Bonus 6

Advanced Master Program on the Treatment of Trauma

Working with Clients That Suffered Abuse or Neglect as Children

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How Childhood Abuse or Neglect Can Create Conflicting Internal Parts in a Patient

Dr. Buczynski: In Module 4, we talked about how we might work with a patient's parts to treat shame that stems from trauma.

And in this video, we're going to look at how to use parts work to help people who have experienced neglect or abuse, and also heal the shame that can often compound that trauma.

You see, when people have experienced neglect or abuse, they often have internal parts that are in near constant conflict with each other.

On the one hand, there are parts that engage in reckless behavior to distract a patient from their pain.

On the other hand, there are parts that work to suppress these urges to "act out."

So where might we begin in approaching these conflicting parts?

Dr. Sweezy: When I'm working with somebody who had a very neglectful caretaking situation in childhood, and it may have been abusive as well, usually, there's a combination deal going on for kids with dysfunctional parents or caretakers. I would see how it's playing out in their life today as an adult and how it's happening in their current relationships because these things get replayed. If there's a lot of acting out going on, I would note that, but look for the inner critic, because that's what charges up the acting out. In other words, the inhibition is what motivates the disinhibition.

> "If we get pulled into trying to control those parts, we're going to lose. What we really need to do is find the fuel that's causing this fire to burn. And the fuel is actually the inhibition, the shaming that's going on internally. And there's a war between inhibition and disinhibition."

Most treatment systems get pulled into focusing on the disinhibition because it can be dangerous and destructive. Substance abuse, sexual risk taking, those kinds of behaviors

cause us to sit up and pay attention. And that's what brings the person into therapy often, because they're endangering themselves with these behaviors, and they don't feel like they can get a handle on it. They can't control it. But if we get pulled into trying to control those parts, we're going to lose. What we really need to do is find the fuel that's causing this fire to burn. And the fuel is actually the inhibition, the shaming that's going on internally. And there's a war between inhibition and disinhibition.

Dr. Buczynski: That's such an important point, that focusing on a patient's disinhibited behaviors often doesn't work.

But how might you approach working with your patient's inhibited parts – those parts that Dr. Martha Sweezy says are often fueling those disinhibited behaviors?

Dr. Sweezy: I want to get with both of those parts, and I want to help both of them be willing to separate enough so that they recognize that there's a third party in there, that the client has a "Self," a resource that's not a part. And if they can't do that, then I'll be the third party. I'll negotiate with them directly, but I don't talk to one without the other. I set it up, so I'm like, "You are reacting. You disinhibition are reacting to all this inhibition. I get that." So I validate parts who are acting out, like, "I totally get that. Would you calm down enough during a session here so that we can talk to the part who's driving you nuts?"

And then I validate the inhibition part and say, "I get it. You're afraid she's going to die from this behavior, or he is. We have to deal with that, but I got to talk to both of you at once because you two are our package deal. You're creating this dynamic with each other, and you're scared of each other, but you both mean well. You both want the best for her or him or them. We can do this together because you, disinhibition, are trying to distract from all that emotional pain, and you inhibition are trying to suppress it. And we can help the emotional pain, so you don't have to do any of that stuff anymore."

Dr. Buczynski: So the idea here is to work with both the inhibited parts AND the disinhibited parts to help your patient shift out of the constant cycle of self-shaming.

Important Nuances to Consider When Building Trust with Your Patient's Parts

But first – and this is essential – you need to build trust with these parts . . .

Dr. Sweezy: I have to demonstrate that I know what's going on, that I'm not going to blame either party, that I'm not going to take sides, that I'm going to care about everybody involved, that I'm going to assume that their intentions are good, that I'm going to offer them something that is going to help everybody, and that I don't expect them to take that on faith. I'm not trying to control them. I'm not trying to make them believe something that they don't think is believable, but I am asking them for just a lab experiment. "Will you give me the time to show you that what I'm talking about is real? And you don't have to sign on for it ahead of time. If you don't like it, you can go right back to what you're doing. I can't control you. The person's "Self" can't control you. We're not here to try and control here. We're here to offer you something, and then it's up to you whether you take it."

> "As long as they feel like you're not trying to control them, they tend to become quite cooperative in the short-run and give you a chance to show something."

And on those terms, protective parts calm down a lot and they're willing. As long as they feel like you're not trying to control them, they tend to become quite cooperative in the short-run and give you a chance to show something.

Dr. Buczynski: So remember, parts need to feel like they have autonomy and are in control before they can feel safe exploring. And what can really help is to tell a patient's parts, "Let's just see what happens." – approach it like a harmless experiment.
Once you get your patient's protective parts on board, then you can slowly introduce them to the idea of giving each other space. And that's when you can finally reach the part of the patient that's ashamed and in pain.

Dr. Sweezy: The next step after demonstrating to parts that I'm trustworthy, that I'm talking about something that's worth investigating, is to do an experiential piece with them around unblending, around separating. This is a really important point. Protectors are often afraid of making any wrong or separating because they're afraid of each other if they're in a conflict. "If I give any space, then that one's going to take over." They have to both agree to calm down at

the same time in session, at least, to make a little room. And they have to also know that that vulnerable part who's got all that emotional pain isn't going to take over if they make room.

So then, if they're worried about that, sometimes I say, "We're just going to send that part an email or call it on the phone. We're not going anywhere near it. We're just sending a message." "If you could get the attention you want," and these parts long for attention, "would you be willing to not overwhelm the client with all those feelings?" And the answer is always "yes." But sometimes there's an addendum which is, "I don't know how not to overwhelm. If you give me an inch, I'll take a mile. I'm going to panic."

Working with a Patient's Part That is Particularly Sensitive

Dr. Buczynski: So how might you help your patient manage a part that feels particularly overwhelming?

Dr. Sweezy: I do personally a little practice session. I say, "Okay, I get that. I can show how we can help you to be with the client without taking over. Are you willing to try that? Are you protectors willing to let us try that?" So you keep negotiating each step. And when everybody says yes and the protectors say, "Well, I may come right back in if I have to. If I have to take her out and dissociate, I will." I say, "Fine, do it. That's no problem. You do your thing, but give me a minute to show how this can work." So then they settle back a little bit. And then I invite the part who has all those painful feelings and the client to imagine a dial, like the dial on a stereo volume, that I'm going to put between them. And then I want the part who's in pain to set the dial, which is how much it shares its feelings with the person, at whatever level the client tells them to.

> "Usually, you can persuade even very panicked exiled parts to dial it down and not overwhelm. And then protectors really relax. As long as they're not afraid of each other, they can hold their agreement in session, then they're not afraid of the Exile."

So I'll say to the client, "What level of feeling is okay so that you can stay with this part without feeling taken over?" And the person might say three. So I'll say to the part, "Okay, set that dial at a three. You can have your feelings. We're not telling you what to feel. No one's trying to control you. But don't share it at any level higher than a three. And I want you two to practice that together." Usually, the client is quiet

for a couple of minutes and then says, "Okay, now we're at a three." So I'll ask, "How does that feel to both of you?" And they might say, "It feels better to me. I can breathe again. This is good for me." Sometimes the part will say, "But I don't feel like she's really getting it. It's not enough for me."

If the part complains, then I'll say, "I get that. We're doing this so you can turn the volume up later on, as high as you need to. But to start, if you don't want those other parts to come in and interfere, we have to practice you two being together safely so that you're both here." So usually, you can persuade even very panicked exiled parts to dial it down and not overwhelm. And then protectors really relax. As long as they're not afraid of each other, they can hold their agreement in session, then they're not afraid of the Exile.

An Essential Aspect to Remember When Working with Parts

Dr. Buczynski: Now during this process, it's essential to regularly check in with each of your patient's parts. Not only that, you also want to make sure you're asking these parts for permission before moving to the next step.

Dr. Sweezy: After helping the Exile to not overwhelm and the protectors to honor their agreement to each calm down, then I would check back with the protectors by asking, "How are you doing? Is this okay with you?" I always ask for permission. At every step I'm always checking in with them , which really forestalls any kind of blowback later on or interference during a session because I invite them to interfere. I'm constantly saying, "You step in if you need to. You tell us if we should stop." And so they do if they need to, but usually they don't. Then I would say, "Is it okay now, at this level of feeling, if this part who's in pain shows the client something?" Not everything, but one thing that was important about their experience that they want the client's "Self" to know.

> "I always ask for permission. At every step I'm always checking in with them."

Then the protectors go, "Okay, as long as it's not the worst thing or as long as we're not having a bad piece of information or something that's not allowed to be shown." So you build basically. You're building trust in a system that has been very shut down and untrusting of each other and of the outside world. You just keep going like that – getting permission, helping the Exile show more and more of whatever it needs to show until it's really feeling securely attached

internally and is ready to let go of those beliefs and feelings that it's been carrying around that have been so toxic about, "I'm unlovable. I'm worthless. I'm bad."

Four Key Signs That Parts Work Has Reduced Your Patient's Shame

Dr. Buczynski: Now to get a sense of how the parts work is going, how it might be impacting your patient's experience of shame, you might want to be on the lookout for a few key signs . . .

Dr. Sweezy: When we're getting ready to finish therapy, and someone has had a lot of what I call the shame phenomenon going on inside them with the internal shaming and a lot of shamefulness, I would first expect that the internal shaming would be way down and that the person's "Self" would be present and available if some part decided to do some criticizing. A lot of parts who are critics don't quit forever. They're always ready to jump back in. But if the "Self" is there, then it doesn't overwhelm. It's like, "Okay, that's a sign that something upsetting just happened. What's going on? Why are you doing that? What are you worried about?" So the person can just get curious about whatever it is that triggered that.

"A lot of parts who are critics don't quit forever. They're always ready to jump back in. But if the "Self" is there, then it doesn't overwhelm."

That's the relationship between the critic, these often young children who are very vigilant, and the client's "Self." And then there's the Exile. What you're aiming for at the end, which ends at least a chapter of treatment, is for that exiled part who's carrying these burdens of, "There's something wrong with me. I'm bad. I'm unlovable. I'm worthless." That part is ready to let go of that belief. And it's ready to let go because it doesn't feel that way anymore. It feels loved. The part feels loved. And when it feels loved, it's like, "Okay, that's something that happened to me. That's not who I am. I'm ready to let that go. I don't have to be that identity anymore. I can be someone who's loved and who can be loud if I want to be, and it's not a crime."

Dr. Buczynski: So Martha just shared four indicators that can help you tell whether your work has been effective in addressing your patient's shame.

The first indicator is a decrease in self-shaming. Now keep in mind that some internal shaming may still be present – but this is normal and even healthy.

Because remember, shame is a protective response. Your job as a practitioner isn't to get rid of your patient's inner critic – it's to help them discover their core "Self" so that they can better manage messages of shame when they pop up.

And in fact, the second indicator that parts work has been effective for your patient is that they're able to access their core "Self."

The third indicator is that your patient is able to get curious about what triggers shame – and they're able to do that largely because they now have access to the "Self."

And the last indicator is that your patient no longer feels shameful, and instead believes they are deserving of love.

Now in the next bonus, we'll get into how to work with shame in survivors of sex trafficking.