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**Intensive Psychotherapy for Persistent Dissociative Processes:
The Fear of Feeling Real**

The Effect of Dissociative Processes on Your Patient's Presentation

Developmental Couple Therapy
For Complex Trauma
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Agenda: Clinicians Must Adapt to Discern Dissociative Processes

- Dissociative processes skew perception
- Dissociative processes help create a coherent, stable mind
- Initiating an assessment for dissociation
- Self-states and dissociative processes
- An attitude of ongoing assessment and repetitive revision

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Dissociative Processes Skew Perception

- Body: depersonalization (DP)
- Visual reality: derealization (DR)
- Time: micro/macro amnesia; intrusions of the past and disorientation for sequencing
- Memory: DP/DR dreamy quality/veracity
- Mental coherence may suffer: narrative regulation; affect regulation; counterfeit coherence
- Psychodynamics are biased by dissociation

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Dissociative Processes are multi-dimensional

- **Psychodynamic** (A. Freud-1936)
 - Isolation, Exclusion, Deflection
- **Psycho-physiologic**
 - **Depersonalization** (DP/DR: Cambridge Depersonalization Scale), Derealization, Amnesia, Identity Confusion, Identity Alteration
Steingard, M. (1993). Structured clinical interview for DSM-IV dissociative disorders. Washington, D.C.: American Psychiatric Press.
- **Neurobiologic** insula, TPJ, ACC, Vermis, L vs. R cortex
 - Dissociable functional links: memory, sensory, movement, time distortion, inner/outer spaces

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Dissociative Processes repair with a price

- **Affective:** intolerable and unbearable emotional experience
 - Isolated affect and loss of relatedness
- **Cognitive:** failures of assimilation and accommodation of adverse events
 - Amnesia and narrative regulation
- **Somatic:** overwhelming physical pain
 - Numbness and ignorance of physical illness
- **Agency:** violation of sovereignty of self
 - Tendency to hide from life and be passive vs. hyper-aggressive
- **Existential:** assertions of non-being
 - Empty living without meaning or relatedness

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Dissociation


Holmes, E. A., Brown, R. J., Mansell, W., Fearon, R. P., Hunter, E. C., Frasquilho, F., & Oakley, D. A. (2005). Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical psychology review, 23*(1), 1-23.

- Always a pathological process?
- An adaptation of a normative process?
- Compartmentalization vs. detachment?
- Are there other views?

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How do we achieve Mental Coherence?



- Association
- Dissociation
- Sorting
- Salience
- Linking
- Integrating
- Coherence
- What about coherence in the therapist?

Mental coherence is required for secure relatedness and psychotherapy

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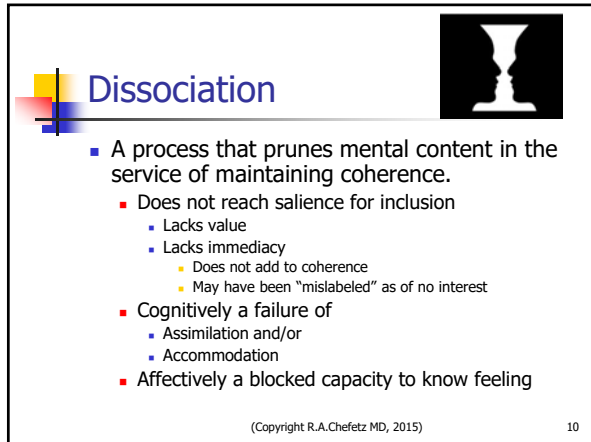
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Association

- Links things together
- Provides coherence
- Evokes salience
- Facilitates autobiographical narrative
- Generates personal and relational scripts
- Too much (tight) association (obsessional): paradoxical dissociation; Freud, 1909; Bermond, 2006

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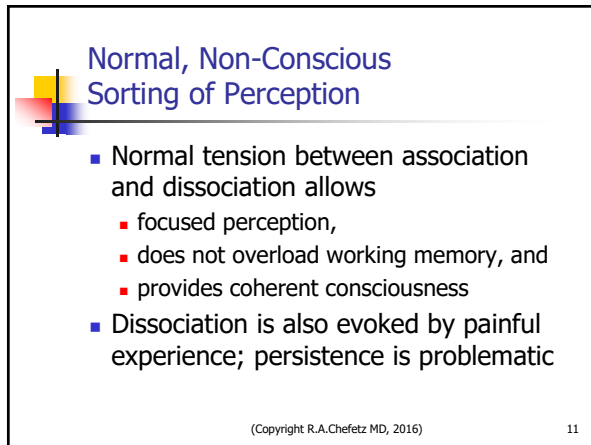


Dissociation

- A process that prunes mental content in the service of maintaining coherence.
 - Does not reach salience for inclusion
 - Lacks value
 - Lacks immediacy
 - Does not add to coherence
 - May have been "mislabelled" as of no interest
 - Cognitively a failure of
 - Assimilation and/or
 - Accommodation
 - Affectively a blocked capacity to know feeling

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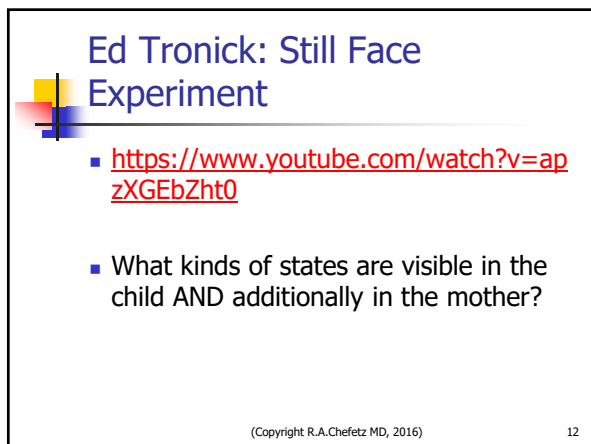


Normal, Non-Conscious Sorting of Perception

- Normal tension between association and dissociation allows
 - focused perception,
 - does not overload working memory, and
 - provides coherent consciousness
- Dissociation is also evoked by painful experience; persistence is problematic

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Ed Tronick: Still Face Experiment

- <https://www.youtube.com/watch?v=apzXGEbZht0>
- What kinds of states are visible in the child AND additionally in the mother?

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What's a "State"


- "A state of mind can be proposed to be a pattern of activation of recruited systems within the brain responsible for (1) perceptual bias, (2) emotional tone and regulation, (3) memory processes, (4) mental models, and (5) behavioral response patterns (Siegel, D. 1999, *The Developing Mind*) (p. 211).
- A "self-state" is a metaphor we can use to describe a recurrent state of being, referring to a persistent observable constellation of "recruited systems" including relational scripts, etc.

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Putnam, F. W. (2016). *The Way We Are: How states of mind influence our identities, personality, and potential for change*. IPBooks.net

- State-ness organizes around core features like intense emotion, behavior, and action to create a kind of "state-space" the trajectory of which can be mapped in 3D
- The core of the experience behaves as a "strange attractor" that collects context, meaning, and "BASKness"
- States are not fixed entities, but can vary considerably, moment to moment
- Shame can act as a strange attractor, a bias on state formation




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Discrete Behavioral States


Wolff, P. (1987). *The development of behavioral states and the expression of emotions in early infancy: New proposals for investigation*. Chicago: University of Chicago Press.

- Basic observable states in infancy:
 - I- Quiet Sleep/Calm
 - II- Restless Sleep
 - III-Alert Inactivity
 - IV-Fussy
 - V- Cry/Distress
 - Smile-delight
 - Hungry
 - Disconnected
- Infants jump from state to state without visible periods of transition



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Isolated Islands of Subjectivity: Self-States

- A predictable, persistent, and consistent sense of self experienced in a “not-me” way (an aspect of self as Other): “I don’t behave like that! What the hell got into me! That’s not me! vs. Identity Alteration: “I’m not Jane, I’m Mary.”

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Self-state formation and Attachment Pattern

- Core emotional range
- World-view
- Relational Scripts
- Behavioral Scripts
- Shame is ubiquitous

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A Misguided Overemphasis on Multiple Personalities?

- Do people present for treatment saying they have multiple personalities, please help me fix this?
 - No, rarely; once: 20 years/400-500 hundred DD pts.
 - Typically it sounds like:
 - My life is falling apart
 - I don't understand what I feel or think, or why I do what I do
- People with dissociative identity disorder neither have multiple personalities, nor do they have a single fully coherent personality;
 - the dissociative mind is highly compartmentalized; high intelligence is typical

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A plea for experience-near metaphors of the subjective experience of mind:

"different ways of being me"

- Klein: P-S vs. Depressive "positions"
- Federn: emotional states
- Fairbairn: internal objects
- Winnicott: true self vs. false self
- Bion: attacks on linking
- Bowlby: segregated subsystems and deactivation
- Kohut: the vertical split
- Bromberg: standing in the spaces
- Putnam: the way we are

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Diagnostic Imperative

- We all have self-states
- We don't all have persistent dissociative processes that bias everyday experience.
- How do you assess for dissociative process?
 - Clinical Observation
 - Psychological Testing in your office

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Identify Dissociative Process


- Dissociative Experiences Scale
 - In ancillary materials and at: <http://tinyurl.com/DissociativeExperiencesScale>
- Cambridge Depersonalization Scale
 - In ancillary materials and at: <http://tinyurl.com/CambridgeDP-Scale>
- Structured Clinical Interview for DSM Dissociative Disorders-SCID-D (American Psychiatric Press Inc.)
- Freud, A. (1936) The Ego & the Mechanisms of Defense

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 **Supplementary Slides**

The slides that follow are to whet your appetite for other dimensions of study in regard to dissociative processes, complex PTSD, and the dissociative disorders.

Best, Rich

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 **Hypnotic Signs and Symptoms**

- Spontaneous trance
- Spontaneous age regression
- Negative hallucinations
- Eye roll and switching states
- Trance logic

■ Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. In R. J. Loewenstein (Ed.), *Psychiatric Clinics of North America* (Vol. 14, pp. 567-604). Philadelphia: W.B. Saunders Company.

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Other Symptoms

- Conversion
- Unexplained medical symptoms
- "Bipolar switching" and rapid cycles
- Blackouts
- Disremembered behavior
- Fluctuation in skills
- Sexual detachment

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The Three Phases of Trauma Treatment

- Stabilization-with detailed history taking
 - cannot safely proceed without focused diagnostic evaluation and screening for DDs
 - Calm presentation
 - Flooded presentation
 - Alternately calm and flooded presentation
- Stabilization
- Stabilization

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The Three Phases of Trauma Treatment

- Stabilization
- Working Through
- Integration, Consolidation, Resolution

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Self-management

Korn, D. L. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research*, 3 (4), 264-278.

- Access emotion without subsequent increase in dissociation, e.g. DP/DR
- Willingness to work toward non-dissociative living
- Demonstrate trusted relationship with therapist
- Have capacity for dual attention: past and present

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Trauma Treatment ALWAYS

- has dissociative components or there could not be a post-traumatic disorder!
- Believing you can intuitively know if somebody is dissociative is folly at best, and dangerous at worst.
- How do I know?

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To recognize and treat trauma and dissociation:

- Add some knowledge
- Emotional set of the therapist
- Capacity to maintain curiosity in the face of chaos
- Confident and competent clinical boundaries, frame, and container
- Colleagues and friends with whom to share experience and help contain
- A life

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The "Stealth" of Dissociation



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Dissociation


- Prevents association/integration
- Unlinks previously associated
- e.g., I'm crying but I don't know why!
(emotion is unlinked from thought)
- Too much dissociation: loss of elements of experience (BASK)

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Dissociative Alterations in the Context of Experience

- **B**ehavior
- **A**ffect
- **S**ensation
- **K**nowledge




(Braun-1988-Dissociation 1:1, March, pp.4-23)

- These are the general "lines of cleavage" in the dissociation of experience that impairs knowing the meaning of experience.

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SCID-D

- Depersonalization
- Derealization
- Amnesia
- Identity Confusion
- Identity Alteration

- Implicitly: compartmentalization & "states"

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Initial Areas of Assessment

- Self-state signs and symptoms
 - Specific behaviors that feel outside personal control
 - Eating, drinking, sexual, speech, travel
 - "I sometimes don't know which version of me is going to show up, and my husband says the same thing."
 - "My mind is filled with chatter."

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Conversational Inquiry: Initial Areas of Assessment

Loewenstein, R.J. (1991) *An Office Mental Status Exam for Complex Chronic Dissociative Symptoms and Multiple Personality Disorder*, PCNA, 14:3 (568-604).

- What are the things about your life that are most difficult for you?
 - Memory-micro amnesias
 - Focus of Attention-eyes
 - Relationship storms and repetitive failures
 - Surprise states of feeling
 - Unpredictable behavior, speech
 - Interrupted thinking-thoughts from "the side"

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10 Areas of Interest

- 1. Discontinuity
- 2. Repetition
- 3. Unreliable Memory
- 4. Sleep Disturbance
- 5. Emotional Storms

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10 Areas of Interest

- 6. Bodily Sensings & Medical Syndromes
- 7. Time distortion (trauma-time)
- 8. Self-harming Behaviors
- 9. Depersonalization/Derealization
- 10. Screening Instruments:
 - Dissociative Experiences Scale (DES)
 - Cambridge Depersonalization Scale (CDS)

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1. Discontinuity

- Need for curiosity
- Colliding mental priorities-interruptions
- Silence
- Eyes and eyelids; spontaneous trance
- Bodily movement
- Sudden changes: mood, room temperature, vocabulary

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2. Repetition Compulsion

- Scripts
 - Behavioral
 - Affective
 - Sensorial
- Mastery
- Dissociative Circuit Breaker
- Isolated shame as barrier

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2. Upgrade for Repetition Compulsion

- Learn the script
- Moments of dissociation
- What's intolerable?
- What are the dynamics
- Enlarge the script: spelling-out
- Gather self-states

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3. Memory

- Implicit
- Explicit
- Global Loss vs. Micro amensias
- Swiss Cheese

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4. Sleep Disturbance

- PTSD
 - REM
 - Non-REM

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5. Emotional Storms

- BPD, DID, PTSD: intrusions of isolated affect as exclusionary processes fail under the influence of associative pressures trying to sort unintegrated experience that is painful
- Self-state phenomena
- Arrive and leave: suddenly
- Bright, shining, noisy keys on a ring

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6. Typical Somatic Entries to Dissociative Experience; R/O

<ul style="list-style-type: none"> Headache Low Back pain Abdominal pain Pelvic pain Rectal pain Choking sensations Nausea Panic 	<ul style="list-style-type: none"> Tastes Smells Sounds Visual disturbances Itch Burning sensations Vulvodynia Involuntary Sleepiness
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7. Time Distortion

- Trauma-time experience and its implications

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8. Self-harm

- Cutting vs. scratching
- Burning
- Constriction
- Picking

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9. Depersonalization

“Feeling Unreal”

- More than an out-of-body experience
 - When the mind is deprived of the sensations of the body:
 - When the mind lacks the feeling of the impact of being in the world:
- DES:
 - Feeling like standing next to yourself
 - Looking in mirror without self-recognition

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9. Depersonalization and Derealization

- Temporo-parietal junction, insula
 - Cambridge Depersonalization Scale
- In consultation work: Use first, then DES, then Beck-II; why?

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10. Screening Instruments

- Cambridge Depersonalization Scale (CDS)
 - 29 items
 - Non-diagnostic
 - Gentle conversational language
- Post-endorsement review of DES and CDS
 - Perhaps best use of these instruments
 - Essential to "get inside" idiosyncratic meaning

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