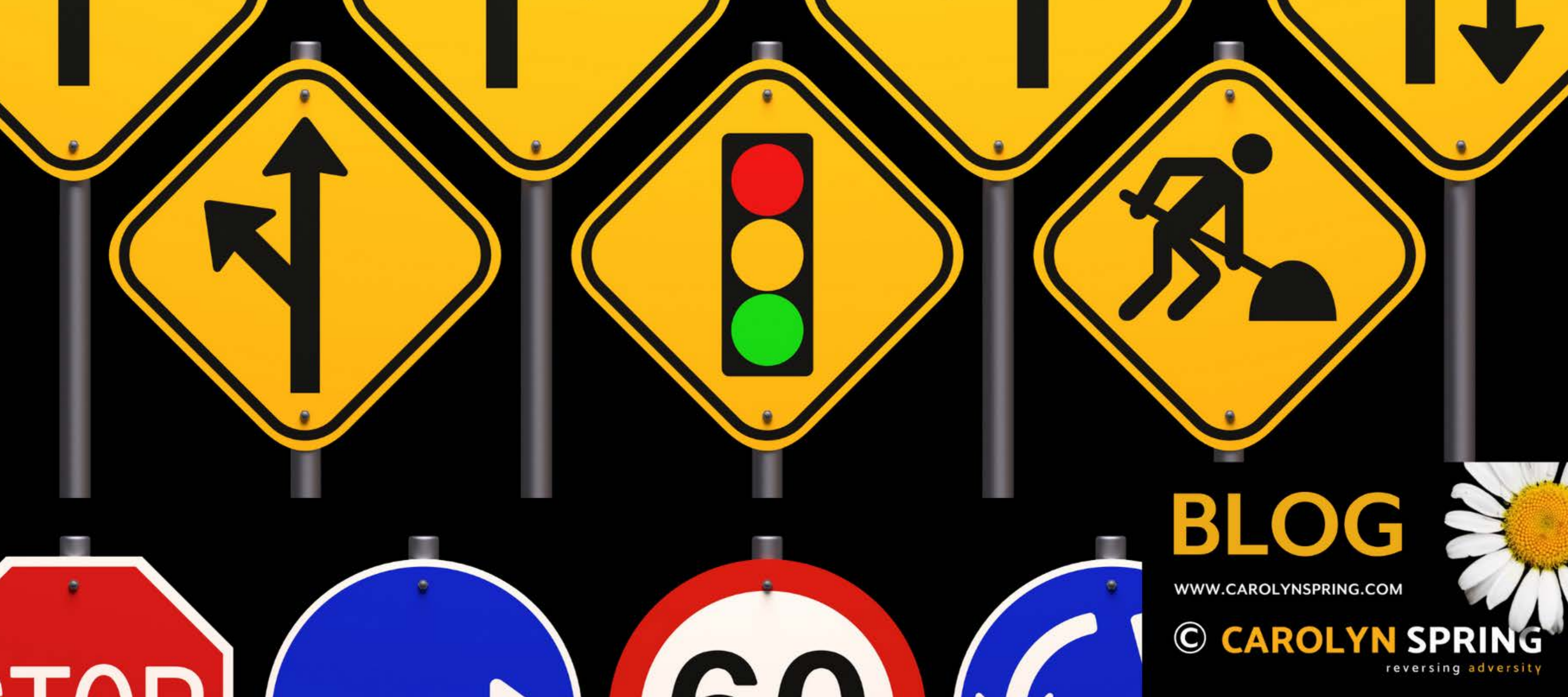

A BRIEF GUIDE TO WORKING WITH DISSOCIATIVE IDENTITY DISORDER

by Carolyn Spring

BASIS OF GUIDELINES

There are no National Institute of Health and Clinical Excellence (NICE) guidelines for the treatment of dissociative identity disorder (DID) and so the best available treatment guidelines are those supplied by the International Society for the Study of Trauma and Dissociation (ISSTD). They can be found here.

DEFINITION

The view of many people with regard to dissociative identity disorder has been influenced by Hollywood representations such as in the book and film Sybil. Many people also believe that it is a rare condition. But an increasing body of research, literature and clinical material is providing a new and more accurate representation of dissociative identity disorder.

Dissociative disorders are characterised by 'a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment'. So for example memories and feelings may not go together – memories may be recalled with no accompanying affect or emotions, or there may be overwhelming feelings with no conscious memory of their cause. There is also often a lack of a coherent sense of autobiography, and this itself leads to problems with a sense of identity – 'Who am I?' and 'What has happened in my life?' This all results from dissociation acting as a creative survival mechanism in the face of overwhelming trauma, whereby the mind shields itself by segregating the experience, or splitting it off into its constituent parts rather than experiencing it as what would be an unendurable 'whole'.

There are a range of dissociative disorders on a spectrum of severity, and this spectrum is usually correlated to how extreme and chronic the trauma experienced in early childhood was. The least extreme on the spectrum is post-traumatic stress disorder (PTSD) and the most extreme is dissociative identity disorder (DID). Other disorders at points on this spectrum in between these two diagnoses include dissociative amnesia (with or without dissociative fugue), depersonalisation/derealisation disorder, other specified dissociative disorder (OSDD) and unspecified dissociative disorder (UDD). OSDD and UDD are what was previously known as dissociative disorder not otherwise specified (DDNOS) which is a diagnosis given when the full diagnostic criteria for other dissociative disorders including dissociative identity disorder are not met.

The DSM-5 states that dissociative identity disorder involves a 'disruption of identity characterised by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning.' It goes on to state that this is accompanied by 'Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.'

The essence of dissociative identity disorder is 'dissociating' or 'splitting off' from an experience – and then in time, splitting off from the 'parts' of the self that hold those experiences – in order to survive otherwise unendurable trauma. It is a creative coping mechanism, not a 'dysfunction'. However, it becomes dysfunctional when the environment is no longer traumatic and yet the person, and all the 'dissociated identities' of that person, still act and live as if it is.

In practice, the vast majority of people with dissociative identity disorder do not obviously present as if they have 'multiple personalities'. Instead they present with a number of both dissociative and post-traumatic symptoms, as well as many apparently non-trauma-related issues such as depression, substance abuse, eating disorders and anxiety. According to Richard Kluft, a leading expert in the field, only six per cent of people with DID present their 'multiple' or 'dissociated' identities publicly and obviously. Elizabeth Howell describes DID as 'a disorder of hiddenness', as the vast majority of people with DID, often motivated by shame, will attempt to conceal their symptoms and way of being. This in part explains why, despite dissociative identity disorder being so prevalent, few people are properly aware of it. In fact, many people with DID are high-functioning members of society with good careers before some crisis or build-up of stressors leads to a sudden and catastrophic 'breakdown'. Others spend a great deal of time in the psychiatric system without receiving

appropriate help and never manage to establish a career. Still others manage a work life, but are severely hampered in their interpersonal relationships. Each person with dissociative identity disorder is unique, even in the way that they respond to and handle their symptoms.

PREVALENCE

Dissociative identity disorder is a well-researched, valid, and cross-cultural diagnosis which despite widespread opinion is not rare: research indicates that it affects between one and three per cent of the general population. This corresponds to between approximately 650,000 and 1.85 million people in the UK.

ETIOLOGY

Many experts in dissociative disorders believe that alternate identities (sometimes known as 'alters' or 'parts' etc.) result from overwhelming traumatic experiences in early childhood, in the context of disturbed caretaker-child interactions resulting in disruptions to the child's attachment system. It is this failure of normal developmental integration which many believe leads to the proliferation of separate 'not-me' parts of the personality. Dissociative identity disorder always develops during childhood but may only become manifest in adulthood as a result of dissociative defences giving way following a build-up of life stresses or 'triggers'.

Dissociative identity disorder is normally caused by severe and chronic childhood trauma, which may include physical and sexual abuse and/or neglect, episodes of extreme terror, and/or repeated medical trauma. Disorganised attachment in one or both parents is also a contributory factor. According to a recent study by Brand et al, eighty-six per cent of the sample of dissociative identity disorder patients reported a history of sexual abuse. Many clinicians position DID in a post-traumatic framework.

DIAGNOSIS

People with dissociative identity disorder often spend many years in the mental health system, and it is often misdiagnosed as schizophrenia or other psychotic disorders, affective disorders, substance abuse disorders, or a personality disorder (most commonly borderline personality disorder). There are a number of well-validated screening tools available to trained professionals to assist in diagnosis, most notably the Dissociative Experiences Scale (DES), the Somatoform Dissociation Questionnaire (SDQ-20) and the 'gold-standard', the Structured Clinical Interview for DSM-IV Disorders (SCID-D). Despite this, perhaps the majority of people with DID will fail to receive a correct diagnosis as some mental health professionals, despite the extensive literature, refuse to believe that it 'exists'.

TREATMENT

The treatment of choice for dissociative identity disorder is long-term, one-to-one, relationally-based psychotherapy. In most cases, therapy will be at minimum once weekly, but this would be dependent on a number of factors such as the client's level of functioning, resources, support and motivation. Longer sessions (of 75 to 90 minutes, or in some cases longer) are often required, and therapy may extend typically for five or more years. An eclectic use of techniques such as cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), eye movement desensitisation and reprocessing (EMDR), and sensorimotor psychotherapy, amongst others, can also be helpful. However, EMDR protocols need to be adjusted for working with DID as standard EMDR treatment, especially at the hands of a practitioner unfamiliar with dissociative disorders, can lead to dangerous flooding of traumatic material and subsequent destabilisation of the client.

The consensus of experts is that phase-oriented treatment is most effective. The three stages most commonly used are:

1. Establishing safety, stabilisation and symptom reduction;
2. Working through and integrating traumatic memories;
3. Integration and rehabilitation.

In reality, there is unlikely to be a linear progression through these three stages: more commonly the work will spiral through each phase, with a frequent need to return to stabilisation work during the middle and later stages. As well as addressing dissociative symptoms, and working through and integrating the underlying trauma, a third area of treatment is that of 'attachment', with the vast majority of dissociative identity disorder clients presenting with disorganised attachment patterns.

ISSUES FOR THE THERAPIST

The extreme and chronic nature of the trauma suffered by many dissociative identity disorder clients can lead to complex and changeable transference and countertransference responses in the therapy. Extreme care must be given to the issue of boundaries: the history of many dissociative identity disorder clients is steeped in boundary violations and so there is significant potential for re-enactments in the therapeutic setting. There must be open and honest discussion and negotiation of boundaries at every stage of the treatment. 'Crisis' may occur regularly at many points during the therapy, but especially when dealing with traumatic memories in phase 2 work. Boundaries that are flexible but hold the treatment frame consistently are essential, especially as it impacts upon the attachment issues evoked by working with 'alternate identities'.

It is the quality of the relationship between therapist and client which is the best predictor of therapeutic success, and so a warm, empathic, consistent, engaged therapist who is willing to be flexible and work long-term with extremely distressing material is essential. Specialist supervision from someone experienced in working with dissociative disorders is advised, as is avoiding isolation by being part of supportive professional groups working in this field. Attention must be paid at all times to the risk of secondary traumatisation due to the extreme and prolonged nature of the abuse suffered by most dissociative identity disorder clients.

WORKING WITH 'ALTER PERSONALITIES'

A client with dissociative identity disorder, at some point during therapy, will invariably present with their 'alternate personalities', otherwise known as 'alters', 'parts' etc. These may present as having different ages, a different gender, different characteristics and often different levels of awareness of their autobiography. Some will be aware of or 'co-conscious' with other 'parts' of the personality, whilst others will not: when there is no co-consciousness, there will often be brief amnesic blanks when that part is 'out' or 'in executive control'. This can be distressing and worrying for the client, who may feel that they are 'going crazy' as they do not know what they have done or said during the preceding period of minutes, hours, or (rarely) days.

It is important to bear in mind that the parts 'are not actually separate identities or personalities in one body, but rather parts of a single individual that are not yet functioning together in a smooth, coordinated, and flexible way'. The ultimate work of therapy is to facilitate an increased coordination between these parts, so that they can indeed function together and perhaps even merge or 'fuse'. By working on increased communication and cooperation between parts, often there is a corresponding increase in levels of co-consciousness, which can help the DID client to feel in much better control of their life.

There have been some helpful ways of understanding and classifying these different 'parts' in terms of the role and function they play in the person's life as a whole. Van der Hart et al propose in their theory of 'structural dissociation' a basic division between the Apparently Normal Personalities (ANPs) and the Emotional Personalities (EPs) – the former tend to be preoccupied with getting on with life and manage by blocking out memories and experiences connected to the past traumatic events, while the EPs are 'stuck' in those experiences and experience them as now rather than as past. Much of the therapy in working with dissociative identity disorder is concerned with resolving conflicts between this basic split, and in resolving a further level of conflicts between different EPs' favoured 'survival response' such as fight, flight, freeze

or submit. The entire personality is structured around the causative trauma, either in experiencing it (the EPs) or avoiding it (the ANPs). The theory of structural dissociation can be very helpful in coming to find helpful ways of working with all of the different parts of the personality.

There has been much debate and controversy about whether engaging with 'alternate personalities' is therapeutic or not, but the ISSTD guidelines do advise engaging with all parts of a person's personality in a non-prejudicial, affirming way. By doing this, the therapist can act as a 'relational bridge' in order to enable the client to begin to make contact with and relate to all the dissociated and disowned parts of themselves, which includes parts of the personality as well as disowned emotions and traumatic memories. However, the therapist must hold in mind that the client is one person with many parts, and not collude with dissociation by encouraging further unnecessary elaboration or autonomy of 'alters'. The therapeutic goal should be to foster integration between disconnected emotions, memories, behaviours and sense of identity. Total 'fusion' of the alternate personalities into one whole may not always be possible, and 'stable multiplicity' may be a more realistic treatment outcome for some, but this should not distract from the goal of increased associative functioning.

Working with dissociative identity disorder clients is demanding and often long-term. There are a number of pitfalls and issues that will arise for the therapist engaged in this work. However, it can also be some of the most rewarding psychotherapeutic work to engage in and good, effective therapy can lead to a very positive prognosis for dissociative identity disorder clients.

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