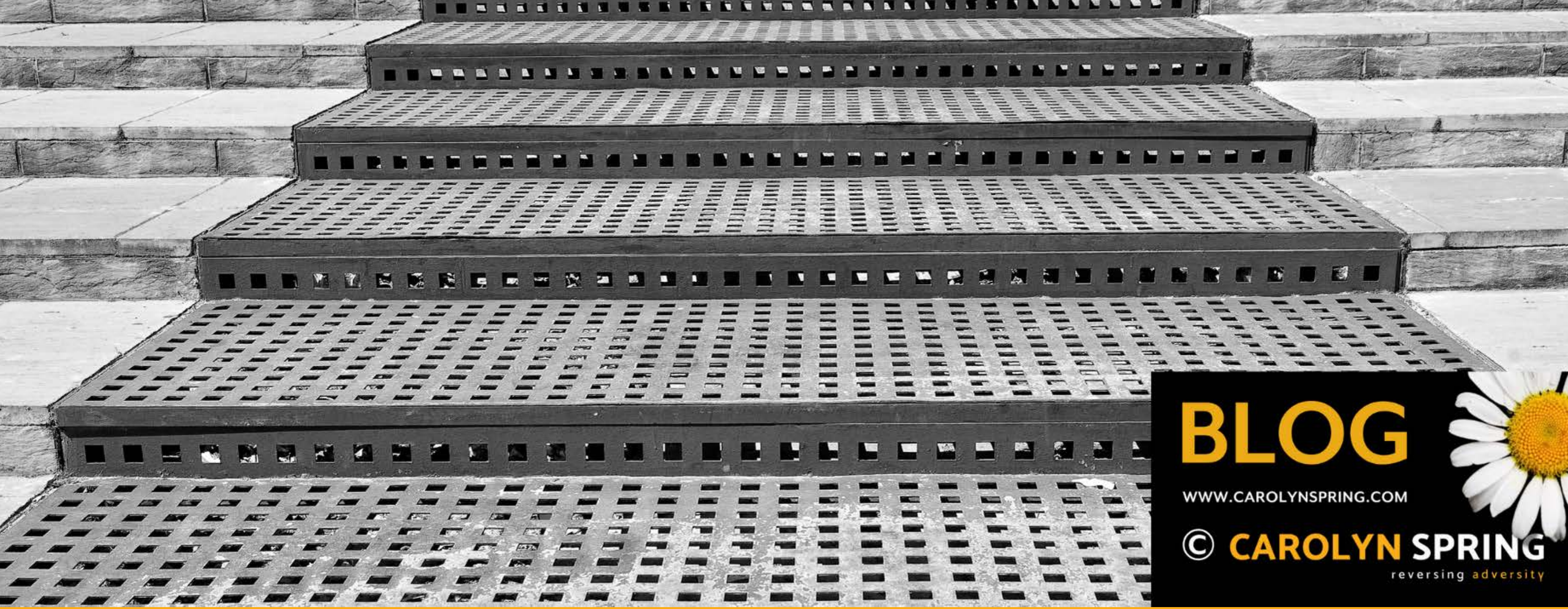

TEN STEPS TO BECOMING A DISSOCIATION-FRIENDLY THERAPIST

By Carolyn Spring

1. ACCEPT THAT DID IS REAL

So the psychiatrist says it doesn't exist, it's an American fad. Or it's attention-seeking hyper-imagination. The GP doesn't have a READ code for it ('computer says no') and it falls between the cracks in this particular mental health service, being neither a mood disorder, a personality disorder not a psychotic disorder. But that doesn't mean to say that DID doesn't exist. Research overwhelmingly indicates that it does exist, that DID is a real and valid diagnosis and this is backed up by cross-cultural studies and a wealth of case reports and epidemiological research.

Those of us with DID also deny it: 'I haven't got proper DID' or 'I'm making it up.' Denial and dissociation are two sides of the same coin and why would we want to accept that we have a 'mental health condition' when there is so much stigma about mental illness? And why would we want to accept DID in particular when it seems incontrovertibly to point towards the trauma history that we have spent our lives denying and avoiding?

How many people, when told that DID doesn't exist and that they have 'borderline personality disorder' or better still 'unstable personality disorder' or that they are schizophrenic or delusional or 'just a bit depressed,' that they are lying and malingering and attention-seeking and making stuff up and being just a downright pain…how many of them, when told that DID isn't real, suddenly see the light and get better? If denial of DID were a good way to treat it, wouldn't everyone's struggles and symptoms have gone away by now?

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So to accept that DID is real, to be willing to work with someone who has this cluster of baffling symptoms, these little time-hops where parts of the day go missing, these unexplained physical complaints, this insomnia, these flashbacks, this panic and hyperarousal and then this flaked-out numb nothingness…just to accept that what we are experiencing is real, that it has a name, and that therefore it might also have a solution, is the first and perhaps most important thing you can do for us.

And not just to believe that DID is real but to believe that there is hope for recovery too—that is priceless.

2. YOU DON'T NEED TO BE AN 'EXPERT'

I'm wary of the 'expert' label because it evokes power and authority. For those of us who have suffered abuse at the hands of people with 'power and authority,' it's a shaky way to start. I prefer the label 'human being.' I value the fact that people are trained and knowledgeable, that therapy is a 'profession' for 'professionals' and that the training is designed to safeguard the vulnerable. But treating DID is not like chasing bacteria out of the bloodstream. It's about a human being coming alongside another human being and giving them the courage to face the trauma and the abuse that has threatened to overwhelm them. In that setting, I don't want some bespectacled expert who can quote chapter and verse. I want someone who at core is a thoroughly decent human being, who is willing to let me be the expert on me, who is willing to learn about me with me, and not assume that I am like every other DID client he or she has ever previously known.

DID is a way of coping with trauma by avoiding it. What that trauma is, what it has meant for me, how I have avoided it, what I need now, the sense I have made of myself and the world—all of that is unique to me and my history. Perhaps some therapists feel a little scared when faced with the prospect of working with people with DID, as if the label is all there is to me and others like me. But I find that they are scared much less by the prospect of working with me as just a traumatised human being. It's incredible how intimidating and off-putting a label can be. And having DID is no big deal. Of course it's difficult, of course it's this overspill of trauma that affects every aspect of our life, of course it's this roller-coaster ride of disowned and then overwhelming emotions, but it's just DID. The therapists who aren't impressed by my diagnosis, and aren't scared by it either, but see me as a human being who has experienced suffering and who needs to heal that suffering, seem to be the ones I am most likely to trust and be able to work with.

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3. BELIEVE OUR SUBJECTIVE REALITY AND HOLD YOUR OBJECTIVE REALITY

The core experience of DID is identity confusion or identity alteration. Those of us with DID don't experience ourselves as singular at core. We don't quite know who we are. We might experience ourselves at times as older or younger than we are chronologically. We might experience fluctuations between different aspects of ourselves that make us feel, quite definitely, that we are someone else. When these floating aspects of ourselves coalesce apart from each other, we call them 'parts' or 'alters' or any other name that describes the sense that they are alternate parts of this most intangible of states—'me'. These parts can be elaborate separate entities with names and ages and genders and experiences and feelings and memories, or they can be an indistinctly-shimmering sense within of just differentness. We exist like this because during childhood development, when we should have been developing a core, unified sense of identity, we were instead overwhelmed by trauma and that integration didn't take place. How we experience the world is true for us. It doesn't need to be true for you.

Sometimes, in our need to feel accepted, we can become militant about our dissociativity, insisting that we are 'multiples' and that 'singletons' need to accept us as we are. I don't share that viewpoint: I am glad that there are people in the world who didn't suffer the trauma I did during childhood and who were able to integrate their sense of self. Because, actually, living like this isn't in the slightest bit fun. I want to figure out the steps that I missed and I want someone who is sufficiently integrated on the inside of them to mirror to me that inner togetherness that I am currently lacking.

Our parts are very real to us but, despite our protestations, we do just have the one body and parts are part of a whole, not separate 'persons.' Multiplicity is a trick of the mind to protect us from trauma. It's trauma that tells us that we want to stay separate. Most of the time it is far too overwhelming to consider 'integration' or 'connection' with these disowned, traumatised parts of ourselves. In therapy, I want to know that what I experience is valid and true for me. I want the freedom to be able to have my own point of view, and for that to be heard. But I don't want to suck my therapist into my world view, the one borne of trauma, the one that whispers that DID is 'just the way it is' and that relegates me to living an disintegrated, painful existence for the rest of my life. So in my therapy I have wanted my therapists to validate my subjective experience but hold fast to their objective reality too. I don't ever want to be cut adrift into a dissociative existence and be told that living separate from myself full of torment and nightmares and

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flashbacks and the incessant heaving self-loathing that parts have for each other is normal and it is all there is. I want to accept my subjective reality of disintegration and dissociation, but always have something to shoot for: life where trauma no longer calls the tune.

4. DON'T FREAK OUT WHEN PARTS APPEAR

One very honest therapist who hadn't worked with DID previously sat in the Q&A at the end of one of my workshops and patiently waited for his opportunity to speak. Then he blurted:

'So at times you act and talk and think as if you're 12 years old?'

'Yes.'

'And at other times it's as if you're four years old?'

'Yes.'

'And this happens all within one session?'
'Yes, sometimes within a matter of seconds or minutes. Parts can come out after another like musical chairs.'

He paused and cleared his throat. 'I think I'd find that a bit difficult. I think I might be a bit freaked out by that.'

I know what he means. In the early months, having DID with practically no co-consciousness at all, in effect I had never ever 'seen' someone with DID switching either. It had freaked my husband, Rob, when he had first encountered younger or traumatised parts of me and my therapist was similarly bizarred-out. But then it became normal, and comprehensible, and part of the relationship. Nowadays, if I didn't switch to another part during a therapy session it would probably mean that I was working to avoid something.

But if my therapist gasped every time I switched, it wouldn't lead to the therapeutic gains, the facing and processing of traumatic material that it preludes. Switching is OK. it's where you do it that matters, so it needs to be somewhere safe.

A friend of mine with DID was looking for a new therapist to work with and met with one who seemed to tick all the boxes. The initial session was going well until she asked what proved to be a double-or-quits question: 'What would you do if I switched?' Without missing a heartbeat, the confident therapist replied, 'Oh that's not a problem. I would just ground you and bring you as the adult back to the here-and-now.' There are good times to do this—at the end of a session, or when as clients we are being assaulted by emotions and we are tumbling out of either the top or the bottom of our 'window of tolerance', when flashbacks are too intense and we are losing simultaneous touch with current day reality. But this therapist was, I assume, working under the false assumption that

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parts being 'out' is a bad thing and that recovery comes by stopping it happening. That's not recovery—that's suppression and denial and it won't work, at least not in the long-term.

Ignoring the traumatised parts of ourselves has been our maladaptive coping strategy which we're coming to therapy to heal. Parts are important and valued parts of the entire personality system and shouldn't be ignored or squished—most of us have done that all our lives, until we couldn't ignore them anymore. We desperately need help to reconnect with them safely and in a safe place. If they can't come out during therapy, which theoretically should be the safest point of our week, when can they come out?

Perhaps the best response to parts appearing is to welcome them genuinely, get to know them, figure out their 'role' or 'function' in the personality system as a whole, and work slowly towards making a bridge between them and the adult host. They have been, generally speaking, disowned and cut-off—in other words dissociated—from the main part of the personality and they need to be welcomed back in. They do not need to be shut out or reacted to as if they are some freakish Frankenstein creation. I have needed my therapists to connect with my parts first in order to allow me to connect with them second. I have been shown how to relate to these disowned parts of me, not by treating them as if they are not real and their trauma is not real, but by accepting them, engaging with them, understanding them.

It seems to me so much more effective to work at figuring out what an 8-year-old part represents, what that part holds, what contribution they have made to the survival of the whole person, than it is to gawp at the woman who thinks she's a child. Even less effective, in my experience, is to engage in a power-struggle of your objective reality ('You're not really 8 years old, you know!') over our subjective one. Why do I feel that I'm 8 years old? What happened when I was 8 years old? How is this affecting the way you're relating to me? What am I avoiding by doing this? What am I facing by doing this? By asking and even answering some of those questions, personally I have made huge strides towards accepting and understanding myself and the totality of my experience in life. By doing so I have become less dissociative and more integrated.

5. TREAT ALL PARTS EQUALLY

It's easy to like some of our 'younger' parts, the attachment-based ones whose unconscious strategy in life is to survive by getting close to you and getting you to come close to them. Ideally they would like you to take care of them. That's what the cuteness, the likeability, is for. And when they talk of the 'nasty ones,' of older parts in the dissociative system, or you

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encounter them for yourself, parts who self-harm or threaten or have rage-binges, it's easy to side with the vulnerable terror of these younger ones and feel at least a certain degree of antipathy towards these 'big ones' or 'evil ones' or 'persecutor parts.' Here is a 4-year-old part who just wants to be comforted and here is an introjected perpetrator part breathing out venom and anger and violence and hatred. It's not a hard choice really, is it?

But of course if you side with the younger ones, then you're missing a great opportunity. For many of us—certainly for me—a major driver for change has been when one of my therapists has been able to sidle up to 'Dark' or 'The Big Ones' and engage their energy for good. Our placatory parts, the attachment-based ones, will be horrified that one of these fury-filled 'big ones' told you to 'F*** off': what if they have upset you, offended you, enraged you? What will you do now? Will you send us away, reject us, hate us for our bad behaviour? We need to switch to a 'little one,' quick, and make our apologies, in case the rage deep down within has been seen and we are cast out for it.

But if you can engage with these angry parts, the parts that are feeling exactly what they ought to be feeling for the things that were done to them, if you can treat them the same way that you treat the loveable little ones, then they can begin to change. What I have found is that while my attachment-based parts have been key at forming and maintaining a relationship with my therapists, it has been the parts with the explosive energy, the raw emotions of the 'what happened,' who have been the catalyst for recovery.

Rather than fighting them constantly, rather than pushing them away out of shame and loathing because I learned as a child that anger is bad and wrong and destructive, I have tried to mirror my therapists' acceptance of them and I have begun to understand that this anger is mine. These emotions—all the 'bad' ones—are mine. And I am incomplete and even ineffectual in life without their drive for justice, without their fight, without their protection. (Anger, I found, is an immensely helpful emotion that is both protective and creative. But that's another article...)

And of course, the whole time, while you're responsive to the 'little ones' but standoffish with the aggressive ones, you're being watched. Maybe not at a conscious level, maybe not at a level that forms an explicit memory for us to pick over afterwards, but at the very least at an implicit level, all of the parts of us are watching how you relate and they are all asking the same questions: Are you going to accept ME? Are you going to be here to help ME? Because maybe I'm not good enough—maybe I don't deserve it because I'm too shameful, too damaged, too toxic, too bad. When you show unconditional

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positive regard to all of us, however that manifests, we learn a vital lesson—that all these disowned parts of us can actually be accepted. They can be heard. They can say what they want to say and not be sent away. They can have the feelings and memories that they hold like unstable isotopes. If you accept them, then maybe we can.

6. TEACH GROUNDING SKILLS FOR OUR BENEFIT, NOT JUST FOR YOURS

'Grounding' is a wonderful thing. We use that term to describe an array of skills and techniques and activities that we use to bring us 'down' from being hyper and frantic, or bring us 'up' from being too hypo and numb. Grounding gets us back in the 'here and now' rather than the 'there and then' of trauma. Grounding gets us back in our bodies, back in our selves, back in the present, back in a place where we are in control. As I say, it's a wonderful thing.

But sometimes, the words 'Let's ground' are spoken not for our benefit but for yours. Trauma processing sounds of course as if it should have nice, clear limits around it—'This is processing trauma; this is not.' Trauma processing sounds as if it should be logical and linear and controlled with an abundance of deep belly-breathing. I understand the concept that trauma is only processed when we're in our 'window of tolerance,' when we can still both think and feel—and that if emotions are just erupting like viscous lava, if our front brain is triggered and shut down, then we will only be retraumatised by this savage reliving of a traumatic event. I get that. But I think a lot of people are intimidated by the idea of 'processing trauma,' as if it only ever happens when you hit the magic balance of close enough but not too close. Better to hang well back than to go too far, surely?

But in reality, many of us just need to be able to feel these feelings that spurt up out of nowhere on the inside of us. It's such a blessed relief, at last, after all this time, to experience the sensation of emotion. Everything has been so suffocated and blacked-out, feelings stuffed down and dissociated, that we wonder if we will ever feel anything that we should have felt, that we must have felt, that we wish we had felt, at the time. So when I have switched to a younger, emotional, traumatised part of myself and they are 'telling,' when their trauma narrative is bubbling out of my mouth with the voracious intensity of terror and trembling and nausea and disgust, at that moment I don't want to 'ground.' I want to ride it. I want to let that part speak. I want to let the memory come and be done with it.

James Chu (2011) said that one of the hardest things to bear in trauma is the aloneness of it. I agree with him and I have found that one of the most healing aspects of processing trauma is not doing it alone. Right here, right now, I am in the room

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with someone who is listening and bearing witness and supporting and empathising and caring. What I am experiencing in my mind and my body is the memory of trauma and the memory of that aloneness. Bringing it out in the here and now, even though it comes through sobs or gasps or incoherent rambling, means that I am no longer alone and it is just a memory. That's not the time to ground me because although I look distressed, I know where I am and I don't want to avoid this trauma any longer. If we don't do this here, in the therapy room, it will explode out of me when I'm not safe and contained.

Sometimes I think it's the distress of seeing this trauma come alive, how unbearable the suffering that it represents, that causes you to seek and grab for 'grounding.' Let's put a stop to it, let's close this thing down. Let's not look at it—you're too upset. It's a fine line but it's a vital one. You have to remember that we didn't just remember this trauma—we endured it. When we talk of rape or torture or incessant aloneness or the stench of sweat and alcohol, we went through it. If we can't get just a little bit upset, in the here and now with you safely here with us, then it will continue to haunt us. Are you really so scared of the emotions—they're just feelings!—that you need to 'ground' it away? Or can you bear to sit with us in the agony of remembering, so that the agony is just a memory, just a feeling, just the memory of a feeling, and nothing more? What I've found is that when it's been allowed to come out, its power fades. And when you can learn when I need to be grounded, and when you need me to be grounded, then the work can continue apace.

7. ACCEPT THAT YOU DON'T KNOW

We may tell you that Uncle James was there, that he gave us gifts, that we felt afraid of him. But if we haven't told you that he abused us, then you can't make that leap for us. Sitting with the unknown is hard, I expect, for both therapist and client. We all want to make meaning out of patterns, we all want to just know. But unless you let us sit in the dim, dark confusion of not knowing, we won't know that we know, only that you know and then, once again, it will be someone else's reality forced upon us and that won't help us at all.

If we are coerced into a dazzling recollection that satisfies your need for completion whilst re-traumatising us, then the work isn't therapeutic. Sometimes we can't blame denial for why we don't know. Sometimes, we simply don't know. So many traumatic memories are stored as somatosensory fragments, as implicit rather than explicit memory, that they won't fall into place as a nice, neat narrative of 'This…then this…then that.'

We need to start simply by trusting our own perceptions, our own awareness of the world, our own bodies. We need to

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tune into what we think and feel, rather than letting you finish the sentence for us. We need to figure it out for ourselves. You can't know whether what we glimpse and call a 'memory' is real or not. You can't know whether it actually happened just as recalled—and neither can you know that it definitely didn't happen either. You weren't there. Surely the most unhelpful response is not to be believed when we share horror and atrocities. But perhaps just as damaging is when you leap up to colour in the dim-grey picture for us, with colours you have taken from other clients, from your own experience, from supervision groups, from books.

Believe everything and believe nothing: you're not an investigator, you're not a judge and you have to let us determine for ourselves what we believe without confusing it with the stories of others. Sitting with the unknown—whether it's about what happened to us, who we are or what we feel—goes against every instinct to pattern-match and complete. Yet unless we build up our own perceptions and thoughts and feelings and memories, we will continue to lack a solid, internal core. It's for us to know or not know and for you to simply bear witness.

8. HOLD YOUR BOUNDARIES, AND THEN FLEX THEM TOO

What are boundaries all about? The 50-minute hour? (Couldn't Freud count?) Whether or not to offer a cup of tea at the start of the session? Getting hung up on these expressions of boundaries can so often lead to forgetting why the boundaries are there in the first place: they are there to protect the vulnerable and to safeguard the work. They're a very good thing. I don't want my therapist suddenly inviting a colleague to sit in on our session, I don't want her to wander off to answer the phone and I don't want to spend my time listening to her talk about flower arranging (the thought of it!) Boundaries are there to protect us both and to facilitate the work we're doing in therapy—therapy is work: hard, hard work. But if 'boundaries' start to oppress the vulnerable and risk the work, then maybe they are missing the point.

Working with DID means working with people whose boundaries as children were chronically invaded—either through active acts of abuse, or passive acts of neglect, or sinister mind games and manipulation and inverted caregiving/careseeking roles. There are a multitude of ways in which we grew up not knowing what it was to be respected, to have choice, to be heard, to have a separate sense of self in an intimate relationship. The boundaries in the therapeutic relationship protect that.

But many therapists flex the boundaries in working with DID and I agree wholeheartedly with that: you can't cram 50 parts of the personality into 50 minutes. You can't squeeze the trauma of disorganised attachment into six sessions.

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In most therapeutic dyads, some form of limited contact between sessions is part of the contract but it is hard for dissociative survivors, especially when in crisis, to contain their distress without support or a 'safe haven' for 7 long days and 7 even longer nights. Working with DID is prolonged, and intense, work and many of us have missed out on a raft of tiny but normal human interactions so that being offered a cup of tea can model self-care and comfort and nurture a thousand times faster than talking about it ever will.

Perhaps this is why therapy in the private sector seems so much better equipped to work with DID, where individual therapists can take thoughtful risks and work according to their own clinical judgement rather than being constrained by policies and procedures and risk assessments that at times seem designed to safeguard the institution more than they are there to empower the disempowered.

Flexing the boundaries is a good thing as long as it's not a reactive thing, as long as it's a decision that you've reflected on and you're comfortable with and you can maintain it. As long as you do not offer it and then retract it: we know of too many people with DID whose therapists have given 'too much,' only to realise months down the line that they can't cope with what they are giving. To escape from their promises, they then quit altogether. Please don't do that.

Flexing the boundaries is a good thing if it's truly in the client's best interests and it's not just there because you can't hold the anxiety of how we are between sessions. Flexing the boundaries is a good thing if it's a mindful act that comes from a deep-and-wide assessment of the plan for therapy that you have co-created with the client and it's not a buckling to the pressure of a traumatic attachment need or a fight-or-flight response.

Above all, hold the boundary of your self and don't become enmeshed and try to rescue. In order to heal from boundary violations, most of all we need you to avoid replicating the dynamics of intimate invasion we encountered in childhood. We need you to remain you and for us to be allowed to become us.

9. JUST BE A GOOD THERAPIST

Sometimes it must feel so confusing and overwhelming. Here is this person with this most controversial of labels and maybe even your colleagues are raising an eyebrow that you've got sucked into this work. You're doing things differently, you're working at the edge of your competence, your supervisor is asking awkward questions and you go to bed at night wondering if you're doing the right thing. Or are you making things worse and should you be struck off for your preposterous hubris in thinking that you can help this label-cum-client?

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I know for many therapists, the pressure to 'refer on' (regardless of the fact that there is no one to refer on to), the pressure to 'look after yourself' (meaning, don't go out of your comfort zone and just work with 'less distressing material') can be overwhelming. Research consistently shows that it is the relationship between therapist and client that is the greatest factor in successful therapy but surely they weren't talking about this kind of client were they?

I may have a 'label'—although who put it there and what right they had to do so is another question entirely—and I may at times have overwhelming symptoms of unhealed suffering. But I am not some other class of human being and I don't need another class of therapist to work with me. And after all, what is therapy really all about? Is it about theories and neuroses and complexes and contracts and transferences and core conditions...or is it about a human being coming alongside another human being to help them work through their suffering and their distress so that they can live again? In my view, therapy shouldn't get clogged up in schools of thought or 'rules' for practice. It should focus first and foremost on our humanity.

In The Psychology of Science (1966), Abraham Maslow said, 'I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.' It sometimes feels as if conflicts between different therapeutic approaches or schools of thought boils down to proving that the hammer is better than the screwdriver. Doesn't it depend on whether it's a nail or a screw that you're trying to deal with? And in working with DID—as in fact in working with every other 'label'—the client is a person, a human being, not some rusty piece of hardware protruding from a lump of rotten wood. Treat your clients first and foremost as suffering human beings.

Then you can treat them as clients to protect them and to help them—not so that you can stand back at a 'professional distance' to keep you safe from their supposed 'contamination'—but so that you don't forget that you are there to help them. Use every tool at your disposal to help them and do the basics of therapy well—be reflective, listen, empathise, show respect, encourage autonomy, be confidential. Use every single tool you can lay your hands on to help the human being in front of you but don't mistake your client for a screw with a rotten thread.

And above all, perhaps, don't get in the way. This is about your client, not you. We are not coming to make you feel good about yourself, to fulfil a need to be needed, or to improve your professional prestige because now you work with 'complex cases'. Trust the process of therapy, because it works and trust yourself to come alongside us, the clients, whose recovery it is.

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Seek attunement, seek to empathise, seek to bear witness, seek to encourage and affirm, seek to listen, seek to care, and 'progress' will come. We are hard-wired both to survive and to heal, and we will recover.

10. GET A LIFE

A burnt-out therapist is a dangerous thing. Working with trauma is traumatic: secondary, or vicarious, trauma is a very real phenomenon and bearing witness week in, week out, sitting with us, week in, week out, empathising and attuning your right brain to our assaulted minds, week in, week out, will have an impact on you. You need to get a life. You need to look after yourself and not feel guilty for doing so. Our lives exist on a drip-feed of trauma in every waking and every sleeping moment: we can't escape it. We are coming to therapy because we don't want it to be like this anymore. So we need a signpost to a better life and we need to know that you're living it first. I don't ever want to do flower arranging (the thought!) but I am glad my therapist does as it reminds me that there is beauty and peace and creativity in the world and there are places and spaces and moments when trauma doesn't reign. It reminds me of what is possible, even when I am feeling that everything is impossible. So have your holidays and your days off and your days out, and replenish your energies and keep coming back refreshed so that you still want to work with us, rather than feeling that you should.

Get a life, and enjoy it, because that's what we want to be able to do too.