What is dissociation?

Many people have made dissociation out to be something very complicated, explained only in scientific or psychological terms. In my opinion, dissociation does not have to be complicated. While science and psychology certainly have unique perspectives through which to view it, dissociation can be explained very simply.

Dissociation is anything that allows (or causes) a person to lose touch with some aspect of the reality of the moment they're experiencing, **and** this cannot be due to drugs, alcohol, medication, or some other medical cause.

This can be something as benign and commonplace as "losing" one's self in a book. Or the classically-cited "highway hypnosis" scenario whereupon a person driving from point A to point B arrives at their destination with no memory of the trip. On the other end of the spectrum, dissociation can be as severe as splitting off a part of the personality to cope with extreme and inescapable pain and terror. All of these examples are instances in which people lose touch with some component of reality in their present moment.

It's important to realize that **everyone experiences dissociation**, to some degree. Our brains are made to allow for it in a wide variety of situations, and not all of those situations necessarily involve trauma. All experiences of dissociation occur on a continuum, from mild and normal, to severe and abnormal. The point at which dissociation becomes a problem is the point at which it begins to disrupt a person's quality of life and ability to function.

Dissociation Symptoms

While there are many commonalities among those who experience dissociation, every person who experiences it is going to experience it as an individual. No two people will have the exact same experience or perception of their experience. There are many formal psychological terms for specific types of dissociative experiences, some of which I have included below, and then there are other terms commonly used but not specific to the psychology community.

- Depersonalization
- Derealization
- Dissociative fugue
- Losing time
- Hearing voices
- Dissociative Identity Disorder (or D.I.D., formerly called Multiple Personality Disorder, or M.P.D.)

Depersonalization
The sensation or experience of watching yourself but feeling as though you are not connected to yourself; that you are speaking and acting but you are not in control of your body. Depersonalization and derealization (see below) are often reported by those who do not normally have regular dissociative experiences in times of extreme crisis (ex: during a car wreck or an assault), when the nervous system is catapulted into an extremely highly alerted state.

Derealization
The feeling or experience that nothing is real; that the world or the things in it are not real. Some have compared it to feeling as if they are in a dream.

Dissociative Fugue
Dissociative fugue is purported to be the sudden inability to recall part or all of one's past, combined with intentional travel away from home or workplace. One may or may not take on an entirely new identity (either complete or partial) during the episode, and the episode cannot occur within the context of a prior diagnosis of Dissociative Identity Disorder. This experience also cannot be attributed to alcohol or drug use, or any other medical condition.

I have not personally experienced this, and do not have any extra insight into it.

Losing Time
Most people experience this symptom in mild forms, particularly when they're extremely engaged in a particular task or experience. For example, a very mild example of losing time would be a person sitting down to read a book and becoming so engrossed in the book that several hours pass without the person's awareness. On the more extreme end of the dissociative spectrum, some people experience the loss of time on a grander scale and lose days, weeks, months, or even years of their lives. They are amnesic for these periods of time, or may have partial amnesia for it. Many people who struggle more severely with dissociation lose smaller increments of time, but more often, leaving gaps in their awareness that, when taken alone, are insignificant. But cumulatively, those frequent losses add up to a bigger generalized loss of awareness of what is happening in their daily lives. This can be confusing to their friends, co-workers, and/or loved ones as well as the person themselves.

For symptoms involving smaller increments of time that happen more frequently, it often begs the question, "How do you know you're losing time if you can't remember having lost it?" The short answer is, you can't. Many people experience this symptom for years without conscious awareness of it. Only when faced with evidence of the passage of time, and the realization that they cannot account for it, do people start to comprehend that such a thing is happening.

Hearing Voices
Many people who experience dissociative symptoms that are on the more extreme end of the continuum oftentimes report hearing voices, which often prompts them to seek help out of fear that they may be "going crazy." Both those with dissociative disorders and those with schizophrenia commonly experience this symptom. The two differ in that those with schizophrenia can usually perceive that the voices are coming from somewhere outside themselves, and the voices are often combined with visual hallucinations. Those who experience dissociation usually feel or sense that the voices are coming from inside their minds, similar to thoughts, but of a nature or tone that doesn't feel totally natural or familiar to them. However, many people with dissociative

disorders report that this experience is so common and “normal” for them, having begun at such a young age, that they don’t realize until they are much older that it is not an experience that everyone has, so they are never prompted to contemplate the experience more deeply.

Dissociative Identity Disorder

Dissociative Identity Disorder is the most extreme form of chronic dissociation on the continuum, the development of which is usually associated with severe, repeated, prolonged traumatic events (such as abuse, severe neglect, or an ongoing crisis situation such as exposure to war or natural disasters) occurring in childhood from which there was no escape for the child. As a result of the terror, pain, confusion, and lack of emotional resources to cope with extreme situations, “alternate personalities” (sometimes called “alters,” and/or various other terms) are formed.

To be formally diagnosed with Dissociative Identity Disorder, there must be at least at least two or more distinct personalities, and those alternate personalities emerge and take control of the body (referred to as “switching”) on a regular basis. During the time an alternate personality is in control, the person has complete or partial amnesia for personal details that could never normally be forgotten, and the memory loss cannot be due to alcohol, drugs, or other medical conditions.

Choosing a D.I.D. Therapist

For those who have decided (or realized) that therapy is needed, the search for a therapist can feel like a formidable task. Those having issues with dissociation, or those struggling with Dissociative Identity Disorder, have the additional challenge of finding a therapist with knowledge in these areas – or else, someone who is willing to learn as they go. Despite the fact that a large percentage of people in therapy have experienced trauma, one can obtain degrees in psychology, psychiatry, and counseling without being required to have an in-depth understanding of trauma or dissociation and its many effects on the psyche.

This list is not meant to be all-inclusive, but simply a starting point. Here are some things to beware of:

Therapists who don't "believe" in Dissociative Identity Disorder.

Unfortunately, they're out there. And they're not uncommon. Dissociative Identity Disorder is a controversial diagnosis, one that can sometimes divide the therapeutic community in half. If you have D.I.D., or suspect that you might have it, finding someone

with experience with dissociation, or *at least* an open mind and willingness to listen and learn, can make a big difference.

Therapists who accept the diagnosis of dissociation/D.I.D. but who aren't comfortable working with inside parts/alters.

Therapists who will only work with the host are going to be very limited in effectiveness, since the host is not usually the one holding the deep pain and awareness of the origin of the different alters. Even if alters are slightly outside their comfort zone, a good therapist needs to have a willingness to work with whatever part of you is present and desiring help at that time.

Therapists who believe integration is the only/ultimate solution.

This is a tricky situation and may actually be compatible with some systems who *want* integration. But there are some systems who don't want that, or aren't sure, and in those cases, they need to be aware up front that their goals may be different from the therapist's and this may become a problem later on. There are many multiple systems that achieve a level of internal communication and cooperation that renders integration unnecessary.

Therapists who automatically assume D.I.D. is the diagnosis, when it's not definitive yet, because they see what they want to see.

On the flip side, there are therapists who see multiples as a phenomenon, or as unique and special (which they are, but this shouldn't be a stipulation for treatment), and – as an extension – it means they are unique and special as therapists in that they are competent enough to treat it. This is a sticky situation but I've seen and heard of it happening. This has contributed to the controversy surrounding D.I.D. as a valid diagnosis, because there are some people out there who claim that it's iatrogenic (therapist-induced). I do believe this can happen in some cases. It would be hard for anyone to resist the idea that they are unique and special in a way that few others are, particularly when the idea is being pushed on them from someone in a position of power, for their own clandestine reasons, and the client has enough of an emotional deficit to seek therapy in the first place.

Therapists who ask leading questions in memory work.

This is another red flag that should immediately be investigated with caution. Memory is already highly suggestible. There is no aspect of memory that isn't subject to influence and change over time. A good therapist will only ask their client unbiased questions that help the client describe what they're seeing, sensing, or feeling – NOT suggest any of the aforementioned to the client. There are times when assistance may be needed, or additional prompting, but a competent therapist will know how to do this without influencing the client to perceive something that's not actually true to their experience.

Therapists who are rude, demeaning, controlling, disrespectful, or hurtful toward inside parts/alters.

I wish I didn't even have to say this, and I wish it went without saying. But there are those out there who believe it's acceptable to treat inside parts/alters very poorly, as if they are less human than the host or front person. This is a tragedy, as those insiders have already dealt with enough abuse in their lifetime, the last thing they need is continued poor treatment from people who are supposed to be trying to help them. There are times when inside parts/alters act out, whether by cutting, yelling, being intimidating, hurting other insiders, etc. - but there are always reasons they do this. The therapist needs to be able to address these inside parts without reacting in hurtful or scary ways. Or, if in the event that they can't (therapists are human too, as we sometimes forget), they need to already have a plan in place for what they'll do if they need to take a step back and deal with their own emotions.

Therapists who don't believe inside parts/alters (or the host) when they talk about memories or experiences.

This is another issue I wish I didn't even have to point out. I wish it was self-evident, but it isn't. So let me say this: it's not a therapist's job to determine whether something that's bothering the client actually happened. With multiples, particularly those who have - or believe they have - undergone trauma-based mind control, the content of their memories can often seem outrageous. But it's not the therapist's place to judge whether something really happened. Maybe it did, maybe it didn't. Often enough, the clients themselves are confused about this. The point is, the pain is real. And it's coming from somewhere. The therapist is there to help the client process and make sense of the pain. Therapists who don't believe their clients' stories, or try to argue that something is or isn't real, are self-defeating.

Goals for Therapy with D.I.D.

One thing that's vitally important for those starting out in therapy is to determine what their short- and long-term goals are. What do you want to get out of your time with a therapist? The answer(s) to this question can even be an important factor in determining whether a particular therapist is a good fit for you. It can be helpful to discuss a particular therapist's ideas of what they believe should happen in your life as well, to see if they are compatible. A good therapist will let the client define what issues they want to improve upon, and give honest feedback as to whether they have the skills to help the client achieve those goals.

Wellness vs. "Disordered"

People with Dissociative Identity Disorder are all very different. "Healing" and "wellness" can mean different things to different people. Don't let anyone tell you what your goals *should* be, or what it means to be well. There is no all-inclusive definition or standard that all people can be held to. You alone can and should determine what you want that to look like. A disorder is only a disorder – that is, only a problem – insofar as it disrupts a person's life and ability to function at their maximum desired level of functioning.

Short-Term Goals

Most of the time, short-term goals involve immediate relief from distressing symptoms and experiences, like loss of time, body memories, headaches, and mental distress caused by alters being unaware of their pursuit of conflicting desires, and/or lack of respect or peace between inside parts.

Long-Term Goals

Long-term goals can vary widely, depending on the system. Some D.I.D. systems want integration. They want to eventually be able to come to terms with whatever events and situations in their past caused them to split apart, and they want to have shared awareness of all thoughts, memories, feelings, sensations, and emotions, all of the time. This is integration; not that any part would "die," or "disappear" – but rather, that ALL alters would be "out" all the time, together.

Some D.I.D. systems are comfortable being separate and sharing a body. They simply want respect and mutual cooperation on the inside, and reduction of symptoms like losing time, flashbacks, and loss of functionality.

Some D.I.D. systems want a combination of the two; perhaps a little bit of both integration and separateness. They don't mind being separate but perhaps want *less* alters, and merging of some – but not others – makes sense for their system.

All of these goals are okay. Goals that are not listed here are okay. Once you have defined some of your short- and long-term goals, be sure to share them with your therapist and evaluate their willingness and ability to help you work toward those goals.