Self-Destructive And Suicidal Behaviour As A Traumatic Attachment Disorder

Part 1 and Part 2

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6 CPD Hours

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Janina Fisher, Ph.D.

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"[Traumatic] stress sculpts the brain . . . Stress can set off a ripple of hormonal changes that permanently wire a child's brain to cope with a malevolent world."

Teicher. 2002

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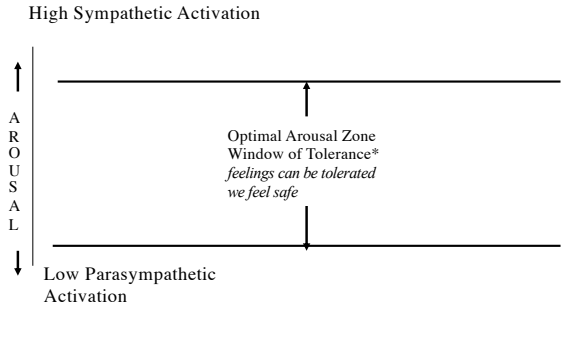
Early attachment relationships condition the nervous system



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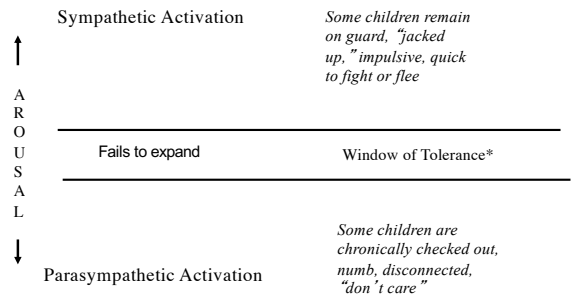
When the parent is frightening, dysregulating instead of regulating,



Ogden and Minton, 2000; Fisher, 2009

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Traumatic Attachment = Frightening Attachment Figures

"[Frightened/frightening] caregiving behavior causes "fright without solution" . . . because 'the caregiver becomes at the same time the source and the solution of the infant's alarm' (Main & Hesse, 1990, p. 163). ***Fear comes to . . . coexist, in the infant's experience, with the soothing provided by proximity to the caregiver."*** *Liotti, 2011, p. 234*

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The Result is "Disorganized Attachment"

- Disorganized attachment beginning at age 1 has been correlated with **maternal behavior characterized as "frightened" or "frightening"** (Liotti, 1999; Lyons-Ruth, 2001).
- Children whose caregivers behave in frightening ways or who appear frightened are statistically more likely to have the same autonomic and neuroendochrine symptoms found in trauma (Ogawa et al, 1997)
- Disorganized attachment is **a statistically significant predictor of Borderline Personality Disorder and DID** in adulthood (Lyons-Ruth, 2001). Disorganized attachment status has been **found in 50-88% of BPD patients** studied (Korzekwa, 2009)

Fisher, 2021

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Maternal Unresolved Attachment = Disorganized Attachment in the Child

•The mothers of disorganized infants have their own histories of trauma, loss, attachment failure, or separation. Even in the absence of specific trauma, these mothers frequently exhibited PTSD and dissociative symptoms

•**"[Rather than arousing impulses to calm and comfort, . . . the activation of the attachment system arouses in these parents strong emotions of fear and/or anger.** Thus, while infants are crying, 'unresolved' parents may interrupt their attempts to soothe them . . . with unwitting, abrupt manifestations of alarm and/or anger."

(Liotti, 2004, p. 477)

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"Frightened and frightening" caregiving is traumatic for children

Frightened Behavior
Backing away
Frightened voice
Dazed expression
Exaggerated startle
Withdrawn
Non-responsive

Frightening Behavior
Looming, attack postures
Sudden movements
Mocking, teasing
Intrusive
Emotionally reactive
Loud, startling noises

Lyons-Ruth, 2000; Fisher, 2003

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Why does "frightened and frightening" caregiving have a traumatic effect on children?

"In human infancy, ***experienced threat is closely related to the caregiver's affective signals and availability*** *rather than to the actual degree of physical or survival threat inherent in the event itself.* ***Equipped with limited behavioral or cognitive coping capacities, the infant cannot gauge the actual degree of threat."***

Lyons-Ruth et al, 2005

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Two "Flavors" of Disorganized Attachment

- The essential characteristic of disorganized attachment is **an internal struggle between the drive to attach or connect versus drives to fight or flee**
- Some of our clients have '**disorganized/unresolved attachment with preoccupied tendencies:**' they pursue, experience intense fears of abandonment and rejection while also mistrustful, suspicious, quick to anger
- Others have '**disorganized/unresolved attachment with avoidant or dismissing tendencies**:' they may long for relationship but keep their distance or push away those who come too close, including the therapist! Fisher, 2011

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The long-term effects of early trauma & traumatic attachment

"If an individual is born into a malevolent and stress-filled world, it is crucial for his survival . . . to maintain a state of vigilance and suspiciousness *that enables him to readily detect danger.* ***He will need*** *. . .the potential* ***to mobilize an intense flight-fight response and to react aggressively to challenge*** *[in order] to facilitate survival . . ."*

Teicher et al, 2002

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"[These animal defense survival responses] markedly augment the individual's capacity to rapidly and dramatically shift into an intense aggressive state when threatened by danger or loss."

Teicher et al, 2002

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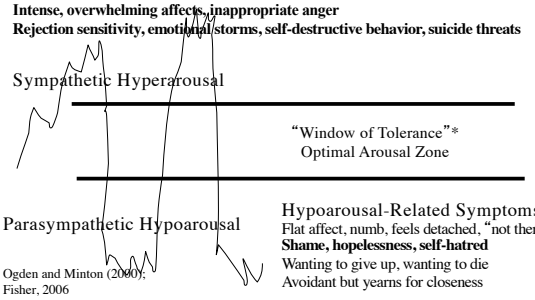
Autonomic Dysregulation & Unsafe Behavior

Hyperarousal-Related Relational Symptoms:
Sensitivity to dysregulation escalates with increasing intimacy or dependency
Chronic hypervigilance, **separation anxiety, preoccupation with relationships**
Intense, overwhelming affects, inappropriate anger
Rejection sensitivity, emotional storms, self-destructive behavior, suicide threats



Hypoarousal-Related Symptoms:
Flat affect, numb, feels detached, "not there"
Shame, hopelessness, self-hatred
Wanting to give up, wanting to die
Avoidant but yearns for closeness

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

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Trauma has extreme effects

The research is clear:

- **Traumatized individuals are** more prone to suicidal ideation and **more likely to make suicide attempts** (Krysinska & Lester, 2020) than non-traumatized individuals. Also more likely to abuse substances or have an eating disorder
- Trauma is also associated with major depression, anxiety disorders, OCD, and diagnoses of bipolar and borderline personality disorder

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Treatments for self-destructive behaviour

- Historically, we have treated suicidality and self-destructive behaviour using:
  - Personality disorder models: labeling suicidality as attention-seeking and manipulative, emphasizing behavioural control over safety
  - DBT and CBT: skill-building approaches, requiring learning alternative responses and retrieving them in the moment of crisis
- Both types of approaches ignore the connection to trauma, and both require that the client's prefrontal cortex retain information and use it in a crisis

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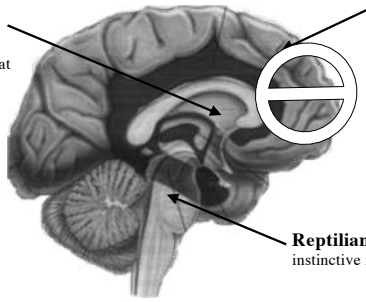
Both types of treatments are defeated by prefrontal inhibition

Limbic system: trauma-related emotions, threat responses

Prefrontal cortex: inhibited under threat, can't access skills or perspective



Reptilian Brain: instinctive impulses

Nijenhuis, van der Hart, & Steele, 2006

Fisher, 2012

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Autonomic dysregulation is at the heart of self-destructive behaviour

Sympathetic hyperarousal drives action-taking:
Adrenaline stimulates action impulses: fight, flight, 'do something'
Trauma-related anxiety and anger increase impulses to action
Prefrontal shutdown interferes with good judgment and awareness of consequences

Sympathetic Hyperarousal

"Window of Tolerance"*
Optimal Arousal Zone

Parasympathetic Hypoarousal

Hypoarousal-Related Symptoms:
Hopelessness and loss of energy prevent non-impulsive action
Numbing, disconnection, and prefrontal shutdown reduce awareness of consequences

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

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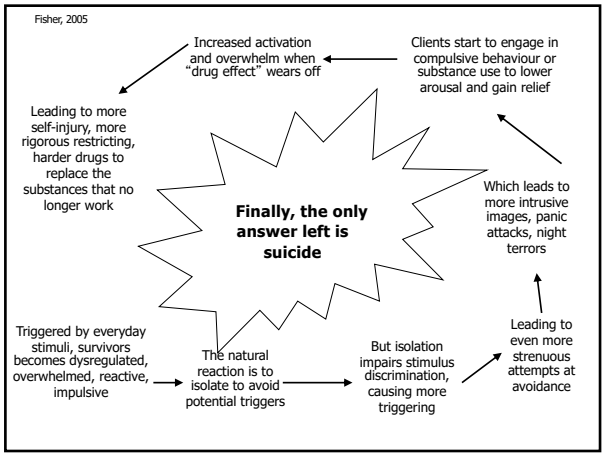
Fisher, 2005



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Self-destructive behaviour and trauma

Self-destructive behaviour arises as a **survival strategy:**

- *To self-soothe and self-regulate*
- *To numb the hyperarousal symptoms: intolerable affects, reactivity, impulsivity, obsessive thinking*
- *To combat helplessness by increasing hypervigilance and feelings of power and control*
- *To "treat" hypoarousal symptoms of depression, emptiness, numbness, deadening*
- *In the service of walling off intrusive memories*
- *As a way to function or to feel safer in the world*

Fisher, 2008

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Core assumptions in a trauma model of self-destructive behaviour

- For trauma patients, **self-destructive behavior is a post-traumatic reaction** triggered by even subtle threat-related stimuli. **Triggers stimulate autonomic responses driving instinctual defenses of flight, fight, or cry for help**
- **The prefrontal cortex shuts down,** blocking access to reason and good judgment and allowing **defensive survival responses to over-ride commitments to safety**
- After an unsafe incident, clients may have little perspective and sometimes little memory of what happened. **They may not recognize that they were triggered or realize <u>how</u> unsafe they were** Fisher, 2021

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How unsafe behaviour 'helps'

- Jan, recalling abuse at age five: *"Every day, I would say to myself, 'I can die tomorrow.' I got through each day by promising myself I could die the next day."*
- Annie, recalling how cutting helped her to function: *"I would cut myself to get off the floor of the closet and go downstairs and make dinner for my family."*
- Anita, recalling a hospitalization at age 13: *"After I got out, I went to a party and had my first beer. I thought, 'If I have beer, maybe I won't have to go back there again."*
- Peter: *"I survived as a kid by locking myself in my room and eating and masturbating til I got numb."*

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How substances "medicate" PTSD

Hyperarousal symptoms:

- Alcohol and marijuana induce relaxation and numbing, facilitate social engagement by decreasing hypervigilence, and allow sleep. Cocaine, speed, and crystal meth counteract relaxation effects or maintain hypervigilance. Heroin dampens rage and impulsivity, while ecstasy combines relaxation with increased energy

Hypoarousal symptoms:

- Speed, cocaine, ecstasy and crystal meth counteract feelings of "deadness," numbing, hopelessness and helplessness, while marijuana and other downers maintain the hypoarousal. Alcohol, at different "dosages," can induce numbing or counteract it. Although a depressant, alcohol in small doses has a stimulating effect

Fisher, 2003

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Compulsive behaviours and self-regulation

- **Eating disorders:** over- and under-eating both induce numbing effects, while purging results in a temporary increase in arousal followed by profound hypoarousal
- **Suicidal fantasies and planning:** thoughts of suicide increase the sense of control, of having choices, a way out, and provide temporary relief from overwhelm
- **Self-injury:** self-harm produces both an adrenaline and endorphin response in the body, increasing energy and feelings of power and clarity but also buffering the pain
- As in substance abuse, prolonged use of these behaviors leads to tolerance: more and more is needed to achieve the same effect

Fisher, 2003

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Core assumptions of integrated model

- **Sobriety or abstinence from self-harm only address the safety issues.** When the behaviour has been a post-traumatic survival strategy, new challenges now arise
- **The client now faces not only the risk of relapse but the risk of post-traumatic flooding**, autonomic dysregulation, increased impulsivity, overwhelming emotions, and flashbacks, all of which predispose the client to relapse
- **Treatment must address the relationship between the trauma and the self-destructive behaviour**: its role in "medicating" traumatic activation, its origins in the traumatic past, and **the reality that recovering from either requires recovering from both**

Fisher, 2007

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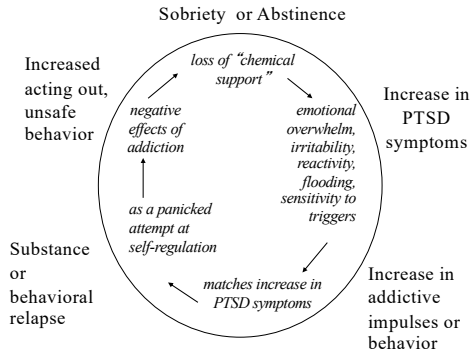
Abstinence/Relapse Cycle



Fisher, 2009

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"First Things First"

- **Increasing the ability to be mindful rather than judgmental:** mindfulness regulates arousal, "wakes up" the frontal lobes, increases self-awareness, and allows observation of patterns that "feed" addictive behavior
- **Building curiosity:** since curiosity regulates the nervous system, it lessens needs to act out
- **Focusing on the relationships between trauma-related emotions and body sensations and compulsive behaviour:** *e.g., by learning to observe overwhelming feelings and impulses, increasing ability to notice the relationship between triggers, symptoms, and addictive behavior*

Fisher, 2013

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Psychoeducation

- **Offer a "crash course"** on addictions/eating disorders as attempts to self-regulate and on the Abstinence/Relapse Cycle
- **Normalize feelings/behaviour** that have been sources of shame **as ingenious attempts to cope**
- **Label the symptoms as "symptoms":** poor judgment and impulse control ("I can't help it"), self-loathing, self-neglect
- **Increase awareness of post-traumatic triggering** and habitual triggered survival responses: "getting" the logic of trauma decreases shame/increases understanding of cause-and-effect
- **Encourage curiosity and compassion:** "That makes sense," "Of course you feel trapped at AA meetings," "12-step programs are just another treatment, and all treatments have side effects"

Fisher, 2003

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Differentiating 'safe' and 'unsafe'?

•If self-harm, eating disorders, addictive behaviour and suicidal ideation are all attempts to self-regulate, it is important not to treat them simply as life-threatening. **We need to distinguish life-threatening unsafe behaviour and behaviour aimed at self-regulation**

•**The therapist should not assume that all of these 'addictive behaviours' are intended to be life-threatening. Ask**: "How does this *help*? What does it do?"

•**Self-injury is rarely life-threatening.** If we respond as if it has suicidal intention, we may unintentionally exacerbate it. We will dysregulate the client and over-protect, robbing the client of the opportunity to regulate her- or himself

Fisher, 2009

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Most common mistakes made by therapists in working with unsafe behaviour

•Failing to validate the **relief** offered by unsafe behaviour

•Failing to understand the fear of relying on other people versus relying on a behaviour under your own control

•Failing to see that care of the body is not a priority for the trauma survivor: when your body only matters as a vehicle for discharging tension, its care becomes meaningless

•Failing to convey that trauma-related shame and secrecy will make it feel "normal" to lie/evade and "unsafe" to disclose

•Becoming engaged in a struggle in which the therapist becomes the spokesperson in favor of safety and the patient the spokesperson for unsafe behaviour, neglecting the task of helping clients to struggle with the opposing forces within them

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Not all suicidality is 'unsafe'

•**Active suicidal ideation and creating suicide plans may be indicators of unsafety, but not always**. Some trauma clients have suicide plans for many years without ever making an attempt.

•With planning and active ideation, **the therapist should be curious and concerned without conveying alarm**. Our alarm increases dysregulation instead of modulating it

•**What should we be curious about?** Curious about how long the client has had the plan, about what has triggered the increased intensity of suicidal longing, about how impulsive or desperate the client is feeling, about whether or not s/he is seeking death or just relief from overwhelm Fisher, 2009

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The good news and the bad news is that therapy and the therapist stimulate the attachment system

"Contact itself is the feared element because it brings a promise of love, safety, and comfort that cannot ultimately be fulfilled and that reminds [the patient] of the abrupt breaches of infancy."

L.E. Hedges (1997, p. 114)

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Stimulation of the attachment system ⟹ stimulation of the fear system

"To be known or recognized is immediately to experience the other's power. The other becomes the one who can give or withhold recognition: who can see what is hidden; who can reach, conceivably even violate, the core of the self."

Benjamin, 1994

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"Help" can feel dangerous

- The lows of hypoarousal and the anxiety or impulsivity of hyperarousal motivate clients to seek help. But the conditioned learning to "maintain a state of vigilance and suspiciousness" complicates seeking therapy
- **Therapists are triggering:** we are human beings and caregivers, and we ask dangerous things—self-disclosure, trust, connection to emotion
- We are well-meaning threats. What if we ask, "Tell me about what happened to you. . ."? What if we abandon the client once we've learned their terrible secrets? What if we take advantage of the client's trust?

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Manifestations of disorganized attachment in relationship

- Intense proximity-seeking behavior alternating with devaluing, distancing, or increased de-stabilization
- Flights from the other: threats to leave, distancing, "one foot in, one foot out"
- Difficulty communicating: inability to articulate issues/feelings; becoming mute or distracted in therapy, shutting down
- Difficulty separating, unable to tolerate distance, separation anxiety, proximity-seeking through texts, emails, telephone calls
- Need for repeated proof of 'caring:' fears of abandonment, need for repeated reassurance

Fisher, 2022

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Manifestations of disorganized attachment, cont.

- Hypervigilent attention to the other: quick to respond defensively, distrust/distortions, fights for control of relationship
- Strong, out of proportion reactions: unable to tolerate others' imperfections/limitations, ways of living and relating
- Repeated requests for changes in distance: more contact/less contact, more support/less support
- Disproportionate distress around separation or absence
- Increased de-stabilization with increased closeness: emergencies, crisis, acting out, increased suicidality or addictive behavior
- Inability to share responsibility for therapeutic relationship

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Addressing the challenges

- **We have to remember that WE are TRIGGERS:** our presence will inevitably stimulate feeling memories of the yearning for closeness along with equally strong impulses to fight or flee.
- We must **avoid interpreting triggered reactions as "manipulation," resistance, or "attention-seeking."** These behaviors are driven by body memories of early experience of clients and associated with life threat
- We must remember that **disorganized attachment behavior is an expression of conflict within the client,** not between the client and us! We are often not experienced as "us"

Fisher, 2015

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Trauma-informed communication

•Keep in mind the type of environment(s) to which your patient was forced to adapt just to survive. **Over-reactions** to our words and body language **are not indications of being "dramatic" or "attention-seeking."**

•They **reflect the experience of knowing that a slight change in an adult's tone or body language can mean the difference between safety and danger.** They reflect the experience of being with adults who seemed to take pleasure in humiliating or intimidating children

•For our interventions to be effective, our communications must be accompanied by body language and facial expressions that feel safe, not threatening Fisher, 2011

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Building attachment in the therapeutic relationship

- "Fear comes to paradoxically co-exist with soothing" (Liotti, 2011): **attachment to the therapist is often longed for but also deeply threatening**. Traumatic attachment means that closeness is associated with danger but also distance and separation
- **With traumatized clients, we must first communicate that we 'get it'—that we understand and accept their reality.** What they experience as 'getting it' may be very different from **our** idea of what constitutes understanding
- Do we communicate that we expect trust or that it's normal for them to feel wary or mistrustful of us?

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Addressing disorganized attachment in the therapy

•**Attune to the effects of disorganized attachment on the therapeutic relationship**: begin by accepting that the therapy relationship poses **as much threat as hope**, avoid induction into the system, recognize countertransference (especially anxiety, the pull to help, wish to connect)

•**Strive for equal validation of both defensive AND attachment drives:** allowing distance, validating mistrust, "going with" resistance rather than opposing it

•**Emphasize mastery instead of relationship:** avoid doing too much for the patient, try taking a "consultant role," increase your tolerance for crisis/stuckness, be curious

Fisher, 2011

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Use right-brain communication

•**"Right brain-to right-brain" communication is non-verbal communication through the social engagement system,** the kind of communication we instinctively use with babies, children, and animals. It relies on the facial muscles, the eyes, larynx, turning movements of the head and neck, as well as on proximity and distance, warmth vs. reserve, and a host of other nonverbal communications

•**When we utilize "right brain to right brain" communication,** we pay less attention to the words we use and more to how we "talk about" it. Our actions, tone and body language are used to shift the nonverbal experience of the other instead of our message Fisher, 2010

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Right-brain communication, cont.

•When attachment has been disorganized by frightened and frightening caregiving, **the therapist must concentrate on trying not to stimulate the sense of threat OR the intense attachment longing**.

•We can avoid stimulating longing or threat by finding a middle ground between too much distance **or** closeness, between warmth and intimacy, support and availability, strength and gentleness.

•We keep in mind that **"too much" closeness evokes too much longing and triggers fear, fight, or flight, while "too much" distance is experienced as abandonment**

Fisher, 2010

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Increasing capacity for social engagement in the therapy is a precursor to repairing attachment patterns

•**The social engagement system is body-oriented**: it relies upon the "muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds." (Porges, 2004, p. 21)

•In the therapy hour, **the therapist must make use of his or her own social engagement muscles**, making sure to utilize facial expression, head movements, intonation, and gaze to evoke the client's social engagement system. Talking about social engagement does not in itself engage the ventral vagal system

Ogden, 2004; Fisher, 2007

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"Dancing" with clients

- Rather than a therapeutic style of listening to the entirety of the patient's monologue before replying with an interpretation or empathic statement, **the therapist engages in a dialogue or "duet" with the client.**
- The client makes an observation; the therapist responds by echoing the words or making a clarification in them; the client reacts to that, and the therapist echoes again or re-directs the client to be curious or . . .
- **When clients use "self-defeating" interpretations, the therapist interrupts or disrupts:** *"Isn't it interesting ? The thought comes up that it's your fault. Wow. . . That's right where your mind went, huh?"*

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"Dancing" with clients, p. 2

- With babies, **each maternal response soothes or builds excitement. T**he attuned caregiver makes sure to track the baby's signals to ensure that she or he isn't being over- or under-stimulated and is enjoying the exchange.
- Similarly, **the attuned therapist observes the client's body to track what elicits the client's curiosity and interest,** what is irritating, reassuring, what helps them come more present, what is soothing and what is not
- **Like a 'good enough' mother, the therapist repeats what maintains the client's positive state** and refrains from repeating words, tone, and body language that dysregulate the client Fisher, 2015

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"Attunement –the intersubjective sharing of affective states—is at the heart of the parent-child attachment. ***Within matched positive affective states, there is reciprocal joy, excitement, and fun****. There is relaxed contentment and pleasant companionship. There is a realization, often implicit, that the pleasure being experienced is greater because it is being shared with the other".*

Hughes 2007, p. 139

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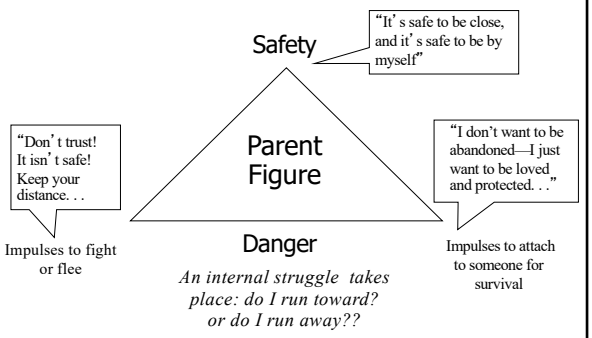
Traumatic attachment raises the questions: is it safe to be attached?



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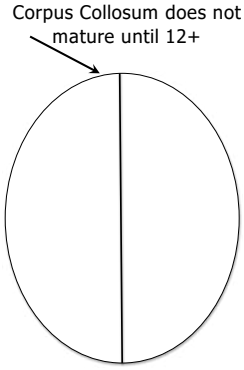
Traumatic adaptation and "splitting"

Left Brain

Dominant as language and cognitive abilities develop, the left brain is verbal and rational. It plans, organizes, learns from experience and makes meaning. It can evaluate danger cues but doesn't feel the sense of threat, so it tends to minimize danger



Right Brain

Dominant in first few years, the right brain lacks words but reads body language and scans 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

Fisher, 2019

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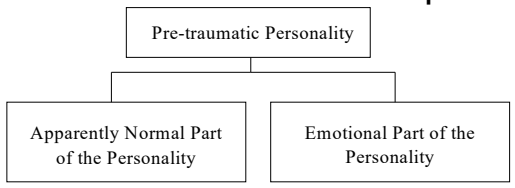
Structural Dissociation theory describes trauma-related splitting



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 sense of threat, implicit trauma responses, and our survival defenses

Van der Hart, Nijenhuis & Steele, 1999

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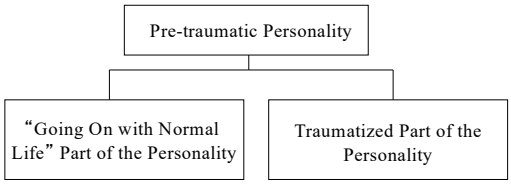
Client-Friendly Language



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 sense of threat, implicit trauma responses, and our survival defenses

Van der Hart, Nijenhuis & Steele, 1999

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What do we mean by a "part of the personality"??

"Neurons that fire together wire together" (Hebb, 1958)

"In the developing brain, [autonomic, affective, somatic and cognitive] states organize [into] neural systems, resulting in enduring traits." (Schore, 2001)

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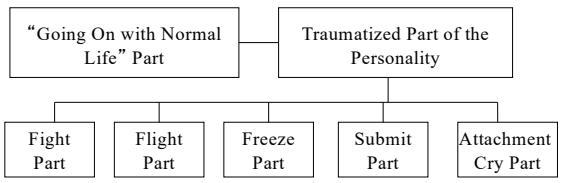
More trauma requires more splits:

BPD, Bipolar, DDNOS, Oppositional Disorders



The right brain-mediated Traumatized Part of the Personality becomes more compartmentalized: separate substates evolve, each reflecting the different survival strategies needed in a dangerous world

Van der Hart, Nijenhuis & Steele, 1999

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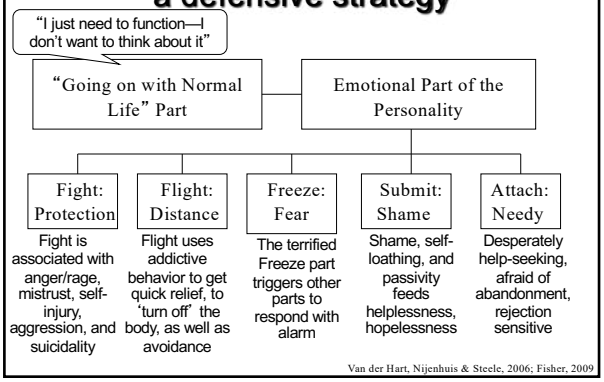
Each part of the personality contributes a defensive strategy



Van der Hart, Nijenhuis & Steele, 2006; Fisher, 2009

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An Evolutionary-Determined Internal Struggle

The inherent tensions between attachment drives and animal defenses drive stuckness and crisis in the therapy and in the client's life

- The longing to attach competes with readiness to flee
- "Submission" (collaboration, willingness to be flexible) competes with resistance and control
- Approach competes with avoidance
- Secrecy competes with disclosure; trust competes with mistrust; dependence competes with counterdependence

Fisher, 2007

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Implications for Treatment

- Based on the attachment research, we can assume that **ALL clients with histories of trauma will demonstrate varying degrees of underlying structural dissociation** and that what we call "splitting" reflects this fragmentation of self
- **When self-destructive behaviour is treated as a trauma-related disorder, it becomes easier to treat!** Crises can be predicted; contradictory behavior can be understood as reflecting internal struggles between parts; clingy or devaluing behavior can be seen as trauma-related
- If we use parts language in treatment, **we will help clients increase mindful awareness** and stimulate the prefrontal cortex so that clients have access to information. Fisher, 2021

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Focus on Cultivating Curiosity

•**Listen with a mindful, curious ear: hear impulses as the impulses of parts**, suspiciousness as a hypervigilant part, intense distress as young parts, hopelessness as a depressed part. If we cultivate client awareness, we **make it feel safer for them to be curious about the parts**

•**Communicate curiosity in your voice and body language:** "Let's be curious about which part got freaked out. . ." *"I wonder what triggered the Fight part today . . ."* "Of course, it makes sense that someone walking into your room would trigger you!" *"I know that you want to change these patterns, so we just have to get more curious about them. I wonder what part reacted so strongly. . ."* Fisher, 2022

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Noticing 'who I am' moment to moment

•**We assume that 'we are what we feel:'** but what "I feel" could be a spontaneous response to the present moment, the implicit memory of a part, **or** a survival response. Assuming that hopelessness means it is hopeless or suicidal ideation means a wish to die is dangerous for our clients

•**To notice fear, hopelessness, addictive impulses or suicidality as communications from parts decreases risk.** Asking the client to notice feelings as a communication from parts increases curiosity and prefrontal activity, decreasing the chances of acting impulsively. Why kill yourself if that thought is the voice of only one part?

Fisher, 2020

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The parts are experienced as feelings and reactions, not as 'parts'

•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

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The parts are also experienced as:

- **Loss of ability to communicate:** client becomes mute, shut down, spacy, 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, ADLs, social engagement
- **Increasing preoccupation with helpers:** the only safe/unsafe place becomes the office/hospital/house
- **Alternating dependence and counterdependence**
- **Chronic self-harm,** suicidality and addictive behavior

Fisher, 2014

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The key to stabilization is the "Language of Parts"

- **The language of parts** as the language of therapy **increases the client's ability to be mindfully aware of parts** without acting on their impulses
- **That means the therapist must translate 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. **Naming distress as a part takes the edge off the intensity** of the emotion

Fisher, 2021

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Learning parts language as a second language

- **Clients speak "I" fluently but not parts language, so we have to provide an intensive language class for them**
- **The therapist becomes a 'simultaneous translator.** Each time the client says, "I feel," the therapist translates the statement into parts language: *"A part of you feels hopeless," "the critical part thinks that's weakness," "a part of you wants to die."*
- **As in a language class, the more intensive the use of the second language, the more quickly the student learns!** The habit of prefacing each feeling with "I" is automatic for most people but dangerous for suicidal clients

Fisher, 2020

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

- When the client identifies with or "blends" with a part, **the thoughts and feelings of that part feel like "me."**
- **"Unblending"** refers to decreasing blending and increasing the ability to hold multiple perspective/parts s in mind.
- Because the client has no awareness that blended feelings come from parts, **it becomes the therapist's job to initiate the unblending:** *"So, there is a part of you here today that feels utterly defeated and worthless."*
- **Unblending is facilitated by awareness of other parts:** *"When the defeated part feels so worthless, how does that affect the part that is so ashamed?"* Fisher, 2013

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"Unblending" [Schwartz, 2001]

- **As feelings, thoughts, or body reactions occur, we "unblend" them for the client:** *"When the hopeless part collapses, notice that there's an annoyed part that pops up." Or "When the word 'hopeless' comes up, I notice a collapse in your chest. . ."*
- **The therapist's job is to both name the parts and foster empathy for them**: *"Yes, that annoyed part is really worried about the defeated part ruining everything, huh?" "Fight was really trying to help by lashing out, wasn't it?"*
- **As the therapist communicates compassion, calm, and acceptance**, the client often becomes more mindful and less blended, increasing the somatic sense of safety and calm Fisher, 2010

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An Unblending Protocol

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?

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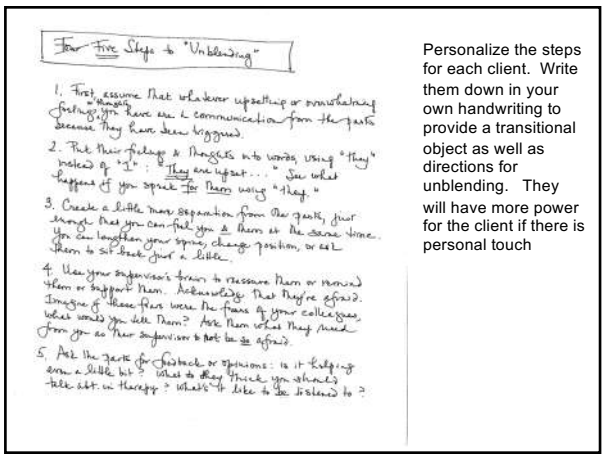

Personalize the steps for each client. Write them down in your own handwriting to provide a transitional object as well as directions for unblending. They will have more power for the client if there is personal touch

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Another Protocol for Unblending

1. Assume that any distressing feeling is a communication from a part. **Remind yourself, "This is not my feeling---it's a part's feeling."**
2. **Put the part's feelings into words using "they," "she" or "he"** feels _____." (See what happens if you speak on behalf of the part by naming the feelings as the part's.)
3. **Create a little more separation from the part by using an object** to represent it so you can see and feel the part
4. **What happens when you assume that the feelings are the part's feelings**, not your feelings?
5. **What would you say to this child** if they/he/she were standing in front of you right now?

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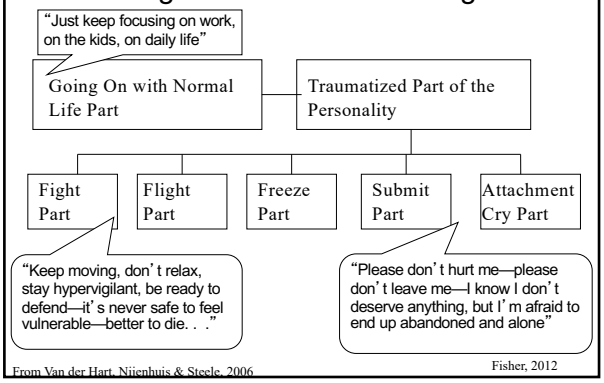
The parts are driven by competing ways of surviving under threat and danger



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Help clients focus attention on the following 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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Working with Unsafe Behavior as a Parts Issue

- **Consistently re-frame the suicidality, self-harm, or addictive behavior as the impulse of the Fight or Flight part, not the client:** "What is the suicidal **part** worried about it you live? What is the alcoholic **part** worried about if you stop drinking?"
- **Cultivate curiosity and re-frame the part's intention as positive:** "How is the suicidal part trying to help? Maybe it doesn't trust you to tolerate your emotions…"
- **Help the client un-blend from the suicidal or addicted part and notice it as having its own aims,** not necessarily the aims of the client

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Working with Unsafe Behavior as a Parts Issue, p. 2

- **Differentiate the goals of Fight and Flight from the goals of the Normal Life self:** "The alcoholic part doesn't care if you lost your job—it just wants to put whiskey in the baby bottle and making the crying stop"
- **Encourage the Normal Life self to negotiate with Fight and Flight:** "Ask that part if it would give you a chance to try to manage the feelings on your own. . ."
- **Teach clients to consistently use parts language:** "Every time you say, 'I want to die,' you give more power to the suicidal part. . . Is that what you really want?"

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Resourcing the Defense

•One way of decreasing resistance to working on unsafe behavior is by **"resourcing" the defense. That means that we ally with the behavior as a "Survival Strategy"**

•For example, "resourcing" a client's intellectualization might consist of admiring the ability to think as a way to survive in a confusing or violent world. 'Resourcing' mistrust and secrecy might take the form of validating that secrecy is safer in an unsafe world.

•**Resourcing the defense is liberating for the therapist, too!** When we re-frame suicidality as a part's attempt to achieve relief from overwhelm or have control over emotion, we too feel less intimidated and anxious

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Engender Compassion for Parts

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

•**Suicidal symptoms:** "Fight keeps a parachute or "bailout plan" ready for you, like a samurai soldier 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 relief—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. . ." "It knows that when you restrict, you can't feel… That's what it wants"

Fisher, 2020

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Allying with Protectors

•**Validate the protector's perceptions:** "It makes sense that the protector would have liked you to be less 'nice' and accommodating to everyone. You and the protector might have goals in common. . ."

•**And validate some more:** "You were more concerned about being liked than about protecting yourself. . .

•**"Maybe there is a middle ground here** . . . Maybe the protector would be willing to let you prove that you can be nice without being a victim. . ."

•**Give the power and control to the protector:** "If it would be OK with the protector, how about asking to be allowed to feel 10% of the feelings to start?" Fisher, 2021

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NUCA: a Protocol for Protectors

N = Notice all resistance, skepticism, and hostility as a protector part

U = Unblend from that part

C = Be CURIOUS: what is that protector worried about? *If you don't hurt yourself? If you stay alive? If you don't drink?*

A = Affirm the protector's efforts to defend! Find alternative ways for it to be protective

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Communicating with Protectors

- **As the therapist acknowledges the protector and conveys respect for its intentions, it is very natural to initiate internal communication:** "Ask that part: "am I right that they are just trying to help?"
- Usually, protectors engage readily in internal dialogue with the client, and the therapist's role is to coach the client in what and how to ask: "Is it true that the protector doesn't trust you to have boundaries? To stand up to people?"
- **Imply that it can be different:** "Maybe the protector still thinks of you as that overwhelmed teenager. . . Maybe he doesn't know you can manage the emotions now. . ."

Fisher, 2021

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Key Negotiating Strategies

- **Asking permission from the protector:** "If it would be OK with the protector to let the little parts share what happened when you were young—could you ask the protector if it would allow you to do that? . . ."
- **Establishing the protector's bottom line:** protector parts do not want to cause a problem—**they want to provide a solution.** "If you can prove to the suicidal part that you really can tolerate the emotions of the child parts, would it be willing to hold off on its plan to kill you?"
- **Make requests small and concrete: "**Would the protector be willing to let you try helping the little parts your way this week? The two of you can see what works better. . ."

Fisher, 2021

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Collaborating with Protectors

•**Protectors can sometimes be focused on stopping the distress of the young parts** using shame, fear, or substances (including body chemicals like adrenaline).

•**Then, clients are often caught in a vicious circle:** protectors hurt, shame, and frighten young parts to stop their cries, but that is only a temporary solution. The child parts shut up, but then become more distressed afterwards

•When the protector agrees to let the client soothe the child parts, the vicious circle stops. However, **unless the result is pointed out to the protectors, it may not register.** "Ask the protector to notice how quiet the child parts are after you soothed them, and look—nothing bad is happening"

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Increasing therapist tolerance for Fight and Flight

•Therapist tolerance for Fight and Flight parts is affected by our concerns about safety. If the first goal of therapy is cessation of their efforts to regulate the body, then they are being treated as 'enemies' and alienated by us

•More therapist support OR control of their behaviors are both triggers: we feel too close or too controlling

•**The treatment is enhanced if the therapist can tolerate bit of increased risk in order to ally with Fight and Flight:** "We're on the same side here. We both want safety for Mary and the child parts. We both want to make sure that no one messes with her ever again." Fisher, 2013

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Decreasing therapist tolerance for Attachment Cry parts

•Initially, **therapists intuitively offer more to Attach** because these parts want relationship, wish to disclose, beg for our support, and seek proximity. They seem to be available for therapy. Over time, however, these parts can push our boundaries and demand increasingly more

•**Decreasing our tolerance for being needed and being available, while increasing our tolerance for client distress, can result in the client's increased activity and functioning**. As long as **we** are willing to care for Attach parts, the client doesn't have to learn how to use their resources and soothe the distressed parts Fisher, 2013

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Working with conflicts between vulnerable parts and Fight/Flight

- Ideally, **Fight and Flight first need to be welcomed and befriended** before work with Submit and Attach is attempted. Ie, defenses must be addressed first before vulnerability is heightened
- **The positive intentions and contributions of Fight and Flight must be acknowledged**, no matter how destructive their behavior and how much a threat to safety. **Thanking them**, appreciating their point of view, **calms the system**
- The positive intentions of Freeze, Submit, and Attach must also be brought to the attention of Fight and Flight

Fisher, 2013

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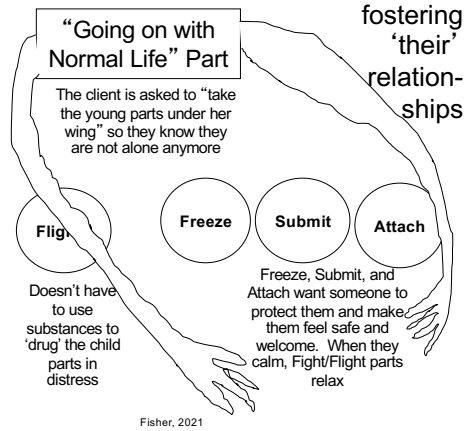
The therapist must act as a family therapist, fostering 'their' relation-ships



Fisher, 2021

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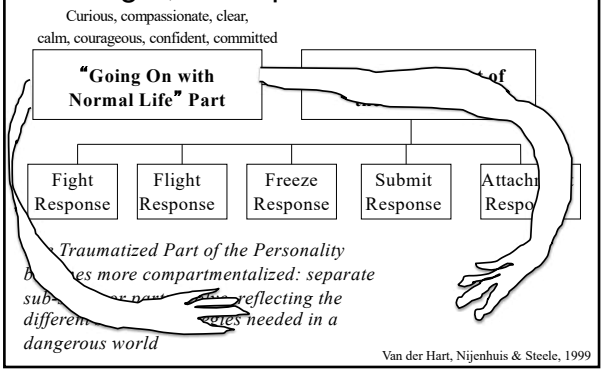
Common Ground: 'we are all held by a stronger, wiser person who cares'



Van der Hart, Nijenhuis & Steele, 1999

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