

Dissociation, Depersonalisation & Derealisation

- How to stabilise, manage & treat within
an EMDR Perspective...

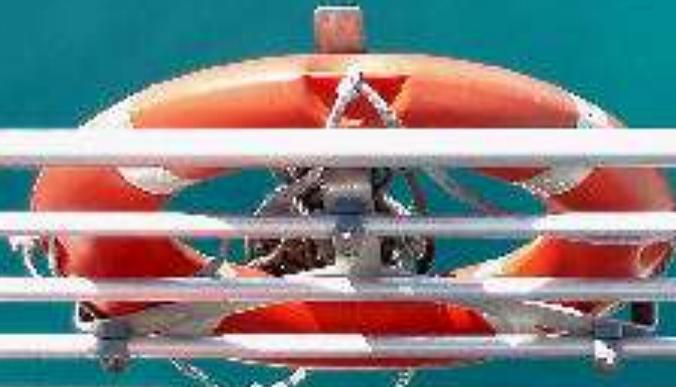
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Dissociation, Depersonalisation & Derealisation

UNDERSTANDING DISSOCIATION





Understanding Dissociation

Your sense of reality and who you are depend on your feelings, thoughts, sensations, perceptions and memories.

If these become 'disconnected' from each other, or don't register in your conscious mind, your sense of identity, your memories, and the way you see things around you will change...

This is what happens during dissociation...



Understanding Dissociation

Dissociation can be seen as helpful, when it's within the continuum of normal dissociation and purposeful when it creates a safety net to enable us to function more effectively in difficult life circumstances or to reduce demands on working memory temporarily, where stress levels are higher than usual, such as in the armed forces.



Understanding Dissociation

Dissociation is a defence mechanism that can help us survive traumatic or difficult life experiences.

Some people train themselves to use dissociation to calm themselves, to avoid or better manage discomfort or for cultural or spiritual reasons...





Understanding Dissociation

Dissociation can be considered as a normal, helpful and protective strategy, in protecting the system from overwhelm in it's primary state.

Dissociation is not classified as a disorder until there are persistent and repeated episodes of dissociation which impact significantly on normal functioning. This tends to be referred to as '*Secondary Dissociation*' or in Dissociative Identity Disorder (DID), '*Tertiary Dissociation*.'



Understanding Dissociation

- Depersonalisation : A feeling that your body is unreal, changing or dissolving, but the rest of the world feels real. It can include out-of-body experiences, such as seeing yourself as if watching a movie.
- As a secondary form of dissociation, periods of detachment from self which is experienced as lacking in control or 'outside' the body, which retaining an awareness that this is only a feeling and not a reality.





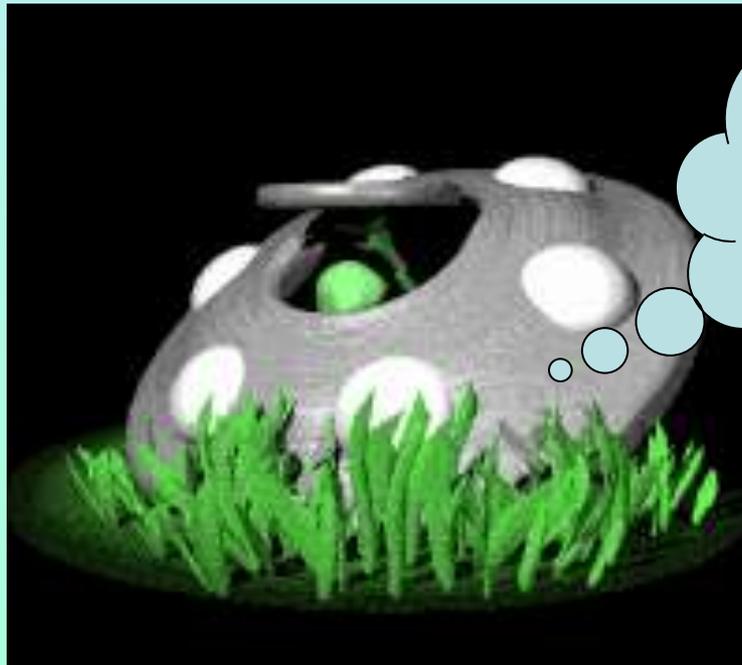
Understanding Dissociation

- Dissociative Amnesia : When you can't remember incidents or experiences that happened at a particular time, or can't remember important personal information.
- In it's secondary form, noticeable impairment of memory recall (e.g. not remembering part of a traumatic event) usually resulting from emotional trauma.



Understanding Dissociation

- Derealisation : The world around you seems unreal, but you feel real. You may see objects changing in shape, size or colour, colours and sounds may seem more intense or you may experience other people as being like robots or aliens.



Hello, Darling...
It's Aunty Margery
– Just thought I'd
pop round for a
spot of tea...



Understanding Dissociation

- Identity confusion : Feeling uncertain about who you are. It may feel there is a struggle within to define yourself. (Puberty)
- Identity alteration : This is when there is a shift in your role or identity that changes your behaviour in ways that others could notice. For instance, you may be very different at work from when you are at home.





Understanding Dissociation

- In it's more severe state, Identity Confusion & Identity Alteration is diagnosed as a secondary dissociative disorder under the category of Dissociative Fugue : Physical desertion of familiar surroundings and experience of impaired recall fo the past. This may lead to confusion about actual identify and the assumption of a new identity.

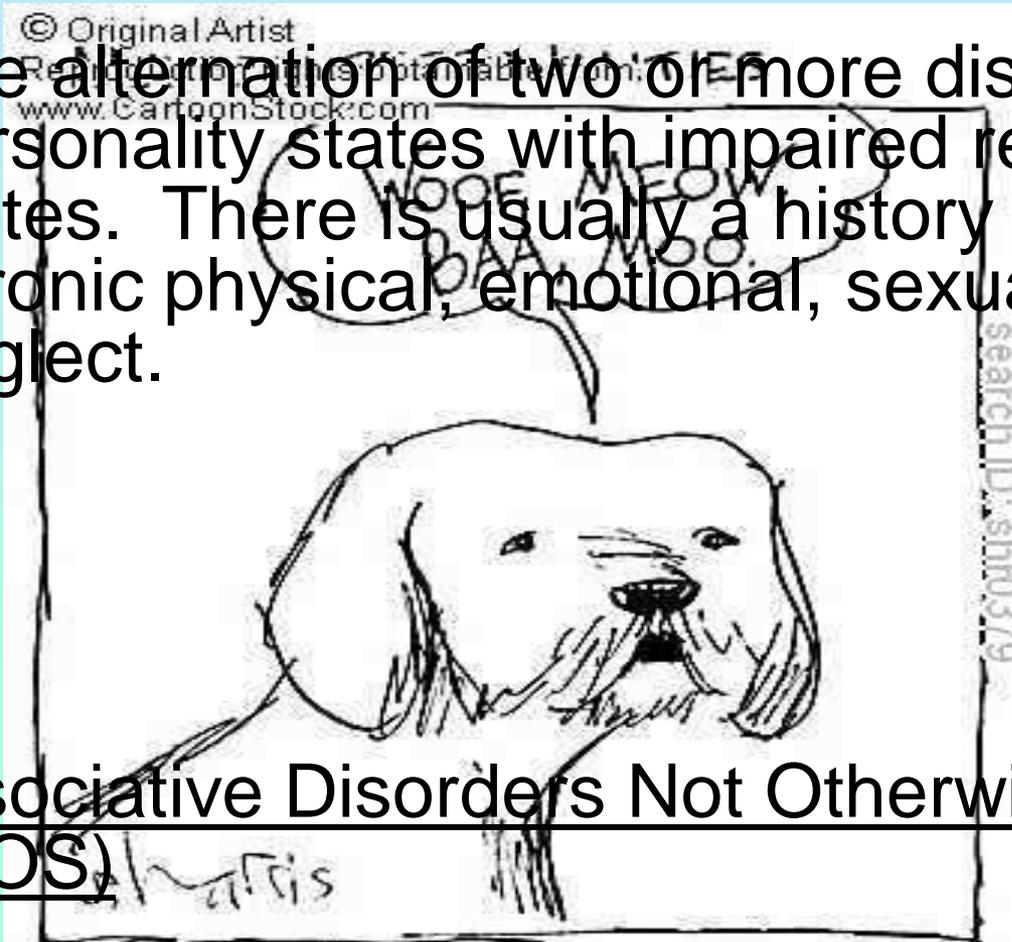




Understanding Dissociation

- Dissociative Identity Disorder : (Tertiary)
(Formally Multiple Personality Disorder)

The alternation of two or more distinct personality states with impaired recall about self-states. There is usually a history of intense and chronic physical, emotional, sexual abuse or neglect.



- Dissociative Disorders Not Otherwise Specified (DDNOS)



Understanding Dissociation

- Dissociative disorders can be defined as conditions that involve disruptions or breakdowns of memory, awareness, identity and / or perception.
- Contrary to *'normal'* forms of dissociation, people with dissociative disorders use dissociation pathologically and involuntarily, which causes 'internal chaos' and may interfere with work, school, social or home life.
- In order to meet criteria for a Dissociative Disorder, symptoms must be persistent & cause significant interference with normal functioning.



Understanding Dissociation

DSM IV Classifications of Dissociative Disorders

1. Depersonalization Disorder
2. Dissociative Amnesia
(Formerly referred as *Psychogenic Amnesia*)
3. Dissociative Fugue
(Formerly *Psychogenic Fugue*)
4. Dissociative Identity Disorder
(Formerly *Multiple Personality Disorder*)
5. Dissociative Disorders Not Otherwise Specified
(DDNOS)



Understanding Dissociation

Special Note re: Conversion Disorder...

ICD 10 classifies conversion disorder as a dissociative disorder whilst the DSM IV classifies it as a somatoform disorder.



Understanding Dissociation

<u>'Normal' (Primary) Dissociation</u>	<u>DSM-IV Diagnosable Dissociative Disorders (Secondary)</u>
Depersonalisation	Depersonalisation
Dissociative Amnesia	Dissociative Amnesia
Identity Confusion	Dissociative Fugue
Identity Alteration	D.I.D.
Derealisation	DDNOS



Understanding Dissociation

“The rabbit-hole went straight on like a tunnel for some way, and then dipped suddenly down, so suddenly that Alice had not a moment to think about stopping herself before she found herself falling down what seemed to be a very deep well...”

**– Alice in Wonderland
(Down the rabbit-hole)
Lewis-Carroll**





Understanding Dissociation

“What was happening around me was like a scene from a war movie. I was observing it, not participating in it. I didn’t feel frightened. It all seemed so strange and unreal”.

- **Bomb attack survivor describing Derealisation as a normal dissociative response, the function of which allowed her to focus on the things she needed to do to survive, including remembering where the nearest exit was...**





Understanding Dissociation

“I remember getting in the car... but don't remember hitting the tree. I remember the sounds of the sirens and someone shining a light in my eyes - The next thing I remember was waking up in hospital”

- RTA Patient – Describing her response following the accident (Dissociative Amnesia)





Understanding Dissociation

“I felt as if my body was not my own. It was like I had no control where I walked or what I did. My head felt woolly – as though I had no brain. I had no sense of where my body began and where it ended. Everything felt numb. I felt like my body was disappearing...”

**– Patient Description
(Depersonalisation)**





Understanding Dissociation

“I was woken up by the sound of an explosion ripping through the building. I ran into the hotel lobby. There were other people screaming and running towards a hole in the wall and I followed them. Outside, I stood amongst them but couldn’t remember who I was. I didn’t know why I was in the hotel. I looked down and saw that I had a ring on my left ring finger and guessed that I must be married – but I couldn’t remember and didn’t know who to. I left, because I could not remember the life I was leaving behind...”

- **Patient Description (Dissociative Fugue – following gas explosion; triggered veteran trauma)**





Understanding Dissociation

[Angry appearance, shouting]

“There’s nothing wrong with me. I take no shit from no-one. I don’t need therapy, you fucking bitch”.

[whispering – high-pitched very young voice]

“I’s scared. I’s only little. I want my Mummy”.

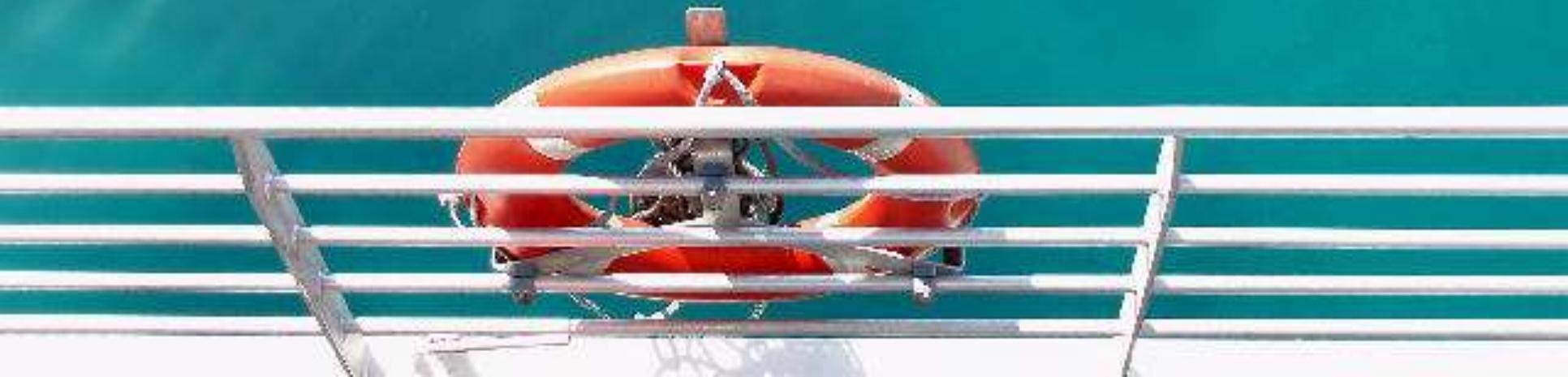
[Down on all fours, crawling... growls – then raises a leg in the air as if a dog, about to pee] “Grrrr...”
[wiggles bottom – tries to bite therapist]

**- Patient Descriptives (DID)
– Pre-Treatment**



Dissociation, Depersonalisation & Derealisation

ETIOLOGY OF DISSOCIATION





Etiology of Dissociation

Dissociative symptoms have been found to correlate with traumatic histories of significant sexual abuse and/or physical abuse (*Coons, 1996; Dell & Eisenhower, 1990; Hornstein & Putnam, 1992; Macfie, Cicchetti, & Toth, 2001; Trickett, Noll, Reiffman, & Putnam, 2001*), as well as war trauma (*Cagiada et al., 1997*) and natural disasters (*Laor et al., 2002*).



Etiology of Dissociation

Patients with dissociative disorders tend to have personality profiles that were intellectualized, obsessive and introverted (*Armstrong & Loewenstein, 1990*).

According to research, these patients have high scores for avoidant, self-defeating, borderline and passive-aggressive personality disorders, but not histrionic or labile personality disorders (*Ellason, Ross, & Fuchs, 1995*).



Etiology of Dissociation

Dissociation-prone individuals were also found in studies to be more prone to alexithymia (*Berenbaum & James, 1994; Irwin & Melbin-Helberg, 1997*), which further appears to correlate with psychological trauma (*Cloitre, Scarvalone, & Difede, 1997; Zeitlin, McNally, & Cassidy, 1993*).

Alexithymia can be characterised by a constriction in experiencing emotions and difficulties in communicating feelings (*Sifneos, 1973*), - not dissimilar to the experience of dissociation itself.



Etíology of Dissociation

- In addition, both dissociation (*Saxe et al., 1994; van der Kolk et al., 1996*) and alexithymia (*Cohen, Auld, & Brooker, 1994*) have been related to somatisation and both are independently associated with self-harming behaviour (*Zlotnick et al., 1996*).

? TF-CBT VS. EMDR -

Which is more appropriate for a client with Alexithymia and PTSD?



Etiology of Dissociation

There is no consensus yet on the exact etiological pathway for the development of dissociative symptomatology, but newer theoretical models suggest impaired parent-child attachment patterns (*Barach, 1991; Liotti, 1999; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997*) and trauma-based disruptions in the development of self-regulation of state transitions (*Putnam, 1997; Siegel, 1999*).



Etiology of Dissociation

Newer theories on dissociation also link maladaptive attachment patterns directly to dysfunctional brain development that may inhibit integrative connections in the developing child's brain (*Schore, 2001; Stien & Kendall, 2003; Diseth, 2005*).

A.I.P. Model...

In terms of treatment, researchers have also argued that recognizing disorganized attachment in children can help alert clinicians to the possibility of dissociative disorders effecting early treatment... (*Waters, 2005*).



Etiology of Dissociation

However, researchers also cite several reasons why recognizing symptoms of dissociation in children is challenging:

- it may be difficult for children to describe their internal experiences;
- caregivers may miss signals or attempt to conceal their own abusive or neglectful behaviours (*James, 1992*);
- symptoms can be subtle or fleeting and disturbances associated with dissociation may be misinterpreted as symptoms of other disorders. (*Steiner et al, 2002*)



Etiology of Dissociation

Some theorists posit that children who learn to dissociate as a protective mechanism early on in life and become 'good at dissociating' are more at risk of developing a dissociative disorder later on in life. Further research into the manifestation of dissociative symptoms and vulnerability throughout development is needed. (*Jans et al*)



Etiology of Dissociation

Unsurprisingly, dissociative symptoms in children have been associated with parenting styles described as neglectful (*Brunner, Parzer, Schuld, & Resch, 2000; Ogawa et al., 1997; Sanders & International Society for the Study of Dissociation 123 Giolas, 1991*), rejecting and inconsistent (*Mann & Sanders, 1994*).

However, it must be noted that each child's reaction to life events is a constructive process that is idiosyncratic, and what might overwhelm one child may not overwhelm another.



Etiology of Dissociation

While not all trauma necessarily results in dissociation, events that have not necessarily been defined as major trauma (e.g., repetitive losses of attachment figures, peer rejection, observation of domestic violence, medical procedures, chronic living instability, emotional abuse) have nevertheless been found in the backgrounds of children displaying dissociative symptoms, which indicates that the protective 'function' of dissociation may later be incorrectly applied to any perceived 'threat' (see: Foa & Rothbaum etc.)



Etiology of Dissociation

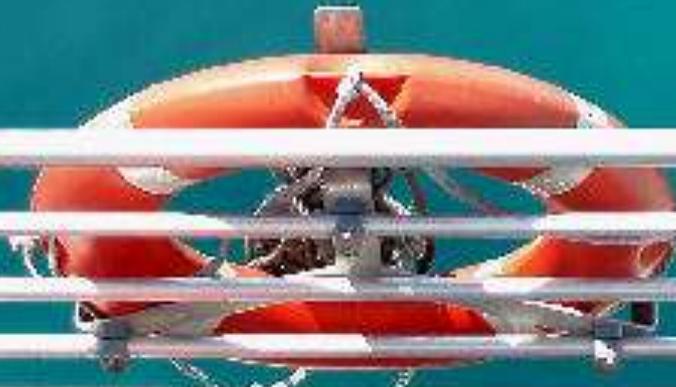
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Dissociation, Depersonalisation & Derealisation

DIAGNOSIS



DÍAGNOSÍS

Diagnostic Scales : (Adult)

Structured Clinical Interview for DSM-IV Dissociative Disorders Revised (SCID-D)

Marlene Steinberg, M.D.

Dissociative Experiences Scale (DES)

Bernstein and Putnam (1986); see also Bernstein Carlson & Putnam, 1993)

Perceptual Alterations Scale (PAS)

Sanders, (1986)

Questionnaire on Experiences of Dissociation (QED)

Riley, (1988)

Dissociation Questionnaire (Diss-Q)

Vanderlinden et al., (1991)

Mini-SCID-D (M-SCID-D)

Steinberg et al., (1992)

Dissociative Processes Scale (DPS)

Harrison & Watson, (1992)

Back of the Head Scale

Knipe



DÍAGNOSÍS

Diagnostic Scales : (Child)

The Child Dissociative Checklist (CDC)

- ages 5-12 years

Putnam et al., (1990)

The Adolescent Dissociative Experiences Scale (A-DES)

- ages 11-18 years

Armstrong, Putnam, & Carlson, (1990)

KID SCID

Fredrick J. Matzner, M.D.

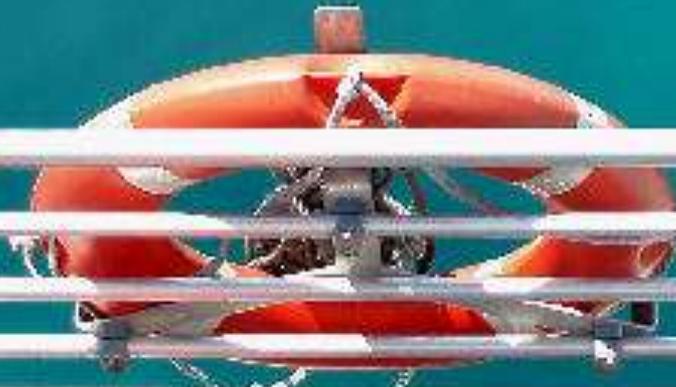
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Dissociation, Depersonalisation & Derealisation

TREATMENT AND STABILISATION



Treatment & Stabilisation

Grounding Techniques ~

What Are They?!

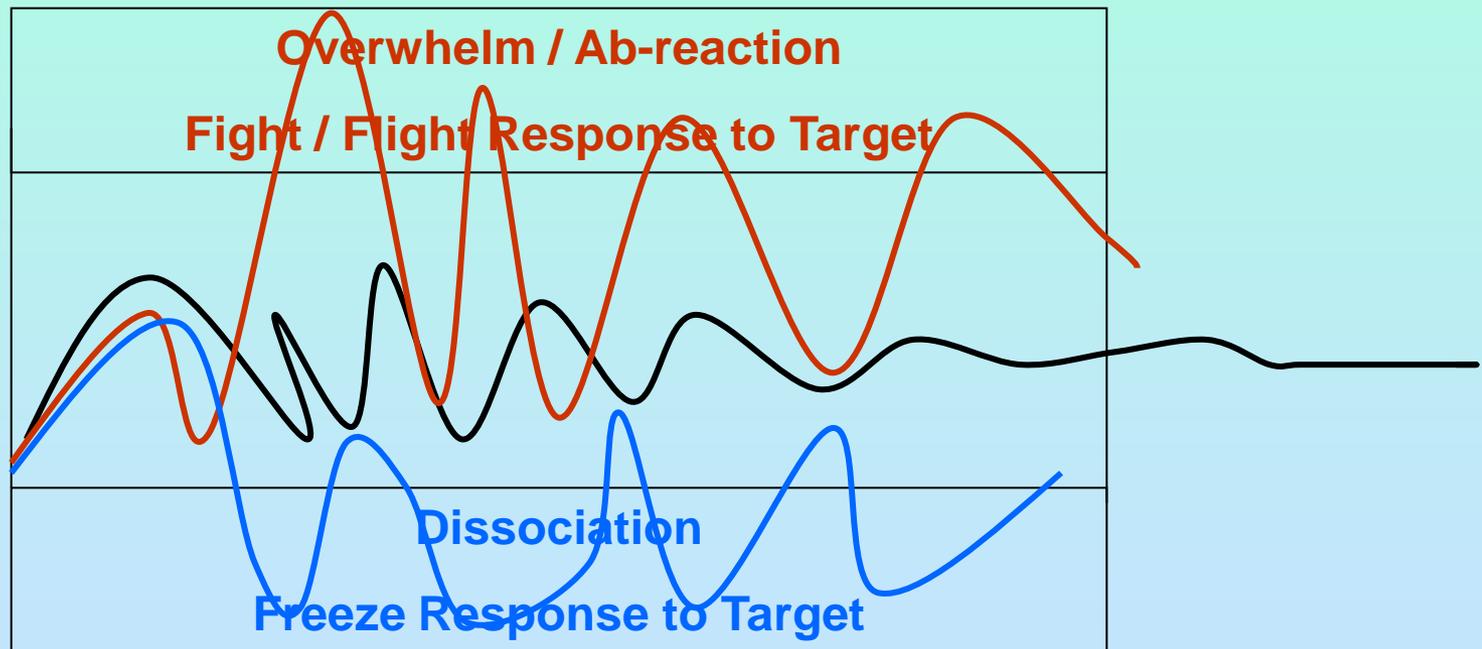
Grounding is about learning to stay present, connected to your body in the here and now...

Grounding Techniques consists of a set of skills/tools to help clients better manage dissociation and / or abreaction, because therapy (either TF-CBT or EMDR) is unlikely to be helpful if your client is dissociating or ab-reacting!



Treatment & Stabilisation

The Window Of Tolerance



Treatment & Stabilisation

Diaphragmatic or deep breathing:

Trauma survivors often hold their breath or breathe very shallowly. This in turn deprives them of oxygen which can make anxiety more intense. Stopping and focusing on deepening and slowing breathing down deliberately can bring clients back to the moment and reduce anxiety / overwhelm.



Treatment & Stabilisation

CIPOS (Constant Installation of Positive Orientation & Safety) :

CIPOS is a way in which to enable a client to 'habituate' (acclimatise) to their experience of trauma in cases where the traumatic target is so overwhelming that focusing on the memory itself causes fight/flight (abreaction) or freeze (dissociation) responses.



Treatment & Stabilisation

CIPOS (Constant Installation of Positive Orientation & Safety) :

This method of slowing down processing and carefully controlling the emergence of potentially overwhelming post-traumatic material is achieved through gradual exposure to an image (or similar) of a trauma and 'pendulating' (alternating) to a distraction task with positive sensations. BLS can be used to strengthen the positive sensations.



Treatment & Stabilisation

Grounding Techniques to increase body awareness ...



- Progressive Muscle Relaxation
- Progressive Muscle Tension
- Mindfulness Body-Awareness
- Positive Body Anchors
- Elastic Bands / Ice-Cubes



Treatment & Stabilisation

Sensory Techniques to increase presence ...



- 4-Elements Exercise
- Olfactory use of smell
- Taste (e.g. Sucking a Mint)
- Touching something sensory
(e.g. Stroking Velvet / 'worry-stone')



Treatment & Stabilisation

Imagery Techniques to reduce distress



- Distancing Techniques
(Fading the image with hands, if needed)
- Container Imagery
- Safe Place Imagery
- Light-Stream Technique



Treatment & Stabilisation

Within the field of dissociative disorders, EMDR clinicians are advised that there should be significant stabilisation in the preparation phase of the standard protocol.

However, where a client has been experiencing depersonalisation and / or derealisation for a significant period of time with a predisposing trauma and resources do not appear to be 'holding' - there may be elements of heightened risk, such as suicidal intent (or behaviour) caused by living in this 'half-life' or 'dream-state'.



Treatment & Stabilisation

For these clients, using a float-back technique to introduce body sensation as a mechanism of grounding can and is highly effective in terms of stabilisation.

This can enable a swifter progression to a place of stability in order to target the cause of dissociation, where it has been triggered by a natural, protective psychological avoidance to a traumatic event and potentially reduce risk of suicide in clients who are experiencing significant distress at being 'trapped' in this 'alternate reality.'



Treatment & Stabilisation

Case Study : Jennifer

Jennifer has a history of childhood neglect, emotional, mental and physical abuse.

She suffers with depersonalisation, derealisation and suspected DID.

The EMDR therapist working with Jennifer has been trying to use resourcing – with some effect – but the levels of dissociation at times make resourcing challenging in-session.



Treatment & Stabilisation

Case Study : Jennifer

Jennifer knows some of the resourcing techniques already mentioned (container; light-stream; 4-elements; safe place).

But the dissociation is making the use of resourcing techniques between sessions more and more difficult for Jennifer to use, when she is in an almost constant state of dissociation...



Treatment & Stabilisation

Case Study : Jennifer

3 days ago, she tried to cut her neck, with intent to commit suicide, feeling *'I don't want to live like this [in dissociation] any more'*.

In the past week, she has also tried various ways to harm herself with intent to die...

She has just arrived for her weekly therapy session...

OPTIONS ?????



Treatment & Stabilisation

Case Study : Jennifer

1. Figure that Resourcing isn't working – and head straight for processing the previous childhood traumas...
2. Use Anticipatory Anxiety protocol to target the fear of dissociation...
3. Continue teaching resourcing techniques that she can use between sessions...
4. Future Template (as a resource) –
Imagine coping with dissociation in the future...



Treatment & Stabilisation

Case Study : Jennifer

5. Float back – connect to body sensation of a time when she WAS grounded (pre-dissociation) then connect to Future Template (Instilling hope and installing body anchor)...

6. Identify body location of dissociation, shift to a different location and see if this enables her to feel a sense of mastery over the dissociation... See if, like safe-place, she can do this without BLS...



Treatment & Stabilisation

Case Study : Katy

Katy has a history of early abandonment and has grown up (from age 4) residing with family members but with a Mother with borderline P.D. who is sporadic in contact. Katy suffers with (secondary) Dissociative Amnesia.

The EMDR therapist working with Katy has been trying to use resourcing – but Katy's 'absences' mean that at times she is scared by finding herself in places she does not recall, which is making her feel she is unable to keep herself safe.



Treatment & Stabilisation

Case Study : Katy

Katy knows some of the resourcing techniques already mentioned (container; progressive muscle-tension, safe place).

But her condition makes it difficult for her to remember to use techniques away from session and she feels she is 'going mad'... Recently she has started talking about suicidal intrusions and reports hearing the voice of her (Deceased) Father asking her to join him...



Treatment & Stabilisation

Case Study : Katy

1. Figure that Resourcing isn't working – and head straight for processing the previous childhood traumas...
2. Continue teaching resourcing techniques that she can use between sessions...
3. Use Future Template (as a resource) – Imagine coping with dissociative amnesia in the future... Working out where she is – use a practical cue (e.g. photo) to help her re-orientate to the present.



Treatment & Stabilisation

Case Study : Katy

4. Identify triggers / cues to her dissociative amnesia and use BLS to strengthen – then move to Future Template...
5. If self-deprecating judgements exist re: 'blank' episodes (e.g. 'I'm a freak') consider Anticipatory Anxiety Template to manage future events likely to occur...



Treatment & Stabilisation

Case Study : Megan

Megan was prostituted by her aunty from age 12, with full knowledge by her Parents. She is currently 14 and in care, as a result.

Megan suffers with secondary depersonalisation, where she feels as if she has '*no body*' and feels '*invisible – as if you could look right through me*'.

She also has secondary depression – but no indications of PTSD – although there are distressing memories from the past.



Treatment & Stabilisation

Case Study : Megan

The EMDR therapist working with Megan has also been trying to use resourcing, to help Megan manage her dissociative disorder between sessions – but Megan is finding this to be unhelpful, away from session.

Megan is not a direct risk to herself, but can become distressed at the feeling of not having any 'body-sense'.



Treatment & Stabilisation

Case Study : Megan

1. Figure that Resourcing isn't working – and head straight for processing the previous traumas...
2. Use Inner-Child work (to rescue 12-year old Megan from prostitution) – *CI : 'Life wanted you' and 'Now, YOU have choices'*.
3. Continue teaching resourcing techniques that she can use between sessions...
4. Future Template (as a resource) –
Imagine coping with dissociation in the future...



Treatment & Stabilisation

Case Study : Megan

5. Float back – connect to body sensation of a time when she had a sense of being IN her own BODY (pre-dissociation) then connect to Future Template (Instilling hope and installing body anchor)...

6. Identify body location of dissociation (Is there any part that feels 'more' present in her body to Megan?), shift to a different location and see if this enables her to feel a sense of mastery over the dissociation...



FOOD FOR THOUGHT...

- **Is Dissociation linked to heightened levels of anxiety (e.g. panic-disorder) ?**

Although depersonalisation and derealisation symptoms are recognised as two of the most common spontaneous panic attack symptoms, the ability to dissociate is not mentioned in the main panic disorder literature. Nor is it mentioned that many people dissociate first and experience a panic attack in reaction to the dissociation.

There has been speculation amongst psychiatrists who work in the area of dissociation, that people with panic disorder do in fact dissociate first and then panic, but there has been no substantial research in this area to date.



Dissociation, Depersonalisation & Derealisation

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~ Thank You ~

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