Working clinically with dissociation

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This article offers reflections on experiences of working with dissociation, both prior to and during clinical psychology training. This includes some of the challenges and key learning points encountered throughout.

DISSOCIATION describes 'the disconnection or lack of connection between things usually associated with each other' (International Society for the Study of Trauma and Dissociation (ISSTD), 2014). This can manifest as disturbances in memory, identity, emotion and perception (Carlson et al., 2009). It is suggested these alterations occur on a spectrum (Dalenberg & Paulson, 2009), with 'mild' examples including driving on 'autopilot'. Pierre Janet extensively documented the concept of dissociation, writing in the late 19th century about the altered consciousness of the patient, 'Lucie' (cited in van der Hart & Horst, 1989).

Dissociative experiences considered problematic, or pathological, are encompassed by the *Diagnostic and Statistical Manual (5th Edition)* within five dissociative disorders. Dissociative identity disorder (DID), the most 'severe' of the diagnoses, includes the presence of 'two or more distinct personality states' (American Psychiatric Association (APA), 2013, pp.292). The cause of dissociative disorders is disputed, but authors suggest it is associated with a history of childhood abuse (Brand et al., 2009). It is not our intention to explore the aetiology of dissociation. Instead, we hope to share some experiences of working with clients who dissociate, and the challenges this work can bring. This is written from the perspective of the first author, predominantly during clinical training.

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First encounters

Prior to clinical training, I worked in a forensic unit. There, I heard the term 'dissociation' used often, seemingly to represent any odd or unusual behaviour. I had little concept of what it was, why it happened or how to help anyone experiencing it. Considering the prevalence of trauma within forensic populations, support with understanding dissociation could have benefited both staff and clients.

I started clinical psychology training in 2011, and attended an event hosted by First Person Plural (www.firstpersonplural.org.uk). They are a survivor-led charity, who had created a DVD sharing client and clinician perspectives of DID. Truthfully, my motivations for attending were largely that it was local, and free. However, I gained knowledge and confidence from the event, and it developed my interest in dissociative phenomena.

At a similar time, I began my adult placement. One client, a young adult female referred for support with intrusive thoughts, presented as highly agitated at a session. Within a short space of time, there was a palpable shift within the room. The person in front of me transformed; her tone, manner and demeanour changed substantially. I was grateful to recall the First Person Plural messages and spent time speaking with this new presence, before the client I typically saw returned to the room. She was understandably shaken by the experience, as was I! I still recall the intensity of the shift, and how exhausted I felt afterwards. For me, it was an important experience in learning that 'just' staying in the room, and appearing calm in response to events within therapy, is both harder than it sounds and incredibly important.

Specialist placement

These and other encounters fuelled my interest in the spectrum of dissociative experi-

ences, and so I sought a specialist placement within an NHS Complex Trauma and Dissociation service with Dr Mike Lloyd. The service was newly established, and offered support to individuals with severe dissociation, particularly those diagnosed with DID.

Activities on placement included attending supervision for staff working with individuals diagnosed with DID, and observing some of Mike's therapy sessions. I found it difficult to describe these sessions; to encounter someone who was not pretending to be a child, but appeared to genuinely be a child, yet knowing there was an adult consciousness present somewhere within the person.

My clients on the placement typically had a history of early traumatic experiences, and some experienced dissociation. The ISSTD (2011) recommend a three-phased approach to working with complex trauma-related disorders/DID: (i) establishing safety, stabilisation and symptom reduction; (ii) working through and integrating traumatic memories; and (iii) identity integration and rehabilitation. These phases are not linear, and the work is typically long-term. As a trainee, this was not an undertaking I could commit to. However, with several clients I conducted an extended assessment and began working with the principles of Phase 1, including grounding techniques and emotion regulation.

I sometimes found this clinical work frustrating; as sessions did not have a clearly defined agenda, it could feel like we were not achieving anything. On reflection, these clients made significant progress, but this would not be captured on traditional outcome measures. After six months of assessment/therapy, clients were able to stay within the therapy room for the full session. They made eye contact more frequently or for longer, and began to disclose more 'pieces of the puzzle', gradually building a picture of their life.

During this placement, I began feeling I was seeing dissociation everywhere. The majority of clients, regardless of their referral, described elements of dissociation. I wondered if this was due to my own interests, and being in a service where dissociation was often discussed. I feared I was looking for it in clients' experiences, and falsely finding it. Mike encouraged me that asking these questions was vital, and holding them in mind would allow me to maintain my curiosity. In fact, the estimated prevalence of dissociative disorders in adult outpatient populations ranges from 12 to 28 per cent (Myrick et al., 2012). For DID, it is suggested 1–3 per cent of the general population would meet diagnostic criteria (ISSTD, 2011). Consequently, it would not be surprising if many clients within secondary mental health services exhibited signs of dissociation.

During my placement, I observed Mike conducting the Structured Clinical Interview for Dissociative Disorders (SCID-D; Steinberg, 1993), a formal diagnostic tool. I was pleasantly surprised to see it appeared natural and conversational, and served to gather much relevant information. I noted it could be beneficial in developing hypotheses and formulations. It also appeared to be a significant process for clients, whereby they could share and explore experiences which may have been previously ignored, or misinterpreted. Within one assessment, the client switched to different 'parts' of herself on multiple occasions. I was struck by how automatic and instant the change was in response to any perceived threat or uncertainty (Gillig, 2009), and wondered how this may affect the client's experience of day-to-day life.

I subsequently conducted the SCID-D with two clients, and was unprepared for how difficult I initially found it. The positioning within the assessment did not feel comfortable, as in order to complete the many questions it is necessary to maintain a steady pace. At times, this necessitated interrupting a client once we had acquired enough information. I was mindful to explain to the client that it may not feel like a 'standard' session, but for me it was valuable to experience the difference between a clinical interview and a therapeutic session.

Perceptions of dissociation

Whilst working clinically with dissociation, I noted numerous different attitudes towards the concept of dissociative disorders. A number of films portray individuals with DID-type presentations e.g. (*Sybil*, *Three Faces of Eve*, and even *X-Men*). I heard it described as 'weird', 'cool', 'mysterious' and 'convenient'.

Having seen the potential effect of DID, I would not ascribe to its convenience. It can be substantially disruptive to daily life, in addition to being both confusing and frightening (Haddock, 2001).

The variation of attitudes towards dissociation has been marked amongst mental health professionals. There are a number of differing opinions regarding the conceptualisation of dissociation, particularly DID (Kluft, 1999; Spitzer et al., 2006). Some professionals have appeared genuinely interested. Others suggested it is a set of symptoms artificially produced by therapists, an 'iatrogenic product of bad therapy' (Brown, 2009, p.586). It is not the purpose of this piece to engage in this debate, but these controversies certainly added extra barriers to the challenging work of supporting individuals experiencing dissociation. From my experience of working within this field, it seems these debates can alienate those at the heart of it, both individuals encountering these distressing experiences and therapists providing an essential service. Whilst I believe we should promote discussion of the nature and validity of different labels, it should not occur at the expense of the people we are trying to help.

The SCID-D also challenged some of my beliefs regarding the utility of different diagnoses. I do not consider myself a diagnostician, and generally lean away from the medical model of mental health. However, the majority of clients I encountered on placement had acquired many mental health labels, and were often grateful to find one that seemed more relevant. The scientific validity of DID as a diagnosis has been disputed (Boysen & VanBergen, 2013; Paris, 2012), but the same is true of many mental health diagnoses. There may be positive aspects associated with receiving diagnoses, such as 'making visible the invisible' (Hayne, 2003, p.726), empowering individuals to understand and manage their difficulties. Regardless of whether dissociation is a style of functioning or a mental illness, individuals with these traits deserve the opportunity to explore their experiences and receive support.

Key reflections

There have been a number of learning points for me throughout my journey of working with dissociation. The most important is that dissociation is a functional, effective way of coping with difficult circumstances (Gold & Seibel, 2009). As Gentile et al. (2013) observe, 'when an individual experiences trauma, dissociation is an attempt to survive, tolerate, consciously escape, or adapt to the situation' (p.23). I have shared this with clients, and they recognised that dissociation may have enabled them to function at difficult times.

It has also been valuable for me learning that working with individuals who experience severe dissociation does not involve anything 'fancy.' The basic principles of therapy become even more important, particularly building trust within a safe therapeutic relationship. Feeling comfortable with, and connecting to, a therapist can be difficult for individuals who experienced early traumas or formed insecure attachments (Gold & Seibel, 2009). I also came to understand that working at a comfortable pace for the client was vital, and structured session agendas were often not followed. Sessions could be unpredictable, and several left me feeling dazed. I noted how important it was for dissociative clients to feel safe and contained at a session's conclusion (Kluft, 1999); I had conversations about films, plants, baking and football teams, all in the name of grounding.

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My final thought is regarding the lack of services and support currently available for individuals experiencing dissociation. As previously indicated, the prevalence of dissociative disorders is suggested to be 1–3 per cent, which is comparable to other diagnoses such as schizophrenia (Bhugra, 2005). The treatment and management of dissociative disorders incur a high level of cost to mental health services, which can be reduced by the provision of specialised services (Brand, 2012; Lloyd, 2011), yet there are few NHS services which provide specialist treatment for dissociation. Whether this is due to lack of funding, interest or confidence is unclear.

Mental health training continues to provide little guidance on working with trauma

and dissociation (Brown, 2009). Whilst on placement, I organised and co-facilitated a workshop on dissociative disorders. The 50 places were booked within three days. This demonstrates the high level of interest and the need for staff support and training in this area. A repeat workshop is also fully booked, with a reserve list that is still growing.

Conclusion

Despite the challenges of working with individuals who experience dissociation, I have thoroughly enjoyed the process of developing my knowledge and experience in this area. I hope that services supporting these clients continue to grow, and that training and support for staff increases; thereby reducing its 'mystery' and ensuring individuals are not forgotten or overlooked.

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