Informed Consent for Treating Trauma & Dissociative Disorders

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This disclosure and information is offered to give you important information about your treatment and provide you with an informed basis to understand the benefits and potential risks in the treatment of traumatic and dissociative disorders. It is important that you receive this information about the the benefits and risks of trauma-focused treatment and be aware of problem areas that may have a bearing on your recovery. This can help you make the most responsible, informed decisions about your treatment and in the interpretation of traumatic material that may emerge as you progress.

Issues about trauma-focused treatment

Many clients experience a variety of symptoms in the course of their treatment that include flashbacks, flooding of emotions, overstimulation, nightmares, anxiety and panic attacks, suicidality, self-destructive or angry impulses, depression, increased dissociative behavior, and feelings of disorganization. Sometimes there may be a need for hospitalization. Some people need to take time off of work or experience increased difficulties with their partner, children, social and family relationships. It is possible to feel worse and less stable, before you feel better, and some people may not feel they get better. Others find they do feel better and in control, able to tolerate life easier and with less distress and are much more emotionally stable and physically more regulated.

Your therapy can feel demanding, and it is important that you consult with friends, practice good self care for support, do daily life activities and develop and apply specific strength-based resources to turn to if you are in a crisis and your therapist is not available. These problems can be anticipated and discussed with your therapist.

On the other hand, most people coming into treatment are already having difficulty and chronic symptoms and feel they need to start therapy because of the problems that they are already facing. In most cases, therapy may be the only way to regain a sense of stability, resilience, safety and conscious awareness. You must decide whether the risks of treatment, even if it turns out not to be not as helpful as you would have liked, are worth trying and acceptable as it does offer more hope for a happier, healthier and more functional life.

The treatment of traumatic and dissociative disorders is still evolving, and it is not possible to predict what your treatment experience will be. This will also depend upon factors in your willingness to make changes and apply coping and recovery techniques and your fit with your therapist.

Ordinarily, your treatment will include a variety of components to help you gain self-control and improve your personal relationships and your functioning in the present. It will address erroneous patterns of thinking, the re-enactment of old conflicts through your behavior, and help to resolve the effects of trauma and abuse. Treatment can take months or years for some and be much briefer for others. There is no way to predict a length of therapy.

There are other approaches that are available to you or that can be used simultaneously. These include a variety of traditional psychotherapies, group therapies, cognitive therapies, behavioral modification techniques, careful use of hypnosis, eye movement desensitization and reprocessing (EMDR) and Brainspotting (BSP), neurofeedback therapies such as LENS and other types and the use of some prescribed medications, as well as over the counter herbs and supplements. Some people feel treatment makes them feel worse and prefer to stop. You need to discuss your plan with your therapist. Consultations or a second opinion can always be requested if you feel stuck.

The mental health field is presently divided in their beliefs and understanding about dissociation and the validity of “repressed” memories retrieved in adulthood or during treatment. On one end of the spectrum are therapists that accept all material as accurate, with no independent corroboration, and they may even suggest the presence of abuse memories based on symptoms even when memories are absent. On the other end of the spectrum are those who do not believe abuse memories are repressed, that repressed memories for severe abuse do not occur but are implanted by poorly informed therapists into unwitting, naïve or suggestible patients. Given this division, even among many credible professionals, an awareness of what you believe is exceedingly important so that your treatment leads you to your own conclusions and you are aware of alternative approaches from which to choose. It is hoped that informed decisions and an open mind will give you the best chance to heal.

Studies to date have clearly established the presence of child sexual, physical and emotional abuse. They have also shown that a variety of adult behaviors and symptoms are correlated with a history of abuse. There are, however, instances where abuse may not always lead to significant disturbance and, simultaneously, many symptomatic individuals may not have a history of severe abuse. Reports of memories for abuse do not guarantee its authenticity. Nor, on the other hand, does a failure to recall abuse mean that none was present.

Our best understanding at present is that memories of abuse may be accurate, distorted, confabulated, dissociated or repressed from conscious recall or contamination by a variety of other factors. Further, memories of traumatic events may change over time as new information that is repressed or discovered becomes available. For this reason, it is wise to suspend judgment on memories until sufficient time has elapsed to allow the dissociated information to emerge and cognitive distortions to be corrected so a fuller and more

accurate assimilation of retrieved material can be completed and a clearer meaning of these events can be integrated.

You should know that amnesia for traumatic events and child abuse is a regularly documented finding. What is also known, and often objected to on the basis of its appearing to reinjure abuse survivors, is the recognition that people can, under a variety of circumstances, appear to remember events that, in fact, never happened. In other instances, events may have happened quite differently than they are remembered. Even inaccurate recall, however, does not mean that some kind of abuse did not occur. Inaccurate recollections can, in some instances, be experienced as being so real and vivid and be accompanied by such significant physical sensations or body pain that they are accepted as real memories with absolute conviction.

This is not meant to discount what you know but to permit you the widest possible latitude in reconstructing your life. Memory is a complicated business. Real memory can also be recalled with intensity, vividness and physical sensations that reflect a representation of the original trauma. This is especially true with repressed memory and particularly in dissociative conditions. In dissociative conditions, the manner in which traumatic material is stored makes this problem especially difficult since both accurate, distorted and inaccurate information can be experienced similarly and believed with the same conviction.

There is no way that professionals can tell with certainty the historical accuracy of any account and therefore it is important to know that professionals cannot validate the historical truth of any memory. The concern about being unable to validate an individual's account of their personal history is presented to help you know the limitations of therapy, and that validation would be something you would have to establish for yourself with independent corroboration or to allow your therapist, if it were appropriate, to contact people in your life directly to attempt to clarify what was true, despite knowing from the literature that there is a pattern of denial in families where abuse has occurred. This would only be recommended if it were therapeutically indicated and then only with your written consent.

This information is not meant to discount the impact on your life of your suffering, or to suggest that you not discuss the material that emerges in your treatment. Recollections, even in people who may inadvertently have accepted inaccurate information as memories, will continue to have a significant impact on how people organize and think about their lives. These recollections, despite the issue of accuracy, are still what shape self-esteem, influence behavior and provide meaning and perspective for people's lives. It is still important, however, that you know that severe child abuse is a known fact and that severe trauma can be forgotten and dissociated by many people and in a variety of situations.

There are times when people recall memories of things that have not occurred to them, and more problematic still are those who will purposely present false memory for their own reasons. A professional therapist has no way of knowing the difference and must help those who may be unknowingly reporting erroneous memory by periodically challenging or trying to understand material in new ways to allow some people to arrive at different or more accurate formulations about their recollections and the impact these recollections have had.

Unfortunately, we cannot distinguish malingering based only on a person's reports either. This does not take away form the seriousness of the problems faced by real survivors. Professionals have encountered memories they have not believed that subsequently turned out to be true, and similarly they have encountered memories they believed to be true that have turned out not to be. This requires that therapists and patients alike work without a pre-established bias and tolerate the ambiguity of what emerges in treatment. This will allow you to grow and resolve what you decide is true for you. I may write and use such terms as "recall," "memory," "repressed memory," a "history of," and similar terms. In the absence of external corroboration, the only responsible position for you and me to know is that these terms are used for convenience in communicating and not as a statement of the validation of their historical truth. This is true not only in the treatment of trauma survivors but in the treatment of all patients where the therapist and patient work only with material that is reported. The treatment remains focused on helping to resolve the patient's suffering and not on establishing historical accuracy.

Some other possibilities suggested for contamination of memory include persuasion by therapists, hypnotic suggestibility, the unwitting recalling of someone else's experiences as one's own memories, the effects of hysterical contagion as in the spread of rumors, mistaking fantasy for reality, deception, substituting a false memory for a more painful reality, the confusion of memory that was encoded during states of disorganization when a preverbal or immature child was not capable of storing memory realistically, and a variety of other possibilities as well. Even in the dissociative disorders there are a variety of coexisting yet different "realities' which are believed Simultaneously.

There are a variety of explanations offered to explain false memory production. While these explanations have been hypothesized, many have not been studied. Further, there is a great deal of research information about memory that is learned from nonclinical populations that may not apply to you. Professionals still have a lot to learn about the problems of memory in non-traumatic situations and more still about the problems of processing memory in survivors of abuse. One cannot necessarily translate information about memory in non-traumatized people to those who were traumatized. It is hoped that the issue of false memories and the polarized viewpoints among professionals can be put aside so that you can receive the best possible treatment for your

condition.

You also need to know that trauma is treatable and that many, many people have been successfully treated and feel better after entering treatment for their traumatic and dissociative conditions.

While treatment approaches may continue to change as professionals learn more, I feel that treatment results do provide a significant hope and expectation for improvement so that you can enter treatment with an understanding that many people have markedly improved or recovered.

I have read the above information about the treatment of trauma and dissociative disorders and have received a copy of this document. I understand the complexities involved in my treatment and with memory in general. I understand I can assist in my treatment planning and I can revoke this consent at any time and discontinue trauma treatment at any time. I agree to trauma treatment based on my own informed consent and I wish to proceed knowing there are risks, as well as potential benefits.

_____ _____

Name Date

_____ _____

Therapist Date