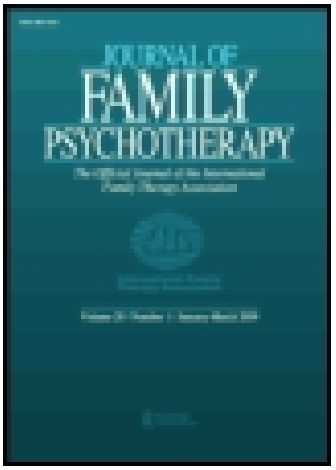

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A Systemic Approach to the Treatment of Dissociative Identity Disorder

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Although dissociative identity disorder (DID) continues to be questioned by some clinicians, those who work with this population understand the complexity of this disorder. Most often DID clients undergo predominantly individual psychotherapy to help them integrate their fragmented parts or personalities usually taking an average of 5 to 7 years. Although there is limited literature on the use of systemic therapy with DID clients, family therapy approaches can be used to conceptualize the treatment of the DID client and their family members. This article discusses how individual psychotherapy from a systemic perspective can be applied to treat DID while family systems therapy can be used to help educate the client's family about DID, the process of treatment, as well as how to recognize and become prepared for any symptoms of recurrence. The internal family systems model of therapy with a DID client is discussed through a case example.

KEYWORDS dissociative identity disorder, family therapy, internal family systems approach

Dissociative identity disorder (DID), which was formerly known as multiple personality disorder (MPD), is a disorder in which an individual has the presence of two or more identities or personality states. These personality states may have distinct names, temperament, identities, and self-images and

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often alternate within an individual's conscious awareness. At least two of these personalities repeatedly assert themselves to control the affected person's behavior. Dissociation is the disruption of the normal integrative processes of consciousness, perception, memory, and identity, which define selfhood. DID is believed to be a result of dissociative processes, which include the splitting off from conscious awareness and control of thoughts, feelings, memories, and other mental components as a response to situations that are painful, disturbing, and unacceptable to the person experiencing them. DID indicates the fragmentation of personality with the absence of a clear and comprehensive identity (Pais, 2006).

DID is increasingly understood as a complex and chronic posttraumatic psychopathology. The interaction of several factors including overwhelming stress; the ability to separate one's memories, perceptions, or identity from conscious awareness; abnormal psychologic development; and insufficient protection and nurture during childhood have been identified in the formation of DID, although how these factors lead to a presentation of DID is unclear. DID tends to have its origin in early childhood, from 2.5 to 8 years of age and the issues often arise in early adolescence (Waseem, Aslam, Switzer, & Perales, 2007). The central component of most theories that explain DID is the protective reaction to severe childhood trauma, which is often sexual in nature but may also include physical and emotional abuse as well as neglect. Numerous studies have found an association between early severe abuse to an increased risk of psychiatric conditions including dissociative identity disorder (Putnam, Guroff, & Silberman, 1986; Sar et al., 2004). It is believed that the alternate identities are formed because a unified sense of self has failed to develop due to trauma, especially if the trauma has occurred before the age of five. Essentially the self is believed to dissociate or split into separate and distinct personalities in an effort to repress the pain and suffering from some traumatic event. The diagnosis of DID is often associated with a history of significant traumatization, usually in childhood. DID clients have a higher rate of early childhood trauma than any other clinical group (Putnam et al., 1986). Severe, repetitive trauma can produce extreme states of experiences in children and can result in the development of discrete personified behavioral states (Putnam et al., 1986).

Despite skepticism there has been considerable clinical recognition of dissociative conditions in the last several years resulting in significant progress in the diagnosis, assessment, and treatment of dissociative disorders and DID. DID and dissociative disorders are not rare conditions. Clinical literature including case reports, treatment outcome studies, as well as studies of psychophysiology, neurobiology, and neuroimaging have been collected from numerous countries such as Australia, Canada, France, Germany, Great Britain, Italy, Israel, Japan, the Netherlands, New Zealand, Norway, Puerto Rico, Spain, Sweden, Switzerland, Spain, Turkey, and the United States (International Society for Study of Dissociation, 2005). The main difficulties in diagnosing DID

result from lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma. Accurate clinical diagnosis affords early and appropriate treatment for dissociative disorders (International Society for the Study of Dissociation, 2005).

DIAGNOSTIC CRITERIA FOR DID

The *Diagnostic and Statistical Manual, 4th edition, Text Revision* (*DSM–IV–TR*; American Psychiatric Association, 2000) defines the following diagnostic criteria for DID (300.14):

A. 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).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. 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). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

TREATMENT OF DID CLIENTS

A DID client is a single person who experiences himself or herself as having separate alternate identities or self-states. Each of these subjective identities have relative psychological autonomy from one another and may take executive control of the person's body and behavior and/or influence the person's experience and behavior. It is therefore important for therapists to understand a DID client as a whole person and clinically hold the whole person to be responsible for the behavior for any or all of the alternate identities despite circumstances such as amnesia or lack of control of behavior (International Society for the Study of Dissociation, 2005).

The treatment of DID includes psychotherapy, group therapy, expressive therapies such as creative art therapy, family therapy, clinical hypnosis, psycho education, and pharmacotherapy. Hospital treatment may also be necessary. Treatment approaches depend on the individual and the severity of their symptoms and usually includes some combination of the previously mentioned modalities. Psychotherapy is the most common modality of treatment for DID clients. The focus of psychotherapy is to help the client

understand what may have caused this condition and find new ways of coping with stressful circumstances that can trigger dissociation. The process of psychotherapy involves working through trauma that triggers the symptoms of dissociation. Although the therapist may address alternate identities as if they were separate, a major principle of therapeutic work with DID is to bring about an increased degree of communication and coordination among them. Experts agree that complex trauma-related conditions including DID are most appropriately treated with a phase or stage oriented approach.

DID treatment often includes three stages. The first stage is the initial phase that sets the stage for the trauma work: for confirming the diagnosis; establishing trust, safety, and rapport; and uncovering and "mapping" the alters or parts. After gathering important information, the therapist and client usually develop a plan for stabilization and symptom reduction. An important part of stabilization is developing a cognitive framework that involves sorting out how an abused child thinks and feels, undoing damaging self-concepts, and learning about what is "normal" (Turkus, 1991). The second stage or the intermediate phase involves teaching coping skills and affect regulation, treating the traumatic memories by working with them in-depth, improving communication between alters, and "fusing" the alters. The treatment frame for DID includes developing acceptance and respect for each alter as a part of the whole internal system. Despite how each alter shows itself be it a delightful happy child or an angry prosecutor, each alter is treated equally. Once the dissociative personality system has been mapped, the internal dialogue work follows to promote cooperation between alters. Communication and cooperation among the alters can help the gathering of ego strength that stabilizes the whole person. This is a critical stage in DID therapy and must be in place before trauma work begins. Revisiting and reworking the trauma may involve abreactions, which can release pain and allow dissociated trauma back into the normal memory (Steele & Colrain, 1990). The third stage is the integration phase of developing a unified, new self that helps the individual manage a complex environment successfully. Documentation of successful clinical outcomes with DID clients have involved treatment that focused on working with alters or personality states (Brown, Scheflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Herman, 1992; Kluft, 1993; Steele, Van der Hart, & Nijenhuis, 2001; Van der Hart, Van der Kolk, & Boon, 1998). As part of the rehabilitation process it is important for the person with DID to continue to master what has been learned so that he or she can live without using pathological structures and defenses. Follow-up maintenance sessions may be conducted on an as-needed basis (Spira, 1996) to help in the adjustment to the integrated personality. Often follow-up sessions are helpful in preventing relapses because DID clients often struggle with attachment, loss, and abandonment issues.

Individual Therapy with the DID Client

Most clinical literature on DID treatment is individually focused. Because dissociative experiences and symptoms can be understood to exist in a continuum of severity, the clinical strategies and therapeutic techniques used with DID clients can be different. For example, when there is lack of integration or compartmentalization of alters, the focus of treatment becomes reactivation and reintegration of the compartmentalized parts. On the other hand when there is detachment and disconnection from the self or the environment, therapy focuses on reducing and terminating the triggers for detachment. Overall the primary goal of treatment for DID is the formation of a cohesive unified personality and the minimization of triggers for stress that can cause detachment. The focus of treatment is to reconnect the individual with the different personality states into one cohesive, well-functioning identity, while maintaining safety for the client. In addition to symptom relief, the goal of treatment is to help the person with DID safely express and process painful memories of trauma, develop new coping and life skills, restore functioning, and improve relationships (Pais, 2006). Individual therapy with adults is usually intensive and long term often lasting on average anywhere from 5 to 7 years.

Although integration is considered healthy and functional, it should not be a treatment goal if the DID client is not ready or motivated to work with trauma. Integration can become distressing to someone who may have relied on dissociation to survive. In such cases, the client can be offered the choice to work on integration when ready (Fine, 1999). It is therefore important for therapists to create assessment and treatment plans that best meet the needs of the DID client. The 2005 guidelines for the treatment of DID from the International Society for the Study of Dissociation state importance of not creating countertherapeutic and iatrogenic outcomes. These guidelines recommend that therapists not treat any alternate identity as more important than any other, not create additional alternate identities by asking the client to name them when there may be none, not suggest that alternate identities function more elaborately or autonomously than they already are, not to ask the client to ignore or "get rid" of alternate identities, and not "play favorites" with any of the alternate identities. Instead the therapist must help foster the idea that alternate identities represent adaptive attempts to cope with or master problems that the DID client experiences. Hence the alternate identities can be helped to find more adaptive ways to solve problems rather than using solutions that are dysfunctional, unsafe, or problematic.

Although the ideal treatment outcome is complete integration and loss of separateness of all the identity states, many DID clients do not achieve complete integration despite undergoing considerable treatment (Kluft, 1993). For such clients a more reasonable long-term outcome is the achievement of optimal integration and functioning among the alternate identities so that

the DID client can have adequate interpersonal, intrapsychic, emotional, and vocational functioning. In these circumstances clients with this outcome often remain vulnerable to experiencing symptoms of posttraumatic stress disorder (PTSD) and DID and can decompensate easily under stress (International Society for the Study of Dissociation, 2005).

Family Therapy with the DID Client's Family

Although systems therapies may advocate for working with extended families of the client, it is important to understand that sessions between a DID client and their allegedly abusive parent(s) and/or the family members can prove to be detrimental. Family therapy for a person with DID may produce significant negative and traumatic memories of other family members, which can be counterproductive to clinical progress (Pais, 2006). If a family session is requested by the DID client, it is important to ensure that the client is clinically able to handle the session and revictimization does not occur. Therefore, the client must be sufficiently integrated and his or her boundaries appropriate and well defined. Partners and children of the client with DID can play important healing roles when they are able to be included in the therapeutic process. They can help map the system of alters, provide emotional support, and contain episodes of rage. Prior to beginning family therapy, the therapist must conduct a thorough assessment of family dynamics and individual members' strengths, coping skills, and levels of safely and trust in self and others (Williams, 1991). Family sessions can help educate the client's extended family about the disorder and its causes. Family members may benefit from understanding why and under what circumstances dissociation takes place as well as understanding the changes that occur as the DID clients' personality becomes integrated. Through family sessions, the DID clients' family can be also be educated about the symptoms of recurrence and what to do when they occur.

According to Figley (1988), the family is the most important supportive resource, if that family is able to mobilize itself and does not collapse under the strain of dealing with past traumas. Family members are usually better able to detect changes of patterns of behavior or splits than the DID client themselves. Within a safe and secure environment, reasonably intact family members can help the DID member to address and sometimes reexperience the traumas while confronting misperceptions or disturbed beliefs of guilt and shame. Additionally, partners and children or other family members may have to be taught to learn ways to cope with hostile alters and techniques to deescalate conflict. Family and partner contracts can be developed to protect the DID client from self-injury or self-homicide when an alter acts out toward self. The therapist may also teach the partner crisis intervention skills and skills to help them deal with substance abusing or socially irresponsible alters (Williams, 1991). Other goals of treatment with the family

include social skills training, creating family intimacy when appropriate, building a trauma history, and learning to deal with the emotional impact of multiplicity especially anger, fear, and pain. When a family is able to manage tension and stress well, coping with the trauma of dissociation and multiplicity becomes easier.

Therefore, according to Williams (1991), therapy with DID clients, their partners, and their families must be flexible, creative, as well as focused on system-wide healing. Partners and children of DID clients can be encouraged to hope for a "calmer" life and more cohesive balanced system. Including partners and children of DID clients into treatment is based on the understanding that DID clients do not live in isolation and need to learn to adapt and evolve into the family system.

INTERNAL FAMILY SYSTEMS (IFS) MODEL

The IFS model developed by Richard Schwartz (1995) represents an integration of two already existing paradigms: systems thinking and the multiplicity of the mind. Concepts and methods from the structural, strategic, narrative, and Bowen schools of family therapy are integrated into the framework of subpersonalities. The premise of the IFS model is the existence of relatively discrete "parts" or minds that have valuable qualities and roles to play within an individual. As we develop, our parts develop and form a complex system of interactions among themselves. Sometimes under conditions such as trauma, chaos, and abuse these parts may be forced out of their valuable roles into extreme roles that then return to their valuable roles when the extreme conditions cease and safety is experienced. Trauma and childhood sexual abuse are important factors that can force the internal families or parts into extreme and/or destructive roles (Goulding & Schwartz, 1995). Additionally, family values and interaction patterns can create internal polarizations that may intensify and impact other relationships. The IFS model focuses on understanding all levels of human organization including intrapsychic, family, and culture.

Schwartz (1995) describes three types of parts that seem to be common across most people. The first type called "managers" are good at anticipating and controlling situations before trouble begins. Managers are parts that run the everyday life of the individual. They help keep the individual safe and functional, help the individual maintain control of inner and outer environments, and ultimately function in a managerial, protective role to protect the parts from feeling any rejection or hurt. Managers often function as inner (or outer) critics, sometimes pushing the individual to strike and assert themselves before anyone else lashes out. The second type of parts known as "exiles" are parts that have been kept locked away by the managers. Exiles are young parts that have experienced trauma and quite often become isolated

from the rest of the internal system in order to protect the individual from feelings such as pain, fear, and terror. These parts carry emotions, memories, and sensations from painful, humiliating experiences from the past and can leave the individual feeling vulnerable and fragile. The third group of parts called "firefighters" become active when an exile becomes distressed. The activation is an effort to control and "extinguish" the feelings of the exiles. The individual feels vulnerable to being hurt again and is flooded with extreme feelings. Firefighters are often impulsive and look for stimulation that helps separate from the exile's feelings. Common firefighter activities include bingeing on drugs and alcohol, food, and sex. Although managers and firefighters have the same goals of keeping the exiles away, they each use very different strategies.

An important aspect of the IFS model is the belief that, in addition to parts, everyone is at their core a Self that contains important leadership qualities such as perspective, confidence, compassion, and acceptance. Every person has a Self and the Self can and should lead the individual's internal system. For parts to work in harmony, they have to be informed by the presence of this core identity or the Self. When differentiated, the Self is secure and able to listen and respond to feedback. An individual's parts are organized to protect the Self at all costs, and in the event of trauma the parts will remove the Self from danger as well as from leadership (Schwartz, 1995). In therapy, the goal of IFS is to differentiate this self from the parts so it can be an effective leader, to release its resources, and then in the state of Self, to help parts out of their extreme roles. The parts respect the leadership of the Self and provide input to it.

IFS Model and the DID Client

Schwartz (1995) refers to the individual person as though he or she were more like an "internal family." According to the IFS approach it is not the parts or subpersonalities by themselves that become an issue. Instead it is the lack of core integrating and coordinating functions that cause the DID client to fragment and become unable to functionally negotiate competing needs. Although integration is considered healthy and functional and the main goal for DID treatment is the integration of the separate personality states into a unified state, the clinical process can be distressing to someone who has relied on dissociation to survive. Therefore, a therapist must be able to assess a DID client's readiness and motivation to work with trauma. DID is similar to PTSD in that both are a result of severe trauma and the resulting hyperarousal is connected to the amygdala in the same manner. The major difference between the two disorders is that DID individuals unconsciously compartmentalize parts of their minds and then push those parts outside their consciousness, while PTSD clients experience emotional numbing. The internal parts are set in motion when emotion has been cut

off from the consciousness or when the brain is hyperaroused such that the DID client reacts as if he or she is faced with extreme danger even if there is none. If this takes place consistently, it impairs normal functioning.

The IFS model is a useful approach to understanding and working with DID clients. From the IFS perspective, DID is one way a person's inner family organizes after being chronically and severely hurt. The DID client's inner family is more polarized, isolated, and protective than the "normal" person's inner family. Hence the inner family of the DID client is less cohesive, and more tortured, than the inner families of those who have not been hurt as badly (Schwartz, 1995). The traditional family systems therapy views the family as a system or unit in which each member is impacted by all other members and the system as a whole is impacted by the individual. Therefore, behavior changes in one person within the system can affect the balance of the entire system. The IFS model understands that the nature of the mind is subdivided into "parts." DID is believed to be a more extreme manifestation of this concept. The goal of the IFS approach is to achieve balance and harmony within the internal system and to increase positive and purposeful communication among the self and other parts (Haddock, 2001). Although Schwartz (1995) views DID as a severe fracture and isolation of one's internal parts, he does not alter the application of the model with this population. When used appropriately with highly traumatized or disturbed clients, the IFS model can decrease the sense of fragmentation as their extreme, polarized, and isolated parts are able to integrate and feel harmony with all the other parts. Difficulty can arise if the therapist does not respect the managers and prematurely activates the exiles, thereby engaging the firefighters to trigger polarization and fragmentation. The techniques used to work with the different parts of the internal system must be used carefully with highly traumatized clients with DID.

Using Insight and Direct Access Techniques

The two different ways of working with a person's internals system or parts are "insight" and "direct access." Insight is a process by which the client describes and identifies his or her inner world and their parts to the therapist. The clients may also be able to differentiate the Self and later have the Self act as the therapist to the group of parts. In between sessions clients are sometimes able to engage insight to manage the parts and their responses. The second method called direct access is when the therapist talks to the parts directly or sometimes watches the parts speak to one another or to the Self instead of the process being described. This method is useful for clients who have difficulty describing the inner world of parts. Direct access also allows for a personal relationship to develop between a part and the therapist (Schwartz, 1995). Besides providing a direct intimate view of the inner system of the client, the therapist may be able to act as the Self for the system.

This method may allow the parts to express themselves more fully than through insight and in situations where the parts are directly relating to one another, the therapist may be able to intervene and create the possibility of emotional healing. It is not unusual to use a combination of both methods in working with clients.

Benefits of the IFS Model for the Client and Clinician

The IFS model is a powerful model for working with DID as the IFS language of parts lends itself well to the concept of fragmentation and dissociation in DID. For DID clients the IFS provides a clear way to address the Self and the parts, allows for a less fragmented internal system of parts allowing a process where the client can become more integrated as the parts are able to engage in positive roles. The concept of firefighters, exiles, and managers provides the DID client a concrete framework upon which he or she can build the process of integration of the fragmented parts or alters. The IFS model is an efficient way to work with resistance and denial, which are often displayed by firefighters and exiles. The language of parts in this framework allows for the mapping of alters in a nonjudgmental way, which helps in self-disclosure. The communication between alters can be achieved with either direct access or insight and finally the model provides a mechanism to differentiate the Self into becoming competent, secure, and self-assured and able to receive feedback. The presence of a unified self is crucial for integration of the DID client who can then learn to manage complex environments successfully.

CASE EXAMPLE

When Emily was referred for therapy by her primary care physician, she was 52 years old. A White American with type 2 diabetes, high blood pressure, migraine, hypercholesteremia, obesity, recurring kidney stones, reflux, severe back pain, among numerous other health problems, Emily was also diagnosed with depression, anxiety, and PTSD.

History

Emily grew up in a home where her parents were not just unavailable to nurture and parent her, they were reportedly physically and emotionally abusive during most of her early childhood years. She also reports being sexually abused by her father and two of her brothers. She has distinct memories of her mother being "unwell," emotionally, with numerous inpatient hospitalizations at the state institutions. She remembers her mother barely being able to parent her. Instead she often took care of her unstable mother when

she was at home. Emily believes that her mother probably suffered from schizophrenia. Emily reports struggling with her parts and dissociating as a young teenager and believes that she usually dissociated when she was being abused. To escape home and abuse, Emily ran away when she was 16 and got married. Emily is a mother to three children who have their own families. She has been married and divorced twice. She reports experiencing abuse in both these marriages including emotional and sexual abuse. She has been in numerous relationships since her divorce and has been a recovering alcoholic for several years. Overall she is challenged by depression, PTSD, and stress-induced anxiety that is often related to the appearance of her alters. Emily states that she would like to be closer to her family, but believes that every time she makes an effort to be closer, her family members distance themselves from her. She reports feeling left out of her family group and somewhat isolated from them.

Initial phase: confirming the diagnosis; establishing trust, safety, and rapport; uncovering and "mapping" parts; and planning for stabilization

Emily approached therapy fairly cautiously. She had been in psychotherapy with several therapists at various agencies in the past to work on issues related to her addiction, abuse, and struggle with relationships. Developing and maintaining trust was not easy for her. She had sought help at different times in her life, usually when her symptoms made her life quite dysfunctional. When she was referred for therapy by her physician, she agreed to work on managing her stress and depression.

Very soon Emily began describing her experiences of depression and loneliness since childhood, the lack of parental nurturance, and the feelings of abandonment as a child. She described anger and disappointment at several members of her family for not being able to be present and supportive of her during difficult times such as when she was experiencing health problems and going through her divorce. It was during a session when she was describing her anger that she also mentioned how angry she was at her brother (one of the siblings who had sexually abused her). This was the moment she split into one of her alters. She described it as the "vengeful, angry" part. In subsequent sessions she reported being diagnosed in the past as having MPD now known as DID. Because she could not remember how long ago she had been diagnosed and she did not have any documentation, we agreed to follow up with appropriate assessments.

Over the next few months Emily was formally assessed as having DID. Emily engaged in therapy almost weekly if her health and physical capacity permitted it. She was very conscientious about our appointments and always called ahead if she had to cancel. Over a period of weeks, I introduced her to the idea of getting to know all her "parts" and working with them together rather than in opposition. Because she was already familiar with the concept of

her internal parts, there was no difficulty with the language of parts. It was also important for me to normalize her multiplicity at the very beginning of this process. This had prompted her to ask me if I had known others like her. I explained the model of IFS in a simple manner. I explained that as person with DID her parts were significantly fragmented and that the leadership of the Self would be an important goal for therapy. She also understood that, in general, parts could be experienced in numerous ways including thoughts, feelings, and sensations; that all parts want something positive for the individual and will use a variety of strategies to gain influence within the internal system; and that parts develop a complex system of interactions among themselves—polarizations develop as parts try to gain influence within the system. She was very aware of the moments when she had experienced polarizations, some of which had made her suicidal or engage in her addiction of choice, alcohol. I explained to her that the overall goals of therapy were to achieve a sense of balance and harmony within her, which in turn would help her feel less chaotic and fragmented and that ultimately her Self would be able to engage all her parts in nonextreme ways. Emily was very amenable to this idea, and she then came up with the analogy of a "committee of parts" sitting at a table to work together, with the Self at the head of the table. The Self would be able to engage with all the parts, receive input from them, and provide leadership to the whole committee effectively.

Despite her understanding of the process and goals of therapy, and coming to a contract for this internal work, Emily was cautious about being vulnerable and did not discuss her inner world right away. She was comfortable discussing her everyday life with chronic pain, diabetes, and depression. At this point it was her manager in the lead trying to develop trust in me. It was only after several sessions that she was comfortable engaging with her more vulnerable parts: the firefighters and the exiles. Emily was able to identify her parts and name them. Although the names did not describe the roles the parts had, she was able to explain each of their roles.

The IFS model assumes that everyone has a Self that, once differentiated, can balance and harmonize the internal system. When a client cannot do this, the client's Self is constrained by imbalances in the surrounding system (Schwartz, 1995). In Emily's case, whenever there is extreme stress, instability, and she experiences disempowerment, her scared and hurt parts (Susan, Judy, and Sally) break out of exile and take over the Self. When Emily's three exiled parts take over, she can be destructive, self-mutilate, and turn to drinking. It was helpful to first separate her two significant exiles from the Self and encourage the Self to calm them, which in turn helped her managers (Heather, Nancy, and Connie). In order to work with the exiles, I had to first seek permission from the managers and for this process as well as for most of the identification of her parts, the direct access method was far

more efficient. Being able to talk directly to Emily's parts especially the exiles provided an understanding of how the parts felt and what fears and concerns they have. Emily was also able to identify her two firefighters Julie and Jessica. Often Julie's impulsive nature could push Emily to polarized views leading to fragmentation, chaos, and destructive behavior. Seeking permission from the managers and directly speaking to the parts can allow all the parts to recognize the process and pace of therapy.

Intermediate phase: teaching coping skills and affect regulation; treating traumatic memories; and improving communication between parts/alters

This phase of work began after Emily's parts were identified and labeled, and the managers and firefighters had been able to negotiate for the exiles to engage. Susan and Sally were the most active hurt parts at the beginning of the work and during a direct access conversation Sally mentioned her fear of being abandoned by Emily and not knowing if she was capable of taking care of her. It was important for Sally to know that she would be able to cope. These extreme feelings and thoughts do not characterize the Self.

The process of retrieving the parts and unburdening them can be difficult. Emily once again approached this phase of work with caution and concern since her internal system felt more vulnerable. Because the exiles or firefighters did not have to respond through their extreme roles, the managers had to be encouraged to express their fears and concerns. Because the nonextreme intention of each part is something positive for the individual and there are no "bad" parts, the goal of therapy is not to eliminate parts but instead to help them find their nonextreme role.

A crucial aspect of this phase of work was to allow the groups of parts to express their emotions in the context of traumatic memories. For example, Sally, an exile, often becomes vengeful and destructive when she realizes that Emily's Self cannot handle or manage a difficult situation. On the other hand Julie who is a firefighter can become aggressive and dominant and overpower Emily. Treatment of traumatic memories included the parts describing the traumatic events and explaining how the extreme roles developed. Initially through direct access it was helpful to speak to each of the parts with curiosity to understand their need to be polarized into extreme roles and emotional states as well as sometimes act as the Self in the system. Emily later stated that it was the first time any of her parts were able to describe a traumatic experience of abuse in the past in a comprehensive way. It was also important for the parts to get to know me and understand that we (Emily and I) were going to help them. Through direct access conversations it was possible to engage the parts into learning to be less polarized by letting them know that Emily would seek their help when she needed them.

At this phase I began using the insight technique to empower Emily to engage her Self to now take the lead in talking to her parts. Through insight, Emily was able to request that the vulnerable parts become calm and to set some expectation for them. She was directly able to directly teach her parts appropriate coping skills and emotions. The developing ability of Emily's Self to engage with her alters or parts, especially when they were vulnerable and ready to become destructive, allowed her to begin creating a distinct sense of identity for of her Self. As Emily began talking to her parts and becoming more comfortable taking the lead, she was able to be more supportive of her parts rather than just direct them. A relationship between two highly polarized parts can take place only when they each can trust that the Self can lead and not let the other take over.

Most of her life Emily believed that having feelings were bad. At this phase of therapy, Emily understood that feelings are a natural aspect of being human and that she needed to modulate her feelings and handle them appropriately. She believed that claiming her feelings was one more way of not letting the abuse control her life. For Emily one of the difficult parts of trying to integrate was accepting her exiles and knowing that they wanted to hurt other parts. Because these thoughts were unacceptable to her, they had to remain dissociated. Accepting the exiles and firefighters allowed her to stop acting on their thoughts and feelings thereby separating the past from the present. Learning nondissociative coping skills such as self-talk through the feelings helped them and other parts to calm down.

Sometimes Emily's constraining external environment made the process difficult and complex. However, the knowledge that the internal system of parts can have their own pace is important. Being able to empower and appreciate the wisdom of the parts can help them avoid polarizing into extreme roles. This phase of work where the parts are able to learn how to manage affect, process trauma from the past, and allow the Self to lead can take some time. It is important to not rush through this phase of clinical work in order to provide a good foundation for the next phase of integration.

Integration phase: developing a unified, new self to manage a complex environment

One of the complex aspects of DID clients is the development of a clear and distinct self. Because a solid Self is necessary to manage a complex environment, it was helpful for Emily to have a metaphor as an anchor to remind her of how her Self is the leader. She described her parts as "a committee" who often needed to come together in a meeting where she would need to lead. Emily was able to visualize her parts that formed the committee sitting at a table while she sat at the head. If while watching her parts Emily reported any extreme feelings or emotions such as being overwhelmed with them, or knowing that they were angry at one another, she was asked to identify the

parts that influenced her to feel the extremes, invite them all to the table and when the Self was ready to take the lead, she could help resolve the issues between them.

In one of the sessions, exile Sally and firefighter Jessica were moving to their extreme positions with a positive intent for Emily to be protected when she had made a decision to go visit a brother in the hospital. Emily was concerned about him, especially because he was in a critical state of health. This was also one of the siblings who had abused her sexually during her preteen years. Emily's attempt to connect with her brother after many years of not seeing or talking to him was motivated by the desire to see how well she could handle herself and all her parts and to let go a part of her traumatic memories. After discussing the issues and having her work though insight with her parts, Emily found the courage to visit her brother in the hospital and face him. This experience was a profound one because she found herself being in charge and despite feeling vulnerable did not fragment. She later reported that she had been able free herself from a powerful emotional memory from her past.

Another important aspect of this phase of work and in using the IFS model with DID clients is to recognize that the Self may take awhile to differentiate and take the lead. In order to ensure that the DID client's Self is always in the lead after a session, it is crucial to ask to speak with the client's Self, after using the direct access or the insight method. It is understood that both the internal and external levels of an individuals system must be assessed. With a DID client this assessment is ongoing and crucial as the parts may take on less polarized roles. It is important to know that while the IFS model can help the parts to be come depolarized, and unburdened, they may return to the extreme roles when faced with new challenges or what may be perceived as stressful moments. Although this may appear to be a relapse in the face of threat, it is to be expected that parts return to their familiar roles temporarily and can hopefully leave their extreme positions once they realize that that the role is not required.

Some Reflections

As a clinician I had to constantly remain aware of whether I was talking to or observing a part or the Self. When I used the direct access method to speak to parts who were fearful and hurt, it was helpful for me to remember that in some instances, I was serving as the Self for the system. Integration is accepting the whole person, including the firefighters and exiles. One of the major fears expressed by Emily was the possibility that, after integration, the parts of her Self would be lost. The reality is that after integration, the parts of the Self are closer and more genuine as the dissociative barrier no longer exists and the aspects of the Self are experienced directly. Another distinct capacity that Emily began to develop as she became more integrated was

the ability to experience internal conflict. Previously different parts and personalities handled different points of view. Presently she is comfortable having different thoughts, feelings, and viewpoints and having the ability to act as she wants in the present. Emily's current goals are to be able to recognize when stressful events occur so that she can experience her polarized feelings and respond appropriately.

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