High-level Trauma and Dissociative Identity Disorder

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In March of this year (2017), the European Society for the Study of Trauma and Dissociation (ESTD[2]) held a two-day conference in Norwich entitled: "**Facing the Challenge: Improving services for people with trauma-related dissociation**". It was something of a landmark, being the first UK conference of its kind co-sponsored by the NHS, marking a sea-change in the way that trauma and dissociation are viewed by mental health professionals.

The main focus of the conference was high-end trauma, resulting in what is known as Dissociative Identity Disorder (DID)[3], formerly called "*Multiple Personality Disorder*". In this condition, the psychological identity (along with the coherent basis for *physiological* identity) is fragmented into discrete parts, each of which may have no inter-communication or awareness of the other. There are probably as many different manifestations of DID as there are people whom it affects, and the fragmentation of *both* psychological identity *and* physiology creates some rather unusual phenomena. For instance, when a person with DID is dominated by one personality and its associated physiological state, a medical illness may be diagnosable. However, if a different personality fragment becomes dominant with its particular physiological makeup, then that illness will be totally undetectable (to ECG, blood tests, etc), but will return when the original identity becomes dominant. A third identity may inhabit a very narrow physiological range and refuse to be affected by even strong medication prescribed for the first. This refusal is due to the fact that each fragment is running its own survival response, may consider that a particular physiological zone is needed for survival, and so will maintain that physiological zone regardless of external factors. There may be just a handful of fragments, or in extreme cases of DID, they may be essentially uncountable (several hundred). The support organisation First Person Plural[4] provides more information about this condition and PODS[5]

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1 The Fulcrum : Journal published by the Craniosacral Therapy Association (UK)
2 http://www.estd.org/
3 Defined in the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V) : http://www.healthyplace.com/abuse/dissociative-identity-disorder/dissociative-identity-disorder-did-dsm-5-criteria/
4 http://www.firstpersonplural.org.uk/
5 http://www.pods-online.org.uk/

(Positive Outcomes for Dissociated Survivors) runs a series of useful training courses focused on the experience and treatment of DID.

A lack of healthy attachment[6] is the primary cause of DID. Young humans and animals depend on adults for their safety, so they have a fundamental biological drive/need to "attach" to a protector-adult. If they do not receive sufficiently strong and repeated signals that they are attached, this is experienced as a mortal threat to their existence. **Healthy Attachment** arises from a "good enough" parent or parents: who are sufficiently self-resourced; are sufficiently consistent; provide sufficient eye contact and other facial expressions of care; provide sufficient nurturing physical and emotional contact; and are able to provide sufficient food, security and other forms of basic care in early life. It is the foundation for a sense of self-worth, internal cohesion of the identity, and ability to form healthy adult relationships. In addition to a lack of healthy attachment, DID also requires severe trauma before the age of about seven – through sexual, physical or mental abuse, torture or other abnormal and extreme events. It is estimated that somewhere between 0.1% and 1% of the population in the UK may suffer from DID[7]. Attachment dysregulation is also a factor in many cases of post-traumatic stress disorder (PTSD), because early-childhood lack of support creates a far greater propensity to traumatisation.

Dissociation may be caused by anything internal or external that (I) stimulates or simulates a survival response in the body, and (2) that survival response appears to have been insufficient or was overwhelmed. So in addition to hysical and emotional trauma, it may initially arise from generational memories, toxicity or hypoxia, or hormone cocktails (such as cortisol) or infection or anaesthesia, and a vast range of other possible stressors. The usual thinking is to view dissociation as being pathological and non-ideal. However, it is clear from these high-level cases – and consequentlyin retrospect all cases of dissociation and PTSD – that dissociation and fragmentation are very intelligent and creative adaptations that allow children (and adults) to survive sometimes unimaginable situations. As with all dissociation, the problem is not the dissociation itself but its lack of self-regulation that prevents renormalisation of the survival responses that we call "trauma". Even where there is not DID, trauma is stored in the body in

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6 Attachment Theory : John Bowlby & Mary Ainsworth. See http://www.psy.med.br/livros/autores/bowlby/bowlby.pdf

7 I still find this statistic hard to grasp. The prevalence of DID for a country at war (e.g. Israel or Gaza or Syria) is more typically closer to 5%, resulting in a population who may find difficulty in self-regulation (thus perpetuating the violence), and whose behaviour may be compulsive and survival-driven - rather than under what is generally considered to be full conscious control.

compartmentalised fragments; each fragment consisting of a hyperarousad and a dissociative component that are in mutual relationship.

If hyperarousal were the only factor, then we could just go for a run and have a nice hot cup of tea with a few friends and any trauma would self-regulate and dissolve. So it is the dissociation that maintains trauma, not the hyperarousal. Hyperaroused states are commonly viewed as "the problem" because they cause loud sensory noises, whereas dissociation causes absences and numbness as opioids are released o in relatively mild situations less extreme than DID, its presence is often unremarkable.

Here is some standard jargon describing DID[8], which may be useful to know:

• A **Multiple** is a person who is suffering from DID – i.e. they have multiple **parts**.

• An **ANP** (Apparently Normal Part) is a fragment of identity that functions well in certain limited situations of normal life. There are normally just a one or a few ANPs, and as a very rough guide, it would be unusual that a single ANP would constitute less than (say) 5% of the total identity of a Multiple. So ANPs tend to be more visible. Most people people walking on the street are not DID/Multiple, but nevertheless often have somewhat compartmentalised personalities that arise in response to specific areas of their lives and specific challenges.

• An **EP** (Emotional Part) is a fragment of identity whose main purpose is to adapt to survive an early situation that is no longer happening. EPs are usually overtly dysfunctional, and/or hidden, but their continued existence usually performs an important survival function for the collective identity, and it would be a mistake to think of EPs as being pathological in nature. Their "job" is to hold and contain the pain of the trauma.

• An **Alter** is a discrete fragment of personality that occasionally becomes visible (and would usually be an EP). As some things done by one Alter may not be known to any other Alter, Multiples sometimes experience time shifts in which they have no idea what they have been doing for the past minutes, hours or even days.

• If someone is very strongly Multiple there may be no single fragment that could be called the **Core Identity**.

8 http://traumaconference.no/wp-content/uploads/2017/06/Marks-Dissociative-Experiences-in-Children-with-Complex-Trauma.pdf

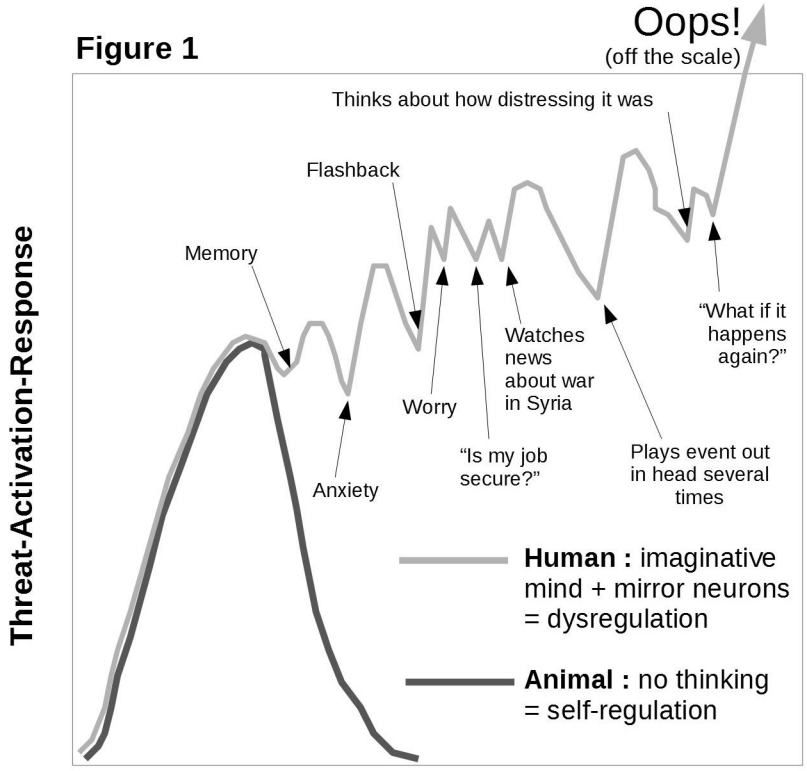
In CST, we like to believe that we can help resolve trauma, and I know from experience that this can be true. But we also need to recognise the limits to our scope of practice. In particular, there are degrees of traumatisation, dissociation and fragmentation, with their specific associated triggers, for which simply being touched, or even being alone in a room with a stranger, would create a catastrophic escalation. It is important to recognise that in certain cases such as these, the use of hands-on bodywork, regardless of how sensitively it is applied, may not be helpful. It's also useful to bear in mind that **Vicarious Traumatisation** resulting from both counter-transference and other feedback loops through the therapists mirror neurons is a very real issue for these high-level cases. Even a high-functioning professional trauma psychotherapist (who does not apply physical contact so is likely to be receiving a far smaller dose of counter-transference), might need one supervision session for every one session of treatment just to ensure that they do not suffer vicarious traumatisation. The way a CST practitioner focuses on health rather than pathology during a treatment tends to be protective against vicarious traumatisation; but nevertheless some caution and extra awareness is necessary when dealing with high level trauma cases.

In my experience of working with DID, it's almost impossible to be outside the trauma field when applying hands-on CST. In a Multiple, the mental field is fragmented, reactive and not fully attached to the body, with each Alter having a more-or-less independent will of its own. No matter where a therapeutic attention is placed, something will dodge it, run rings around it, run off, or do a "beam me up, Scotty". When physical contact is made, we are inevitably meshed via the relational field into some degree of Transference / Counter-transference. As such, with physical contact on Multiples, it is often not even possible to know if their system has collapsed in response to contact because that information is only available to someone who is not "inside the box".

However, it's not a complete loss! If only part of the system goes AWOL (so at least some of it is present) and the patient is *in the majority* of their conscious mind *comfortable enough* with physical contact and has sufficient trust, then some stabilisation and strengthening of the participating Alters is still possible. Over the years I have adjusted my practice so that I sometimes work off-body between three and tenfeet from the patient, which has advantages if used appropriately. But it's not straightforward. Strong trauma may also induce compliance, so patients may externally accept treatment without comment but internally it feels abusive. Or they may even deliberately choose an invasive treatment, as further expressions of compliance to invasion offer a sense of pseudo-safety. In these cases, there is often an increase in comfort

because there is an escalation of dissociation. As a therapist, a clear recognition and acknowledgement has to be made as to where the patient is prepared to go. If they are willing to deal with the dissociation, then some major long term improvements can be made to their quality of life. If this is not the case, sometimes CST can bypass other considerations and renormalise trauma/dissociation. But more often[9] the treatments end up as palliative "fixes".

Figure 1



Most people come for bodywork to help with pain. However in trauma, pain and tightness may be the strongest expression of health and life-force left, and are not actually the things that needs to be "fixed". This is a particularly important understanding that arises directly from PolyVagal Theory and Peter Levine's work – that stiffness, tightness and pain are often signs of hyper-aroused Sympathetic activity. For example, tightening thepsoas or other core muscles may have been the *only* safe way to express a positive, self-protective fight-flight response as opposed to a totally dissociative collapse. This situation is typical in many cases of migraine. So it may be crucial to retain that core tightness until the dissociative / overwhelmed element of the trauma is resolved.

9 This is not a judgement – recognising trauma and dissociation in oneself is not a small matter, and sometimes the dissociation is so strong and "normalised" that this recognition is not easy. Someone has to recognise that they need (and want) treatment in order for treatment to be possible, and the peculiarity of dissociation is such that it may result in an apparent absence of symptoms.

Whilst the relatively, *little-t* traumas that we see in everyday practice might generally respond well to CST, there is a certain point above which techniques applied have to be far more specifically tailored to the individual. As a very general rule, the greater the trauma the less appropriate most specific agendas of change become; the less formulaic and 'off-the-shelf' techniques of any kind work (including midline approaches) are appropriate; the more adaptation is necessary; the more invasive and abusive the therapist's consciousness and will / agenda can inadvertently become; and the more the therapist has to be skilled at self-resourcing and dealing with the after-effects of the session.

Over the last 10 years in the professional trauma community, the emphasis has shifted from an ideal of integration to a realisation that even in healthy core identities – just like in society – there is a multiplicity and a certain "float" in the connection between mind and body. Trauma is increasingly recognised as a common cause of bipolar disorder and schizophrenia; and in cases where a trauma diagnosis is made, these conditions become treatable. Despite this saving the NHS a large amount of money in emergency interventions and medication, there is a long way to go before the link between trauma / attachment dysregulation and mental illness is universally recognised[10].

A keynote speech at the ESTD conference by Dr Angela Kennedy (Consultant Psychologist, Tees, Esk & Wear Valley NHS Foundation Trust), gave an excellent overview of compassion. She pointed out that real compassion requires great strength, courage, self-regulation and care to avoid activation or dissociation, which cannot occur at the same time as shame or anger. This was put in the context of the human tendency to escalate trauma through internal feedback, reiteration and storytelling (Figure 1). She suggested that a continuous revisiting of gratitude for the small things in life – through the people around us and through simple acts of caring – keeps compassion alive. Thus, compassion on the part of the therapist is vital; and the patient being gently guided into a self-compassionate viewpoint is also a critical element in trauma treatment.

Children are remarkably creative, resilient and adaptive – and we heard some wonderful case histories from Dr Renee Marks[11], another keynote speaker. In cases of unbelievable adversity,

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10 Sigmund Freud did originally recognise that incest is a major cause of psychosis, but he was unable to publicly state it in 19th century conservative middle-class Vienna. So he wrote about incest fantasies as a cause of psychosis (thus blaming the victims). Incest is a particularly confusing source of attachment dysregulation.

11 e.g. see Sandra Wieland (ed) (2011) Dissociation in traumatized children and adolescents : theory and clinical interventions. Routledge psychosocial stress series (37) ISBN 978-0-415-87749-7

children survive by hiding their real self away where it cannot be harmed – sometimes not just in one piece. Severe early trauma can result in a few, up to hundreds, of Alter-fragments. Dr Marks is currently publishing a study of pre-birth memories elicited during therapy that have been verified by tracking back in family and medical histories.

This conference was imbued with a feeling of warmth and kindness, was deeply nourishing, and left me with a strong affirmation of humanity. I think everyone working in Trauma treatment recognises that there may never be enough skilled therapists and that we have a common responsibility to nurture, support and encourage each other. As far as I know, I was the only bodyworker present at the event. It is my hope for a greater presence of bodyworkers at future conferences so that the great pool of skills and experience on offer there (and here) can be more widely shared.