International Society for the Study of Trauma and Dissociation

Dissociation 101

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Content warning

Care for *yourself*

- Connect to your environment
- Grounding - use any area of your body that feels safe/resourceful

I would like to acknowledge ISSTD Dr. Mary Anne Kate's contribution to this presentation

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Structure of the webinar

Four 90 minute blocks:

1. Aetiology
2. Diagnosis
3. Models of dissociation
4. Treatment

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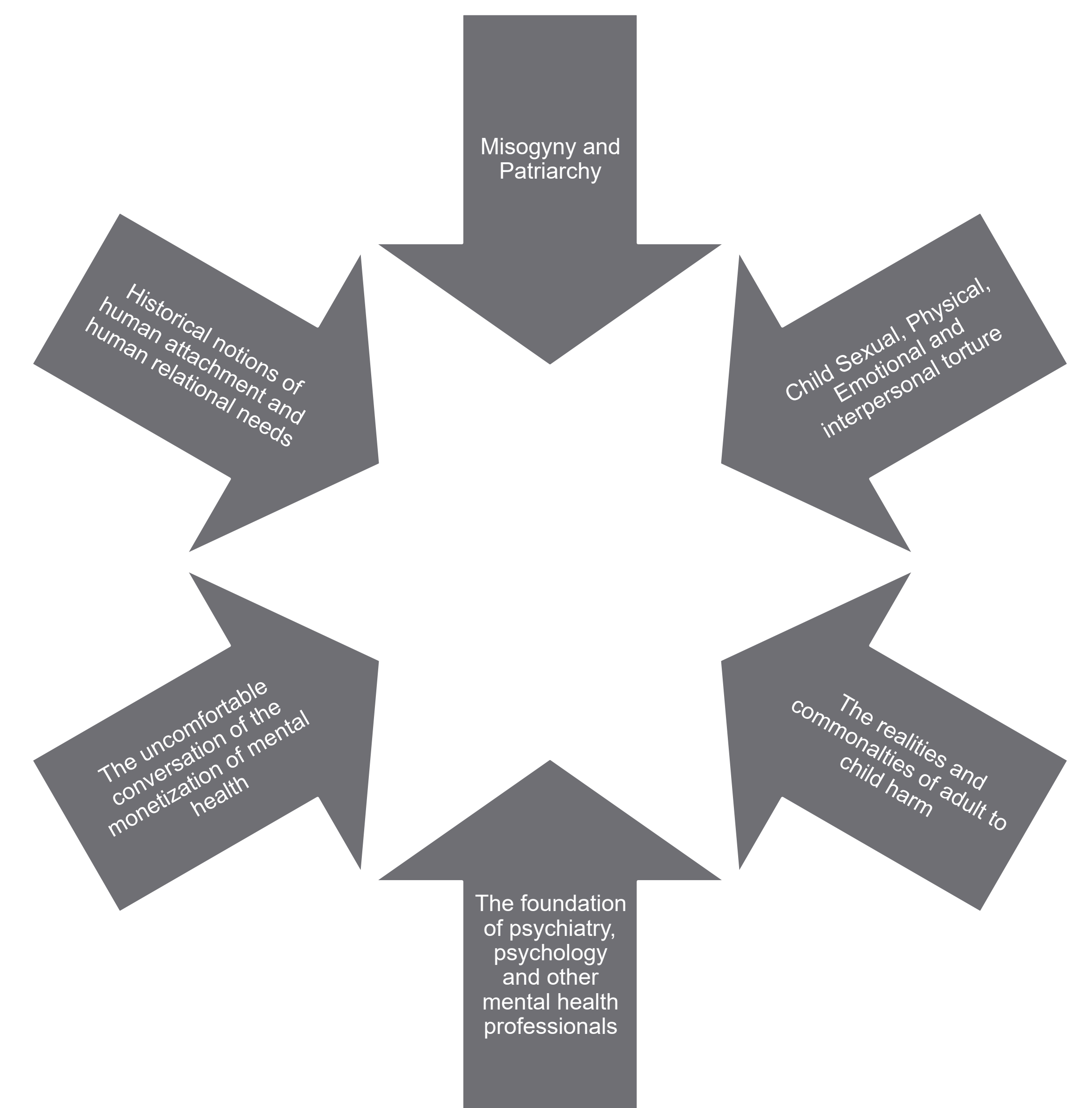
Swimming up Stream

- Respect
- Dignity
- Collaboration
- Perhaps some of our forefathers got some things wrong
- But they did get a lot correct
- The field of dissociation is one of the few areas of human studies that has tried to prove the theory wrong. The scientific method is our friend

There is no way to talk about dissociation without discussing many uncomfortable issues



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What is dissociation?

- **Dissociation** is when a person experiences a disconnection from their memories, feelings, actions, thoughts, body and/or identity
- **Dissociative Disorders** are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour. Dissociative symptoms can potentially disrupt every area of psychological functioning

(DSM-5-TR)

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Dissociative Disorders in the DSM-5

Depersonalization / Derealization Disorder

Dissociative amnesia

Dissociative Identity Disorder

Other Specified Dissociative Disorder

Five key dissociative symptoms

1. **Amnesia or memory problems** involving difficulty recalling personal information

2. **Depersonalization** or a sense of detachment of disconnection from one's self. A common feeling associated with depersonalization is feeling like a stranger to one's self.

3. **Derealization** or a sense of disconnection from familiar people or one's surroundings

4. **Identity confusion** or inner struggle about one's sense of self and identity

5. **Identity alteration** or a sense of acting like a different person

The Structured Clinical Interview for DSM-IV Dissociative Disorders (Steinberg, 1994)

- Some individuals may have one or several of the symptoms of dissociation.

- A person with Dissociative Identity Disorder has all of these symptoms

(Steinberg & Schnall, 2001)

Understanding dissociation

Dissociation is the inability to have awareness or knowledge, either total or partial of sensations, feelings, thoughts, perceptions, memories, impulses, a solid sense of self or a known sense of self. People who chronically dissociate can have trouble feeling their body and body sensations and they may have trouble moving, they may have trouble feeling and interpreting their emotions. They may have trouble feeling real in the world or the world feels unreal. They may not have a united or whole sense of self, They may have bits and pieces of a self that are not cohesive.

(Frewen & Launus, 2015; Lanius, Paulsen & Corrigan, 2014; Reinders, et. al., 2003)

Dissociation is an escape from the full sensorium of experiences during a stressful or traumatic event. To follow this logic, the more stress, the more dissociation might occur.

(Stone, 2006)

Aetiology

What causes dissociation?

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Causes of dissociation

Historical perspective

- Possession
- Hysteria

Current debates

- Trauma
- Fantasy

What causes dissociation?

Across cultural contexts, risk factors for dissociative pathology include earlier onset of trauma; neglect and sexual, physical, and emotional abuse by parents; cumulative early life trauma and adversities; and repeated sustained trauma or torture associated with captivity (e.g., experienced by prisoners of war, victims of trafficking)(Choi et al. 2017; Loewenstein 2018; Stein et al. 2013).

DSM-5-TR

The characteristics of childhood trauma most likely to lead to dissociation

- **Sexual abuse** is the abuse type most associated with a DD in clinical settings.

- In college populations sexual abuse is predictive of a DD, but not dissociation. However, dissociation is significantly linked to **more types** of sexual abuse; abuse by **a parent or relative; frequent and prolonged** abuse; abuse that is accompanied by **betrayal**, or **threats** or **force**; and parental punishment that is **beyond harsh**, unpredictable, or resulted in injury.

  (Aydin, Altindag, Ozkan, 2009; DePrince & Freyd, 2004; Gillen, 1995; Kate, 2018; Martínez-Taboas & Bernal, 2000; Nilsen, 2000; Ross et al., 1989; Sandberg & Lynn, 1991)

- In addition to the number of episodes and types of sexual abuse, Kate (2021) found clinical levels of dissociation were predicted by **experiences that are potentially life threatening to a child**, such as choking, smothering and physical injury that breaks bones or teeth, or that compromise the child's survival needs such as threats of abandonment and deprivation of basic needs.

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Gaslighting: jet fuel for dissociation

Gaslighting is a form of emotional abuse where the perpetrator makes the victim question their sanity, perception of reality, and memories. The result is that the victim becomes confused, anxious, and unable to trust themselves. Gaslighting appears to be an active ingredient in dissociation as it is specifically designed to deny the objective lived experience while creating the perpetrator's desired narrative and reinforcing their position of power.

I doubt myself so much because my mother always said to me, "It's not real. It didn't happen. Something is wrong with you." She always said that to me when things happened. So, I learned to really doubt my own experience. - Naomi

The age at which trauma occurs

Recurrent trauma at younger ages negatively affects:

- the neurobiological system as a whole, including epigenetic expression
- every aspect of the body, mind, emotional and imaginative systems

This leads to mental, physical, emotional, and spiritual symptoms, including personality development and self concept

(Brach, 2003; 2006; Milutinovic, Zhuang, Niveleau, & Szyf, 2003; van der Hart et al., 2006; Perry, 2001; 1999; Perry & Pollard, 1998; van der Kolk, 2003; 2005; 2006; Vermetten & Bremner, 2002).

If the trauma occurs before the age of 5 a child without a unified sense of self maintained across various behavioural and/or psychobiological states

(Chu, 2005; van der Hart et al., 2006).

When traumatic experiences occur during crucial emotional and personality developmental and behavioural stages, the results can be dramatic — the child's "self" is altered

(Ross, 1997)

Disorganized attachment

Dissociation also occurs when the child perceives their potentially protective caregiver as threatening or frightening and the child is faced with a conflict between two incompatible behaviours: seeking and avoiding proximity to the attachment figure.

This relationship between a disorganized attachment style and dissociation is confirmed by longitudinal studies following infants into adulthood (Main & Hesse, 1990; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997).

Disorganised attachment is not always precipitated by overt abuse and may occur when the parent fails to respond adequately to the infant's attachment bids and leaves the child without adequate parental regulation of fearful affect (Lyons-Ruth, 2003).

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Adult attachment style and dissociation

Coe, Dalenberg, Aransky and Reto (1995) correctly classified 89% of students with a fearful adult attachment style based on their dissociation profile.

Kate (2018) found:

- a fearful attachment was the predominant attachment style of dissociative students, and in-patients and out-patients with a DD.
- the clinical group were the only dissociative group that endorsed an attachment style characterised by profound mistrust. However, fearful attachment was the clinical group's predominant attachment style which indicates their desire for emotionally close relationships overrides extreme reservations about the trustworthiness of others and fear of being hurt. This would appear to mirror disorganized attachment in infancy.
- the odds ratio for clinical dissociation was 72 : 1 for an insecure attachment style

Betrayal, attachment and dissociation

- Freyd (1996) developed the theory of ‘betrayal trauma’ to describe the logic of ‘forgetting’ abuse perpetrated by someone whom the child is dependent upon in order to preserve the attachment bond
- In this model, memory of the abuse may be repressed or ‘dissociated from consciousness’.
- The memory does not need to be about a fear-inducing events, but one that threatens the attachment bond necessary for survival.

Freyd (1996) Betrayal Trauma

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Family dynamics and dissociation

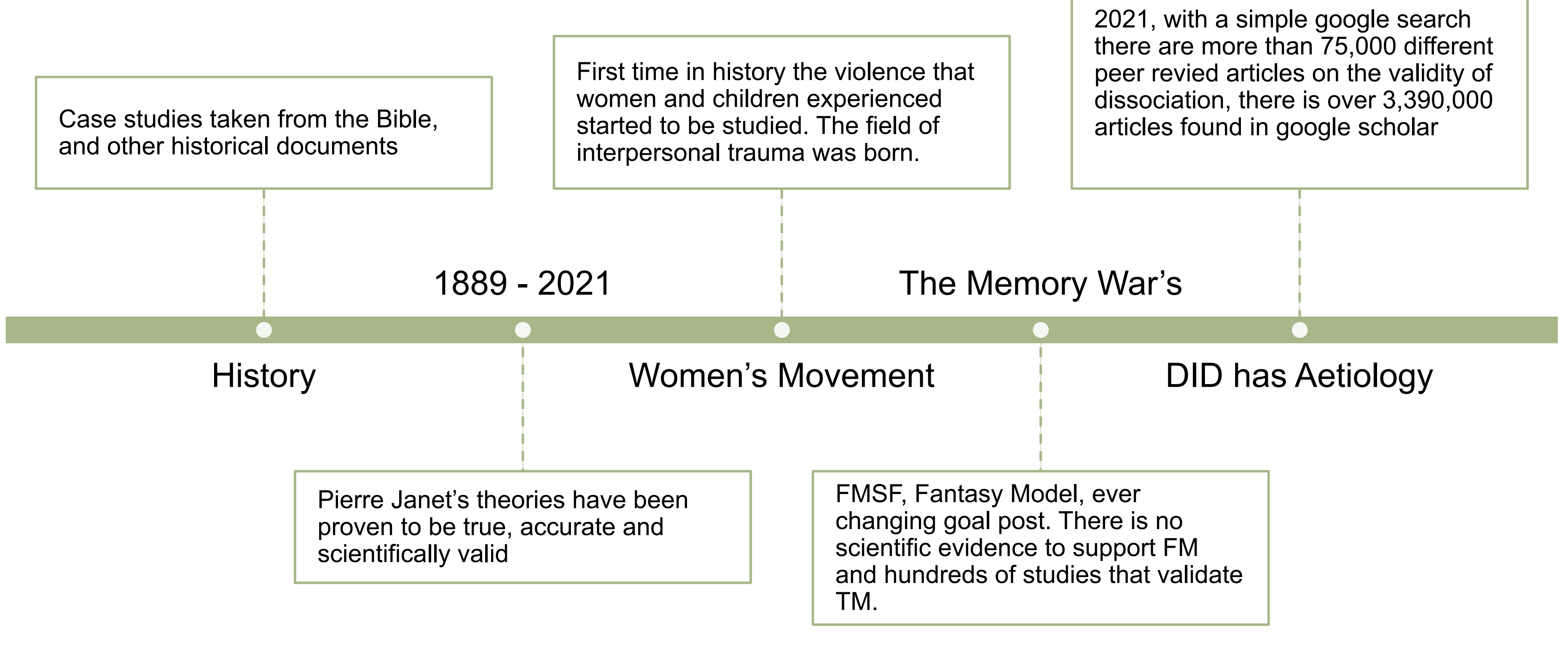
Irwin (1996) found childhood abuse was a far better predictor of dissociation when the perceived **availability of emotional support in childhood** was taken into consideration.

Dissociation occurs in a **negative family environment** (Gipple et al. 2006; Kate, 2018, Sanders & Becker-Lausen, 1995) in which:

- there is a lack of family cohesiveness, a lack of parental care, a high level of control, an undemocratic and disengaged family environment characterised by conflict and enmeshment, inconsistent parenting; and overprotection (Modestin, Lötscher, & Erni, 2002; Nilsen, 2000; Yoshizumi, 2007; & Yoshizumi et al., 2007).

- the parents or caregivers hampers the child's journey towards independent thought, feeling and action by discouraging critical thinking and encouraging dependency and learned helplessness; and fosters an environment of isolation, powerlessness and secrecy where there is a lack of positive interactions both inside and outside that family that would provide opportunities for growth and enable the child to develop and sustain a sense of self and self-worth (Kate, 2018).

Timeline of Dissociation



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Dissociation in the bible

- Mark 5:1–20 describe a man possessed with unclean spirits who lived in a cemetery, injured himself with stones, and broke all chains used to restrain him. When Jesus asked his name, the man said, "**My name is Legion, for we are many**."
- Jesus transferred the unclean spirits into a herd of swine that ran off a cliff and drowned in the sea. This story has been interpreted as representing a case of dissociative identity disorder, successfully cured with exorcism

- North, C. S. (2015). The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations. Behavioral Science, 5(4), 496-517.

A 1584 French case of DID: Jeanne Fery, a 25-year-old Dominican Nun

- Her alter identities included:
  - Mary Magdalene, who was highly rational and helpful in her treatment, appearing at moments of crisis.
  - Two demons functioning as protectors and also responsible for her acts of sacrilege
  - A demon named "Horns" responsible for her bizarrely disturbed eating.
  - A demon that demands pieces of her flesh, i.e. self mutilation
  - A demon named "Throat“ that protects her from feeling the pain of beatings in childhood, but then re-enacts these during her illness by head-banging, body-banging, and suicide attempts attacking the throat with cutting and self-strangulation.
- Jeanne's alters were at times visualized, at times heard arguing inside, and at times took over her body in violent pseudoseizures, rage attacks requiring restraints compulsive suicide attempts, regression to a childlike state, and episodes of prolonged sobbing and intense physical pain (especially headaches), sleep disturbance, severe depression, conversion blindness, mutism, inexplicably lost and found objects, and episodic loss of knowledge and skills.

A 1623 Italian case of DID: Sister Benedetta

- Benedetta was possessed by three ‘angelic boys’ who would at times beat her causing chronic pain.
- These angels would also take over her body, each speaking a different dialect and producing specific facial expressions and tones of voice.
- Benedetta had amnesia for some acts done by these three, including a sexual relationship they initiated with a young nun in her charge.
- Benedetta performed self-mutilation and had disordered eating.

van der Hart, O., Lierens, R., & Goodwin, J. (1996). Jeanne Fery: a sixteenth-century case of dissociative identity disorder. Journal of Psychohistory, 24(1), 18-35.

Early clinical cases and descriptions of dissociation

- 1791, USA – Mary Reynolds – documented case of MPD
- 1812, USA, the first known use of the term 'dissociation' in a psychiatric text
- 1840, report of Estelle, an early child case by Despine
- 1845 Moreau de Tours was one of the first to use the term dissociation
- The splitting off or isolation of ideas a division of the personality is consistently discussed in France, Vienna, USA and Britain over the last 100 years
- More cases are being rediscovered by historians

(Dell & O'Neil, 2009, Putnam, 1989, van der Hart, Nijenhuis, & Steele, 2006)

Pierre Janet

Janet was a philosopher, psychologist, and psychiatrist and offered the most detailed account of ‘dissociation’, which he expressed as a division of the personality and consciousness.

1889– hypotheses that traumatic memories (idées fixes – fixed ideas)

- may alternate with the habitual personality,
- may intrude upon the habitual personality, especially when triggered by salient reminders of the trauma
- trauma causes fragmentation of the personality
- hyper and hypo arousal are forms of dissociation

Janet is also credited for first clinical description of bulimia nervosa, OCD, and transference theory in therapy

(van der Hart and Dorahy, in Dell and O’Neil, 2009, p. 7)

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Freud, 1896

- Freud's lecture on the aetiology of hysteria to the Psychiatric Society which would "disturb the sleeping world"
- The origin of mental illness (hysteria) lay in early sexual abuse These early experiences were real and had lasting damaging effects on the later lives of children.
- Freud's terms:
  - 'rape', 'abuse', 'attack', 'assault', 'aggression', 'traumas'
  - 'seduction' which implies some form of participation by the child, and this term stuck for his later papers.

(Masson, 1985, p. 3)

Freud's 'seduction theory'

Freud description of seduction was "**an act of cruelty and violence which wounds the child in every aspect of her being**" [Freud makes it clear that usually it is a young girl who is the victim]

- Her body is not ready for the adult act of intercourse (which is often an anal rape with life-threatening consequences),
- nor are the child's emotions prepared either for the immediate impact of the sexual passion of the adult or for the later inevitable feelings of guilt, anxiety and fear.
- The adult is venting his own sexual and emotional unhappiness on a child
- too frightened to protest, too weak to defend herself, and too dependent on the continuing care of the adult for her very survival to seek any form of redress.
- The imbalance in the relationship and the sadistic willingness of the adult to exploit his power over the child"

(Masson, 1985, p.4)

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Freud recants his seduction theory

- Freud's lecture was met with a cold reception and called a "fairy tale".
  - "I am isolated as you could wish me to be: the word has been given out to abandon me, as a void is forming around me." (Freud, letter to Fliess, May 4. 1896)

- And later on: "I was at last obligated to recognize that these scenes of seduction had never taken place, and that they were only fantasies which my patients made up." (Freud)

- By giving up his views Freud was allowed to participate again in the medical society that had earlier ostracized him.

- 1905 – Freud publicly retracted the seduction theory and now claimed that these stories were made up.

- 1908 – respected physicians joined Freud.
  - "The psychoanalytic movement was born but an important truth was left behind." (Masson, 1984, p.10)
  - "There have been several times in our history where the topic of trauma and dissociation have been perused and then abandoned. (Herman, 1992)"

- Freud's model began to take a different direction, repression vs. Dissociation

Historically it is not only dissociation that was overlooked, but the prevalence and impact of trauma

- **Child abuse and domestic violence**. For example, as recently as 1975, a basic American psychiatry textbook estimated that the frequency of all forms of incest as one case per million. WWI and following: Shell Shock

- **Combat**. At the beginning of the First World War psychiatrists and psychologists generally believed battle conditions could trigger 'shellshock' – a physiological change in the central nervous system. The view that the majority of psychiatric casualties are not caused by war service took hold soon after, and continued during World War Two and beyond. A range of issues relating to childhood, family life, physical traits, femininity, homosexuality, cowardice and fundamental personality flaws were believed to predispose military personnel to becoming a psychiatric casualty. If none of these factors explained the person's condition, it was assumed they were fabricating their symptoms to avoid active service.**

* James Henderson, "Incest", in A. M. Freedman, H.I. Kaplan and B.J. Sadock, eds., Comprehensive Textbook of Psychiatry, 2nd ed. 1975 p. 1532.

** Muir, K. (2007). "The predisposition theory, human rights and Australian psychiatric casualties of war." Australian Journal of Human Rights 13(1): 195-218

The woman's movement & the Vietnam war: a turning point

- In the mid-to-late 1960s & 1970s: the feminist movement had a major impact on recognizing child abuse and domestic violence
- The psychological impact of war was recognized.
- Research examined the developmental psychopathology and trauma
- Studies of dissociation proliferated in the 1970s

Dissociation in the DSM

- **DSM I**, which was released in 1952, listed "dissociative reaction" together with "conversion reaction" in a section for "psychoneurotic disorders"
- **DSM II**, which was released in 1968, dissociation was classified as a type of "hysterical neurosis" within a section entitled "Neuroses" that also included a separate diagnosis of "depersonalization neurosis (depersonalization syndrome)".
- **DSM III**, which was released in 1980 included Dissociative Disorders in their own right. It also introduced PTSD and ASD as anxiety disorders

(North, 2015, Van der Hart & Dorahy, 2009).

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The 1990s: a promising beginning

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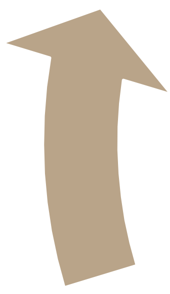
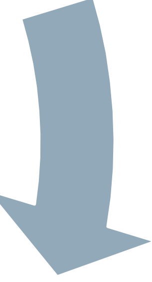

Clinical journals emerged and research articles, theories and discussions about dissociation proliferated

In 1992 Dissociative Disorders are introduced into the World Health Organisation's International Classification of Diseases (ICD-10). In the previous version 'dissociative reaction or state' was listed under Hysteria

DSM-IV, which was released in 1994, no substantial changes made to Dissociative Disorders.

- Although MPD was reamed DID in recognition that the main problem is not a multitude of personalities, but a lack of a single, unified identity and an emphasis on "the identities as centers of information processing". DSM-IV introduced the requirement for "distinct identities or personality states" rather than personalities as while a patient may name and personalise alters, they may lack an independent, objective existence.

In 1992 the ISSTD had a well-attended conference and a large membership.

The 1990s: the memory wars begin

- The False Memory Syndrome Foundation is founded
- Bad therapy, using suggestive techniques, little science, and a belief that memory is veridic
- Focus on MPD/DID than dissociative processes.
- Focus on RA and MC
- Disbanded as of January 1, 2020
- https://www.madinamerica.com/2021/02/false-memory-syndrome/ https://www.thecut.com/article/false-memory-syndrome-controversy.html

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The 1990s: the myth of DID

(1) the disorder is so rare that there is no point in studying or understanding this phenomenon

(2) it is a disorder created by therapists through suggestions of “alter” personalities and/or states, and/or a cultural artefact that ebbs and flows in popularity

(3) it is a self-created disorder that clients use to manipulate and control others and gain attention with being “sick”

(Gelinas, 1995; Haddock, 2001; McHugh, 1995; Putnam, 1989; 1997; Ross, 1997; Steinberg & Schnall, 2001).

The myth of DID continued

1) several iatrogenic cases have been found; therefore all cases are not valid.

2) No treatment has been proven effective, therefore it is not valid.

3) There are fewer cases outside of North America, therefore it is a phenomenon created in North America

4) the numbers of those diagnosed increase and decrease over the years, therefore suggesting that it is a creation of therapists and clients due to "popularity" of the diagnosis

5) it is simply not real because some do not believe in it.

6) the unproven etiology of DID, or the idea that if you cannot prove it, it must not exist

7) DID is an artefact of suggestibility in highly hypnotizable individuals.

Memories - recovered and false

- Recovered memory is a characteristic of dissociative amnesia and other DDs.
- *All* memory is fallible - scientific evidence demonstrates that memories of trauma can be lost and found, continuous memories can be distorted and, under certain conditions, false memories can be created. **Recovered memory and continuous memories are equally accurate and are more likely to be true than false** (Dalenberg, 2006)
- Hundreds of scientific publications spanning well over a century document how the memory of traumatic events, including natural disasters, accidents, war trauma, kidnapping, torture, concentration camps, physical abuse and sexual abuse in childhood, can be lost only to resurface years later (Middleton, Di Marni Cromer, & Freyd, 2005; van der Kolk, 2014).
- **Around 15 percent of people who have experienced any kind of traumatic event report a period of time when they had no memory of it**, with the rate being significantly higher for interpersonal trauma (Elliott, 1997)
- **People are more likely to report forgetting sexual abuse than other types of trauma.** Studies in the general population indicate that between 20 and 32 percent of individuals reporting sexual abuse state there was a time when they could not recall it had occurred(Edwards, Fivush, Anda, Felitti, & Nordenberg, 2001; Elliott, 1997; Scheflin & Brown, 1996; Wilsnack, Wilsnack, Wonderlich, Kristjanson, & VogeltanzHolm, 2002).

Amnesia for traumatic events is uncontroversial in PTSD and Acute Stress Disorder Stress Disorder

Dissociative disorders are subject to a higher level of scrutiny compared to other disorders.

For example, the diagnostic criteria for *PTSD* and *Acute Stress Disorder* in the DSM-5-TR includes:

Inability to remember an important aspect of the traumatic event(s) (**typically due to dissociative amnesia** and not to other factors such as head injury, alcohol, or drugs).

False memory

- Believed-in, plausible memories can be implanted in a laboratory setting Porter, Yuille and Lehman, 1999
- The trait of suggestibility only predicts 3 percent or less of dissociative tendencies, dissociative individuals may be at risk of a false memory if they are directly or indirectly encouraged to imagine and ruminate over a plausible, believed-in event Dalenberg et al., 2012
- Trauma experts agree that **recollections of child abuse experiences may at times mix actual events with fantasy, confabulated details, abusers' rationalisations of the events or condensations of several events** ISSTD, 2011
- As all memory is fallible, it is recommended that clinicians **adopt a respectful neutral stance on memories that are presented**, avoid suggestive and leading techniques and provide ongoing discussion and education about the nature of memory ISSTD, 2011
- False Memory Tasks Do Not Reliably Predict Other False Memories Patihis, Frenda, & Loftis, 2018

Response to the myth that it is impossible to have more than one personality in one body

"DID is not literally real, it is not possible to have more than one personality in the same body. People with DID do not have more than one personality … the reality of the disorder is that it is both real and unreal at the same time … not believing in DID is like not believing in hallucinations … all psychiatrist 'believe in' hallucinations and delusions, grasp the fact that hallucinations and delusions are not real, and understand that they are real psychiatric symptoms."

Ross, 1997, p. 62

The Reality of DID

- Extensive research has established the validity and reliability of this disorder. See: Brand, B.L. Sar., V., Stavropoulos, P., Kruger, c., Korzekwa, M., Tabaos-Martinea, A., & Middleton, W., (2016). Separat ing fact from Fiction about DID *Journal of Harvard Review of Psychiatry,* 24(4), 257-270

- “As with all mental health diagnosis, DID meets the standard of three basic forms of validity, and it can be detected and measured with valid and reliable structured interviews and scales” (Halgin, 2005).

- DID is held up to a standard of validity that other mental disorders, such as schizophrenia and even depression, are not. (Chu, 1989; 2005; Dell, n.d.; Putnam, 1989; Ross, 1997).

- The dorsomedial and dorsolateral prefrontal cortex, bilateral superior frontal regions, (anterior) cingulate, posterior association areas and basal ganglia are identified as neurofunctional biomarkers of pathological dissociation and decreased hippocampal, basal ganglia and thalamic volumes as neurostructural biomarkers. Increased oxytocin and prolactin and decreased tumor necrosis factor alpha (TNF-α) are identified as psychobiological markers. Psychophysiological biomarkers, including blood pressure, heart rate and skin conductance, were inconclusive. For the genetic biomarker category studies related to dissociation were limited and no clear directionality of effect was found to warrant identification of a genetic biomarker. Recommendations for future research pathways and possible clinical applicability are provided. (Reinder, 2021, p.120)

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The current debate

- Dissociative Disorders remain a controversial diagnosis
- There are two competing theories as to the causes of dissociation:
  1. The Trauma Model
  2. The Fantasy Model

The Trauma Model

- **Trauma Model** theorists are of the view that dissociative symptoms arise from physical, sexual and emotional **abuse**, emotional and physical neglect particularly if occurring in childhood, a **disorganized attachment** to the primary caregiver, and other **severe stress or trauma** such as experiencing or witnessing domestic violence.
- DSM-5 is reflective of the Trauma Model.

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The Fantasy Model

Fantasy Model theorists believe that the common cause of symptoms in individuals who meet the criteria for a DD is a process driven by the very belief they have dissociative symptoms. These symptoms, and some (or even all) the memories of trauma that is believed to have led to the dissociation, are due to their **fantasy-proneness, suggestible nature, disrupted sleep, negative emotions, cognitive distortions and compromised reality monitoring**.

Problems with the fantasy model of dissociation

- **Difficult to demonstrate causation as the proposed antecedents are all either related to post-traumatic responses or dissociative symptoms**, noting that even fantasy proneness is a recognized response to harsh and abusive experiences in childhood.

- **Not plausible when one considers the prevalence of DDs**, i.e. the percentage of the population is that is fantasy prone is around 4% (DDs are 10%), and it is implausible that a significant number of this group would be so fantasy prone to enact a disorder they do not have AND be exposed to enough information that could potentially enable them to enact a DD to the extent that it can be diagnosed AND then assimilate that information and believe that they have a DD.

- The **Fantasy Model is prominent in leading psychology textbooks**. The failure to adequately include scientific evidence in support of the Trauma Model in these texts has drawn criticism from the American Psychological Association

Plurality: an intersection between trauma and fantasy?

- Plurality is an umbrella term that anyone with any kind of experience of multiplicity can self-identify with.
- The online community of “Plurals” united through support groups for Dissociative Identity Disorder. These have evolved over the years into a more organized state both linguistically and politically − making Plurality its own culture
- This group often has a very elaborately developed inner world with relationships rich in detail where all parts of the system seem to have knowledge and access, as well as awareness to where they do not have access and why. They are likely to have a high number of “fictive” alters, but included extensive and detailed backstories from movies or video games.
- Often, the development of the inner world and relationships between parts is something that Plurals enjoy and find soothing, which is distinguished from those with dissociative disorders, who are generally phobic of both their internal world and interaction with other parts.
- This description may be their experience of plurality, but does not fit the clinical definition of DID, partial DID, or OSDD1b. It does correspond with what Eli Somer has described as “Maladaptive Daydreaming
- Christensen (2022a; 2022b)

The complexity of plurality

- Differential diagnoses and comorbidities
- Identity
- Sociocultural influences

Plurality

- Dissociative identity disorder
- Maladaptive daydreaming and reality shifting
- Autism
- Complex trauma
- Gender non-conforming
- Dissociation
- Fantasy and absorption
- Hypnotisability

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Plurality

Christensen (2022) found that:

- only 3% of those in the plural community stated their goal for therapy was “integration”, while a majority of 78% reported their goal for therapy was “functional multiplicity” − the new buzz phrase that describes making progress enough in therapy to be able to communicate, cooperate, and collaborate, but without requiring integration as an imposed objective (though it may happen naturally or by choice).
- There is a significant intersectionality of trans and autism populations in this group.
- As to those who identify as Plural but report no trauma history, there are three clinical responses. One is that some of these are not
  - aware yet of their own trauma history, or may otherwise be explained by neonatal or epigenetic factors in way the patient does not yet understand but research is just discovering.
  - the patient may be overlooking the impact of relational trauma,
  - those for whom really have no trauma history, but still identify as Plural, are not “disordered” because they are functioning and not distressed by their expressed identity.

Misdiagnosis Monday: PTSD vs. Autism

Autism

PTSD

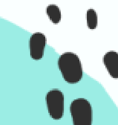
- Presence of traumatic event
- Avoidance behaviors
- Intrusive memories & flashbacks
- Hypervigilance
- Nightmares

PTSD and Autism (overlap)

- Dissociation
- Intimacy Difficulty
- Increased risk of victimization
- Negative beliefs of self and world
- Difficulty managing intense emotions
- Heightened sensitivities to sensory input
- High rates of substance abuse, depression, self-harm, and suicidality
- Hypervigilance/overactive nervous system/heightened startle response
- Impulse control difficulties
- Executive functioning difficulties
- Sleep issues
- Stimming

Autism

- Repetitive behaviors & self-soothes through use of routines
- Difficulty intuitively reading NT social cues
- Sensory sensitivities part of baseline experience
- Special Interests



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MISDIAGNOSIS MONDAY

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Inner worlds

Plurals often have very rich, vivid, and highly detailed inner worlds. Many of these intentionally develop their inner worlds further on apps, video games, or in computer games like “Sims”. Alters may have relationships with each other, including holding cultural or religious ceremonies (externally) to marry each other (internally). Due to the rich inner worlds, alters may have homes, families, jobs, pets, friends, or even babies in the internal world, without any of it being related at all to any specific trauma in their history. Sometimes those families, friends, employers, or babies also become new alters, including non-human alters like pets. From the sharing of these inner worlds externally, the widespread use of fictives has emerged.

Christensen (2022)

Maladaptive daydreaming

- Individuals with maladaptive daydreaming have high levels of dissociation.
- Inversely, individuals with dissociative disorders have high levels of maladaptive daydreaming.
- Maladaptive daydreaming may help us understand cases of dissociative identity disorder with large numbers of ‘personalities’.

(Ross et al, 2020)

Reality shifting

Eli Somer (2021) explains that reality shifting is a trendy mental activity that emerged abruptly following the fare-up of the COVID-19 pandemic in 2020 and seems to be practiced mainly by members of the post-millennial generation. Reality shifting is described as the experience of being able to transcend one's physical confines and visit alternate, mostly fictional, universes. They reportedly employ specifc meditative techniques to facilitate their ostensible "quantum" journeys.

Those practicing reality shifting to escape their current reality may experience high levels of dissociation and a sense of disconnection with their bodies and their surroundings, in favor of a socially acceptable (within the reality shifting subculcuture) focus on their internal world. Moreover, experimenting with an alternate sense of identity (in the desired reality) may either lead to – or be driven by – a dissociative experience of multiplicity of identities.

DID and gender non-conforming alters

In psychotherapies, dissociative identity disorder cases report that they often feel that their body image is distorted dramatically due to involuntary alter personality transitions of different sexual orientations. These alter personalities that take on the opposite sex can see their bodies as if they have a different gender. In fact, when these different gender alters get control, they can even apply to a healthcare institution for sex reassignment surgeries [1,10,16,42]

Ozturk, 2022

Politics of plurality

- Political Plurals often view themselves as political activists and peer support specialists. They are often anti-sysmed, which means "system of medicine" as a reference to the treatment establishment and is a play on words from "cis-gender".
- Most often, political Plurals view treatment as oppressive and outdated at best, and violating at worst.
- "SysMed" has become a derogatory slur used against the treatment establishment, and it is used against organizations, institutions, and publications that are viewed as oppressive – or who are considered to have betrayed the community, such as having supported "cancelled clinicians". It can also be used as a form of political polarity against traumagenic DID systems who consider themselves "disordered" or "distressed" by their symptoms and so want to actively participate in treatment. It is also used against traumagenic DID systems who do not use the Plural term as part of cultural humility, and against DID systems who are against including non-trauma multiples in the Plural community.
- They reject structural dissociation theory because it denies multiplicity, because it is incongruent with lived experience, and because they consider the theory to be "ableist".
- (Christensen 2022a; 2022b)

The hierarchy of trauma and bi-passing

Roberts A.L., Lyall K., Rich-Edwards J.W., Ascherio A., Weisskopf M.G. (2013). Association of Maternal Exposure to Childhood Abuse With Elevated Risk for Autism in Offspring. JAMA Psychiatry. 70(5):508–515. doi:10.1001/jamapsychiatry.2013.447

Roberts, A. L., Lyall, K., & Weisskopf, M. G. (2017). Maternal Exposure to Childhood Abuse is Associated with Mate Selection: Implications for Autism in Offspring. Journal of Autism and Developmental Disorders, 47(7), 1998–2009. https://doi.org/10.1007/s10803-017-3115-3

Chapter 4: All our sons: The developmental neurobiology and neuroendocrinology of boys at risk Schore, A., (2019). The development of the unconscious mind. New York: W.W. Norton & Company

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Connecting the Dots

- Childhood sexual abuse is common
- We know from decades of research
- We know from Arachnid
- We know from more than a century of anecdotal reports
- We know from our own lives
- Someone is doing all of this assaulting
- False Memory Syndrome had been debunked and the foundation is no longer operating.

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Empirical evidence: what types of trauma create a dissociative response?

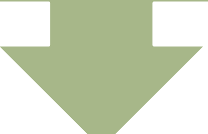
Defining trauma

Polyvagal theory

Age matters: younger children are more vulnerable

Defining trauma

“an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual’s internal resources” (Briere & Scott, 2006, p.4)



“psychological trauma as an infliction of powerlessness. … Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life.” (Herman, 1992, p. 33)

“events are not traumatic in themselves; rather, they may be so in their effect on the given individual. Thus, not every individual who experiences an extremely stressful event will be traumatized.” (van der Hart, Nijenhuis, & Steele, 2006, p.23)

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The age at which trauma occurs

Recurrent trauma at younger ages negatively affects:

- the neurobiological system as a whole, including epigenetic expression
- every aspect of the body, mind, emotional and imaginative systems

This leads to mental, physical, emotional, and spiritual symptoms, including personality development and self concept

(Brach, 2003; 2006; Milutinovic, Zhuang, Niveleau, & Szyf, 2003; van der Hart et al., 2006; Perry, 2001; 1999; Perry & Pollard, 1998; van der Kolk, 2003; 2005; 2006; Vermetten & Bremner, 2002).

If the trauma occurs before the age of 5 a child without a unified sense of self maintained across various behavioural and/or psychobiological states

(Chu, 2005; van der Hart et al., 2006).

When traumatic experiences occur during crucial emotional and personality developmental and behavioural stages, the results can be dramatic — the child's "self" is altered

(Ross, 1997)

Empirical evidence: what parent-child dynamics create a dissociative response?

- Attachment
- Betrayal trauma theory
- Dissociation is an attachment strategy

Disorganized attachment

- Dissociation also occurs when the child perceives their potentially protective caregiver as threatening or frightening and the child is faced with a conflict between two incompatible behaviours: seeking and avoiding proximity to the attachment figure.
- This relationship between a disorganized attachment style and dissociation is confirmed by longitudinal studies following infants into adulthood (Main & Hesse, 1990; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997).
- Disorganised attachment is not always precipitated by overt abuse and may occur when the parent fails to respond adequately to the infant's attachment bids and leaves the child without adequate parental regulation of fearful affect (Lyons-Ruth, 2003).

Betrayal, attachment and dissociation

- Freyd (1996) developed the theory of 'betrayal trauma' to describe the logic of 'forgetting' abuse perpetrated by someone whom the child is dependent upon in order to preserve the attachment bond
- In this model, memory of the abuse may be repressed or 'dissociated from consciousness'.
- The memory does not need to be about a fear-inducing events, but one that threatens the attachment bond necessary for survival.

Freyd (1996) Betrayal Trauma

Childhood Sexual Abuse

Canadian Centre for Child Protection

- Project Arachnid
- An innovative tool to combat the growing proliferation of child sexual abuse material
- As of November 1, 2021, 131billion + images out of those images, 9 million+ CSAM, 85% related to victims are not known have not been identified

Association of Alberta Sexual Assault Services (2020). Summary of key findings prevalence of sexual abuse in Alberta, Maltest

- Approximately two in three females and one in three males experienced sexual abuse.
- These results demonstrate that females are two times more likely than males to experience sexual abuse (60% of females compared to 31% of males).
- Applying the prevalence rate to the adult population of Alberta (3,284,102), it is estimated that a total of 1.48 million Albertans over the age of 18 have experienced some type of sexual abuse in their lifetime.
- One in three Albertans (34%) experienced sexual abuse while they were under the age of 18. Thus, it is estimated that 325,000 Albertans under the age of 18 have experienced some type of sexual abuse. Just under one in two girls (44%) and one in four boys (24%) in Alberta have experienced child sexual abuse
- Among all respondents who are survivors of childhood sexual abuse, the majority experienced sexual abuse which included physical contact (82%)

The Other Side

Do we ever take into consideration the legal ramifications. Children only want to attach. Children cannot fake or make up sensory, motor, and affective information

Do we ever take into consideration psychopathy, gaslighting, DARVO, pathological lying, and that there is just too much evidence that this stuff happens, and it happens A LOT.

Reinders, A., & Veltman, D. (2021). Dissociative identity disorder: Out of the shadows at last? *The British Journal of Psychiatry, 219*(2), 413-414. doi:10.1192/bjp.2020.168

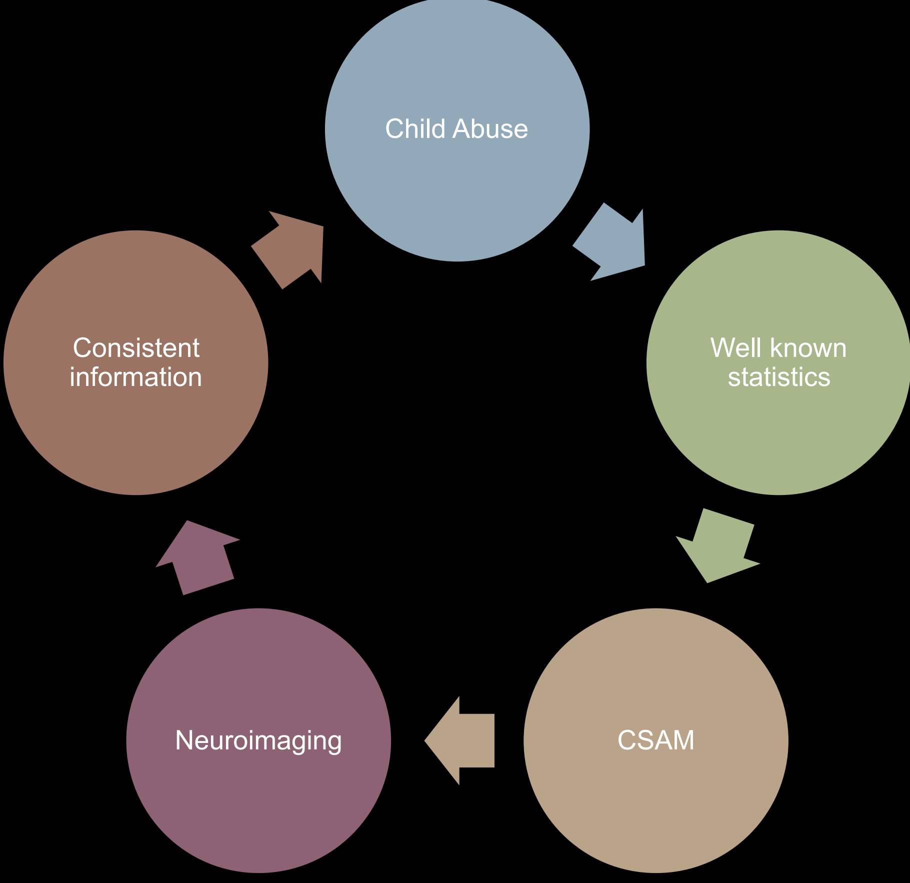
"Supporters of two diametrically opposed views have engaged in passionate debate for decades:Reference Reinders, Willemsen, Vos, den Boer and Nijenhuis1 the trauma model states that DID is a severe form of post-traumatic stress disorder (PTSD) originating in severe and chronic (childhood) traumatisation, whereas the fantasy model postulates that DID is predominately due to suggestion and enactment and is facilitated by high levels of fantasy proneness and suggestibility."

"One reason is that information in undergraduate and graduate textbooks about trauma and dissociation is inadequate or simply wrong, because (a) it is often based on experimental research in non-clinical samples, (b) it is not fully based on scientific research, (c) it contains unbalanced discussions about the detrimental impact of childhood traumatisation and (d) it disregards empirical evidence showing a relationship between dissociation and antecedent trauma. Another reason is reluctance to accept the nature and severity of childhood abuse that individuals with DID report. It is troubling and painful to acknowledge how common and devastating trauma is, especially chronic childhood abuse. Subconscious protective mechanisms can take over to deny the reality of such abuse (in a similar way as denying racism, the Holocaust, or global warmingReference Dalenberg, Brand, Loewenstein, Frewen and Spiegel3) and to believe that DID is a factitious disorder, as stated by the fantasy model.Reference Reinders, Willemsen, Vos, den Boer and Nijenhuis1 However, it becomes increasingly apparent that severe childhood abuse, neglect and maltreatment are part of many psychiatric disorders and of our society.Reference Nemeroff4"

Continued

- "The combination of insufficient training in recognising trauma-related dissociation, limited exposure to accurate scientific information about DID, symptom similarities with other disorders (such as schizophrenia, bipolar disorder and borderline personality disorder) and the aetiology debate has led to a reluctance to consider a diagnosis of DID, leading to under- and misdiagnosis of the disorder, hampering effective treatment.Reference Reinders, Marquand, Schlumpf, Chalavi, Vissia and Nijenhuis5 From the moment of seeking treatment for symptoms to the time of an accurate diagnosis of DID, individuals receive an average of four prior other diagnoses, inadequate pharmacological treatment, have several hospital admissions and consequently spend many years in mental health services. These years of misdirected treatment result in protracted personal suffering and high direct and indirect societal costs. Other factors contributing to under- and misdiagnosing of DID are unfamiliarity with the spectrum of dissociative disorders, the existence of feigned DID, the reluctance of individuals with DID to present their dissociative symptoms, often owing to feelings of shame, and lack of knowledge and appreciation of its epidemiology."

- "The aetiology of DID has been debated for decades, questioning the validity of DID as a diagnostic entity in the DSM. Given that neurobiological and other evidenceReference Şar, Dorahy and Krüger2 supports the trauma model for DID, it remains unclear why the aetiology of DID is still controversial, because for most other major psychiatric disorders, such as psychosis, the aetiology is also insufficiently known without such detrimental impact on diagnostic detection, treatment and patient's quality of life. We therefore propose that, given the available neurobiological evidence, it is time to move DID out of the shadows and to consider it as a mainstream psychiatric disorder."


Child Abuse
Well known statistics
CSAM
Neuroimaging
Consistent information

Diagnosis

Dissociative Disorders

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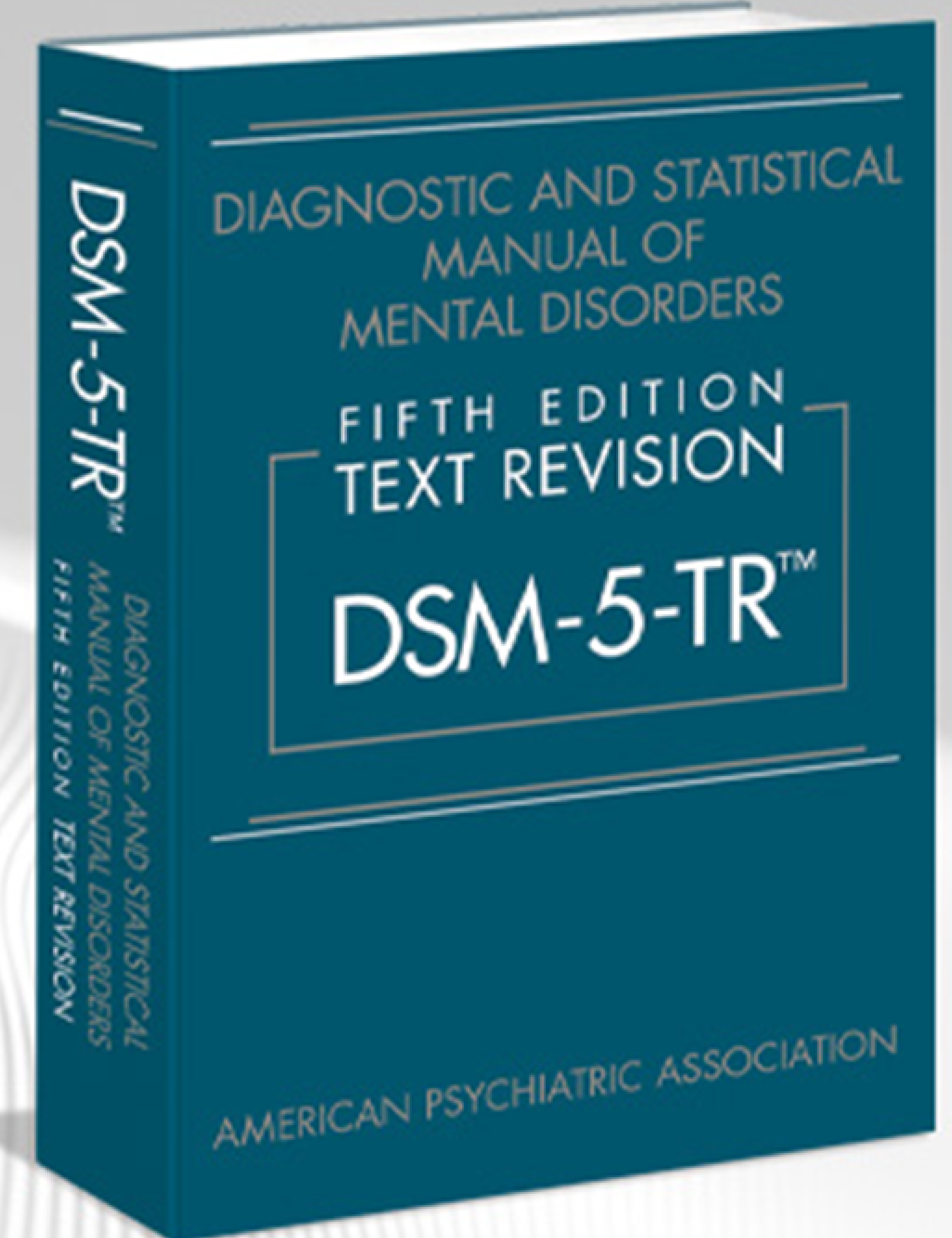

Dissociative Disorders

1. Dissociative Amnesia
2. Depersonalization/Derealization Disorder
3. Dissociative Identity Disorder (DID)
4. Other Specified Dissociation Disorder
5. Unspecified Dissociation Disorder

ICD-11 for Mortality and Morbidity Statistics

6B60 Dissociative neurological symptom disorder

6B61 Dissociative amnesia

6B62 Trance disorder

6B63 Possession trance disorder

6B64 Dissociative identity disorder

6B65 Partial dissociative identity disorder

6B66 Depersonalization-derealization disorder

6E65 Secondary dissociative syndrome

6B6Y Other specified dissociative disorders

6B6Z Dissociative disorders, unspecified

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Dissociative Amnesia (300.12/13)

- Dissociative amnesia (DA) is characterized by an inability to recall autobiographical information that may be localised to an event or period of time, to a specific aspect of an event, or generalised to identity and life history. The holes in memory are too extensive to be explained by ordinary forgetfulness.
- A more severe subtype of amnesia, **fugue**, involves purposeful travel or bewildered wandering with loss of identity. Fugue is rare even among people with Dissociative Amnesia, but is commonly seen in individuals with Dissociative Identity Disorder

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Dissociative Amnesia

Diagnostic Criteria (F44.0)

A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

> **Note:** Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

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

C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).

D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Coding note: The code for dissociative amnesia without dissociative fugue is **F44.0.** The code for dissociative amnesia with dissociative fugue is **F44.1.**

Specify if:

> **F44.1 With dissociative fugue:** Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

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Experiences of depersonalization and derealization

The individual may feel subjectively detached

- from their entire being: “I am no one”, “I have no self”
- from aspects of the self, including:
  - feelings, e.g., hypoemotionality: “I know I have feelings, but I don’t feel them”
  - thoughts, e.g., “My thoughts don’t feel like my own,” “head filled with cotton”
  - whole body or body parts, or sensations, e.g., touch, proprioception, hunger, thirst, libido (APA, 2022).
  - memories, including difficulty vividly recalling autobiographical memories and “owning” them as personal and emotional

DSM-5-TR / ICD-11 (6B66).

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Experiences of depersonalization and derealization

Individuals may also experience:

- extreme rumination or obsessional preoccupation, e.g., constantly obsessing about whether they really exist, or checking their perceptions to determine whether they appear real
- Catastrophic cognitions, e.g., frequent fears of ‘going crazy’ and/or irreversible brain damage
- altered sense of time, such as the subjective experience of time slowing down or speeding up.
- physiological hyporeactivity to emotional stimuli

These are often accompanied by vague somatic symptoms, such as head fullness, tingling, or lightheadedness,

DSM-5-TR / ICD-11

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Depersonalization/Derealization Disorder (300.6)

- Derealization is included in formerly Depersonalization Disorder and it can be designated as either.
- **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
- **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

Depersonalization and derealization

- 23% of the general population report that they have experienced at least fleeting moments of depersonalisation or derealisation in the past year, but these mild and intermittent symptoms are rarely of concern. The DSM-5 criteria for depersonalisation/derealisation disorder specify that the symptoms must be persistent or recurrent.
- (Aderibigbe, Bloch, & Walker, 2001)
- Depersonalization-derealization syndrome is not classified as a Dissociative Disorder in the ICD-10, but under ‘Other Neurotic Disorder’.

Onset

- Onset of Depersonalization-Derealization Disorder can occur in childhood but more typically has its onset in mid-adolescence, with a mean age at onset of approximately 16 years of age. Onset after 25 years of age is very rare.
- Episodes of depersonalization and derealization in Depersonalization-Derealization Disorder may be associated with adverse life events or interpersonal conflicts.
- depersonalization/derealization symptoms are strongly associated with acute traumatic events including motor vehicle accidents and other forms of life-threatening danger (Loewenstein, 2018).
- Drug use

Dissociative Identity Disorder (DID)

- DID, previously known as Multiple Personality Disorder, requires that a person have at least two separate personalities or alters — different modes of being, thinking, feeling and acting that exist independently of one another and that emerge at different times. Each determines the person's nature and activities when it is in command.
- The primary alter may be totally unaware that any other alter exists and may have no memory of what those other alters do and experience when they are in control. Recurrent episodes of amnesia are a requirement for diagnosis.

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Dissociative Identity Disorder

Diagnostic Criteria (F44.81)

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, 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).

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Dissociative Identity Disorder (DID) (300.14)

Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions.

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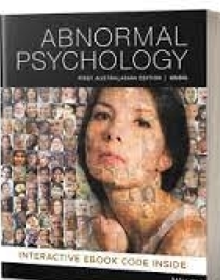

CLINICAL CASE

Symptoms of dissociative identity disorder (DID) prior to diagnosis

In this example, we look at one young Australian woman's medical records compiled from psychiatric hospitals over a five-year period. During this time, a DID diagnosis was never considered by the woman or her therapists. Her records also confirm a history of severe incestuous childhood abuse, which resulted in her father being jailed. These are some excerpts from her medical records.

- Able to give a past history of behaviours suggestive of a borderline personality, identity diffusion, several relationship difficulties, periodic thoughts of self harm, . . . affective instability and longstanding substance abuse
- Within 24 hrs she was describing experiencing hearing voices, both male and female, instructing her to hurt herself. She said that these had occurred periodically for many years
- Has an unusual and unclear story, but apparently she showed abusive behaviour . . . and described visual hallucinations and auditory hallucinations
- By the time she had reached the [Royal St Elsewhere] she denied any memory for the events that had occurred at the Maternity Hospital
- Diagnosis was difficult in the setting of a changing story
- She also described a number of psychotic features such as thought broadcasting, auditory hallucinations and ideas of reference . . . it was decided to recommence Electroconvulsive therapy
- On interview she was extremely distressed and used the word 'we' to describe herself. She felt that there were several people inside herself. There was a Sally, who was small and also ran away the whole time. There was Ruth, who was dirty and a tramp, Gary — the strong one and Annie who works with Gary
- She has no memories prior to the age of 12
- She also described visual hallucinations and olfactory and gustatory hallucinations . . . She described symptoms of PTSD, awakening at night with vivid visions of her earlier sexual abuse
- During her admission, she had episodes of increased psychosis and suicidal ideation. There were periods when she appeared quite well and had several successful leaves. (Middleton, 2004b)

In the five-year period of frequent hospitalisation a dissociative disorder diagnosis was never considered.

QUESTIONS

1. Which criteria for DID are present in this case?
2. What symptoms are similar to schizophrenia and how might you differentiate between the two disorders in this case?

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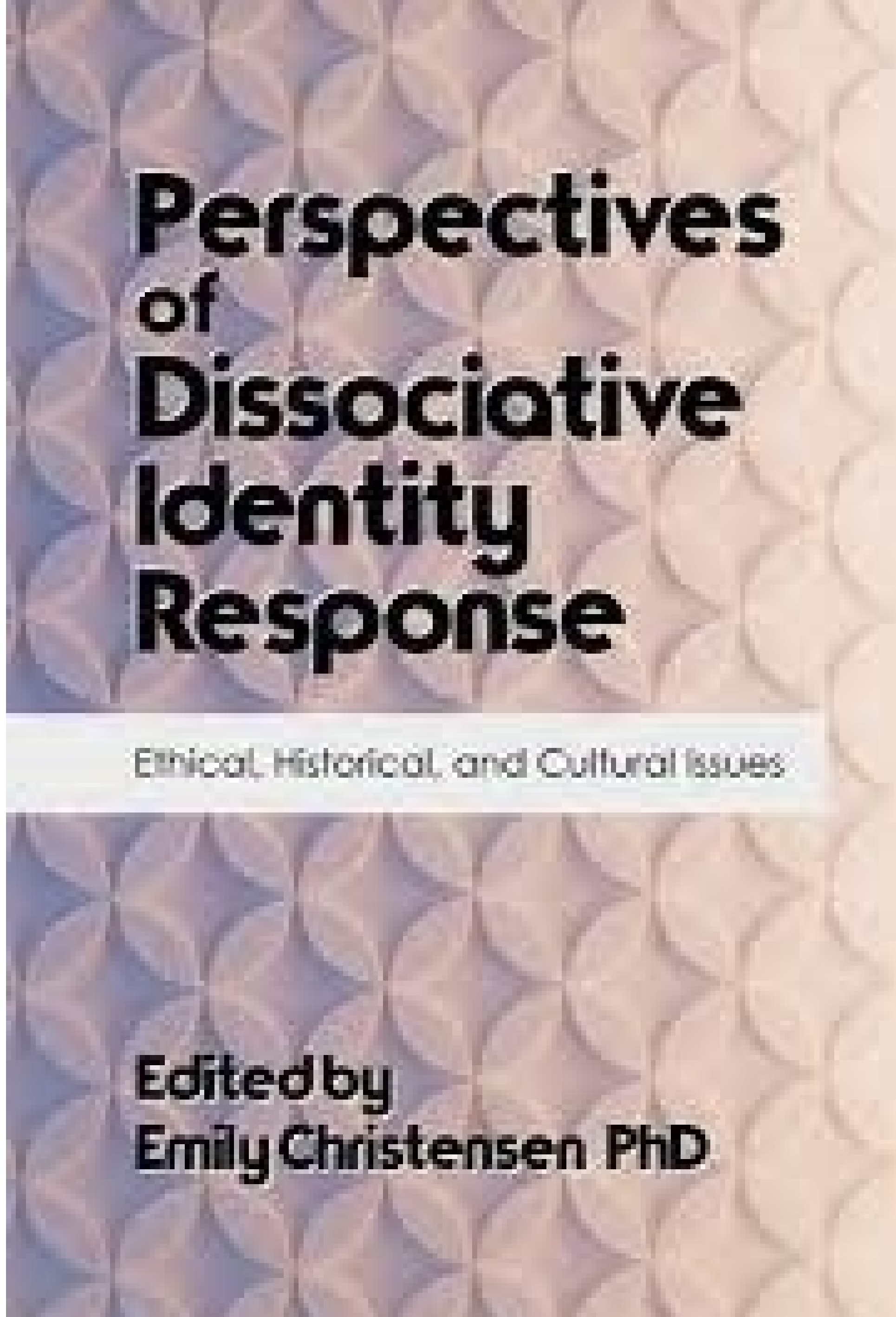
DID: not enough of one personality

Often people assume that people with Dissociative Identity Disorder have several personalities, but what it is actually like is that there are not too many personalities, but not enough of one personality. For them, they feel like it is several people or someone else who is in charge, but they also don’t have an intuitive knowledge of what one sense of self should feel like. “One” sense of self, feels very different than partial bits of a sense of self. The imagination system seems to also be in “overdrive” when the rest of the information systems of the body, emotions, mind and memory are unknown or irregular.

(Forner, 2017)

“Many women spent years, often decades, in the mental health system before their dissociation was detected, which is also consistent with other research (Spiegel, 2011). Most recounted ineffective mental health treatment, including a lack of, or ineffective, psychotherapy, and being overly medicated. Many of the psychiatrists did not consider DID as a possibility, often because they did not "believe in DID". Some of the women were diagnosed incorrectly with schizophrenia. For others, the focus of treatment was on comorbid conditions like depression, anxiety, borderline, or PTSD.”

Kate, M.-A., Jamieson, G., & Middleton, W. (2022). “Dr Who, a Tardis, and a relocation”: Women with Dissociative Identity Disorder reflect on barriers to identifying and disclosing their trauma. In: Christensen, E. (ed) *Perspectives of Dissociative Identity Response: Ethical, Historical, and Cultural Issues*. HWC Press, LLC



Kathy Steele's perspective on dissociative "parts"

From an integrative systems perspective:

- Dissociative Parts are enduring patterns of thinking, feeling, perceiving, predicting, sensing, and behaving organised within multiple and sometimes contradictory senses of self. These are not real "things", "people" or "personalities",
- Each "self" is a centre of (partial) agency and awareness. Each "self is less open to change than usual and has a more limited view of the world.
- "Not real, not true, not mine not me": the inability to realize is a central feature of dissociation
- The emphasis on system as a whole should be reflected in language "Parts of you", "different ways of being you", "the angry part of you".

Kathy Steele (2019) *Treating complex dissociative disorders a practical integrative approach ISSTD bi-annual Australasian conference,* Christchurch, NZ

Notes

Reversible: changeable. Adopts different beliefs and life philosophies consecutively in short time lapses

Potent female: strength and resources to fight against traumatic experiences and abusers, an activist, freedom seeker

Talented: unique skills the host does not have, languages or music

Objective: function as stabilizers

Apparently natural: The original personality is often inactive ("asleep", "frozen" or "inadequate“) after an inability to cope with the original trauma.

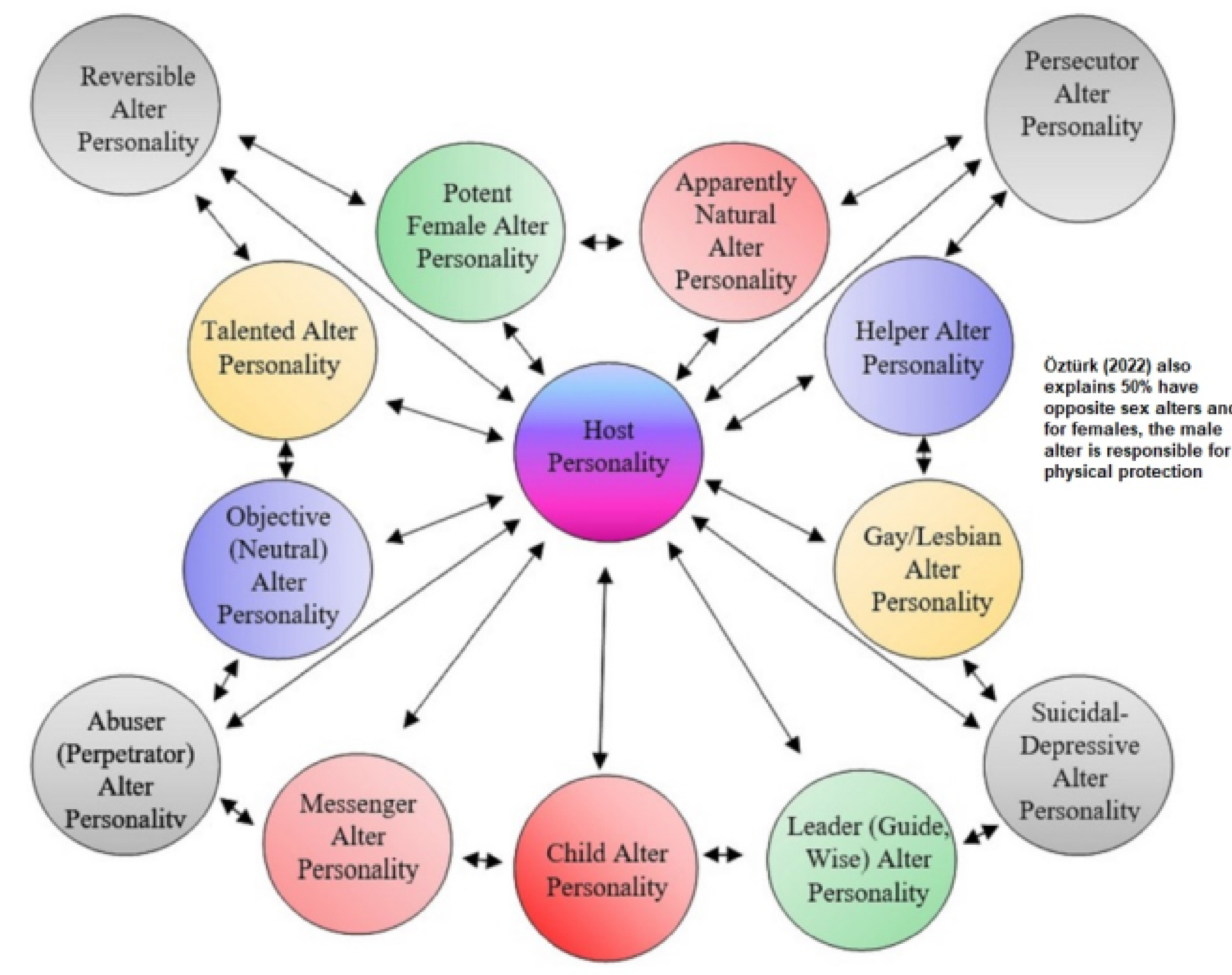


Figure 1. Host and Alter Personalities in the Trauma Based Alliance Model Therapy

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The Burdened Internal System

Graphic by Janet R. Mullen, LCSW
Text adapted by M. Pastor from *Internal Family Systems* by Richard Schwartz, PhD.

Sub-clinical DID in the ICD-11: Partial DID

Partial dissociative identity disorder is characterised by disruption of identity in which there are two or more distinct personality states (dissociative identities) associated with marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment.

One personality state is dominant and normally functions in daily life, but is intruded upon by one or more non-dominant personality states (dissociative intrusions).

These intrusions may be cognitive, affective, perceptual, motor, or behavioural. They are experienced as interfering with the functioning of the dominant personality state and are typically aversive.

The non-dominant personality states do not recurrently take executive control of the individual's consciousness and functioning, but there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours, such as in response to extreme emotional states or during episodes of self-harm or the reenactment of traumatic memories.

Other Specified Dissociative Disorder (OOSD), including subclinical DID

- OOSD is used in situations in which the presentation does not meet the criteria for any of the three specific Dissociative Disorders.
- Although not explicit, OOSD includes **subclinical DID** that was diagnosed as Dissociative Disorder Not Otherwise Specified – Type 1 (DDNOS-1) in the DSM-IV. Here the person experiences **intrusive emotions, thoughts, actions, speech and impulses** from personality states that are less marked than in DID, or they have dissociative identities, but unlike alters seen in DID, their personality states are not sufficiently distinct to take executive control in daily life without the person's awareness.

Other Specified Dissociative Disorder (300.15)

Chronic and recurrent syndromes of mixed dissociative symptoms: Identity disturbances w/o amnesia

Identity disturbance due to prolonged and intense coercive persuasion: Prolonged changes in or questioning of identity due to imprisonment, brainwashing, torture, participation in sects/cults/terror organizations.

Acute dissociative reactions to stressful events: Acute, transient conditions lasting less than 1 month. Constriction of consciousness; depersonalization; derealization; perceptual disturbances, micro-amnesias; transient stupor; and/or alterations in sensory-motor functioning.

Dissociative trance: Acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.

Other Specified Dissociative Disorder

(F44.89)

This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder. This is done by recording "other specified dissociative disorder" followed by the specific reason (e.g., "dissociative trance").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Chronic and recurrent syndromes of mixed dissociative symptoms:** This category includes identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.
2. **Identity disturbance due to prolonged and intense coercive persuasion:** Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity.
3. **Acute dissociative reactions to stressful events:** This category is for acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness; depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); microamnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis).
4. **Dissociative trance:** This condition is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.

Is there any further clarification of what this means?

DSM-5-TR states: Examples include identity disturbances associated with less-than-marked discontinuities in sense of self and agency, alterations of identity, or episodes of possession in the absence of a history of ***episodes*** of dissociative amnesia

People with subclinical DID will often have amnesia for traumatic events and often sections of childhood and autobiographic memory.

The DSM-5-TR would be more accurate if it was consistent with the ICD-11, i.e. stating that "individuals often do not experience amnesia during episodes of dissociative intrusions"

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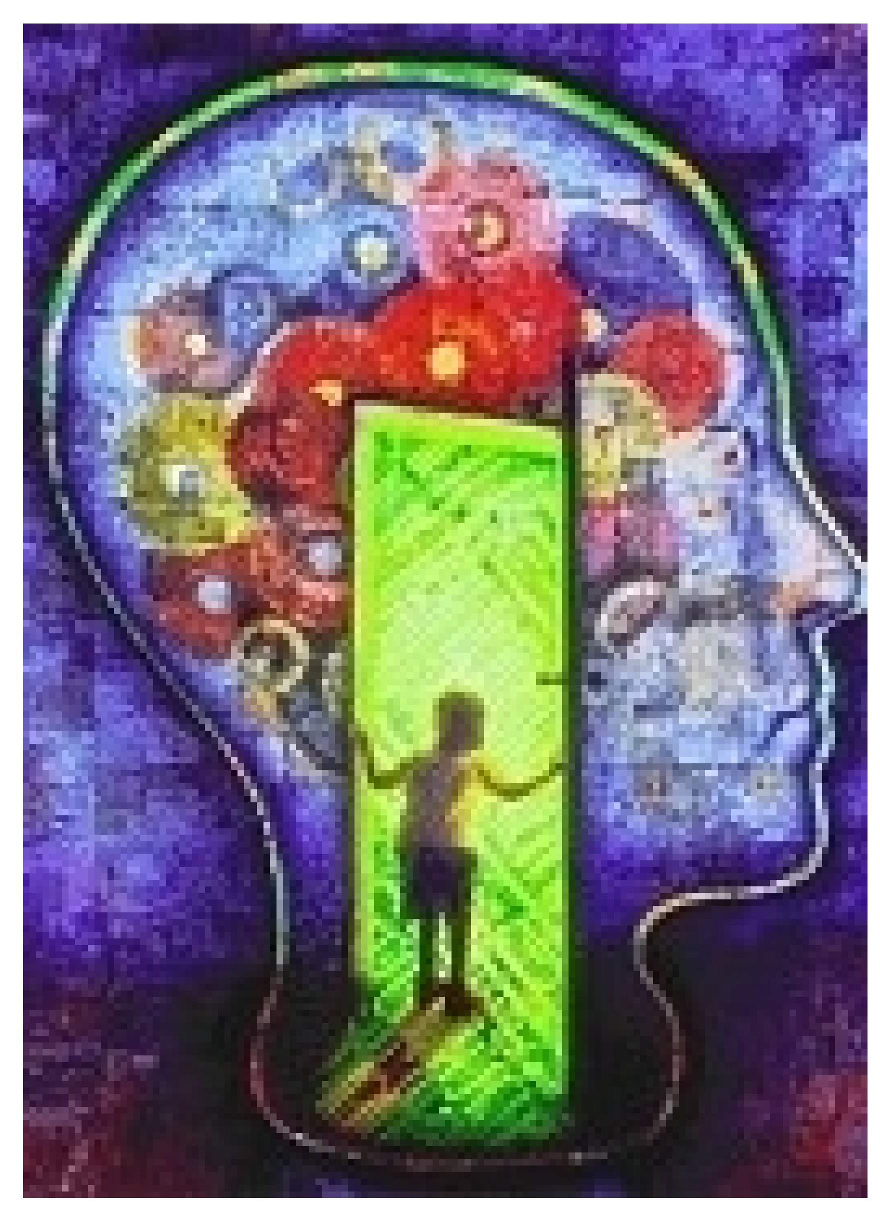

Unspecified Dissociative Disorder (300.15)

Dissociative symptoms cause significant distress or impairment, but do not meet full criteria for any dissociative disorder in this class.

Clinician chooses NOT to specify reason criteria are not met.

Insufficient info to make a more complete diagnosis.

EMERGENCY ROOM!

How common are DDs? Prevalence in the general population using structured clinical interviews

- 1.3% Depersonalization / Derealization Disorder
- 3.6% Dissociative Amnesia
- 3.2% Dissociative Disorder Not Otherwise Specified
- 1.2% Dissociative Identity Disorder
- **9.9% Any Dissociative Disorder**

- Rates are similar in men and women
- Figures represent average rate found in studies conducted in **Canada** (Ross et al., 1989), **USA** (Johnson, Cohen, Kasen, & Brook, 2006), Turkey (Akyüz, Doğan, Şar, Yargiç, & Tutkun, 1999; Şar, Akyüz, & Doğan, 2007); **Netherlands** (Ferdinand, van der Reijden, Verhulst, Nienhuis, & Giel, 1995) and **Iran** (Mohammadi et al., 2005); and in the **UK** with Bebbington & colleagues (1981; 1997) focussing on Depesonalization

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My findings: Prevalence in a university settings

International meta-analysis

- 11% of university students met the lifetime criteria for a DD following structured clinical interviews (*N* = 2,148)
- 17% were identified as high risk of a DD on the basis of scoring 30 or more on the Dissociative Experiences Scale (*N* = 4,061)
- On average, students (*N* = 26,821) self-reported having dissociative experiences 17% of the time

University of New England

- 8% of the sample (*N* = 313) likely to have a DD on the basis of scoring 31 or more on the short version of the Multidimensional Inventory of Dissociation (MID-60). 18% had scores 21 or more indicating a DD or PTSD was likely
- On average, students self-reported having dissociative experiences 13% of the time.

How common are dissociative experiences?
% of the time people report having dissociative experiences, as measured by the Dissociative Experiences Scale

general population – 11%

university students – 17%

no statistical differences in prevalence between men and women

Coons & Millstein, 1992; Kate, 2018; van Ijzendoorn & Schuengel, 1996; Simeon, 2009

clinical populations

- 15% Derealization Disorder
- 24% Depersonalization Disorder
- 33% PTSD
- 36% DDNOS / OSDD
- 39% Dissociative Amnesia
- 46% Dissociative Identity Disorder

Who are the 10% with a DD?

These are not an undiscovered or unique group of individuals

Frequently includes those with depression, anxiety, PTSD, and other mental illnesses, and who self-harm and/or are suicidal

Take home point #1
Dissociation and Dissociative Disorders are not rare

- Dissociation could usefully be conceptualised as being **similar to depression and anxiety**, in that all of these:
  - are a fairly **common reaction** to adverse experiences
  - are a fairly **common experience** amongst the general population
  - **may be clinically diagnosed** if the person experiences severe enough symptoms
  - frequently **co-occur**

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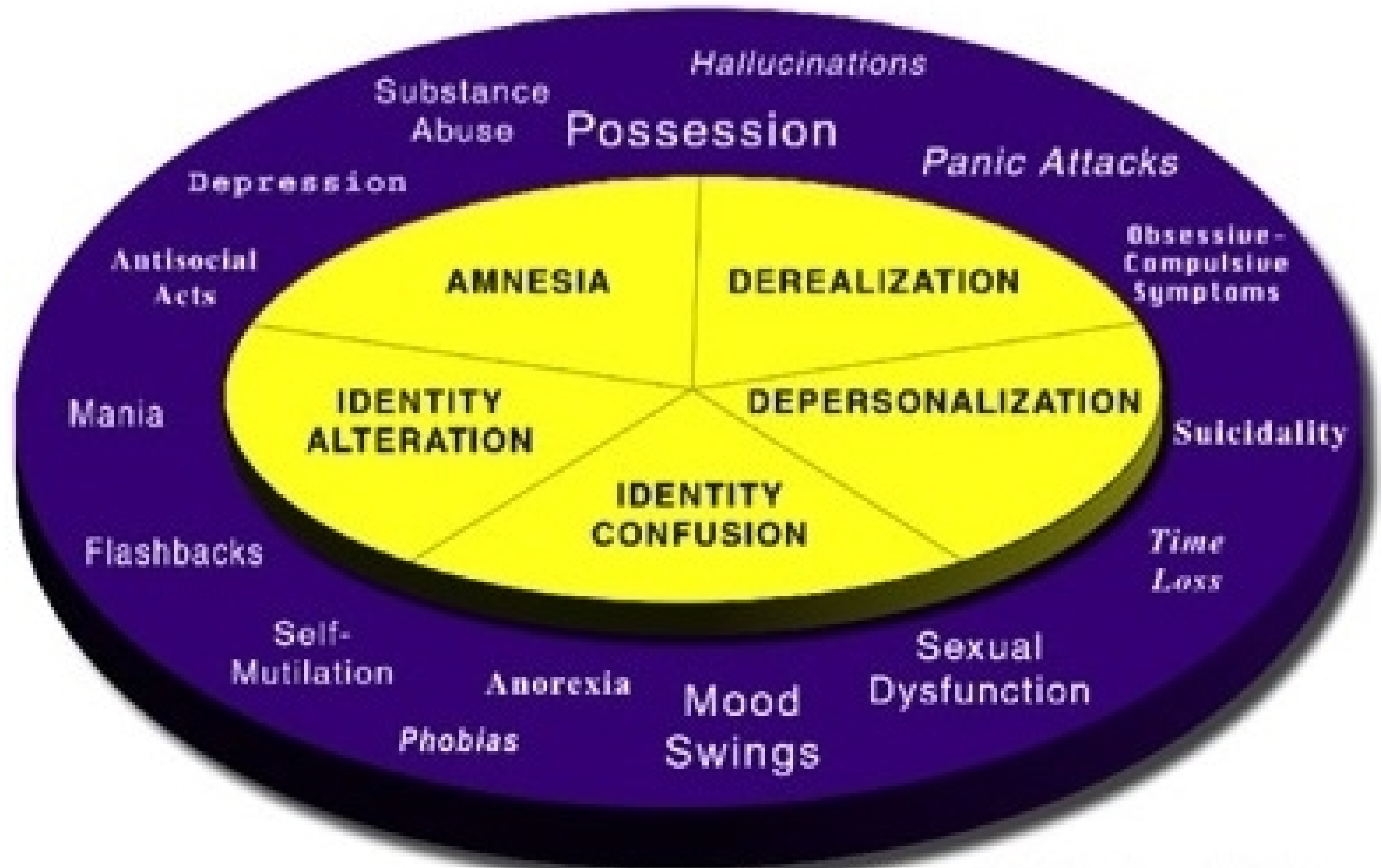

Reprinted from: Steinberg M, *Interviewer's Guide to the SCID-D*, American Psychiatric Press, 1994

DD comorbidity

Research from the Netherlands on the prevalence of Axis 1 disorders in young adults in the general population found:

- DD were the second most common Axis 1 diagnosis (7.4% prevalence rate)
- DDs were comorbid in 76% of cases
- 47% of individuals with a DD also had a sleep disorder

Ferdinand, van der Reijden, Verhulst, Nienhuis, and Giel (1995)

Research from the US general population shows the odds of a DD is higher if the individual meets the criteria for the following:

Johnson, Cohen, Kasen, & Brook (2006)

Axis 2 Personality disorders 6.8 : 1

- Cluster B (**borderline**, histrionic, narcissistic, antisocial) 7.3 : 1
- Cluster A (**paranoid, schizoid, schizotypal**) 4.4 : 1
- Cluster C (avoidant, dependent, obsessive-compulsive) 3.5 : 1

Axis 1 Disorders

- Anxiety disorder 2.7 : 1
- Eating disorder 2.3 : 1
- Mood disorder 2.4 : 1

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Mental health issues associated with DID in clinical populations

- 72% **attempt suicide** and 2% of those clinically diagnosed complete suicide
- 96% have a history of significant **self-harm**
- 90% also have **Post-Traumatic Stress Disorder**
- More than 90% suffer from **major depression**
- Half of people diagnosed DID have a drug and/or alcohol **addiction**
- 35% have either **anorexia** or **bulimia nervosa**
- 31% to 73% of also have **BPD**

Brand et al., 2016; Foote, Smolin, Neft, & Lipschitz, 2008; Middleton & Butler, 1998; Ross et al., 1990

DID occurs within a cluster of diagnoses and symptoms

These include:

- depression
- borderline personality disorder
- panic disorder
- somatization disorder
- substance abuse,
- Schneiderian first-rank symptoms of schizophrenia
- ESP experiences
- secondary features of DID and
- DID itself.

(Colin Ross, 1997, p. ix)

BPD vs DID

It is very important to acknowledge that DD, OSDD/DID is different than BPD, even though they share some similar features.

The differences in DD is the alter personalities, identity confusion and identity alteration, memory loss, internal continuity, and more introspection (Boon and Draijer, 1993).

BPD clients, the main emphasis of the diagnosis is abandonment issues, unstable relationships, impulsivity, recurrent suicidal attempts or self-mutilation and inappropriate displays of anger (Haddock, 2001).

Someone diagnosed with DID can have borderline traits and someone who has been diagnosed with BPD can have dissociative components. Both disorders experience depersonalization and derealisation. It does seem to be that those with DD do statistically have more severe and earlier trauma (Boon and Draijer, 1993).

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DID misdiagnosis, including **schizophrenia**

A 2005 survey of clinical psychologists and psychiatrists in Northern Ireland found that the **majority failed to diagnose DID** as the most likely condition in a clear-cut case Dorahy, Lewis, & Mulholland, 2005

- On average, for a person with DID:
  - **5 to 12 years** elapse between the first mental health assessment and an accurate diagnosis of DID Spiegel et al., 2011
  - their mental health and well-being deteriorates due to years of misdiagnosis and mistreatment
  - **three erroneous diagnoses** are given, most commonly **schizophrenia,** noting that DID patients endorse more Schneiderian first-rank than symptoms than schizophrenic patients Welburn et al., 2003

Diagnostic tools

Clinical interview

Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994)

Dissociative Disorders Interview Schedule (DDIS; Ross et al, 1989)

Self-report instrument

Multidimensional Inventory of Dissociation (MID; Dell, 2006)

Adolescent Multidimensional Inventory of Dissociation

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Screening tools

Adults	Dissociative Experiences Scale-version (DES) Bernstein & Putnam, 1986	Multidimensional Inventory of Dissociation – 60 item version (MID-60) Kate et al., 2020
Children and adolescents	Adolescent Dissociative Experiences Scale (A-DES) Armstrong, et al. 1997	Child Dissociative Checklist (CDC) Putnam, et al. 1993

Child Dissociative Checklist

1. Child does not remember of denies traumatic or painful experiences that are known to have occurred.

2. Child goes into a daze or trance-like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school.

3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.

4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.

5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.

6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.

7. Child shows rapid regressions in age-level behavior, e.g. a twelve-yearold starts to use baby-talk sucks thumb or draws like a four-year old.

8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.

9. Child continues to lie or deny misbehavior even when the evidence is obvious.

10. Child refers to himself or herself in the third person (.g. as she or her) when talking about self, or at times insists on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.

11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.

12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behaviour with other children or adults.

13. Child suffers from unexplained injuries or may even deliberately injure self at times.

14. Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come form "imaginary companions" or sound like the voices of parents, friends or teachers.

15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.

16. Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.

17. Child sleepwalks frequently.

18. Child has unusual nighttime experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).

19. Child frequently talks to him or herself, may use a different voice or argue with self at times.

20. Child has two or more distinct and separate personalities that take control over the child's behavior.

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Models of dissociation

Conceptualizing dissociation

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The Concept of Dissociation

- There are over two dozen models of dissociation in the current literature. I stopped counting at 25. That is why many years ago I wrote an editorial in DISSOCIATION entitled "Dissociation or Dissociations?" ... Then realize that often, when we think we are at out scientific or clinical best, we really should pause and allow ourselves to be humbled by the genius of Lewis Carroll, actually a mathematician and logician in his day job, who wrote the following in Through the Looking Glass:
- "When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean — neither more nor less.' 'The question is,' said Alice, 'whether you can make words mean so many different things.'
- Sadly, in our field (and most fields) there are too many Humpty Dumptys, and too few Alices.
- Kluft, R. (2019, August 29). Dissociative Regression and the Tower of Babel. In. Dissociative Disorders Internet Forum [Online forum comment]. Message posted to http://www.dissoc.icors.org/

Three of the most common academic contextual explanations of dissociative disorders

1. How dissociation manifests itself through its presenting signs and symptoms.
2. Dissociation as a naturally occurring style of mental processing, under certain conditions
3. Focus on underlying causality and structure: how typically integrated psychobiological action systems may become divided through personality development
4. This is changing as individuals with DID are being treated with dignity, validity and respect. There is more advocacy

Framework 1 Dissociative symptoms and phenomena

- Examines the specific definitions of the symptoms/ phenomena of dissociation, or what defines dissociation.
- This area focuses on how dissociation presents in clinical populations and how it is classified, e.g., definitions of depersonalization, amnesia and derealization.

(Dorahy, 2006)

Framework 2 Dissociative Process

Examines the notion that dissociation is a naturally occurring mental-processing style that under certain conditions produces dissociation,

- e.g. a breakdown in integrated mental functioning and processing, with the outcome being a defence strategy."

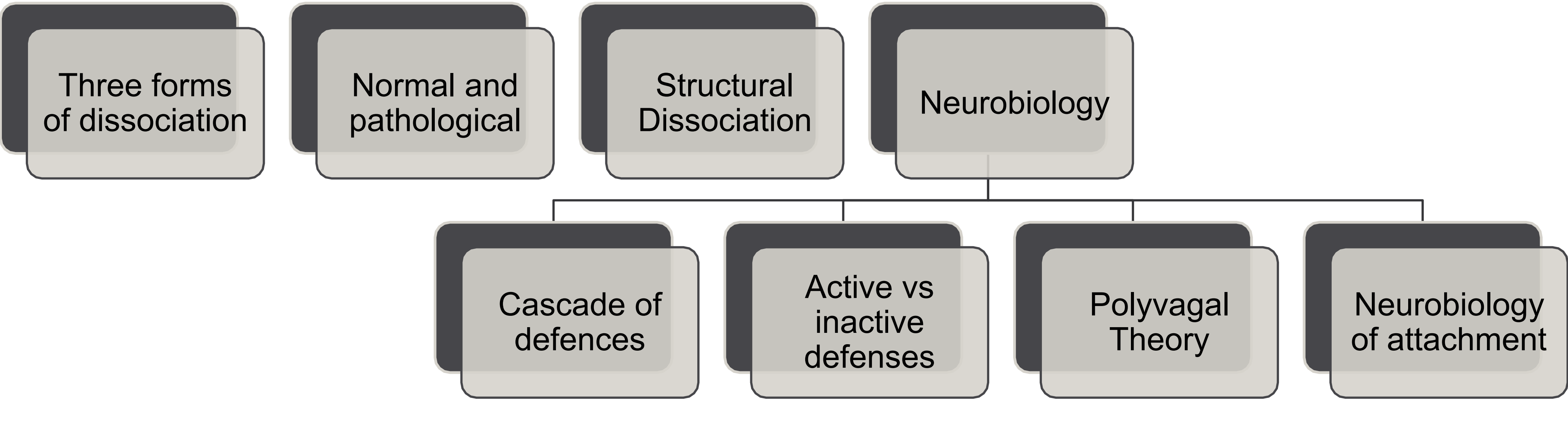
(Dorahy, 2006)

Framework 3 Personality Organization

- Maintains that dissociation is a specific way in which the "personality is organized and developed, e.g., the personality organization [is] characterized by different degrees of division in typically integrated psychobiological actions systems."

  (Dorahy, 2006, p. 30)

Conceptual frameworks



Three Forms of Dissociation

Normal Dissociation	Daydreaming, normal forgetting, i.e. driving. This concept is slowly moving out of the discussion as we learn more about the default mode network and traumatic neurochemistry	“Implies a disruption in the normal integration of the psychological faculties or functioning of a given consciousness with a sense of self” (Dell & O’Neil, 2009)	“Implies the presence of more than one centre of consciousness, more than one self” (Dell & O’Neil, 2009)
	• Faculty Dissociation	• Multiplicity	

Dissention or part of a whole?

- These different definitions can
  - create concerns for those who specialize in this area of study and treatment,
  - add further confusion for those who do not understand what dissociation is or
  - fuel the arguments of those who adamantly deny the existence of dissociative disorders, or more specifically DID.

Normal and pathological dissociation

Frank Putman, the creator of the Dissociative Experiences Scale and its adolescent verion, and the Child Dissociative Checklist, recognized that dissociation can be:

- **Normal**, e.g. daydreaming non-pathological and
- **Pathological**.
- when a person's consciousness, sense of identity, or behaviour is sufficiently dissociated to represent an abnormal and/or pathological process."
- "a failure to integrate or associate information and experience in a normal expectable fashion."
- Putnam's **Discrete States Model of Dissociation** defines pathological dissociation as trauma-induced behavioral states that are separate from normal states of consciousness.

(Putnam, 1989, 1997)

The Cascade Model of Defence

- There is hard freeze, flight, fight, reaching, which are active defenses (Bovine, Ratchford & Mark, in Lanius, et., al., 2014). Then there is the inactive defense of tonic immobility and complete submission (Bovine, et.al., 2014).

- “Dissociation happens, it happens often, and it happens when we are scared and there is no way out or no way to stop the thing that is scaring us. This is what we all do when we are scared. Dissociation is the removal or inability to process information, it is a great command and demand to not process information or react in an active way. Dissociation is all about not knowing that we are trapped, stuck, about to die. Dissociation is usually is quiet, not loud like fight for flight, it is more internal than external, like fight or flight, and it is the master of disguise. It is the defense of disappearing, hiding, and submitting. As you will learn, it can be over-used and become disordered, for others it is the preferred defense strategy for overwhelming fear. Our clever, evolutionary wise bodies and brains use it when they think it is necessary, not when we think it is necessary (Forner, 2017)”.

- For every human, when we reach a point where our fear is beyond our control, when our fear is inescapable we can dissociate. It only makes sense that the more time we spend being scared beyond our control, the more time we spend dissociating.

Active Vs Inactive Defences

Base line	Hard Freeze	Flight	Fight	Attach Cry Panic	Tonic Immobil ity	Shame	Align with perp	Complete Submissio n
Facia								
Sensations								
Feelings								
Perceptions								
Emotions								
Thoughts								
Words								
Imaginings								
Awareness								
Attention								

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It’s not just the tiger

We need to belong

We are hard wired to attach, not only to our caregivers, but to our social group

For our ancestors, social exclusion or ostracization was a death sentence

1 Social Engagement

Talking, engaging, co-regulating, self soothing and calming to inhibit sympathetic-adrenal influence.

2 Mobilisation

Actively combatting the stressor through engaging the SNS. Running, fighting or fleeing. Turns off gut.

3 Immobilisation

Shutting off from the stressor and shutting down the body using the older vagus PNS. Dissociation, collapse, passive avoidance.

Polyvagal theory
Dissociation occurs once all mammalian survival strategies are exhausted and the reptilian brain takes over

Source: Australian Childhood Foundation (2011)

THREE WARNING SIGNS OF STRUCTURAL DISSOCIATION

Adapted from **Janina Fisher, PhD**

Structural dissociation is often overlooked, underdiagnosed, or misdiagnosed as a personality disorder – all of which can be key reasons that a client's progress stalls, or treatments prove to be ineffective. So how can we more effectively recognize structural dissociation?

Janina Fisher, PhD describes three explicit signs, or red flags, that can help you detect structural dissociation.

Paradox and Contradiction

The first red flag is when a client's actions seem to contradict their desires.

This can be a signal that their attachment system is attempting to reach out for comfort while in the same moment their defense system is trying to protect them.

Examples:

- Your client alternately idealizes and devalues you as a therapist.
- Your client reports a certain phobia, but engages in actions that are counterphobic.
- Your client reports feelings of shame, but also acts superior to others.

Terminal Ambivalence

The second red flag is when clients struggle to make decisions or won't follow through on the decisions they have made.

This may look like self-sabotage, but this "stuckness" is actually the result of an inner struggle between the client's desire and a part that's afraid to take a step forward or be visible to others.

Examples:

- Your client struggles equally with decisions big and small – like where to attend college or where to go for dinner.
- Your client completes an assignment or task but is afraid to talk about it or show the results.

Somatic Indicators

The third red flag is when clients report bodily reactions that are unexpected or differ from the norm.

Dissociation can help clients disconnect their mind from bodily sensations – like pain during a traumatic event. But it can also disconnect them from other bodily experiences, like the effects of medications.

Examples:

- Your client reports that prescribed medications have no effect, or the opposite effect.
- A medication that is normally activating puts your client to sleep.

According to Janina, when a client is stuck with various treatments proving ineffective, and the client has a history of turbulent relationships with therapists, this is a likely indicator of structural dissociation.

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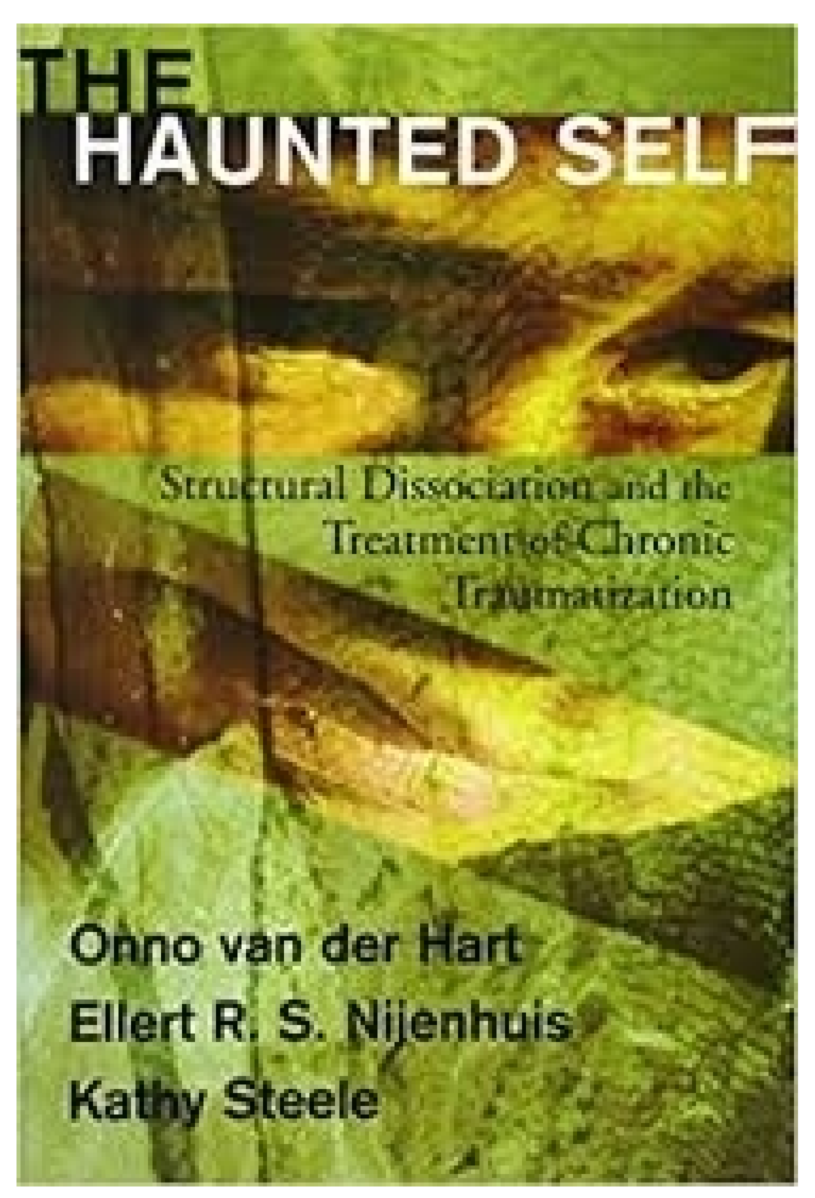
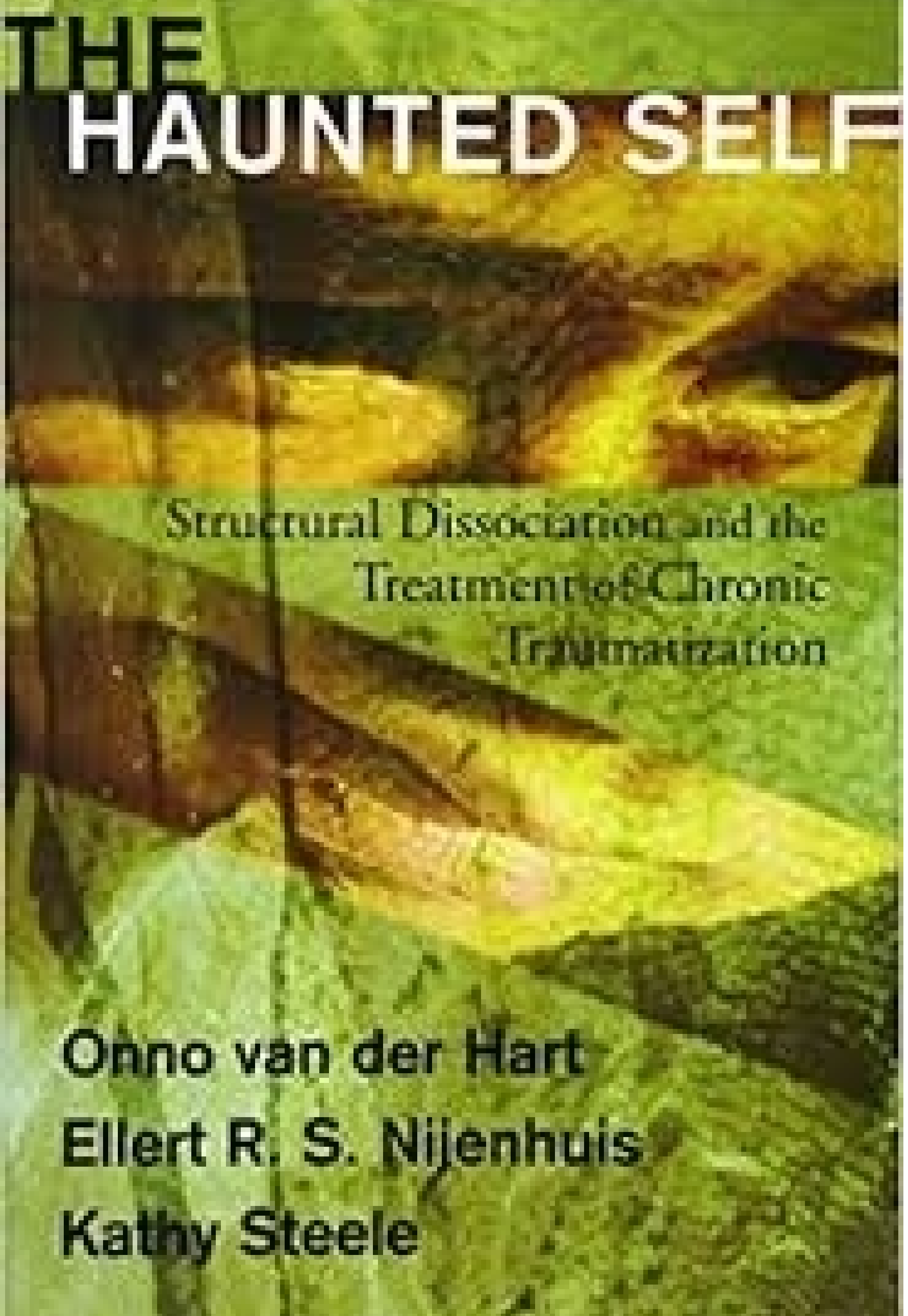


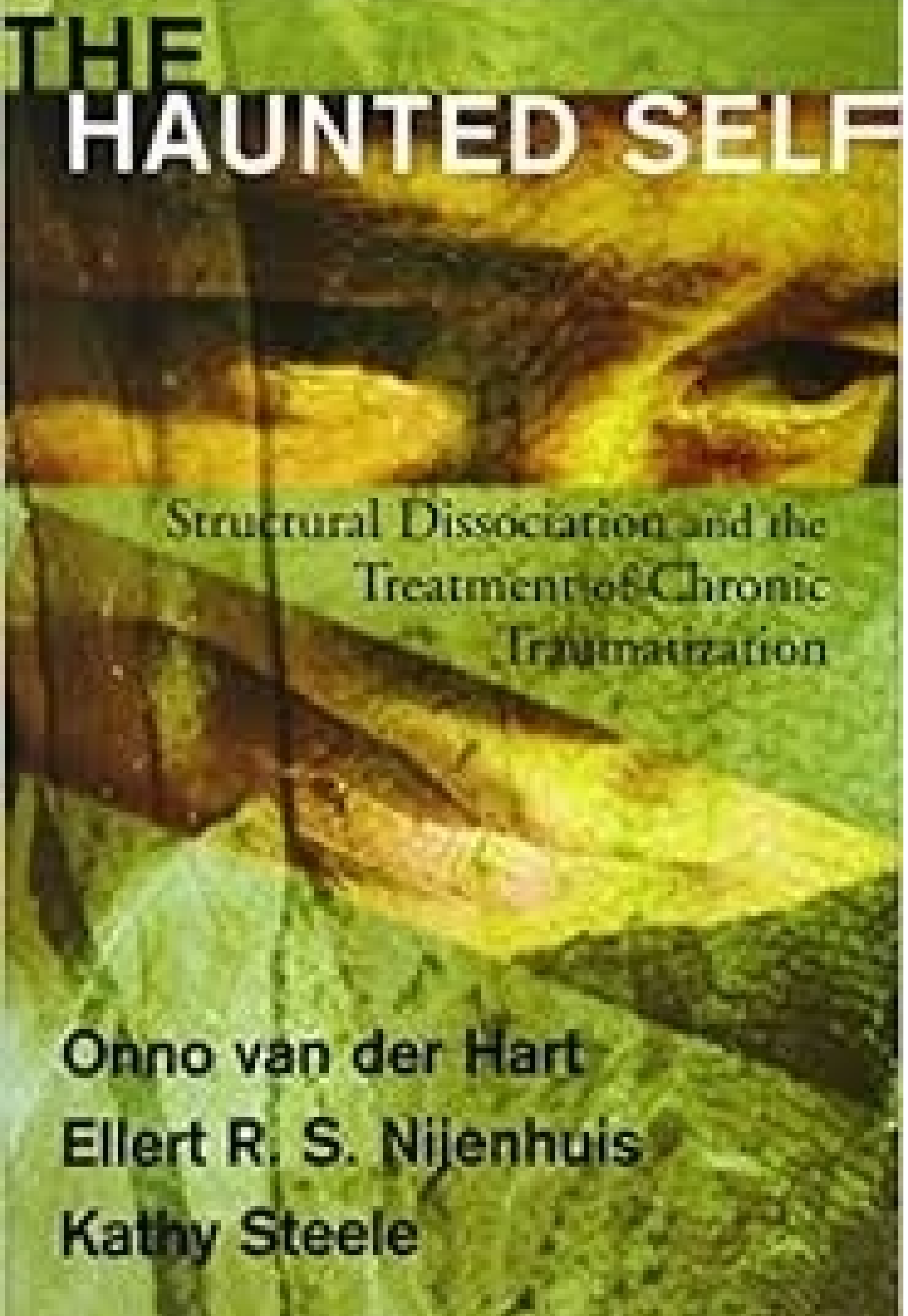
Structural Dissociation van der Hart, Nijenhuis, & Steele, 2006

"an integrated personality is a developmental achievement"



The pathways to dissociation of the personality lie in the traumatic events that a person has experienced.

- For example, in adults who experience trauma but have already developed a more integrated personality systems, the level of dissociation [divisions among ideas and functions] are less severe.
- *When an infant/child (who, during normal development, has not yet developed an integrated personality) is traumatized frequently and the caregiver provides inadequate emotional regulation with insufficient soothing or calming, the child may never develop a normal healthy personality system.*
- *The concept created from this understanding of the unhealthy development of the personality system is the "structural dissociation" of the personality, in which, under traumatic conditions, the personality tends to divide on "fault-lines" in the structure of the personality.*



Structural Dissociation
The Apparently Normal Personality and the Emotional Personality

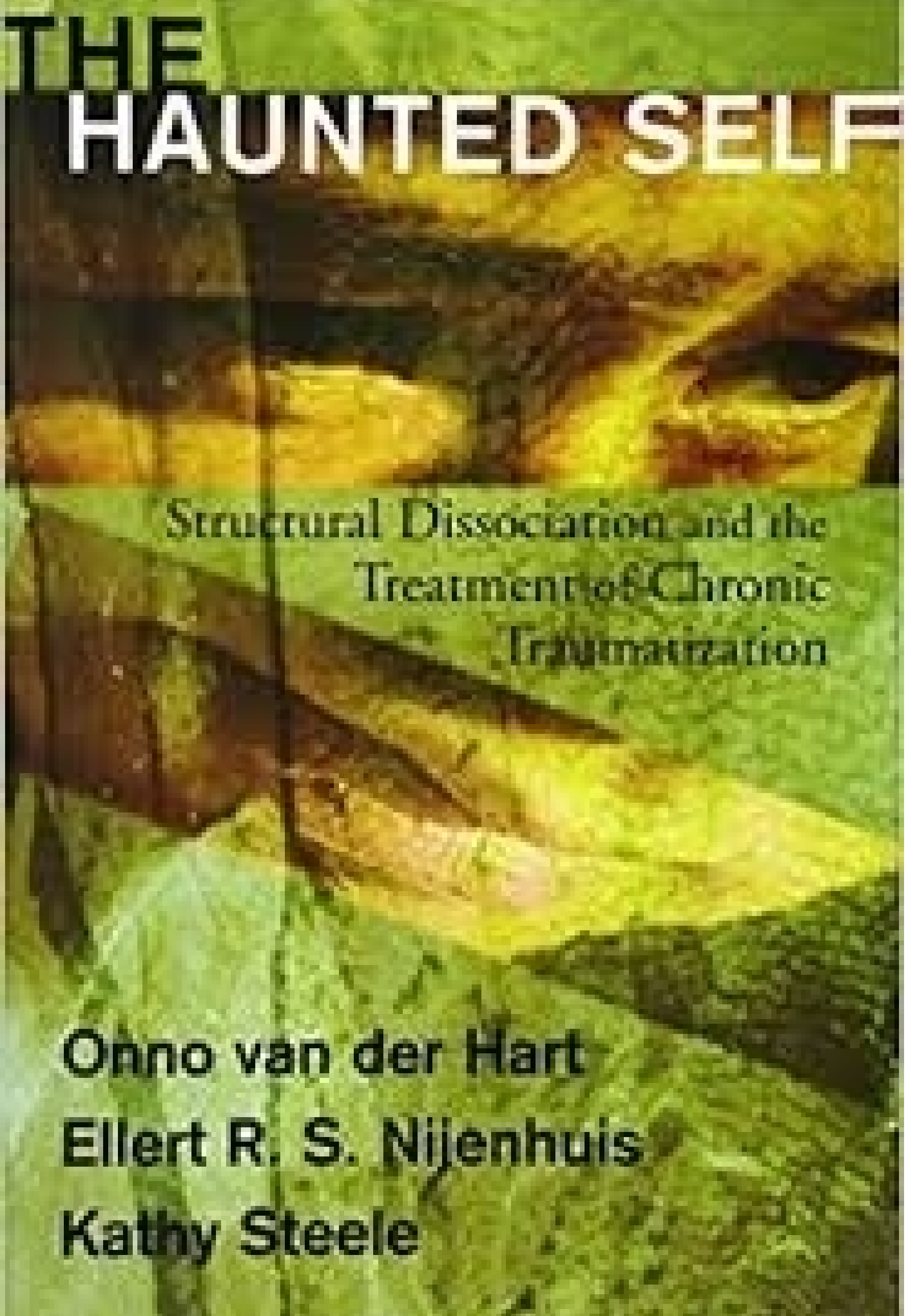
The Apparently Normal Personality (ANP)

- Focuses on normal everyday living when trauma occurs
- fixated upon actions involved in daily life,
  - e.g., caretaking, attachment, enjoyment, etc.,
- while avoiding the traumatic memories.

The Emotional Personality (EP)

- fixated on the trauma, which activates:
- action systems associated with defence, sexuality, guilt/shame and other life preserving activities
- and further subsystems involved in flight, fight or freeze

(O'Shea & Paulsen, 2007; Panksepp, 2003; Porges, 1998; van der Hart, et al., 2006).



Structural Dissociation ANP and EPs continued …

- ANPs and EPs are unduly rigid and closed off to each other.
- **ANPs**:
  - Focused on the future, the continuation of life and/or attachments.
  - Blind to trauma and to EPs associated with trauma.
- **EPs**:
  - Stuck in the past, in the moment of the trauma,
  - In the fear, pain and distress of the moment
  - A persistent need to understand or master the trauma or to complete an act of self-protection that was not completed during a trauma
  - Too preoccupied with survival to recognize or assist other EPs.

(Levine, 1997; Ogden, et al., 2006; Wylie, n.d).

Neurobiology of Dissociation

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The Origin of Domestication

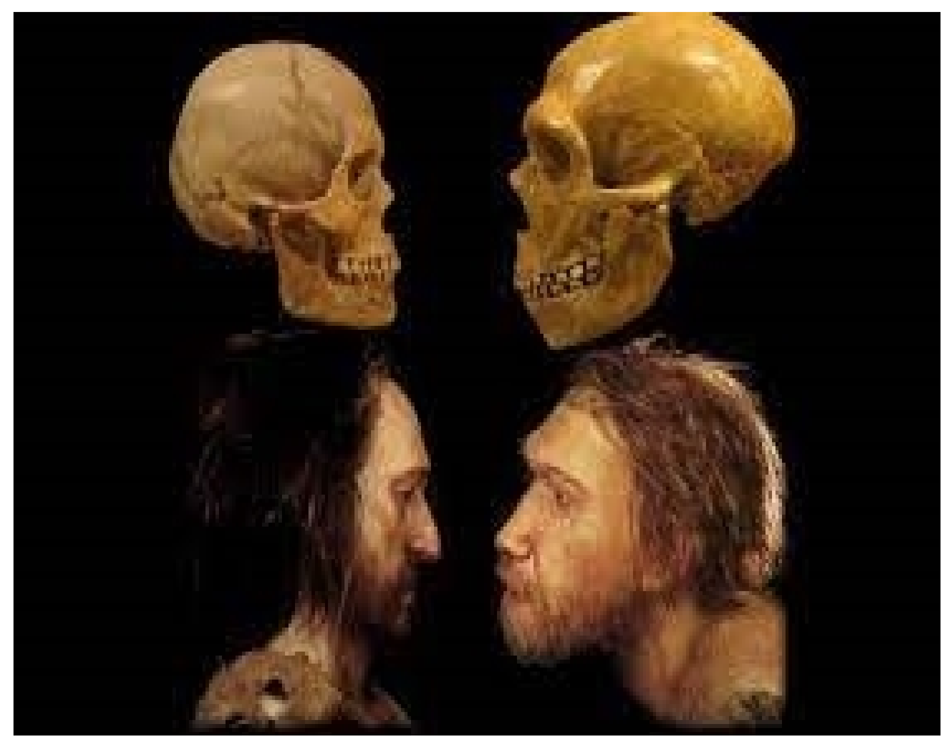
We evolved to be tame, we evolved to be cared for (domestication)

Domestication

The evidence that supports the notion of humans being the first domesticated species, meaning we prefer tame, needs meeting, safe, and secure environments, not the violent ones we are led to believe, is how many of our main characteristics and unique traits have evolved. We evolved to foster safe and secure lives (Spikins et al., 2021).

Belyaev, 1979; Bregman, 2019; Dugatkin, 2020, Godinho, Spikins, & O'Higgins; 2018; Hare, 2017

Wild

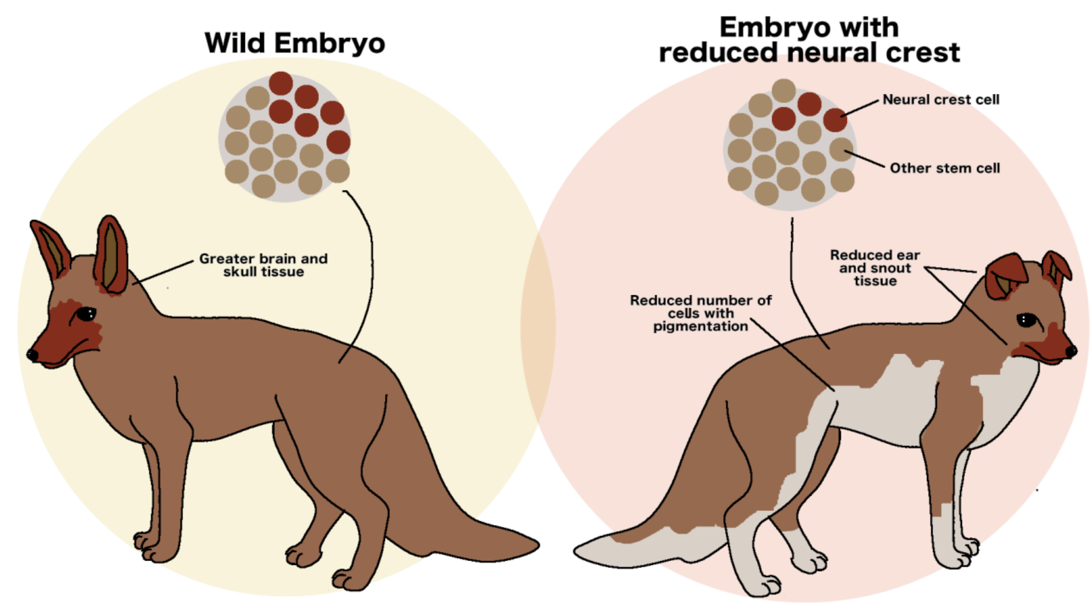


We evolved to be tame, we evolved to be cared for (domestication)

Domestication

- A tame creature is very different than a wild creature. Alpha wolf does not exist in the wild. Humans are utterly intolerant of harm and neglect. Autoimmune, mental illnesses, cancers, digestion problems, many chronic illnesses, psychopathy in all its iterations (racism, genocide, capitalism, greed, war) and human coping are all connected to detachment.
- Belyaev, 1979; Bregman, 2019; Dugatkin, 2020, Godinho, Spikins, & O'Higgins; 2018; Hare, 2017, Spikins et al., 2021

Wild



Wild vs Domestication

Wild

Domesticated

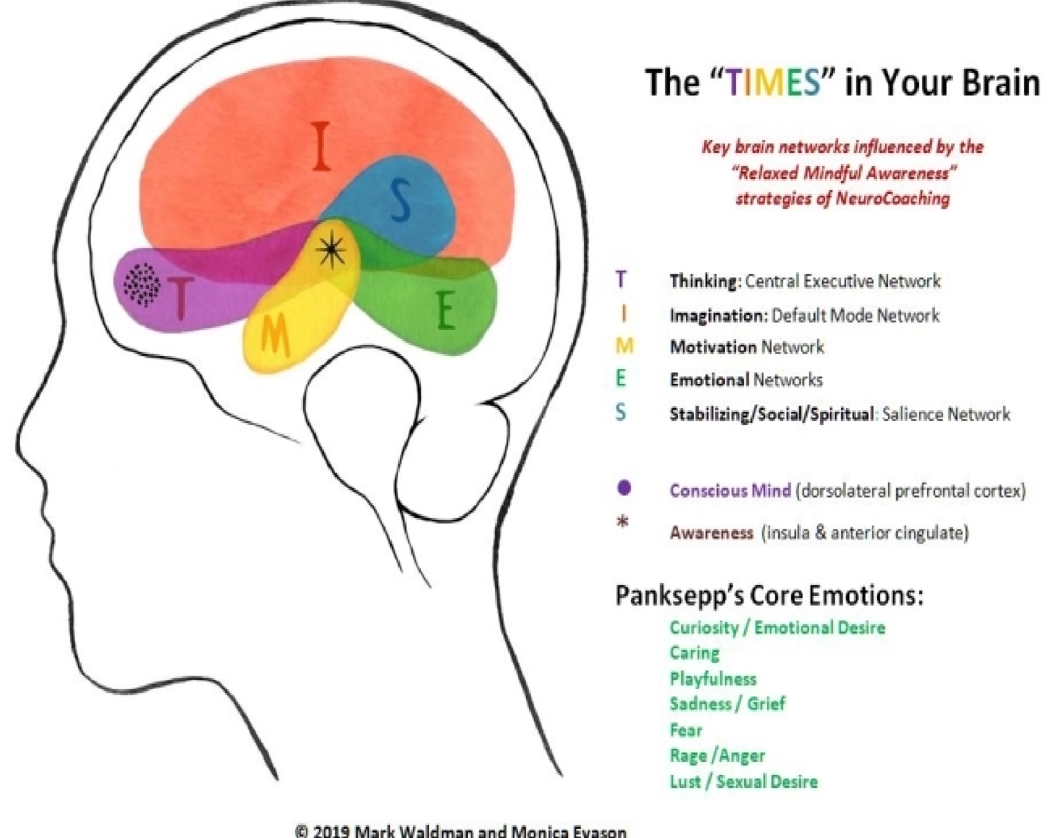
Christine C Forner ICCC 2022

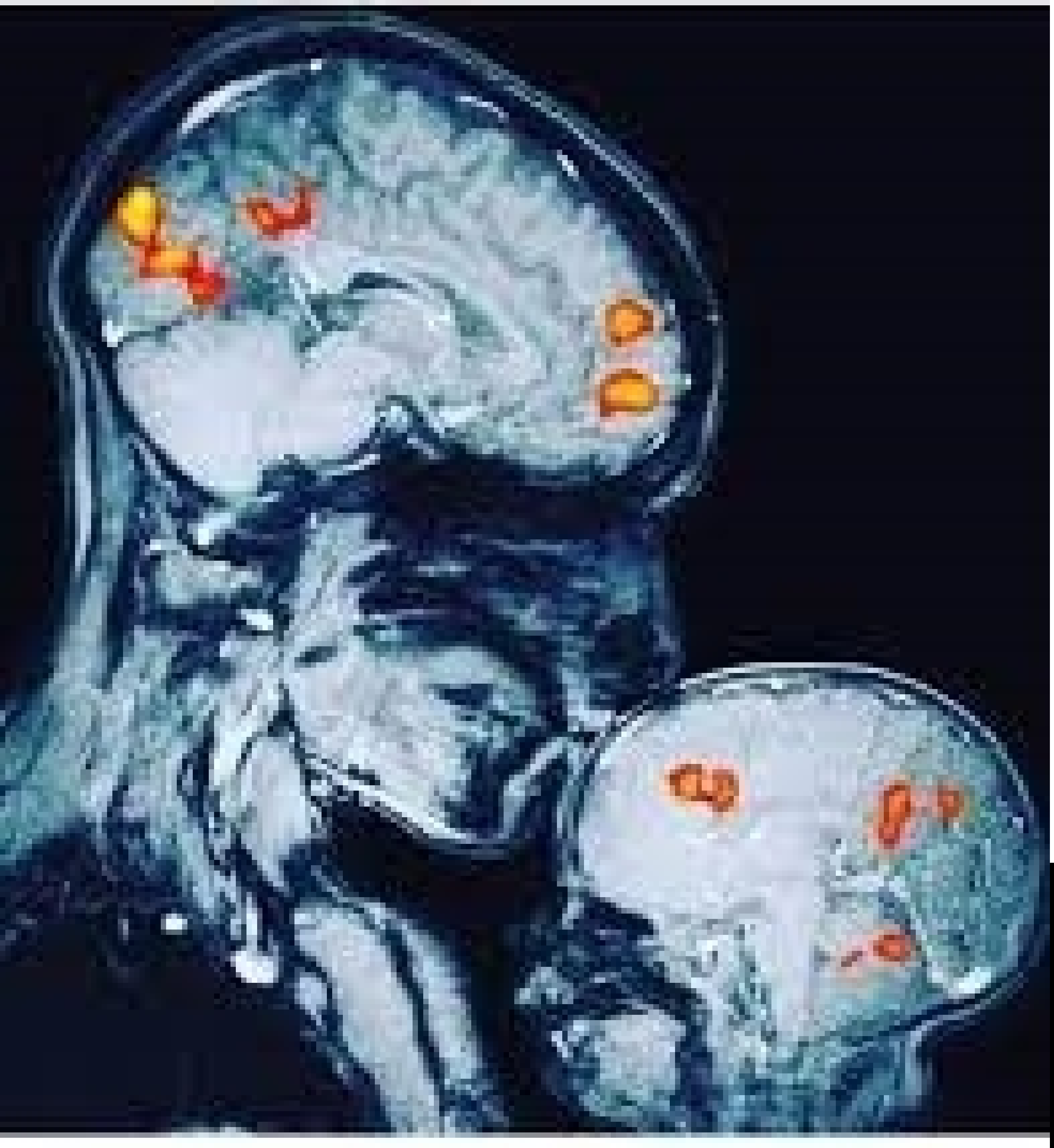
The evolution of the mindful brain

There are nine basic brain functions that are dominant in those who meditate, and in those who are securely attached (Badenoch, 2008; Marks-Tarlow, 2012; Panksepp, 1998, 2002; Perry & Szalavitz, 2010; Porges, 1998, 2003, 2011; Schore, 1994, 2003a, 2003b, 2019; Siegel, 1999, 2007, 2010; 2012, 2017).

These nine brain functions are quite remarkable, especially when you comprehend that they seem to be designed for the sole purpose of understanding, regulating, co-regulating, and gaining deep compassion via empathy and attunement to our fellow humans, (especially our very young humans).

The nine functions are as follows: (1) Body regulation, (2) Attuned communication, (3) Emotional balancing, (4) Response flexibility, (5) Empathy, (6) Insight, (7) Conditioned fear modulation, (8) Intuition, and (9) Morality (Badenoch, 2008; Forner, 2019a; Marks-Tarlow, 2012; Panksepp, 1998, 2002; Perry & Szalavitz, 2010; Porges, 1998, 2003, 2011; Schore, 1994, 2003a, 2003b; Siegel, 1999, 2007, 2010; 2012; Siegel & Bryson, 2007; pp. 42–44; 2011).





The evolution of the mindful brain

These nine brain functions are the key to understanding the connection between mindfulness and secure attachment that create a secureful state. Notably, these nine brain functions and the structure that create them cannot grow well, or at all, when we are alone and/or when we are frightened or unsafe.

These structures become overdeveloped, underdeveloped, or fully atrophied when a human being goes into a state of active or inactive defense (Lebois, et al., 2021; Lanius, 2015; Lanius, Lanius, Fisher, & Ogden, 2006; Lanius, et al., 2018).

These structures function very well when we are safe and they do not function well or at all when we are scared, experiencing threat and when we are in real or perceived danger.

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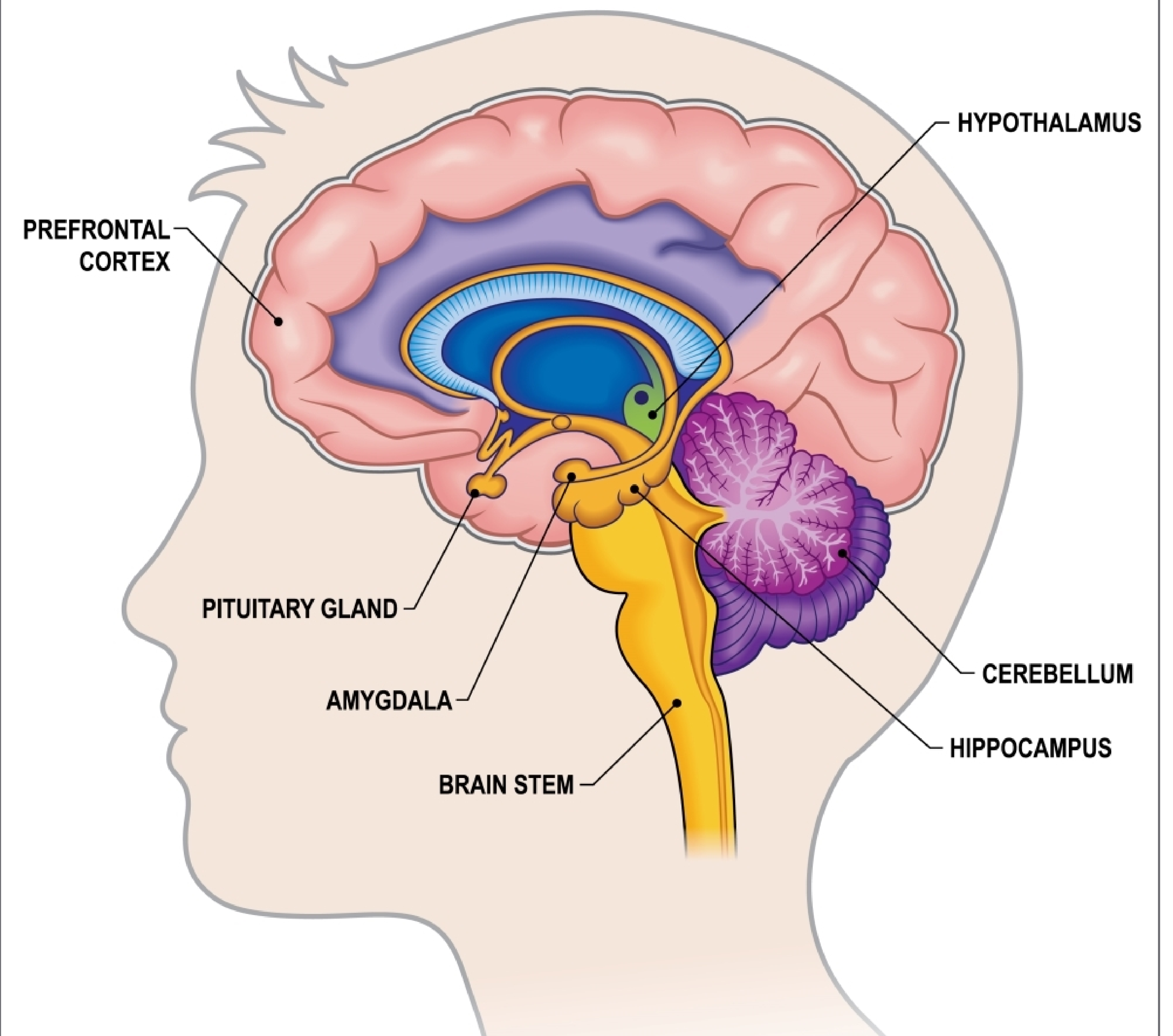

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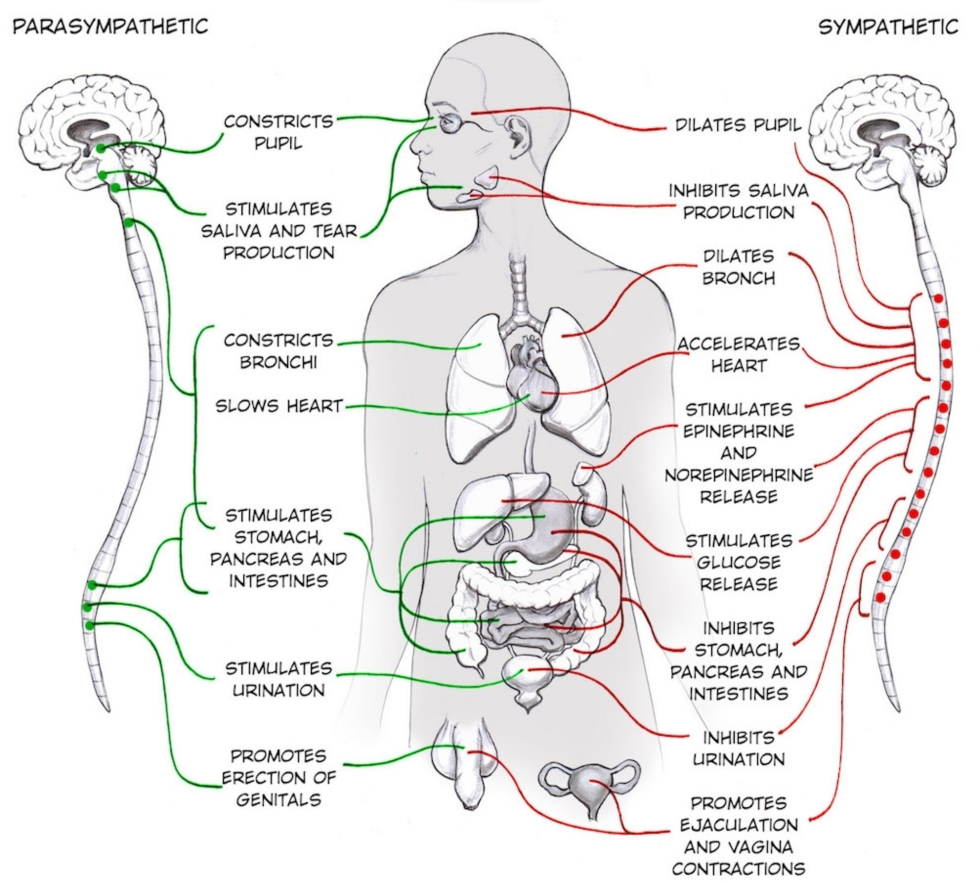

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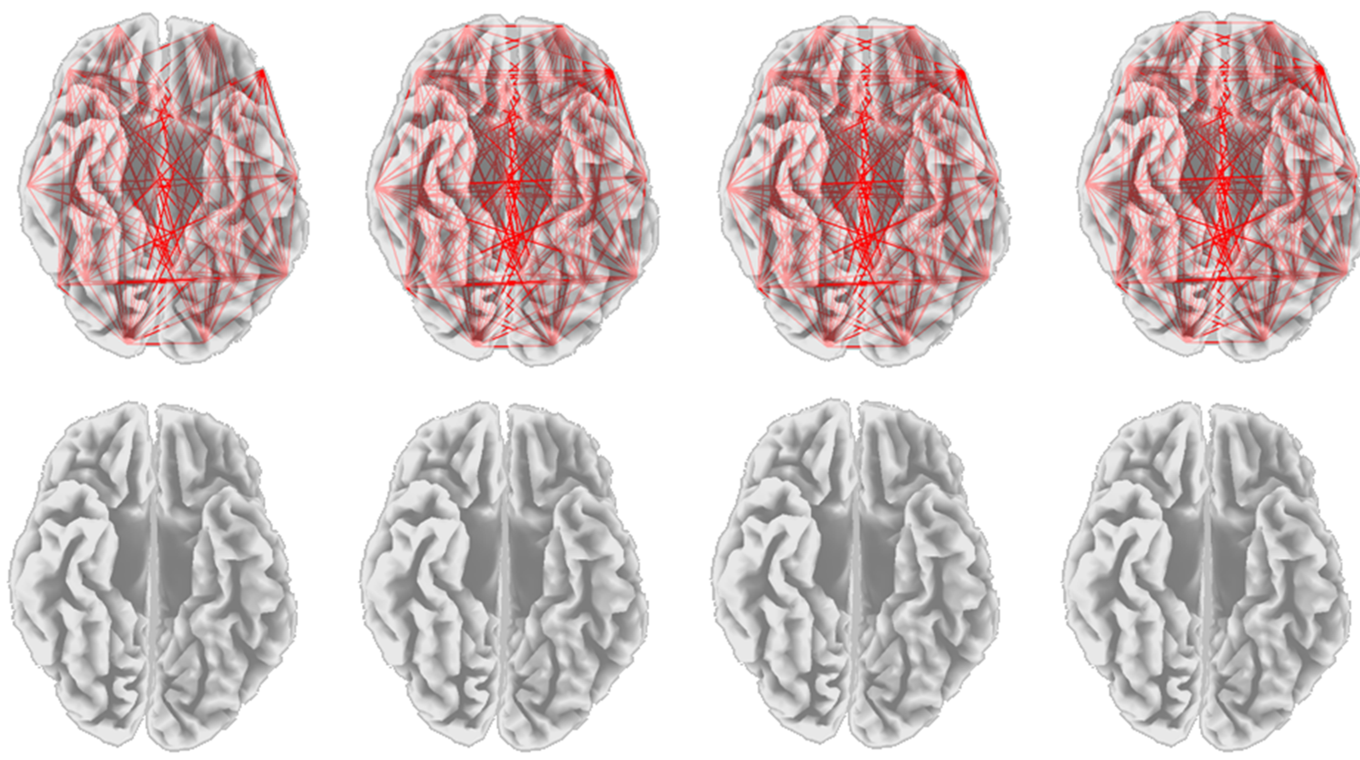

Farina, B., Speranza, A.M., Dittoni, 2014

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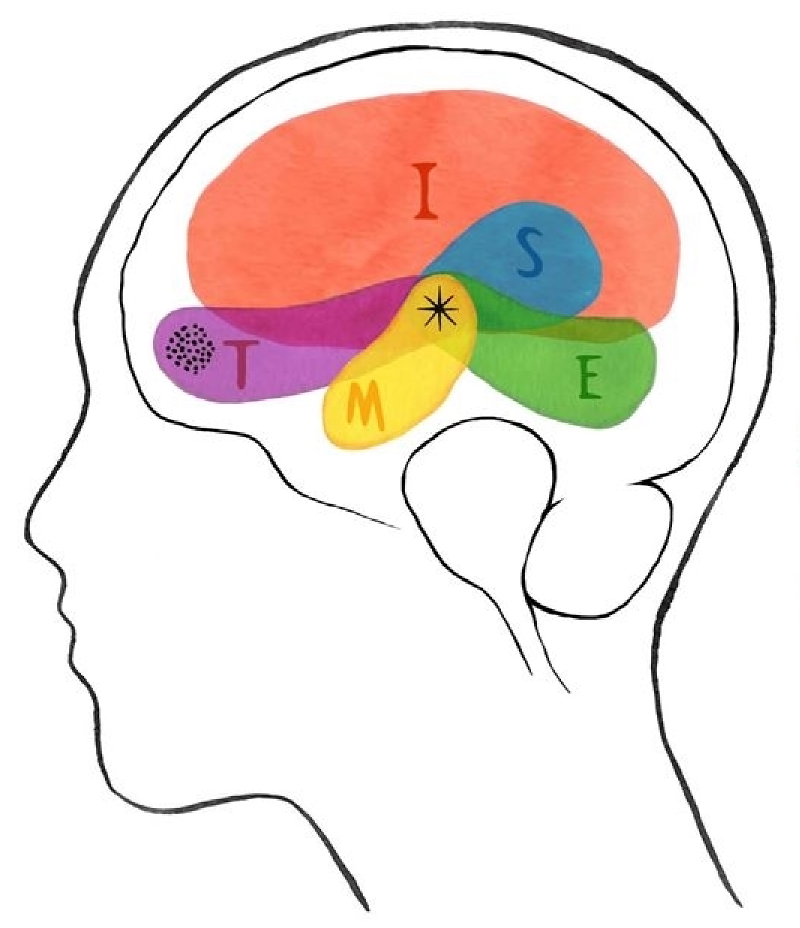
The Brain Stem, Amygdala and Thalamus…Oh My (and the periaqueductal grey)

- Predation
- It has been estimated that the equivalent of 8 mg of morphine gets released when we move into the flight/flee/freeze system (van der Kolk, McFarlane, and Weisaeth, 1996)
- A specific choreography for flight, fight, and freeze
- Each defense has its strengths
- Vesuna, S., Kauvar, I.V., Richman, E. *et al.* Deep posteromedial cortical rhythm in dissociation. *Nature* **586,** 87–94 (2020). https://doi.org/10.1038/s41586-020-2731-9
- Lebois LAM, Li M, Baker JT, et al.: Large-scale functional brain network architecture changes associated with trauma-related dissociation. **Am J Psychiatry** 2021; 178:165–173
- https://doi.org/10.1176/appi.ajp.2020.20121728https://doi.org/10.1176/appi.ajp.2020.20121728



The "TIMES" in Your Brain

Key brain networks influenced by the "Relaxed Mindful Awareness" strategies of NeuroCoaching

- T **Thinking**: Central Executive Network
- I **Imagination**: Default Mode Network
- M **Motivation** Network
- E **Emotional** Networks
- S **Stabilizing/Social/Spiritual**: Salience Network

- ● **Conscious Mind** (dorsolateral prefrontal cortex)
- * **Awareness** (insula & anterior cingulate)

Panksepp's Core Emotions:

- Curiosity / Emotional Desire
- Caring
- Playfulness
- Sadness / Grief
- Fear
- Rage /Anger
- Lust / Sexual Desire

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Stop Feeling, stop knowing

Christine Forner & Mary Anne Kate ISSTD 2023

ARTICLE

Check for updates

Deconstructing dissociation: a triple network model of trauma-related dissociation and its subtypes

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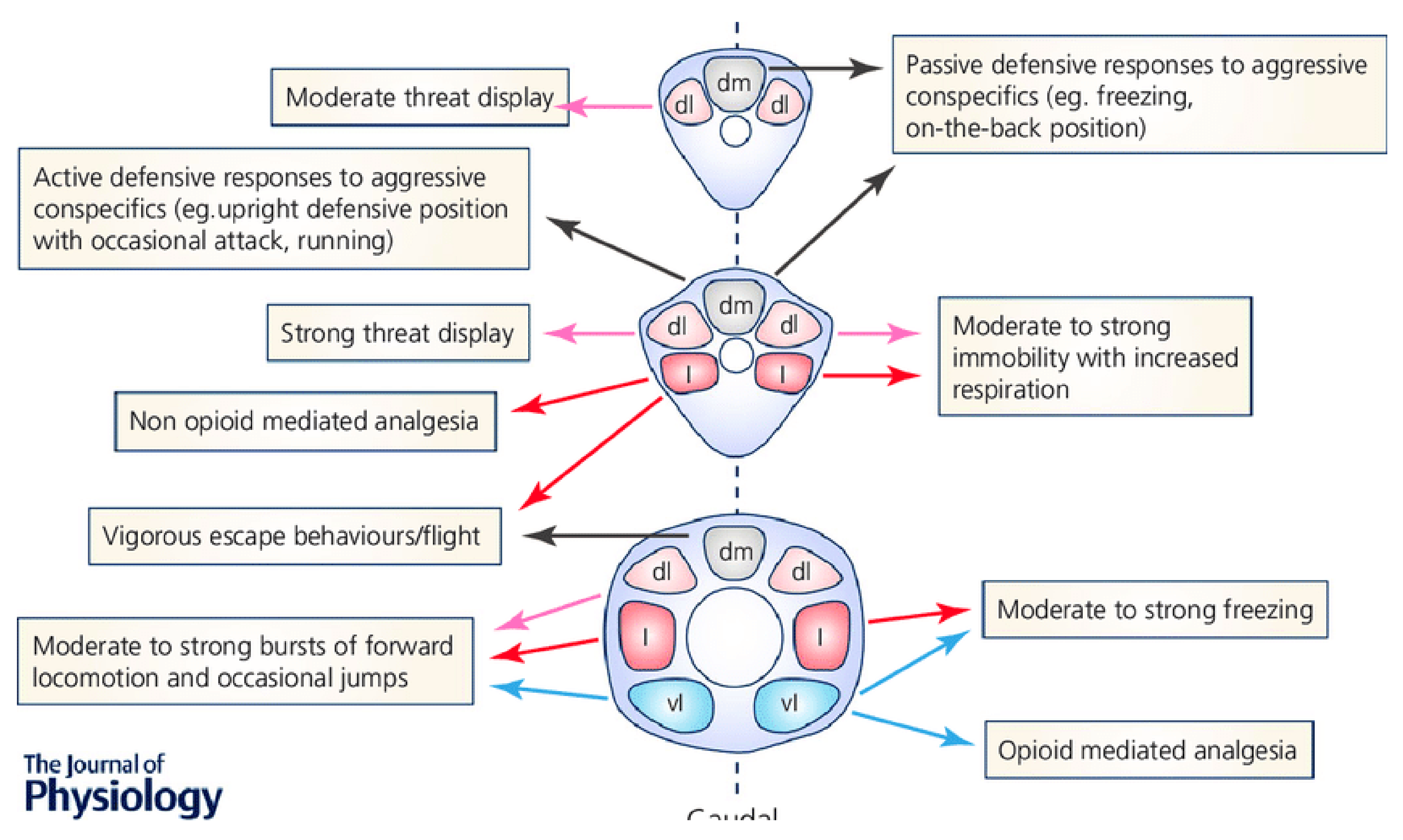
Trauma-related pathological dissociation is characterized by disruptions in one's sense of self, perceptual, and affective experience. Dissociation and its trauma-related antecedents disproportionately impact women. However, despite the gender-related prevalence and high individual and societal costs, dissociation remains widely underappreciated in clinical practice. Moreover, dissociation lacks a synthesized neurobiological model across its subtypes. Leveraging the Triple Network Model of psychopathology, we sought to parse heterogeneity in dissociative experience by examining functional connectivity of three core neurocognitive networks as related to: (1) the dimensional dissociation subtypes of depersonalization/derealization and partially-dissociated intrusions; and, (2) the diagnostic category of dissociative identity disorder (DID). Participants were 91 women with and without: a history of childhood trauma, current posttraumatic stress disorder (PTSD), and varied levels of dissociation. Participants provided clinical data about dissociation, PTSD symptoms, childhood maltreatment history, and completed a resting-state functional magnetic resonance imaging scan. We used a novel statistical approach to assess both overlapping and unique contributions of dissociation subtypes. Covarying for age, childhood maltreatment and PTSD severity, we found dissociation was linked to hyperconnectivity within central executive (CEN), default (DN), and salience networks (SN), and decreased connectivity of CEN and SN with other areas. Moreover, we isolated unique connectivity markers associated with depersonalization/derealization in CEN and DN, to partially-dissociated intrusions in CEN, and to DID in CEN. This suggests dissociation subtypes have robust functional connectivity signatures that may serve as targets for PTSD/DID treatment engagement. Our findings underscore



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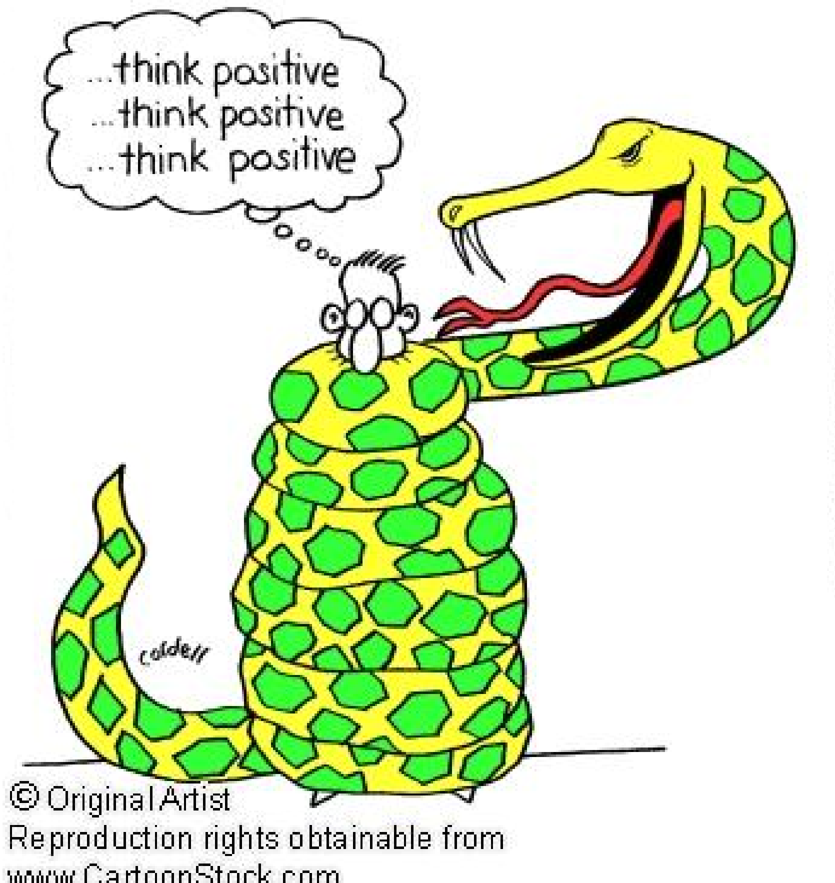
Neuro Researchers to follow

Dr. Simone Reinders

Dr. Ruth Lanius, Dr. Ulrich Lanius, Dr. Paul Frewen

Dr. Melissa Kaufman and Dr. Lauren Lebois



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Conceptualizing dissociation

Thirst

The Land of the Dying and the Land of the Dead

Predation

- As a child, as an individual, as a group

Dissociation only has one concern, to not die – it cares not about the expression of life.

The pain of being alone

Humans are junk food of the African Savanna

The oddity of mindfulness and dissociation (sitting still/being eaten)

The pain of shame and a child's limited capacity to comprehend the source of the feeling

Attachment and neurobiology in dissociation

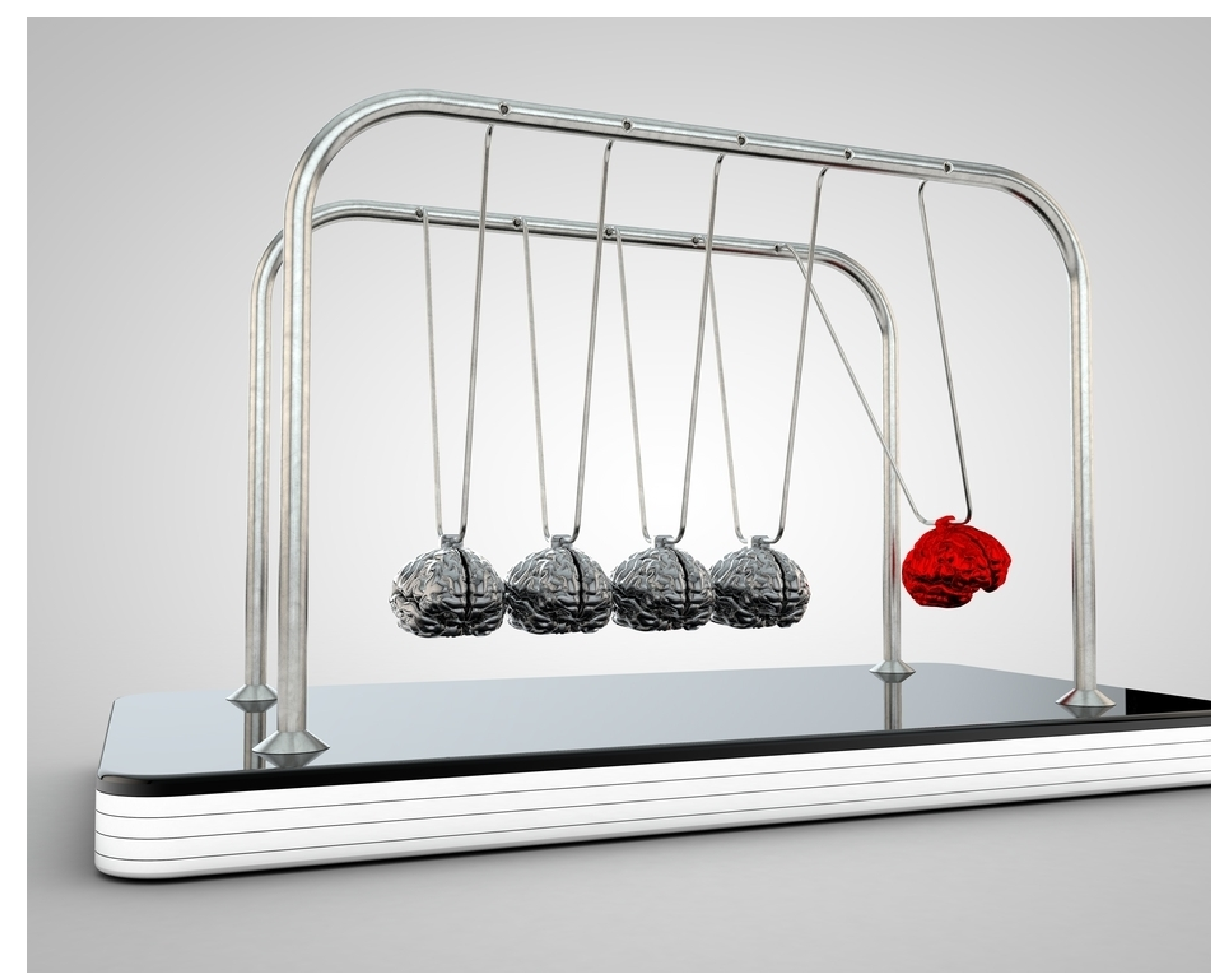
- Regulation and Attunement
- Right brain to right brain (A. Schore & D. Siegel)
- Disorganized attachment style is as much as a predictor of dissociation as trauma (K. Lyons-Ruth)
- Sense of self
- Identity
- Camille Guérin-Marion, Sage Sezlik & Jean-François Bureau (2020) Developmental and attachment-based perspectives on dissociation: beyond the effects of maltreatment, European Journal of Psychotraumatology, 11:1, 1802908, DOI: 10.1080/20008198.2020.1802908
- Byun, S., Brumariu, L., Lyons-Ruth, K. Disorganized attachment in young adulthood as partial mediator of relations between severity of childhood abuse and dissociation Journal of Trauma and Dissociation, 2016, 17(4), 460-479.

More Connecting

- Poly-Vagal Theory
- Attachment Theory
- Mindfulness
- Field of Neuroscience
- MID

The need of an "other"

- We need the constant presence of an "other" to develop our identity, within ourselves and as part of a group, to help us grow our mPFC. This knowledge of the self, the knowledge that we are indeed human, makes us unique and is also one of the two driving forces within us. As far as we know, no other animal on the planet is as relational and self-aware to the same extent as humans. No other animal that we know of, knows that they exist, to the extent that we do. Cheetahs, as far as we know, do not wake up and wonder, "Am I a good enough cheetah". We humans wonder this all the time, "Am I a good enough human". The point of this comparison is not a debate about our superiority as a species, it is about the sensitivity we have in our social-relational experiences (Schore, 1994, 2003a, 2003b).



Newton’s Third Law

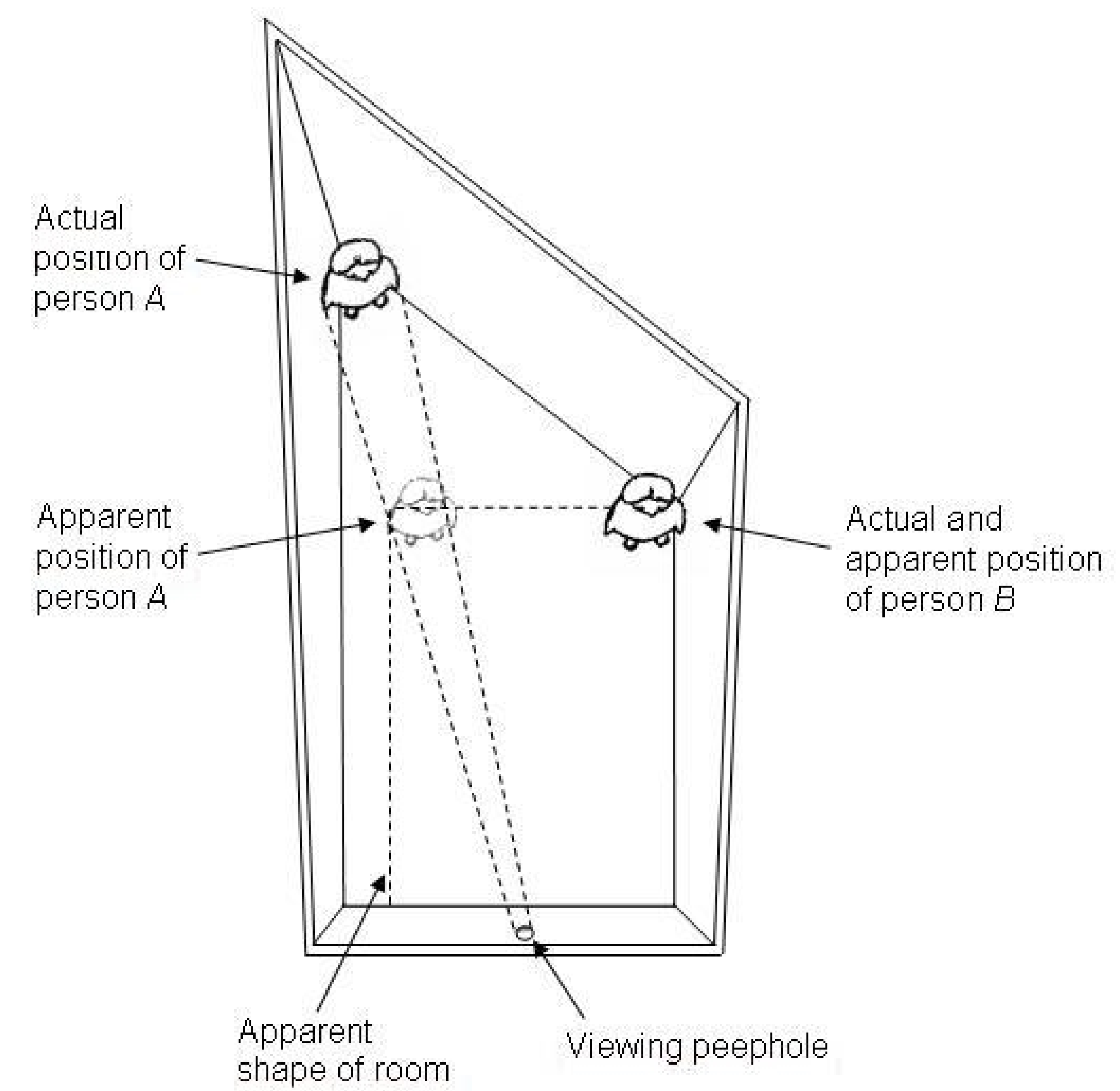
For every action, there is an equal and opposite reaction

(Sanders, Lacy, Scheffer & Sosnowski, 2004).

Ames Room

Everything that we have seen in our physical world affects how we first view this room. The same principles can be applied to those who come from child adverse experiences. The adversity in childhood influence everything from that moment forward

(Forner, 2017).



Treatment

Evidenced-based therapies

These are the most tortured humans

This is not genetic, in the same way that genetics and brain behaviour is understood

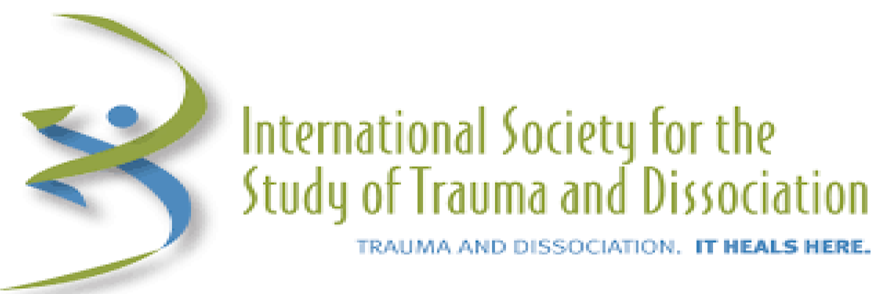
This not a chemical imbalance as commonly understood

This is PTSD on steroids. This is 100% environmental and would not happen if children were kept safe.

This is an inactive defence. This is directed by the CNS

These humans are treated the worst wherever they go

Case examples that show every single system of DID is affected



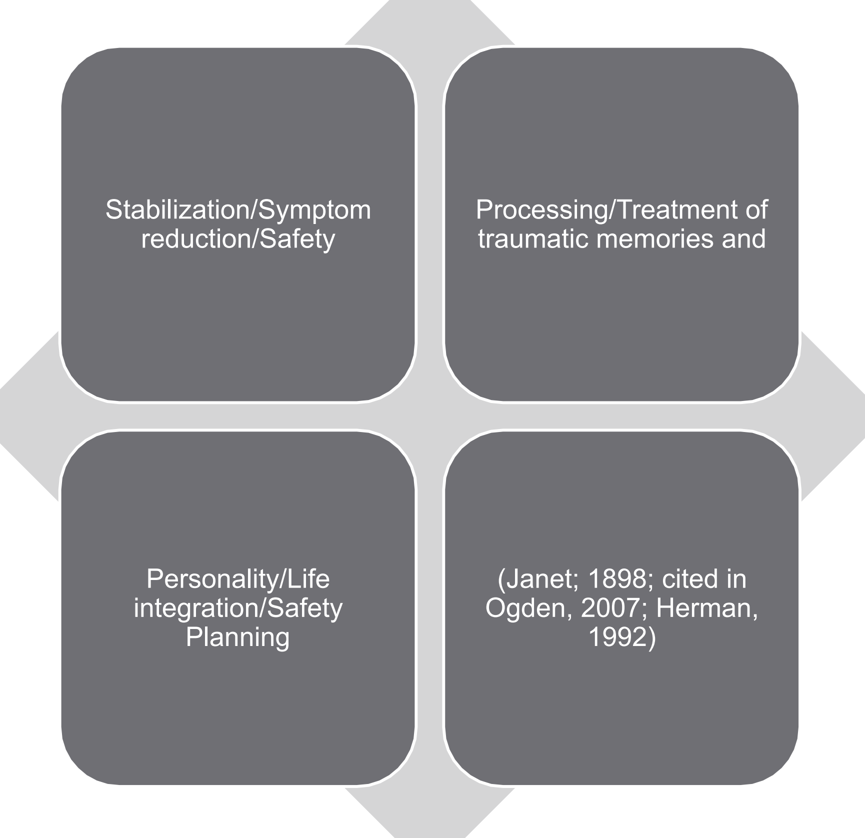
Treatment guidelines

Guidelines for Treating Dissociative Identity Disorder in Adults (2011)

Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents (2004)

https://youtu.be/E2QtK9uRohU

Tri-phasic treatment model



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Phase Oriented Treatment Plan Stage 1

- Establishing a therapeutic alliance, safety, stabilization and symptom reduction
    - (Chu, 1998; Chu, et al., 2005; Dolan, 1991; Haddock, 2001; Herman, 1992; Putnam, 1997; Ross, 1997).
  - Age/developmentally-appropriate psychoeducation for client and caregivers
  - Create an environment of trust
  - see the DD/DID client as a whole person with the alternative identities "sharing" responsibility for the current situation
- Phase 1 is unpredictably long, returning to it now and then is common; higher levels of care may be needed now and then to ensure safety.
- Carers are not the bucket

This stuff hurts

The pain of these injuries

The lack of emotional regulation skill

Emotions are made (Lisa Feldman Barrett)

Mindfulness Article

Stage 1 Interventions

- Adults
  - psychoeducation
  - stabilization
  - grounding
  - affect and body regulation
  - imagery
  - safety
  - attunement
  - reduction of
    - self-harm
    - Addictions
    - unsafe relationships

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Phase-Oriented Treatment Plan Stage 2

- Working directly, and in-depth, with traumatic memories.
- Within this stage, the alters are encouraged (with the assistance of the therapist) to review and come to terms with the abuse within their past.
  - (Chu, 1998; 2005; Dolan, 1991; Haddock, 2001; Herman, 1992; Kluft, 2003; Putnam, 1997; Ross, 1997).

Stage 2 Interventions

Adults

- Processing traumatic material (dual processing), hypnosis, EMDR, SMP, psychodynamic, neurofeedback

Children/Adolescents

- Exposure interventions, as above, that also involve the non-offending caregiver
- May involve therapeutic play, art, narrative or other expressive modalities

Phase-Oriented Treatment Plan Stage 3

- Focus
  - identity integration or
  - alliance and rehabilitation.
- This entails encouraging the client to move toward better integrated functioning
  - (Chu, 1998; 2005; Dolan, 1991; Haddock, 2001; Herman, 1992; Kluft, 2003; Putnam, 1997; Ross, 1997).

Stage 3 Interventions

- Adults
  - Regulation
- Children/Adolescents
  - Continued development to continue with more integrated functioning
  - Psychoeducation focused on:
    - Risk reduction
    - Personal safety skills
    - Increasing awareness
    - External and internal
    - Assertive communication

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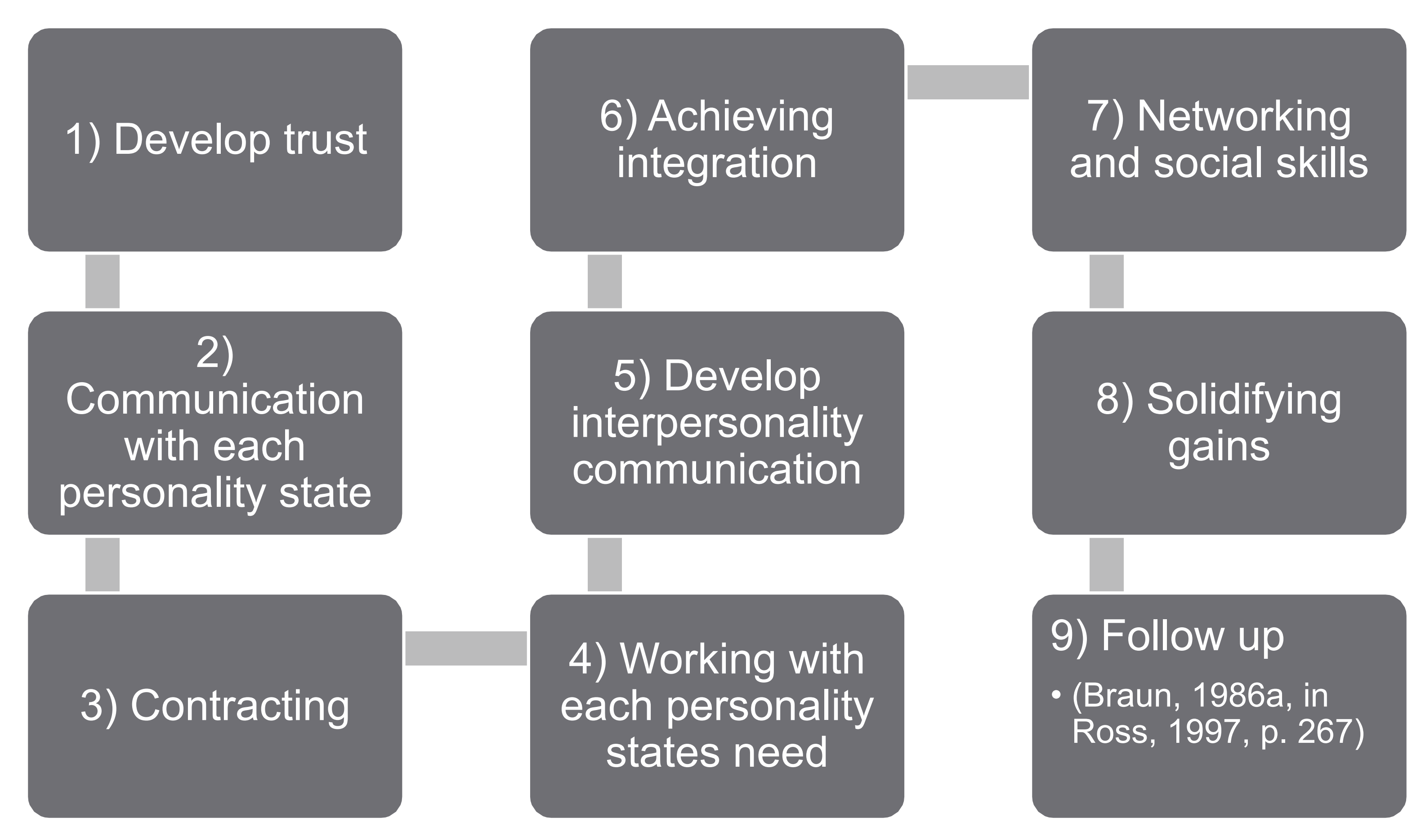
Some Common Interventions Applied to Stages 1, 2 & 3

- Ego State Therapy
- Hypnotherapy
- Psychoanalysis
- Psychodynamic therapy
- Family Systems therapy
- EMDR
- Sensorimotor Psychotherapy

Treatment—This can be integrated into most treatments



Phase-Oriented Treatment Plan — the End Goal

- Strategical integrationalist therapies
  - stem from the psychoanalytic tradition
  - emphasize the flow of the therapeutic process over a wide range of techniques with the goal of integrating the personalities (e.g., Ego State therapy)
- Tactical integrationalist therapies
  - techniques and specific interventions to attain a series of goals and objectives that ultimately proceed towards integration (e.g. hypnosis)
- Personality-oriented treatments
  - to improve the functioning of the alter system until the patient becomes asymptomatic.
  - aim for good resolution; integration is optional
- Adaptationalist approach
  - Prioritizes here-and-now functioning.
  - integration or resolution is secondary, and might not be addressed.
- Minimization
  - attempts to eliminate DID by not reinforcing the alters (this method seems to be the least effective).
- All of the above approached might be useful from time to time, with the exclusion of the minimization approach
  - (Kluft, 2003, p. 81).

Phase Oriented Treatment Plan —End Goal Cont'd

- Richard Kluft's goals (as per Colin Ross, 1997)
  - 1) The treatment goal is integration
  - 2) Help each alter personality to understand that she is one part of a whole person
  - 3) Use the alters' names as convenient labels, not for license for irresponsible autonomy
  - 4) Treat all alters fairly and empathetically
  - 5) Encourage empathy and cooperation between the personalities
  - 6) Be gentle and supportive, remember the severity of the trauma
  - 7) Stay within the limits of your competence
  - 8) Use hypnosis judiciously
  - 9) Do not dramatize symptoms such as amnesia

Treatment outcomes

DDs improves significantly with tri-phasic, trauma-focused psychotherapy that is consistent with the treatment guidelines of the International Society for the Study of Trauma and Dissociation (ISSTD, 2013).

An international study that collects data from 230 DID patients and 50 patients with DDNOS / OOSD and their treating clinicians has found that patient and clinician reports indicate that over 30 months of treatment patients showed decreases in dissociative, posttraumatic, and depressive symptomatology, as well as decreases in hospitalizations, self-harm, drug use, and physical pain. Clinicians reported that patient functioning increased significantly over time, as did their social, volunteer, and academic involvement (Brand et al., 2013).

A meta-analysis of eight treatment outcome studies for any DD and earlier case series and inpatient treatment studies demonstrate that treatment for DID leads to improvements across a wide range of clinical outcome measures (Brand et al., 2016).

They need our care

- They need time in safe place
- They need to be protected
- They need Compassion
- They need Empathy
- They need us to help them regulate to get out of fear
- They need us to show them that the world can be safe

Clinical Support

- ISSTDWorld
- Members range from the world's expert on Dissociative Disorders Dr Richard Kluft MD, to clinicians working with their very first dissociative client.
- Moderator - Richard A. Chefetz, M.D. r.a.chefetz@psychsense.net