Treating Trauma Related Dissociation, Steele Boone Van Der Hart

Chapter 20: Treatment of Traumatic Memory: An Overview

1. Main goal of treatment of traumatic memories is realization.
	1. Best to work with intense emotion within the window of tolerance.
	2. Realize the event has ended and it is part of the past.
	3. Resolve the trauma with all parts to integrate the memory and deactivate the defense action systems.
2. From Reliving to Realization 3 theories
	1. Dual Representation System Theory states 2 types of memory systems: nonverbal (SAM situationally accessible memory) and verbal (verbally accessible memory).
		1. SAM is primitive, amygdala-driven, nonverbal, somatosensory and highly charged.
			1. Somatosensory memories are considered “hot” memories and include “hot” cognitions such as I am a bad person, It is all my fault.
			2. Traumatic memories are stuck in the SAM system without a memory.
			3. These memories remain unrealized
		2. VAM system is slower, involves hippocampus and prefrontal cortex. These memories are more linear, coherent and complete.
			1. Central component of autobiographical memory known as “cool” or “cold” memory without intense emotions.
			2. Can be realized and don’t present in a somatic way.
		3. Traumatic memories are maladaptive SAM’s that should actually be VAM’s.
		4. Treatment involves relieving symptoms of the hot memories and overcoming them with more fully realized cool autobiographical memory.
		5. Treatment addressed the major phobia of traumatic memories and open the door to further integration of dissociative parts of the patient.
	2. Adaptive Information Processing
		1. EMDR Adaptive Information Processing model
		2. Link SAM with VAM
	3. Theory of Structural Dissociation of the personality
		1. Addresses identity and self are dissociated in addition to traumatic material
		2. Parts have SAM or VAM
		3. Address phobic avoidance of traumatic material
		4. Address realization that traumatic events happened, they are over, they belong to all parts which in turn belong to a single whole person.
		5. Synthesis
			1. First step towards realization: linking (binding) and differentiation of experience.
			2. Sharing of the memory among dissociative parts
				1. From each parts perspective to link it to the others so the story becomes more coherent and less intense.
				2. Identifying safety and danger of the here and now.
				3. Deactivation of inappropriate defense system
				4. Synthesis allows the appropriate linking of daily life action systems among parts so they have a more organic flow.
		6. Realization
			1. Awareness not enough, but realize these facts belong to them, their history.
			2. Acceptance of reality as it is versus what they wish it to be.
			3. Own the experience (personification)
			4. Adaptively present in the here and now based on realization (presentifcation) in order to complete integration of the traumatic memory and dissociative parts.
3. Considerations in approaching the treatment of traumatic memories.
	1. Learn stabilization skills
	2. List on page 425-426
	3. Collaborative Pacing of the Treatment of Traumatic Memories
		1. Small doses: 1 or 2 sessions of trauma work interspersed with several sessions to work on realization and inner conflicts as well as several more to work on daily life or other concerns.
		2. Get internal agreement to do the work
	4. The therapeutic relationship
		1. Authentic and compassionate presence of the therapist can provide safety for the client
		2. Bear witness is a vital healing factor for clients.
	5. Table 20.1 page 428-430
	6. The relational context of flashbacks
		1. Uncontained flashbacks can serve the function of attachment seeking in some patients.
			1. Increase in memories may be a cry to elicit care from the therapist or a partner.
			2. Example of Yolanda fearing being alone at end if session
	7. Countertransference in the treatment of traumatic memories
		1. Fascination with the trauma
		2. Overidentify with the client’s avoidance and suffering, may collude to avoid the traumatic material.
	8. Resolution of Major Conflicts about Traumatic Memories
		1. Could be due to fear, shame, betrayal, pain, loneliness, hopelessness or helplessness…
		2. Therapist needs to address each phobia is addressed sufficiently prior to direct work on traumatic memories.
		3. True-not true conflicts
			1. Therapist should compassionately empathize with the conflict
				1. On one hand… dialectic of trauma
				2. Can be hard to believe due to misremembered or distorted memories can coexist with accurate ones and fantasy can become confused with reality
				3. Memory is a representation of what happened and may change over time.
			2. Threats of if they tell
				1. Can be by perpetrator-imitating parts “If you tell you are dead.”
				2. Telling is one step closer to realization.
				3. Magical thinking: if I don’t say it out loud it isn’t real.
				4. Some threats are mimicked by the abuser, some are internal to prevent realization.

Chapter 21 Treatment of Traumatic Memory: Guidelines and Techniques

1. Psychoeducation and Informed Consent
	1. Kluft Rule of 3rds
		1. Preparation in first third or less of session
		2. Synthesis in 2nd third
		3. Grounding, orientation and cognitive work in last third.
	2. Guided imagery
		1. Dissociative table
		2. Safe or healing space
		3. Ideal wise figure or advisor for inner support and guidance
		4. Containment
	3. Guided synthesis
		1. Imaginal exposure
		2. Dual attention between past and present (stay grounded even when emotion is intense)
		3. Distancing and fractioning techniques (working with only a small portion of experience at a time)
	4. Guided realization
		1. Personification
		2. Presentification
	5. Describe the difference between reliving and remembering
	6. Client is in control and can stop at any time.
2. Preparation
	1. Extended sessions may be helpful to further sow down the processing and allow time for adequate synthesis and realization as well as fully grounded to the present.
3. Choose Traumatic Memory
	1. Least intensive first to allow client know they can do the work and have practice before doing more overwhelming events.
4. Decide which parts should participate
	1. Parts may be able to watch from a distance or be in a separate area.
	2. Beware dissociative barriers don’t always hold so do very small work at a time.
5. Stay within the window of tolerance
6. Have an idea of the beginning and end of a memory.
7. Pathogenic kernels
	1. Useful for therapist to know the most threatening or overwhelming parts of the traumatic memory (parts that the clients wants to avoid at all costs).
	2. Can be a feeling, cognition, sound or body sensation.
8. Guided Synthesis: planned and intentional sharing of a traumatic memory among the dissociative parts so there is no longer amnesia for the experience and realization can be made.
	1. Start at a cognitive level
	2. Different than reliving
9. Synthesis versus exposure
	1. Exposure is to reduce emotional intensity, decrease maladaptive thoughts associated with the fear,
	2. Core emotions of traumatic material are beyond fear including shame, rage, guilt, grief, unbearable loneliness.
	3. Exposure is only the beginning of synthesis and does not address the need for dissociative parts to share memories.
10. Binding and differentiation.
	1. Binding= linkage: parts share what happened from their perspective so the person as a whole can develop a perspective of what happened.
	2. Differentiate between fantasy and reality.
	3. BASK
11. Beginning synthesis in session
	1. Hypnotic approaches
	2. ENDR approaches
	3. Combination of hypnosis and EMDR
	4. Somatic approaches
12. Optimal Distance from the memory
	1. Screen Technique: memory observed on a small screen by parts
	2. Split Screen: ½ memory ½ safe place
	3. Imagine watching through the wrong end of the binoculars, watch through adult eyes
13. Dual Attention
	1. All parts involved in synthesis are anchored in the present.
	2. I am remembering and I am here
14. Titration Techniques
	1. Connection with the therapist in the present
	2. SUDS
	3. Rheostat: clients imagine a thermometer where they can turn down particular emotions or sensations.
	4. Pendulation: help client go back and forth between sensation of regulation (safe here with therapist) and dysregulation (notice one small sensation of the fear).
	5. Safe, calm and healing space, visit to regain safety after processing
	6. Brcaketing: memory can be bracketed with a positive memory at the beginning and the end
	7. Time distortions
		1. Clients experiencing traumatic memories as never ending
		2. Anchoring the end of the event: Some part of you knows the event ended because you are here now. At some point in the past you knew the event ended, you can use that knowledge as an anchor to help you remember that you are here now and it ended. Also reinforce that all of the hurt is over now, let your entire self know it has ended, the past is over and you are in the present.
		3. Time Contraction
			1. Speeding up time like in a blink of the eye to focus only on what has been avoided.
		4. Time expansion
			1. Slowing down time while they are recuperating in safe space.
			2. Take a rest for a job well done.
		5. Fractionation
			1. Slow leak technique
			2. Limiting the duration of time that the client experiences the memory during synthesis.
			3. Can count out loud slowly increasing the number of seconds.
			4. Pathogenic kernels-worst aspects of the event often avoided (belief)
			5. Sensation, sight, hearing, smell, taste, or behavior
		6. Ending the Synthesis Sessions
			1. 2/3 through session help close the work, ground and contain, and connect with client. Can include cognitive appraisal of the work.
			2. Ask what the client and parts need?
			3. Now that you have remembered what have you learned about yourself? Check inside and see how all parts are doing.
			4. Encourage good self-care.
			5. Contain any unshared part of the memory.
			6. Slow leak can be utilized to leak any part of the memory needed to be slowly absorbed by the system.
			7. Guided Realization
				1. Help clients realize their history, grieve the losses, and move forward.
				2. What beliefs have changed? What is different for parts?
				3. Grief losses and the loss of idealized fantasies of family while remaining what is good about the present.

Chapter 22 Integration of Dissociative Parts into a Cohesive Personality

Issues in consultation for treatments with distressed activated abuser/protector self-states in dissociative identity disorder; Chefetz

* Set in motion a new capacity for parts to see how they interact and for them to leave consultation with some hope for being able to figure out how to live with each other.
* Therapist must remain aware of a plethora of potential themes and maintain curiosity
* Most problematic areas remain intractability of shame, negativity and traumatizing narcissistic phenotype in abuser/protector states.
1. Enactment
	1. Projective Identification where the patient puts something into the analyst having the analyst struggle with metabolizing it and successfully and gently present back to the patient in a more coherent form.
	2. Chefetz proposed nothing is put into therapist by patient, it is already roughly present.
		1. 2 people in consultation room are each intolerant of specific feeling, state or script.
		2. Feeling may be the same in each person but from a different origin.
	3. Attempt to understand what is being played out between patient and therapist.
	4. Shame, contempt, humiliation, anger, rage, helplessness and hopelessness are typical feelings
	5. Important for therapist to be honest and willing to disclose their feelings may be very useful or even required to resolve these types of impasses.
2. Delusion of Separateness
	1. Separate self-state as outside the patient and outside their control view.
	2. Can present when therapist doesn’t appreciate the extent to which abuser/protector state is taking a not-me position and the therapist approaches the patient as if the self-state has the same interests as the patient overall.
	3. Goal of abuser/protector part is to protect themselves from being overwhelmed or flooded by toxic emotion or forbidden knowledge using techniques against their own mind.
		1. Techniques are a match for those a perpetrator in their life used to control them.
3. Threats of Suicide
	1. Walk a fine line between threat and action.
	2. Living with the threat creates tension in the patient and therapist, but as long as not producing action it could be paradoxically lifesaving to the patient.
	3. Important to understand which self-states carry these feelings and how it helps the person modulate their pain.
	4. Patients benefit form being able to describe their suicide fantasies in detail and exploration from the clinician.
	5. Identify the paradoxical lifesaving nature of keeping in mind an escape hatch.
	6. Imagination doesn’t kill, action does.
	7. “Do you believe you have adequate resources inside you to manage this apparent threat to your safety and keep yourself safe?”
4. Negative therapeutic reaction, negativity and affect phobia
	1. Patient has a carefully balanced internal world that means healing in one area might be experienced as a threat in another.
	2. Therapeutic gains can be met with increased efforts to maintain the old system of being.
	3. ***Must welcome negativity into the treatment and observe as a strategy of self-regulation that is toxic and self-defeating while simultaneously offering benefit of a temporary surge of personal power.***
	4. ***Therapist’s curiosity will eventually be contagious and serve the clinical dyad as well.***
5. Shame
	1. Most toxic of emotions
	2. Can produce shame in the therapist
		1. As a result of own traumatic experience
		2. Developmental or gross sexual/physical abuse
		3. Threats of suicide and loss of a patient
		4. Threat of loss of self-esteem in the event a case fails
		5. Or threat of feeling exposed as incompetent if overwhelmed by the extraordinary emotional pressures of treatment of trauma may generate.
	3. Overwhelmed with feelings of countertransference incompetence
	4. Attacks on the competence of therapist might mimic attacks on the very existence of the patient as a child by parent who was grandiosely narcissistic.

Fraser’s “Dissociative Table Technique” Revisited, Revised: A strategy for working with ego states in dissociative disorders and ego-state therapy

1. Dissociative Table Technique first published in 1991
2. Pre-Table work
	1. Remind presenting personality the aim of therapy is to engage all the personalities in the therapeutic process and form them into a new team.
	2. Elimination of any ego state is NOT in the therapeutic agenda
	3. Table technique is to gain contact with internal system and to sort out the chaos in interactions
	4. Informed consent, may feel more chaotic before it improves.
	5. Safety and stabilization obviously first priority.
3. The Table
	1. Image of a table in a safe room with chairs for the ego states including presenting personality.
	2. Can choose their own meeting area
4. Setting the table
	1. First imagine self in a safe and relaxing place.
		1. Find out if the visualize it
		2. Ask them to change it to a safe room with a table.
		3. Emphasize safety and this is a space where no one gets hurt. We can talk, but not act out.
	2. Ask what they see in the other chairs, parts might already be there
	3. If not direct them to look towards the door and invite the others to take a seat
	4. Parts that appear at the table are each ego state’s own perceived identity.
	5. Visual can offer a lot of information about the system.
5. The Dialogue set-up
	1. The spotlight or Microphone technique
		1. A way to speak with therapist and each other
		2. Spotlight shines on the one who wishes to speak, or pass a microphone to that part.
		3. All will be able to listen when that part speaks. This can decrease dissociative barriers
		4. Practice it.
	2. Mediator technique
		1. If some states are unwilling or unable to speak directly
		2. Ask if the reluctant part would be willing to speak to the presenting personality who could then relate the conversation to the therapist.
	3. Switiching Headaches
		1. Close your eyes and imagine a balloon as big as that headache. Now gently release the air out of that balloon. As the balloon gets smaller and smaller let it go to the back of your mind. As it gets further away so does your headache.
	4. Screen Strategy
		1. When parts may want to let others know of an event before attempt at fusion.
		2. Best to do this sharing little pieces of events versus opening the floodgates.
		3. Use the safe room with the table and notice a screen of some sort (TV, Computer…)
		4. Can use the screen to show a video clip of that event, have control over the sound, picture, etc.
		5. Use screen for parts to learn what happened during an amnestic episode
	5. Inner Self Helper (ISH)
	6. The Changing Room Technique (previously referred to as Transformer Technique)
		1. Can help ego states view themselves differently like aging, gender
		2. Can try on things to see how they feel or fit.
	7. Fusion Strategies
		1. Partial or temporary fusion
			1. 2 or more parts agree to blend
			2. Temporary amount of time to see what it is really like.
			3. Ask what was the experience like for both parts?
		2. Final Fusion
			1. Parts agree to come together as one to share their skills and from now on manage the world together without having to dissociate.
			2. How does it feel?
		3. Post-Fusion Integration
			1. Therapist teaches the person how to handle various life stressors as a fully integrated individual without having dissociation to cope.
			2. Watch for brief dissociative episodes.