

On No-Man Land: Perspectives from healthcare professionals on the impact of loneliness on dissociation as a coping mechanism

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Abstract

Background: Loneliness is a “hallmark” of dissociative disorders (DD), but its impact on DD patients is understudied in the field. Similarly, therapeutic modalities best suited for DD patients is an area of controversy; with research advocating cognitive therapies (CTs) despite the risk of retriggering trauma in patients. **Research objectives:** 1. To explore if dissociative episodes or phases are triggered in individuals as a result of loneliness, using mental healthcare professionals’ experiences in treating such patients. 2. To discuss participants’ recommended therapeutic techniques for DD patients experiencing loneliness. **Method:** Using a qualitative design, fourteen trauma and dissociation practitioners were interviewed with semi-structured questions, and a coded thematic analysis was conducted to extract codes, sub-themes, and themes from the data. **Results:** The findings show a two-way, yet non-linear relationship between loneliness as a trigger and the use of dissociation to cope with it. Participants strongly advocated the use of trauma-based modalities such as EMDR. **Discussion and Conclusion:** The severer the trauma and the less effective the patients’ coping mechanisms are, the severer their dissociation is, and their inability to connect to their own selves, and in turn, to others, which causes them to seek isolation. However, supportive, healthy networks, when patients seek/have them, contribute significantly to developing a sense of safety, which allows DD patients to feel more grounded in their outer realities and allows them to lead more satisfying lives. Practitioners agreed that safe therapeutic alliances are pivotal for patients; it allows them to connect more to their therapists, and subsequently to their social networks. Furthermore, all practitioners advocated moving away from using extensive CTs with DD patients in the initial phase of grounding and moving towards trauma-based and psychodynamic-based modalities. **Recommendations:** For future research, it is recommended that this link be studied by interviewing DD patients themselves, and/or conducted using quantitative designs to raise test-retest reliability.

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Keywords: Dissociation, Coping Mechanism, Loneliness, Trigger

Introduction and Background

Research on dissociation has primarily focused on its development into Dissociative Identity Disorder (DID), and Depersonalization/Derealization Disorder (DDD), which is commonly comorbid with Borderline Personality Disorder (BPD) populations (Mosquera & Steele, 2017; van der Hart, Steele, & Nijenhuis, 2017). However, research has not delved enough into the triggers that may cause dissociative disorders (DD) populations to keep resorting to dissociation to cope. This study looks into how loneliness as a trigger can cause DD populations to keep using dissociation to cope with the discomfort of this trigger.

Looking at this link from an existential psychological standpoint, May (1959) posited a theory in his book that noted that those least comfortable with being alone were likely to resort to mechanisms known today to be dissociative once they became lonely in order to help them cope. To date, only Kearney et al. (2016) investigated the link between trauma and dissociation and loneliness primarily as an outcome of dissociation, though not as a factor contributing to dissociation, which is what this research has done. Other research studies explored the subject of dissociation and loneliness as a byproduct, but in no means assessed a direct link between the two variables (Dorahy et al., 2015; Mauss et al., 2011; Ross, Banik, Dedova, Mikulaskova, & Armour, 2018).

In regards to treatment, practitioners outline in their guides that therapy must ensue in three main stages: stabilization, treating traumatic memories (reconsolidation), and the reintegration of personality and its rehabilitation (Ducharme, 2017; ISSTD, 2015; van der Hart et al., 2017). Some of the literature has advocated the use of cognitive therapies (CT) and exposure exercises as well (Blankenship, 2017; Linehan, 2015; Mosquera & Steele, 2017), whereas others advocate treatments using psychodynamic approaches and other modalities more focused on trauma reconsolidation such as Eye Movement Desensitization and Reprocessing (EMDR) (Alaryian, 2019; Cusack et al., 2016; Kalsched, 2017). Treatment is an important factor in the perceived link between loneliness and dissociation because it breaks the cycle, since it aids patients in developing more adaptive coping mechanisms, one of which, is building social support networks to keep them grounded.

Thus, the literature has very largely focused on dissociation as a coping mechanism for trauma (Mosquera & Steele, 2017), but it has not looked closely enough at a direct link between dissociation as a coping mechanism and loneliness (the lack of a social support network). To that end, this research looked at this gap using the following research question: What is the perceived impact of loneliness on dissociation as a coping mechanism? The research's objectives were, first: to explore if dissociative episodes or mechanisms are triggered in individuals when they experience discomfort as a result of feeling abandoned and involuntarily alone, using mental healthcare professionals' perspectives from their experiences treating such patients; and second, to identify strategies from the perspectives of mental healthcare professionals that should be in place to treat such patients, when loneliness may trigger dissociative mechanisms.

Literature Review

This literature review will discuss the pathology and etymology of dissociation; the theoretical framework upon which this research is built; and recommended treatment guidelines. Critique of the literature reviewed will be the main focus of this chapter; the gaps in the literature presented here are to support the research's following objectives: to explore if dissociative episodes or phases are triggered in individuals as a result of loneliness; and, to identify strategies to treat the trigger of loneliness. The gap in the literature presented below has led to the dissertation's main question: **What is the perceived impact of loneliness on the use of dissociation as a coping mechanism?**

Pathology and Etymology of Dissociation

Dissociation in the shortest definition possible is the severe, maladaptive form of avoidance a patient develops due to intense fear of or inability to bear psychological pain (Schimmenti & Caretti, 2016). According to research, dissociation stems back to childhood trauma (Ducharme, 2017; Sar et al., 2017; Schimmenti & Caretti, 2016). Even if it occurs for the first time in early adulthood, dissociation's roots are hypothesized by current research to have been planted since childhood (Schimmenti & Caretti, 2016). This widely accepted theory takes root in Bowlby's (1973), who investigated how parental attachments in early childhood shape a child's lifespan resilience to environmental pressures, or adversely, their predisposition to mental illness.

Sar et al. (2017) mention in their study that early direct traumatization in life, such as when the child has to become the parent to their parent(s) or for their own selves, is at times severe enough to cause children to develop a dissociative mechanism to help them cope. To children, lacking the stability and sense of security that comes from having stable parental attachments is akin to feeling without safety at all, at the mercy of their environment and acutely aware of their lack of defenses should this environment attempt to harm them. This anxiety-inducing sensation is capable of rewiring the child's brain and neurobiological markers to form mechanisms that lead to chronic lifelong anxiety disorder, which underlies dissociative mechanisms (Kalsched, 2017). However, this is not to say that all individuals with abusive childhoods develop a dissociative disorder or mechanism, and a factor to be considered in this is the genetic predisposition to chronic anxiety that plays a pivotal role in developing dissociation (Krause-Utz & Elzinga, 2018). Environmental factors coupled with genetics can sometimes overcome healthy parental attachments and individuals with a genetic predisposition to chronic anxiety may foster dissociation as a coping mechanism (Soffer-Dudek, 2014).

Theoretical Framework

The sources mentioned here as the theoretical framework amount to seven, but only Dorahy et al. (2015) has looked at the direct link between loneliness and dissociation. The other six sources included make significant contributions in relevant areas that help sustain and elaborate on the workings of such a relationship and how it can indeed exist (Cacioppo, 2016; Kalsched, 2017; Kearney et al., 2016). May (1959) is a part of this literature review despite it being a debatably outdated source, and one with strong ideological underpinnings, because it is the inspiration behind the researcher's choice to look into this topic, and one that posits an

explanation of this perceived link between loneliness and dissociation through an existential psychological perspective; having made a reasonable assumption regarding loneliness, identity, and the social interplay between both.

May (1959) predicted that at their time, the increasing technological advances that were taking place were primary factors of the individual neglecting the individualistic identity and by result, losing touch with an inner part that made it possible for one to be alone but not lonely—in other words, loss of awareness of the self-state. May (1959) claimed that individuals could no longer stand solitude, and once they were rejected from their social circles, were in danger of inner fragmentation severe enough to cause a psychotic episode—depending on how much they depended on social interaction to fill a ‘void’. From afar, such a claim may seem existential at best and lacking sufficient quantitative support. However, dissociation in itself, by testimony of the literature reviewed, is just that—a loss of an ability to connect to the ego, the perpetrator of executive function, the main judge residing in one’s head (Alayarian, 2019; Kalsched, 2017). May (1959) simply noted that this fragmentation became intolerable when vulnerable individuals were left to their own devices, and this inspired the topic of the current dissertation. The ego, when exposed to severe trauma and in preparation of impending death, is concealed and the individual is left feeling like an empty shell (Cacioppo, 2016). Perhaps May (1959) had built his reasoning on individualistic identity and its neglect in modern society—a different cause to dissociation than the one explored here—but his claim that loss of touch with one’s self is a terrifying experience, at times leading to psychosis, cannot be neglected (Cernis, Freeman, & Ehlers, 2020; Pearce et al., 2017).

Kalsched’s (2017) study makes significant contributions to the study of ego and ego function in dissociation. Coming from a psychoanalytic approach, Kalsched (2017) uses some emotive language and allusions to make sense of trauma, such as his paper’s opening line: “Let your heart break and drop the story” (Chodron, 2013, as cited by Kalsched, 2017, p.475), which is a contradiction of traditional psychoanalytic practice to use such humanistic language. Kalsched (2017), using psychoanalytic theory, equates trauma to the ego hiding the ever-hurting child to protect them from further blows, though this explanation is in general supported by other researchers using other schools and approaches (Alayarian, 2019; van der Hart et al., 2017). In an attempt to demonstrate Kalsched’s (2017) theory visually surrounding the reintegration of the self-state’s fragmented others, the researcher here equates it to a circle; Kalsched (2017) is proposing that in order for reintegration of self to occur, trauma must be faced and reconciled with, which is exactly like a cycle. One must complete the circle, so to speak, in order for one to return completely to one self-state.

The main critique the researcher has on Kalsched’s (2017) paper is that though it is psychoanalytic in nature and terminology, Kalsched (2017) is more or less advocating a cognitive behavioral approach of using exposure to help the patient face the trauma and heal from it, though he fails to specifically note that this is a cognitive behavioral approach. In addition, many trauma clinicians and professionals actually denounce using a cognitive behavioral approach with dissociation patients because they firmly believe that the problem is not solely cognitive in nature, and thus cannot be fixed through a cognitive approach, or at least not *solely*, but that rather integrating the body in the process is pivotal for recovery (van der Kolk, 2014).

Other researchers such as van der Hart et al. (2017) and Mosquera and Steele (2017) offer more practical papers on the topic of dissociation, where they attempt to aid clinicians by explaining the cognitive behavioral mechanisms taking place in dissociation and proposing treatment protocols. Though coming from different schools, all three researches support the importance of guiding dissociation patients towards revisiting the trauma and facing it in order to heal (Kalsched, 2017; Mosquera & Steele, 2017; van der Hart et al., 2017). The researcher does wonder whether the three papers being published in the same year is at all relevant to such different schools agreeing on one approach to treating dissociation patients, or whether it is simply to be in accordance with the International Society for the Study of Trauma and Dissociation’s (ISSTD) protocol (2011).

It is worth mentioning here that the protocol published by the ISSTD (2011) is focused on DID patients, and not other DD patients, unlike the researchers discussed above, who are more focused on dissociation ensuing trauma and relevant personality disorders. The main critique here on both sources is that neither

seem to be too concerned with what happens if the agreed upon protocol fails; what happens if the patient after considerable time does not show willingness to revisit their trauma? What happens if they do revisit the trauma, become too overwhelmed (even though stabilization has been thoroughly ensured) and their dissociative state worsens? As discussed with participants, it tends to fail and other protocols of treatment are usually adopted instead to help trauma and dissociation patients, like EMDR (van der Berg et al., 2015; see also Results and Discussion sections).

To their merit, Mosquera and Steele (2017) do well in outlining the dissociative spectrum of BPD, which most research fails to focus on as much as they do on DID. Even better, Mosquera and Steele (2017) do well by outlining the different features of BPD, the dissociative versus the non-dissociative symptoms and pathology. To newly-practicing clinicians, this is invaluable and will go a long way in helping them better identify what kind of issues their patients are facing, especially since dissociative symptoms are not easily discernible. Similarly, van der Hart et al. (2017) go to great lengths to explain the underlying mechanisms that causes individuals to resort to dissociation, and the significance of their contribution to the field is undeniable.

Kearney et al. (2016) attempted to identify whether trauma and dissociation could be predictors of loneliness in a sample of college students, and did so through a sampling of psychology major students, surveying them online and running statistical analyses on the data collected. While the source has been a strong part of the theoretical framework, there are several concerns to it; firstly, the sample they ran the assessments on was not necessarily composed of DD patients, even though they screened for clinically significant symptoms of dissociation and the results fell below their cutoff range. While the researchers ran some strong assessments to screen for trauma and dissociative symptoms, conducting a clinical interview to screen for the severity is irreplaceable, especially since trauma does not always result in dissociative symptoms, and having an episode of dissociation is not the same as being a chronic DD patient (Swart, Wildschut, Draijer, Langeland, & Smit, 2020). Thus, in terms of the data being a determinant of anything to do with long-term DDs and the relationship it has with loneliness, it cannot be taken into consideration in complete faith.

However, it is important to note that through their study, trauma patients were more likely to report feeling lonely, and that is not a small finding to report (Kearney et al., 2016). Similarly, Dorahy et al.'s (2015) research was one of the few that looked into a direct relationship between loneliness and dissociation and had a significant impact on the current dissertation. While their results corroborated those of Kearney et al.'s (2016) and the rest of the literature reviewed in that regard, there were some shortcomings to the sample they used as well. First of all, their overall sample consisted of 73 participants altogether; 36 were diagnosed with DID, 13 with chronic PTSD, and 21 with "mixed psychiatric presentations". Furthermore, their sample consisted of 11 males and 62 females, which furthers the issue of unequal distribution especially since females are more likely to report higher levels of dissociation and loneliness (Kearney et al., 2016; Şar, 2020). The small sample size coupled with unequal distribution between diagnoses and gender causes an issue of reliability and validity of data. Furthermore, effect size for such a sample would not be encouraging and was not reported either.

Finally, Cacioppo (2016) focuses more on the implication of neuroscience into the issue of dissociation and its relationship to loneliness. Cacioppo (2016) argues that the temporo-parietal junction (TPJ) is a pivotal brain region for sense of self, self-agency, and the ability to integrate multisensory information to take place efficiently. Her paper aims to introduce this neurological aspect of the brain into the research on dissociation and loneliness and does a comprehensive job of summarizing and evaluating all the information available on that with neuroimaging, while giving a strong phenomenological explanation on the matter of loneliness and what it is to be a dissociated individual; in fact, Cacioppo's (2016) take on loneliness for dissociated individuals seems to corroborate May's (1959), Kearney et al.'s (2016), and Kalsched's (2017) as well—to feel disconnected from self is to feel disconnected from world because one is no longer certain there is a self left to connect to anyone or anything else. The only shortcoming of Cacioppo's (2016) claim is that it does not attempt to introduce how neuroimaging can help with the care of dissociative patients. How can it be cost-efficient? How can clinicians rely on it to make better judgements and follow better treatment plans?

These are points that would have added more to the practice and research on dissociation.

Recommended Guidelines for Treatment of Dissociation

The ISSTD published a guiding paper on recommended treatments and procedures to follow with patients diagnosed with trauma and dissociation (ISSTD, 2011). The primary issue with the ISSTD's (2011) guidelines is that they mainly target DID treatment, and not the rest of the dissociative spectrum. Though comprehensive in approach, the guide aims more for breadth than depth—it introduces and summarizes all practitioners need to know about DID beginning with its history and pathology, to assessment procedures, socioeconomic factors to consider when beginning treatment, and psychotherapeutic modalities that have shown promise (ISSTD, 2011). The guide advocates for a phase-oriented approach to DID, regardless of the psychotherapeutic modality chosen for treatment. It calls on practitioners to focus on stabilization and creating a safe environment for patients in the first phase; confronting and helping patients integrate traumatic memories in the second; and, working on identity reintegration in the last phase. As a guide published by an official body aiming to regulate the study and treatment of dissociation and trauma, this guide has influenced many researchers' treatment guidelines in their own papers, such as Ducharme's (2017), and Kalsched's (2017), who also advocate for the same phase-oriented approach.

Mosquera and Steele (2017) produce solid guidelines on treating BPD patients with comorbid DDs and outline the possible symptoms that could be the underlying cause for dissociation such as triggers, affect dysregulation, childhood traumas, Complex Traumatic Stress Disorder (CTSD), and more. They do not outline a certain psychotherapeutic modality, but they outline certain factors to be wary of, and how best to tackle them with patients, which may be introductory in nature and lacking depth, but is still one of the few sources that looks into BPD-DD treatment plans.

Most of the literature on treating dissociation and/or trauma advocates for CBT, cognitive therapy (CT), prolonged exposure therapy (PE), EMDR, and/or stress inoculation therapy (SIT) (Blankenship, 2017; Cusack et al., 2016). With the limitation outlined above taken into consideration, Blankenship's (2017) and Cusack et al.'s (2016) papers do make solid contribution in reviewing trials of PTSD patients being treated with one of the modalities outlined above, the limitations of the trial, the effect size, and the strength of evidence in favor of the modality. Cusack et al. (2016) report CT, CBT, and PE as being the modalities with trials reporting the strongest evidence and effect sizes, and EMDR as being of moderate effect size but having lower consistency and certainty.

The primary limitation of the literature in regards to this section of the review is the broad aspects of the dissociative spectrum, its comorbidities, and crossing symptomology. Many researchers try comparing and contrasting between different psychotherapies for treating a dissociative disorder (Cusack et al., 2016; Blankenship, 2017) but the issue here is that they are focusing on *one* dissociative disorder or symptom. For example, BPD with dissociative symptoms/disorder should follow a different treatment plan than a BPD comorbid depression patient, than a BPD comorbid OCD patient, and so forth. Thus, to advocate for one modality over another is probably an impossible task, because each modality presents limitation for a certain population exhibiting certain symptoms/comorbidities as opposed to another (Blankenship, 2017; Cusack et al., 2016; Mosquera & Steele, 2017).

Methodology

Design

A qualitative, thematic analysis design was chosen for this study for several reasons. Thematic analyses are best suited for psychotherapy and counselling research, according to Clarke and Braun (2018), who were the first to introduce the analytical approach in their 2006 paper. A key advantage of this approach in this research is its reflexivity, which entails that the researcher's subjectivity is not regarded as bias, but as being

part of the process (Braun & Clarke, 2020). Furthermore, the richness of the counts and data that is necessary for the research question and objectives to be satisfied cannot be captured through quantitative measures, the objectives of this research need to be analyzed through conducting a discussion with each participant, and cross-analyzing these different discussions to come up with a consensus on the matter; which is where the researcher's reflexivity comes in. Secondly, a thematic analysis allows for a better understanding of the techniques and psychotherapeutic modalities that participants use with their patients, and which is also one of this research's objectives (Clarke & Braun, 2018).

Procedure

Mental healthcare professionals specifically trained in treating trauma and dissociation were recruited for this study. An advertisement for the research, outlining research paper title, question, and objectives, and inclusion criteria, was posted on the International Society of Trauma and Dissociation's (ISSTD) members' newsletter. Furthermore, the researcher approached random participants through the ISSTD's open members' database through email and participants who responded to the email were then sent a Participant Information Sheet containing all the details covering the topic and methodology of the research and a consent form to sign. Once those were returned to the researcher via email, a time and date were set for the interviews and they were conducted over Zoom and recorded. Once all interviews were transcribed, common themes were highlighted, and recorded in all interviews. Subsequently, thematic analysis was conducted to group all relevant information under common themes to be discussed in the Results and Discussion sections.

Materials

The researcher devised ten main open-ended questions with sub-questions surrounding the topic of loneliness and how it affects dissociative states or episodes of DD patients for the interviews, guided by the literature reviewed (Alaryian, 2019; Kalsched, 2017; Parry et al., 2018; van der Hart et al., 2017; for full question list see Appendix C).

Participants

Fourteen participants were recruited for this study. In qualitative analysis for dissertations, collecting data from less than 6 in-depth interviews would not be sufficient for data saturation (in terms of having enough insight from a homogenous population on the topic to warrant conclusions accurate to the best extent possible) (Boddy, 2016; Malterud, Siersma, & Guassora, 2016). Data saturation has been observed to happen with 6 in-depth interviews in most cases, and usually occurs through 12 in-depth interviews (Boddy, 2016; Malterud et al., 2016). Recruiting more than 15 would be unethical as it means collecting unnecessary data.

All participants had been practicing as mental healthcare providers for at least two years with dissociative disorders patients; this was one of the main inclusion criteria outlined in the Participant Information Sheet and the advertisement sent to ISSTD members. Participants were of varying ages spanning late thirties to late seventies, and years of experience spanning at least five with some amounting to more than 20 years of experience with dissociation. Despite recruiting randomly, participants are evenly split in terms of gender; seven females and seven males.

Ethical Considerations

Minimal ethical challenges arose in this research; since this research relies on the sharing of patients' sensitive information, the research and the University's ethics committee ensured every measure was taken to mitigate risk of breaches in confidentiality. Participants were informed of these measures before consenting to taking part in the study. Participants' own identities and personal information has been coded and eliminated, and their patients' sensitive information has not been shared with the researcher in any of the interviews.

Analytical Approach

Coded thematic analysis was conducted through the following six steps as guided by Braun and Clarke (2006):

1. All interviews were transcribed, and read at least twice. A decision was made regarding how data will be analyzed: through an inductive (top-bottom) or deductive (bottom-up) manner. Inductive allows data to be analyzed with minimal theoretical constraints from the researcher, even if the data may seem irrelevant to the specific questions asked, whereas deductive is more analyst-driven, where rich details are not the focus but instead the detailed analysis of the data itself. Deductive was chosen because the interviews were varied in length, details, and cases discussed; participants offered different viewpoints on the link between loneliness and dissociation, and thus an analyst-driven approach was necessary to combine and find common ground between these factors.

2. Notable codes were identified, specific, noteworthy segments from all interviews were highlighted and color-coded according to sub-themes pre-identified by the set of questions devised. Each question targeted a specific factor, and those loosely determined the sub-themes expected to emerge. This was a preliminary step to prepare for the labeling of major themes. The purpose here was to identify the data relevant to research question and objectives.

3. All coded excerpts and data were now sorted into the preliminary sub-themes. At this point, the main themes playing a role in the perceived link between loneliness and dissociation were easy to identify and label.

4. Themes were reviewed critically and any that seemed superfluous or irrelevant to the data were eliminated. Similarly, themes that are too large were broken down into smaller ones, as can be seen in Table 1 in the Results section. All themes and data inserted in Table 1 were ensured to be coherent and logical; if a theme was irrelevant in terms of the research objectives, its significance to the findings was reevaluated before moving further.

5. Labels given to the themes in this phase were further refined for clarification. This, in other words, means that each theme must have a clear and homogenous essence capable of encompassing all sub-themes and codes, no matter how different they may be in nature; each code and sub-theme under a larger theme have something in common, and that was usually defined in terms of their impact on the theme. For instance, the codes that made up the sub-theme of “Lack of communication skills/self-expression,” under the theme of Social Support Networks is intertwined with the other two sub-themes: “Lack of social support networks,” and “Fear of people.” The common ground between the codes and sub-themes in that theme is their overarching effect on DD patients. All three show how these factors/variables hinder DD patients in terms of sociability and how they are a cause in being triggered by loneliness. In this sense, it is apparent why a deductive analytical approach was adopted for this research as well; connecting the themes to the trigger (loneliness) and coping mechanism (dissociation) was necessary for the research question to be answered.

6. Once the connections between themes were made, the significant codes, sub-themes, and themes were organized in a table (see Table 1), and the Results section was written to show how these themes emerged and how they connect to each other to cause the perceived impact of loneliness on dissociation.

In terms of replicability, the deductive approach adopted in this study entails that even if the study is replicated, the findings may be interpreted differently and thus the conclusions drawn may present different results (Braun & Clarke, 2020; Roberts, Dowell, & Nie, 2019). However, in this study, researcher reflexivity is not regarded as bias, but as part of the design as mentioned above.

Results

The findings of fourteen interviews with trauma and dissociation practitioners culminated in four major themes: the impact of social support networks; dissociation as a coping mechanism; loneliness as a trigger; and, recommended psychotherapeutic modalities and techniques (therapy) for DD populations. To show the process of coding and subsequent analysis and categorization into themes; codes, sub-themes, and themes are included in Table 1 below in progressive order. In regards to the primary research question: What is the perceived impact of loneliness on the use of dissociation as a coping mechanism? The findings, in short, show that there is a two-way relationship between loneliness and dissociation as a coping mechanism, with it being a complicated, non-linear relationship but having impact on one another nonetheless. What most, if not all, participants agreed on was that the relationship was indeed significant in DD patients, stating terms such as loneliness “being the hallmark of the disorder,” and “existential emptiness,” but was occupied with major factors that facilitate its occurrence. The major upholding of the impact of loneliness on dissociation takes place in the three themes outlined above; the lack of social support networks at times can cause negative core beliefs about one’s self to become further exacerbated, which can lead to feelings of loneliness and emptiness to become severer, patterns of triggers to occur faster, and dissociation as a coping mechanism to occur. This is one example of how the first three themes interplay together in DD populations.

Table 1: The results of the research: the four major themes, sub-themes, and codes.

Themes	Sub-themes	Codes
Social Support Networks	Lack of social support networks	Feeling misunderstood Feeling different Inability to communicate with/trust others Media showing misconceptions on DD Long histories of abuse
	Lack of communication skills/self-expression	Inability to express themselves; the duress of being around people at times causes them to dissociate to protect themselves Identity being tied to trauma/mental illness—feeling too different
	Fear of people	Inability to trust people even when they are genuine Long histories of abuse Fear of being judged Negative core beliefs
Dissociation as a Coping Mechanism	Inability to connect to one’s self	Severity of trauma dictates ability to connect/recover Lack of strong coping mechanisms to process trauma through Splitting self-states/depersonalizing/derealizing to avoid coping with trauma
	Inability to feel connected to others/world	“Lonelier in crowds” Feeling too different to relate to Inability to connect to one’s self will lead to inability to connect to others
	Discomfort in social settings causes the need to ‘hide’ or dissociate (e.g. switch alters, self-isolate, withdraw from reality, etc.)	Switching self-states Derealizing/depersonalizing themselves Self-isolating from outer world

Themes	Sub-themes	Codes
Loneliness as a Trigger	Triggers as patterns & sequences	Causing a stress response that facilitates dissociation Triggers have patterns and sequences, and patients become accustomed to them, can give them a sense of safety due to familiarity
	Triggers as words and phrases	Trigger words from past trauma can lead to feelings of loneliness Trigger words denoting the lack of having social support can cause loneliness
	Triggers as behavioral activation (e.g. withdrawal, dissociation, etc.)	Seeking solitude when triggered and hating it Seeking solitude for comfort Solitude exacerbating dissociative coping mechanisms
Therapy	Therapeutic alliance	Models what relationships should be like Enables them to gain communication and expression skills Genuine empathy with patients Being yourself with patients Safety is the most important factor in the alliance
	Therapeutic techniques to lessen the need to resort to dissociation	Projection Short, goal-oriented exposure exercises Targeting core beliefs developed since childhood
	Therapeutic modalities	Moving away from cognitive therapies and exposure EMDR Parts Therapy IFS IPNB EFT Psychodynamic approaches and techniques

In reality, the issue is much more complicated with DD populations and there are numerous variables affecting one another. Of the fourteen participants interviewed, the majority were speaking of the DID population primarily. Only two or three discussed Otherwise Specified Dissociative Disorders (OSDD) or DDD diagnoses, such as derealization and depersonalization, and whether loneliness indeed had a perceived impact on dissociation as a coping mechanism for those patients. In itself, this was one of this research’s limitations, since the research was looking at dissociation as a coping mechanism and not at the specific diagnoses of DD and their interplay in the matter. To that end though, regardless of the type of DD patients were diagnosed with, all the cases discussed showed that loneliness indeed was a “hallmark” of the disorder; that there is always a sense of “lonelier in crowds,” regardless of their type of DD, as one of the participants had termed it.

All participants agreed that social support networks were necessary to DD patients, because they can keep them grounded to themselves and to their reality. Yet, most also agreed that without a sense of safety in those networks, they found themselves only feeling lonelier amongst those networks, and withdrawing or self-isolating more often than not, which would in turn cause them to turn to dissociating as a means of finding safety.

The eighth participant’s (P8) was the main interview that showed positive anomalies in the data gathered. Through having a safe attachment to a partner, the case study of a young woman suffering of DID managed

to make considerable steps in reintegration and finding safety in being out in the world, which is to say, through alleviating her sense of loneliness, she was better able to recover and lead a healthier life. Several other case studies discussed with other participants showed considerable positive steps when they were safely attached, or when they were in safe, supportive close relationships with partners, allowing them to counter long histories of abuse and correlating negative core beliefs. On a similar note, being in abusive relationships, especially after childhoods of abuse, were more likely to worsen the use of dissociative coping mechanisms (see Glossary for clarification). Part and parcel of having safety in relationships was for patients to be able to feel understood and empathized with, for them to feel like self-expression of themselves or their self-states was not going to be met with hostility, lack of understanding, or bullying. In some severer cases, practitioners interviewed discussed how their patients' disorders was at times used against them so close members of their circles could take advantage of them.

In a case discussed with P6, identity was a major issue for his patient. This was an implicit theme in all the other interviews as well, but emerged more in the form of core beliefs that patients held about themselves and others, rather than in the term 'identity' specifically. An interesting and important part of the discourse held with P6 was as follows:

I think young people... I think because they haven't been in the pathology as long and because they're more neuroplastic, I think they do better more quickly than somebody who's my age [mid-forties] and has really built a life and an identity around the struggle with the pathology. You know, there's more consequences to getting better... there's always consequences to improvement.

People with chronic illnesses tend to "coordinate" their whole lives around their illnesses, as P6 pointed out. This ties in with their core beliefs about themselves and their core beliefs about how the world and others are going to perceive them and treat them. In terms of the first theme, Social Support Networks, this is a major variable. This variable connects to their inability to express themselves, to their inability to believe even in genuine relationships, to feel that they deserve them when their long histories of abuse have taught them otherwise. This also connects to the theme of Loneliness as a Trigger, because it causes DD individuals to seek the familiarity of being dissociated, of being disconnected. It holds no comfort for them, but the familiarity of the mechanism holds a maladaptive sense of safety. Because their neural pathways have been wired to initiate an extreme response under duress, the fastest way for DD patients to find comfort in stressful environments or situations is to dissociate, as explained by P5 in the following excerpt:

They're not really equipped to deal with the trauma, so they get overloaded; it becomes too much for them and they disconnect. And consequently, one of the things we work with, it's what to do when you feel overloaded, too much stress on you, too many things happening... And within that, their loneliness goes up, they're disconnection from people, and then there, what they end up doing is doing dissociative processes such as that not feeling quite real, that not feeling like they really connect to anybody and they aren't really here, that they don't feel like they have any connections to people other than in trauma.

The final theme, Therapy, was one of the main objectives of the research; to identify which therapeutic modalities and techniques from experience tend to be more effective in treating the use of dissociation as a coping mechanism, and what are the recommendations of practitioners specialized in treating trauma and dissociation. Therapy is a major factor in the perceived link between loneliness and dissociation because it mitigates the use of dissociation and enables patients through skills training to develop social networks that subsequently keep them grounded. While this will be discussed more at length in the Discussion section, it is noteworthy that on the one hand, all the recent literature in the field discussed in the Literature Review points to the use of cognitive therapies (CT) and exposure to desensitize dissociative patients from their stress responses. On the other hand, though, data gathered from participants in this research seldom advocated the use of exposure therapy or techniques with DD patients and favored other, less cognitive in-nature techniques and modalities for treating them. When asked why they were against exposure therapy and/or CTs in general, there was a general consensus amongst participants that the aforementioned modalities tend to work on a level of trauma that most DD patients are not equipped to handle yet. Where exposure exercises were recommended, practitioners made it a point to emphasize their use with caution and with small issues

that were not likely to trigger patients heavily, such as having them grow more accustomed to being outdoors through activities like having lunch at a restaurant, and riding the bus, for example (P8).

In terms of having them reconcile their traumas, the root causes of their DD, practitioners interviewed mainly advocated EMDR, Parts Therapy, and psychodynamic approaches among others. Those three were mentioned in every interview and discussion conducted on the matter. As most of them pointed out, the traumas these individuals endure before developing DD are immense and intricate in nature, and usually occur at a very young age (before the age of six) when the patient has not yet developed a stable sense of self or identity, which is a core identification of DID. Another reason why the participants interviewed did not recommend the use of CT is because of their belief that the stress response wired by the trauma in these patients is not a conscious cognitive task in nature; it happens in the body before the patient can become aware of it at times, which is the reason why dissociative mechanisms, once developed, are never really discarded. Using the processes advocated by CBT for instance to attempt and break these triggers down can be too difficult and triggering for these individuals at times when parts of the trauma cannot be recovered or are hidden. With recurring complex trauma and PTSD, attempting to use a cognitive approach may cause severe somatosensory flashbacks in some severe cases. This is why almost all participants advocated for grounding, and following the three-phase approach advocated by the ISSTD (2011). One participant, P14, mentioned that with DD patients, grounding is the primary phase patients remain in and come back to, even after the other two have taken place:

...for that first stage of grounding; which include journaling, which can be very, very helpful for people to see what their triggers are so they can deal; grounding and stabilization is key, at first, and then you get into that second phase, where memories arise and frankly a lot of mourning has to take place. Sometimes, as the woman I was consulting with said, "You stay in phase one forever; grounding and calming and you help people live better..."

Grounding DD patients helps them maintain a well-regulated system that can identify and deal with stress adaptively, before the response becomes too severe and initiates a dissociative mechanism. Grounding them also includes enabling them with skills to lead meaningful lives without being too hindered by their disorders; in this sense, social support networks are one of the ways that help patients stay grounded and fend off the trigger of loneliness. Social support networks, as participants have discussed, can allow patients to regain a sense of normalcy, safety, and value in their lives, when those networks are genuine and nurturing. Participant 9 remarked that they always rejoice when their patients are in codependent relationships that are not abusive, because they feel safe knowing their patients are unlikely to be abandoned and retriggered, since abandonment is usually at the base of all childhood trauma in one form or the other, and is one of the main triggers DD patients find difficult to defuse:

What I do like, is when they have a significant other and it turns out the significant other is codependent. I'm like, "Yeah! ((exclaims excitedly)) All right, that means that this person is going to stay, is going to help me keep them safe, 'till we get through all this."

In fact, one of the ways DD patients tend to lose ground, so to speak, is by self-isolating, because the lack of need or opportunity to interact with others or with their surroundings gives them space and enables them to dissociate back to safety. In one case discussed with P2, she described a patient of hers who would withdraw into his room away from his wife and children for days on end when his somatosensory flashbacks became too severe and he could not function in the outer world and was dissociating, or switching between self-states too frequently. This was an example of a case that would lose their grounding often and never managed to regain a satisfactory level of stability while living with their disorder. This was also a case where even having a family was not enough to help them stay grounded, mainly because the patient's partner was not able to empathize nor understand his disorder, and only tended to exacerbate his inability to connect to his own self, children, or others.

While other psychotherapeutic modalities have been mentioned by participants and briefly included in Table 1, the methodology of these practices and the theory behind them were not discussed during the interviews.

Modalities such as Parts Work, Internal Family Systems (IFS), Emotional Freedom Technique (EFT), Interpersonal Neurobiology (IPNB) (see Glossary) are all used as alternative manners of helping patients recover and face their traumas without overloading their systems with stimuli that can initiate a severe stress response. These modalities are all focused on helping trauma patients recover and are directed at mechanisms and techniques to help with trauma over other mental illnesses or disorders. Whether or not a practitioner was likely to use one of these modalities depended on their training and educational background.

Lastly, the therapeutic alliance was a major topic of discussion in all of the interviews. Every practitioner interviewed emphasized greatly the impact of a safe therapeutic alliance on patients and their abilities to heal and subsequently form successful relationships modeled on that therapeutic alliance. Most of the practitioners interviewed also emphasized that part of creating a safe therapeutic alliance for DD patients was to be genuine with them, to be able to move away from the traditional cold, analytical stance of the therapist and more into becoming and showing their ‘true selves’ to the patients to help them create trust. In part, this meant that the therapist had to be flexible in the techniques they used with the patients and their approach to the issue, rather than simply follow a modality to the letter blindly and try to mold the patient into it. Furthermore, this also meant that therapists had to respond to the patients’ needs. Several practitioners mentioned that their patients were resisting treatment, perhaps being only invested in venting rather than following a process, and while that may seem counterintuitive, the practitioner had to respect and allow the patient to do what they needed to do.

One important point made in all interviews was the importance of the topic. All practitioners interviewed admitted that the impact of loneliness on the use of a dissociative mechanism was indeed noteworthy and important to consider when treating DD patients. All practitioners also began finding patterns between how therapy was attempting to enhance DD patients’ lives through helping them re-establish positive and unconditionally supportive social networks, which explains how the four major themes intertwine together to answer the research question. Through enhancing these social support networks and helping patients model healthy relationships in relation to their therapeutic alliances, loneliness is alleviated and connection to one’s self can be brought about through projection and mirroring. Consequently, connection to others is made when these techniques can be successfully conducted with others allowing DD patients a safe space to express themselves and their experiences, no matter how different or difficult to relate to they may seem. Finding safety and security in relationships is a major factor contributing to lessening the use of dissociative mechanisms.

Discussion

As seen from the findings reported in the previous section, four major themes emerged from the data (outlined below in Figure 1 as well). The findings are consistent with data reported in the literature reviewed previously, and no anomalies occurred in several major areas. Three major points will be discussed: first, dissociative mechanisms are mostly developed in childhood; second, social support networks are pivotal for DD patients’ wellbeing; and third, voluntary and/or involuntary isolation (loneliness) does facilitate the occurrence of dissociation in DD patients.

First of all, dissociation is indeed a mechanism mostly developed in childhood as stated by researchers and corroborated by participants (Schimmenti & Caretti, 2016). This is relevant to investigating a perceived impact between loneliness and dissociation for multiple reasons: first, if DD patients learn to dissociate in childhood, it means they cannot garner the social skills necessary to keep them grounded. Second, DD patients learn to dissociate early on because they lack the support they need to surpass the trauma that causes them to dissociate. In all of the cases discussed with the participants, all the patients had faced a form of trauma and had found no support to aid them; whether these traumas had occurred in childhood and the patients’ parents were the perpetrators or refused to believe them about the perpetration, or whether they occurred in adulthood, and found no one to turn to (Parry et al., 2018). Parry et al.’s (2018) study, which undertook the same design and analytical approach, looked at how DID patients feel in hospital settings.

Their findings report the frustration these patients feel from their mental healthcare givers, the constant feelings of being misunderstood or at times even patronized (Parry et al., 2018). As a precursor, if patients harbor these feelings towards their mental healthcare givers, they probably model them onto other members of their lives as well, as discussed with the

participants during the interviews. In that sense, the development of this mechanism in childhood causes a vicious cycle (see Figure 2).

Furthermore, as Participant 6 (P6) had mentioned in his interview, the longer a patient co-habits with their diagnosis/illness, the more their identities tend to be built around it, and their core beliefs become harder and harder to change. The longer they live with their dissociation as a coping mechanism, the more established it is as a trigger and pattern, and the lonelier they tend to feel within crowds and when alone (Dorahy et al., 2015; Swart et al., 2020). The “existential emptiness” P7 mentioned, is basically a longstanding coping mechanism coupled with a longstanding core belief acting actively to both prove to the individual that they are not worthy of a social support network and that their dissociation from the outer world is both safe and deserved (Sar et al., 2017; van der Hart et al., 2017). This is indeed an important variable to work on when treating DD patients experiencing loneliness, and is one of the reasons that this research aimed to investigate the best therapeutic modalities and techniques for helping DD patients, which will be discussed at length below.

Second of all, social support networks play a major role in aiding patients lead healthier and happier lives (Dorahy et al., 2015; Kearney et al., 2016; Saltzman, Cross Hansel, & Bordnick, 2020). As already explained in the point above, not only do social support networks give DD patients the grounding necessary to help them find safety while trying to reconcile with early traumas, but they also help them stay grounded to their present lives (Mosquera & Steele, 2017). Mosquera and Steele (2017) discuss how Borderline Personality Disorder (BPD) patients on the dissociation spectrum are at times triggered by their relationships and abandonment issues into dissociation; the researchers explain at length how rehabilitating BPD patients and their social skills and helping them understand their triggers in terms of abandonment is pivotal for their regulation. This was also most apparent in the cases discussed with practitioners who mentioned patients with unhealthy social support networks (P2), or patients had been dependent on social support networks and lost them (P11). The impact of this loss had triggered destructive patterns of behavior including drug abuse and severer dissociation. Healthy social networks help patients lead healthier lives because they alleviate the negative core beliefs patients have about themselves and reinstate a sense of normalcy in their identities and lives (Kearney et al., 2016; Linehan, 2015; Sar et al., 2017). As all fourteen practitioners had commented, the main issue for DD patients is that they usually have very long histories of childhood abuse and they either find it difficult to believe anybody will be able to relate to them, or they find themselves within networks that really cannot show appropriate empathy, which in turn strengthens their negative core beliefs about themselves (Parry et al., 2018; van der Hart et al., 2017).

Thirdly, isolation, whether voluntary or involuntary (i.e. caused by the lack of a social support network and not because the DD patient in question chooses to be alone) does facilitate the occurrence of dissociation, as corroborated in all fourteen interviews (Dorahy et al., 2015; Mosquera & Steele, 2017). All the cases discussed showed that DD patients sought loneliness but never for the pleasure of it, rather for the familiarity of it, which goes to strengthen the two points made above about the early loss of support and how it impacts DD patients’ lifespan development in this regard. An important note here must be made: the onset of COVID-19 has worsened this for patients who depended on support groups like therapy groups, church groups, and occupational groups and interactions to feel grounded (Saltzman et al., 2020; Wild et al., 2020), as remarked by P14 and P10. The lock-down caused as a precautionary measure for the spread of COVID-19 is one of the manners in which DD patients found themselves in involuntary isolation and which has made coping significantly more difficult, according to Saltzman et al. (2020), Wild et al. (2020), and practitioners interviewed. This is an important variable worth investigating in future researches.

In terms of the theoretical framework devised for this study in the Literature Review and the results reported, further points are noteworthy: first of all, May’s (1959) claim that an inability to connect to one’s self will

in turn denote an inability to bear loneliness or the lack of company, has held up indeed. Secondly, in terms of trauma reconsolidation and treatment, Alaryian's (2019), and Kalsched's (2017) claim that trauma must be faced and reconciled with in order for reintegration to occur, has also held up.

Addressing the first point: May (1959)'s premise in his book was meant to encourage people to understand the difference between solitude and loneliness, in an existential, philosophical sense. The ability to rejoice in solitude without feeling the emptiness of loneliness; being able to find one's own company fulfilling (May, 1959). It is thus interesting to see the tie in between the existential psychological sense and the clinical understanding of the impact of loneliness on dissociation. What all participants in this research had agreed on was that DD patients in a sense were not missing the company of others as much as they were missing the company of their own selves. It has been mentioned repeatedly in the interviews that them missing their own selves was far more difficult to bear with than their missing members of their families or circles. An inability to connect to one's self was a major code in the findings and usually denoted that even in the company of others this hollowness was not satisfied, which is the same conclusion May (1959) had also arrived at.

To that end, this addresses the second point: reconciliation of the trauma, which in turn strengthen sense of safety, lessens the protective layer placed on the patient's main self-state or ego state, and lessens the dissociative cover between one's outer experience in reality and one's ability to be present in it (Alaryian, 2019; Kalsched, 2017; van der Hart, 2017). Reconciliation of the trauma is not always going to lead to reintegration, as all fourteen participants had concurred. At times, patients will not reconcile with traumas at all and grounding and symptom-management will be the only possible treatment plans (P6; P10; P13). In other cases, patients will reach a certain level of integration and will choose to stay at this level rather than progress further because their mechanisms are becoming adaptive rather than maladaptive and their ability to control them enables them to lead their lives freely and independently, as they choose to (P8).

While Alaryian (2019), Kalsched (2017), van der Hart et al. (2017) and the ISSTD's (2011) guide all stress the importance of revisiting and reconciling with the trauma(s) endured in theory, practice is a different ground. As seen from the cases discussed with the participants, some patients will not be willing or able to revisit their traumas, depending on their severity and impact (P2). The point of this research, the point also made by all practitioners, is that treatment is supposed to help the patients reach and lead the lives they choose for themselves, not the lives they feel stuck with. Helping them develop social support networks, even if they never reach full reintegration, helps them regain a sense of normalcy and repairs negative core beliefs that hinder them from living the lives they would choose (Kearney et al., 2017; van der Hart et al., 2017).

Therapeutic Modalities

Lastly, in terms of the therapeutic modalities best suited to help DD patients experiencing loneliness or an inability to connect to others, the literature is at odds with what fourteen practitioners have advocated. Most research reviewed in the Literature Review (Blankenship, 2017; Cusack et al., 2016; Mosquera & Steele, 2017; van der Hart et al., 2017) has advocated for cognitive therapies (CT) in addition to the three-phase approach disseminated by the ISSTD (2011) for the treatment of DD patients. Therapy as a theme and objective of this research is relevant to the perceived impact of loneliness on dissociation because it ties into the cycle in Figure 2 above. Therapy helps patients stabilize and subsequently introduces the skills training necessary to aid them in building/maintaining social support networks to lessen their discomfort and lessen their dissociative coping mechanisms. Thus, the best modalities to aid patients in recovering was an important factor to look into in the interviews.

The ISSTD's (2011) guide gives a strong brief on all research conducted on modalities that have shown effectiveness with DD patients. It mostly recommends psychodynamic-oriented psychotherapy, but with elements of CT to help patients recover from stress responses or 'phobic reactions' to certain stimuli (ISSTD, 2011). But the ISSTD (2011) does make an important distinction relevant to the findings of this research as well: it advocates the use of CTs to help patients alter negative core beliefs they develop as a result of their

traumas. This claim in itself strengthens the points of discussion made above about how early trauma causes DD patients to garner core beliefs that impact their ability to connect to the world and their own selves, and is a precursor to their sense of loneliness and its impact as a trigger on their condition. In a sense, their negative core beliefs hinder them from even connecting to their own selves, because they did not have the opportunities to expose themselves to social networks that would disprove these core beliefs for them. In the same manner that CTs such as CBT and DBT (Beck & Beck, 2011; ISSTD, 2011; Linehan, 2015) advocate, these patients never expose themselves enough to the outer world to test the veracity of these core beliefs.

Participants advocated trauma-based modalities such as EMDR, Internal Family Systems (IFS), Parts Therapy, Interpersonal Neurobiology (IPNB) in addition to psychodynamic-oriented treatment and techniques for multiple reasons. First, using CTs was found to be too triggering for DD patients, and exposure in the sense of lessening phobic reactions only strengthened the dissociative mechanism at times (P1; P4; Whalen-Lipko, 2018). According to a study by Whalen-Lipko (2018), exposure therapy is sought less by PTSD victims regardless of many researches showing its effectiveness in treating PTSD. More interestingly, women with traumas of rape and sexual abuse were less likely to be willing to use exposure therapy for treatment of their PTSD (Gutner, Gallagher, Baker, Sloan, & Resick, 2016; Whalen-Lipko, 2018). Gutner et al. (2016) also conducted a study on PTSD victims and their willingness to undergo cognitive therapies in general, and found that 39 percent of patients dropped out of therapy by mid-treatment. Furthermore, since DD is based on complex trauma, patients at times were not insightful enough to know that they had faced trauma, and this is especially apparent in complex DID patients that are able to split and switch between self-states without knowing (P1; P5; P7; Parry et al., 2018; Schimmenti & Caretti, 2016). Therefore, using CTs would not be effective since they are not conscious of their disorder nor the trauma. As P4 had stated, patients tend not to be aware or ‘present’ in their frontal cortexes at times of dissociation, they are more present in lower levels of their bodies; which is why body-based and somatosensory-based techniques and modalities are more effective when grounding and stabilizing DD patients (Blankenship, 2017; Cusack et al., 2016; ISSTD, 2011).

Trauma-based modalities, for the most part, are more effective at regulating stress responses and helping patients revisit painful, complex traumas without causing them to dissociate (Bongaerts, van Minnen, & de Jongh, 2018; P4; P11), though at times, even trauma-based modalities can cause patients to become triggered (P12). The lack of comprehensive research and trials in this area is a huge limitation. It is a limitation in terms of discussing the results of this research and it is a limitation in terms of setting forth a comprehensive guide for trauma and dissociation practitioners.

Trauma-based modalities are key in the first phase of treatment for DD patients, grounding, and remain key throughout treatment in keeping them stable (Blankenship, 2017; ISSTD, 2011; P4). Trauma is regarded as being held in the body, rather than consciously in the mind (P4; P12; van der Kolk, 2014), which is why stimulating certain senses can trigger patients and why these modalities target them in treatment (P13). Furthermore, stimulating their senses, or mindfulness, is one of the most common methods practitioners use to keep patients grounded and help them remain grounded (ISSTD, 2011; Manfield, Lovett, Engel, & Manfield, 2017; P12; P14).

Limitations

Several limitations require outlining in this research. First, having more than ten out of fourteen participants discuss cases all diagnosed with DID somewhat thwarts the validity of the data in terms of looking at the full spectrum of dissociation. The data gathered mostly refers to DID dissociative mechanisms such as switching between self-states, and does not equally address other dissociative mechanisms such as derealization, depersonalization (DDD) or dissociative amnesia, or OSDD. Since the sample of participants chosen was randomized, and so were the cases chosen for discussion during the interviews, this was not a variable intended to be accounted for in this research.

Much of this section and the one before have referred to patients’ core beliefs as being pivotal in understanding

the impact of loneliness on dissociation as a coping mechanism. While this is true, since it is a fact taken into consideration by any practitioner in any clinical setting about any patient they are working with, it was not an official variable that this research intended to investigate.

Lastly, while using a qualitative design for this research was intended and did yield rich data in the manner anticipated, conducting a quantitative version of this research can raise the reliability and validity of the findings. Qualitative designs are difficult to replicate because different participants will understandably have different views and approaches to the issue discussed. Furthermore, different researchers are likely to come up with different codes and analyses, which is a major challenge in thematic analysis designs and affects test-retest validity and reliability (Roberts et al., 2019).

Ethical Challenges

In terms of the research's validity, bias must be accounted for due to this study's design and topic. Participants were randomly recruited. Participants all had different experiences to share with different patients. Yet, when asked to choose a case of theirs to discuss, the majority of participants tended to choose DID patients over other DD patients, and thus the findings may show bias in terms of how loneliness impacts DID patients over other DD patients. This bias is present in the literature reviewed as well, and for future considerations and studies, researchers must narrow down their research focus to one dissociative disorder if they wish to explore the significance of the perceived impact on a certain type of dissociative mechanism.

A possible ethical challenge unforeseen was perhaps neglecting the fact that some mental healthcare professionals have histories of mental illness themselves. And while they have taken great steps to working on themselves and helping others in their capacities as practitioners, speaking about their own mental illness history naturally may trigger them. While they participate in this research knowing the implications, this is an ethical challenge that must be addressed in general and in future research endeavors. Ensuring appropriate resources are available to aid these practitioners should they feel triggered and need this help and/or request it is pivotal.

Conclusion and Recommendations

To conclude, this research looked into whether there is a perceived impact of loneliness as a trigger on the use of dissociation as a coping mechanism in dissociative disorders (DD) population. It also aimed to collect practitioners' viewpoints on the most successful therapeutic modalities for DD patients. In terms of the study's research question, findings point to a two-way relationship between loneliness and dissociation. Loneliness can indeed cause DD patients to dissociate to cope with the discomfort, and vice versa; dissociation in itself causes patients a deep sense of loneliness and "existential emptiness" (P7). Having a supportive network is indeed pivotal to the grounding of DD patients, alongside their therapy processes (Saltzman et al., 2020; Wild et al., 2020). As for recommended therapeutic techniques and modalities as discussed with participants, trauma-based modalities are best suited for grounding and keeping DD patients grounded (Cusack et al., 2017; P12; P14). Cognitive therapies such as CBT, DBT, and so forth are best for uncovering and altering patients' negative core beliefs developed as a result of traumas (ISSTD, 2015; Mosquera & Steele, 2017; van der Hart et al., 2017).

Recommendations

Conducting qualitative, phenomenological research with DD patients to look into the same variables would significantly further understanding and knowledge on how loneliness is perceived by them and how it can impact their lives. It would also aid in generating better treatment procedures that take into consideration the need to help patients rehabilitate their social lives and networks. As seen from the findings of this research, DD patients tend to have their traumas resurface when they know they have strong support systems they can rely on.

A major advantage of this research is it aimed to conduct a discussion on the matter rather than objectively assess if there really is a perceived impact of one variable on the other. However, conducting quantitative research on DD patients directly to assess the impact of loneliness on their use of dissociation as a coping mechanism can show how significant this perceived impact is in a numerical, tangible manner. Reliability and validity can be better assessed in quantitative measures and can give a better indication of the significance of this perceived link (Roberts et al., 2019).

Conflict of Interest Disclosure

There are no conflicts of interest to disclose.

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