Compass Consulting, LLC specializes in the treatment of trauma based disorders and dissociative disorders. This includes: Posttraumatic Stress Disorder (PTSD), Complex PTSD, Other Specified Dissociative Disorder (OSDD), Depersonalization, Derealization, Dissociative Amnesia, Dissociative Fugue, and Dissociative Identity Disorder (DID, formerly known as Multiple Personality Disorder, MPD).

Due to the growing variety of ways to conceptualize and treat both trauma and dissociative disorders we have decided for the sake of clarity and client consent to explicitly provide a statement on how we as a specialty group practice both understand the etiology and manifestation of these experiences and consequently how we approach the healing journey of individuals that seek out our help with these experiences.

Our Conceptualization & Treatment Approach for Complex Trauma Disorders and Dissociative Disorders

Approach to Assessment and Diagnosis

We often go about diagnosing disorders through first a robust clinical interview, and then if further clarity is needed we'll use tools like the Multidimensional Inventory of Dissociation or the Dissociative Disorders Interview Schedule. We can get a general diagnostic picture after these, but we believe that truly understanding the client's experience and "diagnosis" will take time so we don't necessarily rush into diagnoses. However, for insurance purposes (if you were to plan to bill through insurance) we do often have to put a diagnosis on the medical record at the time of the first meeting in order for claims to be processed. This diagnosis can change as needed based on what's most appropriate for describing the client's experience.

Conceptualizing Trauma & Dissociative Disorders

Our stance as a practice in regards to PTSD, Complex PTSD, OSDD, and DID is through the lens of Ego State Therapy that takes the stance that all humans have an internal system of parts. Naturally in healthy environments and in secure attachment relationships, these parts work integratively together creating a fluid experience for the individual. Trauma can then lead to more distinct and robust barriers between these parts of self leading to more fragmentation of experience. Along the continuum from PTSD-Complex PTSD-OSDD-DID where DID is most severe we believe that the emancipation and elaboration of these naturally occurring parts of self become more intense and fragmentation of experience increases as one moves down the continuum leading to amnesia, identity confusion, and intrapersonal dynamics that lead to interpersonal struggles. In OSDD & DID systems we believe the following: 1) the severe impacts of trauma during and/or after attachment ruptures, betrayals, and violations led to the formation of the dissociative system, 2) the unresolved nature of the trauma along with the insecure and/or disorganized attachment style maintains the dissociative system, and 3) treatment involves not only addressing the trauma material that maintains the dissociative barriers, but also addressing the intrapersonal dynamics between parts that also maintains the non-realization of the trauma material and its effects. Here we must take a moment to acknowledge that as we treat the underlying trauma that created the dissociative system we

cannot prevent the spontaneous fusion/integration that can often occur as a result of the trauma resolving. This does not mean that functional multiplicity cannot be a goal, but it does mean that if we're treating the trauma we want clients to understand that we believe fusion/integration could and likely will occur as a result. Our stance is founded in the literature of authors such as Kathey Steele, Onno Van Der Hart, Ellert Nijenhaus, Richard Kluft, Colin Ross, and Frank Putnam. An extensive bibliography can be provided if needed.

Let us be clear though, we don't push for integration if that is not what the individual is wanting, but we do want clients to know we can't necessarily prevent the spontaneous fusion/integration if that is where the resolution of trauma and internal system is leading the client. We do not do forced integration rituals with clients, and 100% believe that integration forced by the therapist 1) will not stick, and 2) is abusive to the client. If fusion or integration were to happen, it is done based on client desire and readiness so if spontaneous integration were to happen this means internally the client was open and ready for this.

However, it is also true that we cannot have a goal of maintaining separateness. Functional cooperation between parts is a necessary step to treatment, and if clients want that to be a treatment goal that is more than doable. However this would end up looking as more fluidity between parts, rather than strengthened individuality of parts. We believe if we are strengthening the individual traits of parts we are only reinforcing trauma, and that this is contraindicated

Treatment Approach

Below we will outline our GENERAL approach to trauma and dissociative disorders, but it is important to understand that with each individual we specialize the treatment to their specific process.

General Time Frame for Treatment (based on research)

Basic PTSD is generally around 2-5 years
Complex Dissociative Disorders are often 6-10 years

Common Treatment Interventions

Ego State Therapy (comparable to Internal Family Systems or IFS)
DBT–for skill development
Attachment Therapy
Psychodynamic
EMDR (with extensive modifications for complex dissociative disorders)

Use of Medications

We do not prescribe medications. We believe at times medication can be helpful, but these are often a short term intervention to help achieve stability for the deeper work of therapy to take place and take root.

Low Dose Naltrexone (LDN)
There is a growing body of research that suggests LDN could be beneficial for individuals with PTSD, dissociative subtype and Dissociative Disorders. A compounding pharmacy is necessary to make LDN, and at this time it is hard to obtain in Colorado Springs.

Medication Assisted Psychotherapy
At this time we do not practice nor endorse the use of psychedelic substances in the treatment of trauma or dissociative disorders which includes things like Ketamine, psilocybin, and MDMA (ecstasy). There are treatment providers that do practice the use of these substances, but as a group practice we are trained to administer or oversee these processes and also fundamentally cannot endorse them without more longitudinal research being done to validate their clinical efficacy. We also believe that the use of substances that induce a dissociative state can be risky for treating individuals already struggling with the uncontrolled nature of dissociation in dissociative and trauma disorders.