CLINICAL PRACTICE

The use of imagery in phase 1 treatment of clients with complex dissociative disorders

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The "standard of care" for clients with complex dissociative disorders and other complex trauma-related disorders is phase-oriented treatment. Within this frame, therapeutic progress can be enhanced by the use of imagery-based therapeutic techniques. In this article, the emphasis is on their application in phase 1 treatment, stabilization, symptom reduction, and skills training, but attention is also paid to applications in phase 2 and phase 3 treatment. Many of the existing imagery techniques are geared toward clients becoming more able to function in a more adaptive way in daily life, which, however, requires the involvement of various dissociative parts of the personality. Such collaborative involvement is also essential in the later treatment phases. Therefore, understanding the dissociative nature of these disorders is helpful in the judicious application of these techniques.

Keywords: *dissociation of the personality*; *phase-oriented treatment*; *phase 1 treatment*; *guided imagery*

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Although DSM-IV dissociative disorders are far from rare, still too often they are not recognized in psychiatric and psychological assessment, and thus clients suffering from such disorders lack adequate treatment. Various studies found, among psychiatric inpatients, prevalence rates of 4–21% for these dissociative disorders as a whole and 1–7% for the most complex dissociative disorder, i.e., dissociative identity disorder (DID) (see Sar, 2011, for an overview). For the complex DSM-IV dissociative disorders, i.e., DID and dissociative disorder not otherwise specified (DDNOS, subtype 1b), as well as for other complex trauma-related disorders such as Complex PTSD, the standard of care is phase-oriented treatment consisting of: (1) safety, stabilization, symptom reduction, and skills training; (2) treatment of traumatic memories; and (3) personality (re)integration and rehabilitation (e.g., Brown & Fromm, 1986; Brown, Scheflin, & Hammond, 1998; Chu, 2011; Courtois, 2010; International Society for the Study of Trauma and Dissociation, 2011; Van der Hart, Nijenhuis, & Steele, 2006). The model takes the form of a spiral, in which different phases can be alternated according to the needs of the client. The standard of care has been developed based on consistent clinical observations that the majority of clients need to develop specific skills prior to the arduous challenges of integrating traumatic memories and their personality. Stabilization skills include arousal and impulse regulation, reflection functioning, energy management, relational skills, executive functioning, healthy relationships, and other daily life skills, in addition to the development of empathic and cooperative relationships among dissociative parts.

As this article will illustrate, guided imagery can play an important role in phase 1 treatment. However, also phases 2 and 3 treatment offers many opportunities for such work. Understanding the nature of dissociation as manifested in complex dissociative disorders and other complex trauma-related disorders may enhance the judicious use of imagery-based techniques.

The dissociative nature of (complex) dissociative disorders

The DSM-IV describes dissociation, i.e., the essential feature of these disorders as "a disruption in the usually

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integrated functions of consciousness, memory, identity, or perception of the environment'' (p. 477). That these disruptions may also pertain to motor and sensation functions, as the ICD-10 states (World Health Organization, 1992), is overlooked. The theory of dissociation espoused in this paper states that it is a division of the personality based on an integrative failure (Van der Hart et al., 2006). The dissociative personality involves subsystems comprised of discrepant and divided first-person perspectives, separated by psychobiological barriers. These subsystems are here called dissociative parts of the personality, but are also known under other names—each term with its own specific disadvantages and advantages. Although dissociation, and thus the dissociative disorders, are primarily due to an initial integrative deficit, the dissociative individual secondarily may use it as a survival strategy (Van der Hart et al., 2006). In his perspective on dissociation in complex PTSD that has some similarities with the view espoused here, Ford (2009) postulates that dissociation ''develops as an automatic (versus consciously instigated and controlled) attempt to reinstate bodily integrity by shifting the body's dominant mode of operation from self-regulation to self-preservation'' (p. 472). This automatic attempt, which involves the maintenance of the dissociation of the personality, basically involves actions from the individual's dissociative part functioning in daily life (see below) to keep the traumatic memories and the dissociative parts involved in them at a distance. In fact, a whole series of inner-directed phobias serve to maintain the dissociation of the personality, including the phobia of traumatic memories and the phobia of dissociative parts. Understanding and respecting the client's need to rely on these phobias is essential in the treatment—including the use of guided imagery—of clients with DID, DDNOS and other complex trauma-related disorders. It implies the need for stabilization skills prior to working with traumatic memories and as part of the resolution of dissociation.

Phenomenologically, dissociation of the personality manifests in dissociative symptoms that can be categorized as negative (functional losses such as aphonia, amnesia and paralysis, loss of certain skills such as reading) or positive (intrusions such as flashbacks or voices), and psychoform (symptoms such as amnesia, hearing voices, thoughts being ''put in'' one's mind) or somatoform (symptoms such as anesthesia or tics, bodily sensations related to trauma) (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006). Furthermore, dissociative parts are characterized by alterations of consciousness, including narrowing of consciousness, absorption, and imaginative involvement: phenomena which are considered by some authors as dissociative in nature but which are certainly not specific for dissociative individuals (Van der Hart et al., 2006).

The theory of structural dissociation of the personality distinguishes two main types of dissociative parts (Myers, 1940; Van der Hart et al., 2006): the so-called *apparently normal part of the personality* (ANP) tends to primarily function in daily life while avoiding reminders of the trauma, and the *emotional part of the personality* (EP) is stuck in trauma-time, chronically reliving traumatic experiences and engaged in related defenses (fight, flight, freeze, ''feigned death'' or collapse). The division of the personality into a single ANP and a single EP, each with its own first-person perspective, is called *primary dissociation of the personality*, and characterizes simple posttraumatic dissociative disorders, including PTSD. When an individual faces chronic or prolonged traumatizing events, particularly in childhood when integrative capacity is naturally lower due to developmental limitations, dissociation can become more complex and chronic. In *secondary dissociation of the personality* there is also a single ANP, but more than one EP. This division of EPs may often be based on the failed integration among relatively discrete defenses of fight, flight, freeze and collapse (Ogden, Minton, & Pain, 2006; Van der Hart et al., 2006). Others may hold intolerable affective experiences such as shame or loneliness. Secondary dissociation might characterize Complex PTSD, trauma-related Borderline Personality Disorder and DDNOS-subtype 1b, i.e., the subtype most similar to DID. Finally, *tertiary dissociation of the personality* involves not only more than one EP, but also more than one ANP; this characterizes DID. The individual's personality becomes increasingly divided in an attempt to maintain functioning while avoiding traumatic memories. In this paper, the emphasis is on guided imagery work with clients characterized by secondary and tertiary dissociation of the personality, in particular those with DDNOS and DID.

Guided imagery during phase 1 treatment

One of the major characteristics of clients with complex dissociative disorders is their high capacity, for better or worse, for imaginative involvement. It is a well-established clinical observation that various dissociative parts of the personality are highly capable of, and often absorbed in, imaginary experiences. Both absorption and imaginative involvement may have a rather involuntary character, such as when traumatizing events (that may or may not include some elements that are purely imagined) are re-experienced by EPs. However, in treatment the client's capacity for imaginative involvement can be utilized for healing purposes probably more often than clinicians generally realize. In phase 1 treatment the focus is primarily on strengthening the ANP(s), i.e., the individual's ability to function in daily life, and on overcoming its (their) phobia of various inner experiences. Overcoming, to some degree,

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the phobia of dissociative parts is essential in the judicious application of many imaginative techniques, that after all involve cooperation among dissociative parts.

The therapist's formal knowledge of hypnosis is an asset in calling upon the client's imaginative capacity (Kluft, 1992), as this expertise involves the realization that all verbal and non-verbal therapeutic communications may function as suggestions that may evoke therapeutic imagery, along with associated emotions and cognitions, as well as changes in breath, posture or movement of the body, that fosters therapeutic change. Such expertise also makes the therapist aware that therapeutic communications inadvertently may also have adverse consequences, such as the creation of threatening images. However, effective therapists in the dissociative disorders field, whether formally trained in hypnosis or not, can be considered to be experts in using clients' propensity for imaginative involvement. In this paper, a few techniques are described that call upon the client's imaginative involvement, in particular, though not limited to, those used in phase 1 treatment (see for more examples, Boon, Steele, & Van der Hart, 2011; Krakauer, 2001).

Imaginary protective gear

One of the challenges for dissociative individuals is that they often encounter situations and relationships in daily life that are too demanding of their resources, and thus may evoke maladaptive responses. For instance, a potential threat, such as encountering an angry person, may reactivate EPs and the reenactment of traumatic memories they engage in, resulting in severe dysregulation or even crisis. Boon et al. (2011) describe a particular imagery exercise that may, to some degree, be helpful in coping more effectively with these dissociative parts. The therapist invites the client to imagine a store with all kinds of protective devices, including protective suits or cloak that shield from the stresses and strains of life. Clients select just the right suit of armor, and perhaps also different protective objects for different parts. When clients' experiences sense of protection, confidence, and relaxation while wearing this imaginary suit, they can practice imaging those formerly stressful situations while remaining in this calm state. Also, when confronted by other people's emotions that set them on edge, these devices can be "worn" for protection.

Inner safe places

Often various dissociative parts, especially particular EPs, need to be protected more strongly from the influence of the outside world or from other parts. A most useful and well-known therapeutic technique is helping the client as ANP to develop with various EPs their *inner safe places* (e.g., Brown & Fromm, 1986; Van der Hart et al., 2006). When external or internal threat can be predicted, the parts that need to be protected from it can preemptively move to these places. One special situation for which this technique is helpful is when some parts need to discuss events or experiences which might reactivate traumatic memories in other EPs (as might be the case when a discussion needs to take place about which traumatic memory will be targeted for integrative work in phase 2 treatment). Some parts might share the same safe place, while others need a safe place on their own. The therapist might provide some examples for inspiration such as a well-hidden log cabin or desert island, but the most important principle is that parts feel entirely contained and safe in the imagined safe place(s). An extremely frightened EP of a highly traumatized client chose the image of a pillbox to create a military bunker with at least one meter thick concrete walls. In addition to inner safe places, the therapist can help the client to create extra protection against unwanted confrontations if needed (e.g., an "inner sound-proof wall").

In Etty, a DID client, child parts wanted to have a safe hole in the ground, under a tree. Two of other parts, including a helper part, dug a narrow passage to the hole. However, an extremely traumatized child part who had been repeatedly locked up in narrow cupboards and was claustrophobic as a result, felt too afraid to go into the hole. The therapist suggested that the helper part could assist the scared one by making both of them temporarily very small, such that the entrance, the passage and the hole itself would seem very large to them.

> Then the two of you can go into the hole, take a look around, and come back out. Then go in again, and come back out. You can stay in or out just as long as you want, and go in and out just as often as needed to get used to this place, and to feel safe here. And then, whenever either of you wants to, you can make both of you a normal size again. How does this sound to you?

This was effective for the client, and she ended up having a safe place for these child parts where they could go when needed. For instance, when the client as ANP knew that a triggering situation would occur, she told the child EPs to go to their safe place. Through a kind of pipeline this ANP could inform the parts inside the hole when it was safe, and support them in coming out again if they wished.

Finally, safe place imagery can also be used for dissociative parts that feel too much pain to cope or fears that they cannot control their impulses (Kluft, 1990a): "At such times, a variant of an inner safe place may be very useful and forestall a hospital admission, a suicide attempt, self-injury, or other counterproductive

acting-out'' (p. 342). While a competent part of the personality (an ANP) agrees to remain in charge of daily life affairs, the therapist suggests that the parts in pain go to their respective safe places in which they can rest with peace, permitting themselves ''to drift toward sleep, a sleep that will last calmly and without disturbance until you actually enter my office for your next appointment'' (p. 342).

Containment of traumatic memories

In phase 1 treatment, the therapist can help the client to create imagined container for the containment of traumatic memories. Images of safes, bank vaults, steel boxes, pillboxes, computer files, or videotapes often are used. Sometimes, an extra safety measure is used: the creation of a lock on the safe with two keys, one for the client and one for the therapist, so the safe can be used to lock these memories away, to be opened when both agree in phase 2 treatment for the integration (synthesis and realization) of these traumatic memories.

The imaginary meeting place

One of the major goals of phase 1 treatment is helping clients, beginning with ANP(s), overcome the phobia of dissociative parts of the personality and develop mutual acceptance and cooperation for problem solving in daily life and for improved inner reflection (Van der Hart et al., 2006). These therapeutic developments strongly contribute to stabilization and symptom reduction, as much dysregulation and many (but not all) of the existing symptoms are intimately related to inner conflicts among dissociative parts.

Inner cooperation among parts is fostered by having the client develop an imaginary meeting place where parts get together and negotiate their various goals and ways to reach them in structured and safe ways. The characteristics of such a place vary with the individual needs of the client, including those of various dissociative parts, but an often used strategy is Fraser's *dissociation table technique* (Fraser, 2003). This involves helping the client, or rather some parts of the individual, to create the image of a table and chairs in a safe conference room. Some clients will prefer another meeting area, as for them rooms are initially experienced as unsafe. The therapist may suggest putting a cloth on the table, which might give child parts something to hide under, and have some niches or dark areas in the room in which parts may hide for the time being while still being able to listen in. Fraser suggests for the actual meeting that imaginary microphones and spotlights are used to facilitate ordered and respectful communication. The therapist emphasizes the importance of the role of the ''chair part,'' the servant of the community of parts that has the responsibility to ensure that all parts have their turn to speak and help them to negotiate and reach agreements. It might be best to first ask the parts who among them would be most suited to fulfill this role. For some clients, it may be an adult ANP, for some others an internal self-helper or a part that knows the whole system. The therapist may also suggest the inclusion of a ''secretary'' who at least writes down (e.g., on an imaginary computer) the decisions made and the points of action. The therapist defines her or his own role in this context as strictly one of consultant, particularly for the ''chair part,'' so that the client develops the skills of having parts meet and negotiate among them, rather than rely solely on the therapist.

For some clients the inner meeting place initially serves as a conference room; for instance, for reaching agreement about the day's agenda and for evaluating during the evening the outcomes of decisions and related actions. In a later stage, however, clients often begin to use the same space for more social, emotional sharing among parts. Martha, a DID client, gives a moving example: When a child part, age five, that often wet the bed because of intense fears at night, was eventually able to feel more safe at night and give up this symptom, he was placed on the table and the other parts shared with him the joy of this accomplishment, by offering applause and congratulations. For other clients, the inner meeting place has this type of character from the beginning.

Inner community building

The inner meeting place, safe places and imagery for containment of traumatic memories may become integrated in a more elaborated inner structure, such as an imaginary house. Marion, a DID client, had constructed such a house with a meeting room, safe places for more grown-up parts, such as the attic for her student part and ''children's rooms,'' where care-taking parts could keep child parts company. The storage space for traumatic memories contained in some EPs was a pillbox, located not far from this imaginary house. Such elaborate structures can further assist in improving inner acceptance and cooperation. For instance, parts can visit each other, increasing inner communication and empathy. Or they discuss which parts need to be in a safe space and which can participate when something potentially upsetting will be discussed. As they work more actively together, they will develop a greater level of inner comfort and safety with each other. In short, such work can help the parts function together as a team dedicated to healing and to participate more fully in the therapy. The more the therapist is able to help the client elaborate these inner spaces, the more each part can feel included. As clients learn to better reflect and self soothe, their imagery should reflect those capacities by becoming increasingly rich and supportive.

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The inner source of wisdom

In psychotherapy using "permissive" hypnosis, the therapist may suggest that the client to check with his or her "unconscious mind" (or "inner mind," "wizard," or "inner source of wisdom") for the solution of existential problems (Erickson, 1980). The client is not only advised to approach this inner mind" with utter respect, but can be instructed to imagine a special place inside where this inner source of wisdom is located, as well as the way which leads to it. For instance, Judith, a client with unresolved grief regarding her father, imaged a long winding staircase in a mountain which she had to descend, until she came to a room with a door which she could open with a special key. In this room her "inner healing" could take place. For this she sat in a chair carved out inside a large, purple crystal ("the Crystal"). In front of her was a panel she could use to ask questions of an old wizard (Van der Hart, 1988). Krakauer (2001) extended this approach to the treatment of clients with complex dissociative disorders: She suggests that parts of the personality consult the "inner wisdom of the unconscious mind" for guidance. An important situation in which recommending this approach to the client is when dissociative parts remain stuck in their decision-making process regarding important issues, with choices often having serious consequences. Examples are: whether or not to start with phase 2 treatment, leaving the mental hospital, separating from one's partner, quitting one's job and looking for another. Of course, the therapist does not relegate all responsibility for the therapy to the client's "inner wisdom," but takes this inner resource seriously as it can enhance the client's sense of autonomy, and thus counteract maladaptive dependency on the therapist (cf., Steele, Van der Hart, & Nijenhuis, 2001).

Guided imagery during phase 2 treatment

Many of the phase 1 techniques using guided imaginary are also most useful for phase 2 treatment, with its main focus on the integration or processing of traumatic memories, thus on the overcoming of the phobia of traumatic memories. First, for a clearer understanding of the challenges the client and therapist face in phase 2, it is important to distinguish between two levels of integration, which are not always clearly distinguished in the literature (Van der Hart et al., 2006). First, *synthesis* involves the *sharing* among ANP(s) and EP(s) of the principal elements of the traumatic experience. This transforms the traumatic memory as a re-enactment into a symbolic verbal (narrative) account that is not depersonalized, but is a genuine autobiographical narrative. Synthesis thus consists of graduated exposure to a particular traumatic memory, prevention of maladaptive mental and behavioral reactions, and promotion of sharing and acceptance of traumatic memories among various dissociative parts. Second, once the client has synthesized the traumatic memory, *realization* that one has experienced the trauma in the past needs to take place. Eventually, the client 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. In the course of therapy the narrative of various events and their consequences must be further integrated within and across each part of the personality. Imagery techniques are especially helpful during the synthesis of traumatic memories.

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, or can at least maintain a reasonably stable relationship with the therapist, can tolerate and regulate arousal, and have developed a degree of inner empathy and cooperation. When the issue of whether or not to start with the integration of a particular traumatic memory, the therapist can invite the dissociative parts that are able to discuss the arguments pro and con, face the contents of the traumatic memories, and become knowledgeable about the EPs involved, to meet. Together they can meet in the inner meeting place, while all other parts who should not be present remain in their own safe places. Depending on the complexity of the target traumatic memory, the client's integrative capacity and those of the parts involved, an agreement may be that the initial synthesis will include only a fragment of the traumatic memory and one or two EPs involved. For instance, if the traumatic memory includes intense feelings of anger, the "fight EP" might share first his or her vehement emotions, with the EPs fearful of such anger being in their own safe places.

When the actual integration in the form of synthesis of the target traumatic memory is about to take place, the therapist inquires if all parts to be involved are present in the inner space designated for this work. Again, all other parts are instructed to be in their own safe places and, if needed, behind a "sound-proof wall". Some parts would need to observe the actual synthesis from a distance. Here the image of looking from another room through a window and listening via an intercom might be helpful. The parts present include the EPs engaged in the traumatic memory, parts that have a supportive and comforting function, and the parts with whom they will "share" their traumatic experiences in a carefully structured manner to prevent re-traumatization and uncontrolled dissociative reactions (Van der Hart, Steele, Boon, & Brown, 1993; Van der Hart et al., 2006). (There are countless ways in which complex traumatic memories can be divided into dimensions that are subsequently synthesized, but a discussion of these ways

is beyond the scope of this article; see, for instance, Kluft, 1990a,b,c; Van der Hart et al., 2006.) This "sharing" is taken literally: the therapist discusses with the client, i.e., the dissociative part representing the other parts involved, the arrangement of the meeting and the sharing. For instance, if one EP needs to share his or her partial experiences, this part may be invited to sit on an imaginary chair, with the other parts (with whom to share the experience) being close in connecting and supportive ways.

When the synthesis of a traumatic memory has been partially completed in a session, the therapist gives suggestions for containment of what still needs to be shared in a following session. In any case, when this part of the session has been completed, the therapist suggests that the parts involved rest and comfort each other. Various images may be added for this purpose. For instance, the parts involved may be suggested to quietly walk to a beautiful meadow with wild flowers, where the sun is shining and a gentle breeze can be felt. They can lie down on the grass if they want, and watch the clouds peacefully drifting in the sky (Watkins, 1990). Eventually, the therapist suggest that they return, fully rested and refreshed, to the session, eventually allow the client safely return home.

Sometimes clients themselves come up with relevant imagery. The case of Martha, a client with DID, is illustrative (Van der Hart et al., 2006). Martha's various parts did great work in the synthesis sessions, but afterwards experienced crises for which she needed brief hospitalization. This was because she felt it was necessary for further integration that the parts who were in their safe places and behind a sound-proof wall during the session needed to be told what exactly had been shared. This proved to be overwhelming for them. The therapist advised her, i.e., the parts in control, to develop a safe procedure for this specific type of sharing. This is what she subsequently wrote (Van der Hart et al., 2006):

> We now come together long before the synthesis session (i.e., one or two weeks in advance) in a soundproof room, where we discuss the next synthesis with those parts who want to share the traumatic memory…We have created a semi-permeable wall ("membrane") between us and the other parts which wasn't present at the synthesis. In this way, dewdrop by drew drop, very smoothly, by osmosis, the information of the shared traumatic experience will enter the system and be received by those who can receive and understand it better. Thus, we don't confront them directly with the hard truth, and in this way we don't have to be admitted [to a crisis center] anymore. (p. 334)

Guided imagery during phase 3 treatment

Part of phase 3 treatment, personality (re)integration and rehabilitation, involves the fusion of parts—often a recurring integrative action—and, eventually, their unification into an coherent and consistent personality, with clearly a coherent life history. Although the synthesis and realization of specific traumatic memories may have involved the fusion of parts involved, this is far from always the case. Some parts need a long time of sharing of their respective life histories, skills, and interests, before they are able to let go of their separateness and become one. However, pressuring these parts to fuse is contra-indicated. When the time is ready, imagery fusion rituals are extremely helpful in eventually realizing such transformations (e.g., Kluft, 1993; Van der Hart et al., 2006). Examples of images helpful in bringing about a fusion among parts include dance, embrace, light and water streams merging together. Such examples may inspire clients to construct and perform their own imaginary fusion rituals. For instance, Mary who loved swimming imagined that the parts ready to become one simultaneously dived into a swimming pool, then under the surface swimming toward and embracing each other. When they emerged from the water, they had become one.

Phase 3 also includes grief work, particularly with regard to having missed so much in life because of one's chronic traumatization. This is a hard and very painful challenge, one that usually needs to be met repeatedly. When the time is right, imagery leave-taking rituals (Van der Hart, 1988) may be very helpful. For instance, the client imagines how, and in which context, she or he is saying goodbye to a deceased parent/perpetrator. The leave-taking can also take the form of an actual ritual, such as solemnly burying a farewell letter and/or disposal or otherwise distancing of a linking object. When the timing is right, by performing such rituals clients can be able to symbolically let go of losses of the past.

Finally, phase 3 work includes overcoming several phobias that impede living a normal, rewarding life, i.e., self-development. Here, guided imagery may involve therapists helping clients to create images of how they would want to behave or relate in different domains of life, such as with regard to intimate relationships. Clients might first see their ideal selves on a TV screen or on a theatre stage performing the desired actions and subsequently imagine themselves entering the screen or stage and merging with their ideal selves. Such work may also involve helping clients to discover new interests and activities (Brown & Fromm, 1986).

Discussion

Imagery techniques are well-known procedures that should be part of the standard repertoire for all therapists who work with clients with complex dissociative disorders as well as other complex trauma-related disorders that may also be dissociative in nature. These techniques are

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presented in this paper as single interventions, but in actual clinical practice they often are utilized in combination. In order to work effectively with these techniques, the therapist needs to understand the dissociative structure of the client's personality. The most appropriate way of applying these techniques is to individualize them according to the needs and characteristics of the client, who is helped to create his or her unique imagery. Any examples that the therapist presents to the client are sources of inspiration.

The application of guided imagery work is not always problem-free. Major pitfalls involve to timing and persuasion. As mentioned above, therapists should always remember that clients with complex dissociative disorders maintain their dissociation and the problems that stem from it by a series of inner-directed phobias. These phobias need to be explored and resolved in a careful, stepwise manner during the various treatment phases, and the introduction of specific imaginative work should be integrated in this approach. Further, the way specific procedures are introduced should also be very gradual: The therapist first checks with the client if parts are in agreement about resolving a certain problem or challenge. Then the therapist could inquire if the client has a solution in mind, and, if not, if she or he would be willing to hear about a possibility. (If not, then the therapist should gently explore the reason(s)). When the therapist eventually presents a specific form of imagery work that might be helpful, perhaps using examples from other clients, she or he also inquires about possible objections from other parts and respectfully deals with them. Overlooking this step can lead to adverse reactions further on. Finally, the specific wording of the technique's introduction may be tantamount to its acceptance or rejection.

It should be noted that there are no empirical data for the use of imagery in the three treatment phases. This should be contextualized, though, by the understanding that few treatment studies exist with regard to complex dissociative disorders (cf., Brand, Classen, McNary, & Zaveri, 2009), even though an important research is underway. Furthermore, the length of treatment and complexity of the variables involved will make it most difficult to study the individual contribution of guided imagery work. Despite this lack of empirical data, it hard to imagine how therapy with clients with complex dissociative disorders could proceed without using at least some of the techniques described here.

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