Trauma-Informed Stabilization Treatment for Addictive, Self-Destructive, and Borderline Clients

Formazione Continua Liquid
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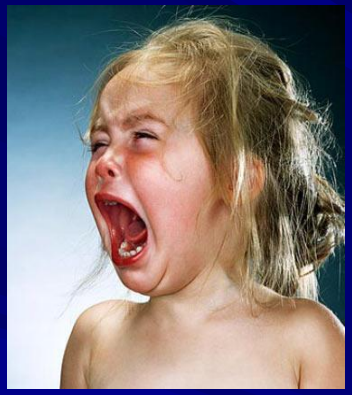
NEUROBIOLICALLY-INFORMED UNDERSTANDING OF TRAUMA

When children are hurt by those who care for them, their source of safety becomes the source of **danger. . .** their source of comfort becomes a source of fear, anger, and shame

Our bodies mobilize the same defensive systems as all mammals

We either cry for help



We try to fight

Or flee

We freeze and try to be invisible

Or we submit in humiliation

When the parent is frightening, dysregulating instead of regulating,

Sympathetic Activation

AROUSAL

Parasympathetic Activation

On guard, "jacked up," impulsive, quick to fight or flee

Wi[illegible]ow of [illegible]olerance*

Checked out, numb, disconnected, "don't care," going through the motions

Fisher, 2009

Nervous System Adapts to a Threatening World

Hyperarousal-Related Symptoms: Fight/Flight

Impulsivity, risk-taking, poor judgment
Chronic hypervigilance, anxiety, ruminations and compulsions
Intrusive emotions, flashbacks, nightmares, racing thoughts
Compulsive behavior providing temporary relief: addiction, self-harm, suicidality

Sympathetic Arousal

"Window of Tolerance"*
Optimal Arousal Zone

Parasympathetic Arousal

Hypoarousal-Related Symptoms: Submit

Flat affect, numb, feels dead or empty, "not there"
Cognitively dissociated, slowed thinking
Cognitive schemas focused on hopelessness
Disabled defensive responses, victim identity

Ogden and Minton (2000);
Fisher, 2006
*Siegel (1999)

Traumatic implicit memories are experienced as:

- "Feeling flashbacks" of desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- Chronic expectation of danger: hypervigilance and mistrust, fear and terror, "post-traumatic paranoia"
- "Body memories:" numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- Impulses and movements: motor restlessness, 'hang-dog' posture, frozen states, impulses to "get out," violence turned against the body, huddling or hunkering down
- Symptoms: vegetative symptoms of depression, anxiety disorders, somatization disorder, OCD, addictive disorders, and Borderline Personality Disorder

Fisher, 2014

Another kind of memory: habits of action and reaction

- **Procedural memory is our implicit memory system for functional learning:** skills, habits, automatic behavior, conditioned responses.
- Driving a car, playing an instrument, dance, swimming or playing tennis, riding a bike, shaking hands and making eye contact and other social behavior, are all examples of procedural learning.
- Procedural learning allows us to respond instinctively, automatically, and non-consciously, increasing our efficiency at the cost of a loss in reflective, purposeful action

Fisher, 2012

Trauma-related Procedural Memory

- **Social behavior:** difficulty making eye contact, asking for or accepting help, expressing feelings in words
- **"Default settings:"** tendencies to automatic self-blame, shame, anger, shutdown, dissociation
- **Behavioral responses:** impulsive acting out, isolation and avoidance, help-seeking, inability to say 'no,' collapse
- **Emotional expression:** emotional disconnection, cathartic expression, overwhelming intrusive emotions
- **Interpersonal behavior**: gets too close too quickly and expects too much from others, becomes the caretaker, or avoids closeness, dependency

Fisher, 2014

Procedural Learning is Meant to be "Indelible"

"[The procedural memory] system involves a relatively slow, incremental learning process. . . . With repetition, performance of procedurally learned processes becomes increasingly automatic. . . . ***Procedurally learned behavior may be altered, [but] it is relatively 'resistant to decay'."***

Grigsby & Stevens, 2000, p. 93

TRAUMA-INFORMED STABILIZATION TREATMENT (TIST)

Trauma-Informed Stabilization Treatment [TIST]

Mission: to create a model for specifically focused on stabilizing chronically at-risk trauma patients. These are patients whose self-destructive behavior has resulted in years of hospitalization without much change in their symptoms.

Some patients also were violent toward staff, which led to their being stigmatized as "bad:" attention-seeking, manipulative, oppositional, passive-aggressive, and non-compliant. The medical doctors who treated their self-inflicted injuries threatened to stop caring for these patients as an attempt to control the behavior.

Trauma-Informed Stabilization Treatment [TIST], p. 2

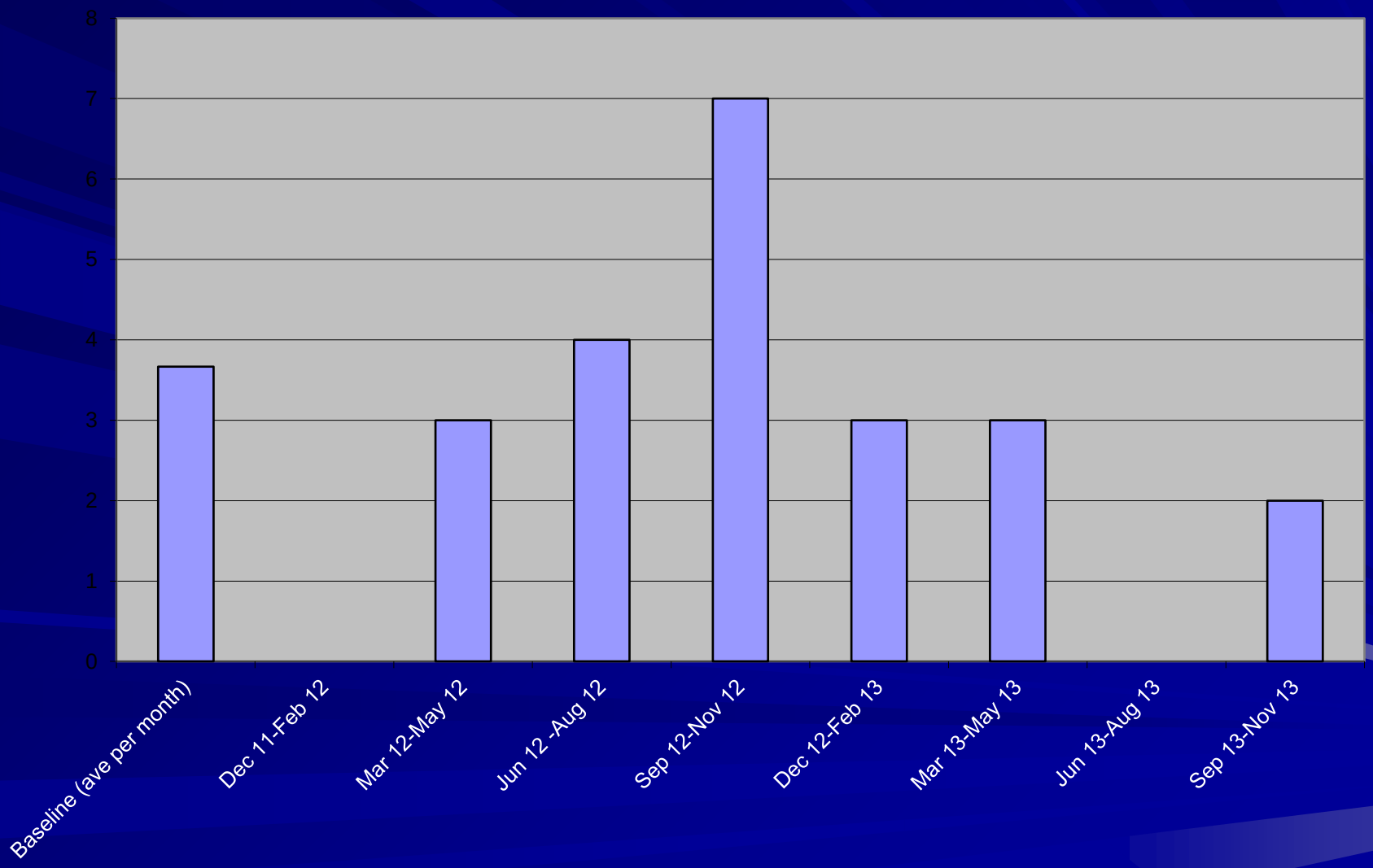
- **The premise underlying the TIST model** is that **self-destructive behavior is inherently a survival strategy** instinctively mobilized to regulate unbearable or unsafe affects/impulses.
- **The high risk results from the absence of judgment caused by inhibition of the prefrontal cortex** in response to stress or danger
- Current treatments do not have their desired results because **these clients are structurally dissociated and internally conflicted:** do I want to be safe? Or do I want relief and a sense of control?

Trauma-Informed Stabilization Treatment [TIST], p. 3

Contributing theoretical models: neurobiologically-informed understanding of trauma-related symptoms and disorders (van der Kolk, LeDoux, Porges), disorganized attachment, Borderline Personality, and dissociation (Liotti, Lyons-Ruth), trauma and the body (Ogden).

Contributing clinical models: Sensorimotor Psychotherapy (Ogden), Internal Family Systems (Schwartz), ego state techniques (Watkins & Watkins), mindfulness-based cognitive therapy, Motivational Interviewing, Acceptance and Commitment Therapy (ACT).

Results of One-Year Pilot Study



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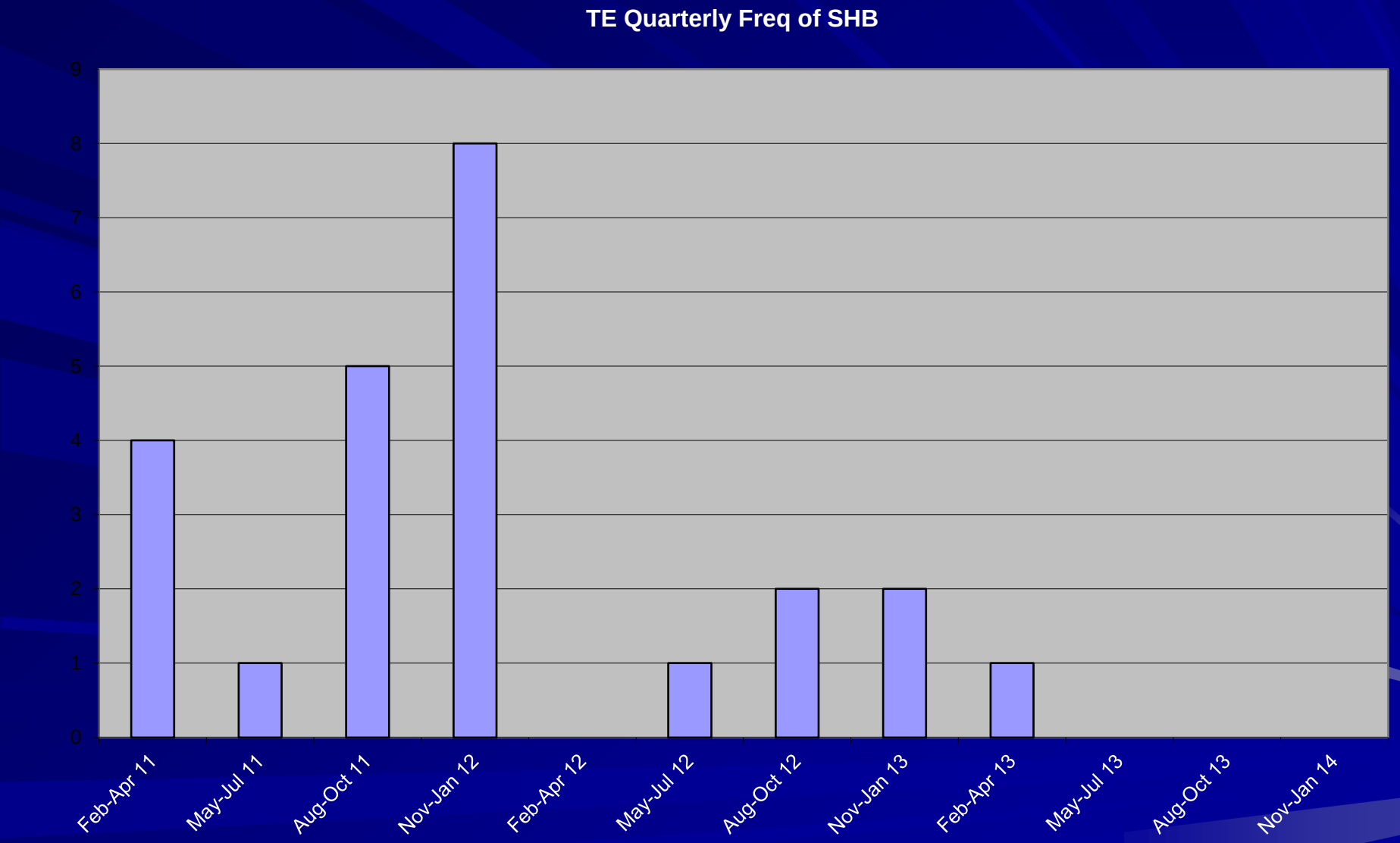


What are the ingredients of TIST?

- Neurobiologically-oriented understanding of trauma
- Focus on reinstating prefrontal cortical activity as the prerequisite for behavior change and trauma resolution
- Psychoeducational component: patients are educated in the method, not just treated with it
- Re-frames and externalizes the symptoms to give client more psychological space between emotion and action
- Combats shame- or paranoia-related interpretations
- Use of mindfulness skills to decrease affect dysregulation
- Assumption of "organicity:" the brain and body's inherent intent is always adaptation and survival

Fisher, 2014

THE ROLE OF DISSOCIATION IN TRAUMA

Trauma and attachment failure → alienation from self

- **Children and adults need psychological distance from traumatic events** to avoid overwhelm. The young sense of self must be kept separate from the treatment it receives

- **Disowning "the bad child" or "wounded child" is a survival response**: we are not that child! Those overwhelming feelings and shame are hers, not ours

- By **disowning traumatized parts, we are also able to disown the abuse or neglect.** And we can disown parts that carry shame or anger, disown needy parts, and disown any part that could provoke more abuse

Fisher, 2022

Alienation from self as a survival strategy, cont.

- It can be adaptive to disown one's vulnerability. When a child disowns needs that can't be met or feelings that are unacceptable, **adaptation to the environment is enhanced---at the cost of alienation from self.** The dangerous feelings and needs become 'bad' or 'not me'
- **Alienation and fragmentation also help maintain the attachment to family** required for survival but over time interferes with self-acceptance and self-forgiveness
- And because parents are a child's 'mirror,' **failed parental attachment precludes internalizing a coherent sense of themselves,** not just a loss of care and connection

Fisher, 2022

Disowning our 'selves'

- **While yearning to 'like' ourselves, disowning** the abuse **or** the vulnerable, ashamed, angry, or depressed parts **results in a profound alienation from self:** *'I don't even know who I am . . .'* is a frequent description we hear

- This sets up a dilemma: *"But I don't want to 'know' myself—I already know I hate myself."* This self-judgment only increases emotional pain and alienation

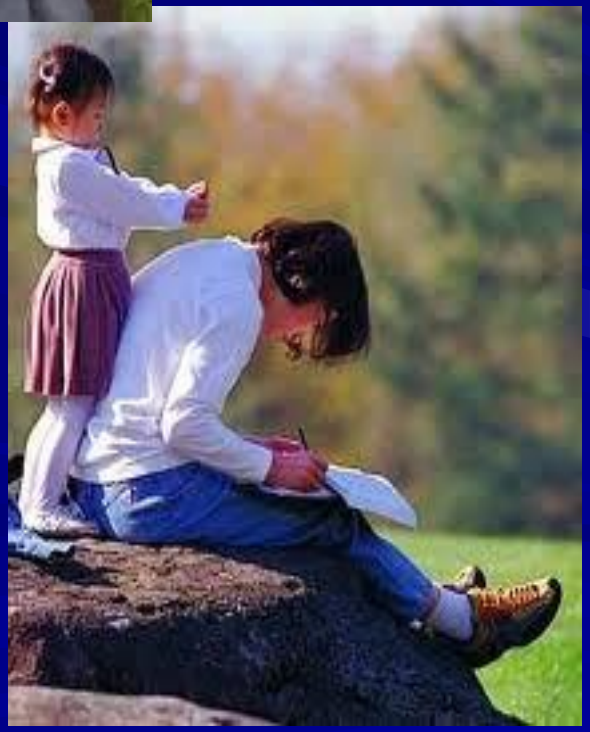
- **The ability to be compassionate or comforting or curious with others is not matched by the ability to offer ourselves the same.** The belief that others deserve or belong or are worth more is confirmed by our own behavior

Fisher, 2012

Comforting? Loving? Accepting? Supportive?

What kind of relationship do we have to our ‘selves’?

Or are they more like these relation-ships?

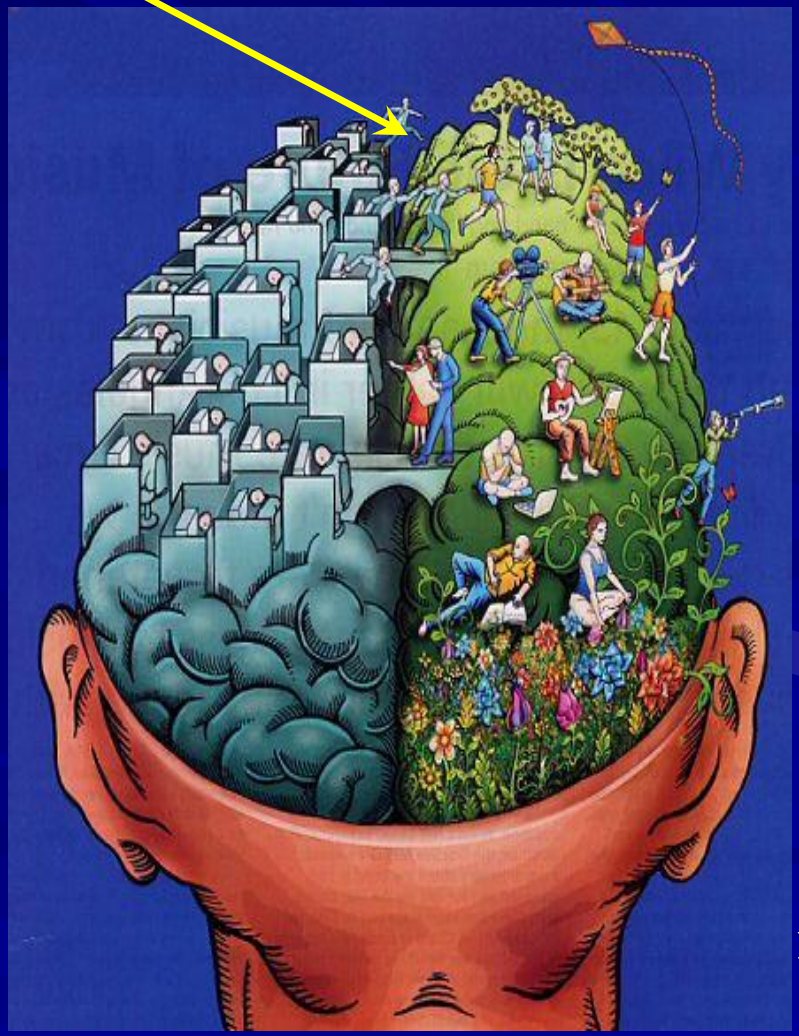


Traumatic adaptation and "splitting"

Left Brain

Increasingly dominant as language and cognition develop, the left brain is verbal and rational. It plans, organizes, learns from experience. It can evaluate danger cues but has positively biased neuroception, so it tends to minimize danger

Corpus Collosum does not mature until 12+



Fisher, 2019

Right Brain

Dominant in first few years, the right brain lacks words but can read body language and scan for danger. It has 'street smarts,' not book smarts. It intuits threat but can't objectively measure the degree of threat. It can respond instinctively but not intentionally

Primary Structural Dissociation: a single incident trauma

At whatever age we are traumatized, we have a pre-traumatic personality that begins undivided

Apparently Normal Part of the Personality

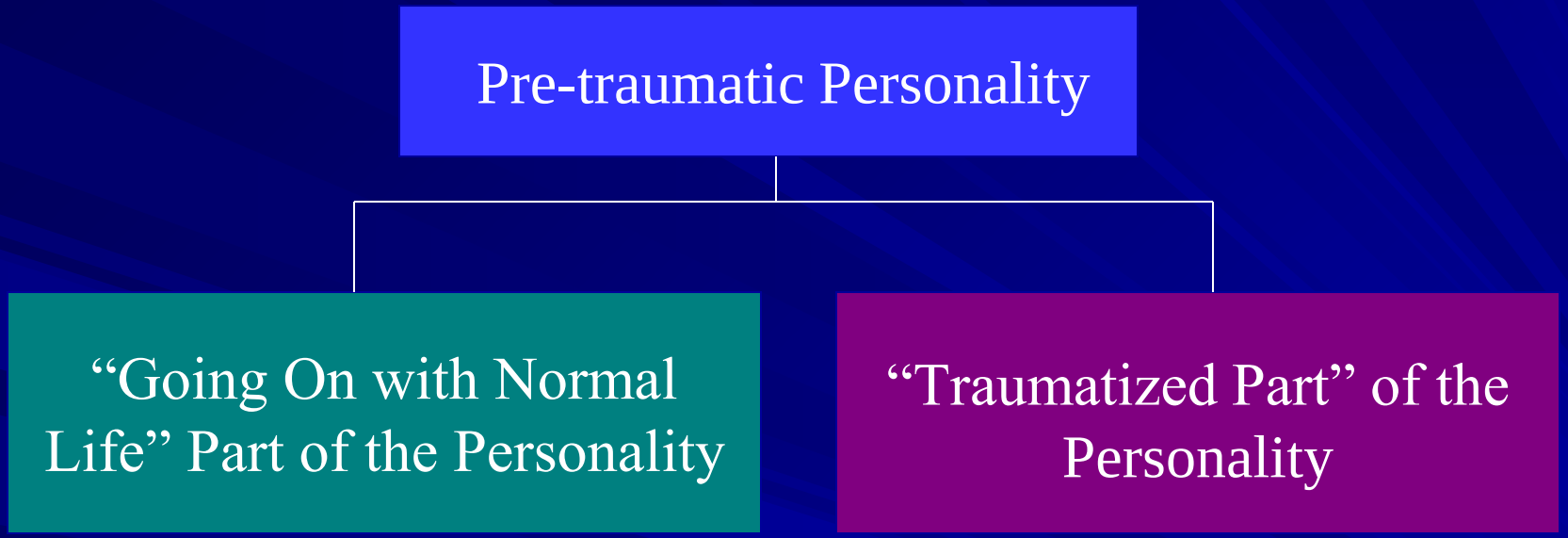
Emotional Part of the Personality

A split occurs between the Left Brain part of the Self that "carries on" with normal life and adaptation during and after the trauma

And the part of the Self that holds the body and emotional memories of what happened and the survival responses needed to survive it

Van der Hart, Nijenhuis & Steele, 2006

Client-Friendly Language



This Left Brain part of the self "carries on" with normal life and adaptation during and after the trauma

This Right Brain part of self holds both the traumatic memories and the survival responses employed

Van der Hart, Nijenhuis & Steele, 1999

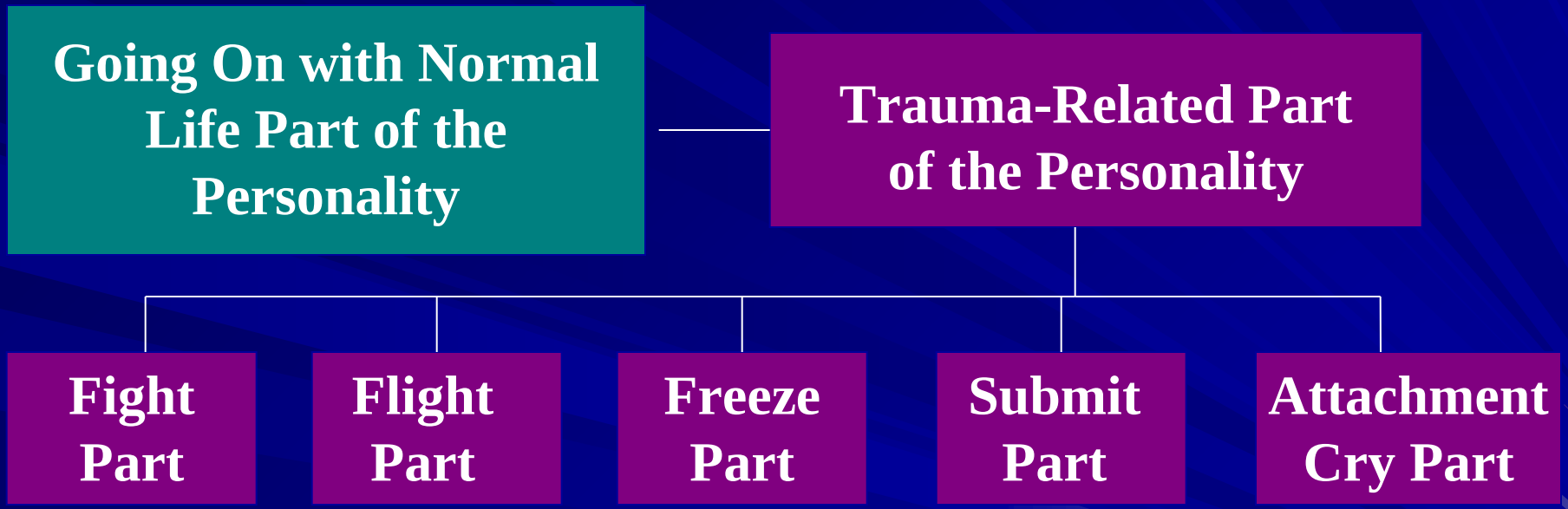
Triggered and dysregulated, the body continues to anticipate danger

"When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. ***Each component of the ordinary response to danger****, having lost its utility,* ***tends to persist in an altered and exaggerated state*** *long after the actual danger is over."*

Judith Herman, 1992

Secondary Structural Dissociation:

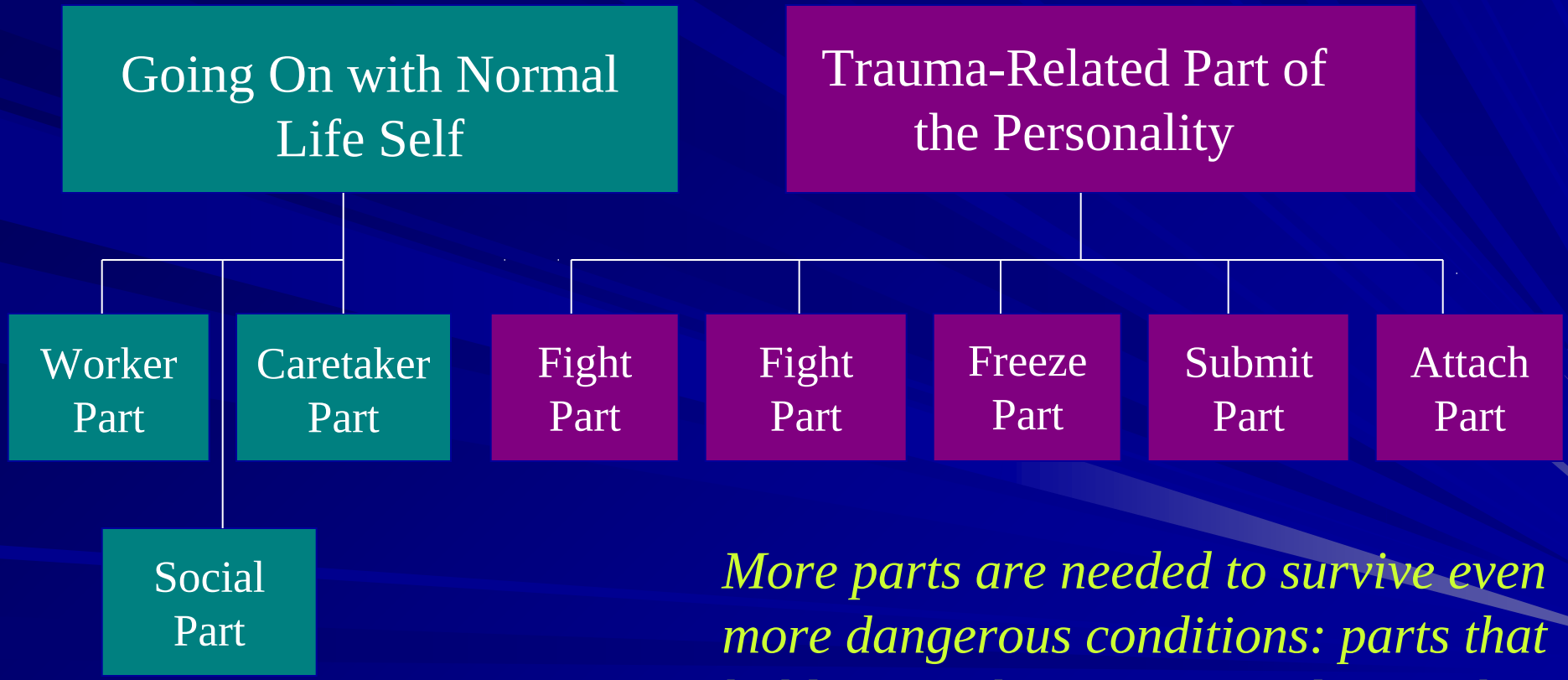
BPD, Bipolar Disorder, DDNOS



The Emotional Part of the Personality becomes more compartmentalized: separate subparts evolve reflecting the different survival strategies needed in a dangerous world

Van der Hart, Nijenhuis & Steele, 1999

Tertiary Dissociation:
Severe DDNOS, DID



More parts are needed to survive even more dangerous conditions: parts that hold survival responses and parts that hold resources

van der Hart, Nijenhuis & Steele, 2006

Each part of the personality contributes a defensive strategy

"I can't **afford** to feel overwhelmed. I have to function!"

"Going on with Normal Life" Part

Emotional Part of the Personality

Fight: Protector	Flight: Distancer	Freeze: Fear	Submit: Ashamed	Attach: Needy
Fight is guarded, angry, and hypervigilant. It drives the aggression needed to cause harm to the body	Flight uses addictive behavior to numb or 'turn off' the body	The Freeze part triggers the body to respond with alarm	The shame, self-loathing, and passivity of Submit stimulates helplessness, hopelessness	The Attach part uses vulnerability and desperate help-seeking to get protection

Fisher, 2019

Evolutionary-Determined Internal Tensions

What threatens stability is not the compartmentalization or the disorder: it is the conflict between competing survival responses:

- *Attachment to the therapist competes with wishes to flee or resist the treatment*
- *"Submission" (for example, willingness to work with the therapist) is in conflict with fighting for control*
- *Going on with normal life and putting the past behind competes with hypervigilence and mistrust*
- *Wanting to live or be stable competes with wishes to die or impulses to get "fast and dirty" relief*

Fisher, 2004

Stabilization = Resolution of Internal Conflicts

- **Unresolved internal conflicts between competing animal defenses interfere with not only stabilization but also resolution** of traumatic experience
- How can the patient 'go on with normal life' when traumatic triggers keep activating traumatized parts?
- If Attach is desperately seeking rescue, Fight is harming the body, and Submit is feeling more and more ashamed and hopeless, clients become stuck in unsafe patterns
- **For resolution, the internal conflicts must first be brought to the client's awareness** and mindfully studied and processed. **But HOW?**

Fisher, 2014

Differential Diagnosis: Borderline? DDNOS? DID?

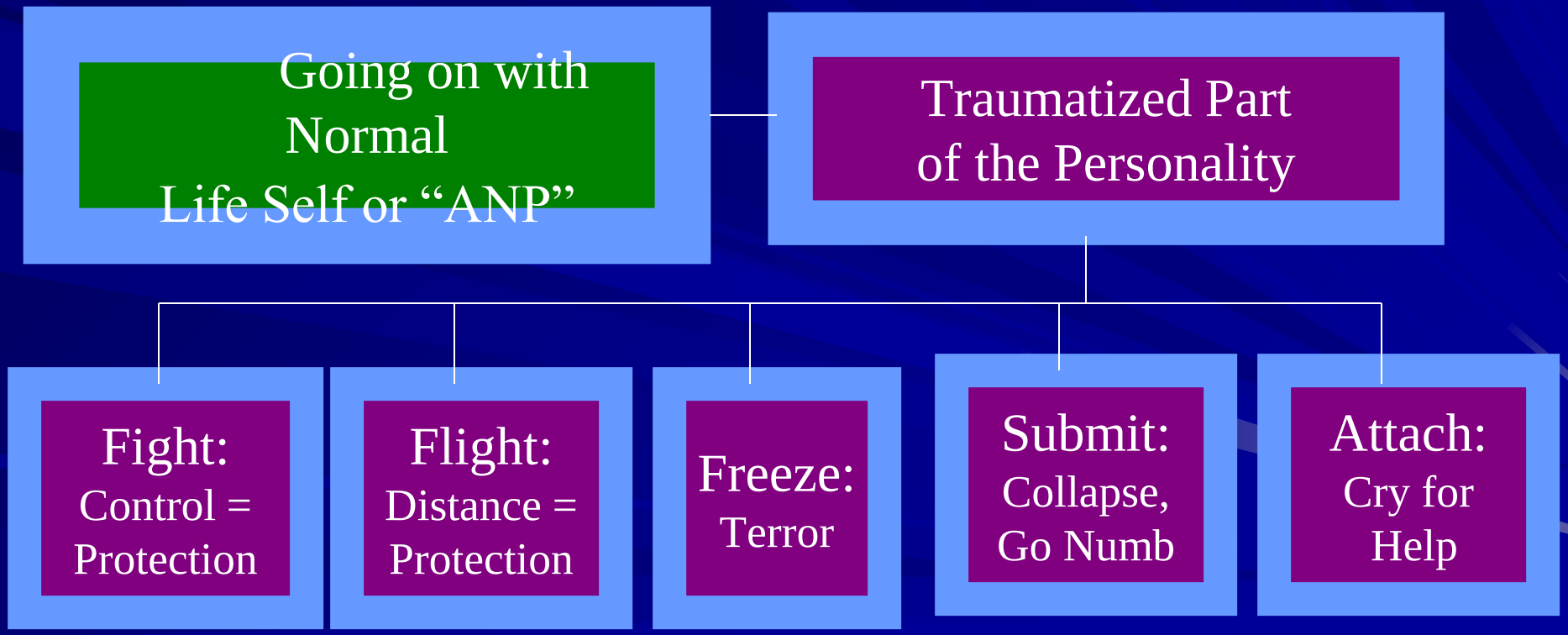
- For **a diagnosis of DID**, two or more parts of the personality must be capable of taking over the body and operating outside of conscious awareness. I.e., there must be time loss or dissociative fugue experiences, but the parts may or may not have different names and identities

- **In DDNOS**, we see clearcut or even dramatic degrees of compartmentalization but without amnesia or time loss

- **In borderline personality disorder,** clients appear more integrated and may function well, yet they too are dysregulated and overwhelmed by trauma-related emotions

Fisher, 2019

When we lose awareness across compartments, as in DID, then each part becomes autonomous. There is a loss of control over actions and reactions



Fisher, 2012

PSYCHOEDUCATION

Psychoeducation

- **Psychoeducation on Structural Dissociation changes the client's relationship to the self-destructive behavior.** Unsafe behavior is understood as the protective effort of the Fight part. Addiction and eating disorders are the Flight's part attempt at a solution.
- **Use the model to be a 'detective:'** what part got triggered? What was the trigger? What did the Fight part do next? What threat was the Fight part worried about? Focus on better understanding of the parts keeps the frontal lobes online. Defensiveness and shame are reduced, and learning is maximized
- **Encourage curiosity and compassion:** "That makes sense," "Of course Flight felt trapped," "Fight parts feel controlled by unsafe authority figures in hospitals—have you told the Fight part you are safe here?"

Fisher, 2014

Connecting the Psychoeducation to the Client's Experience

- As the therapist is explaining the Structural Dissociation model, it is important to help the client connect his own experience to the model by asking:
  - "Do you recognize any of these parts in yourself?"
  - "Which parts are most familiar to you?"
  - "Which ones cause you the most difficulty?"

- If the client can't make the connections, the therapist can help: "What about the part of you that worries about being alone and abandoned?" "What about the depressed part who feels so hopeless? The angry part?"

Fisher, 2019

Connecting the Psychoeducation, cont.

- **Evoke curiosity:** "Which part would you think is the suicidal part? Which part is sensitive to feeling hurt?"
- **Don't be afraid to engage in a discussion:** "Yes, I could see that the Submit part might want to give up and die, but I can't imagine that part having enough energy to hurt your body! Who would have that strength?"
- Psychoeducation can also include the fundamental assumption of Internal Family Systems: **every distressing thought, feeling or physical reaction is assumed to be a communication from a part**

Fisher, 2019

PSYCHOEDUCATION VIDEO

Explaining TIST to Clients

- **In TIST, the clients** are taught that they have been misunderstanding their self-harming, suicidal, eating disordered or addictive impulses. They **are asked to assume that every self-destructive thought, impulse or action is that of a Fight or Flight part**—and every distressing feeling a message from vulnerable parts
- From this point on, **therapists are consistent in re-framing unsafe impulses or emotional distress as belonging to parts.**
- In TIST, we do not expect the clients to remember new information, so we repeat the education many times

Fisher, 2019

Explaining TIST to Clients, cont.

- **The therapist's consistency in using the parts language and theory is crucial to its effectiveness**
- If the therapist sometimes uses parts language and sometimes talks about 'you' or 'your impulse to die,' the client will not benefit from the use of the model
- **Even in emergencies or after a crisis, the therapist has to be even more consistent in using parts language**: "You didn't try to kill yourself---the suicidal part tried to kill you!" "You were determined not to drink, but the alcoholic part was even more determined," "Of course, the anorexic part won't let you eat. . ."

Fisher, 2019

MINDFULNESS-BASED THERAPY: LEARNING TO NOTICE AND FOCUS

Treatment begins with observing the client's organization of experience

In collaboration, therapist and client "study what is going on [for the client], not as disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded. The whole endeavor is more fun and play rather than work and is motivated by curiosity, rather than fear."

Kurtz, 1990, p. 11

The Language of Mindfulness

- "Notice what is happening right now . . ."
- "Let us be curious about that part. . . "
- "What happens inside you when you name the shame as 'her shame'?
- "Notice the sequence: you were home alone, then some part started to feel trapped, and then he just **had** to get out of the house. Let's be curious about what triggered him. . ."
- "As you say those words, notice what part of you is speaking . . .?"

Fisher, 2010

Mindfulness and Re-attribution

[J. Schwartz, 2002]

- **RELABEL.** Ask client to mindfully describe, instead of interpret, what they are experiencing NOW
- **REATTRIBUTE (Re-frame).** Rather than attribute symptoms to self or other, re-frame the symptoms as a trauma response belonging to a part
- **REFOCUS.** Ask clients to re-focus on or notice the triggered feelings and sensations as as a part. What changes?
- **REVALUING.** Find meaning or purpose: empathy for or appreciation of the part for trying to help

Distinguishing Thoughts, Feelings, and Body Sensations is Mindful

In traditional talking treatments, we don't always make clear distinctions between thoughts, emotions, visceral sensations and actions

For example, when clients say, "I feel unsafe,"

- It could reflect a **cognition**: "I am never safe," "The world is not a safe place"
- It could mean an **emotion**: "I'm feeling frightened"
- It could mean **bodily sensation**: "My chest is tight; my heart is racing; it's hard to take a breath"
- It could mean **action**: "I want to hurt myself"

Fisher, 2001

Attributing thoughts, feelings, and physical responses is also mindful

For example, when clients say, "I feel unsafe,"

- It could reflect **a part's belief**: "I am never safe," "The world is not a safe place"
- It could mean **a part is having an emotion**: "She is feeling frightened"
- It could mean **bodily sensations related to parts**: "My chest is tight; my heart is racing; some part is having a hard time taking a breath"
- It could mean **a part wanting to take action**: "A part wants to hurt the body to make the feelings stop"

Fisher, 2019

Intervening with Mindful Curiosity

- **When faced with threats to health and safety, the therapist often feels pressure to DO something.** However, 'doing something' can itself dysregulate the client.
- **We can accomplish the same purpose of reducing risk by increasing curiosity:** *"Notice what happens if we assume that the urge to hurt the body belongs to* ***just one part*** *of you . . . is that better or worse?"*
- *"Let's be curious about what triggered the suicidal part's impulses? Think back to yesterday . . ."*
- *"Assume that the overwhelming urge to drink is a message from your Flight part. . . How is he trying to help? Who is he trying to help?"*

Fisher, 2019

Working with Resistant Clients

- **Intellectualized clients:** evoke curiosity about the part that thinks so much. How did that part help the client survive? "Was the thinking part there when you were a child?"
- **Clients eager to disclose:** "How is the part who wants to tell me hoping to feel as a result of telling me?" Often, parts who urgently want to disclose are hoping for protection from the abusers or hoping to be believed
- **Control-seeking** (devaluing and/or resistant) **clients**: "Each time I suggest something, I see a hesitation—as if there is a part of you that wants **you** to make up your own mind, not take my word for it. . ." "Of course you have a skeptical part—that's important!

Working with Resistance, cont.

- **Affect-phobic clients:** "I want to notice a pattern—each time we start to talk about how angry you've been feeling, some part of you changes the subject!"
- **Hypoaroused clients**: "I want you to notice something extremely funny. . .you want to feel your feelings, but there is a part that just won't let you."
- **Shutdown clients:** "Notice that the shutdown part is here with us now. . . Just in time to make sure that you don't pay attention to the sad part. Very clever."
- **Clients in crisis:** "Let's notice this sense of emergency as a young part of you that has been triggered and feels in danger. . . "

Fisher, 2019

The first goal is to help patients learn to ask this question:

"Which one of the many people who I am, the many inner voices inside of me, will dominate [today]? Who, or how, will I be? Which part of me will decide?"

Hofstadter, 1986

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Foundational Skills for Trauma-Informed Stabilization (TIST)

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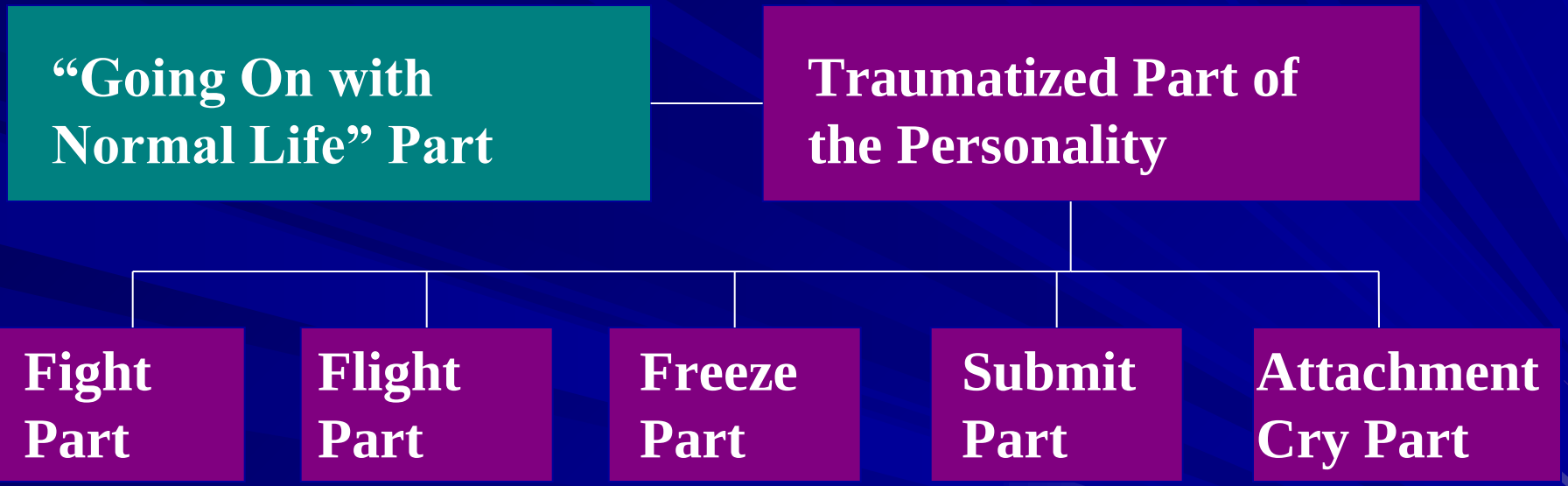
LEARNING TO NOTICE THE SIGNS OF PARTS

The parts don't trust each other or their treaters [From Van der Hart, Nijenhuis & Steele, 2006]



Fight and Flight want Attach to avoid increasing vulnerability, want Submit to be strong, and want Freeze to stay frightened and invisible.

Attach struggles to find a rescuer or protector; Submit tries to keep people pleased and thus less dangerous. Freeze becomes mute and terrified.

Fisher, 2012

Claiming Authority over the Body

- **When triggers stimulate traumatic activation and the prefrontal cortex shuts down, parts highjack the body**. *A loud sound might trigger Freeze; ending of the therapy session might trigger Attach; an empathic failure might trigger Attach and then Fight*
- **Parts holding particular cognitive schemas can also gain authority over the body:** *the judgment of a critical part might trigger an ashamed part, disabling the Going on with Normal Life part.*
- **Parts using the word "I:"** *"I want to die" gives more power and energy to the suicidal part; "I feel hopeless" decreases energy and gives more power to Submit* Fisher, 2019

The parts are not experienced as 'parts of **me**' but as:

- Overwhelming emotions: desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- Chronic expectation of danger: hypervigilance, fear and terror, mistrust, "post-traumatic paranoia"
- Body sensations: numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- Impulses: motor restlessness, 'hang-dog' posture, impulses to "get out," violence turned against the body
- Beliefs: "I hate myself," "No one cares," "I'm not safe here"

Fisher, 2012

Or the parts are experienced as:

- **Loss of ability to communicate:** client becomes mute, shut down, unwilling to speak, can't find words
- **Voices**: usually shaming, punitive, controlling
- **Constriction:** withdrawal, social isolation, agoraphobia
- **Regressive behavior:** loss of ability for well-learned skills, personal hygiene, self-care, social engagement
- **Increasing preoccupation with helpers:** the only safe/unsafe place becomes the office/hospital/house
- **Alternating dependence and counterdependence**
- **Unchecked self-harm,** suicidality and addictive behavior

Fisher, 2014

“De-coding:” identifying “parts”

- Signs of internal conflict: inability to make decisions, stuckness, trying to stay safe alternating with acting out, alternating sobriety and relapse
- Emotions: intrusive, overwhelming, out of proportion, or chronic
- Noticeable shifts in mood or behavior: e.g., from neutral or fearful states to anger and acting out; asking for extra appointments, then not showing up; trust alternating with mistrust
- Behavior patterns: automatic compliance or resistance, always saying ‘yes’ or saying ‘no,’ being open or closed, scared or fearless
- Cognitions: “I am worthless and hopeless,” “I know you are going to leave me,” “I can’t trust you,” “I trust you completely”

Fisher, 2014

Increasing Focus and Concentration

- **Frame the moment or dilemma or distress:** as you empathically listen to the client's complaint or story, bring attention to particular elements that are signs of parts activity, such as patterns of triggering or internal conflicts or negative beliefs

- **Self-study:** what is happening right here, right now, in this particular moment? **What part might be feeling this way?** Where do you feel the part in the body?

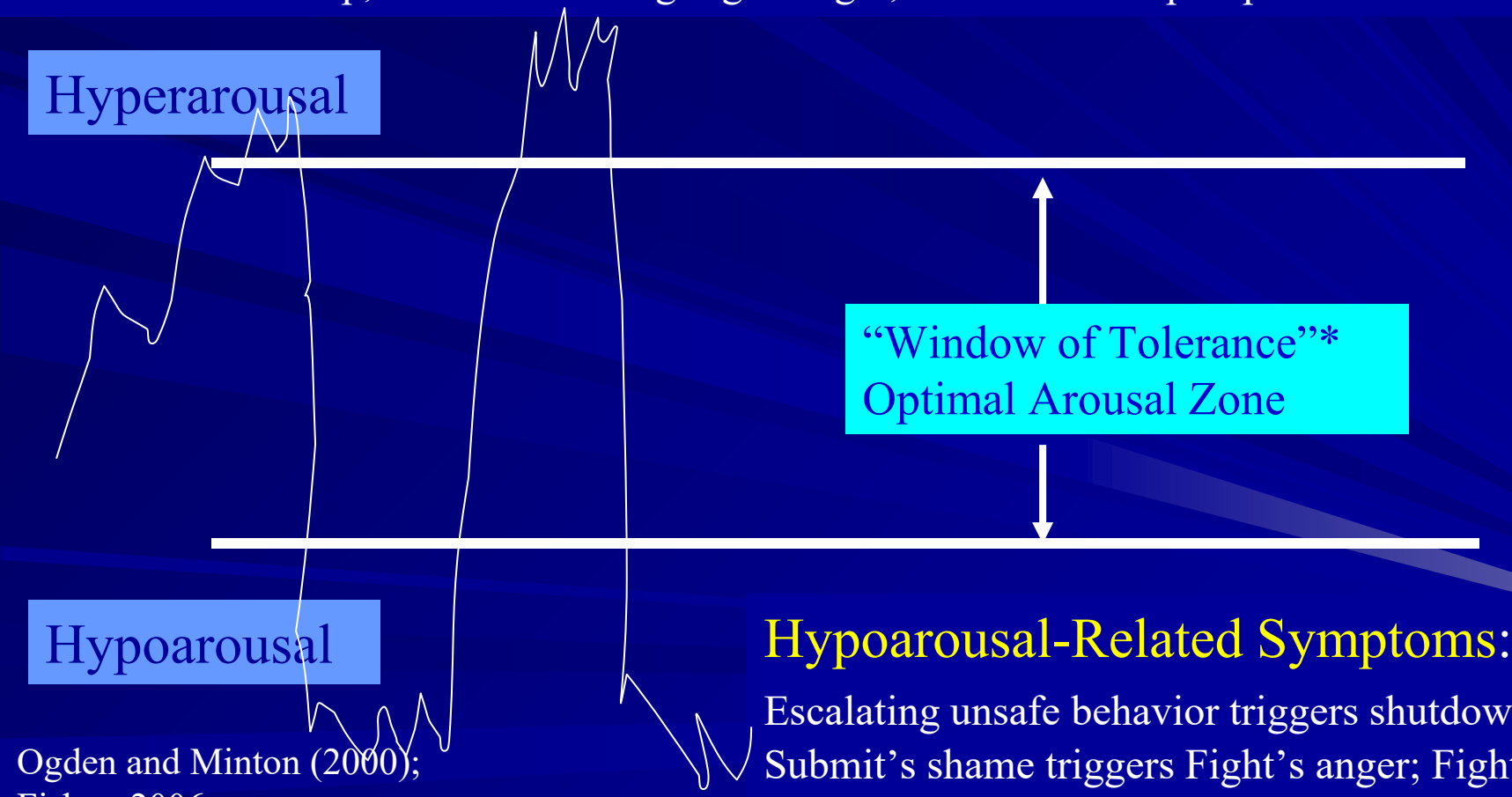
- **Avoid interpretation:** instead, explore frame-by-frame what happened: "First, you felt an alarm go off inside—then a part of you panicked and thought, 'I'm in trouble now'—then what happened? Let's just track what this part is worried about. . ."

Fisher, 2019

Internal Struggles = Parts Trigger Each Other

Hyperarousal-Related Symptoms:

Fight becomes critical and judgmental, triggering shame and hypoarousal
Flight acts on impulse to engage in addictive behavior
Fight threatens suicide, pushes away sources of support
Attach cries for help, further activating Fight/Flight, and the Freeze part panics



Hypoarousal-Related Symptoms:

Escalating unsafe behavior triggers shutdown: Submit's shame triggers Fight's anger; Fight's judgment increases shame and hopelessness

Ogden and Minton (2000); Fisher, 2006
*Siegel (1999)

Dissociative Experiences Log

Time/Day	Thoughts I'm Having	Feelings I'm Having	How I'm Acting	What's Happening in my Body?	Am I older? Younger?	What does this tell me about which part I am right now?

DECODING CRISES AND PROBLEMS AS INTERNAL STRUGGLES BETWEEN PARTS

Curiosity 1st, Intervention 2nd

- **Approaching crises mindfully rather than analyzing or judging consequences:** "wake up" the frontal lobes, increase self-awareness of parts and patterns of triggering: what part got triggered first? What part was triggered by that part? What did the Fight part want to accomplish?
- **Building curiosity:** since curiosity regulates the nervous system, it lessens needs to act out and heightens focus
- **Focusing on the relationship between parts <u>and</u> compulsive behavior:** *learning to observe overwhelming feelings and impulses as "parts," to notice relationships between triggers, symptoms, and acting out behavior*

Fisher, 2013

Connect Symptoms to Parts

In the context of client's having cut herself, therapist tries to evoke curiosity:

Fisher, 2006

Connect Symptoms to Parts, cont.

Therapist continues to ask mindfulness questions:

Yes, if Fight had its way, you wouldn't trust anyone, huh?

So, Fight keeps trying to protect you that way.

Well, maybe you can work with Fight and help it see that you are an adult now who knows **whom** to trust.

Everyone needs a Fight part, so hold onto it—it gives us courage and backbone. But we need our Fight parts to let **us** decide who to trust and how to react.

"It's safer that way—then you don't get hurt"

"But it backfires—because then I can't get help"

"I won't reject my Fight part, though—it saved me in the orphanage"

"I **do** trust a lot of people here"

Fisher, 2006

Mindfully tracking connections between symptoms and triggers

Client just broke his sobriety:

I'm so glad you could tell me you used last night—what triggered you?

"I don't know—I just hate my job"

What was going on just before you used?

"People were getting to me—they have no respect"

How could you tell people were getting to you? That they had 'no respect'?

"One after another, they weren't doing their jobs—I can't rely on anyone"

That's a pretty big trigger! People who don't do their jobs, so you have to carry all the load

"Yeah, just like I have my whole life. . ."

Fisher, 2008

Connecting symptoms to triggers, cont.

Fisher, 2008

MINDFULNESS-BASED PSYCHOTHERAPY II: USING THE LANGUAGE OF PARTS

The key to stabilization is the "Language of Parts"

- **The language of parts** as the language of therapy **increases client ability to be mindfully aware of parts**
- **That means the therapist translating the narrative from "I" language to the language of parts:** *"A part of you feels ashamed," "a part of you feels it was her fault," "a part of you wants to hurt the body."* **Naming the symptoms as a part helps keep the frontal lobes 'online'** by increasing curiosity and concentration.
- **In mindfulness,** a thought is named as "just a thought," feelings as "just feelings," and **parts are named as "just a part that feels ashamed/angry/sad"**

Fisher, 2012

Mindfully Name What We See

- **Imagine that you are a "sports announcer:"** as a therapist, learn to narrate what you notice as you notice it, play by play. When we name the sequence of what's happening in a tone of empathy, curiosity, and/or enthusiasm, it is rarely met with negative reactions.
- **Be prepared for negative reactions especially from hypervigilant Fight parts!** We are seeing and naming a system that was designed to operate in secret, and it's threatening to protectors that we are naming it now
- **Use the client's given name only for the Going On with Normal Life self**. The body is conditioned to respond to the name we use in daily life to be who we are in daily life

Fisher, 2012

Mindfully Name What We See, p. 3

- **Each time we name a part as a part** ('Susie,' 'the 13 year old,' 'a young part') **and the patient as a Going On with Normal Life self, we are increasing awareness of the whole system**

- **With words, we keep painting a picture of the whole system even while talking to just one part of it.** If a child part appears in the office, we should welcome that part but keep awareness of the whole by referencing other parts: "But where is the big Maria when you're so scared like this? Are there any big parts that protect you or take care of you? No?? That's terrible! I must talk to them about that." Note the emphasis on the **system** taking care of them

Deepening Mindfulness by Focusing Concentration

- **Framing:** "Let's pause and notice what part is speaking now. . ."
- **Retrospective Mindfulness:** "Let's go back for a moment to the hopeless part. . . Can you feel that part now? How can you tell she's still there? What happens when she feels your interest in her?"
- **Deepening Self-Witnessing:** "Notice where this part wants to take you?? If you go with his feelings, what will happen next? Will you feel more hopeless or less hopeless? What happens if you notice where he wants to take you without going there?"
- **Increasing curiosity:** "How is that part telling you that she's afraid? Telling you that she's angry? What happens if you just ask inside: "What's the angry part worried about?"

Fisher, 2012

Don't be afraid to be 'relentless'!

- **Relentlessness means that we discipline ourselves to consistently use the language of parts** to counteract the automatic assumption of a unified "I." We have to hold the perspective that there is more than one "I"
- **It means that we consistently challenge thhabitual interpretations and assumptions by re-framing them in the language of parts:** when the client says, "I hate myself," we respond, "Yes, there's a part of you that hates herself—and is there also a part that judges her—or you?"
- Just as with any foreign language, it is important to **practice to become fluent**. The therapist's fluency reassures the client that it isn't a sign of mental illness to have parts

Relentless re-framing, cont.

- In "relentless reframing," **the pronoun "I" is used only to refer to the Going on with Normal Life part.** All other parts of the personality are "parts." Mindfulness is automatically engaged when the "I" observes "them"
- **Experiments can help clients learn the benefits of differentiating parts:** for example, "Would you be willing to use parts language whenever you feel distress?" [or "whenever you feel ashamed? Or suicidal?" Or "Would you be willing to assume that the part that binges and purges is not you? That 'you' are working hard to change those behaviors, but another part of you is not so sure. What happens if you notice those impulses as that part's?"

Fisher, 2011

Which "I" ?

- When clients use "I" to speak "from" a part, **we can ask, "Which 'I' feels that way?** Are there any other points of view inside you?"
- Clients often respond to the language of parts with arguments such as, "Well, wouldn't anyone feel upset about this?!"
- Rather than trying to rationally differentiate child parts from wise minded Adults, it is more helpful to **ask clients to see what happens if they work on the assumption that any distressing feeling, thought, or body sensation represents a communication from a part**

Fisher, 2012

"Self-Leadership" [Schwartz, 1995]

- Fearful of what might happen, therapists have tended to compensate for clients' inability to keep themselves stable by assuming responsibility for their safety. **But the result of that approach is often continued de-stabilization and reliance on the therapist's availability.**
- For traumatized clients to feel truly safe, they must learn "self-leadership," the ability to maintain continuity of consciousness and internal collaboration under stress. **But which parts can do so, and how?**
- Using a mindfulness-based model, **the Internal Family Systems model proposes that all human beings have a Higher Self that endures no matter what**

Fisher, 2012

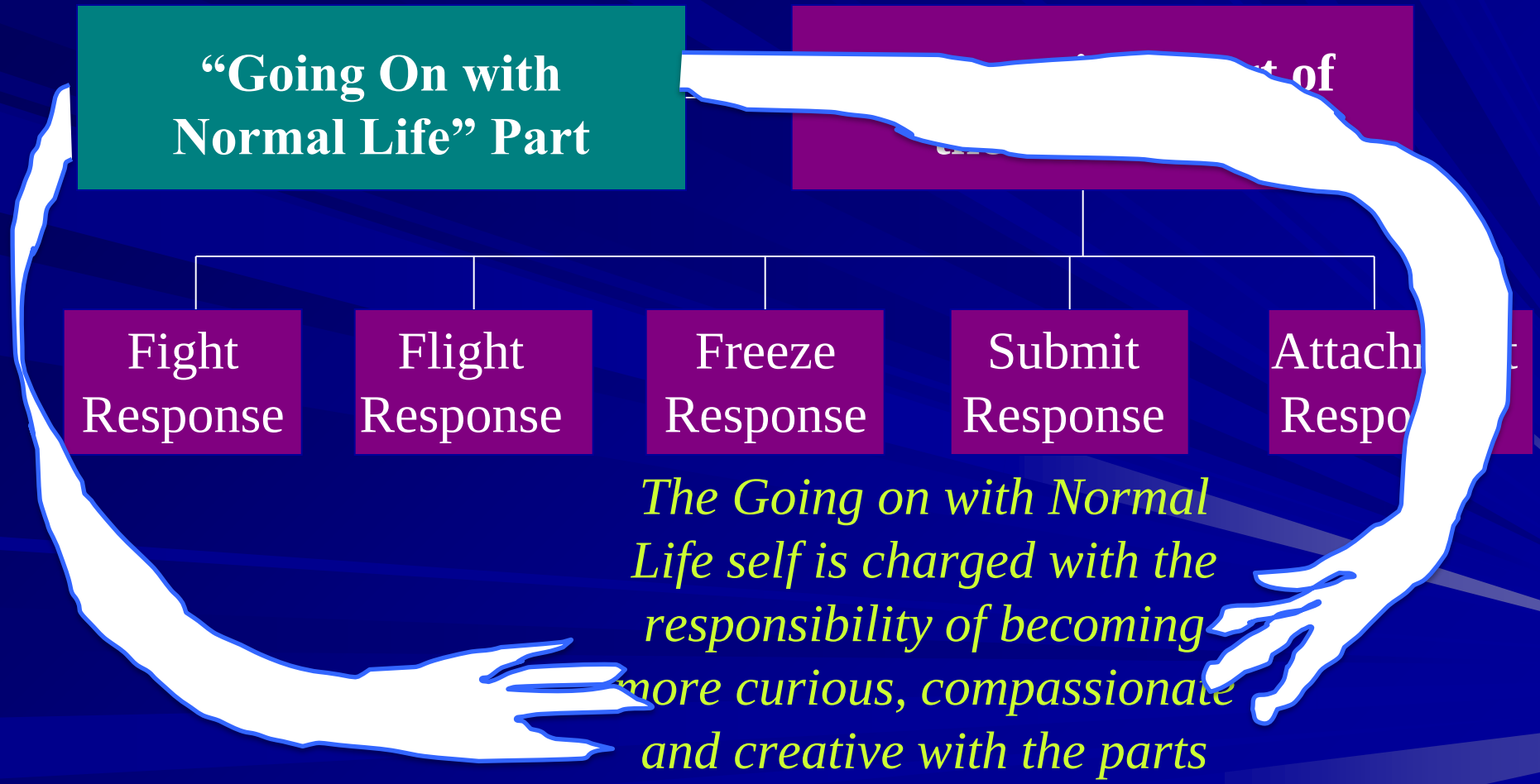
Transformation = Inner Healing

Healing is the outcome of a compassionate connection between parts and Self that creates sufficient safety and trust that the parts can let go of their legacies of the past

Fisher, 2009

Structural Dissociation and IFS

Curious, compassionate,
clear,
creative, calm, courageous,
confident, committed



Fisher, 2013

BLENDING AND UNBLENDING: INCREASING CLIENTS' MINDFULNESS OF PARTS

Blending, Shifting, and Switching

- In **"blending,"** clients experience intrusion or flooding of parts' thoughts and feelings (eg, shame, hurt, anger) as changes in mood or attitude or feeling
- Parts also cause **"shifts"** in states: the client arrived for therapy in his/her Going On with Normal Life self but now has shifted into an angry state or mute childlike state
- Or there is a **switch** during which the client loses touch with other aspects of his/her life or personality. In that moment, the world is seen only through the perspective of that part: eg, during unsafe acting out
- Another form of intrusion is **"hearing voices"** during which parts speak to the adult self or each other Fisher, 2012

How the Parts Dominate: "Blending" [Schwartz, 2001]

- When clients are flooded with a part's feelings or beliefs and identifies with or "blends" with them, **the thoughts and feelings of that part feel like "me."**
- Because they are not aware that they are blended and these feelings belong to the parts, clients act on them or try to suppress them, **forcing the part to become more intense**
- If only to ensure safety, **it becomes the therapist's job to help clients identify that they are blended:** *"There's a part of you here that feels utterly worthless, and you are blended with her. That doesn't help her—or you."*

Fisher, 2021

Mindful "Unblending"

- **Unblending is a two-step process.**
- **As feelings, thoughts, or body reactions come up, we ask the client to notice that they are"blending:"** *"Notice the hopelessness as a communication from a depressed part," "Notice the shame as the shame of that little girl…"*
- **The therapist's job is also to <u>notice the parts and foster empathy</u> for them**: *"Yes, the critical part keeps telling the hopeless part he's ruining <u>everything</u>. . . How does the hopeless part feel then?"*
- *""Maybe the hopeless part is just trying to help avoid disappointment. . . When you blend with him, you agree that it's hopeless—how do you think that makes him feel?"*

Mindful "Unblending," cont.

- **Trying to convince clients that they have an adequate or even competent adult self** is usually unhelpful. It is possible, however, to help clients see when they are mindful
- **As they notice that they are"blended,"** *'you' is not defined as a competent adult but simply as the observer. All we ask of them is to notice the parts and notice when they are blended*
- **They are asked to 'just separate' from the part a little**: *"Just stay with that feeling and notice it as a part trying to tell you how angry he is. . . When you notice it and say, 'He is angry,' do you feel better or worse?"* Most clients report they feel relief when they unblend

Fisher, 2021

Five Steps to Unblending

1. Assume that any distressing or uncomfortable feeling is a communication from a part of you that's been triggered.
2. Put the part's feelings into words using "she" or "he feels _____." See what happens if you speak for the part by naming the feelings as his or hers.
3. Create a little more separation from the parts by sitting back (or changing position, lengthening your spine, engaging your core), so you can feel both them and you
4. Use your [mother/teacher/manager/chef]'s mind to reassure the part that nothing bad is happening right now. Acknowledge the fear or hurt. Imagine these fears belonged to _____: what would you say?
5. Get feedback: do the parts feel you're "getting" it?

~~Four~~ Five Steps to "Unblending"

1. First, assume that whatever upsetting or overwhelming feelings (or thoughts) you have are a communication from the parts because they have been triggered.
2. Put their feelings & thoughts into words, using "they" instead of "I": "They are upset..." See what happens if you speak for them using "they."
3. Create a little more separation from the parts, just enough that you can feel you & them at the same time. You can lengthen your spine, change position, or ask them to sit back just a little.
4. Use your supervisor's brain to reassure them or remind them or support them. Acknowledge that they're afraid. Imagine if these fears were the fears of your colleagues, what would you tell them? Ask them what they need from you as their supervisor to not be so afraid.
5. Ask the parts for feedback or opinions: is it helping even a little bit? What do they think you should talk abt. in therapy? What's it like to be listened to?

Personalize the steps for each client. Write them down in your own handwriting to provide a transitional object as well as directions for unblending. They will have more power for the client if there is personal touch

Sensorimotor Approaches to Unblending

- Notice where in the body each part is felt: *"When you feel the little part's fear, where do you feel it in the body?*
- Increase mindfulness of the physical effects of or communications by parts: *"Notice where you feel the activation in the body. . . if you go with it, where is this activation taking you?"*
- Notice how parts communicate through the body: *"If that restlessness in your legs had words, what would it say?"*
- Focus on regulating arousal helps all parts of the system. If 'blending' and overwhelm are caused by triggering of parts, bodily calm says, "It's going to be OK."

Fisher, 2010

Another Way to ‘Unblend’ is to Externalize the Parts

"Unblending" Brigitta: psychatrist/mother, complains of being burdened by family's needs and becomes angry-judgmental when no one helps, or anxious-obsessive-needy, afraid of being abandoned and homeless, wants to cry but is afraid of making people mad at her

Externalizing Parts Also Facilitates Problem-Solving


Critical Part
Scared Part
Ashamed Part
Attach Part
Protectors
Normal Life Part

Internal problem-solving with diagrams

Med doctor is moving to a clinic

Annie

"I want to stop all my meds"

9

Little Saint

"We don't feel safe there"

"It reminds us of those social workers"

Warrior

Warrior

The Hypervigilent Protectors: "We will be exposed--it isn't safe"

13

Depressed, suicidal: "I need those pills"

3

5

7

"We just want to feel better"

Fisher, 2002

INCREASING SELF-EMPATHY THROUGH POSITIVE RE-FRAMING

Separating Self from Symptom

- When we confuse **who we are** with **symptoms or triggering**, we inadvertently exacerbate them. Suicidal patients do better when the suicidality is defined as the aim of one **"part"** rather than coming from their whole being
- Hopeless clients do better when the hopelessness is attributed to just a **part**, as do ashamed clients or clients abusing substances. But if we don't explicitly use the language of parts, then clients will pick just one feeling or impulse as "who I am" or "me"
- **Parts language also makes it easier for clients to take responsibility:** part of the client would choose a healthier course, but another part didn't or couldn't

Fisher, 2010

Avoidance of "Taking Sides"

- **Our training encourages us to "take sides" when unsafe or addictive behavior is concerned**: we want the client to comply with safety plans, find more resources for support, take more medication, consider hospitalization
- But using that approach, Submit and Attach are over-utilized as they are in trauma, while Fight and Flight are treated as 'bad,' problematic, and dangerous
- A somatic approach encourages us to notice the energy of Fight and Flight, the ability to move and to defend, the hypervigilance and eagerness to take action, as resources. **Do we want to suppress those resources? Or use them?**

Fisher, 2009

Curiosity is Enhanced by Re-framing the Symptoms

- If the therapist responds as if **every symptom is valuable data about how the client survived**, instead of colluding in the assumptions of defectiveness, curiosity is fostered
- We can use psychoeducation to make educated guesses about the meaning of each symptom: **is it a feeling memory? Or a valiant attempt to self-regulate?**
- **Look for what the symptom is trying to <u>accomplish</u>:** Increase hypoarousal? Decrease hyperarousal? Regulate feelings of emptiness or loneliness? Restore a sense of power and control over one's own experience? **Admire the symptom as a survival resource!**

Fisher, 2009

Re-framing Builds Trust and Safety

- In neglect and abuse, a child's positive qualities are ignored or ridiculed, while "mistakes" are punished harshly. Negative feedback therefore tends to be triggering and threatening for trauma clients, decreasing its usefulness
- However, **when we are curious about the adaptive intent of acting out and express that through re-framing**, defenses go down, making clients more available
- Is the suicidal part trying to establish control over feelings that once would have been unsafe? Or trying to demonstrate toughness and strength? **Perhaps s/he is trying to make sure it never happens again**: that the little parts are never so vulnerable to any human being ever.

Fisher, 2013

Resourcing the Defense

- One way of decreasing resistance to working on unsafe behavior by **"resourcing" the defense. That means that we ally with it as "Survival Strategy"**
- For example, "resourcing" a client's intellectualization might consist of admiring his ability to conceptualize as a way that s/he made sense of a confusing violent world. Resourcing mistrust and secrecy might take the form of validating that secrecy is safer before we ask for disclosure.
- **Resourcing devaluing is particularly liberating for us!** If we re-frame devaluing as self-protective, it often takes away its power to intimidate. The devaluing part has no more ammunition because we've supported its position!

Engender Compassion for Parts

Each part "tries to fix things its way" (Annie)

- Suicidal symptoms: "Fight keeps a parachute or "bailout plan" for you, like the samurai soldiers ready to die before defeat. Fight would rather die than feel powerless and overwhelmed"
- Cutting or self-injury: "The part that hurts the body learned to stop the overwhelm and get some relief that way—and it worked because it triggers your body to produce adrenaline and endorphins"
- Mistrust and paranoia: "Fight learned the hard way that it was safer to assume the worst in people . . ."
- Eating disorders and addictive behavior: "Flight found that alcohol took away the fear of being around people. . ." "Yes, when you restrict, you can't feel … it lowers your activation." Fisher, 2008

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