

## **Integrative Therapeutic Interventions of Phase-Oriented Treatment: Additional Reflections on the Case of Lynn**

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*The case of “Lynn” (Stewart, Dadson, & Fallding, 2011) involved theoretical integration with regard to structural dissociation, mentalizing, and disorganized and unresolved attachment. Although the article explored integrative theoretical considerations with case examples, treatment modalities within sessions were not the central focus. Providing a follow-up to the case, this article describes the multimodal approaches and specific therapeutic interventions that were used during session hours, and how these operate within the three phases of treatment for structural dissociation. For example, the progression of a trauma-related issue for Lynn is described from a structural dissociation perspective. This issue is followed through three sessions, one from each phase of treatment, describing the integrative treatment interventions used to facilitate healing. Additionally, the case study provides a description of how the introduction of neurofeedback into the treatment plan drastically improved stabilization with regard to self-harming behaviors.*

*KEYWORDS attachment, complex PTSD, mentalizing, neurofeedback, tertiary structural dissociation*

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Clinical integration of the theoretical frameworks for attachment (Bowlby, 2008; Sroufe, Egeland, Carlson, & Collins, 2009), structural dissociation (van der Hart, Nijenhuis, & Steele, 2006), and mentalization (Fonagy, Gergely, Jurist, & Target, 2004) was presented through the case of “Lynn” (Stewart, Dadson, & Fallding, 2011), a client with a severe trauma history. Given the complexity of both the clinical descriptions and theoretical framework provided within the previous article, specific treatments or techniques used within sessions are not described in detail. It is the purpose of this article, therefore, to describe therapeutic approaches and techniques that fit into the larger integrative theoretical framework previously discussed, and the ways in which these have been applied in sessions with Lynn. It is our understanding that each of the therapeutic approaches described in this article has an underlying theoretical orientation that is similar or complementary to the integrative framework presented in our original case conceptualization. Included in these therapeutic approaches are specific mentalizing techniques (Bateman & Fonagy, 2006), expressive processing through sand tray therapy (Kalf, 2003), sensorimotor psychotherapy (Ogden, Minton, & Pain, 2006), observed and experiential integration (OEI; Bradshaw, Cook, & McDonald, 2011), and neurofeedback (Swingle, 2008).

## CASE AND TREATMENT HISTORY

Lynn is a middle-aged woman who works part time in a professional office environment and is married with three adult children. She was given up for adoption at birth and placed in foster care until she was 9 months old, at which time she was adopted into a family. The family had been deemed unfit for adoption until they went through a private adoption for Lynn’s older brother. Lynn describes her childhood as lonely and terrifying, including extreme neglect as well as severe sexual trauma (abuse bordering on torture) from several abusers, including her brother and a neighbor. When she disclosed the abuse as an adolescent, her parents chose to support her brother, sending her to foster care until she was an adult.

Lynn first sought treatment for an eating disorder through a government health agency. Her government mental health worker quickly recognized Lynn’s complex posttraumatic symptoms and referred her to a private therapy clinic for more intensive therapy than the resources of the government agency would allow. Within the private clinic, Lynn had weekly sessions with a primary therapist and a secondary cotherapist, who had specialized training in trauma-focused therapeutic interventions. (The rationale for having two therapists was covered in detail in Stewart et al., 2011.)

Lynn’s symptoms fit the criteria for dissociative identity disorder and both borderline and obsessive–compulsive personality disorders. Her adult attachment state of mind as assessed using the Adult Attachment Interview

(AAI; George, Kaplan, & Main, 1996) was found to be unresolved (the adult category for disorganized) and fearfully preoccupied with regard to trauma. Stabilization proved a difficult task with Lynn in the early months of treatment, despite concerted efforts from the treatment team to establish containment strategies. For example, Lynn would often collapse into traumatic enactments within the first few minutes of a session. Affect regulation was therefore established only after such enactments, which was less than ideal. Whereas the previous article (Stewart et al., 2011) focused on our underlying theoretical integration in Lynn's treatment, this article provides descriptions of integrative treatment modalities that proved effective in our work with Lynn within each of the three phases of treatment for complex trauma. This article builds on existing research on specific therapeutic techniques by providing a description of how various trauma therapy techniques have been integrated in clinical work. For the purposes of the case study, this article describes how sensorimotor psychotherapy, mentalizing-based treatment (MBT), OEI, sand tray interventions, and neurofeedback accomplished these aims.

## INTEGRATIVE PHASE-ORIENTED TREATMENT APPROACHES

Integrative treatment modalities require cohesive underlying theoretical models. As the foundation for our approach, we conceptualized Lynn's difficulties through the lens of structural dissociation theory (van der Hart et al., 2006), which incorporates concepts of attachment, trauma, and dissociation to describe complex intra- and interpersonal challenges that may emerge as a result. As described in our previous article, our working model integrated attachment and mentalizing theories as key aspects of the dissociative processes described in structural dissociation theory. For a more comprehensive description of how our integrative framework of structural dissociation, attachment, and mentalizing theory shaped our case conceptualization, please see our initial case study on Lynn (Stewart et al., 2011).

### Structural Dissociation Theory: Development and Treatment

In cases such as Lynn's, structural dissociation begins developing early in life: The loss of her mother, her shift into foster care during her first 9 months, an adoption into an unfit family, and pervasive sexual abuse would necessitate protective dissociative divisions within Lynn's developing self. Whereas foundational attachment theory perspectives would label these experiences as potentially disorganizing to the developing child (Hesse, 1999; Hesse & Main, 2000), structural dissociation theory holds disorganized attachment states of mind as organized dissociative parts of the self (van der Hart et al., 2006). Although this is not in opposition to Hesse and Main's (2000) work on

disorganized attachment, it provides a functional, clinical description of the underlying adaptive dissociative mechanisms. For example, a child whose parent is engaging in behavior that is frightening to the child develops two fully activated states: a part of the self that responds to the feeling of fear by seeking proximity with the attachment figure, and another part of the self that responds to the feeling of fear by trying to escape the frightening object. When the attachment figure is both the instinctual “safe” base and the source of fright, the child exhibits seemingly disorganized behaviors, such as reaching out to the parent while simultaneously backing away (Sroufe et al., 2009). Structural dissociation theorizes this to be two structurally organized, dissociated parts of the self engaging in disparate attachment strategies, setting the foundation for further dissociative divisions within the individual when faced with later or ongoing trauma (van der Hart et al., 2006). Such additional trauma throughout development could result in what structural dissociation theory refers to as apparently normal parts (ANPs) and emotional parts (EPs) of the self, with ANPs navigating day-to-day tasks and EPs holding trauma-related content such as memories and affect (van der Hart et al.).

The primary goals of treatment are to move the individual toward increased integration by processes of realization and presentification (Steele, 2009); that is, a holistic recognition that the trauma happened but is no longer happening. Presentification is the mental shift that occurs as the individual moves from a reexperiencing of traumatic events to a remembering of those past traumatic events. Realization occurs when the self recognizes that the trauma happened to all parts, not solely to the EPs that hold specific trauma-related material. As noted in our previous article, when Lynn’s adult ANP could recognize that the traumatic events happened to her, she was able to grieve and find resolution from specific memories.

### Treatment Modalities

Rigid, one-size-fits-all approaches to the treatment of trauma often do not work from one session to the next, let alone with one client to another. An integrative treatment approach can work within a variety of overarching theoretical models, and works adaptively with the client’s needs to thoroughly address trauma-related difficulties. Across all treatment modalities, Siegel (1999) and Ogden et al. (2006) emphasized the importance for traumatized clients to remain within the “window of tolerance,” the optimal range of regulated affect, without moving into paralyzing or stagnating hyper- or hypoarousal. Moving outside of the window of tolerance reactivates the action tendencies related to dissociative parts, rather than facilitating a foundational sense of safety in which integrative processes can occur. Therefore, along with promoting presentification and realization, a primary aim of therapy is to uphold and facilitate the regulation of internal states. It is our belief that these three aims are best achieved through a variety of therapeutic modalities used within a cohesive theoretical foundation.

## Sensorimotor Psychotherapy

Sensorimotor psychotherapy (Ogden et al., 2006) focuses on the somatic experience of trauma; that is, the posttraumatic symptoms and action systems manifested in the body. Through attunement with the client's non-verbal, embodied actions, processing of traumatic affect can take place on a different "level" neurologically, "reorganizing how the traumatic event has been encoded in the body and mind" (Fisher & Ogden, 2009, p. 318). Utilizing movement, clients are able to process layers associated with the three phases of treatment in an integrated format (mind and body; e.g., during Phase II work, completing an action they had been unable to make during their traumatic experience). Between sessions, we encouraged Lynn to mindfully move her body using preestablished somatic resourcing when she felt trapped, which aided in breaking the somatic reexperiencing by bringing the focus to her body in the present, drawing into her awareness that she was neither bound nor pinned by perpetrators.

## Mentalizing-Based Treatment

A healthy relationship between attachment figure and infant creates a natural rhythm of reflection between the child and caregiver, with the caregiver holding an understanding of the infant's mind in his or her own and reflecting it back to the infant in a way that is marked. This markedness aids the child in beginning to make sense of, and differentiating between, his or her own inner states from those of the caregiver. This process provides a neurological foundation for healthy affect regulation and social engagement (Schore, 2003).

MBT focuses on providing the reflective, marked attunement many individuals with complex trauma did not receive. The reflective stance of the therapist engages the client in the process of holding, organizing, and making sense of the mental states in self and others, including affect, cognition, and somatic experiencing. The therapeutic relationship is seen as reparative in its focus on regulation within the relationship. According to Bateman and Fonagy (2004), this allows the therapist and client to build understanding, while processing difficulties with trauma-based transference, psychic equivalence (i.e., that the client's reality is the only reality), and pretend mode (i.e., a stagnation in therapeutic progress taking form in dissociative faux processing in which internal and external realities remain separate).

## Observed and Experiential Integration

With complex trauma clients, the use of eye movement desensitization and reprocessing (EMDR) can be effective in reducing trauma-related symptoms, but might be overwhelming for some clients (Briere & Scott, 2006; EMDR Institute, 2004). A complementary therapy to EMDR that aids in additional

titration of intensity during treatment phases, including the first phase, is OEI (Bradshaw et al., 2011). OEI was developed to overcome particular barriers to using EMDR with highly traumatized clients. For example, when both eyes were unable to track the therapist's hand, fully covering one eye at a time not only aided in more effective tracking, but also revealed significant differences in levels of trauma-related transference with the therapist, as well as variations in perspectives on traumatic experiences (often presenting an ANP with one eye covered and an EP with the other; Bradshaw et al.). Alternately, "switching" (Bradshaw & Cook, 2008) from having one eye covered to the other facilitates an integration of the disparate affective states between parts of the self. This has been similarly observed by Schiffer (1997, 1998) in his use of covering one eye at a time to facilitate trauma processing and affective integration. Although various techniques have developed from such initial findings, the focus of this article is on transference work ("switching" while observing differences in perception of the therapist) and utilizing eye gaze for attachment-based trauma processing.

For our work with clients, including Lynn, we have also used one particular EMDR exercise known as the *butterfly hug* (Artigas & Ignacio, 2010). This technique was made available to the general public by Parnell (2008). The butterfly hug involves clients crossing their arms across their chests as though giving themselves a hug, and alternately tapping each hand at the pace of a slow, steady heartbeat. This exercise engages a client on several levels. First, the person "holding" himself or herself acts in a way that is physiologically containing. The bilateral stimulation (both through touch and sound) helps facilitate neurological regulation (Artigas & Ignacio, 2010). Additionally, it can be helpful to ask clients to mirror the therapist's own butterfly hug. The use of eye contact and mirroring of the therapist aids in engaging the attachment system of the client so that the self-soothing behaviors are experienced as not only restorative of affect regulation within the moment, but reparative within the wider context of their experiences with developmental trauma by learning ways to self-soothe. This aids in affect regulation, and the bilateral stimulation has been observed to help process neurologically "stuck" traumatic material. Throughout each phase of treatment, the butterfly hug aids in calming and stabilization.

## Neurofeedback

Neurotherapy, or neurofeedback, involves the use of quantitative electroencephalogram (qEEG) brain wave data and sensory forms of operant and classical conditioning to help regulate and normalize brain functioning to within optimal ranges (Swingle, 2008). Neurofeedback has been found to be helpful in treatment of affect regulation difficulties in individuals with histories of developmental trauma (Fisher, 2010), clients with dissociative disorders (Brownback & Mason, 1999), and survivors of torture

(Aroche, Tukelija, & Askovic, 2009). Although an in-depth description of neurotherapy is beyond the scope of this article, we should note that Lynn's neurofeedback treatment addressed affect regulation (around anger, agitation, and obsessive qualities) and trauma processing. Prior to beginning neurotherapy, Lynn had alpha wave signatures in the occipital area associated with trauma suppression (Swingle, 2008).

### Sand Tray Therapy

Sand tray therapy was developed as a method for working with Jungian dream analysis with children through symbolic figures (Kalff, 2003). The relatively nonverbal nature of sand tray processing has been effectively integrated with other forms of treatment (LeBel, 2009; Taylor, 2009; Turner, 2005), aiding in the emergence of unprocessed affect not otherwise accessible through verbal, cognitive, or conscious awareness. Kalff (2003) believed that sandplay allowed the individual to symbolically express what exists beneath conscious awareness. It is our belief that, in this way, the use of the symbolic within a safe, contained environment allows for greater right-brained expression of posttraumatic material.

## SESSION REVIEWS FOR EACH PHASE OF TREATMENT

Outlined next are detailed descriptions of integrative treatment modalities and how, within attuned therapeutic relationships, these interventions have effectively facilitated safety, trauma processing, and healing for Lynn. Each phase is described first in overall progress, followed with an account of a full treatment hour.

### Phase 1: Stabilization

One of the most challenging aspects of our work with Lynn was around stabilization. Despite efforts to work on containment strategies and overall affect regulation, Lynn would often collapse into traumatic enactments within the first few minutes of the session so that any stabilization work was being done following enactments (which was, for obvious reasons, not effective for long-term stabilization). Additionally, as noted in the previous article, Lynn engaged in a variety of self-harming behaviors, and had extreme levels of suicidality. At the time of the last article, Lynn's self-harming behaviors had decreased from multiple times daily to an average of once per day; her suicide attempts had decreased from weekly to once or twice per month on average. This was one of the most concerning areas for stabilization, yet strategies around containment, titration of traumatic intensity, and increasing affect regulation had limited results.

## CONTRIBUTIONS OF NEUROFEEDBACK

Since the writing of the previous article, Lynn's therapists referred her to a local clinic for neurofeedback sessions with her secondary cotherapist in attendance to assist with calming and grounding throughout each session. After the first two sessions, Lynn made a quasi-suicide attempt, but has not made any additional attempts since that time (currently more than two years). Her self-harming behaviors reduced immediately to once every several months, with an observable decrease in severity of harming behavior. Lynn reported that the neurofeedback made self-injury too painful, indicating marked decreases in levels of analgesic dissociation. Moreover, as a treatment team, we noted a significant increase in ability to regulate affect, and enactments rarely occurred in session after the initial neurofeedback sessions. Lynn, who had previously had regular contact with the brother who abused her, made the decision to cease contact with him. Each of these changes has remained stable following the five months of neurofeedback treatment.

## WITHIN THE TREATMENT HOUR

This session hour was different than most, in that it was a one-on-one session between Lynn and the secondary cotherapist on her treatment team (due to her primary therapist being away). To help make sense of the following sessions, it is important to note that the secondary cotherapist is female. For the session description, the secondary cotherapist refers to herself in the first person.

This particular session began with Lynn describing that she had been having an increase in bad dreams consisting of dangerous, shadowy figures in the left periphery of her visual field, and a sense of being in peril but never quite able to see who the figures were. As Lynn described the dreams, she noted, "I think the figures are men." I observed with Lynn that, while she described the dream, she was running her hands down her lap in a pushing motion. When Lynn was asked to notice this movement, she stated quietly, "It's like I'm pushing them off." Together, we noticed her body become increasingly tense as she reflected on the pushing motion, and together we tried to see if exaggerating the pushing movement would bring some release. Because her anxiety continued to escalate, I asked Lynn to find where she held the anxiety and tension in her body. After stating it was "everywhere," she was able to feel that the intensity was strongest in her chest. To help prevent Lynn from moving outside of the window of tolerance (Siegel, 1999), I suggested she do the EMDR "butterfly hug" (Artigas & Ignacio, 2010) as a previously established somatic resource. I modeled the hug for her and asked Lynn, who often has difficulty with coordinating the alternating beats, to focus on my rhythm. Lynn was instructed to tap firmly enough that it

was audible, thus engaging in dual sensory processing. As Lynn tapped, she maintained eye contact with me, while I held my gaze with a calm expression. When Lynn becomes anxious, it is common for her eyes to lose focus easily; I would softly and consistently remind her to “find me” whenever her gaze would wander and she visibly calmed each time she reconnected with my gaze.

Once Lynn felt more settled, I suggested we work with the sand tray. I had often used the sand tray to help clients process trauma-related affects underlying persistent dream material in a way that was more contained and regulated than dreaming itself. We chose to have all of the sand tray figures in one box to aid in a more spontaneous, nonverbal experience of connecting with the objects while also aiding in affect regulation for clients such as Lynn by promoting movement and agency in digging and sorting items.

As Lynn worked in the sand tray, due to increased integration both her adult ANP and a protector child EP were both present throughout the process. First, Lynn began by picking out every single human figure from the box and burying them in the corner furthest from her. She then placed fierce dragons on top of the buried people and a cave in the corner closest to herself. Behind the cave was a baby lamb. Lastly, between the buried people and the lamb, she placed a line of protective animals: tigers, elephants, and lions.

Once Lynn’s sand tray was completed, I asked her what she noticed. Speaking increasingly as the protector child EP, Lynn described that all of the people were buried because “people aren’t safe . . . they will say they’re safe but they aren’t . . . people will hurt you, people trick you, you can’t trust anyone.” The dragons were considered protection (“even though people think they are scary, they aren’t, they’ll keep me safe”) and the animals as connection (“animals are nice, they are safe and will protect you and don’t hurt anyone”), but even with these defenses, she still felt the need to hide behind the cave from the people. The following is our conversation (this particular session was videotaped, thus the transcript is verbatim):

- Lynn:* The bad’s buried so they can’t get you.  
*Therapist:* Who is there? (Motioning to the buried human figures.)  
*L:* Everybody.  
*T:* Everybody.  
*L:* People, you can’t trust them. Everybody’s there. You have to hide away.  
*T:* That must be a very big unsafe feeling.  
*L:* That tray makes me feel the, the mad inside feels bigger. I wanna take those people and just smash them and tear them up and throw them in the garbage. I wanna make them go away.

- T:* It sounds like maybe you want them to go away so you can feel safe?
- L:* You can never be sure, there could be someone you missed or someone is there that you forgot about or didn't know about so you need to make sure that you're safe—
- T:* Can you look at me? Can you find me? Good. It sounds like that's a really big unsafe feeling, no wonder you have the mad, it sounds like the mad protected you.
- L:* Don't like the mad, the mad is bad (begins to state this phrase repetitively).
- T:* Why is the mad bad? Can you look at me?
- L:* Okay. Cuz you're not allowed to be mad. Mad is bad, you're evil and you're sinning if you're mad [. . .] You can only be mad at you [. . .] because you sin all the time because you're bad, but you can't be mad at the other—because it's wrong to be mad.
- T:* You feel like you're not even allowed to feel that way—
- L:* That's why then you get mad at yourself because you feel [. . .] angry, but then you're not allowed to feel angry at other people so then it's okay to be mad at yourself.
- T:* So you feel all of that mad feeling, but then you turn it on yourself.
- L:* That's why you just rip yourself apart and tear yourself up into pieces.
- T:* And what you were saying a minute ago is that you wanted to rip *them* apart and tear *them* to pieces.
- L:* But you can't, you aren't allowed, that's why it makes me mad.
- T:* And how do you think I'm feeling when I hear you talk about feeling mad at them? How do you think I feel?
- L:* I don't want you to feel bad because you're not in that mad, you're not there.
- T:* Sounds like you feel worried I might feel hurt.
- L:* Yeah, but you're not in there, you're not in there, you're not in there.
- T:* But do you want to know what I was thinking when you were talking about the mad?
- L:* Okay.
- T:* I was thinking that's a really important feeling and that's a really okay feeling, it's understandable—can you stay with me? (Okay.) When I say that, what's coming up for you?
- L:* I don't like that. I don't like that because it's bad to be mad.

This dialogue exemplifies the concept of the “alien self” (Bateman & Fonagy, 2004); that is, internalization of both the inaccurate reflections from, and aspects of, the perpetrator. Within the sand tray, Lynn was beginning to

separate aspects of her own anger from the “alien” anger of her perpetrators that she had internalized. When she began to experience increased emotional intensity, however, she collapsed back into redirecting the anger toward herself. In this collapse, she was unable to tolerate not only her own earlier perspective (“I wanna . . . smash them and tear them up”) but also my perspective, overriding the marked expression of my own thoughts and feelings of acceptance toward her anger. Because of the destructiveness of the anger of others throughout her childhood, Lynn felt unable to separate her own anger from a sense of destruction. In that, she may have felt the need to protect me from her feelings of anger, rather than feeling able to express her feelings of lack of safety or anger within our relationship that legitimately arise when working with complex posttraumatic issues. As building toward effective mentalizing capacity is an ongoing process, the remainder of this session involved calming and grounding utilizing the butterfly hug and attunement using OEI eye gaze techniques.

Just as stabilization is foundational for working toward effective trauma processing, learning to mentalize within a relationship is necessary before one can mentalize a traumatic experience. Holding Lynn’s anger in a way that is marked (calm, accepting, and differentiated) has helped to build the foundation of safety and relational, as well as internal, growth.

## Phase II: Trauma Processing

Rather than a shift away from Phase I (stabilization), Phase II utilizes the foundational elements established within Phase I to aid in effective trauma processing. Having a sense of safety in the present is an inherent quality to the goal of presentification: One is no longer in the same dysfunctional, traumatic space.

### CONTRIBUTIONS OF NEUROFEEDBACK

Following the significant stabilization achieved through neurofeedback treatments, Lynn began to experience the emergence of additional traumatic memories. At first, it began with Lynn perceiving the neurofeedback treatment office as “really bright” during her session, accompanied by a strong sense of agitation. The secondary cotherapist would use calming and containment strategies to help Lynn stay within the window of tolerance. After one particularly difficult neurofeedback session, in which an agitated Lynn continued to perceive everything as being extremely bright, she arrived to our session in her adult ANP state of mind. As noted in the previous article (Stewart et al., 2011), Lynn’s processing of traumatic memories normally progressed through her system of parts, until she was able to grieve as the adult ANP and stabilize within realization and presentification.

This time, however, the adult ANP began to describe the memory that was emerging. At first, she identified that the brightness was from a light. With great horror, Lynn connected that it was a camera. With her therapists sitting on either side of her for safety and containment, Lynn moved quickly into processing her grief around this specific memory, recalling in a presentified format that her neighbor who had abused her since the age of 3 had enlisted three men to use his home to sexually torture Lynn and to capture the process for further exploitation through child pornography. Based on her descriptions, it is our belief that nearly all of the sexual abuse Lynn experienced throughout her childhood was organized.

Through later sessions processing these memories (the abuse happened on multiple occasions from ages 5 to approximately 16 years of age), child EPs were able to work through the aspects of the traumatic memories they each held, but in a significantly more integrated manner. We attribute much of the rapidity of Lynn's increased integration, specifically full coconsciousness, cohesion within Lynn's system, and the merging of certain child and adult EPs with an adult ANP, to the neurofeedback treatment.

#### WITHIN THE TREATMENT HOUR

Lynn arrived to this particular session reporting that she was feeling upset due to a nightmare she had had. Although she was distressed by the dream, when asked by her primary therapist, Lynn noted she did not think she could find the words, and that to attempt to describe her dream would be too overwhelming. Her primary therapist asked if Lynn might find the sand tray an easier way to convey her dream to us and Lynn agreed. Building the scene was clearly emotional for Lynn, yet the sand tray allowed her to begin to process in a way that was contained. Once the tray was completed, Lynn began to describe her dream, starting with her being trapped in an alleyway, threatened by three women. She was able to escape, but the menacing women followed her to the opposite side of the scene, and within a crowd of oblivious people going about their day, the women cornered Lynn and raped her. Her primary therapist asked if the dream reflected actual experiences in Lynn's life. Lynn nodded and cried softly, noting, "I didn't think I would ever tell anyone about that." This is in marked contrast to the traumatic enactments Lynn experienced for months, even years, when previous trauma memories had emerged.

Viewing this particular dream as a possible continuation of the one described in the previous session (i.e., the Phase I section of this article), we began to process her feelings of being trapped and unsafe. (Again, for ease of reading, the secondary cotherapist refers to herself in the first person.) Because Lynn often described her left periphery as holding the greatest intensity (triggering a sense of danger and hypervigilance), as a safe, female figure in Lynn's life, I stood at a distance directly in front of Lynn. Lynn

felt she was not ready to make eye contact for full OEI processing, so we adapted by using voice. Using a calm, soothing tone, I slowly moved toward the left periphery. Lynn identified the place where she had been experiencing the “shadowy figures.” I asked Lynn to notice any changes in her perception of me. When I shifted into that space and began to speak, Lynn’s left arm raised in a defensive posture and she became visibly anxious. Reminding her that the primary therapist was sitting right in front of her, I asked if she would open her eyes to look at him, to feel anchored in the safety of his presence. Lynn opened her eyes, looking at her primary therapist, and visibly calmed. The primary therapist asked Lynn to reflect on her upraised arm. Together, they observed that her arm was positioned similarly to times when working through memories of being tied or pinned by abusers. Pushing her arm out, as though breaking free from restraint, brought relief of the physical agitation Lynn had described.

The primary therapist asked Lynn to again direct her attention back to me as I stood in the area where Lynn experienced the distressing sensations. Lynn began to become more emotionally activated and dysregulated. We then redirected Lynn to alternate her attention between her sense of fear and lack of safety with her sense of calm, safety, and security she felt with the therapist who sat directly in front of her. Lynn’s anxiety soon dissipated and she described feeling more settled. I moved back to where I had been seated beside her at the beginning of the session.

The primary therapist asked Lynn to reflect on how she was feeling. At this point, the focus of therapy shifted from an intrusive, hyperaroused state toward her preoccupied state of mind with regard to attachment. As her sense of security with regard to her connection with the primary therapist became fleeting and unreal to Lynn, she expressed how painful it was for her that all of the relationships that she holds important always seem so far away. She described the doubt she felt toward her experience of security within her therapeutic relationships, because she was unable to hold it. After exploring this through conversation, with Lynn’s permission I (the secondary cotherapist) stood in front of her and alternated my gaze from her left eye to her right. Lynn observed that she experienced more intensity when I was gazing at her right eye. Because Lynn’s affect regulation seemed to remain within her window of tolerance, I took a step forward and Lynn flinched, reporting that I felt too close. I took a step back and Lynn relaxed. I then took another step backward, and Lynn, distressed, said I felt too far away. I took a step back toward her, within the previously “neutral” area, and Lynn developed a confused expression. I asked what she was noticing, and Lynn confirmed that she felt confused. I asked if I seemed too close, and she said, “Yes, but you also seem too far away at the same time.”

Holding both states simultaneously signaled a step toward integrating (or mentalizing) her state of mind with regard to attachment. This has proven helpful in future instances in which Lynn experienced simultaneous but

unmentalized safe–not safe states of mind, in that we are able to remind her that sometimes we, as people who care about her and are connected with her, seem simultaneously too close and too far. With tears, Lynn began to express the grief she felt at never experiencing herself or the world around her as safe or “okay.” As she calmed, we asked Lynn what she felt we might be thinking or feeling toward her. Lynn described feeling immediately embarrassed and that we must think that she should be “over this by now” and “just get over it.” We both took turns reflecting our supportive stance, disclosing feelings of compassion, and that we felt honored to participate in a healing moment. When the primary therapist asked how Lynn perceived our responses, she noted how alone she felt growing up, crying into her pillow at night while telling herself to be quiet or she would face punishment. This description from Lynn reflects the achievement of presentification, that Lynn could observe that crying with us felt different and secure. To help reinforce the sense of security, we asked Lynn to use the butterfly hug and she did so, calmly mirroring her primary therapist.

Maintaining therapeutic attunement with Lynn allowed us to adapt and integrate treatment strategies from several modalities to facilitate processing of difficult trauma memories. Neurofeedback aided Lynn in the process of realization by increasing overall internal integration. Lynn’s therapists worked with her using integrative treatment to move toward both greater affect and systemic regulation, as well as presentification.

### Phase III: Integration

Phase III has become a major focus in our therapeutic relationships with Lynn, with a significant increase in overall integration, new pursuits and goals with regard to Lynn’s career, and a strong emergence of phobias regarding normal living.

With increased integration, Lynn and her government health care worker found a program that would fund her return to school to work toward a new professional direction. Lynn worked hard, achieved top grades, and was hired in a part-time position. Simultaneously, Lynn also returned to eating-disordered behaviors that had been her initial reason for seeking treatment years earlier. The more empowered Lynn became in her life decisions, the more she seemed to become tangled in expressions of feeling powerless. This exemplifies the phobia of normal living and Lynn’s continued desire to have someone take care of her, the way she needed as a child, rather than fully embracing the ever-increasing ability to care for herself.

As a treatment team, we observed an increase in Lynn’s emphasis on being “ill” despite remarkable evidence toward increases in overall health and functionality. It is noteworthy, however, that Lynn felt she had never experienced connection or caring within relationships until she began

therapy; she may consider severe illness as being the way to maintain these connections and has described feeling frightened that the security she feels within these connections will be removed before she feels ready.

As Lynn became more integrated, the features of borderline personality disorder that she had always had to some degree intensified. This is unsurprising given that Lynn had previously had parts with strong borderline features. Once integrated, difficulties previously connected with a specific part became more diffuse and more consistent within Lynn's system. We conceptualize this as an EP shifting from a dissociative alter to a trauma-related affective state pervasive within Lynn as a cohesive self-state. This resulted in a transitory stage in which there is much movement between Phase I and III with regard to the therapeutic relationships. For example, Lynn had engaged much more vocally and consistently in idealizing and "rewriting" our past therapeutic interactions (with the primary and secondary therapists as idealized caregivers), with an overt emphasis on Lynn's current feelings of helplessness. Although we set consistent boundaries with Lynn, she had increasingly attempted to alter the course of therapy toward her fantasy of the idealized caregiver, having had secondary care-giving professionals (e.g., minister, chiropractor) contact us suggesting we should change those boundaries due to Lynn's "levels of distress." Unfortunately, during our actual session hours, Lynn would rarely express this distress, reestablishing a sense of familiar helplessness while increasingly attempting to put us in the roles of her adoptive parents.

We continued to process Lynn's fear of grief and loss, differentiating between idealization and what we see as our significant yet limited roles in Lynn's life. When we reasserted our actual roles as therapists, Lynn noted that she felt terrified of (a) losing us if she "gets better," (b) the level of grief over never having the family she longed for throughout childhood, and (c) failing at any goals around "normal living" she might set. It is not surprising that the order in which she often presented these fears also reflects the three phases of treatment.

#### CONTRIBUTIONS OF NEUROFEEDBACK

As mentioned, neurofeedback seemed to increase Lynn's internal integration of ANPs and EPs, particularly with regard to amnesic dissociative divisions. Based on reports from the psychologist supervising her neurofeedback sessions, Lynn no longer had the alpha brain wave signatures in the occipital region associated with amnesic trauma memories (Swingle, 2008). This corresponds with the shift we observed within our sessions with Lynn. Additionally, Lynn's AAI indicates that her attachment traumas related to her adoptive parents remain unresolved. These are the only traumas scored as unresolved in Lynn's recent AAI. At this point in treatment, Lynn would be

considered to have secondary structural dissociation due, in large part, to the increased stabilization and integration that neurofeedback helped achieve.<sup>1</sup>

#### WITHIN THE TREATMENT HOUR

Following the processing of Lynn's traumatic experiences with female abusers, we seemed to enter Phase III in a new way. As described earlier, when Lynn began to enter into this third phase of treatment, she became more acutely aware of her present attachment relationships. Due to its focus on attachment-related difficulties such as transference and difficulties with differentiation, MBT featured more prominently in this new phase. Lynn began having more difficulties with her therapeutic relationships, especially with fear of loss. This fear manifested in her relationship with her therapists as well as with other caregivers, including friends, her government mental health worker, her psychiatrist, and her chiropractor.

During one session, Lynn began to describe her longing for greater degrees of security, noting her fears of loss and her desire for a permanent attachment with an idealized figure. She looked at the secondary cotherapist, saying, "I feel like we were really close and now you've just disappeared!" The primary therapist asked Lynn if she felt the secondary cotherapist with her in the room as she spoke and Lynn became anxious, rocking back and forth in her chair. The secondary cotherapist reflected, "I imagine that would be really scary and lonely to feel like I'm not even here with you right now." Lynn nodded and her rocking slowed. "When you mention that I just disappear and how scary that is, it makes me think that feeling comes from a very young place. You had a lot of loss very early and for a child that would be terrifying." Lynn began to cry, describing that "people always leave" and "I will always be alone."

*Primary therapist:* It is very painful and sad because it's been your experience that people always leave and when they leave you feel very alone.

*Lynn:* I have always been alone, my whole life has been about me being alone.

*P:* How do you wish it would have been?

*L:* I wish I never had to be alone. I wish that I would just be loved. Not the kind of love that goes away, but the forever loved feeling, the kind of feeling that is always with you.

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<sup>1</sup> It should be noted that other clients we have seen with tertiary structural dissociation did not all have such strongly positive experiences, possibly due to less awareness and integration around core traumatic experiences, as Lynn had had when beginning the treatment.

- P:* You want the forever loved feeling. (Lynn nodded.) You really needed that feeling when you were a child and you didn't have it then.
- L:* (Crying harder) Yes I do, but I didn't get it. It's not fair, it's cruel. Everyone deserves that feeling.

After reflecting on this and allowing herself to grieve, Lynn turned her attention to her current struggles with her own daughter, who was expecting her first child, and the current and anticipated difficulties she felt about becoming a grandmother. In particular, Lynn feared connecting with the grandchild in case she "fails at that like I did with my kids." We have continued to work on the feelings and memories this life transition has brought up for Lynn, and she is able to explore it in a consistently more regulated manner.

In this session, we focused on facilitating Lynn's ability to reflect on the effects of profound early childhood neglect and abandonment on both her life span and on her current experiences. She became aware of the possibility of permanency, the pain of its absence, and her desire for an internal experience of security. The result was a deep grieving, a greater degree of presentification, and the challenge to incorporate her experience into present daily living. Following this session, Lynn's comments about her therapists (and others) leaving decreased and she began to focus on processing affect around the developmental traumas that her own children experienced as a result of both her and her spouse's difficulties.

## CONCLUSION

An integrative model of treatment allows the therapist to work flexibly and adaptively within the three phases of treatment for trauma-related disorders, maintaining attunement toward the client's needs. In Lynn's case, we utilized a variety of approaches to facilitate affective, cognitive, and somatic awareness and to move toward greater integration and overall healing. Although this was not easy or uncomplicated work, seeing Lynn's positive shifts toward change and personal growth continue to inspire and motivate us to be a supportive presence alongside her in her healing journey.

### Limitations

The preceding descriptions are based on one client and one integrative theoretical model guiding the use of comprehensive therapeutic techniques. This case study is intended as an example of ways to incorporate different techniques within an existing theoretical model and is not intended as a set, recommended approach for all therapeutic relationships. Each client is different and will have different responses to interventions. For example, as

noted earlier, not all of the clients we have referred for neurofeedback have had such drastic, positive results.

Members of Lynn's treatment team have received extensive training in the interventions used. During such training, participating therapists often struggled with how to integrate the techniques into their existing approach. Lynn's case study provides a description of how we utilized a variety of complementary therapeutic techniques within our existing model.

Some of the interventions used come with additional cautions. For example, it is important to note that OEI is considered a new therapy and requires both further research as well as specific training to learn the techniques appropriately; risks are higher with any therapy still considered experimental in nature. For further reading on OEI, we recommend Bradshaw et al.'s (2011) article describing the development and mechanisms of OEI therapy.

### Future Directions

Due to this article's focus on case material, it would be valuable to explore the effect of combined therapeutic interventions on trauma recovery within a clinical sample. Combining qualitative and quantitative methodology would be helpful to evaluate both subjective and objective shifts in trauma-related symptomology.

### REFERENCES

- Aroche, J., Tukelija, S., & Askovic, M. (2009). Neurofeedback in work with refugee trauma: Rebuilding fragile foundations. *Biofeedback*, *37*, 53–55. doi:10.5298/1081-5937-37.2.53
- Artigas, L., & Ignacio, J. (2010). The butterfly hug. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations* (pp. 5–7). New York, NY: Spring.
- Bateman, A. W., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. New York, NY: Oxford University Press.
- Bateman, A. W., & Fonagy, P. (2006). Mentalizing and borderline personality disorder. In J. G. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 185–200). Chichester, England: Wiley.
- Bowlby, J. (2008). *A secure base* (6th ed.). New York, NY: Routledge Classics.
- Bradshaw, R. A., & Cook, A. (2008). *Toward integration: One eye at a time*. Vancouver, BC, Canada: SightPsych Seminars.
- Bradshaw, R. A., Cook, A., & McDonald, M. J. (2011). Observed & experiential integration (OEI): Discovery and development of a new set of trauma therapy techniques. *Journal of Psychotherapy Integration*, *21*, 104–171. doi: 10.1037/a0023966

- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment*. Thousand Oaks, CA: Sage.
- Brownback, T., & Mason, L. (1999). Neurotherapy in the treatment of dissociation. In J. R. Evans (Ed.), *Introduction to quantitative EEG and neurofeedback* (pp. 145–156). San Diego, CA: Academic.
- EMDR Institute. (2004). *A brief description of EMDR*. Retrieved from <http://www.emdr.com/briefdes.htm>
- Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 312–328). New York, NY: Guilford.
- Fisher, S. F. (2010). Arousal and identity: Thoughts on neurofeedback in treatment of developmental trauma. *Biofeedback*, *1*, 6–8. doi:10.5298/1080-5937-38.1.6
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2004). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.
- George, C., Kaplan, N., & Main, M. (1996). *Adult Attachment Interview* (3rd ed.). Unpublished manuscript, Department of Psychology, University of California, Berkeley, CA.
- Hesse, E. (1999). The Adult Attachment Interview: Historical and current perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 395–433). New York, NY: Guilford.
- Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association*, *48*, 1097–1127. doi:10.1177/00030651000480041101
- Kalff, D. M. (2003). *Sandplay: A psychotherapeutic approach to the psyche*. Cloverdale, CA: Temenos.
- LeBel, E. S. (2009). Body, sand and self somatic experience in sandplay therapy. *Journal of Sandplay Therapy*, *18*, 7–18. Retrieved from <http://psychnet.apa.org/psycinfo/2009-18487-001>
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: Norton.
- Parnell, L. (2008). *Tapping in: A step-by-step guide to activating your healing resources through bilateral stimulation*. Boulder, CO: Sounds True.
- Schiffer, F. (1997). Affect changes observed in right versus left lateral visual field stimulation in psychotherapy patients: Possible physiological, psychological, and therapeutic implications. *Comprehensive Psychiatry*, *38*, 289–295. doi: 10.1016/50010-440X(97)90062-6
- Schiffer, F. (1998). *Of two minds: The revolutionary science of dual-brain psychology*. New York, NY: Free Press.
- Schore, A. (2003). *Affect dysregulation and disorders of the self*. New York, NY: Norton.
- Siegel, D. (1999). *The developing mind*. New York, NY: Guilford.
- Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, W. A. (2009). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York, NY: Guilford.
- Steele, K. (2009). Reflections on integration, mentalization, and institutional realization. *Journal of Trauma & Dissociation*, *10*, 1–8. doi: 10.1080/15299730802488668

- Stewart, B. L., Dadson, M. R., & Fallding, M. J. (2011). The application of attachment theory and mentalization in complex tertiary structural dissociation: A case study. *Journal of Aggression, Maltreatment & Trauma, 20*, 1–22. doi:10.1080/10926771.2011.562477
- Swingle, P. G. (2008). *Biofeedback for the brain: How neurotherapy effectively treats depression, ADHD, autism and more*. Piscataway, NJ: Rutgers University Press.
- Taylor, E. R. (2009). Sandtray and solution-focused therapy. *International Journal of Play Therapy, 18*, 56–68. doi:10.1037/a0014441
- Turner, B. A. (2005). *The handbook of sandplay therapy*. Cloverdale, CA: Temenos.
- van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York, NY: Norton.

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