

# Dissociation: The functional dysfunction

## Abstract

This article examines the dynamics of dissociation, its function, and cautions in its treatment. Determining the functionality and dysfunctionality is complex. When taken within the framework of Posttraumatic Stress Disorder, throughout a life span, the complexity and its functionality emerges. Through working with patients with Dissociative Identity Disorder over three decades, there are assumptions that are frequently made by clinicians which are inaccurate and potentially harmful to the therapeutic relationship, treatment efforts, and the patients. How does our mind protect itself when some aspect of reality is too painful to cope with? Like any natural response to pain, we have psychological mechanisms which protect us from severe emotional trauma. For our mind, one of those mechanisms is dissociation. It allows us to continue to function in everyday life without experiencing what could be debilitating emotional pain.

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## Opinion

In healthcare, we have tended to seek to eliminate what we see as being pathologies prior to fully understanding the function that those pathologies support. If we were to examine these adaptive behaviors and/or conditions as ways of maintaining some function, we may find that we are less likely to cause iatrogenic harm. I remember studying under Dr. Harold Greenwald, a psychologist who taught at the United States International University in San Diego. He approached symptoms and conditions asking the questions of what are the “payoffs” and the “pitfalls” of the symptom or condition. This did not only provide clarity, but also clues as to therapeutic direction.

If we experience an emotional trauma that our minds cannot cope with, dissociation allows us a buffer so we can deal with immediate needs. If the trauma is great enough, we may even block the memories of those events until we are strong enough and safe enough to cope with the trauma. For some, personality fragments can form and potentially break off a period of time from the individual's timeline. When this happens, separate parts of personality can form to isolate the events and to provide specific roles which protect us, or defend us from further threat, or allow us to live a functional life going to work and interacting with others. This would be where Dissociative Identity Disorder (DID) exists. It is more common for dissociative fragments to develop which provide an alternate numbed reality, which acts as an anaesthesia, creating a dis-real sense and detachment from some emotions.<sup>1</sup>

What do we know about the neurophysiology of dissociative disorders and Posttraumatic Stress Disorder? There are significant changes in brain structure in individuals who experience PTSD and dissociative symptoms. It has been shown that individuals suffering from prolonged trauma have a decrease in size of the hippocampus and amygdala.<sup>2</sup> Cerebral vascular studies show a reduced bilateral orbitofrontal cortex activity in DID patients.<sup>3</sup> There is evidence in research by Elzinga et al that the dorsolateral and prefrontal regions of working memory also increase in activity.<sup>4</sup> It appears obvious that the traumatic events which give rise to dissociative disorders are profound; impacting the very neurophysiology of the individual.

Biological changes between personalities has been well documented over the last fifty years. In 1986, Putman et al documented that 50% to 60% of DID patients experienced tension

headaches or vascular headaches (i.e., migraines).<sup>5</sup> In 1985, Shepard and Braun identified refraction, visual acuity, ocular tension, color vision, keratometry, visual field in DID patients which changed with personalities.<sup>6</sup> In 1984, Bliss documented reports of body anaesthesia differences in DID patients. From 1984 through 1987, various researchers' documented different personalities responded differently to medications. I have seen different personalities of DID patients require different color overlays to correct Irlen Syndrome distortions. Allergies one personality may have are not experienced by others. Neuroimaging and related measures have shown changes in function of the amygdala and hippocampus in DID patients. More refined subcategorization of DID types and histories needs to be included in research to help clarify the exact variations between subtypes and neurophysiological dynamics.

It is important to understand that the splitting off of personalities at different developmental stages does match with several theoretical schools. For example, if we look at Erik Erikson's stages of social development, we can easily see the potential connection. In the Oral-Sensory Stage (birth to approximately 18months), trust versus mistrust is being established, with the major activities being feeding and basic nurturing. In the Muscular-Anal Stage (18months to 3years), autonomy versus shame/guilt is established, with toilet training being a major activity. In the Locomotor Stage (3years to 6years), initiative versus guilt is being established, with a continual march towards independence. Latency (6years to 12years) focuses on industry versus inferiority. Adolescence (12years to 18years) focuses on identity versus role confusion. Young Adulthood (19years to 40years) focuses on intimacy versus isolation. What if sexuality is introduced during the Locomotor Stage? How would this impact the developmental phase towards independence and issues of guilt? Or during the Muscular-Anal Stage? It is very easy to see how the introduction of abuse during these periods of development can impact perception of the world and life. Rather than attempting to establish cooperative, interactive friendships, and seeking parental nurturing; a sexualized child sees seductive behaviors as a method of gaining parental approval. If the personality development is frozen in an isolated personality, moving on to normal development is also frozen.

What if we were to set aside the normal theories of development for a moment? We have children who experience, and are told, of a normal childhood who then experience ritual abuse, which is in

stark contrast to these images. How are they to reconcile them? Even as adults, with a developed perspective of moral development of good and evil, we have extreme difficulty with this contrast. We have trusted adults acting in ways that would tell us that these acts are acceptable, but then tell us not to tell others. They are secrets. What do we do with trust, or with love, or with feelings of acceptance? Is it any wonder that at these points an individual has to create a psychic break to protect basic concept of self? With these unresolved episodes of life, existing as frozen bubbles of time; dissociation is the only function which can protect the whole. Perhaps, with some review of what is considered normal development, it is time for us to entertain a separate developmental theory for dissociative patients.

For a person with DID, it is not unusual to have personalities which fragment off at different ages. If the person was traumatized during preverbal years, or during times when language was just in the beginning phases of development; the personality may not be able to verbalize feelings and events. Psychotherapy for these personalities requires the spirit of a comforting nurturing relationship, drawing on symbols and nonverbal approaches. This is a good time to review what were some of the comfort foods and toys identified prior to the pre-verbal personality needing attention.

A common personality that develops is the “protector” who will come out when immediate threat is present. Another common personality acts as the “coordinator” who helps keeps the internal group of personalities organized and functional.

A patient, referred as having been diagnosed with Multiple Personality Disorder, over ten years prior, had been in therapy since that point. There were well defined personalities: 3 children, 2 adolescent personalities (with one male and one female), a protector, an adult personality (who wanted to be a housewife and married), and a highly productive business woman. There was a history of repeated ritual sexual abuse. There were other less defined personalities. The personalities were co-conscious (they all knew about each other), and would defer to the dominant business woman personality, a highly accomplished coordinator and executive. One of the personalities was a recovering anorexic-bulimic. The acceptance of the existence of multiplicity was not shared by some of her physicians until she had to go into surgery under general anesthesia. The multiplicity had been discussed with the anesthesiologist prior to the surgery. During the surgery, while under general anesthesia, one of the child personalities came out and a separate anesthesia was used for that personality. In actuality, the additional anesthesia supplied by the anesthesiologist was simply saline, but it provided the respect for that personality, and the suggestion of sedation. The reason that a normal weight patient, with adequate sedation, had a personality come out of the anesthesia during surgery is still unknown. But we cannot underestimate the power of the mind in these cases.

During this patient's ten years of therapy with this psychotherapist, the issue of integration was addressed. Some of the personalities did not wish to integrate for fear of losing the others, and the patient potentially deteriorating and being unable to remain employed. Collectively, the patient's decision was to maintain the separate personalities, but work on the multitude of stressors and emotional issues, each experienced. At one point, while in treatment, the patient contracted a severe infection which was almost terminal. As the infection was controlled, the patient continued to refuse to eat. I was called to the hospital, where I asked the patient what their favorite food was as a child. One of the child personalities came out and said it was

chicken and rice soup. I then asked the ICU nurse to get her chicken and rice soup. The patient began to eat without further problems.

In working with various Posttraumatic Stress Disorder patients with variations of dissociative elements, I have found that some are “co-conscious,” aware of the other personalities while others some are totally unaware of the multiples, simply having blank spots in their memory where other people say that person is acting strangely and like a different person. One of the psychological tests that I find of value is the Detailed Assessment of Posttraumatic Stress (DAPS) which provides a scale for dissociation. I have had individuals who are not coconscious, scoring low on this scale while showing a classic Minnesota Multiphasic Personality Inventory profile of extreme elevations in scales of Schizophrenia, with additional marked elevations (>70 T) on scales for Depression, Paranoia, Psychopathic Deviate, and Psychasthenia.<sup>7</sup> Individuals who are co-conscious tend to have higher dissociative scales in the DAPS.

In examining different diagnoses, I have found that the research does not adequately detail the variations in symptoms and presentation to the point that possible subtypes and differential assessment is possible. The question is if the varying presences of presentation are subtypes, or are variables, of the same condition? If we were to refine the differences within the diagnostic categories prior to research, would we find that we are identifying different diagnoses, or different subtypes, of the same diagnosis?

Working with multiplicity is not something you can learn from a book. It is an art, requiring both sensitivity and intuitive skills, of working with each personality, as well as the person as a whole. In many cases, to insist on integration would only result in the withdrawal of the patient from treatment. Any interruption or event that occurs can trigger a shift in personalities, and the provider finds him/herself treating a different personality. Even the act of the therapist leaving the room for a moment can result in the shift from one personality to another.

The process of integrating these personalities would require helping each to heal and continue the maturing that should have occurred. After treating many patients with Dissociative Identity Disorder, I have been told that even when the therapist is focused on “integration,” the patient maintains the alters quietly in the background ending treatment before the continuation of the “group of alters” is discovered. Integration of personalities may not be the best goal for therapy nor one that the patient wants. To integrate means to risk not having access to the most functional personality for some parts of life that the patient has had who may have been a “hyper-focussed employee”. It also means risking being “alone” inside. It also risks having to be present all the time for life. Each of these, and other, adjustments and sacrifice need to be considered and explored with the patient in developing treatment.

We, as clinicians, make assumptions which may not be accurate. We assume that alters tend to be “personalities” which break off at a point in time, or that resolution is maturing each to the point of the biological self, or that the alters are dormant during the time that others are “out.” It is my opinion that all of these assumptions are false. Each personality is fully active, and gathering their own experiences, during the time that the biological self is experiencing life. This means that each is developing a set of experiences which continuously impact the formation of new neural connections and responses. The different alters do break off, but become a member of

the whole which interacts internally with the others. This makes the use of various personality theories developed for “non-dissociative” individuals only marginally useful. Just as we all hold memories of different points in our life, alters hold the memories and Gestalt of that point in life.

It is not a static state, but a very dynamic element of self. What is interesting is that if the total of the group within is threatened or at risk, they DID patient will protect the total by misdirecting the therapist so the total is not at risk. Each alter maintains its age, but continues to gather life experiences as one would “at that age.” This is one of the reasons that the concept of “integration” is unlikely to work, and the application of various developmental theories does not apply. A more useful psychosocial framework may be to use group dynamics or sociometry, which include various age groups living in continuous co-existence. The goal of therapy is to help the group members to work through issues which each separate personality experience, and which could undermine the functionality of the collective whole.

The goal of treatment is also not to eliminate dissociation. Dissociation is a part of being human and is required for function.<sup>8</sup> Without the ability to dissociate, it would not be possible to effectively detach from situations in order to address emergencies and daily demands. It would also not be possible to step out of ourselves and empathize, imagining ourselves in the other person’s shoes. We need to understand that everything that we call a dysfunction, or a disorder, represents an aspect of which we are that is out of balance with that which is needed for effective function in daily life within the current social setting.

Another case, a patient which presented with multiple issues including: a history of multiple head traumas, seizures since childhood, multiple somatic complaints with undiagnosed physical disorders, sleep walking, and a history of Posttraumatic Stress (the result of abduction and multiple abuse), and other traumatic events over a five year period. After years of treatment for these and related issues, with many of the conditions stabilized, there continued to be episodes of lost periods of time which were not related to seizures. During some of the incidents, the husband had shared that his wife was in what appeared to be a trance-like state where she stated that she was asleep. Speaking in the third person, she used her proper name when stating that she was asleep. During another episode when she thought that she was being abandoned by her husband, she flew into a violent rage, and her personality totally changed to being severely hostile, threatening, and making homicidal statements. Again, she had no memories of this incident. Severe feelings of not being safe, tending to internalize anger fueling depression, and suicidal thoughts emerged. The locus of these emotions, and learning how to deal with them in a healthy manner, was the focus of treatment. As treatment progressed, the incidents of dissociation reduced and then disappeared. As this occurred, other conditions also stabilized and were able to be maintained.<sup>9,10</sup>

Severe feelings of not being safe, tending to internalize anger fueling depression, and suicidal thoughts emerged. The locus of these emotions and learning how to deal with them in a healthy manner was the focus of treatment. As treatment progressed, the incidents of dissociation reduced and have a less negative impact on function. As this occurred, other conditions also stabilized and were able to be maintained.

Are personality fragments or alters ever totally integrated? This is a question which is difficult to answer. As we move through the

different stages of life, it is likely that a change in situation and perceptual scheme can evoke destabilization. If we look at these events as points for further growth, where old defenses may emerge, it is easier to accept them as points in a pathway rather than relapses.

In looking at traumas, we also need to recognize that providing effective therapy at one stage of life does not negate the need for additional therapy at other phases of life. For example, if a person has trauma during childhood and is currently a young adult, they can only work on the issues which are present to that point. When the patient becomes a parent, it is likely that the memories of childhood trauma will be triggered by having a child who may be at risk. This is likely to significantly impact the perception, the role of being a parent, and the relationship with their children. When the patient becomes a grandparent, this new role triggers yet another stage of healing. It is important that we realize that healing is simply not a onetime event, but rather a process. For the patient with DID, the process is more complicated, involving not only therapy for each of the personalities, but attention to the impact of these on the function of the “internal group” as a whole in the outside world. It is the blending of individual and group therapy for a single physical self and its multiple personality membership.

Rather than look to just the normal developmental stages, identified and set forth by the pioneers of child development, we need to accept that these profound diversions from trust, truth, and into the darker side of human existence, need to be seen as assaults to normal development which tear the individual from normal development into an ethereal abyss, which must be transverse by the therapist to help the patient. We need to be willing to reach into the dark places, when the patient is ready, to help them to move back to life and a way of regaining the parts of self who were misplaced. One of the unfortunate realities of both past and many current research projects is that subsets within the sample groups are not assessed separately in reference to various criteria. We tend to use currently accepted diagnostic categories based on DSM criteria. These categories are based on limited detail. If we were to separate out patients who matched different subsets based on biologic differences (i.e., paradoxical response to medications, allergic reactions, symptoms outside the primary diagnosis, course of impairment, family history, genetic predisposition, medical history, and others), it is possible that some of the subtle tendencies being researched may be more significant to some subsets than others. If this was done, it would provide the opportunity to clarify possible new diagnostic categories within the sample group, and clarify subtle differences which could improve selection of therapeutic approaches. With DID, there are always subsets which would separate the sample group into groupings (i.e., personalities with different medical conditions and responses, co-consciousness, different levels of function, characteristics of past abusers, history of therapy, coping mechanisms, responses to various psychological testing, etc.). Unfortunately, this information is frequently lost robbing the professional community of the opportunity to refine and clarify diagnostic categorizations. Perhaps, as we become more skilled at clarifying the subsets within sample groups, we will be able to evolve research to provide a greater yield of knowledge.

## Biography

Rory Fleming Richardson, Dr. Richardson is a Board-Certified Medical Psychologist who is registered as a Clinical, Counselling and Health Psychologist Practitioner in the UK, licensed in Oregon

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## Conflict of interest

The authors declare that there is no conflict of interest.

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