



FROM FRAGMENTATION TO INTEGRATION

TREATING DISSOCIATION IN COMPLEX TRAUMA

DAKOTA LAWRENCE LPC-MHSP

WWW.FOUNDBETWEEN.COM



HI. I'M DAKOTA

ABOUT ME:

I'm a Co-Owner of Mind The Gap, a **trauma-focused** practice in Murfreesboro. My clinical work centers on **complex trauma, dissociation, self-harm, and personality disorders**. I am also the founder of FoundBetween Training Institute, where I develop and deliver advanced clinical training for mental health professionals working at the intersection of **trauma, somatic experience, and nervous system healing**.



MEET SARAH:

34 YEARS OLD

3 PREVIOUS THERAPISTS

PREVIOUSLY COMPLETED
AN EMDR INTENSIVE

JUST LEFT A LONG-TERM
RELATIONSHIP

Sarah is **highly educated**. She knows what a window of tolerance is. She can name her attachment style, identify her inner critic, and describe her childhood as if it was a story she told many times.

What she cannot do is tell you what happened last Tuesday.

When asked to walk through her week, she pauses. Then: "I know I went to work. The **days kind of blur together**. I got to work one day this week and couldn't remember the drive at all. I remember getting in the car and then I was just there." She has found notes in her own handwriting she cannot account for. Her former partner of six years eventually began keeping written records of their conversations because, he told her, **he could no longer tell whether she was lying** or genuinely didn't remember.

In session, she **intellectualizes**. Asked how something made her feel, she tells you what she thinks about how she felt. Asked to notice her heartbeat with a hand on her chest, she sits quietly for a moment and then says, with genuine uncertainty: "I don't really feel it. Is that normal?"

In the first session she says, almost as an aside: "Sometimes **I feel like I'm watching my life instead of living it.**"

The Clinical Question: Sarah has done enormous amounts of work. How do you reach the layer where the trauma actually lives, in a client whose greatest strength is her ability to stay disconnected from it?

TRAUMA

FOUNDATIONS

DEFINITIONS & CORE CONCEPTS

WHAT IS TRAUMA?



WHAT IS TRAUMA?



The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

WHAT IS TRAUMA?



The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

WHAT IS TRAUMA?



The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

Lower-Case “t” Trauma

Events that SHOULD have happened, but did not.

WHAT IS TRAUMA?

The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

Lower-Case “t” Trauma

Events that SHOULD have happened, but did not.



What Makes Trauma “Complex”?

WHAT IS TRAUMA?

The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

Lower-Case “t” Trauma

Events that SHOULD have happened, but did not.



What Makes Trauma “Complex”?

Chronicity - Repeated, prolonged exposure to traumas that take shape over a significant period of time.

WHAT IS TRAUMA?

The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

Lower-Case “t” Trauma

Events that SHOULD have happened, but did not.



What Makes Trauma “Complex”?

Chronicity - Repeated, prolonged exposure to traumas that take shape over a significant period of time.

Interpersonal Nature - Typically, trauma occurs in relation to attachment figure, or other significant relational figure with a significant amount of trust

WHAT IS TRAUMA?

The “event” is not as important as the impact.

Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

Capital “T” Trauma

Event(s) that should NOT have happened, but did.

Lower-Case “t” Trauma

Events that SHOULD have happened, but did not.



What Makes Trauma “Complex”?

Chronicity - Repeated, prolonged exposure to traumas that take shape over a significant period of time.

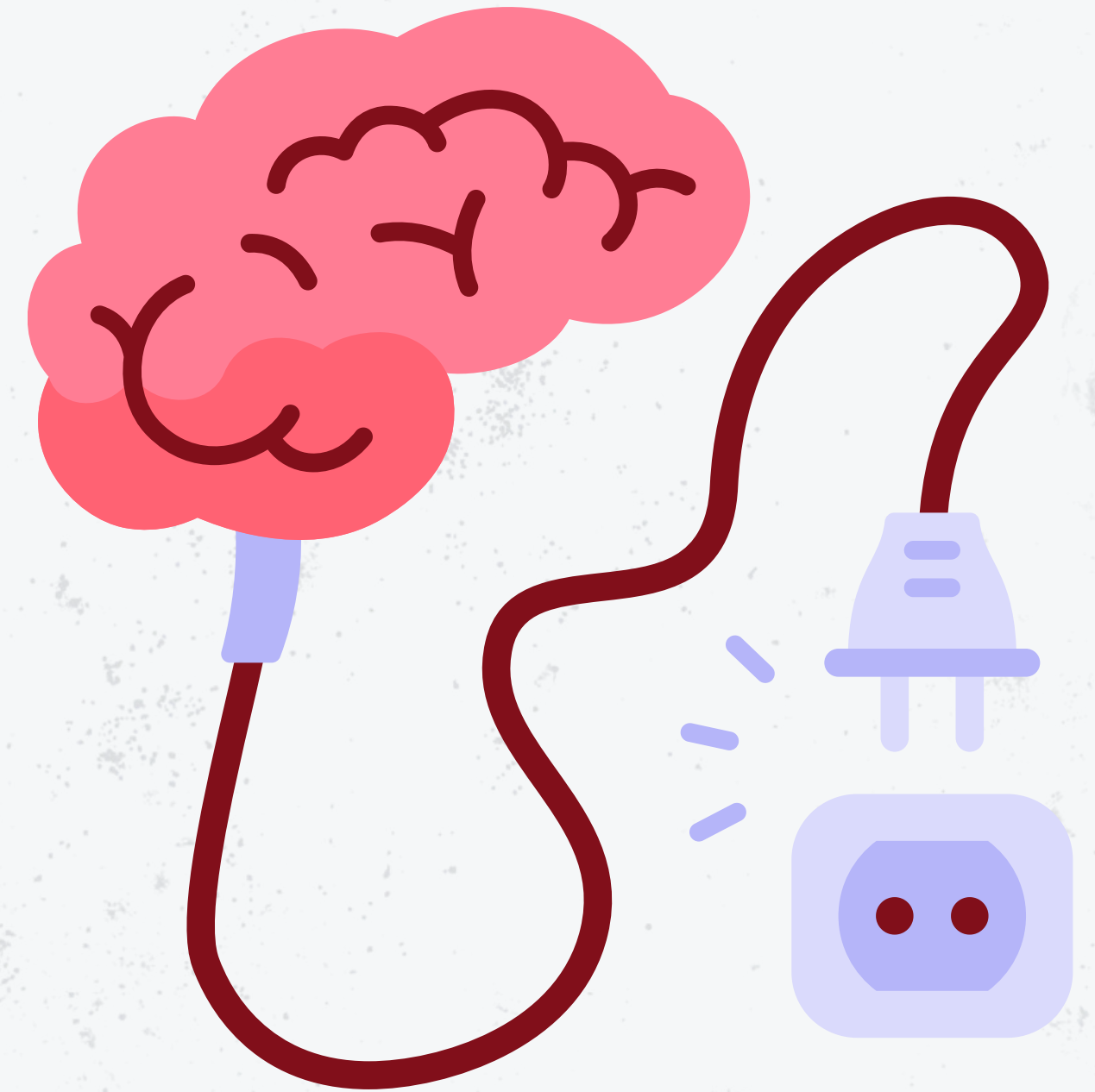
Interpersonal Nature - Typically, trauma occurs in relation to attachment figure, or other significant relational figure with a significant amount of trust

Developmental Timing - Typically occurring in childhood, impacting and affecting concurrent developmental milestones (ref: Neurosequential Development Theory)

WHAT IS DISSOCIATION?

A disruption in the normally integrated functions of consciousness, memory, identity, perception, and sense of self.

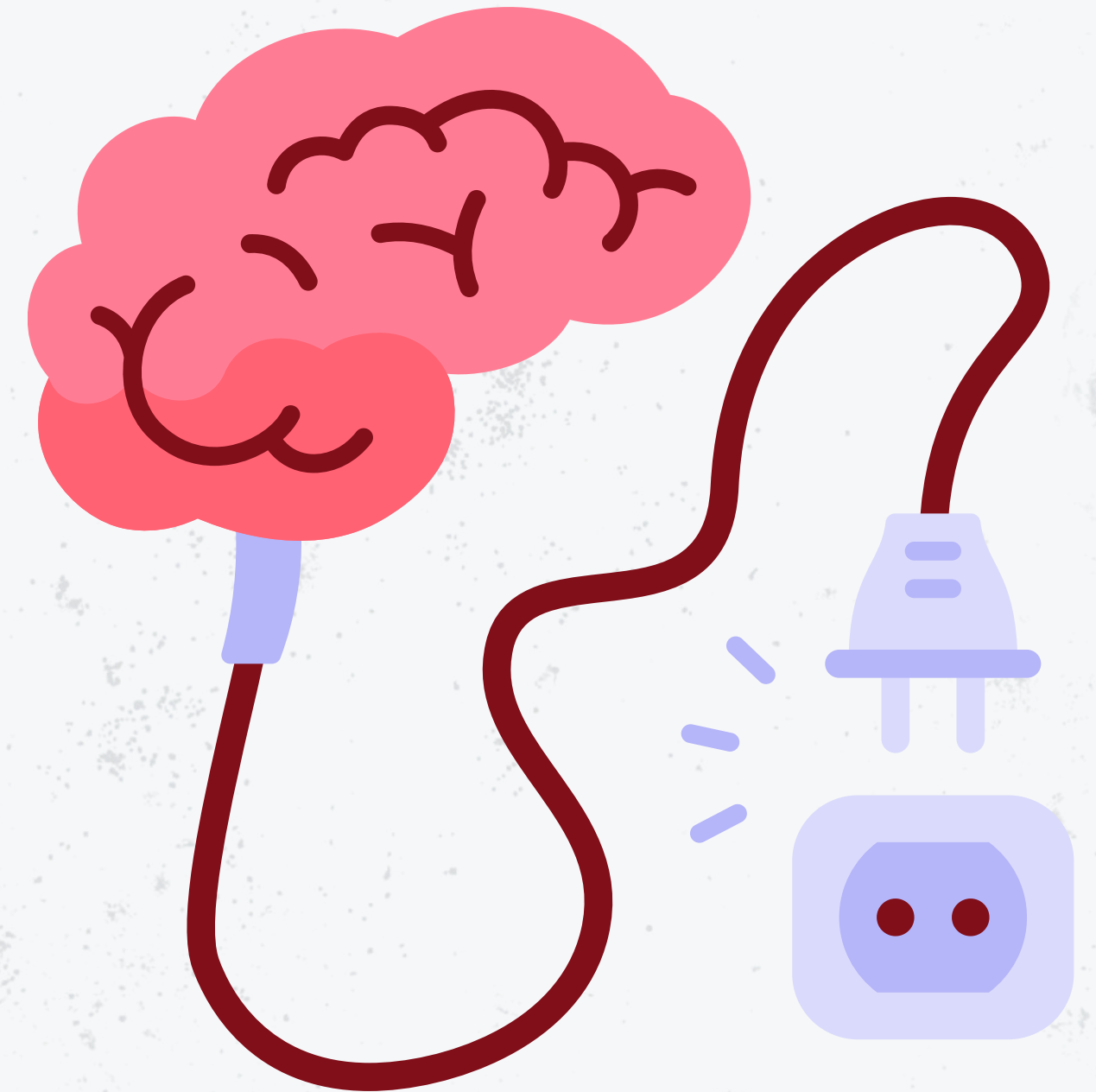
Everyone experiences it from time-to-time. It exists on a spectrum.



WHAT IS DISSOCIATION?

A disruption in the normally integrated functions of consciousness, memory, identity, perception, and sense of self.

Everyone experiences it from time-to-time-. It exists on a spectrum.



**WATCHING YOURSELF
FROM THE OUTSIDE**

LOSING TRACK OF TIME

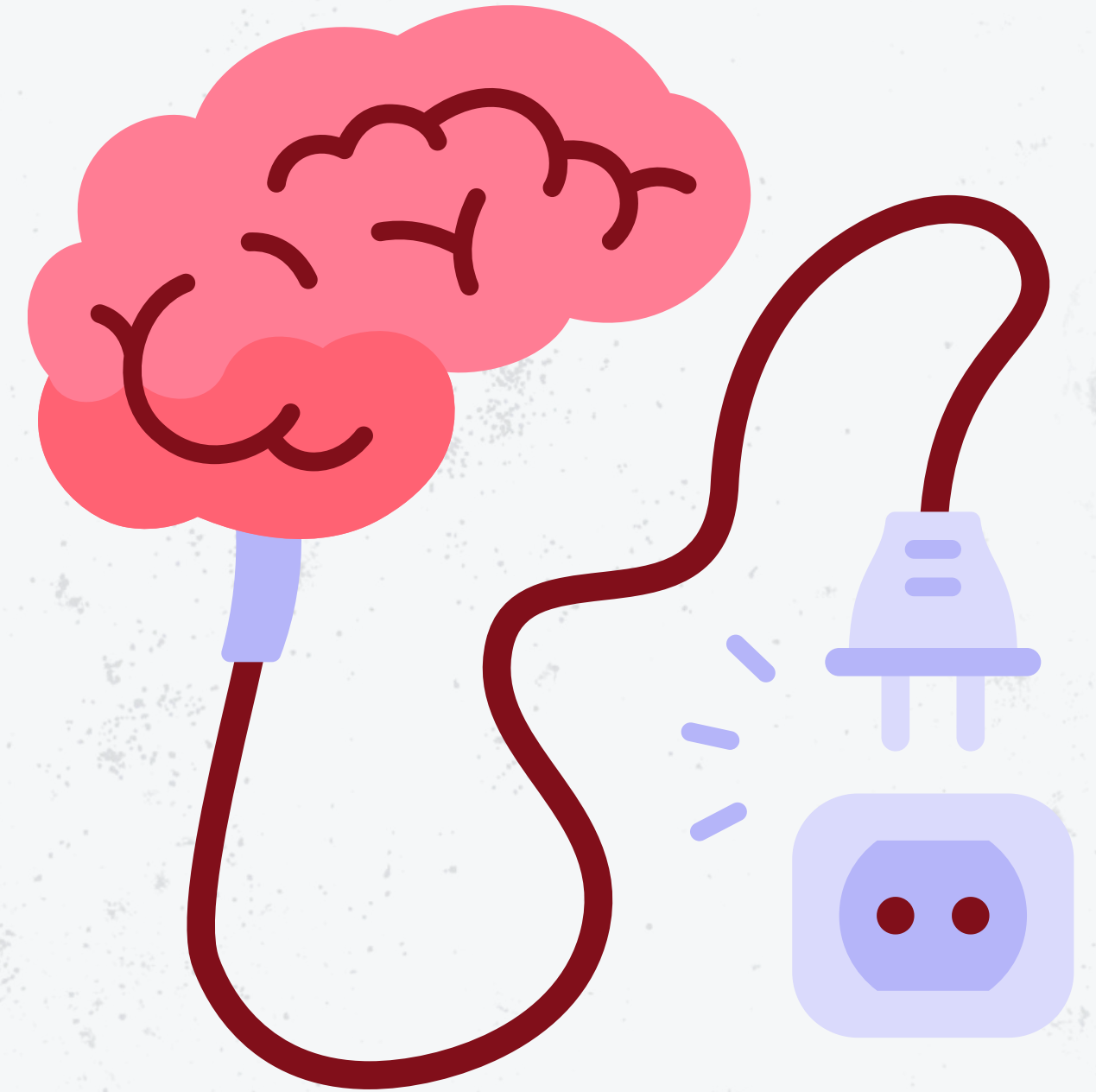
FLASHBACKS

**THE WORLD FEELING FOGGY OR
SEEING IT THROUGH GLASS**

**FEELING LIKE YOUR BODY
DOESN'T BELONG TO YOU**

**EVIDENCE YOU'VE DONE
SOMETHING YOU DON'T REMEMBER**

WHAT IS DISSOCIATION?



UNIVERSAL

CLINICAL

Daydreaming

Emotional
Numbing

Derealization

Highway
Hypnosis

Autopilot
Routine Tasks

Depersonalization

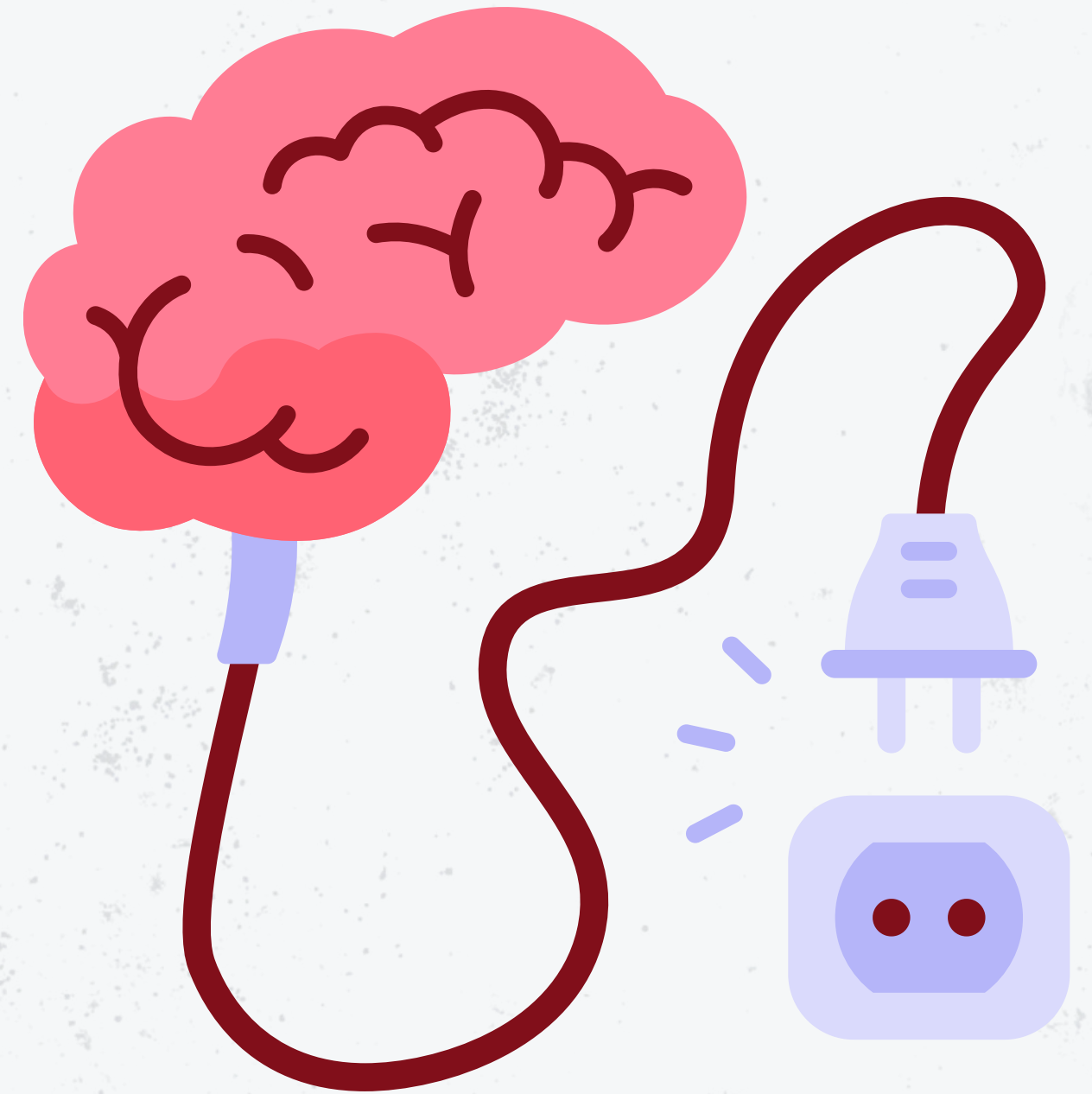
Identity
Fragmentation

WHAT IS DISSOCIATION?

It can be powerful to offer your clients a paradigm shift. Rather than framing dissociation as a “disorder”, introduce it as a “solution” that may no longer be working.

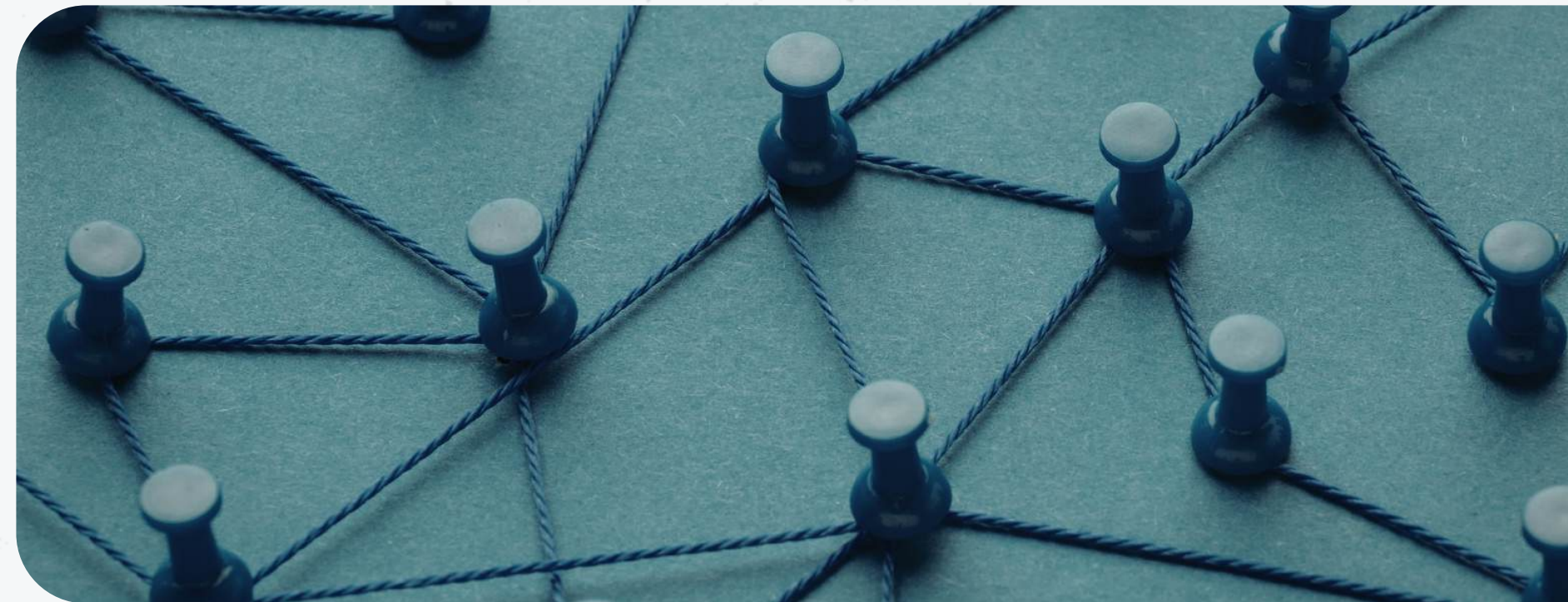
It is the nervous system's response to what feels like an unsolvable problem: "I am experiencing something I cannot survive experiencing fully."

Adaptive in the moment of crisis, problematic when it becomes the default.



THE INTERPLAY OF TRAUMA & DISSOCIATION

Dissociation is the nervous system's response to an experience that exceeds its capacity to integrate the experience. The more chronic, relational, and inescapable the trauma, the more powerful (and sometimes chronic) the experience of dissociation.



Emotional Anesthetic

The brain perceives a painful threat. Preaffective shock arrives. Dissociation allows functioning to continue, upping our odds of survival.

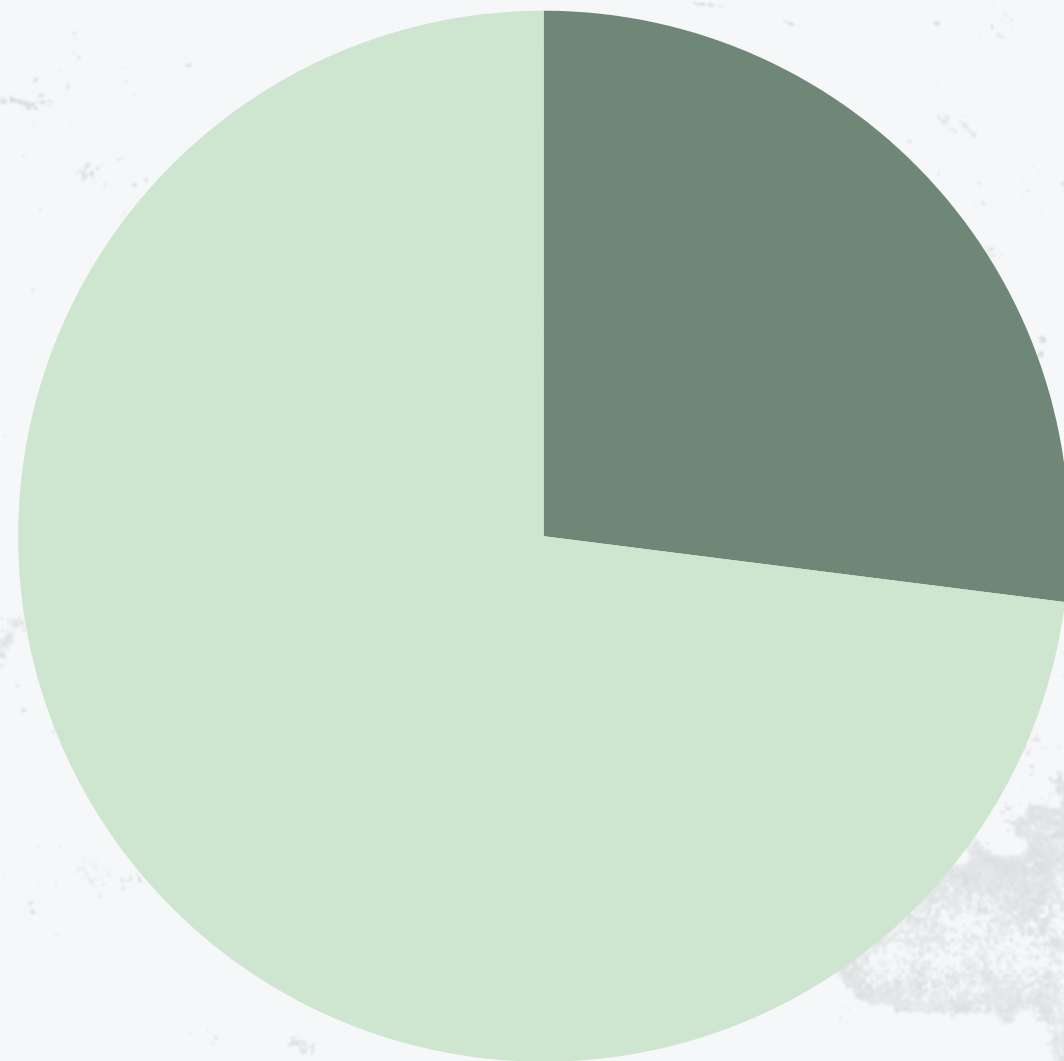
Complex Trauma & Attachment Disruptions

Pain becomes associated with intimate, important relationships, from which there is no running or fighting back. Dissociation becomes the default response. Like all habits, it comes quicker and more automatic.

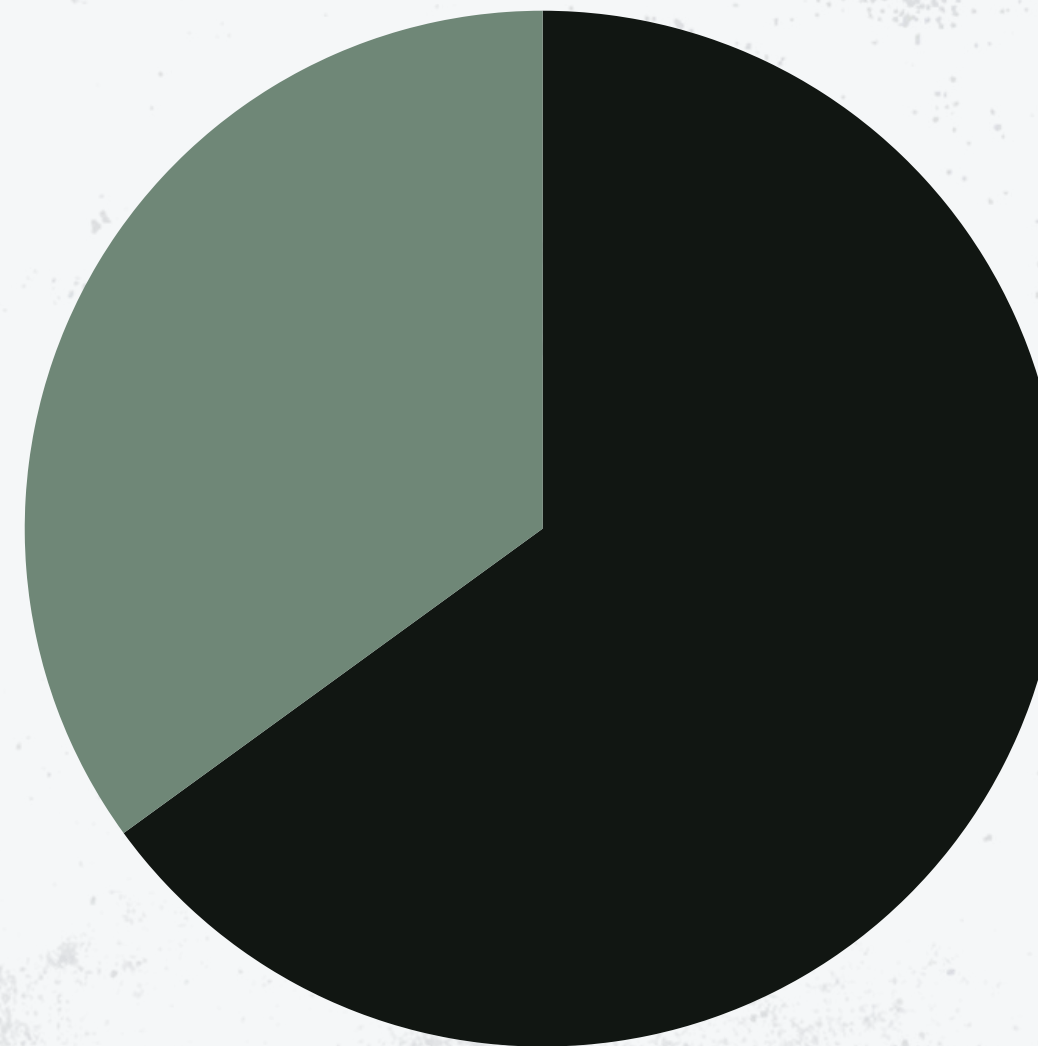
Biological Paradox

When that caregiver is frightening, neglectful, or unavailable & the attachment system fires toward the same person who activates the alarm system the result is disorganization. Dissociation can act as a “resolution” to this paradox.

TRAUMA & DISSOCIATION



73% REPORT EXPERIENCING DISSOCIATIVE SYMPTOMS DURING A TRAUMATIC EVENT



AMONG SURVIVORS OF CHILDHOOD ABUSE, DISSOCIATIVE DISORDER PREVALENCE RANGES FROM 40-60% DEPENDING ON THE CHRONICITY AND TYPE OF ABUSE

CLINICAL SIGNIFICANCE

CLINICAL SIGNIFIGANCE



CLINICAL SIGNIFICANCE

Dissociation can keep trauma **frozen** in ice (or carbonite, for my fellow nerds).

The material we need to engage with is **out of reach**. A key step to trauma working is “thawing” it out, which may **worsen intrusive trauma symptoms in the short term**, before we can reprocess, desensitize, and/or integrate.

Stabilization phase is key!



CLINICAL PRESENTATION



Depersonalization

Feeling **detached** from their own body, thoughts, or feelings, as if **watching themselves** from the outside or going through the motions on **autopilot**.



Derealization

The external world feels **unreal, dreamlike, foggy,** or artificially distant. The surroundings are familiar but feel **strange or flat**



Dissociative Identity

Structural dissociative condition in which the **personality is organized** into two or more **distinct self-states** or identities that take autonomous control of behavior, often with **amnesia** across states

CLINICAL PRESENTATION

<u>DISSOCIATIVE DISORDERS</u>	<u>DISORDERS w/ ASSOCIATED DISSOCIATION</u>
Dissociative Amnesia	Acute Stress Disorder/PTSD/C-PTSD
Depersonalization/Derealization Disorder	Functional Neurological Disorder
Unspecified Dissociative Disorder	Boderline Personality Disorder
Etc.	Etc.

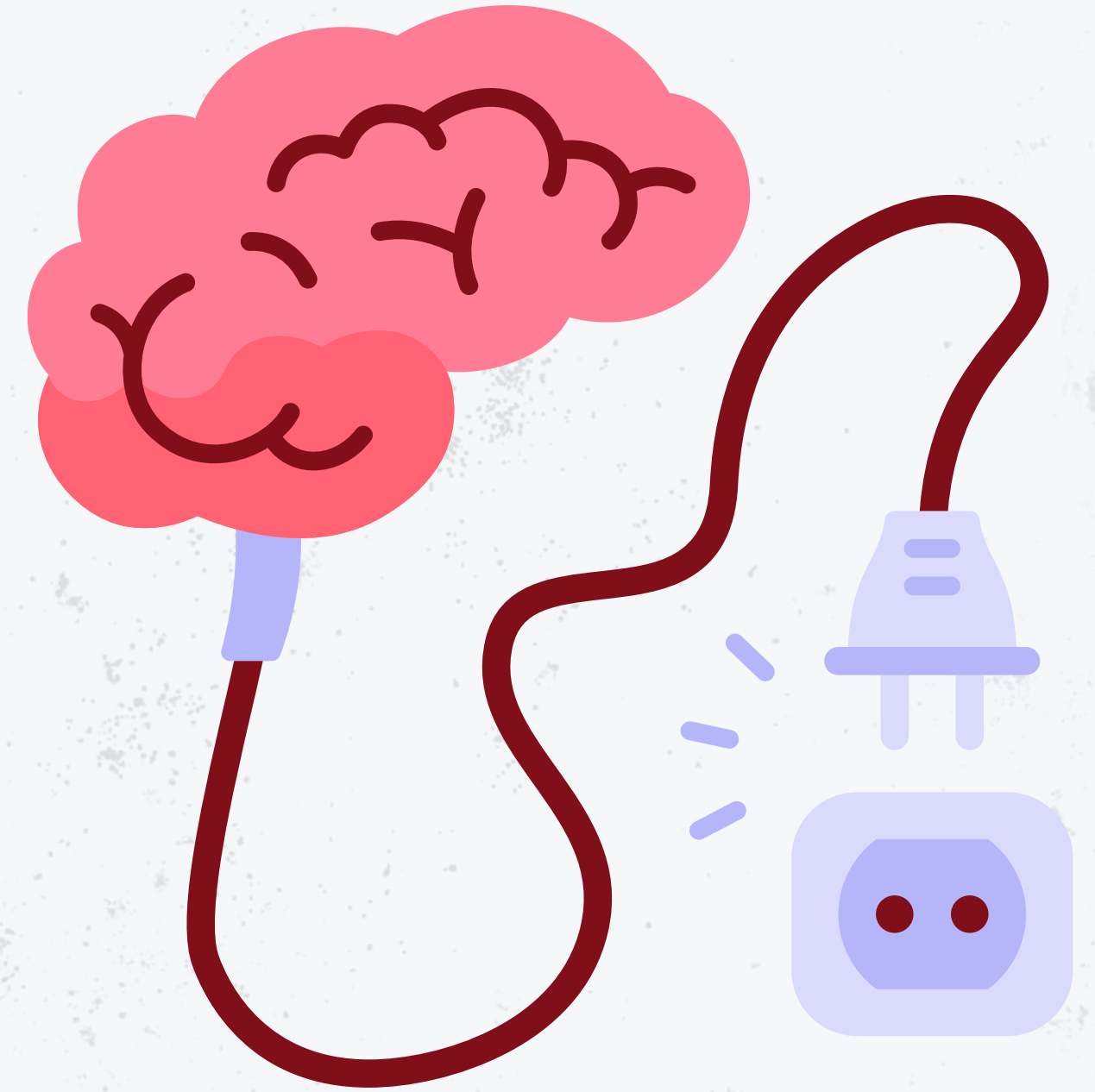
NEUROBIOLOGY OF DISSOCIATION

MECHANISMS & PATHWAYS

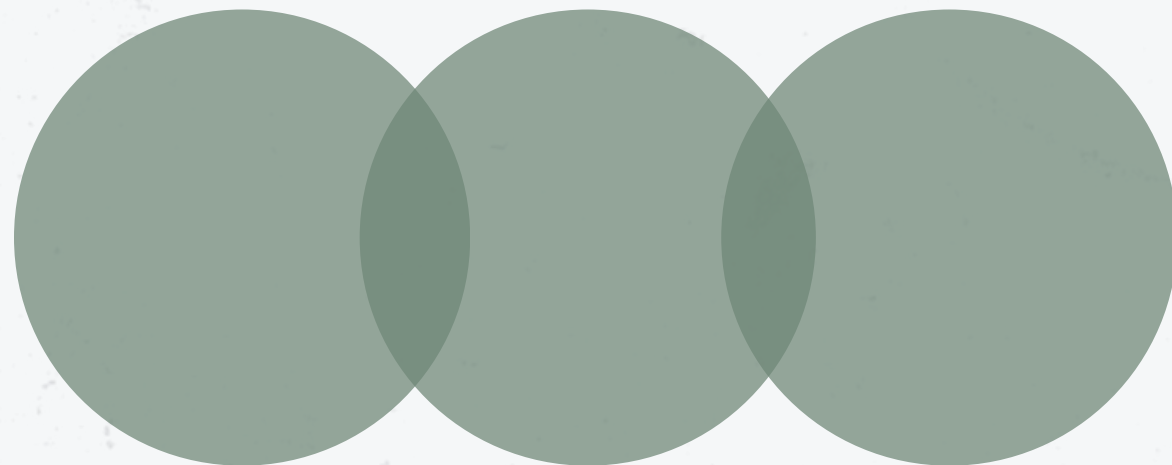
WHAT IS DISSOCIATION?

A disruption in the normally integrated functions of consciousness, memory, identity, perception, and sense of self.

Everyone experiences it from time-to-time-. It exists on a spectrum.



Integration



Dissociative Barrier



Dissociative Barrier

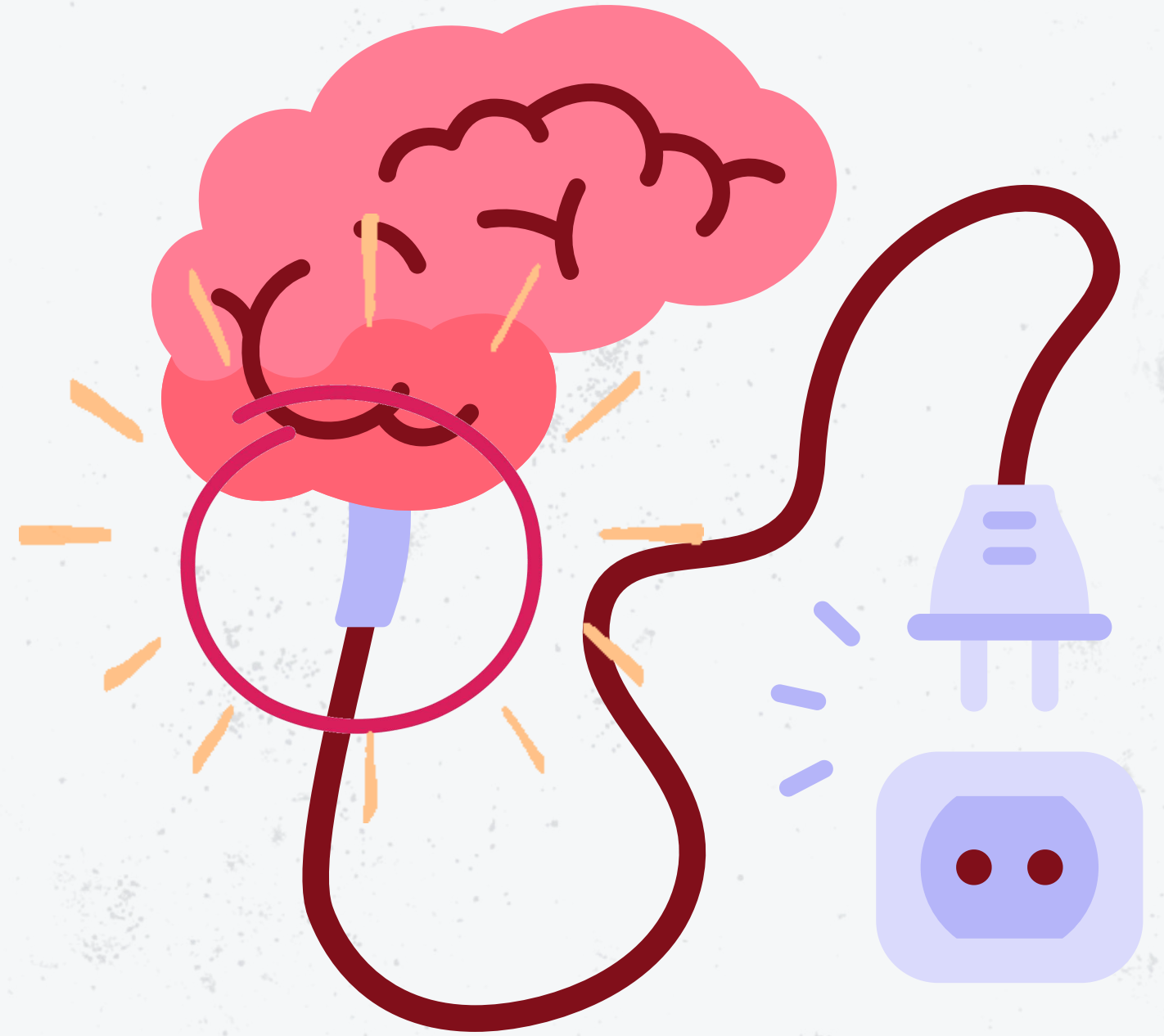


WHERE

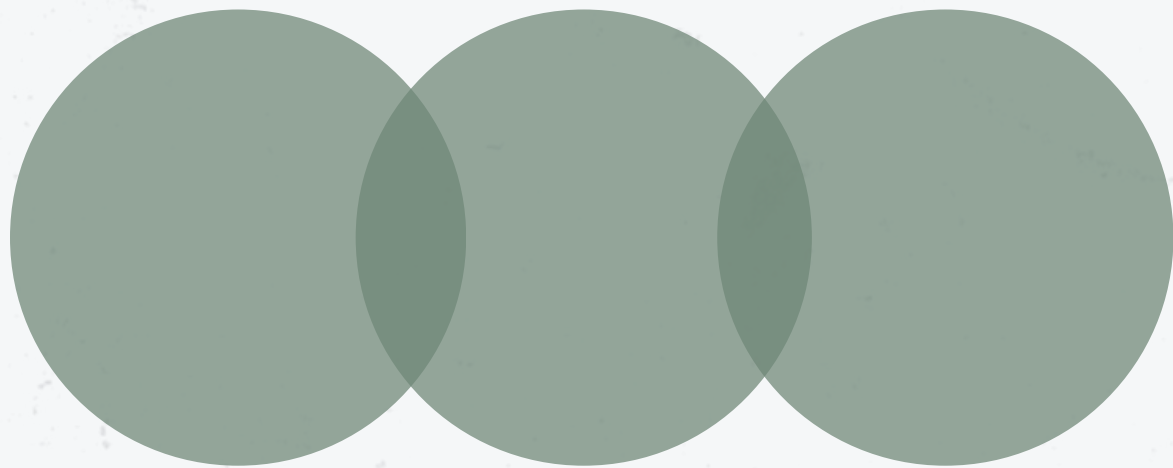
WHAT IS DISSOCIATION?

A disruption in the normally integrated functions of consciousness, memory, identity, perception, and sense of self.

Everyone experiences it from time-to-time-. It exists on a spectrum.



Integration



Dissociative Barrier



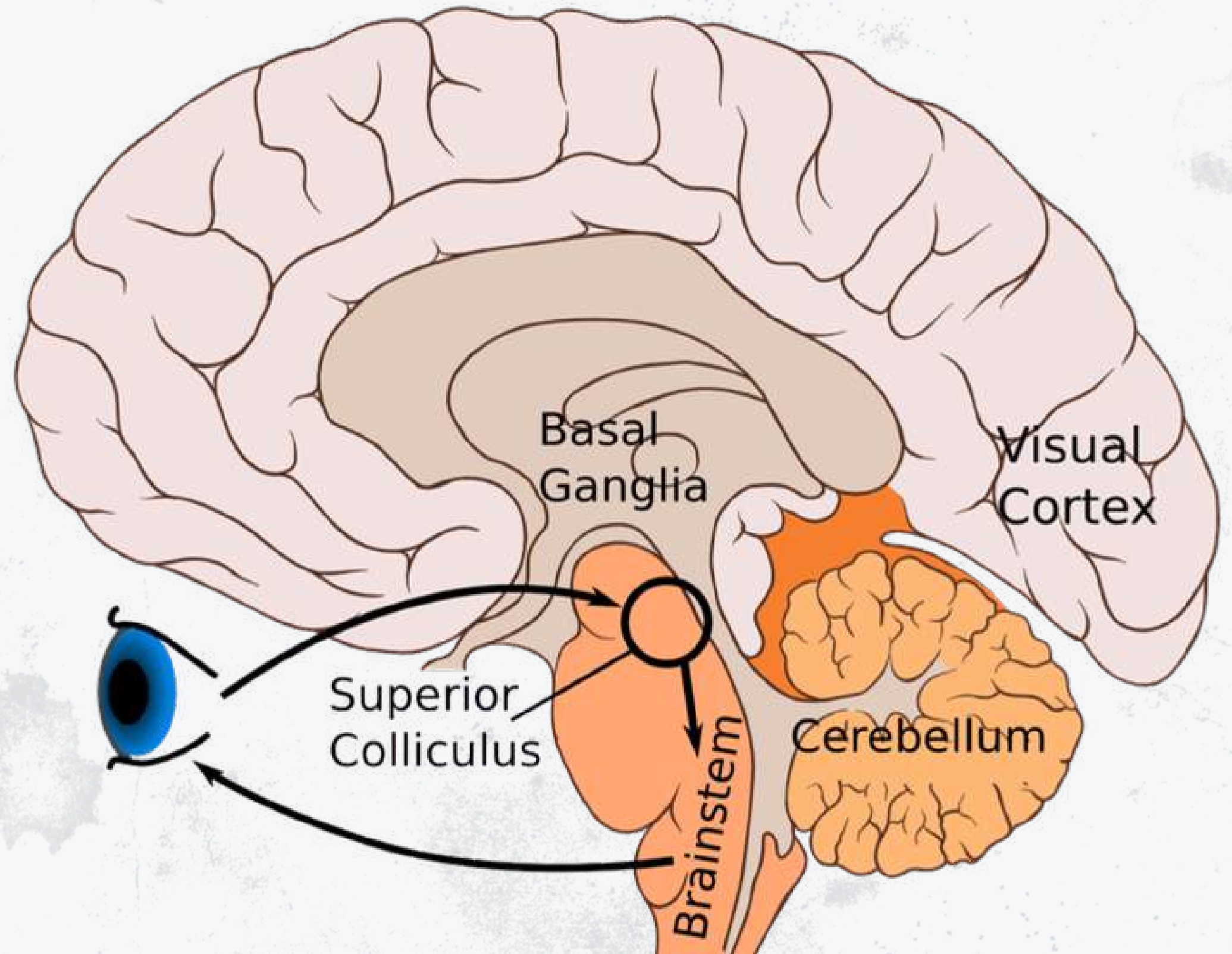
Dissociative Barrier



ANATOMY OF DISSOCIATION

Most trauma models focus on the cortex and limbic system. But the structures that play the largest role in dissociation are older (evolutionarily AND developmentally) and much more powerful.

Understanding three brainstem regions changes how we see, track, and treat dissociative presentations.



THE SUPERIOR COLLICULUS

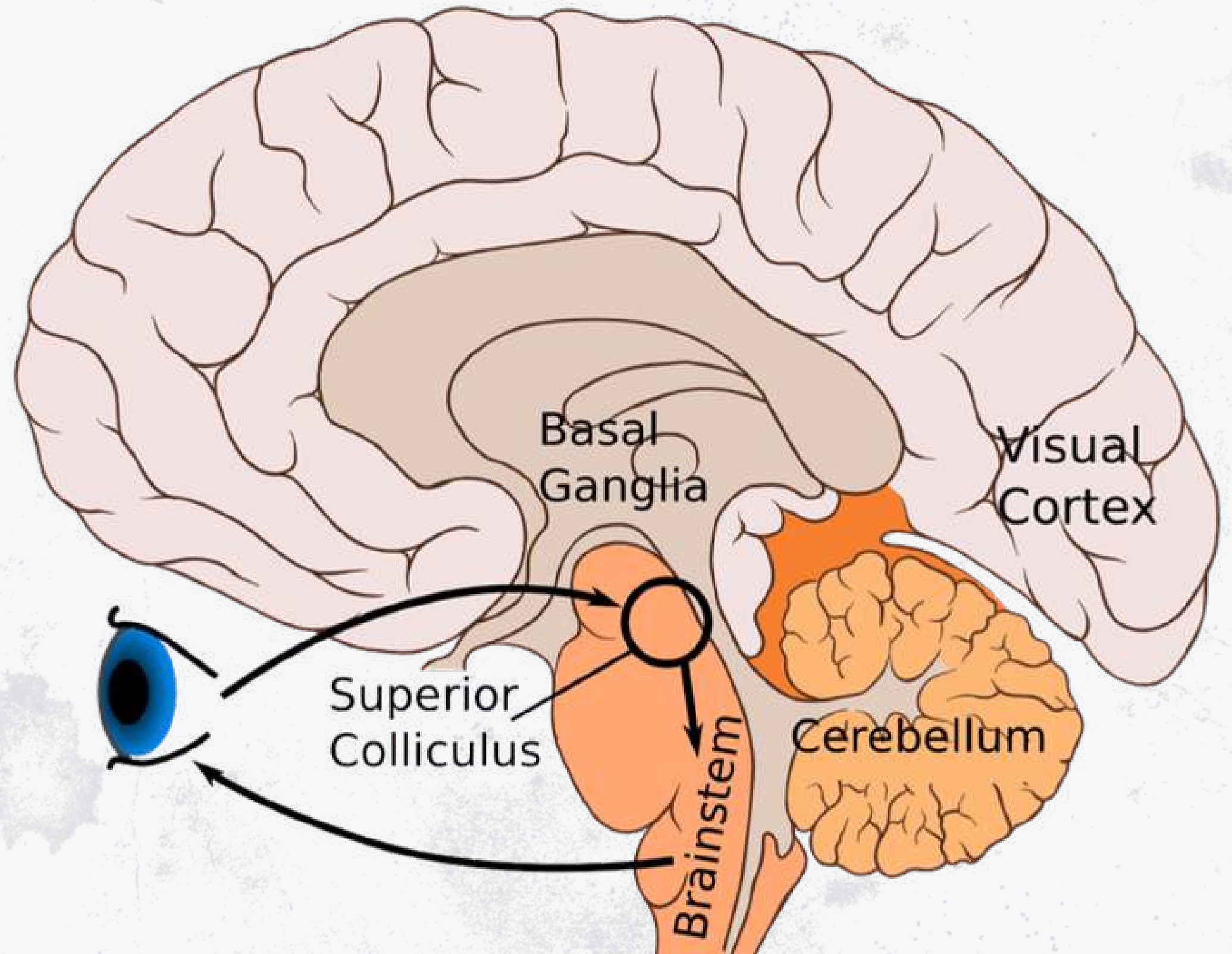
Located in the **midbrain**; one of the oldest structures in the vertebrate brain

Primary function: orienting & detecting what is salient in the environment and where it is in relation to the body

Integrates visual, auditory, and somatosensory input; coordinates eye and head movement toward threat or connection

Operates **faster than conscious awareness** to detect threat before the cortex knows anything has happened

This is the seat of the Collicular Self: the most basic, grounded layer of the self.



THE PERIAQUEDUCTAL GRAY



Active Defenses: Fight & Flight



Active Defenses: Flag & Fawn

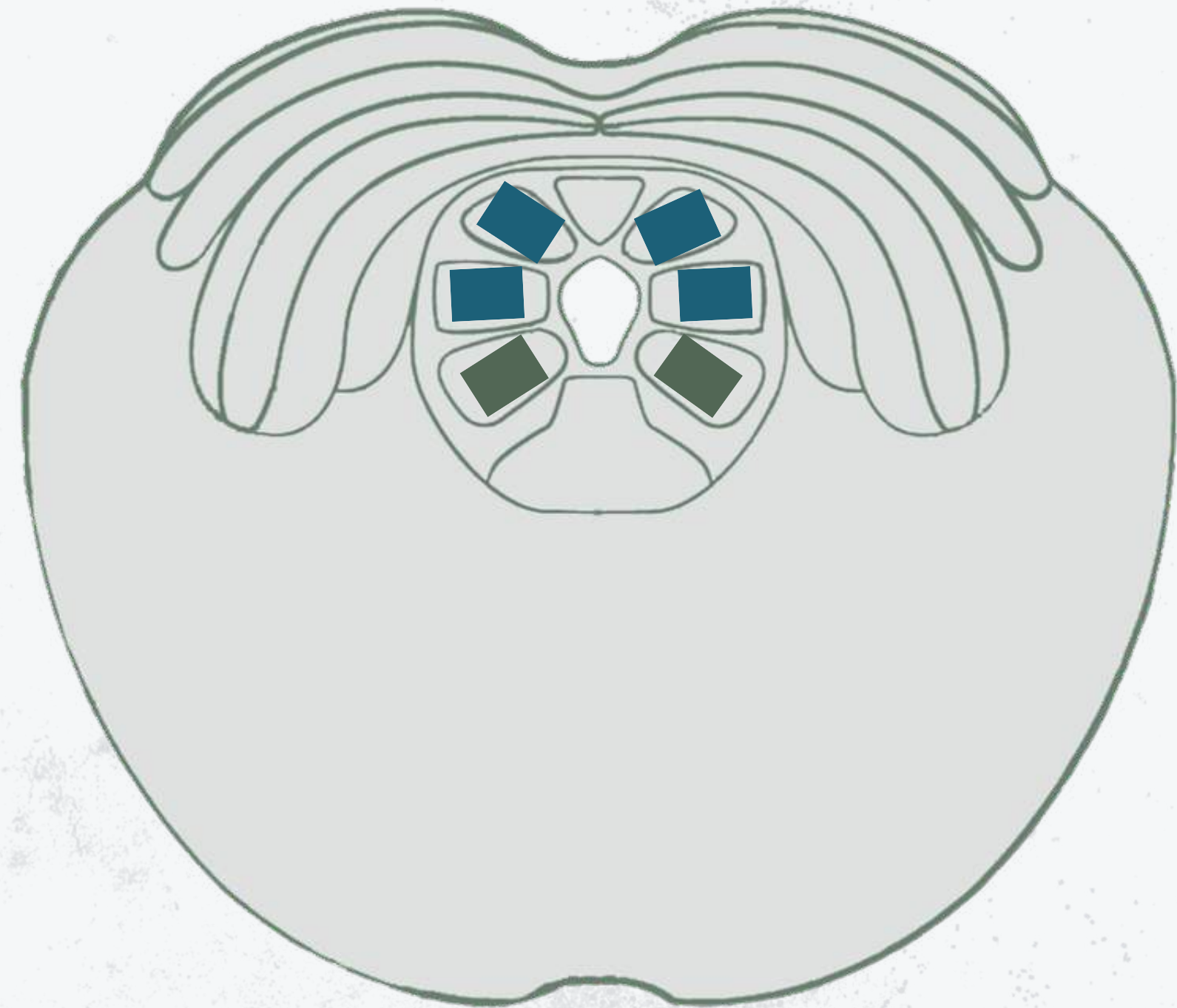
Primary function: generating basic emotional and defensive responses

Four columns with distinct functions:

- Dorsolateral/Lateral → active defense: flight and fight
- Ventrolateral → passive defense: collapsed freeze, tonic immobility, opioid analgesia
- Dorsomedial → shame: urge to hide, curl up, disappear

The PAG activates when threat exceeds a threshold in the Superior Colliculus

When PAG-driven affect becomes overwhelming: neurochemical capping → dissociation



THE LOCUS COERULEUS

Located in the upper brainstem

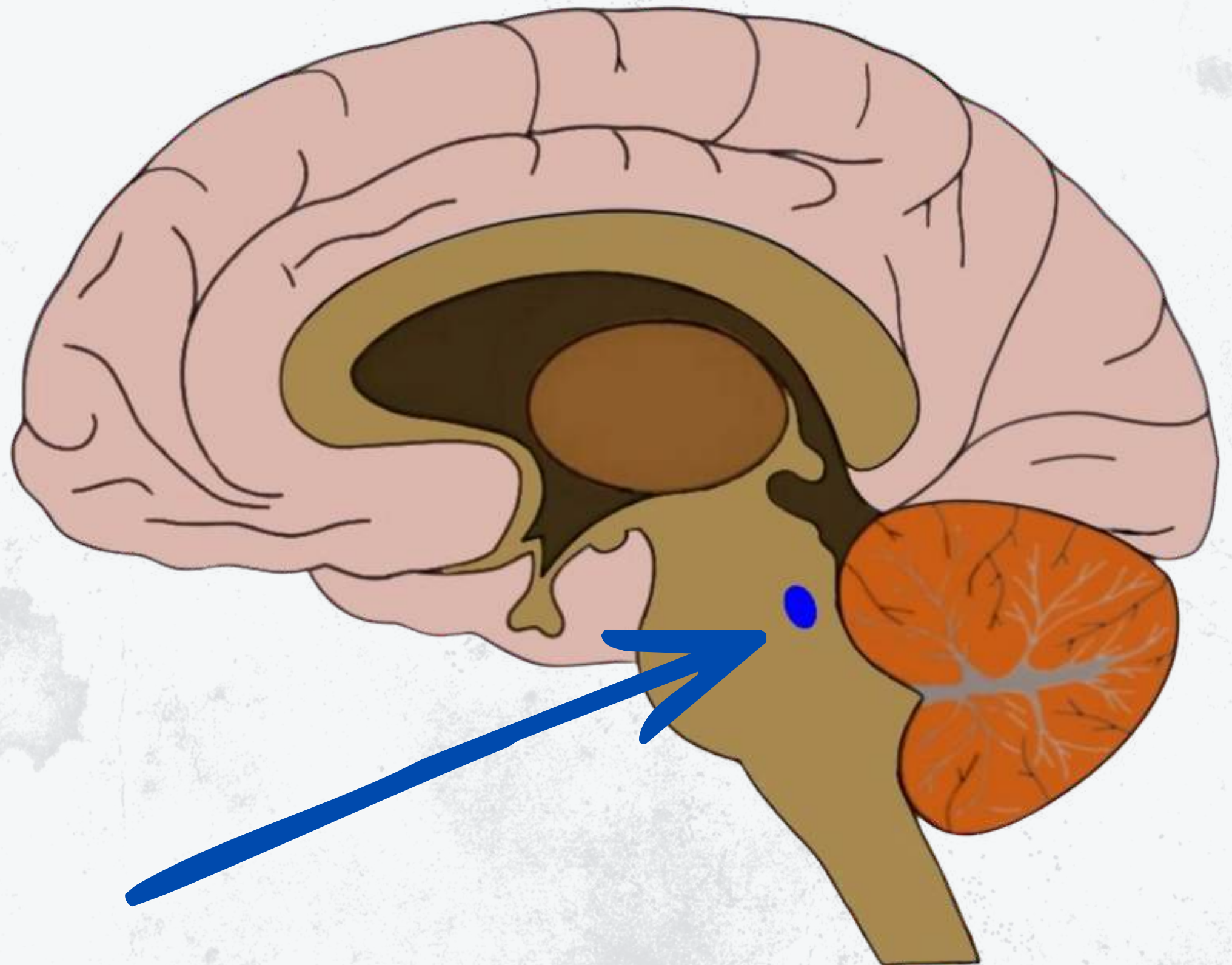
Primary function: producing and distributing noradrenaline throughout the brain

Activated by the SC via a direct alarm pathway (before conscious appraisal)

Produces pre-affective shock: the body's response before any named emotion

Can become **chronically sensitized.**

Widespread flooding from LC activation
→ **derealization and depersonalization**



WHY DOES TRAUMA PRODUCE DISSOCIATION?

Trauma is not stored as “explicit” memory (felt sense of remembering) but as a collection of body states, emotional fragments, visceral sensations, and procedural responses that remain continuously available to be triggered by anything that resembles the original event.



OFFLINE

The Hippocampus

The brain's filing system (memory) cannot contextualize, sequence, or store experience as coherent narrative memory. The event is never filed. It remains perpetually present as a body state.



OFFLINE

Prefrontal Cortex

The brakes fail. There is no observing self to organize what is happening into a story with a beginning, middle, and end.



ONLINE

Brainstem

The superior colliculus, the PAG, and the locus coeruleus are running the show. The body is doing what bodies do under threat: orienting, tensing, flooding with affect, deploying its chemical emergency brake. All of this is encoded below the level of language and narrative.



TWO PATHWAYS TO DISSOCIATION

CHEMICAL & STRUCTURAL DISSOCIATION

CHEMICAL DISSOCIATION

PATHWAY ONE

CHEMICAL DISSOCIATION

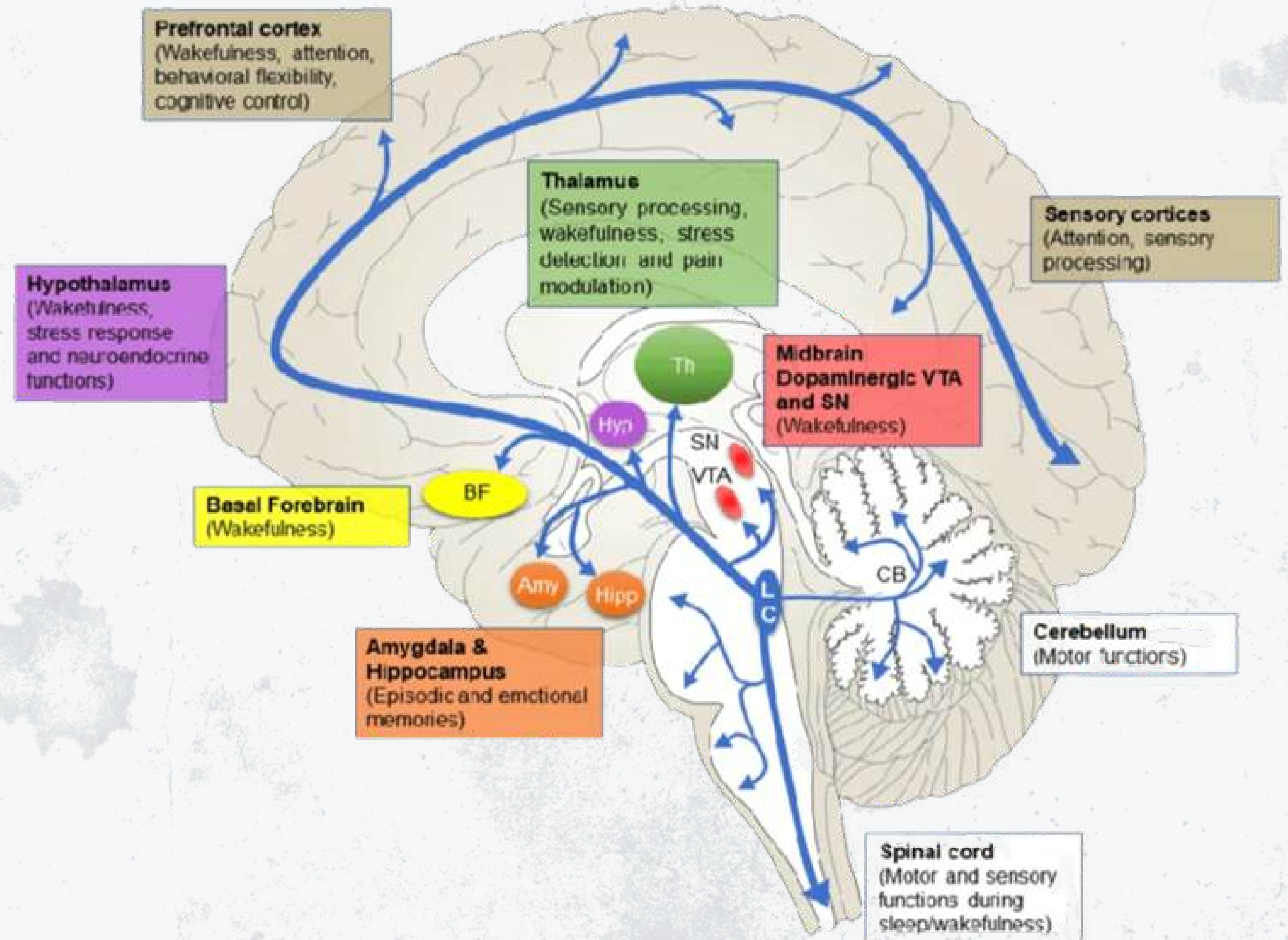
The SC connects to the locus coeruleus (LC), the brain's noradrenaline production center.

This SC→LC pathway activates without conscious appraisal, even from subliminal threat.

Noradrenergic flooding has widespread cortical effects: the world becomes unreal, the self becomes unreal.

Clinical Implication: When a client reports derealization or depersonalization, they are the brainstem is running the show.

Cognitive grounding techniques address the wrong level.





O-T-A-S SEQUENCE

Corrigan's description of the actual brain systems and pathways for immediate processing of events:

O — Orienting:

The SC detects a stimulus and organizes "orienting" action.



T — Tension:

Immediate orienting tension in the neck, face, around the eyes. Fleeting but detectable.



A — Affect:

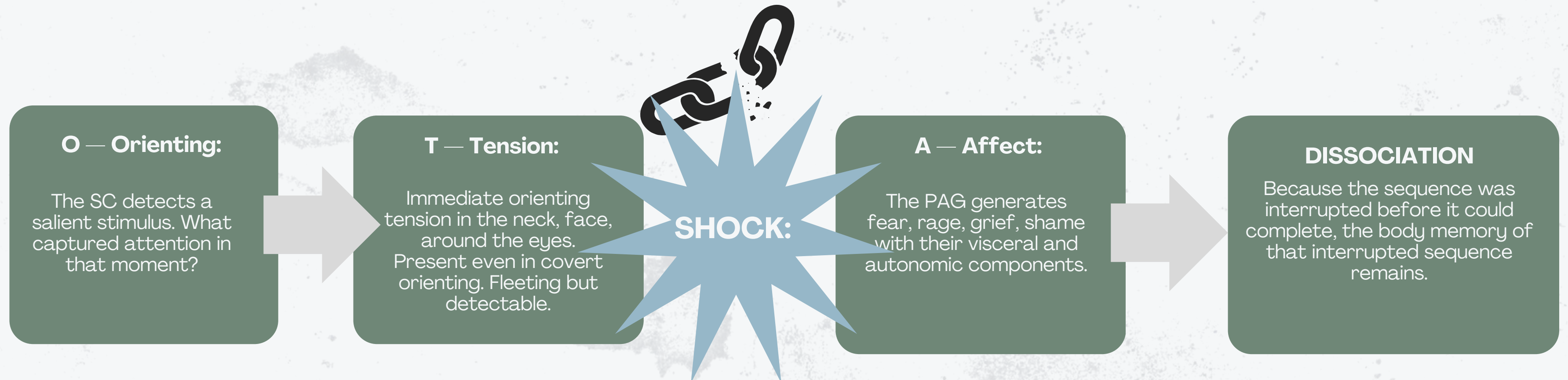
The PAG generates fear, rage, grief, shame with their visceral and autonomic components that organize us for survival-related action.



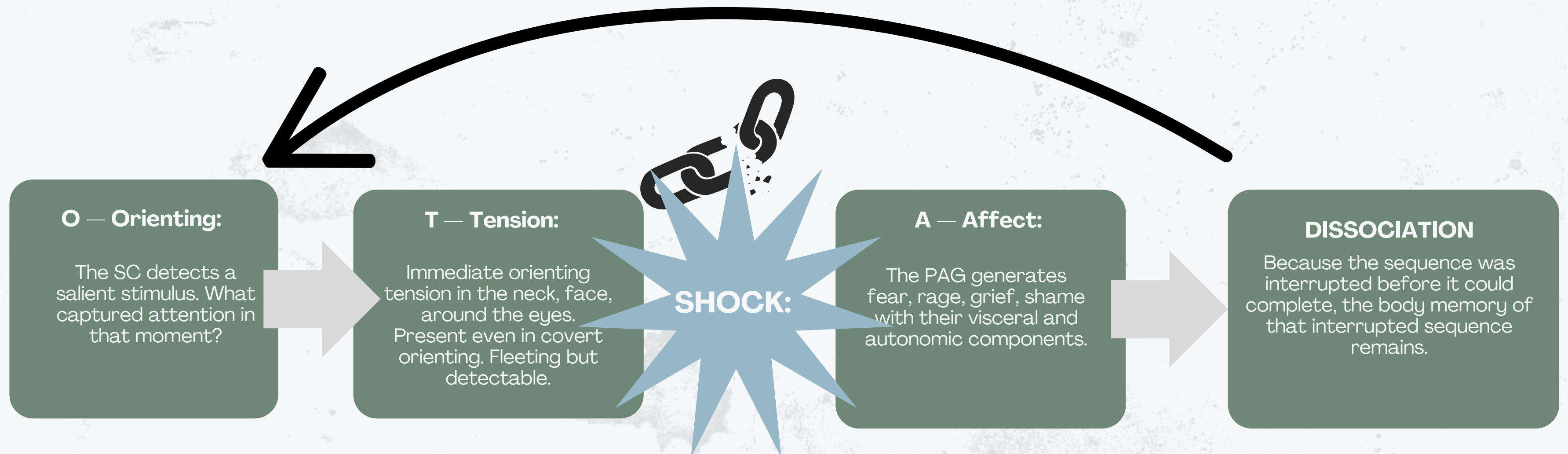
S — Seeking:

The mesolimbic dopamine system adjusts valence (positive/seek or negative/avoid/retreat). Recalibrates its prediction about what is possible, what is safe to move toward, what is worth wanting.

O-T-A-S INTERRUPTED



O-T-A-S INTERRUPTED



The Attachment Loop:

In complex trauma, the O-T-A-S sequence becomes a loop: awareness of aloneness activates orienting, which triggers shock, which fires PAG affect, which loops back into negatively-valenced SEEKING. The nervous system of chronic trauma is a system caught mid-sequence, perpetually trying to complete a process it was never allowed to finish.

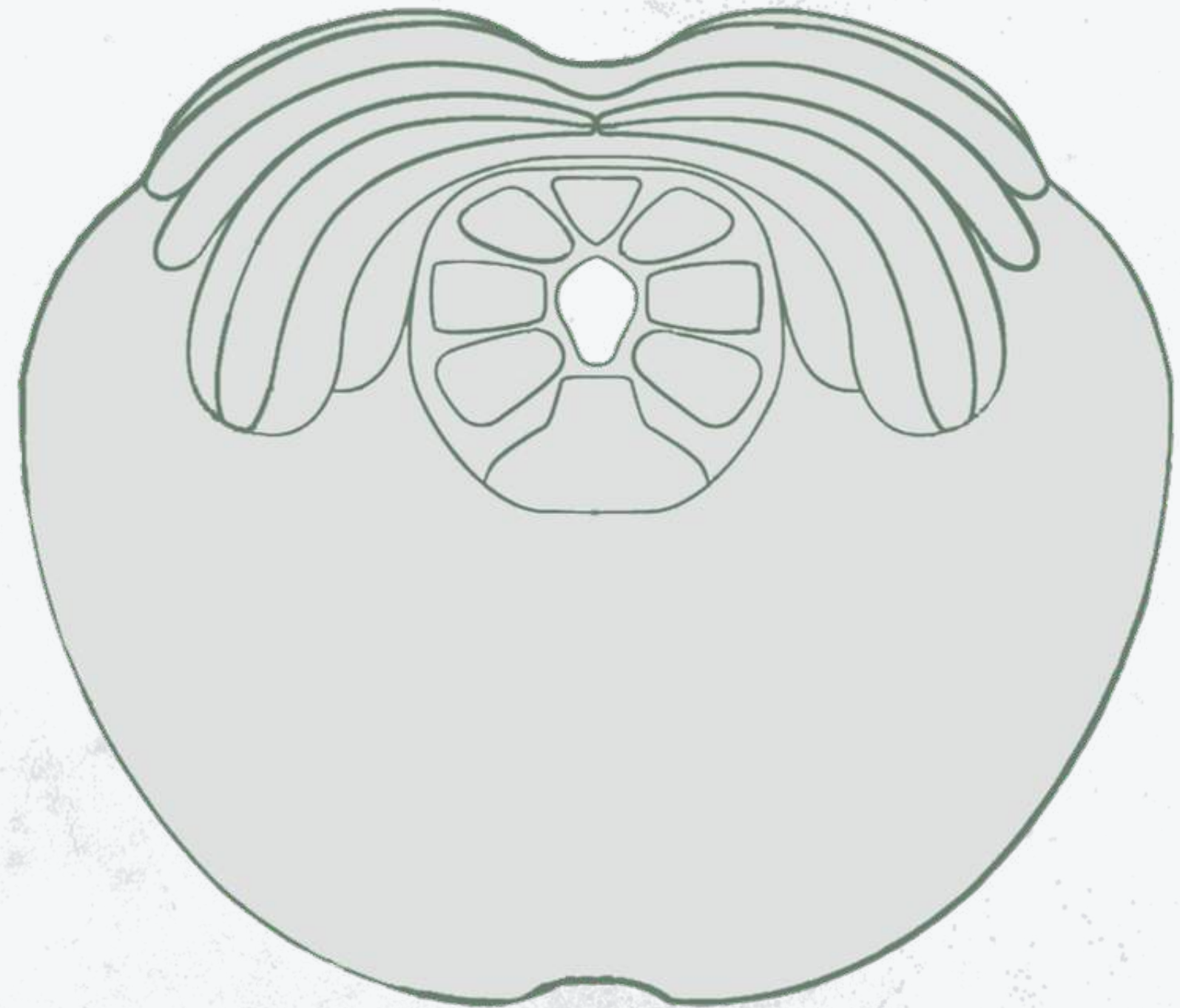
STRUCTURAL DISSOCIATION

PATHWAY TWO

PATHWAY 2: AFFECTIVE OVERWHELM

When PAG-driven affect becomes too intense and prolonged, the brain deploys neurochemical capping: endogenous opioids and cannabinoids that dampen the overwhelming activation.

This creates unprocessed emotional states: affect frozen in time rather than metabolized. These frozen states may be precursors to separate self-states.



STRUCTURAL DISSOCIATION

A disruption in the normally unified structure of the personality in which two or more distinct self-states develop, each holding separate memories, emotions, defensive responses, and a different relationship to the traumatic past.

Where as chemical dissociation is **the event**, structural dissociation is what happens when those events **accumulate and consolidate**.

An enduring organizational pattern

Reshapes the organization of the personality itself.

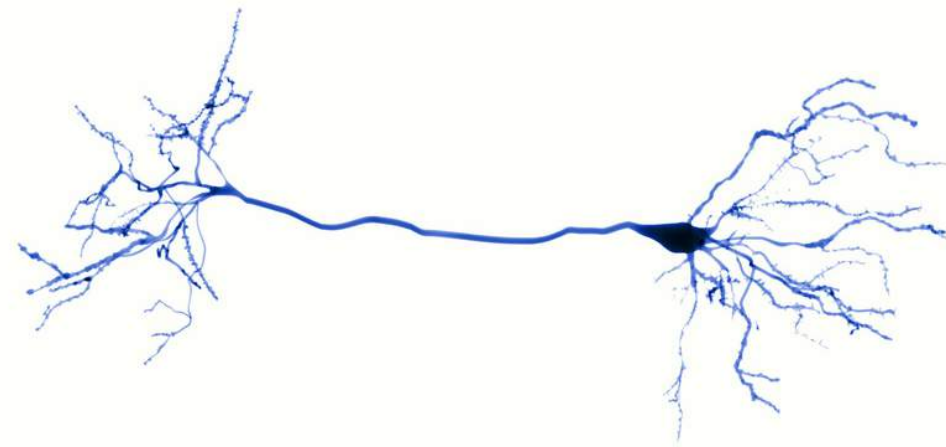
Distinct self-states

Rather than one continuous "I" moving through experience, the personality is divided into separate parts that each carry different memories, emotions, body responses, and beliefs



FROM CHEMICAL TO STRUCTURAL

How Chemical Dissociation Builds Structural Dissociation



The PAG drives an overwhelming affective or defensive response

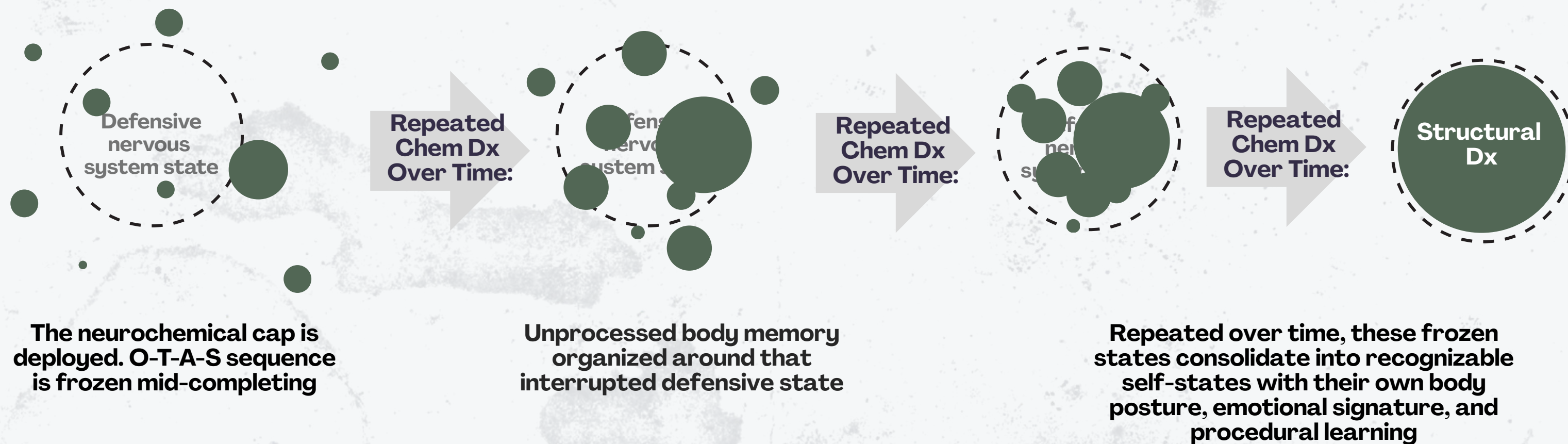
The neurochemical cap is deployed (opioids or cannabinoids) interrupt the activation

The processing is arrested. OTAS sequence is frozen mid-completing

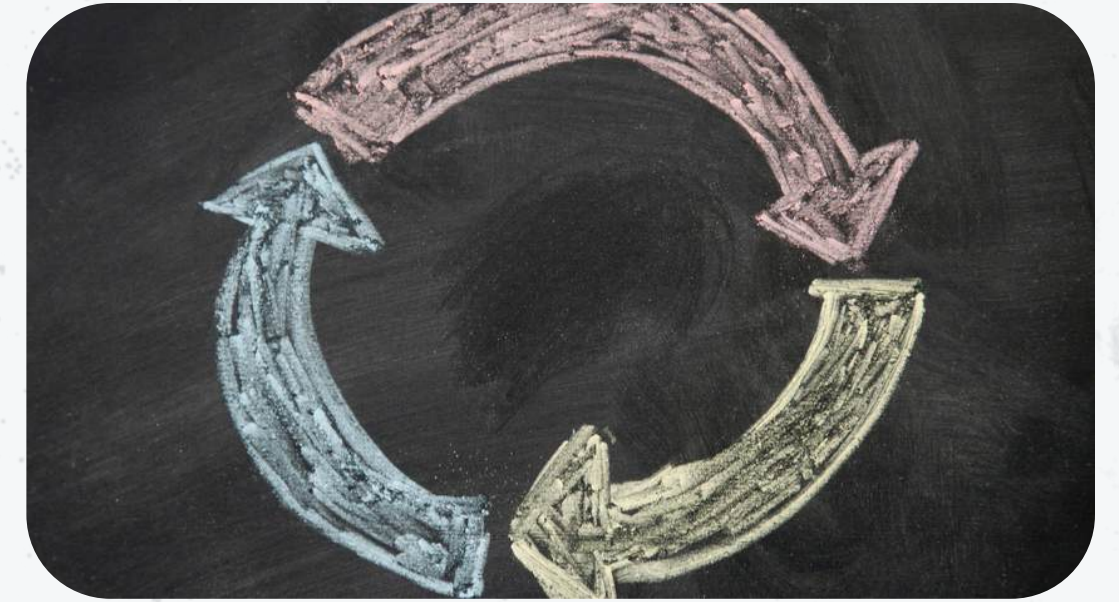
What is left behind is an unprocessed body memory organized around that interrupted defensive state

Repeated over time, these frozen states consolidate into recognizable self-states with their own body posture, emotional signature, and procedural learning

FROM CHEMICAL TO STRUCTURAL



A DISSOCIATIVE SYMPHONY



4) Window of tolerance collapses

Repeated activation of stress responses with no recovery result in a nervous system that is chronically primed for threat. The alarm threshold drops and is sensitized.

How Complex Trauma Builds Structural Dissociation

1) Repeated chemical Interruption of defensive responses.

Each time an overwhelming affective or defensive response was chemically capped (opioids or cannabinoids), a frozen "somatic" memory is left behind. Over years of repeated trauma, frozen states are accumulated.

2) O-T-A-S Loop

With chronic trauma, the OTAS sequence becomes a loop. Nervous system learns that certain stimuli predict danger. This creates an adaptive response during trauma, but becomes outdated across the lifespan.

3) SEEKING system goes negative

Mesolimbic dopamine system (drive, motivation) reorganizes around threat. Nucleus accumbens fear-generating zones expanding. "Wanting" begins to feel worse than "not wanting." "Approach" feels more dangerous than "withdrawal."



WORKING WITH **DISSOCIATION**

ASSESSMENT, MODALITIES, 3-PHASE APPROACH

ASSESSMENT

DISSOCIATIVE EXPERIENCES SCALE (DES-ID)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Select the number to show what percentage of the time this happens to you. (0% Never, 100% Always)

0% 10 20 30 40 50 60 70 80 90 100%

“HIGHWAY HYPNOSIS”

3. Some people have the experience of finding themselves in a place and have no idea how they got there. Select the number to show what percentage of the time this happens to you. (0% Never, 100% Always)

DISSOCIATIVE AMNESIA

6. Some people sometimes find that they are approached by people that they do not know, who call them by another name or insist that they have met them before. Select the number to show what percentage of the time this happens to you. (0% Never, 100% Always)

STRUCTURAL DISSOCIATION

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Select the number to show what percentage of the time this happens to you. (0% Never, 100% Always)

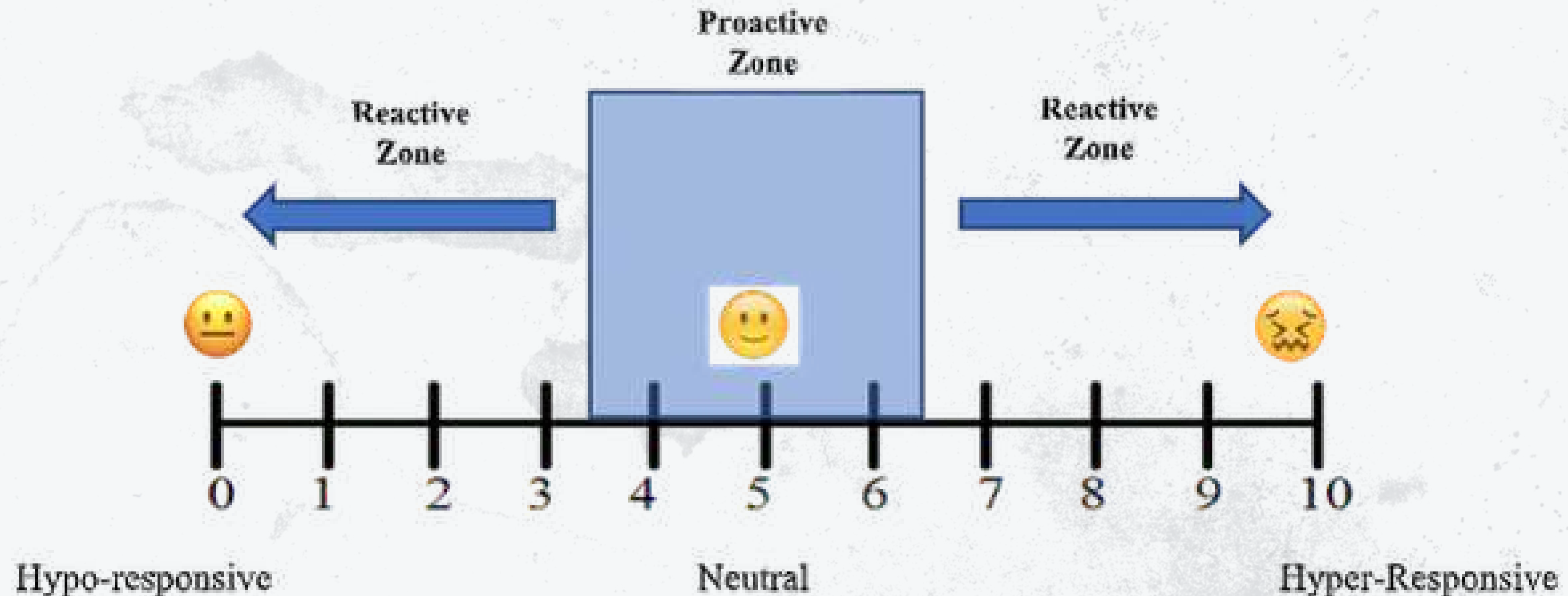
DEPERSONALIZATION

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Select the number to show what percentage of the time this happens to you. (0% Never, 100% Always)

DEREALIZATION

RESPONSIVENESS SCALE

The Responsiveness Scale is a 1–10 self-monitoring tool that tracks nervous system activation in real time — from severe hypoarousal and shutdown at the low end to crisis-level flooding at the high end — giving both client and therapist a shared clinical language for where the system currently is, which direction it needs to move, and which regulatory interventions are most likely to work right now.



A WORD ON MODALITIES...

RECOMMENDATIONS:

<u>Modality</u>	<u>Utility</u>
<u>DBT</u>	Stabilization (Tool Heavy)
<u>Sensorimotor Psychotherapy</u>	Stabilization (Somatic)
<u>Occupational Therapy</u>	Stabilization (Sensory System)
<u>EMDR & Brainspotting</u>	Processing & Tolerance Building, particularly for chemical dx
<u>Deep Brain Reorienting</u>	Processing & Tolerance Building

BE CAUTIOUS WITH:

<u>Modality</u>	<u>Caution:</u>
<u>Internal Family Systems (IFS)</u>	Dissociative Identity Disorder (DID)
<u>Mindfulness</u>	Can be triggering, worsen disconnection with body
<u>EMDR</u>	Without stabilization, above a 30 on DES-II
<u>Hypnosis</u>	Already utilized dissociative capacity
<u>Psychadelic-Assisted Psychotherapy</u>	"Ego death"

PRACTICAL STRATEGIES

SELF- REGULATION



Dissociation Can Be

SCARY

Clients

BORROW

Your Nervous
System

Remember, Resist

URGENCY

Put Your Mask On
First

The therapist's nervous system is an active clinical instrument. Settle your own body. Give yourself a moment to arrive.

Your nervous system is the container within which everything else becomes possible.

PRACTICAL STRATEGIES

THE COLLICULAR SELF

The superior colliculus and our vestibular system are the hub of spatial orientation. These systems allow our brains to orient to where the body is in relation to its environment. Corrigan calls the subjective experience of this the Collicular Self, or Where Self: the most basic layer of the self. Aware. Grounded. Present. Not yet organized into ego states or parts.

It lives below the level of the traumatized self-states. It is available regardless of which part is activated. It is the platform from which DBR processing occurs.



LET'S TRY IT



PRACTICAL STRATEGIES:
GROUNDING

WHAT IS CAND ISN'T GROUNDING

GROUNDING IS NOT RELAXATION

The Goal is not to calm our clients. If they're in a state of hypoarousal already, we don't want to down-regulate them.

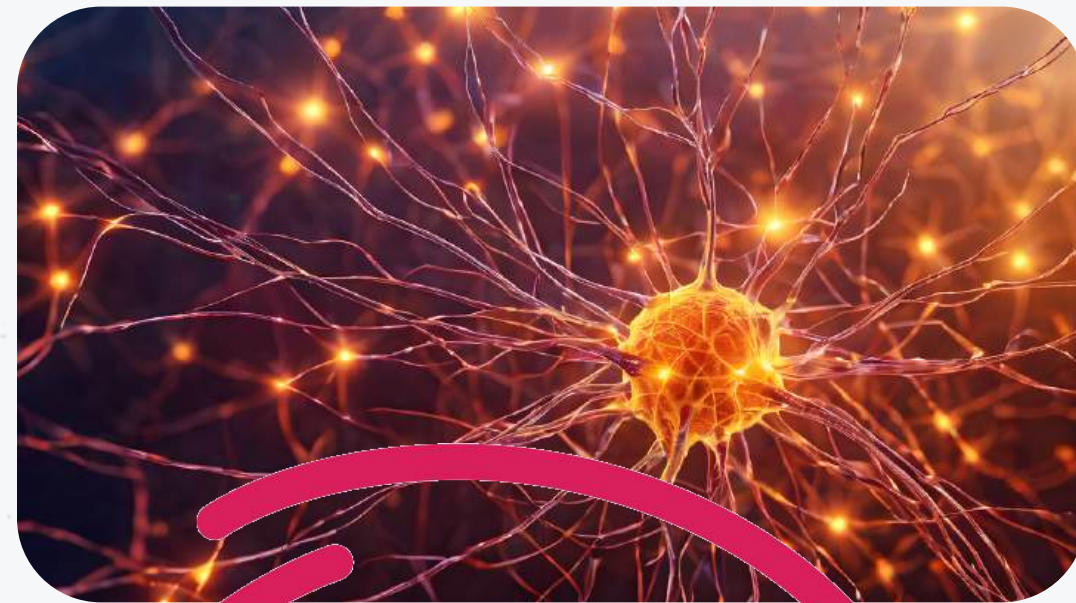
GROUNDING IS;

Orienting our clients more fully into their body. Sensory strategies are key. This may be down-regulating or up-regulating sensory input.



REMEMBER: O-T-A-S

If we're utilizing this model, we understand that dissociation is (at least in part) an "orient" problem. Client interrupted OTAS cycles have sensitized their alarm system over time. Through grounding, we're helping them "orient" to something else.



O — Orienting:

The SC detects a stimulus and organizes "orienting" action.

T — Tension:

Immediate orienting tension in the neck, face, around the eyes. Fleeting but detectable.

A — Affect:

The PAG generates fear, rage, grief, shame with their visceral and autonomic components that organize us for survival-related action.

S — Seeking:

The mesolimbic dopamine system adjusts valence (positive/seek or negative/avoid/retreat). Recalibrates its prediction about what is possible, what is safe to move toward, what is worth wanting.

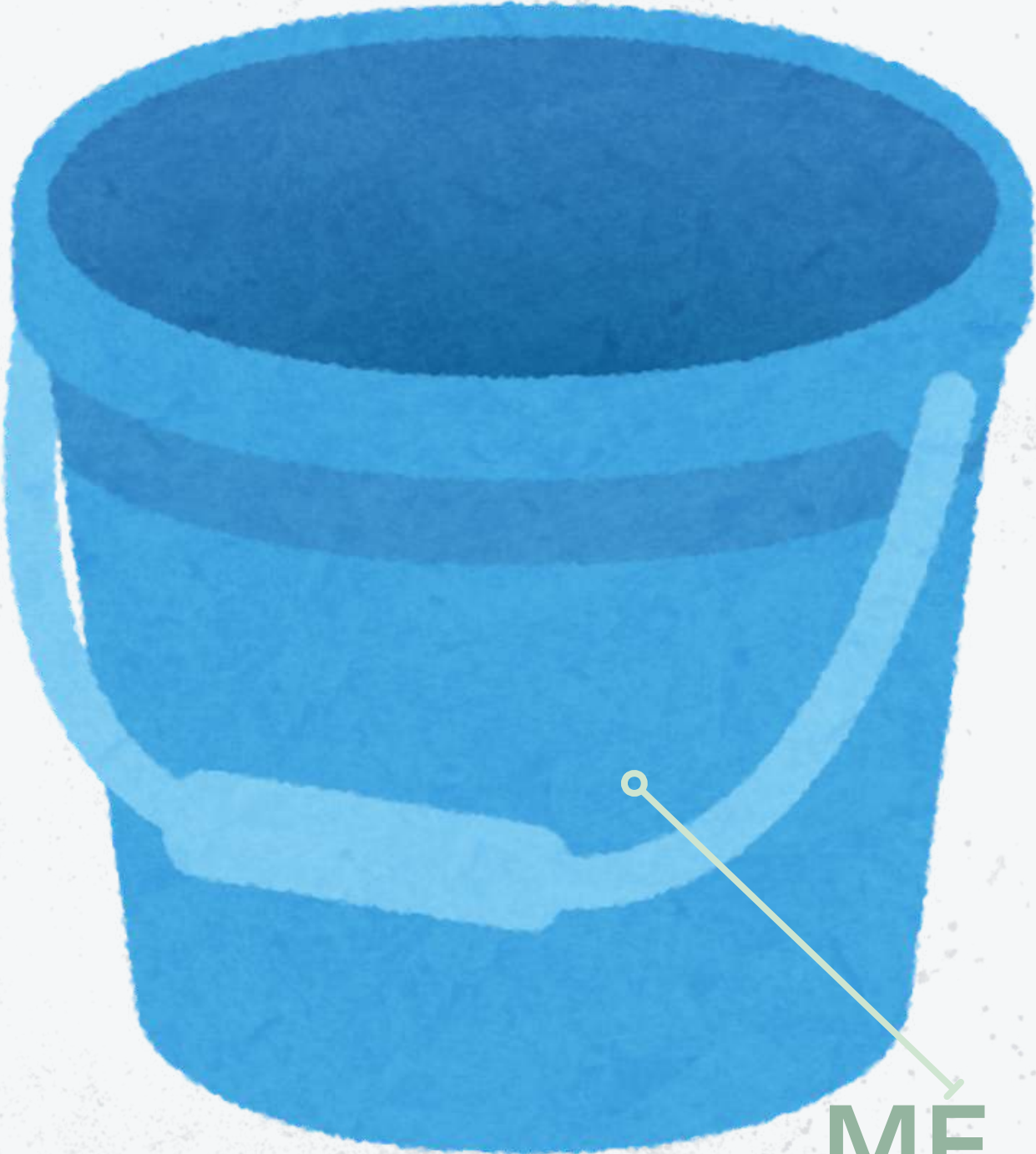
THE SENSORY SYSTEM



SKYE



TOM



ME, TBH



Up-Regulation

When we up-regulate our sensory system, we use stimulating and alerting sensory input.



REGULATING OUR SENSORY SYSTEM



Up-Regulation

When we up-regulate our sensory system, we use stimulating and alerting sensory input.



Down-Regulation

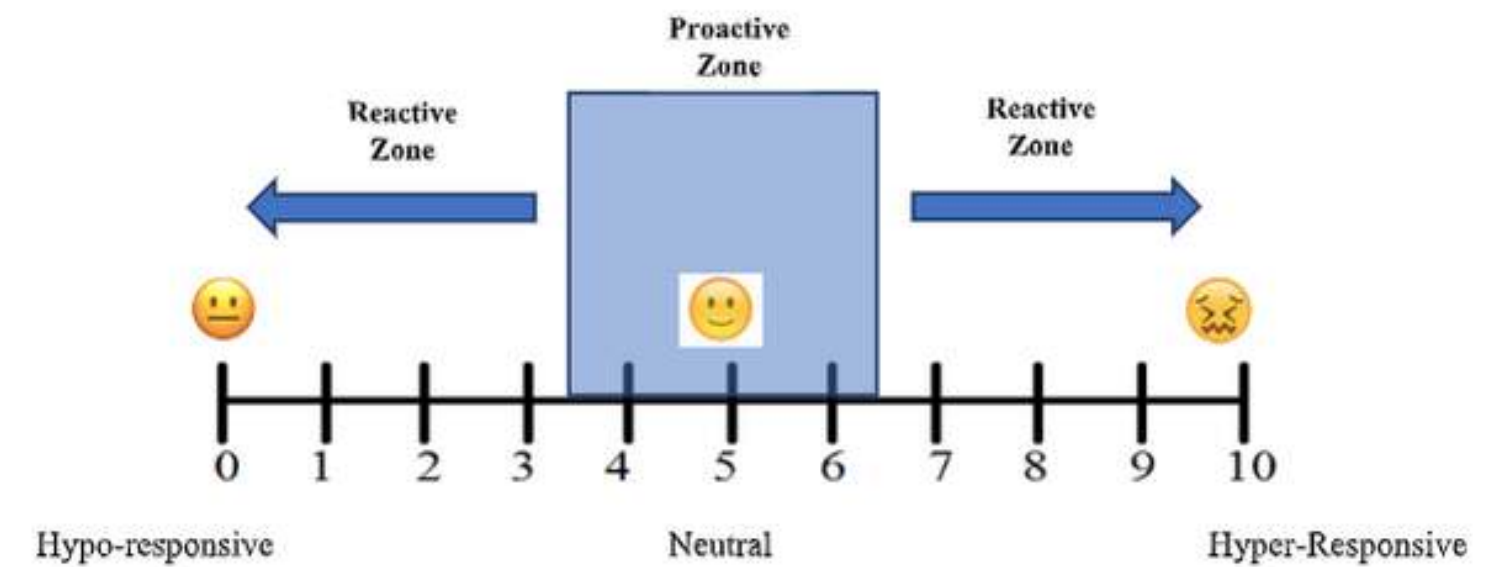
When we down-regulate our sensory system, we use calming and soothing sensory input.



REGULATING OUR SENSORY SYSTEM

PRACTICAL STRATEGIES

ASSESSMENT IN SESSION



Psychoeducation Ahead of Time

Orienting your client to your preferred scale (Responsiveness, somatic, etc) ahead of time is key. If a client is dissociated, new learning is difficult.

High-Arousal Dissociation

AKA “flooded”. The client may appear intensely activated, fragmented, or hyperarticulate, while simultaneously reporting feeling far away, on the ceiling, or like they are watching themselves from outside.

Low-Arousal Dissociation

Fight and Flight are impossible. The brain switches to its deepest shutdown protocol producing the flat affect, cognitive slowing, emotional numbing, and profound absence that looks like calm but is actually the nervous system's equivalent of playing dead.

“HIGH AROUSAL” DISSOCIATION

AKA “flooded”. The client may appear intensely activated, fragmented, or hyperarticulate, while simultaneously reporting feeling far away, on the ceiling, or like they are watching themselves from outside.

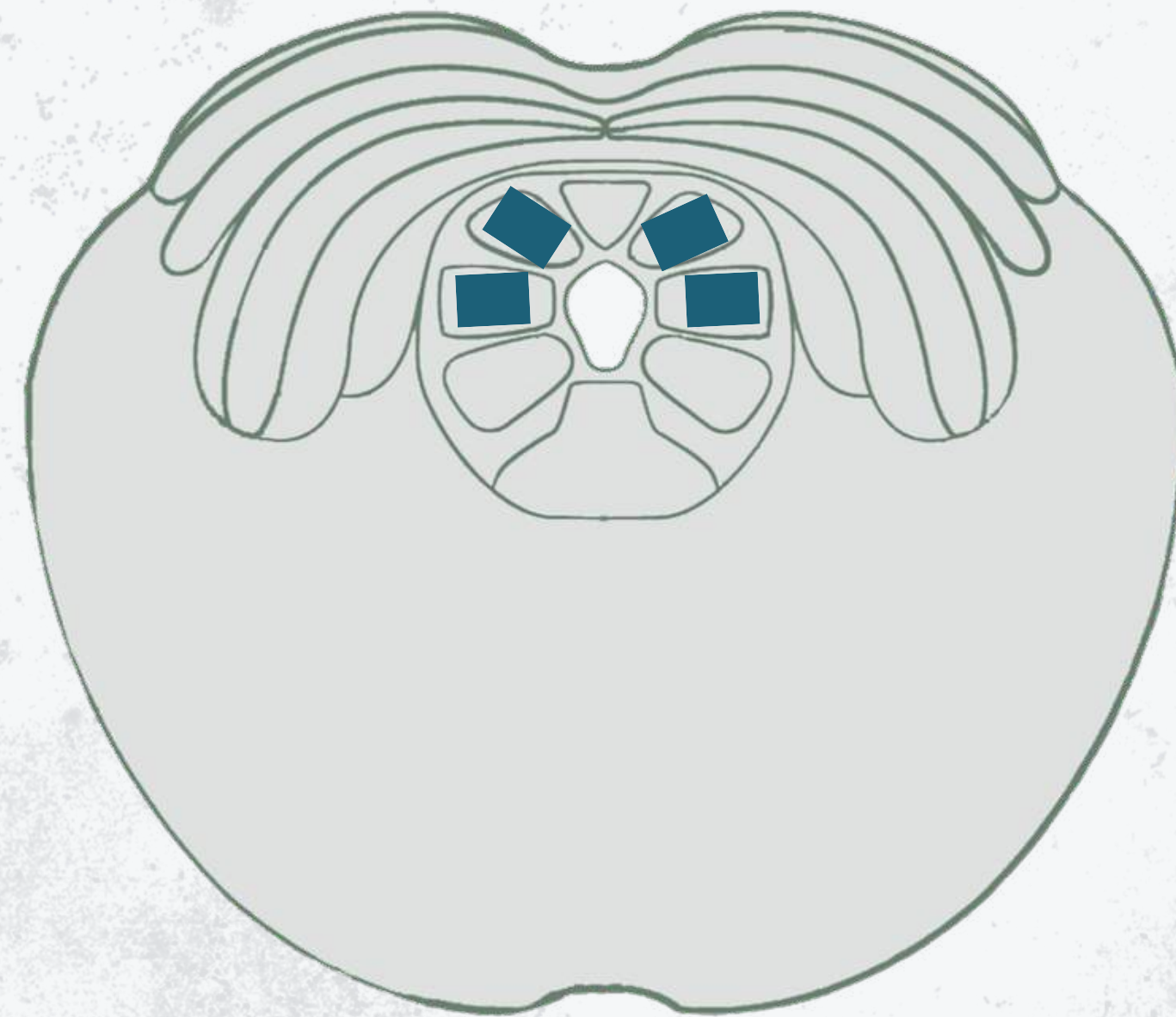
Vitals Are High

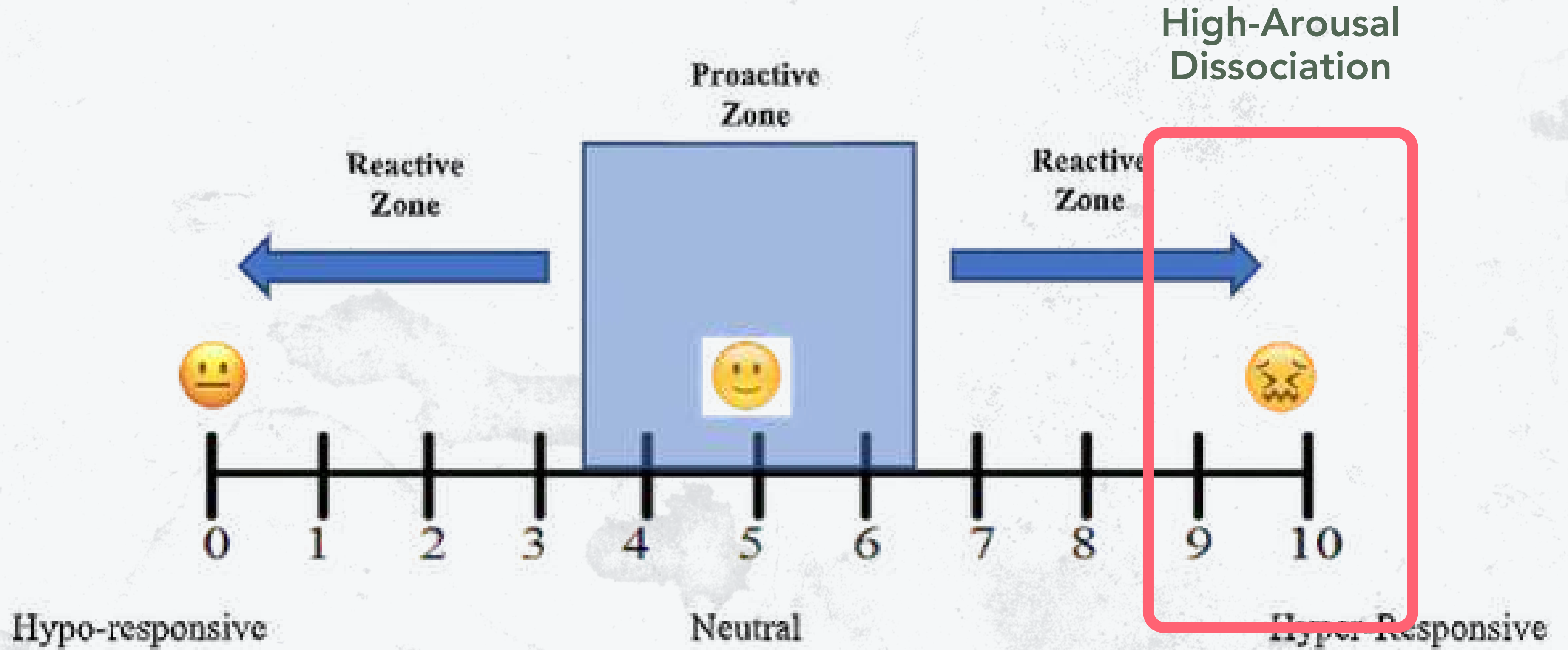
Increase in Muscle tension, increase in respiration, increase in blood pressure, etc

Conection to Body is Low

Feeling of “unreality” (depersonalization and/or derealization”. Difficulty or inability to name and identity body sensation, even if observatble from the outside.

**Dorsolateral/Lateral PAG → active defense: flight and fight
+
Chemical Dissociation**





PRACTICAL STRATEGIES

HIGH-AROUSAL DISSOCIATION



Proprioception

Focus on feet on the ground. Don't just notice. Push into the floor. Push into the wall with hands.

TIPP

Use cold water or ice to activate the dive response (lowering heart rate, body temp)
Focus on breath, extending exhale.

Lower Lights, Voice, Etc.

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

Slow, rhythmic sounds/music

Low music, without words.

“LOW AROUSAL” DISSOCIATION

Fight and Flight are impossible. The brain switches to its deepest shutdown protocol producing the flat affect, cognitive slowing, emotional numbing, and profound absence that looks like calm but is actually the nervous system's equivalent of playing dead.

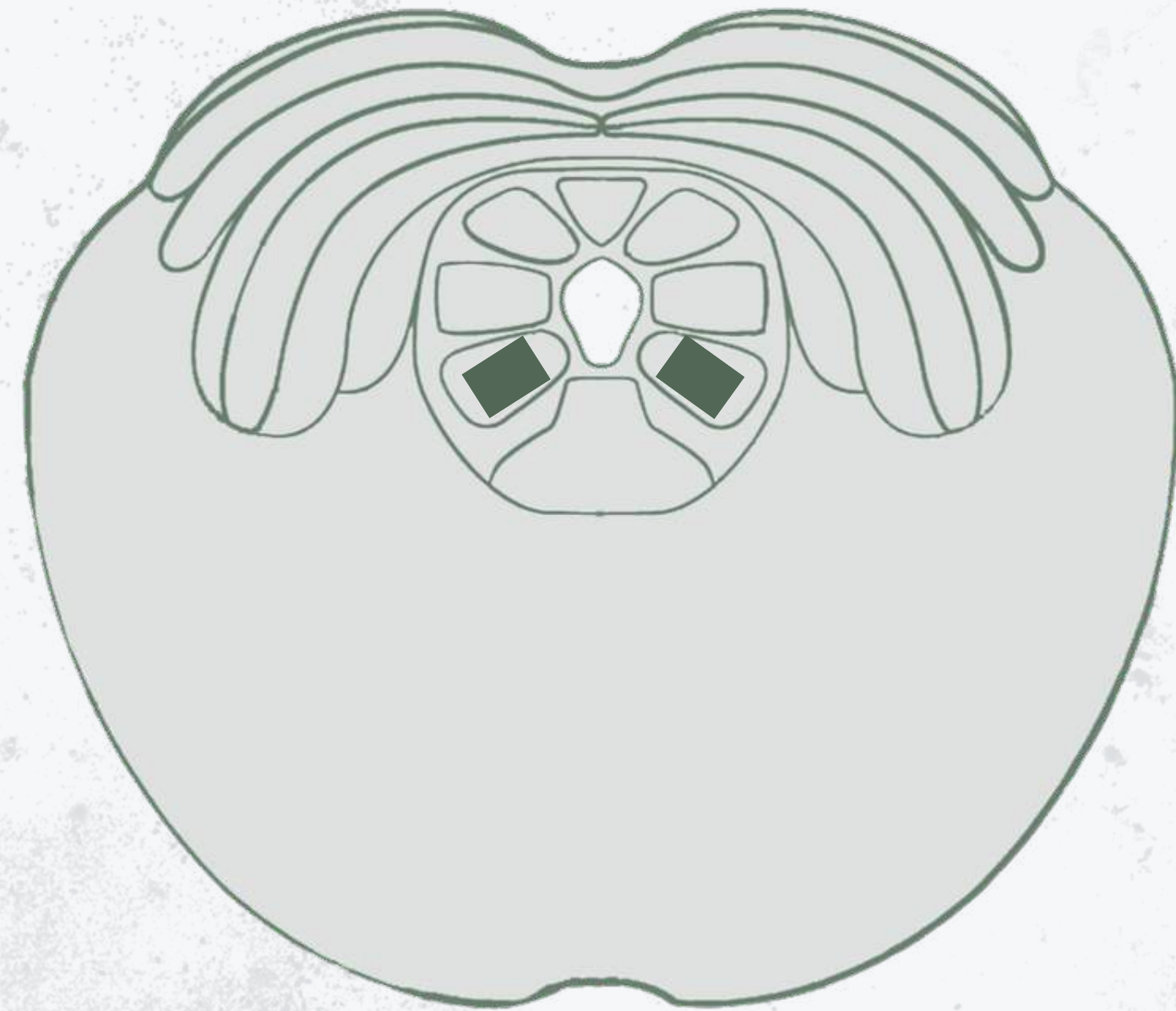
Vitals Drop

Flatter affect, slow responses, and a pervasive sense of heaviness are present.

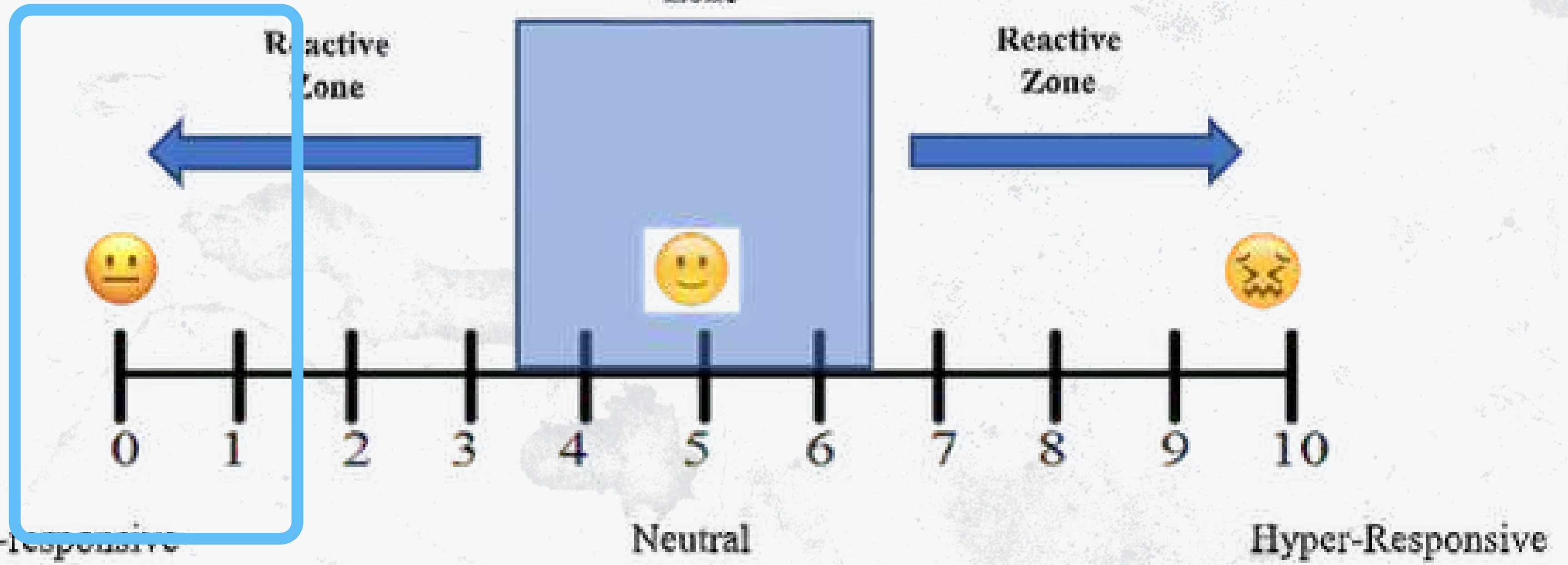
Slowing of Cognition

In high arousal states, clients may be able to “intellectualize”. In low arousal states, the mind slows as well as the body.

Ventrolateral → passive defense: collapsed
freeze, tonic immobility, opioid analgesia
+
Chemical Dissociation



Low-Arousal Dissociation



PRACTICAL STRATEGIES

LOW-AROUSAL DISSOCIATION

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.



Tactical Tools: Hedgehog Ring

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

TIPP

Cold water or ice for shocking sensory input.
Intense movement for a short burst (2-3 minutes).

Go Outside

Especially if the sun is out. Go for a short walk. Standing over sitting.

Pillow-Toss

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

PRACTICAL STRATEGIES

BI-LATERAL STIMULATION



Tactile: Butterfly Hug

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

Auditory: “Bilateral Beats”

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

Visual

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.



**A PATH TOWARDS
LONG-TERM RELIEF**

LONG TERM GUIDELINES



Remember: The Problem Wasn't Created In A Day

What fires together, wires together. Consistent, Predictable, Long-term intervention is key to lasting brain-level change.

Working With It In Session Is The First Step

New learning is not available in a dissociated state. Practicing strategies in session while regulated may not translate to between session dissociation.

Proximal Zone Of Development

First we regulated a client's nervous system for them...

Then with them...

Then coach self-regulation.

REVISITING SARAH:

6TH SESSION

Sarah arrives organized and composed. She wants to talk about a phone call with her mother — something her mother said about the family gathering in the fall, delivered in that particular tone. She begins well. Clear, specific, appropriately frustrated.

About four minutes in, something changes. Her sentences get longer. She moves from the specific incident to the broader pattern — her mother's use of indirect criticism, the function of conditional approval, attachment dynamics in her family of origin. She is more articulate than she was a moment ago. More fluent. More — somewhere else.

Her gaze is on you but not quite landing on you. Her breathing is shallow. Her hands have started moving in small, quick gestures that don't quite match what she is saying.

She stops mid-sentence.
"Sorry — what were we talking about?"

She is not being rhetorical.

Her color is slightly flushed. She is still holding her coffee cup. She has not taken a drink in several minutes and does not appear to know she is holding it. She looks at you and says: "I'm fine. I just lost my train of thought."

Discussion Questions:

1. The shift happened before she lost her train of thought. What was the first sign?
2. She says she is fine. She believes she is fine. What do you do with that?
3. What are your first two clinical moves: How are you assessing and what tools would you use first?

WHAT TO DO
MONDAY MORNING

YOUR FIRST 3 STEPS

1

REVIEW & SELECT AN ASSESSMENT

Use what works best for you and your clients. Then, introduce it to your clients. Practice, practice, practice.

2

INVEST IN SUPPORTS

Keep ice packs in your fridge, buy a pack of hedgehog rings, a bulk bag of sour candy.

3

CONTINUE TO LEARN

Advanced training on dissociation and trauma are readily available both in-person and online



THANK YOU

SO MUCH!

DAKOTA@FOUNDBETWEEN.COM

WWW.FOUNDBETWEEN.COM