You, Me and the Others: Treating Dissociative Disorders

Jan Ewing, Ph.D., FAPS, FASSBI

Further Training

- ISSTD & ASCA -Treatment Guidelines
- ISSTD child/adolescent and adult on-line courses
- ISSTD workshops and conference- Sydney 27-29 Nov 2015
- DISSOC listserv - contact me: J.Ewing@uq.edu.au indicating your profession and qualifications and I will send you the details of how to join (I need to vouch for you)
- Educational slides regarding impact of child abuse including data from ACE study are available on the website http://www.canarratives.org/

Preparations:
Confidentiality, Consent & Self-Care
Defining Dissociation & Dissociative Disorders

- Dissociation describes the disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness.
- Dissociative symptoms can potentially disrupt every area of psychological functioning including consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour.
- Dissociative symptoms ≠ Dissociative Disorder (can occur normally and is also seen in many other disorders eg, Conversion Disorder; Eating Disorders; Psychosis; PTSD).
- Dissociative Symptoms/Disorder ≠ DID.

Dissociative Symptoms

- Positive Dissociative Symptoms: unbidden intrusions into awareness and behaviour, with accompanying losses of continuity in subjective experience, such as fragmentation of identity, depersonalisation, derealisation, hearing voices or crying, intrusive thoughts, "made" emotions, "made" impulses.
- Negative Dissociative Symptoms: Inability to access information or control mental functions that are normally amenable to access or control, such as amnesia, anaesthesia, conversion symptoms.
- Partial vs full dissociation: "Two major kinds of pathological dissociation exist: dissociative symptoms that are partially dissociated from consciousness (intrusions), and dissociative symptoms that are fully dissociated from consciousness (amnesias). When a dissociative symptom is partially dissociated from consciousness, the individual is contemporaneously (and disturbingly) aware of the jarring, alien intrusions into his or her executive functioning and sense of self. In contrast, when a dissociative event is fully dissociated from conscious awareness (ie, when amnesia occurs), the person has no awareness whatsoever of that occurrence.

Dissociative Disorders

- Dissociative Amnesia DSM-5 300.12 with Dissociative Fugue 300.13.
- Derealization/Depersonalization Disorder DSM-5 300.6.
- Dissociative Identity Disorder (DID) DSM-5 300.14.
- Other Specified Dissociative Disorder DSM-5 300.15.
- Unspecified Dissociative Disorder DSM-5 300.15.
- (Other Specified and Unspecified (300.15) formerly DDNOS).
How Common are Dissociative Disorders?

- Dissociative Amnesia: small US community: 1.8% (1% M; 2.6% F)
- Derealization/Depersonalization Disorder: 50% of all adults have experienced at least one episode of transient symptoms; lifetime prevalence for full criteria: approx 2.3% (M:F: 1:1) (Spiegel, et al, 2011).
- Other Specified/Unspecified Dissociative Disorder: unknown
- DID: in general population: lifetime prevalence: 1.5%-3.1% (depends on methodology) (c.f 12mth prevalence of OCD: 1.1%-1.8%)

How Common are Dissociative Disorders?

- In psychiatric patient populations (vary by country & clinical setting): inpatients 4-15%; emergency dept: 6-14%; outpatients: 2%; review by Vedar, 2011: inpatients and outpatients: 10% DID; 5% DID
- Unrecognised dissociative disorders common in psychotic disorders (up to 50% in some studies e.g., Haugen & Castillo, 1999); 24-49% DID previously diagnosed and treated for schizophrenia (Ross & Norton, 1988; Ross et al 1980)
- Other disorders with high rates of DID: alcohol and substance dependence, prostitution and (especially) exotic dancers (39%) Ross et al, 1992
- In prisons; 15-19% chronic dissociative disorders

Conceptual Models in DID

- Attachment/Object Relations Model
- Neurobiological Model
- BASK model
- Structural Dissociation Model
- Discrete Behavioural States Model
- Autohypnotic Model
Overview of Attachment/Object Relations Model
(Bowlby, Ainsworth, Main & Solomon)

Attachment/Object Relations Model
(see Kernberg, 1986, Masterson, 1981)

Secure
Anxious
Ambivalent
Resistant
(Preoccupied)

Insecure
Avoidant
(Dismissive)
Insecure
Disorganized
(Fearful)

Self as confident, competent; Other as predictable, protective; Affect: calm, happy
Self as capable but unreliable; Other as rejecting; Affect: empty
Self as weak, vulnerable; Other as unpredictable; available & supportive; Affect: anxious
Self as powerless, bad; Other as dangerous; Affect: abandonment; depression

Adapted from Blizard, 1997

Common Attachment Strategies
(from Ross & Halpern, 2011)

Attachement to the Perpetrator: traumatic bonding
Victim-Perpetrator-Rescuer triangle
Locus of Control shifts
### Attachment/Object Relations

**Model: example: K**

- **K**: early rejection from family at 2 weeks with re-entry at 5; physical abuse by father; emotional abuse by mother (including forced daily review of social faux pas and apologies); severe sadistic abuse by neighbour and his father from 14; numerous adolescent/adult traumas

- **KT**: self as angry, powerful; rejecting of others as unjust, abusive/neglectful ‘fuckwits’ but tries to convince them to change (locus of control shift; perpetrator/rescuer roles; preserve attachment); disorganised: dismissive

- **KK**: apologetic, self as bad and weak; others as idealised who must be protected from her badness in order not to reject her (locus of control shift; rescuer/victim roles; preserve attachment); disorganised: Anxious pre-occupied

- **KTT**: internal self criticism: self as powerful and protective; internal alters (others/self) as weak, vulnerable, pathetic; need to feel deserving of abuse in order to endure pain (locus of control shift; perpetrator/rescuer roles; preserve attachment); disorganised: dismissive

- **KKK**: self as powerful and in control; Other as pathetic; sadomasochistic transformation of abuse into control and pleasure then please other (locus of control shift; perpetrator/rescuer roles; preserve attachment); disorganised mixed

### Overview: Neurobiological Model

**Overview**: Neurobiological model of hyperarousal and hypoarousal states following disrupted attachment and/or severe/repetitive trauma.

**Birth > infancy**

| Prefrontal/orbitomedial/anterior insular/limbic-VIC regulation | Social communication & self soothing | Inhibit autonomic ‘spiral’ attachment, transitional objects, internal, nonverbal
| --- | --- | --- |
| Prefrontal/orbitomedial/anterior insular/limbic-VIC regulation | Inhibit autonomic ‘spiral’, parent/transitional object, internal, nonverbal | Social communication & self soothing
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Overview of the BASK model example: K

- K: child part (<2yrs) preparing for trauma re-processing work
- Memories can only be re-experienced in BASK domains (self-fractionated as a self-regulation/safety measure - do not disturb!)
- Fractionated again within domains:

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<th>Symptom</th>
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<td>Skin temperature (S)</td>
<td>Prick (“not yet allowed to feel it fully”) (S)</td>
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<tr>
<td>Shaking (S)</td>
<td>Posture: foetal position, left side, hand over stomach as if flat squashing (S)</td>
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<tr>
<td>Choking sensation in throat (S)</td>
<td>Fear (A) +</td>
</tr>
<tr>
<td>Pressure on stomach &amp; nausea (S)</td>
<td>B and K yet to be accessed</td>
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Overview of Structural Dissociation Model:
Van der Hart, Nijenhuis & Steele, 2006

- Always remember a model simplifies complexities to help create explanatory ideas and make predictions

After an overwhelming traumatic event occurs, we can ‘split’:

Pre-traumatic Personality

"Going On with Normal Life” part (ANP) Traumatised part (EP)

Van der Hart, Nijenhuis, Steele, 2006
Diagram adapted from J Fishar, 2008
Structural Dissociation Theory: Repetitive Trauma (diagram adapted from Fisher, 2009)

ANP: Going with normal life self

EP/EP: Traumatized child self or selves

ANP: Adaptive Information Processing Model: Shapiro, 2001; Knipe, *
Putnam's Discrete Behavioural States Model
(Putnam, 1997)

Autohypnotic model: Dell's Three Pathways of Dissociation

Pathway #1: Healthy development: develops a rich set of behavioural states that are well-integrated and more or less effectively self-regulated with a metacognitive sense of self that encompasses all of his/her states

Pathway #2: Unhealthy (with Low-to-Moderate Hypnotizability): child maltreatment/neglect results in poor self-regulation and impulse control (often ODD, Conduct D, ADHD etc) continue to dissociate but not amplified by high hypnotizability: may develop largely non-dissociative PTSD and/or Borderline Personality Disorder (BPD)

Pathway #3: Unhealthy (with High Hypnotizability): a) non-chronic + support may recover or develop PTSD b) chronic or severe (esp multiple perpetrators when young) dissociation amplified by hypnotic escape: DID/ DDNOS +/- dissociative PTSD c) chronic + emotionally distant/abusive parents: dissociative BPD +/- DID +/- dissociative PTSD

The role of hypnotic processes in treating dissociative disorders

"Because the highly hypnotizable bring their unique talents and vulnerabilities with them, it is best to assume that the DID patient is slipping in and out of trance, with all the attendant concerns we would put in place for someone in deep trance. The only way to treat DID without hypnosis is to engage in self-deception and convince ourselves and those who share our self-deception that we have banished from our work a phenomenon most of which we do not control very well at all. In our most intense moments of affective engagement, when we assure ourselves that we are getting to the bottom of things with our patients due to the quality of our relatedness and empathy, and doing it without hypnosis, the spirits of Mesmer, Janet and Herbert Spiegel may pause from their musings and chuckle kindly at our folly."

Kluft, 2010 (personal communication)
Summary: Aetiology & Phenomenology of DID

- Both universal and cultural processes influence the development and phenomenology of DID
- Dissociation and Dissociative Disorders can be found in all cultural settings
- "Every study that has systematically examined aetiology has found that antecedent severe, chronic childhood trauma is present in the histories of almost all individuals with DID"
- "DID develops when a child is exposed to chaos, coercion, and most commonly, overt physical and/or sexual abuse, often with disorganised attachment to caregivers. The child must also have the biological capacity to dissociate to an extreme level, leading to multiple states that do not become integrated over time."

Dohary et al, 2014

Summary: Aetiology & Phenomenology of DID

- Such self-states allow the child to compartmentalise overwhelming and conflicting feelings of betrayal, terror, love and shame (Putnam, 2006, Van der Hart et al, 2006, Dohary et al, 2014)
- The child is unable to integrate discrete behavioural and emotional states into a coherent or relatively integrated self according to the appropriate socio-cultural constructions of self (Putnam, 2006)
- In certain mainstream Western cultures this process is consistent with a fragmentation of internal identities; in other (usually non-Western) cultures it may accord with external spiritual identities that take control of the individual’s consciousness and identity (Dohary et al, 2014)
- DSM-V inclusion of ‘possession-form’ presentations – "not part of a broadly accepted cultural or religious practice" – recurrent, unwanted & involuntary, cause clinically significant distress or impairment

Treatment for Severe Developmental Trauma

Many therapists have the “erroneous conception that the core of the treatment of the traumatized is the processing of trauma. Actually, the core of the treatment of the traumatized is the compassionate overall care of the traumatized individual”

Kluft, 2013, p109
Overview and importance of a phase-oriented treatment approach in dissociative disorders (Janet; Herman 1992)

Phase-oriented Trauma Treatment: Herman (1992)

- Safety: protect patient from further harm, create a safe holding space for treatment, build strengths to stabilize patient and prepare for second stage
- Remembrance and Mourning: painful past is reviewed, the therapist bears compassionate witness to patient's pain and suffering and what has been lost and damaged can be grieved. Traumatic material is processed
- Reconnection: efforts are made to reintegrate the patient's mind, to establish potentially healthy relationships and resume or assume roles and responsibilities of a functioning adult

(From Kulfr, 2013)

Trauma Model Therapy: Ross & Halpern, 2009

- Initial: establish safety and stability and form a solid working alliance; establish internal communication & cooperation (months to years); constantly reworked throughout treatment
- Middle: begins in second half of initial phase and gradually becomes primary focus; increasing communication & cooperation with increasing number of alters to solve daily life problems; fully integrate trauma memories (BASK elements connected)
- Late: consolidation and finalising tasks of middle phase and working on present and future; building and practicing more mature defences, healthy relationships, life skills, activities; grief work (present in all phases but especially in late phase)
ACT-AS-IF model (EMDR)
Sandra Paulsen (2009)

- Assessment
- Containment and stabilisation
- Trauma Accessing
- Alloreactive synthesis
- Skills strengthening
- Integration
- Follow-up

Kluft's Nine stages of DID/DDNOS Treatment

- Establishing the Psychotherapy
- Preliminary Interventions
- History gathering and Mapping
- Metabolism of the Trauma
- Moving towards Integration/Resolution
- Learning New Coping Skills
- Stabilization of Gains
- Follow-Up

Treatment Process
### Kluft’s Dimensions of Therapeutic Movement (Kluft, 1994)

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<tr>
<th>Dimension</th>
<th>Aspect</th>
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<td>Therapeutic Alliance</td>
<td>Quality of interpersonal</td>
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<td>Integration</td>
<td>Relationships</td>
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<td>Capacity for Adaptive Change</td>
<td>Need for Medication</td>
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<td>Management of Life Stressors</td>
<td>Need for Hospital Care</td>
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<td>Alters’ Responsibility for Self-</td>
<td>Integration</td>
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<td>Management</td>
<td>Management</td>
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<td>Restraint from Self-Endangerment</td>
<td>Subjective Well-Being</td>
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<td>Phenomena</td>
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### Treatment Trajectories in DID

- Systematic studies/case series suggest 17-33% final fusion/integration after 6 years
- Steady stepwise improvement (even with highly experienced clinicians) is quite unusual but many patients make significant gains on a yearly-year basis (Kluft, 1994).
- 3 major subgroups with differing prognosis:
  1. High-functioning group who improve most rapidly and are most likely to reach final fusion
  2. Moderate-functioning, more complicated cases, usually with significant comorbidity who show a slower course but demonstrate significant gains/stable resolution (may unravel under stress) with some eventually reaching final fusion
  3. Low functioning group, with low ego strengths and ongoing enmeshed dysfunctional/abusive relationships: goals may remain Phase 1, with Phase 2 work being contra-indicated

### Tips from the ‘horse’s mouth’

- Don’t patronize
- Don’t practice new techniques on DID patients, they are vulnerable enough and if for some reason you feel you have to, don’t read the steps from a book or from notes you have written.
- If you say you are going to do something in the next session - follow it up!?!?!? If, for some reason, it is not appropriate to do what was suggested, acknowledge this. Certain personalities will turn up specifically for certain sessions so if the session does not happen then the whole system into disarray. All parts close down a bit so if this sort of thing continues - there is a lot of ground to make up.
- Emailing is a very good form of discussion outside appt times - patient can read and re-read responses for reassurance. (Remind them that you will get a response WHEN you have time. I always feel better knowing that I am not intruding unnecessarily)
- At the end of formal sessions, remind patient that there could be some memories/feelings/sensations that arise or feel uncomfortable. This may not be unusual for what has gone on in the session but remind them not to close down the system because of the distress. Remind them to write down or email what is going on to get reassurance.
Session Closures

- Checking for distress (especially shame/guilt) in ANP as a result of trauma work (“how does this leave you feeling? How does this leave you feeling about yourself?”)
- Grounding (and Body scan) if not triggering: pre and post alertness/grounded rating to ensure back to baseline; check oriented to place and time
- Preparing for negative responses post-session from alters who were unaware of content or purpose and may only be aware of activated BASK elements

Session Closures

- Closure directives/routines vary: Kluft: from ‘I think that’s enough for now, let’s come back to the room... let’s pause and see if any of the others have something to say...” in next 5 minutes, everything needed to restabilise will come through”
- Imagery/hypnotic suggestion: Putting material back in metaphorical container/book, dimmed screen etc until next session; parts working on trauma in a safe place or asleep between session etc - remember to reverse next session (can make inaccessible or can undermine confidence in barrier) or add suggestion that will remain in place until x minutes into next session or it is reversed in session

Tips from the ‘horse’s mouth’

- Never give a DID patient flippant disregard over any thoughts or things they have said - they have had this most of their life. It just confirms/deepens their own invisibility.
- Try never to show disgust, horror, disbelief, sadness, annoyance etc. Learn to have a great poker face. This lack of emotion (while talking about abuse) is actually reassuring. (Remember, what you may be feeling inside, imagine what they really felt throughout this. If I thought for a moment that I was actually making someone feel uncomfortable by what I was saying I would close down immediately and never raise this particular subject again. I speak from experience!)
- Avoid dependent situations at all costs. It is really important to continually monitor this both in and out of sessions. This, I feel, can be a really damaging situation. If a patient becomes dependent, after the fact, the trust issues are much, much, much worse
- Never try to “trick” the patient. E.G. If the patient does not want hypnosis, do not say that you are going to try relaxation! TRUST! TRUST! TRUST!
Tips from the ‘horse's mouth’

* Clarify things. If you want to know more - explain why. If you want to follow a particular path - explain why. We have always just been told to do things. We have more questions than you could imagine - don’t make this worse. We are much more willing to be guided if we know the “why” of it all.

* Listen to their fears. They are real to them. They are scary and they are things that have probably never been discussed. They are probably small, insignificant things that can easily be brushed off. (This is why flippancy damns us can be a huge setback.) They will not be mentioned until a certain amount of trust has been gained.

Further on this. We (DID people) really don’t know what is important and what is not important. (Abused people have no self worth so nothing they say is important.) Often things are said in passing because we are unsure whether it is something to be concerned about. Sometimes we don’t know what we are saying until we say it. (Sometimes we get to a point when we don’t know what we are saying until we get to a point where we don’t know what we are saying. This is why flippancy damns us can be a huge setback.) Things that are said in passing will not be heard until a certain amount of trust has been gained. Do not underestimate the power of silence.

* Do continue to use the positive affirmation. “Yes, that would be frustrating” etc. we know what you are doing but at the same time it really is reassuring but don’t go overboard using it! (We are crazy, not stupid!)

Tips from the ‘horse's mouth’

* Do use your sense of humour where appropriate, it’s nice to see your human side without getting personal.

* Do send amusing emails or have cartoons to show. A smile for 5 minutes a week is better than nothing at all.

* Do reassure your patient but never promise the impossible.

* Do talk about hope - even if they won’t listen.

* Do show emotions of happiness, joy etc if appropriate. These emotions are positive.

* Do talk about the future, the uncertainties, the possibilities etc (even if they won’t listen)

* Be honest. If you don’t know, say you don’t know. If you disagree, say you disagree but give a reason why.

* Do continue to acknowledge the different parts. Even in general. They ARE confused, scared, angry, happy, jorson, excited, sad, excited, etc and although invisible to the outside world they are most definitely a part of the person. Even in denial, “we” need to be acknowledged. (And eventually heard)

Phase 1: Safety, Containment & Getting to Know You

* History taking (bare bones), assessment and initial diagnosis

* Assessment of tolerances

* Creating Safety

* Improving Stability

* Teaching regulation skills

* Education re trauma, dissociation, comorbidities and treatment plan
Phase 1: Safety, Containment & Getting to Know You

- Getting to know internal structure/parts ("mapping")
- Reducing phobias of diagnosis/having parts/between parts
- Increasing communication and collaboration between parts
- Increasing adaptive strengths and habits
- Establishing internal resources (e.g., recruiting protector parts; Schwartz’s Internal Family Systems; Manfield’s Dyadic Resourcing; Schmidt’s Developmental Needs Meeting Strategy (DNMS) etc.)

Recognising dissociative symptoms: what, when & how to ask

- Embedded within your usual intake interview, intersperse questions about dissociative symptoms (some authors prefer to ask all one section of interview...can depend on tolerance)
- Five axes: amnesia, depersonalisation, derealisation, identity confusion, identity alteration
- Always start open-ended such as: “Do you have any difficulties with...?”
- Then narrow down with additional questions to clarify whether the symptom is within normal range/ can be explained by other factors (head injury, drugs, alcohol) or represents dissociation – ask for several examples
- Then explore nature and severity (frequency, interference with function, subjective distress), triggers, soothing events/activities

Recognising dissociative symptoms: what and when to ask

- Memory problems
- Blank spells
- Coming out of blank spells in a different location
- Objects missing and objects present
- Strangers telling you about things you can’t remember
- Strangers claiming to know you
- Voices (Paulsen, 2009; inner criticisms/ comments? Sounds like crying?); ‘thoughts’ as commentary or commands
- Depersonalization and derealization
- Other ‘people’ inside – gender, ages, characteristics
- Switching
- Ross & Halpern (2009)
Recognising dissociative symptoms: what and when to ask

- Don’t forget somatic symptoms
  - “Body pains, headaches or symptoms that medical doctors can’t explain?”
- High tolerance for pain! Examples:
- Add PTSD symptoms eg
  - Nightmares or flashbacks as if reliving events from the past
  - Intrusive thoughts, images, sensations of a traumatic event
  - Flashbacks

Recognising dissociative symptoms: what to look for

- Kluft and Chefetz: Only 10-15% of people who meet criteria for DID will present in a classic manner with a fully developed alter system and obvious switching
- Dell: overwhelmingly reliance on subjective phenomenology with most symptoms partial (intrusive) rather than full (amnestic) dissociation
- Subtle shifts in state more common than obvious switching: posture, tone of voice, bewilderment, 'tuning out', long pauses in conversation; discontinuities in conversations, blank stares; eye rolls, sudden shift in eye contact; eye closures, blinking; sudden change of subject

A taste of living with parts -

- Volunteer demonstration:
- Therapist
- Presenting Client
- Parts: 6-7 volunteers
- Rest of audience: observers: physical changes; speech, affect; transference/counter-transference
Recognising dissociative symptoms: Formal Measures: tools only!!

- **DESII (A-DES; CDC):** screen; not diagnostic; 0-15 Normal; 15-20 slightly above N; 20-30 Elevated, possible PTSD; DDNOS; 30-40 definitely elevated, possible DID; >40 High: increased likelihood of DID

- **SDQ20 (SDQ-5):** somatic dissociation screen

- **DDIS (Ross):** diagnostic, developed for inpatients; very specific (and can be confronting) questions; sample of 296 DID-correlated correctly identified 90% with only 3% false positive

- **SCIDD (DSMIV):** diagnostic, lengthy, expensive and needs training but useful when inexperienced and to integrate into interviewing as experience increases

- **MID-6 (Dell, 2006):** diagnostic; 168 items on 23 scales: scoring, report and graph requires a programmed Excel spreadsheet: test & scoring available from ISSTD website member only area

Mean DES & SDQ20 scores by diagnosis (Nijenhuis, 2004 in Ross & Halpern, 2009)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>SDQ-20</th>
<th>DES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Mood Disorder</td>
<td>27.2</td>
<td>21.3</td>
</tr>
<tr>
<td>Somatoform Disorders</td>
<td>33.9</td>
<td>18.9</td>
</tr>
<tr>
<td>DDNOS</td>
<td>40.3</td>
<td>34.1</td>
</tr>
<tr>
<td>DID</td>
<td>51.2</td>
<td>47.2</td>
</tr>
</tbody>
</table>

False Positives and False Negatives

- ISSTD: "(these measures) are not a substitute for a thoughtful, skilful, face-to-face interview in a safe clinical setting... In other words, we urge you to make use of your powers of observation and to make your use of these tools as part of an overall empathic approach to your patients".

- All results require careful follow-up. Some false positives due to malingerer especially in context of gain - be careful, SIRS-2 + Trauma Index, DID elevated on PAI NIM: MAL >4-5 is more reliable; MMPI-2: elevated validity and clinical scales (incl Sc 8); Fb, Fp distinguish simulated from genuine (see Brand 2014; Brand, 2015 for details)

- False negatives: It’s all about not knowing: keeping secrets from self (amnesia for amnesia) and from the world (common 7 yrs in mental health system prior to diagnosis)

- Masking by substance use;

- May take years before sufficient trust is established to disclose DID Sx: Average DID client has been in mental health system for 7-8 years before diagnosis
False Negative examples: K & G

- Both complex trauma with severe abuse histories (K sexual abuse not revealed for several years; both abuse alcohol; K also polysubstance abuse; both eating disordered; K self-harm++; K: Bipolar; both had DDNOS/DID as differential diagnosis for many years but very strongly defended and time loss/switching masked by substance use
- K: DES: 43.9; MID6: “PTSD; possible mild DD; Dissociative diagnosis deferred; rule out somatisation disorder”
- G: SDQ20: 50; MID6: “possible mild DD- Dissociative diagnosis deferred” Paul Dell (pers. comm): Likely highly defended DID
- Both flight from therapy when DID confirmed and more directly unmasked: Both now returned to work on dissociative symptoms

Assessing tolerances

- Tolerances will set the pace; lack of recognition and resolution -> looping/blocking
- Tolerance for negative and positive affect: engaging blocking alters; teaching affect modulation
- Tolerating body sensation – assessing somatic dissociation; increasing abilities somatic empathy, somatic tracking, somatic oscillations, somatic micromovements (Kievan SMP, Melinda MBCT)
- Tolerating dependency: psychoeducation; consistent boundaries
- Tolerating closeness: “sucks to ride the breach and repair road” Assessing your own tolerances remember complex trauma -> high sensitivity to nonverbal cues: ‘secret’ disgust, distress, rage, etc. will be detected and invite entry to a victim-perpetrator-rescuer triangle where you both loop around all roles: assess tolerance for suicide, self-injury, seductiveness, no-shows, rage; bearing witness to man’s inhumanity, etc.

Uncovering Dissociation

- Being prepared for destabilising affects of someone recognising the dissociative system (eg K & G flight from therapy)
- The system will only be able to tolerate minimal amounts of cognitive dissonance and gentle nudges toward breaking down dissociation. If statements are too frustrating or do too much to break down dissociation, the patient may become overwhelmed by memories of abuse, and engage in self-abusive or suicidal behaviour to increase the dissociation and re-establish the pathological equilibrium (Fine, 1990; Blizard, 1997)
- Psychoeducation ++ regarding the brilliance of a dissociative system to allow survival and everyday functioning in situations they were in and why now less effective; reassure not going to get rid of parts, not going rush to change the system before knowing how it works and negotiating how we could improve functioning and reduce distress; teach phased and pulsed treatment plan and encourage them to be active participants throughout. Humble optimism “you know the system best, I know how to improve systems; if we work together we should be able to accomplish your goals”
Dealing with Self Harm

- Be aware of your own tolerances
- Be firm and consistent in rules of no harm in therapy setting
- Recognize and understand that to begin with, the patient may have limited support outside therapy (or worse) and limited alternative behaviours in their repertoire.
- Focus on understanding (carefully tracking) triggers, past and current goals and then building matched alternatives (eg no point suggesting a calming alternative if the goal is to feel alive, a rewarding distraction if the goal is punishment)
- Accept and encourage improvements and reduction/abstinence efforts without judgment or shaming for break through acts

Common Self Harm Goals

- To feel real or alive when depersonalised or numb
- To evoke emotional numbness in order to stop feeling too much
- To relieve overwhelming emotions, tension, or traumatic memories
- To make "outside" (body) more congruent with "inside" (emotional pain)
- To refocus inner emotional pain to the outside, to localise it
- To express anger or aggression towards self (self-hatred)
- As a substitute for expressing anger or aggression towards others
- To cope with abandonment, rejection or loneliness
- To reduce shame or guilt
- To diminish feelings of emptiness, confusion or inner chaos

Common Self Harm Goals

- In response to internal command voices (from other dissociative parts of self)
- To have control over inflicted pain ("I will hurt myself before someone else can hurt me")
- To garner attention from others
- To tell what has happened- as a traumatic enactment
- Attempt to harm or kill one dissociative part by another dissociative part
- Punishment for breaking "rules" such as telling "secrets"
- To prevent suicide; ie an inner bargain for a lesser injury instead of death or to get sufficient tension relief/distraction from inner pain to prevent suicide
- To precipitate a switch from one part to another or to prevent a switch
- Self-harm has become addictive- possibly related to release of endorphins associated with feeling euphoric or high
Cycle of Self Harm
(Boone, Steele, Van der Hart, 2011)

Understanding and accepting lack of trust

Primary disability following childhood of abuse, neglect and abandonment is the inability to establish and maintain healthy relationships (patients will look for and find reasons to mistrust)

A reasonable level of trust (especially for phase 2) may take months or years; 'normal' levels of trust usually only towards end of treatment

There will be inevitable crises which require patience to weather the storms - try to avoid nothing to prove how incredible trustworthy you are (you cannot meet all their needs) but also avoid withdrawal in frustration at misrepresenting your behaviour as untrustworthy.

Above all avoid shaming any part for their response and assist all parts to understand the 'past-present' feeling flashback and attachment responses

Help the part/s to gradually fill developmental gaps with external -> internal object maintenance and self-soothing while learning 'mature' trust (vs 'all or nothing' of childhood)

Understanding and accepting lack of trust: examples GB after many years of therapy

ADULT personalities
- Trust of you outside therapy 100%
- Trust of you in therapy 90%
- Trust of son, daughter, friend 75%
- Trust of other people 1%
- Trust of doing EMDR or hypnosis 0%

TEENAGE personalities
- Trust of you outside therapy 75%
- Trust of you in therapy 50%
- Trust of son, daughter, friend 50%
- Trust of other people 0%
- Trust of doing EMDR or hypnosis 0%

In addition here
- Trust of older personalities 0%
- Trust in each other within their groups 40%

5-12 Year olds
- Trust of you outside therapy 0%
- Trust of you in therapy 0%
- Trust of son, daughter, friend 0%
- Trust of other people 0%
- Trust of doing EMDR or hypnosis 0%
Importance of consistent boundaries

These clients have learnt to relate through inconsistent nurturing & grossly distorted family roles.

Parts may expect to be violated, seduced or abandoned.

Other parts may believe seduction/pleasing you is the only way to obtain ongoing attention and approval.

Some parts may be ‘boundary detectors’ checking your responses to vulnerable or acting out parts or ‘tests’: firm boundaries are stabilizing (even when angry, run away, weep etc. the message of consistency gets through).

Boundaries need to be placed according to therapist style and comfort (they will know if you are not comfortable with your own boundaries) but firm consistency is essential.

Boundaries allow you both to maintain your roles in present time: you are not their parent, lover, friend; you will keep them safe within the structure of the work you are doing together and help them be safer in other relationships.

Establishing a safe place/s

Explanation of vicious cycle of rage, shame, fear, and hopelessness inside that contributes to lack of inner safety: the more some parts express their pain, the angrier and more critical other parts become and the angrier they become the more these parts suffer creating an endless loop of inner misery and lack of safety (Boon et al., 2011)

Creation of imaginary inner safe place/s for parts in pain or afraid allows some relief for angry parts as these parts will now be quieter; can also allow for safe resting place when a part is exhausted or a place to be to avoid being triggered while an necessary activity is conducted (medical app, conflict at work) etc.

Private, entry by permission only, set up with whatever is needed to feel safe.

Improving affect regulation

- Learning affect intensity modulators
- Strategies for in session dissociation
- Containment strategies
- Learning dual attention e.g., Back of the Head Scale; CROPS
- Gaining control over flashbacks
- Working with nightmares
Learning affect intensity modulators

- Rheostat/dimmer switch metaphor: imagine intensity with a switch that controls intensity—rate current intensity (eg 0-100%), imagine increasing to 105% then back to 100% then 102% then back to 95% then 85%...
- Practising with a non-trauma image first—orange-bigger, smaller, closer, further away, on a train going by, turned into an apple etc; try with non-trauma memory image, now disturbing image etc; gaining mastery
- Imagine having a comforter with you—teddy, inner guide, dyadic resource, let the feeling associated with that comforter percolate through
- Distraction—temporary distraction as ‘normal’ modulator—exercise, contacting support person, cooking, reading, movie, music, etc
- Survival kit: special container with all modulators filed—written suggestions, tapes, music, photos, smells, etc

Strategies for in-session dissociation

- Careful observation of trance states/zoning out/numbing
- Training in awareness of presence: "how fully present in your body and in the room do you feel right now? What percent? 50% 20% 75%? (assumption of partial dissociation reduces shame)
- Howard Alertness Scale (see Kluft, 2013)
- Explore which grounding strategies assist (for both in-session and out-of-session): Look Hear Feel, breathing, activity, tactile, kinesthetic
- Goal: to orient to present time and place and current safety

Tips from the ‘Horse’s Mouth: grounding
Back of Head Scale (BOHS)

Jim Knipe

Therapist

Client

Continuous Installation Of Present Safety (CIOPS)

Jim Knipe

Present safety

BLS

Present Safety

BLS (assess BOHS)

BLS

Assess BOHS

Containment Strategies

- Containment ≠ "getting rid of"
- Check all parts accept temporary containment of this material/memories/effects... (not parts themselves of safe place)
- Visual imagery for containment: bank vault, balloon, book on shelf in library, computer file, etc
- Some parts might prefer to express their feelings - write or draw with agreement that other parts need not be aware of contents and then put away safely, email to therapist, put away in safe place, take to therapy...

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Gaining control over flashbacks

- Cue stimuli associated with present safety
- Grounding in present (reconnect dissociated knowledge)
- Physiological arousal reduction (felt present safety, reconnect affect and sensation associated with safety)
- Install future awareness that it’s a memory/flashback – education about BASK elements of dissociated memory, practising self-grounding (sig other can be initially engaged); awareness and preparation for known triggers (dual attention practice)
- Enquire re internal helpers available to ensure younger part aware it’s just a bad memory/flashback and assist with calming
- Enquire whether any reason why this would be counter-productive (parts that think they need these experiences) - negotiate

Working with Nightmares

- Recurrent memories will have a theme of significance
- Re-scripting
- Meta-cognition
Orientation to present time, place, body

- Take all opportunities to time orient but be aware how confronting, implications, potential for grief
- Repetition-gentle acceptance that may not be accepted
- "Don’t take my say-so" : take some time and check it out slowly-calendars, newspapers, photos/evidence of parental death/age, looks/hear feel (take a peek)
- 'Look at the hand'; stand up and check height; move chairs
- Psychoeducation re role/habitual patterns/ego states and ability to learn new strategies to achieve same goals (safety, resilience, ability to function independently in the everyday life and relationships)

Phase 1-3: Mapping the system
(a work in progress)

- Many different approaches - drawings, time lines, maps, sculptures, lists with age created, current age and function, customised jigsaw puzzles
- Always understand "that clinical phenomena most easily observed and accessible are likely to be no more than tip of a complex and clandestine iceberg" (Kluft, 2013)
- Lemmerstien et al (1987) case study: patient was required to "sign in" as whatever alter was present at randomly generated times; discovered many more alters playing a role in daily life than expected and external observers were unable to distinguish them or detect most switches taking place
- Fine & Kluft ask pt to write name in middle of page all parts are invited to place their names on the sheet where they feel most comfortable, nearby to those to who they feel closest or have most affinity. May speak inwardly and ask alter forming the writing to be scribe. Alters without names or who are reluctant to share names make a mark, like an X. Subsequently wonder aloud if initially reluctant alters now ready to declare their presence. Different coloured pens. Remain curious about ‘open spaces’. Never push through to disclose something that creates apprehension/misgivings (preserve amnesic barriers)

Mapping the System

Modified from "Got Parts", by AT,W, 2005
Preserving amnesic barriers

- Amnesic barriers were created for a reason: be sure you have established readiness before barriers come down.
- Remember to remind not to share until a time and place for sharing in session.
- Not always easy to regulate and may require post-hoc measures for containment.
- Accept reluctance to disclose and work with what feels safe for them.

Establishing communication channels

- Explore setting up safe inner communication systems, eg GB notes in a ‘vault’.
- Safe place reinforcement.
- Preserving amnesic barriers – reminders to communicate regarding memory work in therapy room: ‘don’t try this at home’ (yet) - be prepared for leakage.
- Dissociative Table technique.
Dissociative Table (Meeting place)

- Used in hypnosis, ego state and gestalt therapies and has various names:
  - Dissociative Table (Fraser)
  - Conference Table (Watkins & Watkins)
  - Board Room (Ross)

- When first used, it is a way of identifying parts of the psyche
- It becomes a way to regularly check in and communicate with the psyche
- Think of it as an internal family meeting

Dissociative Table Instructions

(modified example based on Boone, Steel & Van der Hart, 2011)

Imagine a special place where you and all your parts feel safe and where you or some of you can gather to communicate and make important decisions. Perhaps it’s a kitchen with a kitchen table or conference room with a conference table or any other type of room or even a place in nature that you prefer. This room or place has a table specially made for you with a place for all parts of you to sit should you choose. Perhaps this table is of beautiful wood with intricate inlays or a magnificent piece of marble or something else altogether but it feels right for you. All meetings at this table are special. (Include ground rules for no harm in this room). It can be as big or small as you need it to be, with as few or as many chairs as necessary. Each part can have the type of chair they prefer—soft, high, firm... No part has to sit at the table if they don’t want to. They may prefer to be in an adjacent room where they can communicate without being in the room. Or they may prefer to just listen for now or have another part speak for them. Let yourself go in and sit down. Find when you are there. (What for the room?) Now invite all the various parts of yourself... or all parts who know about it to come into this special room and take a chair. If they can’t sit down, perhaps they can rest on the side or go in an adjacent room. Let yourself watch them come in and take their places. When they are all in there, let me know who and what you see.

Conference Room Example: K

[Diagram showing a therapist filter, dissociating,羞耻,保护者,年老,需要,焦虑,顺从,患者,治疗师]
Working with Parts

- Speaking through to parts
- Direct interactions
- Forging alliances and present orientation
- Working with hostile/persecutory/angry parts
- Working with child parts

Assume All Parts are Listening

- While some parts may be amnesic for the session or parts of the session you should not assume that only the part you are working with is listening/participating, assume all parts are listening unless negotiated otherwise
- Even though you assume this, you can also ask for/invite all parts to listen or if this is not optimum, you can suggest that some parts could go to safe place, sleep...
- When you call out a part or start working with a part, you can ask that part what it thinks about the conversation/work that is taking place (or just took place).

Working with Hostile Parts

- The special importance of working with 'hostile' or punitive parts/introjects loyal to the perpetrator
- See Blizard, R (1997) Therapeutic Alliance with Abuser Alters in DID: the paradox of attachment to the abuser, Dissociation, X, 4, 246-254
Anger as a Defence against Vulnerability: every strategy is a protective strategy

Working with Hostile Parts

- Locus of control shifts: My fault- Their fault (My fault)
- My fault: Internally hostile: identification with perpetrator (introjects)
- Their fault: Externally hostile: Angry protectors from further abuse/humiliation/ powerlessness
- Some Goals:
  - To protect the dissociative barriers
  - To protect attachment to idealised others/
dissociated knowledge
  - To ensure 'Secrets are not disclosed'
  - To ensure 'Internal Rules' are obeyed
  - Eliminate/silence 'weakness'/dependency needs
  - 'Toughen up' weaker parts to endure what must be endured

Working with Hostile Parts

- Acknowledgment of central role in surviving and recovering (don’t patronise!)
- Forging alliances, accepting lack of trust and negotiating safe pace
- Orientation to present time, place, body
- Inclusion as helpers in everyday functioning and memory work
- Inclusion as participants in memory work (treating the phobia and projection of shame)
Tips from the ‘horse’s mouth’

Working with Child Parts

- Remember not a ‘real child’ inside but genuine re-activation of BASK elements that have not been processed and are not oriented to present (“emotions are processes with slow rate of change” Rappaport)
- Goal is for patient to empathize, comfort and nurture their inner child/ren; correct cognitive errors and distortions and allow for acceptance of what happened together with understanding of locus of control, change of circumstances and current strengths; eventually children may ‘mature’ and merge with adult self with child memories

Tips for working with child parts

- Don’t treat child parts as if they are children in reality
- Use your regular voice and refrain from “baby talk”
- Even though the EP has the experience of being young, it’s still the chronological age of your client.
- You may have to use concrete thinking, but this is different than treating them like a child.
- Maintaining and reinforcing the cognitive error that the part truly is a child will haunt you in future phases of treatment
Red Flags for caution and slowing things down

- Becomes more and more pertinent in Phase 2, emphasizing the importance of learning regulation, pacing and containment techniques in Phase 1
- Increased instability as indicated by: increased self harm, increased substance use, increased acting-out behaviours, increased conflict with others; increased FTA
- Increased intrusive experiences, flashbacks, nightmares
- Looping: protective alters may be blocking further work; 'taboo' and previously unexplored topics may have been approached eg shame and there is rapid withdrawal

Phase 2: "Slow is faster"

- Ensuring barriers and objections to addressing particular memory/alter have been negotiated
- When in doubt do less step while you're ahead, try to complete one step no matter how small and not go onto next step unless confidence it can also be completed
- Allow time for entry, processing and closure (90 mins recommended) "Kluft's rule of thirds"
- Creation of a memory/work space if appropriate (e.g. Maxwell Smart's "Cone of Silence") assist with preserving amnesic barriers

FAT: Fractionated Abreaction Technique (Kluft, 1996, 2013)

FAT involves graded exposure to traumatic material beginning with brief and incomplete exposures from which the patient is rapidly extricated, and slowly brings the patient more and more deeply into the material for more and more prolonged periods of time, progressing at a tolerable mutually agreed-upon pace (Kluft, 2015, p. 49).

Building on Vogt & Wolpe, the technique is based on graded hierarchical exposure and facilitated mastery. Prior to exposure, patient (all relevant parts) are taught intensity modulating techniques

Hierarchies are created within a given trauma (rather than hierarchy of trauma) : timelines, intensity of distress, physical vs emotional pain, number of alters involved, BASK dimensions are all considered as elements to be worked into a hierarchy for a stepwise or fractionated approach.
Fractionated Hierarchy: example: K revisited

- K: child part (<2yrs) preparing for trauma re-processing work
- Memories can only be re-experienced in BASK domains (self-fractionated as a self-regulation/safety measure - do not disturb!)
- Fractionated again within domains:

<table>
<thead>
<tr>
<th>Skin temperature (S)</th>
<th>Fear (“not yet allowed to feel it fully”) (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaking (S)</td>
<td>Posture: foetal position, left side, hand over stomach as if flat squashing (S)</td>
</tr>
<tr>
<td>Choking sensation in throat (S)</td>
<td>Fear (A) *</td>
</tr>
<tr>
<td>Pressure on stomach &amp; nausea (S)</td>
<td>B and K yet to be accessed</td>
</tr>
</tbody>
</table>

Phase 2: Memory Work

- Fractionated Abreaction including BASK elements
- Safety stops (eg panic button on Spiegel’s split screen; rheostat dimmer switch)
- Ensuring target alter involved and non-target are protected (be aware of motivated but unprepared alters “slipping in behind”)
- Ensure barriers and obstacles identified and negotiated (“while you were away....”)
- Enlist helper alters as needed or dyadic resource/wise self/older self established in phase 1 (eg dyadic resourcing, DNMS)
- Trauma-focussed CBT, EMDR, Mindfulness-based Core Process Therapy, Somatic Re-experiencing....
- Pulsed trauma work

Other common 'traps'

- Failure to recognise VT – especially if therapist has history of trauma (higher risk of VT and reactivation of own stories)
- Failure to set limits
- Shifts in responsibility and motivation
- Collusion with denial
- Dealing with projection and counter-transference (therapist as rescuer/perpetrator; sleepiness, being scared, being over-protective.....
- Tolerating repetition
- Remembering undisclosed alters may enter therapy late and require phase one work
Other common ‘traps’

- The EP fears to lose her/his power and strength if the dysfunctional emotion (frequently rage) decreases or disappears.
- The part may fear to lose her/his hierarchic position in the internal system.
- The part may distrust the therapist (despite other parts with strong alliance).
- The part may be convinced that the pain will never end.
- The part may think that if s/he focuses on the emotion all the pain will "burst out" and s/he would not be able to contain it.
- The part may think s/he doesn’t deserve to be well. A part who contains traumatic memories may also contain the shame and guilt associated with it.

Managing setbacks

- Setbacks are inevitable—do not take it personally!
- Be ready to acknowledge the problem—don’t be defensive.
- Check whether all parts are OK when the problem is denied but the behaviour suggests a problem.
- Model curiosity as to what went wrong and tolerance for setbacks.
- Check how they have been managing to/planning to manage it.
- Collaboratively negotiate healthy repair (repair is often very new to these clients who usually ‘cut and run’ or are punished when things go wrong).

Phase 3: Integration & New Life

- Integration goal is not to create one big homogenised ego state but a system of ego states or neural clusters that function together well and without amnesia. (Ahern, 2009) (an orchestral metaphor—it is the client’s choice how, when and how much ‘integration’ they wish to achieve to function as they prefer.
- Example: L described her new sense of an (integrated) adult self when encountering a challenging/triggering situation in words to the effect of: "It’s like reading a book with different characters and perspectives and I give/act as a summary of the whole book."
Phase 3: Life after Trauma

- Who am I if I am not in pain?/a patient/?/a survivor/?/a victim/? have an excuse?- do not underestimate the fear of being ‘normal’ after a lifetime of adrenaline-soaked surviving/coping/pretending
- Acknowledge, validate and assist working through grief at what happened, at a lost childhood, lost possibilities
- Difficulty envisioning a future: setting new goals
- Development and consolidation of skills, confidence and competencies (this occurs throughout but is focus of Phase 3)
- Finding meaning, enjoyment and pleasure in the present
- Do not underestimate or rush this stage

DID: A musical perspective: Matryoshka

http://youtu.be/5pbVW_KH58