

Understanding & Treating Dissociative Identity Disorder



© Ujwala Prabhu / www.ujwalaprabhu.com

&

Dissociative Disorder Not Otherwise Specified

JOANNA L. RINGROSE

Understanding & Treating Dissociative Identity Disorder & Dissociative Disorder Not Otherwise Specified. Copyright 2010 by Joanna Ringrose BSc MA UKCP Registered Psychotherapist. All rights reserved. No part of this booklet may be reproduced in any manner without written permission, except in the case of brief quotations embodied in critical articles and reviews. For information contact: Jo Ringrose by e-mailing; Jo@karunatherapy.co.uk.

Contents

Preface _____ *vii*

Acknowledgements _____ *ix*

CHAPTER 1. The Dissociative Disorders &

Presentation Of DID _____ **1**

1.1 Definition Of Dissociation & The Five Disorders In
DSM-IV-TR _____ 1

1.2 Definition Of Dissociative Identity Disorder (DID) _____ 2

1.2.1 Demographics Of DID _____ 2

1.2.2 The Background Of Clients With DID- A Vignette _____ 3

CHAPTER 2. Assessment & Diagnosis _____ **5**

2.1 Assessment _____ 6

2.1.1 Incorrect Or Missed Diagnoses _____ 6

2.2 Features In The History Of Clients With DID _____ 8

2.3 Table Of Common Symptoms _____ 10

2.4 Assessment Of The Client's Functioning _____ 12

2.5 Dissociative Experiences Scale (DES I & II) _____ 13

2.6 Somatoform Dissociation Questionnaire (SDQ-20) _____ 15

2.7 Table Of Common Somatoform Symptoms _____ 19

2.8 Structured Clinical Interview For DSM-IV	
Dissociative Disorders _____	20
Summary _____	23
CHAPTER 3. The Client With DID _____	24
3.1 The Development Of DID – A Vignette _____	24
3.2 The Structure Of The Personality _____	27
3.3 Host _____	27
3.4 The Alter Personalities _____	27
3.4.1 Child Alters _____	28
3.4.2 Persecutory Alters _____	29
3.4.3 Helper Alters _____	30
3.5 Switching _____	30
Summary _____	33
CHAPTER 4. Beginning Phase of Treatment _____	33
4.1 Stabilisation, Containment & Strengthening The Host ____	34
4.2 Building The Therapy Relationship _____	34
4.3 Confirming The Client’s Reality _____	35
4.4 Contracting _____	36
4.5 Different Boundary Guidelines _____	39

4.6 Stabilisation, Challenging Faulty Beliefs & Fostering Empathy	41
4.7 Tempering Empathy	42
4.8 Teaching Coping Strategies	42
4.9 Talking Through The Diagnosis	45
Summary	46
CHAPTER 5. Middle Phase of Treatment	47
5.1 Should Trauma Material Be Worked Through The Host, Or Through The Alters?	47
5.2 Understanding The Dissociative Process With Clients	50
5.3 Checking Everyone Is Comfortable With Trauma Disclosure	52
5.4 Fostering Communication & Co-operation Between The Host & Alters	54
5.5 When Alters Appear As Though They Are Working Against The Host	55
5.6 Mapping The Alters & Getting To Know Them	56
5.7 Working Through Trauma Events	57
5.8 The BASK Model	59
5.9 Pacing Trauma Disclosure	60
5.10 Exploring Somatic Symptoms	62

Summary	46
CHAPTER 6. Integration	71
6.1 Consideration On Integration	71
6.2 Work To Be Completed Before Integration	73
6.3 Co-Presence, Fading & Merging of Alters Prior To Integration	74
Summary	76
CHAPTER 7. Considerations For Therapy	77
7.1 Longer Session Length	77
7.2 Therapy Tends To Be Long Term	77
7.3 Sessions Are Usually More Frequent	78
7.4 Extra Work May Be Necessary In-Between Sessions	79
7.5 One Therapy Approach Is Unlikely To Be Sufficient	80
7.6 A Knowledge & Use of Variety of Techniques is Useful	82
Summary	84
CHAPTER 8. Problems Encountered Working with DID	85
8.1 Toll On Clinicians	85

8.2 Practitioner's Comments On Problems They Have Encountered _____	91
8.3 The Benefits To Working With DID _____	92
RESOURCES & INFORMATION _____	96
REFERENCES _____	96

Preface

My research for a doctorate in psychotherapy at the Metanoia Institute, London, involved me interviewing eight practitioners who specialise in the field of complex trauma and dissociation. The interviews involved me asking these specialists open ended questions about their work with this client group. They were largely working in specialist centres for trauma and dissociation and were therefore immersed in this field of work and had considerable experience. They were sourced by searching the internet for the names of some of the most widely known specialists in the field. The participants came from America, Holland and the UK. The questions I asked looked at all aspects of working with these clients, from initial assessment, through their entire treatment and included asking about some of the problems these practitioners face in this work. The input from these specialists has been invaluable to me and not wanting the material to simply sit on an academic shelf, I decided to incorporate it into a series of booklets. This booklet aims to be accessible to anyone who is just beginning working with someone they suspect may have Dissociative Identity Disorder (DID, formerly multiple personality disorder) or Dissociative Disorder

Not Otherwise Specified (DDNOS). The material has also been derived from a literature review of the work published on the subject over the last thirty years, as well as being informed by my own experience of working with this client group. I hope you find it informative and would very much like to hear your comments. You can contact me via the e-mail address found on page i.

Acknowledgements

I would like to thank my clients for sharing all their experiences so bravely with me. They think I teach them but the learning and experience has come from them more than me.

I also want to thank all the practitioners who gave up their free time to talk to me in my research for my doctorate and for this book. I feel indebted to you all, without your knowledge and experience this book would be much the poorer. Although I have used material from interviews with all the respondents who participated, disappointingly, for client-patient confidentiality reasons, I can only name two, Remy Aquarone and Claire Schulz. I have also kept your names out of the text for this same reason.

Thank you too to Christine Stevens, who has been my academic adviser throughout my doctorate training and Remy Aquarone who has been my academic consultant. Both of you have helped me professionally but also personally to rise to the challenges of this work in my writing and practice.

Thanks too, to members of my cohort at Metanoia Institute but in particular, Maxine Daniels and Val Thomas who have been companions on my research journey and provided both emotional

and practical support, as well as critical ears to check out my ideas.

Last but by no means least thanks to my husband, Mark, two children, Laura and Christopher and my dear friend Julia Nadal. They have patiently listened to my accounts of the trials and tribulations whilst I have been undertaking this research and fed me love, care and enthusiasm when my resources have been depleted.

CHAPTER 1.

The Dissociative Disorders & Presentation Of Dissociative Identity Disorder

1.1 Definition Of Dissociation & The Five Disorders in DSM-IV-TR

“The essential feature of the dissociative disorders is a disruption in the usually integrated functions of consciousness, memory, identity and perception” (p. 519, American Psychiatric Association, 2000).

The five dissociative disorders, as outlined in DSM-IV-TR, are Dissociative Amnesia (DA) Dissociative Fugue (DF) Depersonalisation Disorder (DP) Dissociative Disorder Not Otherwise Specified (DDNOS) and Dissociative Identity Disorder (DID, listed as multiple personality disorder in ICD-10). This booklet contains information on working with complex trauma and DID but due to their similarities, is likely also to be useful for practitioners working with clients with a diagnosis of DDNOS. DID is the severest of all the dissociative disorders and carries significant risk to the client’s safety, as in almost all cases there are incidents of self harm and often suicide attempts.

1.2 Definition of Dissociative Identity Disorder (DID)

“Dissociative Identity Disorder (formerly Multiple Personality Disorder) is characterised by the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behaviour, accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. It is a disorder characterized by identity fragmentation, rather than proliferation of separate personalities” (p. 519, American Psychiatric Association, 2000).

Practitioners sometimes refer to clients with DID as having a host personality, this tends to be the part who presented to therapy initially and one or more alter personalities (see chapter 4). At present, treatment tends to focus on fostering communication and co-operation amongst the host and alters, understanding and processing the trauma each alter has carried and sometimes, towards the end of therapy, there may be integration of the different identities.

1.2.1 Demographics Of DID

The number of clients with DID in the psychiatric population is between one and ten per cent (Kluft 1991; Punam 1989; Ross et al

1991). The vast majority of these are female, with researchers estimating they make up in the region of 80 to 90 per cent (Coons, Bowman & Milstein, 1988; Ross Norton & Wozney, 1989). The mean age at diagnosis is between 28 and 35 years (Allison, 1978 cited in Putnam, 1989; Coons Bowman & Milstein, 1988).

1.2.2 The Background Of Clients With Dissociative Identity Disorder

Vignette

Kerry is twenty eight years old and currently lives alone. She lived with her mother and step father until she was fourteen when she ran away from home to escape sexual abuse by her step father and her uncle. In addition, her mother is an alcoholic and often got angry and violent with Kerry, when drunk. The sexual abuse and violence had gone on for as far back as she can remember. Her biological father left the marital home when Kerry was two and had been out of contact since. Kerry had never got on well with her mother but the relationship broke down completely after she had told her about her step father's abuse and she had not believed her.

At school, teachers reported that Kerry seemed a very bright and able pupil, who had achieved some high results on occasion but was often

reported to lack concentration or consistent good results. She was also branded a trouble maker after apparently being the ringleader in a binge drinking episode in the school. At twelve, she was found passed out in the school toilets, she had cut both wrists having been raped by her step father the previous day. She was seen by psychiatry who asked about her family but she felt unable to tell anyone. She returned home after treatment having nowhere else to go and went back to school but from the age of thirteen missed more days than she attended. On leaving home at fourteen she slept rough, prostituted herself for to buy alcohol and food. She was picked up by social services who found her a place of safety with foster parents but unfortunately the foster father became ill and she had to be moved to a further home six months later. The relationship she had with the second foster parents had a bad start with Kerry's drinking increasing at this time. After three months they said they couldn't cope with her. By this time she was fifteen and had decided she wanted to be alone. She was moved to temporary sheltered housing until she was considered able to live independently.

Currently Kerry isn't working, though would like to go to college but states there is too much getting in the way. She reports losing time and having no memory of what has gone on during these blank spells. She says she finds herself in strange places coming to, not knowing how she

got there or why she's there. This frightens her because she was found wandering the streets in her nightie one night at three in the morning and had to be taken home by the police. Her arms are filled with scars from cutting but she says she doesn't cut. She states she comes to afterwards and it is like someone else has done it. When I ask if she has ever found anything she doesn't recognise in her belongings she pulls out a small book containing handwriting and pictures. She says she doesn't know the artist or the one with the frilly handwriting, neither she says are hers.

A gem of a book providing all of the basic information a practitioner needs in order to begin work with clients with these often chronic and debilitating conditions. Using vignettes, the author describes the structure of the personality of someone with DID and guides the reader through the various assessment tools and considerations for therapy with these complex disorders. In addition, some of the problems practitioners can face, as well as the rewards which can be reaped from doing this work, are outlined and discussed.

"This is what we need: short, with good knowledge of the subject and with a language that everyone understands". Dr Schulz, Top Referent Trauma Centrum, Denneweg 0, 9404 LA Assen, Netherlands.

"An amazing resource". Professor Boat Associate Professor of Psychiatry, Director of the Childhood Trust, ML 0539, University of Cincinnati, Cincinnati, OH 45267.

"This is an impressive piece of work" Dr Pearle, Assistant Professor of Clinical Paediatrics, Mayerson Centre for Safe and Healthy Children, Cincinnati Children's Hospital Medical Centre, Cincinnati, Ohio 45229-3038.

"Excellent work". Remy Aquarone. President Elect of the ESTD (European Society for Trauma and Dissociation).

Also By Jo Ringrose

Detached. The Practitioner's Sourcebook For Depersonalisation.