Chronic Traumatization, Dissociation, and Insecure Attachment: Therapeutic Challenges

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Keynote presentation

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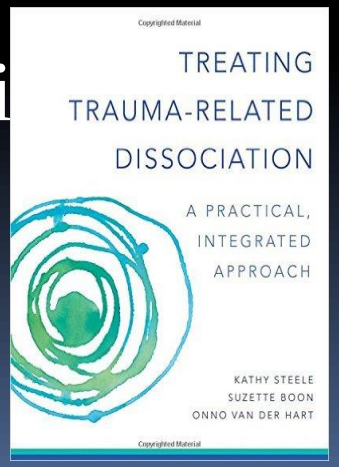


This lecture is dedicated to Giovanni Liotti, *whose studies of dissociation and diorganized attachment have had, and still have, a profound influence on my own understanding of trauma-related dissociation and attachment*

The therapeutic relationship with clients suffering from attachment trauma: preliminary remarks (1)

- "Relationships, including the therapeutic relationship, are major triggers for the reactivation of traumatic memories. After all, patients' traumatic experiences often occurred in the context of important [especially, attachment] relationships, and some of their most severe traumatic wounds [breaking-points] include abuse, neglect, and betrayal in those relationships."
  - Steele, Boon, & Van der Hart (2017, p. 53)

The therapeutic relationship with clients suffering from attachment trauma: preliminal remarks (2)

- "Patients are caught in an impossible conflict between *attachment*, a strong wish for a therapeutic relationship, and *defense* against this same relationship. Therapists should avoid intentionally activating the patient's attachment system until a reasonable degree of stabilization and emotion regulation is possible."
  - Steele, Boon, & Van der Hart (2017, p. 53)
- Our understanding of this impossible conflict is in need of a theory of dissociation of the personality

The mental health field's lack of understanding trauma-generated dissociation (1)

- "Having no way to understand the entrenched self-alienation or intense self-hatred of their traumatized clients, therapists often feel frustrated, baffled, and inadequate to the task of trying to help. Why do they seem to be at war with themselves? Or with us? Although the client has come seeking relief from a burden of trauma-related symptoms and issues, the task of exchanging self-alienation for self-compassion can feel overwhelming or distasteful."
  - Janina Fisher (2017, p. 1)

The mental health field's lack of understanding trauma-generated dissociation (2)

- "Unaware that their symptoms are being driven not just by the traumat[izing] events but by an internal attachment disorder mirroring the traumatic attachment of early childhood, therapist and client have no framework for understanding the chaos and/or stuckness that may soon elude their best efforts at treatment."
  - Janina Fisher (2017, p. 5)

The mental health field's lack of understanding trauma-generated dissociation (3)

- "Neither client nor therapist has a language with which to explain the internal struggles being played out inside the client's mind and body.
- In a mental health world that rejects the notion that personality and identity can be fragmented and compartmentalized, therapists are rarely trained to see the splits, much less the life-or-death battle for control being waged by "selves" with opposite aims and instincts."
  - Janina Fisher (2017, p. 1)

This presentation consists of a discussion of eight challenges in understanding patients with chronic traumatization, dissociation, and insecure attachment

Challenge 1: Developing understanding of trauma-generated dissociation of the personality

Major cases of dissociation highlighting its nature, also in minor cases

- "[W]e must interpret the minor phenomena of dissociation in the light of the major cases, the extreme cases in which the phenomena lend themselves better to investigation. In all such major cases, we find the dissociated activity to be not something that can be adequately described as … the self-conscious purposive thinking of a personality; and, when we study the minor cases in the light of the major cases, we see that the same is true of them."
  - William McDougal (1926, pp. 543-544)

Developing understanding of trauma-generated dissociation of the personality

- To deeply understand this impossible conflict—battle for control--and be able help our patients to resolve it, we need to realize that interpersonal traumatization, in particular attachment trauma, is mind shattering—involves a *trauma-generated dissociation of the personality*, which prevents the development of a more or less fully integrated personality.
- Thus we also need to have clear notions of what characterizes an integrated personality.

Developing understanding of trauma-generated dissociation of the personality

- "With an explanatory model that described each reaction as logical and necessary in the face of threat or abandonment and that reframed them as the survival responses of different parts of the self [personality], to which the individual could relate, each client started to make faster, more sustainable progress.
- The theoretical model that best explained the phenomena described was the Structural Dissociation model [Van der Hart, Nijenhuis, & Steele] ."
  - Janina Fisher (2017, p. 4)

Challenge 1: Developing understanding of trauma-generated dissociation of the personality:

- to be continued…

Challenge 2: Understanding life's task of continuing integrating new experiences in our personality

Understanding life's task of continuing integrating new experiences in our personality

- "Integration … involves ongoing mental actions that both help to differentiate *and* link experiences over time within a personality that is both flexible and stable, and thus promotes the best functioning possible in the present."
  - Van der Hart, Nijenhuis, & Steele (2006, p. 11)
- A mentally healthy individual is characterized by a strong capacity to integrate internal and external experiences.
  - Pierre Janet (1889)

Understanding life's task of continuing integrating new experiences in our personality

- Having a basis of safe attachment fosters our ability to integrate new experiences
- Unsafe attachment, in particular disorganized/disoriented attachment, may seriously hamper this ability

A well-integrated person with a trauma background

- Recognizes and accept reality, including his or her history and present circumstances.
- Has a consistent sense of self
- Experience self as "me," regardless of what he or she is thinking, feeling or doing
- Remembers traumatizing events as narrative memories that can be shared, rather than reliving them
- *Thus is able to engage in intimate relationships without unresolved inner conflicts between proximity/distance*
- Is present in the moment, but has wisdom learned from past experience and realistic goals for the future
- Learns from experience
- Is flexible and adaptable
  - Steele & Van der Hart (2009)

Pierre Janet
1859-1947

Levels of Integrative Actions, as described in Janet's studies

- Synthesis
- Realization

Synthesis

- "Synthesis pertains to those basic integrative mental and behavioral actions through which experiences, such as sensory perceptions, movements, thoughts, affects, memories, and a sense of self, are bound (linked) and differentiated (distinguished from each other)."
  - Van der Hart, Nijenhuis, & Solomon (2010, p.87)

Realization

- “involving higher levels of integration, is defined as developing a high degree of personal awareness of reality as it is, accepting it, and reflectively and creatively adapting to it.”
  - Van der Hart, Nijenhuis, & Solomon (2010, p. 87)

Two Dimensions of Realization

- Personification
- Presentification

Realization: Personification (1)

- "Ownership, that is, personal awareness and acceptance of experience as one's own, is defined as *personification*: "That happened to *me* and I am aware of how it helped shape who I am"; "These are *my* feelings and *my* actions"
- Involves: Taking responsibility for them
  - Van der Hart, Nijenhuis, & Solomon (2010, p. 87)

Realization: Personification (2)

- "Dissociative individuals do not sufficiently own or *personify* their inner and outer experiences, that is, they do not sufficiently integrate them in the context of one cohesive and coherent phenomenal self-model."
  - Van der Hart, Nijenhuis, & Solomon (2010, p. 87)

Realization: Presentification (1)

- "Full realization [also involves] *presentification*, defined as being in the present with a synthesis of all one's personified experiences—past, present, and anticipated future—at the ready to support reflective decision making and adaptive action."
  - Van der Hart, Nijenhuis, & Solomon (2010, p. 87)

Realization: Presentification (2)

- "Well-integrated individuals remain grounded in the present when they remember traumatizing events, and experience the recall as an autobiographical narrative memory rather than a reliving of the past ."
  - Van der Hart, Nijenhuis, & Solomon (2010, p. 87)

Integration versus Dissociation

- "When an experience is acknowledged and accepted, integration inevitably follows because the self cannot help seeking meaning and coherence from experience."
- *Comment*: these actions are already integrative in themselves.
- "When experience is dissociated, however, integration is not possible, and to the extent that dissociation prevails, there is fragmentation of the self. A coherent well-organized self depends on integration."
  - Ogawa et al. (1997, p. 857)

A major developmental task: Integrating our innate *action systems*

- Innate psychobiological motivational or behavioral systems
- Direct or motivate adaptation by influencing *action tendencies*
- Action tendencies involve their own neural networks in the brain
- Each action system is activated or inactivated by various internal and external stimuli
- *Action systems may be complementary or may compete with each other*

It is most difficult to integrate action systems related to opposite goals

- This is especially the case with the social engagement system and the defense action system vis-à-vis the same person.

Normal Daily Life Action Systems

- Exploration
- Orientation
- Social Engagement
  - ***Attachment***
  - Sociability, *cooperation/collaboration*
  - Care-giving
  - Social ranking
- Play
- Energy regulation (rest, eating, etc.)
- Sexuality / Reproduction
- Higher order action tendencies of daily life

Regulatory aspects of attachment that raise integrative capacity

- Secure attachment provides physiological regulatory functions for various developing neural systems in the infant (Polan & Hofer, 1999)
- Early regulatory functions may play a role in the formation of later mental representations of attachment (Hofer, 1995)

Defense Action System

- Attachment cry [panic system]
- Hypervigilance [fear system]
- Freezing
- Flight
- Fight
- Collapse or total submission with anesthesia, analgesia
- Recuperative states
  - Wound care
  - Rest
  - Isolation from the group

Challenge 3: Understanding trauma, as *breaking- point*, interrupting or preventing such integration

Understanding trauma, as *breaking-point*, interrupting such integration

- "All of us have our breaking-point. To some it comes sooner than to others."
  - T.A. Ross (1941, p. 66)

Dissociation as integrative failure vs. defense mechanism

- Trauma-generated dissociation is firstly an integrative failure (cf. "*breaking-point*")
- And, secondly, a defense. "In the psychoanalytic tradition, the term *dissociation* refers to a defense mechanism: a process by which behaviors, thoughts, memories, and feelings split from one another (Kluft, 1990a; O'Neil, 2009; Vaillant, 1994)."
  - Adriano Schimmenti (2016, p. 1)

Challenge 1: Developing understanding of trauma-generated dissociation of the personality:

return

Trauma-generated dissociation (1): Division of the personality

- Trauma-generated dissociation involves, in the first place, an integrative failure.
- It entails a *division of an individual's personality*, i.e., of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioral actions.
- This division involves two or more insufficiently integrated subsystems, called *dissociative parts*, that exert functions.
  - Nijenhuis & Van der Hart (2011, p. 418)

Prototypes of Dissociative Parts

Alternations between
and co-existence of

- Trauma-avoidant part(s), *functioning in daily life*, that experience "too little" –
  - numbing, detachment, amnesia, conscious and unconscious avoidance strategies:
    - ***Apparently Normal Parts of the Personality* (ANPs)**

- Trauma-fixated part(s), *stuck in trauma-time*, that experience "too much" –
  - reliving of trauma and fixation in defense:
    - ***Emotional Parts of the Personality* (EPs)**

ANPs: Primarily Mediated by Normal Daily Life Action Systems

- Exploration
- Orientation
- Social Engagement
  - ***Attachment***
  - Sociability, *cooperation/collaboration*
  - Care-giving
  - Social ranking
- Play
- Energy regulation (rest, eating, etc.)
- Sexuality / Reproduction
- Higher order action tendencies of daily life

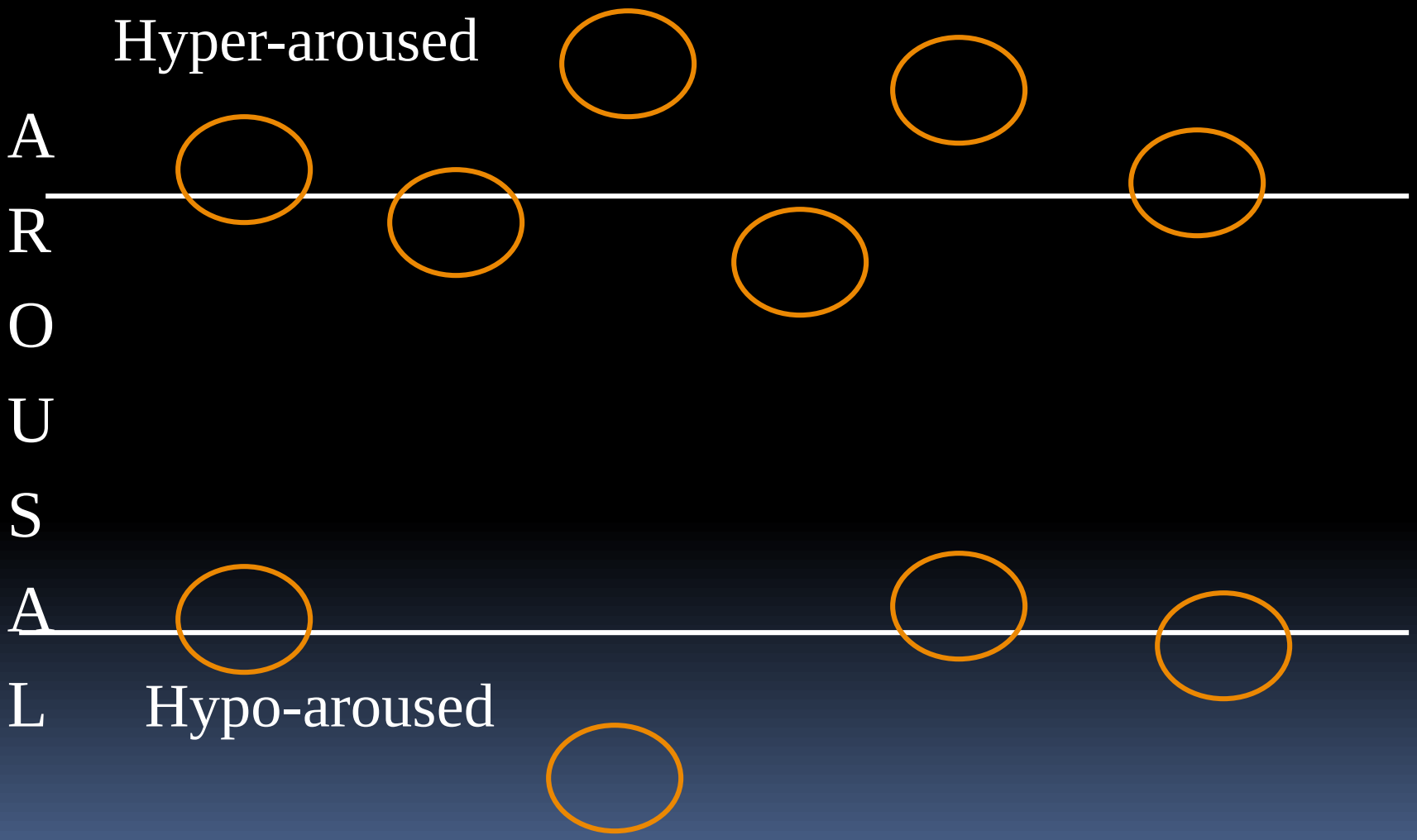
EPs: Primarily Mediated by Defense Action System

- Attachment cry [panic system]
- Hypervigilance [fear system]
- Freezing
- Flight
- Fight
- Collapse or total submission with anesthesia, analgesia
- Recuperative states
  - Wound care
  - Rest
  - Isolation from the group

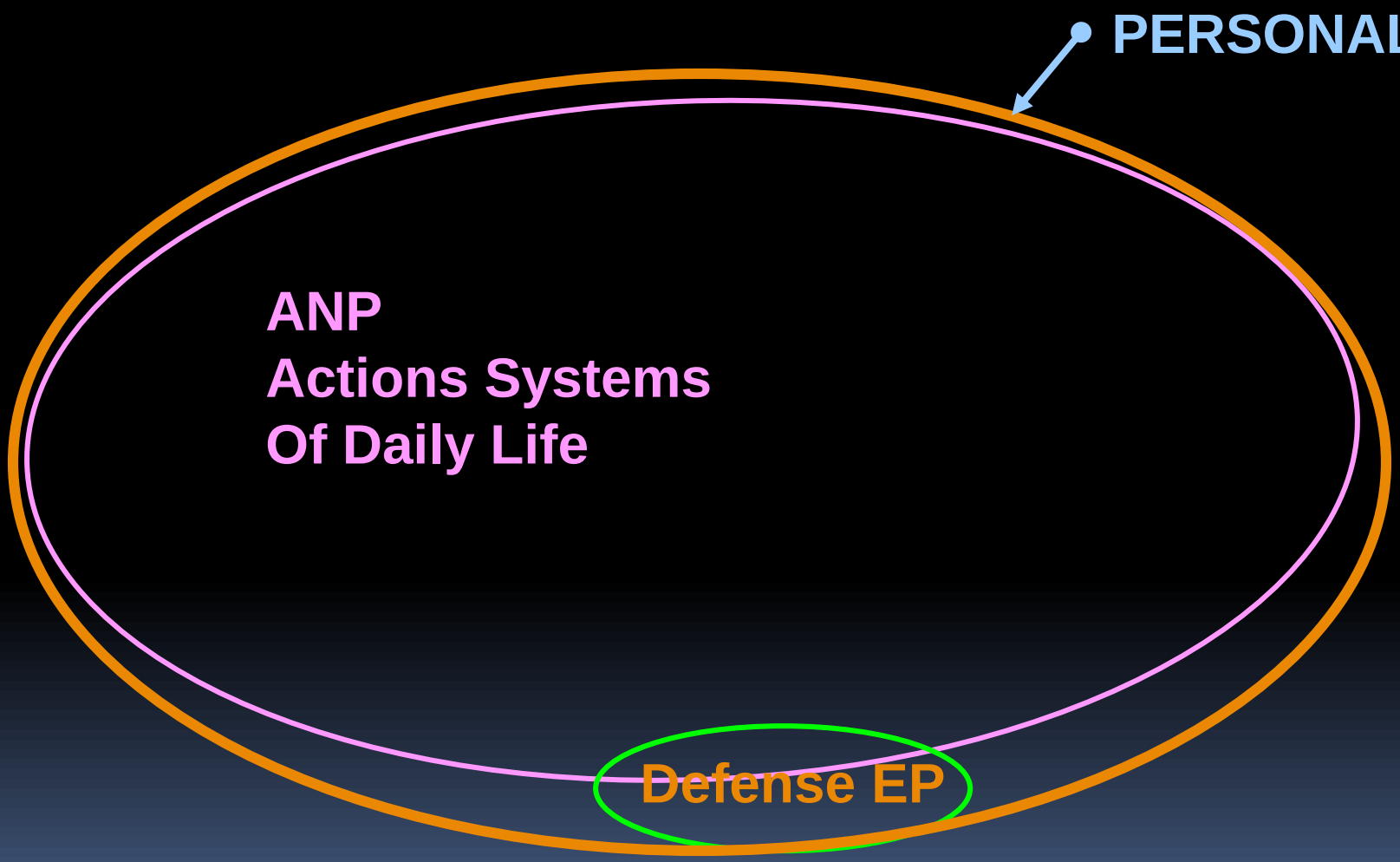
EPs live in trauma-time [important issue in psychoeducation!]

- Even when EPs are not completely re-enacting their traumatic experiences, they do not (sufficiently) differentiate between traumatic past and (safe) present, i.e., *they live in trauma-time*
- Therapists should facilitate ANPs' realization of this fact and help EPs to gradually become more oriented to present reality

EPs live on the edges of Window of Tolerance

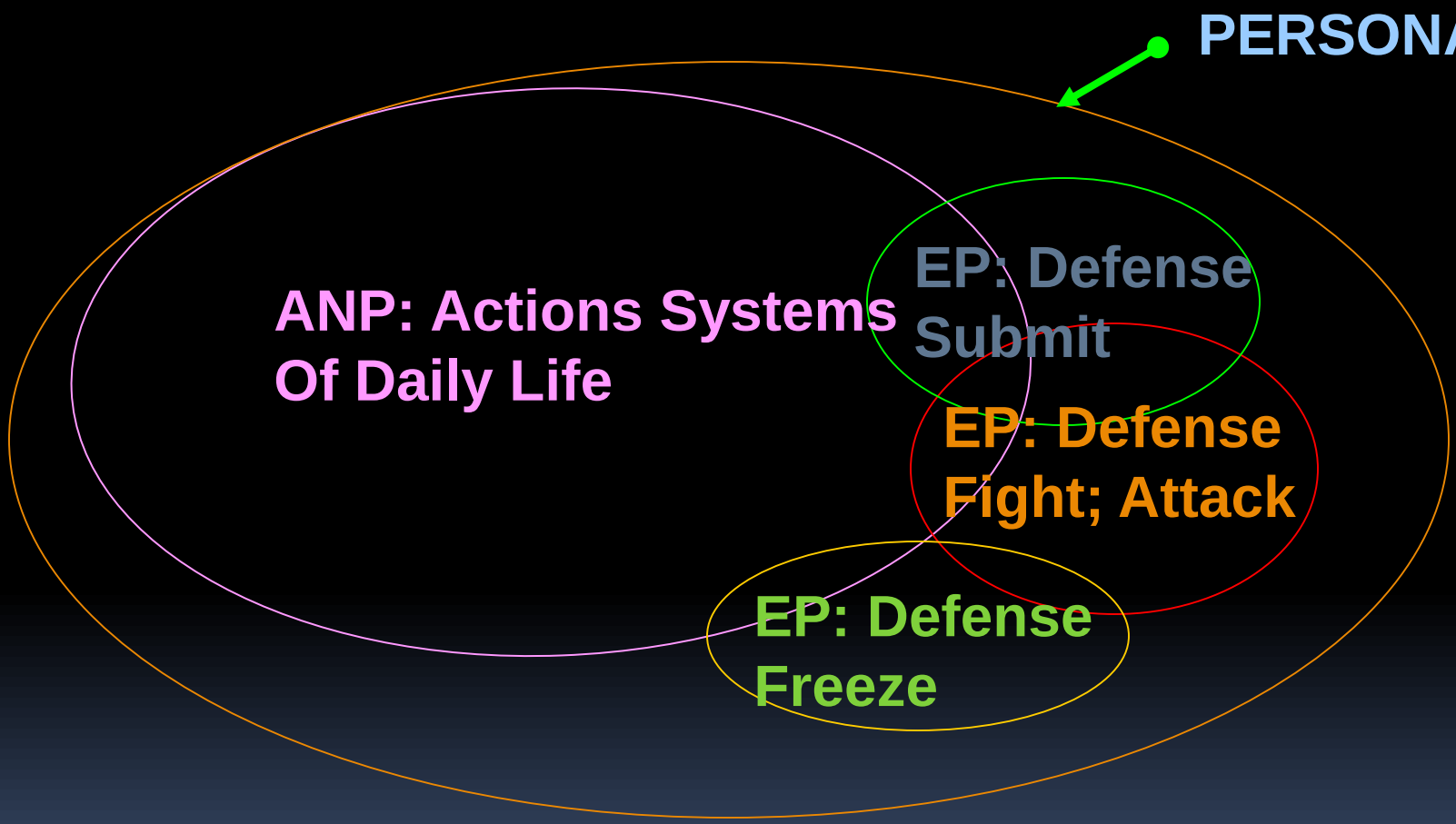


Primary Structural Dissociation of the Personality: Simple PTSD; Acute Stress Disorder



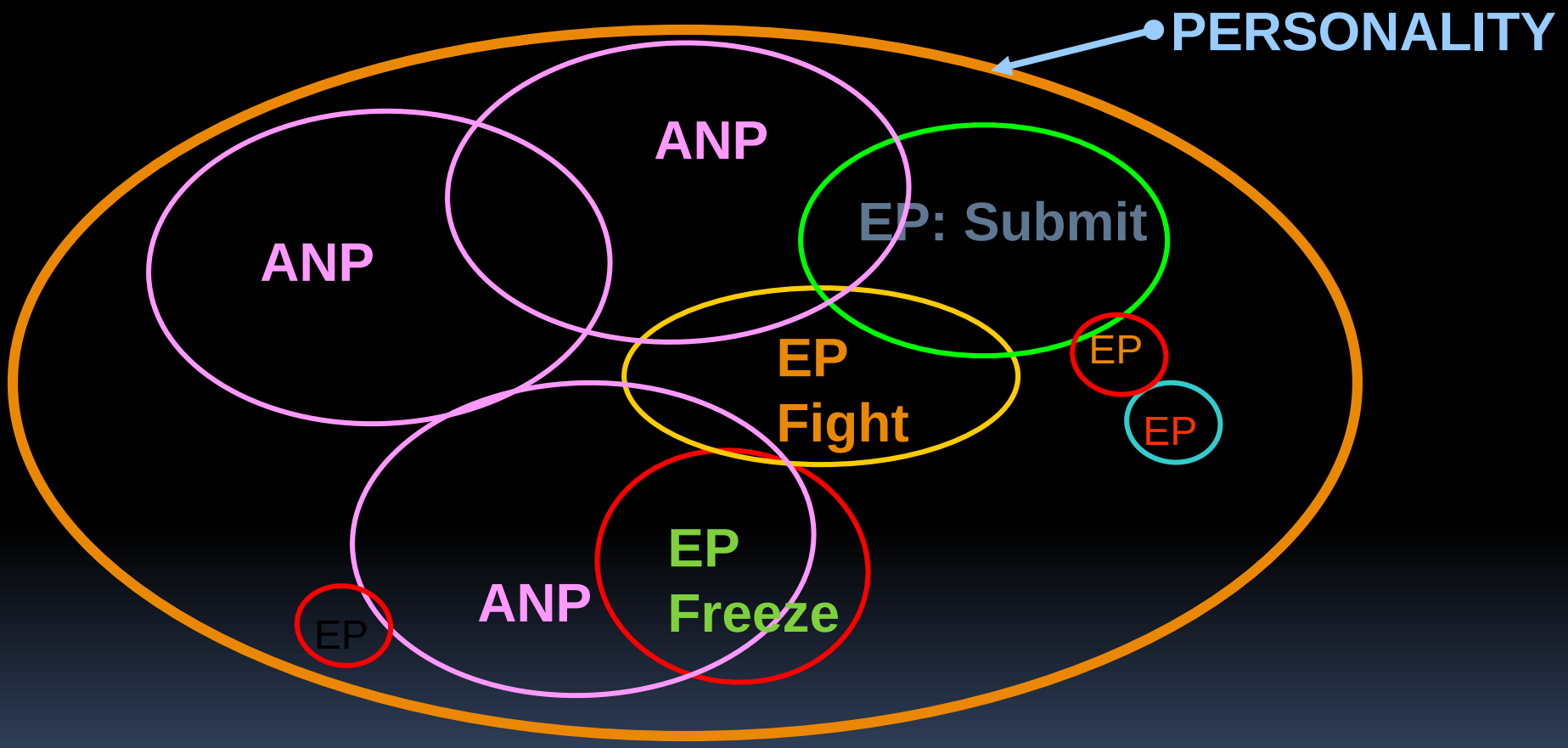
Nijenhuis, Van der Hart, & Steele (2001)

Secondary Structural Dissociation: Complex Trauma, BPD, DESNOS, DDNOS



Nijenhuis, Van der Hart, & Steele (2001)

Tertiary Structural Dissociation:
Dissociative Identity Disorder (DID)



Nijenhuis, Van der Hart, & Steele (2001)

Trauma-generated dissociation (2): Phobic avoidance

- Dissociative parts have *permeable psychobiological boundaries* that keep them divided, but that they can in principle dissolve.
- These boundaries are maintained by *phobias* of traumatic memories and phobias that dissociative parts have regarding each other.
- Reminder: the mental and behavioral actions involved in these phobias are *substitute actions*.
  - Nijenhuis & Van der Hart (2011, p. 418)

Trauma-generated dissociation (3): Conscious and self-conscious dissociative parts

- As each dissociative part, the individual can interact with other dissociative parts and other individuals, at least in principle
  - Nijenhuis & Van der Hart (2011, p. 418)

- This is essential in the treatment of patients with dissociative disorders

Challenge 4: Understanding the impossible conflict a child is in when confronted by a threatening, abusive parent

The Attachment Action System

- Secure attachment promotes activation of other important action systems, such as exploration, play, sociability, energy regulation, etc.
- Secure attachment *inhibits* the fear system (defense action system) during daily life
- Insecure attachment inhibits development of healthy action patterns
- Insecure attachment fails to inhibit the fear system adequately, and the child becomes more fearful in general, and less able to adapt to change.
- Maladaptive action systems can become fixed and rigid.

Exploration system versus attachment system

- When the attachment system, in particular the attachment cry, is activated, the exploration system becomes deactivated. Thus, mentalization is impossible.

Attachment in Child Abuse Families

- “In this climate of profoundly disrupted relationships the child faces a formidable developmental task. She must find a way to form primary attachments to caretakers who are either dangerous or, from her perspective, negligent. She must find a way to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe.”
  - Judith Herman (1992, p. 101)

The double bind of the insecure attachment relationship

- "The attachment figure [children] reach out to for in moments of distress is the same attachment figure that is frightened (most of the time without realizing it) or frightens them with their harsh and punitive behavior. This leads to an approach-avoidance dilemma."
  - Cortina & Liotti (2007, p.207)

Disorganized Attachment

- Such an *insoluble* conflict between two inborn motivational [action] systems, both necessary for survival, exceeds the limited capacity of the infant's mind for organizing coherent conscious experiences or unitary memory structures, and reflects itself in the collapse of any attempt at developing an organized strategy of attention and behavior."
  - G. Liotti (2009, p. 55)

D-Attachment = Traumatic attachment (1)

- "When the source of danger *is* the attachment figure, the mind and body must find a way to maintain an attachment figure, the mind and body must find a way to maintain an attachment bond while simultaneously mobilizing animal defense survival responses to protect the child. These two powerful innate drives [action systems] (to attach and to defend) each remain highly activated, one drive dominating at times and then the other."
  - Janina Fisher (2017, pp. 105-106)

D-Attachment = Traumatic attachment (2)

- "The result is a child (and later adult) caught between two equally strong "pulls"; the yearning for proximity and closeness and the animal defenses of fight, flight, freeze, and submission. "Too much" closeness feels dangerous, but so does "too much" distance."
  - Janina Fisher (2017, p. 106)

D-Attachment = Traumatic attachment (3): Dissociative attachment

- Certain dissociative parts of the personality personify this yearning for proximity and closeness; for instance, child EP in attachment cry.
- Certain other dissociative parts personify these animal defenses of fight, flight, freeze, and submission; for instance, fight EP, submissive EP.
- In other words, *the impossible conflict between closeness and distance takes place between different parts of the personality.*

Challenge 5: Understanding controlling-caregiving and controlling-punitive strategies in the child c.q. the client

Controlling strategies

- "When they reach their sixth year of age, formerly disorganized infants use either a *controlling-caregiving* or a *controlling-punitive strategy* toward their unresolved caregivers (…)."
  - G. Liotti (2009, p. 60)
- *Patients, or rather their dissociative parts, will repeat these strategies in the therapeutic relationship*

Controlling-punitive and controlling-caregiving strategies (1)

- These attachment strategies emerge from, or rather are manifestations of, ***disorganized attachment***.
- "In the *controlling-punitive strategy*, the child, or at least one dissociative part, learns to defensively engage the caretaker in a power struggle of dominance. These patients, or dissociative parts may be angry, obstinate, and highly demanding of the therapist and others around them."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Controlling-caregiving strategy (1)

- "The *controlling-caregiving strategy* is characterized by an exaggerated sense of responsibility, inhibition of aggression, role-reversal, and concern for the well-being of the parent. (…) Controlling-caregiving children take control by entertaining, directing, comforting, and giving approval to the parent."
  - G. Liotti (2009, p. 60)
- We should be aware that such engaging in such a strategy, also in therapy, may involve one or more dissociative parts

Controlling-caregiving strategy (2)

- "In the *controlling-caregiving strategy*, the child, or dissociative part, takes an apparently submissive role, but is actually caring for the caregiver.
- Both strategies are intended to help the child receive what she or he needs."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Controlling-punitive strategy

- "The controlling-punitive strategy is characterized by anger and dominant attitudes toward the parent. (…) Controlling-punitive children take control of the relationship through coercive, hostile, or humilating behavior."
  - G. Liotti (2009, p. 60)
- We should be aware that such engaging in such a strategy may involve, also in therapy, one or more dissociative parts

Controlling-punitive strategy: the gender issue

- "Controlling-punitive behavior is more common in boys, especially in response to maternal hostility. In each case, the child has found a way to defend and attach simultaneously: to remain close to the parent while inhibiting the dependency needs usually associated with attachment."
  - J. Fisher (2017, p. 107)

Parents and their child's controlling strategies

- "[C]ontrolling-caregiving children resort to this strategy as a response to the interaction with vulnerable, frightened, confused "unresolved" parents.
- Controlling-punitive may more likely be the offspring of parents who display neglecting, hostile, or straightforwardly maltreating parental behavior.
- Parents of both controlling-caregiving and –punitive children would be expected to have suffered from unresolved traumas or losses."
  - G. Liotti (2009, p. 60)
- However, also with regard to vulnerable parents, controlling-punitive parts may be present behind dissociative surface!

Controlling-punitive and controlling-caregiving strategies

- "[V]arious dissociative parts can manifest one or the other of these strategies. They are typically two sides of one coin, with one being in the forefront and the other being more implicit. When one part is activated, conflict ensues internally.
- For example, when a controlling caregiving part is solicitous to the caregiver, anger and resentment is often boiling underneath, and may eventually erupt outwardly or inwardly."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Dissociative parts and controlling strategies

- One or more dissociative parts may engage in controlling-caregiving strategies, and other parts in controlling-punitive strategies
- For example, when a controlling-punitive part perceived the other part's controlling-caregiving strategy as ineffective, it may take over.

Conflict between controlling-punitive and controlling-caregiving strategies

- "[W]hen an angry punitive part is acting out toward the caregiver, a caregiving controlling part becomes fearful that the caregiver will be pushed away and retaliate or abandon the child.
- Therapists must be aware of both types of strategies and how they sequence among dissociative parts."
  - Steele, Boon, & Van der Hart (2017, p. 54)

Challenge 6: Understanding reactivated attachment trauma in chronically traumatized patients

The legacy of D-attachment in therapy (1)

- "This legacy of disorganized attachment and controlling strategies affects all later adult relationships, including the therapeutic one [Van der Hart et al., 2006].
- To the extent that traumatized clients come to therapy craving the relief understanding, and care offered by the therapist (proximity-seeking), they are equally likely to experience fear and distrust of both the relationship and the process …The prospect of trusting someone, of being seen, of disclosing one's secrets does not bring relief: it brings trepidation."
  - J. Fisher (2017, p. 107)

The legacy of D-attachment in therapy (2)

- "Because they could not depend upon the protection of the non-offending caretaker, these clients are either loath to depend upon the therapist, or they assume the opposite: that their only safety lies in dependency. The yearning to self-disclose tends to conflict with the fear that self-disclosure will be used against the client, that secrets will not be believed, that he or she will be humiliated, not validated."
  - J. Fisher (2017, p. 108)

The legacy of D-attachment in therapy (3)

- "Rather than feeling comforted by the therapeutic relationship or by the growing closeness that usually occurs as a natural, healthy outgrowth of psychotherapy, the attach parts can often have the opposite reaction. As they feel "closeness" at long last, it is both a relief and a trigger. Their fears of abandonment and sensitivity to emphatic failure typically intensify, often leading to increasing demands on the therapist's time and energy."
  - J. Fisher (2017, p. 109)

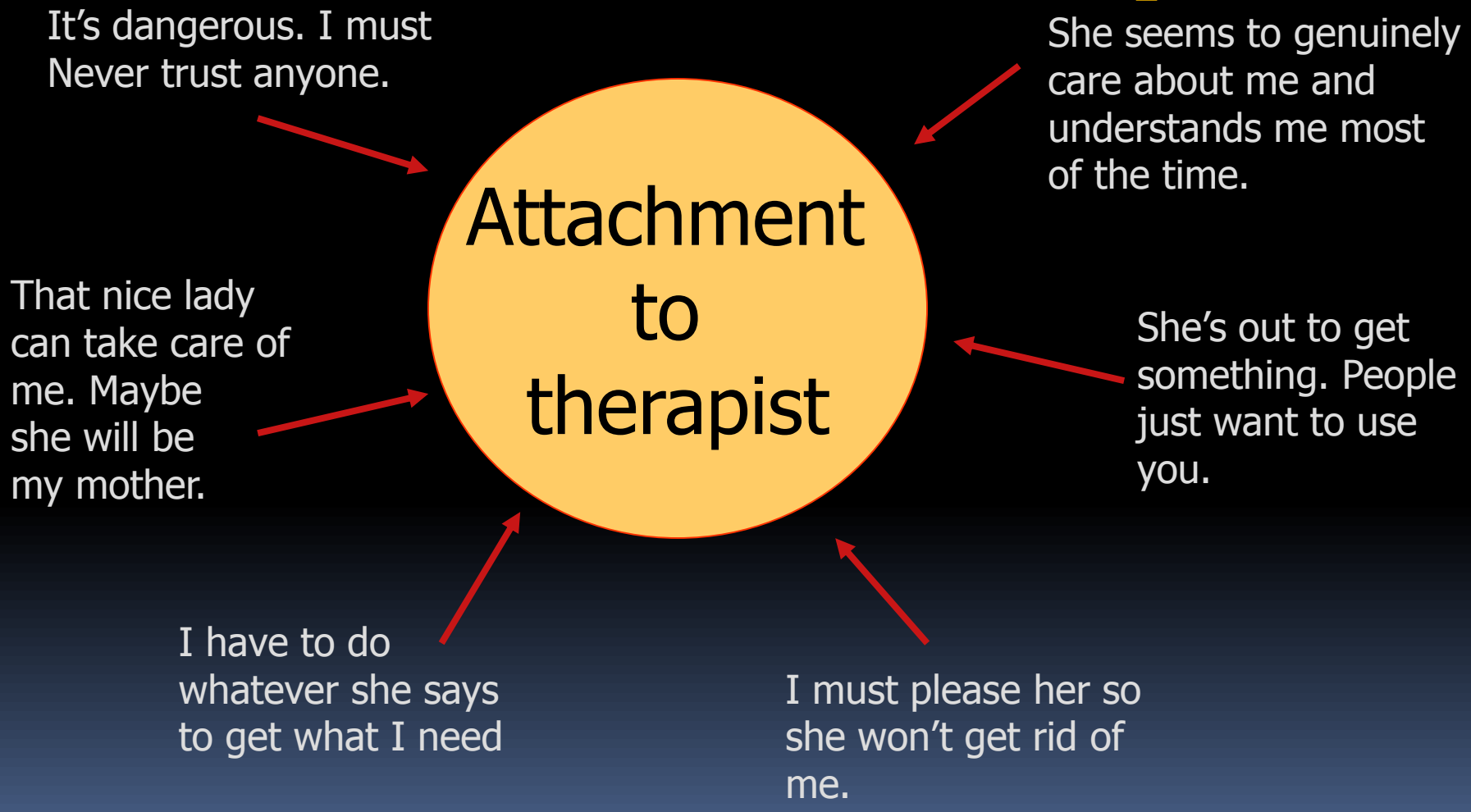
Therapeutic relationship: Different preceptions of the therapist

- "Even if a therapist is able to get through the interpersonal defenses of a patient and is seen as kind or helpful, the patient is thrown into more internal conflict, trying to juggle the fragile sense of the therapist as benevolent with the certainty that the therapist will use or abandon them."
  - James Chu (2011, p. 161)

Confusion induction in the therapist

- "Each structurally dissociated part, driven by a particular animal defense response or combination of responses, tends to be biased in its perspective on attachment versus safety. As each is evoked on different days by different aspects of the treatment, the therapist can become confused and disoriented if he or she does not recognize the fragmentation and identify parts."
  - J. Fisher (2017, p. 109)

Different Parts have Different Attachments to the Therapist



Challenge 7: Dealing with the client's unresolved trauma-related attachment patterns

Dealing with the client's unresolved trauma-related attachment patterns

1. Developing a collaborative therapeutic relationship
2. Fostering acceptance and collaboration among dissociative parts
3. Fostering mentalization
4. Helping patient to create an ideal attachment-figure

The need to limit the activation of the attachment system

- "At the beginning of treatment… complex trauma can best be dealt with by trying to maintain a dialogue that attempts to limit the activation of the attachment system by taking advantage of the natural tendency to want to *cooperate and collaborate on an equal basis level*." [italics added]

  ~ Cortina & Liotti (2014, p. 892)

Traumatic attachment in therapy (1)

- "Because attachment and fear have become intertwined in the client's experience, a therapy focused on the narrative memories or on the transference is likely to ignate an internal struggle between the hunger for closeness in young attachment-seeking parts and their fear of abandonment versus the defensive reponses of fight, flight, and total submission."
  - Janina Fisher (2017, p. 12)

Traumatic attachment in therapy (2)

- "How therapists anticipate this phenomenon and how they help their clients accept and work with it can lead either to deeper healing or to a reopening of attachment wounds in the therapy itself."
  - Janina Fisher (2017, pp. 12-13)

Challenge 7.a: Developing collaboration between therapist and client, respectively between dissociative parts at war

Collaboration versus caregiving (1)

- "The role of the therapist is not that of caregiver, rather much more like a compassionate and interested mentor or guide who ensures that the patient feels safe to explore and learn along with the therapist, and is thus able to work toward therapeutic goals.
- In fact, being in the role of caregiver with highly traumatized patients can be fraught with complications. When caregivers have been the source of pain and danger, and have had all the power and control, a parent-child paradigm is a potential reenactment from the beginning of therapy."
  - Steele, Boon, & Van der Hart (2017, p. 71)

The road to collaboration in therapy

- "In order for collaboration to be possible, *social engagement* must be activated. In a positive feedback loop, collaboration also supports and strengthens social engagement, which allows for the possibility of secure attachment.
- This has major treatment implications for work with dissociative patients. It offers a particular sequence of relating that fosters safety and curiosity rather than dependency and chronic attachment-seeking behaviors."
  - Steele, Boon, & Van der Hart (2017, p. 77)

Therapeutic relationship: fostering collaboration instead of attachment (1)

- "Relationship is so fraught with conflict and threat for dissociative patients that therapists need to examine the paradigm of attachment that they typically use in therapy, that is, a parent-infant model of attachment. Instead, consider that it could be more helpful to establish a collaborative relationship between therapist and patient before attachment issues become an explicit focus."
  - Steele, Boon, & Van der Hart (2017, p. 58)

Therapeutic relationship: fostering collaboration instead of attachment (2)

- "It provides a safer way eventually to work on deeply painful attachment issues without activating overwhelming emotions in the patient too quickly. In fact, mere contact with the therapist at the beginning of therapy can be overwhelming to dissociative patients, as both attachment and defense become activated at the prospect of working closely with someone else in order to get help."
  - Steele, Boon, & Van der Hart (2017, p. 58)

Psychotherapy as collaborative partnership (1)

- "One of the most important ways for therapists to establish a strong working alliance with clients is to work together *collaboratively*—as partners. In the initial session, the therapist's primary aim is to articulate clear expectations for working in this collaborative manner, and, more important, to enact behaviorally those spoken expectations by giving clients the experience of partnership…"
  - Teyber & McClure (2011, p. 48)

Psychotherapy as collaborative partnership (2)

- "Thinking of the working alliance as a collaborative partnership, therapy is not something therapists "do" to clients, it is a shared interaction that requires the participation of both partners in order to succeed."
  - Teyber & McClure (2011, p. 48)

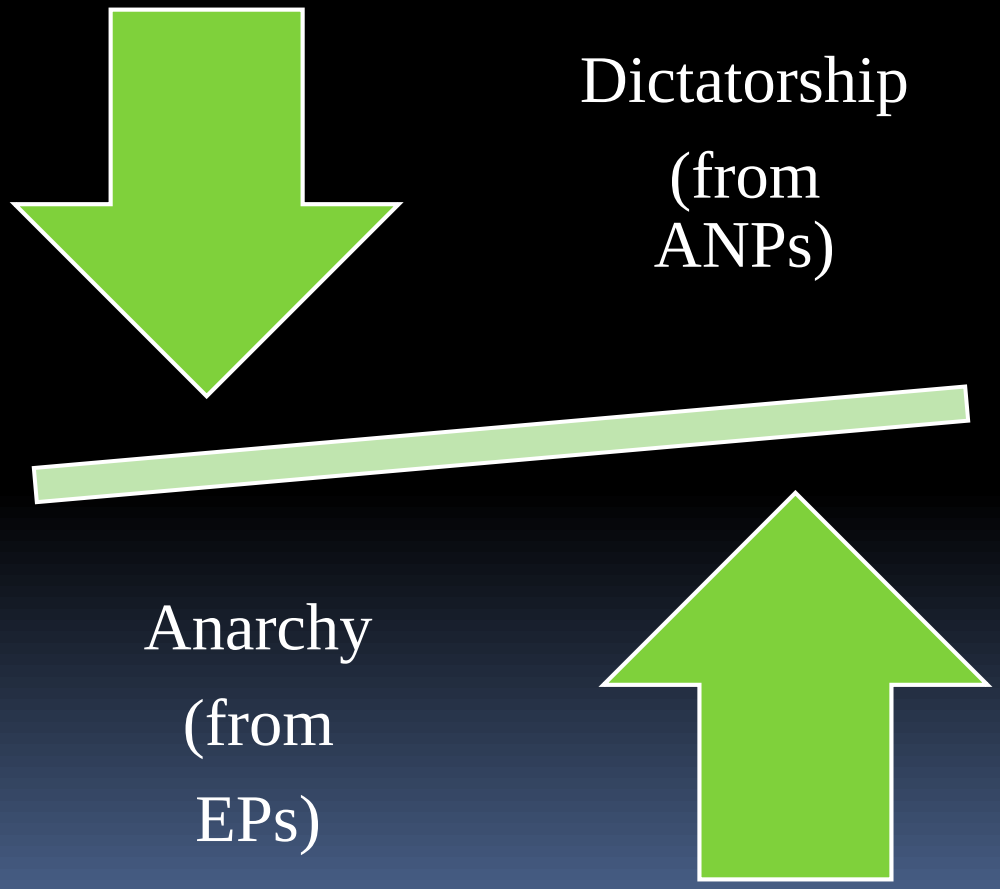
Internal collaboration among dissociative parts (1)

- "In a *collaborative model*, the therapist acknowledges the patient's inner experience, especially the conflicts, ambivalence, and unintegrated experiences among and within dissociative parts of themselves.
- Together with the patient, the therapist begins to understand how various dissociative parts do and do not collaborate with each other, both implicitly and explicitly.
- These internal dynamics are at the core of the distress and lack of coherence and congruity for dissociative patients."
  - Steele, Boon, & Van der Hart (2017, p. 86)

Internal collaboration among dissociative parts (2)

- "Therapists might, for example, empathize with a young part of the patient that wants constant contact—an understandable wish, no matter how unrealistic.
- However, they also acknowledge the rage and shame this evokes in other parts whose intent is to protect from hurt and vulnerability, and how this dependency wish also undermines a sense of competence in the individual who is an adult, not a child.
- They have compassion for the pain and distress of the conflict, the insistence on an idealized fantasy of caretaking, and the eventual grief of losing this fantasy and facing reality."
  - Steele, Boon, & Van der Hart (2017, pp. 86-87)

Internal Conflict between ANP and EP



Challenge 7.b: Developing self-compassion in the client, including ANP's compassion for child EPs

Helping clients as ANP develop compassion to child parts

- "[A] major goal in therapy is to help dissociative patients first accept child parts, develop understanding and compassion for them, and eventually realize they are aspects of themselves.
- They can learn to take care of child parts, and foster the child parts to "grow up" and learn to deal with dependency needs from an adult perspective."
  - Steele, Boon, & Van der Hart (2017, p. 69)

Helping clients as ANP develop compassion to child parts

- "Most importantly, our patients must also grieve what has been lost in childhood—what cannot be undone or loved away no matter how much someone does, or cares, or is available in the present."
  - Steele, Boon, & Van der Hart (2017, p. 69)

Separation Between "Day Child" and "Night Child"

- "Without realizing it, I fought to keep my two worlds separated. Without ever knowing why, I made sure, whenever possible that nothing passed between the compart-mentalization I had created between the day child [ANP] and the night child [EP]."
  - Marilyn Van Derbur (2004, p. 26)

Conflict between parts of the personality

- "My night child [EP] kept her part of the deal. She had "taken it" [the abuse] until I [ANP] was strong and secure enough to come back and rescue her.
- Now, instead of gratitude for her sacrificing herself, I loathed, despised and blamed her."

--Marilyn Van Derbur (2004, p. 191)

Overcoming the conflict

- "…I couldn't find a way to connect with the night child I had abandoned. I just hated her. I had no compassion for her at all.
- I [ANP] was finally understanding that I would be stuck in the muck of dysfunction until I could find a way to stop judging her [EP] so unmercifully."

--Marilyn Van Derbur (2004, p. 281)

Important reasons for working with and accessing dissociative parts (3)

- "*Enlisting more mature [parts] to care for child [parts]*. The treatment of DID is often complicated by the deeply felt needs of child [parts], often expressed in their wishes or efforts to create a tangibly more gratifying childhood in a regressive relationship with the therapist.
- [T]he most appropriate person to respond to such perceived needs is not the therapist but the patient, who should be helped to mobilize more grown-up [parts] to provide the requested nurture and play experiences.
- Addressing the patient as a family of selves and helping particular [parts] work with the child [parts] facilitates this process and reduces the extent to which child [parts] obstruct the psychotherapy."
  - Richard P. Kluft (2006, pp. 294-5)

Developing self-compassion in clients with trauma-generated dissociation (1)

- "As I worked in this way with a range of clients, it became increasingly clear that when they "adopted" or came to love their hurt, lost, and lonely parts, something remarkable happened. Their self-disparagement, self-hatred, and disconnection began spontaneously to yield to self-compassion."
  - Janina Fisher (2017, p. 2)

Developing self-compassion in clients with trauma-generated dissociation (2)

- "By bonding to the lost children inside, their internal states transformed, creating a warm, loving environment that felt safe at last. Best of all, it was evident that this work was not only transformative but also easy for the clients once they learned the basic skills needed to form internal attachment relationships to their parts."
  - Janina Fisher (2017, p. 3)

Challenge 7.c: Developing mentalization

Mindfullness and the language of parts

- "To feel empathy for each part's plight, while not losing sight of the fact that the client is an adult with functional capabilities is a mental ability that often has to be practiced before it becomes second nature.
- With dissociative disorders, the therapist is working with clients who are not an integrated "she" or "he." Viewing them as such is often confusing, rather than helpful, just as viewing clients as inner children with adult resources equally causes confusion." Janina Fisher (2017, pp. 14-15)
- Involves consciously working with ANPs and EPs

Challenge 7.d: Helping the client to develop an ideal parent-figure

Within a collaborative therapeutic relation: help the patient to develop a positive parent figure

- The therapist should "specifically, actively, and efficiently facilat[ing] the development the development of a positive, stable inner working model, or map, of attachment relationships. … The therapist helps the patient to evoke and engage with imagery of positive attachment figures and of secure attachment experience with those figures."
  - D. P. Brown & D. S. Elliott (2016, p. 304)

Challenge 8: Dealing with the therapist's own unresolved attachment issues

The therapist's need for self-reflection

- "As with all therapies, we must begin treatment of complex dissociative disorders by reflecting on ourselves as therapists, because our strengths and limitations as human beings can make or break a therapy."
- "Therapists must be aware of their emotional and somatic experiences with a patient and understand reenactments from the history of the patient that may be playing out."
  - Steele, Boon, & Van der Hart (2017, p. 37)

Non-realization in the therapist

- "Major non-realizations of the therapist can contribute to therapeutic impasses. The therapist's capacity to realize accurately both her or his own experience and that of the patient is essential in keeping therapy on track."
  - Steele, Boon, & Van der Hart (2017, p. 22)

Therapeutic relationship with patients with D-attachment

- "D-attachment requires a careful balance of consistent, predictable presence by therapists. They should strike a balance between being:
  - too warm and close, or too clinical and distant;
  - too inquisitive and probing, or so uninterested as to be unable clarify the patient's experience and understand her or his internal dissociative organization;
  - too directive and rigidly structured, or too dedicated to following the avoidant wanderings of the patient in session; and
  - too emotionally expressive, or too flat and non-responsive."
  - Steele, Boon, & Van der Hart (2017, p. 57)

The tendency to promise more than the therapist can (or should) deliver (1)

- "In efforts to be good enough, to prove to their patients that they are not like their abusers, therapists sometimes promise more than they can deliver, extending limits and crossing or even violating boundaries. Perfection, constant availability, assurances of never leaving, and golden fantasies of a second happy childhood are simply not within our human powers to promise (to anyone) and are unrealistic and unhelpful goals in therapy."
  - Steele, Boon, & Van der Hart (2017, pp. 40-41)

The tendency to promise more than the therapist can (or should) deliver (2)

- "Of course, therapists want to help. We are a decent and well-intentioned group of professionals in general, but our eagerness to relieve suffering or to avoid it sometimes gets in the way of our patients moving forward."
  - Steele, Boon, & Van der Hart (2017, pp. 40-41)

Familial background of many psychotherapists (1)

- "Some years ago a group of colleagues and I were chatting out ourselves when it came out that all six of us had depressed mothers. We concluded that our choice to save, cure, or help people in psychological distress was shaped by this central childhood experience."
  - Louis Breger (2009, p. 3)

Controlling-caregiving strategies in therapists

- Many psychotherapists have a history of caregiving sollicited by our parents (*parentification*)
- An important question is: to what degree did this caregiving have the quality of controlling caregiving?

Exploring the therapist's contributions to traumatic attachment reenactments

- Getting regular consultation
- Getting your own personal therapy
- Taking care of your own personal life
- Deciding whether you are the best person to work with a certain patient or how and when to make referrals
- Requesting help from colleagues in this regard

The outcome of "good enough therapy": A generalization

- "In "earned" secure attachment, the insecure or disorganized attachment of childhood and/or adulthood is resolved to the point that individuals can reflect back on their early attachment relationships without becoming disregulated, without idealizing or demonizing their attachment figures, and feel a sense of acceptance."
  - Janina Fisher (2017, p. 13)