
Working with Dissociative Disorders in the Clinic

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In recent years, dissociative disorders have been more heavily researched, hotly debated and the object of fascination across counseling-related fields. But, establishment of the differences between other psychiatric disorders and dissociation was begun by the pioneer researcher, Pierre Janet in the late 1800s (Janet, 1890). His documentation of cases aided the psychiatric community in the process of breaking out the several diagnoses

from the original blanket diagnosis of hysteria.

A formal and more universally accepted definition and phenomenological description of the various dissociative diagnoses wasn't fully developed until the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (1980), and serious work on treatment protocols did not begin to occur until the 1970s (Hilgard, 1977). This renewed interest in investigation of the dynamics and treatment of dissociation resulted in the works of John Putnam (1989), Richard Kluft (1985), and Bennett Braun (1986). Later, negotiations between American and European psychiatric communities altered the criteria for MPD to Dissociative Identity Disorder (American Psychiatric Association, 1984). The argument for change of diagnosis was based on similarities of some characteristics of the fragmented dissociative state and Borderline Personality Disorder. The manipulative nature of "personalities" (ego states), histrionic reactions, the intensity of some ego states' approaches to relationship, and self-mutilation convinced some of the psychiatric community that multiplicity was attention-seeking behavior.

However, dissociated clients' reports of motivations and experiences surrounding the above mentioned phenomena lead to another conclusion.

First, while Borderlines open a relationship with intensity and quickly become disillusioned, turning to others and manipulating groups, the dissociated individual appears more like what James Masterson has named Closet Narcissism (Masterson, 1988). This nongrandiose self-absorption begs for the love of the more perfect object, thus resulting in a relentless dependent state. Further, clients have reported that the self-mutilating behaviors as retaliations against other “personalities” rather than needs to relieve emotional pressure or dramatic gestures toward others. This is critical to the clinical understanding that drives therapy. As more literature dwells on the fantastical characteristics displayed by the dissociated individual, the major issue of psychotherapeutic concern remains the lack of continuity in memory and resultant life dysfunctions from lost time and situation control (Kluft, 1990).

Even though much recent literature exists, including a distinct fascination with phenomena, the core treatment literature tends to fall within the precepts laid down by the major authors of the 1980s and generally agree that work across dissociative diagnostic states are similar (Maldonado, Butler, & Spiegel, 2002; Barnett, 2004). This is crucial to best practices, as loss of memory and cognitive ability toward life mastery are serious malfunctions with grave consequences, whether they be Alzheimer’s,

dementia, organic brain syndrome, or dissociation (Kluft, 1990).

Some foundational insights are helpful to the practicing counselor for two reasons, to help focus off of the dramatic occurrences and onto therapeutic interventions themselves and to aid the clinician control of countertransference (Putnam, 1989, pp. 167-168, 187-194). The first issue of note is that all dissociative states appear related to many of the same factors across dissociated individuals (Kluft, 1985). The second is that the personality factors are found to some degree in most humans but not to such a degree or in such combinations as to produce classic dissociation (Kluft, 1990).

Most individuals at some time become so wrapped up in something consciously that they function otherwise on autopilot, without recall of events or tasks during that time period. Concurrently, victims of Post Traumatic Stress Disorder report many of the phenomena that exist in dissociation such as depersonalization, derealization, lack of recall of events during high stress periods and even cognitive and behavior deviations that supersede normally existing personality traits in the individual. Dissociation differs in the type of defensive reaction and the several factors which must exist to produce a chronic dissociated state.

Kluft (1985) posited four precipitating factors. These include 1) dissociative ability – suggestibility or hypnotizability – 2) experience(s) that overwhelm nondissociative aspects of the ego structure, 3) shaping influences uncommon between clients but that predict the actual form of dissociative presentation, and 4) inadequate stimulus barriers and restorative experiences, such as social isolation. In the same vein, Frischholz, Lipman, and Braun, (1992) suggest a three factor model. The first, predisposing factors, includes dissociative capacity and psychosocial environment that present the individual with consistent, unpredictable physical or psychological trauma. The second is precipitating factor of a single, highly traumatic event that triggers chaining between several dissociated memories into an affective theme, breaking the memory chain into a dissociated state, much like hypnotic suggestion. If Dissociative Identity Disorder is to occur, there must be a third factor: perpetuating factors that fragment self consciousness and that promote splitting and switching. Without dissociative capacity, the result is denial.

Although the clinical descriptions of precipitating factors may seem academic, they prove to be the key to best practices in counseling. During an in-depth training with Dr. Richard Kluft (1990) it became clear that the

core duty the counselor has is integration of the whole individual and recovery of capacity to full memory chaining. Most other phenomena tend to be distractions from the task at hand. One of the most helpful tools toward this task of integration is to concentrate on motivation toward and practice of memory chaining rather than recovery of traumatic events.

Abreaction can produce horrific and injurious reactions including severe conversion responses or suicidality. As Dr. Kluft (1990) stated to his students, “Bore your client into health.” Traumatic recall will occur slowly, naturally, and somewhat anticlimactically as memory reintegrates.

Thus, treatment falls into several stages that follow chronologically (Putnam, 1989). The first is diagnosis. In simple Amnesia the client tends to be disturbed enough by the stress of loss of identity to seek out and report accurately the disintegration of memory chaining. However, in either Fugue or Dissociative Identity Disorder the client is usually unaware of the existence of alternate ego states either past or present. Resultant dissociated behaviors and personality structure are easily misinterpreted as other disorders. So, one of the hallmarks of dissociation leading to clinical suspicion that dissociation might exist is a history of diagnoses or treatments for diverse disorders later replaced by new pathological presentations (Kluft, 1990). The Dissociative Experiences Scale: II has

been developed to aid in diagnosis (Frischholz, Braun, & Sachs, 1992). Additionally two clinical techniques can improve speed and accuracy of diagnosis in Dissociative Identity Disorder (Kluft, 1990). The first is the time pressure technique. The separate identity states tend to be geared to handle specific life situations and likely respond to suggestions that a clinical interview will last a particular time period. If the session continues beyond the stated time, switching may occur more readily in response to diagnostic questioning. Summoning other identity states may also prove to be constructive.

Once diagnosis is established, initial interventions include gathering history, meeting and describing whatever personality fragments exist, and developing a working relationship. This includes considerations of stability of the client during treatment: safety contracts, determining extent of needed immediate interventions and contingency management including potential intermittent hospitalizations if the client abreacts or experiences destabilizing crises.

Working through acceptance of the diagnosis can be traumatic for the client, particularly in the case of Dissociative Identity Disorder, since the alternate ego states are incongruent and tend to be intolerant of each other.

This requires that methods for communication and cooperation be established. Cooperation tends to be motivated by ongoing successes, advantageous to each individual ego state, so communication is the more practical immediate goal. With any dissociative state, a “blackboard” becomes a handy tool. For less disintegrated dissociative states, this helps chain recovered memories as they occur. For Dissociative Identity Disorder the blackboard allows immediate memory chaining to begin until reciprocal motivating events convince ego states to freely allow other internal ego states to access the memories restricted only to them. For instance, one of the author’s clients reached a compromise to allow the executive personality access memory of the Spanish language so that the lender of this knowledge could have more time “out” rather than abdicate time for the executive personality to relearn Spanish independently.

Using Kluft’s psychotherapeutic approach, negotiations toward memory chaining of immediate life processes takes up a bulk of time in therapy. Methods espoused by Braun, Putnam and other experts lean more toward abreaction and recovery of trauma based memories. Kluft’s method has proven to be less dangerous to the author’s clients. Integration occurs as memory sharing brings about client realization that different ego states have more commonalities, in personality clusters, than differences. Client

ego states begin to realize the nuisance of switching or artificial blackboarding of memory as switching occurs. Either way, traumatic memories will occur over time. Although they are more easily accepted by the client as they naturally surface, using Kluft's methods, the client will have the same difficulties dealing with Post Traumatic Stress symptoms as other trauma victims, without the debilitating responses that abreactions trigger.

Reintegration of either alternate ego states for Dissociative Identity Disorder or with past ego memory chains and identities is the last stage of counseling. This stage overlaps with others and occurs in an asynchratic fashion as either the various ego states find each other compatible and integration advantageous to better function or desensitization to traumatic memory takes place.

Finally, the author has observed that there are some important relational issues for the clinician to attend to regularly for successful treatment, healthy relationship with the client, and personal stability and emotional health of the counselor. This is critically important, as work with dissociative disorders can be both snail paced and the transference issues demanding. The argument by members of the psychiatric community for

disestablishment of the Multiple Personality Disorder diagnosis in favor of Borderline Personality Disorder during debates toward establishment of the *DSM IV* was based in the demands of this transference phenomenon. The issues to be considered by the counselor fall into two categories: psychological issues and developmental issues. It is helpful to document, consider, and deal with them as such.

Developmental issues occur within the realm of all dissociative disorders with serious ramifications, as even amnesic states disallow clients full access to important cognitions toward personal and social mastery and so life fulfillment. Missing life experiences must either be remembered or re-experienced so as to develop the sophistication necessary for social grace and ready response to situations. Retrieved data, skills and understandings will give the breadth of understanding and interpretation of life events to both avoid faux pas and create richer responses. Finally extensive socializing experience is a critical element. One of the author's clients, whose executive personality worked occasionally in the court system, once stormed into a judge's chambers during a recess and cussed at him for a decision he had made that the immature personality state felt was unjust. Another teenager with whom the author worked consistently humiliated herself in front of peers and so was spurned until the teenager began to play

with younger children, more congruent with her emotional age, until she achieved enough sophistication to interact with more mature playmates.

Psychologically, the counselor must be consistent throughout treatment. This is no mean feat. Client transference demands have been described as the black hole of love (Kluft, 1990). Controlling transference requires thoughtfully developed boundaries, because the same transference demands are wearing. At the same time, the clinician must be caring. Finally, the counselor must avoid countertransference that stimulates transference projections. The dissociated client easily sees, sometimes literally, the countertransferred clinician as the source of original trauma. One of the author's clients once began to call him by her father's name while experiencing an abreactive state and feelings of abandonment.

Ultimately, successful work with dissociated clients emanates from dependable, regular, and appropriate supervision. The clinical supervisor should be chosen for both specific expertise and for the willingness to confront counselor issues as they spring from the rigors and stressors of counseling. The clinic-designated supervisor may not have either the proficiency or the temperament to concentrate on the growth and health of the counselor and to provide adequate supervision throughout the duration

of the therapy. The same consistency that is required in counseling is paralleled in supervision. With support and insights provided by a well trained and committed supervisor, full integration can be successfully achieved.

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