Dealing with Pandora's Box:
The therapeutic relationship as a model for fostering collaboration among dissociative parts in clients with complex trauma-related disorders

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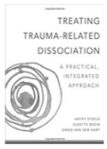


EMDR Advanced Trainings
Natick, MA, April 23, 2017

"Regulating the health of life's regulatory systems"

- "Disrupt life's regulatory system, and pathology results. Restore it, and you return it to health."
  - Andrew Harvey (TLS, 22 July, 2016, p. 27)
- Trauma involves life-shattering disruptions

"Mental Level" (Pierre Janet)
*Includes "integrative capacity"

- "Mental level" - how able an individual is to take in information, & respond adaptively. Mental level involves two factors:
- "Mental **energy"** - (includes physical energy)
- "Mental **efficiency"** - ability to use & focus available mental energy adaptively (THS, 2006)
- But: many survivors have low levels of both.
- Little mental energy - often exhausted, depressed &/or physically ill &
- Low mental efficiency - lowered ability to efficiently focus & use available mental energy.

Historical Perspectives on the treatment of complex dissociative disorders

- 19th Century Artificial Somnambulism: *The patient in charge*
- 19th Century Medical Model: *The doctor in charge*
- Pierre Janet: *From the doctor in charge to the patient in charge*
- 21st Century Psychotherapy: *Toward a Collaborate Approach*

Tomasello on collaborative communication

- "In "shared cooperative activities" the collaborators must first of all be mutually responsive to one another's intentional states… In addition to a joint goal, a fully collaborative activity requires that there be some division of labor and that each partner understand the other's role… [and that be a] shared focus of attention…
- In mutualistic collaborative activities, we both know together that we both depend on another for reaching our joint goal."
  - Tomasello (2009, pp. 61, 67, 70, 90; quoted by D. P. Brown et al., 2016, p. 429)

Treatment of Trauma-related Dissociation of the Personality

- From inner war among dissociative parts, their mutual phobias and ignorance of each other, to mutual recognition, acceptance, cooperation and collaboration
- Involves the gradual resolution of dissociation, this changes from *non-realization* to *realization*
- All this implies fostering *integrative actions*

Trauma-generated Dissociation of the Personality

"All of us have our breaking-point. To some it comes sooner than to others."

-T.A. Ross (1941, p. 66)

A slightly different formulation of "breaking-point"

- "The traumatically induced induced breakdown of the psyche"
  - Ira Brenner (2014, p. 54)

Dissociation in Trauma Defined (1): The essence

- Dissociation in trauma entails a *division of an individual's personality*, i.e., of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioral actions
- This division constitutes a core feature of trauma
  - Nijenhuis & Van der Hart (2011, p. 418)

Dissociation in Trauma Defined (3): Dissociative Subsystems

- The division involves two or more insufficiently integrated dynamic but excessively stable subsystems
- These subsystems exert functions, and can encompass any number of different mental and behavioral actions and implied states
  - Nijenhuis & Van der Hart (2011, p. 418)

Dissociation in Trauma Defined (6): Phobic Avoidance

- Dissociative parts have *permeable psychobiological boundaries* that keep them divided, but that they can in principle dissolve.
- These boundaries are maintained by *phobias* of traumatic memories and phobias that dissociative parts have regarding each other.
- Reminder: the mental and behavioral actions involved in these phobias are *substitute actions*.
  - Nijenhuis & Van der Hart (2011, p. 418)

Charles S. Myers

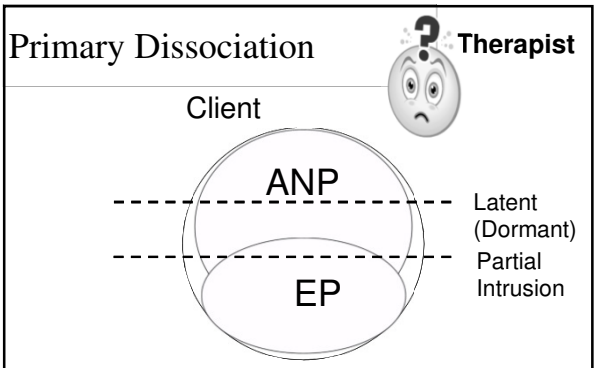
British Psychologist/ Psychiatrist during World War I

Prototypes of Dissociative Parts

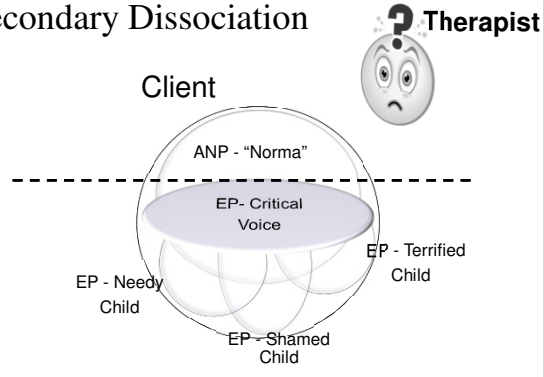
Alternations between and co-existence of

- Trauma-avoidant part(s), functioning in daily life, that experience "too little" –
  - numbing, detachment, amnesia, conscious and unconscious avoidance strategies:
    - ***Apparently Normal Parts of the Personality* (ANPs)**
- Trauma-fixated part(s), stuck in trauma-time, that experience "too much" –
  - reliving of trauma and fixation in defense:
    - ***Emotional Parts of the Personality* (EPs)**

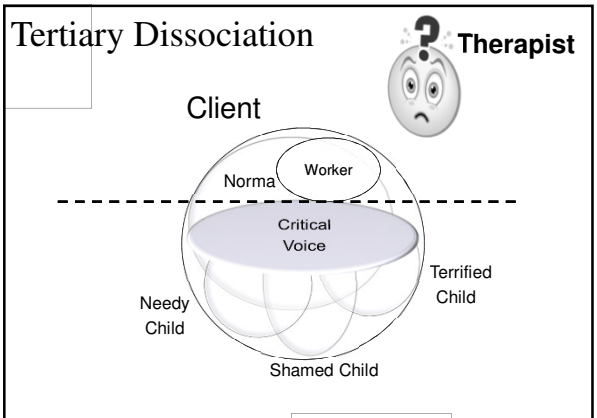
Primary Dissociation



Secondary Dissociation



Tertiary Dissociation



What Drives Dissociative Parts?

- The action systems (aka motivational systems) that mediate dissociative parts are essential aspects of the *resources* they in principle have to contributing to appropriate cooperation and collaboration among them

ANP: Primarily Mediated by Normal Daily Life Action Systems

- Exploration
- Orientation
- Social Engagement
  - *Attachment*
  - Sociability, *cooperation/collaboration*
  - Care-giving
  - Social ranking
- Play
- Energy regulation (rest, eating, etc.)
- Sexuality / Reproduction
- Higher order action tendencies of daily life

EP: Primarily Mediated by Defense Action System

- Attachment cry [panic system]
- Hypervigilance [fear system]
- Freezing
- Flight
- Fight
- Collapse or total submission with anesthesia, analgesia
- Recuperative states
  - Wound care
  - Rest
  - Isolation from the group

Regard symptoms as attempts to problem solve

- Examples: self-mutilation, eating disorders, alcohol or drugs abuse
- Essential: find out about the problem and understand the symptom or disorder this way, before trying to get rid of them
- Help parts understand the survival functions of these symptoms, and thus foster mutual understanding and acceptance, and problem-solving

Liotti's (2013) case "Eva"

- Liotti's patient Eva suffered from dissociative symptoms, including "jerks" (a somatoform dissociative symptom)
- They found out that whenever an EP desperately wished to be soothed and planned to approach an attachment figure, another EP tried to block this action by the "jerk"

Dissociation in Trauma Defined (7): Dissociative Symptoms

- Phenomenologically, this division of the personality manifest in dissociative symptoms that can be categorized as negative (functional losses such as amnesia and paralysis) or positive (intrusions such as flashbacks or voices), and psychoform (symptoms such as amnesia, hearing voices) or somatoform (symptoms such as anesthesia or tics).

"Dissociative" Symptoms in Modern North American Sources

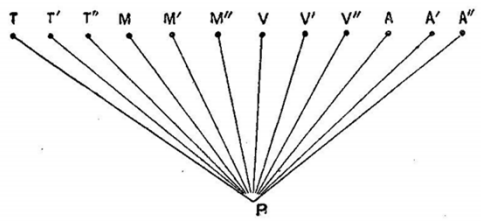
- Symptoms based on Retraction of Field of Consciousness, e.g., Absorption Phenomena
  - "A reduction of awareness of his or her surroundings" (ASD; DSM-IV, p. 432)
  - "My sense of time changed--things seemed to be happening in slow motion" (PDEQ; Marmar et al., 1998)
  - "Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them (DES; Bernstein & Putnam, 1986)

Dissociative Symptoms Psychoform - Somatoform

- ***Negative***
  - **amnesia**
  - **depersonalization**
  - **emotional anesthesia**
- ***Positive***
  - **hearing voices**
  - **"made" emotions**
  - **re-experiencing trauma, affective and cognitive components**

- ***Negative***
  - **analgesia**
  - **bodily anesthesia**
  - **motor inhibitions**
- ***Positive***
  - **localized pain**
  - **"made" bodily feelings**
  - **re-experiencing trauma, bodily components**

Wide Field of Consciousness (High integrative capacity)

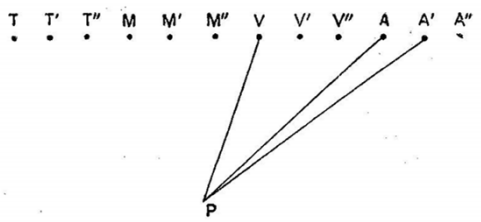


Schneiderian Symptoms of Schizophrenia (Passive Influence)

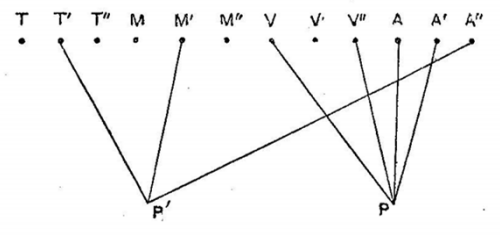
- Voices commenting, arguing, crying (internally)
- Made feelings, impulses, actions
- Thought withdrawal or insertion
- Hallucinations (related to trauma)
- Delusions (related to trauma)
- Feeling body is controlled by someone else

Retraction of the Field of Consciousness

(To Some Visual and Auditory Stimuli)

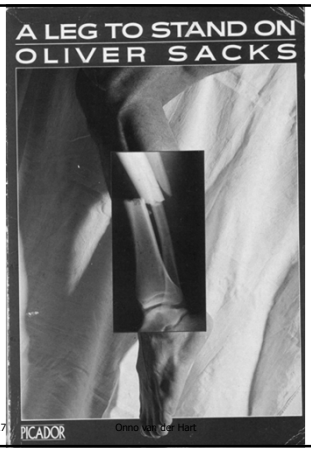


Structural dissociation of the Personality between P and P1 (Janet, 1889)



Dissociative Symptoms: Some North American Sources

	Psychoform dissocation	Somatoform dissociation
Negative	Amnesia	(Discontinuation of motor control)
symptoms	Out-of-body experience	
Positive Symptoms	--	



Dissociative Syptoms, Shame, and Fear

- Dissociation may be a hidden experience that is not discussed by the patient unless the clinician initiates a conversation
- Usually there are huge issues of shame and fear associated with dissociative experiences
- This makes it less likely for the patient to bring up a discussion of his or her experience
- *This maintains the ruptures between parts and prevents mutual acceptance, collaboration, etc.*

Therapist's attitude toward client/patient

- Within the context of fostering a collaborative therapeutic relationship,
- *The therapeutic team:*
- Combine care (which is not care-taking!) and curiosity (exploration)
- Use your own not clearly understanding something that the client communicates or that you feel/sense in yourself as a therapeutic instrument (also functions as a model)

Round 2

Recommended Treatment of Primary Dissociation of the Personality

- "The treatment to be recommended consists in restoring the 'emotional' [part of the] personality [EP] deprived of its pathological, distracted, uncontrolled character, and in effecting its union with the 'apparently normal' [part of the] personality [ANP] hitherto ignorant of the emotional [i.e., traumatic] experiences in question."

Charles S. Myers (1940, p. 69)

Phase-Oriented Treatment of Complex Trauma Disorders

(secondary and tertiary dissociation)

- ***PHASE 1***: Symptom reduction, stabilization, and skills building
- ***PHASE 2***: Treatment of traumatic memory
- ***PHASE 3***: Personality (re)integration and (re)habiliation

Janet (1898); Van der Hart et al. (1989, 2006)

Treatment of Secondary and Tertiary Dissociation of the Personality

Essential Treatment Principles

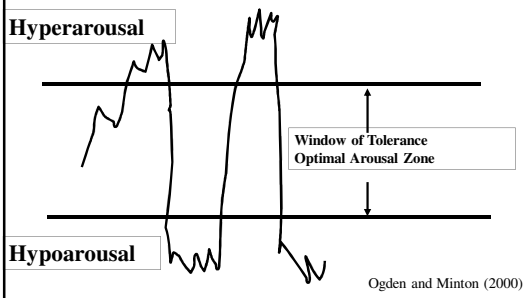
- Join the patient where he or she is
- Use a phase-oriented approach
- Maintain and improve capacity to function in normal life (work, play, self-care, relationships)
- Skills building
- Monitor and regulate psychophysiological arousal levels: Address the regulatory system
- Maintain and raise integrative capacity (mental level)

Van der Hart, Nijenhuis & Steele (2000)

The Danger of Exposure Techniques with Clients with Complex Trauma-Related Disorders

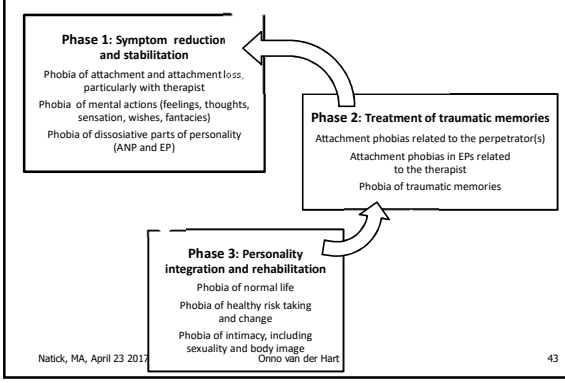
- "For them, … the intense affect stimulated by trauma exposure methods will almost certainly promote decompensation rather than stabilization
- Unless extensive intervention aimed at fostering the acquisition of affect regulation skills that were never previously established is thoroughly carried out first."
  – Gold (2008, p. 280)

Hyperarousal & Hypoarousal: Biphasic Trauma Response



Ogden and Minton (2000)

Dissociative phobias and treatment in phases



Phase 1: Symptom Reduction and Stabilization

- Overcoming the phobia of attachment and attachment loss: contact with the therapist, development of a *therapeutic team*
- Overcoming the phobia of mental actions (feelings, thoughts, wishes, needs, fantasies)
- Overcoming the phobia of dissociative parts of the personality (ANP and EP)
- Overcoming the stigma of getting help: issues of "craziness," control, and dependence.

Phase-oriented Treatment: Phase 1

Fostering Therapeutic Cooperation/Collaboration
versus
Dealing with the Phobia of Attachment and of Attachment Loss regarding the Therapist

Attachment Dilemmas in Treatment

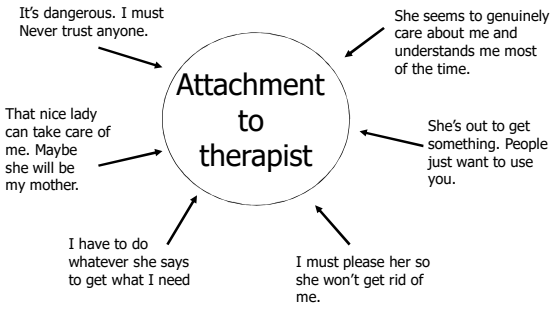
The Phobia of Contact with the Therapist

- "Contact itself is the feared element because it brings a promise of love, safety, and comfort that cannot ultimately be fulfilled and that reminds her of the abrupt breaches of infancy."
  - L.E. Hedges (1997, p. 114)

D - Attachment

- Alternation between dependency and independency
- Alternation between approach and avoidance of attachment
  - Approach: attachment and attachment cry
  - Avoidance: defensive actions

Goal Conflicts Among Parts



A Double Bind (1)

- We must support development of secure attachment in our client
- with availability that is limited to an hour or two of sessions per week, or even less,
- in clients who have profound attachment disruptions and dysregulation,
- and whose trauma is in the relational arena,
- so that relationship itself has become a perpetual source of fear, shame, and suffering

A Double Bind (2)

- The most commonly accepted attachment model for treatment is that of the parent-child, based on attachment theory (e.g., Bowlby, Winnicott)
- While there are many useful approaches that have evolved from this model, it has its limitations, particularly in the treatment of individuals with profound attachment disturbances and complex trauma

Therapeutic relationship: Different preceptions of the therapist

- "Even if a therapist is able to get through the interpersonal defenses of a patient and is seen as kind or helpful, the patient is thrown into more internal conflict, trying to juggle the fragile sense of the therapist as benevolent with the certainty that the therapist will use or abandon them."
  - James Chu (2011, p. 161)

Therapeutic relationship as trigger

- "Patients are caught in an impossible conflict between attachment, a strong wish for a therapeutic relationship, and defense against this same relationship. Therapists should avoid intentionally activating the patient's attachment system until a reasonable degree of stabilization and emotion regulation is possible"
  - Steele, Boon, & Van der Hart (2017, p. 53)

Therapeutic relationship: Controlling-punitive and controlling-caregiving strategies (1)

- These attachment strategies emerge from, or rather are manifestations of, ***disorganized attachment***.
- "In the *controlling-punitive strategy*, the child, or at least one dissociative part, learns to defensively engage the caretaker in a power struggle of dominance. These patients, or dissociative parts may be angry, obstinate, and highly demanding of the therapist and others around them."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Therapeutic relationship: Controlling-punitive and controlling-caregiving strategies (2)

- "In the *controlling-caregiving strategy*, the child, or dissociative parts, takes an apparently submissive role, but is actually caring for the caregiver. Both strategies are intended to help the child receive what she or he needs."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Controlling-caregiving strategies in therapists

- Many psychotherapists have a history of caregiving sollicited by our parents (*parentification*)
- An important question is: to what degree did this caregiving have the quality of controlling caregiving?

Therapeutic relationship: Controlling-punitive and controlling-caregiving strategies (4)

- "And when an angry punitive part is acting out toward the caregiver, a caregiving controlling part becomes fearful that the caregiver will be pushed away and retaliate or abandon the child.
- Therapists must be aware of both types of strategies and how they sequence among dissociative parts."
  - Steele, Boon, & Van der Hart (2017, p. 54)

The Dilemmas (1)

- Attachment seeking deactivates the exploration system and the cooperation/ collaboration system
- When their attachment system is highly activated, some clients are focused exclusively on the availability of the therapist, and are unable to explore their own inner experience

D-attachment and disorganization

- "Activation of their defensively deactivated attachment system brings into the patient's experience a variety of affects and cognitions that are usually defensively excluded and these create disorganization and overwhelm.
- When such disorganizing activation of the attachment system occurs in treatment, mentalization is significantly increased if the therapist structures a response to activate and and shift to the ***cooperative*** behavioral system."
  - D. P. Brown et al. (2016, p. 272)

The Dilemmas (2)

- Thus, it is very challenging to work on attachment problems by activating the attachment system between therapist and client

The Dilemmas (3)

- In dissociative clients, some parts may be dependent and attachment seeking, while others are ashamed, fearful and avoidant of dependency and attachment.
- Thus, therapists need a model that takes into account the contradictions, conflicts, and confusions of multiple attachment and defense strategies within one person
- And should avoid activating attachment to the degree possible

The Dilemmas (4)

- Therapists sometimes confuse four different concepts:
  - Secure attachment
  - Dependence
  - Caretaking
  - *Collaboration*

A New Paradigm (1)

- "At the beginning of treatment… complex trauma can best be dealt with by trying to maintain a dialogue that attempts to limit the activation of the attachment system by taking advantage of the natural tendency to *want to cooperate and collaborate on an equal basis level*."

  ~ Cortina & Liotti (2014, p. 892)

A New Paradigm (2)

- Remember: The developing collaborative therapeutic relationship can function as a working model for fostering inner cooperation and collaboration among parts

Collaboration and Positive Experience (1)

- One of the most powerful positive experiences is of feeling heard and understood by another
- Positive experience and emotion are major contributors to regulation*
- Thus, positive moments of collaboration in therapy will provide regulation
- Draw the client's attention to the felt sense of these experiences (may include those of different parts)

Collaboration and Positive Experience (2)

- However, be aware that experiencing such positive encounters also evoke some degree of realization of how much one has missed them in one's life
- Thus, pain, grief, and shame are the other side of the coin

Psychotherapy as collaborative partnership (1)

- "One of the most important ways for therapists to establish a strong working alliance with clients is to work together *collaboratively*—as partners. In the initial session, the therapist's primary aim is to articulate clear expectations for working in this collaborative manner, and, more important, to enact behaviorally those spoken expectations by giving clients the experience of partnership…"
  - Teyber & McClure (2011, p. 48)

Psychotherapy as collaborative partnership (2)

- "Thinking of the working alliance as a collaborative partnership, therapy is not something therapists "do" to clients, it is a shared interaction that requires the participation of both partners in order to succeed."
  - Teyber & McClure (2011, p. 48)

Psychotherapy as collaborative partnership (3): A mutually negotiated treatment plan

- This "requires that both patient and therapist share relevant expectations and information toward this common goal [goals and best approaches to treatment].
- As Teyber and McClure (2011) state, this process involves "engaging the client in assessing together: the issues and concerns that are most important… [and] what in the past was and was not helpful… [toward] shared treatment goals."
  - D. P. Brown et al. (2016, p. 432)

Psychotherapy as collaborative partnership (4): Shared decision-making

- "This process also requires *shared decision-making* about the best approach to these treatment goals (Katz, 1984). We believe that the best approach when formulating a mutually negotiated treatment plan is full transparency on the part of the therapist (Brody, 1989). The best therapist openly discusses his or her diagnostic impressions and how he or she arrived at these impressions."
  - D. P. Brown et al. (2016, pp. 432-433)

Psychotherapy as collaborative partnership (5): Shared decision-making

- "Transparent therapists openly discuss with each patient their reasoning as to what are the best approaches to treatment with him or her and in some detail explain why. Transparant therapists also openly discuss what difficulties they anticipate arising in treatment, including difficulties in collaboration."
  - D. P. Brown et al. (2016, p. 433)
- Caveat: with DID patients some (potential) goals should rather not be discussed at an early stage, in particular the fusion of parts and unification of the personality

Psychotherapy as collaborative partnership treatment contract

- "The emphasis is not on the contract per se as a signed document, but on the processes of mutual negotiation and collaboration through which the elements of this contract are defined. …
- Since patients with attachment disturbances have impaired collaborativeness, it is especially important to clearly articulate role expectations to help them experience and learn to maintain a relationship based on mutual expectations and clear role definitions."
  - D. P. Brown et al. (2016, pp. 433-434)
- Beware!: we are dealing with really long-term issues

Treatment Implications (1)

- Again, be compassionate without caretaking
- Be consistent and predictable
- Repair, repair, repair
- Focus on helping client learn more collaborative behavior
  - *"Even though I understand it's hard, when you are able to share what you feel with me, we are better able to work together as a team and meet our shared goals."*

Treatment Implications (2)

- At the appropriate time, reframe the phobic and conflictual interactions among dissociative parts as *implicitly* cooperative
- Provide concrete examples (e.g., client as one part is about to commit suicide and, at the last moment, "something" prevents her from it)
- State that a treatment goal could be to transform this *implicit* cooperation into a *explicit cooperation and collaboration*

Creating an ideal parent figure as the medium for attachment-promoting qualities

Within a collaborative therapeutic relation: help the patient to develop a positive parent figure (1)

- The therapist should "specifically, actively, and efficiently facilat[ing] the development of a positive, stable inner working model, or map, of attachment relationships. … The therapist helps the patient to evoke and engage with imagery of positive attachment figures and of secure attachment experience with those figures."
  - D. P. Brown & D. S. Elliott (2016, p. 304)

Within a collaborative therapeutic relation: help the patient to develop a positive parent figure (2)

- "[R]epetition and elaboration of contact with this imagery establishes a new internal model, or map, of secure attachment."
- This method "differs from traditional attachment-based treatments in that the primary agent of change is the the patient's relationship with his or imagined attachment figures rather than the relationship with the therapist."
  - D. P. Brown & D. S. Elliott (2016, p. 304)

Dellucci's Collage of the symbolic family (1)

- This is a competence-oriented tool for people suffering from harmful attachments and identifications. It allows the construction of a supportive bracing with alternative attachment possibilities. By using the iconic dimension of the "collage" and an inner dialogue with this reprsentation, it becomes sufficient to feed the vital attachment need and thus gain relational stability.
  - Hélène Dellucci (2012)

Dellucci's Collage of the symbolic family (2): Steps

1. Choice of figures: *Among the figures that you know, from history, our time, or symbolically, by whom would you like to be influenced or accompanied?*
2. Exploration of the existential values underlying this choice: *What precisely made you choose this personage?*
3. Looking for information about the chosen personage(s).

– Hélène Dellucci (2012)

Dellucci's Collage of the symbolic family (3): Steps

4. Printing one or more pictures of the chosen personage(s). Making a collage of these pictures, putting them in a place which you can see everyday.
5. Creating a dialogue with these representations; notably, in case of the need to be supported, for receiving advise.

– Hélène Dellucci (2012)

Dellucci's Collage of the symbolic family (4): Steps

6. Writing two letters: the first letter is an imaginary one from the imaginary, symbolic personage, and the second letter describes the influence in one's life that one wishes to receive from this symbolic personage.

– Hélène Dellucci (2012)

Phase-oriented Treatment: Phase 1 Collaborating in Overcoming the Phobia of Ttrauma-related Mental Actions

Phobia of inner experience, that is, mental actions

- "Since intense experience, regardless of valence, can open floodgates of affect and cognition, the dissociative individual must continually constrict emotional experience to avoid thoughts, feelings, and situations evocative of the original trauma (Van der Kolk, 1989). By shutting themselves out and shutting down, survivors expend vital energy by keeping new information out (Alpert, 1995)."

– H. Schwartz (2015, p. 57)

Mental Actions

- **That which we experience within ourselves, but usually vis-à-vis other people:**
- Feelings
- Thoughts
- Physical Sensations / Movements
- Wishes and Fantasies
- Memories
- Needs
- Intentions, goals, predictions, evaluations
- Decision-making

Phobia of Feelings

- "I was unable to explain to anyone why I was so tied up, walled off and out of touch with my feelings… To be in touch with my *feelings* would have meant opening Pandora's box."

  –Marilyn Van Derbur (2004, p. 98)

The Relationship Between Phobia of Mental Action and Dissociative Parts

- Treatment of phobia of mental actions has to come first in treatment to a degree, and coexists along with treatment of phobia of dissociative parts

because

- one cannot accept, and collaborate with, dissociative parts if one cannot accept the feelings, sensations, needs, wishes, or impulses contained in dissociative parts

Treatment of phobia of mental actions

- Psychoeducation: "Feelings and behaviors are different;" "What you feel and wish is OK"
- Family history of managing inner experiences
- Family messages about inner experiences (e.g., shaming, betrayal)
- Modeling by therapist of sharing mental actions
- Pacing
- Working with various parts of the personality to desensitize them to aversive mental actions

Resolving Shame Face-to-Face

- "Work on shame dynamics is crucial to the resolution of traumatic insults to one's identity and one's self.
- Work on shame with particular [parts] about experiences and actions they consider mortifying is more effective face-to-face. Such encounters challenge the shamed part's perception that it is 'shorn from the herd' and unwelcome by others."

  – Richard P. Kluft (2006, p. 294)

Round 3

Phase 1: Collaborating in Overcoming the Phobia of Dissociative Parts of the Personality

Basic challenges for better team work

- Accepting that one has parts
- Accepting that one is one of the parts

Working with Secondary Dissociation of the Personality

- Work mainly with ANP
- Work with other parts (EPs) mainly through ANP
- Help ANP to overcome phobia of the other parts (EPs), develop empathy and care for them, and collaborate with them

Phobia of Dissociative Parts

- Client (ANP) fears or is ashamed of, or feels disgust for:
  - The mental or behavioral actions of other parts
  - Losing control to another part
  - Becoming another part
  - Being "bad," "dirty," "needy," "just like my father," based on how they view a particular dissociative part

Phobia of Dissociative Parts

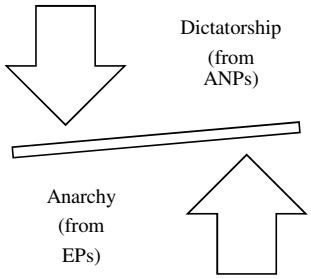
- Based on *non-realization* of the fact that all parts contributed to survival in unbearable circumstances, in inescapable threat,
- On *non-realization* that certain dissociative parts were and are bent to prevent expected worse experiences,
- Including by self-mutilation, submission to or active participation in sexual abuse, suicide attempts

Phobia of Dissociative Parts: Example of Torro and Little Mary

Separation Between "Day Child" and "Night Child"

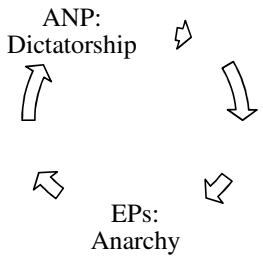
- "Without realizing it, I fought to keep my two worlds separated. Without ever knowing why, I made sure, whenever possible that nothing passed between the compart-mentalization I had created between the day child [ANP] and the night child [EP]."
  - Marilyn Van Derbur (2004, p. 26)

Internal Conflict between ANP and EP



The answer to this vicious circle:

- Striving for democracy involving collaboration…
- Which does not mean that the majority merely exercises its power, but rather involves taking the needs of all parts into serious consideration!



Democracy in Society

- "A permanent democratic debate confirms a common/shared destiny, it creates a sense of unity, straight across all contrasts. It creates trust and a home. And where such a democracy is wanting, the opposite develops: uprootedness, discord."
  - Geert Mak (2016, p. O&D2)
- The same applies to the system of dissociative parts

Therapeutic techniques for helping dissociative patient to become more adapt in decision-making (1)

- Tuning in, joining dissociative parts at where they are
- Helping parts to become more oriented to the present and to engage in mindfulness
- Introducing the metaphor of dictatorship vs. anarchy

Therapeutic techniques for helping dissociative patient to become more adapt in decision-making (2)

- Fostering acceptance of and empathy for other parts
- Stimulating the dissociative parts to function as a team
- Structuring internal deliberations and decision-making: *inner meeting place*

The Dissociative System as Team

- (a) two or more dissociative parts who (b) interact (internally); possess one or more common goals; (d) are brought together to perform organizationally relevant tasks; (e) exhibit interdependencies with respect to workflow, goals, and outcomes; (f) have different roles and responsibilities; and (g) are together embedded in an encompassing organizational system, i.e., the *personality*, with boundaries and linkages to the broader system context and task environment.
  - After Kozlowski & Ilgen (2006, p. 79)

Therapeutic techniques for helping dissociative patient to become more adapt in decision-making (3)

- Aiming for consensus about daily life goals and therapeutic goals
- "Do all parts agree?"
- Calling upon the "inner source of wisdom"

Levels of Decision Making in Dissociative Patients, (3) Therapeutic Goals

- Decision-making involving ordered deliberations among parts, i.e., at least at the level of reflective action tendencies
- Decision-making of the unified/ integrated personality, involving higher level of action tendencies

You Take Care of Them!

- ANP typically avoids or escapes external and internal threat cues, and when EPs are activated
- In treatment, ANPs should learn to take care of EPs
- Therapist should be aware of not doing the job for ANP
- This hope usually co-exists with a broader fantasy that the therapist (i.e., something/one external) can "fix" the client's problems

ANP's phobia of child EP

- "My night child [EP] kept her part of the deal. She had "taken it" [the abuse] until I [ANP] was strong and secure enough to come back and rescue her.
- Now, instead of gratitude for her sacrificing herself, I loathed, despised and blamed her."

--Marilyn Van Derbur (2004, p. 191)

Overcoming the phobia of the child EP

- "…I couldn't find a way to connect with the night child I had abandoned. I just hated her. I had no compassion for her at all.
- I [ANP] was finally understanding that I would be stuck in the muck of dysfunction until I could find a way to stop judging her [EP] so unmercifully."

--Marilyn Van Derbur (2004, p. 281)

Overcoming the phobia of the child EP

- "I had to find a way to *integrate* the night child into the day child, rather than ignoring her, as I had tried to do my entire life.
- Until the night child [EP] had been fully heard, honored and integrated, I [ANP], the adult would continue to fear the night and clutch to my clenched body."

--Marilyn Van Derbur (2004, p. 546)

Working with Dependency

- Encouraging adult parts to care for child parts may be effective, but in some cases, can over-activate the attachment system and evoke attachment seeking and / or defense
- Collaboratively explore with client what prevents child parts from "growing up"
- How might the adult part support the young parts in growing up?
- Encourage more of a "peer" relationship among parts
- "You - all parts of you - are all in this together"

Exploring and relieving symptoms due to [parts'] intrusions

- "Often the most rapid path to symptomatic relief is to address or access the [part] or [parts] "behind" a problematic symptom, behavior, affective state, or perplexity and to negotiate with the [parts] for relief. A [part]-driven intrusion into the dissociative surface is the most common source of such disruptions."
  - Kluft (2006, p. 292)
- Cf. The contracture of *main d'accoucheur*

How to work with "Parts": Focus on their relationships

- Each part has a role to play in maintaining the status quo
- Each part exists for the underlying function of protection, even punitive parts
- Reframe: "Could it be that the part of you that believes you are bad really wants you to be good, and that is why it is so critical of you?

How to Work with "Parts": Focus on their relationships

- Think in terms of how a part fits into a whole system
- Think about why parts experience the need to remain separate: those reasons are entrees for therapeutic interventions
- Always try to include "all parts" in sessions
- Do not treat parts as people, but rather as aspects of one person
- Do not ignore parts and hope they will go away
- Accept the patient's experience of separateness without agreeing yourself
- Find ways to move past fascination and fear
- Always emphasize internal empathy, cooperation, collaboration, and negotiation

Contacting Dissociative Parts

- Promote benign internal communication as soon as possible, foster collaboration
- Structure internal communication
- Initially operate on a cognitive rather than an emotional level
- Avoid triggering [use metaphor of meeting stranger; not discussing traumatic memories]
- Certain techniques may inadvertently trigger parts in uncontrolled ways: EMDR, exposure therapy

Fostering Cooperation, Collaboration, and thus further Integration

Therapist modeling cooperative interaction among parts

- When client as ANP proposes some goal, and before ANP and therapist will agree on a course of action,
- The therapist first wants to know if other parts agree;
- And if not, what their objection(s) is(are);
- Taking this(them) very seriously and inquiring about the reasons,
- Striving toward consensus, including reaching compromises
- Agree on evaluating the outcome

Promoting Cooperative Interaction among Parts

- Create a meeting place or other way to communicate
- Encourage two different parts to communicate with empathy (perhaps with help of therapist)
- Queries:
  - Is some communication already present?
  - What are the different goals of parts, and are they attained?
  - What energy is used or lost with parts?
  - What are your concerns or fears about other parts?

Using Inner Space Metaphors (1)

- Patients often have their own unique perceptions of inner space
- Use their metaphors therapeutically
- For instance, “rooms” can be furnished more comfortably, have intercoms installed, have doors that lead to other inner rooms.
- For instance, parts who exist “in the dark” can be asked to come to “the edge of the light”; parts “in the back” can be asked to move slightly to “the front”

Using Inner Space Metaphors (2)

- Inner space can serve comfort and containment functions
- Do not “lock” parts away, rather frame containment as temporary rest or a break
- Inner containment space can be used for traumatic memories, e.g., boxes, computer files, bank vaults, holes, closets
- Beware that parts often reenact neglect and abuse in constructing space, e.g., an EP “lives” in a closet without food and water

Using Available Resources

- One part may have an action system-based resource that another part lacks
- In exploring this, include respective action systems
- Create cooperation between these parts

Mobilizing currently inaccessible skills (1)

- "Often a DID patient who is currently overwhelmed gives a history of significantly higher function in the past and indicates that the resources (such as job-related knowledge and skills) essential for better function are associated with a particular [part] or [parts] that are currently not available."
  - Kluft (2006, p. 293)

Mobilizing currently inaccessible skills (2)

- "Accessing and mobilizing [parts] with such strengths may prove essential to the rehabilitation of a DID patient. The patient creates his or her own sense of safety through the application of his or her own skills."
  - Kluft (2006, p. 293)

Dealing with Perpetrator-Imitating Parts

The importance of working with "resistance" in DID patients

- "While the notion of a therapeutic alliance … or a working alliance … is hardly novel, the significance … is that certain segments of the mind do not appear to engage in the therapeutic process without active interest on the analyst's part. As though the phenomenon of resistance may literally be personified in this patient population, it becomes necessary at times to "include," "invite," or even seek out the most [dissociative parts] for treatment to progress."
  - I. Brenner (2016, p. 213)

Two types of "fight" parts, both stuck in trauma-time, that need different therapeutic approaches

- Parts stuck in defensive aggression ("*fight parts*"), in need of realizing the safety of the present and that there is no need to defend
- *Perpetrator-imitating parts*: parts that identify with the perpetrator(s), i.e., view themselves (more or less) as the literal perpetrators and re-enact their behaviors

Perpetrator-imitating parts in the therapy room

- "[T]he perpetrators have entered the patients' mind and their representations will inevitably enter the therapy relationship, challenging it at its core.
- [Parts] of a trauma survivor's personality will endeavor doggedly to undermine the treatment in a manner tantamount to having the original perpetrators themselves in the room facing off against the therapist.
- The therapist's awareness, knowledge and skill in handling this particular [part] can make or break the therapy."
  - H. Schwartz (2015, p. 12)

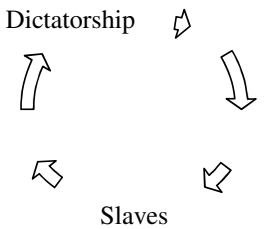
Perpetrator-imitating parts: Blaming the victim

– "By negating any revelations of victimization and vulnerability, perpetrator-[imitating parts] adamantly deny the culpability of the abusers, often blaming other [parts] of the patient's self with which they have completely disidentified. These perpetrator[-imitating parts] see the other [parts] as "not-me" and as deserving all the violations that took place."
  • H. Schwartz (2015, p. 166)

Perpetrator-imitating Parts: Function

- It is always fundamentally easier for the child victim to introject the perpetrator than to be aware of his or her own victimization. (Herman, 1992; Schwartz, 2015; Ross, 1989)
- Doing so provides a sense of power instead.

Perpetrator-imitating parts versus victim-parts: A totalitarian system



Perpetrator-imitating parts

- Virtually all perpetrator-imitating parts "are the terrorized, shame-ridden, desperate, and ruthless child aspects of the personality. When [they] enter the treatment process, they can undermine all prior psychotherapy progress with threats of premature termination, suicide, and/or blackmail.
- Untreated [perpetrator-imitating parts] leave some patients at risk of criminal behavior and re-engagement with their perpetrator(s)."
  – H. Schwartz (2015, p. 14)

Beware of conflict-avoidant parts when abuse is reported

– "There are [parts] seeking only conflict-avoidance and anxiety-reduction that do not wish to engage in any discourse that "rocks the boat."
– These conflict-avoidant, collusive [parts] have little integrity or independent will, and are easily available for activation by both perpetrator-[imitating parts] and victim-[parts] seeking relief from the disruptions of the dissociative status quo.
– Their ready stockpile of distractions and addictions is impressive."
  • H. Schwartz (2015, p. 166)

Working with Perpetrator-Imitating Parts

- Patient (ANP) is usually very afraid of these parts, does not want anything to do with them (critical voices)
- Other EP's are also very afraid, they usually think that these parts are actual external perpetrators
- Perpetrator-imitating parts may be afraid of the therapist and don't want to give up "power position" (afraid therapist will never want to work with them, hate/despise them, will get rid of them)

Perpetrator's use of religious "beliefs" as justification

- "Many child victms are fed religious or spiritual justifications for their abuse, such as God is choosing them, loving them, punishing them, or abandoning them by way of the traumatizing events."
  - H. Schwartz (2015, p. 18)
- Example: "*You are a devil's child, therefore you deserve this punishment*."

Helping ANP with maladaptive responses to inner communications from perpetrator-imitating parts

- Help ANP to realize s/he is not crazy for hearing punitive voices
- Help ANP to change defensive states (e.g., freeze, submission, fight, flight) in response to punitive parts
- Help ANP move out of defensive/avoidant actions, such as drugs/alcohol, self-harm, overwork
- Help ANP develop reflective rather than reflexive actions: start with teaching "stop and breath before acting;" calming, grounding exercises; thinking, planning; deciding whether to act on thoughts or feelings

Bringing perpetrator-imitating parts into treatment (1)

- "[Parts] based on abusers often cause chaos and instigate self-injury behind the scenes but are more likely to become amenable when regularly accessed and brought into therapy. Their defensive narcissistic constellations often preclude their feeling included in approaches that do not address them directly."
  - Kluft (2006, p. 293)

Bringing perpetrator-imitating into treatment (2)

- "Their experience of the clinician's caring and empathy are crucial to their changing in a constructive manner. This concern may be problematic with [parts] of all sorts. Their not being directly addressed is often perceived as a rejection and a narcissistic insult."
  - Kluft (2006, p. 293)

Types of perpetrator parts: Grandiose-contemptuous type (1)

- "While accepting, or even facilitating, the grandiose-contemptuous [part's] expression of negative transference and antagonistic feelings toward therapy and the therapist can be a useful starting point,
- waiting too long to confront and interpret the perpetration inherent in repetitive disparaging or threatening behavior runs the risk of unconsciously abandoning the patient as a whole."
  - H. Schwartz (2015, p. 128)

Types of perpetrator parts: Grandiose-contemptuous type (2)

- "Although convincing to the inexperienced therapist, arrogance is often a brittle mask for profound insecurity and extreme narcissistic vulnerability as well as a manifestation of perpetrator identification.
- The protective carapace surrounded perpetration must be systematically understood and creatively challenged, establishing an alternate, interpersonal form of holding and containment that eventually allows extreme dissociative polarizations to negotiate and relax."
  - H. Schwartz (2015, p. 128)

Types of perpetrator parts: Grandiose-contemptuous type (3)

- "As these [parts] progress in treatment from rigid and repetitive deflections of any alternative to the logic of the internalized perpetrating system, through states of confusion and affective and somatic dysregulation, they can slowly gain greater tolerance for affect, ambiguity, emotional contact, and human tenderness."
  - H. Schwartz (2015, p. 130)

Types of perpetrator parts: Grandiose-contemptuous type (4)

- "These grandiose-contemptuous [parts] experience vulnerability as annihilating, and thus will go to absurd lengths to avoid facing the reality of them being merely a splintered part of a larger whole, and the reality that they were merely pawns in a maniacal perpetrator(s)' game."
  - H. Schwartz (2015, p. 129)

Working Alliance with Perpetrator-imitating Parts

- Therapist gives "Protector speech" early in treatment (has to be repeated over and over!)
- Psychoeducation about typical "perpetrator cognitions"
- Psychoeducation about typical attachment problems of "perpetrator-imitating parts"
- Teach about dependency, autonomy, and healthy interdependancy

Perpetration: Witnessing

- "All therapists treating severe, complex trauma survivors need to be well-versed in the history of torture and perpetration worldwide so they have a broad context within which to hold and contain the patient's traumatic narratives.
- In the witnessing process, the therapist must be careful not to prematurely foreclose the nature or meaning of any given traumati[zing] event or revelation. They must also be mindful not to avoid inquiry or doubting for fear of alienating, retraumatizing, or abandoning the patient."
  - H. Schwartz (2015, p. 164)

The Result of Long Collaboration: Example

- "Something has changed – it's hard to articulate. The feeling of being me is different, I am more together, much more solid. There is an absence – of – I don't know – of the past, yes, of my past interfering with the present. The conflict [among parts] is absent. **We** invited the part of me that wanted to die. She is here and feels free for the first time. She – I - feel here with you, and my mind is clear. I am accepting myself, all of me, all of my past. **This is what we have done together – a team effort of being together to create a miracle."**

Round 4

Phase 2: Resolution of major conflicts about traumatic memories (1)

- "To deny horrible events and to proclaim them out loud has been the central preoccupation of traumatized people."
  - Judith Herman (1990, p. 289)
- "Some parts of the patient may deny that anything at all happened, while others are desperately trying to tell the story. In this case, the therapist must not take either side, but should passionately empathize with the conflict:"
  - Steele, Boon, & Van der Hart (2017, pp. 432-433)

PHASE 2
Treatment of traumatic memories

- **Overcoming the phobia of attachment and detachment:**
  - therapeutic connection with EPs
  - resolution of insecure attachment (traumatic bonding) to the perpetrator
- **Overcoming the phobia of traumatic memories (including their integration)**

Integration of traumatic memories

- Consists of a series of mental processes:
  - Synthesis: Meaningful association of basic psychological phenomena into a complex and coherent mental structure
  - Realization: The process of developing conscious awareness and meaning of personal experiences and facts, becoming fully aware of their implications for one's existence
    - » Personification
    - » Presentification

Dealing with Parts Idealizing the Perpetrator(s)

- Involves delicate inner systems work
- Avoid fostering split between these parts and the "victim-parts"
- Speak in terms of *both/and*, instead of "*either/or*"
- The example of Annie: the male parts idealizing Daddy vs. the girl parts carrying the abuse

Phase 2: Resolution of major conflicts about traumatic memories

- "… *You are questioning this part of you that says he beat you. At the least, you were witnessing some pretty hard things in your house that were terrifying and confusing. Maybe you could just hear what that part ahs to say without judging it? I'm sure that over time you and that part can sort it out. But first you need some space to listen to each other."*
  - Steele, Boon, & Van der Hart (2017, p. 433)

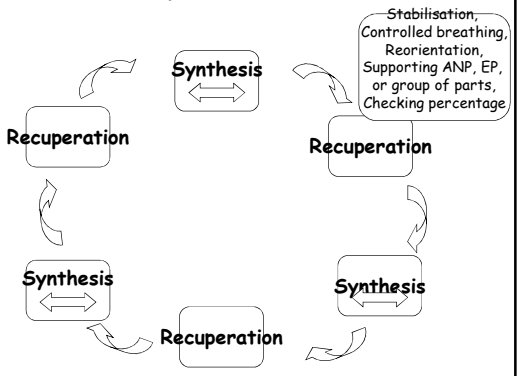
Phase 2: Resolution of major conflicts about traumatic memories: Threats

- "A major conflict with many dissociative patients is a chronic terror of being threatened if they "tell." Most commonly, these threats are re-enacted by perpetrator-imitating parts internally: *Shut up! Don't talk. If you tell you are dead*. The patient feels severely threatened because there is limited realization that the threats are now in the past, not in the present."
  - Steele, Boon, & Van der Hart (2017, p. 434)
- This lack of realization is also related to the fact that these threats function as *malignant posthypnotic suggestions*.

Guided Synthesis of Traumatic Memory

- The initial awareness (sharing) of a traumatic memory that previously has been completely dissociated or only partially recalled
- Purpose is to alleviate dissociation
- Distinct from Abreaction and Catharsis
- Purposeful mental action, based on a conscious decision
- Allows trauma to become a part of the person's history

Guided synthesis in rounds



Guided Synthesis (1)

- "Are you willing to share X in this session?"
- If yes, "Is everybody who should not be present in their own safe place?"
- "And is everybody who needs to be present and participate present?"
- "Just nod when you are ready to share X, and only X."
- If yes, "Okay, begin…"

Guided Synthesis (2)

- "One, Share it with each other"
- "Two, Bring it all together"
- "Three, Make it one whole"
- "Four, Unite all of it"
- "Five, And share what you can share for now"
- "And stop!…"
- "And take a couple of deep, satisfying breaths…" [*Allow for consultation together*]
- "And just nod when you are ready for the next round of sharing only X"

3rd Third of the Session

- Adequate closure and containment
- Talking with the client about her or his experience during the session
- Talking with clients about what they plan for the next few days
- Reminder of safety plan (already set up), if needed

Various Targets of Guided Synthesis

- Pathogenic kernels
- Pathogenic kernel statements
- "Malignant hypnotic suggestions"
- Dominant trauma-related affect
- EP stuck in hyper-arousal
- Trauma-related collapse, total submission (hypo-arousal)
- Extremely shattering traumatic experiences (example K)
- Traumatization involving organized perpetrators (including programming)

Phase 2: Synthesis

FRACTIONATED SYNTHESIS

- One identity (part) or dimension only
- Short sequences
- Interspersed with deep relaxation (and time distortions suggestions)
- Modulation of affect and general arousal
- EMDR

Pathogenic kernels: Example of K's sexual abuse by father (1)

- what he does with the little stick
- what you have to do with is
- other things he does
- other things you have to do
- what you smell
- what you feel
- what you see

Treating Shutdown/Collapse

- This is a state of parasympathetic dominance
- Focus on safety
- In many cases, the patient can continue to hear you, so speak calmly and slowly. "*Just allow yourself to follow the sound of my voice back to here and now, where you are safe in my office*."
- Encourage regular, deep breathing
- "*You can begin to notice that your body is moving and working all by itself. It know just what to do. Feel your heart beating, the rise and fall of your chest as you breathe. With each beat of your heart, and with each in breath, you can realize more and more that you are safe.*"

Phase 3: Personality (Re)integration and (Re)habilitation

- Overcoming the phobia of attachment: the phobia of intimacy with others
- Overcoming the phobia of normal life and change
- Overcoming the phobia of healthy risk-taking
- Overcoming the phobia of the body
- Overcoming the phobia of sexuality

Ongoing integration

- "We are all engaged in integration all the time. It is, by definition, always imperfect and somewhat incomplete.
- Even when all dissociative parts are integrated into a cohesive personality and sense of self, patients continue to change and grow."
  - Steele, Boon, & Van der Hart (2017, p. 466)

DID client reporting on her integrative process (1): Increased personification

- "It (the "it" in myself) threatens/appears to be such that "it" is me and becoming me. My things of the past become mine. It seems"as if there are things that don't have that indecent distance toward me anymore. As if I may "own" them. As if they allow it."

DID client reporting on her integrative process (2): Increased personification

- "As if "we" can, and are allowed to, become more "one" or "together." It seems as if estrangement diminishes and that something "own" starts to come. It is, of course, about strange things (= things that are not my own) but it seems as if I may learn to know and use them."
- "And I cannot tell you otherwise than that I am so happy with it!"

Annie's struggle, as ANP, to realize that she is one of the parts

- "It feels different when I am one of the parts, but also very scary—then another part could take over without me being present… In the past that was often also necessary and did happen. Therefore, it is so difficult to share and own what happened."
- However, Annie realizes that as a part among the others she would have been much less lonely if that could have happened. She concludes that, from her current position, she is now willing to engage in the contact with all parts. There is also the fear that she then won't be able to control everything.

Integration into a cohesive personality

- "The integration of dissociative parts allows for a cohesive sense of self that is consistent and adaptable across time and situations. Patients should no longer experience dissociative symptoms such as amnesia, switching, auditory voices, or passive influence."
  - Steele, Boon, & Van der Hart (2017, p. 467)

Phobia of fusion/unification of parts (1)

- "Most dissociative patients are phobic of the idea of parts coming together in some way and become highly distressed when the therapist tries to discuss it. Thus, while it may be a major goal of treating dissociative disorders, the way in which the therapist first talks about it will make a difference."
  - Steele, Boon, & Van der Hart (2017, p. 467)

Phobia of fusion/unification of parts (3)

- "Over the course of therapy, the therapist should continue to check in with the patient about why parts need to remain separate. A focus on the need for ongoing dissociation can target specific problems that maintain dissociative parts, such as phobia of anger or lack of realization that one was sexually abused."
  - Steele, Boon, & Van der Hart (2017, p. 469)

Phobia of fusion/unification of parts (4)

- "The therapist should ask in a curious way, *I wonder what keeps those parts of you separate from you?* or *Have you ever thought about why those parts still need to be separate from each other? Have you ever thought about why that part of you has never grown up? I'm curious about what might it be like for you if those parts were closer together?*"
  - Steele, Boon, & Van der Hart (2017, p. 469)

Phobia of fusion/unification of parts (5)

- "Two main reasons for avoidance of fusion or unification are the presence of unresolved trauma and dissociative parts that are not yet known to the therapist (and often to the patient [as ANP], both indicating strong phobias."
  - Steele, Boon, & Van der Hart (2017, p. 470)

Unification of parts

- "In general, it is best if the idea of unification comes from the patient, but … the therapist should be gently persistent in questioning the ongoing need for separation between parts." Whether or not the patient needs or wants suggestions or imagery for unification will depend on the individual. Sometimes the therapist can merely be present while all parts "come together." Some patients will suggest their own imagery."
  - Steele, Boon, & Van der Hart (2017, pp. 475-476)

Grief in Phase 3 (1)

- "In Phase 3 the full weight of their suffering sometimes come to bear, as patients really begin to engage in life and realize exactly what they have missed. By now most patients are aware of their autobiography and have begun to realize what could have been, and what never was nor ever shall be."
  - Steele, Boon, & Van der Hart (2017, p. 483)

Grief in Phase 3 (2)

- "Albeit painful, this grieving leads to greater *personification* and *presentification*. The more patients can own and accept their lives, the more they can take charge and act in the present to improve what they can."
  - Steele, Boon, & Van der Hart (2017, p. 483)

Phase 3: The fear of getting well (1)

- "Many patients harbor a secret fear of getting better. This is not because they wish to continue suffering, but because they are afraid of what it might mean. … Some believe it means other people will no longer help them and they must then figfure out how to do everything on their own."
  - Steele, Boon, & Van der Hart (2017, p. 487)

Conclusions

- Treatment involves a *collaborative relationship* between therapist and client, as well as among parts
- Treatment involves working with ANP(s) and EP(s) within their window of tolerance: improve the regulatory system
- Treatment involves performing integrative (mental and behavioral) actions, in particular realization of the traumatic memory and its consequences
- Realization presupposes joint activation of ANP and EP, and requires the highest levels of integrative capacity

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