**ISSTD – Standard Part 1, Class 6**

Chu: Chapter 8 Containment

1. Discuss the role of safety in the first stage of treatment in patients with dissociative disorders
	1. The therapeutic relationship helps to establish safety
	2. Explaining this isn’t “my way” or “your way” these are identified methods to help in the areas you are struggling
	3. Psychoeducation
		1. Cognitive – setting out a psychoeducational framework and conceptualizing approaches to achieve treatment goals AND enlisting the client in an alliance to work toward these goals
		2. Behavioral – instituting and rehearsing interventions then repeating or modifying interventions until the treatment goals are obtained
2. Describe the need for and use of containment in treating dissociative disorder patients
	1. Cognitive psychoeducational component of controlling posttraumatic and dissociative symptomatology is more important than behavioral
	2. Educating clients on the necessity of controlling their symptoms is essential
	3. Therapeutic alliance and a level of trust is important for containment work to occur
	4. Since flashbacks and other symptoms are experienced as happening “to them” there is a learning curve to clients to realize they have control over these experiences
	5. Management Strategies – Grounding Techniques – a well lit environment can be very helpful in implementing these strategies
		1. Sight – indication of date, time, familiarity helps with orientation and equilibrium, eye contact with another individual is very grouding
		2. Hearing – listening to music, reading aloud
		3. Touch – feeling familiar, soothing objects, keep a stone from counselor’s office
		4. Smell – coffee beans, essential oils, potpourri
		5. Taste – pungent, fragrant liquids hot or cold
	6. Safe/Special Places
		1. Guided imagery can be used to promote relaxation and a feeling of safety
		2. Goal is to produce a relaxation response
		3. Clients determine the exact characteristics of safe/special places
		4. These techniques are used for stabilization, containment, and relaxation, NOT for exploration of traumatic experiences
	7. Crisis Plan
		1. A list of sequential activities or interventions to be used in situations where client feels anxious or overwhelmed
		2. Usually helps for the plan to be written
		3. Relaxation, grounding, cognitive strategies are examples – pg 158
3. Apply theory from previous sessions to the cases of Harold

Establishing Safety with Patients with Dissociative Identity Disorder

Bethany Brand

* 4.3%-33% prevalence rate of self-mutilation and suicidality among general psychiatric patients
* Childhood abuse, especially sexual abuse is associated with particularly high rates of self-mutilation and suicidality.
* Higher levels of dissociation have been linked to self-mutilation.
* Self-mutilation rates increase to 34-48% in DID patients.
* Attempted suicide rates 61-72% with 1-2.1% completion in DID patients.
* Typical clinician treating a patient who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, betrayed, disgusted and sad. (Similar in treating suicidal patients). This is a form of projective identification.
* Clinician feels an empathic strain when the burden of chronic suicidality and/or self-mutilation is added to the therapist’s task.
* Kluft 2 stances regarding self-destructiveness
	+ Therapist responds with an immediate and vigorous plan usually involving hospitalization or staying with a concerned other.
	+ Patient given more responsibility for his or her safety. This tends to be felt as more empowering to the patient. Discuss the management of safety crises ahead of time with the patient provides a predictable response for the patient and protects the clinician by avoiding incident by incident decision making regarding how to respond to the patient’s behavior.
* Three abilities clinicians need to help patients with safety problems
* 1. Pragmatic steps for helping patients work through safety problem.
	+ CBT approaches along the lines of Linehan’s DBT
	+ Identify events that precipitate self-harm, teaching emotional regulation, improving distress tolerance, problem solving, and developing self-management and interpersonal skills along with
	+ Supportive psychodynamic interventions: build solid therapeutic alliance, setting limits, emphasizing strengths, and using both praise and suggestions.
	+ Medications: SSRI augmented by a dopamine antagonist, a minor tranquilizer, naltrexone, or lithium. High dose of SSRI like Fluoxetine also can be recommended. Carbamazepine and lithium carbonate can be effective in the treatment of self-destructive behaviors. Severe self-mutilators may benefit from naltrexone which blocks binding of endogenous and or exogenous opiates to opiate receptors.
* 2. Understand why patients become self-destructive and/or suicidal.
	+ Challenge the lack of concern and cognitive distortions with which dissociative clients often regard their chronic problems with safety. \*\*Crucial to teach patients they are responsible for their behavior in all states including dissociative states.
	+ Ambivalence about self-care because they came to believe they were worthless due to chronic childhood abuse and no concept of self-care.
	+ Frequently there is a reenactment of the abuse through self-destructiveness.
	+ Self-destructiveness may have developed because the person had no support group, no words or other holding environment in which to express distress.
	+ Self-destructiveness may be a primary form of communication for those who do not yet have the ways to tame their excruciating inner conflicts and feelings.
	+ There may be a physiological basis associated with early abuse and poor attachment which contributes to acting on affect rather than verbalizing it.
	+ Cognitive distortions
		- Fear of being re-abused, “If I hurt myself, no one else will hurt me.”
		- Self-harm is driven frequently by a desire to punish oneself due to a sense of inherent “badness”.
		- The belief is that patient themselves is the abuser. They might have identified with the aggressor to avoid the helplessness as a child. Challenge the way they are threatening their parts as how they were threatened by their abuser.
		- Belief parts are separate people which can lead to the belief that one part can survive the suicide or homicide of another part.
		- Fear of annihilation. They fear they may be killed off by the therapist or one of the parts.
		- Belief that talking about the abuse may lead to actual harm from their abusers.
		- Death or severe illness of an abuser tends to produce a struggle with safety. This could increase thoughts about the trauma.
		- Ongoing trauma, might still be involved with the abusers.
* 3. Be aware of specific experiences and thinking patterns that are likely to trigger safety problems with dissociative patterns.
	+ Attempt to manage affect, sooth oneself, escape painful experiences, or a graphic way to tell the story of violation.
	+ Change patient’s affective state, distract from feelings of shame or anger.
* 5 Therapeutic Tasks in establishing safety
	+ 1. Determine whether the destructive acts are made outside the person’s awareness. If so they need to be come more aware of which self-aspect is responsible for this behavior. Direct communication with dissociative parts is encouraged.
	+ 2. Assess the function that the destructive urges or behaviors serve and/or the conflict that is creating the urges. “What were you feeling and thinking just before you harmed yourself? How does this behavior help you cope? What did you hope would happen as a result of harming yourself?
	+ 3. Negotiate a “truce” on self-harm with the patient. Page 140 “Although I would like you to stay safe, and I’ll do everything in my power to help you do so, including hospitalization if necessary, I realize I cannot force you to be safe. Although you di not control what happened to your body as a child, you now control what happens to it. Only you can break this pattern of treating yourself violently.”
		- Written safety plans are useful, specific examples on page 141
		- Avoid power struggles
	+ 4. Build an alliance with the parts threatening self-destructive behavior.
		- All parts (even suicidal or self-harming) serve a purpose or important function and should not be viewed by the patient or therapist as bad.
		- What’s good about that? Anger could be viewed as a strength in survival and may benefit other parts to learn to tolerate feeling angry and to protect themselves. This could lead to learning assertiveness.
	+ 5. The conflict is resolved and/or adaptive coping skills are taught.
		- Therapist’s role in the resolution of the conflict among the parts is the facilitator (not peacemaker or police officer). Patients themselves must have the primary responsibility of resolving internal conflicts, although they will need the therapist’s assistance due to the discomfort of confronting intrapsychic conflict.
	+ Teach containment.
	+ Ask how long self-harm makes the patient feel better. They may be interested in a longer term solution versus short term self-mutilation that tends to become chronic and repetitive.
	+ Attempt to manage traumatic material. They may believe it is better to feel physical pain than emotional pain.
	+ Attempt to communicate and manage relationships which are marked by violation, poor attachment and entrapment. Look for reenactments within the therapeutic relationship.