The Many Voices of Trauma: Working with DID

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An Integrative Approach to Working with DID

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Four Ways “Dissociation” is Described in the Literature

1. Alterations in awareness and consciousness (attentional problem)
   • Spaciness
   • Absorption or rumination
   • Profound “dissociative detachment” (J. Allen) – thinking of and aware of nothing (may be related to physiological shut down)

2. Physiological shut down (physiological problem)
   • Dorsal vagal response (Porges; Schore)

3. Depersonalization (perceptual problem)
   • Common peritraumatic experience
   • But also common across diagnostic categories
   • And in normal populations during times of stress, fatigue, or illness

4. Dissociation of self / personality
   • Ego states are a normal variant
   • Dissociative parts (self-states, part-selves, identities, alters, different ways of being you)
   • Each part is overly rigid and not very open to change, making ongoing integration a challenge
   • May encompass all experience:
     • Involves different senses of self
     • Emotion
     • Cognition, memory, and attention
     • Perception (and prediction)
     • Impulses and behavior
     • Somatosensory experience
What is a Dissociative Part?

- “Personality” and “self” are not things.
- They are mental representations of how we are organized as humans, and how we and others perceive us.
- Dissociative parts are not “things,” “people,” or “personalities.”
- They are enduring patterns of thinking, feeling, perceiving, predicting, sensing, and behaving, organized within multiple and sometimes contradictory senses of self.

Continuum of Self (Ego) States vs. Dissociative States

Greater Integration of Self  

**“Normal” Ego States / Self States**

Greater Dissociation of Self  

**Complex PTSD / OSDD**

**DID**

Dissociative Organization of Personality

- DID and OSDD involve a dissociative organization of the personality that includes multiple and often (not always) incompatible senses of self.
- Each “self” is a center of (partial) agency and awareness. Each “self” is less open to change than usual, and has a more limited view of the world than usual.
Dissociation

Dissociation involves an (incomplete) division between a part of the personality or self that is:

• Primarily focused on daily life (may be numb, avoidant, or highly dysregulated; often has at least some amnesia and is avoidant of trauma)

and

• Trauma-fixated, i.e., re-enacting and re-experiencing traumatic memories (overwhelming emotions, stuck in trauma-time, engaged in animal defense: fight, flight, freeze, collapse)

• The latter part(s) intrude on the former; the former often attempt to suppress the latter

Psychobiological Underpinnings of Dissociation

- Environment
- Social Factors
- Emergent Properties
- Psychological Defenses
- Gene Expression

Action Systems

• Action systems are evolutionary prepared tendencies, primarily driven by innate affects
  • Daily life systems
  • Defense systems
• Action tendencies involve their own neural networks in the brain
• Each action system is activated or inactivated by particular internal and external stimuli
• Action systems may be complementary or may compete with each other
• The ability to accurately assess safety and danger underlies the activation of different action systems
Neuroception describes how we distinguish whether situations or people are safe, dangerous, or life threatening at a neural level, before conscious awareness.

--Porges, 2003, 2011
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Social Engagement: Connection to others for safety; Most evolved defense

Attachment Cry / Cry for Help: Cry for help to mobilize a stronger, wiser other

Freeze: Orienting Response; Attentive Immobility; Stop, Look, & Listen; Mild hyper-arousal, increased sensory perception

Flight: Mobilizing Defense; Hyperarousal; increased HR & BP; vasoconstriction; muscle tension and movement; Fear

Fight: Mobilizing Defense; Hyperarousal; increased HR & BP; muscle tension and movement; Anger

Freeze / Frozen with Fear: Immobilizing Defense / Tonic Immobility; Extreme Hyperarousal to Hypoarousal; increased HR & BP; rigid muscle tone; loss of speech & coherent thinking; Terror

Severe Hyperarousal

Severe Hypoarousal

Window of Tolerance

Social Engagement: Safety, Curiosity, Attachment, Learning

Ogden & Minton, 2000; Siegel, 1999; Van der Hart et al., 2000

Siegel, 1999; Ogden et al., 2006; Van der Hart et al., 2006

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**Flag**

<table>
<thead>
<tr>
<th>Immobilizing Defense</th>
<th>Hypo- arousal; decreasing HR &amp; BP; vasodilation; cognitive, emotional, sensory, &amp; motoric shutdown</th>
</tr>
</thead>
</table>

**Faint / Collapse**

<table>
<thead>
<tr>
<th>Immobilizing Defense</th>
<th>“Playing dead” or death feign; large and rapid drop in HR &amp; BP; flaccid muscle tone; loss of awareness and consciousness</th>
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Adapted from Ogden et al., 2006; Porges, 2004, 2011; Schauer & Elbert, 2010; Steele et al., 2017

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**Not Real, Not True, Not Mine, Not Me**

- The inability to **realize** is a central feature of dissociative disorders, which have been called:
  - *Syndromes of non-realization* (Janet, 1935)
  - *Multiple reality disorder* (Kluft, 1983)

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**Failures to Realize**

- Trauma-related disorders primarily involve **nonrealization**
  - The traumatized individual is unable to realize:
  - Traumatic events happened, or
  - Traumatic events happened to “me”
  - Some aspect of the events happened to “me”
  - My actions in the present belong to “me”
  - Events are over, i.e., the past is not happening now
  - The “me” of then is part of the “me” of now
  - I am here and now, not then and there.
Primary Dissociation: 1 Daily Life Part & more than 1 Trauma-fixated Part

Personality

Daily life functioning (adult self)

Trauma-fixated

Secondary Dissociation: 1 Daily Life Part & more than 1 Trauma-fixated Part

Personality

TF: Terrified Child
TF: Angry Adolescent
TF: Needy Child

Tertiary Dissociation: More than 1 daily Life part & more than 1 trauma-fixated part

Personality

TF: Critical Voice
TF: Terrified Child
TF: Needy Child
TF: Angry Adolescent
Caveats About Taking A Trauma History

- Asking to much too quickly can overwhelm the client
- Tell client you respect that some things might feel very private and s/he can choose not to answer at this time
- Avoid allowing client to go into great detail, as this is often very triggering
- Be aware of the story being told in a depersonalized way – usually there is dysregulation after session
- Immediately stop if someone has flashbacks while telling the story

Case Formulation: Dissociation

- What maintains dissociation, that is, what keeps parts separate (in addition to avoidance of traumatic memories)?
- Exploration of willingness to be aware of and accept parts
- Willingness to accept parts as belonging to self? (how to use language to facilitate integration)
- Whether and how parts interact with each other; what are the dynamics between parts?
- Level of functioning of various parts
- Level of structural dissociation

Degree of trauma-related phobias
Degree of personality accommodation to trauma
Overall integrative deficits / capacities

Difficulties tolerating positive emotion
Degree of attachment disturbance
Degree of amnesia (non-realization)

Chronic defenses
Degree of regulatory difficulties
Degree of inner cooperation
<table>
<thead>
<tr>
<th>Degree of amnesia for the present</th>
<th>Amnesia for trauma (in the past)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic derealization or depersonalization</td>
<td>Severe somatoform dissociation</td>
</tr>
<tr>
<td>Passive influence (e.g., voices, made feelings or behaviors)</td>
<td>Severe conflicts among parts</td>
</tr>
<tr>
<td>Frequent switching between parts</td>
<td>Highly invested in DID diagnosis or unable to accept dissociation</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Needs regular crisis intervention</th>
<th>Needs frequent hospitalization</th>
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<tbody>
<tr>
<td>Engages in self-harm</td>
<td>Multiple and ongoing suicide attempts</td>
</tr>
<tr>
<td>Regular and heavy substance abuse</td>
<td>Eating disorder resulting in medical instability</td>
</tr>
<tr>
<td>Persistent compulsive or impulsive self-destructive behaviors</td>
<td>Other unsafe behaviors, such as being in a current violent relationship</td>
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<tr>
<th>Parts (somewhat) able to be oriented to the present</th>
<th>Has some communication and cooperation among dissociative parts, at least regarding daily life issues</th>
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<tbody>
<tr>
<td>Willing to allow therapist to access and work with parts</td>
<td>Sadistic, punishing, or other acting out parts eventually willing to engage with therapist</td>
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<tr>
<td>Has some adult functioning and is willing to be responsible and engage in therapy</td>
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Case Formulation: The Individual as a System

- Think in terms of a deeply conflicted inner “family” system. The way the system works is the problem, not individual parts.
- Include “all parts” in session, when possible.
- “Resistant” or “acting out” parts are not the problem, but rather how the person as a whole approaches and deals with those parts (and related emotions, wishes, behaviors, etc.).

Phase-Oriented Treatment

- Phase 1 – Safety, skills building, stabilization, and symptom reduction; establishing the therapeutic alliance
- Phase 2 – Treatment of traumatic memories and related symptoms; working through the transference
- Phase 3 – Personality integration, adaptive grieving; promoting intimacy

Safety First, Attachment Last

- Establish safety before attachment
- After safety, establish collaboration – working as a team on shared goals in therapy – NOT attachment
- Client’s attachment system is already activated and conflicted
- A collaborative approach prevents further intensity of the “I need you / you are not safe” dilemma of disorganized attachment
Phase-oriented Treatment of Complex Dissociative Disorders

• Phase 1
  • Psychoeducation about dissociation
  • Helping client take responsibility for dissociative parts
  • Understanding the system of the client at the client's pace
  • Promoting systemic stabilization (improving awareness and decreasing inner conflicts)

• Phase 2
  • Sharing of traumatic memories among parts with increasing realization ("This is my memory; this happened to me")

• Phase 3
  • Integration of dissociative parts into a cohesive and coherent self and personality

What Maintains Dissociation?: Treatment Targets for Resolution

• Lack of realization
• Unresolved inner conflicts
• Psychic equivalence (difficulty differentiating between thought and action or internal experience and reality)
• Difficulties with mentalizing / reflecting
• Difficulties with regulation and tolerance of emotions
• Intolerable meanings / schemas / beliefs
• Intolerable needs / yearnings / wishes
• Chronic shame
• Chronic fear

Basic Trauma-related Phobias

• Phobia of inner experience (thoughts, emotions, wishes, fantasies, dreams, sensations, movements)
• Phobia of dissociative parts
• Phobia of attachment and attachment loss
• Phobia of traumatic memories
• Phobia of adaptive change and risk-taking
In order for Phase 2 to begin

The client must:
• have adequate regulatory and relational skills
• be able to stay grounded in present reality to a reasonable degree
• be able to accept some of his or her own inner experience (feelings, impulses, wishes, etc.)
• have developed at least some internal compassion and cooperation
• have a stable relationship with the therapist (meaning ruptures can be repaired)
• be safe (internally and externally)

Modifying Standard Techniques for Dissociative Individuals

Virtually any technique or approach can be used, as long as you understand that:
• All dissociative parts must be included in treatment
• Various dissociative parts may have quite different reactions to a given intervention
• Transference will be complex, with each part having a different reaction to the therapist
• Insights and changes in one part do not necessarily transfer to another part
• Treatment must be within window of tolerance for all parts

~Van der Hart, et al., 2006; Steele & Van der Hart, 2009

When Not to Work with Dissociative Parts

• When all parts are overwhelmed or trauma-based
• During life situations that require the complete energy of the client
• When there is a basic lack of motivation, insight,
• When client is unwilling to maintain adult functioning in daily life
• During short-term or supportive therapies – accessing parts may evoke too much pain and distress
• Parts can be acknowledged if that helps the client, but not directly accessed
  • Kluft (2006, pp. 296)
**A Systemic Approach to Dissociation**

- **ALL interventions are geared toward increasing integration and decreasing dissociation**
- Always use interventions at the highest level of integration possible
- When possible, use interventions that address the whole person at once: talking through; having all parts listen; meeting place
- Use integrative language. "Parts" language is OK, but emphasize "Parts of you."
- Always be curious about what a part is unable to realize

- **Begin work with the adult self of the client so there is a stable foundation for working with parts fixed in trauma**
- If it is not possible to work with all parts simultaneously, then work with two or more parts to increase cooperation
- For example, have an adult part soothe a child part; a functional part support a nonfunctional one; build cooperation among parts that function in daily life
- Avoid working with child parts too soon, or without an adult part present (no "drop-off daycare!")
A Systemic Approach to Dissociation

• If it is not possible to work with two or more parts simultaneously, work with one part to the point of stabilization and immediately bring in other parts
• For example, engaging an angry part that is destructive and helping it become more calm before connecting with other parts
• Avoid letting one part dominate therapy, tell you “secrets,” or suppress other parts

Which Parts to Work With First?

• Parts that function in daily life – to improve functioning
• Parts that can support other parts inside
• Parts that are avoidant of therapy
  • Dismissive of therapy
  • Punitive / punishing / perpetrator-imitating
• Child parts often show up first (dependency issues) but should not be taken care of by the therapist
  • Enlist other parts to care for young parts

One Part Functioning in Daily Life

- Relatively stable
  - Begin identifying and working with parts
- Relatively unstable
  - Identify inner conflicts
  - Begin with stabilization skills
Two or More Parts Functioning in Daily Life

- Two or more parts functioning in daily life
- Little to no amnesia for and few major conflicts about daily life functioning
- Amnesia for other parts or severe conflicts

Begin communication and collaboration to improve daily life functioning

Stabilization skills as required

Stabilization and exploration of resistance to realization

Parts fixed in trauma time

- Awareness of the present time?
- Orient in time as possible; enlist other parts to help
- Explore resistance to realization

Psychoeducation about functions of parts and focus on resolving daily life problems

Awareness of part(s) that function in daily life?

Reinforce safety and felt sense of the present

Attachment to therapist

- It's dangerous. I must never trust anyone.
- That nice lady can take care of me. Maybe she will be my mother.
- She seems to genuinely care about me and understands me most of the time.
- She's out to get something. People just want to use you.
- I have to do whatever she says to get what I need
- I must please her so she won't get rid of me.
Creating Consensus

- All parts generally have unacknowledged common goals
- Virtually all parts want relief or to feel better
- Even parts that don’t want to be in therapy want relief, even if only from other parts that bother them, or if only through being dead

How to Work with “Parts”

- Always keep in mind you are working with a single, adult individual
- Think in terms of a deeply conflicted inner family system. The way the system works is the problem, not individual parts.
- Always try to include “all parts” in session.
- Accept the client's belief of separateness without agreeing yourself (“we can agree to disagree”)
- Always emphasize empathy, cooperation, and negotiation, and conflict resolution within the person as a whole

How to Work with Parts

- Do not blame other parts for trouble in the client’s life; it is a “whole person” issue
- “If you are not part of the solution, you are part of the problem” — This is a system in which each part plays a role in maintaining status quo
- Do not favor parts; treat even-handedly
- Do not try to “get rid” of parts or banish them
- Do not underestimate the degree of nonrealization, and don’t get caught up in it
- Empathize with where a part is in the moment, but set limits on behavior
Talking Through

- Talking to the whole person
- To encourage all parts of the client to work together and engage in treatment ("You are all in this together")
- Reinforce acceptance of all parts, yet as one person
- May need to be more directive than is typical in therapy
- Tools: journal, internal meetings, if these are not destabilizing

Contacting Dissociative Parts (1)

- Promote benign internal communication as soon as possible
- Structure internal communication
- Start with goals in therapy and present day life
- Do not let parts share traumatic memories at first

Contacting Dissociative Parts (2)

- Content
  - Focus on grasping the part’s internal created world
  - Understand the part’s function within the system of parts: how does this part of the client maintain non-realization?
  - Understand its dynamic relationships with other parts
  - Why now? Why does part manifest at this moment in time?
Contacting Dissociative Parts (3)

- What is the relational style of the part? Parts may use attachment minimizing or maximizing strategies, as well as controlling caretaking or controlling punitive strategies.
- What functions does this relational style have within the client as whole?
- Understand reason for resistance to change in this part and in the system as a whole.
- What is this part’s pace and how might it differ from the system as a whole or other highly influential parts?

Inner Meeting Space

- Modified version of the “Dissociative Table Technique” (Fraser, 1991, 2003)
- Create an internal meeting “space” (both internal and external)
- Encourage parts to participate, may have “roles”
- Rules for appropriate behavior in the meetings
- To create safety, encourage parts to problem solve ways to work together, plan, to manage safety

When is an Inner Meeting Space Not Useful

- When the client can already engage in inner communication with the therapist inserting a technique
- When parts are too phobic of each other
- When there is enormous inner conflict
Types of Parts

**Typical parts:**
- Child
  - Terrified
  - Needy
- Adolescent
  - Angry
  - Sexualized
- Adult
- Infant
- Angry / Ashamed parts
- Perpetrator introjects

Occasional Types of Parts

**Not as Common:**
- Playful child
- Animal (usually feral, angry)
- Inanimate objects (e.g., tree)
- Cartoon, movie, book characters
- Religious or spiritual figures
- Imaginary playmates that take on a life of their own
- Other?? Based on the child’s experiences

Hidden Parts

- By definition, dissociation is a problem of hiddenness
- The client “hides” experience from herself
- Parts may be relatively inaccessible in treatment for long periods, influencing the client but unwilling to participate
- This resistance is usually “two-sided”: both the adult self and the dissociative parts have reasons for remaining separate
Working with Perpetrator-Imitating Parts

• These parts are concretized introjects of the perpetrator
• Both therapist and client may want to “get rid of” or “kill off” a “perpetrator-imitating” part
• They also contain the client’s own rage, control, and sadism that must be accepted and resolved by the client
• So what to do?

Functions of Perpetrator-Imitating Parts

1. Protect the client against the threats of the perpetrator, which continue to be experienced as real in the present
2. Defend the client against unbearable realizations of being helpless and powerless as a child
3. Re-enact traumatic memories from the perspective of the perpetrator, as mentalized by the child
4. Serve as a defense against shame through attacking the client and avoiding inner experiences of shame
5. Provide an outlet for the client’s disowned sadistic and punitive tendencies
6. Hold unbearable traumatic memories
7. Maintain attachment to the perpetrator