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Clinical Psychology Forum

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Editorial

Stuart Mitchell & Helena Crockford

DISSOCIATION has been an underrecognised area of mental health, often misidentified as a psychotic experience or personality difficulty, not addressed as a central focus by services and interventions, or simply not identified at all. But this can impact on the outcomes and recovery for service users, with interventions offered likely to be less effective, and at times unhelpful or even iatrogenic as a result. Historically, there have been controversies and myths about this area, resulting in fears about identifying it, the level of resource which may be required, and exclusion from appropriate services – and these continue (Steele et al., 2017).

However, the growing evidence base (e.g. Bailey & Brand, 2017) indicates that accurate identification and appropriate adaptations to treatment can lead to better outcomes, giving more hope to service users and their families, as well as improving cost-effectiveness for service providers (Lloyd, 2016). Interest is growing in ways to do this, and in the UK clinical psychologists are often leading the way in raising awareness of dissociation and trauma-informed care in their organisations. Their experience, however, can be an isolated one, finding themselves the lone voice in a team or service.

This was all too apparent at the successful UK conference in 2017 ‘Facing the Challenge: Improving Services for Trauma-Related Dissociation’. This was a collaboration between the DCP Psychosis and Complex Mental Health Faculty, First Person Plural (an expert-by-experience run national charity for people with complex dissociative difficulties – www.firstpersonplural.org.uk) and the European Society for Trauma and Dissociation-UK. Many psychologists attended and presented at this conference, their papers giving the inspiration for this special issue of CPF (for example, Crockford et al., Walker, and Ormerod & McLellan). A common theme emerged, of psychologists feeling quite alone in their multi-disciplinary setting, and an NHS discussion list sprang up as a result (contact helena.crockford@nsft.nhs.uk to join).

We believe that this special issue is timely as interest in this area continues to grow. We hope to raise awareness and understanding across the profession and beyond, into third sector and service user led organisations. It is likely to have broad interest for those working across a range of settings and client groups. It may also provide support to colleagues in their own services, to hear what others are doing around the country, share new ideas from areas where services are developing to become more trauma-informed, and provide encouragement and guidance for those who find themselves practising in relative isolation.

We have invited a range of papers from general adult mental health, specialist services for personality difficulties, complex trauma and psychotherapy, physical health and veterans services. We also have a strong voice from those who have used services and are therefore experts by experience. There is a common thread on improving services for trauma-related dissociation and learning from the lived experiences of service users. We recognise this is an area of misunderstanding and controversy, which may be new to some and not very well known to others. Dissociation is often overlooked as a disorder of ‘hiddenness’ (Steele et al., 2017), and is often not well assessed or recognised by the clinician (Steele et al., 2017). We also hope to bring to life the lived experiences of dissociation and the effects of different types of service provision, as well as build confidence in clinicians working with service users who experience these difficulties.

The special issue begins with the shared experience of a psychologist (Mike Lloyd) and a service user, who introduce dissociation, the story behind it and their difficulties accessing appropriate

help. They begin to make the case for how services should develop in their awareness of dissociation. Next is a paper by Helena Crockford and colleagues, who outline their strategy within a mental health trust to develop training, consultation and awareness raising. The next paper describes working with people with dissociative difficulties in a neurology department (Walker). Stuart Mitchell and colleagues then offer two powerful accounts of lived experience, embedded within the application of the *Power, Threat, Meaning Framework* (Johnstone et al., 2018) in relation to trauma and dissociation adapted care pathways. Next we hear about the relevance of considering dissociation within veterans services (Ormerod & McLellan). The last paper (Hamilton) describes a qualitative analysis of clinicians' experiences of working with people diagnosed with personality difficulties, complex trauma and dissociation.

We hope that you enjoy reading the papers in the special issue. We would ultimately like to raise interest in developing a set of clinical guidelines for clinical psychologists working with dissociation over the next year, so would like to hear from anyone who is interested in being involved in this project, or has recommended research papers they would like us to consider.

Stuart Mitchell

Chair, Personality and Complex Trauma Network, PCMHfac

Helena Crockford

Former Co-Chair, Personality and Complex Trauma Network, PCMHfac

helena.crockford@nsh.nhs.uk

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Correspondence

I ENJOYED reading Ben Donner's editorial in the November issue of *Clinical Psychology Forum* (CPF 311). I am of the view that recent criticisms of the Stanford Prison Experiment (SPE) have been considerably overstated. For example, much has been made about the newly released audio recording of David Jaffe, SPE warden, trying to persuade one of the student guards, John Mark, to behave in a more 'tough' and 'firm' manner. Listening to this audio recording (purl.stanford.edu/wn708sg0050; 8.38 minutes onwards) left me with the clear impression that the warden failed to influence the guard to any significant extent; John Mark quietly stood his ground, variously responding by saying 'well I don't know about that', 'I don't get into this thing too much' and 'I don't think I am a very good guard for this experiment'. Nor is there any evidence that this attempt to steer the SPE generalised to other prisoners, even though this is implied in the critique. The notion that Zimbardo got the prisoners to behave exactly in ways he wished them to is not born out by this new evidence. If anything, it shows John Mark was effective in his passive resistance to becoming a 'tough' and 'firm' guard.

Further, Zimbardo is the first to admit that he conflated the roles of prison governor and principal investigator (as per my 1993 interview with him in the October *Psychologist* of that year). So I think it is a pity that given both the SPE and the BBC prison experiment (BBC-PE) tackle contextual aspects of social influence that they have been at conceptual loggerheads. Neither Zimbardo's role conformity explanation nor Reicher and Haslam's leadership-based explanation are mutually exclusive. In reality, in complex social situations both are at play; it is not a question of which is better than the other. We learn different things from each about contextually driven influences on behaviour. So, it was heartening to see Phil Zimbardo, Steve Reicher, Alex Haslam and Craig Haney publish a joint statement in the

October 2018 *Psychologist* saying in effect that there is more that unites than divides them (thepsychologist.bps.org.uk/volume-31/october/dealing-toxic-behaviour). It is then really very premature to start talking about rewriting the textbooks, as some commentators have argued. If you'd like to read my more detailed response to the critique, as published in Reicher, Haslam and Van Bavel's letter in the August *Psychologist*, you can find this in the form of an extended comment at the end of an online version of their letter at the bottom of the following page: thepsychologist.bps.org.uk/volume-31/august-2018/time-change-story.

Interestingly, Ben also addressed in his editorial what he sees as the failure of clinical psychology to incorporate Zimbardo's role conformity findings, or indeed the leadership-based explanation from the BBC-PE. To a large extent this is correct in a very literal sense, that there is probably no model of clinical psychological intervention that draws on social influence theory explicitly and systematically. Indeed, the criticism could be broadened to include a lack of social psychology in clinical psychology more generally. This is ironic given social psychology and clinical psychology's focus is a shared one (i.e. on what happens in the transactions between people). In other respects, however, I think the general approach from which both SPE and BBC-PE derive – that is to say one that focuses on the importance of the context provided by each of us for each other's behaviour – is well represented in clinical psychology. Indeed, behaviourism, a cornerstone of cognitive behavioural therapy, is very much founded upon such an orientation and in many ways is a very 'social' paradigm (as has been argued, for example, by Derek Blackman previously).

Other facets of psychology, however, I think pick up on and are related to the Asch/Milgram/Zimbardo legacy, as does, for example, the work of George Brown and Tirril Harris on life events (focusing as it does on

interpersonal loss of one kind or another) and on vulnerability factors (which are largely about depleted or disrupted forms of social support). Their ‘stress x’s diathesis’ model of depression arguably encapsulates a very contextual approach to understanding the aetiology of the ‘common cold of psychopathology’, as Martin Seligman famously called it. Likewise, our well-evidenced understanding of how our position on the socioeconomic gradient affects the likelihood of various health behaviours and outcomes (as after the various empirical works of Sir Michael Marmot, and of Richard Wilkinson and Kate Pickett), sits well

with a situationist, environmental perspective. Clinical psychology, then, has not lost sight of the importance of these aspects of context. Nevertheless, I think it will be important that clinical psychology trainers keep them to the theoretical fore in the minds and practice of successive generations of clinical trainees.

Mark R. McDermott, BA MSc (ClinPsychol), PhD, CPsychol

*Professor of Psychology
University of East London
m.r.mcdermott@uel.ac.uk*

Living with dissociative identity disorder: A client's and therapist's perspectives

Mike Lloyd



This article is co-authored by a person (the client) who has been diagnosed with dissociative identity disorder (DID) and a clinical psychologist who treats this condition (the therapist, Mike). The client discusses her experience of growing up with DID before it was formally recognised, the difficulties she has experienced within NHS mental health systems and her progress during therapy. Mike then adds his perspective on the understanding and awareness of DID as well as the method and potential for successful treatment. The client wishes to remain anonymous.

The client's experience

FIRSTLY, I need to explain why I developed dissociative identity disorder (DID). I'm not going to go into detail – just enough so you understand the story that follows.

I was physically, sexually and emotionally abused by my Dad from as far back as I can remember. 'I' would switch off in my head and 'someone else' would come out and take care of things. I was a high achiever in school and

a bright, happy child. No one knew what was going on because 'I' didn't know myself.

Things started to fall apart in high school when the normal experiences of growing up began to open up doors that previously had remained shut. I stopped eating as a way of coping and teachers at school noticed.

Sent to the GP, I was diagnosed with atypical anorexia and referred to child and adolescent mental health services, where weekly

family therapy sessions began, alongside individual work. I had a wonderful key worker who knew something wasn't right but couldn't do anything because I wasn't able to tell her. The family sessions were a farce, with my dad being able to control and manipulate both the situation and everyone around him.

One day I turned up and said I was very sorry but I was going to kill myself. I didn't want my death to come as a shock to her, but was exhausted and couldn't go on. I was referred to an inpatient adolescent unit on a three-week emergency admission.

The ward manager explained that the aim was to do the work to change my behaviour and then leave to go back home. None of my internal parts (alters) felt safe enough to say anything, so we tried to deal with it on our own – mainly through cutting, burning, bingeing and purging.

This continued throughout my admission(s) and I was labelled a 'difficult patient'. Looking back, I can see that I dissociated a lot during this time – different parts would come out and take over my behaviour and I'd come back from leave with things I didn't remember buying. I could never explain my thought processes when it came to self-harm, and staff often thought I was being obstructive.

Many attempts were made to discharge me and every time a suicide attempt would land me back. These were a mix of genuine, desperate attempts to end my life, and others just to get back into hospital. I didn't like being institutionalised, but going home was terrifying. I had dialectical behaviour therapy, cognitive behavioural therapy and cognitive analytic therapy. Never a diagnosis, but the other patients and I figured out we were being treated as 'borderlines'.

What had started off as an emergency admission turned out to be a cycle of inpatient care that lasted almost three years. Adult services were becoming more of a possibility, (that, or actually making a 'successful' suicide attempt), and something had to happen.

'J', promised to do some outreach work, saying if I went home temporarily she'd help find us an adult foster placement. She'd started

a group in the unit which was essentially play therapy for adolescents, and it gave my 'insiders' a safe space to express themselves. This helped to bridge the gaps between the amnesia and I was able to disclose about my dad.

The police were involved, even though I didn't want that and completely wasn't ready for it. Next to useless during the interview, I was zoning in and out of memories and struggling to follow lines of questioning. I've never seen the tape but understand how it would never have stood up in court.

'J' finished her transition work with me and I moved over to the local community mental health team. I was assigned a fantastic community psychiatric nurse (CPN) who believed me when I spoke about the DID, and did her best to help. She would read my diary filled with everyone's handwriting and listened to how distressed I was. The consultant psychiatrist, however, refused to acknowledge my 'self-labelled' dissociative disorder, and refused to engage in discussion about it whatsoever.

At this point I was living in the foster placement scheme – although none of the placements worked out. They broke down because neither the carers nor myself had any real support in place – I was losing time left, right and centre, and the behaviour of different parts wasn't always easy to cope with.

We tried many more hostels, bedsits and housing projects for young people, and all of them failed – either because of my repeated hospitalisations or my inability to work within their programmes.

Aged 18, I started attending a drop-in and counselling centre for young people 'not in education, training or employment'. The drop-in was helpful – somewhere to go – but sometimes I feel the counselling did more harm than good. (My therapist wasn't trained in dissociation or trauma, and would often trigger me without meaning to, leaving me lost and spacey after sessions.)

Still trying to help, my CPN organised for me to live in supported accommodation for adults with mental health problems. Staff there accepted my diagnosis to a point, but would not (or did not know how to) work

with it. It was a case of 'don't listen to the voices', and although they encouraged me to undertake voluntary work, things did become difficult. My struggles were seen as a refusal to engage and in the end, out of frustration, I left and rented alone.

I had been involved in NHS mental health services for eight years by this point. I wasn't achieving what I knew I was capable of in life and had to do something.

An internet search took me to a specialist centre which enabled me to find a suitably experienced clinical psychologist in my area, Dr Mike Lloyd. He seemed to understand what we said and could provide me with the answers as to why I was the way I was. He also gave me hope that life could get better with the appropriate treatment and support.

Out of my own pocket I completed the SCID-D (see below) with Mike and started therapy with him a week after my 22nd birthday. I have paid for therapy and fought for it since then.

Life has changed so much since seeing Mike – I am living independently, I can drive, I can hold down a job and I can think straight. All of my parts write in a diary so we can see what we're up to, and we talk to each other about what we're thinking and feeling. Traumatic stuff gets worked through in therapy (or even at home, now that we're getting better at it), and we're learning all of the self-care stuff that we never learned as a child.

As brilliant as all of this is, my transition into a 'normal' life has been difficult – over the last few years I've had several emergency visits to GPs, walk-in centres and A&E, all of which have been incredibly stressful and unsupportive. (I would really like to thank the nurses at the walk-in centres, who did treat me like a human being.)

I relocated from my town to another county in order to fit the catchment area for a different clinical commissioning group (CCG), hoping that a different mental health team would be better able to assist. This work is hard enough as it is, without having to fight for it and justify it every step of the way. Every time I slipped or struggled, it was because

'therapy wasn't working' or the 'treatment wasn't appropriate'. It felt as though anything I did reflected on my choice to recover, and that the normal pitfalls of this journey were used against me as justification to not help. Mental health teams would not engage with what I was trying to achieve, with one psychiatrist saying to me, 'Who are you to deserve this funding?'. I know there's a finite pot of money available, but the fact that other people have been given it, with no clear reasoning why I haven't, is what makes it so difficult to accept. Surely two-hour train journeys to therapy showed my dedication to 'recovery'.

There were times in the past when I've literally not known what to do or why I'm carrying on, but I made a promise to myself that if we got through this then we'd make it better for other people. I'm not the only one going through this, and I don't want anyone else to have to go through what I did to access therapy.

Things need to change.

The therapist's perspective

The client begins by helping us understand how DID for her occurred as a result of abuse sustained in childhood. We will use the term DID in this article as this is how the client wishes it to be referenced. Abuse is a common causative factor of DID, though it can also be due to neglect within the context of attachment dynamics, and where an aspect of a complex trauma experience is more likely. For DID to be present, according to DSM-V (American Psychiatric Association, 2013) and the ICD-10 (World Health Organization, 1992), there has to be the presence of two or more personalities, each with their own set of characteristics and behaviours (e.g. the person and one or more 'alters' or emotional personalities, as described within the model of structural dissociation (Van Der Hart et al., 2006)). This has to be present outside of any consequence of substances, disease or head injury, not be part of a cultural/religious system, have elements of amnesia and be distressing to the individual. The prevalence of DID, the most severe form of dissociation, is thought to be between

0.4 and 1.7 per cent (Akyüz et al., 1999) in the general population; the prevalence of dissociation in general is much higher.

The client writes about how her behaviour needed changing, with 'atypical anorexia', self-harm and suicidal thoughts becoming the focus of attempts to treat. This is noted in many people's accounts of their journey with dissociation, with other explanations being offered instead of dissociation, such as autism, ADHD, eating disorders, conduct disorders or emerging personality difficulties. For a broad overview, see Brand et al.'s (2016) dispelling of the myths about DID. In this case, the group therapy was offered without an indication that her father was critical in the cause of her distress. Being able to see past the behaviours for a full understanding of why she may be dissociating was not possible. In DID, there are internal parts, or 'alters', who may have very different behavioural patterns, or 'actions systems', some of which can be seen as persecutory punishment and others more focused on protection, defence or retreat (Van Der Hart et al., 2006).

A key element of DID is amnesia. The client describes finding things she has no awareness of buying. In this case, a dissociated part may have 'taken over' the body, pushing her into the background and gone out to buy things. It can be challenging for family, friends and professionals to understand this. Being able to explain thoughts and behaviour is therefore problematic, and can further promote secrecy about the dissociative experiences as well as the abuse. The 'barrier' between her internal world and hospital staff trying to make her safe led to years of frustration from both sides, with many techniques being tried to little effect.

The presenting behaviours of DID can be confusing and disorientating to watch, with rapid changes of voices, mannerisms and movements. It is not uncommon to see many dissociated identities within the space of a few minutes. Due to a lack of understanding, this can lead to strong rejecting reactions in others. Under such circumstances, foster placements would be nearly impossible to maintain if the

carers were unaware of dissociation. Education and employment can suffer and the potential for quality of life can be quickly lost.

The client points out how frustrating it was to not be able to engage in discussions about her dissociation with staff, and has found this occurring in different areas over the years she has sought therapy. The importance of raising awareness of DID and general dissociation is paramount, and voiced by many people seen within specialist trauma clinics. Locating dissociation at the centre of treatment can prevent further triggering of traumatic memory and behavioural response. She is appreciative now of how difficult it must have been for people to 'hold her', but she could easily have taken on a perspective that she is 'a failure, a lost cause'.

When the client contacted me, we followed the assessment guidelines recommended by the International Society for the Study of Trauma and Dissociation (ISST-D, 2011). This included the self-report screening measure, the Dissociative Experiences Scale – II (DES-II) (Carlson & Putnam, 1993) and the Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D) (Steinberg, 1994). These are internationally validated tools; however, as she points out, even with a diagnosis there was no help to be found within NHS settings.

The client shows how she has changed following the therapy being set up. It began with stabilisation, then trauma exploration and then integration – of the self and into life (ISST-D, 2011). The potential for the client is well on the way to being fully realised, demonstrating how a 'disorder' does not have to be a 'disability'. It is one of the great ironies that a condition like DID, which can be so debilitating at times, can also offer the chance of a wonderful life. Some therapists work toward full integration (i.e. merging all parts into a whole); others work with the parts remaining as support and company.

NHS England and the National Institute for Health and Care Excellence have not developed UK versions of the ISST-D guidelines, despite requests to do so. Self-funding for therapy is costly and beyond the resources of many, especially considering the general

long-term nature of therapy. We continue to work closely with the local CCG to develop service level agreements for assessment, diagnosis and treatment pathways.

Evidence is emerging that offering therapy for people with DID may be very cost effective, as it has been demonstrated that providing therapy focused on working with DID reduces the use of services in more traditional mental health settings, such as inpatient admissions and out of hours crisis contacts (Lloyd, 2011, 2016; Myrick et al., 2017), yet people like this continue to 'fall through the net'. With increasing awareness of dissociation and DID, there is room to hope that such an experience will be less often seen.

For this client to describe her experience in this manner is both courageous and informative, and helps us understand the unique

and individual journey for every person with mental health or trauma difficulties, improving our understanding of how we seek to help. Co-authoring such papers as this builds a joint approach to the literature, which mirrors the process we recognise as being essential in the therapeutic relationship. Writing by following the client's lead (whose article was the first written) helped me as a therapist to understand the need she had for the experience of DID to be accepted, as much as the overwhelming frustrations about lack of access to funded treatment.

Author

Dr Mike Lloyd

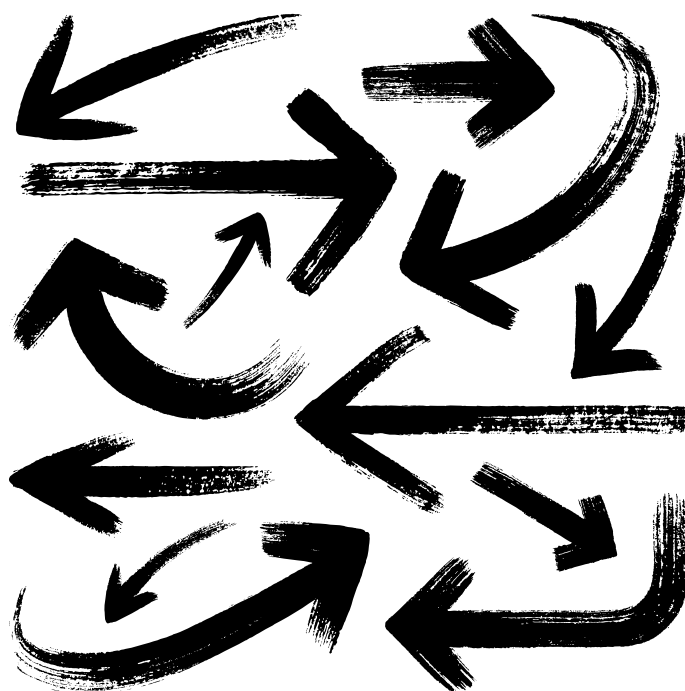
Consultant Clinical Psychologist; Director,
The Complex Trauma and Dissociation Clinic
(www.ctadclinic.co.uk); mike.lloyd1@nhs.net

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'You have to start somewhere': A service improvement strategy for people with trauma-related dissociation in Norfolk

Helena Crockford, Peter Cairns, Roger Kingerlee
& Melanie Goodwin



Trauma-related dissociative difficulties are more common than is generally understood but widely under-recognised in mental health services. Yet when dissociation forms part of the presentation, it can be associated with increased psychosocial impairment and complications in response to treatment, including psychological therapy. Lack of training and awareness amongst mental health staff is a contributing factor. In this paper we describe a four-year strategy to address this, and consider results and reflections.

KATE, aged 28 years old, was given a psychiatric diagnosis of 'paranoid schizophrenia' and referred to the community mental health team (CMHT) psychologist (the first author) by her care coordinator. Despite taking antipsychotic medication as prescribed, Kate still held unusual beliefs and

experienced persistent voice-hearing. She was also anxious and withdrawn with other people, which significantly limited her quality of life. When psychology sessions began, Kate responded well to having regular appointments and a consistent therapeutic approach. She began to find words to articulate her

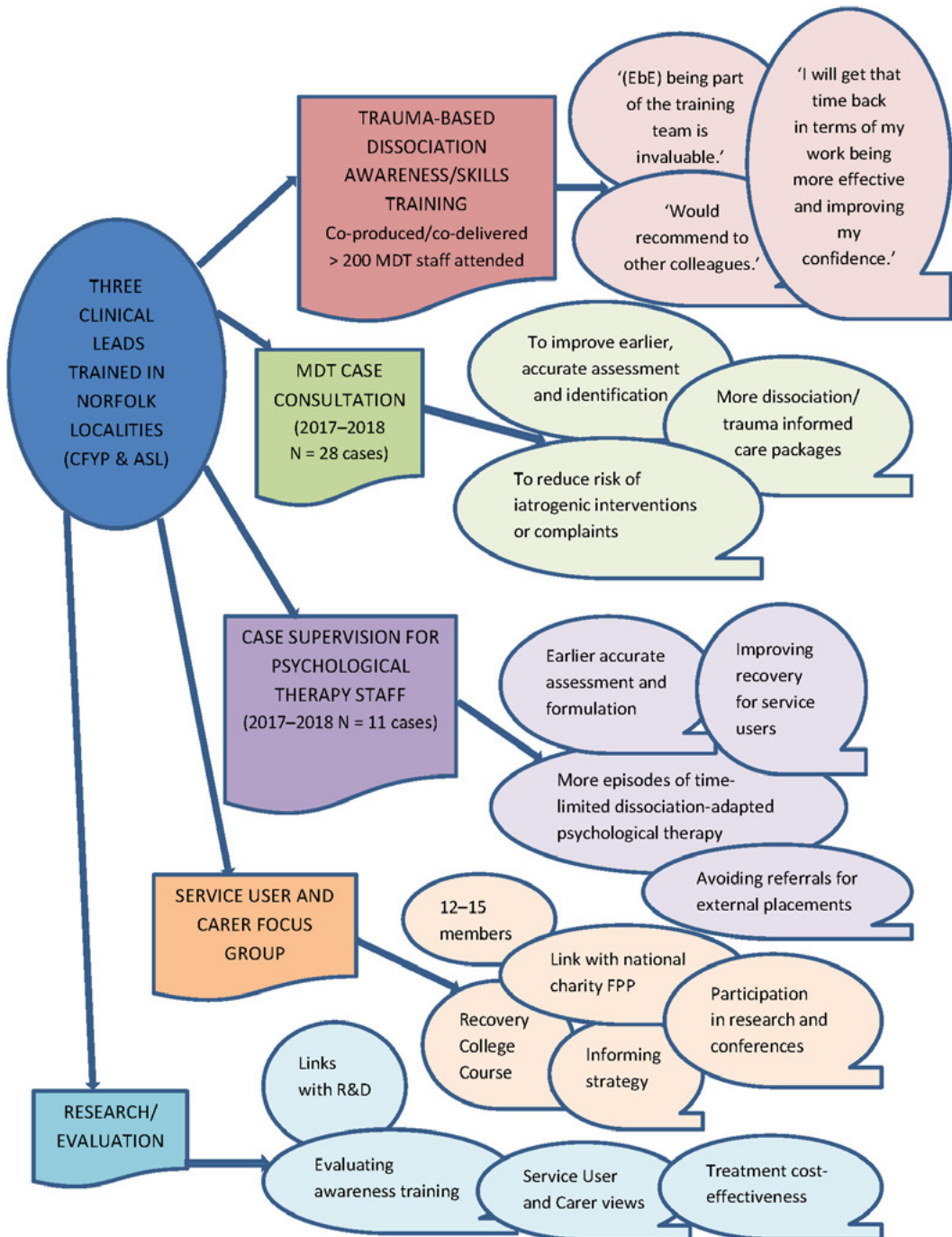


Figure 1: Norfolk dissociation strategy

experiences. Within the first few sessions, Kate described beliefs about being related to a famous person, who she believed was the only person who cared for her. She described a sense of different personalities she could ‘go into’, each with their own name, age and characteristics, and how they helped her cope with different situations. She hinted at an extensive history of childhood sexual abuse and parental neglect and described how she regularly heard the voices of her abusers.

Through supervision, I began to think that formulating Kate’s experiences as trauma-related dissociation rather than psychosis would likely be more helpful to her. I had not knowingly encountered this before in a decade of practice. Dissociation was not covered in my core clinical training, or in subsequent trainings in psychotherapy, working with personality difficulties or trauma. However, the literature on dissociation offered a ‘better fit’ for Kate and how we might work together. It helped us understand her experiences in terms of her history and attempts to survive both then and now, rather than just having ‘an illness’. Unfortunately, the CMHT were not so open – a dissociative diagnosis was controversial (see International Society for the Study of Trauma and Dissociation (ISSTD), 2011), and multidisciplinary team (MDT) staff did not have the specific training, knowledge or skills to understand it. Aspects of the care journey were undoubtedly iatrogenic for Kate at times, and due to the lack of consensus, uncomfortable and somewhat isolating for me.

Over subsequent years, I have found this experience echoed many times, with colleagues locally and further afield. Service users have shared their stories about the adverse effects of delayed recognition, with inaccurate or incomplete diagnosis and formulation, and inappropriate or potentially retraumatising treatment strategies. They have described the therapeutic relief and validation of having dissociative experiences accurately identified.

The literature also suggests these kinds of experiences have been widespread. Prevalence rates of 1–3 per cent (e.g. Johnson et al., 2006) for those meeting criteria for dissociative identity disorder (DID) are cited, equivalent rates to those of other severe and enduring mental health problems. The literature on cost effective treatments is also growing (e.g. Lloyd, 2016). This is not, however, reflected in rates of identification in services or the level of provision offered. Ross et al. (1989) identified the detrimental impact of delayed recognition with average length of time to a diagnosis of DID being 6.7 years, and longer delay associated with higher rates of suicide attempts, self-harm, and in-patient admission. The importance of accurate identification has increasingly been emphasised because severe dissociation is associated with more psychosocial impairment; also, with impacts on treatment, with increased risks of both treatment drop out and relapse (Bailey & Brand, 2017). The ISSTD (2011) guidelines for treating severe dissociation summarise reasons for these failures, including frequent

Table 1: Supervision figures during 12 months of the dissociation strategy

	Number of cases	Hours (approx.)	Types of activity	Service line
Supervision of psychological therapy colleagues	16	32.5	<ul style="list-style-type: none">■ Within regular supervision■ Supervision for one-off cases	<ul style="list-style-type: none">■ Adult■ Youth■ Wellbeing (IAPT)■ Royal Air Force (there is an RAF base in the local area)

co-occurrence of mental health conditions, lack of direct assessment (asking about trauma and dissociation) and limited practitioner knowledge and training.

In Norfolk we decided to address these challenges with a strategy that has developed over the last four years (see figure 1). Alongside the clinical drivers, organisational motivation has arisen from a wish to address high profile complaints from people experiencing dissociation who felt they had not received the appropriate service, and increasing scrutiny on out-of-area placement costs, including external placements commissioned for individuals with a psychiatric diagnosis of DID.

'You have to start somewhere'

The strategy started with several key but basic aims, which would be both realistic and sustainable. We wanted to:

- Improve knowledge and skills in the *psychological therapy workforce* in working with people with dissociative difficulties. This included addressing concerns about what could helpfully be offered within existing resources, and what the service gaps might be, such as capacity for longer term psychological therapy.
- Demystify and improve knowledge, skills and confidence in the *multidisciplinary workforce*.

- *Lower the risk of iatrogenic effects* by reducing delays to accurate identification (diagnosis and/or formulation) and improving the appropriateness of the mental health care that service users received.
- *Improve cost-effectiveness* by reducing inappropriate treatments (e.g. in-patient care, anti-psychotic medication, poorly targeted psychological interventions).

1. Psychological therapy skill development

The Consultant Psychology Group recognised that psychological practitioners within localities and across service lines were challenged by the complexity of dissociative presentations. We set out a cascade model for psychological skill development and in each of the three Norfolk localities we identified a dissociation clinical lead who would access specialist training and supervision and offer support to colleagues in their area with dissociative cases.

A centralised specialist service model was not considered appropriate due to the large rural geography and poor transport links which would limit accessibility.

The *locality clinical leads* were senior clinical psychologists (8b or above) who had existing supervisory roles and local strategic influence. We spanned two service lines (adult mental health and children, families and young people) as well as three geographical localities, which helped provide a broader base for

Table 2: Consultation figures during 12 months of the Dissociation Strategy

	Number of cases	Hours (approx.)	Types of activity	Service line
Consultation to MDT colleagues	22	27	<ul style="list-style-type: none"> ■ 1:1 discussion ■ Phone consultation ■ Team meeting ■ Joint assessment ■ File review ■ CPA review ■ Ward round ■ Support with funding panel application 	<ul style="list-style-type: none"> ■ Adult ■ Youth ■ Wellbeing (IAPT) ■ Medium secure ■ Inpatient

cascading knowledge and skills. We trained via a four-day foundation-level therapist training followed by an ongoing monthly supervision group with an external expert, for discussion of casework, supervision and consultation.

Supervision was then cascaded to psychological therapy colleagues within our own areas. Our experience has shown how helpful this can be: the field of dissociation is so complex, variable and potentially risky that one-off academic learning is not enough. This has been highly valued, yet it has not been an unsustainable demand. Table 1 shows the figures for a 12 month period of supervision.

Supervision has been effective, at times anticipating and resolving potential ruptures. For example, it has been helpful to understand the apparent anger and/or hostility a therapist may encounter from a service user, which may represent one 'emotional part' (EP) and be understood as a small part of the person's 'DID' type presentation (e.g. Van Der Hart et al., 2006). We have also been able to weave our developing expertise into existing supervision arrangements. In this way, we have tended to work with the existing therapeutic preferences and skill sets of staff which has included a whole range of approaches, helping to 'bolt on' further awareness and skill around dissociative issues.

To take one example, a supervisee was able to work with a person with a diagnosis of DID over an 18 month period, building up to using eye movement desensitisation and reprocessing (EMDR; e.g. Knipe, 2014) to effectively and safely increase contact between EPs. This produced an excellent outcome with increased levels of wellbeing, appreciated by the service user and their family.

2. Awareness training and case consultation for MDT staff

We had experienced the complexity of case management within MDTs – the risk of teams becoming split, disagreements over diagnosis, formulation or the correct treatment approach, and failure to manage complex counter-transference dynamics. We saw a need to improve awareness of dissociative experiences across the whole workforce.

Awareness training

A cornerstone of our strategy has therefore been to enhance the level of knowledge and understanding within the organisation as a whole. With expert by experience (EbE) involvement we co-produced a one-day training event which would be relevant to all MDT staff within the organisation. The trust training department supported this, keen to offer in-house CPD opportunities as an economical alternative to external training.

The training aimed to increase:

- (i) the level of knowledge and understanding of trauma-based dissociative difficulties, their causes and how to identify them;
- (ii) staff awareness around the lived experience of dissociation; and
- (iii) skills in working safely and effectively with people who dissociate, reducing the risk of providing iatrogenic interventions.

The training titled 'Working with clients with trauma-related dissociative difficulties: Awareness and skills training', has run for three years, with over 200 people attending so far. The training day covers everyday dissociative experiences (e.g. daydreaming, or coping in an emergency), and more severe dissociation, epidemiology, and assessment. We cover the development of dissociation from an attachment and neuropsychological perspective. The afternoon focuses on the lived experience, and key 'dos and don'ts', as well as principles of engagement, building trust, promoting safety and stabilisation, both within the client and the wider systems (e.g. care team and family). Finally, we also consider the emotional impact and how staff can remain empathic.

The feedback has been positive, and the courses well attended, with all professional groups represented. By invitation, we have done additional adapted versions for IAPT and the medical education programme.

Consultation

Ongoing learning and practice has been supported by the accessibility of case consultation with the locality dissociation leads. In MDT meetings, for example, appar-

ently confusing dissociative presentations or behaviours (a fugue state, for instance) might have been missed, dismissed or unwittingly glossed over. Now such experiences are more likely to be accurately identified as dissociation, formulated in the context of possible trauma and a more appropriate plan made. This tends to contrast markedly with past practice.

Case consultation has also supported MDT staff to help formulate very complex presentations. By consciously bringing notions of dissociation into these conversations, new vistas often emerge. As one would hope, these tend to be of increased understanding and empathy. Table 2 gives a summary of the consultation activity in one 12 month period.

3. Co-production of dissociation informed mental health services

The trust's embracing of the recovery model (e.g. Slade et al., 2012) meant that infrastructure was in place for EbE involvement. We developed invaluable partnerships with local service users and carers to co-produce strategy, the awareness training, a participation group and a recovery college course.

Melanie Goodwin's reflection

'It is a privilege as an EbE to have a respected and active role in writing and providing the awareness training, helping write the trust dissociation strategy, being a member of the dissociation focus group and co-writing the first recovery college course on dissociation.

'I have listened and learned from my inspirational NHS colleagues and then looked at what contributions I can make that are possible within their constraints without compromising my beliefs and knowledge as to what helps people experiencing complex dissociation. It is important to me that what is developed and offered is "enough", enabling clients to reach a place that is sustainable.

'Top of my list supports the Hippocratic oath, "Do no harm" (for example, minimising retraumatising experiences). This must be achieved through education of staff at every level. The awareness training clearly shows how

this is a developmental disorder rather than an illness, and why many brief interventions are often not sustainable due to the profound neurodevelopmental impact of early abuse and neglect. It also provides a foundation that engenders respect, belief, curiosity and a more confident way of being with us, as clients. So often, people with complex dissociation have been tipped further into crisis through disrespect and disbelief on the part of staff at all levels. It has reaffirmed the childhood messages of "worthlessness", "time wasters", "attention seekers"; an informed, open approach that genuinely demonstrates acceptance can be a major positive factor in our journey. We are so often made to feel we have failed the system.

'We are now co-producing a "What is dissociation?" course for the recovery college. This is a project of the Dissociation Focus Group that is now well into its second year. It started with an open invitation from the Trust's Service User and Carer Participation Lead to anyone with lived experience of dissociative difficulties who wished to influence and contribute to the dissociation strategy. It meets three times a year and around 15 service users and carers have been involved. It has been challenging and constructive for all involved and as a service user I felt heard. From this, have also come a survey of service user and carer views, opportunities to co-present at national conferences and to continue to influence strategy development in the trust.

'I remain sad and frustrated that many people experiencing complex dissociation are still a long way off getting the help they need, but I am pleased to be part of what I hope will be a big change based on what is needed. It will enable many people to no longer be "revolving door patients" and for them to be able to contribute to society in many positive ways.'

Overall reflections and next steps

We have been pleasantly surprised by how valued and welcomed this strategy work has been. We have met with less controversy than we feared. Working alongside our EbE partners has helped convey the informa-

tion in a way which increases staff curiosity and empathy. After our early experiences of working with trauma and complexity as a 'lone voice' within a divided team, it has been reassuring and encouraging to witness staff at all levels discovering new ways they can approach the complex needs of these service users.

We realised there were things our services were able to do better, within existing resources. These included being more aware of what service users with trauma and dissociation could experience as harmful, reaching more accurate, dissociation-informed formulations and diagnoses, and ensuring that the work of the MDT – whether psychoeducation, medication, case management or psychological therapy – was dissociation adapted. We have been particularly struck by how relatively little input – for example, a one-off consultation – can help steer a significantly more constructive care pathway.

We also realised, however, that there were aspects of care which were more difficult to provide. The clearest challenge has been the lack of resources for longer-term psychological therapy, which would allow for the attachment informed dissociation and trauma work as recommended by ISSTD (2011). This is something we are working to highlight within the trust, and are developing a business case and a dialogue with commissioners. It has been

vital to develop this strategy as part of a group because of the complex relationship dynamics which can be provoked within services. It has helped us to diffuse controversy, and provided mutual support to protect against burnout. The most frequent feedback from our awareness training has been for additional therapist-level training. We are working on ways to extend the lead role coverage, so more therapists can train and cascade supervision and consultation within their local area and service line. The last author's specific recommendation is for training for those working in a supportive role (e.g. support workers), as this is low cost and would make so much difference to people experiencing dissociation.

Authors

Helena Crockford

Consultant Clinical Psychologist, West Norfolk Adult Service Line, Norfolk and Suffolk Foundation Trust; helena.crockford@nsft.nhs.uk

Peter Cairns

Clinical Psychologist, Early Intervention Service, Norfolk and Suffolk Foundation Trust

Roger Kingerlee

Consultant Clinical Psychologist, Central Adult Service Line, Norfolk and Suffolk Foundation Trust

Melanie Goodwin

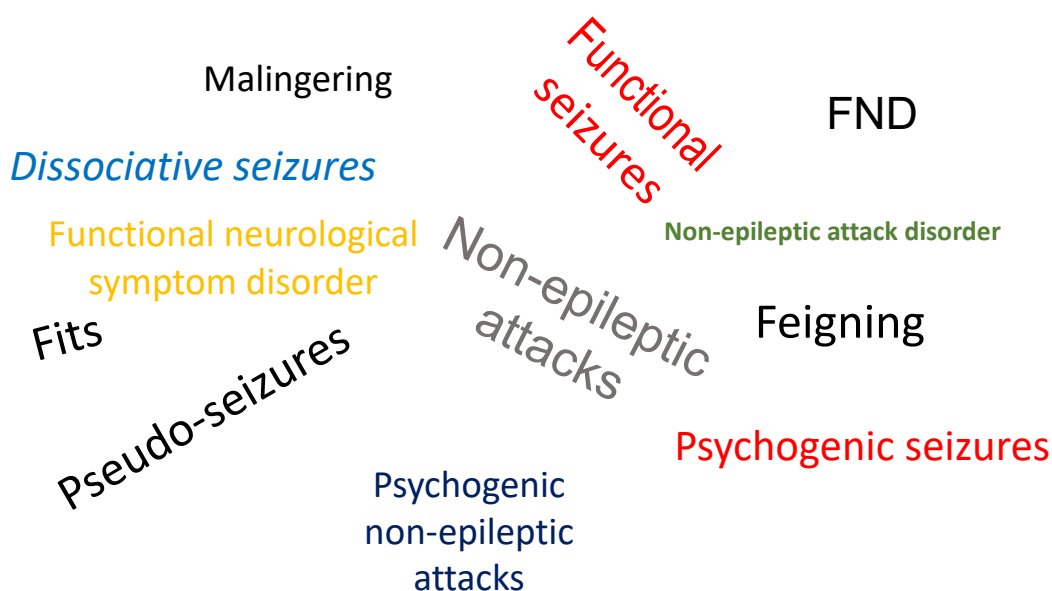
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Developing and commissioning NHS services for individuals diagnosed with dissociative seizures

Tammy Walker



Specialist clinical services for dissociative seizures are rare. Clients typically present to physical healthcare settings due to the physical nature of their symptoms. However, psychological therapy is widely recognised as the treatment of choice despite there being no specific NICE recommended therapies. This article provides an overview of dissociative seizures; considering the underlying neurobiological mechanisms and introducing a permanently commissioned clinical psychology treatment service.

DISSOCIATIVE SEIZURES are episodes of altered movement, sensation, or experience that resemble epileptic seizures but are not associated with abnormal electrical discharges in the brain (Lesser, 1996). Labels typically assigned to these episodes are not based on any diagnostic system and are problematic for many reasons. They are numerous and used interchangeably which can cause

confusion. Many labels are pejorative and lead to assumptions regarding the volition of the patient (e.g. pseudo-seizures) and some say more about what they are not, than what they are (e.g. non-epileptic attacks).

A less controversial label is functional seizure which is the preferred term of neurologists. It distinguishes problems with the functioning of the nervous system from problems

with its structure. Taken more broadly, functional neurological symptom disorder (FND) is an umbrella term used for many symptoms seen in specialist neurology clinics that mimic organic neurological symptoms. There is likely a functional equivalent to all known organic neurological disorders with symptoms such as limb weakness, tremors, pain, cognitive deficits and dizziness common in neurology clinics. Similarly, every specialism within medicine likely has its own functional symptom disorders.

Dissociative seizure does more to explain the proposed underlying mechanism. Clients often demonstrate additional dissociative symptoms (Goldstein & Mellers, 2006) and Bowman and Markland (1996) found that 90 per cent of clients met the Diagnostic and Statistical Manual (DSM-III-R; APA, 1987) criteria for a dissociative disorder.

Prevalence

Prevalence rates for dissociative seizures are cited as 2–33 per 100,000 (Benbadis & Hauser, 2000), but this is likely to under-represent the true prevalence. It is estimated that 25–30 per cent of clients seen in epilepsy centres for refractory epilepsy, where seizures do not respond to anti-epileptic medications, actually have dissoci-

ative seizures (Bodde et al., 2009). The average diagnostic delay from first seizure to final diagnosis is 7.2 years (Reuber et al., 2002).

Diagnosis

Historically, the diagnosis was considered one of exclusion, diagnosed only when organic causes had been ruled out. However, with increased research interest, certain features appear to favour a diagnosis of dissociative seizures over other seizure types. The classification of dissociative seizures and other non-organic neurological symptoms has changed with the 11th revision of the *International Classification of Diseases* (ICD-11; WHO, 2018). The ICD-11 reflects greater appreciation of the underlying dissociative mechanism. Dissociative neurological symptom disorder is characterised by ‘the presentation of motor, sensory, or cognitive symptoms that imply an involuntary discontinuity in the normal integration of motor, sensory, or cognitive functions’.

What predisposes individuals to developing dissociative seizures?

Psychological trauma is frequently quoted as a predisposing factor in the development of dissociative seizures (Beghi et al., 2015). The

Hyperarousal – Too much physiological arousal:
anxiety, panic, hypervigilance, easily startled, agitation

Survival responses – fight, flight

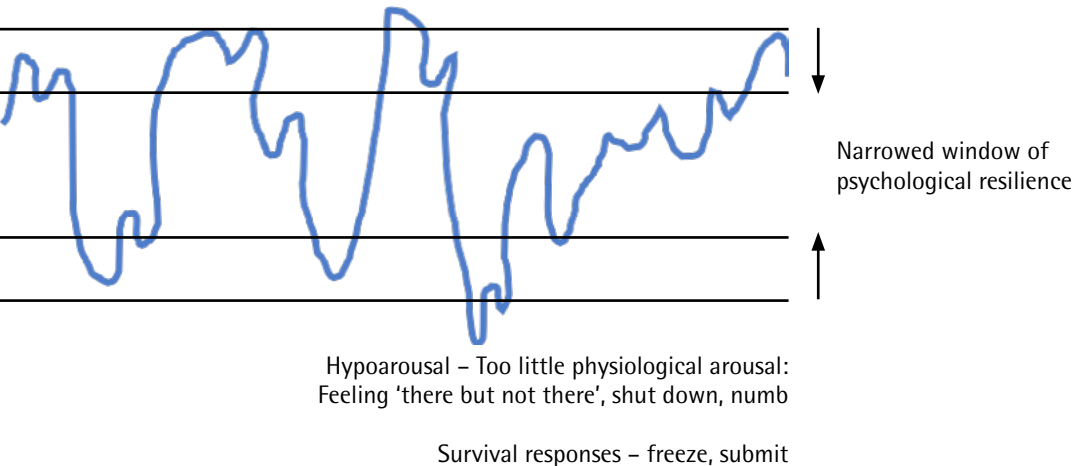


Figure 1: Window of tolerance

causal role of childhood trauma in the development of mental health problems in adulthood is well recognised and encapsulated in the traumagenic model (Read et al., 2014). Yet anecdotally this model is considered controversial when applied to the development of physical symptoms. As such, clients with dissociative seizures are rarely socialised to a psychological understanding of their symptoms. Development in this respect has been delayed by the false dichotomy between physical (soma) and mental or emotional (psyche) disorders.

Psychological trauma in clients diagnosed with dissociative seizures has been investigated. Myers et al. (2013) identified that 73.8 per cent reported at least one traumatic event in their lifetime. Over 40 per cent reported physical or sexual abuse. Other traumas reported included loss of a significant other, psychological abuse, witnessing the abuse of others and medical trauma.

Neurobiology of stress

Early childhood attachment experiences play a crucial role in the development of affect regulation or autonomic homeostasis (Schore, 2003). Siegel (1999) introduced the window of tolerance as a visual representation of this capacity to regulate autonomic arousal (Figure 1).

The polyvagal theory of emotional regulation (Porges, 2009) provides one way of understanding how traumatic experiences, attachment and the nervous system might all come together, and in doing so explain dissociation. The vagus nerve is the 10th cranial nerve. It was considered that the autonomic nervous system (ANS) maintained homeostasis through two interacting branches of the ventral vagal complex; the sympathetic and parasympathetic branches. The former is recognised as a mobilised fight-flight response to danger and the latter, the 'rest-digest' response that facilitates social engagement. Both branches are considered rapid responses owing to the myelination of the phylogenetically newer ventral vagal complex. However, in the polyvagal theory, a third more primitive survival response,

controlled by the phylogenetically older dorsal vagal complex, signals an immobilised response to life-threat; the freeze-submit response which we refer to as dissociation.

Treatments options for clients diagnosed with dissociative seizures

Diagnosis alone is not sufficient to maintain cessation of seizures in most clients (Wilder et al., 2004). Although 14 per cent of clients are reportedly seizure free within three months of diagnosis, the idea being that reframing the problems as psychogenic can be enough to bring about some relief, many clients require further (i.e. psychological) input (Hall-Patch et al., 2010). It is recognised that seizures should be considered a symptom with an underlying cause (LaFrance et al., 2013). Ideally, you would treat both symptom (dissociation) and cause (trauma), to provide the best clinical outcome for the client.

This is not intended to be a review of the literature on the treatment of dissociative seizures or dissociative disorders generally (see Carlson & Nicholson Perry, 2017). However, it is important to note that there are no NICE recommended treatments for dissociative seizures. Only passing reference is made to them within the NICE guidelines for epilepsy which states, 'Where non-epileptic attack disorder is suspected, suitable referral should be made to psychological or psychiatric services for further investigation and treatment' (NICE, 2012, p.18).

Cognitive behavioural therapy (CBT) is advocated as an effective treatment (Goldstein et al., 2010). It is important, however, not to disregard other clinically effective therapies (Mayor et al., 2010). It has been my experience that clients benefit from longer-term interventions. These are becoming less available within the NHS where there is a move towards short-term symptom-focused cognitive behavioural approaches. This has been influenced by austerity policies and resulted in the decommissioning of many longer-term therapy services (Burningham, 2018).

The International Society for the Study of Trauma and Dissociation (ISSTD, 2011),

published guidelines recommending a three-phased treatment approach. In this paper, I outline how we have applied this within the Functional Seizure Service, a permanently commissioned NHS service in the UK.

The development of the functional seizure service and treatment pathway

The Functional Seizure Service (FSS) is one of few specialist dissociative seizure services in the UK. It is a small clinical psychology

service based in an acute NHS trust. The FSS serves a population of 733,000. The initial 18-month pilot was funded internally through an initiative to develop innovative services that could evidence cost-savings for the trust. It was permanently recommissioned in September 2015, with investment from four clinical commissioning groups (CCGs): three of the five county CCGs and the City CCG. The business case was based on both clinical and financial data, some of which is presented below.

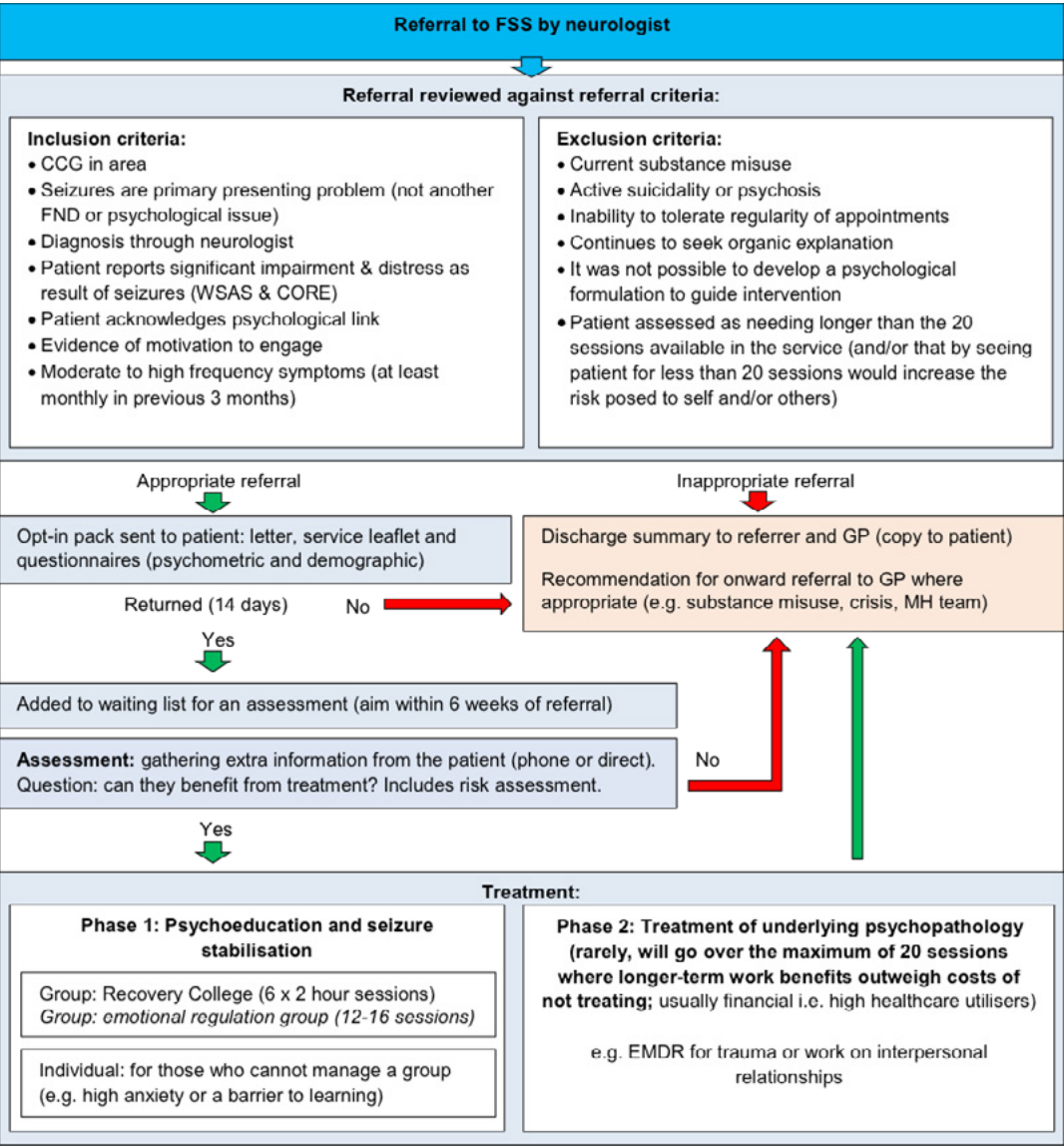


Figure 2: Functional seizure service treatment pathway

Referrals are received from the four epilepsy-specialist neurologists and the general neurology clinics. Referrals are triaged against the inclusion criteria for the service (Figure 2) and invited to opt-in by returning completed pre-treatment measures. They are then offered a comprehensive psychological assessment. Consideration is given to the treatment pathway for the client, based on the preliminary psychological formulation. This approach allows for a tailored formulation-driven treatment that is responsive to the client's needs. This necessitates an eclectic application of therapeutic models (e.g. eye movement desensitisation and reprocessing (EMDR), CBT and interpersonal approaches).

Clients are offered a maximum of 20 sessions. It is recognised that 20 sessions are rarely sufficient regarding the complex nature of the client group. The decision to provide time-limited therapy was based on the limited resource of one full-time clinical psychologist. Offering more would have further reduced the throughput. Routine treatment sessions last 50–60 minutes, assessment and EMDR sessions last 90 minutes.

The service follows the treatment guidelines for dissociative disorders outlined by the ISSTD (2011). The guidelines follow the consensus of experts that complex trauma-related disorders are most appropriately treated in sequenced stages: stage one, establishing safety, stabilisation and symptom reduction; stage two, confronting, working through, and integrating traumatic memories; and stage three, identity integration and rehabilitation.

The first stage of treatment within the FSS is psychoeducation around the condition, drawing on easily digestible elements of the neurobiological concepts around the functioning of the ANS and impact of early trauma. This psychoeducation can help to bring clients on board with a psychobiological

formulation of their symptoms. Once clients understand the mechanisms involved in the body, this provides a rationale for the skills training element of treatment. Clients are presented with two different sets of skills to influence autonomic arousal. Activating exercises work by rebooting the system through increasing autonomic arousal when hypo-aroused (e.g. encouraging the client to move in their seat or stand and move about the room thereby raising blood pressure). Soothing exercises work by reducing hyperarousal (e.g. visualisation or relaxation). The aim is to help clients recognise when they are reaching the boundaries of the window of tolerance in order to remain present and grounded. Stabilisation in this sense is a pre-requisite for progressing to stage two, which focuses on treating predisposing factors to the development of seizures.

If clients are able to remain inside their window of tolerance and there is enough time to commence the work safely, clients might be offered an evidence-based psychological treatment for treatment targets identified in the psychological formulation. For example, EMDR may be offered where there is a clearly identified trauma history. Since standard protocol EMDR is contraindicated with dissociative conditions, EMDR is integrated with stabilisation work and ego state interventions. The work of Knipe (2015) has been a valuable contribution to the approach used. Knipe draws on techniques used to maintain present moment awareness such as constant installation of present orientation and safety (CIPOS), and the Back-of-the-Head Scale¹.

Service data

The service collects routine outcome data. Pre- and post-treatment measures include quality of life, psychological distress, functional impairment, illness beliefs and dissociation.

¹ In the Back of the Head Scale, the client is asked to imagine a line running from a metre in front of their face to a point at the back of their head. They are asked to let the point in front of their face mean that they are completely aware and present, with the point at the back of the head meaning that they are so distracted by thoughts, feelings or memories that it is like they are somewhere else. The purpose is to help the therapist identify when a client is drifting into derealisation and to help the client become more aware of this.

Table 1: Annual cost savings for the first 42 clients seen in the service

Cost-saving source	Annual saving: per client (£)	Annual saving (£): 42 clients
Reduced emergency department attendance and ward admissions	1691	71,022
Predicted reduction in medication use		9112
Ambulance call out (using marginal rate)		4173
Reduction in neurology follow-up activity		8715
Total		93,022

Table 2: Year on year savings over five years

Potential savings over 5 years assuming 50% reduction in treatment effectiveness over each year	Year 1	Year 2	Year 3	Year 4	Year 5
Year receiving treatment	93,022	93,022	93,022	93,022	93,022
Clients treated 1 year ago		46,511	46,511	46,511	46,511
Clients treated 2 years ago			23,256	23,256	23,256
Clients treated 3 years ago				11,628	11,628
Clients treated 4 years ago					5,814
Total annual saving	93,022	139,533	162,789	174,417	180,231
Cumulative savings	93,022	232,555	395,344	569,761	749,992

Data is also collected on healthcare utilisation (i.e. number of healthcare visits in the three months prior to treatment versus post treatment). Finally, there is a qualitative feedback form for clients to complete following treatment, which contains the NHS friends and family test.

Specific clinical outcome data is not presented here, but was recently presented at the third international conference on functional (psychogenic) neurological disorders in Edinburgh (September 2017). The data demonstrated increased quality of life whilst evidencing reduced psychological distress, functional impairment, dissociation and healthcare utilisation. Seizure frequency also

reduced, with clients having fewer seizures a day, but also managing longer periods of time without a seizure. One hundred per cent of clients reported that they would be extremely likely to recommend the service to a friend or family member.

The business case for securing permanent commissioning of the FSS

It is difficult to give specific details on commissioning of services because this will be based on local arrangements. Also, from my experience, commissioning is constantly changing. At the time of securing permanent commissioning for this service, we were advised to contact individual CCGs in the area to

invite them to jointly invest in the service. In May 2015 we presented commissioners with the clinical outcome data from the first 12 months of operation. Commissioners agreed that there was a clinical case for commissioning the service, but they needed to see the financial benefits before investing.

Calculations of cost savings were computed by taking all clients seen within the first 12 months of the service's operation. Their healthcare utilisation in the 12 months preceding contact with the service was compared with the 12 months following contact. Contact was defined as having met with the clinical psychologist, even if this was for assessment only. The savings calculated over the 12 month period were £93,022 (Table 1). This was modelled over five years (Table 2).

In this model, it was assumed that in each treatment year, 50 per cent of treated patients returned to baseline healthcare utilisation. In reality, follow-up has not indicated such a decline in treatment effect; therefore, we can be confident in the projected savings.

Factoring in the cost of a whole-time equivalent psychologist, the total saving to the CCG over five years was calculated at over £400,000. The CCGs accepted this financial

model as a sound investment. The service has now been in operation for four and a half years and it would be useful to remodel the finances to see if the savings were as predicted, but this has not been possible in a busy clinical service without access to a health economist.

Summary and conclusion

In this article, I have tried to highlight the need for services that offer psychological treatment for clients diagnosed with dissociative seizures. More broadly, I hope to have highlighted a substantial population of clients who present to physical healthcare settings due to symptoms that have a psychological cause. The potential cost savings to existing services should serve as the rationale for commissioners to invest in these services.

Author

Dr Tammy Walker

Clinical Psychologist,
Functional Seizure Service,
Department of Clinical Psychology
and Neuropsychology, Nottingham University
Hospitals NHS Trust
walkertammy945@yahoo.com

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Developing trauma-informed care and adapted pathways using the Power, Threat, Meaning framework (Part 1: Being heard and understood differently)

Jan Bostock & Nicola Armstrong



Trauma-informed care for people seeking help with complex experiences of adversity and trauma needs to enable people to be genuinely heard, meaningfully understood, and offered attuned help. We consider how the Power Threat Meaning framework (PTMF; Johnstone et al., 2018) can be applied to understand a person's history and current experience, and we describe how we are adapting pathways of care within mental health services in order that people are helped more effectively.

THIS PAPER focuses on the experiences of Nicola, a patient and carer involvement facilitator who benefited significantly from a collaborative formulation that was part of her cognitive analytic therapy (CAT). She subsequently gained further confidence, understanding and courage from

co-producing and delivering formulation training to hundreds of mental health staff.

Nicola's account

From my earliest memory I felt different. That feeling stayed with me until I could make sense of my experiences and see myself

in a completely different light. After 30 years of accessing mental health services and feeling I didn't fit in the right boxes, I finally realised that managing my symptoms was never going to be an effective way of understanding my distress.

I had always believed that having experienced so much abusive behaviour, it must surely be my fault. The response from mental health services was often retraumatising and added to my despair and distress by focusing only on problems and deficits. At times when I did lose touch with reality, I believe that is what I had to do to survive and get through. I thought no one could comprehend my thoughts and feelings, and I felt completely alone and isolated. Voices I heard were brutal and cruel, constantly demanding that I end my life. I became convinced part of me must be evil, which was my way of making sense of what was happening to me...

I changed from either feeling completely overwhelmed to feeling nothing at all and numb. I had flashbacks that would cruelly replay over and over. I didn't care about not being safe. I was actually disappointed that I was still alive as I could not imagine a way out. I felt like my world wasn't real and that I was part of it, but not really in it. I have lost so many memories and those key milestones in my life, as my brain just blocked them out. People now remind me of good and fun times and I'm embarrassed that I can't recall them.

Understanding my formulation enabled me to understand how what's happened to me affected my core beliefs, self-image and views of the world. I assumed everyone else had the same views about me that I did: 'What you see not only depends on what you look at, but also where you look from.' (James Deacon)

Within health services, there was often a lack of empathy, warmth and compassion. For example, one referral letter from my GP to a consultant psychiatrist said that I was 'just plain miserable and inadequate' and that I was 'an awkward problem'.

I was never asked the key questions to help understand the impact of my experiences to enable me or the staff working with me

to make sense of my troublesome responses and feelings of hopelessness and self-hatred. Interventions were done to me without explanation, and I was given unhelpful labels and diagnoses. I would be assessed and then be left, having opened up a can of worms, then added to another waiting list. Once, a health professional told me he didn't know how to help me and that I was too complex. How could I then tell the whole truth? Would they believe me? How could anyone help me now? This only reinforced my own views of myself, that I wasn't important, that I did not matter and that nothing would work.

Helping others and meeting peers in mental health services enabled me not to feel alone. It gave my life meaning and I felt I had a purpose and could contribute something. I wanted to change and influence services to be more responsive to individual need in a meaningful and more collaborative way.

At the age of 50, with the support of two fabulous staff, a consultant psychiatrist and a nurse therapist, I had validation and understanding. The psychiatrist enabled me to influence how we conceptualised my issues and helped me to take some control about decisions. The nurse therapist simply said to me 'no wonder' I continued to feel so distressed, that my resilience and determination had got me through, and I was brave coming back to therapy. I'd always blamed myself, felt damaged, unfixable, weak and untreatable. Therapy gave me the chance to begin to piece together the jigsaw puzzle of my life and to see the picture in full. I occasionally re-read the letters I received and gave as part of my cognitive analytical therapy, to remind me of how far I've come.

The nurse therapist's responses to my difficult disclosures, reminded me of what a human reaction should look and feel like. I had to relearn how to trust, connect, feel and show emotion. A brilliant example of sharing compassion and power.

I then became involved in developing formulation training as a way of improving services across our mental health and learning disability trust. This has been fundamental

in my education and understanding about what affected my mental health and well-being, and how we can help others. I gained influence in my personal and professional life through training and influencing others.

I now believe that as a young person I had reacted normally to an abusive set of circumstances and know that people misused their positions of power to exploit me and to make me feel ashamed, confused and very fearful.

Understanding my story has changed my views, from once thinking of myself as inadequate and insignificant, to recognising how I contribute and influence positive service change. From my experience it is very important to develop formulation-based, trauma informed care that is compassionate and informed about the impact of adversity and access to power. Then we can genuinely feel understood, heard and valued.

Trauma-informed care, formulation and the PTMF: Being understood differently

Nicola's experiences show how psychological therapy and routine mental and physical healthcare can enable us to recognise how past and ongoing adversity and the abuse of power can have an impact on people's emotional and physical health and functioning (Sweeney, Clement, Filson et al., 2016; Sweeney, Filson, Kennedy et al., 2018). This starts with relationships between people using and providing services respecting each other's' expertise and sharing power and control. It was very significant for Nicola that the consultant psychiatrist 'helped me to take some control about decisions' and her psychological therapist really listened to how she had been abused.

Being sensitively listened to and heard is crucially important, and often a completely new experience for the person concerned. This needs a stance of openness and respect for the person seeking help and an understanding of how power has and is operating in their life, including how it operates in professional and service user sessions. The CAT therapy enabled reflection on this.

As Nicola has observed, sustained abuse,

being trapped, unprotected and having attempts to be heard invalidated when we are young can lead to feelings of responsibility for bad things happening. In all organisational settings, we need to appreciate the strengths and assets that people have and develop, even in the face of ongoing threats or degradation, and that we don't inadvertently reproduce the experience of humiliation or abuse.

Trauma-informed approaches to relationships enable us to move from a focus on 'What is wrong with you?' to considering, 'What happened to you?' (Longden, 2013) and to open up possibilities for greater understanding and increased opportunities to offer help. We know that overpowering and abusive experiences in childhood have lasting consequences physically and emotionally (Van der Kolk, 2014; Herman, 1992). For children and young people, there are ten recognised categories of adversity (Bellis et al., 2015):

- an adult swearing, humiliating or physically intimidating a child;
- an adult physically hurting a child;
- an adult sexually abusing or attempting to abuse;
- no one in the child's family loving them or looking out for them;
- not having enough to eat, being neglected;
- parental separation or divorce;
- the domestic abuse of the child's mother or stepmother;
- living with an adult with addiction problems;
- living with an adult with mental health problems;
- a member of the child's household going to prison.

These categories include the direct experience of physical, sexual and emotional abuse, and also the experience of neglect and insufficient protection from the witnessing of abuse. Holding these kinds of adversity in mind can help us to appreciate possible influences affecting people with persistent mental and physical health issues. The adverse childhood experiences studies (ACEs; www.acestoohigh.com; Felitti et al., 1998;

Bellis et al., 2015) alert us to the consistent findings that two thirds of people experience some ACEs. Those with a greater number of ACEs are at higher risk of poor physical and mental health and social disadvantage in their adult lives. Those who have experienced four or more adverse events are at increased risk of heart disease, diabetes, to have experienced violence recently, and for their life expectancy to be shortened. Thus, different sources of adversity often interrelate.

Formulation provides a way of making sense of people's experiences of abuse and trauma and appreciating the impact of past and current events on their own terms and according to what is meaningful for them as a step towards finding ways to deal with their situations and difficulties (Johnstone & Dallos, 2013). Formulations commonly incorporate the 5 Ps (Bostock, 2017, 2018) and aim to account for presenting issues in the context of predisposing and precipitating factors, issues that perpetuate troubled or troubling behaviour, and protective factors or sources of strength that are in the person's life in addition to their personal resources. We have found this approach to formulation enriches routine care in secondary mental health services and adds to the meaningful understanding of people's experiences and ways in which things can change.

Nicola's account highlights how a formulation is helpful when shared empathically and as part of a collaborative relationship that appreciates a person's resources, how power has been used or misused in their life, how social and family influences have been experienced, and what threats, past and present are relevant now (Smail, 2005).

The PTMF (Johnston et al., 2018) developed from the Division of Clinical Psychology position statement (2013) on the need for an alternative way of understanding the experience of distress and troubled behaviour to a prevailing 'disease' model, and to work with services users to develop a multifactorial and contextual approach which accounts for social, psychological and biological influences. The PTMF explicitly outlines how different

kinds of power operate in individuals' lives and how that power can be:

- (i) embodied through physical health, experience and appearance;
- (ii) coercive or forceful;
- (iii) legal through the operation of rules or sanctions; and
- (iv) economic or material through the control of resources or possessions.

Adverse experiences translate into core threats that may include abandoning relationships, threats to values, physical functioning, emotions, financial and social status, community cohesion, environments, knowledge and meaning. These threats are mitigated by access to biological, psychological, cultural and social resources. Reference to the provisional and general patterns of threat responses described in the PTMF are potentially useful for elaborating people's personal narratives and sense of understanding. The impact of the Power Threat Meaning perspective is linked with the interests and interpretations of individuals and communities. Clearly such an understanding resonates personally for Nicola. She also powerfully conveys the role of social and economic power in her training about formulation that goes beyond the traditional intrapsychic focus of therapy.

Power differences between people can be used benignly or abusively. The misuse of power is often interpersonal where key relationships between children and adults lacked trustworthiness, respect for sexual boundaries, reliability, care, protectiveness and warmth. Social, cultural and ideological power can also be abused. For example, we have seen this in disclosures of widespread and organised childhood sexual abuse by groups of men against young girls that was not recognised, effectively followed up or prevented by education, health, police or social services, as reported in the independent inquiry into child sexual exploitation in Rotherham (Jay, 2014). The lack of recognition of abuse by those in authority influences the personal meaning that individuals and families infer, and can add to a sense of shame and self-blame.

Adversity or injustice can engender physical harm, uncertainty, lack of control and entrapment, and may involve ongoing difficult and conflictual relationships and repeated abuse. Thus, there are often continuing threats that need to be tackled or withstood by the person in distress. Making sense of this is personally mediated with reference to prevailing ideological and social narratives that are influential in the person's world (Hagan et al., 2018). We are all influenced by common discourses about the causes of distress and these affect how we make sense of our feelings, thoughts and behaviour (Johnstone et al., 2018; Hagan et al., 2018).

When Nicola was a young woman, it is worth asking how life for her would have been if someone with authority such as her GP, a family member, a teacher or youth worker had tried to understand what was underlying her distress, and why such an energetic, bright and sporty girl had become so depressed. How different would her experiences have been if someone had used a perspective sensitive to power, threat and meaning to explore her experiences of voices, despair and isolation or asked how much control she had in her day

to day life? Was she being bullied? Were there people she could talk to?

We need to expand our view beyond individual relationships to look at the impact of adversity, disadvantage and discrimination more broadly and how organisations respond (Hagan et al., 2018). Formulations are more likely to be relevant if they refer to different sources of power, an account of the threats people still experience, and how the settings in which they live may still perpetuate adversity and abuse. Ways forward need to be socially validated (e.g. the #metoo campaign), as well as individually driven. We need a combination of kindness, openness and the orientation to listen to painful stories. Reference to the PTMF ultimately helps to make sense of the processes that may exacerbate or ease these difficult experiences.

Authors

Jan Bostock

Consultant Clinical Psychologist, Associate Director, Psychological Services; janet.bostock@ntw.nhs.uk

Nicola Armstrong

Patient and Carer Involvement Facilitator

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Developing trauma-informed care and adapted pathways using the Power Threat Meaning framework (Part 2: Being helped differently)

Stuart Mitchell & Evelyn Thorne

Trauma-informed care for people seeking help with complex experiences of adversity and trauma needs to enable people to be genuinely heard, meaningfully understood and offered attuned help. We consider how the Power Threat Meaning framework (PTMF; Johnstone et al., 2018) can be applied to understand a person's history and current experience and we describe how we are adapting pathways of care within mental health services in order that people are helped more effectively.

THIS PAPER describes the experiences of Eve and how her dual roles as professional and service user interact in the light of her experiences of terrifying violence and threat. The experience illustrates how the PTMF may help inform structured clinical management (SCM) in a way that is helpful to Eve.

Eve's perspective

In my family background and as a child I experienced some trauma. Through my work and training as a clinical psychologist, I came to understand the effects of trauma, particularly chronic and unrelenting trauma such as abuse, as being a very helpful antidote to the label of 'personality disorder' – in the sense that any child who experiences such gross and harmful experiences will react in such a way as to enable their survival. *Personality disorder* as a psychiatric construct does not really help with understanding the traumatic origins of emotional difficulties and their effects on the person, and may even inadvertently stigmatise the person as being flawed or defective in some way.

Five years ago, my son, a service user of the NHS, assaulted me so severely that I was admitted to intensive care for lifesaving

surgery. Following a ten day stay in hospital, I left being both physically and mentally permanently scarred. This trauma has hijacked and derailed every area of my life, including my professional self, which in turn has led to a huge disconnect from myself, my body and others around me. There has been a slow and gradual thawing out process and over time I have gradually defrosted. I say this as I haven't always been aware of the profound state of shock that I have been in and my inability to feel very much except a deep sense of shame.

Within my work context, there were many triggers for my post-traumatic stress disorder, including coming across staff who were treating my son and discovering inappropriately clinical information about him just by going about my day-to-day work. Simply hearing the narratives of other service users also resonated with my own feelings of fear, anxiety, grief and loss. Again, the overwhelming nature of the trauma was such that I was immediately tipped back in time to the assault itself, requiring considerable grounding techniques to bring me back to the here and now. This took its toll on me emotionally.

However, in terms of my professional self, there is a line that I have crossed which

I don't feel able to come back from. Personally and professionally, I am unable to view the world in the same way as I did before the trauma. Due to the treatment my son and I received, and the resulting catastrophic results, I am unable to see mental health services in the same optimistic light. I have lost my protective beliefs within the workplace. So it is not a question of returning to a former state of equilibrium, but a different resting space – one in which I am never able to see the world in the same way again. For me, it is the loss of being able to see the world in such optimistic terms that unites all traumatic experiences. I have given up that protective belief that, 'it's never going to happen to me', or having to think about unbearable and intolerable realities. Over time, and I have needed so much time, I have been able to find a new state of 'being' where I am able to be in the here and now and connected to myself and others. But it comes with the cost of feelings of fear, grief and loss that are never far away.

Understandably, to meaningfully provide psychological care, there is a degree to which staff have to put the 'blinkers' on, in order to have faith in the effectiveness of clinical interventions and to a degree, turn a blind eye to unmet need or to where interventions are not working. To function now within the NHS, there is a degree to which clinicians have to hold protective beliefs when resources and time are so scarce. As a service user and having been a carer to my son with psychosis, I am now unable to do this and cannot reconcile this experience with my professional self, as that in itself feels false.

Additionally, I do think there are barriers within the system which affects the ability of clinicians to listen to the narratives of service users experiencing trauma. The advent of corporatisation and the embedding of a culture around litigation means that it is difficult to genuinely examine the gaps and reflect upon the difficulties in mental health provision. The risk in working with service users who have experienced trauma is of further compounding their trauma, or in other words, covering over their experiences. Not being

able to hear or truly listen to the narrative can feel unhelpful at best, and possibly retraumatising at worst. Part of the essential process of recovery from trauma includes bearing witness to the horrific nature of traumatic events, without as far as is humanly possible turning a blind eye, dissociating or denying the extremity of events.

So in the business of building in trauma-based pathways, it feels a lot of time is needed to acknowledge and process such intensely painful events. There feels something very important about bearing witness to the awful and terrible calamity the individual has had to endure. Part of me finding this new state of being, or a more connected self, has been 'finding my voice' and not feeling as if I am drowning under the weight of what has happened. In this process it has been excruciatingly painful bearing witness to what has happened and what I have lost.

Anyone who undergoes exceptional and out of the ordinary traumatic experiences will do the best they are able to do to survive, even if at times this includes dissociation and other sorts of symptoms of trauma. Whilst many of the methods and techniques offered within psychological therapies are enormously helpful in managing trauma, for me, I think it is the human experience of really being listened to which can make a difference, an acknowledgement that in processing trauma, nothing is ever the same again which brings with it a recognition of all the incumbent losses. And finally, I feel there can be a fundamental sense of hope about the human capacity to try and make the best adaptation that is humanely possible, even in the face of the most severe trauma.

Adapted pathways for complex trauma and dissociation: Being helped differently

Eve's story is not only powerful and emotionally moving, but it is also uplifting and hope-generating about the human spirit and capacity to survive. There is much courage shown here in sharing her story and building a sense of reconnection, which can be lost following overwhelming trauma.

As Eve explained, the effects of trauma on her include the 'huge disconnect' and 'gradual thawing out process', arising from past and current threats and misuse of power differences which are pervasive, painful and enduring. Eve's experiences remind us of the unbearable painful realities of trauma and the deep sense of shame that often goes with that. It may be more difficult in this context to develop helpful responses to trauma and adversity when we too as professionals may be overwhelmed by the story to which we are bearing witness. Eve's account shows powerfully how difficult it can be for a professional to be both in their assigned role and also someone who is concurrently experiencing the effects of a major trauma within the same service setting.

Eve illustrates clearly how truly listening to the client's narrative is so important. The difficulty arises when we stop listening or responding, or deny what we are hearing in some way. To Eve, this feels like a retraumatising process. If we do not fully listen with an open mind, we can give the impression of turning a blind eye, which may then impede recovery. When as a professional Eve experienced this, it has crossed a barrier for her such that any form of denial or lack of recognition could no longer be tolerated. This suggests that in doing what helps, SCM as a therapy approach needs to be a genuine process of collaboration, openness and non-defensive practice. Clinicians need to be careful not to deny traumatic experiences, but to enable their safe acknowledgment and acceptance. This is even more important if there are processes in the present service context which may be similar to past experiences, or are part of an ongoing traumatic experience from which the person is trying to recover.

As mentioned by Eve, barriers in the system may mean staff in mental health services are under pressures that lead to them trying to 'solve' a person's problems with insufficient consideration of trauma and adversity. They may not sufficiently engage collaboratively or connect emotionally with the service user, as was the case for Eve until she felt truly listened

to and connected with. Signs of trauma and dissociation are often subtle, hidden and hard to spot, and the person may feel ashamed of recognising what is happening to them (Steele et al., 2017). The clinician therefore needs to be mindful of this and to use an approach like mentalisation (Bateman & Fonagy, 2016) to acknowledge the experience from the service user's perspective as much as they are able.

SCM is a generalist treatment developed for people presenting with long-standing interpersonal problems and complex trauma histories. Such issues may include difficulties thinking in a balanced way or staying aware of present reality, managing emotions, managing impulsive urges and behaviour, and fostering secure and healthy relationships. SCM involves a structured, coordinated and integrated programme of care which includes a focus on common features including the therapeutic stance, the therapeutic relationship, an active plan of individual and group (problem-solving style) therapy, team supervision, skills in managing risk, crises and suicidality, case management, advocacy, medication reviews, management of acute hospital admission, family involvement, coordination of crisis service availability and assertive outreach for non-attenders (Bateman & Krawitz, 2013). We have found in our delivery of SCM that up to 75–80 per cent of service users also experience complex trauma and a range of dissociative (or disconnecting) difficulties. This is consistent with findings elsewhere (Korsekwa et al., 2009).

The PTMF may usefully inform SCM in a number of ways. For Eve, the deep sense of shame around the effects of her trauma would be addressed through using sensitive language and education that was shared. This talks about trauma, dissociation and adversity, and natural ways we find ourselves managing this without labelling it as 'personality disorder'. The framework could also usefully inform the biopsychosocial formulation using this kind of language. Key here is the collaborative nature of the therapeutic alliance, that she was 'really being listened to' and the person wasn't 'doing to' her.

When dissociative difficulties are present, the person may find it hard to stay present and connected to others. Eve found this was true for her. Rather than label this as personality difficulties or psychosis, the PTMF may inform SCM so that meaning is made from the idea this may be trauma-related and hence explainable. With that in mind, it is important to adapt the model and treatment approach to incorporate adversity, trauma and its effects into the care and treatment methods (Sweeney et al., 2018).

Adapting SCM for trauma stabilisation means fully considering the trauma-related difficulties, listening and formulating these collaboratively, and supporting clients in learning new skills to address these difficulties. In our pathway we have used the Livesley framework of phases 1–3 (Livesley, 2018), adapting the pathway to the service user's needs and degree of stability currently present. Therapy needs to be aimed at strengthening the client's existing psychological and somatic resources, both internal and external (Ogden & Fisher, 2015), whilst recognising trauma-related signs and teaching strategies for coping with these as they arise.

We have developed a two-day training focused on adapting SCM for trauma stabilisation informed by the PTMF for clients with trauma-related difficulties, which we have delivered to one of our specialist community teams. To support this training,

we have developed a SCM trauma stabilisation client workbook (Mitchell, 2018) and two forms of group supervision: a peer forum facilitated by a psychological therapist, and a dissociation-focused group led by a consultant who specialises in trauma, dissociation and personality difficulties. We also provide various stabilisation type groups, incorporating aspects of SCM and dialectical behaviour therapy, where problem-solving and skills to overcome power and threats are learned and practised. We are aware of this being done elsewhere in the UK and in other countries (Boon et al., 2011).

As shown by Eve, being truly heard and listened to can help promote a sense of connection and safety, and begin to provide some hope of overcoming extreme adversity, trauma and abuse. This validation and collaborative venture can enable a rebalancing of power, so that the personal meaning associated with adversity and trauma is understood, and ongoing threats are gauged and understood. In the context of non-threatening situations, this enables reprocessing and connecting with other people so that hope can be restored.

Dr Stuart Mitchell

Consultant Clinical Psychologist,
Trust Lead for Personality Disorder
Stuart.Mitchell@ntw.nhs.uk

Dr Evelyn Thorne

Consultant Clinical Psychologist

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Working with dissociation and complex trauma in military veterans

Jennie Ormerod & Ashleigh McLellan



In this article we will outline some of the special considerations when working with a military population who have a presentation of complex post traumatic stress disorder (CPTSD) and where dissociation may be a feature. We discuss the historical context of the military, the impact of military training and whether dissociation is an adaptive strategy for military personnel, or if it increases the likelihood of later difficulties. We conclude with the treatment implications for working with this client group.

DEAS about the impact of war can be traced back to the 1800s when exhaustion in soldiers was identified and the only solution was to move to the rear of battle for a break (Chamberlin, 2012). World War I saw the emergence of the concept of 'shell shock'. This was poorly defined initially (Shively, 2012). Some believed that bullets produced a concussion like effect causing shell shock; however, not all cases had been exposed to artillery fire. A belief then emerged that it

was due to the emotional effects of combat (Shively, 2012). However, alongside this recognition, there was a societal belief that those affected were lacking in moral fibre and character, and these men were put on trial and even executed for cowardice.

At the Battle of the Somme in 1916, as many as 40 per cent of casualties were suffering from shell shock. During 1917, shell shock was banned as a diagnosis and in World War II replaced by the term 'combat neurosis

and battle fatigue' (Crocq & Crocq, 2000). Although Bion and Foulkes pioneered group analytic treatments with military personnel during World War II, it wasn't until the Vietnam War that there was any systematic empirical research into the impact of warfare. This research led to the 1980 post-traumatic stress disorder (PTSD) diagnosis that we know today (Crocq & Crocq, 2000). Empirical research, along with changing social attitudes has gradually enabled ideas about 'cowardice' to be reframed in terms of vulnerability. However, stigma about admitting the emotional impact of war and beliefs about weakness are ingrained in military history and continue to impact on military personnel today.

After the First World War, trauma was an ever-present possible outcome of war, even if it was not present in every imagining. After 1918, the warrior hero acquired a shadow self; the broken mental patient in a military hospital, or the silent and haunted veteran who would always be waiting in the wings. (Michael Roper, 'Emotional Survival in the Great War')

This quote demonstrates the conflict that we can see in military veterans today. On the one hand, they are held up as heroes who are there to protect us and the country in which we live. On the other, they can be vulnerable and 'broken' by their experiences.

What is this conflict like for military personnel? For some, it may mean that they need to deny and dissociate the part of themselves affected by the trauma in order to maintain other people's image of them as a hero. This may lead to an apparently normal part (ANP), and emotional part(s) (EPs) split, as in Kathy Steele and Onno Van Der Hart's model of structural dissociation (Van Der Hart et al., 2006). The ANP can go about life on returning from a tour of duty in a normal way, be part of a family and society, etc., whilst the EP holds all the trauma memories and is not spoken of, but can at times intrude into the ANP through intrusions and flashbacks when reminded of the trauma.

What impact does military training have on the normal human threat and self-protection system?

An important consideration when working with military and ex-military personnel is that the changes to their stress response reactions are shaped and moulded by military training. So regardless of combat experiences, changes have already been created within the individual (Fothergill, 2001). The military has to invest in altering the stress response system of freeze/flight/fight. Changing the way personnel operate begins in the first days of training: their hair is cut; they're issued with a uniform including underwear; and they are given a number rather than name. They have minimal sleep.

Training involves drills that include simulated weapon fire to give orders. A level of alertness is being programmed, putting their stress response system on standby, so that they have a quicker reaction time. Essentially, the military is trying to eliminate the normal freeze and startle response, and create a 'switched on soldier'; they can be triggered into anger, and ready to explode. Drills are repeated over and over until the recruits have an automatic 'military response'. They are told that they are becoming an invincible fighting machine; the greatest in the world and superior to civilians. This fits within a competitive social rank and status mentality (Gilbert, 2010a). In non-military conditions, this state can mirror many of the symptoms of PTSD.

We can understand this conditioning and relearning as necessary for the military, given what individuals are required to do in the line of duty. For example, if you were standing at the side of a road and there was a car crash which led to a car ricocheting towards you, what would your response be? What would your body be saying? For soldiers, they have to go towards this life-threatening danger, even if their body is screaming the opposite. They have to face into an ambush (Fothergill, 2001). The military training theoretically sets up a response whereby approaching the danger is more likely. This is difficult because our evolutionary responses (Gilbert, 2010a) are far more ancient and powerful than training. Does

this make dissociation more likely? And when military personnel cannot go towards such danger, what is their narrative after the event? What happens to their levels of shame? And what may their self-critic be saying to them?

The army culture and this new 'military response' is perfect for combat. It is a system for war, not peace. From a compassion focused therapy (Gilbert, 2010b) perspective, a veteran's affect regulation system is completely rewired. The threat and self-protection system is much more sensitive to danger, as in combat you could be killed at any time. The incentive/resource (drive) focused system is highly stimulated by levels of excitement (being an 'invincible fighting machine', having powerful armoury on your possession can elicit big 'hits' of dopamine). The affiliative focused system is centred on the others in the platoon. A veteran's buddies are the trusted ones who have their back, who keep each other safe and buddies are whom they calm down with. (Buddies is a term used by the army. In particular, we use a system in the UK called the 'buddy buddy system'. It means to pair up and help each other and look out for each other.)

Post combat, when individuals return home, there is an inevitable cultural mismatch. Individuals often remain in a state of hyperarousal and the threat system stays on alert. They might feel bored because their incentive/resource system is under-stimulated, and they don't feel safe any more because they haven't got their buddies. They might start to think that they don't love their family because their affiliative focused system has been rewired. Ultimately, military personnel who have been through training and combat experience have a brain set up for battle and buddies, not for home and family.

What does the research say about dissociation in the military?

Dissociation is common

Studies have found 88–96 per cent of military personnel undergoing survival school training experience dissociative states (Dimoulas et al., 2007; Taylor et al., 2011). In a sample of soldiers who did not experience traumatic events, they reported higher Dissociative Experiences Scale

(DES II) scores than normal subjects (Gulsum et al., 2009). Anger and dissociation are known risk factors for the development and maintenance of PTSD and significant problems among veterans with PTSD (Jakupcak et al., 2007).

Can dissociation help?

Morgan & Taylor (2013) found soldiers who endorsed dissociative symptoms at baseline were significantly less likely to get in to the special forces. Pathological dissociation is characterised by disturbing symptoms of depersonalisation, de-realisation and identity confusion with long-term repercussions. Non-pathological dissociation is characterised by a state in which attention is deeply absorbed or focused, and or where there is loss of awareness. There is the possibility of deliberate dissociation being helpful, mediated by reduction in hypothalamic-pituitary-adrenal activation, as measured by cortisol. However, further research is still needed, including to determine whether deliberate dissociation is a teachable skill (Morgan & Taylor, 2008).

The Morgan & Taylor (2013) study found spontaneous dissociation was experienced as debilitating, and deliberate dissociation was experienced as facilitative. Whilst it may make intuitive sense to think that if dissociation is chosen it may be protective whereas spontaneous dissociation could represent risk, we still do not know if this is the case.

Dissociation can increase risks

Increased dissociative symptoms during and after trauma exposure are related to higher prevalence and increased severity of PTSD in military and civilian participants (e.g. Bremner & Brett, 1997; Dancu et al., 1996). The relationship between dissociation during an event and the later emergence of PTSD has been shown prospectively (Holen, 1993). Dissociation at the time of the traumatic event (peritraumatic dissociation), has the largest effect size relative to other risk factors such as prior trauma history, family history of psychopathology, perceived life threat during trauma, post trauma social support and prior psychological adjustment (Ozer et al., 2003).

Tsai et al. (2015) found that dissociation is linked to an increase in severity of problems: Among veterans with PTSD those with the dissociative subtype (DSM-5) reported more severe PTSD symptoms, comorbid depressive and anxiety symptoms, alcohol use problems and hostility compared to those without the dissociative subtype.

Anger as ‘active avoidance’

Kulkarni et al. (2012) evaluated 214 male veterans seeking treatment for PTSD and found 76 per cent were above clinical cut-off for anger in the general population: 64 per cent exceeded cut-off in psychiatric populations. Using the DES-II, 76 per cent were above cut-off in the general population, with 21.5 per cent above clinical cut off for PTSD samples, suggesting clinically significant dissociation.

Anger is an ‘active’ avoidance that serves to provide a false sense of control over the environment and is related to other over-controlling behaviours (e.g. hypervigilance). The experience of anger and behaving angrily allows the individual to feel they are doing something about their negative affect rather than being simply impacted without recourse. Anger is very common in veterans and is perhaps consistent with the male gender role. It may therefore be more acceptable than vulnerability, fear or other possible negative emotions related to traumatic experiences. It is also the ‘default’ response that is needed for combat situations, so is understandably prevalent in this population (Kulkarni et al., 2012).

Treatment implications for working with complex trauma and dissociation in military personnel

One of the main challenges in working with military veterans is developing a therapeutic working alliance. As discussed, many veterans experience a sense of shame in acknowledging vulnerability and helplessness. This needs to be directly addressed early in therapy to prevent it becoming a barrier. Veterans may wish to protect the therapist from parts of themselves, or they may wish to maintain

a sense of status or admiration which prevents them experiencing vulnerability. As psychologists, we too need to be aware of and address our own preconceptions of military personnel and the influence of this on the therapeutic relationship.

Making sense of the impact of military training on the normal human stress response and linking this with the evolutionary function can be very de-shaming. Helping veterans understand the neuropsychological response to threat and the way in which trauma memories are processed can also facilitate understanding of their reactions now. De-shaming is an essential part of building therapeutic alliance and emotional attunement. In our clinical experience, it may take longer to build trust with a veteran, but it is important to do the ground work before proceeding to work on trauma memories.

A critical aspect of effective treatment for CPTSD is identifying the coping strategies of dissociation and anger. This may be quite apparent in the presentation of some veterans; however, it can also be hidden. Veterans may need quite direct questions to uncover the level of dissociation they experience as they may be used to operating in quite a fragmented way. The DES-II is often a helpful tool to facilitate exploration of dissociation.

It is important to remember that veterans may experience trauma from both the ‘victim’ and ‘perpetrator’ roles. In other words, they may have killed others as well as being the victim or under threat themselves. In our experience, veterans may have more shame about a trauma from being in a perpetrator role, which may need direct questioning to uncover. There may be a fear or expectation of judgement or misunderstanding in response to these experiences. However, it is important that they can be processed through development of the context the veteran was in at the time.

Finally, it is worth noting that veterans can present with high levels of risk to themselves. For example, veterans are used to carrying weapons and being able to defend themselves. They are used to looking for threat and

returning to civilian life may leave them feeling vulnerable and hypervigilant to all perceived threats. In our experience, other risks include suicide attempts that are often impulsive whilst in a dissociative state. A thorough risk assessment that takes account of their views and experience of death will therefore be important in the early stages of assessment and throughout treatment.

Conclusion

Working with veterans with a level of dissociation is a challenging area. It requires consideration of the unique context in which trauma occurs and the influence of military culture

in developing a therapeutic relationship. However, if these issues can be addressed, veterans often have resources to draw on that can enable them to recover and transition to civilian life effectively.

Authors

Dr Jennie Ormerod

Consultant Clinical Psychologist,
Complex Treatment Service
jenny.ormerod@nhs.net

Dr Ashleigh McLellan

Highly Specialist Clinical Psychologist,
Humber Traumatic Stress Service

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Clinicians' experiences of working with people struggling with personality difficulties, complex trauma and dissociation within a specialist NHS service

Louise Hamilton



This study aims to provide insight into clinicians' experiences of working with clients experiencing personality difficulties, complex trauma and dissociation. Interpretive phenomenological analysis was used to analyse the data from semi-structured interviews. The results emphasised collaborative working and the importance of clinicians' capacity for self-awareness and competence in working with trauma.

THE PSYCHIATRIC construct of personality disorder has been defined as a pervasive disturbance in how an individual might experience themselves and others, leading to disturbing emotional experiences, expression, and behaviour (Tyrer et al., 2015). The diagnosis is a contentious and often stigmatising one (Mind, 2018), and to reflect this the term

'personality difficulties' will be used here to describe these issues. Importantly, in a sample of 600 participants presenting with these types of problems, 73 per cent reported abuse and 82 per cent neglect (Battle et al., 2004).

Working with this client group has been associated with negative perceptions due to interpersonal and behavioural difficulties

and a lack of resources and understanding in services (Aviram et al., 2006; Treloar, 2009). However, clinicians working within community and specialist settings appear to indicate more positive attitudes (Hughes, et al., 2017; Stroud & Parsons, 2013). Clinicians may nevertheless feel overwhelmed by strong countertransference reactions that often impede the clinical work and contribute to negative associations (Gabbard & Wilkinson, 2000).

Around two thirds of people presenting with personality difficulties are estimated to also suffer from dissociative experiences (Korzekwa, et al., 2009). Early attachment disruption is thought to impact upon integration of a person's personality, manifesting in problems of emotional instability and dissociative experiences (Mosquera et al., 2012). A recent meta-analysis suggested these clients experience more dissociation than people with other mental health problems, but less than those with posttraumatic stress (PTSD) or dissociative conditions (Scalabrini et al., 2017). Mosquera and Steele (2017) suggest there are three categories of dissociative experience:

- (i) absorption and detachment, which could occur for everyone;
- (ii) detachment and depersonalisation, which may occur when people feel stressed or ill; and
- (iii) division of the personality, which is believed to be distinct to serious trauma.

The presence of dissociation could inhibit a person's ability to work through traumatic memories or acquire new skills in psychological interventions (Vermetten & Spiegel, 2014).

There are few studies looking at clinicians' experiences of working with dissociation. Strait (2014) used grounded theory to explore therapists' internal experiences of when a client dissociates in session. The author concluded that mirroring of dissociative states created increased attunement and understanding in the relationship. Due to our limited understanding of how clinicians experience working with this client group, the present study aimed to explore this question, including the personal and professional impact of the work.

Method

The study was of a qualitative design using interpretive phenomenological analysis (IPA). IPA studies explore how individuals make sense of their world (Smith et al., 2009). IPA was chosen due to its flexibility to consider experience in terms of the impact on clinicians, as well as how they worked clinically in an area not well explored. The Health Research Authority and Teesside University School of Health and Social Care Research Governance and Ethics Committee granted ethical approval.

Participants

Eight clinicians working within a specialist NHS service for people with personality difficulties participated. Clinicians were recruited at a team meeting using purposive sampling. Pre-qualified or non-clinical staff were excluded as they did not provide psychological therapies. Participants were all female ($n = 8$), white British ($n = 7$) or British Indian ($n = 1$), and ranged in age from 39–48 years (mean age = 43.8). Five of the clinicians were occupational therapists by professional background and two were mental health nurses. These clinicians worked in psychological therapist roles in the service. One clinician was a consultant clinical psychologist. Mean years qualified was 15.5 (range 9–21). All clinicians had worked within the service since its inception (approximately three years). Participants used therapeutic models of structured clinical management (Bateman & Krawitz, 2013), dialectical behaviour therapy (Linehan, 1993) and mentalisation based therapy (Bateman & Fonagy, 2006) with clients.

Data collection and analysis

Data was collected through one-to-one semi-structured interviews. The interview schedule went through several iterations in collaboration with the researcher's field and academic supervisors to reduce closed or leading questions. Pseudonyms were used to protect participants' identity.

Analysis was based upon IPA principles and the six steps suggested by Smith et al. (2009):

1. *Reading and re-reading* – initial immersion.
2. *Initial noting* – descriptive, linguistic and conceptual comments.
3. *Developing emergent themes* – concise statements to capture the essence of the phenomena.
4. *Searching for connections across emergent themes* – exploring relations and developing themes.
5. *Moving to the next case* – repeating steps 1–4 for each case, in keeping with an idiographic approach.
6. Looking for patterns across cases – final themes and narrative interpretation developed.

Data credibility

Yardley's (2000) four principles of good qualitative research in IPA were followed:

1. *Sensitivity to context* (i.e. participants were given the opportunity to explore the validity of emergent themes).
2. *Commitment and rigour* (i.e. transcripts were triangulated by the researcher's supervisors and alternative interpretations were included).
3. *Transparency and coherence* (i.e. the researcher kept a reflexive diary, allowing transparency about her fore-structures and how they developed).
4. *Impact and importance* (i.e. recommendations were made for clinical practice).

Results

The findings reflect participants' experiences of their work with clients struggling with personality difficulties, complex trauma and dissociation. Three superordinate themes were identified, namely 'The relationship

is key', 'Protecting the self' and 'Working in a dialectic', each with a number of sub-themes (see Table 1).

The relationship is key

This first superordinate theme captured the importance given to the therapeutic relationship.

Connecting and nurturing relationships

Forming and nurturing the relationship, and building trust were perceived as key to supporting disclosures and positive outcomes.

Chloe: *I almost want to say back to basics... we go back to validation and developing the attachment and looking after the relationship, preserving that in order to hopefully move it to the position where we can look at change.*

Building trust to support openness

Samantha: *As the self-harm settles the trauma... maybe it's because they feel more safe and... able to talk about it and that whole relationship has been forged... they've locked everything up for years and then as they get to know you... trust you... they form that relationship, they let you into snippets of things.*

Mirrored feelings and separating the self

Clinicians experienced feelings that mirrored those of the clients, including when observing dissociation and hearing about trauma. Being aware of the self and able to separate from these feelings appeared to allow a greater understanding of the client's problems.

Chloe: *Yeah, it feels like a fog in my head... sometimes I'll stumble over questions or it's almost like my behaviour mirrors their behaviour and I lose... sense of exactly the path that I have started on.*

Table 1: Superordinate and subordinate themes

The relationship is key	Protecting the self	Working in a dialectic
<ul style="list-style-type: none"> ■ Connecting and nurturing relationships ■ Building trust to support openness ■ Mirrored feelings and separating the self 	<ul style="list-style-type: none"> ■ Shutting down as coping ■ Drawing upon resources ■ Sharing responsibility 	<ul style="list-style-type: none"> ■ Normal – Extreme ■ Internal pressures – External pressures ■ Flexibility – Solidity ■ Rewarding/energising – Challenging/exhausting

Protecting the self

This superordinate theme captured how clinicians attempt to protect their sense of self.

Shutting down as coping

Shutting down to cope was a strategy used by clients through dissociative experiences and clinicians through detachment when witnessing or hearing of dissociation and complex trauma. Dissociation appeared to be viewed as somewhat 'unhelpful' in the present and detachment as 'helpful'.

Danielle: *I view dissociation as a... way of coping... whether you know healthy or unhealthy... it's a way of coping with... experiences so your mind protecting you and shutting off in some way from the trauma.*

Drawing upon resources

Clinicians appeared to draw upon internal (e.g. their personality/outlook) and external (e.g. supervision, reflective practice group, therapeutic strategies and time with family) resources as protective strategies.

Rosie: *...I'll just imagine painting myself with... a really glittery peach sparkly paint... sort of keeps you protected in a way... you can sit there and it's permeable... so I use imagery a lot.*

Sharing responsibility

Collaborative working and sharing responsibility with clients appeared to reduce the impact of emotional and physical pressures, and risk within their roles.

Isla: *...with personality difficulties you're only gonna maybe get to a point where it's good enough... that locus of change... has to come from them...you can only do so much...*

Working in a dialectic

This superordinate theme captured a sense that the whole experience of the work felt like working within a dialectic. It encompassed the polarities of the clinicians' experiences, feelings of ambivalence and uncertainty, and ways they attempted to overcome their ambivalence and find personal and professional balance.

Normal – extreme

Clinicians appeared to perceive their client's difficulties upon a continuum, from what could be 'normal' or relatable, up to what is incomprehensible or 'extreme' in terms of trauma, dissociation and self-harm.

Abbie: *I've seen someone completely dissociated where it's horrible actually, they just look confused... they're not there... the extreme end of the spectrum, not hearing me, even... touch... they're not responsive.*

Internal pressures – external pressures

This theme appeared to capture ambivalence in clinicians. They appear to deny a role as therapist, because this is beyond their professional competence, but much of their role is trauma work. In addition, within the organisation it seems they are regarded as experts, and in some respects seen as the final destination of these clients, but they appear to be saying they are not the real thing and unable to provide the full package.

Kate: *There's a part about your own unrelenting standards... never quite being good enough... have real anxiety about... do I know enough yet... desperately wanting to consume textbooks...*

Flexibility – solidity

This theme captured how clinicians worked in a flexible manner in response to their clients, whilst also maintaining solidity of self in terms of boundaries, consistency and the structure of the model.

Zoe: *I think my approach is... they think I'm unusual... I had a lady who used to lie down for her appointments... and so I would lie down... being very flexible with what we do...*

Isla: *I think there's still a bit of conflict... I don't know that there is a right way or if it's evidenced enough for working with trauma and personality difficulties... there's still some work to do to bring the two models and treatments together.*

Rewarding/energising – Challenging/exhausting

This work appeared to elicit conflicting feelings for clinicians. They seemed to hold positive attitudes toward their clients and reported their role to be rewarding, and yet

they also found the work challenging and experienced feelings of exhaustion, particularly regarding the levels of risk and expectations they managed.

Chloe: *I find... working in this service is a dialectical balance, I almost have a love-hate relationship with it... it's so exhausting and takes so much... but then the positives are amazing... I almost said life-changing there.*

Discussion

Preparing for and repairing ruptures was highlighted within 'the relationship is key'. Although previous literature emphasises the importance of repairing ruptures to build a positive therapeutic alliance for clients with personality difficulties (e.g. Bateman & Krawitz, 2013), the benefits that preparing for ruptures could have upon building collaboration and trust has not been well explored. The timing and development of the therapeutic relationship was perceived to help clients to develop trust and share their experiences more freely, which is likely to be important where clients experience trauma-related shame (Steele et al., 2017). 'Sharing responsibility' whilst protective for clinicians, was suggested to provide clients a sense of control which fits with recommendations for a collaborative over parent-infant attachment model with dissociative clients (Steele et al., 2017).

Comparable to Strait (2014), clinicians experienced feelings that mirrored the client (e.g. Chloe described 'foginess'); however, they appeared to consciously or unconsciously separate themselves to be able to connect and understand, but not be overwhelmed. The concept of 'shutting down as coping', explaining dissociative type symptoms as either deliberate and helpful or automatic and unhelpful, may reflect debates in the literature of what is 'normal' versus 'pathological' (Mosquera & Steele, 2017). Clinicians may be using a conscious 'detaching' strategy to manage the intensity of the relationship in the moment, so that they aren't overwhelmed, or even to enhance the clinical process.

Similar to previous findings, clinicians experienced both rewards and challenges (Hughes et al., 2017). They appeared to balance the 'challenges' within this dialectic through use of supervision, maintaining well-being and collaborating with clients. Clinicians worked flexibly whilst maintaining solidity of self, suggesting they adapt their work for dissociative symptoms but maintain boundaries necessary for intensive clinical work. Working with adversity, trauma and dissociative difficulties appeared to create ambivalence for clinicians about their competence. This revealed a discrepancy between working with trauma, which they implicitly acknowledged they do with clients with personality difficulties, to providing trauma-focused therapy (i.e. trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR)).

Limitations

Although generalisability is limited by the idiographic nature, the findings were reflective of previous research, suggesting they are likely to be of relevance to current clinical practice. Participants were all female, so the results may not be reflective of the perspectives of male members of staff. Participants were also predominantly white British NHS professionals. Professionals from other cultural backgrounds may have different understandings of the concepts of personality difficulties, complex trauma and dissociation. There is inevitably an influence within the hermeneutic interaction between researcher and participant, where lines of enquiry were likely followed that were of interest to the researcher. Steps were, however, taken to remain as objective and close to the data as possible through applying Yardley's (2000) four principles of good qualitative research.

Clinical implications

There is a role for clinical psychology in terms of a formulation-led approach to clinical pathways to potentially allow for more seamless care across personality and trauma-related difficulties. It is recommended that clients

are given time to develop trust and openness, to reduce the possibilities of falling between gaps in services. Clients with trauma-related difficulties could receive an initial phase of stabilisation and alliance building, prior to further therapeutic work on the presenting problem. The results suggest that the nature of this clinical work, although rewarding, can be intense and overwhelming. Clinicians should be offered regular supervision where trauma and dissociation are a focus,

and opportunities for reflective practice and training to help manage the emotional impact and develop their self-awareness and competence in this work.

Author

Dr Louise Hamilton

Clinical Psychologist, North Tees and Hartlepool Hospitals NHS Foundation Trust
louise.hamilton10@nhs.net

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Dignity and austerity

Dawn Reeves

RESPECT for the dignity of persons and peoples is one of the four guiding principles for professional psychologists outlined in the British Psychological Society *Code of Ethics and Conduct*. As practising psychologists, respect for dignity is something that guides our ethical reasoning, decision making and behaviour every day. To respect dignity is to value the inherent worth of all people. In 2008 the UK government started to implement austerity measures to reduce public spending following the banking crisis of 2007 and a growing government debt. However, there are many losses for the public in the form of severe cuts in services and restrictions on funding. There is growing evidence that austerity is being hardest felt by people in vulnerable situations, or from groups with the least resources in society and the implementation of austerity measures is impacting on people's sense of dignity and self-worth (McGrath et al., 2016). As professionals concerned with self-worth and the protection of dignity for all, we are well aware of the impact of austerity on mental health and are an important voice in promoting the needs and value of all people in society.

In 2011 a parliamentary joint committee on human rights reported on the Welfare Reform Bill and Independent Living and concluded that the reforms were likely to have a negative impact on human rights. Unfortunately, it appears that their warnings were not heeded and many vulnerable people are now struggling. Professor Philip Alston, a United Nations special rapporteur on extreme poverty and human rights, carried out a fact-finding mission during a recent visit in November 2018 to focus on the links between poverty and human rights in the UK. At a press conference marking the end of his visit, he painted

a very sobering picture of the levels of hardship currently facing many individuals and families, especially the working poor, single mothers, people with disabilities and millions of children. Professor Alston also highlighted the role of values underpinning the changes, with the government determined to support the value of 'individual responsibility'. He stated that there has been a change in national values from post Beveridge values of compassion and social responsibility to 'a punitive, mean-spirited, and often callous approach' for people who are vulnerable and suffering (p.3).

Increased levels of financial hardship are often associated with distress, and for some people can be a key risk factor leading to the development of mental health problems. A recent UN report from the Human Rights Council (2017) focused on mental health provision around the world and stated that 'public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools. Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives' (June 2017, point 13).

Austerity measures have triggered a massive programme of social welfare reforms, with a complete overhaul of benefit claims and assessment of need. These changes have been especially felt by people with long-term mental health conditions. In 2017 fifty percent of the 2.36 million claimants of Employment and Support Allowance (ESA) and thirty-four

percent of people receiving Personal Independence Payment (PIP) had a mental or behavioural disorder recorded as their main disability (Mackley, 2018). In the past few years there has been a national programme of reassessment for people in receipt of disability benefits, and anecdotal reports have raised concerns about the after effects of these, especially with regards to increased mental health problems, and in some cases suicide (Barr et al., 2016). Barr et al. found that three mental health outcomes increased in areas of the country where reassessment of disability was being carried out. These were: increased levels of suicide, self-reported mental health problems, and anti-depressant prescriptions. The authors of this research also pointed out that as it is often health professionals who are asked to carry out the reassessments, they should be made more aware of the possible adverse consequences of the process. They were especially concerned with regards to the ethical principle of health and social care professions that they should 'do no harm'.

The Department for Work and Pensions (DWP) has a six-point plan to guide front line assessors about what to do when faced with claimants expressing suicidal ideas and intent (Mackley, 2018). However, it is unclear what kind of training or internal support claims staff receive to deal with this. Disability Rights UK has tried to get the DWP to release figures about the levels of referrals for suicidal claimants, but despite repeated freedom of information requests they have not provided any data. The DWP states that it does not collate records of how many suicidal claimants are referred for help. They did however release forty-nine redacted peer reviews concerning cases where it is alleged that the DWP's actions are linked to the death of a claimant. For many claimants, the experience of having their life, abilities and difficulties scrutinised and assessed is likely to trigger the feeling, at some level, that they are not believed or not going to be believed. This in turn can have a negative impact on a person's sense of self-worth and perception of how others in society value them. When a person feels that their sense of self-worth is being diminished, it can invoke feelings of

threat to their dignity (Shultziner & Rabinovici, 2012).

A House of Commons Work and Pensions Committee (2018) on claimant experiences for PIP and ESA received almost 3500 responses from claimants, an unprecedented number for such committees. Many of the experiences shared by people with mental health conditions suggested lack of understanding, appropriate training and respect for basic dignity of claimants. One woman called Ruth stated: 'When I finally had my assessment, the lady was quite nice, but I was so upset and frightened. I was asked why I hadn't killed myself if as I had written on the forms that I frequently felt that way! Not the sort of thing you should ask someone with severe mental health issues! [...] I found it distressing and humiliating.' (p.14). Another respondent, Sarah said: 'The assessment was done by a general nurse with no mental health training. He concluded that, since I did not appear to be stressed, anxious or show any mental health issues during the assessment, it was "unreasonable to believe" I had mental health issues [...] The stress of the interview actually got me admitted to hospital the next day.' Amanda recalled that: 'The assessor said in the report something to the effect that my mental health wasn't an issue, as I had smiled during my assessment. At the time of my assessment I was highly suicidal.' (pg.15).

When Elaine McDonald felt that her dignity was being compromised by changes to her care package from Chelsea and Kensington Borough Council she took her case to court under Article 8 of the European Convention of Human Rights (2014). Funding cuts meant she would have to lose night-time personal care that assisted her to use a commode, and instead be provided with incontinence pads and sheets. She felt this would cause her to 'lose all sense of dignity' and suffer considerable distress. The UK government argued that budget restrictions and consequent cuts to services were allowed because of the competing interests of the individual and the wider community. During the review, a deputy high court judge actually described the applicant's complaint under Article 8 as 'parasitic'. The European Court of Human Rights agreed

that the change in care was proportionate given the 'economic wellbeing of the state and the interests of other care users'. They recognised that the issue was personal interests versus the general interest of the public authority carrying out its social responsibility in the allocation of scarce resources.

More recently, in 2018, the government was judged to have breached the Human Rights Act (1998) by discriminating against people with disabilities. Claimants had not been awarded the enhanced PIP mobility rate because internal guidance for assessors had advised that if 'psychological distress' was given as the reason for restricted mobility then the claimant would be disqualified from the benefit and no points would be awarded for this by claims assessors. This was in spite of the original legislation having been worded in such a way so as to not discriminate against people needing extra support for mobility due to psychological difficulties, including sensory or cognitive impairment or overwhelming psychological distress.

In the absence of dignity, the implementation of rights can feel hollow at best, and at worse create experiences with no sense of respect or trust. It is a right in the UK to apply for financial help from the state if you are out of work and unable to work, but it would seem that the implementation of this right is not always protecting the dignity of claimants.

Dignity is a core value shared by people across the world. It is a core value guiding much of the work promoting the agenda of human rights. In 1948, article 1 of the Universal Declaration of Human Rights states that 'all people are born free and equal in dignity and rights'. Defining dignity is quite a difficult task and has been much debated by a variety of disciplines from lawyers and politicians to philosophers and ethicists. At a basic level, dignity can be seen as 'the universal human need for and pursuit of positive self-worth', violations of dignity therefore involve 'injuries and threats to people's self-worth, especially humiliation and denials of social recognition more generally' (Shultziner & Rabinovici, 2012, p.107).

Psychoanalyst Eli Marcovitz (1966) considered dignity to be both an intrapsychic

and social phenomenon. It is a feeling that develops inside a person and is also a value of respect that is given during social interaction. Dignity is influenced by the internalisation of social standards and responsibilities or positions of hierarchy in social groups, and it can be destroyed by a sense of social humiliation, loss of power or internal shame (Marcovitz, 2016).

In the age of austerity utilitarian principles of the common good will usually be the stronger argument. The financial wellbeing of the group is prioritised over the financial needs of the individual, especially if the individual occupies a weak social position and has complicated and expensive needs. Yet in terms of actual lived experience, when the group is preferred over the individual, the person affected can feel like there is an assault on their personal dignity and respect. Further infringements on a person's sense of self and integrity can come in the shape of social stigma and shame if they feel discriminated against because of disability or mental health problems (Elliott, 2016), or from the act of applying and receiving state-funded benefits (Baumberg, 2016). In too many societies people can experience a process of dehumanisation if they are deemed to belong to certain social groups that are defined in negative terms and of low value by other more powerful social groups (Haslam & Loughnan, 2014).

Hicks (2016) argues that affronts to dignity can be perceived as threats and for some people can trigger violent reactions. This would surely include self-directed violence such as suicide, suicidal ideation and self-harm behaviours. She suggests that when we honour dignity in our interactions with each other, we can feel connected and good about ourselves and our relationships. However, if we do not honour dignity there is a likely consequence of social disconnection and a hostility towards others leading to a breakdown in relationships. This is the point at which we can start to see the process of dehumanisation of one group by another group. She describes essential elements of dignity that can lead to enduring and respectful relationships:

1. *Acceptance of identity* – Without judgement of worth, superiority or inferiority.
2. *Inclusion* – Make others feel that they belong in all spheres of public life and relationships.
3. *Safety* – Allow people to feel relaxed physically and psychologically.
4. *Acknowledgement* – Active listening and validation.
5. *Recognition* – Generosity in praise and gratitude to others.
6. *Fairness* – Be just, fair and equitable.
7. *Benefit of the doubt* – Start with assumption of truthfulness and well-intentioned motives.
8. *Independence* – Empower others to act for themselves with a sense of hope and possibility.
9. *Accountability* – Take responsibility for actions and humbly apologise to others if you have in some way violated their dignity.

Austerity in its current form of implementation is being experienced as a threat to many vulnerable people's sense of dignity. The current treatment of people in need of social care and welfare payments brings to mind the quote about the greatness of nations

being judged by how they treat their weakest members. Pearl Buck, a Nobel Prize winner for Literature said, 'the test of a civilisation is the way that it cares for its helpless members', and, Hubert Humphrey, US Vice President (1965–1969) said, 'the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped.' (Atkins, 2018). In relation to many other countries in the world, the UK is a society that is very generous to people in need and the value of fairness is strongly represented in British culture. Yet there still remains concern about the effects that successive reforms are having on people when they are at their most vulnerable and one wonders if there is some room to temper the harshness of austerity with more attention to the value and importance of dignity.

Dawn Reeves

Redbridge Intermediate Care And Community Stroke Service, North East London Foundation Trust; e-mail dawn.reeves@nelft.nhs.uk

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Self-help

Felix Q

11 October

Supervision session. Two sessions of CBT with Brian to talk about. Still hasn't done his homework. Said he'd been thinking about doing it but had been pre-occupied with thoughts about his dad since last month. Supervisor has a funny way of looking at me when she says, 'Interesting...'

12 October

Had planned to go to town this morning but traffic awful. Alison says they're building up to Black November. Used to be one day – now it starts any time soon and goes on to the Xmas sales. Pre-occupied with what supervisor told me about her dad – some kind of pharmacist who loved cats ('More than any of us!' from supervisor). Finished session early.

12 October (later)

Alison says Tim is bringing his girl-friend home for Halloween. Name's Rebekah. Says that it's odd how people don't spell their names properly anymore.

25 October

Phone call from Tim – turns out Rebekah is Jewish. Not really interested in Halloween as such – just wanted to meet 'the family'. Doesn't do Xmas, but happy to come. Tim says she celebrates Chanukah which lasts eight days! No presents but lots of candles.

25 October (later)

Mentioned Tim's girl-friend to supervisor. Said loads of analysts are Jewish and, of course, Freud. Passed me a biography by Joe Berke. Freud came from a family of rabbis!

4 November

Finished the Berke book. Freud may have denied the influence of Judaism but it didn't stop him from being hounded out of Vienna. Seems odd going to tonight's bonfire do ('You see, they can't even do Bonfire Night properly if it's not a weekend', from Alison). Let's hope we don't have any disaster like when Tim was little...

5 November

With Brian in A&E last night. Turned out he'd gone to the same do as us and was just on his way to say, 'Hi' when he tripped. Did something to his wrist while knocking my tea all down my trousers. Alison unimpressed on way to the hospital, but very chatty with Brian in the car.

9 November

Supervisor sympathetic about tea incident. Wondered if Brian was unconsciously trying to kill me! Thinks I may be a 'father figure'. Started talking about her dad again... and cats. Hates them.

Felix Q

Book Review

Treating Trauma-Related Dissociation: A practical, integrative approach (1st edn)

(Norton Series on Interpersonal Neurobiology)

Kathy Steele, Suzette Boon, Onno Van Der Hart

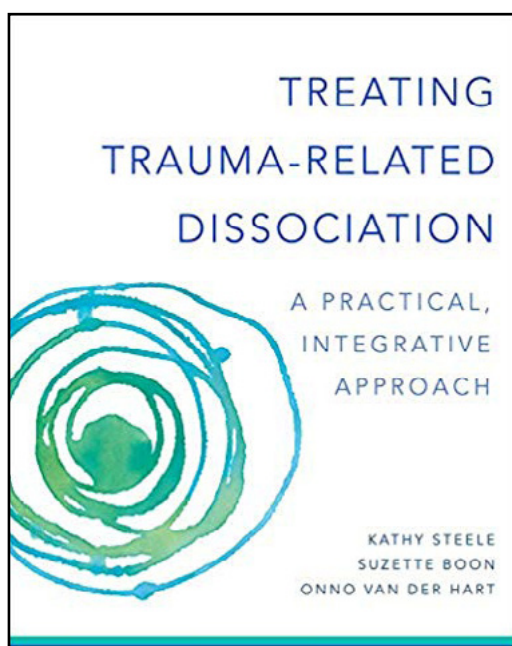
W.W. Norton & Company, 2017)

Reviewed by Louise Hamilton & Stuart Mitchell

CLINICIANS are often at a loss as to how to treat trauma-related dissociation, and may either under or over recognise these difficulties, or see them as part of another problem, such as difficulties labelled as personality disorder, psychosis or substance misuse. The authors, in their positions as world experts, have been instrumental in developing theoretical models and ways of working with this client group. This book clearly benefits from their clinical and research expertise to provide a comprehensive and thoughtful guide for the reader. Following on from their very practical skills training book (Boon et al., 2011), this book integrates multiple theoretical approaches, including attachment theory, cognitive behavioural, psychoanalytic and systemic approaches, in order to understand the complexity of trauma-related dissociation.

The book is divided into five parts, each woven around the phase model of treating trauma (Herman, 1997). Part 1 covers different aspects of the therapeutic relationship, and how client and therapist may both have resistances and aspects of difficulty with 'realisation' of what disturbs them. The solution to most of these difficulties is 'mentalising' and genuine collaboration with the client. The authors distinguish a 'collaborative' model of psychotherapy from other models, such as the 'parent-child' model which they believe does not benefit these clients.

Part 2 thoroughly covers assessment, formulation and treatment planning. The authors are careful to recognise the difficulties with assessment, since most clients present with multiple problems which may look like many things to the untrained eye. For example, so called 'emotionally unstable' personality diffi-



culties often have elements of dissociation present, but sometimes this may be in addition to a bigger problem with dissociation involving amnesia and dissociated parts of the personality. They emphasise the key principles of treatment planning and goal setting, and outline the phase model of stabilisation, processing and integration from Herman.

Part 3 is about using a whole system approach to the client, seeing parts of them as parts of the whole client that require help to move towards gradual integration. The key to this, the authors propose, is through recognising and embracing resistance in all its forms and working with this, so that the various phobias of inner experience, parts, memories, attachment and loss, and healthy change and risk-taking can be gradually faced. There is excellent guidance on how to work with dissociated parts, especially perpetrator-imitator and child parts. Part 4 continues with guidance on how to process traumatic memories (phase 2), whilst part 5 looks toward further integration, adaptation and change within the client's outside therapy life (phase 3).

In addition to providing an insightful guide upon how to work with this client group, the authors remind us to just be with people, through what is often a very challenging and painful journey. This theme is refreshingly threaded throughout the book and is somewhat of a comfort to an early-career psychologist such as myself (Louise), where my experience of working with this client group is in its infancy. We feel this book is essential reading, as a reference to both beginning and experienced therapists on how to structure

and deliver treatment for trauma-related dissociation. It should be widely read, and used to inform all trauma-informed service developments. Highly recommended.

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DCP UK Chair's Update

Julia Faulconbridge

THIS WILL BE my final column as interim Chair of the Division of Clinical Psychology and I am really pleased that through all the work which has been done by the DCP Committee working with the officers and staff of the BPS, we are now in a strong position to really develop into the organisation that you, the membership, have told us that you want us to be. Next year is going to be another very important one as we will be getting the DCP back to full functioning, re-engaging with our members and potential members, and piloting some new models and ways of working.

The structure and workings of the DCP can be a mystery, even to people quite closely involved, so below is a quick guide to how we will be made up in 2019 to help you understand the systems and plans.

The structure of the DCP

Committee (the Executive)

- DCP Chair, Vice Chair (and Chair Elect from 2020)
- Treasurer
- Devolved Nations Chairs – Scotland, Northern Ireland, Wales
- England Lead (newly re-established)
- Faculty Lead (new role)
- Professional Standards Unit (PSU) Lead (newly re-established)
- Membership Standards Unit Lead
- Communications Lead (newly re-established)
- Group of Trainers in Clinical Psychology (GTiCP) Chair(s)
- Expert by Experience (EBE) Representative
- Pre-Qualification Co-Chairs
- Leadership and Management Faculty Chair
- Two Committee Members (new roles)

Representative Assembly

This takes place twice a year and consists of the DCP Committee, Chairs of all faculties and EBE representation. This is a discussion forum bringing together all our networks which then advises the Executive Committee.

Devolved nations

The Chairs of Scotland, Northern Ireland and Wales are all on the Executive Committee and they have all been very successful at developing links to their various legislative and NHS bodies, together with achieving connectivity across the workforce and training communities, etc.

Faculties

We currently have 13 faculties of varying size that range from Children, Young People and their Families at 1071 members, to HIV and Sexual Health at 92. The full list as it stands is:

- Addiction.
- Children, Young People and their Families.

- Clinical Health Psychology.
- Eating Disorders.
- Forensic Clinical Psychology.
- Holistic Psychology.
- Leadership and Management.
- Intellectual Disabilities.
- Oncology and Palliative Care.
- Perinatal Psychology.
- Psychosis and Complex Mental Health.
- Psychology of Older People.
- HIV and Sexual Health.

All are very active, and many have significant links into the policy makers in their area. Many members see the faculties as the reason they are a member of the DCP, and taking an overall view, the faculties produce most of the output but struggle with finding time to do the work. There is considerable scope and interest in more joint working across the faculties, but this often does not happen because of a lack of resources.

In the past, faculties have tended to feel rather isolated from the main DCP and the Representative Assembly is not enough to remedy this. This year, we have been holding monthly telephone calls, and these have been valued but can be hard for people to find time to join and are mainly about information sharing.

There are some possible changes that will be considered in 2019. Some of the smaller faculties are interested in the idea of changing to become special interest groups within a larger faculty. We also want to look at the possibility of creating an overarching Faculty for Adult Psychology, which is a large gap for us. It is due to the historical decisions of non-adult mental health psychologists to create structures that supported them, because they did not work in adult mental health. This may be the time to remedy that.

We should have a Faculty Lead for 2019 to continue the work of building connectivity and exploring changes for the future.

English branches

We have 12 branches, of which 10 are functional at present. There is no branch currently in the East Midlands or North West, and we have plans to try to get them running again in 2019. There is significant variation in how the branches run and much of their activity has been organising events. As an example, some branches are well connected into Heads of Services in their region, whilst others are not.

We have not had an England Chair in recent years, and this role will be re-established now that we have had the elections.

Other groups and committees

These currently consist of:

- Group of Trainers in Clinical Psychology.
- Experts by Experience Strategy Group.
- Pre- Qualification Group.
- Workforce and Training Sub-Committee.
- Finance Sub-Committee.
- Beyond Diagnosis Sub-Committee .
- Power Threat Meaning Framework Sub-Committee.

Professional Standards Unit (PSU)

This PSU has been struggling over the last 18 months, since the resignation of the previous Chair. We now have a new Lead following the elections. The main functions are:

- Publications – This will be an enhanced role in future, as we want to take on timely updates of existing publications and increase the range that are produced, etc.
- Consultations – Currently our Faculties are the main responders to consultations and we need a way for responding when this does not fit into a Faculty, or when the topic covers the whole profession.
- Oversight of *Clinical Psychology Forum*.
- National Assessors – currently link into PSU.

Member Services Unit (MSU)

The main functions will be:

- Conference (with the conference team).
- Continuing professional development (CPD).
- Awards.
- Member benefits like leaflets, promoting the DCP.
- Membership drive.
- Communications strategy led by the newly elected Communications Lead.

Our plans for 2019

Improving connectivity

All parts of the DCP are active and working on behalf of clinical psychology and the people we work with, *but* mainly in isolation and often not aware of what others are doing. The DCP could be significantly strengthened if our networks were able to work more closely together. We are therefore going to work to improve our connectivity. Here, I am talking primarily about the internal connectivity of the DCP, but building that with the BPS is also crucial and will be a future topic. We will start on this by developing:

A new Faculty sub-system

This will bring the faculties together into a better connected network, enabling mutual support, cross working, etc. It will build on the faculty chairs teleconference and be more regular than the Representative Assembly. It will be led by a Faculty Lead, who will sit on the Executive Committee and represent the Faculties there.

A new model for branches

We need an improved regional /local structure in England that may bring together the Branches and the Leadership and Management Faculty. The aim is for branches to improve our co-ordination with Heads of Services, courses and commissioning arrangements at a regional level, which will markedly increase our impact. The work of the branches will be supported and coordinated by the England Chair, who would also represent them on the Executive Committee along with the Leadership and Management Chair.

DCP priorities

These were developed at the Representative Assembly and agreed by the Executive Committee. We intend to focus our resources on:

- Children's and young people's mental health and wellbeing (supporting the Policy Campaign being developed following this winning the Senate vote).
- Workforce and training.

- Inclusivity and diversity.
- Member wellbeing.
- Redeveloping the EbE strategy.
- Prevention and public health.
- AND a membership drive.

One way we hope to achieve this is via:

A new subcommittee structure

We intend to continue to create subcommittees that can draw in more DCP members, who will be able to contribute in their area of interest/expertise, without needing to take on the extra commitments of being a committee member. This model has worked very well, for example, with the Training Subcommittee that we are now expanding to cover Workforce and the EbE Strategy Subcommittee. We are currently in discussions about the creation of a Minorities Subcommittee and we hope more will follow.

How can you become involved?

For the DCP to flourish, we need many more of our members to become actively involved. Obviously, there are times in people's lives when the combination of work and family commitments make it difficult to think of taking on anything else. However, if you can find space to join with us, involvement carries great benefits in terms of career development as well as the opportunities to really make a difference for colleagues, services, and most importantly the populations we work with. Just some ways you can become involved are:

- Join a Faculty or Branch Committee. Elections take place at various times across the year.
- Seek nomination to join the Executive Committee.
- Respond to our calls for evidence/consultation responses, etc.
- Volunteer for a subcommittee.
- Represent clinical psychology on BPS committees, task and finish groups, etc.
- Represent clinical psychology at external forums in conjunction with the DCP.
- Write articles for *Clinical Psychology Forum*.
- Become a national assessor.
- Join the CPF editorial board.
- Tell us what is happening in your area, both positive and negative.
- Go to events organised by your faculty or branch and meet up with your colleagues.
- Attend AGMs and make your views known.

And if nothing else is possible, keep in touch via the e-mails you receive, the blogs and *Clinical Psychology Forum*. With our new Communications Lead starting in January, we hope there will be more and better ways to keep in touch. This will mean that you know what is happening outside your own area of work and will help you when there are local pressures as you will be aware of the wider picture. We will also be developing ways that we can support you in your work, but you need to keep in touch to know what is available.

Update on the apprenticeship and clinical associate psychologist roles

This was described in an earlier column and we now have more detail on these developments provided for us by Ken Laidlaw. The Exeter course is a new training programme developed in response to local service need in Cornwall. The problem of recruiting to clinical psychology and meeting mental health needs in Cornwall was the driver for this development. Working along-

side senior clinical psychology service leads, they have developed a Clinical Associate Psychology (CAP) training. The CAPs programme is being delivered in Cornwall and that is where all trainees complete their placements. The training is at master's level and takes place over 12 months. They recruited 15 trainees sponsored by Cornwall Partnership NHS Foundation Trust, with these trainees receiving a salary at Agenda for Change (AfC) band 5 and university fees paid on their behalf. They will be employed on AfC band 6.

The CAPs course fills a skills gap between assistant psychologist and qualified clinical psychologists with 50 per cent of their training time spent on placement in Cornwall. Supervision is provided by clinical psychologists. After qualification, CAPs can only work under the direct supervision of a clinical psychologist. In Cornwall, this is resulting in new posts being created for clinical psychologists (two new 8a CP posts are about to be advertised in Cornwall), to allow the growth of this new workforce. The CAPs are offered employment post-qualification and are asked to commit to working in Cornwall for two years after qualification. Clinical associate psychologists have been a feature of the applied psychology workforce in NHS Scotland since 2005.

The degree apprenticeship (DA) model is a means of providing funding for this new applied psychology workforce. A trailblazer group is set up for any DA and there must be a minimum of 10 employers representing a national spread. A minimum of two higher education institutions (HEI) are required for a trailblazer group (Tb). The employers are in charge of this and in this particular case, the CEO of Cornwall, is the Chair of this trailblazer group. An initial 23 employers from across NHS England, as well as the current chair of the NHS confederation and partners from the private sector, have expressed interest in joining this group and four or five HEIs are expressing an interest too.

Ken Laidlaw and Eugene Mullan have been working with the chair of the Tb group to ensure that the correct quality assurance to maintain the integrity of the CAPs training is in place. An occupational proposal for a new DA for CAPs was submitted on 7 November, and they are waiting on feedback from the Institute of Apprenticeships (IfA) as to whether the Tb group can proceed and whether the IfA recognises the CAPs as an occupation. They are in the process of setting standards, in terms of KSBs, for the draft occupational proposal. The standards, when agreed in draft form, will be publicly available on the skills for health (HASO) website for approximately six weeks as part of a consultation period. (See <https://haso.skillsforhealth.org.uk/news/>.) This open process gives many people an opportunity to comment.

Degree apprenticeships (DA) allow employers to use their apprenticeship levy to pay for this training, so it is an initiative driven by service need and employers. The DA is about a job role. The training in the DA is set at academic level 7 (11 in Scotland), meaning a master's level PG training. This level 7 is not to be confused with AfC levels. The DA for the CAPs would be a non-integrated degree, meaning that an end-point assessment (EPA) would be conducted separately from any academic or clinical assessments required by universities delivering this training. EPAs are developed as the last stage in a DA. The DA, once developed, is freely available for any appropriate trainer and employer to deliver.

Chair's blogs

We are using regular blogs to inform the membership about what is happening in the DCP, as this is more timely than this column can be. You can read these at:

www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/blog

Julia Faulconbridge

Chair, Division of Clinical Psychology
dcpchairjpf@gmail.com

Division of Clinical Psychology Contacts

National Officers

Chair: Julia Faulconbridge – dcpchairjpf@gmail.com

Vice Chair: Esther Cohen-Tovée – DCPUKViceChairECT@ntw.nhs.uk

Chair Elect: Position vacant

Honorary Treasurer: Simon Gelsthorpe – dcptreasurer@bps.org.uk

Director, Membership Services Unit: Sheelagh Rodgers – dcpmsudirector@bps.org.uk

Director, Professional Standards Unit: Position vacant

Director, Policy Unit – Position vacant

PR & Communications Lead – Position vacant

Chair, Conference Committee: Laura Golding – l.golding@liverpool.ac.uk

Experts by Experience Network – contact c/o Helen Barnett – dcpsucle@bps.org.uk

Ordinary Members: Judith Samuel – dcpldlead@bps.org.uk

Co-opted Members: Alan Blair, Richard Pemberton, John Rose & Lexi Thorpe

Service Area Leads

Adult: Position vacant

Child: Vacant

Clinical Health: Position vacant

Learning Disabilities: Judith Samuel – dcpldlead@bps.org.uk

Older People: Vacant

Devolved Nations

England: Position vacant

Northern Ireland: Petra Corr

Petra.Corr@northerntrust.hscni.net

Scotland: Alison McMullan

alison.mcmullan@nhs.net

Wales: Adrian Neal

Adrian.Neal@wales.nhs.uk

English Branch Chairs

East of England: Frances Blumenfeld

fblume@essex.ac.uk

East Midlands: Vacant

London: Roman Raczka

Roman.Raczka@lbhf.gov.uk

North East: Barry Ingham

barry.ingham@ntw.nhs.uk

North West: Vacant

South Central: Chris Allen

chris.allen@berkshire.nhs.uk

South East Coast: Richard Pemberton

richardpemberton@gmail.com

South West: Alex Dibley

alexandradibley@gmail.com

West Midlands: Lawrence Moulin

lawrencemoulin@outlook.com

Yorkshire & Humber: Annette Schlosser

a.schlosser@hull.ac.uk

Pre-Qualification Group

Alice McNamara (Co-chair)

Sandy Metwally (Co-chair)

dcppqc@bps.org.uk

Faculty Chairs

Children, Young People & their Families:

Katie Hunt

katie@katiehuntpsychology.co.uk

Psychology of Older People: Sarah Butchard

dcpolderpeopleslead@bps.org.uk

People with Intellectual Disabilities: Judith Samuel

dcpldlead@bps.org.uk

HIV & Sexual Health: Sarah Rutter

sarah.rutter@pat.nhs.uk

Psychosis & Complex Mental Health:

Linda Wilkinson & Selma Ebrahim

Linda.Wilkinson@shsc.nhs.uk

Selma.Ebrahim@ntw.nhs.uk

Addictions: Jan Larkin

Jan.Larkin@turning-point.co.uk

Clinical Health Psychology: Anne-Marie Doyle

Anne-mariedoyle@nhs.net

Eating Disorders:

Amy Wicksteed

amy.wicksteed@shsc.nhs.uk

Forensic: Kerry Beckley

kerry.beckley@lpft.nhs.uk

Oncology & Palliative: Marilyn Owens

marilynowens@nhs.net

Leadership & Management: Amra Rao

psychologicalhorizons@gmail.com

Holistic: Jane Street

jane.street@swlstg-tr.nhs.uk

Perinatal: Helen Sharp

hmssharp@liverpool.ac.uk

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