LESSONS LEARNED FROM WORKING WITH SECONDARY AND TERTIARY LEVEL OF DISSOCIATION

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SHARING EXAMPLES TO BUILD CONFIDENCE, ENCOURAGE, NORMALISE, AND INVITE CREATIVITY AND CURIOSITY WHEN WORKING WITH DISSOCIATIVE CLIENTS

NOT SPEAKING AS AN EXPERT

THANK YOU – TO OUR CLIENTS

HOW PROFESSIONALS REACT TO HIGH LEVELS OF DISSOCIATIVE SYMPTOMS

- BARRIER TO EFFECTIVE TREATMENT
- INTERFERE WITH SENSE OF OWN BODY
- UNPREDICTABLE EGO STATE SHIFTS
- CONTINUITY OF SELF
- ABILITY TO EXPERIENCE EMOTIONS AND EMOTIONAL REGULATION
- ……
-

WHAT I WILL TRY TO HIGHLIGHT

- A LITTLE BIT ABOUT THE DISSOCIATION (SPECTRUM AND SYMPTOMS WITH EMPHASIS ON DID)
- WHAT IS THE MODEL OF STRUCTURAL DISSOCIATION
- EXAMPLES TO ILLUSTRATE SYMPTOMS AND CHALLENGES
- WORKING WITH DID
- LEAVE SOME TIME FOR QUESTIONS, SHARING YOUR EXPERIENCES

INTRODUCING MR P

Fragments from Mr P statement:

"I HAD A **MENTAL BREAKDOWN IN JANUARY 2018, WHEN I WAS 52.** UP UNTIL THEN AND FOR AS FAR BACK AS I COULD REMEMBER: • I HAD NO ACCESS TO ANY MEMORIES BELOW 15,.., **NONE OF WHICH I UNDERSTOOD.**"

I KNEW I COULD IF I WISHED REMEMBER SOME BITS FROM 15 TO 25 YEARS OF AGE, I RARELY ALLOWED ANY SUCH THOUGHT TO REMAIN IN MY CONSCIOUS, AS I WAS TOO AFRAID OF THE OVERWHELMING TORTUOUS FEELINGS THAT WOULD RAPIDLY EMERGE

FROM MY BIRTH IN 1965 UNTIL I WAS 25. THE ABUSER WAS MY FATHER (WHO I REFER TO AS O). THROUGHOUT MY CHILDHOOD ALL OF MY FAMILY WERE HIS VICTIMS: MY MOTHER AND MY OLDER SIBLINGS, SISTER AND BROTHER.

...

WE'RE NOW AWARE THAT HE SUBSEQUENTLY SEXUALLY ABUSED AT LEAST 15 OTHER CHILDREN, THOUGH WE BELIEVE THAT THERE ARE MANY MORE CHILDREN WHO HE ABUSED ACROSS SIX DECADES.

MY SISTER COMMITTED SUICIDE WHEN SHE WAS 26

UNTIL MY MID TEENS WHEN MEMORIES BECOME INDIVIDUAL EVENTS OF A SEPARATE BEING WITHIN ME AND THEN BELOW 8 YEARS OLD I CEASE ACCESS TO ANY MEMORIES OR SENSE OF ME OTHER THAN A VERY .

ALTHOUGH I LIVED MY ADULT LIFE NOT BEING ABLE TO SEE THROUGH MY RIGHT EYE, IT WAS ONLY 2020 THAT MY VISION STARTED TO RETURN IN PARALLEL WITH MEMORIES STARTING TO BECOME ACCESSIBLE. THIS LED TO ME DISCOVERING THAT WHEN I WAS 8, O HAD BLINDED ME IN MY RIGHT EYE BY A YEAR'S SENSORY DEPRIVATION

In only recently learning about the concept of dissociation' – I **struggle to make sense of things or express my thoughts in words**.

I have been able to work out the age I was for each, why those memories would indicate there being unkind behaviours of O, and why the feelings are strange (because a child thinks differently).

FOR SOME REASON, FROM A YOUNG AGE I STARTED TO KEEP ARCHIVES . MAYBE THIS HELPED ME TO SACRIFICE ACCESS TO MEMORIES EACH DAY, SO WAS A TOOL TO AID DISSOCIATION GOING FORWARD IN 2025, PERHAPS MY ARCHIVES CAN NOW PROVIDE ME WITH A TOOL TO AID REASSOCIATION

I believe that O's cruel programming led me to sacrifice thought of my wishes, unable to stand up to what was unfair, and I replaced this with learning how to think and act according to what would please him – maybe this was integral to early dissociation from Birth Me's independent person identity, which is why 60 years later I still feel devoid of who I am

It feels to me that dissociation isn't clear cut between one period and another.

DISSOCIATION AND NEUROLOGY

- IT IS A BASIC HARDWIRED NEUROBIOLOGICAL MECHANISM THAT OCCURS IN ANIMALS AND HUMANS
- People show different experiential, psychophysiological, and neurobiological responses to trauma (Paulsen, S.L., Lanius, U.F.)
- hypothesis: two subtypes - one predominantly characterized by hyperarousal, and the other primarily dissociative responses
- Peritraumatic dissociation (narrowed focus – sensory input in conjunction with lowering of consciousness – decreased capacity to integrate the information (structural dissociation other positive and negative dissociative symptoms like hypermnesia, flashbacks, somatization, amnesia, alexithymia, numbing, paresthesia etc)
- The severity of the response likely to be caused by alteration in brain functioning (receptor and synaptic level) influenced by a history of prior trauma and attachment history (evolutionary – predators= increased availability of a passive defense response – freezing, diminished perception of pain, survival advantages and reduces suffering)

STRUCTURAL DISSOCIATION - OVERVIEW

The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization" by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele (2006).

Requires the existence of dissociated compartments in the psyche, which contain ego states, modules, identity states, parts of self, alters, dissociated parts – some possible terms

Dissociated material is held in a second compartment

BASK MODEL

Bennett Braun (1988) BASK model of dissociation encompasses both psychoform dissociation and somatoform dissociation (tracking symptoms and planning intervention) – no requirement for EP to be present

Any element of psychological function can be dissociated and stored elsewhere than in the executive self (can result in amnesia, conversion motor paralysis, psychic numbing) when the dissociated intrudes back to the execute self this is experienced as involuntary ego-dystonic behaviours, values, and ideas that aren't aligned with the ideal self (flashbacks, obsessions, compulsions, affective instability, sudden anger, other symptoms),
(Ross, 2017)

DISOCIATIVE DISORDERS (DSM V)

PTSD and dissociative disorders (dissociated from dissociative disorders)

Dissociative amnesia (fugue)

De-personalisation

De-realisation

DDNOS dissociative disorder not otherwise specified – dissociative disorder not elsewhere classified (DDNEC)

DID DIAGNOSTIC CRITERIA DSM V

- 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 IN IDENTITY INVOLVES MARKED DISCONTINUITY IN SENSE OF SELF AND SENSE OF AGENCY, ACCOMPANIED BY RELATED ALTERATIONS IN AFFECT, BEHAVIOUR, 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 OTHER MEDICAL CONDITION (E.G., COMPLEX PARTIAL SEIZURES) (AMERICAN PSYCHIATRIC ASSOCIATION, 2022).

- ALTERS MAY EACH HAVE THEIR OWN PERCEPTION OF THEMSELF, OR THEY MAY DEMONSTRATE SHARP DISCONTINUITIES THAT GO BEYOND WHAT WOULD BE EXPECTED FROM NORMAL STATE SHIFTING IN AN INTEGRATED INDIVIDUAL.

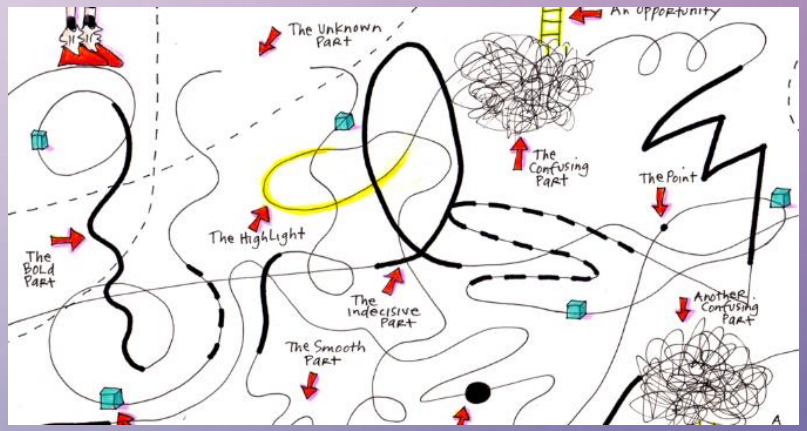
- ALTERS CAN HAVE DIFFERENT DEGREES OF EMOTIONAL EXPRESSIVENESS, BEHAVE IN DIFFERENT WAYS, EXPERIENCE CONSCIOUSNESS IN DIFFERENT WAYS, HAVE DIFFERENT MEMORIES, PERCEIVE THEMSELVES AND THE WORLD AROUND THEM IN DIFFERENT WAYS,

- A SMALL NUMBER OF ALTERS EVEN IDENTIFY OR PRESENT AS ANIMALS OR MYTHICAL FIGURES, PARTICULARLY IN CULTURAL CONTEXTS IN WHICH ALTERS MAY BE INTERPRETED AS SPIRITS OR OTHER EXTERNAL ENTITIES.

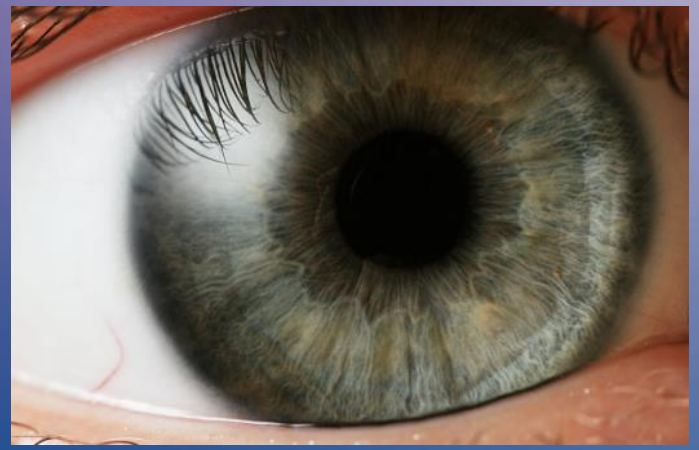
- ATTEMPTS TO CONCEAL SYMPTOMS ARE TYPICAL.

WHAT IS SUGGESTED WHEN WORKING WITH THIS LEVEL OF FRAGMENTATION – BASED ON EXAMPLES

- SAFETY WITH THERAPIST
- UNDERSTANDING OF DISSOCIATION AND TRAUMA RELATED DISORDERS
- SKILLS FOR COPING WITH DISSOCIATION – PHOBIA OF INNER EXPERIENCES (LIKE ADDICTIONS) COMPASSION, GRATITUDE, MINDFULNESS, ANY OTHER APPROACHES (WINDOW OF TOLERANCE – AFFECT TOLERANCE AND REGULATION), ANCHORING (SOMATIC, BODY ORIENTED THERAPY, EGO STATES, IFS, EMDR, CT CBT, OTHER THERAPIES)
- LEARNING TO REFLECT
- WORKING WITH DISSOCIATIVE PARTS
- DEVELOPING INNER SENSE OF SAFETY
- IMPROVING DAILY LIFE
- COPING WITH TRIGGERS AND MEMORIES
- EMOTIONS
- RELATIONHSP WITH OTHERS



Using narrative or any other form of storytelling
(picture Malcolm Murphy)
curiosity,
compassion, re parenting (childs me and selves),
alters – the dog, walksies)
Don’t smile (change),



- MEMORIES FROM MY FIRST 8 YEARS REMAIN INACCESSIBLE, THOUGH I DO HAVE SOME SENSE OF A ‘PRESENCE’ OF THAT AGE, THAT I HAVE A RESPONSIBILITY FOR A CHILD THAT I CANNOT YET SEE, WHO’S JUST WATCHING, LISTENING.

• ACCESSIBLE MEMORIES FROM 9-25 GROW FREQUENTLY, AT TIMES DAILY, BUT A SENSE OF A CONTINUUM OF EXISTENCE BACK THROUGH THAT PERIOD REMAINS ABSENT, DISSOCIATED.

WHAT WAS HELPFUL (FOR MR P)

- CLEAR AND SIMPLE WORDING IN INVITATIONS, WITH CLEAR MAP

- SUPERB – HIGHLY ADAPTIVE WITHIN A SESSION – WHEN THE EXPERT INCORPORATES 'REAL TIME' IN HOW THEY EXPRESS THEMSELVES TO ME, BASED UPON WHAT I MIGHT HAVE JUST SAID

- SUPERB – ASKING ME WHAT I THINK ABOUT SOMETHING, IN WORDS THAT ARE NONJUDGEMENTAL, SIMPLE AND DO NOT CREATE AN EXPECTATION FOR ME TO HAVE TO ANSWER.
- SUPERB – WHEN YOU SEE ME AGAIN, INTRODUCE YOURSELF AS MY FACIAL RECOGNITION CHALLENGES ARE EXACERBATED IN ANXIOUS WAITING ROOM.
- FRIENDLY FACE AND TONE, BUT EXPRESSIONS THAT ARE EASY TO MAINTAIN – I HAVE HYPERSENSITIVITY TO NEGATIVE DISAPPROVING ETC FACIAL PARTS, DISTORTED SO I CAN EASILY MISINTERPRET YOUR FACE IF IT'S OPEN BALANCED THAT DOESN'T MEAN THAT'LL BE WHAT I SEE OF YOU.

- **PRESCRIBED MEDICATION SAVES LIVES. ALTHOUGH I HAD ALWAYS BEEN OPPOSED TO TAKING MEDICATION, PERSISTENCE WITH EXPLANATION HAS HELPED ME.**

- SUPERB – SAY SORRY IF YOU GET SOMETHING WRONG ; I DON'T KNOW WHY, BUT IT ENABLES THE TRIGGERED DISSOCIATED CHILD PART OF ME TO HEAR AN APOLOGY FOR INADVERTENTLY CAUSING THEM TO FEEL PAIN

- YOU'LL GET THINGS WRONG, AND SIMPLY SAYING SORRY WILL MEAN SO MUCH.

FOR PROFFESSIONALS

- PLEASE REMEMBER THAT I NEED YOUR HELP, OTHERWISE I WOULDN'T BE HERE. (MR P)

I have already benefitted greatly from the interventions of mental health experts, but **I know that I have a long journey ahead and how I perceive myself now is a snapshot which will evolve.** I have a myriad of thoughts, memories and feelings that I have not yet made sense of

DIAGNOSTIC TESTS AND INTERVIEWS SCREENING TOOLS

- THE **DISSOCIATIVE EXPERIENCES SCALE AND SDQ-20 CANNOT** GIVE A DEFINITE DIAGNOSIS FOR DISSOCIATIVE IDENTITY DISORDER (SCREENING WHO DOES NOT MEET CRITERIA OR THE NEED FOR A CLINICAL INTERVIEW LIKE THE DISSOCIATIVE DISORDERS INTERVIEW SCHEDULE OR STRUCTURED CLINICAL INTERVIEW FOR DISSOCIATIVE DISORDERS -FOR A DEFINITIVE DIAGNOSIS FOR DISSOCIATIVE IDENTITY DISORDER OR ANOTHER DISSOCIATIVE DISORDER (OR RULE THEM OUT).
- THE DISSOCIATIVE EXPERIENCES SCALE (DES) IS A SELF-ASSESSMENT SCREENING TOOL (A QUESTIONNAIRE) THAT IS USEFUL FOR IDENTIFYING PEOPLE WHO EXPERIENCE A HIGH DEGREE OF DISSOCIATION.
- A DEFINITE DIAGNOSIS SHOULD ONLY BE MADE BY A QUALIFIED CLINICIAN.
- THE TWO CLINICAL INTERVIEWS DEVELOPED FOR DISSOCIATIVE DISORDERS, **THE SCID-D OR DDIS,**
- THE SOMATOFORM DISSOCIATION QUESTIONNAIRE (**SDQ-20**) IS ANOTHER SELF-ASSESSMENT SCREENING TOOL (DISSOCIATIVE IDENTITY DISORDER AND OTHER DISSOCIATIVE DISORDERS - MEASURES PHYSICAL SYMPTOMS HISTORICALLY FOUND TO BE COMMON IN PEOPLE WITH DISSOCIATIVE DISORDERS (INCLUDE SENSORY DISTURBANCES, E.G., TUNNEL VISION, PSYCHOGENIC BLINDNESS, AUDITORY DISTANCING, NUMBNESS/INSENSITIVITY TO PAIN), OTHER CONVERSION DISORDER SYMPTOMS(E.G., PSYCHOGENIC PARALYSIS AND NON-EPILEPTIC SEIZURES), GENITAL SYMPTOMS (DIFFICULTY URINATING, GENITAL PAIN THAT DOES NOT OCCUR DURING INTERCOURSE), ETC

- DISSOCIATIVE DISORDERS INTERVIEW SCHEDULE (DDIS), DEVELOPED BY DR COLIN A. ROSS ET AL. THIS USES SOME OBSERVATION FROM A CLINICIAN, AND IS A STRUCTURED INTERVIEW. NO SPECIAL TRAINING IS NEEDED TO CARRY THIS OUT, AND IT CAN BE DOWNLOADED WITHOUT CHARGE FROM THE ROSS INSTITUTE. THE DDIS HAS BEEN UPDATED FOR THE DSM-5.
- STRUCTURED CLINICAL INTERVIEW FOR DISSOCIATIVE DISORDERS (SCID-D) IS REGARDED AS THE GOLD-STANDARD INTERVIEW FOR DIAGNOSING DISSOCIATIVE IDENTITY DISORDER, OTHER SPECIFIED DISSOCIATIVE DISORDER AND ALL OTHER DISSOCIATIVE DISORDERS.
- IT CAN DISTINGUISH BETWEEN ALL DISSOCIATIVE DISORDERS AND DISSOCIATIVE OR IDENTITY SYMPTOMS PRESENT IN BORDERLINE PERSONALITY DISORDER, SCHIZOPHRENIA, PTSD, MAJOR DEPRESSION, AND ACUTE STRESS DISORDER. EACH DOMAIN OF DISSOCIATIVE SYMPTOMS IS ASSESSED

KEY FACTS

- DISSOCIATIVE IDENTITY DISORDER WAS PREVIOUSLY CALLED MULTIPLE PERSONALITY DISORDER (MPD), BUT HAS ALWAYS BEEN CLASSIFIED AS A DISSOCIATIVE DISORDER; NOT A PERSONALITY DISORDER
- ONLY AROUND 6% OF PEOPLE WITH DID MAKE THEIR DIAGNOSIS OBVIOUS ON AN ONGOING BASIS (R. P. KLUFT, 2009).
- DISSOCIATIVE DISORDERS SHOW A PREVALENCE OF 1% TO 5% IN THE INTERNATIONAL POPULATION. SEVERE DISSOCIATIVE IDENTITY DISORDER IS PRESENT IN 1% TO 1.5% OF THIS POPULATION
- DISSOCIATIVE IDENTITY DISORDER IS NOT RARE
- MOST PEOPLE WITH DID HAVE A MIX OF DISSOCIATIVE AND POSTTRAUMATIC SYMPTOMS, AS WELL AS NON-TRAUMA RELATED SYMPTOMS (E.G., AMNESIA FOR SIGNIFICANT EVENTS IN THE PAST OR FOR EVENTS IN EVERYDAY LIFE - AMNESIA IS NOT LIMITED TO TRAUMATIC OR STRESSFUL EVENTS)
- PATIENTS MAY SPEND UP TO 5 TO 12.5 YEARS IN TREATMENT BEFORE BEING DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER.
- PATIENTS WITH DID COME WITH INCREASED RATES OF NON-SUICIDAL SELF-INJURIOUS BEHAVIOUR AND SUICIDE ATTEMPTS