RUNNING HEAD: TREATMENT OF TRAUMATIC MEMORIES

The Treatment of Traumatic Memories in Patients with Complex Dissociative Disorders

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Abstract

Patients with complex dissociative disorders have different prototypical dissociative parts of the personality. One prototype is a part that engages in daily living, while trying to avoid traumatic memories. Another prototype is a part fixated in these memories, i.e., sensorimotor and highly affectively charged reenactments of traumatic experiences, including mammalian defensive reaction patterns regarding perceived or actual threat. Prone to autohypnosis, dissociative patients are generally amenable to the use of hypnosis as an effective therapeutic intervention when embedded in a phase-oriented treatment--the current standard of care. In the initial stabilization phase, the dissociative parts(s) involved in daily living are strengthened, the dissociative part(s) fixed in traumatic memories are contained, and their phobias of each other are largely overcome. The second phase involves overcoming the phobia of traumatic memories and their subsequent integration. This treatment phase usually alternates with additional periods of stabilization. The therapist ensures that confrontation with traumatic memories will not exceed the patient's capacity to integrate these reenactments, so that the patient can transform them into narrative, autobiographical memories.

The Treatment of Traumatic Memories in Patients with Complex Dissociative Disorders

"First of all, we must not forget that the actions requisite for dispelling traumatic memories, the actions which will achieve liquidation, are often difficult and costly."

Pierre Janet (1919/25, p. 697)

According to the current standard of care, the treatment of traumatic memories of patients with complex trauma-related disorders, including dissociative identity disorder (DID) and dissociative disorder not otherwise specified (DDNOS), involves a phase-oriented treatment approach (e.g., Brown, Scheflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Gelinas, 2003; Herman, 1992; Kluft, 1993, 1997b; Steele, Van der Hart, & Nijenhuis, 2001, 2005; Van der Hart, Nijenhuis, & Steele, 2006/2008). Phase-oriented treatment has its origins in the pioneering work of Pierre Janet (1898a, 1919/25), who described three phases in the overall treatment: (1) stabilization and symptom reduction; (2) treatment of traumatic memories; and (3) personality (re)integration and rehabilitation (Van der Hart, Brown, & Van der Kolk, 1989). The model takes the form of a spiral, in which these different treatment phases can be alternated according to the needs of the patient (Courtois, 1999).

In this article our focus is on Phase 2, treatment of traumatic memories. We will describe this treatment in terms of integration, which encompasses synthesis and realization. As stated above, Phase 1 work is prerequisite. Therefore, we describe some basic initial stabilization approaches necessary before the treatment of traumatic memories is considered. We place our discourse on treatment in the context of the theory of structural dissociation of the personality.

Traumatic Memory and Structural Dissociation of the Personality

Traumatic memories relate to a dissociative organization of the patient's personality across the spectrum of complex trauma-related disorders. An understanding of this organization, i.e., the structural dissociation of the personality in trauma, is essential to the successful treatment of these memories. As described in previous works (cf., Nijenhuis, Van der Hart, & Steele, 2002, 2004; Steele et al., 2001, 2005; Van der Hart et al., 2006/2008), we understand that in trauma, the patient's personality is unduly but not completely divided among two or more psychobiological subsystems. These subsystems are overly rigid in their functions and too closed to each other, resulting in adaptive compromise. One prototypical personality subsystem is called the Emotional Part of the Personality (EP; Myers, 1940). As EP, the patient is fixated in sensorimotor and highly emotionally charged reenactments of traumatic experiences, including action tendencies of defense against perceived or actual threat. That is, EP is fixated in traumatic memories. The other prototype is called the Apparently Normal Part of the Personality (ANP; Myers, 1940), which is fixated in avoidance of traumatic memories and often of inner experience in general, and which focuses on the functions of daily life. As ANP the patient may appear "normal," but has negative symptoms of detachment, numbing, and partial or complete amnesia for the traumatic experience, and experiences intrusions from EP. The undue division of the personality into a single ANP and a single EP represents *primary structural dissociation,* and characterizes simple posttraumatic dissociative disorders, including PTSD. Dissociation between ANP and EP prevents the integration of traumatic memories and blocks their transformation into narrative autobiographical memories.

As the description of primary dissociation indicates, trauma-related structural dissociation is not random, but likely develops along evolutionary prepared psychobiological action systems that guide adaptive mental and behavioral actions (Lang, 1995; Panksepp,

1998; Van der Hart et al., 2006/2008). One major action system is defensive in nature and involves a variety of efforts to survive imminent threat (Fanselow & Lester, 1988). The defense action system is geared toward escape from and avoidance of aversive stimuli, and includes subsystems such as flight, freeze, fight, and total submission (Porges, 2001). Other action systems are concerned with functions in daily life (Panksepp, 1998). These systems include energy regulation, attachment and care-taking, exploration, social engagement (Porges, 2001), play, and reproduction, and involve approaching attractive stimuli (Lang, 1995). Personality is intimately related to action systems, and their integration is a developmental task (Nijenhuis & Den Boer, 2009; Van der Hart et al., 2006). The integration of the action system of defense and the action systems of daily life, i.e., the action systems for approaching attractive stimuli, is a major challenge, particularly when the action system of defense is strongly and recurrently activated because of chronic abuse, and when the survivor's integrative capacity is limited. In this context, the action systems for avoidance of aversive stimuli and approach of attractive stimuli may become sequestered and organized within alternating and competing subsystems of the survivor's personality, i.e., ANP and EP.

EP is predominantly mediated by the animal-defensive system in fixated action tendencies in the face of perceived or actual threat (Nijenhuis, 2004; Van der Hart et al., 2006/2008). EPs have an involuntary, rigid, and extreme narrowed attentional focus, primarily concentrated on perceived threat that is over-interpreted in light of the traumatic past. EP develops a rudimentary (e.g., as seen in acute and simple PTSD) or more elaborated and autonomous idea of self (e.g., as seen in Complex PTSD, DDNOS, and DID). Each ANP and EP is also typically fixated in a particular insecure attachment patterns that involves either approach or defense in relationships (Steele, Van der Hart, & Nijenhuis, 2001). The resulting alternation or competition between relational approach and defense among these parts is a substrate of what has been called a disorganized/disoriented attachment style (Liotti, 1999).

The resolution of traumatic memories, by definition, involves (a degree of) resolution of this insecure attachment style.

When traumatizing events are increasingly overwhelming and/or prolonged, further division of the EP may occur, while a single ANP remains intact. This *secondary structural dissociation* may be based on the failed integration among relatively discrete subsystems of the action system of defense, e.g., fight, flight, freeze, collapse. We consider secondary structural dissociation to be mainly relegated to Complex PTSD and DDNOS, the most common form of dissociative disorder encountered in clinical practice.

Finally, tertiary dissociation involves not only more than one EP, but also more than one ANP. Division of ANP may occur as certain inescapable aspects of daily life become saliently associated with traumatizing events such that they tend to reactivate traumatic memories. The patient's personality becomes increasingly divided in an attempt to maintain functioning while avoiding traumatic memories. This further division of ANP tends to occur along different action systems of daily life. For example, when a DID patient had a child from her stepfather when she was 16 years old, she developed a second ANP that experienced herself to be the mother. This second ANP was mediated by the action system of attachment and care-taking, and raised the child. Meanwhile, the patient as the original ANP had a job and primarily was mediated by the action system of energy management, social engagement, and exploration. She did not believe that she had a child. Tertiary structural dissociation refers only to patients with DID. In a few DID patients who have an extremely low integrative capacity and in whom dissociation has become strongly habituated, new ANPs may evolve merely to cope with the minor frustrations of life. Dissociation in these patients has become a lifestyle, and their prognosis is generally poor.

In cases of early and severe neglect and abuse, there is a very early developmental pathway to structural dissociation that involves hindrance of a natural progression toward integration of discrete behavioral states (Putnam, 1997; Siegel, 1999) that are mediated by different action systems. The sense of self is still highly state-dependent in the infant (Wolf, 1990), and it is within positive and secure interaction with caretakers that young children begin to acquire skills to sustain, modulate, and integrate relatively discrete behavioral states (Putnam, 1997) and of their respective action systems. Thus, in early and chronic traumatization, sets of rudimentary, nonintegrated mental and behavioral states of an infant that are mediated by different action systems can remain unintegrated and become increasingly rigid and closed to each other within the organizational system of the personality as a whole. This can result in persistently unintegrated psychobiological subsystems. These rudimentary subsystems of the personality eventually gain varying degrees of elaboration and autonomy, becoming ANPs and EPs.

Structural dissociation of the personality is predominantly maintained by a series of phobias that characterize trauma survivors and by relational factors (Nijenhuis et al., 2002; Steele et al., 2001, 2005). Janet (1904) described the core phobia as the *phobia of traumatic memories*, which consists of an avoidance of full realization of the trauma and its effects on one's life. Increasing behavioral and mental avoidance, including dissociation of the personality, is needed to prevent what are perceived as unbearable realizations about self, others, and the world. Subsequently, ever-encompassing phobias ensue from this fundamental phobia. Phobias can be maintained by reflexive beliefs such as: "I will go crazy if I start to feel;" or "The abuse did not happen to me;" "It was my fault;" "It was no big deal." Overcoming this complex of phobias and other ways of raising the survivor's mental efficiency (i.e., level of mental functioning) and mental energy levels are essential to

successful treatment. Table 1 presents an overview of these trauma-related phobias as they are approached in the respective treatment phases.

Phase 1: Stabilization and Symptom Reduction

A necessary precursor to treatment of traumatic memories involves (an often lengthy period of) stabilization and development of more adaptive reflective functioning, emotion regulation, and relational and life skills (Brown et al., 1998; Courtois, 1999; Gelinas, 2003; Kluft, 1997b; Linehan, 1993; Ogden, Minton, & Pain, 2006; Steele et al., 2005; Van der Hart et al., 2006/2008). Treatment begins with ANP(s) and those EPs that are intrusive and interfering with life and therapy, and focuses on raising the integrative capacity or mental level these parts of the personality. Patients are supported in overcoming a series of trauma-related phobias that include: (1) relational phobias of closeness, abandonment, loss, and rejection, particularly in regards to the therapist; (2) phobia of mental actions that generate inner experiences (i.e., mental contents) such as emotions, body sensations, thoughts, images, fantasies, wishes, and needs; and (3) phobia of dissociative parts (which have their own rigid mental actions and implied mental contents that may be unacceptable to other parts). Phobic avoidance of (particular) mental actions and contents, especially conflicted or intense emotions and related sensations prevents adaptive confrontation of traumatic memories, and thus must be addressed early in treatment. Since the lack of integration of dissociative parts (ANPs vs. EPs; different EPs regarding each other) is at the root of persistent traumatic memories, it is essential to help the patient overcome the phobia of dissociative parts prior to working with traumatic memories. Phase 1 treatment also helps patients learn to identify and cope with conditioned trauma-related stimuli of both external (e.g., environmental, relational) and internal (e.g., affect, intrusion of EPs) origin. It provides a therapeutic frame for managing the reactivation of EP(s) resulting from these stimuli, and modulation of responses to them. Thus in Phase 1 the patient as ANP is supported in progressing toward normal

functioning within a frame of growing recognition of EPs and cooperation among dissociative parts (Kluft, 2006; Van der Hart et al., 2006/2008), and developing an optimal mental level that will make Phase 2 possible.

A systems approach is essential in working with dissociative parts, and thus with traumatic memories. Every intervention should first and foremost be directed toward improving the adaptation of the individual as a *whole psychobiological system*. To this end, there are several stepwise levels of systemic work. The first line of intervention is generally with the entire personality, and includes techniques such as "talking through." The next usual step is to promote interactions among particular parts, e.g., ANP and EP. It is essential to engage the different dissociative parts in active work with each other, in order to diminish the rigidity and closure among them, otherwise the patient will abdicate the work to the therapist, which only serves to further maintain his or her dissociative organization. The patient as ANP can be encouraged to gradually accept and listen to other parts and to begin to meet their needs. If the previous step is not possible, the therapist may temporarily work with an individual part for the purposes of grounding, orientation to the present, regulation, and correction of major cognitive distortions. Then gradually other parts of the patient are encouraged to begin working with each other to continue to promote systemic adaptation.

Overcoming phobias of mental actions and of dissociative parts implies that patients must learn more adaptive ways to cope with feared or shaming stimuli. Here we mention those therapeutic techniques that have special value for Phase 2. Hypnosis has a special value in the treatment of dissociative patients (e.g., Kluft, 1994, 1999; Ross, 2000), as they are moderately to highly hypnotizable and often engage in autohypnosis, including trance states and trance logic.

ANP's most avoided mental actions typically involve the reactivation of traumatic memories and associated sensory experiences, affects and beliefs. In Phase 1, dissociative parts can learn how to protect themselves temporarily from these highly upsetting memories by using *safe or quiet place imagery*, i.e., images of a place where they feel safe and protected, or, if the concept and experience of safety are still unknown to them, a place where they feel at relative ease. Parts may share such places or have one of their own. The installation of positive resources with techniques such as EMDR (e.g., Gelinas, 2003; Twombly, 2000), or hypnosis (e.g., Hammond et al., 1988) is helpful in gradually increasing the integrative capacity for all dissociative parts of the personality. Various combinations of hypnotic and EMDR techniques that promote stabilization can be helpful if the therapist is thoroughly trained in both modalities (e.g., Beere, Simon, & Welch, 2001; Fine & Berkowitz, 2001). Patients may also be taught containment imagery such as bank vaults, computer storage, and the like (e.g., Brown & Fromm, 1986; Kluft, 1993; Sachs & Peterson, 1996; Van der Hart et al., 1993, 2006/2008). Such imagery enables them temporarily to "store" traumatic memories or other threatening inner experiences. These techniques support patients in learning the difference between maladaptive avoidance and healthy pacing and timing that is within their control. Overcoming the phobia of dissociative parts should result in cooperation and collaboration among parts, with gradual development of internal cooperation and empathy. The creation of an *imaginary meeting place* (Fraser, 1991; Krakauer, 2001) or *imaginary intercom* or *other communication system* (if direct meeting is too threatening) can be helpful in fostering such cooperation. Some parts may be advised under certain circumstances to recuse themselves from such meetings and withdraw to their safe or quiet place when, for the purpose of Phase 2 work, traumatic memories are discussed. Other hypnotic techniques include inner sleep or rest for particular overwhelmed parts, and time distortion (hypnotic extension of moments of rest or calm or feeling present).

These and related techniques for coping with intense affect and promoting manegeable interactions among dissociative parts involve the strategic use of the patient's dissociative and hypnotic capacities while simultaneously raising the patient's integrative level to the point where dissociative parts can acknowledge each other's existence, their conflicts, and their respective needs. For example, fostering internal communication and cooperation among two or more dissociative parts through assignments to plan and carry out tasks of daily life together becomes feasible when dissociative parts know how to share certain inner experiences while containing others, and when those parts can each be focused on the present moment. Phase 1 interventions also include psychoeducation, imaginary and behavioral rehearsal of positive resources (e.g., relaxation skills, structuring daily activities, energy management, promotion of somatic resources such as grounding, and facilitation of expressive movements; Ogden et al., 2006). Still other interventions include modification of substitute beliefs—i.e., maladaptive beliefs that substitute for more difficult mental actions--by enhancing reflective thought and experimental testing of trauma-related ideas that are not adaptive in the present. Finally, development of a flexible, warm, and well boundaried therapeutic relationship is essential in the early phase of treatment, as is work on other current relationships, such that a degree of earned secure attachment may be achieved gradually (e.g., Fosha, 2003; Kluft, 1993, 1997; Steele et al., 2001, 2005; Van der Hart et al., 2006/2008).

(Contra-)Indications for Phase 2 Treatment

Phase 2 may be initiated when integrative capacity has been raised to the extent that ANP(s) and key EPs are able to function more or less adequately in the present, or can at least maintain a reasonably stable relationship with the therapist, can tolerate and regulate arousal, and have developed a degree of inner empathy and cooperation. Contraindications to Phase 2 include the absence of any of the above criteria, as well as current and ongoing interpersonal abuse; ongoing substance abuse or other self-destructive behaviors; current acute external life

crises or times when extra energy and focus is needed in normal life; extreme age, physical or terminal illness; psychosis; any severe characterological problems that interfere with the basic therapy process; and uncontrolled switching among ANPs and EPs (Boon, 1997; Kluft, 1997a; Steele & Colrain, 1990; Steele et al., 2001; Van der Hart & Boon, 1997). The goals of stabilization may be achieved rather quickly in high-functioning patients, but will be time consuming (usually a number of years) in patients that are less functional. Although many of these goals may eventually also be achieved within the group of patients with the least favorable prognosis, Phase 2 work usually continues to seriously destabilize them. In some extremely difficult cases, complete stabilization is not often achieved, and Phase 1 work remains the final goal of treatment. In all cases, patients should have informed consent about moving into Phase 2 treatment.

Countertransference and the Treatment of Traumatic Memories

Therapists can be susceptible to two countertransference positions in relation to dealing with traumatic memories (Van der Hart & Steele, 1999). First, they may develop undue fascination with the content of, and a counter-phobic attitude toward the patient's traumatic memories. This may result in undue and premature focus on traumatic memories, and neglect of the development of essential daily life and emotional skills. Second, therapists may over-identify with the patient's lack of realization, colluding to avoid dealing with traumatic memories at all. Therapists should assiduously examine their motivations and how these intersect with standard of care interventions and therapeutic process.

Some persisting myths about the treatment of traumatic memory remain common among therapists untrained in standard of care trauma work, and can lead to disastrous consequences. These are often based on a fundamental misunderstanding of dissociation and integration. For example, the therapist may not grasp the idea that one dissociative part can recall and re-experience a memory, while another remains completely distant and

depersonalized, resulting in some patients, after years of "memory work" to continue to be dissociated. Or he or she may believe that extreme emotional intensity is a mark of healing, whereas it may actually promote ongoing dissociation due to the patient's inadequate integrative capacity. Finally, the therapist may not grasp that remembering is not sufficient in itself, but rather it is the sometimes long and difficult work of *realization* after recall that is the real key to resolution of traumatic memories.

Phase 2: Treatment of Traumatic Memories

The major goal of Phase 2 work is the integration of traumatic memories, which involves synthesis and realization, rendering dissociation unneccesary. The manner in which this goal is achieved, and the techniques used may vary considerably from patient to patient, as dissociative individuals are a quite heterogenous group. What works well for one patient may be disastrous for another in terms of dealing with traumatic memories. Thus therapists must be flexible in their approaches to the treatment of traumatic memories and collaborate with each individual patient regarding what is most effective.

Regardless of the path to integration, it always includes engagement in previously avoided or unattainable integrative mental actions. First, the principal elements of the traumatic experience must be synthesized, i.e., *shared* among ANP(s) and EP(s), and shifted to a symbolic verbal (narrative) account that is not depersonalized, but is a genuine autobiographical narative. *Guided synthesis*—described in more detail below--is an intervention that consists of graduated *exposure* to a particular traumatic memory, prevention of maladaptive mental and behavioral reactions, and promotion of sharing and acceptance of traumatic memories among various dissociative parts. Once the patient has synthesized the traumatic memory, *guided realization*, another integrative therapeutic intervention, can follow. Guided realization includes the promotion of two additional mental actions, i.e., personification and presentification. *Personification* is the mental action of making one's

personal experience one's own. *Presentification* involves being mindfully present, while remaining aware of the context of one's past and future, leading to adaptive actions in the present. Eventually, the patient as a whole has realized that the event happened and is now over, that the actual present is different from the past and far more real, and that the event has had, and may continue to have certain consequences for his or her life. The patient can make a coherent and flexible narrative of the memory while being present in the moment and without sensorimotor reliving. This narrative must be further integrated within and across each part of the personality.

Over the course of treatment flexibility of mental and behavioral actions gradually develops among previously rigid dissociative parts. As a more fluid and less dissociative personality system is developed, and as dissociative parts become better oriented to the present, there is less need to remain fixed in defensive actions and other automatic reactions to triggers. And even if the individual should face future stressful events, he or she may be able to engage in more effective and adaptive responses. It is vital that the patient understand the key principle of gradual acceptance of EPs and ANP(s) as parts of the same personality, and that each part is responsible to and for all other parts. Otherwise, the patient might use the therapist as a "babysitter," for instance, or expect the therapist to get rid of, punish, or control various dissociative parts instead of taking personal responsibility for their actions, which afterall, are the patient's own.

The chronic alternation of action systems of attachment and defense related to an abusive caretaker is the basis of insecure attachment patterns that are prominent in traumatized individuals (Liotti, 1999; Nijenhuis et al., 2002; Van der Hart et al., 2006/2008). By definition, the resolution of such insecure attachment patterns involves synthesis of relational trauma with those who have hurt the patient. Relational interventions for EPs are geared toward modification of their defensive reactions (e.g., freeze, flight, fight, collapse) in

response to current contact with previous perpetrators, or in reaction to people in the present which they misperceive as threatening. Some EPs are fixed in attachment cry, in which they cling needily and persistently return to contact with the perpetrator, no matter how egregious his or her behavior toward the patient. Interventions for these dissociative parts of the personality are embedded in a context of earned secure attachment with the therapist. In addition, EPs fixed in various susbsystems of defense should become more cooperative and empathic with one another. For example, a submissive EP can begin to have communication and cooperation with a fight EP that can protect this part. However, much work must occur with fight EPs before they can actually protect with empathy and cooperation, as noted in Phase 1.

Overcoming the Phobia of Traumatic Memory.

This is one of the most difficult phobias to overcome, requiring high and sustained integrative capacity of ANP(s) and EP(s). Careful pacing of therapy and regulation of the patient's hyper- and hypo-arousal is crucial to success. Contraindications to initiation of this phase should be strictly followed. The lower the patient's integrative capacity and energy, the slower this step of treatment, with frequent returns to Phase 1 interventions. As noted above, a key healing mental action is integration of traumatic memories, involving their synthesis and realization. Graduated guided synthesis is a modulated and controlled therapeutic intervention, in which the patient as a whole, or some selection of dissociative parts are helped to remain oriented in the present while simultaneously synthesizing the traumatic memory (Van der Hart & Steele, 2000), i.e., its cognitive, sensorimotor, affective, and behavioral components. Although expressions such as *controlled abreaction* or *abreactive work* are often used to describe this intervention in the dissociative disorders field (e.g., Fine, 1993; Kluft, 1988, 1994; Putnam, 1989; Ross, 1989), we prefer the term *synthesis*, which emphasizes the integrative nature of the mental actions involved and which avoids the

suggestion that the expression of vehement emotions in itself is of therapeutic benefit (Huber, 2003; Van der Hart et al., 1993; cf. Van der Hart & Brown, 1992, for a critical analysis). Guided synthesis is preceded by an extentive preparation stage, and is followed by stages of realization and further integration.

Preparation. Careful preparation of guided synthesis maximizes the probability that the work proceeds within the window of the patient's integrative capacity. Thus the therapist and patient aim to prevent vehement emotions that are, by definition, outside the window of the patient's tolerance, and subsequent self-destructive behaviors. At times, it may be helpful to arrange for someone to drive the patient home after a planned synthesis session, and to be available for support afterwards. It may be necessary for the patient to take time off from work or other obligations, or at least plan a schedule that allows for reasonable rest and personal time. Planned extended sessions may be helpful, not to increase intensity and duration of experiences, but rather to more slowly titrate traumatic experiences, and to leave the patient with plenty of time to become re-grounded and fully re-oriented to the present. The patient should have a thorough understanding of the purposes and experience of integrating traumatic memories. Hypnosis may be used to control and support pacing, but only if the therapist is well-trained and the patient is accustomed to its formal use and has been given informed consent.

It is important in Phase 2 to identify and treat *substitute beliefs and behavioral actions* (Janet, 1945) of various ANPs and EPs. These beliefs and behaviors are low quality actions that are substitutes for adaptive action in the present. Cognitive errors and distortions, including substitute beliefs, should be identified and corrected to some degree in Phase 1, but some are only open to modification after synthesis. Substitute fantasies often involve rescue (by family or the therapist), the wish to undo the past and make the "real" past go away, the wish to abdicate responsibility and be taken care of, the hope for a magical cure, and the

"golden fantasy" that every need can be met perfectly by another person, and most obviously, the belief that dissociative parts do not belong to self. Each of these serves as a defense against integrating traumatic memories and the necessary grief that accompanies the work, and thus must be treatment targets prior to working with traumatic memories.

The substitute belief itself is less important than the non-realizations that it obscures (Janet, 1945; Van der Hart et al., 1993), but must be treated, nevertheless. Treatment first consists in identification of the reflexive beliefs ("My uncle was wonderful: I seduced him"; "I don't have to work because I am little"; "That's not my child: I am a single person and want to party," etc.). ANPs and EPs that hold maladaptive beliefs should gradually and gently be confronted by other parts that do not hold those beliefs, i.e., the patient should be directed to dealing with inner conflicted beliefs. For example, a survivor as an adolescent ANP wanted to have freedom and play, denying that she was a mother. She was gradually helped to experience empathy for other children, then for her "inner" child (EP). This led to synthesis of traumatic memories of her own mother physically abusing her when she was a child. She was able to accept the child EP as part of herself, as well as accept that she was now grown up and had an actual child that was hers as she integrated her history. An understanding of relevant facts and context of the abuse are required for eliminating substitute beliefs. For example, once a patient fully realized she had been alone as a very small child in the home of her uncle with no one to help her, and that he had used physical force to sexually assault her, she was able to relinquish the idea that she had seduced him. On the one hand, this significantly reduced her sense of shame, and on the other, led to a further painful realization of her extreme helplessness as a child, which she had assidously avoided.

There are several ways to approach guided synthesis, depending on the skills of the therapist and the needs of the individual patient. Some patients work most effectively by synthesizing memories with certain parts present while others are in a safe place and not

attending to the synthesis, while other find it more effective to synthesize with all parts present at a given time.

If possible, it is useful to prepare the patient by cognitvely exploring the general content of the traumatic memory, including its beginning and end, as well as particular aspects that are most threatening, known as *pathogenic kernels* (Van der Hart et al., 2006/2008) or *hot spots* (Brewin, 2003). This is often best done with those dissociative parts that can report the memory from a rather depersonalized stance without evoking a re-experience. Thus parts that are not yet ready to participate should have withdrawn to their safe places prior to a cognitive discussion of the event. Apart from content, planning focuses on decisions about which parts should initially participate, i.e., part(s) that hold aspects of the traumatic memory, parts with whom the traumatic memory can be shared, and parts that can fulfill a helping role—such as offering courage, structure or comfort--during or directly after the synthesis. Knowledge of the beginning and the end of the traumatizing events is particularly helpful in preventing patients from getting "stuck in the middle" during guided synthesis (cf., Sachs & Peterson, 1996).

However, there are many patients for whom such observing parts are not available or are unable to contain affect adequately. Patients who are unable to objectively share content prior to synthesis can be prepared by helping all parts explore worst case scenarios: "What is the worst thing that you could imagine you might have to deal with in regards to what you remember?; "If that happened, how could we both help you best deal with it?;" "What are some other things with which you might find difficult to cope?" Then the treatment approach might include "gathering" dissociative parts together, while the therapist first facilitates a strong feeling of connection and empathy among them (e.g., suggesting being close and holding hands together, in the same way a very loving and close family might grieve together, or suggesting that each part find his or her own comfortable position of just the right

closeness and distance from other parts, or instructing the patient to touch the tips of her fingers together as a metaphor for parts coming close together). Additional resourcing suggestions can be given, such as noting that each dissociative part has particular strengths (related to the particular action (sub)system mediating its actions), that being together makes each part stronger, that each part can share her own strengths with other parts and also draw upon their strengths. Then suggestions for connection with the safe present and the therapist can be made, and a slow introduction of the traumatic memory can commence, with frequent reminders for dissociative parts to remain together and in the present.

Guided synthesis. The essence of guided synthesis is that the therapist guides the involved dissociative parts in a series of short intensive experiences in which dissociated aspects of the traumatic memory are evoked and shared among dissociative parts. Synthesis is an effort of collaborative and controlled reactivation by the patient and the therapist. Not each and every detail of the traumatic memory need be shared. What is essential to share are the *pathogenic kernels*, i.e., the most threatening aspects of a traumatic experience, which the patient has avoided at all costs. The involved EPs share their respective experiences of the traumatizing event with each other, as well as with other specified parts—often but not always including ANP(s). There is discussion about and agreement between the patient and therapist regarding which life domains (e.g., work, parenting) and related dissociative parts should be protected from the current experience of synthesis, if necessary and possible. For some patients, however, Phase I work has been sufficient such that all dissociative parts can participate in synthesis simultaneously.

For synthesis to succeed, it is essential that the patient's level of arousal not become too high and that both patient and therapist have sufficient control: Panic, switching, and re-dissociation of the traumatic memory should be prevented. To this end, the therapist should explain that the trauma need not be re-experienced as the original overwhelming event, i.e., *it*

need not and should not be relived. Instead, arousal may be modulated, for instance, using some version of Subjective Units of Distress (SUDS, Wolpe, 1969). Dissociative parts are further instructed that they "need only experience that which is necessary to know, to understand, and to heal." Efforts to keep the patient grounded in the present and connected to the therapist are essential to the success of guided synthesis. It is helpful to redirect the patient's attention to his or her bodily experience and to the sound of the therapist's voice with some regularity during a synthesis session, away from the content of the memory, to support regulation and orientation to the present. Taking short rest periods between times of synthesis within a session also help. During these breaks the patient is encouraged to relax (e.g., "You can let go of all tension, breathing quietly and calmly, knowing you are safe in this time and this place"). The patient (and all parts involved in the synthesis) is encouraged to make relational contact with the therapist. Hypnotic suggestions for time distortion, such as experiencing the actual synthesis as much shorter than real time and experiencing the breaks in between as much longer than real time can be helpful. Various suggestions and imagery for healing may also be offered towards the end of the synthesis.

Synthesis can be done in a more encompassing and fast way or in a very gradual way, depending on the patient's integrative capacity and preferences.

Rapid guided synthesis. Van der Hart et al. (1993) described a rapid variant of synthesis. During a thorough preparation with an observing part of the personality an objective narrative account is constructed that includes pathogenic kernels. This account is divided into a number of segments, each accompanied by a number (e.g., from one to five, or one to ten). The therapist counts, and with each count relates to the patient a successive kernel of the traumatic memory, encouraging the parts involved to share their respective partial experiences with each other. Taken together, these experiences encompass the entire traumatic memory. Between each segment, the therapist suggests a break in which the patient

regulates her/his breathing and is grounded in the present. When the end of a round has been reached, the therapist may inquire about what percentage of the whole traumatic memory has been shared and which aspects still remain unshared. When unshared material still exists, another round can be negotiated.

Fractionated guided synthesis. This is a much more gradual approach in which the synthesis of one traumatic memory or one series of traumatic memories is divided into a number of smaller steps, which may encompass several or even many sessions (Fine, 1993; Huber, 2003; Kluft, 1988, 1990a, 1994; Sachs & Peterson, 1996; Van der Hart et al., 1993, 2006/2008). Such an approach is indicated when the patient's integrative capacity and anxiety tolerance are very limited, but the task of integrating a specific traumatic memory seems unavoidable (Kluft, 1990a). Variations of fractionated guided synthesis are endless. For instance, synthesis initially might be limited to the sensorimotor aspects, followed in subsequent rounds by the emotional aspects and cognitions (Ogden et al., 2006). Synthesis may be limited only one sensory dimension at a time, such as fear, pain, or anger, or might involve the sharing of only one EP's experience, or a specific time segment of the traumatic experience, etc. The therapist may structure the synthesis in shorter counts, for instance, five instead of ten counts, each one punctuated by suggestions for rest and comfortable breathing and connection with the therapist. Fractionated guided synthesis can also be paired with training in relaxation and calmness (Kluft, 1990a; Van der Hart & Spiegel, 1993). Finally, suggestions can be given for a very gradual or slow sharing of affect over time, e.g., 5% of the overall affect pertaining to a specific traumatic memory per day (Kluft, 1990b). Titrated synthesis may also occur with the use of EMDR and ample application of SUDS (e.g., Gelinas, 2003; Twombly, 2000). Indeed, when a cognitive framework and the preparations described above are applied, EMDR may be an effective approach for actual synthesis.

Containment. In general, any unshared aspects of a traumatic memory that remains after a seesion should be dealt with in a follow-up session. Precautions are taken that the memory does not overwhelm the patient in the meantime, e.g., by having it stored in an imaginary bank vault or by having dissociative parts agree not to share them with each other between sessions. However, it is often useful to have cognitive processing sessions interspersed between guided synthesis sessions, as there needs to be time and support for the patient to personalize and fully presentify the traumatic experience, as well as deal with ongoing issues of daily life. The patient should receive encouragement for the collaborative and hard work done thus far. Suggestions for comfort and management of feelings in between sessions are essential.

Guided realization. Synthesis alone is not sufficient for integration. In order for the traumatic memory to become a fully narrative autobiographical memory, it must be realized. We noted above that realization consists of two kinds of mental actions: *personification* and *presentification* (Janet, 1904, 1928; Van der Hart et al., 1993, 2006/2008). Realization involves much cognitive and affective work, particularly grieving of what was and what cannot be. When the patient can maintain these high level actions regarding a traumatic memory, he or she can remain in the present when giving a narrative of a traumatizing event, neither reliving it nor being depersonalized. Realization involves tremendous and very high level cognitive and affective work, particularly grieving, leading to acceptance of what is, and the capacity to change and adapt in the present.

Once enough work has been done in Phase 2 to allow the patient to gain higher overall integrative capacity, and the phobia of traumatic memory is no longer in the foreground, Phase 3 work can be initiated. Generally there is rather spontaneous movement back and forth into this phase, as the patient generally has an increasing desire to “get on with life” in the present. Joy and relief about progress alternates with renewed grief about losses suffered, as

realization grows. Grief therapy is an essential approach during all phases, but particularly in Phase 2 and 3, when full realization of losses occurs. With passage of time, however, episodes of grief gradually decrease in intensity and duration. "Survivors come to understand and accept that loss is an inevitable part of trauma, and that it is ultimately a lifelong task to assimilate the ebb and flow of re-experienced grief with equanimity" (Van der Hart et al., 1993, p. 173).

Case Example

The following case example illustrate the more encompassing, fast approach to synthesis.

The Case of Donna

Donna (not her real name) was a 39 year old patient with chronic depression, DDNOS, and complex PTSD. Her symptoms involved inability to recall the traumatizing event(s) around the age of four, and persistent somatosensory experiences that included stereotyped grimacing, shaking her head frantically back and forth, spitting and gagging, excruciating pain in her face and head, and waking up in her closet screaming and in panic. Previously she had been through five years of an intensive expressive and cathartic therapy in which she was encouraged to relive these experiences in the hope of retrieving eidetic memories, without success, and with significant decompensation over time. When she began therapy with one of the authors, the focus of treatment turned to a combination of medication management, psychoeducation regarding dissociation and the nature of traumatic memories, and intensive work on phobic avoidance of mental actions and dissociative parts, which had not been previously addressed. Thorough assessment revealed symptoms of DDNOS, and extreme shame about the existence of inner parts, which she had not shared with her previous therapist. Donna was convinced she was crazy, and weak for "failing" in therapy. These substitute beliefs and her tendency to attack herself and withdraw when ashamed were

vigorously addressed, with careful attention to building a safe therapeutic relationship. She was intelligent and curious, and found bibliotherapy quite helpful, particulary regarding the psychobiology of traumatization. Psychoeducation and reading significantly reduced her shame and fear regarding dissociative parts and her inner experiences. Gradually, Donna became more functional in daily life, and came to the conclusion that she did not have to know exactly what happened in order to resolve her past. However, she continued to have symptomatic episodes.

In preparation for traumatic memory work, Donna increased her awareness and acceptance of three inner parts: a terrified child in severe pain, a "dead" child, and an angry, cynical adolescent part. She provided a inner safe space consisting of a beach house with a special room for each part, and a porch on which parts could gather together. The therapist instructed her to practice imagining this safe space morning and evening, accompanied by progressive relaxation and soothing music that she chose.

Guided synthesis sessions, interspersed with more cognitive sessions, focued on the experience and beliefs of each of these three parts, beginning with the adolescent and moving to the younger ones. Sessions generally began with formal hypnotic induction and deep relaxation. The therapist instructed Donna to enter her safe place and check on each part. In a series of sessions, the therapist invited her to go the room of the "dead" child and sit with her quietly, gradually moving closer to her, taking her hand, talking soothingly to her. The therapist suggested that she look out the window to watch several animals playing and learning how to do things that helped them survive: foraging for food, play fighting, etc. Among them was a small oppossum, whose job was to practice "playing possum," that is, to play dead. Donna (with her psychobiological knowledge of the defense of collapse) watched with fascination as the possum "died" and came back to life over and over. It was suggested that once the "dead" child sensed she was safe, she also could come back to life. Time

progression was used to suggest the dead child move through the beginning, middle, and end of whatever had happened, to experience the minutes, hours, days, months, years, and decades of safety between what had happened and now. Donna spontaneously began crying and saying, "Poor little thing! I'm so sorry. You're safe now with me. I can take care of you. I didn't realize that you were stuck before the end of what happened!" The child part gradually moved a little, and over several months, did indeed "come to life" and experienced being in the present.

In another series of sessions, the therapist instructed Donna to take a single drop of experience from the terrified child part in pain, e.g., physical pain, sterotyped movemments, feeling of panic. The therapist suggested her to put the drop in a cup of steaming hot, soothing tea. As she sipped from the cup and felt the warmth go down and through her body, this drop was absorbed and her body adjusted to it, much like homeopathic medicine, which Donna utlized often. As she grew more tolerant over several sessions, more drops could be added to the tea. In addition, Donna and the child part were asked about "the antidote" best suited to a particular symptom. For example, stereotypic grimacing and spitting required a soothing mouth rinse and the taste of a sweet orange; head pain needed a soft pillow and cool cloth over the eyes and "lots of rest." In this way, each fixated experience could come to a completion. Donna began to accept and realize the experiences of this child part, even without clear memory of what happened. As she did, this part became more amenable to interactions with Donna over time, less fixed in traumatic memory, and more present. Although this part remained nonverbal, it was clear that her traumatic experiences were resolving. Over the course of two years, Donna integrated the three dissociative parts, and her intrusive symptoms completely abated. She believes that she was likely raped in a daycare setting at age 4, but is at peace with not having a clear memory. She returned to work, fully functional after 4 years of treatment.

Conclusions.

The presence of traumatic memories--as opposed to autobiographical, narrative memories of overwhelming events--indicates a dissociative organization of the personality. This organization involves at least one numb, avoidant part that is focused on daily life activities, and at least one part fixated in trauma, and in mammalian defense patterns in reaction to perceived or real threat. The treatment of traumatic memories is a difficult phase of therapy, requiring sufficient integrative capacity of the patient. It must be preceded by a most careful and thorough phase of emotional and life skills building that strengthens ANPs to function in daily life and contains EPs that are interfering with functioning. Then various trauma-related phobias are systematically and gradually addressed, including the phobia of attachment and attachment loss, particularly related to the therapist; the phobia of mental actions; and the phobia of dissociative parts of the personality. This initial phase may be short, long, or the end goal of treatment, depending on the level of the patient's overall mental and behavioral functioning over time. Once the goals of Phase 1 have been met, the treatment of traumatic memories may commence.

The essence of the treatment of traumatic memories is their integration, along with increasing integration of the individual's personality, including sense of self over time and contexts. Such integration requires the development and execution of several new mental actions, i.e., synthesis and realization, the latter of which involves personification and presentification. Guided synthesis is the systematic, rapid or fractionated exposure of selected parts of the personality to traumatic memories, with promotion of synthesis of these involved memories, and prevention of re-dissociation or other forms of mental avoidance. The dissociative parts that are selected involve EPs that contain the traumatic memory (i.e., the part that reexperience a traumatizing event) and the parts that--in the collaboratvie judgment of therapist and patient--need to integrate the memory and have the integrative capacity to do

so. The intervention must be accomplished within the limits of the integrative capacity of the involved dissociative parts. Synthesis is not sufficient for integration, but requires further work toward realization of the traumatic memory. Various techniques, hynotic and otherwise, support these new integrative actions.

As the case example illustrates, preparation and execution of guided synthesis should be tailored for each patient. Some patients need careful and detailed planning and execution, for instance due to their extensive traumatization and extreme dissociation. Other patients, often less extensively traumatized and having less developed and distinct dissociative parts, are less able to prepare in this way, and often do not need this level of detailed work. For these patients, there might be an inner discussion of which (part of a) traumatic memory will be the focus for the next session, and during the actual guided synthesis much less emphasis is given to specific contents to be shared. Therapist training and preferences also may play a role in the choice of therapeutic techniques. For instance, some therapists prefer EMDR instead of the various forms of guided synthesis described above (e.g., Fine & Berkowitz, 2001; Forgash & Copeley, 2008; Gelinas. 2003). Other therapists, who are familiar with both guided synthesis and EMDR, might leave the choice up to the patient. Indeed, there are patients who may alternate preferences, depending on the memory and their needs at the time. However, in all instances the therapist and patient reflectively decide which parts shall and shall not participate in the preparations and guided synthesis.

Finally, some comments on the use of hypnosis in the treatment of traumatic memories in patients with a history of chronic traumatization and complex dissociation are in order. Many of these survivors are characterized by moderate to high hypnotizability, as well as a tendency toward intense absorption and imaginary involvement, which they naturalistically call upon when confronted with traumatic memories. Actually, reactivated traumatic memories and, for instance, the messages given during the traumatic experiences, can be

regarded as malignant hypnotic suggestions. The patient's capacities and tendencies toward absorption, imagination, and dissociation can be used to foster integration. Suggestions for imaginary safe places, inner meeting places, and bank faults for the containment of traumatic memories are prime examples. Several other techniques may be effective in providing structure and containment. For example, the patient's integrative capacity can be supported thorough adding time boundaries during synthesis by starting a round with the word "Begin!" and ending with the word "Stop!," and counting in between, and suggestions for relaxation, recuperation, and time distortion in the breaks between rounds. Thus, there is a definitive place for hypnotic techniques in the treatment of chronically traumatized individuals, including the treatment of traumatic memories.

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Table 1: Phase-Oriented Treatment: Overcoming Trauma-Related Phobias

Phase 1: Symptom reduction and stabilization

- Overcoming the phobia of attachment and attachment loss, particularly with the therapist
- Overcoming the phobia of mental actions (e.g., inner experiences such as feelings, thoughts, sensations, wishes, fantasies)
- Overcoming the phobia of dissociative parts of the personality (ANP and EP)

Phase 2: Treatment of traumatic memories

- Overcoming attachment phobias related to the perpetrator(s)
- Overcoming attachment phobias in EPs related to the therapist
- Overcoming the phobia of traumatic memories

Phase 3: Personality integration and rehabiliation

- Overcoming the phobia of normal life
- Overcoming the phobia of healthy risk taking and change
- Overcoming the phobia of intimacy, including sexuality and body image.