DISSOCIATIVE PHENOMENA IN THE EVERYDAY LIVES OF TRAUMA SURVIVORS

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Interest in dissociation, as a mental ability and as a set of symptoms secondary to trauma, has re-vitalized in the past ten years following a one hundred year hiatus between the work of Janet and the work of the pioneers in the field of trauma in the 1980s and 90s (van der Kolk, 1997; Putnam, 1999; Chu, 1998). Although we have a better understanding of dissociation now than we did ten years ago, it is still a very controversial subject in the field of mental health because it is so routinely equated with Dissociative Identity Disorder. As a result, even experienced clinicians miss the frequent more subtle presentations that appear in our offices on a daily basis. If we look instead to understand dissociation as we would any other mental state phenomenon, we will begin to see that **all human beings dissociate**, and much of our dissociativeness is **adaptive.**

Formally, the term "dissociation" refers to "a disruption of the normal integration of experience" (Chu, 1998). In DSM-IV, it is defined in terms of its role as the essential feature in the dissociative disorders as a "disruption the usually integrated functions of consciousness, memory, identity, or perception of the environment" (American Psychiatric Association, 1994, p. 477). This disruption of "normal integration" has many adaptive, as well as pathological, consequences. Thus, another way of understanding dissociation is to look at the adaptive functions it serves. In the words of van der Hart, van der Kolk & Boon, 1998, "Dissociation refers to a compartmentalization of experience: elements of an experience are not integrated into a unitary whole but are stored in isolated fragments. . . . Dissociation is a way of organizing information."

Like all methods of compartmentalizing experience, dissociation can be used in a healthy, growth-promoting way or can be overused and thereby become stereotyped and maladaptive. In evaluating an individual's adaptive versus maladaptive uses of dissociation, it can be helpful to differentiate three dissociation-related functions or abilities (Putnam, 1999):

- To divide attention into two or more streams of consciousness
- To compartmentalize information and affect
- To alter identity and/or create distance from self

The ability to divide attention is usually illustrated by the example of "highway hypnosis," but other examples also abound in daily life: the abilities to get "lost" in a movie or play, to talk "baby talk," to "multi-task," or to suspend preoccupation with other concerns as a therapist or parent does. Some tasks, like typing or playing a sport or performing, are actually done better in a dissociated state, "in the zone," so that self-consciousness or anxiety do not impede performance.

The ability to compartmentalize information and affect is central to a therapist's ability to sit with a patient and not be overwhelmed by his affect or her history. It underlies peritraumatic dissociation, transient amnestic or depersonalization responses that give us distance from overwhelming events, that allow us to be 'there' but 'not there.' Compartmentalization allows us to live with otherwise irreconcilable conflicts or avoid cognitive dissonance. For children, it allows for the separate but simultaneous awarenesses that what is happening is wrong, while keeping intact their idealization of and loyalty to the adults who mistreat them. In DID and DDNOS patients, the extreme degree of compartmentalization often allows individuals to develop talents or function at work with less vulnerability to disruption by intrusive affects and memories (Putnam, 1999).

The final category of defense made possible by dissociation is that of alteration in self and identity. This category includes such phenomena as depersonalization (the ability to detach from one's self or experience) and structural dissociation (van der Hart, Nijenhuis & Steele 2006) or compartmentalization of the personality via neural systems that organize alter personality or ego states, as found in DID and DDNOS. But many normal examples abound as well: the shy, introverted actor or actress who uses his or her dissociative abilities to "assume" the very different identity of a character in a particular play, for example. Being able to distance from affects like terror or shame can allow the traumatized child to develop at least one or more self-identities that carry a sense of confidence and mastery.

It is crucial to keep these examples of normal or adaptive dissociativeness in mind because they will help us to become more aware of the subtle manifestations of dissociation we encounter every single day of our clinical careers, especially if we work with survivors of childhood neglect and abuse. Remembering the more adaptive uses of dissociation will also combat the tendency to pathologize dissociative symptoms and remind us that we can help the patient to turn maladaptive symptoms into adaptive capabilities.

So, let us think about the signs and symptoms that might alert us to our patients' dissociativeness:

First, treatment history is a potential red flag alerting us to the possible presence of dissociative defenses. The average dissociative disorder patient has been in treatment for an average of seven years and been given an average of 3.6 diagnoses before he or she is correctly diagnosed (Putnam, 1991). So our suspicions should be raised by any patient who has had a number of treaters and diagnoses without a great deal of progress or clarity. Patients whose therapeutic courses have been rocky, or who have struggling internally with alternating idealization and devaluation or approach-avoidance of their therapists, or whose therapies have ended in some unusually dramatic way should also raise our index of suspicion.

Secondly, look for the typical somatic symptoms seen in conjunction with dissociation, such as unusual pain tolerance, or headaches which come on suddenly in the midst of a therapy hour, or eye movements (either constant rapid scanning or eye blinking or drooping), reports of narcoleptic-type symptoms either in therapy or at home, as well as atypical, paradoxical, or non-responsiveness to psychopharmacological medications. Patients who at times assume body postures or exhibit body language that is more typical of young children may also be exhibiting dissociative symptoms, especially if the body language goes hand-in-hand with regressed language or cognition. Behavior usually interpreted as therapeutic "resistance" can also be a dissociative indicator: patients who cannot make eye contact or who "peek out" at the therapist from behind a shock of hair, patients who often have to abruptly leave the session, patients who become mute and cannot be helped to verbalize what they are thinking or feeling are frequently exhibiting the more subtle presentations found in non-DID dissociative disorders.

Third, be alert for any sign that there is a failure to integrate behavior, affect, perception, or experience. For example, a patient who reports being mystified that either you or others have a different recall of events than she has or whose perceptions of events seem to be markedly different at different times or whose subjective affective experience is markedly at odds with her presentation of self. Anything that does not "add up" might cause us to think twice about dissociation: for example, a patient who is very regressed in the treatment hour each week but reports engaging in work or social activities or childrearing at a fairly high functional level. A patient who is both extremely entitled and incredibly devaluing of herself is another example of a possible dissociator, as is the patient who alternately idealizes and then devalues the therapist. As these examples illustrate, a diagnosis of Borderline Personality Disorder should also alert the clinician to the possibility that dissociative symptoms have been interpreted as characterological.

Fourth, patients who have been unable to move forward with their lives, unable to make very basic life decisions despite having sufficient cognitive ability and a favorable or supportive environment, are often more dissociative than they appear. A patient who is "terminally ambivalent" about small everyday decisions (such what to wear, what to do and whether to do it, what to eat) could be experiencing internal struggles between

different ego states or alters. Similarly, difficulty in making larger decisions to an extent that causes losses of opportunity may reflect the same kind of internal conflict creating roadblocks in adult development: for example, patients whose ambivalence about their significant others results in an inability to commit or a sabotaging of those relationships to which they have committed, or individuals whose ambivalence about work and career choice results in frequent job changes, returns to school for more education in a different field, or the inability to finish that education (ABDs, Master's degree candidates who cannot finish the thesis, lawyers who cannot study for the bar exam). A patient who once functioned at a high level and then deteriorated without clear dramatic precipitants also is often a dissociative disorder patient.

Fifth, all kinds of memory problems can be red flags alerting us to the possible role of dissociation in causing such difficulties. Besides the classical memory problems of childhood amnesia, time loss, and finding items of clothing or food the patient does not remember buying, there are a host of other memory symptoms. For example, difficulty in remembering how time was spent in the course of a day, difficulty in maintaining continuity from therapy session to therapy session, "black outs," gaps or time loss while driving, getting lost driving somewhere very familiar (such as getting lost going home from work), forgetting conversations or social occasions or appointments, forgetting how to do things that are usually well-learned (such as how to drive), being told by a friend or relative about some behavior or affect that she does not recall and which seems out of character with her own self-perception.

Last but not least, it is important to be alert to any manifestation of internal conflict about identity or self-definition. These might take the form of a patient wondering about why such a peaceful person as herself suddenly explodes in anger, or why she, who trusts only you, the therapist, sometimes becomes fearful that you will turn "mean" and try to hurt her, or why someone who has so many abilities has been unable to use them in any consistent fashion, or why her behavior in therapy is so inconsistent, or why she works so hard to stabilize but then goes out drinking on Friday night and ends up cutting herself.

We must remember that it is the **rare** patient with a history of childhood trauma who does **not** have dissociative symptoms. So we should **expect** them—not necessarily expect all trauma survivors to have DID or DDNOS—but expect to frequently encounter symptoms of fragmentation, depersonalization, self-hypnosis, out of body experiences, and internal conflict between ego states or aspects of self which will disrupt the patient's life and treatment if not recognized and treated along with all the other symptoms. The "Sane and Sensible Treatment of Dissociative Disorders" model (Fisher, 1999) utilizes techniques that are just as applicable to patients with the subtler manifestations of dissociation as they are to DID and DDNOS patients. In fact, the model does not require the therapist to have to make a dissociative disorder diagnosis but only to have recognized

that the presence of dissociative symptoms is complicating the patient's recovery from Complex PTSD.

The "Sane and Sensible" approach to the treatment of dissociation is a model that focuses on how to stabilize the patient and frame the treatment in such a way that we promote the acquisition of new, healthy self-regulatory abilities which can lessen the need to rely on dissociative defenses and thereby lead to a greater capacity for internal connectedness. Notice that the goals of this model differ from psychodynamic models and even some trauma treatment models which make **affect** the central focus of treatment. In this type of dissociative disorders treatment, the goal is not remembering what happened; it is not the ability to tolerate affect; and it is not integration. Instead, the goal is to help the patient develop the ability **to use dissociative skills in the service of the ego rather than in the service of defense.**

Therefore, the first priority is to foster the ability of an "observing ego" to appreciate how traumatic experiences create the necessity for complex dissociative mechanisms of defense (Perry, 1995) and to notice how an elaborately fragmented psyche **works—**to understand its emotional logic, even when that defies rational logic. We need to help the patient understand how a child being raised in an unsafe environment without safe and reliable objects of attachment learns to use her **mind** as a refuge—by splitting off and compartmentalizing affects, knowledge, cause-and-effect, talents and abilities, even the memories of the traumatic experiences, into what Pierre Janet termed, "emancipated neural networks." In the context of a hostile environment, these networks gradually become more and more compartmentalized until they are disconnected from one another, and continuity of self becomes increasingly a challenge. Instead of developing a **SELF**, the child develops a system of **SELVES**. It is a system that is highly adaptive in an unsafe environment. As van der Hart, Nijenhuis & Steele describe in the Structural Dissociation model (2006), this system relies on our biologically hard-wired animal defense survival responses to facilitate the best possible adaptation in a threatening world. A system of selves must include a part of the personality serving the cause of "going on with normal life:" functioning in daily life, raising the children, being able to provide basic necessities, even enjoying normal developmental tasks or taking up meaningful personal and professional goals. But while one part of all of us is valiantly carrying on normal life, other parts must serve functions of fight, flight, freeze (or fear), submit, and attach for survival or "cling." For example, for a child living with a parent who is withdrawn at some times and violent at others, having a different self or part of self prepared to deal with each of these different challenges is very useful: in response to the panicky alarms of a fearful part (freeze) alerting the individual to potential danger, a caretaker aspect of self (submission) can become the precociously responsible child who tries to protect herself or younger children in the face of the violent behavior, while a "class clown" aspect may try to lift the parent's irritable mood and facilitate relational connection by making him laugh (attach), or a hypervigilant aspect of self (fight) may

become a kind of bodyguard carefully observing the parent's mood and directing the child's activity to best defend against mood-related "frightened or frightening" behavior.

However, in adulthood, the fact that current reality is different from that past reality means that a system which once ran smoothly now finds itself in conflict: some parts of self may want to move ahead professionally, for example, or want to get married and have children, while other parts are phobic of intimacy (fight) or terrified of being anything but invisible (freeze) or distance as soon as the relationship becomes close (flight). To make matters even more complicated, the "going on with normal life" self generally continues to grow and develop age-appropriate social-emotional abilities, while other parts become "frozen in time" at age 3 or 5 or 8 or 12 or 17. Other parts are "frozen" not in terms of age but in terms of perception: like the Japanese soldiers who hid out on small Pacific islands during World War II and emerged twenty years later without knowledge that the war was over, some of the hypervigilant and protector parts of self may still believe they are in danger of being annihilated. Because these parts represent "emancipated neural networks," they are as isolated from new information as those Japanese soldiers. Parts organized around the mobilizing defenses of fight and flight may still believe that hypervigilance, counterdependence, and relentless mistrust are helpful survival skills, especially when the adult survivor is experiencing flooding, physical or emotional vulnerability, **or** becoming more confident, successful, or expansive (i.e., when the submissive, frightened, or needy parts are more activated or the 'going on with normal life' part is 'breaking rules' once punishable in childhood). Fight- and flight-driven aspects of the self that are suicidal or self-harming developed as a way of increasing 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") and may continue to have strong self-destructive impulses in the context of loss or vulnerability. The flight response also drives addictive behavior, eating disorders, sexual addiction, and other sources of relief or 'flight' from the overwhelming trauma-related feelings and sensations. In response to the acting out of fight-flight driven parts, submissive and needy parts may become ashamed, depressed, and filled with self-loathing, while the 'cry for help' parts beg not to be abandoned because of it. However, if attachment- and submission-driven parts grovel too much, fight-flight responses can be triggered, and the cycle begins again.

In order to navigate this level of complexity, we need to have some simple "laws," or rules of thumb, which can help us to focus on the forest rather than getting confused by the trees. The first "law" of dissociative disorders treatment is **"A PART IS JUST A PART,"** meaning that, no matter how regressed, helpless, and confused the patient is at a given moment, there are other parts or states of mind which are confident and competent and adult. No matter how self-destructive the patient is at a given moment, there are other parts which want to live and have fought to survive. In fact, even the suicidal alter or ego state rarely wants to die. That part of the self, driven by fight responses, is fighting to live, struggling for control over feelings of being overwhelmed, powerless, and demoralized. It wants to do something: to take action, not give up. The therapist and

patient must remind themselves that whatever part(s) is dominating consciousness at a particular moment is a fraction of a whole system designed to be in balance.

The next "law" of dissociation is **"THE SYSTEM WAS DESIGNED FOR SURVIVAL, NOT DESTRUCTION."** Remembering that "law" will save the therapist from becoming exhausted by the recurrent crises and prevent needless hospitalizations. It also means that our work is made simpler: we just need to help the patient to **adapt** the system to better fit the different kind of complexities and challenges posed by her adult life in the present. The same dissociative abilities, the same splits in her personality, can be utilized in the service of the ego: in the service of functioning better, having more options, being able to stand her ground, being able to have a meaningful life, or being able to find more pleasure in the life she has created. The fact that the system was designed to be adaptive also means that every crisis, each new "glitch" in the treatment, actually provides an opportunity to re-adjust the system in yet another way, to make it just a little more adaptive in the patient's current life or to understand its workings just a little better.

The third "law" of dissociative disorders treatment is: **"FOR EVERY ACTION, THERE WILL BE AN EQUAL AND OPPOSITE REACTION,"** meaning that every split, every part of the Self, has its polarity or opposite. For example, suicidal states are counterposed by states determined to live and move on with life <u>and</u> by states who are terrified of death and fearful of harm. Parts that carry shame and the wish to be invisible are balanced by parts that have narcissicistic or destructive entitlement or even exhibitionistic tendencies. At any moment, any feeling or decision or point of view you might be hearing from the patient is being internally balanced by its equal and opposite reaction. This balancing of the opposites has both positive and negative consequences because it also occurs in response to positive changes and events. For example, if some parts are developing greater trust and closeness to the therapist, other parts will be threatened and attempt to distance or sabotage the therapy. If some parts are relentlessly testing the therapist's competence and consistency and trustworthiness, other parts will be feeling sad and sorry and may re-double their efforts to please the therapist. If both patient and therapist are aware of this law, they can steer a middle course which takes into account the way in which parts react to each other, as well as to external stimuli.

The last law of dissociative disorders treatment is that **"THE THERAPIST IS THE THERAPIST FOR ALL THE PARTS,"** or, better stated, "**the therapist is the therapist for the WHOLE and therefore for all the parts which make up the whole.**" To work with some but not all, or to work with some but not the system as a whole, is tantamount to saying, "I only work with half the patient." Whether it is the nice half, or the younger half, or the self-destructive half, or the helpless half, or the "good patient" half, we cannot work effectively with only a part of a whole. If the therapist is the therapist for all, then the therapist will be neutral: he will not take sides; he will not keep secrets; he will see the potential and the usefulness each part of self brings to the

therapy and to the system as a whole, including the suicidal, self-destructive, and devaluing parts. He or she will see the interplay between parts and highlight the conflicts noticed, much the way a family therapist would. And similar to the family systems model, the identified patient will not be any one part of self; it will be the system of selves. Because in dissociative patients, the system and the patient are one and the same, the therapist must try to avoid the two most common pitfalls in dissociation treatment: speaking to the system as if it were one integrated human being or allowing the therapy to become a "revolving door" with a procession of "family members" coming in to tell their stories and get the therapist's support for their needs. It is usually most helpful to work with the "parent" or "parents" primarily (that is, the Adult Self or host personality) and to teach the system how to become more cohesive by coaching the Adult Self in developing the skills needed to foster increased internal communication and cooperation.

However, to be the therapist for all the parts and therefore for the Whole involves a veritable gauntlet of **tests.** To the extent that any trauma patient needs to test the therapist's trustworthiness, a dissociative disorder patient will have to double or triple the number of tests. Some parts will test the therapist's trustworthiness and commitment by trying to see how much acting out the therapist will tolerate, while other parts will want to test how much nurturing they can elicit. The system will test the therapist's vulnerability to corruption through challenges to the treatment frame, usually formulated paradoxically as "I can't trust you unless you agree to bend the frame in this particular way." When the therapist does agree to moving the boundary, other parts quickly conclude, "See, I knew I couldn't trust you—you should have known better," or "See, she is so weak—she will never be able to hang in with me for the long haul." The treatment frame and appropriate ground rules will, of course, differ from therapist to therapist, but here are some guidelines:

- The therapy must take place in the office—not over the phone, not while taking a walk, not on a park bench. Scheduled phone appointments for specific reasons are a possible exception depending upon the patient's ability to use the phone in this way and the therapist's comfort with non-face-to-face sessions.

- Therapy sessions should last only as long as the scheduled time and no longer unless planned in advance for clearly stated reasons. (Even very experienced therapists are surprised at how hard it is to end sessions **on time** with dissociative disorder patients.)

- If longer sessions are needed, they should be focused on a particular goal: EMDR, stabilization skills training, DBT training, giving the patient time to resource him- or herself. The number and frequency of longer sessions should be clearly stated at the outset, and the possible

pitfalls of extended sessions should be named and discussed before embarking on them.

- The use of the telephone between sessions must be clearly stated at the outset: for life-or-death emergencies only? For crises? For stabilization? How often? Does the patient pay for telephone time? How long does a phone call last before it becomes therapy? Well-intentioned overuse of telephone support to protect the patient's safety all too often leads instead to regression and loss/failure to gain necessary coping capacities.

- The therapist must make sure to structure the treatment in such a way that he or she still has a life! Therefore, be sure to establish clear policies about weekend and evening availability, about email communication, about your ability to read journaling or letters to you, about the number and frequency of voice mail messages to which you can listen without either your life or your other patients being compromised.

- It is probably helpful to give dissociative disorder patients with a history of therapeutic failures a written statement about your policies and procedures regarding confidentiality, reporting, billing, vacation, emergency coverage, and your legal obligation to hospitalize them if they cannot maintain their own safety.

Fragmentation in the patient requires more consistency and cohesion in the treatment. The therapeutic ground rules must also be established clearly, even the ones that seem obvious and are unspoken in most therapies. They do not have to be presented to the patient, but the therapist needs to have thought them through sufficiently to be able to explain them in an understandable and empathic way. Typical ground rules include:

- Thoughts and feelings must be put into words, not actions. (If the patient feels unsafe, the therapist needs to hear about it; if the patient feels angry, walking out in the middle of a session is not a therapeutically helpful way to express it.)

- "No harm to the body" must be a principle of treatment. A commitment to safety is part of the commitment to treatment. Such a commitment does not mean an absence of suicidal or self-destructive feelings or even an absence of self-injurious behavior, but the commitment to the **goal** of safety must be a part of treatment. Otherwise, the treatment will be containment, not therapy.

- No touching other than a handshake or comforting pat on the back from time to time. (Again, many experienced therapists find themselves caught up in struggles around the issue of physical contact or, worse, find themselves bending the rules far beyond their own comfort level.) Although there are always moments in a therapy where a hug or comforting gesture is just the right clinical intervention, it is safer with dissociative disorder patients to maintain an extra degree of conservatism in regard to physical contact.

- It is usually helpful to be clear in advance how much self-disclosure is comfortable and seems appropriate to the therapist as an individual and then stick to that as his or her personal ground rule. Trauma patients tend to benefit from some information about the therapist or the therapist's life, just enough to decrease the number and variety of projections and distortions, yet not so much that the patient feels she has corrupted the therapist.

- Ground rules about "who" should come to therapy and "who" leaves are also often helpful. For example, the executive ego or Adult Self must always come and always leave each session is one such ground rule. Or the part of self which comes must be the part that leaves. Or only the Adult Self or a part that knows how to drive can leave the session. The ground rule that seems to be most effective for reducing chaos in the system and therefore in the therapy is that the Adult Self and the therapist are in charge of the agenda and may "invite" younger parts of self in need of therapeutic intervention to the therapy session or use the time to discuss the best way for the system to intervene on their behalf.

Once the therapist has been thoroughly tested but has nonetheless managed to establish ground rules and a sturdy but empathic treatment frame, the actual therapeutic tasks of a dissociative disorders treatment are quite straightforward and not so different than if we were treating Complex PTSD. These therapeutic tasks are:

- **Learning to manage the symptoms** so that they do not interfere with or prohibit having a life in the here-and-now

- **Learning to differentiate past from present** so that post-traumatic symptoms are not confused with current reality

- **Learning how to use "therapeutic dissociation,"** taking positive advantage of the dissociative talents of the patient in the service of enhancing functioning and sense of capability

- **Strengthening the ego functions of the Adult Self**, including learning how to differentiate between traumatized child parts of self and adult parts of self

- **Learning how to foster internal communication and cooperation** between selves: developing increased internal dialogue, trust, empathy, and compassion, developing the capacity to self-soothe, developing ways to resolve internal conflict

- **Learning that remembering is not the answer:** resolving trauma so that it feels 'past' happens when we have acquired the ability to be conscious and present, even in the face of triggering, to tolerate the ups and downs of a normal life, and to feel safe in the body.

Managing the symptoms so that they do not interfere with life in the present

The essence of a dissociative disorder is the 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. The work of symptom management is to further **refine** this ability to distance from affect but to do so in the service of the ego, rather than in the service of defense. Practically, this goal is accomplished in several different ways:

- **Using cognition to help affect, or left hemisphere to help right hemisphere.** The splitting between affect and cognition experienced by dissociative disorder patients can be therapeutically shored up and made more conscious. (For example, much of what the patient presents as affect can be conceptualized cognitively as a "symptom of trauma," including self-loathing, panic, suicidal feelings, urges to run or hide, self-harm, fear of other people's displeasure, hypervigilance, and hyperarousal. If this conceptual material can be presented in an empathic, compassionate way, it is both organizing and reassuring.)

- **Teaching an array of cognitive-behavioral and somatic techniques to help patients learn to manage the overwhelming number and complexity of symptoms they experience.** Among these techniques, perhaps the most important are those which help the patient to stay more present and grounded in the body which in turn helps them to stay more grounded in their Adult Selves. (Adjunctive DBT treatment or EMDR stabilization techniques can be very helpful in this regard.)

- **Keeping the treatment focused on symptom management, rather than on the "affect du jour."** Because dissociative disorder patients are so split, they can quickly move from one affect to another to another, or they can become "stuck" in a particular affect (e.g., self-loathing) and be unable to move on to other perspectives or into other states of mind. (Often this phenomenon occurs because the patient has come to believe that her "real self" is her overwhelmed, ashamed, and demoralized state of mind, while her functional, competent, in-the-present parts constitute a fraudulent "false self." It takes a great deal of psychoeducation to help these patients see that all of their parts, all of their states of mind, all of their competencies, all their actions and behavior are **real** and are **"them."**

Learning to differentiate past from present

Given that the cardinal features of post-traumatic stress are **affective intrusions** and **avoidance of affect**, it should not surprise us that the patient's past continues to dominate her life in the present. Either she is assailed by intrusive thoughts, feelings, images, smells, and bodily sensations, or she is disconnected, constricting her life and numbing her emotions in order to avoid the intrusions. Typically, trauma patients interpret both sets of symptoms as here-and-now reality because they experience the feelings or have the thoughts in the context of the present. They may make statements, such as, "I'm not safe even in my own home," meaning that the intrusion of unsafe feelings takes place in their homes, or they may 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 misinterpreted these affects as logical responses stemming from present reality

In order to help dissociative disorder patients learn to differentiate past from present, it is necessary to take on a very different role as a therapist: instead of empathizing with the affect and helping the patient to "sit with it," we need to help the patient learn to distance from the affect, perhaps even temporarily suppress it, and to cognitively interpret its meaning in the light of understanding post-traumatic stress. Because "feeling reality" is misleading for trauma survivors, we need to do the opposite of what we were trained to do: we need to question feeling reality and encourage the development of objective 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 believed 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."

Learning how to use therapeutic dissociation

The dissociative system was designed to work therapeutically in that it functioned to defend the child's psyche against overwhelming assault. It had to work automatically because the child had to be able to respond quickly. If she heard a yell, felt a touch, saw "the look" in an adult's eyes, she had to be able to distance, to go away in the mind and body into a mental state in which she would not feel pain, not feel overwhelmed, perhaps not even know what had happened. In her current life, that involuntary system has become ineffective or even dangerous. For example, when the teacher began to get overwhelmed, she would dissociate either into a hyperactive child self who would try to flee the situation, <u>or</u> into an adolescent self who would hide in a closet and cut herself, <u>or</u> into a suicidal part of self. All of these selves or states of mind had once been the logical places to go when she was a child because each in a different way increased her sense of control and lessened her feelings of being overwhelmed by forces more powerful than she. As an adult who had a stable marriage, two teenage children, a newly completed a Master's degree, and her first teaching job, it was not logical to respond to her current stressors in these ways: it was unsafe, and it was re-traumatizing for her 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.

"Therapeutic dissociation" involves using a combination of displacement and visualization techniques to help the patient get distance from the affect, re-frame the feelings, and use her dissociative abilities to modulate pain and even to self-soothe. At its simplest, it begins with the patient reporting some type of distress which the therapist encourages her to "split off" by asking, "What <u>part</u> of you might have been feeling that way? And why or how might that part have gotten triggered? Is this feeling a communication from that part? What might that particular part be trying to tell you?" Working in displacement, the patient is asked to visualize or imagine that child: his or her age, what the source of the distress might be, what the child might be thinking or feeling. Often patients will visualize photographs of themselves as children, or they may build an imaginative picture of this child in distress. [Notice

that the work of trying to identify or locate the distress in a particular part of the self involves using mental abilities that help to create enough distance from the affect to de-intensify it.] As the patient begins to understand the distress better in displacement, she is asked to use the resources characteristic of her Adult Self to "help" the child part of self who is so frightened and in so much pain. By "splitting off" the affect and assigning it to a much younger and more vulnerable part of self, the patient can get the necessary distance without having to resort to denial or disconnection. It becomes possible to soothe the affect using the feelings of compassion the adult patient can summon for this image of a child in distress. It is easier to see the necessity for avoiding self-harm if the therapist points out that "the child in distress" would interpret the cutting as punishment for abuse. In addition, the patient is usually more willing to work on staying present and grounded, rather than dissociating, because she now has another way to distance from the affect and because she has begun to develop some empathy or sense of responsibility for the child part of her.

Another use of"therapeutic dissociation" is to employ techniques derived from clinical hypnosis and behavioral medicine for calming the mind and body. Perhaps the best known of these techniques is the creation of an imaginative inner Safe Place, a place where the danger and pain currently overwhelming the patient could never occur. Because dissociation involves an alteration in consciousness, dissociative disorder patients are 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, not just a re-experiencing of it, 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," the teacher, created several different kinds of safe places for different combinations of young child parts and older child or teenage caretakers: some were 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 that therapeutic dissociation allows the patient to visualize not only safe places but also caretaking figures who can provide imaginatively provide soothing and reassurance.

Yet another use of therapeutic dissociation involves calling on more competent or more adult states of mind to help with the tasks and challenges of adult life. This approach is very helpful if the Adult Self is becoming depleted by the internal struggles, post-traumatic symptoms, and unsafe sequelae. For example, Annie was overwhelmed by a number of challenges in her teaching job: how to get through an eight-hour day, especially on days when the insolence of her eighth grade students or the authoritarian manner of her principal triggered traumatized child parts. Invoking trance logic, she was asked to identify those parts of self who liked the teaching job or

were not easily intimidated or were good at being healthily assertive or had competencies that might useful in a school setting. Then she was helped to visualize a "teaching team" composed of herself and three parts of self: a self-assertive, unflappable 18-year-old, a "teacher" part (that aspect of her that had sailed through her Master's program), and a "Neighborhood Mom," that part of her who had baked cookies and car-pooled and caught tadpoles with many of the same 8th graders when they were young children growing in her neighborhood with her own two sons. Once she caught on to the image of being able to share the load of the teaching job with these functional, competent parts of herself, the job began to seem a little more manageable. Remembering the rule that "the system was designed for survival, not destruction" will help to remind the therapist that there are always internal resources of which a depleted Adult Self may not be aware. Since the patient is only aware of the states or parts of the mind she is experiencing right now (and those are usually overwhelmed, frightened or angry), it is crucial for the therapist to remember to help her call on all the rich resources she has internally available to her.

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

This is the most challenging but also the most rewarding task of dissociative disorders treatment. Once the patient achieves this ability, the other tasks become easier to accomplish. Learning to differentiate an Adult Self, however, requires the therapist to be willing to take on faith that there is an Adult Self who lives and breathes and functions in current reality in accordance with the reality principle. If the therapist believes that <u>every</u> adult has an Adult Self, no matter how depleted or demoralized, then he or she can teach the patient how to use that Adult Self as an executive ego in charge of directing all efforts and decisions. The patient will often have little consciousness of that Adult Self because his or her attention is drawn to the overwhelming affects or the bizarre behavior she cannot understand or to the latest crisis. Because the Adult Self is reflected in calmer states, the ability to think and conceptualize, in acquired knowledge and skills, the ability to care for others or accomplish tasks, and qualities such as curiosity and compassion, it can be experienced as a "false self," rather than as the more thoughtful, functioning self. Often it helps to have the patient collaborate with the therapist in figuring out what role her Adult Self plays in her life: for example, going to work, taking care of a child, interfacing with the external world, doing things with friends, organizing the ping-pong tournament on the inpatient unit. As these activities are linked to an executive ego able to negotiate the real world, the associated competencies or talents can be noted by the therapist: good with children, efficient and organized, fair-minded, the one others go to for advice, good managerial skills, creative, or rational and calm in a crisis. Once that Adult Self and its competencies have been described, the patient can be helped to notice is NOT the Adult Self: for example, when she feels little and overwhelmed at work, does that fit with what she knows about her Adult Self? Does she feel little and overwhelmed when caring for her children?

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 she feels angry and gets sarcastic with her boss, is that the Adult Self? 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? The answer must be that this response is that of a teenager.

The next step is to ask the Adult Self to take a mental step back and become curious about how to intervene to "help" these younger parts of self. In the example of the client in relationship to her boss above, both the Adult Self and traumatized parts are reacting to the same stimulus (an unfair authority figure) in the context of two different past realities. The child part of self is intimidated, experiencing herself as powerless in an unsafe situation, while the teenage self, while also intimidated, becomes enraged at the unfairness and incompetence. In turn, the Adult Self's ability to be appropriately self-assertive with this boss may be compromised by the reaction of her parts. Or her boss might over-react to the angry, sarcastic teenage part, confirming that part's deepest fears that the workplace is not safe.

In dissociative disorders treatment, the problem-solving of current life dilemmas by the Adult Self must be always accompanied by an awareness of the impact of any solution on child and teenage parts of self in order to ensure that any solution is a solution for them, too. For example, going to talk to the boss might be a logical solution for an Adult Self, but it could also trigger the adolescent part and lead to disaster if the Adult's carefully composed challenge to authority suddenly turned into the teenager's blast of fury. So perhaps a better solution would be to enlist the support of the Human Resources Department or a person senior to the boss. Those responses satisfy the needs of all parts: the Adult Self who wants professional respect; the child who needs a sense of safety and protection; and the teenager who will not be satisfied without some re-balancing of the power inequalities.

This model of Adult Self-child self differentiation can be applied to any problem a dissociative disorders patient brings to therapy, from safety issues to relationship issues to symptoms to feelings to career and family issues. Monotonously, the therapist asks, "What part might be feeling that way? Is it logical that an Adult Self living in your current reality would feel that way? What kind of person would be likely to feel that way? A child? A teenager? A traumatized part? A protector part? What could the Adult Self do to help that part feel differently?" In turn, the Adult Self can draw on a range of techniques or helping possibilities:

- Soothing and reassuring the distressed part of self
- Putting the issue or feeling in context (e.g. "It's a memory")
- Helping the distressed aspect of self go to a safe place

- Enlisting another part to comfort and support the part which is in distress
- Making a change in the management of the patient's current reality which might positively impact the internal reality of these parts

Learning to foster internal communication and cooperation

Notice how all the therapeutic tasks described rely on the imagination or on the capacity to alter and reorganize state of consciousness—the very ability that allows a dissociative disorder system to work. We are making use of the patient's own unique abilities and even her defenses to help her therapeutically. Nowhere is this use of the ability to alter consciousness as evident as when we begin to help a patient develop better internal consensus. Going back to the model of the Adult Self with traumatized younger selves and remembering that dissociation can be used therapeutically, a simple way to begin increasing internal communication is merely to have the Adult Self "ask inside" for information and feedback. "Who is in distress?" "*Ask inside*." "What part cut the body last night?" "*Ask inside*." "How old is that part who cuts under stress?" "*Let's ask inside and just let a number come to mind*." Because the patient is almost continually in a mild state of trance, internal communication can generally be easily stimulated. "Is there an older part who might be able to help the five-year-old not feel so frightened?" "*Ask inside."*

Internal communication thus begins with the Adult Self learning to become a better listener and to ask "inside" for input from the other parts. As a piece of that listening, the Adult Self must be reminded that younger parts of the mind often communicate through feelings and body sensations, not just through thoughts or in words. If a patient 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 traumatized part who gets triggered in that situation and wants the Adult Self 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?"

Another kind of internal communication is often experienced as ambivalence or indecisiveness or confusion. When one or more parts are in conflict with the Adult Self or with each other about a particular issue or decision, that conflict often gets communicated in any one of the following ways:

- "forgetting" that a decision was made
- "changing the mind"
- undoing a decision intentionally or inadvertently
- sabotaging a decision or course of action

- leading a "double life": going to AA but still drinking, dating two men simultaneously
- losing things necessary for a decision to be executed
- "terminal ambivalence": not being able to make even basic decisions (e.g., what to wear in the morning)

If the Adult Self can re-frame indecisiveness or ditzy or self-sabotaging behavior as a reflection of parts of the self, it becomes possible to look at the internal conflicts as communications. "Which part wanted to buy the fairy princess style wedding dress and which part wanted to buy the simple but elegant one?" Could it be that the Adult Self and a dreamy child self had opposing images of the perfect wedding gown? Is that why it took innumerable trips to the bridal shop and input from more than one friend before the simpler one was chosen?

As the Adult Self begins to "hear" these communications, traumatized parts of self may begin to "tell" more, and internal cooperation may slowly and subtly increase. Using the Adult Self as a mediator or Chief Executive or facilitator helps the process immeasurably. **Internal chaos is not communication**: good communication involves taking turns, active listening, and respectful responses, and all of those require an Adult Self to take charge of the process and manage it. If is often helpful to have one or more metaphors to use to help patients understand the importance of internal leadership because there is often resistance to leadership stemming from the experience of being traumatized by powerful authority figures. The metaphor could be:

- a group home for traumatized children
- a team
- a symphony orchestra
- a corporation
- an inner family

Internal cooperation and communication is fostered by an Adult 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. Internal empathy usually evolves in a similar way: 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 devalue the therapy or the part whose criticism and blame undermine the efforts of the Adult Self, but it is imperative that empathy be encouraged for every aspect of self, every feeling and every behavior. For the therapist to have or to teach empathy, it helps to be familiar with the typical roles and functions of parts or alters in a dissociative disorders system:

First, of course, there are some number of traumatized child and adolescent parts frozen in time and holding memories and feelings disconnected and encapsulated. Next, there are

always some number of "protector parts": parts of self whose function it was to ensure the survival of the child, often in ways that, in the present, cause chaos. Protector parts tend to be rough and tough and gruff: they don't want to win friends; they want to keep enemies at a distance. They cut; they headbang; they are homicidal or suicidal or both; they are enraged; they devalue the therapist and the therapy; they are hypervigilent; sometimes they are critical of the other selves to the point of abusiveness. But, if we can look at the survival value of their functions and roles in the context of the patient's childhood, it becomes easier to empathize with how the Angry Part stayed angry and furious and stubborn to mitigate 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 organism; how the part that devalues the therapy has an understandable and appropriate 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.

Last but not least, there are functional or managerial parts of self whose role has been to enable the child and later the adult to meet the everyday challenges of life. There may be a part who raised younger siblings or who went to school and developed skills and talents, or who learned to play the piano, or who practices the patient's current profession or craft. These are the parts who early on can be enlisted as allies and helpers of the Adult Self, either to increase functioning or to become caretakers and nurturers of the child parts of self.

Notice that the essence of the work is capitalizing on the patient's fragmentation in order to work on the issues in displacement: empathy for self is achieved <u>in displacement</u> by having the Adult Self empathize with traumatized 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 patient can develop more conscious and effective defenses. If a system of dissociative defenses enabled the child to survive physically and psychologically, then we have to be exquisitely careful about encouraging the patient to take down those walls. It is often more effective treatment to first shore up the existing walls, to strengthen the Adult Self, and to promote ego strengthening first. We must

make sure that the patient has organized and effective ways of maintaining internal equilibrium before we begin to build on the experiences of internal empathy, trust, and consensus by addressing and processing the traumatic memories. In the model of treatment described here, the focus is first on differentiating ego states or parts of self so that dissociative displacement can be capitalized on, then 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 patient 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.

Learning that remembering is not the answer

If it is hard for therapists to learn that remembering is not the answer, no wonder it is so hard for patients to learn! Throughout a dissociative disorders treatment, the therapist will be doing battle with the parts who want to "tell all" and the parts who resist the therapist and the therapy in order to "not go there." Because the therapist will encounter both points of view with any trauma survivor, it helps to keep in mind that the "answer" 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, and therefore remembering can only be helpful when the patient has learned to choose how, when, and where to remember and when she can remember rather than re-live the trauma.

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