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Opinion Paper

The treatment of traumatic memories in patients with complex dissociative disorders

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ABSTRACT

To overcome their traumatic memories, survivors need to integrate them into their personality. In patients with complex dissociative disorders who generally have experienced severe and chronic relational traumatization, this integration requires a paced and regulated approach within a relational context. Management and resolution of traumatic memories require, above all, an understanding and treatment of dissociation. The dissociative organization of these individuals' personality includes at least one part of the personality primarily engaged in daily living, while trying to avoid traumatic memories, and at least one other part primarily fixated in traumatic memories, i.e., sensorimotor and in many cases highly affectively charged re-enactments of traumatic experiences, including innate defensive action tendencies in the face of perceived or actual threat. The treatment of traumatic memories should generally be embedded in a phase-oriented treatment – the current standard of care – in order to ensure that it will not exceed the patient's capacity as a whole person to integrate these re-enactments.

> "First of all, we must not forget that the actions requisite for dispelling traumatic memories, the actions which will achieve liquidation, are often difficult and costly".
> Pierre Janet (1919/25, p. 697)

According to the current standard of care, the treatment of traumatic memories of patients with complex trauma-related disorders – including dissociative identity disorder (DID) and DSM-5 other specified dissociative disorder [OSDD] (DSM-IV dissociative disorder not otherwise specified [DDNOS]) – involves a phase-oriented treatment approach (e.g., Brown, Scheflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Gelinas, 2003; Herman, 1992; Kluft, 1993; Nijenhuis, 2017; Van der Hart, Nijenhuis, & Steele, 2006; Steele, Boon, & Van der Hart, 2017). Phase-oriented treatment has its origins in the pioneering work of Pierre Janet (1898, 1919/25), who described three phases in the overall treatment:

- stabilization and symptom reduction, to which safety and skills building was subsequently added in the past few decades;
- treatment of traumatic memories;
- personality (re)integration and rehabilitation (Van der Hart, Brown, & Van der Kolk, 1989).

These treatment phases are not linear, but are often alternated or seamlessly interwoven after an initial period of stabilization, depending on the needs of the patient (Courtois, 1999). For example, a brief stabilization intervention may take place in the session, which is followed by work on a traumatic memory and then by some integrative intervention in daily life – all in one session.

This article will highlight the necessary skills for therapists and patients for phase 2, treatment of traumatic memories. We strongly recommend that therapists not engage in these interventions unless they are thoroughly familiar with phase 1 treatments, and the patient is sufficiently stable. That is, the patient must be able to engage in integrative mental actions during and following the confrontation with the traumatic memories, so that they become transformed into narrative memories. Thus, we first describe some initial stabilization approaches that are commonly necessary before the treatment of traumatic memories is considered.

1. Traumatic memory and dissociation of the personality

Traumatic memories are maintained by the dissociative organization of the patient's personality across the spectrum of complex trauma-related disorders. As we described elsewhere

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(cf., Nijenhuis, 2015, 2017; Nijenhuis, Van der Hart, & Steele, 2002; Steele et al., 2017; Steele, Van der Hart, & Nijenhuis, 2001, 2005; Van der Hart et al., 2006), the traumatized patient's personality is unduly (but not completely) divided among two or more psychobiological subsystems. These subsystems are overly rigid in their functions and too closed to each other, resulting in ongoing integrative failures that continue to effect adaptation and creative action in the present. One prototypical personality subsystem is called the emotional part of the personality (EP; Myers, 1940; Van der Hart et al., 2006). As EP, the patient is fixated in traumatic memories, that is, in sensorimotor and in many cases highly emotionally charged re-enactments, especially action tendencies of defense against perceived or actual threat. In some cases, however, as EP patients are fixed in re-enactments that involve a degree of hypoactivation; some may even lose consciousness. The other prototypical dissociative part of the personality is called the apparently normal part of the personality (ANP; Myers, 1940; Van der Hart et al., 2006), which focuses on living daily life, and is fixated in avoidance of traumatic memories, and often of emotional and bodily feelings related to these memories. As ANP, the patient may appear relatively "normal" on first observation, but has negative symptoms of detachment, numbing, and partial or complete amnesia for the traumatic experience, and experiences occasional intrusions from EP.

Dissociative parts of the personality are defined as subsystems that include their own phenomenal experience and conception of who they are, of the world, and of they are a part of this world (Nijenhuis, 2015, 2017; Nijenhuis & Van der Hart, 2011). The term 'phenomenal' stands for 'consciously experienced', and 'known or derived through the senses' (Nijenhuis, 2015, 2017). Like everyone's phenomenal experience and conception of self, world, and self as a part of this world, dissociative parts' phenomenal experience and conception of self, world, and self as a part of this world are not pre-given. These experiences and conceptions are rather enacted, that is, brought forth in ongoing mental action inasmuch as individuals or dissociative parts of an individual are not engaged in dreamless sleep or are otherwise unconscious.

This enactment gives a first-person perspective, a phenomenal experience and conception of being an 'I'. This 'I' includes particular bodily feelings, emotions, perceptions, and thoughts. It constitutes the groundwork of one's point of view regarding oneself (phenomenal 'I-me, myself, mine' relationships, or a quasi-second-person perspective), other people (phenomenal 'I-You' relationships or a second-person perspective), and objects. In the case of physical or 'technical' 'I-thing' relationship, one can speak of a third-person relationship. For example, clinicians engage in a third-person relationship regarding their patients when they assess the presence of a particular mental disorder.

Mentally healthy individuals enact one first-person perspective, one 'I'. They may have internal conflicts, or may not be fully integrated in some other regard. However, their phenomenal experience and conception of who they are remains basically stable. For example, they may say, "one the one hand I want this, and on the other hand I want that", but this 'I' as such remains singular. Individuals with a dissociative disorder bring forth more than one 'I'. This feature is actually the essence of every dissociative disorder. While every dissociative disorder thus involves a lack of integration, not every lack of integration implies the existence of a dissociative disorder (Nijenhuis, 2015). This means that, while the overall goal of therapy – not just Phase 2 – involves fostering integration. Integration remains a challenge for the person after therapy has ended, like for anybody else.

Following Janet, two basic levels of integrative actions can be distinguished: "synthesis" and "realization". Synthesis pertains to those basic integrative mental and behavioral actions through which experiences, such as perceptions, movements, thoughts, affects, memories, and a sense of self, are bound together (linked) and differentiated (distinguished from each other). It forms the basis of the higher-order actions of realization. Realization includes the promotion of two additional mental actions, i.e., "personification" and "presentification". Personification involves the mental actions of making one's personal experience and actions one's own (Janet, 1935; Van der Hart et al., 2006). Personification thus involves two mental actions:

- owning perceptions, sensations, affects, and thoughts;
- developing a sense of agency.

Presentification involves being mindfully present, while remaining aware of the context of one's past and future, and leading to adaptive and sometimes creative actions in the present (Janet, 1928; Van der Hart et al., 2006).

Clinicians who treat individuals with dissociative disorders must realize and appreciate the existence of plural phenomenal experiences and conceptions of self, world, and self as a part of this world. If they fail in this regard, their clinical efforts will remain fruitless. The multiplicity implies that a dissociative part does not experience and conceive a different dissociative part as 'a part of I, me, myself' but as a 'You', or a 'thing'. That is, what should be experienced and conceived in the form of a first-person perspective ('I') and quasi-second-person perspective ('I-me, mine, myself' relationship), is actually experienced and conceived in the form of a second-person perspective ('I-You' relationship) or third-person relationship ('I-thing' relationship) (Nijenhuis, 2017). For example, an ANP may experience and conceive an EP as 'someone else' or as 'a voice' or as a disturbing other 'thing' (e.g., a symptom). The ANP may say or believe, "this girl [an EP] does not belong to me, she should be removed", or "the voice disturbs me, please remove it". When a dissociative part is amnestic of another dissociative part, the amnestic dissociative part can be said to have a zero-person perspective regarding the other part.

The treatment of dissociative disorders involves the progression from a zero-person perspective (if applicable) to a third-person perspective (if applicable) to a second-person perspective, and eventually to a quasi-second-person and first-person perspective (Nijenhuis, 2017). The final goal is in principle a (re)integration of the individual as one conscious and self-conscious system rather than as a collection of two or more conscious and self-conscious subsystems. This work includes the integration of traumatic memories that one or more dissociative parts recurrently re-enact. Whereas the involved re-enactments can occasionally intrude on one or more other dissociative parts, these intrusions do not lead to the integration and realization of the involved traumatic memories for the duration of the dissociative disorder. That is why the integration of traumatic memories is commonly a goal of treatment inasmuch as the traumatized individual can develop the required integrative capacity and motivation.

2. Levels of dissociation of the personality

The undue prototypical division of the personality into a single ANP and a single EP represents "primary dissociation of the personality", and characterizes simple post-traumatic dissociative disorders, including PTSD. In this term, "primary" does not mean the first developmental (i.e., ontogenetic) form, but dissociation's most simple form. It must also be noted that there are milder divisions of personality, such as "ego-states" – which are not identical with dissociative parts – and serious unresolved conflicts among two or more different interests within an individual. Neither of these forms includes the distinct first- and second-person person perspectives as described above. Including these integrative difficulties in the category of dissociation would render

the dissociation concept overly broad and useless (Nijenhuis, 2012, 2015, 2017; Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006).

As the description of primary dissociation of the personality indicates trauma-generated dissociation is not random, but is commonly influenced by evolutionary prepared psychobiological action systems that guide adaptive and creative mental and behavioral actions (Lang, 1995; Panksepp, 1998; Nijenhuis et al., 2002; Van der Hart et al., 2006). One major action system is defensive in nature and involves a variety of efforts to survive imminent physical threat and threat to life itself (Fanselow & Lester, 1988). The defence action system includes flight, freeze, fight, and total submission (Porges, 2001). Other action systems are concerned with functions in daily life (Panksepp, 1998). These systems include energy regulation, exploration, sociability, attachment and care taking (Porges, 2001), play, and reproduction. A major basis of personality, these action systems must be integrated into a coherent and cohesive system during the development of the child (Nijenhuis & Den Boer, 2009; Van der Hart et al., 2006). The integration of the action system of defense and the action systems of daily life is a major challenge, particularly when the action system of defence is strongly and recurrently activated because of chronic abuse or other traumatizing events, and when the survivor's integrative capacity is limited. In this context, the action systems for functioning in daily life and for defence may become relatively sequestered and organized within alternating and competing subsystems of the survivor's personality, i.e., ANP and EP.

ANP is primarily mediated by action systems for functioning in daily life. In this frame, ANP is avoidant of EP, and tends to develop negative symptoms of dissociation, such as a degree of amnesia and bodily anesthesia. However, EP may occasionally intrude on ANP in the form of flashbacks, sensorimotor and affective components of traumatic memories, and other positive symptoms of dissociation. Such jarring intrusions generally increase the avoidance of ANP for EP.

EP is predominantly mediated by the animal-defensive system in fixated action tendencies in the face of perceived or actual threat (Nijenhuis, 2004; Van der Hart et al., 2006). EP commonly has an involuntary, rigid, and extreme narrowed attentional focus. This dissociative part is primarily concentrated on signals that once predicted or referred to threat, and that may continue to predict and refer to threat.

Each ANP and EP is also typically fixated in particular insecure attachment patterns that involve either approach or defence in relationships (Steele et al., 2001, 2017). The resulting alternation or competition between relational approach and defence among these parts is a substrate of what has been called a disorganized/disoriented attachment style (Liotti, 1999). For example, as ANP the patient may avoid attachment needs and behave in counter dependent ways. However, the patient may experience these attachment and dependency needs as EP.

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

Having experienced the danger and frustration of seeking protection and care from abusive and neglectful caretakers, and basically guided by a need for self-determination (Nijenhuis, 2015, 2017), some EPs imitate the abusive and neglectful actions of perpetrators. They tend to reject and punish the "needy" EPs, and the "wimpy" ANP(s). Some EPs that long for attachment may simultaneously be afraid of the caretaker. Thus, the patient as a whole is caught in multiple approach-avoidance conflicts regarding attachment and defence. The resolution of traumatic memories, by definition, involves (a degree of) resolution of this insecure attachment style through a secure and collaborative therapeutic alliance (Brown & Elliott, 2016; Steele et al., 2017).

ANP commonly fears and despises EPs, and EPs feel neglected and abandoned by ANP. Hence, ANP and EP can develop a phobia of each other. A further complication is that ANP may develop a phobia of trauma-related actions and contents in an even more general form. For example, ANP may fear, avoid, and detest particular body sensations when they associate these with traumatic memories and EP. Indeed, dissociation of the personality is predominantly maintained by a series of phobias that characterize trauma survivors and by ongoing attachment disruptions that evoke dysregulation and thus lowered integrative capacities (Nijenhuis, 2015, 2017; Nijenhuis et al., 2002; Steele et al., 2001, 2005, 2017; Van der Hart et al., 2006). Janet (1904) described the core phobia as the "phobia of traumatic memories", which consists of an avoidance of full realization of traumatizing events and their effects on one's life. Increasing behavioral and mental avoidance, including dissociation of the personality, is needed to prevent what are perceived as unbearable realizations about self, others, and the world (for example, in the case above, the part of the personality that denied she had a child). Subsequently, ever-encompassing phobias ensue from this fundamental phobia. Phobias can be maintained by reflexive beliefs such as: "I will go crazy if I start to feel"; or "The abuse did not happen to me"; "It was my fault"; "It was no big deal". Overcoming this complex of phobias and other ways of raising the survivor's mental efficiency (i.e., level of mental functioning) and mental energy levels are essential to successful treatment. Table 1 presents an overview of these trauma-related phobias as they are approached in the respective treatment phases.

According to TSDP, "tertiary dissociation of the personality" refers only to patients with DID, and involves not only more than one EP, but also more than one ANP. The existence of more than one ANP can relate to different causes. DSM-5 uses the criterion of amnesia between parts for differentiating DID and OSDP. However, also patients with secondary dissociation can experience a degree of amnesia between parts. One possibility is that a DID patient has never encompassed an integrated ANP, arguably due to very early onset of pervasive and chronic traumatization. As noted above, in cases of early and severe neglect and abuse, there can be a very early developmental pathway to dissociation. This path involves hindrance of a natural progression toward integration of discrete behavioral states (Putnam, 1997, 2016; Siegel, 1999) that are mediated by different action systems. The first-person and second-person perspectives are still highly state-dependent in the infant

Table 1
Phase-oriented treatment: overcoming trauma-related phobias.

Phase 1: symptom reduction and stabilization
Overcoming the phobia of attachment and attachment loss, particularly with the therapist
Overcoming the phobia of mental actions (e.g., inner experiences such as feelings, thoughts, sensations, wishes, fantasies)
Overcoming the phobia of dissociative parts of the personality (ANP and EP)
Phase 2: treatment of traumatic memories
Overcoming attachment phobias related to the perpetrator(s)
Overcoming attachment phobias in EPs related to the therapist
Overcoming the phobia of traumatic memories
Phase 3: personality integration and rehabiliation
Overcoming the phobia of normal life
Overcoming the phobia of healthy risk taking and change
Overcoming the phobia of intimacy, including sexuality and body image

(Wolf, 1990). It is within positive and secure interaction with caretakers that young, non-traumatized children begin to acquire skills to sustain, modulate, and integrate relatively discrete behavioral states (Putnam, 1997) as well as different action systems. However, there are indications that in traumatized infants, and preschool children, rudimentary behavioral states that are mediated by different action systems can remain unintegrated and may become increasingly rigid and closed to each other, forming a persistent dissociative organization of the personality as a whole. These rudimentary subsystems of the personality eventually gain varying degrees of elaboration and autonomy, and become dissociative parts as seen in DID patients.

It may also happen that an existing ANP becomes divided when certain inescapable aspects of daily life become saliently associated with traumatizing events for this ANP. Subsequently, this ANP will have ever more difficulty in avoiding recalling the traumatic past. In this context, the patient may generate a new ANP that copes with the now compromised aspects of daily life, and another ANP that engages in the aspects of daily life that are not, or in any case, less compromised by these aspects. This further division of ANP tends to occur along different action systems of daily life. For example, when a DID patient had a child by her stepfather when she was 16 years old, she developed a second ANP that experienced herself to be the mother. This second ANP was mediated by the action system of attachment and care taking, and raised the child. Meanwhile, the patient as the original ANP had a job and primarily was mediated by the action system of energy management, social engagement, including attachment and care taking, and exploration. She did not believe that she had a child, which was a severe non-realization regarding the incest and resulting pregnancy.

Finally, in a few DID patients who have an extremely low integrative capacity and in whom dissociation has become strongly habituated, new ANPs may evolve merely to cope with the minor frustrations of life. Dissociation, avoidance, and all forms of non-realization have become a lifestyle in these individuals, and their prognosis is generally poor.

3. Phase 1: stabilization and symptom reduction

A necessary precursor to treatment of traumatic memories in cases of complex dissociation involves (an often lengthy period of) stabilization and development of more adaptive, creative, and reflective functioning, including mentalizing, emotion regulation, and relational and life skills (Allen, Fonagy, & Bateman, 2008; Brown et al., 1998; Boon, Steele, & Van der Hart, 2011; Courtois, 1999; Gelinas, 2003; Kluft, 1997b, 1999; Linehan, 1993; Nijenhuis, 2017; Ogden, Minton, & Pain, 2006; Steele et al., 2005, 2017; Van der Hart et al., 2006). Treatment begins with ANP(s) and those EPs that are intrusive and interfering with life and therapy, and focuses on raising the integrative capacity or mental level these parts of the personality.

Patients are supported in overcoming a series of trauma-related phobias that include:

- relational phobias of closeness, abandonment, loss, and rejection, particularly in regards to the therapist;
- phobia of mental actions, such as emotions, body sensations, thoughts, images, fantasies, wishes, and needs;
- phobia of dissociative parts (which have their own rigid mental actions and implied mental contents that may be unacceptable to other parts).

Phobic avoidance of (particular) mental actions, especially conflicted or intense emotions and related sensations prevents adaptive confrontation of traumatic memories, and thus must be addressed early in treatment. Since the lack of integration of dissociative parts is at the root of persistent traumatic memories, it is essential to help the patient overcome the phobia of dissociative parts prior to working with traumatic memories. Phase 1 treatment also helps patients learn to identify and cope with triggers, i.e., conditioned trauma-related stimuli of both external (e.g., environmental, relational) and internal (e.g., affect, intrusion of EPs) origin. It provides skills for regulation, containment of intolerable experiences rather than suppression, and reflective functioning, all necessary for the integration of traumatic memories. Thus, in phase 1 the patient as ANP is supported in progressing toward more efficient functioning within a frame of growing empathic acceptance of EPs and cooperation among dissociative parts (Kluft, 2006, 2013; Nijenhuis, 2017; Steele et al., 2005, 2017; Van der Hart et al., 2006), and developing an optimal mental level (integrative capacity) that will make phase 2 possible. Overcoming phobias of mental actions and of dissociative parts implies that patients must learn more efficient ways to cope with the fear, shame, and disgust that are evoked by inner and outer stimuli related to traumatic memories.

A dynamic systems approach is essential in working with dissociative parts, and thus with traumatic memories. Every intervention should first and foremost be directed toward improving the functioning of the individual as a whole "biopsychosocial system" in the present. To this end, there are several stepwise levels of systemic work. The first line of intervention is generally with the entire personality, and includes techniques, such as talking through". The next usual step is to promote positive and empathic interactions among particular parts, e.g., ANP and EP. It is essential to engage the different dissociative parts in work with each other, in order to diminish the rigidity and closure among them, otherwise the patient will abdicate the work to the therapist, which only serves to further maintain his or her dissociative organization. The patient as ANP can be encouraged to gradually accept and listen to other parts and to begin to acknowledge and meet their needs. If needed as a prelude to these steps, the therapist may temporarily work with an individual part for the purposes of grounding, orientation to the present, regulation, and correction of major cognitive distortions. The therapist's interactions with a particular part also teaches other dissociative parts that positive interactions with this part are possible and rewarding for both parties, and model positive interpersonal skills. Then gradually other parts of the patient are encouraged to begin working with each other to continue to promote integration and, thereby, the efficient functioning of the patient as a whole system. It is vital that the patient understands the key principle of gradual acceptance, acknowledgement, and realization of EPs and ANP(s) as parts of the same personality, and that each part is responsible to and for all other parts. Otherwise, particular parts of the patient might use the therapist as a "babysitter", for instance, or expect the therapist to get rid of, punish, or control various other dissociative parts instead of taking personal responsibility for their actions, which afterall, constitute the patients as a whole system.

ANPs try to prevent intrusions of EPs fixated in traumatic memories, particularly the affective and sensorimotor components of experience, as well as related maladaptive core beliefs (e.g., "I am a bad and filthy person."). In phase 1, dissociative parts can learn how to protect themselves temporarily from these highly upsetting memories, beliefs, and other feared and despised features of other parts by using "safe or quiet or calm place imagery", i.e., images of a place where they feel safe and protected. If the concept and experience of safety are still unknown to them, it should be a place where they feel at relative ease. The point of the exercise is not the imagined location, but the psychophysiological regulation that results from the imagery. Parts that are relatively comfortable with the presence of other parts may share such

places. However, it is relatively common for parts to prefer to have a safe or quiet place one of their own in cases where acceptance and cooperation are not yet well established In addition, it is essential for the therapist to help the patient begin to experience quiet and safe states in each part of the personality, which provide regulation without the necessity of imaging a safe space (O'Shea, 2009). The imaginary and behavioral rehearsal of positive resources and safe states with techniques, such as EMDR (e.g., Gelinas, 2003; Gonzalez & Mosquera, 2012; Korn & Leeds, 2002), is helpful in gradually increasing the integrative capacity for all dissociative parts of the personality. Dissociation of the personality is relative, not absolute. An increase of felt safety in one part will enhance the functioning of other dissociative parts because there are increasing links among them, despite the fact that they are also dissociated from each other. Patients may also be taught containment imagery, such as bank vaults, computer storage, and the like (e.g., Brown & Fromm, 1986; Kluft, 1993; Van der Hart, 2012; Van der Hart, Steele, Boon, & Brown, 1993, 2006). Such imagery enables them temporarily to "store" traumatic memories or other threatening inner experiences. These techniques support patients in learning the difference between maladaptive avoidance or suppression and healthy pacing and timing that is within their control.

Overcoming the phobia of dissociative parts should result in development of internal empathy and cooperation, that is, in the development of sociability. This often needs to be stimulated with the help of the therapist. The creation of an inner "imaginary meeting place" (Fraser, 1991, 2003; Krakauer, 2001) or "imaginary intercom" or "other communication system" (if direct meeting is too threatening) can be helpful in fostering such cooperation. At times, some parts may be advised under certain circumstances to recluse themselves from such meetings and withdraw to their safe or quiet place.

These and related techniques for coping with intense affect and promoting manegeable interactions among dissociative parts involve the strategic use of the patient's dissociative capacities and natural integrative tendencies in the context a secure (i.e., benign, predictable and controllable) and collaborative therapeutic relationship. Gradually dissociative parts can learn to acknowledge each other without undue phobic reactions. Next, each part can learn to appreciate the roles of other parts in helping the individual as a whole survive and slowly develop inner empathy. Finally, parts can begin to cooperate more effectively on tasks of daily life and on self-regulation. Internal communication and cooperation among two or more dissociative parts can be fostered through assignments to plan and carry out tasks of daily life together, such as getting to work on time and being attentive. This becomes more feasible when dissociative parts can be focused on and collectively share inner experiences related to the present moment, while containing traumatic memories and other distractions. Phase 1 interventions further include:

- psychoeducation;
- relaxation skills;
- regulatory skills;
- develop of daily routines and structure;
- basic energy management (adequate sleep, rest, eating); development of somatic resources, such as grounding, and other use of sensorimotor experiences to foster boundaries and regulation; Ogden et al., 2006;
- respectful confrontation of substitute beliefs, i.e., maladaptive pre-reflective beliefs that substitute for more reflective mental actions;
- development of a collaborative, flexible, warm, and well-boundaried therapeutic relationship is essential in the early phase of treatment, as is work on other current relationships, such that a degree of earned secure attachment may be achieved gradually (e.g., Kluft, 1993, 1997b; Steele et al., 2001, 2005, 2017; Van der Hart et al., 2006).

4. (Contra-)indications for phase 2 treatment

Phase 2 may be initiated when integrative capacity has been raised to the extent that ANP(s) and key EPs are able to function more or less adequately in the present, can maintain a reasonably stable collaborative relationship with the therapist, is able to engage in mentalizing and other reflective functions, have the capacity to tolerate and regulate arousal, and have developed a degree of inner empathy and cooperation. Contraindications to phase 2 include the absence of any of the above criteria, as well as current and ongoing interpersonal abuse; ongoing substance abuse or other self-destructive behaviors; current acute external life crises or times when extra energy and focus is needed in normal life; extreme age, physical or terminal illness; psychosis; or severe characterological problems that interfere with the conduction of a boundaried and effective therapy; and uncontrolled switching among ANPs and EPs (Boon, 1997; Kluft, 1997a; Nijenhuis, 2017; Steele & Colrain, 1990; Steele et al., 2001, 2017; Van der Hart et al., 2006). The goals of stabilization may be achieved rather quickly in high-functioning patients, but will be time-consuming (usually a number of years) in patients that are less functional. Although many of these goals may eventually also be achieved within the group of patients with the least favorable prognosis, Phase 2 work usually continues to seriously destabilize them. In some extremely difficult cases, complete stabilization is not often achieved, and achieving the goals of phase 1 work remains the final goal of treatment. In all cases, patients should have informed consent about moving into phase 2 treatment.

5. Countertransference and the treatment of traumatic memories

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

Some persisting myths about the treatment of traumatic memory remain common among therapists untrained in standard of care trauma work, and can lead to disastrous consequences. These are often based on a fundamental misunderstanding of dissociation and integration. For example, the therapist may not grasp the idea that one dissociative part can recount a traumatic memory in a completely "calm" but highly depersonazlied manner, while another part is fixed in the traumatic memory and has remained unintegrated and not accessed in treatment. Thus after years of therapy, these individuals may continue to remain unintegrated and plagued with post-traumatic intrusions. Or the therapist may believe that extreme emotional intensity is therapeutic in itself, whereas it may actually promote ongoing dissociation due to the patient's inadequate integrative capacity. Finally, the therapist may not grasp that remembering is not sufficient in itself, but rather it is the sometimes long and difficult work of "realization" after recall that is the real key to resolution of traumatic memories. Realization involves higher-order integrative

actions, defined as developing a high degree of personal conscious awareness of reality as it is, acknowledging, and reflectively adapting to it. Realization may imply a motivation and effort to change a particular reality if change is possible.

6. Attachment, dissociation, and traumatic memory

The chronic alternation of action systems of attachment and defense related to an abusive caretaker is the basis for severe insecure attachment patterns (Liotti, 1999; Nijenhuis et al., 2002; Steele et al., 2001, 2017; Van der Hart et al., 2006). By definition, the resolution of such insecure attachment patterns involves management of the reenactment of relational trauma in the therapeutic relationship. These re-enactments evoke intense emotions and action tendencies in both patient and therapist, thus the therapy frame must be strong and clear. It is essential for the therapist to maintain a position of empathic curiosity rather than becoming defensive or enmeshed with the patient.

Relational interventions for EPs are geared toward modification of their defensive reactions (e.g., freeze, flight, fight, collapse, but also attachment cry) in response to current relationships (including the therapist). Some EPs have a phobia of attachment loss, and thus cling needily to the therapist, or persistently have contact with the perpetrator or others who are likely to be hurtful. Interventions for these dissociative parts of the personality are embedded in a context of increased sociability and "earned" secure attachment with the therapist that includes consistent boundaries and limits, and a secure therapy frame. EPs fixed in various subsystems of defense should become more cooperative and empathic with one another. For example, a submissive EP can begin to have communication and cooperation with a fight EP that can protect this part. However, often much work must occur with fight EPs before they can actually protect with empathy and cooperation, as noted in phase 1.

7. Phase 2: treatment of traumatic memories

The major goal of phase 2 work is the integration of traumatic memories, which involves guided "synthesis" and "realization", and implies regulation, rendering dissociation unneccesary (Van der Hart et al., 2006). The manner in which this goal is achieved, and the techniques used may vary considerably from patient to patient, as dissociative individuals are a quite heterogenous group. A particular technique for integrating traumatic memories may work well for one patient but is ineffective or even disregulating for another. Thus, therapists must be flexible in their approaches to the treatment of traumatic memories, have an arsenal of tools and techniques at hand that are always used in the context of the therapeutic relationship, and collaborate with each individual patient regarding what is most effective with a stable treatment frame.

Regardless of the path to integration of traumatic memories, it always includes the patient being able to engage in previously avoided or unattainable integrative mental actions. First, the traumatic memory must be "synthesized", that is, shared among dissociative parts of the personality via modulated exposure to unintegrated aspects of it. Gradually or more rapidly, the sensorimotor and affective re-experiences will develop into to a symbolic verbal (narrative) account that is not depersonalized, but is a genuine autobiographical narative.

7.1. Guided synthesis

Described in more detail below – is an intervention that consists of carefully graduated exposure of dissociative parts to a particular traumatic memory within the regulatory tolerance of the patient as a whole, while preventing maladaptive reactions (e.g., further dissociation, avoidance). Once the patient has synthesized the traumatic memory, "guided realization", with its components of personification and presentification, can follow. Eventually, the patient as a whole has realized that the event happened and is now over, that the actual present is different from the past and far more real, and that the event has had, and may continue to have certain consequences for his or her life. The patient can make a coherent and flexible narrative of the memory while being present in the moment and without sensorimotor reliving. This narrative must be further integrated within and across each part of the personality.

8. Overcoming the phobia of traumatic memory

This is one of the most difficult phobias to overcome, requiring high and sustained integrative capacity of ANP(s) and EP(s). Careful pacing of therapy and regulation of the patient's hyper- and hypo-arousal is crucial to success. Contraindications to initiation of this phase should be strictly followed. The lower the patient's integrative capacity and energy, the slower this step of treatment, with frequent returns to phase 1 interventions. As noted above, a key healing mental action is integration of traumatic memories, involving their synthesis and realization. Graduated guided synthesis is a modulated and controlled therapeutic intervention, in which the patient as a whole, or some selection of dissociative parts are helped to remain oriented in the present while simultaneously synthesizing the traumatic memory (Van der Hart & Steele, 2000), i.e., its cognitive, sensorimotor, affective, and behavioral components. Although expressions, such as "controlled abreaction" or "abreactive work" are often used to describe this intervention in the dissociative disorders field (e.g., Fine, 1993; Kluft, 1990a; Putnam, 1989; Ross, 1989), we prefer the term "synthesis", which emphasizes the integrative nature of the mental actions involved and which avoids the suggestion that the expression of vehement emotions in itself is of therapeutic benefit (Van der Hart et al., 1993; cf. Van der Hart & Brown, 1992, for a critical analysis). Guided synthesis is preceded by an extentive preparation stage, and is followed by stages of realization and further integration.

8.1. Preparation

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

It is important in phase 2 to identify and treat "substitute beliefs and behavioral actions" (Janet, 1945; Van der Hart, 2006) of various ANPs and EPs. These beliefs and behaviors are low quality actions that are substitutes for adaptive action in the present.

Cognitive errors and distortions, including substitute beliefs, should be identified and corrected to some degree in phase 1, but some are only open to modification after synthesis. Substitute fantasies often involve rescue (by family or the therapist), the wish to undo the past and make the "real" past go away, the wish to abdicate responsibility and be taken care of, the hope for a magical cure, and the "golden fantasy" that every need can be met perfectly by another person, and most obviously, the belief that dissociative parts do not belong to self. Each of these serves as a defence against integrating traumatic memories and the necessary grief that accompanies the work, and thus must be treatment targets prior to working with traumatic memories.

The substitute belief itself is less important than the non-realizations that it obscures (Janet, 1945; Steele et al., 2017; Van der Hart et al., 1993), but must be treated, nevertheless. Treatment first consists of identification of the reflexive beliefs ("My uncle was wonderful: I seduced him"; "I don't have to work because I am little"; "That's not my child: I am a single person and want to party", etc.). ANPs and EPs that hold maladaptive beliefs should gradually and gently be confronted by other parts that do not hold those beliefs, i.e., the patient should be directed to dealing with inner conflicted beliefs. For example, a survivor as an adolescent ANP wanted to have freedom and play, denying that she was a mother. She was gradually helped to experience empathy for other children, then for her "inner" child (EP). This led to synthesis of traumatic memories of her own mother physically abusing her when she was a child. She was able to accept the child EP as part of herself, as well as accept that she was now grown up and had an actual child that was hers as she integrated her history. An understanding of relevant facts and context of the abuse are required for eliminating substitute beliefs. For example, once a patient fully realized she had been alone as a very small child in the home of her uncle with no one to help her, and that he had used physical force to sexually assault her, she was able to relinquish the idea that she had seduced him. On the one hand, this significantly reduced her sense of shame, and on the other, led to a further painful realization of her extreme helplessness as a child, which she had assidously avoided.

There are several ways to approach guided synthesis, depending on the skills of the therapist and the needs of the individual patient. Some patients work most effectively by synthesizing memories with certain parts present while others are in a safe place and not attending to the synthesis, while other find it more effective to synthesize with all parts present at a given time.

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

However, there are many patients for whom such observing parts are not available or are unable to contain affect adequately. Patients who are unable to objectively share content prior to synthesis can be prepared by helping all parts explore worst case scenarios: "What is the worst thing that you could imagine you might have to deal with in regards to what you remember?; "If that happened, how could we both help you best deal with it?"; "What are some other things with which you might find difficult to cope?" Then the treatment approach might include "gathering" dissociative parts together, while the therapist first facilitates a strong feeling of connection and empathy among them (e.g., suggesting being close and holding hands together, in the same way a very loving and close family might grieve together, or suggesting that each part find his or her own comfortable position of just the right closeness and distance from other parts, or instructing the patient to touch the tips of her fingers together as a metaphor for parts coming close together). Additional resourcing suggestions can be given, such as noting that each dissociative part has particular strengths (related to the particular action (sub)system mediating its actions), that being together makes each part stronger, that each part can share her own strengths with other parts and also draw upon their strengths. Then suggestions for connection with the safe present and the therapist can be made, and a slow introduction of the traumatic memory can commence, with frequent reminders for dissociative parts to remain together and in the present.

8.2. Guided synthesis

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

For synthesis to succeed, it is essential that the patient's level of arousal not become too high and that both patient and therapist have sufficient control: panic, switching, and re-dissociation of the traumatic memory should be prevented. To this end, the therapist should explain that the trauma need not be re-experienced as the original overwhelming event, i.e., "it need not and should not be relived". Instead, arousal may be modulated, for instance, using an imaginary rheoostat with an inbuilt maximal intensity. Dissociative parts are further instructed that they "need only experience that which is necessary to know, to understand, and to heal". Efforts to keep the patient grounded in the present and connected to the therapist are essential to the success of guided synthesis. That is, the therapist helps the patient maintain a consistent first-person and second-person perspective ("I am an adult in therapy, in relationship with my therapist. These things happened to me, but they are not happening now."). It is helpful to redirect the patient's attention to his or her bodily experience and to the sound of the therapist's voice with some regularity during a synthesis session, away from the content of the memory, to support regulation and orientation to the present. Taking short rest periods between times of synthesis within a session also help. During these breaks the patient is encouraged to relax (e.g., "You can let go of all tension, breathing quietly and calmly, knowing you are safe in this time and this place."). The patient (and all parts involved in the synthesis) is encouraged to make relational contact with the therapist. Hypnotic suggestions for time distortion, such as

experiencing the actual synthesis as much shorter than real time and experiencing the breaks in between as much longer than real time can be helpful. Various suggestions and imagery for healing may also be offered towards the end of the synthesis.

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

8.3. Rapid guided synthesis

Van der Hart et al. (1993) described a rapid variant of synthesis. During a thorough preparation with an observing part of the personality, an objective narrative account is constructed that includes pathogenic kernels. This account is divided into a number of segments, each accompanied by a number (e.g., from one to five, or one to ten). The therapist counts, and with each count relates to the patient a successive kernel of the traumatic memory, encouraging the parts involved to share their respective partial experiences with each other. Taken together, these experiences encompass the entire traumatic memory. Between each segment, the therapist suggests a break in which the patient regulates her/his breathing and is grounded in the present. When the end of a round has been reached, the therapist may inquire about what percentage of the whole traumatic memory has been shared and which aspects still remain unshared. When unshared material still exists, another round can be negotiated.

8.4. Fractionated guided synthesis

This is a much more gradual approach in which the synthesis of one traumatic memory or one series of traumatic memories is divided into a number of smaller steps, which may encompass several or even many sessions (Fine, 1993; Kluft, 1990a, 1996, 2013; Steele et al., 2017; Van der Hart et al., 1993, 2006). Such an approach is indicated when the patient's integrative capacity and anxiety tolerance are very limited, but the task of integrating a specific traumatic memory seems unavoidable (Kluft, 1990a). Variations of fractionated guided synthesis are endless. For instance, synthesis initially might be limited to the sensorimotor aspects, followed in subsequent rounds by the emotional aspects and cognitions (Ogden et al., 2006). Synthesis may be limited only one sensory dimension at a time, such as fear, pain, or anger, or might involve the sharing of only one EP's experience, or a specific time segment of the traumatic experience, etc. The therapist may structure the synthesis in shorter counts, for instance, five instead of ten counts, each one punctuated by suggestions for rest and comfortable breathing and connection with the therapist. A further suggestion for enabling the patient to do the integrative work is add clear time boundaries during synthesis by starting a round with the word "Begin!" and ending with the word "Stop!"

Fractionated guided synthesis can also be paired with training in relaxation and calmness (Kluft, 1990a, 2013; Van der Hart & Spiegel, 1993). Finally, suggestions can be given for a very gradual or slow sharing of affect over time, e.g., 5% of the overall affect pertaining to a specific traumatic memory per day (Kluft, 1990b, 2013). Titrated synthesis may also occur with the use of EMDR and ample application of SUDS (e.g., Gelinas, 2003; Gonzalez & Mosquera, 2012; Twombly, 2000; Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2014). Indeed, when a cognitive framework and the preparations described above are applied, EMDR may be an effective approach for actual synthesis.

8.5. Containment

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

8.6. Guided realization

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

9. Phase 3: personality (Re)integration and rehabilitation

Once enough work has been done in phase 2 to allow the patient to gain higher overall integrative capacity, and the phobia of traumatic memory is no longer in the foreground, phase 3 work can be initiated. Over the course of phase 1 and phase 2 treatment, previously rigid dissociative parts become more flexible and broad in their functioning, eventually making dissociative parts redundant. As a more fluid and less dissociative personality is developed, and as dissociative parts become better oriented to the present, there is less need to remain fixed in defensive actions and other automatic reactions to triggers. The patient is more able to overcome the phobias related to daily life, such as the phobias of healthy risk taking and of intimacy. Even if the individual should face future stressful events, he or she may be able to engage in more effective and adaptive actions. Generally, there is rather spontaneous movement back and forth into phase 3, as the patient generally has an increasing desire to "get on with life" in the present. Joy and relief about progress alternates with renewed grief about losses suffered, as realization grows. Grief therapy is an essential approach during all phases, but particularly in phase 3, when full realization of losses occurs. With passage of time, however, episodes of grief gradually decrease in intensity and duration. "Survivors come to understand and accept that loss is an inevitable part of trauma, and that it is ultimately a lifelong task to assimilate the ebb and flow of re-experienced grief with equanimity" (Van der Hart et al., 1993, p. 173).

9.1. Case example

The following case example illustrates the more encompassing, fast approach to synthesis. Margaret (not her real name) was a 55-year-old patient with chronic depression, panic attacks, DDNOS, and complex PTSD. She presented for treatment for the first time following a major death in her family, after which she became regressed, incoherent, and psychotic. She was subsequently hospitalized and with medication, became more lucid. However, her episodes continued unabated. She believed that her uncle had

"hurt" her sometime between the ages of 3 and 5, when he lived in the same home, but was unsure what might have happened. Margaret struggled with what to believe and the therapist created a neutral and supportive atmosphere that allowed her to simply explore her experience without needing to know "the facts" of the past. Margaret experienced persistent involuntary dissociative episodes that included grimacing, making infant-like sucking sounds, shaking her head frantically back and forth, rolling her eyes back in her head and moaning, spitting and gagging, excruciating sensitivity to sensory stimulation in the environment. These episodes would occur even in public. She was so ashamed of her uncontrollable behaviour hat she completely isolated herself. When she began therapy with one of the authors, the focus of treatment turned to a combination of medication management, psychoeducation regarding dissociation and the nature of traumatic memories, development of regulatory and reflective functioning skills, and intensive work on phobic avoidance of mental actions and dissociative parts. Thorough assessment revealed symptoms of DDNOS, and extreme fears about the existence of inner parts. Margaret was convinced she was crazy, and weak for not being able to function in her daily life. The therapist continuously addressed these substitute beliefs and her tendency to attack herself and withdraw when ashamed, with careful attention to building a safe therapeutic relationship. She was intelligent but not especially curious about her condition and did not want to learn much about it. Very gradually, over the course of three years, her phobic avoidance of her inner experiences, including dissociative parts diminished. Eventually Margaret was able to have empathy for these very young parts of herself that had no verbal content. She became somewhat more functional in daily life over time, and came to the conclusion that she was likely abused in a day care center, but did not have to know exactly what happened in order to resolve her past. However, she continued to have symptomatic episodes.

In preparation for the integration of traumatic memories, Margaret increased her awareness and acceptance of a number of types of rudimentary inner parts: parts that cried, parts that sucked like a baby, parts that grimaced or walked with a halting hunch, parts that shook their head in pain and fear while saying, "No, no, no, no, no, no". She could imagine a cadre of little girls, all looking alike, sitting in the therapy room, where they were gradually able to be quieted and soothed.

Guided synthesis sessions, interspersed with more cognitive sessions, focused on the somatosensory and affective experiences and beliefs of these parts, generally without either patient or therapist clear about which parts were participating or not, as none had much elaboration. Sessions generally began with an induction of deep relaxation, which was helpful to her. The therapist encouraged Margaret to image the little girls in the therapy office, where they were calm and safe. She was instructed to talk with them, and the sound of her voice and mine could remind all parts of her that she was in the safe present. She developed strong empathy with these parts, sometimes holding and rocking them while crying quietly.

In another series of sessions, the therapist instructed Margaret to take a single drop of experience from some of the more overwhelmed parts of herself while remaining in the present. The therapist suggested her to put the drop in a cup of steaming hot, soothing tea. As she sipped from the cup and felt the warmth go down and through her body, this drop was absorbed and her body adjusted to it, much like homeopathic medicine. As Margaret grew more tolerant over several sessions, more drops could be added to the tea, and she was able to tolerate the experiences of her parts and accept them. Margaret began to accept and realize the experiences of her dissociative parts, even without clear memory of what happened. As she did, the parts became less fixed in traumatic memory, and more quiet and restful. Gradually, Margaret was able to allow all the little girls to walk into a bright white light that emanated from her heart, and she took them all in to herself. Margaret completely integrated after 5 years of treatment.

10. Conclusions

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

The essence of the treatment of traumatic memories is their integration, along with increasing integration of the individual's personality, including a coherent and cohesive sense of self over time and contexts, that is, a predominantly stable first-person perspective. Such integration requires the development and execution of several new mental actions, i.e., synthesis and realization, the latter of which involves personification and presentification. Guided synthesis is the systematic, rapid or fractionated exposure of selected parts of the personality to traumatic memories, with promotion of synthesis of these involved memories, and prevention of re-dissociation or other forms of mental avoidance. The dissociative parts that are selected involve EPs that contain the traumatic memory (i.e., the part that re-experience a traumatizing event) and the parts that – in the collaboratvie judgment of therapist and patient – need to integrate the memory and have the integrative capacity to do so. The intervention must be accomplished within the limits of the integrative capacity of the involved dissociative parts. Synthesis is not sufficient for integration, but requires further work toward realization of the traumatic memory. Various techniques, hypnotic and otherwise, support these new integrative actions. Hypnotic or other suggestive techniques are not used for the detection and subsequent exploration of "suspected" traumatic memories.

As the case example illustrates, preparation and execution of guided synthesis should be tailored for each patient. Some patients need careful and detailed planning and execution, for instance due to their extensive traumatization and extreme dissociation. Other patients, often less extensively traumatized and having less developed and distinct dissociative parts, are less able to prepare in this way, and often do not need this level of detailed work. For these patients, there might be an inner discussion of which (part of a) traumatic memory will be the focus for the next session, and during the actual guided synthesis, much less emphasis is given to specific contents to be shared. Therapist training and preferences also may play a role in the choice of therapeutic techniques. For instance, some therapists prefer EMDR instead of the various forms of guided synthesis described above (e.g., Fine & Berkowitz, 2001; Forgash & Copeley, 2007; Gelinas, 2003; Gonzalez & Mosquera,

2012). Other therapists, who are familiar with both guided synthesis and EMDR, might leave the choice up to the patient. Indeed, there are patients who may alternate preferences, depending on the memory and their needs at the time. However, in all instances the therapist and patient reflectively decide which parts shall and shall not participate in the preparations and guided synthesis. And whatever the specific approaches used, in whatever language formulated, all can be explained in terms of the integrative actions described here as synthesis and realization, with its components of personification and presentification.

Disclosure of interest

The authors declare that they have no competing interest.

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