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Notice: The clinical examples are fictitious and are only intended to show how a therapist might handle challenges that arise during trauma treatment.

On Monday a girl goes to school even though she is being sexually abused at home. Her teacher asks her how her weekend was. She answers that everything was just fine. She plays with the other children during recess. At home she does her homework while her father cooks dinner. Her mother drives her to football practice. As usual other than performing her practical duties as a parent, her mother does not pay her any attention. That evening the girl gets ready to go to bed. As night approaches her father becomes the cold-hearted monster.

The girl could have decided to tell someone about what has been going on at home; but the threats, shame and fear weigh on her entire body. The girl is not aware that not all children have the same experience at home. This is part of her everyday life. She is not able to put into words what is happening at home. The pain she experiences disappears as she moves from one room to another in the family's house, and when she goes to school. Days become years. As an elementary school pupil she has learned not to remember painful experiences, not to tell others and not to feel. She has become accustomed to the harsh voice in her head telling her to pull herself together. Oftentimes she bangs her head against walls to make the pain go away.

The child's dilemma becomes the therapist's challenge when the patient seeks treatment for unexplained symptoms as an adult. A history of trauma results in prolonged silence. On average it takes 17.2 years for patients to begin to talk about their own histories of trauma (Steine et al., 2017). Patients with complex trauma can undergo therapy for many years without experiencing improvements. In certain cases, therapy is terminated prematurely (Brand et al., 2022). Therapists may find it difficult to help these types of trauma patients due to obstacles that arise during treatment.

The Trauma Clinic at Modum Bad in Oslo, Norway, receives around 200 patients annually. These are generally patients exhibiting Complex Dissociative Disorder. Clinical experience has highlighted the typical therapeutic challenges that may hinder effective outcomes. These obstacles can be systematized around five central core phenomena that affect the relationship between patient and therapists: distrust, the phobia of inner experience, a fragmented self,

destructive survival mechanism, as well as traumatic transference and countertransference. The therapist is able to put into practice good therapy measures when the therapist is aware of patients' obstacles and how to deal with them. This article employs the Theory of Structural Dissociation of the Personality as a theoretical basis, in addition to neurobiological research on developmental trauma (see text boxes).

The child is now a 35-year-old woman. She is successful at her job, has good friends; but constantly experiences crises in her life. At times she is overwhelmed by hopelessness, suicidal thoughts and often has the impulse to harm herself. She experiences difficulties in taking care of herself on daily basis, and oftentimes becomes easily frightened. In addition she does not understand why she struggles with her inner emotions as an adult. She seeks help, at first at an emergency room, where she is admitted to psychiatric intensive care. She knows that she does not want to die, but cannot explain why she is experiencing these difficulties. The health staff asks her questions about self-harming. She gets the sense that they are asking these questions in order to see if she is harming herself for attention. They tell her that she is a resourceful person with a good job, and that she needs to pull herself together. After a few times at intensive care, she tries to avoid the healthcare system altogether; however she often finds herself in the emergency room again. She is offered a short course of treatment at the regional psychiatric center, but is left without tangible results. When she finally arrives at the Trauma Clinic at Modum Bad she has had many years of treatment as a patient already.

Mistrust

Developmental trauma interferes with someone's ability to enter into trusting relationships (Fisher, 2014; Herman, 2001; van der Kolk, 2014). Relational expectations may result in the patient believing that a psychologist is not able or willing to help. Being asked questions or being given a friendly look can activate a patient's uncertainty and fear of making mistakes. Adequate prior knowledge regarding trauma symptoms helps a therapist to plan in how to provide therapy adequately, already during the first consultation. Understanding shown by a therapist is reflected in the language which the therapist uses, in addition to questions and how they are posed. At the same time the therapist attempts to appear open, calm and friendly towards the patient. The therapist actively takes responsibility for how the consultation progresses. If the patient avoids eye contact and answers "I don't know" to all questions, the therapist might respond by saying: *It is understandable that it is hard to come here and talk. We don't know each other yet. Allow yourself to take your time, learn more about me, and see if I'm someone you'd like to talk with.* While interacting with the patient, the therapist aims to communicates with open curiosity, understanding, respect and acceptance (Ogden & Fisher, 2015).

Regaining a feeling of safety

Because the patient does not feel safe with the therapist, focus shifts to orienting the patient in the room through the various senses. The therapist might ask: *How does it feel to sit the way we are sitting now?* Patient: *I feel so dumb when I can't answer your questions. I get so scared.* Therapist: *Many people find it uncomfortable to sit like this while looking directly at me. If you would like, we*

could move the chairs a little further apart and see if it would make any difference to you? Do you feel calmer or more agitated?

Feeling safe is associated with a physiological state regulated by the autonomic nervous system (Porges, 2011). The therapist invites the patient to try small experiments in order to regulate body activation (Ogden, 2015): *Maybe you want to try to move your legs a little, and remind yourself that you can walk if you want to. Spend some time trying to see if you feel slightly more present.*

Ogden and Fisher (2015) emphasize that well-founded reasons always explain patients' symptoms. Avoiding eye contact can be a way for children living with violence to deflect attention from abusers. Difficulty speaking may be physiologically conditioned. The therapist might say: *How has that helped you to survive?* Patient: *It feels dangerous. I get so scared of punishment.* The therapist may explain that trauma experiences are remembered as emotions, as well as sensory and physical memories: *It's not surprising that your body locks up when you remember bad things. It is important that we have noticed that. It is something we can find out more about together.*

The therapist asks for feedback in order to fine-tune the conversation dynamics: *How did you experience the session? What was the most important thing today?* Patient: *I feel a little calmer now. I felt a little less uneasy when you said it's normal to feel scared before you meet someone new whom you don't know.*

Helping the patient feel safe

Curiosity, reflection and learning are only possible once both parties feel that the relationship is on safe grounds. The therapist reflects on how the consultation room can give the patient a feeling of security, and how the patient can feel somatically safe. The patient is encouraged to try new approaches between consultations, and thereafter return to reflect on them. Trust is attained only through experience.

It takes time before the relationship feels safe. The patient may struggle to believe that expectations connected to prior negative experiences do not end as normally expected. Fonagy calls this epistemic mistrust (2015). It takes time for good relational experiences to become a part of new expectations. Trust is built when the patient feels accepted in spite of her insecurities, and without demands to change those insecurities. *It's okay to come here even if you feel insecure or skeptical.* Small good experiences or "acts of triumph" (van der Hart et al., 2006) promote change.

Phobia of inner experience

Avoidance begins as an adaptation mechanism in reaction to a traumatic upbringing. It then becomes integrated into a personality structure in the form of an ability to disconnect from body and emotions (Knipe, 2015). Developmental trauma is associated with an inability to recognize, to express and to put inner experiences into words (Fisher, 2014). When the patient is invited to work through a therapeutic process, she does not always know how to handle it. The therapist facilitates collaboration with the patient, allowing the patient to connect with inner experiences and to describe them. The therapist becomes someone who organizes and regulates those experiences (Steele et al., 2017).

The patient learns to be aware of inner experiences
Losing awareness of time and place is a protective aspect while the traumatic event is ongoing (Frewen & Lanius, 2015), but it is disruptive when it becomes an automated way of being. The capacity to notice early signs of disconnection is emphasized and strengthened during therapy. The therapist provides a rationale for why this capacity is necessary: *You can't change something you are avoiding*. The therapist slows down the tempo in order to examine what is happening and to create space for reflection. The patient's ability to state when vision is blurred or legs are numb assumes awareness and lead to self-regulation.

The therapist recognizes the patient's avoidance, something which is driven by the fear of being overwhelmed (Knipe, 2015): *Imagine a scale from 0 to 10. How much do you not want to think about it?* Patient: *(laughs) I think I'm at 20, but I want to get better.* Therapist: *What could be some good reasons for the avoidance?* Patient: *I get flashbacks and I don't know where I am again ... it's very painful.* Therapist*: I see that you are having difficulties breathing. It's no wonder you want to avoid these things when the memories of trauma start taking over. It's important to communicate with yourself, letting yourself know that the pain is gone. You're not going back. Look around and remind yourself that you are here, right now, with me in this consultation room.*

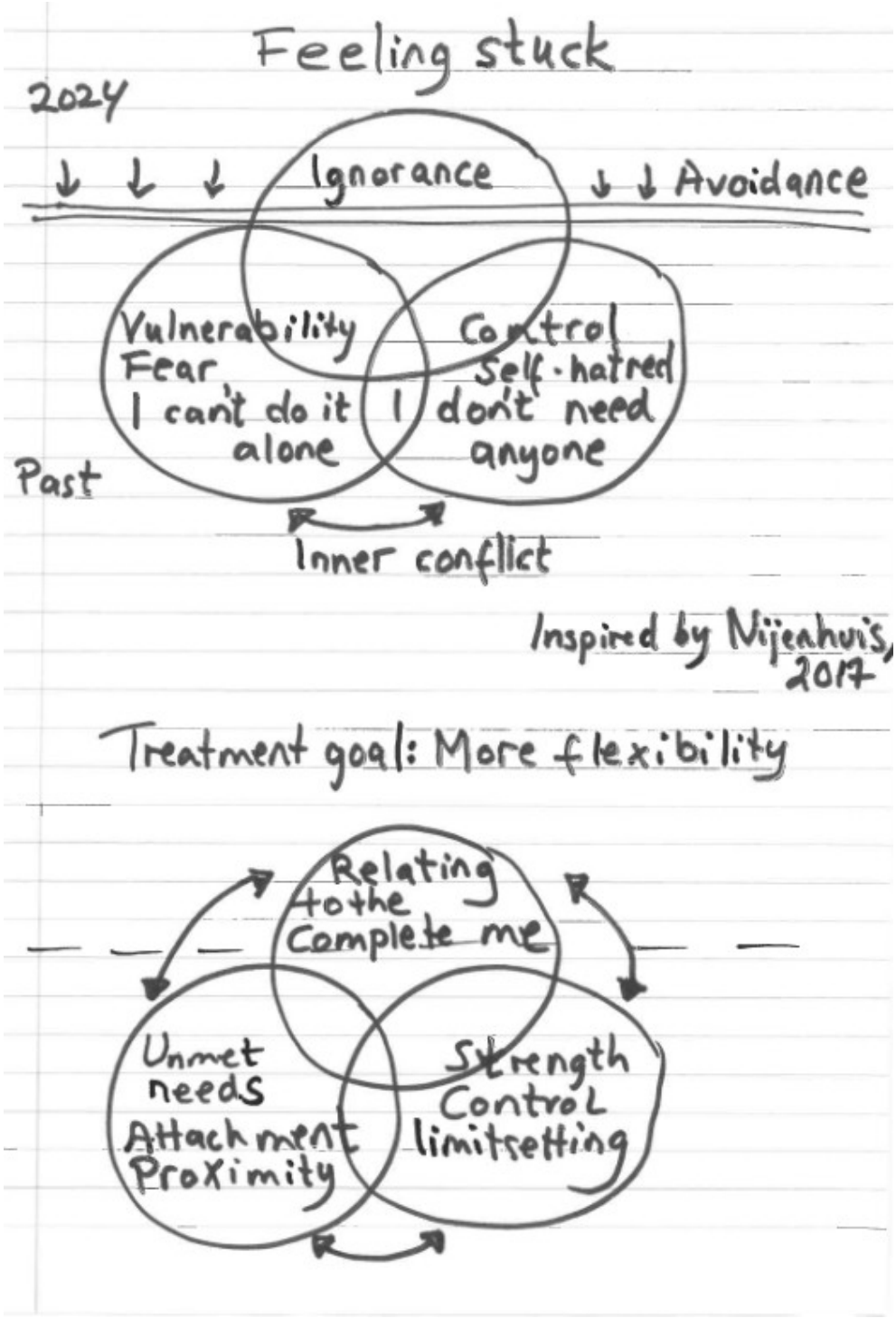
The therapist focuses on the patient's ability to strengthen her own attention (Knipe, 2015): That is, being mentally present in the room with the therapist, while at the same time getting in touch with what has remained immovable from past trauma.

The function of avoidance
Avoidance can be expressed in a variety of conceivable ways, but it creates confusion for both the therapist and the patient. The therapist is responsible for staying focused and not taking part in the avoidance. At the same the therapist becomes curious about how and what the patient is avoiding. For example, it may take the form of talking a lot without being in contact with emotions, or switching between self-states. The patient can vacillate between *I have no trauma* to being completely overwhelmed during crises. The therapist looks for patterns and connections while trying to form hypotheses that are shared with the patient. Awareness of how external events affect internal experiences is necessary. Continuing to ignore inner experiences contributes to emotions and traumatic memories which remain immovable and unregulated. Avoidance revolves often around not understanding the significance of trauma history, which itself is linked to the fear of completely falling apart. The therapist is responsible for finding a safe path.

Gradual exposure
Working with avoidance involves strengthening the patient's capacity to relate within herself. The patient needs to experience that there are alternatives to keeping everything at bay. It is necessary to practice pendulation (Steele et al., 2017): that is 'going to and going from'. The therapist teaches the patient to approach a memory or a trauma-related feeling, and then shift focus to being mentally and emotionally present (Knipe, 2015). Doing this in proper amounts is important in relation to coping with these issues: *Are you willing to go to the pain for a few seconds (5-8 seconds)?* The patient learns to notice degrees of

orientation; from fully present during a moment, to returning completely to past experiences (Knipe, 2015). When the patient experiences gaining control, it becomes easier to face pain. It is necessary to gradually expose the patient to the traumatic memories. This requires a balancing act on the part of the therapist.

Avoidance defenses can be “held” by something in the person (Knipe, 2015). Switching to a self-state that does not remember or does not feel pain is adaptive in a traumatic context, but stands in the way of successful therapeutic outcomes. The therapist asks the patient whether the therapeutic work is being incorporated in the patient's everyday life: *How did it go practicing calming your fear when at home?* Patient: *(laughing) I don't remember the last consultation. I seem to have a bit of dementia. I haven't thought more about it.*



From immobile to flexible

The illustration is used during consultations with patients to get to know their inner world and explore inner dynamics.

Inspired by Nijenhuis, 2017, and reproduced with permission.

A fragmented self

A dissociative disorder is not visible from the outside. The disorder becomes an obstacle because neither the patient nor the therapist recognizes the fragmentation of the self (Brand et al., 2022). How can the therapist recognize it in a consultation room? The therapist can listen for symptoms of the division of the self. Alternating appearances and needs are confusing for both parties, but when it becomes clear during therapy, it can be explored further.

A language for the inner world

Developmental trauma affects the experience of being a coherent, complete and integrated human being (Steele et al., 2017). Common questions such as “will you / are you ...?” are difficult to answer if someone feels chaotic and fragmented within himself. Answers will vary according to the self-state present at a particular moment. Language must be adapted in order to explore and reflect contradictions. We can use a form of 'parts' language (Fisher, 2017; Schwartz, 1995). The therapist might say: *So, one part of you wants to talk about the abuse, while another of part of you stops the words from coming out?* Another therapeutic approach is ‘multi-speak’, which denotes speaking to the patient as representing a system (van der Hart et al., 2006): *It is important that you as a complete person listen. You inhabit an adult body now. You decide for yourself. Let your complete self peer out of your own eyes and experience that you are here - right at this moment. Look around, you are in a safe environment now.*

The therapist begins discussing the patient’s different self-states, while keeping in mind that the patient is a complete person: a person with inner conflict and multiple realities that have not been realized (Kluft, in Steele et al., 2017).

Which of the self-states should assume responsibility for therapy?

A traumatized self can be understood as a system which lacks contact between different ‘me’s and creates discontinuity. The patient might have important realizations during one consultation, but be without access to these realizations during a following consultation. Patient: *When I am at home, you (the therapist) don’t exist to me, and I forget what I have learned here. Another stream of consciousness takes over, and I lose track of it all.* The patient experiences that “it just happens”. The therapist tries to strengthen a self-state that can reflect on these shifts in states, with the patient being able to take responsibility for the complete self (Frewen & Lanius, 2015): *Who in you is doing what and for what reason? (*Nijenhuis, 2017). The aim is to promote the ability to relate to the inner experiences and to understand more of the complete self, as well as to increase contact and flexibility between different self-states. Trauma treatment involves sharing new information throughout the entire system.

A healing inner dialogue

A therapeutic goal is to increase the ability of the patient to operate as a wise adult for the entire self. The different self-states need to be seen, heard and understood. The complete person needs to experience that the traumatic past is over. Inner dialogue based on respect and acceptance between “me in the present” and “me in the past” is essential to mollify the immovable inner conflict.

Triggers in everyday life lead to an avalanche of trauma reactions. They often contribute to the patient capitulating: *I am what I feel*. Self-experience requires affect regulation (Fisher, 2014). One therapeutic approach is to assume that

strong reactions are forms of communication from one part of the self (Fisher, 2017). When the patient feels afraid all the time, the patient should practice separating feeling from the inner person.

The therapist might say: *Can you connect with the fear while creating some distance from it by reminding yourself that you are an adult here with me? What are you noticing?* Patient: *I can feel my heart pounding.* Therapist: *Can you ask if anything in you knows what it's about?* Patient: *I see an image of a small, cold and scared girl lying alone.* Therapist: *Can you ask what she is afraid of?* Patient: *That something bad will happen.* Therapist: *What does she need to hear?* Patient: *I don't know.* Therapist: *What does it make you want to do?* Patient: *Children shouldn't have to feel that way.* Therapist: *Can you tell her that? That you see that she's in pain. She is no longer alone anymore. How does she react?* Patient: *She's not used to anyone understanding. She looks more calm.*

The patient learns to notice and reflect on the experience rather than becoming one with it: *What does a scared child need?* When the capacity to relate to oneself with respect and acceptance is strengthened, it can be combined together again: *Ask the fear in you to share some of the feelings, not all at once, so that the adult in you can receive it without being overwhelmed.*

The patient gradually assumes more responsibility of her own experiences, recognizing what happened, while placing those experiences in their appropriate past periods of time and dealing with them empathetically: *I am that little girl. It happened to me, but it's over now. A small girl cannot defend herself.* This is the path to becoming a more integrated self.

Therapist for the complete self

The therapist maintains a vision of the complete self, while acknowledging conflicting reactions to what is happening. The therapist does not take sides in the patient's inner conflicts. Everything is there for a reason. The therapist asks: *How did you feel when I had to cancel the last consultation?* Patient: *It was not a problem.* Therapist: *Did you notice anything else?* Patient: *There were some conflict feelings inside of me. A part of me thought that she's giving up on us now. That voice that's always there said that's what I already knew, she (the therapist) can't be trusted.*

Therapeutic work with one part affects other parts of the system. Hope and progress during therapy can activate destructive survival mechanisms. Change can be perceived as unpredictable and trigger a feeling of losing control. Good experiences can have a opposite effect.

Strong parts

Therapy activates inner conflicts which lie between vulnerability and control, and also between dependence and independence. Asking for help arouses fear, shame, anger and self-hatred. After a productive consultation session the patient may reveal a history of self-harm. Does therapy contribute to a deterioration of the patient’s situation?

Steele et al (2017) remind us that inner dynamics are created in a child's mind: “The predator of the interior is not at all what it seems. A closer look reveals an embodied survival guide written by a child...” (p. 344). Knowledge about survival

mechanisms can give the therapist increased confidence in examining a patient's destructive forces and inner conflict. The therapist might say: *It seems like one part of you is working to get you to a better place, while at the same time another part of you is not allowing it?* Patient: *Reactions after a consultation are very strong. If I get a feeling of hope here I know from experience that something bad will happen afterwards. I remember I went to get a glass of water, and then I found myself in a pool of blood on the floor.*

Gaps in memory and shifts in self-states are frightening and maintain avoidance mechanisms. The therapist's focus becomes investigating reasons why the patient reacts destructively to positive change. Patient: *Yes, hope takes a beating, and it makes everything worse. It's better to be prepared knowing that life is crap.* Therapist: *It makes sense that something in you was trying to protect you by keeping hope away.*

Moving on from the pain

Children who grow up experiencing abuse, fear and humiliation, such as hearing "I wish you were never born", learn to deal with such abuse by developing a tough and closed outer personality. It is better to feel that love is not deserved than to be overwhelmed by an unfulfilled longing. Resistance to self-compassion is common, because self-compassion is a luxury that cannot be afforded when life is dangerous.

The division of the self occurs when a child is overwhelmed at the worst moments. Some parts remember fear, while other parts want to protect the inner person from the pain. In order to attain a feeling of control, strong parts of the inner self have not realized that they were powerless during the period of abuse. This is maintained by an illusion that the various parts of the self do not inhabit the same body (Steele et al., 2017).

The patient becomes trapped in a repetitive circle of inner pain through which strong parts of the self continue to expose vulnerable parts to criticism, punishment and abuse. This undermines treatment. The therapist must recognize and stop destructive inner dynamics (Brand et al., 2022; Steele et al., 2017). Self-compassion may not be necessary for survival, but must be learned in order to attain a better level of existence. New skills require practice and repetition.

Alliance with the strong parts

The therapist invites strong parts into the consultation room as early as possible during the therapy process in order for them to be heard (Steele et al., 2017). The aim is to create an alliance between the therapist and the entire patient. One possible pitfall is the therapist not picking up on the influence of the strong parts. Even if the patient expresses gratitude for the relationship, the strong parts may perceive the therapist as a potential danger, leading to a distrust of the therapist's intentions. This leads to the strong parts looking for signs of betrayal. What seems good can turn into something bad.

The strong parts have a phobia of weakness. It is important that the therapist intervene more closely and counter the energy levels which arise from the strong parts. The therapist remains friendly and firm, whilst the voice is clear and distinct. Yet if the therapist's voice is perceived as too warm and caring it may activate distrust and disgust.

Strong parts echo characteristics of the abuser. They learned from the abuser to use power, control and humiliation as strategies. The strong parts of the inner system are feared and avoided. They also have a basic fear of not being wanted and believing that the therapist wants them gone. The phobia can diminish in strength, once the therapist empathizes with the strong parts while explaining to the patient how they develop as a coping mechanism. Additionally, the patient learns reasons why the strong part function as they do. (Steele et al., 2017).

Survival mechanism

The therapist tries to understand the trauma-related logic behind these destructive behaviors. Based on a precautionary principle, harming the body can have a protective function. It can act as a message announcing to the patient that she must remain on guard and make sure that nothing is revealed. When the patient understands that it is a survival mechanism, rather than malice, it can be easier for the patient to face the strong parts within herself.

Patient: *You say we should get to know the strong parts in me and that I shouldn't be so afraid. But why are they so mean? They say so many nasty things. If I let them, they gain the upper hand.* Therapist: *How did they learn to talk like that? What do you think they're trying to achieve?*

A key principle is to ask the strong parts for permission to try something new. One must also find safe ways of working with them during therapy (Steele et al., 2017). An alternative to handling destructive behaviors involves the patient agreeing to say ‘stop’ in order to maintain control.

A flexible self

It is important to clarify the therapeutic goals to which the strong parts can agree. The therapist explains that therapy does not make the patient weak, but contributes to increased control in daily life. It is a significant step when the strong parts have the ability to communicate and set boundaries, thus offering support during therapy. Thereafter it is possible to move from a fear-based, reactive and rigid self-organization to a more flexible, nuanced and stable self-organization (Fisher, 2014). Increased access to the various inner self-states makes it possible to listen and take different needs into account. This access contributes to fewer shifts of the self-states, and gives more control. Inner cooperation in daily life within the complete self is promoted. Patient: *What helped was that you understood that I was several parts of a whole.*

Traumatic transference-countertransference

Transference and countertransference can take on a life and death quality in the context of trauma treatment (Herman, 2001). The patient enters all relationships driven by fear. Inner working models which have had their origins in traumatic upbringing weigh upon the relationship between the therapist and the patient already during the first consultation. Much of the relationship surrounds the patient’s attempts in controlling the therapist. The relationship can be experienced as triadic, and it is colored by the close presence of an abuser who sees and hears everything (Herman, 2001).

Traumatic countertransference (Herman, 2001) occurs when the therapist feels the same fear, powerlessness or need for avoidance as the patient does. Models can help to sort through the chaos. Herman describes four positions that both the patient and therapist may experience: uninvolved witness, victim, abuser or rescuing angel.

It is common for the therapist to trivialize the patient’s situation and to keep a personal distance as part of a coping mechanism. The patient’s trauma history seems dramatic and unbelievable. Did it really happen? Likewise, the therapist may become stricter than usual towards the patient, leading the therapist unconsciously to take the position of the abuser, for example feeling the impulse to say, “pull yourself together.” The therapist may feel like a victim. It feels unbearable to listen to the patient's trauma story, thus losing the conviction that anything can be done. Another common strategy is to offer increasingly more help to the patient, yet the help never is enough. Both he therapist and the patient end up feeling that the only one person who can help is the therapist.

There are many pitfalls. The therapist may ally with some of the self-states at the expense of others. Work pressure can make it tempting to prefer the parts of the self which have little contact further within the patient. These are part of the self which learned early on to hide pain. A patient may have learned to submit or act in a congenial way in order to be liked. It is easier to deal with childish needs rather than to begin approaching destructive forces. However, if the therapist only sees vulnerability, and even becomes overinvolved, repercussions will arise. Increased destructive behavior can be a sign that the therapist has lost sight of the entirety of the patient’s being.

The therapist's self-regulation

Faced with obstacles, reactions such as inadequacy, confusion, irritation or condemnation emerge. Left unaddressed, this can lead to responsibility being shifted to the patient. Premature closure of the therapy becomes another layer that reinforces trauma-related patterns: *I don't deserve to feel better.*

The therapist's ability to reflect continuously on countertransferences is crucial (Steele et al., 2017). The therapist may also experience bodily reactions such as blurred vision and difficulty thinking clearly. When the therapist is prepared to meet conflicting transferences, it is easier to reflect on the patient’s challenges and remain grounded during the therapy process. The patient will alternate between experiencing the therapist as supportive while also confusing the therapist’s face with that of the abuser. Traumatic relational expectations are experienced during the therapeutic relationship. They must be recognized in order to be understood. In such a way repair and corrective experiences become possible. Having a genuine relationship with the therapist, as well as being appreciated without being abused or exploited, becomes a new experience for the patient.

Sharing experiences with other therapists

The therapist must maintain an overall view of the process: *What is happening here right now? What belongs to me and what belongs to the patient? Who am I for the patient?* Therapists have “blind spots” in connection to their own countertransferences, not recognizing when the patient’s situation is

deteriorating (Flor, 2019). Time and space are required in understanding the patient's contradictory inner self with regards to continued patient supervision. The therapist should be aware of his own interventions, dare to share mistakes, and be curious about how the situation can be handled in a better way during subsequent consultations. (Miller et al., 2020). The therapist is responsible for finding resources in order to remain open, reflective and present. This is the basis for a good therapeutic collaboration incorporating differing levels of hope, humor, creativity and development.

Summary

It can be uncomfortable to realize that many children grow up in harmful conditions. Therapists can protect themselves behind holding attitudes such as “dissociative disorders don’t exist” or “this is too complex, so I won’t work with it”. There are different perceptions surrounding what works and what does not. (Brand et al., 2009, 2022) Controversy and myths can contribute negatively to a course of therapy. This can lead to patients being met with mistrust about a diagnosis or symptoms for which they are seeking help; thus leading to an aggravation of their problems.

Guidelines for understanding and treating complex dissociative disorders are based on available research and clinical consensus among DID experts (International Society for the Study of Trauma and Dissociation, 2011). Treatment related to these principles shows promising results. There are few treatment studies regarding complex dissociative disorders. In 2015 the Trauma Clinic at Modum Bad in Oslo started a research project on treatment efficacy. This led to the first international RCT study (Bækkelund et al., 2022), which found improvement in function, but no change in symptoms after 20 weeks of group therapy. In-depth interviews from the study are now being analyzed qualitatively with the goal of understanding patients' experience of group therapy and change (Holbæk, in preparation 2022-2025). Patients have reported that they felt more intraconnected and better able to influence their own situations and relate to themselves (Holbæk, 2024). This highlights the need to find more ways to measure change during treatment.

I want to inspire others to see obstacles as an expected and meaningful part of the therapy process. Obstacles encountered during therapy differ as presented in this paper. They do not appear and exist one at a time. Rather, they are all there at one and the same time. When the therapist has an overview of the obstacles listed in this paper, recognizing and focusing on immobile inner dynamics, patient's resources become visible. Healing can take place when working with a patient’s obstacles. Developmental trauma is deeply rooted in the brain, nervous system and in the organization of the personality. There are no simple solutions. Trauma treatment is about reorganizing the self: that is, from having had adapted oneself to a traumatic upbringing to orienting oneself in a new context of safety, flexibility and intraconnectedness.

REFERENCE SECTION (divided into text boxes, etc.)

Terms

Developmental or *Complex Trauma* refers to repeated and severe childhood trauma such as emotional neglect, psychological, physical and sexual abuse (Courtois & Ford, 2009; van der Kolk, 2014).

Complex Trauma Disorders refer to a spectrum of trauma-related disorders, from complex PTSD to the most severe diagnosis of dissociative identity disorder (DID).

Complex Dissociative Disorder (CDD) includes the diagnosis F44.81 Dissociative Identity Disorder (DID) as well as F44.88 other specified dissociative disorders in the ICD-10. The latter is used when the full cluster of dissociative symptoms is not met (see Steele et al., 2017, for assessment of CDD).

It takes 5-12 years before Complex Dissociative Disorder is diagnosed (Spiegel et al., 2011). On average five other diagnoses are made beforehand (Brand et al., 2009). Epidemiological prevalence studies regarding DID suggest a prevalence in the psychiatric population of 5% (Sar, 2011). There is controversy within the field surrounding DID: Do DID diagnoses exist? Does the splitting of the self originate in adaptation to a traumatic upbringing, or is it rather a result of therapy (Dalenberg et al., 2012).

There are different views on the treatment of trauma. The processing of a history of trauma often revolves around exposure of the “earliest and worst” trauma memories. The necessity of skills training and gradual exposure is discussed (Rydberg, 2017). Exposure methods have a drop-out rate of 49.4% (Doran & Deviva, 2018), which means that many patients are not “suitable” to such therapy.

The Theory of Structural Dissociation of Personality

According to the Theory of Structural Dissociation of Personality, dissociative disorders are assumed to exist along a spectrum of complexity. The unsolvable dilemma children experience when a caregiver, who is supposed to represent security to a child, simultaneously poses a threat. The threat will be consolidated in the development of the nervous system and the brain. This forms the basis for a split of the self, of which one or more parts function during a person’s daily life, while other parts remember trauma experiences (van der Hart et al., 2006; Schore, 2006). The ability to divide the self into separate worlds helps a child to maintain attachment to caregivers.

A person with this disorder does not function as an integrated whole, but is characterized by internal conflict between parts possessing different needs. Vulnerable parts refer to self-states that are locked within a child's unmet needs and unprocessed defense reactions such as flight, freeze and submission. The strong parts refer to self-states that are locked within a context of combat defense.

Dissociative parts are characterized by a separate agency with a unique understanding of self, others and the world (van der Hart et al., 2006). The degree of dissociation can vary from “it's me, but it doesn't feel like me” to feeling completely alien, “that's not me”.

It is recommended that trauma therapy be based on a collaborative model through which the therapist has an active role in teaching the patient new skills. The goal is to increase the patient's integrative capacity (Nijenhuis, 2017; Steele et al., 2017).

Recommended reading

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