

# Using a Parts Perspective to Enhance Infant Mental Health Treatment

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# Models of Multiplicity

- There are many psychological theories, both current and past, that incorporate ideas about multiplicity within the human personality, yet somehow most therapists are taught to treat clients as a singular entity.
- Often when people think of parts they think of the extreme presentation of “multiple personality disorder.” (currently Dissociative Identity Disorder, or DID)
- The reality is that all people have experienced at least a degree of psychological wounding, so everyone experiences a variety of self-states.
- The more wounding or trauma experienced by a person, the more separated the self-states become. The continuum goes from mild developmental wounding all the way to the very sequestered parts present in a person with DID.

# What is Dissociation?

Dissociation has multiple meanings that sometimes can be confusing, but there are typically three things people might be describing when they use this word

1. Fragmentation of consciousness, such as in a state of hypoarousal when clients may report being “far away.”
2. Fragmentation of memory, such as in not remembering a traumatic event.
3. Structural dissociation—fragmentation of parts of self.

# Three Takeaways: How Working With Parts Can Benefit Clients

- 1. The empowering effects of **dual awareness** can enhance self-regulation and functioning. Having an observing adult self online along with a triggered traumatized part can help the client gain distance from overwhelming emotion.
- 2. By **bringing the unconscious into conscious awareness** we interrupt procedural patterns that keep clients stuck in the past. We can do this by just naming what's there in the present moment.
- 3. **Giving hope**—"This is only a part of you that's feeling distress, and this distress is about the past and not about what's happening now."

# Infant Mental Health Components To Be Expanded Upon

- **Attachment work**—Our focus is typically on external attachment relationships, but using Janina Fisher’s model we strive for internal earned secure attachment between the parts and the wise adult self. We also expand our awareness of “who” is interacting in the dyad at any given time.
- **The parallel process**—We give to the parent what we want them to give to the child, and we support them in also giving what is needed to their own damaged parts. The child may also have parts with different needs as well.
- **Speaking for the baby**—Sometimes we also have to speak our observations of the parts in both parent and child, and IMH clinicians are well-suited for doing this.

# Internal Family Systems Therapy

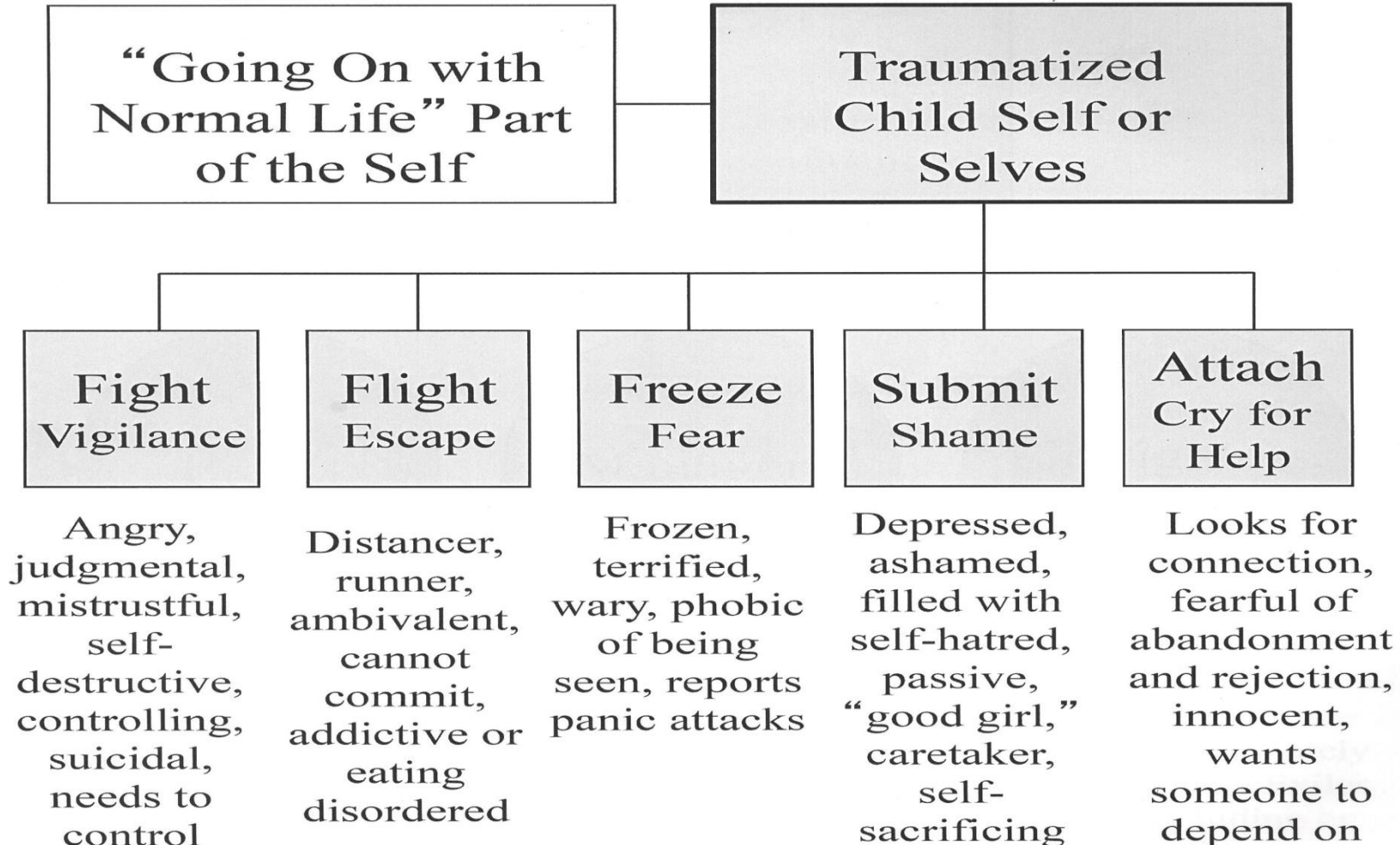
- Developed by Richard Schwartz, who was trained in family systems therapy and adapted components of that model for internal work with individuals.
- Considers multiplicity in personality to be the “normal” organization of the mind.
- Organizes the personality into “exiles,” “managers,” and “firefighter” parts with an overarching “Self.”
- Very accessible for clinicians—many trainings, videos, etc. available.

# Structural Dissociation Theory

- *The Haunted Self*, by van der Hart, Nijenhuis, and Steele outlines this theory.
- Posits dissociative splitting off of parts of the personality as a normal and adaptive response to trauma
- Outlines the “fault lines” around which this splitting occurs—action systems, animal defenses, and right and left brain.
- Janina Fisher, in her book *Healing the Fragmented Selves of Trauma Survivors* combines elements of both IFS therapy and Structural Dissociation to provide a comprehensive parts-based treatment model.

# Structural Dissociation: “Who” is showing up now?

[van der Hart, Nijenhuis & Steele, 2006]



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# Structural Dissociation—What to Look For In Adults (From Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors*)

## **1. Signs of internal splitting**

For example, may function well at work while struggling in personal relationships. May act out a disorganized attachment—a desperate attach part fearing abandonment is followed by a fight part pushing away those who try to get close.

## **2. Treatment History**

Often multiple previous treatments with little progress. Past treatment may be described as “rocky” or ending badly.

## **3. Somatic symptoms**

May be a high tolerance for pain, or an unusual pain sensitivity, headaches, eye blinking or drooping, narcoleptic symptoms, other physical symptoms with no diagnosable medical cause.

# Adult Symptoms (continued)

## **4. Atypical or non-responsiveness to psychopharmacological medications**

## **5. Regressive behavior or thinking**

Body language—or voice—of a young child, shorter sentences, themes relating to separation, caring, and fairness. “More likely to feel empathically failed when not well understood.”

## **6. Patterns of indecision or self-sabotage**

Ambivalence=conflicts between parts with different objectives.

## **7. Memory symptoms**

Memory gaps and time loss. Difficulty remembering therapy sessions, how time was spent in a day, conversations. Getting lost while driving someplace familiar.

## **8. Patterns of self-destructive and addictive behavior**

Fight and flight parts seeking to avoid pain from traumatic past.

**It is the Going On With Normal Life part that is seeking therapy.**

# Structural Dissociation in Children

- Excellent resource: *Healing the Fractured Child*, by Frances Waters.
- The younger the child is when trauma occurs, the less defenses the child has, and the more likely it is that dissociation will occur. This is an unconscious, instinctive response to an overwhelming event, or to repeated negative events such as separations.
- States are often not as well-defined as in adults—they are more malleable to work with in treatment.
- Parts are not developed within the context of an attachment relationship, but within the trauma—they don't have an understanding of appropriate behavior, or of utilizing an attachment figure for comfort.

# Potential Signs of Dissociation in Children

(From *Healing the Fractured Child*, by Frances Waters)

1. History of childhood trauma, including medical trauma
2. Was a supportive person there to comfort or reassure the child at the time?
3. Glazed expression, blacking out, pseudoseizures
4. Eyes roll back or flutter
5. Reports auditory hallucinations
6. Reports internal visual hallucinations
7. Memory problems/amnesia
8. Refers to self as “we,” or in the 3<sup>rd</sup> person

# Symptoms of Childhood Dissociation (continued)

9. Demonstrates regressive behavior
10. Imaginary playmates (persists into adolescence)
11. Sense of depersonalization or derealization
12. Extreme mood switches that are unprovoked, or require minimal provocation
13. Disavows witnessed behavior (lying, for example)
14. Complains of a severe headache before a change in behavior
15. Inadequate progress in treatment despite the child being in a safe, nurturing environment
17. Prior diagnoses and treatment failure

# Goals and Considerations in Treating Dissociation in Children

**1. What is the current home and family situation of the child?**

Is the child in a stable home situation with a supportive and consistent attachment figure?

**2. Does the parent have structural dissociation as well?**

Are triggered parts of the child interacting with triggered parts of the parent?

**3. Regardless of the situation, it is okay to talk to the child about their “inside family,” or “parts.”**

Examples: “That really little part of you doesn’t know that there is a 5-year-old you who can use words to ask for things.” “Seems like that fight part of you thinks he has to push other kids even when they aren’t trying to hurt you—he doesn’t know you aren’t in danger.”

# Goals (continued)

- Work on awareness and cooperation across all states—becoming aware of the current environment and shared body.
- Externalizing parts through the use of a doll or another representative figure can help children to understand the concept of being responsible for managing and caring for the part(s).
- Expanding the window of tolerance—developing coping skills and learning what is dangerous and what is not.
- Parent receives psychoeducation
- “The 6 L’s” --Fran Waters

# Implementation of Parts Work for Infant Mental Health Clinicians—Where to Start

- Introduce a “parts language” into your work. “Sounds like a part of you wants to...., but I hear another part thinking about.....”
- Provide psychoeducation as you begin introducing the concepts to clients. Tailor this to what you think the client is ready for. Psychoeducation is crucial to working with these concepts.
- Assess where the client is—either engaged with the present and current tasks (Going On With Normal Life Part), or distressed and living in “Trauma Time.” (EPs) Intervene accordingly.
- Speak to the parts in the third person. “The little girl part, “That protector part,” etc. The adult self is the only one referred to as “you.” We want to keep the observing adult self online and not blended with the parts.



Getting  
Started—Two  
Clinicians  
Share Their  
Experiences

**Emily Gutman, LLMSW** Starfish Family Services  
*Approaching New Cases From a Parts Perspective*

**Natalia Barna, LMSW** Starfish Family Services  
*Enhancing Clinical Work With Existing Cases  
Using a Parts Perspective*

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