Olga Trujillo, JD
Olga Trujillo Consulting
www.olgatrujillo.com
olga@olgatrujillo.com

Dissociative Identity Disorder: Advocating for Informed Treatment and Legal Proceedings

Goals

01

Explore dissociative identity disorder (DID)

- What it is
- Causes
- Research

02

Examine the impact on peoples lives

- Living with it
- Healing
- Crisis

03

Strategize what you can do to help

What is DID?

- Dissociative Identity Disorder is a severe psychiatric condition strongly correlated with a history of chronic and unremitting childhood abuse, characterized by identity alteration or confusion.

What is DID? (continued)

- A disorder that forms as a result of ongoing trauma in childhood
- Forms if trauma begins before the age of 8 or 9 years of age
- Provides an escape cognitively when there is none physically
- A person with DID feels as if they have within them two or more entities, each with its own way of thinking and remembering about themselves and their life.

DSM - 5

- The DSM – 5 states that DID involves a ‘disruption of identity characterized by two or more distinct personality states.
- The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning.’
- Also involves ‘recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.’

Why do you need to know?

- It Exists

OPEN

Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder

Bethany L. Brand, PhD, Vedat Sar, MD, Pam Stavropoulos, PhD,
Christa Krüger, MB BCh, MMed (Psych), MD, Marilyn Korzekwa, MD,
Alfonso Martínez-Taboas, PhD, and Warwick Middleton, MB BS, FRANZCP, MD

Abstract: Dissociative identity disorder (DID) is a complex, posttraumatic, developmental disorder for which we now, after four decades of research, have an authoritative research base, but a number of misconceptualizations and myths about the disorder remain, compromising both patient care and research. This article examines the empirical literature pertaining to recurrently expressed beliefs regarding DID: (1) belief that DID is a fad, (2) belief that DID is primarily diagnosed in North America by DID experts who overdiagnose the disorder, (3) belief that DID is rare, (4) belief that DID is an iatrogenic, rather than trauma-based, disorder, (5) belief that DID is the same entity as borderline personality disorder, and (6) belief that DID treatment is harmful to patients. The absence of research to substantiate these beliefs, as well as the existence of a body of research that refutes them, confirms their mythical status. Clinicians who accept these myths as facts are unlikely to carefully assess for dissociation. Accurate diagnoses are critical for appropriate treatment planning. If DID is not targeted in treatment, it does not appear to resolve. The myths we have highlighted may also impede research about DID. The cost of ignorance about DID is high not only for individual patients but for the whole support system in which they reside. Empirically derived knowledge about DID has replaced outdated myths. Vigorous dissemination of the knowledge base about this complex disorder is warranted.

Keywords: borderline personality disorder, dissociation, dissociative disorders, iatrogenic, trauma, treatment

Dissociative identity disorder (DID) is defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as an identity disruption indicated by the presence of two or more distinct personality states (experienced as possession in some cultures), with discontinuity in sense of self and agency, and with variations in affect, behavior, consciousness, memory, perception, cognition, or sensory-motor functioning.[1] Individuals with DID experience recurrent gaps in autobiographical memory. The signs and symptoms of DID may be observed by others or reported by the individual. DSM-5 stipulates that symptoms cause significant distress and are not attributable to accepted cultural or religious practices. Conditions similar to DID but with less-than-marked symptoms (e.g., subthreshold DID) are classified among "other specified dissociative disorders."

DID is a complex, posttraumatic developmental disorder.[2,3] DSM-5 specifically locates the dissociative disorders chapter after the chapter on trauma- and stressor-related disorders, thereby acknowledging the relationship of the dissociative disorders to psychological trauma. The core features of DID are usually accompanied by a mixture of psychiatric symptoms that, rather than dissociative symptoms, are typically the patient's presenting complaint.[3,4] As is common among individuals with complex, posttraumatic developmental disorders, DID patients may suffer from symptoms associated with mood, anxiety, personality, eating, functional somatic, and substance use disorders, as well as psychosis, among others.[3–8] DID can be overlooked due to both this polysymptomatic profile and patients' tendency to be ashamed and avoidant about revealing their dissociative symptoms and history of childhood trauma (the latter of which is strongly implicated in the etiology of DID).[9–14]

From Towson University (Dr. Brand); Koç University School of Medicine (Istanbul) (Dr. Sar); Blue Knot Foundation, Sydney, Australia (Dr. Stavropoulos); University of Pretoria (Dr. Krüger); McMaster University (Dr. Korzekwa); Carlos Albizu University (San Juan) (Dr. Martínez-Taboas); Latrobe University, University of New England, University of Canterbury (New Zealand), and University of Queensland (Australia) (Dr. Middleton).

Original manuscript received 29 October 2014; revised manuscript received 27 January 2015, accepted for publication subject to revision 22 May 2015; revised manuscript received 8 June 2015.

Correspondence: Bethany L. Brand, PhD, Psychology Department, Towson University, 8000 York Rd., Towson, MD 21252. Email: bbrand@towson.edu

© 2016 President and Fellows of Harvard College. This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-No Derivatives License 4.0 (CCBY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially.

DOI: 10.1097/HRP.0000000000000100

Why do you need to know?

- Studies show that in the U.S. somewhere between 1 and 3 % of the population have DID.
- Without help – It create chaos and risk for the person that has it.
- People who have it can experience additional challenges when in crisis – new trauma or loss.

Robert Oxnam, left, lives with DID, and is working with McLean's **Milissa Kaufman**, MD, PhD, right, to raise awareness and compassion about the illness.

little girl. It's not me," she said. "If a little girl is being abused at night and has to wake up the next morning and go to school and do sports and do homework and have to do as much as they can to not have people get angry at them, they displace it onto another aspect of themselves.

"A child doesn't have many other ways to cope. They can't go to their parents, since that is the origin. They feel like there are other people inside of them, and they can't tell anybody."

Dissociation can be found in 1-3 percent of the general population and as high as 20-30 percent in psychiatric populations, about the same prevalence as schizophrenia, Kaufman said. A 1986 study by Frank W. Putman and others in the Journal of Clinical Psychiatry found the average patient with DID has been in the mental health delivery system for an average of 6.8 years and has received three other diagnoses. This reflected either misdiagnoses or comorbidities that delayed an accurate diagnosis.

Dissociation occurs along a spectrum, from "spacing out" while driving and missing an exit to being hyper-focused on a topic. Along the range are memory issues, like gaps in recall, often associated with PTSD.

"Dissociation can be found in 1-3 percent of the general population and as high as 20-30 percent in psychiatric populations."

Further along are depersonalization and derealization—which Kaufman described as a profound detachment from sense of self or sense of body, a sensation of being apart from one's self, perhaps viewing what is happening from a distance.

The furthest end of the spectrum is fragmentation of identity,

Research

Efforts to discredit existence causes harm

Psychological Injury and Law
https://doi.org/10.1007/s12207-018-9336-8

Trauma-Related Dissociation Is No Fantasy: Addressing the Errors of Omission and Commission in Merckelbach and Patihis (2018)

Bethany L. Brand[1] · Constance J. Dalenberg[2] · Paul A. Frewen[3] · Richard J. Loewenstein[4,5] · Hugo J. Schielke[6] · Jolie S. Brams[7] · David Spiegel[8]

Received: 1 October 2018 / Accepted: 24 October 2018
© Springer Science+Business Media, LLC, part of Springer Nature 2018

Abstract
Dissociation is commonly a response to trauma that can be associated with significant impairment. In order to deal with dissociation in court from a comprehensive, scientifically informed, and valid perspective, Brand, Schielke, and Brams (Psychological Injury and Law, 10, 283-297, 2017a, b) provided a balanced view of dissociation, its characteristics, evidence base, and best assessment practices. Without an approach such as this, forensic experts risk having insufficient knowledge in its causation, phenomenology, and assessment and accordingly misunderstand trauma-related dissociation (TRD). Brand et al. (Psychological Injury and Law, 10, 283-297, 2017a, b) addressed this issue by providing an overview of TRD relevant to forensic contexts, acknowledging some of the erroneous and misinformed approaches to the topic. Merckelbach and Patihis (2018) offered a critique of Brand et al. (Psychological Injury and Law, 10, 283-297, 2017a, b) that illustrated this lack of knowledge and misunderstanding about TRD. Many of the statements made by these authors are conceptually inaccurate or scientifically misinformed. As we show, they were incorrect when they stated that research is lacking about the inter-rater reliability of dissociative disorder (DD) diagnoses. They were unaware of the error rates of tests and interviews among dissociative samples, which we present here. Merckelbach and Patihis challenged Brand et al., arguing their methods and literature review "lacked a connectivity to existing science" (p. 3), despite extensive citations of studies with DD patients. They argued that we failed to adequately consider malingering despite our discussions of empirically supported methods for assessing it. We show that Merckelbach and Patihis overlooked research that does not support their views. As we review their comments, we illustrate their pattern of misreading and misunderstanding our papers, as well as lapses in their reasoning. The current paper reinforces that in the forensic context, experts can acquire adequate understanding of TRD and its evidence base, and put forward arguments against any harsh critique of the area that is uninformed about, misunderstands, or includes omissions and errors in critical conceptualization, state-of-the-art assessment practices, and research methodology and results.

Keywords Dissociation · Dissociative disorders · Trauma · Expert witness testimony · Bias · Malingering

Dissociation is commonly a response to trauma. However, trauma-related dissociation (TRD) is frequently misunderstood by evaluators, psychotherapists, and researchers. Dissociative symptoms predict the severity of posttraumatic stress disorder (PTSD) symptoms 3 years later (Mayou, Ehlers, & Bryant, 2002), suicide attempts (Briere, Dietrich,

Drs. Brand and Dalenberg contributed equally to this article and share first authorship.

✉ Bethany L. Brand
bbrand@towson.edu

[1] Psychology Department, Towson University, Towson, USA
[2] Trauma Research Institute, California School of Professional Psychology at Alliant International University, San Diego, USA
[3] Department of Psychology, University of Western Ontario, London, Canada
[4] Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD, USA
[5] Sheppard Pratt Health System, Baltimore, MD, USA
[6] California Department of State Hospitals, Napa, CA, USA
[7] Counseling and Consultation Service, Ohio State University, Columbus, USA
[8] Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, USA

Published online: 06 November 2018

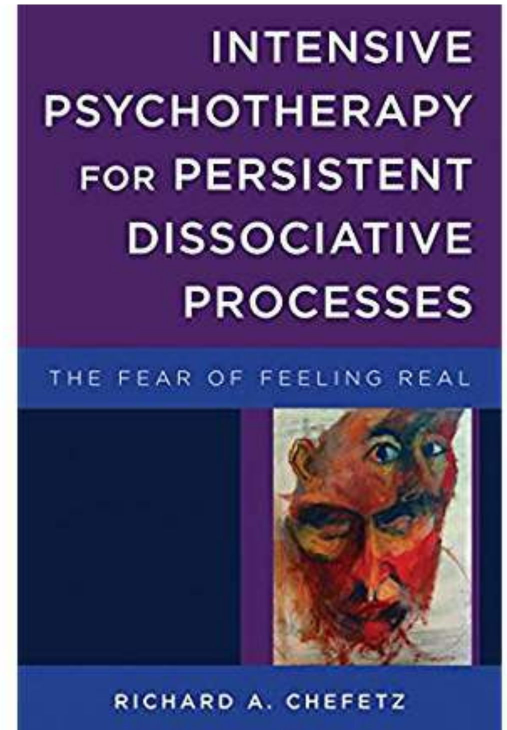
Diagnosed all over the world

With the same symptoms

How do I know?

I was diagnosed when I was 31 years old.

General Counsel of the Office of Justice Programs, USDOJ


INTENSIVE
PSYCHOTHERAPY
FOR PERSISTENT
DISSOCIATIVE
PROCESSES
THE FEAR OF FEELING REAL
RICHARD A. CHEFETZ

the sum of my parts

a survivor's story of **dissociative identity disorder**

An Inside Out Experience of Dissociation & DID

Similar to
this
But more

How it feels

- Voices/Thoughts
- Busy Inside
- Chaotic
- Reactive
- Can’t concentrate

How DID Feels on the inside continued

- A sense of detachment from my body
- Changing perceptions of people or surroundings
- Feelings that you are incapable of doing anything
- Can’t control thoughts
- Can’t control disconnected feelings

Learn

Learn more about DID

- Fact & Fiction
- Impact on People
- Healing Process

Share

Share what you know with colleagues & others

Help

Help people with DID be proactive

Learn more about DID

- Fact & Fiction – Research materials provided in handouts
- More are available upon request
  - 16 studies
  - Harvard Medical School
- Other resources provided

Mental Health Practitioners

- In your work with clients…
  - Listen
  - Consider DID.
  - Make sure you have clinicians that can treat people who have it.
  - Get training and supervision –
    - International Society for the Study of Trauma & Dissociation (www.isst-d.org)

Learn About the Healing Process

Research Shows Healing Happens

- People with DID are generally unresponsive to (and may deteriorate) under standard treatments – CBT & Exposure Therapy for PTSD.
- Phase oriented treatment has been shown to improve DID.
  - Involves Stages of treatment
    - Initial focus on safety and stabilization
    - Containment & processing of trauma
    - Integration & rehabilitation

Therapeutic Modalities

Psychosocial therapy
  - CBT
  - DBT
  - Part work – IFS
- Hypnosis
  - Distance from Memories
  - Containment work between sessions
  - Connection for protection
- Art therapy
- Body work
- Mindfulness Practice - dissociation
- “Emotions work”

Cognitive Behavior Therapy

Reframed how I thought about myself and my abuse

Worked because of neuroplasiticity…

Helped

- Anxiety,
- Depression and
- Manage my world
- Live in the world

Dialectical Behavior Therapy

Didn't have to act on all my thoughts

Notice them

Go behind them

Part Work

Meet	Meet the parts
Learn about	Learn about them •What they do •What they did •How they did it
Compassion	Compassion and Appreciation for them •How to work together •How I can take care of them •Stay in touch with them

Hypnosis

- Distance from the memories
- Re-integrate memories and parts
- Containment between sessions
  - Limited use when I started to get flooded
- Self-hypnosis to help through anxious times

Art Therapy

- Helped to manage flooding
- Helped younger parts
- Reconnected Cartooning

Body Work

Get in touch with "pain in the body"

Release pain

Reintegrate the experience

Good self care

Mindfulness Practice

Emotions Work

Movement work – Release and Experience

Acupuncture

Help Clients be Proactive

Plan for Crisis - Plan for re-traumatization

- Discuss & plan…
- What kinds of things could happen that could create a crisis?
- Who do they want involved to help them?
- Create a card similar to this one – best if from your organization for credibility.
- Language provided.

DID Emergency Information Card — How to Help

I have a condition known as Dissociative Identity Disorder. I am not 'mad' and nor am I attention-seeking or time-wasting. I have a history of severe childhood trauma and DID is a coping mechanism for this. DID is treatable via psychotherapy.

I have different 'parts', 'alters' or 'personalities'. These may present as being of a different gender, age and developmental stage. We may be very frightened and traumatised and have difficulty distinguishing between the past and the present, so we may find it really hard to calm down. Please be careful about touching us and be gentle and patient. 'Alter personalities' may not be aware of what we have done (e.g. self-harm or attempted suicide) or where we are. We may be very disorientated and amnesic for what has just happened. Please try to understand our behaviours in the light of our past experiences.

This card is produced by PODS (Positive Outcomes for Dissociative Survivors). For more information please go to www.pods-online.org.uk, email us at info@pods-online.org.uk or phone 01480 413582 (support) or 01480 878409 (office).

Share with Others

DID Exists & What They Can Do

Safety planning

- Repeat things as often as needed
- Keep it simple
- Talk about dissociation
- Talk about how all need to work together
- Be willing to do this over and over
  - Neuroplasticity

Accessing Services

- Shelter
  - Sharing a room
  - No locks
  - Can’t sleep at night
  - Withdraw
  - Lots going on in one’s head
    - Voices or thoughts
    - White noise
  - Grounding techniques important

Moving Through the World

Plan Ahead

Predictability

- Key to success
- Plan ahead
- Prepare

Limit stimulation

Modes of communication

Talk about trauma related issues and how you'll handle them

Legal proceedings

Inherently triggering

Explore video testimony

Prepare early for legal proceedings

Make it as predictable as possible

What else can you do?

Plan for “triggers”

Encourage supportive connections

Consider support animals or service animals

Grounding techniques

It's a **SUPER POWER**

Resources

The International Society for the Study of Trauma and Dissociation
http://www.isst-d.org

Sidran Foundation
http://www.sidran.org

Olga Trujillo Consulting
http://www.olgatrujillo.com

PsychCentral.com
https://psychcentral.com/disorders/dissociative-fugue-symptoms/