Shrouded in Mist: Uncovering The Hidden Layers Of Dissociation

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Aims for the Day – To Gain A Greater Understanding of Dissociation Through Looking At:

- The ‘what, why and how’ of Dissociation
- Causes, Triggers & Contributing Factors using a biopsychosocial, Psychological, Trauma & Neurophysiological lens
- Recognising Dissociation Signs and Symptoms - The Continuum of Dissociative Experiences & how they may show up in the therapy room
- Differential Diagnoses – EUPD & Schizophrenia
- Introduction to Structural Dissociation
- When We Are Helping: The Importance of Compassion & Patience when Working with Dissociation

Definitions – The What

"A disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior" (DSM)

"The separation of realms of experience that would normally be connected" (Elizabeth Howell 'Understanding and Treating Dissociative Identity Disorder')

So, it is a disturbance in integration of thought, memory, emotional feelings, sense of self, body awareness, and also perception of the external environment.

Dissociation's Many Meanings

- A hypoaroused, foggy & unresponsive state
- An alteration in personality state with switching from one personality or ego state to another Or many personality states
- Feeling detached/estranged from oneself, observing from outside the body or feeling as if one is not real
- Feeling external world as strange/unreal/distant
- Time speeding up/slowing down
- Life feels like its happening in a film/to someone else
- Having no sense of connection to the awful trauma the person is describing
- No memory about the event
- Loss of skills, time, speech, etc
- It is on a continuum & it can refer to two different things - an experience OR how the mind is structured

The Why: Trauma Model: In Essence Dissociation Is Protection

- Dissociative responses are not a sign the brain is malfunctioning. Instead they show the brain's remarkable ability to protect us from overwhelming pain and how it adapts to overwhelming trauma, allowing someone to endure experiences that might otherwise be unendurable

And;

- It is a set of survival mechanisms that develop often in response to chronic childhood trauma, helping us organize these experiences. It allows the brain to disconnect from distressing events moving them outside of conscious memory
- Q: So, what might be the difference between compartmentalising and dissociating?

Why' of Dissociation Cont'd "Mental flight when physical flight is not possible" Kluft

The adaptive brilliance: ***"A mind resorts to self-fragmentation when the experience of how things are cannot be endured... From that perspective, it is a miraculous dynamic allowing vulnerable creatures to survive the unendurable." (Gabor Mate, 2022)***

The mechanism: ***"Its purpose is to take memory or emotion that is directly associated with a trauma and to encapsulate, or separate it, from the conscious self" (Haddock, 2001)***

The Ongoing Protection: ***"Dissociation as a way to defend against feeling overwhelmed by the original trauma and ongoing traumatic triggers in the environment" (Putnam et al, 1993)***

The Physicality of How: Shutdown

When the nervous system perceives extreme threat or helplessness, and neither fight nor flight seems possible:

emotions, body sensations, thoughts, identity, or external reality (and combination of some/all) can be involved/affected. Occurs after a conscious or unconscious trigger

Dissociation – The Change From Adaptive Strategy To Maladaptivity - When Protection Becomes a Problem

- It becomes a default response rather than an emergency response
- It limits the development of other coping strategies
- It cuts off feelings, creates memory gaps, and disconnects us from our body and identity
- There's no integration, which means no processing - fragments remain stuck in trauma time
- Shame, helplessness, and hopelessness take hold
- And because it happens involuntarily, it's frightening and confusing.

The Continuum of Dissociation & Its Many Faces

Dissociation appears to exist on a continuum with the DSM including on that continuum:

These are adaptive strategies to deal with threat.

Dissociative Amnesia & Fugue; Not Just Losing Time

Dissociative Amnesia

- Loss of memory, gaps for past, present & everyday life;
- Loss of time
- Inability to remember personal information including traumatic events/environments – minutes to decades
- Amnesia for present as well as past – loss of awareness of identity and personal history
- In rare, severe cases of generalized D.A. it may include difficulties with previously mastered skills (language, cooking, driving, etc.) - this is less common & not all theorists agree

Dissociative Fugue

- Travel/wandering with no memory – finding themselves somewhere & not knowing how they got there
- May meet someone & talk with them, but later have no memory of the encounter/conversation. This can also happen in therapy - client doesn't remember what happened in session.

What does it feel like?

"I know I went to secondary school - I can tell you the name, picture the building - but when people ask about friends, teachers, what I studied, there's nothing. It's like those years are behind frosted glass. I know they happened because other people tell me they did, but I have no access to them. People will say 'remember when we...' and I'll have absolutely no idea. Then they'll mention something else from the same period and I remember it perfectly. My memory has holes punched through it - some things crystal clear, others completely gone. The worst part is not knowing what I'm missing. I'll be in a conversation and suddenly realize everyone's talking about something I should remember but don't. So I've learned to nod along, to piece things together from context. I'm constantly playing catch-up with my own life. Sometimes I'll see a photograph of myself at 14 and I don't recognize that person. I know it's me, but I don't remember being her."

Things to notice:

The "Swiss cheese" effect; the social navigation required; the exhausting effort to mask the gaps; the disconnect between knowing something happened and having no felt sense of it; the reliance on external evidence; the distress because of this gap

De-Personalisation Lived Experience

"I don't feel real. All the time—literally all the time—I feel like I'm living life from behind a glass screen, or that I'm watching life as it's happening on TV but it's not real. I'm always ten yards removed from it. I don't cry. I don't feel things. I feel like I'm in a dream. I feel like I'm going mad. Even now, talking to you, I'm not sure if this is really happening or not or if I'm just imagining it." **C. Spring, Dissociation.**

De-Personalisation Experiences – What it Feels Like

"Its Like I'm On Auto Pilot"
"I Feel Like I'm Watching Myself From Outside"
"I Know I'm here but I don't feel like me"
"Its like I'm in my body, but I'm not connected to it"

"My body has disappeared"
"I can't see"
"I can't hear"
"I am dead inside"
"I have no self"
"I am made of fog"

"During the abuse, I learned to float up to the ceiling. I could watch what was happening to the little girl on the bed, but it wasn't happening to me. Except now, twenty years later, I'm still up on the ceiling. I'm still watching my life happen to someone else"

Think of it like this: imagine watching yourself on CCTV – you can see yourself moving through your day, but you're viewing the footage, not living the experience

In The Therapy Room You Might Notice:

- Client seems distant, spaced out, not fully there/somewhere else;
- Long pauses, difficulty tracking the conversation;
- It might seem like they person is observing the session rather than being in it
- They may describe terribly traumatic experiences almost dispassionately

- Listen for language like:
  - I saw myself..."
  - "It was like I was watching..."
  - "I could see my body but..."
  - "I knew it was me but it didn't feel like me“
- For some people depersonalisation doesn't stay occasional it becomes persistent & significantly impacts daily functioning & sense of reality. If this is the case a diagnosis of Depersonalisation Disorder is likely to be given
- Impact on us in the room: the person feels disconnected from themselves so we may experience ourself feeling disconnected too (somatic counter transference)

De-realisation

- Estrangement from our surroundings. The world around us feels unreal, unfamiliar, or strange - even people we know well can feel like strangers
- A feeling of detachment and sense of fogginess or dream-like quality.
- World can feel like there is no colour and/or lifeless
- People's voices can feel very far away even when they are close or visually other people may feel far away even when they are close
- Time can feel slower or faster and the world may seem unreal (lockdown)
- There are perceptual differences e.g. feeling like the walls are coming in or ceiling coming down
- We may only realise that connection with present has been lost when we 'come back'

How De-realisation May Show In the Therapy Room

- Client may say something like:
  "Everything felt far away" or "It was like I was in a dream" or "Nothing felt real" or "It was like watching a movie" or "Everything looked flat/grey/lifeless"

- In a session watch for a client who suddenly looks around the room with confusion or unfamiliarity even though they've been there many times. They might say "This room feels strange" or "You sound far away"

- Clients might describe looking at familiar places or people and feeling nothing - no recognition, no connection, even though they logically know who/where they are.

Dissociative Identity Disorder

"A kind of parallel owning and disowning of experience. While one part of you owns an experience, another part of you does not. Thus, people with dissociative disorders do not feel integrated and instead feel fragmented because they have memories, thoughts, feelings, behaviours and so forth that they experience as uncharacteristic and foreign, as though these do not belong to themselves.

(Boon et al, 2011)

DISSOCIATIVE IDENTITY DISORDER (DID) DSM CRITERIA

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

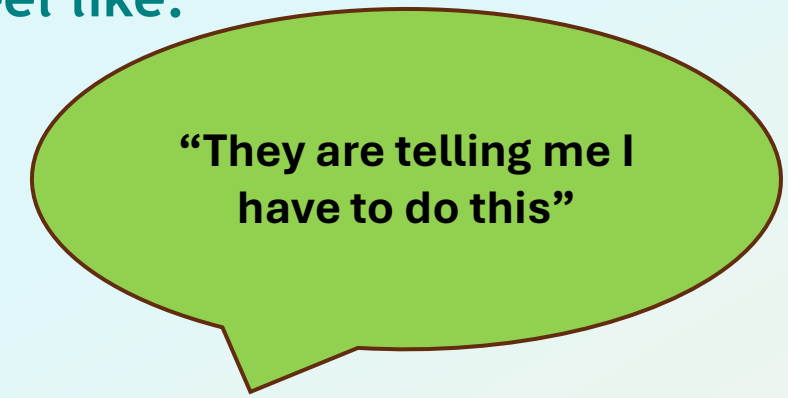
D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

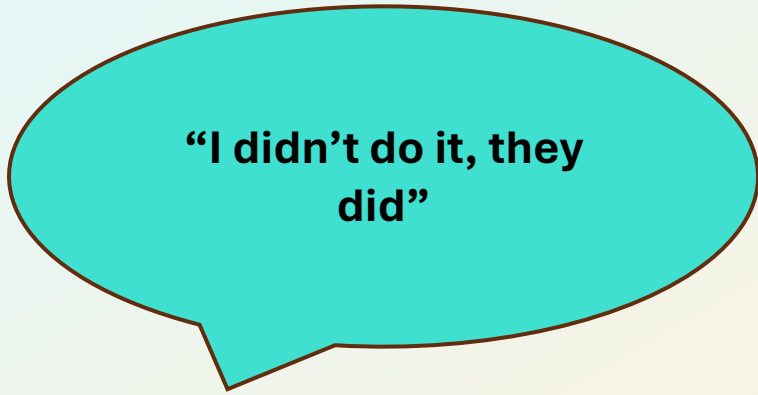
E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition. (e.g., complex partial seizures)

DID – What It Can Look and Feel Like

- Alteration & disruption to their sense of identity. The person feels as though there are different people inside them, often of different ages. There's an inner struggle about who the person is - a fundamental confusion about identity and self

- Lived Experience of this can feel like:





Notice the language - "we," "they," "them." This isn't metaphorical. This is how it feels from the inside

Things the person themselves might notice as evidence of these different parts

- Someone finding themselves in unfamiliar clothes they don't remember putting on
- Things moved around in their home with no memory of moving them
- Skills coming & going e.g. 1 part can read, write, drive, use a computer; another part can’t

DID – What It Can Look and Feel Like Cont'd…

Amnesia: The amnesia in DID goes far beyond everyday forgetting. People have described it like this:

"I just wake up somewhere"

"I find myself coming to but I don't remember where I am or where I have been"

"I find myself in the middle of a conversation I don't remember starting"

- The person might lose hours, days, or longer periods
- They might have no memory of traumatic events, or no memory of what happened in therapy last week, or yesterday, or ten minutes ago
- They may have gaps in their memory for childhood events or important information about themselves

Loss of Control - Can be very distressing as the person can feel they are losing control to "someone else" inside them:

"I find myself sobbing and twirling my hair but can't explain why"

"I buy things I don't remember, I draw things I don't remember, I hurt myself & don't' remember."

How DID May Show Up In The Therapy Room

- References to "we," "us," or "they" when talking about themselves
- References to different names - "Sarah doesn't like when you ask that" or "Little One is scared”
- “I wasn’t here last week” - when you know they were
- Shifts in voice - possibly pitch, tone, accent, vocabulary suddenly different
- Posture changes such as sitting or moving differently
- Age regression - adult client suddenly speaking or behaving like a young child
- Affect shifts - calm one moment, terrified the next, with no apparent trigger
- Different parts having different relationships with you - one might trust you while another is hostile towards you
- Amnesia in the room e.g. a client not remembering telling you something, seeming blank or confused about something they said only moments before or when you reflect their words back
- The person telling you they have no memory of buying something, or conversing with someone until someone says they were, losing time or e.g. finding tickets for activities they have no memory of doing.

DID & Voice Hearing: Different to Schizophrenia

- This needs sensitivity - often clients are afraid they will be told they have schizophrenia. So framing voice hearing as common in people with early life trauma is essential
- The following may help in the differentiation between schizophrenia & DID:
  - People with DID may hear voices as children and continue to hear them into adulthood;
  - They are likely to experience more than 1 voice,usually 3 and importantly -
  - Voices can be adult and child voices - they cover the range of ages of the parts of the person and can be heard over the lifespan whereas:
  - Those with schizophrenia almost exclusively hear adult-age voices (Dorahy et al, 2009);

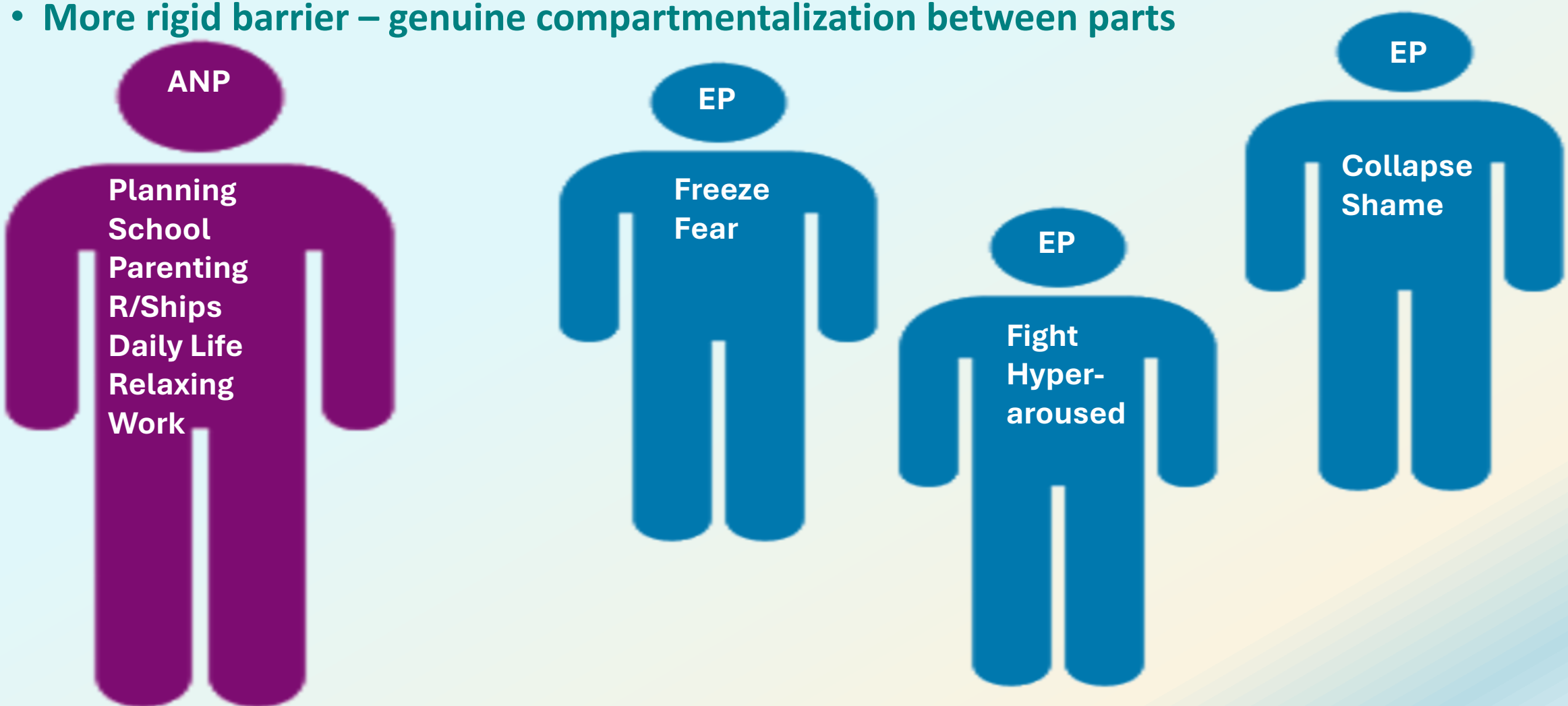
Primary Structural Dissociation – One ANP, One EP

- Seen in PTSD following single-incident or time-limited trauma
- The ANP functions in daily life; the EP holds the traumatic experience
- Less rigid barrier – the parts are not sealed off from each other

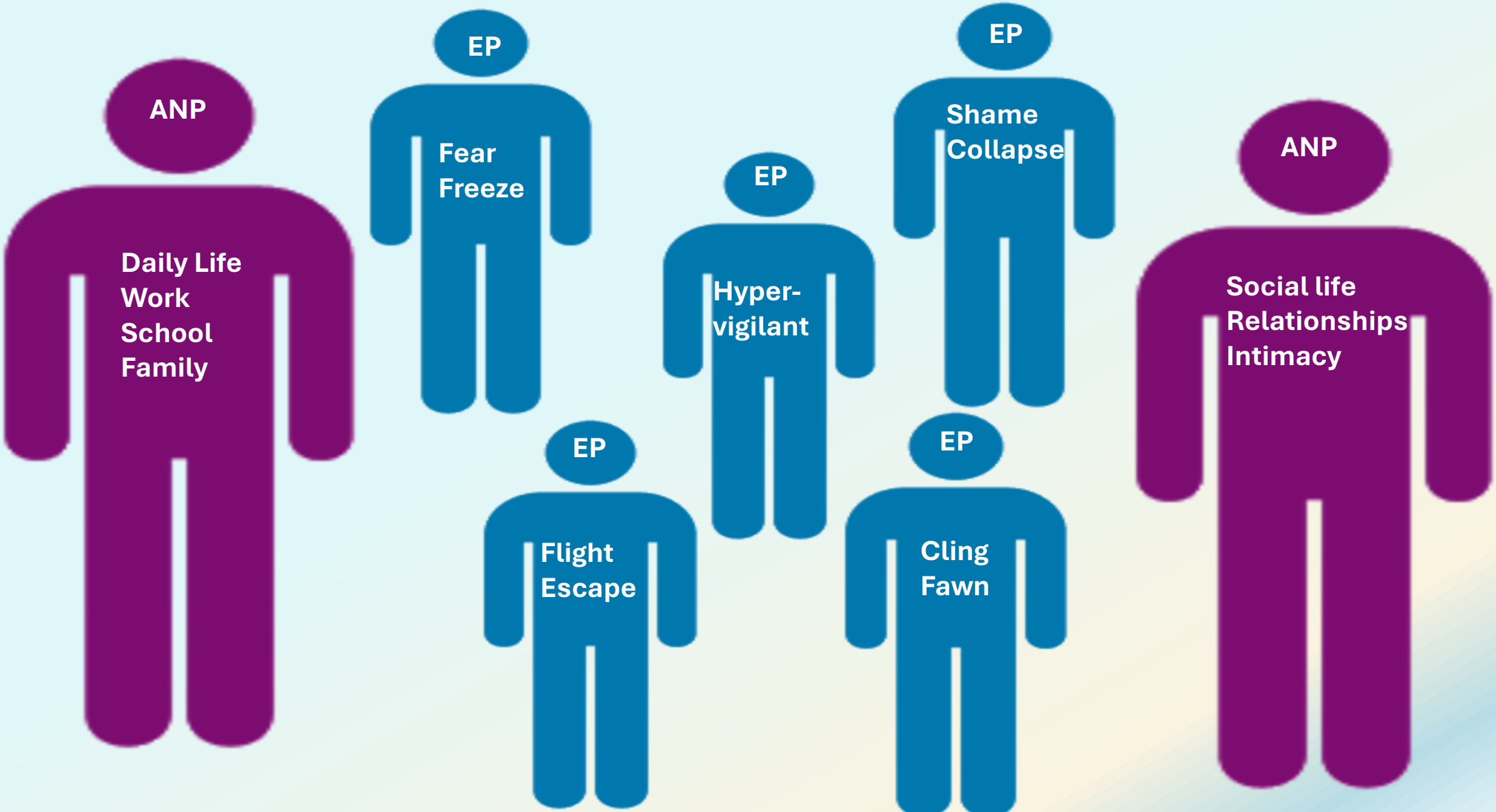
Remember – both are dissociative

Secondary Structural Dissociation – One ANP, Multiple EPs

- Seen in Complex PTSD and chronic childhood trauma
- EP has split into several parts and each hold different trauma fragments (terror, shame, rage, frozen response)
- More rigid barrier – genuine compartmentalization between parts



Tertiary Structural Dissociation – Multiple ANPs, Multiple EPs



Tertiary Structural Dissociation – Multiple ANPs, Multiple EPs

- Seen in Complex PTSD and chronic childhood trauma
- Seen in DID – most severe and complex presentation
- Multiple ANPs, each functioning in specific domains (work, parenting, social)
- Multiple EPs holding different trauma material
- Most rigid barriers – complete amnesia between parts
- These different parts may have a felt sense of individuals/personalities, a mix of child parts and adult parts each with their own story and narrative

Adaptive Survival – Not Pathology

“Creating internal 'parts' or states that can handle different aspects of their trauma is hugely creative on the brain's part because it allows us to live our lives without the 'knowledge' of what has happened. When someone has endured continuous complex trauma which meant they were living in a state of constant threat, their personality often has to change to survive it. So yes, it can be thought of as a personality disorder but I think it is much more that it was an adaptive survival response."

Janina Fisher, Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation

But…

Part IV: Working With Dissociation

- Fisher, Steele, Van der Hart: acknowledge separateness of parts and resolve the almost-phobic reaction to what has been split off so it is no longer active.
- Jamie Marsh: Focus on importance of multiplicity
- IFS (Richard Schwartz): Cultivate Self-leadership so parts can trust they no longer need their extreme protective roles and can naturally unburden
- Carolyn Spring: Reduce the sense of threat that preserves the feedback loop that tells the brain the trauma is still ongoing

Part IV: Therapeutic Stance – Working With Dissociation

- Compassion,
- Patience,
- Reality – The paradox we work with in therapy.

Aim in therapy:

Helping the person move towards greater integration of the various parts and realities

We do this through:

Reducing the sense of threat felt by client because while the threat is still felt the dissociation will continue

Lets briefly look at how we recognize when we are meeting dissociated part rather than just a mood or emotional state

Part IV Indicators You Are Working With A Part:

- Shifts in voice, posture, age or energy
- Client might say: “That wasn’t me”/“I don’t know why I said/did that”
- Client might refer to themselves in third person or as “we”
- You might notice contradictory beliefs/feelings/conflicts held simultaneously, “part of me wants X but another part wants something else”
- Gaps in awareness or memory – e.g. “I don’t remember saying that”
- There may be abrupt emotional shifts that don’t match the conversation or abrupt changes in the narrative
- Clients may shift between self states – e.g. hostile aggression followed by what feels like strong compliance or submission
- **And once we recognize we are encountering a part its helpful to notice whether its an ANP or an EP as our approach may need to adapt. When you're with an ANP vs an EP, here's what to look for**

Part IV - ANP Vs EP – What To Look For

When you are with an ANP you will typically see someone who is:

- Organised, functioning, present-focused
- They may avoid trauma content (“I don’t want to go there”)
- Or they may minimise the impact
- They are likely to be disconnected from emotions or body sensations
- You will see what looks like an adult presentation, capable

When you are with an EP you will typically see someone who is:

- Dysregulated, stuck in past, survival-focused
- Flooded with trauma content or defensive responses
- Highly emotional or shutdown
- Often younger presentation, overwhelmed.

An ‘SD mapping’ slide is in your ‘Additional’ Resources section of this presentation

Part IV How Dissociative Parts Show Up In Therapy

Fisher reminds us: "Parts often show up not as 'parts of me' but as:

- **Overwhelming emotions such as anxiety, despair, fear, shame and self-loathing, rage, hopelessness, helplessness**
- **Expectation of danger which shows as hypervigilance, mistrust, fear, terror, expecting things to go wrong**
- **Body sensations such as numbing, dizziness, feeling sick, sinking, tightness in areas of the body**
- **Movements and Impulses – restlessness, posture, violence against the body, compulsive sex, drugs, rock 'n' roll"**

Janina Fisher 'working with the neurobiological legacy of trauma'

Part IV: Therapeutic Stance – Working With Dissociation

We need:

1. Compassion & Patience
2. AND we also need not to collude with the client's dissociation.
3. We need to be warm, attuned, and compassionate AND we need to help clients move toward the pain, not away from it.
4. We need careful attunement – rather than rescuing

Part IV: Therapeutic Stance – How?!

1. Developing safety through relationship – using our social engagement system.
2. The language we use – gentle, calm, warm.
3. Noticing, mirroring.
4. Staying with process not content
5. Naming and paying attention to how the parts are showing up in the therapy with us (and be curious about their protective function!)
6. Working towards greater integration of the various parts and realities – not separation - talk to the parts as parts not as separate personalities or people

Additional Resources and Slides For Participants

Ways of Working In Session – Integration Not Separation of Parts

- Russian Dolls – different sized dolls represent different parts of the self, let each part have a voice & story, focus on what does the part think, feel, need, how does it show up, have different sized dolls talk & communicate with each other.
- Use creative ways to work with parts, art, sandtray, etc;
- Use a dissociation inventory, log the dissociative experience (e.g. fugue, derealisation, depersonalisation, etc) alongside the trigger, body sensation & thoughts associated;
- Dual Awareness
- Build a toolbox of things that help reduce the dissociation;
- Ground before a client leaves – find out how they want to do it – don't impose your way;
- Keep sensory load to a minimum – soft lighting, reduce noise, proximity, temperature
- Ground yourself before, during and after a session with a client who presents with dissociation
- Therapist Resource Pack previously sent

Factors That Increase Risk of Developing Dissociation

- Severity of abuse experienced
- Degree of coercion and pain
- Younger the child at onset of abuse
- The longer the abuse goes on for
- Abuse by an attachment figure
- Presence of alternative realities – night time abuse vs daytime 'normality'
- Social isolation during abuse - no one to process it with so it remains dissociated
- Society's taboo on speaking about the abuse
- Reality-distorting statements from the abuser such as "that didn't happen, you were dreaming"

C Sanderson 'Counselling Survivors of Trauma'

- Chronic, inescapable stress occurring within the context of prolonged, repeated traumatic experiences (childhood abuse, neglect)
- Exposure to childhood abuse/neglect
- Younger age of onset of abuse
- Longer duration of abuse
- Parental abuse

Ruth Lanius et al, 2018

'Having a disorganised attachment' pattern. This comes from being cared for in infanthood by a caregiver who is persistently 'frightened' or 'frightening' *Main & Hesse, 1996.*

People with DID are frequently misdiagnosed before receiving an accurate diagnosis

- Common misdiagnoses include: Major Depressive Disorder, Bi-Polar Disorder, EUPD, Antisocial PD, Somatic Sympton Disorder, Substance- Misuse Disorder
- On average, people with DID spend approximately 7 years in the mental health system before receiving an accurate diagnosis and receive an average of 3 other diagnoses first (Putnam et al, 1986). It seems that poor clinical education around dissociative disorders remains a significant contributing factor
- Misdiagnosis is common for several well evidenced reasons: overlapping symptoms with depression, anxiety, and psychotic disorders; internal voices being mistaken for hallucinations; shame leading people to conceal dissociative symptoms; and limited clinician training in dissociative disorders. Research shows only 60% of clinicians accurately identified DID from a clinical vignette (Brand et al, 2016)

Parts Might Present As (SD Mapping):

Emotional Parts – Fight Parts - Defence:

Angry child, Fighter parts, Hostile parts, Persecutor parts: holding rage, protective aggression, attacking responses

Emotional Parts – Flight Parts - Defence

Anxious parts, Avoidant parts, Panicked parts: Focused on escape, safety-seeking, running from threat

Emotional Parts: Freeze Parts – Defence:

Scared/fearful child, Shut down parts, Numb parts: Dissociated states stuck in immobility, disconnection, "playing dead"

Emotional Parts: Submit/Collapse Parts Defence:

Shameful child, Depressed parts, Internal critic, Self-harming parts, Hopeless parts "If I collapse/criticize/hurt myself first, they won't"

Emotional Parts: Attach/Cry For Help Parts - Defence:

Hurt child, Vulnerable child, Neglected/abandoned child, Lonely parts, Young parts seeking care/seeking safety, connection, protection

Apparently Normal Parts: Daily Life Parts:

Wise nurturer, Helper, Caretaker, Competent professional, Social/relational parts, Managing functioning, work, parenting, relationships.