Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
the International Society for the
Study of Trauma and Dissociation*

**How Close Encounters of the
Completely Unanticipated
Kind Led Me to Becoming
Co-Editor of *Frontiers***

A. Steven Frankel, Ph.D., J.D.

**Sources for Psychotherapy's
Improvement and Criteria for
Psychotherapy's Efficacy**

Andreas Laddis, MD

**Trying to Keep It Real: My
Experience in Developing
Clinical Approaches to the
Treatment of DID**

Richard P. Kluft, M.D., Ph.D.

**Expanding our Toolkit
through Collaboration: DIR/
Floortime and Dissociation-
Informed Trauma Therapy for
Children**

*Joyanna L. Silberg, Ph. D. and
Chevy Schwartz Lapin, MA*

**From Passion to Action: A
Synopsis of the Theory and
Practice of Enactive Trauma
Therapy**

Ellert R. S. Nijenhuis, Ph.D.

International Society for the
Study of Trauma and Dissociation

TRAUMA AND DISSOCIATION. IT HEALS HERE.

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The Official Clinical Journal of the ISSTD

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EDITORIAL

How Close Encounters of the Completely Unanticipated Kind Led Me to Becoming Co-Editor of *Frontiers*

A. STEVEN FRANKEL, Ph.D., J.D.

Clinical Professor of Psychology, University of Southern California, Past President, ISSTD.

This document is my co-editor's initial statement. It reviews my entry into the field of trauma and dissociation and the pathways and events that took place in my professional life that led to my becoming co-editor of Frontiers, an online journal, created by ISSTD in order to provide a platform for clinicians to share clinical interventions and approaches to treatment of a very deserving population.

I. MY TRAINING YEARS WERE LARGELY DEVOID OF EDUCATION ABOUT TRAUMA:

My graduate training in Clinical Psychology took place at Indiana University in the mid-late '60s. As with many graduate training programs during that era, the approach of the faculty was empirically-based (if you had no data, you dare not speak), and cognitive in orientation (the "cognitive-behavioral" model did not exist when I arrived at I.U., and was in its infancy when I finished my doctoral training there).

Since I'm a "New Englander" from ages 2–21, Indiana was completely alien territory for me, and between the nature of the clinical models I was exposed to and the culture there, I finished all of my pre-doctoral requirements in three years (including my dissertation), and fled to New York, to intern at Columbia University's Psychiatric Institute, which had a "hard core" psychoanalytic orientation (the good news about that experience was that I learned that there are quite a few models of human behavioral problems, and knowing many of them gave me a great set of clinical tools to use with complex patients).

The other difference between my three years at Indiana and my year at Columbia is that, at I.U. the word “trauma” hardly ever was heard, and, when it was, it was applied to war veterans, but not to children. Indeed, the early-mid ‘60s was the dawn of the establishment of child abuse reporting statutes. Child abuse was not a “hot topic” in Bloomington, and when I got through my internship at Columbia, I had learned how to use hypnosis as a clinical tool, and I understood how to work with patients with trauma histories, but was told that dissociative disorders were so rare, that I would probably never see one.

II. DISSOCIATIVE DISORDERS FOUND ME:

Thus, imagine my surprise when, in 1980, in my role as a psychiatric hospital consultant and private practicing psychologist in Los Angeles’ South Bay area, I had an experience that changed my life. My phone rang and a 19 year old young woman told me that her high school counselor—the only person with whom she had a supportive relationship—gave her my name and suggested that she call me when she was taken to a local medical-surgical hospital (no psychiatric unit) when she ran out into the street from her trailer/home in the middle of the night, screaming, because she had received a series of threatening phone messages over a period of days, and when she decided to call the police, she found that her phone line had been cut (as it turns out, by alters), and she became terrified.

I arranged to have her admitted to the open adult unit at Del Amo Hospital, where I served as psychologist/consultant, and housed with three other female patients there. Within 48 hours of admission, the nursing staff called to tell me that she had taken over the clothes closet in her room, with witches robes, high-school cheerleader outfits, and a variety of other stylized clothes, such that her room-mates had no room for their clothes. They also reported that she sat at the room’s window and “howled” at the moon at night, keeping her room-mates awake.

When I told the nurses that I would come right over to the hospital to see if I could assist with these problems, they told me not to bother, as they had already taken all of her clothing away from her and transferred her to the adult closed unit, with a bed that was bolted to the floor and no closet for her clothes. I saw her daily for the next week, conducting a standardized admitting assessment, and when I got to the section on “social/sexual history,” she indicated that she had a “biker boyfriend” who visited her monthly and with whom she knew she had sex, but had no conscious memory of it. I asked a series of questions to try to understand why she could not remember having sexual relations with him (e.g., alcohol consumption? Drugs? Arterial blockage during sex, etc.), but she answered “no” to all of those questions.

Finally, and, to this day, I cannot say “where this came from” in me, I asked if there was some other “aspect” of her that had the sexual contact. To my complete surprise, her attitude, posture, affect, eye contact, etc., changed before my eyes. I was now interacting with a much more adult woman, who told me that “they”—a group of alters—were getting worried about me—referring to me as “Dr. Dense,” because I couldn’t come up with the hypothesis that she had a dissociative disorder.

She achieved full integration in 13 months (except for a brief episode in which a part of her I had never seen or known before entered my office, and I knew that there had been a separation taking place. “She” assured me that there was nothing to worry about, that she was a “temp,” and the cause for the re-splitting was that a male attendant from the hospital had come on to her romantically, after discharge (resulting in his discharge from the staff). She re-fused and, to my knowledge, has remained that way ever since.

III. ONCE FOUND, MANY TIMES NOT SHY. . .

Over the ensuing years, I began to “see” and identify dissociative disorders in other patients, and found that, since I had no training as to these disorders, I made a conscious effort to be “a good student” to my patients, watching for what worked, what didn’t work, and, in essence, how to work with this population. Not being aware of the existence of what was then the International “Society for the Study of Multiple Personality and Dissociation,” I found that, by carefully attending, for each patient that I saw, to what worked for them and what did not, how they changed and how they did not, I became increasingly effective with these disorders.

And even more important, in its own way, I began to notice that some of the questions/comments that came out of my mouth produced profound and powerful responses. Just as my comment to my first DID patient when I asked if another “aspect” of her had sex with the boyfriend, I found that the more I learned to trust myself to say things that made for positive change, and to humbly and calmly apologize for things I said that provoked distress (this population is not used to having anyone apologize for hurting or upsetting them) I became increasingly effective..

Perhaps the best example I can give for learning to trust my own instincts revolved around a male patient who had served in battle for our military and believed that he became “possessed” by a Vietnamese serpent god who gave him the courage to do his work as a “grunt.” Upon his return to the states, he took a job, and began feeling hostility toward a supervisor. He had weapons and his therapist correctly diagnosed him with DID, but could not make headway with his treatment. When I first met him, I asked (among other things) if I could speak with his serpent god. He warned that

the serpent god was very mean, but I maintained an interest in speaking with him. He said "all right" and closed his eyes, and a piercingly loud series of roars came from his mouth. I asked if that was the serpent god, and he screamed "yes." I have no idea where what I was about to say came from in me, but I said: "You've got a great roar!" and he said "do ya like it?") and I said I loved it, and we became partners in helping the patient along the healing path. Such experiences became increasingly frequent as I learned to trust myself.

IV. THE HOSPITAL "GOT THE MESSAGE" AND I FOUND WHAT IS NOW ISSTD, AND ITS FIRST RELATED JOURNAL—*DISSOCIATION*

Del Amo hospital started a sub-program for childhood trauma survivors on the adult unit in the mid-'80s, and, in 1993, opened a separate unit for these patients. I consulted to the new program and the new unit, providing individual and group psychotherapy, and, in 1990, I attended my first meeting of what is now the International Society for the Study of Trauma and Dissociation (ISSTD), at which I was amazed and pleased by being with others who had found their way along the very same kind of path that brought me to working with posttraumatic and dissociative disorders.

I found myself with colleagues who had travelled similar, if not identical pathways that I had followed, reaching similar conclusions and achieving similar results. Since then, I have only missed one of the ISSTD's annual meetings, and I had the honor of serving as its president in 2002.

Through the society, I began to teach others what my patients had taught me about their healing paths. As I read the growing literature and conferred with more experienced colleagues, I learned more, worked more with patients, and assisted colleagues with their work. I found two homes: a hospital at which I could work with the patients who had taught me so much, and a society which "spread the news" about our work and its impact.

When I joined, the ISSTD was blessed to have a journal—"*Dissociation*" which provided clinically oriented papers by highly experienced colleagues. The articles were wonderfully attuned to the work we did, offering conceptualizations and articulations of both the nature of these disorders and the healing pathways that existed for our patients. And, even though the '90s were charged with intense conflict over issues of "false memories" and accusations about dissociative disorders as being created iatrogenically, we persisted in our efforts to assist our patients by sharing our growing knowledge with colleagues.

V. THE ADVENT OF THE JOURNAL OF TRAUMA AND DISSOCIATION AND THE SOCIETY'S TRAINING PROGRAMS

Due to financial difficulties that sometimes face professional societies, our relationship with *Dissociation* came to an end (around the year 2000) and our current journal, the *Journal of Trauma and Dissociation* ("JTD"), was born, with an outstanding editor (Jennifer Freyd, Ph.D.) and with top ratings in the world of academically-oriented research papers. I have been one of the JTD's reviewers from its inception. Along with JTD, the ISSTD developed a series of educational and training programs, with courses for clinicians who were "beginners" in the field, to intermediate and advanced courses.

I have been one of the in-person and online teachers in the society's courses, and the developer of the intermediate-level course.

VI. THE NEED FOR A CLINICAL JOURNAL:

With the growth of the JTD and the training programs, the society began to face a new problem: from the time of the loss of *Dissociation* as a clinical journal, given that the mission of the JTD has been to provide a source of empirical research on the problems we and our patients face, the society lacked a vehicle for the presentation of the therapeutic techniques that had been developed by those of us who were good students of our patients, and learned from our patients how to work effectively with them. I was one of several people who had submitted clinically-oriented papers to JTD, only to have them rejected as inconsistent with the empirical research that JTD serves and shares.

From 2014–2016, the ISSTD reached the conclusion that a new vehicle for clinical training—one of the two major missions of the society—was needed. The new clinical journal—*Frontiers in the psychotherapy of post-traumatic and dissociative disorders*—was created, and as a relatively senior member of our profession's sub-specialty of the diagnosis and treatment of posttraumatic and dissociative disorders, I responded to the invitation to become a co-editor.

I am flattered and honored to be in this position, given the number of highly productive senior colleagues in the field, and am doubly appreciative of the fact that my co-editor is Andreas Laddis, M.D.—himself a senior colleague with years of experience as a scholar and treater of our patients. We have created an on-line journal with a mission of publishing articles which present clinical interventions we have used, how we came to use them, how our use of them has changed over time, etc. Our purpose is to support clinical growth among our readers, thus furthering the interests of our patients as well. We look forward to the growth and success of *Frontiers* in the years to come.