**Steele, Boon, Van der Hart – Beginning Work with Dissociative Parts, Chapter 7**

1. Initial dilemmas in working with dissociative parts of the self
2. Not wanting to accept other parts, hear other voices is understandable
3. It can bring up fear or shame related to what other parts have experienced
4. Fear of losing control to other parts
5. First steps in working with dissociative parts of self
6. Learn to acknowledge dissociative parts and accept sense of being/feeling fragmented
7. First dialogues to increase communication/cooperation
   1. Learning to deal with triggers
   2. Increasing internal/external safety
   3. Working together in therapy
   4. Cooperating to complete daily life tasks
   5. \*traumatic memories, emotions or sensations generally should not be shared among parts at this point
8. Forms of inner awareness and communication
   1. Gradually acknowledge and accept parts of yourself
   2. Each time you are aware of a part of yourself, you can also begin to be aware of how you think and feel about that part of yourself
   3. You can begin to accept them without judgement = less afraid/ashamed/threatened
   4. Begin listening and sharing
   5. It is common to have inner threats when beginning this internal dialogue – this usually comes from an internal, highly critical part of you
   6. Start with “All parts of me wants to feel better”
9. Techniques for Inner Communication
   1. Written forms of communication
      1. Emphasize traumatic memories should be contained for the time being
      2. It may be easier to write on a computer so a file can be quickly deleted
   2. Talk Inwardly
      1. One way communication
      2. May want to use this if feeling agitated, anxious, confused or afraid
      3. Reassure parts you are safe, willing to learn to care for yourself more effectively and getting help
      4. Have all parts look around and notice your surroundings – use anchors to stay present

**Chapter 25**

1. Younger parts
2. Younger parts represent developmental stages they missed or did not completely achieve
3. They are not actual children and need to be dealt with in the context of adult life
4. Ages of dissociative child parts often correlate with particularly traumatizing times in your childhood
5. To a great extent, their behaviors, thoughts, feelings, needs, and wishes are your strivings to achieve the normal developmental experiences from you childhood that you missed – especially attachment from a caring person
6. Child parts often experience shame, fear, loneliness and sometimes hold good memories
7. Being phobic to them perpetuates their inner experiences of loneliness, yearning, need…
8. Child parts should be encouraged to look through the eyes of the adult/temporary blending (traumatic material should not be shared)
9. It may help to let younger parts be out at certain time for certain activities and not switch to a younger part in adult situations
10. Consider the goals of what your whole self is trying to accomplish before deciding how to proceed
11. One reason child parts remain separate is a strong wish to ignore what has happened and create a loving, wonderful childhood
12. There are 4 strategies to work with child parts
    1. Imagery-based inner experiences, such as safe places and imagined activities
    2. Inner cooperation among parts to care for each other
    3. Actual experiences that meet a specific young developmental need, i.e. having a nightlight
    4. Actual present-day experiences that simultaneously meet the needs of all parts i.e. going to the zoom, taking a pleasant walk

**Chapter 27 – Improving Decision Making**

1. The traumatized individual may reflexively make same decisions without thinking and do not attend to clues that contradict their conclusions
2. Considering thoughts and emotions is important in decision making
3. Individuals with dissociative disorders typically have difficulties making certain decisions due to inner conflicts among dissociative parts of themselves
4. Harried, pressured decisions often create a vicious cycle where all parts become overwhelmed by the consequences of poor decisions and are prone to even more emotion-driven impulsive decisions that take less effort
5. Traumatized individuals pay more attention to cues of threat rather than other experiences and interpret ambiguous stimuli and situations as threatening
6. One of the most effective ways to improve decisions making is to trying to imagine accurately the outcomes of making or not making decisions
7. To help with decision making
8. Make a pros/cons list
9. Use a rating system
10. Make conscious decisions
11. Exercise creating an inner meeting space for decision making (Fraser dissociative table)

**The role of clinical experience, diagnosis, and theoretical orientation in the treatment of posttraumatic and dissociative disorders: A vignette and survey investigation**

1. Treatment guidelines and clinical experience have suggested that as patients’ presentations become more complicated, exposure therapies are best withheld until a period of stabilization has been achieved, enabling patients to acquire internal and external resources before facing the magnitude of their trauma
2. Phase-oriented treatment, prioritizes stabilization before exposure, in contrast to exposure therapy, which does not focus on prior stabilization based on the belief that stabilization occurs as the exposure therapy progresses
3. Clinicians were given 2 vignettes, 5 possible diagnoses, and to choose the best of 3 possible treatment options
4. More experienced clinicians had more awareness of negative reactions to Exposure Therapy/CBT
5. Since Exposure Therapy is a technique within CBT, it is likely clinicians with Psychodynamic Therapy orientation were less comfortable with Exposure Therapy
6. Experienced clinicians preferred phase-oriented treatment over exposure therapy

**Therapeutic Interventions in the Treatment of Dissociative Disorders**

**Joan Turkus and Jennifer Kahler**

**10 Key skills and techniques for dissociative disordered patients**

1. Psychoeducation
   1. Undo stigmatization and shame associated with being ill
   2. Change focus from “What’s wrong with you?” to understanding their experience is a normal human response to trauma and how it disrupts one’s life.
   3. Self-help workbooks can be useful
   4. “Expert Consensus Treatment Guidelines for PTSD: A Guide for Patients and Families”
   5. Teach neurobiology of trauma
      1. Normalize physiologic reactions to stress including freezing (a response guided by the limbic system).
   6. Compare survival behaviors with recovery skills
      1. Compare dissociation to grounding
      2. Secrecy versus discretion or privacy
   7. CBT Interventions
      1. Self-nurturing, self-soothing strategies
      2. Boundaries and relationships
      3. Self-injurious behaviors
      4. Understanding substance use within a trauma history
      5. Affect management
      6. Grief and loss
      7. Organization and problem solving
      8. Responsible assertion
      9. Safety planning
      10. Maintaining social support and connection
2. Pacing and Containment.
   1. Encourage dissociative barriers to become more permeable and eventually collapse
   2. Patent learn ego defense of suppression (postponing dealing with traumatic material until an opportune time).
   3. Containment skills can include counting down or dialing down dysphoric feelings, or releasing painful affect to the universe in a slow and controlled tolerable way.
   4. Affect modulation: identify feelings, followed by contextual relationship, and then modulation.
      1. Discern difference between feeling bad, pain, sadness, guilt, shame or anger.
      2. Complex or mixed feelings such as love and anger are often dissociated.
      3. Learn to sit with a feeling, allow self to cry
      4. Modulation involves teaching self-soothing, mindfulness or distraction techniques.
3. Grounding Skills
   1. Sensory awareness encourage patient to focus on present using all 5 senses and awareness of their body position.
   2. Cognitive awareness involves orienting patient to the here and now: name, date, age and location
4. Talking through
   1. Encourages all self-aspects, known and unknown, to become a part of the treatment process.
   2. Use of the eyes and ears can be helpful as it is objectifying the body and promotes listening in and cooperation.
   3. Useful in safety contracts.
5. Internal meetings
   1. Frazer’s Dissociative Table.
6. Traumatic reenactment
   1. Karpman’s Drama Triangle including the role of the “non-rescuer” or “bystander”
   2. These roles are repeated in patients’ lives but also within the world of alters and acting out on parts of self rather than others.
   3. Persecutory self-aspect, can be threatening, hostile and uncooperative in helping attain safety.
      1. Important to address aggression as the problem rather than shame or avoidance.
      2. Empathize with the part as also being hurt and trying to be a protector, but comes at a price.
      3. Lonely place for this part to be.
      4. Can turn out to be a child part which is actually frightened underneath the aggressive presentation.
7. Safety Planning
   1. Give client many choices to attempt to manage the crisis independently before asking the therapist for help.
   2. Triangle of Choices for Safety
   3. Good example page 256 of wording.
8. Healing Place
   1. Different then safe place
   2. Active and creative concept that connotes power of process and hope.
   3. Unique to client and needs (baby room with bottles when client was often starved in past).
   4. Symbol of hope.
9. Journaling
   1. Have parts fold written page to indicate it will not be read until therapy session.
   2. Can assign topics for journal.
10. Artwork
    1. Collage , use a containing or healing border
    2. Construct a survival kit.

**Howell Chapter 10: Facilitating Co-consciousness and Co-participation in Treatment**

1. Co-consciousness
   1. 2 or more alters sharing same mental and/or perceptual space at the same time.
   2. Doesn’t mean behaving as one
   3. Achievement of co-consciousness is necessary to increase harmony, cooperation and a step toward integration of the system.
2. Co-Participation
   1. Participation in treatment on a level of one person and also multiple subjectivities.
   2. Goal to enlist parts in the treatment process.
   3. Lessens dissociative barriers
   4. Parts can feel less isolated or unwanted
   5. Promotes increased information essential to healing
   6. Functioning is more effective when relevant informaiton and affect are available to the one in executive control
   7. Therapist needs to be willing to acknowledge the subjective existence of all of the parts.
3. Working Directly with Dissociative Parts
   1. Ok to ask for parts with Host’s permission
   2. Roll call’s
   3. Naturally emerge
   4. Talking through when parts don’t come forward, limited time, notice about vacation, or safety agreements.
   5. Ask the host to ask inside (breaks down dissociative barriers). Example of girl in dirty slip.
      1. For information and
      2. To restore memory
   6. Helping dissociated parts of the person have empathy for each other (example of rejecting the girl with the dirty slip who is in pain)
   7. Negotiating the time Specific Parts have in session
      1. Adult parts need to drive home
      2. Asking parts to step aside so that other parts may be heard or teach others their skills
4. Working with dissociative parts’ experience of the body
   1. Accept they share the same body with other parts
   2. Ask about how tall they are, post it note on the wall
   3. Body is now an adult and safer
5. Mapping the Organization of Dissociative Identities
   1. Look for what they leave out and include
   2. Look for organization
6. Use of visualization and metaphor to increase co-consciousness, visualizing other parts
   1. Frazer’s table technique
   2. Parts impart knowledge via slow leak of a dripping faucet.
   3. Window-blind technique: picture window with the blinds drawn closed and other parts of the system are on the other side. When ready the client slowly twists the wand of the blind and describes what they see.
7. Hypnosis
   1. Relaxation, grounding, self-soothing, enhanced coping skills, increased sense of self-efficacy, creating safe places and help with the reduction of emotional pain
   2. Kluft interventions:
      1. Bypassing time: hypnotically helping alters go to their safe place until next session, encourage client to look backward in time and is feeling good about how well he or she handled the situation.
      2. distancing maneuvers: library technique where client envisions a trip to the library where there are fascinating volumes, “some of which we study together and close whenever we have read as much as we can absorb.” This provides distance from potentially overwhelming memories.
      3. bypassing affect: put affect in a time-locked vault that will only open a few minutes before the session.
      4. alter substitution: when an alter becomes exhausted/overwhelmed that alter will be replaced with an alter that is not overwhelmed.
      5. These skills teach affect management, alleviate suffering and give patient a greater sense of self-efficacy.
      6. Hypnosis can be used for retrieval of memories \*\*don’t ask leading questions\*\*
   3. Safe place must be made for every known alter
8. EMDR
   1. Use with great care as it intensifies painful affect in the process of resolving it.
   2. Sets should be short
   3. Watch for unmanageable affect