CAROLYN SPRING
reversing adversity

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PowerPoint handouts

Dissociation and DID: The Fundamentals

online training

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- I developed dissociative identity disorder (DID) as a result of chronic, extreme childhood abuse
- I was mostly amnesic for my trauma
- Dissociation protects us from overwhelming trauma
- It says, 'Nothing bad ever happened to **me**' so that we can continue with normal life

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- My life was going well until a catastrophic breakdown in 2005
- Two ways of viewing that breakdown:
  - My dissociative barriers were overwhelmed by triggers
  - OR ... my brain sensed it was the right time to heal

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- I thought I had 'gone mad'
- My trauma was so dissociated that my symptoms didn't appear to be connected to it
- I started 'losing time'
- States of intense distress, including suicidal ideation and self-harm

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- I hid what was going on out of shame and fear
- I didn't realise that my symptoms were 'normal' after trauma
- DID is a brilliant survival strategy but it comes at a price
- 'Trauma-informed' approaches are key
- 'Recovery' is a long-term challenge
- Began to help others

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- The 'myth of specialness'
- Recovery from trauma is not about just 'getting over something'
- Recovery involves building resilience, so that you can cope with whatever life throws at you
- We have already survived the worst
- That change of perspective is fundamental

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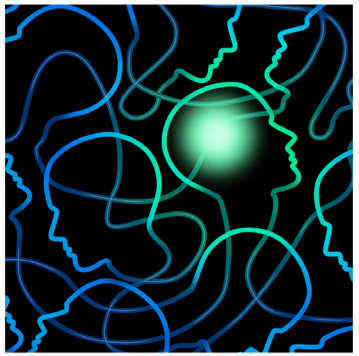
- Dissociative survivors are heroes, not 'mentally ill'
- Interpersonal neurobiology = our brains function in a community of other brains
- We need support to become, and grow into, the resourceful people we already are
- Recovery is brutal – but worthwhile



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- Our brains adapted to cope with awful treatment
- 'How trauma traumatises us …'
- Dissociation is a normal, natural, automatic response to trauma
- It is the way our brain responds and adapts to things it shouldn't have to deal with
- Our brains are plastic – they can re-adapt

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- Pathological dissociation represents a self-reinforcing feedback loop around threat
- The perception of threat keeps the smoke alarm sounding
- We need to be able to feel safe
- We need to resolve the phobia of what is behind our dissociative barriers

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What does the word 'dissociation' mean to you? Does it have a variety of meanings?

What is the purpose and function of dissociation? What would someone do if dissociation didn't 'exist'?

What is 'trauma'? A 'bad' or 'distressing' event? Or what?

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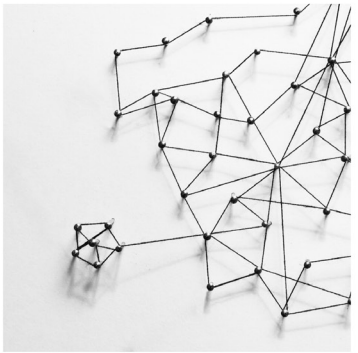
- Dissociation or disassociation?
  - **Sociare** – to join, unite (Latin)
  - **A-ssociate** – to make a connection
  - **Dis-a-ssociate** – to break that connection
  - **Dis-sociate** – to fail to make the connection in the first place
- Dissociation happens at a pre-conscious level



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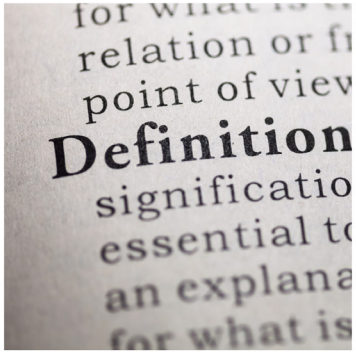
- Multiple meanings of dissociation:
  - Hypoaroused state
  - Switch of personality state
  - Depersonalisation and derealisation (peri-traumatic)



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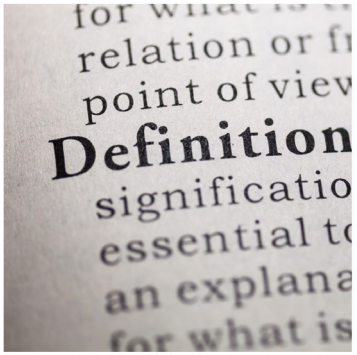
- Multiple meanings of dissociation:
  - Having a dissociative disorder
  - Lack of connections between aspects of experience
  - Traumatic amnesia



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- Dissociation can be understood from various perspectives:
  - At a neurobiological level
  - As a disorder in diagnostic manuals
  - Personal, subjective experience
- It involves a shift in perception
- Therefore, personal/subjective descriptions may not be objectively accurate

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- Dissociation is an entirely normal response to trauma
- It is what the brain is **supposed** to do when its coping capacities are exceeded
- Trauma also has multiple meanings
  - Greek 'trauma' = 'wound'
  - Popular culture: 'trauma' = 'very'

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- Bessel van der Kolk: 'an inescapably stressful event that overwhelms people's existing coping mechanisms'
- Life-threatening powerlessness
- Outside our 'window of tolerance'

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- Trauma elicits a different type of neurobiological response to other events (even distressing ones)
- It renders us powerless; helpless

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- After trauma, the brain changes to deal with future similar events:
  - Hypervigilance for threats
  - Earlier-sounding alarm
  - Body maintained on alert **or** switched off in submission
  - Avoidance of similar threats

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- Being traumatised involves these fundamental body-brain changes, not just being 'upset'
- These changes are automatic and unconscious

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What might 'hypervigilance for threat' look like in practice?

If dissociation is normal and natural as a response to trauma, why do you think it's medically seen as a disorder?

What are the pros and cons of avoiding reminders of trauma?

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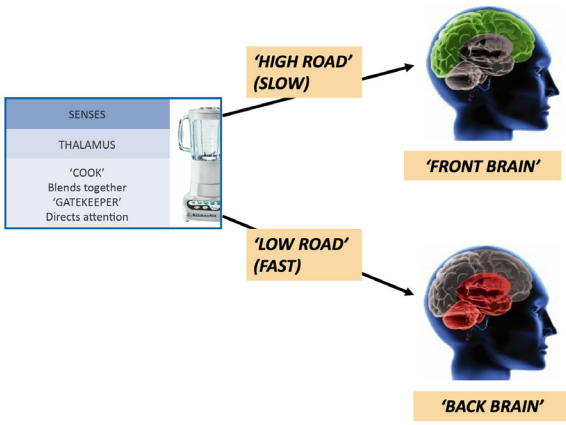
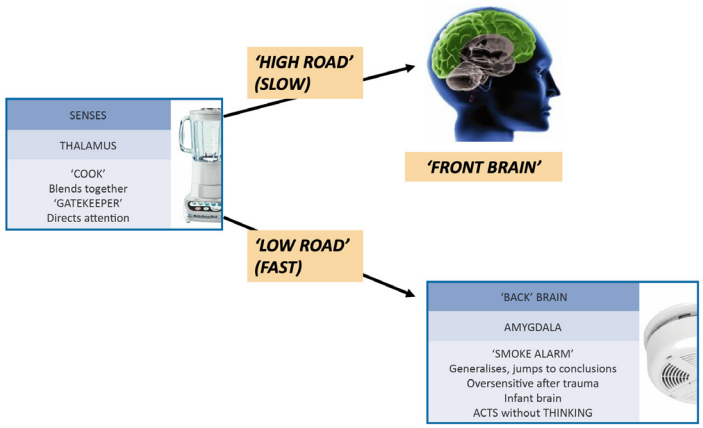
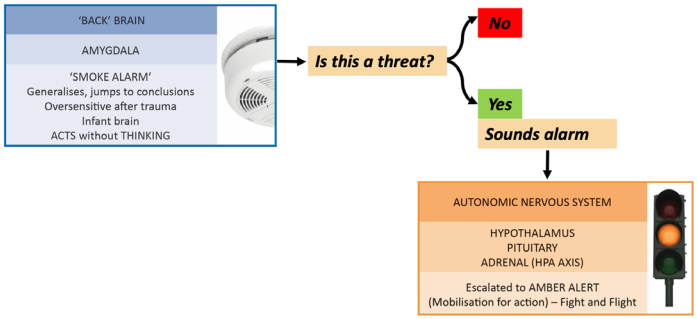
- We are less likely to be traumatised if we are able to respond to the threat actively
- Increased trauma with increased helplessness
- Greatest trauma when the perpetrator is an attachment figure

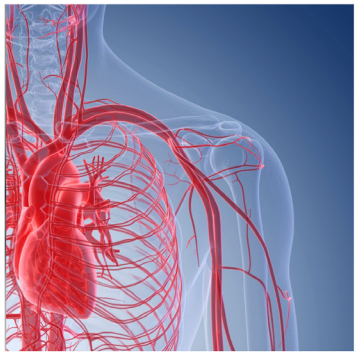






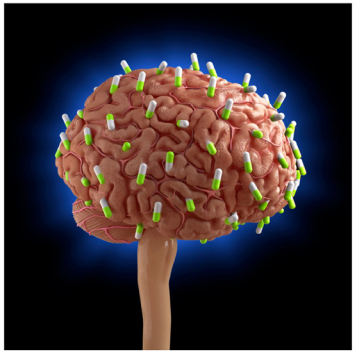
- 'Trauma traffic light'
  - Green = safe
  - Amber = danger, fight/flight
  - Red = overwhelmed, freeze

- In amber, we gear up for action:
  - Heart rate, blood pressure and breathing increase
  - Energy diverted
  - Brain on super-alert
  - Pupils dilate (better vision)



- If action doesn't work, we try inaction
- Red alert state of freeze
- Mediated by the parasympathetic nervous system
- We go still, submit, play dead
- Best attempt to survive when all else fails
- After repeated trauma, the brain goes straight to red (no amber)

- Neurobiological benefits:
  - Endogenous opioids = 'homemade heroin'
  - Numb pain
  - Alter our perception
  - 'Derealisation' and 'depersonalisation'
  - Out-of-body experience
  - Paralysis
  - Sense of unreality



- Red alert response of freeze = dissociation
- 'The freeze response is to the body what dissociation is to the mind' (Ellert Nijenhuis)
- A way of physically and psychologically surviving

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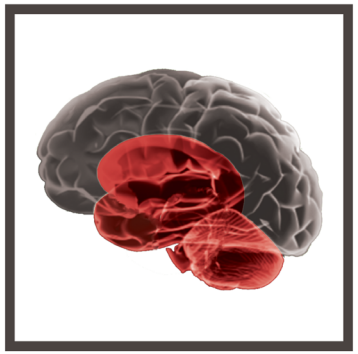
- Dissociation leads to various disconnections:
  - Front brain off, back brain on
  - Explicit memory off, implicit memory on
  - Observer self -v- traumatised self
  - Broca's area and left brain off, emotional wordless right brain on
  - DLPFC (timekeeper) off – past/present/future unlinked



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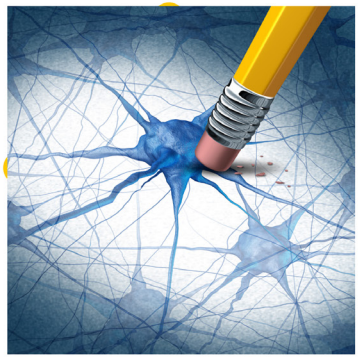
- Dissociation is a 'disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' (APA, 1994)
- Triggers encourage us to avoid anything resembling the trauma
- Dissociation becomes our go-to survival strategy for any level of danger



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When you have experienced a sudden threat or shock, what has the amber 'fight or flight' response in your body felt like?

Have you ever experienced the red zone of freeze or dissociation? What was it like?

In what ways do you or your client try to avoid the trauma ever happening again, by avoiding reminders or triggers of the event?

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- Dissociation is a natural, automatic response to trauma (life-threatening powerlessness)
- How that manifests will be unique to each individual
- Our brains adapt to the unique threats we face

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- 'Standard middle-class upbringing'
- Growing up I was amnesic for / unaware of my trauma
- No overt signs of my abuse
- 'Do not tell' = fear of it being found out
- Secrecy and silence support and drive the dissociation
- Some covert signs

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- Mini-breakdown at University
- Temporary collapse of dissociative barriers
- Preceded by a visit to a relatives' farm, where I'd been abused
- Paradox: loved the farm, hated the farm
- Through working with abused children, I was 're-enacting' my trauma history unconsciously

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- Different parts of the personality began manifesting in my personal life
- Tried to suppress this during therapy
- Loss of usual grounding strategies reduced my ability to prevent switching
- Some parts came with names; others with roles

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- Some parts appeared developmentally younger
- Some with different gender
- Sudden shifts – disorienting
- 'Overwhelming suffering in the room'
- Gradual building of trust between my parts and my therapist
- Modelling awareness and acceptance

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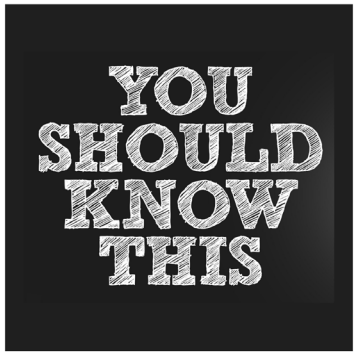
- Initial resistance to acknowledging parts
- Knowing what you're not supposed to know feels counterintuitive
- My self-alienation was exacerbating the problem, not solving it
- If we want to recover from abuse, we have to stop abusing ourselves



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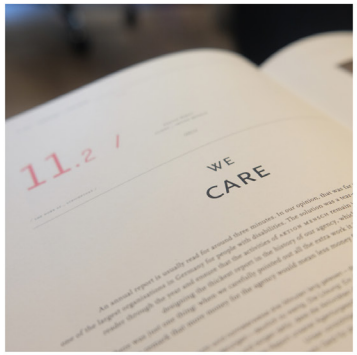
- Developing self-compassion
- Increasing communication between parts
- Parts have a function and a meaning
- Aspects of myself or my experience that I had disowned
- Apparently Normal Personalities
- Emotional/Traumatised Personalities



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- Parts were all trying to protect me, but using different (and sometimes conflicting) strategies
- Began to develop mutual goals
- Increasing co-consciousness
- Tuning in to parts without switching

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What is your experience of people who dissociate, or who have DID?

How would you go about building trust with a dissociative survivor?

Do you think self-alienation was unique to me, or a common experience?

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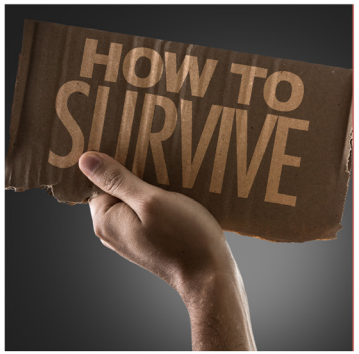
- Dissociative disorders develop as a result of using dissociation as a survival strategy repeatedly during childhood
- DID includes many symptoms of PTSD, but PTSD lacks clear-cut segregated parts
- Theory of structural dissociation
- Basic split in PTSD of main personality and traumatised part



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- Dissociative disorders involve further levels of splitting
  - Numerous splits in 'ANPs'
  - Numerous splits in 'EPs'
- 'Simple' PTSD responsive to treatment such as EMDR, Rewind, etc

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- Treatment less straightforward with 'Complex PTSD' / 'Developmental Trauma Disorder'
- C-PTSD and DDs both involve developmental trauma
- Disturbance in the relationship between child and parent

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- DID is highly correlated with disorganised attachment
- DA = parent is 'frightened and frightening'
- In DDs, combination of trauma with the lack of safe attachment

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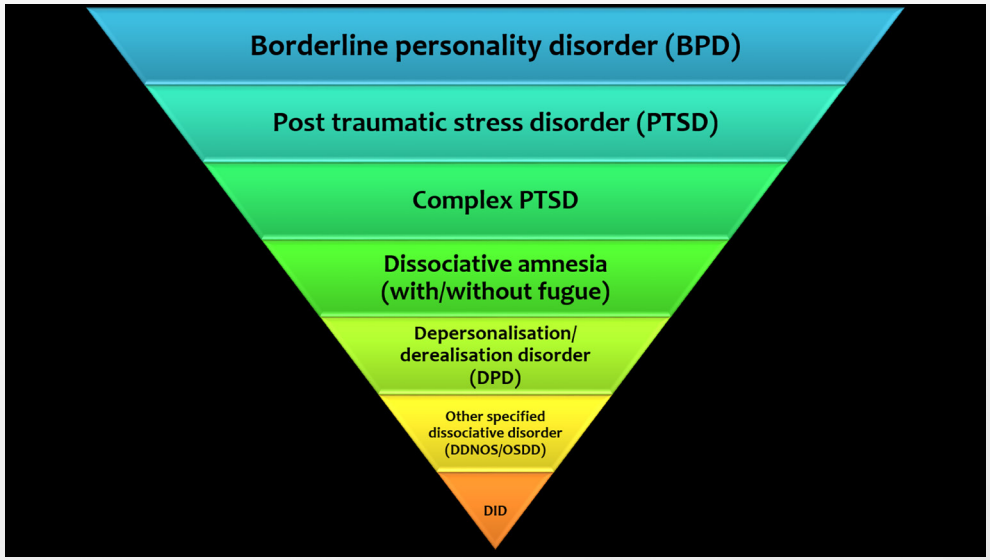
- For DID to develop:
  - Repeated trauma
  - Starting at a young age
  - Perpetrated by attachment figure OR parent unable to soothe
  - Usually higher levels of abuse = pain, coercion, humiliation, threat to life, helplessness



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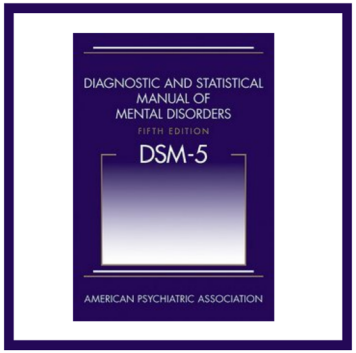
- Diagnosis of dissociative disorders:
  - DSM-5 (APA, 2013)
  - ICD-10 (WHO, 2010)
- Different viewpoints of DDs:
  - DSM: Long-term, developmental, persistent
  - ICD: Short-term, reactive, transient, here-and-now



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- All diagnostic criteria in 'Dissociation Resource Guide'
- Two main criteria for DID:
  - Identity disturbance
  - Memory disturbance
- DDNOS/OSDD: 'not quite' DID

- Many people without discrete 'parts' still experience depersonalisation/derealisation disorder (DPD):
  - 'The presence of persistent or recurrent experiences of depersonalisation, derealisation or both.'

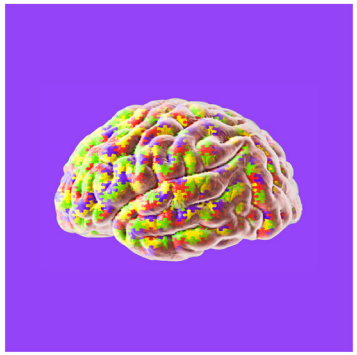
- Depersonalisation:
  - 'Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).'

- Derealisation:
  - 'Experiences of unreality of detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted.)'

- Depersonalisation and derealisation are experienced peri-traumatically
- Altered states of consciousness (endogenous opioids):
  - Perception of reality
  - Sense of time
  - Sense of self

- 'Over-modulation of affect' (emotions switched off)
- Depersonalisation and derealisation: third most common psychiatric symptom after depression and anxiety (Cattell & Cattell, 1974)

- Occurs in many other psychiatric conditions
- Occurs in 'normal' individuals under conditions of stress, fatigue, illness, intoxication etc



'To the depersonalised individual the world appears strange, peculiar, foreign, dream-like. Objects appear at times strangely diminished in size, at times flat. Sounds appear to come from a distance. The tactile characteristics of objects likewise seem strangely altered … The emotions likewise undergo marked alteration. Patients complain that they are capable of experiencing neither pain nor pleasure; love and hate have perished with them. They experience a fundamental change in their personality, and the climax is reached with their complaints that they have become strangers to themselves. It is as though they were dead, lifeless, mere automatons …'

Paul Schilder, German psychiatrist, early 20th century

- Safety cut-off mechanism
- Limbic system shuts down to protect from overwhelming distress
- Enables the brain to still act calmly in the face of threat

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- Main reported dissociative difficulties:
  - Feelings of unreality
  - Difficulties managing emotions and handling triggers
  - Relational problems

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Have you ever experienced feelings of unreality? What was it like? What triggered it?

How do people who don't habitually dissociate manage their feelings?

How does dissociation help people to regulate their emotions?

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- Parts are only part of the problem!
- DID is a 'trick' of the mind which tries to distract attention from trauma
- Parts give us clues about what we cannot bear to bring to mind
- DID solves the paradox of simultaneous knowing and not knowing

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- Basic split between:
  - Daily life (ANPs)
  - Danger (EPs)
- Can be adaptive to not know so that we don't feel so that we can maintain attachment

- Betrayal trauma (Jennifer Freyd)
- 'Betrayal blindness': we don't see the bad if we can't afford to see the bad
- I was unable to 'realise' (see as real) the trauma
- Traumatised parts were unable to 'realise' that the trauma was over

- With our front brains offline, we can't fully 'integrate' events
- Suzette Boon: 'DID is a disorder of realisation'
- Instead we make reality what we want it to be
- Parts are both fully real and a mirage

- Parts protect us from overwhelm by splitting reality down into bitesize chunks
- 'Dissociation is a division of the patient's personality into parts that each have their own sense of self and experience too little or too much as a consequence of non-realisation.' (Boon, 2017)

- 'Each dissociative part of the patient's personality encompasses a unique perception of reality that can contradict the reality of other parts, with an amazing attitude of indifference towards profound inconsistencies.' (Boon, 2017)
- Inconsistency and paradox are typical of the dissociative mind

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- Lack of a unitary sense of reality
- 'These paradoxical experiences are the hallmark of the inability to realise trauma … Dissociative parts are mesmerising sleights of hand that cleverly hold and conceal what cannot yet be realised by the patient.'

(Boon, 2017)

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- If we hold onto segregated parts, we hold onto unresolved trauma
- If we accept (realise) that the trauma is over, we have to live in the reality of that
- We cannot keep using dissociation to deal with life

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- When we are dissociative, we use dissociation (alternate reality) to manage difficult feelings
- Dissociation is a defence against **unbearable** reality

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- We need to be able to bear reality (with new emotional coping strategies) before we can fully remove that defence
- There are often numerous factors in people's circumstances why dissociation cannot be resolved

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What do you think to the idea of 'betrayal trauma' and 'betrayal blindness'?

Can you see how parts might operate in terms of getting on with daily life or being stuck in the trauma response of danger?

What kind of feelings might trauma or abuse evoke? How might they manifest without dissociating?

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- Where to get help?
- Two caveats:
  - An animal doesn't lick its wounds until the fight is over
  - We too need safety first
  - Some people don't want to recover, for various understandable reasons

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- Predicting poor outcomes (Baers et al, 2011): being invested in DID
- 'I tried therapy and it didn't work'
- Recovery is **brutal**
- Psychological intervention must be trauma-informed

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- Three phase approach:
  - Safety and stabilisation
  - Processing trauma
  - Building a new life

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- Change our response to threat
  - Live in green zone
  - Managing flashbacks / triggers
  - Turn down sensitivity of the smoke alarm
  - Bring our front brains online
- Develop new emotional regulation strategies rather than just relying on dissociation
- Mentalising and 'realisation'

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How can you help a dissociative survivor to gain both physical and emotional safety in their lives, to prepare them for healing?

What do you think to the idea that many of our behaviours are simply our best way of trying to regulate out-of-control emotions?

Do you ever find yourself feeling critical or judgemental of anyone who appears to resist being helped? Why might they be resisting you?

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- Two 'myths' of trauma treatment:
  - We will get better by talking about what happened to us
  - We will feel better if we can get someone to understand us well enough

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- Giving up on therapy if it doesn't make you 'feel better' straightaway
- We need challenge as much as acceptance and validation
- Treatment guidelines from the ISSTD
- Individual, long-term, relationally-based, outpatient psychotherapy

- Difficult to get treatment on the NHS:
  - Do you have a mood disorder?
  - Do you have a psychotic disorder?
  - Do you have a personality disorder?
- Appropriate treatment is rarely available

- Funding for treatment at The Clinic for Dissociative Studies: www.clinicds.co.uk
- Private therapy is not just for the rich
  - Sliding-scale fees
  - Charitable organisations

- Do you need a diagnosis?
- Will anyone listen to it?
- Negative consequences:
  - Can make insurance much more expensive
  - May affect employment
- Makes it feel more 'real'
- May cause emotional backlash

- First step: screening tools
  - www.carolynspring.com/screening
  - DES (Dissociative Experiences Scale)
  - SDQ-20 (Somatoform Dissociation Questionnaire)
- Full assessment currently available at the Pottergate Centre: www.dissociation.co.uk

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What do you think the greatest challenges are for people trying to get help for a dissociative disorder?

How important do you think a diagnosis is and what are the pros and cons as you see them?

What support can you provide someone who isn't yet ready for therapy?

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- How do you help a trauma survivor?
- Breaking stigma and shame is huge
- Most people who are unhelpful don't mean to be – they just don't know what to do or say
- You need to be able to manage your own feelings and stay in a 'window of tolerance'
- **Everyone** has a window of tolerance

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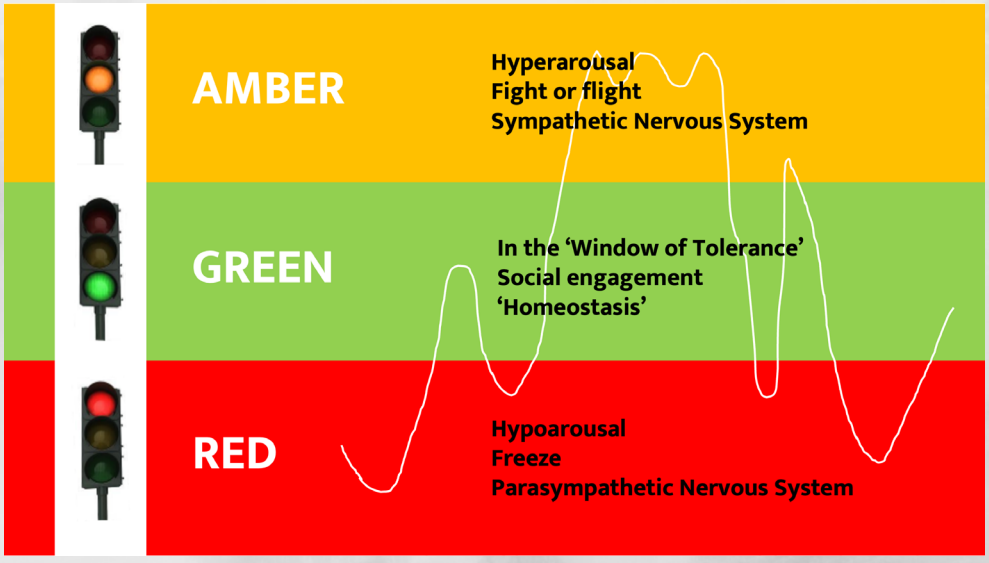
- Balance between being alert (accelerator)
- And being relaxed (brake)
- We can increase or decrease our physiological arousal levels
- Most non-traumatised people have a fairly wide 'window of tolerance'

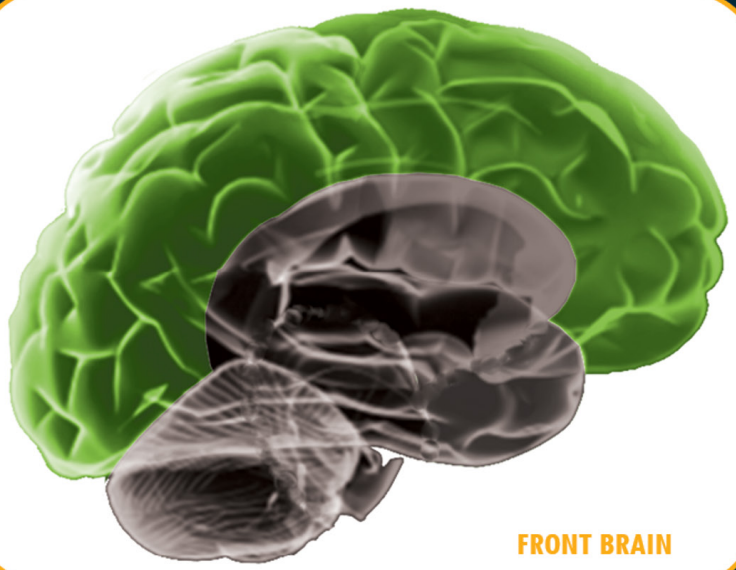
- Green (parasympathetic, myelinated):
  - Safe environment
  - Social engagement
  - Feed and breed / rest and digest

- Amber (sympathetic)
  - Threat in the environment
  - Mobilisation
  - Fight and flight

- Red (parasympathetic, non-myelinated)
  - Overwhelming threat
  - Immobilisation
  - Freeze



FRONT AND BACK BRAIN



FRONT BRAIN

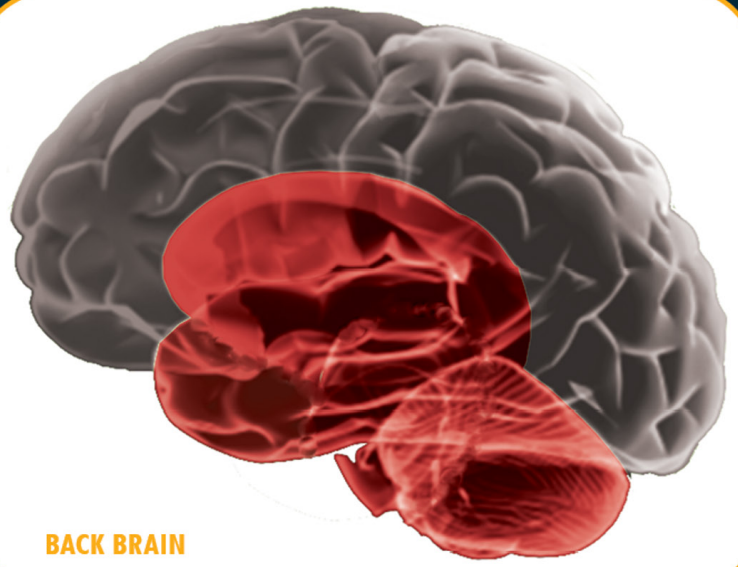
Neo-cortex – 'rational brain'

Conscious

Cognitive, thinking, language

Choosing, planning, reflecting

Empathy



BACK BRAIN

Reptilian and limbic system – 'emotional brain'

Unconscious

Emotional

Survival, automatic

'Physiological housekeeping'

SESSION 9

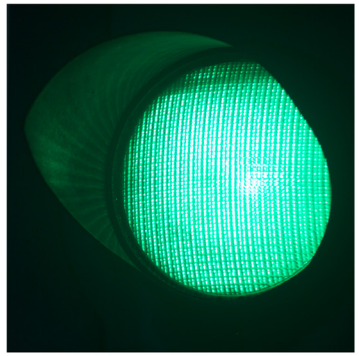
CAROLYN SPRING
reversing adversity

- Don't fall into amber or red along with the person you're trying to help!
  - Flight response
  - Fight response
  - Freeze response

SESSION 9

CAROLYN SPRING
reversing adversity

- Stay green and be an influence!
- The blind cannot lead the blind
- Don't try to process your own trauma by helping traumatised people



SESSION 9

CAROLYN SPRING
reversing adversity

- Stay green and be an influence!
- The blind cannot lead the blind
- Don't try to process your own trauma by helping traumatised people
- Put on your own oxygen mask first

SESSION 9

CAROLYN SPRING
reversing adversity

- Secondary traumatisation
- Picking up someone else's trauma
- The brain's smoke alarm is triggered by the constant sounding of someone else's alarm
- Bring the front brain online and step back
- 'Supervision'
- Firefighters don't just tackle blazes all day every day

SESSION 9

CAROLYN SPRING
reversing adversity

What provision do you have in your life for some form of 'supervision' – of someone else helping you stand back and use your front brain to really think about what's going on?

How would you know if someone else's trauma is triggering you?

How do you know if you're heading into the amber or red zone? What are the signs?

SESSION 10

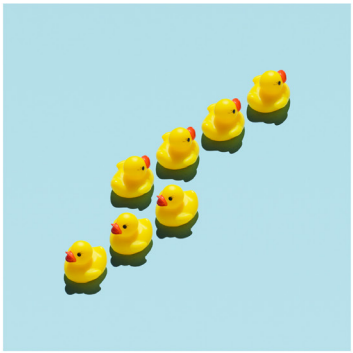
CAROLYN SPRING
reversing adversity

- How do you help someone with explicit, dissociative parts?
- Many people keep their parts hidden; some do not, or cannot
- Is switching a problem?

SESSION 10

CAROLYN SPRING
reversing adversity

- Every part is still a part of the **same** person (but may lack continuity)
- Don't be scared by parts, or impressed by them
- Sociocognitive (fantasy) model of DID recommended not talking to parts, but has been debunked



SESSION 10

CAROLYN SPRING
reversing adversity

- By talking to parts, you model acceptance and encourage communication
- Don't reify or elaborate parts – remember why they're there
- In some circumstances, switching is very problematic

- It's okay to encourage the 'adult' to come back
- May require a 'stepping stone' approach
- Distressed parts survived without you before; they'll survive now
- DID is a great survival strategy

- Help to manage triggers
- Triggers are reminders of a past traumatic event
- They cause a false alarm in the amygdala (smoke detector)
- 'A' man, not 'the' man: general (back brain) to specific (front brain)

- Draw attention to current safety
- Stay calm ('green zone')
- Movement to come out of red zone
- Breathing – breathe with them
- Sigh!
- Normalise triggers

- Encourage them not beat themselves up for being triggered
- Don't open Pandora's box
- Help them to create the right (safe) environment for 'telling'
- Work towards a long-term support plan, not abandonment