Healing the Fragmented Selves of Trauma Survivors

Overcoming Internal Self-Alienation

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of a worksheet, the Dissociative Experiences Log, for helping clients increase the ability to track and differentiate the signs of parts' activity and communication. And Appendix F provides a script for the Four Befriending Questions, a technique that builds inner communication and bonds of love and trust.

Psychotherapists have wondered and worried and philosophized for hundreds of years about the nature of healing. This book describes one theory about healing the effects of trauma and traumatic attachment that emerged from my clinical observations: healing is the outcome of reversing long-standing patterns of self-alienation and building the capacity to love and accept our "selves." When we reclaim our lost souls and wounded children, befriend them, and allow ourselves to trust deeply felt compassionate impulses to reach out to them and build bonds of secure attachment, they feel safe and welcome at long last. And we feel whole.

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CHAPTER **1**

The Neurobiological Legacy of Trauma: How We Become Fragmented

> "If the elements of the trauma are replayed again and again, the accompanying stress hormones engrave those memories even more deeply into the mind. Ordinary, day-to-day events become less and less compelling. Not being able to deeply take in what is going on around [us] makes it impossible to feel fully alive. It becomes harder to feel the joys and aggravations of ordinary life, harder to concentrate on the tasks at hand. Not being fully alive in the present keeps [us] more firmly imprisoned in the past."
> (Van der Kolk, 2014, p. 67)

In the face of abuse and neglect, especially at the hands of those they love, children need enough psychological distance from what is happening to avoid being overwhelmed and survive psychologically intact. Preserving some modicum of self-esteem, attachment to family, and hope for the future requires victims to disconnect from what has happened, doubt or disremember their experience, and disown the "bad [victim] child" to whom it happened as "not me." By holding out some sense of themselves as "good" disconnected from how they have been exploited, abused children capitalize on the human brain's innate capacity to split or compartmentalize. That "good child" might be precociously mature, sweet and helpful, perfectionistic, self-critical, or quiet and shy, but, most importantly, he or she has a way to be acceptable and safer in an unsafe world. Splitting or fragmenting in this way is an ingenious and adaptive survival strategy—but one with a steep price. To ensure that the rejected "not me" child is kept out of the way (i.e., out of consciousness) requires that, long after the traumatic events are over, individuals must continue to rely on dissociation, denial, and/or self-hatred for enforcing the disconnection. In the end, they have survived the failure of safety, the abuse, and betrayal at the cost of disowning their most vulnerable and most wounded selves. Aware that their self-presentation and ability to function is only one piece of who they really are, they now feel fraudulent. Struggling to stay away from the "bad" side and identify with the good side, they have a felt sense of "faking it," "pretending," or of being what others want them to be. For some, this conviction of fraudulence

engenders resentment; for some, shame and self-doubt. For both groups, the legacy of the trauma remains alive rather than resolved.

As children of abuse continue to grow through latency into adolescence and subsequently adulthood, this splitting of the self supports another important aspect of surviving trauma: mastering normal developmental tasks, such as learning in school, developing peer relationships, finding interests on which to focus and even enjoy. The "good" part of the child is free to develop normally while that other part of the child bears the emotional and physical imprint of the past, scans for signs of danger, and braces for the next set of threats and abandonments. To make the individual's situation more complicated, neither the "me" nor the "not me" self is likely to have well-developed chronological memories of the traumatic events that could provide a context for self-understanding. Due to the nature of traumatic memory, what can be "recalled" tends to appear in the form of intrusive images, emotions, and physical reactions (Van der Kolk, 2006; 2014) that occur spontaneously without warning, not a sequence of narrative memories that make a clear-cut case for what happened "beyond a reasonable doubt."

The "Living Legacy" of the Past

Without a clear chronological record of what happened but vulnerable to the uninvited activation of trauma-related feeling and body memories, individuals are left with a legacy of symptoms and reactions with no context that identifies them as memory. Survivors of trauma later present in therapy with descriptions of their anxiety, depression, shame, low self-esteem, loneliness and alienation, problems with anger, and impulsivity or acting out. They might be troubled by chronic expectations of danger: intrusive fear and dread, hypervigilance ("eyes in the back of my head"), chronic shame and self-hatred, a conviction that the worst is about to happen, hopelessness and helplessness, fear of abandonment, numbing and disconnection from emotions. Or they may come to therapy as a last resort because they are fighting a losing battle against addiction, self-harming impulses, eating disorders, or a longing or even determination to die. Often, they can tell us very little about what evokes these self-destructive impulses that bring quick short-term relief at great risk to their safety: "I do it to punish myself," "I hate myself," "I don't deserve to live," "I'm disgusting—I wish I were dead." They sometimes struggle with how to connect these patterns to the past—but, more often, they prefer not to think about what happened then or minimize it: "It wasn't that bad."

In the early history of trauma treatment, therapists relied on the "talking cure," the most commonly accepted practice in psychotherapy from the time of Freud to the present day (Rothschild, in press), to address the strong emotional reactivity of traumatized clients coupled with their lack of clarity for the traumatic events. Clients were generally encouraged to keep retrieving the memories of "what happened" until they had established a detailed narrative of the chronological events. But, when therapists adopted this approach, rather than resolving the traumatic past, clients became flooded with overwhelming

implicit memories and traumatic reactions, increasingly symptomatic rather than at peace (Herman, 1992; Van der Kolk, 2014). Talking about the events of the past, therapists discovered, led to more implicit "reliving" of it. Unwittingly, the therapist and the "good child," now a grown-up client, were at long last validating the events experienced by the disowned "not me" child—while at the same time, activating the trauma-related parts and triggering their implicit memories. Feeling endangered yet again, the "not me" children were crying for help, still without being heard.

I have long believed that trauma treatment must address the *effects* of the traumatic past, not its events. Being able to tolerate remembering a horrific experience is not as important a goal as feeling safe right here, right now—or being able to reassure oneself that the racing of the heart is just a triggered response, not a sign of danger—or being able to relate to shame, grief, and anger as the feeling memories of child selves too young to comfort themselves. In my view, resolution of painful past events cannot truly be achieved without reclaiming the lost children and disowned parts of ourselves, extending to them a helping hand, welcoming them "home" at long last, creating safety for them, and making them feel wanted, needed, and valued. It took many decades of scientific research for the clinical world to accept that child abuse constituted an epidemic, not a rare occurrence, and that untreated post-traumatic stress resulted in tremendous social costs, not just individual suffering. Only in the last ten years have the concepts of implicit memory and bodily-driven responses to trauma become increasingly widespread (Ogden et al., 2006; Van der Kolk, 2014), but, even now, theoretical ideas about splitting, parts of the self, and dissociation are still controversial and often avoided. We as a field have not yet accepted that compartmentalization is normal under stress and much more common than we generally recognize. In a parallel process, the mental health world has had a history of disowning the prevalence of child abuse, dissociation, and fragmentation of the personality, either by ignoring its manifestations or by invalidating it as "factitious" or "malingering." To be the "good child" in the psychiatric treatment world, therapists have been under pressure to "un-see" signs of dissociation, to diagnose voices as a psychotic symptom, and to treat fragmented clients "as if" they were whole integrated human beings. To be an integrated human, as Dan Siegel (2010) insists, requires "differentiation—with linkage," that is, it necessitates the ability to make distinctions between different parts of the self, to name them as parts, but also to link them to other parts and to the whole of which they are a part. Disowning parts of one's self and over-identifying with other parts does not facilitate integration and a sense of being whole, nor does it engender an internal sense of safety that could counteract the after-effects of an unsafe, unwelcoming hostile world.

Parallel Lives: The Disowning of Dissociation

In the history of the trauma field, the concepts of dissociation and splitting have been repeatedly observed as complications of trauma but consistently rejected as "not me," that is, as not valid or believable within the prevailing

diagnostic systems and therefore to be avoided. One of the difficulties with gaining acceptance for the existence of dissociative splitting and especially dissociative disorders has been an absence of studies demonstrating a scientific basis for such dramatic, difficult-to-treat symptoms. Theories of parts tend to be metaphorical rather than biologically or brain-based. In the dissociative disorders world, the explanatory hypothesis has historically been stress-related: when events are traumatic, the theory asserts, they exceed the brain's capacity to tolerate or process them as wholes. Therefore, they must be split or compartmentalized so that overwhelming event memories are shared by dissociated parts of the same age, each carrying some portion of the memory. In this model, each part is viewed as a repository of memory, representing the history of the client at a specific time. In treatment, the parts are encouraged to "download" or disclose their memories so that the "host" can share their pain and accept their shared past. Only then could the parts begin fusing into one homogenized whole (Putnam, 1989). Although this hypothesis makes intuitive sense to many clinicians and clients, it lacks the scientific validity necessary to overcome the skepticism and disowning of dissociation by the mental health world.

Another theory is that multiplicity is normal, that all human beings have multi-consciousness rather than uni-consciousness. A mindfulness-based approach to understanding parts based on this hypothesis is Internal Family Systems or IFS (Schwartz, 1995; 2001). Known for its compassionate tone and cultivation of mindful awareness, IFS also depends upon a metaphorical theory, this one based on intrapsychic defenses: the "not-me" child is termed an "exile," hidden from conscious awareness by the activity of "managers." When the manager parts do not offer enough protection to keep exiles out of awareness, acting out by another set of parts, the "firefighters," creates distraction and crisis. Healing occurs in the IFS model when the exiled parts are reclaimed, can feel safe enough with "self," the higher self of the client, to share the disowned memories and be "unburdened" of the painful emotions and beliefs connected to the trauma.

But to bring credibility to such a controversial "not us" topic as dissociation, good clinical models without a theoretical basis are not sufficient. It took the neuroscience revolution to provide a scientific explanation for the concept of "splitting" and even to the terminology of "parts of the self." It has taken years of research to challenge the fixed negative beliefs about dissociation and dissociative disorders so prevalent in the field (Brand et al., 2016).

Compartmentalization under Stress: Exploiting the Fault Lines

A biological basis for understanding compartmentalization under stress lies in the brain's innate "fault lines," the fact that its functions are tied to and governed by different regions and differentiated structures within each region (Van der Hart et al., 2004). One "fault line" for splitting available even

at birth is the right hemisphere-left hemisphere split. Though children are born with both left and right hemispheres, they are right brain dominant for most of childhood (Cozolino, 2002; Schore, 2001). The slower developing left brain has spurts of growth around the age of language development and again at adolescence, but the development of left brain dominance is only achieved very gradually over the course of the first eighteen years of life. In addition, the corpus callosum, the part of the brain that makes possible right brain-left brain communication, also develops slowly and only becomes fully elaborated around the age of twelve (Cozolino, 2002; Teicher, 2004). Thus, in the early years of childhood, right brain experience is relatively independent of left brain experience, lending itself to splitting should the need arise. Studying brain development in children and adolescents, Martin Teicher has observed a correlation between a history of abuse and/or neglect and under-development of the corpus callosum compared to normal controls (2004), which would also support the hypothesis that trauma is associated with independent development of right and left hemispheres and that deficits in communication between the two brains may hinder right-left integration, leaving clients with "two brains" (Gazzaniga, 2015) instead of one integrated brain.

The "split-brain research" of the 1970s (Gazzaniga, 2015) was the first research to show the degree to which left and right hemispheres of the brain operate independently and quite differently. "Split-brain" research refers to studying patients whose right and left hemispheres have been separated by injury or surgery or who have suffered damage to the corpus callosum. Although these patients demonstrate that there seems to be some shared knowledge available to both hemispheres, only the left hemisphere uses language to describe experience and information, while the right hemisphere is more visual, better able to recognize differences and similarities between stimuli but lacking words to describe it. The right hemisphere tends to remember episodically and implicitly, whereas the left is specialized for autobiographical memory and acquired knowledge. But the left hemisphere's ability to encode information verbally does not imply that its recollection of events is more "accurate." "The left hemisphere has a tendency to grasp the gist of a situation, make an inference that fits in well with the general schema of the event, and toss out anything that does not. This elaboration has a deleterious effect on accuracy but usually makes it easier to process new information. The right hemisphere does not do this. It is totally truthful and only identifies the original [information]" (Gazzaniga, 2015, p. 152); that is, the right hemisphere does not "forget" the nonverbal aspects of experience and does not interpret it. Emotions, these researchers discovered, are experienced on both sides of the brain but can only be verbalized by the left hemisphere; the right hemisphere might act on the emotion but could not describe it in words. And without an exchange of information via the corpus callosum, researchers observed that the left hemisphere might have no memory of the right hemisphere's emotion-driven actions and reactions.

Attachment research has also contributed to the literature supporting the concept of an innate tendency to compartmentalize under stress. In longitudinal studies of attachment behavior (Lyons-Ruth et al., 2006; Solomon & George, 1999; Solomon & Siegel, 2003), researchers have demonstrated that children with disorganized attachment status at age one are significantly more likely to exhibit dissociative symptoms by age 19 and/or to be diagnosed with borderline personality disorder or dissociative identity disorder in adulthood. When attachment figures are abusive, the child's only source of safety and protection becomes simultaneously the source of immediate danger, leaving the child caught between two conflicting sets of instincts. On the one hand, they are driven by the attachment instinct to seek proximity, comfort, and protection from attachment figures. On the other, they are driven by equally strong animal defense instincts to freeze, fight, flee, or submit or dissociate before they get too close to the frightening parent. Liotti (1999) hypothesizes that dissociative splitting is necessitated to manage this irresolvable struggle between two such strong emotional and physical drives and two very different internal working models: biologically, the attachment figure automatically elicits the cry for help response or proximity-seeking drive, yet approaching abusive or threatening adults also elicits fear and fight and flight responses.

Van der Hart, Nijenhuis, and Steele (2004; 2006) cite yet another set of fault lines along which dissociative compartmentalization can occur: the "action systems" or drives that propel the stages of child development and adaptation to the environment. One set of drives can be seen in children's innate propensity to attach, explore, play, and develop social engagement and collaboration skills and then, as older children and adults, learn to regulate their bodily needs, mate and reproduce, and care for the next generation (Panksepp, 1998; Van der Hart et al., 2006). Equally, though, children have to depend upon their instinctive animal defenses (hypervigilance, cry for help, fight and flight, freeze, collapse and submission) to quickly inhibit exploration, social engagement, and regulating functions to ensure automatic self-protective behavior. For children raised in unsafe environments, both types of action system are necessary in response to changing internal and external demands: for example, going to school requires a part of the personality that can explore, pay attention in class, learn, and socially engage with peers and teachers. At home, with parents who may be withdrawn or neglectful at some times and violent at others, the ability to rapidly shift from state to state as needed to deal with different threats could be essential: for example, in response to the sound of the abuser's voice or footsteps, panic or fear could alert the individual to danger. Playfulness might lift the parent's irritable mood and facilitate a positive connection by making him or her laugh (social engagement). At times, it might be helpful to capitalize on the submission response to become the precociously responsible child who tries to protect younger siblings in the face of the violent behavior, but at other times, it could be safer to rely on hypervigilance, staying "on guard," carefully observing the parents' mood, and reacting in whatever ways best defend against their "frightened or frightening"

behavior. These patterns of compartmentalization can be conceptualized as trauma-related procedural learning: it is safer to adapt using a system of selves rather than becoming a fully integrated "self."

Extrapolating from the observations by Charles Myers of "shell-shocked" World War I veterans, Van der Hart and colleagues (2004) labeled these different drives or systems "part(s) of the personality." Although "part of the personality" remains a very controversial term in the mental health world, it has certain advantages: first, use of the word "part" clearly suggests that there is a whole person and personality—of which we are studying just one piece. Secondly, it is a word so commonly used to describe normal ambivalence or inner conflicts (e.g., "Part of me wants to eat that piece of cake so badly, but another part won't let me") that it is easily adopted by clients. And lastly, research has demonstrated the propensity of the brain to develop neural networks holding related neural pathways that consistently "fire" together, and these neural systems often encode complex systems of traits or systems (Schore, 2001) that represent aspects of our personalities or ways of being. For example, if neural pathways activating the proximity drive fire consistently in the presence of the attachment figure, along with neural pathway holding feelings of loneliness and yearning for comfort and a neural network holding the tendency to believe that "she loves me—she would never hurt me," the result might be a neural system representing a young child part of the personality with a toddler's yearning for comfort and closeness along with the magical thinking that the attachment figure will be safe and loving, yet also the uneasy feeling that something is not right. Such neural systems can be complex with a subjective sense of identity or can be a simpler collection of traits associated with different roles played by the individual.

Van der Hart et al. (2006) borrowed the language of Myers in describing the aspect of self driven by daily life priorities as the "apparently normal part of the personality" and parts driven by animal defense responses as the "emotional parts of the personality," or, individually, the fight, flight, freeze, submit, or attach for survival parts. In this book, I will use terms that I have found more useful in clinical practice: the "going on with normal life part" and the "trauma-related parts" of the personality. In avoiding the words, "apparently normal," my goal is to emphasize the positive evolutionary function of parts of us driven to survive or persevere and to challenge clients' tendencies to see their ability to function as a "false self" and their trauma-related responses as the "true self." In addition, emphasizing the positive aims and goals of the "normal life" part encourages clients to strengthen their ability to regulate the tumultuous emotions and autonomic dysregulation of the animal defense-related parts, rather than either trying to ignore them or interpreting them as "the true self." Connecting different parts to the survival responses that drive their actions and reactions challenges the client's automatic shame and self-doubt: experiences of feeling rage make more sense when tied to a "fight part" triggered by an act of unfairness; automatic passivity and the inability to say "no" feels less shameful when connected to a young child submit part whose sense

of safety is tied to pleasing others or feeling "less than." The concept that each part represents a way of surviving dangerous conditions, that each represents a different approach to self-protection, gives meaning and dignity to the fragmentation. The parts in this view are not repositories of memory; they were a means of surviving the 'worst of the worst,' not a means of remembering it. As I often say to my clients, "We wouldn't be sitting here together today if each part had not done its job well, if each hadn't helped you to survive." But as carriers of our instinctive survival responses, the parts remain poised for the next threat or the next trauma-related trigger for decades after "it" is over.

Recognizing the Signs of Structurally Dissociated Parts

Just as each individual responds to trauma differently, we would expect each client's structurally dissociated personality system to be unique. Clients whose histories of chronic trauma and/or multiple types of abuse and/or neglect necessitated more complex structural dissociation are likely to have a well-developed going on with normal life self and several different parts driven by the survival responses of fight, flight, freeze, submission, or cry for help. But even in these clients, fragmentation can be more subtle and permeable or more dramatic and rigid: some clients (e.g., those carrying PTSD or bipolar II diagnoses) might shift between clear-cut states (sometimes irritable, sometimes depressed, at other times anxious). Clients with borderline personality disorder might present at times as regressed and clinging; at other times, cold and angry; then, at still other times, hopeless and passively suicidal, while all the while functioning fairly well at work. With mild to moderate dissociative disorder not otherwise specified (DDNOS), the therapist might encounter clearly observable compartmentalization and some difficulty with memory (e.g., not clearly recalling the intense anger and aggressive behavior of their fight parts or the neediness of a young child part with separation anxiety). In clients with dissociative identity disorder (DID), not only will the number of trauma-related parts tend to be greater overall, but these clients are more likely to have other subparts serving the priorities associated with the going on with normal life self, for example, a professional self, a parenting part, or a part with special talents or social skills. In addition, as the neural systems governing each part become more elaborated and autonomous, DID clients start to exhibit switching and time loss as they are "hijacked" by parts who, when triggered, act outside the conscious awareness of the going on with normal life self.

> While updating her curriculum vita, Celia, a successful organizational consultant, was surprised to discover that she had won an award in 1990 for which she had no memory. Not only could she not recall winning it, she couldn't recall what she had done to deserve it! Annie also discovered disturbing evidence of missing time and dissociative hijacking when she received a letter from her oldest friend asking her never to contact him again under any circumstances. "I will never forgive you for what you said to me last week—it was cruel, and I don't want to be hurt anymore." Lacking a memory of having spoken to him recently, she could not imagine why 'she' had been angry at him and what 'she' could have said that upset him so much.

Characteristically, while the going on with normal life part tries to carry on (functioning at a job, raising the children, organizing home life, even taking up meaningful personal and professional goals), other parts serving the animal defense functions of fight, flight, freeze, submit, and "cling" or attach for survival continue to be activated by trauma-related stimuli, resulting in hypervigilance and mistrust, overwhelming emotions, incapacitating depression or anxiety, self-destructive behavior, and fear or hopelessness about the future, that is, the difficulties that often lead clients to seek psychotherapy.

Symptoms as Communications from Parts

Many clients come for treatment after being flooded or "hijacked" by the trauma responses and implicit memories of the animal defense-related parts; others come when their attempts to disconnect or deny these trauma responses lead to chronic depression or depersonalization. Although some clients may present with diagnosable dissociative disorders, many more will come to therapy with trauma-related symptoms that appear initially straightforward, such as PTSD, anxiety and mood disorders, or personality disorders. However, certain symptoms can alert us to the presence of underlying structural dissociation: for example, see the following.

Signs of Internal Splitting

The client functions highly at work when stimulated by "positive triggers" (work assignments, collaboration with peers, responsibilities) while regressing at home or in personal relationships because of the trauma triggers associated with those environments. Or the client might report alternating fears of abandonment followed by pushing away those who try to get close or a tendency to initially idealize others followed by disillusionment and anger when they fail the client in some way. The fears of abandonment represent communications of the attach or cry for help part as closeness to others exacerbates that part's separation anxiety; the pushing away is the response of a fight part activated by the risk of vulnerability or hurt. Splitting often manifests in paradoxical behavior: fears of triggers might be intense, while the client lacks appropriate fears for real threats; the client plans a family vacation for the following summer while simultaneously ruminating on her determination to suicide; or he describes himself as "enlightened," kind, and reasonable, while family and friends portray the client as typically angry, arrogant, and demanding.

Treatment History

The client reports a number of previous treatments that have resulted in little progress or clarity, or describes those treatments as rocky and tumultuous or having ended in some unusually dramatic way. The therapist or previous therapists report feeling "in over my head," "inadequate for what he or she needs," "don't have the skills," while the client reports fearing therapist abandonment more than therapeutic inadequacy.

Somatic Symptoms

Unusual pain sensitivity or uncharacteristically high pain tolerance, stress-related headaches, eye blinking or drooping, narcoleptic symptoms, even physical symptoms with no diagnosable medical cause can be trauma-related or a symptom of dissociative activity. One of the most common indicators of structural dissociation is atypical or non-responsiveness to psychopharmacological medications (Anderson, 2014). In these instances, parts are communicating somatically: blinking or drooping of the eyelids often signals dissociative switching; a collapsed left shoulder and a tense, raised right shoulder might be evidence of a submissive part on the non-dominant side of the body and a part ready to fight connected to the physically stronger dominant side of the body.

"Regressive" Behavior or Thinking

Sometimes, the client's body language seems more typical of a young child than an adult of his or her chronological age: he or she might appear shy, collapsed, fearful, unable to tolerate being seen, or unable to make eye contact. The message might be: "I'm scared—don't hurt me" or "Please notice me—please like me" or "Please don't leave me." Verbal and cognitive style can also reveal the presence of younger parts of the self: concrete or black/white thinking, words or style of expression more typical of a child than an adult. Children use shorter sentences, express themes related to separation, caring, and fairness, and are more likely to feel empathically failed when not well understood.

Patterns of Indecision or Self-Sabotage

Often misinterpreted as "ambivalence," a client's inability to make small everyday decisions or problems with carrying out his or her expressed intentions can reflect conflicts between parts with opposite aims. Often this phenomenon manifests in frequent changes of job, career, or relationship, or a history of success in life alternating with self-sabotage or inexplicable failure, high functioning alternating with decompensation, hard work being suddenly undone by self-destructive actions. Very crucial life decisions can be involved,

but often this pattern appears in difficulties in daily living such as an inability to choose what to wear in the morning, what to eat for breakfast, or whether to keep a date with a friend for lunch.

Memory Symptoms

While memory gaps and "time loss" are cardinal symptoms of dissociative disorders, more subtle memory problems can be indicative of structural dissociation. For example, all of the following memory issues are common manifestations of parts activity: difficulty remembering how time was spent in a day, difficulty remembering conversations or the focus of therapy sessions, "black outs," getting lost while driving somewhere familiar (such as going home from work), forgetting well-learned skills (such as how to drive), or engaging in behavior one does not recall.

Patterns of Self-Destructive and Addictive Behavior

Many studies have demonstrated correlations between suicidality and self-harm and addictive behavior with a history of trauma, so it should not be surprising that therapists encounter traumatized clients who struggle against their own self-destructive behavior. My assumption is that unsafe behavior consistently reflects the activation of fight and flight-driven parts by trauma-related triggers. While the going on with normal life self of the client seeks therapy because he or she is committed to life, to wanting "all the things everyone wants," fight parts engage in high-risk behavior or attempt to harm the body or end life in the effort to get relief from the implicit memories at any cost. Parts driven by the flight response tend to engage in eating disorders that result in numbing or addictive behavior that alters consciousness, allowing distance from unbearable feelings and flashbacks. Fight-related parts are prone to more violent actions, whether aggression toward others or self-harm and suicidal behavior. In a pilot study using the structural dissociation model with a group of severely symptomatic inpatients hospitalized for 2–10 years to prevent intentional or unintentional suicide, six of the eight subjects demonstrated marked improvement after a year of psychoeducationally based treatment focused on identifying the parts connected to the unsafe behavior and strengthening the ability of the going on with normal life self to identify and separate from the impulses of self-destructive parts (Fisher, in press).

By the time the trauma survivor appears at our doorstep, the neurobiological and psychological effects of a dysregulated autonomic nervous system, disorganized attachment patterns, and structurally dissociated parts will have become a set of well-entrenched, familiar, habitual responses. He or she will be unconsciously driven by post-traumatic implicit procedural learning activated by trauma-related triggers. The symptoms and triggered reactions now will be so familiar and automatic that, subjectively, they feel like "just who I am." Although apparently unrelated to the past, these "just who I am"

responses are the conveyors of a narrative that cannot be fully remembered or put into words, a history held by different parts of the personality with different perspectives, triggers, and survival responses.

> For Gillian, the anger, shame, and hopelessness she felt at age 26 had that quality: she didn't have to account for why she felt those feelings because they were so familiar, so much a part of her. She didn't think to be curious about how fearless she could become when angry or how quickly shame and hopelessness could take over her body and stop her words in mid-sentence. Nor was she curious about how confident she was in her ability as an artist, unafraid to market her work yet so afraid of displeasing people in personal relationships. Gillian didn't even feel alarmed by what her therapist called the "suicidal part"; she simply accepted as normal her strong wish not to live. Normal life was a distant memory—something that had once been important to her—but now long gone. She didn't see the subtle but meaningful signs that her going on with normal life part was still alive and well and had always been, even during the worst of times. She was still a wise, mature mother figure for her little sister and the emotional support of her mother—a role that gave her a sense of control over the chaos in the family. Secondly, she had used her aesthetic and creative abilities as a safe haven as a child—that was the side of her with which she identified as "the good side," leading her to become a professional ceramicist in her early twenties. She minimized it: "Hey, if I didn't have an alcoholic mother, I'd probably go in for drugs, so I'm addicted to making things—so what?"

As Gillian attests, trauma survivors all too often develop other symptoms that represent neurobiologically regulating attempts to cope with the trauma: self-injury and suicidality, risk-taking, re-enactment behavior, caretaking and self-sacrifice, revictimization, and addictive behavior. All of these behaviors represent different ways of modulating a dysregulated nervous system and preparing for the next threat: self-injury and planning suicide induce adrenaline-related responses of power, icy calm, control, and physical strength but also a relaxation effect from increased production of endorphins; restricting, binging and purging, and overeating all induce emotional and bodily numbing; and addictive behaviors can be tailored to evoke either numbing or increased arousal or a combination of both. Historically, in the mental health field, we have addressed these issues first by stabilizing unsafe behavior and then treating the traumatic events. But narrative memories are connected to intense states of autonomic arousal. Because the activation "readies" us for danger, remembering is likely to reactivate self-destructive impulses. Even "thinking about thinking about" the memories (Ogden et al., 2016) is often enough to cause a reactivation of the nervous system as if the events were recurring in the here-and-now. The neurobiological research and a better understanding of the somatic legacy of trauma advise us to take a new and different course in treatment (Van der Kolk, 2014; Ogden et al., 2006). (See Chapter 2 on Understanding Parts, Understanding Traumatic Responses and Chapter 7 on Working with Suicidal, Self-Destructive, Eating Disordered, and Addicted Parts.)

Helping Clients and Their Parts "Be Here" Now

When their symptoms represent implicit memories held by trauma-related parts expressing emergency and survival responses, individuals continue to feel unsafe, and their parts continue to defend, as if threatened now. When trauma responses are misinterpreted in these ways, it threatens the parts: it feels like proof that they are endangered, defective, or trapped in a hopeless situation. Once again, the felt sense is that they are in danger, alone, without protection. Our first priority in treatment must be to challenge this subjective perception that their symptoms are indicative of current danger or proof of their defectiveness or "just who they are." Therapists need to counteract the habitually triggered danger signals and trauma responses by calling attention to these reactions as communications from parts. When clients are provided with psychoeducation about structural dissociation, encouraged to become mindful and curious instead of reactive, helped to develop new responses to triggers, they begin to build the capacity to self-regulate and to "be here now." Then, by pacing the exploration of the past in such a way that the autonomic nervous system gets a chance to experience regulation instead of dysregulation, clients can experience moments of what I call "being present in the present," moments of feeling calm in the body, being able to think clearly, knowing they are safe.

In the next chapter, we will explore how to understand the issues and symptoms described by our clients as manifestations of the "living legacy" of trauma. Without an understanding of post-traumatic implicit memory or structural dissociation, not knowing they have been triggered by some cue reminiscent of the past, they interpret fear, shame, and anger as signs of imminent danger or deep-seated inadequacy. It can be a relief to discover that their stuckness, resistance, chronic depression, fear of change, entrenched fear and self-hatred, crisis and conflict, even suicidality all can be communications from parts who fear for their lives, unaware that the dangers they are bracing against are now in the past. Disappointment, criticism, closeness, or distance, even authority figures, may no longer be life-threatening, but each nonetheless evokes trauma-related implicit memories and the parts that hold them. Helping clients learn to become curious and interested in their symptoms and able to identify the voices that speak through their reactions can change their relationship to themselves and to the past from one of shame and dread to one of compassion. Knowing that each part is charged with the mission to survive, each in its own way, helps clients to see that how they survived was more crucial than how they were victimized. Understanding how each part participated in survival increases

the sense of "we, together" and challenges the sense of being abandoned and alone. Feeling warmth and empathy for young wounded selves feels healing and comforting.

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CHAPTER 2

Understanding Parts, Understanding Traumatic Responses

> "When the images and sensations of experience remain in 'implicit-only' form ..., they remain in unassembled neural disarray, not tagged as representations derived from the past ... Such implicit-only memories continue to shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment, but this influence is not accessible to our awareness."
>
> (Siegel, 2010, p. 154)

Trauma often leaves its legacy in ways that don't fit traditional diagnostic or treatment molds. Rather than finding relief in disclosing their secrets, clients feel ashamed, mistrustful, or exposed. Instead of feeling better, they experience difficulty remembering or generalizing their new learning outside of therapy and return like Winnie the Pooh to the very same place over and over. Or there is no one "she" or "he" with whom the therapist can work. The agitated, angry client of last week is often replaced by someone who is depressed, shut down, unable to say more than a few dark words. Then, the next week, plans for the future are the subject of discussion rather than despair and suicide. When we mention last week's disclosure of sexual abuse, the client is surprised; the disclosure has been forgotten as if it hadn't occurred. Whereas, last week, therapy was the client's only safe place, today it feels unsafe and threatening. Worse yet, the determination to change has given way to the fear of change. Not only is the therapist confused by these shifting states of mind, so too is the client.

In the context of life threat, survival is a necessity. Being able to consciously witness the experience, preserve a sense of time, place, and identity, and clearly encode a memory of what happened frame-by-frame is an unnecessary luxury when human beings are in immediate danger. Faced with potential threat, the brain and body instinctively mobilize the emergency stress response, preparing the individual to take action: fleeing, fighting, ducking, and hiding. As danger cues are perceived by the sensory system, a chain reaction of neurochemical events is set in motion. The *amygdala* (a structure that serves as the

brain's smoke detector and fire alarm) begins to "fire" more rapidly, activating another limbic system structure, the *hypothalamus*, to initiate an adrenaline release to "turn on" the sympathetic nervous system. As the adrenaline release speeds up heart rate and respiration to increase oxygen flow to muscle tissue, the body prepares to engage fight-flight impulses. The individual feels braced and strong; the events unfold in slow motion; an icy calm replaces fear; the eyes narrow; and the body prepares for action, clenching fists, engaging the leg muscles, biceps, and shoulders. As fight and flight responses unfold, release of another neurochemical, cortisol, begins to activate reciprocal activity in the parasympathetic nervous system. The parasympathetic system is best known for its role in recuperation, rest, and states of calm and is often referred to as an "energy conservation system" in contrast to the "energy expending" sympathetic system (Ogden et al., 2006). As the body mobilizes for fight and flight, the parasympathetic system prepares the body to freeze (like a deer in the headlights) to avoid exposure or to submit or "feign death" (Porges, 2011) if the individual is trapped with no way out, no way to defend. The parasympathetic system also helps the body recover from the massive expenditure of energy involved in fighting and fleeing, facilitating feelings of depletion, exhaustion, "just need to sleep," or numbing.

In traumatogenic environments where the threat of danger is ever-present, it is more adaptive for both children and adults when their bodies are conditioned to maintain a readiness for potential danger. These automatic patterns of response may be sympathetically activated (biased toward hypervigilance, high arousal, readiness to take action, impulsivity) or parasympathetically dominant (without energy, exhausted, slowed, numb, disconnected, hopeless and helpless). For children or victims of domestic violence who endure day-in-day-out conditions of threat or for whom being seen and not heard is the safest adaptation, it is common to see parasympathetic patterns of passivity, slowed thinking, and depression or shame dominating the individual's experience. In sympathetically dominant clients, it is more typical to see hyperactivity, reactivity, feelings of anger or fear, a readiness to act first and think later, and mistrust or hypervigilance.

Because survival depends upon sympathetic highs and parasympathetic lows to drive animal defense responses, these clients' nervous systems have been conditioned to dysregulate under stress. The parts connected to sympathetic arousal (fight and flight parts, the attach part, and the freeze part) and those connected to parasympathetic arousal (submit, the going on with normal life self) are primed for activation as the nervous system responds to triggers. Under traumatic conditions, individuals fail to develop or lose the capacity for a "window of tolerance" (Ogden et al., 2006; Siegel, 1999). The "window of tolerance" refers to the individual's bandwidth or capacity to tolerate intense emotions at the sympathetic end and bored, numb, or "low" feelings at the parasympathetic end. Because most threatening conditions for traumatized children are recurrent or "enduring" (Saakvitne, 2000), there is generally very little opportunity to develop a window of tolerance. To adapt,

their bodies have had to be on high alert, ready for action, or to be disconnected, numb, passive, and able to endure whatever comes. When they are triggered later in childhood or as adults, their nervous systems are already conditioned to activate the same autonomic responses and animal defenses that served them best as children (Ogden et al., 2006). As Grigsby and Stevens (2000) stress, "An activity that previously has been adaptive is likely to recur because the brain functions automatically, but probabilistically, to produce that [same] behavior in similar circumstances" (p. 51). The body's instinct to prepare for the next threat, while ensuring survival, is inconsistent with the opportunity to recover from what has just happened, to feel a sense of "it's over now," or to reset the nervous system to a calm, resting state. Years later, clients often report a feeling of anxiety when they begin to access feelings of calm: "It feels so weird," they complain, "I'm not comfortable with it."

In addition, when the autonomic nervous system is repeatedly activated, the *hippocampus* (the part of the brain responsible for putting experience into chronological order and perspective preparatory to being transferred to verbal memory areas) is suppressed (Van der Kolk, 2014). Without a functioning hippocampus or prefrontal cortex, the individual is deprived of an opportunity to witness what happened or to process it and is left instead with only the "sensory elements [of the experience] ... unintegrated and unattached" (Van der Kolk, Hopper, & Osterman, 2001). For the very worst of human experiences, the body's survival responses have impeded the mind and body from making meaning of what has happened. Survivors are left with a confusing array of unfinished neurobiological responses and "raw data," i.e., the overwhelming feelings, physical reactions, intrusive images, sounds, and smells associated with the event encoded as implicit memories and therefore unrecognizable as "memory."

With the advent of brain scan technology in the mid-1990s, it became possible to study traumatic memory by observing the brain's response to "script-driven provocation," a type of research in which subjects recall the details of a specific trauma while their brain activity is scanned and recorded. Bessel van der Kolk (2014; 1994) had been arguing for years that "the body keeps the score:" that traumatic memories did not resolve as did ordinary memories because they were physiologically driven rather than subject to deliberate recall. He believed that this underlying physiology accounted for the occurrence of "re-enactment behavior" in trauma patients and a host of other symptoms we associate with post-traumatic stress disorder (PTSD). In addition, most trauma survivors tended to have either too many unbidden intrusive memories or "not enough" memory to feel certain of what happened, very different from their memories of ordinary events that could be willingly recalled.

The brain scan research slowly but surely revealed the causes of these unique characteristics of traumatic memory: when research subjects recalled a traumatic event in their own words, the language and narrative areas of the prefrontal cortex became inactive, while emotional memory centers in the right hemisphere limbic system, especially the *amygdala*, became highly activated. With the left hemisphere language centers inhibited, these subjects

were speechless, leaving the amygdala to "fire" (i.e., stimulate an emergency stress response) unchecked—as if the event were happening all over again. This research thus confirmed another characteristic of traumatic memory: even if it could not be deliberately retrieved and verbalized, it could be activated by triggers (i.e., stimuli in some direct or indirect way connected to traumatic events), even decades after the events were over. Gillian provides us with a good example of these characteristics of traumatic memory.

> Gillian's traumatic experiences of 10 years before were reflected in triggered implicit memory states: swings from anger to numbing, shame and self-doubt, difficulty attaching to others but also difficulty tolerating aloneness or separation, feeling overwhelmed and wanting to die "to get it over with." She didn't remember clearly her mother's neglect or older brother's incestuous behavior, and she would never have thought to connect her extreme feelings to the events she could recall, but as a 26-year-old still living in her parents' home, she was constantly triggered by apparently benign stimuli. Though her mother was now less depressed and her brother was an adult and out of the home, the house was full of "landmines." The most innocuous stimuli (e.g., being alone in the house, not being "heard" when she tried to express her feelings, disappointment that no one understood her) evoked strong feelings that she still wasn't "safe."

Uninvited Remembering

As difficult as it can be to deliberately recall traumatic experiences as a past event, the brain's "negativity bias" (Hanson, 2014), its tendency to perceive and prioritize negative stimuli more quickly than positive stimuli, results in long-term sensitivity to all cues related to previous danger. Even very subtle cues (e.g., Gillian's being alone at home or feeling disappointed) can stimulate the implicit memories and inadvertent uninvited "remembering." Without stimulus discrimination, unavailable when the prefrontal cortex is inhibited, the body responds as if the individual was facing life-or-death threat now. It instinctively mobilizes the same survival defense responses as if the client were in immediate danger. For survivors of trauma now in their 40s, 50s, and 60s, this reactivation of memory via triggers has been especially costly. Many have been victims of triggering for many more years than they were exposed to the actual traumatic events. Without awareness that their triggered responses are evidence of body and emotional memory, they "believe" the pounding heartbeat, burning shame, braced muscles, inability to breathe, numbing, and/or explosive rage are signs that they are in danger. When it becomes clear that they are not at risk, other fears arise: maybe they are going crazy, or have proof they are defective, or maybe they are just going through the motions of life "pretending." On the basis of this "evidence," many traumatized individuals isolate and withdraw, end healthy relationships prematurely or explosively, or can't end unhealthy ones.

Many function but avoid living life fully to reduce their exposure to triggers, and others engage in self-destructive behavior to manage the overwhelming feelings and activation, only to feel more damaged and defective.

"Remembering" Actions and Reactions

With a more scientific understanding of the neurobiology of trauma, traumatic memory can now be understood as a highly complex phenomenon. How each individual encodes memories of the traumatic past is unique and different, but what each has in common is the way in which memory is fragmented and unintegrated. Some trauma survivors have more explicit memories for events; some have little to none. All have a host of implicit memories, including trauma-related emotions, autonomic arousal responses, muscle and body memories, cognitive distortions, and visceral memories, as well as tactile-olfactory-visual and auditory memories.

And to a greater or lesser degree, all "remember" via trauma-related procedural or conditioned learning (Grigsby & Stevens, 2000), too. The procedural memory system is a subset of implicit or nonverbal memory that encodes function, action, and habit: that is, riding a bike, driving a car, social behavior like shaking hands or smiling on greeting others, and well-learned abilities from playing the piano to playing golf or tennis. Survival "habits" are also encoded as procedurally learned behavior—for example, tendencies to automatically disconnect from strong emotion or to feel overwhelmed by it, difficulty making eye contact, need for a certain physical proximity or distance from others, withdrawal or isolation, difficulty asking for help or disclosing feelings and personal information, a tendency to say "too much" or "too little," phobias of emotions or emotional expression, avoidance of having one's back to others or to doors and windows, habits of freezing, fighting or fleeing in response to stress or triggers.

To the extent that the individual has difficulty identifying implicit emotional, physical, or procedural memories as "memory," reality-testing can become compromised, creating a kind of self-triggering. When particular people or situations are experienced as unsafe, there is a tendency for them to become "demonized," that is, to become associated with danger or menace. Once the trigger is also a trigger, the body responds to it as a danger signal in its own right; the prefrontal cortex shuts down; and there is no witnessing brain to discriminate memory from present reality. Gillian's fear of helping professionals illustrates how innocuous or even positive stimuli can become associated with a sense of threat and thereafter experienced as dangerous. It also demonstrates that if the implicit memories and trauma responses are associated with a child part, reality-testing will be even more challenging because a child part's cognitive style, limited by the age or developmental stage of that part, is likely to be more concrete.

> Gillian developed a fear of therapy and therapists in her early teens: as the family's identified patient, she was sent to one therapist after another to be "fixed." None of them "got" what her behavior was communicating about her mother's alcoholism or her brother's abuse and

> focused on strengthening her relationship with her family by getting her to be more compliant. "Not being understood," "not being heard," or "no one getting it" are all very powerful triggers for traumatized individuals. Without realizing it, the therapists' automatic assumption that this was a healthy but overly permissive family with a challenging child made them triggering stimuli and therefore dangerous. Isolated from her peers, the "best friend" of her fragile mother, dependent on her father's financial assistance, and triggered by the helping professionals, Gillian regarded therapy as a dangerous place she had to navigate rather than as a source of help and safety. Had she known that her fear was a communication from a young child part that longed for help but was triggered by the failure of former therapists to "believe her," Gillian would have been able to make a connection between the past and present. She might even have felt protective of this little girl and tried to stand up for "her." She might have been able to reassure the child that, even if no one else did, Gillian believed her unquestionably. Gillian knew what had happened. She might even have been able to tell the little girl that not being understood or believed was hurtful but it wasn't dangerous—as long as she was in Gillian's care.

For trauma treatment to be effective, no matter what methods we employ, survivors have to be able to integrate past and present. Concretely, this step requires education: about what traumatic memory is and is not, about triggers and triggering stimuli, about learning to accurately label triggered states ("this is a feeling memory"—"a body memory"), and cultivating the ability to trust that triggered states "tell the story" of the past without the necessity to either recall or avoid recalling specific incidents. When the therapist can also help clients connect implicit memory states to young parts of the self, it is easier to address them as a record of old dangers instead of signs of current threat. Also, when the triggered sensations, emotions, and images are reframed as "the child part's feelings," clients are better able to tolerate their intensity. Feeling compassion or protectiveness for younger selves also helps the clients to feel their "big-ness," to appreciate the physical size differences, the adult capabilities and resources, and the greater respect which individuals are accorded as adults and the greater safety it enables them to count on.

Finding "Now," Not "Then"

It is not difficult for traumatized individuals to re-experience the past, explicitly or implicitly. What is more challenging is how to "be here now" when one's body is communicating "danger, danger—red alert!" We now know that, as important as it is to acknowledge the past, it is even more crucial for traumatized individuals to stay connected to present time: "Right now, I can feel my feet—I can see where I am—this is just a moment—it will pass." The past does not have to be denied or avoided. It simply is (Rothschild, in press). Acknowledging the past without exploring it or observing the past intruding

into present experience is very validating for traumatized clients: "Of course you are sensitive to disappointment! After a childhood of neglect and false promises, who wouldn't be sensitive to disappointment?" Acknowledgment of the past while lingering in the awareness of the present is much more helpful to clients in the early stages of therapy than exploring the past in detail and inadvertently evoking its implicit components.

When the implicit aspects of memory reactivate the sense of danger "now" instead of conveying that we are remembering dangers that are over, we can't look back on the past. There is no vantage point in the here-and-now from which to look back and view what happened "then." Rather than remembering what happened, once thought to be the goal of trauma treatment, we know now that resolution of the past requires *transforming* the memories. As Bessel van der Kolk wrote over 20 years ago, "[The] goal of treatment is to find a way in which people can acknowledge the reality of what has happened without having to re-experience the trauma all over again. For this to occur, merely uncovering memories is not enough: they need to be modified and transformed, i.e., placed in their proper context and reconstructed into neutral or meaningful narratives. Thus, in therapy, memory paradoxically becomes an act of creation, rather than the static recording of events ..." (Van der Kolk, Van der Hart, & Burbridge, 1995, p. 2).

"Transformation" or "reconstruction" of traumatic memory occurs as the individual's relationship to both the implicit and explicit memories undergoes change, as tolerance for triggered or dysregulated states expands so that he or she can "be here now," live more fully in the present, and slowly reorganize the unprocessed implicit elements into a new narrative that, as Donald Meichenbaum (2012) says, tells a "healing story."

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