A Multi-disciplinary Approach to Rapid Unification of Dissociative Identity Disorder (DID) Using Neurofeedback

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Keywords: Dissociation, DID, Neurofeedback, Alpha-Theta, Infra-Low, Play Therapy, Sand Tray.

Curriculum, Instruction, and Pedagogy

1. Abstract

2. Introduction: Background and rationale for the educational activity innovation

This is an instruction to a multidisciplinary approach for working with dissociative identity disorder (DID) for the purposes for the purposes of reaching "unification" or integration of the patient with DID. The term "unification" is used to describe a person who experiences internal harmony between all parts but does not relate to the experience of integration. This will be explored more at the end of the article. This work should be done by a psychotherapist or psychologist and requires some prior experience with dissociation, internal family systems, Play Therapy, Infra-low Neurofeedback, and Alpha-Theta Neurofeedback. Regular consultation and supervision are generally advised. For readers who are proficient in these systems, or willing to become proficient, this article may be useful in providing an outline for the rapid resolution of symptoms.

3. Pedagogical framework(s), pedagogical principles, competencies/standards underlying the educational activity

You'll start off by engaging in containment and psychotherapy with your patient. This process will take at least six weeks and elements of it will continue throughout the rest of your work, such as the containment through processing the rules that will be outlined. The second phase, Play Therapy with a sand tray, gives the patient space to express their internal family system. In this work, the patient will be directed to pursue resolution of internal distressing conflict. This stage may be utilized later at any point in a single session for resolution of an acute stressor. In the third stage, Infra-low Neurofeedback is utilized to increase patient regulation of mood, energy, sleep, and to decrease arousal level. The last stage is a Neurofeedback protocol called alpha-theta, which is used until the patient has achieved internal unification or integration. This stage, if done right, is typically experienced with catharsis, rather than re traumatization. Many us therapist can related to be being classically trained to think "you have to feel it

to heal it". At the end of the article, we will explore how this orientation may be misleading for our purposes and any utilization of this philosophy could slow the progress of our patients.

Equipment Needs

a. Sand Tray
b. Fifty or more small toys the size of finger puppets
    i. Various characters meeting characteristics such as aggressive, fanciful, heroes, victims, and abstract.
    ii. Various barriers are also needed.
c. Floor Space (rather than a stand)
d. Neuroamp II
    i. Ag/AgChl sensors
    ii. Sensor jumper
e. Cygnet Software bundle
    i. Task based games
    ii. Passive feedback programs
    iii. Alpha-theta Reflections
f. Marshall Mid ANC Active Noise Cancelling On-Ear Headphones
    i. 3.5mm audio cord
g. Zero Gravity Perfect Chair
h. Call button

Step 1 – Psychotherapy Rules

Using Internal Family Systems with a patient with dissociative identity disorder (DID) comes very naturally because they present with very fractured personalities. These personalities can appear distinctly different from one moment to the next. One moment you may be working with a fully actuated adult and the next the patient may present as in the mental state of a frightened child. These "parts" can be incredibly developed and may seems as if they are entirely whole person, or they may seem extremely simple, as if they are only a moment of a trauma or a part of a memory. This process of splitting parts started because in early development, the patient experienced something that was too complex for a child to process. Adult problems require an adult brain, but the patient did not have an adult brain, so they "split" from the experience, but in time, sometimes decades later, realized that it created a split within themself.

If you ask the patient, "what would happen if you had not split at that moment?", the answer is always the same, "I would have (somehow) died". So, your patient chose to live. This alternative is rarely considered.

Rule: "The first split was the best choice"

Some of the hardest most damaging things are the narratives that we are telling ourselves. Often because of suffering and egocentric developmental stages, every part of a person can have negative beliefs about their experiences and choices. As a therapist, we must help re-orient our clients productively. Splitting is not necessarily the best outcome in all subsequent events, even if used. Once the brain unconscious learns this trick, it becomes more willing to use it and with a lower criteria.

These cuts run so deep, and the divide is so wide that these parts of themselves feel completely alien to them initially. You may have to remind patients that all these parts work within the same central nervous

system and the projections of external communications, such as the therapist/patient relationship, is ultimately too limiting. Patients have very complex relationships to their own information. Some divisions between parts are so deep that semantics apply between parts within your patient. Entire internal conflicts can revolve around parts having different definitions of the same word.

Rule: "The therapist should say only what they know to be true."

Because the patient is comprised as a host of different constructed realities, the therapist must be more careful about that they say. This doesn't mean that the therapist can't propose a theory or state what they think, but there's a difference between how a therapist will frame a theory and how they will state a fact. Being very careful about what you say and how you say it will earn enormous amounts of rapport when you choose to state a rule or other similar finding with certainty. Therapists must be willing to be wrong most of the time so that when the therapist is certain, the patient can orient more effectively to the difference in their stance. The rules outlined in this section are starting place for some certainty. A therapist is not likely much more certainty in this work.

Some of these divides are between parts and some of these divides occur within a single memory and may or may not present as a part. For functional purposes, you can break a memory down into three parts: cognitive, emotional, and the somatic. These three components can be unintegrated, if not completely suppressed. In the case of clinical intake paperwork, this dynamic can cause significant distress in a patient. The paperwork is often extremely distressing because they do not have the ability to negotiate internal consent for the disclosures that you are requesting. Having DID patients fill out paperwork in the lobby should be avoided. It would be best if this was worked on at home or in your office, rather than in the lobby. In the process of recalling cognitive memory, the patient may begin to recall emotional or somatic memories and become distressed. The patient cannot always hold reality and continue with their thought or story.

Rule: "You can change anything and there's no judgement from the therapist."

Sometimes they are suddenly and unexpectedly overcome by internal resistance and there's no way forward. In their regular life, without having this acknowledged in a clinical or close relationship, they may have had to lie to resolve the predicament. You should start off by acknowledging this dynamic and encourage them to do whatever they need to do to get through the session peacefully and that you won't hold future changes against them or be offended. You should encourage them and remind them that you will help them develop verbal or physical cues that indicate when they are having to manipulate something to avoid internal resistance. The therapist must commit themselves to total flexibility and they'll need to repeat this rule and demonstrate it before the patient will trust them. The therapist will also need to negotiate for exceptions around safety and a method of notification. Often there is a part within the internal system that is willing to take on this responsibility.

Gaining trust with a patient takes time and is earned by acting out the rules you repeat the client. Even after the patient has demonstrated trust for the therapist, it is very unlikely that every part has come to trust the therapist. The patient will go through an extended period of orienting to the environment and to the therapist.

Rule: "This space is a safe place for all of you."

Whether the patient presents openly with parts that switch or whether they are more covert, you should encourage them to allow this space to be available for all parts. Repeating this rule will inevitably cause parts to switch to the "front", so that they are speaking and assuming features, such as posture, or in an observational manor, which has different cues for each client. When a part is observing you'll still observe the same personality in front, but you will see gestures, affect, or mutterings, or sometimes a mixed personality occur. Sometimes you'll be unaware of it completely.

The patient will likely be anxious about you working with one or more parts for many different reasons. Some common reasons are safety of others, self-injuring behaviors, denial of DID, and parts that contain too much pain. Therapists generally have good instincts and training in emotional congruence when working with a part of someone filled with pain and grief. Often these parts are suppressed so deep that when they surface, they are not aware of the fact that they are in your office. It's the therapist's discretion as to whether to orient them to their environment or not.

Rule: "When the therapist speaks to a part, they speak to all the parts"

If you discuss something that relates more to another part in the system, or discuss another part directly, they will move towards the front, even if they never front. You don't have to work with all parts because of the use of Neurofeedack into this multi-disciplinary model, but it's worth knowing that you could if you had to do it. There are parts you will have to work with because of acute stressors that are disruptive or could be disruptive to their safety, psychotherapy, or Neurofeedback. Throughout the processes, especially during the psychotherapy and Play Therapy sand tray sessions, your job as a therapist is to model the posture that they lack towards themselves, which is a posture of empathy, curiosity, advocacy, and openness.

Rule: "The therapist models a posture that the patient needs towards their parts."

As with all the rules, it's best to remind them regularly of the rules. You may get a sense that they have a harder time accepting or believing certain rules. This one is more likely to be one of the rules that they have a hard time accepting. You may observe them dissociating from this rule and it may take a while for it to sink in.

The patient is likely going to struggle with the idea of having empathy and openness for many reasons. One reason for difficulty is fear of a part that is dangerous, and this is probably true, but when seen in full context, empathy and understanding are automatic.

Rule: "There isn't a monster inside. There are only necessary heroes."

There wouldn't be a part that strong if it wasn't at some point extremely useful. Often when the narrative comes out in sand tray or Neurofeedback, you can ask, "what would have happened if this part was not so aggressive. They always answer, "I'd be dead" or "something worse". Internal gratitude for our aggressive parts is always the outcome. Knowing these parts better and having a posture of gratitude automatically diffuses the threat.

As a part becomes better known by the patient, unless this process occurs through specific Neurofeedback protocols, they will feel that parts distress and will have to cope with that parts reality.

This occurs whether they experience classic integration or merely a unification of parts where there is no internal conflict and a synchrony between the parts is observed by the patient.

Rule: "Sharing goes both ways"

When experiences, memories, or values are felt from a part, that part in turn becomes more amiable to the patient's value system. The relationship is always a two-way street. Suppression is also a two-way street in the opposite direction, which is why suppression inevitably leads to loss of control in the long run and a posture of openness, empathy, and curiosity will always lead to stability eventually.

Rule: "Every part of the patient wants to be known, loved, and served"

This process meets with little to no resistance because deep inside, every part of every person wants to be known, loved, and served. Reciprocally, these parts of a person can serve the greater function. Even the small lost shards of our patient's trauma that are sometimes merely moments of time or pieces of a moment, but restoration can bring a sense of post-traumatic growth, self-reconciliation, and wholeness.

Rule: "Every part of the patient is significant and purposeful."

Having the patient commit themselves, as they understand themselves, to the purpose of self-recovery is critical. They shouldn't be allowed to come to you with the goal of suppressing parts of themselves further. This may occur occasionally due to overwhelm or due to safety, but generally, with few exceptions, every intervention and every sentenced uttered by the therapist moves the patient to a more unified state if we are intentional about our words and affect.

For many reasons, it is not uncommon for a patient to report that they feel a part has died. This report can come with great certainty and fear. This can happen for many reasons and this state can be maintained for years.

Rule: "No part of the patient is ever lost for good"

If the patient has determined that they are ready to recover this part of themselves, the need only to gather as much of themselves as they can and grieve. It's that simple. If they report that a part has fallen into a deep sleep and cannot be woken, they need only gather as much of themselves as they can and express their desire for reconciliation. The modality that will serve effective for this intervention is the sand tray Play Therapy approach.

Patients are not normally hesitant to start doing sand tray work. As the patient begins to start doing sand tray work or Neurofeedback, they will become nervous of this practice because of it's ability to shift their internal system.

Rule: "Neurofeedback and Sand Tray just help the patient organize their mind"

This is the last rule that you'll repeat. They are often not expecting how much it increases their capacity for organizing their internal system. They do not usually have positive associations with change and this approach brings change. This rule is very important for Neurofeedback because it's such a novel

intervention. Both dynamics will be discussed in later sections. Typically, you will acclimate them to the work of sand tray before adding Neurofeedback. This functions as stair step and the benefits will be explored later in this article.

Step 2 – Sand Tray

The sand tray, for our purposes, is a form of Play Therapy that gives the patient a space to work out their internal system. 1. The sand tray be placed on the floor or wide table. 2. Disrupt the sand with your hand so that it is uneven and disheveled. 3. Pour the toys out onto the space adjacent to the sand tray in-between you and the client. Keep the box nearby in case you need to "close the box", you'll need something to cover the work with when they are done. It is important to restate that prior training in non-directive play therapy would be useful for this exercise, but there is one modification to the non directive model; you will direct the client to "find yourself out of the toys and place it in the sandbox, along with anything else that's up in your mind." From that point on you can assume a non-directive model. This article does not substitute training for competent practice in Play Therapy, but it will highlight the more important tenants.

Remember these principles: 1. Never define something that isn't previously defined by the patient. This goes hand in hand with the rule that the therapist should say only what they know to be true. 2. Never touch the sand tray or its contents once the process starts. 3. Use non-judgmental observation-based comments. 4. You cannot ask questions, but you may occasionally state your curiosity. Use this sparingly, as it will likely disrupt the patient's process. 5. The patient does not clean up after the sand tray. You are supposed to cover it up as soon as it's over. The therapist should keep a cover nearby.

Sand tray is much more efficient than talk therapy with resolving internal incongruences with someone with DID. The patient will likely present as quieter with long pauses in-between shifts in the toy's positions. This process requires the therapist to be supportive through the event by reflecting feeling and content, but it does not often require the therapist to provide more significant interventions. The patient will likely do all the work in their head while holding two toys in the sand for several minutes. At each change, the therapist will verbally reflect feeling and content. The therapist's understanding is not important. The patient will likely explain everything when the process is over. The average sand tray experience last lasts 20-30 minutes on average to resolve a dispute or incongruence within the internal system. The resolution is not difficult, but the implications from the internal shifts from that half hour can be very distressful for the patient because of their negative associations to change. Under the simplest and easiest of sand trays, they will have a headache following the encounter. On more difficult sand tray experiences, they may even feel compelled to go home and sleep. Sand tray is effective but it's hard work. It's also the kind of work that would take a few years if we didn't find ways to improve on it.

Step 3 – Infra-Low Neurofeedback

Integrating Infra-low (ILF) Neurofeedback into the treatment regimen is difficult but can make a substantial difference in the patient's experience. The goal with ILF Neurofeedback is to increase the patient's overall function and stability. Using The Othmer Method, you can see greater management of the headaches, increased sleep regulation, increased dreaming (REM rebound), and decreased arousal.

The patient may need some time getting informed consent to do Neurofeedback. It is wise to use the sand tray to process this therapy with the parts if there is trauma around electrodes from past hospitalization. You can offer to put a pair of sensors in the sand tray toys before the start of sand tray.

You can also offer to let them take the sensors home with them, so they have time to get comfortable with the sensors.

When the patient is ready to do ILF Neurofeedback, you will be following the Othmer Method and additionally, you should start them on a task-based game for the feedback. This will keep them distracted and it will help keep parts from raising too many concerns too quickly. Keep the session to a shorter 15-minute for the first few times. As you start to get progress with symptom tracking and frequency optimizing, you can increase the session length and eventually you can offer a non-task-based feedback option. This will prompt more parts observing, and even fronting to observe the Neurofeedback process. By this time, you have built some trust and favor with the patient, so when parts front, you have a foundation for a positive outcome with other parts, instead of an anxious just rumination.

During the session, the patient may experience different sensations such as tingling in their fingertips or possibly toes. This sensation is a normal response. Some sensations, such as overarousal and under arousal indicators are normal in the optimization period and are generally well understood by Othmer Method trained practitioners but may not be readily felt by or recognized by a dissociative patient. It is best to have a wider and more optimized symptom tracking system. Most clinicians use an online automated system that can be customized to each person. Additional training, biometric equipment, and experience can eventually help with real time optimization of the frequency.

The dissociative patients that feel the effects of Neurofeedback need help normalizing these transient experiences. Some patients are not used to feeling bodily sensations and may have negative associations to normal indicators. The optimization process often requires more attunement, containment, and understanding of your patient than a typical patient.

Patients with well optimized Othmer Method protocols can engage in psychotherapy and sand tray Play Therapy with less distress and headaches. They can go deeper in their work more quickly and tolerate the work longer. Patients will often request or will benefit from being offered ILF Neurofeedback before a difficult or intimidating sand tray experience.

Step 4 – Alpha-Theta Neurofeedback

Once the patient has expressed that their desires are in line with the outcome of the sand tray work, meaning that they are genuinely seeking self-restoration, and the patient has an optimized ILF Neurofeedback protocol, you can start the process of working towards Alpha-Theta Neurofeedback. This is the right time to remind of the rule that Alpha-Theta just helps them organize their mind. If the patient is struggling with adding this intervention, the therapist should re-assure them that the outcome is in line with the work of the sand tray. Alpha-Theta Neurofeedback, when done properly, is more effective, less stressful, and less conscious than the sand tray work.

Alpha-Theta Neurofeedback, for this purpose, is going to be offered daily until unification or integration is reported. This process takes 10-15 days on average once the patient is properly oriented and when done correctly. It is optimal for the patient to be sitting a “zero gravity position”, meaning that they are to have equal tension on all ligaments in their long bones and the chair should be oriented so that their knees are at or above their heart in a position of comfort. This can be done using a Zero Gravity Perfect Chair by Human Touch. The therapist should use noise canceling headphones like the Marshall Mid ANC Active Noise Canceling On-Ear Headphones, which allow for noise canceling, and do not disrupt the sensors or the patients comfort by avoiding pressing the neck of the sensor into the patient’s neck. The software should be Alpha-Theta Reflections with delta inhibits enabled and bi-neural beats enabled. The lights should be dimmed or off. The therapist should regularly discuss comfort level with the patient and make

appropriate adjustments. Once the patient is comfortable with the environment and familiar with the tones of the feedback, the therapist should start to transition to being out
of the office. The patient should have a “call button” that would ideally be familiar from initial orienting phase of alpha-theta that they can use to call the therapist back in the room.

The pre-emptive normalization of the Alpha-Theta experience is a critical part of the process. Most patients will have somatic experiences and shifts within their internal system. The somatic experiences are most often defined as “weird” and are not often accompanied with distress if pre emptively normalized properly. These somatic experiences can be transient experiences of feeling pressure, changes in temperature, tingling over former injuries, bi-lateral peripheral tingling, lucid dreamlike states, vivid recall of past events, muscle tension shift, and much more. Some non-transient changes can occur, such as a shift the perception of color or taste. Most patients will seek re-assurance that these experiences are normal or may just be eager to share their experiences. It is important to remind them periodically that these strange experiences are a positive sign that their nervous system is re orienting.

Patients will experience shifts within their internal system. This is something that, due to sand tray, they are likely to have positive beliefs about, but not positive feelings about, because of their past experiences. These shifts can be quite large and a single shift in one alpha-theta session may prompt the temptation by the therapist to stop and orient to this change, which is always an option, but if safety is still established, often the best protocol is to continue with daily Alpha-Theta. When the patient has experienced a complete unification of their internal system, you can stop and take inventory and additionally you’ll find it to be a very positive session. The patient will experience this closure suddenly, like the landing of a plane. The day before they will likely to be able express the concern that “this weird process will go on forever” and the next day they may walk in and state that they are done. The therapist can offer two or three more sessions to ensure that this is the case, but when the patient speaks this with certainty, the inevitable outcome from additional Alpha-Theta is reported to merely help with energy and wellness, but nothing weird. Following the completion of the protocol you will find that the patients likely have normalized scores on the Dissociative Experiences Scale – II. The patients will report a significant reduction in post-traumatic stress symptoms. Patients still find benefits in general talk therapy and report better results from intervention that the patients previously reported poor response, such as cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), and skills coaching.

4. Learning environment

This process is designed to take place in a individual clinical practice. It is always useful to have referral options or contact resources for local intensive outpatient programs or residential programs when working with severe mental illness, but this approach offers a protocol for more stable patients that can be offered in more accessible environments.

5. Results to date/assessment (processes and tools; data planned or already gathered)

This process detailed in this article has been in development and in use at Alternative Behavioral Therapy, INC (ABT) since 2010. ABT has graduated more than 50 patients using this method and has managed as many as 10 patients at a time with this method. From those 10 patients, 8 graduated with no amendments to the method outlined above and showed normal DES-II scores following their treatment. The average length of treatment for patients responding successfully is 2-6 months. ABT recommends some pursuit of formal study in the area. Some similar research has been conducted, on this topic. Individuals with DID are an area of enormous controversy in part because of their incredible drain on the mental health systems, lack of attenuation from treatment, and difficulty to research. DID may never

be viable for large scale research because of the lack of candidates and because of the difficulty with informed consent when a patient expresses with different parts may later express having not given consent. Conducting research on therapy is a form of dual relationship. Because of these complexities, it's likely that research will grow slowly in this area. Improving clinical practice and clinical outcomes in this specialty would lead to increased availability of publications. Patients who have fully integrated or unified are able and generally willing to consent to research post treatment, but not before.

6. Discussion on the practical implications, objectives and lessons learned

The internal family systems rules, which are often used as a repeated reminder to the client to help orient them in their highly disoriented state often teach the therapist about what is very likely true about all of us, but merely more apparent with DID. Some of these practices are not obviously required in general counseling sessions, but effectively working with the DID population has enhanced and improved therapist approach with their more general clients. These rules are true for everyone. As the American writer and poet Maya Angelou once, "We are more alike than we are different".

With the sand tray Play Therapy, the patient externalizes and projects their internal parts onto a toy. It becomes much harder to dissociate from a physical object that embodies the work. They are grounded by the tactile work in front of them and organized by physical space, rather than using mental. This advancement is usually enough to bridge the gap between failure and success if the therapist maintains the non-directive reflections of feeling and content. Classic psychotherapy uses similar mechanisms, such as the empty chair exercise, where the client speaks to an empty chair. This is done with the individual passed away or is inaccessible. Sand tray is example of the need of externalization, reference, and containment.

Neurofeedback is powerful tool for increasing general regulation and decreasing arousal. The patient can only take so much stress before they become avoidant of the interventions. Using ILF Neurofeedback, we lower their arousal and reduce headaches from sand tray work. This greatly improves their willingness to participate in the activity. The improvements from sleep, mood, focus, and mood help the patient start to develop a better relationship to changes within themselves. The Alpha-Theta Neurofeedback, the last step, resolves the dissociation and normalized the DES-II scores. These individuals don't usually overcome codependency, family, or marital issues automatically after this work, but The patients often report finding benefits from other therapies previously not successful.

7. Acknowledgment of any conceptual, methodological, environmental, or material constraints

NOTE: In 2011 Dr. Carol Clifton contacted me and asked if I was willing or able to offer Neurofeedback like the work of Carol F. Manchester, Tom Allen, and Ken H. Tachiki's *Treatment of Dissociative Identity Disorder with Neurotherapy and Group Self-Exploration* (1998). I had not previously read this research, but upon reading it, I began to build the method as outlined above, which was heavily based on this research. Peniston and Kulkosky's *Alpha-theta brainwave neuro-feedback for Vietnam Veterans with combat related post-traumatic stress disorder* (1991) was also a strong inspiration and encouragement to move forward.

The constraints within the use of this protocol are not known. ABT has only successfully used this protocol on patients older than 30 years old and younger than 60. Patient's with instabilities, such as

migraines, see regulation of these symptoms from ILF Neurofeedback, but irritation of these symptoms by sand tray or alpha-theta. This creates a "balance" and "counter-balance" dynamic with the different treatments and increases the need for protocol shift. This variable increases the possibility that the protocol will not succeed. This approach has not been attempted on patients with epilepsy for safety reasons.

8. Funding Statement

The authors declare that this writing was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. Joshua Moore is the sole contributor to this article. This article is funded by Alternative Behavioral Therapy, INC, which is the clinic that the Author owns. The funder, apart from the author, was not involved in the study design, collection, analysis, interpretation of data, the writing of this article or the decision to submit it for publication. The author declares no other competing interests.

KEY SOURCES:

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