Hypnosis in the Treatment of Pathological Dissociation and the Dissociative Disorders
(Richard Kluft, MD, PhD)
The Treatment of Pathological Dissociation and Dissociative Identity Disorder

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An Introduction to My Thinking

• When I was confronted with my first dissociative patients, I was a resident in training. After a period of time, I developed certain assumptions.
• Understanding them makes my current ideas easier to understand.
My Initial Assumptions, Circa 1974

1. Most mental functions and structures and processes that appear to be unities consist of many elements which, when functioning well, are coordinated or “flying in tight formation.” They are aggregates functioning as and giving the appearance of a single cohesive entity.

Assumptions, Circa 1974

2. When these elements fail to function well, maintain coordination, and are (whether subtly or obviously) failing to “fly in tight formation” they may be described as disaggregated. They no longer function as or give the appearance of being a single cohesive entity. I thought of this as “mental disaggregation,” the way Janet described dissociation in some early writings.

Assumptions, Circa 1974

3. Among the causes of mental disaggregation is trauma.
4. If we wish to treat human behavior with psychotherapy, it is helpful to consider that the clinical phenomena we encounter make sense, even if it is not apparent immediately, or for a sustained period of time, what kind of sense they make.
Assumptions, Circa 1974

• These are the two basic premises of clinical psychoanalysis: that behavior makes sense, and the sense it makes may not be apparent or available to the conscious mind (H. Cohen, personal communication, 1972).

Assumptions, Circa 1974

5. From assumption 4., it follows that a successful therapy should proceed on the basis of discovering what sense the patient’s phenomena are trying to communicate, even in face of the patient’s mind’s efforts to maintain its defensive dissociation and obscure the full meaning its phenomena’s communications.

Assumptions, Circa 1974

6. From these assumptions, it follows that models and metaphors that do not embrace a search for meaning are potentially distracting and irrelevant for the purpose of the therapeutic encounter.

7. From these assumptions follow the caveat that the therapist must take care to avoid the imposition upon the patient of any frame of meaning remote from the patient’s clinical material and the therapeutic encounter.
Assumptions, Circa 1974

8. Further, the understanding of dissociation I use in my clinical work acknowledges what was obvious from my first encounters with DID patients, that they are a group characterized by high hypnotizability.

The Dissociative Tower of Babel

- Over 25 Definitions of Dissociation in Current Use
- Here I will focus on those of most use in addressing pathological dissociation of the type linked to hypnosis and to the diagnostic criteria of the dissociative disorders.
- However, both the dissociative disorders literature that focuses on dissociative processes and relational psychoanalysis relate more to what I will call disavowal, and what has been called vertical splitting.

Normal (Normative) Dissociation - I

- Conventional Approaches to Normative Dissociation hold that All Normative and Pathological Dissociation Involve Two Elements:
  - A telescoping of the attentional field to concentrate on a narrow range of experience and the concomitant exclusion of other material (internal or external) from awareness and, to some degree, from accessibility, which may result in a temporary lack of reflective consciousness, etc. (Butler, 2006)
Normal (Normative) Dissociation - II

- Absorption is thought to be at the heart of normative dissociation
- As focus is narrowed and cognitive resources are committed to the attentional object, other content is excluded from the phenomenal field, and at times this results in an alteration of the context in which the attentional object is excluded. These changes are appreciated in retrospect. (Butler, 2006)

Normal (Normative) Dissociation - III

- It is crucial to appreciate the differences between absorption and attention (Butler, 2006):
  - With attention material is at the forefront of phenomenal awareness, but the surround remains or is easily accessible.
  - In absorption, the focus of attention is more concentrated and stable, and environmental and personal contexts may be diminished or lost, including self-reflection and feelings of volition.

Normal (Normative) Dissociation - IV

- An Expanded Conceptualization would include:
  - Ego State Phenomena with Porous Boundaries
  - Out of Awareness Creativity
  - Simultaneity Phenomena
  - The Elsewhere Thought Known
  - The Phenomena of the Highly Hypnotizable
  - Deliberate State Alterations by Mystics, Prayerful of Many Religions, Meditators, Fantasy-Prone Individuals, and Creative Artists
Normal (Normative) Dissociation - V

• Another Distinction (Butler, 2006):

  – Attention Feels Like Observation.

  – Absorption Feels Like Complete Involvement or Engagement.

Normal (Normative) Dissociation - VI

• Typical Dissociations of Everyday Life (Butler, 2006):

  – Absorption in Everyday Activities
    • In Deliberately Chosen Activities
    • Being in the Zone
    • Positive Experiences
    • Flow
  – Daydreaming and Fantasizing
  – Dreaming

Normal (Normative) Dissociation - VII

• Possible Functions of Normative Dissociation
  – Ludwig (1984) – Seven Possible Functions
    • Automatization of Behaviors
    • Economy and Efficiency of Effort
    • Resolution of Irreconcilable Conflicts
    • Escape from the Constraints of Reality
    • Isolation of Catastrophic Experience
    • Cathartic Discharge of Feelings
    • Enhancement of the Herd Sense
Normal (Normative) Dissociation – VIII

• Possible Functions of Normative Dissociation
     • Daydreaming is Used for Mental Processing
     • Cognitive Involvement in Absorbing Activities or
       Elaborate Fantasies is Used for Escape
     • Positive Dissociative Experiences or Flow Experiences
       Reinforce Worthy Activities

Normal (Normative) Dissociation – IX

• Normal Dissociative Phenomena Appear to Be
  on a Continuum

• They Can Be Hijacked by Trauma Plus/Minus
  Developmental Difficulties and Participate in
  the Formation of Pathological Phenomena

On the Road to Pathological Dissociation - I

• It is Increasingly Clear that When Attachment Figures
  in Dialog with Children Fail to Modulate Fearful
  Arousal, the Development of Dissociative Symptoms
  Is Promoted. Disorganized Attachment is Felt By Many
  to Be an Antecedent to Dissociative Disorders

• While Traumatic Events Are Discrete, and their
  Impacts May Be Resolved Rapidly, the Impacts of
  Problematic Relationships with Attachment Figures Are
  Worked into Identity Early in Life and Are Difficult to
  Resolve. (Lyons-Ruth et al., 2006)
On the Road to Pathological Dissociation - II

• Despite Many Earnest and Vehement Voices to the Contrary, Disturbed Attachment is Not Essential to the Development of Dissociative Disorders. However, It Is a Potent Predisposing and Perpetuating Factor, even if Not a Precipitating Factor, and has become the core of relational thinking about dissociation.

• It is Important to Appreciate that Political Factors Were Prominent in Bringing Attachment to the Forefront of the Study of Dissociation.

On the Road to Pathological Dissociation - III

• It is a historical irony that in the 19th century it was understood that profound shame was a major instigator of dissociation, and played a role in its perpetuation.

• Shame was known to precipitate fugue states.

• In our current at times “Shameless Society,” and with the near dissociation of fugues in DSM 5, it is necessary to rediscover shame.

On the Road to Pathological Dissociation - IV

• Current neuropsychophysiologic models postulate disconnections between/among higher and lower centers of the brain, the flooding of the brain with endogenous opioids with subsequent disconnections, etc., and the like. They lead naturally to approaches to stimulate reconnection or blockading of the endogenous opiates with low-level or high-level naloxone. I will not discuss them.
On the Road to Pathological Dissociation - VI

- Alteration of genetically-modulated behavioral and affective patterns by environmental factors, etc., epigenetic impacts, are a promising but theoretical and often frankly speculative area. This will be noted in passing should time permit.

Dissociation in Clinical Practice - I

- Hijackings of Normative Dissociation Mechanisms May Affect Patients with Almost Any Mental Disorder or Character Type
- These Mechanisms are Highly Related to Hypnosis and Hypnotizability, and the Likelihood of a Patient’s Having Dissociative Aspects to their Psychopathology Can Be Assessed by Utilizing Two Clinical Instruments

Dissociation in Clinical Practice - II

- The Dissociative Experiences Scale
  (Bernstein & Putnam, 1986)
- The Spiegel Eye-Roll
DES – II (Instruction and First Query)

- To answer the questions, please determine to what degree the experience described in the question applies to you, and circle the number to show what percentage of the time you have the experience.
  
  For example:
  (Never) 0% 10 20 30 40 50 60 70 80 90 100% (Always)

- 1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don’t remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.
  0% 10 20 30 40 50 60 70 80 90 100%

Homage to the DES - I

- The original form of the DES, now known as the DES – I, instructed the subject to draw a vertical mark through a 100 mm line, estimating the percentage of time a phenomenon is experienced, from 0 to 100% of the time.

- It was considered too time consuming to measure the locations of the marks, sum their totals, and divide by 28. However it had advantages.

DES - I

0% I_______________________________I100%
Lost Indicators

• The capacity to compromise
  – If the least you can endorse is 10%, those who have experiences rarely have a forced choice between 0% and 10%. Since one original finding in real DID was some endorsement of all or nearly all items, this indicator is lost. Low incidence items may be dramatic and decisive, or at least suggest further inquiry.

• The “methinks thou dost protest too much” sign
  – This is where therapists with dissociative disorders and other sophisticates tip their hands... Overdoing their denials with an impossibly negative indicator.

DES - I

Dissociation in Clinical Practice - III

• The Spiegel Eye-Roll (oversimplified):
  – Is measured by the amount of white (sclera) visible when the subject looks up as far as he/she can, and lets the eye-lids flutter down to close. As the eye-lid begins to flutter down, one scores:
    • 4 – if one sees all sclera (“The Whites of their Eyes”)
    • 3 – if one sees some iris but mostly sclera
    • 2 – if one sees half iris and half sclera
    • 1 – if one sees some sclera but mostly iris
    • 0 – if one sees pure iris
Dissociation in Clinical Practice - IV

- Scores of 3 or More Are Almost Always Found in Patients with Dissociative Disorders or Who Are Highly Hypnotizable.
  - Note: One encounters folks who can dissimulate their true eye roll potential [Kluft’s “Withheld Eye-Roll Sign” – 1987]
  - Note: Patients with Depersonalization Disorder May be Exceptions to these Observations

An Aside to Researchers

- Yes, I am and always have implicitly accepted the distinction between trait and state dissociation, and maintain both are needed to form and sustain chronic complex dissociative disorders. I formulate this, crudely and inelegantly, as follows:
  - “Axis II is where Axis I lives.”
  - Yes, we got rid of the axes in DSM 5. Still....

Other Instruments

- Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders (SCID-D) (Steinberg)
- Dissociative Disorders Interview Schedule (DDIS) (Ross)
- Multidimensional Inventory of Dissociation (MiD) (Dell)
The DSM – 5 Dissociative Disorders

• Dissociative Identity Disorder
  – See Next Pages
• Dissociative Amnesia
  – +/- With Dissociative Fugue
• Depersonalization/Derealization Disorder
• Other Specified Dissociative Disorder
  – See Next Pages
• Unspecified Dissociative Disorders

DSM – 5 DID Criterion A

• Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related changes in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

DSM – 5 DID Criterion B & C

• Recurrent gaps in memory for everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
• The symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning.
DSM - 5 DID Criterion D & E

- The disturbance is not a normal part of a broadly accepted cultural or religious practice.
  - Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
- The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., partial complex seizures).

Other Specified Dissociative Disorder

- Chronic and recurrent syndromes of mixed dissociative symptoms
  - Less than marked discontinuities in sense of agency
  - Alterations of identity or possession without amnesia
- Identity disturbance due to prolonged and intense coercive persuasion
- Acute dissociative reactions to stressful events
- Dissociative trance

Other Conditions Commonly Associated with High Dissociativity

- Acute Stress Disorder
- Posttraumatic Stress Disorder (now subtyped)
- Somatoform Disorders
- Pain Disorders
- Borderline Personality Disorder

- It is No Accident That These Are Disorders Highly Associated with Trauma
Other Conditions in which Dissociation May Be Encountered

- Panic Disorder
- Panic Disorder with Agoraphobia
- Thought Disorders
- Affective Disorders
- Partial Complex Seizures
- Sleepwalking Disorder, etc.
- Intermittent Explosive Disorder
- Gender Identity Disorder
- Eating Disorders

Treating Dissociative Phenomena - I

- "The Patient Dissociates"
- "I think the patient dissociates, but I don’t think the patient has a dissociative disorder."
- Getting beyond global descriptor
- What is meant by dissociation?
- What dissociates in dissociation?

Treating Dissociative Phenomena - II

- Since most dissociative disorder patients go undiagnosed for long periods of time, rule out a disguised or subtle dissociative disorder.
- Use appropriate diagnostic measures in so doing e.g., DES, SCID-D-R, DDIS, MID.
- For each dissociative symptom, determine what is being dissociated from what, and determine whether some particular model of dissociation prevails or characterizes it best.
Treating Dissociative Phenomena - III

• What dissociative disorder do the phenomena most resemble?
• Is the patient likely to have high hypnotizability?
• What are the antecedents of the occurrences of the dissociative phenomena in the patient’s contemporary life?
• What is the context in which dissociative phenomena occur in session?

Treating Dissociative Phenomena – IV

■ What Model or Models of Dissociation Seem to Encompass the Dissociative Phenomena Best?
■ Are you Encountering Spectrum or Taxon Phenomena?
  ■ The Taxon Consists of Several DES Question Scores: Items 3, 5, 7, 8, 12, 13, 22, 27

Treating Dissociative Phenomena – V

• If the Phenomena Are Intermittent and Triggered by Stimuli, Internal or External, Therapeutic Efforts Must Be Made to Reduce the Frequency with which those Stimuli are Triggered
• If the Phenomena Are Fixed and Ongoing, Therapeutic Efforts Must Be Made to Undermine the Phenomena Themselves
Treating Dissociative Phenomena – VI

• Examples of Dissociative Phenomena which are Intermittent and Triggered by Stimuli:
  – Trancing Out Under Stress, Re-experiencing
• Examples of Dissociative Phenomena which Are Fixed and Ongoing:
  – Chronic Depersonalization Disorder, Alters in DID

Treating Dissociative Phenomena – VII

• It is Impossible to Distinguish Between High Hypnotizability and High Dissociativity When Both Are Present
• Expect a High Hypnotizable Patient To Demonstrate Emotional Intensity, Archaic Involvement, Vivid Imagery, Capacities for Positive and Negative Hallucinations, and Loss of General Reality Orientation; i.e., to at times Appear Highly Disturbed, Even Psychotic!

Treating Dissociative Phenomena – VIII

• Having Characterized the Dissociation, Determine What Interventions are Most Likely to Affect It.
• Treatment of Dissociative Phenomena often Parallels the Treatment of the Dissociative Disorder the Patient’s Phenomena Most Resemble
Treating Dissociative Phenomena – IX

- Be Very Cautious about any Therapeutic Approaches that Assure You that Other Approaches and Techniques with Good Track Records Are No Longer Necessary.

- Be Very Cautious About Instituting Vigorous Trauma Treatments Early in Your Work with a Trauma Patient. You May Cause Unwanted Complications. Newer research suggesting prolonged exposure/trauma processing without preliminary strengthening is not ecologically valid for DID/DDNOS.

Treating Dissociative Phenomena – X

- Modalities A:
  - It is Crucial to Appreciate that While Most Attention is Given to the Theory and/or Technique du jour, the Essence of the Treatment is the Relationship of Therapist and Patient (see Diamond, 1984, 1987).
  - Powerful Techniques often Create the Illusion that they will Provide a Powerful Healing Experience, but such Techniques Often Lull Therapist and Patient Alike into a False Sense of Security.

Treating Dissociative Phenomena XI – Modalities B

- Try to remember that many modalities implicitly are using the tools of other modalities.

- The frequent debates between advocates of EMDR and Hypnosis often overlook many factors, two of which are:
  - Some people are not amenable to or accessible to one or the other.
  - When any technique is used with a hypnotizable patient, that capacity will be enlisted.
DID in Depth - I

- Co-Presence of High Dissociativity and Hypnotizability
- Fantasy-Proneness
- The Three Realities
- The Ingenuity and Resourcefulness of Dissociative Defenses
- Comorbidity

DID in Depth - II

- How to live when life’s realities are impossible to contend with
  - The importance of “terms of endearment”
  - The perversion of the concept of safety
  - The need to find a rationale to preserve important relationships or the hope or illusion of them
  - Thinking outside of the box - The development of fantasies that attempt to undo the impossible
  - Multiple personality disorder is the delivery and maintenance system for achieving the true goal, the creation of multiple reality disorder.

CORE DISSOCIATIVE PHENOMENA - I

- Observed Categories of Dissociative Phenomena
  - 1. Alters, also known as personalities, identities, personality states, etc.
  - 2. Identity confusion
  - 3. Amnesia
CORE DISSOCIATIVE PHENOMENA - II

4. Compartmentalization/modularity phenomena
   a) Alters, as above
   b) Segregation of some subsets of information from other subsets of information in a relatively rule-bound manner (Spiegel, 1986)
   c) BASK (Braun, 1988) dimensions (ablative expressions)

CORE DISSOCIATIVE PHENOMENA - III

5. Detachment (as in depersonalization and derealization in the perception of self and/or others and also in concerns over whether memories are real or unreal; also seen in alters’ lacking senses of ownership or responsibility for the actions of other alters)
6. Absorption
7. Altered states of consciousness (e.g., hypnotic/autohypnotic/spontaneous trance phenomena)

CORE DISSOCIATIVE PHENOMENA - IV

8. Failures of compartmentalization such as intrusion phenomena, including both alters, memories, and BASK (Behavior, Affect, Sensation, Knowledge; Braun, 1988) dimensions (intrusive expressions)
9. Simultaneous operation of separate self-aware processes or states of mind, including parallel distributed processing, elsewhere thought known phenomena (Kluft, 1995), unconscious thought (Dijksterhuis et al., 2006), inner world activities, and creativity by alters not in apparent executive control.

10. Simultaneous executive activity by separate self-aware processes or states of mind (copresence phenomena [Kluft, 1984])

11. Inner world and third reality phenomena (events within that inner world that are accorded historical reality and which sometimes intrude into ongoing experiences, and/or impact ongoing experiences from behind the scenes (Kluft, 1998)

12. Switching and shifting

13. Multiple reality disorder (Kluft, 1991), for which dissociative identity disorder, formerly called multiple personality disorder, is the delivery and maintenance system.
THE THREE REALITIES

• AUTOBIOGRAPHIC MEMORY WITH ALL OF ITS VICISSITUDES
• AUTOBIOGRAPHIC MEMORY AS DISTORTED BY POST-EVENT INFORMATION, SUGGESTIONS, INPUT FROM OTHERS, CONTAMINATIONS, FANTASIES, THE MEDIA ("OPHRAGENIC" INFLUENCES)
• EVENTS IN THE INNER WORLD MISPERCEIVED AS EVENTS IN EXTERNAL REALITY

WORKING WITH THE ALTERS

• A BASELINE ASSUMPTION OF THE APPROACHES DISCUSSED TODAY IS THAT IT IS APPROPRIATE AND NECESSARY TO WORK WITH THE ALTERS, OFTEN DIRECTLY.
• EXPERIENCE DEMONSTRATES THAT WORKING WITH ALTERS DOES NOT REINFORCE THEM; VIA EMPATHY AND BOUNDARY EROSION, IT REDUCES SEPARATENESS.

Coping Strategies and Alter Formation - 1

- This did not happen
  A Lois who knows and a Lois who does not
- I must have deserved it
  Bad Lois, whose behavior would explain trauma as punishment
- I must have wanted it
  A sexual alter, Sherrie
Coping Strategies and Alter Formation - II

- I can control it better if I take charge.
- I would be safe if I were a boy.
- I wish I were a big man who could prevent this.

An aggressively sexual alter, Vickie
Louis, Lois’ male twin I were a boy.
Big Jack, based on some person of power

Coping Strategies and Alter Formation - III

- I wish I were the one who could hurt someone, and not be hurt.
- I wish I could feel nothing.

Uncle Ben, or a more disguised identification with the aggressor
Jessie, who endures all yet feels nothing

Coping Strategies and Alter Formation - IV

- I wish someone could replace me
- I wish someone would comfort me

“The Girls,” who encapsulate specific experiences of trauma unknown to Lois
Angel, with whom Lois imagines herself to be while the body is being exploited and “The Girls” are experiencing the trauma.
Ego States
(Watkins & Watkins, 1993)

• We define an ego state as an organized system of behavior and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable. Such a definition includes both true cases of multiple personalities and those less rigidly separated personality segments that lie in the middle of the differentiation-dissociation continuum and that may be more ‘integrated’ and hence more adaptive.

Distinguishing Alters from Ego States - I

• Beyond fulfilling the definition of ego state, alters have an aspect of self – that is, following Kohut, they are centers of both initiative and experience.
• Four features are characteristic of alters:
  – A sense of personal identity
  – A self-representation
  – An autobiographic memory
  – A sense of ownership of personal experience

Distinguishing Alters from Ego States - II

• In DID, at least two alters have recurrently assumed executive control
• Lacking this, the presence of alters qualifies the patient for the diagnosis of Other Known Dissociative Disorder, which would include what some call ‘ego state disorder.’
Talking to Alters

• It is of note that those schools of thought that try to bypass dealing directly with alters have yet to generate a series of successfully integrated DID patients.
• Non-reinforcement, benign neglect, suppression, extrusion, and reframing have failed to show results beyond the short term.
• The “exorcism” research. A cautionary tale.

TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 1

• “A good way to know when someone is afraid to deal with something is when he or she uses a paradigm inimical to his or her paradigm of choice to justify excluding it. A common expression of this occurs when an analyst refuses to deal directly with the alter personalities on the grounds that this might reinforce them, despite the fact that all known cures have involved dealing with the alters.” (Kluft, 1990)

TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 1

1. ACKNOWLEDGING THE DISSOCIATIVE SURFACE
2. DECODING THE DISSOCIATIVE SURFACE
3. MAKES ALTERS STAKEHOLDERS, INVESTED IN THE TREATMENT
4. PUTTING THE “HOST” IN PERSPECTIVE
TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 2

5. APPROACHING RELUCTANCE RESPECTFULLY, FACILITATING PERSUASION
6. DECLINING TO COLLUDE WITH AVOIDANCE
7. UNDERSTANDING ALTERS/ALTERS’ BEHAVIOR AS COMMUNICATIONS OF VITAL PSYCHODYNAMIC MATERIAL

TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 3

8. ERODING AMNESIA BY ENGAGING THE ALTERS
9. EXPLORING AND RELIEVING SYMPTOMS DUE TO ALTERS’ INTRUSIONS
10. DISABLING “BEING NORMAL” AS SELF-SABOTAGE
11. ENHANCING THE IMPACT OF EMPATHY

TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 4

12. BRINGING “ABUSER ALTERS” INTO TREATMENT
13. NEGOTIATING WITH ALTERS AS AN ASPECT OF TREATMENT
14. MOBILIZING CURRENTLY INACCESSIBLE SKILLS
15. CREATING INTERACTIONS THAT ANTICIPATE INTEGRATION
TWENTY REASONS TO ADDRESS ALTERS DIRECTLY - 5

16. REACHING OUT TO AND ENLISTING ALTERS IN THE THIRD REALITY
17. RESOLVING SHAME FACE-TO-FACE
18. ENLISTING MORE MATURE ALTERS TO CARE FOR CHILD ALTERS
19. AVOID RE-ENACTMENTS OF REJECTION AND NEGLECT
20. PAVING THE WAY FOR INTEGRATION

Stepping Up Your Game

• Those experts who achieve most success are keenly aware of subtle indicators of dissociative processes.
• This allows them to intervene earlier, and even preemptively at times.
• Such alertness is criticized by skeptics as promoting or reifying dissociative processes and structures.

WHAT IS THE “DISSOCIATIVE SURFACE”?

• THE DISSOCIATIVE SURFACE IS CONSTITUTED BY THE COVERTLY EMITTED INDICES OF THE ACTIVITY OF ALTERS BELOW THE SURFACE.
• JEAN FRANKLIN DESCRIBED THESE PHENOMENA AS “SHIFTING” TO DISTINGUISH THEM FROM THE MORE OVERT PHENOMENON OF SWITCHING.
• PUTNAM’S “ORDER EFFECT” (1991)
The Dissociative Surface - I

- The Host, or, the “Usual Patient”
- The Semblance of the Host or “Usual Patient”
  - Passing For Isomorphism
- Tag-Teaming
- Copresence Combinations (v.i.)

The Dissociative Surface - II

- Co-Presence Combinations
- Mixed Presentations
  - 1. Cooperations
  - 2. Clashes
  - 3. Vectors
  - 4. Temporary Blendings
- Fluctuating Presentations
  - 1. One-Plus Presentations
  - 2. Shifting One-Plus Presentations

The Dissociative Surface - III

- Instructed Behavior
- Intrusions
  - 1. Simple
  - 2. “Up the Food Chain”
  - 3. From the “Third Reality”
- Imposed or “Made” Behavior
  - 1. Simple
  - 2. “Up the Food Chain”
- Switching, Rapid Switching, and Shifting
Typical Manifestations of  Dissociative Surface Processes
at Work - I

• 1. Brief amnestic moments, apparent amnesia or forgetfulness about matters under discussion or subjects of ongoing concern within the treatment, or abrupt changes of the subject of discourse.

• 2. Derailing of an ongoing conversation by the patient’s appearing spacey, perplexed, or surprised by what is coming out of his or her mouth.

Typical Manifestations of  Dissociative Surface Processes
at Work - II

■ 3. Transient anxiety or distress

■ 4. Palpable but difficult to characterize alterations in the manifestations of an alter

■ 5. Changes in the attitude, emotions about, and stance taken toward matters under discussion

Typical Manifestations of  Dissociative Surface Processes
at Work - III

• 6. Fluttering of the eyelids or rolling of the eyes (suggesting an autohypnotic process)

• 7. Apparent distraction by or attention to internal stimuli
**Typical Manifestations of Dissociative Surface Processes at Work - IV**

- 8. Appearances that suggest a “double exposure” in which one alter’s characteristic appearance seems superimposed upon or rapidly oscillating with the appearance of another, or gives the appearance of blending of two known alters’ patterns of expression.

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**Typical Manifestations of Dissociative Surface Processes at Work - V**

- 9. One aspect of facial expression being discordant with the others, such as smiling while the face otherwise expresses fear or sorrow, or one side of the face (or the ocular region compared with the oral region) expressing one affect while the other side (or region) expresses another.

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**TRACKING – AN EXPANDED PERSPECTIVE**

- We are often trained to track our patients’ verbal productions.
- However, doing the dirty work requires an expanded approach to tracking that involves reading metacommunications as well. Only one can speak at a time, but many communicate at once. Think about music.
### TRACKING WITH SERGEI PROKOFIEV IN PETER AND THE WOLF

Each protagonist has a recognizable voice and theme:
- **Bird – Flute**
- **Duck – Oboe**
- **Cat – Clarinet**
- **Grandfather – Bassoon**
- **Wolf – French horns**
- **Hunters – Woodwind**
- **Gunshots – Timpani and Bass Drum**
- **Peter – String Instruments**

### MORAL OF THE STORY

- **If you can listen to Peter and the Wolf, you can track a complex multiple**
- **It is unusual for more than 6 to be at the surface to a meaningful degree, and the human mind can follow 5 to 7 things – piece of cake!!**

### DISSOCIATION IN DID BEYOND ALTERS

- **One of the major obstacles to treating DID is the focus on what are considered the core dissociative manifestations, amnesia and alters.**
- **However, these other phenomena often are crucial, and offer, at times phenomenal therapeutic opportunities.**
DISSOCIATION: THEORETICAL AND PHENOMENOLOGICAL

• IT IS NOT GENERALLY ACKNOWLEDGED THAT DISSOCIATION AS IT IS DEPICTED IN OUR MAJOR THEORIES IS NOT ISOMORPHIC WITH THE DISSOCIATIVE PHENOMENA WHICH WE CONFRONT IN OUR CLINICAL PRACTICE.
• NO THEORY ENCOMPASSES ALL OF THE CORE PHENOMENA.

That with Which the Road to Hell is Paved.....

• Two Good Intentions Gone Bad......
  – The Attempt to Separate Normal from Abnormal Dissociation
  – The Attempt to Put Forth a Universal Theory of Dissociation and Its Treatment

DISSOCIATION: THEORETICAL AND PHENOMENOLOGICAL
(or, Why Did You Take Us to Middle Earth?)

• IT IS NOT GENERALLY ACKNOWLEDGED THAT DISSOCIATION AS IT IS DEPICTED IN OUR MAJOR THEORIES IS NOT ISOMORPHIC WITH THE DISSOCIATIVE PHENOMENA WHICH WE CONFRONT IN OUR CLINICAL PRACTICE.
• NO THEORY ENCOMPASSES ALL OF THE FOLLOWING PHENOMENA.
• THIS OFTEN IS THE SOURCE OF A RUDE AWAKENING IN THOSE WHO COME TO ME FOR CONSULTATION.
Conceptualizing Dissociation

**DSM-IV-TR (2000):**
The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception.

**David Spiegel (1986):**
Dissociation involves the segregation of some subsets of information from other subsets of information in a relatively rule-bound manner.

**Braun (1979; 1984):**
BASK Model

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Braun’s BASK Model of Dissociation

- Behavior
- Affect
- Sensation
- Knowledge (time)

---

Braun’s BASK Model of Dissociation

- B - Behavior
- A - Affect
- S - Sensation
- K - Knowledge

---
The Watkins’ Ego State Model

• “We define an ego state as an organized system of behavior and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable.”

(Watkins & Watkins, 1993, p. 278)
### Pathways into the Concept of Dissociation

- Most Models Exclude Phenomena Long and Currently Classified as Dissociative.
- The Exclusion by Many of Normal Dissociation Leave a Theoretical and Clinical Vacuum in the Understanding of Many Conditions.
- Some other phenomena are not covered well: Unconscious Thought; Out of Awareness Creativity; The “Elsewhere Thought Known;” and Simultaneity Phenomena

### Pathways into the Concept of Dissociation - I

1. DSM Definition (American Psychiatric Assn.)
2. Information Processing Models (Spiegel)
3. BASK Model (Braun)
4. Dissociation as Splitting – Psychoanalytic (e.g., Davies and Frawley)

### Pathways into the Concept of Dissociation - II

5. Dissociation as unformulated material (D. Stern; P. Bromberg)
6. Dissociation as an adaptation that fuses autohypnosis with conflict-driven drives (Shengold; I. Brenner)
7. Dissociation as both symptom and character style (I. Brenner)
Pathways into the Concept of Dissociation - III

8. Multiple Self-States (Relational Analysis; Bromberg)

9. Ego-State Psychology (Watkins & Watkins)

10. Normal Dissociation, involving Absorption and detachment, and/or the simultaneous operation of separate but self-aware thought processes or states of mind. May be sought after, desired (or connected to what is desired. Also includes modularity understood to be normal. (Butler)

Pathways into the Concept of Dissociation - IV

11. Dissociation as out-of-awareness creativity (e.g., Robert Louis Stevenson)

12. Unconscious thought (making complex decisions outside of conscious awareness; e.g., "I'll have to sleep on that.")

13. Defining both a domain of dissociation and categories of dissociation (Cardena)

Pathways into the Concept of Dissociation - V

Cardena’s (1994) Model (A)

There is no coherent referent or definition that is generally accepted so attempts to define a domain of dissociation, indicating what is embraced under "dissociation."

The term is used in at least three distinct ways:
Pathways into the Concept of Dissociation - VI

First, dissociation is used to characterize semi-independent mental modules or systems that are not consciously accessible, and/or not integrated within the person’s conscious memory, identity, or volition.

Pathways into the Concept of Dissociation - VI

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Pathways into the Concept of Dissociation - VII

Cardena’s (1994) Model (B)

Second, dissociation is viewed as representing an alteration in consciousness wherein the individual and some aspects of his or her self or environment become disconnected or disengaged from one another.
Pathways into the Concept of Dissociation - VIII

Third, dissociation is described as a defense mechanism that affects such disparate phenomena as nonorganic amnesia, the warding off of current physical or emotional pain, and other alterations of consciousness, including a chronic lack of personality integration, such as with Multiple Personality Disorder (MPD); i.e., Dissociative Identity Disorder (DID).

Pathways into the Concept of Dissociation - IX

- Cardena argues that efforts should be made to remove all phenomena that are within the normal spectrum from dissociation, which should be reserved for phenomena qualitatively outside of normal experience. He further is concerned that the use of dissociation to encompass such a range of phenomena dilutes its meaning.

Pathways into the Concept of Dissociation - X

14. Putnam (1997) and Waller, Putnam, & Carlson (1996) found dissociation to consist of pathological dissociation (items relating to amnesia, depersonalization, derealization, and subjective impressions of dividedness or overhearing inner voices), which constituted a taxon, and normal dissociation, which involved a dimensional spectrum of degrees of absorption.
Pathways into the Concept of Dissociation - XI
15. Holmes et al (2005) offered the formulation that there are two qualitatively distinct forms of dissociation, detachment and compartmentalization. Following Allen (2001), Brown (2002), and Putnam (1997), they dichotomized detachment symptoms (depersonalization, derealization, spacing out) and compartmentalization phenomena (amnesia, fugue, and dissociative identity disorder). They propose that the two types might be treated differently.

Pathways into the Concept of Dissociation - XII
16. Damasio (2000) distinguished between a core and an autobiographic self. The core self is based on the continuing cerebral representation of one’s momentary bodily state. It lacks a sense of the past or the imagined future, features required for a sense of an autobiographical self. The autobiographical self may be distorted by environmental influences; there may be different autobiographical selves. In this model, dissociative patients must have one core self, but may have different autobiographical selves.

Pathways into the Concept of Dissociation - XIII
17. van der Hart, Nijenhuis, and Steele have developed the model of structural dissociation. They discuss the dissociation, after exposure to trauma, of an apparently normal part of the personality (ANP; dedicated to daily functioning) from an emotional part of the personality (EP) dedicated to defense. Fixated on a limited number of cues, the EP’s attention is primarily focused on the re-experiencing of trauma as a contemporary event. The ANP is phobic of the EP that encompasses the trauma; avoidance may progress to amnesia, detachment, and numbing.
In primary structural dissociation there is a single ANP and a single EP, as noted above. Secondary structural dissociation involves the further division of the EP. Each EP is characterized by an even narrower focus on traumata and particular defensive subsystems.

In tertiary structural dissociation the ANP is divided as well. This level of dissociation is limited to DID and closely related forms of DDNOS. In tertiary dissociation, some entities may have characteristics of both ANPs and EPs.

18. Depersonalization due to biological factors (Simeon):
   - Drugs
   - Seizure Disorders
### Pathways into the Concept of Dissociation - XV

18. Depersonalization due to biological factors (Simeon):
   - Drugs
   - Seizure Disorders

### Pathways into the Concept of Dissociation - XVI

19. Dissociation as the discrepancy between cognitive and affective expression (Bucci)

### Pathways into the Concept of Dissociation - XVII

20. Dissociation is characterized by subtle deficits in neuropsychological performance, with a tendency toward pseudo-memories and cognitive failures (Giesbrecht, Lynn, Lilienfield, & Merckelbach, 2008)
Pathways into the Concept of Dissociation - XIX


- Each Dissociative Phenomenon Should Be Understood with the Model or Models that Fit It Best, and Treated with that Model or Models in Mind. In a Given Patient, Different Symptoms May Require Different Models for both Understanding and Treatment.

THE IMPORTANCE OF AFFECT

- 22. SHAME AS AN INSTIGATOR AND SUSTAINER OF DISSOCIATION.
- IT IS RARELY RECALLED THAT IN THE 19TH CENTURY SHAME AND GUILT WERE ROUTINELY INVOKED AS CAUSATIVE FACTORS IN DISSOCIATION, PRIMARILY IN FUGUE.

(Nathanson & Kluft, diverse publications)

The Compass of Shame

Withdrawal

Attack Other Attack Self

Avoidance
Pathways into the Concept of Dissociation - XX

23. Neurologically-Driven Disconnections
   Believed by many to require body-oriented treatments or neuropsychophysiological intervention.

24. Opiate Overflow
   Believed by many to require pharmacologic interventions.

Remember the Core Symptoms of Dissociation?

- Didn’t think so. Refer to your handout!

The Downside of Paradigms

- KLUFT (AFTER LAOR, PERSONAL COMMUNICATION):
  - A PARADIGM IS LIKE THE BEAM OF A SEARCHLIGHT OR LIGHTHOUSE........
  - WHAT IT ILLUMINATES, IT ILLUMINATES WITH TREMENDOUS CANDLEPOWER, BUT WHAT FALLS OUTSIDE ITS BEAM IS RAPIDLY SHROUDED IN DARKNESS.
What Gets Lost? How Many of The First 23 Models of Dissociation Address Each Core Phenomenon?

Included: Clearly—Partially/Vaguely—Total

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<tr>
<td>1. Alters</td>
<td>6</td>
<td>4</td>
<td>10</td>
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<tr>
<td>2. Identity Confusion</td>
<td>2</td>
<td>5</td>
<td>7</td>
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<tr>
<td>3. Amnesia</td>
<td>9</td>
<td>4</td>
<td>13</td>
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<tr>
<td>4. Compartmentalization</td>
<td>14</td>
<td>1</td>
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What Gets Lost? How Many of These Models of Dissociation Address Core Phenomena?

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<th>Clearly</th>
<th>Partially/Vaguely</th>
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<tr>
<td>5. Detachment</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>6. Absorption</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>7. Altered States</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>8. Failed Compartmentalization</td>
<td>3</td>
<td>3</td>
<td>6</td>
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More of Same

<table>
<thead>
<tr>
<th></th>
<th>Clearly</th>
<th>Partially/Vaguely</th>
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<tr>
<td>9. Simultaneous Self-Awareness</td>
<td>5</td>
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<td>5</td>
</tr>
<tr>
<td>10. Simultaneous Executive Capacity</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>11. Inner/Third World Phenomena</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>
More of Same

12. Switching/Shifting  
   9  3  12  

13. Multiple Reality Disorder  
   2  3  5  

Ergo.....

• You have heard about the blind men and the elephant...

• The average model, given the benefit of the doubt of the total score, addresses 4.7 of the 13 core phenomena.

• No single model is adequate to encompass the broad realm of dissociative phenomena or to guide clinical decision-making, notwithstanding that model's use in research or theory-building.

• Only 3 of 23, or 13% address absorption, the core phenomenon of normal dissociation and a core phenomenon of hypnosis.

Back to the Road to Hell.....

• The capacity to manifest hypnotic phenomena is genetically driven, and the genetic elements associated with higher hypnotizability are associated, not surprisingly, with aspects of attention. (Raz, et al., 2006)

• DID has the highest average hypnotizability scores of any condition, even though cooperation with the scales can be iffy. (Frischholz, et al., 1992).

• Hypnosis will occur in treatments of DID/DDNOS regardless of the wishes of therapist and/or patient.

• Formulations that omit absorption/hypnosis are taking a rather curious course of action.....
USEFUL HEURISTICS IN DISSOCIATION

- NO THEORY ENCOMPASSES ALL DISSOCIATIVE PHENOMENA, BUT SOME THEORIES ARE MORE USEFUL THAN OTHERS TO THE CLINICIAN:
  - DSM IV (2004)
  - SPIEGEL (1986)
  - BRAUN (1988)
  - WATKINS & WATKINS (1979)
  - KLUFT (2008, BASED ON NATHANSON)

Principles of the Successful Psychotherapy of DID - I

- Secure the Treatment Frame and Establish Firm, Consistent Boundaries
- Focus on Mastery and the Patient’s Active Participation in the Treatment Process
- Establish a Strong Therapeutic Alliance as the Foundation of the Treatment
- Uncover What Has Been Covered Over, and Abreact Sequestered Feelings

Principles of the Successful Psychotherapy of DID - II

- Emphasize the Cooperation, Collaboration, Empathy for, and Identification with One Another
- Move Alternative Realities Toward a Shared Reality; Attain Clarity of Communication
- The Therapist’s Consistency Across Alters Becomes and Assault on Dissociative Defenses
- Restore Morale and Inculcate Realistic Hope
- Pace Carefully and Use Kluft’s “Rule of Thirds”
Principles of the Successful Psychotherapy of DID - III

• Therapist Responsibility and Ultimately Patient Responsibility Are Crucial
• Take a Warm Stance That Allows for a Latitude of Affective Expression
• Identify and Address Cognitive Errors

Confrontations, Boundaries and Limit-Setting

• Undoing Disavowals of Reality Associated with Dissociative Defenses
• Grounding and Reorientation
• Boundaries as Experienced by the DID
• Firmness without Punitiveness
• The Art of Explaining “No”

WORKING WITH THE WHOLE PATIENT AND THE ALTER SYSTEM

• Invitational Inclusionism
• Insistence on Considerateness – “The Golden Rule Mentality”
• Everyone Wins or Everyone Loses
• Double Book-Keeping and Double Appeal
• Working within Alters’ /The Patient’s Subjective Reality (-ies) to Correct Its (Their) Misperceptions and Misattributions
• Attention to Issues of Narcissism, Shame, and Masochism
The Stages of Trauma Treatment  
(Herman, 1992)
- Safety
- Remembrance and Mourning
- Reconnection

Stages of DID Treatment  
(Kluft, 1991)
- Establishing the Psychotherapy
- Preliminary Interventions
- History-Gathering and Mapping
- Metabolism of the Trauma
- Moving Toward Integration/Resolution
- Integration/Resolution
- Learning New Coping Skills
- Solidification of Gains and Working Through
- Follow-Up

Stage 1. Establishing the Therapy
- Mutual Voluntary Participation
- Pragmatic Arrangements
- A Facsimile of Trust
- Aspects of Safety
- The Treatment Frame
- The Therapeutic Alliance (See Next Slide)
- Self-Psychological Interventions
- Demonstration of Expertise
- Dealing with the Diagnosis
- Dealing with Concerned Others
Selected Components of the Therapeutic Alliance with DID

- Active Participation by the Patient
- Assignments
- Exploration of Prior Psychotherapies
- Socialization to the Therapy
- Informed Consent
- Ground Rules
- Psychoeducational Aspects
- Anticipatory Socialization
- Discussion of Management of Intersubjectivity

Stage 2. Preliminary Interventions II

- Ego Strengthening and System Strengthening
- Begin Character Work (See Slide)
- Offering Symptomatic Relief (See Slide)
- Hypnosis with an Emphasis on Temporizing Techniques (See Slide)

Temporizing Techniques in Stage 2.

- Alter Substitution
- Provision of Sanctuary
- Distancing Maneuvers
- Bypassing Time
- Bypassing Affect
- Attenuation of Affect Dsyphoria
- Reconfigurations
HYPNOSIS IN THE TREATMENT OF DID

• DID patients are highly hypnotizable as a group, but whether a given DID patient will allow or participate in hypnosis is an individual matter.
• Hypnosis may be induced (heterohypnosis, self-induced (autohypnosis), or spontaneous.
• Only heterohypnosis is at the discretion of the therapist.

VARIETIES OF HYPNOTIC INTERVENTIONS
- Accessing Alters
- Alter Substitutions
- Reconﬁgurations
- Ideomotor Questioning
- Provision of Sanctuary
- Bypassing/Attenuating Intense Affects
- Slow-Leak Techniques
- Curtailing Abreactions
- Fractionated Abreactions
- Gathering Historical Data
- Time Sense Alteration
- Distancing Maneuvers
- Facilitating Integration
- Temporary Blendings
- Integration Rituals
- Recheck Protocols
- Symptom Relief/Substitution
- Teaching Autohypnosis
- Suppressive Measures
- Trance Ratﬁcation
- Suppressively Prevention

Why Do So Many Claim They Have No Need For Formal Hypnosis?

• Narcissistic investments in theories that minimize the role of hypnosis and hypnotizability.
• Patting themselves on the back prematurely, since no one who claims this orientation has ever presented a series of integrated patients.
• Knowing so much about formal hypnosis that they know how to get there indirectly.
• Believing stupid or ill-informed theorists/teachers/colleagues, or those pursuing agendas of their own.
FORMAL INDUCTION: YEA OR NAY

- **YEA**
  - CONTROL
  - ILLUSION OF REAL CONTROL
  - PREDICTABILITY
  - CONTAIN POTENTIAL REGRESSION
  - PRESERVES "TRANCE" EXPECTANCIES

- **NAY**
  - LESS PERMISSIVE
  - UNNECESSARY
  - INTRUSIVE
  - AUTHORITARIAN
  - INFANTILIZING?
  - REGRESSION
  - REGRESSIVE DEPENDENCY

GENERAL HYPNOTIC TECHNIQUES

- MANY GENERAL APPROACHES WILL PROVE USEFUL, BUT EACH MUST BE EMPLOYED WITH A SENSITIVITY TO HOW IT WILL BLEND WITH DID TREATMENT.

- EXAMPLE: RELAXATION TECHNIQUES MAY CAUSE A DID PATIENT TO FEEL OUT OF CONTROL AND/OR VULNERABLE.

Hypnosis and the Wounded Self in Trauma Treatment (Alladin, Kluft)

- The Wounded Self of the Patient and the Therapeutic Self of the Therapist must reach a relational pattern that permits the therapy to proceed.

- Many patients arrive with prior experiences with hypnosis:
  - Failure Due to Disruptive Events
  - Failure to Enter Hypnosis
  - Amnestic for Whatever Happened
Key Factor

• The strength and safety of the therapeutic relationship is a more powerful determinant of how well the patient’s hypnotic capacities can be mobilized that either theory, technique, experience, or the therapist’s charisma and other qualities (Diamond, 1984, 1987).

• I will repeat this ad nauseum.

The Self (per Kohut)

• A center of initiative and experience

• Pathologies of self may reflect:
  – Developmental problems due to parental failures
  – Responses to life’s vicissitudes
  – Fixed psychopathology

Selfobjects

• Selfobjects are those who function as parts of ourselves in stabilizing and completing us:

  – Accurate empathy and reflection back as mirrors offering affirmations and appreciations of the individual, allowing the individual to see himself or herself
  – Powerful and worthwhile idealized omnipotent others to provide safety, and models for maturation and behavior
  – Connection based on appreciation that much is shared in common with others.
Selfobject Transferences

• These three patterns of relational needs generate respectively:
  – The mirror transference
  – The idealizing transference
  – The alter-ego or twinship transference

These needs create relational pressures in connection with which the patient may experience empathic failure.

Self Pathologies Seen by the Trauma Therapist

• The understimulated self
• The fragmenting self
• The overstimulated self
• The overburdened self

• Mirror-hungry personalities
• Ideal-hungry personalities
• Alter-ego-hungry personalities

The Crucial Role of Shame Reduction

• Will return to this.
The Importance of Dignity

- Circumspect reappraisal
- The slower you go, the faster you get there.
- Sensitization to the destructive impact of theory.

Patience and Restraint: When Less Technique is Better Technique

- Beware the risk of reassurance.
- Beware shame influences how things are heard.
- Assurances of understanding or trustworthiness are to be avoided!
- Until there is a treatment plan, there is not treatment to facilitate, so why push hypnosis?
- Risks of unearthing dissociative phenomena.

Why It is Usually Useless to Convince a Patient to Accept a Technique - I

1. Establishes therapist as motivated to do something to the patient, a power position suggesting a complimentary passivity on the part of the patient. (Never say, “I want you to...”)
2. Patient may fear a menacing loss of control to the therapist or to frightening internal matters.
3. Entry into trance may disinhibit dissociation/repression and bring out difficult material or dissociated structures, or even the misperception of the therapist as an abuser.
Why It is Usually Useless to Convince a Patient to Accept a Technique - II

4. Upset individuals may not have remembered to tell the therapist about ongoing or potential legal issues.
5. Implicit disrespect for the patient, which will be returned down the road in the form of disrespect for the therapist.

Cautions about Relaxation and Eye Closure

• Many traumatized individuals consider their hyperarousal and hypervigilance essential to their survival.
• Some may have been attacked while relaxed or asleep.
• Disinhibition of material and/or switching
• Fantasies/Fears of weakness

Avoid Cookbook/Conventional/Familiar/Preferred Interventions and Techniques

• What is good for you may be terrible for the patient
• Essential to individualize
• Formulaic efforts are more likely to create unwanted events than individualized ones
  – (Hilgard, Orne, Gruzler, Crasilneck, Kluft, etc.)
• A workshop disaster....
Selected Topics of Concern

- Safe places
- Trance ratification and beyond
- Shame reduction techniques
- Dysphoria reduction techniques
- Fractionated abreaction
- Safety in session closure

A Closer Look at Induction

- A Multifaceted Event, More Nuanced than Workshops Often Convey:
  - A clinical phenomenon
  - A change of state and expectations
  - An interpersonal and relational process

NOT SIMPLY A CIRCUMSCRIBED MOMENT
Workshops are great in conveying cognitive info and techniques, but are usually deficient re: attitudes.

When Does an Induction Begin?

- The curious induction technique of Martin T. Orne, M.D., Ph.D., as explained to me in 1971 or 1972.
  - Your call
    - 6 months, or
    - 6 seconds
Cautionary Considerations

- Many concerns about hypnosis are not available to conscious report and may not be revealed by ideomotor explorations.
- The literature demonstrates that adverse effects are much more common than realized (Gruzelier, 2000) and usually not reported (Kluft, 2012).
- These concerns are magnified with DD pts.

A Gentle Reminder

- MacHovec estimated an 8% incidence of unwanted effects in clinical hypnosis, and a 15% incidence in stage hypnosis.
- In fact, in hypnosis research the incidence is often over 30% in normal subjects, which is worse than attributed to hypnosis in Stanford Scale research!
- The failure to report, acknowledge, or elicit information on unwanted events has led to a drastic underestimation of relevant concerns.

Ergo...

- Slow, gentle pacing beats bravura approaches every time. If the patient can bail, you’re both less likely to fail!
- While some DID/DDNOS patients are up front about their misgivings, some, in their efforts to please or avoid criticism, go along and get in trouble.
- Fear of recurrent distress may be denied until it is upon the patient.
Why Ares Some Therapists Just Better than Others?

• Damned if I know, but Michael J. Diamond comes closest to making sense.
• Who is Michael J. Diamond and why do you keep talking about him?
• “...the primary consideration in optimizing the likelihood of a successful induction is related to the degree to which the individual who is about to undergo hypnosis can be helped to achieve a sense of safety.” (Kluft, 2016, summarizing Diamond, 1984, 1987)

Getting Better Results

• Induction is invariably imbricated within a situational, expectational, and relational therapeutic matrix. Within that therapeutic matrix, induction requires the formation of a specialized helping alliance (Luborsky & Crits-Cristoph, 1990) designed to facilitate treatment by harnessing the focusing power and other useful characteristics of trance. What will be required to move toward the formation of this alliance and the attainment of its goals may vary tremendously depending on the unique characteristics of the therapeutic dyad, what must be achieved to lay the foundation for the overall success of the treatment in an optimal manner, and the particular nature, stressors, goals, and demands of each unique therapeutic encounter. Beyond technique, induction inevitably involves and/or elicits expectancies and elements of the transference, the therapeutic alliance, and the real relationship within the therapeutic dyad. Some argue that it initiates another way of relating, unique to hypnosis.

Getting Better Results

• Rather that go with the rather mystic notions of fusion that infect hypnosis and psychoanalysis, I recommend using the selfobject concept to approach this. Those who are more empathically resonant and respond to the predominant selfobject hungers and concerns are going to make their patients feel safer.
What Does One Do to Provide the Selfobject Functions that Provide Safety?

- Wait longer, learn more, and by more accurate understanding, minimize the patient’s chance of failures and shame.
- Load the Dice and Stack the Deck – Always Individualize, Mobilizing Talents and Preferences (Strauss’ Apple Technique)
- Follow the process. Learn from Luborsky’s CCRT.

What Does One Do to Provide the Selfobject Functions that Provide Safety?

- Be sensitive to how you change when you begin to do an induction.
- Do not impose your sense of the passage of time on the patient.
- Be congruent with a model of helping congenial to your patient (Brickman)

What Does One Do to Provide the Selfobject Functions that Provide Safety?

- Brickman et al. (1982) distinguished four models of helping classified by patterns of attribution of responsibility for a problem (who is to blame for a past event) and attributions of responsibility for a solution (who is to control future events).
What Does One Do to Provide the Selfobject Functions that Provide Safety?

- In the medical model, individuals are neither held responsible for their problems nor for the resolution of their problems. They need to receive treatment. In the moral model, individuals are held responsible for both their problems and the solutions of their problems. People need motivation. In the enlightenment model, individuals are seen as responsible for their problems, but need help from responsible others to find and implement solutions to those problems. They are understood to need discipline. In the compensatory model, individuals are not held responsible for their problems, but are held accountable for the solution of those problems. People need the knowledge that provides them with tools and capability to do what needs to be done.
- Efforts to bring the patient into accord with the therapist’s values, however enlightened, are essentially coercive even if their goal is to be permissive.

Other Elements

- Affective Concerns
- Relational Components
- Self Psychological Components
- What About BYOT Inductions (Coasting on autohypnotic or spontaneous trance phenomena)?

Cynical Sidenote

- Many people who take hypnosis courses stop trying to use hypnosis in their practices after a few efforts that fail.
- This is probably because their formulaic efforts do not respect the individuality of the patient, and are doomed to failure.
Specific Techniques

• Most may be used with or without formal induction, depending on the circumstances.
• However, often they work best if first taught with formal induction, leaving a suggestion that formal induction will not be needed in the future.
• Some are far better with formal induction.

ACCESSING ALTERS

• TO A CERTAIN EXTENT, EVERY REQUEST TO SPEAK TO AN ALTER MAY BE SEEN AS A HYPNOTIC SUGGESTION
• AS A TECHNIQUE, A PARTICULAR ALTER OR THE ALTER ASSOCIATED WITH SOME EVENT IS ASKED TO EMERGE.
• OFTEN OTHERS MUST BE PUT ASLEEP OR ELSEWHERE, OR A SAFE PLACE CREATED.

ALTER SUBSTITUTION

• ONE ALTER IS ASKED TO ASSUME EXECUTIVE CONTROL, REPLACING ANOTHER FOR SOME CONSTRUCTIVE REASON; I.E., THE ALTER WHICH IS “OUT” IS FALING, DYSFUNCTIONAL, OR INAPPROPRIATE TO THE CIRCUMSTANCES.
• THE MOST IMPORTANT ASPECT OF THIS TECHNIQUE IS THE NEGOTIATION OF WHO WILL REPLACE WHOM.
RECONFIGURATION

• RECONFIGURATION IS THE PROCESS OF REARRANGING THE INNER WORLD AND/OR OUTER WORLD COMPLEMENT OF ALTERS TO ACHIEVE BETTER FUNCTION OR ACHIEVE A CERTAIN OBJECTIVE.

• IT IS DONE IN CONJUNCTION WITH OTHER TECHNIQUES USEFUL IN STABILIZATION; I.E., PROVISION OF SANCTUARY AND BYPASSING EFFORTS

IDEOMOTOR SIGNALING

• OFTEN ABUSED FOLKS FEEL UNABLE TO TALK ABOUT THINGS, BUT CAN GIVE SIGNALS WHICH WERE NOT EXPLICITLY FORBIDDEN.

• OFTEN IT IS USEFUL TO GET INFORMATION WHICH OTHERWISE WOULD NOT BE ACCESSIBLE.

• FOR PEOPLE WITH SEVERE FEARS OF LOSS OF CONTROL OR NOT YET READY TO HANDLE INFORMATION DEEMED NECESSARY FOR OTHER PURPOSES, GLOVE ANESTHESIA INCLUDING PROPRIOCEPTION MAY BE USEFUL.

• WHICH STYLE OF IDEOMOTOR INQUIRY?

PROVISION OF SANCTUARY

• DOWN TIME IS ESSENTIAL FOR COHORTS IN COMPLEX SYSTEMS

• SANCTUARY FOR CHILD PARTS MAY BE ESSENTIAL TO DIMINISH “NOISE” AND CHAOS IN THE SYSTEM

• TWO MODIFICATIONS OF USUAL SAFE PLACE EFFORTS ARE:
  – MAKE SURE SEVERAL ALTERS CAN INITIATE
  – ALLOW A VARIETY OF SAFE PLACES FOR DIFFERENT TYPES OF APPREHENSION
BYPASSING/ATTENUATING INTENSE AFFECT

• Metaphors which indicate unsettling materials and/or affect can be sequestered;

• Images which can be permuted, such as rheostats and dials, are useful to help patients learn to dial down discomfort.

SLOW LEAK TECHNIQUES

• These suggestions convert a feared lack of control and mastery, the irruption of dysphoric materials and affects into an experience of mastery by suggesting that the feared phenomena will occur in an orderly manner as predicted; i.e.,

• The three mile island scenario

CURTAILING ABRECTIONS

• These interventions allow a potentially out-of-control abreaction to be channeled and contained.

• Example: When one anticipates the abreaction will take too long, one suggests whatever needs to come through to achieve stability will do so in X minutes, and then count it down.
FRACTIONATED ABREATIONS

- THESE INTERVENTIONS WILL BE DISCUSSED LATER IN THE PROGRAM.

GATHERING HISTORICAL INFORMATION

- SOME WOULD HOLD THAT SOME DEITY SHOULD STRIKE YOU DEAD FOR DARING TO DISCOVER OR FERRET OUT MORE THAN THE GIVEN HISTORY.
- LITIGIOUS PRESSURES HAVE COMPROMISED THE USE OF THESE TECHNIQUES.
- THAT IS WHY I EMPHASIZE THE IMPORTANCE OF LEARNING TO ABLATE SHAME, WHICH OFTEN BRINGS OUT SUCH MATERIAL.

TIME SENSE ALTERATION

- IT IS VERY OFTEN HELPFUL TO PSEUDO-ORIENT IN TIME;
- TO SLOW DOWN THE EXPERIENCE OF TIME; OR
- TO SPEED UP THE EXPERIENCE OF TIME.
- EXAMPLE: A PATIENT IS NEEDING MORE TIME TO COMPLETE AN ABREACTION, AND IS HELPED TO EXPERIENCE TIME SLOWING DOWN, ALLOWING MORE TO BE PROCESSED IN THE TIME AVAILABLE.
DISTANCING MANEUVERS

• These techniques allow mastery via mild derealization and depersonalization and cognitive reframing.
• They include screens, split screen, other visualizations which can be permuted in a way that supports the treatment.
• Caveat: Multiples’ inner realities

FACILITATING INTEGRATIONS

• All interventions which promote co-consciousness, co-presence, empathy, cooperation, communication and collaboration facilitate integration between or among the alters involved.
• Example: Bringing two alters to the surface for a shared non-conflictual activity.

TEMPORARY BLENDINGS

• Suggesting that two alters flow together to pool resources in order to accomplish some task in therapy and life.
• Commonly, a more mature and strong part will blend with a child alter.
• Caveat: This technique is part of an overall approach and can be dangerous out of context.
INTEGRATION RITUALS

• IMAGERY OF JOINING, BLENDING, MERGING.
• NOT OF DEPARTURE, DEATH, SUBTRACTION, EXORCISM, ETC.
• INDIVIDUALIZATION IS CRUCIAL AND COOKBOOK TECHNIQUES ARE PROBLEMATIC.
• EXAMPLES: STAR TREK MISSION, DREAM PONIES, STREAMS COALESCING, EMBRACE, DANCE

RECHECK PROTOCOLS

• THE USE OF IDEOMOTOR SIGNALS TO SCREEN FOR THE PRESENCE OF RELAPSE PHENOMENA, DANGEROUS ISSUES BELOW THE SURFACE, SPONTANEOUS INTEGRATIONS, ALTERS’ EFFORTS TO EVADE TREATMENT, ETC.
• A CRUDE BUT EFFECTIVE WAY OF MONITORING TREATMENT ISSUES.

SYMPTOM RELIEF/SUBSTITUTIONS

• SUGGESTING SUBLIMATED OR ATTENUATED EXPRESSIONS OF DISRUPTIVE OR DANGEROUS SYMPTOMS
  – RUBEL’S GAMBIT – THE PARALYZED ARM REPLACING THE INFLICTION OF BLUNT HEAD TRAUMA
  – KLUF'T’S STUDY OF MYSTERIOUS ORBITAL FRACTURES
TEACHING AUTOHYNOSIS

• USEFUL INTERVENTION OR CARRYING COALS TO NEWCASTLE?
• THE RISK OF CREATING A DOUBLE-EDGED SWORD
• BENEFITS OF PARTICULAR SELF-SOOTHING OR CONTAINING EFFORTS
• ILLUSTRATION OF ABUSES OF SELF-HYPNOSIS

SUPPRESSIVE MEASURES

• THESE WILL BE MENTIONED BECAUSE OF THEIR HISTORICAL INTEREST.
• THEIR USE IS ALMOST COMPLETELY CONTRAINDICATED
• SEE RELATED BUT MORE WORTHY AGGRESSIVE TECHNIQUES TO APPRECIATE THE CONTRAST.

TRANCE RATIFICATION

• AN AMAZINGLY HELPFUL TECHNIQUE OR CLUSTER OF TECHNIQUES.
• GLOVE ANESTHESIA WILL BE USED TO ILLUSTRATE WHAT CAN BE DEVELOPED FROM A RATIFICATION EXERCISE.
RELAPSE PREVENTION

• THESE INDIVIDUALIZED TECHNIQUES ARE ABBREVIATED INTEGRATION RITUALS CUSTOMIZED FOR USE WHEN A PATIENT FEELS HIS OR HER STABILITY IS SHAKEY.
• EXAMPLE: AN INTEGRATED WOMAN WHO WITNESSED SEVERE ANIMAL ABUSE – HOW SHE COPED

Building on Basics

• Glove Anesthesia-
  – Transfer Anesthesia by Touch
  – Transfer Anesthesia by “Circulation”
  – The Special Case of Private Hurts
  – Transformation to Manage Psychological Pain
  – Transformations to Manage Dysfunctional Erotic Arousal
  – Installing a Safeguard

STAGE 1 GOALS (KLUFT 1 & 2)

- Mutual Voluntary Participation
- Pragmatic Arrangements
- A Facsimile of Trust
- Aspects of Safety
- The Treatment Frame
- The Therapeutic Alliance (See Next Slide)
- Self-Psychological Interventions
- Demonstration of Expertise
- Dealing with the Diagnosis
- Dealing with Concerned Others
STAGE 1 GOALS (KLUFT 1 & 2)

- Ego Strengthening and System Strengthening
- Begin Character Work
- Offering Symptomatic Relief
- Hypnosis with an Emphasis on Temporizing Techniques

“PROGNOSIS ELEVATION”

- CURRENTLY, I AM MAKING STRENUOUS EFFORTS TO ENHANCE THOSE FACTORS ASSOCIATED WITH GOOD PROGNOSIS IN MY CURRENT PATIENTS.
- PRELIMINARY RESULTS ARE GRATIFYING, BUT MAY BE AN ARTIFACT OF INCREASED ATTENTION, ETC.

ANTICIPATORY SOCIALIZATION

- REVEAL WHAT IS LIKELY TO TRANSPIRE
- THE GENIE CANNOT BE PUT BACK INTO THE BOTTLE
- PAIN, MORTIFICATION, NEGATIVE TRANSFERENCE
WHAT WILL THE TREATMENT DO TO MY LIFE?

■ HELP THE PATIENT ANTICIPATE THE IMPACT OF THE TREATMENT ON CONCERNED OTHERS.

■ WORK OUT HOW COMMUNICATION, IF ANY, WILL BE ARRANGED BETWEEN YOU AND THE CONCERNED OTHERS.

ALLOWING THE THERAPIST TO THINK

THE PATIENT WANTS TO BE BELIEVED, AND WILL ASK TO BE BELIEVED AS A PRECONDITION OF TREATMENT AND/OR OF TRUST.

IT IS THE THERAPIST’S TASK TO HELP THE PATIENT APPRECIATE THAT HE OR SHE IS USUALLY BEING ASKED TO BELIEVE AND DISBELIEVE AT ONCE. AN ATMOSPHERE OF FREE EXPLORATION IS CRUCIAL.

MAPPING, OR, “PRIMUM NON NOCERE,” DID STYLE

• THE HAZARDS OF ACTION OR PROCESS WITHOUT PLANFULNESS
• MAPPING THE SYSTEM
• APPRECIATING THE ALLIANCES
• LEARNING WHICH ALTERS LIVE IN WHICH REALITY, AND WHEN
• LEARNING THE RULES OF ENGAGEMENT AND THE TERMS OF ENDEARMENT
METHODS OF MAPPING

• CROSS-REFERENCING
• MAPPING BY REQUESTED REPRESENTATION (FINE, 1991)
• INSCAPE VISUALIZATION OR PRODUCED REPRESENTATION
• GRADUAL ASSEMBLAGE OF INFORMATION

MAPPING ISSUES

• USES AND ABUSES OF REPEATED MAPPING
• THE ROLE OF THE THERAPIST IN PROMOTING MAPPING
• POST-PRODUCTION ASPECTS OF MAPPING
• MY PERSONAL TECHNIQUE – PERMITS CHRONOLOGY ASSESSMENT ALSO

THE MYSTERY OF HISTORY

• HISTORY-TAKING IS THE NARRATIVE EXPRESSION OF MAPPING
• HISTORY IS TAKEN MANY TIMES
  – INTAKE
  – ALTER BY ALTER
  – IN PREPARATION FOR ABREACTION
  – AMIDST ABREACTION
  – SYNTHESIS OF MULTIPLE NARRATIVES AND REALITIES.
### THE THREE REALITIES

- Autobiographic memory with all of its vicissitudes
- Autobiographic memory as distorted by post-event information, suggestions, input from others, contaminations, fantasies, the media (“ophragnostic influences”)
- Events in the inner world misperceived as events in external reality

### PREPARING THE PATIENT

- Achieve goals of Stage 1
- Prognosis enhancement
- Anticipatory socialization
- Informed consent

### Therapeutic Considerations Relevant to Traumatic Memory

- Dissociation and the unconscious
- “The Elsewhere Thought Known”
- Resistance or Reluctance?
- Shame scripts and unavailable memory
- Memory retrieval by reducing reluctance via shame management
- Potential sources of mental contents
Abreaction

- Spontaneous
- Facilitated
- Definitive (Exposure Model)
- Fractionated (Systematic Desensitization Model)
- What Makes an Abreaction Helpful?

Fractionated Abreactions - I

- Indications:
  A. Compromised Ego Strength
  B. Compromised Physical Strength and Endurance
  C. Intercurrent Stressors
  D. Logistic Constraints
- Goals:
  A. Minimize Regression
  B. Enhanced Mastery
  C. Self-Control of Spontaneous Abreactions and/or Flashbacks
  D. Cognitive Corrections

Fractionated Abreactions - II

- Dimensions Suitable for Fractionation:
  A. Temporal Sequences
  B. Percentage Titrations
  C. Input Divisions
  (BASK Dimensions)
  D. Alter Participants
  (sequentials, overflows, numbers, protectors)
PREPARING FOR EXasperation

• In spite of every preparation, the patient is unlikely to prove a trustworthy ally in the pursuit of truth.
• It does not matter how hard a patient claims to be working unless that work advances the therapy.

SuperEgo Lacunae - I

• These are the blind spots or escape clauses of conscience.
• Most traumatized people, but especially those with DID, are desperate to see themselves and to be seen as good and honest, but they have often developed ways, based on the psychology of the exception, to be good when bad.

SuperEgo Lacunae - II

• The apparent moral resolution is something like, “I will be honest.”
• However, a more nuanced reading would be, “I will be honest unless I or some part of me is afraid of what might be said or of the consequences.”
SUPEREGO LACUNAE - III

- The lapse in honesty is bypassed, or defended with rationales designed to make the therapist feel he or she is an insensitive brute unless he or she agrees with this version of honesty.
- The therapist often feels he or she is owed the truth, and angers. This reenacts being bullied to tell by an abuser, etc.

OBSTACLES TO PURSUING THE TRUTH

- Attachment needs and the terms of endearment trump the desire to recover, bargaining, superego lacunae, psychology of the exception, ongoing abuse, secondary gain, enactment of rescue scenario, purposeful cowardice, layering, deceit, object coercive doubting, endless equivocation, etc.

CLEARING THE DECK - I

- One of the crucial skills of the therapist involves the sheepdog principle, referred to above.
- One of its purest manifestations is demonstrated in the need to restrict the therapeutic field to those alters necessary and able to do a particular piece of work, and keep the others out of the action.
CLEARING THE DECK - II

- Sometimes such efforts are an intrinsic part of an overarching treatment paradigm, such as Fine’s (1991) model of tactical integrationalism or fractionation (Kluft, 1989).
- But often, certain parts are simply disruptive, such as Kid Parts.

KID STUFF - I

- A preoccupation with Kid Parts is a frequent cause of stalemate and therapeutic failure.
- A preoccupation with mother-child attachment and relational issues can dysfunctionally promote this.
- Putnam was right: the proper person to nurture Child alters is another alter, not the therapist.

KID STUFF - II

- A careful and ruthless examination of the DID patient’s contemporary distress often reveals that much of it is due, directly or indirectly, to Child alters being inappropriately involved in things, curious about things, intrusive about things, or trying to press to satisfy perceived needs.
KID STUFF - III

• KID PARTS ARE NOT KIDS
• THEY STATE A STANCE TOWARD THE WORLD WHICH MUST BE UNDERSTOOD
• REAL KIDS ARE EAGER TO GROW AND LEARN; KID PARTS RESIST DOING THIS
• KID PARTS ARE OFTEN PUT FORWARD DEFENSIVELY OR OBSTRUCTIVELY, OR TO STAKE A CLAIM FOR SPECIAL TREATMENT OR CONSOLATION (OGDEN’S TYRANNICAL TRANSFERENCE)

KID STUFF - IV

• IT MUST BE CONSIDERED THAT KID PARTS’ BEING PROMINENT IN TREATMENT DISGUISES THE FACT THAT THEIR ACTIVATION IMPLICITLY PAYS TRIBUTE TO AND REENACTS SUBSERVIENCE TO ABUSERS AND THEIR INNER REPRESENTATIONS.
• THE TREATMENT MUST MOVE “UP THE FOOD CHAIN” TO DISABLE THE ENTIRE PATTERN OF REENACTMENT.

KID STUFF - V

• THEREFORE, RATHER THAN REPAIR EARLY DYADIC DIFFICULTIES, FOCUS ON WORK WITH KID PARTS OFTEN REINFORCES THEIR HELPLESS AND DEPENDENT STATUS IN RELATIONSHIPS, AND EVEN THOUGH IT MAY ULTIMATELY HELP THEM GROW AND BECOME STRONG, IT IS USUALLY PROFOUNDLY INEFFICIENT.
KID STUFF- VI
• All too often chaotic affect and the appearance of decompensation and/or incipient psychotic symptoms are due to unrecognized and unacknowledged kid activities.
• Autism and Profound Childhood Psychosis and what it turned to be...

MISUNDERSTANDINGS AND SABOTAGE - I
• IT IS COMMONPLACE FOR THE THERAPIST’S EFFORTS TO EXPLAIN THINGS OR TO WORK TO ESTABLISH VARIOUS AGREEMENTS AND STRATEGIES APPEAR TO COME TO NAUGHT, WITH THE PATIENT EXPERIENCING HERSELF OR HIMSELF AS A WOUNDED INNOCENT WHOSE EFFORTS ARE UNAPPRECIATED AND CRITICIZED.

MISUNDERSTANDINGS AND SABOTAGE - II
• THE PATIENT BECOMES DEFENSIVE, HURT, ANGRY, SELF-ATTACKING, AND DESPONDENT ABOUT PROGRESS.
• THE ALERT THERAPIST MUST EXPLORE FOR SIGNS OF:
  – ALTERS UNEQUIPPED FOR TASKS THEY ARE DOING
  – SABOTAGE
FREQUENT FORMS OF SABOTAGE

• AUTOHYPNOTIC APPLICATION OF SUGGESTIONS TO FORGET THINGS, MISPERCEIVE THINGS, SEE ONE PERSON AS IF HE OR SHE WERE ANOTHER, ETC.
• PARTS "PROTECTING" BY THWARTING THERAPEUTIC EFFORTS PERCEIVED AS WRONG OR THREATENING.
• PRIORITIZING PROTECTING OTHERS.

TRANSITION TO "DIRTY WORK"

• THIS IS A PRESENTATION COMPLETELY BASED ON THE QUESTIONS I GET ABOUT HOW TO DO THIS TREATMENT.
• A FEW YEARS AGO, REVIEWING MY OWN COURSES AND THOSE OF OTHERS, I DISCOVERED THAT THERE WAS A DISCONNECT BETWEEN WHAT WAS CONSIDERED THE CORE MATERIAL TO BE CONVEYED, AND WHAT MIGHT HONE THERAPISTS’ SKILLS TO A HIGHER LEVEL.

WHAT IS "DIRTY WORK"?

DIRTY WORK IS CHARACTERIZED BY:
1. ITS FOCUS ON UNWELCOME EXPERIENCES AND THEIR RESIDUA
2. ITS ATTEMPT TO MINIMIZE THEIR LASTING IMPACT
3. ITS UNPLEASANTNESS AND POTENTIAL TO DISRUPT LIFE
4. ITS DISAPPROVAL BY MANY
5. ITS NECESSITY, REGARDLESS
## WHAT IS “DIRTY WORK”?

- DIRTY WORK INVOLVES WORK WITH MEMORY, AND PROCEEDS IN THE FACE OF ALL OF THE CONTROVERSIES AND DILEMMAS ASSOCIATED WITH THE STUDY OF MEMORY.
- ALMOST EVERY ASPECT OF DIRTY WORK INVOLVES DECISIONS IN WHICH CLINICAL CONSIDERATIONS MAY CONFLICT WITH THEORETICAL MODELS.

## IS THERE A RATIONALE FOR DIRTY WORK?

- LONG EMPIRICAL TRADITION OF RECOVERY AFTER PROCESSING OF TRAUMATIC MATERIAL
- EXPOSURE IS AT THE CORE OF SUCCESSFUL TRAUMA TREATMENT
- ACCEPTING THE REALITY OF TRAUMA AND ITS IMPACT MUST PRECEDE RESOLUTION OF GENERAL DYNAMICS
- PAUCITY OF CONTRARY EVIDENCE

## PRECONDITIONS FOR DOING THE DIRTY WORK

- PREPARING THE PATIENT
- PREPARING THE THERAPIST
- PREPARING THE “SURROUND” OF THE THERAPY
WHAT MATERIALS GO INTO THE DIRTY WORK?

- GIVEN BIOGRAPHICAL MATERIALS FROM ORIGINAL HISTORY
- GIVEN MATERIALS FROM ALTERS
- MATERIALS FROM EXPLORATION OF SYMPTOMS
- DREAMS, FLASHBACKS, FANTASIES, MATERIALS GIVEN BY THIRD PARTIES, ELICITED IMAGERY
- TRANSFERENCES AND ENACTMENTS

DOES THE MATERIAL HAVE TO BE TRUE?

• NO!!!!!!!
  • WE NEVER KNOW THE VERACITY OF MOST OF WHAT IS PRESENTED TO US!!!!
  • WE INTERVENE WITH WHAT IS DISRUPTIVE TO OUR PATIENTS.
  • I HAVE ONLY MET ONE COLLEAGUE WITH INVESTIGATIVE SKILLS – A FORMER COP!
    MOST OF US PRACTICE HUBRIS, NOT CAREFUL INVESTIGATION.

WHY DEAL WITH MATERIAL WHICH MAY NOT BE TRUE?

• IT MAY BE TRUE
• IT MAY BE A DERIVATIVE OF AN IMPORTANT DYNAMIC, AND PROCESSING IT WORKS THROUGH AN ESSENTIAL ISSUE BY PROXY
• IF FALSE MEMORIES IN FACT CAN BE GENERATED WHICH ARE REALISTIC AND PAINFUL, THEY TOO CAUSE DISTRESS AND REQUIRE PROCESSING.
### RATIONALE FOR WHAT WILL BE TAUGHT TODAY - I

- In a series of studies Kluft (1982, 1984, 1986, 1993) demonstrated that a treatment based on the vigorous processing of traumatic material and problematic adaptations could lead to stable integration.

### RATIONALE FOR WHAT WILL BE TAUGHT TODAY - II

- Cohorts of patients with stable integrations over 20 years in duration have been followed and documented.
- 89% of treatment adherent patients in such psycholytic psychotherapies reached stable integration (RX range 3 mo-34 yrs).

### WHY DO DIRTY WORK? - I

- To discover and detoxify expressions of the deleterious impact of the past upon the present in order to:
  - Remove impediments to healthy growth, repair, and intimacy
  - To remove mental land-mines
  - To make it possible to achieve continuity of autobiographic memory and identity
WHY DO DIRTY WORK? - II

- Those who reenact the past are condemned to live a life that is neither their own nor of their own choosing, forcing them to live controlled by the agendas and histories of those before them, be they abusers or trauma victims or both.

WHY DO DIRTY WORK? - III

- To render encumbered energy and strength accessible
- To make more accurate attributions, permit cognitive clarity, reasonable notions of responsibility, reduction of inappropriate guilt and shame (i.e., to identify and root out negative grandiosity, which defends abusers and trashes the self)
- The aggregate impact of the above permits the rebirth of hope and the recovery of future orientation.
- This permits spiritual renewal in those so inclined.

PSYCHOLYTIC, PALLIATIVE, AND SUPPORTIVE TREATMENTS

- Psycholytic treatments attempt to create major change which eradicates the psychopathology
- Palliative treatments plan to improve the patient’s lot with judicious less thorough changes
- Supportive treatments focus on safety and function
DIRTY WORK ISSUES - I

- Trauma treatment proceeds under the burden of a paradox.
- It is agreed that exposure is an essential aspect of recovery.
- Yet in some areas, concern over the veracity of what is addressed is privileged to override this finding.

DIRTY WORK ISSUES - II

- Paradoxically, we are asked to believe that all good trauma treatment findings are to be put on hold to serve another agenda.
- The dissociative disorders field often tries to bypass this hypocrisy by overemphasizing the importance of attachment.

DIRTY WORK ISSUES - III

- It is imperative to keep in mind that the caveats applied to trauma treatment for those whose alleged trauma involves sexual mistreatment are seldom, if ever, applied to work with different forms of alleged traumatization.
DIRTY WORK - IV

• IT IS HELPFUL, BUT NOT IMPERATIVE, TO REALIZE THAT MODERN RELATIONAL TRAUMA THINKING HAS DRIFTED FAR FROM BOWLBY’S INITIAL FOCUS.
• ATTACHMENT WAS BOWLBY’S ENTRY INTO RESEARCHING THE IMPACT OF REALITY. HE CHOSE IT BECAUSE TOO MANY DISMISSED HIS CONCERNS ABOUT THE REALITY OF REPORTS OF CHILDHOOD SEXUAL ABUSE (BOWLBY, 1991).

DIRTY WORK ISSUES - V

• AN EFFECTIVE TREATMENT OF THE IMPACT OF TRAUMA WILL NOT FLINCH FROM PURSUING AND WORKING ON DETAILS, EVEN ON DETAILS WHICH ARE REPUGNANT, GROSS, AND UNAPPETIZING.
• IT WILL REGARD ALL MANNER OF SECRETS, HOWEVER INVASIVE THEY ARE OF PERSONAL PRIVACY, AS “GRIST FOR THE MILL.”

DIRTY WORK ISSUES - VI

• YOUR DECISIONS ABOUT WHETHER AND HOW TO USE WHAT IS TAUGHT SHOULD BE MADE BEARING IN MIND YOUR OWN CIRCUMSTANCES.
ACCESSING THE SUBJECTS OF THE DIRTY WORK

- Although the stereotype straw man caricature is of the therapist aggressively excavating memories, it is more typical that memories emerge in connection with the exploration of disruptive symptoms in the here and now.
- In second place comes material that emerges during discussion or treatment of material already shared.
- In third place comes material from enactments and transferences.
- In a distant fourth place comes material which emerges from explorations.

ACCESSING THE SUBJECTS OF THE DIRTY WORK

- In my practice, most material initially comes through by virtue of shame reduction, and is elaborated by input from various alters, with projective open-ended imagery thereafter. Hypnotic and other more direct exploration is not frequent. Much comes up in EMDR on other subjects.

PROJECTIVE IMAGERY: PRO AND CON

- At times it becomes important or useful to push more directly.
- In doing this one gets more material very often, but, as with other material, the accuracy is not established. The more genuine risk is disrupted source monitoring; i.e., what is seen is believed to be historically correct.
THE BLANK SCREEN TECHNIQUE

• IMAGINE, IF YOU WILL, A BLANK SCREEN. AS I COUNT FROM ONE TO 10, PERMIT AN IMAGE TO DEVELOP, AN IMAGE THAT WILL OFFER US SOME INSIGHT INTO WHAT WE NEED TO KNOW TO CONTINUE TO HELP YOU WITH OR BETTER UNDERSTAND (YOUR PROBLEM). (COUNT) WHAT DO YOU NOTICE.

WHAT IS PROCESSING ATTEMPTING TO ACCOMPLISH?

• FOR OUR PURPOSES TODAY, IT IS CRUCIAL TO APPRECIATE THAT PROCESSING INVOLVES ASSEMBLING A NARRATIVE, WORKING THROUGH THE NARRATIVE, DETOXIFYING THE NARRATIVE, GRASPING THE MEANING OF THE NARRATIVE, AND REPAIRING COGNITIONS DISTORTED BY THE EVENTS/RELATIONSHIPS BEING PROCESSED.

WHAT DO MOST CLINICIANS FAIL TO ADDRESS IN PROCESSING?

• MOST OF US ARE GREAT WITH THE JIST AND SHY AWAY FROM THE DETAILS.
• THE DEVIL MAY BE IN THE DETAILS, BUT SO IS DELIVERANCE!
• EVERY SENSORY MODALITY MUST BE EXPLORED, OR ORPHAN SYMPTOMS MAY BE LEFT.
WHAT DO CLINICIANS FAIL TO ADDRESS IN PROCESSING

• CLINICIANS KNOW THAT PSYCHOLOGICAL SEQUELAE ARE THE MOST DEVASTATING IN MOST CASES, BUT FEW INQUIRE ABOUT THE VERBALIZED COMPONENTS OF THE TRAUMA EXPERIENCE, THOSE EXPRESSIONS OF DEPRECIATION AND HATRED WHICH ALL TOO OFTEN CONTAIN THE VERY CONTENT OF THE PATIENT’S REITERATED EXPRESSIONS OF SHAME, GUILT, AND SELF-HATRED. PROCESSING IS NOT COMPLETE WITHOUT THIS COMPONENT! PUSH FOR IT!

WHEN GOOD PRACTICE GOES BAD - I

• MANY CURRENT NOTIONS OF GOOD PRACTICE HAVE BEEN DEVELOPED IN THE CONTEXT OF “MEMORY WARS.”
• AS A RESULT, MANY USEFUL TECHNIQUES AND APPROACHES HAVE BEEN DISCARDED OR RECEIVED A BAD RAP.
• STRICT ADHERENCE TO GOOD PRACTICE CAN GENERATE STALEMATES AND FAILURES.

WHEN GOOD PRACTICE GOES BAD - II

• TO THE BEST OF MY KNOWLEDGE, I AM THE ONLY PERSON TO POINT OUT THAT SCRUPULOUS GOOD PRACTICE RE: MEMORY SUPPORTS THE EXISTENCE OF SECRETS IN THE PSYCHOTHERAPY, A PROBLEM KNOWN TO DEFEAT TREATMENT SINCE THE 19TH CENTURY.
• EXCESS MORBIDITY IS A RISK.
WHEN GOOD PRACTICE GOES BAD - III

• TRADITIONAL PRACTICE HELD THAT ASKING QUESTIONS IN EFFECT GAVE THE PATIENT PERMISSION TO SPEAK ABOUT AREAS WHICH MIGHT HAVE BEEN HELD BACK, AND TO EDUCATE THE PATIENT THAT ALL SUBJECTS, EVEN THOSE NORMALLY FORBIDDEN, WERE WELCOME IN THE TREATMENT.

WHEN GOOD PRACTICE GOES BAD - IV

• TRADITIONAL PRACTICE HELD THAT LEADING QUESTIONS WERE POWERFUL METHODS OF GIVING PERMISSION TO SPEAK THE UNSPEAKABLE BY PUTTING THEM INTO WORDS, E.G.,
  • THE WITHDRAWN GIRL – STONE (1989)
  • THE ADULT ONSET MULTIPLE – KLUFTH (2010)

WHEN GOOD PRACTICE GOES BAD - V

• TWO CASE EXAMPLES WILL BE GIVEN, FROM PATIENTS TREATED IN A "SQUEAKY CLEAN" MANNER RE: MEMORY WHO WERE BLOCKED IN TREATMENT WITH THE AUTHOR.
• THE INTERVENTIONS DE ARE NOT PRESENTED AS RECOMMENDATIONS, ONLY AS MATERIAL FOR DISCUSSION.
A WORD ABOUT “HAPPY ENDINGS” - I

• THE URGE TO PROVIDE THE PATIENT WITH MASTERY AND SURCEASE FROM HER/HIS SORROWS BEGETS A PRESSURE TO MODIFY TRAUMATIC SCENARIOS WITH THE GOAL OF PROVIDING THE PATIENT WITH RELIEF AND MASTERY.

• OFTEN ADVOCATED, ITS DOWNSIDE IS RARELY ACKNOWLEDGED.

A WORD ABOUT “HAPPY ENDINGS” - II

■ SUCH TECHNIQUES SHOULD BE USED SPARINGLY, IF AT ALL.
■ SUCH TECHNIQUES:
  ■ THERAPIST ASSUMES GOD-LIKE POWERS
  ■ CONVEYS AND PERMITS A DISRESPECT FOR HISTORICAL TRUTH, WHICH MAY BE GENERALIZED
  ■ ILLUSIONS OF SAFETY, MASTERY, AND OPTIMISM PROMOTE REVICTIMIZATION

A WORD ABOUT “HAPPY ENDINGS” - III

• WHEN IS A DISTORTION OF MEMORY APPROPRIATE?
  − WHEN NO DOWNSIDE RISK CAN BE IDENTIFIED
  − WHEN THERE ARE NO ADDITIONAL MAJOR MEMORIES STILL TO PROCESS, WORK WITH WHICH MIGHT BE CONTAMINATED. ERGO, RARE IN DID!
  − CONSTRUCTIVE EXAMPLE (COURTESY OF EDWARD J. FRISCHHOLZ, PH.D.)
Sources of Traumatic Materials

- Autobiographic Memory (First Reality)
- Impacted Autobiographic Memory, Influenced by Distortions, Fantasies (Spontaneous and Guided), Misperceptions, Transferences, Projections, and Contaminations (Second Reality)
- The Third Reality

Working with Traumatic Materials

- The Readiness of the Patient
- Consideration of Possible Contraindications
- The Sources of Traumatic Materials
- Working with Material of Uncertain Veracity

Is the DID Patient Ready to Work on Traumatic Material?

Basic Considerations
1. Voluntary Cooperation
2. Rational Motivation
3. Life Circumstances: Stressors, Crises, and Supports
4. The Status of Comorbid Conditions
5. Ego Strengths
6. Achievement of Goals of Treatment Phases 1-3
7. Appropriate Progress by DTMI Indices
8. The Therapist’s Readiness and Skill Acquisition
9. Logistics

Unusual Considerations
10. The Unstable Patient
Considerations of Possible Contraindications

- Failure to Achieve Preconditions for Trauma Work
- Therapeutic Objectives with Higher Priorities Require Attention
- Work Would Require Techniques Contraindicated for Other Reasons
- Personality System Unstable
- Cost/Benefit Ratio Unacceptable
  - 1. In View of Family/External Reasons
  - 2. Other Concerns
- Toxic Agendas

Approaches to Materials of Uncertain Veracity

- Typical Topics the Are Received by the Therapist as Material of Uncertain Veracity
- Defensive Functions of Sincere Allegations of Uncertain Veracity
- The Importance of Informed Consent as a Process
- The Top-Down Approach to Material of Uncertain Veracity
  - Typical Therapeutic Pathways with the Top-Down Approach:
    1. Once Put Aside, Such Allegations Fail to Resurface
    2. Once Put Aside, Such Allegations Reemerge after Processing More Mundane Materials
    3. The Material Cannot Be Put Aside

Abreaction

- Spontaneous
- Facilitated
- Definitive (Exposure Model)
- Fractionated (Systematic Desensitization Model)
- What Makes an Abreaction Helpful?
ABREACTION (I)

- Abreaction, the release of strong emotions in connection with an experience or perception, usually a past experience or perceptions of a past experience and its implications, has a long and venerable history in the mental health sciences. It is often regarded as a basic aspect of psychotherapeutic processes.

ABREACTION (II)

- There is controversy over whether the affect expressed during an abreaction has somehow been retained and stored from past experiences somewhere in the mind and/or body and had not been expressed, or whether that affect is generated in connection with revivifications and/or contemporary perceptions of what is being recalled or reflected upon.

ABREACTION (III)

- In an era prioritizing cognitive aspects of mental functioning, many theoreticians and clinicians have become uncomfortable with abreaction as a clinical phenomenon, an aspect of treatment, and an important aspect of understanding the healing of the human mind.
ABREACTION (IV)

- FOR OUR PURPOSES TODAY, IT IS CRUCIAL TO APPRECIATE TWO MAIN CONCEPTS:
  - 1) ABREATION WITHOUT STRUCTURE, PREPARATION, COGNITIVE CORRECTIONS, AND SAFETY IS CONTRAINDICATED AND POTENTIALLY RETRAUMATIZING.
  - 2) THE MOST COMPELLING REASON FOR PLANNED ABREATIONS IS TO AVOID THE RISKS OF SPONTANEOUS ABREATION.

Special Acknowledgment

- I have worked for over 30 years in close association with an amazing colleague to whom I owe a profound debt of gratitude.
- Catherine G. Fine, Ph.D., and I developed a great number of ideas and techniques together. In particular, she played a major role in developing The Fractionated Abreaction Technique, and has published her own version of this approach.
- Catherine G. Fine, Ph.D., also was my own role model for conceptualizing treatment sans hospital.

Fractionated Abreactions - I

- Indications:
  A. Compromised Ego Strength
  B. Compromised Physical Strength and Endurance
  C. Intercurrent Stressors
  D. Logistic Constraints

- Goals:
  A. Minimize Regression
  B. Enhanced Mastery
  C. Self-Control of Spontaneous Abreactions and/or Flashbacks
  D. Cognitive Corrections
Fractionated Abreactions - II

- Dimensions Suitable for Fractionation:
  A. Temporal Sequences
  B. Percentage Titrations
  C. Input Divisions
    (BASK Dimensions)
  D. Alter Participants
    (sequentials, overflows, numbers, protectors)

Fractionation Subtypes


- Kluft (2012, 2013) Full Approach Published

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STRUCTURING THE SESSION ON TRAUMA

• SPONTANEOUS ABRACION IS HIGHLY PROBLEMATIC, USUALLY OCCurring AS A SESSION NEARS ITS END, UNFORCED, BUT UNCONTROLLABLE, IT IS BOTH CLEANER AND DIRTIER THAN PLANNED ABRactive WORK.
• IT PRECLUDES THE APPLICATION OF KLUFT’S RULE OF THIRDS.

KLUFT’S RULE OF THIRDS

• IF YOU PLAN TO DO TRAUMA WORK, BE SURE TO HAVE IT WELL UNDER WAY BEFORE THE END OF THE FIRST THIRD OF THE SESSION SO THAT YOU CAN PROCESS THE TRAUMA IN THE REMAINder OF THE FIRST THIRD AND DURING THE SECOND THIRD, RESERVING THE THIRD THIRD FOR PROCESSING, REVIEW, AND REStabilization.
STRUCTURING THE SESSION ON TRAUMA

• The most important outcome of a trauma session is not the work that is done. It is the patient’s leaving the session safe, stable and not dissuaded from continuing the trauma work.
• When in doubt, discretion should trump going for the gusto.

MODELS OF TREATMENT AND THEIR INFLUENCES

• Strategic Integrationalism
• Tactical Integrationalism
• Ego State Therapy
• Adaptationalism

IMPLICATIONS OF MODELS

• Strategic Integrationalism will bring whatever is dealt with into the entire mind; ongoing stressors
• Tactical Integrationalism will work with alters and within like clusters of alters, delaying the stressing of most alters as long as possible.
IMPLICATIONS OF MODELS

• EGO STATE MODELS WILL WORK WITHIN NEGOTIATED PATTERNS
• KLUIT’S "COMMUTER MODEL" INVOLVES BOTH WORK IN CLUSTERS, AS IN TACTICAL INTEGRATIONALISM, AND PERIODIC UPDATING AND HARDENING OF THE ALTERS NOT ACTUALLY DOING THE TRAUMA WORK.

ESTABLISHING THE GROUNDWORK - I

• IS THERE GENERAL CONSENT FOR THE WORK TO BE DONE?
• ARE OBJECTING ALTERS’ CONCERNS ADDRESSED?
• ARE INTRUDING HERE AND NOW CONCERNS COMPELLING ENOUGH TO POSTPONE PLANNED TRAUMA WORK?

ESTABLISHING THE GROUNDWORK - II

• WHICH ALTER OR ALTERS WILL DO THE WORK?
• WILL RELATED OTHERS KEEP THEIR DISTANCE?
• WILL THOSE WHICH ARE NOT WORKING LISTEN IN, OR BE PROTECTED FROM THE IMPACT OF THE WORK?
ESTABLISHING THE GROUNDWORK - III

- HOW WILL YOU PROTECT/BUFFER THE OTHER ALTERS?
- WILL THE PROTECTION BE SET UP FOR THE ALTERS OR DELEGATED TO THE ALTERS?
- HOW WILL YOU RECHECK THE EFFECTIVENESS OF THESE ENDEAVORS?

SEDUCTION AND POWER

- IT IS IMPERATIVE THAT WHAT WE CONSIDER TRAUMA MAY NOT HAVE BEEN EXPERIENCED AS TRAUMA EITHER FOR A PERIOD OF TIME OR BY SOME ALTERS, OR BOTH.
- IT IS BEST TO ASSUME THAT ALL FORMS OF LOVE MAY HAVE BEEN, AND MAY CURRENTLY BE, EXPERIENCED TOWARD THE ABUSER.
SEDUCTION AND POWER

• Furthermore, over time transformative rationalizations may have supervened, making it imperative that we approach the understanding of such situations with open minds and without preconceptions and without assuming that all connectedness is “attachment.”

GETTING TO THE MATERIAL

• How do you get to the material which needs to be processed?
• One issue is ascertaining the nature of the material that resides within the realm of gathering history.
• The second is how to bring it into the session.

BEGINNING TO PROCESS

• While cleaner, spontaneous trauma processing runs the risk of going out of control and recruiting myriad traumata and their disruptive forces.
• The outcome of a previous negotiated discussion; e.g., “We had agreed to talk about X today…”
BEGINNING TO PROCESS

• Sometimes conversation suffices
• Usually, it does not
• The patient usually will begin to experience stronger affect, and can be encouraged to permit the feelings to emerge

BEGINNING TO PROCESS

• The patient can be asked to allow the memories to come back, and guided into experiencing the associated emotions
• Conversely, the patient can be asked to experience the affect, and to follow it back to the scene in question

BEGINNING TO PROCESS

• Since did patients are highly hypnotizable, it is possible that an hypnotic age regression will occur without instruction, or will plunge deeply into a revivification. In such cases the patient may be reliving the past, and duality must be monitored.
BEGINNING TO PROCESS

• OF COURSE, HYPNOSIS COULD BE USED TO ACCESS THE MEMORY AND AFFECT VIVIDLY

• IF EMDR IS USED, IT IS ESPECIALLY IMPORTANT NOT TO ALLOW THE PROCESSING TO OCCUR WITHOUT PROTECTING MOST PARTS FROM THE PROCESS

PUSHING THE PROCESS TO CONCLUSION - I

• THE PROCESS IS PUSHED GENTLY AND SLOWLY.

• IT IS RARE FOR TRAUMATIC MATERIAL TO BE PROCESSED IN A DIRECT LINEAR FASHION

• MORE TYPICALLY, TRAUMA IS METABOLIZED SLOWLY, IN BITS, ANALAGOUS TO PASS AFTER PASS, AS TOLERATED, WITH MANY A HALT AND MORITORIUM.

PUSHING THE PROCESS TO CONCLUSION - II

• WHILE DRAMATIC PROCESSING AND ABREATION MAY TAKE PLACE, IT IS NOT THE NORM OR IDEAL. THIS IS ESPECIALLY THE CASE WITH COMPLICATED AND/OR PROLONGED SCENARIOS, OR SCENARIOS INVOLVING OR TOUCHING UPON THE CONCERNS OF SEVERAL ALTERS.
PUSHING THE PROCESS TO CONCLUSION - III

- OFTEN ONLY SO MUCH CAN BE TOLERATED, AFTER WHICH A MORITORIUM AND RECOVERY IS IMPERATIVE.
- DO NOT EXPECT A SINGLE EFFORT TO PROCESS WILL BE SUFFICIENT
- IT IS MORE COMMON FOR MATERIAL TO BE WORKED WITH RECURRENTLY FROM TIME TO TIME THAN PROCESSED FROM BEGINNING TO END.

PUSHING THE PROCESS TO CONCLUSION - IV

- PRESERVATION OF SAFETY AND STABILITY ALWAYS IS JOB #1
- MANY CLINICIANS WORK TO KEEP THE ALTERS INVOLVED IN DAY TO DAY FUNCTIONING AWAY FROM THE TRAUMA WORK FOR LONG PERIODS OF TIME, USING VARIOUS STRATEGEMS

PUSHING THE PROCESS TO CONCLUSION - V

- THE WORK TO BE DONE IS NEGOTIATED ACROSS THE ALTER SYSTEM TO MINIMIZE THE CHANCE, OF DISRUPTION, BAIL-OUT, AND SABOTAGE.
- UNLESS THE PATIENT IS STABLE, STRONG, AND SKILLED, AND THE TRAUMA SCENARIO KNOWN, DOING TRAUMA WORK IN SESSION AFTER SESSION IS USUALLY AVOIDED.
PUSHING THE PROCESS TO CONCLUSION - VI

- In general, a session involving painful work would not be followed by another such session.
- My personal rule is that when trauma work has been mastered, when a patient generally reveals little material per session, some work each session may be possible.

PUSHING THE PROCESS TO CONCLUSION - VII

- With others, it is rare for me to consider trauma work in more than two out of five sessions.
- Furthermore, when material emerges more frequently or patients push to do too much too quickly, I take aggressive steps to shut things down.
PUSHING THE PROCESS TO CONCLUSION - VIII

• HENCE THE AXIOM, THE SLOWER YOU GO, THE FASTER YOU GET THERE.
• FEWER DISRUPTIVE MOMENTS AND DECOMPENSATIONS MEAN LESS TIME FOCUSED ON CRISSES
• STABILITY AND PATIENT SAFETY DICTATE THE PACE, BUT.......

PUSHING THE PROCESS TO CONCLUSION - IX

• EXCEPTIONS DO OCCUR:
  – IMMINENT DANGER TO SELF AND OTHERS
  – IMMINENT IRRUPTIONS OF FURTHER MATERIAL AND AFFECT WHICH THE THERAPIST ANTICIPATES MAY DECOMPENSATE THE PATIENT; I.E., WHEN THE THERAPIST AND/OR PATIENT “CAN SEE IT COMING” AND WANT(S) TO PREEMPT THE ANTICIPATED CRISIS.

PUSHING THE PROCESS TO CONCLUSION - X

• MATERIALS MAY NOT CEASE TO BE PROBLEMATIC UNTIL ALL BASK DIMENSIONS HAVE BEEN EXPLORED, ALL INVOLVED ALTERS HAVE PROCESSED IT, AND ANALOGOUS TRAUMATA HAVE BEEN ADDRESSED.
PURSUING SYMPTOMATIC BEHAVIOR

• WHAT IS BEHIND IT? WHAT IS IT ALL ABOUT?
• WHO IS BEHIND IT? WHAT ARE THEY (YOU) TRYING TO SAY?

TO PUSH OR NOT TO PUSH – THAT IS THE QUESTION!

• GIVEN THE NATURAL RELUCTANCE AND RESISTANCE AND THE MAJOR DEFENSES IN PLAY, AND THAT ALTERS OPPOSE ALMOST EVERY REVELATION OF EVERYTHING, IT IS ASTONISHINGLY OPTIMISTIC AND UNREALISTIC TO ASSUME THAT THE TREATMENT CAN PROCEED USING ONLY WHAT IS FREELY GIVEN IN AN UNCONFLICTED MANNER.

WHY PUSH SO HARD FOR CONSCIOUSLY-AVAILABLE MATERIAL TO BE SHARED?

• CONFRONTING PSEUDO-INCAPACITY AND DECLARATIONS OF HELPLESSNESS
• WHAT HAS BEEN WITHHELD IS ALREADY KNOWN: THE RICHER YOUR CAPACITY TO UNDERSTAND WHAT IS FREELY GIVEN, THE LESS YOU NEED TO MAKE INTRUSIVE INQUIRIES.
**WHY PUSH SO HARD FOR MATERIAL STATED TO BE UNAVAILABLE (I)**

- WHAT IS REPRESENTED AS UNAVAILABLE MAY BE AVAILABLE, AND OFFERED --
  - IF THE THERAPEUTIC ALLIANCE IS REINFORCED OR SUPPORT OFFERED
  - IF ALTERS PROHIBITING SPEAKING ARE MOLLIFIED

**WHY PUSH SO HARD FOR MATERIAL STATED TO BE UNAVAILABLE? (II)**

(Continued)
- IF ALTERS AWARE OF IT DECIDE TO SPEAK, THE REQUEST MAY TRIGGER A RESPONSE.
- IT MAY BE POSSIBLE TO TAP INTO “THE ELSEWHERE THOUGHT KNOWN.”
- IT MAY BE POSSIBLE TO TAP A STREAM OF INFORMATION DISSOCIATED BUT NOT IN ALTERS.

**WHY PUSH SO HARD FOR MATERIAL STATED TO BE UNAVAILABLE? (III)**

- OFTEN KNOCKING ON THE DOOR GENERATES A BELATED RESPONSE AS THE BALANCE OF RESISTANCE CHANGES
- IT REMAINS PREFERABLE TO HAVE MATERIAL OFFERED WITHOUT DELIBERATE RETRIEVAL METHODS
CONSTRUCTIVE CONCLUSIONS - I
• OBEY KLUFT’S RULE OF THIRDS
• IF IN DOUBT WHETHER WHAT IS COMING UP CAN BE MANAGED IN THE TIME AVAILABLE, SHUT IT DOWN!
• CONSIDER HYPNOTIC TECHNIQUES TO DISTORT TIME EXPERIENCE AND TO PUSH OUT THE AFFECT THAT MUST BE PUSHED OUT TO ACHIEVE STABILIZATION.

CONSTRUCTIVE CONCLUSIONS - II
• GROUNDING IS A PATHETICALLY INADEQUATE CONCEPT! IT CREATES A FALSE SENSE OF RESTORED CONTROL.
• KLUFT (2013) ADVOCATES NOT JUST GROUNDING (CRUDE REORIENTATION) BUT ALSO TRUNCATING AND TERMINATING
  – TRAUMA PROCESSING
  – TURMOIL AND TREPIDATION
  – TRANCE

BRINGING SESSIONS TO CONSTRUCTIVE CONCLUSIONS
• THIS IS THE MOST IMPORTANT PART OF EVERY SESSION.
• FAILING THIS ACHIEVEMENT, THE PATIENT WILL BECOME INCREASINGLY PHOBIC, DISTRUSTFUL OF TREATMENT, AND PRONE TO TRIGGER DISRUPTIVE REGRESSION AND OUT OF CONTROL NEGATIVE TRANSFERENCES
Session Closure

- The most important achievement of any session is for the patient to leave in a stabilized condition.
- “Grounding” is a limited concept
- For more reliable closure and restabilization:
  - The Terrible Ts
    1) Truncate and Terminate Trauma Processing
    2) Truncate and Terminate Turmoil and Trepidation
    3) Truncate and Terminate Trance

Truncate and Terminate Trauma Processing

- Interruption (Beck, 1986)
- Implicit or Explicit Rain checks
- Interruptions and Eliciting Others’ Comments/Feedbacks
- Directive Countdowns if Necessary
- Alter Doing Processing Steps Back and Enters Restorative Situation or Therapeutic Sleep
- Time Distortion
- Screen Manipulations
- Slow Leak Suggestions
- Protective Barriers

Truncate and Terminate Turmoil and Trepidation

- Placing the affected alters and dysphoria outside the mainstream of daily life.
  - Realistic reassurance
  - Compass of Shame work
  - Safe Places, Diversions, Inactivations
  - Scans, ideomotor and alter system
  - Vaults and Time Locks
  - Reconfigurations
Truncate and Terminate Trance

- Up to 85% of high hypnotizables who state that they are out of trance in fact remain somewhat entranced or in waking hypnosis (Kluft, 2012).
- Therefore, a therapist’s impression or a patient’s statement may not be accurate.
- While such concerns have been trivialized, a review of the characteristics of a person in trance may be informative.

Characteristics of a Person in Trance

- “Of additional importance to the clinical encounter with dissociative patients is a phenomenon little noted outside the field of hypnosis: Highly hypnotizable individuals are vulnerable to slipping into alert trances in which, with eyes wide open, they manifest many of the qualities of the more formally and traditionally hypnotized subject. That is, they may demonstrate (among other phenomena) a decline in their generalized reality orientation (Shor, 1959) a reduction in the alertness and activity of their critical intellect, a toleration of mutually incompatible perceptions without reacting to their incompatibility (trance logic; Orne, 1962), the intensification of affect, rapid mobilization of transference phenomena, and an increased responsiveness to suggestions.” (Kluft, 2012)

A Clinical Dilemma with Ethical Dimensions

- Would you want your patient, your loved ones, or yourself to walk out into the world and conduct your life with those vulnerabilities in place?
- Because passive permissive methods of realtering are in vogue, it is important to understand that recent research (Kluft, 2012) has demonstrated that they don’t work well.
- Directive methods are far more successful.
But...

- How do you get a person out of trance, when the state of hypnosis has yet to be defined in a way that is generally accepted?
- How do you know that you are out of what it is hard to be sure that you are or were in?
- Enter another former student of mine, now a colleague, Hedy Howard, M.D., who studied hypnosis with Peter Bloom, M.D., and now practices in the Washington, DC area. She solved a problem that had puzzled and stumped hypnosis scholars since the time of Mesmer.

Howard Alertness Scale - I

- **Howard Alertness Scale**
  
  1. Pre-hypnosis:
  - We are going to measure how alert you are at this time. This will be measured on a scale from one to ten. On this scale one represents a very low level of alertness, and ten represents a very high level of alertness.
  - To help you assess your level of alertness you will be asked to pay attention to the different ways that you perceive your environment, and also to the way that you are thinking.
  - Take a moment now to notice how awake and alert you feel at this time. Gather information from all your senses:
    - Look around you and notice the various things that you see. Notice how the image appear and the clarity, the color. Notice the sounds around you and the quality of whatever you hear. Notice the feelings in your body including the feeling of the chair against your body and the feeling of your feet against the floor.
    - Notice how connected you feel to your body and how aware you are of your surroundings
    - Notice how present you feel in this time and place.
    - Notice how clearly and logically you are thinking, and how your mind moves from thought to thought as you focus on different things around you.

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    - Notice how present you feel in this time and place.
    - Notice how clearly and logically you are thinking, and how your mind moves from thought to thought as you focus on different things around you.
Howard Alertness Scale - II

- On a scale from 1 to 10, where one is very low, 2 is low, 5 is medium, 9 is high, and 10 is very high, find the number that best describes how alert you feel right now.
- (Circle subject's level of alertness)
- 1 2 3 4 5 6 7 8 9 10
- very low low medium high very high

2. Post-hypnosis

- On a scale from 1 to 10, where one is very low and 10 is very high, what number best describes how alert you feel right now?
- (Circle subject's level of alertness)
- 1 2 3 4 5 6 7 8 9 10
- very low low medium high very high

A Suggestion

- This modification (Kluft, 2011) is being considered for inclusion in the revised HAS.
- Ask the subject to note an experience in each of several sensory modalities or senses of self, and to scale them.
- On recheck, see if all of those have returned to baseline.
- This is more concrete, and more subjects give candid and useful answers.

PATHWAYS TO INTEGRATION

- Gradual Merging
- Facilitation of Merger by Hypnosis Using Imagery and Suggestion
- Spontaneous Sudden Merger
- Individual Alterns Decided to Cease Separateness
- Brokered Mergers and Departures within the Alter System
- Building on Temporary Blendings Toward Firm Merger
RESOLUTION

- A Functioning Outcome Short of Integration
- Resolution May Include Elements:
  - Functional DID
  - Some Integration
  - Tag-Teaming
  - Alter Inactivation
  - Withdrawal into Inner Worlds/Alternate Realities
  - One-Alter Predominance
  - Blended Functioning
  - One-Plus Variations