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The Treatment of Structural Dissociation in Chronically Traumatized Patients

Janina Fisher, Ph.D.

Chronic traumatization, especially beginning early in life, leaves a legacy that poses additional treatment complications for patient and therapist. In this chapter, we will focus on the impact of trauma-related structural dissociation in driving the symptoms, issues, and relational challenges brought to therapy. An understanding of the manifestations of structural dissociation helps the therapist make sense of paradoxical and contradictory symptoms and helps the patient to interpret their emotions, behavior, and physical reactions as information about the effects of trauma rather than proof of their defectiveness. Lastly, we will address therapeutic interventions for treating structural dissociation and its manifestations.

Human infants begin life with an immature brain and body, lacking the capacity to regulate their biobehavioral states without the external mediation of their caretakers. Ideally, during this stage of development, attuned parents interactively regulate babies' dysregulated states, helping them expand their capacity to sustain positive moods, recover more quickly from dysregulation, and communicate via social engagement their physical

and interpersonal needs (Putnam, 1997; Shore, 2004; Ogden et al, 2006). Our capacity for affect tolerance and the achievement of an integrated sense of self later in life is dependent upon these self-regulatory abilities acquired during early development, both the ability for interactive regulation (to be soothed by others) and auto-regulation (soothing ourselves). In addition, because dysregulated autonomic arousal inhibits activity in the prefrontal cortex (LeDoux, 2002), even the child's ability to learn, problem-solve, and verbally communicate is dependent upon self-regulatory capacity and therefore on the quality of early attachment. Without interactive regulation from securely attached parents, small children must depend on their ability to alter consciousness when soothing is needed and on the body's innate "fault lines" for compartmentalizing overwhelming experiences (Van der Hart, Nijenhuis & Steele, 2004; 2006).

One "fault line" for structural dissociation available at birth is the right hemisphere-left hemisphere split. Though children are born with both hemispheres, they are right brain dominant for most of childhood. The slower developing left brain has spurts of growth around age two and again at adolescence, but the development of top-down or left brain dominance is only achieved very gradually. In addition, the corpus collosum, the part of the brain implicated in right brain-left brain communication, also develops slowly and only becomes fully elaborated around the age of 12. Thus, in the early years of childhood, right brain experience is relatively independent of left brain experience, lending itself to splitting should the need arise. Studying brain development in children and adolescents, Martin Teicher has observed a correlation between a history of abuse and/or neglect and under-development of the corpus collosum compared to

normal controls (2004) which would also support the hypothesis that trauma is associated with structural dissociation of right and left brain-mediated parts of the personality.

Attachment research has also contributed to the literature supporting the concept of an innate tendency to compartmentalize under stress. In a number of longitudinal studies of attachment behavior (Lyons-Ruth et al, 2006; Solomon & Siegel, 2003; Solomon & George, 1999), researchers have demonstrated that children with disorganized attachment status at age one are significantly more likely to exhibit dissociative symptoms by age 19 and to be diagnosed with Borderline Personality Disorder or Dissociative Identity Disorder in adulthood. Since the essential contributor to disorganized attachment status appears to be a pattern of parental behavior described by researchers as "frightened or frightening," Liotti (1999) hypothesizes that dissociative splitting is necessitated by an irresolvable conflict between internal working models: biologically, the attachment figure elicits the cry for help response or proximity-seeking under stress, yet approaching abusive or threatening adults elicits fear, fight and flight responses.

Van der Hart, Nijenhuis & Steele (2004; 2006)'s theory of structural dissociation of the personality cites another set of fault lines along which structural dissociation can occur: the "action systems" or innate drives that propel the stages of child development and adaptation to the environment. One set of innate drives can be seen in children's innate propensity to attach, explore, play, and develop social engagement and collaboration skills and then, as older children and adults, learn to regulate their bodily needs, mate and reproduce, and care for the next generation (Panksepp, 1998; Van der

Hart et al, 2006). Equally, children have to depend upon their instinctive animal defense survival action system mobilizing hypervigilance, cry for help, fight and flight, freeze, collapse and submission responses to quickly inhibit exploration, social engagement, and regulating functions in order to ensure automatic self-protective behavior.

For children raised in unsafe environments, both types of action system are necessary in response to changing internal and external demands: for example, going to school requires a part of the personality that can explore: pay attention in class, learn, and socially engage with peers and teachers. At home, with parents who may be withdrawn or neglectful at some times and violent at others, having different parts of the self prepared to deal with different threats could be essential: for example, in response to the sound of the abuser's voice or footsteps, the panicky alarms of a fearful part (freeze) can alert the individual to danger; a playful part might try to lift the parent's irritable mood and facilitate a positive connection by making him laugh (social engagement); a caretaker aspect of self (submission) can become the precociously responsible child who tries to protect herself or younger siblings in the face of the violent behavior; or a hypervigilant aspect of self (fight) may become a kind of bodyguard, carefully observing the parents' mood and directing the child's activity to best defend against their "frightened or frightening" behavior. Extrapolating from the observations by Myers of shell-shocked World War I veterans, Van der Hart and colleagues (2004) labeled the part(s) of the personality driven by daily life priorities the Apparently Normal Part of the Personality and the parts driven by animal defense responses the Emotional Parts of the Personality, or, individually, the Fight, Flight, Freeze, Submit, or Attach for Survival parts. In this

chapter, I will use the terms that I have found more useful in clinical practice: the Going on with Normal Life part and the Trauma-Related parts of the personality. In avoiding the words, "apparently normal," I want emphasize to the positive evolutionary function of the ANP and challenge client tendencies to see their ability to function as a "false self" and their trauma-related responses as the "true self." In addition, emphasizing the positive aims and goals of the "normal life" part encourages clients to strengthen their ability to regulate the tumultuous emotions and autonomic dysregulation of the animal defense-related parts, rather than simply trying to ignore them.

Because structural dissociation theory describes a model for understanding personality structure in chronically traumatized clients, it is consistent with a number of diagnoses, including DID and DDNOS but also Borderline Personality Disorder (Korzekwa, Dell, & Pain, 2009) and Complex PTSD. Just as each individual responds to trauma differently, so each dissociative personality system is unique. Clients whose traumatic experiences were chronic and involved different types of abuse and/or neglect, necessitating more complex secondary structural dissociation, are likely to have a well-developed Going on with Normal Life self and several different parts driven by the survival responses of fight, flight, freeze, submission, or cry for help. In these clients, fragmentation can be more subtle and permeable or more dramatic and rigid: clients with diagnoses of Bipolar II Disorder might shift from irritable moods to depressive states to anxiety, while clients with Borderline Personality Disorder might sometimes present as regressed and clinging, then cold and angry, then hopeless and passively suicidal, while all the while functioning fairly well at work. With mild to moderate Dissociative Disorder

Not Otherwise Specified (DDNOS), the therapist might encounter more clearly observable compartmentalization and more difficulty with memory (for example, not clearly recalling the intense anger and aggressive behavior of their fight parts or the neediness of a young child part with separation anxiety). In clients with DID (Dissociative Identity Disorder), not only will the number of parts tend to be greater but they be more likely to have subparts serving the Going On with Normal Life self or its priorities, for example, a professional self, a parenting part, or a part with special talents or social skills. In addition, as the neural systems governing each part become more elaborated and autonomous, clients start to exhibit switching and time loss as they are "highjacked" by parts who act or act out outside the conscious awareness of the Going On with Normal Life self.

While updating her curriculum vita, Celia, a successful organizational consultant, was surprised to discover that she had won an award in 1990 for which she had no memory. Not only could she not recall winning it, she couldn't recall what she had done to deserve it! Annie also discovered disturbing evidence of missing time and dissociative highjacking when she received a letter from her oldest friend asking her never to contact him again under any circumstances. "I will never forgive you for what you said to me last week—it was cruel, and I don't want to be hurt anymore." Lacking a memory of having spoken to him recently, she could not imagine why 'she' had been angry at him.

Characteristically, the Going On with Normal Life part tries to carry on with daily priorities (functioning at a job, raising the children, organizing home life, even taking up

meaningful personal and professional goals). But those activities are often complicated by intrusive symptoms representing activation of parts serving the functions of fight, flight, freeze (or fear), submit, and attach for survival or "cling" who are triggered in the context of everyday life, resulting in hypervigilance and mistrust, overwhelming emotions, incapacitating depression or anxiety, self-destructive behavior, and fear or hopeless about the future. Many clients come for treatment after being flooded or "highjacked" by the feelings and physiological reactions of the trauma-focused parts; others come when their attempts to disconnect or deny these responses lead to chronic depression or depersonalization. Although some of these clients may present with diagnosed dissociative disorders, many more will come to therapy with trauma-related symptoms that appear initially straightforward, such as as PTSD, anxiety and mood disorders, or personality disorders.

Signs and symptoms of structural dissociation

- Manifestations of internal splitting: i.e., functioning highly at work while regressing in therapy, alternately idealizing and devaluing significant others or the even the therapist, high intelligence coupled with poor judgment.
- Treatment history: a number of previous treaters and diagnoses without much progress or clarity, treatments that have been rocky, tumultuous, or have ended in some unusually dramatic way.

- Somatic symptoms: unusual pain tolerance, stress-related headaches, eye scanning, blinking, or drooping; narcoleptic symptoms; atypical or non-responsiveness to psychopharmacological medications.
- Regressive behavior: body postures, cognition, verbal or body language more typical of young children; inability to make eye contact, running away, becoming mute, fear of abandonment, clinging emotionally
- Patterns of indecision or self-sabotage reflecting internal struggles between parts: inability to make small everyday decisions, difficulty committing to significant others; frequent job or career changes, success in life alternating with failure or disability, high-functioning alternating with decompensation, hard-working in therapy but self-destructive outside of it.
- Memory symptoms: difficulty remembering how time was spent in a day, difficulty maintaining continuity from therapy session to therapy session, "black outs," getting lost while driving somewhere familiar (such as going home from work), forgetting conversations, forgetting well-learned skills (such as how to drive), engaging in behavior they do not recall.
- Patterns of self-destructive and addictive behavior reflecting internal conflicts: the Going On with Normal Life part may be committed to life and to stabilization while the fight and flight parts engage in high-risk behavior or attempt to harm or kill the body in the effort to get relief at any cost. In a pilot study using the structural dissociation model with a group of severely symptomatic inpatients hospitalized for 2-10 years to prevent intentional or unintentional suicide, all six subjects demonstrated marked

improvement after a year of mindfulness and psychoeducationally-based treatment focused on identifying the parts connected to the unsafe behavior and strengthening the ability of the Going On with Normal Life self to identify and emotionally separate from the impulses of self-destructive parts (Fredine, 2013, personal communication).

Impediments to trauma resolution

The structural dissociation model predicts that symptoms of fragmentation, depersonalization, out of body experiences, failures of integration, and internal conflict between parts of the personality are all to be expected as a legacy of traumatic experience in addition to the more common intrusive, numbing, and autonomic symptoms of PTSD. The core impediments to resolution for structurally dissociated clients center around the effects on the trauma-related parts of exposure to trauma-related triggers encountered in normal daily life:

- Trauma-related "highjacking" of the Normal Life part leading to frontal lobe inhibition and loss of the ability to reality-test, manage symptoms, and regulate impulsivity
- Internal struggles between the Going On with Normal Life part and animal defense-related parts: involvement in normal life is limited by fear of leaving the house; wishes for closeness and friendship are countered by fear and mistrust of relationships

- Failure to integrate past and present: while the Normal Life part tries to avoid thinking about the past, the trauma-related parts are chronically preoccupied with danger, loss, and fear
- Inability to soothe overwhelming emotions and regulate dysregulated autonomic activation.

For example, even when the client's normal life is safe and stable and the adult self is competent and capable, trauma-related parts may interpret traumatic triggers as signs that they are in the same danger of being annihilated, humiliated, or abandoned as they were in childhood. Each responds to triggers with different animal defenses: the freeze part might become agoraphobic; the submissive part may retreat to her bed in shame, depression, and hopelessness; a hypervigilant fight part might push people away with irritability, mistrust, or guardedness. Suicidal or self-harming parts, driven by fight/flight responses that once increased the child's sense of having some control ("If it gets too bad, I can die—I can leave—I can go to sleep and never wake up"), may continue to have strong self-destructive impulses triggered by threat, loss, or vulnerability. The flight response of another part might drive addictive behavior, eating disorders, sexual addiction, and other sources of relief or 'flight' from the overwhelming trauma-related feelings and sensations. And then, in response to the acting out of fight-flight-related parts, submissive and needy parts could become ashamed, depressed, and filled with self-loathing, while the 'cry for help' parts beg not to be abandoned. Often, therapists are left feeling confused, helpless, and even overwhelmed: what do we focus on first? Do we focus on the memories of the past or the addictive and self-destructive behavior? Do we try to address the shame and

low self-esteem or the fear of abandonment? Do we respond to the counterdependent hypervigilant parts who challenge us and push us away or to the needy but relational child parts?

Treatment goals and interventions

To address these challenges, there are some simple principles that can guide us in planning the treatment. Even in the midst of crisis and confusion, it is the therapist's job to keep the focus on the sequence of basic therapeutic tasks necessary to good treatment for trauma-related dissociation. Neuroscience research on traumatic remembering tells us that both spontaneous triggering and deliberate recollecting result in activation of the autonomic nervous system and de-activation of the prefrontal cortex in preparation for mobilizing (fight/flight responses) or immobilizing (freezing/submitting) forms of self protection—as if the danger were happening again. Not only do our clients suffer from the effects of each single traumatic incident but also from the repeated re-activation at a body level of the same non-verbal memories of fear, shame, loss of breath, body tension, pulling back, collapsing, rage, the impulse to hide, even the feelings of worthlessness and fault. To differentiate these feeling and behavioral states from normal responses to everyday life requires activity in the prefrontal cortex responsible for stimulus discrimination, the ability to compare a stimulus now from stimuli then. In order to counteract frontal lobe inhibition in traumatized clients, the therapist must focus on the Going On with Normal Life self as the "client" while simultaneously holding in mind that this adult is being influenced moment by moment by emotional and physiological input

from the trauma-related parts. The most important goals of treatment are to increase meta-awareness of the whole system of parts, promote acquisition of new, healthy self-regulatory skills for soothing, calming or energizing them, and foster a greater capacity for internal connectedness, for "association" instead of dissociation.

- **Increasing activity in the prefrontal cortex**: psychoeducation about the Structural Dissociation model, about how we develop parts, and how trauma affects the mind and body can serve to strengthen the Adult self by increasing his or her curiosity and therefore activating the frontal lobes.
- **Learning how to differentiate an Adult Self from traumatized parts:** teaching clients mindfulness-based self-observation to differentiate the moment-by-moment input from child versus adult parts and helping clients develop techniques for regulating autonomic arousal, staying present, and better managing the symptoms so they do not interfere with having a life in the here-and-now.
- **Speaking the "language of parts:"** mindfulness-based techniques require the more complex ability for internal awareness, while using parts language simplifies the task of noticing moment-to-moment responses and eliciting curiosity. Parts language also facilitates increased self-compassion: if an angry or lonely or ashamed feeling is re-framed as a communication from a young part, the Adult often softens toward it or feels more empathy.
- **Learning to identify triggered responses and differentiate past from present** so that post-traumatic symptoms are not confused with current

reality. Intrusive emotions, thoughts, and impulses must be understood as communications from the trauma-related parts, and autonomic hyperarousal or numbing and loss of energy must be framed as symptoms characteristic of a particular part rather than labeled more generally as "my" acting out, rage, shame, depression or passive-aggressive behavior.

- **Teaching an array of cognitive-behavioral and somatic techniques** to help the Going On with Normal Life part learn to manage the overwhelming number of symptoms and autonomic dysregulation associated with PTSD, Complex PTSD, borderline personality disorder, bipolar disorder, and dissociative disorders.
- **Learning how to use "therapeutic dissociation,"** taking positive advantage of clients' dissociative abilities: teaching them how to hold multiple parts in awareness simultaneously, engage in internal dialogue, and create safe places inside
- **Learning how to foster internal communication and cooperation**: helping the Going On with Normal Life self to develop increased trust, empathy, and compassion, increasing the capacity to soothe the parts, developing ways to resolve internal conflict
- **Learning how "to be here now:"** for trauma to feel like 'past' experience requires that we have gained the ability to stay conscious and present even in the face of triggering, to tolerate the ups and downs of a normal life, and to help all parts feel safe in the body.

Increasing activity in the prefrontal cortex

The essence of structural dissociation is perfection of the ability to distance from affect in order not to become overwhelmed. Whenever emotions become unmanageable, a neurological circuit-breaker system facilitates an automatic "switch" to another, more tolerable feeling state held by a different part. The first task of treatment is to further **refine** this ability to distance from affect by fostering the client's ability to understand how a elaborately fragmented system works—to understand its emotional logic, even when that defies rational logic. Because the Going On with Normal Life part is associated with increased prefrontal cortical activity (Reinders et al, 2006), the ability to be curious, to notice experience, is never lost, even in the most regressed or decompensated clients. However, in the context of autonomic dysregulation, dissociative switching, alterations in consciousness (spacing out, numbing and disconnection) and intense struggles between parts, success in attaining this skill is dependent upon the therapist's ability to interactively regulate the client and to keep the focus of the therapy on educating the client about trauma and dissociation. Rather than colluding with the Normal Life part's wish to ignore the symptoms and hope they will go away or the traumatized parts' impulses to flood the mind and body with overwhelming emotions, flashbacks and memories, or unsafe impulses, the therapist must try to stay focused on helping the client to notice the patterns that repeatedly unfold and making sense of them psychoeducationally. Even very regressed clients often show improvement with simple, basic information about trauma: the relationship between triggers and symptoms, cortical inhibition, autonomic arousal and dysregulation, procedural or "body memory," structural dissociation.

Learning how to differentiate an Adult Self from traumatized parts of self

Helping the client differentiate a Going On with Normal Life Part connected to awareness of the here-and-now present is sometimes a matter of faith: we have to believe that every adult has an Adult Self, no matter how depleted or demoralized or low-functioning the client may be. The client will often have little consciousness of that Adult Self because his or her attention is drawn to the latest crisis or to the overwhelming emotions or bizarre behavior s/he cannot understand. Or the client may be aware of skills associated with their Going On with Normal Life parts, such as the ability to think, conceptualize, acquire knowledge and skills, care for others or accomplish tasks, but he or she experiences these states as a "false self," rather than as a more stable, thoughtful, functioning self. Often it helps to have the client collaborate with the therapist in identifying what role the Going On with Normal Life part plays in his or her life now: for example, going to work, taking care of a child, interfacing with the external world, doing things with friends, participating in hobbies. Once that adult and his/her competencies have been re-framed as the Going On with Normal Life part, the client can be helped to notice is NOT the Adult Self: for example, when he feels little and overwhelmed at work, does that fit with what he knows about how his Adult self functions? Does he feel little and overwhelmed when caring for his children? Probably not. Those feelings therefor Probably not. Those feelings must therefore have to belong to a part who would logically feel little and overwhelmed, such as a traumatized child. When he feels angry and gets sarcastic with his boss, is that the Adult? What part would feel angry at an authority figure and not care about the consequences? At what age and stage of life would that be a

characteristic behavior or way of thinking? As the therapist helps the client differentiate what actions and reactions go with adulthood and which with different ages and stages of childhood, while emphasizing the importance of adult leadership in creating safety and stability, there is an implicit message: that therapy is the context within which our higher selves come to the aid of younger distressed or traumatized selves. Much like any adult, the Going On with Normal Life part's job is to keep younger parts feeling safe, stable, and protected—a job that always begins with understanding. When children feel heard and understood, they feel safer.

Speaking the "language of parts"

As the client's Going On with Normal Life self increases the ability to notice the communications from parts in the form of conflicting thoughts, feelings, impulses, and physical reactions, the therapist's job is to be an "auxiliary cortex," to observe the patterns and verbalize them using mindful-based parts language: "I hear that your Going On with Normal Life part really wants a mate, someone to share her life with, and I can hear the attach part talking about how lonely she feels—do you notice those two different feelings about relationships?" Notice that the therapist does not simply ask the client to observe in a mindfulness-based way—we model a mindful way of thinking and talking. We do not expect the client to use the language of parts unless we are speaking it throughout a session. "When you think about your partner, notice how quickly the angry part gets activated. . . It sounds as if the angry part isn't sure you should trust him." As the client responds positively or negatively to whatever we notice, we have an opportunity to amend a statement: "I see—the angry part <u>does</u> trust your boy friend—that's why he's in your

life—but the angry part doesn't want you to make yourself too vulnerable either." Or we might amend our observation in the light of the client's next statement: "And now the ashamed part is feeling that she doesn't deserve love? How sad. . ." When clients have been normalizing their internal conflicts as ambivalence, the therapist's re-framing helps to direct the therapy to the underlying trauma-related issues: "Notice how all these parts are having different reactions to your plan to get married. . . Just thinking about making a commitment to a man triggers their body memories, doesn't it?" Here, the therapist is capitalizing on the mindfulness ability of the medial prefrontal cortex (the "noticing brain") to observe multiple states of consciousness, to be both the observer and the observed. In addition, using the language of parts to describe internal struggles and symptoms generally increases activation in the left prefrontal cortex while decreasing activity in limbic areas stimulating autonomic activation. As the therapist uses terms like "notice," "part," "body memory," "feeling flashback," "traumatic activation," the Going On with Normal Life part often feels less crazy, the nervous system regulates, and then the trauma-driven parts start to settle.

Helping clients learn to speak the language of parts and re-framing their symptoms, conflicts, intrusive emotions, impulsive behavior or inability to act as communications from or emotional memories held by parts aids in developing another important skill: "unblending" (Schwartz, 1995). As they are flooded by the emotional reactions of their parts, most clients "blend" with them: they feel anxiety or anger or shame and name it as "their" feeling: for example, "I feel very anxious today." Then they attempt to interpret the feeling based on the present context: "I think it's because I knew I

was coming to therapy." Next, their actions are chosen based on the intrusive emotions communicated somatically by the parts. *Guiliana repeatedly found herself attracted to unavailable men (her attach for survival part) and repulsed by men who were clearly attracted to her, especially those who were kind and wanted closeness (the fight and flight parts). Although not generally someone who was unkind in her Going On with Normal Life self, she pushed away the available men without regard for their feelings with an air of boredom or disgust (the fight part) while always finding reasons to excuse the unavailable men (the attach part). At other times, she felt alone and lonely: at age 45, she longed for a partner and home. However, because she automatically blended with whatever part was reacting in a given moment, she couldn't resolve the endless internal conflict about relationships—until she began to name each different response as a part: "A part of me appreciates how patient and loving Dennis is with me—which I've always wanted—but another part of me finds him boring and there's a part who complains that she's not attracted to him at all and how can I be with a man to whom I'm not attracted? I tend believe that, so I have to remember how attracted to him I was when we first met."*

In order to teach clients about blending and unblending, it is necessary to take on a very different role as a therapist: instead of empathizing with their emotions and helping clients to "sit with them," we need to help them first learn to mindfully <u>distance</u> from an affect, become curious about it as an implicit, nonverbal memory held by a part, and then to separate from it by using parts language: "She is anxious because it's getting dark so early in the day now . . ." By learning to "unblend," i.e., notice the different feelings and reactions as communications from different parts, clients can begin to make more sense of

their internal struggles and avoid decisions or conclusions based on the input of a single part or group of parts.

Often, therapists are reluctant to use the language of parts for fear of reinforcing dissociative compartmentalization or, even worse, causing iatrogenic worsening. That concern is understandable, but it stems from therapeutic models used in the 1990s to treat dissociative disorders that did not incorporate mindfulness skills or emphasize focusing on the Going On with Normal Life part. When we help clients mindfully notice their thoughts, feelings and body experiences as manifestations of parts, we are actually promoting integrative activity in the brain. As Daniel Siegel (2010) reminds us, "Integration requires differentiation and linkage," meaning that we cannot integrate aspects of ourselves that we have not observed, differentiated and then linked to other aspects. Each time therapists help a client to notice how a feeling is linked to a particular part, has attached an age or state of mind to that part, felt curiosity about it, or has connected it to current triggers or noticed how other parts react to it, they are fostering integrative activity.

Learning to differentiate past from present, part from whole

Given that the cardinal features of PTSD are alternating **affective intrusions** and **avoidance of affect**, it should not surprise us that the past continues to dominate our clients' lives in the present. Either they are assailed by intrusive thoughts, feelings, images, smells, and bodily sensations, or they are disconnected, constricted and numb to avoid the overwhelming intrusions. Because they experience these triggered responses in

their bodies in the context of their present lives, trauma clients tend to interpret them as here-and-now reality. They say, "I'm not safe even in my own home," meaning that the intrusion of unsafe feelings takes place in their homes, or they interpret the feelings as meaning that they are still in danger. One woman was on the verge of giving up her job as a teacher because she felt so "unsafe" at school; another was ready to break her engagement to a very kind and loving man because she felt so "unsafe" with him. In both instances, the positive stress of these major events in their lives had begun to trigger feeling memories of fear, dread, and danger—the very feelings that had been a daily accompaniment to the traumatic stress of their childhoods. Each had been misled by the strong bodily responses and intense affects and had assumed these reactions were logical responses stemming from present reality. For example, when the teacher began to understand her panic symptoms as "feeling memories" of childhood terror and then began to track when they occurred, she noticed that the objective reality was really very different from her feeling reality. She had been convinced that her teaching job was unsafe. When she tracked her panic symptoms, she instead noticed that, at her job, she had fewer symptoms. In fact her panic symptoms got much worse at home, especially during evenings and weekends—in fact, at exactly those times of the day and week she had been most in danger from her alcoholic mother and abusive father. As she began to label the panic symptoms as "memories" and refrained from either "believing" them or exploring them (just noting that they were not a reflection of her present), she found that she was less overwhelmed by them and more able to reassure her traumatized child parts (and thus, herself) that "it's not happening now—you are just remembering how afraid you were then."

Teaching cognitive-behavioral and somatic techniques

Interventions for regulating autonomic arousal, increasing distress tolerance, and decreasing unsafe acting out are better taught once clients have some ability to observe their responses to triggers, notice the inner struggles between parts, become aware of blending, and have some curiosity or compassion about their parts. Often in trauma treatment, we introduce coping or regulation techniques before a therapeutic alliance has developed between therapist and client or between Adult and child/adolescent parts. Without an alliance, the interventions seem rote or can be interpreted as an attempt to silence the parts. For example, it is very typical in trauma treatment to use grounding when clients become spacy or silent, but this skill can be far more effective when used in a relational context and named in parts language: "I notice that there's a spacy part here shutting you [i.e., the Going On with Normal Life part] down—maybe that part doesn't know that you can tolerate the anxiety of the little part. I wonder if it would help the spacy part or even the anxious part if you notice the feeling of your feet on the floor—or even push them into the floor a bit. Is that better or worse?" "OK, so it's better. Good to know that helps the parts. Maybe when you push your feet against the floor, it's easier for them to feel your tall, strong adult body, to know that you can protect them."

In addition to affect regulation and distress tolerance techniques, cognitive restructuring, and other CBT interventions, simple somatic skills or "somatic resources" (Ogden, Minton, & Pain, 2006) can also be introduced within a parts framework. In addition to grounding, the simple act of standing often increases the sense of safety and support or counteracts dissociation and numbing. Placing a hand on the heart and just

noticing the physical effects of feeling the sensations of that simple gesture is helpful in decreasing hyper-activation, emotional overwhelm, and impulsivity. It can also be very soothing for child parts and decrease the sense of aloneness and abandonment. Lengthening the spine by increasing space between the vertebrae in the lower to middle of the back counteracts depression, shame, and parasympathetic hypoarousal associated with numbing. Making a "stop" gesture by raising one or both hands often creates a somatic sense of greater protection by engaging the boundary muscles of the midriff, while reaching out gestures often increase the ability to connect by physiologically opening the chest and heart area. When clients are triggered and lose connection to time and place, often evoking fear and threat, asking them to slowly turn the head and neck 180 degrees to take in their surroundings piece by piece, object by object, reinstates the sense of being safe here, now. Mindfulness-based interventions that call attention to the interaction of thoughts or schemas and bodily responses also can be stabilizing. When we help clients notice the connection between their choice of words and their bodies or nervous systems, often there is a spontaneous shift toward less judgmental or shaming language.

Perhaps the best known technique in trauma treatment is the creation of an imaginative inner Safe Place. Because dissociation involves an alteration in consciousness, trauma patients are almost always in a mild state of hypnotic trance, and for them, therefore, "trance logic" prevails. If they can believe that a flashback is an actual re-occurrence of past trauma, then they can easily believe in a safe place inside them: an "inside" therapist's office, a place in nature where they could feel completely and absolutely safe, or a place where they once experienced the sense of safety. *Annie has*

created several different kinds of safe places for young child parts, older children, or teenage caretakers: some Safe Places have been in nature, some at her home, and one was a school playground. More recently, she has began to create a Safe House with different kinds of rooms for different ages and groups, including a group therapy room and a room in which her therapist could be present for children in distress. Notice in this example that therapeutic dissociation allows the patient to visualize not only safe places but also caretaking figures who can provide imaginatively provide soothing and reassurance.

Learning how to use therapeutic dissociation

Patterns of structural dissociation, less severe in Complex PTSD and most severe in the dissociative disorders, develop to defend the child's psyche against overwhelming assault. Dissociative shifts and switches had to work automatically because children have to respond quickly in an unsafe world. If they hear a yell, feel a touch, see "the look" in an adult's eyes, they have to be able to distance, to go away in the mind and body into a mental state in which they do not feel pain, not feel overwhelmed, perhaps do not even know what had happened. In the client's current life, that involuntary system has become ineffective or even dangerous, but because the body is biased to "default" to survival responses under threat or apparent threat, it continues to be evoked by trauma-related triggers. *For example, Annie's Going On with Normal Life self had achieved a twenty-year marriage, two teenage children, and a newly completed a Master's degree when she took her first teaching job. The evidence of structural dissociation was subtly apparent at that time, but neither Annie nor her therapist recognized her confusing symptoms as*

reflections of traumatized parts. Soon after taking her new job as a teacher, however, Annie began to encounter unexpected triggers related to her childhood past. Once her refuge as a child, school became unsafe by age 11: her father convinced the school director to allow him to take his daughters out of school for "visits," complaining that his ex-wife wouldn't let him see them. These "visits" turned out to be group orgies in which he and his friends would sexually abuse the girls. Although the children never knew which school day would be unsafe, they could be assured that, sooner or later, the unsafe day would come. As a teacher of 12-13 year olds, Annie was frequently triggered both by them, other teachers, and the school director. Sometimes, she could remain in her adult self, but at other times, she would dissociate into either a hyperactive child part who would try to flee the situation, an adolescent self who would become sarcastic and disrespectful, or into a suicidal part who frightened her and the child parts. When Annie was a child, each of these parts increased her sense of control in a different way and lessened her feelings of being overwhelmed by forces more powerful than she, but as an adult it was not logical to respond to her current stressors in these ways, and it was also re-traumatizing because, each time she dissociated into any one of these states, her system re-experienced the sense of danger and powerlessness which had characterized her childhood.

The use of "therapeutic dissociation" as an intervention begins with teaching clients to use a combination of displacement and visualization techniques to get distance from the parts' overwhelm, re-frame the intense emotions as "their feelings," and extend compassion and soothing to young parts in emotional pain. Typically, clients come into therapy blended with the feelings of a part or parts. *For Annie, the feelings she frequently*

reported were shame ("I'm failing again—I'm just a loser") and fear ("I don't how it looks to other people but I feel crazy—I'm afraid I will be fired from my job"). Initially out of touch with the memories that were affecting her, she couldn't understand her own behavior, much less explain it to someone else. Though her concern about holding her job was clearly the Going On with Normal Life's worry, the fear and shame were familiar responses that never facilitated positive change or motivation to work harder as would facilitating shame or anxiety. Therefore, her therapist chose to frame these feelings as a communication from parts: *"So, all the triggering at school is making the ashamed part feel as if she's failed again, and the anxious part is expecting to be punished and rejected. . . And having their feelings overwhelming you make it very hard to go to work each day."* Notice that the pronoun "you" is used only to describe the feelings and reactions of the Going On with Normal Life part. If "you" is an adult connected to present safety and competence, then the client can work with "them" or "the parts" in displacement, can observe them rather than be overwhelmed by their reactivity. Working in displacement, the client is asked next to learn more the child part whose feelings are intruding: how old might the anxious part be? Does she feel younger or older than the ashamed part? What might the ashamed part be worried about? Occasionally, clients will recall photographs of themselves as children or spontaneously recall details that build an imaginative picture of this child part in distress. *When asked to think about how the ashamed part came to hate herself so much, Annie replied, "She got that message every day of her life."* Without exploring any particular memory in detail, the client's Going On with Normal part is encouraged to think in a general way about what the child part has been through:

"So many bad things happened to her, huh? She's been through so much. . . . She could never trust anyone, could she?"

As clients begin to mindfully notice the child parts' distress and understand it in displacement, they are asked to use the resources characteristic of the Adult self to "help" the child parts that are so frightened and in so much pain. By consciously and voluntarily "splitting off" the affect and assigning it to a much younger and more vulnerable part of self, clients can get the necessary distance without having to resort to denial or disconnection. As they come into relationship with these young selves, most clients spontaneously experience compassion for the child: "I feel really sad for him—I want to just pick her up and hold her." The therapist's role is keep the client in a mindful state and focused on the child: "What is it like for him to feel your sadness? To feel that someone cares how he feels?" "See what happens if you reach out to her and just hold her." As clients imagine the reactions of their younger selves, their internal states transform: they feel a sense of warmth, their bodies relax, they feel calmer. To ensure that these positive internal states are more than momentary, the therapist must continue focusing on what happens as the relationship to the part becomes deeper, more compassionate, and more committed. Sometimes, the therapist has to provide psychoeducation to make the point that change will come only through repetition of new patterns: "The more you hold her, the safer she will feel, and then the calmer you will feel. She can let you feel calm and centered if she's not terrified." Sometimes, the same message has to be framed even more empathically: "She doesn't trust you yet, does she?

You'll have to keep showing up, communicating that you care how she feels, before she can truly relax and feel safe."

In session after session, as clients present the issues or feelings most troubling on that day, the therapist must ask them to notice "who" is upset and what has triggered that part. The assumption that upset is always a communication from a part is not scientific fact, of course—it represents a leap of faith that naming compartmentalization and noticing it in a compassionate way is most likely to lead to positive change. However, it is a mindfulness-based. If we as therapists consistently encourage the Normal Life part to repeatedly take a mental step back, increase curiosity about the younger part(s) who are having a hard time, and then experiment with what might help them feel safer, better protected, less ashamed, we will facilitate increased self-compassion and internal connectedness, both of which "treat" post-traumatic symptoms.

Learning to foster internal communication and cooperation

If the opposite of dissociation is association, then not only is mindful consciousness across time and state important but also internal communication. When clients are more integrated, we can ask, "How do you feel?" "What do you think?" But when clients are fragmented, their parts may have different feelings or points of view, some of which can be unconscious or not in present moment consciousness. *If Annie had been asked, "How do you like your teaching job?" she would have provided different answers on different days: "I love the kids," she might have said if speaking from her mothering part; "I hate it" if she were speaking from the 11 year part who was afraid to go to school. How she*

reacted to triggers was also dependent upon which part was activated: Annie couldn't understand why "she" had suddenly ended a conversation with her school director in mid-sentence and then run up the stairs back to her classroom. The director had been trying to give her some feedback about being too harsh with the girls in her class, but since "she" could not recall having been stern with them, Annie didn't know how to respond. The only way she would eventually learn to manage the parts' impulses was to create a line of communication so she could understand what was alarming them.

The simplest way to help clients begin increasing internal communication is to teach the Going On with Normal Life part to "ask inside" for information and feedback. "Ask inside: who is so upset?" "*Ask inside: what part did the cutting last night? And what was she worried about? How was she hoping the cutting would help?"* "*Let's ask inside how old she is and just let a number come to mind*." Internal communication thus begins with teaching the Normal Life part to become a better listener and to ask "inside" for input from the other parts. The client's Adult self must be taught that younger parts often communicate through feelings and body sensations, not just through thoughts or in words. If a client talks about frequent experiences of intrusive anxiety in a particular situation, he or she is encouraged to understand the anxiety as a communication from a child part who gets triggered in that situation and wants the Adult to know or to "do something." Dreams, images, flashbacks, nightmares, memories, and trauma-related body sensations are also re-framed as communications from parts: "If that dream were a communication from a younger part of you trying to tell you something, what would it be saying?" If the Adult self can re-frame reactions such as indecisiveness or confusion or self-sabotaging as

a reflection of parts of the self, it becomes possible to look even at these symptoms as communications.

Internal cooperation and communication are fostered by a Going On with Normal Life self who is willing to listen, to empathize, and to develop a consensus-model style of leadership while still making final decisions based on the reality principle. As the therapist helps the Adult self to empathize with the parts who are in distress or causing the crisis, he or she models and teaches empathy. Here the therapist must often become very creative. It can be difficult to access empathy for a part who cuts or the parts who whose criticism and blame undermine the efforts of the Adult to function, but it is imperative that empathy for every aspect of self, every feeling and every behavior be not only encouraged but also modeled by the therapist.

In Structural Dissociation theory, each part is driven by and manifests some combination of the classic animal defense survival responses: fight, flight, freeze or fear, submission, and cry for help (also called attach or cling for survival). Therefore, we should expect to see one or more vulnerable child and adolescent parts frozen in time and encapsulated with the feelings and survival responses associated with that time and place. Fear, submission, and cry for help are all associated with vulnerability, whether they are organized to defend against the threat of harm and death or against abandonment and rejection. You as therapist might encounter a very withdrawn frightened part visible in your client's shaky voice, downward gaze, and eyes squeezed shut, afraid to look at you. Or you might notice body language suggestive of a very young child peeking at you and

hoping that you will smile at her, and you might find yourself doing that. Or perhaps there are times when your client is very angry at you or others which are hard to understand when, at other times, the same client is very ashamed and apologetic. The protector parts holding fight and flight tendencies are often tough and irritable: they don't want to win friends; they want to keep enemies at a distance. The fight parts are generally the self-destructive ones who cut or headbang, express homicidal and/or suicidal impulses, and are hypervigilant and critical of the Going On with Normal Life self or the therapist or both. But, if we can help the client appreciate their survival strategies in the context of the patient's childhood, it becomes easier to empathize with how the fight part stayed angry and stubborn to fight the fear of annihilation; how the part who cuts learned that she could induce an adrenaline response by cutting and thereby restore calm and clearheadedness to an overwhelmed body; how the part that devalues the therapy has an understandable mistrust of anyone who gets close to the child parts or whom they trust because, after all, look what happened when they got close to "trusted" adults before.

Notice that the essence of the work involves capitalizing on the client's fragmentation: empathy for self is achieved <u>in displacement</u> by helping the Adult self empathize with vulnerable or protector parts. Affect modulation and self-soothing are achieved in displacement as the Adult self learns to calm and soothe distressed parts. Safety is achieved in displacement as the Adult Self negotiates with protector parts who threaten safety, asking them to cooperate with her wish to solve the problems at hand without re-traumatizing child parts and promising in return, that the Adult Self will learn how to better maintain internal stability so that protector parts do not get mobilized so frequently.

The emphasis on greater differentiation between parts as a vehicle for eventual integration often flies in the face of the prevailing wisdom that the therapist must emphasize that the patient is one whole person in only one body. However, when that one mind and body is in chaos or bent on self-destructive behavior or so fragmented that reality-testing is compromised, the goal of treatment must be to restore order and provide a period of stability during which the client can develop more conscious and effective defenses. Similarly, therapists often feel pressure to address traumatic memory as early in treatment as possible, but with structurally dissociated clients, it is often more effective treatment to first shore up the existing defenses, promote ego strengthening, and make sure that the client has effective ways of maintaining internal equilibrium, empathy, and trust before addressing and processing the traumatic memories. In the model of treatment described here, the focus is first on differentiating the parts so that dissociative displacement can be utilized as a therapeutic intervention, then next beginning to build internal communication, consensus and leadership, and finally, developing the ability to soothe and calm distress throughout the system of selves. Paradoxically, this very process is an integrative one: each time the patient makes a cognitive, imaginative or affective connection with a "part," she is simultaneously reversing years of disconnection and increasing the degree to which she is internally integrated. As the ability to be a source of support, strength, and soothing for herself increases, the client can contemplate the work of processing traumatic memories secure in the knowledge that she knows how to use both displacement and self-compassion to titrate or soothe the intensity of the pain.

Conclusion

Throughout treatment, the therapist will encounter parts who want to "tell all" but also parts who resist the therapist and the therapy in order to "not go there." Because we will encounter both points of view, it helps to keep in mind that the goal in trauma treatment is not remembering what happened but the ability to be "here" instead of "there:" to be conscious and present in the here-and-now, to tolerate the ups and downs and the highs and lows of normal life, and to heal the injuries caused by the trauma—the injuries to innocence, to trust, to the heart, to faith—the injuries to the body and the injuries to the heart and soul. Remembering the past is helpful only to the extent that it helps to heal rather than re-open the wounds, to increase self-compassion and a deeper appreciation for all the parts who helped the client to survive and now deserve to be part of a safe and healthy present.

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