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Working Therapeutically with Dissociation

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Aims of presentation

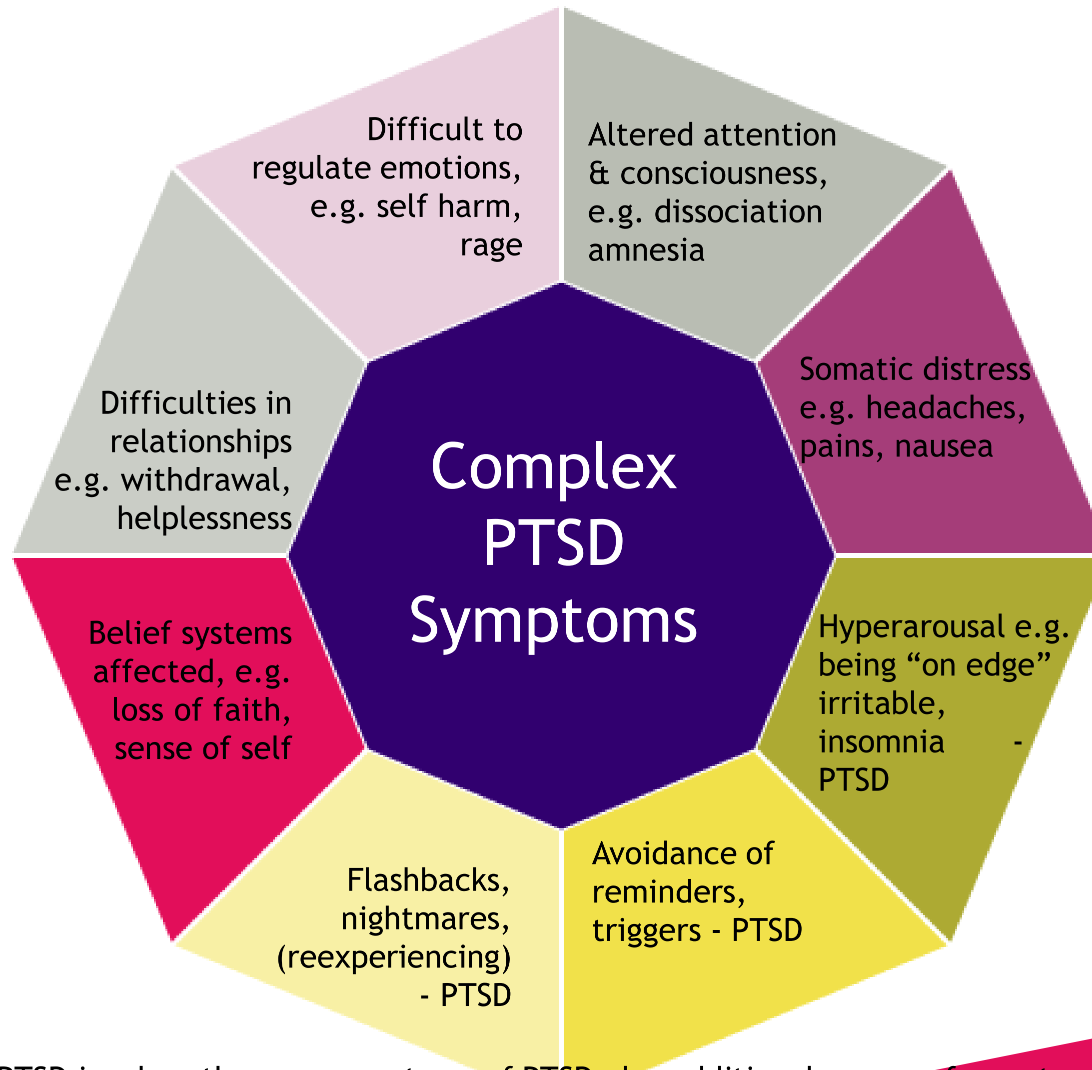
- To offer a brief overview of dissociation and the various disorders (according to DSM-5)
- To consider common features and manifestations of dissociation
- To explore the effects of this in the therapy room
- To share some research on a variety of interventions – including my own (unpublished)

What do we understand by the term "Dissociation"?

"A disruption in the normally occurring linkages between subjective awareness, feelings, thoughts, behaviour and memories, consciously or unconsciously invoked to reduce psychological distress."

Briere & Scott (2006)

What is Complex PTSD?



Complex PTSD involves the core symptoms of PTSD plus additional groups of symptoms
Source: ISTSS Expert Consensus Treatment Guidelines For Complex PTSD in Adults

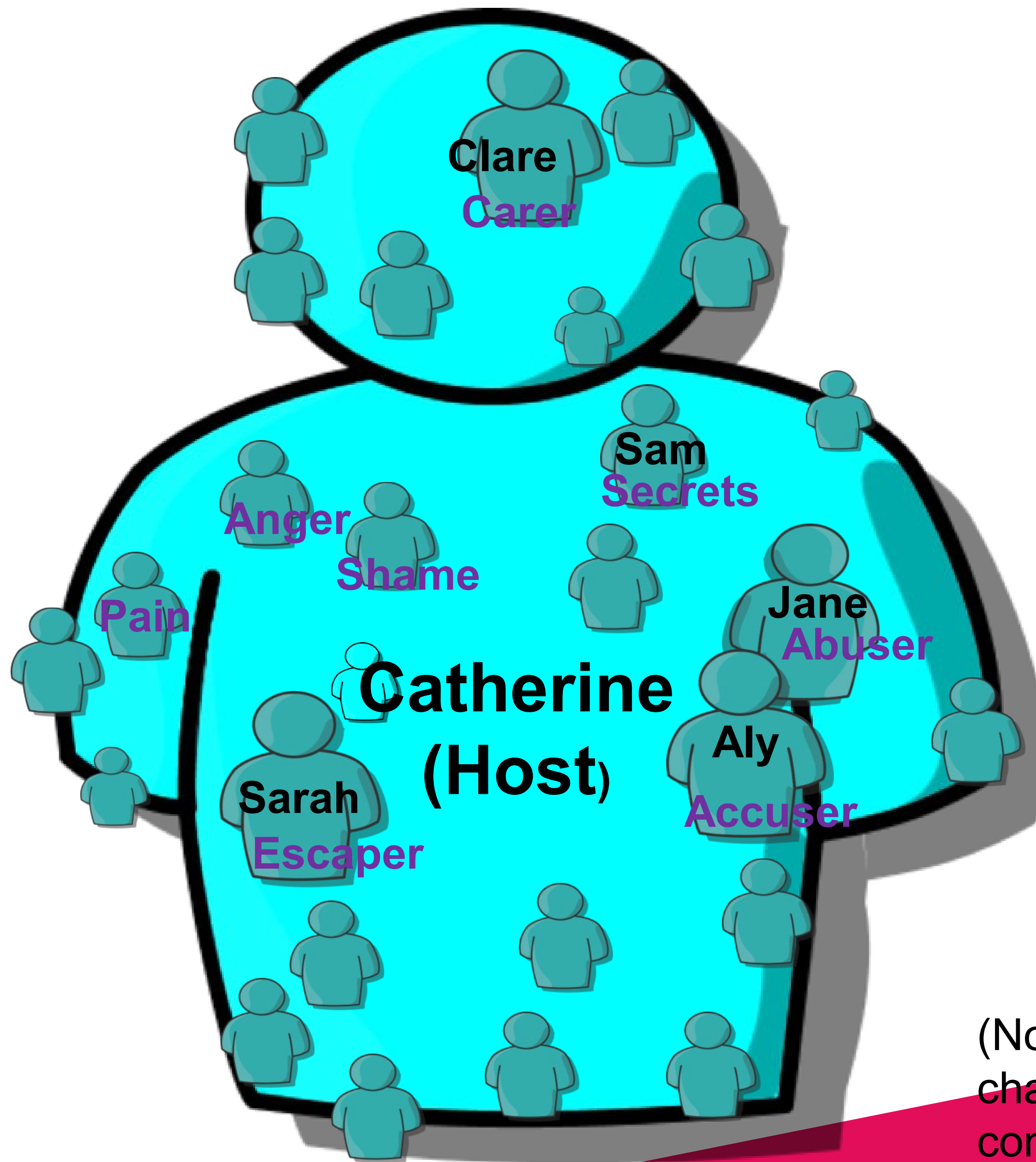
The freeze response to trauma

David Livingstone's reflection – as quoted by Peter Levine (1997)

https://www.youtube.com/watch?v=UpGwt_baExk

The range of dissociation

- Primary - in the face of overwhelming trauma or threat. An inability to integrate the experience - the recall remains fragmented
- Secondary - leaving the body - psychic anaesthetising and withdrawal
- Tertiary - distinct ego states contain the traumatic experience - fragmentation. Can lead to Dissociation Identity Disorder



(Note names change to protect confidentiality)

Dissociative Identity Disorder (DID)

2 or more distinct identities/personalities/alters/parts
Aspects may include:
A host (main identity)
Personality changes
Changed Perceptions or beliefs and ways of relating to the world
Identities may be conflictual
Other adults/children/animals/cartoon characters/ages/genders
Voice changes
A lack of control of those identities
Reports of amnesia when one identity takes control

Derealisation

The world is unreal, foggy or lifeless
Changing objects: shape, size, colour
Unable to connect fully with others

Depersonalisation

Disconnect with body or emotions - detached from self

Floating feeling

Unsure of boundaries of self & others

Out of body experience watching self observing feelings

Dissociative Amnesia

Memory gaps

Difficulty with recall of past events

Dissociative Fugue

Travelling to a different location and unable to remember identity

Possible helpful aspects of Dissociation

- Involuntary response – a biological mediation
- Survival Strategy
- Can assist with sharpening focus in short term
- Prevents feeling overwhelmed
- Anaesthetizes physical & psychological pain
- Allows a degree of functioning to continue with every day life

Possible unhelpful aspects of Dissociation

- A developed and retained pattern - the default setting for any perceived stress
- Addictive or Obsessive
- Isolating, traumatic loneliness
- Estranged within relationships
- Emotionally disregulated
- Reduces attention span & impedes learning and memory
- Not being present
- Limits development
- Risks for personal & other's safety

YouTube
Mind.og.uk/dissociation

https://www.youtube.com/watch?v=UvhtDZ7G6jI&list=PLw8TLvRgeKJ4U0IbynSzUKojAIeL-EcZ2

Clinical Implications

Discuss in pairs: The professional and personal challenges for the therapist?

Clinical Implications

- Confusion
- Miscommunication and misinterpretation
- Not present - unable to process
- Defensive reactions, mistrust, criticism, projection and fear of therapist - projection
- A risk of additional trauma
- Could create barriers & rupture the therapeutic relationship
- Counter-transference

Assessments

- **Dissociative Events Scale (DES)**
  - EB Carlson &FW Putnam
- **Somatoform Dissociation Questionnaires**
  - (SDQ5 & 20) Nijenhuis 1996
- **Clinical Administration PTSD Scale (CAPS)**
  - Impact of Events Scale (Revised) DS Weiss

Window of Tolerance

Hyperarousal Zone

2. Sympathetic "Fight or Flight" Response

Increased sensations, flooded
Emotional reactivity, hypervigilant
Intrusive imagery, Flashbacks
Disorganised cognitive processing

Window of Tolerance
Optimal Arousal Zone

1. Ventral Vagal "Social Engagement" Response

State where emotions can be tolerated and information integrated

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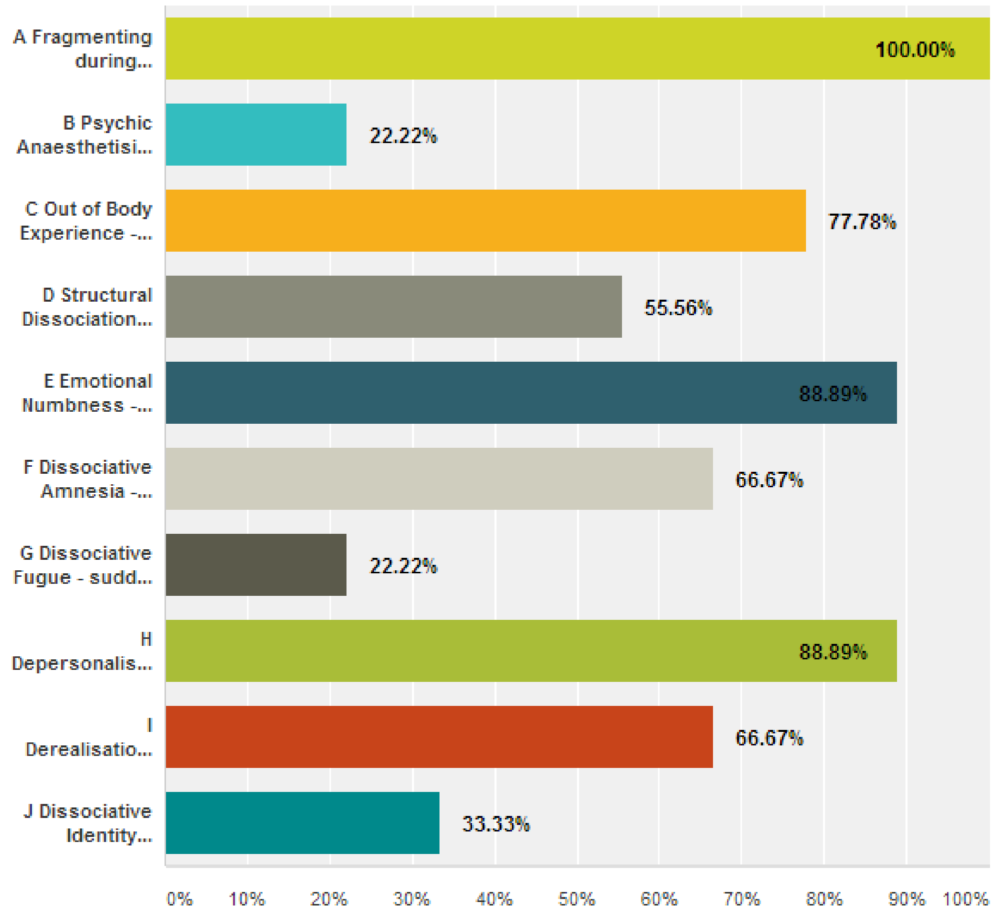
Hypoarousal Zone

3. Dorsal Vagal "Immobilisation" Response

Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

Adapted from Ogden, Minton & Pain, 2006, p.27,32; Corrigan, Fisher and Nutt, 2010, p 2



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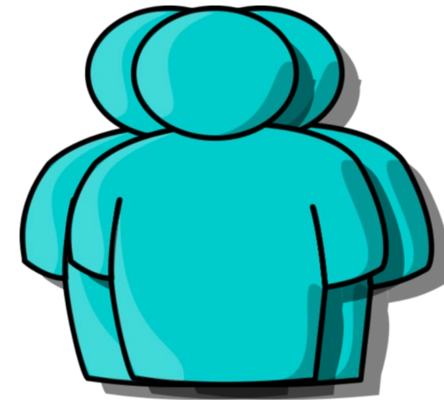
Effective Interventions



- Safety and Stabilisation
- Psycho-education of neuroscience
- Recognising the client's triggers which improve a sense of control and interpersonal functioning – enabling pro-active problem solving (CS)
- Grounding techniques, mindfulness, breathing, awareness, body sensations
- Integration taking ownership, visualisation of inner world (CS)
- Communication encouraged between identities and orientation when switching between identities (CS)
- Naming somatic counter-transference (CS)

- Babette Rothschild suggests working with interoceptors , and exteroceptors
- Dual Awareness such as 'Even though I am feeling …/having a flashback right now, it is in the past and I'm in the here and now.'

Christianne Sanderson's exercises

- Physical activity - moving vigorously to resist immobilising and increase heart rate
- Visual stimulation – avoid trance-like state by scanning surroundings and identifying colours, sounds, smells, objects
- Mental Stimulation – focussing exercises such as counting backwards or counting trees, cars, trucks etc
- Physical Stimulation to address physical numbness – body awareness i.e. where in the body is it numb and where is there feeling. Touch feeling area and say "I am touching…" They could use a brush, something soft, they wrap themselves in a blanket or rub themselves against a surface. If the client is frozen, suggest slight movement, i.e. just fingers or toes or touch end of nose.
- Emotional Stimulation to address emotional numbness. Plotting any emotion on scale 1-10. Trying to get them to hold on to a slight feeling and then increase the amount of time they hold that feeling.
- Temperature changes – if cold, encourage something warming, i.e. blanket or warm soothing drink and vice versa

	Briere & Scott	Babette Rothschild	Christianne Sanderson	Peter Levine	Targeted group	Workshop group
Assessment	√	√	√	√	√	√
Grounding	√	√	√	√	√	√
Emotional Regulation	√	√	√	√	√	√
Focus (Immediacy)	√	√	√	√	√	√
Refocus (Immediacy)	√	√	√	√	√	
Breathing Techniques	√	√	√	√	√	
Relaxation Techniques	√	√	√	√	√	√
Visualisation	√	√	√	√	√	√
Orientation	√	√	√	√	√	
Body Sensations		√	√	√	√	√
Body Movement			√		√	√
Internal sensations	√	√	√	√	√	√
External Sensations	√	√	√	√	√	√
Recognising Triggers	√	√	√	√	√	√
Psychoeducation	√	√	√	√	√	
Awareness	√	√	√	√	√	√
Acknowledgement & Acceptance		√	√			
Diary Keeping			√		√	
Blocking negative thoughts					√	
Creative techniques			√		√	√
Energy Psychology					√	√
Medication	√		√			

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Cautionary notes

- Babette raises some caution of recounting all the specifics of traumatic events as it may worsen the client's condition and not necessarily relieve symptoms vs. Davies and Frawley consider it a necessity
- Briere and Scott warned off touch and shouting and the clinician's need to ground the client, responding to their own discomfort – which could lead to client panic.
- Rothschild and a group respondent suggest touch as a way of re-focussing.
- The targeted group:

  warned against forced cognitive call back
  not rushing the client through a 'process'
  allowing the therapeutic relationship enough time to be 'grounded' in itself
  to recognise that the dissociation can be keeping the client 'safe'
  own threatened reaction to a violent alter entering the therapy room

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