Literature Review of Effective Treatment for Dissociative Identity Disorder

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Dissociative identity disorder (DID) is a disorder in which one person has the presence of two or more identities. Although DID is recognized in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. text revision; American Psychiatric Association, 2000), the controversy is ongoing among practitioners as to whether or not it truly exists. This literature review addresses the interpretations, explanations, and treatment perspectives of psychoanalytic, behavioral, and cognitive-behavioral paradigms. A number of generally accepted ideas about the stages of treatment for DID are also discussed. For the most part, these views are from a cognitive-behavioral standpoint and incorporate stages of safety, remembrance and mourning, and resolution or reconnection. Regardless of theoretical background, the majority of DID counselors incorporate the use of the following stances in their treatment: strategic integration, tactical integration, personality-oriented psychotherapy, adaptationalism, and minimization.

Dissociative identity disorder (DID) is a disorder in which one person has the presence of two or more identities. These identities or alter personalities are not separate individuals in one body but they are personalities separate from the dominant or host personality. According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text revision; American Psychiatric Association, 2000), the individual must have two or more distinct alter personalities that are able to control the behaviors, feelings, and cognitions of the dominant host. The diagnosis also involves amnesia that interferes with the memory of significant life experiences. Finally, the disturbance must not be attributable to a general medical condition or physiological effects of a substance.

Alter personalities may or may not be aware of each other and may have distinctly different histories. DID diagnosis is very complex and is sometimes difficult to distinguish from other disorders. For example, alter personalities often communicate with each other; consequently, the client may report hearing voices—a major symptom of schizophrenia. The client often is unaware of the alter personalities, which lessens the likelihood that he or she would disagree with a diagnosis of schizophrenia. A DID client also is likely to exhibit symptoms of borderline personality disorder; however, a client with DID does not fit the diagnosis of borderline personality disorder because he or she has unusual strength in some areas (Brenner, 1996). Furthermore, clients with borderline personality disorder are more extroverted and tend to engage in black and white thinking by labeling external factors as good or bad, whereas DID clients are more introverted, looking inward into their own private world (Brenner, 1996).

In a case study of a client with symptoms of obsessive compulsive disorder (OCD), Shielagh R. Shusta (1999) found that the client had DID and that the OCD symptoms were a result of lack of communication

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between alter personalities. For example, the client's excessive hand washing was explained by the actions of an alter personality repeatedly taking control without the knowledge that the host had just finished washing. Because symptoms of OCD and DID often overlap, individuals with DID are not usually accurately diagnosed until 6 or 8 years after they begin treatment (Shusta). The majority of DID clients have reported childhood experiences of severe trauma in the form of domestic physical abuse, sexual abuse, or both. The prevailing opinion among psychologists is that the dissociation occurs as a result of an attempt to distance the person from or to disown emotional reactions to this abuse (Shusta). The dissociation may provide an escape from the traumatic event when no other means are possible. Physically, the person cannot avoid the abuse; however, dissociation allows them to disregard that it is happening to them (Phelps, 2000). This in turn allows them to have a "loving" relationship with the abuser, who is often a close relative (Phelps).

Another common characteristic among DID clients is the presence of an alter personality that can be viewed as an internal abuser (Fine, 1999). Catherine G. Fine posited that the child takes on the mindset of the abuser in an attempt to predict when the abuse might occur, and that the internal abuser personality is created as a result of the occurrence of dissociation.

Although DID is recognized in the *DSM-IV-TR* (2000), there is still a great deal of controversy among practitioners as to whether or not it truly exists. Many medical professionals have claimed that the symptoms of DID can be explained as attention-seeking behaviors (Foote, 1999). When confronted by research on the effectiveness of treatment for DID, critics have claimed that the results are tainted by a natural remission of symptoms that would have occurred even in the absence of treatment (Powell & Howell, 1998). According to these critics, the disorder fluctuates between an increase and decrease of symptoms and clients will only seek out treatment when their symptoms are at their worst. Therefore, symptoms likely would go into remission regardless of treatment. Critics also have cited the initial increase in symptoms during early treatment as a result of work with trauma (Powell & Howell). According to Powell and Howell, the difference in severity of symptoms between the beginning of treatment and after 2 years of treatment could be attributed to the absence of intense trauma work that is common in early stages of therapy. Further, if the client's family and the clinician did not reinforce these symptoms, they would cease to exist. The assumption is that the client's unconscious goal is to attract the attention that comes with health crises, and that the counselor creates this disorder by suggesting it as a diagnosis.

Evidence that supports DID as a valid diagnosis includes the fact that clients do not willingly embrace this diagnosis and often fight to reject it. Further, proponents of DID as a valid diagnosis pointed out that symptoms do not cease to exist as a result of ignoring them; rather, this strategy may only encourage the client to stop reporting them (Foote, 1999). In *Dissociative Identity Disorder and Pseudo-Hysteria*, Brad Foote (1999) noted that most of the mental health practitioners who have doubted the existence of DID maintained their doubt when they encountered a client with this disorder, citing that they were not "convinced" that the client's symptoms reflected a DID diagnosis. In an attempt to explain this phenomenon, Foote commented on the effects of countertransferance. By this he meant that a person faced with an elaborate and extraordinary story, assuming that the person begins as a doubter, will naturally have a negative reaction to the report of such events. This observer will view the abrupt changes in cognition, behavior, and affect as superficial, with an increase in variation of identities only serving to strengthen this belief (Foote). In addition, Foote suggested that the error of this doubting perspective lies in the observer's failure to recognize depth in each distinct identity. Critics have posited that the split in identity is shallow and therefore can be described as a horizontal split from a normal level. Horizontal splitting would allow the individual to access different behaviors, affects, and cognitions at a superficial level, floating in and out of these erratic behavior patterns (Foote). Foote suggested that this variance could be explained better as a vertical split where each identity is distinctly different and contains great depth. Furthermore, the counselor's conscious or unconscious negative reactions or skepticism could evoke feelings of powerlessness in clients (Foote). Patients with DID conceivably could have encountered a similar situation if they disclosed that they had been sexually abused and if the person they reported it to did not believe them (Foote). Counselors must be aware of their own parallel processes when dealing with clients. However, special attention should be given to this issue when encountering an abuse victim, as is the case with most DID patients. Counselors also should recognize the controversy surrounding this

disorder and the potential of this controversy to influence the client through external factors. Counselors may want to ask clients with this diagnosis to agree to bring any doubts about the disorder (encountered through literature, other clinicians, or other clients) into the therapy sessions so that they can be adequately processed (Kluft, 1999).

DID TREATMENT FROM DIFFERENT PARADIGMS

DID can be interpreted and explained differently using different paradigms. From the psychoanalytic paradigm, DID is viewed as a character pathology where dissociation is the person's primary defense. The alter personalities are a result of autohypnosis and are aroused as a defense in the here and now due to association with early trauma (Brenner, 1999). During repeated trauma, the individual creates this inner world to escape from the unpredictability of attacks (Brenner, 1999). Furthermore, within the individual is a psychic structure that serves to protect the conscious self by disowning memories and experiences that the person is not yet equipped to address. This structure then personifies these memories and experiences through the alter personalities (Brenner, 1999). The focus of psychoanalytic therapy is to dismantle this inadequate psychic structure. In cases of sexual abuse, those who hold the psychoanalytic perspective have cited defective identification with the same-sex parent as a cause for the dissociation (Phelps, 2000). According to this paradigm, the DID client has a faulty ego structure as a result of the conflict between an abusive parent also being a caregiver (Brenner, 1999). Brenner (1999) stated that the psychoanalytic process does not require accessing any of the client's alter personalities. Rather, the therapist allows the alter personalities to present themselves accordingly when the client experiences anxiety. However, although psychoanalytic views may be beneficial, treatment will not be effective without the use of already established knowledge and techniques (Brenner, 1999).

From the behavioral perspective, DID is discussed as sets of behavioral responses to stimuli. Skinner (as cited in Phelps, 2000) defined *personality* as groups of behavior, which come into play in the presence of the descriptive stimulus. One's personality is a sum of these groups or behavioral repertoires, which suggests that personality is subject to control and modification by environmental factors. Behaviorists believe that all people are made up of these repertoires and that they have developed into one coherent personality through their commonalties. The alternate personalities seen in DID are very diverse and have limited generalization. These are repertoires that have not yet developed into a stable, single personality and therefore may not be viewed as multiple personalities, but as less than one whole personality (Phelps). These repertoires react according to stimulus control, reinforcement, and punishment (Phelps). Because of the unpredictability of the client's early abuse, he or she had difficulty learning what brought about abuse (punishment) or love (reward). Because of this unreliability in their environment, the victim turned to internal stimuli (Phelps). Recurrent dissociative episodes can be explained as learned responses that can be triggered by contextual cues (Meares, 1999). A person with DID has been rewarded throughout life, beginning with early trauma, for remaining less than a whole personality, whereas a person who was not traumatized is rewarded publicly for developing into one coherent personality (Phelps). The focus of behavioral treatment is to extinguish behavioral variability and reinforce generalization. To accomplish this, the counselor points out discrepancies in behavior and encourages the client to ask others to point out these discrepancies throughout everyday life. Again, this strict behavioral perspective should not be applied in absolute terms but should be regarded as a potential resource in addition to more researched and common methods of treatment.

DID STAGES

A few ideas about the stages of treatment for DID are generally accepted. For the most part, these views are from a cognitive-behavioral standpoint and incorporate stages of (a) safety, (b) remembrance and mourning, and (c) resolution or reconnection. During the safety stage, the therapist's goal is to establish a platform from which the client's trauma can be examined. According to Kluft (1999), this stage should create an empathetic atmosphere while strengthening the client as a whole—including all alter personalities—to enhance current functioning. The client should begin to foster communication between alter personalities and learn to control some of his or her alter personalities to avoid self-destructive behavior (Kluft). A process of mapping should begin, wherein the counselor attempts to identify and become more familiar with all of the alter personalities (Kluft). This process also helps the counselor to predict how certain alter personalities might react to issues in therapy and to

choose ally alter personalities that have common goals and can aid in therapy.

In the remembrance and mourning stage, the goal is to bring out past abuse and process it. However, Kluft (1999) stated that the therapist must prepare for this processing. First, she or he should allow for extended sessions so that under no circumstances is a client allowed to leave a session in a dangerous emotional state because of remembered trauma that arose late in the session. Second, the therapist must arrange for a counselor to be available between sessions, in case of an emergency. Third, the therapist must conclude that the client has shown the ability to use skills learned in prior sessions in everyday life. Fourth, the therapist should assess the client as to his or her ability to deal with trauma without regard to DID. For example, can the client effectively deal with depression? Fifth, the therapist should assess the client's current life stressors to avoid any added burdens. Finally, the therapist must determine that the client is motivated to work with his or her trauma (Kluft). It is extremely important not to force this process on the client because forcing it could serve as a reenactment of his or her abuse, which may result in a struggle, submission, or a combination of both (Kluft). The client must understand and appreciate the difficulty and usefulness of working with trauma. Any material that is represented as traumatic must be addressed in order for the client to move toward full integration (Kluft).

In the resolution or reconnection stage, an effort is made for all alter personalities to have successfully worked through the trauma. Increased cooperation, communication, mutual empathy, and identification across all alter personalities are crucial in the process of this stage. Although the DID client must learn to live in the world and make use of alternatives to dissociative coping, clients often resist reconnection or full integration. For these clients, resolution may be a preferable goal. Resolution involves a "smooth collaboration" without integration (Kluft, 1999).

TREATMENT STANCES AND TECHNIQUES

Regardless of theoretical background, the majority of counselors who treat clients with DID incorporate the use of the following stances in their treatment: (a) strategic integration, (b) tactical integration, (c) personality-oriented psychotherapy, (d) adaptationalism, and (e) minimization. The goal of the first three stances is integration. Strategic integration is similar to process-oriented psychotherapy in that the therapist attempts to achieve the same atmosphere for treatment. This stance is focused on the dissociative defenses of the disorder and attempts to alleviate the client's symptoms and difficulties in living. "The condition in essence collapses from within," (Kluft, 1999, p. 293) resulting in integration. Tactical integration is similar to the previous stance; however, it involves the use of discrete goals. The idea is that structure acts as a means of safety for the client (Fine, 1999). Early in the treatment process, the counselor attempts to restructure the client's thinking to prepare him or her for addressing trauma. The goal is to achieve congruence of purpose and motivation between the various parts of the mind (Fine). Although personality-oriented psychotherapy assists the client in becoming integrated, integration is not the goal. Rather, functionality is the focus, and the alter personalities are encouraged to collaborate. Each personality is viewed as an individual and is slowly nurtured back to health (Kluft, 1999). Adaptationalism, stemming from the traditions of supportive psychotherapy, avoids work with trauma and completely focuses on function of the client. This stance may not be appropriate for clients with DID because a client with the potential of a full recovery is denied that opportunity (Kluft). Minimization involves ignoring the existence of the symptoms and is the stance most commonly held by critics of DID diagnosis. According to the minimization view, symptoms of DID are attention-seeking behaviors and will cease to exist if they are not reinforced. However, this approach has not demonstrated widespread clinical utility (Kluft).

The majority of techniques used in treatment, regardless of the counselor's particular stance, are from a psychodynamic or cognitive-behavioral orientation (Kluft, 1999). However, unconventional techniques as well as conventional techniques can be beneficial. One technique is to attempt to address the client in a manner that addresses all of the alter personalities at the same time. The counselor should keep in mind that all of the alter personalities may be listening and should attempt to deal with the person as a system and as a whole (Kluft). Counselors should also encourage the alter personalities to realize that they are part of a whole (Kluft). This is illustrated in Shusta's (1999) case study of a client with OCD. He asked the client to address all of his alter personalities by speaking out loud. In declaring aloud that he had washed his hands, he was able to address the alter personality that felt he was unsanitary and compelled him to excessively

wash. Counselors may also want to consistently encourage any alter personality listening to respond by some means (Kluft). The counselor may want to suggest that the client begin journaling, which could provide an opportunity for reticent alter personalities to emerge, communicate, and vent outside of actual treatment (Kluft). Another technique, which is critical in using tactical integration, is to identify the personalities that are dominant in everyday functioning. By identifying these daily functioning alter personalities, the counselor can avoid prematurely provoking trauma for them, which could seriously affect the functioning of the client before he or she is prepared to address these issues. Fine (1999) suggested attempting to convince alter personalities that their adaptive behaviors are no longer useful. Counselors should also make an attempt to elicit alter personalities in the client and address them directly rather than wait for the client to present them (Kluft). This will aid in the technique of mapping. Mapping, as Fine (as cited in Kluft) suggested, involves an exercise where the host is asked to write his or her name on a piece of paper. The alter personalities are then asked to write their names on the paper in relation to the host. Any alter personality that may be tentative about disclosing his or her identity simply is asked to place a mark on the paper. Fine suggested that this act as an invitation to the counselor to meet each alter personality. This is also beneficial because the dominant personality may not be aware of some of the alter personalities. Therefore, the host cannot be relied upon to accurately map the personalities (Kluft). Another technique that Kluft suggested is to identify cooperative alter personalities that may be able to attend to others. He suggested that higher functioning alter personalities may be able to assist in treatment.

Family and group therapy may help the client and his or her family to cope with DID, but it is not intended for use with the actual dissociation (Kluft, 1999). A danger with family therapy is that any trauma work with the client might involve negative memories of other family members. This would most likely cause family conflict and would only add stress to an already stressful situation (Kluft).

In assessing the type of treatment to employ, therapists should choose a plan that best meets the clients' needs and best respects the clients' wishes (Kluft, 1999). If a client is not ready or not motivated to work with trauma, then integration should not be a treatment goal. The therapist should inform the client that integration will be a choice and that they will make a conscious decision to integrate or not (Fine, 1999). After all, integration in itself can be very stressful for clients who likely have relied on the assistance of dissociation for much of their lives. Integration leaves the client with the problem of daily life (Brenner, 1999). In the perspective of the patient, having just one integrated personality is a disorder (Brenner, 1996). This in itself is reason for continued treatment (Brenner, 1996). Generally, DID patients can be treated effectively with long-term therapy and can go on to lead productive lives (Shusta, 1999).

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