Assessing and Treating Complex Dissociative Disorders

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This chapter focuses on the two dissociative disorders that manifest in distinctive dissociative symptoms and include a division or compartmentalization of sense of self and identity. These complex disorders are considered to be extreme reactions to developmental trauma and require a specific treatment approach. They include Dissociative Identity Disorder (DID) and Other Specified Dissociative Disorder-Type 1 (OSDD-1; APA, 2013). OSDD includes a diverse range of four dissociative problems, but OSDD-1 is considered to be very much like DID with less distinct symptoms.

Because there are so many phenomena that are now considered to be dissociative, this chapter will briefly explore the several definitions of dissociation, as they have different treatment implications, as well as offer a brief overview of assessment and treatment of OSDD-1 and DID.

Definitions of Dissociation in the Literature

More and more symptoms have been brought under the umbrella of dissociation since its original and more limited description over a century ago (Janet, 1907). Subsequently, dissociation has been defined as (1) a "normal" experience involving attentional phenomena such as absorption, detachment, and imaginative involvement; (2) physiological hypo-arousal with resulting disconnection from present experience; (3) a broad array of symptoms of depersonalization and derealization; and (4) a "pathological" type involving trauma-related division of personality and identity. We discuss them here in order to clarify and differentiate them and to discuss treatment approaches to each.

Alterations in Attention and Awareness of the Present

This definition, which sometimes has been referred to as "normal" dissociation, includes various manifestations of alterations in conscious awareness and attention, such as

absorption (over-focus on thoughts or activities such that one is not aware of surroundings); detachment (thinking of nothing and being unaware of surroundings); spaciness resulting in forgetfulness and inattention; excessive daydreaming; and other types of imaginative involvement (Dalenberg & Paulson, 2009; Holmes et al., 2005). These phenomena are considered "normal" because all humans experience them in everyday life, especially when tired, ill, preoccupied, stressed, or so focused on one thing (for example, reading an interesting book or thinking about an upsetting interaction with someone) that we do not notice or register others. They are found in both normal and clinical populations and thus are not specific to dissociative and other trauma-related disorders, though they are typically present in these disorders. Some disorders, such as Attention Deficit Disorder (ADD) or Attention Deficit and Hyperactivity Disorder (ADHD) and Depressive Disorders may involve pathological levels of attentional problems and require differential diagnosis. These disorders may co-occur in individuals with complex trauma and dissociation. While changes in conscious awareness are generally present in OSDD-1 and DID, they are not sufficient in themselves to cause or entirely explain the broad range of mental and somatic symptoms of dissociation that are common in these two disorders.

Treatment of alterations in awareness. When alterations in conscious awareness are in the "normal" range, they require no treatment other than a return to a focus on the present, and good self-care that remedies stress, fatigue, illness, or a tendency towards distraction and absorption. The treatment of serious and chronic problems that interfere with daily functioning, such as chronic absorption, detachment, and maladaptive daydreaming (Somer & Herscu, 2018) primarily includes mindfulness training and development of reflective functioning. These skills are highly recommended for trauma survivors but are not sufficient

in themselves to treat OSDD-1 and DID (Steele et al., 2009). Treatment of ADD/ADHD requires an additional focus on executive functioning skills, such as organizing, planning, prioritizing, time management, and shifting focus from one task to another, along with medication when indicated.

Physiological Shutdown

Dissociation has more recently been described in some of the literature as a physiological shutdown or extreme hypo-arousal due to excessive parasympathetic activation (Porges, 2003, 2011; Schore, 2012). This is an innate defense reaction against life threat that results in rapid loss of energy and movement ("flag") and ultimately in total collapse or death feignt ("faint") (Nijenhuis, 2015; Porges, 2003; 2011; Schauer & Elbert, 2010; Steele, Boon, & Van der Hart., 2017; Van der Hart Nijenhuis, & Steele, 2006). Porges has called this the *dorsal vagal response* (2003, 2011).

Physiological shutdown involves a severe disconnect from present awareness, and is often trauma-related, which is why some refer to it as dissociation. It is likely the physiological correlate of attentional detachment in which the individual sits and thinks of nothing. The problem with this definition is that dissociation also may involve extreme hyper-arousal, as well as dysregulated alternation between hyper- and hypo-arousal commonly found in OSDD-1 and DID. It also does not include other mental and physical symptoms that have been described as dissociative in much of the literature (Steele, Van der Hart, & Nijenhuis, 2009; Steele et al., 2017).

Treatment of dorsal vagal reactions. Treatment of the dorsal vagal response involves activation of the ventral vagal parasympathetic system, which regulates the nervous system. This might include the use of the therapist's voice (calm and a very slightly sing-song

and repetitive) and other sounds that activate the ventral vagal system, breathing exercises, somatic resourcing, concrete orientation to the present ("*Can you touch the fabric of the sofa to remind you that you are here and now and safe?*"), present-centered postural change or movement, and activation of curiosity and relationally collaborative efforts ("*Let's together find a way to help you feel more grounded*") (Dana, 2018; Ogden & Fisher, 2016).

Depersonalization and Derealization

Severe and persistent symptoms of depersonalization and derealization include out-of-body experiences, somatic and perceptual distortions, feeling as if in a dream or on a stage, and slowed time sense before, during, or in the immediate aftermath of traumatic experiences (Bryant & Harvey, 2000). These symptoms are hallmarks of Depersonalization Disorder (APA 2013). They are common acute peritraumatic experiences (Bryant & Harvey, 2000), and are included in criteria for Acute Stress Disorder and in OSDD-Type 3 (APA, 2013). Depersonalization is also a major criterion for the relatively new dissociative subtype of PTSD that is now included in the *Diagnostic and Statistical Manual-5* (DSM 5; APA, 2013) (see also Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012).

More transient symptoms of depersonalization are ubiquitous, found in many mental disorders (Aderibigbe, Bloch, & Walker, 2001; APA, 2013; Leavitt, 2001) and also in the general population as occasional phenomena during periods of stress, illness, or fatigue (Catrell & Catrell, 1974).

Treatment of depersonalization and derealization. Treatment of Depersonalization Disorder and the dissociative subtype of PTSD is challenging and involves the need for the client to learn emotion recognition and tolerance, reflective functioning, and mindfulness and grounding skills, what are generally considered to be stabilization skills (Simeon & Abugel,

2006). Symptoms of both depersonalization and derealization are generally helped by a combination of dynamic trauma-informed psychotherapy, cognitive behavioral therapy (especially third generation types that focus on mindfulness and compassionate acceptance), and emotional skills training. Processing of trauma can be important in reducing symptoms of depersonalization and derealization in many individuals, which can be related to avoidance of painful emotions and experiences. Mindfulness and compassionate acceptance of experience can support individuals to be less anxious about their symptoms, and learn to recognize, tolerate, and regulate painful emotions, thus reducing the need for depersonalization as a defense.

The Original Definition of Dissociation: Division of the Personality

Dissociation was originally described under the rubric of hysteria by Pierre Janet, a French contemporary of Freud. Hysteria is the old term for what are now considered to be a wide range of trauma-related disorders, including OSDD-1 and DID, but also the somatic dissociative disorders described in the *International Classification of Diseases, Tenth Revision* (ICD-10, WHO, 1992). Janet noted hysteria was an integrative failure "characterized by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality" (Janet, 1907, p. 332). Thus, the original definition indicates that changes in conscious awareness are a necessary component of dissociation, but a division of personality is also necessary, a phenomenon not acknowledged in more recent definitions of dissociation. Dissociation as described by alterations in conscious awareness only involves attentional and perhaps perceptual components of experience; the original term "dissociation" encompasses the whole of personality, which can include attention, cognition, emotion, somatic experiences,

perception, prediction, and systems of meaning and identity (Nijenhuis & Van der Hart, 2011; Steele et al., 2009; Steele et al., 2017).

Because of the treatment differences we outlined above among the many phenomena that are called dissociation in the clinical literature, we make the case for distinguishing what we call *structural dissociation (of the personality)*, as originally described by Janet. Structural dissociation involves an inner organization or structure of divided subsystems within an individual's whole personality system that lacks adequate cohesion and coherence, what we identify as *dissociative parts of the personality* (Boon et al., 2011; Nijenhuis, 2015; Steele et al., 2017; Van der Hart et al., 2006). This term emphasizes that dissociation is at the level of personality, not a simple isolation of affect or attentional loss, for example. Many other labels exist for these subsystems, such as alternate personalities or identities or "alters," dissociative states, disaggregate self-states, self-states, ego states, self-aspects, and part-selves. Regardless of what they are called, in dissociative disorders each of these subsystems has its own sense of self and first-person perspective, have unusually closed (but still semi-permeable) boundaries between each other, and can, in principle, interact with each other and other people, unlike the normal subsystems in individuals who do not have a dissociative disorder.

While some clinicians and researchers question whether "parts" language is potentially suggestive for clients, the majority of dissociative individuals reports this language fits their experience and helps them feel more understood. There is consensus among experts in the dissociative disorders field that dissociative subsystems are not separate things or beings within the same person, nor should they be treated as such. Neither are they mere role playing, but rather are manifestations of significant and chronic breaches in the integrity of a single personality (including sense of self) across time and contexts. Thus, a systemic approach that

considers dissociative parts as interrelated subsystems of the individual should be the fundamental foundation for all therapeutic interventions in OSDD-1 and DID.

Because treatment differs among the various phenomena included under the rubric of dissociation, we propose for clarity that alterations in conscious awareness without accompanying division of personality be called by those names (for example, absorption, detachment, imaginative involvement); that physiological hypo-arousal be distinguished from dissociative symptoms per se and from dissociative disorders; that more attention be paid to somatic dissociative symptoms that are emphasized in the ICD-10 (WHO, 1992); and that symptoms of depersonalization and derealization be distinguished from the disturbances of identity in OSDD-1 and DID.

The Roots of Structural Dissociation

Normal integration of self and personality is an ongoing developmental endeavor (Putnam, 1997) that requires continual updating and adaptation across the individual's life (Damasio, 1999; Janet, 1929; Schore, 2003). Dissociative divisions in OSDD-1 and DID prevent the individual from engaging in this normal updating that lends itself to a single autobiographical sense of self across time, situations, and experiences. Instead, each dissociative part is organized by fixed and rather limited ways of thinking, feeling, perceiving, and behaving, impervious to normal changes and updating. The individual is unable to integrate these discrepant parts into a single encompassing sense of self and personality without further skills building. Thus, an important treatment point is that OSDD-1 and DID are not merely dissociative defenses, but rather involve deficits in core skills necessary for self-integration, such as emotion tolerance and regulation, and reflective and mentalizing capacities. Thus, a period of ego strengthening is generally necessary.

DID and OSDD-1 likely have both psychological and biological underpinnings. The psychological value of dissociation is to avoid awareness and ownership of what is perceived to be intolerable. Biologically, structural dissociation seems to occur along evolutionary lines of (1) defense against danger and life threat, and (2) functioning in daily life via distinct neural networks that organize and regulate attention, perception, emotion, physiology and, behavior (Liotti, 2006, 2009, 2017; Nijenhuis, 2015; Panksepp 1998; Porges, 2003, 2011; Steele et al., 2017; Van der Hart et al., 2006). These innate neural pathways are called *motivational* or *action systems*, because they motivate humans to act in particular ways. They are mediated by primary affects, directing us toward experiences that increases the chance of survival and away from danger and threat. For example, most of the action systems of daily life direct us toward prosocial activities: attachment, collaboration, competition, caregiving, play, work, and sexuality (Lichtenberg & Kindler, 1994; Liotti, 2017; Panksepp, 1998; Steele et al., 2017). Defensive systems against threat include flight, fight, freeze and faint (death feigning or collapse). Action systems of daily life and those of defense involve very different physiological states.

Several authors have proposed that these two opposing systems are the underpinnings of disorganized attachment and dissociative disorders like OSDD-1 and DID (Liotti, 2006, 2009, 2017; Nijenhuis, 2015; Steele et al., 2001; Van der Hart et al., 2006). The traumatized child has an insoluble dilemma of meeting two competing biological needs to attach to and defend against the same caregiver, what Main and Hesse (1990) have called “fright without solution.” This results in a collapse of attachment strategies and in subsequent discordant alternation between attachment and defense strategies with their very different physiological, attentional, emotional, perceptual, and cognitive components. This early fragmentation leaves the child

vulnerable to further dissociation across the lifespan (Ogawa et al., 2007) and to revictimization and retraumatization. The development of different dissociative parts can be understood, at least in part, by this chronic involuntary and inharmonious alternations between discrepant action systems (Liotti, 2006, 2009, 2017; Steele et al., 2017; Van der Hart et al., 2006).

In OSDD-1 and DID, dissociative parts of the individual can be said to develop in relative isolation from each other, dependent upon their functional organization via either daily life or threat action systems, and via avoidance of overwhelming emotion, sensations, meanings, and memories. The individual tries to go on with everyday life in dissociative parts that are primarily organized by daily life systems and are typically highly avoidant of the trauma. When the individual is directed by dissociative parts primarily fixed in threat defense, he or she is often reliving and re-enacting the trauma, unable to realize it is over, and unable to participate in daily life effectively. These two types of parts can become increasingly separate, organized by conflicting motivations, emotions, and needs.

Before effective treatment can commence, thorough assessment of dissociative disorders should be undertaken. Below we give a brief summary of the major indications of OSDD-1 and DID.

Assessment of Dissociative Disorders

A major impediment to adequate assessment is the lack of training available to clinicians about dissociation and dissociative disorders in general and about the assessment of these conditions, resulting in problems of both over- and under-diagnosis (Steele et al., 2017). Under-diagnosis is by far the most prevalent problem, as most clinicians do not even consider the possibility of dissociative disorders. Over-diagnosis can occur when clinicians mistake

phenomena such as borderline dynamics, normal ego states, or metaphorical "inner child" states for dissociative parts. It also can occur when an individual presents with malingering or a factitious disorder (Draijer & Boon, 1999; Thomas, 2001).

The dissociative symptoms in OSDD-1 and DID are qualitatively different than in other disorders or problems, which can help in accurate diagnosis (Boon & Draijer, 1993; Korzekwa, Dell, & Pain, 2009; Rodewald, Dell, Wilhelm-Gößling, & Gast, 2011). The clinician should request from the individual several examples of any given dissociative symptom across time, gradually building a case for enduring dissociation that occurs in varied situations.

Amnesia

Dissociative amnesia is a disorder in its own right when other significant symptoms of dissociation are not present (Dissociative Amnesia, DSM-5, APA, 2013). It is a specific criterion required for the diagnosis of DID but is commonly found in most trauma-related disorders, and thus is not a unique marker of DID and OSDD-1. However, many individuals with DID experience not only amnesia for past trauma – a relatively common phenomenon in traumatized populations- but also amnesia for the present, indicating dissociative parts are acting outside of awareness in daily life.

Present-day amnesia can be discerned by reports of engaging in significant activities the individual does not remember doing ("*I know that big report was turned in to my boss, but I have no recollection of doing it*"); of finding strange things among belongings ("*I find cigarette butts in the house, but I don't smoke and don't know how they got there*;" "*I unpacked my groceries and found several boxes of cookies – I don't even like cookies!*); or finding writings or drawings ("*Sometimes I find scary drawings like a little kid would make,*

with a big "HELP" written in red"; "*I found threatening notes in my bedroom written to me, calling me bad names and telling me I deserve to die*."). Individuals may be unable to recall their therapy sessions or be unable to remember significant events such as graduations, weddings, birth of a child, or a death or funeral of a significant other. Some individuals report pervasive amnesia for the past ("*I don't remember anything before age 16;" "I can remember being at school, but nothing about living at home;" "I remember a lot about my father, but don't seem to have any memories of my mother;" "I just draw a big blank between the ages of 8 and 12").*

When an individual reports significant recall difficulties for events in either the past or present, clinicians need to distinguish between dissociative amnesia and failures of encoding involving significant absorption and detachment, as treatment will differ (Allen, Console, & Lewis, 1999; Steele et al., 2009, 2017).

Schneiderian Symptoms

In addition to amnesia, many clients with OSDD-1 or DID show puzzling outward manifestations of dissociative parts that function in an internally constructed world, working "behind the scenes" to influence the individual in a variety of ways, some of which are observable and some of which are not. This phenomenon has been termed "passive influence" (Kluft,1987) or "partial intrusions" (Dell, 2009), and can be identified through questions about so-called Schneiderian symptoms of schizophrenia (Dell, 2009; Foote & Park, 2008; Kluft, 1987; Steele et al., 2017; Steinberg & Spiegel, 2008). These eleven symptoms, originally meant to identify schizophrenia, are more indicative of dissociation in the absence of symptoms of thought disorder, and often found in individuals with OSDD-1 and DID. They include (1) hearing voices commenting (usually internally, but there are exceptions); (2)

voices arguing; (3) visual and perceptual hallucinations; (4) feeling as though one's body is controlled by an outside force; (5) the sense that one's emotions, (6) thoughts, or (7) impulses are controlled by outside forces; (8) the sense that an outside force is adding to, or (9) censoring or withdrawing one's thoughts; (10) thought broadcasting (believing that one's thoughts are broadcast through the radio or TV, for example); and (11) delusions. Thought broadcasting is rare in DID, but the other symptoms are quite common. Visual hallucinations are typically related to flashbacks or other intrusions of trauma. Likewise, delusions are generally found to be trauma-related. For example, many dissociative individuals are terrified that their abuser will hurt them in the present, even though the person may live very far away or even be dead. Delusions and visual hallucinations typically resolve when the trauma can be integrated.

Hearing voices. Many dissociative individuals – like many others with trauma-related disorders - hear auditory hallucinations of "voices," a symptom that sometimes leads to a misdiagnosis of psychosis. Dissociative voices can typically be distinguished from psychotic auditory hallucinations (Dorahy et al., 2009; Steele et al., 2017) in the following ways: (1) they usually begin in childhood long before the onset of psychosis is typical; (2) they include voices of children and adults, and often the child voices are highly distressed; (3) they include voices of people from the client's past, particularly of perpetrators; (4) they are heard regularly or constantly instead of intermittently; (5) they comment about the person or are "overheard" having arguments or fighting with each other; (6) they are generally not accompanied by social and occupational decline or evidence of thought disorder; (7) they have their own sense of self, even if very limited in some cases; and, most importantly; (8) they can be engaged in dialogue with the therapist and the individual, unlike psychotic voices.

Other Intrusions and Losses

Many individuals with OSDD-1 and DID experience puzzling and sometimes jarring symptoms of losses of and intrusions into experience, both mental and somatic (Dell, 2006, 2009; Nijenhuis, 2015; Van der Hart et al., 2006). These are related to the partial intrusions of various dissociative parts into conscious awareness. These symptoms are rarely found in other disorders and are more common than complete shifts from one part to another. Losses might include somatic changes not due to medical conditions, such as temporary paralysis, muscle contracture, physical numbness (anesthesia) and inability to feel pain (analgesia), deafness, blindness, or abrupt (but temporary) loss of a skill such as driving or cooking (see somatic dissociative disorders in ICD-10, WHO, 1992). Mental losses include the sudden loss of emotion ("*My sadness just disappeared!*"), or thoughts ("*That thought was taken away*."), or censoring ("*Something inside won't let me talk about my mother*.").

Somatic intrusions might involve intense and unexplained pain or other sensations that begin and end suddenly without medical explanation (often eventually traced back to sensations felt during a traumatic memory), tics and other movements (again, typically related to trauma), or non-epileptic seizures. Mental intrusions might include sudden emotions or thoughts that are unrelated to the current moment and which the client disavows ("*That is not my anger*;" "*There is a thought in my head that you are going to hurt me, but it doesn't come from me: I trust you and know you wouldn't hurt me*.")

Other Problems with a Dissociative Underpinning

On the surface, structural dissociation may appear to mimic other problems and disorders. For example, self-harm is a commonly used strategy to cope with self-dysregulation and distress by many severely traumatized clients. However, in individuals with

OSDD-1 or DID, self-injury can also be the result of conflicts among dissociative parts. For example, an individual can experience one part cutting or otherwise harming another part as punishment for that part telling about abuse and not maintaining the protection of silence, or to quiet distressed "child" parts that are experienced as crying internally and who are internally blamed for causing the abuse because they expressed distress externally as children.

To the untrained observer structural dissociation can sometimes seem indistinguishable from other disorders, such as Bipolar or Borderline Personality Disorder (BPD), and host of other problems. It may underlie chronic depression or anxiety, sleep and eating problems, sexual problems, and addictions, among others. On the other hand, comorbid disorders are common in developmental trauma, including in individuals with OSDD-1 and DID. Clinicians must determine whether the disorder is stand-alone, or whether it is a symptom of underlying dissociation, as treatment including medication management or psychopharmacology will differ. For example, shifts in mood may be labeled as rapid cycling bipolar disorder, but in OSDD-1 and DID, rapid mood changes may be related to shifts among dissociative parts, and treatment will differ.

Differentiation between Ego States, Borderline Modes, and Dissociative Parts

Ego states. Work in ego state therapy (EST; J. G. Watkins & Watkins, 1997), schema therapy (Young, Klosko, & Weishaar, 2003), and recent studies in neurobiology (Putnam, 2016), indicate that consciousness and self are never completely unitary. All humans have multiple self-states or ego states that comprise the "self." Ego states are defined as "an organized system of behavior and experience whose elements are bound together by some common principle and which is separated from other such states by a boundary that is more or less permeable" (Watkins & Watkins, 1977, p. 25). It is likely that dissociative parts are

extreme variants of ego states (Kluft, 1988; Steele et al., 2017; Watkins & Watkins, 1997) with boundaries that are much more rigid and often impermeable until they are treated. Normal ego states differ from dissociative parts in their lack of autonomy and elaboration, personal experience and memory, unique self-representation and first-person perspective (Kluft, 1988) and ability to function independently. Most individuals recognize normal ego states as belonging to them, and they do not experience dissociative symptoms clusters of amnesia, auditory hallucinations, Schneiderian symptoms, or other dissociative mental and somatic intrusions and losses.

Borderline Modes. Young and colleagues (2003) refer to different modes in individuals with BPD. Modes are comparable to normal ego states and are defined as particular states of mind that cluster schemas and coping styles into a temporary "way of being" to which an individual can shift suddenly (Young et al., 2003). The individual may recognize the mode as belonging to self, but as somewhat independent and dichotomous, for example, "*That was the bad Susie that got drunk; good Susie knows better.*" Susie remembers drinking (she does not have amnesia or impermeable boundaries), and when questioned is able to recognize that she herself was drinking. Like ego states, modes are not accompanied by enduring dissociative symptom clusters.

Many individuals with BPD have a wide array of dissociative symptoms beyond alterations in awareness, but still do not necessarily meet criteria for a dissociative disorder (Korzekwa, Dell, & Pain, 2009). Thus, distinguishing BPD from OSDD-1 and DID can be challenging in some cases. However, in most instances, the unique characteristics and severity and chronicity of dissociative symptom clusters, particularly passive influence symptoms, clarifies the diagnosis of OSDD-1 or DID. A significant minority (approximately 24%) of

individuals with BPD have co-occurring DID, and about the same (approximately 24%) meet criteria for OSDD-1 (Korzekwa et al., 2009), so comorbidity of a dissociative disorder may be present in about half of individuals with BPD.

Resources for Assessment of OSDD-1 and DID

Resources for assessment of dissociative disorders include Brand and Loewenstein, 2010; Dell, 2006; Dell and O'Neil, 2009; Kluft, 1987; Loewenstein, 1991; Ross, 1989, 1997; Spinazzola & Briere, this volume; Steele et al., 2017; Steinberg, 1995, 2004; Steinberg and Siegel, 2008; and Van der Hart et al., 2006.

There are several instruments that aid in diagnosis, including the *Structured Clinical Interview for Dissociative Disorders* (SCID-D [not currently updated to DSM 5], Steinberg, 1995, 2004); the *Multidimensional Inventory for Dissociation* (MID; Dell, 2006); and the *Dissociative Disorders Interview Scale* (DDIS [updated to DSM 5], Ross, 1989). There are several instruments that are not diagnostic but do identify individuals who warrant further clinical assessment for OSDD-1 and DID. The *Multiscale Inventory for Dissociation* (MDI, Briere, 2002) includes a subscale on identity dissociation. Should an individual score generally high on the MDI and specifically on the identity dissociation scale, further assessment is warranted. The *Dissociative Experiences Scale II* (DES-II; Carlson & Putnam, 1996) examines experiences of amnesia, absorption and depersonalization. A taxon for pathological dissociation (DES-T; Waller, Putnam, & Carlson, 1996) includes eight items of the DES-II that are more accurate markers for pathological dissociation, distinguishing it from absorption. A high score on the DES-T warrants further assessment, as do scores above 30 on the DES. Finally, the *Somatoform Dissociation Questionnaire* (SDQ-20; Nijenhuis et al., 1996) can help identify individuals who have somatic dissociation commonly found in

OSDD-1 and DID, phenomena that are less likely to be identified and assessed by clinicians as part of a dissociative profile.

A Brief Overview of Treatment

There is growing evidence that individuals with OSDD-1 and DID benefit from having their structural dissociation directly assessed and addressed. Clinical research shows that managing dissociation leads to decreased levels of dissociation, PTSD symptoms, general distress, drug use, physical pain, and depression, along with an increased sense of self-control and self-knowledge over the course of treatment (Brand et al., 2013; in press, 2019; Jepsen, Langeland, Sexton, & Heir, 2014). Individuals in these studies reported increased ability to socialize, work, study, or do volunteer work, and reported feeling better overall. They engaged in less self-injurious behavior and had fewer hospitalizations than before treatment and demonstrated increased global assessment of functioning (GAF) scores, and improved adaptive capacities over time (Brand et al., 2013; in press, 2019). On the other hand, highly dissociative individuals who do not receive treatment for dissociation do not tend to improve or are not be able to maintain temporary treatment gains (Jepsen et al., 2014). They are prone to ongoing social and occupational difficulties, depression and anxiety, self-harm, suicidality, lack of response to treatment, and increased need for both medical and psychiatric interventions, including hospitalizations.

The treatment guidelines for DID (ISSTD, 2011) are helpful in directing approaches to OSDD-1 and DID, as are the expert consensus survey for Complex PTSD (Cloitre et al., 2011), and the Australian Practice Guidelines for Treatment of Complex Trauma (Kezelman & Stavropoulis, 2012). The latter two can serve as a foundation for treatment to which specialized approaches for structural dissociation are added. Trauma-informed and present-

centered experiential or psychodynamic psychotherapy are the mainstay of the treatment of dissociative disorders, with the addition of specialized techniques and approaches that directly address the undue separation of dissociative parts, the resolution of traumatic memories, and the facilitation of integration of self and personality.

The standard of care for treating dissociative disorders, as with Complex PTSD, is a phase-oriented approach (Brand et al., 2013; Boon et al., 2011; Chu, 2011; Howell, 2011; ISSTD, 2011; Steele, Van der Hart, & Nijenhuis, 2005; Steele et al., 2017; Van der Hart et al., 2006). This approach involves the following components: Phase 1: Safety, stabilization, symptom reduction, skills building and development of a collaborative alliance; Phase 2: Processing and integration of traumatic memories; Phase 3: Further personality (re)integration and (re)habilitation along with the establishment of a life that is less compromised by dissociation, traumatic memories, and other symptoms. These treatment phases are not linear, often requiring the periodic need to return to an earlier phase to relearn skills, or the occasional short excursion into the next phase (Courtois, 2004, 2010; Courtois & Ford, 2012; Steele et al., 2005, 2017; Van der Hart et al., 2006). It is a treatment that explicitly acknowledges stages of change (Prochaska & Norcross, 2018) that involve different rates of motivation and learning and considers the likelihood of relapse as an opportunity for further problem-solving.

Each phase of treatment should have a specific focus on eroding the need for ongoing structural dissociation. To this end, in addition to helping individuals learn more effective regulation and reflecting strategies, clinicians can target trauma-related phobic avoidance of (1) inner experience (for example, thoughts, emotions, sensations, conflicts); (2) attachment and attachment loss (rejection and abandonment); (3) dissociative parts; (4) traumatic

memories; and (5) adaptive change and risk-taking (Steele et al., 2005, 2017; Van der Hart et al, 2006).

Phase 1: Stabilization

Treatment begins with an initial phase of stabilization, safety, ego strengthening, education, and skills building to improve the individual's adaptive functioning and capacity to engage effectively in therapy. A collaborative therapeutic approach is typically effective, with a clear therapeutic frame and boundaries. Excessive caretaking of dissociative individuals should be avoided, as dependency issues are frequent and intense. Clinicians should be mindful of not further activating the already stressed attachment system of the client with either too much closeness or too much distance (Brown & Elliott, 2016; Cortina & Liotti, 2014; Steele et al., 2017).

Dissociative individuals need to learn how to decrease conflicts that are common among their dissociative parts, improve inner collaboration, and support regulation of specific parts that may not always be directly accessible to the individual as a whole. Education and skills-based training in identifying and effectively managing dissociation are helpful (Boon et al., 2011; Brand et al, 2013, in press; Brand & Loewenstein, 2014; ISSTD, 2011; Steele et al., 2017). A number of authors have discussed how to specifically help dissociative individuals with these skills and take step-wise approaches to decrease conflict among dissociative parts by increasing knowledge about the function of each and improving communication among them (Boon et al., 2011; Chu, 2011; Fisher, 2017; Gelinas, 2003; Gonzalez & Mosquera, 2012; Howell, 2011; Kluft, 2000; Knipe, 2018; Ogden & Fisher, 2016; Phillips & Frederick, 1995; Steele et al., 2017; Twombly, 2005; Van der Hart et al., 2006).

We cannot emphasize enough that clinicians should not treat dissociative parts as separate individuals, nor should they ignore them in the hope that they will just "go away." The goal in treating dissociative disorders is always to support integration of the personality and to eliminate the need for ongoing dissociation. Self-compassion, sharing of experience, collaboration, and negotiation among all dissociative parts of the individual are key to successful integration (e.g., Boon et al., Kluft, 2000; Steele et al., 2017; Van der Hart et al., 2006). When possible, treatment should be directed to the individual as whole. While this is not always feasible due to the client's low integrative capacity and high dissociative tendencies, it is a good foundation from which to start and to which to return as often and long as possible. Clinicians can invite "all parts of the mind" to be present in therapy with the adult part of the individual remaining present when possible. The therapist does not seek to establish an individual relationship with each part, but rather serves as an integrative "bridge" between various parts to improve the coherence of the entire system of the individual.

When a shift (or switch) from one part to another or a partial intrusion occurs in session, the process should be noted and explored: What just happened? Why now? What dynamics are at play? Is there a conflict that is being avoided or expressed? What in the therapeutic relationship might be relevant, for instance, is there a shift to a young part that is expressing dependency yearnings that the adult cannot tolerate? In this way, the individual is supported in identifying and resolving ongoing reasons for dissociation in real time, and therapy can stay on track and not be diverted by the different agendas and conflicts among various dissociative parts.

When it is not feasible to make systemic interventions at the level of the whole personality because of the individual's extreme phobic avoidance, the therapist may intervene directly

with two or more dissociative parts (Steele et al., 2017; Van der Hart et al., 2006). For example, several parts may be encouraged to collaborate in accomplishing a task in which other parts are not yet able to participate (e.g., emotion regulation, maintaining safety). Or one part can be encouraged to care for or alleviate the suffering of other parts. There are times when the therapist may elect to work with a single part. Often, due to phobic avoidance of disruptive parts, the client is unable or unwilling to directly address them. As soon as feasible, the therapist supports more direct connection between the parts, thereby reducing phobic avoidance and raising the integrative capacity of the individual.

In stepwise fashion, dissociative parts can be supported to become consciously aware of each other, first to diminish avoidance reactions, orient to the present, and foster understanding and empathy for their various roles; next to facilitate cooperation in daily life functioning; and only then to share traumatic experiences. This work must be carefully paced, as premature attempts to focus on dissociative parts before the client is ready can result in increased dissociation, decompensation, or flight from therapy. Once the individual is more accepting of parts, has adequate capacities to regulate, and inner conflicts among parts are decreased, Phase 2 treatment can begin. However, with highly dissociative individuals, this next phase of work usually needs significant titration, as discussed below.

Phase 2: Integrating Traumatic Memories

Exposure to traumatic memories with simultaneous prevention of maladaptive reactions is considered a fundamental intervention in trauma-related disorders. Although exposure proponents in the field of PTSD treatment have noted that therapists are often more hesitant than is warranted to employ exposure techniques for fear of overwhelming the client (Cahill, Foa, Hembree, Marshall, & Nacash, 2006), therapists in the dissociative disorders

field have learned that premature and prolonged trauma memory processing in dissociative clients who lack the capacity to safely experience and modulate arousal can have serious iatrogenic effects. Due to the severe integrative and self-management deficits found in highly dissociative clients, early and direct confrontation with traumatic memories can be acutely destabilizing, sometimes leading to decompensation and posttraumatic decline. In this regard, treatment of OSDD-1 and particularly DID (as well as many cases of Complex PTSD) differs significantly from a more immediate approach suggested for the treatment of PTSD.

When Phase 2 interventions are initiated in OSDD-1 and DID, several caveats apply. First, clinicians need to understand that not all dissociative parts may have access to a given traumatic memory. Second, exposure does not automatically occur across all dissociative parts. Third, exposure that seems tolerable to one dissociative part may not be to another. Fourth, when arousal is too high, a dissociative individual will respond with further separation between and shifting among parts in an attempt to regulate by avoiding painful traumatic memories that certain parts contain.

Specialized approaches to the treatment of traumatic memories, including titration techniques, can be found in a variety of sources (Howell, 2011; Frederick & Phillips, 1995; Kluft, 1996, 2013; Knipe, 2018; Gonzalez & Mosquera, 2012; Steele et al., 2017; Twombly, 2001; Van der Hart et al., 1993, 2006, 2017). These approaches are unique in that dissociative parts need to be actively included in the work. A collaborative approach is used, inviting “all parts” to explore inner conflicts about or resistances to work with traumatic memory. Once these conflicts and resistances are identified and resolved, all parts of the individual should eventually become aware of and own the traumatic experience as part of a single autobiographical memory, but in a paced manner that may take significant time. Typically,

some parts of the individual have more capacity to accept and own certain memories than others, so this can be an uneven and prolonged challenge. Dissociative parts can be encouraged to share with each other with compassion while remaining grounded in the present-day context.

Because of the limits of the individual's integrative capacity, titration techniques that offer gradual exposure to the traumatic memory can be helpful in supporting ongoing acceptance and ownership of the experience. For example, the therapist might suggest the client only experience "*just a few drops*," "*just a small percentage*," or "*just the edge*" of the traumatic memory, interspersed with periods of grounding, rest, and connection with the therapist. The traumatic experience may also be titrated with time, for example, "*you can remember and know what happened for 15 seconds"* or *"as I count from 1 to 10,"* followed by a period of grounding and rest.

Phase 3: Further Integration of the Personality and Rehabilitation

Dissociative clients experience incremental gains in the ability to experience themselves as whole individuals across the phases of treatment. Phase 3 involves a greater focus on integration of the personality, grieving, and ongoing attention to improving quality of life including relationships. This integrative process mostly occurs in a gradual fashion, but is often brought to fruition in Phase 3, as the reasons for ongoing dissociation are eliminated. The oscillation of the individual between the joy of a new "self," new competencies and enjoyment, and the grieving of loss leads to further integration. It is not unusual for additional traumatic memories and dissociative parts to emerge in Phase 3 in response to a growing capacity to integrate. During such times, reversion back to Phase 1 and Phase 2 work will need to occur.

Some integration of parts occurs spontaneously, while others seem to "fade" or simply cease separate activity. Effective therapy should render the need for dissociation unnecessary. One client said after integration,

> I hated parts at first and didn't want them to exist. I was terrified and ashamed of being so broken inside. Gradually I was able to get a little more curious about them. It was like trying to understand and communicate with weird distant relatives that nobody wanted to invite to dinner, who might act out, or say something crazy. Finally, I came to understand they were all just me trying to cope in different ways, just trying to get by in any way I could. Once I figured that out, I started to relax a lot more. Now it is 'just me' and it seems like the most natural thing in the world."

Other clients experience their dissociative parts more along the lines of a collective of normal ego states following integration. They retain awareness of parts, but there is inner collaboration and compassion rather than conflict and avoidance, and the inner collective supports adaptive functioning and decision-making. All parts accept and own their history and, importantly, have contiguous memory across time and situations. Partial intrusions or passive influence ceases and the distinctive symptom clusters of dissociation abate.

In some cases, integration may not be possible. Some individuals are so phobic and avoidant of their dissociative parts (and traumatic memories) that it is not feasible to address dissociation in therapy or address it completely. Some clients simply may not have the capacity to address their fragmentation. A few may become invested in remaining unintegrated because their inner world has become a fantasy substitute for actual connection with other people. In these cases, interactions with parts keeps loneliness at bay without the risk of needing to be vulnerable with other people. A very few may be invested in having DID

as an identity, defining who they are by the diagnosis. Individuals who do not or cannot integrate, or at least achieve significant inner awareness, collaboration and compassion remain vulnerable to ongoing dissociation and distress, and thus may need ongoing support to remain stable.

Summary

The complex dissociative disorders of OSDD-1 and DID can be diagnosed with accuracy and can be distinguished from other disorders. There is growing empirical evidence supporting clinical observations that treatment focused on dissociation is effective in reducing not only dissociative symptoms, but of other distressing problems as well. Yet many myths, misconceptions, and prejudices about OSDD-1 and DID remain. Clinical training often does not include sufficient attention to dissociation and dissociative disorders; thus, clinicians have little or no knowledge about how to effectively assess or treat these conditions. Another difficulty is the confusion about the symptoms and definition(s) of dissociation; more clarity among the diverse symptoms and their different treatments would be helpful. Obviously, a proper therapeutic focus on dissociative process and experiences should not promote a further sense of separateness. Individuals with OSDD-1 and DID can benefit from a stable, rational and well-boundaried treatment that addresses the many complexities of chronic developmental trauma, with an emphasis on integration of dissociative parts of the personality.

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