurt me. It helps because my therapist is present . . . very, very present . . . and he doesn't force me to go in a direction if I'm not ready because if he did, it would hurt me. I mean, I may not be ready to go somewhere but my therapist will radiate a sense of confidence in me that says, "Okay, when you're ready we'll go there and when we go there, we'll go there together." For example, a few years ago my therapist led me through a therapeutic enactment where I was able to recreate a scene and confront my brothers for raping my sister. It took me years to get to that point but when I was ready my therapist was there and I was able to reclaim my sister as my sister. Through the enactment, I took something back and it was so real . . . so emotional . . . and the people who were there to witness it were so supportive. In terms of stopping me from dissociating, I think it was helpful that my

therapist and I were walking and moving the entire time. There's something critical about that . . . physically moving . . . walking without stopping . . . and somehow that was key in helping me stay present.

It helps because my therapist and I have a good relationship and I trust him a great deal. It's interesting because right now, I'm at a point where I can have a tussle with him and he convinces me that it's okay. My experience in my family was one of conflict-avoidance . . . and conflict-avoidance to a pathological degree . . . and to be able to be angry at someone and know that it's okay has been critical. I can say to him, "You know, you really make me mad!" and for me to be able to say that has been highly therapeutic.

Overall, I'm fairly happy about how my journey has gone. My therapist helped me realize that this is a journey and on this journey, I may experience some losses and I think that was really important for me to know. For example, when I confronted my sister, I lost things. I lost my brothers. I lost those superheroes and . . . and it helped when my therapist made me realize that I never really had those superheroes in the first place ~ silence ~ I still find it very difficult to talk about my brothers. It's like there's this big secret that almost everyone in my family is in denial about and . . . and I don't do secrets! If someone asks me what happened, I'll tell them and in that way, my brothers are afraid of me because if I talk, I'll tell the truth and if I tell the truth, they'll hurt. To a certain degree, I'm free of the hold my brothers have on me but . . . but I know I'm not completely free ~ silence ~ I know that I still have a lot more work to do.

I don't think I've experienced anything really negative or harmful from a therapist. I mean, I wouldn't want my therapist to say, "It will be better once we talk

about something” or “It’ll be good once we get to that part of the journey” because . . . well, because no one knows that! Actually when I think about it dissociation hasn’t really been dealt with until recently because I don’t have a sense that previous therapists did a good job of calling me back. I think some therapists believe that if a person dissociates then that’s okay because the client just needs to go away to a safe place for awhile. That’s true but you know what? I’m 45 years old and maybe my means of escaping is a reflex that’s no longer beneficial. Maybe I’ve been doing it for a long enough time and maybe I need to find ways of **NOT** escaping and staying in the here-and-now.

Advice to therapists? Well, a couple of things come to mind. Be present. Don’t be afraid of dissociation because being able to dissociate is a gift. I’ve never had the experience of dissociating and not coming back so go there with your client and maybe even go into the dissociation and use it to learn what it is that the client is escaping from. Maybe within the dissociation there is a kernel or a key that will open something else up. So explore where your clients goes because maybe where they go is important.

I think it’s also important to really listen to your clients and embody the fact that your client might have something important to say. Clients might already know their own answers and if you talk too much or talk just to fill up the space with words, you might miss learning about what it is that your client knows. It’s also important that therapists give clients control and travel the journey with them because then clients leave with a sense of support and empowerment. For me, it helps because my therapist has the guts to go there and embodies the fact that this is my journey. I mean, I know it’s a journey that my therapist cannot go on for me but he will be with me and if

therapists are safe and there's good rapport then when clients are ready, they will go there and they will be okay.

Over the years, I think I've grown a lot in terms of what I expect from a therapist. For me, a therapist needs to have a certain degree of wisdom and insight and . . . and unconditional positive regard is critical. I hesitate to use the word love because I think that's often laden with stuff we don't want but that's what it is. It's about love and having that unconditional positive regard for another. My therapist convinces me that I'm okay and challenges me in a real caring manner and I think when therapists do that in a genuine way, clients are in a better position to develop love and unconditional regard for themselves.

If I were to give advice to others who share a similar experience, I would have to say, just keep going. Keep up the courage. Once the healing process starts, it's not going to stop and even if you've changed your mind and want to go back to the way things were, you can't. Healing is happening and it's important to know that there will be bumps along the way. Sometimes it might feel as if you're going sideways or backwards but remember you're still moving and in the end you're always moving forward.

### **“Rachel”**

When I was born, my mom was single. She claims that she was at a party and her drink was drugged and that she had me after just a one night thing but . . . but I heard a different story another time. After I was born my mom kept me for the first six weeks and then put me in a foster home and I think that's when the first split happened. You see, I'm multiple. I'm diagnosed with DID and . . . and I think our first split happened

because I had my mom for the first six weeks and then suddenly she was gone. The people at the first foster home were neglectful . . . maybe even abusive . . . and I was slow like I couldn't sit up like a normal baby should so I was taken out of there and placed into another home. The second foster home was better but I didn't stay there long because when I was 3½ my mom came and got me and I went to live with her in a boarding home.

My mom was very good at dissociating herself so she never knew what was going on. She worked everyday and I was sent to a nursery school and that's where the ritual abuse happened. The ritual abuse began when I was 3½ and went on until I was about 12 but . . . but an uncle of the woman who ran the nursery school was also involved in the rituals and he befriended my mom and eventually became my stepfather. My stepfather abused me in both the ritual abuse setting and also at home and that went on until he died when I was 16. Also, another member of the ritual group arranged for me to go to his place after school and he continued the abuse until he killed himself when I was 17 ~ silence ~ by the age of 17, all of the abuse was over.

Right now, I'm on partial disability but I do a bit of work through a mental health agency. As far as I know, we have 180 alters. We're all different ages but I'm 53. I'm not married and I have a son whose 26.

#### Experience of Dissociation

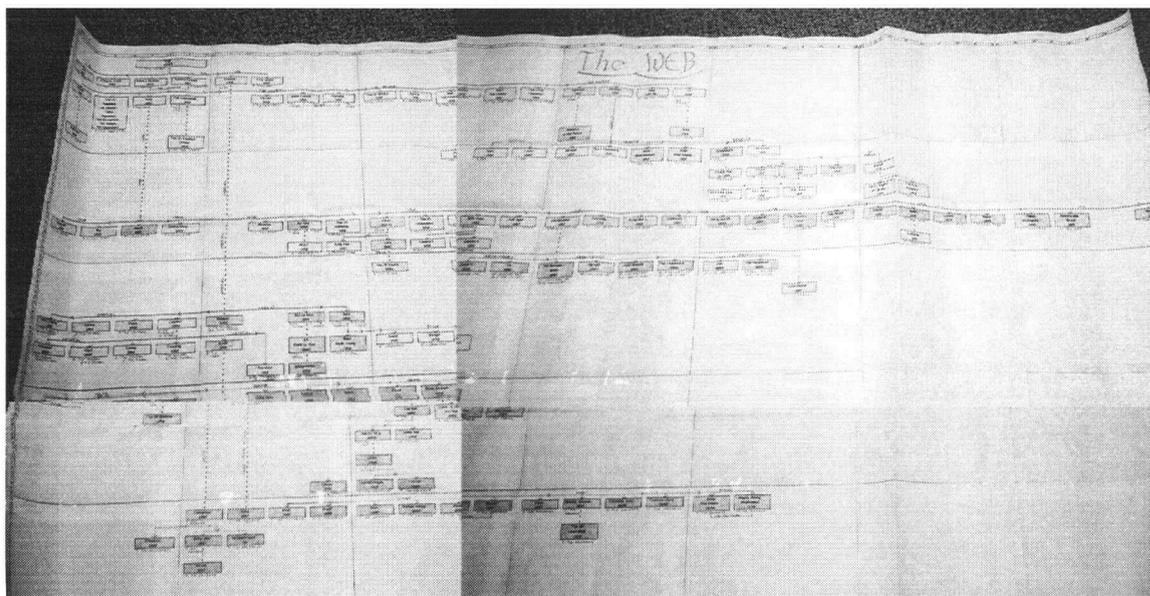
I like the term dissociation but we also call it spacing out, empty, an emotional deadness, dreamlike, unreal . . . sort of like what happens when someone gets stoned on drugs and everything feels very different, unfamiliar, and strange. Dissociation is a feeling of falling backwards or . . . or a sensation of tipping over into darkness. It's deadening . . . dead, dead, no feelings, dead . . . and sometimes, I don't feel any emotion

while at other times I'm overly emotional . . . hysterical . . . and I go into intense emotions that don't seem to match the situation.

For us, there are two kinds of dissociation. One is a numbing or cutting off of awareness. For example, there are all these things we perceive in the world and dissociation cuts off or filters out what I'm hearing so I don't hear certain sounds. The other is focusing. For example, a child being abused might say that she is going to become a bug on the wall and she'll focus on that bug until she is that bug and is able to tune out everything that's happening. The numbing and focusing happen at the same time and with multiplicity it's the same but instead of becoming a bug on the wall we become another person.

This is [part of] The Web (see Figure 4.9). Within The Web, there are seven or eight groups. Tir is the original person. She's soft and quiet but very melodramatic. She experienced some of the abuse but not a lot. I guess she's not officially an alter because if we hadn't been abused, she would be the only one here ~ silence ~

Figure 4.9. Rachel's Web



The first group is The Children of Thirteen. They were created quite early and there's me. My name is Shell and I'm here because another alter created me but . . . but I'm not always the one talking to you. Gabriel is here too. He's very tall and when we walk I can tell that he's here because my stride lengthens. His legs are long and I can feel myself get taller. Ariel's here too. She always knows what's going on and you'll know when she's here because she'll crack a joke or something ~ laughs ~ she loves humor. The kids . . . well, they aren't here today. They find all this research stuff too boring but ~ laughs ~ but Othel's here. He plays a large part in all of this because he's the organizer and he's the one that keeps things going.

For the most part, we all feel very connected. We see ourselves as separate and . . . and it's like we're separate but we have a sense of wholeness and that's why we call it The Web. It's like a spider's web where if you touch one corner the whole thing vibrates and everyone feels it so if one of us is in pain, we all know. The connection we have grew over time. We weren't always this connected . . . not at all . . . because there are some of us that are really destructive ~ silence ~ like Ethan. His way of dealing with things is through psychosis and for years, he was in and out of psychotic states and . . . and then there's Razor Man. He's one of the Thirteen and he's called Razor Man because he likes cutting and his rage would often come forward.

In the past, Razor Man was really out to get me. He wanted to have me out of the way so he threatened me and made life really difficult. A few years ago when we were working with a counsellor, Razor Man was really present. We trusted that counsellor so some of us were making ourselves known and Razor Man didn't like that whatsoever. He felt threatened and wanted control so he wrote notes telling the counsellor that he was making us angry and that we wanted to kill him. I don't think the counsellor was

prepared for that. It got to the point where the agency he worked for told us that we weren't allowed to go near him anymore and the mental health team came and diagnosed me as psychotic, suicidal, and homicidal. The whole thing happened so quickly. The counsellor ended our relationship and it felt like abandonment but . . . but it wasn't me ~ silence ~ it was Razor Man.

For us, dissociation has definitely been a gift. I mean, it's a way of coping and if we didn't have it maybe we would have ended up psychotic or dead. Some of us were put inside a coffin box and dissociation let us go away and be dead just to survive. Others were created out of pain ~ silence ~ I don't know why we all got created but . . . but I guess we needed to.

Different things trigger dissociation. Right now we're triggered every time we drive along a winding country road or when we see a car on t.v. drive through the country side. Ethan is especially triggered by that so I guess it has some connection to the past. When another alter is present, I go into a retreat zone where it's blank . . . nothing . . . nothing happens during that time and then suddenly I come forward, look at the clock, and two or three hours has passed. It's like having a nap and during that time, I'd have no idea what the others have been doing.

Even though dissociation has been positive, it has its downside in terms of spacing out or not being connected. Sometimes I think it makes me lack empathy because it numbs me out emotionally or . . . or I feel that I'm a space case because I don't know how I got somewhere or I experience a loss of time. We used to refer to dissociation as falling into The Red because . . . well, I guess because when you close your eyes, things go red and that's the color you see. When I first started to find out about all these people inside, it was frightening but . . . but having to go through the

abuse memories was far more frightening and when they emerged dissociation took us into The Red . . . a kind of self-hypnotic trance . . . and I would curl up and get lost in all these different alters. It was horrible . . . yelling, screaming, crying ~ silence ~ it's like I would enter into something and couldn't get out.

Excerpts from: Sinking Into Red

Once you look back into  
 The Mirror  
 you will return home again  
 the portal is there  
 for us to return  
 into the deep  
 Red Wandering  
 Red Mist  
 Red Rain  
 Red Smoke  
 that swirls slowly as in a dream  
 A Red Dream  
 The Red  
 hums the song,  
 hums the tone,  
 ringing in waves through and through  
 turning everything to  
 Red.

Walk back into the Dream  
 back into the Light,  
 Rose Red Light  
 swallows you up,  
 closes behind you,  
 enfolds you into  
 the Red Red Drumming,  
 a Red Red Humming.  
 Go back, go back,  
 deeper and deeper into  
 The Red.  
 Fall into its giving  
 Into its easing  
 Fall back laughing in silent tears.

~ written by Rachel

Dissociation is . . . the image we have is sort of like three layers and there's this house and some of us are at the front of the house and those are the ones you will see. We relate directly to the world but just behind us is the second layer of alters who might be leaning out of the windows. This layer can see you and hear the conversation and they can even make comments or step forward to talk but . . . but that doesn't happen very often. The second layer usually doesn't interact with the outside world but they are always very aware of what's going on. The third layer has alters that are way in the back of the house and they may not even be paying attention to what's happening unless one of us calls them forward for information. In this way, The Web is very fluid . . . people coming and going, going and coming . . . with alters moving in and coming forward all the time.

Within these layers of interacting, there are also different levels of knowledge. I'm very low in knowledge. I know very little about what happened and that has protected me because it feels like the abuse didn't happen to me. Sometimes it's frustrating because I don't connect with the memories and I don't have a sense of being there because . . . well, because I wasn't. For those of us who have higher levels of knowledge ~ silence ~ I guess they're protected because they only know a portion of what happened. They have a buffer because the knowledge is split up so one person may know about this but they don't know about that ~ silence ~ to know everything would be too overwhelming.

#### Treatment of Dissociation

In 1990, I fell apart. I was in and out of hospitals, in and out of crises, and quite suicidal. I saw several people before I began working with my current therapist and we have been working together since 1991. My therapist has made a huge difference and

she has influenced us more than anyone has in our entire life. When I dissociate, she makes sure I stay grounded. She talks to us, tells us to look around at the things in the room, and sometimes she uses EMDR. If she thinks that we're really beginning to lose ground she'll say, "I feel that we're becoming ungrounded and I think you need to come back now. We need to stop and do something so we can go home." Other times, my therapist would ask if she could put her arm around me. Most often we would let her and that's helpful because it keeps us connected and tells us that she's there. Also for some of us, stuffed animals are really important. One time she even gave us one of her stuffed rabbits!

My therapist has a great way of working and understands stuff that no one else really can but . . . but I think the thing that helps the most is her presence. My therapist has an openness to her and sometimes she helps by just staying quiet or simply acknowledging that it was a painful thing that we went through. In session, she allows us to go through what we're going through and in some ways, she doesn't care who the alters are because she focuses on what's going on in the moment. If there's pain, she addresses the pain no matter whose it is and . . . and she has an unconditional positive regard that is very helpful. There was a time when I was drinking almost every day and I didn't tell her because I was afraid that she would be mad. When I finally told her she said, "This is a way of coping and I'm confident that you will work through it and that you won't be doing it forever." She always tells me that there is a good reason for the things that I do. She says that it's okay to feel what we're feeling and there's never any judgment or criticism. My therapist has a way of being in the world and . . . and that's how I want to be. In some ways, I've been able to transfer the way she is with me into my personal relationships with others and I think that has been really valuable.

Trust is hard. I don't trust very easily and even now, I don't think I trust my therapist 100%. It's growing though and I think it's grown for a few reasons. First, my therapist and I have been in conflict with each other and even though it's hard, it helps to know that we can be in conflict and still survive. Second, I think the trust grows because my therapist knows how to handle our rage really well. Razor Man used to threaten her too and she would just acknowledge what was happening by saying, "I know you can get really angry and that you could hurt me but I'm going to make sure that you don't. I need to protect myself because I want both of us to be safe." She understands that the rage and our expression of it happen when we feel powerless and she does her best not to do things that would take our power away. Also there are times when we felt like a real pain for phoning her so often but she would say, "You need to talk so it's okay and I'm really glad that you called." She always makes us feel that we aren't doing anything wrong and time and time again she proves to us that whenever we need her, she'll be there.

In terms of specific things that we might have done that helps . . . well, when I first started learning that I had this whole internal world it was as if all the things that were happening in our external world were represented as a symbol in our internal world. As I said, we weren't always this connected and early on, we did a joining ceremony that helped bring some of the alters together. A couple of years later, we had this image of six little children dressed in black capes lying frozen in a circle surrounded by this deep, dark, horrible trauma. We imagined a big log cabin and held a vigil for them where we just sat with them and let them be. It took a long time before we were able to connect with them but bit by bit those children came out of that frozen circle. The transformation was amazing! Now one of them is a bubbly six year old who gets

excited every time he sees a rainbow. It's like he's been reborn. It's like they've come alive!

Also when we were abused it was really drilled into us that we were not to tell ~ silence ~ some of us can't even talk so when we were introduced to art a whole world opened up for us. We were given paper and paintbrushes and for us, it was a doorway that allowed us to express the things that happened without needing to speak. Through art, we were able to tell our story without saying a word (see Figure 4.10).

Figure 4.10. Rachel's Drawing



It's hard to remember the harmful things that therapists might have done but . . . but I know that being in the hospital is definitely not helpful. The first time we went there it was terrifying. We had to wait in this little room so we curled up on the floor because some of the alters were really scared. One of the nurses came in and told us, "Get up! Stop behaving like that!" and that just added to the terror. Another thing is . . . my therapist is really good at sitting back and letting us do our own thing but

sometimes I wish she would ask more questions . . . curious and inviting questions . . . questions that make us think.

Also, it's harmful when therapists have their own agenda and think that they know what it is that we need. Once we worked with an art therapist who would tell us what she thought was happening in our drawings. She would say, "I think this alter really needs the other alters to tell her such and such." Well, maybe she was right but I would have preferred that she asked us what we thought was happening or what we thought we should say or do. I think it's also harmful when people say that we need to integrate. That's not what I want! I've been this way almost all my life and I don't know any other way of being. Some professionals who know a lot about dissociation and multiplicity have their own agenda and that's harmful because when it comes to our healing, we don't like people telling us what to do. When people do that, it feels disrespectful but . . . but right now, it helps because my therapist supports the choices we make and makes us feel that it's our agenda that matters. My therapist says that she doesn't know what it's like to live our life and her role is to be a witness and to walk along beside us.

For therapists working with clients who dissociate just be present. Encourage clients to stay present as well and if stuff comes up from the past then help them put it into context. Tell them that it's okay to feel what they're feeling and if you're safe, the alters will come out when they're ready. Work with them. Create a safe environment. Work with whatever alter wants to work with you. For us, usually one alter will come forward and we'll work with that one for awhile and then another will come forward but . . . but that's a pattern we have and I don't know if it's the same for others. It's important to work with the pain. Work with the now and . . . and it's okay to steer the

course if clients get ungrounded but always be gentle and let them know that if they feel uncomfortable they can stop anytime. It's also really important to believe your clients. There have been many times when we have thought to ourselves that we're making it all up . . . it can't be real! . . . so to have someone say that they don't believe us is absolutely devastating. It also important to have a real interest in how your clients experience the world and . . . and it's also okay to tell them about dissociation because when I first learned what dissociation was, I thought, "Finally, there is a word to describe how I feel!"

For others going through the same thing we are, just trust where you're going. When I first started this process, I had an image of a dark path and as scary as it was, I knew that it was a path that I needed to follow. So trust yourself. A group facilitator told me once that in some ways it doesn't matter what's real or not because what matters is that we follow our truth whatever that truth may be.

## **CHAPTER FIVE THE RESEARCHER'S STORY**

The purpose of this chapter is to give voice to my own personal thoughts and feelings that surfaced in response to each participant's story and add to the collective narrative that unfolds on the experience and treatment of dissociation. As the researcher-observer, I am actively involved in the co-construction of each finding. My reflexive voice provides transparency to my own process of discovery and serves as a bridge between the individual voice of the participants and the shared story that emerged from the themes that appear across narratives. In this chapter, I bring forth excerpts from my own research journal that spans a 15 month period beginning with the completion of my research interviews. By including my voice, I share my story of the participants' stories and shed light on the parallel process in which I travel.

### **Journal Entries**

March 2006. Reflecting back on the seven individuals that I met, I feel a mixture of emotions swirling through my mind. For the past few days, I've re-played each of their interviews several times in my head--re-hearing their words of abuse, re-feeling their pain of betrayal, and re-experiencing their desperate need to escape into an inner world where no one could harm them again. To be honest, the strength of my emotions caught me off guard. I wasn't expecting their stories to touch me so deeply, yet as I write this sentence, I realize that it would have been impossible for them to have not. In a single day, I experience such a range of emotions that it's hard to sort through just what my feelings are. Well, there's sadness. Deep sadness for the lost childhoods and stolen innocence. Admiration. Genuine admiration for the invincible Spirits and their

courage to give voice to a story of abuse . . . and then, there's more sadness. Sadness that there even has to be a story in the first place.

A few years ago, I planted a tree and painted a rock with five simple words: A world free of abuse. I placed this rock at the foot of the tree with the hopes that one day the tree will grow and as it does, so too will the reality of a world without abuse. I want so much to make a difference yet at the same time, I feel helpless to create the changes necessary for such a world to exist. Where do I begin? How do I start? And is the creation of such a world even possible?

I think about this research and the insight I hope it brings. I think about the interviews and the seven people who have allowed me to share a small part of their world. Their stories have touched my life in more ways than they will ever realize and with that, comes a shift within--a shift that I hope will radiate outward and produce a similar shift in others. I guess that's how change happens. It begins with one person--or in this case, seven people--who have the courage to tell their story and with each telling, a ripple effect is created that reaches out and touches the rest of the world. A world free of abuse. Maybe it is possible after all (see Figure 5.1).

May 2006. Research invites a strange sort of dynamic. As a researcher, I ask deeply personal and intimate questions so that the greater we can attempt to know and understand what someone else's experience is like. On some levels, that makes sense but at the same time, I wonder if I'm doing more harm than good. For the sake of research, I've created an experience that produced enough harm, or discomfort, so that each person, at some point in the interview, needed to dissociate. Some spoke through tears until their need to escape took over and the presence, or spark, in their eyes and voice disappeared. For others, the pace of their speech would at times pick up so quickly

that it was as if the rapidness of their words helped them run from the pain. And others spoke strictly from intellect--detached from emotions and causally conversing about a ubiquitous you and only minimally able to connect their experience from the perspective of I.

Figure 5.1. A World Free of Abuse



Being a part of this experience was hard, but not so much because dissociation was so apparent in the room, but because I was the source of their need to dissociate. I felt like an abuser recreating a dynamic by keeping them alone in a closed room and probing them with such personal, if not invasive, questions. Even harder was realizing that not all aspects of the individuals I met with consented to the interview. There were alters that simply did not want to be there and child parts who had no idea where they were, who I was, or why I was asking such questions to begin with. So . . . for the sake of research, I stirred up painful memories, opened a wound, and exposed people to the rawness of their painful histories. How is this different than abuse?

July 2006. The other day, someone asked me what my research was about. I told them that it was about the experience and treatment of dissociation and how I interviewed seven people who shared with me their wisdom of what dissociation is like. The person who asked me the question briefly paused . . . and then replied by saying it was good I was doing such research because it is important to understand what those people are like. My heart sunk. In that moment, I realized just how misunderstood dissociation is.

A few months ago, I read an article for one of my classes about the place that exists between the us and the them and how all too often we as a society create an artificial divide out of ignorance and fear. With dissociation, it is no different for dissociation is seen as someone else's experience--something uncommon, different . . . strange. When I think about how people view dissociation, a flow of words come to mind. Is this really our society's perception? Sadly, I think it is (see Figure 5.2).

Figure 5.2. A Society's View

## D-I-S-S-O-C-I-A-T-I-O-N

**D**ifferent

**I**rreal

**S**trange

**S**pacey

**O**dd

**C**razy

**I**nappropriate

**A**bnormal

**T**ainted

**I**rreparable

**O**ff

**N**ot like the rest of us at all.

October 2006. I spent the week completing the final edits for the individual narratives and as I went through each story I found myself left with more questions than answers. For me, the most prominent question is a question that I have been wondering about for quite some time and through this process of reviewing each story, I'm finding myself even further away from an answer than before. When I think about the statistics and how many children around the world are sexually abused, I wonder how anyone can sexually harm a young child. What possesses someone to do that? Do abusers ever feel genuine guilt or remorse? And do they even realize the devastation they cause?

I know there is a whole body of literature that attempts to explain why abusers abuse. There are the biological theories, the socialization theories, the feminist theories, and the cycle of abuse theories that say abusers are often people who were once abused themselves. All of these theories attempt to answer the question of how a person can sexually harm an innocent child but despite all this, I still don't understand.

I went for a walk in the forest today and even though it was raining really, really hard, I found myself impressed by the way nature comes together to provide a canopy of trees that acts like a natural umbrella for all the creatures in the forest. When I think about our natural environment and how, for the most part, everything functions in harmony, I realize that everything serves a purpose. Rainstorms of the fall and winter

replenish the rivers and forests and provide nourishment to the soil and Earth. Forest fires give life by creating the necessary temperatures for pine trees to release their seeds and grow. Struggles bring strength and the reality of death helps generate life. So where does abuse fit in? Why does a person sexually harm a young child? Perhaps the reason I have yet to find an answer is simply because there isn't one. The sexual abuse of a child serves no purpose at all.

January 2007. For the past few weeks, I've been struggling to put together the themes of everyone's experience and at the moment, the task going through the pages and pages of transcribed text seems overwhelming. Somehow I feel the need to contain the experience and organize my thoughts by capturing the participants' stories in a succinct, yet powerful, manner. So . . . I selected some key words and phrases from each of the seven narratives, added a few of my own images and impressions, and then through a process of cutting and pasting--and cutting and pasting some more--I created a collage depicting a collective story of what dissociation is. Hopefully, the words and images speak for themselves (see Figure 5.3).

March 2007. I'm learning a lot through this process of research and in many ways, this project is taking me to the edge of realizations about myself that I'm not sure if I'm ready, or willing, to have. As I think about the seven individuals and the narratives that I've read, I find myself seeing more and more of my story in their stories and becoming aware of aspects of my own experience in the telling of theirs. In a lot of ways, their fears, confusion, and sadness are the same as my fears, confusion, and sadness and their need to dissociate is just as present in me as it is in them. I've experienced the numbness of emotions, the disconnection of mind and body, the intense



April 2007. A few months ago, a horrible storm violently hit the West Coast with winds of over 100 kilometers per hour. The storm took many by surprise and as the winds howled, heavy raindrops poured from the sky. It was a frightening experience and the impact of the storm was massive. On that night, many were stripped from the basic elements of heat and electricity and for weeks, people lived in fear that more storms could follow. Fortunately, they didn't but from that single storm that struck in that single night, so much was lost.

A few years ago, a horrible person forced a little girl onto a bed and violently raped her. The rape took the little girl by surprise and as she tried to scream, heavy teardrops poured from her eyes. It was a terrifying experience and the impact of the abuse was massive. On that night, the little girl was stripped from the basic elements of trust and safety and for weeks, she lived in fear that more rapes could follow. Unfortunately, they did. The rapes continued for several more years but beginning with that single person who struck in that single night, so much was lost.

Today, many months later, the devastation of the storm still lingers, particularly in the forests where evidence of broken branches and fallen trees remain. To withstand the repeated onslaught of rain and wind, the trees relied on their natural ability to protect themselves and did all they could do to survive. During the storm, the bark of the trees retained moisture and as a result, became thicker to provide an insulating layer of protection that sheltered the trees from the cold and dangers of the outside world. For some trees, parts needed to break away. Trunks splintered, branches snapped, and leaves blew off in the wind. By having portions of the tree take some of the impact of the storm, the core of the tree was left standing and the violent winds were robbed of the

opportunity to take the entire tree down. Through this natural process of self-preservation, many of the trees survived.

As for the little girl who was repeatedly raped so many years ago, the devastation of the abuse still lingers where evidence of broken trust and fallen dreams remain. But as with trees, the little girl also had an innate capacity to survive. To withstand the repeated onslaught of abuse, the little girl developed an insulating layer of protection to shelter herself from the cruelty and dangers of the outside world. Parts of the little girl also needed to break away. Emotions numbed, body detached, and parts of her self needed to separate. By doing this, that horrible person who struck on those terrifying nights was robbed of the opportunity to completely destroy the little girl. Through this natural process of self-preservation, the very core of that little girl's Spirit survived.

May 2007. I watched a documentary the other night about three siblings who experienced sexual abuse at the hands of their father and the struggles they endured to cope with the lingering aftermath of their childhood experiences. It was a hard film to watch. With brutal honesty, the film depicted the reality of cutting, depression, suicidal thoughts, and the all too familiar feeling of distance and disconnection.

In the film, the siblings, now in their late twenties, went through a legal process to gain justice, and acknowledgement, for the traumas they endured. In the end however, their father was acquitted of all charges and generously forgave his children for putting him through the ordeal in the first place. The siblings' stories were disbelieved. Dissociation saved their lives yet at the same time, in the eyes of the law, and in the eyes of society, the siblings' inability to verbally articulate their experiences and express with 100% certainty the details of their abuse resulted in the full dismissal of their childhood

traumas. At the closing of the film, one of the siblings simply stated that his quest for justice was really about wanting to be believed. Unfortunately, he wasn't. As children, society failed to recognize the siblings' cries for help and now as adults, society has once again let them down.

Conclusion. Dissociation is a lifesaving experience. It provides a temporary reprieve from the mind-twisting, reality-altering trauma of childhood sexual abuse. From immersing myself in the narratives of the seven individuals who participated in this study, I recognize the critical need to break through the societal and cultural barriers that tend to dismiss the experience and value of dissociation. As stated by C. A. Courtois and L. A. Pearlman (personal communication, June 24, 2006), we process our feelings according to the societal and cultural norms in which we live. These norms dictate how we, as a society, respond to individual stories and depending on these norms, reparation of past traumas may, or may not, occur. For this research, I have a personal wish. I wish that each voice in this study, and every other voice that shares a similar experience, is fully honored, heard, and believed.

## CHAPTER SIX THE SHARED STORY

The dissociative system is like a labyrinth of mirrors and trapdoors . . . lost in time, fragmented in identity, and ostensibly guarded against all manner of other catastrophes

~ Schwartz, 2000, p. 16

From an holistic-content approach (Lieblich et al., 1998), seven major themes appeared in varying degrees in the stories and narratives of the seven individuals who participated in this research. These themes represent commonalities among the participants' experiences and reflect critical aspects of the experience and treatment of dissociation in individuals who have been sexually abused as children. In this chapter, each theme is discussed individually. Excerpts from each participant's story are used to provide the context in which each theme was experienced and offer readers insight into the complex and multifaceted world of dissociation.

**What is the experience and treatment of dissociation among individuals who have been sexually abused in childhood?** The seven major themes are divided into two broad categories: the experience of dissociation and the treatment of dissociation. The first category encompasses four major themes--disconnection to self, others, and the world; gaps in time, space, and memory; the dissociative process; and personal meaning and insights. Within these themes, 15 subcategories emerged. These include: the disconnected self; a place within; emotional and physical numbing; a separation from body; not an out-of-body experience; disconnection from others; distorted sensory perceptions; focusing; lost in time and space; forgotten memories; cues and triggers; a fight or flight response; a state of nothingness; return to awareness; and mixed emotions.

The second category encompasses three major themes--tools and techniques; challenging the dominant paradigm; and the therapeutic relationship. These themes

include 20 subcategories: a re-integration of the senses; expressive art; creative writing; guided imagery; therapeutic enactment; Eye Movement Desensitization and Reprocessing (EMDR); naming dissociation; going slow; labels and diagnoses; psychotropic medication; normalizing the experience; the fragility of trust; reciprocity; periods of conflict; being there; challenging old patterns; knowing beyond words; a new way of being; a witness to the journey; and the human connection.

The above stated themes have been woven together to create a shared story of the experience and treatment of dissociation in individuals who were sexually abused in childhood. These themes provide a window into an inner world darkened by unspeakable acts of abuse and unimaginable moments of betrayal. Together, these themes give voice to an inner world--an inner world built upon fears, rooted in strength, and shaped by the necessity to survive.

### **EXPERIENCE OF DISSOCIATION**

Dissociation is the escape when there is no escape  
~ Putnam, 1992, p. 104

#### **Disconnection from Self, Others, and the World**

##### **Disconnection From Self**

The disconnected self. All of the participants reported a sense of depersonalization or disconnection from themselves that varied depending upon where they were in terms of their individual process of reparation. This finding supports research in the current literature (e.g., Baker, Hunter, Lawrence, Medford, Patel, Senior, Sierra, Lambert, Phillips, & David, 2003; Dell, 2006; Haddock, 2001; Howell, 2005; Nijenhuis, 2004; Putnam, 1997; Simeon, 2004; Scaer, 2005) that identifies

depersonalization as a significant quality of dissociation and further contributes by demonstrating a range of experiences that exists along a continuum, which spans from a partial to a more complete and total separation from aspects of one's own identity. Given the current debate (e.g., Brown, 2006; Butler, 2002; Chu, 1998; Courtois & Pearlman, 2006; Dell; Holmes, Brown, Mansell, Fearon, Hunter, Frasquilho, & Oakley, 2005; Putnam; Sar, 2006; Scaer, 2007) on whether or not dissociation exists as a typology or a continuum, these findings significantly contribute by offering support for the later. The following excerpts capture the range of depersonalized experiences that appeared in the text of the participants' stories.

**Christopher:** “[Dissociation] is a disconnection from myself. . . . It prevents me from connecting with who I am and seeing myself as successful or good in any way  
~ silence ~”

**Sara:**

When I look at photos of me as a child I see that little girl as being someone else. She looks so desperately sad and I don't feel . . . I don't feel I can connect with the child that I'm looking at ~ silence ~ . . . I also struggle constantly with recognizing myself in the mirror. I know intellectually that it's supposed to be me because I'm the one that lives at that address but . . . but it doesn't look like me. It doesn't look familiar.

**Lauren:** “[For me] dissociation blunts any feeling of embodiment within myself.”

**Kate:** “Gone. Not present. I sort of see myself as . . . as ghost-like with no real form.”

**Catherine:**

Disassociation feels like . . . it is literally not me. . . . It's different characters and these characters are other people . . . a different person . . . and they are trying to

relay to me what this different person's life is like. So it's her life not mine and there's no ownership whatsoever.

**Teresa:**

Dissociation is when you're gone . . . gone to the lost parts and when that happens, you're not aware of it until something tugs at you and brings you back. These lost parts . . . there are about four of them for me . . . four little people and they are all very different. . . . They're the little ones . . . and they split off when the abuse started ~ tears ~

**Rachel:**

As far as I know, we have 180 alters. We're all different ages but I'm 53. . . . My name is Shell but I'm not always the one talking to you. . . . There are some of us that are really destructive ~ silence ~ like Ethan. His way of dealing with things is through psychosis . . . and then there's Razorman. . . . The mental health team came and diagnosed me as psychotic, suicidal, and homicidal . . . but it wasn't me ~ silence ~ it was Razorman.

A place within. For six of the seven participants, the process of disconnecting from the self also involved retreating inward and finding a place within themselves that felt safe and protected. These findings add to the literature by providing details of an inner world that exists for some individuals who use dissociation to cope with the threat and danger of the world around them. The following excerpts underscore the highly adaptive and critical role dissociation plays in helping individuals maintain a sense of emotional and psychological safety.

**Lauren:** “I’d go into my head and chant or say things repeatedly ~ silence ~ angry things directed at my offender and that would be accompanied by holding my breath which allowed me to ward off whatever was happening to me physically.”

**Christopher:**

I’ve been able to find a good place within myself and be comfortable there . . .

Why would I want to be here when it’s so much better over there? . . . Some of my most real feelings of peace occur when I dissociate.

**Rachel:**

When another alter is present, I go into a retreat zone where it’s blank. . . . The image we have is sort of like three layers and there’s this house and some of us are at the front of the house and those are the ones you will see. We relate directly to the world but just behind us is the second layer of alters who might be leaning out of the windows. This layer can see you and hear the conversation and they can even make comments or step forward to talk . . . they are always very aware of what’s going on. The third layer has alters that are way in the back of the house and they may not even be paying attention to what’s happening unless one of us calls them forward for information.

**Kate:**

“This survival gear is wrapped around me  
Like a fortress of stone  
Like a protective suit of amour  
It saved me  
Held me  
Gave me comfort.”

**Catherine:**

Sometimes I go to a dark room in my head . . . behind everything. Sometimes I can see what the characters are doing but it depends on whether or not I’m

paying attention. It's very difficult to pay attention. . . . When I'm there, I'm as small as possible and nobody can see me so that's where I know it's totally safe ~ silence ~ it's way better to be in there than out here.

**Teresa:**

Inside the blackness was silence, nothing, a thoughtlessness that stretched to eternity. I just "existed" there with nothing to feel, nothing to do, no thoughts to promote any action or being of any kind. I guess I don't really know why or how I existed, I just did. . . . I then "felt" a presence, an awareness of something that slipped into my "tummy", something that suggested I needed this blackness to protect "the core". To protect the core from dying.

Emotional and physical numbing. For all of the participants, a disconnection from themselves was further expressed in the form of emotional and/or physical numbing. This finding is consistent with current research (e.g., Baker, Hunter, Lawrence, Medford, Patel, Senior, Sierra, Lambert, Phillips, David, 2003; Brown, 2006; Courtois & Pearlman, 2006; Phillips & Sierra, 2003; Porges, 2004a; Putnam, 1997; Roder, Michal, Overbeck, van de Ven, & Linden, 2007; Sayar, Kose, Grabe, & Topbas, 2005; Scaer, 2007) that identifies numbing as a critical aspect of dissociative behavior. The following excerpts further add to the literature by highlighting the struggles some individuals face as they attempt to navigate through life in a state of emotional numbness.

**Rachel:** "It's deadening . . . dead, dead, no feelings, dead . . . and sometimes, I don't feel any emotion while at other times, I'm overly emotional . . . hysterical . . . and I go into intense emotions that don't seem to match the situation."

**Sara:** “Even if I’m emoting, I can’t make the link between the feeling and the tears. I mean, I might be bawling my eyes out but I couldn’t tell you what feeling matches it.”

**Kate:**

When I’m dissociating I don’t have any feelings. . . . One way I can tell that I’m dissociating is when I find myself having a hard time writing my music. I write all my own songs and I need to be in the right space to do that. I need to be feeling at least some emotion but when I dissociate everything shuts down. It’s empty.

**Teresa:**

Your emotions shut down and you feel spaced out. Empty. . . . I don’t remember having any emotions until I started theatre school at the age of 32 and it was like nothing was there and you learn how to be in life by following what other people do. You’re supposed to be happy when that happens so okay, I’ll act happy.

**Christopher:** “For various surgical procedures, I’ll refuse anesthetic. The other doctors think I’m nuts but I don’t need anesthetic because I know how to go away on my own.”

**Catherine:**

[I need] to figure out what feelings are ~ silence ~ I saw a movie a few weeks ago and for the first time I was able to see what feelings like love, passion, anguish, and shame actually were. . . . If I could see those feelings in a movie then maybe I can start to apply those feelings to myself.

**Lauren:**

I don’t experience much emotion. . . . I actually have a problem separating out basic emotions and that’s frustrating because I don’t have enough of that internal prompting that tells me what it is that I’m feeling. I tend to think what I feel

rather than feel what I feel and that's problematic. I'm mostly aware of anxiety so I tend to describe everything as anxiety and then if I have tears, I describe it as sadness ~ laughs ~ I guess it's pretty limited right now.

A separation from body. Depersonalization was also reflected in five of the seven participants' reported disconnection from their body. This finding supports research in the literature (e.g., Baker, Hunter, Lawrence, Medford, Patel, Senior, Sierra, Lambert, Phillips, David, 2003; Briere, 2002; Courtois & Pearlman, 2006; Dell, 2006; Howell, 2005; Nijenhuis, 2004; Roder, Michal, Overbeck, van de Ven, & Linden, 2007; Ogden, 2006; Scaer, 2007; Simeon, 2004) that identifies a disconnection from the body as a critical aspect of dissociation and highlights the prominence of this experience in individuals where a significant violation to the body (e.g., childhood sexual abuse) occurred. In addition, this finding contributes to the literature by providing detailed descriptions of how four of the seven participants identified themselves as existing only from the head up and how one participant identified herself as existing only from the eyes up. This reported separation from the body was captured not only in the following quotes but also in the reference some of the participants made to the body versus my body.

**Catherine:**

I hate this body! Hate it! . . . My doctor says I'm supposed to exercise but when I do I can feel the body. I can feel the muscles. I can feel the body moving and that's when it gets freaky so I stop. . . . Usually I only exist from the head up. Most of the time the rest of me just isn't there.

**Christopher:** “I’m not aware of any physical sensations but I experience a sense of mastery . . . not mastery over my body but over a skill or . . . or a machine ~ silence ~”

**Kate:** “I don’t have any feelings and from my neck down there’s nothing. I’m just not there. Everything below my neck disappears.”

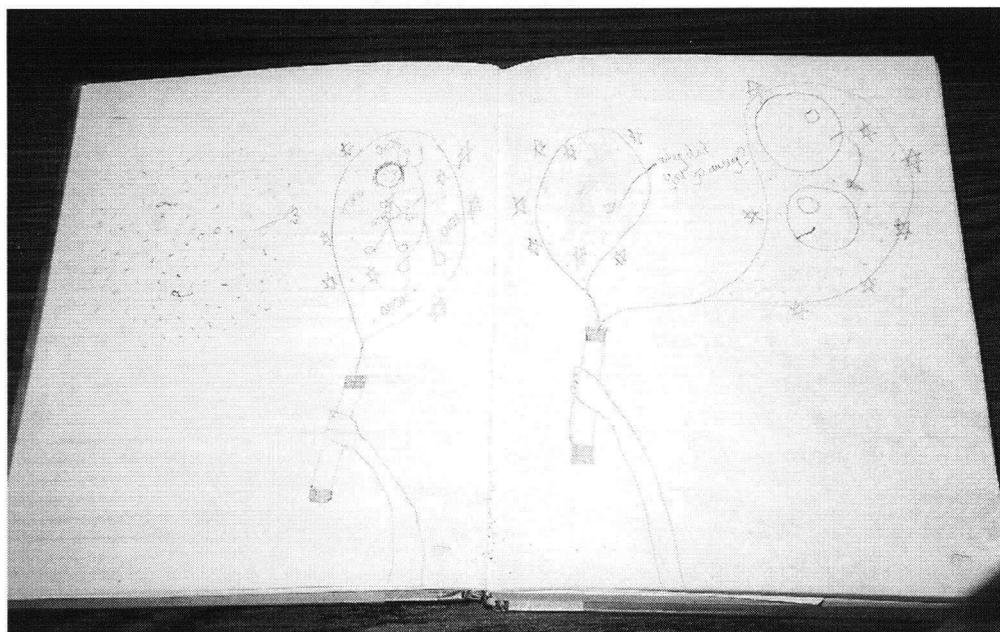
**Lauren:**

Hollowed. I think for me it’s quite metaphorical because when I dissociate I always have this feeling that is akin to being scooped out and that’s accompanied by a numbed out feeling of being hollow from the top of my chest down to my abdomen.

**Teresa:**

The body is phased out so part of your entire make up is gone. . . . It’s hollow ~ silence ~ Little T drew this. These are her eyes . . . no body . . . and her hand is reaching out ~ silence ~ this is dissociation. I’m rubbed out . . . erased . . . gone (see Figure 6.1).

Figure 6.1. Teresa’s Drawing II



**Sara:**

I won't give myself a body ~ laughs ~ because for me, everything happens from the eyeballs up. Not really much of me exists below my eyes. . . . To feel disconnected from one's body is to know that you actually possess one. For me, it's more like the body is not in my understanding at all. To detach from it I have to recognize and acknowledge that I have a body and . . . and that is not always in my level of awareness. I have no sense of my body and for some reason I don't question how I can walk without a body to move me.

Not an out-of-body experience. Despite the reported disconnection from their bodies, none of the participants described dissociation as a sense of leaving their body or rising above themselves as a dominant part of their dissociative experience. In fact, five of the seven participants explicitly stated that this was not a part of their experience. This finding is contrary to information provided in the literature (e.g, Amir & Lev-Wiesel, 2007; Brown, 2006; Gow, Lang, & Chant, 2004; Edge, 2004; Holmes, Brown, Mansell, Fearon, Hunter, Frasquilho, & Oakley, 2005; Irwin, 2000; Murray & Fox, 2005; Scaer, 2007) and as a result, provides a significant contribution by challenging the popular belief that dissociation is an out-of-body experience.

**Kate:** "It's not an out-of-body experience because it happens in your head."

**Lauren:** "I've heard of dissociation being described as floating above and watching things happen but I don't know if I would describe that in myself."

**Christopher:**

There are times when I dissociate and I'm in complete control. I choose when I leave and where I go and in those moments I usually find myself flying. I'm not

really flying but I'm flying in my mind and . . . and it's not an out-of-body experience but a sense of floating in the air.

**Sara:** "Often we hear dissociation described as watching a situation from above but I only remember doing that a bit at my friends' deaths in the car accident."

**Catherine:** "It's not like I'm floating above my head or anything."

#### Disconnection from Others

Six of the seven participants reported a sense of isolation or significant feeling of disconnection from others. This finding is congruent with current research (e.g, Amir & Lev-Wiesel, 2007; Briere, 2002; Fosha, 2003; Howell, 2005; Schwartz, 2000; Porges, 2004a; Putnam, 1997) that recognizes a disconnection from others as a prominent aspect of dissociative behavior. For most of the participants, this experience evoked strong emotions of sadness and/or anger and highlighted their intense desire for human connection. It is interesting to note that at the time of the interviews only two of the participants were in long term intimate relationships.

#### **Christopher:**

For me, it's an experience of being an other . . . an other on the outside looking in. It's a disconnection from myself and others and that's really hard because . . . well, because I'm the disconnected male and the sacrifices of that are huge! . . . I feel apart from everything yet at the same time I have an intense desire to fit in. So it's like wanting to fit in but not being able to . . . it's hard ~ silence ~ maybe that's why I don't have many friends.

**Lauren:** “[Dissociation] blunts my capacity in terms of relationships and connection to others . . . I was pathologically independent for a long time and that was a real impediment in terms of my relationship to others.”

**Kate:**

I don’t know how to be intimate with people. When people are interested in me I immediately go to that place of being shut down and floaty. That makes me angry. I mean, how can I have a relationship with anyone if I keep doing that?

**Teresa:**

I’m used to dealing with things on my own and I don’t tell anyone I’m in trouble until after I’ve figured it all out. . . . I tend to not reach out. There aren’t many people who know my story ~ silence ~ I certainly choose very carefully where and with who I share it.

**Sara:** “I can’t truly be present to those around me if I can’t ~ silence ~ how can I have truly connected relationships if I’m not really connected to the world? ~ tears ~”

**Catherine:**

Learning how to connect with people is important ~ silence ~ I want to do that but my fear gets in the way. It’s difficult reaching out. It’s difficult to hug someone because . . . because I know that nobody stays forever. . . . I like plants. Plants are always good. I know that plants aren’t going to hurt me.

#### Disconnection From The World

Distorted sensory perceptions. Six of the seven participants reported a feeling of derealization or disconnection from the world around them. Derealization was most commonly described as a distortion or alteration in sensory perception and occurred predominately through visual and/or auditory experiences. This finding supports current

research (e.g., Brown, 2006; Courtois & Pearlman, 2006; McFarlane, 2004; Nijenhuis, 2004; Porges, 2004a; Putnam, 1997; Scaer, 2005; Scaer, 2007) that identifies derealization as a critical component of dissociative behavior and further contributes by highlighting the significant sensory disruptions that can occur in individuals who engage in moderate to high levels of dissociation.

**Sara:**

It's very foggy ~ silence ~ . . . . It's like I can see the world in front of me but . . . but I feel really no connection to it. My entire world shifts on an axis so everything looks crooked and I'm extremely dizzy. . . . The near rape thing ~ silence ~ everything was reduced to morbid slow motion . . . like whoop! suddenly everything around me was a slow motion event. . . . I miss parts of conversations . . . like in group discussions I get very confused because there is too much stimuli [and] I'm not able to separate them out so there is just a blob that makes no sense at all. I remember my best friend's accident. People were speaking to me and I could see their lips move but I had no idea what they were saying. I just watched their mouths move but I couldn't hear their words.

**Kate:**

It's like being in a dream but not in a dream. . . . I would hear my voice but it wouldn't sound like it's me talking [or] I'm in the middle of a conversation and someone's talking and . . . and it's like I'm not listening or something.

**Rachel:**

Dream-like, unreal . . . sort of like what happens when someone gets stoned on drugs and everything feels very different, unfamiliar, and strange. [It] is a numbing or cutting off of awareness. For example, there are all these things we

perceive in the world and dissociation cuts off or filters out what I'm hearing so I don't hear certain sounds.

**Catherine:**

Sometimes disassociation is like looking at a movie or a screen . . . it's all fuzzy and something's going on but it's not very clear. Sometimes things move slower. . . . Sometimes when people talk, it's like they're speaking in a different language so nothing makes sense [and] other times, it's like somebody just turned off the sound.

**Teresa:** "Dissociation is like talking through a fog and trying to think through molasses."

**Lauren:**

Dissociation is dream-like . . . when I think about finding my mom's body after she committed suicide I . . . even now when I think about it I have this completely derealized feeling. I can recall it in perfect detail ~ silence ~ I remember everything . . . the room, the light . . . ~ silence ~ I remember it as if I wasn't there.

Focusing. Five of the seven participants described an experience of focusing as a significant component of dissociative behavior. This finding supports current research (e.g., Amir & Lev-Wiesel, 2007; Briere, 2002; Courtois & Pearlman, 2006; Haddock, 2001; Howell, 2005; McFarlane, 2004; Nijenhuis, 2004; Porges, 2004b; Putnam, 1997; Scaer, 2007) that examines focusing as a prominent aspect of dissociation and contributes to the existing literature by emphasizing the important role focusing has on helping individuals psychologically escape the physical and emotional demands of the outside world.

**Christopher:**

I've worked really hard at learning how to induce myself into a trance-like state. For example, if I have to go through a medical procedure that's painful, I'll have specific inductions that I practice where I think about where I want to go and then I see myself going deeper and deeper into that place until the painful experience is over.

**Lauren:**

I generally zone myself out by finding something to fixate on like a picture or the weave of the carpet. The carpet is a really easy one for me ~ silence ~ I can just look at it and eventually it starts to undulate and then I feel calm.

**Rachel:**

The other [form of dissociation] is focusing. For example, a child being abused might say that she is going to become a bug on the wall and she'll focus on that bug until she is that bug and is able to tune out everything that's happening. The numbing and focusing happen at the same time and with multiplicity it's the same but instead of becoming a bug on the wall we become another person.

**Kate:** "I focus in on certain objects . . . like right now I'm focusing in on the title of that book over there. I lose my train of thought and . . . and I'm gone."

**Sara:** "I remember being so completely out of it when I was seeing my first therapist that I fixated so much on an image in her carpet. Sadly, that's all I can remember of her."

## Gaps in Time, Space, and Memory

### Lost in Time and Space

Six of the seven participants reported a gap in time and/or space that manifested in a variety of ways. For five of the seven participants, a loss of time and space was represented as a gap in temporal or spatial awareness. Two of the participants further described this as having a part of themselves lost or frozen in a moment of abuse, while two others spontaneously became aware of this loss of time and space during the course of the interview. These findings are congruent with current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Dell, 2006; Holmes, Brown, Mansell, Fearon, Hunter, Frasquilho, & Oakley, 2005; Howell, 2005; Nijenhuis, 2004; Nijenhuis, van der Hart, & Steele, 2004; Porges, 2004b; Putnam, 1997; Scaer, 2005; Steinberg & Schnall, 2001) that identifies a gap in time and space as a significant component of dissociation. The following excerpts further contribute by demonstrating the variety of ways in which these gaps can occur.

#### **Rachel:**

I feel that I'm a space case because I don't know how I got somewhere. . . . I experience a loss of time [where] suddenly I come forward, look at the clock, and two or three hours has passed. It's like having a nap and during that time, I'd have no idea what the others had been doing.

**Sara:** "Sometimes I would drive somewhere and have no recognition of how I got there. We all do that from time to time but not even noticing traffic lights?!"

#### **Christopher:**

I also used to cycle a lot . . . I'd cycle for hours at a time . . . and I'd end up in places without knowing how I got there. I mean, I know I got there by bicycling

but I'd have no idea what route I took or what towns I cycled through to get to where I was.

**Kate:**

You know, I could be driving and end up somewhere but not realize how I got there and it's amazing how you can do something so important like drive a car and . . . and it's like suddenly you disappear and you're on auto pilot!

**Catherine:**

Sometimes it's like somebody cut the movie in half and there are long periods of absolutely nothing before you jump back in again . . . into a different scene . . . and the person has changed and you're trying to figure out where the lost part of the movie went.

**Rachel:**

We had this image of six little children dressed in black capes lying frozen in a circle surrounded by this deep, dark, horrible trauma. . . . It took a long time before we were able to connect with them but bit by bit those children came out of that frozen circle.

**Teresa:**

Little T. She's three and she's very afraid. She stayed on the stairs that led down to the place where the abuse happened and never got off. She just stayed there . . . third stair down . . . pushed in the corner ~ silence ~ it's like she was frozen there . . . frozen in time.

**Catherine:** “~ silence ~ [7 seconds] right now I can see my mouth moving but I don't really know what I'm saying ~ silence ~ [12 seconds] what was your question again?”

**Kate:**

Sometimes I lose all thought of what I'm supposed to be saying. . . . My mother . . . subconsciously she knew stuff was going on . . . and she didn't ~ silence ~ [5 seconds] she didn't ~ silence ~ [14 seconds]. . . I think I just dissociated ~ silence ~ [12 seconds] I'm gone. What was I supposed to be talking about right now?

**Forgotten Memories**

To differing degrees, all of the participants reported aspects of their abuse that they were unable to recall. Four of the seven participants further identified that they had no recollection of their abuse until memories of their childhood began to emerge in their early to mid thirties. These findings support current research (e.g., Briere, 2002; Brown, 2006; Courtois & Pearlman, 2006; Dell, 2006; Freyd, 2002; Haddock, 2001; Herman & Harvey, 1997; Howell, 2005; Putnam, 1997; Schwartz, Passmore, & Yoder, 2003; Steinbert & Schnall, 2001; van der Hart & Nijenhuis, 2001) that identifies gaps in memory as a significant component of dissociation. The following excerpts represent those participants whose experience of forgetting was specifically discussed in the text of their story.

**Catherine:**

Being forgetful. Very, very forgetful! That's how I would describe it and it's to the point where it's very annoying and frustrating! It's a memory thing and I often think if I could just concentrate harder or pay more attention. . . . [In terms of the abuse] I don't remember a lot. My brother keeps telling me that I should not try to remember because nothing very good is going to come out of it.

Nothing! . . . For me it's been years of not knowing . . . years of not remembering. It's horrible not to know ~ silence ~

**Kate:** "My abuse was mainly when I was really young and I don't think the overt stuff happened much past the age of five ~ silence ~ it's still a bit foggy around that stuff."

**Christopher:** "The sexual abuse started when I was ~ sigh ~ it's amazing how hard it is to remember all of this ~ silence ~"

**Sara:** "I've questioned sexual abuse because of certain behaviors of my own that . . . I can't believe I'm saying this but I've wondered about one of my parents ~ silence ~"

**Rachel:**

I know very little about what happened and that has protected me because the abuse didn't happen to me. Sometimes it's frustrating because I don't connect with the memories and I don't have a sense of being there because . . . well, because I wasn't. For those of us who have higher levels of knowledge ~ silence ~ I guess they're protected because they only know a portion of what happened. They have a buffer because the knowledge is split up so one person may know about this but they don't know about that ~ silence ~ to know everything would be too overwhelming.

### The Dissociative Process

#### A Progression of Dissociative Responses

To varying degrees, all of the participants described a progression of responses that characterized dissociation as a series of autonomic reactions that occurred in a somewhat linear and sequential manner. For some of the participants, this progression began with a trigger that was followed by a physiological state of arousal, a feeling of nothingness, and a heightened sensory reconnection to their environment. This finding

supports current research (e.g., Lanius, Hopper, & Menon, 2003; Nijenhuis, 2004; Ogden, 2006; Ogden & van der Kolk, 2002; Porges, 2004a; Porges, 2004b; Scaer, 2007; Schore, 2002) that recognizes the strong sensory and neurological component of dissociation and adds to the literature by sequentially identifying the series of self-protective responses that are experienced during the process of dissociation. The following subcategories include the four responses--cues and triggers; a fight or flight response; a state of nothingness; and return to awareness--identified by the participants.

Cues and triggers. All of the participants reported an awareness of specific triggers that began a progression of dissociative reactions. Examples of these triggers included physical reminders of the abuse, experiencing feelings and emotions, distorted cognitive schemas, a physiological awareness of the body, and situations that provoke a sense of real or perceived danger. It is also important to note that during the course of the interviews, six of the seven participants recognized that they were dissociating and stated that their tendency to dissociate was triggered by the content and context of interview itself. These findings support current researchers (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2003; Haddock, 2001; Howell, 2005; Nijenhuis, 2004; Scaer, 2005; van der Hart & Nijenhuis, 2001; Waites, 2000) that acknowledge a variety of environmental, emotional, and physiological cues that consciously, or unconsciously, trigger the need to dissociate.

**Christopher:**

Anxiety. Stress. Worry. Those are all things that will lead me to dissociate but I think one of my biggest triggers is having to face certain messages I got in childhood . . . messages that say I'll never be good enough and that I was born

less than. I mean, Who do I think I am? I can't be big. I'm small. I'll never amount to anything!

**Kate:**

When people are interested in me I immediately go to that place of being shut down and floaty and . . . and I think it's the same as the sexual abuse thing. I mean, the attention I got from my father . . . somehow I dissociated with him when he was sexually interested in me and so I do it with everyone else in my life that's interested.

**Sara:**

It can be triggered by physical pain but mostly it's triggered by the need to mentally escape entering any sort of emotional field. For me, it's related to the shame of showing emotion.

**Catherine:**

Stress is a trigger for me. I was molested at night so one thing that's stressful is going to sleep. I have a lot of issues with sleep . . . and feelings. That's another trigger. I try not to feel. I try not to feel anything. . . . I try not to feel my body . . . the body is a big trigger.

**Rachel:** "Different things trigger dissociation. Right now we're triggered every time we drive along a winding country road or when we see a car on t.v. drive through the country side."

**Lauren:** "Any activity that is uncomfortable . . . sexual activity, most kinds of stress . . . are triggers where I will eventually start to leave myself if I don't pay attention."

**Teresa:**

I started passing out at school. We used to have these assemblies and sing hymns every morning and that triggered something in me because I used to pass out and even though it was investigated, no one could ever find a physical or organic reason as to why. . . . Faint Girl is three ~ tears ~ I remember the split completely. It was because of the pain . . . total physical pain . . . and I needed to go because I couldn't stay any longer ~ tears ~

A fight or flight response. Three of the seven participants further described a fear or anxiety-related response that was coupled with an overwhelming sense of losing of control. This experience captures the autonomic flight or fight reactions that immediately follow the conscious or unconscious awareness of a trigger. This finding is congruent with current research (e.g., Dell, 2006; Lanius, Hopper, & Menon, 2003; McFarlane, 2004; Nijenhuis, 2004; Nijenhuis, van der Hart, Kruger, & Steele, 2004; Porges, 2004b; Scaer, 2005; Scaer, 2007; Schore, 2002; Williams, Haines, & Sale, 2003; Yehuda, 2004) that examines the self-protective function these responses have when individuals are confronted with threats of real or perceived danger.

**Catherine:**

I usually hold my breath but that's getting better because now when I hold my breath, it's not to the point where I'm going to pass out. Sometimes when things get really bad, I can feel palpitations in my heart. Like right now, I can feel my jaw clenching and . . . and when that happens, it's like the muscles have their own way of doing things and I have no control.

**Sara:** "I quit breathing . . . right before I dissociate I'm aware that I feel out of control."

**Lauren:**

I've been told that when I dissociate I can look really passive and my eyes usually go off in one direction. I have almost no facial expression and can speak about really difficult things quite matter-of-factly. . . . I feel the anxiety creeping up my body and when that happens I have secondary anxiety about losing control. . . . It starts by me holding my breath and I do that as a way to control the anxiety which is quite physical and manifests as a pressure that is localized in my chest.

A state of nothingness. Six of the seven participants also described a freeze response or a state of nothingness that was void of any thoughts, feelings, or sensations. For some, this state was preceded by the flood of autonomic fight or flight responses described above. This finding supports current research (e.g., Lanius, Hopper, & Menon, 2003; Nijenhuis, 2004; Ogden, 2006; Scaer, 2007; Schore, 2002; Yehuda, 2004) that identifies the innate freeze reaction that occurs after attempts to physiologically escape a situation fails. The results of this study add to the literature by situating this response within a series of dissociative reactions and describing an identified state of nothingness from the voice and perspective of those who dissociate.

**Teresa:** "Inside the blackness was silence, nothing."

**Catherine:** "I don't think I'm aware of anything before I disassociate. . . . It's a place of nothing. It has no feelings. It's blank."

**Kate:** "I don't think I'm aware of anything when I dissociate. I just know that I'm gone."

**Lauren:** "I don't have any thoughts that precede dissociation . . . when I dissociate I don't experience much."

**Rachel:** “Dissociation is a feeling of falling backwards or . . . or a sensation of tipping over into darkness. . . . It’s blank . . . nothing . . . nothing happens during that time.”

**Christopher:** “I don’t know where I go ~ silence ~ I’m just gone. It’s a nothingness and I float off into nowhere.”

Return to awareness. Four of the seven participants reported a return of awareness that occurred when they felt more present, grounded, and alive. To date, few studies have explored the renewed sense of awareness that occurs as individuals became reacquainted with themselves and the world around them. As a result, this finding significantly adds to the literature by identifying this experience within a series of responses and providing a description of what becoming present is like for individuals who engage in moderate to high levels of dissociation.

**Sara:** “It’s like putting on a pair of new glasses. The colors around me are more vivid and the world looks clearer and more alive!”

**Rachel:** “The transformation was amazing! Now one of [the alters] is a bubbly six year old who gets excited every time he sees a rainbow in the sky. It’s like he’s been reborn. It’s like they have come alive!”

**Kate:** “Suddenly I come to and it’s like I wake up and can feel my emotions and my body again.”

**Teresa:**

When I’m not dissociating, I can actually feel! I feel more solid . . . more present . . . and it’s as if someone turned on the light and something is radiating from within me. The world is brighter, colors are stronger . . . more vivid . . . and everything just feels more alive!

## Personal Meaning and Insights

### Mixed Emotions

To differing degrees, all of the participants experienced mixed emotions with regards to their tendency to dissociate. Most identified the positive and negative aspects of dissociation and expressed their struggle to come to terms with the awareness that dissociation allowed them to survive yet at the same time, took away their capacity to fully live. To date, few studies have identified the personal meaning attributed to dissociation. As a result, these findings significantly add to the literature by providing insight into the inner thoughts and feelings individuals have about their capacity to dissociate.

#### **Christopher:**

[Dissociation has] allowed me to withstand some otherwise uncomfortable situations but . . . but at the same time, I feel sad about my escapes because even though they're peaceful, I'm always alone. . . . Lately, I've been seeing dissociation as becoming more problematic all the time. For example, I have a really good job and I'm very proud of what I do but I could be mediocre for the rest of my career because instead of confronting something I'd like to accomplish, I'll retreat and disappear.

#### **Catherine:**

Disassociation is safe. Very safe! I like it because it helps me go ahead and do a lot of things. I am a lot more productive when I disassociate. I can go out, get my job, be in a relationship with my husband, and just do things that are different. Disassociation creates the appearance of being normal. . . . My first therapist said that disassociation saved my life and that it's probably the only reason why I'm

not into any drugs or alcohol. I believe that but . . . but in some ways, dissociation is really no different than being an addict. I like it. . . . I want to rely on dissociation yet at the same time, I know that I can't. As much as dissociation keeps me safe, it interferes with my life because . . . because it's a band-aid. It covers up a wound but it isn't really going to make anything better ~ silence ~

**Lauren:**

In my life, I've have numerous suicide attempts and other things happen where dissociation was quite positive as it blunted the feelings. Dissociation was positive because it gave me control [and] when I began looking at my sexual abuse in therapy, I know I really learned to appreciate my ability to dissociate and get away from it . . . but it's a double edged sword. . . . It has been suggested that dissociation had a very protective function when I was young and I believe that but . . . but now I see it as a total negative because I'm not successful at learning how to undo it. Dissociation is very familiar for me. It has become automatic [and] it's hard to undo something that seems so lodged in my body. The fact that I dissociate means that I'm carrying around the legacy of my abuse all the time and ~ tears ~ and I hate that because it's a chronic reminder of what happened.

**Rachel:**

For us, dissociation has definitely been a gift. I mean, it's a way of coping and if we didn't have it maybe we would have ended up psychotic or dead. Some of us were put inside a coffin box and dissociation let us go away and be dead just to survive. Others were created out of pain ~ silence ~ I don't know why we all got created but . . . but I guess we needed to. . . . Even though dissociation has been

positive, it has its downside in terms of spacing out or not being connected. Sometimes I think it makes me lack empathy.

**Sara:**

There's nothing good about dissociation. During the near rape, I was frozen stiff and dissociation made me unable to protect myself. Once I was walking home from my therapist's office and . . . and some guy came up to me and asked me for the time. He told me he was visiting from Brazil or something and then he shook my hand, went to kiss my cheek, and put his lips on mine. It wasn't until I got home that I realized that some perfect stranger's lips were on mine and I had no idea how they got there!

**Teresa:**

Dissociation is both bad and good. It's bad because when I dissociate I feel half dead but it's also good because without it I honestly believe I would have ended up in the psych ward. It enabled me to function in everyday life . . . it still does . . . because if I get into trouble, I can be on auto mode and still go to work and look after my daughter. . . . Dissociation makes it so that the little ones aren't able to speak and that's a good thing because if they could speak and told someone the bizarre things that were happening, no one would have believed me ~ silence ~ if those parts hadn't gotten lost, I really don't know where I would be.

**Kate:**

I think dissociation definitely helped when I was younger and even now . . . well, I guess it still helps because there are times when it's just not appropriate to have certain feelings because I can't manage them so . . . so in that way dissociation

can be good. It shuts you off and gives you a bit of a breather. It can also be bad because it stops you from being present in your life ~ tears ~ and that's sad because . . . because it's about survival.

### Conclusion

Four major themes--disconnection to self, others, and the world; gaps in time, space, and memory; the dissociative process; and personal meaning and insights--were identified to reflect the experience of dissociation for the seven participants who participated in this study. Within these themes, 15 subcategories emerged. These included: the disconnected self; a place within; emotional and physical numbing; a separation from body; not an out-of-body experience; disconnection from others distorted sensory perceptions; focusing; lost in time and space; forgotten memories; cues and triggers; a fight or flight response; a state of nothingness; return to awareness; and mixed emotions. These findings underscore the strong sense of disconnection experienced by those who dissociate and reflect aspects of the current DSM-IV-TR (2000) definition that defines dissociation as a disruption in the usually integrated functions of consciousness, identity, memory, and perception.

## **TREATMENT OF DISSOCIATION**

Our patients bring to us not only their suffering but their creative attempts to heal themselves

~ R. Cheftez, cited in Schwartz, 2000, p. 172

### Tools and Techniques

#### Re-integration of the Senses

Six of the seven participants expressed the value of having their therapist engage them in a process of reconnecting with themselves and their environment by involving

the use of their senses. This finding supports current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2003; Fosha, 2006; Hunter, 2004; McEvoy & Ziegler, 2006; Ogden, 2006; Porges, 2004a; Scaer, 2005; Steinberg & Schnall, 2001) that identifies the importance of engaging clients in a multi-sensory manner to minimize dissociation and help clients remain within a therapeutic window of tolerance. It is important to note that none of the participants worked with the same therapist. The following findings are therefore representative of the inherent value of the identified techniques and not the result of a single therapist engaging the participants in a standard or therapist-preferred treatment modality. The following excerpts capture the variety of ways in which the participants were involved in a process of sensory re-integration.

**Sara:**

[My therapist] will usually get the lavender out or make me do things like pull my hands together or stomp my feet. The lavender helps. Somehow it snaps me back to the present. I realized the other day that my fingers naturally flick the pen that I'm holding and that makes a noise alerting me to my hands and the rest of my body. I also jump into freezing cold water and that helps a lot! . . . It grounds me and connects me back to the present.

**Lauren:**

When my therapist notices that I'm dissociating, she prompts me to breathe. . . . Sometimes she will ask what I'm noticing in my body. I usually say that I feel anxiety and that makes me pay more attention. She also does that orientation thing where I tell her two things that I can see in the room but overall most of her techniques involve some sort of reminder to breathe. One counsellor that I saw in the past had me put up dots on the walls around my house and when I saw the

dots I was prompted to stop, take a breath, and center into what I was feeling. At that point, I was pretty chronically dissociated so it was helpful in trying to get me to identify feelings and counter the dissociation.

**Kate:**

When [my therapist] sees that I'm dissociating she asks me to feel my feet on the floor or . . . or she would get me to go to my place in nature and connect with my power animals. By doing that, I'm put in a stronger place. I feel more adult in my body and somehow that brings me back.

**Rachel:**

When I dissociate [my therapist] makes sure I stay grounded. She talks to us and tells us to look around at the things in the room. . . . For some of us, stuffed animals are really important. One time she even gave us one of her stuffed rabbits! . . . Other times, my therapist would ask if she could put her arm around me. Most often we would let her and that's helpful because it keeps us connected and tells us that she's there.

**Teresa:**

When I dissociate [my therapist] talks to me and when I hear her voice I'm pulled back to the present. I don't think it matters what she says although at one point, I remember her telling me that my children needed me and it was time to come back.

**Christopher:**

[During the enactment] I think it was helpful that my therapist and I were walking and moving the entire time. There's something critical about that . . .

physically moving . . . walking without stopping . . . and somehow that was key in helping me stay present.

#### Experiential and Expressive Modalities

Six of the seven participants identified the critical role non-verbal interventions, such as art, writing, guided imagery, and enactment played in providing the necessary balance required for both the expression and containment of traumatic memories. This utilization of expressive and experiential modalities enabled the participants to remain actively engaged in the therapeutic process by providing a self-regulatory function that helped minimize the overwhelming need to dissociate. These findings support current research (e.g., Avrahami, 2005; Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2004; Hirakata & Arvay, 2005; Hunter, 2004; Westwood & Wilensky, 2005) that highlights the value of utilizing non-verbal interventions to address traumatic memories and further adds to the emerging literature (e.g., International Society for the Study of Trauma and Dissociation [ISSTD], 2005; U. Lanius, personal communication, March 5, 2007; McEvoy & Ziegler, 2006; Scaer, 2007) that explores the use of such interventions when working with clients who engage in moderate to high levels of dissociation.

The following subcategories address the five expressive and/or experiential interventions that emerged from this study. These interventions include: expressive art; creative writing; guided imagery; therapeutic enactment; and Eye Movement Desensitization and Reprocessing (EMDR).

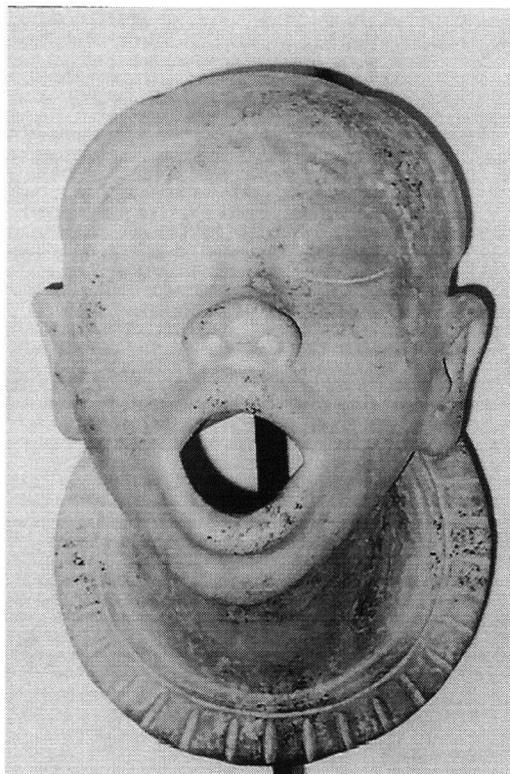
**Expressive art.** Three of the seven participants identified the importance of incorporating art as therapeutic technique in the treatment of dissociation. This finding supports current research (e.g., Howell, 2005; ISSTD, 2005; U. Lanius, personal communication, March 5, 2007; Scaer, 2005; Scaer, 2007; Steinberg & Schnall, 2001)

that emphasizes the value of utilizing art with individuals who dissociate. The following excerpts underscore the critical role art plays in helping the participants move through a frozen state of unspeakable terror by giving voice to those experiences that lack verbal language. Two of the participants further stated the value art had in accessing the child parts of themselves and providing a means through which those non-speaking parts could communicate.

**Sara:**

I have a lot of sculptures in my house and I realize that all of them have big gaping mouths with no arms and legs. Their mouths are wide open because they're screaming but . . . but no sound comes out so you can't hear them. I don't like violence but I love violent art. Somehow the art speaks the emotions I can't (see Figure 6.2).

Figure 6.2. Sara's Sculpture



**Rachel:**

When we were abused it was really drilled into us that we were not to tell ~ silence ~ some of us can't even talk so when we were introduced to art a whole world opened up for us. We were given paper and paintbrushes and for us, it was a doorway that allowed us to express the things that happened without needing to speak. Through art, we were able to tell our story without saying a word (see Figure 6.3).

Figure 6.3. Rachel's Drawing

**Teresa:**

Therapists . . . need to find a way to communicate with those young parts because it was the child parts, not the adult parts that were abused. Little T, Faint Girl, and Wild Girl can't speak and they don't write very well but . . . but they can draw and their pictures are their way of speaking ~ silence ~

Creative writing. Five of the seven participants discussed the value writing had in helping them maintain a sense of presence while facilitating a creative process of expression that enabled them to safely reveal their inner thoughts, feelings, and experiences. For three of the participants, creative writing took the form of symbolically representing their internal world through journaling, poetry, and/or song. To date, few studies have specifically explored the use of creative writing in the treatment of dissociation. As a result, this finding significantly contributes by identifying the importance of symbolic expression and the role creative writing has in helping individuals integrate unspeakable or dissociated aspects of their experience. The following excerpts capture the quotes of those participants whose use of creative writing directly appeared in the text of their narrative.

**Sara:**

Sometimes my therapist asks me to write. He says that my hands move a lot and seem quite busy and that it looks like my hands are trying to say something. . . . It's strange because by writing I can often communicate the things that I cannot say. Writing seems to access my subconscious stuff and it feels much safer ~ silence ~ especially in those sessions when speaking does not come easy.

**Teresa:**

Excerpt from journal entry: The Lions' Den written by Teresa

At that moment a huge lion emerged from the scene and stood beside me . . . the lion told me he would help me to reach into myself to find a way out, but it was me who had to do the reaching . . . then a picture emerged of somehow the lion instilling in me the confidence to go out there with a stance and a "roaring ability" that matched that of the lions. Matched being the main important word.

Not a lion's roar, still human. Not louder than them or in a way that was more aggressive but which carried an "authority", an ability to "stop them in their tracks".

**Rachel:**

Excerpt from *Sinking Into Red* written by Rachel

Walk back into the Dream  
 back into the Light,  
 Rose Red Light  
 swallows you up,  
 closes behind you,  
 enfolds you into  
 the Red Red Drumming  
 A Red Red Humming  
 Go back, go back,  
 deeper and deeper into  
 The Red.  
 Fall into its giving  
 Into its easing  
 Fall back laughing in silent tears.

**Kate:**

Writing helps. I write poems and that has been good and . . . and I write all of my own songs . . . ~ tears ~ my music . . . it saved my life.

Excerpt from *Crone Woman* written by Kate

I was born in a valley of blood  
 And it stained the skin of my soul  
 My body was shamed and trained to believe  
 That I wasn't in control.

And the very first thing that I witnessed  
 My mother's own lack of control  
 I learned to push back pain, like she did  
 Right from birth.

I can't wait to be an old crone woman  
 Cuz then I'll know who I really am  
 I'll hoist my animals onto my shoulders  
 With hands that are calloused and worn.

And I'll carry crystals in my pockets  
 And the moon will rise in my eyes  
 And I'll walk barefoot on strong old muddy feet  
 And sing stories of a well-aged life.

And I won't feel disconnected anymore  
 And on a rock in a place on a hill  
 I'll carve my own name into the stone there  
 And my spirit will float on the wind  
 And young women will sit with me there  
 And I'll wrap my windy arms around them  
 I'll be a windy old crone woman.

Guided imagery. Three of the seven participants identified the importance guided imagery had in helping them feel more grounded, connected, and alive. Two of the participants stated the value this technique had in helping them symbolically express their inner world and as a result, enabled them to access the child parts of themselves by providing a language through which they could communicate. To date, few studies have specifically explored the use of guided imagery in the treatment of dissociation. This finding therefore contributes by identifying guided imagery as a valuable tool for working with individuals who engage in moderate to high levels of dissociative behavior.

**Rachel:**

When I first started learning that I had this whole internal world it was as if all the things that were happening in our external world were represented as a symbol in our internal world. [My therapist and I] did a joining ceremony that helped bring some of the alters together. We had this image of six little children . . . we imagined a big log cabin and held a vigil for them where we just sat with them and let them be.

**Kate:** “Imagery is really powerful for me. My therapist would always get me to imagine myself with a guitar in my hand because that’s when I feel most powerful.”

**Teresa:**

The ritual abuse I experienced was very bizarre but somehow all of this imagery and symbology gives me the roots to understand it. . . . One of the first things [my therapist] did was take me on a journey to find my power animals and I know that sounds crazy but I can’t tell you how much that has affected my everyday life. . . . For me these animals hold a language that everyday language doesn’t hold because if you think about it, I was three when the abuse started. I didn’t have a lot of language and like all children, I saw things in images. Children relate to animals so these visualizations give the little ones a way to communicate. It . . . it offers them a way to heal ~ silence ~ these animals have given me back my life.

Therapeutic enactment. Three of the seven participants emphasized the value of utilizing a form of therapeutic enactment in helping them integrate parts of themselves and/or their lives that were lost or separated as a result of the abuse. Two of the participants further described how enactment facilitated a reparative shift that was felt at a cellular level in their body. This finding adds to the emerging literature (e.g., Briere, 2002; Hirakata & Arvay, 2005; Howell, 2005; ISSTD, 2005; Lanius, personal communication, March 5, 2007; Ogden, 2005; Ogden & van der Kolk, 2002; Rothschild, 2000; Scaer, 2005; Scaer, 2007; Westwood & Wilensky, 2005) that recognizes the value of engaging the body in movement and action and highlights the use of enactment in fostering an integrative process for individuals who engage in moderate to high levels of dissociation.

**Kate:**

I went to a couple of workshops where we did things like danced to music and went on shamanic journeys. Shamanism is a really ancient and spiritual way of life and there is the belief in the animals and the spirits of animals and the spirits of trees. We went on these journeys and I could feel things happening to me in my body on a visceral level.

**Christopher:**

A few years ago my therapist led me through a therapeutic enactment where I was able to recreate a scene and confront my brothers for raping my sister . . . Through the enactment, I took something back and it was so real . . . SO emotional . . . I was able to reclaim my sister as my sister.

**Teresa:**

Therapists need to use something that goes beyond talking . . . something experiential . . . because when abuse happens, there really are no words for it ~ silence ~ an experiential process goes beyond words . . . and takes a person deeper into the experience where healing can occur. . . . A few years ago my therapist led me through an enactment to help me go back and get the little girl . . . Little T . . . who was left frozen on the stairs. We re-created a scene where I became that little girl and enacted it from the perspective of what might have happened if my mom came home and found out what was happening. In a sense, we changed the ending and even though I know that ending didn't really happen the enactment gave the little girl a corrective experience and allowed her to heal and be

embraced by her mother. . . . I felt something change at a really deep and cellular level.

Eye movement desensitization and reprocessing (EMDR). Three of the seven participants discussed EMDR in the text of their story. Of those three only two expressed the value EMDR had in their overall treatment of dissociation and in comparison to the other treatment modalities identified in this research, EMDR was only briefly mentioned. Although the value of EMDR in the treatment of single-incident traumas and posttraumatic stress disorder has been widely recognized, “there is little data on the efficacy of EMDR for complex PTSD and dissociative disorders” (ISSTD, 2005, p. 122). This finding therefore fails to offer substantial evidence for the effectiveness of EMDR in the treatment of dissociation and adds to the emerging body of literature (e.g., Corrigan, 2002; Fine & Berkowitz, 2001; Gelinas, 2003; ISSTD; Lanius, personal communication, March 5, 2007; Scaer, 2007) that continues to explore the use of this intervention for individuals who engage in moderate to high levels of dissociation.

**Sara:** “We do EMDR and that has been helpful in clearing my brain.”

**Kate:** “We did EMDR and that was the best. I found that it made a huge difference in how I am in the world.”

**Lauren:**

I didn’t find EMDR particularly helpful. For one, it was based on recalling a feeling sense and I didn’t have a feeling sense so I found it really hard to think of things that were in any way real. I also didn’t like the eye movement or tapping thing ~ silence ~ I think the proximity of that was too close for me.

## Naming Dissociation

To varying degrees, all of the participants discussed the importance of acquiring information about dissociation and/or having their therapist identify dissociation and provide observational feedback as to how dissociation manifests in therapy. Three of the participants further commented on the educational value of completing the DES-II (Bernstein-Carlson & Putnam, 1993) that was used as a screening tool for participation in this research. For these participants, the DES-II provided them with a means to better define dissociation and gain a clearer understanding of what dissociation is. To date, few studies have specifically explored the therapeutic benefits of naming dissociation and drawing attention to the variety of ways in which dissociation can occur. This finding therefore contributes by highlighting the need to inform clients of their tendency to dissociate and bring awareness to the dissociative behaviors that occur in therapy. The following excerpts capture those experiences in which the identification of dissociation was specifically discussed in the text of the participants' stories.

### **Lauren:**

I've been told that when I dissociate I can look really passive and my eyes usually go off in one direction. I have almost no facial expression and can speak about really difficult things quite matter-of-factly. [My therapist] has made me more aware that I use dissociation as a technique. Initially, I didn't even know dissociation was going on and for me, a valuable part of therapy has been helping me develop more of an awareness of the things that I do.

### **Christopher:**

My therapist will ask questions like, "You seem to be in another place right now. Are you okay? Can you tell me where you are?" And if I say I don't know, he'll

say, "What do you mean you don't know? Let's stop and look at that for a second." By helping me explore what's happening in the moment I can become more aware of what it is that I'm escaping from and somehow find new ways of dealing with things without needing to dissociate.

**Rachel:** "[It's] okay to tell them about dissociation because when I first learned what dissociation was, I thought, 'Finally, there is a word to describe how I feel!'"

**Sara:**

It's been a relief to know that I dissociate. . . . Sometimes just mentioning that I'm not present helps me realize that I'm not here and that in itself can bring me back. In some ways, not pointing out dissociation and educating people about it is harmful because . . . because it's very lonely in here and I would have been constantly beating myself up.

**Catherine:**

[My past counsellor] pointed out the fact that I have disassociation. . . . When she told me that I thought she was crazy. I'm thinking, "This lady is nuts! I don't have any of these things and I must be pretty wacko to pick a stupid counsellor like her!" Now I think she hit the nail on the head. . . . For a therapist to tell someone about disassociation . . . I think ultimately it's a good thing. It's one of those things that you have to do.

Going Slow

Despite the recognized value of the above mentioned techniques, all of the participants expressed the importance of ensuring safety and assessing readiness before proceeding with any intervention. This finding is congruent with current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Howell, 2005; Hunter, 2004; ISSTD, 2005;

McEvoy & Ziegler, 2006; Porges, 2004b; Ogden, 2005; Ogden & van der Kolk, 2002; Rothschild, 2000; Scaer, 2005; Scaer, 2007; Schwartz, 2000) that identifies the critical need for therapists to establish safety and titrate the processing of traumatic material in order to minimize a client's need to dissociate. The following excerpts describe a variety of situations in which some of the participants experienced a significant level of discomfort as a result of their therapist proceeding too quickly.

**Sara:**

For the longest time, my therapist would ask, "What do you feel in your body?" Then he'd say, "Well, what are you feeling? What are those tears about?" And I still couldn't understand. . . . My therapist seemed frustrated by that and that wasn't helping because I can't access what I can't access. . . . It's taken me five years to even begin to talk about my body so don't jump too far ahead. Don't take me to the end before I'm ready.

**Christopher:** "[My therapist] doesn't force me to go in a direction if I'm not ready because if he did, it would hurt me."

**Lauren:**

Sometimes [my therapist] will ask me what I'm feeling and that's helpful but it's also frustrating because like I said, I still can't sort out what basic feelings are. . . . I tested [my therapist] by working on the practical things in my life first. . . . For the first three or four years of seeing her, I probably didn't cry at all.

**Teresa:**

[The therapeutic process] can't be rushed because if it is and we feel pressured, we're no longer safe. Dissociation happens so fast and it takes a real conscious effort to come back. If it's not safe we'll dissociate and be gone.

**Catherine:**

With this disassociation thing . . . you have to be careful . . . you have to go slow because . . . well, it's scary. Very scary! We develop disassociation for a reason and . . . it's kind of like having a safety blanket and all of a sudden that safety blanket that you have had your whole life is being pulled away ~ silence ~ that's the scary part. You are literally taking somebody's safety away. It's their lifeline, I guess.

### Challenging the Dominant Paradigm

#### A Non-Pathologizing Approach

To differing degrees, all the participants reported the need for therapists to identify themselves within a greater social, cultural, and political context and directly, or indirectly, address the dominant paradigm in which dissociation exists. Currently, dissociation is described as a mental disorder in the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR, 2000) where experiences, or symptoms, of dissociation are viewed through a lens of pathology. Cultural myths and social stigmas fuelled by popular North American media further add to the debilitating us-them mindset that fails to recognize dissociation as a highly adaptive, life-saving experience inherently present in all living beings.

To date, few studies have critically examined the dominant discourse that surrounds dissociation and the impact this discourse has on the process of reparation. This finding therefore contributes by drawing attention to the paradigm in which therapists situate themselves and the manner in which dissociation is viewed. The following subcategories--labels and diagnoses, psychotropic medication, and normalizing the experience--bring forth the potentially damaging consequences of applying the dominant medical framework to the treatment of dissociation.

Labels and diagnoses. Two of the seven participants strongly expressed the struggles they experienced from being labeled or diagnosed according to the criteria found in the DSM-IV-TR (2000). For both of the participants, the diagnosis resulted in a broken sense of safety and led to the termination of the therapeutic relationship. This finding challenges the dominant paradigm that views dissociation within a medical and diagnostic framework and questions the efficacy of formally diagnosing dissociative behavior. Although this theme was only identified in two of the seven narratives, the power of this experience in shaping the participants' process of therapy warrants acknowledgement as a critical finding of this study.

**Lauren:**

I was diagnosed as borderline several years ago and that wasn't helpful. I'm not borderline and . . . and it really angered me that someone would say that because when you look at anyone with my history of course they would show up that way. I was also . . . assessed as someone who should be on a positive watch for multiplicity. . . . I've had numerous suicide attempts, problems with relationships and addictions, and maladaptive and highly entrenched ways of meeting the world but all of that is about my abuse history and none of it makes me borderline or multiple. I feel quite sad about how that therapist diagnosed me because we had done some valuable work and those diagnoses really accelerated my sarcasm towards her.

**Catherine:**

The counsellor who told me that I have disassociation then proceeded to tell me that in her professional opinion it is not unusual for people in my circumstances to experience one or more of these problems. For me to just remember all of the

conditions she said I had . . . disassociation, posttraumatic stress, depression . . . it was difficult. . . . In my mind, I just twisted it all around, thought she was the crazy one, and left.

Psychotropic medication. Given our cultural tendency towards valuing medication as a viable treatment modality for various ailments, it is important to comment on the use of medication in the treatment of dissociation. The results of this study revealed that only one of the participants identified medication as a significant part of her overall treatment and consequently, indicates a need for further research in this area. This finding however, adds to the emerging body of literature (e.g., Ginsberg, 2005; Phillips, Hunter, Baker, Medford, Sierra-Siegert, & David, 2003; ISSTD, 2005; Philipsen, Schmahl, & Klaus, 2004; Simeon & Knutelska, 2005; Simeon, 2004) that debates the effectiveness of psychotropic medication in helping individuals manage moderate to high levels of dissociation. Given that this finding reflects an absence of recognition for the use of medication in the treatment of dissociation, no excerpts from the participants' stories are provided.

Normalizing the experience. All of the participants identified the highly reparative value of having their therapist normalize their experience and directly address their fears of being different and/or crazy. For several, this provided a sense of support and validation and significantly facilitated their overall process of reparation. To date, few studies have directly explored the benefits of applying a non-pathologizing approach to the treatment of dissociation. As a result, contributions of this study include the strong need for therapists to situate themselves outside of the dominant framework and acknowledge the innate and self-protective function dissociation serves. The

following excerpts include those experiences in which the need to normalize dissociation was addressed in the text of participants' story.

**Teresa:**

I used to feel that there was something wrong with me . . . that I was different than everyone else [and] I often beat myself up by telling myself, "I should be over this!" or "I shouldn't be having trouble because anyone else would be fixed by now!" All of the labels I put onto myself . . . not seeing myself as normal . . . and believing that if people really knew me, they would run away and leave.

**Kate:**

My older sister is mentally ill so being crazy has been a real fear for me. Even if I dismissed something [my therapist] didn't and that was so reaffirming and validating because I've always felt very crazy in my life.

**Catherine:**

I often wonder if I'm crazy. I wonder if I'm crazy because none of this makes sense . . . my memory . . . my life. . . . It's very important for therapists to convey that you are not crazy, that this is natural, and that we are NOT stupid.

**Sara:**

[My therapist] . . . he ~ tears ~ assures me that I'm not the crazy one and that life around me is crazy ~ silence ~ he treats me saner than I think I am and . . . and that is a very kind thing to do ~ tears ~

## The Therapeutic Relationship

### A Trusting Foundation

To differing degrees, all of the participants emphasized the importance of having a strong and trusting therapeutic relationship yet at the same time, acknowledged the challenges of being able to fully trust. Although the need for trust is widely recognized in the literature (e.g., Briere, 2002; Courtois & Pearlman, 2006; Howell, 2005; Hunter, 2004; ISSTD, 2005; Ogden, 2005; Steinberg & Schnall, 2001) as being an essential ingredient of trauma therapy, little is provided in terms of identifying specific factors that create the level of trust required for effective treatment to occur. The results of this study therefore contribute by providing a list of factors that facilitate trust for individuals who engage in moderate to high levels of dissociation. The following subcategories--the fragility of trust; reciprocity; periods of conflict; and being there--underscore the delicate nature of trust and identify specific experiences described by the participants as being significant contributors to the building of a trusting foundation.

The fragility of trust. To varying degrees, all of the participants identified the fragility of trust and the need to continually assess for potential risks of harm or danger. For several, the struggle to trust involved an ongoing process of negotiation and a constant back and forth movement between feeling an intense fear, and an intense desire, to experience a safe and trusting therapeutic connection. This finding emphasizes the fragility of trust and is congruent with current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Herman, 1992; Howell, 2005; Hunter, 2004; ISSTD, 2005; Schwartz, 2000) that recognizes the heightened vulnerability for individuals whose only sense of safety exists in their ability to dissociate. The following excerpts

include those quotes in which the struggle to trust was directly identified in the text of the participants' stories.

**Lauren:** "The therapist that I'm currently seeing is someone that I have been seeing for eight years. She has been the most helpful . . . I didn't always trust her though ~ silence ~ it has taken me quite a long time."

**Catherine:**

I just started with a new counsellor. . . . For the majority of time, I don't let anybody into my space. If someone tries to enter my space, I always have to assess . . . is this someone going to harm me? ~ silence ~ Trust is a big thing. The world is very scary and you just can't trust anybody.

**Kate:**

I met my current therapist about five years ago and I have been seeing her ever since. I remember the first time I met her. She sat like really close and our knees were almost touching. I was terrified of her so I sat way on the other side of the couch ~ laughs ~ I couldn't face her. I was way too scared.

**Teresa:** "[My therapist] truly cares but I didn't always believe that. I tend to think that if you're paying someone to be there for you then of course they're going to say nice things."

**Rachel:** "I saw several therapists before I began working with my current therapist and we have been working together since 1991. . . . Trust is hard. I don't trust very easily and even now, I don't think I trust my therapist 100%."

Reciprocity. To differing degrees, all of the participants expressed a need not only for themselves as clients to trust their therapist, but also for their therapist to demonstrate a degree of trust and confidence in them. For three of the participants, this

experience facilitated a reciprocal action that was reported to enhance their ability to better engage in a trusting therapeutic alliance. For others however, a lack of trust by their therapist was noted to result in the opposite. To date, few studies have explored the reciprocal nature of trust and the role it plays in building a trusting foundation for individuals who engage in moderate to high levels of dissociation. The following excerpts describe the impact of those experiences in which the participants' therapists expressed, or failed to express, a sense of belief, trust, and/or confidence in them.

**Kate:**

[My therapist] knew me and believed in me long before I did. . . . My music . . . she honed in on it and knew that was what I wanted to do. She's so excited about how far I've come ~ tears ~ she tells me she's proud of me.

**Christopher:**

For me, it helps because my therapist has the guts to go there and embodies the fact that this is my journey. . . . I may not be ready to go somewhere but my therapist will radiate a sense of confidence in me that says, "Okay, when you're ready we'll go there and when we go there we'll go there together."

**Lauren:** "[My therapist] acknowledges my resiliency and that's important because anyone who doesn't is being disrespectful and disempowering and right away, I would dismiss that person's ability to be of any value to me."

**Teresa:**

I had a bad experience where I told a counsellor about a blood ritual I experienced and she told me that was really bad and when things like that happen, a person can be scarred for life and never get better. That was really damaging.

**Sara:**

I can really fool a lot of people including myself and I need my therapist to recognize that on the outside I may look like I'm holding it together but on the inside A and B just aren't matching up. . . . I told my therapist that I was coming to talk with you and he said, "Oh, you're too high functioning for that!" That wasn't helpful. I need for him to acknowledge that this is a problem for me and that I'm struggling.

**Catherine:**

[My previous counsellor] told me that she could tell just by looking at someone that they were in disassociation. I don't think so. I don't know how she can feel what I'm feeling or think that she knows what my mind is doing.

**Rachel:**

Being in the hospital is definitely not helpful. The first time we went there it was terrifying so we curled up on the floor because some of the alters were really scared. One of the nurses came in and told us, "Get up! Stop behaving like that!" and that just added to the terror. . . . [It's] really important to believe your clients. There have been many times when we have thought to ourselves that we're making it all up . . . it can't be real! . . . so to have someone say that they don't believe us is absolutely devastating.

Periods of conflict. Three of the seven participants identified the value of experiencing a period of conflict with their therapist and reported the positive role this had in facilitating a stronger and more trusting therapeutic alliance. For some, this conflict served as a testing ground that enabled them to consciously, or unconsciously,

assess the safety and trustworthiness of their therapist while for others, it offered a reparative opportunity to experience interpersonal tension in a manner that did not result in violence, abandonment, or betrayal. To date, few studies have identified the therapeutic value conflict has in facilitating trust for individuals who engage in moderate to high levels of dissociation. The following reflects those experiences in which a period of conflict significantly enhanced the development of a trusting therapeutic foundation.

**Lauren:**

I was quite rude to [my therapist] in the beginning. I have a larger vocabulary than her and I'd say things like, "Well, I'm a hedonic personality and if you don't know what that means then that's a problem" ~ laughs ~ I would also do things like use sarcasm to fend her off completely or I would roll my eyes or be critical and start to sneer. . . . She allowed me to challenge her and I think that's the only reason I've been able to work with her for so long.

**Rachel:**

My therapist knows how to handle our rage really well. She understands that the rage and our expression of it happen when we feel powerless and she does her best not to do things that would take our power away. . . . My therapist and I have been in conflict with each other and even though it's hard it helps to know that we can be in conflict and still survive.

**Christopher:**

It's interesting because right now, I'm at the point where I can have a tussle with [my therapist] and he convinces me that it's okay. My experience in my family was one of conflict-avoidance . . . and conflict-avoidance to a pathological

degree! . . . and to be able to be angry at someone and know that it's okay has been critical. I can say to him, "You know, you really make me mad!" and for me to be able to say that has been highly therapeutic.

Being there. To varying degrees, all of the participants reported the importance of having their therapist be there for them in a manner in which no one else ever had and the role this played in contributing to a safe and trusting therapeutic alliance. For two of the participants, the ability to depend on their therapist during times of need proved crucial in helping them recognize that they could reach out for support and trust that someone would be there. To date, few studies have directly explored the meaning clients attribute to being able to rely on their therapist and the impact this has in facilitating trust for individuals whose journey in life has been primarily traveled alone. The following excerpts capture those experiences in which the act of being there was directly addressed in the text of the participants' stories.

**Rachel:**

There are times when we felt like a real pain for phoning [our therapist] so often but she would say, "You need to talk so it's okay and I'm really glad you called." She always makes us feel that we aren't doing anything wrong and time and time again she proves to us that whenever we need her, she'll be there.

**Kate:** "[My therapist] . . . I couldn't have gotten through what I did . . . not without her . . . I feel extreme gratitude towards her."

**Lauren:**

I've been able to depend on [my therapist] and ask her for help. . . . I had some significant stuff happen two years ago where I had a violent reaction to something and partially smashed up a house. I was completely dismayed by it

and could have potentially gotten into quite a bit of legal trouble. My therapist was the first person I called. She gave me her home number and I only used it once but the fact that I could was ~ silence ~ I learned from my therapist that I could depend on her ~ silence ~ I asked her to help me out and I knew that she'd be there.

#### A Break from the Past

To varying degrees, all of the participants identified the power of being able to break free from old patterns and beliefs through a corrective experience that occurred within the person to person contact of the therapeutic relationship. This finding supports current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Howell, 2005; Porges, 2004a; Porges, 2004b; Schwartz, 2000) that identifies the multiple ways in which the therapeutic relationship serves to recreate new experiences, re-establish broken attachments, and provide a form of re-parenting for clients whose childhood lacked the necessary conditions for positive growth and development to occur. The following subcategories highlight those factors that occurred within the healing interaction of the therapeutic alliance and were identified by the participants as significant contributors to their overall process of reparation. These subcategories include: challenging old patterns; knowing beyond words; and a new way of being.

Challenging old patterns. Four of the seven participants discussed the value of having their therapist challenge them in a manner that drew attention to old patterns and beliefs that no longer supported them in living a full and healthy life. For some, this challenge directly involved bringing awareness to the disadvantages, or losses, associated with being in a continual state of dissociation. For others, the need to be challenged was expressed as a wish or desire of something they felt was lacking in their therapeutic process. These findings are congruent with current research (e.g., Briere,

2002; Courtois & Pearlman, 2006; Fosha, 2003; Howell, 2005; Schwartz, 2000) that acknowledges the need for therapists to challenge clients and help re-examine those highly debilitating or self-defeating ways of being. The following excerpts reflect those participants' experiences that describe the value, or desire, of having their therapists challenge old or outworn patterns and beliefs.

**Christopher:**

My therapist explores how dissociating helps me and challenges me to understand how it might hurt me. . . . I think some therapists believe that if a person dissociates then that's okay because the client just needs to go away to a safe place for awhile. That's true but you know what? I'm 45 years old and maybe my means of escaping is a reflex that's no longer beneficial. Maybe I've been doing it for a long enough time and maybe I need to find ways of not escaping and staying in the here-and-now.

**Rachel:** "Sometimes I wish [my therapist] would ask more questions . . . curious and inviting questions . . . questions that make us think."

**Lauren:**

It's unhelpful when [therapists] don't challenge me on what I'm doing. . . . I'm really good at deflecting attention away from myself and what I'm feeling and I have learned to present in such a dissociative way that . . . the facilitators of a group didn't do anything about it and I really needed someone to challenge me about what I was feeling right there in that moment.

**Kate:**

Sometimes I wish my therapist was a little more forceful. I mean, I can talk up a storm and she knows that and sometimes she doesn't challenge me on it. I mean,

she's really good at letting me come to my own realizations but there have been a couple of times where I could hear myself say stuff and I'd be wishing that she would stop me and say "What are you talking about?!"

Knowing beyond words. Four of the seven participants reported the value of having their therapist know them in a way that they did not know themselves and give voice to those frozen, or dissociated, thoughts and feelings that they could not express in words. For several, the act of having their therapist understand those non-verbal and often subtle forms of communication provided a corrective experience that helped counter a childhood where struggles to be seen were left unnoticed and silent cries for help were left unheard. To date, few studies have explored the power of the unspoken connection that exists between therapist and client and the close and somewhat intimate relationship they share. This finding therefore contributes by identifying the meaning clients assign to their therapist's ability to understand them in a way that no one else ever had. The following excerpts reflect those experiences in which the participants felt both seen and heard in a manner that extended beyond words.

**Teresa:**

My therapist shows she genuinely cares by knowing me and knowing me beyond words. I often have a hard time using words to communicate and I feel stupid and think that I should just snap out of it and speak but . . . but my therapist can hear what it is that I'm not saying and that helps.

**Kate:** "My therapist saw who I was right from the very beginning. She has gotten really good at reading me and it's awful sometimes because I can't do anything without her seeing ~ laughs ~"

**Rachel:** “My therapist has a great way of working and understands stuff that no one else really can.”

**Lauren:**

Sometimes I wouldn't be able to say a lot but [my therapist] would see and hear what I wasn't saying verbally. . . . It's taken her awhile to have that capacity but she's really in tune with me. That's another way in which she scored points and gained my trust.

A new way of being. Four of the seven participants described the value of having their therapist act as a role model and demonstrate a new way of being that facilitated a greater connection to both themselves and others. For many, this experience provided a sense of hope and created an experience that assisted the participants in being more present and grounded in the world. Although much research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2003; Fosha, 2006; Howell, 2005; Ogden, 2006; Porges, 2004a; Schwartz, 2000) acknowledges the importance of having therapists model positive interpersonal interactions, few studies have examined this from the voice and perspective of those who dissociate. This finding therefore contributes by underscoring the heightened need for therapists to serve as a template for healthy relationships by modeling appropriate boundaries and facilitating honest and open communication. The following excerpts reflect those experiences in which the participants describe the reparative value of having their therapist demonstrate positive and healthy ways of being in the world.

**Sara:** “[My therapist] discloses things about himself and his crazy family that I find extremely helpful because I can see this high functioning individual and realize that it could be me.”

**Rachel:**

My therapist has a way of being in the world and . . . and that's how I want to be. In some ways, I've been able to transfer the way she is with me into my personal relationships with others and I think that has been really valuable.

**Kate:**

[This song] is about my therapist and how I want to be like her . . .

I know a silver woman in the mountains  
There's a raven perched on top of her head  
And she carves out her life all around her  
With fingernails caked in black earth.

And she tells me to hold fast to my truth  
And to lay myself down in the grass  
And she tells me to live in my body  
And worship it too.

. . . she is such a hugely different role model than my parents were and I love her dearly.

**Lauren:**

I never had a sense of how to depend on anyone before. None of that stuff was ever modeled for me in my family and . . . and I feel as if I've been re-parented to a certain degree. . . . I use my relationship [with my therapist] as a model for other relationships that I'm in because . . . because in a way, it's like having a surrogate relationship with a person who teaches you how to be in the world.

**A Witness to the Journey**

All of the participants expressed the value of having their therapist follow their lead and be a witness to their journey by putting aside their own agenda as to what they thought should happen. Several of the participants emphasized the importance of finding their own answers, arriving at their own conclusions, and trusting their own inner

knowing as to what they needed to do. This finding is congruent with current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Howell, 2005; Ogden, 2006; Schwartz, 2000) that identifies the need for therapists to act as a witness and travel with clients in a manner that avoids recreating the abuse dynamic where a person of power (e.g., the therapist) dominates and attempts to control the thoughts, feelings, and/or actions of the person who was once abused. The following excerpts highlight those quotes in which the participants directly discuss the value of having their therapist journey with them in the text of their narrative.

**Kate:**

I think it's important for therapists to always go with the client. One of the things my therapist does is she just goes with whatever I bring up. She lets me come to what I need to come to in my own time and wherever I'm going in my process she follows.

**Teresa:**

Clients need to decide for themselves what route is best and therapists need to facilitate that process and use what clients connect with to do something experiential . . . Therapists should encourage clients to follow their intuition and trust that they know what it is they need even though they may not be consciously aware of it. We need to find our own answers!

**Rachel:**

It's harmful when therapists have their own agenda and think that they know what it is that we need. Some professionals who know a lot about dissociation and multiplicity have their own agenda and that's harmful because when it comes to our healing, we don't like people telling us what to do. . . . My therapist

supports the choices we make and makes us feel that it's our agenda that matters. She says that she doesn't know what it's like to live our life and her role is to be a witness and to walk along beside us.

**Christopher:**

Give clients control and travel the journey with them because then clients leave with a sense of support and empowerment. . . . Listen to your clients and embody the fact that your client might have something important to say. Clients might already know their own answers and if you talk too much or talk just to fill up the space with words, you might miss learning about what it is that your client knows.

**Catherine:** "Awareness is massive but it needs to come from me because when it does, that's when I start to understand."

The Human Connection

Perhaps the strongest theme that emerged from this study was the human to human connection that the participants experienced with their therapist and the role this played in creating a level of safety and connection that they never before experienced. Six of the seven participants discussed this theme in great length and with heightened intensity as they expressed the highly reparative value this connection had in their overall process of reparation. Several of the participants used words such as present, genuine, unconditional regard, love, and transparency to describe those qualities that facilitated a person to person connection that was lacking throughout most of their lives.

Although much research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Haddock, 2001; Howell, 2005; Ogden, 2005; Schwartz, 2000) underscores the value of a strong therapeutic relationship, few studies have specifically explored the

unique qualities that foster such a relationship and the impact it has on those whose first real connection often occurs within the healing embrace of the therapeutic alliance. This study therefore contributes by highlighting the need for therapists to simply be present, human, and real. The following excerpts include those participants' experiences that capture the power of that much needed human to human connection that was shared between therapist and client.

**Kate:**

The connection I have with my therapist has been crucial. I don't know how to describe her because she's unlike anyone I've ever met before. . . . She's real and that's important because if you're not real and transparent, a client is going to pick that up. . . . She gives me unconditional acceptance and love and all of that makes for a deeper connection and that's when healing really happens.

**Sara:**

If I can extend love or care to someone . . . it's like a ribbon that joins us together. It's an extension of love that happens when I'm able to take a sincere interest in someone else. It's about connection. . . . It's about removing the wall or barrier and taking away the isolation. It gives me hope and helps me feel connected.

**Christopher:**

My therapist is present . . . very, very present. . . . [He] convinces me that I'm okay and challenges me in a real caring manner and I think when therapists do that in a genuine way, clients are in a better position to develop love and unconditional regard for themselves. . . . I hesitate to use the word love because I

think that's often laden with stuff that we don't want but that's what it is. It's about love and having that unconditional positive regard for another.

**Rachel:**

I think the thing that helps the most is her presence. My therapist has an openness to her and sometimes she helps by just staying quiet or simply acknowledging that it was a painful thing that we went through. . . . She has an unconditional positive regard that is very helpful. There was a time when I was drinking almost every day and I didn't tell her because I was afraid that she would be mad. When I finally told her she said, "This is a way of coping and I'm confident that you will work through it and that you won't be doing it forever." She always tells me that there is a good reason for the things that I do. She says that it's okay to feel what we're feeling and there's never any judgment or criticism.

**Teresa:**

As a person, my therapist is very genuine . . . for awhile my therapist and I were in regular email contact but at one point her emails just stopped. . . . She didn't have to do this but after some time, she sought me out. She sought me out and said how sorry she was for losing touch. I could hear in her voice that she was feeling some emotion. That was a real pivotal moment and I knew at that point that her care for me was genuine.

**Lauren:**

My therapist is genuine in our relationship and I think that's critical because survivors of trauma know. We know how to recognize whether a person is being real or not and she needed to be genuine with me in order to be successful. . . . In

some ways, your research is looking for techniques that therapists can use to help a person who dissociates but it's really not about techniques. It's about the therapeutic relationship.

### Conclusion

Three major themes--tools and techniques; challenging the dominant paradigm; and the therapeutic relationship--were reflected by the participants as being significant contributors to the overall treatment of dissociation. From these themes, 20 subcategories emerged and of those, 17 were identified as playing an important role in expanding the often narrow therapeutic window and thereby minimizing the need to dissociate. The 17 treatment approaches described as valuable include: a re-integration of the senses; expressive art; creative writing; guided imagery; therapeutic enactment; naming dissociation; going slow; normalizing the experience; the fragility of trust; reciprocity; periods of conflict; being there; challenging old patterns; knowing beyond words; a new way of being; a witness to the journey; and the human connection.

It is interesting to note that the common factor, or underlying reparative experience, existing within all 17 subcategories is connection. According to the participants, these subcategories were noted to facilitate reparation by a) enhancing a greater connection to self (e.g., non-verbal interventions; naming dissociation; and going slow), b) developing a more intimate relationship to others (e.g., building a trusting foundation; a break from the past; a witness to the journey; and the human connection), and/or c) building a stronger and more healthy ability to interact in the world (e.g., reintegration of the senses and normalizing the experience). EMDR, labels and diagnoses, and psychotropic medication were also discussed. These approaches

however, were identified as being harmful or less significant in terms of the positive value assigned to the intervention.

## CHAPTER SEVEN DISCUSSION

**What is the experience and treatment of dissociation in individuals who were sexually abused in childhood?** The purpose of this chapter is to discuss the results of this research and examine how the themes that emerged from this study relate to the current theories and practice on the experience and treatment of dissociation. In this chapter, I identify the significance of the research findings by highlighting the implications these findings have for both theory and practice in the field of counselling psychology. Furthermore, I discuss the limitations of this study and conclude by exploring possible areas for future research.

### Implications for Theory and Practice

#### Experience of Dissociation

Four major themes that describe the experience of dissociation emerged from the stories and narratives of the seven individuals who participated in this study. These themes--disconnection to self, others, and the world; gaps in time, space, and memory; the dissociative process; and personal meaning and insight--are discussed individually and implications for both theory and practice are identified.

Disconnection to self, others, and the world. Researchers (e.g., Briere, 2002; Courtois & Pearlman, 2006; Dell, 2006; Howell, 2005; Nijenhuis, 2004; Putnam, 1997; Roder, Michal, Overbeck, van de Ven, & Linden, 2007; Simeon, 2004) have agreed that dissociation can be described, according to its current definition, as "a disruption in the usually integrated functions of consciousness, memory, identity, and perception" (DSM-IV-TR, 2000, p. 519). Although this definition acknowledges the significant disruptions that can occur within an individual, it fails however, to reflect the heightened sense of

disconnection and the impact dissociation has on the individual's capacity to interact with others and the world. The results of this study revealed that all of the participants identified a strong sense of disconnection, not only from themselves, but from others and their environment and that it was a disconnection rather than a disruption that best reflected their experience of dissociation.

These findings were significantly supported by many of the smaller subcategories that emerged from this research. These subcategories include: the disconnected self; emotional and physical numbing; a separation from body; disconnection from others; distorted sensory perceptions; and focusing. The results of this study therefore contribute by expanding the current definition of dissociation and suggesting that a disconnection from self, others, and the world is the underlying, or defining, feature of the dissociative experience. Implications for practice include providing therapists with a clearer understanding of the experience of dissociation and as a result, be in a better position to support clients who engage in moderate to high levels of dissociative behavior.

The results of this study are also congruent with the continuum theory that states that dissociation includes a range in behaviors that span from a partial to a more complete and total separation from aspects of one's own environment and/or identity. Proponents of this theory (e.g., Briere, 2002; Butler, 2002; Dell, 2006; Courtois & Pearlman, 2006; Putnam, 1997; Scaer, 2007) challenge the notion that dissociation exists as a typology and instead, have recognized how dissociative experiences vary in terms of intensity and degree of disconnection. Implications for practice include the need for therapists to acknowledge that dissociation is not an either/or or us/them experience. Rather, it occurs to differing degrees in all individuals and ranges in

behavior from mild and common (e.g., daydreaming and highway hypnosis) to severe and less common (e.g., dissociative fugues and dissociative identity disorder). A continuum perspective normalizes dissociation and thus removes some of the barriers that prevent individuals from seeking support. The therapeutic implications of normalizing dissociation are further described in the Treatment of Dissociation section discussed below.

The results also contribute to the literature by identifying A Place Within or an inner retreat that provides a means of escaping the fears and dangers of the surrounding world. To date, few studies have recognized dissociation as an experience that includes a process of moving inward and the presence of an inner sanctuary that was described in this study as comforting, peaceful, and safe. Practical implications include the identification of an internal resource that therapists can help clients access during moments when overwhelming fears result in the urge to engage in self-destructive or self-harming behaviors. Although this place within still acts as a barrier to being fully present in the world, it can serve as a safe and temporary reprieve that reduces the need to engage in more harmful methods of self-regulation. This finding also highlights the critical role dissociation plays in helping individuals maintain a sense of emotional and psychological safety. Suggestions include the need for therapists to fully acknowledge the value of dissociation and use caution when attempting to alter or remove a form of coping that provides a much needed source of protection.

A significant contribution of this research further exists in the finding that none of the participants described leaving their body or rising above themselves as a prominent feature of dissociative behavior. In fact, five of the seven participants explicitly stated that this was not a part of their experience. This finding is in direct

contrast with information provided in the literature (e.g., Brown, 2006; Dell, 2006; Gow, Lang, & Chant, 2004; Edge, 2004; Holmes, Brown, Mansell, Fearon, Hunter, Frasilho, & Oakley, 2005; Irwin, 2000; Murray & Fox, 2005; Scaer, 2007) and therefore challenges the notion that equates dissociation to an out-of-body experience. Consequently, it is important for therapists to critically assess popular assumptions and be aware of any preconceived ideas of what they believe dissociation is. Suggestions include engaging clients in a dialogue that enables them to tell their story of dissociation. In doing so, therapists can create a highly validating and empowering opportunity for clients, who were once disempowered and disbelieved, to be an expert in their own experience.

Gaps in time, space, and memory. According to Scaer (personal communication, April 14, 2007), dissociation involves the splitting of memories and perceptions where fugue states, a loss of time, and forgotten histories are prominent features of dissociative behavior. The results of this study support current research (e.g., Briere, 2002; Brown, 2006; Courtois & Pearlman, 2006; Dell, 2006; Freyd, 2002; Nijenhuis, 2004; Putnam, 1997; Scaer, 2006; Steinberg & Schnall, 2001) that recognize the highly disorienting nature of dissociation and the significant gaps that can occur in time, space, and memory. These findings also acknowledge the loss of time and space that occurs, not only as gaps in temporal or spatial awareness, but also in the experience of having parts of the self frozen or lost in time. Two of the participants made specific reference to child parts of themselves that were held frozen in a moment of abuse while others distinctly described a sense of being stuck in past. Implications for practice include the need for therapists to understand the variety of ways in which the boundaries between past,

present, and future often collide. A continual process of reorientation is therefore critical.

The dissociative process. According to researchers (e.g., Briere, 2002; Fosha, 2003; Lanius, Hopper, & Menon, 2003; Nijenhuis, 2004; Porges, 2004a; Scaer, 2006; Schore, 2002; Williams, Haines, & Sale, 2003; Yehuda, 2004), dissociation involves a chain of physiological responses that is consciously, or unconsciously, triggered by a range of internal and external cues. These cues evoke a sense of danger and thus trigger the need to psychologically flee a potentially threatening situation. To varying degrees, all of the participants identified a progression of responses that include: (a) the conscious or unconscious awareness of internal or external triggers that signal the need to psychologically escape a situation, (b) a physiological experience of anxiety and/or fear-related responses coupled with an overwhelming sense of losing control, (c) the awareness of entering into a state of nothingness that is void of any thoughts, feelings, or sensations, and (d) a return to awareness characterized by a distinct sense of being more present, grounded, and alive and where objects and colors in the environment appear brighter and more vivid.

These results are congruent with current research that recognize the neurobiological basis of dissociation and further contribute by outlining the step-by-step reactions that occur in the process of dissociation. Practical implications include helping therapists understand the sequence of reactions that occurs and providing possible moments where grounding techniques can be used to interrupt the chain of responses and thus minimize a client's automatic tendency to dissociate.

Personal meaning and insights. Researchers (e.g., Briere, 2002; Courtois & Pearlman, 2006; Freyd, 1996; Howell, 2005; Putnam, 1997; Scaer, 2005; Schwartz,

2000) state that dissociation is an escape when there is no escape and in incidences of childhood sexual abuse where attempts to physically fight and flee the perpetrator are often unsuccessful, dissociation is the only means of survival. Although the life-saving properties of dissociation are generally recognized by both theorists and clinicians, few studies have explored the personal meaning attributed to dissociation by those who engage in moderate to high levels of dissociative behavior. The results of this study revealed that all of the participants struggled to come to terms with the awareness that dissociation enabled them survive yet at the same time, took away their ability to fully live. This finding therefore contributes by providing insight into the inner tension experienced by clients and the need for therapists to acknowledge both the gains, and the losses, associated with a way of coping that may have become a dominant part of a client's everyday life.

#### Conclusion

The results of this study revealed that dissociation is more accurately defined as: **a sequence of physiological responses that occur in reaction to real or perceived danger resulting in a partial or more complete disconnection from oneself, others, and the world.** Defined in the Merriam-Webster Collegiate Dictionary (2000), disruption is to break apart, upset, and throw into disorder. Disconnection however, is to sever a connection of or between by becoming detached or withdrawn. Synonyms of disconnection include to disengage and free. Given that the findings of this study describe dissociation as a continuum of experiences, versus a break in experiences, and that participants used words such as calm, safe, and peaceful to capture the felt sense of dissociative behavior, the term disconnection is a more accurate reflection of the dissociative experience.

This above stated re-definition therefore incorporates the four core experiences of dissociation described in this study. These experiences include: (a) the heightened levels of disconnection identified as the underlying, or defining feature, of dissociative behavior; (b) the continuum of experiences that range from a partial to a more complete sense of disconnection; (c) the strong physiological basis of dissociation described as a sequence of fight and flight reactions consciously, or unconsciously, triggered by internal or external cues; and (d) the feeling of disconnection that occurs in relation to oneself, others, and the world. The results of this study therefore contribute by offering a definition of dissociation formulated from the voices and perspectives of those who dissociate.

#### Treatment of Dissociation

Three major themes were recognized as being instrumental in the overall treatment of dissociation. These themes include: tools and techniques; challenging the dominant paradigm; and the therapeutic relationship. In this section, each theme is discussed individually and implications for both theory and practice are identified.

Tools and techniques. Researchers (Briere, 2002; Fosha, 2006; Hirakata & Arvay, 2005; Odgen, 2006; Porges, 2004b; Scaer, 2007; Westwood & Wilensky, 2005) have described a variety of tools and techniques that have been useful in minimizing dissociation and integrating lost, or dissociated, parts of the self that became fragmented as a result of the abuse. To varying degrees, all of the participants discussed the reparative value of interventions, such as expressive art, creative writing, guided imagery, and therapeutic enactment, in helping them work through traumatic material in a manner that enabled them to remain present within the therapeutic window of tolerance. Three of the participants further described the critical role such techniques

had in providing a means through which they could express the inexpressible and give voice to those parts of themselves that lacked verbal language. These results are congruent with current research and emphasize the need for therapists to incorporate a variety of experiential and expressive techniques when working with clients who dissociate.

This study also revealed that six of the seven participants stated the importance of having their therapist engage them in a multi-sensory manner and the role this played in facilitating a reconnection to themselves, others, and their environment. Several of the participants described examples in which their therapist encouraged them to feel their feet on the floor, identify objects in their surroundings, or ground themselves with scents such as lavender. These findings support current researchers (e.g., Fosha, 2006; U. Lanius, personal communication, March 22, 2007; McEvoy & Ziegler, 2006; Odgen, 2006; Porges, 2004a; Scaer, 2007) that identify the therapeutic benefits of engaging clients on all levels of tactile, olfactory, auditory, and visual awareness. It is therefore recommended that therapists build sensory acuity to facilitate an integration of the senses and thereby, increase a client's ability to remain present and connected in the world.

The results of this study further described the use of Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of dissociation. Three of the participants discussed the use of this intervention in the text of their narratives however, of those three, only two briefly stated its value. Consequently, this finding suggests the need for further research regarding the use of EMDR in the treatment of dissociation and therefore adds to the existing literature (e.g., Corrigan, 2002; Fine & Berkowitz, 2001; Gelinas, 2003; ISSTD, 2005; U. Lanius, personal communication, April 30, 2007) that

debates the effectiveness of EMDR in the treatment of complex posttraumatic stress and dissociative disorders. Implications for practice include increasing awareness to the possible limitations of EMDR and identifying the need to further research its use when working with individuals who engage in moderate to high levels of dissociation.

Another significant contribution exists in the finding that revealed the importance of having therapists educate clients about dissociation and provide observational feedback as to how dissociation manifests in the process of therapy. To varying degrees, all of the participants expressed the benefits of acquiring information about dissociation and described the reparative role this awareness had in interrupting their automatic tendency to dissociate. To date, few studies have specifically explored the therapeutic value of naming dissociation and educating clients to the variety of ways in which dissociation can occur. It is therefore recommended that therapists inform clients of their dissociative tendencies and engage them in a dialogue that offers both informational and observational feedback. The specific manner, or framework, through which dissociation is presented, is further described in the Challenging the Dominant Paradigm section discussed below.

This study also revealed the need for therapists to carefully assess client readiness and proceed with any of the above interventions in a manner that minimizes re-traumatization. All of the participants expressed the critical need for therapists to go slow and consider the often narrow therapeutic window in which they reside. These results are congruent with current researchers (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Herman, 1992; Howell, 2005; ISSTD, 2005; Porges, 2004b; Ogden, 2006) that state the need for therapists to establish safety and titrate the processing of traumatic material with the building of both internal and external resources. Suggestions

include the need for therapists to engage clients in a dialogue that offers an opportunity for them to assess their own readiness and ultimately, regulate their own process of reparation. In doing so, therapists convey a sense of trust in their clients and assist them in the process of regaining control of their lives. The reparative benefits of reciprocating trust and encouraging clients to act as a lead in their own therapy are described below in the section entitled The Therapeutic Relationship.

Challenging the dominant paradigm. Currently, dissociation exists within the dominant medical paradigm that views dissociation through a lens of pathology and measures levels of dissociation by a cluster of dissociative symptoms identified in the Diagnostic and Statistical Manual (DSM-IV-TR, 2000). The results of this study revealed the potentially damaging consequences of applying the dominant medical model to the treatment of dissociation and the role it had in contributing to the already heightened fears of being different or crazy. Two of the participants described the challenges they experienced by being formally assessed and diagnosed according to the criterion in the DSM-IV-TR and the impact this had in breaking a sense of trust and safety that ultimately led to the termination of therapy. Although this finding was described in only two of seven the narratives, the negative impact this had in shaping the participants' reparative experience warranted identification as a significant finding of this research.

Interestingly, another significant finding exists in the fact that only one of the participants discussed the use of psychotropic medication in the treatment of dissociation. Although this participant stated the benefit of using medication in reducing dissociative symptoms, comments on its value were only briefly described. This finding adds to the emerging body of literature (e.g., Ginsberg, 2005; Phillips, Hunter, Baker,

Medford, Sierra-Siebert, & David, 2003; ISSTD, 2005; U. Lanius, personal communication, March 22, 2007; Philipsen, Schmahl, & Klaus, 2004; Scaer, 2007; Simeon & Knutelska, 2005; Simeon, 2004) that debates the effectiveness of using medication to manage moderate to high levels of dissociation. Further research in this area is therefore needed.

In support of the two findings stated above, this study further revealed the value of normalizing dissociation and applying a non-pathologizing approach when working with clients who dissociate. To date, few studies have critically examined the dominant discourse that surrounds dissociation and the role it plays in creating an isolating dynamic that both silences and shames in a manner that replicates the client's abusive history. Consequently, multiple barriers that prevent individuals from seeking support are established. To varying degrees, all of the participants emphasized the importance of having their therapist normalize their experience and acknowledge the social, cultural, and political climate in which dissociation occurs. As a result, therapists need to situate themselves outside of the dominant framework and critically assess the value of employing a medical paradigm in the treatment of dissociative behavior.

The therapeutic relationship. Researchers (Briere, 2002; Courtois & Pearlman, 2006; Howell, 2005; Hunter, 2004; ISSTD, 2005; Schwartz, 2000) agree that it is essential for therapists to establish a solid foundation of trust and safety when working with individuals who dissociate. Although this need for trust is widely accepted, few studies have explored the specific factors that facilitate the building of this trusting foundation. To varying degrees, all of the participants identified three subcategories--reciprocity, periods of conflict, and being there--that helped them develop a degree of trust that they never before experienced. These subcategories suggest that therapists: (a)

reciprocate a sense of trust and confidence in their clients; (b) allow periods of conflict that provide an opportunity for clients to experience interpersonal tension in a healthy and reparative manner; and (c) simply be there for clients in a way that communicates a sense of support and commitment to the client's reparative journey. With the establishment of a trusting foundation, the therapeutic window gradually expands enabling clients to work through aspects of their abuse in a manner that minimizes their need to dissociate. This study therefore significantly contributes by providing insight into how this much needed foundation of trust is developed.

The results of this research further contribute by identifying the critical role therapists have in facilitating a corrective experience that serves to repair some of the broken attachments that occurred as a result of the abuse. To differing degrees, all of the participants identified the value of having their therapists: (a) challenge old patterns and beliefs; (b) know them in a manner that extended beyond words; and (c) model a new way of being that enabled them to better connect with themselves, others, and the world. According to Schwartz (2000), "the therapist should be someone with whom the [client] can reexperience trauma within a new context and thereby experience for the first time what has been absent in the past" (Schwartz, p. 167). These results therefore support current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2003; Fosha, 2006; Hirakata & Arvay, 2005; Howell, 2005; Odgen, 2005) by acknowledging the reparative experiences that occur within the therapeutic alliance. Implications for practice include helping therapists recognize the specific ways in which the therapeutic relationship serves to facilitate a positive re-experiencing of broken childhood attachments. A sense of safety and connection therefore develops resulting in the minimization of the overall need to dissociate.

Another critical contribution of this study exists in the finding that identifies the value of having therapists follow their client's lead and act as a witness to their client's journey by putting aside their own agenda as to what they think should happen. To varying degrees, all of the participants emphasized the desire to find their own answers and trust their own inner knowing as to what they needed to do. This finding is congruent with current researchers (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2006; Howell, 2005; Ogden, 2006; Schwartz, 2000) that state the need for therapists to work with clients in a manner that avoids replicating an abusive dynamic where the therapist is placed in a position of authority and dominates or controls the thoughts, feelings, and actions of the client. Suggestions for practice include the need for therapists to fully recognize clients as experts in their own lives and serve as witnesses to their client's reparative experience. In doing so, an empowering opportunity for clients to reconnect with their own inner knowing and develop a greater sense of self-trust is provided.

A final contribution of this research exists in the finding that highlights the importance of the deep human to human connection that can occur within the therapeutic alliance. Six of the seven participants discussed in great length, and with heightened intensity, the highly reparative value their therapist had in initiating a process of reconnecting with themselves, others, and the world. Many of the participants used words such as present, genuine, unconditional regard, love, and transparency to describe qualities of their therapist that facilitated an interpersonal connection that they never before had. This finding demonstrates the strength of the therapeutic relationship in minimizing dissociation through the deepening of a client's ability to tolerate a close therapeutic connection that ultimately serves to facilitate a greater ability to experience

close and intimate connections with others. As stated by Schwartz (2000), “adult survivors of severe childhood abuse need many things in treatment but first they need the emotional presence and psychological availability of the therapist” (Schwartz, p. 172). This finding therefore supports current research (e.g., Briere, 2002; Courtois & Pearlman, 2006; Fosha, 2003; Fosha, 2006; Haddock, 2001; Howell, 2005; Ogden, 2006) and further contributes by highlighting the need for therapists to simply be present, human, and real.

### Conclusion

As identified in the Experience of Dissociation section discussed previously, the underlying, or defining, feature of dissociation is the heightened sense of disconnection individuals experience from oneself, others, and the world. The results of this research revealed that the underlying reparative experience for the treatment of dissociation is that of reconnection. Interventions that were instrumental in minimizing dissociation were noted to facilitate a reconnection to oneself, others, and the world and thus creating a new way of being for those whose dissociate.

Although this process of reconnection, and thus reparation, is by no means a simple or straight forward task, this study substantially contributes by: (a) providing support for a new definition of dissociation by highlighting the finding that reparation is best facilitated by a process of reconnection to oneself, others, and the environment; (b) recognizing the re-connective value of engaging clients in a variety of multi-sensory and non-verbal interventions; (c) identifying that a reconnection to the world requires a cultural and societal shift to a non-pathologizing view of dissociative behavior; and perhaps most importantly, (d) underscoring the highly re-connective and reparative experiences that occur through the emotional presence and genuine care of the therapist.

For individuals who engage in moderate to high levels of dissociation, a process of reconnection essential. Through this process, individuals are able to experience a depth of trust and safety in themselves, others, and the world and in doing so, minimize their overall need to dissociate.

#### Limitations of the Study

Although the results of this study revealed several important findings, these findings are limited by the following factors that exist both within the very nature of qualitative research and in the innate qualities and characteristics of dissociative behavior. First, qualitative research seeks to obtain an in-depth view of a specific experience and therefore involves a relatively small number of individuals to participate in the study. Although the findings of this research offer unique insight into the experience and treatment of dissociation, the richness of the data is compromised by the fact that a sample size of seven was used.

Second, all of the participants were adults who were either born in Canada or who have been living in Canada for most of their lives. Six were female and one was male. Consequently, these results do not reflect age, gender, or cultural diversity and thus represent a homogeneous group that limits the ability to generalize these findings.

Third, based on a postmodern view of knowledge and knowing it is my belief that true experiences can never be captured in its original form for each telling and re-telling of a story is co-constructed by the social, cultural, and relational context in which the story is told. These findings are therefore based on my re-telling of each participants' experience which in turn, is further re-told through the unique and personal interpretation of each reader. Contrary to information derived from quantitative research, these findings do not attempt to confirm or deny a single truth or hypothesis

but instead, reflect a co-constructed experience jointly created by the researcher, participants, and readers of this study.

Fourth, given the highly disconnected and fragmentary nature of dissociation, the ability for individuals to fully articulate their experience may have been challenged. Although all of the participants were invited to express their thoughts and feelings through a variety of modalities (e.g., verbal interviews; non-verbal drawings and artwork; and symbolic dreams and poetry), it is important to note that portions of their overall experience may not have been completely reflected in this study. Adding to this limitation is the fact that this research sought to obtain insight into a highly personal experience. Thus, these results represent only those aspects of the experience and treatment of dissociation that the participants felt comfortable sharing.

Finally, it is widely acknowledged that dissociation is spontaneously triggered in situations where an individual's sense of safety is compromised (Briere, 2002; Howell, 2005; Nijenhuis, 2004; Putnam, 1997; Scaer, 2005; Schwartz, 2000). Given that the participants were meeting with me for the first time in an unfamiliar setting to discuss a topic strongly associated with their traumatic past, the fundamental components of trust and safety were only minimally established. Consequently, varying levels of dissociation were noted to occur during the course of the interviews. Although these spontaneous moments of dissociation were recognized as a significant part of the research findings, the impact, or limitation, they posed to the results of this study remain unknown.

#### Recommendations for Future Research

Several areas for future research emerged from the findings of this research. First, quantitative studies engaging a larger sample of individuals can be conducted to

gain a breadth of knowledge into the experience and treatment of dissociation and thus serve to validate or support the results of this research.

Second, additional qualitative studies would also be particularly valuable to further substantiate the four core experiences (i.e., the heightened level of disconnection; a range of experiences that span along a dissociative continuum; the strong physiological fight or flight responses; and a disconnection that occurs in relation to oneself, others, and the world) that were identified as being the defining features of dissociative behavior. Such studies could further involve narrative studies or the use of focus groups to facilitate discussion surrounding these core experiences.

Third, several researchers (e.g., Cason, Grubaugh, & Resick, 2002; Howell, 2005; Krause, DeRosa, & Roth, 2002; Nijenhuis, 2004; Rasmusson & Friedman, 2002; Sar, Akyuz, & Dogan, 2007; Scaer, 2005) have acknowledged the impact gender has on the manifestation of various trauma-related symptoms. Experiences of depression, anxiety, and posttraumatic stress are noted to differ in terms of prevalence, etiology, and treatment for males and females. Consequently, a significant contribution would include the need to explore the possible ways in which gender influences the experience and treatment of dissociation.

Finally, given the findings that identify the critical role therapists have in the overall treatment of dissociation, future research could explore the experience of therapists working with individuals who engage in moderate to high levels dissociative behavior. Specific issues related to treatment as well as vicarious traumatization and therapist self-care could be addressed. This research would therefore substantially contribute by offering critical insight into the personal and professional experiences of therapists working with this highly challenging, yet highly rewarding, client population.

## Summary

Studies on the experience and treatment of dissociation began in the mid 1800's and since then, researchers have made significant advances in terms of obtaining greater insight into the complex and multifaceted experience of dissociation. The strong link between dissociation and childhood trauma, the development of various assessment tools and inventories, and the recognition that dissociation extensively impacts both the mind and body are only some of the vital contributions made in the last century. Despite these important advancements however, more research is needed.

Wisława Szymborska, a poet and Nobel Prize winner for her literary achievements, honoured her own ability to dissociate during the sexual, physical, and psychological abuse she endured as a child during the Holocaust. In her writings, she describes the powerful force that she believes exists within every child--a force so strong that it is capable of moving a child's spirit to regenerate and grow despite all that is lost. In a poem entitled *Autonomy*, Szymborska (1983) depicts this force in the words *non omnis moriar, I shall not die wholly*, as she describes the holothurian, a real life sea creature well-known for its innate capacity to protect itself and thrive.

### *Autonomy*

In danger the holothurian splits itself into two:  
it offers one self to be devoured by the world  
and in its second self escapes.

In the middle of the holothurian's body a chasm opens  
and its edges immediately become alien to each other.

On the one edge, death, on the other, life.  
Here despair, there, hope.

To die as much as necessary, without overstepping  
the bounds.

To grow again from a salvaged remnant.

Here a heavy heart, there non omnis moriar,  
three little words only, like three little plumes ascending.  
( p. 115-116)

**What is the experience and treatment of dissociation in individuals who experienced childhood sexual abuse?** This study significantly contributes to the field of counselling psychology by (a) providing insight into the experience and treatment of dissociation from the perspective of individuals who engage in moderate to high levels of dissociative behavior; (b) identifying a redefinition of dissociation based on the experiences of those who dissociate; (c) challenging the dominant discourse that currently views dissociation through the lens of pathology; (d) highlighting the critical role of the therapeutic relationship in the treatment of dissociative behavior; and (e) giving voice to those whose experiences of dissociation have been primarily silenced and shamed. This research therefore bridges a substantial gap in the current literature by offering readers insight into an inner world built upon a powerful will to survive.

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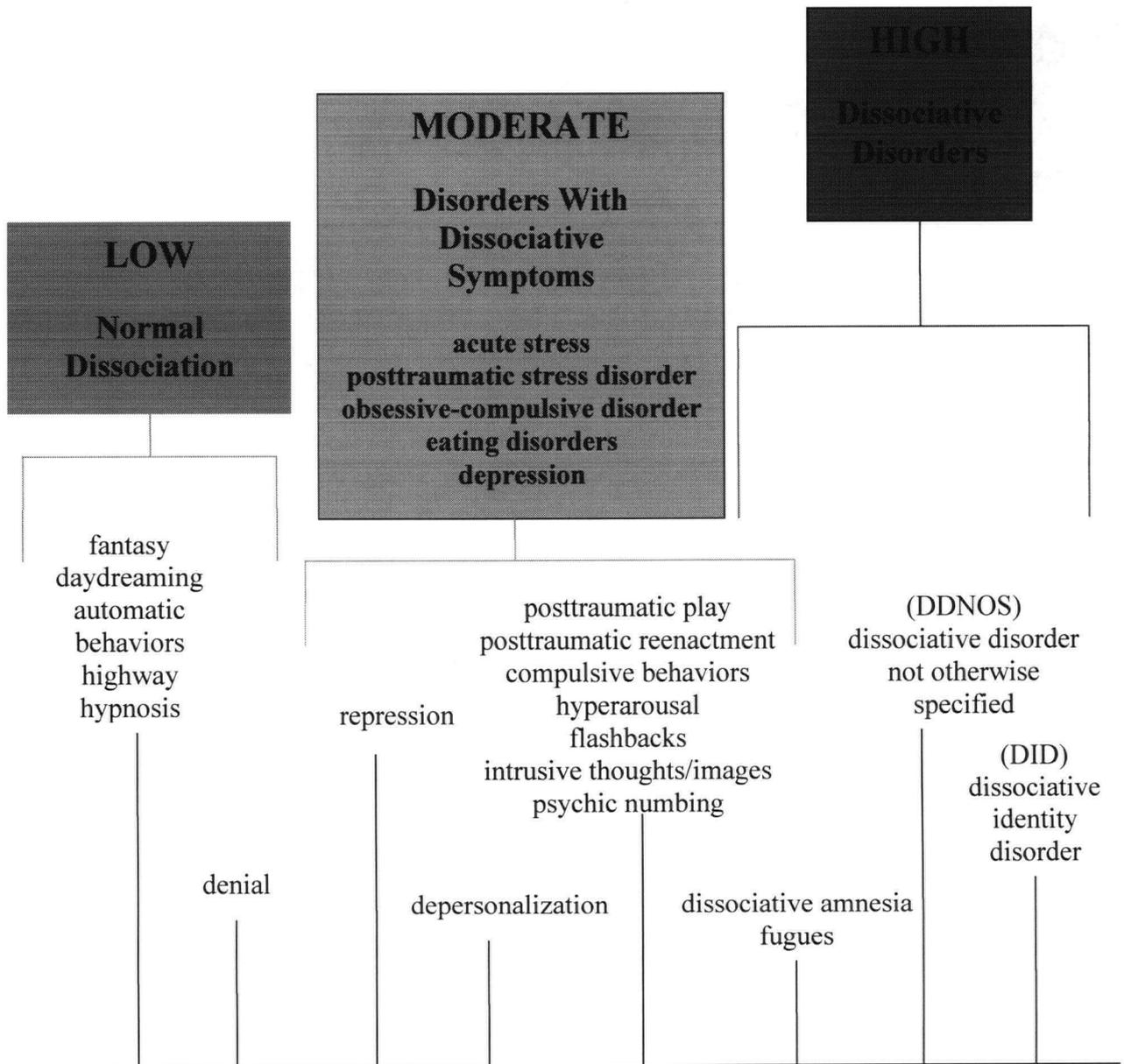
## Appendix A

### SIGNS & SYMPTOMS OF DISSOCIATION

- Losing train of thought
- Frequently changing the subject
- Ending sentences mid-stream
- Disconnected and/or rapid speech
- Twisting hair; hand wringing; picking at imaginary lint
- Glazed eyes; slackened jaw
- Excessive blinking
- Change in pupil size
- Eyes rolling
- Inability to maintain eye contact
- Staring into space or staring out the window
- Staring intently at an object in the room
- Shallow breathing
- Holding one's breath
- Rocking
- Forgetting parts of conversation
- Inability to follow conversation
- Loss of memory
- Experiencing warps in time
- Inability to connect thoughts and feelings
- Talking about a highly traumatic event in an emotionally detached manner
- Numbing of feelings and sensations
- Lack of connection to body and/or environment
- Marked change in conversational style, cadence, mannerisms, voice, etc.
- Significant changes in clothing, make-up, etc.

Appendix B

**THE DISSOCIATIVE CONTINUUM**



## Appendix C

THE UNIVERSITY OF BRITISH COLUMBIA



### INFORMATION NOTICE

**Department of Educational and Counselling  
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### **Narratives of Dissociation: Insights Into the Experience and Treatment of Dissociation in Individuals Who Have Been Sexually Abused in Childhood**

Investigator: Dr. Marv Westwood, Ph.D.

Co-Investigator: Pam Hiramata, Ph.D. (Candidate)

I am a graduate student in the Counselling Psychology program at the University of British Columbia and conducting this study as one of my requirements for the completion of my doctoral degree. The purpose of this study is to develop a set of guidelines that will help therapists work with clients who have a history of childhood sexual abuse and engage in dissociation as a primary way of coping.

You are being invited to participate in this study and share your experiences of what you found helpful, and not helpful, in your therapeutic process. To participate in this study, you must:

- (a) be 19 years or older
  - (b) have a history of childhood sexual abuse
  - (c) have been involved in some form of counselling
  - (d) at times felt:
    - emotionally numb
    - in a dream-like state
    - robot-like
    - disconnected from your self or others
- and/or - detached from your body or experiences

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## Appendix D

THE UNIVERSITY OF BRITISH COLUMBIA  
of this study will contribute to the development of a set of guidelines for therapists to use when working with clients who have a history of

childhood sexual abuse and engage in dissociative behavior. The entire interview will be approximately 2 – 2.5 hours long.

Following our interview, I will gather the information I receive from each participant and analyze it according to the significant themes and patterns that emerge. Once this process is complete, I will ask you to validate the data and the analysis and provide you with an opportunity to clarify and/or offer any further information.

With your permission, I will contact you by phone a few days after our meeting to discuss and/or debrief any thoughts and feelings that may have surfaced as a result of our interview. In the event that any unexpected emotions arise as a result of this research, both my research supervisor and I will be available for you to contact at the phone numbers listed above. If however, you have any concerns regarding your rights or treatment as a participant, you may contact the Director of the University of British Columbia's Office of Research Services at 604 822-8598.

Strict confidentiality will be maintained through the use of a pseudonym. All tapes and documents relating to this study will be kept in a locked filing cabinet to which only the co-investigator will have access. All data will be destroyed 5 years after my dissertation defense.

**Your participation in this study is completely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy. You have the right to refuse to answer any questions and/or provide any information.**

**A p p e n d i x D**

## THE UNIVERSITY OF BRITISH COLUMBIA

A copy of this consent has been given to you for your own records.

By signing below, you acknowledge that you have read and understood this form and consent to participate in this study.

Participant's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix E

THE UNIVERSITY OF BRITISH COLUMBIA



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### **Narratives of Dissociation: Insights Into the Experience and Treatment of Dissociation in Individuals Who Have Been Sexually Abused in Childhood**

#### **INTERVIEW PROTOCOL**

The purpose of this research is to examine the experience and treatment of dissociation in individuals who experienced childhood sexual abuse. In sharing your story, you will not only assist others in feeling less alone in their experience, but you will also contribute to the development of a set of guidelines for therapists to use when working with clients who have a history of sexual abuse and engage in dissociative behaviors.

I recognize that your experiences of therapy and dissociation may be very personal and that there might be certain aspects of your story that you may not wish to share. I fully acknowledge the sensitivity of this research topic and will completely respect and understand any decisions you may have to stop, pause, and/or end our interview.

The following is an outline of how our interview will be structured and the questions that will most likely be asked. This outline will provide you with an opportunity to review the questions before our meeting and help you obtain a better “feel” of what our meeting will be like. A copy of the Informed Consent form has also been included.

#### **The Interview Structure**

The interview will be approximately 2 - 2.5 hours. With your permission, it will be audio-taped and personal artifacts, such as artwork and/or journal entries will be photographed and included in the final dissertation. **All information obtained from this study will remain strictly confidential. Your name and any identifying characteristics will not be included with any of your artifacts.**

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## Appendix E

### THE UNIVERSITY OF BRITISH COLUMBIA

#### **The Interview**

##### **Background Information –**

- General questions to obtain demographic information (e.g., your age, family structure, employment, current relationships)
- Briefly outline your experience of abuse (e.g., age the abuse began and ended, your past and/or current relationship with the perpetrator)
- General information about your own therapeutic process (e.g., past and/or current counselling, types of interventions, length and time in counselling)

##### **Experience of Dissociation -**

- “Dissociation” is a term researchers and therapists have used to describe a set of behaviors. What word or words would you use to describe your experience?
- What is your experience of dissociation? What thoughts/feelings/sensations are you aware of when this occurs?
- What are you aware of just prior to and immediately after moments of dissociation?
- How has dissociation been helpful to you? How has it been not so helpful?
- What does your tendency to dissociate mean to you?

##### **Experience of Addressing Dissociation –**

- How was dissociation addressed in therapy? What did your therapist say? Do?
- What did you find helpful? What did you find not helpful or even harmful?
- How do you address dissociation outside of your therapy sessions?
- What things do you do that are helpful? What things do you do that are unhelpful or even harmful?
- If you could offer your therapist some suggestions as to how he or she could better support you during times of dissociation, what would they be?

##### **Physical Artifacts –**

Sometimes discussing aspects of a certain experience can be difficult to put into words. You are therefore invited to bring personal artifacts (e.g., artwork, dreams, drawings, journal entries, etc.) that captured your experience of dissociation and/or how you or your therapist worked with dissociation in or out of session. During our interview, we will discuss these artifacts in any way you feel comfortable. **Please bring**