Psychotherapy for Trauma and Dissociative Disorders Using Lifespan Integration: Theoretical Assumptions and Clinical Applications.

Joanna Smith

Psychologist, Supervisor, and LI Trainer

2017

Conflicts of Interest:

The author is a trainer and supervisor in Lifespan Integration.

Psychotherapy for Trauma and Dissociative Disorders Using Lifespan Integration: Theoretical Assumptions and Clinical Applications

Keywords: Dissociation; Trauma; Lifespan Integration; Psychotherapy; Self; Emotional Regulation; Anxiety Disorders; Panic Disorder

English Abstract :
Lifespan Integration (LI, Pace, 2014) is currently being used as a psychotherapy for trauma, anxiety disorders and dissociative disorders. The aim of this paper is to describe the theoretical background and clinical applications of LI, with the help of a clinical case. Theoretical background for LI is based on research on brain development, emotional regulation and the construction of the Self during the first years of life, according to affective neuroscience (Panksepp, 1998 ; Schore, 2003 ; Siegel, 2012 ; Cozolino, 2016). The different protocols used in LI aim either at integrating a specific traumatic or painful experience or at repairing attachment wounds to strengthen the Self and quality of emotional regulation.
A clinical case study develops both applications and their positive results in a 28 year old woman suffering from panic attacks and hypochondria anxiety.
LI is a promising therapeutic approach for dissociative and post-traumatic disorders and needs further studies.

Introduction

Lifespan Integration (LSI) therapy is a recent, third-generation, mind-body psychotherapy developed in 2002 by Peggy Pace (Pace, 2014). This psychotherapy uses an original tool, the Timeline, consisting of a chronological list of memories from the patient's life, to activate different ego states over time, in combination with the use of mental imagery. Its goal is to enable the psychological integration of autobiographical experiences, particularly traumatic and/or early experiences. It is therefore presented as a possible treatment for dissociative disorders, psycho-traumatic syndromes, and attachment disorders.

In this article, we will outline the theoretical foundations underlying Lifespan Integration (LI), allowing us to conceptualize its therapeutic effects. We will describe different methods for applying LI, whether in the treatment of single traumatic events or in self-consolidation, with the aim of reducing dissociative symptoms. We will illustrate these with a clinical case and conclude with research and validation perspectives for this approach.

1. Theoretical Basis

1.1 The Brain's Self-Healing Capacity

LI is based on the same neurobiological data that led to the AIP (Adaptive Information Processing) model in EMDR. The underlying premise is that the brain exhibits spontaneous self-healing abilities, which are impaired during traumatic or dissociative processes and can be restored through appropriate therapeutic intervention.
Advances in neuroscience in recent years have made it possible to understand the phenomenon of traumatic memory as resulting from a failure to integrate the traumatic experience, which hinders its dating (for a review, see van der Kolk, 2014). It appears that it is the hippocampus, that performs the task of spatiotemporal integration of memories, particularly during sleep. When this integration process is impaired, the traumatic experience remains undated and triggers the stress system when activated.

Indeed, cortical functioning is usually hierarchically superior to limbic and reptilian functioning, which it modulates. However, when faced with an experience of danger, the reactions of the reptilian and limbic areas of the brains will prevail over cortical functioning: the reflex reactions of these two modes of brain functioning are much faster and more effective in the face of danger than the reflexive cortical process. Responses to stress include flight, fight, or, if both of these responses are impossible or ineffective, freezing. Once the danger is over, the development of a psychopathological reaction will depend on the individual's ability to regain control over their experience at the cortical level and to integrate that the danger has passed. This resumption of cortical control over the limbic and reptilian areas of the brain involves integrating the traumatic experience and orienting it in time (a beginning, a sequence, an end) and space.

If the traumatic experience has not been properly integrated by situating it in space and time, the brain continues to react as if the traumatic event were still occurring, triggering a stress response. The memory of the traumatic experience elicits the same physiological, emotional, and behavioral reactions when reactivated as the actual threatening situation that caused it. For example, a car accident victim may tremble and experience an increased heart rate when attempting to get back behind the wheel, even months after the accident they survived, despite all their attempts at "rational"/cortical control. Furthermore, traumatic memory appears to be primarily linked to activity in the right hemisphere, with extinction of Broca's area. It is an eminently sensory, bodily experience, difficult to express in words: "Trauma, by its very nature, pushes us to the limits of understanding, cutting us off from language based on common experience or an imaginable past" (van der Kolk, 20141).

Traumatic experience therefore represents a dual challenge in terms of integration: it requires integration between different brain levels (cortical, limbic, reptilian) and between the two hemispheres. However, the literature has highlighted how this capacity for integration develops from experiences of emotional regulation by attachment figures during the very first years of life.

1.2 Early Brain Development, Attachment, and Emotional Regulation

It appears that it is the repetition of early experiences of physiological calming in the face of danger that allows the brain to develop its capacities for integration and regaining cortical control. These early experiences initially rely on emotional co-regulation by attachment figures through secure attachment, particularly up to the age of 2 (Schore, 2003). These mechanisms explain the correlation between resilience and secure attachment.

Indeed, the first years of life are a period during which both:

- Significant brain development, with brain size increasing threefold during the first five years of life (Maroney, 2003);
- The development of brain areas involved in detecting and responding to danger, emotional regulation, attention, self-awareness, empathy, and identification with others (Schore, 2003; Siegel, 2012), particularly in the right hemisphere, which develops significantly during this period, well before the left hemisphere.
- The first attachment experiences (Bowlby, 1969/1984), allowing the establishment of an attachment style (secure or insecure).

During this crucial period of brain development, experience has an impact on brain structure itself: "states become traits," as Perry (1995) coined it. The decisive nature of this developmental period has also been tested experimentally in animals. Studies examining the impact of attachment disruptions on emotional regulation in different mammals are numerous and varied. For example, in rats, the intensity of maternal licking during the first 12 hours of life permanently affects the brain's chemical response to stress: rats that received the least amount of licking exhibit more fearful behaviors, produce more stress hormones, and recover less well after illness than rats that received more licking, and this effect lasts throughout their lives (Fish et al., 2004). Cowan et al. (2013) also highlighted an increase in fear in rats deprived of their mothers for 24 hours at 9 days of age, a period thought to be critical for brain development in rats.

In humans, since the work of Spitz (1945), studies on the outcomes of emotionally deprived or traumatized babies have confirmed the importance of proper brain development during the preverbal period for subsequent emotional regulation. These studies have notably highlighted an increased frequency of anxiety disorders and attention deficit hyperactivity disorder in subjects who have experienced traumatic events during their early development, i.e., before the age of 2-3 years (Maroney, 2003; Glover, 2011; Johnson & Marlow, 2011; Somhovd et al., 2012).

Early processes of integrating experience, particularly traumatic experiences, rely on the regular soothing provided by a secure relationship with an attachment figure and allow for the construction of a solid Self, which will gradually free the child from their dependence on their attachment figure for emotional regulation.

1.3 Self-Construction and Emotional Regulation

According to Hermann Hesse (quoted by Schwartz, 2009), "it seems to be a compelling and innate human need to view oneself as a unity. Although often undermined, this illusion persists." This humorous assertion seems to have anticipated the neurobiological discoveries uncovered over the past twenty years. Thus, according to Siegel (2012), "the idea of a unitary, continuous 'Self' is actually an illusion our minds are trying to create." This illusion is nonetheless essential to mental health, as it generates a continuous effort to connect and integrate cognitive, emotional, and bodily experiences linked to disparate ego states. The experience of the Self corresponds, subjectively, to the feeling of one's own identity (uniqueness and belonging) across time and space, enabled by autonoetic consciousness (Tulving, 1985).

The construction and constant work of the Self allows for an illusion of identity continuity over time. This capacity for integration seems to develop from the early co-construction of the autobiographical narrative, relying on attachment figures. Thus, "language and interpersonal interaction allow the creation of a narrative and verbal exchange that connects experience to the Self and enables the integration of affects, thoughts, and sensory information" (Carlson, Yates & Sroufe, 2009). The role of the Self is therefore to enable emotional regulation and a sense of cohesion and identity continuity through the neural integration of experience.

At the physiological level, the child attunes to the brain rhythm of their attachment figure, and this synchronization is recorded in the firing patterns of stress-sensitive limbic regions in the toddler's developing right hemisphere (Schore, 2003). When the attachment figure's brain rhythm is dysregulated (particularly due to psychological trauma or dissociation), the child records this dysregulation in their own developing stress regulation patterns. This sheds light on how the presence of unresolved trauma in the parent predicts attachment disorganization in the child (Liotti, 2009).

Paradoxically, the field of psychotherapy has shown relatively little interest in the treatment of these crucial early experiences, despite their long-standing psychoanalysis (Spitz, 1945; Winnicott, 1976; Bion, 1979; Harris & Bick, 1998; Ciccone and Lhôpital, 2001; Ciccone, 2011). This is undoubtedly linked to the verbal nature of most psychotherapies, making non-verbal experiences specific to development in the first three years of life relatively inaccessible to therapy, despite their crucial importance. This is also undoubtedly linked to the ignorance of the underlying neurobiological mechanisms, until the 1990s. Advances in the field of neuroscience and the study of interpersonal neurobiology (Siegel, 2012) has led to the development of more precise therapeutic interventions and the emergence of new therapeutic interventions to treat trauma and dissociation (Smith, 2016a). Lifespan Integration is one of these.

2 How Lifespan Integration (LI) Therapy Works

LI sessions are conducted through protocols that vary depending on the indication and the type of work to be done. These protocols apply to children, adolescents, and adults and are broadly divided into two categories: protocols involving the integration of a single event, and protocols aimed at consolidating the Self. The session, which lasts approximately one to one and a half hours, consists of a number of repetitions of the Timeline (usually between 5 and 12), starting from the targeted event and ending with the present. This Timeline (TL) is composed of at least 12 to 15 memories and can cover a variable length of the patient's life (from a few hours or days in the processing of recent events to several years). Depending on the needs, it can be combined with mental imagery encouraging the patient of today to imagine caring for their past self.

2.1 Single Event or Simple Trauma Treatment Protocols

These protocols involve activating the painful memory and then proving to the patient's mind-body system that time has passed, through the psycho-corporal experience of the Timeline (TL) and through the therapist's emotional attunement. They aim to integrate a single event, whether it triggers full-blown PTSD (PTSD Protocol) or other post-traumatic sequelae such as incomplete PTSD, phobias, other anxiety disorders, or depression (Standard Protocol). The emotional intensity felt by the patient when the memory is reactivated diminishes rapidly during the TL and during rehearsals. The goal is to allow the patient to "feel" that the traumatic event is over rather than simply "know" it rationally. The Timeline appears to allow the patient to experience the bodily experience of this time that has passed. Attention is constantly focused on keeping the patient within their window of tolerance to avoid re-traumatization.

Accelerating the timeline and anchoring the body in the present are the main tools for avoiding abreactions. These are effective thanks to the therapist's attunement to the patient's emotional state, a fundamental component of LI, regardless of the protocol used.

Because LI is a recent discovery, few published studies have examined its validation to date. However, we should mention the Balkus study, conducted in the United States among 17 women who had suffered psychological trauma and were residing in a women's residential treatment center (cited by Thorpe, 2014). The IES (Weiss & Marmar, 1997) was administered before two LI sessions focusing on a traumatic episode (T1), after the end of the second session (T2), and one month after the end of the second session (T3). The mean intrusion and avoidance scores on the IES increased from approximately 28 to 6/32 between T1 and T2, and reached 3.7 at T3, without intervention between T2 and T3. The results of this exploratory study are encouraging and should be further explored by studying the effectiveness of different protocols for treating a single event with LI.

2.2 Self-Consolidation Protocols

Self-Consolidation protocols aim to develop emotional regulation skills in patients with dissociative disorders, anxiety disorders, difficulties with emotional modulation (anger, sadness, fear), impulsive behaviors (self- or hetero-aggressive acting out), or low self-esteem. They use mental imagery to offer the patient corrective attachment and emotional regulation experiences. The underlying hypothesis is that the repetition of these experiences over the course of sessions will allow the consolidation and neural integration of a new experience that will gradually overwhelm the childhood experience, leading to more appropriate behaviors in the present and greater attachment security. The effects of these self-strengthening protocols have been described in two books (Pace, 2014; Thorpe, 2014), several book chapters (Smith & Pace, 2011; Clément, Smith, Bernardo, 2012; Thorpe, 2013; Smith, 2014a and 2014b; Smith 2015; Clément, 2016; Janner Steffan, 2016; Smith, 2016a, 2016b, and 2016c), and one article (Binet & Tarquinio, 2016), but require scientific testing to demonstrate their effectiveness. Several studies are currently underway in this area.

The effects of these protocols, as described in the literature, include improved emotional regulation, a reduction in dissociative tendencies, a development of a sense of identity cohesion, and an increase in attachment security.

2.3 Illustration by a Clinical Vignette

2.3.1 History

Laetitia is 28 years old and has been consulting for ten years for panic attacks and pronounced hypochondriacal tendencies, accompanied by numerous emergency room visits without proven somatic causes. She has tried analytical psychotherapy and CBT without much improvement, according to her, except that she better identifies her problems as having a psychological cause (outside of attacks, however, because during attacks she is generally convinced of the reality of a serious somatic disorder). She also suffers from attachment disorders; her love life is characterized by a succession of short-lived, passionate conquests, sometimes punctuated by episodes of domestic violence. Laetitia expresses a fear of being abandoned and of not being able to be loved as she is. She consulted for LI psychotherapy, following a new somatic assessment with no identified disorders other than gastroesophageal reflux disease (GERD), which had already been diagnosed and treated. Her medical history was as follows: Laetitia was a wanted child, born to two very young parents (20 years old); she was delivered by forceps; the birth was described by the mother as traumatic. Her childhood was marked by parental unavailability: because her parents were very young, Laetitia divided her daily life between her paternal grandparents, with whom she lived primarily, and her parents, who visited her

some evenings and weekends. Her father was described as tyrannical, intrusive, and chronically anxious, and seemed to constantly set himself up for failure. Her mother suffered from debilitating phobias, particularly of blood, injections, and hospitals. She was generally described as self-centered and emotionally unavailable. When Laetitia was hospitalized for 10 days following a fall from a significant height at the age of 6, her mother was unable to visit her during her hospitalization due to her phobias. Today, when Laetitia talks about this episode with her mother, the latter complains of the distress she felt at her daughter's hospitalization, without any perspective on what Laetitia may have been going through on her side.

At the age of 11, Laetitia was the victim of sexual assault (groping) by an older cousin. She has never spoken to her family about it to this day.

Laetitia has a sister who is seven years younger and has very similar disorders (severe anxiety disorders, including panic attacks). Laetitia has a master's degree in communications and has an above-average intellectual level.

Overall, Laetitia exhibits significant difficulties with emotional regulation, particularly in the form of panic attacks. In her medical history, several risk factors are likely to contribute to this: a traumatic birth, the young age and inexperience of her parents at birth, a partial breakdown of attachment due to living primarily with her grandparents, and difficulties with emotional regulation (anxiety disorders) in both parents. Laetitia also seems to need to integrate certain life events that are still upsetting for her, notably the sexual assault she suffered at the age of 11. The work therefore begins with alternating sessions of Self-Consolidation Protocols and sessions addressing specific events, notably using Affect Bridges, which address her daily difficulties and anxieties. We will illustrate the flow of these sessions first with an example of a session focusing on a specific event (Standard Protocol) and then with a Self-Consolidation Protocol (Attunement Protocol).

2.3.2 Example of a Standard Protocol session, aimed at resolving a specific event.

We are now at a year and a half of weekly follow-up. Laetitia has made significant progress in regulating her emotions: she no longer has panic attacks, and almost no more hypochondriacal anxiety. When these still occur, she is not as overwhelmingly overwhelmed as before: she no longer immediately seeks emergency care, no longer sends panicked phone messages to her loved ones or her therapist in the middle of the night, even though she remains very anxious. At this point in therapy, Laetitia has received 10 Self-Consolidation sessions, 9 sessions focusing on a specific event, and 38 traditional interview sessions. We don't usually conduct this many interviews during LI therapy, but Laetitia frequently expresses the need to vent about the events that occurred during the week and the changes she observes in herself after LI sessions. Laetitia notes that she always becomes attached to men who need her help, surrounding herself with people she

feels compelled to "save." She feels she systematically sacrifices herself for those close to her, even if it means suffering.

We start with the sensation she experiences in her throat and chest when this problem is mentioned and explore it using an Affect Bridge. The focus on her bodily sensations, with her eyes closed, proposed by the Affect Bridge, takes her to the age of 7, when her sister was recently born. Laetitia feels intense anxiety and perceives her mother as helpless in caring for her little sister as a baby. Here is how this protocol works:

a) We lead her to imagine entering this scene as it is today and going to take care of little 7-year-old Laetitia (the part called the Child Self in LI). In her mental imagery, the 7-year-old Child Self refuses to leave the scene to follow the Adult Self in the present, out of concern for her little sister.

We first review the patient's Timeline, from the age of 7 to the present. On a subjective level, the exercise consists of the patient imagining showing her 7-year-old Child Self her story, how she grew up to become who she is today, while maintaining affectionate and caring contact with her. We then take a short break before reconnecting with the source memory. Note that, in this type of LI work, the therapist interacts only with the patient in the present, never directly with the Child Self.

b) This time, Laetitia has sensations in her solar plexus. She feels aggression toward her parents at the time, which we invite her to express imaginatively, from her perspective as an adult today. Then, we continue with a second repetition of the Timeline. We take another break, during which Laetitia expresses her indignation and anger at her parents' incompetence.

c) At the third connection to the source memory, she feels a stomachache. She once again, imaginatively expresses her anger. The relationship with the Child Self is caring, warm, and empathetic.

d) At the fourth connection to the source memory, Laetitia expresses sadness, helplessness, and the feeling of abandoning her sister. We suggest she imagine that her present-day sister comes to take care of herself as a baby back then, which allows her to imagine leaving the scene and reviewing her Timeline once again. At the break, the Child Self, in mental imagery, asks her Adult Self, "Is it okay to leave my little sister like this?"

e) Fifth connection to the source memory, then another repetition of the Timeline. In the present, the Child Self still expresses doubts about being able to leave her sister behind, but the bodily sensations are less strong.

f) 6th connection to the source memory: Laetitia feels sorry for her mother, who is all alone. We perform a 6th repetition of the TL. In the imagery, the Child Self is happy that the Adult Self is there.

g) 7th connection to the source memory: itching appears on the head and neck. Laetitia once again expresses aggression towards her parents, in her imagination, and so does her Child Self. Upon arriving in the present, she feels a great deal of love and tenderness for her Child Self. We end the session with a time of verbal exchange.

The work accomplished during this session allows Laetitia to free herself from her uncontrollable urge to take care of others at her expense.

Less than a month later, during a rather violent argument, she breaks up with her boyfriend, who was living at her expense. We decided to resume a sequence of Self-Consolidation work, due to the violence of the altercation.

2.3.3 Example of Self-Consolidation Work

The work continues, alternating Self-Consolidation sessions with a few sessions processing past events, such as the one described above, based on an Affect Bridge based on his current difficulties. One year later, we have completed five Self-Consolidation protocols, seven single-event processing protocols, and 23 additional interviews. We are once again engaging in a series of Self-Consolidation protocols.

In this case, the idea is to start with the very first experiences of insecure attachment, by having the patient imagine that she is a 15-day-old baby, that is, dependent and vulnerable, in the environment in which she was at the time (Attunement Protocol).

a) This situation almost immediately arouses feelings of chest tightness and anxiety in Laetitia. We have her imagine that the therapist is coming to retrieve her from the past, picking her up as a baby, accompanied by her Adult Self, to bring her into the present to show her that time has passed, while providing her with the attention, care, carrying, calm, and affection necessary at this age. Seeking to maximize the sensation of being carried by a caring and attuned therapist, we unfold the stages of development she went through subsequently (lifting her head, turning around, crawling, etc.) to continue with the Timeline of her memories up to the present. The objective is twofold: to enable us to "date" the sensations emanating from the implicit memory of the 15-day period; To provide the patient with a restorative experience of secure attachment through the imagined sensation of being the baby being held in a supportive manner by the therapist. This is the twelfth session of this type since the beginning of therapy. During the first sessions of this type, Laetitia's anxiety was greater and accompanied by a certain agitation. Today, she feels oppressed at first but relaxes as soon as she feels carried as a baby by the therapist. We go through three repetitions of the Timeline, and the session ends with the patient feeling soothed, with the sensation of being snuggled.

b) At the following session, the connection with the sensation of being in her family of origin for 15 days still aroused anxiety, but it was described as less than during the previous session. The first passage of the Timeline led Laetitia to feel much more relaxed, even though she noticed a tension in her diaphragm during the passage of certain memories from her Timeline. Then, at the second connection at 15 days old, a sensation of falling, emptiness, and loneliness emerged. Two additional repetitions of the Timeline led her to realize how little "touch" her parents were, unlike her paternal grandmother.
c) Following this session, violent dreams of murder and illness occur. Laetitia experiences a resurgence of hypochondriacal fears, but without feeling the need to consult or seek reassurance from a loved one or the therapist. The goal of this self-consolidation work is to provide and repeat sufficient calming experiences, by imagining the baby in the arms of a reassuring person, so that the patient can achieve their own calming and self-regulation in the present. The goal is to provide, through repeated imaginary interaction, the experience of physiological calming that was lacking in the early interaction, based on the observation that an imagined activity activates the same brain areas as real movement (for a review, see Jouvent, 2009/2013). Here, Laetitia's increased self-regulation capacity appears to be a consequence of this experience of increasing calm during the LI session. She can gradually develop her ability to calm herself.
d) We propose a 14th session of the Attunement Protocol (Self-Consolidation, starting at 15 days old): the sensation of dizziness and oppression is still present at the beginning. During this session, we utilized three repetitions of the Timeline, which are marked by sensations of not being held, an urge to cry, and a feeling of loneliness. Again, itching appears.
e) The aftereffects seem to have been less marked than during the previous session. Laetitia says she enjoys her free time more and doesn't have to systematically "fill" it as before. She has new professional projects and finds fulfillment in new artistic activities.
f) During the 15th Attunement Protocol session, the initial tightness is light and Laetitia's postural tone begins to relax. During the second repetition, she is forced to position herself differently because she is so relaxed that she could fall out of the chair. She feels both like a baby being carried in the therapist's arms, which she finds very pleasant, and like an adult, in the here and now. A sense of identity continuity seems evident for Laetitia between these two states. Her bodily relaxation is such that she actually has the appearance of a blissful baby, completely confident.

The patient's sensations during the sessions, as well as her development both during and outside of them, are quite typical of the self-consolidation work that can be offered in LI. Increased autonomy, emotional regulation, and better awareness of oneself and one's needs often result from this type of session. Even more interesting, patients frequently express the feeling of feeling more "themselves," more "unified," and having greater coherence between their different facets and the various beings-in-the-world that make up their daily lives (professional, private, family, etc.), leading to a more solid Self, allowing for a more cohesive sense of identity.

Conclusion

Clinical evidence highlights substantial improvements achieved by LI therapy, particularly in terms of greater self-solidity with increased emotional regulation and reduced anxiety and attachment disorders.
These results are all the more interesting given that they also occur in patients known to be difficult or resistant to other approaches, including medications (borderline personality disorder, addictions, bipolar disorders, PTSD, severe anxiety disorders, self-harm, dissociation, etc.). At the current stage of LI development, it would be useful to conduct research to demonstrate the effectiveness of this approach, better understand how it works, and detail its therapeutic components.

Bibliographic references

Bick, M., Harris M. (1998). Les écrits de Martha Harris et Esther Bick. Larmor-Plage, Editions du Hublot.
Binet E., Tarquinio C. (2016). Intérêt et limites de l'Intégration du Cycle de la Vie (Lifespan Integration) auprès d'adultes victimes du Syndrome de Munchausen par procuration pendant leur enfance, L'Evolution Psychiatrique, 81, 625-640
Bion, W.R. (1979). Aux sources de l’expérience. Paris, PUF.
Bowlby J. (1969, nouvelle édition 1984). Attachment and Loss, Penguin Books.
Carlson, Yates et Sroufe (2009). in P.F. Dell & J.A. O’Neil (2009). Dissociation and the dissociative disorders. New York, Routledge.
Ciccone, A. (2011). La psychanalyse à l’épreuve du bébé. Paris, Dunod.
Ciccone, A., Lhôpital, M. (2001). Naissance à la vie psychique. Nouvelle édition. Paris, Dunod.
Clément, C. (2016). Traitement des troubles de l’attachement, in J. Smith Psychothérapie de la dissociation et du trauma, Paris, Dunod, p. 94-103.
Clément C., Smith J. et Bernardo D. (2012), « Intégration du Cycle de la Vie : thérapie des

troubles de l'attachement, de la dissociation et du trauma », in R. Coutanceau, J. Smith et S. Lemitre, Trauma et résilience, Paris, Dunod, p. 293-304.
Cowan C.S.M., Callaghan B.L., Richardson R. (2013). Acute Early-Life Stress Results in Premature Emergence of Adult-Like Fear Retention and Extinction Relapse in Infant Rats, Behavioral Neuroscience, 127 (5), 703–711.
Glover, V. (2011). The Effects of Prenatal Stress on Child Behavioural and Cognitive Outcomes Start at the Beginning, in stress and pregnancy (prenatal and perinatal), Encyclopedia on early childhood development.
Janner Steffan, A. (2016). Traitement de la dissociation chez l'enfant avec l'ICV, in J. Smith Psychothérapie de la dissociation et du trauma, Paris, Dunod, p. 218-229.
Johnson S., Marlow N. (2011). Preterm birth and childhood psychiatric disorders, Pediatric Research, 69 (5) 11-18.
Jouvent, R. (2013, 1ère édition 2009). Le cerveau magicien. Paris, Odile Jacob.
Liotti, G. (2009) Attachment and dissociation, in P.F. Dell & J.A. O'Neil (2009). Dissociation and the dissociative disorders. New York, Routledge, pp. 53-66.
Fish EW, Shahrokh D, Bagot R, Caldji C, Bredy T, Szyf M, Meaney MJ. (2004). Epigenetic programming of stress responses through variations in maternal care. Ann N Y Acad Sci. 1036:167-80.
Maroney, D. I. (2003). Recognizing the potential effect of stress and trauma on premature infants in the NICU : How are outcomes affected ? Journal of Perinatology 23:679–683.
Pace P. (2014). Pratiquer l'ICV. Paris, France : Dunod.
Pace, P. et Smith, J. (2011), « L'Intégration du Cycle de la Vie : une technique permettant de mettre fin au cycle de la violence familiale », in R. Coutanceau et J. Smith, Violence et famille, Paris, Dunod, p. 305- 313.
Page, G.G. (2004). Are there long-term consequences of pain in newborns and very young infants ? The Journal of Perinatal Education, 13(3) 10-17.
Perry, B. D., Pollard, R. A., Blakley, T. L., et al. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits". Infant Mental Health Journal, 16, 271-291.
Schore, A. (2003). Affect dysregulation and the disorders of the Self. New York, Norton.
Schore 2009 in P.F. Dell & J.A. O'Neil (2009). Dissociation and the dissociative disorders. New York, Routledge, pp. 107-144.
Schwartz R. (2009). Système familial intérieur : blessures et guérison. Un nouveau modèle de psychothérapie, Paris, Elsevier.
Siegel, D. (2012). The developping mind. New York, Guilford.
Smith, J. (2013), « Dissociation traumatique, carences précoces ettroubles de lapersonnalité : approche thérapeutique parl'ICV », in R. Coutanceau et J.Smith,

Troubles de la personnalité, Paris, Dunod, p. 347-355.
Smith, J. (2016a, dir). Psychothérapie de la dissociation et du trauma. Paris, Dunod.
Smith, J. (2016b), « L'ICV comme traitement novateur des victimes et témoins de violences conjugales », in R. Coutanceau et M. Salmona, Violences conjugales et familiales, Paris, Dunod, p. 94-97.
Smith, J. (2016c), « L'Intégration du Cycle de la Vie pour traiter les traumatismes chez les auteurs et les victimes de violences », in R. Coutanceau, C. Damiani, M. Lacambre, Victimes et auteurs de violences sexuelles, Paris, Dunod, p. 137-142.
Somhovd M. J., Hansen B. M., Brok J., Esb- Jorn B., Greisen G. (2012). Anxiety in adolescents born preterm or with very low birthweight : a meta-analysis of case–control studies. Developmental Medicine & Child Neurology 2012, 54, 988–994.
Spitz, R. A. (Trad. fr. 1949). Hospitalism, 1945. R.F.P., XIII, 397-425.
Thorpe, C. (2014). Les stratégies thérapeutiques de l'ICV, trad. fr., Paris, Dunod, 2016.
Thorpe, C. (2014). « Changer les schémas relationnels destructeurs par l'Intégration du Cycle de la Vie », in R. Coutanceau & J. Smith, Violences psychologiques, Paris, Dunod, p. 252-260.
Van der Kolk, B. (2014). The body keeps the score. USA, Viking Penguin.
Tulving (1985). Memory and consciousness. Canadian Psychology, 26(1), 1-12.
Weiss DS, Marmar CR. (1997). The impact of event scale – revised. In: Wilson JP, Keane TM, editors. Assessing psychological trauma and PTSD. New York: Guilford Press, pp. 399–411.
Winnicott, D.W. (1976). De la pédiatrie à la psychanalyse. Paris, Payot.

Psychotherapy for Trauma and Dissociative Disorders Through Lifespn Integration: Theoretical Assumptions and Clinical Applications

Author:
Joanna Smith
Psychologist, Supervisor, and ICV Trainer
4 bis rue de Lyon
75012 Paris
contact@joannasmith.fr
http://www.joannasmith.fr
06 19 84 96 89

*Original language: French. Translated into English 4/17/2025.