WHAT IS THE RECOMMENDED TREATMENT APPROACH FOR THERAPY FOR DISSOCIATIVE IDENTITY DISORDER?

by Carolyn Spring

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 level of functioning, 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. There is no 'quick-fix' and many clinicians advise against any kind of residential setting, as staying connected and involved with 'normal' life is essential for there to be real recovery.

WHAT CONCLUSIONS DOES TREATMENT FOR DISSOCIATIVE IDENTITY DISORDER DRAW?

There is growing evidence that the appropriate therapy for dissociative identity disorder does yield positive results. There is a large international study currently taking place which is following nearly 300 therapists from around the world along with their DID or DDNOS patients (Brand et al, 2009a). The data so far suggests that appropriate treatment leads to fewer dissociative, post-traumatic stress and general psychiatric symptoms; better adaptive functioning; more likelihood of patients being engaged in volunteer work or study; and less likelihood of them being hospitalised.

DISSOCIATIVE IDENTITY DISORDER – STAGES OF TREATMENT

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

- Establishing safety, stabilisation and symptom reduction.

- Working through and integrating traumatic memories.
- 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.

Phase 1 focuses on establishing safety and stabilisation and reducing symptoms. People with dissociative disorders often enter therapy in a very dysregulated, chaotic state and it is important to bring some balance and safety back to their lives before working on traumatic material.

The focus during Phase 1 work is on:

- establishing a therapeutic alliance
- educating patients about their diagnosis and symptoms
- explaining the process of treatment

The goals of Phase 1 work include:

- maintaining personal safety
- controlling symptoms
- modulating affect (managing emotions)
- building stress tolerance
- enhancing basic life functioning
- building or improving relational capacities.

The ISSTD Guidelines (2011) stress the importance of establishing a sound treatment frame during Phase 1 work so that there is sufficient stability to be able to manage the later, more challenging work of confronting and integrating traumatic memories.

Phase 2 work is by its very nature difficult: for many years, traumatic memories have been 'dissociated', i.e. cut off from conscious awareness, and bringing them back into consciousness in order to integrate them into an autobiographical life narrative can be harrowing. As Kluft warns, "The patient often experiences therapy as a guided tour of his or her personal hell without anaesthesia. When a therapist fails to pace the treatment to the tolerance of the patient, the patient may become overwhelmed over and over." (Kluft, as cited in Chu, 2011, p.212) It is important to focus again on safety and stabilisation whenever this occurs: dissociative identity disorder therapy should not destroy the person in the process.

The quality of the relationship between therapist and client 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.

A variety of adjunctive therapies or techniques can be used alongside traditional talking therapies, including cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), eye movement desensitisation and reprocessing (EMDR), and Sensorimotor Psychotherapy, amongst others. Some of these, such as EMDR, need to be modified in order to be safely used with dissociative clients. Many people in the field of dissociative disorders highly recommend Sensorimotor Psychotherapy: for more information go to **www.sensorimotorpsychotherapy.org**.

James Chu quotes Dr David Caul who once observed:

> *Therapists should always remember that good basic psychotherapy is the first order of treatment regardless of any specific diagnosis.*
>
> **(Chu, 2011, p.227)**