CHAPTER 1

Setting the Stage

This book is written, first and foremost, for social workers and social work students who may, in the course of their work, whether in micro, mezzo, or macro settings, encounter clients with dissociative disorders. Since my discipline is social work, I will be most aware of its values, ethics and practices. It is not my intention to exclude readers from other disciplines who are eager to learn about dissociative disorders, as I believe that the content of this book will be applicable to a range of other front-line workers in both mental health and substance abuse services, whether inpatient or outpatient.

TERMINOLOGY

The System and the Parts

It is necessary to have a term for the people who come to you for help. I have had difficulty finding a term that I fully embrace and am comfortable with. Some possibilities are "patients," "clients," "customers," or "consumers." Of these four, the one I dislike the least is "client," so I often use this term. In working with people who have been diagnosed with DID, I also use the term "client," but I also refer to them as a "system." This system consists of a number of parts. Let's say that the person I am seeing is named William Jones. He introduces himself as Bill. In the first session, I think of my client as Bill. I also use the term "client" to refer to the system as a whole.

The next important question to consider is "Who is Bill?" Is Bill the "real" person who has created the others? Is Bill the original personality or the host, and are all the other parts of the system somehow part of or subservient to Bill? Is he the main personality and the others, subpersonalities? Is Bill the leader and the others, followers? Is Bill the prominent adult and the one who routinely runs the body, the one who is out front? I also use the term "the body" to describe the body that is shared by all the alters in the system.

On the basis of my experience in working with people with DID, it is important to think of Bill as one of the parts of the system and to take the time to discover what role Bill plays in the system without preconceived assumptions. When working with a client with DID, I use the client's preferred terminology to refer to the various parts of the system. The easiest way, if the parts have names, is to refer to them by name. I have found that when the parts do not initially have names, the process of naming them can be an important part of the therapy. Making space for the parts to name themselves can be an empowering experience and can help them feel acknowledged, seen, and welcomed into the system.

If the parts do not have names, sometimes clients will refer to them on the basis of their perceived age such as "the seven-year-old" or "the 13-year-old." Some use descriptions such as "the angry one" or simply name the part on the basis of their predominant emotion, such as anger or depression. Some refer to them by their functions, such as the protector or the evil one. Besides the term "parts," other terms I have come across include "the others," "the personalities," "alters," the "people inside," "friends," "versions," "the littles," and "members of the sisterhood." The possibilities are many. In the case studies presented in this book, if the parts have names, I refer to them by name. Otherwise, I refer to them as parts or alters.

In returning to the question "Who is Bill?" the reader will discover in chapter 8 that it is a mistake to look for or believe there is an "original" or "real" person and the rest of the system consists of parts of this real person. At the same time, it is important to acknowledge that the name the client presents to the world is most likely the name of the alter whose main role is to be out front and in charge of the body. To return to my example, this does not mean that Bill has always been the one with this role. In the course of the work, the therapist may discover that Bill was recently given the assignment to go to therapy and that he is not in any way prominent in the system. Another possibility is that the alter who presented himself on the first day, although referring to himself as Bill, was in fact a different alter who was posing as Bill. Perhaps this happened because Bill was hidden away somewhere as the result of a recent traumatic event, and a protector decided to take over the body and sign up for therapy in hopes of getting Bill back. The possibilities are infinite and can be overwhelming. What I suggest is to keep an open mind and allow things to unfold as the client develops trust and openness about their system.

I find it helpful to think of the client as a system made up of alters, each of which has a role or function in the system. Some are children, some are adolescents, some are adults, and others may have other descriptions. One of the first goals in therapy is to identify the responsible adult or adults because they are the ones who need to manage day-to-day activities in the outside world while also becoming more aware and involved in what is going on inside.

More often than not, the part who first presents as the client is one of the responsible adults, and it is not a mistake, until proven otherwise, to treat that alter

as such. One must start somewhere. Consequently, I may refer to the alter with whom I have the most contact, the one who is primarily in charge of the body, as the primary. At the same time, skepticism is called for in order to remain open to other possibilities. If proven otherwise, then the therapist can encourage the responsible adult or adults to come forward and take responsibility for the system so that improvements can be made.

It is also important not to have any preconceived notions regarding the amount of knowledge, understanding, awareness, or clarity present in the system because this will vary greatly among clients with DID. You may meet a client who is totally oblivious to the other parts of the system, whereas others may be well versed in them. Also, the primary may not be aware of other alters, but the other alters may be well aware of each other and purposely keep the primary ignorant of them.

Pronouns

When possible, I use "they," "their," "them," and "themself" as singular pronouns when referring to a person or an alter when their gender is not specified or not known.

Switching

Clients may differ in the terminology they use to describe which alter or alters are present at a particular moment, but usually some version of "being out" or "fronting" serves the purpose. I may ask, "Who am I talking to?" or "Who is out?" or "Are you still Mary, or has someone else come out?" or "Is this Peter?" When the media features characters with multiplicity, there is a tendency to portray the character switching from one alter to another as a complicated dramatic process, with seizure-like movements and recognizable changes in voice and tone of speech. Consequently, clients who are malingering often demonstrate a similar process.

In my experience in working with clients who truly have DID, switching is usually much more subtle, often undetectable. I have had clients who try to trick or test me to see whether I am able to identify who I am talking to. Although it is helpful and important for therapists to be extra alert and attentive to small somatic cues in working with clients with DID, it is not helpful to accept such a challenge. First, it distracts from the therapeutic work. Second, the effort is doomed to fail because in most cases clients have spent their whole lifetime trying to hide the fact that they have separate parts and have become skillful in switching alters without being detected.

So that the responsible adult or adults in the system learn to manage the switching process, I will invite them to allow me to facilitate if, for example, I would like to meet and talk directly to a particular alter. I describe a simple way to

do this in chapter 8. It models a mindfulness and consciousness of the switching process that will help the client to reduce incidents of spontaneous dissociation with accompanying amnesia that are so disruptive to their life.

PREVALENCE OF DISSOCIATIVE IDENTITY DISORDER

Even though reports of persons with multiple personalities and their successful treatment go back to the 1830s and the work of Antoine Despine (Fine, 1988), APA has been slow to acknowledge the prevalence of DID. When I graduated with my master of social work degree from Loyola University in 1983, trauma was not a hot topic in social work education, and the thought that I would eventually be working with people with multiple personalities did not cross my mind. Had I thought about it and consulted with the DSM current at the time (the third edition, or DSM-III; APA, 1980), I would have learned that multiple personality disorder was "apparently rare" (p. 258). Not until the DSM-5 was published in 2013 was its prevalence acknowledged. In spite of this, many therapists, medical providers, substance use counselors, and psychiatrists still believe that DID is rare. Such beliefs are not neutral in their effects and result in clients with DID not getting the effective treatment they need. I explore the issues of prevalence and disbelief in more detail in chapter 5.

When I graduated in 1983, my goal was to become an effective psychotherapist, but graduate school did not prepare me for the complexity and difficulties of such an achievement. I worked in a state-run psychiatric hospital for the first seven years, and in 1990, I began working in a community mental health center as an outpatient psychotherapist. One of my first clients was a woman who shared with me that she frequently found herself somewhere without any knowledge of how she got there and that she in fact had other unique personalities. It is uncommon for clients who have not previously been diagnosed with DID to share their dissociative experiences with a new therapist (ISSTD, 2011, p. 118), so I am thankful to this woman for doing so.

As a new outpatient therapist with no training in working with someone with DID, I would have been working outside of my scope of practice to continue seeing this client. Consequently, I was eager to transfer her care to a more experienced therapist. My clinical supervisor informed me that no other therapists in our center were trained to work with clients with multiple personalities. Because I was working in a community mental health center and the client had no insurance, referring her to a private therapist with such experience was not an option. It was fortunate, for me and for my client, that my agency was willing to pay for me to get specialized training. I discussed this with my client, and she readily agreed that we could learn together.

One of my goals in writing this book is to give clinical social workers an easy-to-use manual for how to approach these clients. Another is to provide an

introductory, down-to-earth guide so that when they encounter their first client with dissociation, they can begin the work in a safe and helpful way. I believe that many experienced clinicians are reluctant to diagnose and treat such individuals, and I hope that this book will awaken them to the possibility that some of their current clients may meet the criteria for DID. Beyond this book, I hope that as many readers as possible will get further training in working with trauma survivors and specifically with those with DID. Once patients with DID are acknowledged and correctly diagnosed, they—and practitioners—can find improved outcomes.

INSIDER AND OUTSIDER INFORMATION

In the context of DID, it is useful to differentiate between insider and outsider information. Insider information can only be provided by those who have a dissociative disorder. Because I do not, I am providing outsider information. Both types of information are important. If you get to know one person with DID, then you have gotten to know one person with DID. People with this disorder are as different from one another as are those with any other disorder. I urge readers to listen closely to clients with dissociation and to always honor their experiences in their work with them.

As an outsider, I do not presume to understand what it is like to deal with multiplicity of identity every day. To offer insider information, I provide descriptions of my direct experiences with clients, which take the form of either a short description or anecdote or a more detailed case study. To protect confidentiality, identifying information has been altered.

EVIDENCE-BASED PRACTICE

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services and the United Kingdom's National Institute for Clinical Excellence equate evidence-based practice with the use of specific treatment approaches. By doing so, they elevate those particular methods as better than other methods. Therapists are advised to become trained in one or more of these methods and maintain fidelity to it. For example, SAMHSA (2011) offers a downloadable evidence-based practice (EBP) kit that outlines several evidence-based practices that are appropriate for treating depression among older adults. SAMHSA does not, however, offer any suggestions as to how to proceed if the client is not interested in pursuing a particular recommended approach.

I worked for a mental health center where grant money was available to train therapists provided the training adhered to one of the evidence-based methods that appeared on one of these lists. This resulted in some restrictions as to the type of training that was available to therapists. Insurance companies may refuse payment if a therapist is not using an approved EBP with a person with a particular diagnosis.

This approach has several problems. First, there is no consensus on how to rate and define a therapeutic modality as evidence based. Is the gold standard of research used in medicine applied? If so, then one would have to perform a study that had the following characteristics:

- randomized, in which patients are assigned to active treatment or placebo
- prospective, in which treatment begins at a starting point and follows forward in time
- double blinded, such that neither the researcher nor the participant knows whether the participant is getting active treatment or placebo
- placebo controlled
- diagnostically well-defined participants
- well-defined inclusion and exclusion criteria
- valid and measurable treatment responses
- replicable
- supported by adequate statistical analyses (Ross & Halpern, 2009)

This set of standards is not realistic for a study of the treatment of those with DID for several reasons. Many clients with DID have co-occurring disorders that would exclude them from such a study. Any chance to show improvement in the treatment of DID would involve a long-term approach that does not fit well with the timeline of these sorts of studies. Also, there would be ethical concerns with offering a placebo treatment for any long-term therapeutic endeavor, and it would be relatively easy for the client to realize that the treatment was a placebo.

A meta-analysis of various psychotherapy approaches used to treat posttraumatic stress disorder (PTSD) found three things: first, that these approaches were more effective than no treatment; second, that there were no significant differences in effectiveness among the therapies studied; and third, that recommending one PTSD treatment over another is scientifically questionable, and patients are better served if they can express their preference for the kind of treatment they find most useful (Benish, Imel, & Wampold, 2008). This supports the idea that to endorse one form of treatment over another simply because it has been determined to be evidence based by a particular body or organization is not helpful.

Wampold et al. (2010) argued that it is more important to look at the specific factors present in multiple forms of treatment that appear to lead to therapeutic success. One of the coauthors of this article, Scott D. Miller, followed up on this discussion in his blog in 2013. He pointed out three factors to consider: "(1) the best evidence; in combination with (2) individual clinical expertise; and consistent with (3) patient values and expectations." He concluded that it is counterproductive to focus on specific treatment approaches deemed to be evidence based and that EBP ought to be considered a verb rather than a noun (Miller, 2013).

This is the approach I take in this book for several reasons: First, no specific modalities have been determined to be evidence based for the treatment of DID.

Second, it is important to be aware of the best research regarding treating both complex trauma and attachment-based wounds and to incorporate those understandings in one's work with clients with DID, no matter what approach one may be using at a given time. Third, adhering to a specific approach with constant attention to its fidelity would, in my opinion, distract from the attunement that is necessary to be successful in treating clients with DID, who are creative and full of surprises. Fourth, to adhere to the social work principle of person-in-situation, a great deal of flexibility is required.

DSM AND THE MEDICAL MODEL

To begin working with individuals struggling with dissociation, one needs a frame of reference. The DSM-5 (APA, 2013) defines diagnostic criteria on the basis of identification and clustering of symptoms but offers no treatment suggestions and, with a few exceptions, ignores etiology. It is not possible to work effectively with this population while ignoring the causes of dissociation. Consequently, in this book I reference the DSM-5 in terms of diagnostic criteria and some of its research base, but it is not this book's primary frame of reference. The medical model is concerned with finding the causes of disease, such as microorganisms, genetic predisposition, hormonal variations, lifestyle choices, organ displacement, poison, or radiation. When physicians operating within the medical model cannot find a cause, they tend to brush aside the symptomatology or consider it to be all in the person's head and refer the patient to a psychiatric provider.

In turn, psychiatric providers have also been trained in, and are immersed in, the medical model. They stand on the shoulders of Freud, but alas, they tend to ignore the unconscious and turn to the chemistry of the brain to explain what the family physician cannot. Although the understanding of brain chemistry has made great strides in the past few decades, few would dispute that it is still in its infancy. For example, science has identified more than 100 neurotransmitters in the brain, and it is likely that many more have yet to be identified. Nevertheless, only a few of the known 100 have been studied extensively (Christensen, 2020). The psychopharmacology industry has produced and continues to produce new medications designed to interact or interfere with the functioning of those neurotransmitters that have been studied without any knowledge about their effects on those that have not. These medications are prescribed to treat every kind of psychiatric condition without a clear understanding of how they affect the chemistry of the brain and the nervous system of the body, resulting in frequent disruptive side effects. Psychiatric providers persist, however, in using the medical model. They do what they can with the tools at their disposal—and rightly so—because, in spite of its limitations, altering brain chemistry provides significant symptom relief for some patients. (See chapter 6 for more details regarding this important topic.)

I have concluded that neither the DSM nor the medical model provides the needed frame of reference for the understanding and treatment of DID.

MINDSIGHT

Having rejected both the DSM and the medical model as suitable frames of reference for understanding how to treat dissociation, I searched for a more suitable model. I have been strongly influenced by narrative therapy, developed by Michael White and David Epston (1990), and I had the opportunity to study under White in Australia in 1999. I remember him emphasizing the importance of assisting clients in becoming curious about their lives, which is a concept I have adopted in my work with all my clients. In treating people with DID, such curiosity is paramount.

White (2007) utilized the metaphor of a journey to describe the process of narrative therapy. Although the destination of such a journey cannot be precisely specified, and the routes cannot be predetermined, it is helpful to have a map to be used as a guide in the journey. He developed a set of these maps and noted that they

> shape a therapeutic enquiry in which people suddenly find themselves interested in novel understandings of the events of their lives, curious about aspects of their lives that have been forsaken, fascinated with neglected territories of their identities, and, at times, awed by their own responses to the predicaments of their existence. (pp. 5–6)

To further articulate these inner enquiries, I turned to Daniel Siegel's (2011a) concept of interpersonal neurobiology. He defined mind as "an embodied and relational emergent self-organized process that regulates the flow of energy and information"; the brain as "the mechanism that allows the flow of energy and information"; and relationship as the "sharing of energy and information flow" (pp. 3–13). Siegel then described a "triangle of well-being" that occurs when these three systems are integrated and work together seamlessly. Siegel invented the term "mindsight" to describe the well-being that occurs when there is a healthy flow of energy and information through these three systems.

Siegel (2011a) describes mindsight as the seventh sense. The first five senses are well known. The sixth sense is the ability to perceive one's internal bodily state, for example, heartbeat, queasiness, and the ways in which fear or joy are manifested in the body. Mindsight involves the ability to "look within and perceive the mind, to reflect on our experience" (p. xi).

River of Integration

Siegel (2011a) describes "integration" as the glue that holds it all together. There are two extremes manifested in different areas of life: chaos and rigidity. Chaos occurs when there is differentiation without linkage. This is true in relationships as well as in one's internal life processes. Rigidity occurs when there is plenty of linkage but an absence of differentiation. Integration seeks the middle way between chaos and rigidity.

Siegel (2011a, pp. 69–71) presented a useful metaphor for these concepts: the River of Integration. One bank is the Bank of Chaos, and the other is the Bank of Rigidity. In between flows the River of Integration. It is much easier to sit on either bank or to bounce from one to the other than it is to enter the flow of the river.

Another metaphor that illustrates these concepts is music. Let's say there are four people interested in creating music together. If each person sings a totally different song, there will be differentiation without linkage, and the result will be chaotic. If, however, all those involved sing the same note, it may be beautiful for a few moments, but if it continues for very long, it will be experienced as monotonous and rigid. To reach the River of Integration, each singer sings the same song but in a different vocal range, such as soprano, alto, tenor, and bass; harmony is achieved; and the listener will find it beautiful.

Another example is marriage. If there is a lack of ongoing communication and connection, the couple will drift apart, and the marriage unit will no longer be functional (differentiation without linkage). The individuals in the marriage could be happy and fulfilled, but the marriage unit itself would be chaotic. If, however, there is no opportunity for each member of the couple to have unique experiences that can be brought back into the relationship (linkage without differentiation), rigidity will set in. Healthy integration between couples in a marriage occurs when each person has the freedom to pursue their own interests (differentiation) while sharing and connecting in creative loving ways together (linkage). The combination of these two creates an integrated marriage.

Similarly, in working with those with severe dissociation, dissociated parts (differentiation without linkage) often make decisions that result in chaotic life experiences. To compensate, the person may attempt to stifle or deny those parts. In other words, they may deny that there are parts within them and insist that they are all connected, that there is no need to communicate or connect with them because they are all fused together (linkage without differentiation). This creates a rigidity that may be manifested as immobility or depression. Treatment involves finding ways for differentiated parts to communicate and cooperate, creating healthy integration.

Many clients with DID bounce from one bank to the other. For example, a female client might be triggered by seeing a person at the store who reminds her of a traumatic experience from the past, but she may not be conscious of the connection. To protect against a flood of distressful emotion, she works hard to push it all down and goes on a kind of automatic pilot, resulting in disconnection from the world and from any internal input. The client is now on the Bank of Rigidity. A few minutes later, the person who triggered the client turns around and makes eye contact with the client. This leads to a flurry of activity from inside, as three different alters fight to gain control of the body. A protective alter who leans toward violence succeeds in taking control and begins to confront the man. Just as they are about to hit him, another alter pushes through and backs away. This stimulates a frightened child alter who takes over the body and runs and hides. The client has

bounced away from the Bank of Rigidity and is now on the Bank of Chaos. Finally, the primary forces herself back out, looks around, abandons her cart, and retreats out of the door, with only snatches of memory of what just occurred.

The Three Cs

Either bank is easy to access. The River of Integration is difficult to find and even more difficult to step into or float down. The key can be found in what are called the *three Cs:* internal communication, cooperation, and co-consciousness (Schwarz et al., 2017, pp. 210–212). As these skills develop, the responsible adult or adults are able to negotiate agreements with the other alters according to common goals. To use the previous example, if the client had developed sufficient skills in the three Cs, she might have had a mutually agreed-upon goal to be able to complete grocery shopping without switching by assigning tasks to different alters.

With the three Cs activated, the client's experience at the store would be very different. A protector alter is assigned the task of looking out for potential dangers. The protector sees a man with a beard and immediately lets the primary know that there is danger. An older, wiser alter is given the task of evaluating whether the danger is real or perceived. The wise alter looks closely, sees that the man with the beard is not in fact a past abuser, and immediately lets the protector know. The protector informs the primary to move quickly to a different aisle and calm down. The primary complies, and a crisis is avoided. The system is floating in the River of Integration, at least for the moment. A more comprehensive description of the three Cs is provided in chapter 8.

The stage has been set. To move forward in the therapeutic process, one must have a sound understanding of trauma, attachment, and dissociation, which are the subjects of the next three chapters.

QUESTIONS FOR REFLECTION

1. List four possible words used to describe the different parts of a DID system. Which one do you prefer, and why?
2. Explain why the author does not want to refer to a client with DID as the host of the system.
3. A client with DID displays dramatically pronounced differences between alters. Which is more likely—that the DID diagnosis is correct or that the client is malingering? Explain why.
4. Janice is a recovering addict who received specialized training and is now working in a chemical dependency treatment program. Does she have insider or outsider information about addiction? Explain how this may help or hurt her in her work.

5. Why will most social workers who enter the field and decide to do therapy encounter clients with DID?
6. List the three factors that Miller (2013) identified as important to consider in deciding what approach to take in therapy. Explain what he means when he says that EBP should be considered a verb rather than a noun.
7. Reconstruct in your own words the argument for rejecting the DSM and the medical model as a suitable framework for DID treatment.
8. Define Siegel's (2011a) triangle of well-being and mindsight.
9. Identify and define the three Cs. Why are they important?
10. Formulate a scenario in which a person jumps from the Bank of Chaos to the Bank of Rigidity along the River of Integration.