

## DID treatment efficacy: The patients' perspective

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If dissociative disorders are to be accepted as a mainstream field in mental health there is a need to elevate the scientific standing of our field by fostering quality research on dissociative disorders (DD) and their effective treatment. One of our main challenges lies now in demonstrating that DD are treatable and that these specific treatments have positive effects and are better than no treatment or alternative interventions.

Since quantitative randomized clinical trials of DD treatment are unrealistic goals and since knowledge about effective treatment components is lacking, explorative qualitative research is more appropriate than conclusive quantitative research.

The critical need in our field, as we see it, is to identify the factors contributing most to healing survivors of chronic trauma and to their optimal functioning, and to demonstrate repeatedly that these particular variables are the specific agents of change. To study DD psychotherapy we decided to talk with individuals who present themselves as having successfully completed their treatment of diagnosed DID.

We decided to adopt a phenomenological approach seeking description, then analysis and understanding of our respondents' experiences. We conducted an international qualitative study of former DID patients living in the United States, Canada, and Israel. Participants were recruited through former clients and several Internet discussion lists of therapists. In-depth interviews

followed a semi-structured interview developed by the researchers. Here is a description of our respondent group:

**N=14 females**  
**Age: M = 50.1**  
**(SD=9.70, Range = 27-62)**  
**Years in Therapy: M = 10.9**  
**(SD = 9.2, Range = 3-39)**  
**Years since therapy: M = 4.6**  
**(SD = 3.4, Range 0.04 [2 weeks]–11)**  
**Eight were married, the rest not.**  
**69.23% had a BA, Masters, PhD**  
**or were working on a PhD**

Participants who had completed therapy for dissociative disorders and considered themselves healed were recruited. Fourteen individuals meeting these criteria were identified and interviewed by telephone, internet telephone or face-to-face. Interviews lasted between one and three hours each. Five interviews were conducted by the first author and nine by the second. Some of the interviews are still being transcribed. Themes were identified related to outcomes of therapy from the informants' perspectives and supported with quotations from transcripts or audio recordings. Today we wish to share some preliminary results pertaining to two issues:

### **Interview Questions**

- 1. What do you consider a successful outcome for DID treatment? What are your various criteria for a successful treatment? To what extent have you attained these goals?**

**Click**

- 2. We are interested in the most effective attributes of the therapy. In other words, what were the main factors or characteristics of therapy that helped you the most?**

### **Attitudes towards integration**

One of the least understood aspects of the treatment of Dissociative Identity Disorder (DID) is the concept of integration. Information on this topic for professionals or individuals with DID is limited. Therapists may have difficulty explaining what integration means and how it will benefit their clients. Here is how one respondent talked about it:

#### **Attitudes towards integration**

***“Integration was the ownership of all thoughts, feelings, fears, beliefs, experiences and memories - (my personalities), as me/mine. It means giving up the option for saying a thought, a memory or a feeling is “not me.” Integration is a process that happened throughout therapy as dissociated aspects of my experience become accepted into my awareness. It brought a kind of peace that comes with fully accepting and loving myself.” (R)***

Integration was also described as a gradual and ongoing by several participants. They saw integration not as a point in time but a process. One interviewee stated, *“It was just a gradual process, and I didn’t even realize it was happening.”* (K1). A second said of integration: *“I don’t think anyone is ever finished until you die.”* (J) Another indicated, *“I kept consolidating after treatment.”* (L)

Most respondents achieved integration but many talked about their apprehensions and worries associated with this widely accepted criterion of therapeutic success. Here is what one Israeli respondent said:

#### **Attitudes towards integration**

***“The concept of integration always scared me and others inside... So it (was) as their death, and I loved my parts, they were real to me, I didn’t want them to die...on the other hand having parts drove me nuts***

***because I couldn't stand losing time anymore...what eased the fear was after the first blending of 2 parts when we realized that no one actually disappeared or died... abilities and traits were integrated, not lost". (O).***

Fear of integration had been a very common source of worry among our respondents during their treatment. Two respondents acknowledged that they still had alternate parts yet considered themselves healed. One did not want to integrate and the other felt integration is the ideal but she still considered herself healed without full integration. Here is what each said about integration:

#### **Attitudes towards integration**

***"...Again, I don't know enough multiples to say for sure, but I feel sure that there must be some of us out there who were (MIS)guided into integration, total integration, by well-meaning therapists who thought that that was the only desirable outcome. Thank God that that wasn't the case with us." (S).***

S., a high-functioning individual with active personality alters, whose psychological testing corroborated her self-reported well being, said the following about integration:

#### **Attitudes towards integration**

***"In the process, I went through and briefly considered the traditional outcome of total integration... It was a case of us becoming someone entirely different, and none of us wanted that. We all wanted to become the best we could be. But the best we could be didn't involve getting lost". (S).***

This individual was delighted at her post-therapy condition and she was not alone. In the words of a former DID client of the first author who was uninterested in integration: *"In times of crisis I have direct access to my*

*subconscious mind. My parts don't take over anymore, but I can engage in "creative disintegration" to find out rapidly what the source of my pain is and I can address it effectively. Can you?"* she asked the interviewer. It was obvious she took pride in her unique ability to access alternate parts upon will and that she cherished her post-therapy sense of control.

Future outcome research will have to determine if a subcategory of DID/DDNOS with minimal or no amnesia, a sense of wellbeing and overall good functioning, can be regarded as healthy. Among the many integrated former DID clients we interviewed, however, consensus about the advantages of integration was evident. Here is how one Israeli client described her experience:

#### **Attitudes towards integration**

***"The best outcome of the therapy is my integration...I like not losing time and being aware of what is going on inside...I just wanted to get control over my life and my memories...I like the fact that I can benefit from the abilities of my parts...I have the joy of life of one part, the social skills of another, the warrior courage of a third part, and so on...I also accepted the fears of my child parts... " (O)***

#### **The hallmarks of successful DID treatment**

The persons we talked to described subtle processes, therapist virtues and the quality of their relationship with their healers as the most important curative agents. Conspicuously underrepresented in our respondents' descriptions were specific techniques or treatment practices. Nevertheless, a few participants pointed out that affect regulating techniques were very helpful. Following is what a typical statement regarding technique:

#### **Hallmarks of good DID treatment**

### ***Affect regulating techniques, e.g. Hypnosis***

***"We worked with hypnosis a lot. I think this is an awesome technique because through it I could see that which I could otherwise not face...I used to look at difficult memories on a darkened TV screen in my imagination...So she suggested hypnosis and the angry part was provided with a padded room inside in which this was safer and this helped a lot."***

**(O)**

Over the past two decades, the consensus of experts is that complex trauma-related disorders—including DID—are most appropriately treated with a phase or stage oriented approach. The most common structure for this is a treatment consisting of three phases or stages:

#### **Hallmarks of good DID treatment**

##### ***Phase-Oriented Approach***

- 1. safety, stabilization and symptom reduction,**
- 2. working directly and in depth with traumatic memories, and**
- 3. identity integration and rehabilitation.**

Phases 1 and 2 are characterized by intense feelings that often require therapist assistance with management of affect and control of behavior. Some of our respondents have identified the implementation of such technique as important factors in their healing.

One of the most threatening emotions our respondents were required to contain and metabolize for recovery to progress was *anger*. For example:

#### **Hallmarks of good DID treatment**

##### ***Containment of patient anger***

***"...and the other thing was that she taught...those of us who were afraid of being angry, not to be afraid of being angry, and she taught those***

***of us who felt that they were consumed with rage that it was all right to express it and to trust our own boundaries in expressing it.” (S)***

***“...and my therapist encouraged (me) to go ahead and express my anger; verbally...physically – on anything that wouldn’t break...no harm was done. That was amazing. That was a revelation.” (O)***

Our respondents seemed to believe that successful treatment for DID was characterized by quality management of intense affect combined with some desensitization to emotions that had been regarded as too dangerous to have or to express. However, most comments about factors leading to successful DID treatment were unrelated to technique. One common theme in our respondents' accounts was the sense of respectful credence on the part of their therapists, feeling believed and listened to. Here is how one former client presented this recurrent theme:

### **Hallmarks of good DID treatment**

#### ***Respectful Credence***

***“My therapist listened. That’s something that I would write down in 36 point type and draw a frame around. Right from the very beginning, she listened, she accepted, she didn’t challenge any of our feelings, she didn’t disbelieve any of the stuff that I went through...”(S)***

Feeling validated seemed to have been an effective healing elixir for many of the survivors we talked to. One of the frustrating experiences shared by many DID clients was a history of professional disregard for their symptoms. The therapist's willingness to acknowledge alternate parts and work with them fairly and respectfully was a recurrent theme, represented well by the following excerpt:

## **Hallmarks of good DID treatment**

### ***Acknowledgement of the reality of multiplicity***

***"...and I said that I could not be in therapy unless D (a part) approves and she (the therapist) said, OK I am willing to discuss this with D, and the next session D came and this was the first time a part introduced itself to somebody else and D realized that that she (the therapist) is harmless...this was a meaningful turning point because I knew that my therapist can handle me". (O).***

Other participants indicated that one of the most effective factors of successful treatment was working with alters.

## **Hallmarks of good DID treatment**

### ***Working with Alters***

***"Until you work with the alters you can't do anything meaningful..." (J)***

But one interviewee who suffered ritual abuse felt naming them contributed to dissociation though working with them was necessary.

***"I was conditioned to believe I was different people...so, unfortunately, when a person is sitting with a client and calls them by one of these different names, it reinforces the disassociation. I'm convinced of that now. What helped me the most was when someone would talk to a part of me that came out, and talk to them without saying the name." (K2)***

The most commonly cited treatment orientation was individual, psychodynamically-oriented psychotherapy with a focus on disordered attachment. The attachment system can be understood as a psychological system for combating stress and modulating stressful arousal (Lyons-Ruth, 2001). The attachment process cannot develop adequately under traumatic conditions, in which the attachment figure fails to provide a protective shield



against the dangers of the environment, or is, herself, dangerous. Adequate treatment for survivors of severe abuse promotes the development of relational knowledge of how to be with another person. The therapist-client relationship should reflect implicit models of healthy relationships to promote the development of internal working models of attachment. Many of our participants commented on their relationship with their therapists as significant elements in their recovery. For example, one individual in the examples below felt her therapist was a gift. The other individual, although she had some trouble with the therapeutic bond, still believed that it was an important factor in her healing.

### **Hallmarks of good DID treatment**

#### ***Therapist as a corrective attachment figure***

***"My therapist. She is such a gift, such an incredible woman...I love her deeply... her personality. I could not stand intimacy at first, I could not tolerate her kindness, her soft voice – I screamed at her to shut up because she was tearing me apart. It hurt so much....she knew that I needed her softness and she found the right balance... she was totally there for me...I have a biological mother, but she (the therapist) created me." (O)***

### **Hallmarks of good DID treatment**

#### ***Therapeutic Bond***

***"...even though I had a little trouble with the therapeutic bond ...it was definitely probably one of the most important factors. I say I had a little trouble with it because I had trouble not thinking of (the therapist) as a friend and .... That was a very difficult thing and yet (the therapist) always seemed to be there ... for the most part, I didn't have a sense of being rejected. The therapeutic bond was something that I think really***

***helped a lot. I had the sense that I wouldn't lose (the therapist)...That (he) would stay with me and be with me as long as I needed it. And I think that was really good."* (L)**

No therapeutic work can succeed if safety has not been adequately secured not only outside but also within the therapeutic treatment situation. Being able to feel safe and supported has helped our respondents to confront trauma-associated memories and behavior patterns. The therapist's task of providing a "secure base", from which the client can safely explore his or her inner and outer realities, has been of crucial importance to our respondents. As Liotti (2004) summarizes it, trauma-centered therapies that are often highly effective for simple types of PTSD can exacerbate rather than resolve patients' difficulties in complex PTSD. Participants in our study have recognized that and have also described the importance of their exposure to a corrective model of care as an important curative element in their healing.

## **Summary**

### **Hallmarks of good DID treatment - Summary**

- Affect regulating techniques, e.g.: hypnosis.
- Phase oriented treatment
- Containment of patient anger
- Respectful credence
- Acknowledgement of the reality of multiplicity
- Working with alters
- The therapist as a corrective attachment figure
- Firm therapeutic bond