 **Trauma-Informed  
Stabilization Treatment**  
(TIST): Treating Unsafe and Addictive  
Behavior in Clients with Histories of Trauma

MODULE ONE

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**Trauma-Informed Stabilization  
Treatment [TIST]**

**Mission:** TIST was developed at the request of a Connecticut state hospital wanting help in stabilizing trauma patients whose chronic self-destructive behavior had resulted in years of hospitalization and emergency treatment without much change.

**Most patients in this group also were violent toward staff,** which led to their being **stigmatized as “bad:”** ‘attention-seeking,’ ‘manipulative,’ ‘oppositional,’ ‘passive-aggressive,’ ‘non-compliant.’ Medical personnel at the local hospital threatened to stop treating the patients with self-inflicted injuries because of the ‘overuse’ of their resources.

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**Trauma-Informed Stabilization  
Treatment [TIST], p. 2**

**Theoretical premise:**

- Older models of treatment premised on Kernberg’s understanding of unsafe behavior as deliberate, ‘manipulative,’ and ‘attention-seeking’ had failed to help these patients. DBT treatments had been tried and failed, too
- The premise of TIST = self-destructive behavior is inherently a survival strategy** instinctively mobilized by a traumatized nervous system. When trauma-related triggers activate fight/flight responses, these patients instinctively attacked others or attacked themselves

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### Trauma-Informed Stabilization Treatment [TIST], p. 3

- DBT had not had the desired effect because it requires **remembering** to use the skills taught. Because trauma inhibits the prefrontal cortex, those skills are not available
- **Inability to exercise good judgment was not intentional but also resulted from trauma-related prefrontal inhibition** caused by autonomic dysregulation.
- The other premise of TIST was that **standard treatments are not geared to understanding severely traumatized clients as fragmented selves and internally conflicted**

Fisher 2020

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### Trauma-Informed Stabilization Treatment [TIST], p. 4

**Contributing theoretical models:** neurobiologically-informed understanding of trauma-related symptoms and disorders (van der Kolk, LeDoux), polyvagal theory (Porges), the Structural Dissociation model (van der Hart, Nijenhuis & Steele), disorganized attachment, Borderline Personality as a trauma disorder (Liotti, Lyons-Ruth), ‘the body keeps the score’ (van der Kolk, Levine, Ogden).

**Contributing clinical models:** Sensorimotor Psychotherapy (Ogden), Internal Family Systems (Schwartz), ego state techniques (Watkins & Watkins), Mindfulness-Based Cognitive Therapy, Motivational Interviewing, ACT

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### The “living legacy” of traumatic memory

*“Under conditions of extreme stress, there is failure of hippocampal memory processing, which results in an inability to integrate incoming input into a coherent autobiographical narrative, leaving the sensory elements of the experience unintegrated and unattached. . . .”*

*Van der Kolk, Hopper & Osterman, 2001*

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**'Sensory Fragments without Words'  
= Implicit Memory**

- All experiences are remembered implicitly but not all are encoded as narrative memories.
- Traumatic experiences often fail to be encoded as **autobiographical memories** (“I remember it happening”) because the brain’s first priority is survival, not memory. **The victim is left with implicit memories:** emotional, physical, sensory responses disconnected from the events
- Verbal recall can re-activate these implicit memory networks**, rather than re-processing them, but implicit memories are also evoked by everyday triggers and interpreted as information about “now”

Fisher, 2017

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**Traumatic implicit memories are experienced as:**

- “Feeling flashbacks”** of desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- Chronic expectation of danger:** hypervigilance and mistrust, fear and terror, “post-traumatic paranoia”
- “Body memories:”** numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- Impulses and movements:** restlessness, slumped posture, impulses to “get out,” violence turned against the body, huddling or hunkering down
- Symptoms:** vegetative symptoms of depression, anxiety disorders, somatization disorder, OCD, addictive disorders, and Borderline Personality Disorder

Fisher, 2020

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**Another kind of memory: habits of action and reaction**

- Procedural memory is our implicit memory system for functional learning:** skills, habits, automatic behavior, conditioned responses.
- Driving a car, playing an instrument, dance, swimming or playing tennis, riding a bike, shaking hands and making eye contact and other social behavior, are all examples of procedural learning.
- Procedural learning allows us to respond instinctively, automatically, and non-consciously, increasing our efficiency at the cost of a loss in reflective, purposeful action

Sensorimotor Psychotherapy Institute

Fisher, 2012

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### Trauma-related Procedural Memory

- Social behavior:** difficulty making eye contact, asking for or accepting help, expressing feelings in words
- “Default settings:”** tendencies to automatic self-blame, shame, anger, shutdown, dissociation
- Behavioral responses:** impulsive acting out, isolation and avoidance, help-seeking, inability to say ‘no,’ collapse
- Emotional expression:** emotional disconnection, cathartic expression, overwhelming intrusive emotions
- Interpersonal behavior:** gets too close too quickly and expects too much from others, becomes the caretaker, or avoids closeness, dependency

Fisher, 2014

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### When the world is frightening, the nervous system adapts to threat

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Sympathetic Activation

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*Fails to expand*

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Parasympathetic Activation

*Children are chronically on guard, “jacked up,” impulsive, quick to fight or flee*

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Window of Tolerance\*

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*Children are chronically hecked out, numb, disconnected, “don’t care,” going through the motions*

Fisher, 2009

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### Nervous System Adapts to a Threatening World

Hyperarousal-Related Symptoms: Fight/Flight  
Impulsivity, risk-taking, poor judgment  
Chronic hypervigilance, anxiety, ruminations and compulsions  
Intrusive emotions, flashbacks, nightmares, racing thoughts  
Compulsive behavior providing temporary relief: addiction, self-harm, suicidality


Sympathetic Arousal

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“Window of Tolerance”\*  
Optimal Arousal Zone

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Parasympathetic Arousal



**Prefrontal cortex shuts down**

Hypoarousal-Related Symptoms: Submit  
Flat affect, numb, feels dead or empty, “not there”  
Cognitively dissociated, slowed thinking  
Cognitive schemas focused on hopelessness  
Disabled defensive responses, victim identity

Ogden and Minton (2000); Fisher, 2006; \*Siegel (1999)      Sensorimotor Psychotherapy Institute

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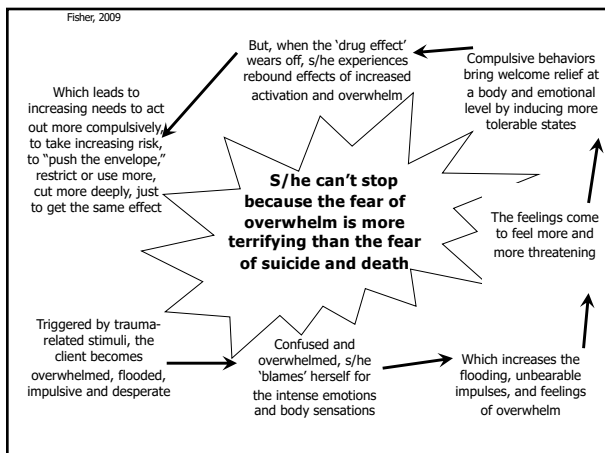
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### How Unsafe Behavior 'Helps'

- Jan, recalling abuse at age five: *"Every day, I would say to myself, 'I can die tomorrow.' I got through each day by promising myself I could die the next day."*
- Annie, recalling how cutting helped her to function: *"I would cut myself to get off the floor of the closet and go downstairs and make dinner for my family."*
- Anita, recalling a hospitalization at age 13: *"After I got out, I went to a party and had my first beer. I thought, 'If I have beer, maybe I won't have to go back there again.'"*
- Peter: *"I survived as a kid by locking myself in my room and eating and masturbating til I got numb."*

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### Differentiating 'Safe, 'Safer,' and 'Unsafe'

- If self-harm, addictive behavior and suicidal ideation are attempts to self-regulate and keep on 'keeping on,' then are they always "unsafe"? **We need to distinguish truly unsafe behavior and behavior aimed at self-regulation**
- We should NOT assume that all headbanging, cutting, or hitting is intended to be life-threatening** but should inquire: "What does this do? How does it help?"
- Cutting is rarely life-threatening.** If we respond as if it has suicidal intention, we may unintentionally exacerbate it. We will dysregulate the client and over-protect, robbing the client of the opportunity to regulate her- or himself

Fisher, 2009

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## How Substances “Medicate” PTSD

### Hyperarousal symptoms:

•Alcohol and marijuana induce relaxation and numbing, facilitate social engagement by decreasing hypervigilance, and allow sleep. Cocaine and speed counteract relaxation effects or maintain hypervigilance. Heroin dampens rage and impulsivity

### Hypoarousal symptoms:

•Speed and cocaine counteract feelings of “deadness,” numbing, hopelessness and helplessness, while marijuana and other downers maintain the hypoarousal. Alcohol, at different “dosages,” either induces numbing or counteracts it. Although technically a depressant, alcohol in small doses has a stimulating effect

Fisher, 2003

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## Eating Disorders and Self-Injurious Behaviors

•**Eating disorders:** under-eating or restricting induces numbing effects accompanied by increased energy. Binging lowers arousal, while purging results in a temporary increase in arousal followed by profound hypoarousal

•**Overeating:** induces numbing with relaxation, spaciness, and loss of energy and motivation, resulting in curtailed activity

•**Self-injury:** self-harm stimulates adrenaline and endorphin production in the body, increasing energy and feelings of power and clarity and also buffering the pain. It is instant relief.

•As in substance abuse, **prolonged use of these behaviors leads to tolerance; more and more is needed to achieve the same effect**

Fisher, 2013

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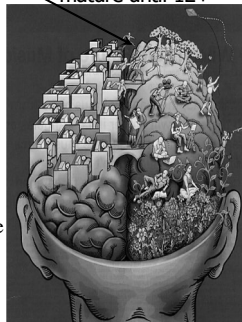
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## A Divided Brain = Survival

### Left Brain

Seat of the “conscious, linguistic self” (Cozolino, 2002), the left brain or “CEO Brain” reasons, plans, organizes, learns from experience, and makes meaning. The left brain is also the self-witness: it has the capacity for both internal and external

Corpus Collosum does not mature until 12+



Ogden, 2008; Fisher, 2009

### Right Brain

The right brain is the survival brain, as well as the playful and creative brain. Our right brains hold a sense of “corporeal and emotional self” The right brain lacks words but reads body language and facial expression. It has ‘street smarts,’ not book smarts

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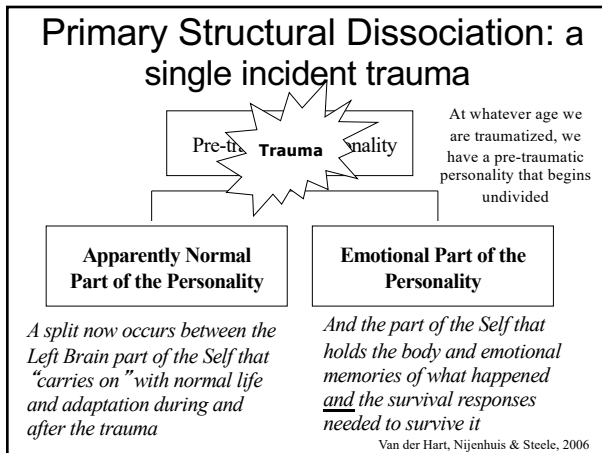
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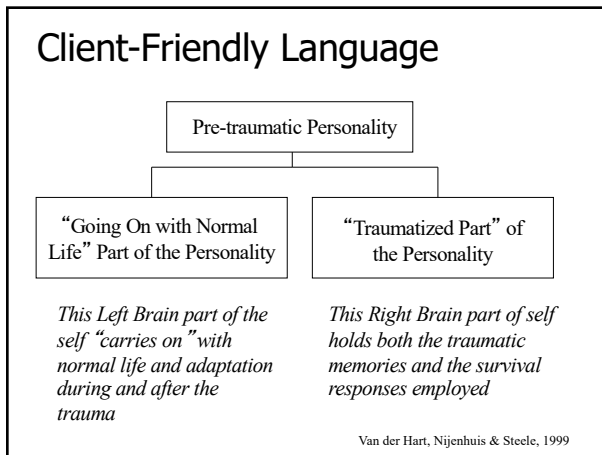
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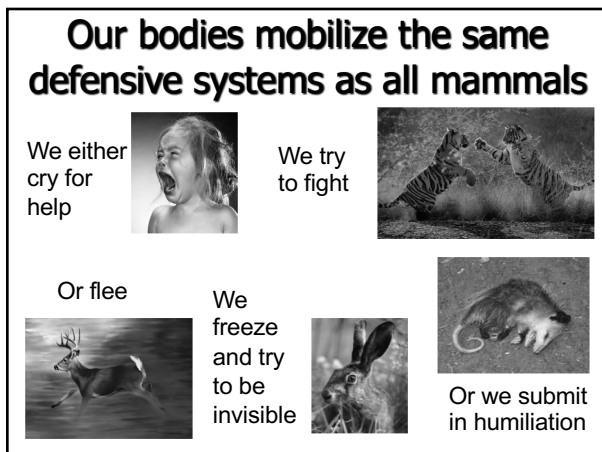
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Triggered and dysregulated, the body continues to anticipate danger

***“When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over.”***

*Judith Herman, 1992*

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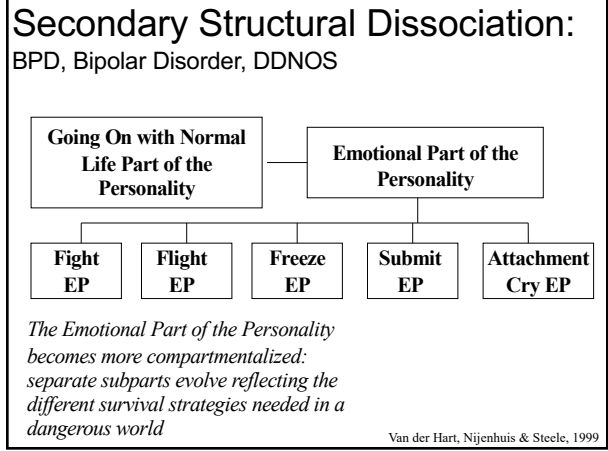
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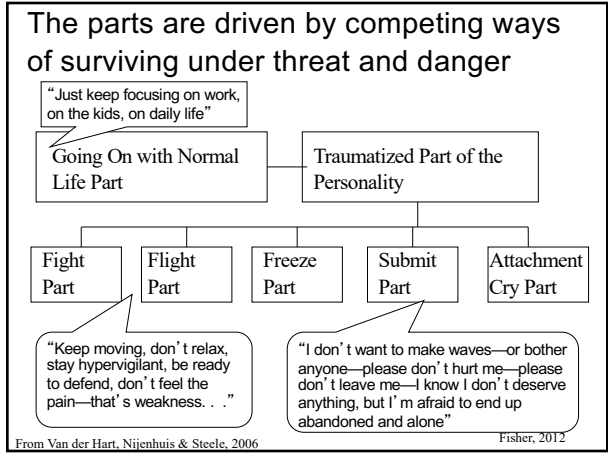
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**The parts don't trust each other or their treaters** [From Van der Hart, Nijenhuis & Steele, 2006]

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    graph TD
      A["Going On with Normal Life" Part] --- B["Traumatized Part of the Personality"]
      B --- C["Fight Part"]
      B --- D["Flight Part"]
      B --- E["Freeze Part"]
      B --- F["Submit Part"]
      B --- G["Attachment Cry Part"]
  
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*Fight and Flight want Attach to avoid increasing vulnerability, want Submit to be strong, and want Freeze to stay frightened and invisible.*

*Attach struggles to find a rescuer or protector; Submit tries to keep people pleased and thus less dangerous. Freeze becomes mute and terrified.*

Fisher, 2012

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**Evolutionary-Determined Internal Tensions**

What threatens stability is not the compartmentalization or the disorder: it is the conflict between competing survival responses:

- Attachment to the therapist competes with wishes to flee or resist the treatment
- "Submission" (for example, willingness to work with the therapist) is in conflict with fighting for control
- Going on with normal life and putting the past behind competes with hypervigilance and mistrust
- Wanting to live or be stable competes with wishes to die or impulses to get "fast and dirty" relief

Fisher, 2004

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**Stabilization = Resolution of Internal Conflicts**

- Unresolved internal conflicts between competing animal defenses interfere with not only stabilization but also resolution of traumatic experience
- How can the patient 'go on with normal life' when traumatic triggers keep activating traumatized parts?
- If Attach is desperately seeking rescue, Fight is harming the body, and Submit is feeling more and more ashamed and hopeless, clients become stuck in unsafe patterns
- For resolution, the internal conflicts must first be brought to the client's awareness and processed.
- But HOW?

Fisher, 2020

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### Claiming Authority over the Body

- **When triggering evokes traumatic activation and the frontal lobes shut down, parts hijack the body.** A loud sound might trigger Freeze; ending of the therapy session might trigger Attach; an empathic failure might trigger Attach and then immediately Fight
- **Parts holding cognitive schemas can also gain authority over the body:** the scathing judgment of a critical part might evoke an ashamed part and shut down the frontal lobes, thereby disabling the Going on with Normal Life part. Parts' use of the word "I" facilitates hijacking: "I want to die" gives more power to the suicidal part; "I feel hopeless" gives more power to Submit

Fisher, 2012

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### The parts are not experienced as 'parts of me' but as:

- **Overwhelming emotions:** desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- **Chronic expectation of danger:** hypervigilance, fear and terror, mistrust, "post-traumatic paranoia"
- **Body sensations:** numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- **Impulses:** motor restlessness, 'hang-dog' posture, impulses to "get out," violence turned against the body
- **Beliefs:** "I hate myself," "No one cares," "I'm not safe here"

Fisher, 2012

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### Or the parts are experienced as:

- **Loss of ability to communicate:** client becomes mute, shut down, unwilling to speak, can't find words
- **Voices:** usually shaming, punitive, controlling
- **Constriction:** withdrawal, social isolation, agoraphobia
- **Regressive behavior:** loss of ability for well-learned skills, personal hygiene, ADLs, social engagement
- **Increasing preoccupation with helpers:** the only safe/unsafe place becomes the office/hospital/house
- **Alternating dependence and counterdependence**
- **Unchecked self-harm,** suicidality and addictive behavior

Fisher, 2012

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### Internal Struggles = Parts Trigger Each Other

**Hyperarousal-Related Symptoms:**  
 Fight becomes critical and judgmental, triggering shame and hypoarousal  
 Fight acts on impulse to engage in addictive behavior  
 Fight threatens suicide, pushes away sources of support  
 Attach cries for help, further activating Fight/Flight, and the Freeze part panics

**Hyperarousal**

**Prefrontal cortex shuts down**

**Hypoarousal**

**Hyperarousal-Related Symptoms:**  
 Escalating unsafe behavior triggers shutdown:  
 Submit's shame triggers Fight's anger; Fight's judgment increases shame and hopelessness

Ogden and Minton (2000);  
 Fisher, 2006  
 \*Siegel (1999)

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### Psychoeducation on Structural Dissociation

**Going On with Normal Life Self** — **Traumatized Child Self or Selves**

- Fight: Protector**  
Anger, mistrust, devaluing, self-destructive behavior, impulsivity, suicidality
- Flight: Distancer**  
Distancing, ambivalence, cannot commit, addictive behavior
- Freeze: Terrified**  
Frozen, terrified, wary, phobic of being seen, agoraphobia, panic attacks
- Submit: Ashamed**  
Depression, shame, self-loathing, passivity, being a "good girl," caretaker
- Attach: Needy**  
Desperation, helplessness, sweet, charming, dependent on therapist, childlike

Fisher, 2006

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### Connect Symptoms to Parts

In the context of client's having cut herself, therapist tries to evoke curiosity:

**Therapist:** I hear you cut last night—what part do you think it was?

**Client:** "I don't know—I just hate myself"

**Therapist:** Let's think about this: was it Flight? Was it Fight?

**Client:** [Looking at diagram] "Well, I guess it was Fight"

**Therapist:** Was Fight upset about the phone call? Or just trying to protect you?

**Client:** "Of course I was upset! I can never trust anyone. But that sucks, too"

**Therapist:** So, you want to trust people, and Fight wants you to mistrust them?

**Client:** "Yeah, Fight thinks I'm a fool for trusting him"

Fisher, 2006

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### Connect Symptoms to Parts, cont.

Therapist continues to ask mindfulness questions:

Yes, if Fight had its way, you wouldn't trust anyone, huh?

So, Fight keeps trying to protect you that way.

Well, maybe you can work with Fight and help it see that you are an adult now who knows **whom** to trust.

Everyone needs a Fight part, so hold onto it—it gives us courage and backbone. But we need our Fight parts to let **us** decide who to trust and how to react.

"It's safer that way—then you don't get hurt"

"But it backfires—because then I can't get help"

"I won't reject my Fight part, though—it saved me in the orphanage"

"I do trust a lot of people here"

Fisher, 2006

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### Mindfully tracking connections between symptoms and triggers

Client just broke his sobriety:

I'm so glad you could tell me you used last night—what triggered you?

What was going on just before you used?

How could you tell people were getting to you? That they had 'no respect'?

That's a pretty big trigger! People who don't do their jobs, so you have to carry all the load

"I don't know—I just hate my job"

"People were getting to me—they have no respect"

"One after another, they weren't doing their jobs—I can't rely on anyone!"

"Yeah, just like I have my whole life. . ."

Fisher, 2008

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### Connecting symptoms to triggers, cont.

When you got triggered, what feelings came up?

So the trauma trigger triggered the addict part!

Well, drinking does calm the nervous system—he was just trying to help out, to make the feelings disappear

We have to figure out a way for you to know you're triggered before the addict takes action. People are going to be assholes sometimes—you don't want to relapse over them!

"I just wanted a burger and a beer"

"F--- it! I don't have to feel this shit"

"But now I'm feeling stupid, and my head is killing me, and I don't want to lose my career"

"That's for sure. They're not worth it"

Fisher, 2008

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### “De-coding:” identifying “parts”

- Signs of internal conflict:** inability to make decisions, stuckness, trying to stay safe alternating with acting out, alternating sobriety and relapse
- Emotions:** intrusive, overwhelming and out of proportion
- Noticeable shifts in mood or behavior:** e.g., from neutral or fearful states to anger and acting out; asking for extra appointments, then not showing up; trust alternating with mistrust
- Autonomic arousal patterns:** collapsed, numb, passive states versus angry or desperate or suicidal states
- Cognitions:** “I am worthless and hopeless,” “I know you are going to leave me,” “I can’t trust you,” “I trust you completely”

Fisher, 2014

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### Noticing ‘who I am’ moment to moment

- We assume that ‘we are what we feel:’** but what “I feel” could be a spontaneous response to the present moment, the implicit memory of a part, or a survival response. Further, what we make meaning of feelings which then affects what we feel about what we feel
- To resolve trauma and to increase impulse control, survivors need an active prefrontal cortex.** Asking the client to notice with curiosity and avoid interpretation facilitates prefrontal activity. Noticing thoughts, feelings, physical reactions and impulses as ‘parts’ also increases activity in the prefrontal cortex

Fisher, 2020

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